# Public Board of Directors

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| **Schedule** | Thursday 1 September 2022, 9:00 — 12:00 BST |
| **Venue** | Microsoft Teams |
| **Description** | This meeting will take place via Microsoft Teams. The meeting will be recorded and the recording will be published on our website after the meeting. The agenda and papers are made available on our website and in due course the minutes of this meeting will also be published. |
| **Organiser** | Amber Fox |

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# 1. Welcome and Introductions:

To Note

Presented by Helen Hirst

## 2. Apologies for absence: Jo Fawcus, Andy Nelson, Robert Markless (invited public governor)

To Note

Presented by Helen Hirst

# 3. Declaration of Interests

To Receive

# 4. Minutes of the previous meeting held on 7 July 2022

To Approve

Presented by Helen Hirst

# Draft Minutes of the Public Board Meeting held on Thursday 7 July 2022 at 9:00 am via Microsoft Teams

**PRESENT**

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| Helen Hirst | Chair |
| Brendan Brown | Chief Executive |
| Cornelle Parker | Deputy Medical Director |
| Lindsay Rudge | Chief Nurse |
| Gary Boothby | Director of Finance |
| Suzanne Dunkley | Director of Workforce and Organisational Development |
| Jo Fawcus | Chief Operating Officer |
| Peter Wilkinson **(PW)** | Non-Executive Director |
| Andy Nelson **(AN)** | Non-Executive Director |
| Karen Heaton **(KH)** | Non-Executive Director |
| Richard Hopkin **(RH)** | Non-Executive Director |
| Denise Sterling **(DS)** | Non-Executive Director |

**IN ATTENDANCE**

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| Anna Basford | Director of Transformation and Partnerships |
| Victoria Pickles | Director of Corporate Affairs |
| Stuart Sugarman | Managing Director, Calderdale and Huddersfield Solutions Ltd (CHS) |
| Andrea McCourt | Company Secretary |
| Amber Fox | Corporate Governance Manager (minutes) |

**OBSERVERS**

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| Christine Mills | Public Elected Governor |
| Gina Choy | Public Elected Governor |
| Peter Bamber | Public Elected Governor |
| John Gledhill | Public Elected Governor |
| Nicola Seanor **(NS)** | Associate Non-Executive Director |
| Holly Smith | Macmillan Cancer Support Service Support Worker **(for item 95/22)** |
| Helen Jones | Macmillan Cancer Information Manager **(for item 95/22)** |

## 88/22 Welcome and Introductions

The Chair welcomed everyone to the public Board of Directors meeting, in particular Victoria Pickles, Director of Corporate Affairs, Lindsay Rudge, Chief Nurse, Cornelle Parker, Deputy Medical Director and Nicola Seanor, Associate Non-Executive Director.

The Chair also welcomed invited governors and observers to the meeting, Peter Bamber, Gina Choy, Christine Mills and John Gledhill.

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

## 89/22 Apologies for absence

Apologies were received from David Birkenhead, Tim Busby, Nigel Broadbent and Robert Birkett.

## 90/22 Declaration of Interests

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

KH declared a conflict of interest in the appointment of Deputy Chair and Senior Independent Non-Executive Director under the Company Secretary report.

**91/22 Minutes of the previous meeting held on 5 May 2022**

The minutes of the previous meeting held on 5 May 2022 were approved as a correct record subject to the following amendment:

- RH pointed out a clarification on page 5 of the minutes which should read under the financial annual plan 'delivery of £20m of efficiency savings and £5m of covid cost savings*'

**OUTCOME**: The Board **APPROVED** the minutes from the previous meeting held on 5 May 2022 subject to the amendment above.

**92/22 Action log and matters arising**

There were no outstanding actions on the action log.

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

**93/22 Chair's Report**

The Chair informed the Board she officially started on Friday 1 July 2022 which coincided with the launch of the new Integrated Care Board (ICB). The Chair observed the webcast of the first meeting of the ICB which was publicly broadcast on 1 July 2022 and was an essential meeting to set off the ICB.

The Chair has so far toured the two hospital sites, visited one of the community teams at Broad Street Plaza, attended the Calderdale Care Partnership Board Development Session where the first meeting in public will be held in July 2022, chaired the first Organ Donation Committee meeting on 6 July 2022 where they are starting to think about utilising opportunities and engagement tools to promote organ donation. The Chair reminded the Board it is Organ Donation week during the first week of September 2022 and Transplant Games at the end of July 2022.

The Chair explained she is part way through her induction programme and will be meeting with colleagues over the next few weeks.

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

**94/22 Chief Executive's Report**

The Chief Executive recorded a warm welcome to Helen Hirst as the new Chair from 1 July 2022.

The Chief Executive formally thanked Cornelle Parker, Deputy Medical Director on behalf of the Board for the past four and a half years as Deputy Medical Director, for her work and support in the organisation and wished her well in next ventures.

The Chief Executive highlighted the national changes taking place to the political environment and he reminded the Board we are still living in a pandemic and that restrictions have been re-introduced that had been previously lifted in the healthcare settings.

The Chief Executive updated the Board on a recent conference with national NHS leaders where they were setting the tone for a refresh of the NHS and Social Care Strategy with a focus on the four Rs – recovery, reform, resilience and respect. The Chief Executive highlighted the Trust's role as an anchor partner within the Integrated Care System (ICS).

The Chief Executive formally acknowledged clinical colleagues go above and beyond every day and the Trust continues to support its colleagues to provide a sense of optimism and hope for the future. He added it is important that the Trust continues to recognise its

work that colleagues have led on the health inequalities agenda and how the Trust takes this agenda forward in partnership with primary care colleagues. The Chief Executive added there is also an opportunity to view how the Digital Strategy can enable different thinking about the work the Trust are doing. The Chief Executive and Director of Corporate Affairs have been in consultation with the national comms teams around health inequalities regarding the work undertaken at the Trust.

The Chair asked about the Covid-19 Public Inquiry. The Chief Executive responded that the Company Secretary has led a piece of work on this which has come to a pause. As the national terms of reference have now been finalised this will continue to grow. The Trust are continuing the work they have been leading on in the background which will pick back up from the Autumn. The Chief Executive added there are listening events planned and the Company Secretary has got the Trust to a good place. A further update will be brought to the Board to provide an overview of the preparation now that the terms of reference have been confirmed.

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

**95/22** **Patient/Staff Story – CHFT Macmillan Information and Support Service**

Holly Smith, CHFT Macmillan Cancer Support Service Support Worker and Helen Jones, Macmillan Cancer Information Manager were in attendance to share a patient story from the Macmillan Information and Support Service at the Trust.

The Macmillan Information and Support Services was funded from Macmillan from 2013 who paid for the main centre at Calderdale Royal Hospital. Gradually the Trust have taken over this funding.

The key statistics for 2021 were shared as follows:

- 4,013 contacts – 27% increase from 2020
- 25% of all newly diagnosed patients in CHFT seen by the service
- £1,305,799.27 in estimated benefit gains for local people from our referrals
- £54,650 awarded to patients in Macmillan grants
- 761 onward referrals to other organisations for support
- 79% of people said contact with the service reduced their anxiety
- 48% of people said they would have gone to health professionals if our services did not exist – saving time and money
- 497 attendances at our patient education programmes and support groups

The presentation outlined the range of support that it provides to patients and carers as a non-clinical service including information and programmes, emotional, financial and practical support.

KH thanked the team for the great service, expressed her support for the service and the importance of promoting it.

The Chief Operating Officer stated it was a great presentation and offered her support to promote the service through her Wednesday brief to all Senior Leaders in the organisation and the Cancer Delivery Group to get the message out to all clinicians.

The Chief Executive stated this is a phenomenal service, recognising the service is incredibly busy and will keep growing. He stated it is important to look at how to resource this service and how to share this resource in the ICS to make sure the team are supported in continuing to deliver a high quality service.

The Chair thanked the team for the superb service they offer.

**OUTCOME**: The Board **NOTED** the staff and patient story from the Macmillan Information and Support Service.

**96/22 Health Inequalities Progress Report**

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

RH highlighted the great progress with data which evidences this. He added that the Trust are ahead of a lot of other Trusts and progress made on waiting times for patients is significant and can be demonstrated. RH pointed out a key action area around the role of a mental health consultant requested that greater reference to mental health is included in future reports and the Director of Transformation and Partnerships highlighted there are a number of examples the Trust are taking with regards to mental health which will be picked up in the next update to Board in September 2022.

**Action: To include updates regarding mental health in future health inequalities reports – Director of Transformation and Partnerships / Chief Nurse / Chief Operating Officer**

AN pointed out it is great to see progress, particularly on waiting lists and specific examples on work with asylum seekers. He asked if 'what's next?' could be included in the next report and suggested there is more that can be done with regards to the voluntary and homeless sector. The Director of Transformation and Partnerships noted the comments and explained this will be considered as part of the refresh of the strategy.

KH highlighted the extent of work is ongoing with partner organisations and asked if the Trust are getting traction from partner organisations and if they are inputting into the process. The Director of Transformation and Partnerships responded there is good traction with partner organisations and health inequalities has been important and a high priority with all partners. She added there is joined up work in Calderdale working on the BAME action plan in response to learning from the pandemic and the Trust are working with primary care in Kirklees. She explained the local Place based new sub-committees have health inequalities as one of their top priorities.

KH asked why the cultural awareness training offer focused on maternity colleagues was not essential or offered on a wider basis to the workforce. The Director of Workforce and OD responded this training has recently been developed and was a specific interest from colleagues in maternity services. She explained this is currently being piloted in maternity and forms part of the leadership programme for all managers. She explained they are reviewing whether it is possible for colleagues to undertake this as part of essential training for all staff which continues to grow.

DS asked if the Trust have taken opportunities with the voluntary organisations, particularly community centres and faith centres who play a large role in the communities. The Director of Transformation and Partnerships confirmed the Trust have been in dialogue with schools, housing, GP partners and the Trust have reached out to local voluntary sector organisations and faith organisations; however, more emphasis is needed here. She explained the Trust worked with local faith leaders as part of the work undertaken in response to the pandemic about how we engage with local faith communities.

PW, Chair of the Health Inequalities Group, stated there is great enthusiasm and energy to do more. He stated he is looking forward to seeing the Strategy in the coming weeks which will focus on what the Trust do next, highlighting it is important that the Trust don't focus on too much at once.

The Chief Executive highlighted the need for further work. He explained he meets regularly with the Chief Nurse and faith leaders and has spoken with the chancellor of the college to

access the links to local Sikh communities and how to promote the work of the Trust. He added there is a stakeholder map required.

The Chair highlighted the inequalities experienced before patients access hospital services and suggested a broader view could be developed across the Place based partnerships to supplement this. This might be evidenced in Place based reports and plans. The Director of Transformation and Partnerships stated addressing and reducing health inequalities for local communities needs to be a partnership approach to amplify the impact. She added the national studies show an inequality for people accessing services such as hip surgery and a there will be a more holistic report in the future.

NS highlighted the different diverse areas the Non-Executive Directors look at which reflects health inequalities work such as End of Life Care and the Patient Experience Group.

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

**97/22** **2021-2023 Strategic Objectives Progress Report**

The Director of Transformation and Partnerships presented a paper to provide an update on progress to the 2021-2023 Annual Strategic Plan. The key points to note were:

- There are 19 key deliverables with RAG rated actions in support of a longer term ten year strategy
- Of the 19 key objectives, one is rated blue (completed), seventeen rated green (on track and making good progress), one rated amber (work ongoing around how we use population health data to reduce inequalities)
- Report includes a description and the key outcome each objective should enable

AN highlighted it is positive to see outcome measures and overall progress and challenged how the report can include targets on each objective or how to measure its success.

The Director of Finance explained the performance measure around use of resources, which has two elements, a general use of resource and in addition, there is also a finance use of resource score. Whilst the Trust continue to demonstrate improvement against the general use of resource score, the finance regime has changed this year and the finance use of resource score will deteriorate this year due to the plan being to deliver a financial deficit.

The Chair noted she was keen to ensure our ambitions for our local population are reflected in strategic objectives and the Director of Transformation and Partnerships explained workshop discussions are taking place to reframe the longer term strategy from April 2023 onwards.

**OUTCOME**: The Board **NOTED** the assessment of progress against the 2021/23 strategic plan.

**98/22** **Recovery Update**

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

- 104 week trajectory by the end of June – one patient waited over four weeks, this patient will be treated in July 2022
- Work continues on the 78 week plan to have 0 waits by the end of March 2023, with a trajectory to achieve this by February 2023
- 52 weeks – aim to substantially reduce this to 0 by March 2023

- Appointment Slot Issues continue to reduce; however, there is a substantial volume of patients and support is being provided by system partners in terms of how to treat these patients
- Holding list – working through a plan to continue to reduce these
- MRI trajectory – Continue to reduce the backlog, 8.2 weeks on average for MRI scan waits, this is now 4.7 weeks, and the Trust continues to work through the backlog with extra capacity in MRI, the new scanners at CRH are up and running

KH noted the Trust is behind with the elective recovery programme and asked if there is confidence in the Trust catching up on activity in order to not lose out on funding. The Chief Operating Officer explained the reason for the position is that surgery did not get full capacity until the third week of May rather than the end of April and the Trust is not yet at full capacity in theatres due to an increase in staff absence.

The Director of Finance responded that the Trust are assuming approximately £12m worth of elective recovery funding being received by delivering 104% of activity levels. However, the Trust are not at this level at month 2 and have not assumed receipt of this funding. There are still some challenges in several elective specialties and at the end of month 2 and 3, the elective recovery fund is not being achieved by any Trust at this point of time and there are discussions taking place about how the elective recovery funding (ERF) is consistently reported. The Director of Finance stated there is lack of clarity about what happens is the funding is not earned. He clarified the monies go back to the ICS if not earned; however, the ICS is likely to give back to Trusts in other forms and they may be re-writing some of the rules. The Trust continue to assume the full £12m will be received.

AN queried whether the funding regime may be staged through the year and the Director of Finance explained complications relating to how to phase the ERF funding and how the money flows, with the clinical commissioning group year-end accounts being completed requiring a break even position. The Chair noted the uncertain position regarding elective recovery funding.

AN asked about progress with theatre productivity and the Chief Operating Officer confirmed new theatre staff joined the Trust in June and there is a trajectory of new staff joining the Trust in July and August 2022. She explained the Director of Operations for Surgery has held some sessions for staff focused on how to get patients to theatre quicker and engaging staff for ideas and she is encouraged by the work taking place.

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

**99/22** **Month 2 Financial Summary**

The Director of Finance presented the month 2 financial summary and highlighted the key points below:

- £6.07m deficit at the end of month 2 which is slightly ahead of plan after not assuming any elective recovery funding
- Cost Improvement Programme (CIP) is in a favourable position at £800k ahead of plan at this stage and a full £20m of schemes and opportunities have been identified
- Continue to forecast delivery of the plan
- Challenges with underspending on the capital plan – schemes planned for back of this year may slip into next year
- Position is based on a £20m deficit plan submitted in April 2022, additional funding was allocated to the NHS to support inflationary pressures which involved the Trust submitting a further plan in June 2022; The additional funding leads to a revised deficit plan of £17.35m. Despite additional funding to support higher than assumed inflation, the risk remains with the Trust and the funding was used to support an improved financial plan.

