Public Board of Directors

Schedule	Thursday 13 January 2022, 9:00 — 12:00 GMT
Venue	Microsoft Teams
Organiser	Amber Fox

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1. Welcome and Introductions:

Brendan Brown, Chief Executive

Jo Fawcus, Chief Operating Officer

Invited Governors: Gina Choy, Robert Markless, Nicola Whitworth and Isaac Dziya

To Note

Presented by Philip Lewer

2. Apologies for absence:

Jim Rea, Managing Director, Digital Health

David Birkenhead, Medical Director

To Note

Presented by Philip Lewer

3. Declaration of Interests

To Note

Presented by Philip Lewer

4. Minutes of the previous meeting held on 4 November 2021

To Approve

Presented by Philip Lewer

Draft Minutes of the Public Board Meeting held on Thursday 4 November 2021 at 9:00 am via Microsoft Teams

PRESENT

Philip Lewer	Chair
Owen Williams	Chief Executive
Ellen Armistead	Director of Nursing/Deputy Chief Executive
Gary Boothby	Director of Finance
Suzanne Dunkley	Director of Workforce and Organisational Development
David Birkenhead	Medical Director
Alastair Graham (AG)	Non-Executive Director
Peter Wilkinson (PW)	Non-Executive Director
Andy Nelson (AN)	Non-Executive Director
Karen Heaton (KH)	Non-Executive Director
Bev Walker	Acting Chief Operating Officer

IN ATTENDANCE

Kirsty Archer	Deputy Director of Finance
Anna Basford	Director of Transformation and Partnerships
Jim Rea	Managing Director, Digital Health
Stuart Sugarman	Managing Director, Calderdale and Huddersfield Solutions Ltd
Andrea McCourt	Company Secretary
Amber Fox	Corporate Governance Manager
Nicola Hosty	Assistant Director of Human Resources **(for item 145/21)**
Devina Gogi	Guardian of Safe Working Hours **(for item 156/21)**
Pamela Wood	Head of Apprenticeships **(for item 145/21)**
Brooke Mitton	Apprentice Healthcare Assistant, Outpatients **(for item 145/21)**
Karen Greenwood	Apprentice Healthcare Assistant, Acute Medicine **(for item 145/21)**
Andrea Dauris	Associate Director of Corporate Nursing **(for item 162/21)**

OBSERVERS

Christine Mills	Public Elected Governor
Brian Moore	Public Elected Governor
John Gledhill	Public Elected Governor
Peter Bamber	Public Elected Governor

138/21 Welcome and Introductions

The Chair welcomed everyone to the public Board of Directors meeting, in particular Owen Williams to his last meeting, Bev Walker, Acting Chief Operating Officer, Devina Gogi, Guardian of Safe Working Hours, Pamela Wood, Nikki Hosty, Brooke Mitton and Karen Greenwood who were in attendance to present a staff story on the Apprenticeship Scheme.

The Chair also welcomed back Gary Boothby, Director of Finance.

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

139/21 Apologies for absence

Apologies were received from Richard Hopkin, Denise Sterling, Stephen Baines and Peter Bell.

140/21 Declaration of Interests

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

141/21 Minutes of the previous meeting held on 2 September 2021

The minutes of the previous meeting held on 2 September 2021 were approved as a correct record.

OUTCOME: The Board **APPROVED** the minutes from the previous meeting held on 2 September 2021.

142/21 Action log and matters arising

The action log was reviewed and updated accordingly.

The Board were reminded to contact the Director of Workforce and Organisational Development with any comments on the health and wellbeing hour before the next report to the Board in January 2022.

Stocktake on Dementia Screening

A stocktake on dementia screening paper was circulated for Board members to note, which closed an action arising from the last meeting.

OUTCOME: The Board **NOTED** the updates to the action log and the stocktake on dementia screening update.

143/21 Chair's Report

The Chair updated the Board on the North East and Yorkshire Elective Recovery Event held by NHS Improvement / England on 30 September 2021, where the region was challenged about performance in relation to long waits and elective recovery. There was a challenge to co-operate across the West Yorkshire Association of Acute Trusts (WYAAT) and the Integrated Care System (ICS) of West Yorkshire. The Chair explained the information received has been discussed with colleagues and a further meeting has been arranged with Bev Walker, Acting Chief Operating Officer. The Chair will report back to the Board after the next meeting on 3 December 2021.

The Chair informed the Board that an appointment of a new Chief Executive has been unanimously agreed by the interview panel and Brendan Brown will start with the Trust on 1 January 2022. All due diligence checks have been completed. The Chair formally passed on his thanks to the Director of Workforce and OD for all her support during this period.

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

144/21 Chief Executive's Report

The Chief Executive updated the Board on non-surgical oncology following ongoing service delivery issues across the region linked to clinical resilience. He explained Sir Mike Richards had been commissioned to undertake a review and his initial findings of this work will be shared later this week.

The Chief Executive stated it is unlikely the current model across West Yorkshire for non-surgical oncology will be an option moving forward. He confirmed CHFT will continue play a fundamental part in cancer and oncology services, particularly non-surgical, not only within CHFT but Mid Yorkshire Hospitals NHS Trust, Bradford Teaching Hospitals NHS Foundation Trust and Airedale NHS Foundation Trust. The Chief Executive formally thanked Jo Dent, Consultant - Medical Oncology, and the oncology team, oncology managers and support staff who champion and advocate for our patients throughout their journey. He explained they are going above and beyond, providing care across a wider footprint. The Chief Executive stated it should be clear in the next few weeks what the

West Yorkshire position is. The Chief Executive re-assured the Board there has been patient involvement in this work that has been progressed throughout to ensure that the correct solutions for patient care are identified.

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

145/21 Staff Story – Apprenticeship Scheme

Nikki Hosty, Assistant Director of Human Resources introduced Pamela Wood, Head of Apprenticeships, Brooke Mitton and Karen Greenwood, Apprentice Healthcare Assistants who shared a staff story about the Apprenticeship Scheme.

Pamela Wood formally passed on her thanks to the Chief Executive in his last Board meeting for all his support of the Apprenticeship Programme.

The key points to note from the presentation were:

- Apprenticeships first commenced in July 2013 via a sub-contact agreement with a local college
- In May 2017 CHFT gained Employer Provider status when the Trust began its own delivery
- In June 2019, the Trust had a new provider monitoring visit to assess progress towards a full Ofsted inspection, the Trust were graded 'reasonable progress' across all three themes
- Currently there are 239 colleagues on apprenticeships at the Trust
- Between 2013 – 2017 a total of 148 apprentices completed the clinical support worker apprenticeship framework, of these 63 received a distinction, 42 received a merit and 3 received a pass
- The national Qualification Achievement Rate average is 51% for all providers and is 80.6% for CHFT
- CHFT are the best performing Trust in the North of England

Pamela Wood described the Covid-19 challenges which resulted in many apprentices being redeployed to critical areas such as the Emergency Department, ICU, and respiratory care. She explained that an Ofsted inspection of the Trust as a new provider of the apprenticeship scheme took place from 7 - 9 July 2020. The Trust achieved an overall rating of 'Good' and very positive feedback was provided by inspectors following their conversations with apprentices.

Brooke Mitton started as an apprentice in January 2021, she described when she first started at the Trust on a Covid-19 ward. She has since been moved to Orthopaedics Outpatients and explained it has been very exciting experience.

Karen Greenwood introduced herself as joining the Trust during the Covid-19 pandemic. She applied for the apprenticeship scheme and started on a Covid-19 ward. She explained her experience and how important it is to deliver outstanding, compassionate care. She said they never stop learning about equality and inclusion. She described the structure of the apprenticeship scheme as fantastic, explaining how it has helped her career aspirations and develops colleagues. She highlighted her next steps are to undertake associate training and to become a nurse. She stated how proud she was of the support provided for apprentices and diversity by the Trust which allows everyone a chance to grow as a person.

KH re-iterated these success stories and the compassion shown by the apprentices and said the Trust and team should be proud.

The Chair thanked Pamela, Nikki, Brooke and Karen for attending the Board, stating their enthusiasm is infectious and 'One Culture of Care' shone really brightly.

OUTCOME: The Board **NOTED** the staff story on the Apprenticeship Scheme.

146/21 Nursing and Midwifery Time to Care Strategy

The Director of Nursing presented the Nursing and Midwifery Time to Care Strategy and shared a 'Time to Care' video created by colleagues. The key points to note were:

- Nursing and Midwifery Strategy Time to Care was launched in January 2020 with an ambitious plan of action
- A video is available on the intranet which showcases some of the achievements of the Time to Care Strategy
- Local teams will use the framework and make the priorities a reality
- Action plans will be tracked through the Nursing and Midwifery Committee
- Strategy is based on the Trust's four embedded pillars with set ambitions – We Put the Patient First, We Go See, We Work Together to Get Results and We Do the Must Do's
- The priorities will be reviewed annually against each of the ambitions
- 1 Year Strategy (Plan on a Page) for the Nursing and Midwifery Time to Care Strategy was shared

The Chair formally thanked the Director of Nursing and colleagues who contributed and put the video together. The Director of Nursing agreed to pass on thanks to the colleagues in the video.

KH commented that the video was powerful and emotive. She highlighted the One Year Strategy looks very ambitious in the circumstances. The Director of Nursing responded that they had thought long and hard about the priorities, some workstreams are streamlined and the Trust has to deliver the priorities.

OUTCOME: The Board **APPROVED** the Nursing and Midwifery Time to Care Strategy.

147/21 Health Inequalities Progress Report

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

The key points to note from the workstreams were:

- Director of Transformation and Partnerships leads on the external environment – A project has commenced on the development of a Directory of Services for Emergency Department staff, particularly to help people who are homeless or asylum seekers by improving the signposting into support services
- Director of Nursing leads on the lived experience – at the end of July, 56% of women from a BAME background have been booked onto a Continuity of Carer pathway. Early feedback from the discovery interviews has been overall positive; however, has also highlighted areas for improvement, a training programme has been completed for cultural and competent care and staff have undertaken a survey which will form a wider ambition of delivering culturally competent care
- Using our data to inform stabilisation and reset is led by the Acting Chief Operating Officer - this is well embedded with strong support from clinical colleagues, all patients with a learning disability now have a TCI date.
- Diverse and Inclusive Workforce is led by the Director of Workforce and OD – international colleague engagement continues with focus on engaging with as many international colleagues as possible, a range of activities took place during National Inclusion Week including a Jerusalame dance which the Chair and Director of Nursing took part in
- Digital Inclusion – CHFT has several representatives on partnership Digital Inclusion Boards

- Next steps – Mental Health will be explored through the Health Inequalities Group and work will continue to look at identifying any link in complaints and incidents to protected characteristic groups

PW chairs the Health Inequalities Group meeting which he stated continues to meet monthly, the meeting is also joined by Christine Mills, public elected governor and her contribution is valuable and appreciated. He explained the important contribution of the information team in understanding some of these issues.

KH recognised the good progress with lots of work taking place, recognised there is still lots of work to do, noted CHFT is leading the way on this and queried what the support is nationally in terms of drive and money. The Chief Executive responded that the planning guidance now clearly states expectations, i.e., elective recovery, organisations looking to access such funding need to articulate what progress has been made in regards of health inequalities. He confirmed there is a recognition there is still more work to do. The degree to which elective recovery can be achieved at the levels it needs to be achieved may be a challenge. He stated that CHFT has evidenced it is possible to both reduce the elective recovery list and close any particular gaps across different groups, i.e., BAME, learning disability. He commented that further data analysis will continue to identify health inequalities.

The Chief Executive explained several organisations are now focused on this and there is an opportunity for NHS England and the Department of Health to become clear that this will remain an area of focus nationally.

KH agreed this can make a real difference to people's lives going forward and is hoping that the Trust can attract some support funding to progress this even further in future.

AG highlighted it is positive to see overall waiting times for P2s (priority 2 to be seen within one month) and P4s (delay of 3 months) reducing. He mentioned the Trust have had an initial focus on the maternity lived experience for 12 months and asked if the Trust will be moving to another area of focus. The Director of Nursing confirmed that maternity will continue to be a huge focus due to the clear link between outcomes and not addressing some of these issues. She confirmed issues in the mental health service needs to be the next priority as well as delivering culturally competent care.

AN highlighted partnership working in the Community and the work taking place at the Gathering Place and asked if the Trust can see a reduction in the number of patients attending the Emergency Department. He asked if the Trust could correlate the data with severity of cases, for example, longer waits for certain conditions. The Chief Executive responded that this would be the next evolution on where this journey will bring us. He highlighted feedback from clinical colleagues is having the ability to see their own data and what it is telling them helps change practice in various ways. In addition, the next step of analysis is to review groups of patients to other groups in different categories against their co-morbidities. The Chief Executive stated CHFT are one of the best placed organisations to make this step due to the richness of its digital data. The 'Getting it Right First Time' Programme provides individual clinical colleagues with their own data which will now include IMD group information of their patients.

The Director of Nursing formally thanked the Board for their continued support and challenge in this area.

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

148/21 Strategic Objectives 2021-2023

The Director of Transformation and Partnerships presented the Strategic Plan 2020-21 progress report for the period ending September 2021.

The refresh of the annual strategic plan was presented, which provides an updated set of strategic objectives for the period November 2021 – March 2023. It is a light refresh as many of the areas of work continue to be relevant and appropriate.

AN re-iterated the good progress that has been made and asked if the 10 year strategy reference to fostering a learning culture and best practice should be referenced in the annual strategy as an objective. He asked if the Trust are clear about what the outcome measures are by March 2023 and acknowledged some of these may roll over. He challenged that a progress report should be required as an outcome measure for each of these. The Director of Transformation and Partnerships acknowledged this.

AG referenced the refresh under workforce for the future which states the senior management team reflect the diversity of the workforce and asked if this should be changed to reflect the communities that we serve. He explained if the workforce is not represented then the senior management team would not be represented.
Action: Director of Transformation and Partnerships to update the wording to 'the senior management team reflect the communities that we serve'

OUTCOME: The Board **NOTED** the Strategic Objectives 2020-2021 progress report and **APPROVED** the Annual Strategic Plan for the period November 2021 – March 2023.

149/21 Month 6 Financial Summary 2021/22

The Deputy Director of Finance presented the month 6 financial summary and highlighted the key points below:

- Year to Date position for the first half of the financial year (H1) reported a breakeven financial position as planned
- Overspend in pay expenditure has been seen in month 5 (August) and month 6 (September) linked to both operational pressures and covid numbers
- Pay costs are above the planned level year to date, the adverse variance is largely driven by the agreed enhanced bank pay rate which has been in place since late July and has been driving additional pressure
- Pay pressures have been absorbed in full in the first quarter, which was balanced off by elective recovery funding
- Overall, the Trust delivered a breakeven position for first half with high expenditure
- Invoices paid within 30 days in month 6 is 94%, very close to the target of 95%

OUTCOME: The Board **NOTED** the Month 6 Finance Report and the financial position for the Trust as at September 2021.

150/21 2021/22 Finance Plan (H2)

The Deputy Director of Finance presented the 2021/22 Finance Plan and highlighted the key points below:

- Timescales have been tight pulling together the plan for the second half of the year (H2)
- Guidance was issued on 30 September 2021 for a financial period starting on 1 October 2021
- Planning for the current period which is already moving at fast pace
- Financial allocations have been issued at the Integrated Care System (ICS) level and split to provider level largely on a fair shares basis
- Expenditure in H1 was high and looking to invest in areas such as winter pressures in H2 (second half of financial year); therefore, expenditure run rate is seen to increase compared to no funding to cover costs

- Rules around elective recovery funding are still emerging
- Activity performance that determines whether the Trust is awarded this income is dependent on the whole of the ICS
- £6.7m proposed efficiency target
- Working with system partners on funding contribution
- Residual financial gap of £1.7m having assumed achievement of £6.7m efficiency
- Recommendation from Finance and Performance Committee was to submit an operational plan excluding technical accounting assumptions at a breakeven position, noting the risks and opportunities
- To note elective recovery funding also has a capital element to it (Targeted Investment Fund) which seeks to encourage investment to drive further elective recover – £6.5m bids submitted by the Trust which would increase the annual capital plan to additional funding and investments

AG asked what work is happening at ICS level to try collectively make sure that we maximise chances of securing the Elective Recovery Fund monies. The Deputy Director of Finance confirmed a lot of activity is ongoing to gather the assessment and secure the funds. The route to secure the funds are complex i.e., investment in the independent sector to deliver activity (commissioners can access this funding), and Trust activity performance around delivering certain levels of activity against 2019/20 thresholds. This is all being gathered to undertake an assessment on the current forecast.

The Acting Chief Operating Officer added the established weekly elective recovery meeting with all Director of Operations and Chief Operating Officers looks at opportunities to work collaboratively together and enable opportunities; however, this also brings a significant number of challenges. She explained the Trust are working closely with Mid Yorkshire and possibly using some of their estate and staffing for Paediatric surgery and dental work. She added that it is difficult to move staff around the system due to workforce issues and significant operational pressures due to the increased numbers of Covid-19.

AN asked if there are any other accounting adjustments other than what the Trust has already assumed for Covid-19. The Deputy Director of Finance responded the current forecast for Covid expenditure is expected to increase during the second half of the year compared to the first half of the year. She added the Trust have already included in the plans an element of maximising technical accounting benefits and the Trust would continue to seek these as much as possible.

AN asked if the competition for agency staff and bank staff resource is still a pressure across the region. The Deputy Director of Finance confirmed this is still a pressure and the Trust are now using a higher rate agency; however, remain under the NHS Improvement trajectory that was set. She confirmed bank pressure is the area of greater spend.

The Chair stated he attended the Finance and Performance Committee where this was discussed in detail and challenged. PW added the efficiency target of almost £7m is a challenge which will require a lot of work during the second half of the financial year.

OUTCOME: The Board **APPROVED** the 2021/22 Finance Plan (H2).

151/21 West Yorkshire and Harrogate and Health and Social Care Partnership Root Out Racism Campaign

The Director of Workforce and OD presented the Root Out Racism Campaign across West Yorkshire and Harrogate which fits within the Trust's Inclusion Strategy. The key points to note were:

- The Campaign responds to the health inequalities from the Covid-19 pandemic
- Talia Kelly Martin, the Trust's BAME co-ordinator has been working with the BAME network to develop personal stories and resources

- Members of the Board have all signed the pledge as strong advocates to root our racism and have been asked to tell their story
- From 8 November 2021 there will be a strong push to roll out this campaign

AN asked about the reverse mentoring at Airedale NHS Foundation Trust and if we use this approach. The Director of Workforce and OD confirmed CHFT have already introduced this and will continue to use this approach.

The Chief Executive confirmed the Trust have been offering reverse mentoring for several years with a position to treat everyone equitably and is a stance the Trust are taking. He asked the Director of Workforce and OD for some details on the Trust's reverse mentoring scheme as he has received a further request.
Action: Director of Workforce and OD to share details of the Reversed Mentoring Campaign with the Chief Executive

The Director of Workforce and OD informed the Board when colleagues see the stories it really shows how clear the Trust's stance is with the Root Out Racism Campaign.

OUTCOME: The Board **NOTED** the Root Out Racism Campaign.

152/21 Freedom to Speak Up Self-Assessment

The Director of Workforce and OD presented the Freedom to Speak Up Self-Assessment. The key points to note were:

- Over 30 Freedom to Speak Up Ambassadors across a diverse range of colleagues
- Clinical Freedom to Speak Up Guardian appointed supported by two Champions
- CHFT have gone above what is recommended nationally
- Formal summary of the Board's freedom to speak up self-assessment detailed in the paper, an annual requirement
- Series of actions to improve commitment and the process itself
- Some of the actions include a Board Development Session focused on Freedom to Speak Up to:
    - Improve confidence and understanding in the process, explicitly identify how the Board can support the Guardians and offer a 'Go See' opportunity, provide an overview of the issues being raised by colleagues, triangulate grievance access points and develop a few case studies for the Board in common issues and how the Trust have responded to them, present to the Council of Governors with a great ambassador Peter Bamber who is now one of our public elected governors, every Board appraisal will include our understanding and support in Freedom to Speak Up, develop a local Freedom to Speak Up Strategy and process to enhance the national strategy already in place.
- Next steps are to progress the actions identified and offer any Board member who feels they need to improve their confidence a 1-1 with our Freedom to Speak Up Guardian or Champions

KH was very supportive of this and explained there has been an increase in the number of issues submitted; however, she highlighted a lot of issues are reported anonymously which needs some further work. KH asked if there is a national Freedom to Speak Up Guardian. The Director of Workforce and OD confirmed there was a regional and national guardian; however, CHFT has increased its support for Freedom to Speak up which has been a good tool for colleagues to raise concerns.

The Director of Nursing explained it is important to normalise these processes and triangulate this work with areas of critical concern as in reality people might not recognise when they should be speaking up.

AG agreed with KH's comments and asked if there will be an assessment elsewhere in the organisation further to the self-assessment of the Board. The Director of Workforce and OD confirmed the Trust are planning an assessment across the organisation to understand whether colleagues can generally feel they can bring problems to us.

OUTCOME: The Board **APPROVED** the Freedom to Speak Up Self-Assessment and the associated action plan.

153/21 Winter Vaccination Plan

The Medical Director presented the Winter Vaccination Plan. The key points to note were:

- Public Assurance Checklist is available at the end of the paper
- Using a vaccination clinic based approached running on both sites for a period of 8 weeks which will move to drop-in sessions when activity reduces
- Influenza vaccines will move to a peer vaccination campaign
- Covid-19 vaccine is more complex to deliver in a non-clinical setting due to the nature of the vaccine
- Weekly data available from NHSE/I on uptake which is being monitored closely
- Availability of staff to deliver vaccines in the centres has been challenging with vacant slots appearing; therefore, only one vaccine centre can be open at one time which has resulted in some delays

AN pointed out 91% of vaccine uptake was achieved for the first dose and was lower for the second dose at 89%. He asked why the percentage of eligible people for the booster programme was much lower. The Medical Director responded the target remains the same with 92% receiving both doses with the aim to achieve this again. He explained the lower percentage for booster eligibility is due to a timing matter in delivering the Covid vaccine after the 180 day eligibility rule. Roughly 50% of eligible staff have received a booster dose to date.

The Chief Executive stated there are certain constituent groups of colleagues such as Black Caribbean, Pakistani, Asian Bangladeshi etc. where percentages are a distance away from 90%. He stated it is important to take a time out linked to health inequalities to look at some of the sub-categories around this.

The Medical Director confirmed there are two data sets, with one supplied by NHSE/I showing a 92/93% figure. He stated all vaccines must be uploaded to a national system which links to ESR data for all staff, not just front-line workers and explained they are trying to get some clarity on this, which includes vaccines provided by the GP. The Medical Director stated the limiting factor is capacity as opposed to the opportunity provided for vaccine take up.

OUTCOME: The Board **NOTED** the Winter Vaccination Plan.

154/21 Director of Infection Prevention Control (DIPC) Q2 Report

The Medical Director presented the Healthcare Associated Infections (HCAIs) position of performance for Q2 from 1 July to 30 September 2021.

The key points to note were:

- The majority of indicators are amber
- C.difficile position of 13 has improved compared to this time last year; however, there are still challenges regarding c.difficile
- Covid-19 still presents the greatest challenge to infection prevention and control
- ANTT (Aseptic non-touch technique) competency assessments, particularly for medical staff are impacted by the changeover of medical staff in August, hoping to see improvements and targeted work is taking place
- Back to the basics approach

AN asked what environmental issues mean with regards to a Covid-19 outbreak. The Medical Director confirmed the most important thing is ventilation on ward areas which has been challenging due to estates work currently taking place at Huddersfield Royal Infirmary which requires ward windows to be closed.

OUTCOME: The Board **NOTED** the performance against key Infection Prevention Control targets and **APPROVED** the Q2 report.

155/21 Learning from Deaths Q2 Report

The Medical Director presented the Learning from Deaths Q2 Report covering the period 1 July to 30 September 2021.

The key points to note were:

- Challenging to achieve 50% target for initial screening reviews, still our ambition
- Full establishment of the medical examiner's office within CHFT who are reviewing all inpatient deaths which contributes to the learning from death process
- Any areas of concern identified by the team will be submitted for a structured judgement review
- Establishing the medical examiners process for community deaths
- Learning themes and concerns identified from the structured judgement reviews is on page 3 of the report which will feed into the Care of the Acutely Ill Patient Programme

AG asked for clarity about the initial screening review wording compared to the chart which demonstrates a discrepancy in completion rates for June and July. The Medical Director explained this is due to a time lag between the two as screening reviews are completed as close to the death as possible and there are often delays due to staff pressures. The wording has been updated to reflect the increase in completion rate. AG asked if this could be made more explicit in future reports.
Action: Medical Director to explain the discrepancy in data for the initial screening reviews in future reports which is due to a time lag.

KH asked what happens next with the structured judgement review which received a very poor care score. The Medical Director explained those flagged with very poor care are often flagged as a serious investigation or complaint in which case would be investigated. If this is not the case, these will be progressed into a more detailed review with learning taken from this.

AN stated it is good to see the full establishment of the Medical Examiner's office and asked if this is helping mitigate the low initial screening rates and whether 50% feels achievable. The Medical Director responded prior to Covid the team were achieving close to 50%, he explained it is important to balance the collection and review of data with individual learning. He highlighted that themes can be pulled out from a lower number of reviews, so this does not cause concern. The Medical Director explained the Medical Examiner is independent of this process; however, contributes to the process and provides a further check by contacting the family to discuss any concerns they had.

OUTCOME: The Board **NOTED** the Learning from Deaths Q2 Report and the recommendations.

156/21 Guardian of Safe Working Hours Q2 Report, 2021-22

Devina Gogi, Guardian of Safe Working Hours presented the Guardian of Safe Working Hours Q2 report which covers the period of 1 July 2021 to 30 September 2021. The key points to note were:

- Slight increase in exception reports, 26 this quarter as opposed to 15 in the last quarter
- 24 relating to hours of working and 2 relating to service support available to the doctor – all were dealt with appropriately
- Majority of exception reports were closed by overtime payments or time off in lieu, 3 are currently unresolved and will be closed imminently
- Efficient filling of rota gaps in this quarter
- Delivery of exception report teaching in Trust induction
- Successful hosting of the first Junior Doctors forum held on 30 September 2021 with good engagement; however, this could be better
- The 'Doctor Toolbox' needs to be updated with important information so that it can be a useful resource for junior doctors
- Lack of availability of rooms for junior doctors to attend meetings has been flagged
- Reconfiguration plans were discussed at the last forum
- Rota gaps were filled by agency and bank
- Majority of rota gaps were in the Medical Division
- Appointed a new Junior Doctor Lead for Training Recovery, Dr Louise Finn
- Active participation in the Trust Induction, advocating the importance of junior doctor forums with good nominations for this
- Presentation and teaching on exception reporting were provided at the Trust induction

OUTCOME: The Board **NOTED** the Guardian of Safe Working Hours Report for quarter 2.

157/21 Quality Report (inc. Maternity Services Update)

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

- Continued engagement with CQC relationship managers
- Re-instigated the ward accreditation process, called Journey 2 Outstanding Reviews (J2O), several visits taken place across both sites to ward and clinical areas with feedback shared on necessary improvements and highlighting good areas of practice
- CAS alerts – clear plan to deliver outstanding CAS alerts and not anticipating much further delay in terms of closing these down
- Observe and Act Programme was put on hold for some time and is now back in place with excellent engagement, she highlighted Brian Moore, public elected governor asked for the findings to be shared from this at the last Council of Governors meeting
- Trust BAME Community Engagement Advisor is creating engagement opportunities with the local BAME communities from various groups
- Lessons learnt impact story is being produced per month to go in the IPR, along with a 'You Said, We Did'
- The visiting work stream established a task and finish group to progress a review of current restrictions to enable increased visiting whilst maintaining patient safety
- Complaints and PALs contacts are seeing an increase, a request by the Lead Governor also asked the Trust to highlight compliments and the Trust are speaking with Band 7's for their compliment letters
- Legal team are undertaking Getting it Right First Time (GIRFT) benchmarking as an initiative being led by NHSR
- Incidents are facing some challenges in closing some of the actions, reflection of the workload in the Divisions

- Medicine safety – some challenges around quoracy of medicine safety, one neighbouring Trust CQC inspection showed some early findings around medicine safety; therefore, spot checks are taking place
- Maternity Services Ockenden review - Regional Chief Midwife will be visiting the origination to undertake a review over the next few months, Chief Midwifery Officer at the Trust is undertaking a round of engagement events with Boards, listening events for staff are also taking place
- First allocation of funds has been received which will support 10.9 wte midwives
- £50k non-recurrently has been received to support newly qualified midwives
- 24% of woman booked on a continuity of care pathway and 56% of BAME
- 1-1 care in labour is at 98.9% - key marker of safety
- Current visiting restrictions in maternity is currently being reviewed
- Quality Account priorities and focussed priorities – increased focus on clinical documentation supported by the Managing Director for Digital Health, a Chief Nurse Information officer is now in post who is undertaking an internal review to inform a procurement process to recruit someone external to review our electronic patient records processes
- Falls remains a challenging area, falls alarm pads for patients are being rolled out
- Pressure ulcers has seen some improvement; however, still remains a challenge, there has been an increased focus on heel pressure ulcers, the Tissue Viability Team will now provide a seven day service

AG asked for an update on the lack of quoracy at the medicine safety and compliance group and highlighted nursing staff do not have time to ensure fridge doors are shut to monitor fridge temperatures. The Director of Nursing responded a system is in place for electronic fridge temperature monitoring and snapshot audits have been required to pick up on these improvements. She explained the quoracy of the group reflects some of the pressures in the organisation and representatives for several different Divisions will be reviewed.

AN highlighted continued concern was raised at the Patient Experience Group around staffing, however, is encouraged by the actions being taken. He stated it was positive Divisions were asked for the first time to talk about what they are doing for patient experience at the meeting, which was encouraging. AN suggested a Development Session next year should focus on patient experience to share this learning from Divisions.

AN asked how the Trust can achieve the must assessment for nutrition and hydration which is low and has a 95% target and he asked how the journey to outstanding feels.

The Director of Nursing responded that the ambitions in the Time to Care Strategy includes getting patient feedback then and there is crucially important. She highlighted part of the role of a matron is to continuously check in with patients, this needs to happen consistently. There is an element of understanding whether the must assessments aren't being completed or if they are being completed out of the timeframe or not recorded correctly. She assured the Board there is lots taking place around the winter must do's.

The Director of Nursing explained the Journey to Outstanding (J2O) is received very well and includes an improvement plan which will become part of the performance management review meetings going forward. Through Observe and Act and J2O there has been lots of positive feedback from patients about their experience.

AN highlighted a story of a complaint where communication was not working well which resulted in 14 touch points; however, the care was great. The Director of Nursing agreed to use the caring domain framework to bring patient experience to a future Development Session.

Action: Director of Nursing to plan and lead a caring domain session focused on patient experience for a future Board Development Session.

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

158/21 Integrated Performance Report (IPR) – September 2021

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

- September's performance score has deteriorated compared to August, worst position in year
- Deterioration is shown in complaints, Summary Hospital-level Mortality Indicator (SHMI) and stroke
- Safe, care and effective domains remain green; however, there remain some significant challenges within these domains
- Responsive domain alongside workforce domain are the most worrying domains
- Stroke has not achieved any of the key measures, access to the service is driving much of this deterioration
- Emergency care standard has deteriorated, patients are waiting a long time for inpatient beds which is a concern
- Continue to achieve cancer performance compliance, apart from screening
- Working closely with system partners to enact improvement which remains a challenge

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

159/21 Board Assurance Framework

The Company Secretary presented the second update of the Board Assurance Framework for 2021/22 which is a key source of evidence that links the Trust's strategic objectives to risk and assurance.

The report shows the risk profile which is largely the same and no new risks have been added since the last update. The paper describes risk scores increasing for four of the risks around service capacity, seven day services, quality and safety and colleague engagement. One long standing risk has reduced in score around medical staffing, from a score of 20 to 16, reflecting improvement in the net recruitment position and appointments within Radiology. This risk remains at a score of 16 as a result of the medical staffing pressures seen in the Emergency Department.

OUTCOME: The Board **APPROVED** the Board Assurance Framework.

160/21 Revised Governance Arrangements

The Director of Transformation and Partnerships presented a paper which describes an updated approach to manage the effective use of resources that will be implemented from 1 November 2021. The Trust needs to ensure there are strong mechanisms of governance to develop and deliver financial efficiencies to support delivery of the Trust's financial plans. A forum called Effective Resources Group will be established and meet weekly, chaired by the Chief Executive. The paper was approved at the Finance and Performance Committee and is for the Board to note. The Chair reminded the Board that any Non-Executive Director is welcome to join these meetings.

The Director of Transformation and Partnerships presented a paper which sets out the interim arrangements for the designated senior responsible owner. This report seeks approval that the CHFT Director of Nursing and Deputy Chief Executive whilst undertaking the role of Interim Chief Executive from 7 November 2021 and until Brendan Brown is in

post, is appointed as the Senior Responsible Owner (SRO) for the programme of service and estate reconfiguration at CHFT.

OUTCOME: The Board **NOTED** the updated approach to manage the effective use of resources from 1 November 2021 and **APPROVED** the Interim Senior Responsible Owner for Reconfiguration.

161/21 Governance Report

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

AN highlighted the following changes to the governance structure which were the Patient Experience Group now meets monthly and the Green Planning Committee reports into the Transformation Programme Board and meets monthly.

The Company Secretary updated the Board on the recruitment for Associate Non-Executive Directors which will be a pilot role for 12 months initially. She confirmed appointments have been made for CHFT and CHS which were ratified by the Nominations and Remuneration Committee of the Council of Governors. Further detail will be brought to the Board in January 2022.

The Board workplan for the end of this financial year and workplan for the new financial year 2022-23 were shared for any comments and feedback.

There was only one item for signing and sealing in the last quarter as detailed in the paper.

OUTCOME: The Board **APPROVED** the updated Governance Structure subject to the changes above and **NOTED** the update on the Associate Non-Executive Director appointments, Board of Directors workplans for 2021-22 and 2022-23 and use of the Trust Seal during the last quarter.

162/21 Board Sub-Committee Annual and Bi-Annual Reports for 2020/21

The Quality Committee Annual Report was received. The Director of Nursing confirmed the terms of reference for the Quality Committee were reviewed and approved in January 2021 and the level of attendance is shown by members. Details were shared of areas of deep dives undertaken. It was confirmed that the Quality Committee has fulfilled its role in ensuring continuous and measurable improvement in the quality of services the Trust delivers

The Nursing and Midwifery Safer Staffing (Hard Truths Requirements) Bi-Annual Report for the reporting period January to June 2021 was received. The report provides an update regarding safer nursing and midwifery staffing and an overview of measures being taken to address risk within the Trust, including a self assessment against 14 recommendations relating to Workforce Safeguards. The Trust is fully compliant with eight of the recommendations and partially compliant with six, with an action plan in place to achieve these. The Director of Nursing reminded the Board of the importance of understanding the levels of staffing, which feeds into Gold command meetings.

Andrea Dauris, Associate Director of Corporate Nursing presented slides which provided an overview of the safer staffing report which included detail of the current sickness/absence position and impact in terms of nurse staffing and vacancies by clinical division, fill rates and care hours per patient day, red flag escalation and quality indicators Friends and Family Test, falls and pressure ulcers and impact on patient experience. The short term and medium - long term response from the Trust was also shared, which includes a dashboard on nurse metrics (care hours per patient day and fill rate) and a worry dashboard by division with a large number of metrics which feeds into the weekly Safer Staffing Group.

AN echoed the comments about triangulation, noted the challenging position and asked if this is prompting any more action. The Director of Nursing responded a weekly/daily review takes place looking at all the Trust are doing and the importance of creating thinking. She added it is important to be clear about the registered nursing position and how to use the workforce in a different way, for example, the Trust opened bank shifts up to medical staff colleagues who can work as a bank nurse which adds incredible value.

The Director of Nursing formally thanked Andrea Dauris who has been driving the safer staffing requirements.

AN asked if the Trust are similar to other Trusts, the Director of Nursing confirmed this was the case for CHFT and experiences and ideas are shared.

The Chief Executive asked if there has been any relationship between the described staffing position and freedom to speak up activity. The Director of Workforce and OD confirmed there is a relationship and a review of staffing in that area will take place.

OUTCOME: The Board **NOTED** the Committee Review Annual Reports for the Quality Committee and **NOTED** the Nursing and Midwifery Safer Staffing (Hard Truths) Bi-Annual Report.

163/21 Board Sub-Committee Chair Highlight Reports

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

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

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

164/21 Annual / Bi-Annual Reports in the Review Room

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

1. Huddersfield Pharmaceuticals Specials Annual Report

OUTCOME: The Board **RECEIVED** the Huddersfield Pharmaceuticals Specials Annual Report.

165/21 Items for Review Room

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

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

- Finance and Performance Committee minutes of the meeting held 30.08.21
- Quality Committee minutes of the meeting held 16.08.21 and 13.09.21
- Audit and Risk Committee minutes of the meeting held 12.10.21
- Workforce Committee minutes of the meeting held 30.09.21
- Charitable Funds minutes of the last meeting held 23.08.21
- Organ Donation Committee minutes of the last meetings held 13.01.21 and 07.07.21 – The Chair stated this is a brilliant team who do a really good job in some very challenging circumstances.

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

166/21 Any Other Business

The Chair formally wished Owen Williams, Chief Executive goodbye, stating it has been a privilege to work with him and he will be missed. The Chief Executive was wished well in his next role.

The Chief Executive responded by sharing a touching farewell video.

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

167/21 Date and time of next meeting

Date: Thursday 13 January 2022
Time: 9:00 – 12:30 pm
Venue: Microsoft Teams

5. Action Log and Matters Arising

To Note

Presented by Philip Lewer

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC) 2021

Position as at: 04.11.21

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

DATE DISCUSSED	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
04.11.21 157/21	Quality Report Director of Nursing to plan and lead a caring domain session focused on patient experience for a future Board Development Session.	EA	To plan this in the Board Development Plan for 2022/23.	13.01.22		
04.11.21 155/21	Learning from Deaths Report Medical Director to explain the discrepancy in data for the initial screening reviews in future reports which is due to a time lag.	DB	Next report due March 2022.	03.03.22		
04.11.21 151/21	Root Out Racism Campaign Director of Workforce and OD to share details of the Reverse Mentoring Campaign with the Chief Executive	SD		13.01.22		04.01.22
04.11.21 148/21	Strategic Objectives 2021-2023 Director of Transformation and Partnerships to update the wording to 'the senior management team reflect the communities that we serve'	AB	The strategic objectives (plan on a page) has been updated as requested.	13.01.22		04.01.22
02.09.21 125/21	Quality Report (inc. Maternity Services Update) Director of Nursing to progress a further review of stillbirth figures at the Quality Committee and provide a more detailed report for the next Board meeting (inc. any trends in community or vulnerable groups)	EA	**07.10.21 Update** - Stillbirth paper to go to Quality Committee in November and Board in January 2022.	13.01.22		04.01.22
02.09.21 117/21	Health and Wellbeing Update Director of Workforce and OD to share the more detailed papers (inc. costs) on the Health and Wellbeing Hour presented to Executive Board with Board members Board members to provide any feedback and comments to the Director of Workforce and OD on what they would like to see in the next update to Board.	SD All	**03.11.21 Update** - The Board are reminded to share any feedback and comments to the Director of Workforce and OD. It has also been suggested that rather than circulate the papers that went to weekly Executive Board, it might be better to take an	13.01.22		04.01.22

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC) 2021

Position as at: 04.11.21

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

DATE DISCUSSED	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
			updated report that incorporates the feedback from the task and finish group reviewing the wellbeing hour for medical colleagues and have a report go to the Board in Q4 21/22.			

6. Chair’s Report

To Note

Presented by Philip Lewer

7. Chief Executive’s Report

To Note

Presented by Ellen Armistead and Brendan Brown

Transforming and Improving Patient Care

8. Patient Story - Continuity of Carer in Maternity - Presented by the Home Birth Team and a Patient

To Note

Presented by Lindsay Rudge

9. Health Inequalities Update

To Note

Presented by Ellen Armistead, Jo Fawcus and Suzanne Dunkley

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 13 January 2022
Meeting:	Public Board of Directors
Title:	Health Inequalities Progress Report
Authors:	Ellen Armistead, Director of Nursing / Deputy CEO Anna Basford, Director of Transformation and Partnerships Suzanne Dunkley, Director of Workforce and OD
Sponsoring Director:	Ellen Armistead, Executive Director of Nursing / Deputy CEO
Previous Forums:	Health Inequalities Group

Purpose of the Report

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

Key Points to Note

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

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

External environment: how we connect with our communities: The work undertaken to conduct an internal audit to review A&E attendances and admissions for individuals from people who are homeless, asylum seekers, refugees and high intensity users has been completed. The actions suggested from the audit along with the user experience stories to improve the support available in the community has received funding from the ICS to develop a pilot project to create and implement Care Navigator roles in both our A&E departments.

A Social Value Portal (SVP) action plan has been developed using nationally approved methodology for measuring and quantifying social value in terms of economic, social and environmental impact of the Trust's planned estate investment at CRH and HRI. This action plan has quantified the expected social return that will be generated by contractors and their supply chain to support a reduction in health inequalities experienced by our local communities.

The lived experience, initial focus on maternity services: At the end of December 55% of women from a BAME background have been booked onto a Continuity of Carer pathway.

Following the first round of discovery interviews with staff that highlighted a need to offer further training and support 2 training modules are now being piloted with a group of staff to increase awareness and understanding.

Translation of letters into 6 key languages for parents of babies eligible for BCG vaccination has been completed. This follows national changes which have affected delivery at Trust level. The letters explain clearly what to expect following discharge.

Funding has been allocated by the Integrated Care System (ICS) to implement the NHS Long Term Plan over the next 3 years, ringfenced to smoking in pregnancy. The Trust will receive 93K in year 1 to cover 40% of women who smoke at time of booking.

Using our data to inform stabilisation and reset: The children's waiting list although challenging to establish due to low numbers of learning disability flags on individuals' electronic patient records, a clinical review of the whole paediatric waiting list took place with further validation from the Matron Lead for learning disabilities. 19 children and young people were eventually identified and of those 84% have received the treatment.

The learning disability dashboard on Knowledge Portal Plus (KP+) is now an all-age reporting system, and the data has been pulled to create a reporting dashboard for divisions

Further developments on the **Health Inequalities dashboard** are in the planning and are articulated within the report.

Diverse and Inclusive workforce: CHFT worked in partnership with CCG and hosted a virtual Calderdale EDS2 (Equality Delivery System) event on 7 December 2021. The aim of the event was to share how CHFT are working on services that deliver better health outcomes for all. The audience included members of local community groups, patients and service users.

We are assessed and rated on the day the outcome being overall achieving with one outstanding rating.

EQIA – Equality Impact Assessment

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

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

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

Recommendation

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

HEALTH INEQUALITIES PROGRESS REPORT

January 2022

1. Introduction

Health Inequalities are defined as:

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

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

2. Background and Context

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

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

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

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

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

3 Workstream Updates

<u>External environment: how we connect with our communities.</u>

Partnership Working: The work undertaken to conduct an internal audit to review A&E attendances and admissions for individuals from people who are homeless, asylum seekers, refugees and high intensity users has been completed. This work included hearing

the lived experiences from refugees and asylum seekers facilitated by the St Augustine's Centre in Calderdale and the Resettlement Team in Kirklees. This learning has also been shared with the Integrated Care System (ICS) to support their aim to become an ICS of Sanctuary. The actions suggested from the audit along with the user experience stories to improve the support available in the community has received funding from the ICS to develop a pilot project to create and implement Aversity Trauma Care Navigator roles in both our A&E departments. This pilot is being developed collaboratively between the ICS and the Trust, along with wider health and care system and VCS partners.

Work has continued with the Greenwood PCN to reduce inequalities identified in emergency asthma admissions in PCN and CHFT data. A joint meeting was held in December with members of the Greenwood PCN, CHFT Clinical Leads and General Managers in the Respiratory and Paediatric Services, Locala and Kirklees Public Health. Collaborative next steps were agreed and are now being developed into a joint action plan action plan.

Social Value: The Social Value Portal (SVP) has supported the Trust in measuring and reporting the delivery of social value. An SVP action plan has been developed using nationally approved methodology for measuring and quantifying social value in terms of economic, social and environmental impact of the Trust's planned estate investment at CRH and HRI. This action plan has quantified the expected social return that will be generated by contractors and their supply chain and the Social Value assessment is based on a local needs analysis and targeted actions to support a reduction in health inequalities experienced by our local communities.

The output from this is now being used to inform our implementation plans for the estate developments to ensure the investment secures wider social benefits that are targeted to reduce health inequalities**.**

Reconfiguration Equality Impact Assessment (EQIA) & Quality Impact Assessment (QIA): As part of the process of continuous assessment in relation to the Trust's Public Sector Equality Duty and as reported previously, a refreshed assessment of the EQIA and QIA impact of the proposed service changes and estate developments at CRH and HRI has been undertaken. This was completed using the new and strengthened process to assess the EQIA and QIA impacts which included meetings with groups of people that have protected characteristics to directly inform, advise and confirm the assessment and any mitigations required.

The completed EQIA and QIA were also shared with Trust Board in October 2021 as part of the business case approval process for the Full Business Case (FBC) for the new A&E at HRI and the Outline Business Case (OBC) for the Reconfiguration Programme and have now been shared with NHSE/I and DHSC colleagues as part of the regional and national approval process for the business cases. EQIA and QIA will continue to be a refined and developed further during the next stage of detailed design work for the estate developments.

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

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

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

Continuity of Carer: work continues to develop continuity of carer with the two new Community Clinical Managers recently appointed. There are 2 'Complex Needs' Midwives delivering continuity to the most vulnerable women including refugees, teenage Mums and Mum's with physical and/or learning disability. Our current compliance is 26% for all women and 55% for women form BAME backgrounds.

Service User Experience: a wider range of colleagues have been asked to contribute to the process of discovery interviews as part of their professional development and to increase colleague engagement with the health inequalities work.

Culturally Competent Care: Following the first round of discovery interviews with staff that highlighted a need to offer further training and support 2 training modules are now being piloted with a group of staff to increase awareness and understanding.

Overcoming language barriers: translation of letters into 6 key languages for parents of babies eligible for BCG vaccination has been completed. This follows national changes which have affected delivery at Trust level. The letters explain clearly what to expect following discharge.

Smoking in pregnancy: Funding has been allocated by the ICS to implement the NHS Long Term Plan over the next 3 years, ringfenced to smoking in pregnancy. The Trust will receive 93K in year 1 to cover 40% of women who smoke at time of booking. Referrals to stop smoking services from Maternity have increased significantly in 2021/22 with over 231 electronic referrals to Yorkshire Smoke Free in Calderdale, Auntie Pam's Peer Support in Kirklees and the Living Well Stop Smoking Service in Bradford.

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

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

Learning Disability: The Trust now has a project manager for health inequalities in post whose main focus is the development of the enhanced care pathway for people with learning disabilities. A task and finish group has been established with divisional colleagues and expert by experience and self-advocacy representation. The terms of reference, agenda and minutes are all produced in an easy read format.

The children's waiting list was difficult to establish due to low numbers of learning disability flags on individuals' electronic patient records. A clinical review of the whole paediatric waiting list took place with further validation from the Matron Lead for learning disabilities. 19 children and young people were eventually identified and of those 84% have received the treatment

The learning disability dashboard on Knowledge Portal Plus (KP+) is now an all-age reporting system, and the data has been pulled to create a reporting dashboard for divisions. This allows divisions to see where people with a learning disability access services, specific issues with appointments and waiting lists for diagnostics. This data show that people with a learning disability access neurology, Gastroenterology and ENT services the most from an outpatient perspective.

Further developments on the **Health Inequalities dashboard** including:

- Additional outpatient sheet enabling analysis of outpatient activity, Did Not Attend (DNA%) and telemedicine update per head of population by Index of Multiple Deprivation (IMD) Decile, ethnicity, age group and gender.
- Enhancements to the inpatient sheet to enable analysis of inpatient reasons for admission, admission type and procedures over time, age group, gender, IMD and ethnicity.
- A Statistical Process Control (SPC) chart over time with filters to help highlight changes over time.
- A map sheet so delivery of services, and potential health inequalities can be viewed from a geographical perspective.

An End of Life/Palliative care dashboard is currently in development.

Diverse and Inclusive Workforce.

EDS2: CHFT worked in partnership with Clinical Commissioning Group (CCG) and hosted a virtual Calderdale EDS2 (Equality Delivery System) event on 7 December 2021. The aim of the event was to share how CHFT are working on services that deliver better health outcomes for all. The audience included members of local community groups, patients and service users.

Kate Heighway, Julie Mellor and Amanda McKie were prepared to share their 'Better Health Outcomes' Story.

We are assessed and rated on the day the outcome being overall achieving with one outstanding rating.

The Kirklees virtual EDS2 event will be hosted on 13th January 2022.

Summary

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

Ellen Armistead
Executive Director of Nursing/Deputy CEO
January 2022

Appendix 1

Calderdale and Huddersfield NHS
NHS Foundation Trust

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

As at 18th October 2021

compassionate care

Calderdale and Huddersfield NHS
NHS Foundation Trust

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

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

Source: Knowledge Portal Plus

compassionate care

Calderdale and Huddersfield NHS
NHS Foundation Trust

IMD P2 Backlog daily snapshot for 27 May, 18 Oct

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

Source: Knowledge Portal Plus

compassionate care

Calderdale and Huddersfield NHS
NHS Foundation Trust

P2, P3, P4 Combined
27 May, 18 Oct

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

Source: Knowledge Portal Plus

compassionate care

10. Calderdale PLACE: Partnership Working and Governance

To Approve

Presented by Anna Basford

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Date of Meeting:	Thursday 13 January 2022
Meeting:	Public Board of Directors
Title of report:	Place Based Working in Calderdale
Authors:	Anna Basford – Director of Transformation and Partnerships
Sponsor:	Brendan Brown – Chief Executive
Previous Forums:	Previous discussions have taken place at Trust Board development workshops regarding the white paper published by the Department of Health and Social Care in February 2021 that sets out the key components of a statutory integrated care system ("ICS"). One of these components is "*strong and effective place-based partnerships*" in local places between the NHS, local government and key local partners, interfacing with a statutory ICS.

Purpose of the Report

The purpose of this report is to provide an update on progress to develop the place based partnership agreement in Calderdale.

An earlier draft of the agreement was discussed at the Trust Board Development Workshop held on 2nd December 2021.

Since then the partnership agreement document has been updated to incorporate comments from CHFT and other partners. The Trust Board is now requested to formally confirm agreement to sign up to the attached Calderdale Cares partnership agreement.

The proposed place-based agreement does not give rise to any legal obligations; the agreement is designed to complement the partners' existing statutory obligations and to respect organisational sovereignty.

Key Points to Note

The West Yorkshire and Harrogate Health and Care Partnership (ICS) has been progressing work to develop future governance arrangements to implement the proposed legislative changes set out in the White Paper from 1st April 2022.

This includes the establishment of a West Yorkshire Integrated Care Board (ICB) from April 2022. The West Yorkshire ICB will primarily discharge its duties through delegation to place, alongside work that is delivered at WY level. It is expected that most decisions will be made at place level, in support of local Health and Wellbeing Board priorities. At system level, the ICB board will have a key role in executing the strategy set by the Integrated Care Partnership; its delivery in place and through provider collaboratives; and through engagement with partners at WY level.

The West Yorkshire ICS has confirmed the importance of subsidiarity. Each place across West Yorkshire has identified that a Place-Based Committee of the ICB is the preferred structure to make decisions about ICB functions and resources at place level. These committees will be established by the WY ICB Board, which will formally agree their Terms of Reference and membership. However each Place has significant discretion to design their place-based committees and the arrangements for partnership working at local level that will be described in a local Memorandum of Understanding (MoU) that partner organisations in each place will sign up to.

In Calderdale work has been progressed to develop the place based working arrangements and a Memorandum(s) of Understanding to describe this. CHFT has been involved and had input to these discussions in recent months through representation of the previous CEO, the Director of Transformation and Partnerships, and the Director of Finance. The final partnership agreement document is attached at **Appendix D2.**

EQIA – Equality Impact Assessment

The proposed legislative changes to partnership working outlined in this paper seek to address the needs of the whole population thought enhanced partnership working to reduce health inequalities.

At WY and place based level there is commitment that future governance arrangements must improve the diversity and inclusivity of our leadership at every level and ensure meaningful representation across all places and communities in WY.

Recommendation

The Board is asked to:

- **Approve:** that CHFT signs up to the Calderdale Cares Partnership Agreement.

CALDERDALE CARES PARTNERSHIP AGREEMENT

DRAFT v1.3

1. CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

2. CALDERDALE LOCAL MEDICAL COMMITTEE LTD

3. CALDERDALE METROPOLITAN BOROUGH COUNCIL

4. HEALTHWATCH CALDERDALE

5. LOCALA COMMUNITY PARTNERSHIPS CIC

6. NHS CALDERDALE CLINICAL COMMISSIONING GROUP

7. SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST

8. VOLUNTARY AND COMMUNITY

CALDERDALE CARES PARTNERSHIP AGREEMENT

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CALDERDALE CARES PARTNERSHIP AGREEMENT

This Partnership Agreement ('this Agreement') is made between:

1. **CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST** of Acre Street, Lindley, Huddersfield, West Yorkshire, HD3 3EA;
2. **CALDERDALE LOCAL MEDICAL COMMITTEE LTD** of E139 Dean Clough Mills, Halifax, HX3 5AX;
3. **CALDERDALE METROPOLITAN BOROUGH COUNCIL** of Town Hall, Crossley Street, Halifax, West Yorkshire, HX1 1UJ;
4. **HEALTHWATCH CALDERDALE** of The Elsie Whiteley Innovation Centre, Hopwood Lane, Halifax, HX1 5ER;
5. **LOCALA COMMUNITY PARTNERSHIPS CIC** of Beckside Court (First Floor), Bradford Road, Batley, WF17 5PW;
6. **NHS CALDERDALE CLINICAL COMMISSIONING GROUP** of 2nd Floor, Westgate House, Halifax, HX1 1PW;[1]
7. **SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST** of Fieldhead, Ouchthorpe Lane, Wakefield, WF1 3SP; and
8. **VOLUNTARY AND COMMUNITY** of Resource Centre, Hall Street, Halifax, HX1 5AY.

Together these organisations are referred to as 'the Partners' and as a collective form the formal leadership for the Calderdale Cares Partnership ('the Partnership').

1. Background

1.1. Calderdale Cares began in 2018 as the Calderdale place-based model for integrated health, care and wellbeing. At the heart of Calderdale Cares were the principles of better wellbeing for all, harnessing the strengths of people and communities, seamless services for those that need help, and partners working collaboratively to make this all happen.

1.2. The aim was to create strong collaboration across Calderdale where organisations, including the NHS, Calderdale Council and the voluntary and community sector, work together and share resources to deliver a range of support to meet each person's individual needs, within their own community.

1.3. Calderdale is one of five places within the West Yorkshire Health and Care Partnership, a partnership of places, provider collaboratives and system. The West Yorkshire Health and Care Partnership is grounded in its agreed principles:

[1] In endorsing the Agreement Partners recognise that it is anticipated NHS Calderdale Clinical Commissioning Group will transition to be part of the NHS West Yorkshire Integrated Care Board from July 2022.

1.3.1. We will be ambitious for the people we serve and the staff we employ.

1.3.2. The West Yorkshire Partnership belongs to its citizens and to commissioners and providers, councils and NHS. We will build constructive relationships with communities, groups and organisations to tackle the wide range of issues which have an impact on health inequalities and people's health and wellbeing.

1.3.3. We will do the work once – duplication of systems, processes and work should be avoided as wasteful and potential source of conflict.

1.3.4. We will undertake shared analysis of problems and issues as the basis of taking action.

1.3.5. We will apply subsidiarity principles in all that we do – with work taking place at the appropriate level and as near to local as possible.

1.4. Additionally the West Yorkshire Health and Care Partnership is underpinned by a set of shared values:

1.4.1. We are leaders of our organisation, our place and of West Yorkshire.

1.4.2. We support each other and work collaboratively.

1.4.3. We act with honesty and integrity, and trust each other to do the same.

1.4.4. We challenge constructively when we need to.

1.4.5. We assume good intentions.

1.4.6. We will implement our shared priorities and decisions, holding each other mutually accountable for delivery.

1.5. In February 2021 the Department of Health and Social Care published a white paper[2] ('the white paper') which set out intentions to establish statutory integrated care systems (ICSs). In doing so the white paper emphasised the need for place based collaboration between the NHS, local government and wider key partners such as the voluntary and community sector.

1.6. In response to the white paper each place within the West Yorkshire Health and Care Partnership is continuing to develop their place based partnership, bringing together the NHS, local government, and other partners. In Calderdale it is recognised that what this requires is an evolution of the original Calderdale Cares concept, building on the strong foundations already developed and moving forwards as the Calderdale Cares Partnership.

2. Status and Purpose of this Partnership Agreement

[2] *Integration and Innovation: working together to improve health and social care for all* (Department of Health and Social Care, February 2021: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/960548/integration-and-innovation-working-together-to-improve-health-and-social-care-for-all-web-version.pdf)

2.1. The Partners have agreed to work together on behalf of the people of Calderdale to work collaboratively and to further develop the Calderdale Cares Partnership. In doing so the Partners will identify and respond to the health and care needs of the Calderdale population and deliver integrated health, support and community care to develop – and ultimately deliver – improved health and care outcomes for the people of Calderdale.

2.2. This Agreement sets out the key agreements of the Partnership, including:

2.2.1. The vision of the Partnership and the vision's supporting objectives.

2.2.2. The shared principles, values and behaviours that the Partners have agreed to adopt throughout their joint working.

2.2.3. The governance structures and supporting arrangements underpinning the Partnership.

2.3. This Agreement is not legally binding and does not impose any legal obligations on any Partners, nor does it add to or override any existing contractual obligations held by any Partners. In endorsing the Agreement Partners fully retain their organisational sovereignty and continue to be accountable for their respective statutory responsibilities.

