Public Board of Directors

Schedule	Thursday 7 July 2022, 9:00 — 12:00 BST
Venue	Microsoft Teams
Organiser	Amber Fox

Agenda

9:00	1. Welcome and Introductions: - Victoria Pickles, Director of Corporate Affairs - Lindsay Rudge, Chief Nurse - Cornelle Parker, Deputy Medical Director - Emma Rhodes, Human Resources Advisor (Observer) - Nicola Seanor, Associate Non-Executive Director (Observer) - Invited Public Governors – Peter Bamber, Alison Schofield, Gina Choy, Christine Mills, John Gledhill To Note - Presented by Helen Hirst	1
9:01	2. Apologies for absence: David Birkenhead, Tim Busby, Nigel Broadbent, Robert Birkett To Note - Presented by Helen Hirst	2
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11:40	23.	Review of Board Sub-Committee Annual Reports 2021/22 - In the Review Room a) Workforce Committee b) Finance and Performance Committee c) Quality Committee To Receive	285
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1. Welcome and Introductions:

- Victoria Pickles, Director of Corporate Affairs
- Lindsay Rudge, Chief Nurse
- Cornelle Parker, Deputy Medical Director
- Emma Rhodes, Human Resources Advisor (Observer)
- Nicola Seanor, Associate Non-Executive Director (Observer)
- Invited Public Governors – Peter Bamber, Alison Schofield, Gina Choy, Christine Mills, John Gledhill

To Note

Presented by Helen Hirst

2. Apologies for absence: David Birkenhead, Tim Busby, Nigel Broadbent, Robert Birkett

To Note

Presented by Helen Hirst

3. Declaration of Interests

To Receive

4. Minutes of the previous meeting held on 5 May 2022

To Approve

Presented by Helen Hirst

Draft Minutes of the Public Board Meeting held on Thursday 5 May 2022 at 9:00 am via Microsoft Teams

PRESENT

Philip Lewer	Chair
Brendan Brown	Chief Executive
David Birkenhead	Medical Director
Ellen Armistead	Director of Nursing/Deputy Chief Executive
Gary Boothby	Director of Finance
Suzanne Dunkley	Director of Workforce and Organisational Development
Jo Fawcus	Chief Operating Officer
Alastair Graham (AG)	Non-Executive Director
Peter Wilkinson (PW)	Non-Executive Director
Andy Nelson (AN)	Non-Executive Director
Karen Heaton (KH)	Non-Executive Director
Richard Hopkin (RH)	Non-Executive Director
Denise Sterling (DS)	Non-Executive Director

IN ATTENDANCE

Anna Basford	Director of Transformation and Partnerships
Stuart Sugarman	Managing Director, Calderdale and Huddersfield Solutions Ltd (CHS)
Jim Rea	Managing Director, Digital Health
Andrea McCourt	Company Secretary
Amber Fox	Corporate Governance Manager (minutes)
Jenny Dyson	Lead Nurse for High Intensity Users **(for item 67/22)**
Alistair Christie	Community Matron, District Nursing **(for item 67/22)**
Devina Gogi	Guardian of Safe Working Hours **(for item 76/22)**
Richard Hill	Head of Health and Safety **(for item 77/22)**

OBSERVERS

Veronica Woollin	Public Elected Governor
Isaac Dziya	Public Elected Governor
Nicola Whitworth	Public Elected Governor
Christine Mills	Public Elected Governor
John Gledhill	Public Elected Governor
Nicola Seanor	Associate Non-Executive Director
Helen Hirst	Chair Designate
Tim Busby	Incoming Non-Executive Director
Nigel Broadbent	Incoming Non-Executive Director

60/22 Welcome and Introductions

The Chair welcomed everyone to the public Board of Directors meeting, in particular Jenny Dyson and Alistair Christie who were in attendance to share a staff story.

The Chair also welcomed invited governors and observers to the meeting.

The Board meeting took place virtually and was not open to members of the public in light of NHS Infection Prevention and Control requirements in healthcare settings. The meeting was recorded, and the recording will be published on our website shortly after the meeting. The agenda and papers were made available on the Trust website.

The Chair formally recorded his admiration, appreciation and thanks on behalf of the Board for Alastair Graham as this was his last Board meeting, stating he is extremely grateful for his advice, guidance and leadership.

The Chair noted it was his last Board of Directors meeting as Chair before his retirement at the end of June 2022.

61/22 Apologies for absence

Apologies were received from Peter Bell, publicly elected governor.

62/22 Declaration of Interests

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

63/22 Minutes of the previous meeting held on 3 March 2022

The minutes of the previous meeting held on 3 March 2022 were approved as a correct record.

OUTCOME: The Board **APPROVED** the minutes from the previous meeting held on 3 March 2022.

64/22 Action log and matters arising

There were no outstanding actions on the action log.

OUTCOME: The Board **NOTED** there were no outstanding actions on the action log.

65/22 Chair's Report

The Chair informed the Board he attended the West Yorkshire and Harrogate Chairs and Leaders Reference Group and will be attending a further meeting before his departure.

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

66/22 Chief Executive's Report

The Chief Executive reported the Board agenda reflected the focus over the past few months and for the future which remains challenging, and the conversation reflects our response to date.

The Chief Executive informed the Board that the Health and Care Bill has been passed which is the most significant change in health and social care legislation in over a decade. He explained this is about how health and social care is delivered, specifically in relation to health inequalities and how we safeguard women and children.

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

67/22 Patient/Staff Story – 'The High Intensity User Service and our impact on Patient Care'

Jenny Dyson, Lead Nurse for High Intensity Users and Alistair Christie, Matron presented a patient story which described the impact of the High Intensity User Service.

The High Intensity User Service (HIUS) is a multi-agency group which meet monthly to discuss service users who have either attended the Emergency Department (ED) five times or called 999 five times within a month.

There has been some form of HIUS within the Trust for many years; however, it has recently come into focus how impactful this service can be to some of CHFT's most vulnerable service users.

The High Intensity Unit at Calderdale Royal Hospital (CRH) is led by Jenny Dyson who previously worked as a Community Matron and the Huddersfield Royal Infirmary (HRI) HIU is led by Alistair Christie, a former ED Charge Nurse.

Jenny Dyson gave the background of how the service had developed, including governance, information sharing, performance monitoring and cost saving and shared patient stories from the HIUS which evidenced the positive impact the service is having on patients.

Jenny explained how the "Burnt Bridges" report, a thematic review into the deaths of five men living street based lives over a four month period during the winter of 2018/19 was an impetus for change within Calderdale. There are now fortnightly 'Complex Lives' multi-disciplinary teams (MDTs) where vulnerable people are discussed among professionals from various agencies. The HIUS has also recently started a clinic on Union Street, Halifax looking at engaging directly with this population and offering support.

Alistair Christie shared data from the dashboard which showed the total visits to ED for HIUS for the three months prior to intervention, visits to ED three months following the initial intervention and the impact this had in the reduction of visits to ED and the total cost. This dashboard allows the team to see the statistical and financial impact of the HIU involvement and allows the team to work more proactively.

Board members complemented the team on their focus on patients, partnership working, leadership, commitment and innovation.

Discussion took place on:

- the value of metrics to measure the impact of the service and the success of the scheme given the complexity of agency working and differing national approaches to HIUS, with most services run by a voluntary agency rather than nurses (Nicola Seanor)
- interest in hearing how the service progresses and potential for further clinics in different locations (Karen Heaton)
- next steps - the Managing Director for CHS shared details of a similar scheme in Lancashire that had been peer reviewed by the University and Council and offered to put the HIU team in contact with the leads
- how agency working had been achieved (Alastair Graham), noted to be by working at an individual patient level, for mutual benefit with close partnership working
- how to link this service with other homeless charities (AN) - it was noted the service has input with the MEAM (Making Every Adult Matter) Strategy Group and strong relationships with an alcohol and drug managers for Calderdale Council and the Mission homeless service at Kirklees

The Director of Nursing stated how proud she is of the team and the service which has many benefits, such as helping with operational pressures in A&E and patient experience, commitment to reducing health inequalities with a real value of community services working together, noting how nurses are at the forefront of this innovation.

OUTCOME: The Board **NOTED** the staff and patient story from the High Intensity User Service.

68/22 Health Inequalities Progress Report

The Director of Nursing updated 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 noted key achievements to date. The key points noted from the workstreams were:

- External Environment – continue to work with partners across Kirklees Council to look at inequalities that have arisen as a result of the pandemic

- Lived Experience– good progress in terms of smoking cessation, key driver of clinical outcomes for mums and babies
- Discovery interviews in maternity continue – most women are happy with the care, useful feedback received around visiting arrangements
- Public Health Registrar working with the Trust, cultural competency training package will be rolled out and health inequality dashboard being developed
- Mental Health Nurse Consultant for Midwifery has been appointed
- Continuity of Carer – 26 women booked onto a carer pathway and 76% of women from BAME background have been booked onto this
- National leader / public health registrar and colleagues from the Health Informatics Service are attending NHS Expo in June 2022 to talk about the great work being undertaken at CHFT on reducing health inequalities and future plans

Discussion took place on the following:

- Positive progress made and the need for the Board to hear from staff networks about their work (KH)
- Details of how the Mental Health Nurse Consultant role will support addressing health inequalities, in response to a question from RH given the risk on the risk register re: caring for young people with mental health issues
- Key actions that have reduced waiting time differentials (AG) - noted to be sharing data with clinicians and discussion with patients waiting a long time to refocus case management
- Future plans for lived experience work (AG) - it was noted the current focus of discovery interviews currently is maternity to improve the provision of culturally competent care
- Approaches to reduce DNA rates in more deprived areas (DS) - noted this was due to work commitments with a focus on giving enough notice or supporting people in those circumstances and communicating with the communities on the best use of resources in their area

OUTCOME: The Board **NOTED** the progress in relation to CHFT's response to NHS expectations of providers in tackling health inequalities.

69/22 Place Based Working in Kirklees

The Director of Transformation and Partnerships presented a paper to provide an update on progress to develop the place based partnership agreement in Kirklees and seek agreement to approve the Kirklees Place-Based Partnership Collaboration Agreement, for the Trust to be a member of the Kirklees Integrated Care Board.

The Director of Transformation and Partnerships explained the West Yorkshire Integrated Care System (WY ICS) has been progressing work to implement the Health and Care Bill which will see the ICS as a statutory body from July 2022. This is an important step for West Yorkshire and there will be a local Sub-Committee of the WY ICS that will make decisions about planning and spend going forward.

The Chair explained the Trust have a similar agreement with Calderdale.

OUTCOME: The Board **APPROVED** the Kirklees Place Based Partnership Collaboration Agreement.

70/22 Operational and Financial Annual Plan 2022/23

The Director of Finance presented the draft operational and financial plans for 2022/23 for approval which had been reviewed by the Finance and Performance Committee.

The key points to note from the financial plan and budget book were:

- Final financial plan submitted shows a £20.1m deficit plan for next year
- This is a £3m improvement from the previous plan proposed at draft stage
- This is after delivery of £20m of efficiency savings and £5m of covid costs (a 5% efficiency target)
- The financial plan incorporates additional expenditure in relation to the recovery of planned clinical activity in line with national expectations of achieving 104% of 2019/20 activity levels. It is assumed that Elective Recovery Funding will be secured in support of this, though this is dependent on ICS performance.
- Risks flagged: assumptions around the levels of covid activity, significant improvements on number of patients in beds who are fit for discharge (delayed transfers of care)
- Overall financial plans remain challenging with challenge by the ICS
- Number of deep dives are taking place
- Work will continue over the next few months to improve the financial plan
- Capital plan – intending to spend £39m on capital next year, £17m is internally generated funds, £22m on supporting reconfiguration and Scan for Safety

RH reiterated as Chair of the Finance and Performance Committee that this plan has been thoroughly reviewed in detail at the last few meetings. There will be a significant challenge for 2022/23 operationally and financially; however, both the operational and financial management teams are positive about the challenge and a good start has been made identifying and progressing efficiency savings through the Effective Use of Resources Group.

KH recognised the significant challenge where there are higher inflation costs and asked the Director of Finance if they are undertaking some modelling to look at the impact of the inflation on the deficit. The Director of Finance responded that certain assumptions have been made on the level of inflation running on higher rates. There is a challenge around energy prices being more than suggested uplifts. He explained the Finance and Performance Committee approved a paper regarding sterilisation contract costs and the Trust have been negotiating with suppliers where there will be a 13% inflationary uplift after negotiation.

AN highlighted the assumptions in the national guidance which looked challenging and asked if there is any guidance from the centre or Integrated Care System about how to treat this. He asked if the plan assumptions of 104% activity levels and delayed transfers of care at 70 will be achieved throughout the year or at a point. The Director of Finance responded the 104% is a cumulative position at year end and is a phased approach to gradually improve elective activity throughout the year. Each ICS has submitted its version of plans. There is further challenge such as inflationary costs and discussions remain ongoing.

The Chief Executive stated the NHS has had significant investment and the Trust financial position has been a problem for a significant period of time. There is a need to get to a break-even position and think about a pragmatic phased approach on how to achieve this by working in partnership. The Chief Executive explained a robust equality impact assessment (EQIA) system is in place which needs to continue going forward.

OUTCOME: The Board **APPROVED** the 2022/23 plan and associated budget book.

71/22 Recovery Update

The Chief Operating Officer provided an update to the Board on the recovery position which was discussed in detail at the Finance and Performance Committee. The key points to note were:

- Ongoing work to do on P3 patients (waiting less than 3 months)

- Good progress has been made on P4s (waits over 3 months) and reducing pathways
- Significant progress on 104 week trajectory
- Echo and neurophysiology diagnostics still have significant problems, external companies are being used to support both diagnostic standards
- Positive recruitment into Echo posts going forward
- West Yorkshire review of neurophysiology and neurology will hopefully provide a medium to long term solution
- Significant progress is being made on the MRI trajectory and clearing the backlogs
- Follow up backlogs - numbers have started to reduce, lots of work remains across all services in the Trust
- Echo – work on Community diagnostic hubs
- Cardiac network involved in Echo are looking at echo solutions across the network

AN highlighted that more work is taking place on Knowledge Portal Plus (KP+, business intelligence system) with a detailed set of models to understand how to track to 104% which is great to see. He queried whether the Trust, having been an outlier on this, are now in line with trajectories set and asked if the P2 (waits less than one month) and P3 trajectories need to be re-set. The Chief Operating Officer confirmed the team will re-set the trajectories and look at these through a different lense. She noted regulators remain nervous across the whole system around the 104 week and 78 week position this year. She added the Trust are still seeing Covid sickness absence which impacts on loss of theatre capacity. A weekly meeting with NHS England / Improvement is taking place to look at the recovery position and backlogs and daily meetings take place to review patients on these trajectories with regular communication to the patient. The deadline for the 104 week wait is the end of June 2022.

OUTCOME: The Board **NOTED** the recovery update.

72/22 **Month 12 Financial Summary 2021/22**

The Director of Finance presented the month 12 financial summary and highlighted the key points below:

- Delivered the overall year end position with a surplus of £40k, subject to audit
- Final accounts will show a £300k deficit due to technical adjustments re impairments etc.
- Overall strong financial position
- Cash levels are high
- Capital expenditure was higher than planned which is positive, more was spent on maintaining the estate and developing services as agreed during the year, this was not an overspend
- Use of Resources score of 2 – Finance and Performance (F&P) Committee continue to monitor this

PW assured the Board detail had been provided at F&P Committee this week which shows a positive position. He gave credit to the Director of Finance and finance team, particularly given the challenges over the last 12 months and ongoing challenge.

AG acknowledged that given the challenges with the second half of the year it is a great credit to the organisation to deliver a break even position. AG explained he was delighted to hear about the Capital Programme delivering much needed improvements.

Tim Busby asked for an update on the £5m adjustment referred to next year. The Director of Finance explained this is a complex technical adjustment relating to reconfiguration and potential write off.

Nigel Broadbent stated it is an enormous credit to bring it in within £40k of the plan which is an achievement. He asked if the additional funding that covered the shortfall in the efficiency savings requirement is an issue for the current year or if this year starts from scratch. The Director of Finance explained the efficiency challenge is a recurrent one each year and the Trust worked with partners as a system this year to achieve the required funding.

OUTCOME: The Board **NOTED** the Month 12 Finance Report and the financial position for the Trust as at 31 March 2022.

73/22 **CHFT Green Plan (Climate Change)**

The Managing Director for Calderdale and Huddersfield Solutions (CHS) presented the progress update relating to the Green Plan and accompanying Sustainability action plan. The key points to note were:

- Green Plan was approved March 2021 and progress is monitored via the Green Planning Sub-Committee chaired by AN and the plan has been approved at ICS level
- 110 out of 191 actions have been completed
- Audit Yorkshire feedback from an audit confirms that CHFT is demonstrating a commitment to minimising its adverse impacts on the environment.
- An application for Salix funding has been made which if successful would finance air source heat pumps, Solar PV and Low Loss Transformers across Huddersfield Royal Infirmary (HRI), Huddersfield Pharmacy Specials (HPS) and Calderdale Royal Hospital (CRH)
- Biodiversity action plan approved by Transformation Programme Board (TPB).
- LED lighting scheme due to commence at CRH in May 2022, already in place at HRI and is making energy savings
- CHS Managing Director designated as Net Zero Lead

AN highlighted the good story and positive progress made with 110 tasks completed. He stated the Green Plan aligns well with ICS plans. He explained further work is taking place on the carbon footprint dashboard to understand how the outcomes of these tasks are being measured i.e., seeing the carbon footprint reduce.

AG thanked the Managing Director for CHS and AN for the progress on this. He asked for an update on the bid for charitable funds for the landscaping where the old nursing block was demolished at HRI. The Managing Director for CHS responded the bid was successful for £80k and a biodiversity wellbeing area for staff to use is being created in this area.

The Managing Director for CHS stated there is a high level of ambition for this agenda, confirming that 94% of the Trust's fleet is electronic or hybrid.

KH highlighted the great commitment to this agenda and congratulated the team on the progress. She explained it is important to demonstrate the difference and asked how staff are getting engaged and committed in this agenda. The Managing Director for CHS shared the variety of ways staff are engaged such as staff attending both sites to talk about waste, the benefits of using the correct waste stream and the financial savings. KH asked if there are local green champions which the Managing Director for CHS confirmed.

DS highlighted the positive advances being made since the last report and asked how much progress is being made looking at cleaning materials being used around the sites. The Managing Director for CHS responded the Trust are constantly monitoring cleaning products with the facilities team and the costs. In terms of weed control no chemicals are being used and the Trust are keen to go all electric for the shuttle bus; however, our ambitions are ahead of the market.

Tim Busby highlighted the impressive actions being taken and asked if the Green Plan focuses only internally at the Trust or extends to the supply chain. The Managing Director for CHS confirmed the plan also looks at the supply chain and links to procurement and catering and where the Trust can buy local.

OUTCOME: The Board **NOTED** the Green Plan progress in relation to the accompanying Sustainability Action Plan.

74/22 **Workforce and Organisational Development Strategy including Staff Survey Results and Action Plan**

The Director of Workforce and OD presented the 2021 staff survey results and action plan. It was noted that as the 2021 survey is now aligned with the NHS People Promise, making comparisons against 2020 survey data limited. Nationally, staff survey scores have deteriorated, they indicate colleague 'burn out'. The Trust had a 48% response rate (2% lower than in 2020, a similar position to other WY Acute Trusts except one) and a 6.7 engagement score (-0.2 from 2020). Detail was shared on the top and bottom five scores against benchmarking average, most improved and most declined scores. Key priorities and actions were shared, noting One Culture of Care is our guiding principle and drives the Trust response. Oversight of progress with actions is via the Workforce Committee and the Board response and leadership role was highlighted. It was noted that the Trust's People Strategy is being refreshed.

Discussion took place on:

- the results being as expected (KH) and noted the Board response was appropriate, offered her support and commented emphasis must be on leadership and managers at every level who are accountable for delivering this change and values and behaviours displayed which are not aligned with those of the Trust need addressing. DS supported this and was pleased to note this was part of the Board response.
- A need for a more systematic approach to leadership visibility is needed to make an impact (Chief Executive), which will be led by the Director of Corporate Affairs in partnership with the senior management teams.
- Recurrent themes in staff survey (AN) such as appraisals and asked what the continual mechanisms are for this and other themes. The Director of Workforce and OD responded the Freedom to Speak Up, disciplinary and grievance and people pulse are all mechanisms of ongoing surveys and noted the Trust are looking at changing the emphasis of appraisals so that they become the ownership of the employee. Impact of survey timing on results and difficulties of leader and manager visibility (AG)
- Trust actions to address staffing levels and burnout (Tim Busby) - the Director of Workforce and OD responded the turnover and vacancy rates are better than they have ever been, the complexity of covid inpatients and flow has made staffing availability far worse and colleagues feel comfortable to raise concerns, and nursing staffing levels are closely managed.

The Chief Executive stated this will be a collective responsibility of the Board and asked the Director of Workforce and OD how she will hold the Board to account.

OUTCOME: The Board **NOTED** the 2021 Staff Survey results and action plan.

75/22 **Director of Infection, Prevention and Control Q4 Report**

The Medical Director presented the Director of Infection, Prevention and Control report for Q4 from 1 January to 31 March 2022. The key points to note were:

- Covid-19 outbreaks on wards have been managed well
- Numbers of Covid-19 cases have been decreasing over the last month
- Challenge remains for Clostridium difficile (c diff) which exceeded the maximum objective of cases at year end and all organisations have seen an increase during the Covid-19 period relating to the use of antimicrobials in patients with respiratory infections, a mixture of hospital and community onset
- Isolated cases – control measures around spread of c diff remained effective during this time
- No MRSA cases have been seen within the hospital for the end of year position – this is positive and reflects the efforts all colleagues are making regarding infection prevention and control
- MRSA screening is at 87% which is a data quality issue to be rectified in the report, this is proving challenging
- Seen an occasional outbreak of norovirus during Q4
- Low influenza activity

AN asked how much Clostridium difficile is community onset compared to hospital onset and what unpreventable meant. The Medical Director responded that hospital onset is patients who have acquired c.diff within our care and community onset are patients who have been in hospital and get c.diff within 28 days of discharge. Each case is deemed preventable or unpreventable. He explained that 20-30% of people carry c.diff in their gut which can allow overgrowth in a hospital setting which the hospital try to prevent.

OUTCOME: The Board **APPROVED** the Director of Infection, Prevention and Control Q4 Report.

76/22 Guardian of Safe Working Hours Annual Report (including Q4 Report)

Devina Gogi, Guardian of Safe Working Hours presented the Guardian of Safe Working Hours (GOSWH) Annual Report for 2021/22. The key points to note were:

- Overall decrease in the exception reports compared to previous years
- Increase in exception reports from within the Medical Division reflecting the higher clinical workload, increased patient acuity and staffing issues during recurring Covid peaks
- No exception reports logged for immediate safety concerns this year
- Rota gaps were efficiently filled by bank and agency locum
- Normal rotas have been in place since mid-March 2021
- Improved engagement by the Trust and GOSWH with the Junior Doctors, which was encouraged through successful Junior Doctors Forum meetings and Trust induction
- Two Junior Doctors Forums were held in 2021/22 – 30th September 2021 and 20th January 2022 with a further forum scheduled in May 2022
- Updated the Doctor Toolbox with important information to be a useful resource by junior doctors to carry out their routine clinical activities properly
- Dr Rob Moisey, Consultant Physician was invited to talk about Reconfiguration
- A new Junior Doctor lead for training recovery was appointed to focus on ways to improve training opportunities for Junior Doctors
- Exception reports – 74 in total (majority in Q2 and Q4 related to hours of working) with a considerable dip in Q3, of which the majority were closed off in time with time off in lieu or payment
- Maximum unfilled rota in the Medicine Division
- Junior Doctor Awards scheduled on 25 May 2022 with multiple categories – leadership, going the extra mile, compassionate care
- Approximately £60k was used in Health Education England (HEE) Training Recovery monies to fund training courses and a post for a training recovery lead and SIM lead and ultrasound lead

- HEE study leave underspent monies of approx. £24.5k due to more use of online learning opportunities by postgraduate trainees

KH asked if the decrease in exception reports is positive or negative. Devina responded they try to encourage more exception reports and most of the reports are coming from trainees, as more senior trainees are aware that they get the time off.

The Medical Director formally thanked Devina Gogi for taking on the GOSWH role during these particularly difficult times and supporting staff and noted that she will be a great loss to the Trust as the Guardian as she has resigned due to a move to a post closer to home.

OUTCOME: The Board **NOTED** the Guardian of Safe Working Hours Annual Report.

77/22 Health and Safety Update

Richard Hill, Head of Health and Safety presented an overview of the health and safety activities during 2021/22 and progress against the health and safety action plan.

KH stated it is good to see progress being made against the action plan and asked to see more data in the report to understand the types of health and safety injuries and the number, as it was noted there was a peak in the number of junior doctor sharp injuries.

AN highlighted there has been lots of encouraging progress and it would be good to see outcome data. He asked if the Trust benchmark against other Trusts to see how we compare and acknowledged more work is needed in terms of the violence and aggression piece.

The Head of Health and Safety responded the Trust are in a good place and leading the way in terms of NHS Workplace Health and Safety standards being implemented, compared to other Trusts. The Security and Resilience Group are assisting as much as possible for compliance in the safety of staff and a Task and Finish Group has been established with plans in place for the next 12 months which should see violence and aggression in a better place.

Nicola Seanor asked if the Trust has collaborated with social care colleagues who have personal safety requirements. The Head of Health and Safety responded the community members of staff share their approaches and important work has started in terms of lone working. Nicola stated she is keen to hear outcomes of this moving forward.

The Chair thanked the Head of Health and Safety for the update.

OUTCOME: The Board **NOTED** the progress made against the action plan presented and receive the Health and Safety Update.

78/22 CHFT Response to the Ockenden Review

The Director of Nursing detailed the background to the Ockenden report regarding maternity services and presented the CHFT response to the Ockenden 2 Report recommendations via a self-assessment.

The final Ockenden 2 report has been received and a formal response is due by the middle of June 2022. The Trust have been addressing the immediate and essential actions and they are all either partially or fully compliant. There are some red areas highlighted in the action plan where work is ongoing, or the Trust are awaiting national or regional guidance around some of these. The Trust remains on track to submit a formal response by mid-June 2022.

On 1 April 2022, Trusts received instruction to immediately assess the midwifery staffing position and make a decision about the continuation or suspension of Maternity Continuity

of Carer. The Director of Nursing confirmed a decision will be made on this in the private Board session.

The Director of Nursing confirmed reviews are taking place internally to look at a number of indicators. KH, Maternity Safety Champion, highlighted she attends regular monthly surveillance meeting that involves external colleagues i.e., Local Maternity System which provided a good indication for where the Trust are. KH formally thanked Karen Spencer who has recently retired for her leadership for this.

The Director of Nursing and Medical Director have sent a letter to all colleagues in maternity services reminding them to speak out if they have any safety concerns.

DS confirmed the Quality Committee receive a maternity report on a monthly basis and was pleased to hear the letters have been issued to all staff members in maternity.

AN asked if an assessment will be undertaken with a RAG rating on the action plan with owners and dates. The Director of Nursing provided assurance that this is taking place and the Quality Committee will be reviewing an update on actions.

OUTCOME: The Board **NOTED** the CHFT Response to the Ockenden Review of Maternity Services.

79/22 Quality Report

The Director of Nursing presented the Quality Report which has previously been through the Quality Committee. The key updates are:

- CQC are undertaking system reviews across West Yorkshire around urgent and emergency pathways and CHFT have been on standby but have not been visited to date
- CQC are on site on 12 May 2022 to undertake a deep dive as part of their engagement
- Journey to Outstanding (J2O) reviews – full suite and timetable has been developed for all areas to be looked at with focused J2O reviews being introduced
- Dementia screening – further work required, the team are having a renewed focus in assessment areas with some early learning and rapid improvement from this
- Carers Strategy agreed at the Patient Experience Group – using volunteers to increase uptake of Friends and Family Tests and seeing how patients are feeling
- Continue to have challenges around complaints performance data – partly relating to sickness absence in the team
- Incidents – details of learning included in the report
- Quality priorities – some serious incident investigations resulting in harm due to falls
- Introduced a weekly review to look at high impact interventions
- Maternity Ockenden review – data shows a level of transparency
- Four cases with the HSIB (Healthcare Services Investigation Branch) into maternity services

AG highlighted the number of incidents was 755 in March 2022 which states is a decrease from 718 reported in February which should state it being an increase. He added the Board need to understand if incidents have increased, with 14 having resulted in serious harm. The Director of Nursing confirmed all incidents go through a Divisional incident panel and those red rated go to a Serious Incident (SI) Panel every week chaired by the Director of Nursing and Medical Director. She explained assurance is provided on rapid action having taken place and incident learning before a full review and some incidents are reported externally. An overview report of all SIs is presented to Quality Committee and if a theme is identified a deep dive will be commissioned. AG asked if there is any reason for the increase. The Director of Nursing clarified this is due to a variety of reasons.

RH highlighted the challenges in terms of achievement against the pressure ulcer and falls objectives and asked for assurance of the actions being taken to address these challenges. The Director of Nursing confirmed a weekly high impact action review has been introduced where a pressure ulcer or fall has taken place and a Band 7 and Matron is invited in with a plan of action to support the Division in making improvements. She acknowledged patient acuity has increased which affects this and a number of escalation areas are open at the moment which has affected staffing levels. The Trust are closely monitoring the impact of staffing to ensure areas are safely staffed. She added the re-introduction of visiting will have a positive impact and the Trust are looking at physiotherapy assistance on the wards.

DS asked if Inpatient Acute Palliative Care would move to seven day working from September 2023 or 2022. The Director of Nursing confirmed this will be starting in September 2022.

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

80/22 High Level Risk Register

The Director of Nursing presented the High Level Risk Register which has been presented at the Risk Group and Quality Committee. The key points to note were:

- No new risks proposed
- No increased risks
- Narrative of risks with a reduced score is included in the paper
- Medical Devices – need to be clearer on the narrative

AN highlighted a recent risk management deep dive took place at the Audit and Risk Committee presented by Kim Smith, Assistant Director for Quality and Safety and Lisa Cook, Risk and Compliance Manager and he was encouraged by the work in hand to improve the risk management process. He highlighted that most risks are up to date; however, a few require an update.

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

81/22 Integrated Performance Report (IPR) – March 2022

The Chief Operating Officer presented the performance position for the month of March 2022 with an overall performance score of 63.7%, highlighting the key points which were:

- All domains for March 2022 are amber
- Continue to see a rise in attendances to A&E
- Surges of Covid-19 cases continue
- Achieving the Stroke standard is a continuing challenge – noted rise in stroke admissions which continues an upward trend
- All cancer standards were achieved in March which is a great achievement and celebration for staff and patients
- Transfers of Care patients– average of 100 – lots of focus internally
- Continued focus on One Culture of Care and Health and Wellbeing in terms of recovery for the year ahead

OUTCOME: The Board **NOTED** the Integrated Performance Report and current level of performance for March 2022.

82/22 Governance Report

The Company Secretary presented the governance items for approval in May 2022.

a) Compliance with the Trust's provider licence conditions
Each year NHS England / Improvement (NHS E/I) requires all Foundation Trusts to complete self-certifications to provide assurance that the Trust is compliant with the conditions of their NHS provider licence or provide explanatory text where this is not the case. The self-assessment is signed off by the Chair and the Chief Executive.

b) Request for delegation of 2021/22 Quality Accounts approval to the Quality Committee
The Quality Committee has a meeting scheduled for 20 June 2022 where it would review the Quality Accounts with a view to approving these to enable approval and submission within the deadline date and publication of the Quality Accounts on the Trust website by 30 June 2022.

It is recommended that the Trust Board agree delegation of authority to the Quality Committee for the approval of the 2021/22 Quality Accounts.

c) Update on Non-Executive Director Appointments
It was noted that Tim Busby and Nigel Broadbent have been appointed as Non-Executive Directors and the inductions are underway.

d) Board of Director Attendance Register 2021/22
The attendance of Directors at Board of Directors meetings during 2021/22 is detailed within the annual report for 2021/22.

e) Board of Directors 2022-2023 Workplan
The Board workplan provides the basis for the preparation of Board agendas for the coming year. Ad-hoc items and reports will be included on meeting agendas as necessary.

OUTCOME: The Board **APPROVED** the content of the self-certification documents for the signature of declarations, delegation of authority to the Quality Committee to approve on behalf of the Board, at its meeting of 20 June 2022, the 2021/22 Quality Account, **NOTED** the update on the Non-Executive Director recruitment and **APPROVED** the Board of Directors Attendance Register for 2021/22 and Workplan for 2022/23.

83/22 Review of Board Sub-Committee Terms of Reference

a) Finance and Performance Committee
RH explained the terms of reference have been updated to allow for more flexibility for replacement of Non-Executive Directors if one could not attend for quoracy which was approved by the Committee in November 2021.

b) Transformation Programme Board
As per the paper.

OUTCOME: The Board **APPROVED** the updated terms of reference for the Finance and Performance Committee and the Transformation Programme Board.

85/22 Board Sub-Committee Chair Highlight Reports
The Chair highlight reports were received for the following sub-committees:

- Finance and Performance Committee
- Quality Committee
- Audit and Risk Committee
- Workforce Committee

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

86/22 Items for Review Room

- Calderdale and Huddersfield Solutions Ltd – Managing Director Update April 2022

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

- Finance and Performance Committee minutes of the meetings held 28 February 2022 and 4 April 2022
- Quality Committee minutes of the meeting held 21 February 2022 and 21 March 2022
- Workforce Committee minutes of the meeting held on 15 February 2022

OUTCOME: The Board **RECEIVED** the Calderdale and Huddersfield Solutions Limited (CHS) Managing Director Update for April 2022 and the minutes of the above sub-committees.

87/22 Any Other Business

The Chair formally thanked Ellen Armistead, Director of Nursing for her contribution to the Board and the challenge to him as Chair, acknowledging her retirement at the end of June 2022.

The Chair who retires at the end of June thanked all colleagues for their patience with him, stating how much he has enjoyed being Chair of CHFT and will miss all colleagues.

The Chief Executive formally recorded a thanks to Philip Lewer, Ellen Armistead and Alastair Graham who shortly depart the Trust.

The Chief Executive thanked the Chair for his stewardship, leadership, good grace, and the way he has led the organisation in the last year, he recognised how much the Chair has done for CHFT and he leaves behind a strong legacy. A heartfelt thank you was expressed to Philip Lewer on behalf of the Board, Council of Governors and colleagues.

The Chair formally thanked the Board of Directors, colleagues and governors for their attendance and closed the meeting at approximately 12:20 pm.

88/22 Date and time of next meeting

Date: Thursday 7 July 2022
Time: 9:00 – 12:00 pm
Venue: Microsoft Teams

5. Matters Arising

To Note

Presented by Helen Hirst

6. Chair’s Report

To Note

Presented by Helen Hirst

7. Chief Executive’s Report

- Update on the Covid-19 Public Inquiry

To Note

Presented by Brendan Brown

Transforming and Improving Patient Care

8. Patient Story – CHFT Macmillan Information and Support Service

Presented by: Holly Smith, CHFT Macmillan Cancer Support Service Support Worker and Helen Jones, Macmillan Cancer Information Manager

To Note

9. Health Inequalities Update

To Note

Presented by Anna Basford

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 7 July 2022
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 Suzanne Dunkley, Director of Workforce and OD Jo Fawcus, Chief Operating Officer
Sponsoring Director:	Anna Basford, Director of Transformation and Partnerships
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 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 requiring a response from service providers. 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: Lindsay Rudge Interim Chief Nurse. Urgent Actions: 1,2,5,6,8)
- Using our data to inform stabilisation and reset. Lead: Jo Fawcus, Chief Operating Off icer. (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)

CHFT presented at the NHS Expo in Liverpool in June regarding the waiting list Health Inequalities work done at CHFT. The title was: *Inclusive recovery: Tackling health inequalities when bringing down the elective backlog*. Presenters got positive feedback and have had subsequent enquiries from other providers.

Health Inequalities group commissioned the public health registrar to work on a strategy and update the plan on a page.

External environment: how we connect with our communities: Listening and discovery meetings have been held with asylum seekers and refugees - to understand and inform improved support needed for people that access A&E services that have experienced trauma. The Trust is undertaking work to ensure our procurement, workforce and estate investments maximise the impact of public expenditure to get the best possible outcomes for the local area and target reduction in health inequalities.

The lived experience, initial focus on maternity services: Maternity Voices Partnership are helping with Discovery Interviews with plans to increase engagement through local agencies and social media.

ESOL courses for pregnancy antenatal classes **–** Working in partnership with Calderdale College, a 4-week pilot course will begin on 21st June at Jubilee Children's Centre. A new Smoke-free Pregnancy Pathway is in development. Going to advert for two maternity support workers/health advisers to deliver the Smoke-free Pregnancy Pathway. The Trust approach to CoC has been reviewed in line with the expectation of the Ockenden review. The Trust has made a decision to prioritise all CoC activity in areas of highest deprivation and women from the BAME community.

Using our data to inform stabilisation and reset: For P2, BAME patient waits have reduced over time and now wait just 0.1 weeks more than white patients compared to an extra 7.8 weeks in May 2021. For P2, IMD 1&2 patients now wait just 0.6 weeks longer than IMD 9&10 compared to 8.5 weeks in May 2021.

Diverse and Inclusive workforce: There have been a range of activities taking place across the Trust to recognise Windrush Day and Pride Month. Work continues to support the range of equality support groups.

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

7th July 2022

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: Interim Chief Nurse (Urgent Actions: 1,2,5,6,8)
- Using our data to inform stabilisation and reset. Lead: Jo Fawcus, 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 Workstream Updates

CHFT have presented at the NHS Expo in Liverpool in June regarding the waiting list Health Inequalities work done at CHFT. The title was:

- Inclusive recovery: Tackling health inequalities when bringing down the elective backlog

Health Inequalities Group commissioned the public health registrar to work on a strategy and update the plan on a page

External environment: how we connect with our communities.

Work has continued with partner organisations on a range of projects to support addressing health inequalities. Examples of this work includes:

- Work with Asylum seekers and refugees – listening and discovery meetings have been held with asylum seekers and refugees - to understand and inform improved support needed for people that access A&E services that have experienced trauma. Trauma Adversity Coordinators have been appointed and are working in A&E to provide support for people to access support and services in community settings.
- Work with primary care and local GP practice populations – the Trust has worked with GP practices to analyse data and inequalities in access to A&E services for people with asthma and respiratory conditions. In some GP practices people from BAME communities and IMD 1&2 had higher emergency attendances. We are working with families, schools, GP practices, Housing & Council partners to develop improved support in the community to reduce the need for urgent and emergency attendances.
- Delivering Social Value – The Trust is undertaking work to ensure our procurement, workforce and estate investments maximise the impact of public expenditure to get the best possible outcomes for the local area and target reduction in health inequalities. Collaborating with health and social care partners we have developed investment plans that will support delivery of social value and economic benefits across Calderdale and Kirklees. This includes:
    - job creation
    - knowledge and skills development (e.g. training placements, in-reach to colleges / schools, apprenticeships, Project Search)
    - citizenship, volunteering, building confidence and trust in communities
    - achievement of net zero carbon, and state of the art built environment that meets needs and creates sense of wellbeing
    - public confidence in using services and that services are culturally competent

The lived experience, initial focus on maternity services

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.

Discovery Interviews: Maternity Voices Partnership are helping with Discovery Interviews with plans to increase engagement through local agencies and social media. Leaders in maternity services have been set a target of each speaking to at least 5 service users per week and feeding back into Head of Midwifery.

ESOL (English to speakers of other languages) for pregnancy antenatal classes – Working in partnership with Calderdale College, a 4-week pilot course will begin on 21st June at Jubilee Children's Centre in HX1. The aim is to improve patient awareness and experience of maternity services, to reduce health inequalities and improve pregnancy

outcomes for women who do not speak English. This pilot has been co-designed with and is to be supported by the Public Health Midwife. Grant funding was sourced by Calderdale College for this pilot.

Staff Training and Cultural Awareness: Training package Maternity colleagues are to be invited to undertake online Cultural Competency training on ESR, not linked to EST at this time and therefore voluntary. **Staff Survey** Plan for repeat of the staff survey during July/August following the launch of Cultural Competency training package.

Smoking cessation: A new Smoke-free Pregnancy Pathway is in development. Going to advert for two maternity support workers/health advisers to deliver the Smoke-free Pregnancy Pathway. New carbon monoxide monitors have been received and distributed to Community Midwives although we are experiencing supply issues with the safe breath mouthpieces. An Action Plan is in place to improve essential data collection to meet the target of 95% for CO testing at booking and 36 weeks.

Continuity of Carer (CoC): 26% of women have been booked onto a CoC pathway, 76% of women from BAME backgrounds have been booked onto a CoC pathway. The Trust approach to CoC has been reviewed in line with the expectation of the Ockenden review. The Trust has made a decision to prioritise all CoC activity in areas of highest deprivation and women from the BAME community.

<u>Using our data to inform stabilisation and reset</u>

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.

Our initial focus was on patients with a clinical priority of 2 - where treatment should take place within 30 days of prioritisation. Having established a worrying variation by ethnicity and IMD we prioritised managing out this variation as part of our recovery framework.

Ethnicity P2 Backlog daily snapshot

Patient Group	27/05/2021		18/10/2021		22/12/2021		19/04/2022		16/06/2022	
	P2 Patient Numbers	Weekly Average Waiting Times	P2 Patient Numbers	Weekly Average Waiting Times	P2 Patient Numbers	Weekly Average Waiting Times	P2 Patient Numbers	Weekly Average Waiting Times	P2 Patient Numbers	Weekly Average Waiting Times
All Patients	406	12.6	266	6	320	4.4	326	3.6	397	3.7
White	338	12	235	5.7	283	4.4	286	3.6	349	3.7
BAME	45	19.8	28	8.8	35	4.2	29	3.8	35	3.8
Not Stated	23	7.7	3	2.3	2	1	5	1.7	9	3.7

For P2, BAME patient waits have reduced over time and now wait just 0.1 weeks more than white patients compared to an extra 7.8 weeks in May 2021.

IMD P2 Backlog daily snapshot

Patient Group	27/05/2021		18/10/2021		22/12/2021		19/04/2022		16/06/2022	
	P2 Patient Numbers	Weekly Average Waiting Times	P2 Patient Numbers	Weekly Average Waiting Times	P2 Patient Numbers	Weekly Average Waiting Times	P2 Patient Numbers	Weekly Average Waiting Times	P2 Patient Numbers	Weekly Average Waiting Times
All Patients	406	12.6	266	6	320	4.4	326	3.6	397	3.7
IMD Score 1 & 2 Only	111	17.1	70	6.4	91	4.9	79	3.7	97	3.7
IMD Score 9 & 10 Only	51	8.6	23	3.9	42	2.9	36	3.3	37	3.1

For P2, IMD 1&2 patients now wait just 0.6 weeks longer than IMD 9&10 compared to 8.5 weeks in May 2021.

P2, P3, P4 Combined

Patient Group	27/05/2021		18/10/2021		22/12/2021		19/04/2022		16/06/2022	
	Patient Numbers	Weekly Average Waiting Times	Patient Numbers	Weekly Average Waiting Times	Patient Numbers	Weekly Average Waiting Times	Patient Numbers	Weekly Average Waiting Times	Patient Numbers	Weekly Average Waiting Times
All Patients	5028	33.3	4656	28.6	4995	24.1	5225	24.5	5443	23.2
White	4152	32.7	3939	28.2	4268	23.8	4418	24.1	4556	23.0
BAME	599	37.8	573	29.8	629	25	674	25.3	702	24.8
Not Stated	287	33.7	144	35	98	35.1	106	36.6	124	24.3
IMD Score 1 & 2 Only	1377	36.1	1234	28.6	1331	25.3	1498	25.1	1516	24.6
IMD Score 9 & 10 Only	503	30.5	460	26.4	520	21.6	498	24.1	517	21.6

For P2, P3, P4 combined BAME patient waits have reduced over time and now wait just 1.8 weeks longer than white patients compared to an extra 5.1 weeks in May 2021.

For P2, P3, P4 combined, IMD 1&2 patient waits have reduced significantly over time and now wait 3 weeks longer than IMD 9&10 patients compared to an extra 5.6 weeks in May 2021.

Community

Health Inequalities – IMD incorporated into waiting list and KP+ reviews. Also incorporated into new anticipatory care services and close working with each PCN to tailor those services to population and neighbourhood need.

Medicine

- Divisional working group established
    - Initial focus on Learning Disabilities
    - Reduced LOS but rising readmissions
    - Understand the reason for repeat admissions
    - Link with community to increase the use of Emergency Care Plans
- Looking ahead to LD awareness week w/c 20th June with the aim to
    - Increase the number of LD champions across the division
    - Promote the use of the LD flag in EPR
    - Supported with presentation to CQC

Surgery

Annual Learning Disabilities Review

- The division treated 231 inpatients with a learning disability in 2021/22 and 1,962 outpatients

Ophthalmology remains the highest used service used by people with a learning disability. Consistently followed by ENT and then Audiology in Qs 1&2 and T&O in Qs 3&4.

- Working alongside divisional LD champions and the LD team to celebrate LD Awareness week (w/c 20th June) and raise awareness
- Review LD LoS with a goal of reducing in line with General Public figures
- Review waiting time data with HIS to ensure this is on track

FSS

Continue to adopt the principle of a clinical needs approach but takes account of health inequalities where possible. Some of the key initiatives are described below:

- Appointment booking – Flag on KP+ and ASI to enable LD patients booked first
- Ethnicity status of 'not stated' and 'unknown' reset back to blank in EPR
- Ethnicity capture in Intouch Kiosks now has direct feed linking back into EPR
- In Children's, work on prioritising patients with learning disabilities is ongoing – consultant checklist planned
- Recruited Transition CNS and start date confirmed
- Diabetes patient advocates presented QI project at RCPCH
- An inequalities and wellbeing group has been set up in Radiology. Conducting a gap analysis of all parts of current service. Once areas have been identified these will be pulled together into an action plan.
- Gynaecology working with Amanda McKie to ensure appropriate care an planning for LD pts
- Maternity working with Amanda McKie to add LD Care Plan to Athena
- Maternity undertaking cultural competency survey as precursor to specific training offer
- COC 2 teams locality based mixed risk team in areas of high IMD code.
- ISHS – Individualised integrated sexual health services in areas of high deprivation eg North and Central Halifax
- Working with partners voluntary and statutory to ensure service delivered to hard to reach client base Outreach Services – Ebenezer - homeless shelter, Brunswick Centre Outreach drop-in service with substance misuse vulnerable women and sex workers Tailored 1:1 care for patients with learning disabilities

Diverse and Inclusive Workforce.

Equality Groups: CHFT has four established Equality Groups (Disability / LGBTQ / BAME / Armed Forces / Womens Voices) all with chairs and Executive Sponsors. The Trust also has two health networks (Mental Health & Menopause) – the purpose of these groups is to provide a platform to raise colleague experiences and develop a plan to support education and awareness.

Pride Network - A session has been held with the Charity 'Just Like Us' where we heard trans and non-binary experiences when accessing healthcare. This gave colleagues within the network a deeper insight into how our transgender and non-binary patients (and staff) may feel when accessing healthcare at CHFT and how we can best support them.

The Trust has recognised Pride Month by holding a range of events including flying the flag and hosting stalls to chat with colleagues about the importance of Pride month and the reason behind Pride month.

Windrush event has been supported by Brendan Brown, Chief Executive and Denise Sterling Executive Sponsor, sharing why we need to talk and raise awareness of Windrush, stalls across Huddersfield and Halifax sites to engage with colleagues.

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.

Leadership & Development

Leadership Development Programme / Stepping into Leadership has inclusive leadership and wellbeing at the heart of conversations included in the sessions

Education and Information

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 encouraging colleagues to share their views around what more we can do to be an inclusive Trust.

Worked with West Yorkshire Trusts and public companies to support ‘Root out Racism’ campaign.

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 remain 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.

Anna Basford, Director of Transformation and Partnerships
July 2022

10. 2021-2023 Strategic Objectives Progress Report

To Note

Presented by Anna Basford

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Date of Meeting:	Thursday 7 July 2022
Meeting:	Public Board of Directors
Title of report:	Annual Strategic Plan – Progress Report
Author:	Anna Basford, Director of Transformation and Partnerships (with input from all Executive Directors)
Sponsor:	Brendan Brown, Chief Executive
Previous Forums:	None

Purpose of the Report

Provide an update on progress against the annual strategic plan for period ending June 2022.

Key Points to Note

In November 2021 the Trust Board approved an 'annual' strategic plan describing the key objectives to be progressed during the period November 2021 to March 2023 that will support delivery of the Trust's 10-year strategy. Each of the objectives has a named Director lead accountable and responsible for delivery. As requested at the Trust Board meeting in March a description of the key outcome to be achieved for each outcome has been included in this report.

This report highlights that of the 19 objectives:

0 are rated red
1 is rated amber
17 are rated green
1 has been completed

EQIA – Equality Impact Assessment

For each objective described in the annual strategic plan the 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 is asked to **NOTE** the assessment of progress against the 2021/23 strategic plan.

Calderdale and Huddersfield NHS Foundation Trust
2021-23 Strategic Plan – Progress Report for period ending June 2022

Purpose of Report

The purpose of this report is to provide an update on progress made against the Trust's 2021-23 strategic plan (Appendix 1).

Structure of Report

The report is structured to provide an overview of progress against key objectives, 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 objective a summary narrative of the progress and details of where the Board will receive further assurance is provided (appendix 2).

Summary

This report highlights that of the 19 deliverables:

0	are rated red
1	is rated amber
17	are rated green
1	has been completed

Recommendation

Note the assessment of progress against the 2021/23 objectives.

Appendix 1

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, fostering a learning culture and best practice to improve patient experience : • 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. (BW/JF)	Develop an approach to inclusive recruitment panels and assessment processes to ensure a senior management team that reflects the diversity of our local communities. (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)	

Goal: Transforming and improving patient care			
Deliverable	**Progress rating**	**Progress summary**	**Outcome Measure & Assurance route**
Implement a programme of transformation based on learning from the COVID-19 pandemic to deliver 'Business Better than Usual'.	**BLUE** completed	In January 2022 Audit Yorkshire reviewed the BBTU programme and their report concluded that there was high level of assurance regarding the processes which have been put in place to ensure that positive learning from the pandemic is being embedded within the Trust. In March 2022 the Trust Board agreed that the learning and developments from BBTU will now transition to and be further progressed through the main annual planning and longer term strategic planning processes in the Trust. The stand-alone BBTU programme and objective has been closed.	**Ensure learning from the Pandemic is embedded in the longer term strategies of the Trust** **Lead: AB** Transformation Programme Board
Trust Board approval of reconfiguration business cases for HRI and CRH.	**GREEN** on track	The Full Business for the new Accident Emergency Department at Huddersfield Royal Infirmary has been approved by NHSE. Construction has commenced and is scheduled to complete in Summer 2023. The Reconfiguration Outline Business Case has been approved by NHSE and DHSC and submitted for Treasury approval. Colleagues from Treasury visited the Trust during June and decision is awaited. In anticipation of approval of the OBC work has commenced on the next stages of the programme to develop the Reconfiguration Full Business Case by Summer 2023.	**NHSE and Treasury Approval of Reconfiguration Business Cases** **Lead: AB** Transformation Programme Board, Trust Board ICS, NHSE, DHSC
Progress implementation of the Trust's Clinical Strategy working with partner organisations across West Yorkshire.	**GREEN** on track	The Board approved clinical strategy is supporting discussions within WYAAT and the ICS on the development of WY service strategies into the future. Significant work progresses on the delivery of non-surgical oncology (NSO) including support into the Mid Yorkshire hospital Trust service and Bradford Teaching	**Clear plans agreed with partners to implement improved, resilient and innovative service models in Calderdale and Kirklees**

		Hospital. An independent report on NSO by Professor Mike Richards has recommended a 2-hub model with CHFT as a hub. Work continues to secure agreement across the acute Trusts on the future service model. 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. The Trust is currently working on the implementation of a joint laboratory computer system across WYAAT. A WYAAT diagnostics board is being established to oversee progress of both Pathology and Radiology networks. Monthly Placed based meetings have been established in Calderdale and a partnership working group between CHFT and MYHT.	**and across West Yorkshire** **Lead: DB** Weekly Executive Board Quality Committee Trust Board
Trust Board approval of a 5-year digital strategy supported by an agreed programme of work and milestones.	**GREEN** on track	The 5-year Digital Strategy (July 2020 – July 2025) continues to make positive progress - key activities outlined are in development. • The Infrastructure Strategy focused on moving towards the cloud is now defined. THIS remains focused on delivery of first stages of the data integration platform in year one. • Scan for Safety developments are ongoing supporting wider trust strategies such as Reconfiguration. • Capital funding for 22/23 is allocated including a Trust wide refresh of End User Devices, WiFi upgrades and network infrastructure refresh. • Continued support of Trust Reconfiguration activities including innovation workshops and digital transformation scope definition. Engagement with vendors on strategic planning and implementation of physical infrastructure. • EPR Team structure to support optimisation team is being defined in conjunction with BTHFT to include contract extension and possible future partnerships with Cerner, regional organisations, place based entities and other acute Trusts	**Continued progress towards strategic objectives to include key milestones for data integration, ERP Optimisation and delivery of key capital projects including Reconfiguration** **Lead: JR** Divisional Digital Boards Divisional Operational Boards Data Quality Board Digital Executive Board. Report to Board and Finance and Performance Committee by exception.

		• Digital Governance at Divisional Level is now established but time is needed to fully embed Technical/project management support assigned to each divisional board to provide specialism. • Multiple Digital Funding bids have been submitted again enabling the trust to further invest in digital technology in line with Digital Strategy.	
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 has been considered 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. 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. Through the Access Delivery Group further work is being progressed to ensure a greater level of scrutiny is in place for oversight of elective waiting lists.	**To see a sustained improvement in the waiting time differential. To reduce the incidence of harm as result of waiting for treatment.** **Lead EA** Weekly Executive Board Board of Directors Access Delivery Group Learning Improvement Review Board Health Inequalities Oversight Group (England)
Goal: Keeping the base safe			
Deliverable	**Progress rating**	**Progress summary**	**Outcome Measure & 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.	**GREEN** on track	We are continuing to work with all partners and communities to support increased population uptake of the Covid-19 vaccine and spring booster campaign. The Trust is ensuring national guidance in relation to IPC measures are implemented. There is a re-launch of the health and well-being risk assessments. 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	**Staff accessing HWB assessments receive timely and effective outcomes**. **Lead: EA** Weekly Executive Board Trust Board Workforce Committee

		our recovery plans support a continued reduction in health inequalities.	
Maintain the Trust CQC overall rating of 'good' and increase the number of services achieving an out-standing' rating.	**GREEN** on track	The new style accreditation Journey to Outstanding (J20) has been tested and is being rolled out. There is a timetable of visits planned for the next 12 months. 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. Significant work has been put in place to ensure optimum state of readiness for future CQC assessment across a number of services.	**Maintain the Good rating, achieve some outstanding ratings.** **Lead: EA** Quality Committee Weekly Executive Board
Involve patients and the public to influence decisions about their personal care fostering a learning culture and best practice to 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 is embedded 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. CHFT have appointed a Nurse Consultant for Mental Health to address the unique needs of this group pf service users.	**To see an improvement in the feedback from service users as part of the Observe and Act process.** **Lead: EA** Quality Committee Weekly Executive Board

Work with system partners to achieve key performance metrics for urgent and emergency care and elective recovery.	**GREEN** on track	The Trust is making good progress on its elective recovery plans. At the end of May the Trust has delivered a 4% higher volume of patient access to: outpatient, emergency, and elective treatments compared to pre-pandemic activity levels in 2019/20. In terms of 104wks there will be one patient waiting at the end of June. Treatment plans were in place but due to patient illness this has been moved forward to July. However, this is a significant improvement from December 2021 when there were more than 140 people that had waited longer than 2 years. Systems to closely manage elective recovery through the Access Delivery Group have been established. The Trust is achieving all cancer access standards ensuring that people who have an urgent referral from their GP for suspected cancer receive the timely treatment they need. The Trust continues to provide support to Mid-Yorkshire Hospitals Trust to ensure timely access to cancer services for residents in North Kirklees. The Trust's performance on the Accident and Emergency 4 hour waiting time standard continues to perform better than most Trusts.	**Achieve key performance metrics for urgent and emergency care and elective recovery** **Lead: JF** Integrated Board Report Weekly Executive Board Audit and Risk Committee Finance and Performance Committee Access Delivery Group Cancer Delivery Group Urgent & Emergency Care Delivery Group
Deliver the actions in the Trust's Health and Safety Plan.	**GREEN** on track	The health and safety management system is making good process in its development across all relevant areas of the Trust which includes a review of policies, procedures and risk assessments. Sub-groups are well established to help strengthen divisional engagement. A continued focus around COVID compliance assurance measures by improvements to risk assessments and monitoring oversight has taken place and continues. A lens has also been placed upon improving compliance across THIS, HPS to ensure they have the right local measures in place. Direct working has taken place with the Community Healthcare Division to understand their needs and	**Implement actions in the Health and Safety Plan** **Lead: SD** Quality Committee Trust Board

		expectations around lone working and violence and aggression prevention with a focus group, expanded to include all other community run services. First aid training in the non-clinical areas has been reviewed, with an uplift of 45 extra trained colleagues Home working display screen equipment assessment tool has been revised and planned for sharing to all relevant colleagues during 2022.	
Goal: A workforce fit for the future			
Deliverable	**Progress rating**	**Progress summary**	**Outcome Measure & 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, thus retaining a turnover below 10%.	**GREEN** on track	Our recruitment strategy 2022/2023 was agreed in April 2022. As part of our strategy, work continues as per plan including:- • Achievement of the national target of 0 vacancies through the Healthcare Support Worker Programme. • Continued progress on reducing registered nurse vacancies. • Enhanced international nurse recruitment • Extension of international recruitment approach to AHP roles • Increase in substantive medical workforce numbers particularly in key hot spot areas (Emergency Medicine, Anaesthetics and Radiology). Work continues in the Workforce and Organisational Development team and clinical divisions to improve our recruitment and retention position through developing initiatives including Kickstart, Inclusive Volunteering, St John's Cadets, Sector Work Based Academies, Project Search and the Princes Trust 'Get Into' programme.	**Improved vacancy rate overall. Improved vacancy rate for N&M and M&D staff groups.** **Turnover below 10%** **Stability above 90%** **Lead: SD** Workforce Committee
Develop an approach to talent management that further embeds our approach to succession planning, whilst maintaining fair and equal opportunities	**GREEN** on track	Progress has been made with regard to the following:- • People Strategy refreshed with talent management as 1 of 6 core themes. • Talent management framework established capturing a holistic approach including key themes	**Improved National Staff Survey, WRES and WDES scores** **Lead: SD**

of employment, resulting in an increased number of internal promotions.		recruitment, retention, reward and recognition, engagement and involvement, development, performance management and succession planning/pipeline management. • Talent development toolkit developed to support colleagues and their managers. • Appraisal documentation refreshed in advance of 2022/2023 appraisal season launch in July. • 'Development for All' programme and brochure produced and published.	Workforce Committee
Revise our Leading One Culture of Care and Management Essentials programme to support managers to successfully lead their teams through Recovery and beyond	**GREEN** on track	Recent developments comprise:- • A Trust values and behaviours refresh positioning One Culture of Care at its centre ensuring 'we put people first'. • Creation of One Culture of Care charters for every team/service area by 31 August 2022 • Compassionate Leadership sessions for our leaders/managers have been delivered with an ongoing programme to ensure we capture a critical mass that facilitates embedding essential leadership behaviours in support of One Culture of Care • Introduction of a 'taught' leadership development programme with opportunities for networking and shared coaching/problem solving. This is supported by the leadership development e-platform that comprises a library of leadership and management resources • Participation in an NHS England/Improvement pilot of a Team and Engagement Development (TED) tool. TED is an evidence-based diagnostic, structured around key features of highly engaged and high performing teams. TED contains a team development toolkit to help teams develop and maintain high performance. There are resources linked to the areas measured by the diagnostic to provide specific guidance and development tools.	**Improved National Staff Survey, WRES and WDES scores** **Lead: SD** Workforce Committee

		TED aims to improve individual engagement, team engagement and team working.	
Develop an approach to inclusive recruitment panels and assessment processes to ensure a senior management team that reflects the diversity of our local communities.	**GREEN** on track	Inclusive recruitment is a key element/objective in our recruitment strategy 2022/2023. A review of the existing approach to inclusive recruitment was completed in February 2022, using 10 High Impact Actions published by NHS England/Improvement. Areas for development/change were highlighted across our recruitment processes. A plan to implement change will be available in July 2022. Additionally, a values-based applicant screening tool is in development with an implementation and 'go live' plan to be determined.	**Improved National Staff Survey, WRES and WDES scores** **Lead: SD** Workforce Committee
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.	**GREEN** on track	Our 2021 staff survey health and wellbeing response scores endorsed the Trust's approach to colleague health and wellbeing. There was a 10% increase in colleague perception that the Trust is interested in and takes positive action in relation to their wellbeing. Our focus in facilitating access into individualised services, for example the internal Listening Ear service and CareFirst, our external employee assistance programme provider remains. Our first Health and Wellbeing festival was held in May 2022. 250 colleagues participated. During the festival consultation was undertaken in relation to the wellbeing hour. Future arrangements for this and further evolution of our wider wellbeing package will be confirmed in July. This will include increased opportunities for participation in wellbeing activity. The Trust is seeking to make an appointment to an in-house colleague psychologist role. The Health and Wellbeing Risk Assessment has been relaunched to support colleagues with concern about the relaxation of IPC rules. The responses help us to support individual colleague needs and work through	**Improved National Staff Survey scores** **Lead: SD** Workforce Committee

		the key issues and themes by establishing health and wellbeing information directly from colleagues. A Wellbeing Recovery Action Plan (WRAP) Support Assessment has been designed and implemented. This supports colleagues who are returning to work after a period of long-term sickness absence and or maintain attendance at work whilst managing a long-term condition or a condition which may require consideration of workplace adjustments. It is intended to identify any specific concerns colleagues may have and for colleagues and line managers to agree together the most reasonable and practical steps to take in the workplace to support a return to work and sustain attendance at work.	
Goal: Sustainability			
Deliverable	**Progress rating**	**Progress summary**	**Outcome Measure & Assurance route**
Deliver the regulator approved financial plan.	**GREEN** on track	The Trust delivered the financial plan for 2021/22 with a £40k surplus on a control total basis. For 2022/23 a deficit plan of £17.35m has been submitted and agreed with ICS. At month 2 the plan is being delivered.	**No intervention from NHSEI or ICS.** **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. The plan for 2022/23 is a deficit plan which would score 3 on the finance use of resource metrics and not meet all the CQC actions required (one of which was to deliver financial balance).	**Completion of all CQC actions except financial balance.** **Finance Use of Resource score of 3 as per plan** **Lead: GB** Reported to Finance & Performance Committee Quality Committee Monthly regulator discussions
Implement the Trust Board approved Green Plan demonstrating progress against the agreed action plan that will support reduction in the Trust's carbon footprint.	**GREEN** on track	The Green Plan was first approved by Transformation Planning Board in March 2021. Delivery is managed by the CHS and progress against the Sustainable Action Plan (SAP) is monitored through the Green Planning sub-group. The Green Plan is a Board approved document which is submitted at ICS level. Some of the key progress this year include: • 94% of CHS fleet currently ultra-low emissions vehicles • 100% of our energy is bought from green sources • CHS is rolling out Carbon Literacy training for colleagues • a Travel Plan has been adopted by the Trust to support more active travel • HRI reconfiguration scheme is on track to meet BREEAM Excellent requirements for sustainable design in new construction • 10 new secure cycle lockers and 2 Sheffield Stands with capacity for up to 8 bikes each, installed in key locations across the site at HRI along with new shower and locker facilities	**Strong working relationships with partners on the climate emergency. Delivery of our Green plan and Travel plan** **Lead: SS** Transformation Programme Board Trust Board

		• a Biodiversity Management Plan has been developed covering our estate • CHS is an active member of Kirklees climate commission and Calderdale Councils climate action plan.	
Collaborate with partners across West Yorkshire and in place to deliver resilient system plans.	**GREEN** on track	The West Yorkshire Health and Care Partnership (ICS) has established the Integrated Care Board (ICB) structures and governance to implement the legislative changes set out in the Health and Care Bill from 1st July 2022. Local place based sub-committees of the ICB have been established in Calderdale and Kirklees and the Trust is a partner member of these. The Trust has aligned senior leadership capacity to support the new place based working arrangements. Several Trust Board development workshops have been held (and further workshops planned) to discuss and ensure the Trust adopts new ways of working to build partnership relationships and effectively support the strategic development of place based system plans as an 'anchor' partner. This will inform a refresh of the Trust's 10 year strategy. The Trust continues to work collaboratively and contribute to the West Yorkshire Association of Acute Trusts programme of work in relation to clinical support services (e.g. imaging, pharmacy, pathology, scan for safety), corporate services (e.g. workforce, procurement, health inequalities) and clinical services (e.g. vascular and non-surgical oncology). CHFT also works proactively with Trusts to provide mutual aid to support service resilience and recovery from the pandemic.	**Strong working relations with partners with clear system minded rationale for decisions to deliver improved population health, tackle inequalities, enhance productivity and efficiency, and support social value generation and economic development.** **Lead: AB** Trust Board WYAAT Committee in Common Calderdale and Kirklees subcommittees of ICB System Leadership Meetings with NHSE and WY ICS

Sustainability

11. Recovery Update

To Note

Presented by Jo Fawcus

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NHS Foundation Trust

Board of Directors

7th July 2022

Recovery Trajectory

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Key Targets 2022/23

	23/06/2022	Current Trajectory as of 16th June	Variance to trajectory
104 Weeks RTT	4	0	4
78 Weeks RTT	313	338	-25
52 Weeks RTT (External plan)	2340	2439	-99
52 Weeks RTT (To get to 0 by March 23)	2340	1925	415
Total ASI's	11876	10940	936
ASIs over 22 weeks	1143	1059	84
Holding List overdue	26061	19690	6371

104 Weeks position at month end was 1 ENT patient

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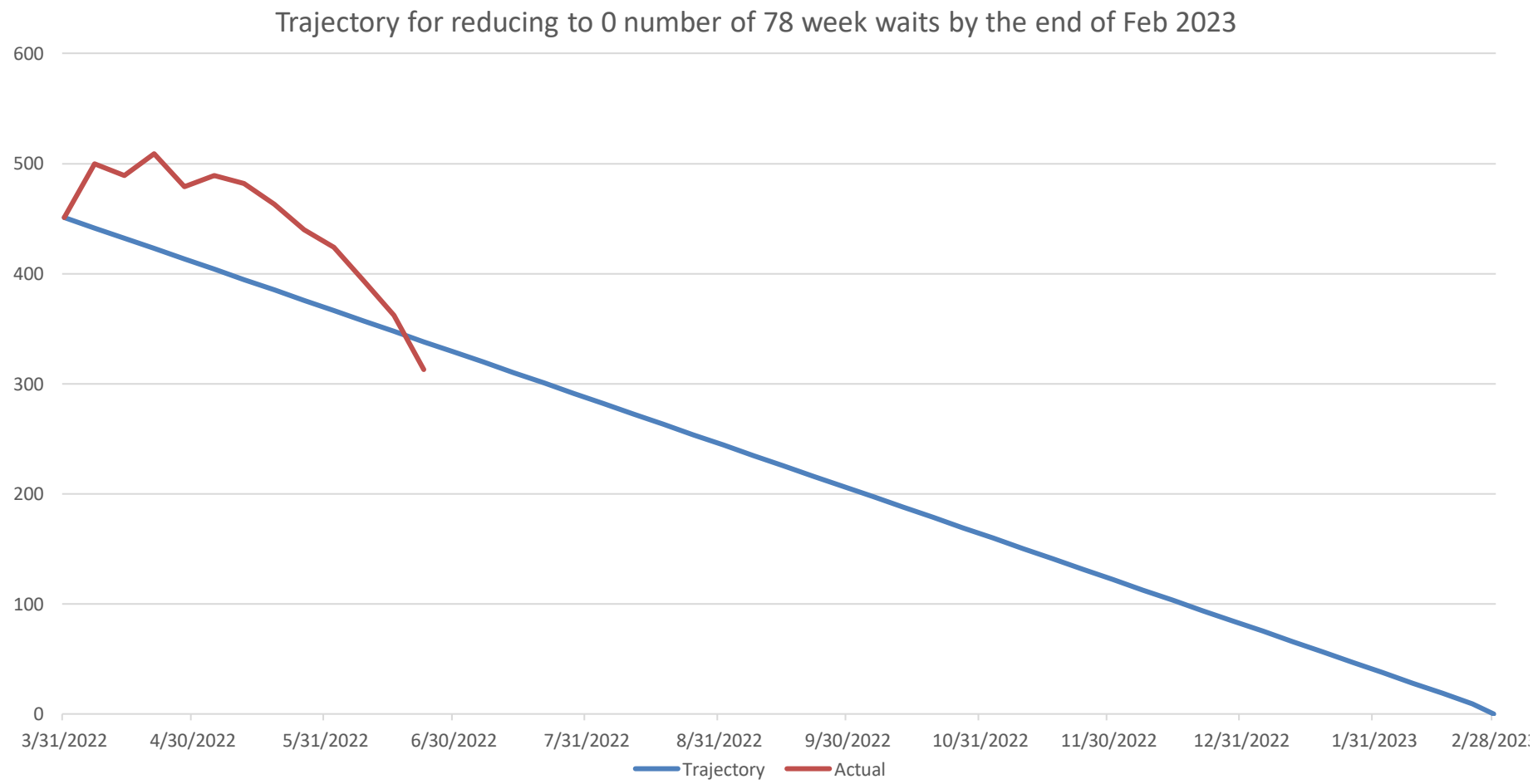
RTT Over 78 Weeks
Trust Position