**OUTCOME**: The Board **NOTED** the Month 2 Finance Report and the financial position for the Trust as at 31 May 2022.

## 100/22 People Strategy Refresh

The Director of Workforce and OD presented the refreshed People Strategy which launched on 4 July 2022 for the Board to endorse and champion. She explained it has been three years since former Strategy was launched, the Cupboard, and the aims and actions in this strategy served the Trust well throughout the pandemic; however, acknowledged it is timely to refresh this strategy given the size and pace of change. The overarching aim of the Strategy is to deliver one culture of care.

The Strategy was co-created with colleagues across the Trust over a period of 6-12 months via hot house events, working together to get results sessions, tea trolley rounds, listening events, staff survey and pulse survey results and qualitative data from freedom to speak up.

The Trust is delighted to be hosting the Kirklees workforce role within the Kirklees Place Partnership and are also working with Calderdale College to build a curriculum for health and social care for members of the community in Calderdale.

Feedback received mainly focused on clarity, ambition and scope on the aims in the previous strategy. The aims and priorities have been set in some clearer chapters. Colleagues wanted clarity on how the four pillars and one culture of care fit together and as a result, the 'We put Patients First' has been refreshed to 'We Put People First' which provides an emphasis that colleagues are also patients.

The six key chapters have a clear aim and are Equality, Diversity and Inclusion, Health and Wellbeing, Engagement, Improvement and Talent Management and Workforce Design.

The Director of Workforce and OD formally thanked all colleagues who took a part in this refresh.

KH highlighted the great piece of work and that this is a living document and links into the main strategy for every leader to take on. She stated it is very clear and succinct and builds on what we have learned and what has been actioned throughout the pandemic. The Board are asked to endorse the Strategy and progress will be monitored through the Workforce Committee.

RH highlighted the excellent piece of work and a great document, he stated that one of the outcomes will be some hard data and the challenges around absence and vacancies.

**OUTCOME**: The Board **ENDORSED** the Refreshed People Strategy 2021-2027.

## 101/22 Director of Infection, Prevention and Control Annual Report

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

- Very active year for the Infection Prevention Control teams
- MRSA – 0 case reported in this year – positive to meet this objective for the reporting period
- Increase in c.diff throughout the year and breached the target in November 2021, significant decrease in preventable cases (not preventable – antibiotic prescribing, actions to address any issues are described in the report)
- Ongoing monitoring of covid-19 cases and outbreak with ongoing variants causing peaks throughout the year

- Forward looking plan for IPC – continue responding to the ongoing covid-19 pandemic and new guidance as it is issued, to work across the regional footprint around c.diff and the implementation of the new cleaning standards

The Chief Nurse explained an increase in Covid-19 is being seen in the local population. As a result, the Trust have had to increase the bed base to provide isolation areas for Covid-19 positive patients with admissions seen into critical care. The peak is expected to run throughout July and August 2022. There as also been an increase in staff absence relating to Covid-19. The Winter vaccination programme is due to start in September 2022 for Covid-19 and Flu following the guidance issued. There has been updated guidance on the monkeypox vaccination programme and the Trust are offering an occupational vaccine to colleagues who are deemed as high risk.

AN stated it is good to see the positive progress on preventable c.diff and MRSA cases and asked for an update on the seven actions in progress around cleaning on the IPC Board Assurance Framework and the reset and stabilisation of the IPC functions. The Chief Nurse responded this is around the ongoing stepping up and stepping down around cleaning standards and the deep clean programmes in response to the new cleaning standards. There were some challenging targets set around cleaning in high risk areas and the frequency of these; therefore, there is ongoing monitoring of these areas to ensure they are embedded. In terms of stabilising the IPC team, the team have been working in a very reactive programme and as a result had to step some of the audit programme down last year and are now going back to business as usual.

The Chair thanked the Infection Prevention and Control Board for all their hard work on behalf of the Board.

**OUTCOME**: The Board **NOTED** the Director of Infection, Prevention and Control Annual Report.

**102/22 Learning from Deaths Annual Report**

The Deputy Medical Director presented the Learning from Deaths Annual Report for 2021/22. The key points to note were:

- Three elements to mortality surveillance and assurance which comprise of metrics from the NHS Digital alerting system, casenote review and themes and learning
- Hospital Standardised Mortality (HSMR) is in the 'as expected' range with a 12 month rolling average of 104.18. The latest in-month position (to end of March 202 2) is 94.69
- Summary Hospital-level Mortality (SHMI) remains within expected limits at 104.15 and has stabilised following last year's declining performance
- Crude mortality national bench-marked position remains stable
- Processes have been refined around mortality alert reviews
- Volume of national mortality alerts has declined
- Case note review is not a direct measure of quality of care
- Initial screening reviews internal target is 50% - achievement of 47% which has now risen to 50.5%
- Structured judgement review is the second stage review – approximately 10% of deaths undergo a structured judgement review
- Medical Examiner Office is now fully established and completed a full year of operation. During the last 12 months it has reviewed 87% of all in-patient deaths and contact made to 77% of relatives of those deceased
- The Care of the Acutely Ill Patient (CAIP) Programme has been established as a quality improvement initiative focusing on mortality impact. It comprises 7 workstreams: deteriorating patient, sepsis, clinical coding, stroke, acute kidney injury, discharge acuity and learning disability

AN stated it is good to see improvements and highlighted the positive impact of the Medical Examiner Office. He asked if HSMR was a coding issue rather than a care issue and if there were any key themes from the discussions with relatives of those deceased. The Deputy Medical Director confirmed HSMR is not a coding issue, which is a mortality metric as the coding is scrutinised carefully. She explained the issue in relation to a particular code that only the Specialist Palliative Care team can use, and the team has struggled with staffing over the last 18 months. She also referenced there has been an increase in complexity of the patients and HSMR has adjusted this measure which has caused significant problems; however, the last two data points are trending in a better direction. The Deputy Medical Director responded there are no key themes arising from the discussions with bereaved relatives; however, this allows discussions with relatives a lot earlier to discuss any concerns and has received positive input by bereaved relatives.

KH stated it was an excellent report, very detailed and clear and she supported the recommendations.

RH recognised the good progress getting close to the 50% target and highlighted it was a positive report, congratulating the Deputy Medical Director and the team.

DS expressed her support for the recommendations, particularly around the quality improvement programme for the deteriorating patient and stated she is looking forward to hearing how the Trust get this programme running.

**OUTCOME**: The Board **NOTED** the Learning from Deaths Annual Report and **SUPPORTED** the following recommendations:

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

**103/22 Quality Report**

The Deputy Medical Director presented the Quality Report which has previously been reviewed by the Quality Committee. The Deputy Medical Director described a different approach to the report in future where an Executive Summary presentation will be shared by the Chief Nurse and Medical Director alternatively. The key updates were:

- Complaints – ongoing challenge and one of the focused quality priorities, additional measures have been put in place which has seen an improvement to complaints closed within the target timeframe (from 35% in April to 57% in May), a dashboard has been developed for complaints to monitor performance more closely, an escalation process and a weekly confirm and challenge is now in place with the Chief Nurse and the Director of Corporate Affairs and the new Parliamentary and Health Service Ombudsman complaints standards have been reviewed with the Trust considering being an early adopter of these
- Recognition and timely treatment of sepsis is a quality account priority and there has been reasonably good progress this year against measures in the sepsis six and this is one of the workstreams of the Care of the Acutely Ill Programme
- An interface between the Electronic Patient Record and many point of care tests should be in place later this month, this will allow for improved auditing and compliance
- Sepsis skills training is now in place and part of Essential Skills Training and the Deputy Medical Director suggested this should be pulled into the Deteriorating Patient Programme as there is scope for improvement

AN highlighted the encouraging progress in relation to pressure ulcers and falls. He queried whether the real cause of the complaints issue has been identified and stated there is more to do in terms of how well the Trust learn from complaints. The Chief Nurse responded the complaints numbers fluctuate and confirm and challenge meetings maintain focus to put remedial actions in place where necessary. The Trust are providing additional support to Divisions in getting these processes robust. One of the elements is to increase confidence that the Trust are learning from complaints and embedding learning in practice.

In response to a query from AN on the further work on medicines management, the Deputy Medical Director noted issues with medicines management remain and staffing pressures experienced over the last 12 months has not helped. In terms of journey to outstanding assessments, there is a detailed assessment around the assurance for medicines management which requires continued focus.

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

**104/22 CHFT Response to the Ockenden Review**

The Chief Nurse detailed the background to the Ockenden Review and provided an update on the final report into the independent review of Maternity services at Shrewsbury and Telford NHS Trust.

Maternity services shared an action plan at the previous Board meeting around the maternity transformation plan and the further 15 recommendations around immediate and essential actions for organisations to respond to and demonstrate compliance.

The Regional Maternity Team assurance visit took place on 28th June 2022 around the first seven essential actions and feedback from the visit was positive in terms of the Trust position and compliance. The key headlines were that staff in all areas were welcoming, it was clear there were good governance processes in place with patient safety being a priority, staff feel valued by the teams in an open and responsive culture, there are comprehensive training packages and the teams have learnt from incidents and complaints. The feedback from the regional team was that they could see the real value of the end to end maternity system with personalised care embedded, clear evidence of team commitment to addressing health inequalities and the audit was well embedded with positive multidisciplinary team working. Recommendations were around strengthening areas in relation to covid i.e. face to face meetings with the Maternity Voices Partnership.

The report highlighted the position around continuity of carer which confirmed the Trust continues to focus on antenatal and postnatal care continuity, with a focus on health inequalities. An update on the position will be presented to the private Board of Directors on 3 November 2022.

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

The Chair highlighted this report provides a good example of the value working in partnerships adds.

PW highlighted this was a well-written clear report and asked if the independent clinicians are from within the Trust or external. The Chief Nurse confirmed that one is internal and one is external. The internal clinician is an anaesthetist who has a strong safety focus and the second is an independent midwife from within the Local Maternity System.

KH, as Maternity Champion, re-assured the Board that the transformation plan is extremely detailed and very thorough, and the Trust should celebrate what they are doing well. She shared her feedback from the regional visit that staff were enthusiastic, transparent and that staff were really pleased with the positive feedback. The Chief Nurse agreed and confirmed the transformation plan combines both Ockenden and various other assurance plans within maternity services and red scores will be reviewed on an ongoing basis as an ongoing Board Assurance Framework plan moving forward.

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

**105/22 Integrated Performance Report (IPR) – May 2022**

The Chief Operating Officer presented the performance position for the month of May 2022 with an overall performance score of 63.8%, highlighting the key points which were:

- Sustained pressure in urgent care – 12% rise year to date
- Covid numbers remain stable – slight increase in covid admissions over last few weeks
- Achieved all cancer performance against the key cancer standards, with the exception of the 62 day referral from screening to treatment target missed which continues to be a challenge
- Transfer of care position remains at 80 or below, this should be lower, the Trust are building relationships with partners to improve the access to care in the community; however, there is more work to do on this

AN asked if the 12% sustained pressure in urgent care is against pre-pandemic levels and asked if the differing performance in Emergency Department (ED) teams that is being observed is a cause of some of this performance. The Chief Operating Officer acknowledged there is a difference in demand at night versus during the day and a differing structure in the teams. There are more gaps in medical staff at night and the Trust are trying to level out the staffing levels looking at a heat map of the day. The time to triage and time to referral response times are being reviewed to ensure the Trust implement the professional standards and a reset week is planned in August 2022. The Trust have been successful in recruiting consultants in the emergency teams. The Chief Operating Officer confirmed the activity is against pre-pandemic levels and more detail will be brought back to the Finance and Performance Committee on urgent care activity.

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

**106/22 Board Assurance Framework – Update 1 2022/2023**

The Company Secretary presented the first update of the Board Assurance Framework (BAF) for 2022/23 for review.

*The Director of Transformation and Partnerships left the meeting.*

Due to the sequence of meetings, the review of the Board Assurance Framework at the Audit and Risk Committee will take place on Tuesday 26 July 2022.

Since the last update, there is a new risk relating to the health and wellbeing of colleagues which is scored at 12 and is overseen by the Workforce Committee.

There are four risks with a reduced score reflecting the work implementing actions to mitigate the risks, with rationale for the movement provided in the report.

There is an increase to the commercial growth risk from 6 to a 9, in relation to Huddersfield Pharmacy Specials (HPS).

AN stated he is pleased to see the BAF continues to improve, with good quality updates showing it is an active tool. He added there is a small tidying up of actions to align with the gaps and he suggested the risk 5/20 on service capacity due to Covid-19 is rephrased to look more at recovery.

**Action: Risk 5/20 to be re-phrased to look more at recovery – Company Secretary / Chief Operating Officer**

KH stated she was surprised to see the risk on climate change reduce on the basis a plan was in place and approved. AN clarified that there is a detailed action plan which is monitored at the Green Planning Committee and Transformation Programme Board where it was made clear 60-70% of the action plan has made lots of progress.

**OUTCOME:** The Board **APPROVED** the additional risk (1/22) and the updates to the risks and **NOTED** the movements in the risk scores (4/19, 6/19, 4/20, 6/20 and 15/19) and **CONSIDERED** if there are any further risks to the achievement of strategic objectives.

**107/22 Governance Report**

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

**a) Change to the Trust Constitution**

Following recent discussion of succession plans at the Nominations and Remuneration Committees of the Board and Council of Governors, an amendment is proposed to the Trust's Constitution regarding an increase in the composition of the Board of Directors, which currently has six Executive Directors and seven Non-Executive Directors including the Trust Chair.

The proposed amendment is to increase the number of Executive Directors by one and the number of Non-Executive Directors by one. This would mean the Trust will have seven Executive Directors and eight Non-Executive Directors, including the Chair. The roles will provide capacity to support the Trust over the next five years areas across our Calderdale and Kirklees Places, provider collaboration development, the health inequalities agenda and service transformation for community services, as well as ensuring that a Deputy Chief Executive is in place.

The proposals have been considered and supported by the respective Nomination and Remuneration Committees and were supported by the Board.

The Standing Orders of the Board of Directors also detail the Board composition and the relevant section of these will also be amended to reflect the change.

**b) Appointment of Deputy Chair and Senior Independent Non-Executive Director**

The Company Secretary explained this appointment is a Board of Directors decision that is subsequently asked to be ratified by the Council of Governors.

Following review and discussion with the Chair and Non-Executive Directors, it was proposed that Karen Heaton be appointed to the SINED and Deputy Chair role from 1 September 2022.

The Trust wishes to formally thank Richard Hopkin, who will stand down as Non-Executive Director, Deputy Chair and SINED for his contribution since he joined the Trust as a Non-Executive Director on 1 March 2016.

**c) Use of Trust Seal**

The Trust Seal has been used twice since January 2022, in relation to the Lease, Lease Plan and License for Alterations for the Clock House, Elland and the License to Alter at Broad Street Plaza, Halifax.

**d) Board of Directors Meeting Dates 2023**
The proposed schedule of meeting dates for 2023/24 was presented for approval.

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

The workplan will be undergoing a review and development with the new Chair and the Director of Corporate Affairs which may change moving forward.

**OUTCOME:** The Board **APPROVED** the change to the Trust Constitution, the appointment of the Deputy Chair and Senior Independent Non-Executive Director from 1 September 2022, the Board of Directors future meeting dates for 2023/24, the Board of Directors Workplan for 2022/23 and **NOTED** the use of the Trust seal during the last quarter.