3. Approvals

3.1. Each Partner acknowledges and confirms that it has obtained the required authorisation to enter into this Agreement and that its own Board / Cabinet / Governing Body has approved the content of this Agreement.

4. Duration and Review

4.1. This Agreement shall take effect on 01 April 2022 and will continue in full effect until such time the Partners agrees that alternative arrangements would better serve the needs of the Partnership.

4.2. The Partners will initially review the terms of this Agreement in April 2023 and at such intervals thereafter as the Partners may agree. The Partners may agree to update the Agreement to reflect developments as appropriate.

Part A: The Partnership's Vision, Objectives, Principles, Values and Behaviours

5. Vision and Objectives

5.1. The Partners have agreed to work towards a common vision for Calderdale as follows:

'Our vision for Calderdale is for a place where you can realise your potential whoever you are, whether your voice has been heard or unheard in the past.

We aspire to be a place where talent and enterprise can thrive.

A place defined by our innate kindness and resilience, by how our people care for each other, are able to recover from setbacks and are full of hope.

Calderdale will stand out, be known and be distinctive.

A great place to visit, but most importantly, a place to live a larger life.'

5.2. In pursuit of the vision the Partners have agreed to work towards the following objectives:

5.2.1. Reducing health inequalities across the borough of Calderdale.

5.2.2. Investing in prevention and 'home first', helping people to avoid admission to care homes and hospital beds wherever possible.

5.2.3. Developing a sustainable health and care system for Calderdale.

5.2.4. Integrating services and their supporting workforce to deliver joined up care.

5.2.5. Looking after our workforce and ensuring they are happy and fulfilled at work.

5.2.6. Making best use of Calderdale's resources and getting the most out of the 'Calderdale pound'.

5.2.7. Working in partnership with our localities, communities and citizens.

6. Principles, Values and Behaviours

6.1. The Partners have agreed to adopt the following principles in their work together as a Partnership:

6.1.1. We start with prevention and invest in keeping people as well as they can be.

6.1.2. We take a person-centred approach in all we do, joining up services around the needs of citizens.

6.1.3. We value and support Calderdale’s unique health and wellbeing assets and help people to benefit from them.

6.1.4. We work together with people and communities and help empower them to be healthy and independent.

6.1.5. We work relentlessly to reduce inequalities in health and wellbeing.

6.2. The Partners have agreed to adopt the following values in their work together as a Partnership:

6.2.1. Honesty and integrity.

6.2.2. Compassion and kindness.

6.2.3. Trust and respect.

6.3. The Partners have agreed to adopt the following behaviours in their work together as a Partnership:

6.3.1. We focus on making a difference for Calderdale people and communities.

6.3.2. We support each other and work collaboratively.

6.3.3. We challenge constructively and hold one another to account.

6.3.4. We use strengths-based approaches.

Part B: Delivering the Vision, Objectives, Principles, Values and Behaviours

7. Problem Resolution

7.1. The Partners agree to approach problem resolution in a way which recognises the objectives, principles, values and behaviours set out above and which:

7.1.1. Seeks solutions within a shared culture of 'no fault, no blame'.

7.1.2. Seeks to resolve any disputes in an open, amicable and communicative manner.

7.1.3. Treats the Partners as equal parties within the resolution of any dispute.

7.1.4. Seeks solutions which are mutually beneficial as far as possible.

7.1.5. Accepts that confrontational attitudes waste time and other resources and should be avoided at all times.

7.2. If any Partner receives a formal enquiry or complaint from a party external to this Agreement and the enquiry or complaint relates to this Agreement, the receiving Partner will agree the contents of their response with the full Calderdale Cares Partnership Board before the response is issued.

8. Partners' Roles and Responsibilities

8.1. Each Partner agrees to:

8.1.1. Work collaboratively with the other Partners in line with the Calderdale Cares Partnership vision, objectives, principles, values and behaviours.

8.1.2. Work collaboratively with the other Partners and with colleagues more widely to deliver the ambitions of the West Yorkshire Integrated Care Partnership strategy and the NHS West Yorkshire Integrated Care Board (once established).

8.1.3. Work collaboratively to best serve Calderdale's population rather than pursuing organisational interests.

8.1.4. Work collaboratively with the other Partners to further develop the Calderdale Cares Partnership.

8.1.5. Work collaboratively with the other Partners to develop and provide a single place based response to parties external to this Agreement where requests for information are made.

Part C: Governance Arrangements

9. Governance Model

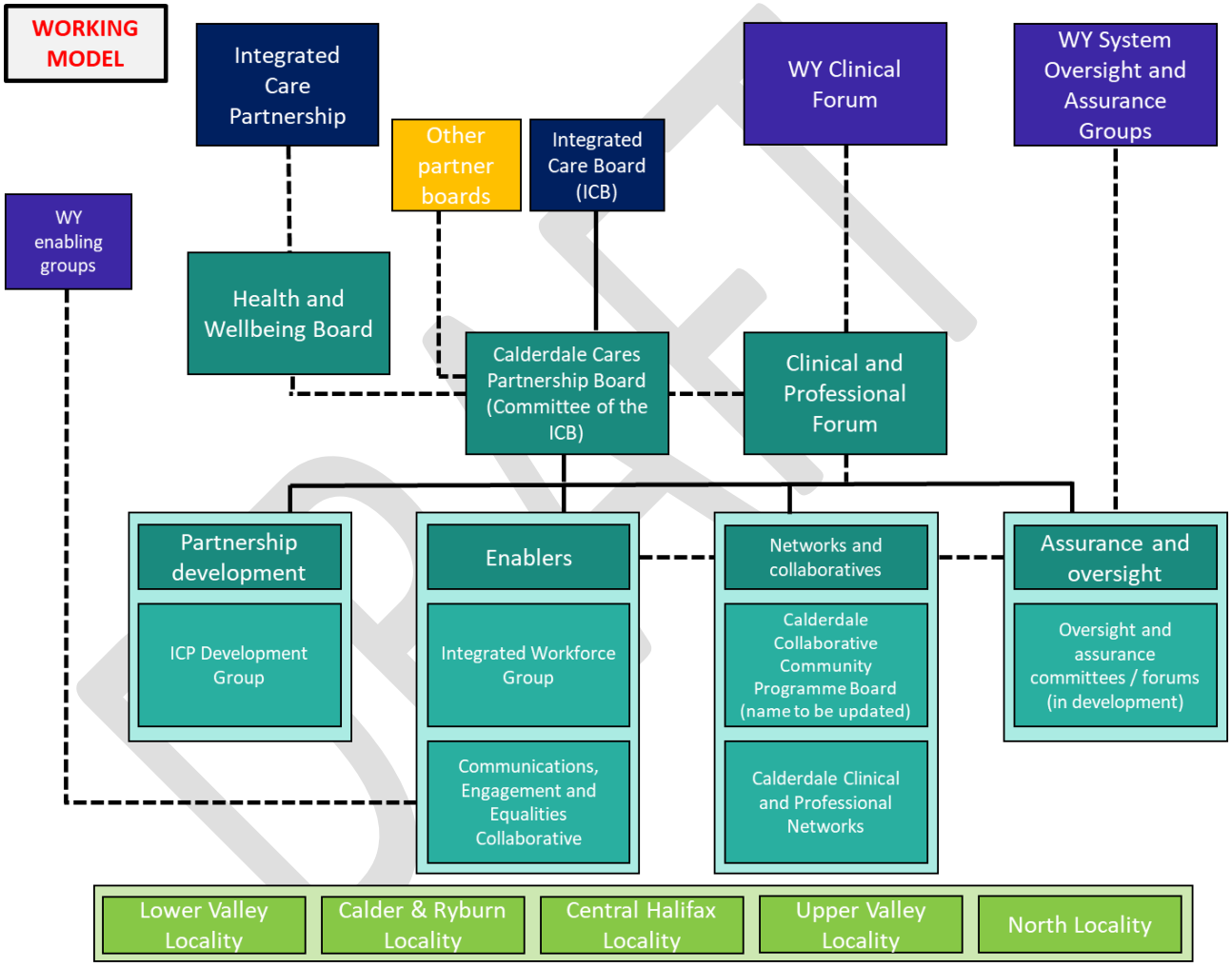
9.1. In addition to the Partners' own Boards / Cabinet / Governing Body, which retain their existing responsibilities and accountability, the governance model for the Calderdale Cares Partnership arrangements (as shown below) comprises:

9.1.1. The Calderdale Cares Partnership Board;

9.1.2. The Health and Wellbeing Board;

9.1.3. The Clinical and Professional Forum; and

9.1.4. Delivery and assurance infrastructure.



Calderdale Cares Partnership Board

9.2. The Calderdale Cares Partnership Board provides the formal leadership for the Calderdale Cares Partnership. The Board provides oversight for Calderdale health and care business and provides a forum through which to make decisions on those matters which are best addressed collectively.

9.3. From July 2022 the Board will be a committee of the NHS West Yorkshire Integrated Care Board and from that time will be responsible for matters delegated to it in

accordance with the Integrated Care Board's constitution and scheme of reservation and delegation.

9.4. The Board is led by an independent Chair and includes representation from: independent lay members; Calderdale Metropolitan Borough Council; NHS West Yorkshire Integrated Care Board; Calderdale Local Medical Committee; Calderdale and Huddersfield NHS Foundation Trust; Healthwatch Calderdale; Locala Community Partnerships; South West Yorkshire Partnership NHS Foundation Trust; the voluntary and community sector; general practice; the Calderdale Clinical and Professional Forum; public health; quality and safety; finance; and performance.

Health and Wellbeing Board

9.5. The Health and Wellbeing Board provides a forum through which political, clinical, professional and community leaders come together to develop a shared ambition for improving health and wellbeing and addressing health inequalities in Calderdale. The Health and Wellbeing Board is responsible for setting the Health and Wellbeing Strategy for Calderdale and holding to account the Calderdale Cares Partnership Board for the health and care service contribution to that strategy. The Health and Wellbeing Board continues to be responsible for undertaking Calderdale's Joint Strategic Needs Assessment.

Clinical and Professional Forum

9.6. The Clinical and Professional Forum provides clinical and professional leadership to the Partnership and makes recommendations to inform decisions made by the Calderdale Cares Partnership Board. The Forum acts as a gateway to the Calderdale Cares Partnership Board, whereby proposals first go to the Clinical and Professional Forum (unless it is agreed that the content of the proposal is not relevant to the Forum) before going to the Board for a decision.

Delivery and assurance infrastructure

9.7. Reporting into the Calderdale Cares Partnership Board are a number of groups leading on and overseeing programmes and initiatives to deliver positive outcomes for Calderdale's population. Alongside these groups sit oversight and assurance functions to support the Partnership in adopting and maintaining a place based approach to shared priorities in matters such as quality and safety. Especially key to the delivery of outcomes and high quality care will be Calderdale's five localities, coterminous with

Calderdale's five primary care networks, through which strategic ambition will be effected at a more local level.

10. Information Sharing and Conflicts of Interest

10.1. Subject to compliance with the law the Partners agree to share all information relevant to the work of the Partnership in an honest and timely manner.

10.2. The Partners will:

10.2.1. Share the details with other Partners of any real or potential conflict of interest which does or may arise in connection with this Agreement or the operation of the Calderdale Cares Partnership Board as soon as they become aware of the conflict of interest.

10.2.2. To the best of their ability ensure that their representatives on the Calderdale Cares Partnership Board comply with the above when acting within the remit of this Agreement.

CALDERDALE CARES PARTNERSHIP AGREEMENT

PARTNER ENDORSEMENTS

Signed by [INSERT NAME AND ROLE] [SIGNATURE]

for and on behalf of **CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST** [DATE]

Signed by [INSERT NAME AND ROLE] [SIGNATURE]

for and on behalf of **CALDERDALE LOCAL MEDICAL COMMITTEE LTD** [DATE]

Signed by [INSERT NAME AND ROLE] [SIGNATURE]

for and on behalf of **CALDERDALE METROPOLITAN BOROUGH COUNCIL** [DATE]

Signed by [INSERT NAME AND ROLE] [SIGNATURE]

for and on behalf of **HEALTHWATCH CALDERDALE** [DATE]

Signed by [INSERT NAME AND ROLE] [SIGNATURE]

for and on behalf of **LOCALA COMMUNITY PARTNERSHIPS CIC** [DATE]

Signed by [INSERT NAME AND ROLE] [SIGNATURE]

for and on behalf of **NHS CALDERDALE CLINICAL COMMISSIONING GROUP** [DATE]

Signed by [INSERT NAME AND ROLE] [SIGNATURE]

for and on behalf of **SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST** [DATE]

Signed by [INSERT NAME AND ROLE] [SIGNATURE]

for and on behalf of **VOLUNTARY AND COMMUNITY** [DATE]

Sustainability

11. Month 8 Financial Summary

To Note

Presented by Gary Boothby

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 13 January 2022
Meeting:	Public Board of Directors
Title:	Month 8 Finance Report
Author:	Philippa Russell – Assistant Director of Finance
Sponsoring Director:	Gary Boothby - Director of Finance
Previous Forums:	Finance and Performance Committee

Purpose of the Report

To provide a summary of the financial position as reported at the end of Month 8 (November 2021).

Key Points to Note

Year to Date Summary

Year to date the Trust is reporting a £1.60m deficit, a £0.04m adverse variance from plan. Plans have now been agreed for the second half of the year (H2) and Trust budgets have been aligned with that plan. Whilst the Trust has submitted a balanced plan for the year and has delivered a break-even position in the first half of the year (H1), the financial position remains challenging. H2 includes a significant efficiency requirement of £6.7m, with only £3.9m identified of which £3.3m is currently forecast to deliver. The deficit position is driven by a combination of staffing pressures, in particular the high cost of temporary staffing (enhanced bank rates and high-cost agency) and Recovery costs, including the cost of Independent Sector support. The Trust has not been able to access the Elective Recovery Fund (ERF) so far in H2 to offset some of these additional pressures. Activity remains below the current threshold for both the Trust and the Integrated Care System (ICS) as a whole.

- Funding for H2 continues on a block contract basis, with fixed Top Up funding allocated by the ICS (Integrated Care System) to cover the Trust's underlying deficit, growth and Covid-19 expenditure. For H2, the Trust has been allocated £21.16m of System Top Up funding, £12.75m of System Covid funding and £1.76m of Growth funding, a total Top Up of £35.66m for H2. £2.32m of additional Capacity funding has been allocated to the Place to support winter and urgent care pressures, of which £1.5m has been agreed by the Urgent & Emergency Care Board to support Trust pressures.
- In addition, the Trust continues to have access to funding for Covid-19 costs that are considered to be outside of the System Envelope and year to date has accounted for £5.20m of additional funding to cover costs incurred for Vaccinations, Covid-19 Testing, 3rd Year Student Nurse contracts and Isolation Hotels for overseas recruits. Income up to the end of M6 has now been approved and received, the remainder remains subject to approval.
- In total the Trust has incurred costs relating to Covid-19 of £15.09m. Costs were driven by: Covid-19 virus testing, vaccinations (on hospital site and for local vaccination centre), the segregation of patient pathways (particularly within the Emergency Department), ICU staffing models and remote management of patients.
- Year to date the Trust has delivered efficiency savings of £4.44m, but largely on a non-recurrent basis.

- Agency expenditure year to date is £4.18m, £1.70m lower than the NHS Improvement Agency expenditure ceiling. However there has been a large increase in Bank costs that has accelerated over the last 5 months due to the enhanced pay agreement.
- Total planned inpatient activity was 96.3% of the month 8 2019/20 baseline, although within this total Elective inpatient activity was only at 84.9%. No ERF has been assumed for Month 7 or 8, with overall planned activity below the required threshold.

Key Variances

- Income is £7.60m higher than planned year to date. This includes £3.57m income to support the unplanned and backdated 21/22 pay awards. Additional income to offset outside of system envelope Covid-19 costs is £4.35m higher than planned year to date. ERF is below the planned level at £3.63m, an adverse variance of £0.67m year to date.
- Pay costs are £6.04m above the planned level year to date, although this includes £3.57m of H1 backdated pay awards which are funded, leaving an underlying variance of £2.47m adverse. £0.92m of Covid-19 costs are outside of envelope and therefore also offset by additional income, this is offset by Recovery costs that are £0.37m lower than planned. The adverse variance is largely driven by the agreed enhanced pay for Bank staff, an additional cost of £0.66m in month and £3.17m year to date, (£1.81m adverse variance). Covid pressures have also increased over the last few months; Emergency Department segregation and enhanced staffing models on Wards and in Critical Care continue to drive higher costs.
- Non-pay operating expenditure is higher than planned by £1.81m. This variance includes Covid-19 related expenditure of £3.62m for vaccination costs and Covid-19 testing that are offset by income, the underlying position is therefore a £1.81m underspend, linked to lower than planned commercial activity.

H2 (Oct-Mar) Forecast

The plan for H2 is to deliver a break-even plan, (excluding a one off non-recurrent technical accounting adjustment of £5m). In order to deliver this position, the Trust will need to find efficiencies of £6.7m, of which only £3.9m are currently identified, and there remains a further risk due to a £1.7m funding gap that has yet to be resolved. Costs have increased significantly over the last few months due to a high number of Covid patients and significant staffing shortages, and going into winter this will be extremely challenging to reverse. The Trust is continuing to work with partners at Place and ICS level to manage this risk and there are also various routes to access Elective Recovery Funding which could further mitigate this position.

Attachment: Month 8 Finance Report

EQIA – Equality Impact Assessment

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

Recommendation

The Board is asked to receive the Month 8 Finance Report and **NOTE** the financial position for the Trust as at 30 November 2021.

EXECUTIVE SUMMARY: Total Group Financial Overview as at 30th Nov 2021 - Month 8

KEY METRICS

	M8				YTD (NOV 2021)				Forecast 21/22			
	Plan £m	Actual £m	Var £m		Plan £m	Actual £m	Var £m		Plan £m	Forecast £m	Var £m	
I&E: Surplus / (Deficit)	(£0.32)	(£0.36)	(£0.05)		(£1.56)	(£1.60)	(£0.04)		£0.00	£0.00	£0.00	
Agency Expenditure (vs Ceiling)	(£0.74)	(£0.73)	£0.00		(£5.88)	(£4.18)	£1.70		(£8.82)	(£6.75)	£2.07	
Capital	£0.88	£1.90	(£1.02)		£8.70	£6.30	£2.40		£18.99	£19.35	(£0.36)	
Cash	£47.00	£44.91	(£2.09)		£47.00	£44.91	(£2.09)		£38.75	£36.36	(£2.39)	
Invoices paid within 30 days (%) (Better Payment Practice Code)	95.0%	94.7%	0%		95.0%	94.1%	-1%					
CIP	£1.32	£1.28	(£0.04)		£4.43	£4.44	£0.00		£9.70	£6.31	(£3.39)	
Use of Resource Metric	3	3			3	3			2	2		

Year to Date Summary

Year to date the Trust is reporting a £1.60m deficit, a £0.04m adverse variance from plan. Plans have now been agreed for the second half of the year (H2) and Trust budgets have been aligned with that plan. Whilst the Trust has submitted a balanced plan for the year and has delivered a break-even position in the first half of the year (H1), the financial position remains challenging. H2 includes a significant efficiency requirement of £6.7m, with only £3.9m identified of which £3.3m is currently forecast to deliver. The deficit position is driven by a combination of staffing pressures, in particular the high cost of temporary staffing (enhanced bank rates and high cost agency) and Recovery costs, including the cost of Independent Sector support. The Trust has not been able to access the Elective Recovery Fund (ERF) so far in H2 to offset some of these additional pressures. Activity remains below the current threshold for both the Trust and the Integrated Care System (ICS) as a whole.

• Funding for H2 continues on a block contract basis, with fixed Top Up funding allocated by the ICS (Integrated Care System) to cover the Trust's underlying deficit, growth and Covid-19 expenditure.
For H2, the Trust has been allocated £21.16m of System Top Up funding, £12.75m of System Covid funding and £1.76m of Growth funding, a total Top Up of £35.66m for H2. £2.32m of additional Capacity funding has been allocated to the Place to support winter and urgent care pressures, of which £1.5m has been agreed by the Urgent & Emergency Care Board to support Trust pressures.
• In addition the Trust continues to have access to funding for Covid-19 costs that are considered to be outside of the System Envelope and year to date has accounted for £5.20m of additional funding to cover costs incurred for Vaccinations, Covid-19 Testing, 3rd Year Student Nurse contracts and Isolation Hotels for overseas recruits. Income up to the end of M6 has now been approved and received, the remainder remains subject to approval.
• In total the Trust has incurred costs relating to Covid-19 of £15.09m. Costs were driven by: Covid-19 virus testing, vaccinations (on hospital site and for local vaccination centre), the segregation of patient pathways (particularly within the Emergency Department), ICU staffing models and remote management of patients.
• Year to date the Trust has delivered efficiency savings of £4.44m, but largely on a non-recurrent basis.
• Agency expenditure year to date is £4.18m, £1.70m lower than the NHS Improvement Agency expenditure ceiling. However there has been a large increase in Bank costs that has accelerated over the last 5 months due to the enhanced pay agreement.
• Total planned inpatient activity was 96.3% of the month 8 2019/20 baseline, although within this total Elective inpatient activity was only at 84.9%. No ERF has been assumed for Month 7 or 8, with overall planned activity below the required threshold.

Key Variances

• Income is £7.60m higher than planned year to date. This includes £3.57m income to support the unplanned and backdated 21/22 pay awards. Additional income to offset outside of system envelope Covid-19 costs is £4.35m higher than planned year to date. ERF is below the planned level at £3.63m, an adverse variance of £0.67m year to date.
• Pay costs are £6.04m above the planned level year to date, although this includes £3.57m of H1 backdated pay awards which are funded, leaving an underlying variance of £2.47m adverse. £0.92m of Covid-19 costs are outside of envelope and therefore also offset by additional income, this is offset by Recovery costs that are £0.37m lower than planned. The adverse variance is largely driven by the agreed enhanced pay for Bank staff, an additional cost of £0.66m in month and £3.17m year to date, (£1.81m adverse variance). Covid pressures have also increased over the last few months; Emergency Department segregation and enhanced staffing models on Wards and in Critical Care continue to drive higher costs.
• Non-pay operating expenditure is higher than planned by £1.81m. This variance includes Covid-19 related expenditure of £3.62m for vaccination costs and Covid-19 testing that are offset by income, the underlying position is therefore a £1.81m underspend, linked to lower than planned commercial activity.

H2 (Oct-Mar) Forecast

The plan for H2 is to deliver a break-even plan, (excluding a one off non-recurrent technical accounting adjustment of £5m). In order to deliver this position, the Trust will need to find efficiencies of £6.7m, of which only £3.9m are currently identified, and there remains a further risk due to a £1.7m funding gap that has yet to be resolved. Costs have increased significantly over the last few months due to a high number of Covid patients and significant staffing shortages, and going into winter this will be extremely challenging to reverse. The Trust is continuing to work with partners at Place and ICS level to manage this risk and there are also various routes to access Elective Recovery Funding which could further mitigate this position.

Total Group Financial Overview as at 30th Nov 2021 - Month 8

INCOME AND EXPENDITURE COMPARED TO PLAN SUBMITTED TO NHS IMPROVEMENT

YEAR TO DATE POSITION: M8

CLINICAL ACTIVITY

	M8 Plan	M8 Actual	Var
Elective	2,587	2,858	271
Non-Elective	38,952	35,757	(3,195)
Daycase	31,459	31,128	(331)
Outpatient	270,485	272,747	2,261
A&E	109,442	118,144	8,702
Other NHS Non-Tariff	1,095,202	1,124,312	29,110
Other NHS Tariff	62,194	60,254	(1,940)
Total	**1,610,322**	**1,645,200**	**34,878**

TOTAL GROUP: INCOME AND EXPENDITURE

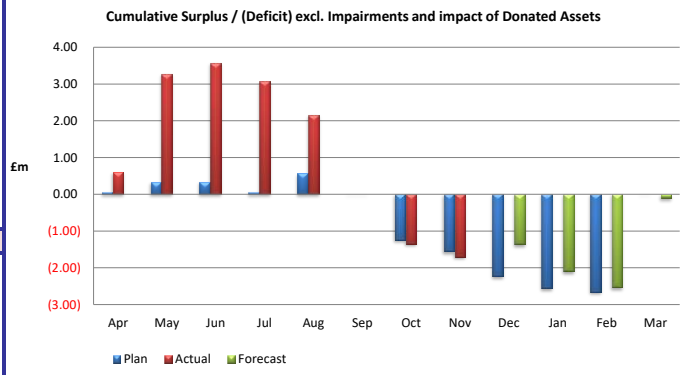
	M8 Plan	M8 Actual	Var
	£m	£m	£m
Elective	£7.65	£7.65	£0.00
Non Elective	£75.06	£75.06	£0.00
Daycase	£17.19	£17.19	£0.00
Outpatients	£23.19	£23.19	£0.00
A & E	£15.90	£15.90	£0.00
Other-NHS Clinical	£112.48	£121.16	£8.68
CQUIN	£2.26	£2.26	£0.00
Other Income	£34.52	£33.30	(£1.22)
Total Income	**£288.24**	**£295.70**	**£7.46**
Pay	(£197.64)	(£203.68)	(£6.04)
Drug Costs	(£28.09)	(£27.86)	£0.23
Clinical Support	(£24.63)	(£25.76)	(£1.14)
Other Costs	(£40.92)	(£41.83)	(£0.91)
PFI Costs	(£8.68)	(£8.68)	£0.00
Total Expenditure	**(£299.96)**	**(£307.80)**	**(£7.85)**
EBITDA	**(£11.72)**	**(£12.10)**	**(£0.39)**
Non Operating Expenditure	(£19.08)	(£18.73)	£0.34
Surplus / (Deficit) Adjusted*	**(£30.79)**	**(£30.84)**	**(£0.04)**
System Top Up Funding	£29.24	£29.24	£0.00
Surplus / Deficit*	**(£1.56)**	**(£1.60)**	**(£0.04)**

* 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

	M8 Plan	M8 Actual	Var
	£m	£m	£m
Surgery & Anaesthetics	(£58.98)	(£60.77)	(£1.79)
Medical	(£70.04)	(£77.54)	(£7.50)
Families & Specialist Services	(£56.92)	(£56.95)	(£0.03)
Community	(£17.48)	(£17.17)	£0.31
Estates & Facilities	£0.00	£0.19	£0.19
Corporate	(£34.92)	(£35.28)	(£0.37)
THIS	£1.05	£1.38	£0.33
PMU	£1.97	£1.71	(£0.26)
CHS LTD	£0.54	£0.53	(£0.01)
Central Inc/Technical Accounts	£239.07	£239.31	£0.24
Reserves	(£5.84)	£2.99	£8.83
Surplus / (Deficit)	**(£1.56)**	**(£1.60)**	**(£0.04)**

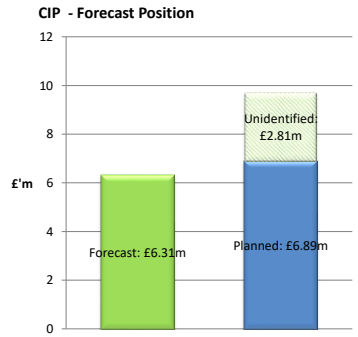
TOTAL GROUP SURPLUS / (DEFICIT)

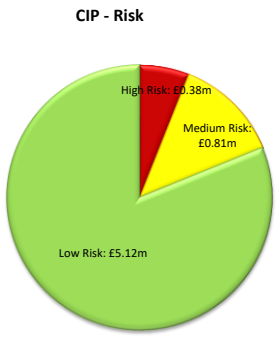


KEY METRICS

	Year To Date			Year End: Forecast			
	M8 Plan	M8 Actual	Var	Plan	Forecast	Var	
	£m	£m	£m	£m	£m	£m	
I&E: Surplus / (Deficit)	(£1.56)	(£1.60)	(£0.04)	£0.00	£0.00	£0.00	
Capital	£8.70	£6.30	£2.40	£18.99	£19.35	(£0.36)	
Cash	£47.00	£44.91	(£2.09)	£38.75	£36.36	(£2.39)	
Invoices Paid within 30 days (BPPC)	95%	94%	-1%				
CIP	£4.43	£4.44	£0.00	£9.70	£6.31	(£3.39)	
	Plan	Actual		Plan	Forecast		
Use of Resource Metric	3	3		2	2		

COST IMPROVEMENT PROGRAMME (CIP)





Total Planned: £9.7m[1] **Total Forecast £6.31m**

[1] £3m target for H1 plus £6.7m target for H2

YEAR END 21/22

CLINICAL ACTIVITY

	Plan	Actual	Var
Elective	3,958	4,247	289
Non-Elective	58,213	54,032	(4,181)
Daycase	47,497	45,579	(1,919)
Outpatient	409,301	411,501	2,199
A&E	164,537	172,884	8,346
Other NHS Non- Tariff	1,650,603	1,684,218	33,615
Other NHS Tariff	92,256	90,750	(1,506)
Total	**2,426,366**	**2,463,210**	**36,844**

TOTAL GROUP: INCOME AND EXPENDITURE

	Plan	Actual	Var
	£m	£m	£m
Elective	£11.39	£11.39	£0.00
Non Elective	£112.76	£112.76	£0.00
Daycase	£25.29	£25.29	£0.00
Outpatients	£34.85	£34.85	£0.00
A & E	£23.16	£23.16	£0.00
Other-NHS Clinical	£171.08	£185.48	£14.40
CQUIN	£3.37	£3.37	£0.00
Other Income	£52.88	£52.25	(£0.64)
Total Income	**£434.78**	**£448.54**	**£13.76**
Pay	(£300.23)	(£310.47)	(£10.24)
Drug Costs	(£42.56)	(£42.34)	£0.21
Clinical Support	(£39.79)	(£39.40)	£0.40
Other Costs	(£54.13)	(£58.75)	(£4.62)
PFI Costs	(£13.03)	(£13.46)	(£0.43)
Total Expenditure	**(£449.74)**	**(£464.41)**	**(£14.67)**
EBITDA	**(£14.96)**	**(£15.86)**	**(£0.90)**
Non Operating Expenditure	(£28.38)	(£27.48)	£0.91
Surplus / (Deficit) Adjusted*	**(£43.34)**	**(£43.34)**	**£0.00**
System Top Up Funding	£43.34	£43.34	£0.00
Surplus / Deficit*	**£0.00**	**£0.00**	**£0.00**

* Adjusted to exclude forecast £5m non-recurrent accounting adjustment and 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

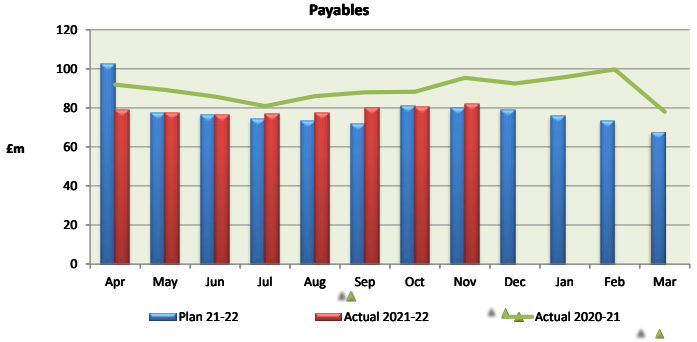
	Plan	Forecast	Var
	£m	£m	£m
Surgery & Anaesthetics	(£91.40)	(£94.31)	(£2.92)
Medical	(£109.66)	(£118.33)	(£8.67)
Families & Specialist Services	(£86.17)	(£85.99)	£0.18
Community	(£26.56)	(£26.20)	£0.36
Estates & Facilities	£0.00	£0.19	£0.19
Corporate	(£52.88)	(£53.24)	(£0.36)
THIS	£1.61	£1.78	£0.17
PMU	£2.95	£2.45	(£0.50)
CHS LTD	£0.81	£0.73	(£0.07)
Central Inc/Technical Accounts	£359.02	£359.25	£0.22
Reserves	£2.27	£13.68	£11.40
Surplus / (Deficit)	**£0.00**	**£0.00**	**£0.00**

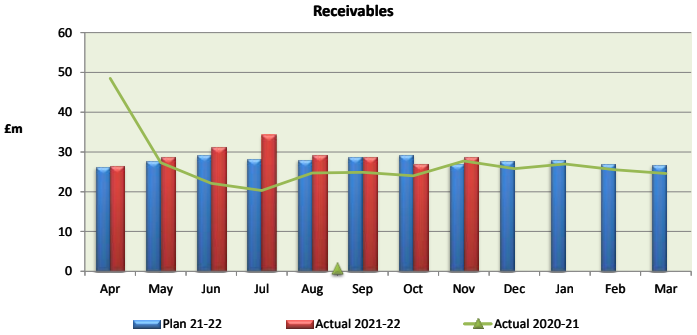
Total Group Financial Overview as at 30th Nov 2021 - Month 8

CAPITAL AND CASH COMPARED TO PLAN SUBMITTED TO NHS IMPROVEMENT

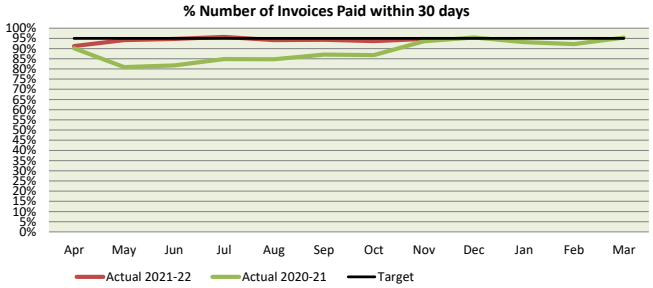
WORKING CAPITAL

	M8 Plan £m	M8 Actual £m	Var £m	M8
Payables (excl. Current Loans)	(£79.74)	(£81.83)	£2.09	
Receivables	£27.01	£28.66	(£1.65)	



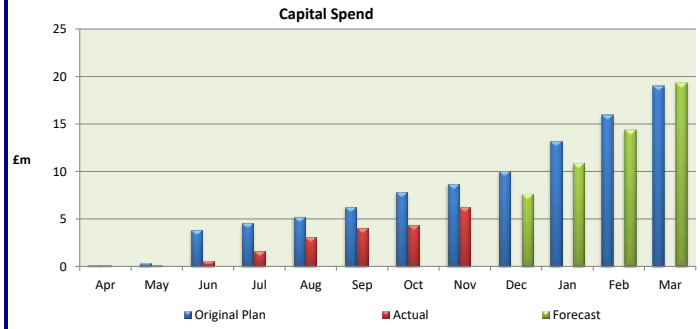


BETTER PAYMENT PRACTICE CODE



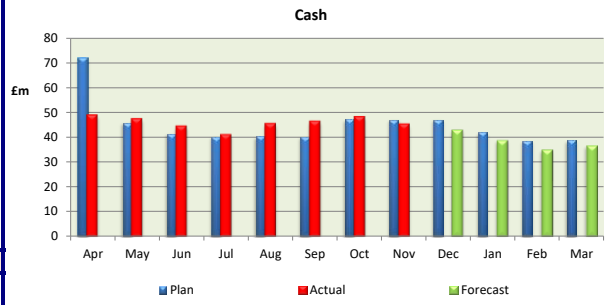
CAPITAL

	M8 Plan £m	M8 Actual £m	Var £m	M8
Capital	£8.70	£6.30	£2.40	

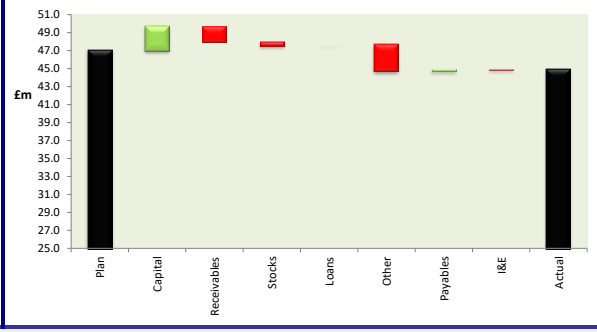


CASH

	M8 Plan £m	M8 Actual £m	Var £m	M8
Cash	£47.00	£44.91	(£2.09)	
Loans (Cumulative)	£17.67	£17.67	£0.00	



CASH FLOW VARIANCE



SUMMARY YEAR TO DATE

- Year to date the Trust is reporting a £1.60m deficit, a £0.04m adverse variance from plan. The deficit position is driven by a combination of staffing pressures, in particular the high cost of temporary staffing (enhanced bank rates and high cost agency) and Recovery costs, including the cost of Independent Sector support.
- Funding for H2 continues on a block contract basis, with fixed Top Up funding allocated by the ICS (Integrated Care System) to cover the Trust's underlying deficit, growth and Covid-19 expenditure. For H2, the Trust has been allocated £21.16m of System Top Up funding, £12.75m of System Covid funding and £1.76m of Growth funding, a total Top Up of £35.66m for H2.
- Total planned inpatient activity was 96.3% of the month 8 2019/20 baseline, although within this total Elective inpatient activity was only at 84.9%. No ERF has been assumed for Month 7 or 8, with overall planned activity below the required threshold.
- The Trust has incurred costs relating to Covid-19 of £15.09m, of which £5.20m are considered as 'outside of system envelope' and for which additional funding is available.
- Capital expenditure is lower than planned at £6.30m against a planned £8.70m.
- H2 includes a significant efficiency requirement of £6.7m, with only £3.9m identified of which £3.3m is currently forecast to deliver.
- NHS Improvement performance metric Use of Resources (UOR) stands at 3 against a planned level of 3.

NOTES

- The Trust is planning a break-even position for H2, although this position excludes a planned one off financial accounting adjustment of £5m.
- The forecast includes £3.8m cost of Independent Sector contracts in H2. Based on the current activity plan and initial guidance, the Trust has not planned for any ERF to offset this cost, although guidance continues to evolve and there may still be opportunities to mitigate this pressure which are being explored.
- In order to deliver the planned position, the Trust planned to find efficiencies of £6.7m. Costs have increased significantly over the last few months due to a high number of Covid patients and significant staffing shortages, and going into winter this will be extremely challenging to reverse. The current forecast is to deliver £3.3m of efficiencies in H2, a shortfall of £3.4m, although there are additional schemes being scoped that may deliver subject to QIA.
- The planned position also assumes that the remaining £1.7m funding gap can be closed and the Trust is continuing to discuss opportunities to support the operational position with CCG partners at Place level.
- The total loan balance is £18.77m as planned. No further loans are planned for this financial year.
- The Trust is forecasting to spend £19.35m on Capital programmes in this financial year, an increase of £0.36m compared to the planned value. This includes additional Capital funding bids have been approved via the Targeted Investment Fund (TIF) for elective recovery, that were not included in the Capital Plan
- The Trust has a cash balance of £44.91m, £2.09m lower 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

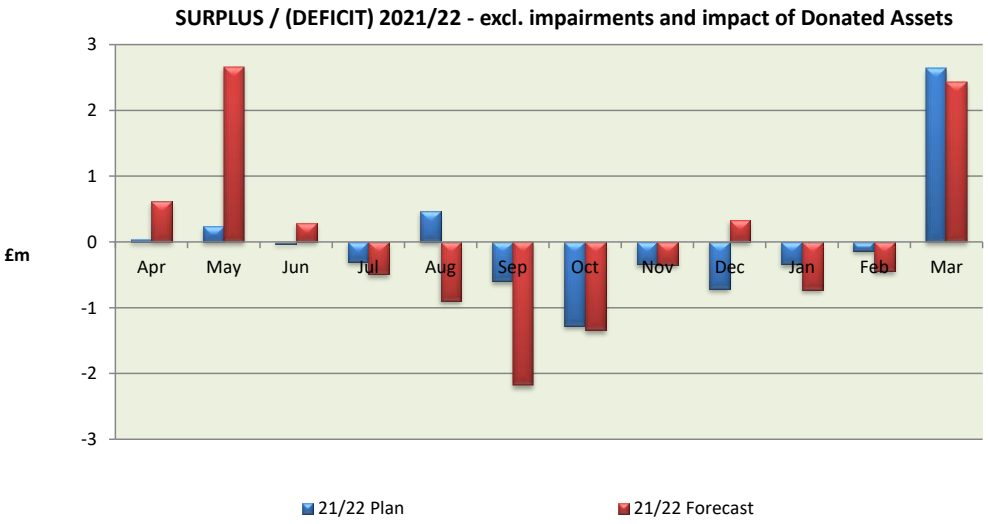
FORECAST POSITION 21/22

H2 Forecast (31 Mar 22)

Statement of Comprehensive Income	Plan[2] £m	Forecast £m	Var £m	
Income	£478.21	£492.31	£14.11	
Pay expenditure	(£300.23)	(£310.47)	(£10.24)	
Non Pay Expenditure	(£149.51)	(£153.94)	(£4.43)	
Non Operating Costs	(£28.81)	(£28.01)	£0.80	
Total Trust Surplus / (Deficit)	**(£0.34)**	**(£0.11)**	**£0.23**	
Deduct impact of:				
Impairments (AME)[1]	£0.00	£0.00	£0.00	
Donated Asset depreciation	£0.43	£0.43	(£0.00)	
Donated Asset income (including Covid equipment)	(£0.08)	(£0.43)	(£0.34)	
Net impact of donated consumables (PPE etc)	£0.00	£0.11	£0.11	
Gain on Disposal	£0.00	(£0.00)	(£0.00)	
Adjusted Financial Performance	**£0.00**	**£0.00**	**£0.00**	

Notes:
1. AME - Annually Managed Expenditure - spend that is unpredictable and not easily controlled by departments
2. Plan and Forecast excludes impact of £5m non recurrent technical accounting adjustment.

MONTHLY SURPLUS / (DEFICIT)



Forecast for H2 (Oct 21 - Mar 22)

- The H2 forecast after mitigations and efficiencies is a operational break-even position.
- This excludes the impact of a £5m non recurrent technical accounting adjustment relating to Project Echo.
- Costs have increased significantly over the last few months due to high number of Covid patients and significant staffing shortages, and going into winter this will be extremely challenging to reverse.
- Recovery costs were planned to increase in H2 and no associated Elective Recovery Funding (ERF) has been planned at this stage. As in H1, ERF funding will only be available to Systems that exceed the required thresholds in totality and the increased threshold requirements make it likely that there will much less funding available to the system than that received in H1.
- The increased costs have been mitigated in the forecast by planning a very challenging efficiency target of £6.7m for H2. As at month 8 the Trust forecast is to achieve £3.3m of this £6.7m target, although further schemes are still being scoped.
- There remains a further £1.7m funding gap that it is assumed will be mitigated. The shortfall in efficiency identification is currently adding to that funding gap. The Trust is continuing to discuss opportunities to close this remaining gap and support the operational position with CCG partners at Place level.

Forecast Assumptions:

- The forecast assumes £7.01m of recovery costs, including £3.8m for Independent Sector contracts.
- The forecast assumes that £3.3m of efficiency will be delivered versus the £6.7m target.
- The forecast reflects the fact that Bank pay enhancements of 50% are now likely to continue until the end of the financial year, adding a further financial pressure of £0.84m compared to plan.
- No activity related Elective Recovery Funding (ERF) assumed as instructed by the ICS.
- Assumes that Covid-19 costs continue at the current rate for the remainder of the year.
- Forecast includes a significant level of assumed non-recurrent benefits that will not continue into 2022/23.
- It is assumed that the Trust will be able to access additional income from the system in support of recently submitted additional Elective Recovery bids and all costs related to these bids are also included in the forecast position.
- The forecast reflects recently agreed £1.5m allocation of Capacity Funding, £0.7m lower than planned.

Risks and Potential Benefits

- The Trust forecast does assume that at least some additional funding is secured in support of recent Elective Recovery bids.
- The plan submitted to the ICS is a £5m deficit and includes the potential financial impact of Project Echo. If approved in this financial year by NHSI this would result in a £5m non recurrent technical accounting adjustment. There is potential that this transaction is delayed until the next financial year, resulting in a break-even position for the Trust.
- The Trust may be able to access some ERF funding if activity thresholds are exceeded at both Trust and System level.
- Discussions continue at both Place and System level regarding final funding allocations and there are likely to be opportunities to reduce the remaining £1.7m gap.

COVID-19 & Recovery

Covid-19 Expenditure YTD NOV 2021	Pay £'000	Non-Pay £'000	Total £'000
Expand NHS Workforce - Medical / Nursing / AHPs / Healthcare Scientists / Other	517	0	517
Remote management of patients	328	545	873
Support for stay at home models	40	0	40
Increase ITU capacity (incl Increase hospital assisted respiratory support capacity, particularly mechanical ventilation)	703	156	859
Segregation of patient pathways	5,445	196	5,641
Existing workforce additional shifts	677	67	744
Decontamination	0	169	169
Backfill for higher sickness absence	248	2	250
Remote working for non patient activities	0	0	0
PPE - other associated costs	0	1	1
Sick pay at full pay (all staff types)	2	0	2
Other COVID-19 virus / antibody (serology) testing (not included elsewhere)	516	7	523
Enhanced PTS	0	235	235
COVID-19 virus testing - rt-PCR virus testing	100	2,628	2,728
COVID-19 - Vaccination Programme - Provider/ Hospital hubs	610	1	611
COVID-19 - Vaccination Programme - Vaccine centres	0	1,549	1,549
COVID-19 - Vaccination Programme - Vaccination of Healthy 12-15s (via SAIS)	7	66	74
NIHR SIREN testing - antibody testing only	17	2	19
COVID-19 - International quarantine costs	0	23	23
COVID-19 - Deployment of final year student nurses	182	0	182
Total Reported to NHSI	**9,391**	**5,648**	**15,039**
PPE - locally procured	0	43	43
Internal and external communication costs	0	1	1
Grand Total	**9,391**	**5,692**	**15,083**

Recovery Costs YTD NOV 2021	Pay £'000	Non-Pay £'000	Total £'000
Independent Sector	0	3,736	3,736
Additional Staffing - Medical	758	0	758
Additional Staffing - Nursing	248	0	248
Additional Staffing - Other	289	0	289
Non Pay	0	874	874
Enhanced Payment Model - Medical	664	0	664
Enhanced Payment Model - Nursing	897	0	897
Total	**2,857**	**4,611**	**7,468**

Covid-19 Costs

Year to date the Trust has incurred £15.09m 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 £9.90m versus a plan of £7.42m. Outside of envelope costs are highlighted in the table to the left and total £5.20m year to date. **The underlying overspend on Covid is therefore £2.48m,** driven by the continuation of some enhanced workforce models on wards and in ICU, a continuation of Emergency Department segregation and enhanced Bank pay rates. An increased expenditure plan for H2 has been agreed in line with recent run-rates, against which the Trust is underspent Year to date by £0.13m.

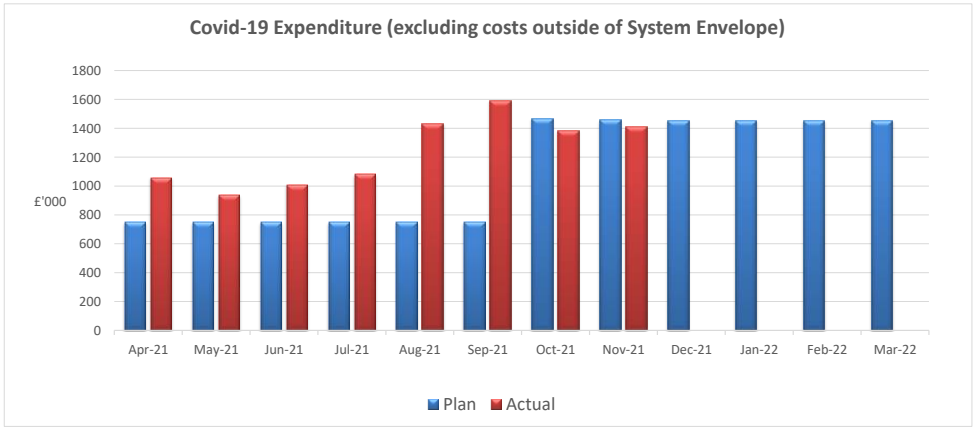
Covid-19 Funding

The Trust has been allocated block funding by the ICS to cover any Covid-19 costs totalling £15.52m year to date. In addition the Trust has requested retrospective Covid-19 funding of £5.20m to cover costs relating to Vaccinations, Covid-19 Testing, 3rd year student nurses and Isolation Hotels for overseas recruits.

Recovery

Recovery costs totalling £7.01m for H2 have been approved in conjunction with the Trust's activity plan. These costs are in part driving the Trust's challenging efficiency target and remaining funding gap, as no ERF in expected to be allocated to offset these costs, based on the current activity plan and existing thresholds. There does however remain a question as to whether the Trust may be able to access ERF for Independent Sector spend over and above 19/20 levels, but this will be dependent on total System Independent Sector activity against this baseline.

- Year to date Recovery costs are £7.47m.
- The majority of the costs incurred related to use of the Independent Sector for outsourcing and insourcing. The Trust has agreed outsourcing contracts with Optegra, BMI, Spire and 'This Is My', as well as insourcing arrangements with Remedy, Ormis and Pioneer.
- Elective Recovery Fund (ERF) Funding is allocated at System level and only paid where the Integrated Care System (ICS) as a whole exceeds activity thresholds.
- The Trust did receive additional funding via the Elective Recovery Fund for Quarter 1 as the thresholds agreed for April, May and June activity were exceeded and £3.63m of income has been received.
- The announcement by NHS Improvement that the threshold for ERF has been increased to 95% from Month 4 has resulted in a significant reduction in forecast ERF for the Trust. No ERF has been assumed in either year to date or forecast for H2 due to the increase in the threshold.



A Workforce for the Future

12. Health and Wellbeing Update

To Note

Presented by Suzanne Dunkley

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 13 January 2022
Meeting:	Public Board of Directors
Title:	Health and Wellbeing Progress Report
Author:	Nicola Hosty, Assistant Director of Human Resources
Sponsoring Director:	Suzanne Dunkley, Executive Director of Workforce and Organisational Development

Purpose of the Report

To inform the Board of progress made against the wellbeing agenda, highlighting the challenges that lay ahead and ask for their support to promote colleague wellbeing.

Key Points to Note

Employee wellbeing has become a particular concern throughout the pandemic.

Mental ill health rates are rising; the Office for National Statistics (2021) reports the number of adults diagnosed with depression has more than doubled since before the pandemic.

Many people have suffered loss, isolation, illness, and stress during this time, and while individual circumstances are outside the control of employers, the need for an understanding, compassionate, and flexible approach to work is more critical than ever.

CHFT have significantly increased their attention on regularly updating the offer / strategy to support colleagues at different times

These slides highlight the activity that the team have supported in 2021 and the proposed approach for 2022.

EQIA – Equality Impact Assessment

The wellbeing offer is regularly discussed at CHFT's equality group forums to understand if its accessible, useful, needs enhancing, fit for purpose to ensure the support suits the needs of the diversity of our people.

Recommendation

The Board is asked to **NOTE** the contents of the paper and support the recommendations for 2022 activity.

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NHS Foundation Trust

CHFT Colleague Wellbeing

December 2021

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Introduction

Employee wellbeing has become a particular concern throughout the pandemic.

Mental ill health rates are rising; the Office for National Statistics (2021) reports the number of adults diagnosed with depression has more than doubled since before the pandemic.

Many people have suffered loss, isolation, illness, and stress during this time, and while individual circumstances are outside the control of employers, the need for an understanding, compassionate, and flexible approach to work is more critical than ever.

CHFT have significantly increased their attention on regularly updating the offer / strategy to support colleagues at different times.

These slides highlight the activity that the team have supported in 2021 and the proposed approach for 2022.

Wellbeing Activity Jan – Dec 2021

NHS
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NHS Foundation Trust

A personalised service to meet the needs of CHFT's diverse workforce:

Statistics	Activity
• ***150*** - Wellbeing Ambassadors • ***217*** - Socrates Referrals • ***42*** - Wellbeing Coaching referrals - Dave Corbett • ***400*** - Halsa on line wellbeing sessions • ***180*** - 24 hour Employee Assistance Programme contacts • ***500*** - Friendly Ear Calls hosted by the Wellbeing team • ***100*** - Health and Wellbeing Calls (More Anxious than usual) • ***12*** - Schwartz Rounds (***360*** attendees) • ***210*** - Boost Bags per week (***2100*** distributed) • ***80*** - Site Visits / Listening Events / Debriefs • ***65*** Mindfulness sessions (***325*** attendees) **Total number of connections – 4500 plus**	• Simplified communications – 2 x clear access channels • Wellbeing Hour • Appointed a BAME Engagement Advisor – Charitable Funding secured for a resource dedicated to BAME Colleague Wellbeing • Development and Delivery of a Menopause Group & Mental Wellbeing Group • Check In/Check Out – End of Shift Once Culture of Care Wellbeing Resource • A wide range of wellbeing self care resources developed including Resilience document • Phycology/Wellbeing Group implemented • Wider Place Wellbeing Support • Promotion of hydration, rest and nutrition (must do's)

Life saving support which has led to wellbeing team members nominated for Unsung Hero, CHuFT and STAR awards

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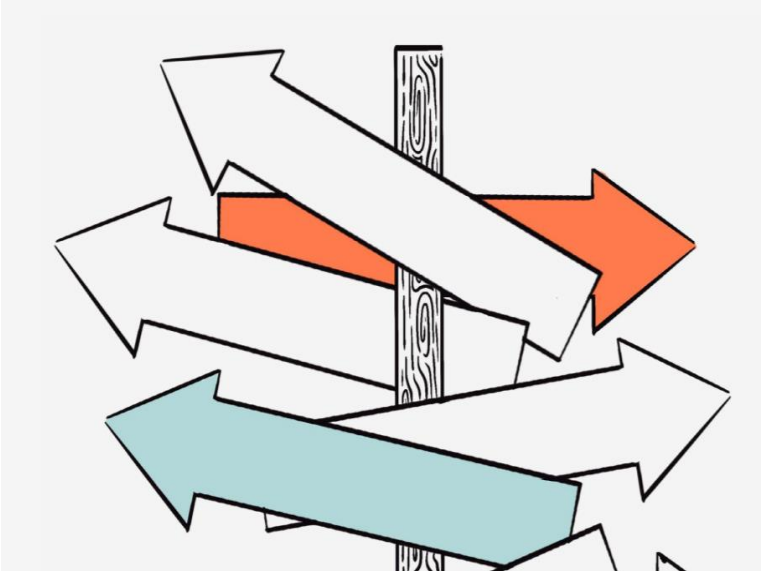
The Challenge Ahead

- Some colleagues are nearing fatigue – mental and physical exhaustion - Tiredness / Burnout / Exhaustion /PTSD
- Some colleagues have extremely complex mental health issues
- Internal teams and cross divisional teams working together
- There are a high number of colleagues exhibiting unusual behaviours
- Sickness absence remains a concern
- Need to cope with backlog whilst still dealing with COVID +patients
- Not just about COVID – personal circumstances/family and relationship issues
- Managers don't feel equipped to have a wellbeing conversation



Considerations to Evolve the Offer

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- One Culture of Care approach aims to embed a positive, inclusive health and wellbeing culture through preventative health and wellbeing interventions.
- We will aim to reduce stigma around mental health - encouraging conversations around mental health at an earlier stage, rather than waiting until an issue has escalated or until a person is in crisis
- Our leaders will lead this change and WOD will develop a education and awareness programme to ensure leaders have the confidence and trust to build wellbeing into the heart of conversations with their colleagues
- We will empower our colleagues to take accountability for their health and wellbeing and aim to create a sustainable wellbeing culture
- Integrated talent management programmes will provide clarity of purpose, growth, increased opportunities, aspiration discussions
- Prioritise connectivity over productivity – encourage membership of a internal/external group, participate in a development programme, growing your network, focus on the social element of wellbeing, encouraging conversations, building community involvement, having fun, building relationships, meeting new people
- Its Good to Talk - we are more likely to learn about people's experiences outside work, therefore we need to have the skills and to offer support where needed. Listening to how an issue is impacting someone's ability to work, rather than judging them for it, is imperative.
- Utilising digital methods to enhance connectivity and flexibility.

The Plan for 2022

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NHS Foundation Trust

- Leadership wellbeing programme – equipping managers with the right skills and capabilities to support their own wellbeing and that of those around them including wellbeing education and awareness, positive behaviours and understanding their impact, role modelling, harness curiosity, be genuine, authentic, and empathetic, create time and space to talk
- Qualitative/Quantative data insights – decision ready information, health and wellbeing dashboard to report health and wellbeing themes which will inform future activity
- Partners - specific professional support, providing relevant subject matter expertise, guidance on best practice and insight into what works including enhanced support for financial and physical health
- Engaging, clear communications – designed with the colleague in mind, clarity about the help that's on offer and how to access it, supporting "it's okay not to be okay" campaigns and reducing the stigma of mental health
- Wellbeing Events – a range of fun, engaging, insightful events for everyone to get involved, learn and share (mental, physical, social and financial .
- Utilise organisational diagnostic tools to assess impact ie TED, NHS E/I Wellbeing diagnostic
- Access to different opportunities - Care Club, volunteering to be an ambassador (wellbeing, freedom to speak up, equality representative)
- Improving the local environment - Wobble rooms, healthy onsite food facilities, rest and reflection facilities
- Effective deployment of Mental Health First Aiders & Pastoral matrons
- Increase opportunity for Cross Divisional Peer to Peer networking 'challenge and support' groups

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Outcomes

Calderdale and Huddersfield NHS Foundation Trust

Through focussing on Once Culture of Care for our colleagues and compassionate care for our patients we aim to embed a culture where wellbeing is at the forefront of colleagues minds which will lead to the following positive outcomes:

- Enables teams to perform at their best
- Produces better outcomes for our patients
- Builds resilience after a difficult period personally and professionally
- Enables our people to deal with challenging and stressful situations more effectively
- Build and maintain confidence and trust in one another
- Cross divisional networks
- Improve the experience of under represented groups
- Improve the recruitment, retention, progression, development and experience of CHFT colleagues
- Become an inclusive employer of choice

Measurement

- Annual Staff Survey
- Pulse Survey
- Leadership Development feedback
- Wellbeing/Engagement walkarounds
- Sickness
- Take up of wellbeing interventions
- Reductions in grievances/disciplinaries
- Increase Freedom to Speak up concerns
- Increase membership of equality groups

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13. Freedom to Speak Up Mid-Year Review (Themes)

Andrea Gillespie, Freedom to Speak Up Guardian

To Note

Presented by Suzanne Dunkley

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 13 January 2022
Meeting:	Public Board of Directors
Title:	Freedom to Speak Up Mid-Year Review
Author:	Andrea Gillespie, Freedom to Speak Up Guardian
Sponsoring Director:	Suzanne Dunkley, Director of Workforce and Organisational Development
Previous Forums:	Workforce Committee November 2021

Purpose of the Report

This paper provides information regarding Freedom to Speak Up (FTSU) activity in the Trust from 1 April 2021 to 30 September 2021.