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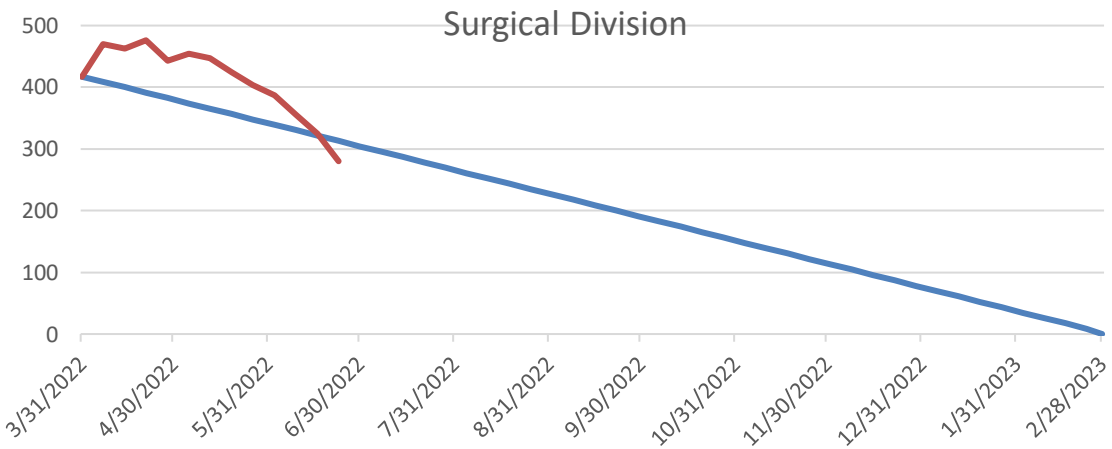
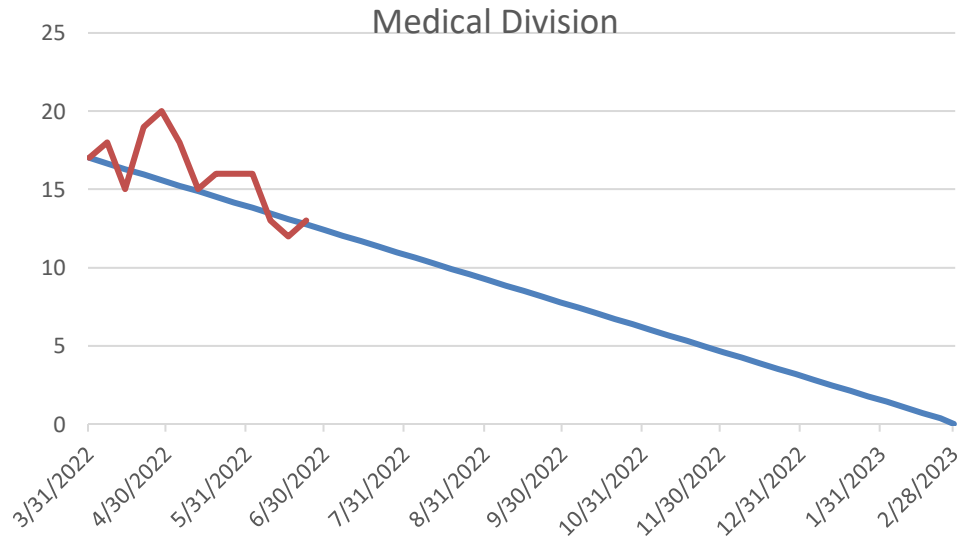
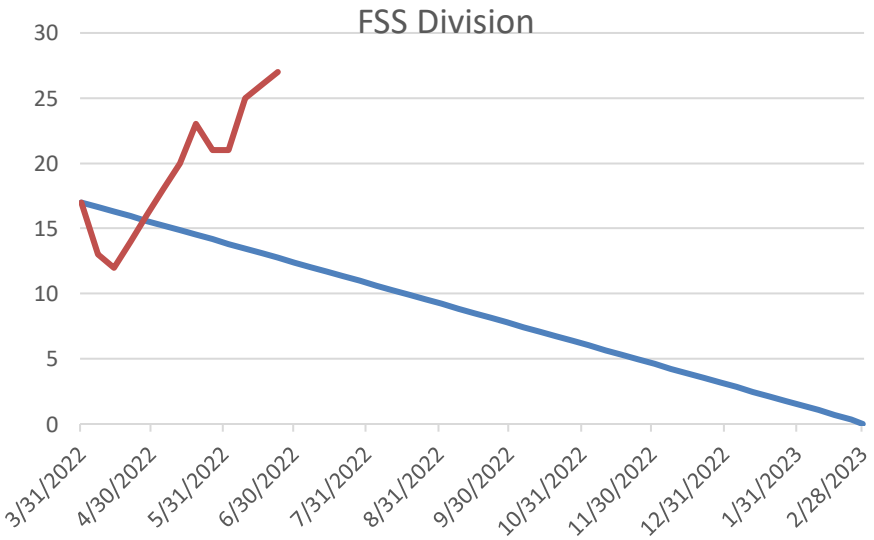
RTT over 78 Weeks Divisional Breakdown







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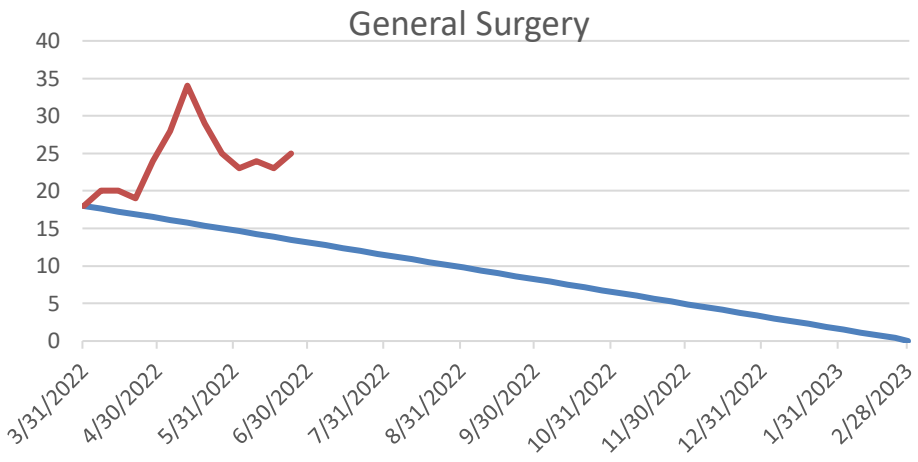
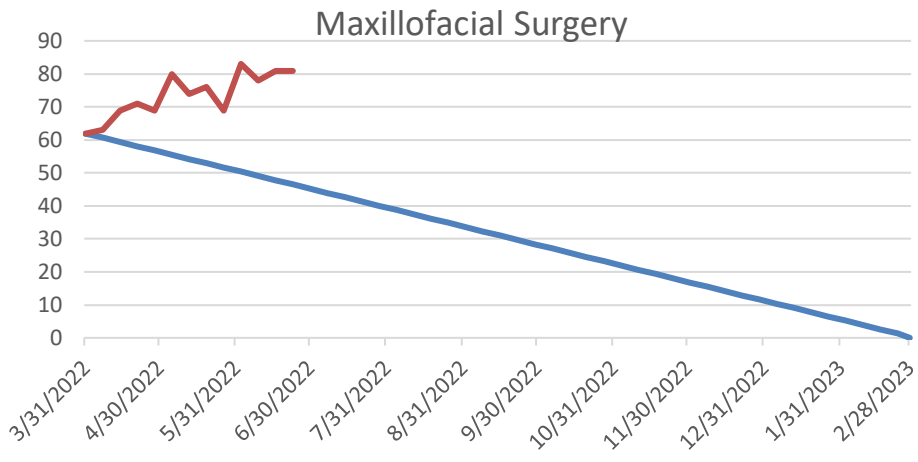
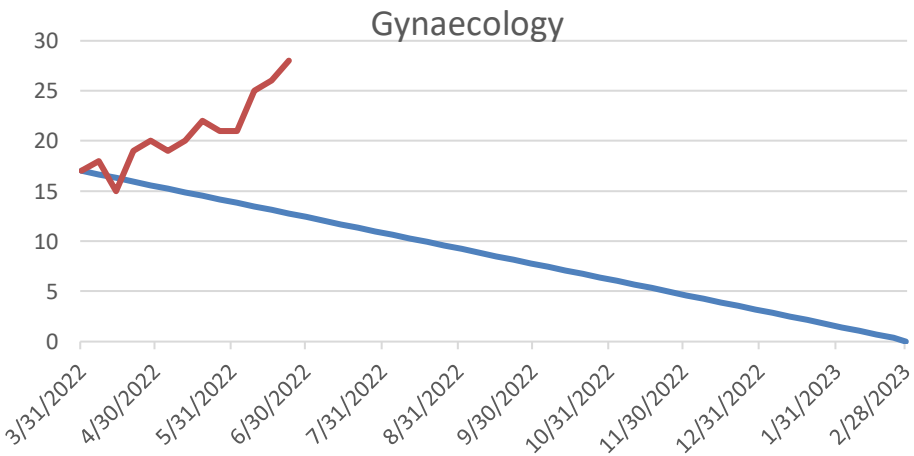
RTT Over 78 Weeks







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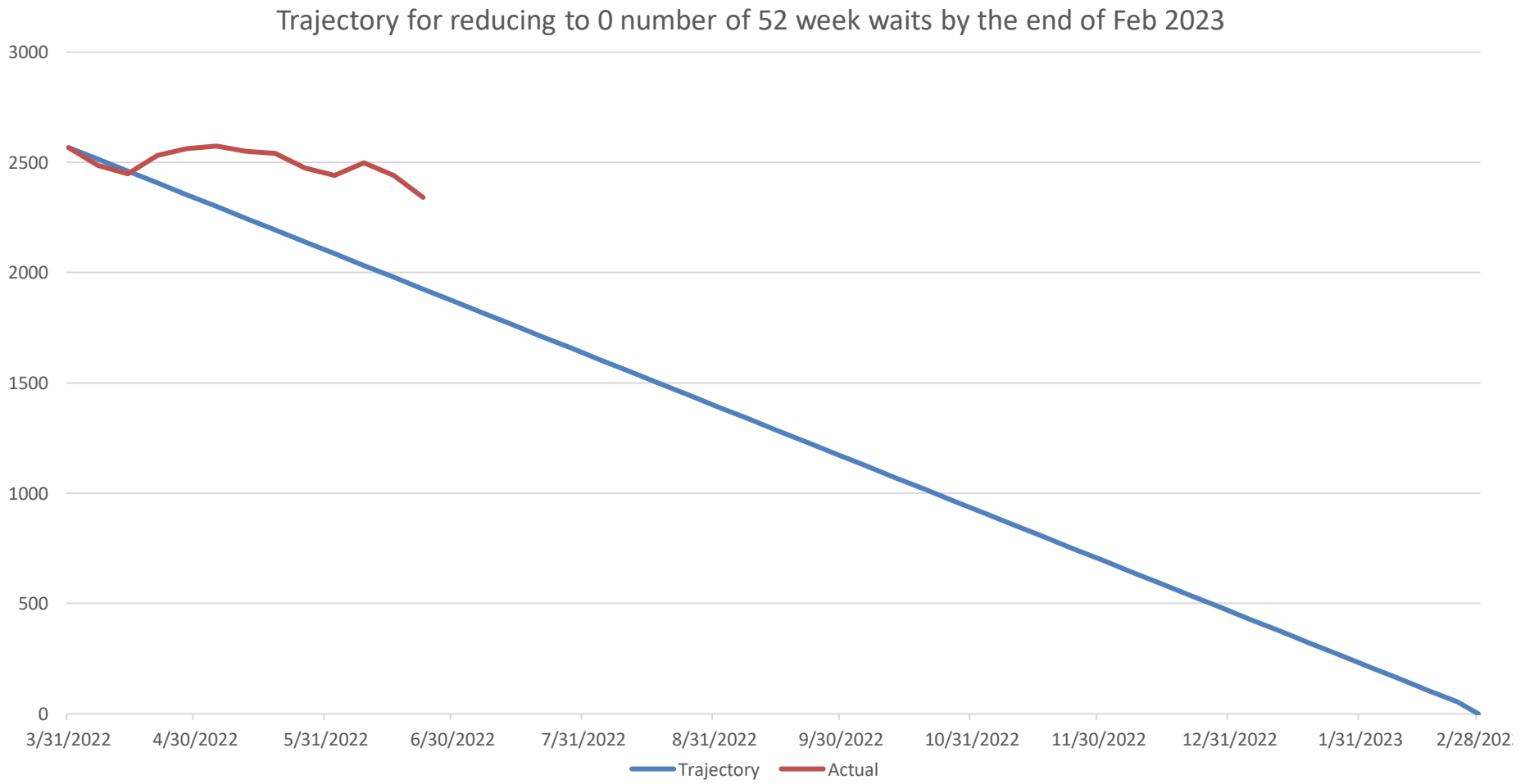
RTT Over 52 Weeks
Trust Position



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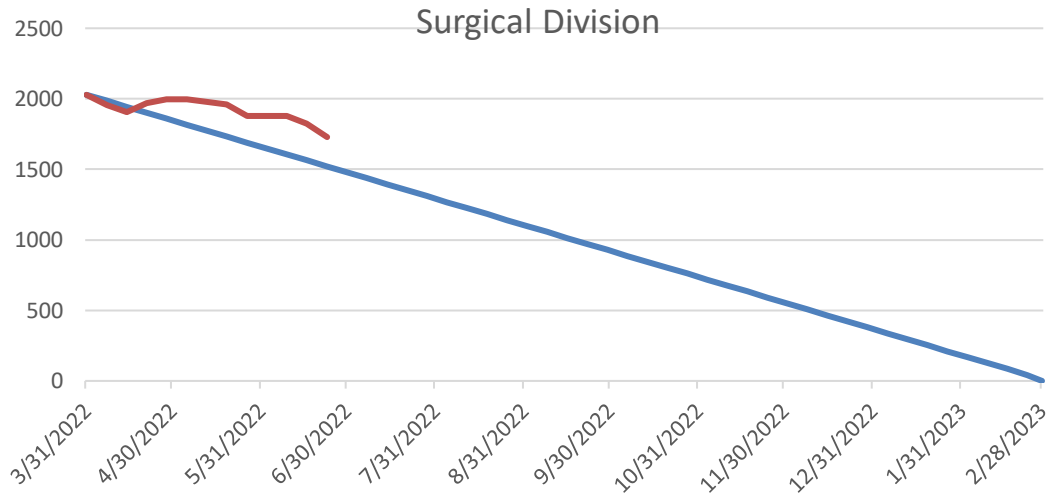
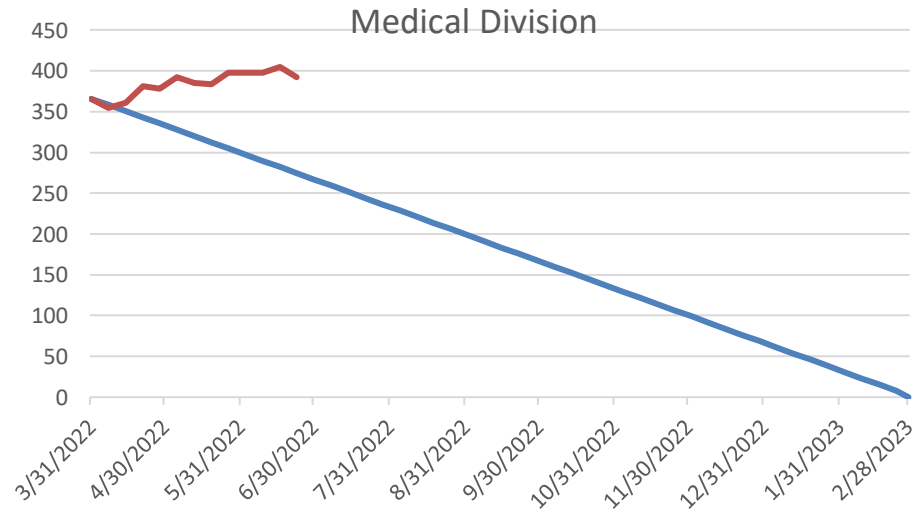
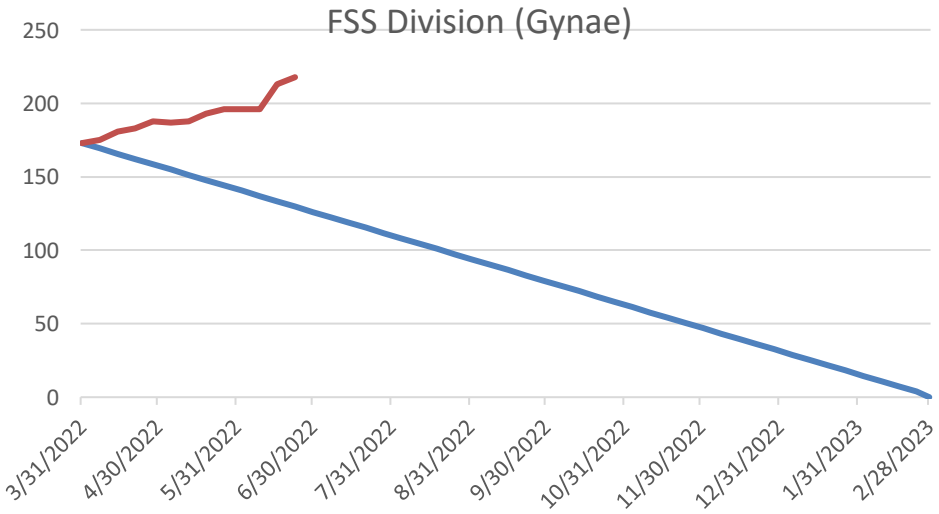
RTT over 52 Weeks Divisional Breakdown







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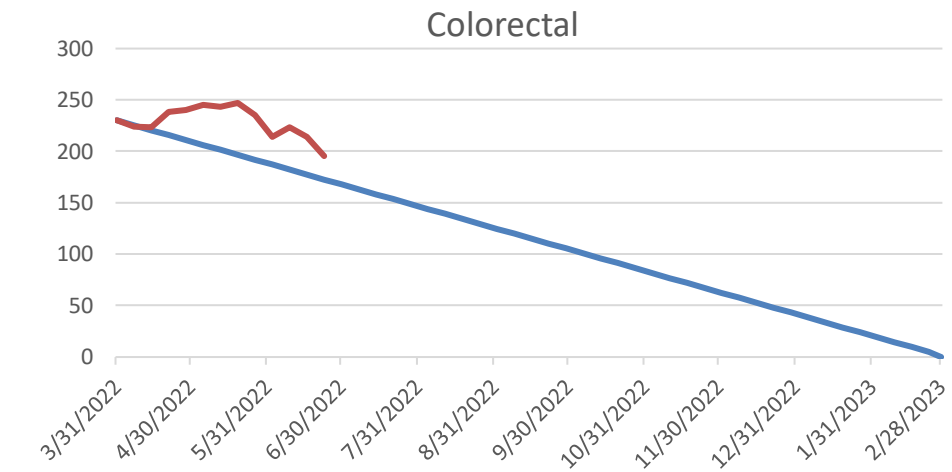
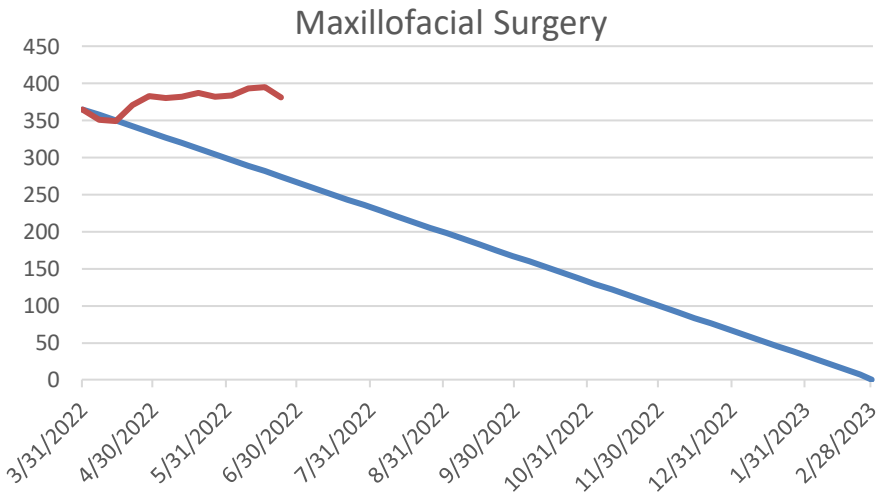
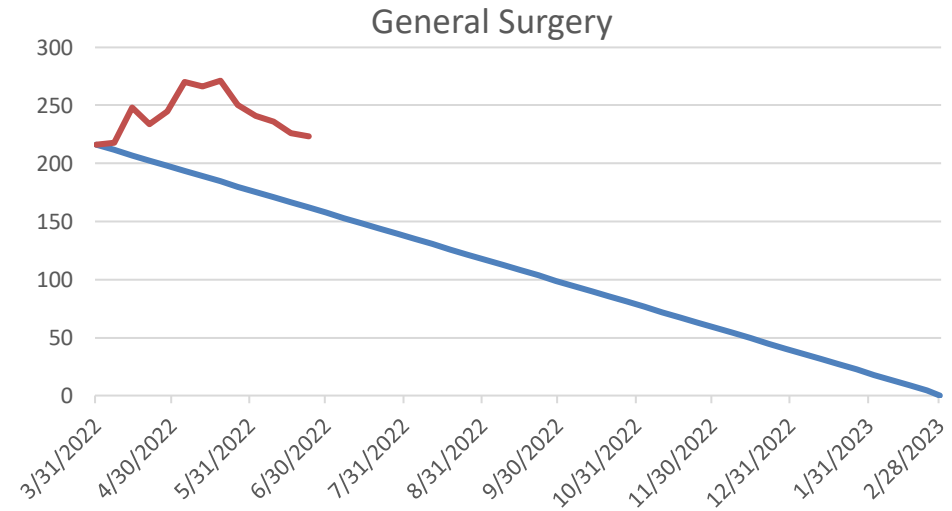
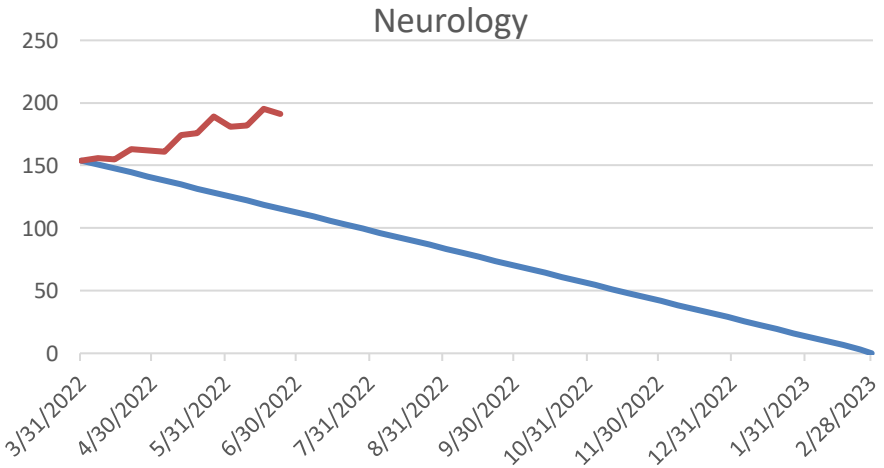
RTT Over 52 Weeks









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ASIs

Trust Position

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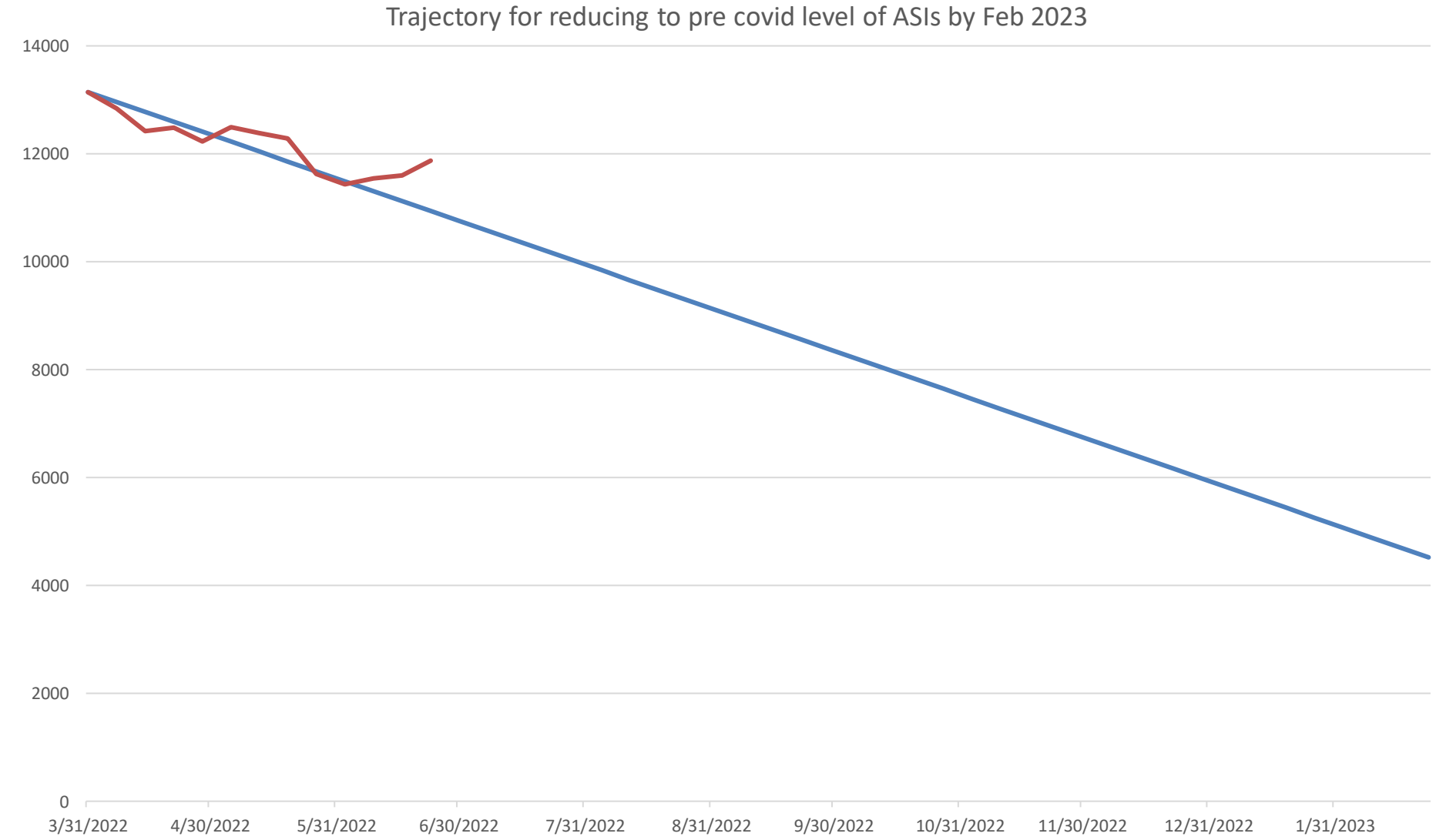

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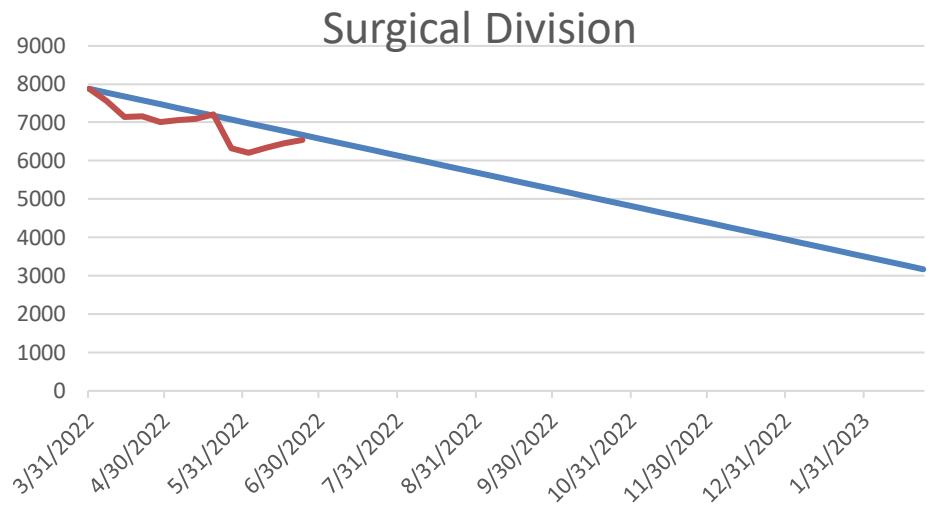
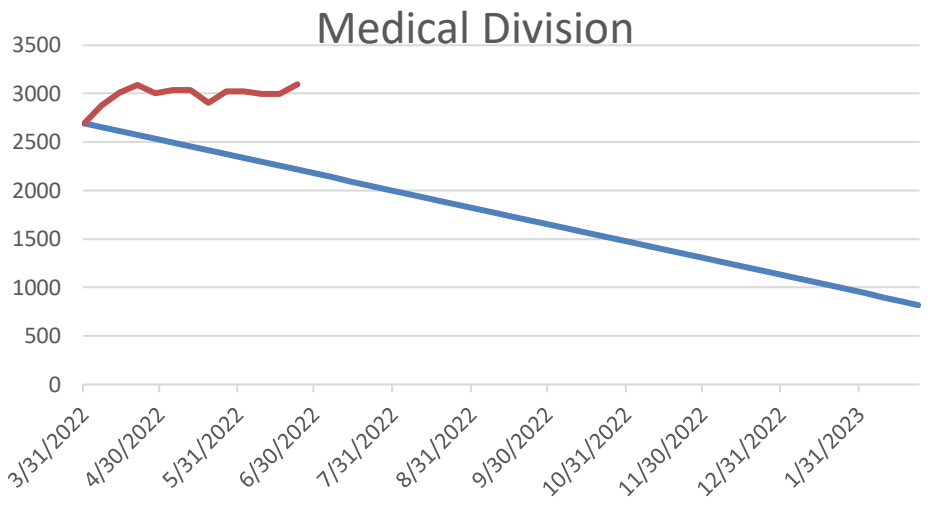
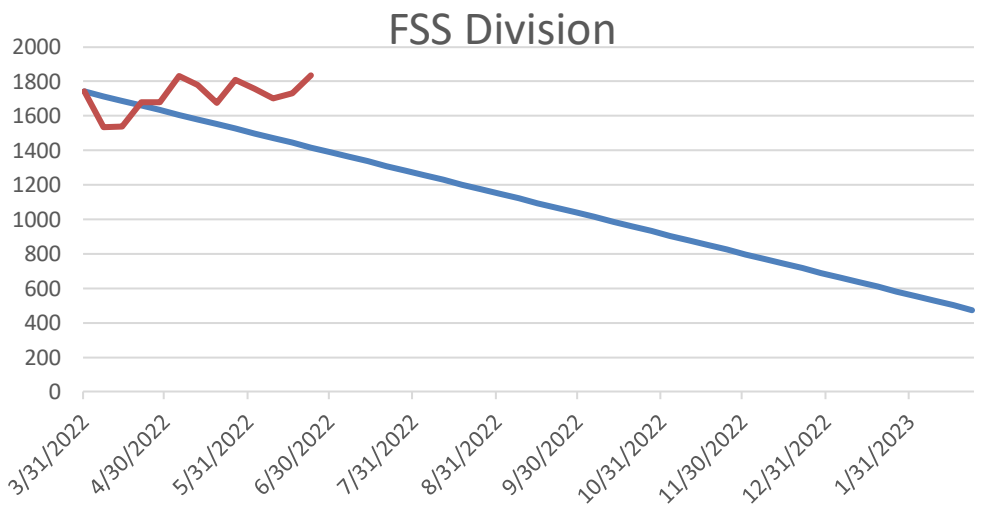
ASIs
Divisional Breakdown







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ASIs
Key Specialties

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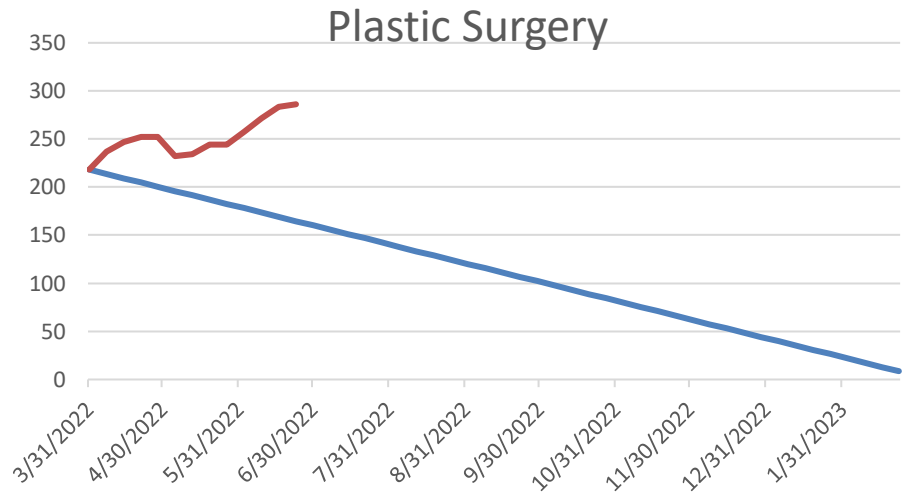

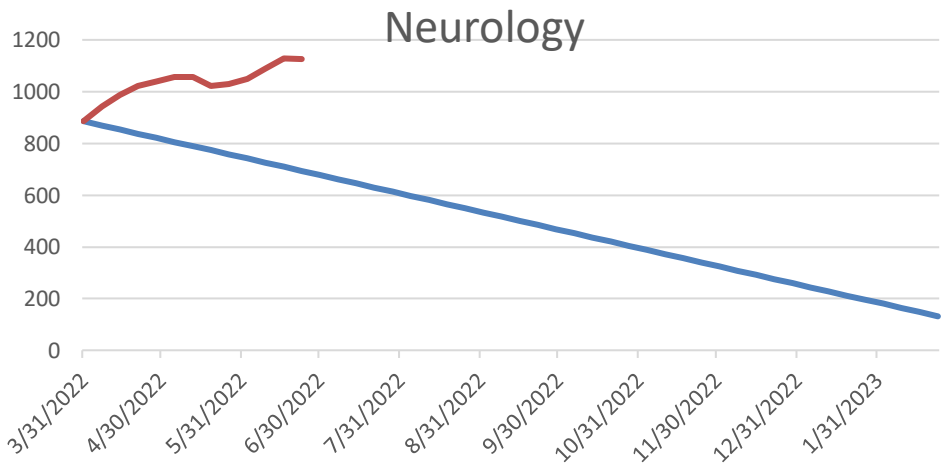

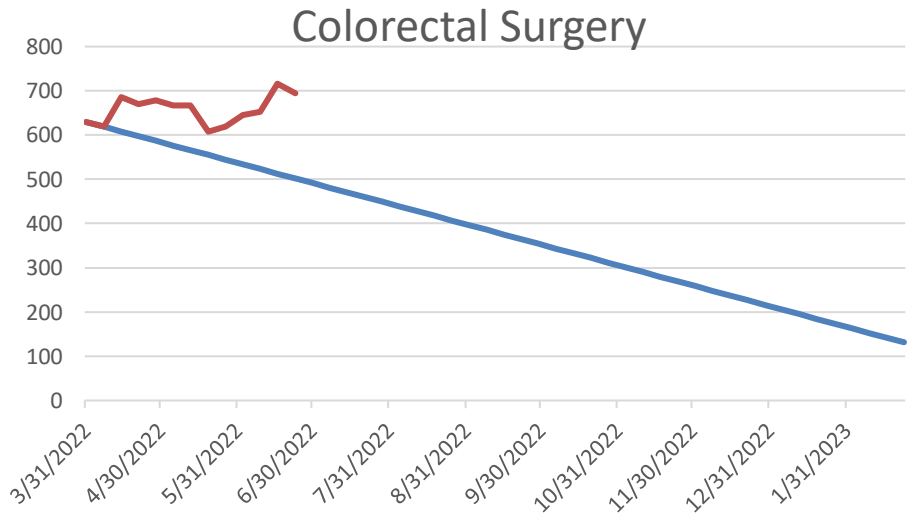

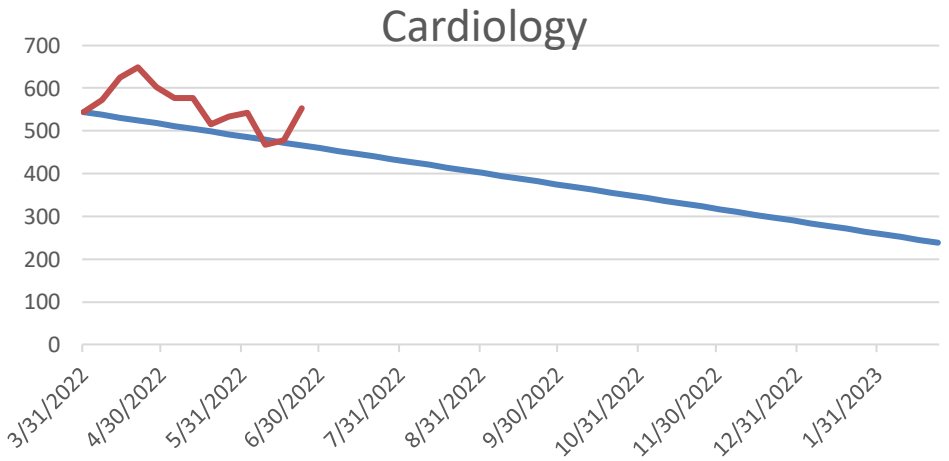

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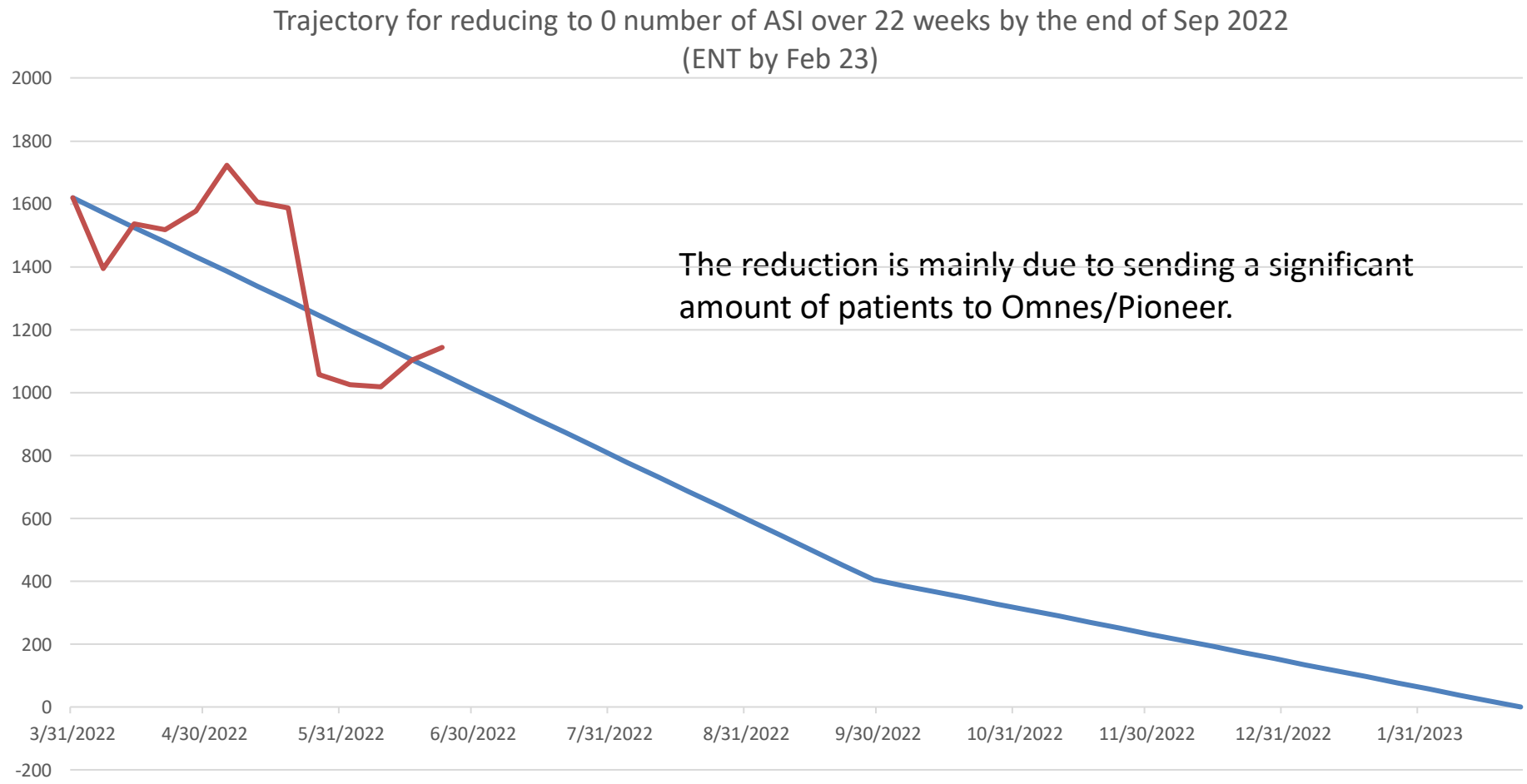
ASIs over 22 Weeks
Trust Position



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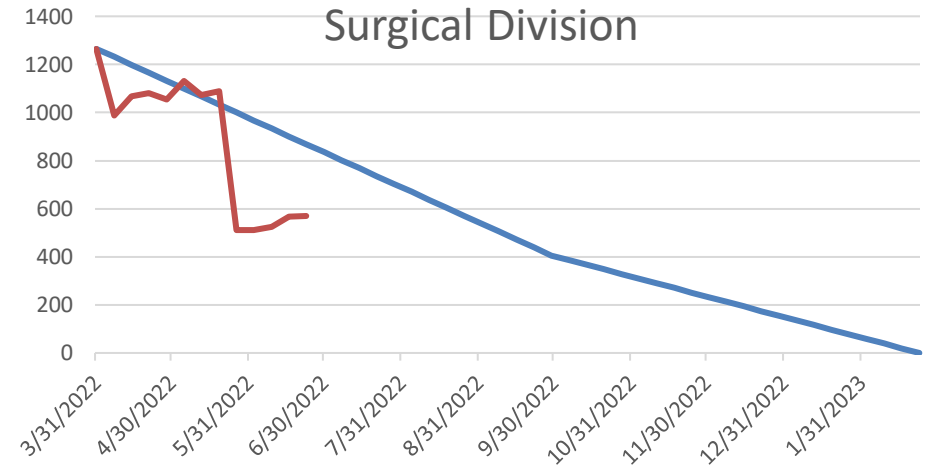
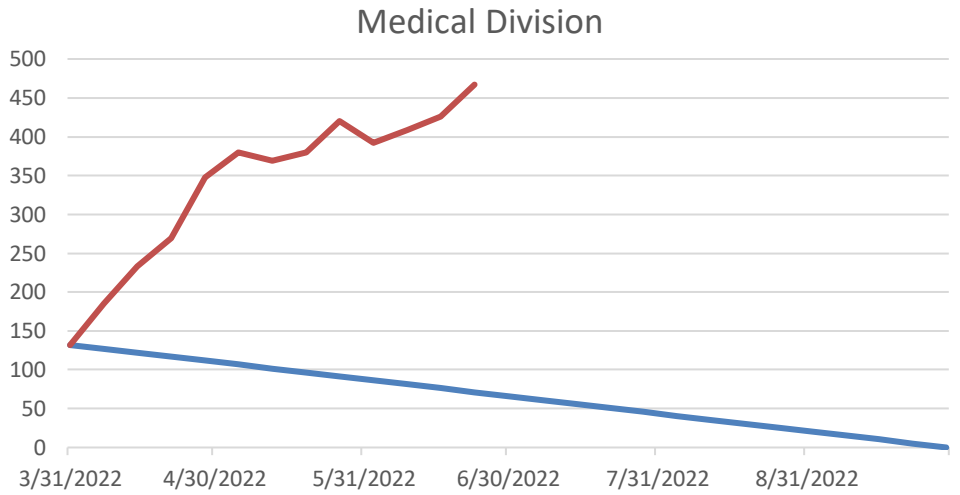
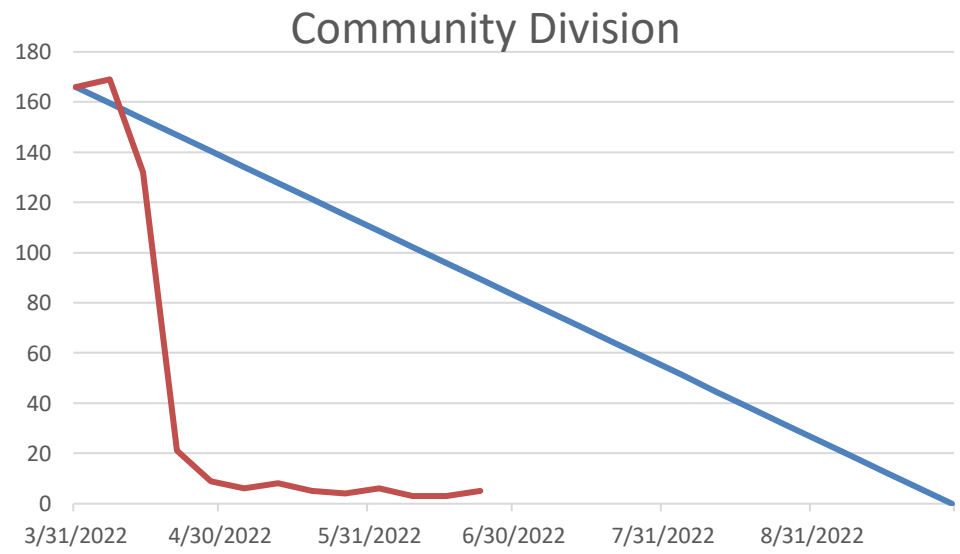
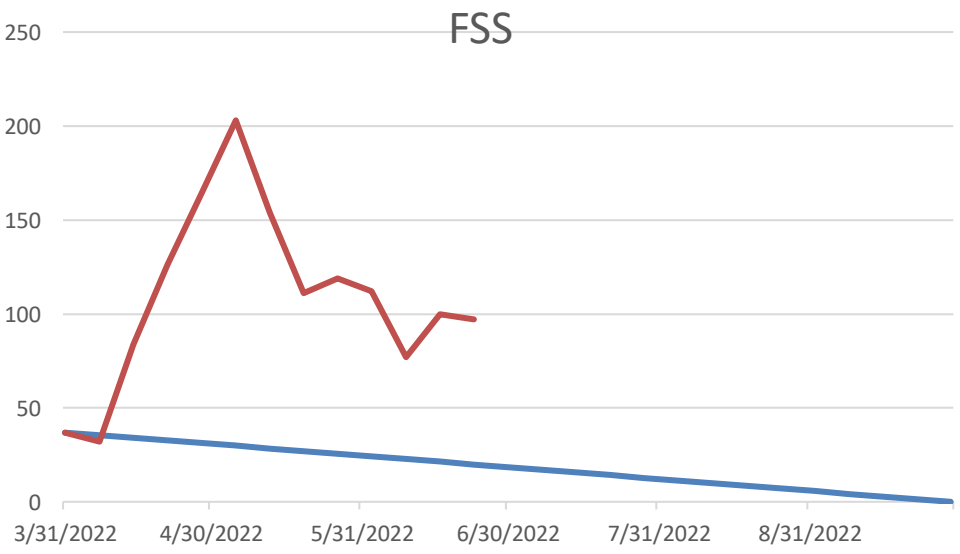
ASIs over 22 Weeks Divisional Breakdown









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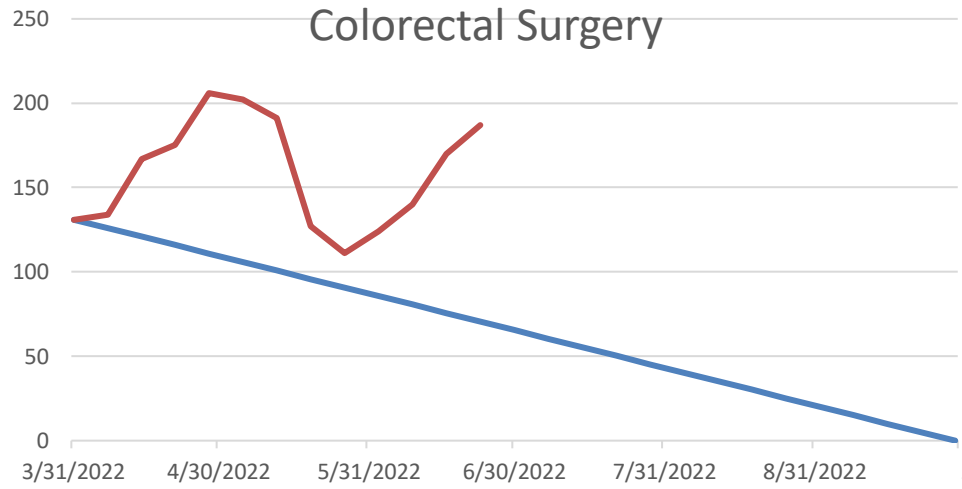
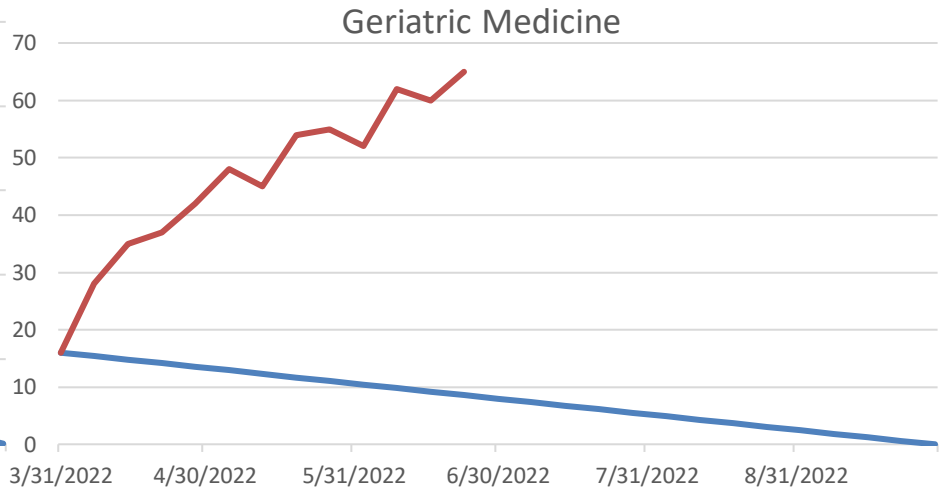
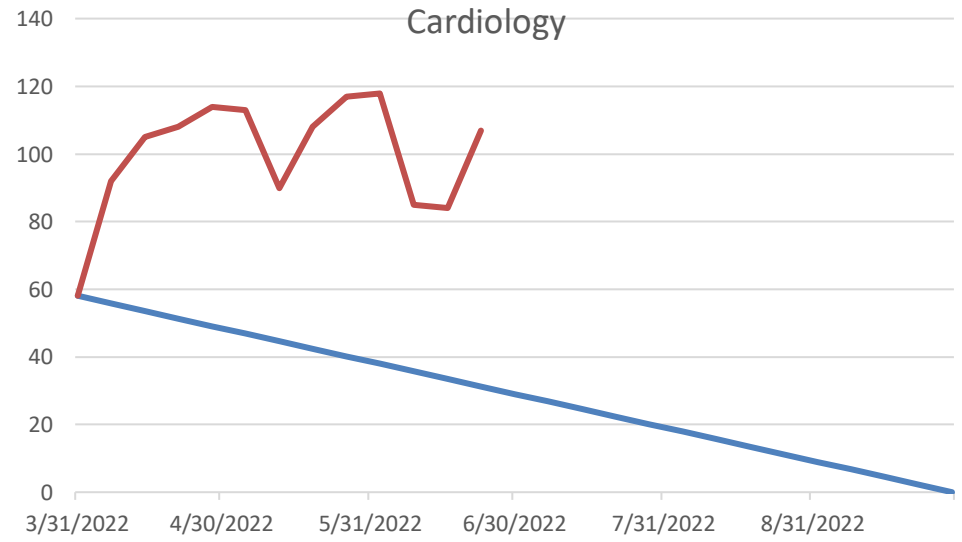
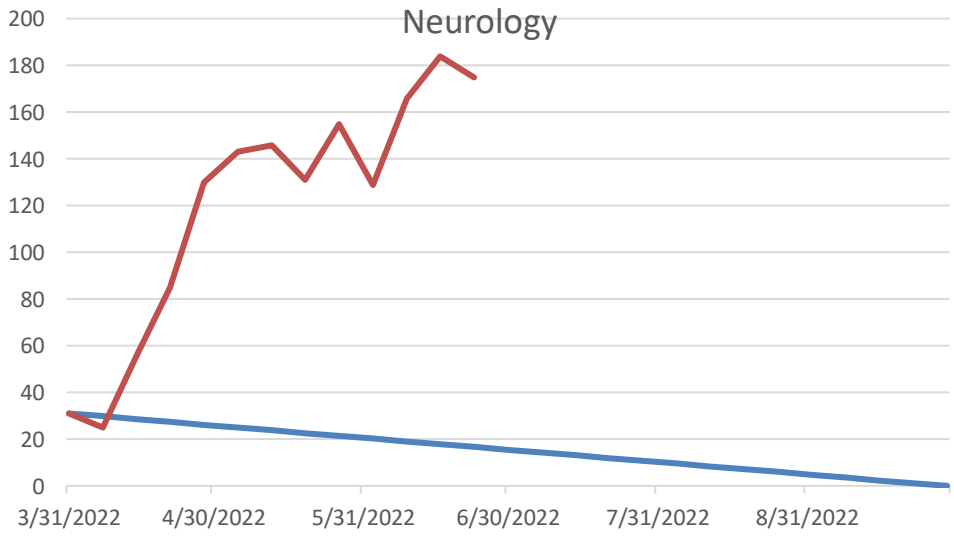
ASIs over 22 Weeks Key Specialties

Calderdale and Huddersfield NHS Foundation Trust









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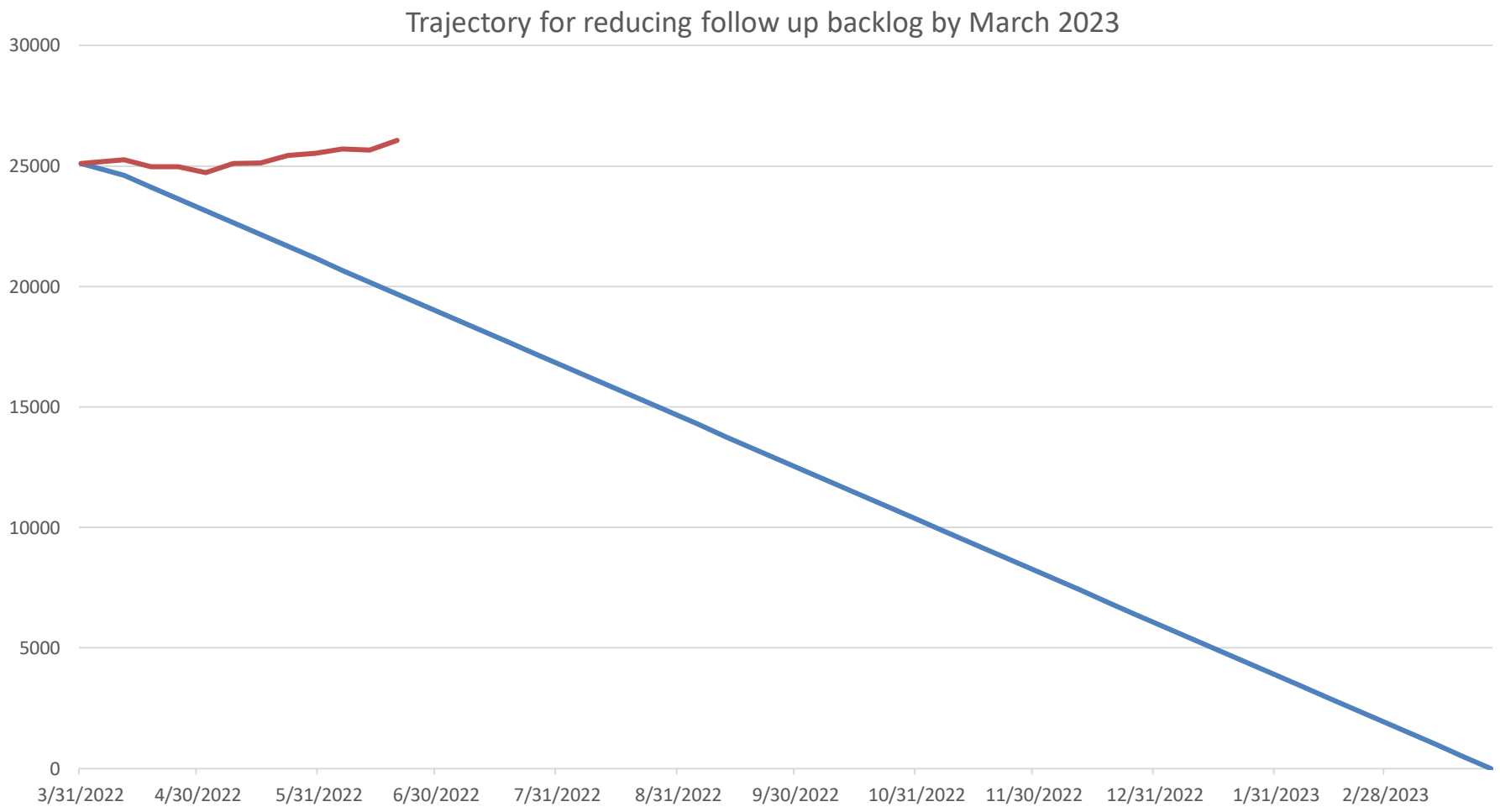
Follow up Backlog Trust Position



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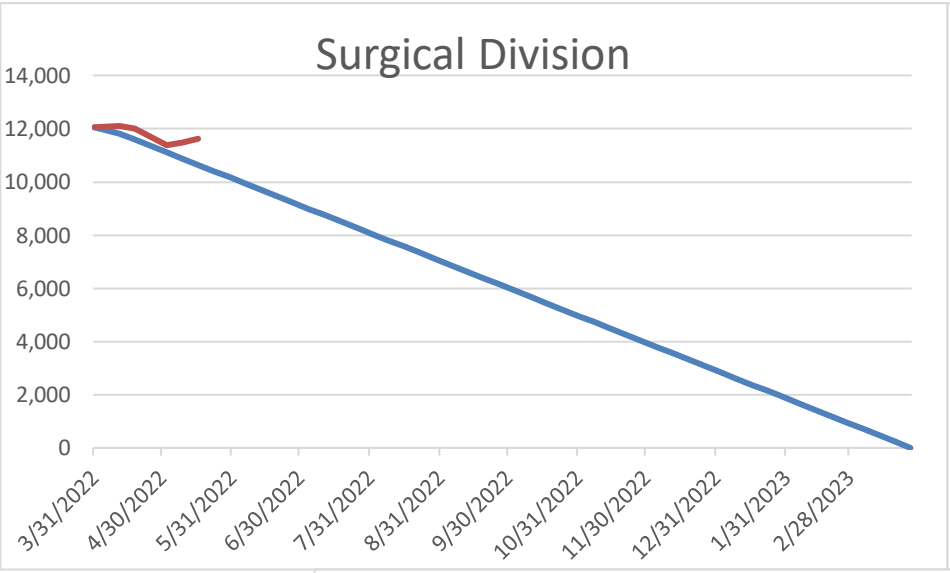
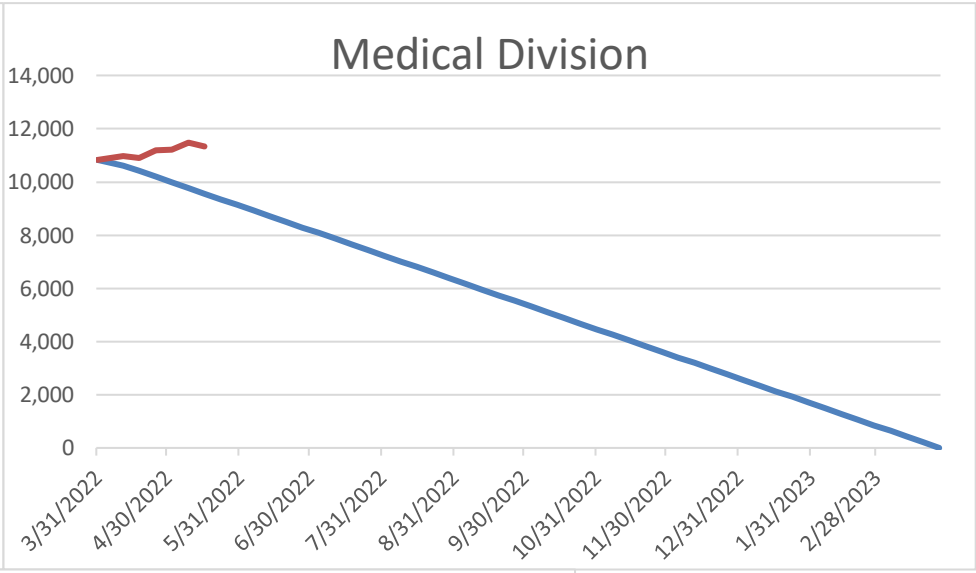
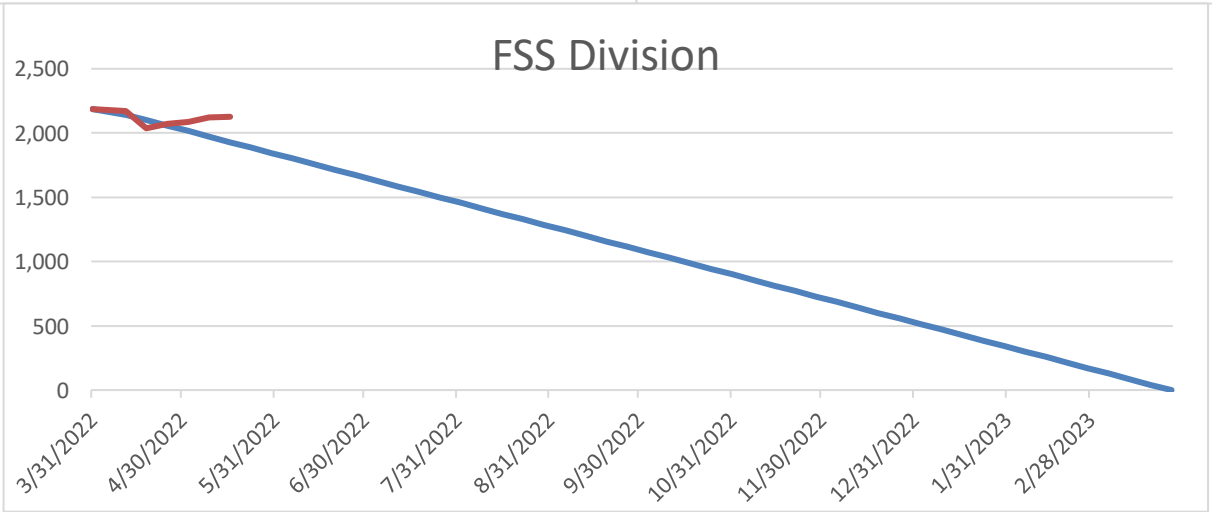
Follow Up Backlog Divisional Breakdown







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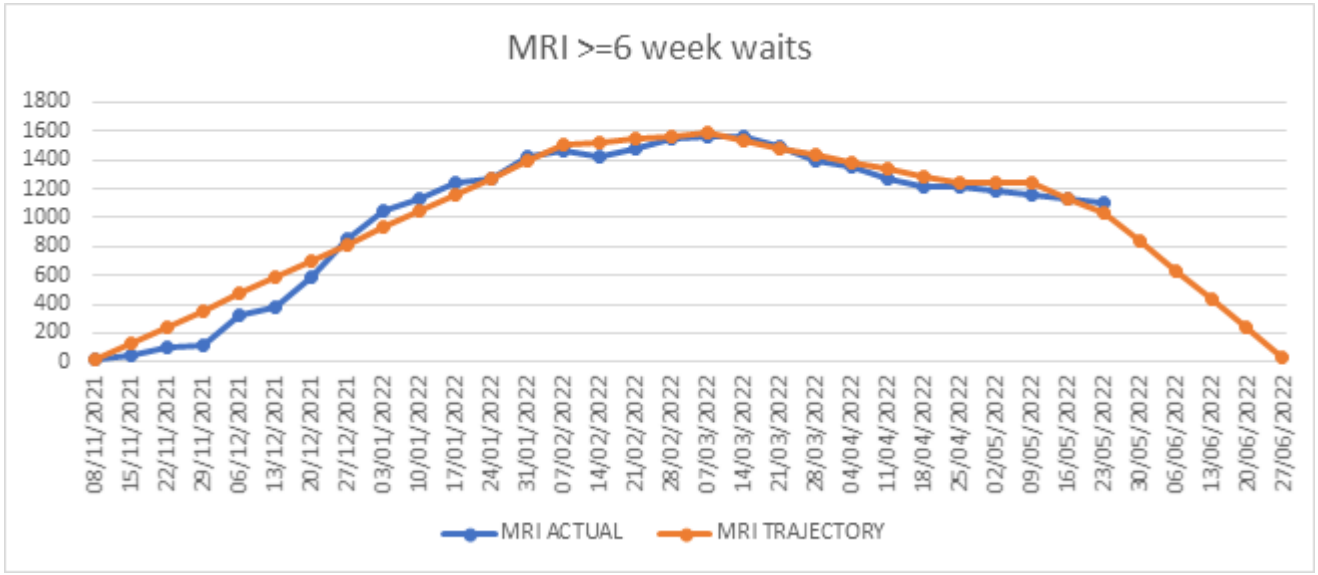
MRI Trajectory



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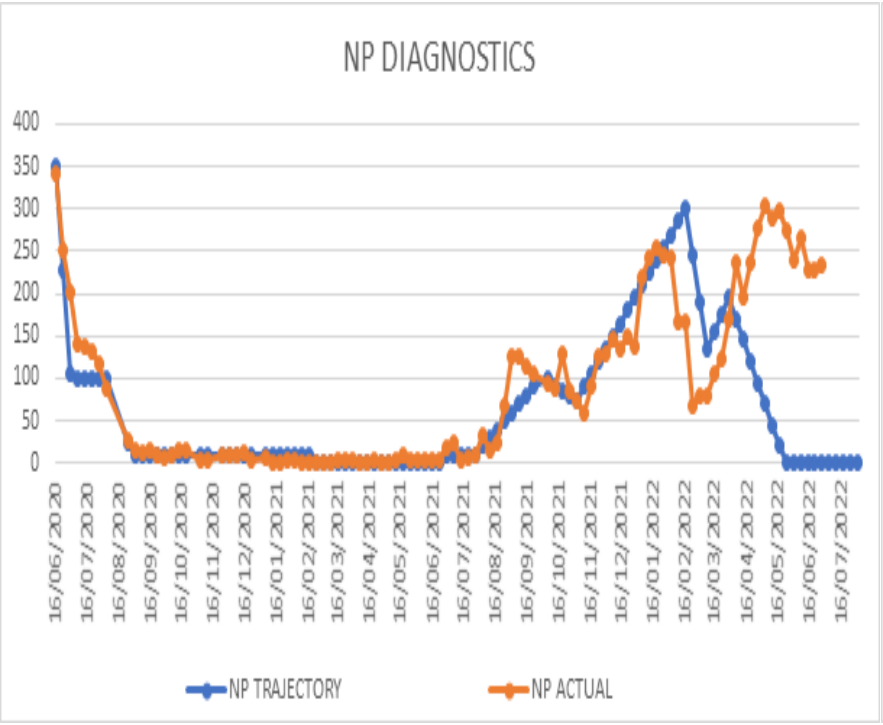
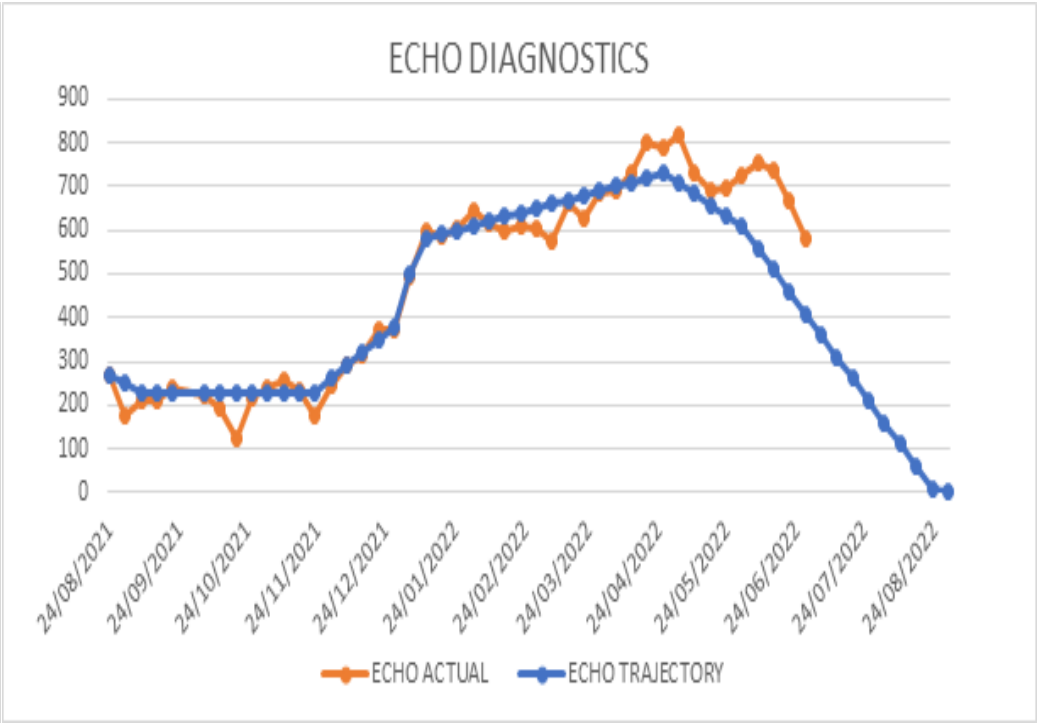
Echo & Neurophysiology Trajectory





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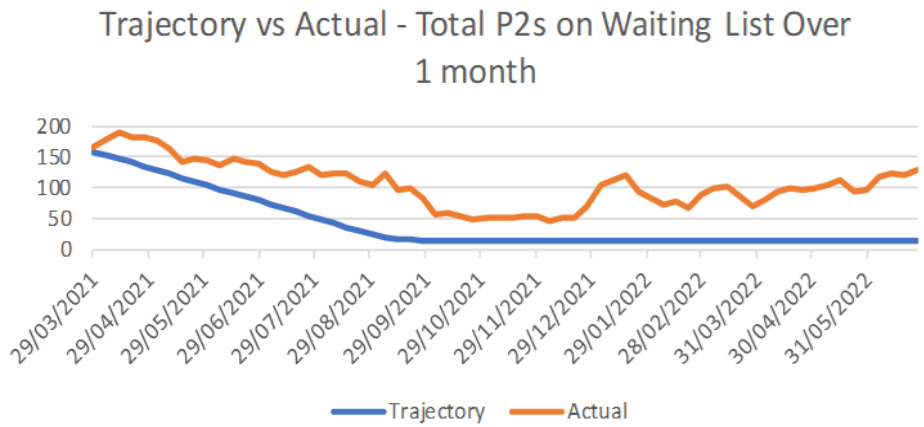
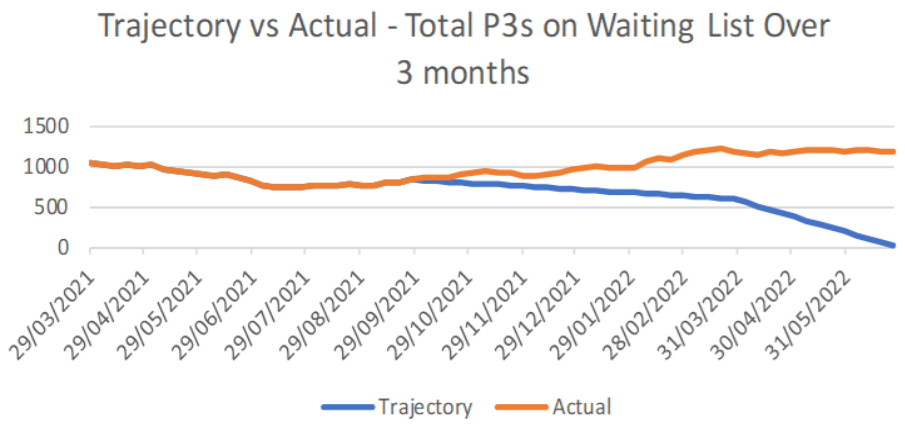
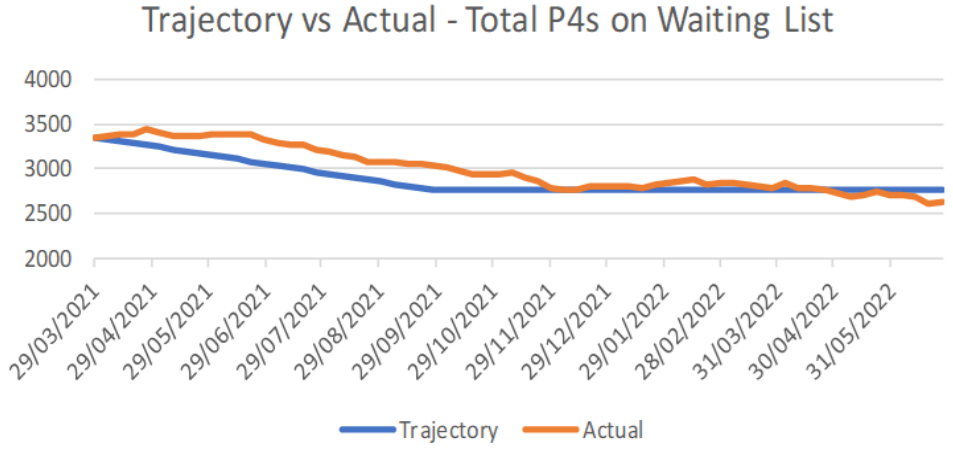
Admitted Waiting List – By P Value







12. Month 2 Financial Summary

To Note

Presented by Gary Boothby

Date of Meeting:	Thursday 7 July 2022
Meeting:	Public Board of Directors
Title:	Month 2 Finance Report
Author:	Philippa Russell, Assistant Director of Finance
Sponsoring Director:	Gary Boothby, 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 2 (May 2022).

