Public Board of Directors

Schedule	Thursday 10 November 2022, 10:15 — 13:15 GMT
Venue	Forum Room 1A & 1B, Learning Centre, Sub-Basement, Huddersfield Royal Infirmary
Description	This meeting will take place in Forum Room 1A & 1B, Learning Centre, Sub-Basement, Huddersfield Royal Infirmary. The agenda and papers are made available on our website and in due course the minutes of this meeting will also be published.
Organiser	Deborah Melia

Agenda

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    Date: Thursday 12 January 2023
    Time: 10:15 am
    Venue: TBC, Calderdale Royal Hospital

1. Welcome and Introductions:

Gerry McSorley, Observer

Invited Public Governors: Robert Markless, John Gledhill, Stephen Baines, Brian Moore

To Note

Presented by Helen Hirst

2. Apologies for absence: Karen Heaton

To Note

Presented by Helen Hirst

3. Declaration of Interests

To Note

4. Minutes of the previous meeting held on 1 September 2022

To Approve

Presented by Helen Hirst

Draft Minutes of the Public Board Meeting held on Thursday 1 September 2022 at 9:00 am via Microsoft Teams

PRESENT

Helen Hirst	Chair
Brendan Brown	Chief Executive
David Birkenhead	Medical Director
Lindsay Rudge	Chief Nurse
Suzanne Dunkley	Director of Workforce and Organisational Development (OD)
Tim Busby **(TB)**	Non-Executive Director
Nigel Broadbent **(NB)**	Non-Executive Director
Peter Wilkinson **(PW)**	Non-Executive Director
Karen Heaton **(KH)**	Non-Executive Director
Denise Sterling **(DS)**	Non-Executive Director

IN ATTENDANCE

Anna Basford	Director of Transformation and Partnerships
Robert Birkett	Managing Director, Digital Health
Victoria Pickles	Director of Corporate Affairs
Stuart Sugarman	Managing Director, Calderdale and Huddersfield Solutions Ltd (CHS)
Kirsty Archer	Deputy Director of Finance
Andrea McCourt	Company Secretary
Jonathan Hammond	Director of Operations (on behalf of the Chief Operating Officer)
Diane Tinker	Director of Midwifery
Joanna Ambler	Community Midwife
Jason Eddleston	Deputy Director of Workforce and OD
Amber Fox	Corporate Governance Manager *(minutes)*

OBSERVERS

Stephen Baines	Public Elected Governor / Lead Governor
Gina Choy	Public Elected Governor
Nicola Seanor **(NS)**	Associate Non-Executive Director

114/22 Welcome and Introductions

The Chair welcomed everyone to the public Board of Directors meeting, in particular Jonathan Hammond, Director of Operations, Diane Tinker, Director of Midwifery, Joanna Ambler, Community Midwife and Jason Eddleston, Deputy Director of Workforce and OD.

The Chair also welcomed invited governors, Stephen Baines, Gina Choy, and observers to the meeting.

The Board meeting took place virtually and the recording will be published on our website shortly after the meeting. The agenda and papers were made available on the Trust website.

115/22 Apologies for absence

Apologies for absence were received from Jo Fawcus, Andy Nelson, Robert Markless, Gary Boothby and Brian Moore.

116/22 Declaration of Interests

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

117/22 Minutes of the previous meeting held on 7 July 2022

The minutes of the previous meeting held on 7 July 2022 were approved as a correct record.

OUTCOME: The Board **APPROVED** the minutes from the previous meeting held on 7 July 2022.

118/22 Action log and matters arising

The Board noted that there were no outstanding actions on the action log.

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

119/22 Chair's Report

The Chair updated the Board on the activity of the Chair since the last meeting. Focus has been on the Chair's induction and meeting with the Non-Executive Directors, Executive Directors, governors and colleagues at the Trust, taking part in the shortlisting of the first monthly CHuFT awards and attending Board Committee meetings.

The Chair informed the Board she has attended three Calderdale Cares Partnership Board meetings and is meeting with the Chairs of Trusts across West Yorkshire.

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

120/22 Chief Executive's Report

The Chief Executive set the context of the Board agenda which is focused on the three P's, the People, Performance and the Public Pound.

He drew attention to the enthusiasm and energy of colleagues during a sustained period of operational and clinical pressure and referenced maternity services which are under scrutiny doing the right thing for families and women.

He noted the significant political challenge being faced, with changes expected over the next few weeks. The Trust is reviewing their stakeholder map to review the implications to the organisation.

The Chief Executive highlighted the situation across the country affecting acute Trusts and health and social care organisations, including financial and workforce challenges. The Director of Corporate Affairs is leading a piece of work reviewing the key performance metrics for the current operating environment. KH agreed the performance report metrics produced may not all be required or needed as frequently. The Chief Executive stated this will be a national initiative and the Integrated Care System and Integrated Care Board have a clear set of metrics to monitor performance which may need to be mirrored in Trust reporting. The Board should expect a revised Integrated Performance Report with focus on key metrics at future Board meetings with a recommendation to the next meeting on 10 November 2022.

Action: Director of Corporate Affairs to share alongside the current performance metrics a recommendation of metrics monitored at future Board meetings that focus on priorities and key risks - 10 November 2022.

The Chair informed the Board that future Board agendas will try and focus more on strategy and our vision and direction for the future. The Board of Directors Development Session on 6 October 2022 will focus this and governance. The Director of Corporate Affairs stated the Trust need to utilise its governance process with the routes of accountability and scrutiny that are available to enable the Board to focus on strategy. The timings of when data is reviewed also needs to be considered alongside the new reporting arrangements with the Integrated Care Board to ensure the Board has the opportunity to

understand its own performance first. This will be worked through at the 6 October Board Development session.

TB expressed his full support of the approach and suggested defining the key performance indicators (KPIs) based on strategic issues. The Chief Executive added that the Trust could make greater use of benchmarking against regional and national performance data.

NS expressed her support of the simplification of KPIs and suggested the Trust should always strive to triangulate harder data with softer data to tell the story such as patient experience, patient stories, thematic themes, communication and information from Healthwatch.

NB offered his support as a Non-Executive Director for this review as he was previously responsible for performance management at the local authority.

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

121/22 **Maternity Patient Story and CHFT Response to the Ockenden Review**

Jo Ambler, Community Midwife shared a patient story with an emphasis on the professional and the family working together, multi-agency working and family centred care. The story relates to the Ockenden Review by illustrating how colleagues listen to women and families and involve women in decision making. The story focused on a pregnancy journey affected by substance misuse and the offer and support that was provided by the Trust.

Jo Ambler highlighted the support already being received by the couple before they entered the maternity service which was invaluable. She explained the multi-disciplinary team working was very effective throughout this pregnancy journey and the couple were very proactive taking on the help and advice being offered to them.

Continuity of carer was provided by Jo Ambler and Val Lunn, who were the lead midwives throughout the pregnancy and took part in home visits to plan the birth and provide individualised care.

Ellen Armistead, former Director of Nursing together with managers in maternity services supported the couple in terms of visiting hours after birth to support the bonding with baby. Jo Ambler confirmed the care has now been transferred to the health visitor and the baby and parents are doing well.

KH thanked Jo Ambler for sharing the story and stated it was important that the parents were working with the service and were very open and honest. She asked how important it was for the maternity service to join up with other services for their help and support. Jo Ambler confirmed the parents were accessing some of this care already prior to the pregnancy which was a good starting base.

The Chief Nurse formally thanked Jo Ambler for sharing this story which demonstrates the complexity of women and families and provides context to what the midwifery teams must do to manage complexities and work in partnership to join up services.

Diane Tinker, Director of Midwifery thanked Jo Ambler and the community midwives for the fantastic work they do which achieve great outcomes. She highlighted the importance of establishing safe relationships and explained there has been an increase in the complexity and vulnerability of women which requires the service to broaden their skills to provide the best care.

The Director of Midwifery presented a more general update on maternity services and the Trust's response to the Ockenden Review based on the report previously provided. The

presentation demonstrated how the service is aligned to the Trust's four pillars and demonstrates One Culture of Care and the Trust response to the Ockenden review. The report detailed a position statement regarding progress with immediate and essential actions from the Ockenden Review within the Maternity Transformational Plan. It noted positive feedback from a regional maternity team assurance visit on 28 June 2022, which assessed the Trust compliance against the initial seven immediate and essential actions form the first Ockenden report.

KH, Maternity Safety Champion congratulated the Director of Midwifery and the team for the incredible progress and highlighted the positive report from the assurance visit to the service which is a good news story.

The Chair asked the Director of Midwifery if there was one single thing we could do better not withstanding workforce issues and the Director of Midwifery responded it would be strengthening bereavement support and governance processes.

The Director of Corporate Affairs highlighted that there were over 200 actions in the Ockenden action plan that required returns and evidence collecting by the service to highlight to the Board the pressure and scrutiny on maternity services and management team who have continued to deliver. The Chief Nurse re-iterated this comment and added how important it was for us to support the service to deliver on all actions.

PW thanked the Director of Midwifery for the presentation and highlighted the number of incidents and complaints for June and July overall seemed quite low, he asked if this was a reduction throughout the year. The Director of Midwifery responded complaints have reduced over the past year; however, incidents are static as the maternity service are the largest reporter of incidents in the Trust as all incidents are reported and reviewed as part of maternity governance arrangements.

OUTCOME: The Board **NOTED** the Maternity Patient Story and CHFT Response to the Ockenden Review.

122/22 Health Inequalities Progress Report

The Director of Transformation and Partnerships updated the Board on activity and progress in relation to the current workstreams that support the Trust's ambitions to tackle health inequalities and noted key achievements of the four key workstreams to date.

PW asked if a review of the strategy commissioned by the Health Inequalities Group will be shared at the November Board meeting and confirm the areas of focus. The Director of Transformation and Partnerships confirmed a draft strategy is being presented to the next Health Inequalities Group and will come to the next Board meeting on 10 November 2022.

KH highlighted the good progress that has been made and asked how the Trust monitor how its construction partner IHP are delivering the social value asked of them. The Director of Transformation and Partnerships responded there is a Project Board specifically around the new build of the Accident and Emergency Department with a range of standing reporting requirements with particular targets around the social value action plan. Social value is one of the key benefits of the Programme.

Action: Director of Transformation and Partnerships to share the reporting information around social value with KH.

KH asked what the Integrated Care Board (ICB) are doing to maximise the limited resources in this area. The Director of Transformation and Partnerships responded there are a number of programmes of work at ICB level with investment funding. The Director of Transformation and Partnerships agreed to collate some information on this and share at the next meeting.

Action: Director of Transformation and Partnerships to collate what the ICB are doing to maximise the limited resources and provide investment funding and share at the next meeting.

The Chair suggested watching the videos on the ICB website on the impact and improvement events following two big inequalities conferences which demonstrate the impact to date.

The Director of Workforce and OD suggested the Board of Directors Development session on 6 October 2022 will be a good opportunity to discuss this further. She shared an update on the workforce health inequalities work and suggested the workforce health inequalities data is included in future reports which is used to refresh the People Strategy. The Director of Workforce and OD informed the Board the Trust will be joined by a BAME fellow from the Fellowship Programme across West Yorkshire who will have a specific task to review workforce health inequalities data and staff networks.
Action: Director of Workforce and OD / Director of Transformation and Partnership to include more focus on equality, diversity and inclusion (EDI) and Workforce Race Equality Standard (WRES) data in future health inequalities reports.

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

123/22 Recovery Update

Jonathan Hammond, Director of Operations provided an update to the Board on the recovery position which would be discussed in detail at the Finance and Performance Committee on 6 September 2022. The key points to note were included in the recovery slides presented.

The Chair asked about the confidence levels of turning the red areas to green for activity against the 104% plan. The Director of Operations confirmed there is confidence that the trajectory will improve based on the actions put in place, with a sharp increase in the number of extra lists in September 2022. Neurology is the most challenged specialty in the medical division and there has been some outsourcing for this service. However, there remains significant challenges for staffing levels and a retention exercise has taken place, with significant improvements in recruitment and retention for Surgery.

The Chief Executive stated the uncertainty of industrial action in the country will have an impact on elective recovery. The national position on elective recovery shows the West Yorkshire Integrated Care System lower down in the league table for elective recovery; however, within that, CHFT remains higher up, noting the challenges to maintain this position.

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

124/22 Month 4 Financial Summary

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

- Income and expenditure – year to date deficit of £8.44m, a slightly favourable variance from plan of £0.46m
- Operational pressures, including additional capacity requirements, continue to drive additional costs, offsetting the efficiency delivery programme benefit year to date and presenting a significant risk to the forecast delivery of the 2022/23 financial plan
- Agency expenditure year to date is £3.95m, £1.97m higher than planned. It is expected that the NHS Improvement agency expenditure ceiling will be set at our existing planned level based on the latest guidance

- Challenging position with an overall forecast planned deficit position of £17.35m
- Cash position is over £52m against a plan of £58.6m due to timings on payments of capital expenditure, the overall cash position remains healthy
- Capital forecast is expected to get back on plan

KH highlighted the Trust need to keep a close review on agency spend. She asked for an update on how the increase in energy costs is being factored in and if this will create more pressure. The Deputy Director of Finance responded the original plans factored in a level of increase in energy costs and the excess inflationary pressures were recognised nationally. This resulted in the £20m deficit reducing to a £17.35m deficit, as a result of the additional funding awarded nationally. There is unexpected pressure being forecast to the Calderdale Royal Hospital (CRH) site contract with greater challenge and pressure for the next year when energy contracts end. Work is being undertaken across WYAAT to draw together an overview of where these pressures are expected in energy bills.

TB suggested it would be helpful to see the quantification of risks in the forecast such as, inflation, PFI contract costs, Huddersfield Pharmacy Specials income and any opportunities and mitigations identified at any point in time.
Action: Deputy Director of Finance agreed to provide the additional information to the forecast on risks, opportunities and mitigations to TB.

TB highlighted that part of the Private Finance Initiative (PFI) contract has a retail price index (RPI) mechanism attached to it and asked if there was opportunity to renegotiate to a more reasonable inflation basis. The Deputy Director of Finance explained this has been an issue historically and is part of the overall deficit plan. There is no refinement or targeting of the way the funding is distributed nationally of those with PFIs or without PFIs.

NS asked how the Trust compares on agency spend with other organisations. The Deputy Director of Finance summarised actions that had taken place some years ago to reduce peak agency spend to stop using agencies and focus on bank and recruitment / retention. The agency trajectory is set in line with plan and is proportionately lower than other Trusts in the region. The Chief Executive suggested including where the Trust benchmarks, and the level of confidence based on the trajectories.
Action: Deputy Director of Finance to share where other organisations are with agency spend and where CHFT benchmark and include benchmarking and mitigations of the risks that are the Trusts in future reports.

NB re-iterated that the Elective Recovery Funding risk for the second half of the year depends on system performance rather than individual Trust performance therefore benchmarking information will be useful in the Integrated Performance Report and Finance report in future.
Action: Deputy Director of Finance to include benchmarking on performance across the system in future reports based on the criteria to meet the Elective Recovery Funding.

NB clarified that even if the plan is achieved, the cash position would stand at less than £20m at year end. The Deputy Director of Finance confirmed this and explained the cash position diminishes across the year due to the deficit position and the Trust have a significant capital programme. She reassured the Board the cash balance is significantly healthier compared to previous years and the year-end position for cash would be comfortable. With this ongoing trajectory for next year, the Trust would exhaust the cash for next year and would need to look at how this is managed across the ICB and what revenue support is available.

OUTCOME: The Board **NOTED** the Month 4 Finance Report and the financial position for the Trust as at 31 July 2022.

125/22 Progress with Staff Survey Action Plan

The Director of Workforce and OD presented the progress in implementing the actions identified in response to the Trust's 2021 staff survey results and the leadership commitments it made to embedding One Culture of Care. A more detailed action plan is overseen by the Workforce Committee. The next staff survey will launch in September 2022.

Information was shared on how members of the Board have contributed to embedding One Culture of Care. The Chief Nurse, as the Executive Sponsor for the Emergency Department shared feedback on how she is actioning One Culture of Care, for example regular drops ins, supporting staff to have conversations, regular meetings with the Clinical Director and General Manager, holding listening events in theatres and maternity, handing out appreciation cards and having compassionate conversations with colleagues.

KH added One Culture of Care is part of the Workforce Committee agenda and they are trying to integrate this into conversations. She added that the Trust are continuing tea trolley visits and she would like to see more activity around this visiting different areas.

DS highlighted the work of the Quality Committee and explained authors of the reports are asked to give thought to how the report supports and can evidence One Culture of Care.

KH commented that colleagues also need to make sure they identify and respond to behaviours and values which do not align with One Culture of Care.

Feedback from the Director of Operations was the One Culture of Care strapline has been helpful in having direct conversations with colleagues and staff have grasped this.

The Deputy Director of Workforce and OD has been involved in creating a 'how to guide' for Board members. He highlighted there is work required to ensure leadership activity and commitment to support One Culture of Care is captured better and fed into the staff survey planning year on year and influence the design and content of the People Strategy.

OUTCOME: The Board **NOTED** the progress with the staff survey action plan.

126/22 Health and Wellbeing Update

The Director of Workforce and OD presented a review of health and wellbeing activity undertaken since January 2022. The key points to note were:

- The Trust's enhanced colleague health and wellbeing support focuses on mental, physical, social and financial aspects
- The first wellbeing festival was held in May/June 2022 connecting with 400 colleagues
- An appreciation event was held in July 2022, 572 colleagues said thank you and/or
- confirmed their appreciation of others
- Through the wellbeing festival colleagues shared views about and confirmed they wish to retain the wellbeing hour
- Simplified guidelines to support wellbeing hour implementation are to be issued in
- September 2022
- The Trust wellbeing offer is being strengthened; it is aligned to our refreshed People Strategy
- Changes are being made to the health and wellbeing hour so that more colleagues can take it
- Feedback from colleagues who join the Trust has been that the Health and Wellbeing Strategy makes this organisation different and CHFT should be proud of this

KH highlighted the health and wellbeing offer is a way of showing the Trust cares and expressed her full support of this continuing. She asked about financial wellbeing and if the

Trust are promoting this. The Director of Workforce and OD confirmed a new financial organisation has joined the Trust to offer low interest rate loans. The Trust offers a car salary sacrifice scheme and is offering support to colleagues who spend a lot on fuel in the course of their work in advance payments as opposed to in arrears. The Director of Workforce and OD confirmed there is a big financial aspect of the health and wellbeing strategy; however, there is more to do here in light of fuel and energy increases.

DS shared the health and wellbeing champion in Pharmacy has been very effective and the role was valued within the service, she would like to see more health and wellbeing champions in most areas. The Director of Workforce and OD confirmed there are 125 health and wellbeing ambassadors across the Trust and they will try to ensure every area has a champion.

OUTCOME: The Board **ENDORSED** its continued support for colleague health and wellbeing and **NOTED** the health and wellbeing activity undertaken since January 2022.

The Chair provided the governors the opportunity to comment at this point on the Board agenda and share any observations. Stephen Baines stated one of the governors' responsibilities is to ensure the Non-Executive Directors challenge the Board of Directors and they do an excellent job of this. Gina Choy thanked the Board for the opportunity, she commented the vibe has been really positive, and the Board are innovative and have a very open and responsive culture which has come across in the meeting.

127/22 Freedom to Speak Up Annual Report

The Freedom to Speak Up Annual Report was received, but due to the absence of the lead for this area, it was agreed that a further discussion will take place at the Board of Directors meeting on 10 November 2022.

Colleagues were asked to submit any comments or questions on the Freedom to Speak Up Annual Report to the Company Secretary or Corporate Governance Manager in advance of the next Board meeting.

OUTCOME: The Board **RECEIVED** the Freedom to Speak Up Annual Report and **NOTED** a discussion will take place at the next Board meeting on 10 November 2022 with any questions submitted to the Company Secretary or Corporate Governance Manager in advance.

128/22 Director of Infection, Prevention and Control Q1 Report

The Director of Infection Prevention and Control (IPC) presented the Director of Infection, Prevention and Control Q1 Report. The key points to note were:

- Covid-19 has continued to have a significant impact on the Trust and the work of the IPC team with changing guidance
- Number of Covid-19 ward based outbreaks in all organisations which largely reflects community transmission rates
- Clostridium difficile rates are higher than previous years, also seen across many NHS Trusts; this may be due to the increase and treatment of respiratory infections associated with Covid-19
- Small number of outbreaks linked to clostridium difficile; however, the vast majority were sporadic cases and not an obvious outbreak
- MRSA outbreak on Special Care Baby Unit affecting a small number of babies which was managed effectively
- Quality improvement and audit work by the IPC team continues.

OUTCOME: The Board **NOTED** the performance against the Infection, Prevention and Control targets during Q1 (1 April 2022 – 30 June 2022).

129/22 Medical Revalidation and Appraisal Annual Report

The Medical Director presented the General Medical Council (GMC) revalidation and appraisal compliance for non-training grade medical staff for 2021/22.

There have been some challenges in relation to appraisal and revalidation of medical staff due to Covid-19 and the method of revalidation was paused for a year and is now resumed. A total of 94% of medical colleagues have been appraised, 5.3% were not required to complete an appraisal either due to long term absence, maternity leave or they recently joined the organisation. A total of 89 Drs have been recommended to revalidate and two were referred for more data to be gathered to make a positive revalidation.

The paper included a recommendation to the GMC and statement of compliance which the Board approved.

KH stated the completion rates have been excellent under the circumstances. She asked what the lack of engagement of three doctors meant. The Medical Director explained there were three doctors who had an unapproved missed appraisal and did not engage this year. KH asked if this impacts on revalidation and the Medical Director confirmed a conversation would take place with the GMC if this repeated which may result in the doctor not receiving a positive recommendation to revalidate as the GMC recommend a regular appraisal.

OUTCOME: The Board **APPROVED** the Statement of Compliance (Annex D) - A Framework of Quality Assurance for Responsible Officers and Revalidation (NHS, July 2021) and **NOTED** the contents of the report.

130/22 Learning from Deaths Q1 Report

The Medical Director presented the Learning from Deaths Q1 Report for 2022/23. The key points to note were:

- There is a lag issue that relates to report timing as the review may be undertaken a month after the patient death, therefore, it has been requested future reporting addresses the data lag
- During Q1, there were 411 adult inpatient deaths and 73 of these have been reviewed using the initial screening tool against a target of 50; however, this will not be a final number for Q1
- Learning from this is important to highlight any themes from these reviews and translate into the quality improvement programme
- This is a two stage process, an initial screening review and structured judgement review if any poor care has been identified, the medical examiner can refer into this process
- Any significant care issues identified are referred to the Serious Investigation (SI) process.

Action: Chair and Medical Director to discuss how the learning from deaths informs the Trusts improvement work.

OUTCOME: The Board **NOTED** the Learning from Deaths Q1 Report.

131/22 Safeguarding Adults and Children Annual Report

The Chief Nurse presented the Safeguarding Adults and Children Annual Report. The key points to note were:

- The Trust have maintained compliance with the requirements around Prevent
- The BAME Network have raised concerns around the Prevent Programme and the Trust are working with the Department of Health and Social Care around these concerns and meetings are planned to influence this at a national level
- Increase in complex mental health patients and substance misuse in adults and children, continue to review and monitor this in line with partners

- Work continues on the Hidden Harms agenda at Place level, with an increase in complexity during the Covid-19 pandemic
- Liberty Protection Safeguarding implementation has been deferred nationally with no date for this to go live at present
- Success story around the 'I was not brought' Policy and management of patients not attending has been noted as an area of good practice
- The service level agreement with South West Yorkshire Partnership Foundation Trust has been updated to ensure that mental health services provided to CHFT continue effectively
- There has been an increase in mental health issues in maternity and a weekly specialist maternity panel is in place for good governance
- The safeguarding team have maintained significant activity and response throughout the Covid-19 pandemic and has fulfilled its statutory safeguarding responsibilities

The Chair clarified that the same arrangements are in place for Kirklees and Calderdale, the Chief Nurse responded to confirm there is no difference between the two Places.

KH raised concern around the training element where there are reds. The Chief Nurse assured the Board there is now a different approach that will rectify this.

The Chair asked how the system as a Place will produce annual reports on safeguarding and if this would form part of the combined report. The Chief Nurse confirmed this annual report would be incorporated in the system report, except for children looked after, which is a separate report.

DS raised concern in case study one which shows good working across other agencies; however, asked how the approach used to request support from child and adolescent mental health services impacts on our pressure and capacity in the service. The Chief Nurse confirmed this is an ongoing challenge, the increase in children presenting into services is seen nationally. This is monitored on a case by case basis and the Trust are working with the Lead for Children and Young People from NHS England at a regional level to understand how to manage this and work differently as an acute Trust.

DS asked how the Trust is communicating that safeguarding is everyone's responsibility. The Chief Nurse responded there has been much more emphasis over the years on the importance of safeguarding and the Trust do well in this; however, there is always room for improvement.

OUTCOME: The Board **NOTED** the key activity of the Safeguarding Team for the reporting period April 2021-March 2022.

132/22 Quality Report

The Chief Nurse presented the Quality Report which has previously been reviewed by the Quality Committee. The key updates were:

- Progress and position provided against the three key quality account priorities – recognition and timely treatment of sepsis, reducing the number of hospital-acquired infections and reduce the waiting times for individuals attending the Emergency Department and the Chief Nurse and Medical Director have met with the leadership team of two of the three groups to track progress against targets at year end
- Challenge around infection prevention and control with predicted further waves of Covid-19
- OPEL status and challenges in the Emergency Department remain
- Overview of the focused quality priorities was provided with examples of progress
- Focus on end of life care continues

- Legal services are looking to incorporate learning from inquests, claims and Getting It Right First Time (GIRFT) into the new processes
- Incidents and lessons learnt from serious incidents – there were two further never events reported for the period of June and July 2022, four in total, two never events are historical events from July 2019 and June 2019 and recent never events dated May 2022 and February 2022. A meeting with the surgical division has taken place to review these and ensure lessons learnt and immediate action has been undertaken. One investigation is complete, two are due to be completed by end of September, one due to be complete by the end of October 2022. The Serious Investigation (SI) panel has oversight of these reports being completed.

The Chair asked for an update on the end of life care priority area. The Chief Nurse explained the leadership has been strengthened and the Associate Director for Quality and Safety now attends the Patient Safety Quality Board to support this workstream and is expecting this to improve to amber in the next report. The Chair asked for an update on the clinical prioritisation focused quality priority. The Medical Director responded there is a risk that patients are in the wrong priority who are not receiving care in a timely manner which results in patient delays and risk of harm in those groups. A validation and prioritisation piece of work is taking place for early intervention if needed with an unknown risk in this group.

TB asked how the Trust track all the lessons learnt and cross reference from incidents, complaints and freedom to speak up concerns to embed learning. The Chief Nurse responded that further work can be done to triangulate this.

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

133/22 Integrated Performance Report (IPR) – July 2022

The Medical Director presented the performance position for the month of July 2022 with an overall performance score of 58%, highlighting the key points which were:

- Steady deterioration from April to July 2022
- OPEL 3 heading into OPEL 4 due to high admissions into A&E and high bed occupancy rate and challenges in the Emergency Department are likely to continue
- Never events have deteriorated the position in the Safe domain, some being historical
- Missing some metrics previously met for stroke due to a high number of stroke patients being seen, with a number of actions in place to manage this
- Summary Hospital-Level Mortality Indicator (SHMI) has stabilised in the expected range; however, not where the Trust wants it to be, as previously the Trust had been in the best quartile
- Hospital Standardised Mortality Ratio (HSMR) has increased over the last year from a best quartile position and is heading towards an outlier position; the Deteriorating Patient Programme will aim to bring quality improvement activities together and start to see an impact
- Challenges remain around dementia screening; action plans and deep dives are in place to tackle this area
- Significant improvement in month on fractured neck of femur performance
- Cancer performance remains positive and best in the region

The Chair commented on the need for and benefits of a collective narrative on integrated performance.

PW highlighted the Integrated Performance Report does not include benchmarking or the economic and external environment which could help provide context to the report. The Chief Nurse confirmed this conversation has started.

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

134/22 Risk Appetite Statement

The Company Secretary presented the annual update of the Risk Appetite Statement for review which proposes a new process for assessing risks against risk tolerance and identifying areas of risk exposure to the Board. There were two minor changes highlighted in red.

TB did not feel the risk appetite for reputation was particularly high and suggested this should be moderate. The Company Secretary explained the context for setting the risk appetite for reputation as high when the risk appetite was first developed. The Director of Transformation and Partnership explained the original risk appetite was developed from specific Trust workshops based on the external environment at that time and it is now time to revisit this as the external environment has changed and the membership of the Board has changed. She agreed it was a good time to align this and understand what type of risk appetite will remain key to the strategy.

DS felt the new wording to the commercial risk appetite of "consider" new opportunities was passive and should become to explore new opportunities.
Action: Company Secretary to discuss the revised wording with the Director of Finance outside the meeting.

The Chair suggested a further discussion on strategy and vision takes place as part of the strategy refresh and an updated risk appetite is presented to the Board via the Board Assurance Framework on 10 November 2022.
Action: Updated risk appetite statement to be presented to the next Board on 10 November 2022.

OUTCOME: The Board **NOTED** the risk appetite statement and the process for determining risk tolerance and risk exposure and **NOTED** an updated risk appetite statement will come back to the Board on 10 November 2022 as part of the Board Assurance Framework update.

135/22 High Level Risk Report

The Chief Nurse presented the High Level Risk Report and explained the changes in the risk reporting process and consequent increase in the number of risks. The Chief Nurse and Director of Corporate Affairs will have oversight of this process moving forward.

TB stated it was not clear what the mitigations were for each of the risks. The Chief Nurse agreed some of this detail is in the risk register appendix, such as the gaps and assurances in controls; however, she agreed this needs to be clearer in the summary which will be part of the new report.

OUTCOME: The Board **APPROVED** the high-level risk report and note the ongoing work to strengthen the management of risks.

136/22 Governance Report

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

a) Non-Executive Directors and Board Committees
The Non-Executive Director membership by Board Committee as of 1 September 2022 was confirmed and a further discussion will take place in October and be presented to the Board meeting on Thursday 10 November 2022.

b) 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 workplan will be undergoing a review and development with the Chair and the Director of Corporate Affairs and a Board workplan for 2023/24 will be presented at the Board meeting on 10 November 2022 for approval.

OUTCOME: The Board **NOTED** the Board Committee membership for those Board Committees reporting to the Board with effect from 1 September 2022 and **APPROVED** the Board of Directors Workplan for 2022/23 and **NOTED** the Board of Directors workplan for 2023/24 is being reviewed and will be presented at the Board meeting for approval on 10 November 2022.

137/22 Review of Board Sub-Committee Terms of Reference

a) Audit and Risk Committee
The Audit and Risk Committee terms of reference required an annual review and were reviewed by the Audit and Risk Committee and approved on 26 July 2022. No changes to the terms of reference were proposed and the Board are asked to note that Nigel Broadbent will take on the role of Audit and Risk Committee Chair from 1 September 2022.

OUTCOME: The Board **APPROVED** the Audit and Risk Committee Terms of Reference and **NOTED** that Nigel Broadbent will take on the Audit and Risk Committee Chair role from 1 September 2022.

138/22 Board Sub-Committee Chair Highlight Reports
The Chair highlight reports were received for the following sub-committees:

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

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

139/22 Board Sub-Committee Annual Reports 2021/22
The Audit and Risk Committee Annual Report for 2021/22 was received in the Review Room.

OUTCOME: The Board **RECEIVED** the 2021/22 Audit and Risk Committee Annual Report.

140/22 Items for Review Room

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

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

- Audit and Risk Committee minutes of the meetings held 5 July 2022 and 26 July 2022
- Finance and Performance Committee minutes of the meetings held 5 July 2022 and 5 August 2022
- Quality Committee minutes of the meeting held 20 June 2022 and 18 July 2022
- Workforce Committee minutes of the meeting held 14 July 2022

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

141/22 One Culture of Care

The Director of Workforce and OD commented there was a good balance of discussion about people, performance and the public pound and the Board agenda was people focused.

Gina Choy thanked the Board for allowing the governors to observe the meeting.

142/22 Date and time of next meeting

The Chair formally thanked the Board of Directors, colleagues and governors for their attendance and closed the meeting at approximately 12:24 pm.

Date: Thursday 10 November 2022
Time: 9:00 – 12:00 pm
Venue: Venue to be confirmed

5. Matters Arising and Action Log

For Review

Presented by Helen Hirst

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC) 2022

Position as at: 3.11.22

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

DATE DISCUSSED	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
01.09.22 134/22	**Risk Appetite Statement** Company Secretary to discuss the revised wording to the commercial risk appetite with the Director of Finance outside the meeting. Updated risk appetite statement to be presented at the Board on 10 November 2022 within the update Board Assurance Framework.	Company Secretary	Agreed to use the word 'explore' rather than 'consider' for the commercial risk category following discussion with the Director of Finance. Action closed.	10.11.22		
01.09.22 130/22	**Learning from Deaths** Chair and Medical Director to discuss how the learning from deaths informs the Trust's improvement work.	Chair / Medical Director	Meeting being arranged	16.12.22		
01.09.22 124/22	**Month 4 Financial Summary** Deputy Director of Finance agreed to provide the additional information to the forecast on risks, opportunities and mitigations to TB. Deputy Director of Finance to share where other organisations are with agency spend and where CHFT benchmark and include benchmarking and mitigations of the risks that are the Trusts in future reports. Deputy Director of Finance to include benchmarking on performance across the system in future reports based on the criteria to meet the Elective Recovery Funding.	Deputy Director of Finance	To be covered within presentation of month 6 financial summary on 10.11.22. As above Update to be given by Chief Operating Officer	10.11.22		

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC) 2022

Position as at: 3.11.22

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

DATE DISCUSSED	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
01.09.22 122/22	**Health Inequalities Progress Report** Director of Transformation and Partnerships to share the reporting information around social value with KH. Director of Transformation and Partnerships to collate what the ICB are doing to maximise the limited resources and provide investment funding and share at the next meeting. To include more focus on equality, diversity and inclusion (EDI) and Workforce Race Equality Standard (WRES) data in future health inequalities reports.	Director of Transformation and Partnerships	At the November Board meeting the Trust's Population Health and Inequalities Strategy 2022 - 24 will be presented for approval. Progress and update reports in relation to the actions described in the Strategy will presented at future Public Board meetings including focus on the EDI and WRES standards. Information regarding West Yorkshire ICB work on Health Inequalities has been shared with Board members.	10.11.22		
01.09.22 120/22	**Integrated Performance Report – Recommendation** Director of Corporate Affairs to share alongside the current performance metrics a recommendation of metrics monitored at future Board meetings that focus on priorities and key risks.	Director of Corporate Affairs	Board Development – 6 October 2022	12.01.23		
07.07.22 106/22	**Board Assurance Framework – Update 1** Risk 5/20 - service capacity due to Covid-19 to be re-phrased to look more at recovery.	Company Secretary / Chief Operating Officer	Next BAF update due 10 November 2022. This action is complete.	10.11.22		28.9.22

6. Chair’s Report

To Note

Presented by Helen Hirst

7. Chief Executive’s Report

a) Report following the Independent Investigation into East Kent Maternity and Neonatal Services - Presented by Chief Nurse - additional paper to follow

b) Panorama Programme: Mental Health / Learning Disabilities Trust Response - Presented by Amanda McKie and Ian Noonan

To Note

Presented by Brendan Brown and Lindsay Rudge

Date of Meeting:	10 November 2022
Meeting:	Board of Directors
Title:	REVIEW OF THE INDEPENDENT INVESTIGATION INTO EAST KENT MATERNITY SERVICES (IIEKMS) REPORT - READING THE SIGNALS
Author:	L Rudge, Chief Nurse D Tinker, Director of Midwifery
Sponsoring Director:	L Rudge, Chief Nurse D Birkenhead, Medical Director
Previous Forums:	NONE

Actions Requested:

To note – the internal review of the Independent Investigation into East Kent Maternity Services report - Reading the Signals

Assurance – to assure the Board that effective systems of internal control are in place to review the findings, recommendations and further actions for CHFT in response to the independent investigation report.

Purpose of the Report

The purpose of the report is to provide the Board of Director's with assurance that the Independent Investigation Into East Kent Maternity Services (IIEKMS) Report - Reading The Signals has been reviewed and a provisional assessment against the findings has been undertaken by Calderdale and Huddersfield NHS Foundation Trust. The report will also provide an overview of further actions that will be undertaken and reported through the Trust's governance framework to the Quality Committee and then to the Trust Board.

Key Points to Note

Independent Investigation into East Kent Maternity Services report – Reading the Signals

Key Points:

- The investigation examined East Kent Hospitals University NHS Foundation Trust's maternity services in two hospitals, the Queen Mother Hospital (QEQM) in Margate and the William Harvey Hospital (WHH) in Ashford, between 2009 and 2020
- The report details that, over that period, the Trust provided clinical care that was "suboptimal" and led to significant harm
- The report shows that, during this period, there were multiple missed opportunities that should have led to these problems being acknowledged and tackled effectively
- Had care been given to the nationally recognised standards, the outcome could have been different in nearly half of the 202 cases assessed by the Panel.
- The outcome could have been different in 45 of the 65 baby deaths more than two-thirds of cases.
- The report acknowledges that the report includes "minimum estimates" of the frequency of harm, with the panel having only worked with families who volunteered to be involved in the report
- The panel has "not been able to detect any discernible improvement in outcomes or suboptimal care" in the decade between 2009 and 2020

Key Themes identified in the report

- Failures in teamwork
- Failures in professionalism
- Failures of compassion
- Failure to listen
- Failures around investigations
- Failures when responding to investigations

The report makes the following recommendations

1. Monitoring safe performance – finding signals among noise
2. Standards of clinical behaviour – technical care is not enough
3. Flawed teamworking – pulling in different directions.
4. Organisational behaviour – looking good while doing badly.

The key recommendation specifically for the East Kent Hospital Trust is to accept the reality of these findings; acknowledge in full the unnecessary harm that has been caused; and embark on a restorative process addressing the problems identified, in partnership with families, publicly and with external input.

CHFT provisional review

- Review of complaints and incidents within maternity and neonatal services 2020-2022
- Review of neonatal deaths and still births between 2020- 2022
- Review of freedom to speak up and actions undertaken
- Review of CHFT responses and actions undertaken following the Morecombe Bay report and the Ockenden report.
- Review of the Journey to Outstanding review of Maternity Services undertaken in 2022

EQIA – Equality Impact Assessment

The report sets out equality of access to maternity and neonatal care and this will be considered as part of the further review of the Trust's position.

Recommendation

The Board is asked to **NOTE** the findings from the report and the internal provisional review that has been undertaken.

To **APPROVE** the further actions required and reporting processes into the Quality Committee.

1. INTRODUCTION

On 13 February 2020 the Minister of State, Department of Health and Social Care (DHSC), confirmed in Parliament that, following concerns raised about the quality and outcomes of maternity and neonatal care, NHS England and NHS Improvement (NHSEI) had commissioned Dr Bill Kirkup, CBE to undertake an independent investigation into maternity and neonatal services at East Kent Hospitals University NHS Foundation Trust. The terms of reference were published on 11 March 2021.

The primary reason for this report was to set out the truth of what happened, so that maternity services in East Kent could begin to meet the standards expected nationally, for the sake of those to come. This report identifies 4 areas for action. The NHS could be much better at:

- identifying poorly performing units
- giving care with compassion and kindness

- teamworking with a common purpose
- responding to challenge with honesty

2. BACKGROUND

The investigation examined East Kent Hospitals University NHS Foundation Trust's maternity services in two hospitals, The Queen Mother Hospital (QEQM) in Margate. and the William Harvey Hospital (WHH) in Ashford, between 2009 and 2020.The report details that, over that period, the Trust provided clinical care that was "suboptimal" and led to significant harm. The report identifies that, during this period, there were multiple missed opportunities that should have led to these problems being acknowledged and tackled effectively. Had care been given to the nationally recognised standards, the outcome could have been different in nearly half of the 202 cases assessed by the Panel. The outcome could have been different in 45 of the 65 baby deaths more than two-thirds of cases. The report acknowledges that the report includes "minimum estimates" of the frequency of harm, with the panel having only worked with families who volunteered to be involved in the report. The panel has "not been able to detect any discernible improvement in outcomes or suboptimal care" in the decade between 2009 and 2020.

2.1 Key Themes

Failures in teamwork: The report refers to "grossly flawed teamworking among and between midwifery and medical staff."

Failures in professionalism: "Staff were disrespectful to women and disparaging about the capabilities of colleagues in front of women and families,"

Failures of compassion: "Caring for patients in any setting requires not only technical skills but also kindness and compassion. This is no less true for mothers and babies in maternity care," states the report. "Yet we heard many graphic accounts, from staff as well as families, that showed just how far from the required standards behaviour had fallen at the Trust."

Failure to listen: Which, "directly affects patient safety, as we found repeatedly in the Trust's maternity services, because vital information is ignored,"

Failures around investigations: "…there appears to have been a collective unwillingness to engage with families and a reluctance to invite them to contribute to investigations; some families were not even made aware that an investigation was taking place," explains the report.

Failures when responding to investigations: For example, one midwife recalled how, when new guidelines were introduced in response to incidents but no one explaining why: "Staff [weren't] involved in improvement plans and yet they [knew] what went wrong. They [knew]how it could be fixed but they weren't invited to comment."

3. NATIONAL REPORTS INTO MATERNITY SERVICES

3.1 Morecambe Bay

The Morecambe Bay Investigation was established by the Secretary of State for Health in September 2013 following concerns over serious incidents in the maternity department at Furness General Hospital (FGH). Covering the period January 2004 to June 2013, the report concludes that serious failures of clinical care led to unnecessary deaths of mothers and babies. The report drew attention to serious problems in 5 main areas:

- Clinical competence of a proportion of staff fell significantly below the standard for a safe, effective service. Essential knowledge was lacking, guidelines not followed and warning signs in pregnancy were sometimes not recognized or acted on appropriately.
- Poor working relationships between midwives, obstetricians and paediatricians. There was a 'them and us' culture and poor communication hampered clinical care.
- Midwifery care became strongly influenced by a small number of dominant midwives whose 'over-zealous' pursuit of natural childbirth 'at any cost' led at times to unsafe care.
- Failures of risk assessment and care planning resulted in inappropriate and unsafe care.
- There was a grossly deficient response from unit clinicians to serious incidents with repeated failure to investigate properly and learn lessons.

The DHSC approved a series of recommendations for development at Morecambe Bay (UHMB) and an action plan was produced. CHFT reviewed the UHMB action plan and considered local deficits and areas for improvement in light of the UHMB recommendations.

A local action plan was produced by the multi-disciplinary team. All identified actions have now been completed

The final update on progress of the CHFT Action Plan in Response to the Recommendations of the Morecambe Bay Investigation (Department of Health 2015) was taken to the Quality Committee in March 2016.

3.2 Ockenden Report Independent Review of Maternity Services at Shrewsbury and Telford

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 described 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 these. CHFT had an assurance review completed by external reviewers and met all 7 Immediate Essential actions. Further actions are being undertaken to address the 15 Immediate Essential actions in the final report and these have been presented previously to the board of directors to ensure oversight and assurance that these are being progressed

4. REVIEW OF INCIDENTS AGAINST THE THEMES FROM - READING THE SIGNALS REPORT

The governance team, in partnership with the Family and Specialist Services Division (FSS) governance team have undertaken a review of all incidents and complaints from 2020 to date and mapped against the themes. Further work will be undertaken to ensure actions from these are embedded. There have been a range of improvements made across the services which have been detailed within the Maternity Transformation plan. Progress against these improvements, as well as a report detailing any incidents and complaints is presented to the Quality Committee. The FSS governance team provide a weekly newsletter to share learning and any immediate actions from incidents and complaints.

5. FREEDOM TO SPEAK UP CONCERNS (FTSU)

All concerns raised around maternity are being addressed as part of the Maternity Transformation plan. The Maternity Transformation plan brings together the themes of the FTSU concerns with the findings and recommendations of the Ockenden Final report from the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust. The recommendations from the East Kent report will be included into the transformation plan. There have been a range of listening events across services to support colleagues to discuss concerns and enable supportive actions to be put into place to respond to these.

6. REVIEW OF STILL BIRTHS

The Quality Committee commissioned a review into still births following an increase in cases 2020-2021 and this was presented to the Committee in December 2021.

The review highlighted that there are no additional factors that have impacted on the increase in the number of still born babies over the 12-month period from October 2020. It is also recognised that the overall numbers are low when assessing statistical differences.

7. NEONATAL and STILLBIRTH DEATHS

All neonatal deaths and still birth deaths that occur at CHFT are reviewed at the weekly maternity governance meeting and a 72-hour timeline line presented at the Weekly Divisional Orange Panel meeting.

Following review at the panel meeting the neonatal deaths are graded to yellow investigation or escalated as an orange or red investigation. All Neonatal deaths that meet the requirement for referral to HSIB are referred as soon possible. A 72-hour timeline is still presented at the weekly divisional orange panel meeting to ensure any immediate learning or actions are undertaken

For neonatal deaths that occur outside of CHFT they are also referred to the Maternity Governance team via the Child Death Overview Panel Process (CDOP).

All neonatal deaths that met the criteria for the Perinatal Mortality Review Tool have had a multidisciplinary review.

Orange, Red and HSIB neonatal deaths

- 4 neonatal deaths were referred and accepted by HSIB for investigations, 2 of these were classified as orange and 2 as red.
- 2 HSIB investigations identified no safety recommendations and actions.
- 1 HSIB investigation identified learning, but this did not affect the outcome.
- 1 HSIB investigation identified recommendations

8. SUMMARY OF INTERNAL MATERNITY FOCUSED JOURNEY 2 OUTSTANDING REVIEW:

Both Acute and Community Maternity Services at Calderdale & Huddersfield NHS Foundation Trust were reviewed as part of the Journey 2 Outstanding (J2O) Review programme. The review was commissioned as a snapshot review of maternity services and was undertaken in June 2022 by a team of CHFT Colleagues.

The Journey 2 Outstanding Review has been developed with the aim to provide a 360-degree evaluation of the ward environment, workforce, patient safety and patient experience. The aim of the J2O Review is to give Ward Managers and their Teams the opportunity to showcase the Safe and Compassionate Care which is delivered to patients across the Trust every day. The framework is also designed to identify where extra support may be needed for services to ensure that they are on their Journey 2 Outstanding.

As part of the review Senior Maternity Colleagues, Medical Staff, Service Leads, Nursing staff and Health Care Assistant were interviewed. Onsite visits were initiated to Ward and Community areas, and a Medicines Audit was undertaken. The Observe & Act review was also run alongside the J2O and focused on patient experience.

Some noted areas of good practiced identified by the reviewers included:

"All staff could articulate patient pathways for this area of working. Recently implemented the Birmingham Symptom Obstetric Triage System whereby women are assessed according to their symptoms and allocated a colour code so that staff can see at a glance who needs to be prioritised. Staff have seen a reduction in women attending unnecessarily and women who require to be seen sooner are so. Good management - Co-Ordinator on the unit providing support - deploying staff where needed to keep flow progressing in the department. Good visibility of Ward Manager and staff feel well supported by management."

"Positive visit to the Maternity Assessment Unit - good practices that have recently been implemented with a positive effect on the woman's experience. Clear supporting information available for those attending Maternity Assessment Unit. Staff incredibly friendly."

"A pleasure to have a discussion with the service lead, very knowledgeable about her team and ward, she spoke highly of her team and the support she received from her matron and ADN and valued their daily visibility."

"I really enjoyed interviewing this afternoon. Service Lead came across as a compassionate, enthusiastic, and inspiring ward manager. She clearly enjoys working on the birth centre and managing a team that she is very proud of. She described a real learning culture and a can-do attitude within the unit where staff feel supported and not worried about raising any issues if they need to. It also felt like she inspires others to come up with ideas, innovate and develop the service. "

"The ward Manager greeted me on arrival to the unit. She was welcoming and keen to showcase her department. Very evident she well respected by staff I spoke to. Safeguarding was a particularly strong area for the staff. Staff confident in describing process and gave examples of typical cases. Good knowledge of support in place and SG lead for maternity. MDT working also came out as a strong theme. This was referred to in training, regular safety huddles and routes of escalation. Staff member described teamwork as aspect she was most proud of. Communication - lots of references to communication strategies such as huddles, alerts / flags. Responsive - good examples provided of how staff adapt management plans according to individual preference and risks. Number of references to keeping mother and baby safe.
Leadership - Staff spoke highly of ward manager and felt well supported. Good clinical presence from Matron on daily basis. Learning from complaints and incidents - good understanding of how reporting incidents and receiving complaints can result in learning. Staff confident in respect to IPC process such as their role, accessing information and promoting safe practice."
"Midwife was really sensitive to the needs of the women she was caring for throughout the antenatal clinic. She afforded them time, was really thorough, provided documentation to support information given and recorded care appropriately electronically. “

9. CONCLUSION

The report provides a high-level provisional review of the East Kent independent investigation and the provisional review against the findings undertaken at CHFT. Further work will be undertaken and a detailed review and report will be taken to the trusts Quality Committee.

10. RECOMMENDATIONS

- The Board is asked to note the findings from the report and the internal provisional review that has been undertaken

- To approve the further actions required and reporting processes into the Quality Committee.

Classification: Official

Publication reference: PR2099

To:
- Trust Chief Executives
- Trust Chairs
- ICB Chief Executives
- LMNS Chairs

cc.
- Regional Directors
- Regional Chief Nurses
- Regional Medical Directors
- Regional Chief Midwives
- Regional Obstetricians

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

20 October 2022

Dear colleagues

Report following the Independent Investigation into East Kent Maternity and Neonatal Services

Yesterday saw the publication Reading the Signals; Maternity and Neonatal Services in East Kent – the Report of the Independent Investigation.

The report sets out the devastating consequences of failings and the unimaginable loss and harm suffered by families for which we are deeply sorry.

This report reconfirms the requirement for your board to remain focused on delivering personalised and safe maternity and neonatal care. You must ensure that the experience of women, babies and families who use your services are listened to, understood and responded to with respect, compassion and kindness.

The experiences bravely shared by families with the investigation team must be a catalyst for change. Every board member must examine the culture within their organisation and how they listen and respond to staff. You must take steps to assure yourselves, and the communities you serve, that the leadership and culture across your organisation(s) positively supports the care and experience you provide.

We expect every Trust and ICB to review the findings of this report at its next public board meeting, and for boards to be clear about the action they will take, and how effective assurance mechanisms are at 'reading the signals'.

The report outlines four areas for action:

- To get better at identifying poorly performing units

- Giving care with compassion and kindness
- Teamworking with a common purpose
- Responding to challenge with honesty.

NHS England will be working with the Department of Health and Social Care and partner organisations to review the recommendations and implications for maternity and neonatal services and the wider NHS.

In 2023 we will publish a single delivery plan for maternity and neonatal care which will bring together action required following this report, the report into maternity services at Shrewsbury and Telford NHS Foundation Trust, and NHS Long-Term Plan and Maternity Transformation Programme deliverables.

The publication of the delivery plan should not delay your acting in response to this report and the actions you are taking in response to the report of the independent investigation at Shrewsbury and Telford NHS Foundation Trust. Immediate and sustainable action will save lives and improve the care and experience for women, babies and their families.

Yours sincerely,

Sir David Sloman
Chief Operating Officer
NHS England

Dame Ruth May
Chief Nursing Officer
NHS England

Professor Stephen Powis
National Medical Director
NHS England

Date of Meeting:	**10 November 2022**
Meeting:	**Board of Directors**
Title:	**Briefing Paper – BBC Panorama "Undercover Hospital: Patients at risk" and "Will the NHS care for me" – CHFT review and response**
Authors:	**Alison Edwards – Head of Safeguarding** **Amanda McKie – Nurse Consultant Learning Disabilities** **Ian Noonan – Nurse Consultant Mental Health**
Sponsoring Director:	**Brendan Brown – Chief Executive** **Lindsay Rudge – Chief Nurse**
Previous Forums:	

Purpose of the Report

This briefing paper is to provide to the Board of Directors the background to the two recent panoram a programmes, review the common themes highlighted by the programmes,
review CHFT current position, future plans and aid discussion with the Board of Directors
on further actions and recommendations that should be put in place.

Key Points to Note

Themes highlighted by both programmes:

- Serious concerns over the use of restraint and seclusion
- Abusive practices and a closed culture
- Repeated failures of NHS Trust to meet legal duties under Mental Capacity Act and Equality Act
- Failing to meet the legal requirements of the Mental Health Act
- Lack of awareness of the needs of people with learning disability
- Lack of awareness on how to care for people with complex mental health needs and Autism
- Not following policy and procedures or escalating via safeguarding or freedom to speak up process.

Please note CHFT current position within the paper and existing further actions taken.

We welcome a discussion with Board of Directors on could this happen here? How would we know? How Robust is the assessment of services and the culture of services? Are we visible enough to hear from patients, their families and to all staff on the ward?

We welcome a discussion with Board of Directors on areas for discussion and development.

EQIA – Equality Impact Assessment

Mental health and Learning disabilities come under the Health Inequalities agenda and are recognised Trust Priorities

Recommendation

Discussion at Board of Directors to discuss and agree CHFT action plan

Briefing paper – BBC Panorama "Undercover Hospital: patients at risk" and "Will the NHS care for me?" CHFT review and response

Introduction

The BBC Panorama programme "*Undercover Hospital: Patients at Risk"* showed patients being abused whilst in the care of an NHS Mental Health Hospital. The undercover footage highlighted alleged verbal and physical abuse of vulnerable patients with mental health problems and autism. The programme raised serious concerns about the harmful and dangerous practices including unnecessary restraint and seclusion, near mistakes with medication, falsification of observation records and verbal and physical abuse.

A further Panorama programme "*Will the NHS care for me?"* screened two weeks later, highlighted why people with a learning disability are more likely to die from avoidable causes than the rest of the population. It highlighted individual cases of people been denied life sustaining health care treatment, lack of understanding of the law, and stated that that continued failings of the NHS and the discrimination against people with a learning disability need to be addressed. Many National charities and organisations have called for the Government to take urgent action to address the health inequalities faced by people with a learning disability. Ending the programme, Actor and Activist Tommy Jessop said: "Now more than ever, people with a Learning Disability want to be heard, and we should be treated like everyone else."

Unfortunately, "*Will the NHS care for me?"* follows many damning reports over decades (as shared with the Board in the dedicated session on Learning disabilities in June 2021) and the more recent Learning from Lives and Deaths of people with Learning Disability and Autism (LeDeR) programme that has highlighted the significant health inequalities faced by people with a learning disability.

All Chief Executives of Mental Health, Learning Disability and Autism service providers were written to by the National Director for Mental Health to urgently consider findings uncovered by the programme and undertake assurance reviews within their own organisations. This briefing paper and the discussion at Board of Directors on 10th November 2022 is CHFT review, response, and any recommended actions.

Themes highlighted by both programmes

- Serious concerns over the use of restraint and seclusion
- Abusive practice and a closed culture
- Repeated failures of NHS Trust to meet legal duties under Mental Capacity Act (2005) and Equality Act (2010)
- Failing to meet the Legal framework of the Mental Health Act (2007)
- Lack of awareness of the needs of people with a learning disability
- Lack of awareness on how to care for people with complex mental health needs and Autism
- Not following policy and procedures or escalating via Safeguarding or Freedom to Speak up process.

Regional/National response

The recent state of Health Care and Adult Social Care in England 2021/22 stated a closed culture is a poor culture that can lead to harm, including human rights breaches such as abuse. It reinforced that the care of people with learning disability and Autistic people is still not good enough, and that health and social care providers need to do more to make their

services accessible. It is vital that everyone, inclusively, has good quality care, and equal access, experience, and outcomes.

The National Mental Health Team are considering what more can be done nationally, with regulators. They affirm that ways abuse is prevented is by registered staff taking accountability for theirs and other's actions, by teams who regularly review the quality of care they provide, by local leaders who support, challenge and role model, by senior clinicians and managers, who train colleagues and have an open door and by boards who have line of sight to data, complaints, other intelligence, who walk the patch and who create a safe environment for people to speak up about poor care.

CHFT current position

Current provision and good practice examples already in place at CHFT:

- One Culture of Care – our values and behaviours
- Freedom to speak up Policy, Freedom to Speak up Guardian and ambassadors
- Trust Policy and Procedures including Management of allegations against staff policy; Safeguarding Adults and Children policy, Learning Disability Policy including standard operating procedure, Restrictive Practice guidelines for children and adults, Mental Capacity Act Policy
- Safeguarding training and Safeguarding supervision
- Learning Disability awareness training an EST for all staff – 80% compliance since May 2022
- PALS/Complaints reporting which record protected characteristics
- DATIX reporting of incidents which record protected characteristics
- Safeguarding Committee and operational group, Patient Experience and Caring Committee, Mental Health Operational Group, Enhanced Learning Disability task and finish group, Mortality Surveillance Group
- Student nurse policy for escalating concerns in place in partnership with the university.
- Staff survey questions about culture and confidence to raise concerns
- Relationship with SWYPFT – MHLT/MHA papers receipt and scrutiny
- CHFT commitment to people with learning disabilities during reset and recovery – priortised on surgical waiting list, backlog and now 18 weeks for P3 and P4
- Learning Disability dashboard, KP+ data, learning disability data on IPR since April 2022, and on Outpatient Transformation Board data October 2022.
- Special needs Covid vaccination clinics 2021/22 for people with a learning disability
- People with learning disability on SIT REP report and ownership by clinical matrons
- Learning Disability care plan on EPR since June 2021
- Mental health patients awaiting a specialist bed on SIT REP report
- Senior clinical leadership from Nurse Consultants for Mental Health and Learning Disabilities
- Commitment from Trust on health inequalities for both learning disabilities and mental health
- Journey to Outstanding framework
- Observe and Act – we are actively recruiting people with learning disability to be involved
- Friends and Family test – protected characteristics

Existing further actions in place

The Nurse Consultant posts are new to the Trust and will provide senior clinical leadership and subject expert matter specialist in both learning disabilities and mental health. The roles will provide further education and training to the workforce with initiative in place already on the induction, nurse preceptorship programme and many other initiatives.

CHFT is piloting its first learning disability student nurses to the acute floor on an 8-week placement in November and has plans to look towards mental health student nurses in the future, with a robust evaluation in place regarding this. The workforce of the future is really key to this work for both pre-registration and existing staff and including medical and allied health professionals.

Safeguarding supervision is in place in the Trust but these needs widening and to include clinical supervision, especially for new starters and international nurses going forward, with a real focus in the learning and themes from the Panorama programmes.

The Trust commitment to learning disabilities and health inequalities as made great progress with some deep dive audits into DNA, Readmission rates, cancer data and some real improvement work and initiatives from this with expert by experience. A business case and job description has been developed for care navigator roles to ensure people with a learning disability have the right care at the right time and in the person-centred way they need, which will also ensure we meet our legal obligations needs progressing within the Trust.

CHFT is leading at a ICS level on supporting acute Trusts across the ICS on the quality of data and people with learning disability and the reset and recovery agenda.

Discussion and Recommendations

Whilst CHFT has a clear vision that together we will deliver outstanding compassionate care for our patients and one culture of care for our colleagues, and many examples of good practice, It is important for the Board of Directors to ask themselves:

- could this happen here?
- how would we know?
- how robust is the assessment of services and the culture of services?
- are we visible enough and do we hear enough from patients, their families, and all staff on a ward e.g., the porter, cleaner, HCAs?

Some ideas to consider.

<u>Leadership</u> –

Quality Monitoring visits are undertaken by non-executive directors and governors to provide an objective view of services provided by the Trust. In addition, there is a senior leadership visibility programme to provide a further opportunity for patients, carers and staff to share their experiences of Trust services.

Leadership training, particularly for Band 6 & 7 staff who may transitioned from team member to team leader as this may be a risk point for not being able to challenge the behaviour of former peers. Training to challenge poor practice based on Dignity in Care booklet and to meet expectation 4 of Right People, Right Place, Right Time guidance – to include managers and senior AHP.

Role modelling from Ward to Board – making sure our one culture of care is embedded into everything we do, and our leaders are visible to patient, carers and staff

How do we work with our partner organisations more closely when they have areas for concern with care providers/private hospitals, and more complex patients are coming back to area via transforming care programme (TCP)?

How do we develop further our existing good working relationships with partner organisations such as SWYFT, Kirklees & Calderdale, to ensure a joined-up response?

How do we look at capturing concerns within our reporting systems for care facilities for people with learning disability and mental health that we may not recognise as a care facility?

Do we need to consider the low-level reporting that does not meet threshold for a DATIX and create an “exceptions” record where “low-level” steps outside of our values and behaviour, that are successfully resolved locally, and where learning has taken place, are collated anonymously? This could then be reviewed to see if more training, support, or investigation were needed for a particular area, service, or theme where the cultural values and behaviour are not being consistently demonstrated.

We have a good system in place to act on reports or signs of abuse or neglect and staff receive safeguarding training. There may, however, be additional risks of diagnostic overshadowing for people with a learning disability or mental illness where the sign or symptom of neglect or abuse is attributed in some way to their disability or illness; and a risk of the person’s communication about abuse or neglect being not recognised or not believed.

Should we arrange additional ward and department visits – gaining a greater understanding of what it feels like to be on the wards. Specially to speak to ED and AF who have the most patients with learning disability and mental health

Should we send a staff survey to ask our staff how they feel about the learning disability training and what more training is required (survey Is ready and would welcome a Board response to go to all Trust Staff who are identified on EST), this could be replicated in mental health.

How do we ensure staff are aware of and use the Freedom to Speak process?

How do we review of current training offer and ensure staff understand their and colleagues’ professional boundaries? Do we need more training and what does this look like, given our current staffing pressures?

We look forward to Board of Directors discussion and will ensure action plans are in place to address CHFT response to the Panorama programmes and welcome being invited back for further discussion.

Calderdale and Huddersfield NHS

NHS Foundation Trust

CHFT review and response to *Undercover Hospital: patients at risk* and *Will the NHS care for me?*

Amanda McKie – Consultant Nurse for Learning Disabilities
Ian Noonan – Consultant Nurse for Mental Health
Alison Edwards – Head of Safeguarding

compassionate care

- “Now more than ever, people with a learning disability want to be heard, and we should be treated like everyone else”

- the undercover filming showed a “toxic culture” among staff of “corruption, perversion, aggression, hostility, lack of boundaries”

Themes highlighted by both programmes

- Serious concerns over the use of restraint and seclusion
- Abusive practice and a closed culture
- Repeated failures of NHS Trust to meet legal duties under Mental Capacity Act (2005) and Equality Act (2010)
- Failing to meet the Legal framework of the Mental Health Act (2007)
- Lack of awareness of the needs of people with a learning disability
- Lack of awareness on how to care for people with complex mental health needs and Autism
- Not following policy and procedures or escalating via Safeguarding or Freedom to Speak up process.

Current provision and good practice

Important questions for consideration

Could this happen here?

How would we know?

How robust is the assessment of services and the culture of services?

Are we visible enough and do we hear enough from patients, their families, and all staff on a ward e.g., the porter, cleaner, HCAs?

Areas for discussion and development

- Leadership visibility
- Quality monitoring visits
- Leadership training
- Role modelling *Ward to Board*
- Partnership working sharing causes for concern
- Partnership working developing and improving practice
- Exception reporting
- Professional curiosity and follow up of cues of concern in people with LD or experiencing mental illness
- Training needs and focus

8. Digital Health Strategy

To Note

Presented by Robert Birkett

Date of Meeting:	Thursday 10th November 2022
Meeting:	Public Board of Directors
Title:	5 Year Digital Strategy Annual Review (2 year)
Author:	Rob Birkett, Managing Director - Digital Health
Sponsoring Director:	Rob Birkett, Managing Director - Digital Health
Previous Forums:	THIS Divisional Board CHFT Finance and Performance Committee

Purpose of the Report

The CHFT Digital strategy was approved by the Board of Directors in July 2020. In creating the Digital Strategy, we engaged with over 300 stakeholders through workshop sessions, digital hothouses and one to ones, this was with both internal and external colleagues.

We are now into the 3rd year of the 5-year Digital Strategy, and this is the second annual review. We are proud of what has been achieved over this time, especially over the past year. This update aims to provide the Board and colleagues with assurance on the digital teams' ability to deliver on our objectives and provide a forward view on what is around the corner. We will continue to build on our foundations to ensure that CHFT is recognised as one of the most digitally advanced trusts in the country, digitally enabling our workforce and healthcare professionals to provide the best compassionate care to our patients and the people of Calderdale and Kirklees.

Our vision continues to be about "delivering outstanding compassionate care to the communities we serve" with digital being the key enabler in supporting clinical and non-clinical colleagues to provide that care to all our patients, as well as digitally empowering patients to be involved in that care. It is fundamentally important that the Digital Strategy continues to align with "one culture of care" in that we support and empower patients and colleagues on their own digital journey.

Whilst we have successfully delivered many projects there is further work still to do in making sure our digital solutions are fully adopted by Trust colleagues. Digital needs to become mainstream for everyone and we need everyone to become an ambassador for digital in their own right.

Our core Digital Strategy principles are still valid today, we will aim to continue to:

- Improve the reliability and quality of clinical care to support early discharge of patients
- Improve adoption/optimisation of current systems
- Make available an integrated care system
- Give patients control over their care
- Ensure our corporate divisions are digitally enabled to support compassionate care
- Support the sustainability agenda
- Support strategic systems decision making and future planning

What we said we would do:

In the Digital Strategy we laid out what our aims were around a number of priorities and the positive impact they would have for colleagues and patients. The key points outlined in this paper show the progress we have made within 2021-22.

Priorities	We will do this by	This will result in:
Digital technologies to improve the quality and reliability of clinical care	• Providing "real time" patient records and care plans • Reduce the number of standalone IT Systems • Remove the need for paper from board to ward	✓ All relevant clinical information through a single access point ✓ Right access; right information correct? ✓ Effective alerting prompts across multiple pathways ✓ Improving patient safety
Digital technologies to support early discharge of patients	• Reviewing current systems/processes • Remote home monitoring	✓ Improve Patient Satisfaction ✓ Improving the quality of care for the patient
Adoption/Optimisation of current systems and hardware	• Showcasing areas of good practise • Supporting areas to adopt/optimise current systems	✓ Efficiency gains in utilising established digital offering ✓ Reduced reliance on face to face patient and clinical interactions
Make available to our staff an integrated healthcare system across the Integrated Care System (ICS) and beyond	• Identifying opportunities to increase interoperability across systems	✓ Improved and more timely clinical information ✓ Reduce patient risk
Giving patients control over their care and protecting privacy	• Enhancing Virtual Consultations • Promoting and enhancing access to the Patient Portal and self-care advice	✓ Improve Patient/carer's and relatives experience ✓ Improving quality and reduce patient risk
To ensure our corporate workforce are digitally enabled to support clinical care through responsive and up-to-date technology	• Utilising digital collaboration tools • Provide the necessary hardware to support • Review of our corporate systems	✓ Continue and Improve Agile Working capability ✓ Reduction of travel between sites
Support the sustainability challenge	• Use Artificial Intelligence to predict • Utilising collaboration tools for patients/colleagues • Review our finances, and workforce process and systems	✓ Reduction in travel amongst the communities we serve ✓ Protecting our environment and reducing carbon footprint ✓ Reduce pressure on our estate

Key Points to Note

Progress against the CHFT Digital Strategy: The key messages from 2021/22 are:

Scan4Safety:

- Point of Care Test EPR Integration – Ensuring results (inc blood/gas/glucometer/ketone etc) are captured and fed directly into Cerner. This makes access to patient results immediately available to all clinical staff involved in patient care.

- 5 Omnicell fingerprint access to electronic medicines cabinets (LDRP, ED and ICU) – safer medicine storage, saving staff time looking for keys, reduction in medication errors as the meds dispensed are recorded against the named patient and only the relevant meds drawer opens with illumination to show the prescribed meds location. Resulting in improved safety and reduction of errors. This also saves time for nursing and pharmacy staff when checking the medicines cabinets as only opened draws need to be checked and restocked.

- Closed loop milk system in maternity - Ensuring that mothers' milk is labelled and scanned before being given to the baby; this reduces the risk of the wrong milk being given to a baby, reducing errors.

- 350 temperature monitoring units – Digitally taking the temperature of the meds fridges each hour. Providing an hourly audit trail of meds fridge temperatures, with alerts for temperature excursions. Efficiency and safety through clinical colleagues not having to manually record temperatures on paper each day.

Integration:

Integration continues to be challenging due to supplier engagement and the complexity of multiple resources however, progress has been made over the last 12/18mths in some key areas:

- Point of Care Testing (POCT) - Integration with EPR is now complete, significantly improving the safety of our patients through availability of data and reduction of transcription (patient story relating to this is available for distribution with a 'Go-see').

- Electronic Controlled Drugs Register - Ordering CDs is processed and dealt with quicker meaning less chance of missed or delayed doses for patients. Reduction in cost for ordering CD registers and order books. CQC compliant making sure all errors are dealt with in a timely manner and enforces accurate documentation in the CD register.

- E-consent – A digital consenting process is enabled for the Trust and in use in orthopaedics. The digital consent record is stored in EPR for ease of reference and supporting information emailed to patients and carers to support decision making. Roll-outs to other areas to be started this year.

- EMIS Pharmacy EPR Integration – This first of type integration between EMIS and Cerner has removed manual transcribing in pharmacy, improving patient safety by reducing errors and supporting faster processing of orders and support of TTOs. Well received on wards as easy to use and saves nursing time and aids discharge.

- Yorkshire Ambulance Service Transfer of Care Integration – CHFT have agreed and progressed work with YAS to develop the integration of the patients' vital signs directly into EPR whilst on route to ED. This will aid both triage and flow whilst also providing some efficiency. This is only the second project of this type in region and the first into an Oracle/Cerner EPR.

- Work has progressed on connectivity to the YHCR (Yorkshire and Humber Care Record) as both a provider and consumer of data. Completion is expected spring 2023.

Digital Projects and Initiatives:

- Nervecentre solution on Zebra devices in ED – Improving the quality, safety and timeliness around patient observations whilst clearly recognising the deteriorating patient. Patients who need them will receive observations and have them recorded contemporaneously and patients who don't need regular observations can be placed on appropriate models to reduce nursing workload. The solution also alerts staff to a high observation scores prompting actions and escalations in both nursing and clinical teams.

- EPR code upgrade – We continue with our yearly upgrade to EPR which keeps the system up to date and allows the implementation of new improvements as well keeping the base safe on a key critical system. The last code upgrade in early 2022 was successful with the next upgrade due in Nov 2022.

- EDDI Emergency Department booking system – This solution was successfully implemented after a national mandate during the pandemic. As the functionality has aged there is a now a new solution to replace this direct into our EPR using the national BaRS (Booking and Referral System) approach.

- Maternity Community Shared Care Record – The first in region to submit data, we now share maternity data into the YHCR around pregnancy and birth information. This will add to the wider data sets in a move towards place and region based data sets.

- Canon printer upgrade – The upgrade has replaced the original set-up from 2017 with current infrastructure and a more robust solution. This has also enabled more granular control of colour printing and enhanced reporting, resulting in better management and a reduction of printing spend.

- Refresh of Community Division digital hardware – In order to support efficient patient care and an improved colleague experience, all laptops requiring a refresh due to either age or specification have been replaced. Mobile phones have also been replaced with a clinical grade mobile device with enhanced features for staff safety, better IPC and device support.

- Plan for Every Patient (Linked to Digital White Boards) – Two areas of focus have been piloted (Ward 5 and Acute Floor) with a project in place to rollout across the Trust. The first is an improved section in EPR for the full MDT to be able to review, access and action the nursing and clinical teams 'must do's at the ward level. The second part is the digital enabler for this project which is the hardware (Digital Whiteboards on walls). The key to this project is the Change process to guide and educate the new ways of working by going to see the staff and help support at the elbow.

Core Infrastructure:

Cloud Provision - The Trust is now connected to a CHFT instance within Microsoft Azure (Cloud) by resilient network connections from both hospital sites. The development servers have been tested successfully and work has commenced to identify those services best placed to move to the CHFT Cloud. This is foundational work and will give the Trust options in the future that don't require costly new data centres as part of the reconfiguration of services.

Network Attached Storage – A change in the technology we use for network storage. The capital investment has enabled us to reduce the physical space required from 4 large cabinets to 2 small devices. This has in turn reduced both power and cooling requirements by approx £80k per annum.

CRH Network upgrade/refresh – All new network edge devices have been installed across the CRH site resulting in increased security (DSPT), manufacturer support and lower power consumption.

WiFi network refresh – Higher bandwidth, better coverage and more features including Real Time Location Services (e.g. for tracking equipment) and the ability to support the Internet of Things (IoT).

End user devices – Rolling program of end user equipment replacement including PCs and Laptops based on specification and device role rather than age.

Mobile Handheld Zebras for community – Replacing all mobile phones with newer Zebra devices. This will introduce a safe lone working mechanism, remotely supportable devices, increased security and MS Teams capability.

MS Teams Rooms (Hybrid Working) – Procured (not installed, Nov 2022) 30 devices to enabling a mix of face to face and remote teams attendance in meeting rooms, replacing legacy Cisco video conferencing technology.

Business Intelligence and Health Inequalities:

Following a history of some pioneering work around identifying and improving Health Inequalities by CHFT we continued to progress in 2021/22.

- The development of a Health Inequalities Vulnerability Matrix (VM) to support clinicians and patients through early identification of those patients in our care who may be vulnerable. This will help to facilitate early intervention resulting in better planning and outcomes. Currently being developed for Rheumatology with plans for further rollout across services.

  This only scratches the surface of what could be possible through this approach and will be a specific focus throughout 2022/23 for the digital teams given the potential benefits to patients and the possibility of reshaping patient care from the learning.

- Future work on predictive analytics has been progressed in several areas. The first been around national mortality indicators enabling more real time decisions when reacting to mortality trends and proactively anticipate mortality alerts. The second is around anticipating future covid admission numbers, aiding patient flow planning in the Trust. This is also an area we hope to see growth in over the next few years as business intelligence evolves.

- The Business Intelligence teams have played a significant role in shaping the areas of focus for both clinical and operation staff by using SPC (Statistical Process Control) to present Trust data. This is well highlighted in the work completed on supporting the challenges of elective recovery and emergency patient flow introduced in CHFT mid-2022. Senior analysts provide a wealth of expertise in supporting the services understanding BI though KP+.

- The Trusts Business Intelligence Platform Knowledge Portal plus (KP+) has seen many new developments.

  These include a functionality addition called 'write-back' to do data collection direct into KP+ and improved step change reporting with Statistical Process Control SPC charting.

  Also, several new KP+ dashboards have gone live including Complaints and OPEL (Operational Pressures Escalation Levels) saving hours per week of administrative burden for clinical staff.
  KP+ is seeing a year on year growth of both data been entered but also access by clinical and operation colleagues. Due to this, In September 22 KP+ models were accessed over six thousand times.

  New data sources accessed include the 'Plan for Every Patient Digital' whiteboard information. The handover and action plan status information is critical in supporting drives to increase patient flow.

Reconfiguration:

All the work undertaken within the projects and programmes outlined in this paper is supporting the Trust in becoming digitally ready for reconfiguration.

- Digital is a key part of all the Target Operating Model (TOM) sessions as well as undertaking a dedicated digital TOM to feed with wider digital and technical opportunities into the process.

Health Information and Management System Society (HIMSS):

Whilst the digital developments over the last 12 months highlighted in this paper have significantly improved our position in relation to HIMSS EMRAM (Electronic Medical Record Adoption Model) we continue to be at a HIMSS level 5.

It has been a long-term ambition for the Trust to reach level 6 and we have therefore commissioned a revised gap analysis in order to achieve HIMSS Level 6 EMRAM in spring 2023 with a focus on further closed loop technologies (specifically meds) which will result in significant safety improvements for patients and a reduction in serious incidents.

Plans for progress against our other HIMSS models will also continue with a real focus on the AMAM model as the availability of data, how it is being shared and its ability to predict and shape patient care grows quickly.

Our current position:

- Electronic Medical Record Adoption Model (EMRAM) – 5
- Infrastructure Adoption Model (INFAM) – 4
- Analytics Maturity Cumulative Capabilities – (AMAM) rated 4

Digital Governance:

- The governance as described in the strategy is in place and working

- Division Digital Boards are now embedded and the right conversations are happening within the divisions on a more local level. These Divisional Boards continue to feed into the CHFT Digital Operations Board, and whilst working well, we are looking to improve attendance and contribution.

- Investment decisions are supported by robust business cases and key stakeholders from across the Trust. All business cases are now approved and monitored through the Business Case Approvals Group (BCAG)

- We were once again able to submit a return of compliance to the Data Security and Protection Toolkit (DSPT). As the toolkit had tightened its requirements this year, some capital investments played a part in us being able to achieve this.

- CHFTs Digital provision also recertified to 4 key standards again in 21/22:

- Cyber Essentials – National Cyber Security Centre
- ISO9001 (Quality Management)
- ISO20000 (IT Service Management)
- ISO27001 (Information Security Management)

Digital Capability:

- We have continued to reshape our digital capability through ringfenced budgets for technical training to ensure our digital teams are skilled in the most up to date technologies and thinking.

- We have increased our capability, skills and capacity through the development of an Assistant Chief Technology Officer (ACTO) role. Supported by new technologist roles specialising in Cloud, O365 and Connectivity with a view to add Integration Specialist to the team in the coming months.

- We have re-established the Digital Health Team with a new CCIO (Chief Clinical Information Officer) and Programme Manager to support our CNIO (Chief Nursing Information Officer) and Digital Operational Lead roles

- Capacity within the EPR Support Team remained challenging as the team were carrying a number of vacancies during 21/22 which have now been filled. We are still under represented in some skill sets including in-house M-page developers resulting in higher costs through contracting for some work packages.

Optimisation Plan

The Optimisation Plan in its full sense has been paused due to affordability however, we continue to tackle the key issues that the optimisation plan looked to address on an individual basis.

This includes the continued functionality of the systems, the embedding of good practice and the development of the workforce to address them.

For example, a focus on the continued development of nursing care plans/clinical documentation and MPage developments in EPR, the provision of change resource to embed good practice over and above training as well as developing colleagues with the skills required to keep moving forward digitally with existing systems.

Digital Inclusion

- Promoting digital inclusivity as part of the wider work on Health Equalities is critically important and continues to be a digital strategy focus via our EQIA governance. The pandemic has allowed us to implement technology that has enabled us to connect with patients, relatives and our workforce, it has introduced a way of working that has become the norm.

  There is more to do to ensure we expand our reach across the whole system and patient populations.

Integrated Care System (ICS) Collaborations

- CHFT has an increased digital footprint within the ICS via THIS digitally supporting 4 of the 5 ICBs (Calderdale, Kirklees, Wakefield and Bradford) as well as a number of other regional/system partners including Spectrum CIC, Community providers, Hospices and 3rd Sector.

- We continue to be the digital lead for the Regional Laboratory Information Management System (LIMS) and Enterprise Integrated Clinical Environment solution (ICE) as well as providing a support service for regional LIMS and CDCs as they come into service.

- We continue to have a presence on both Calderdale and Kirklees Digital Boards as well as WYAAT and ICS CIO Forums.

Moving Forward:

As we move forward, we will keep pushing the progress on all our digital programmes through to completion. We will develop partnerships with our suppliers whilst remaining challenging of the services we receive from them and look to secure skilled capability in order to keep CHFT in strong position when it comes to digital maturity and national influence.

We will continue to take advantage of the wealth of data that can help address the issues across our patient populations with a focus on how we distil and use this data to support patient care, aid safe discharge and improve outcomes, both at Trust and at system level.

We will take stock of our current position, both in terms of our Digital Strategy and being 5 years into our EPR journey. We will improve on the basics and strengthen our EPR offering through improvements around care plans, clinical documentation, integration and training our colleagues to use the system in a consistent and efficient way.

Whilst the Strategy in the main focuses on improvement across clinical settings, we need to ensure the corporate areas remain at the forefront of our thinking especially as we design our reconfiguration plans and the design of our building. An agile and mobile workforce underpinned by systems and solutions that allows information exchange in all areas and reduces duplication or any manual data input will be required and always be part of our overall plans.

Patients and colleagues will be digitally enabled to access and provide care wherever this is needed to transform the experience, safety and efficiency of our services.

EQIA – Equality Impact Assessment

The Digital Strategy aims to promote inclusivity as part of the wider work on health inequalities.

CHFT are progressing well in this space and will continue to work locally, regionally and nationally on addressing health inequalities including but not exclusively around learning disabilities, using our data and technological capabilities to understand our patient populations.

We want to continue to push the boundaries of interoperability using the Health Information Exchange and Medical Interoperability Gateway software as well as regional and national offerings such as Yorkshire and Humber Care Record and the Yorkshire Ambulance Service Transfer of Care Project. We will do this by working with partners around data sharing agreements so we can ensure information is available at the point of care so those patients that don't have digital access to the information can get the appropriate care and information when meeting their health care professional.

CHFT have a Digital Strategy that supports continued improvement, making sure people are fully adopting the technology we have. Whilst the technology provides the enablement, engagement with workforce/people/patients is critical and we need to make sure this is ongoing under the umbrella of "one culture of care". We have and will continue to support engagement sessions around the Digital Strategy including patients, relatives and workforce colleagues so they can continue to contribute to our strategy. Digital needs to be seen as mainstream not as an add on 'people first-then technology'.

Recommendation

The Board is asked to **ACKNOWLEDGE** the good progress that has been made against the commitments laid out in the Trust 5 year Digital Strategy for 2021/22.

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NHS Foundation Trust

CHFT DIGITAL HEALTH STRATEGY 2020 - 2025

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Contents

Foreword

Calderdale and Huddersfield NHS Foundation Trust (CHFT) is an integrated Trust providing acute and community health for the populations of Huddersfield and Calderdale. The Trust has invested heavily in digital in recent years making it one of the most **Digital Advanced Trusts** in the country. In the challenging times of the Coronavirus Pandemic Digital Solutions have supported our patients, our colleagues whilst working alongside our partners in delivering the highest quality of care. The current situation has driven us to **accelerate projects** at pace such as virtual clinics, components of voice recognition and nerve centre devices. There has been rapid improvements in our **infra-structure** to enable colleagues to continue to work in an agile way .

The vision of CHFT is **"together we will deliver outstanding compassionate care to the communities"** digital is a key enabler in supporting clinical and non-clinical colleagues to provide compassionate care for our patients.

In providing **one culture of care** it is fundamentally important that patients and staff are supported on **their own personal digital journey**. Acknowledging that some in our communities are digitally isolated and a partnership approach to support them in engaging with the hospital in a digital manner will be required.

In formulating the strategy we **engaged over 300 stakeholders this included** patient forums, colleague and wider partners organisations through various engagement sessions. This feedback was invaluable and helped us shape the Digital Strategy.

Our Digital Future Section outlines the direction of travel and reflects the digital ambition of the Trust. It also acknowledges that we operate in an eco-system with our partners benefiting from the digital advances we have made.

Dr Owen Williams OBE

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"Digital is the key enabler in supporting clinical and non-clinical colleagues to provide the compassionate care for our patients"

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Executive Summary

One Culture of CARE

Executive Summary

Our Digital Journey

This 5-year Digital strategy will take us beyond clinical systems we have the ambition to ensure all our workforce and the processes used by them are digitally enabled.

In 2012, the Trust developed a Digital Clinical Systems strategy and high-level plan that described how the Trust planned to use technology to fundamentally change the way it delivers its services, with an emphasis on improving the quality and safety of patient care. In February 2015, CHFT, in partnership with Bradford Teaching Hospital Trust, successfully deployed a single instance of the Cerner Millennium Electronic Patient Record (EPR) across well over a third of the population of the West Yorkshire & Harrogate Health and Care Partnership footprint. The programme was labelled as one of the biggest and broadest Big Bang deployments in Europe. The EPR system is stabilised however, there is more to do before the Trust can truly deliver a fully (robust) interoperable EPR used by patients and clinicians alike.

There are many internal and external factors that will drive change. We intend to continually develop and implement new technologies. Consideration will be given to the NHS publications, strategies and programmes as part of the overall strategy; putting the patient at the heart of everything we do.

Business intelligence and Data capture will advocate organisation wide coverage adopting principles that will focus on "getting it right first time". The Knowledge Portal will continue to drive the standard requirement of as much information as possible.

The level of investment needs to ensure our infrastructure remains resilient, current and future proof. The investment plan will need to align with the use of resources framework set out by the Clinical Quality Commission (CQC) in ensuring the Trust is using its resources to provide high quality, efficient and sustainable care. CHFTs strategic objective is that they will achieve a CQC rating of outstanding. Building the ability to horizon scan and establish how emerging technologies can benefit and be introduced into CHFT will be fundamental to this.

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"The Trust has demonstrated rapid progress on their digital maturity"

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Purpose of Digital Strategy

One Culture of CARE

Purpose and Scope of Digital Strategy

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Calderdale and Huddersfield Foundation Trust Vision

The vision of CHFT is, "together we will deliver outstanding compassionate care to our communities". Digital is a key enabler in supporting clinical and non-clinical colleagues to provide compassionate care for our patients. It will empower us to work together and provide compassionate care in a virtual world.

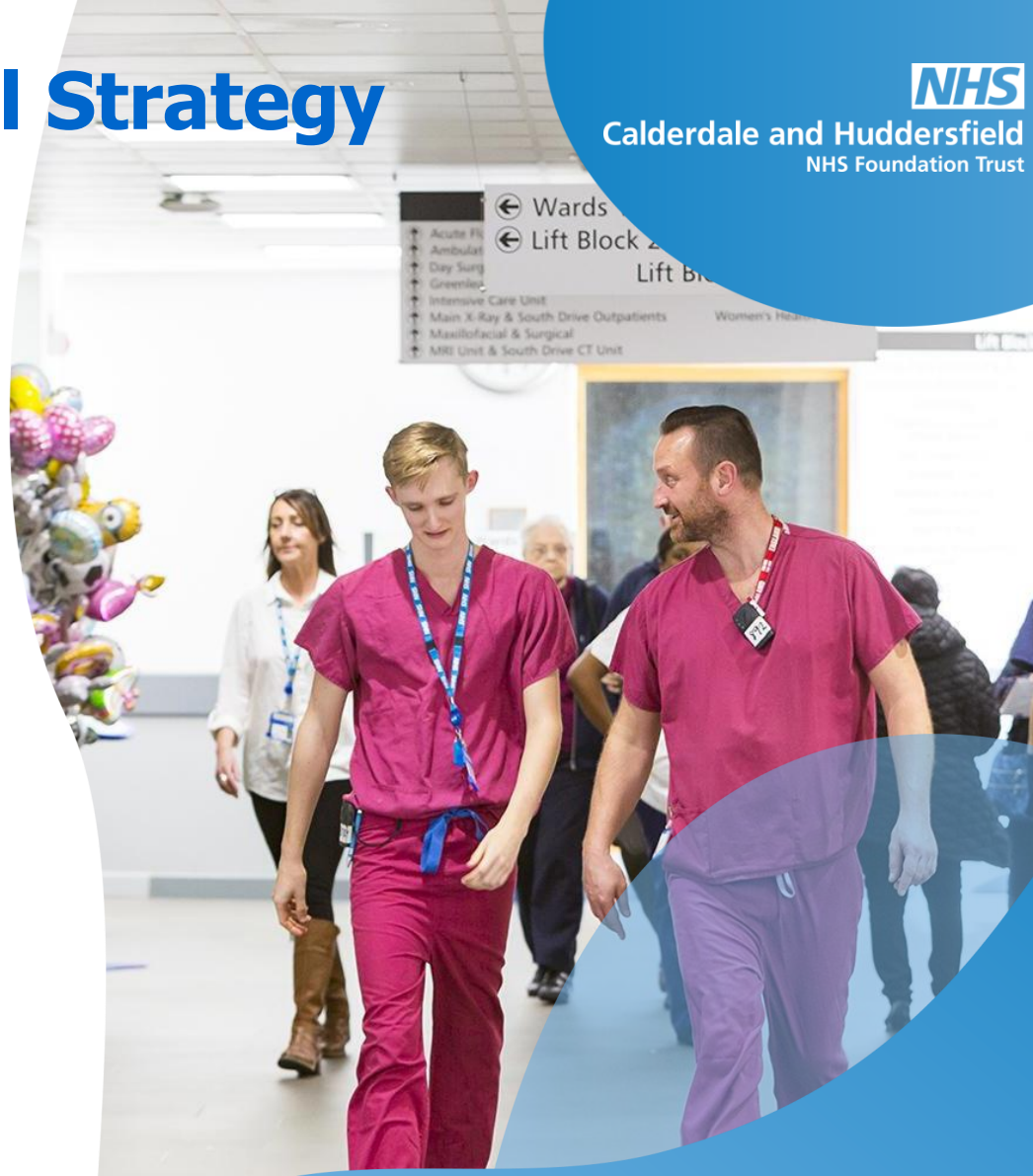
In providing 'one culture of care', it is fundamentally important that patients and staff are supported on their own personal, digital journey. The Coronavirus Pandemic has driven us to accelerate our digital programmes and we intend to use the learning from these rapid deployments in developing the strategic direction of this 2020-2025 Digital Health strategy. This will be set out in 4 key areas; each one putting the patient at the centre of all we do.

- ✓ **Digital Journey** – 2012 to 2020 and how CHFT has fundamentally changed the way it delivers clinical services improving the quality and safety of patient care

- ✓ **National and Regional Context** – Consideration will be given to external factors that will drive change from a digital perspective in line with the NHS long term plan.

- ✓ **Business Intelligence** – Making Data count. The knowledge portal will continue to drive the standard requirement for as much information as possible.

- ✓ **Our Digital Future** – Our future direction of travel and the ongoing digital transformation as we prepare to reconfigure our services. The design of our building will incorporate the latest advancements in digital technology.



"together we will deliver outstand compassionate care to our communities "

Purpose and Scope of Digital Strategy

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Our clinical priorities have been described in the Trusts clinical strategy. We will ensure the strategy aligns with our clinical priorities.

Priorities	We will do this by	This will result in:
Digital technologies to improve the quality and reliability of clinical care	• Providing "real time" patient records and care plans • Reduce the number of standalone IT Systems • Remove the need for paper from board to ward	✓ All relevant clinical information through a single access points ✓ Right access; right information correct? ✓ Effective alerting prompts across multiple pathways ✓ Improving patient safety
Digital technologies to support early discharge of patients	• Reviewing current systems/processes • Remote home monitoring	✓ Improve Patient Satisfaction ✓ Improving the quality of care for the patient
Adoption/Optimisation of current systems and hardware	• Showcasing areas of good practise • Supporting areas to adopt/optimise current systems	✓ Efficiency gains in utilising established digital offering ✓ Reduced reliance on face to face patient and clinical interactions
Make available to our staff an integrated healthcare system across the Integrated Care System (ICS) and beyond	• Identifying opportunities to increase interoperability across systems	✓ Improved and more timely clinical information ✓ Reduce patient risk
Giving patients control over their care and protecting privacy	• Enhancing Virtual Consultations • Promoting and enhancing access to the Patient Portal and self-care advice	✓ Improve Patient/carer's and relatives experience ✓ Improving quality and reduce patient risk
To ensure our corporate workforce are digitally enabled to support clinical care through responsive and up-to-date technology	• Utilising digital collaboration tools • Provide the necessary hardware to support • Review of our corporate systems	✓ Continue and Improve Agile Working capability ✓ Reduction of travel between sites
Support the sustainability challenge	• Use Artificial Intelligence to predict • Utilising collaboration tools for patients/colleagues • Review our finances, and workforce process and systems	✓ Reduction in travel amongst the communities we serve ✓ Protecting our environment and reducing carbon footprint ✓ Reduce pressure on our estate

Purpose and Scope of Digital Strategy

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Governance

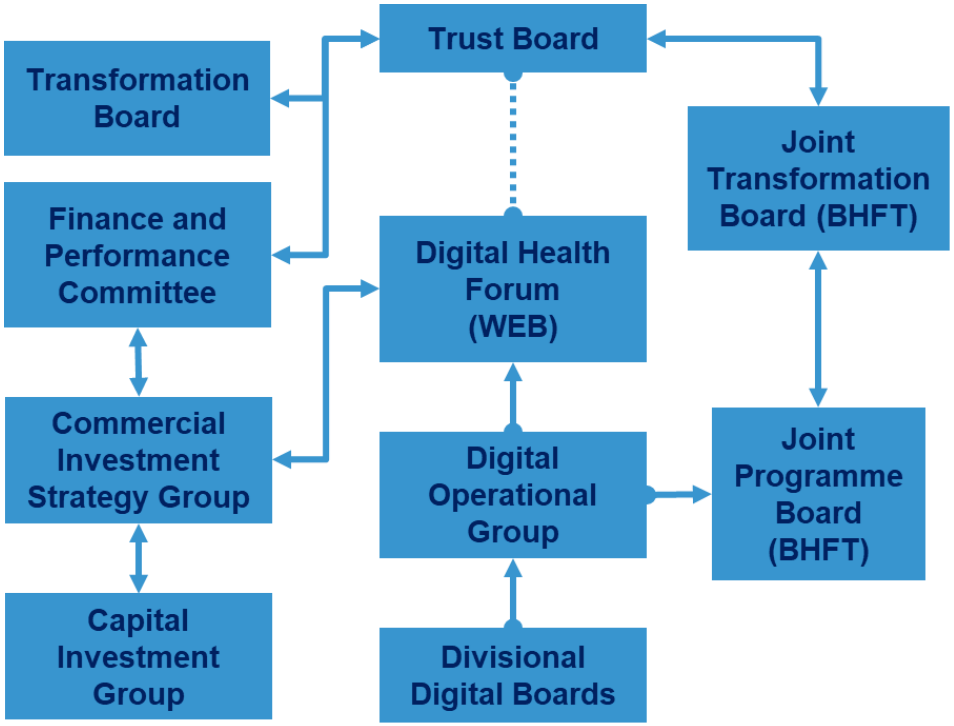
The Board will champion the Digital Health Strategy that will enable the provision of high-quality care by investing in technology for innovation and transformation. Embedding good governance around the strategy is vital. The monthly Digital Operational Group and Digital Health Forum will continue to report on and support the implementation of the projects relating to the digital strategy, including benefits realisation. The digital strategy will focus on the quality and safety of the care we provide to our patients that will ultimately drive efficiencies that will transform the way we deliver care and run our hospitals. Governance will ensure General Data Protection Regulations (GDPR) will be met and Equality Impact Assessments (EQIA) will ensure we meet the needs of all those required.

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

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

As the Trust continues to open new digital opportunities, they will need to develop more robust processes around capturing the agreed benefits. The Trust has launched an engagement methodology, Digital Ways of Working (DWOW) that sets out to involve key stakeholders across the whole workflow that is about to be digitalised.

DWOW will help our workforce to understand the "as is" with a focus on the impact of the "to be", ultimately allowing those involved to support and lead how staff will transition through future digital change and capture benefits from the start. CHFTs strategy aims to achieve a CQC rating of outstanding by being recognized as a well-led and governed Trust whilst achieving financial sustainability.



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Digital Journey

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Digital Journey - 2012 to 2020

CHFT is an integrated Trust providing acute and community health care for the populations of Huddersfield and Calderdale. In 2012, CHFT developed a Digital Clinical Systems strategy and high-level plan that described how the Trust planned to use technology to fundamentally change the way it delivers its services. The strategy made several recommendations, mainly relating to the clinical systems functionality and how it would be deployed to digitise the patient record, with an emphasis on improving the quality and safety of patient care.

In order to deliver the strategy, the Trust needed an underlying, modern and reliable infrastructure. It made a commitment to continue to invest in the Trust's Information Management & Technology (IM&T) Infrastructure in order to ensure it could support the delivery of the plan. As a result, the following elements were procured and deployed:

- New wired infrastructure for both hospitals.
- Improved computer room facilities at CRH and new facility at HRI.
- Resilient Data storage platform.
- Cross site resilient server platform.
- Wireless Network across all CHFT sites.
- Updated, site resilient email platform.
- Improved PC Estate.

A list of further additions to the infrastructure were also approved and deployed:

- Single Sign-On.
- Input Devices (PC's, Laptops, Tablets etc)
- Unified Communications (single bleep, single number reach inc mobile etc).
- Video Conferencing.
- Managed Data Services.
- Limited Virtual Desktop Infrastructure (VDI).
- Manage Print Services.

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"The infrastructure work plan gave the Trust a solid foundation/platform to build future technology solutions on"

Digital Journey - 2012-2020

Whatever product the Trust chose as its strategic option, it was acknowledged that it would take some time to procure and implement a core product set. At that time, there were some emerging issues that the Trust faced,; issues that technology could help alleviate by deploying some new technologies. As a result, several business cases were approved:

- ✓ Bluespier Theatre System deployed in October2014.
- ✓ Electronic Document Management System deployed February2015.
- ✓ NerveCentre E-Observations deployed in October2015.
- ✓ K2 Athena Maternity EPR deployed in June 2015

The Trust's ambition was always to assess its status with regards to an accepted model for measuring progress towards achieving a full EPR. It chose to work towards the HIMSS European EMR Adoption Model; evidence shows that when Trusts achieve these later stages of this model, the real benefits start to accrue for both the health professional and patients.