Key Points to Note

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 number of concerns reported anonymously remain high as in previous years and actions in response to the questionnaire completed by Board members in June 2021 are in progress. FTSU is included in the response to the One Culture of Care Winter Must Dos.

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 are asked to **NOTE** the contents of the report, the number of concerns raised in Q1 and Q2 2021 and the work of the FTSU Guardian and Ambassadors.

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

BOARD OF DIRECTORS

13 JANUARY 2022

FREEDOM TO SPEAK UP MID-YEAR REVIEW

1. PURPOSE

This paper provides information regarding Freedom to Speak Up (FTSU) activity in the Trust from 1 April 2021 to 30 September 2021.

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 the Trust 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, Andrea Gillespie in September 2021. She has come to the role with some experience of FTSU and is currently reviewing our existing processes and documentation with 'fresh eyes'.

Currently there are twenty-six active and dedicated FTSU Ambassadors that come together as an FTSU network group. 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 FTSU network meets bi-monthly. The meeting is chaired by the Guardian and regular agenda items include updates and minutes from the Regional Meetings and National reviews, i.e., case reviews performed by the NGO. Going forward each recommendation of the case reviews will be reviewed by the FTSU Guardian to ascertain which ones are relevant to us. The relevant recommendations will then be actioned to ensure we meet the expected standards.

3.2 FTSU concerns raised in Quarter 1 (Q1) and Quarter 2 (Q2) at CHFT (1 April to 30 September 2021)

The table below shows the number and types of concerns raised in Q1 and Q2:

Quarter	No. of concerns	No. raised anonymously	No. with element of patient safety/ experience	No. with element of bullying/ harassment	No. with element of worker safety
April to June 2021	10	6	1	4	0
July to September 2021	14	11	6	2	3

Please note in March 2021 the NGO updated the Recording Cases and Reporting Data guidance. A new category 'worker safety' was added in response to a statement from the Health and Safety Executive (HSE), 'All workers are entitled to work in environments where risks to their health and safety are properly controlled'.

On review of the concerns raised during Q1 and Q2 no specific common themes have been identified however the number of concerns raised anonymously is notable and suggests that colleagues might not feel safe to raise concerns confidentially or openly.

3.3 Update on themes and actions produced as a result of FTSU Board Assessment

In June 2021 Board members completed a questionnaire based on the NHS England/ Improvement Freedom to Speak Up review tool (2019). Board members were asked to confirm their views based on evidence available to them on how compliant the Trust is in relation to statements set out in the tool. The results were summarised in a paper to Board in September 2021 with four themes and proposed actions. An update on the actions is provided below: -

Promotion

Throughout Speak Up month in October 2021, a FTSU screensaver featured each day and there are now plans to run different screensavers for one week of each month starting from December 2021. New promotional materials including leaflets, posters and banners, are at the design stage and will be visible in staff areas around the Trust very shortly. The FTSU Guardian is working with the Trust's CQC compliance lead who is sharing the intelligence in relation to FTSU that is acquired through the Journey to Outstanding reviews and identifying areas where targeted promotion might be appropriate and ways in which the reviews may be used to support the promotion of FTSU.

In early 2022 two of the three FTSU e-learning packages will be added to the Electronic Staff Record (ESR). The two programmes are, 'Speak Up' accessible to all colleagues and 'Listen Up' for managers. The third package, 'Follow Up', for senior leaders is due to be launched nationally in 2022.

Grow confidence in FTSU processes

All communications and promotional materials to provide key messages of reassurance, such as: -

- In accordance with our duty of candour, our senior leaders and the entire Board are committed to an open and honest culture
- If you raise a genuine concern you will not be at risk of losing your job or suffering any detriment as a result
- We will always thank you for raising your concern, will treat you with respect and support you throughout
- We will always look into what you say
- It does not matter if you turn out to be mistaken as long as you are genuinely concerned
- We will not tolerate the harassment or victimisation of anyone raising a concern
- Concerns can be raised openly, confidentially or anonymously.

FTSU is delivered in line with national guidance

Reviews of the FTSU intranet pages, the FTSU reporting portal, promotional material and our local FTSU policy are in progress to ensure that guidance from the NGO is reflected and met.

The FTSU Guardian has facilitated a FTSU working relationship with a local trust, Bradford Teaching Hospitals NHS Foundation Trust. The Guardians at both trusts will 'buddy up' to provide support and supervision and share resources and learning. In the new year both trusts

are looking to provide some training for new FTSU Ambassadors and refresher training for existing ambassadors and will join up to plan and deliver this.

Sharing the responsibilities so FTSU is part of business as usual

It is acknowledged that in order to reach out to our c6000 colleagues the FTSU network requires help to spread the word. Help and support from senior Divisional colleagues is currently being sought and to date discussions have taken place with the Division of Medicine and the Division of Surgery and Anaesthetics. Meetings with the Division of Families and Specialist Services, the Community Division and Calderdale and Huddersfield Solutions Limited will be scheduled shortly.

4. WINTER MUST DO'S

FTSU is included in the response to the One Culture of Care Winter Must Do. Concerns are raised via the FTSU process by colleagues that have had experiences of not being treated with care and compassion by other colleagues. A review of concerns raised in Quarter 2 confirmed that 50% of the concerns raised described elements where One Culture of Care was not demonstrated.

To illustrate here are two examples: -

Concern raised in April 2021

One staff member reported that rumours about her were being spread around her place of work by a small group of her colleagues which was causing her distress and anxiety. She went to her immediate line manager who told her to 'laugh it off' and then to a senior manager who said, 'she couldn't help because it wasn't a work-related matter'. Following this she describes feeling 'trapped and alone with no idea of whom to ask for help'. She went on sick leave as she expressed thoughts of suicide to her GP and then later submitted her resignation.

Concern raised in November 2021

This is a concern raised by a member of staff who describes the care received by another member of staff whilst a patient at the Trust. The concern is complex and whilst describing good compassionate at some points of the patient journey there are frequent examples where One Culture of Care was not demonstrated. An action plan for investigation and progress will be monitored by the Freedom to Speak Up Guardian.

Intelligence received through FTSU will be used to determine some of the actions that might be required to fulfil the Must Do and an additional tick box will be added to the FTSU portal to highlight and record the concerns that exhibit a lack of kindness or compassion.

5. CONCLUSION

The Board of Directors are asked to note the contents of the report, the number of concerns raised in Q1 and Q2 2021 and the work of the FTSU Guardian and Ambassadors.

Andrea Gillespie
Freedom to Speak Up Guardian
January 2022

Keeping the Base Safe

14. Health and Safety Annual Report and Update

Presented by Richard Hill, Head of Health and Safety

To Note

Presented by Suzanne Dunkley

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Date of Meeting:	Thursday 13 January 2022
Meeting:	Public Board of Directors
Title:	Annual Health and Safety Report
Author:	Richard Hill, Head of Health and Safety
Sponsoring Director:	Suzanne Dunkley, Executive Director of Workforce and Organisational Development
Previous Forums:	CHFT Health and Safety Committee

Purpose of the Report

To provide the Board with an overview of the health and safety activities during 2020/21 and the progress against the 5-year strategy.

Key Points to Note

The purpose of this report is to provide an update of health and safety compliance within CHFT, during the reporting period stated and since it was last shared with the Board in January 2021.

An overview of the 5-year strategy which was also shared previously with the Board and approve d by the Audit and Risk Committee at the start of 2021 is included in Appendix (A) of the report.

EQIA – Equality Impact Assessment

The Health and Safety Committee meets bi-monthly to review RIDDOR reportable accidents, DATIX and Freedom to Speak up concerns relating to Health and Safety. Improvement needs to be made in the analysis of these reports based on protected characteristic, and this has been included as an agenda item at the Health and Safety Committee in February 2021 and will be featured as a key priority for the actions in 2021/2022.

A review of Health and Safety Training is currently underway. All training will be reviewed to ensure that it is in plain English and is applicable to those colleagues who are neuro diverse.

Recommendation

The Board is asked to **NOTE** the progress made against the Health and Safety annual report.

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Health & Safety Annual Report Summary (31st March 2020 – 1st April 2021)

13th January 2022

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Summary

- **8000 doors** displaying occupancy limits and planned ward **assurance audits**, reporting into the IPC tactical meetings.
- **New COVID risk assessment viewed by 507 ward managers**, providing a sense of wellbeing to front-line colleagues.
- **8 health and safety compliance group meetings set-up** improving visibility of risk for the CHFT health and safety committee members.
- **45 newly qualified first aiders in the non-clinical departments**, providing peace of mind to front line non-clinical colleagues.
- **Air monitoring carried out on 9 department**s handling Entonox, giving assurance to front-line nurses.
- **Lone working precaution improvements taking place for all 600 front-line community practitioners** across 19 CHFT community services

New Governance Streams set-up in 2021yr

- Health Informatics Service (**THIS**) health and meetings.
- Huddersfield Pharmacy Specials (**HPS**) health and safety meetings.
- **Community Healthcare** Compliance Group (replaced 2022).
- **Sharps** Management Health and Safety Group.
- (**DSE**) Display Screen Equipment/Workstation Task and Finish Group.
- **COSHH** Management Task and Finish Group.

Key aims for 2022/2023

Governance
Additional creation of a new health and safety sub-group for community front-line colleagues. Plans are in place to replicate this approach in Families and Specialist Services, (January – March 2022).

Training
A revision and improvement upon the health and safety induction material provided to new-starters to read, which makes it CHFT specific (January-March 2022).

Covid-19
Continuation of COVID compliance including risk assessment, ward visits and non-clinical inspections programme/information gathering (January – December 2022).

More details of other commitments found in the 5yr strategy

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

BOARD OF DIRECTORS

13 JANUARY 2022

HEALTH AND SAFETY ANNUAL REPORT – 1 APRIL 2020 – 31 MARCH 2021

1. PURPOSE

The purpose of this report is to provide an update of health and safety compliance within CHFT, during the reporting period stated and since it was last shared with the Board in January 2021.

An overview of the 5-year strategy which was also shared previously with the Board and approved by the Audit and Risk Committee at the start of 2021 is included in Appendix (A) of this report.

2. PROGRESS AND ACTIONS

- Emergency first aid training has been given to an extra 45 colleagues working within the non-clinical workplaces which are those places outside the hospital environment. This provides comfort to colleagues that emergency treatment is provided quickly.
- Strengthening of the governance arrangements by the set-up of 9 sub-health and safety compliance meetings/task and finish groups, reporting into the Trust Health and Safety Committee, giving a wider voice for colleagues, and sharing successful outcomes and opportunities to learn.
- The risk assessment tool for home workers has been reviewed and will shortly be shared so that working from home in front of the computer screen will be ergonomically comfortable as much as is reasonably practicable. This assessment tool will reach excess of 300 colleagues and compliment the original work carried out in 2019/2020 concerning best practice.
- COVID environmental compliance inspections of the community sites and the hospitals has taken place across the year, giving assurance to colleagues and the Board that CHFT continues to be committed to providing a COVID compliance workbase.
- Weekly COVID compliance inspections of the non-patient facing departments with the rest being added in 2022. This will provide assurance to colleagues and the Board that precautions continue to be monitored and compliment the patient facing areas.
- An updated version of the non-clinical environmental COVID-19 risk assessment that has reached 519 ward managers by email, which has helped continue the focus attention upon the importance of the controls.
- Replenishment of 8000 door occupancy notices across each of the hospital and community sites, meaning colleagues can be confident that room sizes and occupancy limits have been considered.

3. TRUST HEALTH AND SAFETY MANAGEMENT - HEALTH AND SAFETY COMMITTEE

The Health and Safety Committee met in the following months during the reporting period 1 April 2020 and 31 March 2021:

- April 2020
- June 2020
- October 2020
- December 2020
- February 2021

The purpose of the Health and Safety Committee is to provide oversight of all Health and Safety issues relating to CHFT. This includes any activity led directly by CHFT and activities led by our partners, including ICS and ISS, ENGIE etc.

Any matters for escalation are identified at the Committee meeting and referred to the Audit and Risk Committee.

Overall attendance at Health and Safety Committee is satisfactory. Work is underway to ensure that each Division sends a representative to Committee to highlight any health and safety concerns from that Division.

The Terms of Reference, format and reporting lines to and from Health and Safety Committee have been reviewed and there are no proposed changes at this time.

4. HEALTH AND SAFETY PERFORMANCE

RIDDOR / Accident Performance Tables

Under the Health and Safety at Work Act 1974, there is a requirement to report to the Health and Safety Executive certain accidents that result in more than 7 days of work and / or are serious enough to warrant reporting which are referred to as RIDDOR's (Reporting of injuries, Diseases and Dangerous Occurrences). NHS Trusts do not share accident data that would otherwise provide benchmarking performance.

The following table (1) represents the type of injuries upon which attention is placed. Historical DATIX incident submissions have demonstrated that there are 3 most common types of injuries which for the purpose of this report are given focused attention here. Please remember the reporting of violence and aggression incidents is excluded because these are reported and handled by other workstreams, however they can be produced later if requested by the Board.

Accident Performance Table (1)

Manual Handling Injuries 3-year Trend Analysis	2020/2021	2019/2020	2018/2019
Injured during moving/handling patient or other person	19	2	14
Injured during moving/handling object/equipment	6	6	5
Injured during moving/handling load	5	2	4
Stretching or bending injury, other than lifting	1	1	5
Total	31	11	28

Slips, Trips and Falls 3-year Trend Analysis	2020/2021	2019/2020	2018/2019
Fall from height/chair – Staff	8	0	6
Fall on Level – Staff	25	16	19
Slips, trip, falls Outdoors (Hospital grounds) – Staff	3	1	0
Slip/fall on ice/snow/wet floor/leaves – Staff	29	11	1
Tripped over object – Staff	6	1	9
Total	71	29	35

Needle-Stick Injury 3-year Trend Analysis	020/2021	2019/2020	2018/2019
Injury from Clean Sharps	8	14	4
Injury from Dirty Sharps	88	72	80
Total	96	84	84

RIDDOR's – (Reporting of Injuries, Diseases and Dangerous Occurrences) these accidents are unique because they must be reported to the Health and Safety Executive (HSE). The HSE have produced a list of specified injuries that (under legislation) must be reported. This can also extend to any type of accident which is 'work related' and leads to more than 7 days off work. The purpose is to help the HSE form a national picture of the most frequent injuries and put in their own strategies. It also allows them to investigate any injury at their discretion.

RIDDOR Performance Table (2)

RIDDOR's 3-year Trend Analysis	2021/2020	2020/2019	2019/2018
Total	18*	13	8

* The uplift in accidents/RIDDOR is a potential indicator of the awareness piece included in 2020 newsletter published via comms team to encourage colleagues to report incidents, including RIDDOR's. This awareness piece was shared Trust-wide in 2020.

5. INITIATIVES 2020-2021

5.1 Governance Improvements - The following meetings have been formed during 2020/2021. The aim of these sub committees is to provide a platform for stakeholders to express opportunities for improvements and share successful outcomes. It is also a platform to drive forward the NHS Workplace Health and Safety Standards, which is the health and safety management system for CHFT. The minutes are shared with the Trust Health and Safety Committee.

- Health Informatics Service (THIS) health and meetings.
- Huddersfield Pharmacy Specials (HPS) health and safety meetings.

- Electrical Compliance Meetings (HTM requirement).
- Health Informatics Service (THIS) health and safety meetings.
- Huddersfield Pharmacy Specials health and safety meetings.
- Community Healthcare Compliance Group.
- Sharps Management Health and Safety Group.
- COSHH Management Task and Finish Group.
- Display Screen Equipment/Workstation Task and Finish Group.
- Slips, Trips and Falls Prevention health and safety meetings (planned in 2022).

5.2 First Aid – CHFT took a deep dive review of the emergency first aid training in place for non-patient facing areas of the Trust, which include but not limited to colleagues working in WOD, THIS, HPS, Learning and Development Centre etc. The result of that review has filled gaps so that 45 extra colleagues will be given training in emergency first aid (between January-February 2022). This should provide assurance to the Board and colleagues that all corners of the Trust now have in place immediate access to life saving treatment by a trained first aider.

Key Features
45 extra colleagues provided with training in emergency first aid within the non-clinical workplaces which are those placed outside of the hospital environment.

5.3 Nitrous Oxide Air Monitoring (Entonox) – this is used as a pain relief for patients experiencing high levels of pain and discomfort. If the gas supply/pipe connections are not under controlled conditions, it can escape, settle as low-level pockets of gas and breathed, causing nausea, sickness and dizziness. Just like other NHS trusts, CHFT has been committed to ensuring this gas is monitored with engineering interventions, where required. A total of 9 clinical wards/departments were monitored by air consultants. Only one ward (Labour Ward) produced unacceptable levels, upon which action was taken to resolve it. This should provide the Board and colleagues confidence the risk is firmly under control and continues to be monitored every year.

Key Features
A total of 9 clinical wards/departments were monitored by Peritus Air Consultants. Only one ward (Labour) produced unacceptable levels, upon which action was taken to resolve it.

5.4 Dangerous Goods Safety Compliance (DGSA) - just like most other NHS Trusts, CHFT received a DGSA audit, which concerns the safe delivery, movement, storage and disposal of dangerous portable gasses. The previous audit completed in 2019 required 13 improvements and all have been addressed. The DGSA auditor has since returned and CHFT are waiting their report. This should provide the Board and colleagues with assurance that CHFT have a grip on this risk.

Key Features
The previous audit completed in 2019 required 13 improvements and all have been addressed.

5.5 Accident Reporting – Efforts have been taken to increase the importance of accident and near miss reporting across all parts of the Trust, so that CHFT can have confidence upon reliable reporting. A Trust-wide communication piece was shared on CHFT Intranet home screen to urge colleagues to report accidents/near misses. The outcome of that piece of work will be measured in 2022, after like-for-like DATIX results are available in June/July 2022. It is expected the results will show either an uplift of reported incidents or unchanged, either way it will act as a benchmark for future years. The most common incidents are sharps injuries, moving and handling injuries and slips, trips and falls. To respond and decrease these, meetings are planned across 2022, listed below;

Key Features

- Slips, trips and falls meetings
- Facilitators' moving and handling meetings
- Sharps Management meeting

5.6 Slips, Trips, Falls

Work has started upon improving due diligence to reduce the risk of these injuries, which are often seen as the most likely types of injuries that lead to claim for compensation (Reference: CHFT Claims Submission Data <2020). The root cause of these in non-patient facing areas is often considered (but not exclusively) the floor-plate conditions, so a partnership approach has been created with ISS/EQUANS/CHFT/CHS Ltd and involves a collaborative approach for risk assessment, floorplate inspections, training and management audit oversight. This partnership will start to develop in the early part of 2022. The outcome will be a shared understanding concerning floor cleaning patterns, closer scrutiny of floor-plate wear and tear repairs and audit data, which can easily be evidenced. All these measures will also provide a stronger defence against the risk of financial risk, driven by compensation liability claims but ultimately provide assurance to CHFT colleagues.

Key features

A partnership approach has been created with ISS/EQUANS/CHFT/CHS Ltd and involves a collaborative approach for risk assessment, floorplate inspections, training and management audit oversight.

5.7 Lone Working

Front-line colleagues (circa 600) working in the community and visiting patient's home does present inherent personal anxieties concerning the threat of assault and other forms of violence. Work has started to form a task and finish group which is being represented by 19 CHFT service leads, including but not limited to Community Healthcare, Crisis Team and Midwifery Team. The meetings are taking place in January to March 2022 with a lens placed upon the requirements of the Community Lone Working Guidelines (v2). The Board should be assured that by the end of this project, all front-line colleague and line managers will have in place the reinstatement of the following; buddy system, emergency contact lists, pre-visit home risk assessments, personal devices, and de-escalation training to front-line colleague practitioners. All of this will be monitored / audited centrally with a dashboard produced and shared with the Trust Health and Safety Committee, periodically.

Key Features

Work has started to form a task and finish group which is being represented by 19 CHFT service leads, including but not limited to Community Healthcare, Crisis Team and Midwifery Team.

5.8 Engagement with Stakeholders

Collaboration with CHS, ISS, EQUANS continues to be solid across the year with strong support given by Ian Rawson (Contracts & Compliance Manager) to bring the conversations meetings, expectations and outcomes together.

6. CONCLUSION

Over the 12 months, work has been done to improve compliance across, both hospital site, in community settings and also HPS and THIS. It is clear to see from the increased number of health and safety sub-meetings now in place that CHFT's Health and Safety Committee has greater oversight of risks which help decision making conversations, yet there will be more work taking place to get closer alignment with the four Divisions non-clinical risks.

To continue strengthening COVID compliance, an increasing amount of time will be spent by the Head of Health and Safety during 2022 to carry out audits across the hospitals and community sites. The success of the work in 2020/2021 is a credit to the commitment of colleagues who continue to embrace and involve themselves in the work being done, despite the unprecedented pressures faced by COVID-19.

7. RECOMMENDATION

The Board of Directors is asked to note the progress made against the action plan presented, and to approve the Health and Safety Annual Report for 2020/2021

Richard Hill
Head of Health & Safety
December 2021

Appendix A - The 5-year Priorities

(*Please note line 3 which will now extend to all 19 front-line services, including midwifery, phlebotomy, crisis team etc.)

Ref	Priorities	1	2	3	4	5
1	Development and Implementation of the NHS Workplace Health and Safety Standards across all departments which include reference to risk assessment review. Outcome: reliable and measurable management systems in place, providing a safe environment for everyone	x	x	x		
2	COVID-19 Compliance Review and Monitoring Standards. Outcome: a safe environment for everyone entering and using CHFT services	x	x	x	x	x
3	Community Division Compliance Project Improvement Plan and Collaborative Working with subject matter experts. Outcome: safer environment and stronger oversight of standards for colleagues and service users	x	x			
4	Accident Reduction Planning/Initiatives. Outcome: ability to identify upward trends and early intervention	x	x	x	x	x
5	Developing Health and Safety Training and Collaborative Working with Training Lead. Outcome: improvement in the content quality which is relevant to CHFT	x	x			
6	Collaborative working with CHS Ltd and ENGIE/ISS Ltd on building compliance matters, including floorplate safety. Outcome: direct oversight of the compliance data produced by our partners, including risk assessments and inspections	x	x			
7	Networking across NHS Trusts to benchmark and share best practice . Outcome : best practice within CHFT		x			
8	RIDDOR reporting awareness campaigns. Outcome : the Board has as a true picture and reduction plans can be developed and mobilised	x		x		x
9	Engagement with the reconfiguration building plan meetings for CRH and HRI. Outcome : to monitor risk and provide relevant input when necessary leading to a successful build	x	x	x	x	x

15. Director of Infection Prevention and Control Q3 Report

To Approve

Presented by Lindsay Rudge

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 13 January 2022
Meeting:	Public Board of Directors
Title:	Quarterly Director of Infection Prevention and Control (DIPC) report Q3 – 1st October 2021 to 31st December 2021
Authors:	Gillian Manojlovic - Senior IPC Nurse Lindsay Rudge - Deputy Director of Nursing / Assistant DIPC
Sponsoring Director:	David Birkenhead, Medical Director
Previous Forums:	None

Purpose of the Report

To provide assurance against key infection prevention and control performance and quality indicators.

Key Points to Note

The revised version of the Board Assurance Framework (BAF) has been published and is in the process of being reviewed.

C.Difficile objective for 2021/22 has been breached. Other Trusts are experiencing the same increase.

EQIA – Equality Impact Assessment

This report relates performance information relating to Infection Prevention and Control. It is not expected that the performance metrics reported will be significantly affected by ethnicity, however disability may predispose individuals to certain infections. Information on flu uptake has been analysed by ethnic group and reportedly separately.

Recommendation

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

DIPC Report to Quality Committee
1st October to 31st December 2021

1. Introduction

This report covers the period from 1st October – 31st December 2021 unless otherwise noted. Calderdale and Huddersfield Foundation Trust recognises that effective infection prevention practice, underpinned by the implementation and audit of evidence-based policies, guidelines and education are fundamental to the reduction of risk and patient harm from Healthcare Associated Infections (HCAI). The report will provide assurance against key infection prevention and control performance and quality indicators.

2. Performance targets

Indicator	End of year ceiling 2021/2022	Year to date performance	Actions/Comments
MRSA bacteraemia (trust assigned)	0	0	
C.difficile (trust assigned)	Objective = 22	30	19 HOHA = 5 preventable, 9 unpreventable, 5 pending 11 COHA = 6 unpreventable, 4 pending
MSSA bacteraemia (post admission)	None set	11	
E. coli bacteraemia (post admission)	Objective = 91	60	28 post admission cases 32 COHA cases.
MRSA screening (electives)	95%	69%	
ANTT Competency assessments (medical staff)	90%	68%	Improvement in the medical staff, small deterioration of 1% with nursing staff/AHP etc
ANTT Competency assessments (nursing and AHP)	90%	89%	
Hand hygiene	95%	99.5%	
Level 2 IPC training (Doctors	90%	88%	This continues as an e-learning package.
Level 2 IPC training (nursing and AHP)	90%	89%	

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

3. Quality Indicators

Indicator	Year-end agreed target	YTD performance	Comments
MRSA screening (emergency)	95%	92%	
Isolation breaches	Non set	Not recorded this quarter	COVID-19 patients continue to take priority for side room isolation
Cleanliness	Non set	97.1%	

4. MRSA bacteraemia:

No cases to report during the current reporting period.

5. MSSA bacteraemia:

There have been 2 post-admission MSSA bacteraemia cases during the current reporting period with a total of 11 cases year to date The IPC team will continue to review cases monthly.

6. Clostridium difficile:

The objective for 2021-22 is 22 cases, a reduction of 1 case on the 2019 data (calendar year). The current number of cases is 30, made up of 19 HOHA and 11 COHA. The objective has been breached.

All cases are subject to an investigation of which:

- 5 deemed as preventable,
- 9 unpreventable
- 5 pending.

7. E. coli bacteraemia:

There have been 9 post-admission *E. coli* bacteraemia cases plus 8 COHA cases during the reporting period with a total of 60 cases year to date. This is on track to meet the objective of 91 cases.

8. Outbreaks & Incidents:

8.1 Outbreaks

There have been 7 COVID19 outbreaks during the reporting period; wards H15, C6B, C6C, H20, H5, H21 and H22. All outbreaks are managed in line with COVID19 outbreak management guidelines and are monitored for 28 days. Issues identified included:

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

8.2 Healthcare associated COVID19 Infections (HOCI's)

All probable and definite HOCIs are investigated at CHFT following a process agreed with the divisions and the risk team. Any immediate learning is also discussed at the IPC gold meeting and communicated where relevant. For this reporting period there have been 46 HOCI cases (19 definite, 27 probable).

8.3 Staff Covid test and trace

Processes updated in line with national changes for staff with Covid-19 confirmed in a member of their household. The number of positive staff has increased significantly within December. Further detail and vaccine update will be outlined in the Occupational Health report.

9. FFP3 use

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

FFP3 masks have been made available to all staff to wear irrespective of the cCovid-19 status of unplanned care patients.

10. Audits

COVID Assurance audits including:

- IPC BAF framework self assessment – new framework released 24/12/21
- Daily must do compliance by ward managers
- Weekly leadership walkround every Wednesday
- Weekly IPC Covid 19 assurance – completed by the Matrons
- 2 weekly FLO audits
- Night matron's assurance audit to monitor compliance OOHs to IPC and social distancing recommendations
- 7 day on site Senior Leadership rota

Quality Improvement Audits

The programme was once again put on hold during the reporting period, this has been reviewed and was planned to recommence in January 2022. However, due to the effect of the Omicron variant on the workload of the IPC team, matrons and service performance this will be delayed.

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

11. Recommendations

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

16. Guardian of Safe Working Hours Q3 Report

Presented by Devina Gogi, Guardian of Safe Working Hours

To Approve

Date of Meeting:	Thursday 13 January 2022
Meeting:	Public Board of Directors
Title:	Quarter 3 report (1st October 2021- 31st December 2021) from the Guardian of Safe Working Hours (GOSWH), CHFT
Author:	Ms Devina Gogi, Guardian of Safe Working Hours
Sponsoring Director:	Dr David Birkenhead, Medical Director
Previous Forums:	None

Purpose of the Report

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

Key Points to Note

1. Decrease in exception reports in this quarter.
2. Efficient filling the of rota gaps in this quarter.
3. Attendance of Virtual National Conference of GOSWH.

EQIA – Equality Impact Assessment

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

Recommendation

The Board is asked to:

1. **NOTE** and **APPROVE** the report.
2. To **ACKNOWLEDGE** the need for extra support & flexibility with training and rota for junior doctors in the training recovery phase.

Q3 report: (1st October 2021 to 31st December 2021)

Guardian of safe working hours (GOSWH), CHFT

Executive summary

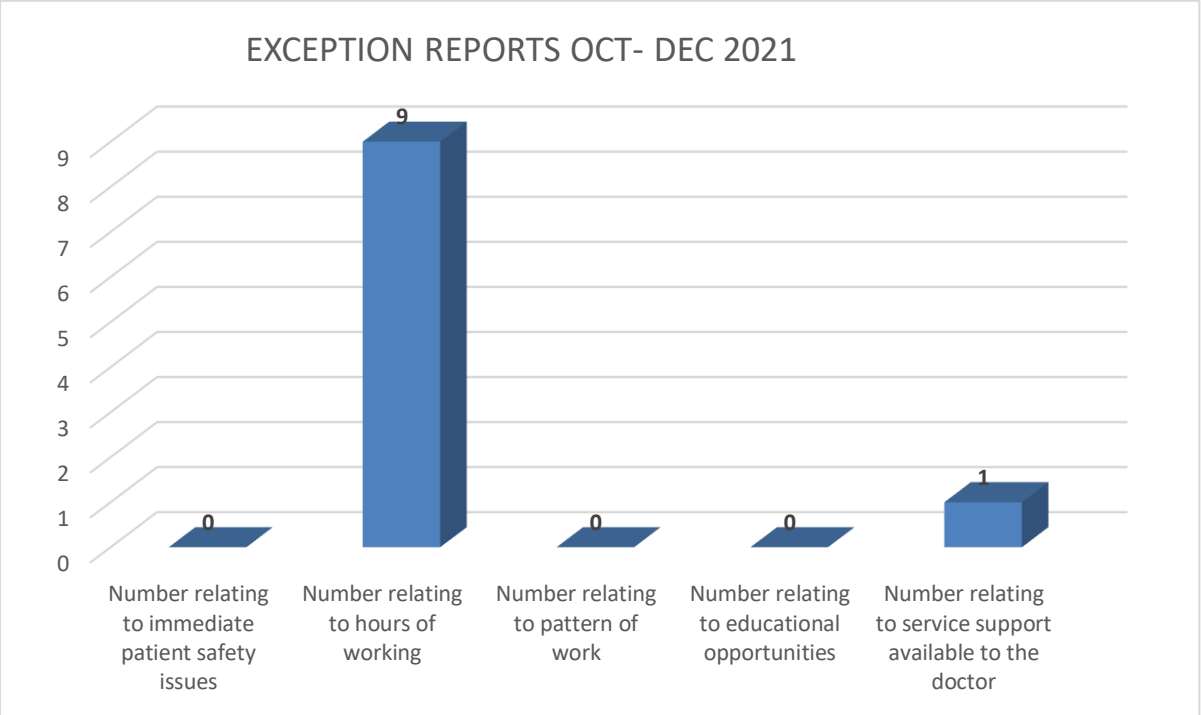
This quarter showed a decrease in the number of exception reports. Most exception reports were related to extra hours of working and were resolved by Time off in Lieu (TOIL) or overtime payments.

Gaps in rotas from vacancies, sickness absence, and other unplanned absence were filled efficiently by agency staff and internal bank locums, with a fill rate of 80% of the junior doctor's posts across the trust.

The Junior Doctor Forum was cancelled in December 2021 due to insufficient attendees because of leave or exceptional circumstances. The forum meeting has been postponed to 20th Jan 2021.

a) Exception reports and trends

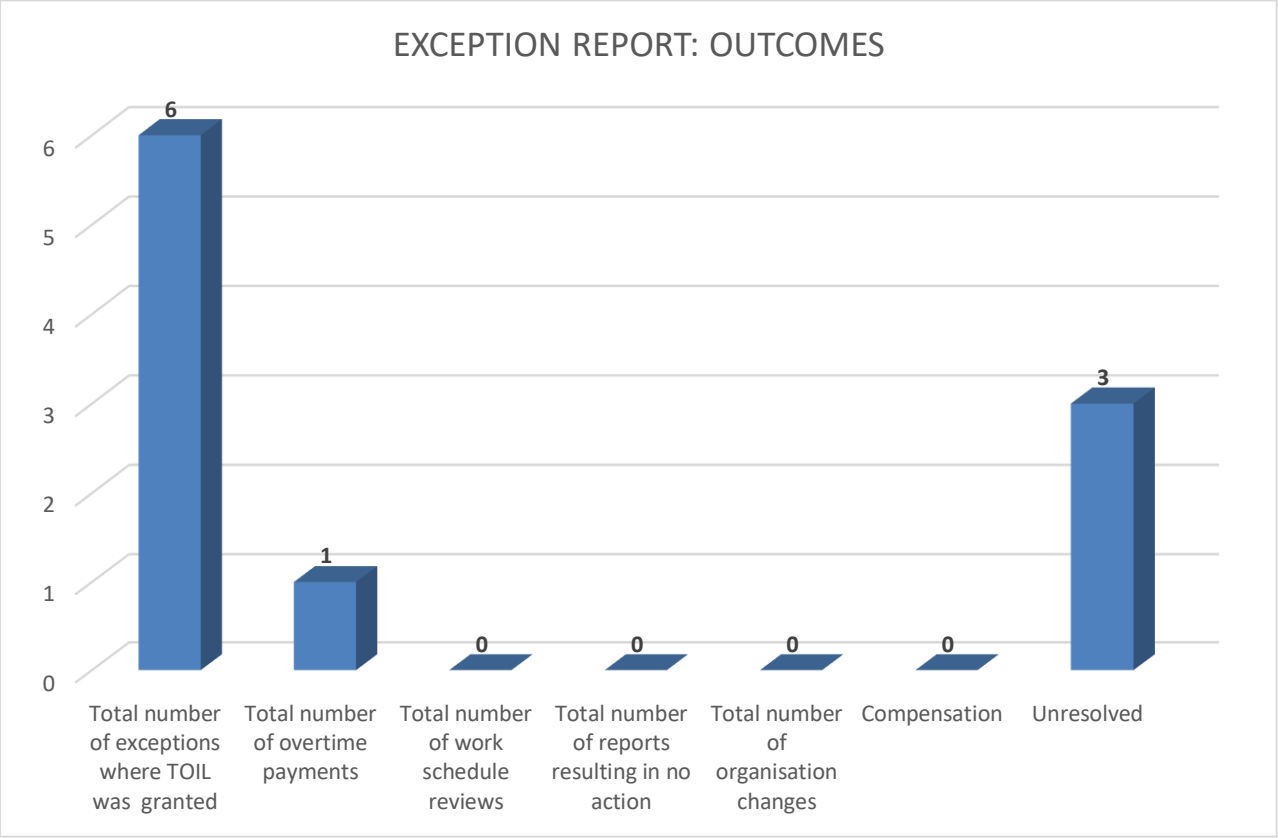
There have been 10 Exception Reports (ER) this quarter. This is considerably less than the previous quarters. This could be because of improved working practices or it may illustrate less engagement by junior doctors.



9 ER were related to hours of working whilst 1 was due to issues with service support. There were no ER related to immediate patient safety issues or educational opportunities.

Regarding the ER related to service support, the Medical Assessment Unit (MAU) Core Trainee was unwell, and no locum cover was available so there was a reduction in the number of staff available on the night shift. All three doctors based in MAU had to deal with poorly

patients whose condition was deteriorating, in addition to clerking new patients across both MAU and wards.



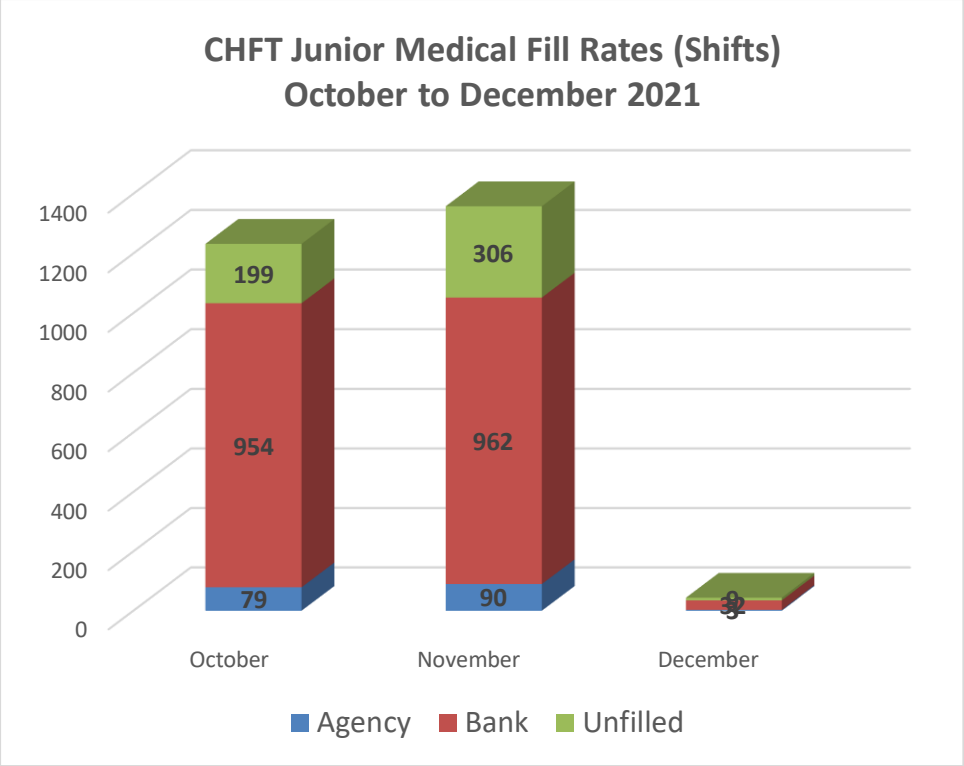
The ER were closed by TOIL & overtime payments. Three are unresolved, as they haven't yet had the initial meeting with the supervisor.

No guardian fines have been levied this quarter.

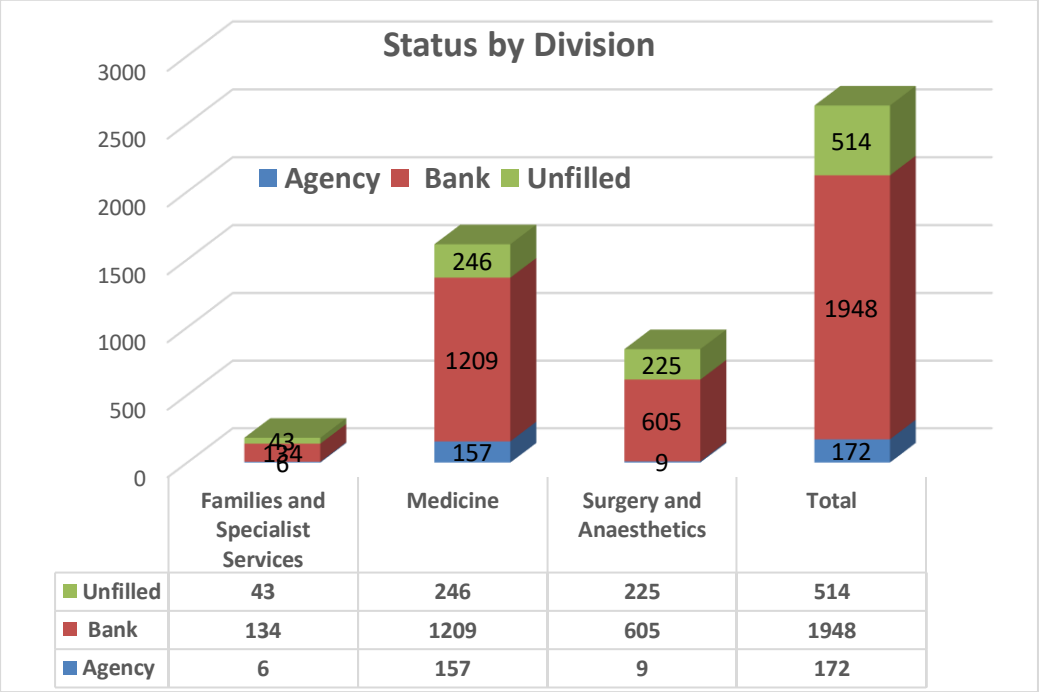
b) Rota Gaps between October to December 2021

There were some rota gaps from October to December 2021, but they were filled by agency staff and bank locum shifts.

The data for December is not 100% complete as it was prepared before 24th December and therefore any last-minute rota gaps during the Christmas and New Year period are not captured in this report.



The gaps were almost equal across the Medicine division and within the Surgery and Anaesthetics division. With the inclusion of bank & agency locums the total unfulfilled posts were around 19.5%. This is a higher proportion of unfilled shifts than seen ordinarily.



	Families and Specialist Services	Medicine	Surgery and Anaesthetics	Total
Unfilled	43	246	225	514
Bank	134	1209	605	1948
Agency	6	157	9	172

c) Rota Changes

In December 2021, changes were made to the start and end time of the Long Day and Night Shifts when on call in Medicine. The biggest driving factor in initiating these changes was

feedback from the GMC survey. The changes were discussed and agreed to improve patient care as it enables a longer morning handover.

Within Urology, the rota is being reviewed due to an increase in the number of people in post, from five to seven. This work has not been completed yet, but consultation will commence as this is a mixed economy rota made up of trainees and Specialty Doctors.

c) Attendance of Virtual National Conference of Guardian of Safe Working Hours (GOSWH)

Ms Gogi attended the national conference of GOSWH on 9th December 2021. It was an informative day with virtual interaction with GOSWH from other regions. The most important issue that was highlighted was the need to improve engagement with junior doctors. Different ideas were discussed to improve engagement which included: having an active Health & Wellbeing Committee, Ward to Board events, which would give Junior doctors the opportunity to speak to and engage with Board Members. There were also ideas to try and reward the junior doctors for their hard work, such as having an ice-cream van visit for the day with treats and giving spa day coupons.

Here at CHFT, we have previously held Awards specifically for doctors in training which have been received positively so it's likely we will continue to hold these, as well as discussing the ideas proposed with our trainees at the next Junior Doctor Forum in January 2022.

d) Junior doctor forum (JDF)

The JDF was originally scheduled for 16th December 2021, however it has been postponed to 20th January 2022.

We have invited Dr Rob Moisey, Consultant Physician within the Medicine division, to this meeting to discuss reconfiguration plans in CHFT. This will allow trainees to gain a greater awareness of the planned changes and how these will affect the Medical Education centre and the availability of meeting rooms. It will also enable them to get involved in consultation meetings and share their insight into how the changes can benefit patients and staff.

The Post Shift Rest Facilities document was updated & circulated to all junior doctors.

e) Recommendation

At CHFT, this quarter saw considerable decrease in the exception reporting in this quarter. There is an active need to engage with the junior doctors and this will be discussed in the next JDF

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

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

Devina Gogi
Guardian of Safe Working Hours
January 2022

17. Quality Report

- Maternity Services Update

To Note

Presented by Lindsay Rudge

Date of Meeting:	Thursday 13 January 2022
Meeting:	Public Board of Directors
Title:	Quality Report (Reporting period October & November 2021)
Author:	Enzani Nyatoro, Interim Assistant Director for Patient Safety
Sponsoring Director:	Lindsay Rudge, Deputy Director of Nursing
Previous Forums:	None

Purpose of the Report

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

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

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

Key Points to Note

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

- Care Quality Commission (CQC)
  - CQC Inspection Actions - There is substantial assurance regarding the one outstanding CQC "Must Do" action. This has progressed, despite the current environment. Planning for the next financial year is taking place.
  - The Journey 2 Outstanding Reviews (J2O) were re-established in September 2021 with a full schedule of reviews to the end of 2021. A team of CHFT colleagues form the inspection review teams with two reviews scheduled each month. Wards that have undergone J2O reviews have action plans in place to ensure progress is made against any non-compliance. Divisional Associate Directors of Nursing provide bi-monthly updates on action plan progress and compliance against recommendations at the CQC and Compliance Group. Operational pressures and medical colleagues' involvement present challenges to the process. A discussion regarding the involvement of medical colleagues to support the process is scheduled at the next Clinical Directors forum in January.
  - CQC Insight Report - CQC continues to publish the insight report and identifies that CHFT continue to be performing much worse nationally in relation to actioning and completing Central Alert System (CAS) alerts, due to two alerts being outstanding for some time. These are currently being progressed with one outstanding action on each. The ligature risk assessment alert is in the final stage and awaiting policy sign off.

- Dementia Screening

  There has been a slight dip in dementia screening training from the previous month as compared to three months of continuous improvement. The low numbers have been attributed to having rotational medical trainees who have recently joined the Trust and are yet to complete their training. Several actions are in place to help to improve training uptake and compliance. A risk relating to the failure to meet the target been added to the risk register with identified actions to address the risk.

- Experience, Participation, Equalities

  Significant development has been made to recognise the vital role carers have in supporting patients. The Carers Strategy has been moved forward and is envisaged to be signed off through the Patient Experience and Caring Group in early 2022. It has also been recognised that a more robust approach to engagement is required and work is ongoing with third-sector organisations and Clinical Commissioning Group (CCG) engagement teams to develop a specific engagement plan to meet the needs of the wider health economy.

- Legal Services
  - Acting Head of Legal Services has been seconded from Weightmans LLP (NHS Panel Solicitors) for the next 8-12 months. This secondment will allow the Trust time to make permanent arrangements whilst support and leadership to the Legal Services Team in the interim. The trust continues to work with the Coroner's Office regarding the considerable backlog in relation to inquests.
  - Within the Trust, the legal team is developing processes to ensure oversight and awareness within speciality areas to identifying and act on learning in real time, rather than when a claim has concluded, as traditionally has been the case. This will also ensure that the 5 Point Action Plan recommended by getting it right first time (GIRFT) can be achieved on a continual basis, rather than once a year with the release of the Data Pack.
  - The Trust plans to improve engagement with Panel Solicitors by involving them in identifying trends within the Trust's claims and thereafter supporting clinicians with targeted training. In addition, Panel will assist the Trust in analysing the NHS Resolution Claims Scorecard and providing Benchmarking data.

- Incidents
  - The Risk team has reviewed the management of serious incidents and is focusing on historic serious incidents which have outstanding actions. This is being undertaken alongside work within the divisions to manage outstanding actions.
  - There is recognition of the operational pressures and the impact this is having on the management of serious incidents. The risk team continue to provide support to clinical teams. The risk team have good oversight of serious incidents and continue to work closely with the divisions to support a consistent process across the trust and ensure all actions are responded to in a timely manner, with robust evidence.

- Medicine Safety

  The Medication Safety and Compliance Group (MSCG) continue to raise awareness of the importance of safe storage, prescribing and administration of medication. Priority work streams include:
    - Storing and handling medication - working on action plans to improve performance.
    - Development of an electronic recording solution for controlled drug (CD) registers to improve CD compliance and adherence to legislative requirements.

- Installation of electronic medication storage cabinets and the “go live” for active temperature monitoring for medication stored in fridges is also a priority. The first automated medication storage cabinets have been installed in the emergency department at HRI, a cabinet in majors and in resuscitation.

A recent unannounced medicine spot-check audit identified some areas of improvement. Actions to address areas of poor compliance with standards have been developed and will be monitored via governance processes.

- Maternity Services
  - Maternity services leaders continue to work closely with the Local Maternity Service (LMS) to meet the system wide requirements of the Ockenden report. The second part of the report is expected soon.
  - New guidance of implementing full Continuity of Carer (COC) was issued in October with a recognition that full implementation should not compromise safe staffing levels across any part of the system. Maternity services met with regional and national COC leads to describe our continued planned roll out of mixed risk locality based COC team, including the potential challenges of staff engagement and recruitment.
  - Maternity services noted a rise in stillbirths from October 2020 which has continued through 2021. A review of all cases has been undertaken which identified that deprivation, smoking and access to antenatal care all impacted on outcomes for babies. Only 3 of the women tested positive for COVID-19 on admission. The impact of COVID-19 on pregnancy has not been fully understood, though as with the general population it is those women with underlying health problems or from BAME communities who have been admitted to hospital. Currently approximately 40% of pregnant women across the CHFT footprint have received a covid vaccination
  - The Women’s Directorate is currently reporting 7% absence rate; a combination of both long- and short-term sickness and the impact of isolation due to Covid- 19; which is impacting on all areas. Matron colleagues attend the twice daily trust wide nursing and midwifery staffing meetings and colleagues are flexed across maternity areas to meet the needs of women.

- Quality Priorities

  The Trust has continued to focus on its quality priorities. There remain several priority indicators with limited assurance as progress has been limited due to the pressures within teams. The informatics team have supported divisions by pulling division specific data to allow each division to track its own progress and report progress at Performance Review Meetings (PRM) and to the quality priority leads. FSS and Community have reviewed the narratives against Pressure Ulcer and waiting times indicators to fit with the context of their services. These will be included in future reports.

EQIA – Equality Impact Assessment

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

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

It is not anticipated that the contents within this report will have a detrimental impact on any

of the protected characteristics but seeks to give the assurances that as a Trust we are doing everything in our power to reduce risk and ensure high quality and safe care for all to include improvements for dementia screening for our patients aged 75 and over.

The Equality Impact Assessment is an ongoing process, and every effort is made to ensure it is an integral part of service delivery and enable us to demonstrate that the Trust is offering a service that meets legislation, encourages equal access for all and reduces as many negative impacts identified as possible in terms of its overall delivery of high-quality care.

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

Recommendations

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

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1. Introduction

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

The paper seeks to brief the Quality Committee and Board of Directors on the developments and progress against the Quality Strategy and improvement work underway.

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

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

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

2. Care Quality Commission (CQC) workstreams

During October and November 2021, the CQC workstreams remained guided by the continuous engagement with the Trusts CQC Relationship Mangers, Trust's recovery plan, national guidance and CQCs Emergency Support Framework.

2020/21 CQC Exceptions Action Plan – Update on 'Must Do' and 'Should Do' Actions

Of the outstanding actions from the 2018 CQC inspection, the Trust now has one action to complete.

In brief the one 'must do' action is not yet embedded in the Trust and remains incomplete pending further consideration of the quality and financial position of the Trust as set out in Table 1.

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

Table 1

Compliance	Current Position	Further Actions	Assurance
MD1 - The trust must improve its financial performance to ensure services are sustainable in the future	The Trust's submitted draft financial plan for 20/21 was in line with the required five-year Financial Improvement Trajectory, this plan was overridden subsequently due to COVID-19. The month 5 reported position was break-even, based upon the temporary financial regime in place to support COVID-19 pressures.	This action is a long-term action which continues to progress a further update is scheduled to be received at the April 2021 CQC and Compliance Group.	**Substantial Assurance**

	Very long-term strategic recommendation, the plans linked to this were around reconfiguration. We continue to progress but due to current environment we are breaking even on a month-on-month basis to support COVID-19 activity. Planning for the next financial year is taking place		

Journey 2 Outstanding Review

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

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

Reviews to Date

Eight J2O Reviews have taken place to date. All visted wards have action plans in place to ensure progress is made against any non-compliance. Monthly meetings have been initiated within the division of Medicine to ensure Ward Managers and Ward Matrons are held accountable for all action plans.

Divisional Associate Directors of Nursing are scheduled to give bi-monthly updates regarding action plan progress and compliance against recommendations at the CQC and Compliance Group.

Challenges

There have been ongoing challenges to ensure medical colleagues are involved in the J2O reviews both from a review team perspective and to be interviewed as part of the inspection. This is to be discussed at the next Clinical Directors forum in January.

Emerging Trends and Non-Compliance

All emerging trends (positive and negative) and any non-compliance that is picked up through the J2O reviews is now shared monthly at the Friday Matron and Ward Manager Forums. Table 1 sets out the good practice trends and Table 2 sets out key areas of non-compliance across the reviews.

Table 1

SAFE	EFFECTIVE	RESPONSIVE	CARING	WELL-LED
• Good overall compliance with medicines management as part of J2O Review. • Ward Areas are tidy and clutter free. • Staff have been able to describe processes around Safeguarding	• Good staff knowledge around referral systems for acute, chronic and cancer pain • Meals have been well presented • Staff awareness of dietary requirements	▪ Staff have been responsive to patients needs ▪ Staff have been able to give examples of where care has been adapted to peoples needs.	• Patient experience and feedback has been really positive across all the reviews. • Patients reported they feel safe and care for. • Observations of clinical discussions with patients have been positive and patients have reported they understand the treatment they are receiving	• Ward managers have shown exceptional leadership within areas. • Staff have demonstrated good communicatio n between the team • Ward Managers are sharing with staff information from the Friday Morning Briefing sessions

Table 2.

SAFE	• Signage / posters out of date, Staff Awareness of Ligature points, Ligature Risk Assessments, Use of I AM Clean Stickers, Touch Point Cleaning / Time to Clean, Ward Manager Monthly Meds Audit not Always Completed, Computers left Unattended with Patient Records Open.
EFFECTIVE	• Space in Ward Areas for MDTs, Use of Red trays & Utilising Red Lids at Meal Times, MUST Score, Prepping Patients for Mealtimes
RESPONSIVE	• Estimated Date of Discharge not consistently set on admission, Treatment initiated before Care Plans in place on EPR
CARING	• Noise at Night, PJ Paralysis, Out of Date Patient Information
WELL-LED	• Awareness of CHFT Vision & Strategy (4 Pillars), Visibility of Senior Leaders, Awareness of FTSU network, Staff Morale

J2O Review Next Steps

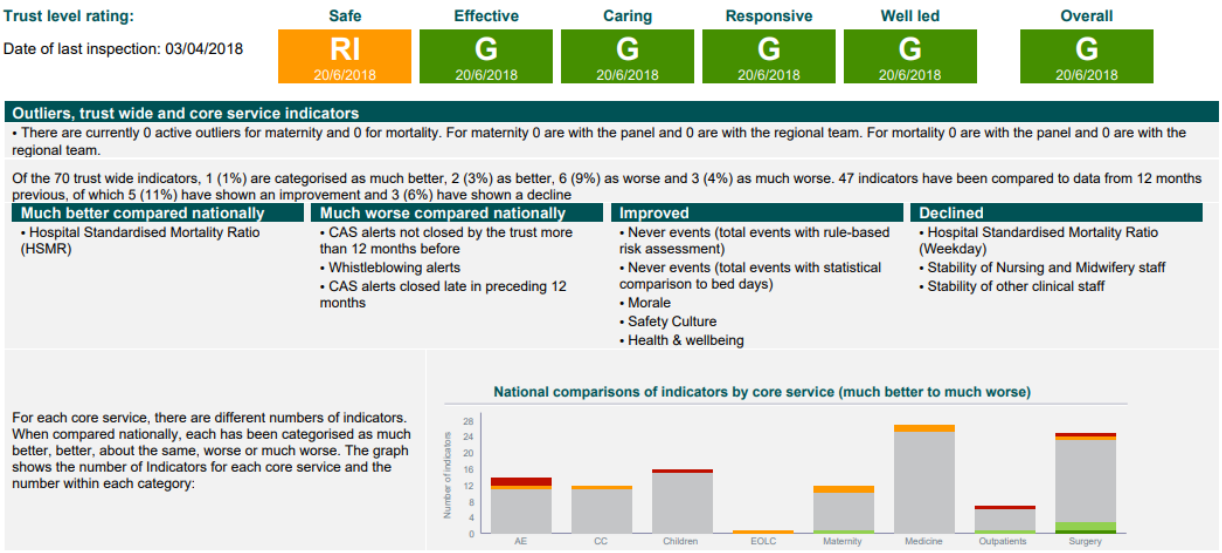
Now the Ward based J2Os are established across the organisation plans are in place to develop the J2O toolkit to fit other services across the trust. Priority areas for Q4 2021-22 include:

- Children and Young Peoples Services
- Maternity Services
- Urgent and Emergency Services
- Community Services (Health Centres)

CQC Insight Report

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

CHFT Performance Summary:



Central Alert Systems (CAS) Alerts

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

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

Alerts	
2	Overdue

3	Open and within timescale

The following patient safety alerts are currently overdue:

- **NatPSA/2020/001/NHSPS - Ligature & ligature point risk assessment tools and policies**
  Lead: Janet Youd
  Nov 2021 update: Weekly task and finish groups continue to take place. An environmental risk assessment is to take place on 16 November, with trials to take place on some wards before wards carry out their own assessments

- **NatPSA-2020-005-NHSPS** - **Steroid emergency card to support early recognition and treatment of adrenal crisis in adults**
  Lead: Dr Julie Kyaw-Tun
  Nov 2021 update: Task and finish group being held on Thursday, 4 November 2021and further review of learning from other organisations on implementation

The following patient safety alerts are currently within deadline date:

- **NatPSA-2021-003/NHSPS** - **Eliminating the risk of inadvertent connection to a medical air via a flowmeter**
  Lead: Medical Engineering and Medical Gases and Non-invasive Ventilation (NIV) Group
  Nov 2021 Update: Work underway

- **NatPSA-2021-009-NHSPS** - **Infection risk when using FFP3 respirators with valves or Powered Air Purifying Respirators (PAPRs) during surgical and invasive procedures**
  Nov 2021 Update: Actions being led by the Infection Control Team

- **NatPSA-2021-008-NHSPS** - **Elimination of bottles of liquefied phenol 80%**
  Nov 2021 Update: Actions being led by Pharmacy, Podiatry and Theatres

3. Dementia Screening

Dementia Screening Compliance

Month	Nov-21	Oct-21	Sep-21	Aug-21	Jul-21	Jun-21	May-21	Apr-21
Trust %	37.60	44.15	46.32	36.90	22.59	26.90	29.34	28.44
FSS %	-	-	-	-	0.00	-	100.00	-
Medicine %	39.18	45.68	49.10	39.70	23.08	28.22	30.54	28.70
Surgical %	27.87	37.35	35.96	22.78	20.91	21.57	23.23	27.27

There has been a recent dip in screening compliance; however, this is linked to the new rotational medics starting and plans are in place to increase compliance these include:

- A Standard Operating Procedure (SOP) has been circulated to the new rotational medical colleagues and has been added onto Padlet for medics to review in their own time.
- A daily email of the list of patients with an overdue dementia screen is sent out to consultants/ward managers/ward sisters and matrons of the assessment units to prompt medical staff to complete.
- A "Dementia Screening – What is it and why do we do it?" has been developed for medical colleagues to support them to understand the importance of dementia screening and impact on patient experience.