Key Points to Note

Year to Date Summary

Year to date the Trust is reporting a £6.07m deficit, a £0.22m favourable variance from plan. The Trust has submitted a plan to deliver a £20.1m deficit for the year. Additional funding for inflationary pressures has since been announced, and the Trust is due to resubmit the plan shortly to reflect this additional funding. This is expected to improve the planned deficit for the year to £17.35m.

- Funding for 22/23 is based on an Aligned Payment Incentive (API) approach with a fixed element based on agreed activity levels and a variable element to support recovery of elective services. £11.94m of Elective Recovery Funding has been assumed in the plan but is subject to delivery of 104% of 19/20 elective activity.
- The Trust has been allocated block funding of £5.9m for the year to support Covid-19 costs by the Integrated Care System (ICS) and continues to have access to funding for Covid-19 costs that are considered to be outside of the System Envelope: Vaccinations and Covid-19 Testing. These will be subject to approval.
- Year to date the Trust has incurred costs relating to Covid-19 of £3.44m, £1.18m higher than planned. Covid-19 activity remains higher than planned driving additional staffing costs and consumables, with some extra capacity opened that was planned to be closed by the start of the new financial year.
- Year to date the Trust has delivered efficiency savings of £2.45m, £0.80m higher than planned.
- Agency expenditure year to date is £1.80m, £0.32m higher than the NHS Improvement Agency expenditure ceiling (planned value yet to be confirmed).
- Total planned inpatient activity, for the purpose of Elective Recovery, was only 97% of the activity planned year to date.

Key Variances

- Income is £1.24m below the planned year to date. This includes £1.48m of planned Elective Recovery Funding, that has not been assumed due to the activity levels delivered year to date being below plan.
- Pay costs are £1.85m below the planned level year to date. The underspend is primarily linked to vacancies, particularly in Community and FSS Divisions and lower than planned Recovery costs. The majority of pay related efficiency plans are profiled to start

later in the year, including those relating to the exit from Covid-19 costs and this likely to put greater pressure on pay budgets as the year progresses.

- Non-pay operating expenditure is £0.65m higher than planned year to date: with pressure on consumables due to additional capacity requirements; inflationary pressures, (in particular on the PFI contract), due to the growth in RPI; and the cost of the MRI Mobile scanner due to delays in installing the new hospital scanners.

Forecast

The Trust is forecasting to deliver the planned £20.1m deficit. This forecast is expected to improve to reflect additional inflationary funding once the revised plan has been submitted to NHS Improvement on the 20th June. The forecast assumes full delivery of a challenging £20m efficiency target. As at the end of May 22, the full £20m of efficiency has been identified and is forecast to deliver.

Attachment: Month 2 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 and **NOTE** the Finance Report and note the financial position for the Trust as at 31 May 2022.

EXECUTIVE SUMMARY: Total Group Financial Overview as at 31st May 2022 - Month 2

KEY METRICS

	M2				YTD (MAY 2022)				Forecast 22/23			
	Plan	Actual	Var		Plan	Actual	Var		Plan	Forecast	Var	
	£m	£m	£m		£m	£m	£m		£m	£m	£m	
I&E: Surplus / (Deficit)	(£3.14)	(£3.03)	£0.11		(£6.28)	(£6.07)	£0.22		(£20.10)	(£20.10)	£0.00	
Agency Expenditure (vs Ceiling)	(£0.74)	(£0.92)	(£0.19)		(£1.47)	(£1.80)	(£0.32)		(£8.82)	(£5.88)	£2.94	
Capital	£1.05	£0.16	£0.89		£3.69	£0.26	£3.43		£41.99	£42.08	(£0.09)	
Cash	£45.22	£64.66	£19.44		£45.22	£64.66	£19.44		£14.53	£17.83	£3.30	
Invoices paid within 30 days (%) (Better Payment Practice Code)	95.0%	87.7%	-7%		95.0%	90.4%	-5%					
CIP	£0.84	£1.64	£0.81		£1.65	£2.45	£0.80		£20.00	£20.00	(£0.00)	
Use of Resource Metric	3	3			3	3			3	3		

Year to Date Summary

Year to date the Trust is reporting a £6.07m deficit, a £0.22m favourable variance from plan. The Trust has submitted a plan to deliver a £20.1m deficit for the year. Additional funding for inflationary pressures has since been announced, and the Trust is due to resubmit the plan shortly to reflect this additional funding. This is expected to improve the planned deficit for the year to £17.35m.

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- Non-pay operating expenditure is £0.65m higher than planned year to date: with pressure on consumables due to additional capacity requirements; inflationary pressures, (in particular on the PFI contract), due to the growth in RPI; and the cost of the MRI Mobile scanner due to delays in installing the new hospital scanners.

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Total Group Financial Overview as at 31st May 2022 - Month 2

INCOME AND EXPENDITURE COMPARED TO PLAN SUBMITTED TO NHS IMPROVEMENT

YEAR TO DATE POSITION: M2

CLINICAL ACTIVITY

	M2 Plan	M2 Actual	Var
Elective	880	747	(133)
Non-Elective	9,703	8,630	(1,073)
Daycase	7,978	7,959	(19)
Outpatient	69,322	69,065	(257)
A&E	28,424	28,245	(179)
Other NHS Non-Tariff	305,064	309,855	4,791
Total	**421,371**	**424,501**	**3,130**

TOTAL GROUP: INCOME AND EXPENDITURE

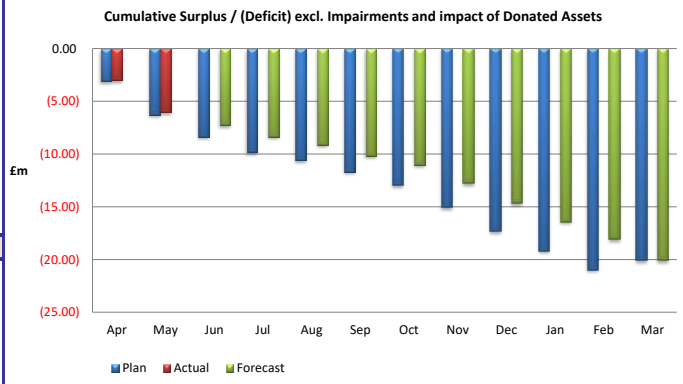
	M2 Plan	M2 Actual	Var
	£m	£m	£m
Elective	£3.48	£2.90	(£0.58)
Non Elective	£20.72	£19.19	(£1.53)
Daycase	£4.98	£5.49	£0.51
Outpatients	£5.00	£6.22	£1.22
A & E	£4.78	£4.60	(£0.19)
Other-NHS Clinical	£31.99	£31.41	(£0.58)
CQUIN	£0.00	£0.00	£0.00
Other Income	£8.95	£8.86	(£0.09)
Total Income	**£79.91**	**£78.67**	**(£1.24)**
Pay	(£54.66)	(£52.81)	£1.85
Drug Costs	(£7.54)	(£7.43)	£0.11
Clinical Support	(£6.40)	(£6.22)	£0.18
Other Costs	(£10.04)	(£11.00)	(£0.95)
PFI Costs	(£2.17)	(£2.17)	£0.00
Total Expenditure	**(£80.82)**	**(£79.62)**	**£1.20**
EBITDA	**(£0.91)**	**(£0.95)**	**(£0.05)**
Non Operating Expenditure	(£5.37)	(£5.11)	£0.26
Surplus / (Deficit) Adjusted*	**(£6.28)**	**(£6.07)**	**£0.22**

* Adjusted to exclude items excluded for assessment of System financial performance: Donated Asset Income, Donated Asset Depreciation, Donated equipment and consumables (PPE), Impairments and Gains on Disposal

DIVISIONS: INCOME AND EXPENDITURE

	M2 Plan	M2 Actual	Var
	£m	£m	£m
Surgery & Anaesthetics	(£16.71)	(£16.36)	£0.36
Medical	(£20.79)	(£21.05)	(£0.26)
Families & Specialist Services	(£14.73)	(£14.00)	£0.73
Community	(£4.57)	(£4.30)	£0.27
Estates & Facilities	£0.00	(£0.00)	(£0.00)
Corporate	(£8.89)	(£8.88)	£0.01
THIS	£0.20	£0.16	(£0.04)
PMU	£0.44	£0.02	(£0.42)
CHS LTD	(£0.04)	£0.06	£0.10
Central Inc/Technical Accounts	£59.05	£58.47	(£0.58)
Reserves	(£0.25)	(£0.20)	£0.05
Surplus / (Deficit)	**(£6.28)**	**(£6.07)**	**£0.22**

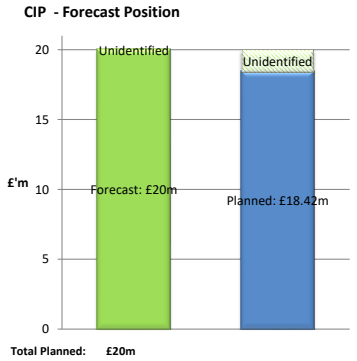
TOTAL GROUP SURPLUS / (DEFICIT)

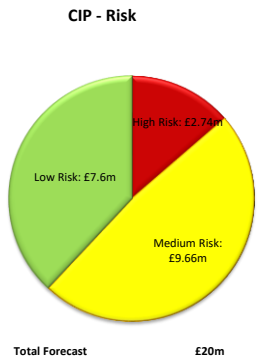


KEY METRICS

	Year To Date			Year End: Forecast		
	M2 Plan	M2 Actual	Var	Plan	Forecast	Var
	£m	£m	£m	£m	£m	£m
I&E: Surplus / (Deficit)	(£6.28)	(£6.07)	£0.22	(£20.10)	(£20.10)	£0.00
Capital	£3.69	£0.26	£3.43	£41.99	£42.08	(£0.09)
Cash	£45.22	£64.66	£19.44	£14.53	£17.83	£3.30
Invoices Paid within 30 days (BPPC)	95%	90%	-5%			
CIP	£1.65	£2.45	£0.80	£20.00	£20.00	(£0.00)
	Plan	Actual		Plan	Forecast	
Use of Resource Metric	3	3		3	3	

COST IMPROVEMENT PROGRAMME (CIP)





YEAR END 22/23

CLINICAL ACTIVITY

	Plan	Actual	Var
Elective	5,776	5,776	0
Non-Elective	58,360	58,360	0
Daycase	50,173	50,173	0
Outpatient	436,084	436,084	0
A&E	170,928	170,928	0
Other NHS Non- Tariff	1,873,315	1,873,315	0
Total	**2,594,636**	**2,594,636**	**0**

TOTAL GROUP: INCOME AND EXPENDITURE

	Plan	Actual	Var
	£m	£m	£m
Elective	£22.89	£22.89	£0.00
Non Elective	£122.44	£122.44	£0.00
Daycase	£31.73	£31.73	£0.00
Outpatients	£32.44	£32.44	£0.00
A & E	£28.56	£28.56	£0.00
Other-NHS Clinical	£194.79	£194.32	(£0.47)
CQUIN	£0.00	£0.00	£0.00
Other Income	£49.67	£49.44	(£0.22)
Total Income	**£482.51**	**£481.82**	**(£0.70)**
Pay	(£318.79)	(£318.76)	£0.03
Drug Costs	(£45.79)	(£46.04)	(£0.25)
Clinical Support	(£38.80)	(£45.29)	(£6.49)
Other Costs	(£53.96)	(£45.08)	£8.87
PFI Costs	(£13.03)	(£14.60)	(£1.58)
Total Expenditure	**(£470.36)**	**(£469.77)**	**£0.60**
EBITDA	**£12.15**	**£12.05**	**(£0.10)**
Non Operating Expenditure	(£32.25)	(£32.15)	£0.10
Surplus / (Deficit) Adjusted*	**(£20.10)**	**(£20.10)**	**£0.00**

* Adjusted to exclude all items excluded for assessment of System financial performance: Donated Asset Income, Donated Asset Depreciation, Donated equipment and consumables (PPE), Impairments and Gains on Disposal

DIVISIONS: INCOME AND EXPENDITURE

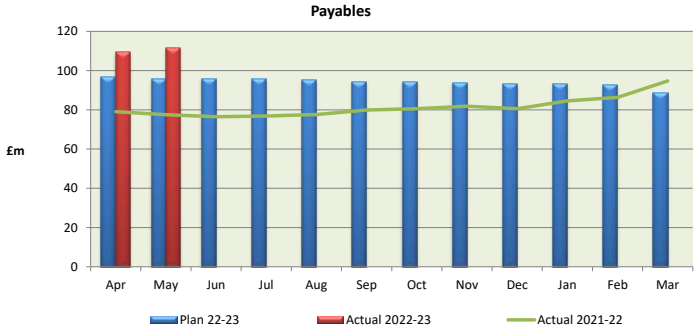
	Plan	Forecast	Var
	£m	£m	£m
Surgery & Anaesthetics	(£101.00)	(£101.01)	(£0.01)
Medical	(£122.74)	(£122.73)	£0.01
Families & Specialist Services	(£87.57)	(£87.57)	£0.00
Community	(£27.31)	(£27.31)	£0.00
Estates & Facilities	£0.00	(£0.00)	(£0.00)
Corporate	(£52.92)	(£52.92)	(£0.00)
THIS	£1.24	£1.24	£0.00
PMU	£2.64	£2.64	(£0.00)
CHS LTD	£0.54	£0.54	(£0.00)
Central Inc/Technical Accounts	£364.14	£364.20	£0.06
Reserves	£2.88	£2.82	(£0.07)
Surplus / (Deficit)	**(£20.10)**	**(£20.10)**	**£0.00**

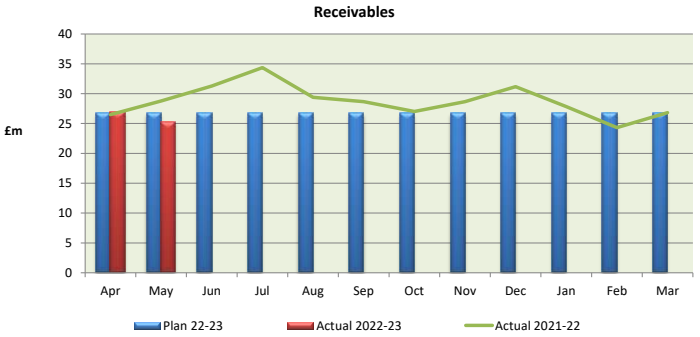
Total Group Financial Overview as at 31st May 2022 - Month 2

CAPITAL AND CASH COMPARED TO PLAN SUBMITTED TO NHS IMPROVEMENT

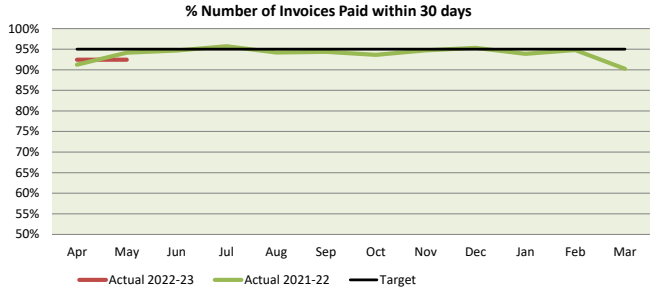
WORKING CAPITAL

	M2 Plan £m	M2 Actual £m	Var £m	M2
Payables (excl. Current Loans)	(£95.87)	(£111.72)	£15.85	
Receivables	£26.70	£25.33	£1.37	



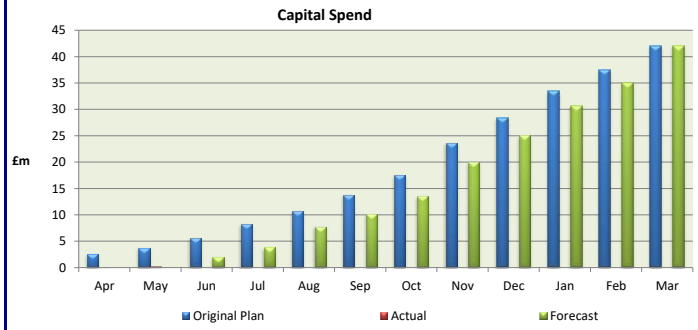


BETTER PAYMENT PRACTICE CODE



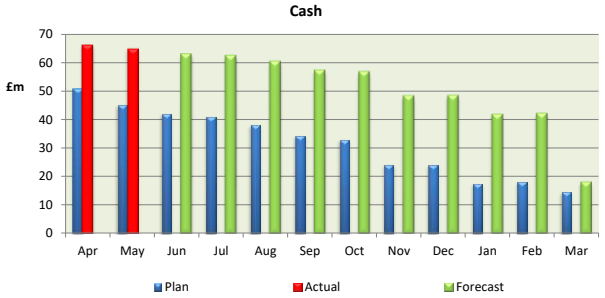
CAPITAL

	M2 Plan £m	M2 Actual £m	Var £m	M2
Capital	£3.69	£0.26	£3.43	

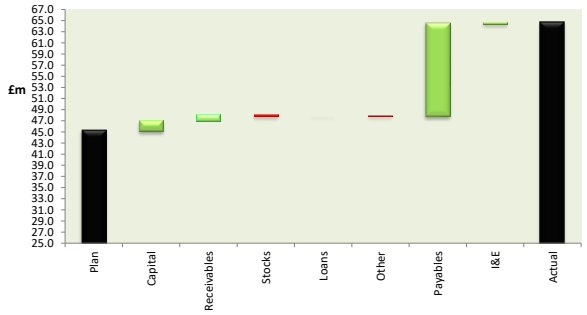


CASH

	M2 Plan £m	M2 Actual £m	Var £m	M2
Cash	£45.22	£64.66	£19.44	
Loans (Cumulative)	£16.57	£16.57	£0.00	



CASH FLOW VARIANCE



SUMMARY YEAR TO DATE

- Year to date the Trust is reporting a £6.07m deficit, a £0.22m favourable variance from plan. The deficit position is driven by a combination of staffing pressures,
- Funding for 22/23 is based on an Aligned Payment Incentive (API) approach with a fixed element based on agreed activity levels and a variable element to support recovery of elective services. £11.94m of Elective Recovery Funding (ERF) has been assumed in the plan, but is subject to delivery of 104% of 19/20 elective activity.
- No ERF has been assumed in the year to date position.
- Total planned inpatient activity for the purposes of Elective recovery was 97% of the activity planned year to date.

- Year to date the Trust has incurred costs relating to Covid-19 of £3.44m, £1.18m higher than planned.

- Capital expenditure is lower than planned at £0.26m against a planned £3.69m. Capital plans now also including any new leases.
- Year to date the Trust has delivered efficiency savings of £1.245m, £0.80m more than planned.
- NHS Improvement performance metric Use of Resources (UOR) stands at 3 as planned.

NOTES

- The Trust has submitted a plan to deliver a £20.1m deficit for the year. Additional funding for inflationary pressures has since been announced, and the Trust is due to resubmit the plan shortly to reflect this additional funding. This is expected to improve the planned deficit for the year to £17.35m.

- The forecast position assumes full delivery of a challenging £20m efficiency target. At the end of May 22, the full £20m of efficiency had been identified and is forecast to deliver.

- The total loan balance is £16.57m as planned. No further loans are planned for this financial year.
- The Trust is forecasting to spend £42.08m on Capital programmes in this financial year including £2.92m on leases. The £0.08m adverse variance to plan is due to an increase in forecast donated assets (funded through charitable funds).

- The Trust has a cash balance of £64.66m, £19.44m higher than planned. This is primarily due to bringing forward monthly reporting processes which is now in advance of the monthly payroll payment.

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

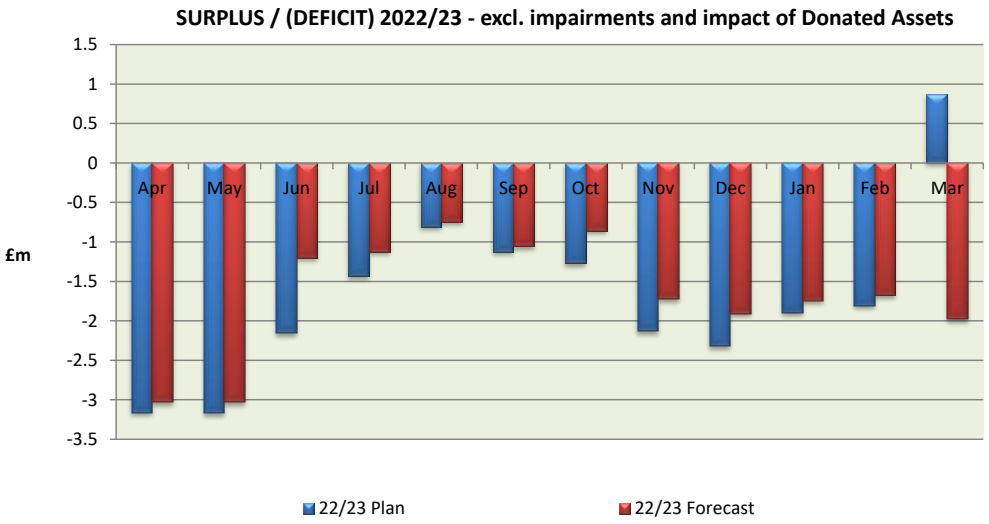
FORECAST POSITION 22/23

22/23 Forecast (31 Mar 23)

Statement of Comprehensive Income	Plan[2] £m	Forecast £m	Var £m	
Income	£482.60	£481.90	(£0.70)	
Pay expenditure	(£318.79)	(£318.76)	£0.03	
Non Pay Expenditure	(£151.58)	(£151.01)	£0.57	
Non Operating Costs	(£32.68)	(£32.67)	£0.01	
Total Trust Surplus / (Deficit)	**(£20.44)**	**(£20.54)**	**(£0.10)**	
Deduct impact of:				
Impairments (AME)[1]	£0.00	(£0.00)	(£0.00)	
Donated Asset depreciation	£0.43	£0.52	£0.10	
Donated Asset income (including Covid equipment)	(£0.08)	(£0.08)	£0.00	
Net impact of donated consumables (PPE etc)	£0.00	£0.00	£0.00	
Gain on Disposal	£0.00	£0.00	£0.00	
Adjusted Financial Performance	**(£20.10)**	**(£20.10)**	**£0.00**	

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

MONTHLY SURPLUS / (DEFICIT)



- The Trust is forecasting to deliver the planned £20.1m deficit.
- This forecast is expected to improve to reflect additional inflationary funding once the revised plan has been submitted to NHS Improvement on the 20th June. Additional funding for inflationary pressures has been announced nationally and will flow in the form of an increase in Tariff. The Trust will amend the plan to reflect this additional funding which is expected to improve the planned deficit for the year to £17.35m.
- The Pharmacy Manufacturing Unit did not deliver the planned surplus in the first two months of the year and there is a risk that the organisation is not successful in recovering this position.
- Vacancies have driven underspends in Community and FSS Divisions in the year to date. A continuation of this position may mitigate the risks above to some extent.

Risks and Potential Benefits

- The forecast assumes full delivery of a challenging £20m efficiency target. As at the end of May 22, the full £20m of efficiency has been identified and is forecast to deliver.
- The forecast assumes that the Trust will deliver it's elective activity plan and secure in full £11.9m of Elective Recovery Funding.
- Whilst additional funding has been secured for inflationary pressures, this funding only covers inflation to the extent that it was included in the plan. The Trust is already seeing further inflationary pressures in relation to RPI linked PFI and BBraun contracts and there is a risk that further inflationary pressures will emerge as the year progresses.
- The Trust had planned to close most of the additional capacity wards used over winter by the 1st of June. There is a risk that this will drive additional costs over the next few months if operational pressures continue.

COVID-19 & Recovery

Covid-19 Expenditure YTD MAY 2022	Pay £'000	Non-Pay £'000	Total £'000
Expand NHS Workforce - Medical / Nursing / AHPs / Healthcare Scientists / Other	178	0	178
Remote management of patients	39	141	179
Increase ITU capacity (incl Increase hospital assisted respiratory support capacity, particularly mechanical ventilation)	0	21	21
Segregation of patient pathways	2,437	76	2,513
Existing workforce additional shifts	36	0	36
Decontamination	0	0	0
Backfill for higher sickness absence	0	0	0
Remote working for non patient activities	0	0	0
PPE - other associated costs	0	0	0
Sick pay at full pay (all staff types)	0	0	0
Enhanced PTS	0	83	83
COVID-19 virus testing - rt-PCR virus testing	58	182	240
COVID-19 - Vaccination Programme - Provider/ Hospital hubs	0	0	0
COVID-19 - Vaccination Programme - Vaccine centres	0	40	40
COVID-19 - Vaccination Programme - Vaccination of Healthy 12-15s (via SAIS)	0	0	0
NIHR SIREN testing - antibody testing only	3	1	3
COVID-19 - International quarantine costs	0	0	0
COVID-19 - Deployment of final year student nurses	0	0	0
Total Reported to NHSI	**2,750**	**542**	**3,293**
PPE - locally procured	0	0	0
Other COVID-19 virus / antibody (serology) testing (not included elsewhere)	137	0	137
Support for stay at home models	0	5	5
Internal and external communication costs	0	0	0
Grand Total	**2,887**	**547**	**3,435**

Recovery Costs YTD MAY 2022	Pay £'000	Non-Pay £'000	Total £'000
Independent Sector	278	2	280
Additional Staffing - Medical	0	356	356
Additional Staffing - Nursing	0	49	49
Additional Staffing - Other	0	184	184
Non Pay	740	0	740
Enhanced Payment Model - Medical	0	0	0
Enhanced Payment Model - Nursing	0	84	84
Total	**1,018**	**674**	**1,693**

Covid-19 Costs

Year to date the Trust has incurred £3.44m of expenditure relating to Covid-19. Excluding Covid-19 costs that were outside of System envelope and for which funding can be claimed retrospectively, the year to date cost is £3.15m versus a plan of £1.62m, an adverse variance of £1.53m. This overspend was driven by higher than planned Covid-19 related activity leading to higher staffing and consumables costs and delays in closing some additional Medical capacity including Ward 11 and the Discharge Lounge. Outside of envelope costs are highlighted in the table to the left and total £0.28m year to date.

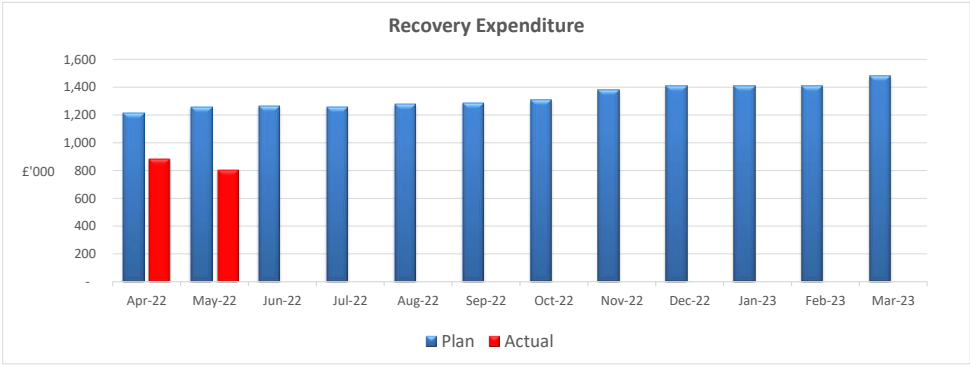
Covid-19 Funding

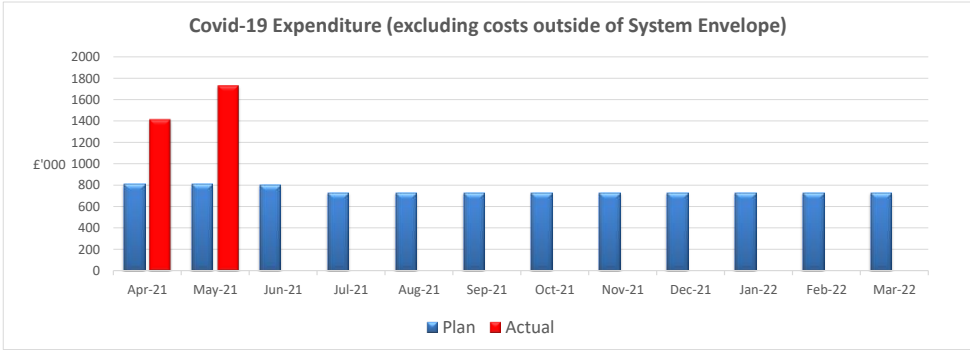
The Trust has been allocated block funding by the ICS to cover any ongoing Covid-19 costs and associated impacts totalling £5.90m for the year (£0.98m year to date).

Recovery

- Year to date Recovery costs are £1.69m, £0.78m lower than planned.
- Total planned Recovery costs for the year are £15.97m to deliver the required 104% of 19/20 activity.
- Funding of £11.9m of Elective Recovery Funding (ERF) is assumed for the year, receipt of which is reliant on the Trust achieving it's activity targets as planned. No ERF has been assumed in the year to date position due to a shortfall in activity delivery.

Note: Both Covid-19 and recovery plans assume that associated CIP schemes are delivered in full.





A Workforce for the Future

13. People Strategy Refresh

To Note

Presented by Suzanne Dunkley

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 7 July 2022
Meeting:	Public Board of Directors
Title:	Refreshed People Strategy 2022-2027
Author:	Suzanne Dunkley, Executive Director of Workforce and Organisational Development (OD)
Sponsoring Director:	Suzanne Dunkley, Executive Director of Workforce and OD
Previous Forums:	Board of Directors: 7 March 2019, 9 January 2020, 6 May 2021 Workforce Committee: 6 June 2022

Purpose of the Report

To provide the Board with an overview of CHFT's refreshed People Strategy for the period 2022-2027.

Key Points to Note

- CHFTs People Strategy 'The Cupboard' was launched in June 2019
- 'The Cupboard' was an innovative approach that focused on 'what' we would do to achieve CHFTs purpose of delivering Outstanding Compassionate Care to the Communities we serve
- It also focused on 'how' we would create the environment, policies and processes to ensure a happy healthy and productive workforce
- CHFT has made good progress on the actions identified in the strategy
- The Health and Wellbeing Strategy articulate in 'The Cupboard' was a key part of our COVID pandemic response
- The focus on health and wellbeing has led to a significant increase in our Staff Survey score on health and wellbeing
- Throughout the pandemic, our absence has benchmarked well against other Trusts across the North East and Yorkshire
- The pandemic and our continued response and recovery necessitates a review of our People Strategy – accounting for all the changes and challenges faced by the NHS workforce
- Colleagues, Leaders and Managers are seeking clarity and certainty in an ever changing world
- It is important that CHFT continues to offer support to colleagues as we approach the next challenges
- The Refreshed People Strategy seeks to build on the good work delivered by 'The Cupboard' by being more focused, with clearer and more succinct descriptors of 'what' we will do and 'how' we will do it. It retains the six key areas of focus, which are:

    1. Equality Diversity and Inclusion
    2. Health and Wellbeing
    3. Engagement
    4. Improvement
    5. Talent Management
    6. Workforce Design

The Corporate Responsibility chapter has not been carried forward into the new People Strategy.

- The refreshed People Strategy will be more neutral in language, imagery and brand
- Sub strategies for example Recruitment Strategy, Inclusive Talent Framework, OD plan and Inclusion strategy have a clear golden thread from the NHS People Plan, WY&H People Plan, our 10 year Strategy and our People Strategy
- The refreshed People strategy also identifies how we will measure progress including how we will use our staff survey responses each year to assess our progress against the 'what' and the 'how' of our People Strategy
- In keeping with 'The Cupboard', the refreshed People Strategy has been a collaborative exercise with all colleagues across CHFT. We have engaged and involved colleagues in listening events, Hot Houses, Tea trolley rounds and focused feedback sessions.

EQIA – Equality Impact Assessment

The People Strategy refresh has been built collaboratively with our colleagues. Feedback from engagement events and from our staff networks have helped to build an inclusive approach to our people responsibilities and activities. The People Strategy has a dedicated commitment to Equality, Diversity and Inclusion as one of its six chapters.

Recommendation

The Board of Directors is asked to **NOTE** the refreshed People Strategy for 2022-2027.

Keeping the Base Safe

14. Director of Infection, Prevention and Control Annual Report

To Note

Presented by Lindsay Rudge

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 7 July 2022
Meeting:	Public Board of Directors
Title:	Director of Infection Prevention and Control (DIPC) Annual Report
Authors:	Gillian Manojlovic, Lead Nurse IPC Dr Vivek Nayak, Consultant Microbiologist, Infection Control Doctor
Sponsoring Directors:	David Birkenhead, Executive Medical Director, Director of Infection Prevention and Control Lindsay Rudge, Interim Chief Nurse
Previous Forums:	None

Purpose of the Report

To provide the Board of Directors an annual report of the position against the IPC statutory requirements and performance for 2021-22.

Key Points to Note

- The Meticillin-Resistant *Staphylococcus aureus* (MRSA) bacteraemia cases zero objective met for the reporting period.
- There have been a total of 37 Clostridium Difficile cases against the objective of 22 cases at year end, including 10 COHA cases. The objective was breached in November 2021. All were subject to a Root Cause Analyses (RCA) – 5 of these cases were identified as potentially avoidable. Learning from the RCAs is fed into a Trust-wide action plan and divisional actions plans, to minimise the risk of patients acquiring CDI.
- A national objective of 91 cases was set including both Hospital Onset Healthcare Associated (HOHA) and Community Onset Healthcare Associated (COHA) cases. A total of 72 cases have been reported in 2020/21. The HOHA cases remain comparable to the previous year.
- There have been 37 COVID-19 outbreaks during the year, with the majority occurring in the final quarter with the emergence of the Omicron variant.
- The Trust participated in the mandatory orthopaedic surgical site infection surveillance (SSIS) programme with a SSI rate within accepted parameters.
- All core policies, as required by The Health and Social Care Act 2008: Code of Practice 2008 (DH 2015), have been reviewed in line with the Annual Programme 2021/22.
- ANTT continues to be a priority with overall Trust compliance at 90.72% by the end of March 2022.
- The IPC team have continued to support all relevant COVID-19 workstreams over the pandemic and maintained standard operating procedures for the testing and IPC management of patients in-line with national IPC recommendations.

EQIA – Equality Impact Assessment
This report relates performance information relating to Infection Prevention and Control. With the exception of COVID it is not expected that the performance metrics reported will be significantly affected by ethnicity, however disability may predispose individuals to certain infections. Whilst IPC guidelines apply to all patients and visitors COVID has had a greater impact on the elderly and some members of the BAME community. The restrictions placed to control nosocomial infection therefore have had a greater impact on those communities.
Recommendation
The Board is asked to **NOTE** the assurances in the 2021/22 Annual Infection Prevention Control report that: • there were effective systems in place for infection prevention control (IPC) during the year. • the performance against key IPC targets in 2021/22 and objectives for 2022/23.

Calderdale and Huddersfield
NHS Foundation Trust

Director of Infection Prevention and Control Annual Report 2021-22

Executive Summary

The Trust has a statutory responsibly to be complaint with The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and associated guidance (updated 2015) and the Care Quality Commission (CQC) guidance. Compliance is demonstrated through the Board Assurance Framework that includes the 10 criteria identified in the code.

The annual report outlines the position against the IPC statutory requirements and performance for 2021-22.

Key points:

- The Meticillin-Resistant *Staphylococcus aureus* (MRSA) bacteraemia cases zero objective met for the reporting period.
- There have been a total of 37 Clostridium Difficile cases against the objective of 22 cases at year end, including 10 COHA cases. The objective was breached in November 21. All were subject to a Root Cause Analyses (RCA) – 5 of these cases were identified as potentially avoidable. Learning from the RCAs is fed into a Trust-wide action plan and divisional actions plans, to minimise the risk of patients acquiring CDI.
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- There have been 37 COVID-19 outbreaks during the year, with the majority occurring in the final quarter with the emergence of the Omicron variant.
- The Trust participated in the mandatory orthopaedic surgical site infection surveillance (SSIS) programme with a SSI rate within accepted parameters.
- All core policies, as required by The Health and Social Care Act 2008: Code of Practice 2008 (DH 2015), have been reviewed in line with the Annual Programme 21/22.
- ANTT continues to be a priority with overall Trust compliance at 90.72% by the end of March 2022.
- The IPC team have continued to support all relevant COVID-19 workstreams over the pandemic and maintained standard operating procedures for the testing and IPC management of patients in-line with national IPC recommendations.

Contents

1. Infection Control Arrangements

The Infection Prevention and Control (IPC) team provides advisory, educational, investigative, development and monitoring activities for the Trust. The purpose of this service is to support the Trust to deliver clean safe care, improve and maintain quality in the delivery of care and meet all statutory and contractual responsibilities relating to IPC.

The Director of Infection Prevention and Control (DIPC) leads the Infection Prevention and Control Team (IPCT), and is supported by the Deputy Chief Nurse/Deputy DIPC, the Lead Nurse IPC and the Infection Control Doctor (ICD). Full details of the IPC arrangements are available in the Trust Policy: Infection Prevention and Control Arrangements.

The IPC team is available 24/7 with an on-call advisory service outside of the standard Monday-Friday office hours. The IPCT has a proactive approach with the emphasis on being visible, particularly on in-patient areas, so expert advice and support can be accessed, supporting the quality and safety agenda through the support of divisions and engagement with partner organisations.

Assurance pertaining to IPC is received and scrutinised by both the IPC Performance Board and the Infection Control Committee, which report to the Quality Committee and to the DIPC directly. The Quality Committee and DIPC report to the Executive Board and the Board of Directors. The Director of Infection Prevention and Control (DIPC) has presented the Trust Board with the following standard agenda items on IPC during 20/21:

- The annual DIPC report 2020/21 – endorsed.
- Quarterly DIPC reports – endorsed.
- Quarterly Infection Control Committee minutes.
- Monthly Trust HCAI data: MRSA bacteraemia, Clostridium *difficile* and E-coli bacteraemia position against objectives and areas of concern plus MSSA data.
- IPC board assurance framework

The IPC Board assurance framework was updated in 2020/21 and reviewed in line with guidance alongside a review of the Health and Safety review of acute providers and the CQC framework and key lines of enquiry. The IPC BAF is monitored by the CQC & Compliance Group.

The table below shows the current position against the IPC Board assurance framework aligned to the 10 elements of The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and associated guidance (DH 2015).

IPC BAF SECTION	Lead Director	In Progress	Compliant	Fully Compliant
1 Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users	D Birkenhead	2	2	11
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.	S Sugarman/ G Boothby	7	0	10
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.	D Birkenhead	0	0	4
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion	E Armistead	0	0	6
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.	J Fawcus	3	2	13
6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.	S Dunkley	0	0	12
7. Provide or secure adequate isolation facilities	J Fawcus	0	1	6
8. Secure adequate access to laboratory support as appropriate	J Fawcus	2	0	11
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections	E Armistead	0	0	5
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection	S Dunkley	0	5	16
Total		**14**	**9**	**94**

Infection Control Budget 2021/22

The Infection Control Team budget is managed by the Lead Nurse IPC. The team has had access to both the pay and non-pay budget plus a surge budget to support the supply and maintenance of respiratory PPE.

2. Mandatory reporting of Healthcare Associated Infections (HCAI)

Mandatory reports are made to Public Health England (PHE) of the following organisms causing the stated infection.

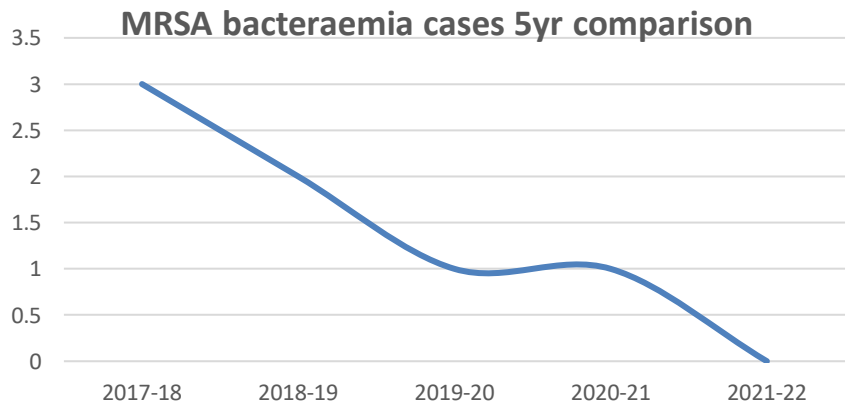
- Orthopaedic Surgical Site Infection (3 month minimum monitoring period)
- *Staphylococcus aureus* bacteraemia (MRSA and MSSA)
- *Escherichia coli* bacteraemia which are diagnosed 48 hours after admission i.e. Hospital onset Healthcare Associated (HOHA) and Community Onset Healthcare Associated (COHA).
- *Clostridium difficile* toxin positive infections which are diagnosed 48 hours after admission i.e. Hospital onset Healthcare Associated (HOHA) and Community Onset Healthcare Associated (COHA).

2.1 Surgical site Infection Surveillance

It is a mandatory requirement for acute trusts to participate in the collection of surgical site infections for a minimum of one orthopaedic category over one surveillance period each financial year. In 2021/22, this was completed from 1st July to 30th September. During this surveillance period we had 2 infections in 58 operations of repair of fractured neck of femur giving a rate of infection of 3.4%. A review of the 2 cases was undertaken and actions agreed. This SSI module is to be repeated in 2022/23.

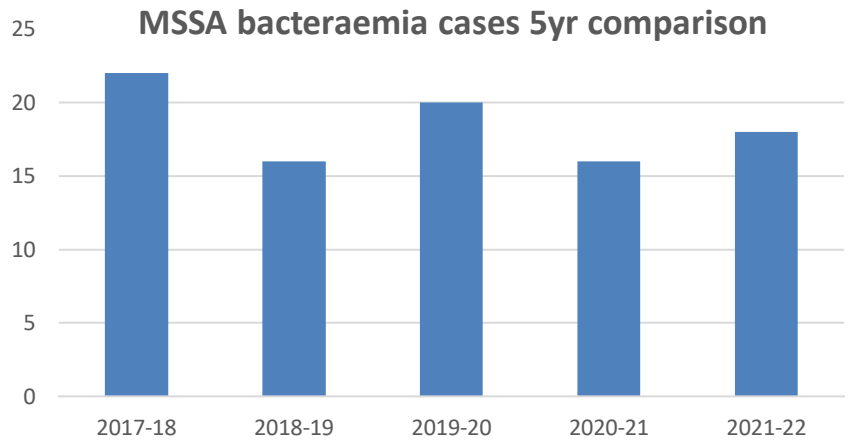
2.2 Meticillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia

The objective of zero required for Trust-apportioned MRSA bacteraemia (blood stream infection) cases for 2021/22 was met. This is the first year that there have been no cases of MRSA bacteraemia attributed to the Trust. The chart below shows the MRSA bacteraemia data for the past 5 years.



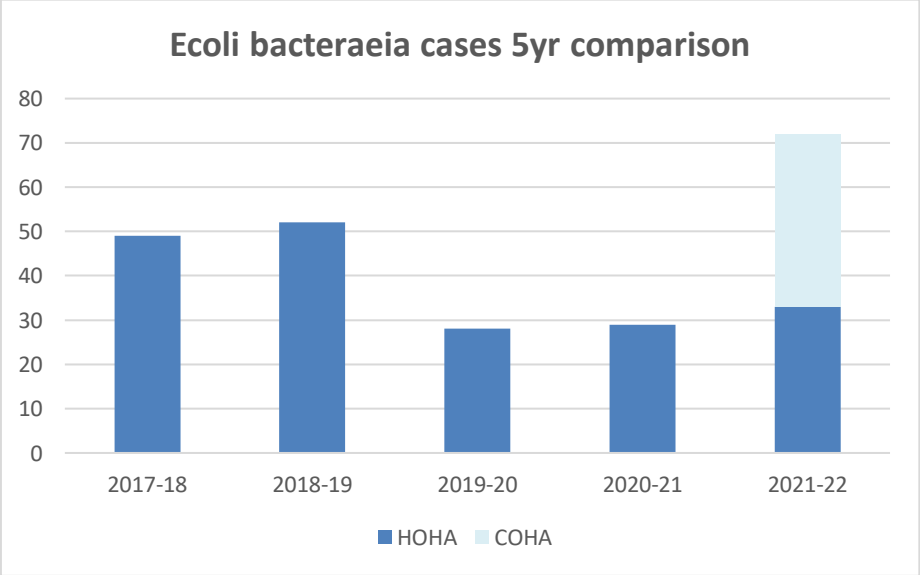
2.3 Meticillin-sensitive Staphylococcus aureus bacteraemia

MSSA (Meticillin-sensitive *Staphylococcus aureus)* bacteraemia are reported nationally although there are no mandated reduction targets set. 18 Trust apportioned cases were reported during 2021/22. The chart below shows the number of post admission MSSA bacteraemia.



2.4 E.coli bacteraemia

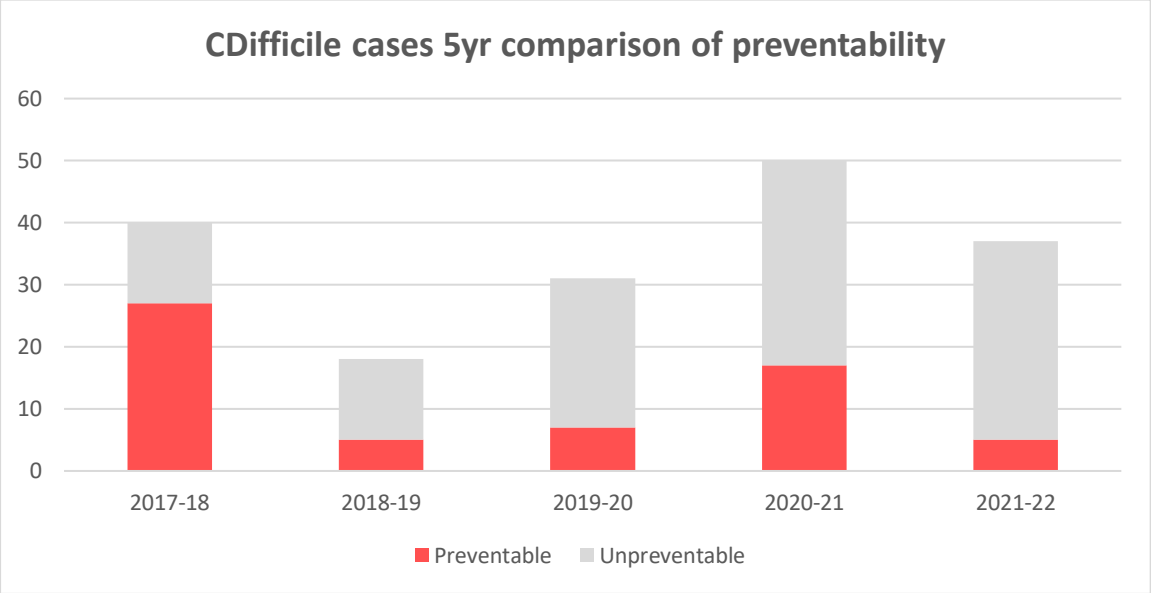
There is an aspirational national objective for the reduction of *E.coli* **bacteraemia** for 50% reduction by 2024. For 2021-22 a national objective of 91 cases was set (for the first time including both Hospital Onset Healthcare Associated (HOHA) and Community Onset Healthcare Associated (COHA) cases. A total of 72 cases have been reported in 2020/21, well below the objective. The HOHA cases remain comparable (n=33) to the previous year (n=29).



2.5 Clostridium *difficile* Infections

The objective for 2021-22 was 22 cases, a reduction of 1 case on the 2019 data (calendar year). The objective includes both HOHA cases (hospital onset, healthcare associated) plus COHA (community onset, healthcare associated) infections where there has been an inpatient episode within the previous 28days. There have been a total of 37 cases against the objective of 22 cases at year end, including 10 COHA cases. The objective was breached in November 21. The increased prevalence of CDifficile infection at the Trust has also been reported in Trusts across the region. Every case is investigated to find a root cause and identify improvements in practice required. Cases are classified either preventable or unpreventable. The chart below illustrates the cases by preventability over a five year period.

A full review of all preventable cases from 20/21 was published in April 21 with key themes and learning identified. Antimicrobial prescribing as well as timely sampling and isolation were identified as areas for improvement. Improvement work regarding all these elements has been undertaken by the divisions, the Antibiotic Management Team and the IPC team and a significant drop in preventable cases during 21/22 has been reported.



3. Incidents and Outbreaks

Outbreaks are managed in line with outbreak of infection policy. The policy remains under review following changes in COVID-19 guidance.

3.1 Norovirus: Norovirus is an easily transmissible infectious disease, causing symptoms of diarrhoea and vomiting. When an area is closed with viral gastroenteritis patients are not admitted into available beds on the area, nor are patients on the area discharged to other healthcare settings e.g. care homes, to prevent onward spread of infection. There

have been 10 outbreaks of Norovirus reported over the year resulting in 201 lost bed days.

3.2 COVID-19 pandemic:

Management of the COVID-19 pandemic through 2021/22 has remained a whole organisation response. The pandemic has been managed and monitored via the Incident Management Team (IMT) and subsequently by the Executive Board via escalation structures. IPC issues have been discussed daily at bronze command and weekly at IPC tactical to provide assurance that appropriate arrangements are in place to manage and monitor the prevention and control of infection. IPC is also represented at the visiting workstream and testing workstream plus clinical area groups to support ongoing plans.

Several specific actions in response to the pandemic were undertaken by the IPCT these are summarised below.

Implementation of National Guidance: Rapidly changing national guidance from PHE/UKHSA supplemented by additional guidance from professional bodies has required interpretation. The level of implementation of guidance was risk assessed taking into account the prevalence in the local communities and in the services and predicted direction of travel. The IPCT led this process producing patient pathways and Standard Operating Procedures (SOPS) for clinical staff including guidance on isolation and cohorting, collection and transport of high consequence infectious diseases samples, placement of patients and management of stepping down precautions. In addition, IPC have supported Occupational Health in producing staff SOPs for case and contact management of staff.

Command forums: IPC has attended regularly and has worked closely with the bed team, commanders, divisional managers, supplies, estates and cleaning services to support patient safety, patient placement and cohort management while maintaining patient flow.

Operationalising pathways: all areas have been supported during changes to the pathways, be that planning how to deliver a change in an area or face to face support in the area for staff.

Risk assessments of all clinical areas: in line with national guidance, the ventilation in all clinical areas of the Trust were assessed and mitigations put in place where needed.

Health economy and partnership working: attendance and input at regional DIPC meetings chaired by NHSE/I, Y&H IPC Lead meetings, West Yorkshire lead nurses group and CCG meetings (Calderdale and Kirklees). Invaluable meetings throughout the pandemic to learn from partners, debate new guidance and remain updated on local and national issues.

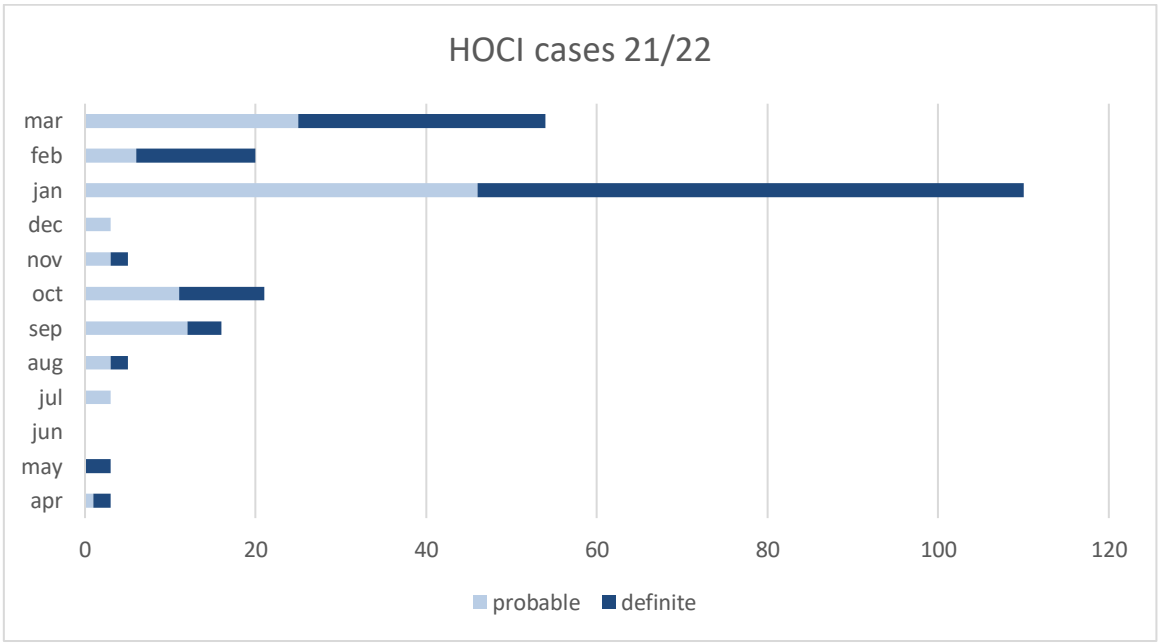
Case and incident management: Outbreaks and HOCIs were identified rapidly and outbreak policy initiated when required. In collaboration with Trust health informatics and the EPR team, timely data on new COVID positives, indeterminate results and

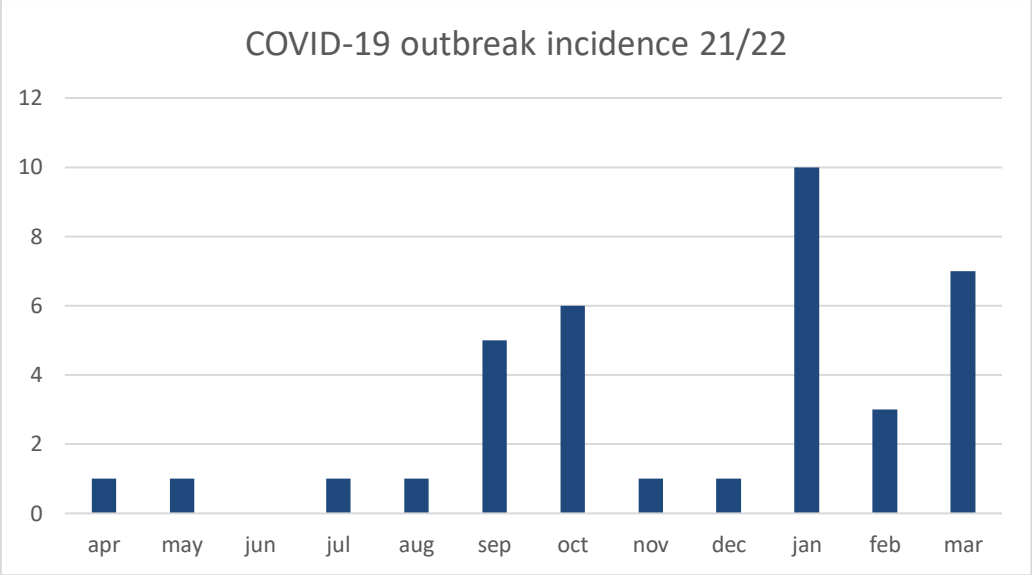
HOCIs informed patient segregation and cohorting plans and any rapid changes as required.

COVID-19 outbreaks: There have been 37 COVID-19 outbreaks during the year, with the majority occurring in the final quarter with the emergence of the Omicron variant. All outbreaks were reported into the UKHSA portal and managed in line with COVID19 outbreak management guidelines and monitored for 28 days. Issues identified when managing the outbreaks have included:

- Mobile patients with cognitive impairment
- Timely retesting and isolation where results returned inconclusive.
- Environmental issues especially difficult with maintaining social distancing for patients
- Multiple bed moves
- Breaches in PPE
- Staff not recognising early or minor symptoms of COVID and then attending work.

Healthcare – Associated COVID Infections (HOCI's): A probable HOCI is defined as a new positive result between day 8 and day 14 of admission and a definite HOCI is a positive new result at day 15 onwards. All HOCI cases, whether probable or definite are reported via the Trust incident reporting system (Datix). A total of 243 patients were reported as HOCI, an increase of 18 cases on the previous year. The majority of cases were reported in January 2022 (initial Omicron BA.1 wave) and March (Omicron BA.2 wave). A significant number of these cases resulted in outbreaks, demonstrated in the two peaks of outbreak incidence coinciding with the HOCI peaks.





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 tactical meetings, attended by all divisions and at other professional forums for onward sharing.

Assistance from NHSE/I was offered in response to the increasing numbers of outbreaks and healthcare onset Covid-19 infections (HOCI) cases. Mitigations put in place by the Trust were supported.

Communication: - The IPCT have supported communication in the following ways:-

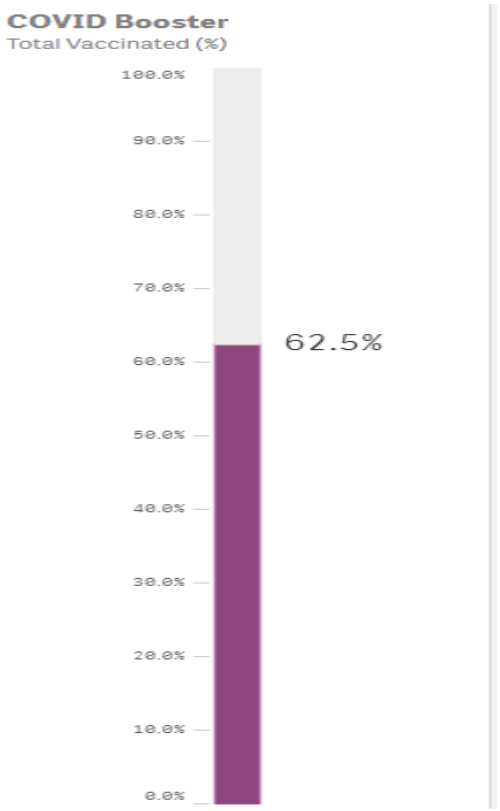
- Ongoing review of the IPC elements of the Trust COVID intranet page for staff to access relevant IPC guidance, pathways and SOPs including PPE donning doffing videos and patient and staff COVID testing strategies.
- All new information/guidance was communicated via COVID IMT, work streams, daily tactical meetings and workforce briefings.
- IPC red border emails communicated any Trust-wide essential messages rapidly.
- IPC team worked closely with the Trust communications and other relevant work streams to support campaigns on IPC must-do's, COVID signage, PPE compliance, patient/visitor information, Influenza and COVID vaccination, work force well-being and social distancing.

4. Occupational Health

Staff absence due to Covid infection significantly reduced following to the roll out of vaccines to staff but the three waves seen in 2021/22 saw increases in staff infection.

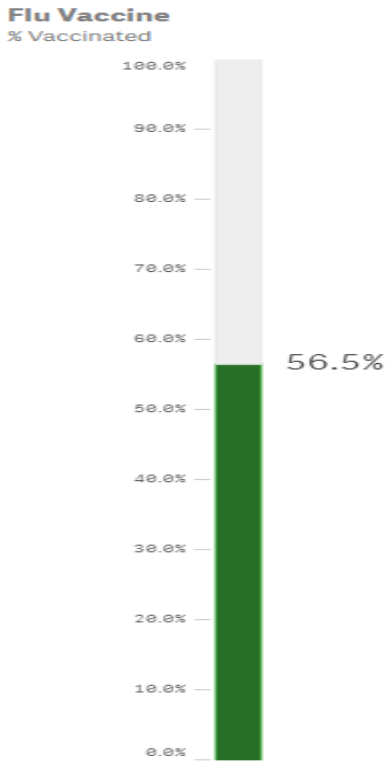
Staff Covid immunisation data 2021/22: (Taken from KP+)

	% Vaccinated (All)	% Vaccinated (Eligible)
Totals	**62.5%**	**74.8%**
Calderdale & Huddersfield Solutions Ltd	50.2%	64.1%
Central & Technical	35.7%	44.4%
CHFT Staff Bank	-	-
Community	66.4%	76.0%
Corporate	66.3%	82.2%
Families & Specialist Services	65.9%	77.4%
Health Informatics	58.3%	77.6%
Medical	58.4%	70.7%
Pharmacy Manufacturing Unit	62.3%	79.6%
Surgery & Anaesthetics	65.4%	76.4%



Staff Flu Immunisation Data 2021/22: (taken from KP+)

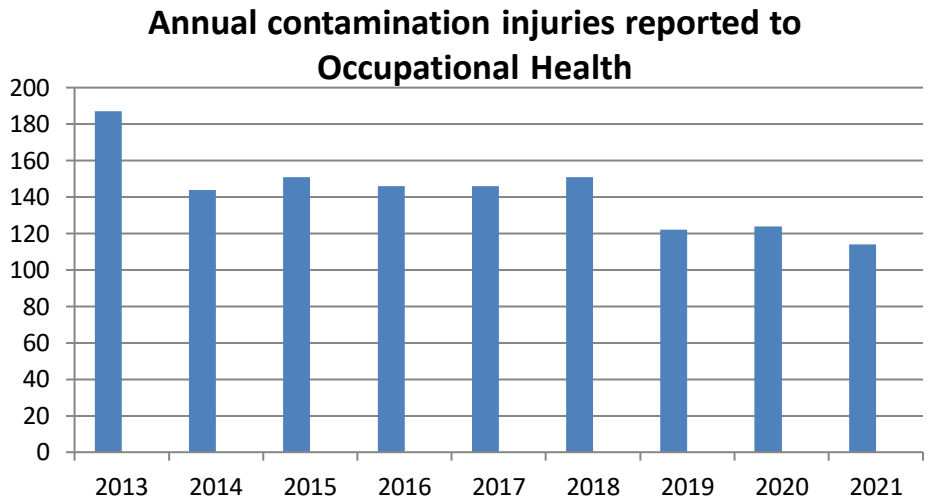
	% Vaccinated (All)	Total Staff
Totals	**56.5%**	**6348**
Calderdale & Huddersfield Solutions Ltd	41.7%	446
Central & Technical	28.6%	14
CHFT Staff Bank	-	0
Community	63.7%	727
Corporate	59.5%	481
Families & Specialist Services	60.8%	1458
Health Informatics	43.0%	230
Medical	52.4%	1624
Pharmacy Manufacturing Unit	50.7%	69
Surgery & Anaesthetics	60.0%	1299



EPP Worker checks: New starter immunisations for EPP Workers has continued throughout Covid outbreaks and all new EPP Workers were appropriately screened at pre-employment checks

Routine staff immunisations: Following a review of outstanding immunisations, catch-up clinics for routine staff immunisation were introduced in June 2021.

Contamination injuries: A quarterly report is presented to the Infection Control Committee by Occupational Health for contamination injuries. A Sharps injury group investigates any patterns of incidents and makes recommendations for practice improvements. Currently no trends have been identified, other than a small increase in injuries to junior doctors with no specific pattern of injury noted. Overall reported incidents are showing a steady decline.



5. Antimicrobial Prescribing

Antimicrobials Overview

Consumption:

Average quarterly values demonstrate a decrease in overall consumption for 2021/22 versus 2020/21. CHFT total antibiotic usage is currently below the regional and national average.

Work is ongoing to further reduce antibiotic use through targeted antibiotic ward rounds, educational interventions, optimisation of EPR stewardship capabilities (work pending with Eprescribe) and focus on improving early sampling in infection.

Standard Contract

Antibiotic consumption performance update for the NHS Standard Contract 2021/22

The NHS Standard Contract 2021/22 set out a target to achieve a 2% reduction in total antibiotic consumption during 2021/22. This reduction is as compared to calendar year 2018 Acute Trust total consumption data baseline (DDDs total and DDDs per 1000

admissions). CHFT are meeting this target at present, the final data for the 2021/22 is expected summer 2022.

CHFT antibiotic consumption data (course UKHSA data hosted on FutureNHS website):

Total DDDs/1000 admissions 2018	Total DDDs/1000 admissions Q4 2020/21 to Q3 2021/22	% Difference in DDDs/1000 admissions from 2018 baseline	MEETING or NOT YET MEETING the 2% reduction target
4221	4121	-2.4%	MEETING (data for Q4 not yet released)

For the financial year (2022/23), the NHS standard contract requirement is to reduce broad spectrum antibiotic consumption by 4.5% from 2018 calendar year baseline in NHS providers of acute care. Broad spectrum antibiotics are those classified as “watch” or “reserve” in the adapted WHO AWARE categorisation of antibiotics. As well as working to reduce overall consumption, the AMT have been working to reduce broad spectrum use and as such are already on target to achieve this reduction. Maintaining and building on this reduction will be a focus of work throughout 2022/23.

CHFT broad spectrum antibiotic consumption data (course UKHSA data hosted on FutureNHS website):

Total Watch + Reserve DDDs per 1000 admissions 2018	Target in Watch + Reserve DDDs per 1000 to give 4.5% reduction	Total Watch + Reserve DDDs per 1000 admissions Q4 2020-21 to Q3 2021-22	% difference in Watch + Reserve DDDs per 1000 admissions from 2018 baseline	MEETING or NOT YET MEETING the 4.5% reduction target
2193	2095	1888	-13.9%	MEETING currently

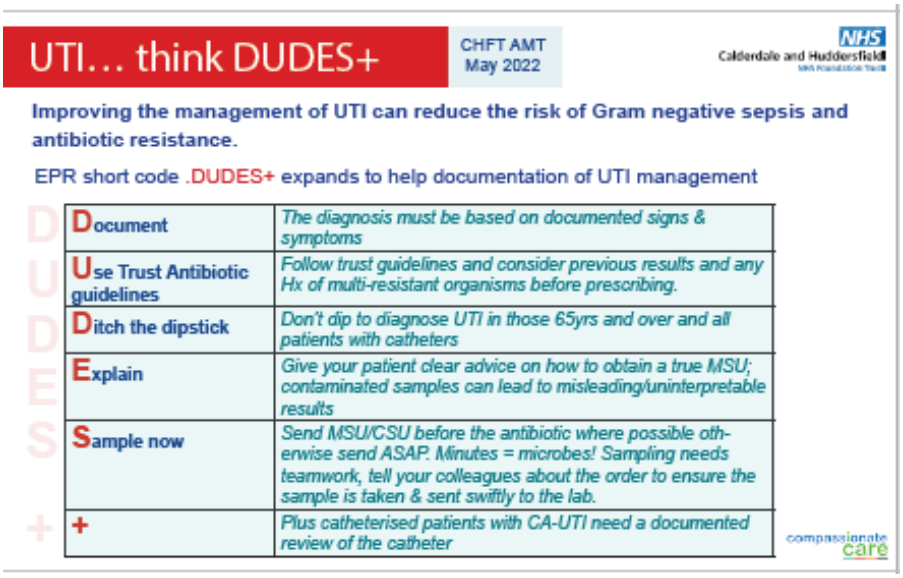
CQUIN

The AMT are leading on the 2022/2023 CQUIN: Improving the management of UTI: appropriate antibiotic prescribing in adults aged 16+

Description	Achieving 60% of all antibiotic prescriptions for UTI in patients aged 16+ years that meet NICE guidance for diagnosis and treatment.
Numerator	Of the denominator, the cases where all the following actions were applied: 1. Documented diagnosis of specific UTI based on clinical signs and symptoms 2. Diagnosis excludes use of urine dipstick in people aged 65+ years and in all catheter associated UTI (CAUTI) 3. Empirical antibiotic regimen prescribed following NICE/local guidelines 4. Urine sample sent to microbiology as per NICE requirement 5. For diagnosis of CAUTI, documented review of urinary catheter use is made in clinical record.

A baseline (pre-CQUIN) audit was completed in April 22. Overall compliance was **37%** (each case MUST achieve all elements in order to achieve compliance).

The following actions have since been undertaken: The above CQUIN targets (and advice on improving these) have been presented at various forums (medics & nursing), via trust screensavers and have been included in the trust Antimicrobial newsletter. EDs and wards have been visited with an educational trolly promoting the CQUIN and the newly devised EPR short code to aid documentation when treating a UTI. Prompt cards were distributed to colleagues to encourage the use of DUDES+



Data collection for the Quarter 1 performance is in progress.

Antibiotic Ward rounds

- The review of patients prescribed who have been on antibiotics for over 7 days has been continued this year. Any patients that are felt to require further review are discussed with the clinical team.
- Once weekly ward rounds were undertaken to review patients prescribed intravenous cephalosporins.
- Antibiotic pharmacists support the COVID outpatient service (CMDU)

Audit Work

- Point Prevalence Survey across the trust was completed in August 2021. Specialities collected their own data which was analysed by AMT and the results were fed back. AMT collated feedback and action plans.
- MRSA suppression treatment audit was completed in June 21 and December 21.
- Gentamicin snapshot audit was completed in November 21, findings were fed back to individual prescribers and the Surgical Divisional Director.
- The AMT participated in the national Co-Gent audit. Data has been submitted, with analysis currently underway.
- Collaborated with sepsis group colleagues for the piperacillin/tazobactam Macoset audit in ED.

Antibiotic Awareness Week

- The following were undertaken during Antibiotic Awareness Week (AAW) November 2021:
    - Launched Trust Antimicrobial newsletter – this is circulated around colleagues every 2 months promoting antimicrobial stewardship, new initiatives/changes to guidelines and sharing feedback from incidence and antimicrobial reviews.
    - Gentamicin Audit Undertaken - Findings fed back during AAW to relevant clinicians
    - Microbiologist led session to nursing colleagues 19th November – discussing the role of nurses in stewardship
    - Screensavers on CHFT computers, piece in CHFT News and resources on our Antibiotic Intranet page
    - Senior leaders from our organisation produced short videos promoting Antimicrobial Stewardship for release during AAW
    - Microbiologist led training sessions to GP trainees
    - Microbiologist presenting re AAW at the Medical Workforce Meeting 18th Nov
    - Emails sent ICN, pharmacy teams and Antibiotic Champions to promote AAW and AMS

Education

- The AMT have delivered antimicrobial stewardship training to ED middle grades/ APs, GP trainees, FY1 doctors, nursing colleagues, pharmacy, podiatry students and phlebotomy colleagues.
- Continued participation in Trust and ED specific junior doctor inductions.

6. Decontamination

The Decontamination Committee chair is the Managing Director of CHS and Deputy Chair to Head of Medical Engineering and Decontamination Services CHS with bi-monthly meetings scheduled. The Decontamination contract novated to Calderdale Huddersfield

Solutions (CHS) in 2020 and an SLA remains in place for Decontamination manager from AGH Solutions 1 day per week.

Surgical instrumentation: The Decontamination contract to be continued with BBraun, for a further 5 years up to 2027. During that time the Pathfinder group are to scope options for the future. BBraun contract KPIs during 21/22 were met.

Endoscopy decontamination: The units at both sites have raised concerns regarding the high ambient temperature within these areas. Mitigations were put in place and longer term plans to address this part of the estates workplan.