In August 2019, the Trust completed an assessment against the new standards. The Trust was confirmed as a stage 5 hospital, putting CHFT well above the UK (2.3) and European (2.1) average for a Trust of our size (Appendix 1). The Trust has maintained their commitment to invest in digital, and as a result CHFT has moved to the top of the NHS England's national Clinical Digital Maturity Index (CDMI) from a position 2 years ago of outside of the top 100, cementing its position as one of the most digitally advanced Trusts in the country. Further evidence can be taken from the Digital Maturity self-assessment that takes into account the broader digital perspective this was last completed in 2017 the Trust once again demonstrated considerable progress, over the same 2 year period CHFT has risen from 113th in the country to a position of 13th place There are plans in place to improve this position with an ambition to reach HIMSS stage 6 in 2020.

STAGE	HIMSS Analytics® EMRAM EMR Adoption Model Cumulative Capabilities
7	Complete EMR; External HIE; Data Analytics, Governance, Disaster Recovery, Privacy and Security
6	Technology Enabled Medication, Blood Products, and Human Milk Administration; Risk Reporting; Full CDS
5	Physician documentation using structured templates; Intrusion/Device Protection
4	CPOE with CDS; Nursing and Allied Health Documentation; Basic Business Continuity
3	Nursing and Allied Health Documentation; eMAR; Role-Based Security
2	CDR; Internal Interoperability: Basic Security
1	Ancillaries - Laboratory, Pharmacy, and Radiology/Cardiology information systems; PACS; Digital non-DICOM image management
0	All three ancillaries not installed

Digital Journey – EPR

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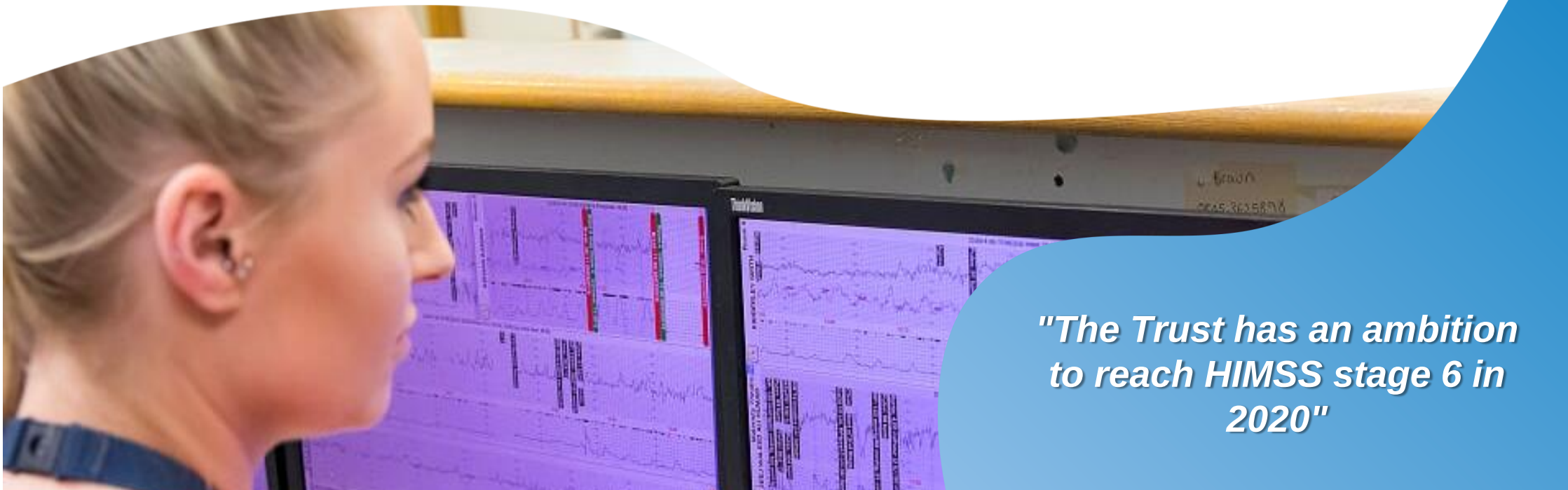
The most significant deployment of our digital journey was the introduction of the Cerner Millennium Electronic Patient Record (EPR). CHFT, in partnership with Bradford Teaching Hospital Foundation Trust (BTHFT), successfully deployed a single instance of the Cerner Millennium EPR across over a third of the population of the West Yorkshire & Harrogate Health and Care Partnership footprint. This was labelled as one of the biggest and broadest Big Bang deployments in Europe.

The Trust's progress on the introduction of digital technology is enabling clinicians and patients to access and interact with 'real-time' patient records and care plans wherever they are. All GPs in Calderdale and Greater Huddersfield are now able to view the hospital electronic patient record within their own patient record. Hospital clinicians can also view the GP record for all Calderdale and Greater Huddersfield patients within the hospital Cerner (EPR). Calderdale Community Service staff can also view the Calderdale GP record for both SystemOne and EMIS.

Work has also commenced to progress digital interoperability with the Calderdale Social Care System to enable integration of the adult health and social care records by early 2020. There is still more to do to ensure all local health partners are fully integrated. The intention is to connect with mental health, ambulance services and other local community healthcare organisations. This will align with the national programme LHCRE.

The Trust has some of the highest utility of the national electronic staff record (ESR), has been successfully using an App (application software) for the recruitment of bank staff and has deployed an e-rostering solution for nursing. The Board of Directors and Executives lead by example; all meetings are now paperless, and meetings can be accessed virtually. The level of organisational adoption already achieved at CHFT gives the Trust a distinct advantage for rapid progression to a fully, paperless environment.



"The Trust has an ambition to reach HIMSS stage 6 in 2020"

Digital Journey – Next steps

Digital Next Steps

Whilst the long-term Strategy for the Trust is being developed, it was agreed that several Digital Next Steps needed to be implemented to ensure the digital maturity continued to progress. Subsequently, a report was developed and approved by the Board in June 2018. The Digital Next Steps described a phased approach that would address issues systematically as prioritised by the Trust and would act as the interim to the overall Digital strategy.

The plan was to approach the issues in three phases:

Phase 1 Stabilisation - which addressed some key changes to improve the overall efficiency of the system.

Phase 2 Optimisation - which focused on the completion of numerous projects that had been put in place to improve access to other systems that were not part of the original scope. The majority being solutions that Cerner did not offer such as Medisoft, (Ophthalmology EPR). The introduction of virtual clinics and the switch-on of the Patient Portal would also be considered.

Phase 3 Obtaining and Improving Functionality - Prioritising a number of digital solutions that needed replacing or would be better placed as a Cerner solution.

Collectively, these phases would aim towards delivering a single access, one source of the truth, patient record whilst reducing our reliance on paper.

"EPR is now stabilised but we have more to do to optimise it"

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National and Regional Context

National Context

There are many internal and external factors that will drive change. These will require us to continually develop and implement new technologies. Consideration will be given to the following publications/organisations as part of the strategy.

NHS Long Term Plan

The NHS long term plan was published in January 2019. The Plan describes the NHS ambitions over the next ten years to ensure the NHS is fit for the future. The plan describes the improvements to be delivered in the following key areas:

- Improving out-of-hospital care (primary and community services).
- Strengthening the NHS contribution to prevention and reducing health inequalities.
- Reducing pressure on emergency hospital services
- Delivering person-centred care.
- Delivering digitally enabled primary and outpatient care
- Focusing on population health and local partnerships with Integrated Care. Systems having a central role in the delivery of the Plan

NHSX is a new joint organisation for digital, data and technology ⇞ and has been formed to drive digital standards that will digitally enable the NHS Long Term Plan.

NHS Digital Strategy 2015 - 2020

The strategy describes how, by 2020, all the citizens who want it will have access to national and local data and technology services. This will enable them to see and manage their own records, undertake a wide range of transactions with care providers and increasingly manage their own healthcare. At the same time, clinicians will have access to the right information when they need it, where they need it. Progress has been made but there is a long way to go. The Local Health Care Record Exemplar (LHCRE) were set up to enable this.

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The Topol Review 2019

The Topol review is an overarching review that provides a focus on developing and enabling our staff to be prepared for the digital developments in the NHS. It acknowledges that the healthcare workforce needs expertise and guidance to evaluate new technologies, that the adoption of new technologies should enable staff to gain more time to care, promoting a deeper interaction with patients. Patients need to be included as partners and informed about health technologies, ensuring the use of technology is equitable and does not reinforce inequalities

Regional Context

West Yorkshire and Harrogate Integrated Care System (WY&HICS)

The Trust is a member of the West Yorkshire and Harrogate Health and Care Partnership Integrated Care system (ICS). This is the second largest ICS in the country covering a population of 2.6 million people and a budget of over £5 billion. The purpose of the partnership is to deliver the best possible health and care for everyone living in the areas of, Calderdale; Kirklees; Bradford District and Craven; Leeds; Wakefield; Harrogate. The Partnership is made up of care providers, commissioners, voluntary organisations and Councils working closely together to plan health and care. With a vision to create a regionwide efficient health care system that embraces the late thinking and best practise, we want to bring together patient information systems and clinical and social care systems providing health care professionals and others supporting our patients with a full picture of their care pathway, many of which will be underpinned by this digital technologies.

Scan4Safety

The programme has been launched across WYAAT (West Yorkshire Association of Acute Trusts) working in collaboration with Leeds to share and implement best practise. Scan4Safey is attempting to harness global standards to increase quality and improve efficiencies and its core aims are to ensure that the - Right Patient, Right Product, Right Place, Right Process.

The department of health mandated the adoption of GS1 and PEPPOL messaging standards throughout the healthcare sector and its accompanying supply chains in the NHS Procurement Strategy. NHS Improvement has made £15m available to accelerate the adoption of Scan4Safety across WYAAT.

This is underpinned by GS1 standards, which provides a consistent data structure for the identification of patients, products and places and the use of barcodes to scan and record the whereabouts of these inputs to patient care.

Local Healthcare Record Exemplar (LHCRE)

This is a national initiative that aims to build information sharing environments across the NHS. The Yorkshire and Humber Health Care Record (YHCR) is being developed as part of the programme building on some of the principles published in the WATCHER Review on interoperability and data sharing. CHFT will be part of phase 2 for YHCR however, are already making progress in this area locally.

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"We have a vision to create a regionwide efficient healthcare system"

Partnership Working

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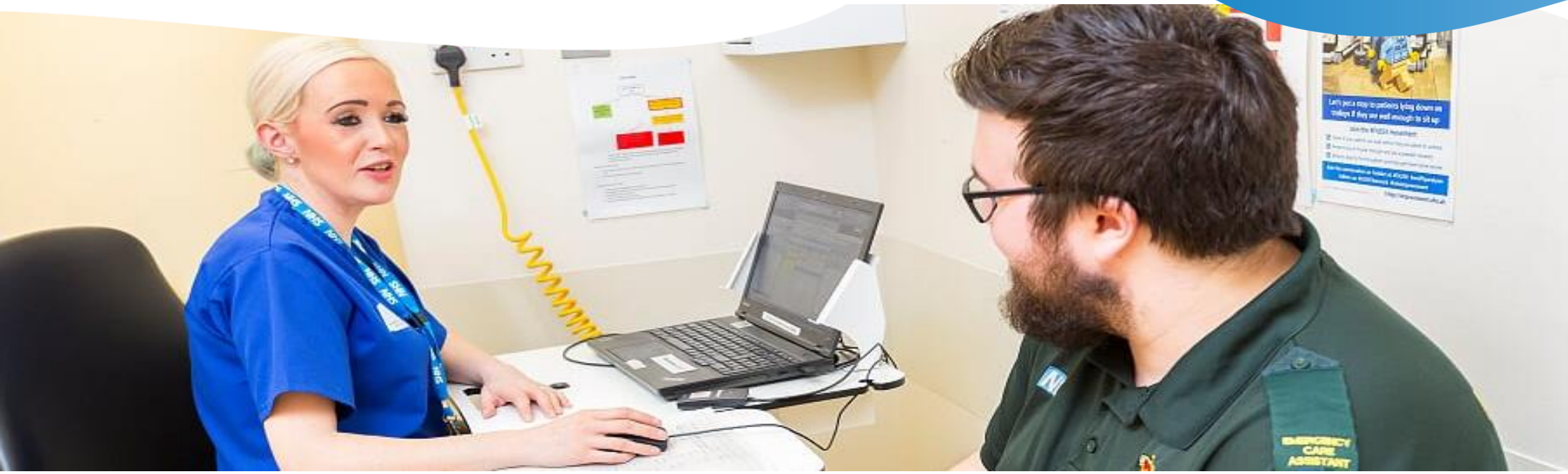

Electronic Patient Record (EPR)

At a more local level, in January 2018, Calderdale and Huddersfield NHS Foundation Trust and Bradford Teaching Hospitals Foundation Trust developed a proposal, a shared vision that described the next phase following the deployment of the single instance. The proposal set out the basis for a strategic partnership agreement with Cerner UK. The strategic partnership is founded on:

- A shared EPR Objective -The primary case for an EPR is to improve patient safety, improve outcomes and improve the experience our patients.
- A shared strategic objective of being fully digital.
- Proven success of a single instance deployed between two Trusts that can host other Trusts.
- Both Trusts' interest in a strategic relationship to progress their digital ambitions.

The Trusts' proposed a multi-stream approach whereby progress is made in parallel on each workstream to achieve benefits at pace. Each Trust would benefit from the others Trust leadership in the work stream from design through implementation. This confirmed CHFTs ambition to lead on 0ptimisation - Usability & Digital Breadth and BTHFT to lead on the Quality Improvement that supports teaching and research and Population Health.

epr electronic patient records

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Business Intelligence

Business Intelligence

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Business Intelligence (BI)

Business intelligence joins together the strategies and technologies used by organisations that enables the data analysis of business information. BI technologies provide historical, current, and predictive views of business operations. CHFTs Business Intelligence strategy advocates organisational wide coverage where key departmental systems reporting outputs are transparent and are understood. The trust is already benefiting from the richness of the real time data from our digital systems particularly EPR and will continue to do so. The following continue to be principles that will be adopted:

- Reporting systems will be viewed from both an internal and external lens and integrated to provide a single version of the truth, to facilitate improved outcomes.
- Getting it Right First Time, will be integral to our business.
- Using data to help model and prioritise the needs of our patients.
- Improved efficiency will provide all information from ward to board available as necessary through increased automation.
- A simple self-sufficiency solution will allow access to critical decision-making data.
- Key organisational "signed off" reports with a distinctive branding will be produced following a rationalising process led via the Performance Management Framework (PMF).
- Visibility of greater data richness provided from clinical systems in the form of new Clinical Information reports will be led by the clinical services.
- The Knowledge Portal will continue to drive the standard requirement of as much information as possible.
- Consider how other digital reporting systems are utilised and captured to ensure all data is included as part of the overall BI strategy.
- The Business Intelligence team within CHFT will be recognised as a Centre of Excellence.
- Augmented and Artificial Intelligence (AI) will be considered as we develop our digital systems.

"The Business intelligence team in CHFT will be recognised as the centre of excellence"

Business Intelligence

Data Quality

In a mainstream digital world, data quality has never been more important. HIMSS Analytics have created the Adoption Model for Analytics Maturity (AMAM). The standards described in the model are reliant on good data governance and data content and will help develop our future information strategies. Our ambition will be to achieve stage 6 by 2021. The model is focused on four specific areas

- **Data content** - data collection requirement, from basic data used to run a business to more advanced data needed in support of personalised medicine. The data content sought is balanced to support operational and financial analytics as well as clinical orientated efforts.
- **Infrastructure** - Analytics infrastructure includes not only the database and reporting tools, but the ability to extract, transform, and load data from a variety of internal and external data sources in a timely manner.
- **Data Governance** - Data Governance efforts grow to ensure analytics efforts are aligned with organisational strategic priorities and that analytics serves the needs of the business effectively.
- **Analytical competency** - The tools to compliment intuition and experience-based decision making with data driven decision making are put into place and then exercised to the appropriate Stage level identified by the organisation.

STAGE	HIMSS Analytics AMAM Adoption Model for Analytics Maturity Cumulative Capabilities	
7	Personalized medicine & prescriptive analytics	Mass customization of care
6	Clinical risk intervention & predictive analytics	Advance clinical, operational, and financial analytics
5	Enhancing quality of care, population health, and understanding the economics of care	
4	Measuring and managing evidence based care, care variability, and waste reduction	
3	Efficient, consistent internal and external report production and agility	
2	Core data warehouse workout: centralized database with an analytics competency center	Build a strong foundation
1	Foundation building: data aggregation and initial data governance	
0	Fragmented point solutions	

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Our Digital Future

Investment in Digital

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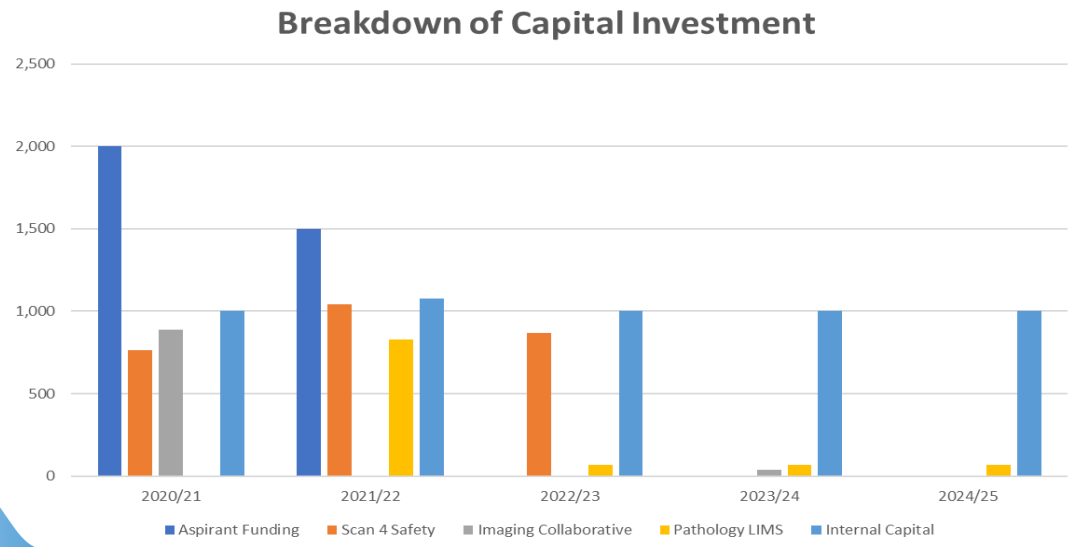
Capital Investment

CHFT's digital strategy builds on the significant investments made to date and the successful delivery of projects that have led to demonstrable benefits to both our patients and colleagues but also those of the wider healthcare community. As significant investment has been made to date; there is a requirement to continue to support and refresh the technologies in place. This includes replacement of hardware and systems but also the infrastructure supporting all these systems. This also includes additional security to comply with the latest best practice standards.

Funding the strategy will come from various sources. The plan outlines the Investment in Digital over the next 5 years and the funding streams available to us. Breakdown of capital investment over the next 5 years (Appendix 2).

1. Internal Capital
2. Aspirant Funding
3. Scan for Safety
4. Pathology LIMS
5. Imaging Collaborative

Year	Total Funding
20/21	£4.6m
21/22	£4.2m
22/23	£1.92
23/24	£1.1m
24/25	£1.0m



"Successful delivery of projects that have led to demonstratable benefits to both our patients and colleagues"

Investment in Digital

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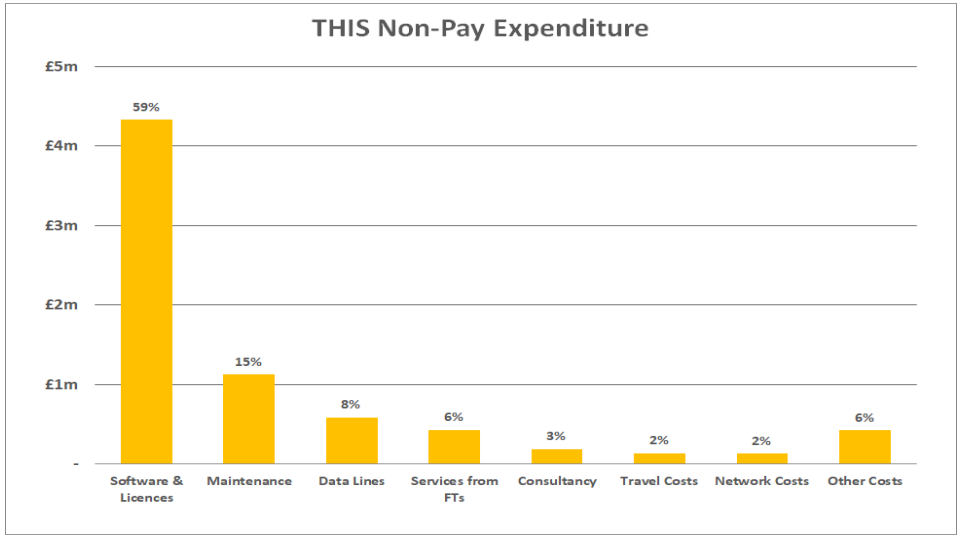
Revenue Expenditure

Revenue streams are already in place to replace existing systems. Additionally, it is likely that new funding streams will become available for specific developments and this may impact on the prioritisation that takes place. A total of £7.3m Revenue Expenditure is budgeted for 20/21 and this shows the level of commitment towards digital at the Trust. Going forward, it is expected that expenditure will be increasingly revenue based due to the nature of Digital services provided i.e. cloud hosting.

The Digital Aspirant funding has a mixture between Capital and Revenue which reflects this changing nature of expenditure. Whilst CHFT is a leader in the use of digital technologies in the provision of healthcare across the UK, further investment is required to both maintain this position but more importantly to continue to push the boundaries and to deliver further benefits to patients and colleagues.

The financial governance supporting any investment is vital and any investment must be able to offer demonstrable benefits. This is not always easily defined for investments that continue to deliver what is currently in place. For this reason, it is proposed to develop two financial elements to the digital health strategy.



The first relates to ongoing technologies and infrastructure and the second to adoption of new technology. A provisional financial envelope will be created to support both elements of the strategy. This will comprise both capital and revenue expenditure.

Our Digital Future

Reconfiguration and Digital

In December 2018, Department Health and Social Care (DHSC) announced £196.5m for reconfiguration for the Trust. The Service Model for both sites will be reconfigured and some of the key aims:

- ✓ Improve Clinical Outcomes and Safety
- ✓ Improve Service Delivery and Patient Experience
- ✓ Improve the recruitment and retention of staff
- ✓ Optimise the use of available hospital estate
- ✓ Create a therapeutic healing patient environment and a high-quality working environment

The design of the building will incorporate the latest advancements in digital technology and be aligned to the Digital Health Strategy. The intention is to incorporate future proofing to ensure that when the emerging technologies are at a mature stage these advancements can be included.

The Digital strategy will aim to provide a robust digital platform for the new building design and service models. We will ensure our network capacity meets the needs of our digital expansion.

The principles described in the Trusts infrastructure strategy are designed to give direction for the Trusts IT infrastructure and also provide the basis for long term investment and decision making. The principles will contribute to the Trusts economic sustainability and also be adaptable to any reconfiguration requirements as part of the Trusts overall strategic plan.

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"Designing the new hospital with digital at the heart of the design from the onset is a fantastic opportunity"

Our Digital Future

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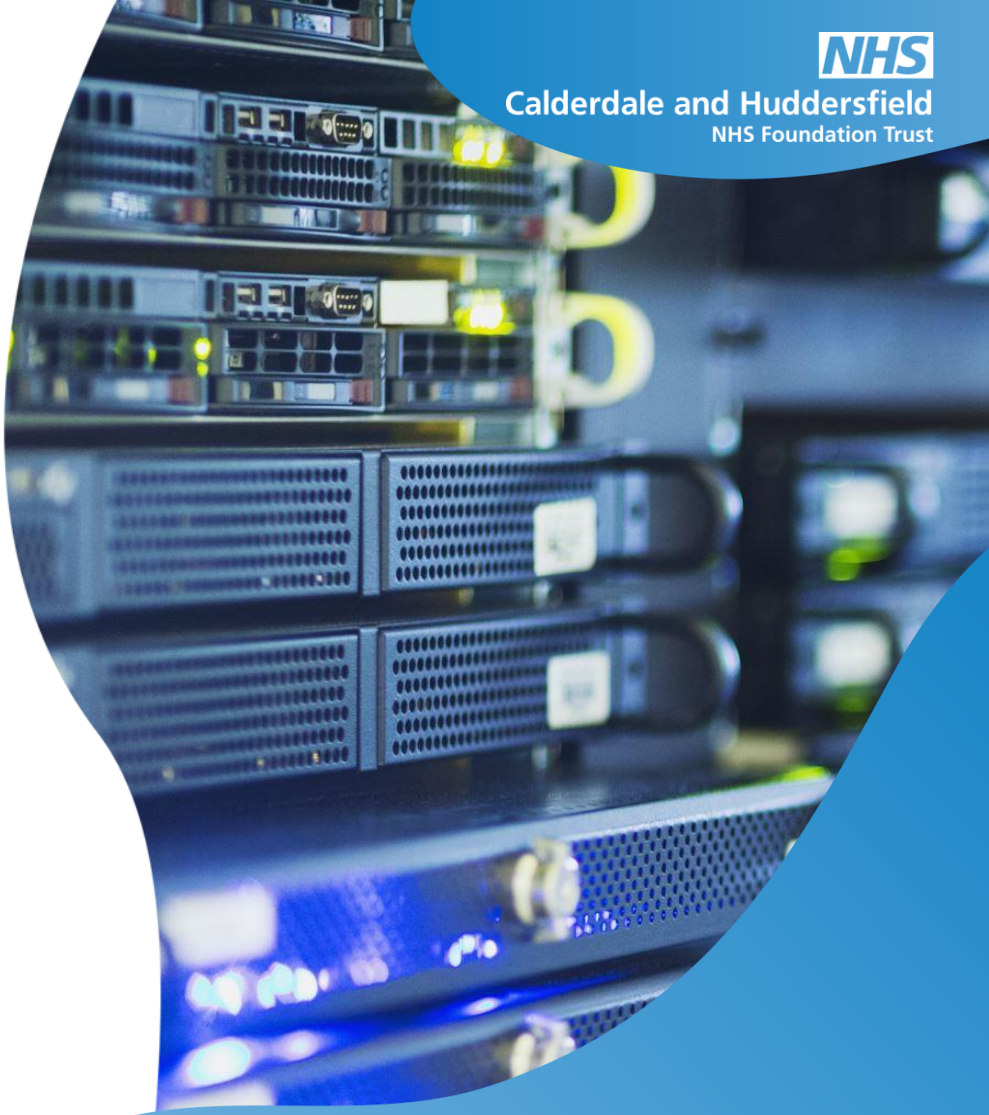
Infrastructure

To support the aspirations of this Digital Strategy, it will be essential to provide a robust and responsive infrastructure that will sit at the heart of all we do. The infrastructure needs to support a hybrid of legacy and future system provision; thus ensuring it will provide the platform required to transition to modern ways of Cloud and service provision.

It needs to enable staff to have a positive user experience when interacting with any of the digital systems they use through the provision of a modern digital workplace. We want to allow staff to easily and quickly find the information they need, wherever they need it. We will ensure that many of the barriers that can often be associated with digital adoption are removed.

As more digital systems move to a modern way of delivery, such as Apps and Containers, the devices that are used to interact with them should support that move to a more modern way of working too. Moving away from the multiple devices required currently to enable staff to carry out their roles, we must look to rationalising devices so that we can bring the hospital into the palm of their hands for as many systems as possible on a singular device. Enabling collaboration by removing the need to be physically present and supporting modern ways of multidisciplinary working using voice and video technology will be a key enabler for many strands of this strategy.

Underpinning all of this is a requirement to ensure that the infrastructure will ensure staff, patients and the organisation are protected from the ever evolving world of cyber security threats whilst staying compliant with the many mandatory and regulatory requirements such as the Data Security Protection Toolkit (DSPT), General Data Protection Regulation (GDPR) and the Data Protection Act 2018 (DPA 2018).



"A robust and responsive infra-structure that will sit at the heart of all we do"

Our Digital Future

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Infrastructure Adoption Model

Advancing through the Stages of the Infrastructure Adoption Model (INFRAM) is a progressively sophisticated process. To achieve INFRAM Stage 7, an organisation must first successfully achieve a Stage 6 validation. The INFRAM standards are meant for organisations that are pursuing advanced infrastructure capabilities and have taken into consideration how the INFRAM can support their digital transformation. INFRAM Stage 6 focuses on helping organisations assess its infrastructure strategy.

The Stage 6 review process looks at the current infrastructure capabilities and assesses whether the organisation is on track with respect to its infrastructure ambitions. An INFRAM Stage 6 organisation is able to demonstrate that it has the strategy, governance processes, technology and culture needed to ensure the deployment of an advanced infrastructure which is capable of fully supporting the operational, financial and clinical areas and goals of the organisation. Achieving Stage 6 indicates the organisation has established a strong foundation upon which to ultimately achieve INFRAM Stage 7. CHFT currently would be able to evidence the standards to support stage capability and would look to do a full assessment to meet the standards of a stage 6 by March 2021.

STAGE	HIMSS Analytics® INFRAM Infrastructure Adoption Model Cumulative Capabilities
7	Adaptive and flexible network control with software defined networking; home-based tele-monitoring; internet/TV on demand
6	Software defined network automated validation of experience; on-premise enterprise/hybrid cloud application and infrastructure automation
5	Video on mobile devices; location-based messaging; firewall with advanced malware protection; real-time scanning of hyperlinks in email messages
4	Multiparty video capabilities; wireless coverage throughout most premises; active/active high availability; remote access VPN
3	Advanced intrusion prevention system; rack/tower/blade server-based compute architecture; end-to-end QoS; defined public and private cloud strategy
2	Intrusion detection/prevention; informal security policy; disparate systems centrally managed by multiple network management systems
1	Static network configurations; fixed switch platform; active/standby failover; LWAP-only single wireless controller; ad-hoc local storage networking; no data center automation
0	No VPN, intrusion detection/prevention, security policy, data center or compute architecture

Our Digital Future

Workforce Experience

One of the key takeaway themes from the Digital Hothouse Engagement forums was **making what we have work for us**. The focus of our work must be releasing value from what we currently have with the dedicated support from staff with the necessary skills. A combination of education, change management opportunities that can be funded to maximise the Digital Aspirant Programme that **will enable us to make what we have work seamlessly**.

We recognise our digital ambition does not solely lie in bringing in new technology and innovation, optimising our current systems is at the centre of our aspirations. From our staff engagement we found that colleagues were keen to move from a point of adoption of digital to a phase of optimisation.

Optimising the use of technology will allow patient pathways to be improved, communications will work seamlessly helping us produce a much richer Electronic Patient Record (EPR). This in turn will deliver better patient care, improve reporting and increase staff satisfaction improving all our working lives.

Optimisation will involve a diverse group and we will identify Digital Champions within each division to help share our ambitions and be a resource to help optimise but also to help embed our digital message. Optimisation will not just focus on improving the digital records but how we interact digitally within our community embracing all levels of digital adoption.

A plan will be developed and resourced to ensure our workforce have the tools, knowledge and support that will enable them to be prepared for all our digital developments, new and old, in line with the Topol review published in 2019.

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"A plan will be developed making what we have work for us "

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Patient Experience

The NHS Long term Plan is looking at improving how services are delivered. Building on the progress already made on digitalising appointments and prescriptions they describe "a digital NHS front door" will provide advice, check symptoms and connect people with healthcare professionals. The Coronavirus Pandemic will also give reason to review the plan and the progress that has been made, at pace, against the key deliverables.

Project 2020

Transforming Patient Services launched in 2018 and led by CHFT in collaboration with the local health communities has seen a variety of new clinical service models and pathways being developed. The strategy will continue to develop the principles set out in the project to improve the patient experience. Offering choice, for some patients, would mean a reduction in the traditional face to face visits to the hospitals. Engagement will be outside of the hospital building, spreading across the patient population and communities. Improving our communication methods and accessibility through different channels such as:

- Patient Portal
- Direct messaging
- Virtual Consultations
- E-Consent/Virtual Consent
- SMS Messaging
- Software Applications
- Self-assisted care solutions
- Virtual visiting

Ensuring patients are supported on their digital journey in accessing the hospital in a virtual manner will be provided to ensure Digital Inclusivity. Improving convenience for patient's alternative consultation methods can have a significant impact on population health by reducing NHS related travel. The NHS Long Term Plan (2018) has set targets of 33% reduction of current hospital-based outpatients' activity over the next 5 years.

"We want to improve our communication methods and accessibility for all our patients"

Our Digital Future

Digital in the Community

Digital features heavily in the majority of people's lives through the increased use of social media, internet shopping and banking now becoming mainstream. Accessing healthcare through digital means will continue to grow.

Digital is an enabler that can bring communities together and can transform care for patient groups, however there are people within these communities that lack the necessary digital skills. To support digital skills, we will provide easy to use guides/videos to enable to people upskill where appropriate. When introducing digital solutions patients will be involved and engaged ensuring all users requirements are considered. Ensuring that equality and diversity/inclusivity will be at the forefront of the design.

Digital Inclusion

Digital Isolation is when people do not have the technology or infrastructure to participate in the digital solutions offered. Supporting those patients that are digitally isolated to access hospital in a virtual manner needs a partnership approach as other services for instance from the council/central government are provided digitally. This will ensure that we do not duplicate effort but also ensure the community have a consistent approach supporting them on the journey.

Working with our partners to address digital isolation throughout communities will be needed. Our engagement in regional forums such as the Kirklees Digital Board and Calderdale 2020 is supporting us in tackling digital inclusivity at a community level allowing us to build that greater picture. Going forward, greater emphasis on the Digital Skills will enable us to prioritise Digital Inclusion.

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"Working with our partners to address digital isolation throughout our communities"

Our Digital Future – Continuation

CHFT have continued to improve on the digital functionality and maturity of the healthcare environment. A number of projects are in progress and will conclude during the life of the strategy.

Theme	Project	Outcome
Transformational	**Outpatient Transformation**	Supporting the delivery of the Virtual Consultations for Outpatient Clinic utilising Microsoft Teams Booking App.
	Patient Portal	Re-launching of the patient portal followed by increase adoption and improvements in the content to enable patient led care.
	Agile Working	Supporting Agile Working Principles to maximise the opportunity of using collaboration tools like MS Teams.
Partnerships	**Health Information Exchange**	Enabling our Primary Care to view the live patient record from within their own system (EMIS/Systm One)
	Medical Interoperability Gateway (MIG)	Enables Secondary care to view Primary Care with further developments into the social care record, Ambulance and the mental health trust.
	Scan 4 Safety	Continuation of the 3 Year Scan 4 Safety Programme harnessing the power of scanning capabilities to improve patient outcomes.
	LHCRE	Local Health care record extend interoperability across the whole region, allowing the sharing of key patient information.
	Upgrade to Cerner version	Upgrade to the latest version of our Electronic Patient Record (Cerner Millennium).
Digital Health Team	**Endoscopy**	Nursing documentation is completed into the Electronic Patient Record viewable to all immediately resulting the removal of paper.
	Voice Recognition	Deployment of Voice Recognition technology throughout the organisation
	Ascribe Integration	Integration from the Ascribe system into the Electronic Patient Record to the digital end to patient improving safety
	Medisoft Integration	Ophthalmology integration for clinical and booking information
	E – Consent	Ability for patients to electronically and virtually provide consent for procedures
	Electronic Document Management system	Upgrade to support the storage of electronic documentations and open in context

Our Digital Future – Ambition

Ambition

CHFT is now part of the national Aspirant programme and are expected as part of this programme to build on the work already undertaken Global Digital Exemplar organisations. The programme was awarded to both CHFT and BTHFT in order to capitalise on the EPR single Instance and a placed based expansion of digital technology.

Both CHFT and BTHFT have a shared ambition to achieve a HIMSS stage 6 in 2020/21. Both Trusts have committed to a joint project to complete the remaining safety elements of HIMSS level 6. These elements include:

- Closed loop technology for Medication, blood products and Human Milk administrations.
- Cardiology imaging accessed through EPR.

Currently there are only 6 hospital trusts at stage 6 and zero at stage 7. This accreditation will provide the opportunity for CHFT to once again be recognised as one of the NHS advanced digital leaders.

The Aspirant programme will help fund some but not all our digital ambitions. The investment plan already details the current investment in digital so we intend to review our investment plans regularly as there will always be significantly more demand for digital than there is funding.

We will introduce some priority principles so we can ensure investment decisions offer the appropriate evidence throughout the governance process.

Options appraisals will also be developed that will encompass areas that require significant investment such as Cardiology, Intensive care, theatres and Endoscopy. We need to ensure that these critical clinical systems are not constantly being de-prioritised purely on cost, when we know that by simply digitalising documentation can only be a short-term solution.

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"CHFT have an ambition to achieve a HIMSS stage 6 in 2020/21"

Our Digital Future – Ambition

Calderdale and Huddersfield NHS Foundation Trust

Prioritisation

Cerner Millennium is the core clinical system for the CHFT, it has always been the intention to adopt a "Cerner First approach" as we grow its functionality. The recent focus has switched to developing a plan to integrate existing systems that can be accessed through Cerner ensuring all healthcare professionals have a single access route to patient information. This is pushing the boundaries around interoperability and integration whilst aligning with the Trust objectives described in the 5year strategy (plan on a page) on delivering **a robust interoperable EPR that is used by patients and clinicians alike.** The engagement sessions highlighted colleagues supported a focus on the interoperability and integration of existing systems in order to make access to patient information seamless and efficient. A set of criteria have been agreed that will help prioritise those systems yet to become part of the core clinical system.

1. Patient Outcome | **2. Statutory Regulations** | **3. Burning Platform** | **4. Funding Limits**

System	Outcome	System	Outcome
Infection Control Solution	Reduce number of incidents and improve patient safety	**NICU Badger Net**	Eliminate the need of an integration solution
Cardiology (All systems)	To enable access to all results and reporting and imaging within EPR	**Integration of medical devices**	Improved Quality and safety enable the transfer of results straight into EPR
ICU (Ward watcher)	Improve Patient safety	**Pathology**	To enable access to all results and reporting within EPR
Theatres	Introduce anaesthetic module as overall package	**ICE**	GPs to place orders direct into EPR
Maternity	Cerner used for all patient encounters across the Trust	**e Prescribing advances**	Improved patient safety by Closed loop/dose range checking.
Audiology	To enable access to all results and reporting within EPR	**Radiology (HSS RIS)**	To enable access to all results and reporting within EPR
Neurophysiology	To enable access to all results and reporting within EPR	**Oncology (PPM)**	Improve stability across multiple organisations (MDT)

Our Digital Future

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Innovation

One of the challenges and opportunities Digital presents is the constant pace of change in digital technologies. Building the ability to horizon scan and establish how these emerging technologies can benefit and be introduced into CHFT will be really important if we want to remain leaders in the digital space especially across the NHS. Our research will take us beyond the boundaries of the NHS and the UK, we should seek to learn from international best practise and innovation.

- Virtual Reality
- Drones
- Predictive Analytics
- Artificial Intelligence
- Robotics/Robotic Process Automation
- Wearable Technology

Just some themes where the technology needs to be exploited and to ensure that we are at the forefront of the technological advancements and prepare to accept within the next 10 years.

Whilst the Strategy in the main focuses on improvement across clinical settings, we need to ensure the corporate areas remain at the forefront of our thinking especially as we design our reconfiguration plans and the design of our building. An agile and mobile workforce underpinned by systems and solutions that allows information exchange in all areas and reduces duplication or any manual data input will be required and always be part of our overall plans.

Innovation Hub

Over the next 5 years we want to establish an Innovation Hub to create a physical and virtual space which will support us in developing the upcoming digital trends. The objective is for all Digital Ideas including corporate areas can be developed in a space that will give us an opportunity to showcase our digital work. It will allow us to be better informed around our digital ambitions as we confirm the design plans for the reconfiguration.

"Horizon scanning is not predicting the future but challenging thinking and providing more options "

Digital Strategy – Our Four Pillars

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Delivery of the Digital Strategy

The Digital Strategy will be delivered using the behaviours and values of the four pillars

Digital Strategy Engagement

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Engagement Forums

This Digital Strategy has been discussed at a wide range of engagement forums during the development of this strategy. In addition multiple individual stakeholders inputted.

Forum	Date	Discussion
Engagement Non-Executive	Multiple	Support/Guidance
Engagement CEO	Multiple	Alignment with Organisation Vision
Director of Digital Transformation	Multiple	Transformation Component
Chief Technology Officer	Multiple	Infra-Structure Component
Kirklees Digital Transformation Board meeting	04.02.20	High-level Overview
Digital Presentation at Joint Practice Leads	12.02.20	High lever Overview
Governors/Non-Executive Directors Meeting	13.02.20	Key Themes for the strategy
Digital Hot House – HRI	19.2.20	Workshop – Clinical/Non-Clinical Colleagues
Greater Huddersfield Public Engagement	26.02.20	Review and Input
Digital Tea Trolley Round – Urology/Orthopaedics	03.03.20	Feedback from colleagues - CCIO
Calderdale Commissioning Leads and Joint Practice Managers	26.02.20	Review and Input
Digital Hot House – CRH	09.03.20	Workshop – Clinical/Non-Clinical Colleagues
Digital Tea Trolley Round (Ward 19/20 HRI)	10.03.20	Feedback – Director of Digital Transformation
Digital Tea Trolley Round (Ward 8 CRH)	10.03.20	Feedback from colleagues by – CNIO
Digital Tea Trolley Round – Research Team, E Rostering, Workforce	16.03.20	Feedback from colleagues by MD
Digital Strategy – Investment Plan Finance Team	29.04.20	Review and input on finance component
Divisional Directors Meeting	02.06.20	Review Draft
Digital Health Team	04.06.20	Review Draft
THIS Leadership Team	10.06.20	Review Draft
Executive Team	11.06.20	Review Draft
Caldicott Guardian Principles	15.06.20	Review Draft
Multiple Meeting – Clinicians x3	18.06.20	Review Draft
Executive Director of Transformation	18.06.20	Review Draft

compassionate care

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Appendices

One Culture of CARE

Appendix 1 – CHFT EMRAM SCORE

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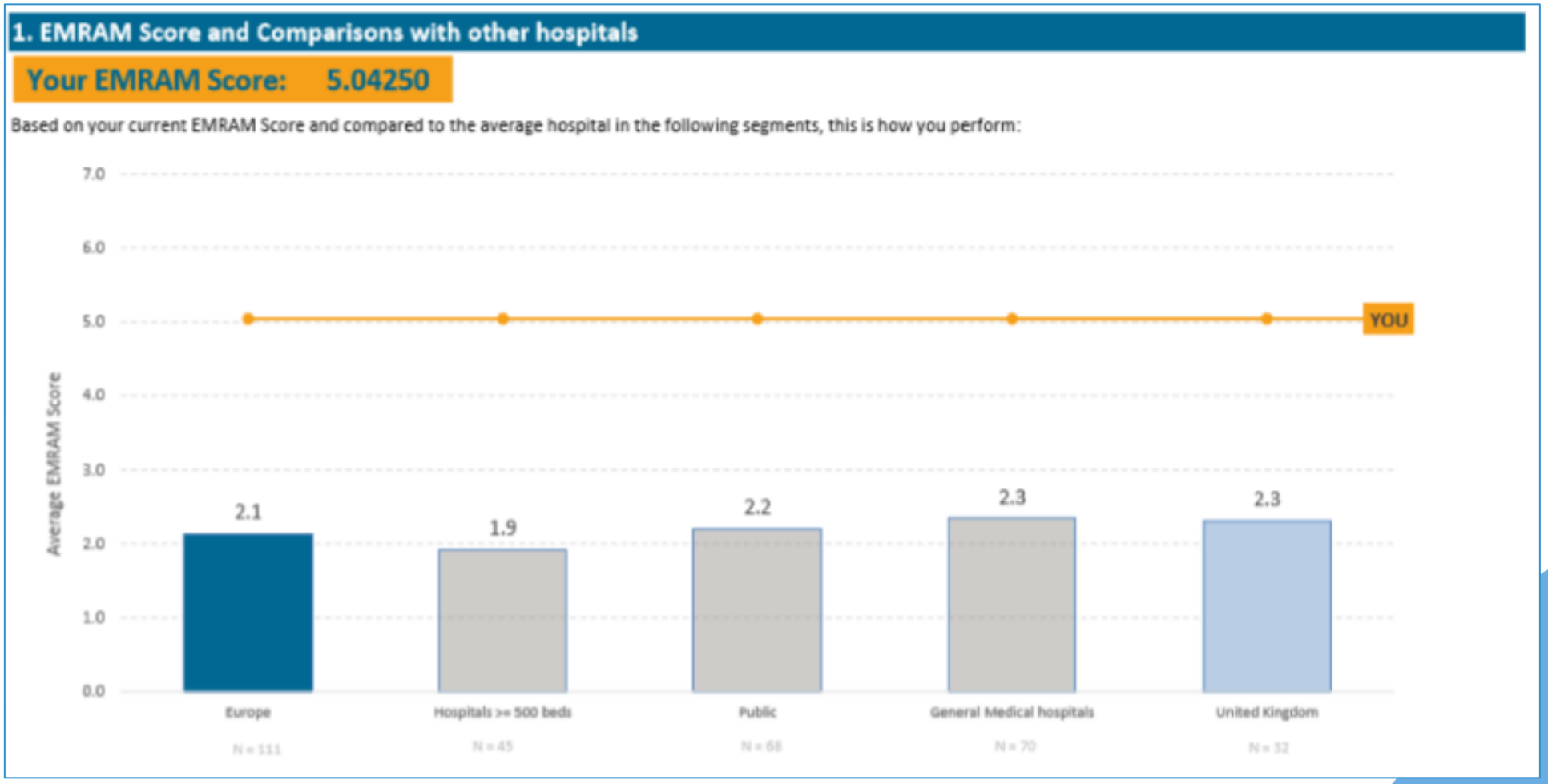
CHFT EMRAM Score



Appendix 2 - Investment

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Investment Plan

Next slides outlines the detail behind the capital and revenue expenditure for some of our specific programmes

Investment - Scan4Safety

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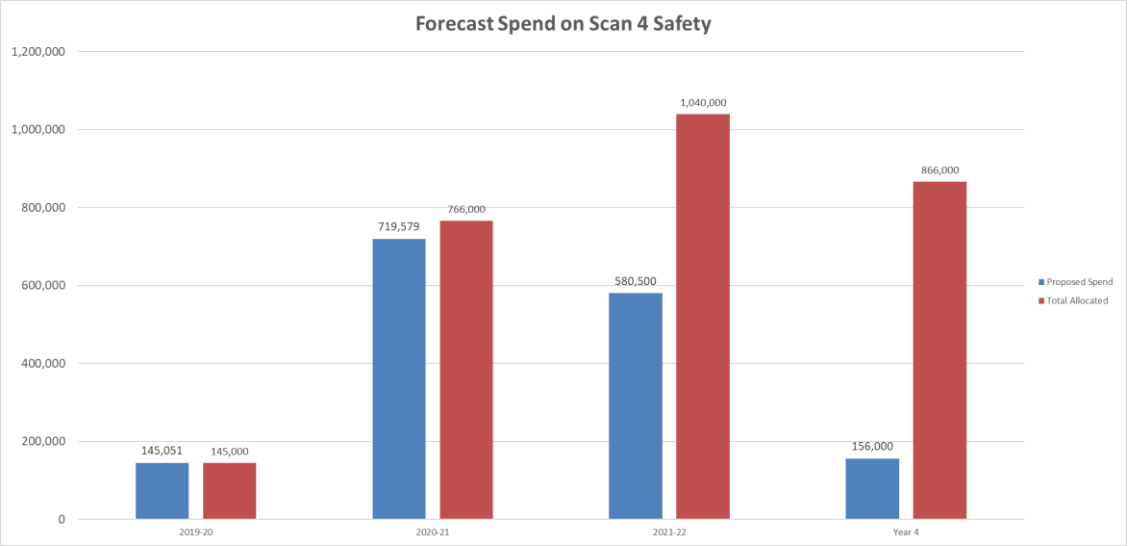
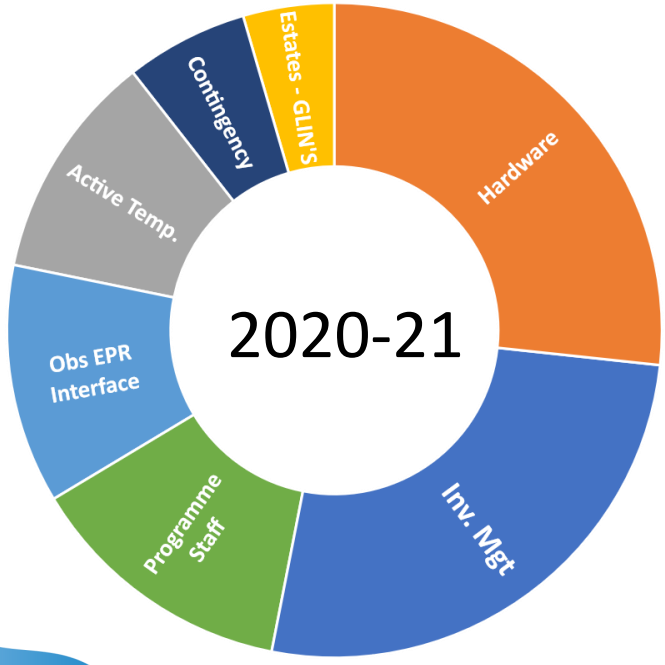
SCAN4SAFETY
Patient. Product. Place. Process.

The allocation of funding for Scan4Safety has been provisioned for four years. Year 1 and Year 2 funding has been allocated. Year 3 and Year 4 we are currently refining the allocation of the funding to ensure that latest business needs are accounted for.





Scheme	2020-21
Inventory Management	202,056
Hardware (TC51/Griffin Cabinets)	204,499
Active Temperature Monitoring	86,042
Estates - GLIN'S	34,493
Observation to EPR Interface	90,490
Programme Staff	102,000
Contingency	46,421
Total Funding Allocation	£766,000

Investment - Scan4Safety Priorisation

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		Benefits						
Case Study	**Description**	**Patient Benefits (50%)**	**Score (0/10)**	**Staff Benefit (25%)**	**Score (0/5)**	**Financial Benefit (25%)**	**Score (0/5)**	**Total**
Asset Tracking	The capability of tracking key assets around the hospital	Critical Equipment is tagged and easily trackable	**8**	Reduction in time spent looking for equipment releasing time to care for patient	**4**	High Value Assets are able to be tracked Significant saving with reduction in timeliness of finding	**4**	**80%**
Inventory/Catalogue Management	Deploying an inventory/catalogue management across the organisation (.e. theatres/wards)	Inventory is effectively managed throughout the organisation and ready for patients when and where needed	**6**	Reduction in time administrating inventory (i.e. stock takes) releasing time to care	**3**	Increased ability to automatically monitor inventory throughout the organisation	**3**	**60%**
Temperature Monitoring	Ability to automate the monitor of fridges/ambient storage areas	All inventory held in fridges is held at the appropriate temperature not impacting effectiveness.	**10**	Promoting a paper lite organisation. Removing administration duties from the organisation .	**4**	Supporting a paper lite organisation. Reduction in wastage of inventory	**2**	**80%**
GS1 Wristband	Implementing Global Standards on the patients wristbands	Supporting Closed Loop Medicine across the estate improving Patient Safety	**8**	Making the environment a safer place to work by using digital solutions reducing opportunities for errors to be made	**4**	Enabling the effective delivery	**2**	**70%**
G LINS	Implementing Global Standards in Location Tracking	Global Stand Standards of Location supporting organisational efficiencies	**5**	Reduction in time in locating inventory items around the trust	**2**	Enabling the efficient delivery of inventory/items throughout the organisation removing wastage	**2**	**45%**
Observations to EPR Interface	Interface Vital Observations Machine directly into the Electronic Patient Record	Timeliness of patient vital sign data entering the system	**10**	Reducing the need to manually type and reducing opportunities for mistakes	**4**	Increasing efficiency of staff conducting	**2**	**80%**
Multi Functional Devices	Deployment of a Multi Functional Devices on the wards supporting Nerve Centre, Voice Recognition etc.	Patient Experience is increased as one device at the bedside completes multiple tasks	**8**	Reduction in using multiple devices on the Wards	**4**	Reducing the burden of a mixed device estate in the organisation	**2**	**70%**

Investment - Digital Aspirant

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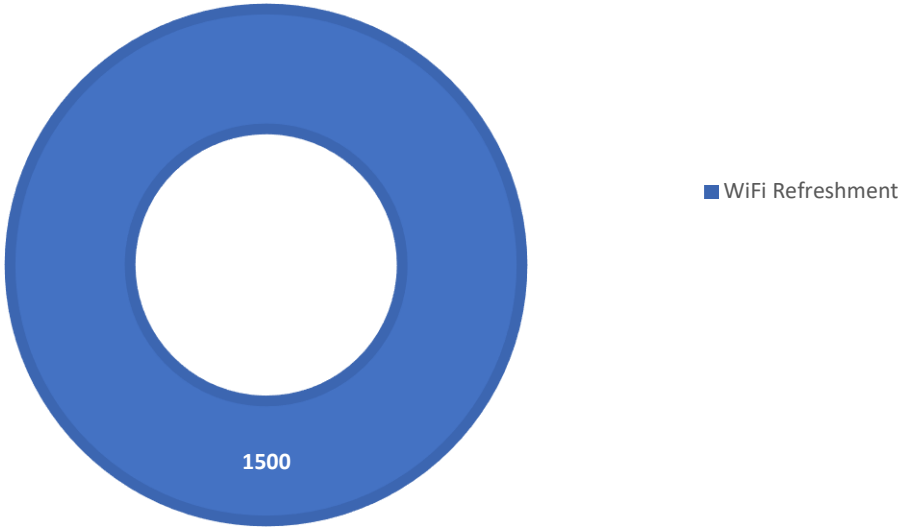
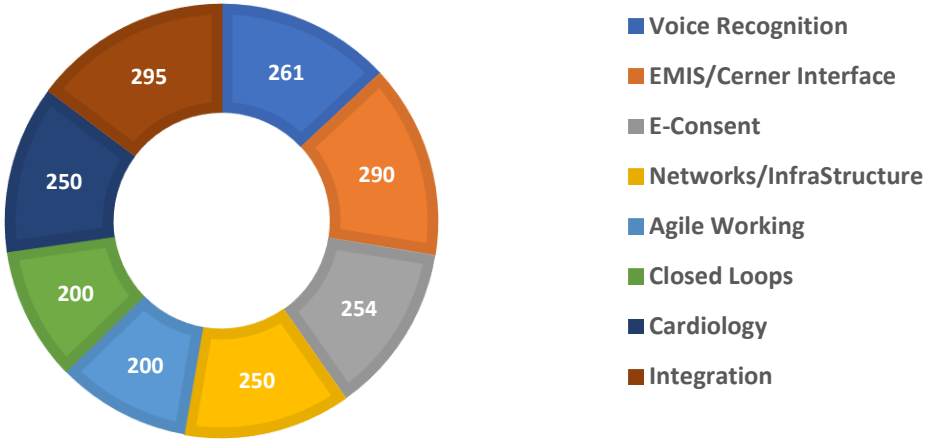
There are 23 Trusts that are part of the Digital Aspirant programme with the objective of the funding supporting Digital Transformation to enable us to provide safe and efficient care. The aim is to accelerate procurement, deployment and most importantly, uptake of the technology that is a platform for digital transformation to thrive.

The table below outlines what the organisation is planning on spending on Digital Aspirant Funding in the upcoming years.

DIGITAL ASPIRANT FUNDING YEAR 21/22



DIGITAL ASPIRANT FUNDING YEAR 20/21



Investment Digital Aspirant Priorisation

Calderdale and Huddersfield NHS Foundation Trust

Scan4Safety the allocation of funding has been provisioned

		Benefits						
Case Study	**Description**	**Patient Benefits (50%)**	**Score**	**Staff Benefit (25%)**	**Score**	**Financial Benefit (25%)**	**Score**	**Total**
Voice Recognition	The ability to use Voice Recognition to input speech into clinical systems and non clinical systems	Enriched patient record by enabling clinicians to enter information at the time of consultation	**8**	Reduction in staff completing administration duties creating future capacity for increase demand	**4**	Limited financial saving however improvements in quality	**2**	**70%**
e-Consent	To digitise the documentation of a patient's informed consent prior to an investigation or treatment is undertaken	Streamlined digital process for patients along with a standardise approach to consent	**8**	Reduction in administration duties of handling paper time and making the environment safer for clinicians to work in	**3**	Reduction in cost saving attached to printing and scanning costs.	**3**	**70%**
EMIS/Cerner Interface	Interface between prescribing system (EMIS) and Electronic Patient Record (EPR)	Reduction in risk of adverse drug events occurring by removing dual entry into systems	**8**	Safer environment for clinicians to work by removing transcribing between two systems	**4**	Reduction in administration costs for the organisation releasing time to care	**3**	**75%**
Wi-Fi	Refreshment of Wi-Fi Infrastructure	Patients ability to connect	**8**	Continuation of service	**4**	Reduction in deployment	**3**	**75%**
Closed Loop	Enabling Closed in Medical Management and Administration	Increased safety for patients as all elements are connected	**10**	Safer environment for clinicians to work	**5**	Reduction in errors	**3**	**90%**
Cardiology	Interoperability within the Cardiology Suite of systems	Seamless interaction for all Cardiology Suite of Systems	**9**	Able to access information	**6**	Effective utilisation of clinical systems	**3**	**90%**
Network/ Infra-structure	Refreshing the organisation network is secure and high performance	All medical systems /hardware are on the latest network	**7**	Systems/Equipment working at optimal performance for staff to complete duties	**7**	Reduction in time wasted	**4**	**90%**
Agile Working	Supporting agile working for the workforce	Reduction in non-clinical staff onsite supporting social distancing	**6**	Enable to effectively, safely wok from home	**5**	Less reliance on the hospital estate	**5**	**80%**

Acronyms

Calderdale and Huddersfield NHS Foundation Trust

Acronym	Description	Acronym	Description
CHFT	Calderdale & Huddersfield NHS Foundation Trust	**PMF**	Performance Management Framework
EPR	Electronic Patient Record	**AI**	Artificial Intelligence
CQC	Care Quality Commission	**AMAM**	Analytics Adoption Model for Analytics Maturity
DWOW	Digital Ways of Working	**DHSC**	Department of Health & Social Care
VDI	Virtual Desktop Infrastructure	**DSPT**	Data Security Protection Toolkit
CMDI	Clinical Digital Maturity Index	**GDPR**	General Data Protection Regulation
BTHFT	Bradford Teaching Hospital Foundation Trust	**DPA 2018**	Data Protection Act 2018
ICS	Integrated Care System	**MDT**	Multi Disciplinary Team
WYAAT	West Yorkshire Association of Acute Trusts	**EqIA**	Equality Impact Assessment

9. Health Inequalities Strategy - Presented by Rachel Crossley, Public Health Specialty Registrar

To Approve

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 10 November 2022
Meeting:	Public Meeting of the Board of Directors
Title:	Population Health and Inequalities Strategy, 2022 - 24
Author:	Rachel Crossley, Public Health Specialty Registrar
Sponsoring Director:	Anna Basford, Deputy Chief Executive
Previous Forums:	CHFT Health Inequalities Group

Purpose of the Report

This strategy sets out CHFT's approach to improving population health and reducing inequalities in the communities we serve. The strategy presents the Trust's vision and principles for our role in population health and inequalities, the priority areas in which we will take action, and an action plan for how we will deliver this. The Trust Board is requested to approve the Strategy.

Key Points to Note

The Strategy outlines the four priority areas for action:

- Connecting with our communities and partners
- Access and prioritisation
- Lived experience and outcomes
- Diverse and inclusive workforce

These priority areas recognise the different responsibilities and areas of influence where CHFT can take action to promote the health and wellbeing of our local population and address the inequalities in health they experience. We recognise, as the local response to the pandemic and the inequalities it highlighted showed, that acting on these issues requires using data and intelligence to understand the problem and evaluate impact, alongside working collaboratively with partners to achieve change and ensuring we have strong ambition and leadership to enable change.

Progress on this strategy will be regularly reviewed by the CHFT Health Inequalities Group and reported on to the Executive Board and Trust Board.

EQIA – Equality Impact Assessment

The aim and purpose of this strategy is to reduce health inequalities experienced by our local communities.

Recommendation

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

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Calderdale and Huddersfield NHS Foundation Trust

Population Health and Inequalities Strategy, 2022 - 24

Executive Summary

CHFT is on a journey to expand its role and impact in improving population health and addressing health inequalities in the communities we serve.

Health inequalities are avoidable and unjust differences in health experienced by different groups. There is a wealth of evidence showing that certain groups in our communities (e.g., those experiencing social deprivation, ethnic minority communities, people with a disability) experiencing poorer health outcomes, and poorer access to and experience of health and care services. The Covid-19 pandemic exposed and exacerbated these long-standing inequalities, particularly among ethnic minority communities and for communities living in the most deprived areas, highlighting the need for the NHS to take urgent action in response.

CHFT responded by establishing a Health Inequalities Group to oversee development and delivery of workstreams and actions to address health inequalities. This work has included, for example: reviewing waiting list data to identify and address any inequalities; ensuring high priority care for patients with a learning disability; work on health communication and improvement in maternity services; promoting a diverse and inclusive workforce; and ensuring we use our role as an anchor institution to deliver social value and work with our partners on local priorities.

This work to date has shown that we can achieve significant impact. We must now ensure this progress is sustained and built on.

This strategy sets out CHFT's approach to improving population health and reducing inequalities in the communities we serve. The strategy presents the Trust's vision and principles for our role in population health and inequalities, the priority areas in which we will take action, and an action plan for how we will deliver this.

The Strategy outlines the four priority areas for action:

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Progress on this strategy will be regularly reviewed by the CHFT Health Inequalities Group and reported on to the Executive Board and Trust Board.

Background

Health Inequalities and Population Health

Many of our local communities experience poorer health and wellbeing than communities living in other parts of the country. We also know that within our local population there are significant disparities in health, with some groups and communities at greater risk of experiencing poor health outcomes, and the conditions which lead to them, than others. These inequalities in health are long-standing and systemic, driven by social, economic, and environmental inequalities. Crucially, they are also preventable.

What are health inequalities?

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 (known as the wider determinants of health) influence how we think, feel and act and can impact both our physical and mental health and wellbeing (The Health Foundation, 2018).

When we talk about health inequalities, we often think of this in terms of inequalities in health outcomes and status, but it is important to also recognise the inequalities in access to and experience of health care. Often, people at the greatest risk of experiencing health inequalities due to their socioeconomic and environmental conditions are also those most likely to experience challenges in accessing care (Tudor Hart, 1971; Marmot, 2018).

Health inequalities can include (The King's Fund, 2022):

- health status (for example, life expectancy and prevalence of health conditions)
- access to care (for example, availability of services or ability to access services)
- quality and experience of care (for example, levels of patient satisfaction)
- behavioural risks to health (for example, smoking rates)
- wider determinants of health (for example, quality of housing).

Health inequalities are often analysed and addressed across four factors (The King's Fund, 2022):

- socioeconomic factors (for example, income or social deprivation)
- geography (for example, region or whether urban or rural)
- specific characteristics including those protected in law (for example, sex, ethnicity, or disability)
- inclusion health groups (people who are socially excluded, for example, people experiencing homelessness)

These factors and groups are not homogenous. People will experience different combinations of these factors and the ways in which these factors interact with each other and influence an individual's health and the inequalities they are likely to experience will vary.

Taking action on these inequalities has always been important, but the impact of the Covid-19 pandemic has made this more urgent by exacerbating and highlighting these inequalities. The stark inequalities seen during the pandemic were not created by Covid-19; they existed long before and will continue to persist and worsen now if purposive action is not taken.

What is population health?

Population health is about improving physical and mental health of people, whilst reducing health inequalities, across an entire population. Reducing health inequalities requires taking action at a population as well as an individual level, in order to address those factors which result inequity between different groups. Recognising the importance of population health means thinking about how actions we take can influence the health of the whole of the population we serve, not just individual patients. Population health also has a focus on preventing ill health, shifting the focus towards preventative and proactive rather than responsive care taking action on the wider determinants of health that are known to play the greatest role in determining health outcomes.

Our local population

CHFT serves a diverse population of approximately 460,000 across the local authority areas of Calderdale and Kirklees, with around 14% of the population from a BAME background. The population is socially and economically diverse with areas of high deprivation and other areas of relative affluence, as shown on the map below. There are significant inequalities both between the local population and other areas of the country, and within the local population.

Men and women in both Calderdale and Kirklees experience significantly lower life expectancy than the England average, and higher rates of premature mortality due to preventable causes (*Public Health Outcomes Framework*, OHID). Both areas also experience relatively high levels of deprivation. Out of the 317 local authorities in England, Calderdale is ranked as the 66th most deprived and Kirklees as the 82nd most deprived (Indices of Deprivation, 2019). Both areas have significantly higher levels of child poverty than the national average, with around 1/5th of children growing up in a low-income household (*Public Health Outcomes Framework*, OHID).

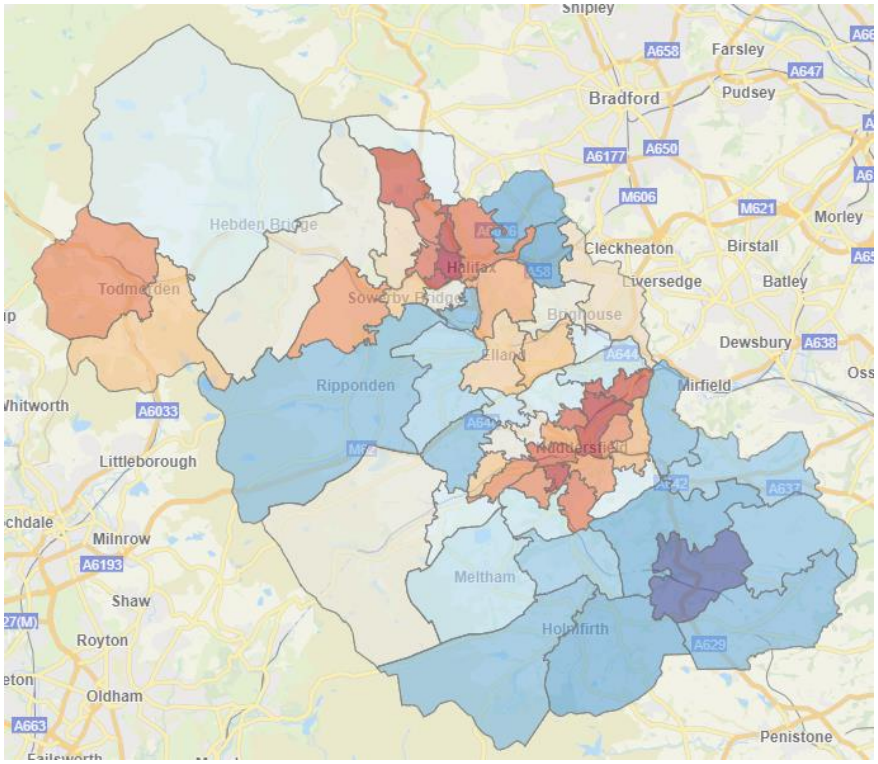

Figure 1: CHFT catchment area showing relative deprivation levels by ward (dark red being areas that are the most deprived through to dark blue being the least deprived).

There are also significant health inequalities that exist within the local population, with a clear social gradient in life expectancy and health: i.e., the more deprived a local area is, the worse the health outcomes are and the lower the life expectancy. For instance, those living in the most deprived areas in our local population have lower life expectancy and spend more years in poor health compared to those living in the most affluent areas (*Public Health Outcomes Framework*, OHID).

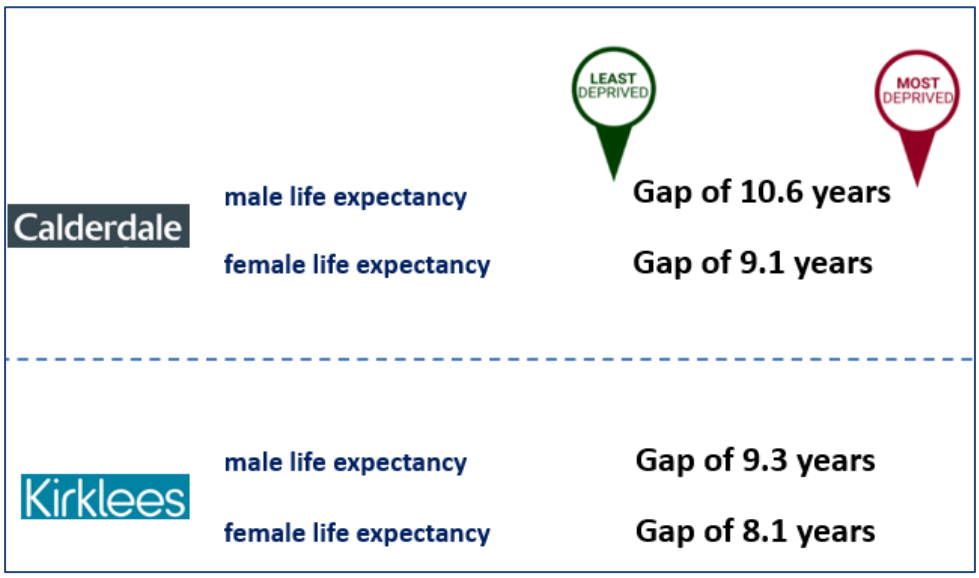

Figure 2: Life expectancy inequalities by deprivation in Calderdale and Kirklees

More information on the health of our local population and the inequalities they experience can be found at:

The Calderdale Joint Strategic Needs Assessment

The Kirklees Joint Strategic Assessment

Our role in addressing health inequalities

Context

As outlined above, health inequalities are not inevitable; they are preventable. These inequalities can be reduced but doing so requires deliberate and sustained action from all parts of society and public services, not least the NHS.

Reducing health inequalities has been a prominent feature of health policy in England at least since the 1990s, and yet many inequalities only appear to be widening, seen, for instance, in the stalling and in some cases falling gains in life expectancy for those living in the most deprived areas (The King's Fund, 2022). Recent analysis has also shown that there are consistent and growing inequalities in access to planned care, which must be addressed through removing barriers to access, prioritisation of care, and addressing the wider determinants of health which also contribute to these inequalities (The Strategy Unit, 2021).

Tackling health inequalities is not only a matter of fairness and population health, but a matter of optimal service delivery with health inequalities contributing to unscheduled hospital activity and increased demand on health services. For instant, recent analysis suggests that increasing access to elective care for those in the most deprived areas is likely to lead to reductions in emergency care overall and to inequalities in levels of emergency care (The Strategy Unit, 2021).

We have a responsibility to ensure that access to and experience of our services is equitable, and that our decision-making and service delivery considers impact on population health and inequalities and opportunities to promote population health and reduce inequalities.

The national context

The NHS Long-Term Plan (2019) committed to taking a more concerted and systematic approach to reducing health inequalities and unwarranted variation in care, as well improving prevention of avoidable illness and its exacerbations.

Since then, specific guidance and requirements for the role of NHS organisations in addressing health inequalities has been published, particularly in light of the health inequalities that were highlighted and exacerbated by the Covid-19 pandemic.

In developing this strategy and our four aims and priority areas, we have particularly sought to address the five key priority areas set out by NHSE to guide action on health inequalities and consider the Core20PLUS5 approach to reducing health inequalities.

The five priority areas are:

- restoring NHS services inclusively
- mitigating against digital exclusion
- ensuring datasets are complete and timely
- accelerating preventative programmes
- strengthening leadership and accountability.

The Core20PLUS5 approach particularly highlights the importance of focussing on communities within the 20% most deprived areas and other groups known to be at increased risk of experiencing health inequalities in your local population.

The NHS Oversight Framework (latest version 2022/23) sets out NHSE's approach to oversight and includes metrics to be measured at an ICS and Trust level within five national domains of oversight, with one focused on preventing ill health and reducing inequalities: quality of care, access and outcomes; preventing ill health and reducing inequalities; people; finance and use of resources; and leadership and capability. Each of these domains is also considered in this strategy.

Further detail of these are set out in **Appendix 1**.

The local context

Internal links:

The Population Health and Inequalities Strategy links to delivering the Trust's strategic objectives, specifically:

- We will have an optimal configuration of services and demonstrated improved outcomes for local people
- Working with partners we will regularly use population health data to address health inequalities

The Strategy also has links to the Digital Strategy and Workforce Strategy, recognising there are shared priorities and interdependencies.

External links:

The West Yorkshire and Harrogate Health and Care Partnership (Integrated Care System) brings together partners across the West Yorkshire footprint, including CHFT as a care provider and the **Kirklees and Calderdale Integrated Care Boards**, to support the local system in furthering action on health inequalities and health improvement. The Partnership's priorities are set out in Better health and wellbeing for everyone: Our five year plan.

The West Yorkshire Association of Acute Trusts (WYATT) is an agreement between the six Hospital Trusts of West Yorkshire to work together so we can deliver more joined up, high quality, cost effective care for our patients, including through sharing learning and collaborating on approaches to addressing health inequalities.

Calderdale Health and Wellbeing Strategy

Kirklees Health and Wellbeing Plan

Our vision and priorities

Our **vision** for population health and inequalities is:

"CHFT will play a leading role locally in improving population health and tackling inequalities, taking bold action, and working with our partners to deliver impactful change for the communities we serve. We will ensure equitable access and excellent experience of care to improve outcomes for everyone."

Addressing health inequalities is a complex issue which requires a multi-pronged approach and sustained action and progress over a long period of time. As such, it will be necessary to set long-term priorities and establish the incremental actions which will work towards achieving them.

There are four key **aims** of this strategy:

1. To harness our role as an anchor institution and **connect with our communities and partners** to promote health and equity in the local population.
2. To reduce inequalities in **access** to care and ensure **prioritisation** promotes equitable access and outcomes.
3. To ensure all patients **experience** high-quality, compassionate, and holistic care to improve **outcomes** and reduce inequalities.
4. To promote a **diverse and inclusive workforce** which reflects the populations we serve and where everyone feels valued.

Taking action

Priority areas for action

To deliver the aims of this strategy, action will be focused in four priority areas.

Connecting with our communities and partners
Harnessing our role as an anchor institution and key partner in the local health and care system, we will work to address inequalities in the wider determinants of health in our local communities, deliver social value, and work with system partners to identify and deliver shared priorities to improve population health.

Access and prioritisation
We will reduce inequalities in access to care by removing barriers, improving access for the most vulnerable groups, and moving towards a more holistic approach to prioritisation where a broader range of risk factors are considered.

Lived experience and outcomes
We will address disparities in experience of care to improve patient outcomes. We will focus on improving the lived experience of patients, particularly those known to be most at-risk of experience inequalities and poor outcomes. We will take a holistic and compassionate approach, recognising the importance of behavioural and wider determinants of health.

Areas of focus will include patients with a learning disability, maternity services, and mental health.

Diverse and inclusive workforce
We are committed to ensuring our workforce reflects the diverse populations we serve and that we take action to promote equality of opportunity. We will promote colleague health and wellbeing and create a compassionate and inclusive environment in which all our workforce feels valued in line with our One Culture of Care approach.

An action plan setting out specific priorities and actions to be progressed under each of these areas has been developed to ensure effective implementation of this strategy. These areas build on workstreams already progressed as part of our existing work on health inequalities, following work to evaluate our progress on health inequalities so far and identify future priorities.

Ways of working

Achieving these aims and implementing successful action in the priority areas will require embedding three enabling principles into our ways of working:

- **Using data and intelligence to inform implementation and evaluation**
  Data and intelligence will be an enabler for all our work on population health and inequalities. We will maximise the collection and use of data to understand and address inequalities, continuously monitoring key indicators of inequality and measuring the impact of our actions. We will use evidence-based approaches and share our learning to increase impact.

- **Working collaboratively as part of place partnerships**
  Addressing health inequalities is complex and requires joined-up action across; we will work collaboratively with partners across the local health and care system to achieve this.

- **Organisational leadership and governance to promote action**
  There will be a shared vision and ambition for reducing health inequalities across the organisation, regularly communicated by leadership to the workforce so that everyone understands their role in this. Systems must be in place to ensure that the impact on health and inequalities is considered in all decision-making, policies and service delivery.

Governance

The Health Inequalities Group will ensure oversight of this strategy, the action plan, and all workstreams resulting from it. The Group meets monthly and will regularly review progress against the strategy.

It is proposed that regular updates be provided to the Trust Executive Team, and quarterly reports on progress presented to the Trust Board.

Action Plan

The action plan sets out specific priorities and actions to be progressed in order to deliver the four key aims of the Population Health and Inequalities Strategy.

The action plan has been developed by the Health Inequalities Group, following evaluation of progress to date and identification of future priorities. The plan will be updated and edited over time to reflect progress in implementation and any appropriate changes.

Priority area: Connecting with our communities and partners

What have we achieved so far?

- Established and led a multi-agency working group to reduced inequalities in asthma within a Primary Care Network Area (Greenwood PCN, Kirklees).
- Created a new service called BLOSM within our emergency departments to tackle health inequalities and engage with vulnerable service users attending ED (BLOSM stands for Bridging the Gap, Leading a change in culture, Overcoming adversity, Supporting Vulnerable People, Motivating Independence and Confidence)
- Implemented robust process and governance for including Equality Impact Assessments as part of any service changes.
- A refreshed assessment of the Equality Impact Assessment (EQIA) and Quality Impact Assessment (QIA) impact of the proposed service changes and estate developments at CRH and HRI has been undertaken.
- The Trust has worked with the Social Value Portal (SVP) to support the Trust in measuring and reporting the delivery of social value from our estate investments.
- Supported the delivery of the Calderdale BAME Action Plan. The Group was Chaired by CHFT's Director of Transformation and Partnerships.

Going forwards

Director Sponsor: Anna Basford				
Action	**Output**	**Impact**	**Timescales**	**Action owner**
Continue and conclude work with Greenwood PCN on reducing inequalities in asthma. Assess potential to expand the new ways of work established through	Delivery of the action plan established by the working group Produce evaluation report, including	Improved respiratory pathways for patients through increased partnership working.	To complete in 2023	Neeraj Bhasin

the Greenwood PCN asthma inequalities pilot across the CHFT footprint.	recommendations for how the model may be extended across the CHFT footprint.			
Continue with the roll out of trauma informed practice training to all ED staff within CHFT.	All ED staff to have completed trauma informed training.	Increased knowledge and competence of ED staff in trauma informed care.	To complete in 2023.	Jason Bushby
Continue delivery of the new BLOSM service (including the Trauma Navigator pilot) in ED and collect data and evidence to evaluate impact of the service.	Evaluation of impact of the new service and the trauma navigator pilot.	Increased early intervention and support for vulnerable users attending ED.	Ongoing.	Jason Bushby
Use the output from the Social Value Assessment to inform implementation plans for the estate developments.	Ensure the investment secures wider social benefits that are targeted to reduce health inequalities.	Estates investments maximise social value impacts.	Ongoing.	Anna Basford

Priority area: Access and prioritisation

What have we achieved so far?

- Analysed waiting list data through an inequalities lens and reduced gaps in waiting times seen between White and BAME patients, and patients from the most and least deprived communities
- Started work to develop a “Health inequalities vulnerability index” to identify patients at increased risk of experiencing inequalities and take a holistic approach to prioritisation and care.
- People with learning disabilities were prioritised under the reset and recovery programme, with all known people with a learning disability on existing waiting lists having their surgery.
- Continued work with partners on Outpatient Transformation. This includes remote appointments project, and implementation of patient-initiated follow-up (PIFU) pathways. Specific actions relating to digital inclusion, and the development of referral information required to identify where reasonable adjustments may be needed to enable equitable access have been progressed.

Director Sponsor: Jonathan Hammond				
Action	**Output**	**Impact**	**Timescales**	**Action owner**
Continue to monitor and proactively respond to inequalities in waiting times.	KP+ dashboards with relevant data maintained. Data regularly reviewed and responded to where appropriate.	Equity in access to planned care is achieved and maintained.	Ongoing	Rob Birkett / Jonathan Hammond
Analyse data on unplanned admissions, emergency attendances, and "Did Not Attend"s through an inequalities lens (and where possible, triangulate with discovery work).	Identification of any inequalities and options for actions to address these.	Improved access to services and reduction in inequalities in access.	2023	Rob Birkett / Jonathan Hammond
Monitor data quality of inequalities indicators, including completeness of ethnicity data.	Data quality regularly reviewed.	Ensures we have appropriate data to continue monitoring and responding to inequalities.	Ongoing.	Rob Birkett / Peter Keogh
Development and piloting of the health inequalities vulnerabilities matrix as a predictive risk identification tool to support a more holistic approach to prioritisation and care.	A tool to test and pilot within medical division.	A more holistic approach to patient care and prioritisation and increased awareness of patient risk factors for harm and inequalities.	Ongoing, anticipated to be piloted in 2023.	Rob Birkett / Jonathan Hammond
Review of patient contact preferences and requirements. Ensuring systems are implemented to capture and utilise the information shared (to happen as part of the reasonable	Development of a formal process for noting and acting on patient contact preferences.	Improved communication with patients, to result in reduction in missed appointments and the appropriate appointment	Ongoing anticipated to be piloted in 2023.	Claire Sibbald

adjustments review).		type being used (face to face, telephone or video).		
Audit of readmissions of patients with a learning disability within medical division.	Audit findings and any relevant recommendations for improvements.	Sustained improvements in readmission rates and patient care.	Ongoing	Amanda McKie
Development and implementation of the Digital Inclusion Strategy (to ensure outpatient referral pathways and new ways of delivering outpatient services such as telephone and video appointments do not exclude people or widen inequalities).	Digital Inclusion Strategy developed to take account of potential impact on inequalities (linked with reasonable adjustments work)	Digital pathways are inclusive and patients are offered the most appropriate appointment type based on their need, recognising different needs and barriers.	To be completed 2023.	Claire Sibbald

Priority area: Lived experience and outcomes

What have we achieved so far?

- Launched “My Pregnancy Notes”, a “single point of access” patient interface enabling online booking for pregnancy care and access to maternity notes.
- Undertaken discovery interviews in Maternity to gain insight into women’s experiences of care and engage those less likely to send in feedback.
- Pilot of English as a Second Language pregnancy antenatal classes.
- Improved language accessibility of maternity services, including welcome signs produced in top 10 local first languages and mapping of multi-lingual resources available.
- Carried out a staff survey on cultural competence with maternity staff and piloted rollout of a cultural competence training package.
- Smoking in pregnancy research undertaken and published.
- Vitamin D / Healthy Start Scheme being promoted by Midwifery teams to increase uptake of Vitamin D and access to healthy food ‘vouchers’ for pregnant women and new mothers on very low incomes to spend on veg, fruit and milk.
- A wide programme of work has taken place to improve the experience of patients with a learning disability, with an enhanced task and finish group established to take this forward, to ensure that patients with a learning disability were prioritised on the waiting list and their care access and experience improved.

Director Sponsor: Linsday Rudge				
Trust wide				
Action	**Output**	**Impact**	**Timescales**	**Action owner**
Implementation of Long-Term Plan smoking cessation pathway for all inpatients.	Proportion of patients screened for smoking and referred to smoking cessation services as appropriate.	Improved identification of and support for patients who smoke.	To be implemented in 2023.	Tbc.
Maternity				
Action	**Output**	**Impact**	**Timescales**	**Action owner**
Increase engagement with maternity discovery interviews.	Number of discovery interviews carried out.	Increased insight into patient experience to lead to improvements in care.	Ongoing into 2023	Kate Heighway
Evaluate pilot of the ESOL for pregnancy antenatal classes and provide further classes.	Evaluation report on pilot classes and expansion of the classes based on findings.	Increased engagement with vulnerable women during pregnancy to	Ongoing into 2023	Kate Heighway

		build health literacy.		
Repeat the cultural competence staff survey following rollout of cultural competency training. Identify any further training and development needs.	Survey results on cultural competence and recommendations for any further training needs.	Increased cultural competency of staff to support compassionate care and high quality patient experience and outcomes.	Ongoing into 2023	Kate Heighway
Continuity of care model to be reviewed following suspension (in line with recommendations from Ockenden review) – focus on safe staffing and antenatal / postnatal continuity.	To be determined when national recommendations made.	To be determined when national recommendations made.	Expected January 2023.	Kate Heighway
Implementation of Smokefree Pregnancy pathway.	Increase in women accessing smoking cessation support in pregnancy.	Reduction in women smoking at the time of delivery (national target 6%)	To begin October 2022.	Kate Heighway
Brief interventions for nutrition, emotional wellbeing, physical activity & referrals to community services, delivered through antenatal education – "Healthy Pregnancy" classes.	Increase in women engaging in health promotion activities during pregnancy.	Improved health literacy and healthy behaviours of women in pregnancy.	To being in 2023.	Kate Heighway
Development of Vitamin D in pregnancy guideline.	New guideline on vitamin D screening and supplements in pregnancy developed and implemented.	Improved identification of women suitable for enhanced vitamin D supplement.	To complete in 2023.	Kate Heighway
Learning disability				
Action	**Output**	**Impact**	**Timescales**	**Action owner**
Further rollout of the essential LD e-learning.	90% staff to have done essential LD e-learning by June 2023 (this is currently at 77%)	Improvement in patient experience and outcomes for patients with LD.	June 2023	Amanda McKie

Reasonable adjustments audit.	Completion of audit with report of findings and any recommendations.	Improvement of implementation of reasonable adjustments, leading to improvement in experience for LD patients.		Amanda McKie
Progressing the business case for LD care navigators.	Completion and approval of the business case.	Care navigators in place to enable improved care pathways and experience for LD patients.	2023	Amanda McKie
A deep dive into care pathways for LD patients (including the ED 4-hour target, cancer pathway, and readmission rates in medicine).	Report of findings and recommendations for any service changes as appropriate.	Improved care pathways and experiences for LD patients.	2023	Amanda McKie
Mental Health				
Action	**Output**	**Impact**	**Timescales**	**Action owner**
Work with the University of Huddersfield Health and Wellbeing Academy to offer six support sessions on goal setting to all Trust patients to aid transition from secondary care to self-management.	Pilot and evaluate the goal setting support sessions.	Improved patient empowerment and self-management.	2023	Ian Noonan
Promote use of Whooley questions for inpatients to screen for depression and refer to services as appropriate.	Increased identification of patients requiring mental health support.	Improved holistic and compassionate care.	2023	Ian Noonan

Priority area: Diverse and inclusive workforce

What have we achieved so far?

- Established several Colleague Voice equality groups.
- Guidance developed to include engagement with all internal network groups and links to engagement team as part of Equality Impact Assessments for service design/

- Embedded process for previewing all cases of racial discrimination in disciplinaries & complaints prior to progress through formal stages.
- New recruitment strategy developed and launched, including bold and ambitious statements for equality of opportunity.
- Inclusive talent toolkit and framework developed and embedded in People Strategy.

Director Sponsor: Suzanne Dunkley				
Action	**Output**	**Impact**	**Timescales**	**Action owner**
One Culture of Care values and behaviours implemented into recruitment.	One Culture of Care values and behaviours referenced in all recruitment processes.	One Culture of Care embedded throughout organisation and into all recruitment processes.	Bi annual review of progress. June/Dec	Nicola Hosty.
ED&I Awareness and Education Programme (face to face for managers and e learning for colleagues)	Enhance understanding of difference, improve relationships between colleagues and improve services for patients	Informed decision making, placing ED&I at the forefront of thinking and delivery of service	Bi annual review of progress Apr/Sept	Nicola Hosty.
Leadership development for managers. ED&I Module dedicated to increase cognisance of difference and how managers can be an inclusion ally	Enhance understanding of how they need to flex their style to support the diversity of the members in their team and they teams they work closely with – role modelling the change we want to see in the Trust	Challenging inappropriate behaviours, improving colleague engagement, make equitable decisions, ggrow talent and promoting development opportunities.		
Reverse Mentoring / Coaching Opportunities	Support colleagues from Black, Asian and ethnic minority backgrounds	Relationship building, growing their networks, learning from one anothers		

	by providing development opportunities and to offer support and advice on career progression	experiences		
Appraisal Process inc discussion around ED&I	Quality conversation to enable discussions around wellbeing, belonging and development	Improve colleague engagement, connect colleague with development opportunities, support them with their wellbeing		
Shadow Board	Provides the opportunity to succession plan and to increase diversity of thought at the senior level of an organisation	Provide assurance, corporate governance plus support talent management strategies		
Root out Racism programme	Aims to tackle structural and institutionalised racism, as well as addressing health and social inequalities across the area	Take action to address bullying and harassment		
Diversity in Health and Care Partners Programme	This initiative will provide thought leadership, tools and tips to help put your organisation	Create an environment where difference is welcomed and celebrated		

	at the forefront of equality, diversity and inclusion (EDI) practice			
Utilising widening participation channels as a tool to support inclusive recruitment / talent development. Growing the apprentice programme, including level 5 & 7 apprenticeships.	Increased recruitment and development through the Widening Participation team. Number of apprenticeships supported by the Trust.	Our recruitment is inclusive to support a workforce reflective of our communities. Increased employment and develop offer for local communities	Ongoing into 2023.	Nicola Hosty.
Monitor proportion of colleagues accessing the staff wellbeing offer. All colleagues encouraged to complete a risk assessment on an annual basis.	Number of colleagues accessing the wellbeing offer. An opportunity for colleagues to gain access to the right support quickly, appropriately and efficiently	Improved employee wellbeing. Assurance for all parties that we're putting people first	Review the strategy bi annually Review HWB risk assessment process bi annually	Nicola Hosty.
Continue to promote, support, and engage with the Equality networks.	Equality networks continue to grow, creating space to think, learn and make improvements	Equality networks provide a supportive space for engagement, improvements, enhancements and make an impact on the way the Trust does things around here, taking into account different views/experiences.	Equality Networks outputs and impact will be reviewed by the Inclusion Group on an annual basis	Nicola Hosty.

12-month inclusion event programme	Host a range of events to bring a multitude of people together to discover new perspectives, support professional development, and empower voices from different walks of life	Networking opportunities, relationship building, better understanding of difference, bring together allies to work towards a common purpose of inclusion		

Appendix 1: National Policy Context

The five priority areas for tackling health inequalities:
https://www.england.nhs.uk/wp-content/uploads/2021/03/B0468-implementation-guidance-21-22-priorities-and-operational-planning-guidance.pdf

The five priority areas were outlined in the 2021/22 Operational Planning Guidance. Should these be updated as updated guidance is released, we will continue to ensure that our approach to health inequalities aligns with any updated national priorities and requirements.

Priority 1: Restore NHS services inclusively
At national level, the decline in access amongst some groups during the first wave of the pandemic broadly recovered in later months. Insight work has, however, highlighted that in some cases pre-existing disparities in access, experience, and outcomes, have been exacerbated by the pandemic. It is therefore critical that systems use their data to plan the inclusive restoration of services, guided by local evidence. This approach should be informed by NHS performance reports that are delineated by ethnicity and deprivation, as evidence suggests these are the areas where heath inequalities have widened during the pandemic.

Priority 2: Mitigate against digital exclusion
Systems are asked to ensure that:

- providers offer face-to-face care to patients who cannot use remote services
- more complete data collection is carried out, to identify who is accessing face-to-face, telephone, or video consultations, broken down by relevant protected characteristic and health inclusion groups
- they take account of their assessment of the impact of digital consultation channels on patient access.

Priority 3: Ensure datasets are complete and timely
Systems are asked to continue to improve the collection and recording of ethnicity data across primary care, outpatients, A&E, mental health, community services, and specialised commissioning.

NHS England and NHS Improvement will support the improvement of data collection across all settings, including through the development of the Health Inequalities Improvement Dashboard, which will contain expanded datasets where there is currently a relative scarcity of intelligence, e.g. for people experiencing post- COVID syndrome.

Systems should also implement mandatory ethnicity data reporting in primary care, to enable demographic data to be linked with other datasets and support an integrated approach to performance monitoring for improvement.

Priority 4: Accelerate preventative programmes that proactively engage those at greatest risk of poor health outcomes
Uptake of the COVID and flu vaccination has increased significantly across all groups, but inequality has also widened, particularly by deprivation and ethnicity. Systems and providers should take a culturally competent approach to increasing vaccination uptake in groups that had a lower uptake than the overall average as of March 2021.

Preventative programmes and proactive health management for groups at greatest risk of poor health outcomes should be accelerated, as set out in the main 2021/22 planning guidance, including:

- Ongoing management of long-term conditions
- Annual health checks for people with a learning disability
- Annual health checks for people with serious mental illness
- In maternity care, implementing continuity of carer for at least 35% of women, with the proportion of Black and Asian women and those from the most deprived neighbourhoods meeting and preferably exceeding the proportion in the population as a whole.

Priority 5: Strengthen leadership and accountability
Systems and providers should have a named executive board-level lead for tackling health inequalities. and should access training made available by the Health Equity Partnership Programme."

The Core20PLUS5 approach: https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/

Core20PLUS5 is a national NHS England and NHS Improvement approach to support the reduction of health inequalities at both national and system level. The approach defines a target population cohort – the 'Core20PLUS' – and identifies '5' focus clinical areas requiring accelerated improvement.

Core20

The most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD). The IMD has seven domains with indicators accounting for a wide range of social determinants of health.

PLUS

PLUS population groups we would expect to see identified are ethnic minority communities; inclusion health groups; people with a learning disability and autistic people; coastal communities with pockets of deprivation hidden amongst relative affluence; people with multi-morbidities; and protected characteristic groups; amongst others.

Inclusion health groups include: people experiencing homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system, victims of modern slavery and other socially excluded groups.

5

The final part sets out five clinical areas of focus. Governance for these five focus areas sits with national programmes; national and regional teams coordinate local systems to achieve national aims.

1. Maternity: ensuring continuity of care for 75% of women from Black, Asian and minority ethnic communities and from the most deprived groups.
2. Severe mental illness (SMI): ensuring annual health checks for 60% of those living with SMI (bringing SMI in line with the success seen in learning disabilities).
3. Chronic respiratory disease: a clear focus on Chronic Obstructive Pulmonary Disease (COPD) driving up uptake of COVID, flu and pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations.
4. Early cancer diagnosis: 75% of cases diagnosed at stage 1 or 2 by 2028.

5. Hypertension case-finding and optimal management and lipid optimal management: to allow for interventions to optimise blood pressure and minimise the risk of myocardial infarction and stroke.

The NHS Oversight Framework and NHS Oversight Metrics for 2022/23: https://www.england.nhs.uk/nhs-oversight-framework/

The NHS oversight framework for 2022/23 replaces the NHS system oversight framework for 2021/22, which described NHS England and NHS Improvement's approach to oversight of integrated care boards (ICBs) and trusts.

This framework outlines NHS England's approach to NHS oversight for 2022/23 and is aligned with the ambitions set out in the NHS Long Term Plan and the 2022/23 NHS operational planning and contracting guidance.

The framework describes how the oversight of NHS trusts, foundation trusts and integrated care boards will operate. This supports our ambition for system-led delivery of integrated care in line with the direction of travel set out in the NHS Long Term Plan, Integrating care: next steps to building strong and effective integrated care systems across England and the government's white paper on integration – Joining up care for people, places and populations.

A set of oversight metrics has been published, applicable to integrated care boards, NHS trusts and foundation trusts, to support implementation of the framework. These will be used to indicate potential issues and prompt further investigation of support needs and align with the five national themes of the NHS oversight framework: quality of care, access and outcomes; preventing ill health and reducing inequalities; people; finance and use of resources; and leadership and capability.

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10. Strategic Objectives 2021-2023 Progress Report

To Note

Presented by Anna Basford

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Date of Meeting:	**10 November 2022**
Meeting:	**Public Meeting of the Trust Board**
Title of report:	**Annual Strategic Plan – Progress Report**
Author:	**Anna Basford, Deputy Chief Executive (with input from all Executive Directors)**
Sponsor:	**Brendan Brown, Chief Executive**
Previous Forums:	**None**

Actions Requested:

- Note the assessment of progress against the annual strategic plan.

Purpose of the Report

Provide an update on progress against the annual strategic plan for period ending September 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
- 0 are rated amber
- 18 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

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 September 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
0	is rated amber
18	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 a decision is awaited. Delay in Treasury decision on the business cases could impact on programme timescale and affordability.	**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 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.	**Clear plans agreed with partners to implement improved, resilient and innovative service models in Calderdale and Kirklees and across West Yorkshire** **Lead: DB**

		The Trust is engaging with partners to procure a single Chemotherapeutic prescribing system to further facilitate network development. A South Sector implementation manager has been appointed and DB is chairing an implementation Board. The Pathology Partnership between LTHT, CHFT and MYHT (NPP) has been established and both an oversight Board and operational groups have been established. A single Laboratory Information management system has been purchased and is being implemented across the network as a single instance overseen by a Digital Implementation Board. Bradford/Airedale to go live with Blood transfusion and Histopathology Nov 2022. A WYAAT diagnostics board is established to oversee progress of both Pathology and Radiology networks Work is ongoing to develop a business case to establish a Bariatric surgery hub, for patient within WYAAT and further afield. Monthly Placed based meetings have been established in Calderdale and a partnership working group between CHFT and MYHT.	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. The Trust is now connected to a CHFT instance within Microsoft Azure (Cloud) by resilient network connections from both hospital sites. • A focus on how data is used at both Trust and Regional level, specifically around further progress on health inequalities but also a predictive approach to vulnerability and learning disabilities as two examples. • Scan for Safety is coming to an end as a programme however, work continues with the technology in supporting wider trust strategies such as Reconfiguration.	**Continued progress towards strategic objectives to include key milestones for data integration, ERP Optimisation and delivery of key capital projects including Reconfiguration** **Lead: RB** Divisional digital boards Divisional Operational Boards Data Quality Board Digital Executive Board. Report to Board and Finance and Performance Committee by exception.