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

Dementia Training Compliance – Target 95%

November 2021:

Community	99.14%
Health Informatics	99.14%
Pharmacy Manufacturing Unit	98.53%
Corporate	98.11%
Families and Specialist Services	97.38%
Calderdale and Huddersfield Solutions Ltd	97.05%
Medical	95.84%
Surgery and Anaesthetics	95.65%
Central and Technical	92.86%
Grand Total	**96.94%**

Person-Centred Dementia training:

This is currently placed on hold whilst a review is undertaken.

4. Patient Experience, Participation and Equalities Programme

Workstream	Progress Update	RAG Rating	Future Developments
Strategy, Policy & Programme	**Patient Experience & Caring Group (PEG)** The meeting was held with positive feedback from the members of the group. Patient Stories were introduced as a method of learning and sharing the voice of the patients and their relatives. It was recognised that it was an interactive group and a positive forum for sharing good practice across each division.	**Reasonable Assurance**	There will be a newly appointed Associate Non-Executive Director taking over the role as Chair of the group. The workplan for 2022 along with the terms of reference for the group will be reviewed in January 2022.
Equality	**BAME Lead** Further meetings have taken place with the trust BAME representative to look at ways to strengthen our relationships with BAME residents within our locality, particularly those within harder to reach areas (high areas of deprivation and rural locations). **EDS Group** The Trust was invited to attend the virtual Equality Delivery System (EDS) group hosted by local health organisations. This was an opportunity the showcase what has been done to support patients and public through the pandemic. The first of two EDS sessions was held on 25th November 2021. With CHFT scoring highly. Stakeholders were very impressed with the work within maternity services. We have added a section to the NHSE complaints survey to monitor the ethnicity of complainants.	**Reasonable Assurance**	Further development of our 'People Bank' – Patient Representatives signed up to help us heard from and engage minority groups within the local health economy. Quality Improvement Manager – Patient Experience to work with our LTBTQ+ Representative (a voluntary staff member) with regards to developing the role of the Pride steering group. A further EDS session will be held in January 2022. The outcome will be shared in following updates. Survey of Q1 &Q2 complainants to be sent out in December 2021.

Experience	**Commitment to Carers** We have made significant progress with our Carers strategy which will go for sign off at the PEG in January/February 2022. We have started to develop a Carers Group and have strengthened our relationships within the third sector within our health economy. We **Making Complaints Count** Taking into consideration the operational demands on the service, and the volume of complaints received into the trust it is recognised that improving the quality of our investigations and responses is essential. The Lead Nurse, Quality Directorate is looking to streamline the processes so improvements can be made to the quality, response times and learning. **Winter and COVID Volunteering Programme** The pilot, which was NHSE funded has seen over 35 volunteers recruited to help at front of house and wards at CRH and HRI has had a positive impact for patients, staff and the volunteers themselves. The programme is due to be handed over to Workforce and Organisational Development (WOD) on 31st December 2021 where it will continue until at least June 2022.	**Reasonable Assurance**	We are working towards launching our Carers Passport during Carers week, June 2022. We have agreed the use of a Carers lanyard within the trust. Carers Strategy Manager for Kirklees Council has agreed to finance these. Task and Finish Groups have been planned for the January and February 2022. Representatives from each division will be in attendance The final project report to be completed for sign off. It is hoped that additional funding can be secured to continue this work after June 2022. Volunteers to be provided with the most recent COVID guidance to allow them to safely comply with trust guidance.

			Volunteers to be provided with a thank you gift as a token of appreciation for their time, effort and energy within the pilot. Volunteers and WOD team to be provided with a comprehensive handover to ensure a seamless move to WOD.
Engagement	**Engagement Plan**: We are currently developing an engagement plan for 2022. It is recognised that further COVID restrictions could limit what we can deliver, however we are strengthening our network within the voluntary sector, through the HOPE network and Clinical Commissioning Group (CCG) engagement team. **Improving the experiences for Patients with a visual Impairment:** Reviews of Acre Mill and CRH have been completed with service users. These have been videoed, so we can understand the challenges and good practice from a patient perspective.	**Reasonable Assurance**	An engagement plan for 2022 will be submitted to the PEG in January/ February 2022. We are awaiting the opportunity to meet with the patient user group. This is likely to be in January 2022, when a further update will be provided.

5. Patient Advice and Complaints Service (PACS)

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

Key Objectives

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

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

Progress against key objectives

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

	October	November
Complaints received	47	56
Complaints closed	34	35
Complaints closed outside of target timeframe	16	8
% of complaints closed within target timeframe	53%	77%
Complaints reopened *[1]	8	13
*[1] Work is ongoing to validate this figure due to informal methods of handling further contacts on Datix		
PALS contacts received	205	209
Compliments received	27	49
PHSO complaints received	0	0
PHSO complaints closed	0	1
Complaints under investigation with PHSO (total)	4	

Making Complaints Count Collaborative

The Making Complaints Count (MCC) steering and operational groups have been reviewed to ensure effective use of colleague input across both groups. A Task & Finish Group has been identified and 6 sessions have been scheduled to focus on Quality, Performance and Learning, these will commence early January.

6. Legal Services

Introduction

Calderdale and Huddersfield NHS Foundation Trust is committed to:

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

Synopsis

A new Head of Legal services has joined the Trust as a secondee from Weightmans LLP (NHS Panel Solicitors) for the next 8-12 months. This secondment will allow the Trust time to make permanent arrangements and will provide support and leadership to the Legal Services Team in the interim.

Whilst considerable work has been done by the team to reduce the inquest portfolio (total down from 179 to 150), this has been complicated by ongoing operational pressures within the Trust at every level and irregularity within the Bradford Coroner's Office. The Acting Head of Legal will be meeting with the Senior Coroner in the New Year to agree a more productive and efficient working relationship moving forward.

Recent Data

This report covers the period **1 October – 30 November 2021**.

Clinical Negligence

- 167 active clinical negligence claims
- 4 new clinical negligence claims were received.
- 12 clinical negligence claims were concluded.
- Damages totalled £317,500

Employers' and Public Liability (EL/PL) Claims

- 23 active EL/PL claims
- 1 EL/PL claim was received
- 1 EL/PL claim was concluded
- Damages totalled nil

Lost Property

- 14 active lost property claims
- 5 lost property claims were received
- 2 lost property claims were concluded
- £478.49 paid in respect of lost property claims

Inquests

- 150 active inquests
- 19 inquests were opened
- 22 inquest files were closed

Objective	Quarter 2	Quarter 3	Quarter 4	Oct and Nov 2021	Assurance
System in place to ensure effective communication within the Legal Services Department	KPIs set and implemented	98% compliant with department KPIs	100% compliant with department KPIs	**Acting Head of Legal to incorporate communication and sharing procedures within new Legal Standard Operating Procedure (SOP).**	**Limited assurance**
Datix Module for Legal Services reviewed and updated	Not implemented	Datix reviewed with Trust Datix Lead, stages streamlined, and actions set up for Inquests. Further work required in Q4.	Legal Services Department together with wider Governance Department moved offices and sites during Q4. Work on Datix module was paused during this time to focus on the move.	**Acting Head of Legal to incorporate into SOP.**	**Limited assurance**
Audit of Legal Services files on Datix	Not implemented	Not implemented	Not implemented	**Acting Head of Legal to incorporate communication and sharing procedures within new Legal SOP.**	**Reasonable assurance**
SOP for DP7 requests	SOP set up	In Q3 the role and responsibility for managing all DP7 requests was given to Legal Services. Currently no SOP in Trust for handling these.	Confirmed that DP7 requests from the Police that relate to Trust staff or incidents that have happen on Trust property. All other requests will be handled through Access to Data DP7 requests have been added to Datix as a type in claims module and managed under the SOP for legal disclosures.	**A finalised SOP from Access to Health Data is currently awaited.**	**Reasonable assurance**.
Disclaimers for personal property on EPR	Not implemented	Not implemented, discussions being undertaken with EPR Team in relation to	The Digital Health Team are looking into how disclaimers can be added to EPR.		**Limited Assurance**

Objective	Quarter 2	Quarter 3	Quarter 4	Oct and Nov 2021	Assurance
		this.			

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

As part of ongoing service improvement work, the introduction of a learning document has taken place. On the closure of each claim and inquest, a '7 Minute Briefing' document will be completed by the case handler and circulated to Divisions for learning, following approval by the Head of Legal. The document will be saved on the Datix file thereafter. Learning will therefore be recorded on each case and circulated for wider sharing. **An example of this document is appended herewith.**

A review of the Legal procedures in also underway, with the Acting Head of Legal looking to incorporate learning from Inquest and Claims and Getting it right first time (GIRFT) into the new processes. Legal Services are planning to link in with Speciality Teams across the Trust on a regular basis in relation to claims and inquests. Whilst there are already established links in some areas, the aim is to standardise this engagement so that no clinical/divisional areas are excluded.

There will be two strands to this engagement:

- The first will be to ensure that all Divisional and Speciality Leadership, as well as individual clinicians involved in providing care, are sighted on all claims at the following stages.
- The second strand of improved engagement will be with Speciality Leadership. Legal Services will arrange to meet with each Speciality, once a quarter, to review their new, on-going, and closed claims and inquests.

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

The Trust will also improve engagement with Panel Solicitors by involving them in identifying trends within the Trust's claims and thereafter supporting clinicians with targeted training. Further, Panel will assist the Trust in analysing the NHS Resolution Claims Scorecard and providing Benchmarking data. This information, along with the GIRFT Litigation Data Pack will assist Clinical Teams in understanding where their services fit into a national picture and where further scrutiny might be required.

Guide to 7-minute briefing

We have introduced ‘seven minute briefings’ to allow leaders within teams to deliver a short briefing to colleagues regarding on key topics – they can also be used to support reflective discussion with practitioners.

Research suggests that seven minutes is an ideal time span to concentrate, and learning is more memorable as it is simple and not clouded by other issues and pressures. Their brief duration should also mean that they hold people’s attention, as well as giving team leaders something to share with their staff.

Clearly such short briefings will not have all the answers, but it is hoped that they will act as a catalyst to help teams and their managers to reflect on their practice and systems. The expectation is that team leaders will present briefings to their staff, on a regular basis – seven minutes is manageable in most services so why not discuss one in your next team meeting?

Thanks must go to Manchester Safeguarding Partnerships for sharing this learning tool publicly. Examples of briefings can be found on their website
https://www.manchestersafeguardingpartnership.co.uk/resource/seven-minute-briefings/

1. Background (Synopsis)

2. The incident (Allegations)

3. Internal Investigations

7. Implementing change

4. External Investigations

5. Liability (Fault)

6. Learning (Recommendations)

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Action Plan

Project name:

Team Name:

Team Manager

Contact Details:

Identify the learning or recommendations that are relevant to your team and summarise your teams' discussion on those points

1.

2.

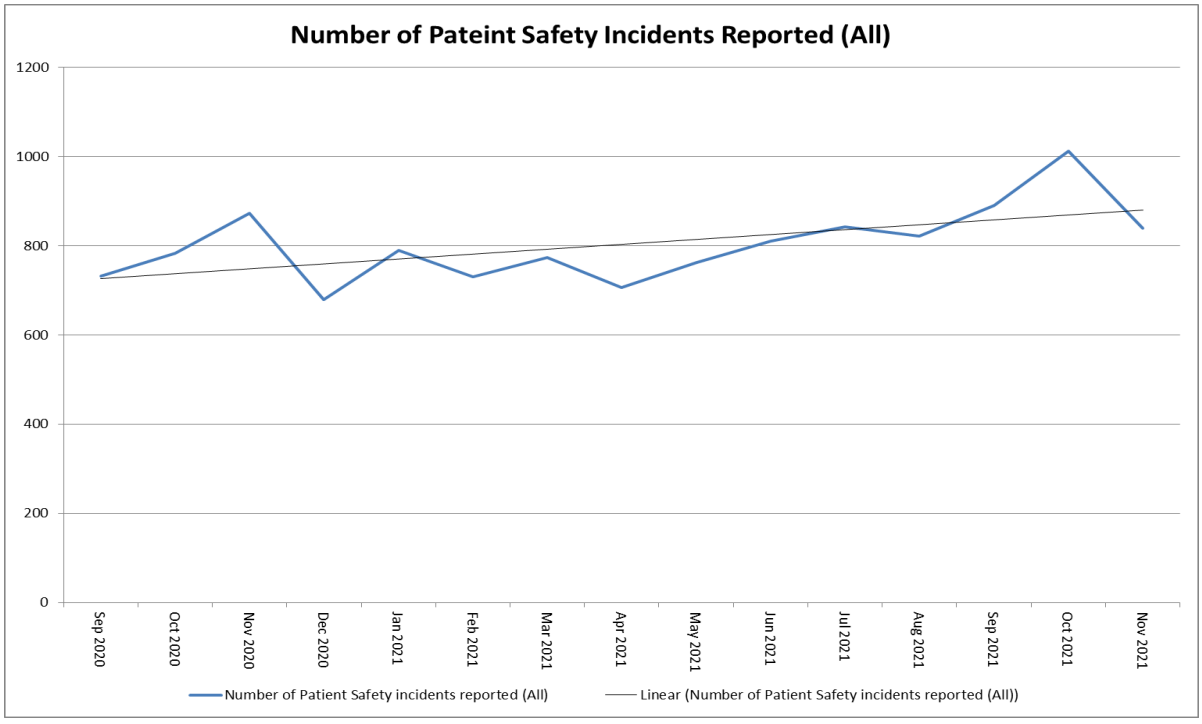
3.

7. Incidents

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

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

Month reported	Number of Patient Safety Incidents reported (all)	Number of Patient Safety Incidents of severe harm or death	Serious Incidents by the month externally reported on StEIS
Sept 2020	732	5	4
Oct 2020	783	6	2
Nov 2020	873	25	1
Dec 2020	679	11	3
Jan 2021	790	30	5
Feb 2021	730	18	2
Mar 2021	774	3	2
April 2021	706	5	4
May 2021	763	6	2
June 2021	810	7	6
July 2021	843	4	3
Aug 2021	822	9	2
Sept 2021	890	10	4
Oct 2021	1012	12	6
Nov 2021	839	13	7



Never Events

No further Never Events have been reported during October and November 2021.

Summary of Progress with Serious Incident Actions

- The Risk team has reviewed the management of serious incidents and is focusing on historic serious incidents which have outstanding actions. This is being done alongside work within the divisions to manage outstanding actions.
- There is recognition of the operational pressures and the impact this is having on the management of serious incidents. The risk team continue to provide support to clinical teams. The risk team have good oversight of serious incidents and continue to work closely with the divisions to support a consistent process across the trust and ensure all actions are responded to in a timely manner, with robust evidence.
- A total of 3 StEIS (Strategic Executive Information System) incidents were reported; 2 for October and 1 in November.

Learning from Serious Incidents

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

Incident Summary	Learning Need and Organisational Learning
Datix ID 198277 Patient underwent angiography procedure in August 2020 performed by Cardiology Consultant. A CXR in October 2020 showed a retained wire in the patients neck.	Short introducer guidewires used for vascular access can be retained within patients. Checklists at the end of a procedure whilst helpful to identify missing guidewires will not prevent the type of procedural error leading to retention. A time out during the procedure to ensure that the guidewire is visualised and controlled at all times should be used as well as operator confirming guidewire has been removed.
Datix Id 197202 Retrospective review of a patients CT images following concerns raised in a complaint has identified that a rib lesion was missed on the CT report	When reading CT scan results readers must always use MPR (Multiplanar Reformation (conversion of images so that they can be viewed from different dimensions); check the images in all window settings and use a structured approach. Always compare images with previous images if they are available and document that this has been the case. A comparison to previous images was undertaken in this case, unfortunately the Reporting Radiologist missed the 10th rib focus.
Datix id 198440 A Patient deteriorated within the Emergency Department who required an urgent procedure The patient died before the procedure was undertaken.	Clear communication within teams is essential to ensure all tasks are allocated and completed Optimise the use of technology already implemented in other areas of the Trust to support contemporaneous recording of observations. Where protocols are relevant in elective, urgent and emergency situations, they should contain the required information for each circumstance to support decision-making For chronic and potentially life-threatening conditions, consider whether there is the opportunity for the patient to take part in advanced care planning

8. Medicines Safety

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

The priority MSCG work streams are:

- Review of ward compliance with medicines management must do's for storing and handling medication. Working with divisions on action plans to improve performance
- Development of an electronic recording solution for controlled drug (CD) registers to improve our CD documentation and compliance with legislative requirements.
- Phase one of installation of electronic medication storage cabinets. This first phase is for installing the required cabinets in our Emergency Departments to ensure we have robust storage facilities, reduce risk of medication error selection, reduce risk of medication diversion and free up nursing time to care.
- Go live for active temperature monitoring for medication stored in fridges and then expansion of system to include ambient temperature monitoring

Main concerns/ escalations:

- Recent unannounced spot checks of medicines management standards on wards on both sites have shown disappointing results and a quite different picture to those reported by the J20 planned visits.
- Poor compliance with the Must Do medicines standards has been shared with both pharmacy staff and nurse managers
- Pharmacy staff reminded that medication storage and handling is part of their core responsibilities when visiting wards and any deviations from the required standards must be escalated to the ward managers
- Ward managers asked to feedback on what actions they have put in place to ensure Must Do's are adhered to.
- Lack of quoracy at MSCG due to gaps of divisional / cancellation of last meeting due to operational pressures. Pharmacy leading on all current medication safety work streams. Refresh needed to ensure medication safety priorities are viewed as a multidisciplinary responsibility
- Training requirements of ward staff for use of electronic CD registers and Active temperature systems. Both systems due to go live in the next 3 months and will require release of ward staff to complete training.

Issue	Update	Risks	Mitigations	Next steps	Assurance
Non-compliance of the medicines management 'must do's **Ongoing objective requiring continual monitoring**	Bi-annual pharmacy audits continue to be completed and highlight both areas of good and poor practice. Electronic meds management audit tool developed. Awaiting staff lists so that audit tool will notify correct teams of audit results Spot checks have reported a worsening picture of compliance with core standards- oxygen cylinders not stored in brackets/ IVs made up in advance/ fridges not monitored nor temp deviations acted upon/ unsafe storage of medicines keys	Audits only give a snapshot of routine practice It appears there is a difference in the results seen on planned visits when the ward is informed in advance they are being audited compared to ad hoc/ unannounced visits indicating the planned audits may not be seeing the true picture	Ward managers and senior nurses reminded of the core standards and their professional responsibility to adhere to them Pharmacy teams supporting wards to alert senior nurses if standards aren't being met. To offer support when capacity t do so in terms of emptying returns bin/ putting deliveries away/ removing expired medication from fridge	Where spot checks have highlighted issues / concerns, reported to ward manager and action plan agreed. Re-audit Staff reminder of Incident management policy with regard to if repeated incidents are highlighted, next steps include a formal disciplinary process	**LIMITED ASSURANCE**
Annual medication fridge temperature monitoring audit highlighted only 39% of all areas 100% compliant. Repeated audits continue to show poor compliance. **Go live for Stanley Active temperature monitoring system- target completion date delayed from**	Temperature assets placed in clinical areas to identify any potential areas of noncompliance before system go live. SOP for how to access and update active temp system approved Pilot areas to test training module identified Pilot area staff, who need to be able to action temperature deviation	Audits show that staff are not acting on temperature deviations Staff may tamper with new temperature devices as they may not know what they are Staff have turned off current' traditional' fridge thermometer alarms (reliant on for manual monitoring of fridges until the active system go	Screensaver and comms issued to clinical staff showing pictures of monitoring devices including instruction stating not to tamper with devices Daily manual recording of fridge temperatures continues until active system Go Live Pharmacy audits continue to check 'traditional' fridge monitor alarm correctly switched on and daily monitoring of temperatures is recorded	Ward managers reminded of must do's /manual fridge temperature monitoring requirements (until Go live with active temperature monitoring system) Comms to nursing teams of active temp system, Go Live date and requirement to complete training Relevant staff to complete training Once 70% staff trained/ Go live to be agreed	**Limited assurance that manual temperature monitoring is being completed 100% time**

Issue	Update	Risks	Mitigations	Next steps	Assurance
Aug to Dec 21	alerts, identified and requested to complete training package and feedback on any issues (note: not all ward staff need training), Once 70% staff trained, system will go Live. Aiming for December Go Live	live). This results in no audible alarm i.e., when fridge door left Once Go Live for fridge monitoring, aim go live with ambient temperature monitoring and there is a financial risk for any areas whose temperature is consistently above 25 degrees Celsius as they may need air con installing	For any areas storing meds at higher than recommended temperatures, there is a pharmacy led process of reducing expiring dates (depending on exposure length and temp reached). This carries the added risk of increased waste of medication/ cost		
To improve medical gas training to ensure compliant with HTM (health technical memorandum) requirements	SWAY oxygen training package completed. Training being rolled out DNO virtual group formed – holding bi-annual meeting at which updates on relevant oxygen and medical gas information shared	Not all clinical staff may be up to date with training	Completion of Datix reports when any incidents relating to medical gases including poor practice occur	. Promotion of the training would include posters, bite size info on the monthly newsletters, block emails to managers, etc, and their ESR would be put on red until it completed Await national updates to HTM and Medical Gas Group Terms of Reference (as per HSIB report recommendations)	**Reasonable assurance**

9. Maternity Services

Ockenden report

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

Work is continuing with partners across the Local Maternity System (LMS) to develop a tertiary level maternal medicine centre, and also to embed the LMS Serious Incident review panel.

Maternity services nationwide are currently awaiting the release of the second Ockenden report.

Continuity of Carer (COC)

The CHFT maternity services team met with regional and national COC leads on the 9th December to share our plans for the further development of the COC model of care at CHFT. This meeting followed the publication of amended national guidance on planning implementing and monitoring the delivery of midwifery continuity of carer at full scale published in October 2021.

The guidance recognised the long standing challenges in local implementation, and that the transition to full COC should not put undue pressures on midwives or compromise safe staffing levels across any part of the system. As a first step the LMS must be the 31st January 2022 agree a local plan that describes how COC will be achieved as the default model of care offered to all women. The key changes to the national implementation strategy:

- Not all maternity providers are able to meet the same level of implementation of COC due to service user choice
- Universal deadlines for full implementation do not account for local workforce challenges
- COC must be implemented at a pace that is safe for women and midwives across the service
- Maternity services and LMS need sufficient resources – including midwives to deliver COC.

Despite the challenges of the Coivd-19 pandemic CHFT maternity services have continued to provide COC to women from 4 established teams, 2 of which are based in areas of highest deprivation in both Huddersfield and Halifax. These teams originated with a focus on women from BAME communities. Each month the 4 teams offer COC models of care to approximately 23% of women, which rises to 51% of BAME women (April – Nov 21). The next steps in the roll out of COC would be the formation of mixed risk geographically based teams, commencing with teams in those areas of highest deprivation which the literature suggest are linked with poorer outcomes from families.

Resources remain a significant challenge locally, which is supported by the November 2020 Birth Rate + report which highlighted a deficit of 20 whole time equivalent midwives to deliver 54% COC. The additional funding from NHSEI to support the recruitment of 10.0 whole time equivalent midwives remains unused as despite multiple iterations of a rolling recruitment programme it has not been possible to recruit the additional midwives required.

The modelling tool within the amended guidance suggests that to deliver full COC at CHFT would require 119 whole time equivalent midwives working in 15 teams, with a further 101 whole time equivalent midwives required to care for mothers and babies in the Consultant led antenatal clinics, antenatal day units and maternity assessment centre, the postnatal ward and a small number for those women who require an extended stay on the labour ward.

The service will submit plans to refresh our current community midwifery offer, working with colleagues in Kirklees to develop Family Hubs which will allow us to offer a model of community midwifery based around the hubs rather than GP practices. This will then mirror the offer in Halifax where our community midwives are based in Children's Centres alongside colleagues who support families such as Health Visitors.

We also recognise the importance of socialising the national direction of travel towards full COC with midwifery and obstetric colleagues, being mindful of midwives preferences and those colleagues with flexible working agreements or health concerns which would impact on the ability to provide COC. It is also vital to ensure that all midwives have an updated training needs analysis to ensure they are confident and competent to deliver safe care in all areas of midwifery practice.

Perinatal Mortality Review Tool (PMRT)

The perinatal mortality review too was designed to ensure there is a comprehensive multidisciplinary review of all perinatal deaths from 22+0 days gestation until 28 days after birth*; excluding termination of pregnancy and those with a birth weight <500g.

In Quarter 2 (1st July to 30th September 2021) CHFT reported 7 cases of stillbirth or late fetal loss to PMRT and 1 neonatal death.

- all cases were notified within the timeframe of 2 working days
- 100% of all deaths of babies suitable for review using the Perinatal Mortality Review Tool (PMRT) have been started within four months of each death.
- FSS Division have notified to CHFT Legal department of 100% of NHS Resolution (NHSR) Early Notification Scheme (ENS) cases
- CHFT legal department have notified 100 % of reportable cases to NHSR ENS.

Stillbirth

Maternity services noted a rise in stillbirths from October 2020 which as continued through 2021, which led to a review of 44 cases between April 2019 and October 2021 with a focused review of the 31 babies born between October 2020 and October 2021.

To note in the time period April 2019 to September 2020 there were 13 stillborn babies compared to 31 babies in the time period October 2020 to October 2021. The table below indicates the numbers each month.

	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec
2019				0	1	0	3	0	0	1	0	2
2020	0	0	1	1	0	1	2	1	1	2	3	0
2021	3	1	2	3	3	3	2	1	4	4		

A review of the 44 cases identified that 52% of women lived on areas of highest deprivation; smoking was a risk factor in women who identified as white at booking and whilst the majority of women (34%) had no identified antenatal problems, cumulatively access to care was the greatest risk factor for stillbirth (16%).

Access to care within the cases reviewed included late booking, unbooked, receiving antenatal care out of area. This reiterates not only the importance of women having direct access to midwives to book for maternity care but also the importance of multidisciplinary working with Health and Social Care colleagues including third sector agencies to reach the most vulnerable women in our communties.

3 women who experienced a stillbirth tested positive for Covid- 19 at the time of admission. These women were all admitted between July and August 2021. The impact of Covid-19 on pregnancy has not been fully understood, though as with the general population it is those women with underlying health problems or from BAME communities who have been admitted to hospital. Currently approximately 40% of pregnant women across the CHFT footprint have received a covid vaccination.

Of the 31 babies born between October 2020 and October 2021, 28 records were reviewed. In 7 cases there were known Safeguarding concerns related to Domestic Violence, illegal substance and alcohol abuse. Of these 7 women 3 persistently did not attend for Antenatal Care.

A further 3 women had babies with known congential abnormalites to such an extent that a poor outcome was expected. These women chose to continue with their pregnacy.

Support for familes

Maternity services are extremely fortunate to benefit from charitable donations from families which has allowed us to provide a dedicated bereavement room on the labour ward. This has been decorated and furnished in such a way to be as non-clinical as possible. We are also able to provide memory boxes, photographs, hand and foot prints both on paper and as casts for familes. We have cool cots (a mattress filled with cold water) which means that families can spend as much time as they want with their baby without the body deteriorating. We also work closely with the Forget Me Not Children's Hospice to ensure that parents who wish to can access their facilities.

Following the loss of a baby all families are offered the support of the bereavement midwife who is available to support families through the bereavement and grieving process either face to face or virtually

Healthcare Safety Investigation Branch (HSIB)

As of the 13th December 2021 the maternity services position is:

Cases to date	
Total referrals	31
Referrals / cases rejected	7
Total investigations to date	24
Total investigations completed	18
Current active cases	6

Maternity Incidents

Maternity incidents reviewed at weekly maternity governance multi disciplinary team (MDT) meeting. All incidents are reported via Datix and coded as maternity incidents.

Month 2021	**July**	**Aug**	**Sep**
Post-Partum Haemorrhage	11	10	13
Shoulder dystocia	14	2	10
3rd 4th Degree perineal tears	7	2	5
Admissions to the Neonatal Unit	19	24	18
Born Before Arrival	8	5	6
Stillbirth / Intrauterine Death Neonatal Death	3	3	3
2nd theatre opened	7	6	1
Delay in Emergency Caesarean Section	4	7	3
Postnatal readmission	3	5	0

Maternity Complaints

Maternity services currently have 7 open complaints under investigation and within timescale.

Maternity Staffing

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

2021	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
1:1 Care in labour	98.9%	100%	100%	98.2%	98.9%	98.8%	98.4%	96.6%

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

Midwifery has welcomed 13 whole time equivalent (WTE) newly qualified midwives into the organisation in October 2021. However, there is a further 7 WTE vacant posts form the current workforce establishment plus the newly funded 10 WTE midwifery posts that despite our best efforts we are unable to recruit to. This position is reflective of the shortage of midwives nationally.

Absence rates in the Women's Directorate is currently 7%, ad is a combination of both long- and short-term sickness and the impact of house isolation for staff who are household contacts of Covid- 19 or are confirmed to be COVID-19 positive. Matrons and ward mangers flex staff across all maternity areas to meet the needs of women.

User feedback

The Head of Midwifery and Community Midwifery Matron continue to attend the quarterly Maternity Voices Partnership meeting, and we are looking forward to a time when we can welcome our Maternity Voices Partnership (MVP) colleagues back into maternity services to support our patient experience work streams.

10. Quality Priority updates

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

Quality Account Priorities

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

Focussed Quality Priorities

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

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

Operational Leads – Dr Rob Moisey and Paula McDonagh

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

What do we aim to achieve?		Update	Progress rating
QP1.	Increase our concordance with the administration of intravenous antibiotics in the emergency depts. within 60minutes of recognition of sepsis to 80% for the severely septic patient. This will be measured by using the Red Flag Criteria for severe sepsis recognition. Concordance is captured by the timing from the earliest suspected sepsis alert to the administration of the first intravenous antibiotic through the electronic patient record system.	**October 2021- 51.1%** **November 2021- 62.7%** The above percentages are based on all patients with suspected sepsis in the Emergency Department (ED) at both sites. **Progress work** - Sepsis trollies moved Into Resus to assist in speeding up administration of intravenous antibiotics as the sickest patients are treated there. - Macoset device introduced to assist with mixing the antibiotic Pip Tazocin - Mobile phones requested for the ED Registrars to carry 24/7, this is so they can be contacted quickly to review patients and any escalations can be discussed. ED team have suggested we trial this. - A clinician has met with informatics and have agreed how the red flag data can be pulled from the electronic patient record (EPR), this has now been actioned so we can now report red flag sepsis patients going forward. - Sepsis nurse delivering training to ED staff on Teams twice weekly. **Risks and mitigation's** - Sepsis trolleys require further attention relating to stocking up and consistent usage. **Action-** ED sepsis champions communicating usage guidelines and process for re stocking. - Not all staff using Macoset device to mix Pip Tazocin so further communication re usage given, **Action** sepsis nurse will monitor, and check stock levels are sufficient. Use of Macoset device introduced to acute floors and Frailty due to success in ED, positive feedback on reducing preparation times. - Informatics are now able to pull red flag patient (sickest sepsis patients) data, we have looked back at 2021 up to month 11 and the average % for antibiotics administered under 1 hour is 56% rising to 87% administration under 2 hours. - Compliance of sepsis training reduced due to staffing shortages and vacancies. **Action-**Sepsis nurse delivering Team's training to both Emergency depts with aim to complete all staff (RNs and HCAs) by March 2022. education for Clinicians is being provided. - Staffing shortages have been affecting patient reviews and treatment times. **Action –** ED teams initiated cross site staffing support lead by lead nurse each site, use of flexible workforce and extra duty payments.	**Reasonable Assurance**

What do we aim to achieve?		Update		Progress rating
		Successes Category 2 patients in the emergency dept are been seen in rapid assessment at HRI rather than waiting for a cubicle. This has improved treatment times for patients with sepsis. Recruitment of sepsis champions in both EDs. Agreed that further purchase of sepsis trolleys required as part of reconfiguration plan.		
QP2.	Compliance of all elements of the sepsis 6 (BUFALO) to be improved to 50% **single elements to be improved to 90%**	**October 2021**	**November 2021**	
	Blood cultures	83.0%	81.7%	**Reasonable**
	Urine output	69.6%	68.3%	**Reasonable**
	Fluids	100%	97.5%	**Substantial**
	Antibiotics	100%	99.2%	**Substantial**
	Lactate	Unable to add Lactate to EPR		
	Oxygen	93.8%	95%	**Substantial**
	Each element will be measured (with exception of Lactate) from the sepsis screening tool and power plan within the electronic patient record.	**Progress work** - Element for blood culture has been confirmed as being measured accurately. - Recognition that drop in compliance in some elements e.g., fluids and antibiotics is affected by data pull not working with Athena for maternity patients. Effects 1 to 2 patients per month - Point of Care Testing Business case funding now passed and waiting next stage to initiate the reporting of blood gas and urinalysis results from Lab to EPR. Aim is for this to be completed by 31/03/2022 **Risks and mitigation's** - Not all Red flag sepsis patients are receiving blood cultures when sepsis six care bundle requests this, this is more prevalent in ward areas. **Action-** sepsis collaborative members to media the requirement through their work channels, sepsis nurse to visit clinical areas and remind clinicians, article added to sepsis press re importance of this element measure. Additionally, sepsis 6 education now on junior doctors induction training. - Data pull not working from Athena into KP+ this is affecting compliance figures of septic maternity patients. **Action-** sepsis bundle will be available in Athena in December which will then allow information to be present in the knowledge portal meaning maternity patient sepsis treatment compliance will be reported accurately. In meantime informatics are actioning a manual data pull.		

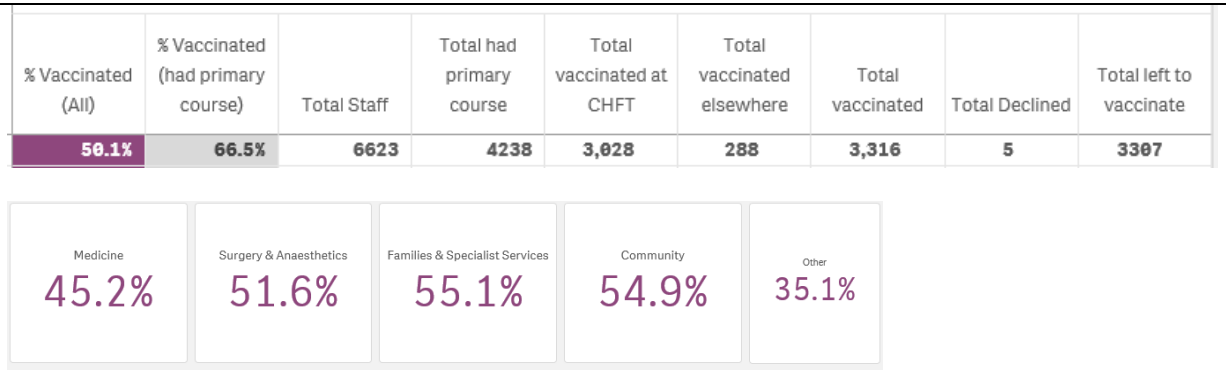
What do we aim to achieve?	Update	Progress rating
	<u>Successes</u> Target of total (50%) compliance achieved in Sept 55.9% Oct 56.3% and Nov 51.7%. Oxygen element changed to measure target saturation compliance resulting in more accurate recording.	
QP3. Establish sepsis skills training as part of essential safety training and achieve 40% concordance for eligible staff in year 1. This will be measured by training compliance records extracted from ESR and Lead Sepsis Nurse presentations.	Business intelligence have now provided the training numbers: - Consultants (except Obstetrics and Gynaecology) 250 - Foundation years (except Obstetrics and Gynaecology) 82 - CT (except Obstetrics and Gynaecology) 31 - ST (except Obstetrics and Gynaecology) 69 - Clinician Total **432** - Registered Nursing Total **672** **Progress work** - Sepsis training continuing on Teams and face to face with 50 eligible staff being trained in last 4 weeks. **Total so far 240** - Sepsis presentation now separated into clinician and registered nurse. To be approved at January's sepsis collaborative meeting then proceed to approval at WEB and nursing/midwifery group before upload to Essential training. - Sepsis champions supporting the training of registered nurses in clinical areas. **<u>Risks and mitigations</u>** - Sepsis recognition and treatment not currently part of essential safety training. **Action-** agreed at sepsis collaborative that training should be mandatory and with a 3-year update. - Access to training staff proving difficult at times due to ward/dept pressures and movement of staff to support staffing shortages. **Action-** sepsis nurse providing access to training evening and weekends and utilising sepsis champions to assist where possible.	**Limited assurance**

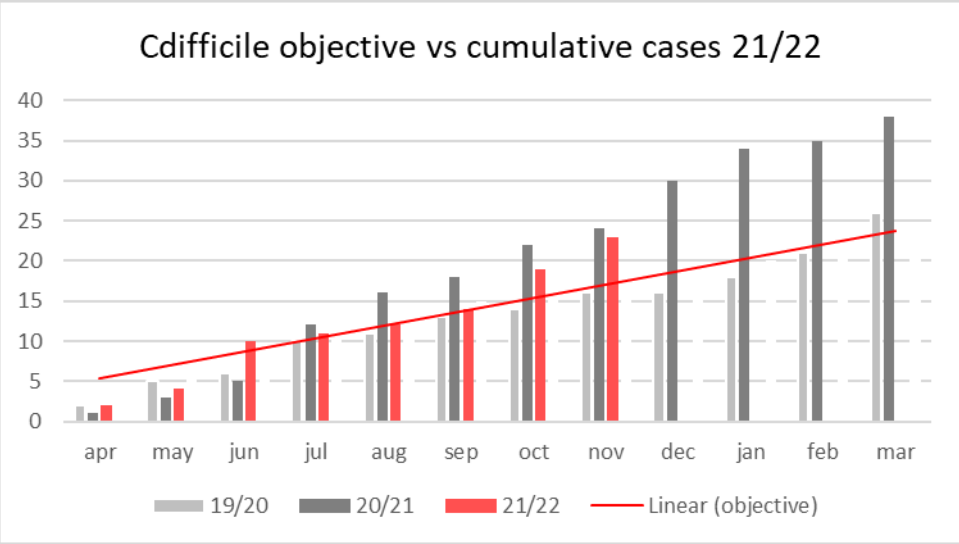
10.2 Reduce number of Hospital Acquired Infections including COVID-19 (Quality Account Priority)

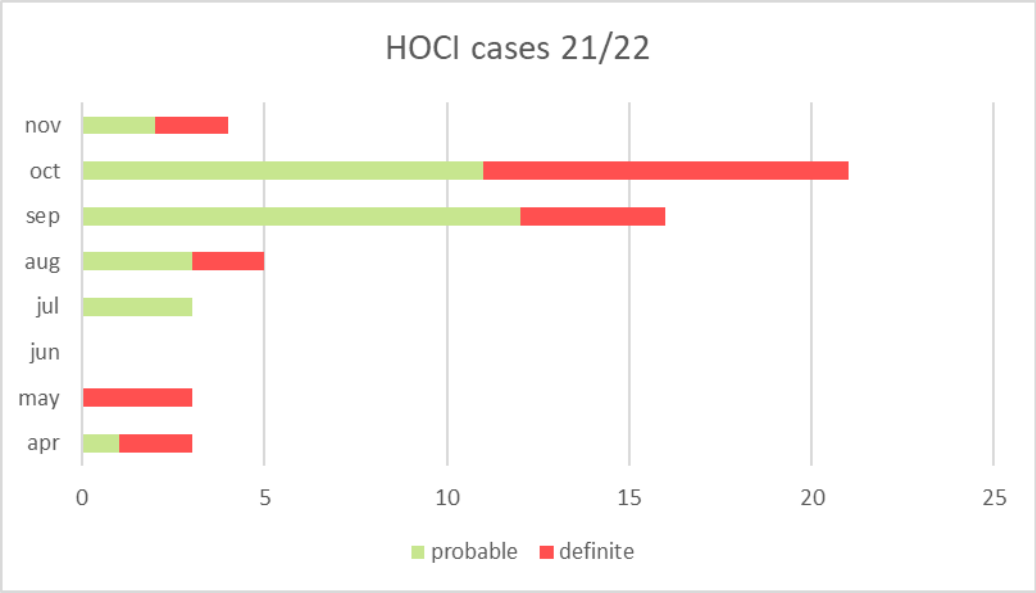
Operational Leads – Dr David Birkenhead, Dr Vivek Nayak and Gillian Manojlovic

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

What do we aim to achieve?	Update	Progress rating
QP1. Through the testing workstream we will ensure that all CHFT patient and colleague testing strategies are compliant with National and Local guidance. This will be measured by performance against patient testing regimes.	CHFT are compliant with the minimal national patient testing regime and also include additional tests as part of our local guidance	**Full assurance**
	Covid testing compliance stands at 86%	**Reasonable Assurance**
	Lateral Flow Device (LFD) testing is in place as per national guidance for staff. This is to be encouraged with staff but is not mandated. The last data reported identified a decreasing trend for LFD. We are no longer able to track this data due to staff being instructed to upload results onto the National portal. Continuing actions taken to promote LFD uptake include communication via leadership briefings and the MUST Do messages.	**Reasonable Assurance**
QP2. Support a system wide approach to Covid-19 vaccination programme through CHFT vaccine centres and support to the national programme.	The trust continues to plan for its vaccine programme and will implement this alongside national guidance. Staff vaccination booster clinics have been opened (27/09/21)	**Substantial assurance**
2a Establish specialised vaccine clinics for people with Learning Disabilities (LD)	Specialised clinics have been established to support people with a learning disability to receive their vaccines and will be included in future planning	**Substantial assurance**
2b Establish clinics for people with allergies	Specialised clinics for patients with multiple allergies and/or previous anaphylaxis were undertaken, again outside of the routine clinics, supported by a Consultant Anaesthetist, senior nursing, and administration staff. A total of 17 allergy patients have been through the clinics.	**Full Assurance**

What do we aim to achieve?		Update	Progress rating
		The final allergy clinic session was on the 28 June 2021 for the administration of second doses. All future allergy referrals for the whole of West Yorkshire where there is the need to administer the vaccine in an acute setting will be managed at Airedale Hospital.	
	2c Through our community teams support the vaccine programme across Calderdale	The community healthcare division has proactively supported the vaccination programmes across Calderdale place and has included this in the system wide winter planning.	**Substantial assurance**
	2d Through our partnerships support the vaccine programme across Kirklees	CHFT have remained an active partner on the Executive Partnership meeting for Kirklees and have contributed both in leadership activities and resource support to the programme	**Substantial assurance**
	This will be measured as a narrative against the indicators and numbers of people vaccinated where data is available		**Reasonable Assurance**
QP3.	Reduce the number of preventable	A 'deep dive' of the 49 C-diff cases from 2020/2021 was undertaken in May 2021; key learning was identified, and an action plan has been developed which is being led by the Infection Control	**Limited assurance**

What do we aim to achieve?		Update	Progress rating
	Clostridium Difficile infections This will be measured by ensuring we do not exceed the threshold of 22 cases set in 20/21	Doctor/Consultant Microbiologist. The 21/22 objective for C.difficile objective of 22 cases which is a reduction of one case based on the 2019 data of 18 hospital onset healthcare associated (HOHA) cases plus 5 community onset healthcare associated (COHA) cases. This will be monitored in the Integrated Performance Report (IPR). As of the end of November the objective has been exceeded – currently 23 cases.  	
QP4.	Ensure strategies are in place to minimise Hospital Onset Covid-19 Infection (HOCI) This will be measured by the rate of HOCI each month.	COVID patient pathways are in place to minimise the risk. Any Hospital-Onset COVID-19 Infections (HOCI) identified are reported immediately and a rapid RCA completed. HOCIs are currently reported weekly to Infection Prevention and Control (IPC) Gold and monthly to IPC Performance Board. Every action count tools are being used to support alongside the updated IPC guidance Lessons learnt from HOCI are shared to support organisational learning. The IPC Board Assurance Framework (BAF) is reviewed within the governance structures.	**Reasonable Assurance**

What do we aim to achieve?	Update	Progress rating
	A significant increase in October and November was associated with a number of outbreaks. A review of the Trusts management of HOCI cases was undertaken by NHSEI and no additional actions were advised.  	

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

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

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

What do we aim to achieve?	Current update	Progress rating
QP1. Implement and monitor effectiveness of the standard operating procedure to prevent any 12-hour breaches within the Emergency Department (ED) This will be measured by: • Number of (NHSE/I) reportable 12-hour breaches	Presented to Digital Quality Board in June that new reporting mechanism (on discharge) implemented April 2021 ensures that all length of stay (LOS) in the ED are captured and reported accurately. **No change still capturing any LoS >12 hours and no reportable 12 LOS have ensued**	**Reasonable Assurance**
• Internal standard: Number of patients who waited >12 hour within the department from time of arrival	Zero tolerance as reportable. There were two patients over 12-hour breaches last month discharged home non-reportable. **This has increased to 178 patients having a LoS over 12 hours non-reportable in November all patients have been risk assessed and RCA completed on datix**	**Limited assurance**
• Training delivered for on call teams to support implementation of the SOP	Surge and escalation document in use ensuring wide communication between all on call elements and tactical leads. **In use and distributed to clinical commanders / night matrons and on call managers session delivered by ED consultant**	**Limited assurance**
QP2. To align reporting systems with Cerner and the DATIX incident reporting system. This will be measured by • Establishment of >12hr DTA breach report from Cerner that matches incident reporting	New datix format for 12-hour LOS implemented by risk	**Substantial assurance**

What do we aim to achieve?	Current update	Progress rating
QP3. Improved documentation of Intentional care rounds to ensure patients are receiving effective pressure area care, nutrition and hydration. This will be measured through: • No of colleagues who undertake training for intentional care rounds	Documentation audit in place to provide assurance to lead nurses that standards are met. Requires further monitoring to establish success. **Ongoing**	**Reasonable Assurance**
• Monthly audit of patient cases to review compliance with clinical documentation	Care is reviewed via datix	**Reasonable Assurance**

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

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

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

What do we aim to achieve?	Current update	Progress rating
Reduce the total number of falls. Reduced number of harms falls by 10%.	- Falls Collaborative continues to meet every 6 weeks. - Patient and carer falls leaflet has been updated. - Carrying out an audit of the moderate to severe harm falls over the last six months to identify themes and generate an action plan. - Falls prevention intervention care plan has been created and will be disseminated across the wards. Currently working with Communications team to create this. This care plan will eventually be uploaded onto EPR however until then the wards will be informed via their matrons, ward managers and senior nurses. See attached - Falls and Fragility Fracture Audit Programme (FFFAP) Quality Improvement project underway. Identified area: Lying and Standing Blood Pressures on HRI Acute Floor. - Compliance with the SureFalls devices has significantly improved and will continue until all wards hit their 75% compliance rate. The ward managers have been informed of how to order the falls devices once their reach their compliance rate. - Falls policy has been updated to reflect specific timeframes for assessments. - Learning from Serious Investigations will be disseminated through the Falls Collaborative. HRI 6 have mapped out their ward and identified areas that are high risk of falls following an increased number of falls. Since mapping out where staff should be located in relation to use of laptops, their number of falls have significantly reduced. and the Falls lead have met to create a risk assessment to support the ward managers/nurses in charge with their decision making as to where a patient will be placed on a ward. i.e. in a visible bed/bay/cohorting patients/use of side rooms. - Falls Link Practitioners – Falls Leads are in process of developing the initial learning/education session. Names are still being collected and a role specification has been drafted. - Bed rail guidance being reviewed and developing a flow chart for staff to follow re bed rail risk assessment.	**Reasonable Assurance**

<table>
<tr><th>What do we aim to achieve?</th><th>Current update</th><th>Progress rating</th></tr>
<tr><td></td><td>
<table>
<tr><th>Month</th><th>Dec-2019</th><th>Jan-2020</th><th>Feb-2020</th><th>Mar-2020</th><th>May-2021</th><th>Jun-2021</th><th>Jul-2021</th><th>Aug-2021</th><th>Sep-2021</th><th>Oct-2021</th><th>Nov-2021</th><th>Dec-2021</th></tr>
<tr><td>No. of Falls</td><td>154</td><td>166</td><td>146</td><td>157</td><td>151</td><td>158</td><td>152</td><td>189</td><td>166</td><td>197</td><td>144</td><td>127</td></tr>
<tr><td>No. of Harm Falls</td><td>6</td><td>1</td><td>0</td><td>2</td><td>3</td><td>1</td><td>4</td><td>3</td><td>5</td><td>3</td><td>3</td><td>4</td></tr>
<tr><td>Falls per 1000 bed days</td><td>7.2</td><td>7.8</td><td>7.4</td><td>8.8</td><td>8.8</td><td>9.5</td><td>8.3</td><td>9.9</td><td>8.7</td><td>10.0</td><td>7.4</td><td>8.7</td></tr>
</table>
</td><td></td></tr>
<tr><td>Slip trip policy to include measurable falls assessment risk target</td><td>This is still in progress in line with the falls EPR workstream and review of the multifactorial risk assessment and Falls care plan on EPR with Bradford’s Falls Lead. This is ongoing.</td><td>Limited Assurance</td></tr>
<tr><td>Implement audits to check progress against targets</td><td>Audits on lying and standing blood pressures, mobility assessments and medication reviews currently being collected on W6.
Challenges have been identified with auditing accurately on EPR due to staff documenting in areas that cannot be audited. Work is being undertaken with Bradford’s falls leads to review the multifactorial falls risk assessment on EPR to include lying and standing blood pressures, mobility assessments and medication review sections to be fully audited.
The Falls Leads are in process of drafting up the falls link practitioner roles, they will support with auditing on their wards.
Audits are being completed weekly in relation to the Surefalls device training compliance.
FFFAP QI project has been launched and is focussing on improving lying and standing blood pressure readings to be completed within 48 hours of admission into hospital.</td><td>Reasonable Assurance</td></tr>
</table>

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

Operational Leads – Mary Kiely, Christopher Roberts and Christopher Button

We will this year undertake quality improvements to:

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

What do we aim to achieve?	Current update	Progress rating
QP1. Implement a 7-day service across community services Measure impact of 7 day working across the Key Performance Indicators End of Life (EoL) dashboards	The 7 day service is now in place. Data is successfully being collected via a digital platform and the service is achieving on all Key Performance Indicators (KPI's). KPI data is reported directly to the monthly community patient safety and Quality Board (PSQB) meeting.	**Substantial assurance**
QP2. Implement a 7-day service within the in-patient areas Measure impact of 7 day working across the Key Performance Indicators EoL dashboards	Due to staffing/ capacity issues a 7 day service is not currently feasible. Recruitment drive in place however it is likely it will be mid 2022 before a full 7 day service will be in place.	**Limited assurance**
QP3. Improve access to Electronic Palliative Care Co-ordination Systems (ePaCCs) for patients within Frailty service This will be measured through an audit of records every quarter	Improve access to EPaCCs – Currently there is limited staff within the acute trust who have access to see or document on EPaCCs template through SystmOne Project underway to increase the number of people to have access to SystmOne and training on EPaCCs.	**Limited assurance**
QP4. Introduce a standard(s) that will improve a person's experience pre & post bereavement delivered by ward teams This will be measured by qualitative narrative quarterly by EoL care facilitator.	Further information to be circulated. The bereavement support service/team has recently won several awards recognising the success of the service.	**Substantial assurance**
QP5. Review the Bereaved relatives telephone support service This will be measured by a qualitative and quantitative review of the service established during the pandemic	Further information to be circulated. The bereavement support service/team has recently won several awards recognising the success of the service.	**Substantial assurance**
QP6. Review Visitors guidance in line with national guidance and monitor compliance This will be measured by a Quarterly audit of the guidance in relation to EoL patients	The guidance has now been revised to reflect patient prognosis.	**Substantial assurance**

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

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

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

What do we aim to achieve?	Current Update	Progress rating
QP1. Optimise the Clinical Record 1a. Complete the in-depth analysis	Company identified – stuck in the procurement process at the moment. July 21 – Meeting arranged with company 20.07.21 Sept 21 – Meeting took place with the company new Chief Nursing Informatics Officer (CNIO) needs to become up to date with background and then drive this forward to bring a plan back to next meeting. Dec 21- New CIO looking at ways of optimisation currently the external review has been paused.	**Reasonable Assurance**
1b. Benchmark	Subject to the outcome of the in-depth analysis	**Reasonable Assurance**
1c. Set local standards	Subject to the outcome of the benchmarking	**Reasonable Assurance**
QP2. Trial the use of the Digital White Board Identify areas to trial over a 4-week period - implement the white boards identifying data that can be pulled and measured to determine progress and future planning.	Trial period commenced – end date 15th June 21. July 21 – evaluation of the trial underway. Sept 21 – trial completed and CNIO and Chief Clinical Informatics Officer (CCIO) to meet to review feedback and discuss future innovations with Cerner. Dec 21- Further meetings taken place with Cerner re: White board and working with Director of Operations (DOP) for medicine to configure the white boards to CHFT needs and work alongside plan for every patient. Task and finish group taken place and electronic patient record (EPR) team building a mock board in cert to review and start a trial.	**Substantial assurance**

What do we aim to achieve?	Current Update	Progress rating
QP3. Carry out a full review of the Ward Assurance within the Knowledge Portal Plus (KP+). 3a. Look at current data captured with service users	This will be reviewed by the subject matter experts (SMEs) and Ward Managers following the Work Together Get Results (WTGR) piece. Work to commence July 202. July 21 – Task and Finish Groups to be formed now WTGR completed to look at data capture. Sept 21- Task and finish groups under way. All first ones undertaken and subject matter expert's (SME) reviewing the documentation to bring back to next meeting. Dec 21- Task and finish groups completed and Chief Nurse Information Officer (CNIO) and corporate matron meeting with Robert Cox and team to make sure all areas are pulling from the correct place.	**Substantial assurance**
3b. Assess whether data relevant	Full review of data to be carried out regarding not only relevance, but also how staff can make it more meaningful to them in addressing shortfalls. July 21 – Task and Finish Groups to be formed now WTGR completed to assess whether data relevant. Sept 21 – SME's reviewing documentation bring back to task and finish groups. Dec 21- All key metrics have been agreed by SME's and are all in line with national guidance. Some questions modified and removed.	**Substantial assurance**
3c. Agree metrics for collection	Metrics already agreed upon – review of data being extracted. Sept 21- Metrics may change according to task and finish group decisions. Dec 21 – As above meeting with data team and ward assurance team to improve data collection.	**Substantial assurance**

What do we aim to achieve?	Current Update	Progress rating
QP4. Ensure Ward Managers and Matrons own their own ward data using KP+ 4a. Ensure that all Ward Managers and Matrons have access to KP+	Staff groups contacted already – awaiting feedback. Aim to complete this by end of June 2021. July 21 – engaged with Matrons and Managers – access arranged for those who did not have access. Sept 21- This has been put on hold until task and finish groups complete there woke to train all staff the correct way. Dec 21- Meeting with CNIO and data quality team to make sure all the data is pulling correctly in ward assurance to give the wards the correct data.	**Reasonable Assurance**
4b. Provide training in the use of KP+ for Ward Managers and Matrons	This was carried out in November 2020 – further engagement with staff on the 6th August 2021 through Chief Nurse's briefing. Sept 21- All ward managers have been asked to make sure they have access to KP+ Dec 21- Plan to roll out in January 2022.	**Reasonable Assurance**
4c. Embed review of KP+ into daily practice	This will be an action from the WTGR – start end of July 2021. July 21 – further training 6th August 2021 at Chief Nurse's briefing. Sept 21- Once task and finish groups completed this will be a session on Chief Nurse's briefing. Dec 21- Review of KP+ and to work with senior nursing leaders to improve dashboards for ward managers/ Matrons	**Reasonable Assurance**

What do we aim to achieve?	Current Update	Progress rating
QP5. Audit clinical records using an audit tool. Audit 5 sets of records per week by Ward Manager reporting and act upon findings.	Audit to be carried out by Matrons – one per month per each of their wards – to start end of July 2021. July 21 – roll out delayed due to delay in completion of WTGR Sept 21- As above. Dec 21- Individualised care document to be updated and distributed to Matron's and ward managers. Changes implemented on feedback from ward 5 pilot making it easier for staff to access certain areas of the notes. This then needs to be driven by Associate Directors of Nursing (ADN)	**Reasonable Assurance**
QP6. Identify and establish a project team that can drive the improvement of data entry into EPR across the Trust. 6a. Identify the team	This will include Associate Director of Nursing, Matron and Ward Managers across the Trust.	**Substantial assurance**
6b. Identify outcomes wanting to achieve	Working Together Get Results completed at the end of July, face to face to ensure optimum engagement obtained. Action Plan to be completed from the results of the WTGR. Sept 21- Task and finish groups have been established. Which are being led by the subject matter experts Dec 21 – Clinical Records and Optimisation group will drive this forward in the future alongside ward Assurance tool.	**Reasonable Assurance**
6c. Agree defined goals and action plan that reflects this	Outcome of the WTGR will determine the action plan – aim for this to be available by the end of July 2021. July 21 - Sessions completed end of July – working towards action plan middle of August 2021. Sept 21-. Subject matter experts leading the review of assessment documentation within EPR. Amendments can then be made to extract data at the backend of EPR Dec 21- Review of the ward assurance will continue.	**Reasonable Assurance**