7. Cleaning Services

The Trust cleaning services are provided by CHS (CHFT Partner) at HRI and ISS (PFI partner) at CRH.

As part of the monitoring arrangements both companies self-monitor the performance of cleaning services against key performance indicators. These are reported to the Trust on a monthly basis for analysis and challenged where appropriate by the Service performance team and via escalation to the IPCT.

In addition, the standard of cleanliness is monitored fortnightly by the ward/dept manager as part of the FLO (frontline ownership) audits which forms part of the assurance framework.

The past year has proved challenging as a result of the Covid19 Pandemic and as such in addition to delivering a high quality patient focussed service, Cleaning Services have been required to become more reactive and work flexibly in order to meet the needs of the Trust.

Additional cleaning resource has been provided on Covid19 wards to ensure IPC guidelines and expectations were achieved.

Support with several ward moves at short notice with deep cleans carried out once COVID-19 wards reverted to their original speciality.

8. Estates

The IPCT continue to advise and support estates with refurbishments within the Trust. This has required attendance at key design and planning meeting and the review of plans to ensure they meet minimum build standards.

Water sampling for *Legionella* and Pseudomonas was undertaken in accordance with L8 and health technical Memoranda (HTM-04). Any remedial action was successfully undertaken on outlets that did not meet the required standard.

Annual performance and verification checks were undertaken on all critical ventilation systems including theatres revalidation.

Testing and validation was carried out on the mechanical ventilation systems to ensure that there were sufficient air changes to allow Aerosol Generating Procedures in suspected COVID positive patients to take place safely and to calculate the necessary settle time.

Reconfiguration work has been carried out at the HRI site over the year, and the IPC Matron Lead was recruited to lead the IPC element of this work including IPC safety during works and IPC considerations in the new builds. Mitigations have been implemented to maintain the safety of vulnerable patients during the demolition and ground works.

9. Infection Prevention and Control Policies

All core policies as required by the Hygiene Code 2008 are reviewed as set out in the Annual Programme and are published on the Trust Intranet and Internet. The following policies have been approved at Executive Board during 2021/22:

Section A – Infection Control Arrangements
Section B – Notifiable Disease
Section J - Management of Patients with Multi Resistant Organisms inc. VRE, PRP and ESBL
Section M – Management of Contamination Injuries
Section O – Transmissible Spongiform Encephalopathies
Section P – Care of the Deceased Body
Section S – Tuberculosis
Section T – MRSA and PVL Policy
Section U – MERS-CoV
Section W – Bed Management Policy
Section Z – Blood Culture Policy
Section new - Aspergillus Policy

10. Education and Training

Since the COVID pandemic was declared face to face training has been kept to a minimal ensuring social distancing is maintained. Level 2 IPC training is now delivered by e-learning and will remain so going forward with bitesize and bespoke training session arranged as required.

Education is provided on a one to one basis during routine clinical visits by the IPCNs and in response to patient specific clinical enquiries from wards and departments.

The IPCT also deliver Aseptic Non Touch Technique (ANTT) assessor training, supporting compliance and safety metrics and zero harm; the Trust overall compliance at the end of March 2022 was 90.72%.

Comprehensive Infection prevention training for the Junior doctor's induction day, including the assessment of ANTT.

The IPCT has led FIT testing for FFP3 masks throughout the year including the recruitment of a permanent respiratory protection support worker. External fit testers have also been utilised to support the delivery of the national standards.

The IPCT has kept up to date with current national policies and guidance, attended relevant study days, meetings and conferences.

11. Conclusion

Infection prevention and control is the responsibility of all Trust employees and the IPCT does not work in isolation. The successes over the last year have only been possible due to the commitment for infection prevention and control that is demonstrated at all levels within the organisation. A number of key risks and challenges exist and the focus on COVID19 control has had and will continue to have an impact on other aspects of infection control activity. Clearly COVID19 control is extremely important but the need to prevent and maintain control of other types of infections must not be overlooked.

The IPC annual programme for 2022/23 includes the following key objectives

- To ensure that compliance with the Health & Social Care Act (2008) Code of Practice on the Prevention & Control of Infections and Related Guidance (DH, 2015) is maintained.
- Ensure systems and processes are in place for the safe clean care of patients and the safety of staff.
- Monitor and ensure compliance with changes in the management of Covid-19/respiratory infections.
- CPE screening/isolation toolkit implementation
- National Cleaning Standards 2021 – implementation.
- Fit testing provision review and development for the long-term organisational requirements.
- Reduction in the number of preventable Clostridium Difficile infections
- Explore the IPC input into post infection/outbreak reports in order to strengthen the learning and improve future patient care and outbreak management.
- Develop the SSI surveillance programme in collaboration with the surgical and FSS divisions.
- Reset and stabilise the IPC function.
- Review the training strategy.

The IPC Team should be commended for their continued enthusiasm, resilience and commitment to ensuring safety of our patients, visitors, and staff.

15. Learning from Deaths Annual Report

To Note

Presented by Cornelle Parker

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 7 July 2022
Meeting:	Public Board of Directors
Title:	Learning from Deaths 2021/22 Annual Report
Authors:	Dr Cornelle Parker, Deputy Medical Director
Sponsoring Director:	David Birkenhead, Executive Medical Director
Previous Forums:	Quality Committee 20th June 2022

Purpose of the Report

- To provide the Board of Directors with assurance of the Learning from Deaths mortality review process
- To provide a review of mortality during 2021/22
- To provide focus on Learning Disabilities mortality

Key Points to Note

Learning from Deaths Annual Report 2021/22

- Hospital Standardised Mortality (HSMR) is in the 'as expected' range with a 12 month rolling average of 104.18. The latest in-month position (to end of Mar 2022) is 94.69
- Our Summary Hospital-level Mortality (SHMI) remains within expected limits at 104.15 and has stabilised following last year's declining performance. The in-month
- Our crude mortality national bench-marked position remains stable
- The Medical Examiner Office is now fully established and completed a full year of operation. During the last 12 months it has reviewed 87% of all in-patient deaths and contacted 77% of relatives of those deceased
- 791 Level 1 Initial Screening Reviews took place covering 47% of deaths against a target of 50%. This compares favourably with the 2020/21 figure of 31%.
- 164 Level 2 Structured Judgement Reviews (SJR's) took place compared with 121 in 2020/21
- The Care of the Acutely Ill Patient (CAIP) Programme has been established as a quality improvement initiative focusing on mortality impact. It comprises 7 workstreams: deteriorating patient, sepsis, clinical coding, stroke, acute kidney injury, discharge acuity and learning disability

EQIA – Equality Impact Assessment

Demographic characteristics relating to age, gender, ethnicity and index of multiple deprivation are included in the report.
Deaths of those with learning disabilities aged 4 and upwards: managed through the national LeDeR programme (learning disabilities mortality review). All deaths in patient with learning disabilities are 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. A review of Learning disability deaths for 2021/22 is presented within this paper.

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 by HSIB 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 Annual Report and support the following recommendations:

1. Expansion of the Medical Examiner Service to include colleagues from General Practice in the team and to incorporate community deaths. Central funding is available.
2. Focus on Learning Disabilities – complete existing action plan, agree and complete outcome measures as part of CAIP Programme
3. Deteriorating patient – consider a bespoke quality improvement programme to focus on monitoring, response and escalation.

Learning from Deaths Annual Report 2021/2022

Executive Summary

- This report covers the period April 2021 to March 2022 spanning the second year of the COVID-19 global pandemic. Of note, Hospital Standardised Mortality Ratio (HSMR) and Standardised Hospital Mortality Index (SHMI) both exclude COVID-19 deaths.

- During 21/22 1696 adult in-patients died compared with 1789 in 20/21. In 21/22 the total number of COVID deaths was 260 and non-COVID deaths was 1436. The total COVID deaths from the start of the pandemic to March 2022 was 758.

- Trust in-hospital mortality metrics are in the 'as expected' range and currently reflect a stable mortality position. However, between July 2021 and Jan 2022 our Trust HSMR moved from being a positive national outlier to 'as expected'. We have undertaken a series of measures analysing clinical coding and quality of care through Structured Judgement reviews in those clinical specialities highlighted through the mortality alert process. There have been no significant concerns identified.

- We have identified a decline in specialist palliative care coding as the main contributing factor to the rise in HSMR. This is a factor adjusted for in HSMR and relates to a clinical code attributable to direct input from the specialist palliative care team. A combination of staffing pressures, team deployment and increasing patient complexity underpins this effect. A different approach to targeted input is being adopted by the specialist palliative care team.

- SHMI remains in the expected range (latest release Feb 2022 is 105.02 compared with 113.64 for Feb 2021). Crude mortality for 21/22 was 1.59% reflecting an improvement on 2020/21 when it was 2.21%, with crude mortality benchmarking remaining stable.

- The Care of the Acutely Ill Patient (CAIP) Programme has been established as a quality improvement approach to focus on themes that have emerged from Learning from Death reviews and monthly mortality alerts from Healthcare Evaluation Data (HED). It comprises 7 workstreams: deteriorating patient, sepsis, clinical coding, stroke, acute kidney injury, discharge acuity and learning disability.

- The Medical Examiner Service is now established with scrutiny of all in-patient deaths. Benefits include improvement in the quality of death certification, support offered to bereaved relatives and improved communication with the Coroner's Office.

- 791 Level 1 Initial Screening Reviews took place covering 47% of deaths against a target of 50%. This is an improvement on 2019/20 when 32% of deaths were reviewed.

- 164 Level 2 Structured Judgement Reviews (SJR's) took place compared with 121 in 2020/21.

- This paper includes a particular focus on Learning Disabilities mortality as the Learning from Deaths process has highlighted some recent issues regarding quality of care in this population.

Progress against 20/21 recommendations

1. To support the additional actions scrutinising Standardised Hospital Mortality Index (SHMI) including the establishment of the Care of the Acutely Ill Patient (CAIP) quality improvement programme
    - CAIP established
2. To support the requirement of the Medical Examiners' Office to review deaths within the community. We will begin to scrutinise community deaths by the end of Q3, aiming to be at 50% capacity by the end of Q4 (2021/22)
    - Target achieved. Currently at 87%
3. A target of 50% of all in-patient deaths to be subject to Initial Screening Review by June 2022. Deaths in Elderly and Respiratory specialities account for half of inpatient adult deaths. The Mortality Surveillance Group (MSG) have asked the mortality leads and clinical directors for these areas to develop a plan of action to address the deficit in reviews for 2020/21
    - Progress towards target of 50%. Currently at 47%, increased from 31% in 20/21

Mortality Metrics

Introduction

It is important to note that the principle national benchmarking mortality metrics, HSMR and SHMI were not designed for a global pandemic such as we have been experiencing over the last 2 years with COVID-19. Both measures exclude COVID deaths, whereas crude mortality includes all in-hospital deaths. Although COVID deaths are excluded from HSMR and SHMI there has been a substantial change in the pattern of non-COVID deaths as a result of the pandemic. The implications for HSMR and SHMI are still not clear as evidenced by the substantial fluctuations in expected deaths calculations which underpin these calculations.

It is important to recognise that neither HSMR nor SHMI are a direct measure of quality of care. The expected number of deaths for each Trust is not an actual count of patients but is a statistical construct which estimates the number of deaths that may be expected at the Trust on the basis of average England figures and the characteristics of the patients treated here.

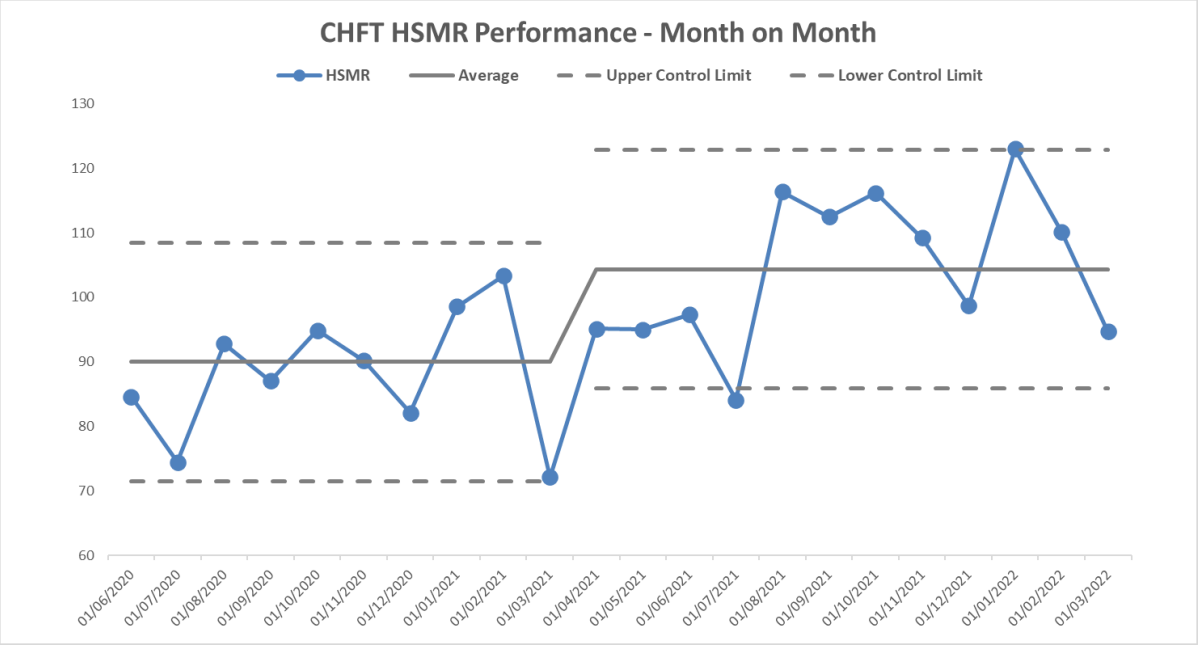
HSMR

The HSMR (Hospital Standardised Mortality Ratio) compares how many hospital inpatients die, with how many we would have predicted to die given their age, gender, diagnoses and co-morbidities. It also, in contrast to SHMI adjusts for area-level deprivation and specialist palliative care coding.

Data has been released in **June** for HSMR incorporating performance data up to **March 2022**

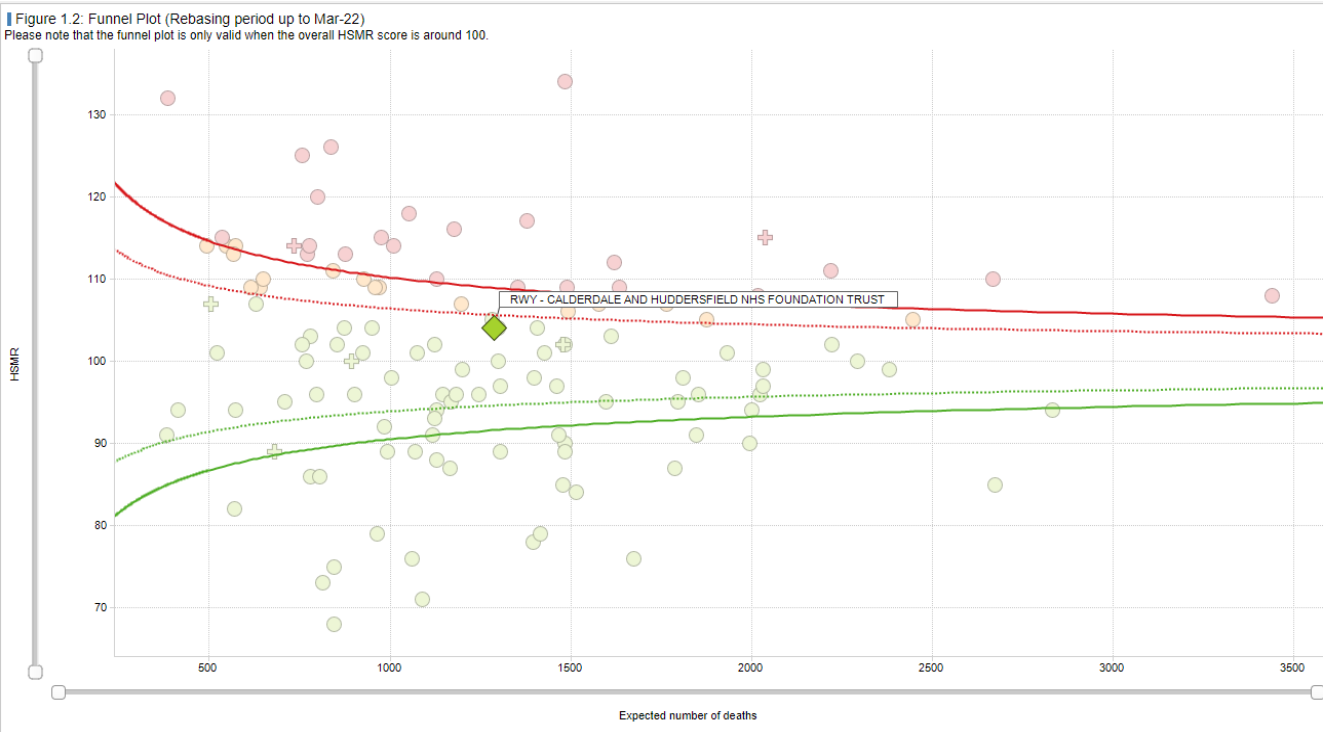
As can be seen in Figure 1, following an extended period of a low HSMR between Jun 2000 and July 2021, this measure then rose significantly peaking in Jan 2022. The last 2 data points show improvement back towards historical levels. Looking at the rolling 12-month HSMR (April 2021 – March 2022), the score is **104.18**. compared with **103.01** from the previous rolling 12-month period of (March 2021 – February 2022). The in-month position for March 2022 shows an improvement to **94.69.**

Figure 1. Trust HSMR rolling 12 months



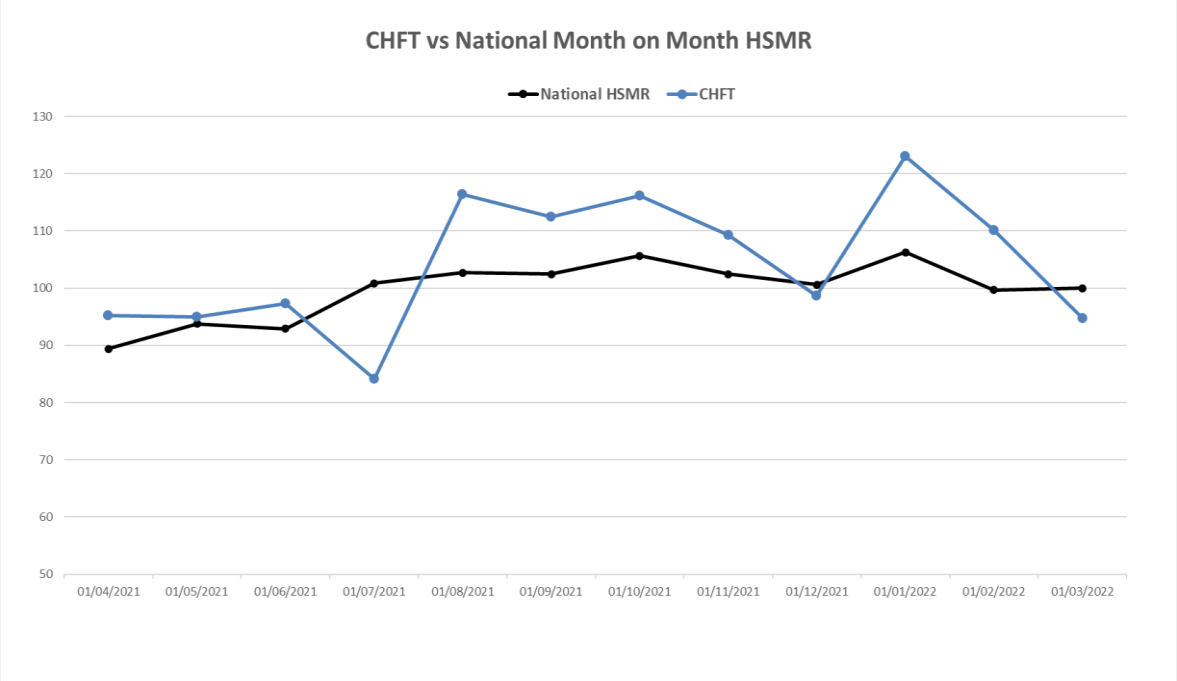
As a result, our Trust HSMR has moved from being a positive national outlier to within the 'as expected' range (Figure 2). The Trust's current HSMR (as at May release) is 90.06 which positions CHFT as a positive outlier nationally (top 5%) as shown in the Poisson funnel plot below.

Figure 2. Poisson funnel plot HSMR



Of note, the national benchmark for HSMR has also fluctuated over the last year (second year of the COVID-19 pandemic) as can be seen in Figure 3.

Figure 3. HSMR – CHFT in comparison to national trend



We have conducted a deep dive into our rising HSMR. We have undertaken a series of measures analysing clinical coding and quality of care through Structured Judgement reviews in those clinical specialities highlighted through the mortality alert process. There have been no significant concerns identified.

We have identified a decline in specialist palliative care coding as the main contributing factor to the rise in HSMR. This is a factor adjusted for in HSMR and relates to a clinical code attributable to direct input from the specialist palliative care team. A combination of staffing pressures, team deployment and increasing patient complexity underpins this. A different approach to target input towards those most likely to benefit from specialist palliative care input is being adopted by the CHFT specialist palliative care team.

SHMI

The SHMI (Summary Hospital-level Mortality Indicator) is the ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die, on the basis of average England figures given the characteristics of the patients treated here. SHMI = Observed Deaths/Expected Deaths

For the SHMI a death is attributed to a Trust if the patient dies in hospital or within 30 days of discharge.

SHMI does adjust for age, gender, current and underlying medical condition and birthweight (perinatal diagnosis group only). SHMI does not adjust for severity of condition, palliative care coding or deprivation score.

Previously we have reported that there was a discrepancy between our in-hospital mortality rate and our out-of-hospital (within 30 days of discharge) mortality rate such that the rates appeared to point towards a greater mortality rate in the community. We did extensive in-depth analysis around this looking at various factors to aim to understand this however we were not getting any clear indicators of the cause of this discrepancy from this analysis.

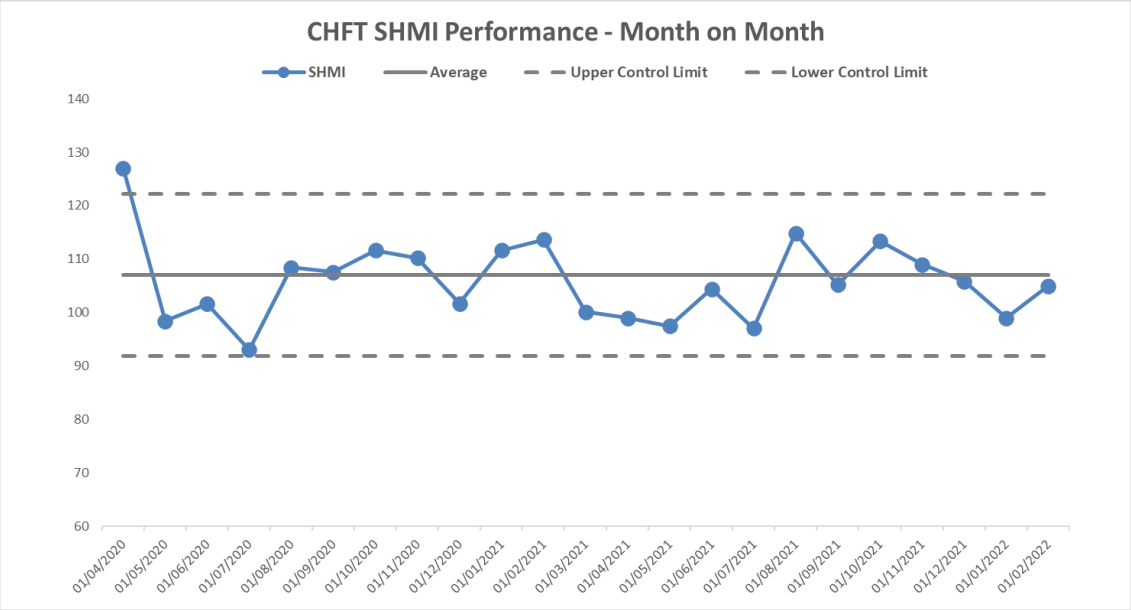
We contacted Professor Mohammed, Professor of Healthcare Quality and Effectiveness at the University of Bradford who has worked with the Trust in the past to commission a piece of work examining this.

The conclusion was essentially that this particular statistic was providing a false red flag. In vs out of hospital analysis is local to the HED system from whom we receive our datasets and is not part of the national SHMI methodology. In addition, the methodology introduces a key bias that SHMI was intended to overcome. It does this by incorporating deaths within hospital in the denominator of the community deaths and deaths out of hospital in the denominator of the in-hospital deaths. Professor Mohammed's advice was to not focus on this statistic and continue to look at the overall SHMI indictor for further analysis. Our current report reflects this.

Data has been released in **June** for SHMI incorporating performance data up to **February 2022**

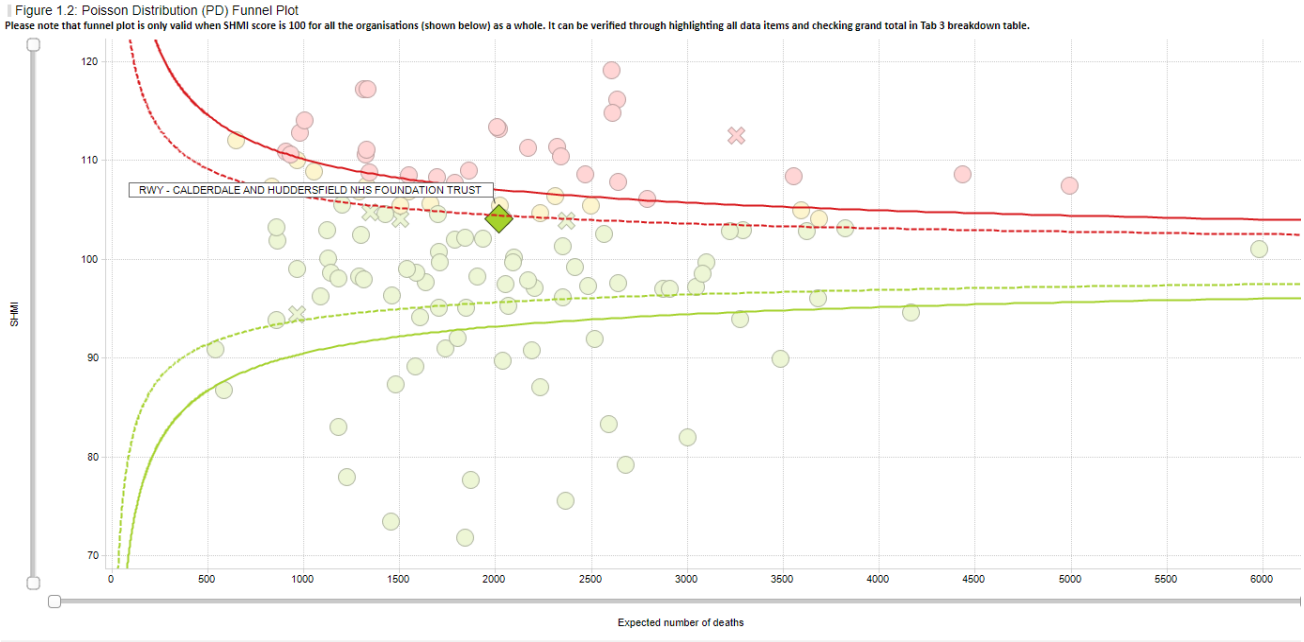
- Looking at the rolling 12-month SHMI (March 2021 – February 2022) the score is **104.15**. This is an improving position from the **105.25** from the previous rolling 12-month period of (February 2021 – January 2022)
- The site breakdown shows HRI at 107.23 and CRH 99.01
- SHMI performance continues to track at above the 100 mark. However we have seen a stabilisation over more recent months: this stabilisation has been seen at both sites. CHFT are also seeing a reduction in the number of SHMI alerts for the latest data release (Table 3)

Figure 4. Trust SHMI rolling 12 months



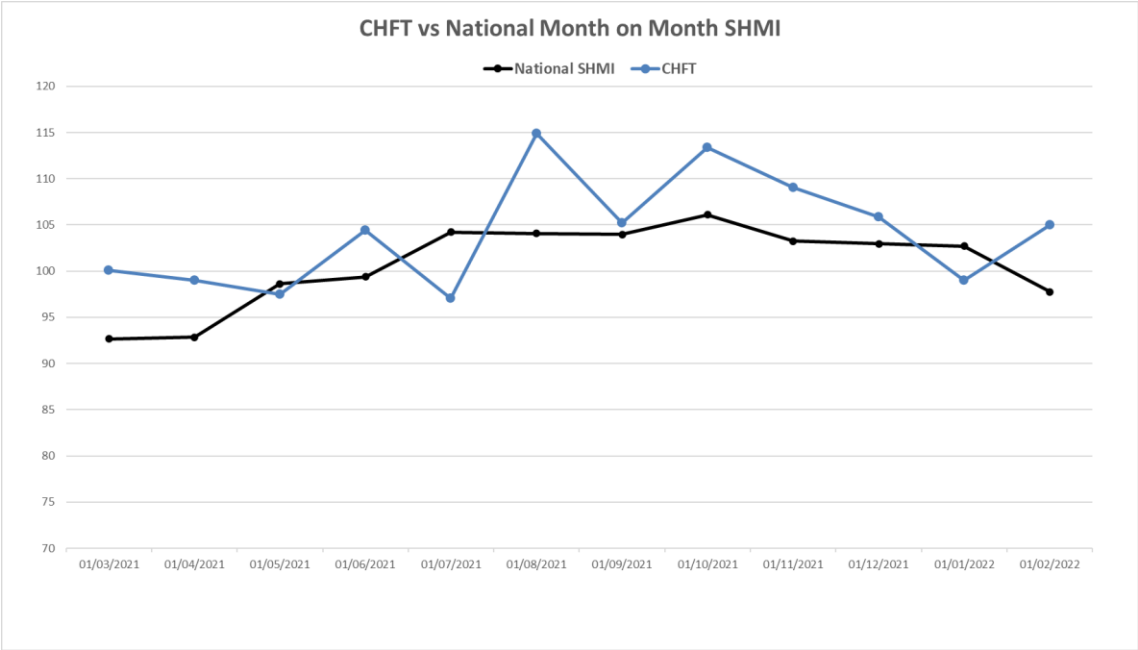
The Trust remains within the 'as expected' range, illustrated in the Poisson funnel plot below.

Figure 5. Poisson funnel plot SHMI



Once again, although the national median is held to be 100 we can see this also fluctuates, and is shown in Figure 6 to illustrate this variation.

Figure 6. SHMI - CHFT in comparison to national trend



Crude mortality

Crude mortality is calculated from observed/expected deaths with no adjustments. It includes COVID deaths. The 12month crude mortality for April 2021 to Mar 2022 was 1.59% compared with 2.21% in 2020/21 so an improving figure. Crude Mortality for May 22 is **1.50% -** orange line (138 deaths).

Figure 7. Crude mortality

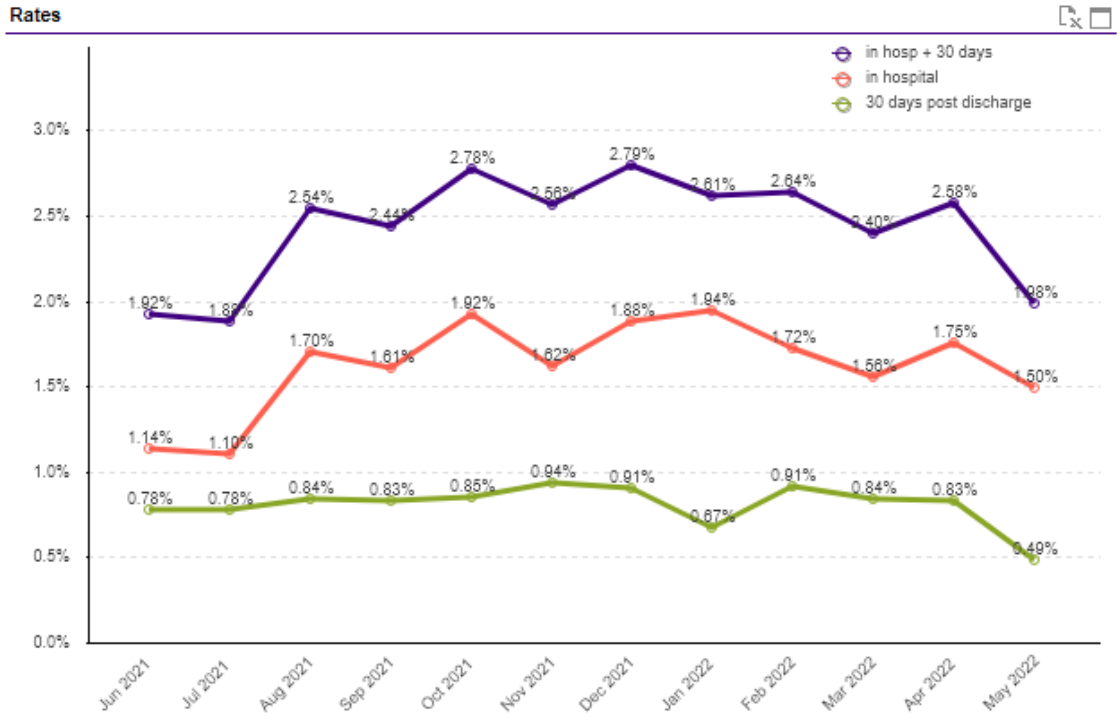
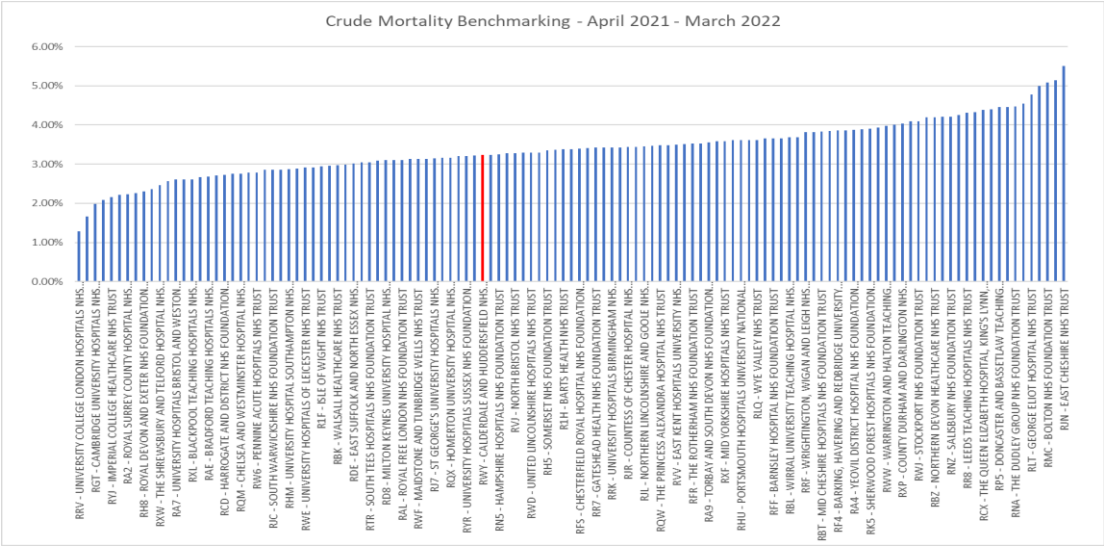


Figure 8 shows the Trust's national position for Crude mortality rate. The Trust sits in 51st position out of 124 Trusts. Looking at the rolling 12 months figure (June 21 – May 22) crude mortality is 1.61% (1,765 deaths). This is virtually identical to the previous rolling 12-month period (May 21 – April 22), 1.60% (1,746 deaths).

Figure 8. Crude mortality benchmarking (red line represents CHFT)



Demographics

Charts describing demographic breakdown for age, gender, ethnicity and decile of index of multiple deprivation (IMD) score are included in Appendix 1.

Across the Trust population profile of mortality, crude mortality was higher in older, male, white patients and across the broad range of IMD deciles. It should be noted however, that the average age of death in IMD 1 (greatest level of deprivation) was 73.9 and in IMD 10, 82.5 years, a difference of 8.6 years.

Between Apr 2021 and Mar 2022, 260 people died of or with Covid, and 1436 patients died of non-Covid related causes. When breaking the data down into those who died of or with Covid and those who died of non-Covid related causes, in both categories patients were again more likely to be white, older and male with a pattern of higher numbers in the lower IMD bands. These observations are in keeping with national profiling in relation to Covid and non-Covid deaths.

Mortality reviews

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

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

Each Trust should at a minimum ensure there is:

- Meaningful engagement and support of bereaved families and carers
- The introduction of structured case record reviews when reviewing patient deaths

CHFT response:

- In 2020 the Medical Examiner's Office was established. The medical examiner team review all Trust inpatient deaths and engage with and offer support to families and carers
- The Trust's case record review consists of 2 levels – Initial Screening Reviews (ISRs) and second level Structure Judgement Reviews (SJRs).

Medical Examiner office

The Trust's Medical Examiner (ME) service has just completed its first full year of function. It routinely scrutinises deaths that do not automatically fall under the jurisdiction of the coroner. This equates to approximately 90% of the total deaths within the organisation being scrutinised by a Medical Examiner.

The purpose of this scrutiny is to agree an acceptable wording for the Medical Certificate of Cause of Death (MCCD) that will be supplied to the local registrars of births, deaths & marriages. Advice is available to medical staff to decide whether registration is possible, or whether a coronial referral will be necessary.

In most cases, the Medical Examiner service contacts the bereaved relatives to explain the cause of death and ascertain whether they have any concerns regarding the death. The ME team signpost such concerns to the appropriate pathway (PALS, SJR, Datix or, in a small number of cases, to the coroner).

Having become established within the Trust, the team is currently being expanded to support rollout into the local community, where we will support colleagues in General Practice. We anticipate that the service will become fully statutory within 2022/23.

Table 1. Medical examiner office activity

Number of deaths 2021/22	Deaths scrutinised	Relative contact by ME office	No relative contact	Coroner referral – after scrutiny	Coroner referral – no scrutiny	SJRs
1863	1624 (87%)	1428 (77%)	196 (10%)	151 (8)	93 (5%)	58 (3%)

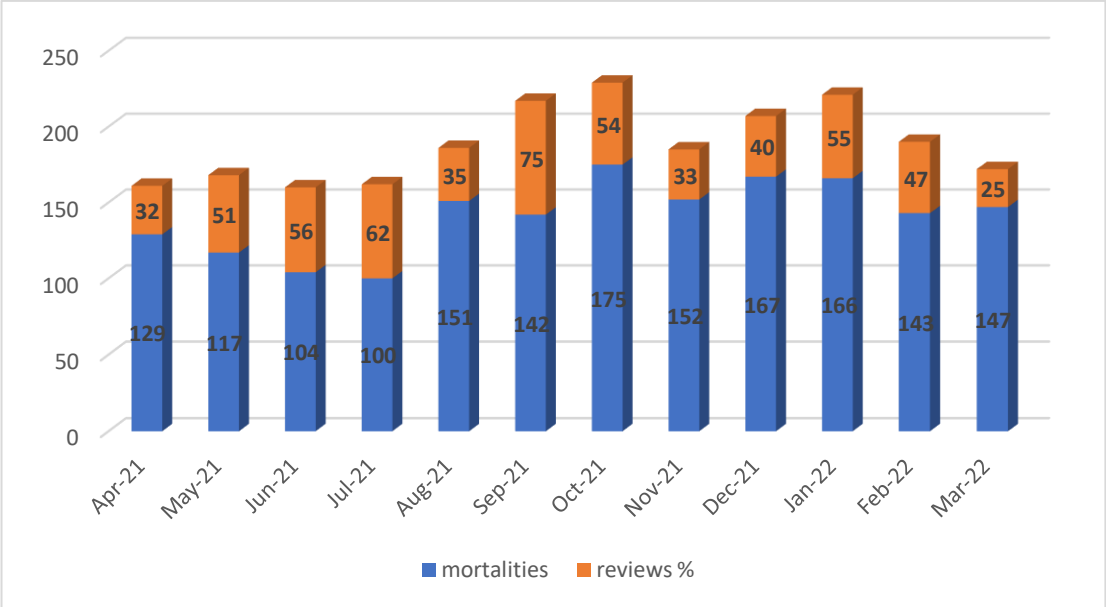
Initial Screening Review (ISR)

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

During 2021/2022, 1693 adult in-patients died. Of these 791 **(47%)** have been reviewed using the initial screening tool (ISR). This process aimed to achieve an ISR review of 50% of all CHFT adult inpatient deaths. This target has not been met; however, compliance is steadily increasing month on month since May 2021, in comparison to March 2021 when compliance was 30%.

Of note, there is a lag between death and completion of review. In 20/21 during the COVID-19 pandemic, completion of ISRs was suspended temporarily for several months. As anticipated, the numbers of completed reviews as increased month on month as COVID-19 pressure on services decreases.

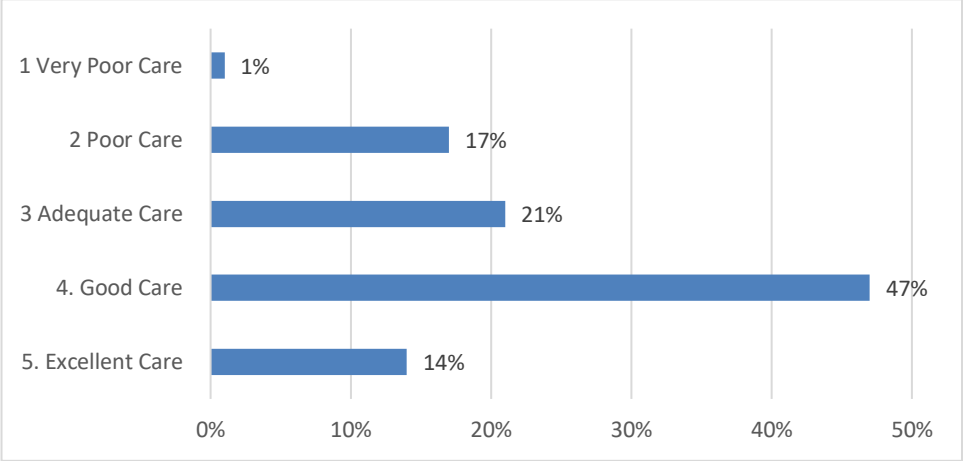
Figure 9. Number of adult inpatient deaths reviewed by ISR (%) by month



The increase in compliance in February 2022 and March 2022 can in part be attributed to the support that has been given via the Trust CT1 trainees. Supported by Dr Matthew Nelson, 8 CT1 trainees undertook 10 mortality reviews each. 80 reviews have now been undertaken. A letter of appreciation has been sent to all trainees by the Trust Mortality Lead.

In the 791 cases reviewed the quality of care was assessed as follows:

Figure 10. Quality of Care Score distribution for completed ISR's



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

Structured Judgement Reviews (SJR's)

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

The identified phases of care are:

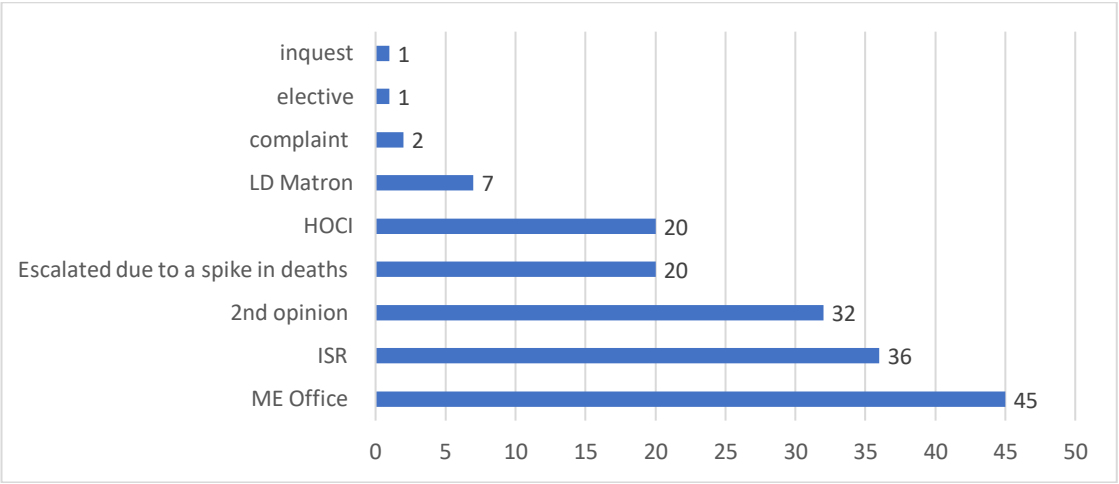
- Admission and initial care - first 24 hours
- Ongoing care
- Care during a procedure
- Perioperative/procedure care
- End-of-life care (or discharge care)
- Assessment of care overall

In 2021/22 **164** SJRs were completed (121 completed in 2020/21) The chart below shows the rationale for these SJRs. Of note, request for SJR's are increasing from the medical Examiner team as ME review becomes an increasingly valuable early screening tool.

This number includes assurance reviews requested by the Mortality Surveillance Group following a spike in deaths in August 2021 and in response to diagnostic group alerts

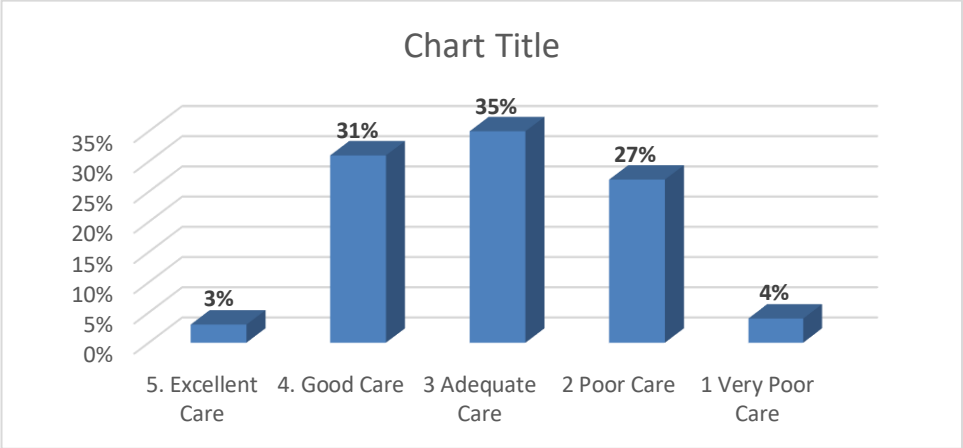
- Adequate, good or excellent care was identified in 69% of cases
- Poor or very poor care was identified in 31% of the SJRs

Figure 11. Indication for SJR's requested in 2021/22



As with the ISR's the SJRs give an overall care score. The chart below gives the breakdown of quality care scores for completed SJRs in 2021/22.

Figure 12. Quality Care Score distribution for 164 completed SJRs



- All SJR reviews, irrespective of care score, are shared with the relevant division
- All cases given a care score of Poor or Very Poor are subject to a 2nd opinion SJR
- Following 2nd opinion SJRs any cases agreed as a care score of 1 or 2 are reported as Orange incidents onto Datix if they have not already been reported by division
- If there is a discrepancy of more than 1 between SJR scores, the 2 reviewers are requested to discuss the case to reach a common score.
- If an agreement is not achieved, escalation takes place to the Deputy Medical Director for arbitration as the Trust mortality lead

Structured Judgement Reviews due to mortality spike:

Due to a spike in deaths in August 2021 the Learning from Deaths Team escalated 20 cases selected at random to our Structured Judgement Reviewers to identify if there were any significant care concerns with these cases. No care concerns were identified in 18 cases, 1 case was subject to an orange investigation, 1 case is still under review.

Learning from Mortality
Structured Judgement Reviews

Areas of good practice

- Emphasis on a multi-disciplinary team approach
- Good documentation in the last days of life and use of the specialist palliative care team to support patients in the dying phase
- Good examples of well-documented communication between medical teams and patients' relatives and carers despite the visiting restrictions in place with the pandemic
- Clear documentation that the Matron Lead for Learning Disability is involved in care and provides excellent support
- Good, clear documentation regarding plans of care

Areas requiring improvement

1. **Earlier identification and adherence to the Mental Capacity Act (MCA) principles**

   Response
   The Safeguarding Team are currently taking the following steps to support staff in relation to their understanding of the MCA

- MCA increased awareness during safeguarding week via Trust news and briefings/team walkabouts. The Safeguarding Team are delivering face to face training sessions via teams during safeguarding week (June 20-24 2022)
- Training in relation to MCA/ DoLS has been revised in preparation for Liberty Protection Safeguards which are due to replace the Deprivation of Liberty Safeguards (DoLS). This has been approved at WEB and it will increase training requirements for all relevant staff. Compliance with training is monitored by the Safeguarding Operational Group and Committee
- A briefing will be circulated via divisional and departmental meetings and is available on the safeguarding intranet page
- The Safeguarding team have developed a programme of walk rounds to test staff safeguarding knowledge/ MCA/ DoLS knowledge and this will help inform future actions

2. **Lack of evidence of clinical ownership by senior doctors and over-reliance on the Trust Learning Disability Matron**

   Response

- Introduction of guidance for in-patients with Learning Disabilities (Mar 2022)
- Patients with learning disabilities identified on the operational situation report (Mar 2022)
- Learning disability e-Learning package established as Essential Skills Training for all staff (May 2022)
- Raising awareness of identification of people with Learning disabilities on Electronic Patient Record (EPR)/reasonable adjustments and hospital passport –with production of educational film (Jun 2022)
- Increase Think Learning Disability champions within divisions (Jun 2022)
- Develop ED Standard Operating Procedure (Jul 2022)
- Promote Acute Care Toolkit 16: Royal College of Physicians published April 2022 (Jun 2022)

3. **Late acknowledgement of dying phase, with missed opportunities to adequately palliate**
   Response

- The End-of-Life Steering Group has recently been re-established. This group will identify and triangulate concerns and learning from Serious Incidents and Structured Judgment Reviews

- Through the CAIP programme we can now identify frailer patients, at greater mortality risk through their admission Rockwood scores and institute earlier advanced care planning

4. **Suboptimal response to a deteriorating patient**
   Response
   The deteriorating patient workstream is established as part of the CAIP programme. Current focus is on timely observations, response times to deteriorating patients and escalation to critical care.

Serious Incidents

There is currently a substantial delay in the orange investigation process due to operational pressures in the Division of Medicine. As a result, the risk team are bringing cases for earlier scrutiny to Serious incident (SI panel) to manage this risk. When SJR outcomes are very poor/poor these will be passed to the risk team directly to identify any urgent response or action required. Learning posters will be circulated when orange investigations are complete.

Healthcare Safety investigation Branch (HSIB)

HSIB look at factors that have harmed or may harm NHS patients. HSIB work closely with patients, families and healthcare staff affected by patient safety incidents, and never attribute blame or liability.
Maternity incidents are assessed against the HSIB criteria by the governance midwife and those which meet the criteria are submitted to HSIB. Each of these incidents will also be presented at the Trust's weekly Serious Incident (SI) panel so any immediate learning can be identified.
There have been 18 referrals to HSIB between 1 April 2021 and 31 March 2022 with 8 of these accepted for HSIB investigation.

Neonatal/still births

There were 26 stillbirths in 2021/22 and 8 neonatal deaths.

- All stillbirths and neonatal deaths had a first level mortality review and were presented at the weekly maternity governance meeting and orange/red panel. All HSIB and local investigations have an individual action plan

Learning:

- Ongoing audit of stillbirths and neonatal deaths to monitor trends. The audit findings are presented at the clinical audit meeting, Saving Babies Lives group and Maternity Forum
- The 'Weekly View' is a newsletter sent to all maternity staff. This newsletter includes learning from the weekly maternity governance meeting, updates on guidelines and changes in practice.
- All cases of stillbirth and perinatal deaths are presented at the perinatal mortality meeting, including cases of known congenital abnormality. If there has been an investigation, the presentation will be incorporated in the conclusion of the report.
- CHFT are working collaboratively with the West Yorkshire and Harrogate maternity services to reduce stillbirths
- Quarterly reports of stillbirth and neonatal death cases presented to staff, the Saving Babies Lives Group and Maternity Forum.
- Project work commenced January 2021 around health inequalities
- All national recommendations for the reduction of stillbirth and perinatal deaths are RAG rated (red, amber, green regarding compliance) against the current care at CHFT and action plans formulated for areas of non-compliance

- All stillbirths and perinatal deaths are included in the local clinical dashboards. Data is used to compare trends in stillbirth and perinatal death rates

Escalation to Serious Incident Panel

30 deaths were confirmed as serious incidents and underwent investigation.
On initial presentation of a timeline to SI panel, any early learning is identified and communicated with the Divisions.

Table 2. Distribution of Serious Incidents by Directorate

Directorate	Number
Acute medicine	12
Critical Care	1
Emergency Department	4
General & Specialty Surgery	7
Integrated Medicine	1
Medical Specialities	5
Women's Services	1

Learning Disabilities Mortality

CHFT has been monitoring the deaths of people with a learning disability over a 10-year period. Since 2016, all deaths of people with a learning disability who die whilst an in-patient at CHFT have been subject to a Structured Judgement Review (SJR).

An annual report is presented to the Mortality Surveillance Group and Clinical Outcomes Group and summarises the key themes and trends from the SJRs reported between 1st April 2021 and 31st March 2022. It includes analysis of:

- Age of death
- Month of death
- Gender
- Ethnicity
- Causes of death
- Overall assessment of the quality of care

CHFT had 12 deaths reported and 11 subject to a SJR during 1st April 2020 – 31st March 2021 – compared to 13 in 2020-2021. Of these cases the majority were male (83%). 92% of adults with learning disabilities whose deaths were reviewed were white. The most common confirmed cause of death was a respiratory condition (42%) and sepsis (42%).

Average age of death was 57 years which is younger than the national average age of 61 years (2020/21). 58% had a severe learning disability, 9% a moderate and 33% mild.
54% of completed reviews concluded that individuals received adequate or good care, with 46% concluding care was poor/very poor. This represents a deterioration in quality of care scores over the last 2 years. To enable additional focus on this vulnerable patient group, Learning Disabilities is now incorporated as a work stream within CAIP.

Areas of good practice

- Very complex patient. Throughout his journey every step taken was considering his wellbeing
- Some examples of very good communication with family
- Very clear documentation
- Wider MDT involvement around end-of-life decision making process

Areas of Concern

- Lack of escalation
- Discharging with follow-up outpatient investigations in complex cases
- Some examples of poor communication with family
- Poor adherence to the principles of the MCA and lack of capacity assessment and early best interest process
- Poor or no palliation for distressing respiratory symptoms

Actions included in LD annual report and progress

  - Development of guidance for inpatients with Learning Disabilities – Mar 2022 **completed**
  - People with learning disabilities to be identified on the daily situation reports – **Mar 2022 completed**
  - Learning disability E-Learning package to be a Essential Skills Training for all staff – **May 2022 completed**
  - Raise awareness of identification of people with Learning disabilities on EPR/reasonable adjustments and hospital passport – produce education film – Jun 2022 – **Go live in 20th June, film completed**
- Increase Think Learning Disability champions within divisions – produce poster/purchase merchandise – June 2022 – **on target**
- Develop Emergency Department SOP – July 2022 – **on target**
- Promote Acute care toolkit 16: Royal College of Physicians published April 2022 – June 2022 – **ongoing**
- Ensure action plans for SI are combined and have Trust wide oversight – **Risk team to action**

National Service evaluation of bereaved relative's satisfaction with patient's end of life care 2021

CHFT participates in the national survey of the quality of end-of-life care, organized by the Association for Palliative Medicine of Great Britain and Ireland. The aim of the survey is to see how well we do in our care of patients referred to palliative care services. This information is needed so we can improve services and make sure that all patients receive the best possible care towards the end of their lives.

The aim of the survey is to measure bereaved relatives' satisfaction with the end-of-life care service provided to their deceased relative using the FAMCARE 2 tool.

In 2021 almost 20% more surveys were analysed nationally compared to 2020. More services also participated in 2021 (63, compared to 51 in 2020).

Calderdale Specialist Palliative Care Team Key Messages

- The local response rate of 62% is higher than that achieved in 2020 which was 52% and significantly higher than the national response rate of 34%
- The proportion of CHFT responses classified as 'very satisfied' exceeds the national average in all areas
- In 11/17 domains scores improved, in 4/17 they remained unchanged and in 2/17 they declined
- An action plan is being developed by the specialist palliative care team

Developments 21/22

Care of the Acutely Ill Patient (CAIP) Programme

The CAIP Programme has been established, chaired by the Deputy Medical Director as a quality improvement initiative to focus on themes that have been highlighted through Learning from Death reviews and monthly mortality alerts from Healthcare Evaluation Data (HED). Work stream leads have been identified and outcome measures for each work stream agreed.
The 7 workstreams are:

- Sepsis (Quality Priority)
- Deteriorating Patient
- Stroke
- Acute Kidney Injury
- Discharge acuity
- Clinical Coding
- Learning Disability

Revised approach to mortality alerts

CHFT are signed up to HED (Healthcare Evaluation Data) which is an online benchmarking solution designed for healthcare organisations. It allows organisations to review their performance across multiple indicators. When the mortality rates for certain diagnostic codes go above a statistically identified threshold, the Trust is issued with an alert from HED. Alerts do not necessarily indicate issues with the quality of care being provided. This can only be determined by clinical case note review. These alerts can, however, be used as a temperature check and give organisations an indicator that certain deaths may warrant further review. There are 4 different types of alerts:

SHMI Alert – SHMI alerts are based on 12 months of data and trigger for red outliers (upper 99.8% limit) for ALL diagnostic groups

HSMR Alert – HSMR alerts are based on 12 months of data and trigger for red outliers (upper 99.8% limit) for 56 diagnostic groups only

HSMR CuSum Alert – CuSum uses monthly data aggregated by Trust and diagnosis group. The CuSum value increases when patients die and decreases when they survive. They are calibrated with a 'trigger' value and are 'reset' after each trigger. A trigger value of 5.48 is used for alerts which has been confirmed by CQC. These alerts occur in-month and may not persist.

SHMI VLAD Alert - VLAD alerts are in month alerts referring to a single months' worth of data using the SHMI methodology. These alerts are designed to act as an 'early warning' indicator for a CCS group that has shown adverse expected deaths within that month, this is to highlight potential CCS groups that could generate a full SHMI alert and allow for action to be taken before this was to occur.

We have adapted our mortality alert process as follows:

1. Every month HED issue a monthly alerts email to the Trust. This is sent to the Trust Mortality Lead, the Learning from Death Lead, the Clinical Information Manager and the Information Analyst for Mortality

2. A meeting is held within a week of receipt between the Trust Mortality Lead, the Learning from Death Lead, the Clinical Information Manager and the Information Analyst for Mortality

3. At the meeting the team review:

    a. Any previous alerts against the CCS (diagnostic) code in the last 24 months and establish what assurance was gained
    b. Supporting data behind the alert, including but not limited to: expected deaths, observed deaths, palliative care coding and co-morbidities (Charlson) scoring

c. If the data supports possible concern, the clinical coding team review patient level data including admission and discharge coding and recorded cause of death to identify any coding irregularities
d. For any alerts that warrant further review, patient level data is sent to the appropriate lead clinician for review and to provide comment back to the Mortality Surveillance Group

Over the course of the last 12 months the Trust has received no alerts for HSMR, however we have received alerts in several diagnostic groups for SHMI. The current SHMI red alert position issued 7th Jun 2022 for the period Feb 2021-Jan 2022, is provided below. These alerting categories will be subject to the above process. Previous case note review into cardiac dysrhythmias has not identified any quality of care concerns.

Table 3.

SHMI	Mar 2021 - Feb 2022	146 - Diverticulosis and diverticulitis	4.71	13	286	276.13	Red
	Mar 2021 - Feb 2022	55 - Fluid and electrolyte disorders	31.33	48	517	153.21	Red

Recruitment of CT1 trainees to participate in ISR's

8 CT1 trainees have undertaken 10 mortality reviews each i.e. 80 reviews have now been undertaken. Positive feedback has been received from the trainees. A letter of appreciation has been sent to all trainees by the Trust Mortality Lead.

New SJR reviewers

During 2021/22, two members of the SJR team reviewers stepped down, the LfD team wish to thank Dr Mary Kiely and Dr Sandeep Goyal for their valuable contribution. We have recruited two new SJR reviewers and welcome Dr Elizabeth Dodds, Consultant in Acute Medicine, and Dr Pravin Dandegaonkar, Consultant in Anaesthesia to the SJR team.

SJR training

In March 2022, the Yorkshire and Humber Allied Health Science Network's Improvement Academy offered a half day SJR Training session. Feedback was excellent. The Academy are offering the training again in June 2022. This training will support our newer reviewers and serve as a refresher for existing reviewers promoting consistency in our reviews.

Recommendations for 22/23

1. Support expansion of the Medical Examiner Service to include colleagues from General Practice in the team and to incorporate community deaths. Central funding is available for this expansion
2. Focus on Learning Disabilities – complete existing action plan, agree and complete outcome measures as part of CAIP Programme
3. Deteriorating patient –Consider a bespoke quality improvement programme to focus on monitoring, response and escalation.

Glossary of Terms

CHFT
Calderdale and Huddersfield NHS Foundation Trust

CUSUM
A cumulative sum statistical process control chart plots patients' actual outcomes against their expected outcomes sequentially over time. The chart has upper and lower thresholds and breaching this threshold triggers an alert. If patients repeatedly have negative or unexpected outcomes, the chart will continue to rise until an alert is triggered. The line is then reset to half the starting position and plotting of patients continues. The CQC monitor CUSUM's at a 99.9% threshold to determine outliers.

HSMR

The Hospital Standardised Mortality Ratio (HSMR) is the ratio of observed deaths to expected deaths for a basket of 56 diagnosis groups, which represent approximately 80% of in hospital deaths. It is a subset of all and represents about 35% of admitted patient activity.

ISR
An initial screening review is a level 1 mortality review. We aim to review 50% of all in-patient deaths.

ME
Medical examiners (MEs) are senior medical doctors who are contracted to undertake medical examiner duties, outside of their usual clinical duties. They are trained in the legal and clinical elements of death certification processes. The purpose of the medical examiner system is to provide greater safeguards for the public by ensuring proper scrutiny of all non-coronial deaths, ensure the appropriate direction of deaths to the coroner, provide a better service for the bereaved and an opportunity for them to raise any concerns to a doctor not involved in the care of the deceased, improve the quality of death certification, and improve the quality of mortality data. The Medical Examiner (ME) system was introduced in April 2020 and was established in the Trust by August 2020.

MSG
The Mortality Surveillance Group (MSG) meets monthly and is chaired by the Deputy Medical Director. MSG responsible for reviewing deaths to identify problems in care and commissioning improvement work, to reduce unwarranted variation and improve patient outcomes.

SHMI
The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. It covers in-hospital deaths and deaths that occur up to 30 days post discharge for all diagnoses excluding still births. The SHMI is an indicator which reports on mortality at trust level across the NHS in England and it is produced and published as an official statistic by NHS Digital.

SI
Serious Incident requiring investigation. SI panel comprises representation from the Senior Nursing Team, Medical Director's Office and Risk team and convenes weekly to review cases, and determine if the incident meets the threshold for declaration of a serious incident. Any immediate learning is identified, approach to duty of candour agreed and lead investigators identified. Completed Serious Incident Investigations and action plans are also reviewed.

SJR
Structured Judgement Review (SJR) is a second level mortality review process for undertaking a review of care

Appendix 1

The following charts report the demographic breakdown of mortality 2021/22. Figures 1-4 describe the demographic characteristic across the Trust. Figures 5-8 describe the same characteristics comparing Covid and non-Covid deaths.