**108/22 Review of Board Sub-Committee Terms of Reference**

**a) Workforce Committee**
KH highlighted the only change to the terms of reference was to include the Director of Corporate Affairs in the membership.

**OUTCOME**: The Board **APPROVED** the updated terms of reference for the Workforce Committee.

**109/22 Board Sub-Committee Chair Highlight Reports**
The Chair highlight reports were received for the following sub-committees:

- Finance and Performance Committee – IPR performance reduced slightly, specific reference in report to ongoing deep dives on areas such as stroke, fractured neck of femur and workforce and a deep dive into A&E performance to address some of these concerns.
- Quality Committee – received an update report regarding split paediatric service on HRI and CRH sites, felt there was more work was to be done to review the escalation process for paediatric oversight, requested this work is reviewed and comes back to Quality Committee, maternity services and Ockenden report received at every monthly meeting with continued oversight via regular progress reports, reviewed the quality accounts for 2021/22 that were approved, area of concern relating to learning disabilities mortality report which showed a decline overall, requested this plan comes back to the Committee.
- Workforce Committee – Focus on the refreshed People Strategy and the recruitment strategy is on its way to being finalised. A number of deep dives have taken place focused on vacancies, turnover and age profile of the workforce, freedom to speak up, leadership development progress, wellbeing and equality, diversity and inclusion activity.

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

**110/22 Board Sub-Committee Annual Reports 2021/22**
The Annual Reports for 2021/22 were received in the Review Room for the following sub-committees:

- Workforce Committee
- Finance and Performance Committee
- Quality Committee

**OUTCOME**: The Board **RECEIVED** the 2021/22 Annual Reports of the above sub-committees.

**111/22 Items for Review Room**

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

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

- Audit and Risk Committee minutes of the meeting held on 26 April 2022
- Charitable Funds Committee minutes of the meeting held on 11 May 2022
- Finance and Performance Committee minutes of the meetings held 3 May 2022 and 7 June 2022
- Quality Committee minutes of the meeting held on 20 April 2022 and 16 May 2022
- Workforce Committee minutes of the meeting held on 12 April 2022

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

**112/22 Any Other Business**

The Chair invited the governors in attendance to comment on the Board meeting. Gina Choy provided feedback that much of the discussion takes place at the Quality Committee where she attends as an observer. Peter Bamber stated he remains re-assured the hospital is looked after well. Christine Mills added it is interesting to hear everything that happens and how it all comes together in one meeting.

The Chair formally thanked Richard Hopkin on behalf of the Board for his contribution over the six years whose tenure comes to an end at the end of August 2022.

The Chair formally thanked the Board of Directors, colleagues and governors for their attendance and closed the meeting at approximately 12:11 pm.

**113/22 Date and time of next meeting**

**Date:** Thursday 1 September 2022
**Time:** 9:00 – 12:00 pm
**Venue:** Microsoft Teams

# 5. Matters Arising and Action Log

To Note

Presented by Helen Hirst

# ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC) 2022

Position as at: 25.08.22

| Red | Amber | Green | Blue |
|---|---|---|---|
| Overdue | Due this month | Closed | Going Forward |

| DATE DISCUSSED | AGENDA ITEM | LEAD | CURRENT STATUS / ACTION | DUE DATE | RAG RATING | DATE ACTIONED & CLOSED |
|---|---|---|---|---|---|---|
| 07.07.22 106/22 | **Board Assurance Framework – Update 1** Risk 5/20 - service capacity due to Covid-19 to be re-phrased to look more at recovery | Company Secretary / Chief Operating Officer | Next BAF update due 10 November 2022. | 10.11.22 | | |
| 07.07.22 96/22 | **Health Inequalities Progress Report** To include updates regarding mental health in future health inequalities progress reports | Director of Transformation and Partnerships | Included in the Health Inequalities paper on 1 September 2022 and will be included in future reports. Action closed. | 01.09.22 | | 25.08.22 |

# 6. Chair’s Report

To Note

Presented by Helen Hirst

# 7. Chief Executive’s Report

To Note

Presented by Brendan Brown

# Transforming and Improving Patient Care

# 8. Maternity Patient Story and CHFT Response to the Ockenden Review

Presented by the Chief Nurse and Diane Tinker, Head of Midwifery

Patient Story presented by Jo Ambler and Val Lunn, Community Midwives

To Note

Presented by Lindsay Rudge

| | |
|---|---|
| **Date of Meeting:** | Thursday 1 September 2022 |
| **Meeting:** | Public Board of Directors |
| **Title of report:** | Maternity Patient Story and CHFT Response to the Ockenden Review |
| **Author:** | Diane Tinker, Director of Midwifery and Women's Services |
| **Sponsor:** | Lindsay Rudge, Chief Nurse, Board Maternity Safety Champion |
| **Previous Forums:** | Quality Committee - 17 August 2022 |

**Purpose of the Report**

The purpose of the report is to provide a progress report across maternity services including the Maternity Transformation Plan, incorporating the Ockenden Immediate Essential Actions (IEAs), Midwifery Staffing and the Perinatal Mortality Review Tool (PMRT). The report provides assurance to the Board that the service has oversight of its position against key recommendations within the plan, safe staffing and national reporting.

**Key Points to Note**

- Midwives Valarie Lunn and Joanna Ambler will present a patient story with an emphasis on the professional and the family working together, multi-agency working and family centred care. The story relates to Ockenden because it illustrates listening to women and families whilst involving women in decision making.

- The maternity service had a Regional Maternity Team Assurance Visit on 28 June 2022 where compliance with the first 7 Immediate Essential Actions (IEAs) was assessed. The initial feedback on the day was extremely positive and a full report is expected by the end of August 2022.

- A RAG rating review of the initial 7 IEAs and the new 15 IEAs has been undertaken, with these included in an overarching Maternity Transformation Plan, this also includes the Maternity Incentive Scheme (MIS), the staff survey action plan and the self-assessment tool (recommendation from Ockenden). Regular progress updates are provided to Divisional Board, Quality Committee and the Trust Board.

- Actions are in place to respond to any Freedom to Speak up concerns.

- A new monthly Confirm and Challenge process to review of the Transformation Plan will be undertaken with the Director of Midwifery, Clinical Director, General Manager, Quality Governance lead with critical oversight and scrutiny from a corporate patient safety perspective by the Assistant Director of Quality and Safety, this will then be reviewed by the Chief Nurse.

- Maternity services submit workforce data to NHSEI each month and as of the 8 July 2022 recorded 157.98 whole time equivalent (WTE) midwives against an establishment of 186 WTE midwives. This was a reduction of 4.57 WTE from the 25 April 2022.

- Two of the most important safe staffing indicators relate to the provision of 1:1 care in labour and the supernumerary status of the labour ward (LDRP) coordinator. In June 2022 the LDRP co-ordinator was supernumerary on 100% of the shifts and 1:1 care in labour was 97.4%.

- The Chief Nurse and the Associate Nurse Director for FSS will be attending the Kirklees Adults Health and Social Care Scrutiny Board on the 6 September 2022 to provide an update on Maternity services and the response and actions being undertaken within CHFT following the publication of the final Ockenden report. This will be a joint meeting with the Mid Yorkshire Hospital Trust.

- All cases that were within the criteria for reporting were notified to Perinatal Mortality Review Tool (PMRT) within 7 working days.

- 100% of all deaths of babies eligible for review using the Perinatal Mortality Review Tool (PMRT) occurring from 6 May 2022 have been started within two months of each death.

**EQIA – Equality Impact Assessment**

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

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

**Recommendation**

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

**MATERNITY SERVICES BOARD REPORT SEPTEMBER 2022**

## 1.0 OCKENDEN UPDATE

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

The first report made explicit recommendations around 7 Immediate Essential Actions (IEAs) with an expectation that all providers provide assurance against, and the final report includes a further 15 IEA recommendations, again with an expectation that all Trusts will ensure compliance.

A RAG rating review of the initial 7 IEAs and the new 15 IEAs has been undertaken, with these included in an overarching Maternity Transformational Plan which also includes the Maternity Incentive Scheme (MIS), the staff survey action plan and the self-assessment tool (recommendation from Ockenden). Regular progress updates are provided to both Divisional and Trust Boards.

The maternity service had a Regional Maternity Team Assurance Visit on 28 June 2022 where compliance with the first 7 IEAs was assessed. The initial feedback on the day was extremely positive and a full report is expected by the end of August 2022.

On the day feedback from the visit:

- Staff in all areas are really welcoming and willing to speak to the visiting team
- Clear governance processes, with patient safety a priority and is valued
- Open and responsive culture
- The 'weekly view newsletter' is received by all and provides feedback and learning to all staff. Staff value this.
- Evidence of staff involvement of developing new processes and risk assessments (ATAIN risk assessment)
- The MVP chair feels very valued and listened to. The MVP is well funded
- Comprehensive training packages with good compliance and trajectories, which is responsive to learning from incidents, complaints & relevant national policy
- The value of an end-to-end maternity system is threaded throughout, ensuring personalisation of care and ability to audit quickly and accurately
- Clear evidence of commitment to addressing inequality
- Audit is being embedded as an everyday occurrence with everyone responsible for it
- Good Multi-Disciplinary Team (MDT) working

A new monthly Confirm and Challenge process to review the Transformation Plan will be undertaken with the Director of Midwifery, Clinical Director, General Manager, Quality Governance lead with critical oversight and scrutiny from a corporate patient safety perspective by the Assistant Director of Quality and Safety. The Chief Nurse will review overall progress each month, including reporting areas for escalation in the monthly reporting cycle.

In addition to the information detailed on the table below, a tracking system will be utilised to enable monitor progress for each element within the transformation plan to support assurance and identifying any reduction in compliance or assurance, and any support required to progress actions.

Areas for concerns will be identified which may not be achieving or achievable within the timeframe or that impact on direct patient safety and quality. For any area of concern identified

a rationale and narrative including clear description of actions to mitigate any impact will be included and escalated to the Quality Committee for review.

The board safety champions have scheduled visits planned and completed in line with the requirements of the roles.

A weekly meeting is in place which is chaired by the Chief Nurse with the Maternity Leadership team, Matrons and Lead midwives to review progress of the plan and to focus on areas where actions have not been commenced.

The table below provides high level oversight of the actions against each aspect of the plan and the current position.

| Maternity Transformational Plan | | |
|---|---|---|
| **Action Plan** | **Focus Area** | **Current Position – July 22** |
| **Safe Care & Trained Workforce** | ***Well Led / One Culture of Care*** | **15 Actions in Total**<br>**9 Completed**<br>**6 In Progress** |
| | ***Seek to Understand*** | **3 Actions in Total**<br>**3 Completed** |
| | ***Well Trained Workforce*** | **6 Actions in Total**<br>**4 Completed**<br>**2 In Progress** |
| **Governance** | ***We Keep the Base Safe*** | **6 Actions in Total**<br>**5 Completed**<br>**1 In Progress** |
| | ***We Work Together to Get Results*** | **9 Actions in Total**<br>**5 Completed**<br>**4 In Progress** |
| | ***Finance*** | **2 Actions in Total**<br>**2 In Progress** |
| **Ockenden 1** | ***Well Led / One Culture of Care*** | **35 Actions in Total**<br>**29 Completed**<br>**4 In Progress**<br>**2 Not Commenced** |
| **Ockenden 2** | ***Essential Actions*** | **90 Actions in Total**<br>**27 Completed**<br>**44 In Progress**<br>**12 Not Commenced**<br>**7 Awaiting Nation Update** |
| **NHS Resolution** | ***Safety Actions 1 - 8*** | **55 Actions in Total**<br>**24 Completed**<br>**15 In Progress**<br>**16 Not Commenced** |
| **Maternity Self-Assessment** | ***Directorate Care Group Infrastructure and Leadership*** | **177 Actions in Total**<br>**44 Completed**<br>**70 In Progress**<br>**63 Not Commenced** |

### 1.2 Freedom to Speak Up (FTSU)

The Ockenden report describes staff within the services reviewed felt unable to speak up and have their concerns heard or acted upon. The Maternity Improvement plan brings together the themes of the FTSU concerns with the findings and recommendations of the Ockenden Final report from the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust. Freedom to Speak Up concerns raised within maternity services are being addressed as part of the Maternity Improvement plan.

In response to concerns raised the following actions are being undertaken:

- A face to face one culture of care session with the community midwives with the Chief Nurse
- The Executive Director of WOD supporting the FSS leadership team with a range of leadership programmes
- The Assistant Director, Engagement/Wellbeing portfolio hosting a range of listening events with midwives
- Matrons within Maternity services are hosting a range of engagement sessions with the community midwives
- Anaesthetic Consultant with specialist skills in patient safety and human factors is providing an external review

### 2.0 MIDWIFERY STAFFING

Maternity services submit workforce data to NHSEI each month and as of the 8 July 2022 recorded 157.98 whole time equivalent (WTE) midwives against an establishment of 186 .0 WTE midwives. This was a reduction of 4.57 WTE from the 25 April 2022.

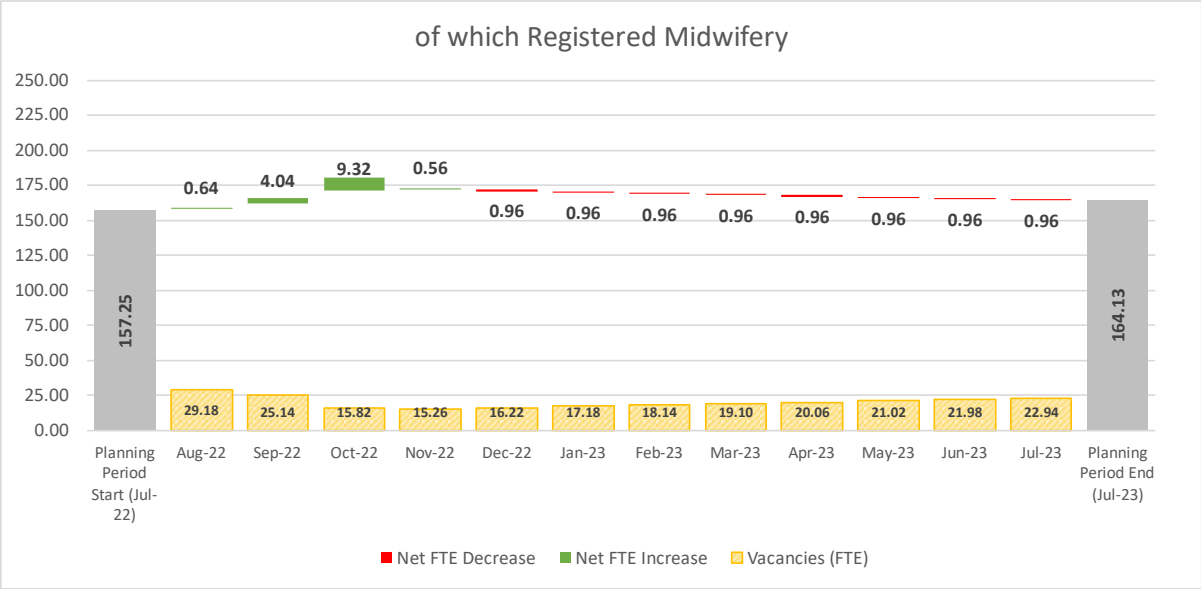
In March 2022 the service was allocated recurrent funding to support the requirements of the first Ockenden report. This funding supports the recruitment of an additional 12.0 WTE midwives increasing the funded establishment to 198.0 WTE midwives.