What do we aim to achieve?	Current Update	Progress rating
QP7. Ensure training in the use of EPR reflects the standards laid down by the Trust and that it reflects training needs of the staff 7a. Support the Training team to ensure training meets the needs of the service user – fully aligned to roles and responsibilities	Task and Finish Group set up 2/12 ago to review the training plans for medical, nursing and healthcare assistant (HCA) groups as a priority. Some representation from nursing but not medical teams – seeking support from them. July 21 - Progressing well with projected completion by the end of August 2021. Sept 21- Training team for digital health are attending ward areas also with set goals to achieve. CNIO working with Matrons and ward manager for the area to make sure correct goals are set. Ward 5 identified as first ward. Dec 21- Supporting the training team to introduce working again in the trust from being at home throughout the pandemic. Further areas identified for them to work in in coming months.	**Reasonable Assurance**
7b. Encourage Training Team to explore ways in which service users can be supported e.g. online, face to face, digitally	This is being reviewed within THIS. Initial plans e-Learning developer starting in post on 21.06.21 with an immediate action to create e-Learning modules for medical, nursing and HCA roles for August 2021. July 21 – E Learning Developer now in post and e learning sessions already underway. Sept 21- Training team attending ward areas for 3 weeks at a time working with nurses on the ward making sure EPR is being used to its most effective and documentation is all in the correct place. Dec 21 –New E-Learning modules have been produced and are currently in the testing phase.	**Substantial assurance**

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

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

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

What do we aim to achieve?	Current update	Progress rating
1. A minimum of 90% of staff required to complete Malnutrition Universal Screening Tool (MUST) training will be compliant	For the month of November all Divisions remain above 90% compliance except for Medicine. **Action:** The Medical Matrons have been asked to encourage and support all areas in completing this training. If compliance doesn't improve individual letters will be sent out to the staff not compliant encouraging them to complete. There is currently an issue with Community data – they are showing as 100% compliant but with only 3 members of staff registered as needing the training. **Action:** Community teams are looking into this with the IT/ESR team to rectify	**Substantial assurance**
2. A minimum of 90% of staff required to complete Screening Tool for the Assessment of Malnutrition in Paediatrics (STAMP) training will be compliant	November compliance with STAMP training still progressing well and has now reached 80%	**Reasonable assurance**
3. 100% of adult in-patients will have a MUST assessment within 24 hours of admission/transfer	October 2021 – 13.9% November 2021 – 12.9% which is a slight reduction from October **Mitigation** ▪ Safety huddle inclusion within clinical areas as prompt for completion for clinical staff. ▪ Inclusion within Journey to Outstanding clinical area reviews.	**Limited assurance**

<table>
<tr><th>What do we aim to achieve?</th><th>Current update</th><th>Progress rating</th></tr>
<tr><td></td><td>Actions
WTGR improvement work ongoing with regards clinical documentation. It has been agreed that we will remove the need for a MUST assessment completing on Transfer. This should improve compliance
Changes are live and staff are being reminded during other training sessions</td><td></td></tr>
<tr><td>4. Trust aspiration to achieve 100% of paediatric in-patients having a STAMP assessment within 24 hours of admission & weekly thereafter</td><td>This data isn’t currently available on the ward assurance dashboard on K+, a request has been made to include this and is underway.</td><td>Reasonable assurance</td></tr>
<tr><td>5. 100% of adult in-patients with a MUST score of 2 or above will be referred to the dietetic service</td><td>November 2021 3.2% compliant

The above figure doesn’t reflect the current position. The automated system has resulted in an increase in referrals daily. An issue has been identified with data capture and will be reviewed. The dietetic team have also been making some changes to the referral data required from wards. This will improve the quality of information received on the referrals</td><td>Limited assurance</td></tr>
<tr><td>6. 100% of paediatric in-patients with a STAMP score of 4 or above will be referred for nutritional support (i.e., dietician, nutritional support team or consultant)</td><td>This data is not currently available on the ward assurance dashboard on K+, a request has been made to include this and is being progressed.</td><td>Limited assurance</td></tr>
<tr><td>7. A minimum of 90% of staff from wards that are regular users or high users of nasogastric tube feeds will be compliant with nasogastric training</td><td>High Users Regular Users<table><tr><td>17</td><td>ICU</td><td>Paeds</td><td>Comm Paeds</td><td>Hoop</td><td>Resp</td><td>6AB</td><td>8C</td><td>Stroke</td><td>20</td></tr><tr><td>88.5%</td><td>56.2%</td><td>58.7%</td><td>92.9%</td><td>91.7%</td><td>84%</td><td>8.7%</td><td>57.1%</td><td>78.9%</td><td>61.2%</td></tr></table>All areas have seen a significant increase in training compliance except ward 6AB.
Action:
Ward manager and matron have been contacted by the lead nurse for nutrition to arrange training. Places available on Respiratory for 6AB to join also.
Individual letters will be sent out to staff encouraging them to arrange training.</td><td>Reasonable assurance</td></tr>
</table>

What do we aim to achieve?	Current update	Progress rating
8. Nasogastric and STAMP training will be added to the electronic staff record (ESR) platform to enable monitoring by ward managers & matrons	Nasogastric tube training data is available via education and learning dashboard of Business Intelligence spine of ESR 3.6.21 update - ESR compliance is based on the target audiences on position not on an individual level. It must be everyone in that position as they do the same job. Option: To try to put through the essential safety training (EST) proforma and ask it to be set up as an EST role specific course. 3.6.21 update - STAMP training has been requested via EST process to be reported. There is currently a delay with changes on ESR due to the system having an update. This action will be revisited in January 2022.	**Limited assurance**
9. Meal service will be safe, organised, and well led on all wards at CHFT	Divisional actions plan and observation of service delivery in ward areas. Patient feedback collated by ISS and Calderdale and Huddersfield Solutions (CHS) catering depts. Feedback through patient discussions and complaints/incidents Observation of mealtimes during Observe and Act framework, practice will be monitored through this process and shared at ward level. There is currently a new process being trailed on ward 5 HRI which includes protected mealtimes for patients. A routine has been developed regarding preparing patients for meals (cleaning tables, sitting patients up or out in a chair if needed, providing hand hygiene wipes). All tests/discussions with patients unless urgent to be carried out before or after meals Medications to be administered after patients have eaten. Feedback regarding this process will be reviewed in the New Year and a SOP developed. Leadership observations at ward level	**Reasonable assurance**

What do we aim to achieve?	Current update	Progress rating
10. The red tray/lid and jug lid alert system will be used consistently and appropriately on all adult in-patient wards	Trust wide initiative not consistently utilised in all ward areas. The use of Red Trays/Lids will be encouraged in each ward area by matrons. Patients with additional nutritional needs will be discussed daily in the ward safety huddles The use of magnets behind the beds will also be reviewed by the matrons and support given to the wards to ensure correct use. Question included within Observe and Act observation tool to monitor local compliance (Theme D. Food and drink) Key themes to date (3 wards)-preparation and assistance at mealtimes and utilisation of red trays and red jugs lids	**Reasonable assurance**
11. CHFT guidelines, policies, strategies, pathways, decision making tools will reflect current NHS guidelines & NICE guidance	CHFT Policies and guidance is reviewed against current NHS guidelines & NICE guidance via the nutrition operational meeting. Includes: • Nutrition and hydration policy (including allergen management) • Food hygiene policy • Parenteral nutrition policy Reviews undertaken as new guidance released and via CHFT policy review process.	**Substantial assurance**
12. The ward assurance indicators for nutrition and hydration will be reviewed for appropriateness and accurate affiliation with CHFT's nutritional policies, guideline etc.	Ward assurance documentation indicators reflect the current guidance within the current Nutrition and hydration policy. Further actions-for discussion of ward assurance indicators at WTGR	**Reasonable assurance**
13. A staff education plan to be developed and actioned to ensure staff know when a fluid balance chart is indicated and understand the importance of monitoring and recording correctly within EPR	The group have investigated the Fluid balance charts on EPR. All patients must have a fluid balance chart initiated within 8 hours of admission regardless of need. Work is ongoing regarding trying to identify some triggers for the initiation of the fluid balance chart. The lead nurse for nutrition is working on adding the Must competency to the	**Limited assurance**

What do we aim to achieve?	Current update	Progress rating
	healthcare assistant (HCA) competency pack. Trust compliance with clinical recording of fluid balance on EPR remains static **Nov 2021 – 18.8%** <u>Risks</u> Inaccurate monitoring and recording of fluid balance chart on EPR impacting on patient's clinical outcome and patient experience. <u>Mitigation of risks</u> Clinical based actions-requests via medical team with clear guidance as to rationale for FBC. Accuracy of monitoring/compliance through ward assurance documentation <u>Further Actions</u> NVQ team to make additions to HCA competencies. Review process of indication/recording/monitoring requirement through WTGR workshop.	
14. Theme D (Food & Drink) of Observe & Act reports to be monitored at monthly Nutrition Operational group meetings for information, discussion, and potential shared learning	Multiple areas completed utilising Observe and Act framework completed. <u>Further actions</u> Monthly agenda item for discussion and shared learning at nutrition operational meeting.	**Substantial assurance**
15. A CHFT Food & Drink strategy to be developed to sit alongside the comprehensive CHFT Nutrition and Hydration policy (recommendation of the 2014 Hospital Food Standard panel report Department of Health)	Strategy to be developed with identified lead- New Lead identified work will now commence of developing a CHFT Food & Drink strategy	**Reasonable assurance**

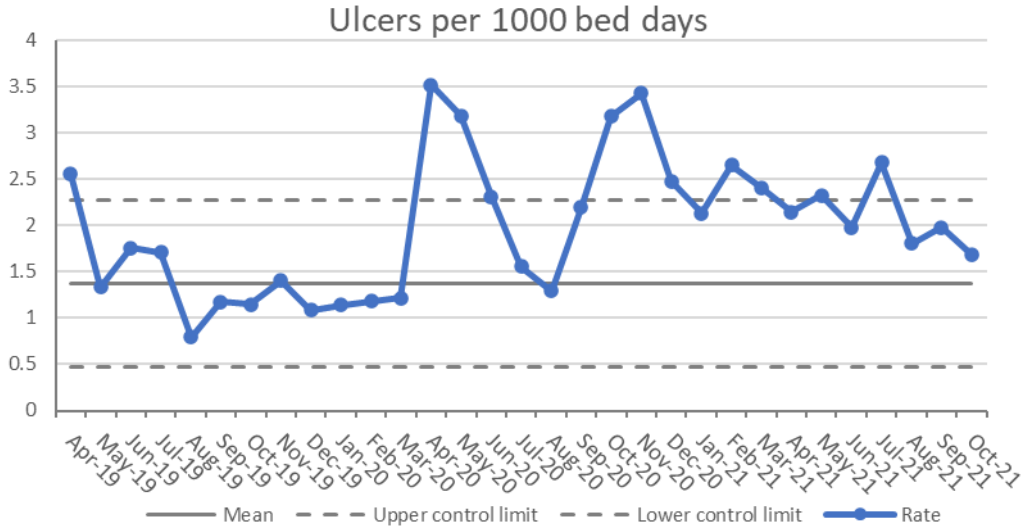
10.8 Reduction in the number of CHFT acquired pressure ulcers (Focused Quality Priority)

Operational Lead – Judy Harker

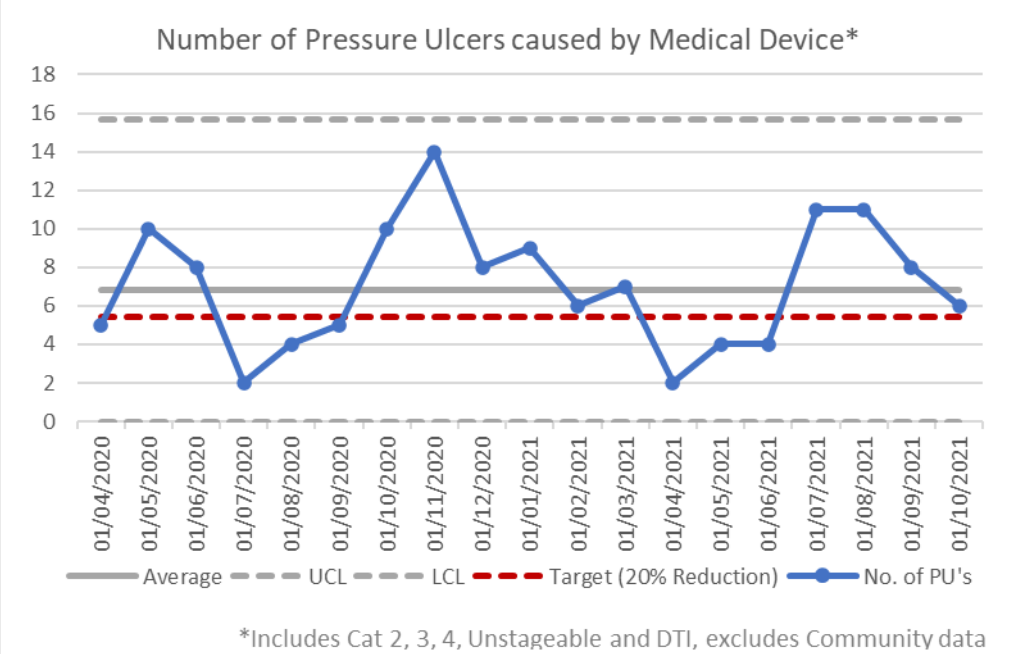
Incidence of hospital acquired pressure ulcers remains within target including heel and medical device pressure ulcers. Good progress has been made with ward assurance metrics which have been aligned to NICE quality standards and EPR as part of record keeping quality priority. Community pressure ulcer KPI has been agreed with data to follow in the next Quality Priority update. The Trust has witnessed an increasing trend in red pressure ulcer incidents. Learning from pressure ulcer investigations continues to be a key focus for the collaborative.

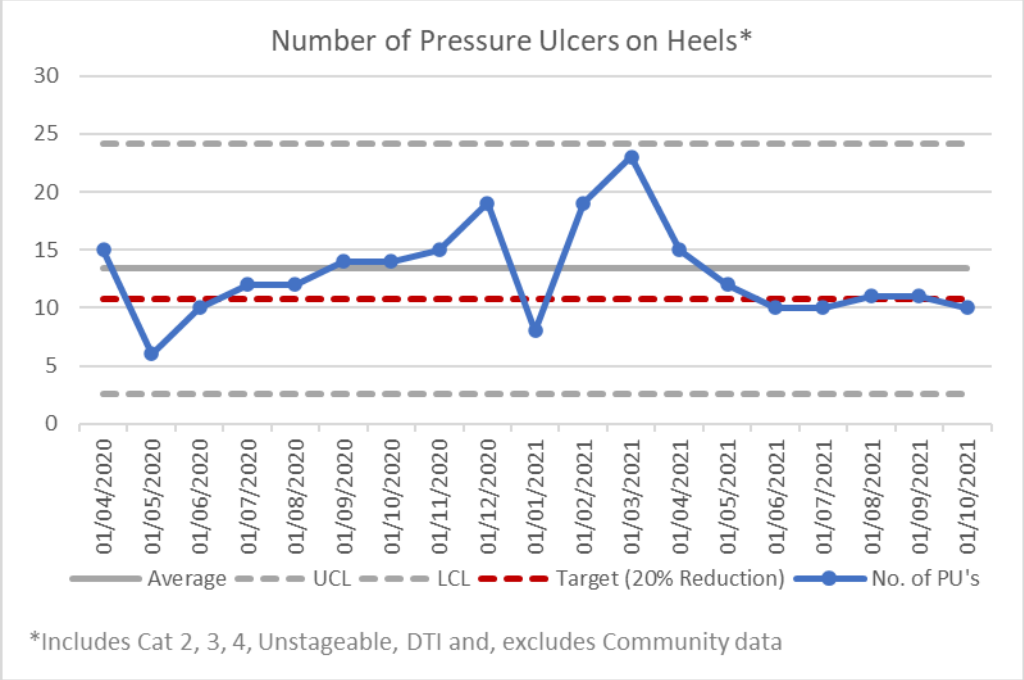
We will this year undertake quality improvements to:

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

What do we aim to achieve?	Current Update – September / October 2021	Progress rating	Next period
Reduction in the Incidence* of hospital-acquired pressure ulcers by 10%. This will be measured by incident data		**Reasonable assurance**	Continue to monitor and validate November data As frontline pressures allow, continue to embed quality initiatives into clinical practice Trust Pressure Ulcer Prevention and Management policy to be ratified and launched in January 2022.

What do we aim to achieve?	Current Update – September / October 2021	Progress rating	Next period
	There has been a reduction in incidence of hospital acquired pressure ulcers from September to October 2021. Overall, the incidence rate has fallen from 2.15 in April to 1.69 in October 2021. **Risk** Due to operational frontline pressures, there has been a delay in quality improvement work within the Divisions and Tissue Viability service. Further risk of staff not reporting pressure ulcers via Datix due to high workload. **Mitigation** Once the capacity in the Tissue Viability service is increased following recruitment of additional specialist nurses, there should be more opportunities for quality improvement to support divisions. 2 out of 3 specialist Tissue Viability Nurse posts have now started in post. Divisions have identified Quality Priority Leads for pressure ulcer reduction. Improvement work is being reported into Pressure Ulcer Collaborative Group. Enhanced Ward Dashboard now available via Knowledge Portal which highlights wards which are outliers against staffing and nursing / pressure ulcer quality indicators. Divisional ADNs are reviewing all pressure ulcers acquired on enhanced ward dashboards on a weekly basis Quality and Safety Team are revising Datix support and training to all clinical areas. The Trust has purchased and implemented 160 new alternating pressure mattresses for use across HRI. Training has been delivered and outdated equipment decommissioned.		

What do we aim to achieve?	Current Update – September / October 2021	Progress rating	Next period
Reduction in the incidence* of hospital-acquired medical device related pressure ulcers by 20%. This will be measured by incident data	 There has been a decrease in the number of device related pressure ulcers from August to October 2021. Devices causing pressure damage in October 2021 included CPAP hoods, endotracheal tubes, catheters, cannulae and compression devices. **Risk** Predicted increase in device related pressure ulcers over coming weeks / months in response to surge in covid admissions.	**Reasonable assurance**	Continue to monitor and validate October data. Collaborate with other Trusts to share learning. Trust Pressure Ulcer Prevention and Management policy to be ratified and launched in January 2022. Share resources and learning from Leeds Critical Care Pressure Ulcer educational event.

What do we aim to achieve?	Current Update – September / October 2021	Progress rating	Next period
	Mitigation Medical device related pressure ulcers featured as a bite-sized training event during Stop the Pressure week November 2021. Recording available on Tissue Viability webpage and shared with Critical Care staff. ICU are conducting an evaluation of a foam medical device to be used during proning to protect vulnerable areas such as the face. Materials Management are keeping key preventative dressings and gel pads on ICU top up.		
Reduction in the incidence* of hospital-acquired heel pressure ulcers by 20%. This will be measured by incident data		**Reasonable assurance**	Continue to monitor and validate October data Remaining wards will receive Off-loading devices on top up via Materials Management Heel Device Selection Guide to be devised by Podiatry Team in January 2022 Explore feasibility of using QR codes on plaster casts to provide pressure ulcer information

What do we aim to achieve?	Current Update – September / October 2021	Progress rating	Next period
	Hospital acquired heel pressure ulcers remain with within target. 70% of the Trust adult wards have inflatable heel devices on top up via Materials Management. Heel Pressure Ulcer Working Together to Get Results events took place in September and October 2021. Action plan developed.		Spread QI from Orthopaedic OPD to Orthopaedic wards in relation to heel pressure ulcer prevention
Reduction in the number of Orange harm pressure ulcers by 50%	Statistical Process Control (SPC) charts to follow in next report. Note: Level of harm and investigation can change depending on outcome of validation at Orange Panel. Data can therefore change over time. Meetings have been held between Divisional Governance Leads and Tissue Viability to ensure consistency in processes for managing pressure ulcer incidents. 3 Orange incidents were declared in September. Due to delays in validating incidents, October data is not currently available.	**Reasonable assurance**	Actions in place to address lapses in care identified in RCAs. Work to commence on reviewing Datix build and have capability to extract pressure ulcer contributory factors to support system wide learning.
No Red serious pressure ulcer incidents	There have been 2 red incidents since April 2021. 199109 from the 24/6/21 - patient attended plaster room for removal below knee backslab, applied in A/E 7th June unstageable sore seen behind crease of knee, grade 4 sore to lateral malleolus, 202745 from the 8/9/21 Significant deterioration to pressure ulcer during admission. Previously a category 3 which has deteriorated to a category 4. HRI ward 15. Tissue Viability Nurse (TVN) involvement with both cases	**Limited assurance**	Serious incident (SI) investigation ongoing, report due at CCG 20/1/22 Si investigation ongoing, report due at CCG 02/02/22

What do we aim to achieve?	Current Update – September / October 2021	Progress rating	Next period
95% or more of patients in hospital will have a pressure ulcer risk assessment within 6 hours of admission to Trust / transfer to ward. This will be measured by ward assurance	31% of patients in hospital received a risk assessment within 6 hours of admission/transfer. **Risk** Data would indicate that 98% of patients have received a risk assessment within 7 days. Analysis of data would suggest that whilst risk assessments are being carried out in ED, they are not consistently being repeated once a patient has transferred to a new ward. This results in a failure to implement or delayed implementation of preventative interventions. **Mitigation** Record Keeping Pressure Ulcer Quality Priority improvement work is now nearing completion. Record keeping 'must do's' identified. Collaboration with Informatics to ensure data is extracted from correct location within EPR. Surgical divisions are using safety huddles to highlight pressure ulcer risk assessment requirements following actions agreed at sisters meetings	**Limited assurance**	Training to be rolled out across Trust regarding EPR 'must do's'. Screensaver to be shared with staff to increase awareness of risk assessment expectations.
95% or more of at-risk patients in hospital will have a sskin bundle identified and completed. This will be measured by ward assurance	Data incomplete. **Risk** Gaps in skin bundles poses risk for pressure ulcer development. **Mitigation** Record Keeping Pressure Ulcer Quality Priority improvement work is now nearing completion. Record keeping 'must do's' identified. Collaboration with Informatics to ensure data is extracted from correct location within EPR. Each element of the aSSKINg (Assessment, Surface, Skin Inspection, Keep Moving, Incontinence, Nutrition and Hydration, Giving Information) bundle was covered in virtual training delivered during Stop The Pressure week Nov 2021.	**Limited assurance**	Training to be rolled out across Trust regarding EPR 'must do's'. Skin bundle fields on EPR being reviewed jointly with BHFT. Changes to EPR to require ED to initiate skin bundles. Meeting with ED staff to understand how sskin bundles will fit with patient pathways on EPR.

What do we aim to achieve?	Current Update – September / October 2021	Progress rating	Next period
95% or more of at-risk patients in hospital will have a pressure ulcer care plan initiated. This will be measured by ward assurance	All patients with a Waterlow of 10 > had a pressure ulcer prevention care plan initiated. Joint work underway with Bradford Hospital Foundation Trust in developing a new suite of pressure ulcer care plans. Pressure ulcer care plans feature in the WTGR documentation project. The group is seeking to eradicate inconsistency in the use of care plans across the Trust. Record Keeping Pressure Ulcer Quality Priority improvement work is now nearing completion. Record keeping 'must do's' identified. Collaboration with Informatics to ensure data is extracted from correct location within EPR.	**Substantial assurance**	The Digital / EPR team are in process of updating and relaunching the SOP for completing pressure ulcer care plans for Powerchart. Finalise revisions to Bradford Hospital Trust / CHFT care plan.
95% or more of patients will have a completed Waterlow pressure ulcer risk assessment within 7 days of admission to District Nursing caseload. This applies to patients who have been on caseload for more than 28 days. This will be measured by SystmOne audit.	Progress made. Meeting held with relevant teams to agree data and extraction methods. In Sept 2021, 12 unstageable pressure ulcers were discussed at Orange Panel, of which only 3 were found to be associated with CHFT lapses in care. Whilst not aligning to a specific quality target, care homes have been identified as an area requiring pressure ulcer care support. The Trust is working with Primary Care Networks, Calderdale Council and Care Home Managers to support the delivery of the fundamentals of pressure area care.	**Not applicable**	Data to be provided from Nov 2021
95% of relevant staff (Registered Nurses, Nursing Associates and HCAs) will have completed React to Red Pressure or equivalent Pressure Ulcer training in last 2 years. This will be measured by Essential Safety Training (EST) compliance data	81% of staff have completed React to Red Training. Additional virtual and ward-based training has been provided on pressure ulcer prevention to support staff. Improved traction with divisional quality improvement pressure ulcer leads to address non-compliance of staff with regards to training. National pressure ulcer e learning tool in development which will replace React to Red. This forms part of the wider National Wound Care Strategy which CHFT is following closely.	**Reasonable assurance**	Divisions to continue to address non-compliance Meet with Workforce team to implement new national e-learning tool. Screensaver to raise awareness of

What do we aim to achieve?	Current Update – September / October 2021	Progress rating	Next period
			training.

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

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

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

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

PHSO / Reg Standard Focus for the priority - What do we aim to achieve?	Current update	Progress rating	Next Period
examples.	• A page has been developed within the Datix complaint module to support the front end of the complaints process • A triage process has been built into Datix, which enables each complaint to be assessed (by the Head of Complaints) as standard or high and actions required. This is based on the consequence of the issues raised • A revised response template has been designed and introduced which is in the style of a letter rather than a report		etc)
1.5. Organisations put measures in place to capture feedback from those who make complaints (as well as the staff involved) on their experience. They use this to demonstrate how the organisation has performed towards meeting the Complaint Standards and what users expect to see, as set out in My Expectations	• Service user survey ready for use, but not started to issue this • Output from the MCC 3Rs session has been used to direct the future approach to managing the Making Complaints Count project - there has been a change in senior complaints staff, therefore this is useful background to the project	**Reasonable Assurance**	• Agree the approach for issuing the service user survey • Use the findings from (result, reality, response) 3Rs stocktake to direct the project, the findings recommend a 2 phased approach: - Phase 1: process improvements, to bring about the rapid improvement in performance. - Phase 2: the remaining improvements that are needed against the PHSO standards
2.6 Each stage in the complaints procedure is responsive to the needs of each individual. Every stage meets the needs of minority and vulnerable groups and makes reasonable adjustments where required	• As part of the CHFT Health inequalities task and finish project (Index of Multiple Deprivation (IMD) data / analysis), some analysis of complaints has been undertaken. Using the Ethnic Diversity Index (EDI), the indication is that BAME communities are accessing the service above the current %population figures. Maternity specific complaints have also been reviewed but there are too few too complaints to draw any conclusions around IMD or	**Reasonable Assurance**	• Ethnic Diversity Index (EDI): This remains on the agenda for the Health Inequalities group, however it is on hold awaiting for a new appointment to the senior manager in the Quality and Safety team • Look at more effective ways of capturing equality monitoring data to enable complainants to record this information themselves rather than being asked the questions by the PALS and complaints team • Agree a process for distribution of the complaints

PHSO / Reg Standard Focus for the priority - What do we aim to achieve?	Current update	Progress rating	Next Period
	ethnicity • Equality monitoring data is now captured as part of the service user survey and at the point of access into the service • Access to reasonable adjustment services are in place e.g., interpreting for the spoken language and British Sign Language (BSL) • Support is also available via Healthwatch for anyone requiring support to submit a complaint		survey – the feedback will be used on an ongoing basis to monitor views of complainants
2.8 Staff make sure they respond to complaints at the earliest opportunity. Staff consistently meet expected timescales for acknowledging a complaint. They give clear timeframes for how long it will take to look into the issues, taking into account the complexity of the matter.	• Service has moved to negotiated timelines in partnership with families – Datix is updated to reflect any revised timelines *(Process is that the complaint handler calls the complainant and negotiates the timeline. Currently take the opportunity to highlight current staffing challenges and therefore may take longer; Aim to deal with the majority of complaints within 40 working days and the more complex at 60 working days - this can be extended up to 6 months)*	**Reasonable Assurance**	• Review the process re negotiated timelines with Divisional Colleagues (Use PDSA cycle (Plan, Do, Study, Act) approach to ensure that revised process is working effectively)
3.2 Organisations make sure all staff who look at complaints have the appropriate resources, support and protected time to do so in order to meet these	• The role of Patient experience and quality support leads has been revised to increase the 'improvement' element of the role – an action learning set approach is in place for these staff members with Head of Complaints • An investigation training programme is ongoing -	**Reasonable Assurance**	• Conclude the work to build a 'complaints' element into the Clinical Director programme – look into this (was being led by Assistant Divisional Director) • Conduct scoping / mapping of current investigators

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

Risk/ Issue	Owner	Action	Progress

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

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

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

18. Recovery Update

To Note

Presented by Jo Fawcus

19. Integrated Performance Report – November 2021

To Note

Presented by Jo Fawcus

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 13th January 2022
Meeting:	Public Board of Directors
Title:	Quality and Performance Report
Authors:	Peter Keogh, Assistant Director of Performance Kirsty Archer Deputy Director of Finance Cornelle Parker Deputy Medical Director Lindsay Rudge Acting Chief Nurse Jason Eddleston Deputy Director of Workforce and OD
Sponsoring Director:	Jo Fawcus, Chief Operating Officer
Previous Forums:	Quality Committee, 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 November 2021.

Key Points to Note

Trust performance for November 2021 was 62% which is further deterioration from the October position with the key change being in the FINANCE domain which is now red.

The **SAFE** domain remains green. The **CARING** domain remains amber with 2 of the 5 FFT areas green (Inpatients and Community) but maintaining performance in Complaints is still a challenge. Dementia screening has fallen in month following 3 months of improvement and at 35% is still some way short of target. The **EFFECTIVE** domain remains green although SHMI remains above 100 and #Neck of Femur access is around 57% in month and year to date. The **RESPONSIVE** domain is the most volatile during this period of operational challenge and is still amber with no real change in performance in month. Stroke indicators alongside the underperformance in the main planned access indicators and ED are the main challenges. **WORKFORCE** remains amber with short-term non-Covid sickness at its highest rate in over 12 months. Return to Work Interviews are at lowest rate since January. **FINANCE** domain is now red following deterioration in a number of indicators in month.

EQIA – Equality Impact Assessment

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

Recommendation

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

Calderdale and Huddersfield NHS Foundation Trust

Performance
November 2021

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

Number of attendances at both hospital sites have fallen from their peak earlier in the financial year however the acuity/dependency is still significantly higher and has led to some very challenging operational issues. We have seen the impact on our 4-hour Emergency Care Summary (ECS) performance over recent months although still often better than other Trusts in West Yorkshire. We have continued to see long waits in both emergency departments which is an extremely poor patient experience.

The demand for our services including the beds required for Covid patients means that we have seen some deterioration in performance over the last 3 months although we have still managed to maintain key cancer metrics whilst in strategic gold command and control. Mitigations are in place to keep the organisation safe for patients.

Year to date the Trust is reporting a £1.60m deficit, a £0.04m adverse variance from plan. Plans have now been agreed for the second half of the year (H2) and Trust budgets have been aligned with that plan. Whilst the Trust has submitted a balanced plan for the year and has delivered a break-even position in the first half of the year (H1), the financial position remains challenging. H2 includes a significant efficiency requirement of £6.7m, with only £3.9m identified of which £3.3m is currently forecast to deliver. The deficit position is driven by a combination of staffing pressures, in particular the high cost of temporary staffing (enhanced bank rates and high cost agency). The agreed enhanced pay for Bank staff drives an additional cost of £0.66m in month and £3.17m year to date. This sits alongside Recovery costs, including the cost of Independent Sector support. The Trust has not been able to access the Elective Recovery Fund (ERF) so far in H2 to offset these additional pressures. Activity remains below the current threshold for both the Trust and the Integrated Care System (ICS) as a whole.

Costs have increased significantly over the last few months due to a high number of Covid patients and significant staffing shortages and going through winter this will be extremely challenging to reverse. The Trust is continuing to work with partners at Place and ICS level to manage this risk and there are also various routes to access Elective Recovery Funding which could further mitigate this position. The forecast continues to be the delivery of the financial plan but this is risk assessed as extremely high.

One Culture of Care Must-Do's have been identified to support colleagues as part of our approach to managing through the winter months. This focuses on colleague rest and recuperation for wellbeing, health and wellbeing risk assessments, clear access points for support including the internal listening ear service and the external psychologist-led employee assistance programme provided by CareFirst, refreshed leader/manager guides and ensuring there is an understanding of the opportunities to raise concerns through our speak up

processes.
A review of November 2021 data indicates that the combined RN and non-registered clinical staff metrics resulted in 26 of the 28 clinical areas having fewer Care Hours per Patient Day (CHPPD) than planned, with a total deficit of 1.0 CHPPD across the Trust. The gap in CHPPD is at its broadest with the Registered Nurse workforce representing 1.0 deficit and Healthcare Support Worker 0.1 deficit. This position, whilst still not at desired state, demonstrates an improvement on the October position as a result of newly recruited staff coming out of their supernumerary period. The successful recruitment to Healthcare Assistant roles has enabled increased shift fill to provide support to the reduced RN availability. Professional judgement is used daily to redeploy staff on a shift basis and establish the safest staffing possible in all areas.

A review of the nurse sensitive indicators demonstrates a reduction in the number of falls for November in both the Medical and Surgical divisions. Pressure ulcers are reported a month in arrears so are representative of the challenging October staffing position.

The Trust remains committed to achieving its nurse and midwifery staffing establishments. The November position remains below the required level, but is an improvement on the October position as anticipated.

The use of the enhanced metrics dashboard (previously 'worry ward' dashboard) is embedded in the weekly senior safer staffing review meeting. Areas with less than 85% shift fill rate are scrutinised with a suite of nurse sensitive indicators. Specific action plans are generated by the ADNs and reported through the Gold Command structure.

In response to the changing situation as a result of the emergence of the Omicron strain of Covid, activity is underway to plan for any surge in clinical demand and/or significant staffing challenges as a result of staff absence.

compassionate care

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Integrated Performance Report

November 2021

Report Produced by : The Health Informatics Service

Data Source : various data sources syndication by VISTA

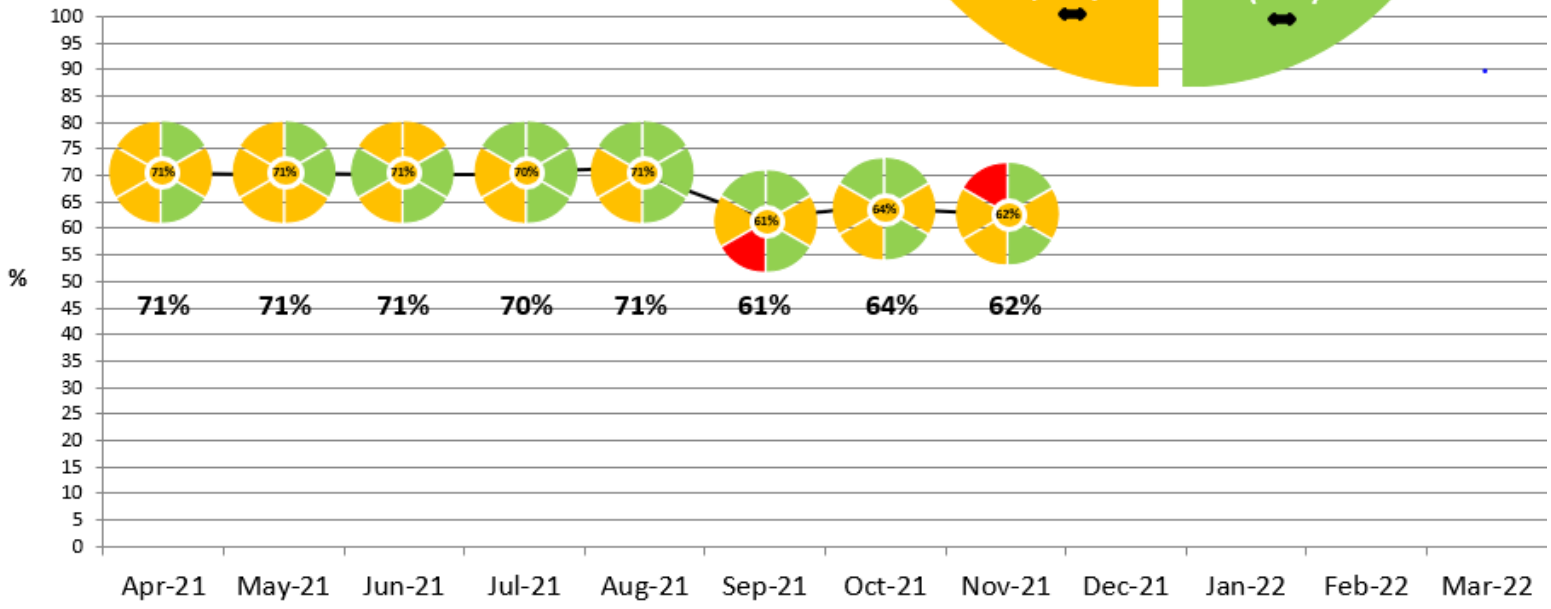
Performance Summary

November 2021

OVERSIGHT FRAMEWORK

SAFE	
VTE Assessments	Never Events
CARING	
Mixed sex accommodation breaches	% Complaints closed
FFT Inpatients FFT Community	FFT Maternity FFT Outpatients FFT A&E
EFFECTIVE	
MRSA	Preventable Cdiff
HSMR	SHMI

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



Key Indicators

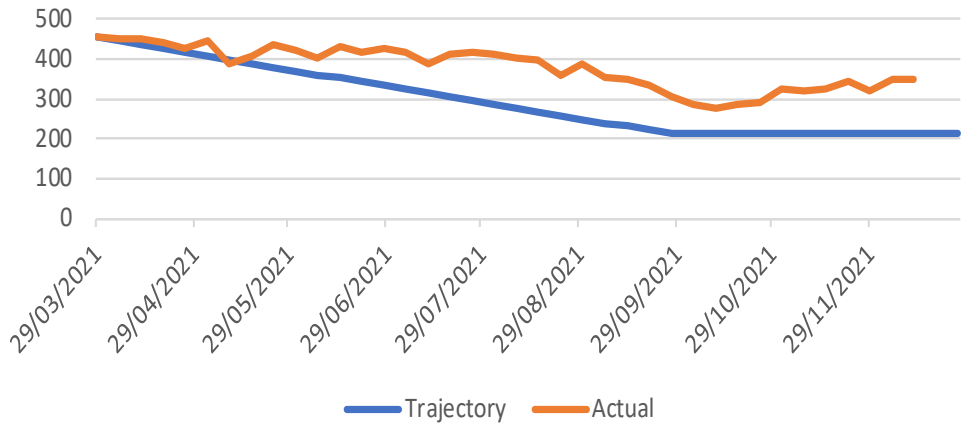
	20/21	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	YTD	Performance Range		
SAFE																							Green	Amber	Red
Never Events	2	0	1	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0		>=1
CARING																							Green	Amber	Red
% Complaints closed within target timeframe	60.07%	93.8%	81.8%	80.0%	69.6%	71.4%	53.9%	44.1%	50.0%	41.7%	63.0%	52.9%	60.00%	100.00%	87.50%	100.00%	69.44%	55.10%	71.43%	58.82%	in arrears	71.51%	100%	86% - 99%	<=85%
Friends & Family Test (IP Survey) - % Positive Responses	91.09%	COVID	COVID	COVID	COVID	COVID	COVID	COVID	COVID	93.63%	93.46%	88.32%	96.82%	96.75%	95.62%	97.00%	96.38%	96.61%	97.33%	98.26%	in arrears	96.84%	>=90% / >=95% from		<=79%
Friends and Family Test Outpatients Survey - % Positive Responses	93.27%	COVID	COVID	COVID	COVID	COVID	COVID	COVID	COVID	93.37%	93.10%	93.28%	92.38%	92.45%	92.20%	92.29%	91.88%	91.77%	91.49%	91.51%	in arrears	91.94%	>=90% / >=93% from		<=79%
Friends and Family Test A & E Survey - % Positive Responses	90.16%	COVID	COVID	COVID	COVID	COVID	COVID	COVID	COVID	90.38%	90.91%	89.37%	90.48%	85.13%	85.90%	82.98%	78.53%	81.33%	80.85%	81.01%	in arrears	82.32%	>=80% / >=85% from		<=69%
Friends & Family Test (Maternity) - % Positive Responses	98.86%	COVID	COVID	COVID	COVID	COVID	COVID	COVID	COVID	98.00%	100.00%	100.00%	91.89%	85.71%	90.00%	91.23%	97.53%	95.19%	97.69%	93.98%	in arrears	95.25%	>=90% / >=95% from		<=79%
Friends and Family Test Community Survey - % Positive Responses	100.00%	COVID	COVID	COVID	COVID	COVID	COVID	COVID	COVID	100.00%	100.00%	100.00%	100.00%	99.50%	93.80%	93.37%	87.74%	92.52%	94.27%	91.12%	in arrears	92.45%	>=90% / >=95% from		<=79%
EFFECTIVE																							Green	Amber	Red
Number of MRSA Bacteraemias – Trust assigned	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		>=0
Preventable number of Clostridium Difficile Cases	6	1	1	2	2	0	0	0	0	0	0	0	0	0	1	0	1	0	1	0	0	3	4		3.4
Local SHMI - Relative Risk (1 Yr Rolling Data)	100.94	98.4	98.68	99.05	99.74	100.88	101.31	102.27	102.71	100.94	104.11	103.15	102.26	99.91	101.91							101.91	<=100	101 - 109	>=110
Hospital Standardised Mortality Rate (1 yr Rolling Data)	90.49	91.32	91.56	92.39	91.88	92.85	93.32	93.3	92.98	90.32	90.49	90.76	89.46	88.24	88.99	90.00						90.00	<=100	101 - 109	>=111
RESPONSIVE																							Green	Amber	Red
Emergency Care Standard 4 hours	88.81%	92.59%	95.24%	94.76%	93.72%	90.65%	88.93%	81.25%	81.42%	86.82%	87.82%	86.48%	87.83%	88.22%	86.70%	86.16%	78.59%	79.57%	78.29%	75.97%	76.81%	81.23%	>=95%	81% - 94%	<=80%
% Stroke patients admitted directly to an acute stroke unit within 4 hours of arrival	65.30%	71.43%	71.93%	67.24%	54.41%	58.33%	50.94%	49.18%	55.90%	65.30%	56.06%	25.42%	38.60%	61.02%	49.06%	54.90%	42.29%	43.14%	42.00%	33.87%	33.33%	45.27%	>=90%		<=85%
Two Week Wait From Referral to Date First Seen	98.74%	98.24%	99.02%	98.52%	98.92%	99.65%	97.85%	99.04%	98.50%	98.91%	98.55%	98.80%	98.76%	98.31%	99.02%	97.84%	97.87%	98.46%	98.62%	98.60%	99.21%	98.50%	>=93%	86% - 92%	<=85%
Two Week Wait From Referral to Date First Seen: Breast Symptoms	97.86%	100.00%	100.00%	97.70%	95.87%	100.00%	99.27%	100.00%	94.78%	98.70%	97.35%	96.45%	97.34%	98.28%	98.04%	100.00%	98.68%	100.00%	97.96%	98.45%	96.83%	98.46%	>=93%		<=92%
31 Days From Diagnosis to First Treatment	98.08%	99.42%	97.37%	98.26%	97.83%	97.69%	100.00%	98.67%	96.23%	96.71%	96.82%	98.55%	99.22%	99.46%	99.41%	97.63%	98.94%	97.91%	95.88%	94.83%	98.82%	97.87%	>=96%		<=95%
31 Day Subsequent Surgery Treatment	90.99%	96.88%	96.00%	69.57%	86.84%	91.30%	100.00%	96.30%	96.30%	86.21%	73.91%	92.31%	100.00%	97.14%	100.00%	100.00%	97.78%	94.44%	84.78%	100.00%	91.30%	95.21%	>=94%		<=93%
31 day wait for second or subsequent treatment drug treatments	99.15%	100.00%	100.00%	97.87%	97.83%	100.00%	100.00%	100.00%	100.00%	100.00%	96.55%	100.00%	98.04%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	>=98%		<=97%
38 Day Referral to Tertiary	54.64%	76.00%	45.45%	40.00%	65.00%	47.06%	39.13%	58.33%	35.71%	50.00%	43.75%	61.54%	91.67%	50.00%	63.16%	50.00%	72.73%	44.44%	54.55%	58.82%	50.00%	55.12%	>=85%		<=84%
62 Day GP Referral to Treatment	91.47%	93.61%	91.41%	85.59%	91.72%	91.16%	93.03%	89.67%	94.76%	90.00%	90.10%	87.58%	95.65%	93.14%	90.09%	91.97%	91.38%	91.40%	89.35%	91.43%	92.09%	91.34%	>=85%	81% - 84%	<=80%
62 Day Referral From Screening to Treatment	63.98%	72.22%	37.50%	0.00%	0.00%	33.33%	0.00%	83.33%	81.82%	85.19%	83.33%	73.91%	100.00%	72.22%	57.89%	48.48%	32.14%	55.26%	32.00%	55.56%	68.75%	52.86%	>=90%		<=89%
Faster Diagnosis Standard: Maximum 28-day wait to communication of definitive cancer / not cancer diagnosis for patients referred urgently (including those with breast symptoms) and from NHS cancer screening	79.84%	70.98%	85.89%	73.70%	80.21%	83.19%	82.94%	82.52%	80.91%	81.48%	71.76%	82.50%	80.21%	73.08%	67.40%	69.04%	73.42%	69.61%	70.89%	76.13%	78.76%	72.32%	>=75%		<=70%
WORKFORCE																							Green	Amber	Red
Sickness Absence rate (%) - Rolling 12m	4.52%	4.12%	4.23%	4.25%	4.25%	4.24%	4.24%	4.30%	4.41%	4.46%	4.53%	4.59%	4.52%	4.37%	4.35%	4.44%	4.61%	4.76%	4.89%	5.00%	5.01%	-	<=4%	<=4.5%	>4.5%
Long Term Sickness Absence rate (%) -Rolling 12m	3.07%	2.61%	2.69%	2.72%	2.73%	2.73%	2.73%	2.78%	2.86%	2.93%	2.99%	3.07%	3.07%	3.01%	2.99%	3.07%	3.17%	3.29%	3.36%	3.39%	3.38%	-	<=2.5%	<=2.75%	>2.75%
Short Term Sickness Absence rate (%) -Rolling 12m	1.45%	1.51%	1.54%	1.53%	1.52%	1.51%	1.52%	1.52%	1.55%	1.52%	1.54%	1.52%	1.45%	1.36%	1.35%	1.38%	1.44%	1.48%	1.53%	1.61%	1.63%	-	<=1.5%	<=1.75%	>1.75%
Overall Essential Safety Compliance	94.90%	93.61%	94.11%	94.24%	95.85%	94.42%	95.28%	95.51%	95.18%	95.16%	95.02%	94.86%	94.90%	94.85%	94.68%	95.64%	95.48%	93.93%	93.81%	93.22%	93.01%	-	>=90%	>=85%	<85%
Appraisal (1 Year Refresher) - Non-Medical Staff	95.15%									95.15%	95.15%	95.15%	95.15%									-	>=95%	>=90%	<90%
Appraisal (1 Year Refresher) - Medical Staff (Rolling 12mth)	41.05%																					-	>=95%	>=90%	<90%
FINANCE																							Green	Amber	Red
I&E: Surplus / (Deficit) Var £m YTD	2.27	(0.00)	0.00	0.00	0.00	0.00	0.00	0.95	0.16	-1.00	0.41	0.58	1.18	0.55	2.39	0.28	-0.22	-1.40	-1.62	0.00	-0.05	-0.04			

SWOT Analysis

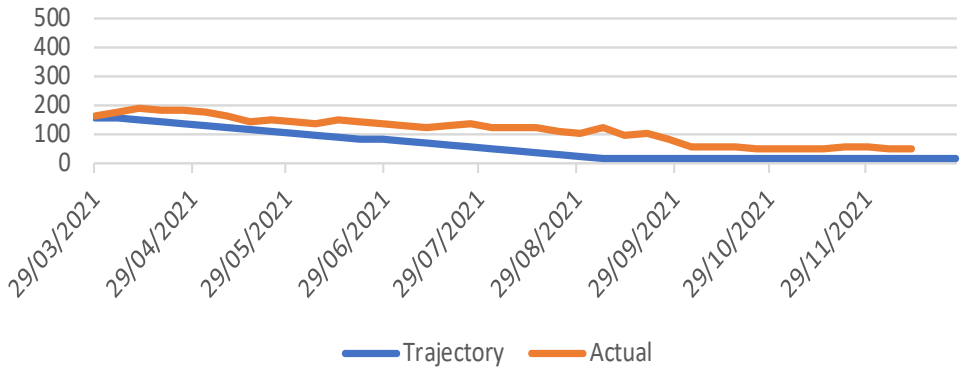
Strengths	• Continuing to focus on Trust agreed priorities for elective patients, e.g. ensuring we prioritise patients with learning disabilities, P2s and long waiters (104 weeks). • Ongoing comprehensive theatre staff engagement and workforce development programme – starting to receive positive feedback from staff. • Endoscopy backlog continues to reduce - due to be 6-week compliant in December. • Community Pharmacist roles continue to add significant value in Quality Improvement (identifying and managing medication incidents), supporting effective assessment and care planning across nursing and therapy services and helping manage some of the discharge based risks and issues with handover of medicines management. • Continue to support Mid Yorkshire Hospital Trust with Non-Surgical Oncology care for breast and lung cancer and we are also now providing some in-reach support to Bradford. • The Tytocare trial has now completed the initial period of 6 weeks in the Emergency Department following clinical safety sign-off and sign-off by the Divisional senior management team. The aim of the trial was to utilise new technology to enable virtual consultant presence in the emergency department; this should reduce the overall length of stay in the department and increase the number of patients who have a decision within one hour. The trial is currently being evaluated in Medicine and next steps confirmed with a formal review scheduled for early January. • Focus on recruitment in both clinical and admin roles to support winter planning and recovery. Using alternative roles and thinking differently for hard to recruit areas. Also exploring risks and benefits to over recruitment to minimise bank and agency spend. • Have demonstrated ability to deliver significant change in the delivery of the Urgent Community Response and wider 0-72 hour integrated team on schedule and in advance of national expectations. • Have introduced a locally developed acuity and complexity score for District Nursing caseloads which is adding value in weighting caseload management but also evidencing increased acuity in demand. • Insourcing arrangements in place for ENT (OP & Surgery), Orthopaedics (CHOP LLP) and Ophthalmology (OP, diagnostics & Surgery) to help tackle elective backlogs. • Agreed Recovery Framework. • Automated medicine cabinets installed at HRI and pharmacy robot business case approved. • Continue to respond to a challenging Covid Vaccination Programme 12-15 yr old requirements including planning for new 2nd dose and 5-12 yr old requirements.
Weaknesses	• Bed pressures continue to be significant. Continued sustained pressure on ICU (Covid and non-Covid demand). • The staffing position continues to be extremely challenging across all divisions in particular among nursing teams and is being closely monitored and managed on a daily basis through the Gold meetings. • Ward 11 is now a 24/7 medical ward but with an establishment only for Monday-Friday • High levels of staff having to isolate leading to low levels of staffing across clinical areas. • Staffing shortages in theatres leading to continued reduced capacity to operate on patients. • Having to pull outsourced patients back from BMI and Spire due to not being dated within current local waiting time targets. • MRI downtime in Radiology due to equipment issues. ED and IP prioritised to ensure flow was not compromised. • 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. The programme is fully now live in 11 ward areas. • Opportunities for acceleration of community based Early Supported Discharge and urgent response function for winter/surge plans plus maintaining elective recovery through control on non-elective demand i.e. increasing in-reach of Respiratory team and support for earlier discharge for oxygen weaning via CVW. Within Calderdale and across wider footprint. • 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. The pilots have been extended until the end of December and a joint business case with the CCGs is now in draft format. We have managed to secure a significant increase with GP shifts in the hubs. Demand going through the UCHs has now increased to 18% of attendances. • Developing SOP to stop mandatory 3-day isolation for low-risk pathways - will help reduce health inequalities and help backfill late notice cancellations. • From December weekend Endoscopy insourcing will focus on tackling surveillance backlog which will also help the Trust's 52-week position. • 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. • Accelerating integration with partners in the Community to deliver optimal and timely episodes of care.
Threats	• We continue to see the significant and sustained increase in demand for both our emergency departments which continues to create pressure at the front door and driving ongoing increased staffing. • Staff being stretched due to increased number of Delayed Transfers of Care and increased Covid bed base. • Community services are increasingly seeing more complex and acute presentation with impacts on wider anticipatory care and Long Term Condition (LTC) management. • Patients are presenting with increased acuity and complexity which is resulting in a longer length of stay and challenges around timely discharge into the community. • Staff fatigue due to ongoing pressures and frustration due to prolonged changing and increasing workloads. • Cost pressures increasing dependencies on overtime and bank. • Potential stopping of some elective services to move RNs to support medical wards - significant health and wellbeing implications to these staff as well as the risk they resign from CHFT. • Expected Paediatric medical surge which would impact elective activity. • The increasing prevalence of the Omicron Covid variant is of particular concern. We are working through some modelling to understand the potential impact in the coming weeks. • Winter pressures. • Amendments to pay enhancement scheme for elective recovery could risk losing more theatre capacity • Potential stopping of some elective services to a) move RNs to support medical wards, or b) move staff from Endoscopy or theatres in the event of increased ICU demand - significant health and wellbeing implications to these staff as well as the risk they resign from CHFT. • Increasing number of complaints due to prolonged waits and poor patient experience. • Health and safety risks due to ageing estate across the Trust. Working with stakeholders to mitigate risks and explore permanent solutions that align with wider Trust reconfiguration plans.