		• Capital funding for 23/24 is limited however includes a continued refresh of End User Devices and network infrastructure refresh. • Continued support of Trust Reconfiguration activities including innovation workshops and digital target operating model sessions. Engagement with vendors on strategic planning and implementation of physical infrastructure. • EPR Team structured to support steps towards optimisation through trust aligned pieces of work with a focus on 'getting the basics right' (e.g. Clinical Documentation). Collaboration with BTHFT to continue and include contract extension, possible future partnerships with Cerner, regional organisations inc Education, place based entities and other acute Trusts (inc Airedale) • 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 Central Funding bids have continued to be submitted 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.	**GREEN** on track	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: LR** Weekly Executive Board Board of Directors Access Delivery Group Learning Improvement Review Board Health Inequalities Oversight Group (England)

		A Health Inequalities strategy has been developed to further enable the trust to address health inequalities within the communities we serve	
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 and flu vaccines. The Trust is ensuring national guidance in relation to IPC measures are implemented. There has been 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 our recovery plans support a continued reduction in health inequalities. The trust has reviewed its recovery plans to ensure it meets the national performance targets in place for 2022.	**Staff accessing HWB assessments receive timely and effective outcomes**. **Lead: LR** Weekly Executive Board Trust Board Workforce committee
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. Maternity Services has had an external Ockenden Assurance review and met all 7 immediate essential actions (IEA).Children and Young People services has undertaken an internal	**Maintain the Good rating, achieve some outstanding ratings.** **Lead: LR** Quality Committee Weekly Executive Board

		review with the NHSE/I regional transformation lead providing external scrutiny.	
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. Further work is being undertaken to ensure shared learning from incidents and complaints. The trust is working towards the implementation of the new national Patient Safety Incident Response Framework (PSIRF).	**To see an improvement in the feedback from service users as part of the Observe and Act process.** **Lead: LR** 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 and at the end of September is achieving 102% of 2019/20 activity levels and has plans in place to achieve 104% of elective activity by the end of the financial year In relation to long waits, bar 1 over 104 week waiter (identified through robust validation processes) the Trust is on track regarding no over 104 week waits and is on track in meeting the no over 78 week requirements by the end of the financial year. The Trust is also in a good position to meet the requirements for reducing over 52 week waiters. The Trust continues to achieve 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.	**Achieve key performance metrics for urgent and emergency care and elective recovery** **Lead: JH** Integrated Board Report Weekly Executive Board Audit and Risk Committee Finance and Performance Committee Access Delivery Group

		The Trust's performance on the Accident and Emergency 4 hour waiting time standard continues to perform better than most Trusts. This is also the case for timely handover of patients from the ambulance service a key metric of focus over winter.	
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 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.	**Implement actions in the Health and Safety Plan** **Lead: SD** Quality Committee Trust Board
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,	**GREEN** on track	Our recruitment strategy 2022/2023 was agreed in April 2022. To deliver the strategy we continue to focus on:- • Achievement of the national target of 0 vacancies through the Healthcare Support Worker Programme. • Continued progress on reducing registered nurse vacancies.	**Improved vacancy rate overall. Improved vacancy rate for N&M and M&D staff groups.** **Turnover below 10%** **Stability above 90%**

thus retaining a turnover below 10%.		• 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 between 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. In addition, T-Level Nursing and Healthcare Science pathways have been developed in partnership with Calderdale and Kirklees Colleges.	**Lead: SD** Workforce Committee
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.	**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 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. • Refreshed Appraisal documentation in use during the extended appraisal season ending on 31 December 2022. • 'Development for All' programme and brochure produced and published. • Widening Participation and Apprenticeships ensure we have a robust entry level pathway pipeline of motivated and talented individuals wishing to progress a career in the NHS.	**Improved National Staff Survey, WRES and WDES scores** **Lead: SD** Workforce Committee

		• Empower and Stepping into Leadership Programmes provide colleagues with the tools they require to enable their career aspirations Reciprocal Mentoring is to be relaunched in Winter 2023	
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. TED aims to improve individual engagement, team engagement and team working. • Equality, Diversity and Inclusion Awareness and Education Programme launches by 31 January 2023.	**Improved National Staff Survey, WRES and WDES scores** **Lead: SD** Workforce Committee

		• Refreshed Management Essentials Programme currently in Development launches by 31 January 2023.	
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 an 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. We are implementing a values-based applicant screening tool. In addition, we are building the West Yorkshire Inclusive Recruitment toolkit into our recruitment processes, and this will be available by 31 January 2023.	**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 Autumn/Winter 2022/2023 Health and Wellbeing Strategy focusing on our colleague wellbeing offer has been launched. The approach generates an enhanced focus on financial wellbeing communications and sign posting to the available support. An appointment to a newly established internal colleague Psychologist role has been made and a start date of 21 November 2022 agreed. 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	**Improved National Staff Survey scores** **Lead: SD** Workforce Committee

		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 6 the Trust has an adverse variance to plan in the year to date but the reported forecast continues to be delivery of the deficit plan as submitted to regulators. A range of risks and opportunities continue to be managed to deliver this position.	**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. 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). Performance against the agency expenditure ceiling brings a pressure to the use of resources score and means that the Trust must deliver the planned deficit in order to maintain a score of 3.	**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 bi-monthly Green Planning sub-group Chaired by Andy Nelson. The Green Plan is a Board approved document which is submitted at ICS level. Some of the key progress this year include: • Audit Yorkshire – Sustainability audit gave significant assurance and confirmed that CHFT is demonstrating a commitment to minimising its adverse impact on the environment. • CHS can now provide in house Carbon Literacy Training for staff. • The CHFT Sustainability Website is now live • A heat decarbonisation plan with actions has been developed for both hospital sites • 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 • 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 group.	**Strong working relationships with partners on the climate emergency. Delivery of our Green plan and Travel plan** **Lead: SS** Transformation Programme Board Trust Board

Collaborate with partners across West Yorkshire and in place to deliver resilient system plans.	**GREEN** on track	Following the legislative changes set out in the Health and Care Bill that was enacted on 1st July 2022 the West Yorkshire Health and Care Partnership (ICS) has established a West Yorkshire Integrated Care Board (ICB) and local place based sub-committees of the ICB in Calderdale and Kirklees. The Trust has confirmed senior leadership capacity to support the new place based ICB working arrangements. Trust Board development workshops have been held to discuss partnership working and the role of the Trust as an 'anchor partner' to support and enable integrated working in local Places. This is informing a refresh of the Trust's corporate 5 year strategy that will be submitted for Trust Board approval in February 2023. The Trust continues to collaborate as a member of the West Yorkshire Association of Acute Trusts (WYAAT) to develop and implement new ways of working across hospital Trusts in West Yorkshire, this includes developments related to: • clinical support services - imaging, pharmacy, pathology, digital developments such as scan for safety • corporate services - workforce, procurement • clinical service models - vascular and non-surgical oncology The Trust is working closely with partners to provide 'mutual aid' and enable service recovery and resilience.	**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

11. Finance and Performance Chair Highlight Report

For Assurance

Presented by Andy Nelson

Calderdale and Huddersfield NHS Foundation Trust

CHAIR'S HIGHLIGHT REPORT
to the Board of Directors

Committee Name:	Finance and Performance Committee
Committee Chair:	Andy Nelson, Non-Executive Director
Date(s) of meeting:	7 October 2022 (chaired by Nigel Broadbent) 1 November 2022
Date of Board meeting this report is to be presented:	10 November 2022

ACKNOWLEDGE

- Continued excellent performance in Cancer – CHFT a top 3 performer nationally among acute trusts.
- Despite growing ED attendance CHFT continues to be a top-10 performer nationally with regard to 4-hour wait times.
- Recovery performance still largely on track with strong achievement on 78- and 104-week waiters and 52-week waiters compared with the external plan and with Diagnostics overall performance now above 93%.
- The cost per case model in theatres recognised regionally and nationally as innovation with positive feedback from WYAAT on theatre start times.
- Blandine Renou has been shortlisted for the Nursing Times Preceptor of the year.
- Good progress on execution of THIS Commercial Strategy after 6 months – on track to meet targets set for 2022/23.
- The committee reviewed progress in the third year of the Digital Strategy – some notable projects, such as Point of Care Testing and Pharmacy EPR Integration, which have delivered both efficiency and patient benefits.

ASSURE

- Review of Recovery Performance to take place against revised trajectories and forecasts for the second half of the year to ensure overall 104% target is met and progress is maintained on long waiters.
- The committee were assured that action plans and deep dives are in place to tackle areas where elective recovery performance is not hitting target.
- Productivity and Improvement programme in place for theatres.
- There were no further never events in August and September.
- Review of approach to 22/23 efficiency target from Effective Resources Group ('ERG') and progress to date – on track to mee CIP target of £20m in 2022/23.
- 2nd Review of High-Level Risks attributable to F&P Committee under the Board Assurance Framework with no new risks attributable to the Committee.
- Work Plan for 22/23 approved.
- Integrated Performance Report (IPR) and framework being refreshed to update for NHS performance and local performance metrics. Draft version of revised IPR to be brought to F&P January meeting.

AWARE

- Current trajectory is that theatre staffing will be fully established by mid-December – key to meeting elective recovery targets.
- Business case regarding stroke pathway, stroke hub and community beds being reviewed for affordability.

- Backlog volume of ASIs and Follow-Up appointments still a concern – will it lead to greater pressure on 52-week waits.
- At the end of month 6 the trust is reporting a deficit position of £11.21m which is £0.88m adverse to plan. This is driven primarily by Covid costs and agency spend and latterly paying enhanced rates for Bank work.
- Although the trust continues to forecast a £17.35m for the year in line with the plan there is an increasing risk that this will not be met. The finance team have modelled some scenarios and the 'likely case' is now showing a further deficit against plan of £5.5m. This assumes the current operational pressures continue but CIP is achieved and pay awards and elective recovery are fully funded. Winter will bring further pressures and there is the risk of industrial action.
- The committee were assured that all risks to the financial plan are getting the necessary executive attention including working with partners at place and ICB level.

ONE CULTURE OF CARE

One Culture of Care considered as part of the performance and finance reports and commitment of operating services staff noted as part of the surgery and theatres deep dive and staff recruitment taking place within the stroke unit.

12. Integrated Performance Report – September 2022

To Note

Presented by Jonathan Hammond

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Date of Meeting:	Thursday 3rd November 2022
Meeting:	Board of Directors
Title:	QUALITY & PERFORMANCE REPORT
Author:	Peter Keogh, Assistant Director of Performance Kirsty Archer, Deputy Director of Finance Neeraj Bhasin, Deputy Medical Director Andrea Dauris, Interim Deputy Director of Nursing Kim Smith, Assistant Director of Quality Jason Eddleston, Deputy Director of Workforce and OD
Sponsoring Director:	Jonny Hammond, Acting Chief Operating Officer
Previous Forums:	Executive Board, Finance & Performance Committee

Purpose of the Report

To provide the Board of Directors with a single combined narrative that seeks to triangulate current performance for the month of September 2022.

Key Points to Note

September has seen performance improve across a number of domains and puts the Trust overall at its best position since May in terms of achievement of performance indicators.

The **SAFE** domain indicators have seen their best performance in the last 2 months due to an improvement in % Emergency Sepsis patients receiving antibiotic treatment within 1 hour of diagnosis.

The **CARING** domain has not seen any change with only 1 of the 5 FFT areas achieving target whilst both complaints and dementia screening are still some distance from target but with action plans in place.

The **EFFECTIVE** domain has improved overall and also shown a small improvement in #Neck of Femur performance. With regard to HSMR, the current rolling position reporting to July 2022 is 107.98 which continues to mean CHFT lies above the 'as expected' range. The HSMR position over the last 4 months appears to be lower than the end of 2021 into early 2022. With regard to SHMI, the current rolling position reporting to June 2022 is stable at 107.85 meaning CHFT lies within the expected range and is not an outlier.

The **RESPONSIVE** domain has improved with Cancer 28-day faster diagnosis performance achieving target again. For stroke patients those scanned within 1 hour of hospital arrival has improved. ED performance at 75.44% was the 3rd best monthly performance this calendar year whilst % Diagnostics seen within 6 Weeks at 93.45% was its best performance in over 12 months. Patient numbers waiting > 52 weeks also continues to decrease.

WORKFORCE domain has improved with rolling 12-month non-Covid absence rate at 4.73%, its lowest point since March 2022. Return to Work Interviews have fallen to their worst position since December.

FINANCE From a financial point of view, year to date the Trust is reporting a £9.83m deficit, a £0.88m adverse variance from plan. The in-month position is a deficit of £1.38m, a £0.51m adverse variance. The adverse variance in month is driven by inflationary pressures and staffing costs, in particular the impact of Enhanced Bank rates, (£0.9m in Month 6), and high-cost Agency staff.

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 for September 2022.

Calderdale and Huddersfield NHS Foundation Trust

Performance
September 2022

Benchmarking
CHFT has been recognised nationally as 1 of only 3 organisations to achieve consistently the Two-Week target (93%) to see patients urgently referred with Suspected Cancer since August 2019. This is an outstanding achievement.

In addition:
For the period April to June 2022 CHFT's Cancer 62-day Referral to Treatment performance was in 1st position nationally for all acute Trusts.

For the period April to July 2022 CHFT's ED 4-hour type 1 performance was in 7th position nationally for all acute Trusts.

This just confirms our excellent performance nationally for these 2 key indicators.

We also continue to perform well in terms of our Recovery position around 104 weeks, 78 weeks and 52 weeks.

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 year, Covid attendances are beginning to rise again. 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 sustained periods in OPEL 3; however we have also seen a good 10 days through the month of September where we remained in OPEL 2 and well exceeded 80% day on day against the ECS target. We continue to have extra capacity open on both the Huddersfield and Calderdale sites to maintain our position and this creates both nursing and medical staffing issues. We also continue to see an elevated TOC list with very few days where the position has dropped below 100. We have continued to see long waits above 8 and 12 hours in both emergency departments which is an extremely poor patient experience, and we know increases risk for patients in terms of outcomes.

Covid numbers continue to rise, with a significant number of outbreaks reported. Asymptomatic elderly patients that are tested before going to a care home are causing us delays as they are then unable to be discharged for another 10 days due to care home insurance issues, this is increasing the LOS for patients and impacting on patient flow. We have gone back to our named Covid positive areas to manage this current wave and have resumed testing on all admitted patients.

We have achieved a small HPV programme to try to prevent the continued rise in C-diff, with wards 5, 6, 15 and 20 all undergoing a ward move and full HPV.

Responding to complaints in a timely fashion continues to be a challenge, however it should be noted that we continue to remain at approximately 45% of complaints closed in line with the target timeframe. There continues to be an increased level of oversight and scrutiny at both divisional level and corporate level, with weekly oversight meetings which will help us to continue on this trajectory.

With regard to HSMR, the current rolling position from October, reporting to July 2022, is 107.98 which continues to mean CHFT lies above the 'as expected' range. For context, the national position

is just below 102. The HSMR position over the last 4 months appears to be lower than the end of 2021 into early 2022.

With regard to SHMI, the current rolling position from October, reporting to June 2022, is stable at 107.85 meaning CHFT lies within the expected range and is not an outlier. For context, the national position is tracking at 103.

The 'observed deaths' has reduced over the last 3 months with 'crude mortality' in September 2022 being 1.15%, the lowest since pre-Covid. This will, however, take some time to impact on HSMR. With respect to crude mortality the Trust is sitting in 52nd position out of 124 trusts.

There is a reduced rate of red SHMI alerts, and where an alert comes in, there is a process for a clinical structure judgement review to validate a documented pathology and identify any care concerns. This is more an internal assurance process to understand the mortality alert rather than an ability to retrospectively amend the data.

With respect to HSMR data there are some continuing themes which are being investigated. These are around: the clinical input from the specialist palliative care team, to determine if the SSNAP parameters in stroke are impacting on mortality and performing clinical reviews in sepsis to determine if a more specific initial clinical diagnosis could have been documented rather than a more generic first admission documentation of 'sepsis' which will drive up sepsis mortality indicators.

From a financial point of view, in the year to date the Trust is reporting a £9.83m deficit, a £0.88m adverse variance from plan. The in-month position is a deficit of £1.38m, a £0.51m adverse variance. The adverse variance in month is driven by inflationary pressures and staffing costs, in particular the impact of Enhanced Bank rates, (£0.9m in Month 6), and high-cost Agency staff.

Agency expenditure year to date is £6.31m, £3.30m higher than planned. The Integrated Care Board has set the Trust's Agency expenditure ceiling for the full year at £6.9m, and the Trust is already close to exceeding that ceiling.

ERF of £5.46m has been assumed in the year-to-date position in line with plan. It has been confirmed that ERF will not be clawed back for the first half of the year, but this remains a risk going into the next 6 months, as activity year to date was below the planned level and some claw back might be required if the Trust is unable to catch up this activity in future months. Updated guidance on securing this funding is awaited.

The Trust has a plan to deliver a £17.35m deficit for the year and continues to report a forecast in line with this plan. The risk to delivery of this forecast remains significant due to inflationary impacts, a Pay Award funding shortfall of £0.84m and Bank and Agency staffing pressures linked to capacity requirements. The forecast assumes full delivery of a challenging £20m efficiency target and that the Trust will deliver its elective activity plan and secure in full £11.9m of Elective Recovery Funding.

Colleague health and wellbeing activity continues so everyone feels appropriately supported whilst at work. This means concentrating attention on One Culture of Care must-do activity including colleague rest and recuperation, hydration and nutrition, use of the wellbeing hour, health and wellbeing risk assessments and clear access points for our internal Listening Ear service and external psychologist-led employee assistance programme provided by CareFirst. Our rolling 12-month non-Covid absence rate is at 4.73%, its lowest point since March 2022.

Essential Safety Training (EST) core programme compliance remains strong albeit there is a general downward trend which is subject to close monitoring. Data Security Awareness, Fire Safety and

Infection Prevention and Control EST are all below our 90% target.

The 12-month turnover rate is at 9.32%, continuing an increasing trend, although it remains below the 11.5% ceiling.

There has been a significant increase in vacancies in establishment in 2022/23, in part due to a different approach to budget setting. Budgets and vacancies have been planned across the year to include Covid planning, winter planning and elective recovery. Funding that is typically allocated to these areas have been translated into WTE and therefore reflect in the vacancy position. Affected areas include extra capacity wards, Emergency Department streaming, elective recovery and associated admin. The vacancy position would be offset where possible against recruitment to posts and bank and agency.

A review of September 2022 data indicates that the combined RN and non-registered clinical staff metrics resulted in 23 of the 28 clinical areas having fewer **CHPPD** than planned, with a total deficit of 0.7 CHPPD across the Trust compared to the planned position. The gap in CHPPD is at its broadest with the RN workforce representing 0.8 deficit whilst HCSW CHPPD was as planned. This position, whilst recognising actual care hours are still below planned, demonstrates a steady state in actual care hours delivered to our patients across the past 3 months and positions CHFT at the top of the 3rd quartile when benchmarked nationally according to Model hospital data.

The CHPPD planned vs actual gap is most prominent in the FSS division (2.0 CHPPD deficit). This is largely attributable to the staffing challenges in Maternity due to vacancies. Any patient safety risk is mitigated, when necessary, by cohorting the birth centre with the Labour ward to ensure appropriate 1:1 care of women in labour.

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 and attrition has now created a 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 the workforce model.

compassionate care

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Integrated Performance Report

September 2022

Report Produced by : The Health Informatics Service

Data Source : various data sources syndication by VISTA

Key Indicators

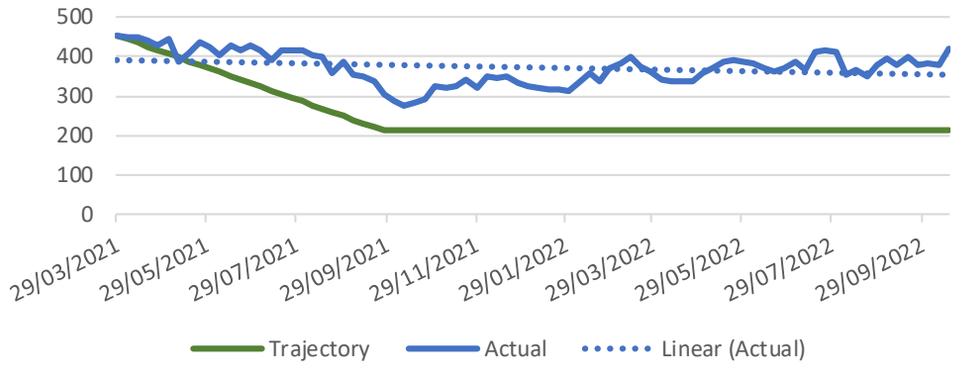
	21/22	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	YTD	Performance Range		
SAFE																			Green	Amber	Red
Never Events	2	1	0	0	0	0	0	0	0	0	1	0	1	1	1	0	**0**	**3**	0		>=1
CARING																			Green	Amber	Red
% Complaints closed within target timeframe	63.61%	100.00%	69.44%	55.10%	71.43%	58.82%	94.29%	70.73%	37.50%	44.44%	29.41%	27.08%	48.98%	28.57%	44.64%	55.32%	**45.45%**	**42.29%**	100%	86% - 99%	<=85%
Friends & Family Test (IP Survey) - % Positive Responses	96.91%	97.00%	96.38%	96.61%	97.33%	98.26%	97.47%	97.35%	97.10%	97.36%	96.36%	97.57%	97.14%	97.60%	98.27%	98.02%	**in arrears**	**97.68%**	>=90% / >=95% from	September	<=79%
Friends and Family Test Outpatients Survey - % Positive Responses	92.16%	92.29%	91.88%	91.77%	91.49%	91.51%	92.45%	93.02%	93.20%	92.15%	93.71%	91.82%	92.24%	90.33%	92.02%	90.48%	**in arrears**	**91.46%**	>=90% / >=93% from	September	<=79%
Friends and Family Test A & E Survey - % Positive Responses	82.76%	82.98%	78.53%	81.33%	80.85%	81.01%	82.39%	84.40%	86.40%	84.69%	76.52%	83.18%	81.09%	79.94%	79.63%	83.03%	**in arrears**	**81.33%**	>=80% / >=85% from	September	<=69%
Friends & Family Test (Maternity) - % Positive Responses	94.64%	91.23%	97.53%	95.19%	97.69%	93.98%	93.20%	98.33%	92.30%	91.00%	95.12%	96.74%	97.92%	95.90%	93.48%	93.48%	**in arrears**	**95.26%**	>=90% / >=95% from	September	<=79%
Friends and Family Test Community Survey - % Positive Responses	92.44%	93.37%	87.74%	92.52%	94.27%	91.12%	95.86%	93.68%	95.50%	91.21%	98.32%	94.79%	94.52%	88.96%	92.73%	94.51%	**in arrears**	**92.80%**	>=90% / >=95% from	September	<=79%
EFFECTIVE																			Green	Amber	Red
Number of MRSA Bacteraemias – Trust assigned	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**	0		>=0
Preventable number of Clostridium Difficile Cases	5	0	1	0	1	0	0	1	1	0	0	2	1	1	0	1	**0**	**5**	<3		>=3
Local SHMI - Relative Risk (1 Yr Rolling Data)	106.36	105.07	105.49	105.91	105.39	106.60	106.99	106.36	104.79	104.38	104.58	105.39	107.98	107.85				**107.85**	<=100	101 - 109	>=110
Hospital Standardised Mortality Rate (1 yr Rolling Data)	102.2	90.00	90.56	92.19	93.78	95.20	97.00	99.27	102.20	102.64	104.59	105.86	106.69	107.31	107.98			**107.98**	<=100	101 - 109	>=111
RESPONSIVE																			Green	Amber	Red
Emergency Care Standard 4 hours	78.99%	86.16%	78.59%	79.57%	78.29%	75.97%	76.81%	72.95%	75.70%	73.92%	74.05%	72.64%	75.85%	72.97%	72.52%	73.27%	**75.44%**	**73.79%**	>=95%	81% - 94%	<=80%
% Stroke patients admitted directly to an acute stroke unit within 4 hours of arrival	36.71%	54.90%	42.29%	43.14%	42.00%	33.87%	33.33%	23.19%	16.67%	15.79%	25.45%	25.53%	28.81%	13.33%	24.60%	19.18%	**33.30%**	**23.59%**	>=90%		<=85%
Two Week Wait From Referral to Date First Seen	98.38%	97.82%	97.93%	98.51%	98.80%	98.58%	99.21%	97.96%	98.39%	98.35%	97.56%	97.76%	98.46%	98.03%	97.77%	97.80%	**96.36%**	**97.69%**	>=93%	86% - 92%	<=85%
Two Week Wait From Referral to Date First Seen: Breast Symptoms	97.53%	100.00%	98.68%	100.00%	97.96%	98.45%	96.84%	96.00%	93.84%	97.25%	93.50%	96.92%	96.27%	98.20%	97.83%	100.00%	**100.00%**	**98.22%**	>=93%		<=92%
31 Days From Diagnosis to First Treatment	98.21%	97.63%	98.94%	97.92%	95.88%	94.89%	99.02%	99.37%	98.35%	99.39%	98.31%	97.58%	98.87%	99.00%	99.45%	97.80%	**98.84%**	**98.58%**	>=96%		<=95%
31 Day Subsequent Surgery Treatment	95.43%	100.00%	97.78%	94.44%	84.78%	100.00%	92.59%	100.00%	93.33%	96.55%	94.44%	96.00%	100.00%	100.00%	100.00%	96.77%	**97.22%**	**98.53%**	>=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%	95.45%	98.63%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	**98.70%**	**99.76%**	>=98%		<=97%
38 Day Referral to Tertiary	50.00%	50.00%	72.73%	47.06%	52.17%	61.11%	50.00%	37.93%	35.00%	66.67%	30.77%	55.17%	64.71%	40.74%	28.57%	25.00%	**42.86%**	**42.40%**	>=85%		<=84%
62 Day GP Referral to Treatment	90.62%	91.87%	91.23%	91.40%	89.77%	91.51%	93.43%	87.32%	89.59%	86.82%	89.71%	91.63%	87.70%	90.69%	85.32%	84.98%	**87.11%**	**87.81%**	>=85%	81% - 84%	<=80%
62 Day Referral From Screening to Treatment	59.47%	48.48%	32.14%	55.26%	32.00%	55.56%	76.19%	81.25%	62.50%	50.00%	96.30%	92.59%	73.68%	70.37%	87.88%	86.67%	**88.24%**	**83.66%**	>=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%	68.93%	73.27%	69.07%	70.56%	76.23%	78.16%	76.82%	76.50%	83.12%	79.54%	77.76%	76.91%	74.07%	76.00%	73.70%	**77.05%**	**75.84%**	>=75%		<=70%
WORKFORCE																			Green	Amber	Red
Sickness Absence rate (%) - Rolling 12m - Non-Covid related	4.83%	4.00%	4.13%	4.23%	4.33%	4.43%	4.49%	4.58%	4.66%	4.63%	4.83%	4.90%	4.91%	4.88%	4.82%	4.77%	**4.73%**	-	<=4.75%	<5.25%	>=5.25%
Long Term Sickness Absence rate (%) -Rolling 12m - Non-Covid related	3.21%	2.85%	2.92%	3.01%	3.07%	3.10%	3.10%	3.12%	3.15%	3.17%	3.21%	3.24%	3.23%	3.20%	3.15%	3.10%	**3.06%**	-	<=3.0%	<3.25%	>=3.25%
Short Term Sickness Absence rate (%) -Rolling 12m - Non-Covid related	1.62%	1.17%	1.21%	1.23%	1.26%	1.33%	1.39%	1.46%	1.52%	1.57%	1.62%	1.66%	1.68%	1.69%	1.68%	1.67%	**1.66%**	-	<=1.75%	<2.00%	>=2.00%
Overall Essential Safety Compliance	92.90%	95.64%	95.48%	93.93%	93.81%	93.22%	93.01%	93.28%	92.50%	92.57%	92.90%	92.54%	92.94%	92.61%	92.63%	91.89%	**90.46%**	-	>=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%	12.04%	17.00%	30.80%	44.51%	54.57%	60.90%	61.72%	63.51%	65.54%	69.06%	0.64%	2.79%	5.94%	9.36%	17.18%	**48.64%**	-	>=95%	>=90%	<90%
FINANCE																			Green	Amber	Red
I&E: Surplus / (Deficit) Var £m YTD	2.27	0.28	-0.22	-1.40	-1.62	**0.00**	-0.05	0.17	0.02	-0.06	-0.11	0.11	0.11	0.59	-0.34	-0.83	**-0.51**	**-0.88**			

SWOT Analysis

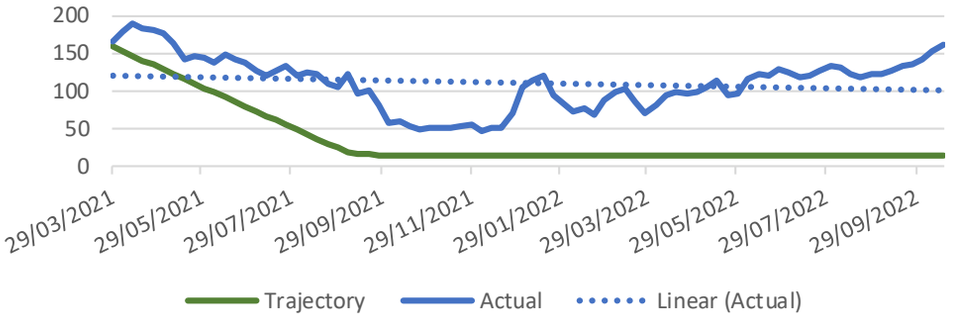
Strengths	• Agreed Recovery Framework. • Continuing to focus on Trust agreed priorities for elective patients, e.g. ensuring we prioritise patients with learning disabilities, P2s and long waiters (104 weeks). • Ongoing comprehensive theatre staff engagement and workforce development programme. • Progressing 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. • CMDU programme started 17th January in collaboration with Locala and Mid Yorkshire to reduce hospital attendances. This funding has now been extended for the whole of 22/23. • Urgent Community Response 0-2 hour service started 6th December and is being well received and utilised with on average 187 referrals per month and 85 admissions avoided. • Cost per case model implemented and tested by a number of specialties, to roll out to others and allocate according to backlogs • Ward 11 back under the surgical team (now ward 14), await the build up of elective lists in the pipeline, utilising for acute surgical patients currently to support the site pressures
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. • 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. • 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 VW plans were submitted on w/c 13th June, with further CKW workshops diarised to look at cross patch efficiencies and implementation planning. Plans are now well underway and we have a target bed plan to be staggered over the next 18 months. Recruitment is underway with the aim to have the first VW beds live at the start of November. • CHFT Community have agreed to work as a pilot site for developing a community currency tool with NHSE The Community division are currently working up a number of business cases with external partners to maximise some system money earmarked for innovation. In addition we are submitting a business case to Parkinson's UK for some pump primed funding to enhance the Calderdale Parkinson's service. • 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. It has now been agreed to uplift Community DN's to band 7 backdated to January 2022 • 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. • Risk around recruitment to virtual ward posts as initial plans support recruitment of circa 150 WTE posts across the West Yorkshire footprint. 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. • There is currently an ongoing exercise to understand procurement options for Intermediate Care Beds in Calderdale. There is a significant risk to the stability of wider intermediate care provision and pathways the beds go out for open procurement.

INPATIENT WAITING LIST - P2

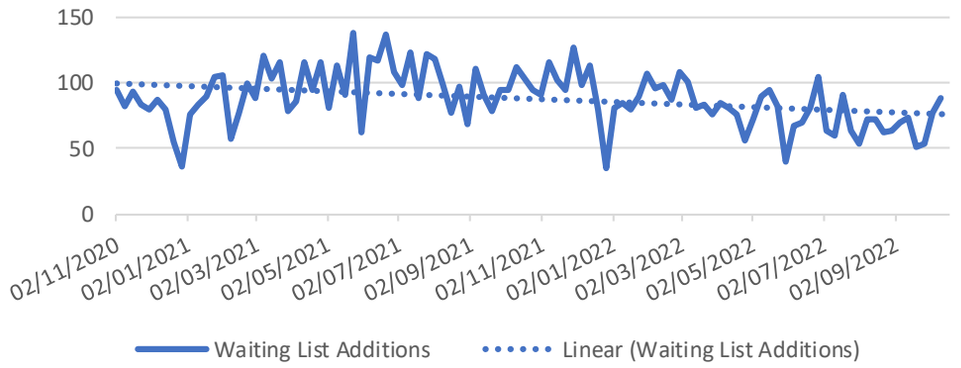
Trajectory vs Actual - Total P2s on Waiting List



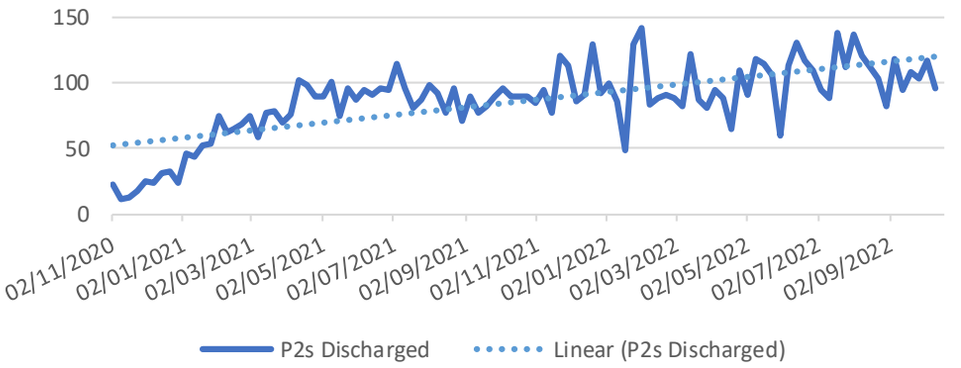
Trajectory vs Actual - Total P2s on Waiting List Over 1 month



P2 waiting List Additions

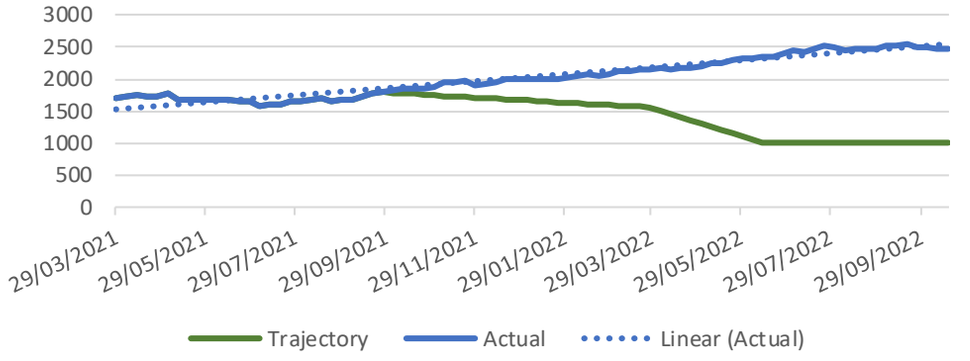


P2 Surgery done in the week

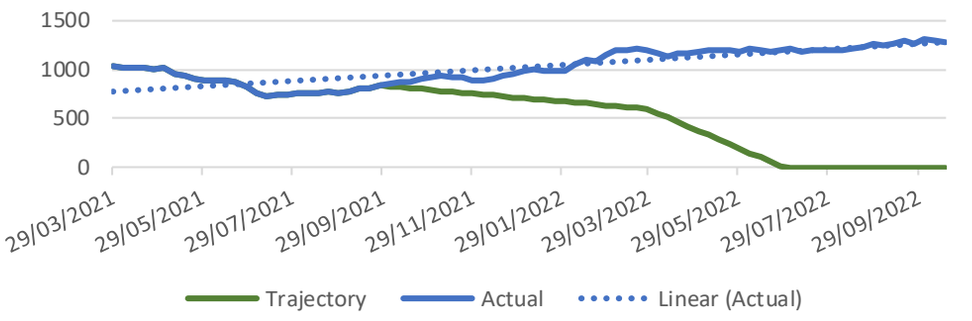


INPATIENT WAITING LIST - P3

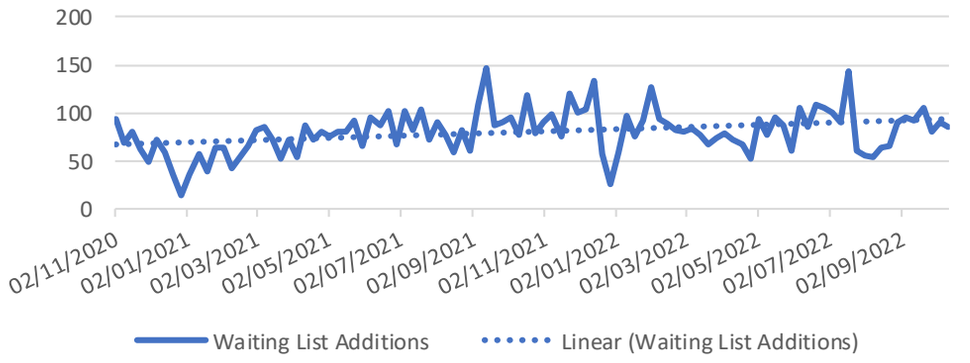
Trajectory vs Actual - Total P3s on Waiting List



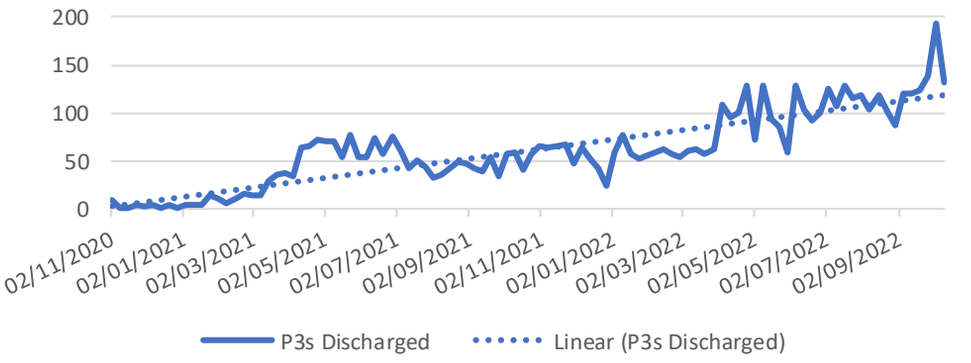
Trajectory vs Actual - Total P3s on Waiting List Over 3 months



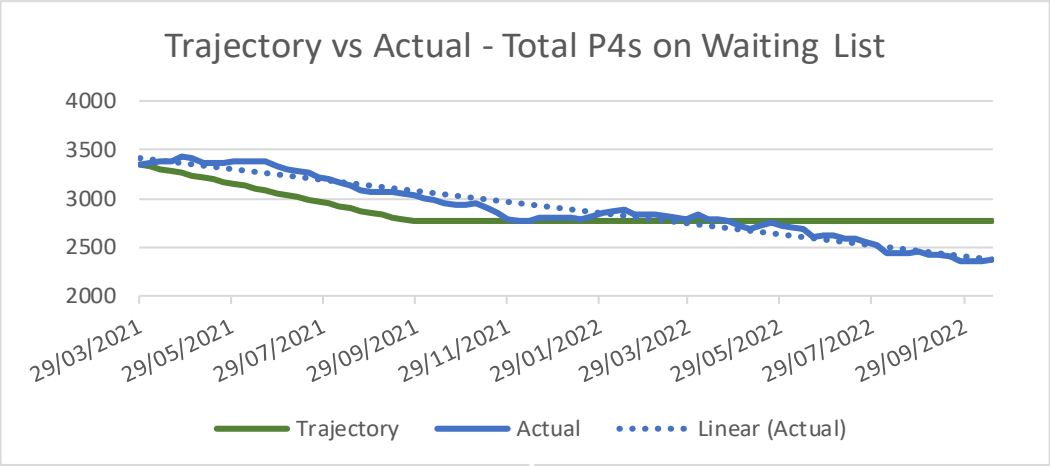
P3 waiting List Additions

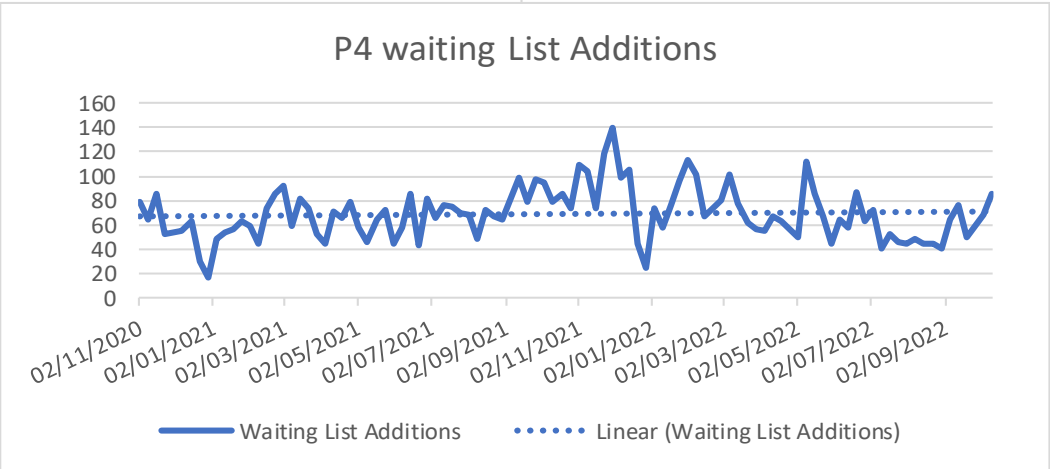


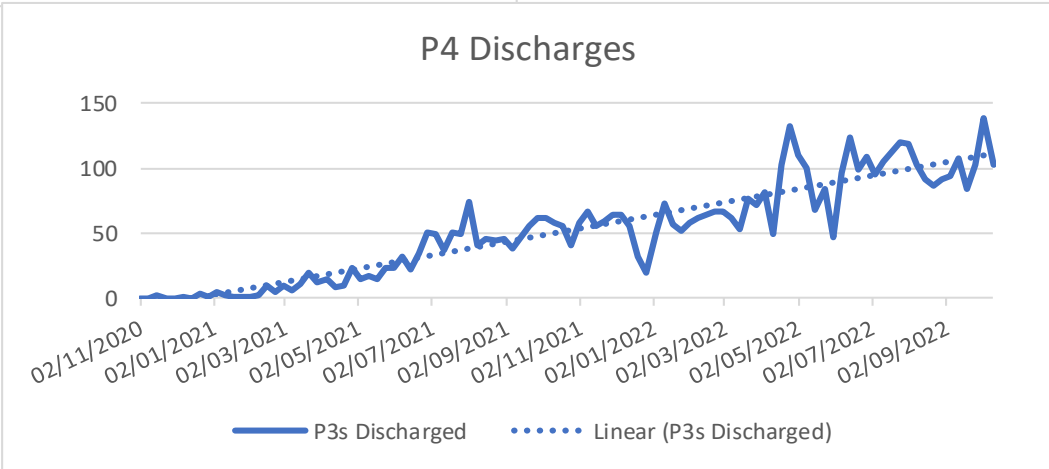
P3 Discharges



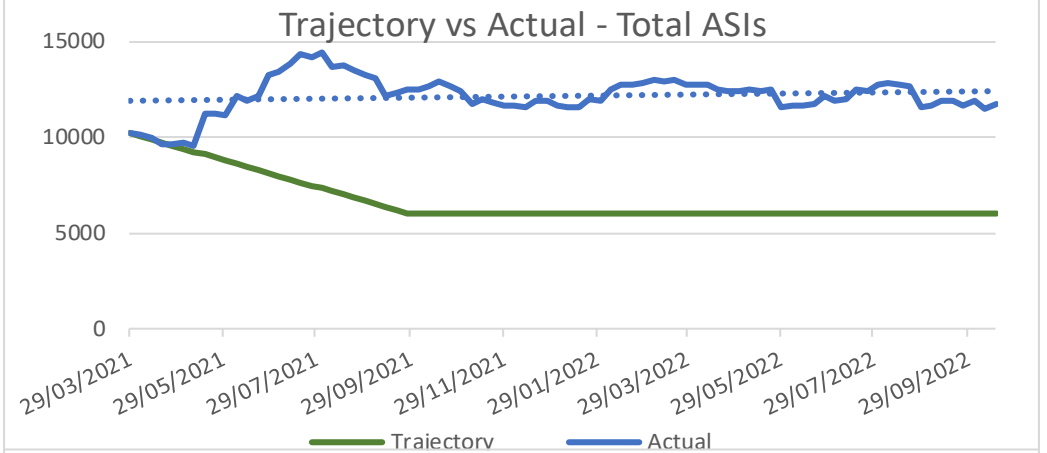
INPATIENT WAITING LIST - P4

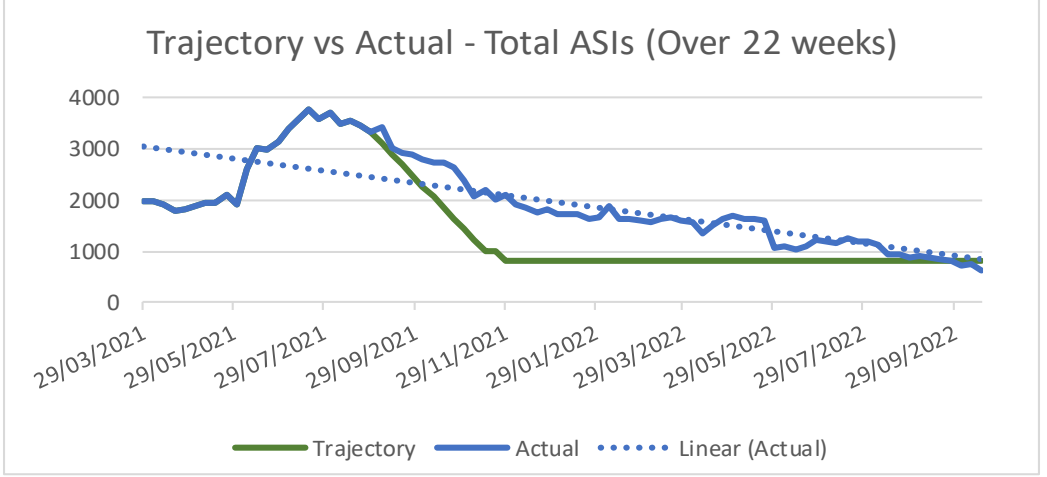






ASIs

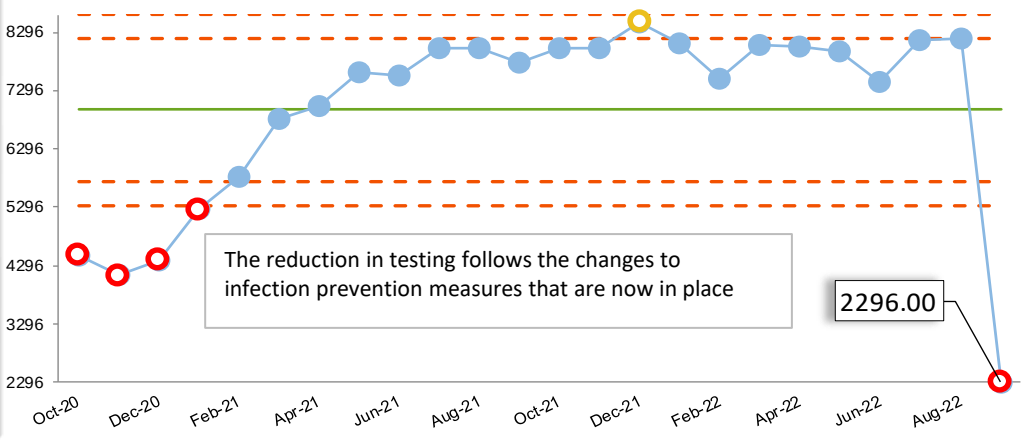

Trajectory vs Actual - Total ASIs
15000
10000
5000
0
29/03/2021
29/05/2021
29/07/2021
29/09/2021
29/11/2021
29/01/2022
29/03/2022
29/05/2022
29/07/2022
29/09/2022
Trajectory
Actual


Trajectory vs Actual - Total ASIs (Over 22 weeks)
4000
3000
2000
1000
0
29/03/2021
29/05/2021
29/07/2021
29/09/2021
29/11/2021
29/01/2022
29/03/2022
29/05/2022
29/07/2022
29/09/2022
Trajectory
Actual
Linear (Actual)

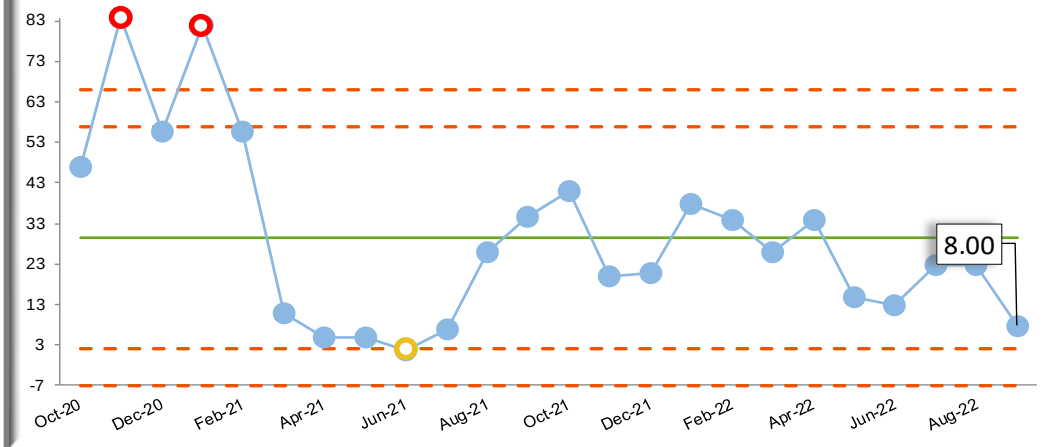
Covid-19 - SPC Charts

Warning Critical Activity Trend Target Line Average Line Control Line Last Data Point

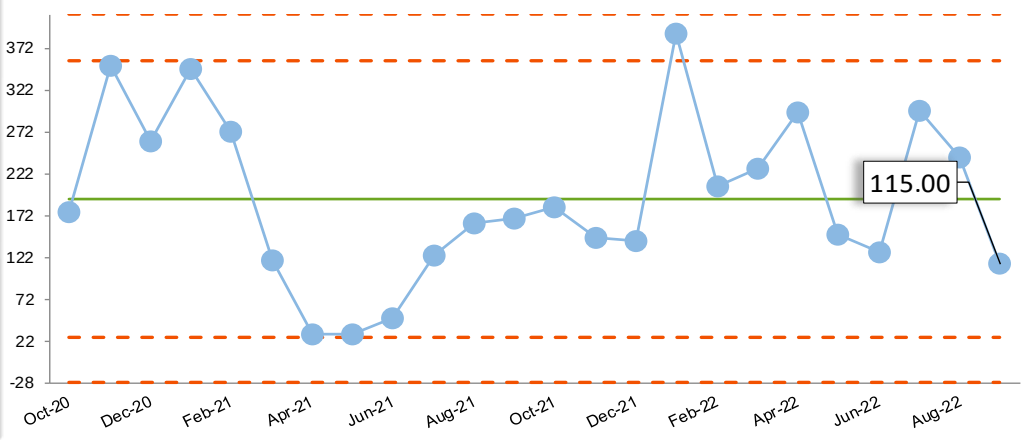
Number of Patients Tested for Covid-19



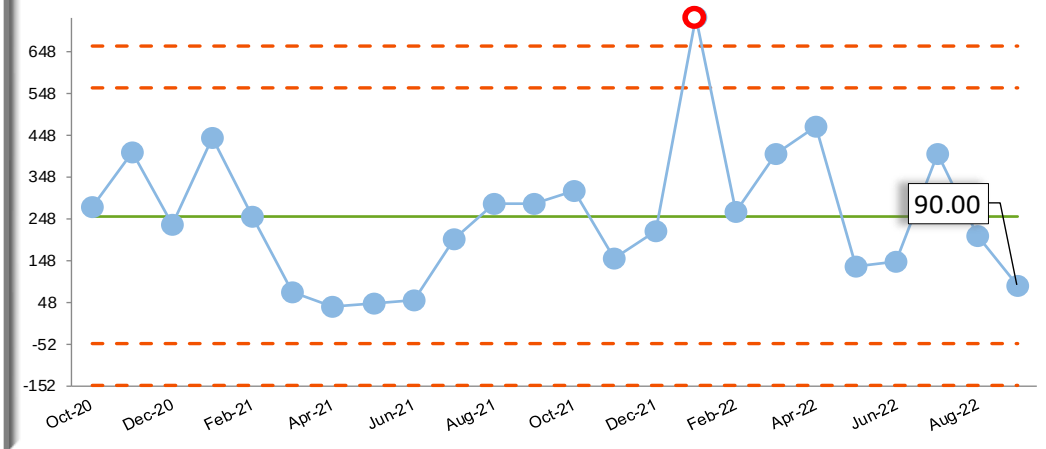
Number of Covid+ Deaths



Number of Covid+ Patients Discharged Well

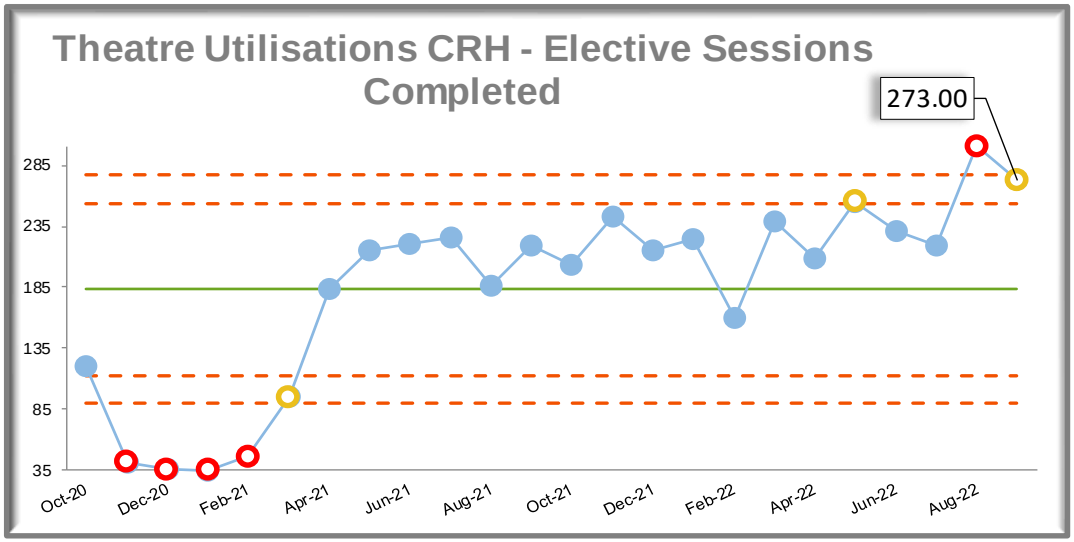


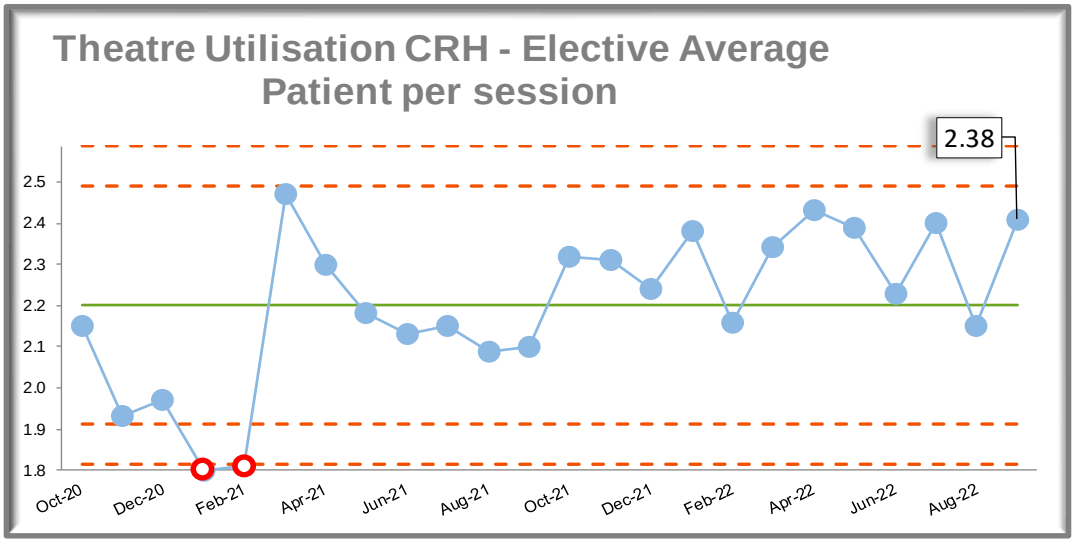
Number of New Covid+

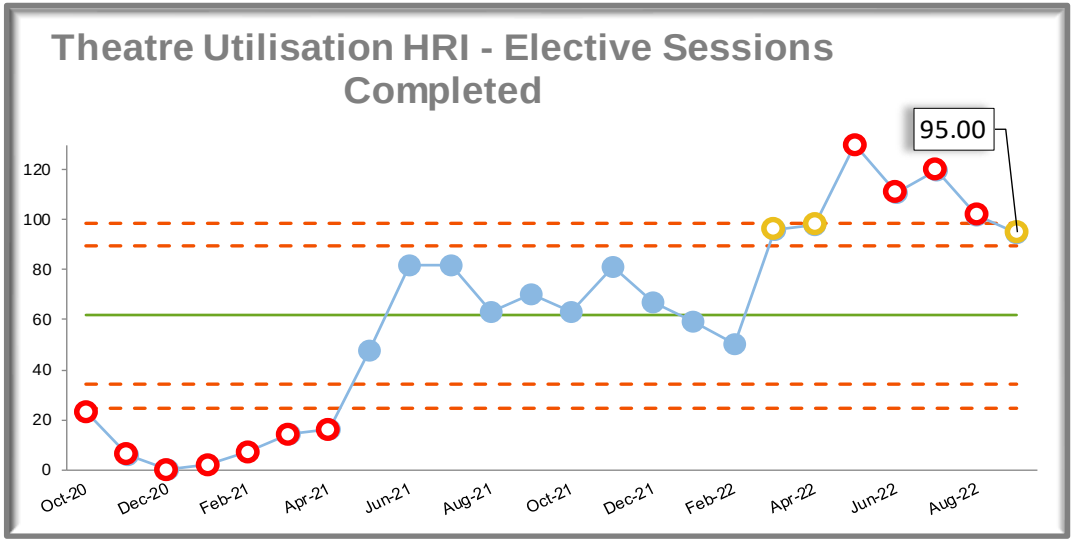


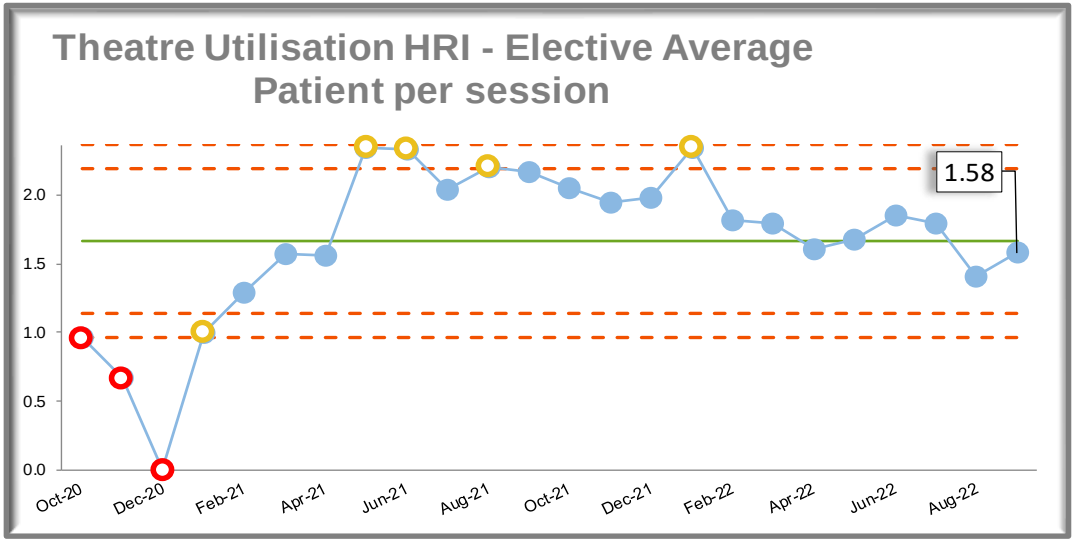
Theatres - SPC Charts

Warning Critical Activity Trend Target Line Average Line Control Line Last Data Point

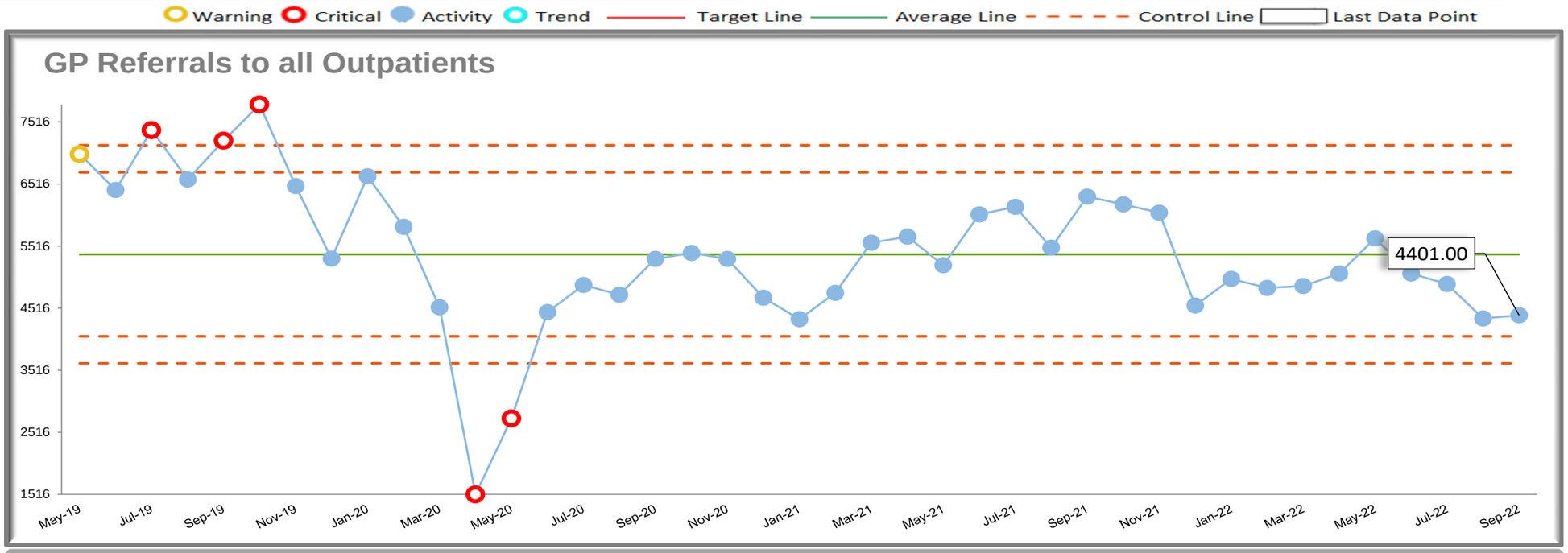


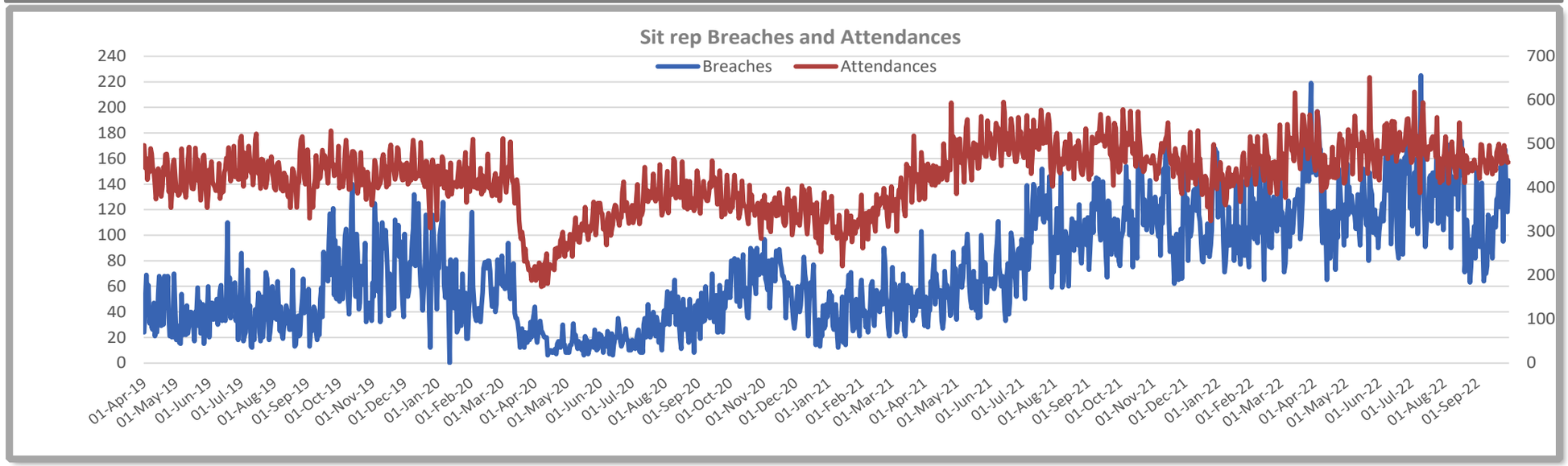




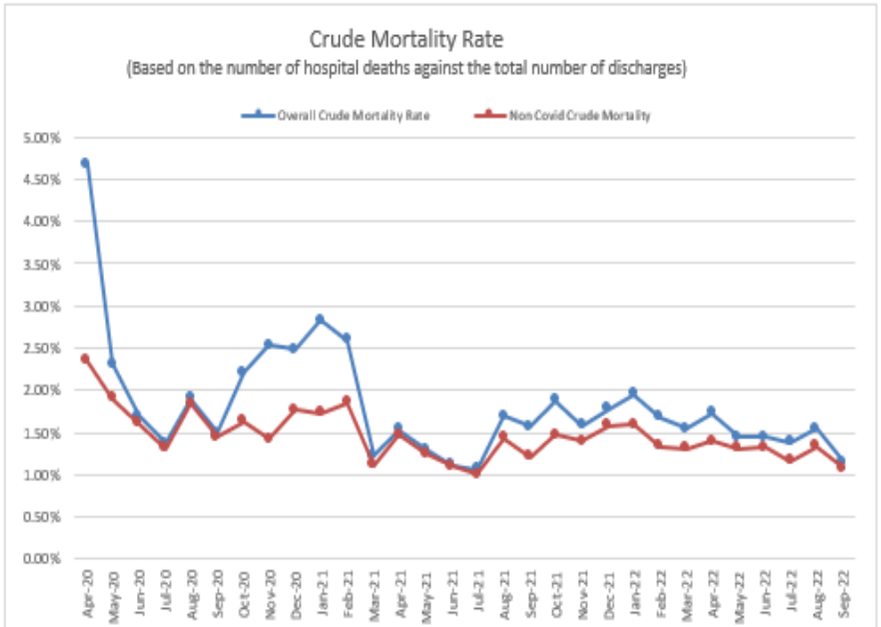


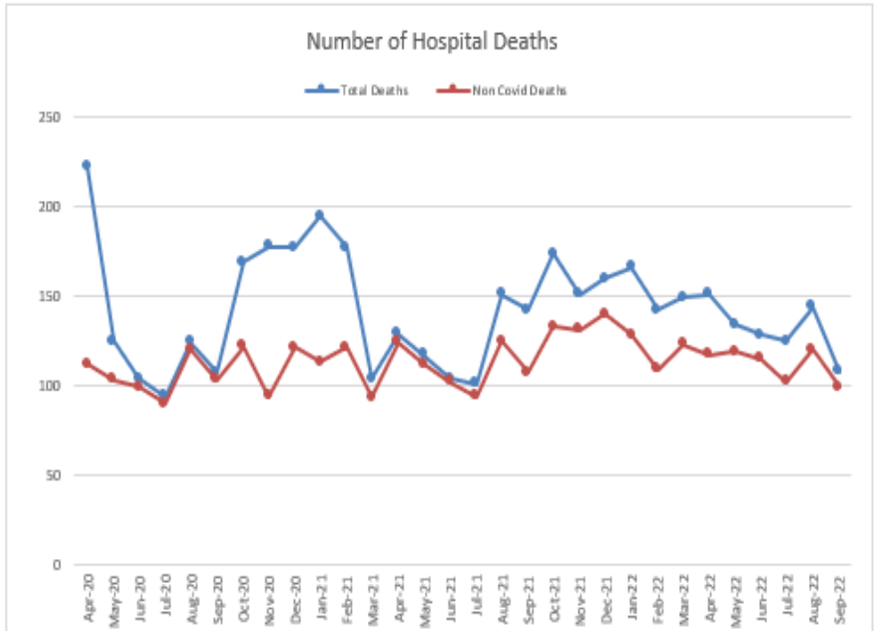
Capacity and Demand

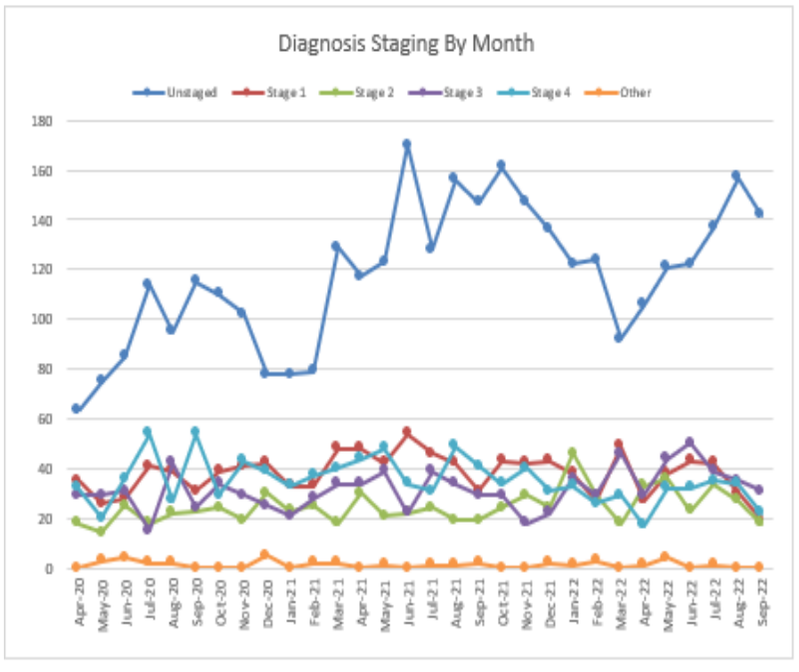


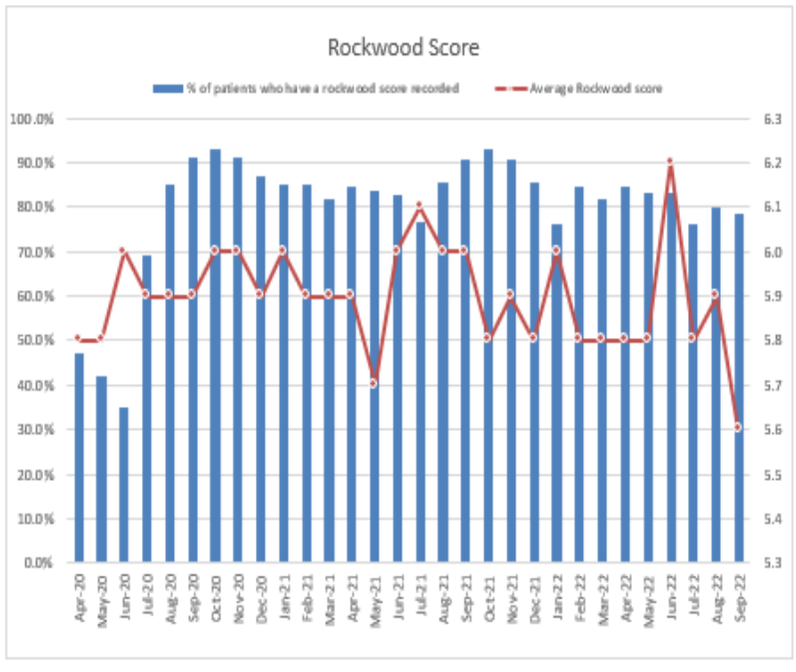


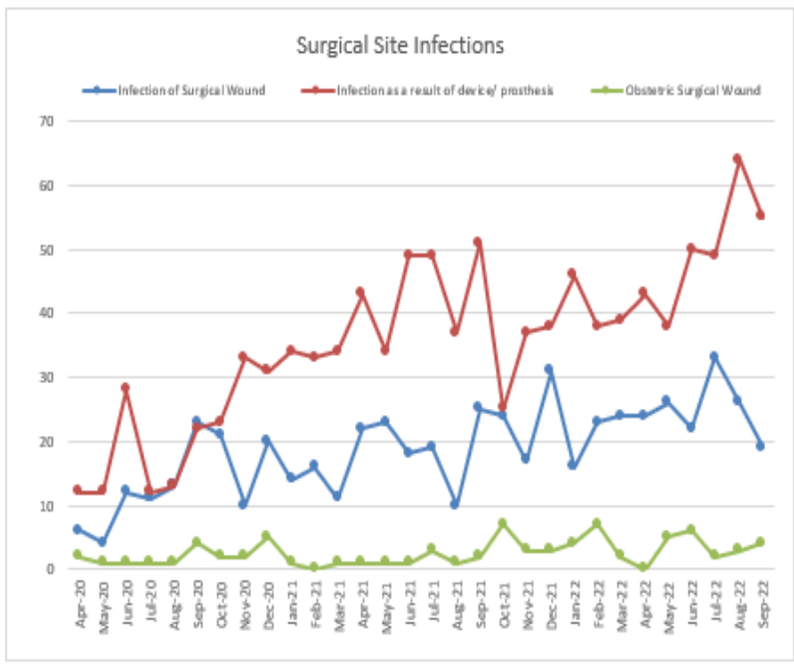
Outcome Measures





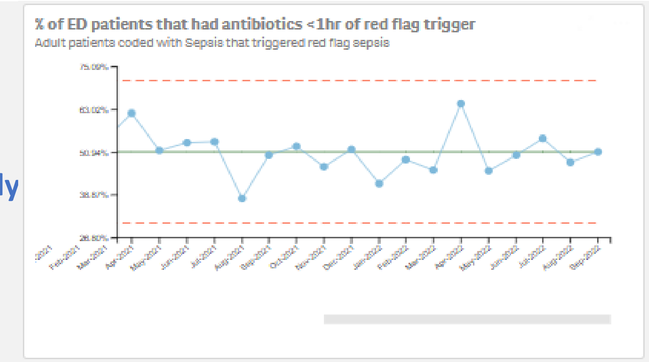


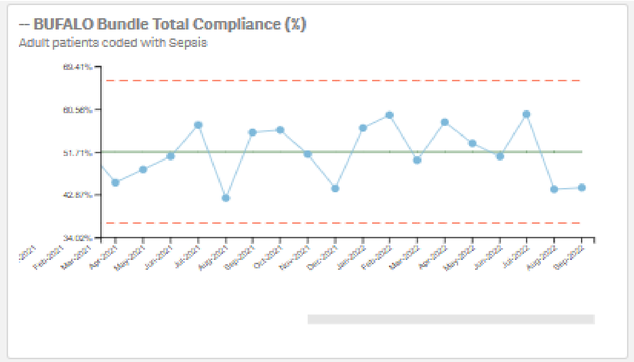




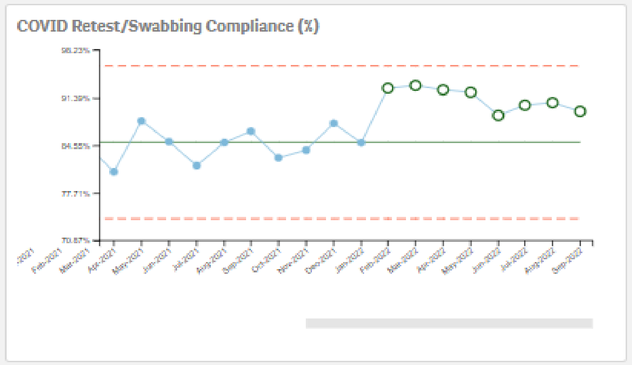
Quality Priorities - Quality Account Priorities

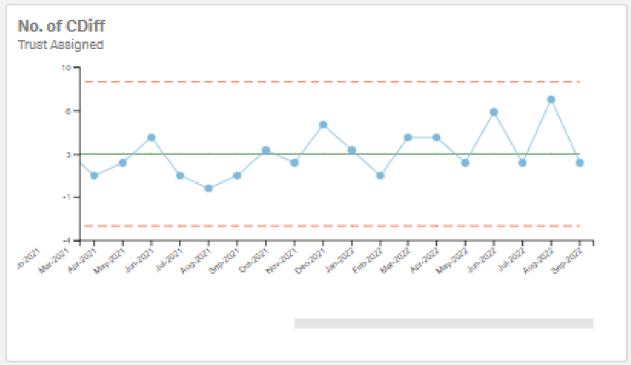
Priority 1
Recognition and timely treatment of Sepsis

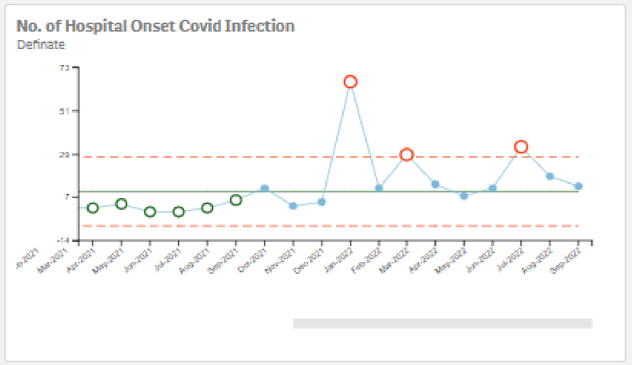




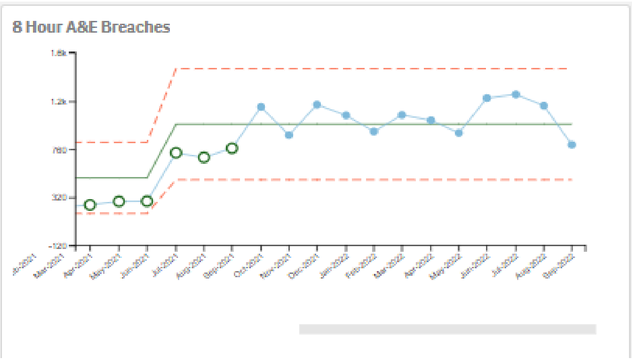
Priority 2
Reduce number of hospital acquired infections including COVID-19

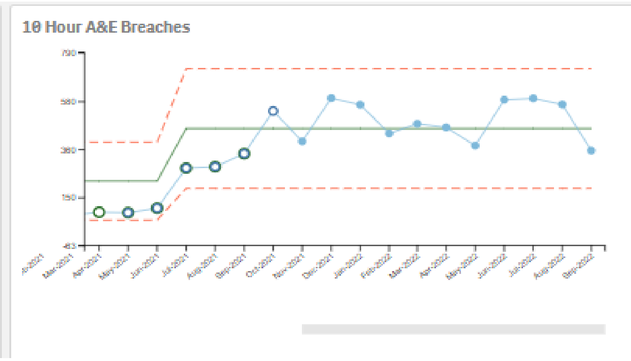


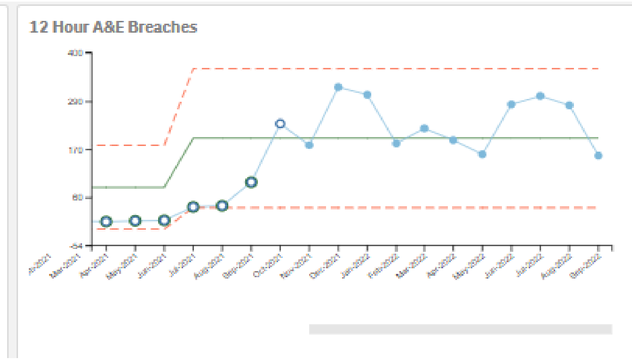




Priority 3
Reduce waiting times for individuals in the Emergency Department

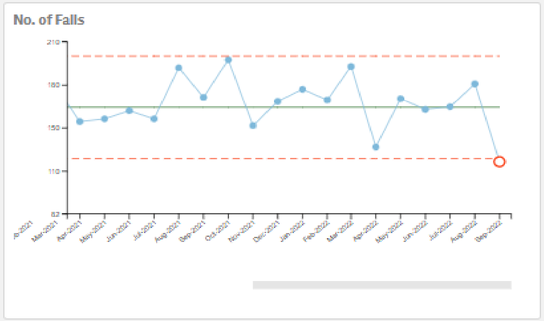


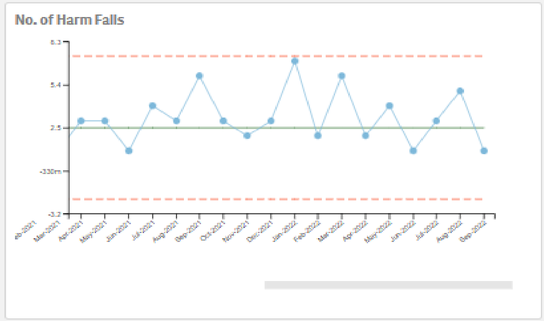


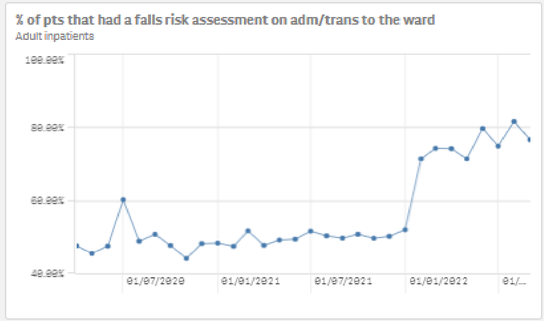


Quality Priorities - Focused Priorities

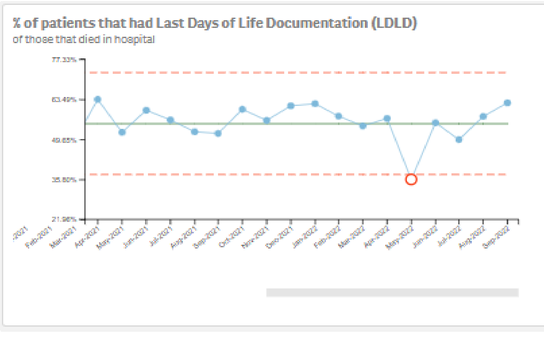
Priority 1
Reducing the number of falls resulting in harm

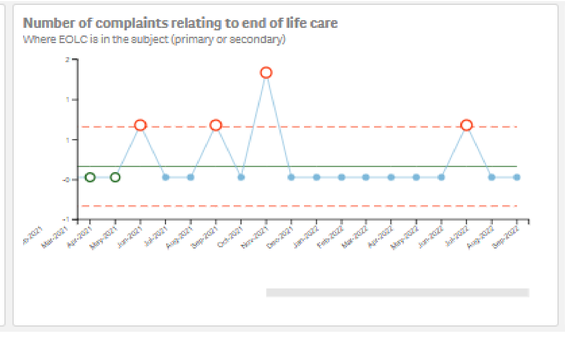


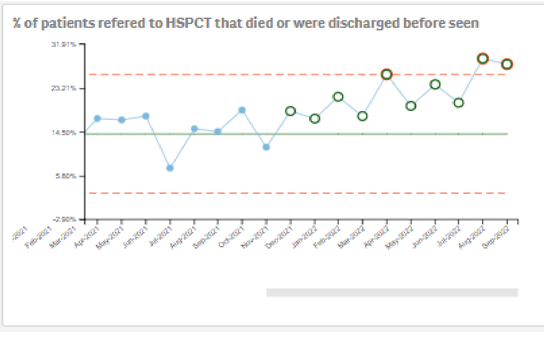




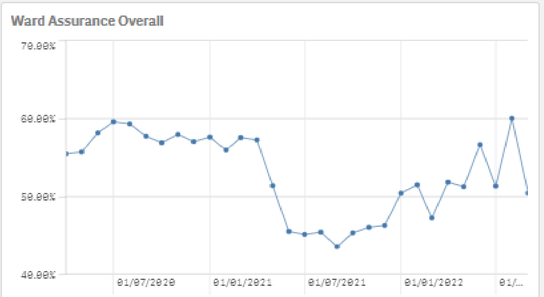
Priority 2
End of Life Care

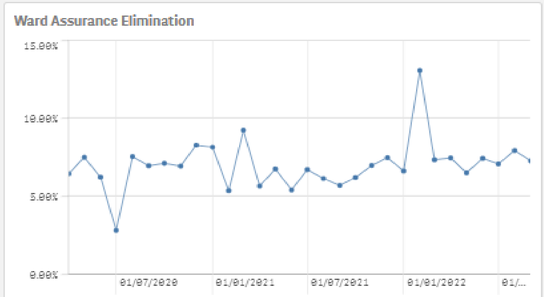


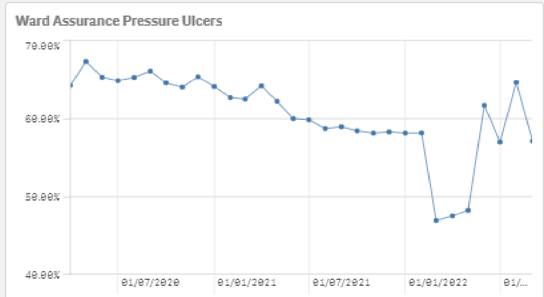




Priority 3
Clinical Documentation





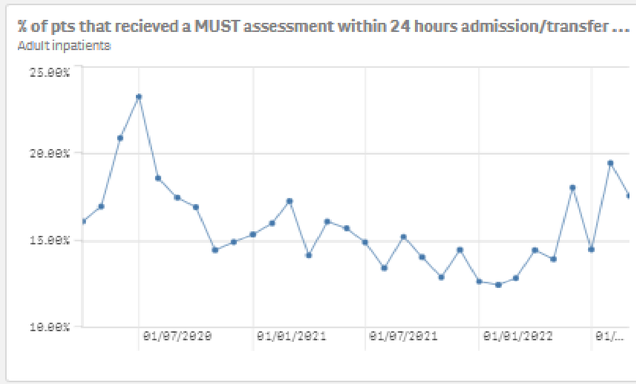


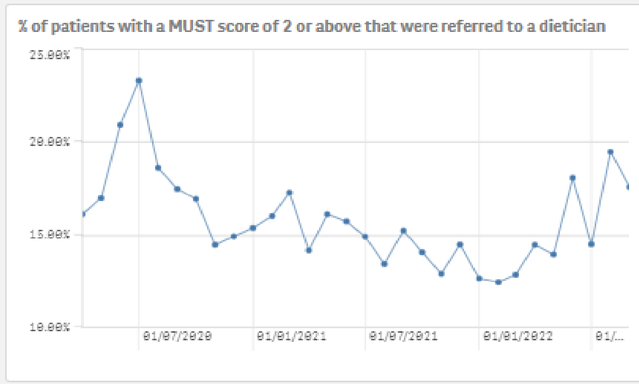
Priority 4
Clinical Prioritisation

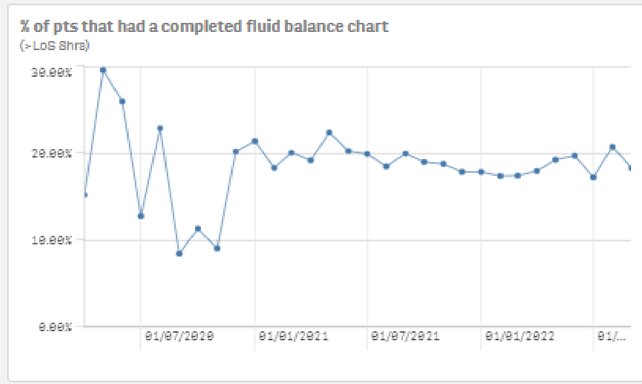
Not Yet Available

Quality Priorities - Focused Priorities

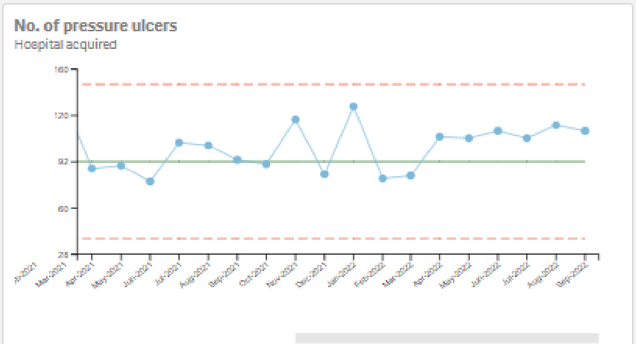
Priority 5
Nutrition and Hydration



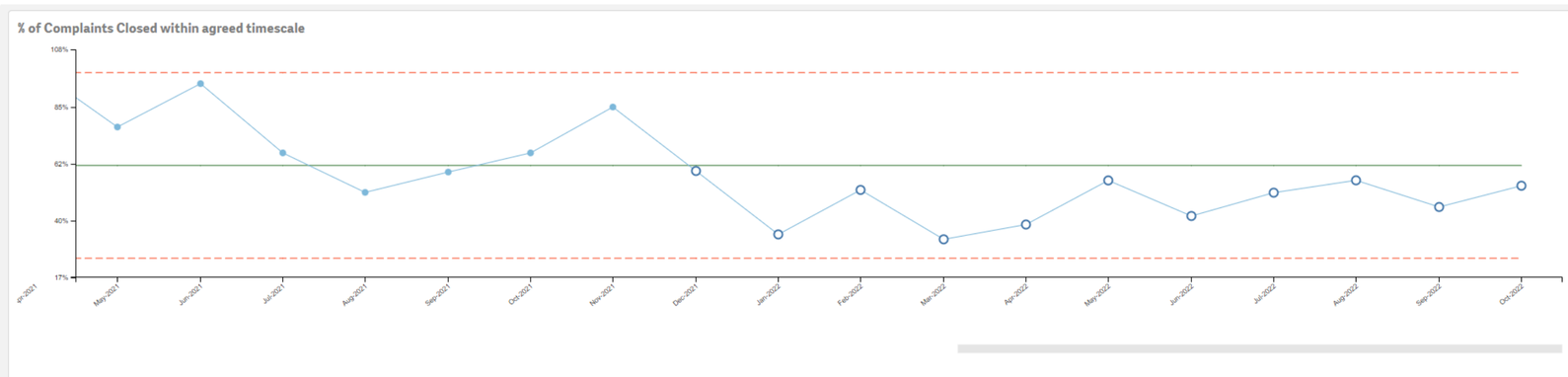




Priority 6
Reduction in the number of CHFT acquired pressure ulcers



Priority 7
Making complaints count



CQUIN - Key Measures

Indicator Name	Description	Top 5	Target	Apr-22	May-22	Jun-22	Q1	Jul-22	Aug-22	Sep-22	Q2	Oct-22	Nov-22	Dec-22	Q3	Jan-23	Feb-23	Mar-23	Q4
CCG1: Flu vaccinations for frontline healthcare workers	Achieving 90% uptake of flu vaccinations by frontline staff with patient contact.	N	Min 70%, Max 90%	Data collection starts in Q3				Data collection starts in Q3											
CCG2: Appropriate antibiotic prescribing for UTI in adults aged 16+	Achieving 60% of all antibiotic prescriptions for UTI in patients aged 16+ years that meet NICE guidance for diagnosis and treatment.	Y	Min 40%, Max 60%	57.00%			57.00%												
CCG3: Recording of NEWS2 score, escalation time and response time for unplanned critical care admissions	Achieving 60% of all unplanned critical care unit admissions from non-critical care wards of patients aged 18+, having a NEWS2 score, time of escalation (T0) and time of clinical response (T1) recorded.	Y	Min 20%, Max 60%	Data not yet available															
CCG4: Compliance with timed diagnostic pathways for cancer services	Achieving 65% of referrals for suspected prostate, colorectal, lung and oesophago-gastric cancer meeting timed pathway milestones as set out in the rapid cancer diagnostic and assessment pathways	N	Min 55%, Max 65%	1.28%			1.28%												
CCG5: Treatment of community acquired pneumonia in line with BTS care bundle	Achieving 70% of patients with confirmed community acquired pneumonia to be managed in concordance with relevant steps of BTS CAP Care Bundle.	N	Min 45%, Max 70%	0.00%	0.00%	0.00%	0.00%												
CCG6: Anaemia screening and treatment for all patients undergoing major elective surgery	Ensuring that 60% of major elective blood loss surgery patients are treated in line with NICE guideline NG24.	N	Min 45%, Max 60%	100%	100%	100%	100%												
CCG7: Timely communication of changes to medicines to community pharmacists via the discharge medicines service	Achieving 1.5% of acute trust inpatients having changes to medicines communicated with the patient's chosen community pharmacy within 48 hours following discharge, in line with NICE Guideline 5, via secure electronic message.	N	Min 0.5%, Max 1.5%				14.60%												
CCG8: Supporting patients to drink, eat and mobilise after surgery	Ensuring that 70% of surgical inpatients are supported to drink, eat and mobilise within 24 hours of surgery ending.	Y	Min 60%, Max 70%	83.33%	54.84%	96.30%	78.00%												
CCG9: Cirrhosis and fibrosis tests for alcohol dependent patients	Achieving 35% of all unique inpatients (with at least one-night stay) aged 16+ with a primary or secondary diagnosis of alcohol dependence who have an order or referral for a test to diagnose cirrhosis or advanced liver fibrosis.	Y	Min 20%, Max 35%	4.65%	2.56%	0.00%	2.80%												
CCG14: Assessment, diagnosis and treatment of lower leg wounds	Achieving 50% of patients with lower leg wounds receiving appropriate assessment diagnosis and treatment in line with NICE Guidelines.	Y	Min 25%, Max 50%	28.40%			28.40%												

CQUIN - Key Measures

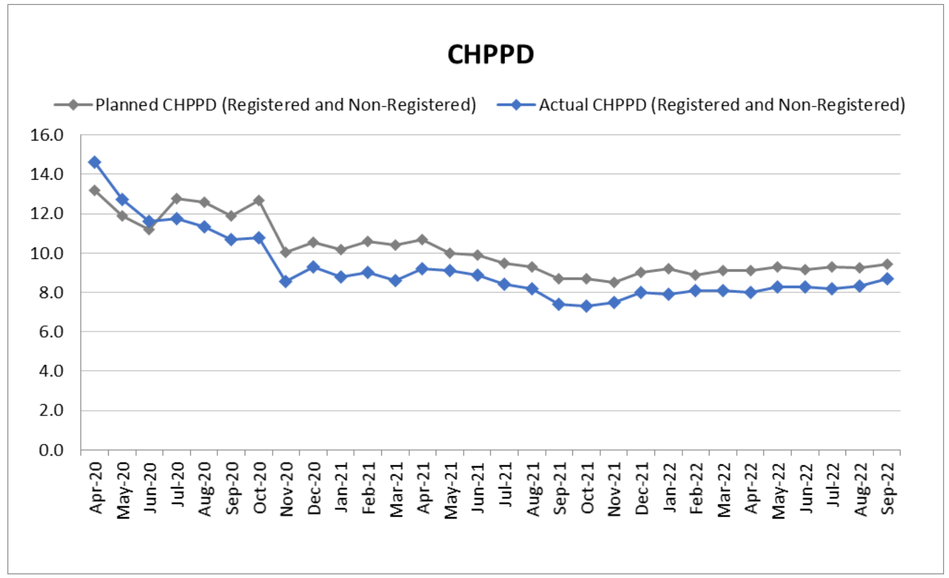
Indicator Name	Reality	Response	Result
CCG2: Appropriate antibiotic prescribing for UTI in adults aged 16+	Achievement of the 5 elements of the UTI Diagnosis/Management CQUIN requires overall compliance of >60% to receive full payment. After 1st quarter we are achieving 57% overall compliance. The element requiring greatest degree of intervention is the sampling element.	A campaign is being prepared to improve urine sampling for launch early in Q3.	Aiming for overall >60% compliance with elements of the CQUIN.
CCG3: Recording of NEWS2 score, escalation time and response time for unplanned critical care admissions	Data not yet available	The data for this CQUIN has only recently started being collected and so no data is available for Q1, however we should be in a position to provide data next month	Achieving 60% of all unplanned critical care unit admissions from non-critical care wards of patients aged 18+, having a NEWS2 score, time of escalation (T0) and time of clinical
CCG4: Compliance with timed diagnostic pathways for cancer services	In the first quarter we are achieving 1.28% compliance	This data is taken to a monthly collaborative meeting to assess current position. Assessment of the response of the 5 tumour sites is ongoing	Achieving 65% of referrals for suspected prostate, colorectal, lung and oesophago-gastric cancer meeting timed pathway milestones as set out in the rapid cancer diagnostic
CCG5: Treatment of community acquired pneumonia in line with BTS care bundle	For the first quarter we are achieving 0.00%, this may be due to monitoring rather than an actual reflection of achievement	The low compliance is not a true reflection of current practice, there needs to be a means of recording the care bundle in EPR This may be a quality improvement project for a junior doctor in the team	Achieving 70% of patients with confirmed community acquired pneumonia to be managed
CCG9: Cirrhosis and fibrosis tests for alcohol dependent patients	For the first quarter we are achieving 2.80%	Response not yet available	Achieving 35% of all unique inpatients (with at least one-night stay) aged 16+ with a primary or secondary diagnosis of alcohol dependence who have an order or referral for a test to diagnose cirrhosis or advanced liver fibrosis.
CCG14: Assessment, diagnosis and treatment of lower leg wounds	As of the first quarter we are achieving 28.40% compliance, the reason for low compliance this quarter is due to the data collection framework not being in place	Data collection framework is now in place with a meeting set to take place every 4 weeks to sense check the data	Achieving 50% of patients with lower leg wounds receiving appropriate assessment diagnosis and treatment in line with NICE Guidelines.