Following the regional recruitment programme for newly qualified midwives CHFT have successfully recruited 10.44 WTE who will be joining our team in October 2022, and we have also recruited 3.12 WTE Band 6 midwives who will be joining our team within the next few months. As part of our ongoing rolling recruitment programme further Band 5 and Band 6 posts will be advertised.

With the continued staffing challenges through the maternity service a review of acuity and staff availability occurs each shift, with LDRP completing the Birth Rate Plus acuity tool 4 hourly and staff redeployed within the hospital setting to appropriate areas to maintain safer staffing levels.

Options when in escalation also include the utilising of the on-call community midwives and non-clinical midwives, and temporary relocation of Calderdale Birth Centre to LDRP. This escalation is in addition to the current suspension of the labour part of the Maternity Continuity of Carer pathway in line with national guidance and the ongoing suspension of services at Huddersfield Birth Centre.

The table below demonstrates recruitment trajectory within the service as of the 17 August 2022.




## 2.1 Maternity Safe Staffing Indicators

Two of the most important safe staffing indicators relate to the provision of 1:1 care in labour and the supernumerary status of the labour ward (LDRP) coordinator.

In June 2022 the LDRP co-ordinator was supernumerary on 100% of the shifts.

The table below describes the 1:1 care in labour position over the previous 6 months.

| Month | Jan 22 | Feb 22 | Mar 22 | Apr 22 | May 22 | June 22 |
|---|---|---|---|---|---|---|
| 1:1 care in labour | 99.7% | 98.8% | 98.7% | 97.5% | 97.9% | 97.4% |

## 2.2 Better Births – Maternity Continuity of Carer (MCoC)

A proposed plan to recommence the roll out of MCoC from January 2023 has been shared with the Local Maternity System (LMS), this would commence with focusing on teams within the areas of highest deprivation.

## 3.0 NHS RESOLUTION MATERNITY INCENTIVE SCHEME

Following the decision by NHS Resolutions to relaunch the Maternity Incentive Scheme (MIS) on 6 May 2022, the maternity service is working towards compliance against all ten safety actions, in preparation for submission on the 5 January 2023.

## 3.1 Perinatal Mortality Review Tool (PMRT)

The PMRT programme was introduced to support standardised perinatal mortality reviews across NHS maternity and neonatal units in England, Scotland, and Wales. There should be comprehensive and robust review of all perinatal deaths from 22+0 days gestation until 28 days after birth.

Completion of the PMRT to the required standards is Safety Action 1 within the Maternity Incentive Scheme Year 4 (MIS). The standards are:

- All perinatal deaths eligible to be notified to MBRRACE-UK from 6 May 2022 onwards must be notified to MBRRACE-UK within seven working days and the surveillance information where required must be completed within one month of the death.

- A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 6 May 2022 will have been started within two months of each death.

- At least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, from 6 May 2022 will have been reviewed using the PMRT, by a multidisciplinary review team. Each review will have been completed to the point that at least a PMRT draft report has been generated by the tool within four months of each death and the report published within six months of each death.

- For at least 95% of all deaths of babies who died in your Trust from 6 May 2022, the parents will have been told that a review of their baby's death will take place, and that the parents' perspectives and any questions and/or concerns they have about their care and that of their baby have been sought.

- Quarterly reports will have been submitted to the Trust Board from 6 May 2022 onwards that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety and Board level safety champions.

## 4.0 INCIDENTS AND COMPLAINTS

### 4.1 Healthcare Safety Investigation Branch (HSIB)

As of the 27 July 2022 the maternity services position is:

| **Cases to date** | |
|---|---|
| Total referrals | 39 |
| Referrals / cases rejected | 11 |
| Total investigations to date | 28 |
| Total investigations completed | 24 |
| Current active cases | 4 |
| Exception reporting | 1 |

### 4.2 Maternity Incidents

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

| | **June 22** | **July 22** |
|---|---|---|
| PPH- no adverse outcome | **10** | **12** |
| Shoulder Dystocia | **4** | **5** |
| Term admission to the Neonatal Unit | **13** | **14** |
| 2nd Theatre opened | **3** | **8** |

| | | |
|---|---|---|
| 3rd or 4th Degree perineal tear | **1** | **3** |
| Delay in Emergency Caesarean Section | **4** | **7** |

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

| Month | Maternity SI's | Maternity Never Events | Open HSIB cases | Total Stillbirth (SB) / Neonatal Death (NND) | Stillbirths Antenatal | Stillbirths Intra-partum | HIE Grade 2/3 | Early NND | Late NND | Notification to ENS | Maternal Mortality |
|---|---|---|---|---|---|---|---|---|---|---|---|
| July 22 | 0 | 0 | 4 | 0 | 2* | 0 | 0 | 0 | 1 | 0 | 0 |

### 4.3 Maternity Complaints

Maternity services currently have 9 open complaints as of 2 August 2022, 1 complaint overdue, which has now been approved in division awaiting Trust approval. The division are continuing to work with the Trust complaint's team to improve compliance with timely complaint responses.

## 5.0 KIRKLEES ADULTS' HEALTH AND SOCIAL CARE SCRUTINY BOARD

The Chief Nurse and the Associate Nurse Director will be attending the Kirklees Adults Health and Social Care Scrutiny Board on the 6 September 2022 to provide an update on Maternity Services and the response and actions being undertaken within CHFT following the publication of the final Ockenden report. This will be a joint meeting with Mid Yorkshire Hospital Trust.

## 6.0 CONCLUSION

This report has provided oversight of the current position against the number of recommendations across the key assurance reports/ schemes across Maternity Services which have been consolidated into one Transformation Plan. The report has provided the trusts current staffing position including the incoming recruitment into the service and the daily monitoring and escalation processes in place to provide assurance to the Board that safe staffing is in place across the service. The report has demonstrated that the service promotes open and transparent reporting of incidents including those reported to the Healthcare Safety Investigation Branch. The NHSI/E Assurance visit to the Trust provided external assurance that the service has progressed the 7 IEAs within the first publication of the Ockenden Report and that progression is now being undertaken against the further recommendations contained within the final publication.

## 7.0 RECOMMENDATIONS

The Board of Directors is asked to note the report.

**Diane Tinker**
**Director of Midwifery and Women's Services**

# 9. Health Inequalities Update

To Note

Presented by Anna Basford

| | |
|---|---|
| **Date of Meeting:** | Thursday 1 September 2022 |
| **Meeting:** | Public Board of Directors |
| **Title:** | Health Inequalities Progress Report |
| **Authors:** | Anna Basford, Director of Transformation and Partnerships<br>Lindsay Rudge, Chief Nurse |
| **Sponsoring Directors:** | Anna Basford, Director of Transformation and Partnerships<br>Lindsay Rudge, Chief Nurse |
| **Previous Forum:** | 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 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: Chief Nurse (Urgent Actions: 1,2,5,6,8)

Health Inequalities Working Group commissioned the Public Health Registrar to work on a strategy and update the plan on a page. The first draft of the Strategy will be presented to the Group as its meeting in September 2022.

1. **External environment: how we connect with our communities**
   Work has continued with partner organisations on a range of projects to support addressing health inequalities. Examples of this work includes:

- Work with Asylum seekers and refugees
- Work with primary care and local GP practice populations
- Delivering social value

**2. The lived experience, initial focus on maternity services**

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

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

**3. Using our data to inform stabilisation and reset**

In relation to ensuring waiting times across the wider Health Inequality agenda significant progress has been made in the management of patients. For patients that have the same clinical priority (P2), BAME patient waits have reduced over time and now wait the same time (4 weeks) as white patients compared to an extra 7.8 weeks in May 2021. For P2, IMD 1&2 patients now wait just 0.3 weeks longer than IMD 9&10 compared to 8.5 weeks in May 2021.

**4. Diverse and Inclusive Workforce**

A number of initiatives are ongoing to support colleagues, these include:

- Developing a suite of financial wellbeing support for colleagues
- Challenging inappropriate behaviour from patients/service users' guidance developed
- Inclusion Group developed
- Cultural Awareness digital education booklet developed
- International nurses support event held.

Further details on the work undertaken are detailed in the body of the report.

**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

**1 September 2022**

## 1. INTRODUCTION

Health Inequalities are defined as:

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

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

## 2. BACKGROUND AND CONTEXT

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

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

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

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

- External environment: how we connect with our communities. Lead: Anna Basford, Director of Transformation & Partnerships. (Urgent Actions: 1,3,4,6,8)
- The lived experience, initial focus on maternity services. Lead: Interim Chief Nurse (Urgent Actions: 1,2,5,6,8)

- Using our data to inform stabilisation and reset. Lead: Jo Fawcus, Chief Operating Officer. (Urgent Actions: 1,2,5,6,7,8)
- Diverse and Inclusive Workforce. Lead: Suzanne Dunkley, Director of workforce and OD. (Urgent Actions: 1,5,6,7,8)

## 3. WORKSTREAM UPDATES

The Health Inequalities Working Group commissioned the Public Health Registrar to work on a strategy and update the plan on a page. The first draft of the Strategy will be presented to the Group as its meeting in September 2022.

### 3.1 External environment: how we connect with our communities.

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

#### 3.1.1 Work with Asylum seekers and refugees

Listening and discovery meetings have been held with asylum seekers and refugees - to understand and inform improved support needed for people that access A&E services that have experienced trauma. Trauma Adversity Coordinators have been appointed and are working in A&E to provide support for people to access support and services in community settings.

#### 3.1.2 Work with primary care and local GP practice populations

The Trust has worked with GP practices to analyse data and inequalities in access to A&E services for people with asthma and respiratory conditions. In some GP practices people from BAME communities and IMD 1&2 had higher emergency attendances. We are working with families, schools, GP practices, Housing & Council partners to develop improved support in the community to reduce the need for urgent and emergency attendances. The Public Health Registrar that is working in the Trust is supporting the coordination of this work and progression of the agreed action plan. The actions include engagement and education sessions in local community settings (e.g. Mosques).

#### 3.1.3 Delivering Social Value

The Trust is undertaking work to ensure our procurement, workforce and estate investments maximise the impact of public expenditure to get the best possible outcomes for the local area and target reduction in health inequalities. Collaborating with health and social care partners we have developed investment plans that will support delivery of social value and economic benefits across Calderdale and Kirklees.

In July the Trust's construction partner (IHP) who are building the new accident and emergency department at HRI (due to open Autumn 2023) confirmed their plans that will embed social value within their processes, procedures and ways of working. The plan focuses on: job creation, employing apprentices, and supporting people to develop employability skills by engaging with local schools and colleges, delivering training and providing work placement opportunities; encouraging employment of local people and inviting local businesses to supply products and services; supporting local community groups and charities focused on building

healthier, safer more resilient communities, and; implementing waste reduction and carbon reduction measures through the project and use of sustainable materials and products. Going forward the Trust will work with all selected construction partners to similarly develop Social Value delivery plans across all aspects of the Trust's planned Reconfiguration programme of estate investments.

The Trust has continued to work with the Purpose Coalition in relation to the national Levelling Up programme. A wide range of examples and evidence of the work the Trust is implementing with partners in relation to the 14 Levelling Up Goals has been submitted for review. This will generate an impact assessment report (that is expected in September). From this report the Trust will work with the Purpose Coalition to generate a future action plan.

At the July meeting of the Calderdale Cares Partnership Board approval was given to establish a Calderdale provider collaborative. The Trust is closely supporting this development and one of the key priorities is for health and social care providers to collaborate and share learning and best practice to demonstrate how provider procurement and investment decisions can maximise the beneficial impact of public expenditure to generate additional social value for the local area that will support reduction in health inequalities.

In Kirklees the Trust has had very positive meetings and dialogue with colleagues at Kirklees Council and is taking forward discussion regarding joint working and partnerships to progress and optimise delivery of social value.

### 3.2 The lived experience, initial focus on maternity services

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

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

#### 3.2.1 Organisation of care

Continuity of care teams:
In line with recommendations from the recent Ockenden Report the care delivered through continuity of care midwifery teams has been reviewed. Midwifery teams will focus on antenatal and postnatal continuity of care, whilst intrapartum continuity models are suspended temporarily to maintain safe staffing, with plans to review again in January 2023.

Kirklees Stillbirth Rates: A Task & Finish group was set up to conduct a deep dive into why rates of stillbirth in areas of Kirklees are higher than Calderdale and whether there are modifiable risk factors linked to Health Inequalities that could be addressed. A report with a list of recommendations was presented to Maternity

Forum in July and escalated to PSQB.

### 3.2.2 Communication / health literacy

Discovery Interviews: Collated feedback from discovery interviews to date has highlighted that women make comparisons with the maternity care in their country of origin, no issues of concern have been identified relating to care at CHFT. Plans are in place to increase engagement for discovery interviews through the Maternity Voices Partnership, multi-agencies and social media.

### 3.2.3 English to Speakers of Other Languages (ESOL) for pregnancy antenatal classes

Working in partnership with Calderdale College, a 4-week pilot ESOL for pregnancy course was successfully delivered at Jubilee Children's Centre in HX1. Seven pregnant women and 2 partners enrolled, and 6 participants completed the course. The aim was to improve patient awareness and experience of maternity services, to reduce health inequalities and improve pregnancy outcomes for women who do not speak English. A full report will be available in September 2022 and plans are being made to offer another course in Autumn 2022.

### 3.2.4 Staff Training and Cultural Awareness

Training package:
Maternity colleagues have been invited to undertake the online Cultural Competency training package through ESR.

Staff Survey:
Plan for repeat of the staff survey during September/October 2022 following the launch of the Cultural Competency training package.

### 3.2.5 Smoking in pregnancy

NHS Long Term Plan:
Two maternity support workers (health advisers) have been appointed to deliver the NHS Long Term plan under the supervision of the Public Health Midwife. A new Smoke-free Pregnancy Pathway will include an in-house stop smoking service for pregnant women at their booking appointment with 10 weeks follow up support. The service is planned to launch during October and will initially target women living in areas of high deprivation and high smoking prevalence.

An Action Plan is in place to improve essential data collection to meet the target of 95% for CO testing at booking and 36 weeks for all women, including changes to the maternity EPR smoking assessment.

### 3.2.6 Obesity and diabetes

A recent audit showed that 56% of pregnant women were overweight or obese at booking in 2021. A further audit of women who attended the BMI antenatal clinic in a previous pregnancy shows that approx. 95% had gained weight between pregnancies and therefore booked with a higher BMI than previously. To improve healthy lifestyles, discourage weight gain in pregnancy and reduce the risk of gestational diabetes, all pregnant women and their partners would benefit from healthy nutrition and lifestyle information in early pregnancy.

A Three R's (Reality, Response, Result) proposal has been put forward to suggest how the service could reach more families in early pregnancy through antenatal education, including use of videos, to support the advice and information given by Midwives. Targeted courses will be offered close to home for families living in areas of high deprivation to educate and support families with healthy nutrition and lifestyle in pregnancy.

### 3.3 Using our data to inform stabilisation and reset (waiting times)

#### 3.3.1 Elective Waiting Lists

In relation to ensuring equitable waiting times across the wider Health Inequality agenda significant progress has been made in the management of patients. For patients that have the same clinical priority (P2), BAME patient waits have reduced over time and now wait the same time (4 weeks) as white patients compared to an extra 7.8 weeks in May 2021. For P2, IMD 1&2 patients now wait just 0.3 weeks longer than IMD 9&10 compared to 8.5 weeks in May 2021.