INPATIENT WAITING LIST - P2

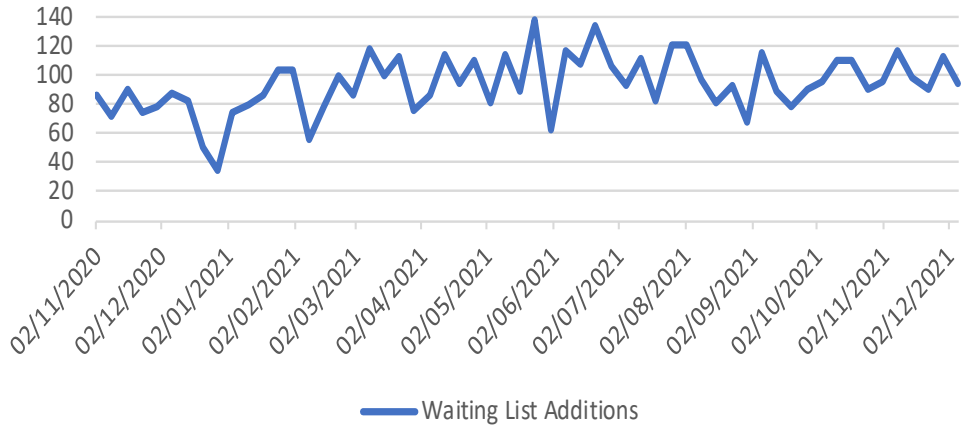
Trajectory vs Actual - Total P2s on Waiting List



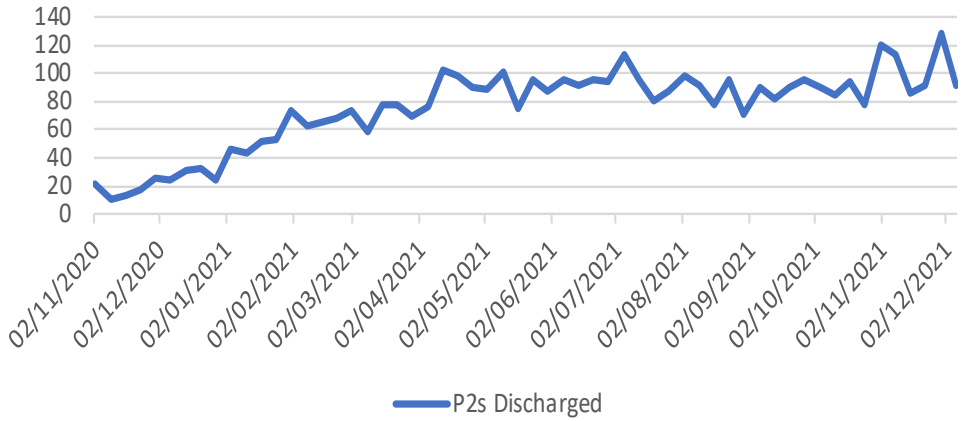
Trajectory vs Actual - Total P2s on Waiting List Over 1 month



P2 waiting List Additions

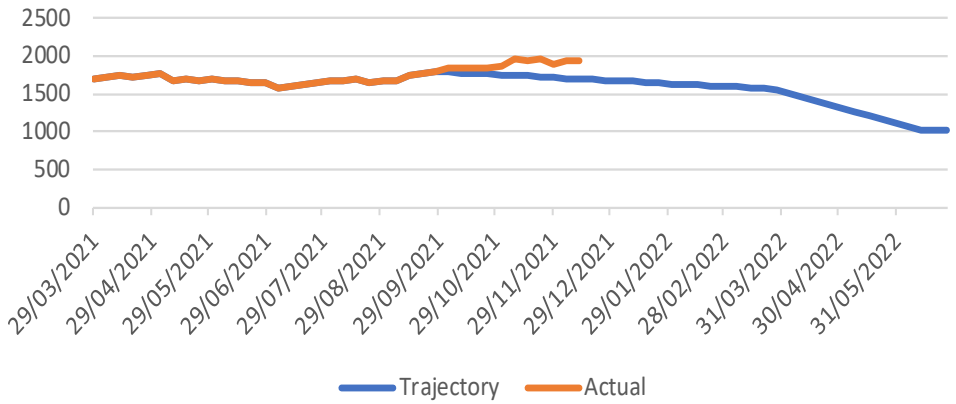


P2 Surgery done in the week

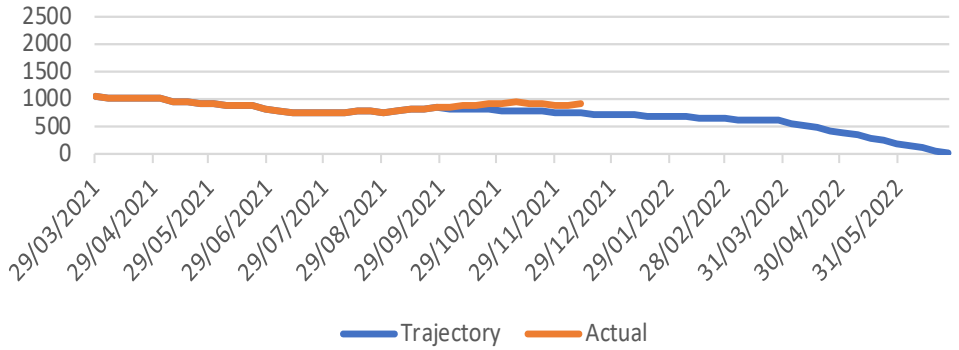


INPATIENT WAITING LIST - P3

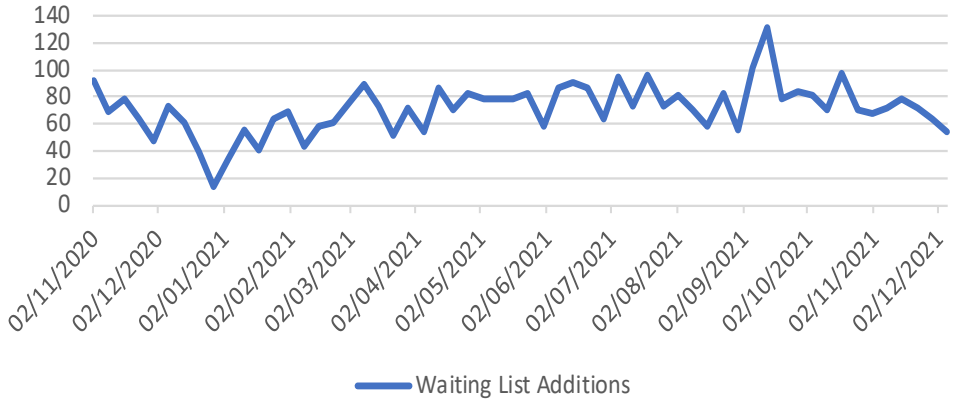
Trajectory vs Actual - Total P3s on Waiting List



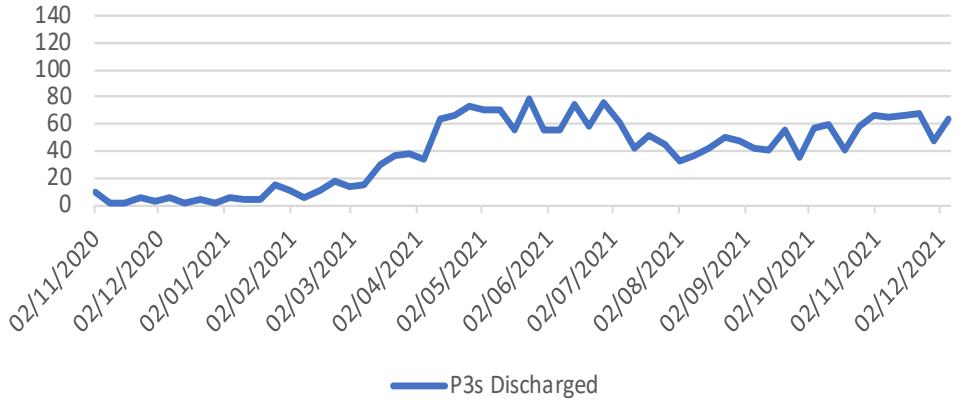
Trajectory vs Actual - Total P3s on Waiting List Over 3 months

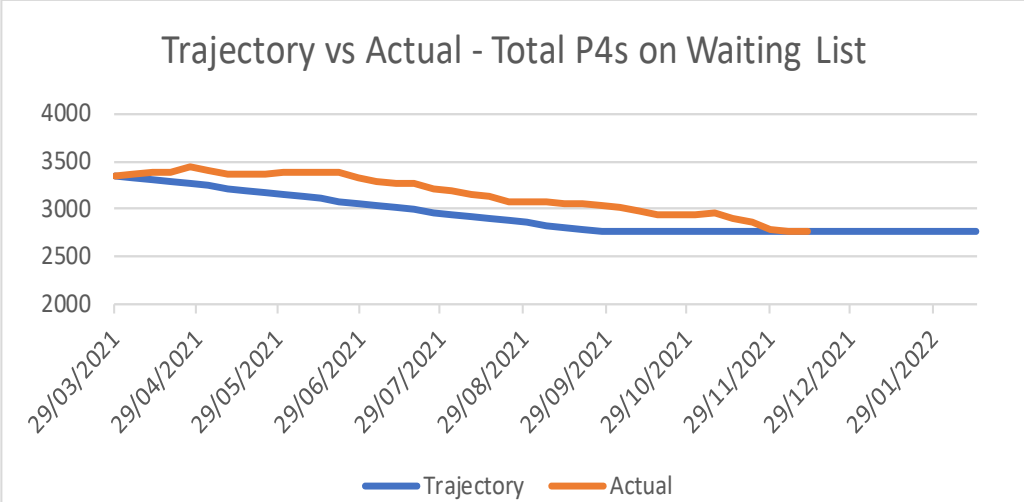


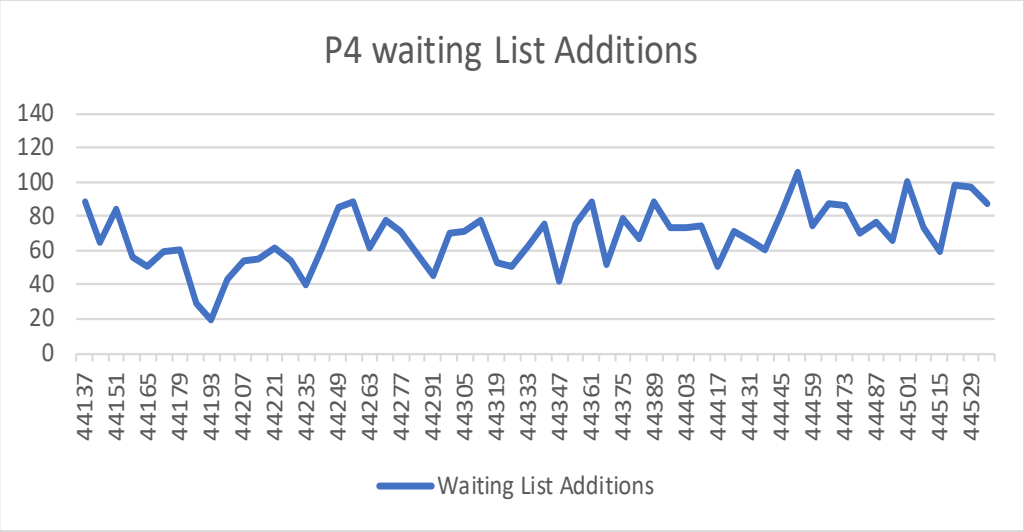
P3 waiting List Additions

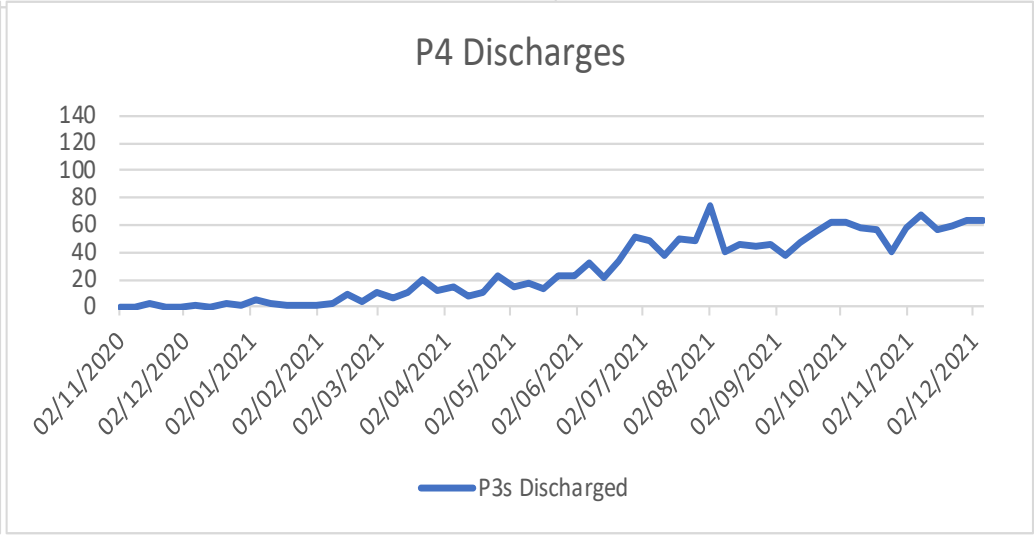


P3 Discharges

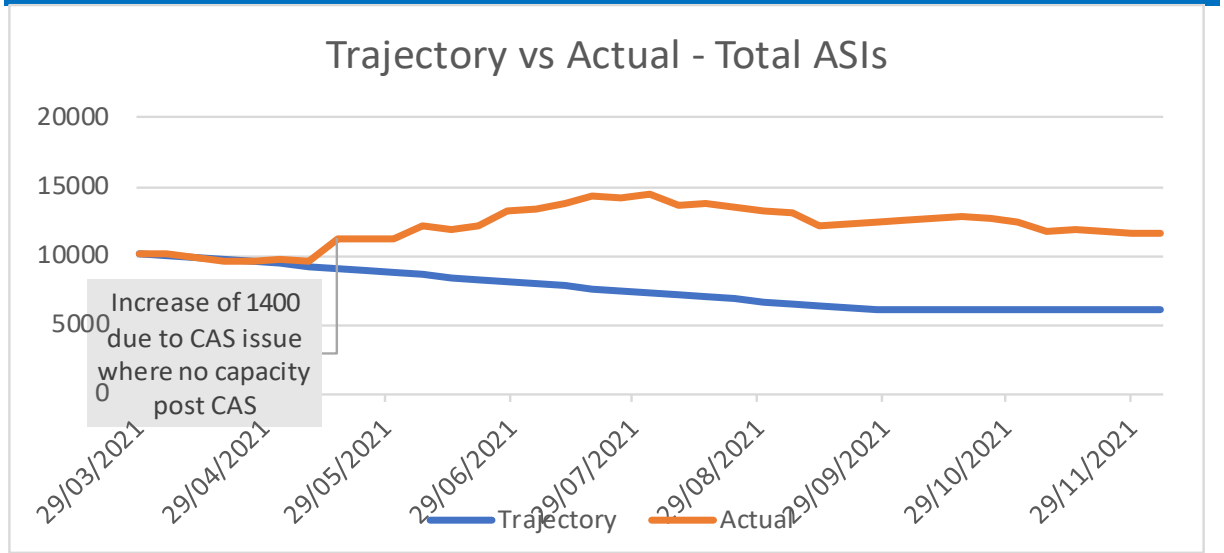


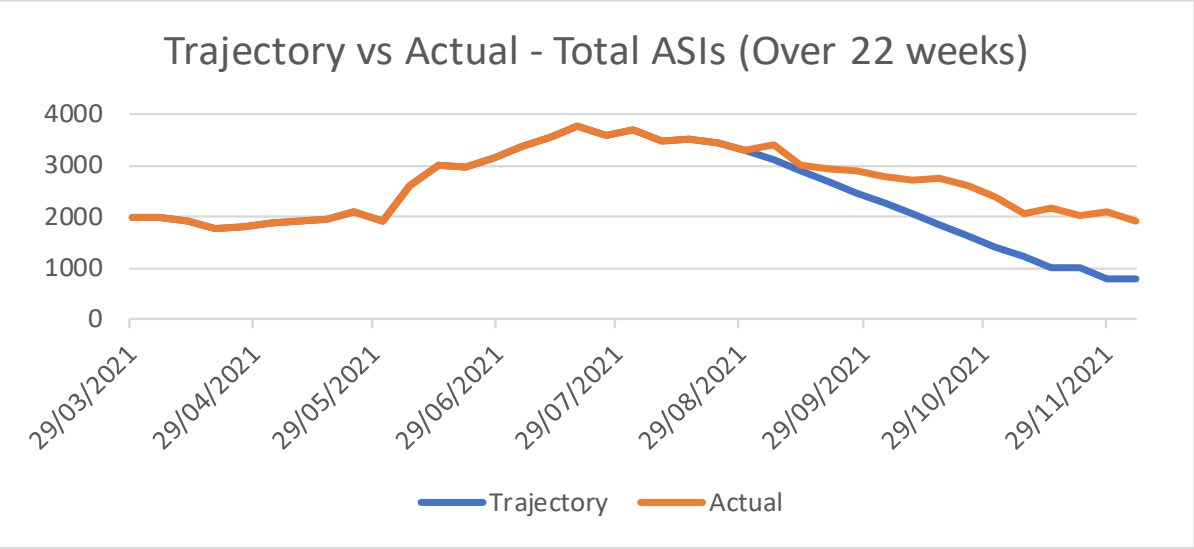

Trajectory vs Actual - Total P4s on Waiting List
4000
3500
3000
2500
2000
29/03/2021
29/04/2021
29/05/2021
29/06/2021
29/07/2021
29/08/2021
29/09/2021
29/10/2021
29/11/2021
29/12/2021
29/01/2022
Trajectory
Actual


P4 waiting List Additions
140
120
100
80
60
40
20
0
44137
44151
44165
44179
44193
44207
44221
44235
44249
44263
44277
44291
44305
44319
44333
44347
44361
44375
44389
44403
44417
44431
44445
44459
44473
44487
44501
44515
44529
Waiting List Additions

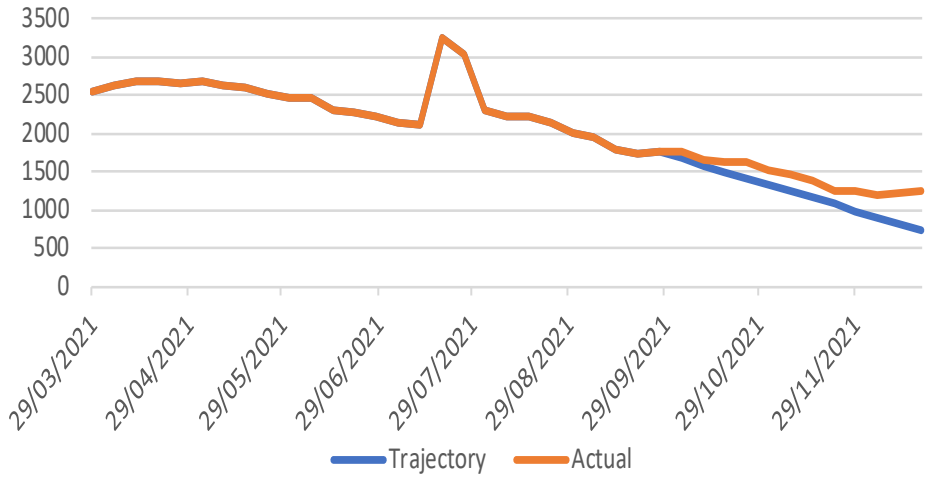

P4 Discharges
140
120
100
80
60
40
20
0
02/11/2020
02/12/2020
02/01/2021
02/02/2021
02/03/2021
02/04/2021
02/05/2021
02/06/2021
02/07/2021
02/08/2021
02/09/2021
02/10/2021
02/11/2021
02/12/2021
P3s Discharged

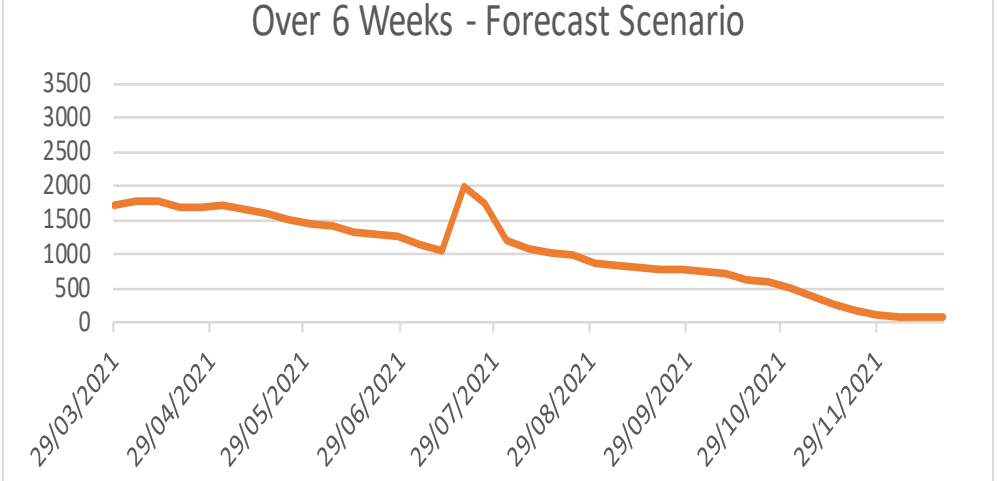
ASIs

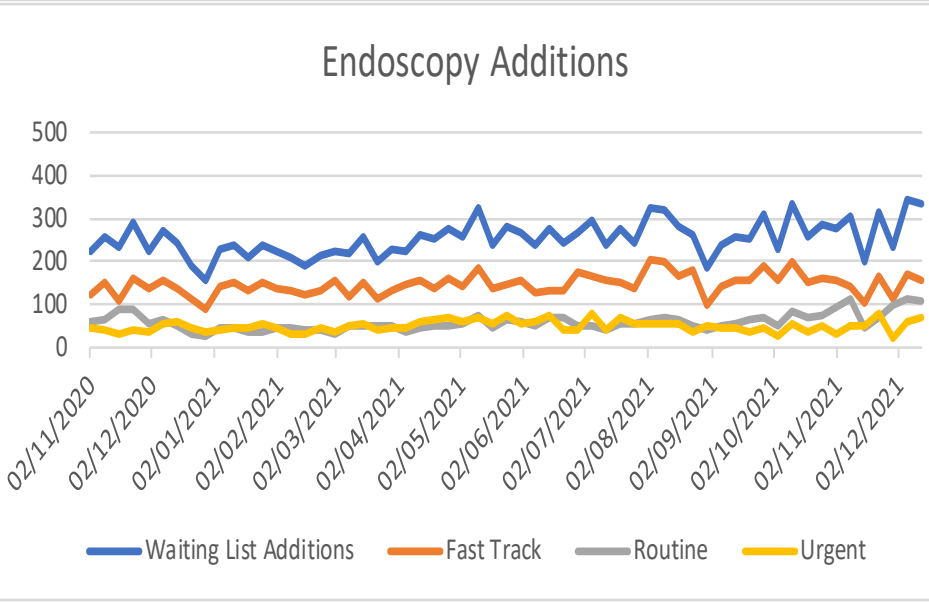

Trajectory vs Actual - Total ASIs
20000
15000
10000
5000
0
Increase of 1400 due to CAS issue where no capacity post CAS
29/03/2021
29/04/2021
29/05/2021
29/06/2021
29/07/2021
29/08/2021
29/09/2021
29/10/2021
29/11/2021
Trajectory
Actual

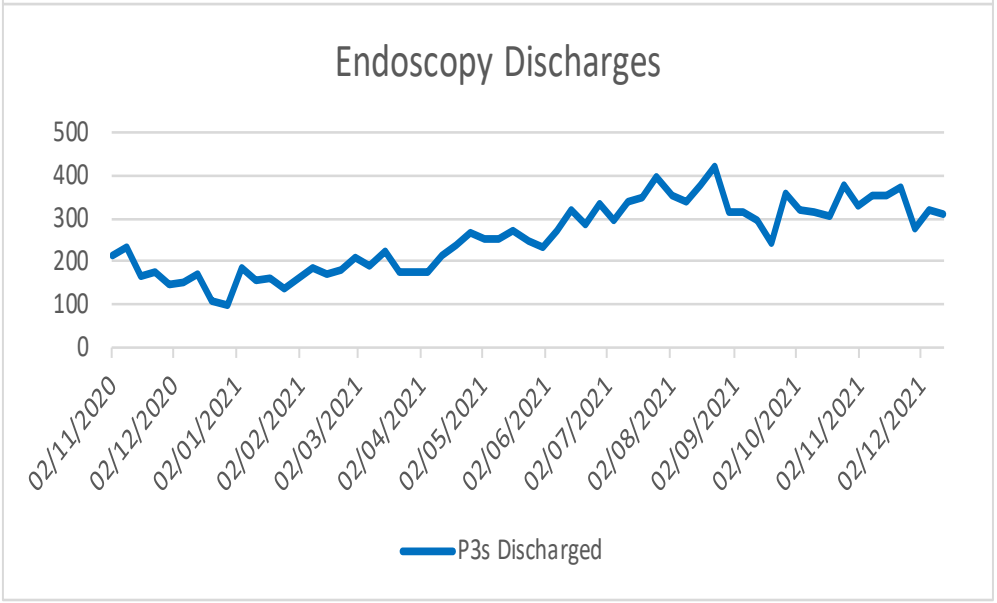

Trajectory vs Actual - Total ASIs (Over 22 weeks)
4000
3000
2000
1000
0
29/03/2021
29/04/2021
29/05/2021
29/06/2021
29/07/2021
29/08/2021
29/09/2021
29/10/2021
29/11/2021
Trajectory
Actual

Endoscopy Waiting List



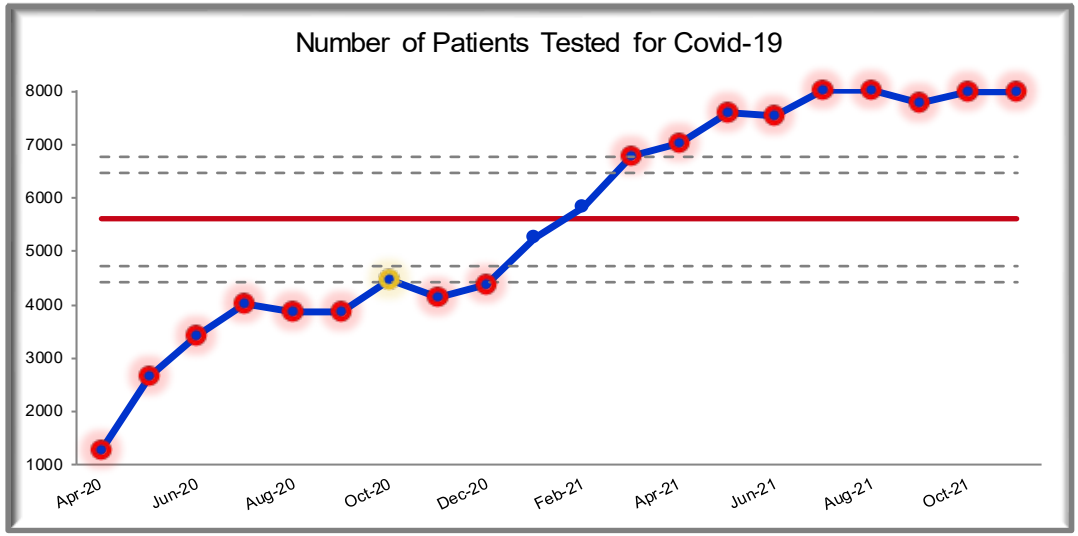


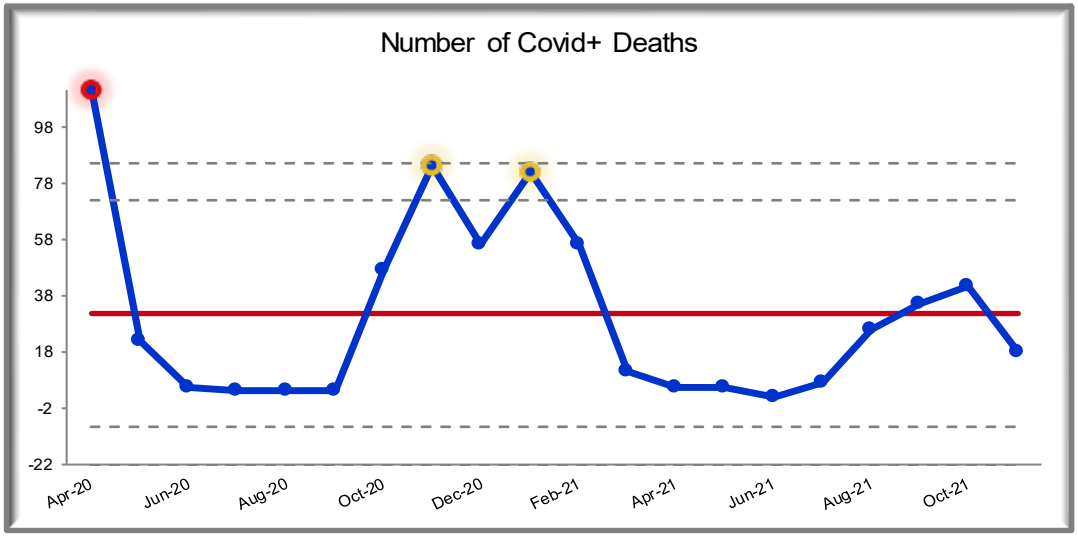


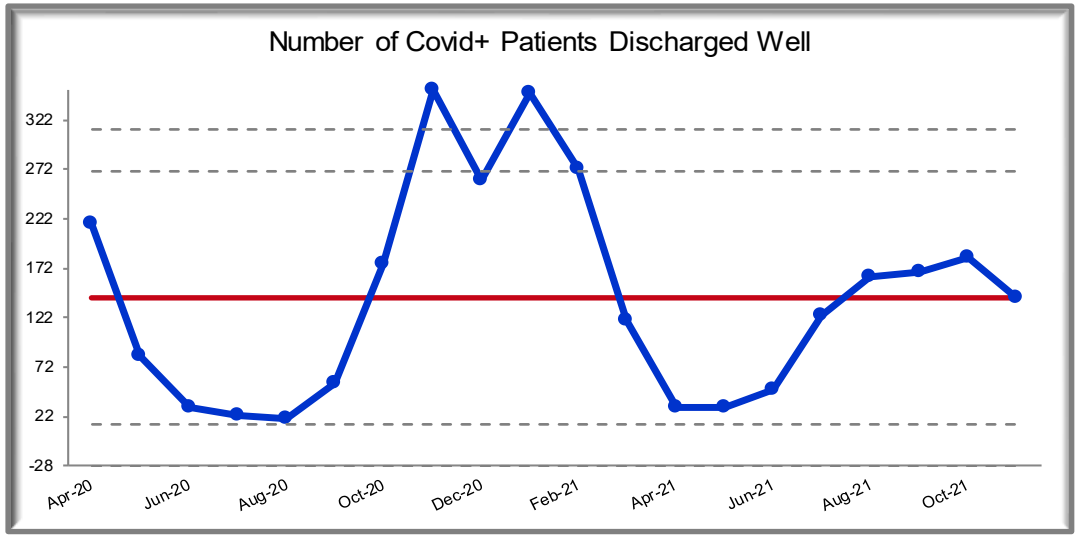


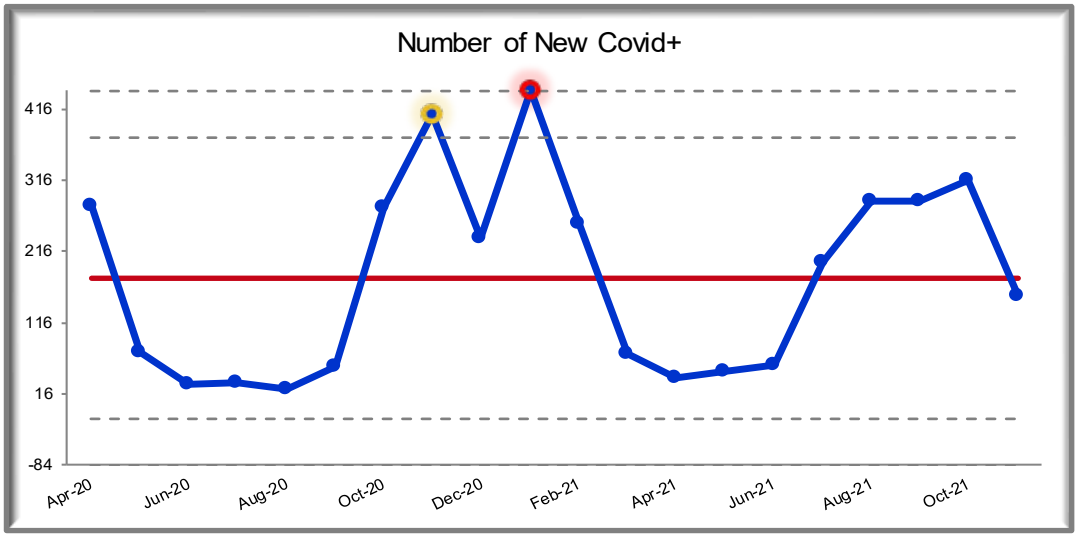
Covid-19 - SPC Charts

Average | Values | Target | Control Limits | Warning | Critical | Trend | Good Over Target / Good Below Target



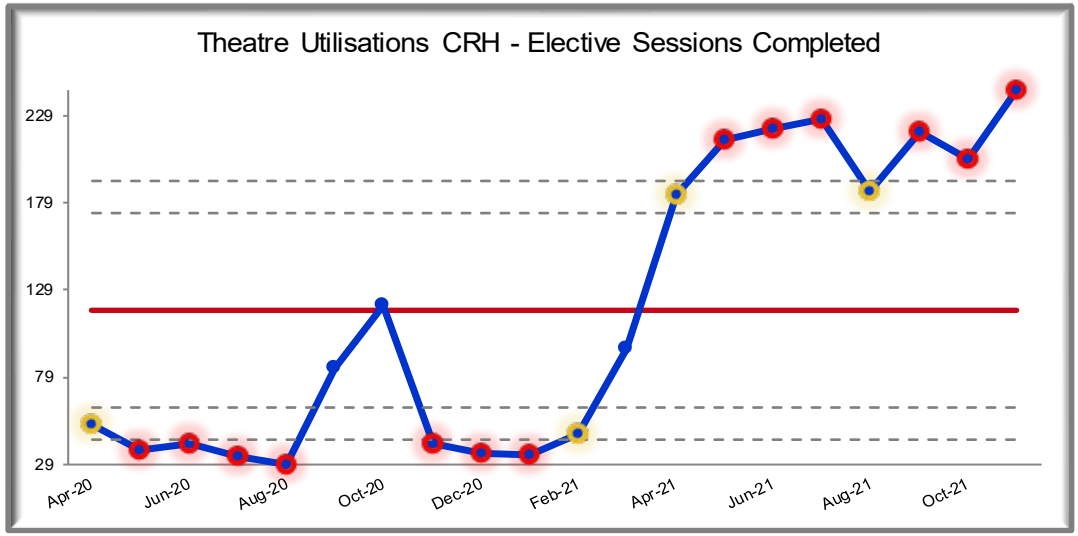


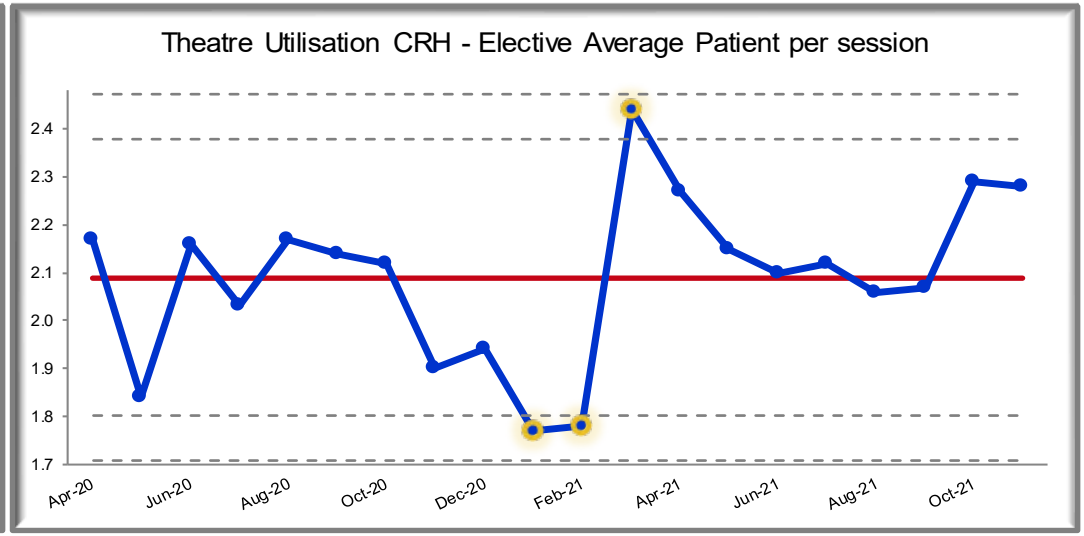


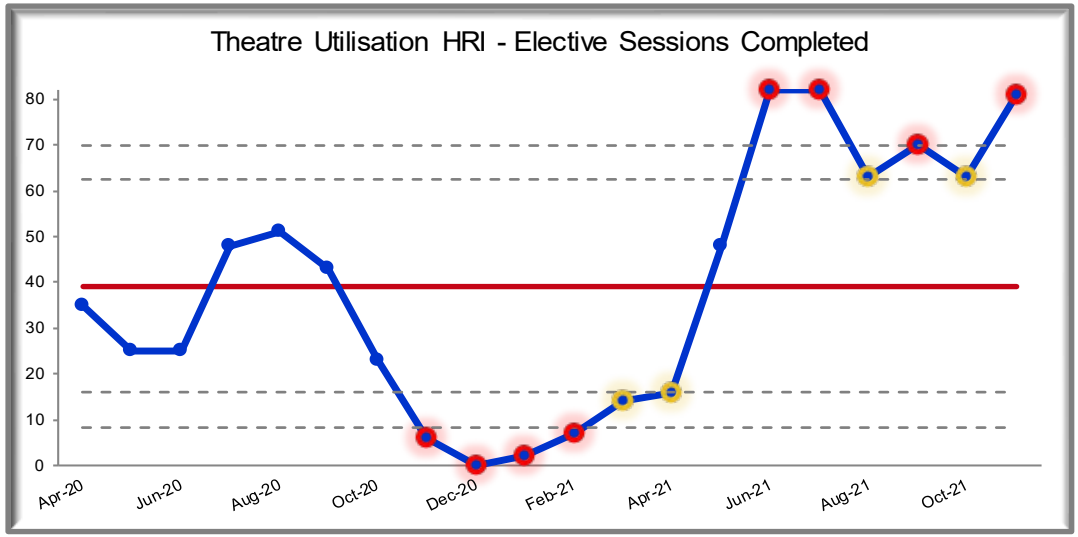


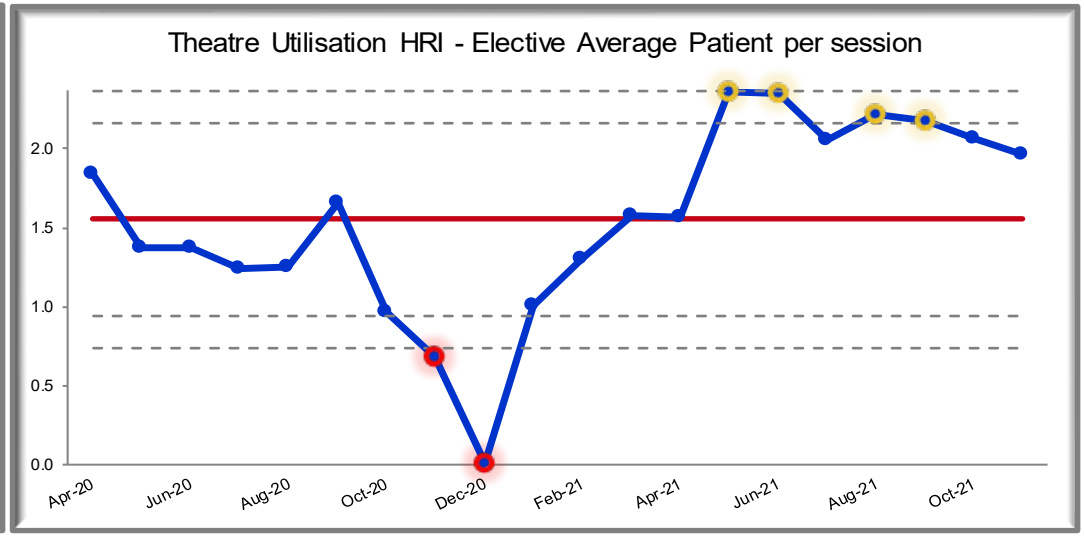
Theatres - SPC Charts

Average — Values — Target — Control Limits — Warning — Critical — Trend — Good Over Target / Good Below Target

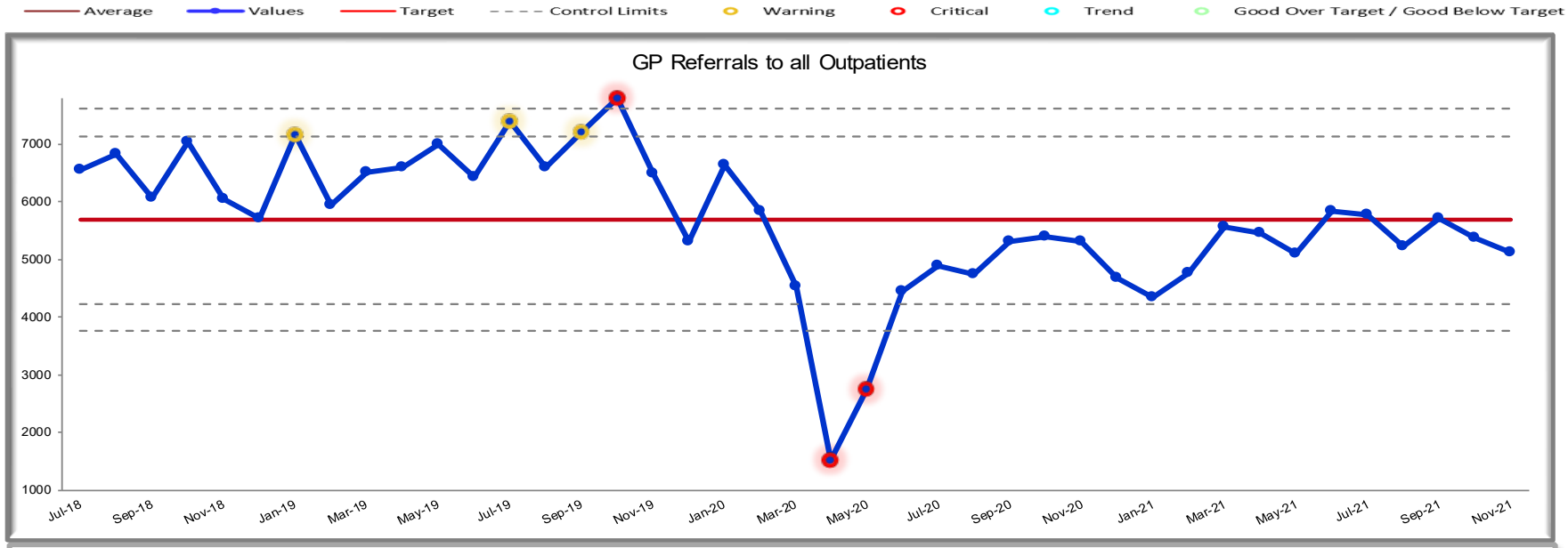


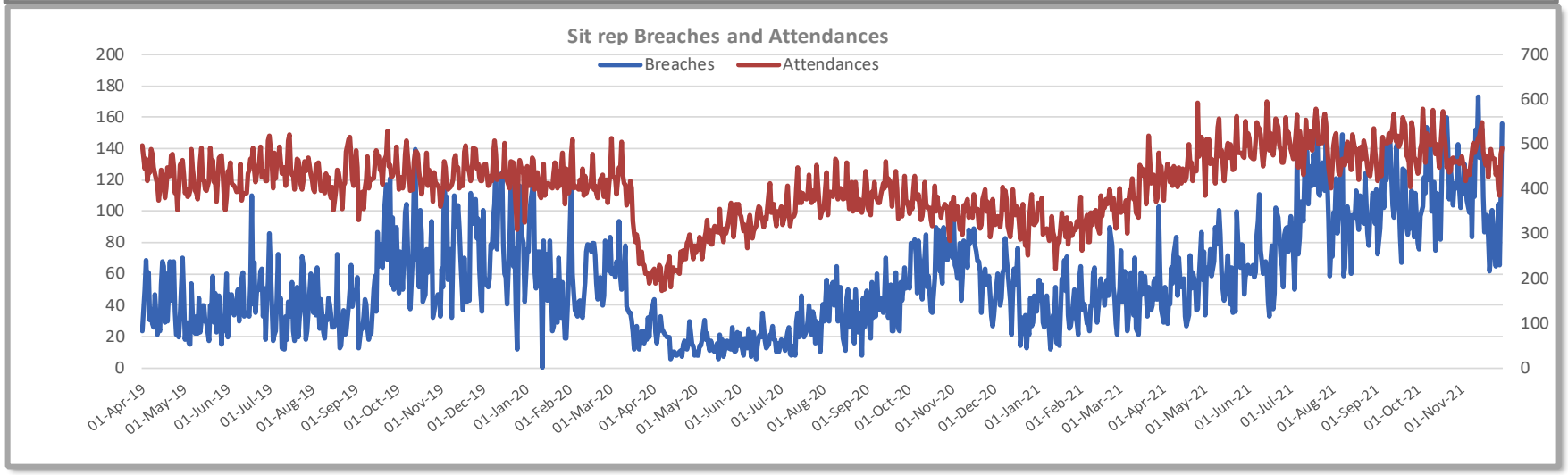






Capacity and Demand

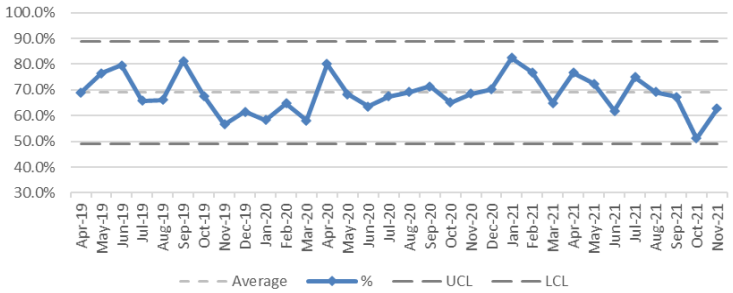




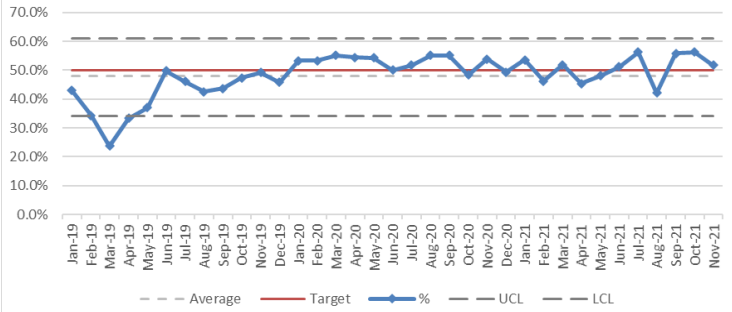
Quality Priorities - Quality Account Priorities

1. Recognition and timely treatment of Sepsis

% of ED patients coded with Sepsis that received antibiotics within 1 hour of the earliest alert

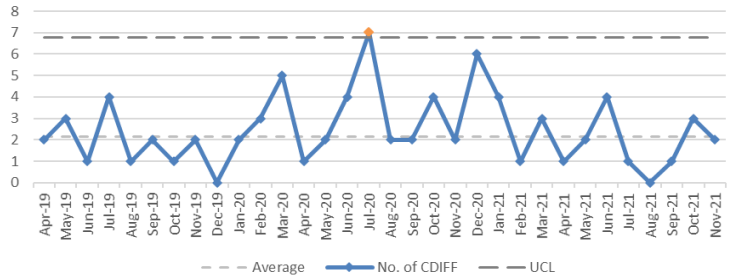


% of patients coded with Sepsis that received all elements of the BUFALO bundle (exc. lactate) - Trust

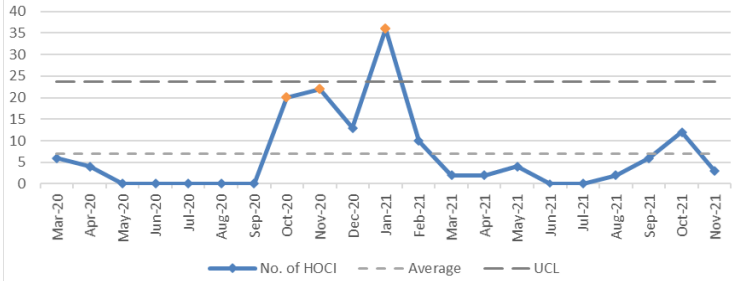


2. Reduce number of Hospital Acquired Infections including Covid 19

Number of C Diff Cases - Trust Assigned - Trust

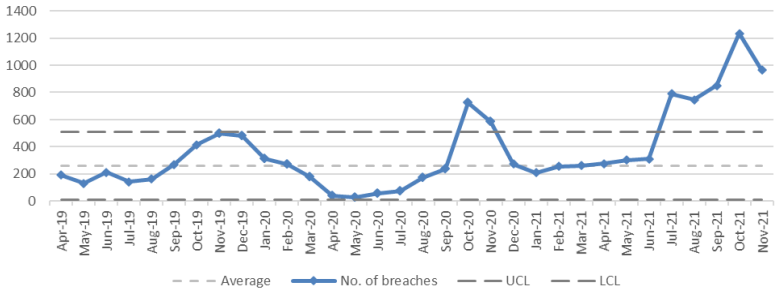


Number of Hospital Onset COVID Infections (HOCI) - Trust

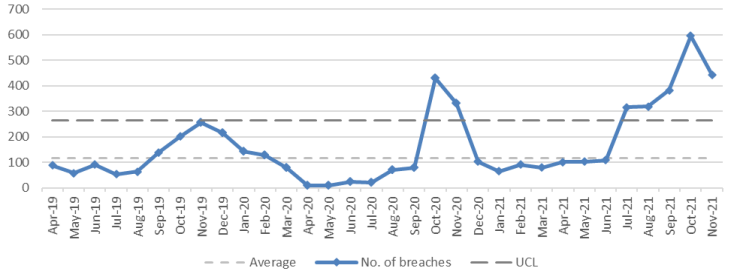


3. Reduce waiting times for individuals attending the ED

8 Hour A&E Breaches based on checkout time

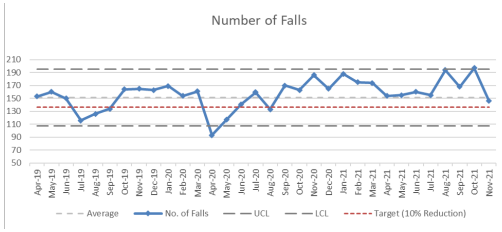


10 Hour A&E Breaches based on checkout time

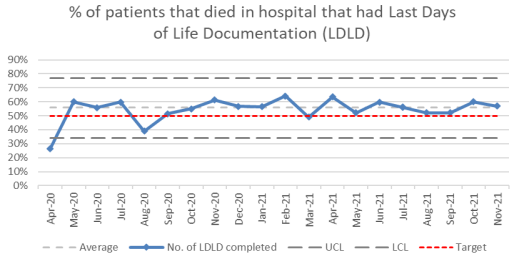


Quality Priorities - Focussed Quality Priorities

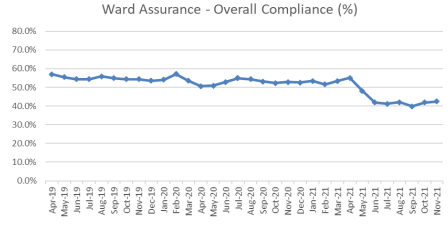
1. Falls Resulting in Harm



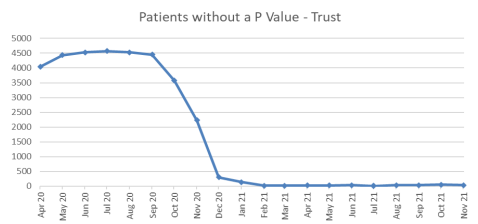
2. End of Life Care



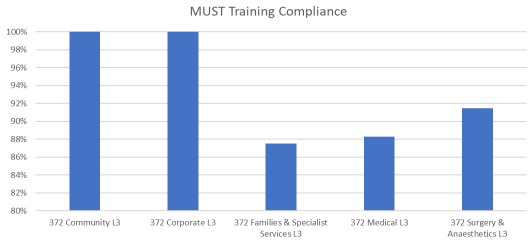
3. Clinical Documentation

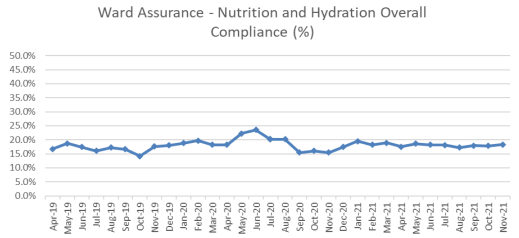


4. Clinical Prioritisation (Deferred care pathways)



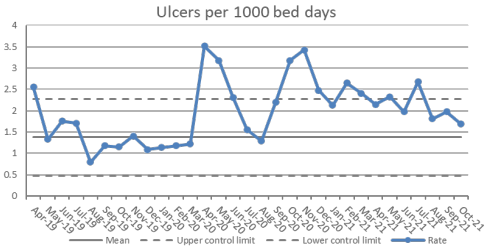
5. Nutrition and Hydration

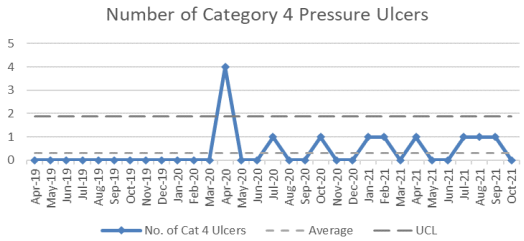




6. Pressure Ulcers

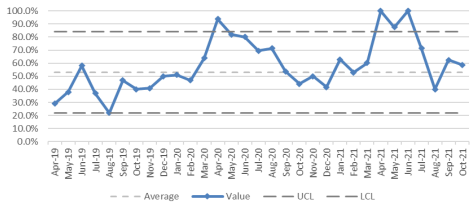
(Reported a month in areas)





7. Making Complaints Count

(Reported a month in areas)

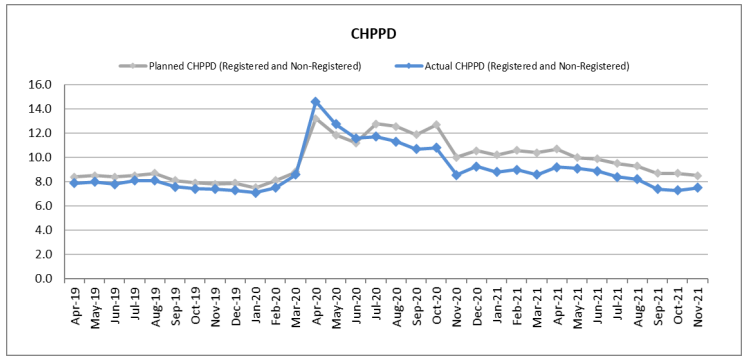


Hard Truths: Safe Staffing Levels

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

	Sep-21	Oct-21	Nov-21
FILL RATES - DAY (REGISTERED & NON REGISTERED CLINICAL STAFF)	86.5%	84.5%	88.1%
FILLRATES - NIGHT (REGISTERED & NON REGISTERED CLINICAL STAFF)	89.6%	90.3%	95.5%

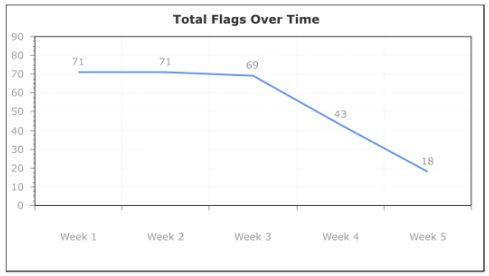
PLANNED CHPPD (REGISTERED & NON REGISTERED CLINICAL STAFF)	8.7	8.7	8.5
ACTUAL CHPPD (REGISTERED & NON REGISTERED CLINICAL STAFF)	7.4	7.3	7.5

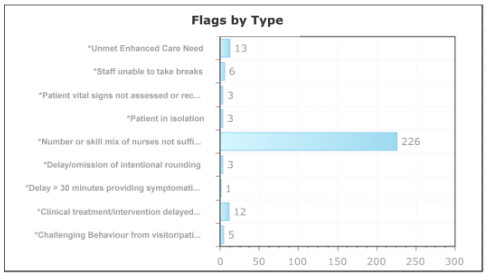


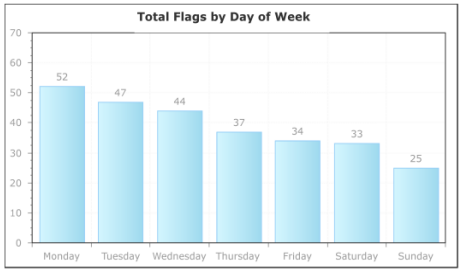
CHPPD provides a single, consistent and nationally comparable way of recording and reporting deployment of staff to provide care on inpatient wards. CHPPD is not a stand alone measure and should be used alongside clinical quality and safety outcome measures.

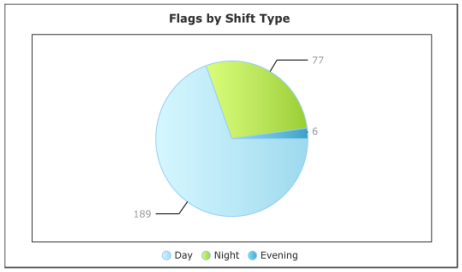
A review of November 2021 data indicates that the combined RN and non-registered clinical staff metrics resulted in 26 of the 28 clinical areas having fewer CHPPD than the planned, with a total deficit of 1.0 CHPPD across the Trust. The gap in CHPPD is at its broadest with the RN workforce representing 1.0 deficit and HCSW 0.1 deficit. This position, whilst still not at desired state, demonstrates an improvement on the October position as a result of newly recruited staff coming out of their supernumerary period. The successful recruitment to HCA roles has enabled increased shift fill to provide support to the reduced RN availability. Professional judgement is used daily to redeploy staff on a shift basis and establish the safest staffing possible in all areas.
A review of the nurse sensitive indicators demonstrates a reduction in the number of falls for November in both the Medical and Surgical divisions. Pressure ulcers are reported a month in arrears so are representative of the challenging October staffing position.

STAFFING RED FLAG INCIDENTS









A Red Flag Event occurs when fewer Registered Nurses than planned are in place, or when the number of staff planned is correct but the patients are more acutely sick or dependent than usual requiring a higher staffing level (NICE 2015). As part of the escalation process staff are asked to record any staffing concerns through safe care live. These are monitored daily by the divisions and monthly through the Nursing workforce strategy group.

The Red Flags are reviewed as part of the daily staffing meetings and immediate mitigate put in place as required.

Hard Truths: Safe Staffing Levels (2)

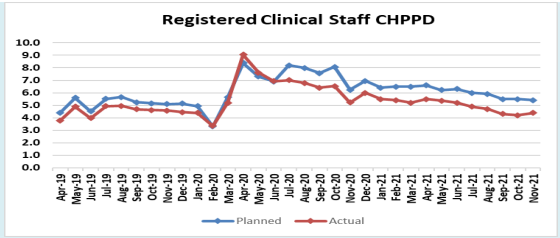
Aggregate Position | Trend | Result

CHPPD BY STAFF TYPE

Registered Clinical Staff

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

CHPPD was 5.4 for planned and 4.4 For actual for Registered Clinical Staff

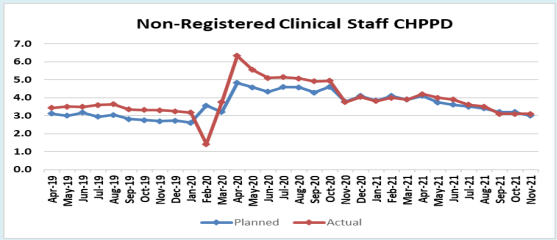


Overall there is a shortfall of 1.0 CHPPD against an overall requirement of 5.4 CHPPD for registered staff. Professional judgement informs decision-making at the twice daily staffing meetings to mitigate the risk across the clinical areas, and staff are redeployed to optimise safety. A suite of nurse 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. For those indicators reported there has been a reduction in the number of falls, partly in response to an improved staffing picture and partly as a result of increased use of falls prevention equipment and increased training.

Non Registered Clinical Staff

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

CHPPD was 3.0 for planned and 3.1 for actual for Non Registered Clinical Staff



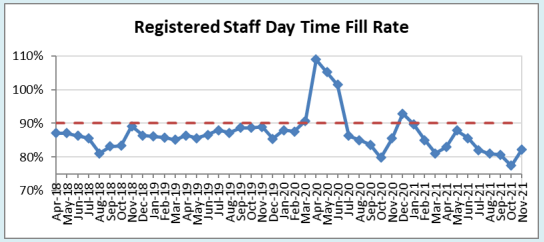
Overall there is an increase in the CHPPD of 0.1 for non-registered clinical staff, which is reflective of the national campaign to achieve a zero vacancy position (achieved April 2021 and subsequently maintained). This slight increase in availability of the non-registered workforce allows provision of 1:1 care needs where required, particularly during the night shift when there are fewer people on the wards to observe patients. There is also a skill mix response to mitigate the risk to meet the needs of patients due to the shortfall in Registered Clinical Staff CHPPD.
The fill-rate percentage of non-registered clinical staff (table below) shows a drop due to an increased demand in the requirement for 1:1 care needs and the need for additional staff due to the increased bed base capacity, rather than an inability to staff established workforce model shift requirements for this workforce.