Figure 1. Gender

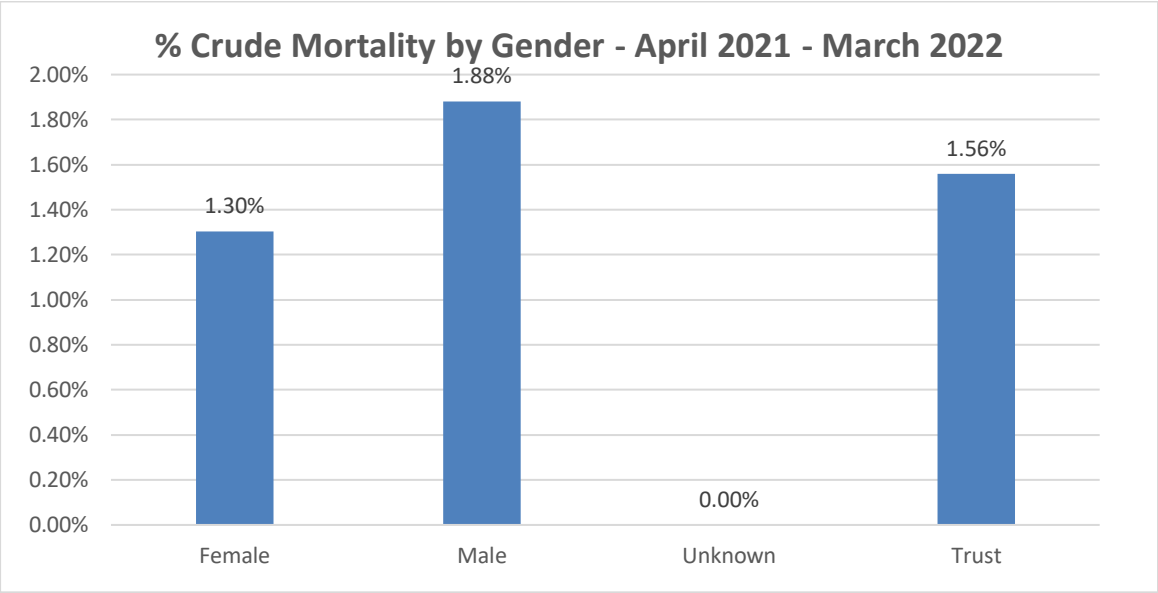


Figure 2. Age

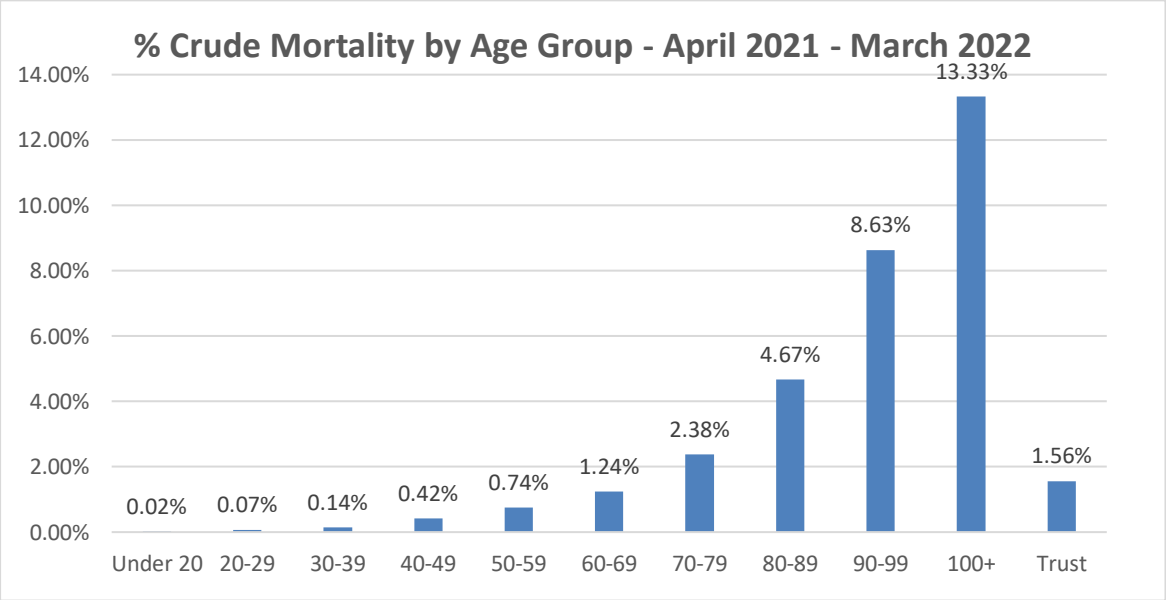


Figure 3. Ethnicity

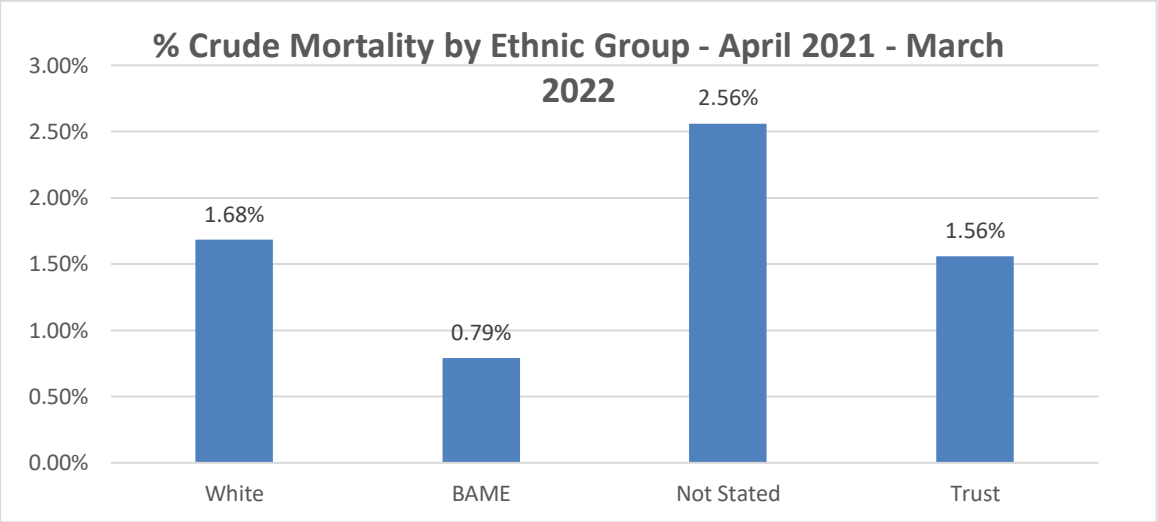


Figure 4. Index of Multiple Deprivation (IMD) decile

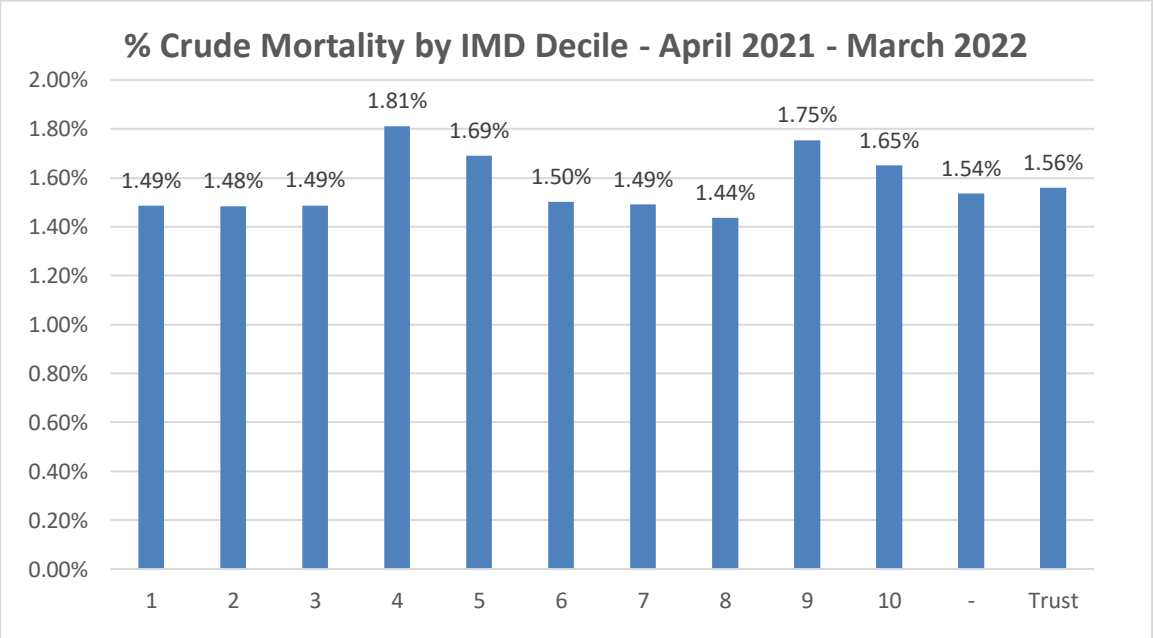


Figure 5. Gender: Covid and non-Covid deaths

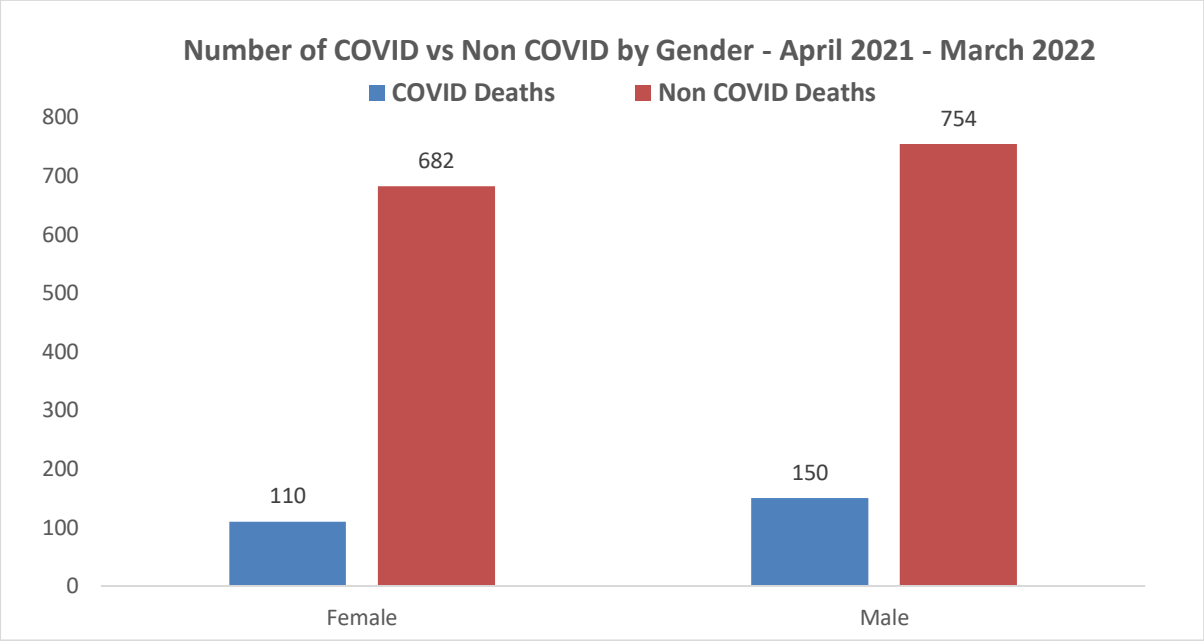


Figure 6. Age: Covid and non-Covid deaths

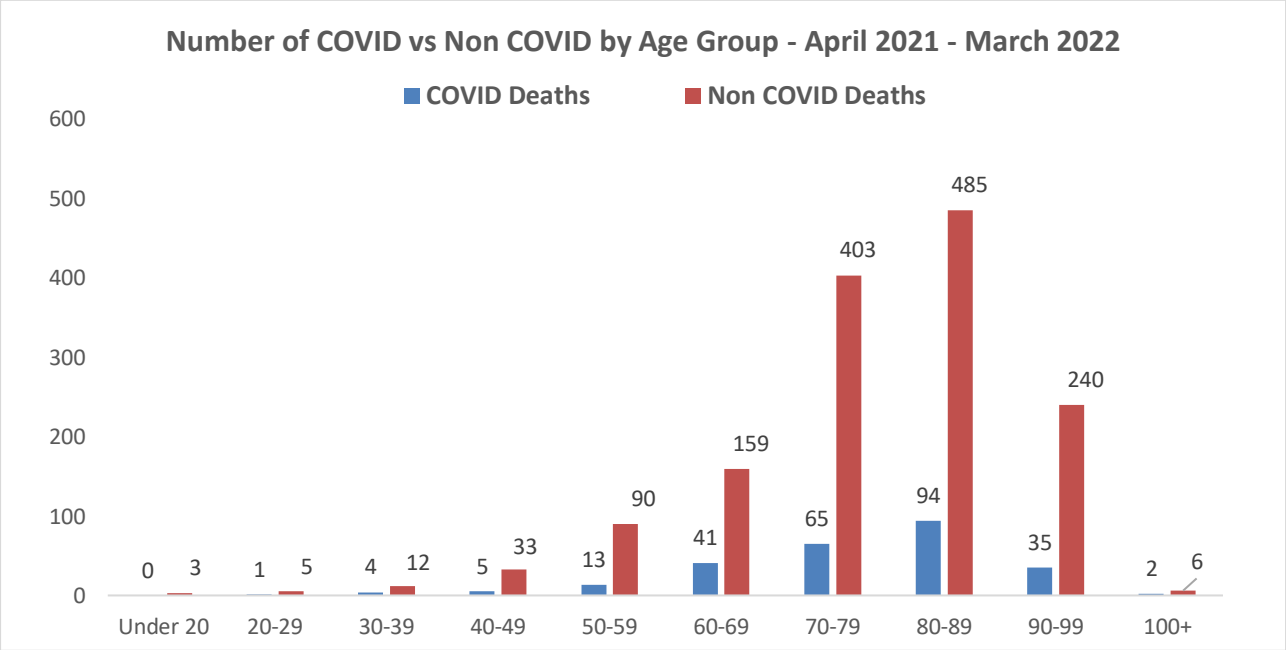


Figure 7. Ethnicity: Covid and non-Covid deaths

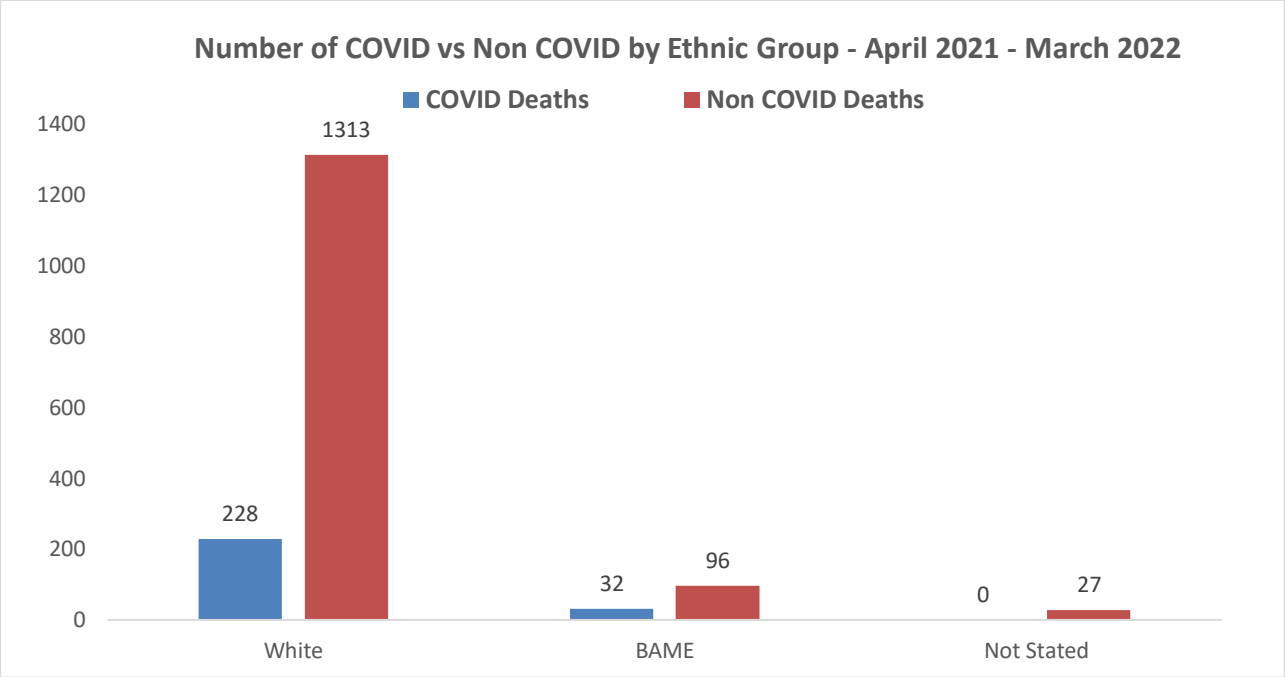
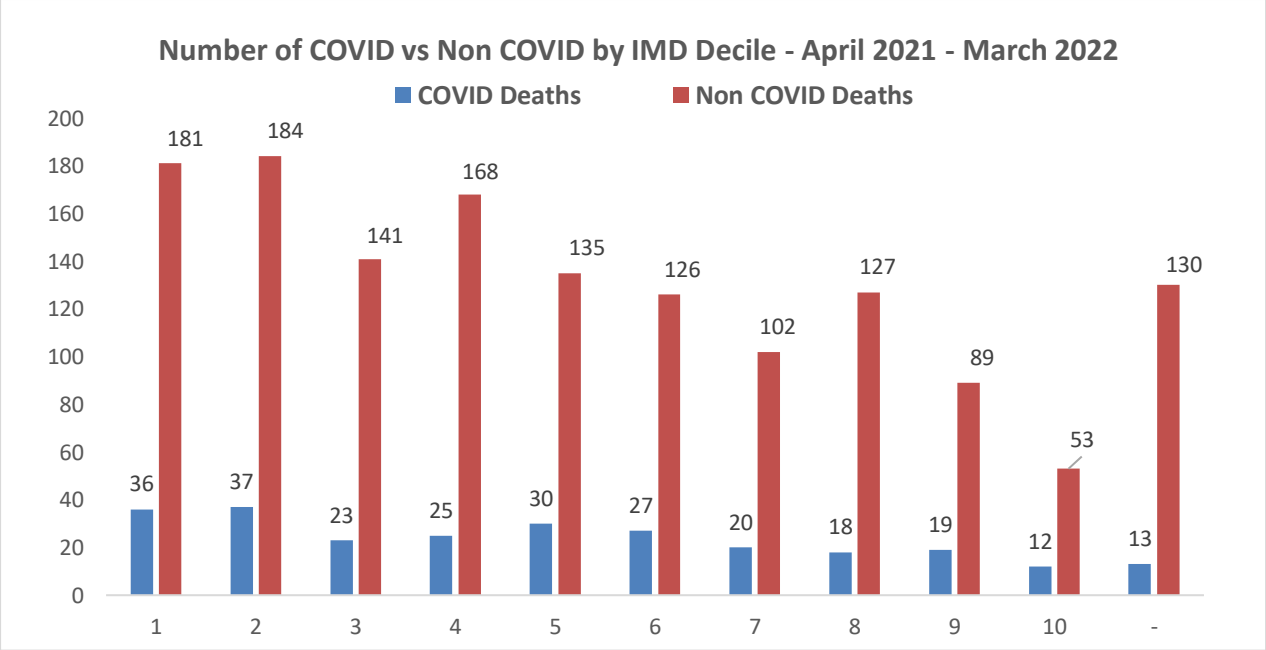


Figure 8. IMD: Covid and non-Covid deaths



16. Quality Report

To Note

Presented by Cornelle Parker

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 7 July 2022
Meeting:	Public Board of Directors
Title:	Quality Report (Reporting period April to May 2022)
Author:	Kim Smith - Assistant Director for Patient Safety
Sponsoring Director:	Lindsay Rudge - Deputy Director of Nursing Cornelle Parker, Deputy Medical Director
Previous Forums:	Quality Committee – Monday, 20 June 2022

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 Quality Committee and 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

This report covers the period of April 2022 to May 2022 and provides assurance that the Trust has continued to maintain compliance with its statutory regulatory requirements, by implementing a number of proactive actions and adopting an innovative yet safe approach to quality governance.

The update for the committee will focus on key workstreams as well as Quality Priorities and 7 Focused Quality Priorities including:

- Care Quality Commission (CQC)
- Dementia Care and Screening
- Patient Experience, Participation, Equalities
- Patient Advice and Complaints Service (PACS)
- Legal Services
- Medicine Safety
- Incidents
- Lessons Learnt from Serious Incidents

See separate Executive Summary on PowerPoint.

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 are asked to **NOTE** the content of the report and the ongoing activities across the Trust to improve the quality and safety of patient care.

Quality Report (April – May 2022)

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 paper seeks to brief the Quality Committee and Board of Directors 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 April and May 2022: the progress updates for the Quality Account Priorities and the Focussed Quality Account Priorities for 2022/2023.

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.

Contents

2. Care Quality Commission (CQC) workstreams

During April and May 2022, the CQC workstreams have continued to be guided by the continuous engagement with the Trusts CQC Relationship Managers.

2021/22 CQC Exceptions Action Plan – Update on 'Must Do' & 'Should Do' Actions

Of the outstanding actions from the 2018 CQC inspection, the Trust has one action to complete. This is action will remain open to ensure full scrutiny and oversite.

"*MD1 - The Trust must improve its financial performance to ensure services are sustainable in the future*"

CQC Engagement Meeting

Regular catch-up meetings between CQC and CHFT have continued to take place throughout the COVID-19 pandemic with both the Acute and Community Healthcare Services.

No formal agenda engagement meeting with CQC has taken place within the reporting period, however, CHFT did have a planned CQC onsite visit with a focus on Medicine. See CQC Onsite Visit section in report for details.

Journey 2 Outstanding Review

The planned Journey 2 Outstanding (J2O) 2022 inspection programme was suspended in April 2022 due to undertaking a programme of Focused J2O Reviews in preparation for a possible onsite CQC inspection as part of the, West Yorkshire ICS focusing on Urgent and Emergency Care (U&EC) pathways across acute, primary, and adult social care Inspection (see further in report for update).

It was also agreed that all June planned J2Os would also be suspended so a Focused J2O can be undertaken in Maternity services in preparation for a planned external Ockendon Assurance Visit on 28th June 2022. The planned J2O programme will be reinstated from w/c 04th July 2022.

West Yorkshire Integrated Care System Inspection

During April, CQC conducted inspections across the West Yorkshire ICS focusing on Urgent and Emergency Care (U&EC) pathways across acute, primary, and adult social care.

The aim was to support improvement in patient experience and the quality of care received when accessing services and pathways across urgent and emergency care.

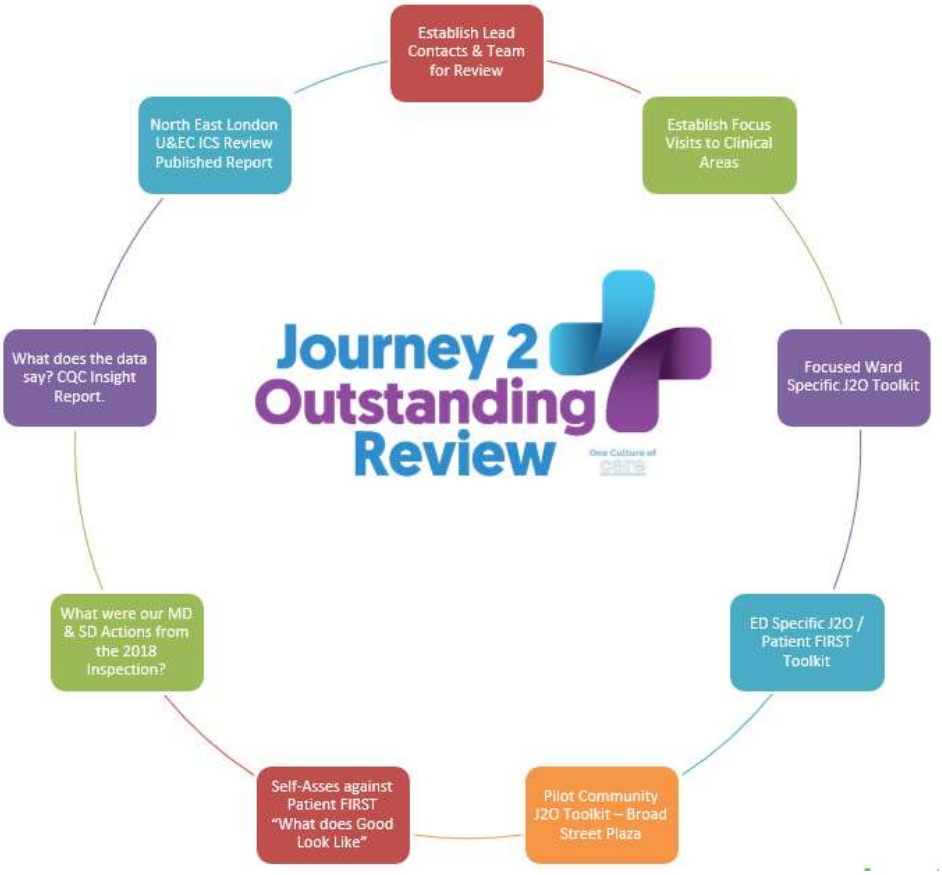
To achieve this, CQC coordinated activity where appropriate to positively influence the system-wide response to the challenges across urgent and emergency care pathways and drive system wide accountability.

CHFT was not inspected by CQC as part of the ICS review, but extensive work went into preparation as described in the 'CHFT Response to Inspection Activity Notification' section.

CHFT Response to CQC Inspection Activity Notification

In response to the possible CQC inspection activity, CHFT coordinated an initial project plan to prepare for any possible activity. Image 1 sets out the key stages of preparation.

Image 1



It was agreed that both a Ward Based, Community and Emergency Department (ED) specific J2O Toolkit would be developed for use to aid with the Trusts CQC Prepartion.

These toolkits were focused and specifically inlcuded key lines of enquiry which we use as part of the Urgent & Emergency Care Pathways and also areas in which the Trust had specific Must Do & Should Do recommendations at the last CQC Inspection in 2018.

The J2O CQC preparation Toolkits included:

- Observations of all staff and roles at ward level and in the Emergency Departments.
- Enviroment and Equipment Observations
- Testing Staff Knowledge

The ED Specific toolkit also included recommendations as set out in the Patient FIRST CQC ED publication.

A team of colleagues from across the Trust then coordinated unannounced visits to Ward, Community and Emergency Departments throughout April to ensure CQC inspection readiness.

Focused Urgent & Emergency Care Pathways J2O Reviews - Outcomes

A full focused J2O programme was created to ensure all areas that CQC may visit as part of the pathways was reviewed.

A daily CQC Preparation Huddle was established which had representatives from all divisions across the Trust as well as, Executives, Quality & Safety, IPC team, Estates team and Medical Devices.

Areas reviewed include:

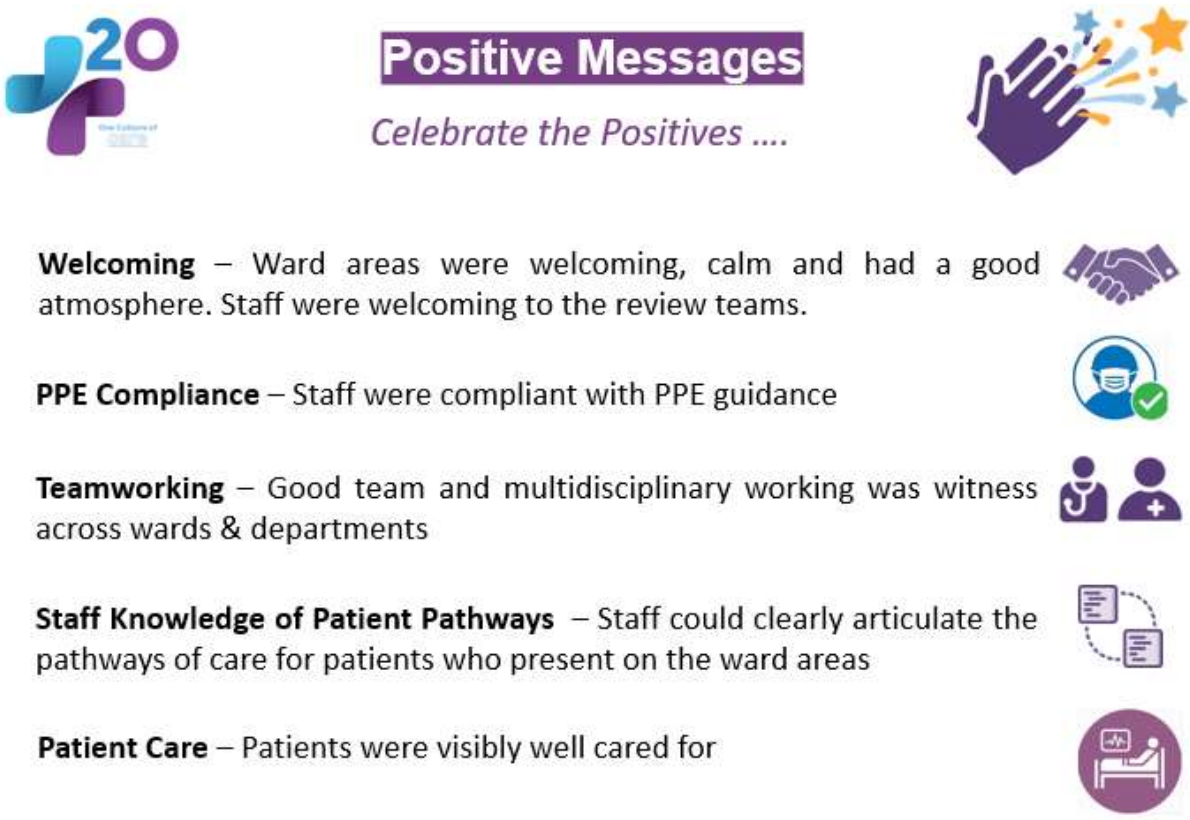
Medicine Division	▪ CRH Emergency Department ▪ HRI Emergency Department ▪ Medical Same Day Emergency Care – HRI ▪ Medical Same Day Emergency Care – CRH ▪ Stroke Floor – CRH ▪ Medical Acute Floor – CRH ▪ Medical Acute Floor - HRI ▪ Respiratory Floor – CRH ▪ Ward 6 HRI – Elderly Care ▪ Ward 6A/B CRH – Acute Medical ▪ Ward 5 HRI – Elderly Care ▪ Ward 15 HRI – Elderly Care
Urgent & Emergency Care Pathways	▪ Gastrointestinal Bleed ▪ Stroke ▪ Mental Health ▪ Paediatric ▪ Frailty
Surgical Division	▪ Surgical Same Day Emergency Care – HRI ▪ Ward 11 HRI – Extra Capacity Area ▪ Ward 14 HRI – Discharge Lounge
Family & Specialist Services	▪ Paediatric Assessment Unit ▪ Acre Mill Outpatients Department ▪ Maternity assessment Centre ▪ Labour Ward ▪ Gynaecology Assessment Unit & Early Pregnancy Assessment Unit
Community	▪ Broad Street Plaza ▪ Lister Lane Health Centre ▪ Beechwood Health Centre

By undertaking the focused programme trends and themes in non-compliance were identified and were able to be acted on immediately with oversight and scrutiny from the representatives in the 'Daily CQC Preparation Huddles'.

Any areas or wards of specific concern were supported, and extra resources were implemented where needed.

Some excellent examples of good practice were also identified (as set out in image 2) and the daily group was used to share the key learning:

Image 2



CQC did not visit CHFT as part of the U&EC IC Inspection BUT the work undertaken to date has re focused colleagues and teams into a state of CQC readiness. The daily huddles will continue to run twice weekly to ensure a continued focus on ensuring CQC is part of business as usual for all teams.

CQC Planned Onsite Visit

As part of the regular engagement between CHFT and the CQC Inspection and Relation Manager, a planned onsite visit took place on Thursday 12th May 2022.

The onsite visit schedule included:

- Updates from Executive Director of Nursing, Executive Medical Director and Chief Operating Officer
- Meet with the Senior Divisional Medical Team
- Visit to HRI ED
- Visit to Ward 15 HRI – Elderly Care

Whilst onsite the CQC team had a walkaround HRI ED as well as Ward 15 and had the opportunity to meet with the department and ward teams.

The senior medical team gave a comprehensive presentation on the Medical Division which included an overview of:

- Medical Team
- Medical Team Strategy
- Staffing & Workforce Pressures

- A&E Demand
- Acute Bed Demand
- Discharge Improvement
- Top Risks
- Celebrating the Successes

The CQC Team gave excellent feedback about the visit and praised the Medical Teams for welcoming them to the department and ward areas.

CQC has further requested an onsite visit on 08th July 2022 with a focus on Maternity Services.

Maternity Services - Ockenden Assurance Visit

In April CHFT was notified that the Local Maternity System (LMS) would be visiting the Trust on 28th June 2022 to undertake a Ockenden Assurance Visit.

The scope of the visit is to ensure that the Trust is compliant with the recommendation as set out in Ockenden 1.

The review team will comprise of:

- LMNS Representatives
- Regional Team Representatives
- ISB Designate Chief Nurse
- CCG Chief Nurse
- Maternity Voices Partnership Representative

The visit will be over 1 day and will include:

- Engagement with Staff at all Levels including Senior Leaders
- Ward Visits
- Observations
- Evidence Review (deadline for evidence submission is 13th June 2022)

The Trust has taken the same approach in preparation as the U&EC ICS Inspection.

A twice weekly Maternity Huddle has been established and a full programme of Focused J2O Reviews will be undertaken.

A full Mock CQC Inspection is also scheduled to take place w/c 13th June 2022.

CQC and Compliance Group

The CQC and Compliance Group continues to meet monthly; the meetings terms of reference are now due for annual review, giving the opportunity to relook at the meetings attendees, purpose, reporting and function within the CHFT governance structure.

The review of the groups terms of reference links to two other key workstreams which are the review the organisations Divisional Compliance Registers and External Inspection and Review policy.

The plan is to review the three workstreams as a whole to ensure robust processes, reporting and governance are in place to ensure Compliance and Assurance is embedded across the organisation.

3. Dementia Screening

Dementia Screening Compliance:

	Month	May-2022	Apr-2022	Mar-2022	Feb-2022	Jan-2022	Dec-2021	Nov-2021	Oct-2021	Sep-2021	Aug-2021	Jul-2021	Jun-2021	May-2021
Division	**Ward**													
Totals		26.67%	25.57%	28.41%	23.15%	19.25%	29.77%	38.82%	44.67%	42.19%	29.00%	20.68%	27.69%	24.78%
	Totals	25.57%	21.70%	21.18%	24.02%	20.21%	30.39%	40.86%	45.29%	48.13%	32.57%	21.43%	29.94%	27.05%
	2A CRH	29.41%	25.81%	11.76%	47.06%	30.77%	35.71%	31.58%	35.29%	35.71%	58.82%	9.09%	33.33%	25.00%
	2BCD CRH	25.00%	21.31%	11.96%	26.17%	23.23%	41.00%	50.00%	49.49%	61.80%	42.70%	26.92%	27.78%	28.81%
	6 HRI	70.45%	67.86%	48.94%	29.63%	20.69%	36.73%	54.55%	60.00%	60.47%	37.50%	66.67%	63.27%	69.57%
Medicine	Acute Floor HRI	14.29%	14.21%	20.50%	19.78%	16.75%	23.04%	33.69%	40.46%	39.08%	22.78%	11.06%	21.39%	14.94%
	Totals	26.83%	31.25%	61.54%	20.00%	20.00%	33.33%	32.35%	45.76%	20.00%	19.44%	25.64%	14.04%	16.28%
	SAU HRI	26.83%	31.25%	61.54%	20.00%	20.00%	33.33%	32.35%	45.76%	20.00%	19.44%	25.64%	14.04%	16.28%
	Totals	38.71%	69.23%	62.07%	18.18%	6.45%	20.00%	17.39%	26.67%	0.00%	3.45%	8.11%	26.92%	13.95%
	19 HRI	41.18%	73.33%	60.00%	17.65%	4.76%	20.69%	18.18%	20.00%	0.00%	4.76%	10.34%	31.25%	6.90%
Surgical	21 HRI	35.71%	63.64%	66.67%	18.75%	10.00%	18.18%	16.67%	40.00%	0.00%	0.00%	0.00%	20.00%	28.57%

Dementia screening has been added onto the risk register (risk no 8093). As screening compliance is improving, the risk will be reviewed accordingly. However, risk remains as compliance not yet near 90% target. Screening compliance has dropped recently, this may be linked to staffing levels.

To improve compliance, the below has been implemented:

- A Standard Operating Procedure (SOP) has been circulated to the new rotational medical colleagues and has been added onto Padlet for medics to review in their own time. The SOP has also been uploaded onto the Dementia intranet page for all staff to view.
- A daily email of the list of patients with an overdue dementia screen is sent out to consultants/ward managers/ward sisters and matrons of the assessment units, W19 and W21 to prompt medical staff to complete.
- A “Dementia Screening – What is it and why do we do it?” educational package has been developed for medical colleagues to support them to understand the importance of dementia screening and impact on patient experience. This has been presented at the induction for all new rotational medics and is uploaded on the Intranet for staff to view.
- The Dementia Lead has attended the most recent induction for medics and presented the above dementia screening educational package. This has been recorded and will be presented to all future medics.
- Dementia screening is requested by consultants in board round to be completed.
- Physician Associates have been approached and asked to complete dementia screens between hours of 12:00-14:00.

Compliance is not improving despite the above interventions. Discussions held with medical staff on Acute floor and SAU. It was noted that the assessment is a lower priority in comparison to other medical tasks. It was identified that the assessment should be done as part of clerking process or during the daily ward round. However, due to the assessment not being easily accessible on EPR when clerking it is often not completed.

Planned actions:

- Focussed work with the ward matrons and medical teams to improve compliance.
- Electronic whiteboard implementation to provide a visual reminder to medical staff re dementia screening.
- Review with EPR team re Clinician workflow and establish if Dementia Screening can be added or prompted. Attempted to have a pop-up visual prompt on EPR however this was identified as not appropriate.
- Discussion held around mandating the assessment and patient not being transferred from the ward until assessment complete. The Medical Director is having discussion regarding this.

Dementia / Delirium Care Plan:

The Dementia Lead has met with Bradford Dementia Led Nurse to create a more in-depth care plan for staff to follow for patients with a diagnosis of dementia. Separate delirium care plan also in process of being developed. This aim is for care plans to be triggered through Dementia, Delirium and Depression screen. This is ongoing piece of work and needs to be linked with dementia screening compliance. Once drafted, the Dementia Lead will work with EPR team to ensure this is built onto EPR.

Enhanced Care Team:

Risk 7998 – Recruitment of a band 4 colleague was successful. The team are working on supporting the wards with reopening their day rooms and engaging with staff around use of a activity.

It has been noted that an increased number of patients with aggressive behaviour are being referred, joint work with colleagues in quality and performance and health and safety is taking place to address this, which includes the use breakaway training and Enhanced Conflict Resolution Training.

Dementia Operational Group:

The last meeting took place in February 2022. Next meeting planned is due to take place on 13th June 2022.

The Dementia Link Practitioners training in process of being drafted, Matrons have been asked to submit names of staff on their wards. Training will take place monthly and will focus on person centred care across the wards, MCA/DOLS, communication/approaches, psychosocial interventions, environment, carers etc.

Community:

The Dementia Lead is working with Kirklees Dementia Hub, Gateway to Care and Admiral Nurses to develop a hospital admission pack for people with dementia. The aim is to provide people with dementia at point of diagnosis so that they can keep the pack and add to it prior to any admission. Included in this will be the See Who I Am care plan to support the wards with caring for a patient with dementia.

Post diagnostic support for people with dementia in Calderdale has been out to tender – Calderdale Dementia Hub has been successful in winning the bid. Calderdale and Kirklees will be consistent with their information and support provided. An introductory meeting is

planned with Calderdale Dementia Hub manager in next 4 weeks to plan how to work together and progress this work.

Dementia Lead Role:

Reviewing patients daily on elderly care wards who have delirium and dementia in relation to their care needs, DOLS, capacity assessments and discharge planning, providing advice and guidance to staff where required. The Dementia Lead noted an increased number of referrals which is positive step. Feedback received so far has been positive and this aim is to increase the number of referrals received. A dementia specific care plan is being developed with Bradford Dementia Lead

Dementia Training Compliance:

Due to data not being available for May/June compliance, a verbal updated with be provided to the meeting.

4. Patient Experience, Participation and Equalities Programme

Community Friends and Family Test (FFT): National Benchmarking Figures - NHS England

	March 2022	April 2022
Bradford	98%	97%
Calderdale	**89%**	**94%**
Leeds	89%	96%
Mid Yorkshire	99%	99%
Sheffield	99%	87%

Nationally Community FFT response rates decreased by 9% between March and April 2022. Locally, CHFT experienced a 73% increase in responses between April and May 2022. This has been largely down to a significant increase in responses from Children & Family Services.

What patients valued:

- Great support and advice
- Staff showing care and support
- Helping patients feeling involved in decisions about their care

Inpatient FFT: National Benchmarking Figures – NHS England

	March 2022	April 2022
Barnsley	92%	90%
Bradford	98%	98%
Calderdale	**96%**	**97%**
Leeds	94%	95%
Mid Yorkshire	97%	95%
Sheffield	87%	90%

Nationally Inpatient FFT response rates decreased by 9% between March and April 2022. CHFT experienced a similar decrease between April and May 2002, when responses fell by 8%. CHFT has however managed to deliverer against the national target of 95% positive feedback during these months.

What patients valued:

- Staff showing empathy and understanding
- Great communication
- Attention to detail

Outpatient FFT: National Benchmarking Figures – NHS England

	March 2022	April 2022
Barnsley	93%	
Bradford	93%	
Calderdale	**92%**	
Leeds	95%	
Mid Yorkshire	98%	
Sheffield		

Maternity Friends and Family Test

	March 2022
Barnsley	100%
Bradford	93%
Calderdale	**92%**
Leeds	95%
Mid Yorkshire	98%
Sheffield	81%

Emergency Department (ED)

	March 2022	April 2022
Barnsley	73%	76%
Bradford	49%	60%
Calderdale	**77%**	79%
Leeds	77%	78%
Mid Yorkshire	70%	70%
Sheffield	76%	77%

The national average response rate for Community FFT for March was 91%, this dropped by 16% to 75% in April. The figures for May are yet to be published by NHS England.

What we do know from our own data is that between April and May our ED response rates have dropped by 30%, however CHFT are performing above the national average with the total number positive responses. For April CHFT and LTH were the highest performing Trusts in the region.

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.

An internal audit is currently underway, and all evidence has been submitted with feedback awaited on any actions or recommendations that may be required.

The new PHSO complaint standards have been fully reviewed and the options of becoming an early adopter of these are being explored, to ensure we are in a positive position when the new standards are formally introduced later on this year.

An escalation letter from the Interim Chief Nurse has been agreed to be sent to Investigating Officers within Divisions when complaint responses have breached the specified timeframe – this was actioned in an attempt to improve Trust's performance. A response is expected within 5 working days of the letter and contact with the complainant is also requested to be made a priority.

Continued work is taking place with our colleagues in THIS to develop the dashboard for complaints on KP+ which will help the team, alongside the Divisional Teams, to monitor the performance more closely and identify areas where intervention is required. This is a helpful resource when identifying complaint investigations, which require the escalation letter mentioned above to be sent. This dashboard will also be used in the future to monitor complaints and map them to IMD groups and protected characteristics to ensure all our complainants are being treated fairly and equally.

The Division of Medicine have recently appointed an additional Band 5 to support the Division with the investigation and drafting of complaint responses. Initially the post will sit within the Corporate Complaints Team to fully understand the Trust's processes, eventually transferring to the Division of Medicine to manage complaints and support Patient Experience.

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. Standard Operating Procedure currently being drafted to ensure all Divisions are following same process. Escalation process has been agreed when complaint response are outside of timeframe (letter from Interim Chief Nurse to be sent to Investigating Officer). Work is on-going with THIS to ensure data on KP+ is accurate. Data cleanse on-going to ensure data quality is optimum. Support has been offered to Divisions to re-negotiate timeframe and extend where possible to avoid breaches.
2. Making Complaints Count & Working Together to Get Results: Delivering on collaborative action plan / quality priority	**REASONABLE Assurance**	Work is on-going to embed learning and the process surrounding this. Support is being offered to Divisions regarding quality of complaint responses.

Progress against key objectives

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

	April 2022	May 2022
Complaints received	34	30
Complaints closed	46	51
Complaints closed outside of target timeframe	30	32
% of complaints closed within target timeframe	35%	57%
Complaints reopened *[1]	6	9
*[1] Work is ongoing to validate this figure due to informal methods of handling further contacts on Datix		
PALS contacts received	133	156
Compliments received	43	14
PHSO complaints received	0	1
PHSO complaints closed	0	1
Complaints under investigation with PHSO (total)	5	

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.

Synopsis / Present position

Sarah Mather continues in the seconded role as Acting Head of Legal from Weightmans LLP (NHS Panel Solicitors) however, has accepted to substantive post. A formal start date is to be confirmed shortly.

Claims

There continues to be operational pressure around claims particularly due to new NHSR investigation processes and increased activity around claims. A new Legal standard operating procedure (SOP) is currently being trialled to streamline the claims process. The new process includes stages and triggers for escalation, HoL review and approval, SBAR briefings for divisional/executive awareness and a system of audit. This also allows for deeper scrutiny of claims and escalation to the Divisions, Finance and the executive teams where organisational risk is identified.

Paralegal assistance from Weightmans LLP continues and has allowed for a full review of the claims portfolio resulting in a number of historical claims being closed. The claims portfolio has so far reduced from 203 to 152.

A SOP and escalation process is also in place for Calderdale and Huddersfield Solutions (CHS) Claims is currently in place to ensure the files are being dealt with correctly and efficiently. Legal are continuing to provide a Quarterly Report to CHS (by 1st March, June, September, December) with the Head of Legal or representative attending the CHS Patient Safety Quality Board on a quarterly basis.

Inquests

The backlog and difficulties at Bradford Coroner's Office continue to impact upon our ability to prepare for inquests and divisional pressure. A meeting between the Acting Head of Legal, Executive Medical Director and Executive Director of Nursing and Senior Coroner is planned to establish a line of communication with the Coroner's Office and agree a more productive and efficient working relationship moving forward. Due to the backlog at the Coroner's Office, this meeting has not yet taken place, but communication is being shared with the Coroner's Office via email correspondence.

The new legal SOP is also being trialled within the inquest portfolio which is allowing the inquest handlers to be more proactive and have better oversight of the risks within the inquest portfolio. Case plans have been fully implemented and include a risk rating of each inquest case.

The inquest portfolio has reduced to 69 (provisional assessment confirms 3 high, 15 moderate, 31 low and 16 minimal risk inquests (4 cases under review).

Moving forward, moderate and high-risk inquests will include executive and divisional awareness and include strategy meetings between panel solicitors, legal and senior leads from the divisional and assurance teams to discuss planning for the inquest, witness support and mitigation.

Medical records disclosure

Several issues have been identified within Legal and Patient Advice and Liaison Service (PALS) and Complaints Teams relating to the disclosure of patient records including the risk of duplication across various services. There also appears to be a disproportionate number of emails from claimant's solicitors / HMC advising that records released by Legal are incomplete and a separate process has become necessary to deal with locating missing records. This has been placed on the Trust risk register.

A SOP is already in place however, further measures have been implemented including a system of cross checking of the medical and tailoring of record requests to limit the scope of disclosure (and likelihood of missing records). **A Task & Finish Group has been set up to explore a unified Trust process including staff access and a learning package to ensure consistency and avoid duplication across the Trust.**

Statement disclosure

Legal Services are currently trialling a new workstream in which all safeguarding and Police requests for information will come via Legal Services. This will allow Legal to review and facilitate formal requests as well as quality checking the statements prior to disclosure.

Datix is to be modified to capture the number of requests made, the origin of the request and the Divisions involved with further reporting to follow.

Recent Data

This report covers the period **1 April – 31 May 2022**.

Clinical Negligence

- 132 active clinical negligence claims
- 16 new clinical negligence claims were received (**an increase of 5 from the last report**)
- 7 clinical negligence claims were concluded
- Damages totalled **£14,555,638** (Obstetric claim settled for £14.4 million, 2 cases discontinued against the Trust)

Employers' and Public Liability (EL/PL) Claims

- 20 active EL/PL claims
- 5 EL/PL claims were received
- 7 EL/PL claims were concluded
- Damages totalled **£10,203** (2 cases discontinued against the Trust)

Lost Property

- 14 active lost property claims
- 8 lost property claims were received
- 2 lost property claims were concluded
- Compensation totalled **£129**

Inquests

- 69 active inquests
- 14 inquests were opened
- 23 inquest files were closed

Objective	Q3	Q4	Q1 – April to May 2022	Assurance
System in place to ensure effective communication within the Legal Services Department	Acting Head of Legal to incorporate communication and sharing procedures within new Legal SOP. This is to be implemented by March 2022. An escalation process has been agreed with the Divisions for triangulation and efficiency.	This is ongoing. The proposed claims and inquest process is to be shared with the Division. We are currently working on Claims and Inquest reports to be shared with the Executive and Divisional Teams.	**New Legal SOP is being trialled. This includes communication and escalation procedures to senior, executive and divisional levels.** **Strategy meetings are also being trialled for an any moderate or high risk inquest/claim to ensure effective planning and triangulation of information.** **Legal are also participating in the new Mortality (SJRS) Incidents, Complaints claims and Inquest (MICCI) meetings to share pertinent information.** **A new executive fortnightly inquest dashboard report has been created. Divisional Leads also receive a fortnightly inquest schedule confirming listings by directorate and witness involvement.**	**Reasonable assurance**
Datix Module for Legal Services reviewed and updated	This has stalled in the absence of a Datix Manager. It is noted steps have been taken to recruit for this role. Acting Head of Legal to incorporate into SOP to be implemented by March 2022. Case Plans have already been	This continues as the new Datix Manager is yet to be appointed. Further fields have been added to Datix including Trust risk probability and financial reserving. In addition, case plans have been implemented to record salient information.	**No major changes. This continues as the new Datix Manager is to start shortly. A meeting has been scheduled to discuss changes required.** **Further fields have been added to Datix including Trust risk probability and financial reserving. In addition, case plans have been implemented to record salient information.**	**Reasonable assurance**

Objective	Q3	Q4	Q1 – April to May 2022	Assurance
	implemented in the Inquest portfolio to record salient information. This is to be rolled out in Claims shortly.		**Once Datix is reconfigured for legal case management use, further reporting will be explored via KP+.**	
Audit of Legal Services files on Datix	File audit continues in association with quarterly and bi-monthly reporting, plus ad hoc sampling, therefore more regularly than quarterly. This is supported by the introduction of Case Plans to ensure accurate and up to date information is maintained on file.	This continues. Learning is to be communicated at weekly portfolio meetings and discussed as part of monthly technical training sessions.	**This continues. Learning is communicated at weekly portfolio meetings and will be feedback in 1-1's.**	**Reasonable assurance**
SOP for DP7 requests	A finalised SOP from Access to Health Data has been received. The Medical Records disclosure process is currently being reviewed. This has been added to the Risk Register given the operational, financial and reputational risk.	**As detailed above.**	**A new SOP for statement requests (including DP7) is in the process of drafting.** **Disclosure of medical records is also currently being reviewed Trust wide as part of a Task & Finish Group led by Louise Croxall, Neil Staniforth and Graham Walsh.**	**Reasonable assurance**.

Legal Service Learning - Sharing Learning from Inquest and Clinical Negligence Claims

Legal are looking to incorporate learning from Inquest and Claims and Getting It Right First Time (GIRFT) into the new processes. Legal Services are planning to link in with Speciality GIRFT Leads and Divisions across the Trust on a quarterly basis in relation to claims and inquests. Whilst there are already established links in some areas, the aim is to standardise this engagement so that no clinical/divisional areas are excluded.

There will be two strands to this engagement. The first will be to ensure that all Divisional and Speciality Leadership, as well as individual clinicians involved in providing care, are sighted on all claims and inquests at the relevant stages. As above, this has been implemented.

The second strand of improved engagement will be with Speciality Leadership. Legal Services will arrange to meet with each Speciality, once a quarter, to review their new, on-going, and closed claims and inquests.

Reporting of this information is currently being reviewed as well as appropriate forums; however, it is anticipated this will be aimed at middle to senior levels and clinical forums.

This will ensure oversight and awareness by the Speciality and improve identifying and acting on any learning in real time, rather than when a claim has concluded, which traditionally has been the case. This will also ensure that the 5 Point Action Plan recommended by GIRFT can be achieved on a continual basis, rather than once a year with the release of the Data Pack.

In the interim, upon the closure of each claim and inquest, a '7 Minute Briefing' document will be completed by the case handler and circulated to Divisions for learning, following approval by the Head of Legal. Learning will therefore be recorded on each case and circulated for wider sharing.

7. Incidents

Below is a summary of patient safety incidents and incidents with severe harm or death, for the year June 2021 to May 2022, 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
Jun 2021	812	8	5
Jul 2021	847	4	3
Aug 2021	830	7	2
Sept2021	901	11	4
Oct 2021	1020	10	4
Nov 2021	833	11	7
Dec 2021	804	4	1
Jan 2022	930	13	2
Feb 2022	718	8	3
Mar 2022	763	14	5
Apr 2022	748	3	2
May 2022	750	15	2


Number of Patient Safety Incidents (ALL)
1200
1000
800
600
400
200
0
812
847
830
901
1020
833
804
930
718
763
748
750
Jun 2021
Jul 2021
Aug 2021
Sep 2021
Oct 2021
Nov 2021
Dec 2021
Jan 2022
Feb 2022
Mar 2022
Apr 2022
May 2022
All Patient Safety Incidents
Linear (All Patient Safety Incidents)

Never Events

One Never Event was reported in May 2022 in relation to retained product following a procedure 5 years ago.

Summary of Progress with Serious Incident Actions

The Risk team continue to have oversight of all serious incidents and are working closely with the divisions and clinical teams to support and ensure a consistent process is followed across the Trust. All actions are responded to in a timely manner, with robust evidence to support this

A total of four StEIS (Strategic Executive Information System) incidents were reported; two for April 2022 and two in May 2022.

Learning from Serious Incidents.

Serious incident reports submitted to the Clinical Commissioning Group (CCG) in April 2022 and May 2022 are as follows:

Incident Summary	Learning Need and Organisational Learning
Cancer - Dx failed or delayed	Learning is in relation to recognition of omental disease and has been communicated to the Radiologist.
Cancer - Dx failed or delayed	It is noted that from the external reporting company that the individual concerned as undertaken personal reflection/learning from this incident: In addition, the reporting Radiologist has undertaken a personal reflection and learning on clinical aspect of reporting for internal purposes, which our Clinical Lead has reviewed and confirmed that the appropriate learning has been recognized and will be applied to their reporting.
Unexpected admission to neo-natal unit	• Intervention to expedite breech birth is required if there is evidence of poor fetal condition or if there is a delay of more than 5 minutes from delivery of the buttocks to the head, or of more than 3 minutes from the umbilicus to the head' • All women who plan vaginal breech births should be counselled that due to the majority of breech births being delivered surgically, some senior Obstetric Staff may not encounter many vaginal breech births during their training or career. All staff undergo annual simulation training on vaginal breech births. This frank counselling should be documented in the notes.
Deteriorating patient/failure to rescue	The trust policy for patient identification must be followed at all times: Staff must positively confirm the identity of the patient before initiating or withdrawing treatment

Incident Summary	Learning Need and Organisational Learning
Test results/reports - failure/delay to report test results	• There should be a process in place to ensure that there is a formal handover of the need for the result of an MRI scan to be assessed, particularly out of hours. The options available on HOOP can be altered, although this is not easy and comes at a cost. The present relevant options are “CT request/review” and “Xray request/review” but could be altered to • Radiology request/review” with further free text added. This would mitigate against further changes being required in future as other modalities come on stream. • Radiology department acute reporting workload may need reviewing in light of the delay in reporting the MRI scan.
Hospital Acquired Pressure Ulcer Category 4	• Importance of undertaking timely and appropriate intentional roundings, SSKIN care bundle and care plans • Importance of completing pressure ulcer risk assessments as per Trust policy using a holistic approach • Importance of initiating the sepsis screening tool and completion of Sepsis 6 care bundle
Deteriorating patient/failure to rescue	• The importance of timely escalation in response to a raised NEWS score • The importance of clear documentation of care plans with identified lead clinician • The importance of effective communication when different teams are involved in the care for a patient • The importance of following trust policy in relation to patient transfers

8. Medicines Safety

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

Medicine Safety Compliance Group Attendance

Quoracy at these meetings remains a challenge with a struggle to get full divisional attendance. If a core member is unable to attend, the terms of reference states that a deputy is nominated. This is not routinely happening.

Safe medication storage

Whilst the recent CQC preparation ensured that both senior nurses and pharmacy staff delivered focused reviews on medication storage standards which has resulted in measurable improvements, it also highlighted that not all ward teams were viewing safe storage of medicines as a priority. In some areas, medicines cupboard locks were broken, and it was not clear if these had been reported to Estates. The MSCG, with support from nursing leadership, need to consider how to re-establish medicines safety must do's into professional practice.

Some wards had adopted new practices i.e., installation of digilocks on POD lockers and whilst these resolved some issues (i.e., lost medicines keys), they bought in additional risks i.e., if patients self-medicated and all lockers had the same code, a patient could access multiple medicines cupboards and potentially have access to other patients' medication. Ideally when wards are looking to change practice and service development in terms of medication security, this should be presented and discussed at the Trust Medication Safety Group, in order that all risks and benefits can be reviewed and any wraparound governance i.e. updating the Trust Medicines Code / Standard Operating Procedures, is also actioned. Since this issue of POD locker digilocks was identified, the Trust Medicines Management Nurse is now updating the Medicines Code to include a section on digilocks and a good practice guidance around their management.

The Trust Medication Safety Officer (MSO) is going to review all medicines storage locking options, comparing their costs, risks and benefits and making a recommendation to the Medicines Safety Group for future purchases of lockable units.

Compliance with Medicines management training

A recent deep dive into training compliance highlighted that only 1215 CHFT clinical colleagues were compliant with completion of this mandatory 3-yearly training. All colleagues involved in the prescribing, handling and administration of medicines should ideally complete regular medicines management update training, including pharmacy, doctors, nurses, ODPs, midwives and AHPs involved in medicines prescribing or administration. The current e-learning module is a School of Medicines Optimisation package and has not been updated since 2018. It is lengthy to complete this module and repetitive.

To ensure the training delivered to colleagues is current and relevant to their roles, the MSCG propose developing a bespoke package with modules relevant to prescribers, staff administering medicines, staff handling medicines and community nursing staff. A further piece of work to identify a Trustwide training needs analysis (TNA) to ensure all staff involved in medicines are identified to complete the relevant modules. The need for this Trust wide TNA was also highlighted by the Trust Education Committee.

A key risk to highlight is the time required to complete this bespoke training package. For the next few months, there will be clinical staff involved in medicines prescribing and/or administration who have not completed the relevant training. To ensure our training is relevant to each professional staff group we will need key stakeholder engagement and support from the medical and nursing teams. The e-learning developers have indicated that it will take considerable time to develop such a package. Also, to highlight the Medicines management nurse who is leading on this work has reduced her working hours and her part-time replacement has not yet been recruited to, which will again impact on a realistic completion date for this work. Divisions are asked to acknowledge this risk on their risk registers in the interim.

Electronic Controlled Drugs Register (eCDR) Development

UAT for the controlled drugs (CD) register software identified a few fixes that are required before moving to the pilot phase. Both the pharmacy department and the software supplier are working closely to ensure a tool is produced that in addition to meet CD legal requirements, also helps save both nursing and pharmacy time. A final product is hoped to be available by the end of July 2023.

Active Temperature Monitoring

At the point of writing this report, 28 out of 51 wards and clinical areas were live with the Stanley active temperature monitoring system. The system allows real time alerting to any fridge temperature deviations, ensuring ward staff can respond to these alerts in a timely way. It replaces the requirement to manually record daily temperatures on a log sheet. Training on the new system takes approximately 10 minutes to complete. Previously, compliance with manual temperature monitoring was poor, hence, ward / clinic managers are encouraged to adopt this new system as soon as possible to improve compliance to correct fridge temperature monitoring and response time to deviations.

Switchboard have reported that on those wards who have successfully trained >75% of their staff on the system, they are getting contacted by some of the wards out of hours with queries on how to use of the system / respond to alerts. It is important for wards to ensure all relevant staff have completed the training. Access to the training and the Stanley system standard operating procedure can be found via the following link on the medical engineering Trust webpage:

https://intranet.cht.nhs.uk/non-clinical-information/medical-engineering-service/medical-engineering-department/mobileview-asset-tracking-and-temperature-monitoring/in-progress

9. Maternity Services

Ockenden report

The service continues to work through the action plan developed as a result of the independent review of the evidence submitted against the 7 Immediate and Essential Actions (IEA's). Maternity services have a planned external support visit by the Regional Chief Midwife's team on 28th June 2022 to review progress with 7IEA's from initial Ockenden report.

The Chief Nurse and The Head of Midwifery attended the Calderdale Adults Health and Social Care Scrutiny Board on the 1 June 2022 to provide an update on Ockenden. The Chair thanked Officers for their presentation and well-prepared answers and invited Officers to return in 6 months for further update.

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. This monthly meeting has superseded the previous bimonthly maternity safety champion's meetings.

Better Births – Continuity of Carer (COC)

On 1 April Trusts received a letter from the NHS Chief Executive, Chief Nursing Officer and National Medical Director in response to the publication of Dame Donna Ockenden's review. The letter made particular reference to the Trusts submissions of their MCoC plans; in line with the national maternity transformation programme; by the 15th June, which must take now take account of the requirement within IEA 2 Safe staffing:

"All Trusts must review and suspend, if necessary, the existing provision and further roll out of Midwifery Continuity of Carer (MCoC) unless they can demonstrate staffing meets safe minimum requirements on all shifts."

The letter asks Trusts to immediately assess their staffing position and make one of the following recommendations:

- Trusts that can demonstrate staffing meets safe minimum requirements can continue existing MCoC provision and continue to roll out
- Trusts that cannot meet safe minimum staffing requirements for further roll out of MCoC, but can meet safe minimum staffing requirements for existing MCoC provision should cease further roll out and continue to support at the current level of provision or only provide services to existing women on MCoC pathways and suspend new women being booked into MCoC provision
- Trusts that cannot meet safe minimum staffing requirements for further roll out of MCoC and for existing MCoC provision should immediately suspend existing MCoC provision and transfer them to alternative maternity pathways of care.

A paper was presented at Executive Board on the 28th April 2022 outlining our current position and recommendations, summarised below:

CHFT currently has 4 teams who book an average of 25% of women on to a MCoC pathway each month and an average 50% of all BAME women. However, due to vacancy levels and staff unavailability, it is becoming increasingly difficult to maintain this position and safe staffing levels in all areas. Traditional Community caseload teams have been reviewed and

aligned into small teams of approximately 4 midwives to deliver antenatal and postnatal care.

The recommendations are that two mixed risk locality-based teams in areas of highest deprivation would suspend the delivery of care in labour and focus on increasing antenatal and postnatal continuity from a named midwife and buddy.

Current community midwife out of hours on call service would continue to support women wishing to birth at home.

From October 2022 onwards over 12-18 months midwives would be rotated to all community midwifery teams with a vision to recommence the roll out of MCoC teams focusing on areas of highest deprivation.

These recommendations were approved and accepted at Executive Board and Private Board, with a further review of the Midwifery Continuity of Carer position to be present at the Private Board of Directors on the 3 November 2022.

The changes to the rotas will be instigated from the 20 June 2022.

NHS Resolution Maternity Incentive Scheme

In response to the on- going Covid- 19 pandemic and the pressures experienced across all areas of healthcare the NHS Resolution suspended year 4 of the Maternity Incentive scheme in December 2022 for a period of 3 months initially.

A decision has been announced that the NHS Resolutions relaunched the Maternity Incentive Scheme (MIS) on 6th May 2022 with a submission date of the 5 January 2023. The updated MIS has been extended and new requirements included in light of Ockenden Report, yet to been published. The scheme's conditions have also been reviewed and strengthened.

Healthcare Safety Investigation Branch (HSIB)

As of the 3 May 2022 the maternity services position is:

Cases to date	
Total referrals	37
Referrals / cases rejected	11
Total investigations to date	26
Total investigations completed	22
Current active cases	4
Exception reporting	0

Of the current cases the position is:

HSIB case number: MI-005708
HSIB criteria: Neonatal Death
Incident date: 15/12/21
Referral date: 29/12/21

Brief History
Baby was transferred to Leeds General Infirmary (LGI) at 4 days of age. Baby was known to have an echogenic bowel on antenatal ultrasound scans and was admitted to NICU at 7 hours of age due to poor feeding and a flexion deformity of the hips and knees, hypertonia of all four limbs and no suck reflex.
A laparotomy at the LGI confirmed necrotising enterocolitis

HSIB case number: MI-005964
HSIB criteria: HIE/ Cooling (Neonatal Death)
Incident date: 13/01/22
Referral date: 17/01/22

Brief History
Baby born at Calderdale Birth Centre; mum received her antenatal care from Dewsbury midwives. Admitted in labour and progressed quickly, significant meconium was noted at delivery and baby required resuscitation. Transferred to NICU where baby's condition deteriorated and following discussion with EMBRACE was transferred to a tertiary centre where baby subsequently passed away.

HSIB case number: MI-006831
HSIB criteria: HIE (NND at 7 days of age)
Incident date: 20/02/22
Referral date: 22/02/22

Brief History
Twin pregnancy, normal birth of twin 1 followed by cord prolapse of second twin. All clinicians' present. Unsuccessful instrumental delivery, transferred to obstetric theatre. Baby delivered by Caesarean Section. Cord tight around neck. Born in poor condition, transferred to Bradford for active cooling.

HSIB case number: MI-008801
HSIB criteria: HIE
Incident date: 26/0/22
Referral date: 28/04/22

Brief History
Baby born in poor condition following category 1 Emergency caesarean section 26/4/22 for a fetal bradycardia when attending scheduled antenatal clinic appointment. Needed resuscitation and admission to neonatal intensive care unit. Passively cooled and transferred to Bradford Royal Infirmary for active cooling later that evening.

Maternity Incidents

Maternity incidents reviewed at weekly maternity governance MDT meeting. All incidents are reported via Datix and coded as maternity incidents. The comparative data for April 2022 and May 2022 is described below.

	April 2022	**May 2022**
PPH- no adverse outcome	**9**	**10**
Shoulder Dystocia	**3**	**1**
Unexpected admission to the Neonatal Unit	**10**	**12**
2nd Theatre opened	**3**	**4**
3rd or 4th Degree perineal tear	**3**	**6**
Delay in Emergency Caesarean Section	**2**	**3**

At the monthly perinatal quality surveillance meeting a further specific set of safety metrics are reviewed. These are included in the table below.

	Maternity SI's	Maternity Never Events	Open HSIB cases	Total Stillbirth (SB) / Neonatal Death (NND)	Stillbirths Antenatal	Stillbirths Intra-partum	HIE Grade 2/3	Early NND	Late NND	Notification to ENS	Maternal Mortality
May 2022	0	0	4	3	3	1	0	0	0	0	0

24+4 weeks IP stillbirth – vaginal breech birth, no signs of life following birth, birth weight <1st centile

37+2 weeks AN stillbirth – presented at MAC with 2-day history of reduced fetal movements, intrauterine demise confirmed

29+1 weeks AN stillbirth – attended MAC with antepartum haemorrhage and abdominal pain, intrauterine demise confirmed

Maternity Complaints

Maternity services currently have 4 open complaints and 2 reopened complaints as of 3[1st] May 2022, 1 complaint is overdue, actions are in place to address this

Maternity Staffing

Maternity services submit workforce data to NHSEI each month and as of the 30th April 2022 recorded 165.53 whole time equivalent (WTE) midwives against an establishment of 186WTE midwives.

In March 2022 the service was allocated recurrent funding to support the requirements of the first Ockenden report. This funding supports the recruitment of an additional 12WTE midwives increasing the funded establishment to 198WTE midwives. This increase closes the establishment gap described in the November Birth Rate Plus report which suggested an establishment of 206WTE midwives to deliver a traditional model of maternity care.

For those midwives working in hospital based birthing environments a risk assessment takes place each shift, using the Birth Rate Plus patient acuity score, and the number of midwives

available (including on call Community Midwives and non-clinical midwives) to ensure safe staffing levels are maintained through the deployment of midwives to provide 1:1 care in labour and the temporary relocation of Calderdale Birth Centre to LDRP.

Additionally, from the 20th June 2022 following the approval to pause intrapartum care for the Maternity Continuity of Carer teams, midwives have been rotated from community to the inpatient services to increase the inpatient workforce with the aim at reducing the requirement to redeploy midwives throughout the service and to reduce the need to relocate the Calderdale Birth Centre. This rotation also includes rotating the newly qualified midwives (from September 2021) from community following the Ockenden recommendation that newly qualified midwives should not be allocated to community within the first 12 months.

Maternity Safe Staffing Indicators

1:1 care in labour is one of the most important safe staffing indicators and is reflected on the maternity dashboard. The table below describes the position over the previous 6 months.

Month	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	Apr 2022
1:1 care in labour	96.6%	98.1%	99.7%	98.8%	98.7%	97.5%

10. Quality Priority updates

The report details each priority and the measures to be monitored and reported into the Quality Committee this coming year.

Quality Account Priorities:

- Recognition and timely treatment of Sepsis

Focussed Quality Priorities

- Falls resulting in harm
- Pressure Ulcers
- Making Complaints Count

Quality Priority (2022-2023)

Recognition and timely treatment of Sepsis

Focus

- Percentage of adult patients that triggered in the Emergency Department (ED) for red flag Sepsis that had antibiotics administered within 1 hour of trigger
- BUFALO Bundle Total Compliance (%)
- Sepsis ESR Training Compliance (%) (Not Yet Available)

Reporting

- Sepsis Collaborative
- Care of the Acutely Ill Patient (CAIP) Programme
- Clinical Outcomes Group
- Quality Committee

Will undertake quality improvements

To improve the recognition and timely treatment of Sepsis.

Executive Lead

Dr Cornelle Parker

Operational Leads

Dr Rob Moisey
Paula McDonagh

What do we aim to achieve?	**Update** (March to April 2022)	Progress rating
Aim 1 Percentage of adult patients that triggered in ED for red flag Sepsis that had antibiotics administered within 1 hour of trigger	**Red flag patients** ▪ **March 2022 = 46.8 %** **April 2022 = 63.3%** The above percentages are based on all patients coded with sepsis in the Emergency Department (ED) who have triggered one or more red flags at both sites. **Progress work** ▪ Sepsis trollies in use. ▪ Introduction of ED Registrar carrying phone so can be contacted quickly to prescribe sepsis treatment. ▪ Trial of shift sepsis nurse who oversees time critical assessments and treatment. ▪ ED sepsis champion, clinician and nurse feeding back audit results. ▪ Sepsis info boards in central areas. **Risks and mitigations** ▪ Continued use of sepsis trolleys being monitored. ▪ Registrar sepsis phone not always being used, sepsis nurse discussed with clinicians and will send Comms out on SOP ▪ Patients admitted to Resus with sepsis do not always have their IV antibiotics signed for in timely way due to time critical administration,	**Reasonable assurance**

<table>
<tr>
<td></td>
<td>sepsis nurse looking at improving this issue. Possible effect of data compliance results.
▪ Compliance of sepsis training reduced due to staffing shortages and vacancies. <u>Action</u> - Sepsis nurse delivering training to RNs and noted to have improved attendance in April.
▪ Staffing shortages have been affecting patient reviews and treatment times. <u>Action</u> – ED teams initiated cross site staffing support lead by lead nurse each site, use of flexible workforce and extra duty payments.

<u>Successes</u>

▪ Category 2 patients in the ED are being seen in rapid assessment at HRI rather than waiting for a cubicle. This has improved treatment times for patients with sepsis.
▪ Mobile phones delivered and SOP set up.
▪ Recruitment of sepsis champions in both EDs.
▪ Agreed that further purchase of sepsis trolleys required as part of reconfiguration plan.
Sepsis boards in both EDs</td>
<td></td>
</tr>
<tr>
<td>Aim 2

BUFALO Bundle Total Compliance (%)

Each element will be measured (with exception of Lactate) from the sepsis screening tool and power plan within the electronic patient record.</td>
<td>
<table>
<tr><th></th><th>March 2022</th><th>April 2022</th><th>Progress Rating</th></tr>
<tr><td>Blood Cultures</td><td>73.3%</td><td>75.7%</td><td>Reasonable</td></tr>
<tr><td>Urine Output</td><td>73.5%</td><td>73.0%</td><td>Reasonable</td></tr>
<tr><td>Fluids</td><td>99%</td><td>100%</td><td>Substantial</td></tr>
<tr><td>Antibiotics</td><td>99%</td><td>100%</td><td>Substantial</td></tr>
<tr><td>Lactate</td><td colspan="3">Unable to add Lactate to EPR</td></tr>
<tr><td>Oxygen</td><td>90.2%</td><td>96.4%</td><td>Substantial</td></tr>
<tr><td>TOTAL</td><td>50%</td><td>57.7%</td><td></td></tr>
</table>
<u>Progress work</u>

▪ Element for blood culture has been confirmed as being measured accurately, sepsis nurse actioning drop ins to clinical areas to remind clinicians about taking blood cultures within red flag sepsis criteria.
▪ Sepsis screening tool now live on Athena, informatics are now able to gain compliance data.
▪ Point of Care Testing Business case funding now agreed and waiting next stage to initiate the reporting of blood gas and urinalysis results from Lab to EPR. Aim is for this to be completed by 31/03/2022. Working groups in place. No update available.
</td>
<td>See table</td>
</tr>
</table>

	▪ Blood culture 3Rs meeting taken place to initiate blood culture compliance improvement work in the EDs **Risks and mitigation's** - Not all Red flag sepsis patients are receiving blood cultures. **Action-** sepsis collaborative members to media the requirement through their work channels, sepsis nurse to visit clinical areas and remind clinicians, action group to be set up by sepsis nurse, article added to sepsis press re importance of this element measure. Additionally, sepsis 6 education now on junior doctors induction training. Noted that nurses within ward based areas do not take blood cultures so added to agenda on IV working group for discussion/action. **Successes** ▪ Target of total (50%) compliance ▪ Oxygen element changed to measure target saturation compliance resulting in more accurate recording. ▪ Consistent month on month substantial progress reporting fluid and antibiotics. ▪ Point of Care Testing (POCT) funding agreement to report arterial and venous blood gas results (Lactate).	
Aim 3 Sepsis ESR Training Compliance (%) (Not Yet Available)	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** **Progress work** ▪ Sepsis training continuing on Teams. **Total so far 350** ▪ Sepsis presentation now separated into clinician and registered nurse. RN approved at January's sepsis collaborative meeting approved at nursing and midwifery group on 20/4/2022. Clinician training approved at the sepsis collaborative and approved by Cornelle Parker. Both sent to Nicky Hosty and Paula Gladwell for processing. ▪ Sepsis champions supporting the training of registered nurses in clinical areas.	**Reasonable assurance**

	Risks and mitigations ▪ Sepsis recognition and treatment not currently part of essential safety training. **Action-** agreed at sepsis collaborative that training should be mandatory and with a 3-year update. ▪ Access to training staff proving difficult at times due to ward/dept pressures and movement of staff to support staffing shortages particularly in last month **Action -** sepsis nurse providing access to training evening and weekends and utilising sepsis champions to assist where possible. Attendance improvement noted in April and May 2022.	

Focused Quality Priority (2022-2023)

Reduction in the number of CHFT-acquired pressure ulcers

Focus

- Support a system wide approach to pressure ulcer prevention and management
- Strengthen clinical leadership at the frontline by empowering healthcare workers to provide exemplary care
- Implement over-arching policy recommendations aligned to national guidance
- Review, amend and implement new documentation processes on EPR
- Engage, challenge, motivate and educate healthcare workers via a robust training programme

Reporting

- Pressure Ulcer Collaborative
- Clinical Outcomes Group
- Quality Committee

Will 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.

Executive Lead

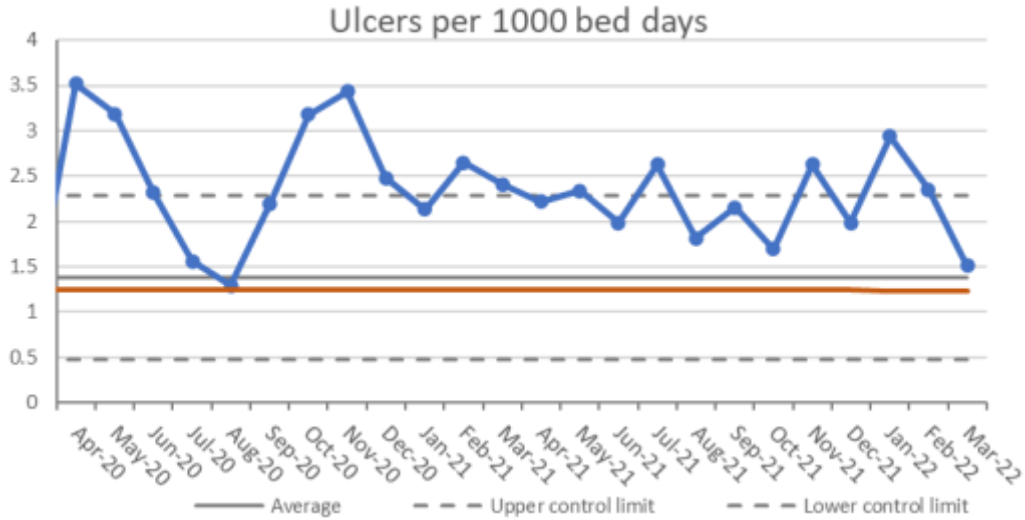
Lindsay Rudge

Operational Leads

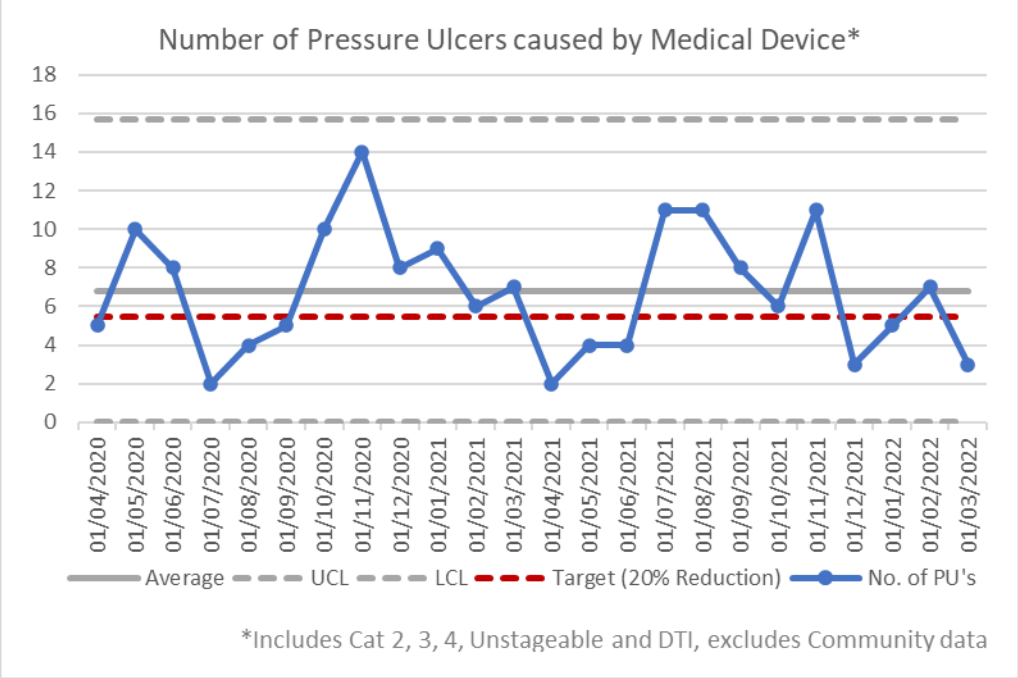
Judy Harker

Please note that Pressure Ulcers report one month in arrears.