#### 3.3.2 Learning Disabilities

Waiting lists continue to be monitored on a monthly basis to ensure that people with a Learning Disability do not experience inequality in access to services. There are currently 18 children and adults waiting. One child is currently awaiting an outpatient appointment prior to listing and is outside of the agreed reset and recovery timeframe. However all other patients have an agreed date for treatment within the standard of 18 weeks. The Trust is also progressing work to develop a routine 'flag' on referrals for people that have a learning disability so that we can proactively prioritise and make any adaptations to improve their access and experience.

The Essential Safety Training (EST) learning disability awareness training compliance is at 67.4% which has been achieved within 3 months of it going live. The Matron lead for Learning Disabilities has received positive feedback and staff have really reflected on their services and how they could make improvements.

The learning disability care plan compliance is monitored monthly and currently compliance is below target. There was improvement in June likely due to learning disability week, especially recognising the hospital passport. Awareness campaigns are planned more frequently throughout the year.

A DNA/was not brought audit has taken place and shared with divisional colleagues and this will enable review to inform development of an action plan. Plans are also in place to audit re-admission data with the Medical Division due to a significant decrease in length of stay during quarter three and four during 2021/22 for people with a learning disability compared to previous two quarters and compared to the general population.

The Think Learning Disability Champion campaign has successfully recruited double the number of Learning Disability champions across the Trust compared to last year's campaign. There has been a planned campaign to ensure posters are displayed in wards and departments and a communication strategy for patients and carers.

The progress the Trust has made to reduce inequalities in waiting times and to improve access and support for people with a Learning Disability is nationally

recognised as good practice. Two case studies of this work are included in the report of the NHS England Director for Healthcare Inequalities. The Trust is participating in learning events with other NHS Trusts to share experience and also to learn of other approaches being taken to reducing inequalities in elective waiting times experienced by patients.

### 3.4 Diverse and Inclusive Workforce

A number of initiatives are ongoing throughout CHFT to support colleagues, these include:

- Developing a suite of financial wellbeing support for colleagues.
- Challenging inappropriate behaviour from patients/service users' guidance developed.
- Inclusion Group developed.
- Cultural Awareness digital education booklet developed.
- International nurses support event held.

### 3.5 Mental Health

People with severe and enduring mental illness are at greater risk of poor physical health and reduced life expectancy compared to the general population.

Mental illness is closely associated with many forms of inequalities.

People living with serious mental illness experience some of the worst inequalities, with a life expectancy of up to 20 years less than the general population.

The Trust has appointed a Nurse Consultant for Mental Health to support the Trust to improve care provision for people who access services across CHFT and work in partnership across our local places to address the inequalities experienced by people.

## 4. SUMMARY

The Trust continues to demonstrate significant progress to reduce health inequalities and is a recognised national leader in this arena. Whilst the Trust has made good progress there remains much to do and we are at the start of the journey to outstanding in tackling health inequalities.

**Anna Basford, Director of Transformation and Partnerships**
**September 2022**

# Sustainability

# 10. Recovery Update

Presented by Gemma Berriman, Director of Operations

To Note

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# Board of Directors

## 1st September 2022

## Recovery Trajectory

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# Areas Covered

- Activity (including delivery against the 104% trajectory)
- Activity – risk areas & mitigations
- Standards – update against 104/78/52 weeks, ASIs, Follow-up backlog
- Diagnostics

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# Activity against the 104% Plan

| | | Performance Against Plan to July 2022 | | | | | | | | | Performance Against 2019/20 Baseline to July 2022 | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | Activity Variance against plan | | | | | | | % of 2019/20 (target of 104%) | | % Variance against baseline | | | |
| | | 2022/23 Plan | 2022/23 Actual | Variance | Meeting Plan | Medical | Surgical | FSS | Community | Comments | 2019/20 Baseline | 2022/23 Actual | | Meeting 104% | Medical | Surgical | FSS | Community |
| Daycase | Sub-total | 16,693 | 15,882 | - 811 | No | 820 | - 1,484 | - 149 | - | - Year to date phasing of plan indicates circa 586 day case and elective spells and 436 endoscopy spells too high which will smooth out in coming few months<br><br>'- Further coding of activity will cause activity to shift between 'daycase' and 'endoscopy' lines<br><br>'- Endoscopy below YTD plan at Trust level | 15,398 | 15,882 | 103% | No | 116% | 94% | 93% | - |
| Elective | Sub-total | 1,879 | 1,467 | - 412 | No | 13 | - 422 | - 3 | - | | 1,695 | 1,467 | 87% | No | 119% | 87% | 35% | - |
| Day case and Elective | | 18,572 | 17,350 | - 1,223 | No | 833 | - 1,906 | - 152 | - | | 17,093 | 17,350 | 102% | No | 116% | 93% | 88% | - |
| Outpatient First | Sub-total | 50,527 | 48,225 | - 2,302 | No | - 81 | - 2,804 | 603 | - 20 | - Main specialties below plan = ENT, Neurology, Clinical Haematology, Ophthalmology & Vascular Surgery | 46,802 | 48,225 | 103% | No | 105% | 90% | 134% | 122% |
| Total Elective Recovery | | 69,099 | 65,574 | - 3,525 | No | 752 | - 4,710 | 451 | - 20 | | 63,895 | 65,574 | 103% | No | 108% | 84% | 128% | 122% |
| Outpatient Follow-up | Sub-total | 94,223 | 93,796 | - 427 | No | - 832 | 572 | - 873 | 706 | - Main specialties below plan = General Surgery, Orthoptics, ENT, Cardiology, Diabetic Medicine, Gynaecology | 84,442 | 93,796 | 111% | Yes | 105% | 120% | 88% | 105% |
| | | | | | | | | | | Outpatient Follow-up - target reduction of 25% v 2019/20 | 84,442 | 93,796 | 111% | Yes | 105% | 120% | 88% | 105% |

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# RTT Progress

| | | As of 08/08/2022 | Current Trajectory as | Variance to trajectory | Meeting Trajectory | Variance against trajectory | | | | Main areas above Trajectory |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | Medical | Surgical | FSS | Community | |
| Elective Backlogs | 104 Weeks RTT | 0 | 0 | 0 | Yes | 0 | 0 | 0 | - | |
| | 78 Weeks RTT | 218 | 282 | -64 | Yes | 19 | -87 | 3 | - | Max Fax & Neurology |
| | 52 Weeks RTT (External plan) | 2003 | 2375 | -372 | Yes | 34 | -439 | 32 | - | Max Fax & Gynaecology & Neurology |
| | 52 Weeks RTT (To get to 0 by March 23) | 2003 | 1604 | 399 | No | 144 | 171 | 84 | - | |
| | Total ASI's | 12838 | 9840 | 2998 | No | 2009 | 49 | 846 | 121 | Neurology, Max Fax & Colorectal Surgery, Gynae & Cardiology |
| | ASIs over 22 weeks | 1147 | 790 | 357 | No | 631 | -311 | 101 | -72 | Neurology & Colorectal Surgery & Gynaecology |
| | Holding List overdue | 23535 | 16736 | 6799 | No | 4430 | 1609 | 524 | - | Max Fax, Urology, Cardiology, Dermatology, Gastro, Neurology & Respiratory Med |

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# RTT Progress

## Current 104 Weeks RTT

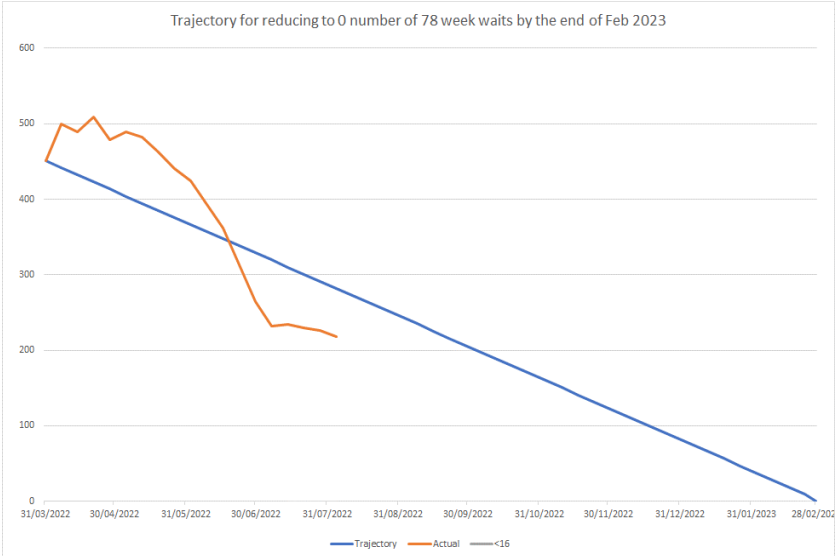
Our end of July 2022 position for 104 Weeks RTT was 0.
This is a reduction compared to the 1 at the end of June 2022.

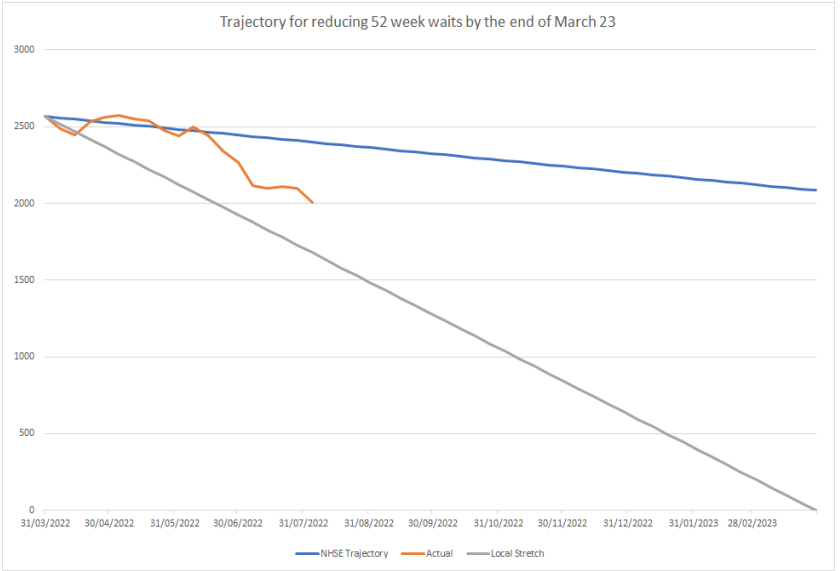
## Current 78 Weeks RTT

Our end of July 2022 position for 78 Weeks RTT - 218 (Trajectory 367)
This is a small reduction compared to the 234 at the end of June 2022 and we are on trajectory to have no 78 week waits by the end of Feb 2023.
The Majority of our remaining 78 week waits are in ENT, Max Fax Surgery & Colorectal Surgery.

## Current 52 Weeks RTT

Our end of July 2022 position for 52 Weeks RTT was 2,003 (NSHE Trajectory 2,375, Internal stretch Trajectory 1,604)
This is a reduction compared to the 2,052 at the end of June 2022.
The Majority of our remaining 52 week waits are in ENT, Max Fax Surgery, Colorectal Surgery, Neurology, Gynaecology, Trauma & Orthopaedics and General Surgery.



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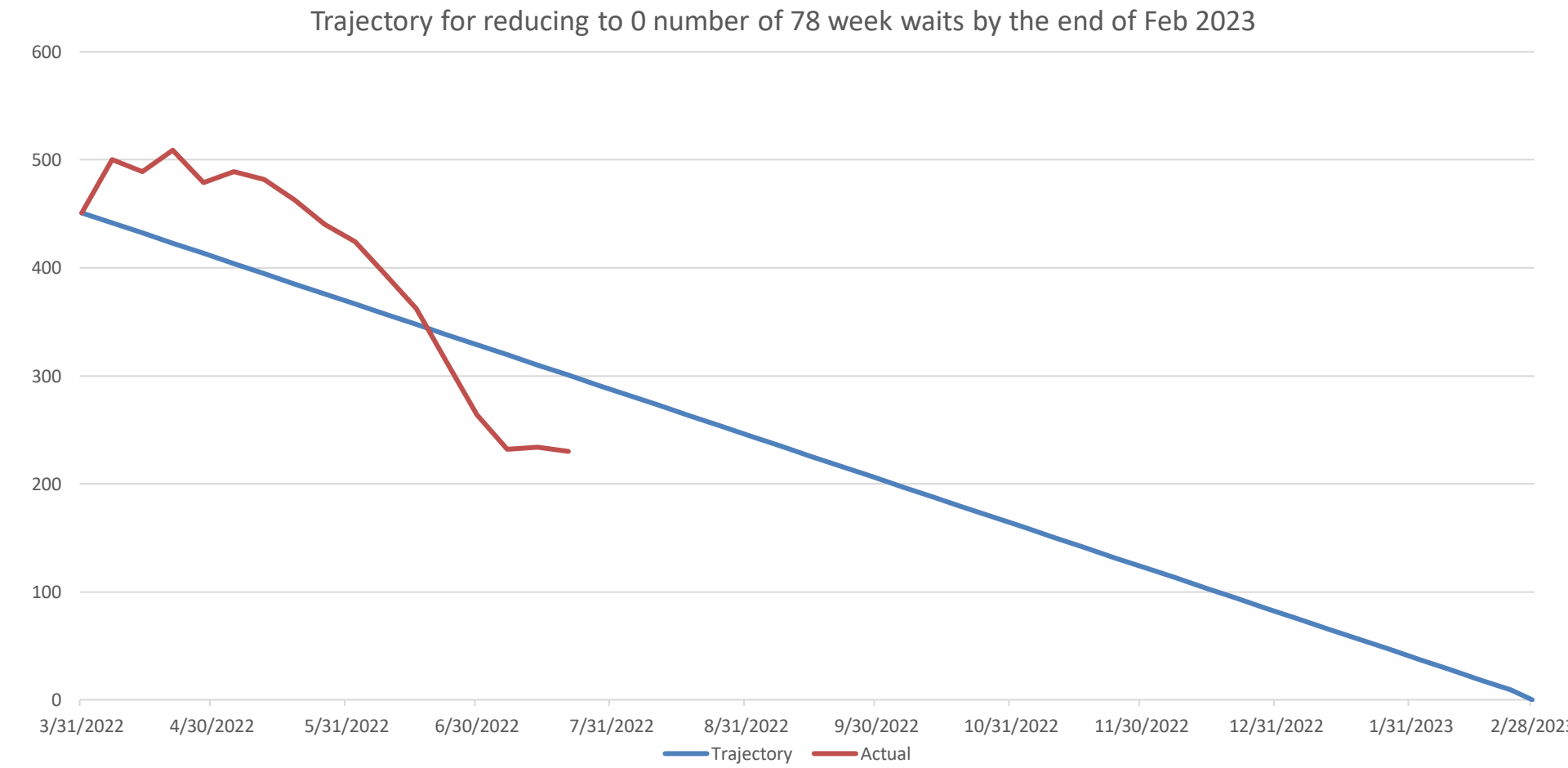
# RTT Over 78 Weeks
# Trust Position