Hard Truths: Safe Staffing Levels

TRUST - CHPPD & FILL RATES (REGISTERED & NON REGISTERED CLINICAL STAFF)

	Jul-22	Aug-22	Sep-22
FILL RATES - DAY (REGISTERED & NON REGISTERED CLINICAL STAFF)	88.6%	88.6%	88.6%
FILLRATES - NIGHT (REGISTERED & NON REGISTERED CLINICAL STAFF)	92.7%	92.7%	92.7%

PLANNED CHPPD (REGISTERED & NON REGISTERED CLINICAL STAFF)	9.3	9.3	9.4
ACTUAL CHPPD (REGISTERED & NON REGISTERED CLINICAL STAFF)	8.2	8.3	8.7



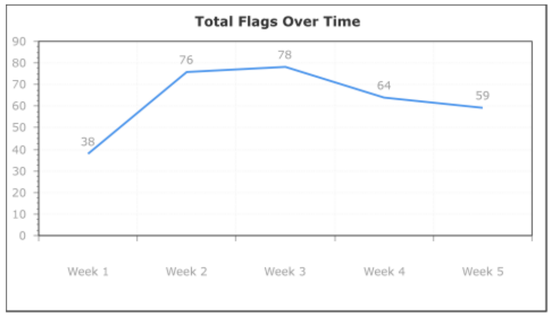
CHPPD provides a single, consistent and nationally comparable way of recording and reporting deployment of staff to provide care on inpatient wards. CHPPD is not a stand alone measure and should be used alongside clinical quality and safety outcome measures.

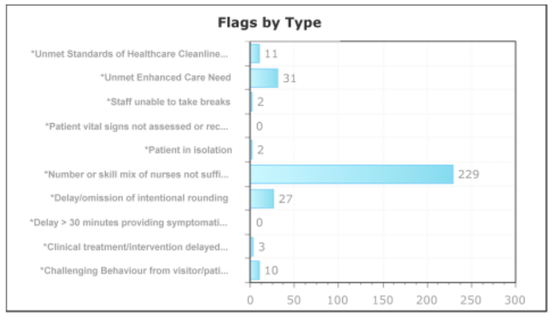
A review of September data indicates that the combined RN and non-registered clinical staff metrics resulted in 23 of the 28 clinical areas having fewer CHPPD than planned, with a total deficit of 0.7 CHPPD across the Trust compared to the planned position. The gap in CHPPD is at its broadest within the RN workforce representing 0.8 deficit whilst HCSW CHPPD was as planned. This position, whilst recognising actual care hours are still below planned, demonstrates a steady state in actual care hours delivered to our patients across the past 3 months and positions CHFT at the top of the 3rd quartile when benchmarked nationally according to Model hospital data.
The CHPPD planned vs actual gap is most prominent in the FSS division (2.0 CHPPD deficit). This is largely attributable to the staffing challenges in maternity due to vacancies. Any patient safety risk is mitigated, when necessary, by cohorting the birthcentre with the Labour ward to ensure appropriate 1:1 care of women in labour.

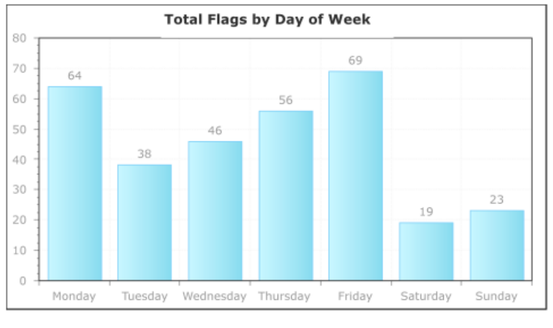
The 2021 successful recruitment to HCA roles has enabled increased shift fill to provide support to the reduced RN availability. However adjustment to workforce models and attrition has now created a vacancy pressure in this workforce group, which is being addressed by central recruitment. Professional 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.

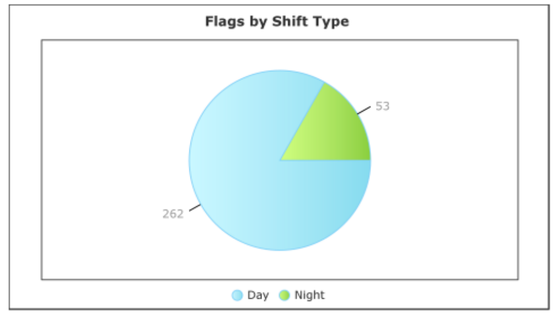
A review of the nurse sensitive indicators demonstrates incidence of falls within normal variation whilst pressure ulcer prevalence is slightly elevated in the medical division. This is being addressed through increased training.

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)

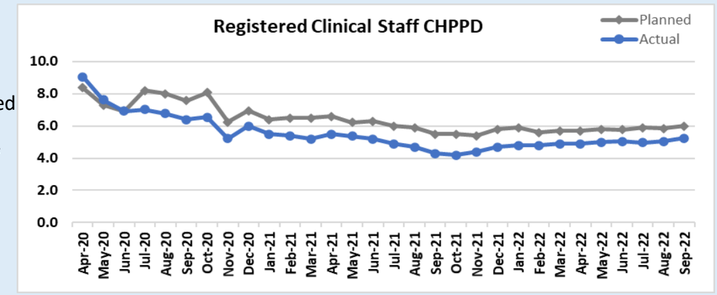
	Aggregate Position	Trend	Result

CHPPD BY STAFF TYPE

Registered Clinical Staff

Monthly hours (day and night combined) divided by average patient count at midnight

CHPPD was 6 for planned and 5.2 For actual for Registered Clinical Staff

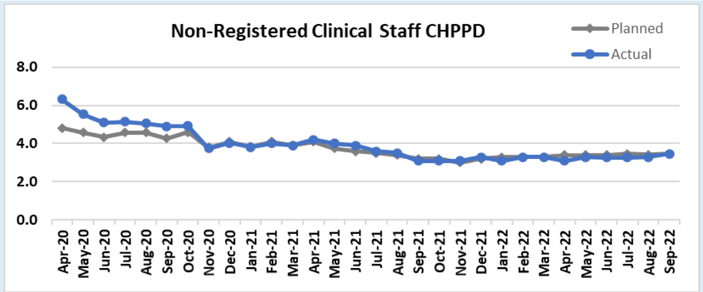


Overall there is a shortfall of 0.8 CHPPD against an overall requirement of 6.0 CHPPD for registered staff. Professional judgement informs decision-making at the twice daily staffing meetings to mitigate the risk across the clinical areas, and staff are redeployed to optimise safety. A suite of nurse sensitive indicators have also been incorporated into this section of the report to monitor for any correlations alongside the CHPPD in line with national recommendations.
Continued training is being promoted to prevent falls and improve pressure area care.

Non-Registered Clinical Staff

Monthly hours (day and night combined) divided by average patient count at midnight

CHPPD was 3.5 for planned and 3.5 for actual for Non-Registered Clinical Staff



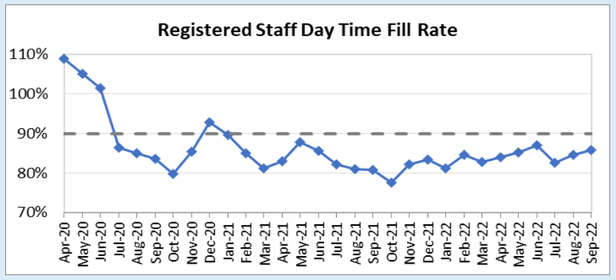
Overall the CHPPD delivered by non-registered clinical staff was as planned. The day time fill-rate percentage of non-registered clinical staff (table below) shows a slight increase on the previous two months and is attributed to the recruitment drive for this staff group.
Nightshift fill is prioritised over 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.

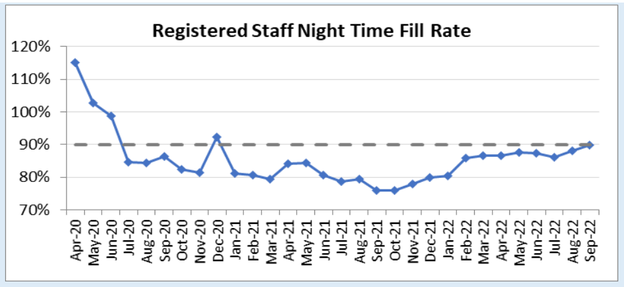
85.85% of expected Registered Clinical Staff hours were achieved for day shifts.



Registered Staff Night

Monthly expected hours by shift versus actual monthly hours per shift only. Night shift only.

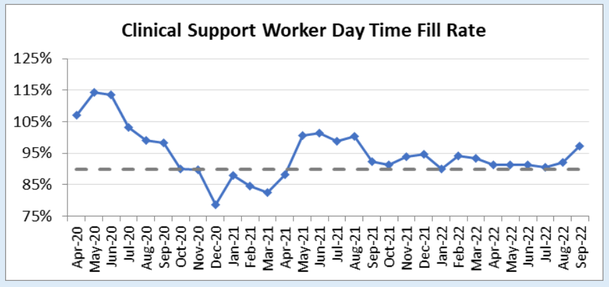
89.78% of expected Registered Clinical Staff hours were achieved for night shifts.



Non-Registered Clinical Staff Day

Monthly expected hours by shift versus actual monthly hours per shift only. Day shift only.

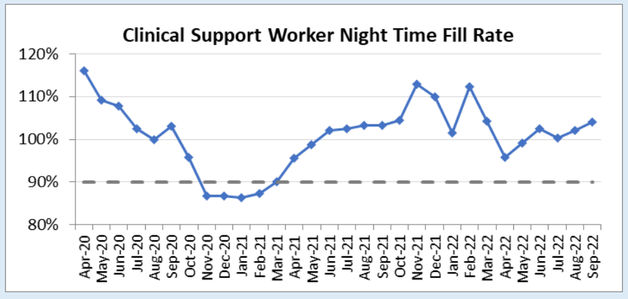
97.25% of expected Non-Registered Clinical Staff hours were achieved for Day shifts.



Non-Registered Clinical Staff Night

Monthly expected hours by shift versus actual monthly hours per shift only. Night shift only.

104.06% of expected Non-Registered Clinical Staff hours were achieved for night shifts.

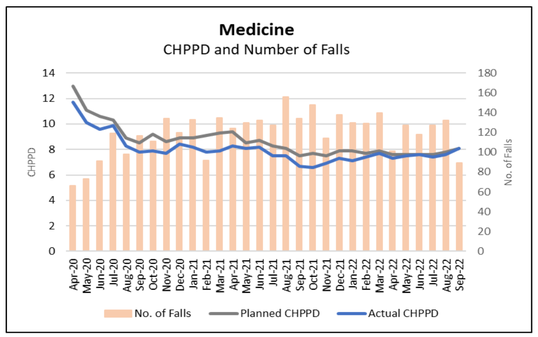


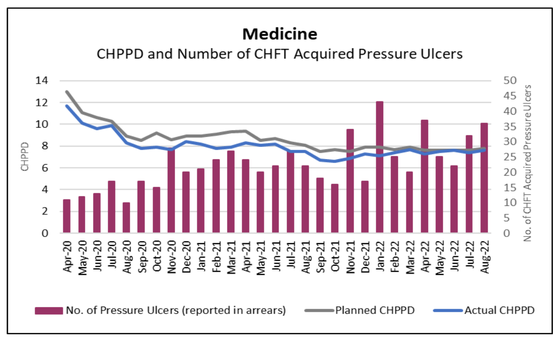
Hard Truths: Safe Staffing Levels (3)

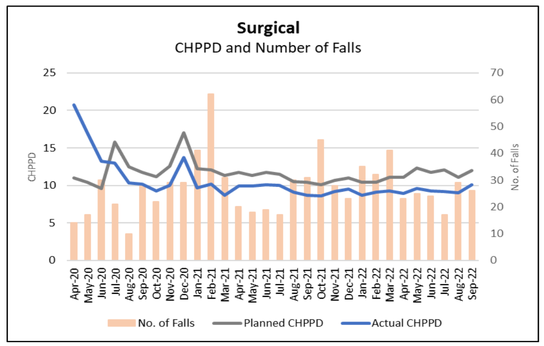
NURSING QUALITY INDICATORS AND FILLRATES BY WARD AND DIVISION

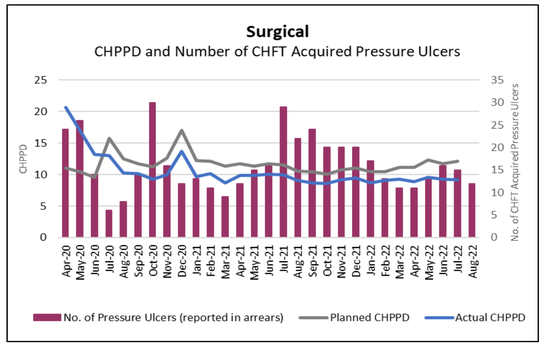
Ward	Average Fill Rates: DAY - Registered Clinical Staff (%)	DAY - Non Registered Clinical Staff (%)	NIGHT - Registered Clinical Staff (%)	NIGHT - Non Registered Clinical Staff (%)	CHPPD: Total PLANNED CHPPD	Total ACTUAL CHPPD
CRH ACUTE FLOOR	90.4%	91.1%	100.6%	97.1%	8.4	7.9
HRI ACUTE FLOOR	93.6%	91.3%	100.8%	95.0%	8.4	8.0
RESPIRATORY FLOOR	72.8%	87.3%	89.2%	95.2%	8.7	7.3
WARD 5	81.7%	112.1%	101.5%	129.0%	8.4	8.7
WARD 6	76.8%	66.5%	98.6%	95.8%	4.1	3.4
WARD 6C	99.9%	96.5%	100.0%	107.6%	11.8	11.9
WARD 6AB	99.9%	96.5%	100.0%	107.6%	6.1	6.1
WARD CCU	80.6%	90.0%	95.8%		8.6	7.6
STROKE FLOOR	168.3%	154.8%	97.8%	120.7%	7.9	10.9
WARD 12	95.4%	88.1%	98.3%	96.7%	7.7	7.3
WARD 15	81.3%	133.3%	98.4%	131.2%	9.3	10.3
WARD 17	79.1%	114.7%	98.7%	135.1%	7.0	6.9
WARD 18	71.8%	106.3%	71.0%	180.5%	9.3	9.1
WARD 20	87.3%	127.0%	99.2%	120.5%	8.7	9.3
Medicine	**92.1%**	**104.4%**	**96.4%**	**110.8%**	**8.1**	**8.1**
WARD 21	85.0%	103.2%	97.9%	123.7%	7.9	8.0
WARD 22	93.2%	97.8%	94.5%	100.0%	6.7	6.4
ICU	78.0%	56.9%	78.6%	58.9%	44.3	32.8
WARD 8A	56.1%	66.1%	58.5%	92.3%	17.2	10.8
WARD 8C	95.8%	72.8%	98.3%	89.1%	14.8	13.2
WARD 10	72.3%	96.1%	85.7%	97.0%	9.3	7.9
WARD 14	55.3%	57.5%	65.8%	81.4%	20.3	12.9
WARD 19	87.7%	96.0%	101.1%	101.7%	7.5	7.2
SAU HRI	93.6%	97.2%	100.7%	103.2%	8.1	8.0
Surgical	**79.3%**	**81.7%**	**84.7%**	**93.9%**	**12.0**	**10.1**
WARD LDRP	82.1%	81.2%	80.1%	94.9%	24.3	20.0
WARD NICU	85.6%	69.4%	93.0%	70.0%	11.6	10.0
WARD 3ABCD	78.7%	84.0%	74.8%	87.2%	13.5	10.5
WARD 4ABC	85.2%	97.7%	89.8%	95.0%	5.7	5.1
Ward 1D	92.1%	88.9%	99.9%	95.5%	11.6	11.0
FSS	**82.3%**	**84.7%**	**82.2%**	**89.2%**	**11.8**	**9.8**
TRUST	**85.85%**	**97.25%**	**89.78%**	**104.06%**	**9.4**	**8.7**

Nursing Quality Indicators









KEY: >100% | 100- 96% | 95-85% | <85%

Hard Truths: Safe Staffing Levels (4)

Conclusions and Recommendations

Conclusions

The Trust remains committed to achieving its nurse and midwifery staffing establishments to provide safe and compassionate care to patients.

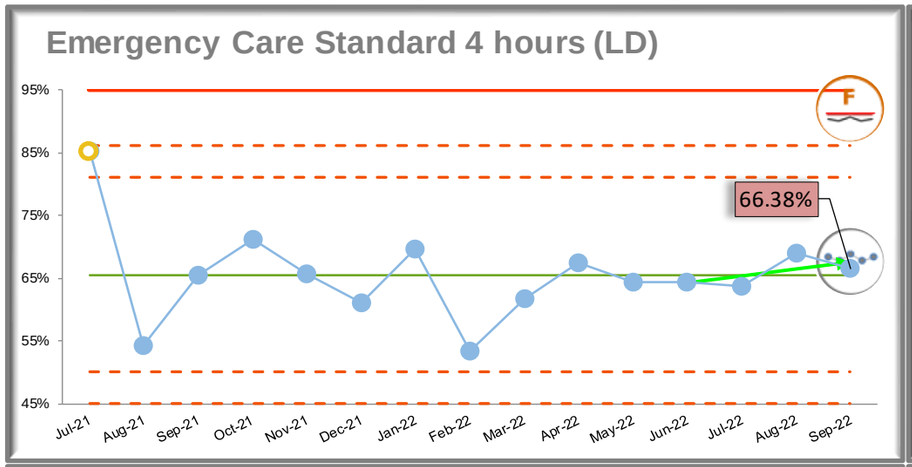
Ongoing activity:
1. A revised dashboard has been approved as part of the Hard Truths section of the IPR which closely aligns the workforce position to an agreed suite of nurse sensitive indicators.
2. The Nursing and Midwifery Workforce Steering Group is progressing work to understand the detail of the vacancy position and potential leavers and aligning this to the recruitment/training strategy in partnership with the local HEI, as well as high impact retention strategies.
3. A section on Knowledge Portal Plus has been developed to support triangulation of the workforce position to the agreed suite of nurse sensitive indicators and has been supported with a staff engagement and training exercise.
4. A review of the current Nursing and Midwifery workforce plans is underway and supported by Workforce Business Intelligence, reviewing directorate specific pressures to inform recruitment and retention strategies. Additional training is underway to enable greater reliability and validity of the Safer Nursing Care Tool (Acuity/Dependency Scoring) prior to the next bi-annual review.
5. Required Workforce Models to deliver safe, effective and compassionate patient care in light of planned reconfigured services are being developed.
6. The International recruitment project continues to progress well with 50 recruits of the planned 100 resident in the UK in mid October. The remaining 50 are in pipeline to arrive across October, November and December. CHFT were successful in the bid for funding to recruit to 5 International Midwives to arrives before the end of July 2023 and 3 International Occupational Therapists to arrive before the end of March 2023 .
7. Trainee Nursing Associate apprenticeships and Registered Nurse Apprenticeships continue to be supported to assist the RN workforce recruitment strategy.
8.There is a commitment to retract from Agency spending, commencing with the high cost agencies.

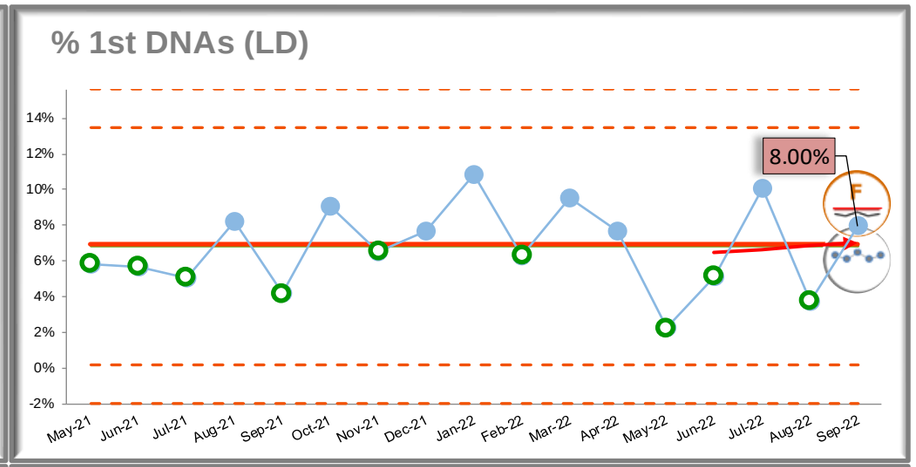
LD - Key measures

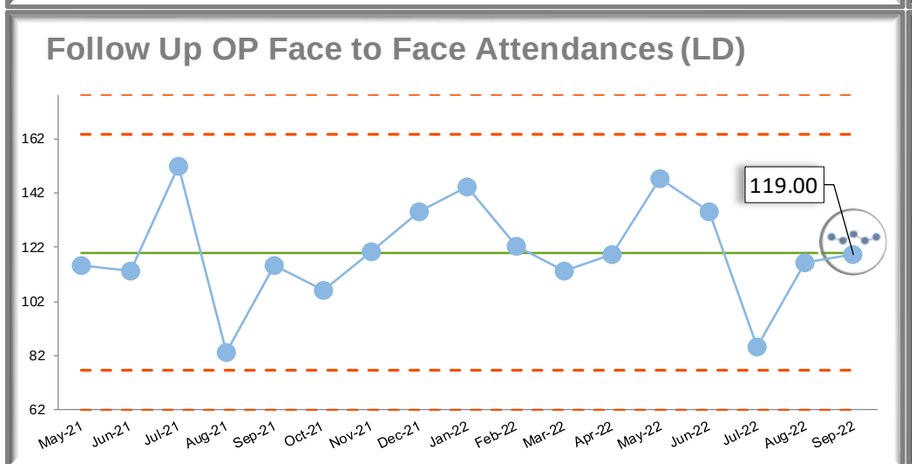
	21/22	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	YTD	Performance Range		
																Green	Amber	Red
Recovery																		
Total P2 on Waiting List (LD)	32	4	2	3	4	3	2	4	1	11	7	4	4	**6**	**33**	No target		
Total P3 on Waiting List (LD)	119	13	10	10	7	8	11	11	14	16	12	9	10	**10**	**71**	No target		
Total P4 on Waiting List (LD)	58	9	9	3	3	2	1	1	2	3	4	4	2	**2**	**17**	No target		
Emergency Care																		
Emergency Care Standard 4 hours (LD)	65.74%	65.31%	71.05%	65.65%	61.02%	69.57%	53.33%	61.62%	67.26%	64.23%	64.35%	63.54%	68.93%	**66.38%**	**65.77%**	>=95%		<95%
Waiting Times																		
18 weeks Pathways >=26 weeks open (LD)	569	54	56	58	69	61	63	54	50	47	54	41	35	**37**	**264**	0		>=1
RTT Waits over 52 weeks Threshold > zero (LD)	409	41	37	41	45	41	47	38	35	38	42	30	16	**27**	**188**	0		>=1
% Diagnostic Waiting List Within 6 Weeks (LD)	83.63%	0.851	0.8713	84.85%	84.97%	90.43%	73.54%	68.48%	82.40%	84.64%	83.19%	85.63%	79.51%	**87.80%**	**83.56%**	>=99%		<=98%
Cancer																		
Two Week Wait for Referral to Date First Seen (LD)	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	**100.00%**	**100.00%**	>=93%	86% - 92%	<85%
31 Days From Diagnosis to First Treatment (LD)	100.00%	not applicable	not applicable	not applicable	100.00%	not applicable	not applicable	not applicable	100.00%	not applicable	100.00%	not applicable	not applicable	**100.00%**	**100.00%**	>=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	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	100.00%	not applicable	not applicable	**100.00%**	**100.00%**	>=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	26	34	33	38	38	24	31	37	38	41	40	48	**53**	**257**	No target		
New Outpatient Attendances - Non Face to Face (LD)	256	18	26	19	25	18	16	18	12	20	15	9	11	**15**	**82**	No target		
Follow up Outpatient Attendances - Face to Face (LD)	1426	115	106	120	135	144	122	113	119	147	135	85	116	**119**	**721**	No target		
Follow up Outpatient Attendances - Non Face to Face (LD)	845	60	69	74	47	45	56	67	54	60	61	41	48	**49**	**313**	No target		
Activity - % DNAs																		
% 1st DNAs (LD)	7.22%	4.23%	9.09%	6.58%	7.69%	10.87%	6.35%	9.59%	7.69%	2.30%	5.19%	10.14%	3.80%	**8.00%**	**6.12%**	<=7.0%	7.1% - 7.9%	>=8.0%
% Follow Up DNAs (LD)	5.72%	6.17%	8.30%	5.93%	8.10%	5.79%	6.13%	5.39%	6.58%	7.24%	3.72%	4.52%	6.52%	**9.20%**	**6.42%**	<=7.0%	7.1% - 7.9%	>=8.0%

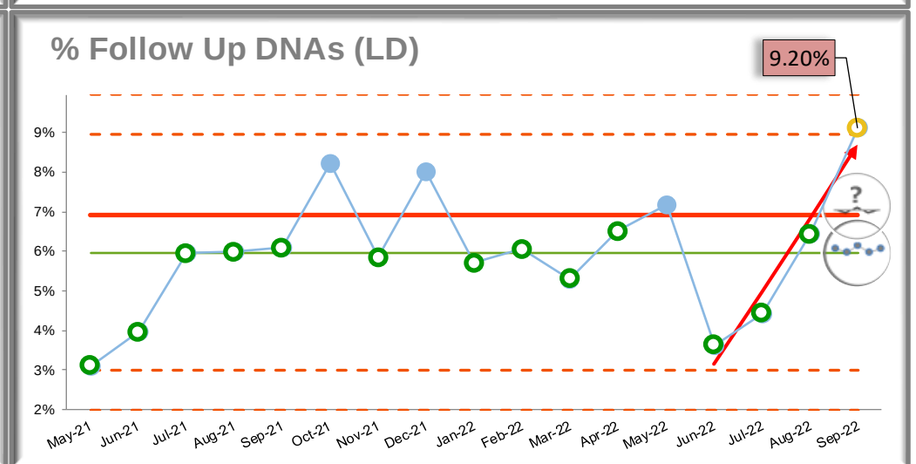
LD - SPC Charts

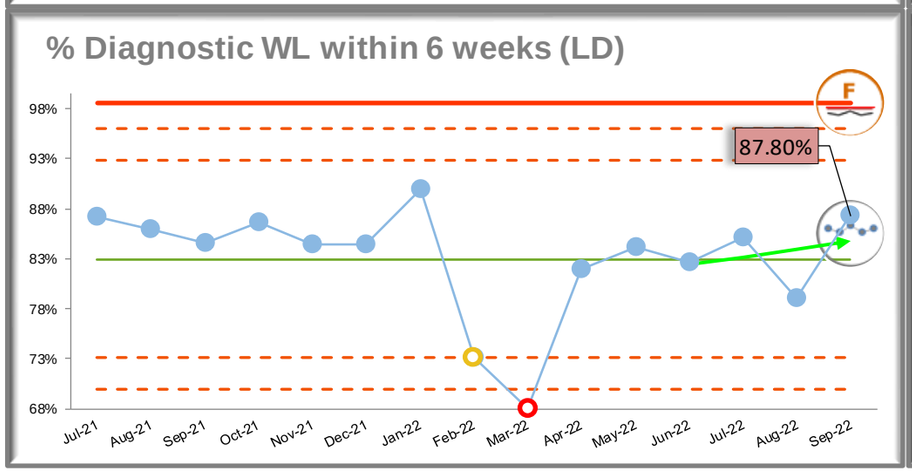
Warning | Critical | Activity | On Target | Trend | Target Line | Average Line | Control Line | Last 6 Points Directional Flow | RAG Rated Last Data Point

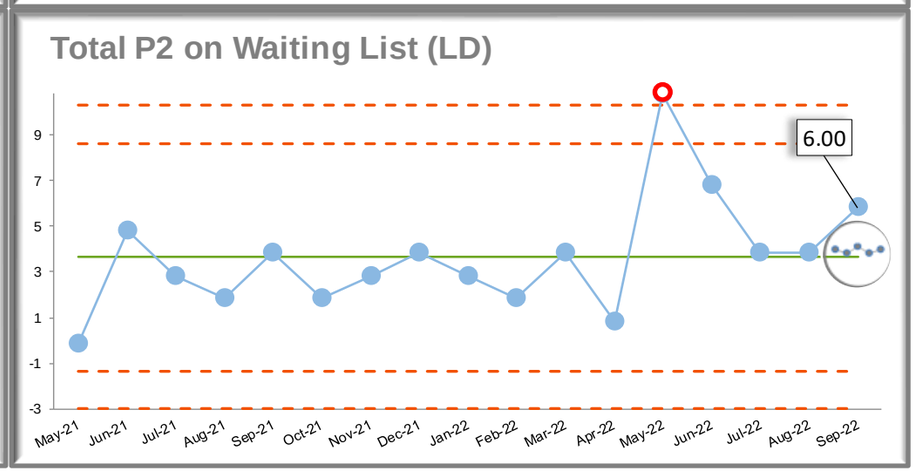












13. Month 6 Financial Summary

For Assurance

Presented by Kirsty Archer

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Date of Meeting:	Thursday 10th November 2022
Meeting:	Board of Directors
Title:	Month 6 Finance Report
Author:	Philippa Russell – Acting Deputy Director of Finance
Sponsoring Director:	Kirsty Archer – Acting Director of Finance
Previous Forums:	Finance & Performance Committee

Purpose of the Report

To provide a summary of the financial position as reported at the end of Month 6 (September 2022)

Key Points to Note

Year to Date Summary

Year to date the Trust is reporting a £11.21m deficit, a £0.88m adverse variance from plan. The in month position is a deficit of £1.38m, a £0.51m adverse variance. The adverse variance in month is driven by inflationary pressures and staffing costs, in particular the impact of Enhanced Bank rates, (£0.9m in Month 6), and high cost Agency staff.

- 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. ERF of £5.46m has been assumed in the year to date position in line with plan. It has been confirmed that ERF will not be clawed back for the first half of the year (H1), but this remains a risk going into H2, as activity year to date was below the planned level and some claw back might be required if the Trust is unable to catch up this activity in future months.
- 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 subject to approval 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. Requirements for additional funding for testing have reduced significantly as national procurement has expanded and the Autumn vaccination programme is funded differently, on a fixed cost per vaccine basis.
- Year to date the Trust has incurred costs relating to Covid-19 of £9.88m, £4.91m higher than planned. Covid-19 activity remains higher than planned driving additional staffing costs and consumables, with extra capacity opened that was planned to be closed by this point in the year.
- Year to date the Trust has delivered efficiency savings of £9.07m, £0.65m higher than planned.
- Agency expenditure year to date is £6.31m, £3.30m higher than planned. The Integrated Care Board has set the Trust's Agency expenditure ceiling for the full year at £6.9m, at the Trust is already close to exceeding that ceiling.
- Total planned inpatient activity, for the purpose of Elective Recovery, was only 96% of the activity planned year to date.

Key Variances

- Income is £6.57m above the planned year to date due to funding to support the pay award (£3.5m YTD) and additional funding to support increased bed capacity and for Non-Surgical Oncology. Higher than planned NHS Clinical income is offset to some extent by lower than planned funding for 'outside of envelope' Covid-19 due to a reduction in testing costs now that most testing consumables have moved to a national procurement mechanism.
- Pay costs are £4.12m above the planned level year to date, including £3.88m relating to the higher than planned Pay Award. Additional funding has been allocated to offset this pressure, although this is not currently sufficient to entirely offset the cost. Excluding pay award, the underlying year to date variance is £0.23m above the planned level, with an adverse variance in Month 6 of £1.21m. This overspend was primarily linked higher than planned Bank and Agency costs, with the 50% enhanced Bank rate driving a total cost in month of £0.89m.
- Non-pay operating expenditure is £3.63m higher than planned year to date with pressure on consumable costs due to additional capacity requirements and inflationary pressures in particular on utilities and the PFI contract.

Forecast

The Trust has a revised plan to deliver a £17.35m deficit for the year and continues to report a forecast in line with this plan. The risk to delivery of this forecast remains significant due to inflationary impacts, a Pay Award funding shortfall of £0.84m and Bank and Agency staffing pressures. The forecast assumes full delivery of a challenging £20m efficiency target and that the Trust will deliver its elective activity plan and secure in full £11.9m of Elective Recovery Funding.

Attachment: Month 6 Finance Report.

EQIA – Equality Impact Assessment

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

Recommendation

The Board is asked to receive the Finance Report and **NOTE** the financial position for the Trust as at 30th September 2022.

EXECUTIVE SUMMARY: Total Group Financial Overview as at 30th Sep 2022 - Month 6

KEY METRICS

	M6				YTD (SEP 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)	(£0.87)	(£1.38)	(£0.51)		(£10.33)	(£11.21)	(£0.88)		(£17.35)	(£17.35)	£0.00	
Agency Expenditure (vs Ceiling)	(£0.49)	(£1.20)	(£0.70)		(£3.01)	(£6.31)	(£3.30)		(£6.90)	(£12.41)	(£5.51)	
Capital	£3.06	£0.48	£2.58		£13.80	£4.33	£9.47		£41.99	£42.71	(£0.72)	
Cash	£52.51	£53.04	£0.53		£52.51	£53.04	£0.53		£19.26	£18.88	(£0.38)	
Invoices paid within 30 days (%) (Better Payment Practice Code)	95.0%	91.5%	-4%		95.0%	90.6%	-4%					
CIP	£2.02	£1.47	(£0.55)		£8.42	£9.07	£0.65		£20.00	£20.00	£0.00	
Use of Resource Metric	3	4			3	4			3	3		

Year to Date Summary

Year to date the Trust is reporting an £11.21m deficit, a £0.88m adverse variance from plan. The in month position is a deficit of £1.38m, a £0.51m adverse variance. The adverse variance in month is driven by inflationary pressures and staffing costs, in particular the impact of Enhanced Bank rates, (£0.9m in Month 6), and high cost Agency staff.

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Total Group Financial Overview as at 30th Sep 2022 - Month 6

INCOME AND EXPENDITURE COMPARED TO PLAN SUBMITTED TO NHS IMPROVEMENT

YEAR TO DATE POSITION: M6

CLINICAL ACTIVITY

	M6 Plan	M6 Actual	Var
Elective	2,836	2,246	(590)
Non-Elective	28,829	26,311	(2,518)
Daycase	24,798	24,485	(313)
Outpatient	217,206	218,321	1,115
A&E	88,963	87,526	(1,437)
Other NHS Non-Tariff	935,734	981,162	45,429
Total	**1,298,365**	**1,340,051**	**41,686**

TOTAL GROUP: INCOME AND EXPENDITURE

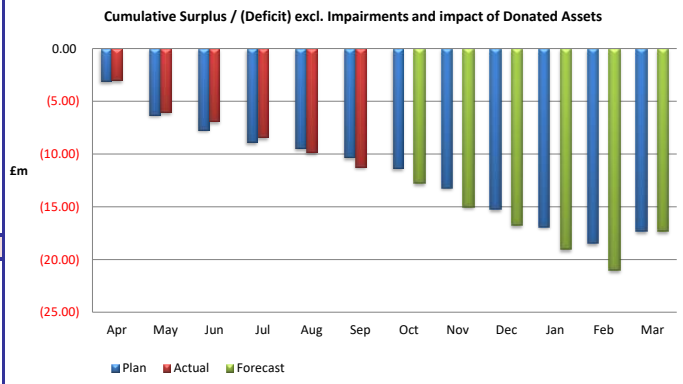
	M6 Plan	M6 Actual	Var
	£m	£m	£m
Elective	£11.37	£8.62	(£2.75)
Non Elective	£64.72	£62.10	(£2.62)
Daycase	£17.48	£16.77	(£0.71)
Outpatients	£19.80	£21.50	£1.70
A & E	£14.88	£15.36	£0.47
Other-NHS Clinical	£86.93	£96.52	£9.59
CQUIN	£0.00	£0.00	£0.00
Other Income	£26.86	£27.75	£0.89
Total Income	**£242.06**	**£248.63**	**£6.57**
Pay	(£159.73)	(£163.84)	(£4.12)
Drug Costs	(£22.86)	(£21.93)	£0.93
Clinical Support	(£19.10)	(£18.66)	£0.44
Other Costs	(£27.43)	(£32.28)	(£4.85)
PFI Costs	(£7.15)	(£7.30)	(£0.15)
Total Expenditure	**(£236.26)**	**(£244.01)**	**(£7.75)**
EBITDA	**£5.79**	**£4.62**	**(£1.18)**
Non Operating Expenditure	(£16.12)	(£15.82)	£0.30
Surplus / (Deficit) Adjusted*	**(£10.33)**	**(£11.21)**	**(£0.88)**

* 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

	M6 Plan	M6 Actual	Var
	£m	£m	£m
Surgery & Anaesthetics	(£50.93)	(£49.48)	£1.44
Medical	(£60.57)	(£64.43)	(£3.86)
Families & Specialist Services	(£44.44)	(£42.93)	£1.50
Community	(£13.91)	(£13.46)	£0.46
Estates & Facilities	£0.00	(£0.00)	(£0.00)
Corporate	(£26.79)	(£27.05)	(£0.26)
THIS	£0.46	£0.41	(£0.05)
PMU	£1.19	£0.56	(£0.63)
CHS LTD	£0.19	£0.02	(£0.16)
Central Inc/Technical Accounts	£185.16	£185.76	£0.60
Reserves	(£0.68)	(£0.60)	£0.08
Surplus / (Deficit)	**(£10.33)**	**(£11.21)**	**(£0.88)**

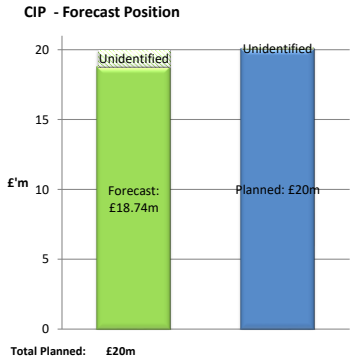
TOTAL GROUP SURPLUS / (DEFICIT)

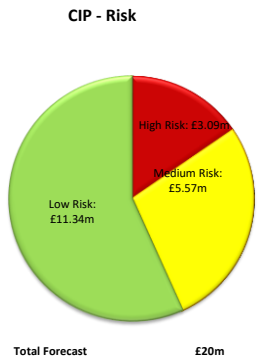


KEY METRICS

	Year To Date			Year End: Forecast		
	M6 Plan	M6 Actual	Var	Plan	Forecast	Var
	£m	£m	£m	£m	£m	£m
I&E: Surplus / (Deficit)	(£10.33)	(£11.21)	(£0.88)	(£17.35)	(£17.35)	£0.00
Capital	£13.80	£4.33	£9.47	£41.99	£42.71	(£0.72)
Cash	£52.51	£53.04	£0.53	£19.26	£18.88	(£0.38)
Invoices Paid within 30 days (BPPC)	95%	91%	-4%			
CIP	£8.42	£9.07	£0.65	£20.00	£20.00	£0.00
	Plan	Actual		Plan	Forecast	
Use of Resource Metric	3	4		3	3	

COST IMPROVEMENT PROGRAMME (CIP)





YEAR END 22/23

CLINICAL ACTIVITY

	Plan	Actual	Var
Elective	5,774	4,625	(1,149)
Non-Elective	58,360	53,455	(4,905)
Daycase	50,173	50,114	(59)
Outpatient	436,084	497,964	61,881
A&E	170,928	168,295	(2,633)
Other NHS Non- Tariff	1,867,647	1,960,386	92,738
Total	**2,588,966**	**2,734,839**	**145,873**

TOTAL GROUP: INCOME AND EXPENDITURE

	Plan	Actual	Var
	£m	£m	£m
Elective	£23.08	£17.69	(£5.39)
Non Elective	£123.29	£119.23	(£4.06)
Daycase	£35.10	£34.77	(£0.34)
Outpatients	£40.60	£45.51	£4.91
A & E	£28.76	£29.77	£1.01
Other-NHS Clinical	£180.77	£197.31	£16.54
CQUIN	£0.00	£0.00	£0.00
Other Income	£53.66	£56.01	£2.35
Total Income	**£485.26**	**£500.28**	**£15.02**
Pay	(£318.79)	(£329.61)	(£10.83)
Drug Costs	(£45.79)	(£43.91)	£1.87
Clinical Support	(£38.80)	(£41.26)	(£2.46)
Other Costs	(£52.67)	(£59.08)	(£6.41)
PFI Costs	(£14.31)	(£14.60)	(£0.30)
Total Expenditure	**(£470.36)**	**(£488.47)**	**(£18.10)**
EBITDA	**£14.90**	**£11.81**	**(£3.09)**
Non Operating Expenditure	(£32.25)	(£29.16)	£3.09
Surplus / (Deficit) Adjusted*	**(£17.35)**	**(£17.35)**	**£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

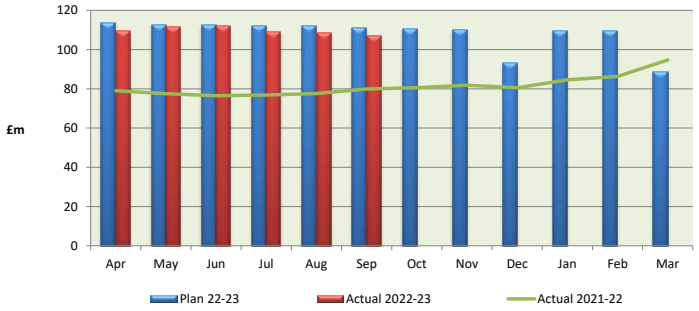
	Plan	Forecast	Var
	£m	£m	£m
Surgery & Anaesthetics	(£102.25)	(£101.79)	£0.45
Medical	(£124.40)	(£131.67)	(£7.27)
Families & Specialist Services	(£89.70)	(£87.84)	£1.85
Community	(£27.98)	(£27.47)	£0.51
Estates & Facilities	£0.00	(£0.00)	(£0.00)
Corporate	(£53.65)	(£54.09)	(£0.44)
THIS	£0.95	£0.79	(£0.16)
PMU	£2.38	£1.10	(£1.28)
CHS LTD	£0.54	£0.26	(£0.28)
Central Inc/Technical Accounts	£374.53	£377.43	£2.89
Reserves	£2.23	£5.94	£3.71
Surplus / (Deficit)	**(£17.35)**	**(£17.35)**	**(£0.00)**

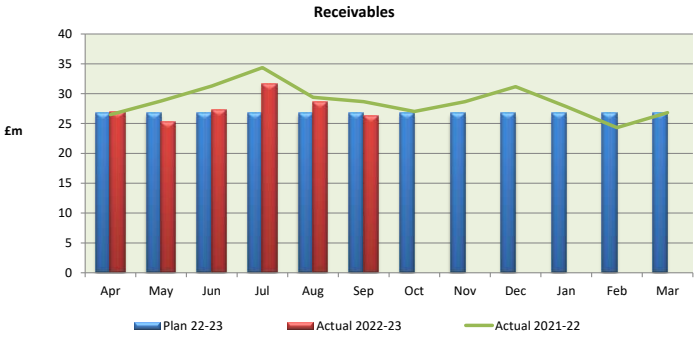
Total Group Financial Overview as at 30th Sep 2022 - Month 6

CAPITAL AND CASH COMPARED TO PLAN SUBMITTED TO NHS IMPROVEMENT

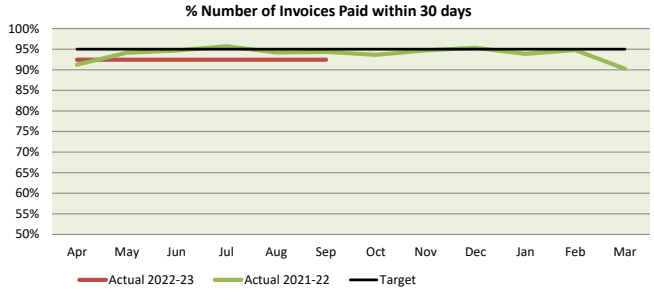
WORKING CAPITAL

	M6 Plan £m	M6 Actual £m	Var £m	M6
Payables (excl. Current Loans)	(£111.05)	(£106.81)	(£4.24)	
Receivables	£26.70	£26.19	£0.51	



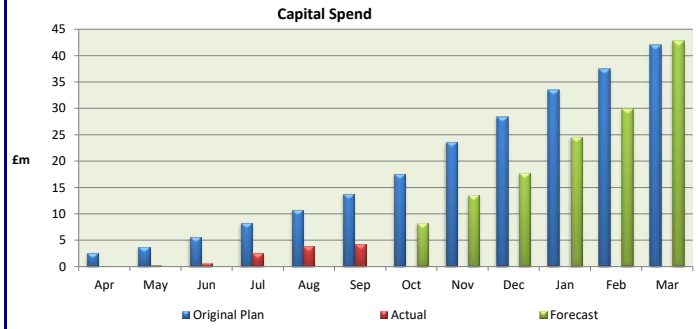


BETTER PAYMENT PRACTICE CODE



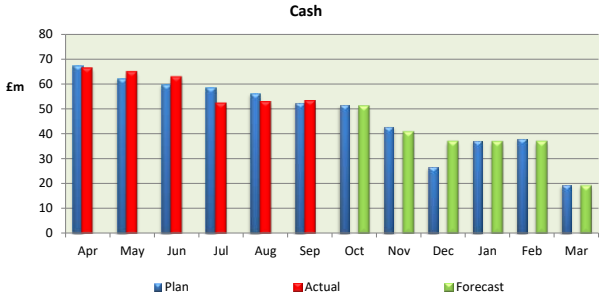
CAPITAL

	M6 Plan £m	M6 Actual £m	Var £m	M6
Capital	£13.80	£4.33	£9.47	

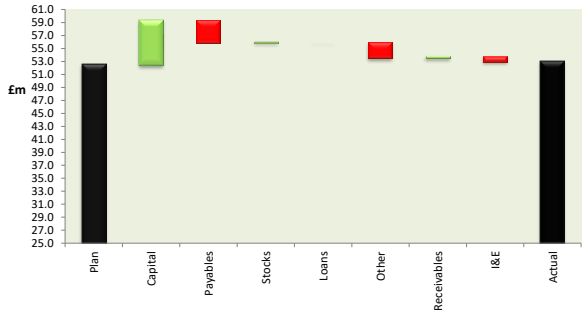


CASH

	M6 Plan £m	M6 Actual £m	Var £m	M6
Cash	£52.51	£53.04	£0.53	
Loans (Cumulative)	£16.57	£16.57	£0.00	



CASH FLOW VARIANCE



SUMMARY YEAR TO DATE

- Year to date the Trust is reporting an £11.21m deficit, a £0.88m adverse variance from plan.
- Operational pressures, including additional capacity requirements, continue to drive additional costs including the impact in month of Enhanced Bank rates.
- 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.
- £5.46m of ERF has been assumed in the year to date position as planned. It has been confirmed that ERF will not be clawed back for the first half of the year (H1), but some potential clawback remains a risk for H2.
- Total planned inpatient activity for the purposes of Elective recovery was 96% of the activity planned year to date.
- Year to date the Trust has incurred costs relating to Covid-19 of £9.88m, £4.91m higher than planned.

- Capital expenditure is lower than planned at £4.33m against a planned £13.80m. Capital plans now also include any new leases.
- Year to date the Trust has delivered efficiency savings of £9.07m, £0.65m more than planned.
- NHS Improvement performance metric Use of Resources (UOR) stands at 4, worse than planned, with 2 metrics currently away from plan.

NOTES

- The Trust plans to deliver a £17.35m deficit for the year. The risk to delivery of this forecast remains significant due to inflationary impacts, a Pay Award funding shortfall of £0.84m and Bank and Agency staffing pressures.

- The forecast position assumes full delivery of a challenging £20m efficiency target. At the end of September 22, £18.74m 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.

- The total loan balance is £16.57m as planned. No further loans are planned for this financial year.
- The Trust is forecasting to spend £42.71m on Capital programmes in this financial year including £2.92m on leases. The £0.72m adverse variance to plan is due to an increase in forecast donated assets (funded through charitable funds) and additional PDC funded Reconfiguration expenditure.

- The Trust has a cash balance of £53.04m, £0.53m higher than planned.

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

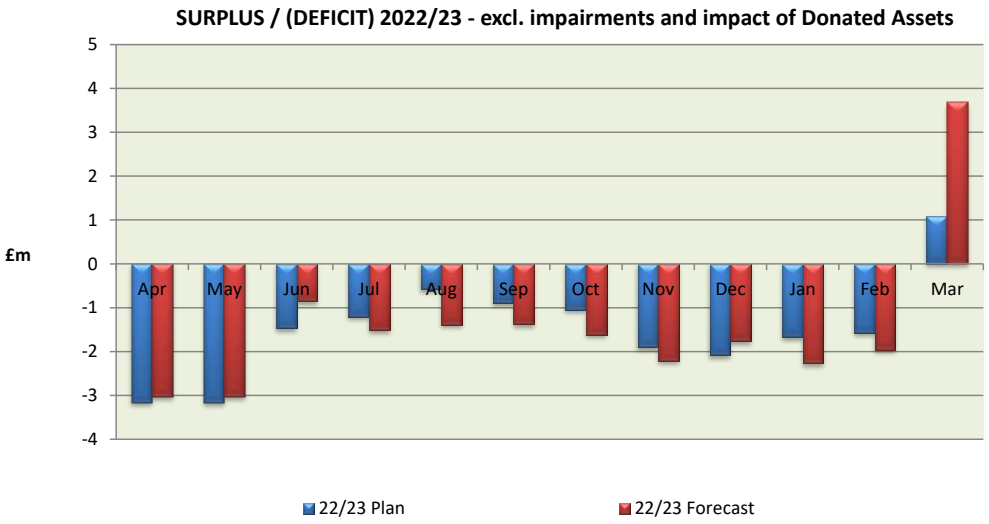
FORECAST POSITION 22/23

22/23 Forecast (31 Mar 23)

Statement of Comprehensive Income	Plan[2] £m	Forecast £m	Var £m	
Income	£485.35	£500.72	£15.37	
Pay expenditure	(£318.79)	(£329.61)	(£10.83)	
Non Pay Expenditure	(£151.58)	(£158.85)	(£7.28)	
Non Operating Costs	(£32.68)	(£29.69)	£2.98	
Total Trust Surplus / (Deficit)	**(£17.69)**	**(£17.44)**	**£0.25**	
Deduct impact of:				
Impairments (AME)[1]	£0.00	(£0.00)	(£0.00)	
Donated Asset depreciation	£0.43	£0.53	£0.10	
Donated Asset income (including Covid equipment)	(£0.08)	(£0.44)	(£0.35)	
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	**(£17.35)**	**(£17.35)**	**£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 revised plan of a £17.35m deficit.
- Whilst forecasting to deliver this planned deficit, this remains challenging and mitigation will be required to offset the ongoing operational pressures that have continued throughout the summer period. Capacity requirements continue to be above the planned level due to higher than planned Covid-19 activity, Delayed Transfers of Care and other operational pressures. This is driving additional costs, particularly in relation to bank and agency expenditure.
- The additional funding for inflation was required to flow in full to improve the Trust overall financial position and assumed that plans included sufficient funding to cover any pressures. The increase in RPI since March 22 is driving additional inflationary pressures over and above the planned level, particular in relation to Energy costs and the PFI contract. It is also impacting on the ability to achieve planned procurement savings.
- The forecast assumes full delivery of a challenging £20m efficiency target and elements of the plan are no longer expected to deliver, particularly those schemes reliant on the exit of Covid-19 costs. However, work is already underway to identify additional schemes to mitigate this slippage and the expectation is that sufficient opportunities have been identified to close this gap.
- The Pharmacy Manufacturing Unit has not delivered the planned surplus in the year to date and there is a significant 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 pressures above to some extent.
- The forecast continues to assume that the Trust will deliver it's elective activity plan and secure in full £11.9m of Elective Recovery Funding.
- Whilst some potential mitigation has been identified to offset Divisional forecast pressures of around £8.5m, a gap remains and the current 'likely case' forecast is an adverse variance of £5.5m.

Risks and Potential Benefits

- The forecast assumes full delivery of a challenging £20m efficiency target.
- ERF will not be clawed back for H1, but it is not yet clear whether there will be any potential clawback in H2. Based on current under delivery of Recovery, this remains a risk.
- The details of the funding mechanism for the recently announced pay award have now been released and a £0.84m shortfall in funding has been identified.
- The forecast assumes that the 50% enhanced Bank rate is withdrawn by the middle of November. A further extension of this arrangement would drive additional costs of around £0.9m per month.
- The Forecast assumes that the current Covid-19 wave has now peaked and that activity returns to the planned level. There is a risk that Covid-19 impact over the Autumn and Winter period is more severe than expected. A Covid-19 surge similar to that seen last winter could drive additional costs of up to £2.8m.
- The financial impact of Utilities price caps is being assessed and may provide some opportunity to reduce forecast inflationary pressures.
- A wide range of mitigations are currently being considered both in relation to the efficiency gap and also forecast operational pressures. This includes a review of Elective Recovery costs and ongoing Covid-19 related expenditure.

COVID-19 & Recovery

Covid-19 Expenditure YTD SEP 2022	Pay £'000	Non-Pay £'000	Total £'000
Expand NHS Workforce - Medical / Nursing / AHPs / Healthcare Scientists / Other	625	0	625
Remote management of patients	108	0	108
Increase ITU capacity (incl Increase hospital assisted respiratory support capacity, particularly mechanical ventilation)	0	43	43
Segregation of patient pathways	7,782	205	7,987
Existing workforce additional shifts	94	0	94
Decontamination	0	6	6
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	223	223
COVID-19 virus testing - rt-PCR virus testing	164	98	262
COVID-19 - Vaccination Programme - Provider/ Hospital hubs	0	0	0
COVID-19 - Vaccination Programme - Vaccine centres	96	0	96
COVID-19 - Vaccination Programme - Vaccination of Healthy 12-15s (via SAIS)	0	0	0
NIHR SIREN testing - antibody testing only	8	2	10
Total Reported to NHSI	**8,877**	**578**	**9,454**
COVID-19 - Vaccination Programme - Vaccine centres (Locally Funded)	15	0	15
COVID-19 - Vaccination Programme - Provider/ Hospital hubs (Locally funded)	23	1	23
PPE - locally procured	0	-16	-16
Other COVID-19 virus / antibody (serology) testing (not included elsewhere)	395	-5	390
Support for stay at home models	0	14	14
Internal and external communication costs	0	-1	-1
Grand Total	**9,309**	**571**	**9,880**

Recovery Costs YTD SEP 2022	Pay £'000	Non-Pay £'000	Total £'000
Independent Sector	1,077	6	1,082
Additional Staffing - Medical	14	1,136	1,150
Additional Staffing - Nursing	0	232	232
Additional Staffing - Other	0	537	537
Non Pay	2,408	0	2,408
Enhanced Payment Model - Medical	0	0	0
Enhanced Payment Model - Nursing	0	382	382
Total	**3,498**	**2,293**	**5,791**

Covid-19 Costs

Year to date the Trust has incurred £9.88m 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 £9.51m versus a plan of £4.61m, an adverse variance of £4.91m. This overspend was driven by higher than planned Covid-19 related activity leading to higher staffing and consumables costs and delays in closing additional Medical capacity. Outside of envelope costs are highlighted in the table to the left and total £0.37m year to date.

The Autumn Covid-19 vaccination programme has started and funding will be provided on a fixed cost per vaccine basis.

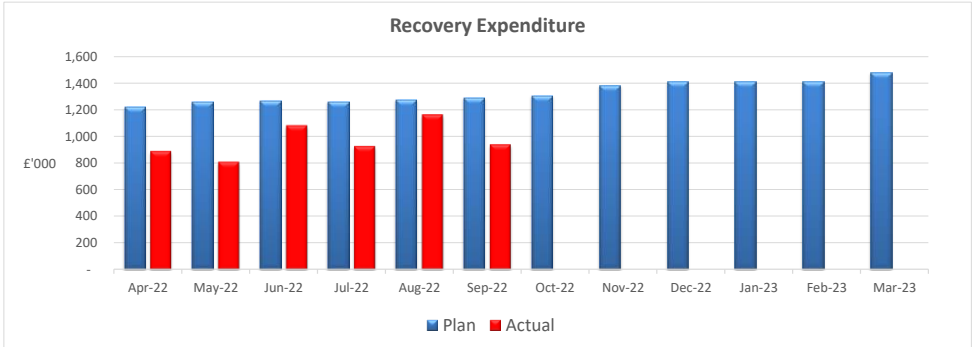
Covid-19 Funding

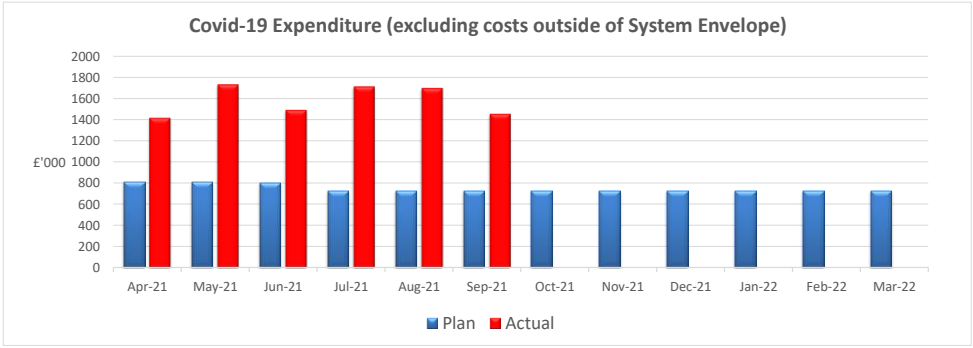
The Trust has been allocated block funding by the ICS to cover any ongoing Covid-19 costs and associated impacts totalling £5.90m for the year (£2.95m year to date).

Recovery

- Year to date Recovery costs are £5.79m, £1.78m 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. £5.46m of ERF has been assumed in the year to date position as planned, (profiled in line with activity plans). ERF will not be clawed back for the first half of the year (H1), but this remains a risk going into H2, as activity year to date was below the planned level and some claw back might be required if the Trust is unable to catch up this activity in future months.

Note: Both Covid-19 and recovery plans assumed that associated CIP schemes would be delivered in full.





14. Workforce Committee Chair Highlight Report

For Assurance

Presented by Suzanne Dunkley

Calderdale and Huddersfield NHS Foundation Trust

CHAIR'S HIGHLIGHT REPORT
to the Board of Directors

Committee Name:	Workforce and OD Committee
Committee Chair:	Karen Heaton
Date(s) of meeting:	11 October 2022
Date of Board meeting this report is to be presented:	10 November 2022

ACKNOWLEDGE

The following points are to be noted by the Board following the meeting of the Committee on 11 October 2022.

- IPR- concern remains over the level of short-term sickness absence and the number of return-to-work interviews remains below target with further work planned to improve this. The Committee will receive a report at its next meeting in December on a new approach. Fire safety and data security training completion levels are low, and action is underway to address these. Overall EST levels have fallen slightly. A review of all EST is currently underway to ensure we are identifying what is "essential" and this will be considered by the newly formed Education Committee.
- The Trust is participating in the Diversity in Health and Care Partnership Programme to enable a sharing of good practice.
- The Committee received an update on the recruitment strategy which is operationally progressing using value- based recruitment.

ASSURE

- The Committee received detailed reports and presentations covering Nursing and Midwifery Safer Staffing, an update on the Nursing Workforce Programme, Developing Workforce Safeguards- Nursing, Midwifery and Medical and an update on the Medical Workforce Programme. It was assuring to see that there continues to be a significant amount of work, commitment and planning to ensure safe staffing levels are maintained. It was clear that the safe level is not simply dependent on numbers but also relies on the skill mix of colleagues. This remains a key priority.
- The Board Assurance Framework covering Colleague Engagement was discussed and whilst it was recognised the score hadn't changed the actions to mitigate the risk had been revised and continue to be ongoing.

AWARE

- A new approach to undertaking Return to Work Interviews will be presented to the December meeting
- EST levels are moving downwards and the Committee is monitoring this closer
- Staffing levels continue to remain a challenge alongside turnover. Although recruitment has been going well and in particular international recruitment.

ONE CULTURE OF CARE

- One Culture of Care considered as part of the workforce reports and in discussions.

15. Comfort Break

16. Quality Committee Chair’s Highlight Report

- Director of Infection, Prevention and Control Q2 Report - Review Room
- Learning from Deaths Q2 Report - Review Room

For Assurance

Presented by Denise Sterling

Calderdale and Huddersfield NHS Foundation Trust

CHAIR'S HIGHLIGHT REPORT
to the Board of Directors

Committee Name:	Quality Committee
Committee Chair:	Denise Sterling, Non-Executive Director
Date(s) of meeting:	12 September 2022, 24 October 2022
Date of Board meeting this report is to be presented:	10 November 2022

ACKNOWLEDGE

- Report received on the Patient Safety Incident Response Framework(PSIRF) which replaces the Serious Incident Framework. A task and finish group is to be established to ensure the PSIRF is implemented within 12 months from September 2022.Progress updates to Quality Committee.
- The End-of-Life Care Annual Report received and provided an update on the progress made within the workstream and the work undertaken that supports the local and national priorities.
- Update provided on End-of-Life Care CQC engagement event.
- Split site Paediatric service - committee had requested that the paediatric escalation was revisited, update provided on the current consultant paediatric cover and risk mitigation including a SOP for the escalation of the deteriorating patient on ward 4, 24/7 APNP cover, CQC transformation plan .Review of the risk of the APNP model at HRH to be reported to committee.

ASSURE

- Internal Audit Follow up Report Complaints – Confirmation provided that the action plan is on track for the recommendations to be fully implemented by the end of October 2022.
- Maternity Services Oversight report- a new confirm and challenge process has been introduced to review the Transformation plan with monthly overall progress review undertaken by the Chief Nurse. Areas of concerns identified will be escalated to Quality Committee for review. The service currently has 3 active cases with the health care safety investigation branch and information on the cases provided in the report. The report from the Regional Maternity Team Assurance visit has been received and CHFT has been assessed to have met all the 7 immediate essential actions recommended in the Ockenden report.
- BAF Risk 6/19 Compliance with Quality and Safety reviewed and risk score reduced from 15 to 12.
- Received Annual Complaints Report,2021/22, there has been an increase in PALS and formal complaints and reduction in overall performance from the previous year. Committee noted areas of focus and actions in place to improve performance. The new PHSO standards being introduced.
- IPR - Both HSMR and SHMI position deteriorating and work being done on these metrics, A+E pressures continue and increase in patients presenting with stroke. Noted patient story showing good impact for pts/carer, staff and community engagement.
- Quality Report - Update on the quality priorities and focussed quality priorities.
- IPC Report Q2 – reviewed performance against targets, C Diff remains a challenge and C Diff improvement plan in place.

AWARE

- Dementia screening options appraisal received ,committee supported the preferred option which would improve dementia screening compliance. Further discussions required before final decision made as this would impact on nursing staff workload.
- Medical Gas and Non-Invasive Ventilation (NIV) Group Report- The Committee was asked to note the slow progress with all areas of work of the group as a result of the availability of divisional staff representatives to attend meetings and progress the work.
- Q2 Learning from deaths report, noted the ongoing work to understand the increased reporting within the poor care category.

17. Quality Report

To Note

Presented by David Birkenhead

Date of Meeting:	**10 November 2022**
Meeting:	**Board of Directors**
Title:	**Quality Report (Reporting period August to September 2022)**
Author:	**Sharon Cundy – Head of Quality and Safety**
Sponsoring Directors:	**Lindsay Rudge - Chief Nurse Dr David Birkenhead - Medical Director**
Previous Forums:	**Quality Committee**

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.

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

Key Points to Note

See separate PowerPoint Executive Summary

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 will 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 Quality Committee and 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.

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 that has been carried out and continues to be carried out every day.

This report provides assurance 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 August and September 2022: and 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)

Key highlights are included within the PowerPoint slides at appendix 2.

3. Patient Experience, Participation and Equalities

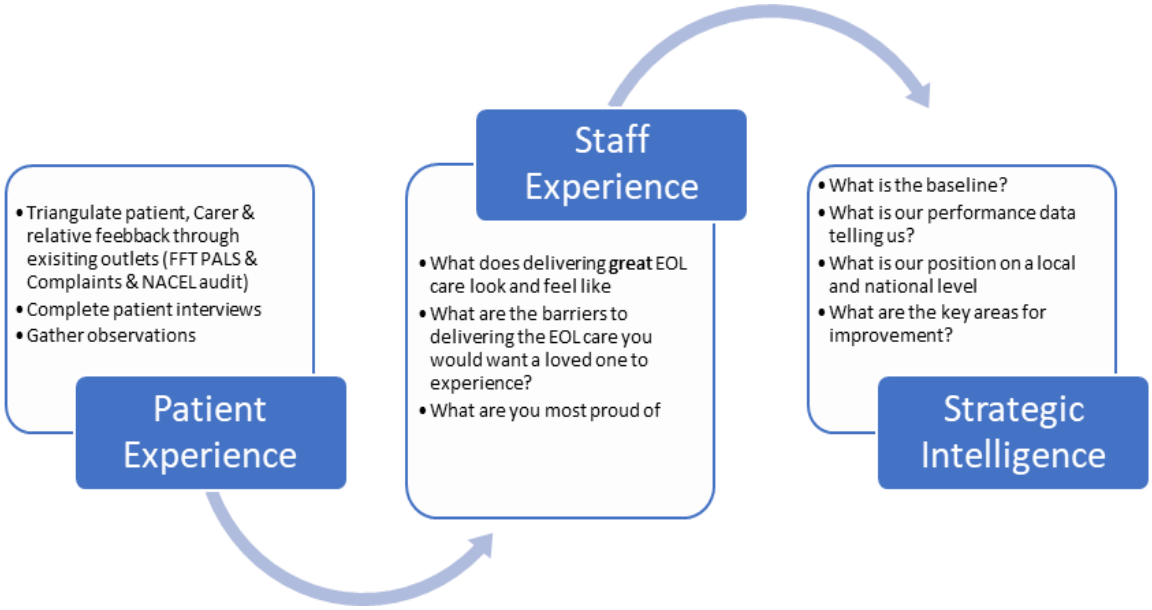
In the previous quality report, the End-of-Life Care (EoLC) plan was included to show how the service will gather intelligence, map challenges and work on sustainable improvements. The plan is used alongside strategic intelligence to drive measurable improvements.

The EoLC team have not only highlighted challenges within the service, but they have promoted their successes. These will be evident in the EoLC presentation that will be given to the Committee today.

The Trust is still experiencing challenges in increasing the response rates to the Friends and Family Tests (FFT), however, there has been significant improvement in the narrative describing our patient's experiences. The team are working together to not only display evidence of the changes they have made using the 'you said, we did' template, but to promote the FFT to friends and family when they use our service.

The patient experience team continue to work with our local third sector carers support groups to identify how we can help support carers when accessing our services. A 'Mystery Shopper' pilot scheme has been designed to help encourage carers to share their real time experiences of our outpatients' services. We currently have 12 independent carers signed up to the process. The pilot will be completed at the end of December 2022 and data collated and results shared within the new year.

To align to the Trust quality priorities, we continually strive for improvements by triangulating all of the information received.



4. Patient Advice and Complaints Service (PACS)

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

Key Objectives

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

Objective	Current level of assurance	Comments
1. Working with the divisions effectively to deliver strong complaints performance and user centric service	**REASONABLE Assurance**	A Standard Operating Procedure is currently being drafted to ensure all Divisions are following the same process. Weekly meetings are now taking place which includes all Divisions. This meeting is led by the Associate Director of Quality & Safety to assess the Trusts complaints position; those complaints that are in the pipeline and to identify complaints that require escalation. Weekly meetings with individual Divisions also take place and these are led by the Head of Complaints & Patient Advice Liaison Service (PALS) to discuss up to date positions.
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 the quality of complaint responses.

Patient Advice and Liaison Service (PALS) & Complaints team to undertake quality improvements:

- 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.

Progress against key objectives
Complaints and Patient Advice and Liaison Service (PALS) Performance Summary

	Aug 2022	Sept 2022
Complaints received	55	37
Complaints closed	45	44
Complaints closed outside of target timeframe	19	23
% of complaints closed within target timeframe	42%	48%
Complaints reopened	12	8
PALS contacts received	141	120
*Compliments logged	148	64
PHSO complaints received	0	0
PHSO complaints closed	0	0
Complaints under investigation with PHSO (total)	6	

***Please note, as mentioned in the last report, there was a backlog of compliments to be logged which have now been done, hence the high numbers.**

5. Legal Services

Introduction

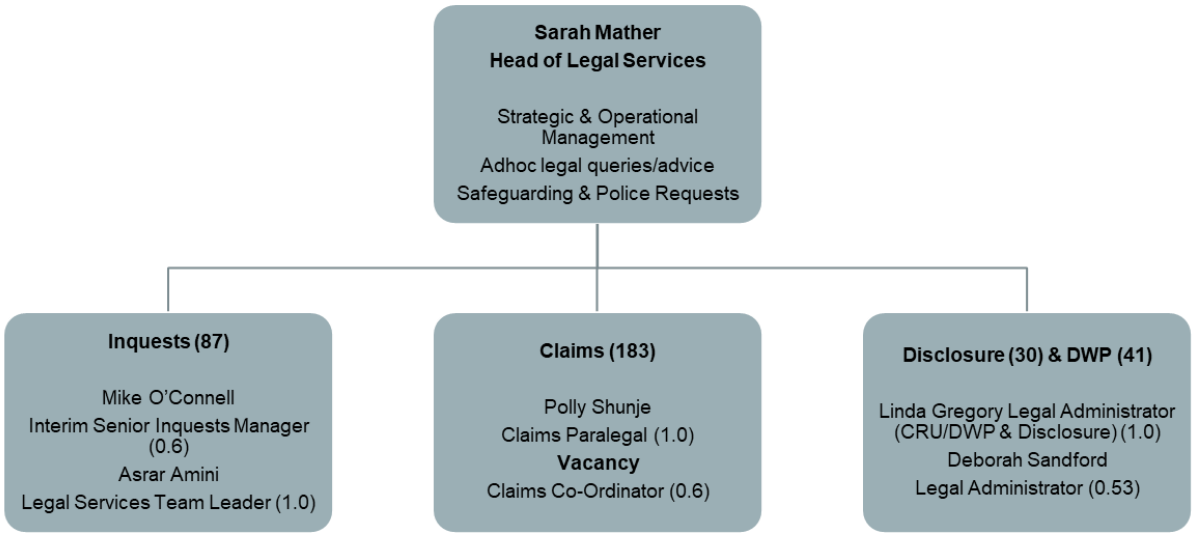
Calderdale and Huddersfield NHS Foundation Trust is committed to:

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

The secondment for Acting Head of Legal has come to an end with Sarah Mather commencing the substantive post on 27 September 2022.

The current team structure is as follows:



Claims

The growing demand around claims continues, with an increase in portfolio size from 170 to 182 since last reporting. **There has also been a slight increase in potential claims (requests for medical records) from 24 to 30.**

Whilst the new Legal Standard Operating Procedure (SOP) allows for deeper scrutiny of claims and escalation to the Divisions, Finance, and the executive teams, due to the increase in claims activity and the absence of a substantive Claims Co-ordinator this is impacting upon the Trust's ability to meet court deadlines and scrutinise cases as efficiently as hoped. To manage this risk, the Head of Legal has temporarily taken on a more active role in managing high risk claims and settlement meetings whilst a business case is prepared providing a review of current resources, operational need, and long-term sustainability. Legal are also being assisted temporarily by a bank member of staff who is supporting the claims handling function.

A weekly task list is also being provided by panel solicitors to highlight any impending deadlines and cases which need to be prioritised. This is being reviewed twice weekly to progress matters as swiftly as possible.

Inquests

The inquest portfolio has increased to 87 (from 79) and the risk assessments for these are currently scored at 3 x high, 18 x moderate, 37 x low and 29 x minimal.

The backlog of inquests and the difficulties at Bradford Coroner's Office with last minute adjournments and disclosure, continue to impact the legal team's ability to prepare for inquests. The team fervently work under the legal SOP to identify risks in advance of inquest and mitigation planning.

Moderate and high-risk inquests continue to have executive and divisional oversight via legal briefings and strategy meetings between panel solicitors, legal and senior leads from the divisional and assurance teams. This has allowed the Trust to be more proactive in terms of collating information and mitigating risks prior to inquests. There has been full support and shared ownership from the Divisions which has been enormously helpful.

A fortnightly inquest dashboard report (and inquest timetable) is also shared with the Assistant Director of Quality & Safety, Divisional Directors and Quality Governance Leads for awareness. This report is also reviewed as part of the Governance MICCI (Mortality Review, Inquests, Claims, Complaints, Investigations) meetings to triangulate with the Trust's investigation and review workstreams.

A meeting with the Senior Coroner is still to be planned to establish a line of communication with the Coroner's Office and agree a more productive and efficient working relationship moving forward. The new Patient Safety Investigation Response Framework (PSIRF) will also be discussed to share with HMC how the Trust intend on sharing and demonstrating learning from inquests. **It is noted the Senior Coroner is currently presiding over a 3-month inquest and will not be available to meet until the new year.**

An internal review of the Trust's inquest portfolio by Audit Yorkshire is currently underway. It is hoped the results of the audit will be shared in the next report.

Medical records disclosure

Several issues have been identified within Legal, Patient Advice and Liaison Service (PALS) and the Complaints Team relating to the disclosure of patient records including the risk of duplication across various services presenting a litigation, reputational and financial risk to the organisation. This has been placed on the Trust risk register accordingly.

A Task and Finish Group has been set up to explore a unified Trust SOP / process including staff access and a learning package to ensure consistency and avoid duplication across the Trust. At the recent Clinical Records Optimisation Group meeting, the Task and Finish Group advised that they are hoping to close this risk in the next few months. In the interim, a SOP is in place which includes a system of cross checking of the medical records and tailoring requests to limit the scope of disclosure (and likelihood of missing records).

Statement disclosure

All Safeguarding and Police requests for information continue to come via Legal Services. This has enabled the Trust to review requests for information, challenge these where appropriate and support staff to prepare their statements. A SOP is currently being worked on and will be shared with the Divisions for awareness.

From 1 August to 30 September 2022 there have been 9 requests for information made by the Local Authority and Police.

Emerging Trends

Following the report of an unsafe Deprivation of Liberty Safeguarding (due to incorrect paperwork being completed), it has been agreed with South West Yorkshire Partnership NHS Foundation Trust that any 'unsafe' deprivations and paperwork identified as substandard will immediately be escalated to the Head of Safeguarding and Head of Legal Services for onward escalation.

The Legal Team are currently seeing a flurry of safeguarding and best interest cases which have led to an impasse. As a result, Divisions are seeking legal advice and guidance on how best to proceed. The Head of Legal is to work with the Head of Safeguarding and the wider team to further understand the current processes and any training needs.

Recent Data

This report covers the period **1 August – 30 September 2022**.

Clinical Negligence

- **157** (from 148) active clinical negligence claims
- **12** (from 17) new clinical negligence claims were received
- No clinical negligence claims have been concluded

Employers' and Public Liability (EL/PL) Claims

- **26** (from 22) active EL/PL claims- **12 open PL/ 14 EL open active**
- **2 new** EL/ claims were received / 0 new PL
- **0** EL/PL claims were concluded

Lost Property

- **15 active lost property claims**
- **1** lost property claims were received
- **0** lost property claims were concluded
- Compensation totalled **£0**

Inquests

- **87 (from 79) active inquests**
- **23 (from 14)** inquests were opened
- **20** inquest files were closed

Objective	Q1	Q2	Q3	Assurance
System in place to ensure effective communication within the Legal Services Department	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.	This continues however, due to a reduction in staff it is expected this will be impacted in the following months. A legal restructure review is underway however, a comparison with neighbouring Trusts with similar portfolio sizes suggests the Trust Legal Services Team is understrength. The Head of Legal is also working operationally to assist with claims, inquests and court hearings.	A new Legal standard operating procedure (SOP) has been implemented to streamline the claims and inquest process. The process now includes stages and triggers for escalation, Head of Legal (HoL) review and approval, SBAR briefings for divisional / executive awareness and a system of audit. This has allowed for deeper scrutiny of claims and inquests and escalation to the Divisions, Finance and the executive teams where organisational risk is identified. As above, the Head of Legal is currently assisting operationally due to staff shortage and increased demand within the portfolio. A business case is underway to provide a review of current resources, operational need, and long-term sustainability.	**Reasonable assurance**
Datix Module for Legal Services reviewed and updated	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.	The new Datix Manager has started, and a mapping exercise has taken place. The Datix Manager is to work on the proposed changes. In the interim, case plans have been implemented to record salient information. Once Datix is reconfigured for legal case management use, further reporting will be explored via KP+.	**This continues.**	**Reasonable assurance**

Objective	Q1	Q2	Q3	Assurance
Audit of Legal Services files on Datix	This continues. Learning is communicated at weekly portfolio meetings and will be feedback in 1-1's.	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.	An internal review of the Trust's inquest portfolio by Audit Yorkshire is currently underway. It is hoped the results of the audit will be shared in the next report. It is anticipated that a Claims audit will follow.	**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.	This continues.	**This continues and is being monitored by the Clinical Records Optimisation Group.**	**Reasonable assurance**.

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

The 2022 Litigation data pack has now been received. The legal team will need to complete the Getting It Right First Time (GIRFT) 5-point action plan, with the support of clinicians and our panel law firms and summarise any learning in accordance with the NHS Resolution / GIRFT claims best practice guide. Once the claims for each specialty has been reviewed using the 5-point action plan, the Trust will need to complete a short survey by **16th December 2022.**

Legal are currently filtering through the data to compare any duplicates from last year's data (and cases already reviewed) and will liaise with the Divisions to agree a plan to review the claims by way of directorate.

Claims and inquests portfolios (including learning) are now being shared via Divisional Patient Safety and Quality Board meetings.

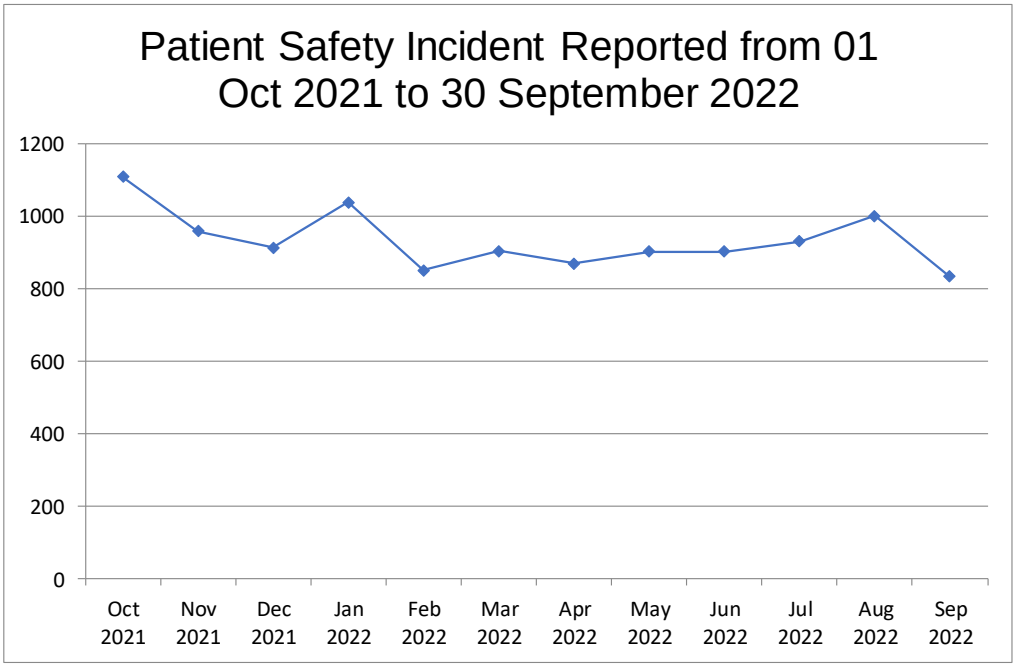
6. Incidents

Below is a summary of patient safety incidents and incidents with severe harm or death, for the year 01 October 2021 to 30 September 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 resulting in severe harm or death	Serious Incidents by the month externally reported on StEIS
Oct 2021	1107	10	4
Nov 2021	958	11	7
Dec 2021	912	5	1
Jan 2022	1037	13	2
Feb 2022	850	9	3
Mar 2022	902	13	5
Apr 2022	869	4	2
May 2022	901	11	5
June 2022	901	5	1
July 2022	929	13	6
Aug 2022	1000	16	5
Sept 2022	824	9	2
Total Over rolling 12 Months	**11190**	**119**	**43**

The number of patient safety incidents reported in September 2022 is slightly below average. The Average for the rolling 12 months is 932 patient safety incidents per month. Patient safety incidents reported in August 2022 demonstrated an increase. When analysing the increase (incident numbers report in August and September), there were no trends, patterns or concerns to indicate over reporting in August or under reporting in September 2022.



Over the last 12 rolling months (01 October 2021 to 30 September 2022), Health Care Associated Infection and Treatment / Care Delivery was the most frequently reported type of incident that result in either severe/catastrophic harm or death. Over the last 12 months there has been 18 Health Care Associated Infection (HCAI) that have resulted in catastrophic harm or where death was recorded as Harm.

The 18 Health Care Associated Infection incident reported in that period, are all but 1 were in relation to Hospital onset to covid.

There was also a total of 18 incidents (reported between October 2021 to September 2022) that were relating to treatment and care delivery that either resulted in severe harm, catastrophic harm or death. When analysing the 18 care delivery incidents (that had been reported in the rolling year) the majority were in relation to Treatment/Care Plan not followed or a delay in treatment. When analysing this data further this did not indicate any trends or patterns for a specific ward/dept.

Below Table shows the top 10 incidents reported between 01 October 2021 to 30 September 2022, that either resulted in severe or catastrophic/death harm only.

Type of Incident	Severe harm	Catastrophic or Death	Total
Health Care Associated Infection (HCAI)	0	18	**18**
Treatment/Care delivery	5	13	**18**
Possible delay or failure to monitor	6	8	**14**
Diagnosis, failed or delayed	10	2	**12**
Complication of treatment (expected/unexpected)	2	10	**12**
Slip, Trip or fall - Patient	4	6	**10**
Tests/results	4	1	**5**
Transfer	3	1	**4**
Hospital Acquired Pressure Ulcer/MASD	3	0	**3**
Administration/management of medication in a clinical area or Nurse Involvement	2	0	**2**

Between the 12-month rolling period of 01 October 2021 to 30 September 2022, the most frequently and common type of incident reported (regardless of the level of harm), is Slips, Trips-and Falls with 2035 incidents reported in the 12-month rolling period. This is closely followed by Pressure Ulcers / Moisture Associated Skin Damage (MASD) with 1617 and Appointment / Admission / Transfer / Discharge with 1607 reported incidents.

On analysis of the incidents reported during 01 October 2021 and 30 September 2022, there are no trends or patterns that can be identified with the numbers reported during that reported. 95% of incidents reported during 01 October 2021 and 30 September 2022 resulted in either no harm or minimal harm to patient.

August and September 2022 Data:

During the month of August 2022 and September 2022, a total of 1831 incidents were reported. There were 1000 patient safety incidents reported in August 2022 and 831 patient safety incidents reported in September 2022. The average number for patient safety incidents reported each month is 932 incidents per month,

94.5% of all patient safety incidents reported in both August 2022 and September 2022 resulted in either no harm or minor harm to the patient.

The top 10 most common type of incidents between 01 August 2022 and 30 September 2022 are shown below:

Type of Incident:	Aug 2022	Sep 2022	Total
Slips, trips and falls	190	130	**320**
Pressure Ulcers/Moisture Associated Skin Damage (MASD)	155	159	**314**
Appointment / Admission / Transfer / Discharge	127	99	**226**
Assessment / Treatment / Diagnosis	88	95	**183**
Medication	78	78	**156**
Maternity Incidents	66	70	**136**
Infection Control	63	23	**86**
Infrastructure/Resources/Staffing	46	33	**79**
Health and Safety/Sharps/Security	40	36	**76**
Confidentiality/Communication/Consent/IG	38	36	**74**

As with the previous quality report (June 2022 and July 2022 report), slip trips and falls continues to be the most frequent type of incidents reported during August and September 2022. The slips, trips and falls incidents reported during August and September 2022 were trust wide, with no obvious trends or pattens and the majority of these incidents resulted either in no harm or low harm. All were classed as suspected falls.

Never Events

Between 01 October 2021 and 30 September 2022, the Trust has reported 4 Never events, however one of the serious incident investigation reports, has been reviewed by the Integrated Care Board (ICB), and agreement has been made to have Datix ID 211712 (retained foreign object post procedure) downgraded from a Never event to a Serious Incident Investigation. The final investigation concluded that the gastric band was not subject to a formal counting/checking process as it was inserted during a procedure performed at a different Trust.

Following the downgrade of Datix ID 211712, the Trust, currently has 3 Never events that have been reported in the current year 2022.

The Table below shows the current stages of the ongoing Never event investigations including the never event that was downgraded recently.

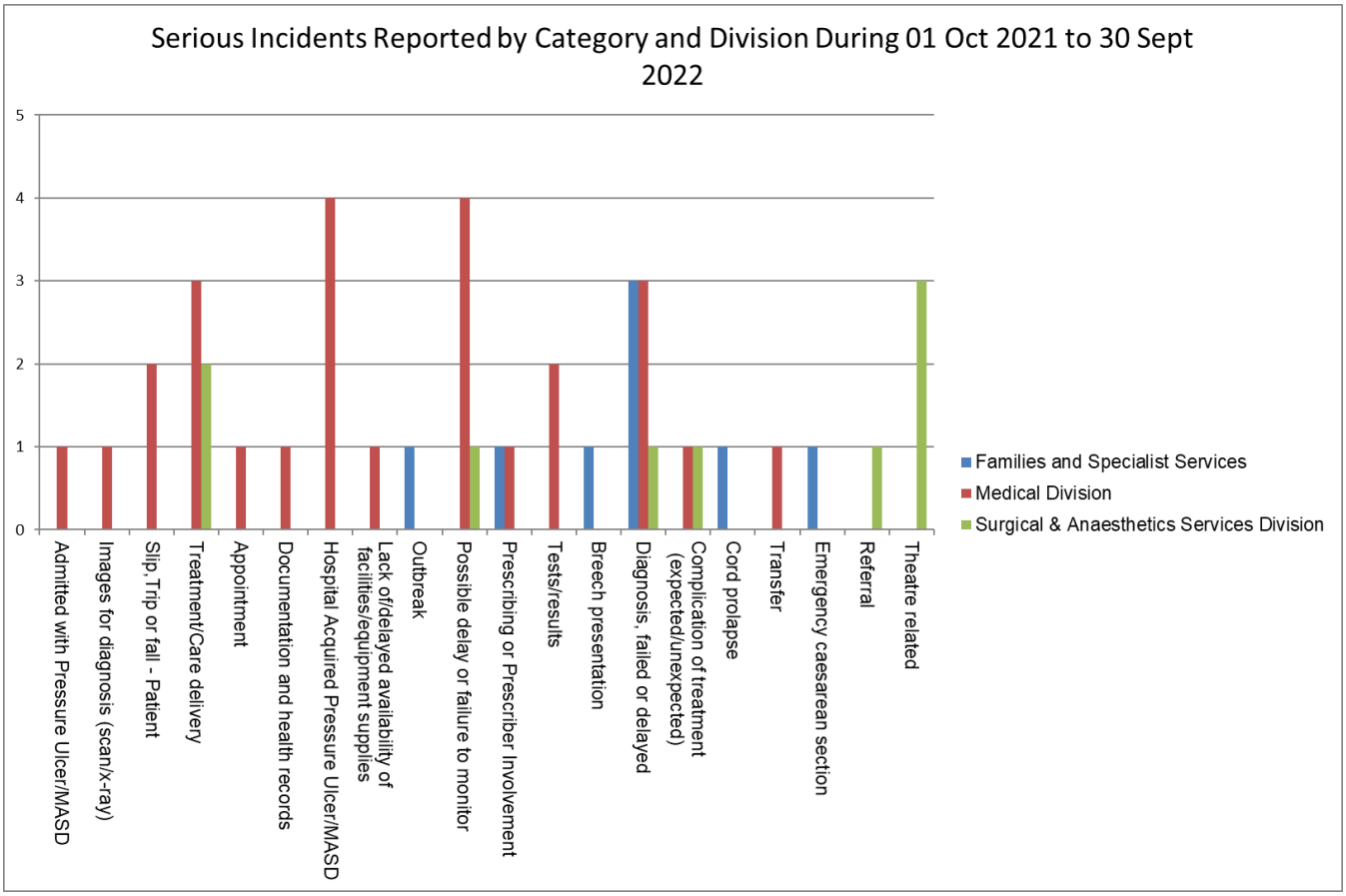
ID	Date Reported	Division	Subcategory	Description	Current Progress
208731	11/03/2022	Surgical & Anaesthetics Services Division	Wrong site surgery (Never event)	Botox injected into neck and the product should have been injected into the mouth.	Report approved at SI Panel and submitted to Integrated Care Board for furthereview and approval
211996	10/06/2022	Medical Division	Prescribing Wrong Dose or Strength	Patient prescribed 15mg Twice in one day instead of 10mg twice a week. -	Currently under investigation
213644	22/07/2022	Surgical & Anaesthetics Services Division	Wrong site surgery (Never event)	Patient had biopsy of 3 lesions of which one was a melanoma in situ. The surgeon did a wider excision of the benign lesion and not the insitu lesion.	Currently under investigation

There were no Never Event incidents reported during the month of August and September 2022

Serious Incidents (reported from 1st Oct 2021 to 30th Sept 2022)

In total, for the rolling month of 1 October 2021 to 30 September 2022, there has been 43 Serious Incidents declared on Strategic Executive Information System) StEIS that are either under investigation or the investigation has been completed and closed. The 43 SI's have been recorded across 3 divisions: Families and Specialist Services (8), Medical Division (26) and Surgical & Anaesthetics Services Division (9)

The below table demonstrates the number of serious incidents reported by category and division:



The most frequently reported category for a serious incident reported over the last 12 rolling months (from 1st October 2021 to 30 September 2022) is, 'Delay or Failure to Monitor'(4) and 'Hospital Acquired Pressure Ulcer'(4)

The 4 serious incidents relating to possible delay or failure to monitor were a combination of lost to follow up and failure to act upon adverse symptoms.

The 4 serious incidents in relation to hospital acquired pressure ulcer all relate to patients who had previously had a pressure ulcer, but whilst admitted as an inpatient, the pressure ulcer went on to develop into a category 4.

Current Progress of SI Investigations:

As of 1st October 2022, the Trust has 21 serious incident investigation that are currently under investigation. The 21 ongoing serious incident investigation are across 3 divisions: Families and Specialist Services (5), Medical Division (11) and Surgical and Anaesthetic Division (5). This includes the two Never event incidents as mentioned on page 5 of this summary.

The below table shows the 21 serious incidents investigations that are currently under investigation broken down by the type of serious incident:

SI relating to:	Families and Specialist Services	Medical Division	Surgical & Anaesthetics Services Division	Total
Images for diagnosis (scan / x-ray)	0	1	0	**1**
Treatment / Care delivery	0	2	0	**2**
Hospital Acquired Pressure Ulcer / MASD	0	1	0	**1**
Outbreak (MRSA)	1	0	0	**1**
Possible delay or failure to monitor	0	3	0	**3**
Prescribing or Prescriber Involvement	1	1	0	**2**
Tests / results	0	1	0	**1**
Diagnosis, failed or delayed	0	1	1	**2**
Complication of treatment (expected / unexpected)	0	0	1	**1**
Cord prolapse	1	0	0	**1**
Transfer	0	1	0	**1**
Emergency caesarean section	1	0	0	**1**
Referral	0	0	1	**1**
Theatre related	0	0	2	**2**
Poor outcome for baby	1	0	0	**1**
Total	**5**	**11**	**5**	**21**

Summary of Progress with Serious Incident Actions

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

Serious incidents reported between August 2022 and September 2022

A total of 7 incidents have been reported to StEIS during the period 01 August 2022 and 30 September 2022. Five serious incidents were declared in August 2022 and 2 in September 2022. Below is a table demonstrating serious incidents reported during the period August and September 2022:

SI Category	Aug 2022	Sept 2022	TOTAL
Treatment / Care	0	1	**1**
Possible delay or failure to monitor	2	0	**2**
Diagnosis, failed or delayed	0	1	**1**
Transfer	1	0	**1**
Referral	1	0	**1**
Theatre-related	1	0	**1**
TOTAL	**5**	**2**	**7**

Serious Incidents Closed by Integrated Care Board in August and September 2022.

There were 2 serious incident investigation reports that were approved and closed by the ICB during the month of August and September 2022. A brief detail of these incidents can be found in the below table:

Datix ID	Division	Category	Brief Description	Conclusion	Date Closed by ICB
197023	Families and Specialist Services	Intra Uterine Death (IUD)	Patient confirmed not to be pregnant. A sonogram was commenced. The images were reviewed, and the radiographer proceeded to a CT. A CT identified significantly developed fetus / pregnancy was detected and the radiographer stopped the CT scan immediately.	The sepsis and AKI bundle to be reviewed to include that in women of childbearing age with abdominal distension an ultrasound scan to rule out possible pregnancy should always be considered even if the woman denies that a pregnancy is possible. Radiologist enlarges any sonogram prior to proceeding to a CT scan on patients who are of childbearing age where there is a CT request to exclude intra-abdominal sepsis in order to identify any fetus and to reduce the risk of carrying out a CT scan on an unknown pregnancy	August 2022
204053	Medical Division	Documentation not completed	A patient was placed on a Section 2 of the Mental Health Act and not all the correct processes were followed	All senior ward staff band 8,7 and 6 to do the in-house training for receipt and scrutiny process A robust handover between the mental health team and the physical health team must take place to ensure that all MHA documentation is completed correctly and that this is contained within the patients notes, this included all sections of the H3 form A process (checklist) should be in place to ensure that the patient is given their section 132 rights and it is documented that they have understood these Any error / omission in completing any part of the MHA documentation during any stage of the patient's admission should be escalated to the Matron and the safeguarding team so that this can be rectified in a timely manner	Sept 2022

Learning from Serious Incidents

Five completed serious incident investigation reports have been submitted to the Integrated Care Board (ICB) in August 2022 and September 2022 for closure. These are as follows:

Incident Summary	Learning Need and Organisational Learning
211712: Patient underwent elective gastric band removal 2017. Five years later, claim has been received for retained section.	Dividing the band increases the chance of a piece being retained In order to ensure that no pieces are retained following cutting the band, reasonable checks should be undertaken, to include reconstructing the pieces in theatre and doing a visual check following the procedure
209366: The reporting radiologist missed the abnormal tissue at the back of the abdomen. It may be that the radiologist missed this finding; alternatively, given the context of the information provided, it is possible that it was seen but not felt to be relevant to the history provided and that may be why this appeared to have been overlooked. However, in retrospect, this was related to what the final diagnosis turned out to be approx. 12 months later	All clinicians and staff involved in the patient pathway should be aware they should submit an incident as they become aware or contact the Risk team to check if an incident has been raised
203255: Patient has been missed on surveillance- Rectal cancer surgery 2017. Anterior resection. No follow up investigations or OPA since his reversal of ileostomy in 2018. He should have 6/12 CEA blood test and annual CT scans and colonoscopy. Admitted Sept 2021 and found to have liver and bilateral lung metastases.	To ensure that clinical activity relates to the appropriate episode and that follow-up appointments are linked/created within the electronic patient record appropriately. To ensure that any cancellations are communicated with the responsible clinical teams' administrative staff for the appropriate queries to be raised.
207589: CT scan performed on 15 November 2019 - missed a right ovarian mass which was subsequently identified on 20 January 2022 CT scan and looks malignant with local invasion. Missed cancer.	An audit of a proportion of all a portal venous CT imaging and reports to ensure that no identifiable abnormalities have been missed. All Radiology Colleagues will be asked to reflect on the incident so that they are mindful of the need to review gynae organs identified on relevant CT scans and to flag any bulky ovaries as an incidental finding.
208731: (Never Event): injected Botox into neck and the product should have been injected into the mouth.	Consultant-to-consultant referrals should be formally documented, not an informal email. The referral should unambiguously state the reason for referral and, in case of request for an intervention, a clear and accurate description of it. Positive patient identification is an important step in every interaction with a patient and can prevent incidents and harm The type of procedure/ intervention should be confirmed with the patient at the time, and patient given adequate time and opportunity to ask any questions, as part of informed consent. Consent, even if verbally obtained, should be documented in the notes. Medication administration should be documented in accordance with Medicines Management Policies. All staff should advocate for the patient, ensuring informed consent

7. Medicines Safety

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

Electronic Controlled Drugs Register (eCDR) Development

We are in the final stages of implementation of the new Solidsoft electronic Controlled drugs register software. User accepter testing is nearly complete. Training on the new system will be a 'Train the Trainer' style method, with SolidSoft Reply (the supplier) providing training to 'Pilot users & identified ward/area Superusers' who would then be available to assist colleagues during the phased Roll out. The training will be Virtual/Ward based, as per stated preference and split over a 3-week period (3/10/22 – 21/10/22) broken down into 2 x categories:

- Pharmacy
- Ward & Theatre Style

Onsite ward-based training has been agreed & scheduled for HRI Ward 12, Ward 19, SAU, ICU, & Oncology Clinic from 3rd - 7th October 2022.