What do we aim to achieve?	Current Update – March 2022	Progress rating	Next period
	New Key Performacne Indicators (KPIs) agreed for 2022/2023 ▪ **Aim 1:** Monitor number of hospital-acquired pressure ulcers ▪ **Aim 2: (a)** 95% of inpatients receive a pressure ulcer risk assessment within 6 hrs of admission/transfer (**b)** 95% of patients have a PU risk assessment within 7 days of admission to DN caseload ▪ **Aim 3:** 95% of relevant staff will have completed Pressure Ulcer Prevention training		

What do we aim to achieve?	Current Update – March 2022	Progress rating	Next period
Reduction in the Incidence* of hospital-acquired pressure ulcers by 10%. This will be measured by incident data	 Sharp reduction in incidence of hospital acquired pressure ulcers from January to March 2022. **Risk** Further hospital acquired category 4 pressure ulcer in March 2022. Initial SI investigations would indicate however that no significant lapses in care could be identified. There have been instances where wards have failed to Datix hospital acquired pressure ulcers. This poses a risk that the data may not be providing a true reflection of the current position on pressure ulcers. Data from Datix for patients with multiple pressure ulcers on different body sites has been difficult to extract accurately.	**Reasonable assurance**	Continue to monitor and validate April data Pressure ulcer checklist to be embedded into Datix Roll out of Pressure ulcer KP+ to Matrons, Ward Managers. Utilisation of Todays Patient Data on KP+ to identify patients without a risk assessment

What do we aim to achieve?	Current Update – March 2022	Progress rating	Next period
	Mitigation Daily safety huddles continue between Tissue Viability team and Matrons to discuss high risk patients with pressure damage and moisture damage and to allow for rapid escalation of omissions in care. New build of pressure ulcer section in KP+. This will provide live data on the Trust's current position with pressure ulcers according to Datix reporting. It will allow identification of patients who have not received a risk assessment within 6 hours of admission. Due to the increase in CHFT acquired category 4 pressure ulcers, divisions are providing enhanced focus and scrutiny on pressure area care Divisional ADNs are reviewing all pressure ulcers acquired on enhanced ward dashboards on a weekly basis Medical division are rolling out the provision of slide sheets at every bed space to improve compliance with use. The slide sheets will be stored in lockers. The Bed Check SOP will include the provision of slide sheets to ensure they are replenished after every patient episode. PURPOSE T pressure ulcer risk assessment tool endorsed by NHS England now built on Cerner and being aligned to new clinical pathways. Testing underway. Plan for implementation July 2022. Medical Division are relaunching the Tulip repositioning boards at every bed space. This tool will allow recording of time / frequency of repositioning and act as a visual prompt to support compliance. Plan For Every Patient boards have been updated with icon indicating pressure ulcer risk / cast in situ on orthopaedic wards and disseminated within Medicine and FSS division.		

What do we aim to achieve?	Current Update – March 2022	Progress rating	Next period
	Clinical Governance support has identified that majority of pressure ulcer risk assessments are carried out at night. Work underway to address this and increase quality of skin and risk assessments. Focused documentation audit to take place on orthopaedic wards in May 2022. The new Policy for the Prevention and Management of Pressure Ulcers is now available on the Intranet.		
Reduction in the incidence* of hospital-acquired medical device related pressure ulcers by 20%. This will be measured by incident data	 There has been a decrease in the number of device related pressure ulcers from February to March 2022.	**Reasonable assurance**	Continue to validate March data. Sustain strong culture of reporting device related pressure ulcers. Plaster Room are undertaking a 'Go See' at BHFT to look at quality improvements used Plaster room. They hope to explore

<table>
<tr><th>What do we aim to achieve?</th><th>Current Update – March 2022</th><th>Progress rating</th><th>Next period</th></tr>
<tr><td></td><td>Devices causing pressure damage in March 2022 for whole Trust include urinary catheter (2), oxygen mask (1), orthopaedic device (2) and ET tube (1).

Risk
Lack of sustained reduction in medical device related pressure ulcers.

Mitigation

There has been a relaunch of the new Plaster Room at HRI involving visits to ward areas to talk about pressure ulcer risk in patients with casts. This has resulted in collaboration between Surgical Division and FSS / Plaster Room offering ward visits by Plaster Technicians to support care of patients in casts. Spreading expertise from Plaster Room to general ward areas is fundamental in the prevention of medical device related pressure ulcers. Ward visits are being offered twice a week.

The Plaster Room are now providing nurse-led telephone follow up of all patients with casts in care homes. This service involves the provision of advice and support to health and social care staff in the management of medical-device pressure ulcer risk.</td><td></td><td>use of QR codes on plaster casts.

Check list for staff caring for patients with cast to be available via EPR.</td></tr>
<tr><td>Reduction in the incidence* of hospital-acquired heel pressure ulcers by 20%. This will be measured by incident data</td><td><table><tr><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mar</td></tr><tr><td>23</td><td>23</td><td>26</td><td>21</td><td>15</td></tr></table>
Incidence data not available for report.

Risk

Continued development of heel pressure ulcers.

Mitigation

Medical Device training compliance to be addressed within divisions to provide assurance</td><td>Reasonable assurance</td><td>Continue to validate April data

Heel Device Selection Guide to be devised by Podiatry Team</td></tr>
</table>

<table>
<tr><th>What do we aim to achieve?</th><th>Current Update – March 2022</th><th>Progress rating</th><th>Next period</th></tr>
<tr><td></td><td>that staff are competent in use of air mattresses and offloading heel devices.

All relevant wards have inflatable heel devices on top up via Materials Management. Training video disseminated widely.

Heel inspection mirrors continue to be being promoted and distributed across Trust.</td><td></td><td></td></tr>
<tr><td>Reduction in the number of Orange / moderate harm pressure ulcers by 50%</td><td>
<table>
<tr><th>Month and Year</th><th>Moderate harm</th></tr>
<tr><td>Apr 2021</td><td>5</td></tr>
<tr><td>May 2021</td><td>6</td></tr>
<tr><td>Jun 2021</td><td>5</td></tr>
<tr><td>Jul 2021</td><td>7</td></tr>
<tr><td>Aug 2021</td><td>6</td></tr>
<tr><td>Sep 2021</td><td>14</td></tr>
<tr><td>Oct 2021</td><td>1</td></tr>
<tr><td>Nov 2021</td><td>10</td></tr>
<tr><td>Dec 2021</td><td>12</td></tr>
<tr><td>Jan 2022</td><td>18</td></tr>
<tr><td>Feb 2022</td><td>7</td></tr>
<tr><td>Mar 2022</td><td>8</td></tr>
<tr><td>Total</td><td>99</td></tr>
</table>

Risk
Moderate harm incidents are subject to change upon verification at Orange Panel. No sustained reduction in moderate harms in last 12 months.

Mitigation
There is a need to understand the journey of an incident and identify who is responsible for</td><td>Limited assurance</td><td>Datix checklist to be merged into Datix and enable causal omissions and contributory factors to be identified.</td></tr>
</table>

What do we aim to achieve?	Current Update – March 2022	Progress rating	Next period
	updating Datix at different stages of an investigation. Additional Orange Panels have been organised within divisions to reduce backlog. Medical Division have developed a SOP for orange panel which is out for consultation. The purpose of the SOP is to improve attendance, quality of investigations and learning. Once completed this will be shared across the organisation.		
No Red serious pressure ulcer incidents	There has been a further red serious incident in March 2022. This is a category 4 pressure ulcer to the natal cleft. Themes from red incidents have been very similar. They include gaps in skin inspection and repositioning, provision of incorrect pressure redistributing equipment, inconsistent documentation and incorrect or late risk assessment. These all constitute the fundamentals of pressure area care.	**Limited 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	At March 2022 29% of patients in hospital received a risk assessment within 6 hours of admission/transfer. There has been no improvement on this measure. **Risk** Data would indicate that 98% of patients have received a risk assessment within 7 days. SI investigations and focused work in medical division has shown that night staff undertake the majority of risk assessments. This poses a further risk as lighting can be poor at night and opportunities for skin inspection limited. Admission checklist not used consistently across Trust. **Mitigation** Divisions addressing issue of timing of risk assessments. Medical Division are leading on developing a standardised checklist and embedding this in all clinical areas. The checklist will prompt staff to complete pressure ulcer risk assessments.	**Limited assurance**	

What do we aim to achieve?	Current Update – March 2022	Progress rating	Next period
	Audit support provided for this quality priority. Identification of barriers to completing risk assessments will be focus of enquiry. Meeting has taken place with Information Management and Tissue Viability to undertake sense check of data. Data verified. KP+ Pressure Ulcer data will support this KPI as discussed		
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** Guidelines for Documenting Individualised Care through EPR now published and circulated to clinical areas. Informatics are building a live dashboard on KP+ to help identify patients who have not received necessary risk assessments.	**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 skin bundles will fit with patient pathways on EPR.
95% or more of at-risk patients in hospital will have a pressure ulcer care plan	All patients with a Waterlow of 10 > had a pressure ulcer prevention care plan initiated. Pressure ulcer prevention and management care plans devised with BHFT to align to new pressure ulcer risk assessment tool (PURPOSE T). Currently in build phase with EPR team.	**Substantial assurance**	Launch of care plans July / August 2022.

What do we aim to achieve?	Current Update – March 2022	Progress rating	Next period
initiated. This will be measured by ward assurance	These will be rolled out at time of launch of new tool.		
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.	70.8 % of contact on Community caseload Waterlow completed or not appropriate within 7 days 29.1 % not completed Continued data cleansing by senior nurses. Work required to include community performance data on KP+ Pressure Ulcer Dashboard.		Review of SystmOne care plans to align to new PURPOSE T risk assessment tool.
95% of relevant staff (RNs, Nursing Associates and HCAs) will have completed	82% of staff have completed React To Red Training. This is an increase from February 2022. Additional virtual and ward-based training has been provided on pressure ulcer prevention to support staff. Bite-sized training delivered to target medical / surgical wards and community nursing	**Reasonable assurance**	Divisions to continue to address non-compliance Screensaver to

What do we aim to achieve?	Current Update – March 2022	Progress rating	Next period
React To Red Pressure or equivalent Pressure Ulcer training in last 2 years. This will be measured by Essential Safety Training (EST) compliance data	teams. Tissue Viability Link Practitioners now being competency assessed in pressure area care and educational materials shared so they can disseminate the training. Going forward, new Pressure ulcer build on KP+ will include EST training compliance which can be drilled down to division and ward / team level. National pressure ulcer e learning tool will replace Trust's e learning resource once the new pressure ulcer risk assessment tool is implemented across the organisation.		raise to promote new national e-learning module once PURPOSE T risk assessment tool launched.

Focused Quality Priority (2022-2023)

Reducing the number of falls resulting in harm

Will undertake quality improvements

To reduce the number of inpatient falls and those resulting in harm

Focus

- Number of falls
- Number of falls resulting in harm
- All adult inpatients will receive a falls risk assessment on admission / transfer to the ward (ward assurance)

Executive Lead

Lindsay Rudge

Reporting

- Falls Collaborative
- Clinical Outcomes Group
- Quality Committee

Operational Leads

Dr Abhijit Chakraborty
Lauren Green
Helen Hodgson

What do we aim to achieve?	**Update** (May 2022)	Progress rating
Aim 1 Monitor the total number of falls and implement actions to reduce these	Falls dashboard updated monthly and fed back through the Falls Collaborative. The total number of falls have significantly increased since November 2021, linking in with staffing levels and ward acuity. However, in April 2022 the number of falls dropped below the Trust average **(See chart 1 – Number of falls)**	**Reasonable assurance**
Aim 2 Monitor the total number of Number of falls resulting in harm and implement actions to reduce these	Falls dashboard updated monthly and fed back through the falls collaborative. Number of harm falls have been variable since November 2021, linking in with staffing levels and ward acuity. March 2022 saw the highest number of harm falls, with 10 in total. In April 2022, this has dropped to one, with mitigating actions in-situ below. **(See chart 2 – Number of harm falls)**	**Reasonable assurance**
Aim 3 Ensure all adult inpatients will receive a falls risk assessment on admission/ transfer to the ward (ward assurance)	The data shows an improvement in patients receiving a falls risk assessment upon admission. Work is ongoing via the Falls Link Practitioners and electronic patient record (EPR) team to improve this. **(see Table 1)**	**Reasonable assurance**

Chart 1 – Number of Falls

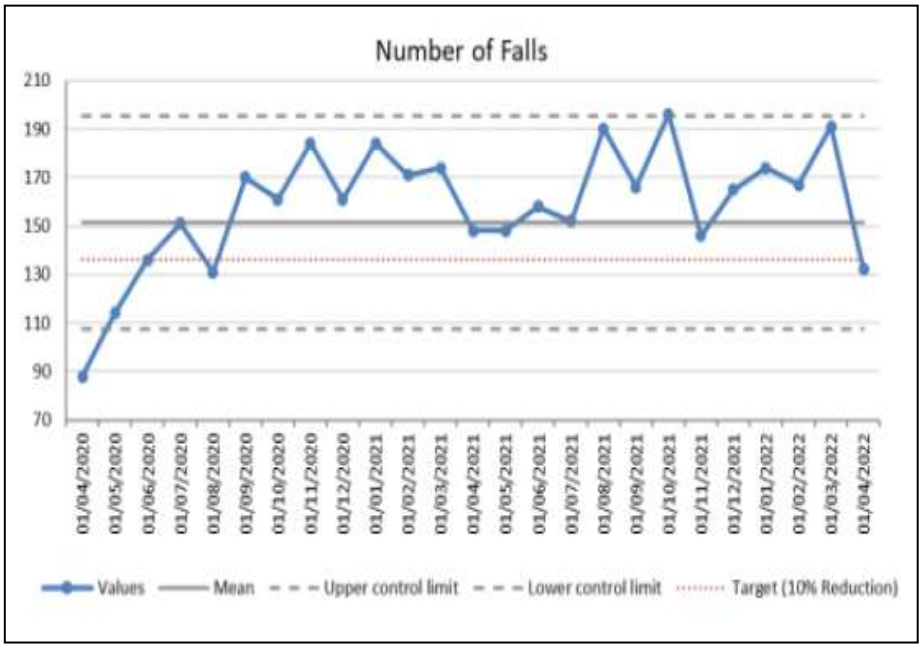


Chart 2 – Number of Harm Falls

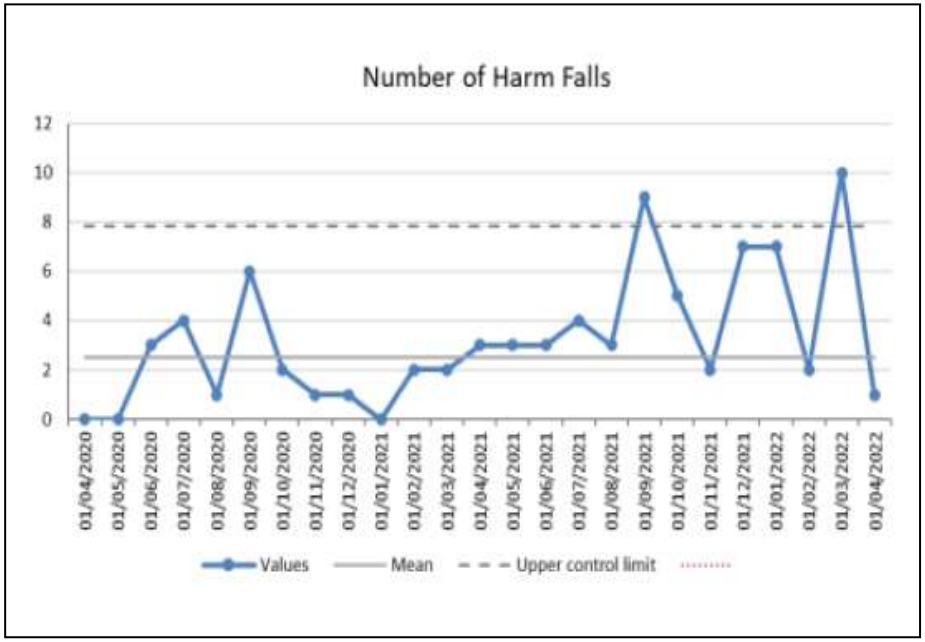


Table 1

	May 2021	June 2021	July 2021	Aug 2021	Sept 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	Apr 2022
All adult inpatients receive a falls risk assessment on admission / transfer to ward	49.1%	49.4%	51.5%	50.3%	49.7%	50.7%	49.6%	50.1%	51.9%	71.5%	74.3%	74.2%

Progress

- Falls Link Practitioners training underway. The training sessions are tailored to risks identified i.e. next session is on use of bed rails.
- Falls policy has been updated and is awaiting finalisation through the weekly executive board (WEB), this includes decision-making flowchart for bed rail use, timings and pre/post fall assessment protocols.
- Ward mapping and PDSA work being undertaken.
- Work ongoing with EPR team to update the falls risk assessment and the Falls care plan

Risks identified as appropriate

- Risk 5862 ongoing.

Mitigating actions taken / to be taken

- Falls Collaborative continues to meet every six weeks.
- The falls EPR workstream lead has identified that the current falls assessment tool and falls care plan require improvement. Work is ongoing with Bradford's falls lead to adapt the falls assessment tool on EPR. Positive feedback has been received from Bradford to change the assessment tool used, and now waiting to meet with EPR team following next Falls Collaorative to agree and implement changes.
- The Patient and Carer falls leaflet has been updated, and agreed through the Falls Collaborative – this will be uploaded onto the intranet for colleagues to access and hand out to all patients/carers.
- A falls intranet page is in the process of being developed, in liaison with the Health Informatics Service. The page will have all information for Falls Link Practitioners, resources, learning from Serious Investigations, best practice guidelines, link to updated falls policy, link to EPR SOP, updated bed rail guidance, QI projects and outcomes, video demonstrations how to use equipment to support a patient who has fallen. This will be regularly reviewed.
- A Falls prevention intervention care plan has been created and will be disseminated across wards. The interventions have been added to the updated Falls Policy. This care plan will be uploaded onto EPR however, until then, wards will be informed via their matrons, ward managers and senior nurses.
- Bed rail risk assessment in process of being updated, bed rail flow chart drafted up and has be finalsed the most recent Falls Collaborative.
- Falls and Fragility Fracture Audit Programme (FFFAP) Quality Improvement project is underway. The aim identified is for 80% of patients admitted onto the Acute Floors (CRH & HRI) over age of 65 to have a Lying and Standing blood pressure recorded within 48 hours of admission, documented in the appropriate section on EPR.
- All wards are now compliant with the Sure Falls Devices and Stealth Mats. Ward managers have been informed of how to order the falls devices once their compliance rate has been reached. Wards do not need to purchase their falls alarms, as there is a central stock in medical devices.
- Learning from Serious Incident (SI) investigations will be disseminated through the Falls Collaborative.
- Audit completed of harm falls across the Trust. Themes identified and action plan generated:
  - Mapping floors to identify high risk areas. Utilising ward staff and remote laptop stands. Wards mapped to date include ward 6 HRI, HRI Acute floor Ward 6AB CRH. Working with Health Informatics regarding laptop provision.
  - Developing a risk assessment to support nursing staff with their decision making as to where patients are placed on a ward upon admission depending on their level of falls risk.

Action(s) to be taken for the next forthcoming period

- Falls Link Practitioner training to be rolled out and embedded across all wards

- Falls intranet page to be developed
- Falls risk assessment and care plan on EPR to be updated to support ward staff with their assessments and decision-making regarding fall prevention interventions

Focused Quality Priority (2022-2023)

Making Complaints Count

Focus

- Fully align the work of the Making Complaints Collaborative to ensure it is delivering against the national complaints regulations and the emergent Parliamentary and Health Service Ombudsman (PHSO) standards.
- Support a trust wide / user led approach to 'Making Complaints Count'.
- Review existing processes, policy and operating procedures as needed to be assured of compliance and that operations are fully supported.

Reporting

- Making Complaints Count Collaborative
- Patient Experience and Caring Group
- Quality Committee

Will undertake quality improvements

- To implement success measure will be a shift change in the assurance from red to green over the year. Improvements will be noted via performance reporting

Executive Lead

Lindsay Rudge

Operational Leads

Emma Catterall

What do we aim to achieve?	**Update** (April 2022 to May 2022)	Progress rating
Aim 1 % of Complaints Closed within agreed timescale	To support this aim, an escalation letter from the Interim Chief Nurse has been drafted to be sent to Investigating Officers within Divisions when a complaint is approaching/breached the timeframe. It requests that the response is drafted within 5 working days and immediate contact is made with the complainant apologising for the delay. To further support this, complaints that have breached have recently been extended with complainants to agree a new deadline.	The letter has been agreed and will be sent week commencing 13 June 2022. A large proportion of complaints that were due have been extended with the complainant to ensure the new timeframe is adhered to.

What do we aim to achieve?	**Update** (April 2022 to May 2022)	Progress rating
Aim 2 Number of reopened complaints	The quality of complaint responses has been a focus to avoid re-opened complaints. 15 Complaints have been re-opened from 1/04/2022 – 31/05/2022 out of 97 that were closed (15%), a number of which have requested Local Resolution Meetings. This continues to be a priority moving forward.	Limited assurance due to number re-opened, however continues to be our priority to respond to complaints effectively first time round.
Aim 3 Number of concerns that escalate into complaints	This is currently being monitored and usually occurs when Division have not been pro-active in responding to low-level concerns. In line with national standards, we have 72 hours to address and respond to PALS concerns, when this has not been achieved, they will escalate to formal complaints. Over the coming months, work will take place with Divisions to reiterate the importance of responding to concerns as quickly and effectively as possible to avoid them escalating to complaints.	In this reporting time period 6 concerns have escalated to a formal complaint. This will continue to be monitored, however all 6 appear to be genuine formal complaints that need a level of investigation and response.

Focused Quality Priority (2022-2023)

Increase the quality of clinical documentation across CHFT

Focus

- Optimise the Clinical Record through:
  - In-depth analysis of the current process around electronic documentation
  - Benchmark
  - Set standards

Reporting

- Clinical Outcomes Group
- Quality Committee

Will 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.

Executive Lead

Dr David Birkenhead

Operational Leads

Louise Croxall
Mr Graham Walsh

What do we aim to achieve?	Update (June 2022)	Progress rating
Aim 1 Optimise the Clinical Record by improving the work flows and making it easier to achieve the Must do's	Task and finish group set up to look at the nursing admission process involving ward managers from a different areas and back office EPR team. This will then extend to other workflows and care plans. Doctors teaching being reviewed with three junior doctors and the training team.	**Substantial assurance**
Aim 2 Making sure assessments are achieved within a timely manner on admission and throughout the hospital stay as needed.	Work ongoing with admission process as above.	**Substantial assurance**
Aim 3 Implement the hospital white board across the trust to assist in completion of accurate documentation and assessments	Whiteboard pilot on Ward 5 currently, rolling out to Acute floor and SAU and HRI.	**Substantial assurance**
Aim 4 Improve overall performance on documentation by assisting ward managers and matrons to access information and report figures monthly into their quality boards.	June 2022: New dashboard being created with the data quality team on KP+ making it easier for ward managers, matrons to access their data.	**Substantial assurance**

Appendix 1 – 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.

Calderdale and Huddersfield NHS Foundation Trust

Quality Report Executive Summary- Reporting Period April 2022- May 2022

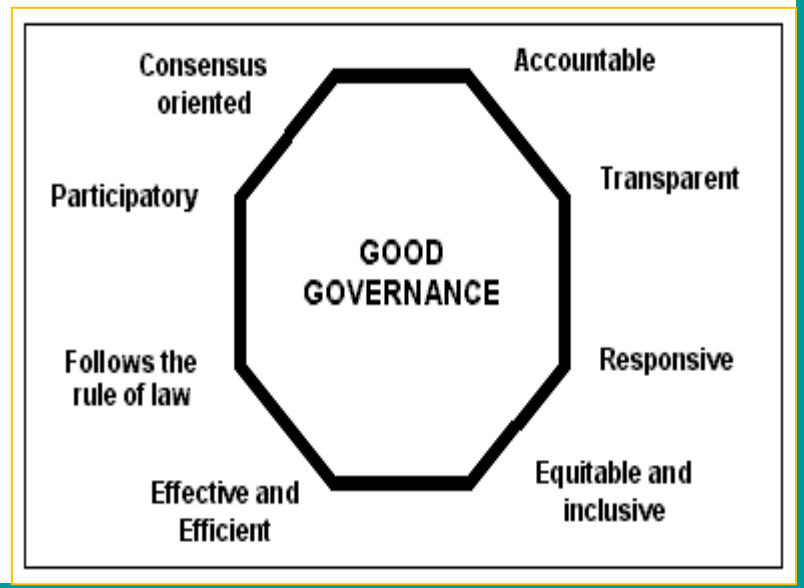
Purpose of the Paper:

The purpose of this paper is to provide key updates and assurance to the Quality Committee and Board of Directors in relation to the core quality work streams of the Trust.

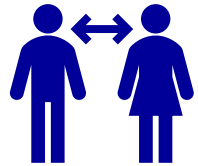
It covers the period of April 2022 to May 2022 and provides assurance that the Trust has continued to maintain compliance with its statutory regulatory requirements, by implementing a number of proactive actions and adopting an innovative yet safe approach to quality governance

The update for the committee will focus on key workstreams as well as Quality Priorities and 7 Focused Quality Priorities including:

Care Quality Commission (CQC)
Dementia Care and Screening
Patient Experience, Participation, Equalities
Patient Advice and Complaints Service (PACS)
Legal Services
Medicine Safety
Incidents
Lessons Learnt from Serious Incidents



Care Quality Commission



No formal agenda engagement meeting with CQC has taken place within the reporting period, however, CHFT did have a planned CQC onsite visit with a focus on which took place on Thursday 12th May 2022.

This included

- Updates from Executive Director of Nursing, Executive Medical Director and Chief Operating Officer
- Meet with the Senior Divisional Medical Team
- Visit to HRI ED
- Visit to Ward 15 HRI – Elderly Care

Whilst onsite the CQC team had a walkaround HRI ED as well as Ward 15 and had the opportunity to meet with the department and ward teams.

Care Quality Commission

The senior medical team gave a comprehensive presentation on the Medical Division which included an overview of:

- Medical Team
- Medical Team Strategy
- Staffing & Workforce Pressures
- A&E Demand
- Acute Bed Demand
- Discharge Improvement
- Top Risks
- -Celebrating the Successes

The CQC Team gave excellent feedback about the visit and praised the Medical Teams for welcoming them to the department and ward areas.

CQC has further requested an onsite visit on 8th July 2022 with a focus on Maternity Services.

Care Quality Commission

- During April, CQC conducted inspections across the West Yorkshire ICS focusing on Urgent and Emergency Care (U&EC) pathways across acute, primary, and adult social care.

- The aim was to support improvement in patient experience and the quality of care received when accessing services and pathways across urgent and emergency care.

- To achieve this, CQC coordinated activity where appropriate to positively influence the system-wide response to the challenges across urgent and emergency care pathways and drive system wide accountability.

- CHFT was not inspected by CQC as part of the ICS review, but extensive work went into preparation as described in the 'CHFT Response to Inspection Activity Notification' section.

Care Quality Commission

Ward Based, Community and Emergency Department (ED) specific J2O Toolkit was developed for use to aid with the Trusts CQC Preparation.

These toolkits were focused and specifically included key lines of enquiry which we use as part of the Urgent & Emergency Care Pathways

By undertaking the focused programme trends and themes in non-compliance were identified and were able to be acted on immediately with oversight and scrutiny from the representatives in the 'Daily CQC Preparation Huddles'.

Examples of Good Practice Identified

Positive Messages

Celebrate the Positives ....

Welcoming – Ward areas were welcoming, calm and had a good atmosphere. Staff were welcoming to the review teams.

PPE Compliance – Staff were compliant with PPE guidance

Teamworking – Good team and multidisciplinary working was witness across wards & departments

Staff Knowledge of Patient Pathways – Staff could clearly articulate the pathways of care for patients who present on the ward areas

Patient Care – Patients were visibly well cared for

Dementia Care and Screening

Dementia Screening compliance continues to remain a challenge for the Trust , additional processes implemented to address this included :-

- Focussed work with the ward matrons and medical teams to improve compliance.
- Electronic whiteboard implementation to provide a visual reminder to medical staff re dementia screening.
- Review with EPR team re Clinician workflow and establish if Dementia Screening can be added or prompted.
- Discussion held around mandating the assessment and patient not being transferred from the ward until assessment complete. Led by the Medical Director is having discussion regarding this.
- In-depth care plan for staff to follow for patients with a diagnosis of dementia are being developed with Bradford as well Separate delirium care plans

Patient Experience, Participation, Equalities

Community Friends and Family Test (FFT): National Benchmarking Figures - NHS England

Nationally Community FFT response rates decreased by 9% between March and April 2022.

CHFT experienced a 73% increase in responses between April and May 2022. This has been largely down to a significant increase in responses from Children & Family Services.

Inpatient FFT: National Benchmarking Figures – NHS England

Nationally Inpatient FFT response rates decreased by 9% between March and April 2022.

CHFT experienced a similar decrease between April and May 2002, when responses fell by 8%. CHFT has however managed to deliverer against the national target of 95% positive feedback during these months.

Patient Experience, Participation, Equalities

What our patients valued :-

- Great support and advice
- Staff showing care and support
- Helping patients feeling involved in decisions about their care
- Staff showing empathy and understanding
- Great communication
- Attention to detail

Patient Advice and Complaints Service (PACS)

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

	April 2022	May 2022
Complaints received	34	30
Complaints closed	46	51
Complaints closed outside of target timeframe	30	32
% of complaints closed within target timeframe	35%	57%
Complaints reopened *1	6	9
*1 Work is ongoing to validate this figure due to informal methods of handling further contacts on Datix		
PALS contacts received	133	156
Compliments received	43	14
PHSO complaints received	0	1
PHSO complaints closed	0	1
Complaints under investigation with PHSO (total)	5	

Patient Advice and Complaints Service (PACS)

It should be noted from the previous slide that they had been an increase in complaints closed with target timeframe from 35% in April to 57 % in May .

There is continued focus on performance with additional measures in place such as :-

Development of dashboard for complaints on KP+ which will help the team, alongside the Divisional Teams, to monitor the performance more closely and identify areas where intervention is required

Escalation process in place for Investigating Officers within Divisions when complaint responses have breached the specified timeframe to enhance the level of oversight and scrutiny

The new PHSO complaint standards have been reviewed, with the Trust consisted being an early adopter of thrse

Legal Services

A legal SOP is being trialled within the inquest portfolio which is allowing the inquest handlers to be more proactive and have better oversight of the risks within the inquest portfolio. Case plans have been fully implemented and include a risk rating of each inquest case.

The inquest portfolio has reduced to 69 with the claims portfolio having reduced from 203 to 152. This enables the Trust to focus on high risk/ high value cases and ensure effective strategies are in place to manage these

Legal are looking to incorporate learning from Inquest and Claims and Getting It Right First Time (GIRFT) into the new processes, In the interim, upon the closure of each claim and inquest, a '7 Minute Briefing' document will be completed by the case handler and circulated to Divisions for learning, following approval by the Head of Legal. Learning will therefore be recorded on each case and circulated for wider sharing.

Medicine Safety

- The Medication Safety and Compliance Group (MSCG) continue to raise awareness of the importance of safe storage, prescribing and administration of medication and are working alongside clinical colleagues to ensue this remains a priority.
- It is planned to include medicines safety must do's are incorporated into professional practice as a further level of assurance
- Medicines Management training has been reviewed to ensure the training delivered to colleagues is current and relevant to their roles, with a proposal of developing a bespoke package with modules relevant to prescribers, staff administering medicines, staff handling medicines and community nursing staff.
- A further piece of work to identify a Trust wide training needs analysis (TNA) to ensure all staff involved in medicines complete the relevant modules.

Incidents and Lesson Learnt from Serious Incidents

- Below is a summary of patient safety incidents and incidents with severe harm or death, for the year June 2021 to May 2022, and number of serious incidents (SIs) reported by month.
- It should be noted that 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.
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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
Jun 2021	812	8	5
Jul 2021	847	4	3
Aug 2021	830	7	2
Sept2021	901	11	4
Oct 2021	1020	10	4
Nov 2021	833	11	7
Dec 2021	804	4	1
Jan 2022	930	13	2
Feb 2022	718	8	3
Mar 2022	763	14	5
Apr 2022	748	3	2
May 2022	750	15	2

Examples Lessons Learnt from Serious Incidents

The need to ensure timely escalation in response to a raised NEWS score

The Trust policy for patient identification must be followed at all times

Importance of initiating the sepsis screening tool and completion of Sepsis 6 care bundle

Staff must positively confirm the identity of the patient before initiating or withdrawing treatment

Clear documentation of care plans with identified lead clinician

Importance of completing pressure ulcer risk assessments as per Trust policy using a holistic approach

Quality Priorities

Quality Priorities are agreed each year to support the achievement of the long-term Quality Goals in our Trust Strategy. The Trust has 3 key Quality priorities with 7 focussed quality priorities. Examples of progressed against the priorities are shown below , with further details contained within the body of the report :-

Recognition and timely treatment of Sepsis

- Category 2 patients in the ED are being seen in rapid assessment at HRI rather than waiting for a cubicle. This has improved treatment times for patients with sepsis.
- BUFALO Bundle Total Compliance (%)

	March 2022	April 2022	Progress Rating
Blood Cultures	73.3%	75.7%	Reasonable
Urine Output	73.5%	73.0%	Reasonable
Fluids	99%	100%	Substantial
Antibiotics	99%	100%	Substantial
Lactate	Unable to add Lactate to EPR		
Oxygen	90.2%	96.4%	Substantial
TOTAL	50%	57.7%	

Focus Quality Priorities

Reducing the number of falls resulting in harm

- Improvement in patients receiving a falls risk assessment upon admission. Work is ongoing via the Falls Link Practitioners and electronic patient record (EPR) team to continue improve this
- Falls policy has been updated and is awaiting finalisation through the weekly executive board (WEB), this includes decision-making flowchart for bed rail use, timings and pre/post fall assessment protocols

Making Complaints Count

- The quality of complaint responses has been a focus to avoid re-opened complaints. 15 Complaints have been re-opened from 1/04/2022 – 31/05/2022 out of 97 that were closed (15%)

Increase the quality of clinical documentation across CHFT

- Task and finish group set up to look at the nursing admission process involving ward managers from a different areas and back office EPR team. This will then extend to other workflows and care plans.

17. CHFT Response to the Ockenden Review

To Note

Presented by Lindsay Rudge

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 7 July 2022
Meeting:	Public Board of Directors
Title of report:	Ockenden Final Report - Independent Review of Maternity Services at Shrewsbury and Telford NHS Trust
Author:	Diane Tinker, Interim Head of Midwifery
Sponsor:	Lindsay Rudge, Interim Chief Nurse, Board Maternity Safety Champion
Previous Forums:	None

Purpose of the Report

- To provide an overview and update of the final report into the independent review of Maternity services at Shrewsbury and Telford NHS Trust (the Ockenden report).
- To provide an update of further actions and timescales with regards to the Ockenden Report which includes the 7 Immediate and Essential Actions from the initial report published in December 2020 and the subsequent 15 Immediate and Essential Actions from the final report published in March 2022.
- To provide an update of the approved recommendation of the continuance of Midwifery Continuity of Carer (MCoC) in response to the letter received by all Trusts on the 1st April 2022.
- To provide an update of further actions and timescales within the Maternity Services

Key Points to Note

- Additional Immediate Essential Actions (IEA)
- Approved recommendations in relation to Midwifery Continuity of Carer (MCoC)
- The Chief Nurse and the Head of Midwifery attended the Calderdale Adults Health and Social Care Scrutiny Board on the 1st June 2022 to provide an update on Ockenden and the response and actions being undertaken within CHFT.
- The Trust has appointed 2 clinicians independent of the service to undertake a review of compliance against the action plan by way of an additional level of assurance to the Board and external regulators.
- The service continues to progress the action plan in relation to both the initial 7 IEA and the further 15 IEA and these are reported into the Trust Board.

- The service continues to prepare for the Regional Maternity Team Review on 28th June 2022 where compliance with the 7 IEAs will be assessed.
- The service has confirmed the Trust position in relation to MCoC to the Local Midwifery System (LMS) on 15th June 2022 and will provide a formal review of the MCoC to the Private Board in 6 months on the 3rd November 2022.

EQIA – Equality Impact Assessment

There is significant evidence which demonstrates that the experiences and outcomes of mothers and babies from BAME groups and those from the areas of highest levels of deprivation are more likely to be poor.

Maternity services have an active Health Inequalities work stream to drive improvement work for those most at risk. CHFT's midwifery reader has produced a cultural survey that has been shared with staff to understand knowledge gaps ahead of developing training opportunities for midwives and obstetricians.

Recommendation

The Board of Directors is asked to **NOTE** the contents of this paper.

Independent Review of Maternity Services at Shrewsbury and Telford NHS Trust – Ockenden Report

Background

On the 30th March 2022, the Secretary of State for Health and Social Care published Dame Donna Ockenden's final report from the independent review of maternity services at Shrewsbury and Telford Hospital NHS Trust. This second report builds upon the first report published in December 2021.

The review team found failures in governance and leadership, failure to follow national guidelines, failure to escalate and work collaboratively across disciplines. The report describes a culture of "them and us" between midwives and obstetricians leading to a fear amongst midwives to escalate concerns to obstetricians, which led to a lack of psychological safety in the workplace and an inability to make positive change.

In terms of clinical governance investigatory processes were not followed and were not to a standard that would have been expected at the time. Reviews were not multidisciplinary and maternity governance teams downgraded serious incidents to local investigations to avoid external scrutiny.

The review found that the Trust board did not have oversight or a full understanding of the issues and concerns within the maternity service, and there was a lack of oversight by the Trust board when investigations took place.

This first report made explicit recommendations outlined in the 7 Immediate Essential Actions (IEAs) with an expectation that all providers provide assurance on compliance against each of the 7 detailed below:

- Enhanced Safety
- Listening to Women and Families
- Staff training and working together
- Managing complex pregnancies
- Risk assessments during pregnancy
- Monitoring foetal well-being
- Informed consent

The Final report includes a further 15 IEA recommendations, again with an expectation that all Trusts will ensure compliance, these are detailed below:

- Workforce Planning and Sustainability
- Safe Staffing
- Escalation and Accountability
- Clinical Governance and Leadership
- Clinical Governance and Leadership – Incident Investigation and Complaints

- Learning from Maternal Deaths
- Multi-Disciplinary Training
- Complex Antenatal Care
- Pre-term Birth
- Labour and Birth
- Obstetric Anaesthesia
- Postnatal Care
- Bereavement Care
- Neonatal Care
- Supporting Families

Maternity Continuity of Carer (MCoC)

A significant recommendation of the review has been the expectation that all Trusts will review their plans for implementation and provision of MCoC.

MCoC is a system of midwifery care delivery where a midwife follows a woman through ante natal, intra-partum and post-natal care pathways. All Trusts have been monitored against the milestone targets set by NHSE, and this has proved to be a challenge nationally in terms of staffing levels to support transition to the model.

On the 1st April 2022, Trusts received a letter from the NHS Chief Executive, Chief Nursing Officer and National Medical Director in response to the publication of Dame Donna Ockenden's review.

The letter made particular reference to the Trusts submissions of their MCoC plans, in line with the national maternity transformation programme. The letter stated that providers must now take account of the requirement within immediate essential action (IEA)2Safestaffing: *"All trusts must review and suspend if necessary, the existing provision and further roll out of Midwifery Continuity of Carer (MCoC) unless they can demonstrate staffing meets safe minimum requirements on all shifts."*

The letter asks trusts to immediately assess their staffing position and make one of the following recommendations:

- Trusts that can demonstrate staffing meets safe minimum requirements can continue existing MCoC provision and continue to roll out
- Trusts that cannot meet safe minimum staffing requirements for further roll out of MCoC, but can meet safe minimum staffing requirements for existing MCoC provision should cease further roll out and continue to support at the current level of provision or only provide services to existing women on MCoC pathways and suspend new women being booked into MCoC provision
- Trusts that cannot meet safe minimum staffing requirements for further roll out of MCoC and for existing MCoC provision should immediately suspend existing MCoC provision and transfer them to alternative maternity pathways of care.

A paper was presented at Executive Board on the 28th April 2022 outlining our current position and recommendations, summarised below:

CHFT currently has 4 teams who book an average of 25% of women on to a MCoC pathway each month and an average 50% of all BAME women. However, due to vacancy levels and staff unavailability, it is becoming increasingly difficult to maintain this position and safe staffing levels in all areas. Traditional Community caseload teams have been reviewed and aligned into small teams of approx. 4 midwives to deliver antenatal and postnatal care.

The recommendations are that two mixed risk locality-based teams in areas of highest deprivation would suspend the delivery of care in labour and focus on increasing antenatal and postnatal continuity from a named midwife and buddy.

The current community midwife out of hours on call service would continue to support women wishing to birth at home.

From October 2022 onwards over 12-18 months midwives would be rotated to all community midwifery teams with a vision to recommence the roll out of MCoC teams focusing on areas of highest deprivation.

These recommendations were approved and accepted at Executive Board and Private Board, with a further review of the Midwifery Continuity of Carer position to be present at the Private Board of Directors on the 3rd November 2022.

The changes to the rotas will be instigated from the 20th June 2022.

Maternity Improvement Plan

In terms of clinical outcomes, the Trust performs well on all elements of the safer births key performance indicators. However, what Ockenden reminds us of is the importance of "softer" intelligence sources. As such the Trust has put in place enhanced systems to enable staff to speak out safely in the event of having any concerns around quality of services.

In addition, the Trust has appointed 2 clinicians independent of the service to undertake a review of compliance against the action plan by way of an extra level of assurance to the Board and external regulators. All the action plans have been assimilated into an overarching Maternity Improvement Plan to ensure a co-ordinated approach to sustainable change and improvement.

Calderdale Adults Health and Social Care Scrutiny Board

The Chief Nurse and the Head of Midwifery attended the Calderdale Adults Health and Social Care Scrutiny Board on the 1st June 2022 to provide an update on Ockenden. The Chair thanked colleagues for their presentation and well-prepared answers and invited colleagues to return in 6 months for further update.

Further actions and timescales

The service continues to progress the action plan in relation to both the 7 IEA and 15 IEA and report into Trust Board.

The service continues to prepare for the Regional Maternity Team Review on 28th June 2022 where compliance with the 7 IEAs will be assessed.

The service will confirm the Trust position in relation to MCoC to the Local Midwifery System (LMS) on 15th June 2022 and will provide a formal review of the MCoC to the Private Board in 6 months on the 3rd November 2022.

To continue to progress the independent review of maternity services.

The service will consider the recommendations from the East Kent and Nottingham reviews and respond to the findings and recommendations.

18. Integrated Performance Report – May 2022

To Note

Presented by Jo Fawcus

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 7 July 2022
Meeting:	Public Board of Directors
Title:	Quality and Performance Report
Author:	Peter Keogh, Assistant Director of Performance, Kirsty Archer Deputy Director of Finance, Andrea Dauris Associate Director of Nursing, Jason Eddleston Deputy Director of Workforce and OD, Cornelle Parker Deputy Medical Director, Kim Smith, Assistant Director of Quality
Sponsoring Director:	Jo Fawcus, 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 May 2022.

Key Points to Note

May's Performance Score is at 63.8% which is a deterioration on the April position mainly due to a never event and also missing the Cancer 62-day screening to treatment target.

The **SAFE** domain is now amber due to the never event. The **CARING** domain remains amber with 2 of the 5 FFT areas now green but maintaining performance in Complaints is still a challenge. Dementia screening is back below 25%. **EFFECTIVE** domain remains amber with #Neck of Femur dropping back to 61% after a better month in April. The **RESPONSIVE** domain remains amber with cancer 62-day referral from screening to treatment target missed. Stroke indicators alongside the underperformance in the main planned access indicators and ED remain a challenge moving forward. **WORKFORCE** remains amber with peaks in the 12-month running total for overall sickness and short-term sickness although all areas had reduced levels in May. Return to Work Interview activity has improved in month. **FINANCE** domain remains amber.

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 May 2022.

NHS
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Performance
May 2022

Recovery
At the end of June there was just 1 patient waiting over 104 weeks at CHFT which is a great achievement.

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.

ED attendances for both hospital sites continue to increase with a 12% rise in numbers attending on previous years, however COVID cases where a patient needs to be admitted has fallen to below 20 with a small upward spike since the early June bank holidays. Along with increased attendances, acuity/dependency is still significantly high and has led to some very challenging operational issues, this has had an impact on the 4-hour ECS performance. We have had some sustained periods in OPEL 2 however we have also seen increasing periods spent in OPEL 3 over recent months. Despite this we continue to perform well within the region and outperform a number of other Trusts in West Yorkshire. We have continued to see long waits in both emergency departments which is an extremely poor patient experience, and we know increases risk for patients in terms of outcomes.

Hospital Acquired Covid numbers continue to drop, and outbreaks are becoming less frequent, although we are still seeing some asymptomatic positive cases within ward areas and these do cause some outbreaks. We have also seen throughout April, May and June norovirus and this has caused several bouts of ward areas being closed particularly in elderly care. This has caused issues across patient flow and has required extra capacity to be opened such as Discharge Lounge opening to inpatients and beds within the Acute Floor and Respiratory floor flexing up to their maximum numbers.

The numbers of patients on the transfer of care list remains a challenge, however we have seen an improved and sustained position across the last month achieving and maintaining a position below 80 with some weeks seeing a position below 70. We are looking at work going forwards to manage and monitor our length of stay and hope this work will continue to support our discharge position in both pathway 0 and pathway 1-3.

Responding to complaints in a timely fashion continues to be a challenge, however it should be noted that there has been an improvement in complaints closed in line with the target timeframe in May to 49%. There is an increased level of oversight and scrutiny at both divisional level and corporate level which will help us to continue on this trajectory.

HSMR is stabilising from having been a positive outlier historically but rising in the latter half of 2021. The current rolling position is **102.2** which is classed as being in the 'as expected' range. The in-month HSMR position for March 2022 shows an improvement to **94.69.** SHMI has also stabilised in the expected range (latest release February 2022 is 105.02 compared with 113.64 for Feb 2021) and crude mortality benchmarking is also stable.

Having examined the HSMR data in detail, we have identified the issue as being a reduction in those patients receiving specialist palliative care input and a reduction in the utilisation of the corresponding code. The reason for this is a combination of staffing vacancies and sickness within the specialist palliative care team and increasing complexity of patients.

The Medical Director and Deputy Medical Director have discussed this with the specialist palliative care team, who are now are working with Informatics to proactively identify those patients who may

benefit from specialist palliative care input and providing in-reach into those ward areas via their MDT meetings.

From a financial point of view, the Trust is reporting a £6.07m deficit, a £0.22m favourable variance from plan in the year to date. The Trust has submitted a plan to deliver a £20.1m deficit for the year. Additional funding for inflationary pressures has since been announced, and the Trust is due to resubmit the plan shortly to reflect this additional funding. This is expected to improve the planned deficit for the year to £17.35m.

Covid activity remains higher than planned, alongside other issues described above leading to extra bed capacity pressures driving additional staffing and consumables costs. Income is £1.24m below the plan year to date. This includes £1.48m of planned Elective Recovery Funding that has not been assumed due to the activity levels delivered year to date being below plan and the required threshold. This has been offset by lower than planned Recovery costs and delivery of efficiency savings of £2.45m, £0.80m higher than planned in the year to date.

The full year forecast assumes full delivery of a challenging £20m efficiency target which has been fully identified and supports the overall forecast financial position in line with plan.

One Culture of Care must-do activity including colleague rest and recuperation for wellbeing, health and wellbeing risk assessments, clear access points for our internal Listening Ear service and external psychologist-led employee assistance programme provided by CareFirst, refreshed leader/manager guides and ensuring there is an understanding of the opportunities to raise concerns through our Speak Up processes remains our focus. Non-Covid sickness decreased in-month with the overall, short-term and long-term absence rates showing compliance against our ceiling rate of 4.75%, 1.75% and 3% respectively.

A review of May 2022 data indicates that the combined RN and non-registered clinical staff metrics resulted in 24 of the 28 clinical areas having fewer CHPPD than planned, with a total deficit of 1.1 CHPPD across the Trust. The gap in CHPPD is at its broadest with the RN workforce representing 0.8 deficit and HCSW 0.3 deficit. This position, whilst recognising planned care hours are still in deficit, demonstrates a steady increase in the actual care hours delivered to our patients since October 2021.

The CHPPD planned vs actual gap is most prominent in the Surgical division (2.7 CHPPD deficit). This is largely attributable to the staffing in ICU which continues to report the planning for a COVID escalation workforce model. However, 'actual' levels represent the staffing required to care for the patients each shift according to the Guidelines for the Provision of Intensive Care Services safe staffing ratios.

The 2021 successful recruitment to HCSW roles has enabled increased shift fill to provide support to the reduced RN availability. However, adjustment to workforce models has now created a small vacancy pressure in this workforce group which is being addressed by central recruitment. Professional judgement is used daily to redeploy staff on a shift basis and establish the safest staffing possible in all areas and is supported through the twice daily staffing meetings which are chaired by the Associate Directors of Nursing and supported by mitigations reported within the Safecare system.

Challenges of the requirement to staff additional capacity areas continue to impact on the ability to staff all areas according to workforce model.

compassionate care

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Integrated Performance Report

May 2022

Report Produced by : The Health Informatics Service

Data Source : various data sources syndication by VISTA

Performance Summary

May 2022

SYSTEM OVERSIGHT FRAMEWORK

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

May's Performance Score is at 63.8% which is a deterioration on the April position mainly due to a never event and also missing the Cancer 62-day screening to treatment target.

The **SAFE** domain is now amber due to the never event. The **CARING** domain remains amber with 2 of the 5 FFT areas now green but maintaining performance in Complaints is still a challenge. Dementia screening is back below 25%. **EFFECTIVE** domain remains amber with #Neck of Femur dropping back to 61% after a better month in April. The **RESPONSIVE** domain remains amber with cancer 62-day referral from screening to treatment target missed. Stroke indicators alongside the underperformance in the main planned access indicators and ED remain a challenge moving forward. **WORKFORCE** remains amber with peaks in the 12-month running total for overall sickness and short-term sickness although all areas had reduced levels in May. Return to Work Interviews have improved in month. **FINANCE** domain remains amber.

Key Indicators

	21/22	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	YTD	Performance Range		
SAFE																Green	Amber	Red
Never Events	2	0	1	0	0	0	0	0	0	0	0	1	0	**1**	**1**	0		>=1
CARING																Green	Amber	Red
% Complaints closed within target timeframe	63.61%	87.50%	100.00%	69.44%	55.10%	71.43%	58.82%	94.29%	70.73%	37.50%	44.44%	29.41%	27.08%	**48.98%**	**38.14%**	100%	86% - 99%	<=85%
Friends & Family Test (IP Survey) - % Positive Responses	96.91%	95.62%	97.00%	96.38%	96.61%	97.33%	98.26%	97.47%	97.35%	97.10%	97.36%	96.36%	97.48%	**in arrears**	**97.48%**	>=90% / >=95% from September 21		<=79%
Friends and Family Test Outpatients Survey - % Positive Responses	92.16%	92.20%	92.29%	91.88%	91.77%	91.49%	91.51%	92.45%	93.02%	93.20%	92.15%	93.71%	89.80%	**in arrears**	**89.80%**	>=90% / >=93% from September 21		<=79%
Friends and Family Test A & E Survey - % Positive Responses	82.76%	85.90%	82.98%	78.53%	81.33%	80.85%	81.01%	82.39%	84.40%	86.40%	84.69%	76.52%	79.07%	**in arrears**	**79.07%**	>=80% / >=85% from September 21		<=69%
Friends & Family Test (Maternity) - % Positive Responses	94.64%	90.00%	91.23%	97.53%	95.19%	97.69%	93.98%	93.20%	98.33%	92.30%	91.00%	95.12%	96.77%	**in arrears**	**96.77%**	>=90% / >=95% from September 21		<=79%
Friends and Family Test Community Survey - % Positive Responses	92.44%	93.80%	93.37%	87.74%	92.52%	94.27%	91.12%	95.86%	93.68%	95.50%	91.21%	98.32%	94.35%	**in arrears**	**94.35%**	>=90% / >=95% from September 21		<=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
Preventable number of Clostridium Difficile Cases	5	1	0	1	0	1	0	0	1	1	0	0	0	**0**	**0**	4		3.4
Local SHMI - Relative Risk (1 Yr Rolling Data)	106.36	104.78	105.07	105.49	105.91	105.39	106.60	106.99	106.36						**106.36**	<=100	101 - 109	>=110
Hospital Standardised Mortality Rate (1 yr Rolling Data)	102.2	88.99	90.00	90.56	92.19	93.78	95.20	97.00	99.27	102.20					**102.20**	<=100	101 - 109	>=111
RESPONSIVE																Green	Amber	Red
Emergency Care Standard 4 hours	78.99%	86.70%	86.16%	78.59%	79.57%	78.29%	75.97%	76.81%	72.95%	75.70%	73.92%	74.05%	72.64%	**75.85%**	**74.33%**	>=95%	81% - 94%	<=80%
% Stroke patients admitted directly to an acute stroke unit within 4 hours of arrival	36.71%	49.06%	54.90%	42.29%	43.14%	42.00%	33.87%	33.33%	23.19%	16.67%	15.79%	25.45%	25.53%	**28.81%**	**27.39%**	>=90%		<=85%
Two Week Wait From Referral to Date First Seen	98.38%	99.08%	97.82%	97.93%	98.51%	98.80%	98.58%	99.21%	97.96%	98.39%	98.35%	97.56%	97.75%	**98.38%**	**98.08%**	>=93%	86% - 92%	<=85%
Two Week Wait From Referral to Date First Seen: Breast Symptoms	97.53%	98.68%	100.00%	98.68%	100.00%	97.96%	98.45%	96.84%	96.00%	93.84%	97.25%	93.50%	96.92%	**96.32%**	**96.62%**	>=93%		<=92%
31 Days From Diagnosis to First Treatment	98.21%	99.41%	97.63%	98.94%	97.92%	95.88%	94.89%	99.02%	99.37%	98.35%	99.39%	98.31%	97.56%	**98.58%**	**98.03%**	>=96%		<=95%
31 Day Subsequent Surgery Treatment	95.43%	100.00%	100.00%	97.78%	94.44%	84.78%	100.00%	92.59%	100.00%	93.33%	96.55%	94.44%	96.00%	**100.00%**	**98.55%**	>=94%		<=93%
31 day wait for second or subsequent treatment drug treatments	99.51%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	95.45%	98.63%	100.00%	100.00%	**100.00%**	**100.00%**	>=98%		<=97%
38 Day Referral to Tertiary	50.00%	61.11%	50.00%	72.73%	47.06%	52.17%	61.11%	50.00%	37.93%	35.00%	66.67%	30.77%	57.69%	**58.33%**	**57.89%**	>=85%		<=84%
62 Day GP Referral to Treatment	90.62%	90.95%	91.87%	91.23%	91.40%	89.77%	91.51%	93.43%	87.32%	89.59%	86.82%	89.71%	91.54%	**85.78%**	**88.59%**	>=85%	81% - 84%	<=80%
62 Day Referral From Screening to Treatment	59.47%	57.89%	48.48%	32.14%	55.26%	32.00%	55.56%	76.19%	81.25%	62.50%	50.00%	96.30%	92.59%	**68.75%**	**83.72%**	>=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	74.31%	67.41%	68.93%	73.27%	69.07%	70.56%	76.23%	78.16%	76.82%	76.50%	83.12%	79.54%	77.93%	**76.99%**	**77.46%**	>=75%		<=70%
WORKFORCE																Green	Amber	Red
Sickness Absence rate (%) - Rolling 12m - Non-Covid related	4.83%	3.91%	4.00%	4.13%	4.23%	4.33%	4.43%	4.49%	4.58%	4.66%	4.63%	4.83%	4.90%	4.91%	-	<=4.75%	<5.25%	>=5.25%
Long Term Sickness Absence rate (%) -Rolling 12m - Non-Covid related	3.21%	2.77%	2.85%	2.92%	3.01%	3.07%	3.10%	3.10%	3.12%	3.15%	3.17%	3.21%	3.24%	3.23%	-	<=3.0%	<3.25%	>=3.25%
Short Term Sickness Absence rate (%) -Rolling 12m - Non-Covid related	1.62%	1.14%	1.17%	1.21%	1.23%	1.26%	1.33%	1.39%	1.46%	1.52%	1.57%	1.62%	1.66%	1.68%	-	<=1.75%	<2.00%	>=2.00%
Overall Essential Safety Compliance	92.90%	94.68%	95.64%	95.48%	93.93%	93.81%	93.22%	93.01%	93.28%	92.50%	92.57%	92.90%	92.54%	92.94%	-	>=90%	>=85%	<85%
Appraisal (1 Year Refresher) - Non-Medical Staff	69.06%														-	>=95%	>=90%	<90%
Appraisal (1 Year Refresher) - Medical Staff (Rolling 12mth)	82.43%	7.61%	12.04%	17.00%	30.80%	44.51%	54.57%	60.90%	61.72%	63.51%	65.54%	69.06%	0.64%	2.79%	-	>=95%	>=90%	<90%
FINANCE																Green	Amber	Red
I&E: Surplus / (Deficit) Var £m YTD	2.27	**2.39**	**0.28**	**-0.22**	**-1.40**	**-1.62**	**0.00**	**-0.05**	**0.17**	**0.02**	**-0.06**	**-0.11**	**0.11**	**0.11**	**0.22**			

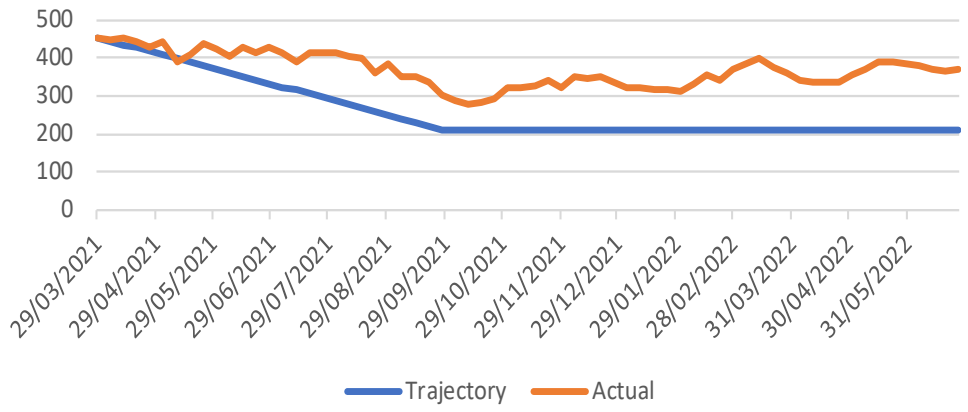
SWOT Analysis

Strengths	• Agreed Recovery Framework. • 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. • Progressing installation of two new permanent MRI scanners which are being ramped and shimmed which is the process by which the main magnetic field is made more homogenous. • Ward 11 back under the surgical team, await the build up of elective lists in the pipeline, utilising for acute surgical patients currently to support the site pressures • 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 also now providing some in-reach support to Bradford. • Focus on recruitment in both clinical and admin roles to support 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. • Insourcing arrangements in place for ENT (OP & Surgery), Orthopaedics (CHOP LLP) and Ophthalmology (OP, diagnostics & Surgery) to help tackle elective backlogs. • Automated medicine cabinets installed at HRI and pharmacy robot business case approved. • Urgent Community Response 0-2 hour service started 6th December and is being well received and utilised with 132 referrals in April primarily from CHFT services, other HCP's GP's and YAS. • Community 7-day on-call manager rota in operation to respond to and support pressures in the system.
Weaknesses	• Bed pressures continue to be significant. • The staffing position continues to be extremely challenging across all divisions in particular among nursing teams. • Theatre lists still not up to pre covid numbers but pipeline staffing showing a positive position over the next few weeks and months. • Some specialties i.e. large complex cases are not recovering at the same pace as others. • Issue retaining Community Pharmacists in Quest due to conflicting demands with PCN Pharmacists. • Disparity with availability of clinical educators into Therapy services to support staff retention and education. • 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. • Maternity team working to review the Ockenden report recommendations and developing action plan. • 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 Monday-Friday 08.00-18.00 with the service reverting to Local Care Direct outside of these hours. • Using Myosure in Gynaecology to see and treat patients in an ambulatory setting where previously they would have needed theatre. Supports capacity and improved patient experience. • Development of workforce plan including ODP apprentices, Nurse Associate role. • Opportunity to work with NHSE as a part of the pathfinder pilot looking at hospital patient transport (HTCS) for both inpatients and outpatients. • Money received from HEE for Allied Health Professions Workforce Supply Strategy Planning project work started and planned to be undertaken between December 2021 and June 2022. • School aged Immunisations - expression of interest to tender for the Calderdale Immunisations contract for a potential further 5 years completed. • Patient appliance trustwide budget is to be consolidated into the community division, this will come with a cost pressure but streamlines operational pressures and improves patient pathways. • Virtual wards - CKW working groups have been established for virtual wards to ensure pathways are streamlined across the CKW footprint. Initial focus pathways are Frailty and Respiratory. Initial Virtual Ward plans were submitted w/c 13th June, with further CKW workshops diarised to look at cross-patch efficiencies and implementation planning. • IC Beds current provision extended for a further 12 months under the existing contract but on reduced beds (now 15 in total) and will be re looked at through 3CPB.
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. • Deterioration of Head and Neck service in terms of consultant cover and Speech and Language Therapy, started some WYAAT conversations re: a regional response. • Significant delay in Theatre refurbishment (theatres 7 & 8), unable to commence as plan, in conversation re: delaying until next year due to threat to recovery. • 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. • Potential further covid waves could delay the recovery through sickness or possible deployment • Increasing number of complaints due to prolonged waits and poor patient experience. • Significant cost pressure within the division due to Private Ambulance costs over and above CCG YAS commissioned service. This service has moved to the corporate division from May 2022. • Risk of further vacancies in community nursing due to local organisations rebanding DN roles to Band 7. • Risk around long term funding of Virtual ward, this comes with 1 year pump priming, 1 year match funding and should be sustained through existing resource from 2024/25. Community are working in collaboration with other CHFT divisions as well as across CKW for longer-term efficiencies. • 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.