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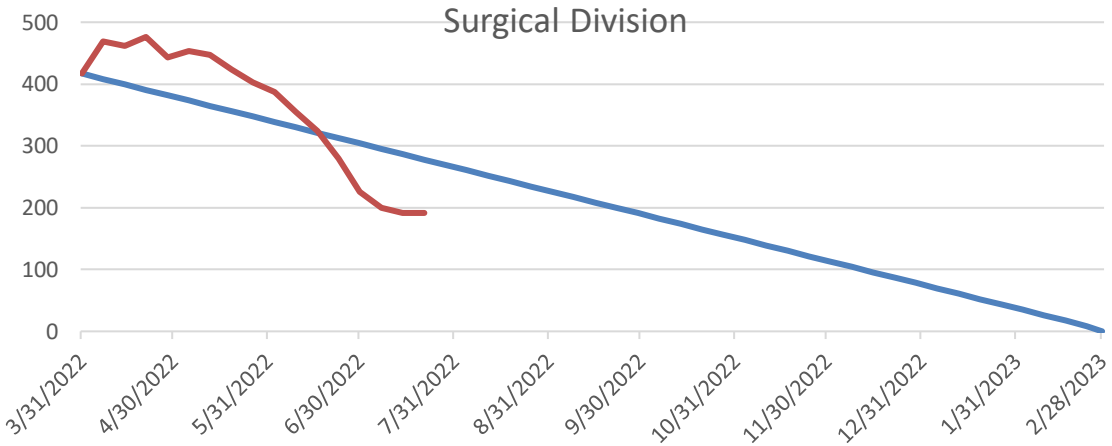
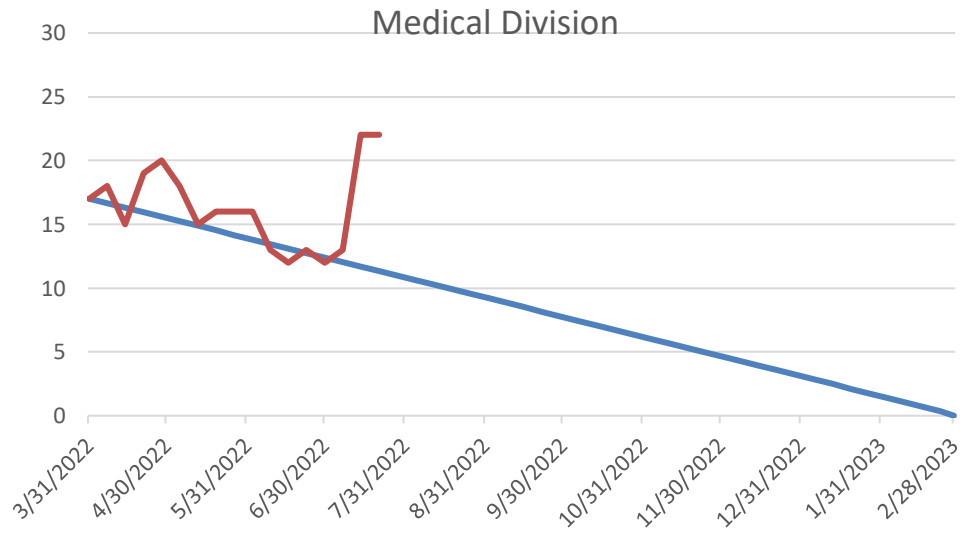
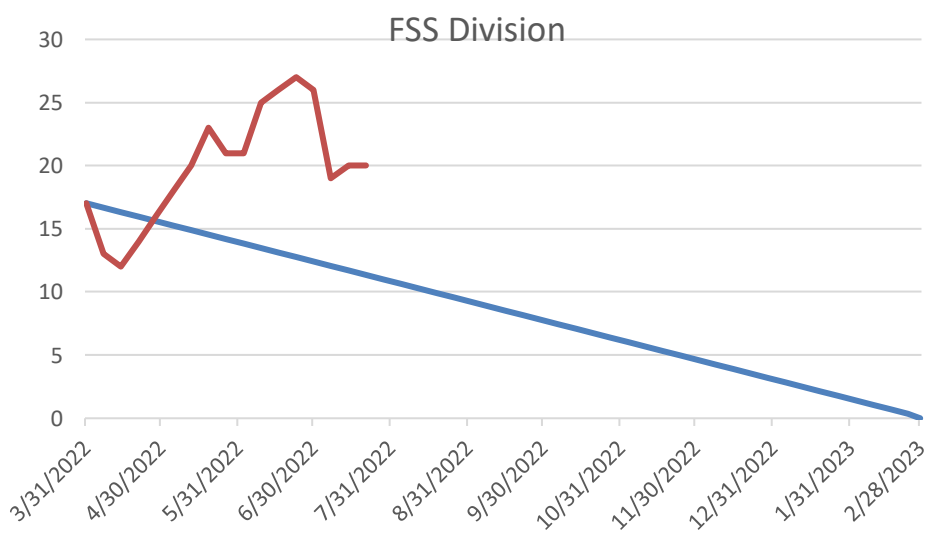
# RTT over 78 Weeks Divisional Breakdown



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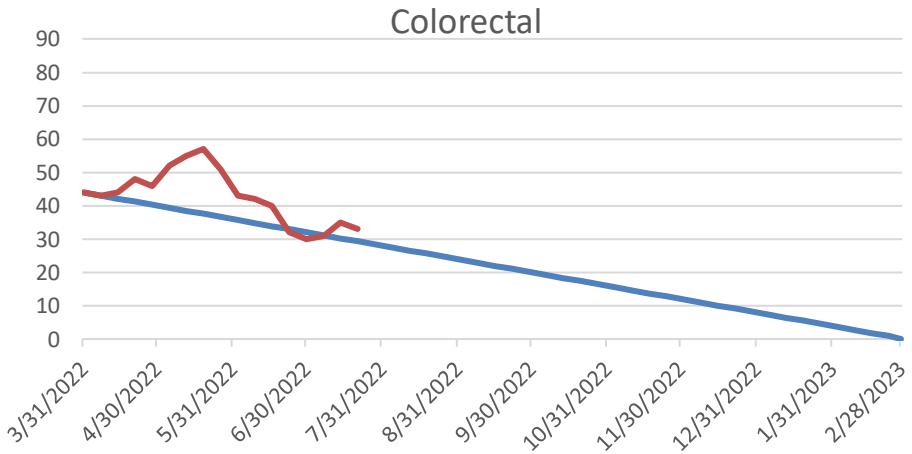
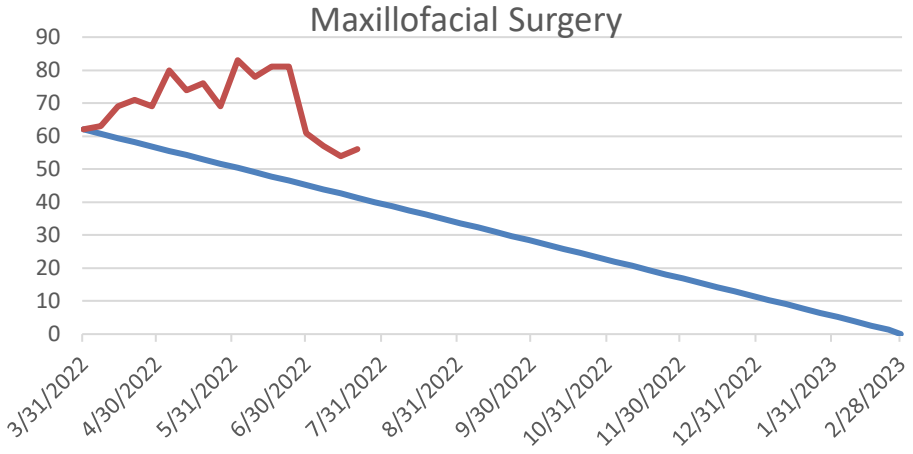
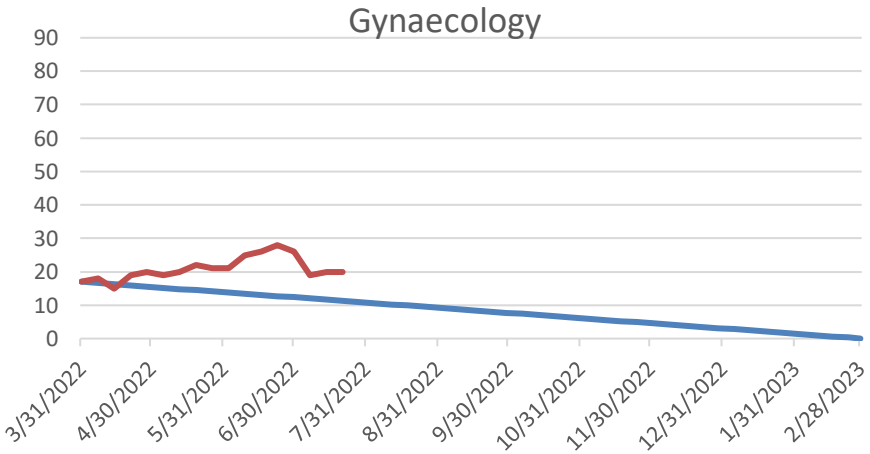
# RTT Over 78 Weeks



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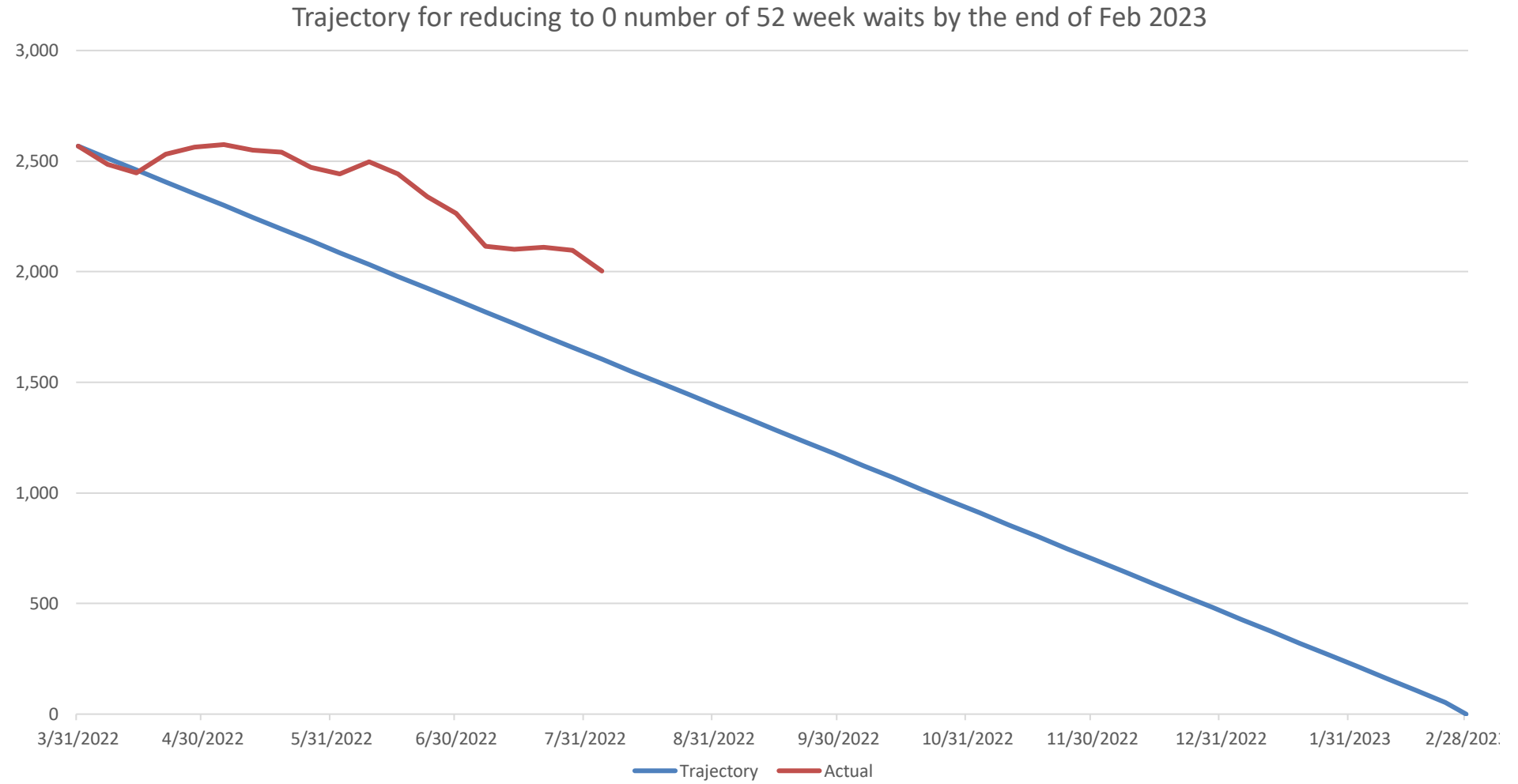
# RTT Over 52 Weeks
# Trust Position



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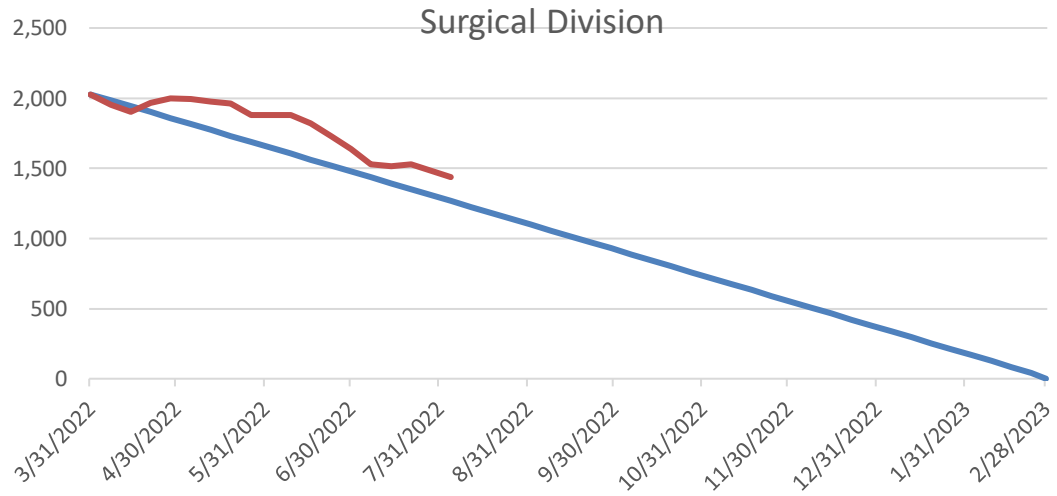
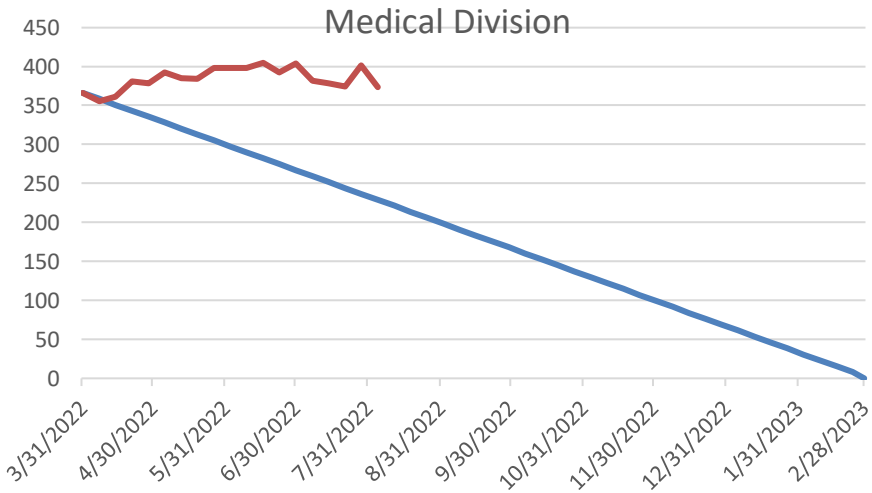
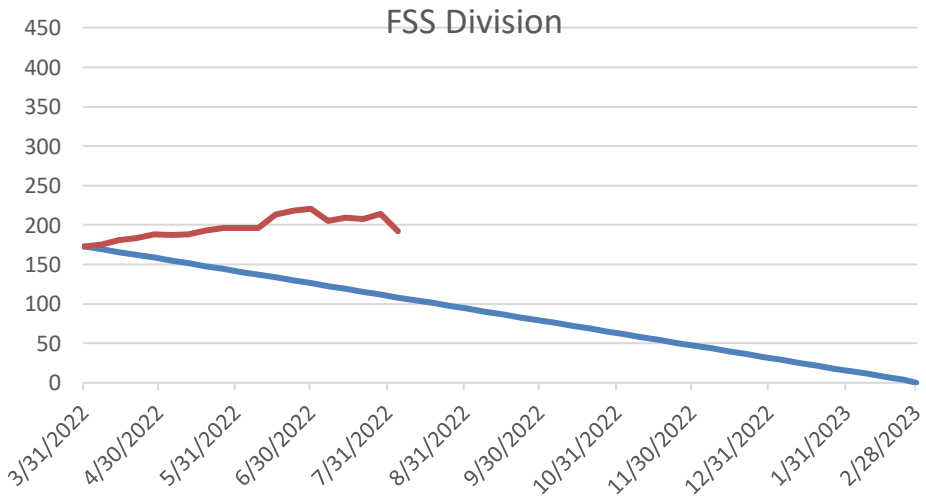
# RTT over 52 Weeks Divisional Breakdown