The virtual training sessions will be delivered via 'MS Teams' and attendance will be captured to inform numbers of colleagues trained. Training materials/recorded virtual sessions will be shared with the identified wards/areas, at least 2 weeks prior to their expected implementation date, so that the necessary review/training & competency can be captured prior to access & use of the system.

The implementation comprises of the following phases, with the pilot starting on the 31/10/2022:

HRI = 40 locations to be completed by 19th December 2022
Pilot Phase (1 week) – 3 wards/areas: ward 12, 19 and oncology clinic
Phase 1 (2 weeks) – Further 18 ward/areas
Phase 2 (2 weeks) – Remainder 19 ward/areas

CRH = 48 locations to be completed by end of February 2023
Phase 3 (2 weeks) – Further 24 ward/areas
Phase 4 (2 weeks) – Remaining 24 ward/areas

Going forward, competency training has been requested to be added to the Trust's ESR platform and it is expected that once approved, the training materials/videos provided by SolidSoft will form the necessary basis to allow new users to complete the required competency prior to using the system. We will also have a requirement to add the training materials/videos provided by SolidSoft to the DLS Platform to allow 'Agency Staff' access to the learning & competency requirements, prior to starting a shift at CHFT

Active Temperature Monitoring

The Stanley temperature monitoring system for fridge and freezer active temperature monitoring is now live on most wards and clinical areas.
The remaining wards to go live: Medicine Division – A&E HRI, Neurophysiology Dept, Ward 7 HRI – Chemo

Medication shortages NatPSA/2022/006/DHSC = Shortage of Alteplase and Tenecteplase Injections.

The required actions have been taken by pharmacy in response to this alert.

1. Review areas stocking alteplase
2. Centralised stock where possible
3. Conserve for acute stroke patients
4. Communicate alternative therapeutic options- streptokinase added to ED Omnicell on both sites (1 vial) and CCU
5. Reduced wastage by ensuring use of appropriate vial size
6. Order in line with normal usage; procurement - managed regionally. Only to order allocation
7. Escalate to region if we are running low on alteplase stock

Previous alerts highlighted issue with Moviprep and remifentanil. The bowel prep supply issues are now resolved. There are still supply constraints with remifentanil, but we have contingency with more stock of higher strengths.

Review of Trust Medicines management training

Pharmacy and the medication safety team are working with 'THIS' digital health e learning developer to develop a bespoke training package that will be more reflective of medication safety issues reported at CHFT than the current version. We are looking to develop 3 modules, a medicines administration and governance module, a prescribing module and a community-based module, each based on three scenarios (all of which will be based on recent Trust Datix reports)

Medication Safety Dashboard

Progress is also being made with the Medication Safety Dashboard which will give us greater oversight of the medication safety standards and wards compliance with these standards.

Update on Parkinson's Medications:

Pharmacy team meeting with Parkinson's Consultant, date to be agreed to discuss and implement a plan to improve the patient experience.

Quality Priority (2022-2023)

Recognition and timely treatment of Sepsis

Executive Lead

Dr Elizabeth Loney

Operational Leads

Dr Rob Moisey
Paula McDonagh

Reporting

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

What do we aim to achieve?	Update	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 ED, patients who have triggered one or more red flags at each site** **August 2022 = 48.0%** **September 2022 = 48.9%** **All patients coded with sepsis ED** **August 2022 = 67.6%** **Sept 2022 = 60.5%** **External reporting compliance (within hour of clinical assessment) = 86%** **Current position** ▪ Compliance of antibiotics administered within 60 mins of earliest alert for red flag has not improved. We know clinician and nurse staffing gaps have impacted review and treatment times. Most non-compliant severely septic patients receive their antibiotics within 85 minutes. ▪ Trial of pre-made intravenous Piperacillin Tazobactam introduced and well received in Dept.. This was initiated due to high use at HRI ED and to support quicker administration time for patients with infections and sepsis. Before this informatics will look at the patient data so discussions can take place regarding the findings. A decision will then be made if supplies of premade will be permanent. ▪ ED consultant continuing sepsis write back audit. This looks at patients coded with sepsis who did not meet the 60minute antibiotic administration target. Reasons for this are identified, with Dr delay and nurse delay being the main findings. This is fed back at handovers and clinician	**Reasonable Assurance**

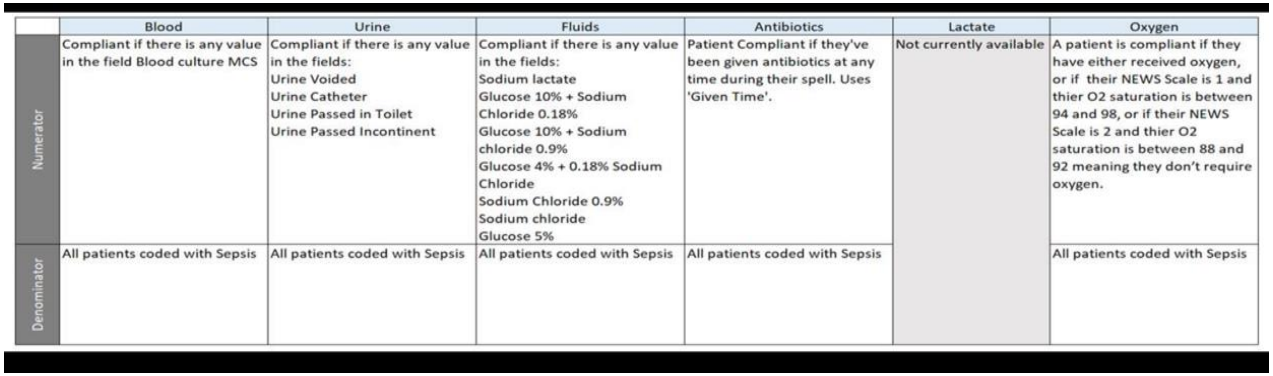
What do we aim to achieve?	Update	Progress rating
	meetings. It has also been noted that some patients have Red flagged when they are not septic, an example of this is a trauma patient who is tachycardic with a low blood pressure. These patients are then excluded from the audit. The sepsis nurse liaises with coding should changes be required. ▪ Mobile phone and dectphone introduced at both sites so middle grade doctor can be contacted quickly by nursing staff for quicker reviews and prescriptions deteriorating patients. Guidelines of contact are sited all around the Dept. ▪ Nerve centre going live in October, message option available in handsets for doctors to use also under review. Training of all staff is near completion. This system will calibrate when observations are due based on the previous NEWS2 score. Sicker patients will be escalated through the nerve centre to the medics, Outreach/HOOP teams. This is a very positive step to support deteriorating sepsis patients reviews and treatment plans. It will not replace verbal communication alerts but add a structured layer of patient assessment/alert through baseline observations. ▪ Trial of shift sepsis nurse who oversees time critical assessments and treatment is ongoing. ▪ ED sepsis champion, clinician and nurse feeding back audit results. ▪ Sepsis info boards in central areas, compliance noted on boards, so staff have site of %s. ▪ Sepsis trolleys in use, another has been located which will be used in HRI rapid assessment as patients with sepsis are treated here, this will give the nurse immediate access to all treatment items should a patient deteriorate and a treatment cubicle not be available. ▪ Compliance data now available site specific, no significant difference noted in last 2 months. ▪ Option within EPR for nurses to record time of antibiotic given retrospectively…. in Resus only. **Risks and mitigations** ▪ Use of sepsis phone variable, HRI have introduced allocated Dr onto the staffing board and the ED coordinator has been asked to monitor usage. As problems still occurring with use this was discussed at the sepsis collaborative meeting. The ED consultant will oversee usage and report back at the next meeting. The sepsis nurse will speak with the nurses and gather their views. At CRH the phone has only started being used due to technical issues that has caused a 6 week delay. A dectphone is required as there is no mobile phone signal in Dept. Matron has reported the doctor's reluctance to use the sepsis phone and is currently sorting out processes	

What do we aim to achieve?	Update	Progress rating
	with monitoring with the senior clinicians. ▪ Further discussions regarding signing for antibiotics on time as 'given' in Resus have taken place. Matrons do not wish to introduce a process to sign retrospectively should patients critical condition delay record keeping. Sepsis nurse has communicated to both teams that should there be a delay in signing the registered nurse must go into the patient's electronic prescription sheet and sign for the drug at the time they administered it. Gold standard practice requires a signature as soon as administered. The delay signing for antibiotics could be affecting compliance figures (patients in septic shock or with severe sepsis are mostly admitted to resus to commence their treatment) ▪ Staffing shortages have been negatively impacting patient reviews and treatment times. There has been a noted increase in agency nursing staff which may be affecting administration response as they are not used to processes in the Depts. The ED Depts have successfully recruited several substantive registered nurses who are currently undergoing induction. The sepsis nurse is speaking at one of the induction training days about sepsis, targets and treatment. Use of flexible workforce continues to assist unfilled shifts for both RNs and clinicians. Also, the ED coordinators risk assesses staffing cross site and move staff between the two hospitals to support safety of patient care. ▪ The duty ED sepsis nurse role is being filled more frequently on the late shift (we see most sepsis patients arriving during this shift). The depts have been unable to fill this shift during the night and on the early as staffing numbers are less stable. Nurses report that the role works well but if staffing shortages occur it is the first role to be pulled from to support another part of the emergency dept. the plan is to continue filling the role so we can collect information regarding compliance and staff support with deteriorating patients. **Next steps:-** -Improve use of sepsis phone at both sites so the sickest patients are reviewed, and treatment prescribed quickly. -Sepsis write back findings to be routinely communicated at ED handovers. -Trust sepsis nurse to monitor new sepsis trolley usage in rapid assessment.	

What do we aim to achieve?	Update	Progress rating
	-HRI ED to appoint new sepsis champion due to maternity leave. -Trust sepsis nurse to maintain networking with Bradford Trust. The Trust measures treatment within 60 mins from Dr review, there is no specific Red flag data available, their compliance is equal to CHFT at 86% -Work underway to improve EPR sepsis screening methods in line with national guidance. HRI ED consultant will report back progress at the October sepsis collaborative meeting. - Patient group directive (PGD) being considered for use of IV Pip tazocin in the EDs. Trust sepsis nurse liaising with Yorkshire sepsis network team so a 'Go see' exercise can be undertaken with another Trust. CHFT can then explore if a PGD will be of benefit with antibiotic treatment times. **Successes** ▪ Introduction of CHFT Sepsis Press which is sent out bimonthly, this supports messages, information, training and audit findings. Staff are invited to contribute, and we also share a ward/Dept success story and patient story. Collaboration with other workstreams is highlighted in the press too. ▪ Sepsis boards highlighting data, information in both EDs ▪ Sepsis essential training now on all eligible staff ESR accounts from July 2022 ▪ Agreed that further purchase of sepsis trolleys required as part of reconfiguration plan. ▪ Trust sepsis nurse attending new starter induction programmes.	
Aim 2 BUFALO Bundle Total Compliance (%)	**August 2022** **September 2022** (Total BUFALO target = 60% and > 90% target for each element)	
Blood Cultures	70.0%. 78.7%	**Reasonable**
Urine output	62.0% 58.9%	**Reasonable**
Fluids	99.0% 98.9%	**Substantial**
Antibiotics	98.0% 98.9%	**Substantial**

What do we aim to achieve?	Update	Progress rating
Lactate (waiting adding to EPR)	Awaiting Lactate being added to EPR	
Oxygen	94.0% 90.0%	**Substantial**
TOTAL	**44.0%** **41.1%**	
Each element will be measured (with exception of Lactate) from the sepsis screening tool and power plan within the electronic patient record.	**Current position** ▪ Blood culture compliance has not improved however remaining above 70% in last 6 months. ▪ Urine output remains variable with September (58.9%) being the lowest level of compliance within the last 6 months. ▪ Fluids, antibiotics and oxygen remain good at > 90% ▪ POCT for arterial and venous blood gases results will report directly into EPR from this month. A full month lactate compliance should be available at the end of November. ▪ Total % has dropped. In order for full compliance the data measures if the patient has had all elements (except lactate) of the sepsis care bundle completed, if not it is classed as a fail. ▪ Blood culture 3Rs meeting with the EDs and the acute floors has taken place, issues raised regarding obtaining blood cultures are: - supply of blood culture bottles, cultures not routinely taken at night on the acute floors, mostly doctors taking cultures, it is seen as more of a medical task. Patients can be moved before senior review task are actioned. There is sometimes patient reluctance if has had blood samples taken earlier in the day. ▪ Blood culture volume rates are averaging 4/5 ml when should be 10ml. Contamination rates are in line with other organisations regionally ▪ Sepsis collaborative reviewing new blood culture guidance on our current position. ▪ Urine output measurement is very basic therefore not representing good data collection (see below). However once the POCT testing work has been completed for urine, it should be possible to measure the data in more detail. ▪ IV fluids and antibiotics are consistently over 95% ▪ Oxygen is slightly less compliant; this can be representative of a patient going slightly out of target range eg. 93% but may not require oxygen as then scores within target range when observations repeated.	

What do we aim to achieve?	Update	Progress rating



	Blood	Urine	Fluids	Antibiotics	Lactate	Oxygen
Numerator	Compliant if there is any value in the field Blood culture MCS	Compliant if there is any value in the fields: Urine Voided Urine Catheter Urine Passed in Toilet Urine Passed Incontinent	Compliant if there is any value in the fields: Sodium lactate Glucose 10% + Sodium Chloride 0.18% Glucose 10% + Sodium chloride 0.9% Glucose 4% + 0.18% Sodium Chloride Sodium Chloride 0.9% Sodium chloride Glucose 5%	Patient Compliant if they've been given antibiotics at any time during their spell. Uses 'Given Time'.	Not currently available	A patient is compliant if they have either received oxygen, or if their NEWS Scale is 1 and thier O2 saturation is between 94 and 98, or if their NEWS Scale is 2 and thier O2 saturation is between 88 and 92 meaning they don't require oxygen.
Denominator	All patients coded with Sepsis	All patients coded with Sepsis	All patients coded with Sepsis	All patients coded with Sepsis		All patients coded with Sepsis

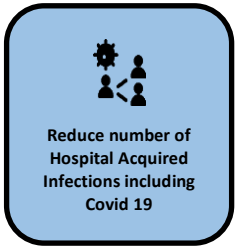
Risks and mitigation's

- Sepsis nurse continuing communicate process for blood culture taking at both sites, also using sepsis press to deliver message. Poster drops taken place. ED and acute floor consultants reminding their teams. Agreed at sepsis collaborative that registered nurses who perform venepuncture skills should be trained to take blood cultures (some years ago, this was stopped). The IV therapy working group have now reconvened and are meeting to discuss training on the 11/10/22. Who will be responsible for the training will be decided. Messages regarding correct volume when obtaining blood cultures is being delivered though all available resources. New message App for CHFT doctors to be utilised, similar to Clindoc.
- POCT work for urine has remained static, no update available regarding fluid balance being added to nerve centre. Unable to change measurement criteria until this work is completed. Sepsis and Renal nurse will continue to communicate good fluid balance recording in EPR.
- Clinical Lead and sepsis nurse reminding clinicians that all elements of sepsis 6 care bundle should be completed. One issue identified is that if the patient does not require oxygen when assessed, there is a tendency to leave the box blank rather than indicating 'No', this is sometimes left blank in case the patient goes on to require oxygen. Clinicians are being reminded they can submit another entry if this is the case.

What do we aim to achieve?	Update	Progress rating
	Next steps ▪ POCT funding passed and work to report ABGs, VBGs and Glucose directly into EPR is commencing in October. ▪ Push on Blood culture compliance via medical and surgical clinician meetings. Sepsis nurse will visit ward/Dept handovers. ▪ Sepsis nurse to complete a 20-patient audit to identify trends and themes regarding non-compliance, this will be reported back at October sepsis collaborative.	
Aim 3 Sepsis ESR Training Compliance (75%)	Business intelligence have now provided the training numbers: **Current Position** ▪ Sepsis nurse has agreed eligible clinicians and registered nurses and approves new position list. ▪ Sepsis training went live on all eligible staff ESR accounts on the 25/7/22. ▪ Data of compliance to be reported by informatics in November, delay due to staff absence. ▪ Sepsis nurse continuing face to face training for new RN starters. ▪ Sepsis nurse supporting community educator with online and face to face training. **Risks and mitigations** ▪ Issues self-declaring that training completed identified, this has been actioned with further communication. We are not aware of numbers of staff completing training online due to informatics being unable to pull data at this time. We have been advised this will be available in November. ▪ Both Training packages were unable to support questions for knowledge Test due to specific Tech person no longer being in post. Other methods of testing knowledge were explored but were not suitable. This requires attention if the post is reinstated. ▪ Sepsis nurse has trained 450 staff prior to going on ESR, these staff have been asked to self-declare.	**Reasonable assurance**

What do we aim to achieve?	Update	Progress rating
	Successes ▪ CHFT essential sepsis training now on all eligible staff ESR accounts. ▪ Community sepsis training reviewed and on ESR. ▪ Trust sepsis nurse support ED education leads and community education lead. Also attends new starter inductions and apprentice training programme. **Next steps** ▪ Sepsis nurse to continue ward visits to remind all eligible staff to complete their training. ▪ Sepsis nurse to share progress with Yorkshire Sepsis Network members as per previous interest. ▪ Continue attending CHFT new starter induction training monthly to deliver sepsis Presentation. ▪ Sepsis nurse attending new learning disability nurse training programme monthly from November 2022 to discuss sepsis and provide education. ▪ Continue supporting patients post severe sepsis with signposting information and discussing recovering from sepsis so they are informed and understand the complexities of recovery.	

Quality Priority (2022-2023)



Reduce the number of Hospital-acquired infections including COVID-19

Executive Lead

Dr David Birkenhead

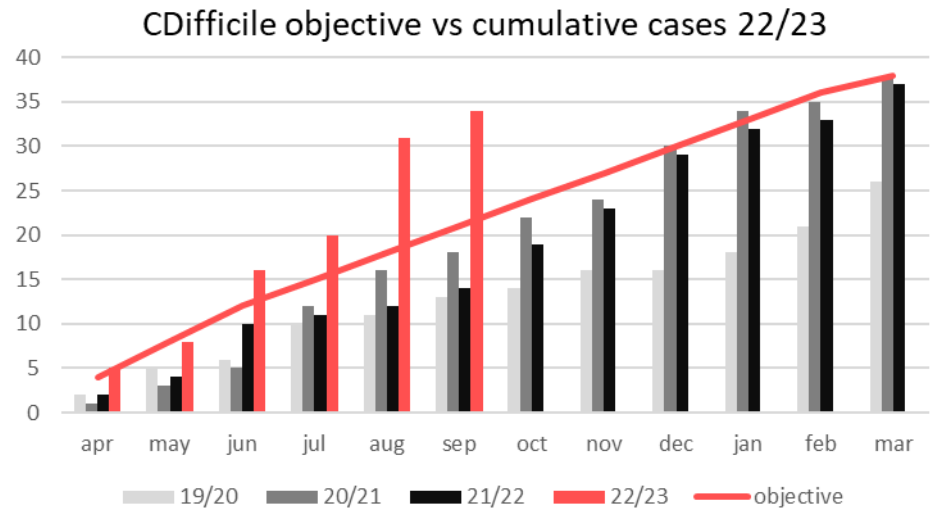
Operational Leads

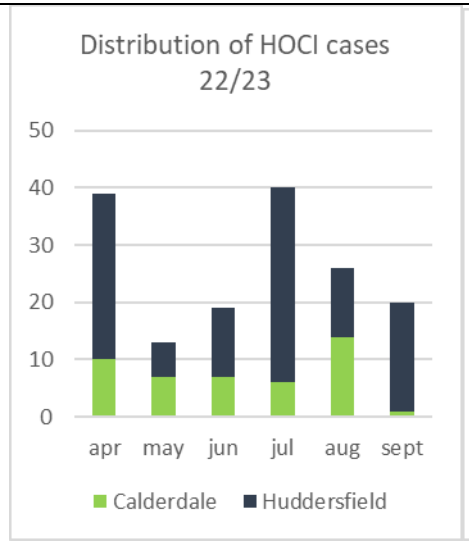
Dr Vivek Nayak
Gillian Manojlovic

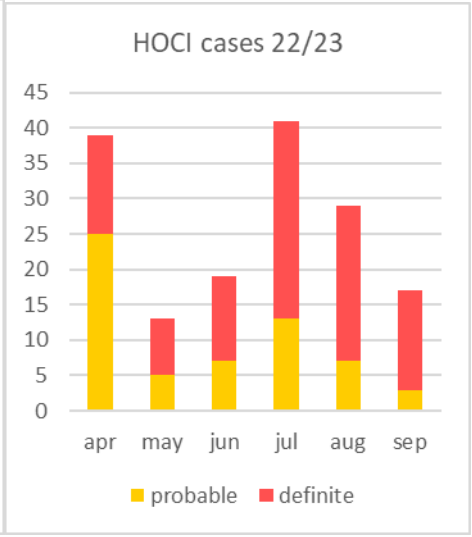
Reporting

- Infection Control Performance Board
- Infection Control Committee
- Quality Committee

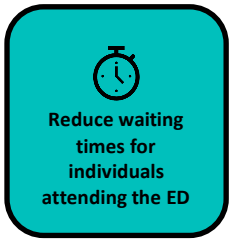
What do we aim to achieve?	Update	Progress rating
Aim 1 COVID 19 in patient testing compliance (%)	The schedule of in-patient testing had been suspended after the last report. As of 10/10/22, all admissions are tested on arrival, but no further testing is carried out unless symptoms occur. **Compliance is not reportable for the period from July-Sept as patients were not being tested.**	NA
Aim 2 Number of c. diff: Trust-assigned (not to breach the 22/23 objective of 38 cases)	The number of C.difficile infections is monitored nationally, reported via the UKSHA HCAI data capture system. The number of C.difficile infections have increased over the past 2 years. The increase in C.difficile is not limited to CHFT but is being seen across many NHS Trusts. This may be due to the increase in and therefore treatment of respiratory infections associated with the Covid-19 pandemic. The response to this increase includes a programme of HPV deep cleaning of elderly medicine wards, C.difficile wards rounds, antimicrobial ward rounds, and a review of the PIR process for hospital onset C.difficile cases. **Currently, there are 34 cases reported including 16 Community onset, healthcare associated cases. This is over the trajectory for the year.**	**Reasonable Assurance**

		
Aim 3 Number of Hospital Onset Covid-19 Infections (surveillance)	Hospital Onset Covid-19 infection (HOCI) increases and decreases in line with that seen in the wider population. This data provides an overview of the numbers of HOCI year to date. The Covid-19 control measures were changed in June 22 in line with national guidelines including cessation of regular testing of all in-patients. August and September saw a reduction in the number of HOCI. An increase has been seen in October 22 which will be included in the next report. **The following charts include the data to date for definite and probable HOCI and the distribution across the two sites. This reflects the outbreaks experienced at HRI in the orthopaedic and elderly medicine wards during the current wave. The open nature of some of the ward environments makes outbreak control more of a challenge.**	**Substantial assurance**


Distribution of HOCI cases 22/23
50
40
30
20
10
0
apr
may
jun
jul
aug
sept
Calderdale
Huddersfield


HOCI cases 22/23
45
40
35
30
25
20
15
10
5
0
apr
may
jun
jul
aug
sep
probable
definite

Quality Priority (2022-2023)



Reduce waiting times for individuals attending the Emergency Department

Executive Lead

Jonathan Hammond (Interim Chief Operating Officer)

Operational Leads

Jason Bushby
Dr Amjid Mohammed
Jayne Robinson

Reporting

- Medical Division PSQB
- Trust PSQB
- Quality Committee

What do we aim to achieve?	Update	Progress rating
Aim 1 Monitor 8 Hour A&E Breaches and ensure timely escalation and prevention of patients remaining in the department longer than the national / local standards	September 2022 -13,918 attendances in month 508 patients had length of stay (LoS) between 8-10 hours of which 340 patients were admitted No patients came to harm Further review of non-admitted patients to be completed	**Reasonable assurance**
Aim 2 Monitor 10 Hour A&E Breaches ensure timely escalation and prevention of patients remaining in the department longer than the national / local standards	September 2022 – 13,918 attendances in month 245 patients had LoS between 10–12 hours of which 175 patients were admitted No patients came to harm and care needs met	**Reasonable assurance**
Aim 3 Monitor 12 Hour A&E Breaches ensure timely escalation and prevention of patients remaining in the department longer than the national / local standards	September 2022 – 13,918 attendances in month 186 patients had LoS above 12 hours of which 51 patients were admitted 2 decision to admit (DTA) breaches (MH patients) waiting for MH bed No patient harms and care needs met 75.44% achieved Emergency Care Standard (ECS)	**Reasonable assurance**

Focused Quality Priority (2022-2023)

Reducing the number of falls resulting in harm

Executive Lead

Lindsay Rudge

Operational Leads

Dr Abhijit Chakraborty
Lauren Green
Helen Hodgson

Reporting

- Falls Collaborative
- Clinical Outcomes Group
- Quality Committee

What do we aim to achieve?	Update	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 varied over the last 6 months, September 2022 saw a significant decrease in the number of falls within the medical division. Although we saw a peak in falls in August, the number of falls within the medical division is now comparative to Aprils figures which demonstrates a downward trend. **(See chart 1 – CHFT Falls Per Division)**	**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 fall's collaborative. Number of harm falls have been variable since November 2021, linking in with staffing levels and ward acuity. August 2022 saw an increase in harm falls across the trust, with six reported during the month. September was a more positive picture with only two harm falls across the trust. An audit into harm falls is to be completed to identify any themes or trends. Once completed, an action plan will be developed and implemented in the Falls Collaborative Steering Group.	**Reasonable assurance**
Aim 3 Ensure all adult inpatients will receive a falls risk assessment on admission/ transfer to the ward (ward assurance)	The data continues to demonstrate an improvement in patients receiving a falls risk assessment upon admission, however over recent weeks there has been a drop in the number of assessments completed in a timely manner. Work is ongoing via the Falls Link Practitioners and electronic patient record (EPR) team to improve this.	**Reasonable assurance**

Chart 1 – Number of Falls

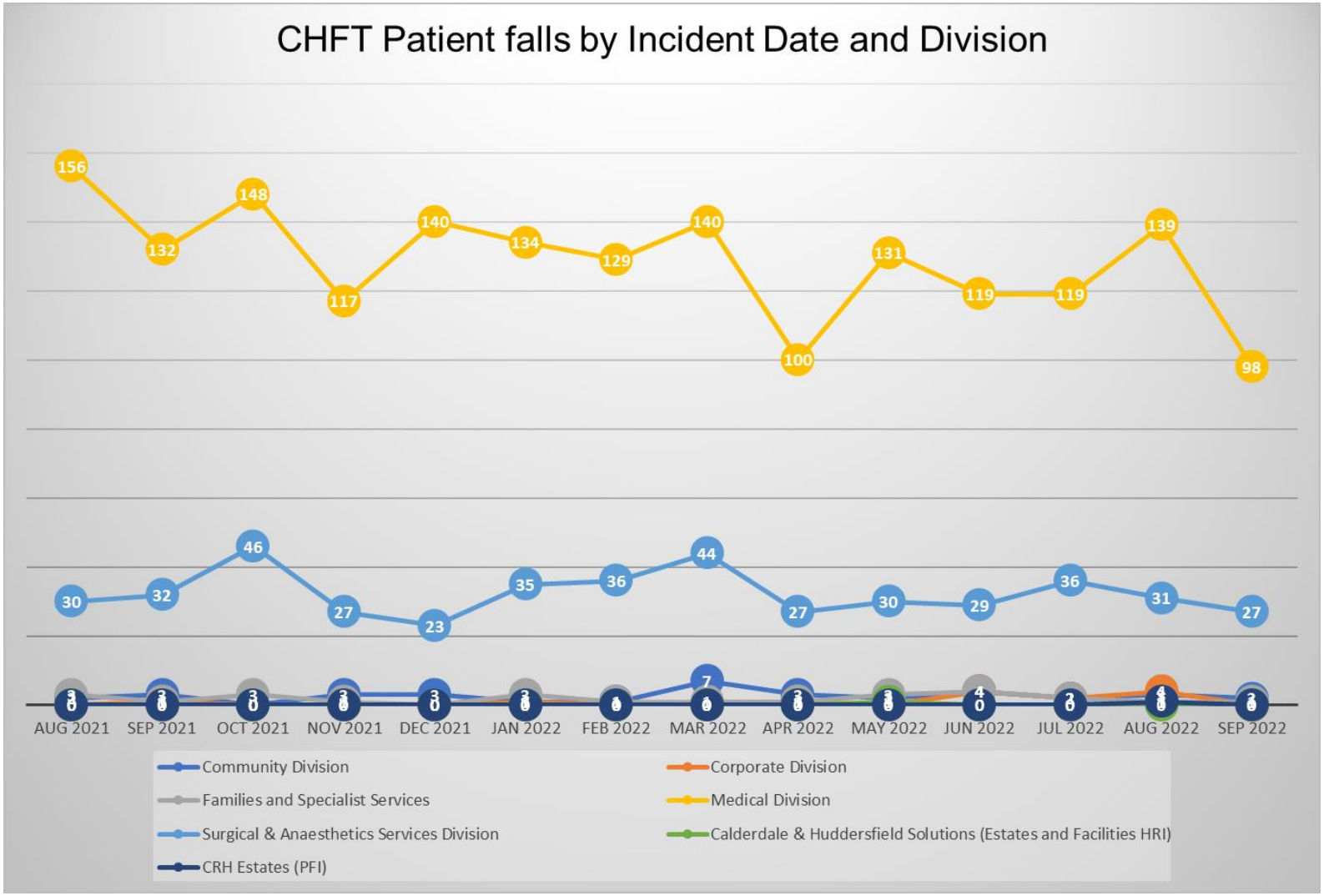
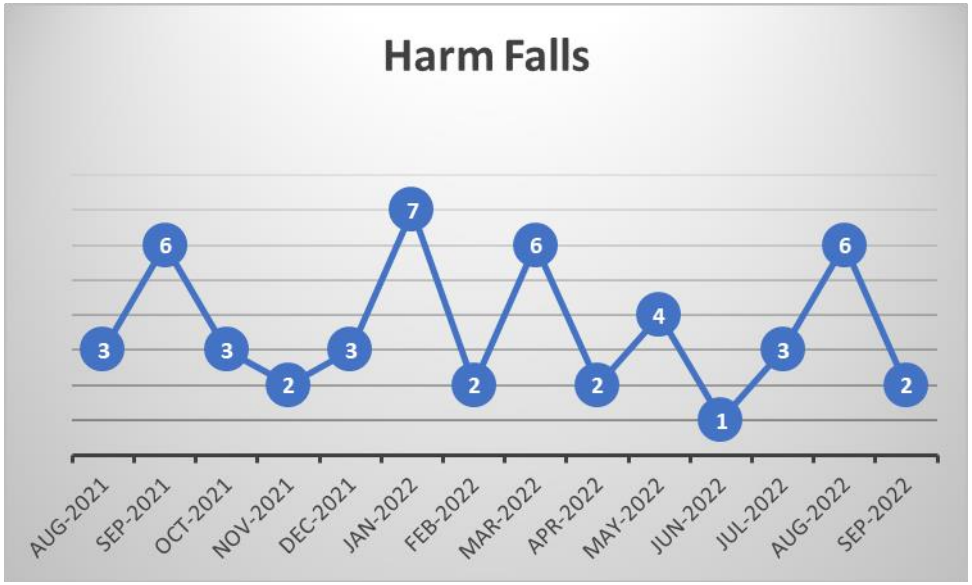


Chart 2: Harm Falls



Falls Risk Assessment: Assurance

Week	04/07/2022	18/07/2022	25/07/2022	01/08/2022	15/08/2022	22/08/2022	29/08/2022	05/09/2022	19/09/2022	26/09/2022
Question	%	%	%	%	%	%	%	%	%	%
Totals	53.06%	52.93%	55.13%	54.42%	53.47%	55.47%	54.53%	54.09%	55.74%	53.82%
All adult inpatients will receive a falls risk assessment on admission/ transfer to the ward?	74.51%	73.94%	77.05%	76.54%	74.44%	82.45%	78.15%	78.71%	76.93%	72.03%

Focused Quality Priority (2022-2023)

Increase the quality of clinical documentation across CHFT

Executive Lead

Dr David Birkenhead

Operational Leads

Louise Croxall
Mr Graham Walsh

Reporting

- Clinical Outcomes Group
- Quality Committee

What do we aim to achieve?		Update	Progress rating
Aim 1	Optimise the Clinical Record by improving the workflows and making it easier to achieve the Must do's	Awaiting confirmation from Head of EPR re: resource and costings. Can we achieve what is needed in current resource or is recruitment needed with new skill sets. Documentation audit currently being performed by ward managers to highlight areas that are being missed in EPR and where focus needs to be to improve work flows.	**Reasonable assurance**
Aim 2	Making sure assessments are achieved within a timely manner on admission and throughout the hospital stay as needed.	Work completed with data quality team re: ward assurance and some elements have been removed. All data is pulling into correct area now.	**Substantial assurance**
Aim 3	Implement the hospital white board across the trust to assist in completion of accurate documentation and assessments	Business case been approved, and procurement has gone out for the screens. Project board still in operation and planning on roll out across the wards and how this can be achieved,	**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.	Awaiting a meeting to finalise dashboard and how this will feed all information in so ward managers and above have one source of the truth.	**Reasonable Assurance**

Focused Quality Priority (2022-2023)

Clinical Prioritisation (deferred care pathways)

Executive Lead

Dr David Birkenhead

Operational Leads

Divisional Directors
Directors of Operation
Kimberley Scholes

Reporting

- Recovery Framework Board
- Quality Committee

What do we aim to achieve?	**Update** (August to September 2022)	Progress rating
Aim 1 Number of validations in month	The Trust currently has 15,917 outstanding clinical validations. This comprises 6,485 incomplete order patients and 8,760 holding list patients. The incomplete order patients do not have an order on the system therefore will never receive an appointment until clinically validated. Of the outstanding validations 10,057 patients have been waiting >90 days to be reviewed. The target is for no patient to wait more than 30 days. The longest wait currently stands at 619 days. We are currently looking at recruiting more admin staff to re-admin validate the long waiting patients.	**Limited Assurance**
Aim 2 Number of prioritisations in month	The number of clinical prioritisations given in month are as follows June 1,409, July 1,608, August 2,082 and September 1,729. This indicates the number of prioritisations being completed is not sufficient to reduce the backlog.	**Limited Assurance**
Aim 3 % of prioritisations that resulted in discharge	Since Mpage go live 23,462 patients have been recorded as already having an appointment before they could be clinically validated indicating a significant wait for prioritisation. The monthly breakdown is as follows June 1,466, July 1,442, August 1,165 and September 573. This number is expecting to increase due to the backlog and delay in validation. A number of patients are discharged following clinical validations, had these patients been validated some would have been discharged and therefore the capacity could have been used for other patients needing to be seen.	**Limited Assurance**

Focused Quality Priority (2022-2023)

Pressure Ulcers

Reduction in the number of CHFT-acquired pressure ulcers

Executive Lead

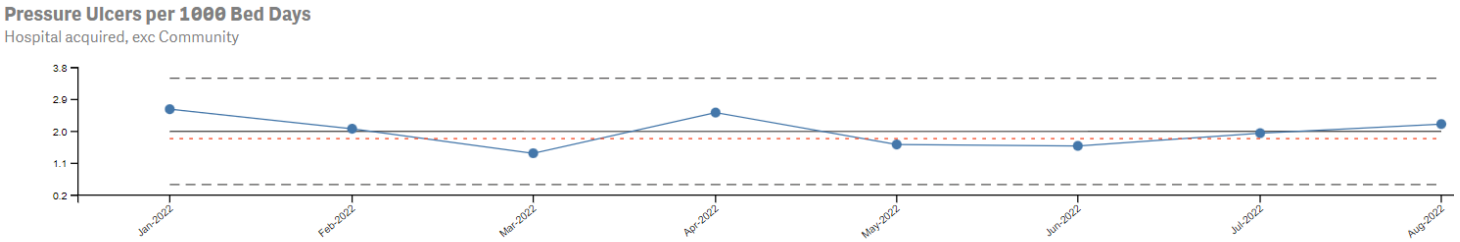
Lindsay Rudge

Operational Lead

Judy Harker

Reporting

- Pressure Ulcer Collaborative
- Clinical Outcomes Group
- Quality Committee

What do we aim to achieve?	Update	Progress rating
Aim 1 10% reduction in the incidence of hospital acquired pressure ulcers per 1,000 bed days	**Hospital acquired pressure ulcers per 1,000 bed days** The graph below demonstrates that the incidence of hospital acquired pressure ulcers were above target but within upper control limits for July and August 2022.  **Numbers of CHFT acquired pressure ulcers by division** The table below demonstrates that the majority of CHFT acquired pressure ulcers occur in the community. In August 2022, 55% of CHFT pressure ulcers developed in the community setting. Several patients in the community receive skin care in care homes or from home care agencies.	**Reasonable assurance**

What do we aim to achieve?	Update	Progress rating

	Jan-2022	Feb-2022	Mar-2022	Apr-2022	May-2022	Jun-2022	Jul-2022	Aug-2022
COMMUN	64	41	47	49	64	60	55	57
FSS	1	-	1	-	2	1	4	2
MED	41	24	21	43	20	20	25	33
SAS	17	14	10	11	14	12	15	12

Categories of CHFT acquired pressure ulcers

The majority of pressure ulcers are category 2 and deep tissue injury, followed by unstageable and category 3 / 4. As deep tissue injuries and unstageable pressure ulcers resolve or evolve over time, Datix incidents are updated wherever possible.

Note: If a pressure ulcer deteriorates, it is reported again as a separate incident to capture any learning. Therefore, the data below may include pressure ulcers which have been counted twice. A meeting will take place this week with the Incident and Datix Manager to review the process.

In July and August 2022, no patients developed a category 4 pressure ulcer.

	Jan-2022	Feb-2022	Mar-2022	Apr-2022	May-2022	Jun-2022	Jul-2022	Aug-2022
Total number of CHFT acquired pressure ulcers	123	79	79	103	100	93	99	104
Category 2	54	49	47	39	48	39	47	47
Category 3	4	2	1	0	0	3	0	0
Category 4	1	0	3	1	2	0	0	0
DTI's	43	19	19	46	32	39	33	46
Unstageables	21	9	9	17	18	12	19	11

Medical Device Related Pressure ulcers

Devices causing skin damage in July and August 2022 include oxygen masks, faecal management systems, orthopaedic devices, compression hosiery, saturation probes and endotracheal tubes. Majority of pressure damage occuring in critical care is caused by medical devices. The Trust is moving to a new pressure ulcer risk assessment tool later this year which includes the presence of medical devices.

	Jan-2022	Feb-2022	Mar-2022	Apr-2022	May-2022	Jun-2022	Jul-2022	Aug-2022
Total number of CHFT acquired pressure ulcers	7	8	5	9	11	11	18	12
Category 2	5	8	5	6	8	7	9	4
Category 3	0	1	0	0	0	2	0	0
Category 4	0	0	0	0	0	0	0	0
DTI's and Unstageables	2	1	0	3	3	5	9	12

<table>
<tr><th>What do we aim to achieve?</th><th>Update</th><th>Progress rating</th></tr>
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Level of investigation for CHFT acquired pressure ulcers

A large proportion of incidents are reported as having no omissions in care. In August 2022, 57% of incidents were categorised as green / no omissions in care, 41% recorded as yellow / local level investigation and 2% orange / divisional.

	Jan-2022	Feb-2022	Mar-2022	Apr-2022	May-2022	Jun-2022	Jul-2022	Aug-2022
Green - Local review (no omissions)	72	50	51	54	66	65	66	58
Orange - Divisional level investigation	9	3	1	9	5	2	6	2
Red - Serious incident investigation	-	-	2	-	-	-	-	-
Yellow - Local level investigation	42	26	25	40	29	26	27	44

Improvement Work

Presence of Tissue Viability Nurses on wards at weekends since July 2022.
New e-learning module developed for pressure ulcer risk assessment.
New SOP written for pressure ulcer risk assessment in hospital setting.
New pressure ulcer care plan written for SystmOne.
New moisture associated skin damage care plan written for SystmOne.

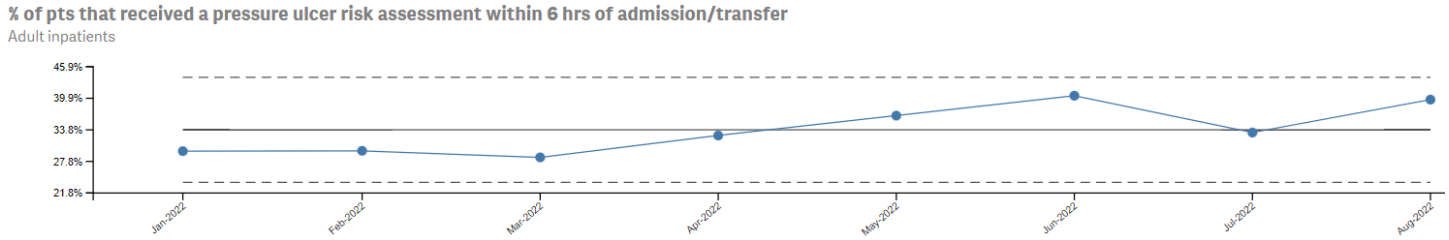
New lateral tilt bariatric mattresses now available in hospital setting (previously only available in community). Seating guidance is currently being reviewed with Community Loans Store, Calderdale Council and Tissue Viability.

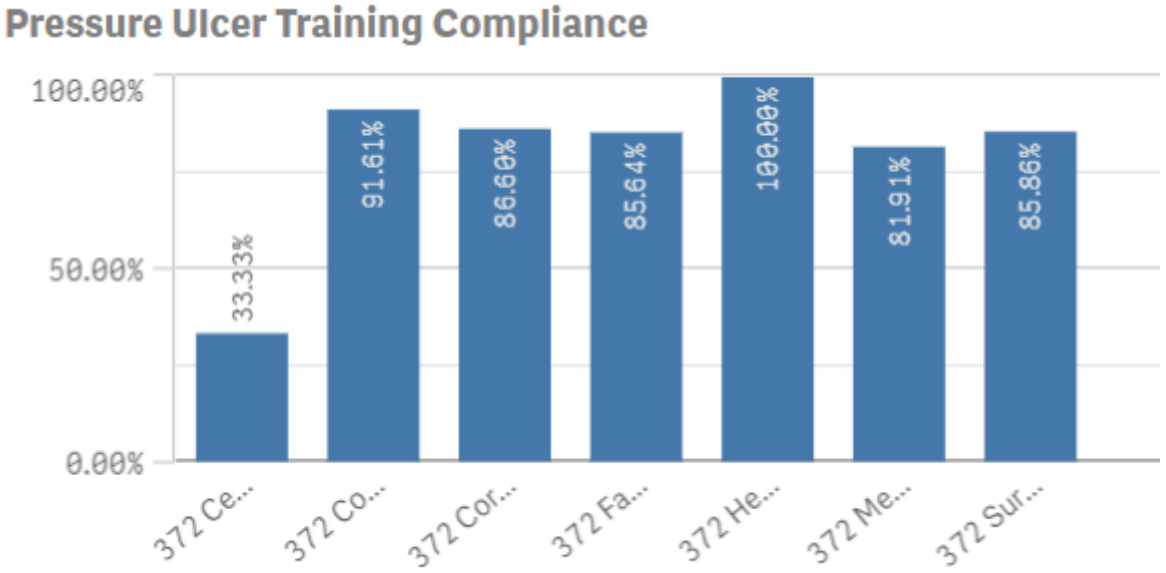
</td><td></td></tr>
<tr><td>**Aim 2**

2a. 95% of inpatients receive a pressure ulcer risk assessment within 6 hrs of admission/transfer</td><td>The graph demonstrates improvement for Q1, however this was not sustained in July 2022. According to KP+ data, there continues to be under-performance on this target at approximately 39%. Work is ongoing to ensure data around risk assessment is being extracted from the correct patient record, e.g. Patients in maternity are currently excluded from this data source. A maternity workstream is currently in place to look at how we capture the data going forward.

Pressure ulcer risk assessment is also audited in Journey to Outstanding Reviews. Compliance for risk assessment from this data source for 2021/22 stands at 81%. This contradicts what Knowledge Portal is showing. Further scrutiny of risk assessment data will continue.

Quality Priority Divisional Leads complete ward audits to review compliance. Risk assessment highlighted on aSSKINg care bundle action cards. Risk assessment is going to be focus of Worldwide Stop The Pressure</td><td>**Limited assurance**</td></tr>
</table>

What do we aim to achieve?	Update	Progress rating
	week in November 2022. The Trust will renew its focus on risk assessment when launching new risk assessment tool, PURPOSE T. This new pressure ulcer risk assessment tool and a suite of care plans have been built for Cerner. The tool already exists on SystmOne. Implementation is due later in the year.  	
2b. 95% of patients have a PU risk assessment within 7 days of admission to DN caseload	SystmOne record review indicates that for July 2022, 63% of patients had a Waterlow pressure ulcer risk assessment completed within 7 days of being admitted onto a community nursing caseload. This KPI continues to be measured via manual data cleansing.	**Limited assurance**
Aim 3 95% of relevant staff will have completed Pressure Ulcer Prevention training	85% of staff have completed React To Red Training as of October 2022. Data available on KP+. Training provided to all Pressure Ulcer Collaborative members on how to review the information. Good evidence of divisions targeting key wards to improve performance. Best performing division is community showing 91% compliance with pressure ulcer training. Medicine 82%, SAS 86% and FSS 86%.	**Reasonable assurance**

What do we aim to achieve?	Update	Progress rating
	 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 teams. Face to face training has recommenced. Joint venture with BTHT to build e-learning for pressure ulcer risk assessment tool (PURPOSE T). Completion due later this year.	

Focused Quality Priority (2022-2023)

Nutrition and Hydration for inpatient adult and paediatric patients

Executive Lead

Lindsay Rudge

Operational Leads

Vanessa Dickinson
Jonathan Wood
Dr Mohamed Yousif

Reporting

- Nutrition Operational Group
- Quality Committee

What do we aim to achieve?	Update	Progress rating
QP1 . % of adult patients that received a MUST assessment within 24 hours admission/ transfer to the ward	The operational group has removed the condition for MUST to be repeated on transfer to the ward as this is not a national requirement and will unnecessarily skew the figures. 19.4%. Gradually improving. Informatics involved to remove unnecessary streams of patients such as paediatrics, newborns, maternity. Work is being carried out via the operational group to cascade the need down to the wards through the safety huddle. Work needs to be instigated with the acute admissions wards and clinical educators to see any major impact.	**Limited Assurance**
QP2 % of patients with a MUST score of 2 or above that were referred to a dietician	100%. We know this to be accurate representation due to it being an automated response. As long as the MUST assessment is completed.	**Full Assurance**
QP3. % of patients (>LoS 8hrs) that had a completed fluid balance chart	20.2%. Data collated for this month demonstrate that there has been a decrease of 9% on last month's figures. Not all admitted patients will require a fluid balance chart. How this is to be undertaken and who will be identified has yet to addressed.	**Limited Assurance**

Focused Quality Priority (2022-2023)

Making Complaints Count

Executive Lead

Lindsay Rudge

Operational Lead

Emma Catterall

Reporting

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

What do we aim to achieve?	**Update** (Aug 2022 to Sept 2022)	Progress rating
Aim 1 % of Complaints Closed within agreed timescale	Meetings continue to take place on a weekly basis with individual Divisions. These meetings are led by the Head of Complaints to not only understand the current position but to review any concerns which require escalation and any responses that are upcoming. To further support this, a weekly meeting is now established with all Divisions. This meeting is chaired by the Associate Director of Quality & Patient Safety to reaffirm our current position and discuss any potential issues or concerns arising. The meeting continues to work well and is now pivotal for escalating issues in a timely fashion.	**Reasonable Assurance** Since these meetings have been implemented, communication between the divisions and the corporate team has been more effective. As the department moves towards full capacity, we remain optimistic that the complaints will be closed in the timescale agreed so that we align with our Trust policy.
Aim 2 Number of reopened complaints	The quality of complaint responses continues to be a priority for the department. A rota has been established within the Executive Team to approve and sign complaint responses to ensure that a varied oversight is achieved. 20 complaints have been re-opened from 1/08/2022 – 30/9/2022 out of 89 that were closed. This sees an increase of 2% on last month.	**Limited Assurance** The rise in complaint numbers continues to be our priority. The department is striving to improve customer complaint responses effectively first-time round. As the department moves towards full capacity, we are hopeful that the numbers will begin to decrease.

What do we aim to achieve?	**Update** (Aug 2022 to Sept 2022)	Progress rating
Aim 3 Number of concerns that escalate into complaints	This continues to be regularly monitored. Concerns not only occur when Divisions have not been pro-active in responding to low-level concerns due to operational pressures, we are finding that they may have initially been mis-judged and they should have been logged as a formal complaint at the outset. Work continues to take place with all the Divisions to reiterate the importance of responding to concerns as quickly and effectively as possible to avoid them escalating to complaints.	**Reasonable Assurance** In this reporting time period, 5 concerns have escalated to a formal complaint. This continues to be monitored. All 5 concerns reviewed are attested formal complaints that need a level of investigation and response.

Focused Quality Priority (2022-2023)

End of Life Care

Executive Lead

Lindsay Rudge

Operational Leads

Mary Kiely
Gillian Sykes
Christopher Button

Reporting

- EoLC Steering Group
- Clinical Outcomes Group
- Quality Committee

What do we aim to achieve?	Update	Progress rating
Aim 1 To monitor the number of patients referred to HSPCT who die or are discharged from hospital before an encounter with the team to identify themes and trends	**August/September 2022** The Hospital Specialist Palliative Care Team commenced a 7-day service on 1st September 2022. In September, the first month of 7-day service: 82 referrals in September 2022, of whom 19 died before they were seen, and 10 were discharged. This is 25.9% of patient died or were discharged before been seen. That is down from 29% in August (92 referrals in August 2022, of whom 19 died before they were seen, and 10 were discharged)	**Reasonable Assurance**
Aim 2 That 50% of patients seen in the frailty service identified at Rockwood 8 are offered the opportunity to create an advance care plan	**August/September 2022** Full reporting is not yet available across the CHFT footprint. However, data available for Kirklees is starting to show an increase in the number of Advance Care Plans recorded on EPaCCS. EPaCCS figure for September 22 was 1439 which is up from 1408 in August. This is the first time the figure has gone up in over a year. In September 22 there were 147 EPaCCS added in the month. Again, this is the highest it has been in over a year and September also saw the lowest number of deaths on the	**Reasonable Assurance**

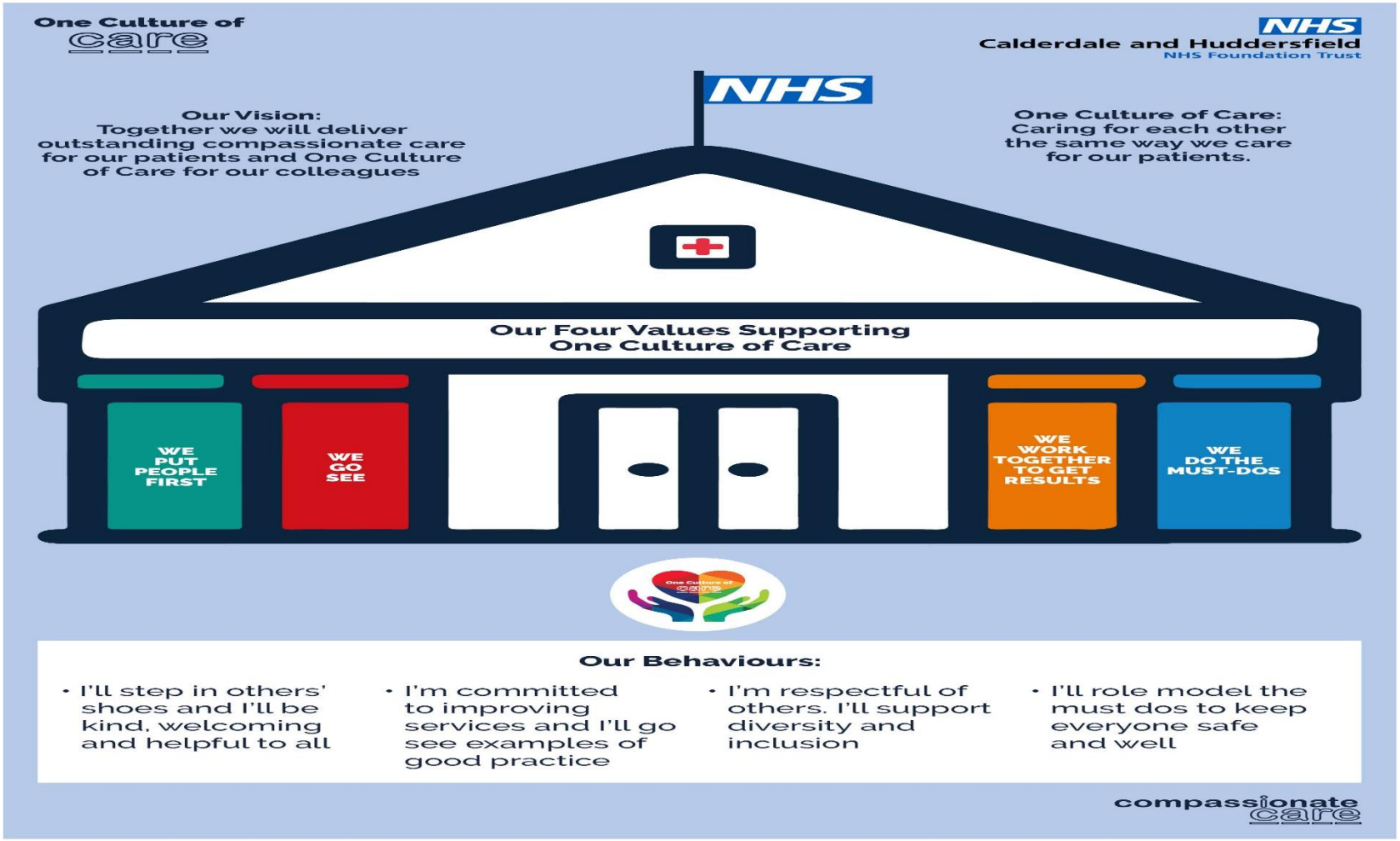
What do we aim to achieve?	Update	Progress rating
	register for over a year with 192 deaths. 590 (41%) people who have an EPaCCS record also have an ACP. This is the highest number for some time (was 568 last month) but still low to where we'd want it to be. Where a diagnosis was given 467 (32%) people on the register had a cancer diagnosis with 681 (47%) people had a non-cancer diagnosis. Of the 192 people that died in September 22, 38% were on the EPaCCS register.	
Aim 3 Monitor and report the number of complaints, concerns and compliments related to end-of-life care to identify themes and trends to implement lessons learned	**August/September 2022** • The Quality Improvement manager for patient experience has presented the data obtained at the EOLC steering group and a 6 month plan developed. • Two / three new members have started with the EOLC/Bereavement Support team and are currently being inducted. The 3rd member will start on 17 October. • The EOLC Facilitator and leads are attending PSQBs/ N&M leadership meeting and IMS meetings to share NACEL report key findings. Including communication, involvement of families and symptom management.	**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 August to September 2022



Purpose

The purpose of these slides are 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 August 2022 to September 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 will focus on key workstreams as well as three Quality Account Priorities and Focused Quality Priorities including:

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

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 three key quality priorities with seven focussed quality priorities. Examples of progress against the priorities are shown below, with further details contained within the body of the report:

Recognition and timely treatment of Sepsis

- Blood cultures – issue with compliance in relation to obtaining blood cultures. 20% of patients are not getting blood cultures completed when red flagged for sepsis. Meetings currently being held with acute floors and ED to improve within this area
- Antibiotics within 60 minutes – compliance remains poor for red flag sepsis. A trial of pre-made intravenous Piperacillian Tazobactam, this is currently being evaluated to ascertain improvements made
- Training – Sepsis training is now on ESR (25/07/22). A separate package for clinicians and RN's, currently working through issues with IT in regards to compliance data. Sepsis nurse has trained 450 nurses her herself.

Quality Priorities

Reduce the number of Hospital-acquired infections including COVID-19

- The schedule of in-patient testing had been suspended after the last report. As of 10/10/22, all admissions are tested on arrival but no further testing is carried out unless symptoms occur.

- Hospital Onset Covid-19 infection (HOCI) increases and decreases in line with that seen in the wider population. This data provides an overview of the numbers of HOCI year to date.

- The Covid-19 control measures were changed in June 22 in line with national guidelines including cessation of regular testing of all in-patients. August and September saw a reduction in the number of HOCI. An increase has been seen in October 22 which will be included in the next report.

- The number of C-Difficile infections is monitored nationally, reported via the UKSHA HCAI data capture system. The number of C-Difficile infections have increased over the past 2 years. The increase in C-Difficile is not limited to CHFT but is being seen across many NHS Trusts. This may be due to the increase in and therefore treatment of respiratory infections associated with the Covid-19 pandemic.

- The response to this increase includes a programme of HPV deep cleaning of elderly medicine wards, C-Difficile wards rounds, antimicrobial ward rounds, and a review of the PIR process for hospital onset C-Difficile cases.

Quality Priorities

Reduce waiting times for individuals attending the Emergency Department

Aim 1 (Monitor 8 Hour Breaches):

- September 2022 -13,918 attendances in month
- 508 patients had length of stay (LoS) between 8-10 hours of which 340 patients were admitted
- No patients came to harm
- Further review of non-admitted patients to be completed

Aim 2 (Monitor 10 Hour Breaches):

- September 2022 – 13,918 attendances in month
- 245 patients had LoS between 10–12 hours of which 175 patients were admitted
- No patients came to harm and care needs met

Aim 3 (Monitor 12 Hour Breaches):

- September 2022 – 13,918 attendances in month
- 186 patients had LoS above 12 hours of which 51 patients were admitted
- 2 decision to admit (DTA) breaches (MH patients) waiting for MH bed
- No patient harms and care needs met
- 75.44% achieved Emergency Care Standard (ECS)

Focused Quality Priorities

Examples of progress against the priorities are shown below, with further details contained within the body of the report:

End of Life Care (EoLC) - Performance and Intelligence Lead is developing an EoLC dashboard which will contain complaints, compliments and concerns, in order to monitor trends, areas of excellent and concerns.

Increase the quality of clinical documentation across CHFT
New dashboard being created with the data quality team on Knowledge Portal+ (KP+) making it easier for ward managers and matrons to access their data. Successful implementation of white board across the Trust.

Clinical Prioritisation (deferred care pathways)
The Trust currently has 15,917 outstanding clinical validations. This comprises 6,485 incomplete order patients and 8,760 holding list patients. The target is for no patient to wait more than 30 days. The longest wait currently stands at 619 days.

Making Complaints Count - In this reporting time period, eight complaints have been re-opened compared to 12 in August. This will continue to be monitored and the process reviewed. 64 compliments were logged in September.

Focused Quality Priorities

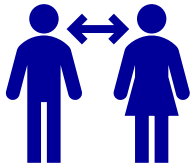
Examples of progress against the priorities are shown below , with further details contained within the body of the report:

Reducing the number of falls resulting in harm - Falls dashboard is updated monthly and fed back through the falls collaborative for assurance. Number of harm falls have been variable since November 2021, linking in with staffing levels and ward acuity. September saw a significant decrease in the number of falls reported within the medicine division.

Reduction in the number of CHFT-acquired pressure ulcers - Presence of Tissue Viability Nurses on wards at weekends since July 2022. Team now provides an extended service until 18:00hrs, Monday to Friday which has been well received. New e-learning module developed for pressure ulcer risk assessment.

Nutrition and hydration for inpatient adult and paediatric patients - The operational group has removed the condition for the Malnutrition Universal Screening Tool (MUST) to be repeated on transfer to the ward as this is not a national requirement and will unnecessarily skew compliance rates.

Care Quality Commission



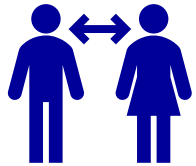
2018 CQC Action plan

A review of all ‘Must Do’ & ‘Should Do’ actions is underway to ensure progress has been maintained and identify any potential gaps . This will be monitored by CQC and Compliance group.

The Trust has one action to complete. *MD1 - The Trust must improve its financial performance to ensure services are sustainable in the future* This action will continue to be monitored to ensure full scrutiny and oversight.

The focused Journey to Outstanding (J20) process continues across the Trust, with themes and trends which are identified escalated and monitored via the weekly Trust CQC & Improvement huddle. This maintains engagement across all services and assurance can be sought that outstanding areas of compliance are progressing in line with expectations.

Care Quality Commission



An engagement meeting took place with the CQC on 5th October 2022. CQC met with the senior End of Life Care (EoLC) Team and visited Ward 18.

Two focused J2O reviews took place in October. The focused areas were and feedback will be given once data collated:

- Acute Medicine inc. Acute Floor HRI / CRH & Ward 6AB CRH
- Children and Young People (C&YP) Services - with a focus on areas where children are seen alongside adults such as the Outpatients Department and the Emergency Department (ED).

Alison Smith, C&YP Transformation Lead at NHS England will be an external reviewer leading the C&YP Review on 11th October 2022.

Patient Experience, Participation, Equalities

Friends and Family Test

The Trust is still experiencing challenges in increasing the response rates to the Friends and Family Tests (FFT), however there has been significant improvement in the narrative describing our patient's experiences. The team are working together to not only display evidence of the changes they have made using the 'you said, we did' template, but to promote the FFT to friends and family when they use our service.

Commitment to Carers

The patient experience team continue to work with our local third sector carers support groups to identify how we can help support carers when accessing our services. A 'Mystery Shopper' pilot scheme has been designed to help encourage carers to share their real time experiences of our outpatients services. We currently have 12 independent carers signed up to the process. The pilot will be completed at the end of December 2022 and data collated and results shared within the new year.

Patient Advice and Complaints Service (PACS)

	Aug 2022	Sept 2022
Complaints received	55	37
Complaints closed	45	44
Complaints closed outside of target timeframe	19	23
% of complaints closed within target timeframe	42%	48%
Complaints reopened	12	8
PALS contacts received	141	120
*Compliments logged	148	64
PHSO complaints received	0	0
PHSO complaints closed	0	0
Complaints under investigation with PHSO (total)	6	

*Please note, as mentioned in the last report, there was a backlog of compliments to be logged which have now been done, hence the high numbers.

Legal Services

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

- The 2022 Litigation data pack has now been received. The legal team will need to complete the Getting It Right First Time (GIRFT) 5-point action plan, with the support of clinicians and our panel law firms and summarise any learning in accordance with the NHSR/GIRFT claims best practice guide. Once the claims for each specialty has been reviewed using the 5-point action plan, the Trust will need to complete a short survey by **16th December 2022.**

- Legal are currently filtering through the data to compare any duplicates from last year's data (and cases already reviewed) and will liaise with the Divisions to agree a plan to review the claims by way of directorate.

- Claims and inquests portfolios (including learning) are now being shared via Divisional PSQB meetings.

Incidents and Lessons Learnt from Serious Incidents

Never Events

Between 01 October 2021 and 30 September 2022, the Trust reported four Never Events, however, one of the serious incident investigation reports, has been reviewed by the Integrated Care Board (ICB), and agreement has be made to have Datix ID 211712 (retained foreign object post procedure) downgraded from a Never Event to a Serious Incident Investigation. The final investigation concluded that the gastric band was not subject to a formal counting / checking process as it was inserted during a procedure performed at a different Trust.

Following the downgrade of Datix ID 211712, the Trust, currently has three Never Events that have been reported in the current year 2022.

Serious Incidents:

In total, for the rolling month of 1 October 2021 to 30 September 2022, there have been 43 Serious Incidents declared on Strategic Executive Information System (StEIS) that are either under investigation or the investigation has been completed and closed. The 43 SI's have been recorded across three divisions; Families and Specialist Services (8), Medical Division (26) and Surgical & Anaesthetics Services Division (9)

18. Complaints Annual Report

To Approve

Presented by Victoria Pickles

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 10 November 2022
Meeting:	Public Meeting of the Board of Directors
Title:	Annual Complaints Report
Author:	Emma Catterall, Head of Complaints
Sponsoring Director:	Victoria Pickles, Director of Corporate Affairs
Previous Forums:	Quality Committee, 24 October 2022

Purpose of the Report

The purpose of this report is to provide the Board of Directors with data and narrative for the year 2021/22 relating to the Trust's Patient Advice and Liaison Service (PALS) & Complaints Service and performance.

Key Points to Note

- An increase in both PALS concerns and formal complaints
- Most prevalent theme across both concerns and complaints is communication
- Complaint performance overall has decreased in comparison to the previous year
- Actions have been implemented to ensure an improvement in both quality of responses and performance.
- As part of its review of the report, the Quality Committee requested additional information, particularly in relation to the learning from complaints, be included in future reports.
- For 2022/23 it is anticipated to bring the Annual Report earlier in the year, to enable a fuller discussion on shared learning and any improvement work required to ensure that our complaints process is easy to access, timely and effective.

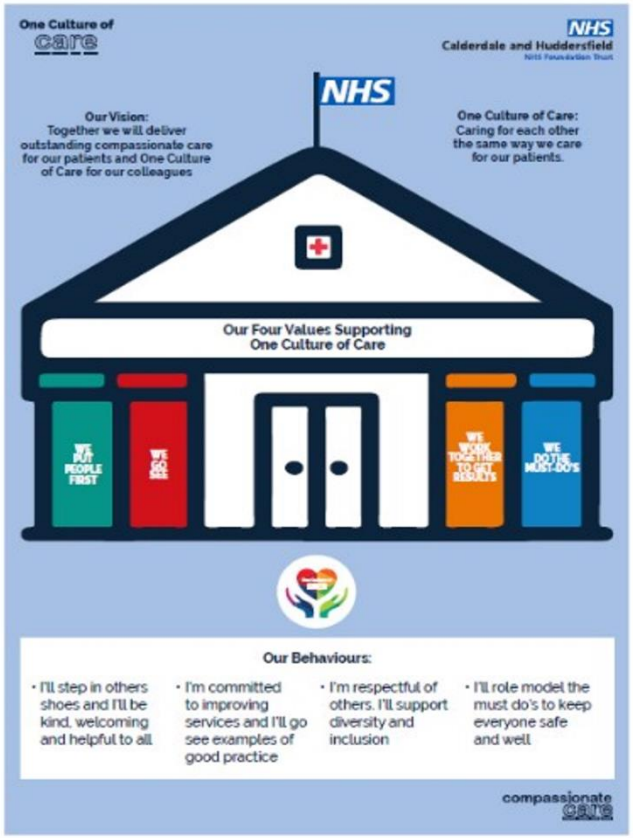
EQIA – Equality Impact Assessment

This report considers the impact on all 'protected` groups under the Equality Act 2010 including parents/carers and/or socio-economic groups. Equality monitoring of complainants could be improved and we will be working on this as part of our wider complaints improvement work.

Recommendation

The Board is asked to **RECEIVE** and **NOTE** the Annual Report.

Calderdale & Huddersfield NHS Foundation Trust's Annual Complaints Report 2021/22



CALDERDALE AND HUDDERSFIELD FOUNDATION TRUST
COMPLAINTS ANNUAL REPORT
2021/2022

1. INTRODUCTION

Feedback from patients, relatives and carers provides the Trust with a vital source of insight about people's experiences of healthcare at Calderdale and Huddersfield NHS Foundation Trust, and how our services can be improved. The ultimate aim of the Trust's complaints process is to listen and respond to the issues being raised and use the information received to improve our services and, in turn, the experience of our patients.

This report provides information on the complaints received in the Trust between 1 April 2021 and 31 March 2022. It provides a summary of the complaints received, the areas concerned, the main issues raised, and trends identified, and the actions taken in response or those planned.

The Report has been produced in line with the statutory complaints' legislation (The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009), under regulation 18. The legislation expects that each responsible body has arrangements for dealing with complaints to ensure that:

1. complaints are dealt with efficiently.
2. complaints are properly investigated.
3. complainants are treated with respect and courtesy.
4. complainants receive, so far as is reasonably practical:
   I. assistance to enable them to understand the procedure in relation to complaints; or
   II. advice on where they may obtain such assistance.
5. complainants receive a timely and appropriate response.
6. complainants are told the outcome of the investigation of their complaint; and
7. action is taken, if necessary, in light of the outcome of a complaint.

The report will provide a detailed view of performance in respect of meeting target times, alongside qualitative complaints information. The information in this report has been based on analysis of data from the Complaints module within our risk management system and from the Trust's Knowledge Portal (KP+) data system.

2. PATIENT ADVICE AND LIAISON SERVICE

2.1 PALS Process

Patient Advice and Liaison Service (PALS) is a first-stop service for patients, their families and carers who have a query or concern about our hospitals or services. The team provides an impartial and confidential service and aims to help resolve issues by addressing them as quickly as possible.

Patients, their families, and their carers can contact PALS via telephone or email, or face to face by appointment (limited currently due to the impact of the national pandemic). A contact could be a compliment, enquiry, feedback, service to services, and a referral to external organisations. A concern is an issue raised which should be resolved within 72 hours.

2.2 Data Analysis

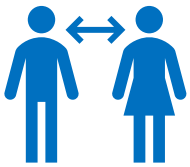
There were 2270 PALS concerns and enquiries received during this reporting period of April 2021 – March 2022. This equates to an average of 44 PALS contacts per week. This is an increase of 494 (22%) PALS concerns from the previous year (2020/21).

This may be attributable to some delays in appointments being rescheduled and restrictions still placed on the NHS due to the Covid-19 pandemic.

There were 2229 PALS concerns and enquiries responded to/closed within this reporting period, compared to the previous year when 2111 PALS concerns, and enquiries were closed. 118 (a small increase of 5%) more concerns were closed in this reporting period.

2.3 Themes and trends

The most common themes from concerns during the year were:

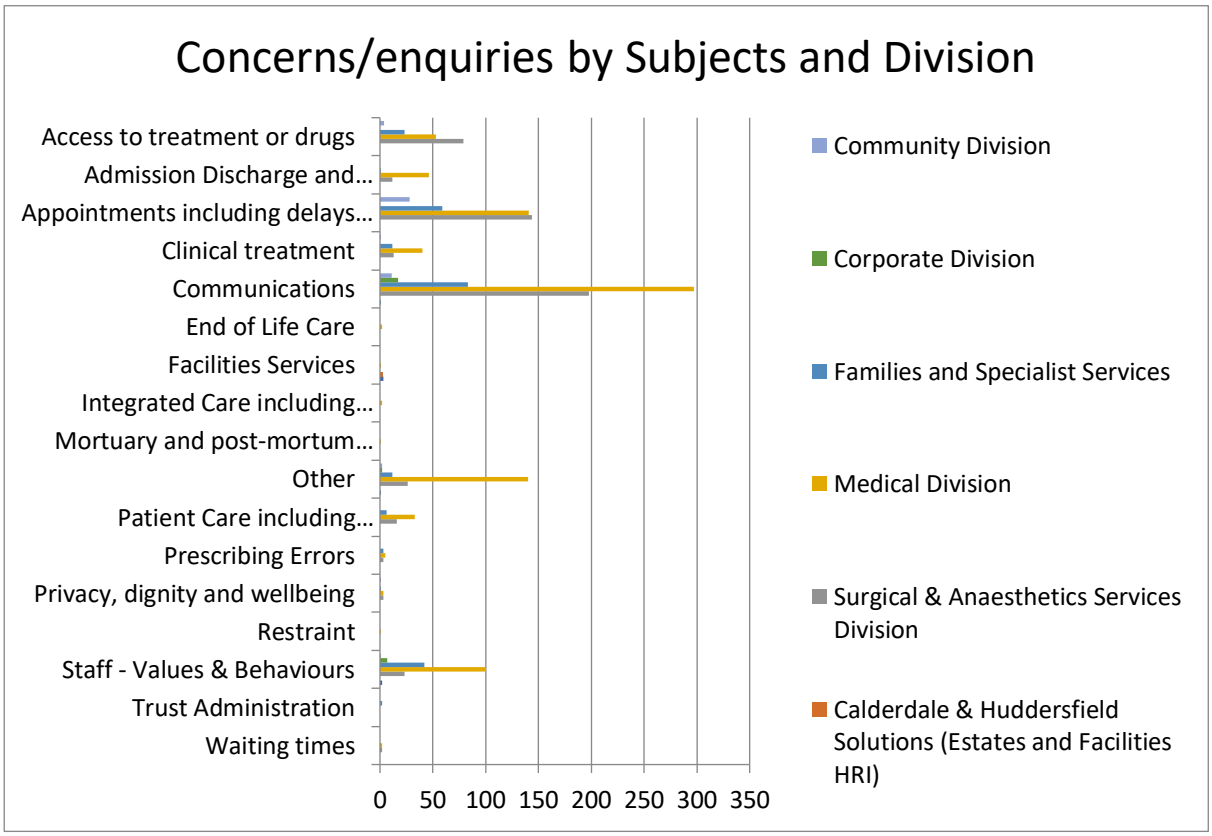


Communication
- communication with the patient, relatives and carers
- delay in giving information or results
- method and style of communications

Appointments
- appointment cancellations
- appointment delay (including length of wait)
- failure to provide adequate follow up

The focus on ensuring these are addressed in real time continues to reduce the likelihood of either concerns or enquires resulting in a complaint.

The graph below provides details in relation to the subjects of the PALS concerns and enquiries.



3. FORMAL COMPLAINTS

3.1 Process

The following definitions are used to provide clarity about whether an issue of concern is handled within the NHS complaints procedure and to ensure that the Trust provides the most appropriate response:

Complaint: A complaint can be defined as an expression of dissatisfaction with the service provided (or not provided) or the circumstances associated with its provision which requires investigation and a formal written response to promote resolution between the parties concerned. A number of complaints we receive can be very complex or require a joint response from more than one service or organisation and it can take time to gather and consider all the information needed for the investigation.

Concern: A concern can be defined as a matter of interest, importance or anxiety which can be resolved to the individual's satisfaction within a short period of time (by the end of the next working day after the concern is raised or longer if agreed with the person raising the concern). Where it has not been possible to resolve the concern quickly and to the satisfaction of the person/s raising it, they will be asked if they would like their concern investigated as a formal complaint under the NHS Complaints Regulations (2009). All concerns whether resolved by the next working day or not, will be recorded and reported and reviewed, collated, and analysed along with the data recorded from complaints. In many respects, the distinction between a concern and a complaint is artificial. Both indicate some level of dissatisfaction and require a response. It is important that concerns and complaints are handled in accordance with the needs of the individual case and investigated fairly and proportionately

Complaints are received by the Patient Advice and Complaints Team, formally acknowledged, and sent to the divisions within the given timescale.

The response will then be sent to the Complaints Management Team for quality checking. Following this there is a final review and sign-off by the Executive team

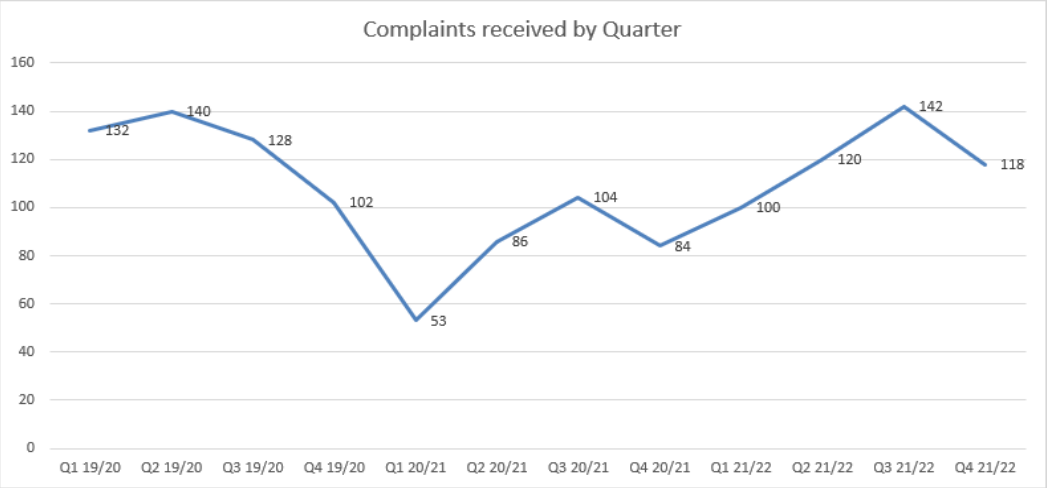
3.2 Complaints, Concerns & Compliments 2021/22

Formal complaints RECEIVED **480**	This is a significant increase from 2020/21 (316). This could be to be attributable to increased operational demands on services and in-patient wards as a direct result of the effect of the Covid-19 pandemic. It may also be related to restriction in relation to visiting and reconfiguration of services relating to Covid-19. Emphasis continues to be placed on resolving concerns in real time and as quickly and effectively as possible, however due to an significant increase in operational demands have seen a rise in concerns escalating to complaints.
Formal complaints CLOSED **379**	379 formal responses have been sent throughout this reporting period which equates to 7 per week on average. 337 formal complaints were closed the previous year, demonstrating that 42 more complaints were closed during this reporting period which is a 12% increase.

Concerns responded to **2229**	The PALS service, along with the valued support of divisional clinical and operational staff have responded to and closed 2229 concerns and enquires. On average over 8 concerns per working day were responded to.

3.3 Data Analysis

Below are graphs highlighting the numbers of complaints received per quarter over the last 3 years, complaints received by Divisions and by primary subjects. There is also a graph detailing the Trust's performance regarding complaints closed within agreed timeframes.

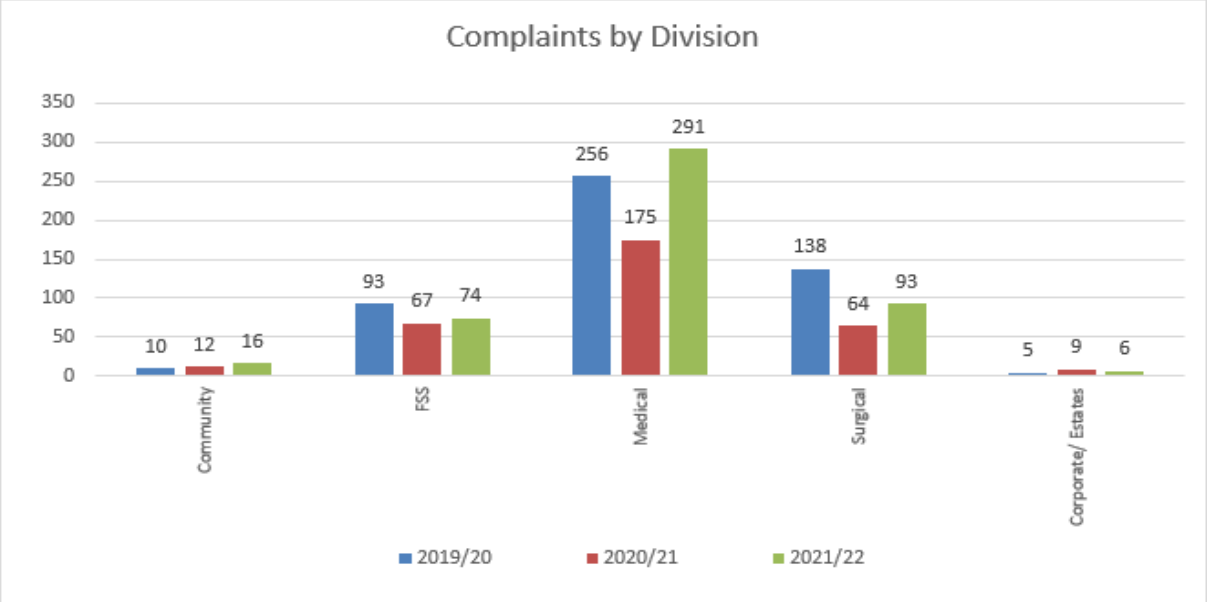


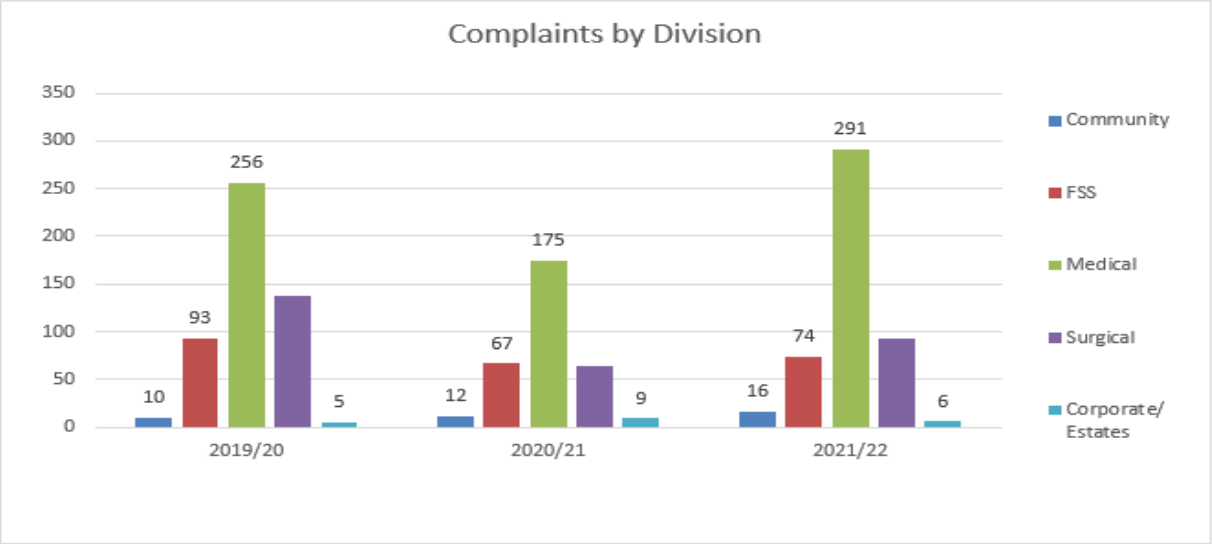
It is evident from the data shown above that over the years highlighted, the highest numbers of complaints were received in quarter 3 of this year. This coincided with Covid 19 restrictions being lifted nationally, however remaining in NHS services.

It was considered by the PALS & Complaints Team if the increase in formal complaints during this reporting period was linked to a possible lower tolerance of when a concern should be addressed as a complaint. However, following analysis of the data, this does not appear to be the case as emphasis is still placed on resolving issues as quickly as possible and in real time without the need to escalate to a formal complaint.

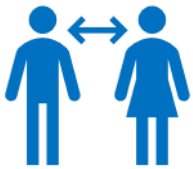
3.3.1 Divisional analysis

The Medical Division (which acts as the front door to many acute Trust services via the Emergency Department) continues to receive the largest number of complaints. The spread of complaints across the divisions is in line with what would be expected for an acute Trust with CHFT's pattern of services.

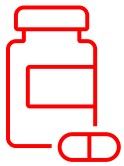




3.4 Themes and Trends - The primary issue identified in each complaint is demonstrated below as well data provided with the graph. It should be noted that as with PALS concerns, the most common themes for complaints during the year were:

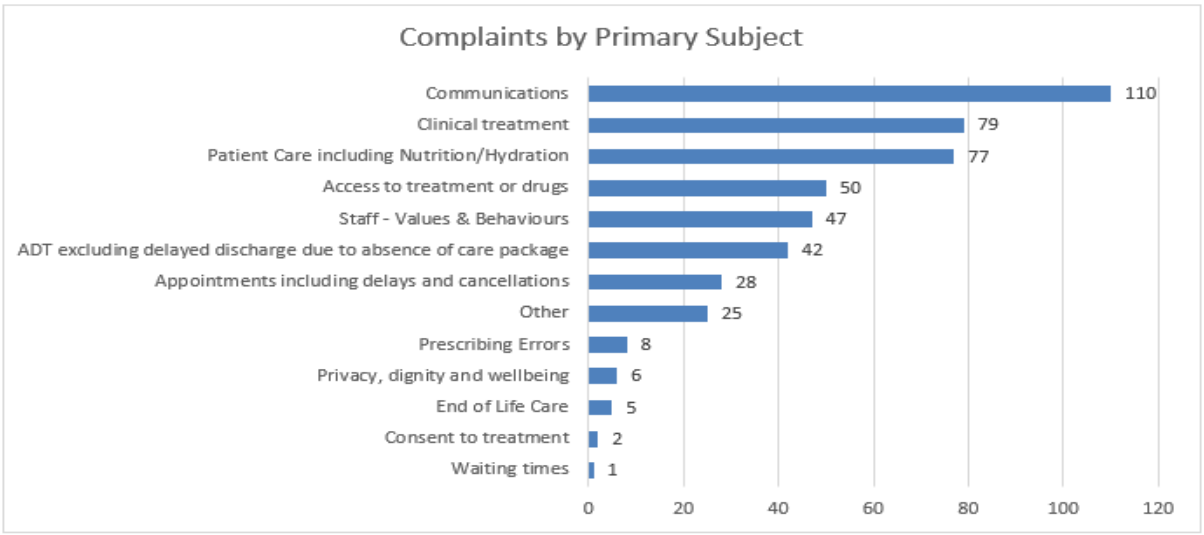


Communication
- communication with the patient, relatives, and carers
- the patient did not feel they were listened to
- incorrect/no information provided



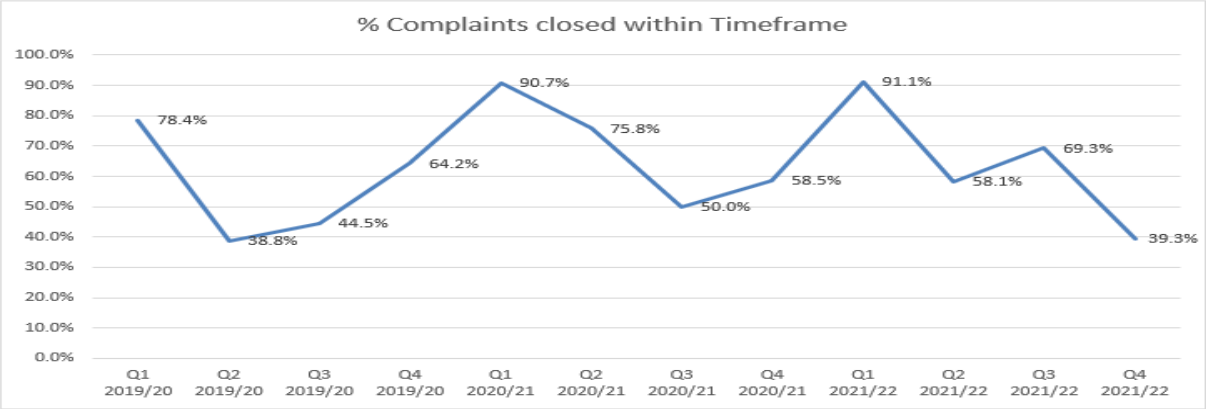
Clinical Treatment
- delay or failure to diagnose
- delay or failure in treatment or procedure
- inadequate pain management

Patient care
- patient's care needs not being adequately met
- inadequate support provided to the patient



4. COMPLAINTS PERFORMANCE DATA

The graph below demonstrates the Trust's performance compared to previous years. It is acknowledged that this is below the expected target, focussed work is on-going to improve the performance and the quality of complaint responses with the divisional Senior Management teams.



5. IMPROVEMENTS IN COMPLAINTS HANDLING

5.1 Quality Assurance

We have enhanced our quality assurance process for complaints with the introduction of weekly performance and quality meetings within the divisions. This has resulted in improved complaints responses and has reduced the number of re- opened complaints.

Monthly complaints reports continue to be submitted to Quality Committee and Patient Experience Group. These reports identify key themes across various sources of intelligence and to provide a level of assurance to our Trust Board. They provided evidence of how we use all feedback and the lessons learnt from complaints to help improve service design and delivery.

5.2 Quality Improvement

During the year we have focused on improving the way in which we process, investigate, and respond to complaints. It is important to understand this so that we can implement changes to improve patient care. Therefore, we identified our complaints process as one of our focused quality priorities, the aim of this is not only to ensure that we were delivering against the national complaints regulations and the emergent Parliamentary and Health Service Ombudsman (PHSO) standards but also to have a real focus on quality and getting our response "first time right".

To ensure we provide a high-quality service and to improve response times the Trust is investing in a new telephone system within our PALS team, in the next financial year – 2021/22. This will enable the us to monitor the number of calls being received, how long each call is active, how long service users are waiting to be answered and how many calls we were unable to respond to, to ensure we are meeting the needs of our service users and that the PALS service is responsive to the people accessing the service.

To improve the End of Life experience for our patients, their relatives and Carers it has been suggested that the Trust undertake an Experienced Based Design (EBD) approach. This is an ambitious co-design approach, however, would be extremely valuable in shaping the Trust's EOL strategy.

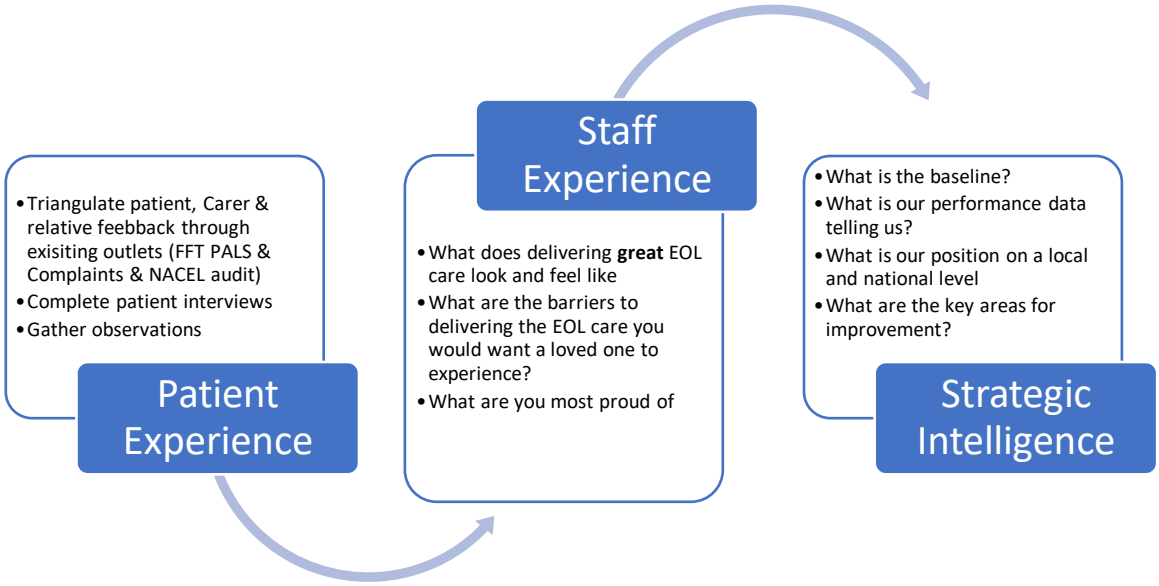
EBD is an approach that enables staff and patients (Carers and relatives included) to co-design services and/or care pathways, together in partnership. The approach is different to other service

improvement techniques. EBD can reveal a surprising level of commonality between staff and patients.

The EBD approach fits with CHFT organisational aspirations around delivering 'compassionate care', it is also delivering patient involvement, patient experience and multidisciplinary working, as this project will deliver across these agendas. As EOL care is already a quality priority, and it is identified that a change is needed.

EBD involves gathering experiences from patients and staff through in-depth interviewing, observations and group discussions, mapping key 'touch points' (emotionally significant points) and assigning positive or negative feelings. Staff and patients are then brought together to explore the findings and to work in small groups to identify and implement activities that will improve the service or the care pathway.

The approach has already been widely used within the NHS in a range of clinical services, including cancer, diabetes, drug and alcohol treatment, emergency services, genetics, inpatient units, intensive care, mental health, orthopaedics, and dementia services.
A plan is in place which will support the gathering of intelligence, mapping challenges to overcome and work on developing sustainable improvements.



Although this is a positive experience, teams must be prepared to accept the challenge of constructive criticism and rethink existing ways of working. Staff will be fully supported throughout the process. The patient and staff feedback will be used alongside strategic intelligence to drive measurable improvements.

Progress of the EBD will be shared through the EOL Steering Group, Patient Experience & Caring Group and appropriate PSQB's.
It is expected that through the EBD process patient experience will feed into the Trust's EOL strategy.

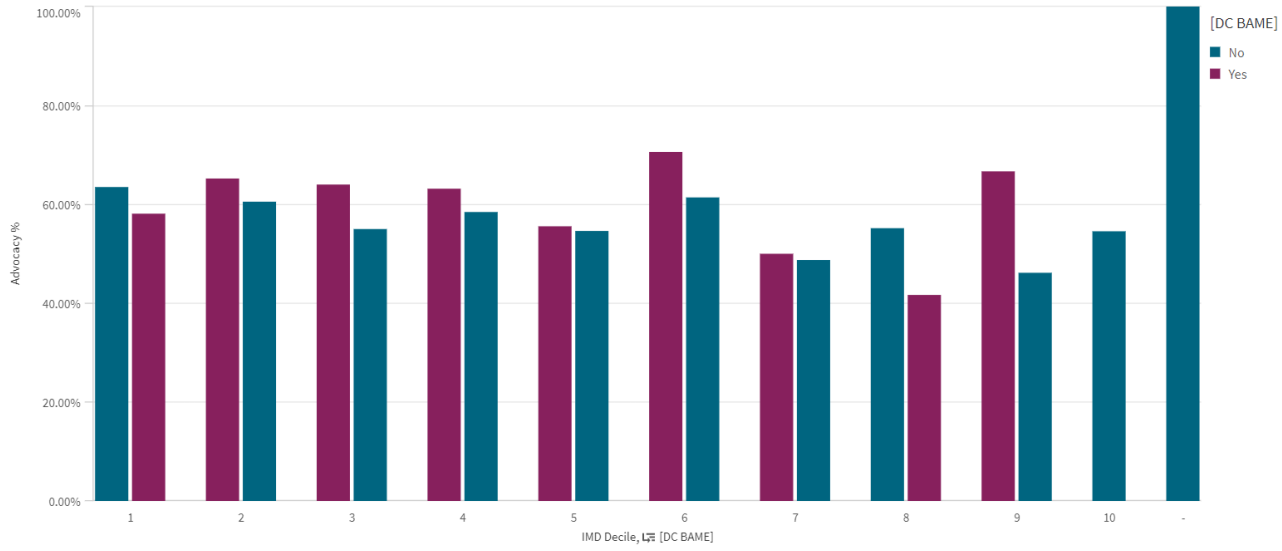
5.3 Reporting Health Inequalities data – the tables below demonstrate that we have started to capture self-explanatory data reflective of protected characteristics and IMD (Indices of Multiple Deprivation)

IMD Decile	Complai…	Open Complaints	Closed Complaints %	Advocacy %	Overdue Complaints	Overdue Complaints (re-opened)	Average Days to Reply	BAME %	Average Age
Totals	**1,733**	**180**	**89.61%**	**55.34%**	**69**	**54**	**82.58**	**12.93%**	**53.71**
1	212	22	89.62%	60.38%	8	5	82.01	34.91%	50.17
2	238	21	91.18%	61.76%	8	7	88.74	19.33%	47.25
3	171	19	88.89%	56.73%	9	8	74.65	14.62%	50.75
4	177	11	93.79%	58.19%	3	2	82.82	10.73%	56.02
5	168	19	88.69%	53.57%	7	6	79.53	10.71%	56.96
6	177	22	87.57%	62.71%	10	8	85.24	9.60%	56.56
7	178	26	85.39%	47.75%	8	6	81.37	5.62%	55.22
8	164	13	92.07%	53.05%	6	5	86.93	7.32%	54.48
9	127	15	88.19%	45.67%	5	4	84.48	2.36%	57.99
10	70	10	85.71%	54.29%	4	2	77.82	0.00%	59.57
-	51	2	96.08%	29.41%	1	1	72.50	0.00%	41.50

KPIs by Ethnicity

Ethnic Group	Complai…	Open Complaints	Closed Complaints %	Advocacy %	Overdue Complaints	Overdue Complaints (re-opened)	Average Days to Reply	BAME %	Average Age
Totals	**1,733**	**180**	**89.61%**	**55.34%**	**69**	**54**	**82.58**	**12.93%**	**53.71**
Asian	151	12	92.05%	62.25%	9	7	90.20	100.00%	46.07
Black	29	4	86.21%	58.62%	1	1	83.80	100.00%	57.21
Mixed	31	1	96.77%	54.84%	1	1	64.48	100.00%	33.45
Not Known	161	5	96.89%	45.34%	3	2	84.77	0.00%	31.13
Other	13	4	69.23%	53.85%	2	1	104.30	100.00%	50.77
White	1,348	154	88.58%	55.71%	53	42	81.66	0.00%	56.41

Advocacy by IMD and Ethnicity



Examples of learning

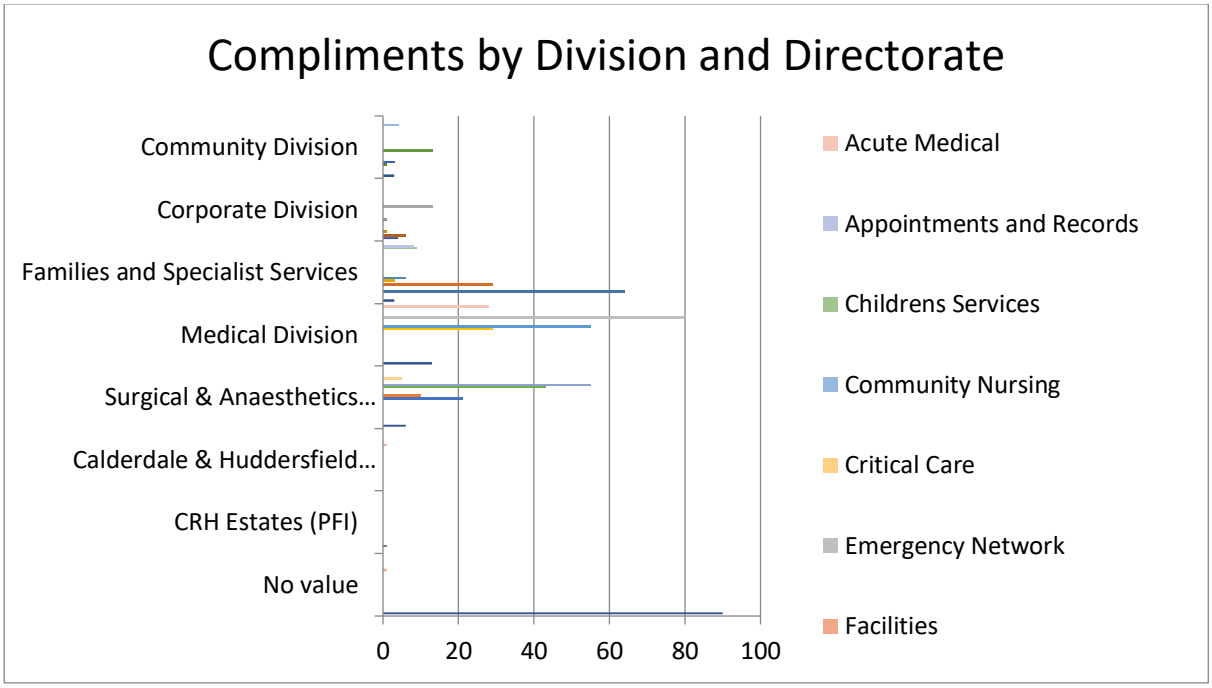
We also continue to aim to improve the learning from complaints and actions required to ensure similar occurrences do not happen again. This is a key priority over the next 12 months and the Trust plans to embed learning and actions as a rolling agenda item in key meetings such as Patient Experience Group (PEG), Trust PSQB and Divisional PSQB's (please see action plan at the end of this report).