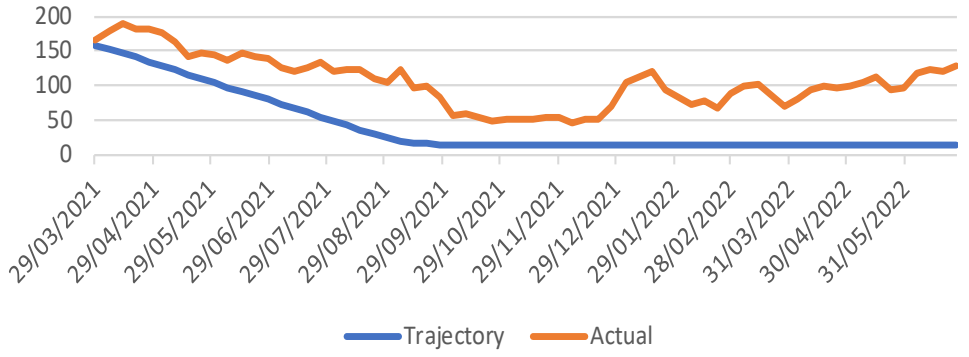
Recovery

INPATIENT WAITING LIST - P2

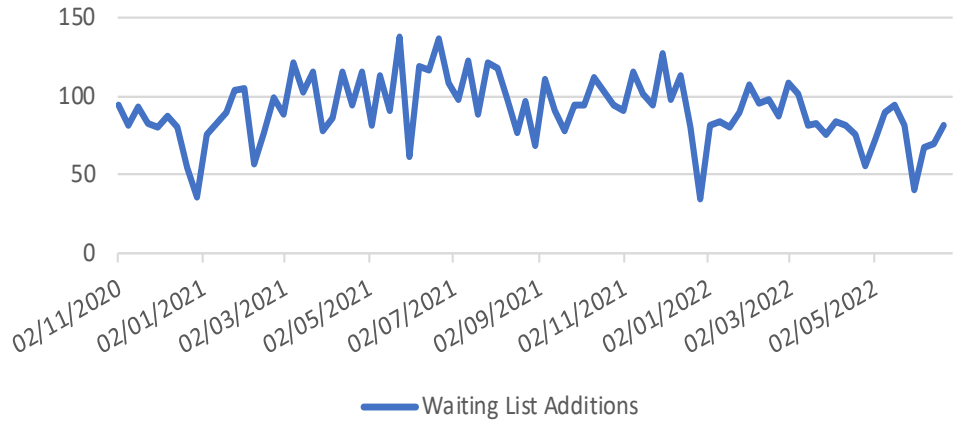
Trajectory vs Actual - Total P2s on Waiting List



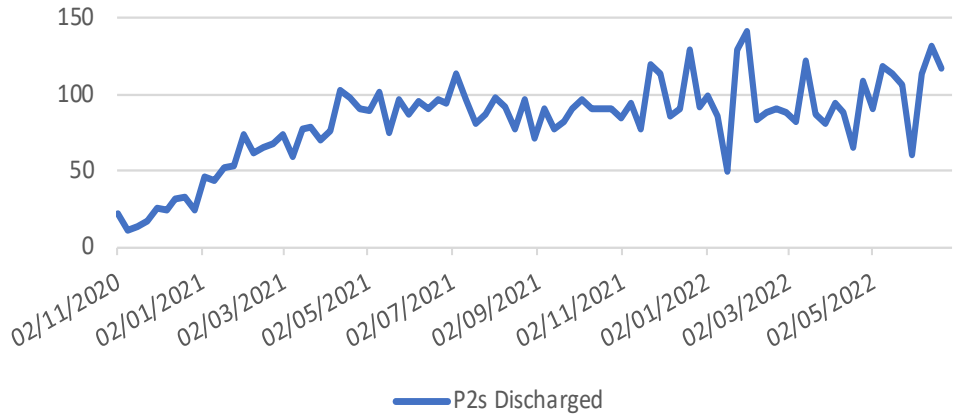
Trajectory vs Actual - Total P2s on Waiting List Over 1 month



P2 waiting List Additions

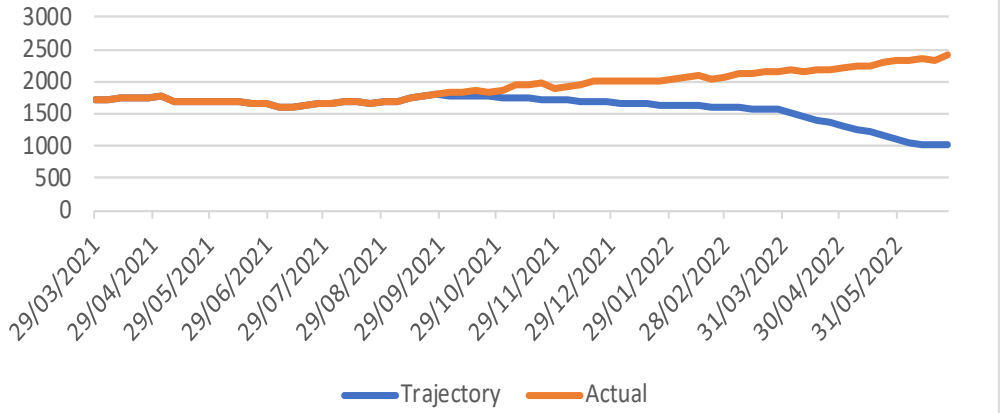


P2 Surgery done in the week

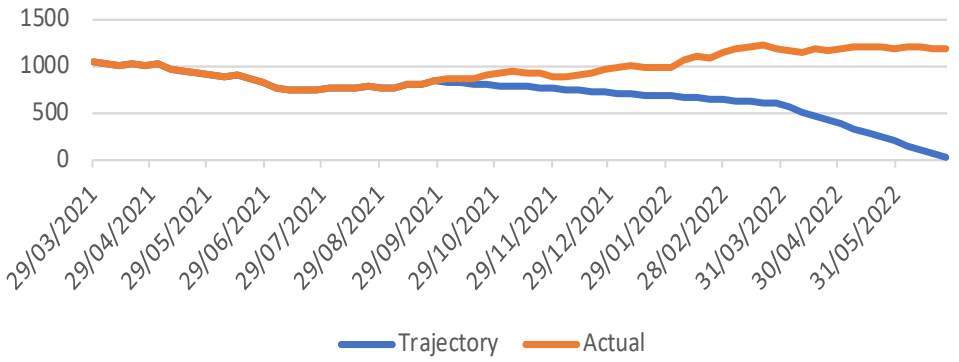


INPATIENT WAITING LIST - P3

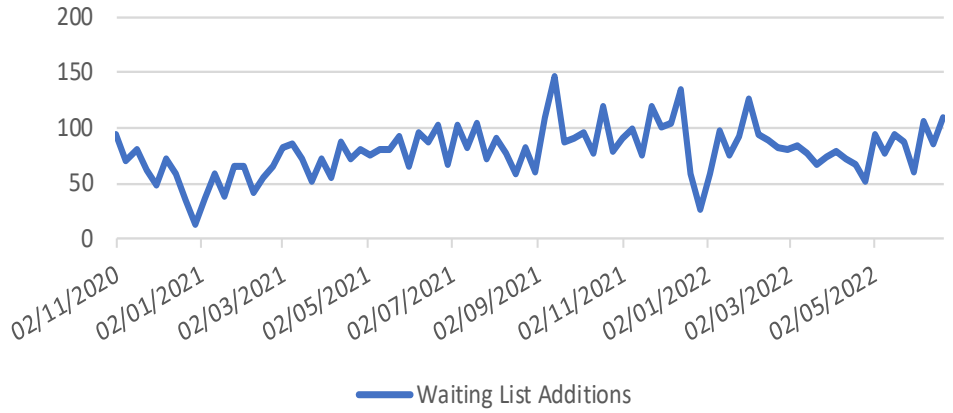
Trajectory vs Actual - Total P3s on Waiting List



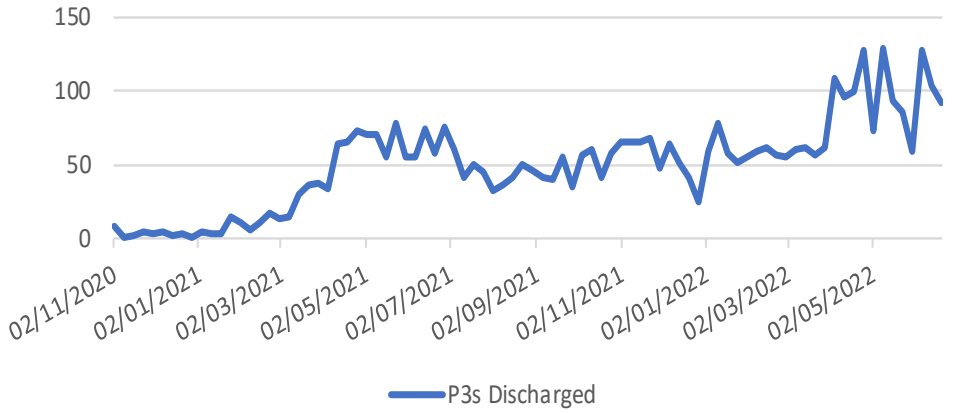
Trajectory vs Actual - Total P3s on Waiting List Over 3 months



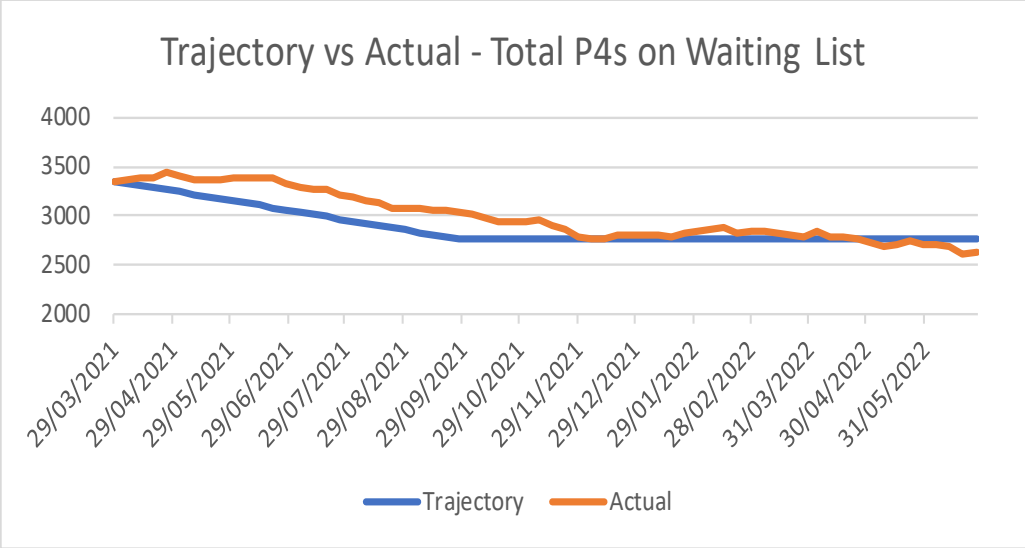
P3 waiting List Additions

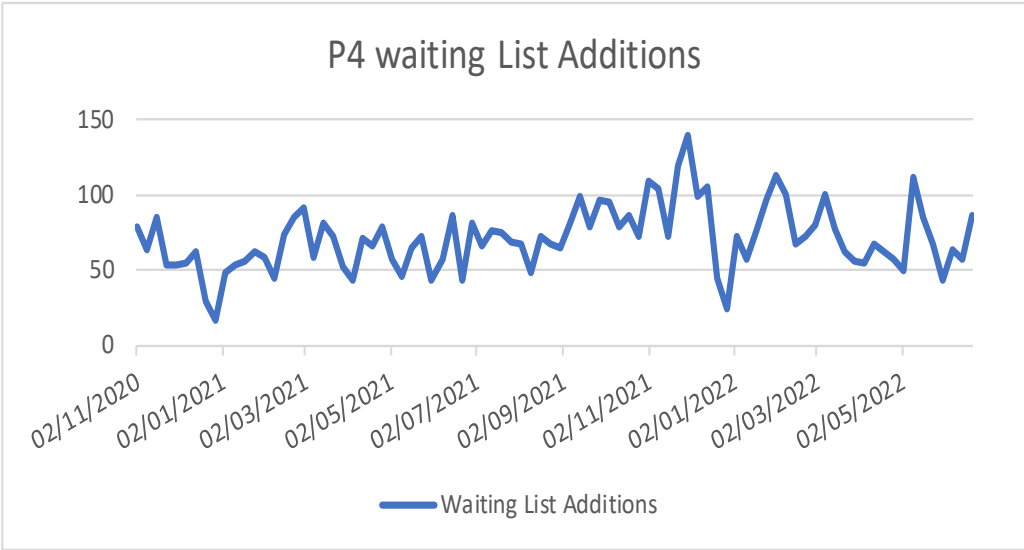


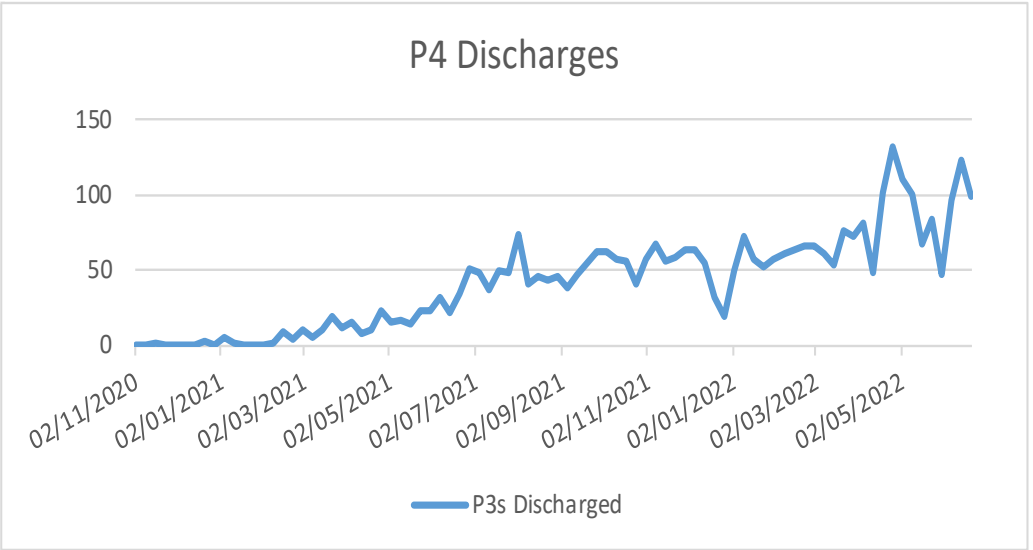
P3 Discharges



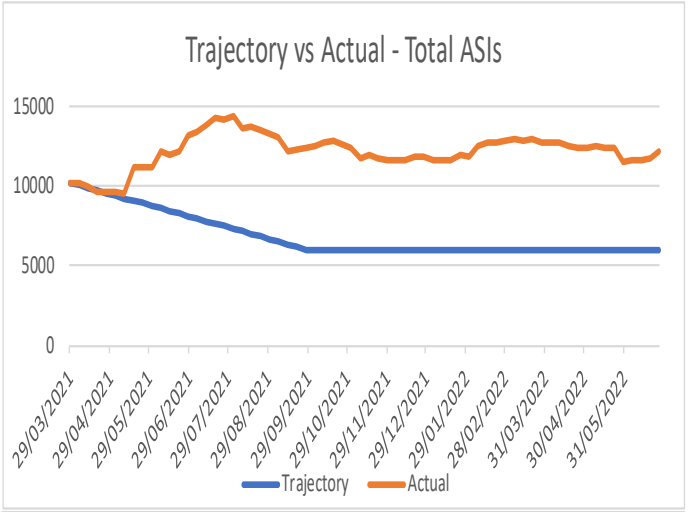
INPATIENT WAITING LIST - P4







ASIs


Trajectory vs Actual - Total ASIs
15000
10000
5000
0
29/03/2021
29/04/2021
29/05/2021
29/06/2021
29/07/2021
29/08/2021
29/09/2021
29/10/2021
29/11/2021
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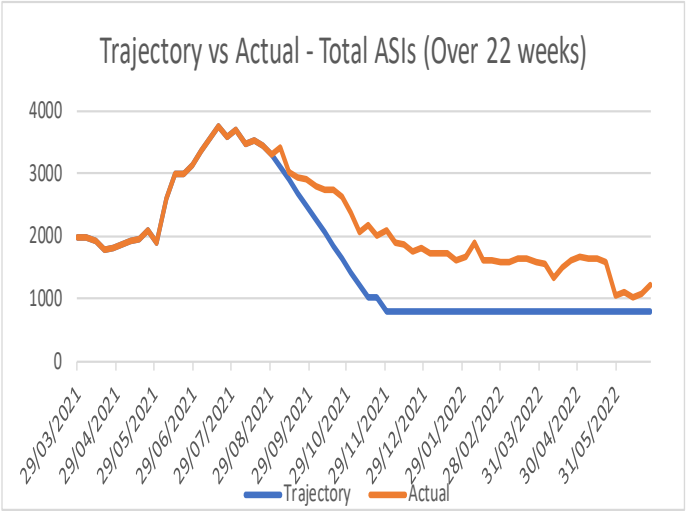
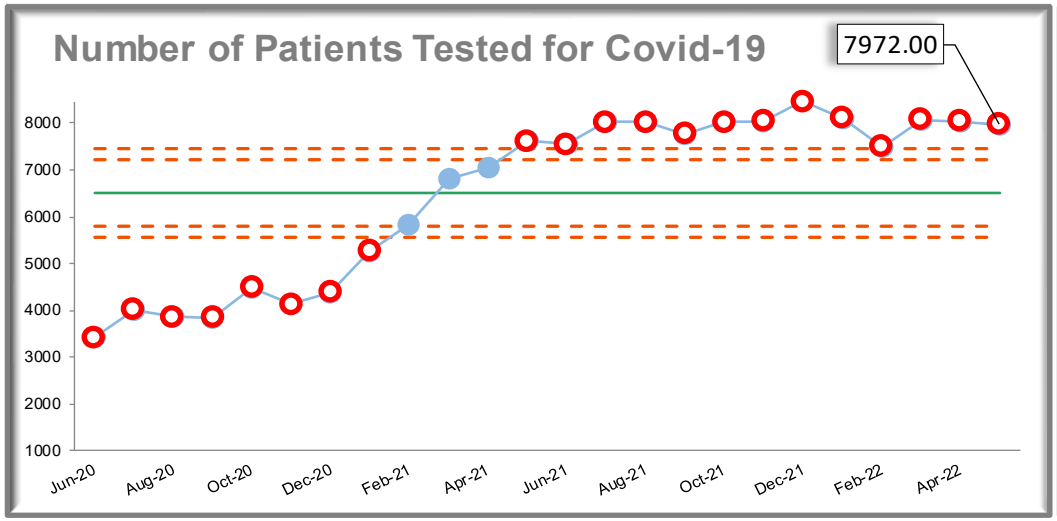
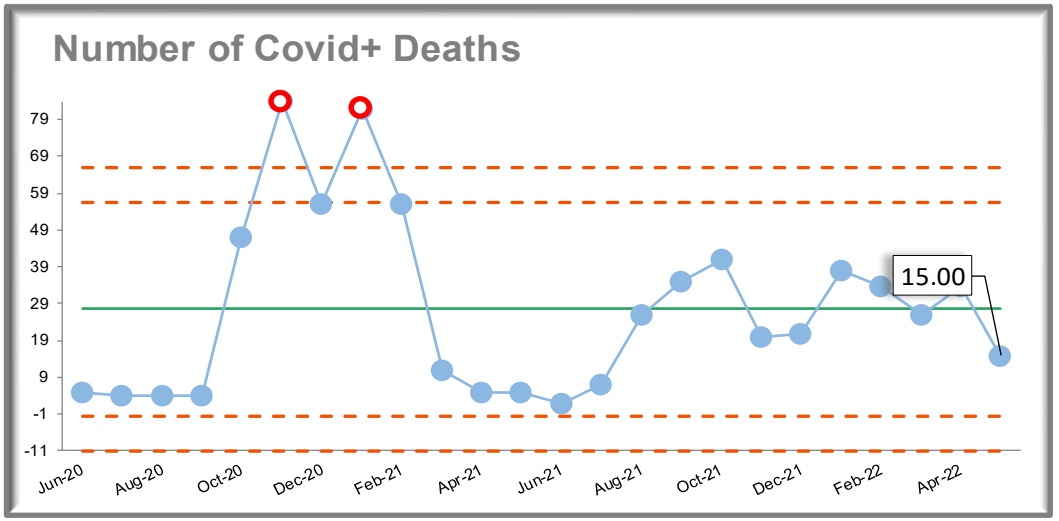
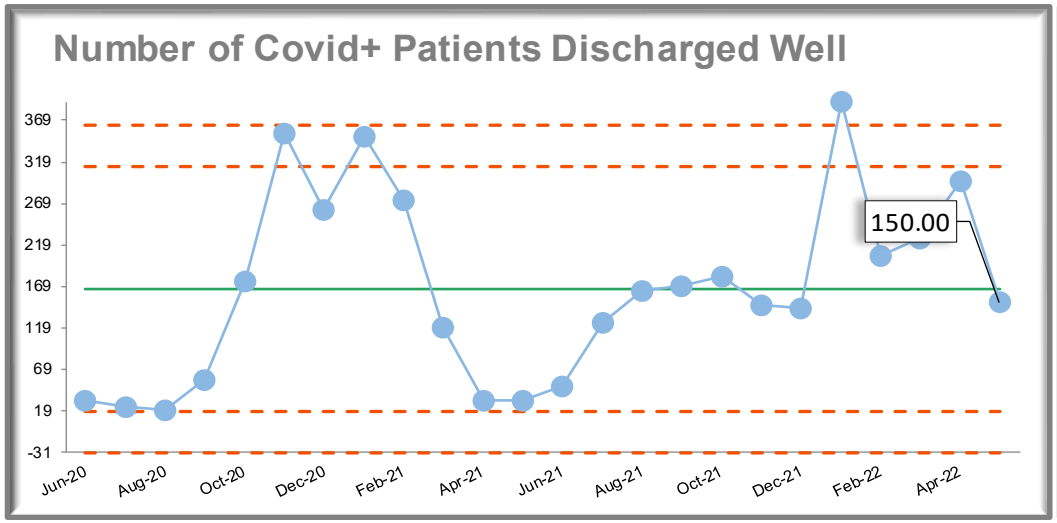
31/03/2022
30/04/2022
31/05/2022
Trajectory
Actual

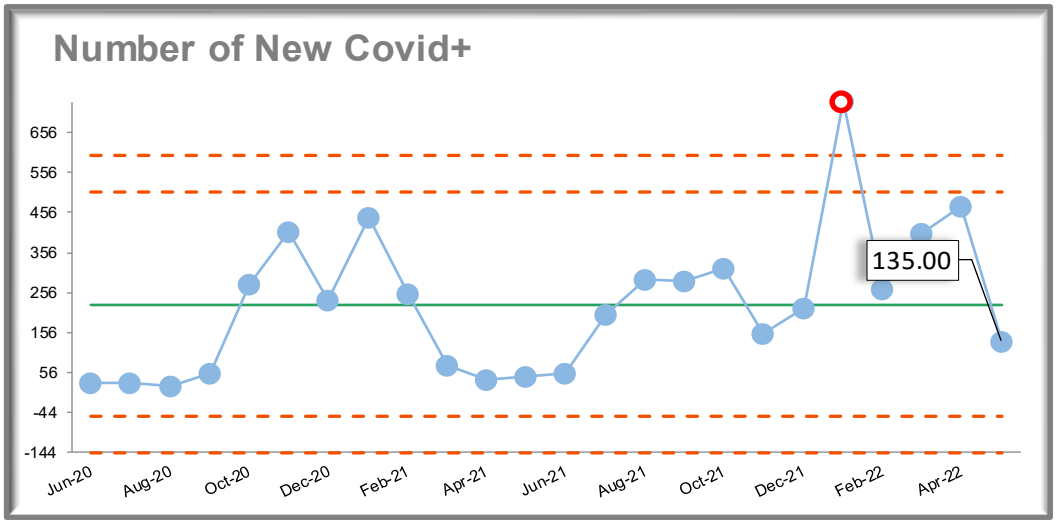

Trajectory vs Actual - Total ASIs (Over 22 weeks)
4000
3000
2000
1000
0
29/03/2021
29/04/2021
29/05/2021
29/06/2021
29/07/2021
29/08/2021
29/09/2021
29/10/2021
29/11/2021
29/12/2021
29/01/2022
28/02/2022
31/03/2022
30/04/2022
31/05/2022
Trajectory
Actual

Covid-19 - SPC Charts



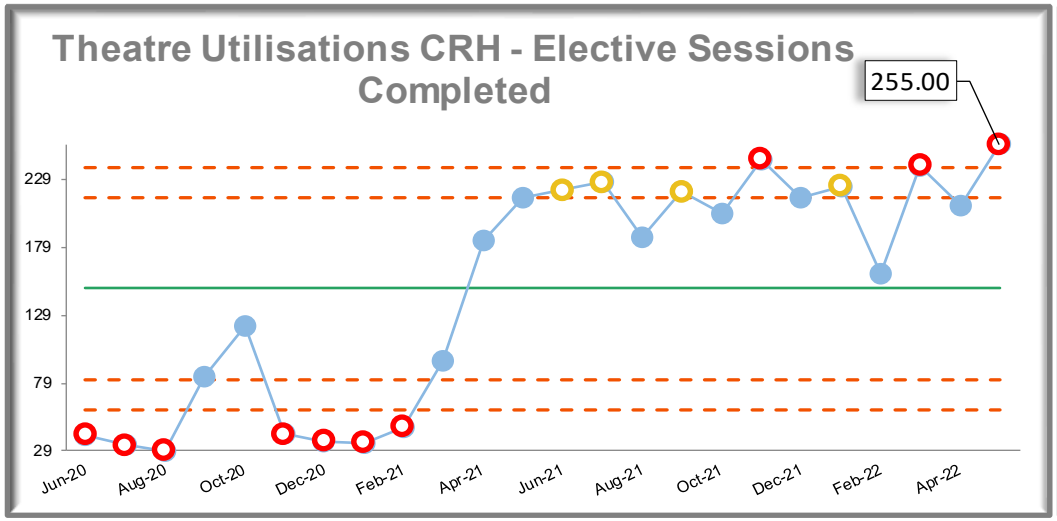


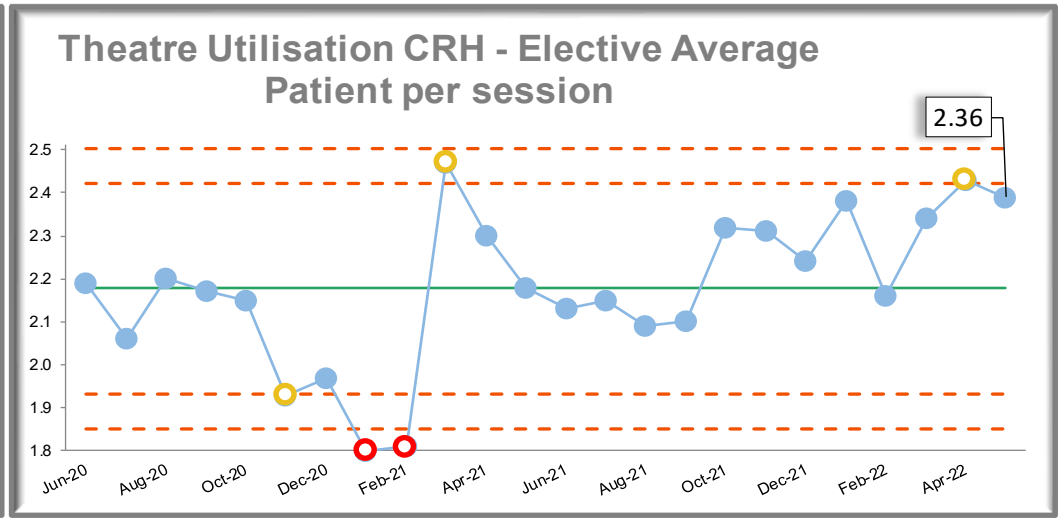


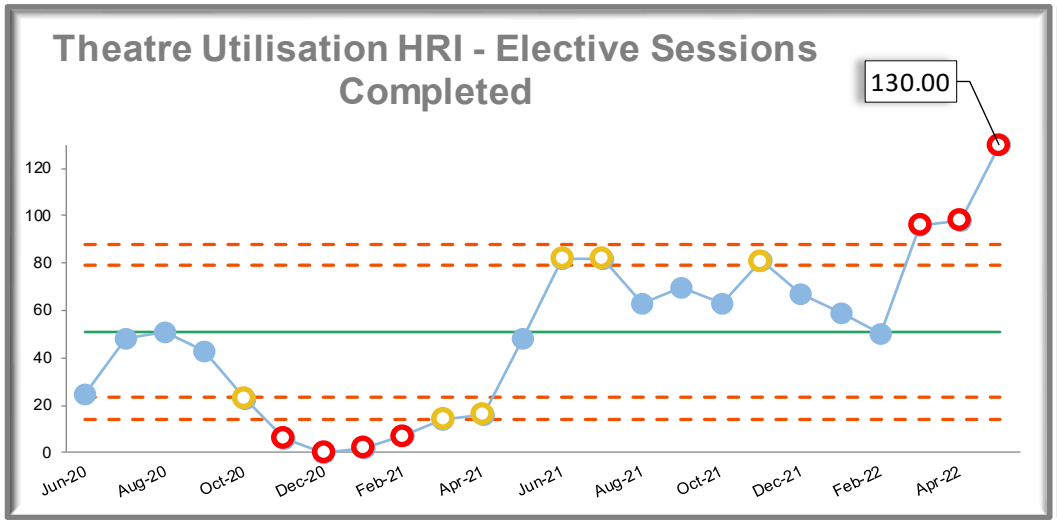


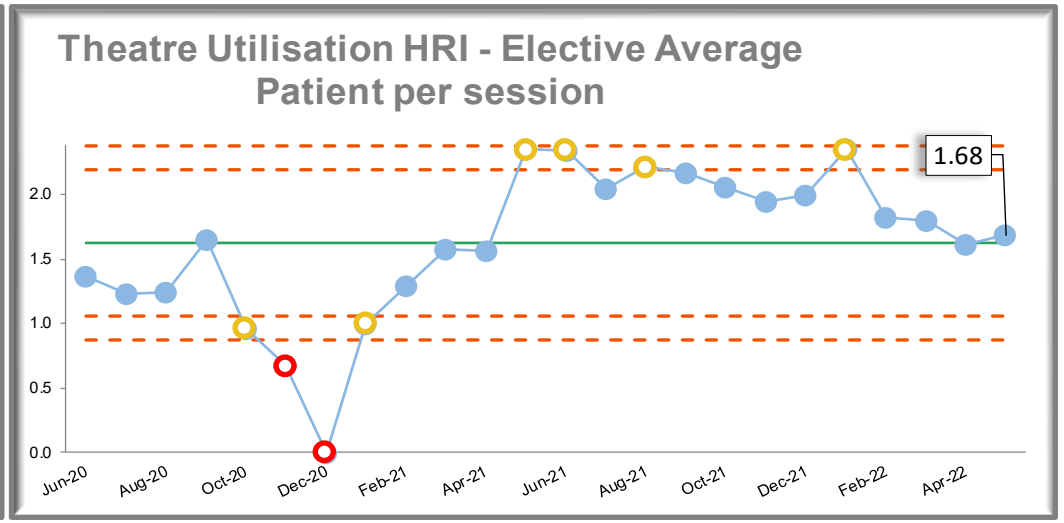
Average | Values | Control Limits | Target | Warning | Critical | Trend | On Target

Theatres - SPC Charts



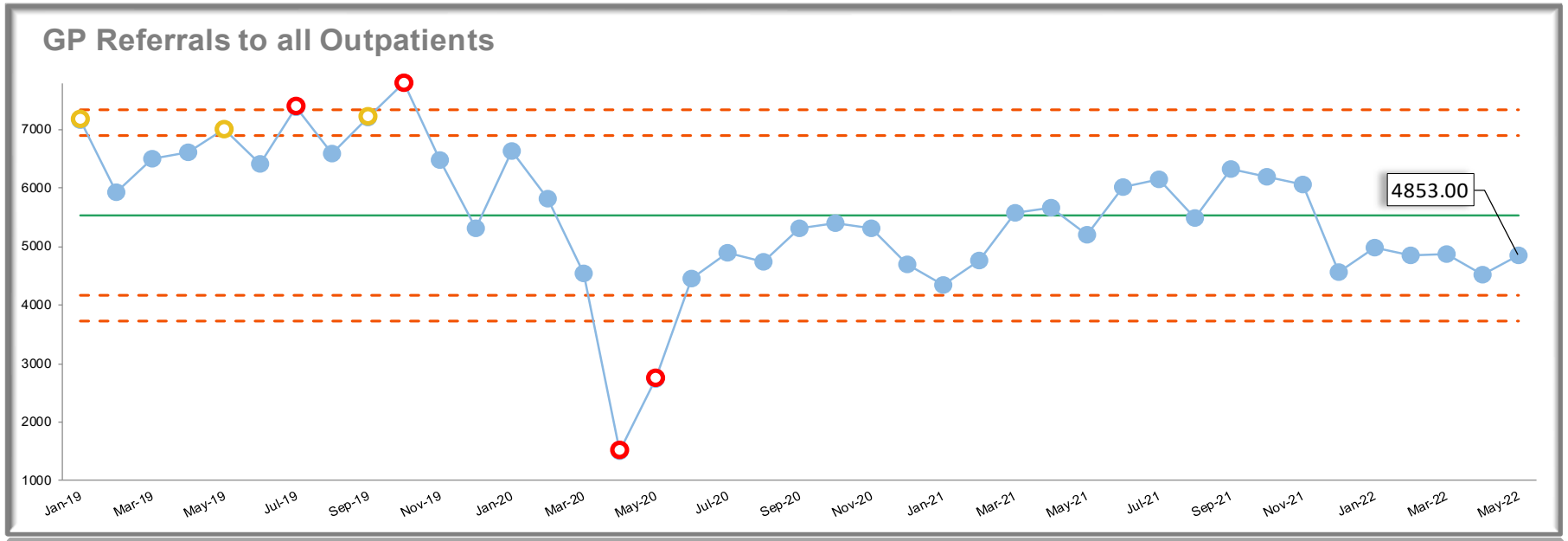


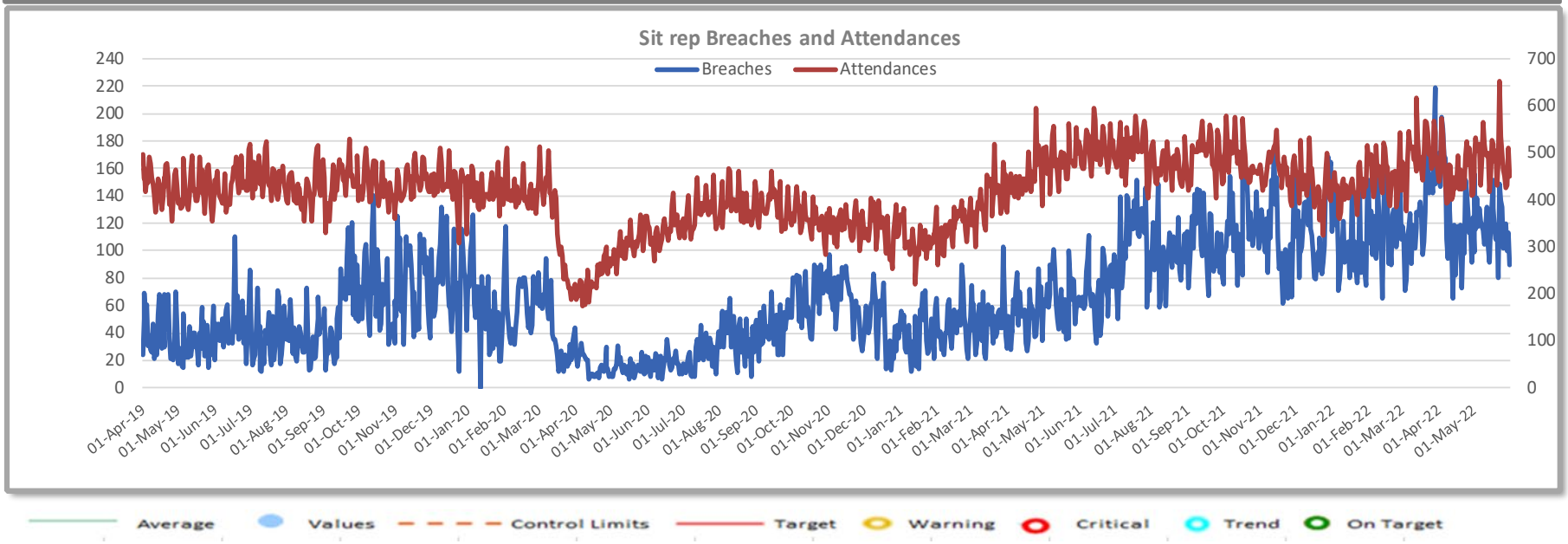




Average | Values | Control Limits | Target | Warning | Critical | Trend | On Target

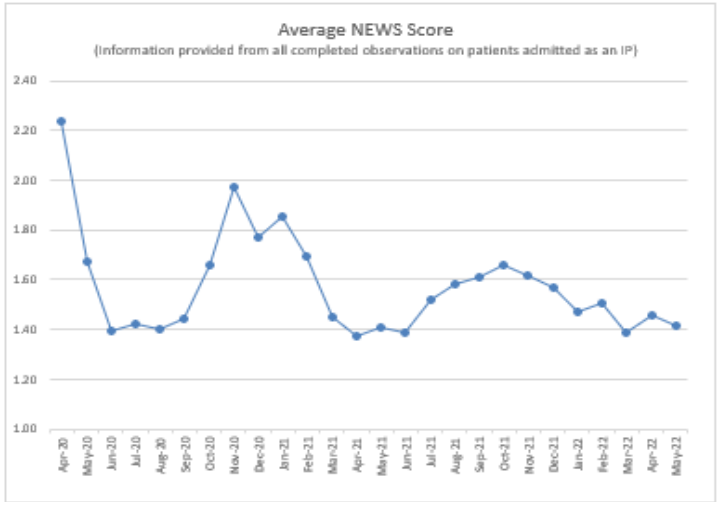
Capacity and Demand

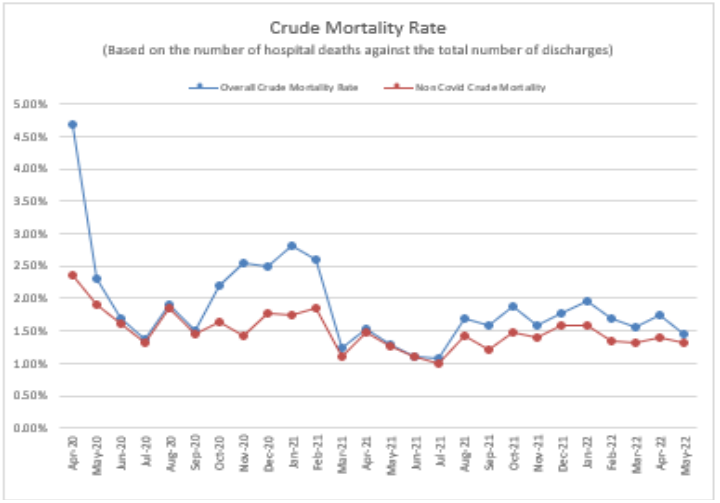


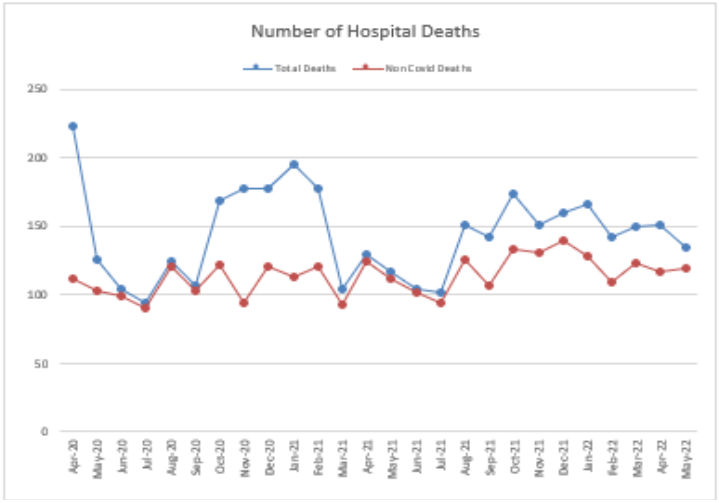


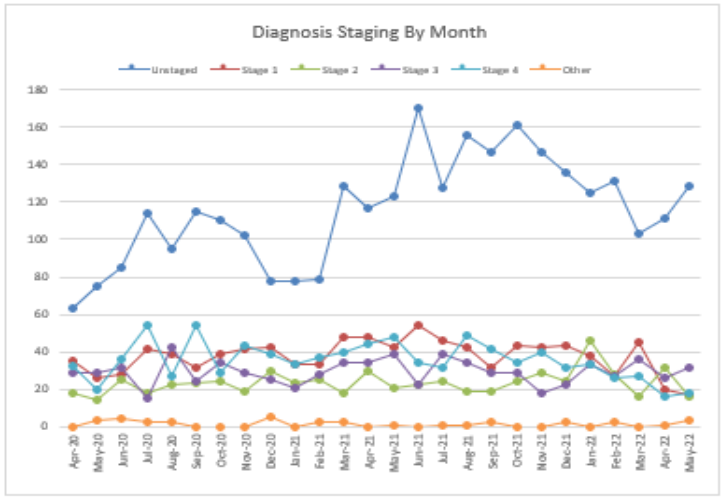
Average | Values | Control Limits | Target | Warning | Critical | Trend | On Target

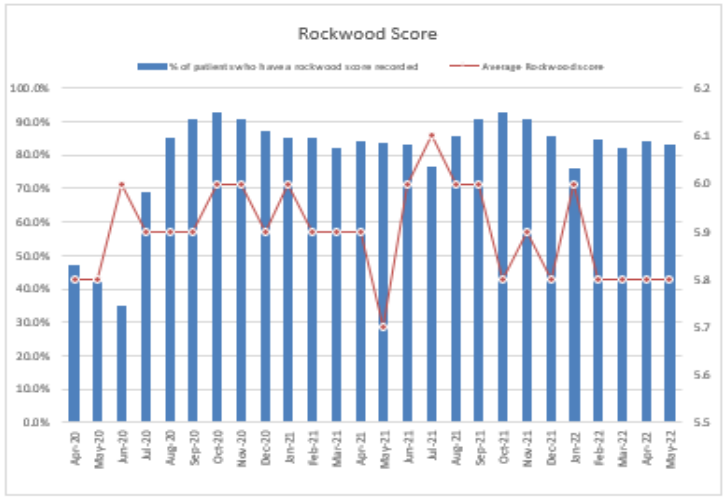
Outcome Measures

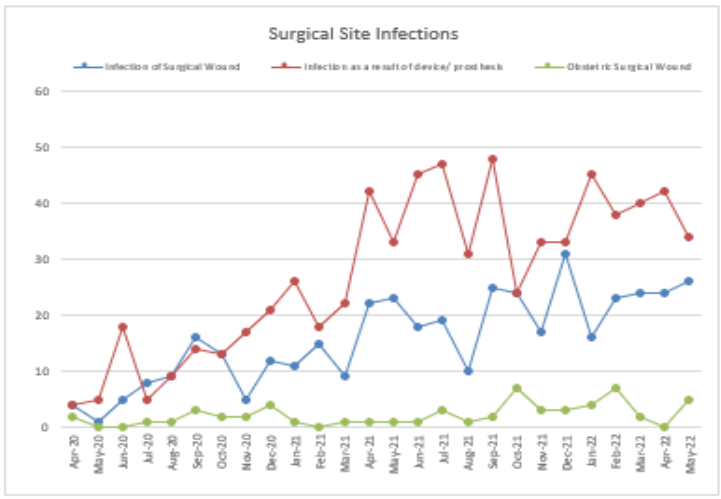






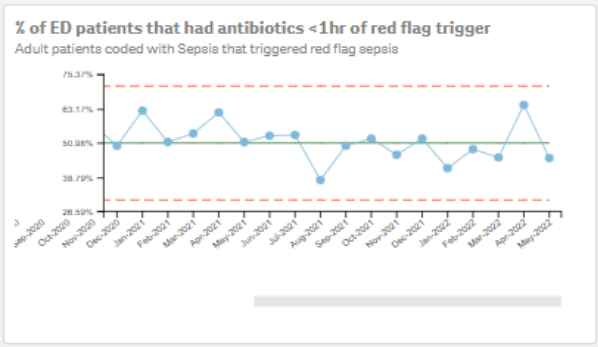


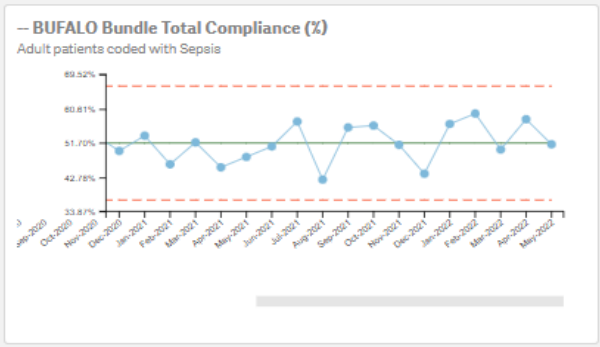




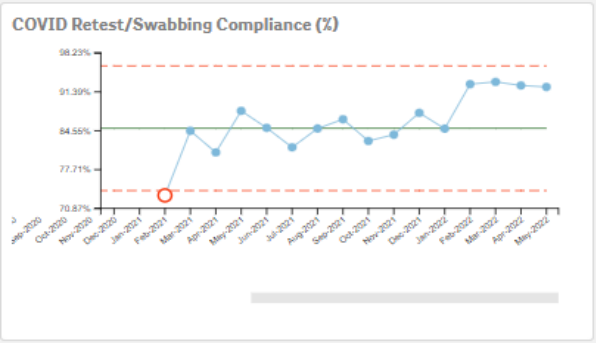
Quality Priorities - Quality Account Priorities

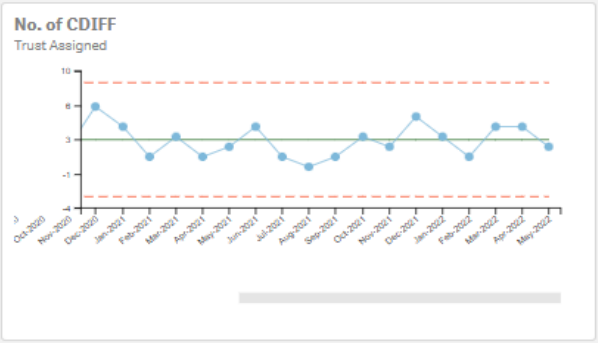
Priority 1
Recognition and timely treatment of Sepsis

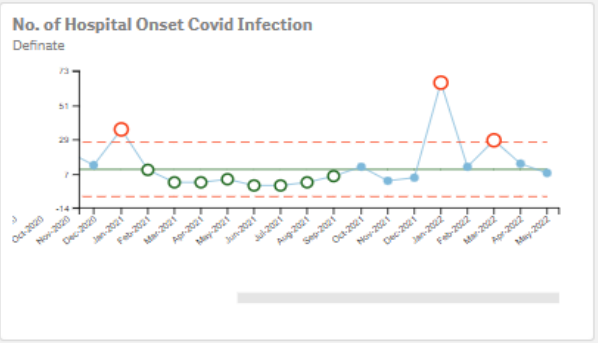




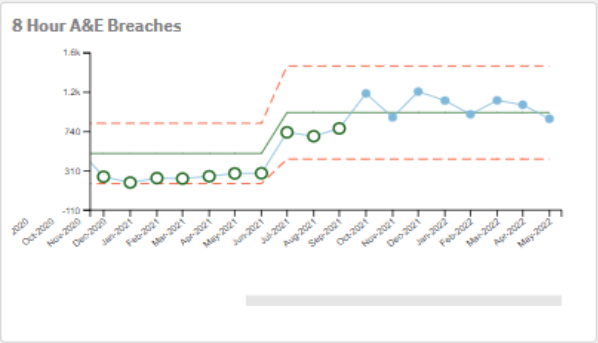
Priority 2
Reduce number of hospital acquired infections including COVID-19

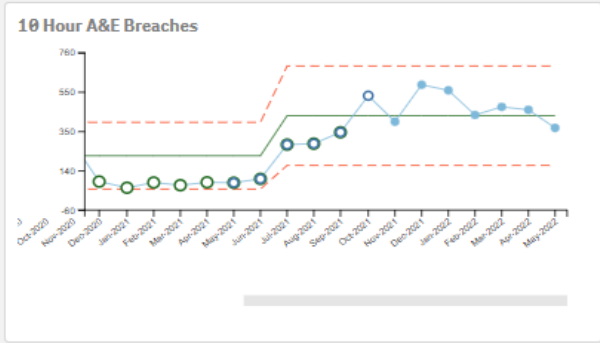


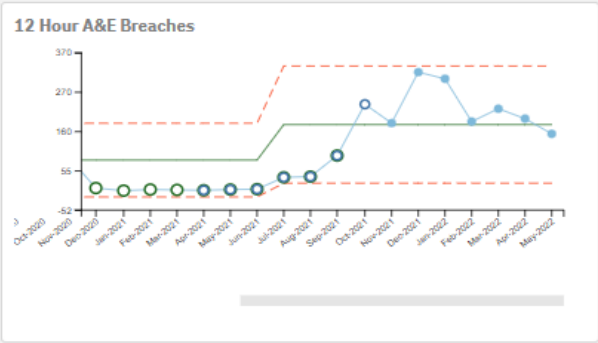




Priority 3
Reduce waiting times for individuals in the Emergency Department

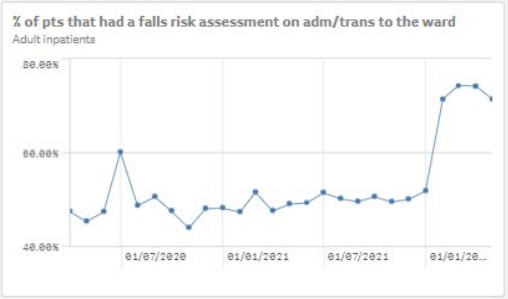




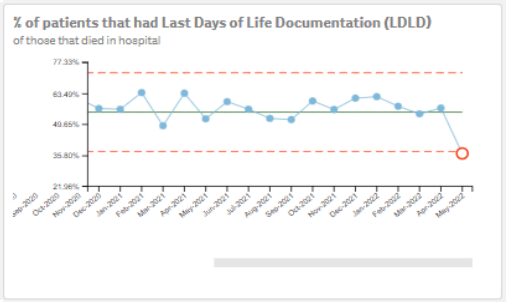


Quality Priorities - Focused Priorities

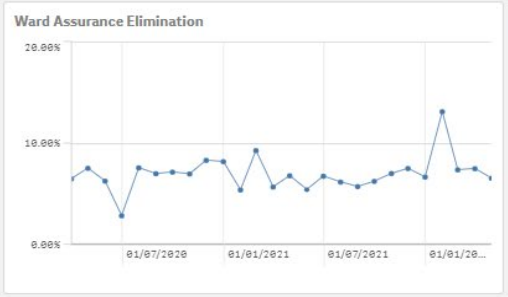
Priority 1
Reducing the number of falls resulting in harm



Priority 2
End of Life Care



Priority 3
Clinical Documentation

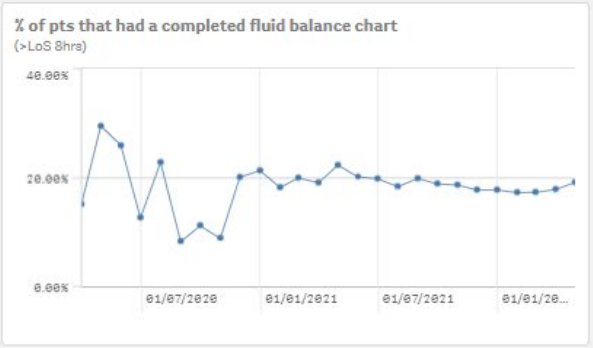


Priority 4
Clinical Prioritisation

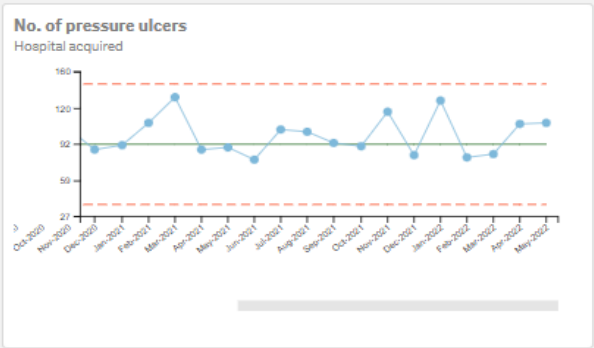
Not Yet Available

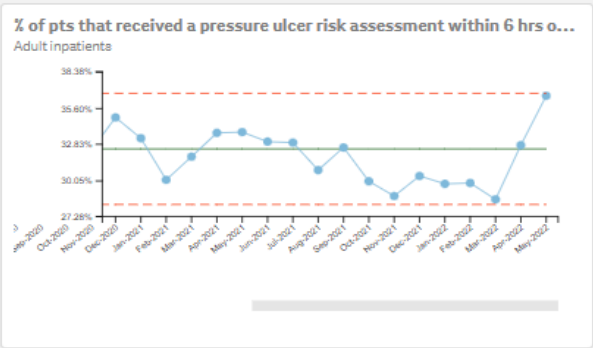
Quality Priorities - Focused Priorities

Priority 5
Nutrition and Hydration

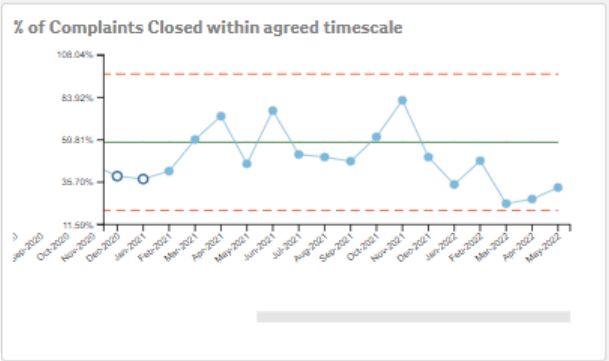


Priority 6
Reduction in the number of CHFT acquired pressure ulcers





Priority 7
Making complaints count

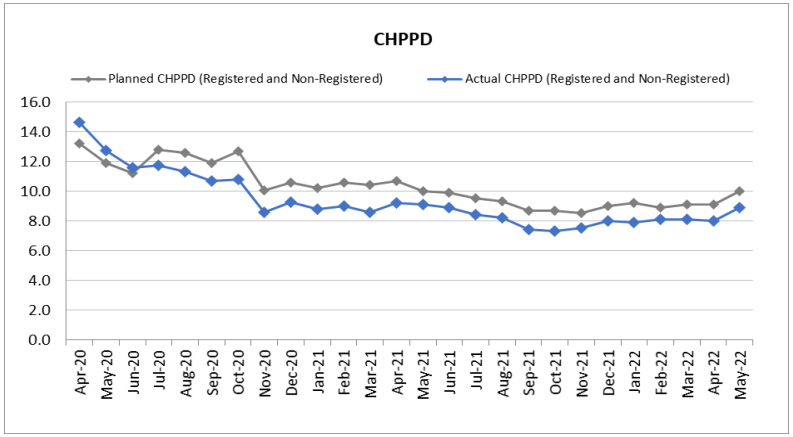


Hard Truths: Safe Staffing Levels

TRUST - CHPPD & FILL RATES (REGISTERED & NON REGISTERED CLINICAL STAFF)

	Mar-22	Apr-22	May-22
FILL RATES - DAY (REGISTERED & NON REGISTERED CLINICAL STAFF)	88.1%	87.7%	87.6%
FILLRATES - NIGHT (REGISTERED & NON REGISTERED CLINICAL STAFF)	95.5%	91.2%	91.7%

PLANNED CHPPD (REGISTERED & NON REGISTERED CLINICAL STAFF)	9.1	9.1	10.0
ACTUAL CHPPD (REGISTERED & NON REGISTERED CLINICAL STAFF)	8.1	8.0	8.9

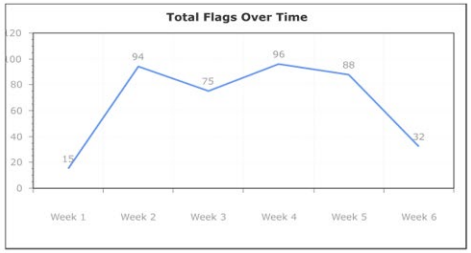


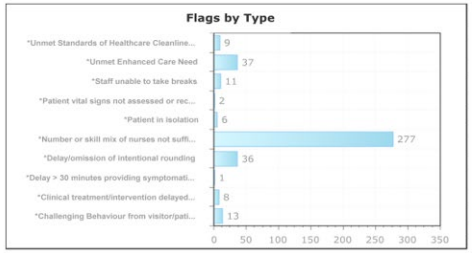
CHPPD provides a single, consistent and nationally comparable way of recording and reporting deployment of staff to provide care on inpatient wards. CHPPD is not a stand alone measure and should be used alongisde clinical quality and safety outcome measures.

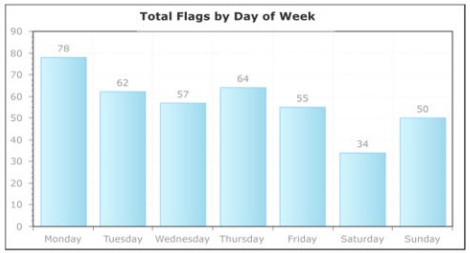
A review of May 22 data indicates that the combined RN and non registered clinical staff metrics resulted in 24 of the 28 clinical areas having fewer CHPPD than the planned, with a total deficit of 1.1 CHPPD across the Trust. The gap in CHPPD is at its broadest with the RN workfoce representing 0.8 defecit and HCSW 0.3 defecit. This position, whilst recognising planned care hours are still in deficit, demonstrates a steady increase in the actual care hours delivered to our patients since October 2021.
The CHPPD planned v actual gap is most prominent in the Surgical division (2.7 CHPPD defecit) This is largely attributable to the staffing in ICU which continues to report the planning for a COVID escalation workforce model. 'Actual' levels represent the staffing required to care for the patients each shift according to GPICS ratios.

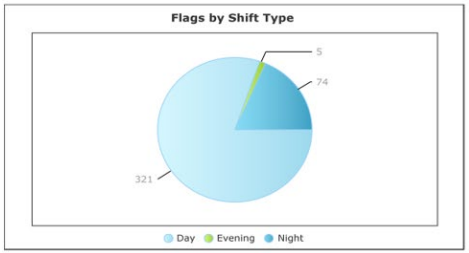
The 2021 successful recruitment to HCA roles has enabled increased shift fill to provide support to the reduced RN availablity. However adjustment to workforce models has now created a small vacancy pressure in this workforce group which is being addressed by central recruitment. Professional judgement is used daily to redeploy staff on a shift basis and establish the safest staffing possible in all areas.
Challenges of the requirement to staff additional capacity areas continue to impact on the ability to staff all areas according to workforce model.

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 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)

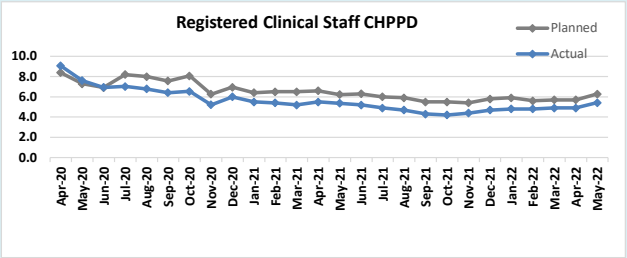
Aggregate Position | Trend | Result

CHPPD BY STAFF TYPE

Registered Clinical Staff

Monthly hours (day and night combined) divided by average patient count at midnight

CHPPD was 5.7 for planned and 4.9 For actual for Registered Clinical Staff

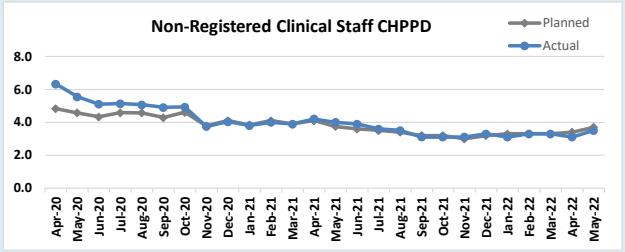


Overall there is a shortfall of 0.8 CHPPD against an overall requirement of 5.7 CHPPD for registered staff. Professional judgement informs decision-making at the twice daily staffing meetings to mitigate the risk across the clinical areas, and staff are redpolyed to optimise satefy. A suite of nurse sensitive indicators have also been incorporated into this section of the report to monitor for any correlations alongisde the CHPPD in line with national recommendations.
Continued training is being promoted to prevent falls and improve pressure area care. These indicators remain within normal variation in month.

Non Registered Clinical Staff

Monthly hours (day and night combined) divided by average patient count at midnight

CHPPD was 3.4 for planned and 3.1 for actual for Non Registered Clinical Staff



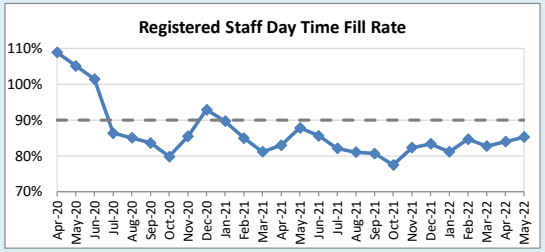
Overall there is a shortfall in the CHPPD of 0.3 for non-registered clinical staff. The day time fill-rate percentage of non-registered clinical staff (table below) shows a decline due to an increased demand in the requirement for 1:1 care needs and the need for additional staff due to the increased bed base capacity, rather than an inability to staff established workforce model shift requirements for this workforce.
Nightshift fill is prioritised ovr day shift due the increased vulnerability of patients and having fewer health professionals on the wards.

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.

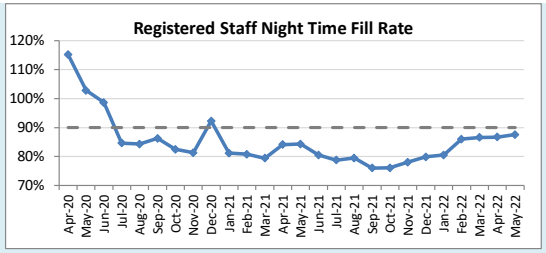
85.23% of expected Registered Clinical Staff hours were achieved for day shifts.



Registered Staff Night

Monthly expected hours by shift versus actual monthly hours per shift only. Night shift only.

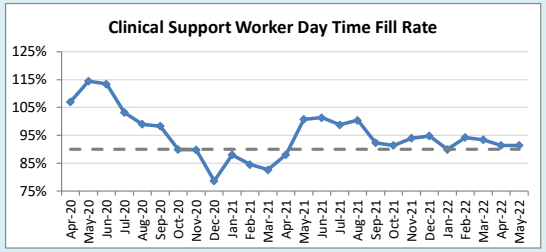
87.58% of expected Registered Clinical Staff hours were achieved for night shifts.



Non Registered Clinical Staff Day

Monthly expected hours by shift versus actual monthly hours per shift only. Day shift only.

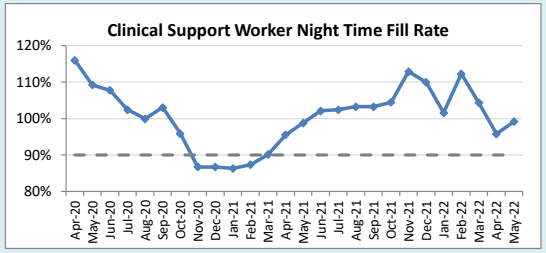
91.41% of expected Non Registered Clinical Staff hours were achieved for Day shifts.



Non Registered Clinical Staff Night

Monthly expected hours by shift versus actual monthly hours per shift only. Night shift only.

99.13% of expected Non Registered Clinical Staff hours were achieved for night shifts.

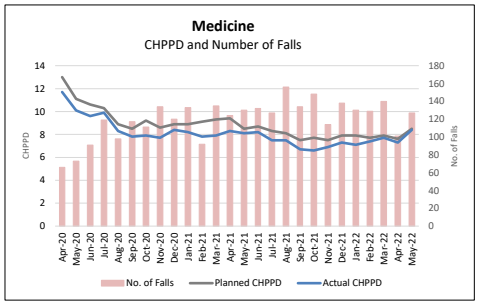


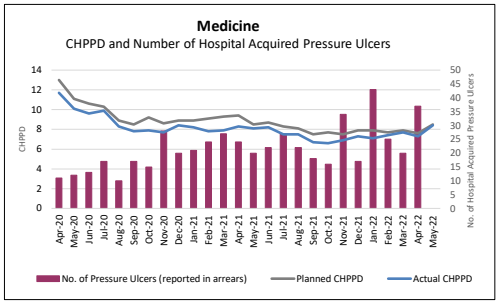
Hard Truths: Safe Staffing Levels (3)

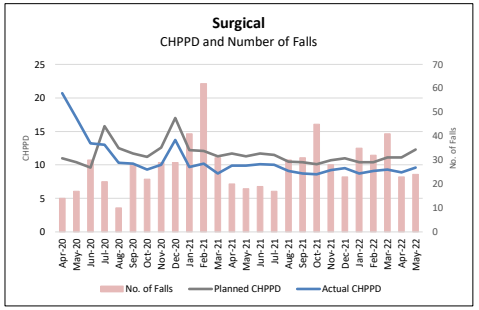
NURSING QUALITY INDICATORS AND FILLRATES BY WARD AND DIVISION

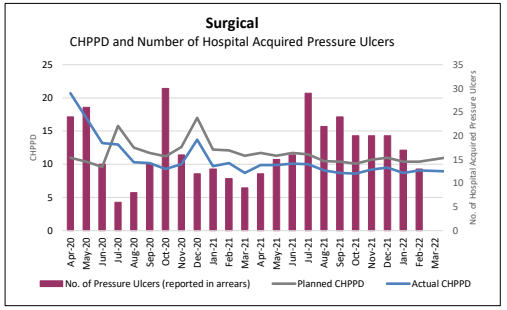
Ward	Average Fill Rates: DAY - Registered Clinical Staff (%)	DAY - Non Registered Clinical Staff (%)	NIGHT - Registered Clinical Staff (%)	NIGHT - Non Registered Clinical Staff (%)	CHPPD: Total PLANNED CHPPD	Total ACTUAL CHPPD
Medicine	**93.8%**	**99.8%**	**96.1%**	**108.0%**	**8.5**	**8.4**
CRH ACUTE FLOOR	120.9%	102.1%	126.2%	114.2%	10.3	8.9
HRI ACUTE FLOOR	86.3%	79.6%	93.4%	88.9%	9.1	7.2
RESPIRATORY FLOOR	72.7%	85.2%	79.1%	86.4%	7.1	7.0
WARD 5	78.6%	98.7%	103.5%	123.0%	4.3	3.5
WARD 6	77.1%	63.0%	98.4%	96.9%	12.0	11.9
WARD 6C	100.4%	96.3%	99.7%	103.3%	6.1	6.1
WARD 6AB	100.4%	96.3%	99.7%	103.3%	8.5	6.8
WARD CCU	73.1%	49.4%	94.0%		7.6	9.7
STROKE FLOOR	152.5%	144.9%	98.5%	103.7%	7.7	7.0
WARD 12	91.8%	77.4%	102.3%	104.9%	7.5	8.7
WARD 15	79.4%	148.3%	87.3%	152.3%	6.9	6.7
WARD 17	81.8%	102.2%	97.7%	127.7%	8.9	8.8
WARD 18	96.0%	100.4%	74.3%	138.1%	6.5	6.6
WARD 20	82.2%	118.0%	96.8%	112.8%	6.7	6.3
Surgical	**77.6%**	**73.5%**	**79.5%**	**82.1%**	**12.3**	**9.6**
WARD 21	85.3%	87.2%	95.7%	93.2%	8.0	7.2
WARD 22	92.3%	101.8%	96.6%	108.1%	6.7	6.6
ICU	77.8%	57.3%	78.1%	61.3%	45.7	33.8
WARD 8AD	41.0%	43.2%	46.7%	81.8%	20.1	9.2
WARD 8B	100.4%	61.3%	95.1%	75.6%	11.9	10.0
WARD 10	78.3%	95.2%	76.4%	82.4%	9.9	8.1
WARD 11	54.9%	43.1%	49.2%	46.9%	20.2	9.9
WARD 19	86.1%	95.6%	97.1%	101.1%	7.7	7.2
SAU HRI	95.7%	91.2%	98.3%	95.0%	8.5	8.1
FSS	**78.7%**	**85.1%**	**80.3%**	**90.4%**	**12.5**	**10.1**
WARD LDRP	71.5%	63.9%	74.3%	88.0%	29.8	21.8
WARD NICU	82.9%	85.4%	88.9%	93.5%	14.1	12.1
WARD 3ABCD	78.4%	98.0%	75.1%	84.7%	13.0	10.3
WARD 4ABC	86.6%	100.0%	94.1%	96.0%	5.7	5.3
Ward 1D	98.3%	57.7%	103.2%	41.6%	20.4	17.3
TRUST	**85.23%**	**91.41%**	**87.58%**	**99.13%**	**10.0**	**8.9**

Nursing Quality Indicators









Hard Truths: Safe Staffing Levels (4)

Conclusions and Recommendations

Conclusions

The Trust remains committed to achieving its nurse and midwifery staffing establishments and Workforce Development forms a key priority of the Time to Care Nursing strategy.

On-going activity:

1.The use of the enhanced metrics dashboard is embedded in the weekly senior safer staffing review meeting. Areas with less than 85% shift fill rate are scrutinised with a suite of nurse sensitive indicators. Matrons from affected areas present their analysis of indicators at the Nursing and Midwifery Safer Staffing forum where recommendations and actions are agreed to respond to the current position.

2. The Nursing and Midwifery Workforce Steering Group agenda has been re-established to focus upon medium to long-term strategies to support the Nursing, Midwifery and AHP workforce requirements. This includes an ongoing review of the current Nursing and Midwifery vacancy position and workforce plans reviewing directorate specific pressures to inform recruitment strategies.

4. Work continues to maximise the use of HealthRoster and the confirm and challenge process, to ensure a reduction of planned variability of shift fill across weekdays and weekends, as well as ensuring Annual Leave and Study leave is planned within agreed headrooms.

5. A piece of work has just completed and has been rolled out to key Nursing and Midwifery forums to support the principles of effective rostering and annual leave management.

6. Work at CHFT is in progress to meet our ambitious target of 80 international RN recruits during 2022, we continue to adopt a varied approach to securing applicants, including the use of agencies and a international nurse specific job advert in which nurses can apply direct to Trust via our recruitment system. There is a interview schedule across the year to support this strategy with arrivals expected through to December 2022. Work is in place to explore opportunities for International AHP recruitment in the coming year. Currently awaiting further information from NHSE/I

7. Data collection for the next round of the bi-annual establishement reviews (Hard Truths) will take place in June 2022. Analysis of this data will be conducted in July with any recommended establishment changes being presented to panel by early September.

8. Recruitment of the next cohort of apprentices to top-up from Nursing Associate to Registered Nurses(NA to RN) has begun with an anticipated 7 places to commence in October 2022. This route to registration allows career progression for those unable to access traditional undergraduate courses and forms part of our offer to promote equitable and levellling up opportunities.

LD - Key measures

	21/22	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	YTD	Performance Range		
																Green	Amber	Red
Recovery																		
Total P2 on Waiting List (LD)	32	0	5	3	2	4	2	3	4	3	2	4	1	**11**	**12**	No target		
Total P3 on Waiting List (LD)	119	0	17	14	18	13	10	10	7	8	11	11	14	**16**	**30**	No target		
Total P4 on Waiting List (LD)	58	not available	10	9	11	9	9	3	3	2	1	1	2	**3**	**5**	No target		
Emergency Care																		
Emergency Care Standard 4 hours (LD)	65.74%	not available	70.59%	85.05%	54.21%	65.31%	71.05%	65.65%	61.02%	69.57%	53.33%	61.62%	54.86%	**53.41%**	**54.14%**	>=95%		<95%
Waiting Times																		
18 weeks Pathways >=26 weeks open (LD)	569	not available	55	51	48	54	56	58	69	61	63	54	50	**47**	**97**	0		>=1
RTT Waits over 52 weeks Threshold > zero (LD)	409	not available	41	38	40	41	37	41	45	41	47	38	34	**38**	**72**	0		>=1
% Diagnostic Waiting List Within 6 Weeks (LD)	83.63%	not available	0.8757	87.74%	86.49%	85.10%	87.13%	84.85%	84.97%	90.43%	73.54%	68.48%	82.70%	**84.00%**	**79.74%**	>=99%		<=98%
Cancer																		
Two Week Wait for Referral to Date First Seen (LD)	100.00%	not applicable	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	**100.00%**	**100.00%**	>=93%	86% - 92%	<85%
31 Days From Diagnosis to First Treatment (LD)	100.00%	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	100.00%	not applicable	not applicable	not applicable	not applicable	**not applicable**	**not applicable**	>=96%		<95%
31 Day Subsequent Surgery Treatment (LD)	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	**not applicable**	**not applicable**	>=94%		<93%
38 Day Referral to Tertiary (LD)	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	**not applicable**	**not applicable**	>=85%		<84%
62 Day GP Referral to Treatment (LD)	100.00%	not applicable	not applicable	not applicable	100.00%	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	**not applicable**	**not applicable**	>=85%	81% - 84%	<80%
62 Day Referral From Screening to Treatment (LD)	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	**not applicable**	**not applicable**	>=90%		<89%
Activity - Number of Attendances																		
New Outpatient Attendances - Face to Face (LD)	366	22	26	34	24	26	34	33	38	38	24	31	36	**37**	**73**	No target		
New Outpatient Attendances - Non Face to Face (LD)	256	12	18	23	35	18	26	19	25	18	16	18	12	**18**	**30**	No target		
Follow up Outpatient Attendances - Face to Face (LD)	1426	115	113	152	83	115	106	120	135	144	122	113	121	**151**	**272**	No target		
Follow up Outpatient Attendances - Non Face to Face (LD)	845	88	86	90	81	60	69	74	47	45	56	67	51	**50**	**101**	No target		
Activity - % DNAs																		
% 1st DNAs (LD)	7.22%	5.88%	5.71%	5.13%	8.24%	4.23%	9.09%	6.58%	7.69%	10.87%	6.35%	9.59%	7.79%	**2.38%**	**5.09%**	<=7.0%	7.1% - 7.9%	>=8.0%
% Follow Up DNAs (LD)	5.72%	3.19%	4.04%	6.03%	6.06%	6.17%	8.30%	5.93%	8.10%	5.79%	6.13%	5.39%	6.61%	**7.07%**	**6.84%**	<=7.0%	7.1% - 7.9%	>=8.0%

LD - SPC Charts

19. Board Assurance Framework – Update 1 2022/2023

To Approve

Presented by Andrea McCourt

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 7 July 2022
Meeting:	Public Board of Directors
Title:	Board Assurance Framework – Update 1 2022/23
Author:	Andrea McCourt, Company Secretary
Previous Forums:	None

Purpose of the Report

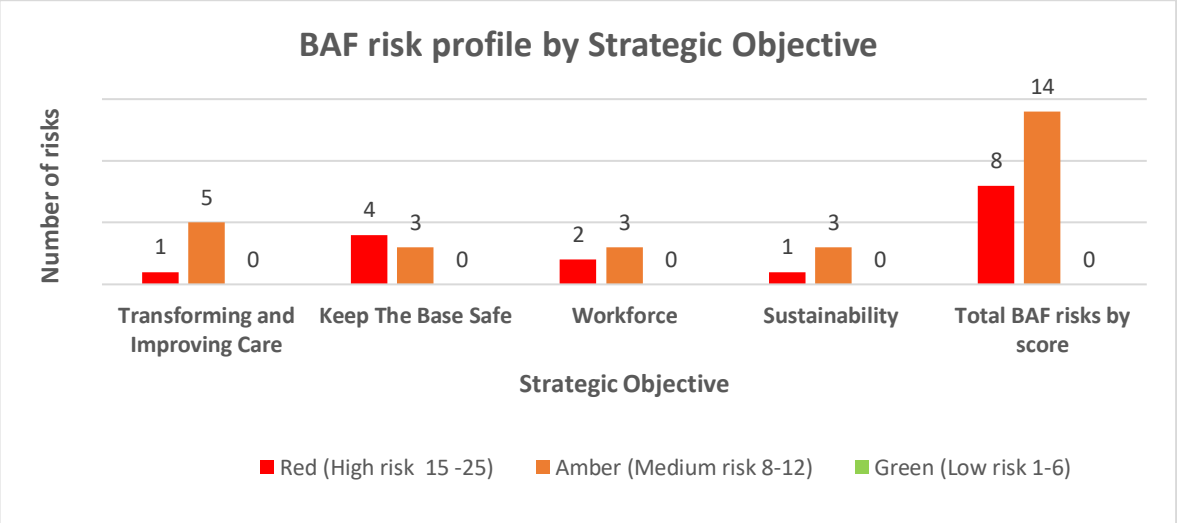
The Board Assurance Framework is the key source of evidence that links the Trust's strategic objectives to risk and assurance. It is the main tool that the Board uses for discharging its overall responsibility for internal control and is presented to the Board three times a year.

This report presents the first update of the Board Assurance Framework (BAF) for 2022/23 for review.

Key Points to Note

Risk Profile

The Trust has the following risk profile for risks to its strategic objectives as at 24 June 2022 with a total of 22 risks. The Keeping the Base Safe strategic objective has the greatest number of high (red) risks, at 4 of the 22 risks on the BAF.



There is one new workforce risk on the Board Assurance Framework (BAF) relating to the Health and Well-Being of colleagues. This is risk 1/22 scored at 12 and is the risk of colleague wellbeing deteriorating due to wellbeing priorities not being integrated throughout the organisation, embedded in our culture, leadership and people management resulting in the ability to deliver transformational change being compromised, potential to affect the quality of patient care, low staff morale and non–achievement of key Trust priorities.

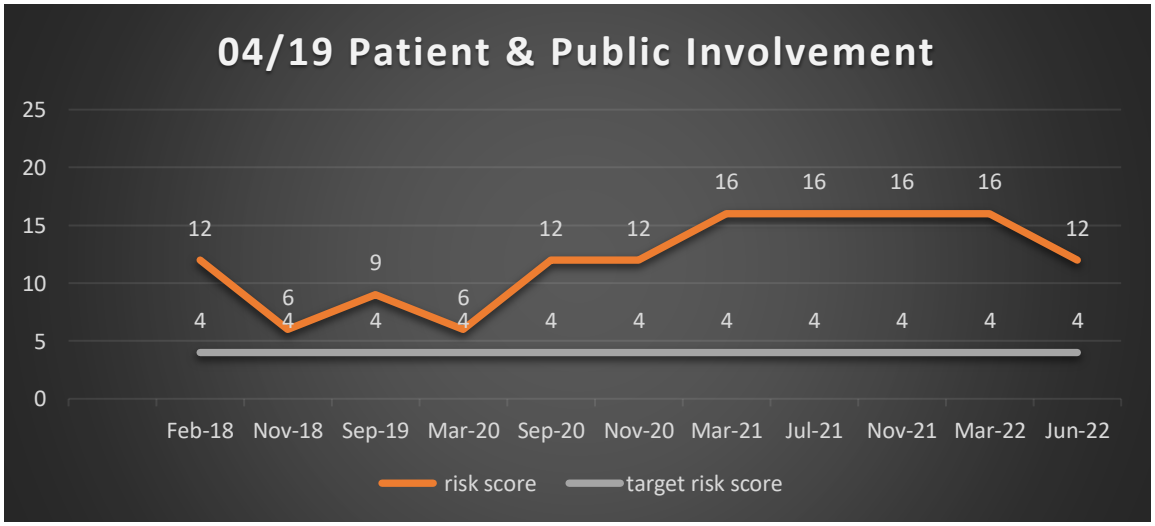
All BAF risks have been reviewed and updated by the lead Director and / or teams with updates shown in red font for ease of reference in the enclosed worksheets within the BAF.