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.

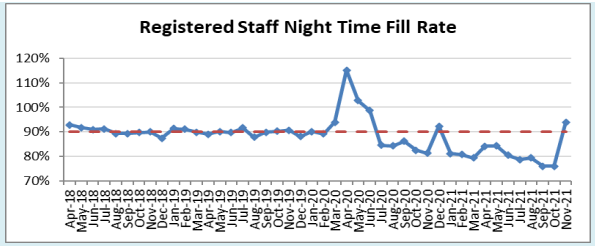
82.29% of expected Registered Clinical Staff hours were achieved for day shifts.



Registered Staff Night

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

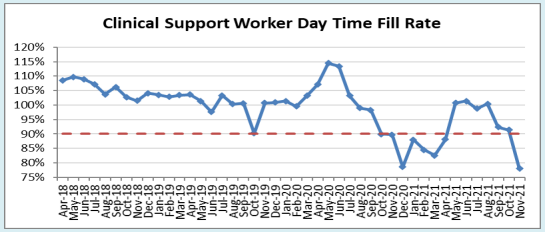
93.94% of expected Registered Clinical Staff hours were achieved for night shifts.



Non Registered Clinical Staff Day

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

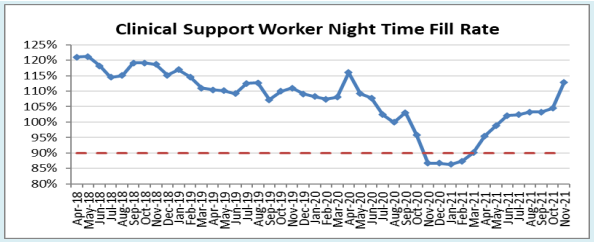
78.04% of expected Non Registered Clinical Staff hours were achieved for Day shifts.



Non Registered Clinical Staff Night

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

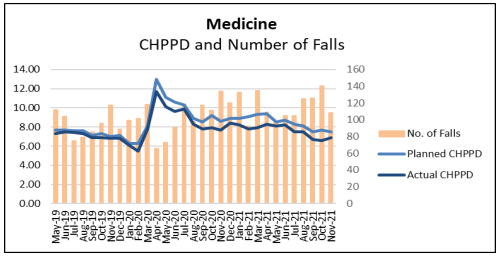
112.87% of expected Non Registered Clinical Staff hours were achieved for night shifts.

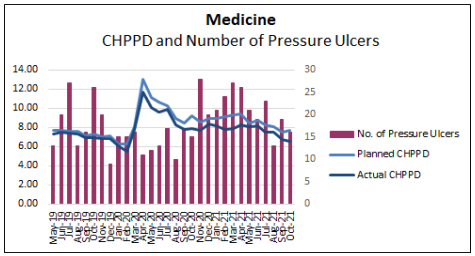


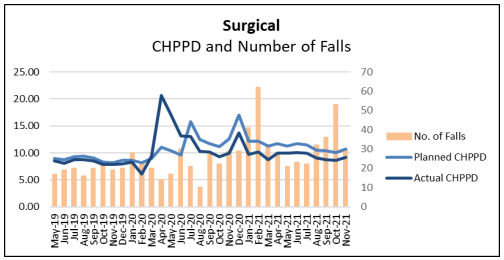
Hard Truths: Safe Staffing Levels (3)

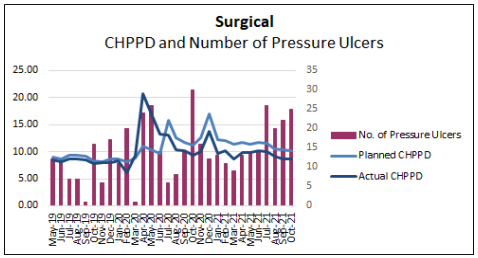
NURSING QUALITY INDICATORS AND FILLRATES BY WARD AND DIVISION

Ward	Average Fill Rates				Care Hours Per Patient Day		Nursing Quality Indicators					Safecare	
	DAY - Registered Clinical Staff (%)	DAY - Non Registered Clinical Staff (%)	NIGHT - Registered Clinical Staff (%)	NIGHT - Non Registered Clinical Staff (%)	Total PLANNED CHPPD	Total ACTUAL CHPPD	MRSA Bacteraemia (post cases)	Pressure Ulcer (Month in Areas)	Falls	Staffing Red Flags	Ward Assurance	Number of red shifts	Number of amber shifts
Medicine	**85.4%**	**95.4%**	**78.3%**	**116.6%**	**7.5**	**6.9**	**0**	**13**	**100**	**156**	**49%**	**559**	**90**
CRH ACUTE FLOOR	91.1%	92.9%	82.1%	110.4%	6.8	6.3		4	17	25	53.7%	61	5
HRI ACUTE FLOOR	87.1%	91.1%	89.7%	92.9%	7.7	7.0		2	16	27	49.7%	58	8
RESPIRATORY FLOOR	73.9%	62.8%	70.9%	76.3%	9.5	6.7			11	6	47.7%	52	11
WARD 5	71.6%	103.2%	74.2%	122.0%	7.1	6.5			3	16	43.9%	43	8
WARD 6	76.3%	74.1%	99.3%	108.3%	4.1	3.5			8	1	53.4%	21	9
WARD 6C	86.3%	85.9%	85.4%	113.3%	11.6	10.8			5		46.9%	11	
WARD 6AB	86.3%	85.9%	85.4%	113.3%	5.8	5.4		1	9	23	47.2%	52	5
WARD CCU	74.2%	63.4%	67.9%		7.9	6.1			2	1	52.2%	22	4
STROKE FLOOR	151.8%	124.6%	79.6%	129.1%	8.0	9.7		1	7	27	42.6%	13	6
WARD 12	90.2%	92.6%	98.4%	100.1%	7.5	7.1		4	4		44.6%	11	2
WARD 15	64.3%	116.6%	56.7%	151.4%	7.5	7.2			5	13	52.5%	50	10
WARD 17	72.5%	106.7%	81.5%	163.3%	5.8	5.5		1	5	7	38.8%	57	9
WARD 18	62.6%	136.1%	74.2%	173.2%	9.1	8.9				2	56.3%	51	4
WARD 20	77.5%	113.2%	65.9%	151.0%	6.9	7.0			8	8	52.6%	57	9
Surgical	**81.3%**	**90.1%**	**76.9%**	**110.7%**	**10.7**	**9.2**		**16**	**27**	**49**	**52.3%**	**202**	**44**
WARD 21	75.1%	87.3%	72.0%	112.8%	9.0	7.6			6		52.4%	21	5
WARD 22	88.7%	96.1%	79.4%	125.9%	6.7	6.3		1	2	3	48.5%	44	7
ICU	80.4%	83.1%	79.9%	77.2%	37.4	30.0		6		3	60.6%		
WARD 8A	92.2%	60.3%	65.0%	100.0%	16.3	12.5			1	3	62.5%	9	3
WARD 8B	97.6%	88.5%	100.6%	133.0%	6.5	6.5				1	53.3%	30	9
WARD 8D	75.3%	59.9%	58.3%		20.5	13.6				2	53.0%	11	
WARD 10	72.0%	103.0%	78.6%	95.1%	8.9	7.4			2	5	53.2%	27	5
WARD 11	62.9%	104.2%	57.4%	135.8%	10.0	8.5			6	15	46.0%	10	4
WARD 19	82.9%	99.1%	83.1%	110.0%	7.9	7.3			6	1	56.8%	9	5
SAU HRI	95.9%	90.8%	82.6%	114.9%	7.5	6.9		9	4	16	37.0%	41	6
FSS	**77.5%**	**84.6%**	**79.4%**	**80.3%**	**9.4**	**7.5**	**0**	**0**	**0**	**2**	**13.2%**	**65**	**9**
WARD LDRP	71.2%	70.3%	73.9%	77.1%	22.0	16.0					13.5%		
WARD NICU	82.9%	93.8%	86.4%	63.3%	13.0	10.8				1	11.2%		
WARD 3ABCD	74.5%	92.7%	77.5%	80.3%	10.6	8.3					15.4%		
WARD 4ABC	86.8%	90.8%	87.3%	92.0%	3.9	3.4				1	12.8%	65	9
TRUST	**82.29%**	**93.94%**	**78.04%**	**112.87%**	**8.5**	**7.5**							









Hard Truths: Safe Staffing Levels (4)

Conclusions and Recommendations

Conclusions

The Trust remains committed to achieving its nurse and midwifery staffing establishments. The November position remains below the required level, but is an improvement on the October position as anticipated.

On-going activity:
1.The use of the enhanced metrics dashboard (previously 'worry ward' dashboard) is embedded in the weekly senior safer staffing review meeting. Areas with less than 85% shift fill rate are scrutinised with a suite of nurse sensitive indicators. Specific action plans are generated by the ADNs and reported through the Gold Command structure.
2. The Nursing and Midwifery Workforce Steering Group agenda has been incorporated into the twice weekly Senior Nurses' Staffing Meeting and is progressing work to understand the detail of the vacancy position and potential leavers and aligning this to the recruitment/training strategy in partnership with the local HEI.
3. A review of the current Nursing and Midwifery workforce plans is underway and supported by Workforce Business Intelligence, reviewing directorate specific pressures to inform recruitment.
4. Work is ongoing to maximise the use of HealthRoster and the confirm and challenge process, to ensure a reduction of planned variability of shift fill across weekdays and weekends, as well as ensuring Annual Leave and Study leave is planned within agreed headroom.
5. The International recruitment project continues to progress well with 67 recruits of the planned 70 resident in the UK at the end of November. A further 5 are in place for arrival prior to the end of December. Plans for further International Recruitment in 2022 are being implemented with a commitment from WEB to support a further 80 International Recruits in 2022.
6. Trainee Nursing Associate apprenticeships and Registered Nurse Apprenticeships continue to be supported to supplement the RN workforce recruitment strategy, with cohort 4 of the TNAs due to register in January 22 providing a further 13 registrants for the NewYear. Cohort 7 will commence at the end of December to which 20 HCAs have been recruited to commence the TNA apprenticeship.
7. CHFT was successful in a bid to secure funding from HEE to support a band 6 project lead for 6 months to improve the use of health roster to facilitate student placements. This will enable improved experience by removing the peaks and troughs of student presence in an area by allocating across the 7-day week and 24hr shift patterns. This will enable closer working patterns aligned to practice supervisors and assessors. It will also allow for an increase in student placement capacity by approximately 20%.
8. In response to the changing situation as a result of the emergence of the Omicron strain of Covid, activity is underway to plan for any surge in clinical demand and/or significant staffing challenges as a result of staff absence.

20. High Level Risk Register

To Approve

Presented by Lindsay Rudge

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 13 January 2022
Meeting:	Public Board of Directors
Title:	High Level Risk Register
Author:	Lisa Cook, Head of Risk and Compliance
Sponsoring Director:	Lindsay Rudge, Interim Chief Nurse
Previous Forums:	Risk Group – October and December Quality Committee

Purpose of the Report

To provide the Trust Board with assurance as to the identification and ongoing work in the management of risk across the Trust, and to present an update on risks on the High-Level Risk Register.

Key Points to Note

There are governance processes in place for the identification, scoping, management, and oversight of risk. There is ongoing work to strengthen the monitoring of actions and to identify measurable outcomes linked to risk scores. This will enable clearer oversight of the effectiveness of mitigations and the impact of any gaps.

The Risk Group reviews the High Level Risk Register (HLRR) and is the forum for decisions over proposed acceptance and removal of risks from the HLRR.

This paper reports the current HLRR and highlights changes from the Risk Group meetings in October and December 2021.

As of the 15 December 2021 there were 25 risks on the high level risk register, with the following profile:

Risk Score	Number of Risks
25	2
20	9
16	9
15	5

An overview is below with the detail in the following summary report

Appendix 1 provides the full high level risk register summary report from 15 December 2021
Appendix 2 details risk movement, the heat map and risk score history

No new risks onto the HLRR since last report to Board (September 2021)

Existing top risks

7809 (25) Theatre and clinic capacity (Covid risk)

6345 (25) Nurse staffing risk

7689 (20) Waiting for diagnostics, operations and outpatients (COVID)

8057 (20) Risk of not achieving the Full Year 2021/22 Financial Plan (Corporate)

7078 (20) Medical staffing risk

7328 (20) Uncovered tier one non-resident Ear, Nose and Throat (ENT)

7454 (20) Radiology Staffing Risk

7474 (20) Medical devices

7479 (20) Caring for young people with acute mental health issues – Family and Specialist Services (FSS)

Risks removed from High level risk register since last report to Board (September 2021)

8021 Theatre capacity for emergency obstetrics (FSS)

8041 Training and safe delivery of oxygen (Medicine)

8026 Lack of estate in Emergency Department (ED) (Medicine)

7981 Reduced senior cover in both Emergency Departments (Medicine)

8029 Open Maternity pathway (FSS)

7769 Progression of eye diseases resulting in increased risk of sight loss (Covid risk)

Rationale for risk removal from the HLRR is given in Appendix 1.

Movement of risks remaining on the HLRR (see Appendix 1 for detail)

Risks **reduced** in score

7930 Ophthalmology delayed treatment for glaucoma resulting in an increased risk of sight loss (Covid risk)

Risks **increased** in score

6453 Fractured Neck of femur - repair within 36 hours

7615 Not meeting the four hour emergency care standard

6345 (25) Nurse staffing risk – This risk has increased in score from a 20 to a 25.

EQIA – Equality Impact Assessment

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

Recommendation

The Board is asked to **NOTE** and **APPROVE** the current risks on the High level Risk Register.

Appendix 1 - High Level Risk Register – November 2021

EXISTING TOP RISKS (20 and above) 10 in total

7809 - Theatre and clinic capacity (C5 x L5 = 25) SAS

There is a risk of being unable to deliver timely clinical activity
Due to a lack of capacity (theatre and clinic)
Resulting in potentially poor outcomes for patients and a poor experience.
Current Update: November 2021
Status quo with elective theatre capacity still running significantly lower than pre-covid levels. Insourcing arrangements for additional surgery in ENT, ophthalmology and orthopaedics (through CHOP LLP) in place
Action: Risk Team to meet with the senior team in surgery to identify measures and link to risk score.

7689 - Waiting for diagnostics, operations and outpatients (C4 x L5 = 20) Trust wide

There is a risk that patients may have to wait for outpatient appointments, diagnostic tests or routine operations
Due to cancellations of routine surgery and rescheduling of clinics
Resulting in patients waiting longer than is best practice for outpatient appointments, their condition deteriorating, with a potential impact on treatment options available and a less positive outcome.
Current Update: November 2021
Face to face clinics continue to increase with social distancing at 1M in Outpatient seating areas. Face to face Insourcing clinics have now commenced in ENT (with 2 providers) Neurology, Glaucoma Diagnostics (F/Up) and General Ophthalmology. Customer contact meetings are running and monitoring capacity, demand and recovery plans across the insourcing and CHFT appointments.
Action: Risk team to link in with the lead of Customer contact meetings to identify measures that can be linked to the risk score, in order to monitor progress.

8057 - Risk of not achieving the Full Year 2021/22 Financial Plan (C5 x L4= 20) Corporate

There is a risk that the Trust fails to meet their plan to break-even resulting in a deficit position
Due to a significant reduction in funding compared to the first half of the year. Funding for half 2 (H2) is estimated and lack of a national funding settlement / national guidance means there is uncertainty regarding the funding regime for the second half of the year.
Resulting in a likely very high efficiency requirement estimated at £13.2m, which would equate to a 6.2% efficiency challenge.
Latest update: September 2021
For the second half of the year, the risk of not achieving the financial plan is assessed to be Extremely High. The financial plan for H2 is based on a number of high level assumptions due to fact that a national funding settlement has not yet been reached and no planning guidance has yet been issued. The Trust's Business as Usual expenditure has increased significantly over the last 12 months and it is unclear whether national funding will increase in line with these cost increases. The H2 plan already assumes a significant increase in funding compared to the five year plan submitted back in 19/20, based on the assumption that there was no requirement to deliver any efficiency during the pandemic. The plan also assumes that Financial Recovery Funding continues at the level previously agreed by NHSI via the Financial Improvement Trajectory. Based on these assumptions the Trust would still have a very high efficiency requirement for the second half of the year that would equate to around 6.2% of operating expenditure and schemes to deliver this efficiency have not yet been developed.
Whilst no formal guidance has yet been issued as at Month 4, indications are that existing funding arrangements will continue less a 3% efficiency. Whilst this would reduce the efficiency requirement to some extent, a funding reduction of 3% versus H1 would equate to a 4.5% efficiency, given the existing £3m efficiency target already built into the H1 budget. There also remains significant uncertainty regarding the availability of Elective Recovery Funding for H2 and costs are already being committed to support the recovery effort for which funding is not assured.
Risk Rating agreed by Finance and Performance Committee April 21
Action: Risk team to work with finance team to identify measurable outcomes to link to risk score.

6345 - Nurse staffing risk (C5 x L5 = 25) Corporate

There is a risk of not being able to deliver safe, effective and high quality care
Due to a lack of nursing staffing
Resulting in an increase in clinical risk to patient safety due to inability to deliver required level of care, reduced level of service and less specialist input

- negative impact on staff morale, motivation, health and well-being and ultimately patient experience
- negative impact on sickness and absence
- negative impact on staff mandatory training and appraisal
- cost pressures due to increased costs of interim staffing

Latest Update: December 2021

Despite reducing Trust Registered Nurse vacancies through International recruitment (70 in year) and Newly Qualified Nurse Recruitment (63 from Sept cohort), the Trust has experienced a significant impact from the Covid Omicron variant and the number of staff being absent due to Covid sickness or isolation, with many areas experiencing greater than 35% staff absence.

The NHSE Winter Planning Guidance has been implemented along with its Associated Assurance Framework. This includes the instigation of Twice Daily Senior Staffing Meetings Chaired by the Associate Director's of Nursing and weekly scrutiny of nurse sensitive indicators via an enhanced metrics dashboard when shift fill falls below 85%. Detailed plans are enacted to address any identified deterioration in the following nurse sensitive outcomes: increased pressure ulcer prevalence; increased numbers of falls; increased number of hospital acquired infections; increased numbers of complains or clinical incidents.

To prepare for any surge activity, plans are in place to enable upskilling of staff, using skills passports, should additional Intensive Care Uni (ICU) or Respiratory nursing skills be required.

The risk impact of the situation is being assessed and mitigated on a shift by shift basis through the staffing meetings, with Operational Pressures Escalation Levels (OPEL) triggers and actions in use. Further work is underway to review the OPEL actions cards to respond to the deteriorating staffing picture facilitated by the Associate Director of Nursing for Corporate Services and supported by Divisional ADN's and Matrons from clinical areas.

Enhanced rates for additional hours worked remain in place and lead times for high cost agencies have been increased for specialty areas to increase the likelihood of shift fill. This is noted to increase the financial risk.

Due to the latest challenging position, the decision was made at the Nursing and Midwifery Workforce Strategy Group to increase this risk to 25 (Risk of serious harm due to inability to delivery necessary care on a daily basis).

Work continues to strengthen international recruitment and development of Nursing Associates as well as supporting the Registered Nurse apprenticeship programmes.

Action: Risk team to link with risk lead to add measures and review risk score as target date has passed.

7078 - Medical staffing risk (C4 x L5 = 20) Corporate

There is a risk of not being able to deliver safe, effective and high quality care
Due to difficult to recruit to Consultant posts in Gastroenterology, Radiology, Dermatology and Ophthalmology,
Resulting in increase clinical risk and patient safety
Current Update: **November 2021**
Significant operational pressures continue for our clinicians and recruitment activity continues to minimise the vacancies. There has been a net gain in the number of doctors employed year on year – 41 more people in post October 2021 compared to October 2021. Of a budgeted funded establishment of 691 medical and dental staff there are 29 vacancies. This is really good progress, however, there are some sub-specialties that are still very difficult to recruit to. These include Emergency Medicine, Stroke Medicine, Acute Medicine and Respiratory Medicine. AACs have been scheduled for Gastroenterology and Respiratory Medicine in November, when it is hoped we will make successful appointments as we have received applications.

With regards to the implementation of the 2021 SAS Contract progress has been affected by the 3% pay award given to medical and dental staff in all grades except the 2021 contract holders. This is likely to reduce the number of people who will benefit financially from the transfer. Whilst NHS Employers have pointed out the other benefits of the new Terms and Conditions, the risk of owing monies upon transfer to the new contract seems likely to deter individuals in the short term. NHS Employers have confirmed that there is no expectation that the 3% pay increase will be applied to the 2021 Contracts so this position will not change.

The SAS Advocate role is going to be introduced as part of the SAS reform programme. This person will fulfil a different remit than that covered by the current SAS Lead and will be able to focus on providing support for SAS doctors and to ensure that they are aware of and able to access the wellbeing packages that are in place.

Following a review of the training and induction programme available for Clinical Directors two sessions have been

held with HR colleagues, to ensure an understanding of the key policies and procedures and to commence the leadership training package. A full package of support has been developed to build upon their skills and ensure effective peer support.
Action: Risk team to link with lead to review score based on increase to establishment.

7454 - Radiology Staffing Risk (C4 x L5 = 20) Families and Specialist Services

There is a risk to Radiology service provision capacity
Due to a reduction in Radiology Consultants
Resulting in reduced capacity to cover in some specialist areas with the potential to breach national targets
Current update: November 2021
The overseas doctors recruited as part of the global fellows scheme are awaiting entry exams (delayed by covid) so their start date is delayed until further notice. The trainee due in September commenced as planned. A second VIR consultant has been appointed through an NHS locum contract and is due to commence December 2021. We are working with LTHFT to develop new shared posts. A business case is currently being worked on to gain approval from Leeds, CHFT already has the necessary funding through vacancies
Action: Risk team to link with risk lead as position appears to have improved, so to review risk score.

7474 - Medical devices (C4 x L5 = 20) Trustwide

There is a risk of out of service medical devices being in circulation and in use across CHFT
Due to the lack of assurance about the Trust Asset Register being up to date as it doesn't include equipment which has been gifted or bought without CHS involvement and wards/departments not managing their equipment effectively
Resulting in potential patient harm to patients.
Current Update: November 2021
2021/11/01-Update High risk risen (from 940 to 949), Medium risen (from 3220 to 3231), Low risen (from 1637 to 1683) a total of (from 5797 to 5863). this month will see the first reverse KPI submitted to Divisions with assets not submitted for maintenance to be presented/identified within month, if not the asset will be archived as not found, if identified maintenance plan to be put in place, if presented maintenance to be completed ASAP. Have engaged with THIS to give access to all Trust staff to the asset database Integra eQuip.
2021/10/01-Update High risk fallen (from 958 to 940), Medium fallen (from 3273 to 3220), Low fallen (from 1695 to 1637) a total of (from 5926 to 5797). Progress has been affected by lack of staff due to Positive covid cases, covid isolation, higher demand and reactive repairs due to increase usage of assets. Have started the process of recruiting Bank staff. The proposed action plan should enable the rectification of the compliance targets if accepted.

7479 – Caring for young people with acute mental health issues (C4 x L5 = 20) FSS

There is a risk that young people will be managed on the paediatric ward for an extended period of time waiting for a specialist bed or Children's Social care management
Due to a National shortage of inpatient provision for Young people with acute mental health issues
Resulting in staff caring for vulnerable young people in not an appropriate environment and without the appropriate skill set or professional training to manage patients safely, resulting in potential harm to the patient with mental health needs, other patients, carers and staff.
Current update: November 2021
Initial joint meeting with Camhs, CCG to scope new ways of working and channels for escalation.
Action: Risk team to link with risk leads to review gaps in assurance and action plans.

7328 - Uncovered tier one non-resident ENT (C4 x L5 = 20) SAS

There is a risk of uncovered tier one non-resident ENT on-call rota gaps
Due to only 4 out of 6 posts currently filled.
Resulting in staff burn out and risk of uncovered on-call shifts. Possible knock-on effect includes impact on outpatient clinics and theatre lists activity post busy on-call if consultants end up covering the gap. This also adds a financial pressure.
Current update: October 2021
The middle grades are still providing tier 1 on call cover - business case to be developed for ACP's to support/provide first tier on-call day/night and emergency clinic cover
Identified Lead – Sharon Berry
Action: Risk team to link with risk lead, identified at last update that team is recruited to establishment. Risk score and gaps in assurance to be reviewed.

INCREASED RISKS

6345 - Nurse staffing risk Increased to (C5 x L5 = 25) Corporate

There is a risk of not being able to deliver safe, effective and high quality care
Due to a lack of nursing staffing
Resulting in an increase in clinical risk to patient safety due to inability to deliver required level of care, reduced level of service and less specialist input
- negative impact on staff morale, motivation, health and well-being and ultimately patient experience
- negative impact on sickness and absence
- negative impact on staff mandatory training and appraisal
- cost pressures due to increased costs of interim staffing

6453 – Fractured Neck of Femur (#NOF) - repair within 36 hours (C4 X L4 = 16) Increased to (C4 x L5 = 20)

There is risk of poor patient experience, safety, quality of care, extended length of stay due to failure to undertake surgical repair of fractured neck of femur (#NOF) within 36 hours of admission and maintain BPT in 85% of patients.
Due to availability of surgeons with appropriate skills to undertake THR and surge in activity of #NOF & general trauma.
Resulting in extended length of stay and increased mortality in this patient group.
Reason for increase:
Reviewed at fractured neck of femur multi disciplinary group. Around 17 Trauma 2 theatres cancelled over last few months due to inability to staff with theatre team has had an effect on ability to meet standards for <36hrs to theatre. Mortality rate on National Hip Fracture Database now available showing a mortality rate increase from 5% previously to 8.5% Nov 2020. Audit of mortality rates taking place and to be monitored monthly, slight decrease on monitoring of mortality rate of 7.4% August 2021.

7615 – not meeting the four hour emergency care standard (C3 x L5) Increased to (C4 x L5 = 20)

There is a risk of not meeting the four hour emergency care standard
Due to increasing demand on Emergency Care, patient flow issues, delays in assessment and discharge due to lack of social care staffing (hospital based social work team), lack of timely domiciliary care in community
More recently there have been increasing demand for side rooms due to the need to isolate patients with possible COVID-19, this has caused increasing delays.
Resulting in poor patient experience, patient harm, increased scrutiny and reputational damage
Reason for increase: Risk score increased and agreed at Patient Safety Quality Board

RISKS WITH REDUCED SCORE

7930 - **Ophthalmology delayed treatment for Glaucoma resulting in sight loss (C5 x L4 =20) reduced to (C4 x L4 = 16)**

There is a risk of progression of glaucoma and sight loss
Due to due to the impact of COVID-19 pressures and subsequent backlog of patients who were initially stratified as low risk, being deferred 6 months now converting to high risk and in need of face to face assessment. Continual social distancing measures are continuing to result in 2/3 reduction in capacity through the glaucoma service
Resulting in long delays to receive follow up assessment which may impact on prognosis, clinical outcomes and quality of life.
Reason for reduction:
Diagnostic clinics now up and running in addition to insourcing company capacity.

RISKS REMOVED FROM HLRR

8021 Theatre capacity for emergency obstetrics (FSS) (C3 x L4 = 12)

There is a risk of delays in category 1 and category 2 caesarean sections, repair of third and fourth degree tears and manual removal of placenta.
Due to the current arrangement for access to maternity theatres in an emergency situation
Resulting in potential increased blood loss and pain, and an increased risk of infection and poorer outcomes for mothers and babies.

Reason for Reduction: Close monitoring of all incidents and delays through weekly governance group. No incidents of harm have been identified.

8041 Training and safe delivery of oxygen (Medicine) (C3 x L4 = 12)

There is a risk of staff not receiving the required level of training for the safe delivery of Oxygen.
Due to the current electronic training package is out of date and there are no identified trainers to deliver the training.
Resulting in the potential harm to patients/delay in receiving treatment or protocol/policy not followed
Reason for Reduction: New training package developed and Trialled, Changes made to the medical device training created and trialled. New training package approved by the NIV/O2 & Medical Gas committee.

8026 Lack of estate in ED (Medicine) (C3 x L4 = 12)

There is a risk of poor patient safety and experience in the emergency department
Due to lack of estate for the current service that is being delivered and across a Covid-segregated ED with 2 x resuscitation rooms, and no separate child friendly cubicles
Resulting in inadequate service provision for all patients attending the Emergency Departments.
Reason for Reduction: Orthopaedic outpatients now used as urgent care hub. Children's waiting area reinstated within department. Rooms 1-5 being utilised for paediatrics and another 2 rooms for Emergency Department Dr's to see patients.
HRI remodelled to create isolated high risk area and increase flexible area and increase capacity for ambulance handovers.

7769 Progression of eye diseases resulting in increased risk of sight loss (Covid risk)
There is a risk of progression of eye pathology and sight loss
Due to the impact of COVID-19 pressures and the need to cancel all non-essential outpatients and surgeries throughout 2020/21
Resulting in an impact on prognosis and clinical outcomes.
Reason for closure: The Trust has reopened out-patients to a full service with the ability to provide all sub-specialty new and routine appts including high, medium and low risk stratified patient appts.
There are notable backlogs and patients overdue, but validations are being managed and coordinated by the failsafe team and Consultants.
It has been decided to close this risk due to reopening a full service.

Appendix 2

TRUST RISK PROFILE AS AT 08/12/2021

KEY: = Same score as last period ↓ decreased score since last period

! New risk since last period ↑ increased score since last period

LIKELIHOOD (frequency)	CONSEQUENCE (impact/severity)				
	Insignificant	Minor	Moderate (3)	Major (4)	Extreme (5)
Highly Likely (5)			= 6715 Poor quality / incomplete documentation	= 7078 Medical Staffing = 7454 Radiology staffing = 7689 Diagnostics, OPD, operations = 7474 Medical Devices = 7479 Caring for young people with acute mental health issues = 7328 ENT staffing Shortage = 7615 Emergency care standard	=7809 Theatre and clinical capacity ↑ 6345 Nurse Staffing
Likely (4)				= 6596 Delay in SI investigations = 7634 Vacancies in theatre = 2827 Over reliance on locum middle grade doctors in A&E = 7683 Isolation facilities = 7678 Covid impact on medical staffing = 8037 - Insufficient estate to support community based services = 7834 Elective orthopeadic theatre capacity = 8196 colon capsule service ↓7930 Ophthalmology delayed treatment Glaucoma	= 8057 Risk of not achieving 21/22 financial plan = 6453 Delay of surgical report #NOF
Possible (3)					= 5747 Vascular /interventional radiology service = 7413 Fire compartmentation HRI = 7414 Building safety = 7015 Nurse staffing SAS
Unlikely (2)					
Rare (1)					

	Risk No	Div	Dir	Dep	Opened	Status	Objective	Risk Description plus Impact	Existing Controls	Gaps in Controls	Initial	Current	Target	Action Plans	Progress Update	Review	Target	Tolerate	RC	Exec Dir	Lead
Very High	6345	Corporate	Workforce & Organisational Development	Resourcing / Recruitment	Jul-2015	Active	Keeping the base safe	There is a risk of not being able to deliver safe, effective and high quality care with a positive experience for patients due to: - insufficient nursing staff, i.e. not achieving recommended nurse staffing levels (as per Establishment reviews/CHPPD and national workforce models) - Inability to adequately staff flexible capacity ward areas resulting in: - increase in clinical risk to patient safety due to reduced level of service / less specialist input - negative impact on staff morale, motivation, health and well-being and ultimately patient experience - negative impact on sickness and absence - negative impact on staff mandatory training and appraisal - cost pressures due to increased costs of interim staffing Nurse Staffing Risk (see also medical staffing risk 7078 and therapy staffing risk 7077). Risk was also referenced in Risk 5937 - this has now been merged to Risk 6345.	Nurse Staffing To ensure safety across 24 hour period: - use of electronic duty roster to set nurse staffing within agreed workforce models, approved by Matron and general managers - risk assessment of nurse staffing levels for each shift reviewed at least three times each 24 hour period using the Safer Care tool with formal escalation to Director of Nursing to agree mitigating actions. - staff redeployment where possible - nursing retention strategy - flexible workforce used for shortfalls (bank/nursing, internal, agency) and weekly report as part of HR workstream - Active recruitment activity, including international recruitment - Introduction of new roles e.g. Nurse associate - Identification and training of volunteers to meet and additional surge demand	Low numbers of applications to nursing posts across grades and specialities National shortage of RGN's Large numbers of staff isolating due to Covid 19.	16 4 x 4	25 5 x 5	9 3 x 3	• Local/domestic recruitment - monthly assessment centres • International recruitment project • Nursing associate role development and deployment of graduating cohorts • Workforce transformation (NA's, TNA's and ACP's) • Developing nursing retention strategy • Use of flexible workforce • Utilisation of nursing workforce using safe care live • Response to the NHS interim people plan - significantly grown the number of undergraduate Health students to improve the pipeline of nurses to recruit	July 2021 International recruitment ahead of target. More streamlined recruitment process allowing shorter time for onboarding. Students due to qualify in September now aligned to wards and mapped to vacancy positions Successful recruitment of 7 NAs to undertake Top-up degree to RN to commence Oct 21. A further 3 to commence Feb 22 Sickness/Covid Absence and A/L Challenges impacting on day to day staffing. Close scrutiny of leave and sickness guidance enforced.	Jan-2022	Mar-2022		WF	Ellen Armistead, Suzanne Dunkley	Janet Youd
Very High	7809	Surgery & Anaesthetics	All Directorates S&A	All Departments/Wards S&A	Jun-2020	Active	Keeping the base safe	There is a risk of being unable to deliver timely clinical activity due to a lack of capacity (theatre and clinic) resulting in a potentially poor outcomes for patients and a poor experience.	Patients are being reviewed and allocated P values. Theatre lists being allocated according to the trust's priority criteria. Enhanced payments have been approved to support additionality for elective activity (initial model had limited uptake; a new model was launched from late Jul).	Elective theatres are running on both sites but not at full pre-covid capacity yet due to lower staffing levels in theatres.	16 4 x 4	25 5 x 5	3 1 x 3	Each directorate team is managing their waiting lists and backlogs.	Nov 2021: status quo with elective theatre capacity still running significantly lower than pre-covid levels. Insourcing arrangements for additional surgery in ENT, ophthalmology and orthopaedics (through CHOP LLP) in place Sep 2021: elective theatre capacity still running significantly lower than pre-covid levels - due to higher vacancy levels, isolation, health and wellbeing hours, staff redeployment (relatives line). A limited number of weekend lists are planned for Sep through the enhanced payments	Dec-2021	Jun-2022		PSQB	William Ainslie	Thomas Strickland

Very High	7328	Surgery & Anaesthetics	Head and Neck	Ear, Nose and Throat	Sep-2018	Active	Keeping the base safe	Risk of uncovered tier one non-resident ENT on-call rota gaps due to only 4 out of 6 posts currently filled. This could result in staff burn out and risk of uncovered on-call shifts. Possible knock-on effect includes impact on outpatient clinics and theatre lists activity post busy on-call if consultants end up covering the gap. This also adds a financial pressure.	- All current staff (AP, TT) are signed up on bank to help cover gaps (Nov 2018) - Previous trainees (DM, BY) and Speciality doctors (JI) are also signed up on bank (Oct 2018) - Spec Doctor ENT job advert gone out. Interviewing 2 candidates on 14/11/18 - Tier 2 non-resident consultant rota staffed ACP's from ortho and ENT GPST providing a first tier on call for night cover from Sept 2021 - intensity of night not reduced greatly for Middle grades	Sep 2018 rotation of trainees includes a Less Than Full Time (LTFT) colleague (60% FTE) therefore in October 2018, the situation may get worse.	12 3 x 4	20 4 x 5	1 1 x 1	13.12.21 set up Teams session with middle grades, ACPs and GPST's to understand problems and devise any how to guides or referral pathways documents to ease pressure of calls overnight to the 2nd tier on call Recruit more ENT doctors (Nov 2018)- completed	Nov 2021 - discussion between CD, GM and clinical lead regarding future plans - business case to be developed for 2 locum posts to support this rota, support recovery and ensure registrars meet clinical requirements for training. ACP's and middle grade session to be set up to discuss any further training needs etc. 25.10.21 the middle grades are still providing tier 1 on call cover - business case to be developed for ACP's to support/provide first tier on-call day/night and emergency clinic cover 16.9.21 - recruited to establishment	Jan-2022	Sep-2022		PSQB	Thomas Strickland	Sharon Berry
Very High	7689	Trustwide	All Divisions	All Departments/Wards	Mar-2020	Active	Keeping the base safe	There is a risk that patients may have to wait for outpatient appointments, diagnostic tests or routine operations Due to cancellations of routine surgery and rescheduling of clinics Resulting in their condition deteriorating, potential impact on treatment options available and a less positive outcome	EPR booking and validation processes Urgent fast-track processes in place Risk assessment for re-prioritisation of appointments Virtual appointments commenced in some prioritised areas	Unable to meet target KPI's for RTT and diagnostics, and that patients will wait longer than is best practice for outpatient appointments with an increase in the ASI list and holding list.	20 4 x 5	20 4 x 5	4 2 x 2	Clinical review and prioritisation of essential patients Medicine: risk assessment of booked and due, consider remote or delay 3-6 months. Working up CAS model and recovery plan. Incident reporting for identifying patient harm or impact on prognosis or outcome Complaints and PALS Team logging enquiries and concerns re waits for appointments, and patients not wishing to attend for appointments	December 21 F2F clinics are still increasing which have been booked in priority order after clinical validation All areas adhering to social distancing rules. Insourcing still ongoing in the same key areas in order to reduce ASI waits. Recovery plans still ongoing at this stage November 21 - F2F clinics continue to increase with social distancing at 1M in OP seating areas. F2F Insourcing clinics have now commenced in ENT (with 2 providers) Neurology, Glaucoma Diagnostics (F/Up) and General Ophthalmology. Customer contact meetings are running and monitoring capacity, demand and recovery plans across the insourcing and CHFT appointments.	Jan-2022	Mar-2022		NA	Helen Barker	T Strickland, S Shepley, A Ameen, L Willia
Very High	8057	Corporate	Finance and Procurement	Trustwide Finance	May-2021	Active	Financial sustainability	Risk of not achieving the Full Year 2021/22 Financial Plan: The Trust is planning a break-even position for the second half of 21/22. There is a risk that the Trust fails to achieve this plan resulting in a deficit position due to: - a significant reduction in funding compared to the first half of the year. Funding for H2 is estimated and lack of a national funding settlement / national guidance means there is uncertainty regarding the funding regime for the second half of the year. - a likely very high efficiency requirement estimated at £13.2m, which would equate to a 6.2% efficiency challenge. - ongoing cost of Covid-19 and the potential for an Autumn / Winter surge. - Recovery plans generate costs in	Business As Usual Controls: Standing Financial Instructions set spending limits Project Management Office in place to support 'Business Better than Usual' and the identification of efficiencies. Accurate activity, income and expenditure forecasting Finance and Performance Committee in place to monitor performance and steer necessary actions Executive review of divisional business meetings Budget reviews hold budget holders to account Accountability guidance and escalation process for budget holders. Controls around use of agency staffing. Approval process for new investments through Commercial Investment Strategy Committee	National guidance not yet published for H2 - uncertainly about funding envelope for H2. Potentially very high efficiency target for H2 which is materially unidentified. Uncertainly regarding costs and funding for Recovery. Access to the Elective Recovery Fund will depend on System performance and not the performance of individual organisations. Reduced focus on financial efficiency due to impact of Covid-19 and Recovery requirements. Lack of direct consequence to budget holders for poor budgetary management. Capacity planning challenges - including impact	20 5 x 4	20 5 x 4	12 4 x 3	• Divisional budgets have been set for the full financial year, but there remains uncertainly regarding the financial regime for H2. A further plan update will be required in advance of Month 7 to incorporate national guidance once it is published for H2. • The Trust is undertaking an 'Efficiency Engagement Project' over the next few months to identify opportunities for efficiency. • Recovery plans are due to be completed by the end of May and any expected expenditure / funding impact will be incorporated into the Trust Forecast.	For the second half of the year, the risk of not achieving the financial plan is assessed to be Extremely high. The financial plan for H2 is based on a number of high level assumptions due to fact that a national funding settlement has not yet been reached and no planning guidance has yet been issued. The Trust's Business as Usual expenditure has increased significantly over the last 12 months and it is unclear whether national funding will increase in line with these cost increases. The H2 plan already assumes a significant increase in funding compared to the five year plan submitted back in 19/20, based on the assumption that there was no requirement to deliver any efficiency during the pandemic. The plan also assumes that Financial Recovery Funding continues at the level previously agreed by NHSI via the Financial Improvement Trajectory.	Sep-2021	Mar-2022		FPC	Gary Boothby	Philippa Russell

								excess of budgeted levels, not offset by additional funding.	High level of scrutiny around agency and bank expenditure including monthly Exec lead meeting. Access to Elective Recovery Fund to support expenditure required for Recovery above threshold activity expected to continue into H2 as national funding confirmed for full year. Approval process agreed for Recovery expenditure - WEB to sign off following recommendation by Recovery Oversight and Co-Ordination Group	of external pressures					Based on these assumptions the Trust would still have a very high efficiency requirement for the second half of the year that would equate to around 6.2% of operating expenditure and schemes to deliver this efficiency have not yet been developed. Whilst no formal guidance has yet been issued as at Month 4, indications are that existing funding arrangements will continue less a 3% efficiency. Whilst this would reduce the efficiency requirement to some extent, a funding reduction of 3% versus H1 would equate to a 4.5% efficiency, given the existing £3m efficiency target already built into the H1 budget. There also remains significant uncertainty regarding the availability of Elective Recovery Funding for H2 and costs are already being committed to support the recovery effort for which funding is not assured. Risk Rating agreed by Finance and Performance Committee April 21						
Very High	8198	Surgery & Anaesthetics	Critical Care	ICU	Nov-2021	Active	Developing our workforce	There is a risk to the wellbeing of staff within ICU due to the current pressures resulting in human errors and potential patient harm. This includes all staff, consultants, middles grades, nurses, outreach and there is a risk of staff burn out leading to staffing shortages and risk to patients needing ICU/HDU. Evident by recent Datix and incidents.	Doubling up of staff on call to support demand and pressures on site.	On call workforce reduced. Increasing stress/exhaustion related sickness	20 5 x 4	20 5 x 4	0 0 x 0	Looking to recruit locum support for ICU and Anaesthetics	Agreed at DMT 13/11/21. 22/11/21 - Pending PSQB approval.	Feb-2022	Nov-2022		PSQB		Nataika Drapan
Very High	6453	Surgery & Anaesthetics	Orthopaedics	All wards/departments Orthopaedic	Sep-2018	Active	Transforming and improving patient care	Risk of poor patient experience, safety, quality of care, extended length of stay due to failure to undertake surgical repair of #NOF within 36 hours of admission and maintain BPT in 85% of patients.	- Senior clinical review of patients waiting for surgery - Anaesthetic pathways of care embedded - Job plans to provide cross cover for THR surgeon availability - Discuss with theatres the need for additional trauma lists as and when needs arise	- Availability of surgeons with appropriate skills to undertake THR - Surge in activity of #NOF & general trauma overwhelming capacity to treat within 36 hours of admission. This has now been further compounded due to Covid 19 pandemic and lack of theatre capacity for trauma. - No additional trauma theatre sessions in place 3 per week to keep up with demand following second wave of Covid-19 pandemic	16 4 x 4	20 4 x 5	9 3 x 3	Enhanced monitoring and escalation as required.	23/11/21 - < 36hrs to theatre and overall BPT remain below target. Action plan in place and monitored at monthly #NOF MDT. internal audit of mortality rates continues and slight reduction end September 2021 YTD 6.7%. Business case submitted to Division for Locum Consultant for Trauma, fixed term for 12 months as part of plan to increase overall performance levels 17/09/21 - reviewed at #NOF MDT. around 17 Trauma 2 theatres cancelled over last few months due to inability to staff with theatre team has had an effect on ability to meet standards for <36hrs to theatre. Mortality rate on NHFD now available showing a mortality rate increase from 5% previously to 8.5% Nov 2020. audit of mortality rates taking place and to be	Dec-2021	Apr-2022		DB	Jo Fawcus	Simon Sturdee

														monitored monthly, slight decrease on monitoring of mortality rate of 7.4%							
Very High	7078	Corporate	Medical Director's Office	Operational	Oct-2017	Active	Keeping the base safe	Medical Staffing Risk (see also 6345 nurse staffing, 2827 A&E middle grade, 7454 radiology, 5747 interventional radiology) Risk of not being able to deliver safe, effective and high quality care with a positive experience for patients due to difficult to recruit to Consultant posts in Gastroenterology, Radiology, Dermatology and Ophthalmology, and dual site working which impacts on medical staffing rotas resulting in: - increase in clinical risk to patient safety due to reduced level of service / less specialist input - negative impact on staff morale, motivation, health and well-being and ultimately patient experience - negative impact on sickness and absence - negative impact on staff mandatory training and appraisal - cost pressures due to increased costs of interim staffing - delay in implementation of key strategic objectives	Medical Staffing Job planning established which ensures visibility of Consultant activity. E-rostering roll out commenced to ensure efficient use of Consultant time Establishment of staff bank to ensure vacant posts filled WYAAT networked approach to pressured specialties Medical Workforce Group chaired by the Medical Director. Active recruitment activity including international recruitment at Specialty Doctor level - new electronic recruitment system implemented (TRAC) - HR resource to manage medical workforce issues. - Identification of staffing gaps within divisional risk registers, reviewed through divisional governance arrangements	Medical Staffing Risk of pensions issue impacting on discretionary activity National shortage in certain medical specialties Regional re-organisation could potentially de-stabilise the workforce E-rostering partially implemented for doctors (expected by Sept 2020) - centralised medical staffing roster has commenced but not fully integrated into the flexible workforce team - measure to quantify how staffing gaps increase clinical risk for patients	20 4 x 5	20 4 x 5	9 3 x 3	• Monitored by Medical Workforce Programme Steering Group • Active recruitment including international	October 2021 Significant operational pressures continue for our clinicians and recruitment activity continues to minimise the vacancies. There has been a net gain in the number of doctors employed year on year – 41 more people in post October 2021 compared to October 2021. Of a budgeted funded establishment of 691 medical and dental staff there are 29 vacancies. This is really good progress, however, there are some sub-specialties that are still very difficult to recruit to. These include Emergency Medicine, Stroke Medicine, Acute Medicine and Respiratory Medicine. AACs have been scheduled for Gastroenterology and Respiratory Medicine in November, when it is hoped we will make successful appointments as we have received applications. With regards to the implementation of the 2021 SAS Contract progress has been affected by the 3% pay award given to medical and dental staff in all grades except the 2021 contract holders. This is likely to reduce the number of people who will benefit financially from the transfer. Whilst NHS Employers have pointed out the other benefits of the new Terms and Conditions, the risk of owing monies upon transfer to the new contract seems likely to deter individuals in the short term. NHS Employers have confirmed that there is no expectation that the 3% pay increase will be applied to the 2021 Contracts so this position will not change. The SAS Advocate role is going to be introduced as part of the SAS reform programme. This person will fulfil a different remit than that covered by the current SAS Lead and will be able to focus on providing support for SAS	Dec-2021	Dec-2021		WF	David Birkenhead	Pauline North

														doctors and to ensure that they are aware of and able to access the wellbeing packages that are in place. Following a review of the training and induction programme available for Clinical Directors two sessions have been held with HR colleagues, to ensure an understanding of the key policies and procedures and to commence the leadership training package. A full package of support has been developed to build upon their skills and ensure effective peer support.						
Very High	7454	Family & Specialist Services	Radiology	Main X-Ray	Apr-2019	Active	Keeping the base safe	Service Delivery Risk There is a risk to Radiology service provision due to a reduction in Consultant capacity resulting in a reduction of cover in some specialist areas and overall general capacity with the potential for breaching national targets.	- Agency Sonographer cover. - NHS Locum cover. - Lung and chest: Additional reporting support from external providers and temporary change to job plan. Ad hoc support from WYAAT Trusts. - IR: Daytime support from neighbouring organisation (1 day per week); reconfiguration completed in November and now sharing OOH cover with WYVAS, NHS locum in place providing block cover (x weeks on/ x weeks off). Head & Neck - part time consultant in post, US scanning supported by locum sonographer - Additional reporting support from external providers. - Neuro: Additional reporting support from external providers and temporary change to job plans. - General on-call: Increase in use of external provider cover and existing Consultants picking up additional stand-by shifts.	Vacancies in all areas, including: - Lung and chest: Gap during annual leave of one remaining Consultant. - IR: Gap when contracted NHS Locum is on annual leave/other leave. - Neuro: Reduced capacity and no capacity during annual leave/other leave. - Paediatrics. - Head and Neck.	15 3 x 5	20 4 x 5	1 1 x 1	- Actively seeking recruitment in all areas including use of introduction agencies. - Actively seeking NHS and agency locum for all required areas. - Actively seeking a second overseas fellow. - Existing consultants working through competencies to enable coverage of gaps. - Outsourcing increased to free up capacity where possible. - Locum support employed when available e.g. breast radiologists - Appointed an NHS Locum Chest Radiologist, due to commence August 2020. Feb update - this consultant has now given back word.	October and November 2021 update - the overseas doctors recruited as part of the global fellows scheme are awaiting entry exams (delayed by covid) so their start date is delayed until further notice. The trainee due in September commenced as planned. A second VIR consultant has been appointed through an NHS locum contract and is due to commence December 2020. We are working with LTHFT to develop new shared posts. A business case is currently being worked on to gain approval from Leeds, CHFT already has the necessary funding through vacancies. November 2021 Update: A number of new Radiologists have come into post in October/November.	Dec-2021	Mar-2022		DB	Stephen Shepley	Sarah Clenton
Very High	7474	Trustwide	All Divisions	All Departments/Wards	May-2019	Active	Keeping the base safe	There is a risk to the organisation of out of service medical devices being in circulation and in use across CHFT due to the lack of assurance about the Trust Asset Register being up to date as it doesn't include equipment which has been gifted or bought without CHS involvement resulting in potential patient harm to patients. This is also due to wards/departments not managing their equipment effectively, those which are out of service date and have not been seen for extended periods of time and are in use or available for use within CHFT for patient care, there is risk of patient harm. CHS Risk 7438	CHS Medical Engineering are attempting to rectify the problem and identify all devices in the high, medium and low risk category to provide an up to date register. To check if devices have a date on when they were last inspected as this would assist CHFT colleagues to identify equipment out of date. CHFT staff are aware of the need to report medical devices requiring maintenance/repair however a reminder is deemed appropriate to ensure colleagues follow this process which will support CHS achieve their objectives. Equip database enabled providing increased divisional control and ability to see which items of	Failure to manage, maintain and service medical devices which are both know/unknown to EBME	5 5 x 1	20 4 x 5	6 3 x 2	Schedule the maintenance of those devise identified prioritising high risk devices first 2021/03/01-Update- working with divisions to audit asset register and ensure devices are in correct locations, adding assets to asset tracking system and to allocated ward areas. 2021/04/01-Update- Audits ongoing will continue and be in progress for the next few months will also be aligning with Theatre audit days. Staff recruitment ongoing to mitigate lack of staff relative to increased asset base. 2021/07/01-Update- Audits ongoing contracts compliance at highest level, staff recruited and in post to aid maintenance and	2021/12/01-Update High risk fallen (from 949 to 781), Medium risen (from 3231 to 3739), Low fallen (from 1683 to 1640) a total of (from 5863 to 6160). This is prior to the first round of assets that have not been presented/located/identified being decommissioned as per the action plan submitted to Divisions at Medical Device Procurement & Management Group (MDPMG), Divisions will be presented a list of assets for disposal as lost for financial write off, these assets will be archived/decommissioned on eQuip should they be found at a later date the record/asset can be reactivated. All Trust staff can access the asset database Integra eQuip, by downloading from software centre and using Login - Guest & Password -	Jan-2022	Apr-2022		RC	Ellen Armistead	Robert Ross

									equipment are overdue.					mitigate risk, overtime authorised to rectify position. 2021/10/01- Update- We have been completing the audits within ward/department areas, and additionally we have been targeting Theatres as part of the audit days, however we are now at the point where we need to propose at the next Medical Device Procurement & Management Group, that the route forward is to compile a compliance report for Divisions on a monthly basis where we drill down to a ward/ department areas outstanding work, this will come as a percentage and compliance target. Green will require; • >95% High Risk assets. • >90% Medium Risk. • >85% Low Risk. Amber will be: • 90% to 95% High. • 85% to 90% Medium.. • 80% to 85% Low. Red will be: • <90% High. • <85% Medium. • <80% Low. Any assets listed as out of compliance to be presented/identified in month to Medical Engineering for maintenance, if not found by the Ward/Department in month these assets are to be written off by the Division, these assets will then be archived within eQuip, which will remove them from the compliance targets, but will enable them to be reactivated if found at a later date once outstanding maintenance has been completed.	Guest. 2021/11/01-Update High risk risen (from 940 to 949), Medium risen (from 3220 to 3231), Low risen (from 1637 to 1683) a total of (from 5797 to 5863). this month will see the first reverse KPI submitted to Divisions with assets not submitted for maintenance to be presented/identified within month, if not the asset will be archived as not found, if identified maintenance plan to be put in place, if presented maintenance to be completed ASAP. Have engaged with THIS to give access to all Trust staff to the asset database Integra eQuip.						
Very High	7479	Family & Specialist Services	Children's Services	Children's Ward CRH (3)	Jun-2019	Active	Keeping the base safe	There is risk that young people with acute mental health needs will managed on the paediatric ward for an extended period by staff that do not have the appropriate skillset. There is a significant concern around children and young people with self-harm, suicidal ideation, eating disorders, and the increased complexities associated. Due to a national shortage of inpatient provision for young people with acute mental health issues there waiting for a specialist bed or Children's Social care management. Resulting in potential harm to the	1. Agreed joint admissions guidance with CAMHS provider 2. Restrictive holding policy in place 3. Mental health awareness training undertaken for key staff 4. All incidents investigated 5. Paediatric representation at the mental health operational group 6. All requested for one to one shifts immediately escalated 7. Paediatric/CAMHS partnership meetings commenced 8. Clear escalation plans formulated 9. CAMHS hot and cold debriefs instigated 10. Clinically related challenging behaviour guidelines 11. Restraint and use of force guidance 12. Clinical PEARLS	Skill set of staff to care for children with complex psychological needs Inability to provide a one to one support from staff with the correct skill set and experience Consistency of escalation during out of hours periods Lack in joint pathway agreement between social care, CAMHS and CHFT	20 4 x 5	20 4 x 5	4 2 x 2	Two orange incidents to be investigated further MDT approach to one case arranged - with multi-professional attendance We can Talk QI project Wider roll out of We can Talk training for all staff Ian Kilroy in discussions with SWYFT to design physical intervention training package for high risk areas within CHFT. Plan to deliver training to all band 6 clinical paediatric colleagues in receipt and scrutiny. Joint training delivery with CAMHS Community Registrar reviewed recent cases and incidents to	November 2021 - Initial joint meeting with Camhs, CCG to scope new ways of working and channels for escalation. Sept 21 - Escalation at PSQB, PRM, Tactical, and externally to the Division as required. Escalation to CCG, CAMHS, Social Care, and ODN. Escalated concern regarding lack of 1:1s to CCG - CCG coordinating CAMHS supporting this. July 2021 - The situation continues to be challenging. Daily MDTs to support patients continue, however there have been issues with attendance from Social Care. Good support from CAMHS. Plan to get an escalation process in place across teams. April 2021 The situation has worsened due to the pandemic and not having access to school etc. Also, Calderdale	Dec-2021	Jan-2022		HSC	Nikhil Bhuskute	Elena Gelsthorpe-Hill/Julie Mellor/Louise Riby

								patient, other patients, carers and staff. COVID-19 has had a significant detrimental impact on the number of acutely unwell children and young people with mental health conditions. This increase has been seen both locally and nationally, in numbers and acuity.						identify key learning/trends. To review policy guidance around detention and custody restraint policy	has a high number of children in care that have been relocated and the private providers are unable to deal with the behaviours and therefore they present at ED						
Very High	7615	Medical	All Directorates Medical	All Departments/Wards Medical	Dec-2019	Active	Keeping the base safe	There is a risk of not meeting the four hour emergency care standard Due to increasing demand on Emergency Care, patient flow issues, delays in assessment and discharge due to lack of social care staffing (hospital based social work team), lack of timely domiciliary care in community More recently there have been increasing demand for side rooms due to the need to isolate patients with possible COVID-19, this has caused increasing delays. Resulting in poor patient experience, patient harm, increased scrutiny and reputational damage	Operational procedures to improve patient experience and flow are in place and reviewed at 3 hourly bed meetings Ambulance hand over time Time to triage Seen in 60 minutes by a medic Digital - manages time and RAG rates Clinical site commanders KPI - refer for inpatient bed before 3 hours Coordinators managing ED Matrons in place at both EDs Urgent care action cards direct staff Housekeepers providing fundamental care External support for dept in times of pressure - e.g. gynae, paeds Surge and Escalation plan - OPEL Training of on call managers and teams Skill mix- training for newly qualified nurses Streaming from the front door and admission avoidance services - frailty, streaming, Covid IMT and tactical oversight of patient flow ED improvement plan is being monitored through Gold as part of the flow "must do"	Partners not being able to deliver YAS - transport - escalation and response times and transfer to bed base Interruption of the Local Care Direct Service, GP closures for training Vacancy Non-compliance with action cards and process without escalation Engagement and understanding of the risk at ward level and across teams Continued increase in demand in ED High bed occupancy levels due to increased demand and restricted social care services	15 3 x 5	20 4 x 5	1 1 x 1	Patient Flow action plan in place Governance - reported monthly at WEB Patient Flow one of the 4 core must do's is being monitored at gold. owner – DOP for medicine Accountability- Directors Relaunch of the safer project System wide working action owner is John Parnoby	November 2021 - Risk score increased and accepted at PSQB October 21 - Plan for every patient program relaunched with additional resource to accelerate role out. ED improvement plan is being monitored through Gold as part of the flow "must do" System wide working action owner is John Parnoby. (Updated by L Taylor following a risk meeting with J Hammond)	Dec-2021	Dec-2021		WEB	Ellen Armistead	Jonathan Hammond
High	7634	Surgery & Anaesthetics	Theatres & Operating Services	Theatres CRH	Jan-2020	Active	Keeping the base safe	There is a risk of theatre lists being cancelled due to the volume of staff vacancies (Band 5/6 leaving and retiring between December 2019 and October 2020), resulting in a loss of specialist skills and reduction in theatre activity.	Band 6 vacancies currently being advertised with divisional board approval to over recruit suitable candidates as part of succession planning Weekly staffing meetings with matron and clinical operations managers to review theatre lists by case and staffing requirements, identification of where staff can be released and redeployed cross site. Theatre lists and staff allocations reviewed daily by the theatre co-ordinator. Potential risks are escalated to the matron, inpatient operational manager and GM. All unfilled shifts are sent to bank following roster final approval and to	Pace of recruitment Unfilled agency shifts Not all remaining staff have transferable skills for each speciality. Currently high levels of staff sickness October 2021 - some agency lost due to other trust offering different pay December 2021 updated	9 3 x 3	16 4 x 4	4 2 x 2	Plan to implement Band 6 development programme in all theatre areas, with clinical educator responsible for delivery of theatre specific competencies. SOP -Procedure to follow prior to request to cancel theatre list due to unsafe staffing levels to be agreed at February DMT.	October 2021 - staff recruitment ongoing, new starters are in post but this is a constant rolling of staff and advertisements at present. 2 weekly staffing to look at starters, leavers, retirement & new starters awaiting pin numbers reviewed and WTE recalculated every 2 weeks to work towards more theatre list. at present we are at 82 list per week. .	Dec-2021	Mar-2022		DB	Thomas Strickland	Sarah Bray

									agency 21 days prior to the list date. Review and postpone all non-essential training. October 2021 - 2 weekly meetings & theatre recruitment meeting. December 2021 2 weekly meeting continue										
High	7678	Trustwide	All Divisions	All Departments/Wards	Mar-2020	Active	Keeping the base safe	There is a risk of reduction in safe Medical staffing levels below the minimum required to maintain safety Due to the impact of Covid-19 on capacity particularly in Critical Care, Respiratory Medicine, Acute Medicine, Elderly Medicine and Emergency Department Resulting in unsafe levels of patient care In addition, because Covid-19 directly impacts sickness absence and self-isolation of the medical workforce, a reduction in the medical workforce is to be expected. Outside of surges of COVID-19 impact is reduced but non-COVID activity remains high.	Options implemented during COVID surges and episodes of high activity and stood down when activity and staffing pressures lessen Identified lead for Medical redeployment (CP) Covid Incident Control meetings and governance arrangements Staffing Incident Command once or twice-daily meetings Cancellation of annual leave Cancellation of study leave Suspension of appraisal Tools used Guidance on shaping the Medical Workforce Staffing framework for ICU used Developed acuity tool to inform doctor deployment	SPA time for revalidation and appraisal Do not have all staff on e-rostering Reporting of sickness absence and self-isolation is not consistent for medical staffing Overseas recruited medical staff cannot travel to UK to commence work - anaesthetics, gastro, ED, Radiology	20 4 x 5	16 4 x 4	6 3 x 2	Work with regional partners to mitigate impacts on smaller services Staff testing to identify those safe to return to work Redeployment of staff to critical areas Return to Practice Doctors being approached by Health Education England Bank adverts across grades and specialties Continue recruitment as usual Consolidated junior doctor rotas New rotas for middle grade (start 6.4.20) and consultant on-site 24/7 cover (start 13.4.20) - second phase start 9 November 2020 Mapping capacity against minimum and stretch levels in non-high and intensity areas Skilllsets - Physician CPAP trained, non-physician training package for high intensity areas	16.7.21 COVID-19 activity has reduced but is climbing again, non-COVID activity is high with rising attendances in ED and increased medical admissions. Plans to clear extensive elective backlog underway. Current medical staffing pressures occurring as a result of staff being infected with COVID-19 and requirement to isolate/childcare. Gaps being covered through increased flexibility and movement of trainees and increased bank activity. Proposals being considered for increasing and standardising additional duty payments. Acuity tool developed and on KP+ to help support trainee placement. EST paused	Aug-2021	Nov-2021		WF	David Birkenhead	Cornelle Parker, Pauline North
High	7683	Trustwide	All Divisions	All Departments/Wards	Aug-2020	Active	Keeping the base safe	There is a risk of not having adequate isolation (Side room) facilities Due to an increase in demand and initiation of testing of asymptomatic patients Resulting in failure to safety isolate patients and further transmission of Covid-19 to vulnerable patients and impacting patient flow	Infection Control policies and procedures PHE guidance In-house testing of patients. Daily IMC VC meetings. SITREPS Monitored by Tactical with reporting and escalation into Covid re bed capacity and patient flow. Reason to Reside reviewed on a daily basis and meeting arranged with GP, CCG and social care partners Discharge team working with consultants to expedite discharges Strategic Command	One platform for testing and if this goes down will need to revert for testing to Leeds with results taking longer to receive Aerosol generating respiratory interventions should be in single side rooms or require all in the area to wear PPE.	12 4 x 3	16 4 x 4	6 3 x 2	In-house testing to move negative out of isolation - in place POC testing in place to reduce the need to admit directly to a side room and reduce risk to other patients on the ward. Review anti-microbial protocols for antibiotic prescribing to reduce patient contact and move to early discharge Plan for commencement of testing of asymptomatic patients - in place Manage patient flow, discharge planning, admission avoidance, reason to reside assessment	August 2021- Ward 18 HR remains open with Covid positive and Covid contact patients placed on this ward unless their clinical need necessitates them staying in speciality. POC testing in place for all patients admitted to the wards from ED. This is carried out by a dedicated swabbing team on both sites. All patients requiring admission to speciality beds from Ed or clinics are POC tested before admission. Resp floor at CRH is currently open with 3 wards specifically for Covid positive patients with all AGPs on ward 5B where staff are in full PPE and access is prohibited to other staff to reduce the risk of transmission.	Sep-2021	Sep-2021		NA	David Birkenhead	Claire Speight, Bev Walker