	You said	We did
Keeping on caring 	Patients and relatives valued the high standard of compassionate care our staff provided, doing more than 'just a job', 'making Mum feel comfortable', 'remembering the little things', 'keeping Dad's dignity'. Feedback from Carers highlighted that their role was not always recognised.	Observe & Act framework provides an opportunity to examine a patient's total experience of a service from their perspective along with their carers.
Communication during Covid-19  	Not being able to visit loved ones during the Covid- 19 pandemic resulted in some patients and their loved ones feeling upset, distressed, disconnected and anxious about how the care we provided was being received.	Set up a temporary Virtual Services team which received over 115,000 contacts when visiting restrictions were in place. This was done through Relatives' Line, Virtual Visiting and Letters to Loved Ones.
Patient Stories 	FFT, PALS, complaints and surveys do not always allow the patient and/or their loved the opportunity to portray how their experience felt.	We have introduced patient stories as a tool to get a better understanding of individuals' experiences and perspective of our EOL care.

6. COMPLIMENTS

The number of compliments received are highlighted below, these are broken down by divisions and directorates. All compliments are valued by staff and are a useful source of intelligence on what the Trust is doing well, for example:

- Patients felt well cared for whilst recognising staff are under pressure whist in our Emergency Department
- All staff displayed empathy and went above and beyond whilst being treated by our Chemotherapy Team
- Cared for in a calm, patient and considerate manner when attending our Urology Outpatients



7. THE PARLIAMENTARY & HEALTH SERVICE OMBUDSMAN

The Parliamentary and Health Service Ombudsman (PHSO) continue to work with the NHS and other public service organisations, members of the public and advocacy groups to develop a shared vision for NHS complaint handling.

7.1 PHSO Complaint Standards Framework

The new PHSO Complaint Standards Framework sets out a single set of standards for staff to follow and provides standards for leaders to help them capture and act on the learning from complaints. These are to be launched towards the end of 2022. The PHSO has introduced some internal changes in relation to how they manage and handle their referrals. The PHSO have seen an allocation time of referred complaints of up to 46 weeks resulting in increased concern for the general public at the length of time taken for the PHSO to assess complaints.

8. CONCLUSION

In concluding our review of the year's activity, it is important to recognise the effort made during 2021/22 to address concerns, make changes and to share these openly and honestly with patients and their families.

Whilst the pandemic has provided challenges in various aspects of the complaints process the organisation remains committed to working differently to support patients and families and to reinstate face to face contact in line with guidance.

The Trust will continue to improve its complaints performance and ensure a greater focus on shared learning is developed in 2022/23. Complaints and learning from complaints is a Trust quality priority and we will utilise improvement approaches to ensure sustainable improvements are made.

The introduction of the new PHSO standards provide a further opportunity for the Trust to continuously improve and work with patients, families and carers to address concerns raised. Further work regarding Health Inequalities will be progressed in 2022/23 to enable targeted actions in response to the data analysis.

Calderdale & Huddersfield NHS Foundation Trust – Annual Complaints Report – Action plan

ACTION	WHAT DOES 'GOOD' LOOK LIKE	RESULT TIME FRAME	LEAD	RAG RATING
To share learning from complaints, concerns and compliments Trust wide and implement "smart" actions in a timely manner	Triangulate data from all patient feedback, including complaints, concerns and Friends & Family Test (FFT) and present meaningful information to PSQB's to disseminate Develop a group to identify and share learning from Mortality, Incidents, Complaints, Claims and Inquests (MICCI)	On-going to March 2023	Associate Director of Quality & Safety with support from Heads of Service	
To capture and analyse data for protected characteristics and health inequalities – Index of Multi deprivations (IMD – means of identifying the most and least deprived areas)	To work alongside colleagues in THIS to develop complaints data into the Datix IMD model to enable analysis that supports the Trust's ambitions to tackle health inequalities. To attend the Trust's monthly Health Inequalities Group to present data reflecting the breakdown of complaints and concerns from this cohort of patients to ensure they are represented and are able to access services and raise concerns	June 2022 On-going	Head of Complaints & PALS Emma Catterall	
Review complaints policy/process to ensure it reflects a patient friendly process which complies with national guidance. Accessible user-friendly complaints process, with information available across the Trust to inform service users how to raise concerns Information clearly displayed on Trust website	That all patients and their relatives are aware of how to access services and raise concerns/complaints and will not be treated any differently as a result.	July 2022	Head of Complaints & PALS Emma Catterall	
To reintroduce face to face meetings for complainants when restrictions are lifted	To offer local resolution meetings to complainants in an attempt to swiftly address any concerns face to face – meetings are felt to be more beneficial at time as they enable all parties to express experiences and information more effectively and resolve concerns without the need for a formal written response.	As soon as restrictions allow – aim for October 2022	Head of Complaints & PALS (supported by divisional colleagues) Emma Catterall	
Introducing patient stories as an alternative to raising a formal complaint	Again, this method of sharing experiences is felt to be very powerful for both staff and patients and also therapeutic to those sharing their experience which highlights to staff how they were made to feel and why	June 2022	Patient Experience Lead supported by Head of Complaints & PALS	

19. Audit and Risk Committee Chair Highlight Report
- EPRR Annual Report - Review Room
- Fire Safety Annual Report - Review Room

For Assurance

Presented by Nigel Broadbent

Calderdale and Huddersfield NHS Foundation Trust

CHAIR'S HIGHLIGHT REPORT
to the Board of Directors

Committee Name:	Audit and Risk Committee (ARC)
Committee Chair:	Nigel Broadbent, Non-Executive Director
Date(s) of meeting:	25 October 2022
Date of Board meeting this report is to be presented:	10 November 2022

ACKNOWLEDGE

- A deep dive on Information Governance was presented to the meeting including details of the current priorities in this area.

ASSURE

- The Emergency Preparedness Resilience & Response (EPRR) annual report, the EPRR Core Standards return and the Fire Safety report were all reviewed and agreed by the Committee. ARC asked for an update in six months time of progress towards meeting the Core Standards.
- The second update of the Board Assurance Framework (BAF) was recommended to the Board with increases in the risks on quality and safety standards (following the recent Internal Audit report), and transformation (given that approval to the reconfiguration business case had not been received yet). The health and safety risk has also been updated.
- The work plan for the Committee for the next 12 months is being updated and will be circulated prior to the next meeting.
- Internal Audit reports on quality governance and sickness absence which have limited assurance but are currently in draft form will be presented to the next meeting.

AWARE

- There are a number of outstanding recommendations from internal audit reports which are overdue and some which do not have revised target dates for completion. These need to be completed as soon as possible as they help inform the Internal Audit opinion on the organisation's framework of governance, risk management and control.
- The latest update on counter fraud was received by ARC and the need to continue to be vigilant for potential fraud and to undertake awareness training.
- ARC noted the current position on declarations of interest and the need for these to be completed.
- ARC was updated on the current position with the audit of the Trust's self-assessment on its financial sustainability. It was agreed that the final return would be circulated to ARC members for information and for approval if required.

ONE CULTURE OF CARE

- One Culture of Care considered as part of the annual reports on Emergency Preparedness Resilience & Response and Fire safety particularly in relation to protection of colleagues and personal emergency evacuation plans for staff.
- One Culture of Care also considered within the Board Assurance Framework in relation to the health and well-being of colleagues.

20. Freedom to Speak Up Annual Report - Presented by Andrea Gillespie

To Approve

Date of Meeting:	Thursday 10 November 2022
Meeting:	Public Board of Directors
Title:	Freedom to Speak Up Annual Board Report
Author:	Andrea Gillespie, Freedom to Speak Up Guardian
Sponsor:	Suzanne Dunkley, Director of Workforce and Organisational Development
Previous Forums:	Workforce Committee 6 June 2022

Purpose of the Report

This paper provides information to the Board in respect of the Freedom to Speak Up (FTSU) arrangements at CHFT and FTSU activity in the Trust from the 1st April 2021 to the 31st March 2022.

Key Points to Note

- There has been a very minimal decrease in the number of concerns raised by colleagues in 2021/2022 when compared with previous years
- 56% of concerns raised in 2021/2022 were raised anonymously. This percentage remains static in comparison to previous years
- The Registered Nurses and Midwives staff group has submitted the highest number of concerns in 2021/2022
- No CHFT colleagues have reported suffering any detriment or demeaning treatment as a result of speaking up
- The main themes of concerns are related to colleague attitudes and behaviours
- Multiple concerns have been raised around maternity and HRI theatre services
- Many actions are being undertaken to create a culture where staff feel safe to speak up and make FTSU business as usual at CHFT

EQIA – Equality Impact Assessment

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

Recommendation

The Board of Directors is asked to **APPROVE** the contents of the report, the number of concerns raised in 2021/2022 and the work of the FTSU Guardian and Ambassadors.

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

BOARD OF DIRECTORS

1 SEPTEMBER 2022

FREEDOM TO SPEAK UP ANNUAL REPORT

1. PURPOSE

This paper provides information to the Board of Directors in respect of the Freedom to Speak Up (FTSU) arrangements at CHFT and FTSU activity in the Trust from the 1st April 2021 to the 31st March 2022.

2. BACKGROUND

Freedom to Speak Up is vital in healthcare if we are to continually improve patient safety, patient experience and the working conditions for colleagues. The National Guardian's Office (NGO) believes a positive speaking up culture makes for a safer workplace, for workers, patients, and service users. At CHFT we are working towards making speaking up business as usual.

Effective speaking up arrangements help to protect patients and improve the experience of NHS workers. Having a healthy speaking up culture is an indicator of a well-led Trust. The Care Quality Commission (CQC) assesses a Trust's speaking up culture during inspections within its Key Line of Enquiry (KLOE) approach as part of a Well-Led review.

3. PROGRESS UPDATE

3.1 The FTSU Network at CHFT

The Trust appointed a new FTSU Guardian (FTSUG), Andrea Gillespie in September 2021 who currently works 22.5 hours per week. She came to the role with some experience of FTSU, reviewed our existing processes and documentation with 'fresh eyes' and created an opportunity for a FTSU refresh. The FTSUG attends the FTSU Yorkshire and Humber network monthly meeting where there is attendance from the NGO and buddy's the FTSU Guardian at Bradford Teaching Hospitals. Both Guardians meet monthly via MS Teams for peer support.

Suzanne Dunkley, Director of Workforce and Organisational Development, is the Executive Sponsor for FTSU and there are 23 FTSU Ambassadors. The Ambassadors promote the FTSU agenda in their areas of work and are a point of contact and source of support for any colleague who wants to raise and escalate a concern. The Ambassadors currently have no protected time to dedicate to FTSU within their substantive roles.

The FTSU network meets bi-monthly. The meetings are chaired by the FTSUG, and regular agenda items include updates and minutes from the Regional Meetings, data submissions and National reviews, i.e., case reviews performed by the NGO.

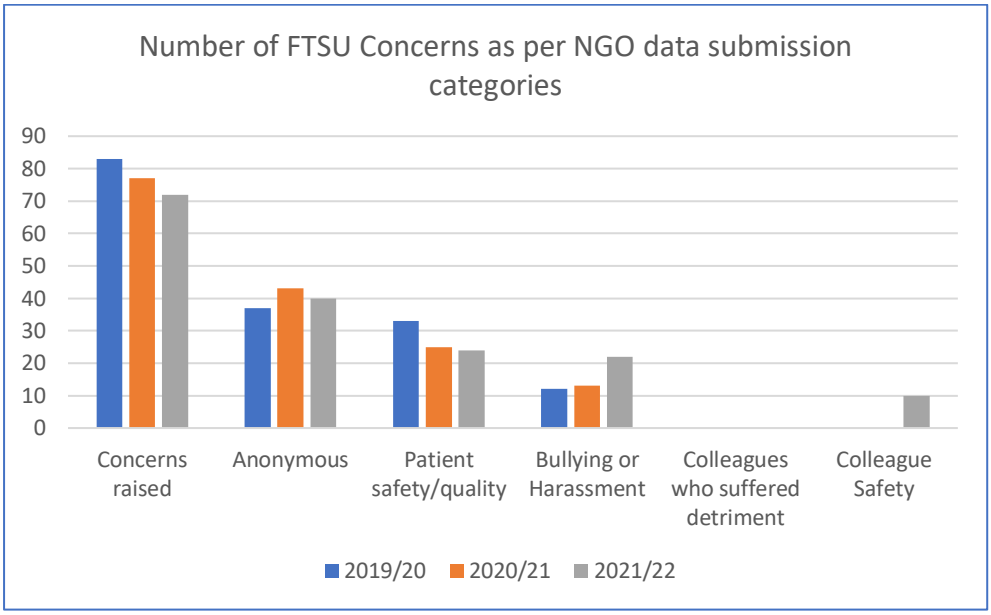
Recently drop-in support clinics have been introduced to create a regular opportunity for the FTSU Ambassadors to speak with the FTSUG in a 1:1 situation and an opportunity for the FTSU Guardian to provide advice, help and wellbeing support for the FTSU Ambassadors.

3.2 FTSU concerns raised from the 1st April 2021 to the 31st March 2022

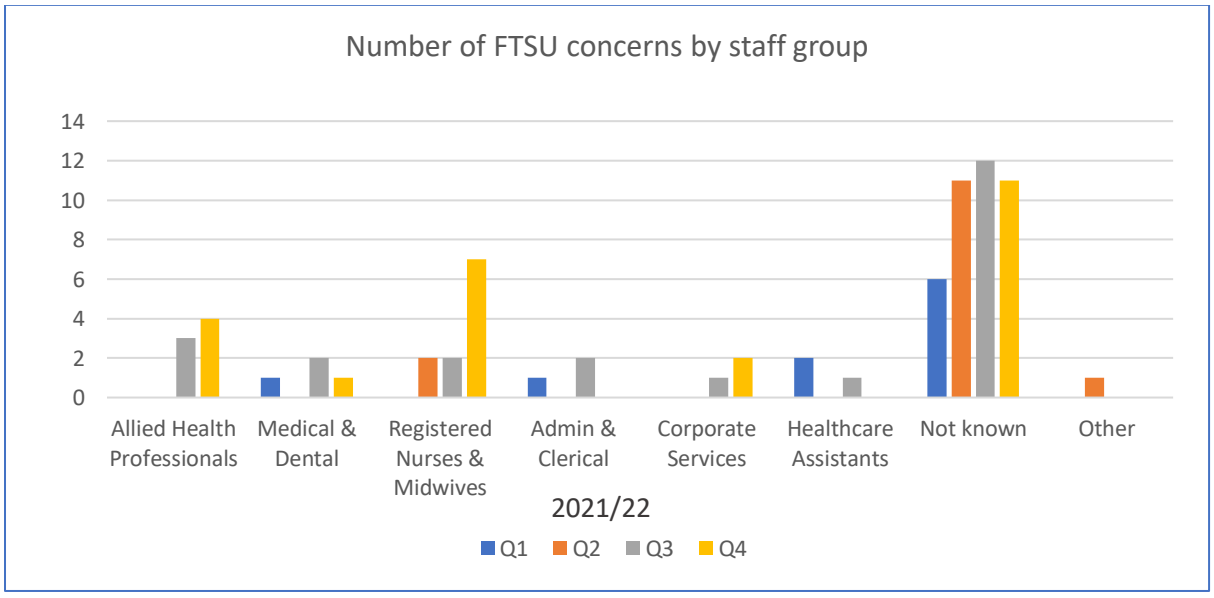
The graph below shows the total number of concerns raised in 2021/2022 and the number of concerns raised as per the NGO's submission categories. Data for 2019/2020 and 2020/2021 have been added to provide a comparison.

No colleagues have reported suffering any detriment or demeaning treatment as a result of speaking up.

There is only data for 2021/2022 in the colleague safety category as it was introduced in March 2021.



Colleagues raising FTSU concerns are requested to indicate which professional/ worker group (as defined by the NGO) that they belong to. The graph below indicates the number of concerns raised per quarter by staff group at CHFT. Registered nurses and midwives have submitted the highest number of concerns. The data is utilised to identify staff groups where more FTSU promotion and education is required. The 40 'not known' are the colleagues who have raised their concerns anonymously.



The subjects of the concerns raised are extremely varied however there are common themes. The main themes are related to colleague attitudes and behaviours with several references made specifically to the behaviours of managers and leaders. Colleagues describe a lack of understanding for their personal situations, and a lack of kindness, compassion and support.

Multiple concerns have been raised around maternity and theatre services. The concerns raised around maternity are being addressed as part of the Maternity Improvement plan. The Maternity Improvement plan will bring together the themes of the FTSU concerns with the findings and recommendations of the Ockenden Final report from the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust. The concerns raised around theatre services at Huddersfield Royal Infirmary (HRI) are being addressed divisionally using several actions being monitored by the Executive Lead for FTSU, Suzanne Dunkley and the FTSUG.

In May 2022 an FTSU escalation process was developed and communicated to senior leaders. It includes criteria for when the FTSUG should escalate concerns to the FTSU Executive sponsor and criteria for when the FTSUG Executive sponsor should escalate concerns to the Executive Board.

As a result of concerns raised many actions have been taken which have led to learning and improvement. Examples include:

- As a result of a concern several actions were taken to improve the safety and experience of patients being nursed in an area which was opened during Covid for extra capacity.
- As a result of a concern raised in relation to an unsafe discharge of a patient from the Emergency Department, an investigation was conducted by a nurse and occupational therapist to identify potential learning for both staff groups.
- As a result of a concern raised in relation to colleague safety the security team have joined up with the communications team to develop an infographic highlighting what support is available for colleagues. A colleague engagement group where security issues are discussed is also being planned.

The FTSUG uses opportunities during discussions to share the learning from concerns. In addition, a template for a quarterly FTSU newsletter is in development where learning will be shared also.

Nationally there are now over 800 Freedom to Speak Up Guardians in more than 400 organisations (50% of which are NHS Trusts) which submit quarterly data to the NGO. All of the submitted data is published on the NGO website and in the Culture and Engagement compartments of the Model Health system which enables each organisation to benchmark against similar types and sizes of organisations. The data is varied, however on average at CHFT (classified as a medium sized Trust using the NGO data set) the data is consistent with other medium sized Trusts.in our region. At a number of Trust's including CHFT, the number of concerns raised per quarter fluctuate and are gradually increasing in number and/or complexity.

ORGANISATION	SIZE	Q1	Q2	Q3	Q4	**TOTAL 21/22**
Calderdale & Huddersfield NHS FT	**Medium**	**10**	**14**	**22**	**26**	**72**
Airedale NHSFT	Small	3	8	6	5	**22**
Barnsley Hospital NHSFT	Small	32	21	24	12	**89**
Bradford Teaching Hospital NHSFT	Medium	19	13	18	10	**60**
Doncaster & Bassetlaw Teaching Hospital NHSFT	Medium	21	16	27	33	**97**
Leeds Teaching Hospitals NHST	Large	26	9	29	8	**72**
Sheffield Teaching Hospitals NHSFT	Large	6	10	10	9	**35**
The Mid Yorkshire Hospitals NHST	Medium	45	45	39	93	**222**
Harrogate & District NHSFT	Small	3	4	8	9	**24**

*As per NGO guidance:
Small organisation – up to 5,000 workers
Medium organisation – between 5,000 and 10,000 workers
Large organisation – more than 10,000 workers

Data published on the NGO webpages can be accessed via this link:
https://nationalguardian.org.uk/learning-resources/speaking-up-data/

In April 2022 an updated version of the CHFT FTSU portal went live. The portal has undergone many improvements to make it more user friendly and to ensure that all the data required by the NGO is easily accessible.

Colleagues who have raised their concerns anonymously can now re-access the portal to view what actions have been taken in response to their concern, monitor progress and add more detail if they wish to do so. Similarly, the FTSUG can now request more detail, make enquiries re the colleague's wellbeing, and provide information about the support they can access if required.

Improvements to the portal have also simplified the way in which colleagues can give feedback. Subsequently more responses to the NGO feedback question, 'Given your experience, would you speak up again?' and feedback comments are being received.

Feedback received in Quarter 1 2022/23 has been very positive. Here are some examples:

- 'Thank you again for your support and for caring. I would definitely speak up again if I felt I needed to'.

- 'I felt supported throughout the whole process, and I would use the service again. I have encouraged members of my team to use it too'.

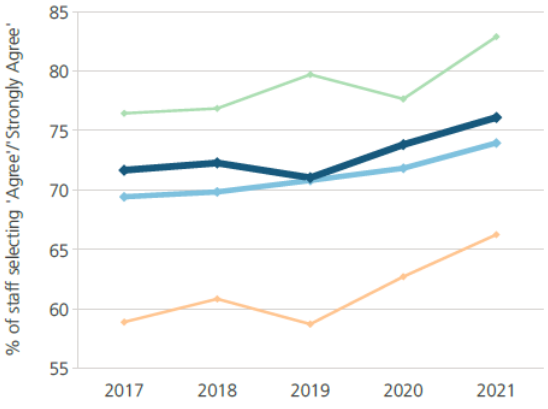
- 'FTSU is a means of addressing concerns that involve processes and culture in a manner that is challenging but non-confrontational'.

3.3 Staff survey results

The annual staff survey provides an opportunity to monitor how CHFT is performing in relation to other organisations classified as the best, average, and worst performing in respect to raising concerns.

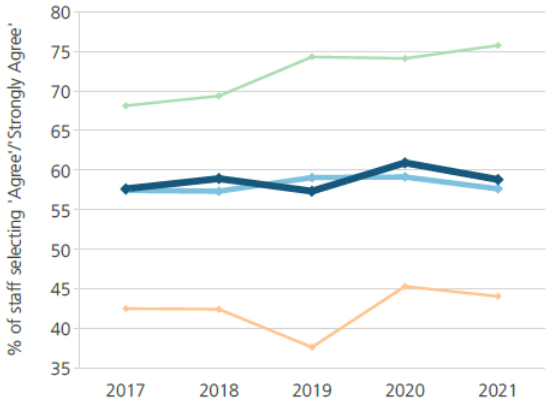
The graphs below illustrate a steady increase in CHFT colleagues feeling safe to raise their concern about unsafe clinical practice since 2019 and a decrease in confidence that their concern would be addressed since 2020.

Q17a
I would feel secure raising concerns about unsafe clinical practice



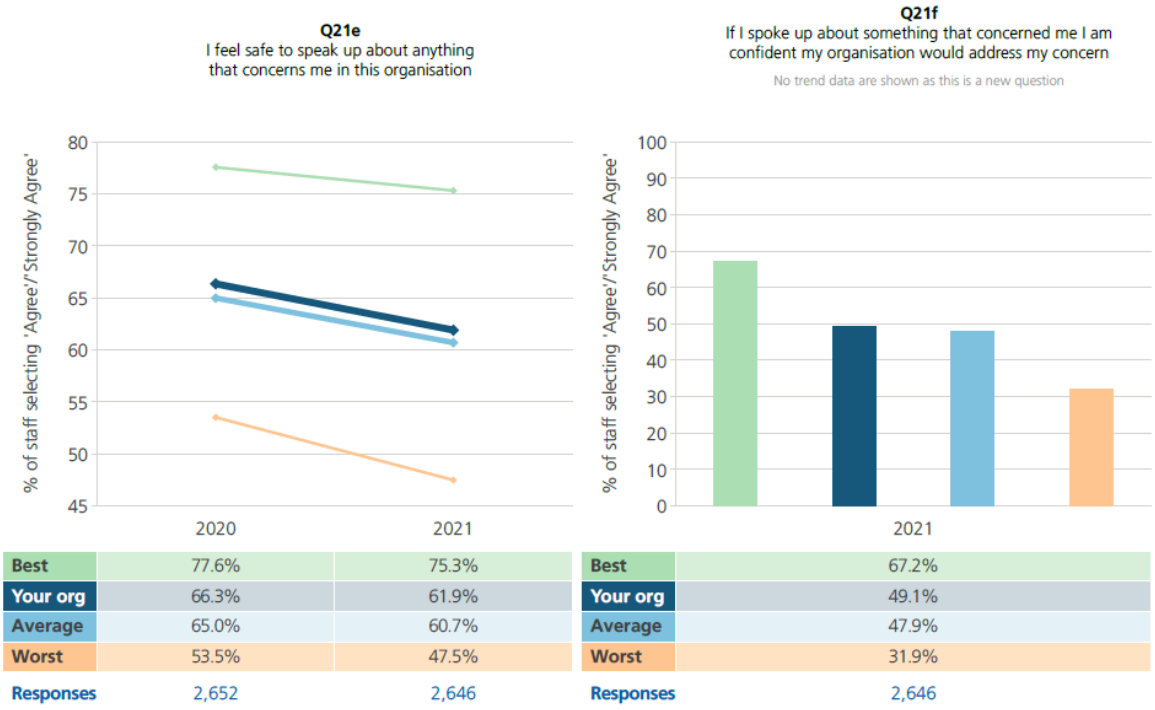
	2017	2018	2019	2020	2021
Best	76.4%	76.9%	79.7%	77.7%	82.9%
Your org	71.7%	72.3%	71.0%	73.8%	76.1%
Average	69.4%	69.8%	70.8%	71.8%	73.9%
Worst	58.9%	60.8%	58.7%	62.7%	66.2%
Responses	2,348	2,640	2,473	2,663	2,675

Q17b
I am confident that my organisation would address my concern



	2017	2018	2019	2020	2021
Best	68.1%	69.4%	74.3%	74.1%	75.7%
Your org	57.6%	58.9%	57.3%	60.9%	58.8%
Average	57.4%	57.3%	59.1%	59.1%	57.6%
Worst	42.5%	42.4%	37.6%	45.3%	44.1%
Responses	2,343	2,632	2,475	2,659	2,676

The graphs below illustrate a decrease in CHFT colleagues feeling safe to raise their concerns about anything and 49.1% of colleagues having confidence that CHFT would address their concern.



	2020	2021
Best	77.6%	75.3%
Your org	66.3%	61.9%
Average	65.0%	60.7%
Worst	53.5%	47.5%
Responses	2,652	2,646

	2021
Best	67.2%
Your org	49.1%
Average	47.9%
Worst	31.9%
Responses	2,646

4. NGO UPDATE

In November 2021 a new National Guardian was appointed, Dr. Jayne Chidgey-Clark who is a registered nurse.

In February 2022 the NGO published new guidance, 'Recording Cases and Reporting Data' to be implemented on the 1st of April 2022. The key changes are:

- A new category, 'An element of other inappropriate attitudes or behaviours' has been introduced.
- The category, 'An element of worker safety' has been extended to include wellbeing.
- The definitions of bullying and harassment published by the Advisory, Conciliation and Arbitration Service have been introduced.
- The professional/worker group category has been updated.

In April 2022 the NGO launched FTSUG Foundation training which all Guardians must complete by October 2020. It consists of e-learning divided into two parts; part one to be undertaken by established Guardians and part two for new Guardians. Alongside the training a mentor scheme has also been developed where established Guardians will mentor new Guardians.

During the last 12 months the NGO, in collaboration with Health Education England has developed and launched three e-learning modules:

- Speak Up – This core training is for all workers including volunteers, students, and those in training. It will help colleagues understand how to speak up and what to expect when they do.
- Listen Up - This training is for all line and middle managers and is focussed more on listening up and the barriers that can get in the way of speaking up.
- Follow Up - This training is aimed at all senior leaders including executive board members (and equivalents), Non-Executive Directors, and Governors to help them understand their role in setting the tone for a good speaking up culture and how speaking up can promote organisational learning and improvement.

The Speak Up and Listen Up training modules are on the Trust's e-learning platform and Follow Up will be available in the next 2-4 weeks. The FTSUG is working with the Communications team to plan a launch of the training and add details of the training to the Training section of the intranet. Colleagues will access the modules on their ESR using a simple link or a QR code.

5. FTSU COMMUNICATIONS & ENGAGEMENT

The overarching objective of all communications and engagement will be to make FTSU business as usual at CHFT and create an open and honest culture where colleagues feel safe to raise their concerns.

The FTSU intranet pages and the CHFT FTSU policy were reviewed and updated in January 2022. The NGO is currently revising the FTSU policy guidance and when available the policy will be reviewed and renewed in line with this.

Promotional materials have been updated and are currently being distributed across all wards and departments including community settings. The new resources include a QR code which when scanned takes colleagues directly to the FTSU intranet pages where they can raise their concerns.

FTSU information and updates feature regularly in CHFT news and as screensavers. FTSU at CHFT is incorporated in to Trust induction, included in the induction resources for students and the FTSUG delivers an interactive teaching session at preceptorship days. Arrangements for FTSUG to attend medical staff induction are in progress.

6. RISK ASSESSMENT

Regular evaluation of the number and complexity of concerns received is essential for assurance that the resource available to lead, manage and co-ordinate FTSU at CHFT ensures a timely, appropriate, and supportive response for colleagues raising a concern and enables a full and proper enquiry and resolution of the concern. A sudden increase in the number and/or complexity of concerns or an increasing trend that is not appropriately considered and attended to could create risk to the integrity and credibility of FTSU at the Trust. FTSU activity is reviewed regularly by the FTSUG in conversation with others and any additional resource requirements are considered. Expansion and further development of the Ambassador network is a key component of the FTSU publicity and colleague engagement plan in the Trust and will help mitigate any immediate requirement for support to the FTSUG.

7. CONCLUSION

Moving forward in to 2022/2023, the priorities are to increase the promotion of FTSU and ensure the learning and improvements produced as a result of the concerns are captured and shared widely.

Data will be used to identify where barriers may exist, and a communication strategy will be developed and implemented. The communication strategy will ensure all the different channels of communication available are utilised and barriers to speaking up are addressed.

Additional routes for the sharing of learning and improvements will be explored and utilised if attainable.

Both priorities will be progressed with the support of the CHFT Communications team.

The Board of Directors is asked to note the contents of the report, the number of concerns raised in 2021/2022 and the work of the FTSU Guardian and Ambassadors.

Andrea Gillespie
Freedom to Speak Up Guardian
August 2022

21. Winter Plan

To Approve

Presented by Jonathan Hammond

Date of Meeting:	10 November 2022
Meeting:	Board of Directors
Title:	Winter Plan
Authors:	Director of Operations – Corporate
Sponsoring Director:	Chief Operating Officer
Previous Forums:	Urgent and Emergency Care Delivery Group Urgent Care Delivery Board

Purpose of the Report

For approval by the Board of Directors.

Key Points to Note

The Trust's Winter Plan has now been updated for winter 2022/23 and describes the structure within which the operational pressures during the winter period will be managed.

Preparedness for this winter in particular is imperative to ensure we keep our patients and staff safe and we remain resilient as an organisation, whilst continuing with our elective recovery programme to reduce backlogs. Detailed divisional plans are included in this report for approval.

EQIA – Equality Impact Assessment

The Winter plan aims to design and implement service policies and measures that meet the diverse needs of our service, population and workforce ensuring that none are placed at a disadvantage over others.

We therefore aim to ensure that in both employment and services no individual is discriminated against by reason of their gender race, disability, age, sexual orientation, religion or religious/philosophical belief or marital status.

Recommendation

The recommendation is for the Board of Directors to **APPROVE** this plan.

Calderdale and Huddersfield
NHS Foundation Trust

Winter Plan 2022/23

Version 2

Document Summary Table	
Status	Draft
Version	1
Implementation Date	September 2022
Current/Last Review Dates	December 2021
Next Formal Review	September 2023
Author	Director of Operations-Corporate
Where available	Emergency Preparedness, Resilience and Response Section of the Trust Intranet
Target audience	Executive Directors, On-call General Managers, Directors, General Managers, Senior Nursing Colleagues, Matrons, Senior Ward & Department staff, on call teams and CHS.

Ratifying Committee	
Executive Board	

Consultation Committees		
Committee Name	**Committee Chair**	**Date**
Urgent and Emergency Care Delivery group Urgent Care Delivery Board	Gemma Berriman/ Jonny Hammond Chief Officer, Calderdale CCG	TBC

Does this document map to other Regulatory requirements?	
Care Quality Commission	Outcomes 4B, 6D, 10E and 14A

Document Version Control	
V1	Updated for Winter 2022/22
V2	
V3	

Contents

Section **Page**

Appendices

1. Introduction

The winter plan describes the structure within which operational pressures during the winter period will be anticipated and managed. It provides the framework for managers and clinicians in the Trust to work together and with other organisations.

2022 has brought many challenges to the NHS due to the worldwide pandemic and starting to live with COVID-19 as it moves from pandemic to endemic. Preparedness for this winter in particular is imperative to ensure we keep our patients and staff safe and we remain resilient as an organisation, as well as continue with our elective recovery programme to reduce backlogs.

Whilst the winter period is normally defined as the period from November through to the end of March the pandemic is likely to resurge before then, so the winter plan/phase 3 plan needs to be prepared, tested and daily monitoring of data in place to trigger OPEL and escalation.

2. Purpose of the Winter Plan

The objectives of the Plan are as follows:

- To support existing plans by increasing the operational focus on winter as an issue that challenges the resilience of the Trust.
- To provide a framework for the management of the winter response
- To provide the basis for agreement and working with other partners & organisations
- To provide reference material for use in the Trust
  To set out the information systems to be used to manage the response.

NHS England has reiterated that trusts are expected to respond appropriately to the demands of winter through attention to the following areas:

- Creating capacity through plans to address increasing numbers of patients without a reason to reside.
- Reducing variation in best practice (Improving patient flow and effective discharge planning)
- Demand and capacity planning using new NHSE bed modelling
- Planning for Peaks in demand over weekends and Bank Holidays, resurgence in COVID-19 and other winter illnesses.
- IPC guidance
- Staff workforce resilience- staff wellbeing and vaccination programme

3. Definitions

Import - the monthly report on take up of influenza vaccination in staff.

Organisational resilience - the ability to adapt and respond to disruptions to deliver organisationally agreed critical activities.

Sitrep - a daily report to NHSE which highlights pressures in Trust's capacity. Sign off will be required by 11:00, Monday-Sunday from the beginning of November 2022 until the end of March 2023.

THIS will support the reporting of the Sitrep on a daily basis and the Chief Operating Officer or deputy will complete the sign off.

4. Duties (roles and responsibilities)

Chief Operating Officer

- Reportable officer at Executive level for Winter Planning
- Will represent Trust on the Urgent Care Delivery Board.

Director of Operations-Corporate

- Chair the Winter Planning Group
- Represent the Trust on the Urgent and Emergency Care Board Winter Partnership planning meetings
- Represent the Trust on the WY&H ICS System Resilience Workshops
- Update the winter planning group and divisional leads of the situation across the local healthcare system
- Respond to requests for assurance from the CCG and NHS England
- Benchmark and share good practice from partner organisations
- Ensure that winter plans are aligned with the Trust Emergency Management Arrangements and associated emergency plans
- Collate departmental plans for the Christmas and New Year period and ensure they are accessible to staff on-call and on-duty over the period
- Ensure that contingency plans that are in place for surge in non-elective demand for inpatient capacity, resurgence of COVID-19, outbreaks of winter infectious diseases and severe winter weather are appropriate and will deliver safe patient care and experience and organisational resilience.
- Ensure that the Trust Winter Plan aligns with those across the local health & social care system.
- Develop a plan to run tabletop exercises to test the winter plan
- Lead in Partnership with the Chief Nurse specific plans to support the organisation to manage resurgence of COVID-19 through the creation of Isolation capacity and new operating model for managing patients with infections that require isolation.

Divisional Directors

- Ensure each Division takes responsibility for securing sufficient capacity to meet out of hours demands on a daily basis.
- Ensure collaboration across Divisions to ensure compliance with Patient First principles.
- Ensure each Division has robust arrangements for escalation and any associate operational and tactical meetings.

Chief Nurse

- Lead in partnership with the Director of Operations for Corporate specific plans to support the organisation to manage resurgence.
- Support the divisional teams to implementation of any new IPC guidance.
- Lead in Partnership with the Director of Operations for Corporate specific plans to support the organisation to manage resurgence of COVID-19 through the creation of Isolation capacity and new operating model for managing patients with infections that require isolation.

Divisional Director of Operations

- Ensure that appropriate plans are in place to manage an increase in non-elective activity through the winter period within the division.
- Ensure that divisional plans are joined up across the organisation.
- Ensure that contingency plans are in place for surge in severe winter weather and outbreaks of winter infectious diseases.
- Ensure that key staff groups are aware of the risks and response arrangements for winter.
- Ensure robust communication of the winter plan is in place and the division is represented on the winter planning group and tabletop exercises.
- Ensure all Business continuity plans are updated following learning from the COVID-19 pandemic.

CHS, Clinical Site Matrons, Commanders Site Commanders

- Liaise with Local Council Highways departments to clear roads for urgent patient transport requirements.
- Contact alternative transport providers if required.
- Work with IPC to optimise inpatient isolation capacity.
- Liaise with those contracted to arrange access to 4X4 vehicles for transport services if required.

CHS/EQUANS

- Ensure that there are sufficient supplies of salt/grit for clearing car parks, pathways and roads on site and in community buildings where CHFT staff and patients are working/attending.
- Ensure that additional staff accommodation is available if required.
- Cascade weather updates throughout the year including winter.
- Be prepared for additional outbreak cleaning and curtain changes as and when required.
- Ensure staffing levels are maintained by calling upon generic pool of bank workers.
- Ensure cleaning requirements are in place to manage infection outbreaks and possible resurgence of COVID-19.

5. The Trust's Winter Strategy

The winter plan is based on the following strategic aims.

- To continue to provide high quality health and social care to the communities of Calderdale and Kirklees.
- To ensure that patients receive treatment in the most appropriate environment at the time most beneficial to their needs.
- To work collaboratively with other health and social care providers to effectively manage capacity.
- To assess risks to continued service provision and put plans in place to mitigate those risks.
- To put in place a communications strategy that assists the public in gaining access to appropriate health and social care services.
- To ensure optimum occupancy and staffing levels over the winter period to minimise the risk of harm.
- To ensure patients do not wait in any part of the system unless clinically appropriate.
- To ensure learning from Winter 2021/22, the COVID-19 pandemic and WY&H ICS Resilience Workshops is incorporated into 2022/23 Winter Plan.

6. Winter planning arrangements

The Trust Operational Lead for winter planning is the Director of Operations for Corporate in collaboration with the Divisional Senior Management Teams.

The local Urgent Care Delivery Board has overall responsibility for ensuring that the health and social care service in Calderdale and Huddersfield is adequately prepared to manage an expected increase in activity and acuity over the winter period. The CHFT Winter Planning Group reports to the Urgent Care Delivery Board and, in addition to internal escalation arrangements, is responsible for ensuring that the Trust has plans in place for severe winter weather, COVID-19 resurgence, seasonal infectious disease outbreaks and Christmas and New Year bank holidays.

In 2022 the Trust's internal Urgent and Emergency Care Delivery Group with membership of all Clinical Director's, contributed to winter planning by developing new innovative schemes providing increased resilience and clinical effectiveness for the winter period. Through the Phase 3/winter planning further initiatives are being implemented. All innovations are being monitored against clear aims and KPIs:

Work Stream	Description	KPIs
Plan for Every Patient Digital Boards	Electronic whiteboards to pull and use information already gained through the EPR system, updated by nurse in charge during ward and board rounds so clear patient journey and timescales can be developed. Currently in pilot phase on wards 5 and Acute Floors at HRI.	• Releasing time to care • Adding value to patient journey with clear actions • Reduction in use of paper-based notes • Improved dementia screening and VTE screening

		• Reduction in LOS • Increased discharges before lunchtime
Reason to Reside	A daily review of all patients who do not have a reason to reside. Information available and live on KP+ with parameters set out by NHS England. Daily meeting to discuss plans and challenge decisions on remaining in hospital	• Reduction in LOS • Clear plans of care • Utilisation of community services such as virtual ward, UCR and OPAT
Criteria Led Discharge	Criteria to allow a patient to be discharged should they meet a required set of parameters set by the clinician, without the requirement for a further review.	• Early discharge • Freeing up of clinician time to see other acutely unwell patients • Improved discharges at the weekend
Social History Programme	Social history collected at admission and given same level of importance as medical information. Collected and held in one place on EPR and therefore one source of the truth Supporting early signposting and referral enables family support and 'working with families'	• Improved complex discharges and reduce LOS
UCR	The Service Aim for the Calderdale UCR is to provide a 0–2-hour response **for all age adults** to accelerate the treatment of urgent care needs closer to home and prevent avoidable hospital admissions. These 0-2hour and 2-day urgent response standards are part of a range of commitments which aim to help keep people well at home and reduce pressure on hospital services. In Calderdale the UCR service will supplement other aspects of the Ageing Well programme such as. •Discharge to assess pathways •Enhanced Health in Care Homes •Anticipatory Care •Frailty Strategy	• Reduction in hospital admissions
Virtual Ward	Early supportive discharge and admission avoidance, providing remote monitoring linking	• Reduction in LOS • Reduction in admissions

	with Urgent Community Response, and Discharge to Assess. Prescribing and offering diagnostics.	

7. Command, control and co-ordination

During the period 1 November 2022 to 31 March 2023, a daily Sitrep (Sun-Mon) will be completed for submitting to NHS England by the Health Informatics Service. Sitreps will be signed off by the Chief Operating Officer/Director of Operations/Chief Nurse after high level validation with fully validated data submitted daily. Arrangements have been confirmed to ensure that there is adequate cover in case of absence. COVID-19 Sitreps will also continue to be submitted.

A Bronze, Silver and Gold command structure will continue to be in place and will be based on the OPEL scoring framework. CHFT will continually be in bronze command during all OPEL levels, should OPEL 3 be reached silver Command will then be triggered. When OPEL 4 is met gold command will be triggered. These meetings will follow the structure below:

Bronze Command
Times
07:00hrs-Team Handover
09:00hrs
12:30hrs
15:00hrs
17:00hrs
20:05hrs-Team Handover

Chairs
Clinical Site Matrons

Site Management Agenda

- ED Position
- Bed Position including Speciality Bed Position (Stroke, Elderly, Respiratory, Cardiology, Paediatrics)
- Extra capacity open
- COVID Position
- ICU Position
- Inpatient Swabbing Results
- Staffing Update
- Mental Health Patients in Acute Beds
- Learning Disability Patients in Acute Beds
- Daily Sitrep Returns
- OPEL Score and Actions
- TOC Discharges
- Other Discharges

Extra Agenda Items at Times of Incident

- PPE Issues
- Mortuary Capacity
- Ethics Issues

Silver Command

Times

13:00hrs (Daily whilst in OPEL 3 or 4)

Chairs

DOPs-On a weekly rota basis
Gemma Berriman-Corporate
Michael Folan-Community
Tom Strickland Surgery
Helen Rees-Medicine
Stephen Shepley-Families and Specialist Services

A loggist will minute this meeting

Site Management Agenda

- Status from the 12:30hrs site management meeting
- OPEL Actions linked to the OPEL Action cards prevention of deterioration of position
- Escalations from site management meeting
- Discharge position/TOC
- IPC Update
- System position
- Must Do dashboard overview
- Bed modelling
- Elective recovery
- System escalation

Extra Agenda Items at Times of Incident

- PPE Issues
- Mortuary Capacity
- Ethics Issues

Gold Command

Times

14:00hrs (Daily whilst in OPEL 4)

Chairs

Executive Directors
Chief Executive-Brendan Brown
Chief Operating Officer-Jonny Hammond
Chief Nurse-Lindsay Rudge

A loggist will minute this meeting

Site Management Agenda

- National Update
- System Update
- Silver Update
- Status from 12:30hrs site management meeting including OPEL Level
- HR/Staff Update
- Recovery Coordination

Extra Agenda Items at Times of Incident

- PPE Issues
- Mortuary Capacity
- Ethics Issues

8. The National Escalation Framework

The 4 Hour Emergency Care Standard (ECS) performance is one measure of a whole health and social care system experiencing pressure, but it is not the only one. An Emergency Department (ED) could be experiencing isolated difficulties but the rest of the system is coping well for example there are sufficient beds available and there is good flow through the system. Alternatively, an ED could be managing well whilst the rest of the hospital, and the wider system, community beds, community services and social care are experiencing high pressures due to a lack of capacity.

Escalation Triggers at Each Level

Local Urgent Care Delivery Boards have aligned their existing systems to the OPEL escalation triggers and terminology used below and adds to the triggers listed as appropriate. The escalation criteria detailed over the following pages are not an exhaustive list of triggers, nor do they constitute a rigid system where criteria must be met sequentially for escalation to take place.

Not all parts of the system need to meet all triggers in order to escalate – escalation can be service specific if agreed locally.

Operational Pressures Escalation Levels	
OPEL 1	The local health and social care system capacity is such that organisations are able to maintain patient flow and are able to meet anticipated demand within available resources. The local Urgent Care Delivery Board (or A&E Delivery Board) area will take any relevant actions and ensure appropriate levels of commissioned services are provided. Additional support is not anticipated.
OPEL 2	The local health and social care system are starting to show signs of pressure. The local Urgent Care Delivery Board will be required to take further escalation. Enhanced co-ordination and communication will alert

	the whole system to take appropriate and timely actions to reduce the level of pressure as quickly as possible. Local systems will keep NHS E and NHS I colleagues at sub-regional level informed of any pressures, with detail and frequency to be agreed locally if needed.
OPEL 3	The local health and social care system are experiencing major pressures compromising patient flow and continues to increase. Actions taken in OPEL 2 have not succeeded in returning the system to OPEL 1. Further urgent actions are now required across the system by all Urgent Care Delivery Board partners, and increased external support maybe required. Regional teams in NHS E and NHS I will be aware of rising system pressure, providing additional support as deemed appropriate and agreed locally. National team will ALSO BE INFORMED BY DCO/Subregional teams through internal reporting mechanisms.
OPEL 4	Pressure in the local health and social care system continues to escalate leaving organisations unable to deliver comprehensive care. There is increased potential for patient care and safety to be compromised. Decisive action must be taken by the local Urgent care Delivery Board to recover capacity and ensure patient safety. All available local escalation actions taken, external extensive support and intervention required. Regional teams in NHS e and NHS I will be aware of rising system pressure, providing additional support as deemed appropriate and agreed in different parts of the country are declaring OPEL 4 for sustained periods time and there is an impact across local and regional boundaries, national action may be considered.

Local Urgent Care Delivery Boards are able to demonstrate that appropriate triggers have been met to warrant escalation. NHS England sub-regional and regional teams will also use the framework to moderate and challenge in discussions with local systems.

To ascertain the OPEL status at CHFT a scoring system is in place base on several key sets of data.

					TACTICAL (SILVER)		STRATEGIC (GOLD) COMMAND	
	Steady State		Moderate Pressure		Severe Pressure		Extreme Pressure	
	OPEL 1		OPEL 2		OPEL 3		OPEL 4	
Trust wide Emergency Departments attendances last 24 hours	Attendances <420	1	Attendances 421-480	2	Attendances 481 - 500	3	Attendances > 501	4
12-hour Length of Stay Waits in the ED's	0	1	1-5	2	5-15	3	15+	4
Ambulance Turnaround over 60 minutes	0	1	1-5	2	5-10	3	10+	4
Trust wide non-elective admissions	Admissions 120 - 150	1	Admissions 151 - 175	2	Admissions 176 - 200	3	Admissions 200+	4
TOC	<50	1	50 - 65	2	66 - 80	3	80+	4

Infection Control Position	Isolated in bays or side rooms – empty beds available	1	Ward closure with no empty beds	2	Empty beds in closed ward, 2-5 wards closed or 1 acute floor closed	3	Infection outbreak across more than 5 wards or infection closing both acute floors	4
Outliers – Total Trust wide	<5	1	6-10	2	11-25	3	25	4
Extra Beds Open	<5	1	6-10	2	11-25	3	25	4
Critical Care Bed Access	Available	1	Available in under 4 hours	2	Ward patients requiring Critical care with no bed availability and no network beds	3	Ward patients requiring Critical care with no bed availability, Cancellation of specific elective cases- No network beds and limited regional beds	4
Staffing Escalation (relate to acuity and dependency score & Care hours- ADNs to confirm) (See Appendix C)	No Concerns	1	Moderate Concerns	2	Severe Concerns	3	Severe Concerns	4
Bed availability	Beds and/or assessment capacity immediately	1	Beds and or assessment capacity available within next 2 hours.	2	Beds and or assessment capacity not available within next 4 hours.	3	Prolonged bed waits/risk of 12-hour trolley breaches and capacity will not meet demand over 50%	4
Occupancy Levels	87.5% or less	1	87.5-92.5%	2	92.5- 97%	3	97%	4
Cancelled Operations	Normal Activity	1	5 cases or 1 full list	2	Whole lists cancelled including cancer patients*	3	Tertiary activity refused- no elective activity	4
Total Score								
	13 or less		**14-26**		**27-39**		**40 - 54**	

The OPEL score is a live system within KP+ and will be displayed within the command centre at both HRI and CRH, this is also available for all trust staff to access. The OPEL score for that day will be determined by the clinical site matron at the 09:00hrs site management (bronze meeting) and the initiation of further command structure meetings will be determined. CHFT's Clinical Site Matrons will be contacted by Yorkshire Ambulance Service twice daily either by phone or email firstly at 09:00 each morning and secondly in the afternoon for the escalation level (OPEL) status for inpatient capacity and any associated comments noted by hospitals on the Daily Bed Alert Status Report. In addition to this the Clinical Site Matrons will complete a Sitrep report to go to NHS England and an exception report where we fall below 75% for the ECS standard.

OPEL-Winter command and control arrangements (internal)

Operational Pressures Escalation Level (OPEL) 1 when operating within normal parameters. At OPEL 1 and 2, we would anticipate operations and escalation to be delegated to the relevant named individuals in each organisation across the Urgent Care Delivery Board. At OPEL 3 and 4 however, it would be expected that there would be more executive level involvement across the Urgent Delivery Board, as agreed locally.

A second assessment of capacity alerts will be made at 16:00 and the capacity status for each hospital again reported.

The site management meetings chaired by the Clinical Site Matrons involving the patient flow team and Divisional Managers of the day, Matrons and on call managers/Matron of the day will monitor activity on each site and determine operational action cards related to the OPEL scoring system. The Director of Operations will report direct into the partner organisations involved in the Joint Surge and Escalation Plan. Each division and department are responsible for the successful implementation of their escalation and action plans.

9. Workforce

Staffing levels

Agreed workforce plans and skill mix are in place for all inpatient areas and community services over the 7-day period. These will be used to assess the risk of reduced staffing due to absence and to assist in the redeployment of staff if necessary. Nurse rosters are signed off by Divisional Matrons to ensure robust cover an arrangement especially over the Christmas and New Year period and to ensure annual leave is managed appropriately over this period. Staffing gaps should be identified and mitigated by Divisional teams in hours, only last-minute absences will be actioned by on-call, out of hours teams.

CHFT will run twice daily site staffing meetings 7 days a week these will be chaired by the Associate Directors of Nursing Monday to Sunday. The use of an OPEL scoring system for staffing. will be undertaken and the relevant actions undertaken depending on OPEL scoring level. This will feed into the main scoring as seen above.

For Christmas & New Year a further review will be completed weekly from the beginning of December with a final sign off and escalation of any risks with mitigation plans by week commencing 28th November 2022.

Vaccination

The target for Trust staff to have had the ‘flu vaccine for this year for Calderdale and Huddersfield the ambition is to achieve 100%of frontline staff. The emphasis will be on staff in clinical and clinical support roles, but the vaccine will be available to all staff. The campaign this year has been well communicated and information on scheduled sessions, ‘myth busting’ and league tables of performance have been advertised on the intranet. Additional groups of staff are being trained to administer the vaccine so that it can be more accessible to staff. District nursing services provide flu vaccination to patients on their caseload as well as working with GPs to ensure that all vulnerable people are offered the vaccine.

Vaccinations booster for COVID-19 are now released and should be offered to as many frontline staff as possible.

Personal Winter Plan/Engagement Plans

All members of staff have a personal responsibility to ensure that they are available for work and that they have alternative arrangements for carer responsibilities and journeys to work. All staff will be reminded of preparations they should make for winter – seasonal flu vaccination, checking public transport alternative routes, vehicle preparation as well as contingency plans. This will continue to be reinforced through the business continuity management system and staff communications strategy. In severe weather conditions staff in District nursing, community midwifery and other community services will report to their nearest team to their home not necessarily where they usually work. The Trust's attendance management, carer leave and adverse weather policies will be used to support staff and to maintain service levels.

Wellbeing Support / Winter Season

The wellbeing of the Trusts staff is extremely important, especially due to the pressure/anxiety caused by the COVID-19 pandemic and winter pressures. Additional support as described below is now in place.

Peer to Peer Support	Wellbeing Support	Partners & Other Support
• Wellbeing Ambassadors • Equality Networks • Inclusion Ally • Freedom to Speak up • Engagement Team	• Emotional /Psychological Support • 24/7 & 365 Friendly Ear Service • Wellbeing Events • Counselling • Listening/Debrief face to face/teams sessions • Wobble Rooms • High Intensity Areas – 1 to 1 support	• Socrates • Mindfulness • Schwartz • 1 Hour Wellbeing Protected Time • Leadership Development/Empower • The Cupboard/Intranet (Self Care Resources) • One Culture of Care • Appraisals • CHFT App

Support information is available through the trusts intranet pages, links below

Colleague support - CHFT Intranet (cht.nhs.uk)

Coronavirus - CHFT Intranet (cht.nhs.uk)

A round up of other services available is as follows:

- **Care First**. Support when you need it the most – 24hrs a day, 365 days a year. Whatever you need support with, whenever you need it, Care First can provide confidential advice, guidance, help and support. Call free on 0800 174 319 or use their online lifestyle portal here. Username: cht and Password: cht4321
- **Samaritans** – 24/7 listening support for the stressed, distressed, or suicidal plus signposting to specialist services. Call free on 116 123
- **24-hour mental health support line**. For residents of Calderdale, Kirklees, Wakefield, Barnsley & Leeds. Call free on 0800 183 0558
- **FRONTLINE** – national NHS service offering staff health and wellbeing support advice and signposting to other services. 24/7 support by text. Text FRONTLINE to 85258 or call 0300 131 7000 between 7am and 11pm any day of the week.

- **Friendly Ear** – Listening service for all CHFT colleagues. Offering support and signposting to self-help resources and specialist support services. To book a call contact Wellbeing@cht.nhs.uk (Available Mon-Fri 9:00-5:00, if outside of these times please call Care first on 0800 174 319 who are available 24/7/365)
- **Frontline 19** – free confidential psychological support service for NHS staff and other health emergency and social care workers in the UK. To arrange support from an experienced therapist, visit www.frontline19.com
- **Nurse Lifeline** - the listening service, here for you. Free, confidential, UK-wide and peer-led, space to offload and decompress and chat with another nurse or midwife who gets it. Available Monday- Friday 7pm- 11pm. Tel: 0808 801 0455 or see their website

All colleagues should be encouraged to complete the health and well-bring questionnaire available on the intranet

Health and Wellbeing Risk Assessment - CHFT Intranet (cht.nhs.uk)

Managing absence

The Trust's Adverse Weather Policy will be followed at all times to ensure that there is consistency across the organisation in the event that severe winter weather causes staff to be later, absent or work excess hours.

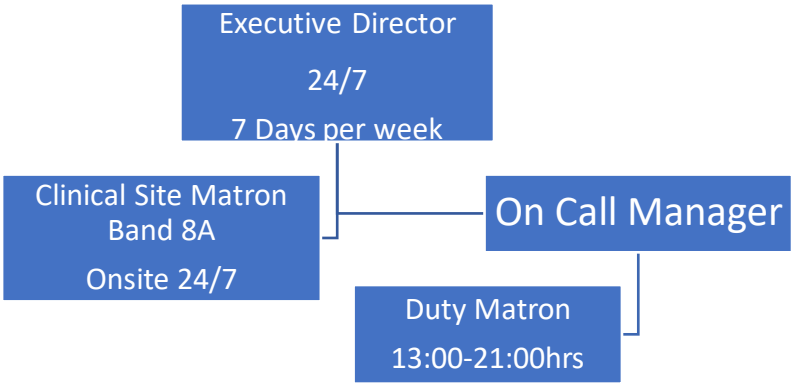
In the event that essential staff have difficulty getting to work and there are no alternate travel options, including car sharing or public transport, it may be possible for the hospital transport team to collect staff from their homes. Where staff have difficulty getting home from work and there are no other options hospital provided transportation is also an option. It may also be possible to provide additional staff overnight accommodation. Requests for additional hospital transport services or accommodation should be made by a matron or general manager to the General Manager of Operations and Facilities.

The adult community nursing team work flexibly in winter. Healthcare workers visit patients closest to their home address and are able to work from an alternative location that is closer to their home address.

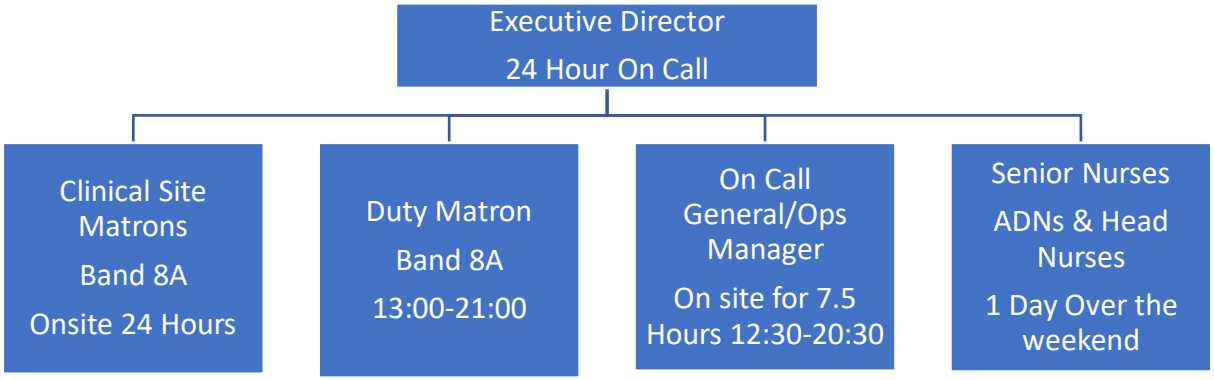
10. Operational Structure

There will be a Divisional support for winter to support the patient's journey, ensuring safe effective admissions, transfers and discharge on a daily basis. On top of these people in the division there will be 24 Hours cover on site. These teams will provide clinical and operational expertise. There will also be a duty matron present on site 7 days per week.

Monday-Friday



Saturday and Sunday



Reducing Admissions

Same Day Emergency Care in medicine and medical admission avoidance will be available on each hospital site to prevent avoidable medical admissions. Same Day Emergency Care for Frailty will be in place with in-reach in ED at HRI. Same Day Emergency Care in Surgery will be available on the HRI site with dedicated additional surgical registrars on specific days over the Christmas and New Year period.

11. Divisional Winter Plans

CHFT's Divisional teams have prepared their winter plans through analysing their expected demand, using the new bed modelling tool tracking assumptions against their business plans and understanding the impact transformational work is having.

Medical Division Winter Planning

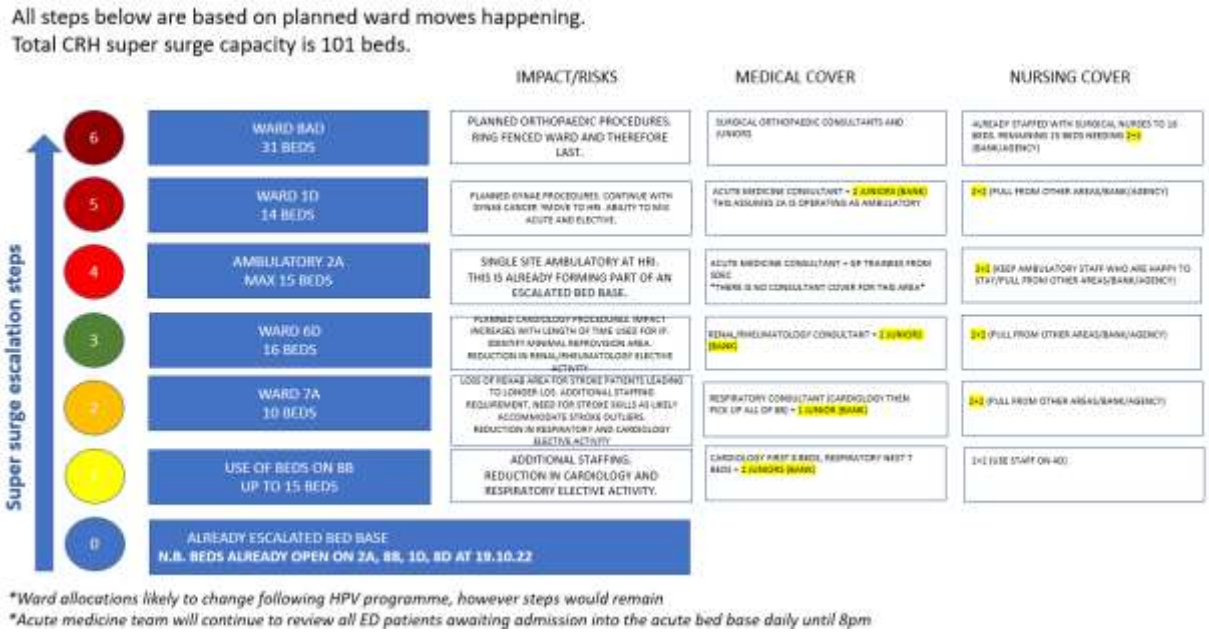
The medical division will endeavour to maintain its usual bed base during winter pressures by:

- Focusing on the reason to reside list- a new Lead nurse will work with medical matrons, medical wards and medical consultants alongside community colleagues to reduce length of stay across the hospital.
- Admission avoidance.

- Working with community services and partners to expedite discharges.

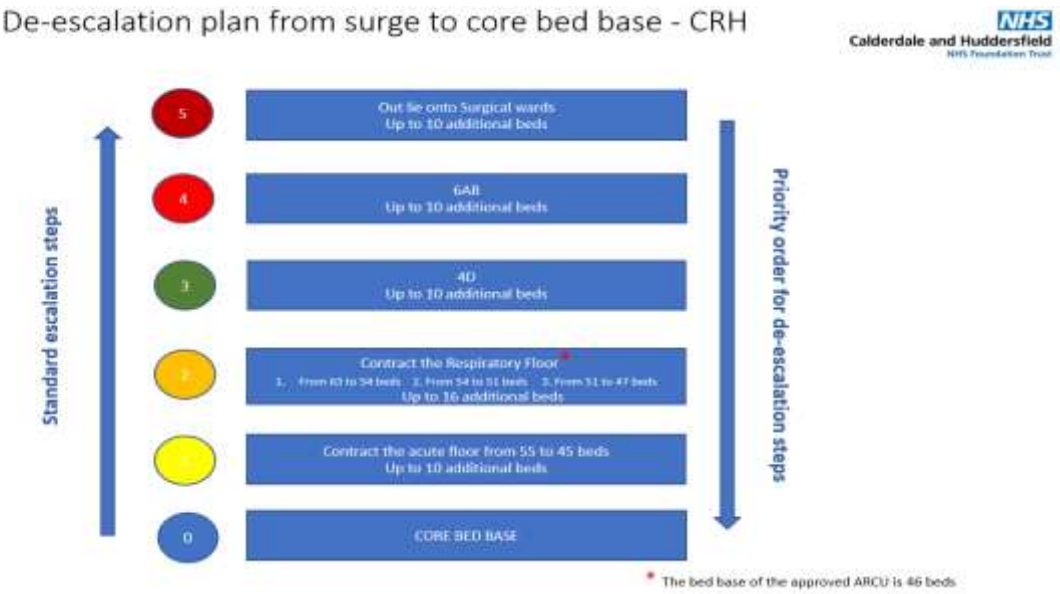
However should surge be required this will be done in the following way:

Super Surge Capacity CRH

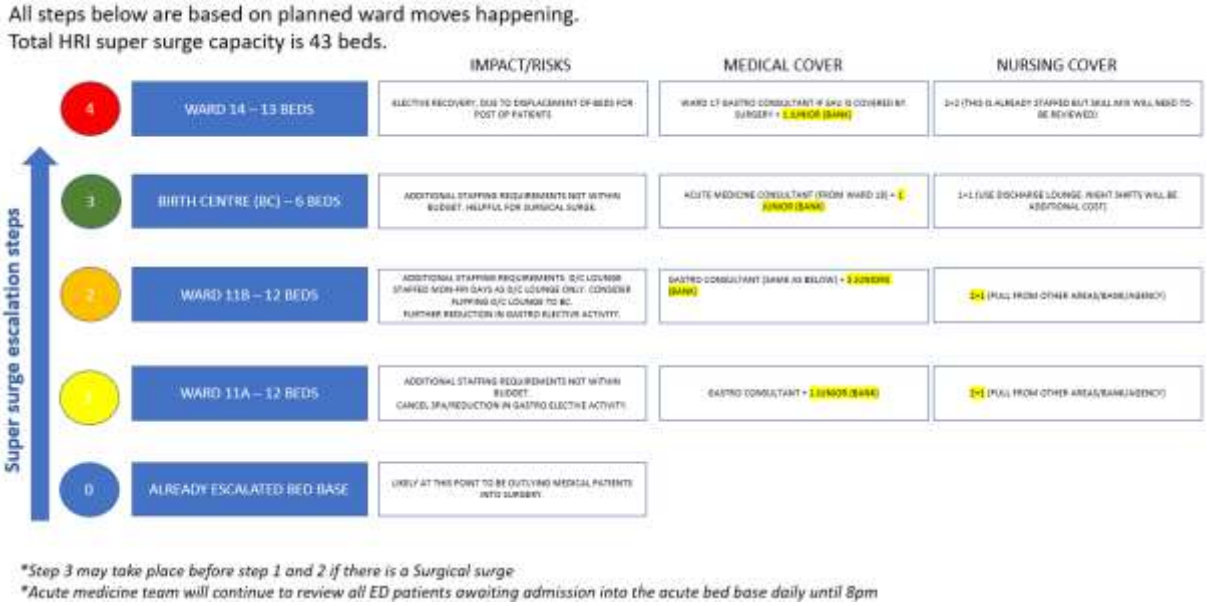


**Ward allocations likely to change following HPV programme, however steps would remain*
**Acute medicine team will continue to review all ED patients awaiting admission into the acute bed base daily until 8pm*

De-escalation CRH

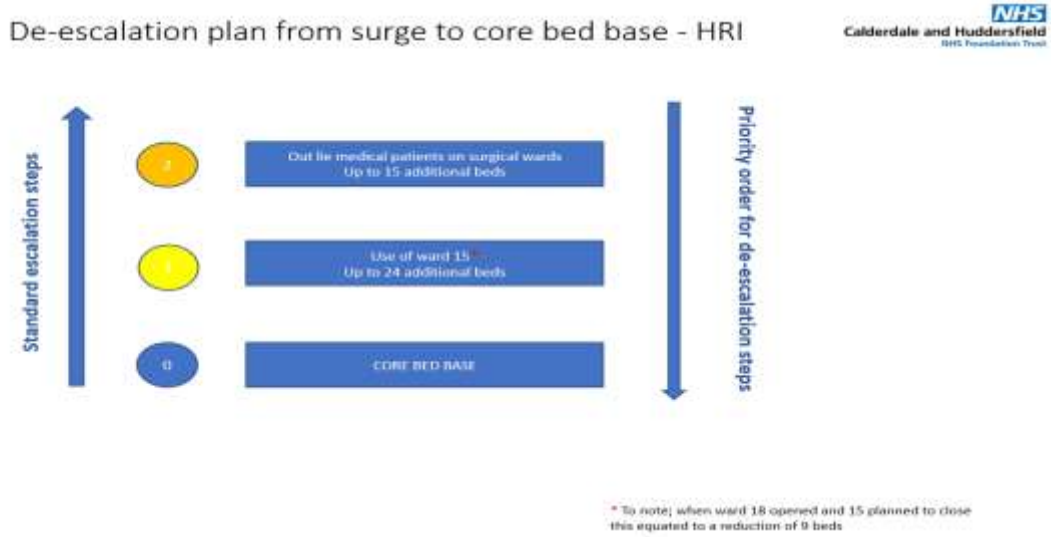


Super Surge Capacity HRI



**Step 3 may take place before step 1 and 2 if there is a Surgical surge*
**Acute medicine team will continue to review all ED patients awaiting admission into the acute bed base daily until 8pm*

De-escalation HRI



* To note; when ward 18 opened and 15 planned to close this equated to a reduction of 9 beds

Directorate specific plans

Acute Directorate

- Frailty SDEC
  Ward 3 HRI 8am-Midnight Monday to Friday

SDEC ED PATHWAY - FINAL.docx

SDEC Criteria Second Draft.pdf

- Virtual Frailty Service-dedicated phoneline directly to geriatricians.

- Admission avoidance 10am-6pm Monday to Friday in ED at CRH.
  Admission avoidance available afternoons Monday to Friday in ED at HRI
  Extra consultant booked for October/November/December.

Emergency Care Directorate

- Introduction of a Social Distancing RAG rating escalation tool for the Emergency Department to be escalated into tactical meetings.


Escalation Protocol CRH Amber ED.docx


Escalation Protocol CRH Green ED.docx

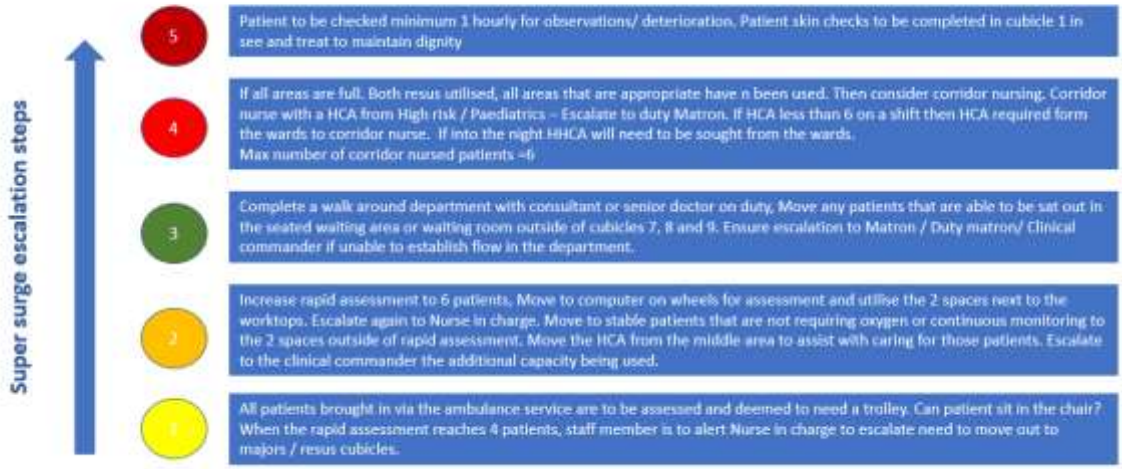

Escalation Protocol HRI Amber ED.docx


Escalation Protocol HRI Green ED.docx

- ED Escalation level tool to feed into the Site Management Meeting

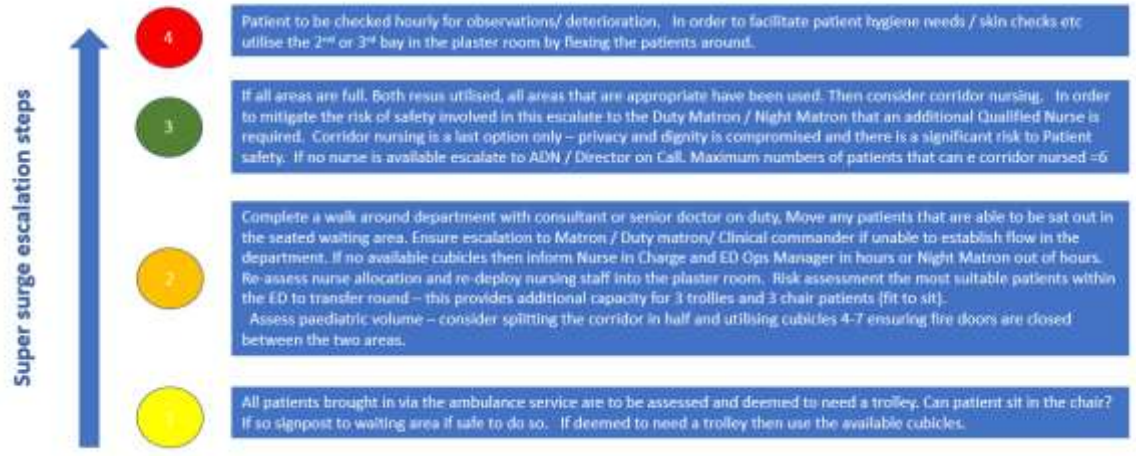
	GREEN	AMBER 3 OR MORE	RED 2 OR MORE	BLACK 3 OR MORE IN RED
PATIENTS IN DEPT	<35	35-50	>50	
ARRIVALS/HOUR	<15	>15	>25	
TRIAGE TIME	<15 MINS	15-30 MINS	>30 MINS	
AMBULANCE	<15 MINS	15-30 MINS	>30 MINS	
RESUS	>2 SPACES	1 SPACE	0 SPACES	
CUBICLES	3+ SPACES	<3 SPACES	0 SPACES	
TIME TO DR	<1 HR	>1 HR	>3 HRS	
BED WAITS	<3	>3	>5	
MEDICAL STAFF	FULL	1 DOWN	2+ DOWN	
NURSING STAFF	FULL	2 DOWN	3+ DOWN	
INVESTIGATION RESULTS	<1 HR	>1 HR	RESOURCE UNAVAILABLE	

Winter 2022 Super Surge ED Capacity – HRI – INTERNAL ED



- There will be continual monitoring of the situation with escalations to the site matron and tactical meetings, with silver and gold meetings established where necessary.
- ED waiting room
  Options if more patients in waiting room than there is capacity for seating given social distancing:
  - Physiotherapy corridor area
  - Support needed from other areas

Winter 2022 Super Surge ED Capacity – CRH INTERNAL ED



- There will be continual monitoring of the situation with escalations to the site matron and tactical meetings, with silver and gold meetings established where necessary.
- ED waiting room
  Options if more patients in waiting room than there is capacity for seating given social distancing

- Orthopaedic area main waiting room area

Medical Specialities Directorate

- Respiratory Floor to remain on 4 pods
  5ab - Low risk pathway

  5c - Flex ward for Covid capacity

  5d - Covid Positive Ward

The respiratory floor will flex between 47 and 63 beds and will deliver CPAP for patients not requiring or not appropriate for full ventilation.

- Respiratory Ward Standard Operating Process will be in place.
- Direct pathway in place so COVID positive patients can go directly to the respiratory floor from the Emergency Department.
- Respiratory Hot Clinics will be introduced for both Calderdale and Kirklees patients so that patients can be sent home to return to a clinic within 24 hours.

Surgical Divisional Plans

The Surgical Division has developed plans to be able to respond to increased non-elective demand.

Critical Care

- The escalation plan and standard operating procedure for the demand for critical care exceeding capacity ICU is at Appendix 9 (to include when summarised)

Trauma & Orthopaedics

- In addition to current planned trauma lists, additional increases in demand will be delivered by following the Trauma Surge Pathway in Appendix 10.
- 4 Additional Trauma 2 lists available which in turn can be flipped to a 2nd acute theatre supporting all specialities.
- Acute fracture clinic referrals direct from ED for Consultant led treatment for patients with confirmed fractures are in place maximising virtual fracture clinics.
- Improved access to theatre will reduce pre-op bed days and overall LOS for some Minor/intermediate and complex trauma. Performance will continue be monitored regarding delays to theatre
- An additional plaster room and adjoining clinic room capacity for fracture patients will be advantageous to T&O and this is now being sought.
- Continue with the SDEC streaming from ED triage, maximise SDEC pathways, extended opening plan currently being written.
- The elective inpatient orthopaedic surgery at CRH will continue as per the Phase 3 planning.

General and Specialist Surgery

- Current medical workforce on SAU will be increased with an additional middle grade to maximise reviews, ambulatory care and reduced length of stay.
- The elective inpatient surgical theatre capacity at HRI will continue as per the Phase 3 planning due to the ringfenced 'green' nature.

Inpatient Length of Stay

The Reason to Reside work is integral in reducing length of stay within all specialties and maximise community pathways with a particular focus on T&O.

Where there is a surge in demand for surgical beds then the divisional plan would be enacted:

- All GM's, Ops managers and matrons are deployed to support ward discharges
- GM's to contact consultants to ensure senior reviews have taken plan
- Using the reason to reside list, to ensure the 'medically fit' are reviewed and progressed to discharge
- Non-essential meetings would be stood down
- Ensure senior representation at Flow meetings and tactical command

Cancer Pathway and Elective Pathway

The cancer agenda and targets will be maintained throughout winter. Elective surgery and cancer have rarely been cancelled due to bed pressures previously and this will continue to be the standard we adhere too. Attendance at MDT's and performance will be maintained over Christmas time and throughout winter. This will be managed by authorisation/monitoring of the number of consultants that are off at any one time over this period.

Family & Specialist Services

There will be daily attendance in the Site Management Meetings of Operational management from FSS to support patient flow, support prioritisation of diagnostics during increased demand.

Paediatrics

1. During the winter period the Matron for the service continues to undertake a daily situation report during the week and will risk assess situations regarding staffing and activity on the Paediatric ward, to support and underpin this there is an Escalation Plan in place
2. Continued support to the paediatric stream in the Emergency Departments (ED) at peak times in both EDs and planned at Huddersfield Royal Infirmary
3. The Paediatric ward operates on a workforce model that accounts for surge during the winter period which strengthens nurse staffing and leadership during the winter period with the plan to have a senior Nurse Band 6 and 7 working clinically across all shifts
4. The service has introduced rapid access clinic which will support reviewing some patients who had previously been seen in ED or referred via there GP to paediatric assessment.

5. From a medical perspective the following actions will be taken between Nov and Feb to support winter pressures: A new rota has been introduced that will ensure that there is a tier one and two doctors on Paediatric assessment to triage and manage flow.
6. The Consultant scheduled for Ward 4 HRI will cover in the morning and will if appropriate to undertake a virtual round of ward 4 patients by phone utilising EPR this will ensure they are available to help on the ward round on the Ward 3 CRH – to improve flow and timely discharge at times of peak activity.
7. Paediatric Escalation and Surge plan is attached in appendices of this document
8. APNP escalation can also be found in appendices of this documents

Neonates

Neonatal services work in partnership with Maternity services as part of a wider network that is managed by transport service Embrace

During the winter period the Matron for the service continues to undertake a daily situation report during the week and will risk assess situations regarding staffing and activity on the Neonatal unit to support and underpin this there is an Escalation Plan in place Appendix 5.

Gynaecology

During the winter period the activity theatre plan has been planned to ensure the surge in medical winter emergency activity is supported.
In addition, prior to transferring to ward 1D the patient must be assessed against essential criteria as outlined below

CRITERIA FOR MEDICAL TRANSFERS TO: - THE GYNAECOLOGY AREAS

Prior to transferring to ward 1D or GAU the patient must be assessed against essential criteria as outlined below.

If the criteria to outlie are not met please escalate to the Matron for Gynaecology, On Call Duty Matron or Night Matron as appropriate.

- Side room not required
- No acute delirium, confusion, disorientation
- Patient is not on the End-of-Life Care Pathway
- Minimal risk of falling
- Minimal assistance required with mobility
- For patients requiring reablement, intermediate or 24-hour care section 2 physio and OT referrals must have been completed
- NEWS within expected limits
- Patient does not require specialist nursing skills i.e. Nippy, peg feeds, unstable cardiac symptoms, unstable diabetic, active seizures, probable CVA
- Patient with a known ongoing complaint/ grievance must have Senior review to assure that a move is in the best interest of the patient
- Patient has not been admitted with a diagnosis of long-term substance misuse (eg alcohol or drugs)

Maternity

Maternity will need to continue to provide essential services in line with NICE/RCOG guidance.

- During the winter period the Clinical Managers / Matrons for the inpatient and Birth Centre services continue to undertake a daily situation report during the week and will risk assess situations regarding staffing and activity throughout the Maternity Unit. This may happen more frequently dependant on the initial sit rep report.
- The Clinical Managers / Matron for community will also review staffing/acuity on a daily or more regular basis as the need requires.
- If weather does not permit home visiting (particularly for postnatal care), the midwife is to contact the woman by telephone / virtual appointment to conduct a review of maternal and baby wellbeing.
- If an essential visit is required, the midwife / manager must undertake a full risk assessment and utilise the 4x4 service if all other options have been explored (i.e. staff members with 4x4's undertaking visit or transporting another member of staff – to go in 2's)
- On call midwifery staff should ensure their vehicle is in a place where easier access is enabled.
- On call midwifery staff should follow the loan worker policy and alert the LDRP Coordinator of being called out and ascertain if safe to do so.
- There is an Escalation Plan in place – see appendix 4 that provides information for steps to take dependant on staffing and acuity levels which winter may affect. Escalation Plan can be found on the intranet here: https://documentation.cht.nhs.uk/uploads/715/April%202022%20NEYMaternity%20Escalation%20Policy%20%20Operational%20Pressures%20Escalation%20Levels%20Framework.pdf

Radiology

There is a central contact point for in-hours escalation of specific issues – contact details are available to flow teams.

A second on-call system for the Emergency Department X-ray will enable extra capacity OOH during periods of exceptional demand throughout the winter period (November to March); triggers will be agreed with the ED team.
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Pathology

Urgent blood sciences results will be available within 60 minutes of receipt in the laboratory. For any escalation of urgent results please contact Haematology or Biochemistry on the relevant site.

In the circumstances of increased demand in the laboratory due to COVID or any other outbreak the service will be flexible to support demand.

Pharmacy

Pharmacy staff will work with medical and nursing staff to prioritise supply of medicines for discharge.

Wards should identify patients due for discharge on all ward areas as soon as possible, and e-discharge should be sent to pharmacy in a timely manner so that these can be processed quickly. Where possible, discharge prescriptions for patients who have monitored dosage systems (MDS) should be sent to pharmacy the day before discharge.

Pharmacy and nursing staff should identify patients who already have sufficient supplies of medicines at home before a request is made for a supply for discharge, which will enable pharmacy to dispense items which are genuinely required more quickly.

At HRI the Safari discharge team can help write and prescribe TTOs and can be contacted by the following 07503981265. On the Acute floor there is an enhanced pharmacy service covering 8am-6pm 7 days per week who can also assist with prescribing TTOs and medication supply.

If any medication is required urgently and pharmacy is closed, if this medication is not available in the Out of Hours emergency medicines cupboard, then the on-call pharmacist should be contacted,

Community Division

Discharge Team

- There is daily huddles Monday to Friday with both local authorities at 9am each morning to discuss all patients on the TOC list and escalate as appropriate where there are delays and no progress. There is an internal CHFT meeting around discharges that the discharge team will attend at 12 each day Monday to Friday.
- Working hours will be reviewed daily as part of the huddle and extended as required. Staff will work flexibly to support the service.
- A representative from the discharge team will attend 12:30pm tactical meeting Monday to Friday.

Contacts for the Discharge Team

Eleanor Speak – Clinical lead (Weds-Fri)	07769300408
Andrea Liqourish – Clinical lead (full time, starting in service 5th Dec 2022)	TBC
Christine Bentley – Discharge Sister (part time)	07766905534
Rachel Crowther – Discharge Sister (full time)	07469125526

Priority 1 Clinical Services

The following services have been deemed as **Priority 1 Clinical Services:**

- District Nursing priority one patients(complex wound care, blocked catheters, administration of medications, OPAT and palliative care)
- Administration of medications including IV therapy and syringe drivers
- Palliative Care
- UCR
- Intermediate Care bed base/ Discharge to Assess Beds
- Reablement
- Palliative care priority one patients
- Gateway to Care
- Quest Matron support to Care Homes
- Community Respiratory Service
- Community Heart Failure Service
- Home Enteral Feeding
- Community Matrons
- Community Rehabilitation Team

Community Services Available

Gateway to Care

Gateway to care is a hub for health and social care and can take referrals provide advice for professions, patients and public.

Hours of Operation	8.45am-5.30pm Monday to Thursday and 8.45am-5.00pm Friday
Contact Details	01422 393000

Intermediate Care

The intermediate care service is delivered by an integrated partnership of health and independent care home provider, ensuring a multi-disciplinary approach to care. Care is provided in one of our bed bases:

Brackenbed View (15 beds) and 5 additional beds for Winter (location to be confirmed but will be outside of Brackenbed View).

The Service Aims to:

- Promote a faster recovery from illness
- Prevent unnecessary presentation and admission to an acute hospital bed
- Prevent premature and unnecessary admission to long term care
- Maintain independence as long as possible

Service Criteria:

- Service user/patient must be over 18 years of age
- Medically stable
- Be able to consent to referral

- A resident of Calderdale or Registered with a Calderdale GP
- Consent to rehabilitation
- Have an active rehab goal where it is expected that they will achieve this goal in a 6-week period.
- They must require a bed base at this time – if needs can be managed at home, an individual should be referred to a home-based service such as Reablement or package of care.

Hours of Operation	24 hours a day, 7 days a week
Referrals Accepted	Via Gateway to Care (in-hours) and via Crisis Intervention Team (weekends)
Lead Manager	Stef Walker
Contact Details	07471517082 (CHFT therapy team clinical lead)

Heatherstones provides temporary accommodation for adults for up to 6 weeks and facilitates early discharge, or prevents the need for admission to hospital, residential or respite care. The service is most appropriate for people who want to live independently but need short-term alternative accommodation or short-term help and support to achieve this.

The service aims to reduce individuals' dependency and reliance on direct services and prevent their level of need from increasing with people returning to their own home with the confidence and level of care required to enable them to cope long- term. Residents are expected to cook their own meals and do their own shopping and laundry. Reablement assistants provide support where needed.

Hours of Operation	Monday to Sunday 8.00am – 9.45pm 7-day service
Lead Manager	Nicola Gayle
Contact Details	01422 392229

Reablement

The Reablement service provides therapeutic care and support; with therapy care plans provided by CHFT community therapy team and then delivered by social care reablement staff. Access to reablement is via Gateway to Care following an assessment by a social worker.

Reablement is offered for up to 4 visits a day for a period of 6 weeks with the aim to increase function and reduce dependence. If care is required following a period of reablement, a care package will be commissioned and a means test assessment will be undertaken to determine what financial contribution will be required by the individual.

Hours of Operation	8.00am-9.00pm, 7-day service
Lead Manager	Tracey Proctor (Council) Emily Sutcliffe (CHFT therapy
Contact Details	07748 797896 (Tracey) 07826535497 (Emily)

Reablement Team	**Allocator**	**Contact number**

Lower Valley	Julia Green	01484 728943
Upper Valley	Karen Willows	01422 264640
Central	Jo-Anne Rice	01422 383584

Urgent Community Response Team

Urgent Community Response Team will provide support to someone in crisis in their own home for up to 72 hours. For example if someone is struggling in their own home after a fall, or discharge from hospital where packages of care cannot start immediately. They also assess suitability for intermediate care beds. They are a responsive service and will assess within 2 hours for urgent referrals and 24-48 hours for routine referrals.

The team consists of ACPs, Specialist Practitioners (nurses and therapists with blurred boundary training) – response times are between 2hr and 24hrs dependent on the referral that is made. Rehabilitation assistants in the team offer up to 4 visits a day for a period of 72 hours with the aim to increase function and reduce dependence. If further reablement is required after 72 hours, the locality reablement teams continue the care. The aim will be to respond in 2 hours. The Independent Living officer team work for CHF on behalf of the council and complete assessments and rehab with patients who are not suitable to move on to reablement and where a long-term care need is identified.

Referrals are made via Local Care Direct for ACP support and urgent 2hr calls. Referrals can also be made directly to service for example when support is needed for hospital discharge.

Hours of Operation Assessors	8.00am–7.00pm 7 days a week
Reablement Service Work	8.00am-9.00pm 7 days a week
Lead Nurse	Susan Johnson
Contact Details	01422 307333/07917 106263

End of Life Out-of-Hours Team

This is collaboration between Overgate Hospice, Marie Curie and CHFT. This small team provide crisis support to people out of hours who are near the end of their life. The Specialist Palliative Nurse supports the person with symptom control, physical and emotional support and works with a Marie Curie Support Worker. They provide support to the person, carers and families.

Hours of Operation	7-day service
Lead Nurse	Abbie Thompson
Contact Details (9am-5pm Mon-Fri)	01422 310874
Contact Details (Out-of-Hours)	07917 106263 Out-of-Hours Service/ 01422 379151

OPAT/ IV Therapy

This team provides antibiotic intravenous therapy to patients in their own homes and in the care home setting. Patients remain under the care of their Physician or

Consultant. This prevents some admissions and certainly reduces the LOS for many more.

- Patients have to be medically stable. Need to be under consultant referrals
- Commissioned for 12 administrations a day
- Compatible drugs need to be administered within 30 minutes

Hours of Operation	7-day/24-hour service
Lead Nurse	Jayne Woodhead
Contact Details	07795 825106

Community Nursing Services

District Nurses visit housebound patients that have complex health care needs. Patients that are able to be transported are expected to attend treatment rooms.

Hours of Operation	7-day/24-hour service
Contact Details Core Hours (8am-6pm)	01422 652291
Contact Details Evening/Night/Weekends(6pm-8am)	07917 106263

Only **priority 1/urgent patients** are seen at night i.e. palliative care requiring symptom management, blocked catheters and patients requiring prescribed medication at agreed intervals.

Quest for Quality Service

CHFT has a well-established multi-disciplinary team consisting of community matrons, pharmacist, therapist and consultant geriatrician who caseload residents in all residential and nursing homes in Calderdale. The team's main role is to reduce the number of calls made to general practitioners to prevent avoidable admissions. They use Telecare and Tunstall Telehealth to promote health and wellbeing to the residents within the care homes. Throughout the COVID-19 pandemic an enhanced service was implemented. This enhanced service is being commissioned to be in place permanently.

The team have a responsive function to the care homes dealing with calls that would have been received by a GP and managing the residents. They also provide support to the care home staff to better manage their residents through training and education. Every Care Home will have a named GP.

The pharmacist role has greatly helped with reviewing patient medication, reduction in polypharmacy and education and training of care home staff.

Hours of Operation	9am-6pm, 7 days a week
Lead	Emma Vant
Contact Details	07795061342

Community Matron Service

Community Matrons provide a service to people with Long Term Conditions (LTC) who have complex health and social care needs which without effective case management are likely to result in the individual having repeated and avoidable hospital admissions and increased lengths of stay in hospital and frequent contact with primary care services.

They are based in localities with District Nursing Teams.

Hours of Operation	8.30am-4.30pm, Mon-Fri
Lead	Louise Byrom 07919057419

Locality	Base	Matron	Contact Details
Upper Valley	Todmorden Health Centre	Kim Scarlett	07833353162
Lower Valley	Church Lane Surgery	Louise Watson Kay Foley Sarah Jenkins	07717347547 07795603605 07464493519
South Halifax	Elland and Allan House	Rachel Bulmer Katie Berry	07795825215 07789944447
North Halifax	Beechwood	Louise Nattrass	07795825199
Halifax Central	Lister Lane	Sheryl McGinn Vicky Leah	07769365247 07768207674

Specialist Nursing

There are a range of specialist nursing services that support people in community settings.

Service Area	Hours of Operation	Lead Nurse	Contact Details
Bladder and Bowel	7.00am-4.30pm Mon-Fri	Joanne Hoyle	01422 252086
Respiratory	8.30am-4.30pm 7-days/Week	Gareth McMahon	01422 835195
Heart Failure **Cardiac Rehab**	9.30am-5.30pm Mon-Fri 7.30am-4.30pm Mon-Fri	Clair Jones	01422 224260
Parkinson's	9.00am-5.00pm Mon-Fri	Gloria Tizora	07831120229
TB	9.00am-5.00pm Mon-Fri	Mary Hardcastle	07824 343770
Lymphoedema	9.00am-5.00pm Mon-Fri	Katherine Stubbs	01422 350755

Respiratory Team

During the winter period the Respiratory team will increase their working hours until 8pm and double capacity at the weekend to have two members of staff instead of one. This will enable the team to provide further focus upon key services offered to reduce pressures on the hospital:

- ESD – facilitating patients going home as soon as possible with support from the respiratory team 7 days a week
- Admission avoidance from ED 7 days a week, 9am-8pm and will also support Kirklees residents to be discharged directly from ED into locala services
- Crisis management for community patients via the SPA. Direct telephone access for patients 7 days a week
- Admission avoidance from the community 7 days a week

Hours of Operation	8.30am-4.30pm 7 days a week
Lead Nurse	Gareth McMahon
Contact Details	01422 835195

Cardiac Rehabilitation Services

There will be increased capacity which will support extended working hours Monday – Thursday supporting the Cath Lab. This will allow the team to facilitate earlier discharges. When the Cath Lab sessions are scheduled for Saturdays this will be mirrored by the team facilitating patient flow. In focusing upon facilitating earlier discharges this would also allow the team to offer Cardiac rehab at the weekend which could reduce readmissions.

Early Supported Discharge for Stroke

This team provides support to enable patients who have had a stroke to be supported at home to reduce length of stay and increase function by facilitating people to be as active as possible. An enhanced service will be in place from November as part of the innovation scheme plans.

Hours of Operation	8.30am-5.00pm Mon-Fri
Lead Therapist	Sally Grose
Contact Details	01422 358146

Therapy Services

Therapy services provide interventions across in-patient, intermediate care and Community Services and will work flexibly across all areas to provide support where pressures manifest during the winter period.

Lead Manager	Debbie Wolfe 07825902363

Community Rehabilitation Team – Calderdale

The Community Rehabilitation Team covers the whole of Calderdale and see any patients with a rehab need and goal over the age of 18 years. This service is not an urgent response service and operates over Monday to Friday. The team cover a vast range of presenting complaints, diagnoses and reasons for referral. Referrals into the service can come from professionals or self-referrals from patients. The service

includes provision for Physio, OT, SALT, and dietetics. The team work closely together and have blurred boundary competency training where appropriate. This service sees the vast majority of patients in their own homes.