Risk Score Movement
There has been a reduction in risk scores for four risks and an increase for one risk, with the rationale for the movement in each risk score given below together with the risk score history.

Risk score movement	Risk score	BAF Risk reference and score
↓	12 (reduced from 16)	4/19 Patient and Public Involvement
↓	12 (reduced from 15)	6/19 Quality & Safety Standards
↓	12 (reduced from 16)	4/20 CQC rating
↓	8 (reduced from 12)	6/20 Climate Change
↑	9 (increased from 6)	15/19 Commercial Growth

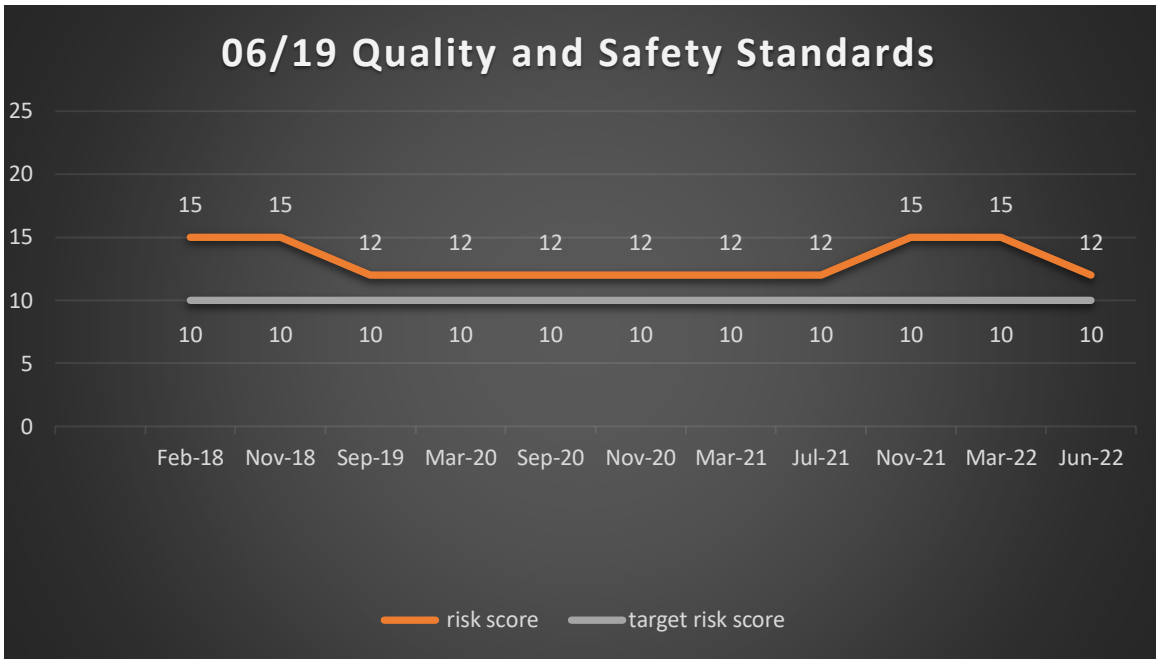
- ***4/19 Patient and Public Involvement risk*** - risk score reduced from 16 to 12 with a reduction in the likelihood score from 4 to 3. This is due to increased oversight by the Head of Complaints and PALS and joint working with the Patient Experience Quality Improvement Manager. A workplan for the Patient and Service User Engagement is being implemented. There is enhanced reporting on patient experience within quality governance sub-groups via patient experience section on divisional Patient Safety Quality Board agendas and the corporate Patient Safety Quality Board agenda, with increased oversight of family and friends actions as a result of this.

  The score history of the risk is given below:

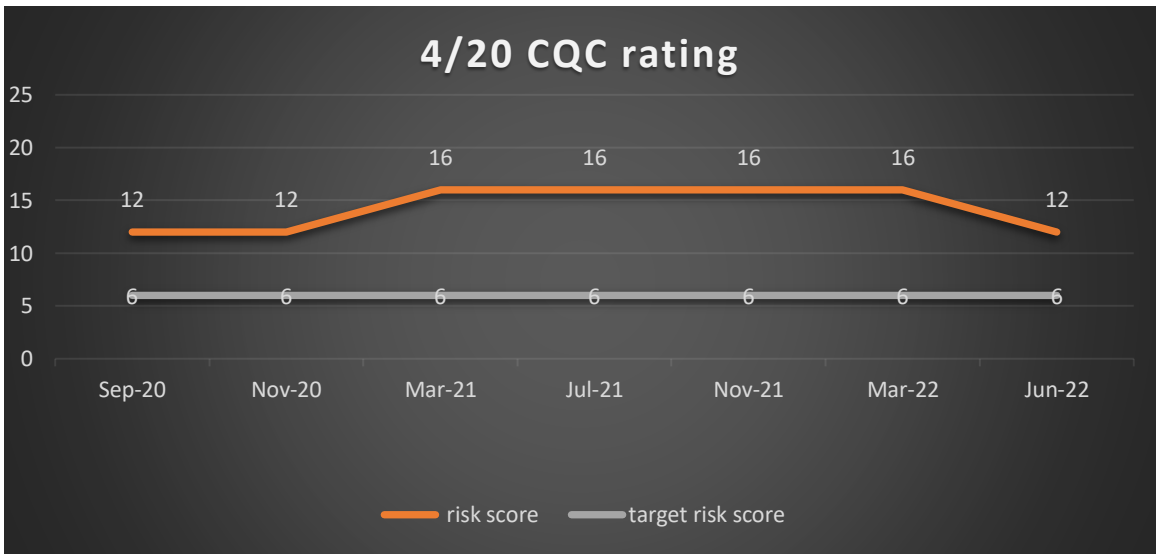


- ***6/19 Quality and Safety risk*** - reduced from a risk score of 15 to 12 with a reduction in the likelihood score from 5 to 4 due to greater scrutiny on quality and quality reporting. Quality priority key performance indicators are monitored by quality sub-groups. The Journey to Outstanding programme is embedded in the organisation with a clear process for actions and learning, including daily huddles. A positive assurance has been received from an internal audit review of the serious incident investigation process and the backlog of actions has been addressed, with a greater level of assurance by our commissioning partners.

  The score history of the risk is given below:

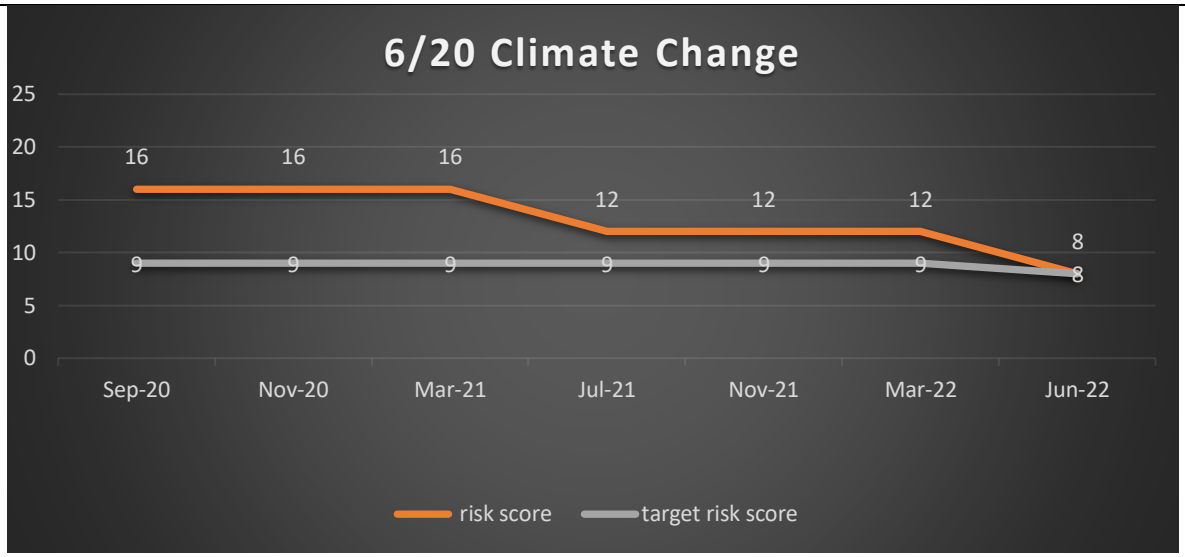


- ***4/20 CQC rating*** - the score has been reduced from 16 to 12, due to a reduction in the likelihood score from 4 to 3 reflecting intense internal organisation-wide scrutiny via the Journey to Outstanding (J2O) programme which is now embedded and a focused J2O programme which has to date included Emergency Departments and maternity services. Positive feedback has been received from recent CQC informal engagement visit and walkarounds.



6/20 Climate change - the score has been reduced from 12 to 8, due to a reduction in the likelihood score from 3 to 2 reflecting the fact that the Green Plan has been approved by the Board, a Green Planning Group is in place and carbon literacy training has taken place. Although the risk is now at its risk target score, it will remain on the Board Assurance Framework as it is key to the Trust's strategic objective relating to sustainability.

The risk score history is given below.



15/19 Commercial Growth - the risk score had previously been reduced to the target score of 6. The increase in score from 6 to 9 is due to an increase in the likelihood score from 2 to 3 reflecting the fact that the contribution from wholesaling in Huddersfield Pharmaceutical Services has reduced due to a key customer no longer trading with HPS. Additionally, a review is taking place for the Contract Pricing Unit to determine if Pharmacy Manufacturing Units should access NHS negotiated prices for external business.

The score history of the risk is given below:

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) 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 24 June 2022 the risks overseen by this Committee Trust has seven areas of risk exposure summarised below.

Strategic Goal: Transforming and Improving Care	Risk Score	Risk Appetite category	Risk Appetite
7/20 Health Inequalities	12 =	Harm and safety	Low
Strategic Goal: Keeping the Base Safe	**Risk Score**	**Risk Appetite category**	**Risk Appetite**
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	12=	Workforce	Low
1/22 Colleague health and well-being	12!	Workforce	Low
Strategic Goal: Sustainability			
18/19 Long term financial sustainability	16=	Financial/Assets	Moderate

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:

i. **APPROVE** the addition of risk, 1/22, colleague health and well-being
ii. **APPROVE** the updates to the risks
iii. **NOTE** the movement in the risk scores for risks 4/19 patient and public involvement, 6/19 quality and safety, 4/20 CQC rating, 6/20 climate change and 15/19 commercial growth
iv. **CONSIDER** if there are any further risks to the achievement of strategic objectives.

Update 1 - June 2022
2022/23

Calderdale and Huddersfield NHS Foundation Trust

BOARD ASSURANCE FRAMEWORK
2022/23 Update 1

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, 7413	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	12 ↓	4	LR	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	JR	None	Innovation/ Technology	High
07/20	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.	16	12 =	8	LR	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	12 ↓	10	LR	7809,7689,7683,7474, 7834,6453,2827,7615	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	GB	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	JF	7615, 6453	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	None	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	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	12 ↓	6	LR	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	JF	7689, 7683, 7809, 7834, 7634	Harm and safety	Low
A workforce fit for the future								

SUMMARY BOARD ASSURANCE FRAMEWORK RISKS BY TRUST STRATEGIC GOAL

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	LR	6345	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
1/22	Risk of colleague health and well-being deteriorating due to well-being proprities not being intergated throughout the organisation, embedded in our culture, leadership and people management	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	**12 =**	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 =**	**9** ↑	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	**8** ↓	8	SS	None	Strategic/ Organisational	Significant

Area of risk exposure

HEAT MAP

LIKELIHOOD (frequency)	CONSEQUENCE (impact / severity)				
	Insignificant (1)	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Extreme (5)**
High Likely (5)				05/20 Service Capacity due to Covid-19 response =	
Likely (4)		15/19 Commercial growth ↑	02/20 Digital Strategy = 12/19 Staff engagement = 6/19 Compliance with quality standards ↓	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)			16/19 Health & Safety = 3/19 Seven day services =	1/22 Health and Well-Being ! 4/19 Patient & Public involvement ↓ 04/20 CQC rating ↓ 14/19 Capital = 11/19 Clinical leadership = 01/20 Clinical Strategy = 07/20 Health Inequalities =	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 ASSSURANCE FRAMEWORK
JUNE 2022
TRANSFORMING AND IMPROVING 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 JUNE 2022 Risk category: Regulation Risk appetite: Moderate**		
								Initial	**Current**	**Target**
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 providing extended cover- regular staffing meetings held to endure cover for key services/ movement of staff should staffing levels drop to unacceptable levels • Radiology staffing has improved with a number of recent Consultant appointments. Increased demand for acute imaging has somewhat diminished the impact of these posts, however the service overall is more robust and better able to respond to pressures including increased staff absence due to COVID. • 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 • Use of independent service provision for endoscopy, echo and neuro-physiology	First line HSMR and SHMi remain within expected range but are greater than 100. Second Line Integrated Board report with SHMI/HSMR reporting. Annual Learning from Deaths (LfD) report to Board July 2021, 7 July 2022 . Quarterly Learning from Deaths report to Board (3 March 2022 (Q3), 7 July 2022 (2021/22 annual report) Clinical Outcomes Group re-established reviews reports on LFD group and monitors quality improvement programme. Seven day services Assurance report to Quality Committee 20 June 2022, with audit of 4 key Keogh standards demonstrating compliance. Third line None	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. Action: Revised workforce models and recruitment campaign in A&E- see BAF risk 10a/19 medical staffing Lead:Clinical Director A&E Timescale: Ongoing Radiology - insufficient staff to provide MRI diagnostic capacity (national challenge) Pressures on diagnostic capacity post-Covid recovery Action: SOP for next day follow up of urgent patients requiring out of hours MRI . Development of Community Diagnostic Hubs which should reduce some elective work Timescale; 2023 Lead:Divisional Director for Family Specialist Services cardiac(stress tests , angiography delays from Covid) / neurophysio are challenging Action: plan for additional internal activity as part of Recovery response: lead Chief Operating Officer	• Scope for futher implementation limited without service reconfiguration or additional investment 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.	**5x3 = 15**	**3x3= 9 =**	**2x2 = 4**

BOARD ASSURANCE FRAMEWORK
JUNE 2022
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 JUNE 2022 Risk category: Regulation Risk appetite: Moderate
06/19	Quality Committee	Interim 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 Bi month reports to Quality Committee for assurance , Monthly reports to Trust PSQB for oversight and scrutiny Quality and Safety Strategy - each clinical division reports into performance review meetings on delivery of the ambitions of the strategy . • Serious incident (SI) investigation process identifies recommendations to improve care with strong governance in place and process in place to address any immediate learning • 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 , further scrutiny at Quality Committee revised quality priorities with specific KPIs in place • Focused Journey to Outstanding (J2O) programme and review of maternity services on implementation of Ockenden recommendations • Programme of ward assurance visits in place - clinical area quality dashboard in place reviewed at 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 revised and refreshed • Learning and Improving: Quality and Safety Strategy agreed and rolled out Refresh and relaunch of Nursing and Midwifery Strategy (8 October 2021) which reinforces importance of real time monitoring of quality of care.	First line Assessment of compliance with NICE guidance Ward accreditation - J2O Journey to outstanding process embedded with focused J2O taking place Performance against safety 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 Second line Clinical audit plan reviewed Bi-monthly Quality Report to Quality Committee and Board - increased scrutiny. Maternity report to Quality Committee. Regular report to Board on maternity - response to Ockenden review 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 Further update December 2021 Serious incident report to Quality Committee which includes lessons learnt section and "backlog" investigations addressed with positive feedback from CCG Safer Staffing Hard Truths report to Board 4.11.21., 3.3.22. Refreshed Nursing and Midwifery Strategy (2021) approved by Quality Committee and Board. Maternity Services report to Board (March, May, July 2022) Third line CQC rating of Good, regional Ockenden Assurance Visit (28.6.22.)CQC In patient Children's and Young Peoples survey 2021. Quality Account reviewed by stakeholder bodies for 2021/22 with positive feedback . Independent assurance on clinical audit strategy. Feedback through ongoing relationship with arms length regulatoy bodies. CQC TMA visits have taken place in ED, Maternity and Vaccination centre. Independent Service Reviews (ISR) and accreditations. Health Services Investigation Branch reports and on site visits	• Investigator capacity to support Si investigations and standard of serious incident investigations needs further improvement log of investigators now kept , training programme in place - still some concerns re availability of investigators due to clinical commitments Alternative model for investigators to Quality Committee Children and Young Peoples Improvement Plan being developed Timescale TBC lead ADN Family & Specialist Services	• CQC assessed the Trust as requires improvement for safe domain • There has been a move away from non essential activity by relevant regulators in response to the pandemic.	Initial: 3x5 = 15 Current: 3x4= 12 → Target: 2x5 = 10

Action	Timescales	Lead
Develop alternative model for serious incident investigators and present to Quality Committee Develop Children and Young Peoples Improvement plan	September 2022 TBC 2022	LR ADN Family & Specialist Services

Links to risk register:
7809 theatre and clinical capacity, 7689 waits for diagnostics, operations and outpatients, 7683 isolation facilities, 7474 Medical devices, 7834 Elective orthopaedic inpatient theatre capacity, 6453 delay of surgical repair of #NOF, 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
JUNE 2022
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 JUNE 2022 Risk category: Regulation Risk appetite: Moderate		
								Initial	Current	Target
7/19	Finance & Performance Committee	Director of Finance	**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 Effective Resources Group in place meets weekly, chaired by Chief Executive, which reviews delivery of effective resource use / Trust's efficiency programmes to support financial plans Finance brief produced to ensure Board awareness of both current and historic financial challenge	First line 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. Second line 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. On a control total basis the Trust delivered it's 2021/22 financial plans with positive external audit VFM assessment. Third line 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 and 2021/22 with a score of 2.	Recurrent efficiency opportunities to be agreed by Effective Resources Group Action: Effective Resources Group to identify 5 year opportunities by 30.9.22. Lead: Director of Finance Agree timescale for Finance Strategy to be adopted. Lead: Director of Finance by 30.9.22.	• Performance against key targets - recurrent balanced budget Reconfiguration business case yet to receive Treasury approval Timescale tbc by Treasury	5x5 = 25	4x5 =20 =	2x5 = 10

Action	Timescales	Lead
Effective Resources Group to identify 5 year recurrent efficiency oppprtunities	30.9.22.	Director of Finance
Consider development and promotion of Finance Strategy	30.9.22.	Director of Finance

Links to risk register: None

BOARD ASSURANCE FRAMEWORK
JUNE 2022
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 JUNE 2022 Risk category: Regulation Risk appetite: Moderate**		
8/19	Finance and Performance Committee	Chief Operating Officer	**Risk** Risk of failure to achieve local and national performance targets, including Recovery Plan targets **Impact** - deterioration of patients waiting longer for treatment - Poor patient experience -Elective recovery Funding - 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 . WYAAT system approach to capacity management. Urgent Care System Board and ICS Discharge Forum with social care providers to plan / consider options, supplemented with Reason To Reside Work 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 Bronze, Silver and Gold levels as appropriate. Operational dahsboards for recovery reviewed by divisional senior leadership teams highlight any issues on a daily and weekly basis and via groups below. Access Delivery Group, Cancer Group, Urgent Care Delivery Group meet monthly (since April 2022) to monitor recovery programmes, standards and waiting lists. Clinical Reference Groups for Modelling and Health Inequalities supporting the shaping of capacity. Clinical prioritisation/holistics needs assessment matrix. Continue to utilise external capacity for backlogs, internal enhancement scheme being reviewed and new scheme in place to try and secure further additionality. Elective Care Improvement Group led by primary care discusses exceptions and agrees next steps. Plans for Acute Respiratory Care Unit (ARCU) by November 2022 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	First line Daily Bronze meeting and silver when required with process to enact GOLD if needed. Trust feeds into weekly silver meeting with partners. Risk registers reviewed at Divisional PSQBs & PRMs. Integrated Performance report focus of one WEB each month for detailed scrutiny of recovery performance and activity. Regular monitoring of waiting time past due date for clinically prioritised Second line Board sub committee detailed appraisals of position and actions. Integrated Performance Report discussed at each Board sub committee and Board of Directors. Clinical Prioritisation agreed as a key Quality Indicator, led by Medical Director reporting via PRMs and into Quality Committee Detailed review of backlog position across planned care through Finance & Performance Committee. Monitoring of Covid position. Third line Routine reporting to NHS E/I.	Insufficent theatre capacity for elective work and across the system . Action: Recruitment pipeline in place, enhancement scheme, in sourcing companies utilise theatres at week-end - to March 2023. Non-elective impact on community - workforce issues resulting in a significant deficit of care hours in the community which will result in delayed transfers of care (DTOC) and increased presure on urgent care • Action: weekly ICS Discharge Forum and focus on internal management of TOC patients - Ongoing 2. Improvement Programmes reporting to Finance & Performance Committee for theatre transformation to improve prdoductivity and Emergency Department to ensure consistency of service delivery Lead: COO Timeframe: 2022/23 3 MRI Capacity - plan for further mobile scanning capacity to manage backlog and demand lead COO - by June 2022	Development of further outcome metrics for IPR. Lead: Chief Operating Officer Timescale: Autumn 2022	**Initial** 4x5 = 20	**Current** 4x4 = 16 =	**Target** 4 x 3 = 12
Access Delivery Group, Cancer Delivery Group and Urgent Care					**Timescales**			**Lead**		
Performance reporting - development of further outcome metrics Improvement Programmes - Theatres and Emergency Department Further mobile scanning capacity to manage backlog and demand					March 2022 April 2022 - March 2023 Q1 2022/23			Chief Operating Officer all actions		
Links to risk register: 7615 - 4 hour Emergency Care standard, 6453 delay of surgical repair of fractured neck of femur										

BOARD ASSURANCE FRAMEWORK
JUNE 2022
KEEPING THE BASE SAFE

TRUST GOAL: 2. KEEPING THE BASE SAFE

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								Initial	Current	Target
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 •Premises Assurance Model (PAMs) illustrates to patients, commissioners & regulators that robust systems are in place in regarding the premises and associated services are safe • 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 DATs building to reduce backlog maintenance. Head of Estates and H&S lead from CHS now attend the Risk Group to align Trust and CHS risk registers • 6 monthly insepctions of cladding at HRI with report to CHS Board and Transformation Programme Board - programme of cladding works towards the end of the reconfiguration timetable Capital has been secured for 20202/23 to meet the 2022/23 plan and requirements as agreed in the annual internal capital planning round.	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 Audits of routine checks, estates * 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 2022. 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 Authorised Engineers inspections against HTM standards. WEB reports on medical devices July 2019 6 Facet estate condition survey presented to Board 4 July 2019 is informing estates investment plan for HRI Third line CQC Compliance report.PAMS. 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.	* Funding secured for ED HRI and MSCP CRH and in 2022/23 capital plan. • MSCP is reliant on agreement with Albany at CRH for access to site and succesful variation in parallel with or in advance of Project ECHO. HMT Treasury visit on 26th May to progress ECHO. Albany visit 10th June to progress variations. Whilst additional funds have been secured, there remains a backlog maintenance issue at HRI including funding for cladding solution. A bid has been made into the ICS long term capital bidding process that covers the cladding issue.	PLACE assessment (Patient-Led Assessments of the Care Environment) re-start October 2022 by Quality Performance and Service Manager	4x4 = 16	5x3= 15	2x4 = 8

Action	Timescales	Lead
ICS longer term capital commitments to be debated and confirmed	July 2022	Director of Finance

Links to risk register:
Risk 7413 - Fire compartmentation risk, HRI
Risk 7474 - Medical Devices

BOARD ASSURANCE FRAMEWORK
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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, relevant policies reviewed and shared with stakeholders specific to roles and responsibilities. •Health and Safety Policy (revised 2022) 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, asbsetos) 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. 8 H&S subgroups formed - maintains traction upon stakeholder responsibilities • Health & Safety action plan in progress • 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. • COSHH Lead person (interim) Richard Hill/Task & Finish Group set-up circa end July 2022	First line 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 . Second line Board joint responsibility for risk understood. WEB reports on mandatory training, health and safety training compliance currently at target levels Audit and Risk Commitee periodic engagement Audit Yorkshire January 2021 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.F52 Updates to Board on H&S 3 September 2020, 14 January 2021, 1 July 2021, 13 January 2022 Third line External health and safety review (Quadriga) 2019. HSE inspections (speculative for 2023yr)	Development and implementation of NHS Workplace Health and Safety Standards Lead: Head of H&S Timescale: December 2022 Monitoring/Auditing of Compliance of the NHS Workplace Health and Safety Standards Lead: Head of H&S Timescale: From January 2023	When the NHS Workplace health and safety standards are embeded into the Trust it is not possible to audit and produce dashboard assurance reports, but this will take place early 2023, when the standards are all embedded across the organisation.	3x3 = 9	3x3 = 9	2x2 = 4

Action	Timescales	Lead
Stage 1 -Development and implementation of NHS Workplace Health and Safety Standards	Up to December 2022	Head of H&S
Stage 2: Monitoring/Auditing of Compliance of the NHS Workplace Health and Safety Standards	From January 2023	Head of H&S

Links to risk register:
7413 fire compartmentation, 7474 medical devices

BOARD ASSURANCE FRAMEWORK
JUNE 2022
KEEPING THE BASE SAFE

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								Initial	Current	Target
04/20 July 2020	Quality Committee	Interim Executive Director of Nursing	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. Journey to Outstanding (J20) implemented with increased breadth and depth of assurance - working towards business as usual model Focused Journey to Outstanding programme review of maternity services	**First Line:** Reports to CQC & Compliance Group from divisions with increased scrutiny Journey to Outstanding results and action plan and findings shared with wards and presented to CQC & Compliance Group . Also have focused J20 process **Second Line:** Quality Committee reports from CQC Group and as part of Bi monthly quality report Quality update report to each Board bi monthly Review by Quality Committee and Board of progress with CQC action plan . Quality report to 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 and rolling programme of on sight visits Current CQC rating of "good" including well-led governance	Uncertainty of direction of future CQC inspection and rating regime. CQC focus on high risk organisations with targeted inspections . Scaled back inspection regime due to IPC risk of on-site infections. Action: Risk and Compliance team have regular updates CQC and attend update meetings. Developments identified from well-led governance review deferred due to operational pressures. Action: Review of KLOEs for well-led governance assessment by Executive leads. External assessment to look at well-led preparedness. Q2 2022/23 Lead: Executive Team / Linday Rudge	J2O Programme Action: Timetable of J2O visits for next 12 months agreed. Programme for 2022 /2023 now being developed Lead: Lindsay Rudge CQC new regulatory framework not yet implemented nationally - on hold because of pandemic. Now likely to be 2023 for full roll out Action: Regular updates of CQC plans, internal assurance from J2O reviews Lead: Lindsay Rudge	4x3=12	→ 4x3=12	3x2=6

Action	Timescales	Lead
Liaison with CQC to understand position on CQC plans for inspections Journey to Outstanding implementation underway via rolling programme Refresh of audit of 2 recently closed CQC actions (Critical Care Anaesthetic cover, ED Consultant cover) with report CQC and Compliance Group Divisional review of must do and should do actions from 2018 CQC report Review of KLOEs for well -led governance assessment	Ongoing (update from CQC expected July 2022) 12 month rolling programme August 2022 (KS) August 2022 - lead Quality Governance Leads (linking with Divisional Senior Management Team) September 2022	ADN Quality and Safety and Interim Director of Nursing / Medical Director Interim Director of Nursing and Medical Director Executive Leads

Links to risk register:
None

BOARD ASSURANCE FRAMEWORK
JUNE 2022
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 JUNE 2022 Risk appetite: Low (Ham and Safety)**		
								Initial	**Current**	**Target**
05/20 July 2020	Finance and Performance Committee	Chief Operating Officer	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	Surge plan in place 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.Review of surge plan.on. IPC pathways amended to reflect national guidance which will increase elective capacity , 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 Independent sector. 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, overssen by Health Inequalities Group. Regular reporting at IMD level now available showing progress in closing the 'waits gap' since March 2021. This is also available for BAME/Non-BAME patients. Working with system partners on referral pathways Health & Well-Being risk assessment of staff Scenarios modelled for various configurations of covid activity.	**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) Discussion on key elective recovery metrics.	1. Reset plans have interdependency risks on workforce availability that will limit capacity. Action: Daily monitoring of workforce availability		4 x 5 - 20	4 x5= 20 =	2x4=8

Action:	**Timescales**	**Lead**
1. Monitoring of workforce availability	Daily	Chief Operating Officer, Jo Fawcus

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 due to vacancies

BOARD ASSURANCE FRAMEWORK
JUNE 2022
A WORKFORCE 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 JUNE 2022 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 - annual workforce planning activity to continue • CESR programme to increase Consultant workforce in appropriate specialties, Emergency Medicines scheme for oversease doctors with Royal College (Hybrid International Emergency Medicines) supports recruitment and retention. Global fellows in Radiology, Guardian of Safe Working ensures safe working hours for junior doctors. • E -job planning in place for Consusltants ensures efficient use of medical staff workforce and visibility of Consultant workforce activity (50% sign off complete by 31.5.22.) • • 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 . 2 ED Consultants and 3 Specialists - to commence Sept 2022 • 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 , SAS asdvocate appointed and new SAS tutor appointed - these support more effective engagement with SAS cohort	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 in ED, work with Deanery to develop those in post, additional 6 PAs.. 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 less than 10%. Vacancy rate 7%, with expanded establishment 704.9 wte. 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 29 medical and dental posts from April 2021 to April 2022. Deep dive of risk to Workforce Committee 15.2.22., 6.6.22. 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., 13.1.22., 3.5.22.) on working hours to Board - investing in improved facilities for trainees. Refresh of Recruitment Strategy post Covid underway 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 partially implemented for doctors - Implementation of NHSE/I Medical Deployment systems project March 2023 for Phase 1 completion. Pensions rules remain a concern and affect willingness of medical staff to deliver additional work Review Trust approach to options on reycling pension at WEB - 23 June 20222 - lead SD 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 Action - monitor via succession planning work, vacancies and agency usage - Sree Tumula Accumulated annual leave from Covid-19 may pressure clinical service delivery. Action: HRBPs assessing scale of	Unpredictability of staff absences and impact on services at short notice in context of staff fatigue impact on staff health and well being. Short term sickness absence may be under-reported by medical staff. Action: return to work interviews by divisional teams.Implementation of e-rostering to record sickness absence (2023), resources for e-rostering impacted by Covid related work . Neuro-physiology, neurology and stroke specialty vacancies - all difficut to recruit to posts. Work with Integrated Medical Services Clinical Director, explore use of new specialist grade role Action: Exploring use of recruitment agency for executive search for Stroke medicine vacancy - 6 month. Nerurophysiology- explore CESR approach to	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 (Associate Specialists) doctors have electronic job plans /85% junior doctors electronically rostered, 55% Consultants electronically rostered Work with Integrated Medical Specialties (IMS) Clinical Director re recruitment to Stroke, Neurology and Neurophysiology vacancies and explore use of specialist grade role	31 March 2023 50% at 31 May 2022, 85% Junior Doctors August 2022 November 2022	Lisa Cooper, Medical Workforce with Jackie Robinson, Dr Sree Tumula, Associate Medical Director Dr S Tumula, Clinical Director IMS

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
JUNE 2022
A WORKFORCE 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 JUNE 2022 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	• Senior nurse leadership rota provides ongoing visibility and dialogue across clinical areas, supports staffing escalation • 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 • Staffing Command links to availability, OPEL level escalator, senior medical and nursing leadership oversight and directly links to bronze command. • Strengthened escalation and reporting arrangements for quality and safety (short term and medium/long term), including enhanced dashboard which provides clear visibility on workforce and impacts on patient experience, quality and safety, revised Safer Staffing OPEL action cards • 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. 20% bank enhancements continues for registered workforce 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 Workforce Steering Group, meet monthly monthly meeeting reviews operational issues, strategy and seeks assurance Nursing and Midwifery Safer Staffing Groups meets twice weekly to review the Enhanced Dashboard Metrics	First line Divisional business meetings and PSQBs consider staffing levels as part of standard agenda Bi-annual reviews of Nursing and Midwifery staffing levels Trust recruting to fill all HCSW vacancies 2022/2023 International nurse recruitment programme Second line Monthly performance meetings (PRM) review workforce reports Workforce Commitee receives updates on recruitment and retention issues. May 2022 Nursing and Midwifery Safer Staffing vacany report shows a deteriorating position on nursing vacancies following the annual planning cycle (from 73.85FTE to 188FTE) due to investment into clinical services. Quarterly Quality Report to Quality Committee and Board 6 monthly Hard Truths report to Workforce Committe and then Board of Directors (last reported 3rd March 2022) 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, 3.2.22.). From 1 April 2022 revert to previous arrangements with criteria established to trigger a further appraisal of current arrangements. Work completed in establishing CHFT compliance against the Winter 2021 preparedness: Nursing and midwifery safer staffing (NHS Nov 2021) which sets our 18 recommendations. Overall a positive position with work underway to provide assurance against the 18 recommendations. 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:** **March 2023**	Filling shifts is significantly challenging. Ward accreditation process updated Journey to Outstanding) which will include an assessment of staffing levels. Rolling out across all clinical areas over next 12 months. Plan to discuss safe staffing at the Quality Committee lead:Andrea Dauris, Associate Director of Nursing (Corporate) Ongoing	Initial: 4x4 = 16 Current: 4x5 = 20 Target: 3x3 = 9

Action	Timescales	Lead
To refocus nursing workforce on key deliverables of Time to Care	Mar-23	Andrea Dauris

Links to risk register:
Risk 6345 - nurse staffing risk

BOARD ASSURANCE FRAMEWORK
JUNE 2022
A WORKFORCE 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 JUNE 2022 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.	• Recruitment strategy for 2022-25 agreed. • OD Plan developed • Deployed a screening tool for values and behaviours as part of the onboarding process. • Board to agree Succession Planning approach which links to co-ordinated talent management pipeline programme including Empower programme and Enhance talent approach • Inclusive Leadership is one of the modules within our core Leadership Development programme. Each module is a three hour education session with action to implement practical application of the learning. Check in sessions will then be held to collate evidence of the application which will enable the organisation to monitor the growth of inclusive leadership. • Workforce Committee seeks assurance on recruitment, retention and reviews key workforce indicators • New recruitment microsite now in place • Focused recruitment and retention work through medical, nursing and AHP workstreams provides an opportunity to review traditional methods of recruitment which includes looking at alternative roles • 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. • Refreshed our values and behaviours • Clinical Director review complete with induction programme developed and now in place • Workforce design methodology developed to support with workforce remodelling. • 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 24/7 helpline for colleagues to receive support with their mental health including specialist psychological help if required • Well being hour and appointment of 50 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 roles across the Trust - see BAF risk 10a • Workforce Committee reviews key workforce indicators at its meetings • CHuFT Awards Recognition programme, 130+ nominations from a range of grades, Divisions and specialisms colleague to colleague nomination Second line Integrated Performance Report and Workforce Committee reports show Turnover of 8.28% Results of Medical turnover review discussed at Executive Board. Reduction in vacancies to 115.26 Revalidation report to Board. Talent Management framework to Board in July 2022. Third line GMC survey of trainees is positive, with CHFT having no negatively outlying results in comparison with other WYAAT trusts.	• Lack of comparative workforce data for medical and AHP staff groups compared to nursing, due to the delayed implementation of e-rostering. ACTION: Complete Medical roll-out by March 2023. • Review of inclusive recruimtent approaches ACTION: Complete review and further actions required to increase diversity		**Initial**	**Current**	**Target**
								4x4 = 16	**3x4 =12**	**3x3 = 9**
Actions					**Action, Lead, Timescales**			**Lead**		
Review inclusive recruitment approaches Complete roll-out of e-rostering for Medical and AHPs					31/12/2022 31/03/2023			Suzanne Dunkley David Birkenhead/Lindsay Rudge		
Links to risk register: None										

BOARD ASSURANCE FRAMEWORK
JUNE 2022
A WORKFORCE 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 JUNE 2022 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 / Quarterly Pulse Survey	• Refreshed People Strategy and values and behaviours • 4 Hot Houses per year • Spring and Autumn leadership conferences • 9 point plan for moving to a engagement score of 7 which is monitored by Workforce Committee. • HR Business Partners present monthly Divisional updates on Staff Survey actions to WOD. WOD Senior leaders challenge progress. • External validation of our staff survey action plans and reflecting on results. • Workforce and OD Engagement Team in place with a defined role and iterative activity programme. • Clear responsibility for colleague engagement in Assistant Director of HR portfolio. • Colleague engagement focused on listening events, friendly ear and supportive events to engage colleague offering over difficult few years. • Trust appointed 50 HWB ambassadors to engage with colleagues across all services areas. All have been trained in trauma support. • 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 • Weekly Communication to staff by Chief Executive with Q&A session: operational update(Mondays), CHFT LIVE meeting (Wednesdays), Chief Exeutive Update (Fridays) • Freedom to Speak Up (FTSU) resource - appointed clinical FTSU guardian so that colleagues who want to raise safety concerns feel more able to do so • FTSU Ambassador network is established. • Medical CHFT's Got Talent Awards • CHuFT awards • Wellbeing festival and appreciation day • Colleague engagement groups, now expanded to include following networks: Women's Voices, Armed Forces, Carers, International Colleagues in addition to REN network, Colleague Disability Action Group, Pride. Network chairs meet regularly to share best practice. • Community engagement post established in engagement team works with patients and communities and links to REN network, balancing colleague and patient experience	First line Monthly workforce monitoring meeting reviews all workforce data sets • Apprenticeship services assessed as GOOD with one area of Outstanding A43in July 2021 Second line Workforce Committee reviews progress with colleague engagte,ent with health and well being activities / programmes. PRMs monitoring roll out of staff survey actions. Third line Quarterly People Pulse survey/ national staff survey Investors in People accreditation - Silver award to 2021. CQC rating of Good for well-led domain	Pandemic response limiting visibility of and access for leaders and managers in service areas and contact with service teams. Action: Clarity about leadership and manager visibility Lead: Executive Team Colleagues in Operational areas have 1 hour a year to focus on development conversation. Action: refresh appraisal, host appraisal workshops, develop development for all brochure and communicate widely.	Lack of assurance of the progress being made with Divisional actions from Staff Survey results. ACTION: HR Business Partners present monthly Divisional updates to WOD. WOD Senior leaders challenge progress. Discussions at PRM.	Initial: 3x4 = 12 Current: 3x4 =12 = Target: 1x4 = 4

Action to address gap in control	Action and timescale	Lead
Clarity about leadership and manager visibility led by executive team. Refresh appraisal, host appraisal workshops, development for all brochure	June 2022 August 2022	Suzanne Dunkley all actions

Links to risk register:
No high level risk register related risks scoring over 15.

BOARD ASSURANCE FRAMEWORK
JUNE 2022
A WORKFORCE 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 JUNE 2022 Risk Category: Workforce Risk appetite: Low
1/22 Jue 2022	Workforce Committee	Executive Director of Workforce and Organisational Development	**Risk** Risk of colleague wellbeing deteriorating due to wellbeing priorities not being integrated throughout the organisation; embedded in our culture, leadership and people management. **Impact** - Ability to deliver transformational change compromised. - Potential to affect the quality of patient care. - Low staff morale. - Non–achievement of key Trust priorities	• Workforce and OD Wellbeing Team in place with a defined role and iterative activity programme so that promoting and supporting employee wellbeing is at the heart of our purpose. Healthy workplaces help people to flourish and reach their potential. • Clear responsibility for wellbeing in Assistant Director of HR portfolio. • Employee Assistance Programme through CareFirst • Friendly Ear Service • 50 Health and Wellbeing ambassadors to engage with colleagues across all services areas as investing in employee wellbeing can lead to increased resilience, better employee engagement, reduced sickness absence and higher performance and productivity • Health and Wellbeing Risk Assessment available to all colleagues. • Recruitment of a Workforce Psychologist currentl progressing. • Wellbeing festival held bi-annually.	First line Monthly workforce monitoring meeting reviews all workforce data sets Second line Sickness absence metrics reported to every Board meeting via the Integrated Performance Report. Quarterly metrics provided by CareFirst. Workforce Committee reviews progress on health and well being activities / programmes. Third line None	Difficulty in embedding the wellbeing hour in some areas. ACTION: Health and wellbieng fesitval asking colleagues to shape the future of the health and wellbeing apporach. SD to take options appraisal back to exec colleagues on 4 July 2022.		Initial: 3x4 = 12 Current: 3x4 =12 ! Target: 1x4 = 4

Action to address gap in control	Action and timescale	Lead
Clarity about leadership and manager visibility led by executive team. Refresh appraisal, host appraisal workshops, development for all brochure	June 2022 August 2022	Suzanne Dunkley all actions

Links to risk register:
No high level risk register related risks scoring over 15.

BOARD ASSURANCE FRAMEWORK
JUNE 2022
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 2022 Risk Category: Financial / Assets Risk appetite: Moderate**		
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 Business Case Approval Group, including forecasting and cash payment profiling. Prioritised capital programme. Historic delivery of the plan. Contingency set within annual plan Transformation Programme Board has 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 approved by NHS E/I 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. Actual costs for cladding are not yet confirmed Lead: Director of Finance	5 year capital plans submitted to ICS but allocation process is still to be agreed. Lead: Director of Finance Backlog maintenance costs will remain in excess of planned capital spend. No firm agreement reached with ICS for prioritisation of funds to cover cladding Price not yet agreed for CRH and remains subject to change Full Business Case 2023 Lead: Chief Executive, Director of Partnerships and Transformation and Director of Finance Treasury approval of reconfiguration business case	**Initial** **4x5 = 20**	**Current** **4x3 = 12**	**Target** **3x4=12**

Action	**Timescales**	**Lead**
Ongoing monitoring of financial position through Finance &Performance Committee and Board Continued pursuit of agreed ICS prioritisation of cladding	Ongoing Ongoing	Director of Finance all

Links to risk register: None

BOARD ASSURANCE FRAMEWORK
JUNE 2022
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 2022 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: THIS Commercial Strategy approved by Board September 2021 HPS Commercial Strategy approved annually at HPS Board Health Informatics Service (THIS) contract income for all customers approved and monitotred via quarterly contract review meetings Director of Finance monitors monthly budget performance Joint Liaison Committee for CHS - reviews overall CHS financial performance and reporting on commercial ventures, review of CHS commercial strategy	**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. Board review of HPS funding options 2021	HPS contribution from wholesaling reduced due to loss of key customer. Additional challenge from Contract Pricing Unit re: HPS access to NHS negotiated prices. Action: CPU to respond to report from DoF demonstrating implications if remove access to NHS prices and impact on contribution for all PMUs. HPS requires further capital investment to continue to grow. Action: National announcement of capital expected, bid for this prepared. Impact for HPS to be considered given agreed national direction for PMUs. Action: Details to be confirmed by national group before Trust can progress. Lead: Director of Finance Commercial Director not yet appointed, CHS Action to recruit (SS)	Report from CPU confirming position re HPS access to NHS prices. National capital not yet announced for Pharmacy Manufacturing Units Lead: Director of Finance External bodies to confirm timescale.	3x3 = 9	3x3 = 9 ←	3x2= 6

Action	**Timescale**	**Lead**
Ongoing monitoring of financial position through F&P and Board	Ongoing	Director of Finance
Explore future options for HPS, consider impact for HPS once NHS E/I confirms next steps for implementation of national strategic direction for Pharmacy Manufacturing Units	Ongoing NHS E/I (Chief Pharmacist) to confirm plans and timescales	Director of Finance Director of Finance
CHS to recruit Commercial Director	Autumn 2022	Managing Director CHS

Links to high level risk register: None

BOARD ASSURANCE FRAMEWORK
JUNE 2022
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 2022 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 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 working towards balanced financial plan for 2022/23 (June 2022) <u>Third line</u> Monthly return to NHS E/ I CRH Outline Business Case submitted November 2021	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.	System financial recovery plans being developed with Place partners Action: External resource to lead work Timescale: Completion of work Autumn 2022 Lead: Director of Finance	**5x5 = 25**	**4x4 = 16**	**3x4=12**
Action					**Timescales**			**Lead**		
System financial recovery plans to be developed led by external resource					Autumn 2022			G Boothby, Director of Finance		
Links to high level risk register risks: Risk relating to 2022/23 pending approval following review at Finance and Performance Committee in June 2022										

BOARD ASSURANCE FRAMEWORK
JUNE 2022
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 2022 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 (meets monthly) 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. Travel Plan in place to support more active travel, less car use and more car sharing Reconfiguration design and build principles led by a Sustainability design brief and overseen by Transformation Programme Board. Green Plan approved and in place The Green Planning Committee (with approved terms of reference) meets monthly, monitor progress against sustainability action plan, focusing on idea generation and initiatives to reduce carbon emissions, eg re-usable items. Quarterly update to Transformation Programme Board Funding successfully awarded through Salix Low Carbon Skills Fund for the development of the Trust's Heat Decarbonisation Plan. External controls - Environment Manager and MD of CHS connected into a range of West Yorkshire sustainability groups involving the WYCA, WYATT, Kirklees & Calderdale Councils.	First line Monthly monitoring of the Trusts energy consumption Quarterly Update on progress with Green Plan and Sustainability Plan to Transformation Programme Board Second line 1. Monitor against our Green Plan and Sustainability Action Plan (SAP) approved at 6 May 2021 Board meeting, following reviewed by Transformation Programme Board 8 March 2021. Submitted Green Plan to ICS. 2. Annual Board paper on sustainability/climate change, May 2022 Climate change sustainability brief for the reconfiguration agreed and taken to Board 5 November 2020 Third line Share energy data records with NHS E/I on new NHS energy data platform	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. Lead: Stuart Sugarman via Environmental Co-ordinator Timescale: June 2023	Developing a dashboard to monitor impact of the Green Plan Lead: Environmental Co-ordinator Timescale: 31.08.22.	4x4 = 16	4x2 = 8 →	4x2=8
Action					**Date**			**Lead**		
Review QIA procedure and business case applications re sustainability					Jun-23			Stuart Sugarman via Environmental Co-ordinator		
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
EPAU	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
DHSC	Department of Health and Social Care
IPC	Infection Prevention Control

	New risk
	Breach of risk appetite/ risk exposure
1-6	Low risk
8-12	Medium risk
15-25	High risk

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
AM	Andrea McCourt, Company Secretary
SS	Stuart Sugarman, Managing Director CHS
BB	Brendan Brown, Chief Executive
LR	Lindsay Rudge, Interim Director of Nursing
KA	Kirsty Archer, Deputy Director of Finance
ALL	All Board members

20. Governance Report

a) Change to the Trust Constitution

b) Appointment of Deputy Chair and Senior Independent Non-Executive Director

c) Use of Trust Seal

d) Board of Directors Meeting Dates 2023

e) Board of Directors Workplan

To Approve

Presented by Andrea McCourt

Date of Meeting:	Thursday 7 July 2022
Meeting:	Public Board of Directors
Title of report:	Governance Report
Author:	Andrea McCourt, Company Secretary
Sponsor:	Brendan Brown, Chief Executive
Previous Forums:	None

Purpose of the Report

This paper presents the following governance items to the Board:

a) Proposed amendment to the Trust Constitution
b) Appointment of Deputy Chair and Senior Independent Non-Executive Director
c) Use of Trust Seal
d) Board of Director Meeting Dates 2023
e) Board of Directors Workplan

Key Points to Note

a) Proposed amendment to the Trust Constitution

The Trust Constitution sets out the principles and processes that the Directors and Council of Governors follow, providing a corporate governance framework for the organisation. As situations change amendments can be made to the Constitution under section 44 of the Constitution. Any proposed amendments must be approved by more than half of the Council of Governors of the Trust voting approving the amendments (section 44.1.1.) and more than half of the members of the Board of Directors voting approving the amendments (section 44.1.2.).

The NHS Foundation Trust Code of Governance (July 2014), Section B Effectiveness, states that the Board of Directors should ensure it retains the necessary skills within its Board and Directors and works with the Council of Governors to ensure there is appropriate succession planning.

The Trust's governance arrangements include a Nomination and Remuneration Committee of the Board of Directors for Executive Director appointments and a Nomination and Remuneration Committee of the Council of Governors responsible for Non-Executive Director appointments. It is within the remit of both Committees to consider succession planning to ensure that an appropriate balance of skills and experience within the Board of Directors is maintained.

Following recent discussion of succession plans at these Committees, an amendment is proposed to the Trust's Constitution regarding an increase in the composition of the Board of Directors, which currently has six Executive Directors and seven Non-Executive Directors including the Trust Chair.

The proposed amendment is to increase the number of Executive Directors by one and the number of Non-Executive Directors by one. This would mean the Trust will have seven Executive Directors and eight Non-Executive Directors, including the Chair. The roles will provide capacity to support the Trust over the next five years areas across our Calderdale and Kirklees Places, provider collaboration development, the health inequalities agenda and

service transformation for community services, as well as ensuring that a Deputy Chief Executive is in place.

The proposals have been considered and supported by the respective Nomination and Remuneration Committees.

In line with the process for an amendment to the Constitution, the Council of Governors, at its meeting on 27 June 2022, considered and supported the following amendment to the Trust Constitution regarding an increase in Board composition:

24. Board of Directors – composition

24.1 The Trust is to have a Board of Directors. It is to consist of executive and non-executive directors.

24.2 The Board of Directors is to comprise:

24.2.1 a non-executive Chair;
24.2.2 up to 7 other Non-Executive Directors;
24.2.3 up to 7 Executive Directors.

The Standing Orders of the Board of Directors also detail the Board composition. Subject to approval of the change to the Board composition, the relevant section of these will be amended to reflect the change.

RECOMMENDATION

- The Board is asked to **APPROVE** the amendment to the Board composition within the Trust Constitution at section 24.2.2 and 24.2.3 as noted above, increasing the number of Executive Directors by one and the number of Non-Executive Directors by one and the same amendment to the Standing Orders of the Board Directors at section 1.2, Board composition.

b) Appointment of Deputy Chair and Senior Independent Non-Executive Director

The Trust's current Deputy Chair and Senior Independent Non-Executive Director, Richard Hopkin, ends his tenure with the Trust on 31 August 2022. The Board of Directors therefore needs to appoint another Non-Executive Director to this combined role from 1 September 2022.

The Trust's Constitution contains the following directions relevant to the appointment of a Deputy Chair and Senior Independent Non-Executive Director by the Board of Directors:

25.Board of Directors – appointment and removal of the Chair, Deputy Chair and other non-executive directors

25.1. The Council of Governors shall appoint a Chair of the Trust.
25.2. The Board of Directors will appoint one non-executive director to be Deputy Chair of the Trust. This individual may, through agreement with the Chair, take on the role of Senior Independent Non-Executive Director (SID).
25.3. The Chair and Deputy Chair will be the Chair and Deputy Chair of both the Council of Governors and the Board of Directors.

Section 15.1 of the Constitution additionally confirms that the Council of Governors shall ratify the appointment of the Deputy / Vice Chair at a general meeting.

The SINED role, as detailed in the NHS Foundation Trust Code of Governance (July 2014), section A.4.1. provides a sounding board for the Chair and serves as an intermediary for the other Directors when necessary. The senior independent director should be available to governors if they have concerns that contact through the normal channels of Chair, Chief

Executive, Finance Director or Company Secretary has failed to resolve, or for which such contact is inappropriate.

Proposed changes to the Code of Governance by NHS England / Improvement that are currently being consulted on advises that the Audit Committee Chair should not ideally be the Deputy Chair (section B2.5).

Following review and discussion with the Chair and Non-Executive Directors, it is proposed that Karen Heaton be appointed to the SINED and Deputy Chair role from 1 September 2022. With a new Chair from 1 July 2022 the appointment of Karen Heaton to the combined Deputy Chair / SINED role will help ensure Board stability, particularly amongst the Non-Executive Directors, as she has been with the Trust the longest, since March 2016. Karen Heaton's tenure has been extended to 27 February 2024, subject to satisfactory appraisal, at the Nomination and Remuneration Committee of the Council of Governors on 22 June 2022.

The Trust wishes to formally thank Richard Hopkin, who will stand down as Non-Executive Director, Deputy Chair and SINED for his contribution since he joined the Trust as a Non-Executive Director on 1 March 2016.

RECOMMENDATION: The Board is asked to **APPROVE** the appointment of Karen Heaton as Deputy Chair and Senior Independent Non-Executive Director from 1 September 2022.

c) Use of the Trust Seal

The Trust Seal has been used twice since January 2022, in relation to:

- the Lease, Lease Plan and License for Alterations for the Clock House, Elland
- the License to Alter at Broad Street Plaza, Halifax.

RECOMMENDATION: The Board is asked to **NOTE** the use of the Trust Seal since January 2022.

d) Board of Directors Meeting Dates 2023

The proposed schedule of meeting dates for 2023-24 is presented at Appendix M3 for approval.

RECOMMENDATION: The Board is asked to **APPROVE** the public Board meeting dates and Board Development Sessions for 2023/24 and note the venue and format of these meetings will be confirmed in due course.

e) Board of Directors 2022-2023 Workplan

The Board workplan provides the basis for the preparation of Board agendas for the coming year. Ad-hoc items and reports will be included on meeting agendas as necessary. The 2022/23 workplan at Appendix M4 is presented for approval.

RECOMMENDATION: The Board is asked to **APPROVE** the Board of Directors workplan for 2022/2023.

EQIA – Equality Impact Assessment

The content of this report does not adversely affect people with protected characteristics.

Recommendation

The Board is asked to **APPROVE** the:

- Change to the Trust Constitution
- Appointment of Deputy Chair and Senior Independent Non-Executive Director
- Board of Directors meeting dates and Board Development Sessions for 2023/24
- Board of Directors Workplan for 2022/2023

The Board is asked to **NOTE** the use of the Trust Seal during the last quarter.

CALDERDALE & HUDDERSFIELD NHS TRUST: REGISTER OF SEALING OR EXECUTIONS – REPORT FOR THE PERIOD JANUARY– JUNE 2022

CONSECUTIVE NUMBER	DATE OF SEALING OR EXECUTION	DATE OF AUTHORITY	DESCRIPTION OF DOCUMENTS SEALED OR EXECUTED PERSON	PERSONS ATTESTING SEALING OR EXECUTION
01-22	7 January 2022	7 January 2022	The Trust signature and seal for the Lease, Lease Plan and License for Alterations for the Clock House, Elland. The documents are a continuation of an Agreement To Lease signed in November last year. The Clock House, Elland is a new property leased to enable the relocation of the Rainbow Centre currently at Calderdale Royal Hospital as part of the reconfiguration approved via Programme Transformation Board.	NAME: David Birkenhead TITLE: Medical Director NAME: Brendan Brown TITLE: Chief Executive Date: 7 January 2022
02-22	8 March 2022	8 March 2022	The documents required Trust signature and seal for the License to Alter at Broad Street Plaza, Halifax. The works are to install a new flue but as they are outside of our demise therefore, we require a license from the landlord.	NAME: Jo Fawcus TITLE: Chief Operating Officer NAME: Brendan Brown TITLE: Chief Executive Date: 8 March 2022

Calderdale and Huddersfield NHS Foundation Trust

Public Board of Directors Meetings Dates Proposal for 2023-2024

Date	Time	Location
Thursday 4 May 2023	9:00 – 12:00 pm	Microsoft Teams Or alternate sites between Huddersfield Royal Infirmary and Calderdale Royal Hospital
Thursday 6 July 2023	9:00 – 12:00 pm	Microsoft Teams Or alternate sites between Huddersfield Royal Infirmary and Calderdale Royal Hospital
Thursday 7 September 2023	9:00 – 12:00 pm	Microsoft Teams Or alternate sites between Huddersfield Royal Infirmary and Calderdale Royal Hospital
Thursday 2 November 2023	9:00 – 12:00 pm	Microsoft Teams Or alternate sites between Huddersfield Royal Infirmary and Calderdale Royal Hospital
Thursday 11 January 2024	9:00 – 12:00 pm	Microsoft Teams Or alternate sites between Huddersfield Royal Infirmary and Calderdale Royal Hospital
Thursday 7 March 2024	9:00 – 12:00 pm	Microsoft Teams Or alternate sites between Huddersfield Royal Infirmary and Calderdale Royal Hospital

Bank Holidays 2023
Monday 2 January 2023 (New Year's Day)
Friday 7 April 2023 (Good Friday)
Monday 10 April 2023 (Easter Monday)
Monday 1 May 2023 (Early May Bank Holiday)
Monday 29 May 2023 (Spring Bank Holiday)
Monday 28 August 2023 (Summer Bank Holiday)
Monday 25 December 2023
Tuesday 26 December 2023

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Board Strategy Development Sessions
Proposal for 2023-2024

Date	Time	Location
Thursday 6 April 2023	9:00 – 12:00 pm	Microsoft Teams Or alternate sites between Huddersfield Royal Infirmary and Calderdale Royal Hospital
Thursday 1 June 2022	9:00 – 12:00 pm	Microsoft Teams Or alternate sites between Huddersfield Royal Infirmary and Calderdale Royal Hospital
Thursday 3 August 2023	9:00 – 12:00 pm	Microsoft Teams Or alternate sites between Huddersfield Royal Infirmary and Calderdale Royal Hospital
Thursday 5 October 2023	9:00 – 12:00 pm	Microsoft Teams Or alternate sites between Huddersfield Royal Infirmary and Calderdale Royal Hospital
Thursday 7 December 2023	9:00 – 12:00 pm	Microsoft Teams Or alternate sites between Huddersfield Royal Infirmary and Calderdale Royal Hospital
Thursday 1 February 2024	9:00 – 12:00 pm	Microsoft Teams Or alternate sites between Huddersfield Royal Infirmary and Calderdale Royal Hospital

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	4 April 2022	1 June 2022	19 July 2022	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*		✓		✓

DATE OF MEETING	5 May 2022	7 July 2022	1 Sep 2022	3 Nov 2022	12 Jan 2023	2 Mar 2023
Digital Health Strategy		✓ Deferred to September	✓			
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 (Annual Report)	✓Q1	✓Q2		✓ Q3
Safeguarding update – Adults & Children			(Annual Report)			✓
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			

DATE OF MEETING	5 May 2022	7 July 2022	1 Sep 2022	3 Nov 2022	12 Jan 2023	2 Mar 2023
Freedom to Speak Up Annual Report			✓ Annual Report		✓ 6 month report FTSU themes	
Public Sector Equality Duty (PSED) Annual Report						✓
GOVERNANCE & ASSURANCE						
Health and Safety Update	✓				✓	
Health and Safety Policy (May 2023)						
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	✓ *(TBC)*					
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	✓ QC ✓ F&P ✓ TPB	✓ Workforce	✓ARC			✓QC ✓ NRC BOC

DATE OF MEETING	5 May 2022	7 July 2022	1 Sep 2022	3 Nov 2022	12 Jan 2023	2 Mar 2023
Constitutional changes (+as required)	✓					✓
Compliance with Licence Conditions	✓					
Huddersfield Pharmaceuticals Specials (HPS) Annual Report				✓		
Fire Safety Annual Report		~~✓~~ Deferred to September	✓			
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 and Risk Committee Annual Report 2021/2022		✓				
Workforce Committee Annual Report 2021/22		✓				
Finance and 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)

21. Review of Board Sub-Committee Terms of Reference

a) Workforce Committee

To Approve

Presented by Karen Heaton

WORKFORCE COMMITTEE

TERMS OF REFERENCE

Version:	2.4 Amendments following review by Committee Chair and Director of Workforce and Organisational Development 2.5 Amendments following November 2020 review by Committee. 2.6 Director of Corporate Affairs added to core membership of the group.
Approved by:	Board of Directors
Date approved:	5 July 2018,
Date issued:	5 July 2018, January 2021, May 2021
Review date:	May 2022 May 2023

WORKFORCE COMMITTEE TERMS OF REFERENCE

1. Constitution

1.1 The Trust hereby resolves to establish a Committee to be known as the Workforce Committee ("the Committee").

2. Authority

2.1 The Committee is constituted as a Standing Committee of the Board of Directors ("the Board"). Its constitution and terms of reference are subject to amendment by the Board.

2.2 The Committee derives its power from the Board and has no executive powers, other than those specifically delegated in these terms of reference.

2.3 The Committee is authorised by the Board to investigate any activity within its terms of reference – it is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

2.4 The Committee is authorised by the Board to request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary.

3. Purpose

3.1 The purpose of the Committee is to provide assurance to the Board on the quality and impact of workforce and organisational development strategies and the effectiveness of workforce management in the Trust. This includes but is not limited to recruitment and retention, colleague health and wellbeing, learning and development, colleague engagement, organisational development, leadership, workforce spend and workforce planning.

3.2 The Committee will assure the Board of the achievement of the objectives set out in the 'A workforce fit for the future' section of the Trust's 10-year strategy.

3.3 The Committee may set up subgroups aligned to key areas of its activity as it deems appropriate.

4. Duties

4.1 The Committee is required to:-

4.1.1 Consider and recommend to the Board, the Trust's overarching Workforce Strategy and associated activity/implementation plan.
4.1.2 To obtain assurance of the delivery of the strategy through the associated activity/implementation plan.
4.1.3 To obtain assurance of the delivery of strategies and associated activity/implementation plans in relation to Equality, Diversity and Inclusion, Freedom to Speak Up, Staff Survey, education and training, leadership development, one culture of care
4.1.4 Provide advice and support on the development of significant workforce related policies .
4.1.5 Consider and approve strategies associated to the delivery of the Workforce Strategy
4.1.6 Consider and recommend to the Board the key workforce performance

targets for the Trust and

4.1.7 To receive regular reports to assure itself that key workforce performance targets are achieved and to request and receive exception reports where this is not the case.

4.1.8 Review the workforce risks of the high level risk register and the Board Assurance Framework.

4.1.9 Hold the Executive Director of Workforce and Organisational Development to account in relation to risk, risk mitigation and future activity/plans.

4.1.10 Receive reports in relation to internal and external quality and performance targets relating to workforce.

4.1.11 To conduct reviews and analysis of strategic workforce issues and to agree an operational response.

5. Membership and attendance

5.1 The Chair of the Committee is a Non-Executive Director and at least one other Committee member will be a Non-Executive Director. In the absence of the Chair, the other Non-Executive Director shall be nominated and appointed as Chair for the meeting.

5.2 The Chair of the Board of Directors shall not be a member of the Committee but may be in attendance.

5.3 Formal Committee meetings will be supported by at least four strategic sessions known as Hot Houses. Arrangements for the strategic sessions are set out in Appendix 1.

5.4 The core membership of the Committee is as follows:-

Two Non-Executive Directors, Director of Workforce and Organisational Development, Chief Operating Officer, Director of Nursing, Medical Director, Director of Finance, Director of Corporate Affairs, Company Secretary, Deputy Director of Workforce and Organisational Development, Workforce Business Intelligence Lead, Public Governor.

<u>The following may be requested to attend as required for specific agenda items:-</u>

Workforce and Organisational Development Assistant Directors and Human Resources Business Partners.
Staff side representatives.
Divisional Directors and Directors of Operations from each Division.
5 ‘free’ places to any member of staff, with a minimum of 3 apprentices.

5.5 A quorum will be four members and must include at least one Non-Executive Director and one Executive Director.

5.6 Attendance is required at 75% of meetings, Members unable to attend should indicate in writing to the Committee Secretary at least 7 days in advance of the meeting and nominate a deputy except in extenuating circumstances of absence. In normal circumstances any members who are unable to attend must nominate a deputy who is appropriately briefed to participate in the meeting.

5.7 A register of attendance will be maintained and the Chair of the Committee will follow up any issues related to the unexplained non-attendance of members. Should continuing non-attendance of a member jeopardise the functioning of the Committee, the Chair will discuss the matter with the member and, if necessary, select a substitute or replacement.

6. Administration

6.1 The Committee shall be supported by the Secretary, whose duties in this respect will include:-

- In consultation with the Chair develop and maintain the reporting schedule to the Committee
- Collation of papers and drafting of the agenda for agreement by the Chair of the Committee
- Taking the minutes and keeping a record of matters arising and issues to be carried forward
- Advising the group of scheduled agenda items
- Agreeing the action schedule with the Chair and ensuring circulation within 48 hours of each meeting
- Maintaining a record of attendance

7. Frequency of meetings

7.1 The Committee will meet quarterly as a minimum to carry out a deep dive review of workforce performance and metrics and quarterly to discuss strategic issues (Appendix 1).

8. Reporting

8.1 The Committee Secretary will produce and maintain a standard agenda; any additional agenda items must be sent to the Secretary no later than 10 working days prior to the meeting, urgent items may be raised under any other business.

8.2 An action schedule will be articulated to members 48 hours following each meeting and must be duly completed and returned to the Secretary for circulation with the agenda and associated papers.

8.3 The agenda will be sent out to the Committee members 5 working days prior to the meeting date, together with the updated action scheduled and other associated papers.

8.4 Formal minutes shall be taken of all Committee meetings. Once approved by the Committee, the minutes will go to the next Board meeting.

8.5 In accordance with the Committee reporting schedule, receive assurance from the Committee's sub-groups, currently the Education Committee. It should review reports and any associated recommendations, including actions to gain assurance of compliance and quality improvement.

8.6 A summary report will be presented to the next Board meeting.

9. Review

1.1 As part of the Trust's annual committee effectiveness review process, the Committee shall review its collective performance.

1.2 The terms of reference of the Committee shall be reviewed by the Board at least annually.

Appendix 1

The following is the proposed list of invitees to the quarterly strategic, Hot House sessions:-

Group one: Chief Operating Officer, Director of Nursing, Medical Director, Director of Finance, Director of Corporate Affairs and their Deputies plus any member of the Executive group with a special interest in the subject.

Group two: A maximum of 3 x Non-Executive Directors, 2 x Governors as invited by the Chair of the Workforce Committee.

Group three: Workforce and Organisational Development team members who lead on the 'hot house' topic plus Deputy Director of Workforce and Organisational Development, Workforce and Organisational Development Assistant Directors and Human Resource Business Partners.

Group four: Staff side representatives.

Group five: Network colleagues from colleague engagement network and BAME network.

Group six: a minimum of 3 apprentices.

Group seven: 5 'free' places to any member of staff who has a particular interest in the subject.

Group eight: national leaders in the subject field and/or representatives from best practice organisations.

Hot House topics will be determined at the end of the calendar year and can be subject to change as service need dictates.

22. Board Sub-Committee Chair Highlight Reports (Minutes in the Review Room)

- Finance and Performance Committee
- Quality 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 of meeting:	7 June 2022
Date of Board meeting this report is to be presented:	7 July 2022

ACKNOWLEDGE

- Recovery performance still largely on track with strong achievement on P2s and 104 week waiters and improved position on diagnostics
- Continuing strong performance on cancer metrics with all targets met in April
- Overall IPR score of 68% in April due primarily to Workforce improvements (albeit against new targets); some improvement noted in # neck of femur and DTOC position (currently down to 74)
- April result (£3.0m deficit) slightly better than plan and efficiency savings of £0.82m in line with budget
- Schemes now identified to meet total efficiency target of £20m for 22/23, with £16.2m fully developed.

ASSURE

- Review of Recovery Performance to end of April against revised trajectories
- Review of approach to 22/23 efficiency target from Effective Resources Group ('ERG') and progress to date
- Review of ICS / Place financial position to 30 April
- Review of BAF and High Level Risks attributable to F&P Committee
- Terms of reference for F&P (primarily replacement of Chief Executive by Director of Corporate Affairs on Committee) and new Access Committee approved
- Work Plan for 22/23 approved.

AWARE

- Continuing key performance issues including – stroke indicators, dementia screening, complaints closure, sickness absence
- High volumes and acuity of attendances in ED; only 73% achieved in April against 4 hour standard.
- Overall waiting list backlog and average wait times still a major challenge.
- Covid costs and agency spend ahead of plan in April; planned inpatient activity only 94% of budget – no ERF assumed
- BAF risk relating to commercial growth increased from 6 to 9 (relating to HPS) and HL risk on 22/23 financial performance agreed at 20.

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
Dates of Meetings:	16th May 2022, 20th June 2022
Date of Board meeting this report is to be presented:	7th July 2022

ACKNOWLEDGE

- Split Paediatric Service –Update on the development of paediatric pathways on both HRI and CRH sites, review of the associated risks in both ED and paediatrics. Work ongoing to formalise governance arrangements, Committee requested the review of the original escalation process for paediatric oversight of patients who are currently under the care of adult surgeons
- Received Quality Committee Annual Report 2021/2022
- Noted Learning from Deaths Annual Report and recommendations including increased focus on Learning Disabilities

ASSURE

- May Maternity Report – final Ockenden report published with 75 recommendations, initial RAG rating identified actions required and MDT action plan in development. Year 4 of the NHS Maternity Resolution Scheme relaunched in May with extended and additional requirements, although challenging CHFT should meet the requirements.
- Received overarching Maternity Transformational plan which puts together all elements of work being undertaken in maternity services. Regular progress reports to QC.
- Approved the process for the review and refresh of the Quality and Safety Strategy.
- Noted Quality Report April/May 2022 and Quality Priority updates
- Seven Day Service report- CHFT compliant with all key standards.
- Quality Outcomes Group report – oversight and scrutiny of the workstreams provided significant assurance of 10 workstreams, Limited assurance on the mental health operational group and End of Life Care, a focussed approach has now been agreed for this workstream.

AWARE

- Learning Disabilities Mortality Report shows a decline in care. A plan on a page to be presented to QC to also include the work being undertaken by the SI panel. It was noted that MDT engagement is required.
- IPR- stroke remains a concern with bed capacity for stroke patients, more work to be done internally.
- Quality Accounts 2021/22 reviewed and approved

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:	Tuesday 6 June 2022
Date of Board meeting this report is to be presented:	Thursday 7 July 2022

ACKNOWLEDGE

The following points are to be noted by the Board following the meeting of the Committee on 6 June 2022.

- EDI Strategy update demonstrated good progress with actions and work continues.
- The Committee recognised the excellent work in progressing the Apprenticeship Strategy and in generally the approach to "growing our own talent".
- The Committee recognised the significant improvement in the health and wellbeing offering and the positive response from staff during the pandemic.
- IPR- concern remains over the level of short-term sickness absence which is now showing signs of levelling off and the number of return-to-work interviews remains below target with further work planned to improve this. Sickness absence targets have been revised upwards to reflect reality which has the support of the Committee. Fire safety and data security training completion levels are low, and action is underway to address these.
- Age Profile- the Committee had requested a specific report on the age profile of the Trust which shows an aging workforce in general. The Committee requested periodic updates and any associated plans.
- Board Assurance Framework- Risk10/19 Medical Staffing. The Committee received a comprehensive report on progress against actions. The level of risk remains unchanged; however, the Committee were assured that a significant amount of work is being undertaken to address areas of concern. Update from BAME Chair was well received and the Committee welcomed the interaction with colleagues and extended an invitation to attend the committee to other staff networks.
- The annual FTSU report was presented (and will now be presented at Board) showing an increase in numbers but with the majority being in nursing and midwifery and anonymous.

ASSURE

The Committee continues to keep a close watch on the level of sickness absence and expects a continued improvement in the number of RTWs undertaken. BAF risk remains unchanged for Medical Staffing. It was noted that the Committee felt assured by the actions underway as presented in the detailed report.

AWARE
• Workforce metrics remain amber, and concerns remain over the sickness absence rate, return to work interviews (RTW) and Data Security Awareness and fire safety EST compliance. The wellbeing of the workforce is of continuing concern. • Excellent work being undertaken to improve engagement with the workforce and their development and progress with the EDI Strategy. • The Trust has an aging workforce.

23. Review of Board Sub-Committee Annual Reports 2021/22 - In the Review Room

a) Workforce Committee

b) Finance and Performance Committee

c) Quality Committee

To Receive

24. Items for Review Room

1. Calderdale and Huddersfield Solutions Managing Directors Report – June 2022

To Receive

Presented by Stuart Sugarman

25. Date and time of next meeting

Date: Thursday 1 September 2022

Time: 9:00 am

Venue: Microsoft Teams

To Note

Presented by Helen Hirst