High	2827	Medical	Emergency Care	Accident & Emergency CRH/HRI	Apr-2011	Active	Developing our workforce	Risk of poor patient outcomes, safety and efficiency due to the inability to recruit sufficient middle grade emergency medicine doctors to provide adequate rota coverage results in the reliance of locum doctors to fill gaps. Risks: 1. Risk to patient safety using staff unfamiliar with department processes and systems, results in complaints and clinical incidents 2. Risk to the emergency care standard due to risk above and increased length of stay 3. Risk of shifts remaining unfilled by flexible workforce department 4. Risk to financial situation due to agency costs ***It should be noted that risk 6131should be read in conjunction with this risk.	Associated Specialist in post and Regular locums used for continuity appointed Middle Grade Doctors moved within sites to respond to pressures Part-time MG doctors appointed Consultants act down into middle grade roles to fill gaps temporarily 4 weeks worth of rota's requested in advance from flexible workforce department Expansion of CESR programme Ongoing ACP development Weekly meeting attended by flexible workforce department, finance, CD for ED and GM EMBeds website for induction of locum staff. Allocated a further 10 Senior ED trainee placements by School of EM	Difficulty in recruiting Middle Grade and longer term locums Variable quality of locum doctors Relatively high sickness levels amongst locum staff. Flexible Workforce not able to fill all gaps ACP development will take 5 yrs from starting to achieve competence to support the middle grade level Inability to recruit to CESR posts. CESR training will extend time to reach Consultant level with no guarantee of retention Inability of School of EM to allocate trainees.	20 4 x 5	16 4 x 4	12 4 x 3	1. Recruitment including overseas and part time positions 2. Increase to senior ED trainee placement	Dec 21 - PA's appointed to support MWFM Nov 2021 - No change to June update June 2021 - actively recruiting onto middle grade rota using overseas agencies	Jan-2022	Jan-2022		WEB	David Birkenhead	Amjid Mohammed
High	6596	Corporate	Corporate Quality	Governance and Risk Quality	Jan-2016	Active	Keeping the base safe	There is a risk of not complying with the national SI framework March 2015 due to not conducting timely investigations into serious incidents (SIs) resulting in delays to mitigate risk, to realise learning from incidents and share the findings with those affected.	- Revised Incident Reporting Policy aligns with national framework, with template reports, clarity on process for divisional sign off and Trust sign off of SIs. - Director led panels held weekly to ensure quality assurance of final reports. Meet commissioners monthly on SIs - Scheduling of SI reports into orange divisional incident panels to ensure timely divisional review of actions. - Patient Safety Quality Boards review of serious incidents, progress and sharing of learning - Investigator Training - to update investigator skills and align investigations with report requirements. - Serious Incident Review group chaired by Chief Executive to ensure senior Trust wide oversight and peer challenge of SIs - Risk Team support to investigators with timely and robust Serious Incident Investigations reports and action plans - Learning summaries from SIs presented to Quality Committee, Serious Incident Review Group monthly and shared with PSQB leads for divisional learning - Investigation Pack and plan for each SI investigation, with initial and midpoint meetings with Risk to monitor progress	1. Operational pressures and impact on capacity to undertake investigations in a timely way, further exacerbated by Covid 2. Sharing learning from incidents within and across Divisions 3. Training of investigators to increase Trust capacity and capability for investigation, particularly doctors. 4. Lack of access to documents on EPR to non-clinical investigators. 5. Operational pressures impacting on time for conducting investigations 6. Requirement to undertake SI investigations is not in Consultant job plans 7. delivery of RCA training workshop suspended due to Covid	16 4 x 4	16 4 x 4	4 4 x 1	Increase number of trained investigators Be clear in delivering training there is a requirement to participate in SI investigations - complete Learning Group to develop approach on learning and a learning event - Quality Priority for 2020/21 Paper with options for investigators - complete Use of staff who are shielding to support investigations Quantify volume of Covid incidents meeting threshold for investigation in accordance with SI Framework	November 2021: Investigation training delivered to 7 staff in October 2021. Head of risk and Risk manager appointed to. Further support for SI investigations by bank staff (45 hrs/week). Currently 53 open SI investigations. Risk meeting 7/12/21 to review status and progress of all SI's.	Aug-2021	Oct-2021		QC	Ellen Armistead	Lisa Cook

High	8196	Surgery & Anaesthetics	General and Specialist Surgical	Endoscopy	Nov-2021	Active	Transforming and improving patient	There is a risk of being unable to develop an additional ERCP list and colon capsule service due to not having a budget to increase the current wfm resulting in longer stays, delay in patient flow and being unable to provide a colon capsule service that is sustainable.	The additional ERCP list is not in place at present. The colon capsule service is run adhoc without consistency with only 2 staff members being capable to carry this out due to capacity to train other staff. These 2 staff members have covered it on overtime or reduced the numbers on day in the workforce and run it at risk.	Staff 2x band 5, 2x band 3 5hrs per week to carry out an additional weekly ERCP session. 1x band 6 (0.52wte) to coordinate train and develop the colon capsule service which would result in a better patient experience and the number of patients requiring an endoscopic procedure.	16 4 x 4	16 4 x 4	2 1 x 2	To agree finance and budget holders to obtain funds to develop these services if successful to then revise the current WFM to incorporate additional shifts. Following this to recruit into the additional hours the equipment for both ERCP and colon capsule are already in place and a time slot agreed for any extra ERCP list.		Feb-2022	Mar-2022		NWG	Tracy Burland	Michelle Roberts
High	8197	Surgery & Anaesthetics	Theatres & Operating Services	All Theatres	Nov-2021	Active	Keeping the base safe	There is a risk of delayed surgical treatment for Ophthalmic conditions due to shortage of Ophthalmic trained theatre staff resulting in the inability to open a second theatre. This will impact on clinical outcomes and patient safety due to continual rise in surgical waiting lists and delays in treatment.	Rolling trac advert for ophthalmic theatre staff. Use of Pioneer (insourcing) on weekends Outsourcing - Optegra for Cataract surgery	Continual staff vacancies for ophthalmic specific theatre staff Gaps in competencies and training support across the range of sub-speciality provision. No dedicated Ophthalmic clinical educator to lead training of current and new staff Ophthalmic on call provision reduced to 9pm 6 months ago - on review not fit for purpose due to shortage of workforce and competence. Deskilling of surgical workforce due to lack of theatre exposure. .	16 4 x 4	16 4 x 4	0 0 x 0	Recruitment fair - Ophthalmic stall 14/11/21 Rolling trac advert - reviewed November 21 Zoe Matthewman to support competencies and training Scope - ophthalmic theatre specialist role to support new workforce	17/11/21 - Joint meeting with theatres and Ophthalmology to discuss current reality on workforce, recruitment and training. 22/11/21 - PSQB approval pending	Feb-2022	May-2022		PSQB		Nataika Drapan
High	8037	Community Healthcare	Divisional	Divisional	Apr-2021	Active	Keeping the base safe	There are current issues and evolving risks of insufficient estate to support community based healthcare delivery in Calderdale. Root causes of this issue and risks include: 1. Existing services hosted in other organisations premises being asked to vacate those premises i.e. specialist palliative nursing from Overgate Hospice and district nursing from Stainland Road. There is a long history of similar examples 2. Reconfiguration of services to align with PCN hubs and expected expansion of community services to meet annual planning requirements and wider care closer to home agenda i.e. UCR, anticipatory care 3. Consolidation of 1st floor of Broad Street Plaza causing primary impacts of restricted desk	1. Where possible moving staff into existing premises (i.e. palliative to Allan House). 2. Where existing premises are not suitable (capacity, location…) finding short term solution to bridge to longer terms solutions (i.e. Calder and Ryburn PCN District Nursing to Elland) 3. Analysis of community staffing numbers and estate footprint (increasing numbers and decreasing footprint summary) 4. Met with CCG lead for PCN estate strategy. Included some outline WTE expansion numbers in those requirements. 5. Divisionally absorbing infrastructure costs for new locations (kitting out new offices, networks) but risk on recurrent costs (articulated as part of 4 above) 6. Liaising with Local Authority to look at opportunities for co-location of	Team needs to have access to welfare facilities & handovers, printer etc.	16 4 x 4	16 4 x 4	0 0 x 0	1. Where possible moving staff into existing premises (i.e. palliative to Allan House). 2. Where existing premises are not suitable (capacity, location…) finding short term solution to bridge to longer terms solutions (i.e. Calder and Ryburn PCN District Nursing to Elland) 3. Analysis of community staffing numbers and estate footprint (increasing numbers and decreasing footprint summary) 4. Met with CCG lead for PCN estate strategy. Included some outline WTE expansion numbers in those requirements. 5. Divisionally absorbing infrastructure costs for new locations (kitting out new offices, networks) but risk on recurrent costs (articulated as part of 4 above)	Oct 21 - Trust approved office expansion at Lister Lane. The new office space will provide agile working for 22 staff. This will help to mitigate the reduction in agile working space at Broad Street Plaza whilst supporting the location of the Urgent Community Response (UCR) team. No timescales provided to date for the completion of the refurbishment works. (Score to remain the same until completion timescales identified)	Jan-2022	Dec-2022		PSQB	Michael Folan	Helen Webster-Mair

							space for administrative functions based in Broad Street and secondary impacts of overflow of administrative functions and activity of clinical activity using valuable clinical rooms and capacity 4. Central PCN pressures at Lister Lane currently and likely increasing challenge in next 12 mths with expansion of Crisis Team to evolve into Urgent Community Response and links with increasing Reablement capacity 5. Social Distancing reducing capacity in key location i.e. Lister Lane 6. Staff health and wellbeing i.e. although they are absolutely working agile and reducing unnecessary return to base the community does not classically have break out room, does not have dining rooms etc and staff do need to have lunch, complete their record keeping etc and from a uniform and IPC perspective they can't just pop into a cafe	services.					6. Liaising with Local Authority to look at opportunities for co-location of services.								
High	7834	Surgery & Anaesthetics	Orthopaedics	All wards/departments Orthopaedic	Jul-2020	Active	Keeping the base safe	There is a risk that Orthopaedic elective patients are unable to have surgery within timescale, due to their being no availability of elective theatres or ward staff resulting in lengthily delays and poor patient outcomes. There is currently no elective Orthopaedic inpatient theatre capacity at CHFT.	A number of Elective Day case lists have been sourced in the independent sector at the Spire and BMI hospitals up to 24 December 2020. After this the NHSE IS contract finishes and there is currently no agreement in place for IS theatre capacity thereafter. All Consultants are reviewing their current waiting lists and telephone clinics have been established for review and stratification of the patients on the waiting lists. Following clinical validation the patients are clinically prioritised and categorised from 1 (that being the most urgent) - 4 (being the least urgent) according to Royal College guidance on clinical prioritisation of surgical patients.	There is currently no elective Orthopaedic inpatient theatre capacity at CHFT. Limitations of IS criteria for patient cohort dependent on co-morbidities. A lot of our patients don't fit the criteria for surgery in the independent sector. The nursing staff from the Orthopaedic elective ward at CRH have been redeployed during the Covid-19 pandemic to the acute respiratory floor and there are no current plans for their return into Orthopaedics. A number of patients that were risk stratified in May/June time at a certain level (1-4) are now moving into the lower more urgent categories with no plan to operate.	16 4 x 4	16 4 x 4	9 3 x 3	There is currently no elective orthopaedic inpatient theatre capacity at CHFT and there are no actions we can take to alleviate this.	23/11/21 - update - around 90 lists cancelled from the reduced allocation of 2 lists per day Monday - Friday. Continue to prioritise listing of > 104 week waits and P2's over 1 month. Continue to use Independent sector (Spire/BMI) & Nuffield Leeds for outsourced capacity and local insourcing of CHOP lists. Trajectories developed and plans being put in place to ensure no . 104 week waits or P2's over 1 month by end of Financial year. 17/09/21 - update. 2 lists all day elective lists in place at CRH from April 2021. continue to use IS for additional capacity. additional capacity sourced at Nuffield, Leeds and patients being identified and IPT'd over off waiting lists for primary hip & knee and some upper limb. concerns in Directorate re number of elective lists at CRH being cancelled due to lack of theatre staff in excess of 40 lists over last couple of months same being monitored and alternative arrangements made where possible to manage P2/> 104 week waiters.	Jan-2022	Mar-2022		PSQB	William Ainslie	Simon Sturdee

High	7930	Surgery & Anaesthetics	Head and Neck	Ophthalmology	Nov-2020	Active	Keeping the base safe	There is a risk of progression of glaucoma and sight loss due to the impact of COVID-19 pressures and subsequent backlog of patients who were initially stratified as low risk, being deferred 6 months now converting to high risk and in need of face to face assessment. Continual social distancing measures are continuing to result in 2/3 reduction in capacity through the glaucoma service resulting in long delays to receive follow up assessment which may impact on prognosis, clinical outcomes and quality of life.	Department continuing to undertake risk stratification according to Moorfields Eye Hospital guidance that has been approved by the Royal College of Ophthalmologists and implemented nationally. Additional sessions added ad hoc where possible.	Lack of clinical space and waiting room space to see the required demand resulting in an increase in holding list and ASI lists. Lack of dedicated diagnostic machines Lack of IT support for diagnostics delaying virtual models	20 5 x 4	16 4 x 4	1 1 x 1	Risk stratification guidance being followed Validate all patients due an appointment up to the end of December 2020 Consider alternative ways of working- diagnostic clinic, high volume IOP check clinics. Seek additional estate. 10/21 To update how many glaucoma patients overdue – in view of commencing diagnostic clinics and virtual reviews	06/12/2021-ASI reduced to 120 and holding list past end date to 198 18/10/21- Diagnostic clinics now up and running in addition to insourcing company capacity. Virtual review delays due to IT issues. 09/09/21 Insourcing company agreed to work on reducing holding list	Jan-2022	Jan-2022		PSQB	PNT Laloe	Emma Griffiths
High	7413	Corporate	Finance and Procurement	Corporate Finance	Feb-2019	Active	Keeping the base safe	There is a risk of fire spread at HRI due to insufficient fire compartmentation in areas which could result in fire spread / damage to buildings / equipment and harm to staff, patients and visitors.	Following a fire compartmentation undertaken in 2014 capital funding has been made available to improve compartmentation and fire safety across HRI Site. Fire committee has been established in November 2019 where fire safety is discussed and any risks escalated. Chief Operating Officer, is the nominated executive lead for fire safety Works undertaken by CHS includes:- • Replacement of fire doors in high risk areas • Replacement fire detection / alarm system compliant to BS system installed • Fire Risk Assessments complete • Decluttering of wards to support ensure safe evacuation • Improved planned preventative maintenance regime on fire doors • Regular planned maintenance on fire dampers Fire Safety Training continues throughout CHFT via CHS Fire Safety Office • Face to face • Fire marshal • Fire evacuation • Fire extinguisher	Number of areas awaiting fire compartmentation works Consequence of decanting ward area to carry out risk prioritised compartmentation works	15 5 x 3	15 5 x 3	1 1 x 1	May 2021 The fire strategy has been produced by outside consultants and a work plan is being developed. The fire policy is ready to be approved by the fire committee. Dec 2019 - CHFT Fire Committee established with involvement from CHS and PFI. Fire Strategy to be developed to provide a short, medium and long term plan aligning with Trusts reconfiguration plans. Fire Committee to review fire risks. July 2019: NHSI capital bid for 19/20 June 2019: Fire risk assessments, installation of sockets May 2019: Delivery of fire training Feb 2019: Walk around on wards between CHS, CHS Fire Officer and Matrons with the aim of de-cluttering wards to ensure a safe and effective evacuation. Feb 2018 The Trust has bid to NHSI for early release of capital monies to support further fire compartmentation work. However, in order for CHS to manage this in a prioritised risk based approached it is essential the Trust are able to decant areas to enable CHS to complete building works to a satisfactory standard.	June 2021 Position still the same, we need the awareness of what building stock is to stay and what is removed, so we can target work to fit the reconfiguration.	Jul-2021	Mar-2022		FIREC	Helen Barker	CHS / CHFT

High	7414	Corporate	Finance and Procurement	Corporate Finance	Feb-2019	Active	Keeping the base safe	Building safety risk - there is a risk of falling stone cladding at HRI which is due to the aged and failing fixings originally designed to retain the cladding to the external structure of the building. This could result in significant incident and harm to patients, visitors and staff. CHS RISK = 7318	Damaged cladding observed at HRI Ward Block 1 resulting in immediate action to ensure surrounding area safe. Capital funding provided to support works. CHS commissioned Structural Engineers to repair the areas observed along the west side elevation of the building and carry out a site wide survey of the existing cladding surrounding HRI. Areas originally observed requiring immediate repair were made safe and full detailed site survey carried out. CHS carry a detailed visual inspection of all the cladding every 6 months. The area beneath any panels that are identified as 'requiring immediate attention' is cordoned off and made safe whilst repairs are carried out. Panels that are identified as 'needs attention' are noted and are reinspected on the next inspection date alongside all other panels.	CHS and Trust received the full structural site survey which identified areas of high, medium and low risk and a solution to rectify the risk. Further capital funding required to support the planned work.	15 5 x 3	15 5 x 3	1 1 x 1	The HRI Strategic Development Plan had identified an investment strategy to address the risk. Until August 2021 an over cladding solution had been identified as the preferred solution. Unfortunately consultation with Building Control Officers identified the need to remove the existing timber window and panel frames as part of the solution. This work could not be completed without the need for a phased full ward closure on each and every ward on each elevation. A full review of the impact of this requirement is being evaluated together with alternative proposals including the full removal and replacement of cladding. Construction plans for this financial year have been suspended, whilst additional feasibility studies are carried out. Progress is managed at monthly Governance Contract and Performance meetings between CHS and CHFT. Any risks =>15 are escalated to Risk and Compliance for discussion / approval. Discussion to take place at Capital Planning to support prioritised plan	August 2021. The final over cladding solution has not been agreed with building control officers and the timeline associated with the start of work has been suspended following a full review of options. The revised approach will be submitted in a paper to the Transformation Board. In the meantime 6 monthly inspections are continuing with the next inspection due in December 2021. It should be noted the inspections are showing fewer issues requiring remedial work, indicating a confidence in this mitigating measure. JULY 2021. The Feasibility Study is still in progress. A mock up of the preferred solution was installed as planned. Decisions concerning the final solution requires agreement with Building Control and Planning. The 6 monthly inspection was planned. The next inspection is due in December 2021.	Sep-2021	Oct-2021		FC	Gary Boothby	C Davies / Ian Rawson
High	8199	Surgery & Anaesthetics	Critical Care	ICU	Nov-2021	Active	Keeping the base safe	There is a risk of harm to patient and risk of lack of provisions of services if a timely ICU bed is not available within the trust or network.	Network updated everyday and information passed to site commanders and team Flexing beds where appropriate Theatre recovery if no bed avaible in ICU Transfer into network if suitable		15 5 x 3	15 5 x 3	0 0 x 0	Network peer review 29/11/21 Escalation actions cards agreed through Gold.	Agreed DMT 13/11/21 22/11/21 - Awaiting PSQB approval	Feb-2022	May-2022		PSQB		Shaheed Rahman

High	6715	Corporate	Corporate Nursing	Workforce and Clinical Development	Apr-2016	Active	Keeping the base safe	There is a risk to patient safety, outcome and experience due to inconsistently completed documentation on EPR. This has the potential to result in a negative impact for the patient in increasing their length of stay, lack of escalation should deterioration occur, poor communication both internally and externally and difficulties with efficient multidisciplinary working. In addition to this, inaccurate coding and submissions, appropriate remuneration for care delivered and the inability to be able to be able to establish the correct patient pathway in response to review, complaints, serious incidents and legal requirements.	Structured documentation within EPR as per induction training. Training and education around documentation within EPR - development of E Learning Modules for training. KP+ Model regarding monthly and weekly ward assurance. Doctors and nurses EPR guides and SOPs. Datix reporting Relevant Boards and specialist groups that support clinical documentation which include -Clinical Records Group -Clinical Outcomes Group -Information Governance and Record Strategy Group -Deteriorating Patient -Pressure Ulcer Collaborative -Nutrition and Hydration Quality Priority for 2021/22 in relation to strengthening record keeping within the Trust.	Remaining paper documentation not built in a structured format in EPR which has been a challenge to the organisation since go live of the electronic patient record due to KP+ reporting tool does not provide assurance around documentation - requires review of components being extracted. There are gaps in recruitment currently within the nursing, training and EPR Change Team which would support an improved electronic record. Not all SOP's are in date.	20 4 x 5	15 3 x 5	6 3 x 2	September 2020 - Action plan to review current status and progress improvement - Clinical Records Group - review attendance and TOR - Review data extraction for clinical records relating to Ward Assurance in KP+ model to ensure accuracy. - Roll out White Board Functionality in EPR - identify areas to formulate improvement before roll out across the organisation - Support improvement at ward level in improvement of key metrics - promote ward ownership - Implementation of Optimisation Strategy in stages - Stage 1 In-depth Analysis of current working practices amongst staff working in the trust - OPD and In-patient services. Stage 1 results will determine Stage 2 relating to recommendations and development of Digital Champions - Explore Training and Support - alternative methods of delivery and at the elbow support - Work Together Get Results - Workshops to collectively discuss and promote digital record keeping within the work environment - understand barriers for failure to comply and put measures in to support change as a result	Nov 2021: Task and finish groups completed and documentation is being updated to reflect changes. CNIO working with training teams to make them more visible on wards and work with clinical staff to make sure documentation is in the correct place at all times. Clinical Records group attendance has been renewed and agenda changed to incorporate divisional updates on documentation and also optimisation. This will also be a standard agenda item on divisional digital boards going forward.	Dec-2021	Jan-2022		WEB	Ellen Armistead	Louise Croxall/Graham Walsh
High	7015	Surgery & Anaesthetics	All Directorates S&A	All Departments/Wards S&A	Jul-2017	Active	Keeping the base safe	Risk of nurse staffing levels on wards and departments falling below CHFT agreed WFM due to high vacancy levels and sickness in some areas resulting in potential harm to patients, poor staff and patient experience and an increased use of bank and agency staff.	Safe staffing tool completed by all wards and overseen by Matron for each area Monthly confirm and challenge meetings to sign off rosters Active participation in recruitment events Proactive approach to staying in touch with new recruits Completion of exit interviews to identify and action themes Roster sign off by matron Proactive approach to sickness and absence monitoring Agency requests managed as per CHFT Standard operating procedure Early requests to FWD Support from HRBP into high levels of sickness with plans in place to address SOP in place regarding flexible working in ICU	Some areas remain difficult to recruit to Bank fill rates low in some areas Last minute cancellation of bank and agency staff Skills of bank and agency staff not always adequate for some areas ie: theatres , endoscopy Low completion of return to work interviews On day sickness difficult to manage	12 3 x 4	15 3 x 5	9 3 x 3	Specialist areas to run separate job advert Reinforce exit interviews and return to work interviews and address any themes Participate in dependency studies and hard truths process Ensure effective roster management and utilisation of hours through allocate at confirm and challenge meetings Continue to promote the surgical division as a great place to work update 19.9.19 daily staffing meetings continue working to embed use of safe care tool effectively Confirm and challenge meetings - require new annual leave process at peak holiday times Shifts out to FWD at roster sign off uplift of band 6s in some areas Support for overseas nurses and TNAs being developed	November 2021 update - Lots of staff movement over COVID period - WFMS reviewed and agree to set vacancy factor at 20% across. Matrons overseeing through twice daily staffing meetings and managing risk through staff movement Though ward areas have seen an improved position in terms of staffing, Operating Theatres vacancies remain very high 27/10/2021 Endoscopy - position improved with minimal vacancies Theatres - workforce transformation programme underway, looking at recruitment campaign, number of new starters, different roles incorporating Nurse Associates into WFM Wards - very difficult staffing position within all wards, high numbers of covid sickness and isolation, vacancy position not improving, health and wellbeing issues with staff, additional wards open due to capacity pressure.	Dec-2021	Feb-2022		PSQB	Thomas Strickland	Rachel Rae

														Senior team support into recruitment events Working with safe care lead to develop red flags to identify impact of staffing issues more effectively development of area specific SOPS to standardise approach 29.4.2020 action review : Daily staffing meetings continue 24 hour roster check process sent out to ward managers managing excess staff through pooled roster	Creating recruiting, looking at roles within wards e.g. pharmacy technicians, nurse associates, additional housekeepers, care club. Using Datix and safe care red flag system to identify and build theme sanctioned							
High	5747	Family & Specialist Services	Radiology	Angiography & Fluoroscopy	Mar-2013	Active	Keeping the base safe	Service Delivery Risk There is a risk of patient harm due to challenges recruiting to vacant interventional radiologist posts resulting in an inability to deliver OOH vascular cover as part of the WYVAS commitment and in hours on site cover.	- 1 NHS Locum in post (on 12 month contract, due to be renewed in the Summer). - 1 NHS (Bank) Locum supporting the service in tandem with the above. - 1 day per week support from a neighbouring organisation. - 1 day per week support under private agreement from a private provider (ended August 2020) - Working closely with WYVAS to plan and secure adequate cover.	- Uncertainty over date vascular reconfiguration will be complete. Aug 2020 update - date set for 16th Nov 2020 - Difficulty in securing cover long term whilst reconfiguration discussions are ongoing. - Reconfiguration of services completed in November 2020	16 4 x 4	15 5 x 3	6 2 x 3	1. Continue to try to recruit to the vacant post, advertising for joint post with Bradford Teaching TH. 2. Working with WYVAS to progress a regional approach.	March 2021 update - current cover is via temporary arrangements but cover is stable. Working with WYVAS colleagues to plan future strategy/joint cover. July and November 2021 Update: Position remains the same as March 2021. We are currently in the process of recruiting new Radiologists.	Dec-2021	Mar-2022		DB	Stephen Shepley	Sarah Clenton
High	7153	Surgery & Anaesthetics	Critical Care	ICU	Dec-2017	Active	Keeping the base safe	There is a risk of increased demand for ICU Critical Care beds cross site (impacted by the Covid-19 pandemic). This is due to beds being limited at HRI to 8. Resulting in movement of staff and patients to CRH as non clinical transfers to accommodate them ultimately contributing to increased length of stay.	• Move staff across site to maintain safe staffing at both units • Close equivalent bed at HRI to release staff (1 x level 3 or 2 x level 2 beds) - none Covid-19 levels • To utilise flexible staffing, bank and agency to increase staffing to facilitate increased capacity at CRH • To reduce the bed base back down at CRH when able • Where unable to admit patient to CRH for intensivist to assess patient most appropriate to undergo non clinical transfer to other unit in Critical Care Network • Not being able to move staff due to sickness, leave etc • Not always able to cover the shifts with critical care trained agency staff. • Reconfiguration within the trust, has the plan for the critical care unit to be on one site only. 15.12.20 - This risk has been mitigated by using mutual aid within the network according to CritCon levels and also the use of flexible staffing (for example the Red Squad). Also made provision to expand in to recovery if required at Huddersfield.	• Not being able to move staff due to sickness, leave etc • Not always able to cover the shifts with critical care trained agency staff.	15 5 x 3	15 3 x 5	12 3 x 4	Reconfiguration within the trust, has the plan for the critical care unit to be on one site only. 17.11.20 - The Matrons and Band 7 are completing nursing workforce models to increase Critical Care capacity cross site, facilitated by the utilisation of staff from other areas such as elective theatres.	November 2021 update - increased likelihood to 5 - Heavy reliance on bank and agency at the moment, due to no deployed staff and high sickness/isolation. staff are currently covering but as National restrictions ease these may not be covered as readily. Recruitment is in a positive position however will be a few months until all in post and out of supernumerary status. Part of reconfiguration. ICU flexing to 16 bed when possible and RA allows to support increase in bed pressures.	Dec-2021	Dec-2025		PSQB	Thomas Strickland	Suzanne Thompson

21. Governance Report

a) Change to the Trust Constitution

b) Update on Associate Non-Executive Director Appointment

c) Risk Management Strategy and Policy

d) Board and Committee Meeting Dates

e) Board of Directors Workplan

To Approve

Presented by Andrea McCourt

Date of Meeting:	Thursday 13 January 2022
Meeting:	Public Board of Directors
Title:	Governance Report
Author:	Andrea McCourt, Company Secretary
Sponsoring Director:	Brendan Brown, Chief Executive
Previous Forums:	None

Purpose of the Report

This report brings together a number of governance items to the Board for January 2022.

Key Points to Note

a) Change to the Trust Constitution

Calderdale and Huddersfield NHS Foundation Trust has been keen to appoint high quality Non-Executive Directors (NEDs) who are local to the area. Section 25.4 of the Trust's Constitution currently states: *To be eligible for appointment as a non-executive director of the Trust the candidate must live and/or work within the West Yorkshire and Harrogate area.*

In light of the significant demand for Chair and NED roles at present in the NHS and partnership organisations, particularly within the proposed establishment of statutory integrated care systems (ICS) Boards, to ensure the best possible field of candidates for these important roles it is proposed to extend the geographic eligibility criteria for NEDs to allow applicants from a broader geographical area in Yorkshire, extending this to North Yorkshire and South Yorkshire. When recruiting for new Non-Executive Directors a commitment to our local communities will continue to be specified as a requirement.

The proposed broadening of the geographical eligibility criteria below requires a change to our Constitution and approval by the Board (change proposed shown in red font):

Section 25. Board of Directors – appointment and removal of the Chair, Deputy Chair and other non-executive directors

Section 25.4: *To be eligible for appointment as a non-executive director of the Trust the candidate must live and/or work within the West Yorkshire ~~and Harrogate area~~, North Yorkshire or South Yorkshire. Candidates from North Yorkshire or South Yorkshire must be able to demonstrate a commitment to the Trust area and the communities it serves.*

The Council of Governors unanimously approved the amendment to Section 25.4 of the Constitution as above on 14 December 2021 at an extra-ordinary meeting. This proposed amendment to the Constitution is therefore presented to the Board of Directors for approval as per the process for amending the Trust's Constitution.

RECOMMENDATION: The Board is asked to **APPROVE** the change to section 25.4 of the Trust Constitution to extend the geographical eligibility criteria for Non-Executive Director appointments to include North Yorkshire and South Yorkshire.

b) Update on Associate Non-Executive Director Appointment

Following a successful recruitment process and approval by the Nominations and Remuneration Committee of the Council of Governors and ratification by the Council of Governors the Trust on 14 December 2021 the Trust has appointed an Associate Non-Executive Director, Nicola Seanor, who commenced on 15 December 2021. Nicola Seanor is a local resident, has a background in commissioning healthcare in prison and police custody to improve health outcomes, undertakes voluntary work and has a passion for lived experience. Nicola Seanor will support the Trust's quality agenda, working with Denise Sterling, Non-Executive Director and Quality Committee Chair, and will focus on patient experience and end of life care initially.

RECOMMENDATION: The Board is asked to **NOTE** the appointment of Nicola Seanor as an Associate Non-Executive Director for 12 months from 15 December 2021.

c) Risk Management Strategy and Policy

The Board is asked to note that a refresh of the Risk Management Strategy and Policy is underway and will be presented to the Board for approval on 3 March 2022. The current Risk Management Strategy and Policy is therefore extended from January to March 2022. This allows for the refreshed strategy to be reviewed by the Audit and Risk Committee on 25 January 2022, which has oversight for risk management, prior to review by the Board in March 2022.

RECOMMENDATION: The Board is asked to **NOTE** the extension of the Risk Management Strategy and Policy to March 2022.

d) Committee Membership and 2022 Calendar of Board and Committee Meetings

Enclosed is a paper detailing Committee membership and a summary of Board and Committee meeting dates for 2022 at Appendix P2 and P3.

RECOMMENDATION: The Board is asked to **NOTE** the Committee membership and calendar of Board and Committee meeting dates for 2022.

e) Board Workplan

The Board workplan for 2022 is presented for information at Appendix P4.

RECOMMENDATION: The Board is asked to **NOTE** the Board workplan for 2022.

Recommendation

The Board is asked to:

a) **APPROVE** the amendment to section 25.4 of the Trust Constitution as detailed in the paper
b) **NOTE** the Associate Non-Executive Director appointment
c) **NOTE** the extension of the Risk Management Strategy and Policy
d) **NOTE** the calendar of Board and Committee meeting dates and Committee membership for 2022
e) **NOTE** the Board workplan for 2022

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NHS Foundation Trust

COMMITTEE MEMBERSHIP 2022

	Chair	Non-Executive Directors	Executive Directors	Standing Invites (non-voting Directors)	Governor Observer (Non-voting)	Quoracy
Finance and Performance Committee	Richard Hopkin	Peter Wilkinson	Brendan Brown Gary Boothby Jo Fawcus	Anna Basford Jim Rea	Robert Markless Brian Moore Deputy: Isaac Dziya	4 members including Chair or Vice Chair and 1 Executive Director
Quality Committee	Denise Sterling	Karen Heaton	Ellen Armistead David Birkenhead		Gina Choy Jo Kitchen Deputy: Chris Matejak	4 members of the Committee and must include at least three Board members of which one must be a Non-Executive and one an Executive Director
Workforce Committee	Karen Heaton	Denise Sterling	David Birkenhead Suzanne Dunkley		Peter Bamber Chris Matejak Deputy: Gina Choy	4 members and must include at least one Non-Executive Director and one Executive Director
Audit and Risk Committee	Andy Nelson	Richard Hopkin Denise Sterling	Gary Boothby (in attendance)	Jim Rea (in attendance)	Isaac Dziya Liam Stout Deputy: John Gledhill	2 of the 3 NED members
Organ Donation Committee	Philip Lewer		Gary Boothby		Nicola Whitworth Peter Bell Deputy: Sally Robertshaw	A quorum will be two core members and one other member
Charitable Funds Committee	Philip Lewer	Peter Wilkinson Richard Hopkin	Gary Boothby Ellen Armistead David Birkenhead		John Gledhill Jo Kitchen Deputy: Christine Mills	3 members of the Committee, this must include at least one Non-Executive Director and one Executive Director

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BOARD OF DIRECTORS AND COMMITTEE MEETING DATES 2022

	Finance and Performance Committee *	Quality Committee 3 - 4.30 pm	Workforce Committee 3 - 5 pm	Audit & Risk Committee 10 - 12.15 pm	Organ Donation Committee	Charitable Funds Committee 10:30 – 12 pm	Board of Directors 9 – 12 pm
JANUARY 2022	Thurs 6 January 10 – 12 pm	Wed 5 January		Tues 25 January	Wed 5 January 10:30 – 12:30 pm		Thurs 13 January
FEBRUARY 2022	Mon 31 January 11 – 1 pm	Mon 21 February	Tues 15 February			Tues 8 February	
MARCH 2022	Mon 28 February 11 – 1pm	Mon 21 March					Thurs 3 March
APRIL 2022	Mon 4 April 11 – 1 pm	Wed 20 April	Tues 12 April	Tues 26 April			
MAY 2022	Tues 3 May 11 – 1 pm	Mon 16 May				Wed 11 May	Thurs 5 May
JUNE 2022	*TBC*	Mon 20 June	Mon 6 June	Accounts TBC			
JULY 2022	*TBC*	Mon 18 July		Tues 26 July	Wed 6 July 11:30 – 1:30 pm		Thurs 7 July
AUGUST 2022	*TBC*	Wed 17 August	Tues 16 August			Tues 9 August	
SEPTEMBER 2022	*TBC*	Mon 12 September					Thurs 1 September
OCTOBER 2022	*TBC*	Mon 17 October	Tues 11 October	Tues 25 October			
NOVEMBER 2022	*TBC*	Mon 14 November				Wed 23 November	Thurs 3 November
DECEMBER 2022	*TBC*	Mon 19 December	Wed 7 December				

*to note F&P meeting dates to be confirmed during early January 2022 and calendar updated

PUBLIC BOARD WORKPLAN 2022-2023

DATE OF MEETING	5 May 2022	7 July 2022	1 Sep 2022	3 Nov 2022	12 Jan 2023	2 Mar 2023
Date of agenda setting/Feedback to Execs	TBC	TBC	TBC	TBC	TBC	TBC
Date final reports required	22 April 2022	24 June 2022	19 August 2022	21 October 2022	30 December 2022	17 February 2023
STANDING AGENDA ITEMS						
Introduction and apologies	✓	✓	✓	✓	✓	✓
Declarations of interest	✓	✓	✓	✓	✓	✓
Minutes of previous meeting, matters arising and action log	✓	✓	✓	✓	✓	✓
Patient/Staff Story	✓	✓	✓	✓	✓	✓
Chair's report	✓	✓	✓	✓	✓	✓
Chief Executive's report	✓	✓	✓	✓	✓	✓
Integrated Performance report (Inc: Quality, Finance, Workforce)	✓	✓	✓	✓	✓	✓
Recovery Update	✓	✓	✓	✓	✓	✓
Financial Update	✓	✓	✓	✓	✓	✓
Health Inequalities	✓	✓	✓	✓	✓	✓
Quality Committee Chair's Highlight Report & Minutes	✓	✓	✓	✓	✓	✓
Audit and Risk Committee Chair's Highlight Report & Minutes	✓	✓	✓	✓	✓	✓
Finance and Performance Committee Chair's Highlight Report & Minutes	✓	✓	✓	✓	✓	✓
Workforce Committee Chair's Highlight Report & Minutes	✓	✓	✓	✓	✓	✓
Charitable Funds Committee Minutes	✓	✓	✓	✓	✓	✓
Council of Governors Meeting Minutes		✓	✓		✓	
STRATEGY AND PLANNING						
Strategic Objectives – 1 year plan / 10 year strategy		✓ *- 2021-2023 Strategic Objectives Progress Report*		✓		✓
Digital Health Strategy		✓				

DATE OF MEETING	5 May 2022	7 July 2022	1 Sep 2022	3 Nov 2022	12 Jan 2023	2 Mar 2023
Workforce OD Strategy	✓					
Risk Management Strategy						✓
Annual Plan	✓	✓				✓
Capital Plan					✓	
Winter Plan			✓			
Green Plan (Climate Change)	✓					
QUALITY						
Quality Board update	✓	✓	✓	✓	✓	✓
Director of Infection Prevention Control (DIPC) quarterly report	✓Q4		✓Q1	✓Q2	✓Q3	
DIPC Annual Report		✓				
Learning from Deaths Quarterly Report		✓Q4	✓Q1	✓Q2		✓ Q3
Safeguarding update – Adults & Children						✓
Safeguarding Adults and Children Annual Report			✓			
Complaints Annual Report			✓			
WORKFORCE						
Staff Survey Results and Action Plan	✓	✓				✓
Health and Well-Being			✓			
Nursing and Midwifery Staffing Hard Truths Requirement			✓ Bi-Annual			
Guardian of Safe Working Hours (quarterly)	✓Q4		✓Q1	✓Q2	✓Q3	
Guardian of Safe Working Hours Annual Report	✓					
Diversity						✓
Medical Revalidation and Appraisal Annual Report			✓ Annual Report			
Freedom to Speak Up Annual Report			✓ Annual Report		✓ 6 month report FTSU themes	
Workforce Committee Annual Report	✓			✓		

DATE OF MEETING	5 May 2022	7 July 2022	1 Sep 2022	3 Nov 2022	12 Jan 2023	2 Mar 2023
	2019/2020			2021/22		
Public Sector Equality Duty (PSED) Annual Report						✓
GOVERNANCE & ASSURANCE						
Health and Safety Update	✓	✓			✓	
Health and Safety Policy	✓					
Health and Safety Annual Report					✓	
Board Assurance Framework		✓ 1		✓ 2		✓ 3
Risk Appetite Statement			✓			
High Level Risk Register	✓		✓		✓	
Calderdale Huddersfield Solutions Managing Directors Report	✓	✓	✓	✓	✓	✓
Standing Orders/SFIs/SOD review	✓					
Non-Executive appointments				✓		✓
Annual review of NED roles			✓			
Board workplan	✓	✓	✓	✓	✓	✓
Board meeting dates		✓				
Use of Trust Seal		✓		✓		✓
Council of Governor elections						✓ timetable
Declaration of Interests – Board of Directors (annually)						✓
Attendance Register – (annually)	✓					
Fit and Proper Person Self-Declaration Register						✓
Seek delegation from Board to ARC for the annual report and accounts 2021/22	✓					
BOD Terms of Reference						✓
Sub Committees Terms of Reference	✓ F&P ✓ TPB	✓ Workforce	✓ARC			✓QC ✓ NRC BOC
Constitutional changes (+as required)	✓					✓

DATE OF MEETING	5 May 2022	7 July 2022	1 Sep 2022	3 Nov 2022	12 Jan 2023	2 Mar 2023
Compliance with Licence Conditions	✓					
Huddersfield Pharmaceuticals Specials (HPS) Annual Report				✓		
Fire Safety Annual Report		✓				
Fire Strategy 2021-2026 and Fire Policy Update						✓
Emergency Planning Annual Report (Bev Walker/Ian Kilroy/Karen Bates)			✓			
Charitable Funds Report 2021-22 and Accounts (Audit Highlights Memorandum)					✓	
Committee review and annual reports		✓				
Audit & Risk Committee Annual Report 2021/2022		✓				
Finance & Performance Committee Annual Report 2021/2022		✓				
Quality Committee Annual Report 2021/22		✓				
WYAAT/WY&H Partnership Reports	✓	✓	✓	✓	✓	✓
WYAAT Annual Report and Summary Annual Report					✓	

Colour Key to agenda items listed in left hand column:	
Items for approval	To formally receive a report or strategy for discussion and particularly approve recommendations or a particular course of action
Items to receive	To discuss in depth, noting the implications for the Board or Trust without formal approval
Items to note	For the intelligence of the Board without in-depth discussion
Items for assurance	To assure the Board that effective systems of internal control are in place (see Review Room papers)

22. Board Sub-Committee Chair Highlight Reports (Minutes in the Review Room)

- Finance and Performance Committee
- Quality Committee
- Workforce Committee

To Note

Presented by Richard Hopkin, Denise Sterling and Karen Heaton

Calderdale and Huddersfield NHS Foundation Trust

CHAIR'S HIGHLIGHT REPORT
to the Board of Directors

Committee Name:	Finance and Performance Committee
Committee Chair:	Richard Hopkin, Non-Executive Director
Date(s) of meeting:	29 November 2021
Date of Board meeting this report is to be presented:	13 January 2022

ACKNOWLEDGE

- P2 (and to a large extent P3, P4) numbers and other recovery metrics largely in line with revised trajectories
- Performance on cancer metrics generally strong while continuing to provide support to Mid Yorkshire Hospital Trust
- Effective Use Of Resources Group ('ERG') now established to provide governance for future delivery of 'efficiency requirement', with initial meetings held

ASSURE

- Review of Recovery Performance to end of October against revised trajectories, together with H2 Operational Planning assumptions
- Review of High Level Risks attributable to F&P, with the risk relating to the 21/22 Financial Plan held at 20 (although additional funding sources may ultimately reduce this risk)
- Proposed schedule of key STOP metrics reviewed (to be shared with Board)
- Work Plan for 21/22 approved

AWARE

- Relatively low overall IPR performance score of 65% (following 61% in Sept)
- Key IPR issues included – complaints performance, FFT results, stroke indicators, dementia screening, #neck of femur, DTOC
- High volumes and acuity of attendances in ED; only 76% achieved in Oct against 4 hour standard
- Highest short term sickness rate (non Covid) for 12 months; overall absence rate of 5%
- Reported deficit of £1.2m in month 7 as planned; H2 break even plan assumes £6.7m efficiency savings
- Enhanced bank payments cost £0.7m in October (YTD £2.5m) with little apparent impact on staff take up

Calderdale and Huddersfield NHS Foundation Trust

CHAIR'S HIGHLIGHT REPORT
to the Board of Directors

Committee Name:	Quality Committee
Committee Chair:	Denise Sterling, Non-Executive Director
Dates of meetings:	8th November 2021 and 6th December 2021
Date of Board meeting this report is to be presented:	13th January 2022

ACKNOWLEDGE

- GIRFT report - The approach used for the GIRFT programme at CHFT is receiving national recognition. There is partnership working with the national GIRFT team on a number of initiatives. Ongoing time commitment is now a challenge that needs to be addressed.
- Committee received presentation on NHSI mandated Patient Safety Specialist role being introduced as part of the NHS patient safety strategy. Proposal for a wte post being developed.
- Consent policy rewritten incorporating GMC guidance, presented and approved.

ASSURE

- Deep dive BAF Risk 6/19 - compliance with quality and safety standards, key controls reviewed and updated risk rating remains the same at 12.
- Deep dive BAF Risk 4/20-CQC rating, progress has been made with Journey to Outstanding work, concerns have been identified which require action plans to ensure compliance in a number of areas. The risk rating remains at 16.
- Received report of the Maternity Services still births review, it was identified that access to antenatal care, smoking and deprivation has impacted the outcomes. Other services in the local maternity system have also experienced increased still births. CHFT to be part of region wide review. CHFT maternity guidelines are compliant with NICE guidance.
- Since its inception the medical examiner service has made significant progress in the development of the service. A high percentage of deaths have been scrutinised over the past 11 months. In the last quarter 92% which is above the regional average of 71% and direct contact has been made with 93% of bereaved relatives. Opportunities for further development identified.

AWARE

- Ockenden report - still awaiting visit from Regional Chief Midwife, feedback received on the evidence submitted to show compliance with the recommendations and further work on the evidence is underway.
- PSQB Q2 report - Update on never event declared relating to an angio procedure, changes have been put in place to minimise the risk happening again in the angio department. Escalated to committee possible rise in safeguarding incidents with a possible indicator of harm to patients. Increase in emergency callouts and workloads in the Community, leading to increased volume, and staffing pressures.
- IPR October improved performance from September position, highlighted areas of concerns complaints, diagnostics 6 weeks, the emergency care standard and cancer at 62 days which is being monitored and should improve next month. Other key issues - a reduction in performance of quality priorities particularly sepsis, fracture neck of femur, dementia screening with specific improvement work ongoing. Assurance provided that CHFT performing reasonably well against the infection prevention and control metrics.

Calderdale and Huddersfield NHS Foundation Trust

CHAIR'S HIGHLIGHT REPORT
to the Board of Directors

Committee Name:	Workforce and Organisational Development Committee
Committee Chair:	Karen Heaton, Non-Executive Director
Date(s) of meeting:	Monday 8 November 2021 and Monday 6 December 2021
Date of Board meeting this report is to be presented:	Thursday 13 January 2022

ACKNOWLEDGE

The following points are to be noted by the Board following the meetings of the Committee on 8 November and 6 December 2021.

- Quarterly Vacancy deep dive which is being managed against mandatory vaccine programme for staff.
- Deep dive into Estates and Ancilliary sickness absence with a significant number of days lost throughout the year.
- Freedom to Speak Up mid -year report with number of cases increasing, however the majority remain anonymous.
- The Trust's wellbeing package continues to evolve and is well received by staff.
- Education Committee remit has now been agreed and the Committee looks forward to receiving regular progress reports.
- International recruitment is progressing well.
- GMC survey of trainee doctors 2021 – 100% response rate from CHFT-concern nationally about bur out rate
- Developing Workforce Safeguards – action plan in place and annual report will be presented to the Committee February/March 2022.
- Medical workforce programme update – positive but a significant shortfall (c49000FTE) doctors nationally.

ASSURE

The Committee continues to keep a close watch on the level of sickness absence and expects a continued improvement in the number of RTWs undertaken. BAF risk remains unchanged for Nurse Staffing.

AWARE

Workforce metrics remain amber and concerns remain over the sickness absence rate, return to work interviews (RTW) and Data Security Awareness EST compliance. The wellbeing of the workforce is of continuing concern.

23. Board Sub-Committee Terms of Reference

1. Organ Donation Committee

To Approve

Presented by Philip Lewer

Calderdale and Huddersfield
NHS Foundation Trust

ORGAN DONATION COMMITTEE

TERMS OF REFERENCE

Version:	1.0 Amendments following clarification of reporting route 26.10.21
Approved by:	Board of Directors TBC
Date approved:	
Date issued:	
Review date:	November 2024

ORGAN DONATION COMMITTEE TERMS OF REFERENCE

1. Authority

1.1 The Trust hereby resolves to establish a Committee to be known as the Organ Donation Committee ("the Committee").

2. Purpose and Duties

The purpose of the Committee is to:

2.1 Influence policy and practice to ensure that organ donation is considered in all appropriate situations and that potential for organ donation is maximised. Identify and resolve any obstacles to this.

2.2 Ensure that local policies and operational aspects of donation are reviewed, developed and implemented in line with national guidelines and policies.

2.3 Monitor organ donation activity using the potential donor audit. Understand the reasons for missed opportunities and be assured that appropriate actions are taken consistently to support organ donation at end of life.

2.4 Be assured that information about organ donation activity is fed back to relevant staff.

The Organ Donation Committee should also:

2.5 Support publicity and education around organ donation within the hospital

2.6 Support NHS Blood and Transplant's publicity and education around organ donation in the communities served by the Trust

2.7 Support local activity supporting national campaigns such as organ donation week.

3. Membership and attendance

3.1 The Chair of the Committee is currently a Non-Executive Director. In the absence of the Chair, another member shall be nominated and appointed as Chair for the meeting.

3.2 The membership of the Organ Donation Committee is as follows:

Chair of the Organ Donation Committee (core member)

Specialist Nurse for organ donation (core member)

Clinical lead for organ donation (core member)

Donor family representative, if available

Recipient representative, if available

Organ Donation Ambassador, if available

Council of Governors representative, if available

Communications Department representative

Emergency Department representative if available

The group may invite additional members with specific skills/ areas of interest as required. Different members will bring different skills and resources to enhance opportunities for organ donation.

3.3 A quorum will be two core members and one other member.

3.4 A register of attendance will be maintained and the Chair of the Committee will follow up any issues related to the unexplained non-attendance of members.

3.5 Members unable to attend should indicate in writing to the Secretary, at least seven days in advance of the meeting. Core members should nominate a deputy who is adequately briefed to attend.

4 Administration

4.1 Administrative and secretarial support will be provided by the critical care directorate, whose duties in this respect will include:

- In consultation with the Chair developing and maintaining the reporting schedule to the Committee
- Collating papers and drafting of the agenda for agreement by the Chair of the Committee
- Items for the agenda should be sent to the Secretary a minimum of 7 days prior to the meeting. Urgent items may be raised under any other business.
- Sending the agenda to members one week before the meeting with all associated papers, including minutes of previous meeting, organ donation activity and any other relevant local or national papers arising since the last meeting
- Taking the minutes and circulating these within two weeks of the meeting, keeping a record of matters arising and agreed actions to be carried forward
- Advising the group of scheduled agenda items
- Agreeing the action schedule with the Chair and ensuring circulation within two weeks of each meeting
- Maintaining a record of attendance

5 Frequency of meetings

5.1 The Committee will meet bi-annually.

5.2 Further extraordinary meetings may be required at times to deal with more urgent matters.

6 Reporting

6.1 The Committee will report via minutes to the to Trust Board twice yearly including information on comparative donation activity and any remedial action required.

7 Review

7.1 The Committee shall review its collective performance at agreed periods.

7.2 The terms of reference of the Committee shall be reviewed by the Board at least every three years.

24. Annual / Bi-Annual Reports (In the Review Room)

1. Charitable Funds Annual Report and Accounts 2020-2021

For Information

Presented by Philip Lewer

25. Items for Review Room

1. Emergency Preparedness Resilience and Response (EPRR) Core Standards Submission
2. Calderdale and Huddersfield Solutions Managing Directors Report – December 2021
3. Charitable Funds Committee minutes of the last meeting held 22.11.21
4. Finance and Performance Committee minutes of the last meetings held 04.10.21, 01.11.21 and 29.11.21
5. Quality Committee minutes of the last meetings held 11.10.21, 08.11.21 and 06.12.21
6. Workforce Committee minutes of the last meetings held 08.11.21 and 06.12.21

To Note

26. Date and time of next meeting

Date: Thursday 3 March 2022

Time: 9:00 am

Venue: Microsoft Teams

To Note

Presented by Philip Lewer