Hours of Operation	8.00am-5.00pm, 5-day service
Lead Therapist	Dave Nuttall
Contact Details	07785456582

Senior Managers in Community Healthcare Division

Senior Managers on-call rota, contact Calderdale Royal Switchboard on **01422 357171.**

Senior managers contact details are as follows:

Name	Role	Work mobile
Michael Folan	Director of Operations	07785416708
Helen Rees	Assistant Director of Finance/	07500761369
Liz Morley	Associate Director of Nursing	07747 630989
Jennifer Clarke	Associate Director of Therapies	
Debbie Wolfe	Head of Therapies and Service Manager for OP Physio, MSK, Podiatry, Orthotics, Speech and Language Therapy, Dietetics Children's Therapies	07825 902363
Caroline Lane	Head of Nursing	07713739144
Susan Scriven	Matron for Specialist Nursing	07770542879
Hannah Wood	Therapy Services Manager - Community	07584538456
Karen Turkington	Therapy Services Manager - Inpatients	
Nicola Glasby	Therapy Services Manager – Outpatients and Children's services	
Sarah Wilson	Matron District Nursing/Lymphedema & Wound Management	07557157096
AbbieThompson	Matron EOL	07747472125
Louise Byrom	Matron District Nursing/Community Matrons	07919057419

12. Severe Winter Weather

Overview							
Business Impact							
• Absence of staff because they cannot get to work • Difficulty for staff and patients to travel around and between sites • Difficulty for community staff to access patients homes • Increase in minor injuries from slips, trips and falls • Reduced patient transport service	**Impact**	**1**	**2**	**3**	**4**	**5**
	Likelihood					
	1					
	2				X	
	3					
	4					
	5					

• Difficulty discharging patients because reduced public transport, patient transport or impassable roads to their homes or other healthcare facilities • Difficulty for suppliers to get supplies to hospital
Proactive strategy
• Adverse winter weather plan in place and reviewed. • Weather forecasts and gritting information published on the local authority websites. • Stockpile of salt/grit for car parks and access ways to Hospital sites. • Access roads to CRH and HRI are on Local Council Highways Priority Gritting Routes. • Yorkshire Ambulance Service winter plan. • Secure contingency 4x4 vehicles through voluntary services to transport staff to and from their place of work. • Community staff advised to work to nearest location to their homes
Reactive strategy
• Implement flexible working arrangements where possible (adult community nursing) • Implement the joint surge and escalation plan • Contact Local Council Highways to request roads are gritted for essential appointments and discharges (this will not always be possible). • Provide accommodation for essential staff who cannot get home from work • Request that the hospital transport service collect essential staff and bring them to work (this will not always be possible)

Trigger	Received by	Immediate action
Met Office Cold Weather Alert	Estates/Associate Director of Urgent Care	• Cold weather alerts will be forwarded to members of the winter (surge) planning group for onward circulation to departments. • Clinical Site Commanders will assess the consequences for discharges • The Calderdale & Huddersfield Solutions have a planned process for maintaining the Hospital grounds. • Review by the outpatients and surgical management teams of impact on performance.
YAS PTS notification that journeys are affected or have been stopped	Clinical Site Commander	
Significant number of out-patient DNA	Outpatient manager	
Staff absence reporting	Department managers	• All members of staff should make an early assessment of travel plans during inclement weather. It is the responsibility of staff to exhaust every potential transport arrangement that will enable then to attend for duty. • Staff accommodation for inclement weather will be supported by the Trust as in previous years via the Accommodation Manager • All service areas will maintain up-to-date contact lists for all their staff • Managers will use the Trust's adverse weather policy and the carer leave policy to manage staff absence. • Staff will be reallocated according to service need.

Cold Weather Alerts

Alert trigger	Trust Actions
OPEL 1 Winter Preparedness	• Work with partner agencies to co-ordinate cold weather plans • Work with partners and staff on risk reduction awareness • Plan for a winter surge in demand for services • Identify those at risk on your caseload

OPEL 2 Alert and readiness (60% risk of severe weather)	• Communicate public media messages • Communicate alerts to staff and make sure that they are aware of winter plans • Implement business continuity plans • Identify those most at risk • Check client's room temperature when visiting
OPEL 3 Severe Weather Action	• Communicate public media messages • Activate plans to deal with a surge in demand for services • Communicate with those at risk regularly • Ensure that staff can help and advise clients • Signpost clients to appropriate benefits • Maintain business continuity
OPEL 4 Emergency Response Exceptionally severe weather of threshold temperatures breached >6days	• Activate emergency management arrangements • Communicate public media messages • Activate plans to deal with a surge in demand for services • Communicate with those at risk regularly • Ensure that the hospital sites are kept clear and accessible • Maintain business continuity

Road Clearance

In the event of severe winter weather requiring roads to be cleared of snow and ice Kirklees Council will clear the pavement outside HRI to the boundary of the hospital site as part of its planned snow clearance operations. Acre Street and Occupation Road are on priority gritting routes. The access roads to CRH (Dryclough Lane, Godfrey Road, Dudwell Lane and Huddersfield Road) are all on priority gritting routes. Information on the priority gritting routes can be found at:

http://www2.kirklees.gov.uk/winterUpdates/default.aspx
http://www.calderdale.gov.uk/transport/highways/winter-service/index.html

There may be occasions in severe winter conditions where the hospital requires urgent deliveries such as medical gases and the site road access is impassable. In these situations the Local Councils may assist with road clearance where possible.

Kirklees Council will be operating "gritter twitter" this winter which gives real time information on the council's response to the winter forecast. This information can be used to plan journeys and has been used by schools to assess whether or not to open. The link to twitter can be found at the Kirklees Council weblink above. Calderdale Council regularly update their website with information about planned gritting routes during periods of severe weather.

Kirklees Council will do what is possible to help ambulances with gaining access to patients that require urgent treatment / transport to outpatient appointments and

hospital discharges. Examples of urgent outpatient treatments include renal dialysis and administration of drugs for life threatening conditions. Any assistance will be on the basis that the hospital confirms that the situation is urgent. Kirklees Council Highways can be contacted 24hours a day on 0800 7318765. Any Trust patient phoning the council to ask for help will be directed to contact the relevant hospital department. The hospital department will inform the patient flow team who will be responsible for liaising with Kirklees Council Highways.

Calderdale Council Highways commit to responding to requests from the emergency services only but may be able to assist in the event of an urgent request from the Hospital to grit a particular highway. The Calderdale Council Highways can be contacted via the Street Care / Customer Care number 0845 2457000.

Transportation 4x4

Roads that are impassable to cars due to ice or heavy snow are sometimes accessible to four-wheel-drive vehicles. In the event of disruption to public transport at difficulties in staff getting to work a 4x4 is on standby through Medevent. All requests must come through the Clinical Site Matrons.

The 4x4 should only be used if all other options have been exhausted and the staff member lives more than 3 miles away.

The following voluntary organisations in Yorkshire and the Humber also have access to 4X4 vehicles:

- St John's Ambulance
- British Red Cross
- Yorkshire 4X4 club (4X4 Response)
- Age UK

It is essential that community nursing teams are able to travel to visit service users in their homes. The adult community nursing team managers maintain a list of staff with 4X4 vehicles and ensure that the nursing teams have access to 4X4 vehicles in instances of severe winter weather.

The adult community nursing teams also work closely with Calderdale Council Adult Social Care to make best use of resources.

Equipment Ordering and Provision

Patients in the community may require equipment to keep them safe, assist daily living skills and improve mobility/function in their own home.

Physiotherapists, Occupational Therapists, Nursing Teams and the Crisis Intervention Team are regular referrers to access equipment. Equipment is arranged via the Loan Stores for Calderdale patients and the service is based at Unit 13, Ainley Top Industrial Estate, Ainley Bottom, Elland, HX5 9PJ.

Loan Stores Hours of Operation	8.00am-4.30pm Monday-Friday

	8.00am-12.00pm Saturday
Lead Manager	Andrew Mould
Contact Details	01422 261396

Escalation plans and business continuity plans

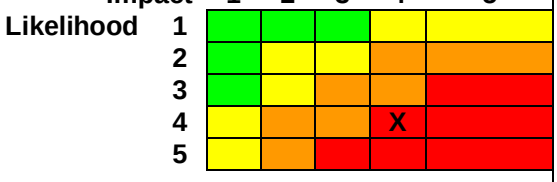
There are escalation plans that have been developed to support operations across all divisions. All escalation plans are found on the intranet.

Each clinical division has identified the critical patient services they provide. Directorates have undertaken business impact analysis to identify what service functions can be reduced or suspended and have developed business continuity plans that describe the process for reducing non-critical activity and using the capacity generated to sustain critical patient services. All Business Continuity Plans will be updated following learning from COVID-19 pandemic outbreak.

Useful contact information

Organisation	Contact Name	Telephone / Email
4X4 Response	24hr call out number	Available in Command Centre
British Red Cross		
Calderdale Council Highways		01422 288002
		OOH 01422 288000
Calderdale Council Emergency Planning Team		01422 393134
CHFT Accommodation		Via General Office
CHFT Hospital Transport Service		Via help desk
Kirklees Council Emergency Planning Team		01484 221000
Kirklees Council Highways		01484 414818
St John's Ambulance	24hr pager	Via switchboard

13. Seasonal influenza & Covid-19 Surge

Overview	
Business Impact	
• Absence of staff due to influenza illness and/or Covid-19 • Spread of the virus to staff due to ineffective use of personal protective equipment • Lack of available supplies of personal protective equipment • Increase costs of delivering care because of requirement of FFP3 masks and fit testing in some clinical areas	

<table>
<tr><td colspan="3">• Lack of available side rooms to isolate infectious patients
• Lack of available capacity on intensive care units to treat flu patients with serious illness
• Closure of ward areas and loss of bed days due to outbreaks of infection
• Increased monitoring and reporting requirements for flu-related activity</td></tr>
<tr><td colspan="3">Proactive strategy</td></tr>
<tr><td colspan="3">• Immunise staff for seasonal flu & Covid-19
• Community staff continue support people to stay at home
• Restate the risks and infection control requirements for managing flu patients
• Key messages reinforced by community staff
• Purchase additional supplies of face masks, gowns and goggles
• Create and manage a stockpile of FFP3 masks
• Fit test staff who may be required to use FFP3 face masks (medical, nursing and physiotherapy staff working in ED, ICU, Respiratory and MAU)
• Near patient testing in A&E for patients with suspected seasonal flu</td></tr>
<tr><td colspan="3">Reactive strategy</td></tr>
<tr><td colspan="3">• Promote key flu & Covid-19 messages for patients (if you’ve got flu, stay at home)
• Follow standard infection control precautions for managing flu & Covid-19 patients
• Reassign or redeploy staff in high-risk groups as appropriate
• Implement the joint surge and escalation plan
• Implement the escalation plan for critical care if required</td></tr>
<tr><td>Trigger</td><td>Received by</td><td>Immediate action</td></tr>
<tr><td>DH reporting - proactive</td><td>DIPC</td><td rowspan="3">• Alert forwarded by email rule to Director of Operations, Chief Nurse, Director of Infection Prevention and Control.
• Staff in the Emergency Departments and outpatient departments will remind relevant patients to have their flu & Covid-19 jabs if they have not already done so.
• Implement management of flu & Covid-19 arrangements.</td></tr>
<tr><td>Surge in flu related activity</td><td>ED matron/CD</td></tr>
<tr><td>Surge in flu admissions</td><td>Infection control team</td></tr>
</table>

Infection Control

There is an expected surge of patients with ‘flu’ and Covid-19 in 2022/23. Guidance through public health and CHFT internal IPC team including the lead clinician will be managed through the Pandemic Influenza Planning Group with all key partners within CHFT.

Point of care testing will be available in both EDs for both Covid-19 testing and flu testing, the testing and swabbing team will conduct these swabs 24 hours a day.

Patients who need isolating will have a respiratory isolation sign should be displayed on the side room door (further information on isolation of patients is available in the Isolation policy section K). All staff must wear personal protective clothing (PPE) when entering the side room. When performing aerosolising procedures staff must wear an FFP3 mask and eye protection. Transfer and movement of patients around the hospital should be kept to a minimum.

In the event that there are number of admissions with confirmed or suspected influenza it may become appropriate to cohort patients in a single bed bay or ward area. The IPC team will be instrumental in developing the operational plan when cohorting is required.

Some members of staff will be at greater risk from influenza because of a pre-existing medical condition or pregnancy. The risks to staff should already have been identified and managed through existing occupational health protocols

Personal Protective Equipment

Wards and departments should ensure that they have sufficient supplies of personal protective equipment including gloves, plastic aprons and surgical masks.

A central stockpile of surgical masks, thumb in loop gowns and eye protection is established on each site. The stockpile is managed by the materials management team and accessible to the relevant wards and departments.

FFP3 masks or the positive pressure hood are required for specific infectious diseases (MERS and by staff performing cough inducing procedures for patients with suspected or confirmed infectious condition spread via respiratory secretions. FFP3 masks must be worn when performing the following procedures:

- Intubation, extubation and related procedures (e.g., manual ventilation and open suctioning)
- CPR
- Bronchoscopy
- Surgery and post-mortem procedures involving high speed devices.
- Some dental procedures (e.g., drilling).
- Non-invasive ventilation (e.g., bi-level positive airway pressure and continuous positive airway pressure ventilation)
- High-frequency oscillating ventilation; Induction of sputum.

Staff performing these types of procedures will include staff in ED, theatre, respiratory ward, ICU, and the acute floors in addition to staff groups such as Anaesthetists, Intensivists, endoscopists and physiotherapists (chest). Many wards and departments stock these masks and the following wards are 'top up' areas:

HRI = SAU, acute floor, 18, ICU, Emergency Department

CRH = acute floor, 3, 5, ICU and Emergency Department

Fit Testing for FFP3 Masks

Prior to using an FFP3 mask the make/model and size of mask MUST be fit tested to the user to ensure a seal can be attained and the member of staff will be safe. Face masks come in various shape sizes so users can determine the most effective.

There are competent ‘fit testers’ in most clinical areas within the Trust who can carry out the assessment (register held on the intranet). Fit test kits are available from the IPC team for competent fit testers to use. It is the responsibility of the fit testers in each area to fit test their staff and to record the make model and size of mask that they require. Staff who have been fit tested are adding onto the equipment training database by the fit tester or the staff members manager.

Where a member or staff does not successfully fit test with the FFP3 mask used by the Trust, each management team must put in place appropriate risk mitigation measures to protect the member of staff from being exposed to a respiratory infection at work. This may involve:

- Training to use the positive pressure hood
- Reassigning to an alternative task

Positive pressure hood systems have been purchased for use in the emergency departments on both sites. Training is required prior to use by a competent user.

14. Christmas and New Year Bank Holidays

Staffing

The clinical divisions will have arrangements in place to ensure staff cover on the bank holidays over the Christmas, New Year period and the during this period when there is anticipated surge in emergency/acute demand. There will be senior divisional management cover over the Christmas and New Year period.

Reduced services

The Christmas and Bank Holiday arrangements for different services will be shared in the on-call pack which will be available in each Patient Flow office. Copies of the operational arrangements for theatres and clinical support services over the Christmas and Bank Holiday period will be again available for the on-call teams over the Christmas and New Year period.

Partner organisations

The Christmas and New Year cover arrangements for primary care, social care and safeguarding will be shared with the on-call teams for the Christmas and New Year period and stored in the patient flow offices on both CRH and HRI sites.

Communications

The Communications Team will issue media statements during winter to reinforce key health messages.

When there is a community outbreak of diarrhoea and vomiting a press release will be issued promoting basic hand hygiene and asking the public to stay away from hospital if possible because they risk passing on an infection to vulnerable patients.

Prior to the Christmas and New Year period a press release will be issued reminding the public them when it is appropriate to use primary care services rather than accident and emergency departments and to stock of home medicines cabinets prior to the holiday.

In the event of a significant infection outbreak the Trust communications team will work with Calderdale and Greater Huddersfield CCG to implement a media and communications strategy utilising key messages which will include advice for visitors.

Training and Implementation of the Winter Plan

The Divisional Director of Operations and identified leads for winter planning have overall responsible for ensuring that those with identified roles in the plan are familiar with the protocols set out in this document. This will be achieved by.

- Involvement of leads from each division in winter planning
- Discussion at the appropriate divisional committees
- Cascade of messages to key staff groups through email circulation and Trust news
- Publication of related documents on the Preparing for Emergencies section of the staff intranet
- Publication of the plan on the Trust intranet; and
- To improve capability and resilience in CHFT senior management/clinical teams there will be a number of Table-top exercises to test the winter plan.

Trust Equalities Statement

Calderdale and Huddersfield NHS Foundation Trust aims to design and implement service policies and measures that meet the diverse needs of our service, population and workforce ensuring that none are placed at a disadvantage over others. We therefore aim to ensure that in both employment and services no individual is discriminated against by reason of their gender race, disability, age, sexual orientation, religion or religious/philosophical belief or marital status.

Monitoring Compliance with this procedural document

The Deputy Chief Operating Officer and Divisional Director of Operations in collaboration with key service winter leads are responsible for the successful implementation and monitoring of the winter plan. The plan and its effectiveness will be reviewed throughout the winter period and learning shared and acted upon. The Urgent Care Board membership will also play a key role in the review process.

Associated Documents/Further Reading - Intranet

The Trust has a number of policies and plans that would be used in dealing with problems caused by winter conditions. They are both clinical and non-clinical and some are season-specific and others are for general use:
All can be found on the intranet- link
https://intranet.cht.nhs.uk/non-clinical-information/emergency-preparedness-resilience-response-local-secuirty-management-specialist/

a. Adverse weather policy
b. Pandemic influenza
c. Major Outbreak of Infection Policy

d. Emergency Management Arrangements
e. Escalation guidelines for the maternity units
f. Discharge Policy/Transfer of Care Policy

There are also some whole system plans that will be implemented as appropriate:
g. Joint Surge and Escalation & Winter Plan (2012/23 plan)

Appendices

APPENDIX 1
OPEL Scoring & Action Cards


OPEL Score.docx


OPEL Two Actions.docx


OPEL Four Actions.docx


OPEL One Actions.docx


OPEL Three Actions.docx

APPENDIX 2
Staffing OPEL Scoring & Actions


Staffing OPEL Levels.docx

APPENDIX 3
SOP/Checklist for opening and closing extra capacity


Checklist on opening additional beds.docm

APPENDIX 4
Medicine Super Surge Plan


Super surge plan - medicine v3.pptx

APPENDIX 5
Paediatric & Neonates Escalation Plan

20210803 NICU Surge and Escalatio

20210804 Paediatric OPEL and Suspensic

APPENDIX 6
Advanced Paediatric Nurse Practitioner Escalation Plan

2016__Sept__-_APN P_escalation_process

APPENDIX 7
Maternity Escalation Policy

Escalation Policy (Maternity).pdf

APPENDIX 8
Calderdale and Greater Huddersfield Winter Plan 2022/2023

Calderdale and Huddersfield Urgen

APPENDIX 9
ICU Escalation Plan

APPENDIX 10
Trauma Surge Pathway

HRI trauma surge pathway.docx

22. Guardian of Safe Working Hours Q1 and Q2 Report - Presented by Dr Shiva Deep Sukumar, Guardian of Safe Working Hours

To Note

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	10th November 2022
Meeting:	Board of Directors
Title:	Quarter 1 and Quarter 2 report (1 April 2022 to 30 September 2022) from the Guardian of Safe Working Hours, CHFT
Author:	Dr Shiva deep Sukumar
Sponsoring Director:	Dr David Birkenhead, Medical Director
Previous Forums:	None

Purpose of the Report

To provide an overview and assurance of the Trust's compliance with safe working hours for doctors/dentists in training across the Trust, and to highlight any areas of concern.

Key Points to Note

1. Increase in exception reports since August 2022 with the new cohort of trainees
2. Successful delivery of the presentation about Exception reporting at induction.
3. Information about cover arrangements for out of hours rota gaps

EQIA – Equality Impact Assessment

The opportunity to exception report is available for all doctors in training and Trust doctors on the 2016 Contract irrespective of any protected characteristics.

Recommendation

The Board of Directors is requested to **RECEIVE** and **NOTE** the report for the period 1 April 2022 to 30 September 2022 from the Guardian of Safe Working Hours.

Guardian of Safe Working Hours (GOSWH) Report - April - September 2022

Introduction:

The purpose of this report is to give assurance to the Board that the doctors in training are safely rostered and that their working hours are complaint with the Junior doctor's contract 2016 and in accordance with the Junior Doctors terms and conditions of service (TCS).

The report includes the data from April 2022 to September 2022. Ordinarily, the Board would receive a report every three months, however the previous Guardian of Safe Working Hours (GOSWH), Ms Devina Gogi left the Trust and was not able to present to the Board for April to June 2022. This paper captures data from two quarters, from April to June and July to September 2022.

The new guardian for the GOSWH role is Dr Shiva deep Sukumar from September 2022.

Executive Summary:

The Trust has used Allocate software since August 2017 to enable trainees to submit exception reports. All doctors in training and locally employed Trust doctors employed on the 2016 Terms and Conditions have an Allocate account. Educational supervisors and clinical supervisors also have access to this software.

The number of exception reports (ERs) shows that Foundation year doctors still account for the highest number submitted. This is a pattern that has been seen before and is due to several factors. For Foundation Year 1 (FY1) trainees that commence in August, this is their first experience of working in the NHS. They may take longer than colleagues to undertake some tasks, which, with practice will reduce time pressures. They are gaining an understanding of protocols and working practices and may initially be more reluctant to hand over jobs that have not been completed. It may also reflect the successful induction programme when exception reporting is discussed, and a presentation is given.

There are some ERs that remain on reports and show as unresolved, even though they have been discussed and the outcome has been agreed with the trainee. Despite repeated reminders (via email and telephone) by the GOSWH, some of these have not been closed on Allocate.

All our junior doctor rotas are fully compliant with the 2016 TCS. Rota gaps remain a challenge, when/where Health Education England do not provide a trainee, however a number of Trust doctors are recruited to cover wherever possible. Where there are out of hours gaps the flexible workforce team work to cover these shifts with bank/agency locums, with the junior doctor's cross-covering during the day.

High level Data:

Number of doctors / dentists in training (total): 260

Number of doctors / dentists in training on 2016 TCS (total): 260

Amount of time available in job plan for guardian to do the role: 2 PAs

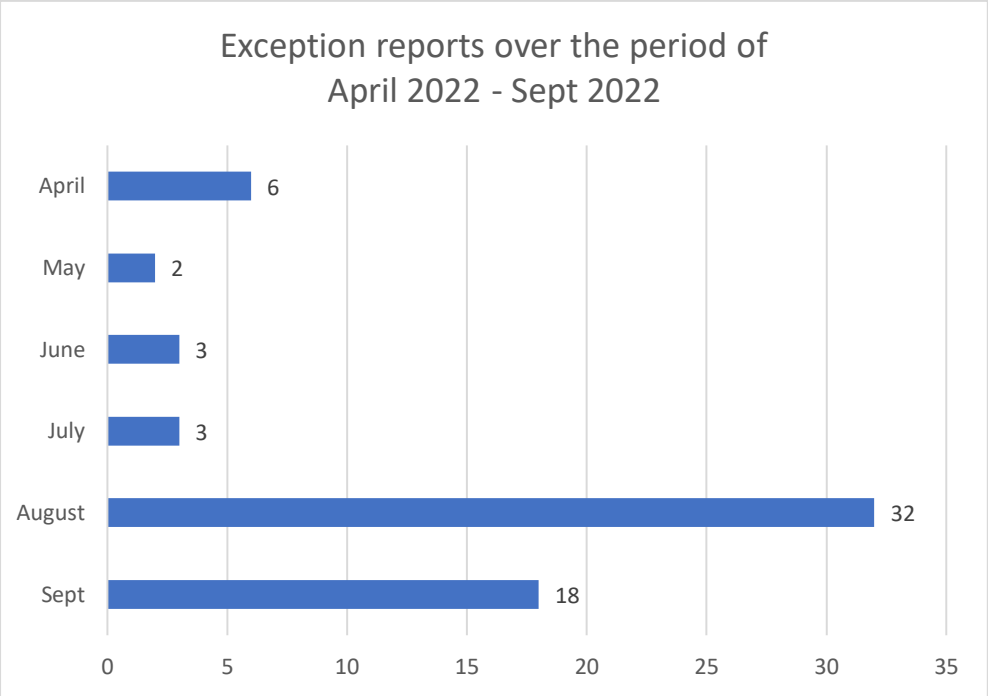
Administration support provided to the Guardian: The Medical HR team manage the payment for exception reports wherever this is agreed and create Allocate accounts for all those that need access. They also do initial prompts to clinical supervisors and educational supervisors regarding exception reports. There is a regular meeting scheduled with the GOSWH and the Medical HR manager for additional support if required. The Medical Education team manage the invites, agenda, and minutes for the quarterly Junior Doctors Forum meeting.

Amount of job-planned time for Educational Supervisors: 0.25 PAs (professional activities) per trainee as per Health Education England recommendations

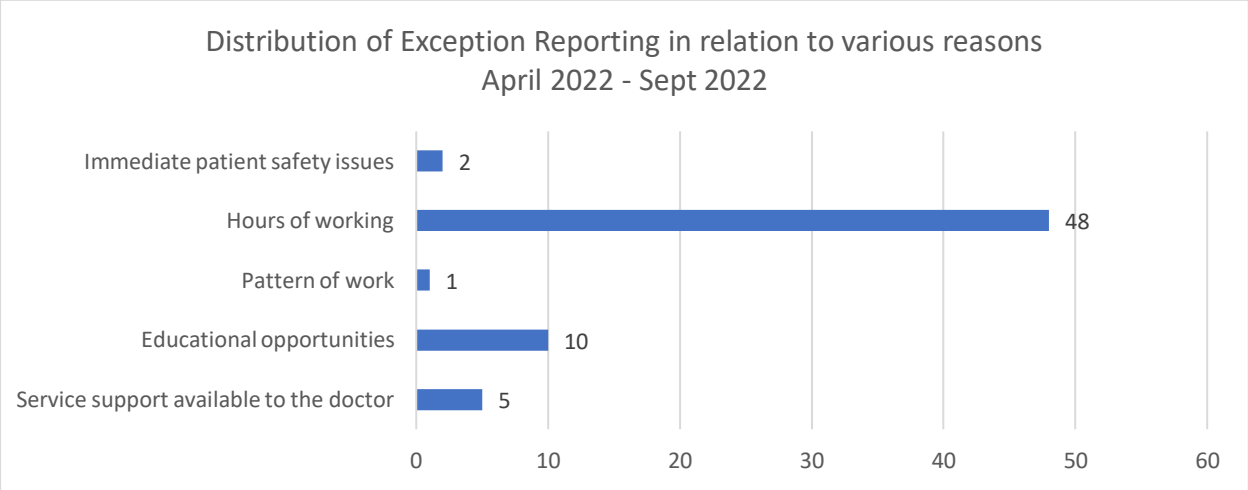
Job-planned time for Clinical Supervisors falls within core SPA (supporting professional activities)

A) Exception reports:

Exception Reports from April 2022 to Sept 2022



Distribution of exception reporting in relation to various reasons



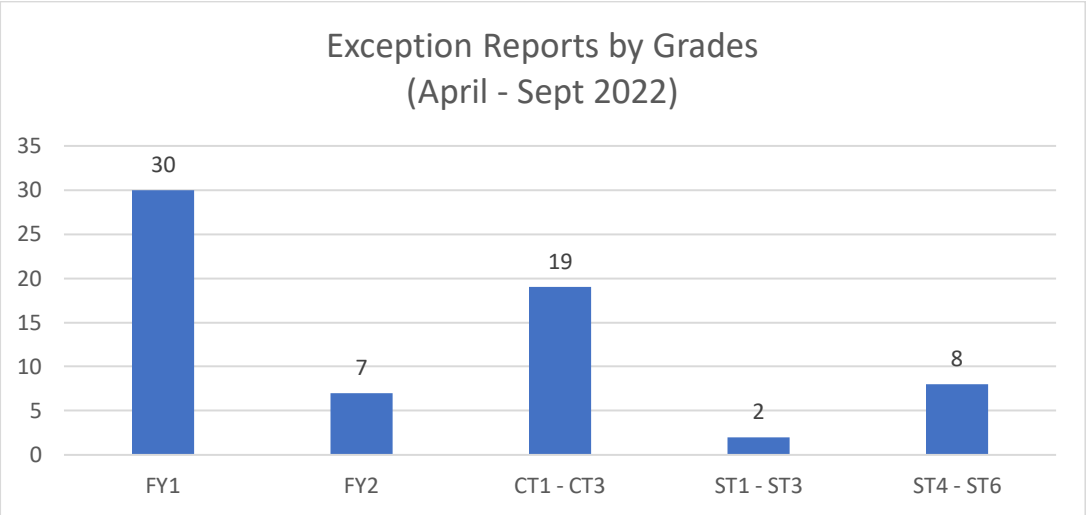
ER from April 2022 – Sept 2022 = 66
ER carried from last report (not included in the chart) = 10
Out of these 10 reports, 8 are related to hours of working and pattern and 2 are related to service support available to the doctors

Safety concern raised through Exception Report:

The safety concern was raised by a Junior Doctor working in Geriatric medicine. They had stayed late, without breaks, to respond to the needs of patients and the service. There was a new GP trainee, working alongside the Geriatric trainee, however, due to the complex illnesses of some of the patients more support was needed.
The issues that were raised through the exception report were escalated to the management/Joint geriatric medicine department meeting. It was agreed by the division that the minimum number of staffing by juniors on ward 20 should be increased to 3 as there are 30 patients most of them are

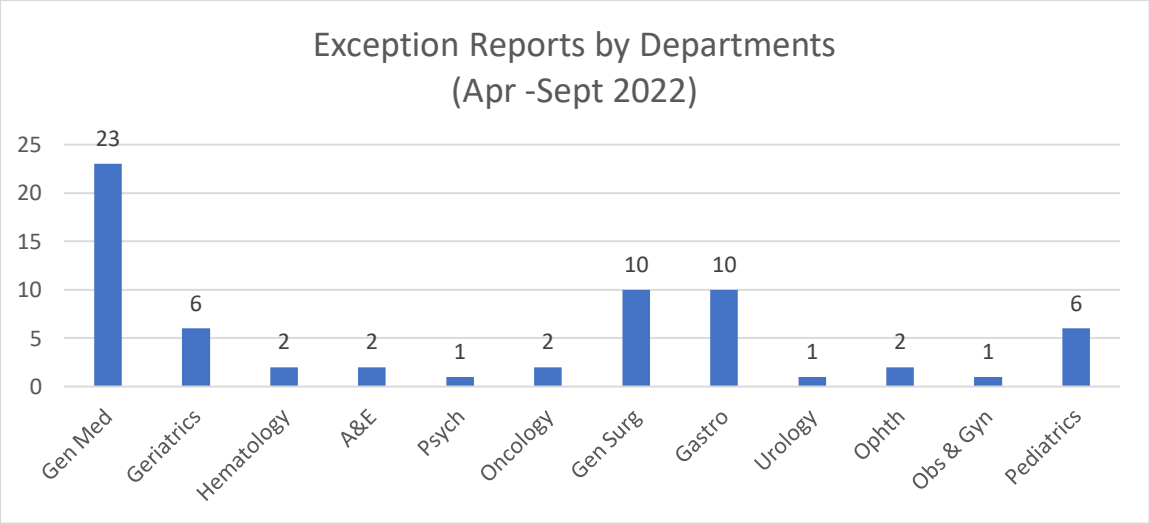
complex. There is always a consultant available for decision making too, but the increase in available staff should help more junior trainees and reduce any risk of delays in treatment to patients.

Exception report by Grades



ER from April 2022 – Sept 2022: 66
ER carried from last report: 10 (7 by FY1, 3 by ST1-ST3)

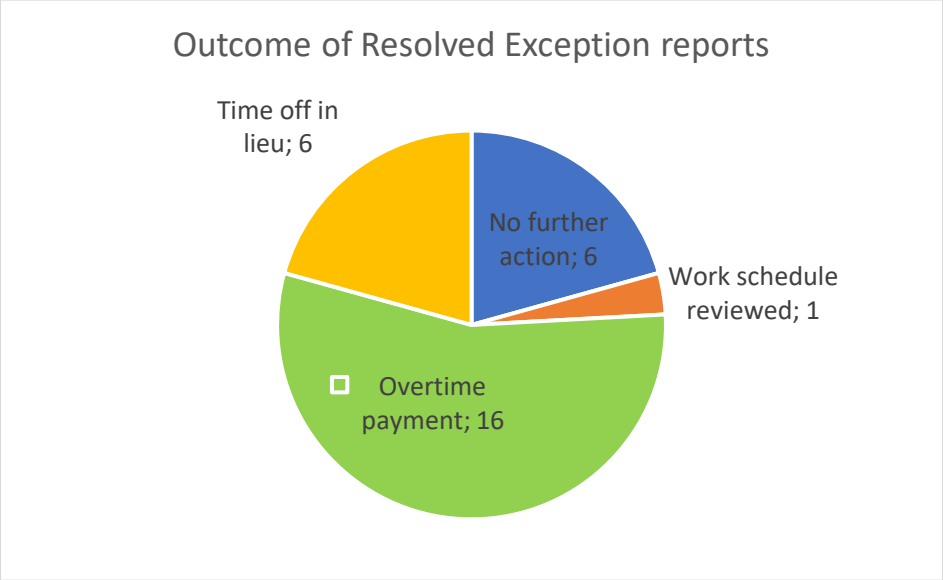
Exception reports by Departments



ER from April 2022 – Sept 2022 66

ER carried from last report 10 (3 from General Medicine, 4 from Emergency Department, 2 from Obstetrics and Gynaecology and 1 from GP)

Outcome of resolved exception reports



Number of ERs resolved – 29
Number of ERs unresolved – 47

A) Work Schedule review has been undertaken:

1 FY1 personalised work schedule review was requested in General Medicine which took place on 11th April 2022 by the previous GOSWH.

B) Trainee Vacancies:

Data on rota gaps is challenging to obtain, as most rosters up to the Consultant level are covered by a combination of doctors in training, Trust doctors and specialty doctors. When Allocate E rostering is fully rolled out, this data will become easier to access.

Where there are trainee vacancies, a Trust doctor may be recruited for a fixed term to cover that gap. Or alternative cover may be arranged for out of hours commitments.

As can be seen from the data held within ESR most of our training posts are filled currently.

As referenced above, as all rotas are populated by different Medics there may still be gaps in cover.

	Budgeted FTE	Actual FTE	Vacancies by FTE
Foundation Year 1	48	52.5375	-4.5375
Foundation Year 2	36	32.64375	3.35625
Specialty Registrar	176.76	174.89375	1.86625
Total	260.76	260.075	0.685

In addition to those trainees captured above we have 88 GP trainees in post, currently working off-site in Primary care settings.

C) Shifts covered by Bank and Agency:

Out of hours shifts on trainee rotas can arise for a number of reasons. There may be a vacancy, sickness absence, restrictions on working hours for health reasons, maternity leave, less-than full-time working in a full-time rota slot. In all of these examples the flexible workforce team will work to arrange alternative cover through offering bank shifts or by booking an agency locum. AS you can see from the table below, most shifts are filled with alternative cover.

Bank and Agency fill rates by division- July-September 2022			
	% Unfilled hours	% Filled Bank hours	% Filled Agency hours
Family and Specialist Services	1.79%	90%	8.21%
Medicine	1.49%	74.10%	12.30%
Surgery and Anaesthetics	12.77%	84.77%	2.47%

D) Fines:

There have not been any fines issued in either of these quarters.

E) Communication with trainees:

I have a regular slot at the junior doctor induction days and my presentation includes the key changes in the new contract, rota rules, work schedules, exception reporting and the role of the GOSWH and the junior doctor forum. So far 3 inductions have taken place in last 2 months.

I email the trainees and supervisors as and when needed in relation to the exception report submitted.

F) Regional GOSWH meetings and other interactions and learning:

The GOSWH has not attended any regional GOSWH meetings to date, although is booked to attend a GOSWH Virtual conference to be held on 25 November 2022.

The GOSHW has been invited to attend the webinar for GOSWH arranged by the British Medical Association, to gain a greater understanding of their view of the role of the GOSWH in relation to the implementation of the 2016 Contract.

The GOSWH is a member of an online GOSWH Network via WhatsApp which has been set up so that Guardians can share information and advice.

G) Junior Doctors forum (JDF)

This is scheduled for the 17 November 2022 and feedback will be included in the next GOSWH report.

H) Talent awards:

CHFT's Got Medical Talent Awards has been provisionally arranged for 25 May 2023, with an update in the next report.

I) Payment for Untaken Annual Leave

A Junior doctor has raised a query regarding payment for unused holidays if they are unable to take leave due to rota issues.

Whilst it is recommended that the trainees take leave to rest and recuperate at regular intervals, the Trust can pay trainees for untaken annual leave if the department has not been able to give the leave when they rotate to another training placement. However, this does not happen routinely, but is reviewed on a case-by-case approach after discussion.

J) Contact with Trainees that have rotated away from CHFT

Those doctors in training that move to another Trust lose their CHFT email address and hence cannot be contacted. Allocate software should have provision for doctors to feed additional email to contact in case they move to another Trust. The aims is for Allocate to include this in their list of future developments for the software.

Summary:

The trainees here at CHFT all have Allocate accounts to enable them to raise an exception report if they work outside of their agreed rota, or there are any issues that they wish to escalate, including gaps in educational support. Training is given on how and when to exception report when they first start in post and representatives have been sought for the Junior Doctor Forum. The rotas that are in place are all fully compliant with the rules of the 2016 contract and there is scope to review these where feedback highlights when changes may be needed. Whilst there are some exceptions that are still open on the system, they were resolved prior to the trainee leaving the organisation so I will work with Allocate to close these.

As a new GOSWH I look forward to working with the trainees and other colleagues to minimise issues, and to ensuring that any problems that are highlighted are resolved as quickly as possible.

23. Nursing and Midwifery Staffing Hard Truths Bi-Annual Report

To Approve

Presented by Lindsay Rudge

Date of Meeting:	**10 November 2022**
Meeting:	**Board of Directors**
Title:	**Nursing, Midwifery and Allied Health Professional Safer Staffing Report**
Author:	**Andrea Dauris – Interim Deputy Director of Nursing**
Sponsoring Directors:	**Lindsay Rudge – Chief Nurse**
Previous Forums:	**Workforce Committee (11 October 2022)**

Purpose of the Report

The purpose of this report is to provide the Workforce Committee with an overview for Nursing, Midwifery and Allied Health Professional (AHP) staffing capacity and compliance within Calderdale and Huddersfield NHS Foundation Trust in line with the National Institute for Excellence (NICE) Safe Staffing, National Quality Board (NQB) and the NHS Improvement Workforce Safeguards guidance.

This is supported by an overview of staffing availability over the reporting period and progress with assessing acuity and dependency of patients on ward areas. This data collection has been used to inform the Nursing and Midwifery establishment reviews for 2022-2023.

It is a national requirement for the Board of Directors to receive this report bi-annually.

Key Points to Note

The following details what are considered the key points to note:

- Based on the current Nursing and Midwifery recruitment strategies, September's vacancy position is reported at 124.64 WTE, a deteriorating position since the previous report. Current recruitment strategies, indicate this position will have reduced in September 2023 to a vacancy position of 92.89 WTE.
- The cost of the approved changes is £1,608k, of which the bed capacity funding identified is non-recurrent and is only available to support costs in this financial year. The costings do not include any additional premium cost due to agency or bank fill.
- The unprecedented challenges that continue, has resulted in staffing fill rates during the day continuing to fluctuate between 85%-90%.
- The continued focused leadership to support this agenda.
- The CHPPD at Trust level has remained stable demonstrating where safely possible the workforce is being flexed in line to meet patient activity and patient needs.

- During the reporting period 127 nursing and midwifery staffing related incidents have been reported through the DATIX reporting system. All incidents were recorded as no harm (125) or minor harm (2) and the appropriate actions were taken at the time.
- During 2022 our ambition to recruit 80 international registered nurses is in progress. The Trust were successful in securing additional fund via the "Go Further" programme which has increased our ambition by a further 20 international registered nurses. The Trust is on track to realise this ambition.
- Since the last report there has been capacity issues with the NMC Test of Competency Centres, which has caused delays in our International Registered Nurses being able to take their OSCE's. This was escalated to regional and national teams.
- The impact upon patient experience and the quality agenda if the Trust fails to provide safe staffing numbers across all clinical areas.

EQIA – Equality Impact Assessment

Ethnicity, age, disability, sexuality, socio-economic status, religious beliefs, non-English speakers and being a member of a social minority (e.g. migrants, asylum seekers, and travellers) may all influence rates of access to CHFT patient services. These factors may also influence the level of nursing staff required to provide safe care.

Consideration of the impact of equality issues on the provision of safe care to all patients is an integral part of standard nursing practice. As such, considering equality issues that may influence the provision of safe staffing forms an integral part of the scoping document.

Evidence shows us a direct correlation between quality, safety and patient experience and nurse staffing levels. Failure to have staffing in place that meets the care needs of patients means there is a potential risk of poor outcomes for all service users. Should this be the case then people from protected characteristic groups could have been disproportionally impacted given the evidence to suggest a less favourable experience for people from these groups across all NHS services.

Recommendation

The Board of Directors is asked to note the content of the report for assurance.

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1.0	Introduction
2.0	Safer Staffing
3.0	National compliance
4.0	Sickness and Absence levels
5.0	Hard Truths data
6.0	Escalation and reporting arrangements for Quality and Safety
7.0	Recruitment and Registered Nurse Trajectory
8.0	Nursing and Midwifery Workforce
9.0	Summary
10.0	Recommendations
APP 1	Safer Staffing OPEL cards

1.0. INTRODUCTION

The purpose of this report is to provide an overview for Nursing, Midwifery and Allied Health Professional (AHP) capacity and compliance with the NICE Safe Staffing, National Quality Board (NQB) Standards and the NHS Improvement Workforce Safeguards guidance. Demonstrating safe staffing is one of the essential standards that all health care providers must meet to comply with the Care Quality Commission (CQC) regulation and Nursing and Midwifery Council (NMC) recommendations.

This is supported with an overview of staffing availability over the previous six months and progress with assessing acuity and dependency of patients on ward areas. This data has supported the review of the Nursing and Midwifery establishment reviews for 2022/2023 in addition to providing a cumulative oversight of Care Hours Per Patient Day (CHPPD) and fill rates.

It is well documented that there is an established relationship between higher Registered Nurse (RN) staffing levels and improved patient outcomes and care quality (Griffiths et al 2020).

Developing Workforce Standards (2018) was established from safe staffing work when system leaders identified a gap in support around workforce and built on the National Quality Board (2016) guidance. The standards provide a framework for the approach taken to determine safe staffing processes which includes three components:

- Evidence base tools and data
- Professional judgment
- Outcomes

It is this framework that has been used to determine CHFT's safe staffing processes and the recent safer staffing review.

Within Midwifery Services, a baseline assessment was commissioned using Birthrate Plus, which continues to inform the recent safer staffing review.

This report describes CHFT's position in response to the national guidance for the reporting period February 2022 to September 2022.

CHFT's Reality

2.0 SAFER STAFFING

2.1 Nursing and Midwifery Establishment review 2022/2023.

Since the last establishment review, the Trust continues to approach the setting of nursing and midwifery establishments as set out in NQB standards. This includes the implementation of the Safer Nursing Care Tool (SNCT), an evidence-based workforce planning tool that provides patient acuity and dependency intelligence, which has informed the Trust establishment setting process. SNCT is an objective tool that utilises levels of care to support workforce planning and has been recognised for supporting safe staffing across in-patient wards, receiving the endorsement from NICE in 2014.

During the reporting period the Hard Truths review process commenced in June with Safer Care Nursing Tool (SNCT) data collection, followed by four divisional panels presented to the Chief Nurse during the month of August.

This included an appraisal of the proposed workforce models, in addition to identification of the right skills, in the right place at the right time, supporting any divisional training plans. Decision making was premised on the principles as set out in the Developing Workforce Safeguards guidance (2018) which drew together SNCT data analysis, professional judgement, and a suite of metrics such as: sickness/absence data, nurse sensitive indicators and complaints to inform recommendations.

The table below summarises the changes which were approved:-

Division	Area	Current WTE	Agreed WTE	Comments	22/23 Cost	Proposed Funding method
Medicine	Emergency Departments	181.22	181.22	A request to reduce the late shift by 1RN and 1HSCW and move this to the night shift was supported based on professional judgement. This was supported by Matrons and ADN	0	Cost neutral

Medicine	**CRH AMU**	**72.06**	**95.27**	**The SNCT principles and professional judgement have been applied. This increase is reflective of this area being in continued escalation from the bed base of 45 to 60 beds. This was supported by Matrons and ADN**	**£539k (£59k per month)**	**Funded Non-Rec through Business Planning Apr-Jun only. Additional Non-Rec Income secured from Bed Capacity Fund to cover Jul 22 -Mar 23[1].**
Medicine	6A/B	33.54	45.38	The SNCT principles and professional judgment have been applied. The changes reflect the continued escalation of this ward area from 24 to 32 beds. This was supported by Matrons and ADN	£494k (£55k per month)	Funded Non-Rec through Business Planning Apr-Jun only. Additional Non-Rec Income secured from Bed Capacity Fund to cover Jul 22 -Mar 23[1].
Medicine	4d	10.88	10.88	Professional judgement has been applied. 4d is a 10 bedded area which continues to be an escalation ward. This was supported by Matron and ADN	£545k (£91k per month)	Funded Non-Rec through Business Planning Apr, May, Dec-Mar only. Additional Non-Rec Income secured from Bed Capacity Fund to cover Jun-Nov costs[1].
Surgery	8b	12.07	12.07	Professional judgement has been applied. Minor changes to the WFM moving a HCSW from twilight to night shift has been informed by professional judgment. This was supported by	0	Cost neutral

				Matron and ADN		
Surgery	Ward 14	16.70	13.13	Ward 14 has been previously used as an area for medical outliers, increasing to 16 beds. It now needs to progress as a 12 bedded surgical step-down area. Professional judgement informed the WFM. This was supported by Matron and ADN	0	Cost Neutral
Surgery	Ward 22	35.94	35.94	To trial a pharmacy technician and reduce the RN shift to 4 RN. The SNCT principles and professional judgment have been applied. This was supported by Matron and ADN.	0	Cost Neutral
Community	District Nursing	142.41	143.41	Clinical Educator to be funded permanently via tariff monies. Recommendation to adjust WFM in each of the hubs approved based on professional judgement and demand. This was supported Matron and ADN.	£30k (£58k Full year impact)	Non-Rec CPD Funding is available for this financial year. Longer term it may be possible to fund through the generation of additional HEE Education and Training Clinical Tariff income. Subject to approval by the Education Committee
Community	OOH Palliative Care Service	4.24	5.38	8:00pm-05:00 am existing services. Trial WFM 7:00pm – 08:00. Currently joint funding with division and Marie	0	Non rec funding in place for 22/23. Requires business

				Curie. Evaluation will determine next steps.		case to secure long-term funding.
Total					**£1,608k**	

Note: Funding requested for additional bed capacity does not include any additional premium cost due to Agency or Bank fill. This is likely to be an additional unfunded pressure in this financial year. The Bed Capacity Funding identified is non recurrent in nature and is only currently available to support costs in this financial year.

2.2 Maternity Services

The previous report highlighted the gap in registered midwives between the recommendations from Birthrate Plus to the funded establishment. Birthrate Plus was commissioned to undertake a full baseline assessment for the period 1 April 2019 – 31 March 2020 and the report was produced and provided to the Trust in November 2020. Birthrate Plus methodology is consistent with the recommendations in the NICE safe staffing guideline for midwives in maternity settings and has been endorsed by the Royal College of Midwives and the Royal College of Obstetricians and Gynaecologists. A current maternity workforce gap analysis was also a requirement within the 7 immediate and essential actions in response to the Ockenden Report.

The review highlighted a requirement for 226.84 wte clinical and non-clinical staff of which 20.81 wte could be suitable qualified support staff at agenda for change bands 3 or 4. To note Birthrate Plus does not include band 2 support staff within their review. The requirement of 206.03 wte (226.84 wte total - 20.81 wte support staff = 206.03 wte) registered midwives was to provide traditional midwifery care, the review further highlighted the requirement for 213.41 wte registered midwives to provide maternity continuity of carer for 54% of the total women booked at CHFT.

The funded gap of 20 wte registered midwives (226.84 - 20.81= 206.03 vs establishment 186 wte) and 9.44 wte band 3 support staff (20.81 - 11.37) was reduced when CHFT successfully submitted a bid and received a share of the £95.9 million initial investment into maternity services from NHSE/I. This funding was aimed at filling the staffing gaps evidenced by their workforce gap analysis and was an action following the publication of the Ockenden Report. CHFT maternity services submitted a bid for 20 wte registered midwives based on the November 2020 Birthrate Plus report and were allocated funding for 10.9 wte in April 2021. In April 2022 recurrent funding was received for both midwifery and obstetric staffing, the allocation for midwifery staffing was 12 wte registered midwives, therefore the current funded establishment for registered midwives is 198 wte.

The last two reports have highlighted a risk in recruitment to these posts, which despite a programme of rolling adverts for midwifery posts at CHFT, these posts remain unfilled. Additionally, over the last year, CHFT has experienced unprecedented midwifery staffing shortfalls against planned workforce levels across all areas due to vacancy, sickness, and maternity leave. In September 2022 overall midwife staffing vacancy including vacancy and maternity leave was 26.21% (Table 1 and 2). To ensure the safety of women and babies, and in accordance with guidance from NHS England/NHS Improvement (NHSE/I), the maternity service has prioritised provision

of 1:1 care for women in established labour, this has contributed to decisions to temporarily suspend services at Huddersfield Birth Centre and the suspension of maternity continuity of carer. Two of the most important safe staffing indicators relate to the provision of 1:1 care in labour and the supernumerary status of the labour ward (LDRP) coordinator. NHS Resolution's Maternity Incentive Scheme states that the midwifery coordinator in charge of labour ward must have supernumerary status, which is defined as having no caseload of their own during their shift to ensure there is an oversight of all birth activity within the service. 1:1 care in labour has remained consistently above 98% over the last six months and the coordinator remaining supernumerary has remained consistently at 100% over the last 4 months (Tables 3 and 4).

Table 1: Vacancy levels August 2022

	Births	Planned WTE (MW and RN)	Actual WTE	Vacancy WTE	Planned Leavers (to end Oct)	Midwives and RN in recruitment pipeline
CHFT	4712	198	154.86	43.14	8.52	13.56

Table 2: Staff unavailability end September 2022

		Annual Leave (Target 15%)	Maternity Leave (1%)	Sickness (4%)	Total* (Uplift 22%)
CHFT	RM	14.58%	4.42%	7.69%	31.13%*
	MSW	14.48%	0%	6.52%	25.38%*

*Total includes annual leave, maternity leave, sickness, study leave, working day unavailability and other leave

Table 3: 1:1 care in labour position over the previous 6 months.

Month	Mar 22	Apr 22	May 22	June 22	July 2022	Aug 2022
1:1 care in labour	98.7%	98.9%*	99.7%*	98%*	99.7%	100%**

*Data reviewed and updated August 2022
** Data excluding born before arrivals (BBA)

Table 4: Co-ordinator supernumerary over previous 4 months

Month	May 22	June 22	July 22	Aug 2022
Co-ordinator supernumerary	100%	100%	100%	100%

Despite these challenges women continue to be offered three choices of place of birth in line with the aspirations of Better Births: home birth, midwife led alongside birth centre and consultant led unit.

Local exit interviews suggest the main reasons midwives leave are due to leaving the midwifery profession, promotion, and retirement. A maternity recruitment and retention working party has been established which is developing a recruitment and retention strategy. The maternity services have a Matron and Band 7 who lead on workforce with 2 clinical educators who work clinically with the newly qualified midwives to provide support, these posts are externally funded by NHSE/I as part of the national midwifery recruitment and retention campaign.
With the continued staffing challenges through the maternity service a review of acuity and staff available occurs each shift, with LDRP completing the Birth Rate Plus acuity tool 4 hourly and staff are redeployed within the hospital setting to appropriate areas to maintain safer staffing levels. The service has a robust escalation policy, with responses that include utilising the on-call community midwives and non-clinical midwives, and temporary relocation of Calderdale Birth Centre to LDRP. All episodes of escalation are reported via the incident reporting system and then reviewed at the weekly Maternity Governance meeting.

Table 5: Birthrate Plus acuity data

	% RAG rated Red*	% RAG rated Amber*	% RAG rated Green*
01/08/22	2%	38%	52%
08/08/22	12%	52%	36%
15/08/22	17%	43%	40%
22/08/22	7%	36%	57%

*Red more than 3 midwives short in the census period
*Amber up to 3 midwives short in the census period
*Green number of midwives available meets the acuity

Due to the continuing challenges facing the midwifery workforce, both locally and nationally, a proposed new way of working was approved at Hard Truths in September 2022. This proposal included the recruitment of additional maternity support workers and registered nurses to backfill registered midwifery vacancies, in addition to strengthening governance, public health, perinatal mental health and bereavement services. This position has been recognised as a short-medium term strategy as the long-term strategy would not be to reduce the number of registered midwives. A bid has also been submitted on the 19 August 2022 to NHSE/I for midwifery international recruitment funding, the bid proposed that the Trust recruit to 5 international midwives.

2.3 Nursing and Midwifery Forward Planning

The Emergency Department (ED) tool for Safer Nursing Care Tool (SNCT) has recently been published and nationwide training is being delivered by NHSE/I. The Trust has acquired the license for use and has registered the Associate Director of Nursing, Head of Nursing and Midwifery Workforce and Education and Matrons for ED for training in the use of the tool. When this has been undertaken the Corporate

Nursing Directorate will lead a programme for acuity and dependency scoring cycles to help further inform the establishment review process going forward.

2.4 Allied Healthcare Professional (AHP) Overview

There is no single guidance or standard approach to inform safe staffing levels required in services provided by Allied Health Profession (AHPs) with the exception being for stroke https://www.rcplondon.ac.uk/guidelines-policy/stroke-guidelines (RCP, 2016) and critical care https://www.ficm.ac.uk/sites/ficm/files/documents/2021-10/gpics-v2.pdf (GPICS, 2019). For other areas, each AHP has profession specific information and guidance only, available to support staffing levels of a particular type of service.

NHSI have mandated all AHP roles and they have electronic job plans in place. This project has commenced and is on track for delivery. The Community Division is also supporting a workforce manager to embed the recommendations from Health Education England's (HEE) AHP Workforce Strategy and proceed with the associated recruitment initiatives across AHPs. Recent recruitment to a clinical educator will promote the early years' experience of new graduates, embedding role specific preceptorship.

The work of the Nursing, Midwifery and AHP Workforce Steering Group, has commissioned the development of an AHP recruitment and retention tracker. This tracker provides projections based on current turnover rates to determine and provide oversight of potential clinical hotspots. Below provides an overview of current vacancy positions across the areas with a high vacancy position and a descriptor of the strategies that are being employed to address shortfalls.

2.4.1 Dietitians

The current vacancy position represents a 22% shortfall equivalent to 5.03 wte, which is expected to further increase based on current leavers and new funding streams aimed at strengthening dietitian support into nursing homes. Primary Care Networks (PCN) have also demonstrated a demand for these roles which places further pressure on the workforce supply locally.

Actions taken:

- Skill mix to assistant and assistant practitioner roles.
- Dietetic apprenticeships to form part of the business case for September 2023.

2.4.2 Occupational Therapists (OT)

With a current vacancy rate of 6.75 wte (15%), gaps are predominantly in the acute therapy teams with leavers choosing to work in the community or with external providers.

Actions taken:

- Apprenticeships – 2 CHFT employees to start September 2022.

- International Recruitment – bid approved to recruit 3 OTs by March 2023.
- Return to Practice – due to support one OT via this route.
- Development of the CHFT and wider Calderdale and Kirklees places rotational roles to broaden opportunities.
- Recruitment to an OT professional lead who will work with service managers to ensure the profession is developed in line with national guidance and to meet the needs of the local population, ensuring staff are given the correct learning opportunities and developed to aid retention.
- Development of the support workforce with support from a professional lead.
- Retire and return promotion.

2.4.3 Radiographers

Radiographers currently have 28 wte vacancies representing 19% of the workforce.

Actions taken:

- International recruitment
- Increased roles for support workforce
- Apprenticeships

2.4.4 Speech and Language Therapists

Speech and Language Therapists currently have 7 wte vacancies representing 18% of the workforce vacancy rate. Feedback has indicated staff are moving to neighbouring Trusts with a higher allocation of Continuing Professional Development (CPD) time and specialist development opportunities.

Action taken:

- Bank and fixed term contracts for past employees.
- Locum advertisements.
- Development of highly specialist roles and associated opportunities for lower grade colleagues.
- Professional lead.
- Aim to support assistants to take up a degree level apprenticeship.
- Expand opportunities for student placements to allow for supply from the new University of Huddersfield graduates in 2024.

3.0 NATIONAL COMPLIANCE

The Developing Workforce Safeguards published by NHSE/I in October 2018 were designed to help Trusts manage workforce planning and staff deployment. Trusts are now assessed for compliance with the triangulated approach to deciding staffing requirements described within the NQB guidance. This combines evidence-based tools with professional judgement and outcomes to ensure the right staff, with the right skills are in the right place at the right time.

As part of this cycle of establishment review divisions provided an overview of nurse/midwifery leadership structures and clinical nurse specialist post holders. It is intended that further analysis will be undertaken to inform how this is integrated into future establishment reviews.

The recommendation from the Chief Nurse is there is good compliance with the Developing Workforce Safeguards.

4.0 SICKNESS AND ABSENCE LEVELS

Figures 1 - 5 show the sickness level at the Trust during the reporting period. Data has also been included from "Covid-19 related absence" which is coded differently within the electronic staff records, however, is an impact of the pandemic which directly affects the availability of the nursing and midwifery and nursing support workforce.

During the reporting period total absence continued to be a challenging position with peaks in March and April for both workforce groups. This position is attributable to COVID positive colleagues as well as other absence such as stress, anxiety, and depression.

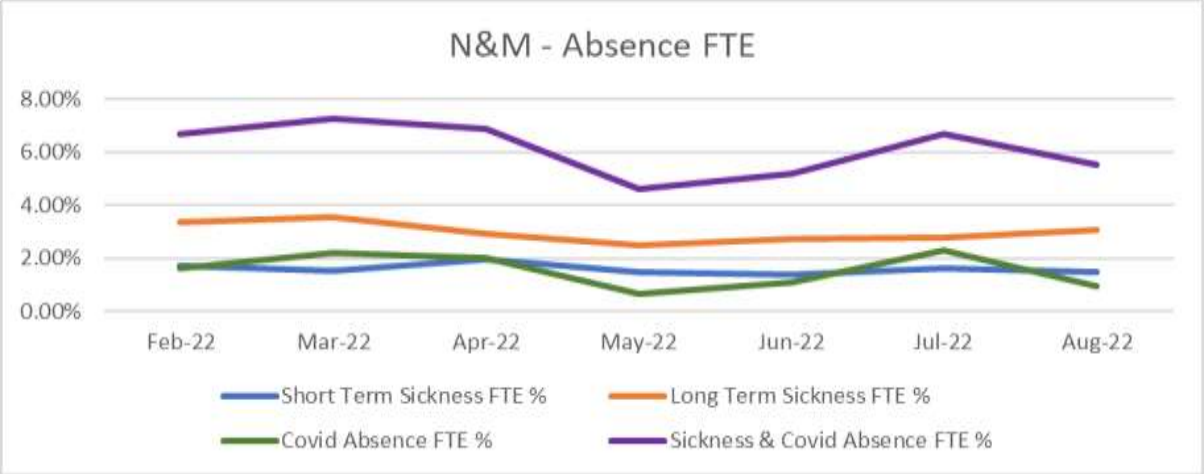
Whilst these findings are not peculiar to nursing and midwifery, CHFT recognises that support for colleague wellbeing is vital pre, during and post the pandemic. The health and wellbeing support available at CHFT continues to be refined and tailored to support the diversity of our people and continues to be a critical response to supporting the health and wellbeing of nursing, midwifery and AHP colleagues.

Qualified Nursing & Midwifery

(Figure 1)

	Sickness Absence							Covid-19 Related		Sickness & Covid-19
Month	ST FTE Lost	LT FTE Lost	Total FTE Lost	Available FTE	Short Term Absence FTE %	Long Term Absence FTE %	Total Absence FTE %	Covid FTE Lost	Total Covid Absence FTE %	Total Absence FTE %
2022 / 02	822.62	1,585.03	2,407.65	47,230.74	1.74%	3.36%	5.10%	757.00	1.60%	6.70%
2022 / 03	790.92	1,862.93	2,653.84	52,360.47	1.51%	3.56%	5.07%	1,163.68	2.22%	7.29%
2022 / 04	981.76	1,464.61	2,446.37	49,967.89	1.96%	2.93%	4.90%	1,002.97	2.01%	6.90%
2022 / 05	756.48	1,288.78	2,045.26	51,416.66	1.47%	2.51%	3.98%	329.45	0.64%	4.62%
2022 / 06	683.53	1,349.04	2,032.57	49,720.71	1.37%	2.71%	4.09%	545.29	1.10%	5.18%
2022 / 07	830.83	1,417.20	2,248.03	51,308.84	1.62%	2.76%	4.38%	1,183.07	2.31%	6.69%
2022 / 08	760.24	1,572.20	2,332.44	51,262.30	1.48%	3.07%	4.55%	494.85	0.97%	5.52%

(Figure 2)

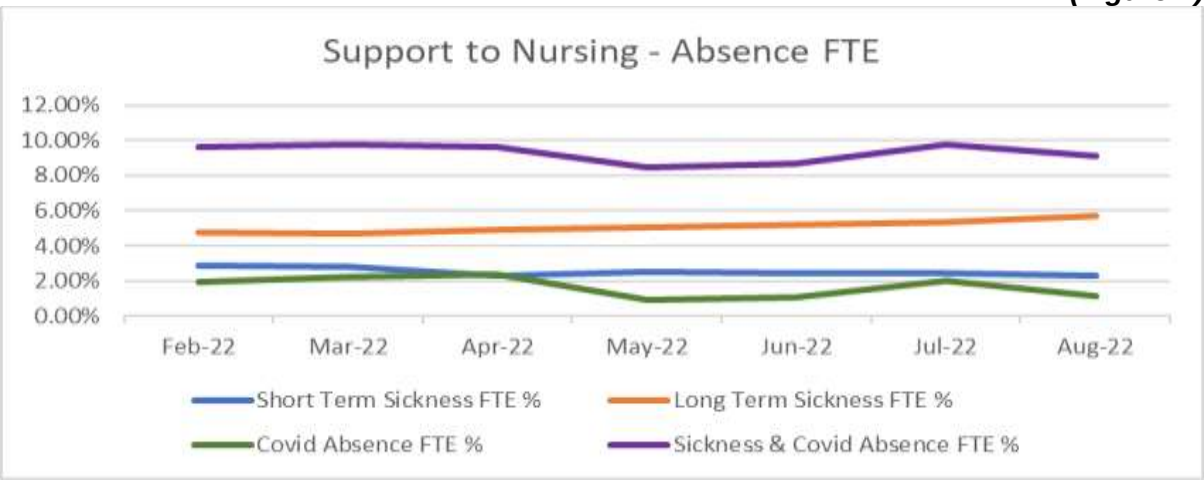


Nursing support

(Figure 3)

	Sickness Absence							Covid-19 Related		Sickness & Covid-19
Month	ST FTE Lost	LT FTE Lost	Total FTE Lost	Available FTE	Short Term Absence FTE %	Long Term Absence FTE %	Total Absence FTE %	Covid FTE Lost	Total Covid Absence FTE %	Total Absence FTE %
2022 / 02	695.85	1,149.17	1,845.03	24,050.48	2.89%	4.78%	7.67%	466.85	1.94%	9.61%
2022 / 03	755.85	1,267.87	2,023.72	26,923.62	2.81%	4.71%	7.52%	601.32	2.23%	9.75%
2022 / 04	605.49	1,276.57	1,882.07	26,019.58	2.33%	4.91%	7.23%	616.71	2.37%	9.60%
2022 / 05	661.33	1,348.95	2,010.29	26,649.09	2.48%	5.06%	7.54%	236.55	0.89%	8.43%
2022 / 06	628.29	1,324.81	1,953.11	25,657.60	2.45%	5.16%	7.61%	275.93	1.08%	8.69%
2022 / 07	640.37	1,416.24	2,056.61	26,568.21	2.41%	5.33%	7.74%	540.71	2.04%	9.78%
2022 / 08	608.11	1,507.89	2,116.00	26,531.20	2.29%	5.68%	7.98%	306.44	1.16%	9.13%

(Figure 4)



The impact of the combined actual RN wte and average sickness absence position has been further modelled across the four divisions to give context to the workforce challenges.

	Medicine	Surgery	FSS	Community – (DN hubs and OOH)
Budgeted RN WTE	539.45	428.51	272.58	87.86
Actual RN wte	448.24	387.32	252.54	83.90
RN vacancy wte	91.21	41.19	20.04	3.96
RN % vacancy gap	16.90%	9.61%	7.35%	4.50%
Average absence above budgeted headroom (22%)	10.60%	7.27%	5.22%	7.08%
Total combined vacancy and average absence position above headroom.	27.50%	16.88%	12.57%	11.58%

*Data source: Healthroster budgeted vs actual position 29th August 2022 (***Figure 5)***

(This position has been compounded by the actual RN workforce supporting additional capacity which has included Ward 14, 6AB, 4D, 11 and 15. As an example, to support the 27 beds on Ward 15 requires an additional 22.48 wte registered nurses.)

5.0 HARD TRUTHS DATA

As indicated earlier safe staffing is one of the essential standards that all health care providers must meet. NHS England and the Care Quality Commission (CQC) issued guidance in 2014 detailing their ongoing commitment to publishing staff data, referred to as “Hard Truths.”

Hard Truths is a commitment to greater openness and transparency and is achieved by publishing staffing data regarding nursing, midwifery and care staff levels.

This is provided through the Trust reporting nursing and midwifery staffing numbers including registered and unregistered to NHSE/I via a monthly nursing and midwifery staffing return. The data includes oversight of care hours per patient day (CHPPD) which is a national measure for safer staffing. NHSE/I began collecting CHPPD formally in 2016 as part of the Carter Programme and data at Trust and ward level for all acute Trusts is now published on NHS Model Hospital.

CHPPD provides a single consistent way of recording and reporting deployment of staff working on inpatient wards/units.

It is calculated by adding together the total number of registered nurses, nursing associates, and in some cases allied health professionals, along with healthcare assistant hours on each ward and dividing by the number of patients on the ward each

day at midnight. The aim of this is to enable national benchmarking, reduce variation and increase efficiency. Given the way it is calculated, actual CHPPD is influenced not only by numbers of staff on duty, but also the bed occupancy, with wards with fewer patients, or with high numbers of day-case patients who are discharged prior to midnight, demonstrating significantly higher CHPPD.

It should be noted that CHPPD reflects the total hours of nursing and support worker availability on the ward per patient. It does not reflect the care hours required, which is calculated separately on Safecare, based on patient acuity and dependency, which is used to inform the twice daily staffing meetings to ensure deployment of staff according to care demand.

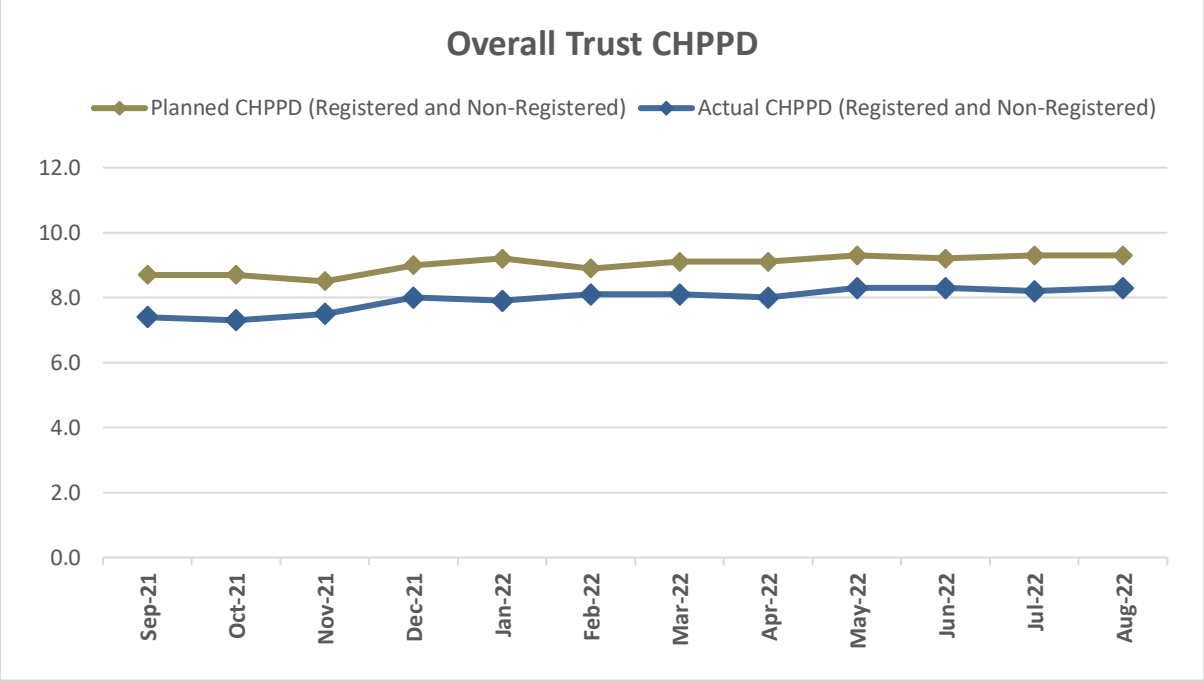
CHFT can benchmark nursing workforce data against the national average, as well as 'Peer Hospital' data, on the Model Hospital platform https://model.nhs.uk. The data is compiled and returned to NHS England, reporting quarterly for most parameters.

The latest information on CHPPD is from July 2022. Review of this data reveals CHFT to be at the top of quartile 3 in comparison with national data, providing 8.9 CHPPD at Trust level (Figure 6). The national median is 8.3, with peer median being 8.4. Three of our peers provide more CHPPD than CHFT (highest 9.2 CHPPD), with the remaining 7 peers providing fewer CHPPD (lowest 6.5 CHPPD). This compares favourably to the previous report where CHFT was in the lower quartile of CHPPD provision by nurses, midwives and AHPs at 7.3 CHPPD. (Data from October 2021).

(Figure 6)

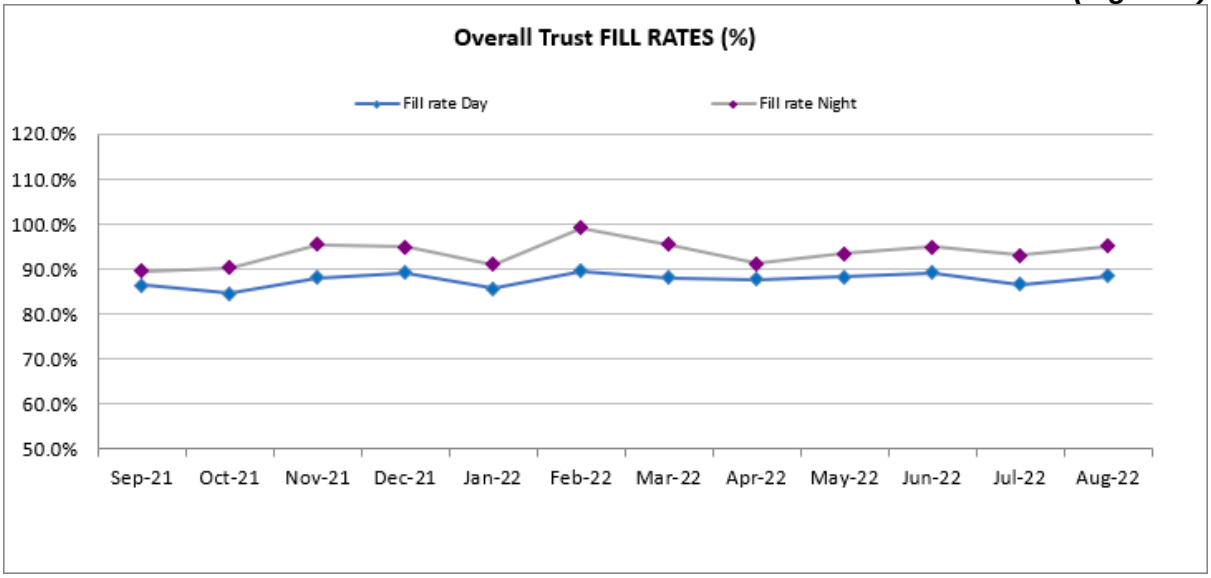
CHPPD

(Figure 7)



Fill rates

(Figure 8)



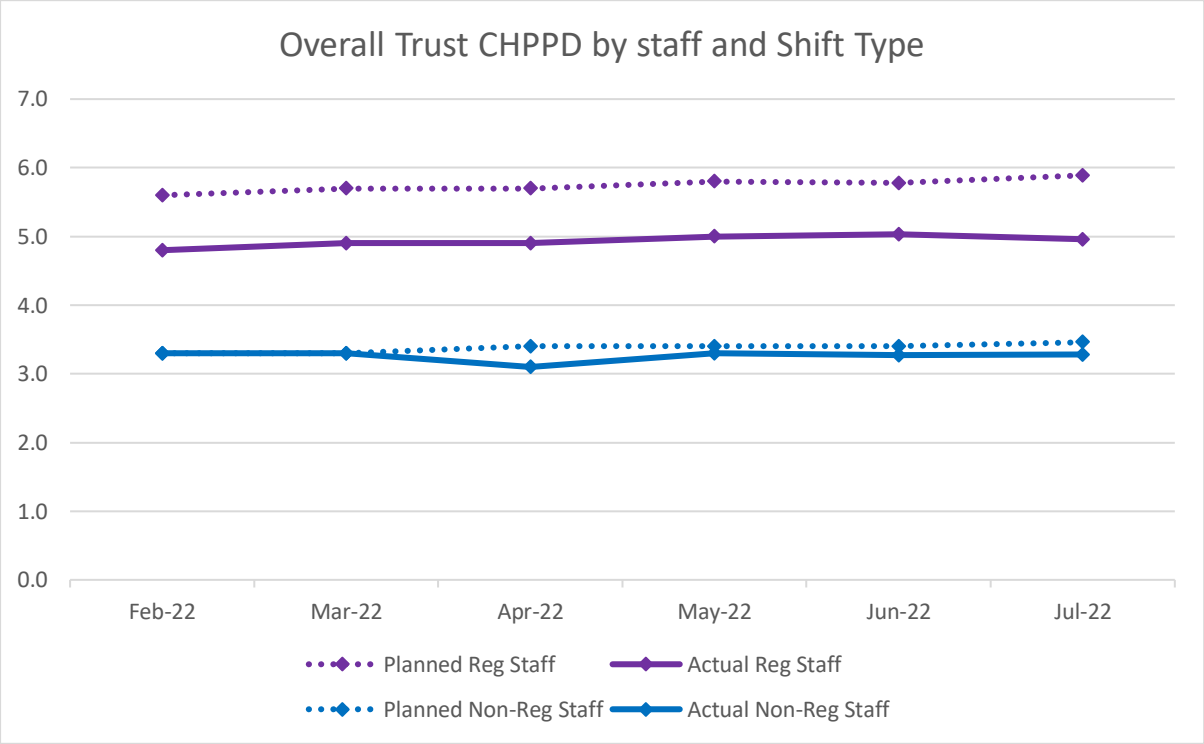
Whilst fill rates are no longer a reporting requirement to NHSE/I they continue to be a useful measure for analysis. Fill rates are calculated by comparing planned hours against actual hours worked for both registered nurses (RNs) and health care support workers (HCSW). Factors affecting fill rates include:

- Sickness (lower if not filled)
- Vacancies (lower if not filled)
- Enhanced Care Support Worker requirements, otherwise known as 1:1 observation (when additional staff above agreed WFM are rostered on to support)

Trust overall fill rates have not regained the pre-pandemic position which trended around the 90-95% position. For the reporting period, fill rates continued to fluctuate between 85% - 90% during the day (Figure 8). This position continues to impact on the overall Trust CHPPD position with an ongoing shortfall reported between planned and actual care hours during the reporting period (Figure 7). This is reflective of the ongoing challenging sickness/absence position, restarting of services to a pre-pandemic position, opening of additional escalation areas, in addition to supporting enhanced service delivery in some areas.

In recognising the established relationship between higher registered nurse staffing and improved patient outcomes and care quality (Griffiths et al 2020), Figure 9 breaks down the CHPPD by staff groups, which highlights the most challenging gap can be seen within the RN workforce.

(Figure 9)



Divisional narrative from Associate Directors of Nursing and Matron teams highlights ensuring safe staffing across all services has been a constant process that has been significantly challenging for all involved. Nonetheless, staffing resource has been safely flexed to meet patient demand, activity, and acuity. The workforce loss generated from the pandemic has been unprecedented and widespread, and the continued effort given by our teams to ensure service provision has been outstanding.

5.1 Red Flag Escalation

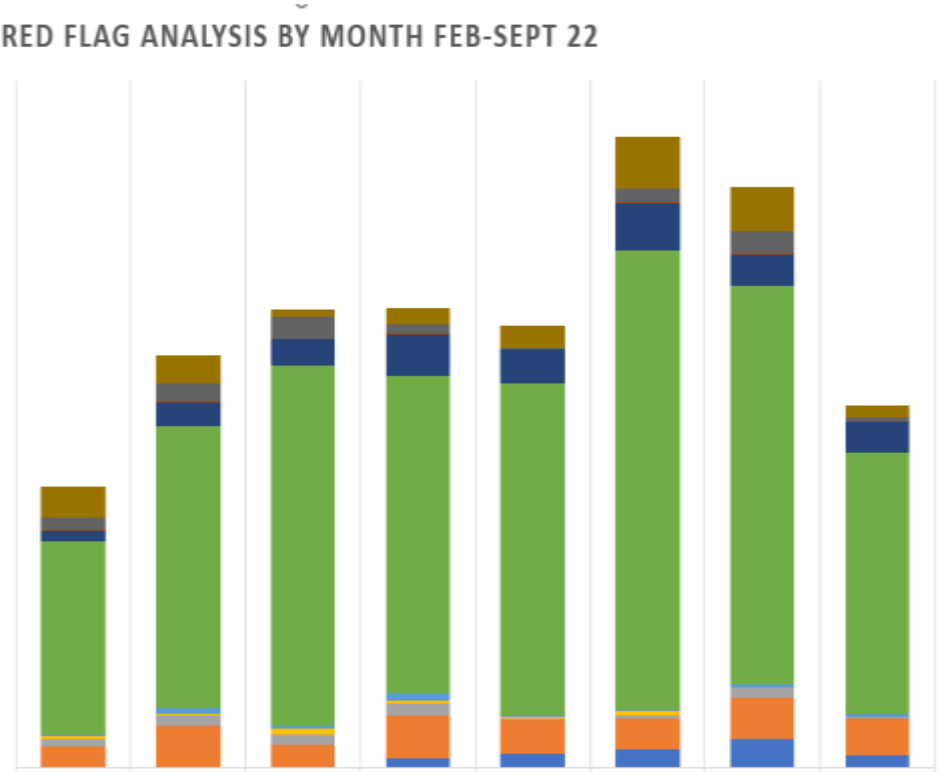
To supplement the process of rating the status of staffing requirements within the roster system, a system of red flag escalation has been developed in line with NICE (2014) guidance. Nursing red flags are events that have an impact on the way care is delivered to patients, therefore requiring a prompt response by the Nurse in Charge

or a more senior nurse to mitigate patient safety concerns. Nursing red flags can be raised at any point during a shift.

The red flag process forms a key part of the governance arrangements and ongoing monitoring of the staffing position.

Figure 10 provides a breakdown of red flags for the reporting period 1st February 2022 – 30th September 2022.

(Figure 10)



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Challenging behaviour from a visitor or patient	27	24	6	13	19	45	39	10
Clinical treatment/intervention delayed	11	16	20	8	2	12	19	3
Delay >30minutes in providing symptomatic pain relief	1	1	0	1	0	1	1	0
Delay/Omission of intentional rounding	9	20	22	36	29	41	27	27
Number or Skillmix of nurses insufficient	168	247	315	278	290	401	348	229
Patient in Isolation	2	4	2	6	1	1	3	2
Patient vital signd not assessed or recorded	2	2	5	2	1	4	0	0
Staff Unable to Take Breaks	7	9	10	11	2	2	8	2
Unmet Enhanced Care Need	19	37	20	37	29	28	37	32
Unmet Standards of Healthcare Cleanliness	0	0	0	9	13	16	25	11

There continues to be a stepped changed in the reporting of Red Flags which may reflect the strengthened governance arrangements in this area.

In isolation this data does not provide a clear understanding of the actual impact upon patient experience or the workforce in delivering patients' care. It is recognised that despite no adverse clinical outcome, the delays in care will have negatively impacted the overall experience of patients and colleagues.

5.2 Quality

As highlighted earlier there is a well-established correlation between staffing levels, safe care and patient experience.

As such it is important for any staffing review to take into consideration the quality of the care provided using nurse sensitive indicators. For this report three recognised nurse sensitive indicators have been used: Friends and Family Test, falls and pressure ulcer data.

Since the last report the Enhanced Dashboard Metric has been fully integrated into clinical practice and was reported against during the Divisional Hard Truth Panel meetings, supporting the triangulation of several quality metrics against the acuity and dependency data, thereby informing establishment reviews.

Additionally, the Enhanced Dashboard Metric is reported into the Nursing and Midwifery Safer Staffing meeting on a weekly basis. Data within this report is analysed through Divisional Teams to determine the actions required to respond to data triangulation and mitigation against any impacts.

5.2.1 Friends and Family Test (FFT)

The performance data reported below is a combined rating of all 9,896 FFT responses submitted between 1 February 2022 – 31 August 2022.

The main FFT question asks patients**: Thinking about your stay in hospital overall, how was your experience of our service?** With options ranging from very good to very poor. The breakdown of positive vs negative results is a useful barometer to monitor performance through a patient feedback lens.

All	Very Good	Good	Neither Good nor Poor	Poor	Very Poor	Don't Know
% of Total	86.61%	10.76%	1.14%	0.16%	0.18%	1.14%
Combined	**Positive: 97.37%**			**Negative: 0.35%**		

The overall positive FFT score of 99.37% is a positive position which is against a national position of 95%.

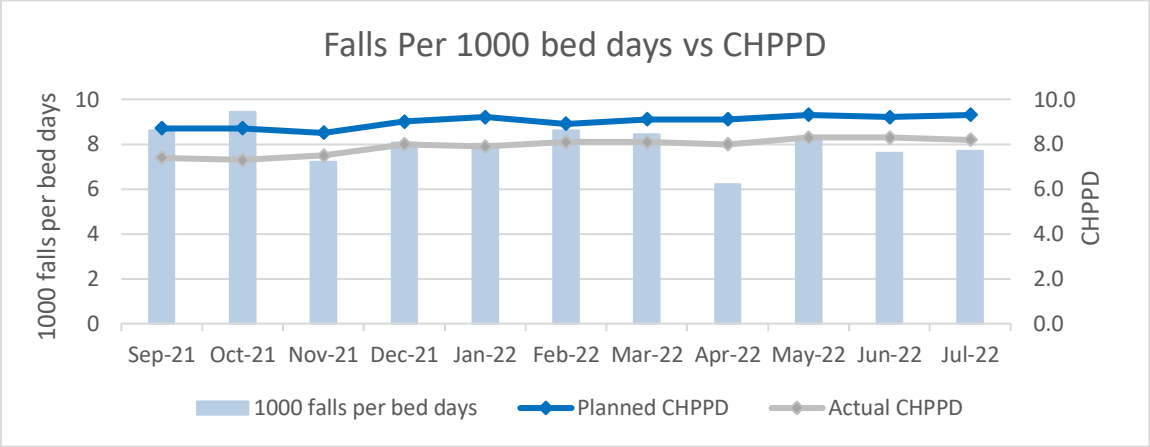
5.2.2 Falls and Pressure Ulcers

The charts below provide an overview of the reporting of incidents related to falls per 1000 bed days (Figure 11) and ulcers per 1000 bed days (Figure 12).

Falls

Throughout the reporting period there is a shortfall between the planned and actual CHPPD which fluctuates between 0.8 and 1.1, with the incidence of falls peaking in February (Figure 12).

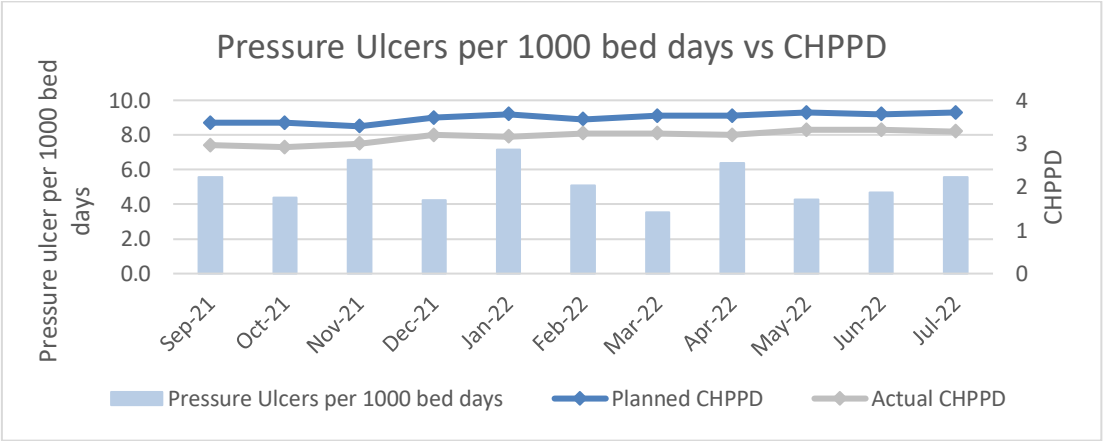
(***Figure 11)***



<u>Pressure Ulcers</u>

Due to validation processes for the purpose of the reporting period of this report pressure ulcer data is only available up until July 2022. Data for pressure ulcers per 1000 bed days demonstrates a fluctuating position with the highest incidence identified in April where CHPPD demonstrated an overall gap between planned and actual of 1.1. The same CHPDD deficit position was report in July where the incidence of pressure ulcers was 2.23 per 1000 bed days.

(Figure 12)



Analysis of the data indicates variability in the incidence of the two nurse indicators that may be attributable to the gap in planned and actual CHPPD.

Given the established relationship between higher registered nurse staffing and improved patient outcomes and care quality (Griffiths et al 2020), and the gap in CHPPD continues to be identified as the most challenging for the RN workforce (Figure 9).

It is reasonable to suggest the impact of the recovery agenda, ongoing enhanced delivery of some services, additional capacity, current vacancy position and the impact of staff sickness absence has impacted upon the patient experience.

5.2.3 Incident reporting

During the reporting period of 1 February 2022 to 30 September 2022 there were 125 Nursing and Midwifery staffing related incidents that were reported through the Datix reporting system, all of which were reported as no significant harm to patients. One hundred and twenty-five (125) of these incidents were reported as no harm and 2 as minor harm. There was appropriate escalation when the incidents occurred, and this is recorded within the incident records.

There continues to be a strong theme around staff being redeployed to support other areas and the impact of this.

Due to staffing capacity, annual leave and other urgent pieces of work, the ongoing work to link incidents with activity levels in the Trust that would help triangulate information has been put on hold. As the Risk Team moves towards full capacity, it is anticipated this piece of work will restart soon. The Quality and Risk Team safety huddles are now established and have oversight of all incidents. This provides the opportunity to immediately escalate any incidents and seek assurance about the outcome for any patients (if relevant) or the wellbeing of staff involved.

CHFT'S RESPONSE

Short-term strategies

6.0 ESCALATION AND REPORTING ARRANGEMENTS FOR QUALITY AND SAFETY

Throughout the pandemic Safe Staffing has been a key focus and is one the Trust's Must Do priorities. Addressing this has been a key focus of the Senior Nursing Team, and a range of actions remain in place to manage risk.

- The senior nurse leadership rota established earlier this year continues supported by the Chief Nurse, Deputy Chief Nurse and Associate Directors of Nursing to provide ongoing visibility and dialogue across clinical areas, and support staffing escalations across the 7 days.

- Twice daily Nursing and Midwifery Staffing meetings chaired by the Associate Director of Nursing are in operation 7 days a week, operating with a revised term of reference and Safe Staffing OPEL escalation cards (appendix 1).

The purpose of this meeting is to review the real-time safer staffing assessments and agree actions required to respond to short-term staffing escalations and changing acuity and dependency to assist with staff deployments.

Real-time staffing is provided through Safecare which gives a live view of the nursing staffing position measured against the acuity and dependency of our patients, facilitating comparisons of staffing levels and skill mix to the actual patient demand to maintain safe staffing across the Trust as a whole. Safecare LIVE plays a pivotal role in these meetings providing visibility across wards, transforming rostering into an acuity based daily staffing process that unlocks productivity and safeguards patient safety.

In addition, Safecare allows the nursing team to assist the ward manager with real-time roster management to ensure we have the right person, in the right place, at the right time to inform operational decisions to maintain safer staffing Trust wide.

Decision making within this forum is informed by an appraisal and risk assessment of the divisional information presented and any staffing shortfalls are mitigated against.

- The twice daily nursing and midwifery safer staffing meetings have a direct escalation into the Nursing and Midwifery Workforce Safer Staffing Group chaired by the Chief Nurse.

- The Enhanced Dashboard Metric provides visibility on the workforce position and potential impacts on the patient experience, quality, and safety agenda. This dashboard includes several metrics that sit across all four divisions, in addition to divisional specific metrics which will enable true triangulation of the datasets.

The Enhanced Dashboard provides weekly visibility on a suite of metrics enabling a rapid appraisal of each metric and determination of a response where impacts can be seen on the patient experience.

6.1 Staff Health and Well-Being

The nursing, midwifery and AHP workforce recognise the ongoing impact of the Covid-19 pandemic on NHS staff well-being. This continues to remain an area of significant focus with ongoing support from colleagues within Workforce and Organisational Development department (WOD). Recognising the ongoing exceptional circumstances colleagues are working and evolving a suite of services that continue to be refined to respond to those ongoing needs

These include:

- The Wellbeing Hour is actively encouraged and supported.
- Leader/Manager Resource Kit to support wellbeing to be at the heart of conversations with colleagues.
- Freedom to Speak up – Guardian.
- Trauma / PTSD therapy offered by Socrates Psychological Services.
- Money Advice Service - the NHS has partnered with the Money and Pensions Service to bring financial wellbeing support.
- Ongoing daily coaching/debrief for critical care staff.
- Ensuring staff feel safe and protected.
- Ensuring safe spaces for rest and recuperation.

- Appraisal of flexible working.
- Ongoing promotion and completion of the Trusts health and wellbeing risk assessment.
- Duty Matron rota established 7 days a week.
- 7-day senior nurse leadership rota.
- Wellbeing handover.
- Listening events.
- Financial Wellbeing support / workshops.

Medium-long term strategies

7.0 RECRUITMENT AND REGISTERED NURSE TRAJECTORY

The NHS Long Term Plan has set a target of reducing nursing vacancies by 5% by 2028 and the Trust remains committed to driving down the vacancy position at CHFT. This will be addressed by a comprehensive, multi-pronged Recruitment Strategy with ongoing alignment to the NHS People Plan and government mandate. This includes specific commitments around:

- **Looking after our people** – with quality health and wellbeing support for everyone.
- **Belonging in the NHS** – with a particular focus on tackling the discrimination that some staff face.
- **New ways of working and delivering care** – making effective use of the full range of our people's skills and experience
- **Growing for the future** – how we recruit and keep our people, and welcome back colleagues who want to return.

This is supported by the launch of the Trust's People Strategy and Recruitment Strategy 2022-2025. The Recruitment Strategy is supported by a detailed action plan which is underpinned by several principles including:

- International recruitment across all staff groups
- Values based recruitment
- Learning from the pandemic and developing a flexible, adaptable workforce
- Valuing development for all
- Growing our own and retention of our workforce

Below provides further detail surrounding our recruitment strategy:

7.1 International Nurse Recruitment

During 2021 we committed to recruiting 70 International Nurses before the end of December 2021. Due to delays related to travel restrictions and quarantine requirements we had 6 nurses remaining to recruit to meet this target. These nurses arrived in Spring completing our target for 2021 and have now successfully registered with the Nursing and Midwifery Council (NMC). Our original 2022 target was set at 80 and we have seen significant recruitment activity across this reporting period.

During this reporting period 44 internationally educated nurses have arrived in the UK for employment at CHFT. 6 of these were the outstanding recruits from the 2021 commitment. Out of the remaining 38 only 1 nurse has taken the NMC competency test and registered. The rest are at different stages of their training with exams booked between September-January. There is currently a national delay to test availability resulting in extended training times and a longer timeframe for NMC registration.

All nurses are supported to transition into life within the UK, in addition to a robust training package and wrap around pastoral support that has seen positive results with 0% attrition during the 2022 programme.

Pastoral support has been at the centre of this project since its inception and recognised by HEE and NHSE/I as imperative to making international recruitment work. CHFT pride themselves on a programme of pastoral support which exceeds the expectation set out by HEE and NHSE/I and includes:

- IR Facebook page for social engagement before and after arrival.
- Access to CHF/T's international recruitment specialist who guides recruits through the whole process from interview to taking their test. Assisting with transport, accommodation, visas, registering with GPs, shopping and the local area, booking tests including travel to Ireland.
- A welcome session and booklet that includes information about the UK, the local area and also the NHS including its background and the role of a nurse in the UK today.
- An open-door policy where during working hours all candidates past and present can drop in for support.
- Clinical support and orientation.
- Welcome packs and meet and greets (we are the first people recruits meet when they arrive).
- Support with NMC registration.

During 2022 the impact of this approach can be measured against the attrition which currently sits at 0%.

The Clinical Education Team are now working towards receiving the remaining internationally educated nurses from our original target of 80 and we expect this to be achieved on time, our next cohort of 12 arrive in September 2022. Based on the success of the last 2 years a "go further" target has been set at a further 20 taking the new overall target for 2022 to 100. Final interviews are taking place over the next few months to ensure we have enough nurses in the pipeline and we have received confirmation from NHSEI that international students that have trained in the UK can be counted towards our numbers. Combining both strategies there is a high level of confidence that the target will be reached.

In addition to the ongoing work across acute services work has commenced in partnership with Locala to support their programme of international nurse recruitment aimed at Community Services. This will further open opportunities for internationally trained staff whilst addressing the vacancy position within Community teams.

Work has also commenced with maternity colleagues and NHSEI with an aim to recruit 5 internationally educated midwives by July 2023. This project is in its infancy, but scoping work has commenced to establish a successful strategy for their recruitment.

As the numbers of internationally educated nurses increase, attention is turning towards professional development opportunities and revalidation support. This is integral in ensuring the Trust has a valued and supported workforce. Activity includes linking with regional and national groups to benchmark CHFT against other organisations and supporting some planned listening events in collaboration with our colleagues from inclusion and diversity.

7.2 Recruitment of Newly Qualified Nurses

Following the pandemic our 2022 Recruitment Strategy for new graduates continued to have a digital/virtual emphasis. Over the Summer some face to face recruitment sessions where reintroduced. The success of the recruitment sessions has resulted in 69 graduates accepting posts across various divisions, they are due to commence in post across September – October 2022. A welcome event for all new graduates was held in July, in addition to the new graduates enrolling in role specific induction and preceptorship programmes which will enhance competence and in turn confidence with the aim of retaining those recruited.

The Clinical Education Teams (CET) preceptorship package was shortlisted for a National Nursing Times award last year and this year the team is engaging in the work that is being led by NHSEI relating to developing a preceptorship framework. This work will allow us to benchmark more widely within a recognised national preceptorship framework.

Attracting our final year students remains a priority and recruitment events are planned for October and November. The CET are working with Workforce and Organisational Development and local Universities to create digital and promotional materials which will be used from initial recruitment/adverts through to onboarding and commencement in post.

7.3 Nursing Associate Apprenticeships (TNAs)

13 apprentices successfully registered as Nursing Associates (NAs) in June 2022, these have been allocated to vacant RN positions across the Trust. A further 9 are due to complete in quarter 3 following the completion of cohort 5's training.

There are 4 active cohorts of Trainee Nursing Associates (TNAs) (55 apprentices in total, of which 9 are due to qualify in December 2022). Business case approval was granted securing the programme until 2024 when a further business case will be required, this translates into a further 40 places across 2023.

As Nursing Associate numbers grow attention has started to turn to professional development opportunities and revalidation support. A listening event is scheduled in October fostering the Trust's values to put people first and hear from the staff. It is anticipated the information gained from this will inform and strengthen the support offer and future development of the role. Various workforce planning events have also taken

place with divisions to consider utilisation, governance and how the role can be embedded further into our clinical teams and services.

7.4 Registered Nurse Degree Apprenticeships

The 2 apprentices on the full 3-year apprenticeship will be moving into their final year as we move into quarter 3 (qualifying in January 2024).

The 1st cohort of 7 Nursing Associates on the 2-year shortened RN apprenticeship are all due to successfully complete the course in January 2023. The CET are working with apprentices and divisional colleagues to ensure their successful transition to vacant registered nurse posts. They will subsequently be enrolled into the relevant preceptorship groups and support will continue to ensure they successfully transition into their new role.

The 2nd cohort of Nursing Associates started their registered nurse apprenticeship in October 2021 which is progressing well with a view to qualifying in October 2023.

An opportunity for a further cohort of Nursing Associates shortened programme presented in Spring. Discussions were held with finance and nurse leaders and a small cohort of 7 was agreed. These posts have been recruited to and are due to commence the apprenticeship programme in October 2022..

Projected numbers and associated business cases for 2023 and beyond are being finalised within Trust and with partner Universities. Is it expected that recruitment will commence in Spring/Summer.