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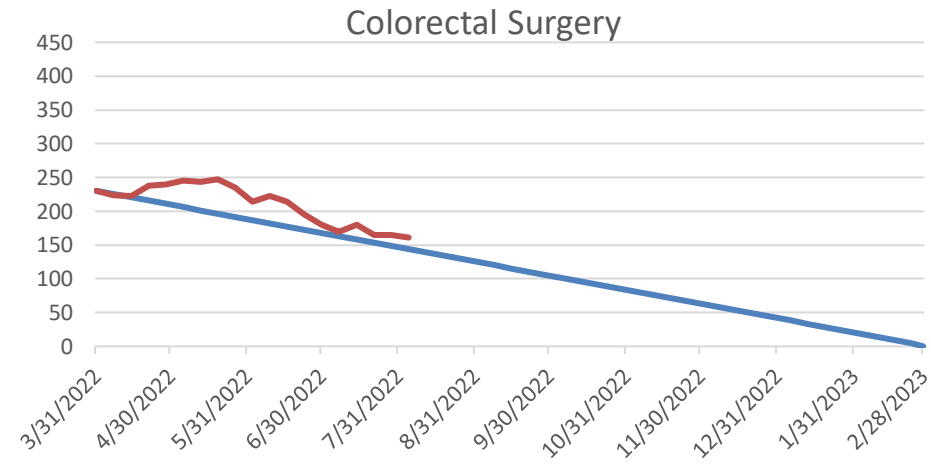
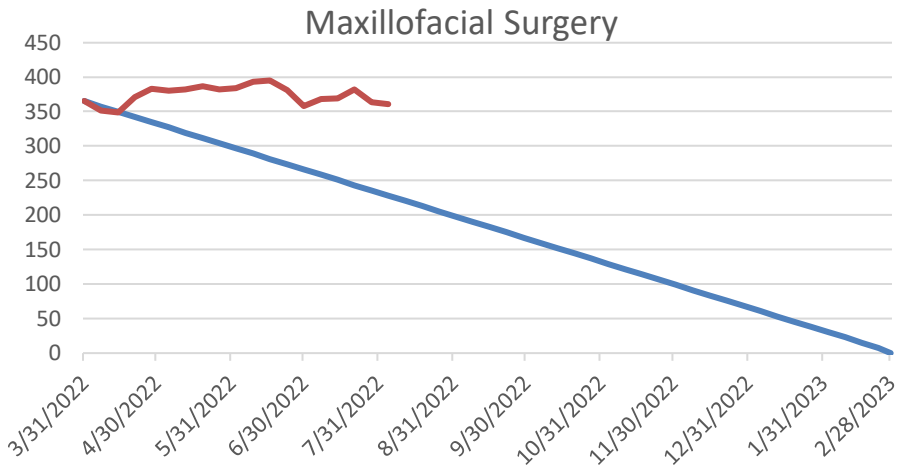
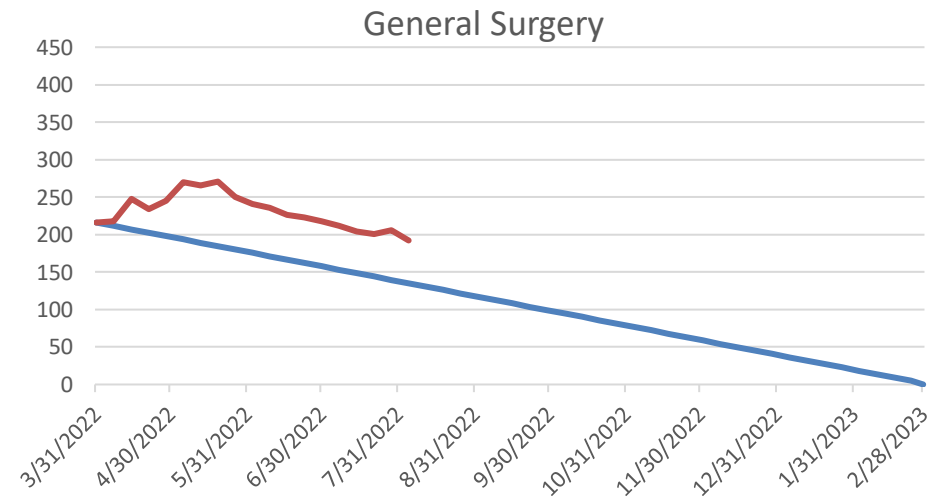
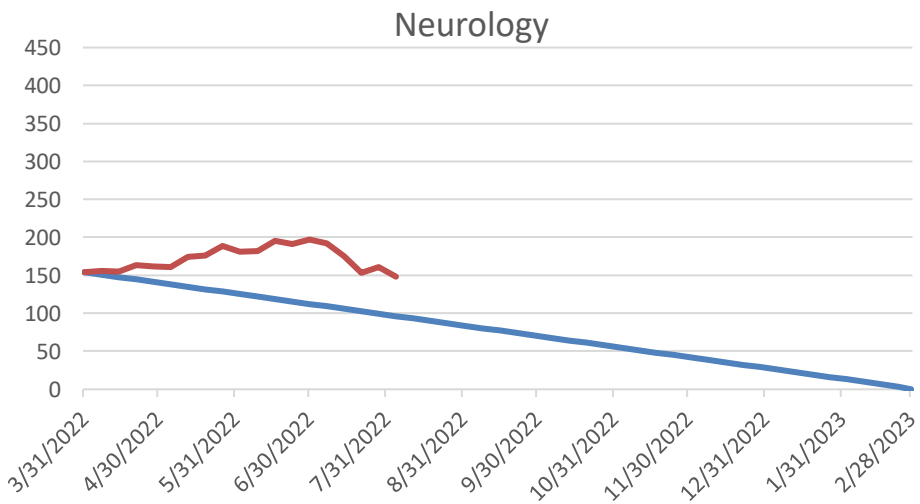
# RTT Over 52 Weeks



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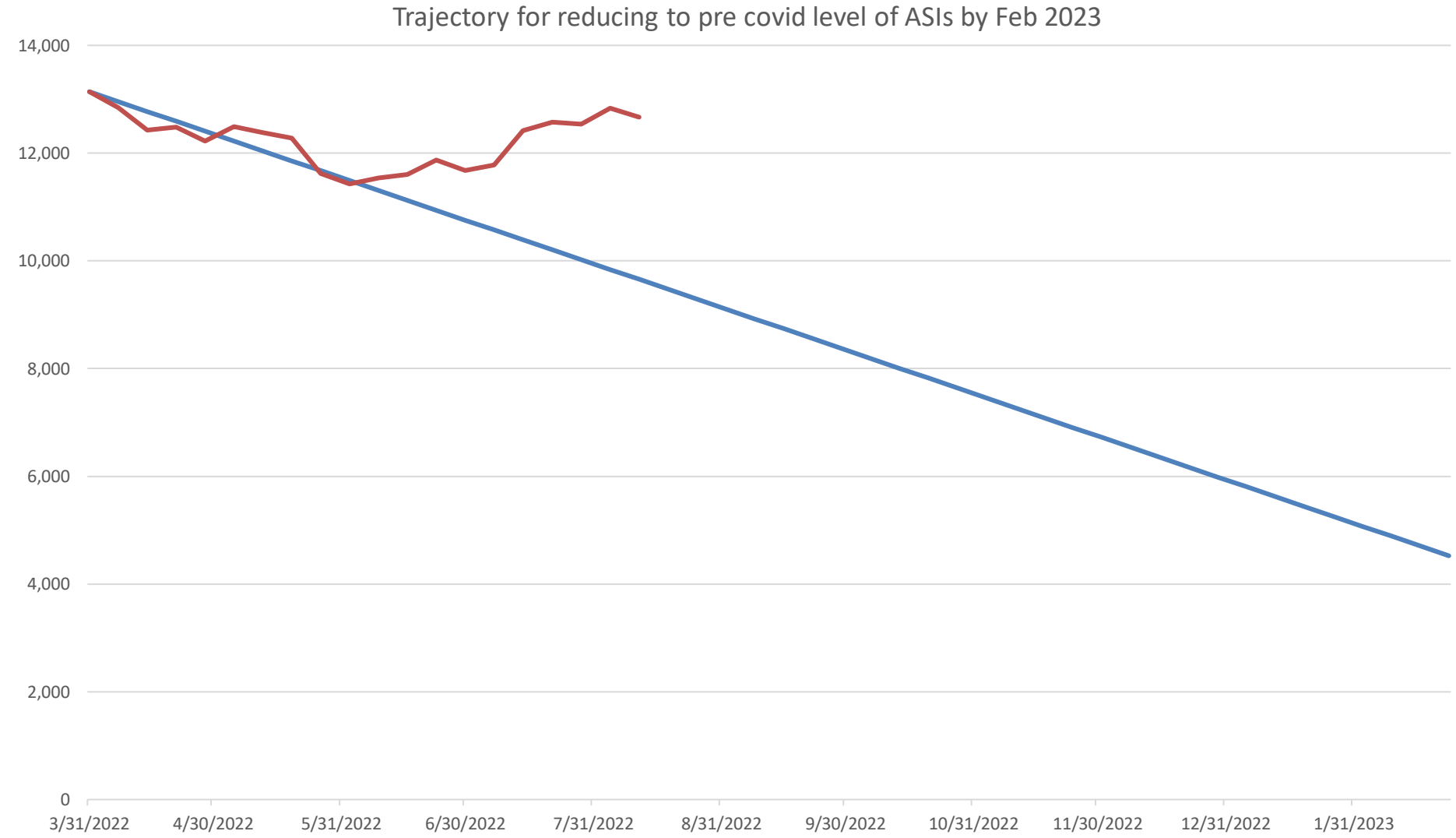
# ASIs

# Trust Position

Calderdale and Huddersfield NHS Foundation Trust



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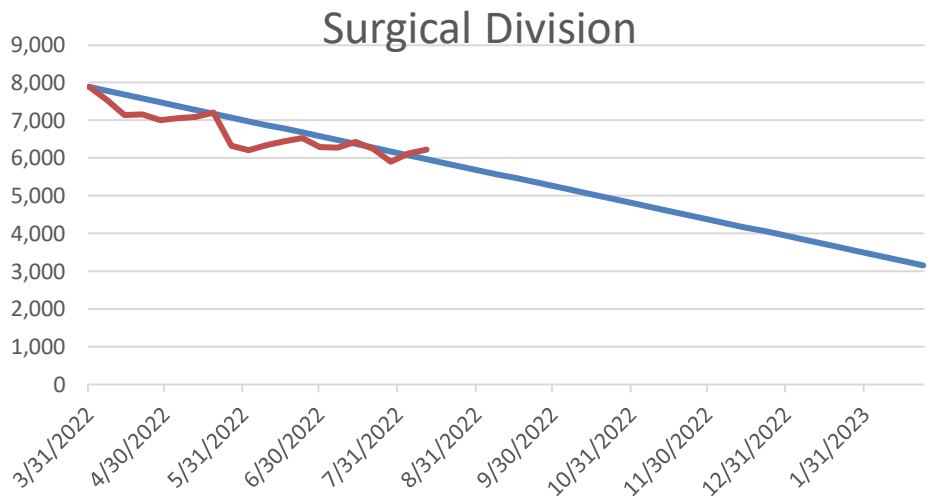
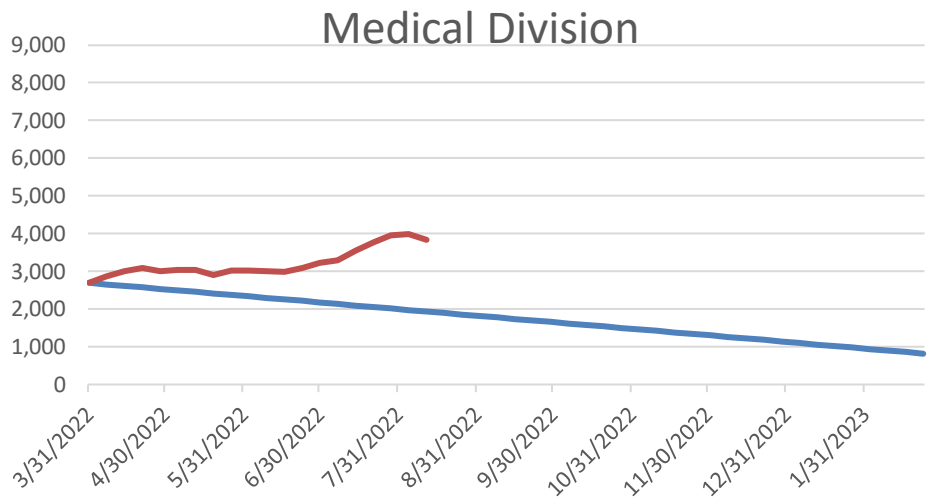
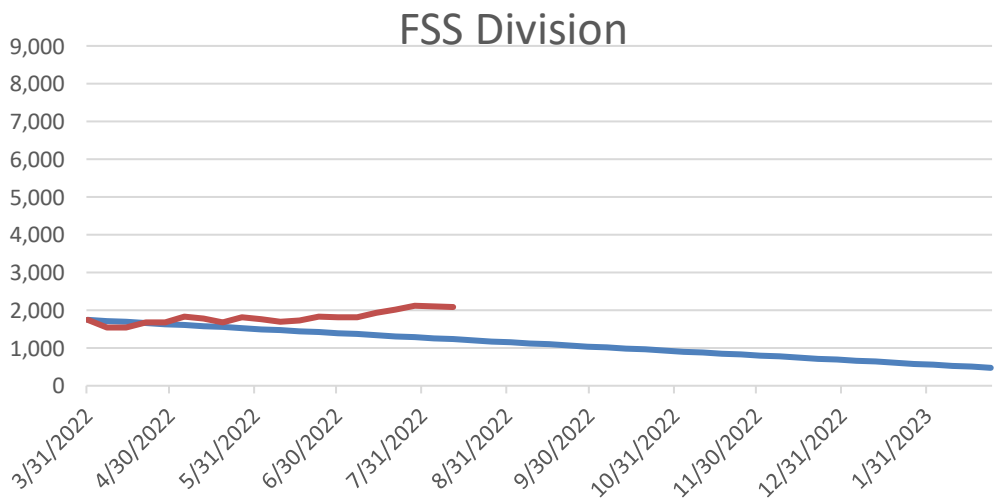
# ASIs
# Divisional Breakdown