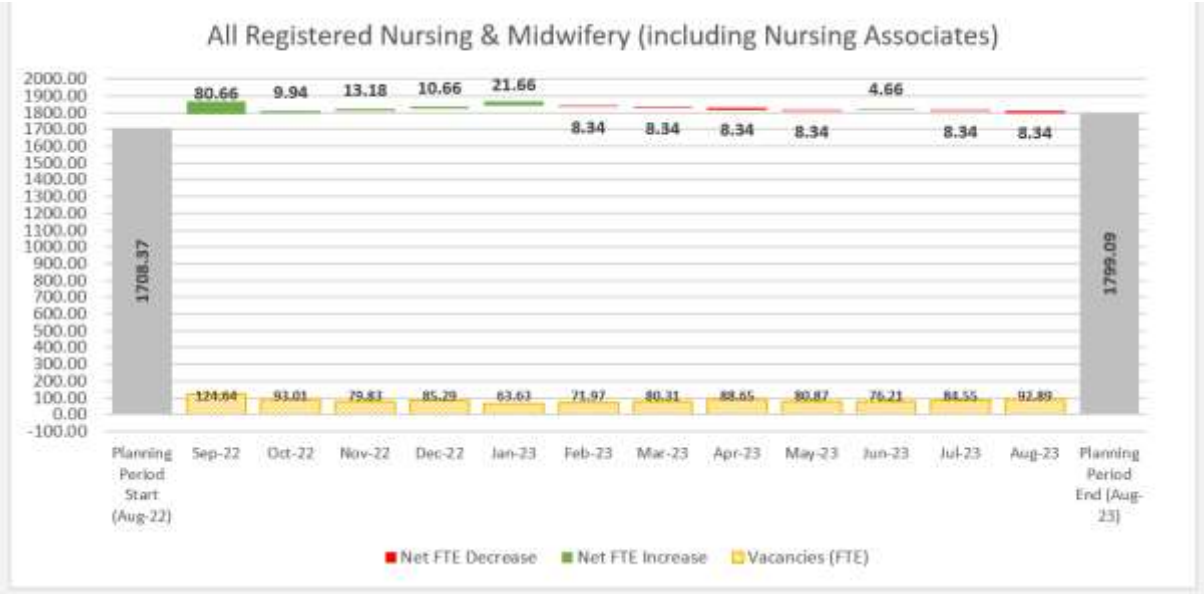
7.5 Return to Practice Nurses

1 nurse returned to practice in February 2022 and has now completed the course and registered with the NMC. The next cohort is due to commence in September 2022 and 3 people have been enrolled onto the course. In response to the low number of applicants across recent years, a review of the current strategy is underway which includes new recruitment materials, opportunities for other professional groups and exploring alternative training opportunities in collaboration with Workforce and Organisational Development, HEE Project Team and local course providers.

7.6 Summary position

Based on the current Nursing and Midwifery recruitment strategies, September's vacancy position sits at 124.64 FTE. Incorporating the current recruitment strategies, projections indicate this position will have reduced further in September 2023 to a vacancy position of 92.89 FTE. The vacancy position has deteriorated since the last report, given the incorporation of vacancies associated with the ongoing staffing of escalation areas.

(Figure 13)



7.7 Health Care Support Workers (HCSW)

The national 'Zero HCSW Vacancy' campaign continues into 2022, the aim of the programme is to meet a zero HCSW vacancy position.

A focus of the programme remains on employing HCSWs with no prior healthcare experience to avoid the destabilisation of other healthcare providers, notably the private sector.

Due to the existence of an established, successful Clinical Apprenticeship, all band 2 HCSWs must meet qualification and experience requirements, restricting the employment of new to care candidates. This is to ensure clear differentiation between apprentices and band 2 HCSWs, particularly as there is a pay disparity between the two. Currently Clinical Apprentices are the only 'new to care' candidates employed.

A weekly review of HCSW leavers data has identified an urgent need to focus on stabilising retention. Increasingly there are more leavers per week than joiners resulting in no change to the unfilled vacancy position, insight work has begun to understand the reasons for voluntary resignation within this workforce.

The HCSW Recruitment Team continue to identify vacancies via the triangulation report and attendance to Nursing and Midwifery Workforce Safer Staffing meetings, this allows allocation of successful candidates to priority areas in which position fill is low. Administrative time for Clinical Leads also remains reduced as new starter tasks such as uniforms and IT access is completed within the HCSW Recruitment Team, allowing a more streamlined induction into the Trust. Delays across recruitment have been minimised by having a central service that advertise, shortlist, interview and appoint.

7.8 Employability at CHFT

The Employability Team have been developing a range of entry pathways into the Trust supplemented with targeted employability interventions that seeks to support additional recruitment into clinical and nonclinical areas. Guiding principles within employability focuses on leveraging local talent, supporting internal CHFT colleagues and removing barriers to entry for applicants in accessing development opportunities at CHFT.

Since August 2021, The Widening Participation Team have achieved some amazing outcomes which has included:

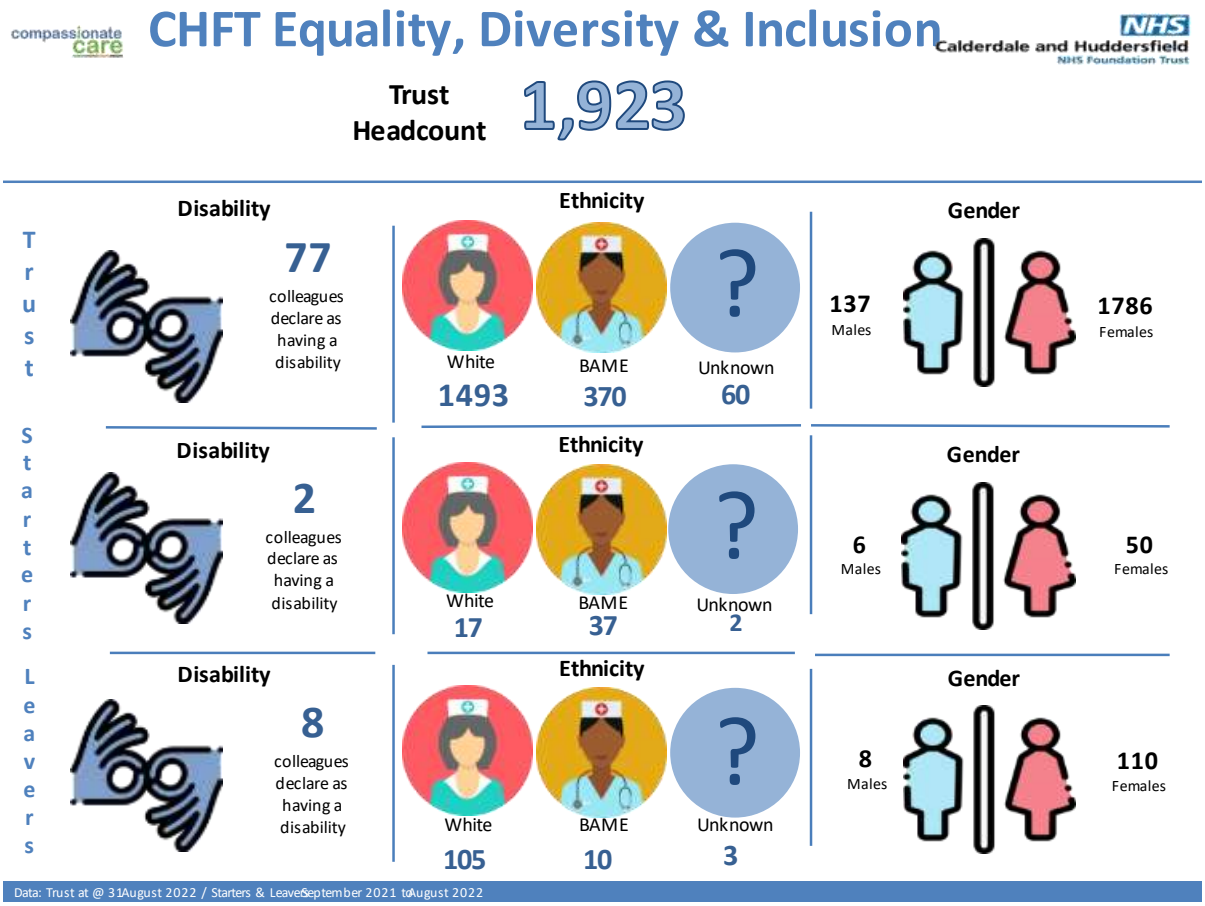
- Created new entry pathways for both clinical and non-clinical careers into CHFT which include The Princes Trust, NHS Cadets, Kickstart, Project Search, Volunteering, Sector Work Based Academies (SWAP) and T levels (in planning). 96% of participants aged 16-24 years.
- 45 x local participants progressing into apprenticeships and substantive posts from across our Widening participation projects.
- Achieved greater reach into our local communities particularly those who face additional barriers such as the long term unemployed or those from underrepresented communities.
- Gained national recognition from HEE and NHSI for our “Inclusive Care Club” volunteer to career pathway. We have recruited over 120 volunteers aged 16 – 30 years across 30 CHFT areas.
- Relaunched work experience supporting over 150 x local students aged 16-18.
- Income generation from NHSI, Kickstart and currently awaiting outcome from HEE recent submission to extend our current volunteering project.
- Developed and delivered a range of employability workshops for both internal CHFT colleagues and external participants from a range of local education institutions.
- Co-locality working and partnership development with a range of organisations including REALISE – a free offer of Maths, English and Digital Skills for our unregistered workforce, C+K Careers Advice and guidance workshops, Princes Trust co-locality project alongside Locala and a range of local health care providers supporting 70 unemployed residents into sustained employment, SWAP alongside Kirklees LA and JCP+ and a range of a local careers’ events across Kirklees and Calderdale reaching over 3800 local young people.

In line with the Trust’s People and Recruitment Strategies this work supports the “grown our own” and retention strategy.

8.0 NURSING AND MIDWIFERY WORKFORCE

8.1 Equality Diversion and Inclusion

(Figure 14)



The current qualified nursing workforce comprises of 1923 staff, 77 (4.0%) of which have declared a disability, comparable to CHFT as a whole at 4.52%.

370 (19.2%) of all registered nurses (RNs) at CHFT are of BAME ethnicity, this is below the reported overall CHFT figure of 22.3%, while just over 3% have not declared their ethnic origins.

The majority (93%) of RNs are female, this is above the Trust whole workforce gender split of 81.2% female, 18.7% male.

Over the reporting period for Nursing and Midwifery there has been a net…

…decrease of 1 disabled colleague.
…decrease of 29 white staff.
…increase of 101 BAME staff.
…decrease of 2 staff of unknown ethnic origins.
…increase of 16 males.
…increase of 54 females.

8.2 Revalidation

Revalidation is the process that all nurses and midwives in the UK and nursing associates in England need to follow to maintain their registration with the Nursing and Midwifery Council (NMC). Revalidation promotes continual development and reflection in practice and is a requirement to undertake every three years.

In 2022 approximately 424 nurses, midwives and nursing associates revalidated (based on 2025 projections), with 130 due to revalidate during 2022.

The NMC provides a comprehensive suite of resources which support registrants through the process of revalidation. This is signposted through CHFT intranet page which also provides additional information to support the process.

As part of the 2022 Nursing and Midwifery workplan the CET have provided targeted revalidation sessions to international nurses, Nursing Associates, and new registrants as part of their preceptorship programme.

8.3 Nursing and Midwifery Council (NMC) referrals

During 2022 there are 10 active cases that have been referred to the NMC with a further 11 cases that have been closed.

9.0 SUMMARY

- During the reporting period establishment reviews have been undertaken which continue to focus upon the recovery agenda and returning many services to pre-covid workforce models.

- The Chief Nurse Safer Staffing Panel approved the decision to recruit to the vacancies associated with the workforce model requirements in the escalation areas which have maintained this position for over six months.

- The impact of the combined actual RN wte and average sickness absence position modelled across the four divisions is creating a deficit and impacting upon the ability to meet the actual CHPPD, which describes an unmet patient need.

- Close monitoring of nurse sensitive indicators and red flag escalations also demonstrates a trend which corresponds to the RN shortfall position.

10.0 RECOMMENDATIONS

The Board is asked to: -

- Receive this report and note the on-going plans to provide safe staffing levels within nursing, midwifery and AHP disciplines across the Trust.
- Note the maternity staffing position and the local position which is common with the national profile.

- Note the compliance standards used in relation to SNCT, and the ongoing quality of data it provides to underpin the Trust establishment process.
- Note the assurance regarding the daily processes to monitor and manage nurse and midwifery staffing levels at ward level.

NHS Calderdale and Huddersfield NHS Foundation Trust

Appendix 1: Safer Staffing OPEL cards. (Review date January 2023)

Safer Staffing Levels of Escalation and Recommended Mitigations			
Escalation Level	**Acute Trusts**	**Community Care**	**Action**
OPEL 1	**No staffing issues identified** **Use of specialist units/beds/wards have capacity** • Demand for services within normal parameters • There is capacity available for the expected emergency and elective demand. • No technological difficulties impacting on patient care • Good patient flow through ED and other access points. Pressure on maintaining 4-hour Emergency Care Standard • Infection control issues monitored and deemed within normal parameters	**No staffing issues identified** Community capacity available across system. Patterns of service and acceptable levels of capacity are for local determination	• Monitor current situation (daily staffing meetings) • Where surplus staff to patient care needs identified, feed into staffing meetings to support other areas. • Ensure changes to staffing are reported accurately with safe care. • Review actual staffing levels, understanding the gaps and the actions required to close them. • Ensure breaks and annual leave is taken as planned (working within Annual Leave Policy) • Ensure live recording of Safe Care describing service area acuity and professional judgement • Divisional Confirm and Challenge meetings • Regular staffing meetings should be adhered to. • Effective roster management - ensuring safer staffing planning reflects the principles of good health roster management and KPI's, including adherence to headroom. • Send shortfalls in WFM to Flexible Workforce Department in a timely manner • Daily safety huddles • *Identify what activity can be brought forward

*Community Specific Actions

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Escalation Level	Acute Trusts	Community Care	Action
OPEL 2	**Lower levels of staff available but appropriate mitigation to maintain services** **Opening of escalation beds likely (in addition to those already in use)** **Capacity pressures on PICU, NICU, and other intensive care and specialist beds** • Anticipated pressure in facilitating ambulance handovers within 60 minutes • Insufficient discharges to create capacity for the expected elective and emergency activity • Infection control issues emerging • Lack of beds across the Acute Trust • ED patients with DTAs and no action plan	**Lower levels of staff available, but are sufficient to maintain services** • Patients in community and / or acute settings waiting for community care capacity • Lack of medical cover for community beds • Infection control issues emerging	• All appropriate actions at Level 1 completed • Liaise with buddy wards to source any additional support (this may be a 2-3 hours etc) • Escalate concerns through safe care • Ensure clear communication of expectations of what the escalation beds require from a workforce model. • Refer to local action cards that are established for clinical areas • Ensure communication with health roster teams to initiate the builds to proposed escalations. • If required, offer additional hours at agreed enhanced payments & volunteers to rearrange annual leave to provide extra capacity • Consider additional support from ward clerk role to support patient flow (admissions and discharges) • Chase reviews and diagnostics to expedite discharges • Nurse in charge on ward areas to acknowledge and act on right to reside data • *Consider stopping accepting referrals for patients on the Practise Nursing caseloads – weekends and annual leave • *Inform CCG of any change to service provision and/or requests made to other providers for support/mutual aid

*Community Specific Actions

NHS Calderdale and Huddersfield NHS Foundation Trust

Escalation Level	Acute Trusts	Community Care	Action
OPEL 3	**Actions at OPEL Two failed to deliver capacity** **Significant unexpected, reduced staffing numbers (due to e.g. sickness, weather conditions) in areas** **Serious capacity pressures escalation beds and on PICU, NICU, and other intensive care and specialist beds** • Significant deterioration in performance against the 4-hour Emergency Care Standard (e.g. a drop of 10% or more in the space of 24 hours) • Patients awaiting handover from ambulance service within 60 minutes significantly compromised • Patient flow significantly compromised • Unable to meet transfer from Acute Trusts within 48-hour timeframe • Awaiting equipment causing delays for a number of other patients • Problems reported with Support Services (IT, Transport, Facilities Pathology etc.) that cannot be rectified within 2 hours	**Significant unexpected, reduced staffing numbers (due to e.g. sickness, weather conditions) in areas where this causes increased pressure on patient flow** Community capacity full	• All appropriate actions at Level 2 completed • Daily sit-rep reporting of position by affected services • Where appropriate, cancel/defer all meetings not immediately required for the provision of safe services • Consider cancelling all non-essential training (risk assessed within divisional areas and oversight by ADN's for consistency of approach) • Implementation of daily Nursing and Midwifery Safer Staffing meeting (this will receive escalations from staffing meetings) • Band 7 visibility on the clinical area – leading from the front, supporting staff to take breaks • Staff on days off or annual leave contacted to see if available to support. • Visible senior leadership walk rounds to clinical areas • Maximising the opportunity for the right staff, with the right skills are in the right place and at the right time (Prompt:- consideration of multi-professional response) • Mobilise ward helper support (e.g. from care club or volunteers) to support clinical services • Non-essential procedures postponed where clinically indicated. • Undertake reviews of specialist nursing roles and risk assessment of ability to release nursing capacity to clinical areas (mobilisation will be activated in OPEL 4) • Organise 'Buddy Matron' roster to ensure coverage on both sites 7 days per week. (Implement at OPEL 4) • Depending on where the pressures lie within the system, ensure attendance at the • *Suspend District Nursing clinics • *Consider declining new OPAT referrals • Offer additional hours at agreed enhanced payments • *Community Matrons to cancel non urgent visits to support District nurses and Quest Team • Review all patients due for discharge to assess whether discharge can take place sooner

NHS Calderdale and Huddersfield NHS Foundation Trust

Escalation Level	Acute Trusts	Community Care	Action
OPEL 4	**Actions at OPEL Three failed to deliver capacity** **Unexpected, reduced staffing numbers (due to e.g. sickness, weather conditions) in areas where this causes increased pressure on patient flow is at a level that compromises service provision / patient safety** **Severe capacity pressures on PICU, NICU, and other intensive care and specialist beds.** **Infectious illness, Norovirus, severe weather, and other pressures in Acute Trusts (including ED handover breaches)** • No capacity across the Acute Trust • Severe ambulance handover delays • Emergency care pathway significantly compromised • Unable to offload ambulances within 120 minutes • Problems reported with Support Services (IT, Transport, Facilities Pathology etc.) that cannot be rectified within 4 hours	**Unexpected reduced staffing numbers (due to e.g. sickness, weather conditions) in areas where this causes increased pressure on patient flow is at a level that compromises service provision / patient safety** No capacity in community services	• All appropriate actions at Level 3 completed • Staffing ratios will be reduced outside national guidance. The staffing position will be assessed at twice daily meetings chaired by the ADN. Professional Judgement will be used to mitigate risk on shift-by-shift basis, the risk of which will be escalated through Gold Command. • Matrons will be deployed to clinical shifts as determined by the ADN. • 'Buddy Matron' rota will be implemented to ensure presence on both sites 7 days per week. • Daily Huddles will be undertaken by the Outpatient departments to provide support where possible to other clinical areas. • Consider deferring essential safety training • If required, defer appraisals and 1:1s unless high risk • Mobilisation of deployment of specialist nurses as identified in OPEL 3 planning stage • Admission avoidance – consider only accepting hospital discharges • Use of other staff within CHFT (not including core services) with correct skill set to meet presenting need where appropriate • All colleagues with a clinical registration to be available to support essential services and critical functions if required. • *Consider providing essential visits only • *Where possible, suspend non-core services to support core services • *Contact other healthcare providers to provide support for essential service delivery

24. Board Assurance Framework – Update 2

To Approve

Presented by Andrea McCourt

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 10 November 2022
Meeting:	Board of Directors
Title:	Board Assurance Framework – Update 2 2022/23
Author:	Andrea McCourt, Company Secretary
Previous Forums:	Audit and Risk Committee 25 October 2022 - full Board Assurance Framework

Purpose of the Report

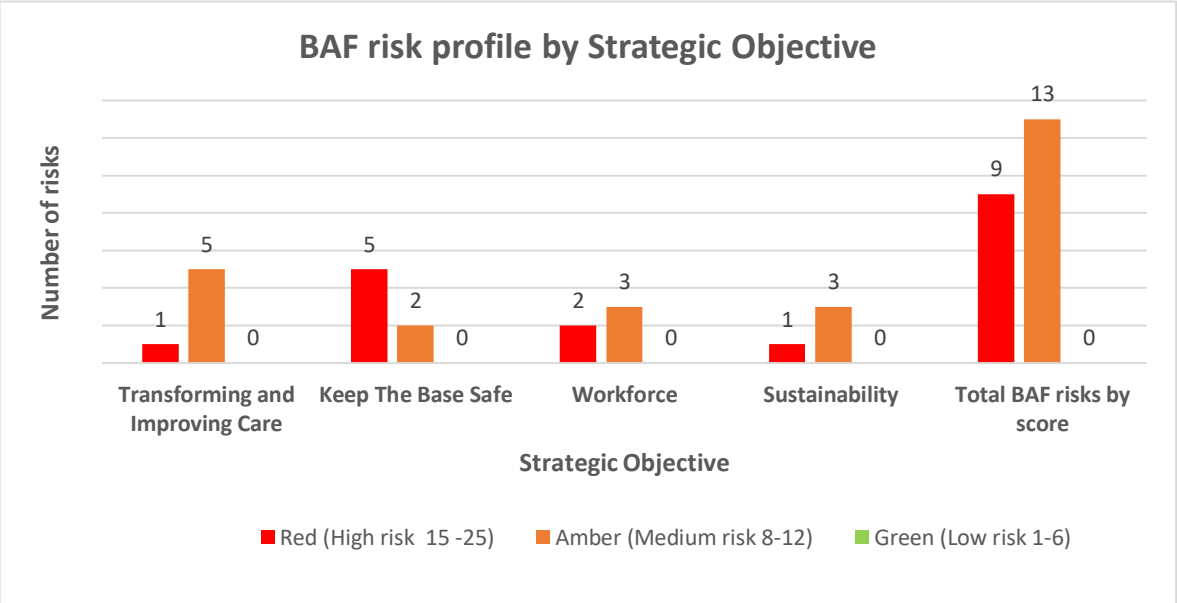
The Board Assurance Framework is the key source of evidence that links the Trust's strategic objectives to risk and assurance. It is the main tool that the Board uses for discharging its overall responsibility for internal control and is presented to the Board three times a year.

This report presents the second update of the Board Assurance Framework (BAF) for 2022/23 for approval, having been reviewed by the Audit and Risk Committee on 25 October 2022 which recommends it to the Board for approval.

Key Points to Note

Risk Profile

The Trust has the following risk profile for risks to its strategic objectives as at 2 November 2022 with a total of 22 risks. The Keeping the Base Safe strategic objective has the greatest number of high (red) risks, at 5 of the 22 risks on the BAF.



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.

Top Risks

The BAF, via the heat map, shows the top two risks for the Board, both with a risk score of 20, which are:

1. Workforce - nurse staffing
2. Transforming and Improving Care - approval of hospital reconfiguration strategic outline case, outline case and full business case.

To note risk 18/19 relates to the long term financial sustainability of the Trust and has a risk score of 16. In terms of the 2022/23 financial plan the Trust corporate risk register has a risk ref 8057 with a risk score of 20, reflecting the risk of not achieving the 2022/23 financial plan.

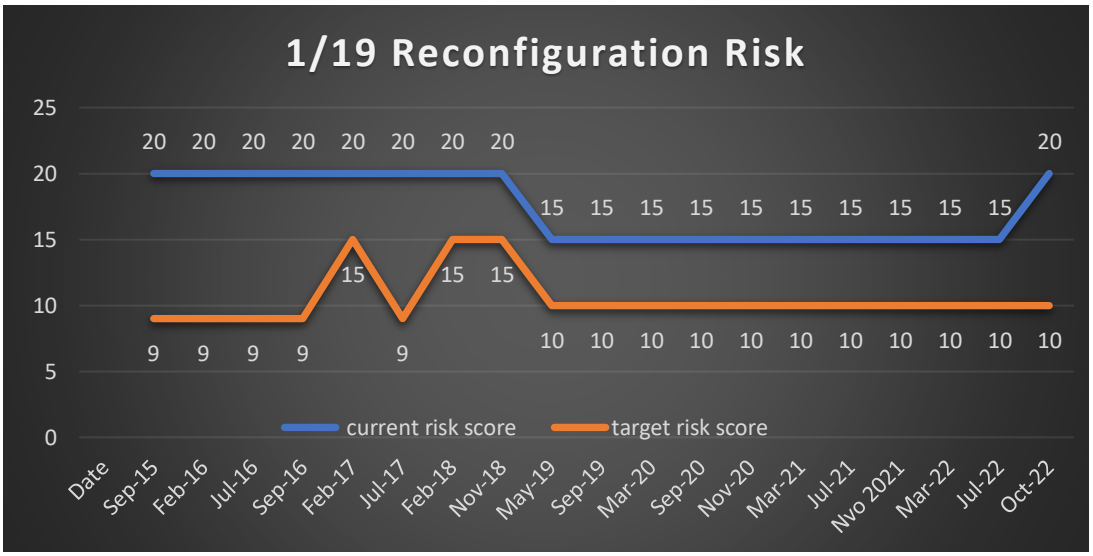
There are no new risks on the Board Assurance Framework (BAF) or risks proposed for a removal.

Risk Score Movement

There are two risks with upward movement in risk score and two risks with a reduced risk score as detailed below. The rationale for the movement in risk score given together with the risk score history is given for each of these risks.

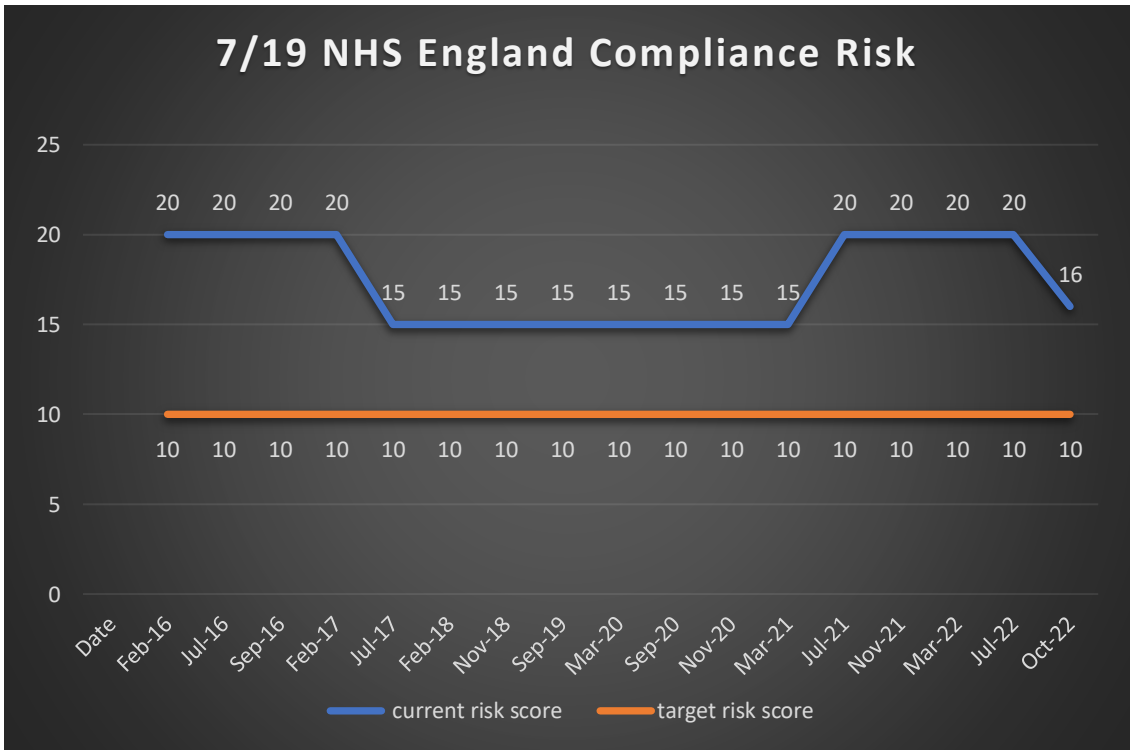
Risk score movement	BAF Risk reference and score	Risk score
↑	1/19 Reconfiguration	20 (increased from 15)
↑	6/19 Quality & Safety Standards	15 (increased from 12)
↓	7/19 Compliance with NHS England	16 (reduced from 20)
↓	5/20 Elective recovery	16 (reduced from 20)

- ***1/19 Reconfiguration*** - increased from a risk score of 15 to 20 with an increase in the likelihood score from 3 to 4 due to delays in a decision by the Treasury regarding the reconfiguration business case due to the political situation. The score history of the risk is given below:

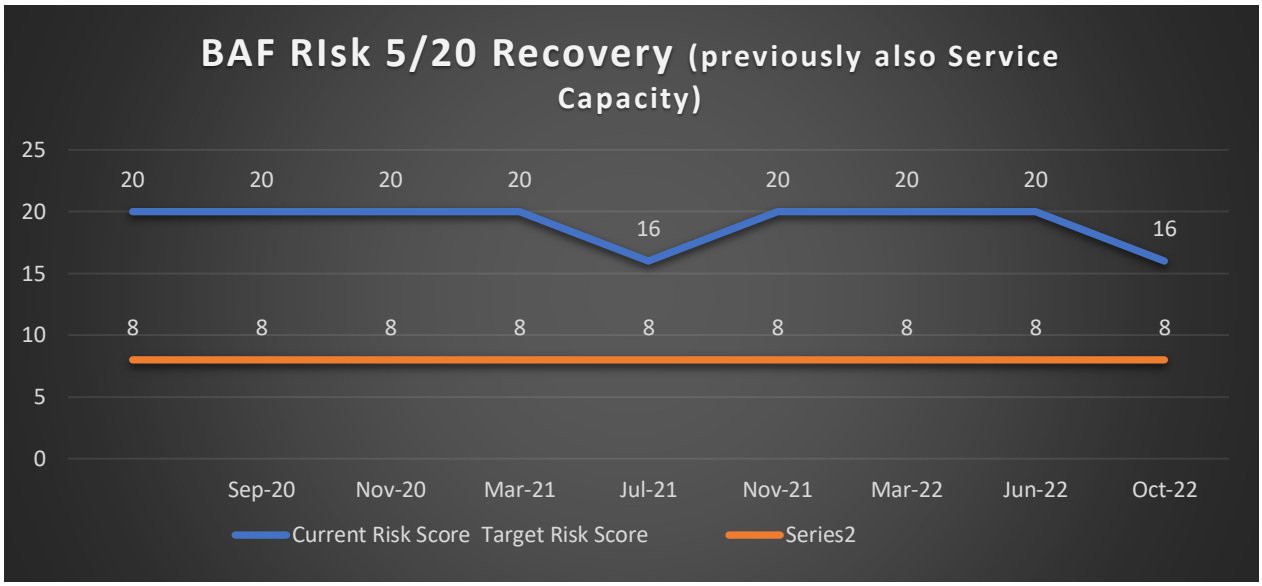


- ***6/19 Quality and Safety risk*** - increased from a risk score of 12 to 15 with an increase in the likelihood score from 4 to 5 due to internal audit limited assurance report on quality governance structure. The score history of the risk is given below:

- ***7/19 Compliance with NHS England*** - risk reduced from a risk score of 20 to 16 with a decrease in the likelihood score from 5 to 4 due to NHS England's confirmation of the segmentation process within the 2022/23 Oversight Framework. The Trust has not been under scrutiny by NHS England for operational performance within this new framework, hence a reduction in the likelihood and risk score (see also the Governance report section on Oversight and Assurance - Winter Resilience). The score history of the risk is given below:



- ***5/20 Recovery*** - The Board of Directors requested this risk be re-focused on recovery, having been previously also focused on managing capacity for Covid in-patients. The risk description has now been revised accordingly. The risk score has reduced from a risk score of 20 to 16, with a decrease in the likelihood score from 5 to 4. The reduction in score reflects the Trust's current level of good performance against recovery trajectories. In considering the extent of the reduction in the likelihood score, it has been agreed that as the winter period may impact on performance prior to the financial year end, it is prudent not to reduce the score further at this point. 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 2 November 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	16 ↓	Regulation	Moderate
8/19 Performance targets	16 =	Regulation	Moderate
5/20 Recovery of elective activity	16 ↓	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. **NOTE** the increased risk scores for risks 1/19 reconfiguration and 6/19 quality and safety standards and reductions in risk scores for risks 7/10 NHS England compliance and 5/20 elective recovery ii. **APPROVE** the updates to the risks on the Board Assurance Framework iii. **CONSIDER** if there are any further risks to the achievement of strategic objectives

Update 2 -November 2022
2022/23

Calderdale and Huddersfield NHS Foundation Trust

BOARD ASSURANCE FRAMEWORK
2022/23 Update 2

Contents:

compassionate care

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	20 ↑	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	RB	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	15 ↑	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	16 ↓	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	JH	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 the Trust is not able to achieve its recovery targets, due to operational pressures resulting in patient harm, potential adverse impact on health inequality and impact on PLACE and Integrated Care System and partners	20	16 ↓	8	JH	7689, 7683, 7809, 7834, 7634	Harm and safety	Low
A workforce fit for the future								
10a/19	Risk of not being able to deliver safe and effective high quality care and experience for patients due to insufficient medical staff caused by an inability to attract, recruit, retain, reward and develop colleagues.	16	16 =	9	DB	2827,7078, 5747	Quality/Innovation & Improvement	Significant

SUMMARY BOARD ASSURANCE FRAMEWORK RISKS BY TRUST STRATEGIC GOAL

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	8057	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

CHFT RISK APPETITE STATEMENT - Revised September 2022

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, and local impact, 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 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**

HEAT MAP

LIKELIHOOD (frequency)	CONSEQUENCE (impact / severity)				
	Insignificant (1)	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Extreme (5)**
High Likely (5)			6/19 Compliance with quality standards ↑		
Likely (4)		15/19 Commercial growth =	02/20 Digital Strategy = 12/19 Staff engagement =	18/19 Long term financial sustainability = 8/19 National and local performance targets = 10a /19 Medical Staffing levels = ↓ 05/20 Recovery 7/19 Compliance with NHS Improvement ↓	10b/19 Nurse Staffing levels = 1/19 Approval of hospital reconfiguration strategic outline case, outline business case and full business case ↑
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 =	9/19 HRI Estate fit for purpose =
Unlikely (2)				6/20 Climate change =	
Rare (1)					

= no change to risk score

Assessment is Likelihood x Consequence

BOARD ASSSURANCE FRAMEWORK
OCTOBER 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 OCTOBER 2022 Risk category: Strategic Risk appetite: Significant**	
1/19	Board of Directors / Transformation Programme Board	Director of Transformation and Partnerships	Risk that the Trust does not secure approval of the Hospital Services Reconfiguration Strategic Outline Case (SOC), Outline Business Case (OBC) and Full Business Case (FBC) from NHSI, DHSC, Ministers and HM Treasury and as a result the Trust is unable to progress changes that will improve the quality of care, workforce resilience and mitigate estate risks **Impact** Trust unable to improve long term clinical quality and deliver compliance with statutory, regulatory and accepted best practice.	Formal governance structures established: - Transformation Programme Board, formal sub-committee of the Trust Board oversees service transformation and reconfiguration plans. - Quarterly review meetings with NHSE&I, and DHSC colleagues to advise on planning assumptions used in business cases to ensure compliance with HM Treasury and DHSC requirements and facilitate future approval(s). External professional and technical capacity and expertise procured with design partner appointed in March 2020. Turner Townsend have been appointed to provide a Project Director. Close working with: - Joint Health Scrutiny Committee, wider stakeholders and colleagues to ensure full involvement in the development of the plans and business cases. - West Yorkshire Health & Care Partnership and Calderdale Cares Partnership and Kirklees Health and Care Partnership to ensure alignment of the reconfiguration plans with their strategic objectives to facilitate the ICS and Place based formal letters of support for the business cases. A Round Table Board is established that has members from NHSE, WY ICS, DHSC, Calderdale and Kirklees Places and meets quarterly to ensure system alignment and support for business case planning assumptions and development.	First line Transformation Programme Board-oversight of governance and content of business case development including relationship management with Stakeholders and the ICS, NHSE/NHSI, DHSC Second line Trust Board approval of business cases (SOC approved, March 2019). Reconfiguration OBC and FBC for new A&E at HRI approved by Trust Board in October 2021. Travel Plan approved by the TPB and the Green Plan by the Trust Board. Planning Permission for the new A&E at HRI was approved in September 2021. Planning Permission for the build of a Multi-storey car park and the new clincal buildings at CRH was approved by Calderdale Council in March 2022 Third line ICS and NHSE/NHSI review and approval of business cases prior to submission to DHSC. SOC approved by DHSC in November 2019. FBC for new A&E at HRI approved by NHSE Joint Investment Sub-Committee (JISC) in December 2021. The Reconfiguration OBC was approved by NHSE Joint Investment Committee (JIC) on 25th February 2022. Reconfiguration OBC submitted for approval by Treasury with expectation that this would be in July 2022. National political uncertainty has delayed this decision generating risk to the timely progression of the programme.	• See below for further detail. 1. Her Majesty's Revenue and Customs (HMRC) advice on preferred procurement route 2. Agreement for development on the CRH site.	Work has been undertaken and presented to Transformation Programme Board (TPB) to define the skills and capacity needed for next stage of the programme to develop the Reconfiguration Full Business Case. Approval has been given to secure the necessary additional capacity / expertise. Project structures for the next phase of work have been implemented and progress is reported into the TPB each month.	**Initial** 5x5 = 25	**Current** ↑ 5x4 = 20	**Target** 2x5 = 10

Gaps in Control	**Timescales**	**Lead**
1.Trust and CCGs need to agree clinical protocols with Yorkshire Ambulance Services to ensure patients are transported to the hospital that provides the services that will meet their clinical needs – whether this is in Halifax, Huddersfield or other specialist providers, such as Leeds. 2. The Trust must obtain advice from Her Majesty's Revenue and Customs (HMRC) regarding the preferred procurement route through the Trust's wholly owned subsidiary (Calderdale & Huddersfield Solutions Ltd). 3. The Trust will have concluded discussions with the PFI Special Purpose Vehicle (SPV) to enable the development on the CRH site. 4. Provision of aditional car parking at CRH.	1. Discussions have taken place with YAS and activity modelling and clinical protocols have been agreed. 2. The Trust has written to HMRC regarding the preferred procurement route through Calderdale and Huddersfield Solutions. 3. An agreement with the PFI Special Purpose Vehicle has been drafted and is progressing to completion -this will require Treasury approval. 4. Build of a Multi-storey car park at CRH by 2024.	AB for all actions

Links to risk register from current service configuration:
2827 - over reliance on middle grade doctors in A&E - workforce standards, A&E and critical care
7413 - fire compartmentation risk HRI

BOARD ASSSURANCE FRAMEWORK
OCTOBER 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 OCTOBER 2022 Risk category: Regulation Risk appetite: Moderate**		
3/19	Quality Committee	Executive Medical Director	**Risk** Risk that the Trust will be unable to deliver appropriate services across seven days due to staffing pressures resulting in poor patient experience, greater length of stay and reduced quality of care **Impact** - Reduced quality of care - Increased length of stay - Increased HSMR / SHMI - Delayed discharges	• Governance systems and performance indicators in place, Learning from Deaths group and Care of the Acutely Ill Programme re-established, reports to Clinical Outcomes Group and Quality Committee. Quality Comittee oversight of SHMI / HSMR. • Rosters focussed on managing Covid-19 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, cardiac 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), 1 September 2022 (Q1 2022/23) 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, subject to national funding following submission of business case Timescale; 2023 Lead: Associate Director of Strategy Cardiac(stress tests , angiography delays from Covid) / neurophysiology are challenging Action: plan for additional internal activity as part of Recovery response: Planned recovery for Neurophysiology - March 2023 Planned recovery for echo - December 2022 lead Interim Chief Operating Officer	Scope for futher implementation limited without service reconfiguration or additional investment	**Initial** **5x3 = 15**	**Current** **3x3= 9 =**	**Target** **2x2 = 4**

Action	**C**	**Lead**
Radiology - SOP for next day follow up of urgent patients requiring out of hours MRI. Development of Community Diagnostic Hubs (CDH). Ongoing review of staffing pressures A&E Plan additional diagnostic capacity as part of Recovery response	March 2023 (CDH) Ongoing Ongoing	Interim Chief Operating Officer Interim Chief Operating Officer Clinical Director A&E

Links to risk register:
No high level risks with score >15

BOARD ASSSURANCE FRAMEWORK
OCTOBER 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 OCTOBER 20222 Risk category: Regulation Risk appetite: Moderate**		
4/19	Quality Committee	Chief Nurse	**Risk** Risk that the Trust does not listen, involve and engage patients and the public to influence decisions about their personal care, delivery and improvement of services, and people from black, minority ethnic groups and all other protected characteristic groups receive suboptimal care due to lack of , capacity and capability to respond in a meaningful way to patient and service user feedback resulting in not designing services using patient recommendations **Impact** - poor patient experience Non delivery of improvements in services - inequitable service / care for patients - Risk of legal challenge - Reputational impact	• Patient Experience Group (PEG) mandates the workplan and oversees progress and audit activity for public involvement and patient experience, governor and Healthwatch are members •Dedicated senior leadership post for patient experience, equality and diversity and matron for complex care needs •Patient and Service User Engagement Strategy approved by Quality Committee. Observe and Act patient observation tool as part of Journey to Outstanding reviews •Carer's Strategy approved March 2022, developed with service users and local voluntary sector organisations that: raises the profile of carers, improves education and training, supports person centred care, and reviews CHFT as an employer. Recruited and trained over 120 ward volunteers to help combat feelings of loneliness and isolation for patients (and training opportunities for local residents). • Patient engagement in Outpatient Transformation Programme •Patient Story Process Map 2022 in place with a robust process for capturing, sharing, and learning through patient stories, which are now a standard agenda item within our Patient Experience & Caring Group, also presented at each divisional PSQB • Nursing and Midwifery Strategy which enables staff time to care for patients • Patient-led Visual Impairment Group • Health Inequalities group and workplan with a focus on the experience of BAME services users and people living with learning disabilities, Governor attends Health Inequalities Group as lay member. BAME Community Engagement Advisor Engagement with Race Equality network group create engagement opportunities with local BAME communities . • Matron on Reconfiguration Team leads on patient experience • Complaints mapped to IMD groupings	First line Patient Experience Group. Regular review by Quality Committee as part of bi monthly quality report Examples of good practice with patient feedback, service users include co design and development of children's community hub, a 'sleep well at night' training video, continuity of carer maternity teams supporting greater engagement in decisions about personal care (BAME / areas of deprivation), engagement on relocation of Rainbow Child Development Service, project to improve access to healthcare for disadvantaged groups focused in ED, high intensity users group in place developed with partners, new Clinical Nurse Specialist post for transition of young people with neruo-disability, improved pathway for cancer patients accessing treatment as EOL care workstream,patient line for cardiology and haematology 24/7 accessed by 80 per month, dedicated oncology patient helpline Second line Patient Story to Board meetings and to PEG Governor attends PEG and is chaired by Associate Non-Executive Director. PEG reporting to Quality Committee quarterly, Commissioner member at Quality Committee. Board quality report includes a section in relation to service users involvement. Third line Quality Accounts, CQC rating of Good - report referenced positive examples of patient engagement. Healthwatch reports (Outpatients post Electronic Patient Record, Syrian Refugees)	Lack of central system for patient engagement and involvement data - lead AD Quality and Safety / Quality Governance Lead for Patient Experience Develop Patient Experience engagement plan and mechanism for systematic involvement of members of BAME communities. Action: Refresh of Patient and Service User Engagement Strategy , Assistant Director Patient Experience Timescale: March 2023 Lead: Monitored through our Patient Experience & Caring Group. Regular updates provided within the patient experience section of our divisional PSQB's. Current operational pressures are impacting on the pace of progression of some workstreams due to focus on recovery plan		**Initial**	**Current**	**Target**
								3x4 = 12	**4x3 = 12 =**	**1x4 = 4**
Action					**Timescales**			**Lead**		
Refresh of Patient and Service User Engagement Strategy					March 2023			Quality Directorate / L Rudge		
Links to risk register: No risks on the high level risk register										

BOARD ASSSURANCE FRAMEWORK
OCTOBER 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 OCTOBER 2022 Risk category: Strategic Risk appetite: Significant**		
Ref: 01/20 Added July 2020	Transformation Programme Board (TPB)	David Birkenhead, Medical Director	Risk of not delivering the ambitions described in the Trust clinical strategy due to lack of collaboration across the West Yorkshire system to enhance the quality and resilience of clinical services due to lack of time, commitment, relationships and absence of shared vision, resulting in missed opportunities in terms of quality, efficiency, capacity, patient experience and workforce NB: See 1/19 reconfiguration risk which has signifcant overlap with this risk	Refreshed Clinical Strategy - describes Trust position on service development across West Yorkshire (WY) Transformation Programme Board - clinical strategy informing decisions made to reconfigure services and ensure that the redesigned hospital model is fit for purpose ICS - member of the WY& H Partnership Board which agrees service direction, strategy and financial allocations and controls. More effective working relationships with partners and establishment of networked approaches to Pathology and Vascular Surgery. Transformation Programme Board ensures estate is aligned with the clinical strategy. Recently established Planned Care Alliance to co-ordinate and plan phased approach to reset, including redesign to planned care Member of WYAAT which identifies, agrees and manages programms of work targeted to improve services and patient experience across West Yorkshire. WYAAT governance framework with specific forums for acute Trusts including Chief Exec forum, Committeee in Common and programme office with oversight. Recruiting for additional Oncology staff to strengthen capacity Report into Oncology Services for WY by Mike Richards complete and supports CHFT as a hub. Independent reivew report (Dec 2021) recommends two site service model for NSO CHFT/ MYHT Partnership Board established which discusses fragile services and fosters closer working relationships Establishment of Integrated Care Board (ICB) and PLACE level clinical and professional forums (sub group of ICB) with oversight of care across the ICS system, PLACE based forums will influence local service developments	**First Line** Clinical strategy developed and shared with WEB (23.5.19.) **Second Line (Board / Committee)** Clinical strategy - Board 4 July 2019 (private), refreshed Clinical Strategy July 2021 Board approved Board Business Better Than Usual report to 2 July 2020 Board describing learning from Covid-19 will help to inform any necessary adaptation of the Clinical Strategy ICS clinical forum 7 July 2020 discussed Planned Preventative Care post Covid-19 Response to COVID-19 has by necessity driven enabling work for the strategy, including remote working, developments in community care, and virtual outpatients. **Third Line** Vascular network established with Bradford WYAAT Pathology Board established. Common LIMS procured now being rolled out Diagnostics Board and Imaging Collaborative established across West Yorkshire	Non-Surgical Oncology (NSO) - acute system pressures across WY require additional support from CHFT. Working with LTHT, MYHT to ensure short term service support in place, whilst sustainable WY solution in place. Action: Service model will be subject to ICS support and ongoing dialgoue with Oversight & Scrutiny Committee re public engagement West Yorkshire and Harrogate WYAAT Clinical Strategy under development. Action: Following pause during Covid, WYAAT clinical lead restarting clinical strategy work,including refresh of workforce data, linking with fragile services work. ICS to develop clinical strategy - ICS Medical Director to confirm timeframe, WYAAT and ICS system-wide approaches to reset. Performance of CHFT in relation to Covid recovery programme may reduce ability to deliver new services	Implementation of agreed West Yorkshire Oncology Service model. Project Manager appointed for South sector (CHFT and Mid Yorskhire Hospitals Trust). Action: Implementation Board to be organised in November 2022. Lead: David Birkenhead Review alignment of Trust clinical strategy with ICS 5 year plan for Better Health and Well-Being for everyone. Lead: David Birkenhead Timescale: 31.1.23.	**Initial** 3x5=15	**Current** 3x4=12	**Target** 2x5=10
Action					**Timescales**			**Lead**		
Implemetation of West Yorkshire Oncology service model - Implementation Board to be set up WYAAT - Refresh of West Yorkshire Clinical Strategy, incorporating work on fragile services ICS Clinical Strategy to be developed - Medical Director to confirm plans Review alignment of Trust clinical strategy with ICS 5 year plan for Better Health and Well-Being for everyone					Initial meeting of Implementation Board November 2022, implementation 2023 WYAAT to confirm ICS Medical Director to confirm 31 January 2023 - lead David Birkenhead			David Birkenhead, Medical Director WYAAT clinical lead / WYAAT Chief Executives, David Birkenhead		
Links to risk register: None See 1/19 reconfiguration BAF risk										

BOARD ASSSURANCE FRAMEWORK
OCTOBER 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 OCTOBER 2022 Risk Category; Innovation/Technology Risk Appetite: High**		
02/20 July 2020	Transformation Programme Board	Managing Director - Digital Health	Risk of not securing appropriate investment to fund the Digital Strategy ambitions, ensuring infrastructure and technology is up to date and future proof due to funding not being available locally and nationally impacting on workforce efficiency and patient experience	Year 3 of 5 year Digital Strategy and continued review by Weekly Executive Board and annually to Board which will meet the needs and build the foundation for the 10 year digital strategy Digital Aspirant and Scan for Safety funding to March 2023 and committed capital funding from the Trust which will enable progression along the national Digital Aspirant Programme Dedicated Digital Transformation Director role co-ordinating digital programmes and providing leadership. Governance via Digital Health Forum and Digital Operations Board. Digital Operations Board chaired by Managing Director Digital Health, with reviewed terms of reference Monthly meetings with Managing Director Digital Health and Director of Finance reviewing progress with digital investment strategy. Divisional Digital Boards which report into the Digital Operations Board with revised terms of reference which will ensure clarity of purpose of group and consistent approach. Digitial governance investment reviewed by Business Cases Approval Group (BCAG).	**First Line:** Digital Operations Board meeting bi-monthly, programme of work and progress presented at each meeting. **Second Line** Board approved Digital Strategy and associated investment plan (2 July 2020) provides direction . Additional funds for digital capital expenditure for 2023/24 secured. 10 November 2022 Digital Strategy Progress and Update to Board with plan to 2025. 2 September 2021 Board approved THIS Commercial Strategy confirms the Trust contribution target and allows for re-investment into THIS. Review 10 November 2022 Board. BCAG provides assurance that digital benefits are realised and digital business cases are aligned to the Trust Digital Strategy. **Third Line:** Digital Aspirant Trust Scan for Safety Programme in progress. WYAAT Chief Information Officer meetings ensures alignment of stategy on regional digital deployment.	Business case for review of digital health team capacity and capability now aligned to BTHFT and possible addition of third Trust on current EPR tenant. Action: Business Case Approvals Group to consider business case which redefines scope of digital health programme in line with EPR optimisation, reconfiguration and cross - organisational partnerships Lead: Managing Director - Digital Health Timescale: March 2023 Alignment of work priority to Trust requirements whilst continuing business as usual activity. Action: Embed clinical resources in prioritisation process and monitor capability and capacity requirements. Lead: Managing Director - Digital Health Timescale: March 2023 Recruitment to Digital Transformation Director post by November 2022, lead Rob Birkett.	Prioritisation process not clinically led to be reviewed again. Action New CCIO in post from 1.11.22. with focus on alignemnt of work priorities to Trust alignment. Timeframe: Review by 31.1.23.	**Initial**	**Current**	**Target**
								4x3 = 12	**4x3 = 12**	**3x3=9**

Action	**Timescales**	**Lead**
Review clinicial priritisation process for efficacy and revise workforce model as needed	31 January 2023	Rob Birkett, MD - Digital Health
Review of digital health team capacity and capability and redefine scope of digital health programme	March 2023	Rob Birkett, MD - Digital Health
Monitoring via Finance and Performance Committeee	Ongoing	Gary Boothby

Links to risk register see linked 1/19 reconfiguration risk

BOARD ASSSURANCE FRAMEWORK
OCTOBER 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 OCTOBER 2022 Risk category: Harm and Safety Risk appetite: low**		
								Initial	**Current**	**Target**
07/20 Added July 2020	Trust Board	Chief Nurse / Deputy Chief Executive	Risk of slow progress addressing health inequalities in the 20% of the most deprived patients in our communities, due to incomplete population health and patient ethnicity data, healthcare service delivery not matching patient needs in the most deprived areas, lack of quality priorites to advance health equity, lack of resource allocation and programmes for health prevention, ineffective partnership working and lack of sustained focus on actions to address ill health and prevention, resulting in the Trust not reducing health inequalities for our most vulnerable patients with protected characteristics.	Director of Nursing & Deputy Chief Executive named Board Executive providing accountable leadership for tackling health inequalities. Chief Executive expertise in health inequalities. Actively addressing the urgent actions for health inequalities set out by NHS E/I. Health Inequalities Group, chaired by NED, ensures oversight of all Trust workstreams in relation to health inequalities. Equality impact assessment (EQIA) process for service and policy changes. Health Inequalities is reported formally into Trust Board. Board development sessions include deep dives on issues relating to health inequalities to increase knowledge of Board members on why addressing health inequalities is important and provide insight to local health inequality issues Public Health registrar supports health inequalities work with an objective to update the Trust Health Inequalities strategy Restoration service activity performance monitoring to include deprivation data (index of multiple deprivation) for patients from 20% most deprived neighbourhoods and communitties Diversity - 1 Non-Executive BAME members of the Board brings lived experience to help tackle health inequalities. Trust Diversity and inclusion networks and 5 year plan for inclusion (Staff).The ethnicity of the Trust Board reflects its workforce and local communities. BAME representative on interview panels. West Yorkshire and Harrogate Healthcare Partnership (ICS) - Trust plays a full part in Health and Well-Being Boards and place-based partnerships, where reducing inequality is an ICS goal and exemplified in the Professor Dame Donna Kinnair DBE review. CHFT part of the Health Inequalities Academy to share best practice and agree workstreams.	**First Line** - developing data and performance information to enable greater activity analysis of access and outcomes through routine performance monitoring. Project in Maternity Services underway to look at outcomes and experiences of those from most deprived areas in the community. **Second Line** - Board development session 3 June 2021 re health inequalities locally and the imapct of becoming an anchor organsiation. : Regular updates to Board by Health Inequalities Group leads (6.5.21., 1.7.21. 2.9.21, 4.11.21.,13.1.22., 3.3.22., 5.4.22., 7.7.22.) with workstream updates. Approved Board succession plan seeks to ensure clear talent pipelines for each Executive and non Executive role in the Trust, including actions to ensure inclusive recruitment, and actions to ensure that the Board reflects the gender make up of local communities. EQIA referenced in all Board paper front sheets WYAAT Committee in Common report by Trusts on impact of inequalities on patients, elective recovery and waiting times 27.7.21. **Third Line** The Trust is working with and reporting to the ICS and WYAAT.	Health Inequalities Academy workstreams yet to be defined. An action plan to support a move to a more diverse Board and senior staffing group that is consistent with the local community. Discussions about succession planning for Board level and senior posts across the organisation is ongoing. Steps to publicise Board level posts more widely and to under represented groups are being taken in respect of vacant posts and/or future opportunities. Plan to explore approach to diversity with WYAAT and ICB colleagues to ensure a regional approach. The Trust is working to deliver NHS wide high impact actions in respective of equality and diversity. Lead: Director of Workforce and Development Timescale: March 2023 Update requested.	Health Inequalities Group to review use of the Health Inequalities Leadership Framework Tool (NHS Confederation) locally and national Core20PLUS5 (ICS approach to health inequalities improvement). Lead: Public Health Registrar to incorporate within Health Inequalities Strategy Timescale: December 2022.	4x4=16	4x3=12=	2x4=8

Action	**Timescales**	**Lead**
Action Plan for more diverse Board and senior staffing consistent with local community and explore with WYAAT /ICBs	March 2023	Suzanne Dunkley
Health Inequalities Group to review use of the NHS Confederation Health Inequalities Leadership Framework	31/12/2022	Public Health Registrar

Links to risk register: 2827

BOARD ASSURANCE FRAMEWORK
OCTOBER 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 OCTOBER 2022** **Risk category: Regulation** **Risk appetite: Moderate**		
06/19	Quality Committee	Chief Nurse/ 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 • Clinical Outcomes Group monitors workstreams for patient safety and quality, reporting into Quality Committee • 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. • Children and Young Peoples Improvement Plan	<u>First line</u> 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 <u>Second line</u> 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) <u>Third line</u> 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	• Implement Patient Safety Incident Response Framwork (PSIRF) and draft investigation model that aligns with PSIRF framework Lead: Assistant Director Quality & Safety Timeframe: March 2023 Gaps in control within the quality governance structure resulting in not providing an effective quality review function. Action: Implement recommendations from Internal Audit report on quality structure Lead: Associate Director Quality & Safety Timeframe: December 2022	• CQC assessed the Trust as requires improvement for safe domain	**Initial** 3x5 = 15	**Current** ↑ 3x5= 15	**Target** 2x5 = 10
Action					**Timescales**			**Lead**		
Implement Patient Safety Incident Response Framwork and draft investigation model that aligns with PSIRF framework					March 2023			Associate Director Quality & Safety		

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
OCTOBER 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 OCTOBER 2022 Risk category: Regulation Risk appetite: Moderate
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 (NHS Etable) **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 • Business Case Approval Group ensures sound decision-making on investments and monitors delivery of benefits. • Strategic outline case (SOC) approved by Board and accepted by commissioners and Integrated Care System (ICS) • Transformation project support in place • Use of Resources (UoR) 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 Efficient Use of 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, Covid and recovery spend Minutes from Capital Management Group and Business Case Approval 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. Internal audit review on Business Cases Pre and Post Implementation given significant assurance, August 2022. Third line Reporting of financial position and forecast monthly to WY Integrated Care Board and NHS E/I	Recurrent efficiency opportunities to be agreed by Effective Resources Group Action: Effective Resources Group to identify 5 year opportunities by 31.10.22. Lead: Director of Finance Agree timescale for Finance Strategy to be adopted. Lead: Director of Finance by 30.11.22.	• Performance against key targets - recurrent balanced budget Reconfiguration business case yet to receive Treasury approval Timescale tbc by Treasury	Initial: 5x5 = 25 Current: 4x4 =16 → Target: 2x5 = 10

Action	Timescales	Lead
Effective Resources Group to identify 5 year recurrent efficiency oppprtunties	31.10.22.	Director of Finance
Consider development and promotion of Finance Strategy	30.11.22.	Director of Finance

Links to risk register: None

BOARD ASSURANCE FRAMEWORK
OCTOBER 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 OCTOBER 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.	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. Review of revised IPR indicators with Board members 6.10.22. 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: Intrerim COO Timeframe: March 2023 3 MRI Capacity - plan for extended mobile scanning capacity to manage residual backlog and demand. Lead Interim COO -	Development of further outcome metrics for IPR. Lead: Interim Chief Operating Officer Timescale: Revised IPR report in December 2022 reporting on November position.	**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					December 2022 April 2022 - March 2023 December 2022			Interim 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
OCTOBER 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 OCTOBER 2022 Risk category: Strategic Risk appetite: Significant		
								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, • Funding secured for ED HRI and MSCP CRH and in 2022/23 capital plan • 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.	• 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. The Trust awaits the outcome of the business case review process with HM Treasury before further progress can be made. 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. ICS 5 year capital planning is scheduled for October 2022.	PLACE assessment (Patient-Led Assessments of the Care Environment) re-start October 2022 by Quality Performance and Service Manager Audit of HTM Compliance to confirm appropriate control measures in place to manage the HRI and community estate. Action: Review of compliance, October 2022. Report expected December 2022.	4x4 = 16	5x3= 15	2x4 = 8

Action	Timescales	Lead
ICS longer term capital commitments to be debated and confirmed Review of HTM compliance	October 2022 Report December 2022	Director of Finance Head of Estates

Links to risk register:
Risk 7413 - Fire compartmentation risk, HRI
Risk 7474 - Medical Devices

BOARD ASSURANCE FRAMEWORK
OCTOBER 2022
KEEPING THE BASE SAFE

TRUST GOAL: 2. KEEPING THE BASE SAFE

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								Initial	Current	Target
16/19 9/1/20	Audit and Risk Committee	Director Champion - Executive Director of Workforce & OD	Risk of not being compliant with the Health and Safety at Work Act (1974) and supporting regulations and healthcare safety and welfare standards due to lack of clarity on roles in Health and Safety Policy between CHS and the Trust and health and safety resource, resulting in harm to staff, patients, the public, visitors, potential regulatory failure and reputational damage Internal audit review of H&S action plan underway	•Board approved 5 year H&S strategy with 6 key priorities, NHS Workplace Safety Standards provides framework for H&S activity, relevant policies reviewed and shared with stakeholders specific to roles and responsibilities. The Strategy has been revised in September 2022 with now 8 priorities and will be presented to the Board. **Date ?** •General Health and Safety Policy (Updated September 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 • Individual health and safety policies under continous review across 2022/23 and shared with CHFT health and safety commitee - each policy with individual subject matter expert ownerships • 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 firmly established. • 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 • Annual report on Health and Safety to Board, • Health and Safety with updates to Board, Audit and Risk Committee oversight and future attendance to present at Quality Committee every 6 months . • Health and Safety mandatory ESR training for staff (3 years). • Health and Safety training on staff induction. • COSHH Lead person (interim) Richard Hill	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 H&S Committee reporting to Audit and Risk Commitee, with annual deep dive. Quality Committee engagement planned for 2022, 18 October 2022 and then every 6 months. Audit Yorkshire January 2021 9 January 2020 external Health and Safety review presented to Board • 2020/21 Annual Health and Safety report and action plan to Board - 13 January 2022 • Health and Safety Strategy revised September 2022 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.	Development and implementation of NHS Workplace Health and Safety Standards - 90% achieved, expected full by end of 2022. 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: Early / mid 2023 COSHH sub group meetings with divisional leads / key users to commence, 3 monthly frequency, to review COSHH incidents / near misses and review current policy. Action: COSHH sub groups established. Lead: Richard Hill Timescale: November 2023.	When the NHS Workplace health and safety standards are embeded into the Trust it is possible to audit and produce dashboard assurance reports, but this will take place early 2023, when the standards are all embedded across the organisation. • 2021/22 5 year Health and Safety strategy to be revised Action: Health & Safetyy Committee to review revised 5 year strategy in November 2022 for presentation to Board January 2023. Lead: Richard Hill HSE inspections (speculative for 2023)	3x3 = 9	3x3 = 9 =	2x2 = 4

Action	Lead: F	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
OCTOBER 2022
KEEPING THE BASE SAFE

TRUST GOAL: 2. KEEPING THE BASE SAFE

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								Initial	Current	Target
04/20 July 2020	Quality Committee	Chief Nurse	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 Divisional review of must do and should do actions from 2018 CQC report, September 2022 **Second Line:** Quality Committee reports from CQC Group and as part of Bi monthly quality report Quality update report to each Board bi monthly CQC well-led governance phase 2 report shared at Board workshop July 2021 Board Development Session 7 October 2021 on CQC effective domain. Maternity Services Update to Board 5.5.22. Caring Domain CQC Board Development Session 9.6.22. **Third Line:** Formal engagement meetings with CQC and rolling programme of on site visits. Current CQC rating of "good" including well-led governance	External assessment to look at well-led preparedness. Q3 2022/23 Lead: Executive Team / Director of Corporate Affairs	2023 move to Single Assessment Framework for future CQC inspections and rating regime. Action: Further clarity to be sought on implementation - Lead : Chief Nurse, March 2023	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 Review of KLOEs for well -led governance assessment Seek clarity on local implementation of new Single Assessment Framework for CQC inspections	Ongoing (update from CQC expected July 2022) 12 month rolling programme August 2022 - lead Quality Governance Leads (linking with Divisional Senior Management Team) - LR to check and update December 2022 March 2023, Chief Nurse	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
OCTOBER 2022
KEEPING THE BASE SAFE

TRUST GOAL: 2. KEEPING THE BASE SAFE										
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								Initial	**Current**	**Target**
05/20 July 2020	Finance and Performance Committee	Chief Operating Officer	Risk that the Trust is not able to achieve its recovery targets, due to operational pressures resulting in patient harm, potential adverse impact on health inequality and impact on PLACE and Integrated Care System and partners. See also BAF 08/19 re performance targets and BAF 7/20 health inequalities	Access Delivery Group holds divisions to account for delivery of recovery plans as required for any performance issues, reports into F&P Committee. Recovery plans set to achieve national standards. These link to transformation plans. Winter Plan includes super surge planning for various scenarios including at what point elective work would stop. Implementing national initiatives to improve patient flow and discharge. 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. Monthly Divsional performance review with Executive team, exception reporting and review to progress issues 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	**First Line:** Daily review of Covid-19 activity and weekly review of all other waiting list data. Each division has weekly review of activity, recovery and performance against plan feeding into the Access Delivery Group and divsional performance reviews. 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) Recovery Update reports to public Board meetings (13 January, 3 March, 5 May, 7 July, 1 September 2022) 6.10.22.Discussion with Board on key elective recovery metrics. 10 November 2022 Board presentation of Winter Plan 2022/23, including super surge and patient flow initiatives.	1. Reset plans have interdependency risks on workforce availability that will limit capacity. Action: Daily monitoring of workforce availability 2. Finance - pressures on pay impacting workforce availability Action: Discussions on pay in senior forums (WEB, Board, Finance and Performance Committee (5.10.22.) Lead: COO/ Director of Workforce and OD 3. Elective Recovery Funding arrangements not yet confirmed for remainder of 2022/23 Action: Respond to NHS E/I and ICS plans re funding once known. Lead: COO/ Director of Finance	Agree key IPR metrics for monthly reporting to Board and Committees Action: Revised IPR metrics and report for December 2022 (for November position). Lead: COO	4 x 5 - 20	4 x4= 16 →	2x4=8

Action:	**Timescales**	**Lead**
Monitoring of workforce availability	Daily	Interim Chief Operating Officer
Impact of pay pressures on workforce availability being reviewed	Autumn 2023	Interim COO / Director of WOD
Monitoring position re elective recovery funding arrangements	Autumn 2023	Interim COO/ Director of

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
OCTOBER 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 OCTOBER 2022 Risk Category: Quality, Innovation & Improvement Risk appetite: Significant		
								Initial	Current	Target
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 (planning for April 2023/24 underway) • • 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 1 Specialist now commenced in post (1 specialist later in the year) • 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 Steering Group meetings provides overview of the programme and this is undergoing a full refresh to ensure full visibility, shared view and tracking of all medical workforce based projects. 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 Associate 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 5.8% , with expanded establishment 712.2 wte. Medical workforce 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 quartely 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 Medical Workforce Programme Update to Workforce Committee 11.10.22. Specialty doctor appointed to CESR post in Neurophysiology - starting late October 2022 Third Line Plans discussed with NHS E/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 affect willingness of medical staff to deliver additional work Review Trust approach to options on reycling pension at WEB 23.6.22 - follow up WEB 3.11.22. lead Suzanne Dunkley. 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 via Medical Workforce Steering Group. Accumulated annual leave from Covid-19 may pressure clinical service delivery. Action: HRBPs assessing scale of annual leave carry over to March 2024 Lead DB/SD	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: Divisional directors to monitor and manage. Working Together to Get Results sessions to build on success of embedded Physician Associate scheme by providing development opportunities and additional support to junior doctor rotas and aid retention. Lead: Deputy Medical Director Timescale: Meetings to be held by December 2022, plan to be developed 2023 Develop business case for lead Physician Associate: Deputy Medical Director 31.3.23.	4 x 4= 16	4 x4=16 =	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.	31 March 2023	Lisa Cooper, Medical Workforce with Jackie Robinson, Divisional clinical management teams / Deputy Medical Director
2023/24 job planning for medical staff	31 March 2023	
Commisioned external recruiter for stroke vacancies	31 January 2023 - lead Pauline North	
Pensions Recycling	November 2022 - lead Suzanne Dunkley	
DevePhysicians Associate - create developpment work - working together to get results sessions across 3 divisions	Sessions held by December 2022	
Business Case for lead Physician Associate	31.3.23.	
Assessing scale of annual leave carry over to 2024	TBC	

Links to risk register:
2827, 7078, 5747

BOARD ASSURANCE FRAMEWORK
OCTOBER 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 OCTOBER 2022 Risk Category: Quality, Innovation & Improvemnent Risk appetite: Significant**		
								Initial	**Current**	**Target**
10b/19 2021/22	Workforce Committee	Chief Nurse	**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, 10 November 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** Expanded capacity across the bed base and increased demand in community services diluting existing workforce capacity Action: Review nursing and midwifery workforce programme Lead: Deputy Chief Nurse Timescale: December 2022	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 discusse safe staffing at the Quality Committee lead:Andrea Dauris, Associate Director of Nursing (Corporate) Ongoing	4x4 = 16	4x5 = 20	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
Maternity risk

BOARD ASSURANCE FRAMEWORK
OCTOBER 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 OCTOBER 2022 Risk Category: Quality, Innovation & Improvemnent Risk appetite: Significant		
								Initial	Current	Target
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 launched and action plan underpinning it to go to WC in October 2022. • Recruitment strategy launch meetings taken place with nursing and medical workforce leaders • Progressed into implementation phase for values based recruitment • 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 • Presented Inclusive Recruitment approach to Race Equality Network steering groupon (Ask RP). REN happy with progress. • Values Based Recruitment 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. Including alignment with national inclusive recruitment toolkit.		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
OCTOBER 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 OCTOBER 2022 Risk Category: Workforce Risk appetite: Low**		
								Initial	**Current**	**Target**
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 2 appreciation events • Homeworker appreciation event • One Culture of Care checklist to aid visibility visit and provide consistency • 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 • Equality, Diversity and Inclusion events	First line Monthly workforce monitoring meeting reviews all workforce data sets • Apprenticeship services assessed as GOOD with one area of Outstanding in July 2021 • 658 appreciation messages received during Appreciation Week 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. Deep dive of risk 12/19 at Workforce Committee on 11 Oct 2022. 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. Lack of assurance of the One Culture of Care checklist outcomes. **ACTION**: Audit of the process Lead: Workforce and OD Business Manager by December 2022.	**3x4 = 12**	**3x4 =12 =**	**1x4 = 4**

Action to address gap in control	**Action and timescale**	**Lead**
Audit of the One Culture of Care checklist process	December 2022	Workforce and OD Business Manager by December 2022

Links to risk register:
No high level risk register related risks scoring over 15.

BOARD ASSURANCE FRAMEWORK
OCTOBER 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 OCTOBER 2022 Risk Category: Workforce Risk appetite: Low**		
								Initial	**Current**	**Target**
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 to commence in post in November 2022. • Wellbeing festival held bi-annually. • Mens Health 5-a-side event • Financial wellbeing resources currently in development • Refreshed guidelines on wellbeing hour • Weekly Wellbeing advisor walkarounds • Domestic abuse support session • Suicide prevention resource pack • Connect and Learn session successfully trialled in WOD and will be rolled out to each Division, improving visibility of the Wellbeing Team. •Revised appraisal documentation with greater emphasis on health and well-being	<u>First line</u> Monthly workforce monitoring meeting reviews all workforce data sets <u>Second line</u> 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. <u>Third line</u> None	Deteriorating patterns in return to work interviews performance from compliance **ACTION**: Develop a revised approach to completing return to work interviews. **Lead**: HRBPs by December 2022		**3x4 = 12**	**3x4 =12 =**	**1x4 = 4**

Action to address gap in control	**Action and timescale**	**Lead**
Develop a revised approach to completing return to work interviews.	Dec-22	HR Business Partners

Links to risk register:
No high level risk register related risks scoring over 15.

BOARD ASSURANCE FRAMEWORK
OCTOBER 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 OCTOBER 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. September 2022 process for prioritising capital spend October 2022 - March 2023 completed. Historic delivery of the capital plan. Contingency set within annual plan Transformation Programme Board has oversight of significant strategic investment, chaired by Non-Executive Director with relevant commercial experience. Senior Finance participation in West Yorkshire Integrated Care System Capital Group which meets regularly to review capital forecasts from all partners to manage regional capital envelope and reports to ICS Finance Forum.	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 ICS response re cladding awaited.	5 year capital plans submitted to ICS but allocation process is still to be agreed by ICS partners. Lead: Director of Finance Backlog maintenance costs will remain in excess of planned capital spend. Action: Internal capital spend is prioritised on a risk basis. No firm agreement reached with ICS for prioritisation of funds to cover cladding Price not yet agreed for CRH reconfiguration works and remains subject to change. Progressing elements where possible, eg Multi-storey car park CRH build. Full Business Case 2023 Lead: Chief Executive, Director of Partnerships and Transformation and Director of Finance Treasury approval of reconfiguration business case Action: Close monitoring of Treasury plans via NHS E/I on behalf of Trust	**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
OCTOBER 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 OCTOBER 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 and new Executive Director lead for overall HPS performance from November 2022. Joint Liaison Committee for CHS - reviews overall CHS financial performance and reporting on commercial ventures, review of CHS commercial strategy. CHS Head of Commercial Projects	**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	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	Director of Finance
	NHS E/I (Chief Pharmacist) to confirm plans and timescales	Director of Finance

Links to high level risk register: None

BOARD ASSURANCE FRAMEWORK
OCTOBER 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 OCTOBER 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 Efficient Use of Resources Group (meets weekly, with Chief Executive Chair) monitoring cost improvement plan delivery in year and development of 5 year cost improvement plans. 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) Internal audit report on efficiencies provided significant assurance April 2022 WYAAT Board to Board event September 2022 re: efficiency identified themes for new WYAAT strategy. <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 completed work, report being finalised and signed off by all partners, with review by Integrated Care Board. Timescale: Completion of report October, meetings to be held during November 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					Nov-22			Director of Finance		
Links to high level risk register risks: Risk 8057 relating to 2022/23 financial position scored at 20 See BAF risks 10a and 10b re workforce shortages										

BOARD ASSURANCE FRAMEWORK
OCTOBER 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 OCTOBER 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.Dashboard monitors the impact of the Green Plan. 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, WYAAT, 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	.	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
JH	Jonny Hammond, Interim Chief Operating Officer
RB	Rob Birkett, Managing Director of Digital Health
AM	Andrea McCourt, Company Secretary
VP	Victoria Pickles, Director of Corporate Affairs
SS	Stuart Sugarman, Managing Director CHS
BB	Brendan Brown, Chief Executive
LR	Lindsay Rudge, Chief Nurse
KA	Kirsty Archer, Deputy Director of Finance
ALL	All Board members

25. High Level Risk Report

To Approve

Presented by Victoria Pickles

Date of Meeting:	Thursday 10 November 2022
Meeting:	Public Board of Directors
Title:	High-Level Risk Report
Author:	Richard Dalton, Head of Risk and Compliance
Sponsoring Director:	Victoria Pickles, Director of Corporate Affairs
Previous Forums:	Risk Group

Purpose of the Report

The purpose of this report is to provide an overview of the risks scoring 15 or above.

Key Points to Note

Introduction
At that last meeting, the Board were informed that there is work underway to review and refine the risk identification, management and mitigation process and clarification on how these are reported.

As this work progresses, this report provides a summary of the highest scoring risks, so that you continue to have oversight of those areas which present the biggest risk to delivery of our services, as well as an update on the progress of the work to improve our risk reporting and management arrangements.

Current risk process and position
The Trust manages and documents risk using a bespoke risk register. When a risk is identified, the risk and impact on patient care is documented on the electronic risk register, is considered in detail by the appropriate department and governance structure. All the appropriate information surrounding the risk is documented including all mitigating actions to ensure the safety of patients and staff is maintained. The Trust uses the information to learn and develop as an organisation. As such each risk has an action plan developed to manage the risk of the risk register. All risks are reviewed monthly at the Risk Group.

Currently there are 64 risks that rated as high and 21 very high risks. There have been 5 new risks added; 6 have had their risk score reduced; and 5 have had their risk score increased.

Each risk is aligned to one of the Trust's strategic objectives. Against each of these objectives the current risks scoring very high (20-25) are on the following themes:

- Transforming care:
  - Reconfiguration

- Keeping the base safe
  - Achievement of key targets impacting on patient safety and quality of experience; Patient flow due to capacity with partners; Outpatient waiting times

- Workforce fit for the future
  - Nurse and therapy staffing in key areas e.g. ED and maternity; Medical staffing in key areas e.g. Radiology, ophthalmology; Use of agency staffing
  - Community services capacity and workforce

- Sustainability
  - Financial plan; funding related to increasing activity to clear the backlog from covid as per the national target.

Themes of risks scoring high (15-16) are:

- Transforming care
  - Digital systems – use and business continuity

- Keeping the base safe
  - The number of referrals into services; appointment availability; level of unplanned and emergency care activity; demand on inpatient capacity; lack of theatre capacity to meet recovery plans; support for mental health patients; health inequalities because of the elective recovery and follow up back log.

- Workforce
  - Maintaining the wellbeing of our workforce; and the use of agency staff to support patient demand

- Sustainability
  - Developing funding streams using the new ICS framework to ensure stability

These risks reflect the key areas of challenge reflected in the board agenda today and align to the strategic risks set out on the Board Assurance Framework.

Future development work

Currently all divisional risk registers are undergoing a detailed review to ensure that risks are being identified, managed, and monitored in line with the Risk Management Strategy and Policy, and risk exit or mitigation plans in place are effective and appropriate to the risk score. Alongside this, the process is being reviewed to ensure it fits with the new PSIRF requirements, whereby risks and serious incidents will be brought together so that learning can more easily be identified and shared. This work is ongoing with recommendations and remaining actions due to be presented to the executive team at the end of November. The next high level risk report will provide more detail on the risks, mitigations and any remaining improvement work.

EQIA – Equality Impact Assessment

Risks are assessed considering any impact on equality.

Recommendation

The Board is asked to **CONSIDER** and discuss the high-level risk report and note the ongoing work to strengthen the management of risks.

26. Governance Report

a) Programme of Service Reconfiguration – Appointment of Programme Senior Responsible Officer

b) Oversight and Assurance - Winter Resilience

Going Further on Winter Resilience Plans - Review Room

c) Updated Governance Structure

d) Use of Trust Seal

e) Board of Directors Workplan to March 2023

To Approve

Presented by Andrea McCourt

Date of Meeting:	Thursday 10 November 2022
Meeting:	Public Board of Directors
Title of report:	Governance Report
Author:	Andrea McCourt, Company Secretary
Sponsor:	Victoria Pickles, Director of Corporate Affairs
Previous Forums:	None

Purpose of the Report

This paper presents the following governance items to the Board:

a) Senior Responsible Owner for the Reconfiguration Programme
b) Oversight and Assurance - Winter Resilience
c) Governance structure
d) Use of Trust Seal
e) Board of Directors workplan to March 2023

Key Points to Note

a) Senior Responsible Owner for the Reconfiguration Programme

The Senior Responsible Owner (SRO) for the Reconfiguration Programme is the 'owner' of the programme and associated business cases - accountable for all aspects of governance. The Trust is required by DHSC and Government to have an appointed 'Senior Responsible Owner' for this programme.

The CHFT Chief Executive is the current SRO reporting to the Trust Board.

RECOMMENDATION

i. The Board is asked to **REVIEW AND CONFIRM** the on-going role of the CHFT Chief Executive as the Senior Responsible Owner (SRO) for the programme of service and estate reconfiguration at CHFT

b) Oversight and Assurance - Winter Resilience

In October 2022, NHS England wrote to all Chairs and Chief Executives of Trusts and Integrated Care Boards (ICBs) setting out the asks for winter resilience plans. A copy of the letter, Going Further on Winter Resilience Plans, is included in the Review Room.

These plans cover increasing community support (such as community based falls service, virtual wards and additional support for care homes); maximising bed capacity and the setting up of a 24/7 System Control Centre monitoring at a Trust and ICB level Type 1 Emergency Department (ED) performance; over 12-hour length stays in ED ; Category 1, 2 and 3 ambulance response times ; OPEL status; Community Rehabilitation Bed Occupancy; and Virtual ward bed state. There also needs to be continued focus on patient flow, vaccination and infection prevention and control measures and workforce. Alongside this Trusts are expected to continue to deliver the elective recovery and cancer targets. All of this comes with new oversight and assurance arrangements and last week, those Trusts

who are challenged in the delivery of these targets received a self-assessment assurance letter. CHFT was not one of those Trusts, but as a Board, it is important that through our governance and performance management arrangements that we continue to have clear oversight of our delivery against the actions set out in the winter resilience letter and our performance against the key identified targets.

RECOMMENDATION:

ii. The Board is asked to **NOTE** the continued need for oversight and assurance on winter resilience plans and performance against key targets.

c) Governance Structure

The Trust's governance structure has been updated to reflect changes to Non-Executive Directors Chair roles and updates to reporting groups.

RECOMMENDATION:

iii. The Board is asked to **APPROVE** the updated governance structure.

d) Use of the Trust Seal

The Trust Seal has been used on five occasions since July 2022, once in relation to land transfer at the former St Luke's Hospital, Crossland Moor, Huddersfield and on four occasions in relation to the change of partner in the Pennine Property Partnership from Henry Boot PLC to Assura Properties Limited.

RECOMMENDATION:

iv The Board is asked to **NOTE** the use of the Trust Seal since July 2022.

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 is presented for approval.

RECOMMENDATION:

f) The Board is asked to **APPROVE** the Board of Directors workplan to March 2023.

EQIA – Equality Impact Assessment

The overall impact of the Reconfiguration in relation to EQIA and QIA is positive, there is no differential discriminatory impact, and appropriate mitigating actions have been identified. Engagement will continue and expand further into community groups throughout the development of the building proposals and changes to care pathways.

Recommendation

The Board is asked to:

i. **REVIEW AND CONFIRM** the on-going role of the CHFT Chief Executive as the Senior Responsible Owner (SRO) for the programme of service and estate reconfiguration at CHFT
ii. **NOTE** the continued need for oversight and assurance on winter resilience and performance against key targets
iii. **APPROVE** the updated governance structure
iv. **NOTE** the use of the Trust seal
v. **APPROVE** the Board of Directors workplan to March 2023.

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GOVERNANCE STRUCTURE
NOVEMBER 2022

Stakeholder Reconfiguration Round Table (NHS E/ DHSC / ICS/ICB

WYAAT Committee in Common West Yorkshire ICS

Kirklees Health & Care Partnership Calderdale Cares Partnership

BOARD OF DIRECTORS

Charitable Trustees

Charitable Funds Committee
Chair: Helen Hirst / Frequency: Quarterly

Organ Donation Committee
Chair: Helen Hirst / Frequency: Bi-annual

Council of Governors
Chair: Helen Hirst / Frequency: Quarterly

Nominations & Remuneration Committee (Sub Committee to the Council of Governors)
Chair: Helen Hirst / Frequency: Ad hoc

Audit and Risk Committee
Chair: Nigel Broadbent
Frequency: Quarterly

- **Risk Group** Chair: AD for Patient Safety Frequency: Monthly
- **Information Governance & Risk Strategy Committee** Chair: CIO Frequency: Quarterly
  - **Clinical Records Group**
- **Data Quality Board** Chair: COO Frequency: Monthly
- **Health & Safety Committee** Chair: ED Workforce & OD Frequency: Monthly
  - **Fire Safety Response Committee**
  - **Security & Resilience Group**

Transformation Programme Board
Chair: Peter Wilkinson
Frequency: Monthly

- **Green Planning Committee** Chair: Andy Nelson Frequency: Monthly

Finance & Performance Committee
Chair: Andy Nelson
Frequency: Monthly

- **Effective Use of Resources Group**
- **Capital Management Group**
- **Business Case Approvals Group**
- **The Health Informatics Service Board**
- **Huddersfield Pharmacy Specials Board**
- **Divisional Performance Reviews Executive Lead &** Chair: **COO** Frequency: Determined by position e.g. monthly, bi-monthly or quarterly
- **CHS & CHFT Joint Liaison Committee**
- **CHFT/PFI Quarterly Contract Meeting**
- **CHFT/Pennine Property Partnership Board**
- **A&E Board (System Resilience Group)**
- **Access Delivery Group**
- **Urgent and Emergency Care Delivery Group**

Nominations & Remuneration Committee (Board of Directors)
Chair: Karen Heaton
Frequency: Ad hoc at least once annually

Workforce Committee
Chair: Karen Heaton
Frequency: Bi-Monthly

- **Education Committee** Chair: Deputy Director Workforce & OD Frequency: Bi-monthly
- **Inclusion Group** Chair: Deputy Director Workforce & OD Frequency: Bi-monthly
- **Infection Prevention and Control Committee**
- **Antimicrobial Strategy Group**
  - **Infection Prevention and Control Board** Chair: Medical Director Reporting: Quarterly

Quality Committee
Chair: Denise Sterling
Frequency: Monthly

- **Research and Innovation Group** Chair: Deputy Medical Director Reporting: Annually
- **Clinical Ethics Group** Chair: Associate Medical Director Reporting: Quarterly
- **Safeguarding Committee** Chair: Deputy Chief Nurse Reporting: 6-monthly
- **Trust Patient and Safety Quality Board*** Chair: AD Patient Safety Reporting: Monthly
- **Cancer Board** Chair: Chief Operating Officer Reporting: Quarterly (minutes only)
- **Consent Working Group**
  - **Clinical Effectiveness and Audit Group** Chair: Associate Medical Director Reporting: Quarterly
- **Patient Experience and Caring Group** Chair: Nicola Seanor Frequency: Monthly
- **Clinical Outcomes Group*** Chair: Medical Director Reporting: Monthly
- **Antimicrobial Strategy Group** (formulary / policy updates)
  - **Medicines Management Committee** Chair: Consultant Oncologist Reporting: 6 monthly
- **Medical Gases Group** Chair: Acute Consultant Reporting: 6 monthly
- **CQC & Compliance Group** Chair: Chief Nurse Reporting: Bi-Monthly

Trust Executive Board
Frequency: Weekly
Chair: CEO
Frequency: Weekly
One meeting per month focused on quality and performance, one on Digital Health

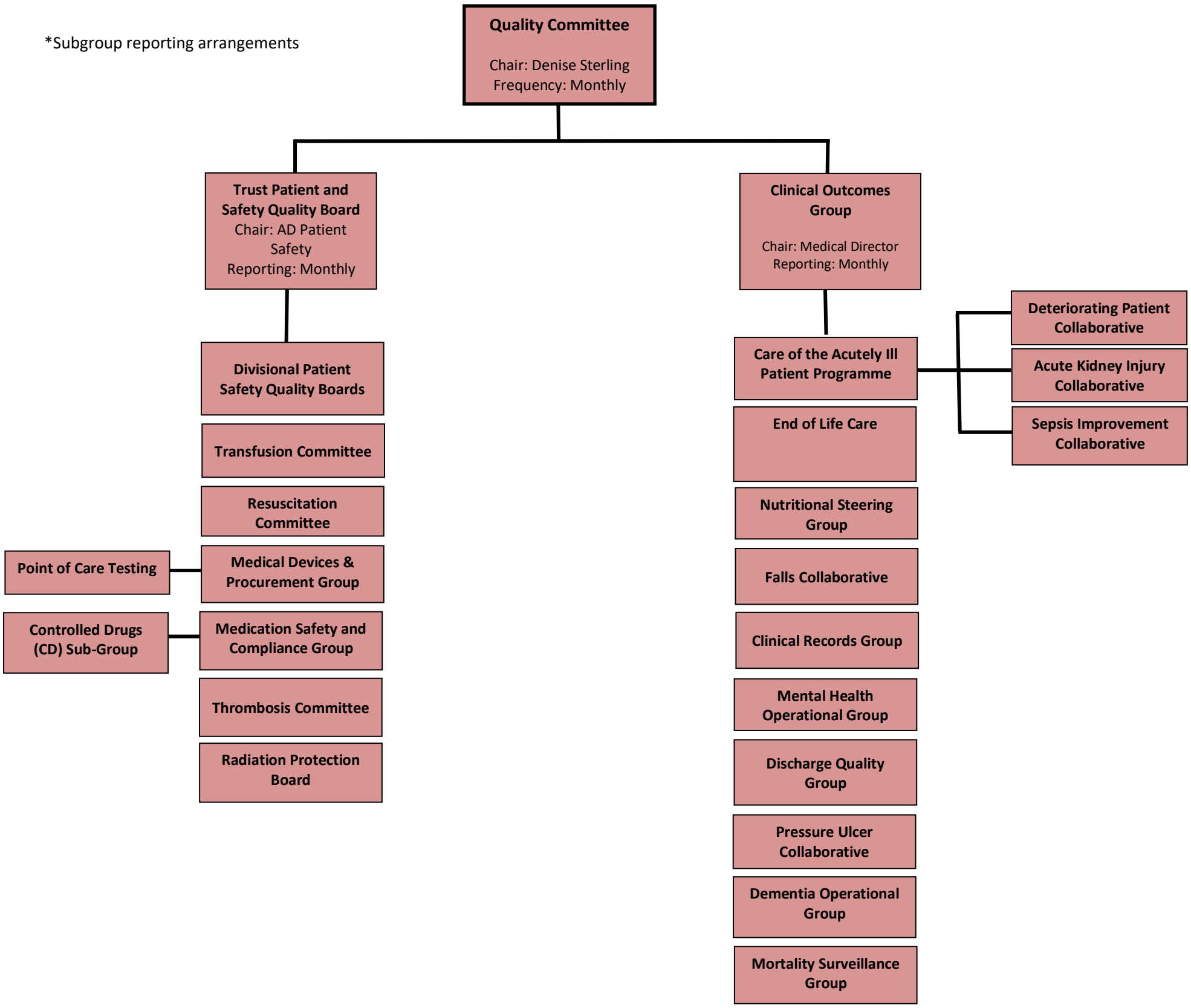
Digital Operational Board
Frequency: Monthly

- **EPR Partners** Frequency: Quarterly
- **Divisional Digital Boards** Frequency: Monthly

Compliance Reporting only

November 2022

*Subgroup reporting arrangements



CALDERDALE & HUDDERSFIELD NHS TRUST: REGISTER OF SEALING OR EXECUTIONS – REPORT FOR THE PERIOD JULY – OCTOBER 2022

CONSECUTIVE NUMBER	DATE OF SEALING OR EXECUTION	DATE OF AUTHORITY	DESCRIPTION OF DOCUMENTS SEALED OR EXECUTED PERSON	PERSONS ATTESTING SEALING OR EXECUTION
03-22	3 August 2022	3 August 2022	Signature and seal for the HM Land Registry Title Transfer of land at Newhaven, formerly St Lukes Hospital, Blackmoorfoot Road, Crossland Moor, Huddersfield between Pennine Property Partnership and LIDL (title number: WYK696805) This follows and exchange of contracts in December 2021 in relation to the disposal of the residual land at St Luke's Hospital - seal register reference 04/21	NAME: Gary Boothby TITLE: Director of Finance, Director of Pennine Property Partnership on behalf of the Trust NAME: Andrea McCourt TITLE: Company Secretary Date: 8 August 2022
04-22	1 September 2022	1 September 2022	Signature and seal relating to changes of PPP joint venture partner: Deed of release between CHFT and Henry Boot developments Limited Amendment and restatement deed relating to a members agreement dated 24 March 2011 between CHFT, PPP LLP and Assura Properties Limited (page ref 80720675-12, page 52/53) Members Agreement relating to Pennine Property Partnership LLP between CHFT, PPP LLP and Assura	NAME: David Birkenhead TITLE: Medical Director NAME: Andrea McCourt TITLE: Company Secretary Date:1 September 2022

			Properties Limited (page ref 80720675-1252/53) Deed of Release relating to Pennine Property Partnership LLP between CHFT, PPP LLP and Assura Properties Limited (page ref 97)	
05-22	5 September 2022	5 September 2022	Deed of Release of between Barclays Bank PLC and Pennine Property Partnership LLP re security documents (legal charge, deed of charge over credit balances, debenture) Loan Instrument Variation and Consent signed - no seal required - between CHFT, Assura and PPP LLP.	NAME: David Birkenhead TITLE: Medical Director NAME: Andrea McCourt TITLE: Company Secretary Date:5 September 2022
06-22	5 September 2022	5 September 2022	Exit and Admission Agreement by CHFT and Trust as a member of Pennine Property Partnership (as member of LLP) with Henry Boots Development Limited, Henry Boot PLC and Assura Properties Limited. Agreement and transaction document which sets out the terms agreed by the parties re; the exiting member ceasing to be a member of the LLP (Henry Boot) and Assura being admitted as a new member.	NAME: David Birkenhead TITLE: Medical Director NAME: Andrea McCourt TITLE: Company Secretary Date:5 September 2022

07-22	5 September 2022	5 September 2022	Assura Facility Agreement - Execution by CHFT (as member of LLP) Debenture - Execution by CHFT (as member of LLP) Deed of Priority - Execution by CHFT (as member of LLP)	NAME: David Birkenhead TITLE: Medical Director NAME: Andrea McCourt TITLE: Company Secretary Date: 5 September 2022

PUBLIC BOARD WORKPLAN 2022-2023

DATE OF MEETING	5 May 2022	7 July 2022	1 Sep 2022	10 Nov 2022	12 Jan 2023	2 Mar 2023
Date of agenda setting/Feedback to Execs	4 April 2022	1 June 2022	19 July 2022	12 October 2022	15 November 2022	17 January 2023
Date final reports required	22 April 2022	24 June 2022	19 August 2022	28 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	✓	✓	✓	✓	✓	✓
Strategy including a Patient/Staff Story	✓	✓	✓	✓	✓	✓
Chair's report	✓	✓	✓	✓	✓	✓
Chief Executive's report	✓	✓	✓	✓	✓	✓
Integrated Performance report (Inc: Quality, Finance, Workforce)	✓	✓	✓	✓	✓	✓
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 Chair's Highlight Report & Minutes	✓	✓	✓		✓	✓
Council of Governors Meeting Minutes	✓	✓	✓			
STRATEGY AND PLANNING						
Strategic Objectives – 1 year plan / 10 year strategy		✓ - *2021-2023 Strategic Objectives Progress Report*		✓		✓
Digital Health Strategy		~~✓~~ Deferred to November		✓ + Patient Story		

DATE OF MEETING	5 May 2022	7 July 2022	1 Sep 2022	10 Nov 2022	12 Jan 2023	2 Mar 2023
Workforce OD Strategy	✓					
Risk Management Strategy						✓
Annual Plan	✓					✓
Capital Plan					✓	
Winter Plan				✓		
Green Plan (Climate Change)	✓					
QUALITY						
Quality Board update	✓	✓	✓	✓	✓	✓
Director of Infection Prevention Control (DIPC) quarterly report	✓Q4		✓Q1	✓Q2 – Review room	✓Q3 – Review room	
DIPC Annual Report		✓				
Learning from Deaths Quarterly Report		✓Q4 (Annual Report)	✓Q1	✓Q2 - Review room		✓Q3 – Review room
Safeguarding Adults and Children Update			✓ (Annual Report)			✓ (Bi-Annual)
Complaints Annual Report				✓		
WORKFORCE						
Staff Survey Results and Action Plan	✓		✓			✓
Nursing and Midwifery Staffing Hard Truths Requirement				✓ Bi-Annual		✓
Guardian of Safe Working Hours (quarterly)	✓Q4			✓Q1 & Q2	✓Q3	
Guardian of Safe Working Hours Annual Report	✓					
Diversity						✓
Medical Revalidation and Appraisal Annual Report			✓ Annual Report			
Freedom to Speak Up Annual Report			✓ Annual Report		✓ 6 month report FTSU themes	
Public Sector Equality Duty (PSED) Annual Report						✓ Review room

GOVERNANCE & ASSURANCE						
Health and Safety Update	✓				✓	
Health and Safety Policy (May 2023)						
Health and Safety Annual Report					✓ Review room	
Board Assurance Framework		✓ 1		✓ 2		✓ 3
Risk Appetite Statement			✓			
High Level Risk Report	✓		✓	✓	✓	✓
Calderdale Huddersfield Solutions Managing Directors Report	✓ Review room	✓ Review room	✓ Review room	✓ Review room	✓ Review room	✓ Review room
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
Constitutional changes (+as required)	✓					✓
Compliance with Licence Conditions	✓					
Huddersfield Pharmaceuticals Specials (HPS) Annual Report					✓ Review room	
Fire Strategy 2021-2026 and Fire Policy Update						✓ Review room

Charitable Funds Report 2021-22 and Accounts (Audit Highlights Memorandum)					✓ Review room	
Committee review and annual reports		✓ Review room				
Audit and Risk Committee Annual Report 2021/2022		✓ Review room				
Workforce Committee Annual Report 2021/22		✓ Review room				
Finance and Performance Committee Annual Report 2021/2022		✓ Review room				
Quality Committee Annual Report 2021/22		✓ Review room				
WYAAT/WY&H Partnership Reports	✓ Review room	✓ Review room	✓ Review room	✓ Review room	✓ Review room	✓ Review room
WYAAT Annual Report and Summary Annual Report					✓ Review room	

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)

27. Items for Review Room

1. Minutes of Board Committees

Finance and Performance Committee 6 September and 7 October 2022

Quality Committee 17 August and 12 September 2022

Workforce Committee 16 August 2022

2. Calderdale and Huddersfield Solutions Managing Directors Report – October 2022

3. Partnership papers: Kirklees Health and Care Partnership - https://www.kirkleeshcp.co.uk/publications/icb-committee-papers/ and Calderdale Cares Partnership - https://www.calderdalecares.co.uk/about-us/meeting-papers/

28. Date and time of next meeting

Date: Thursday 12 January 2023

Time: 10:15 am

Venue: TBC, Calderdale Royal Hospital