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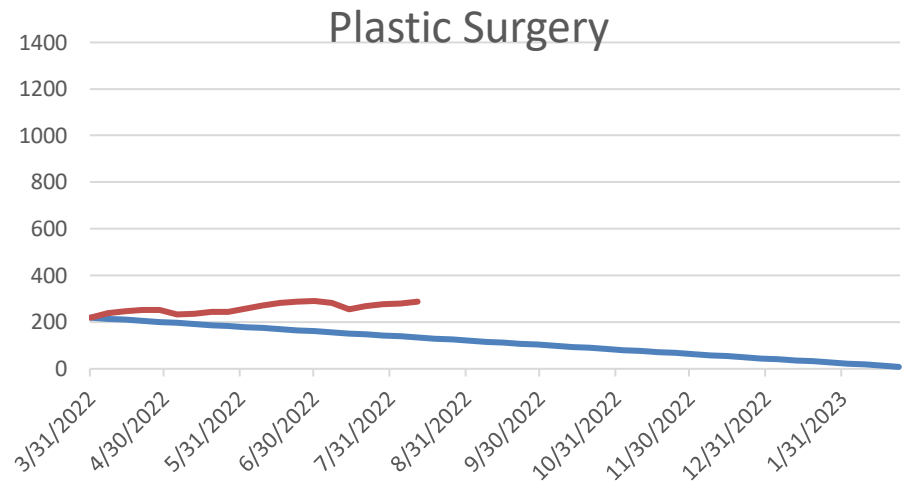
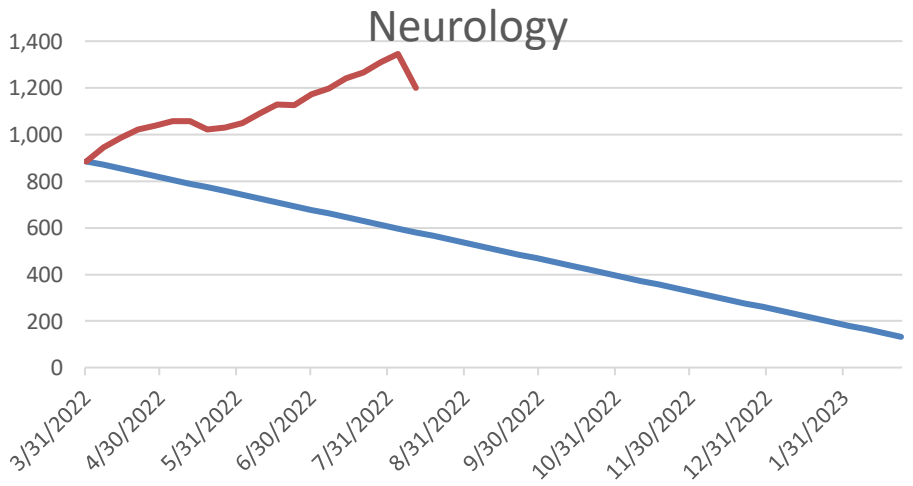
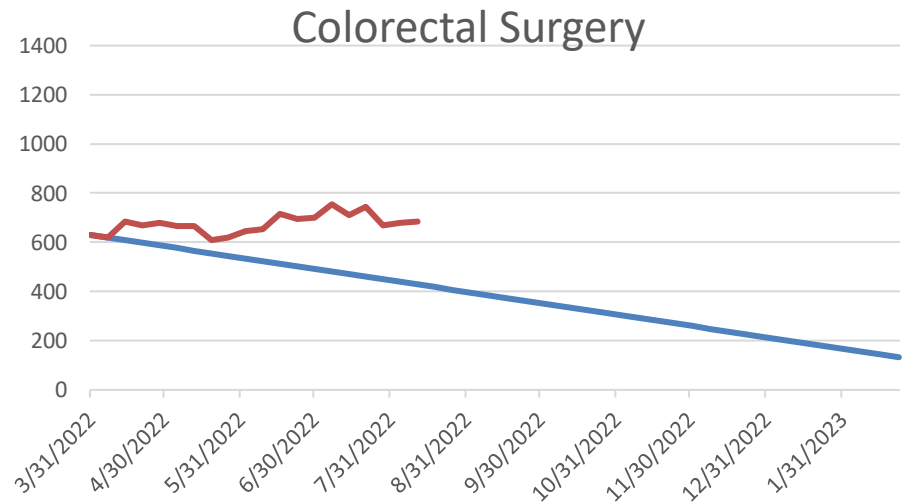
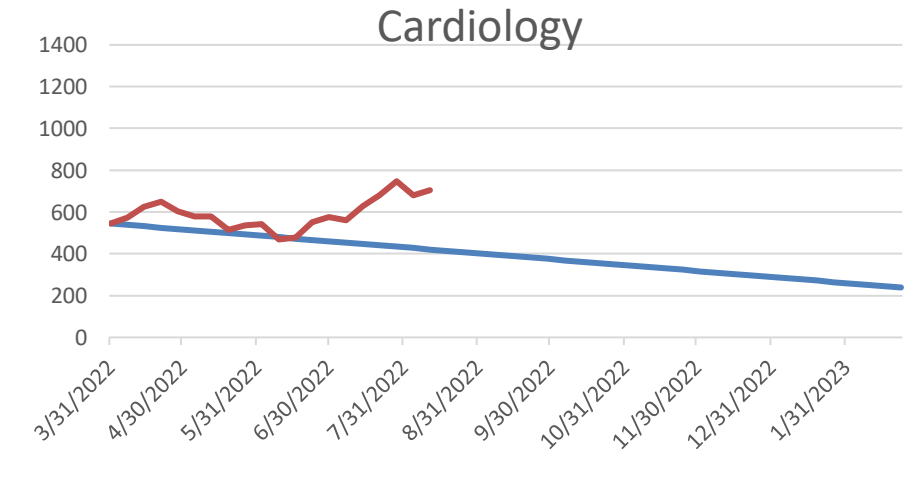
# ASIs
# Key Specialties



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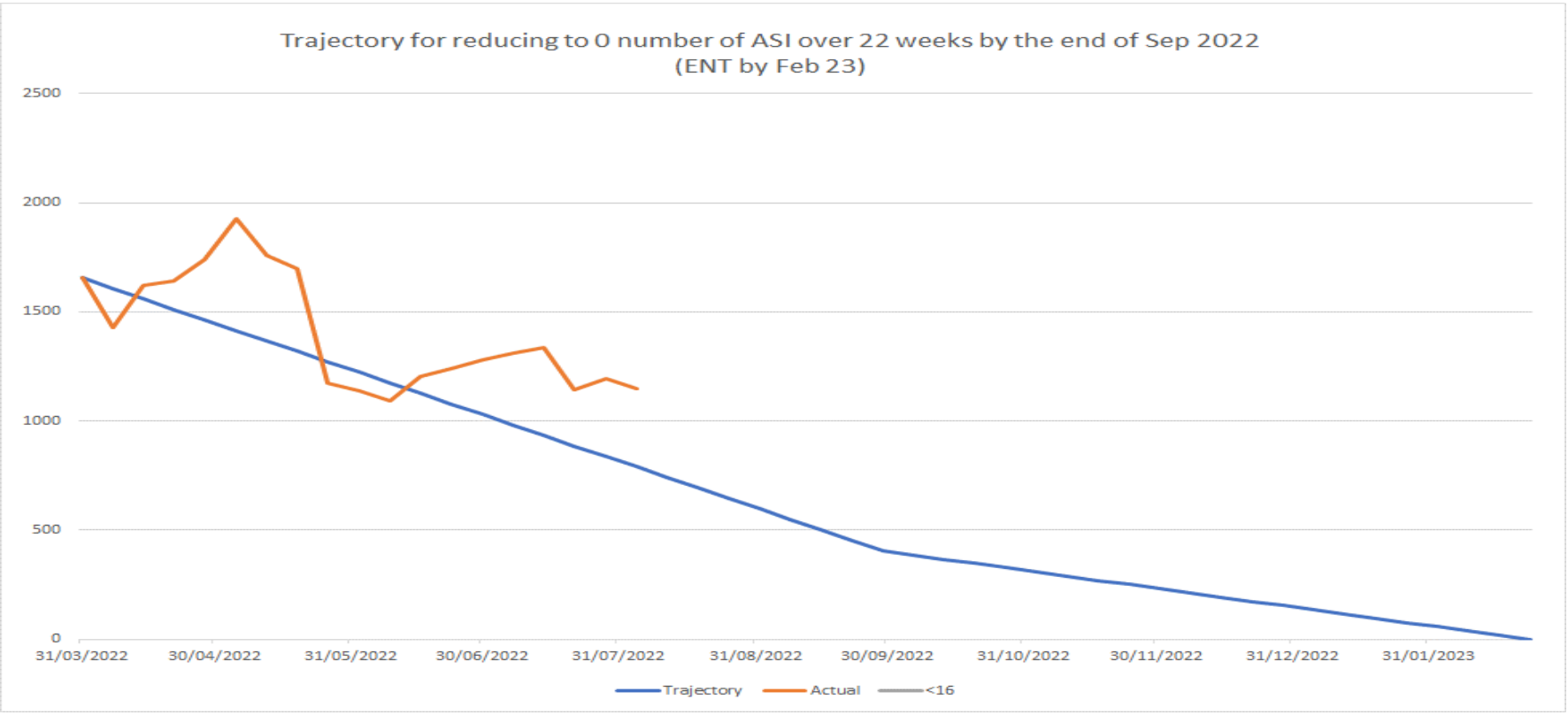
# Current ASIs > 22 Weeks

Our end of July 22 position for ASIs > 22 Weeks - 1,147 (Trajectory 790 reducing to 0 by end of September, ENT by February 2023).

This has been a reduction of almost 50 in the last month but we are still behind trajectory.
The Majority of our remaining ASIs > 22 weeks are in Colorectal, Plastic Surgery, Cardiology, Neurology and Gynaecology.



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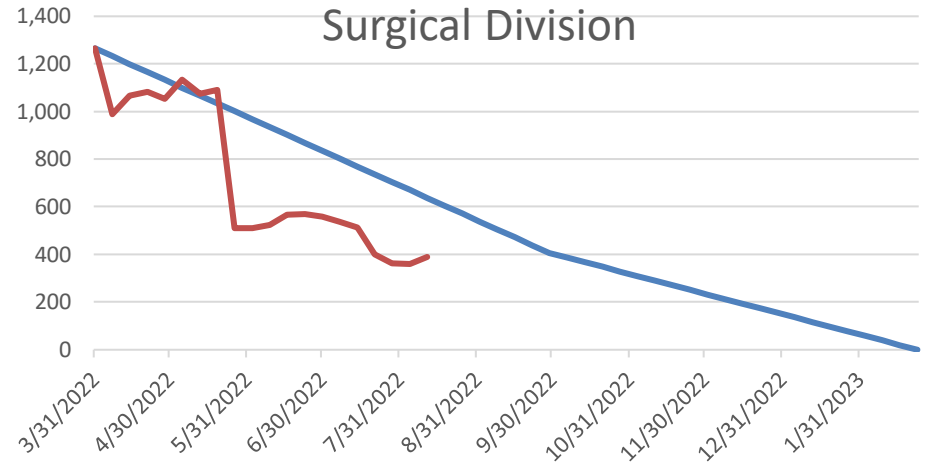
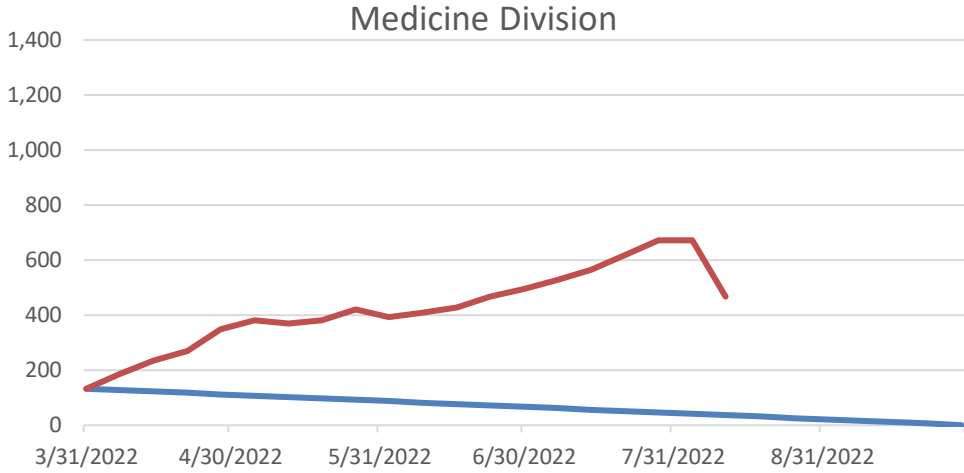
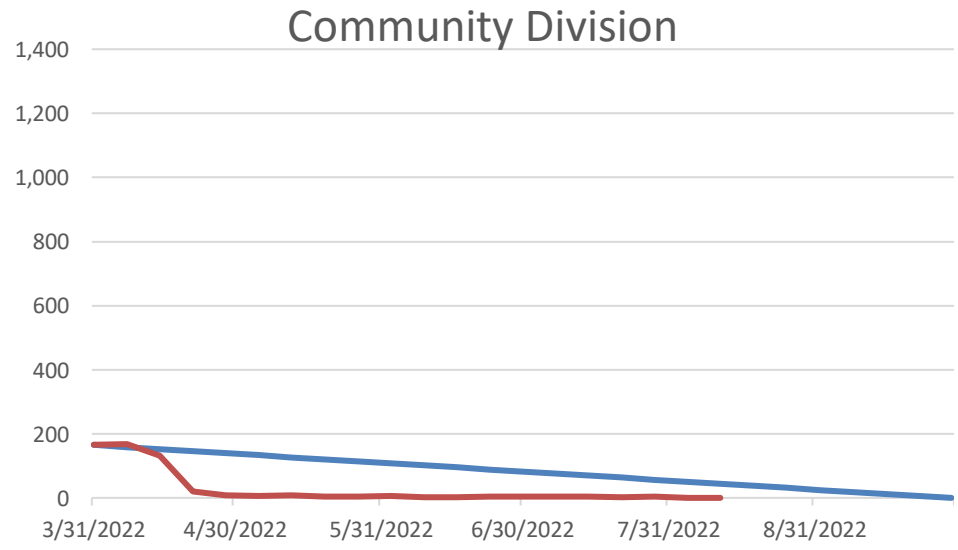
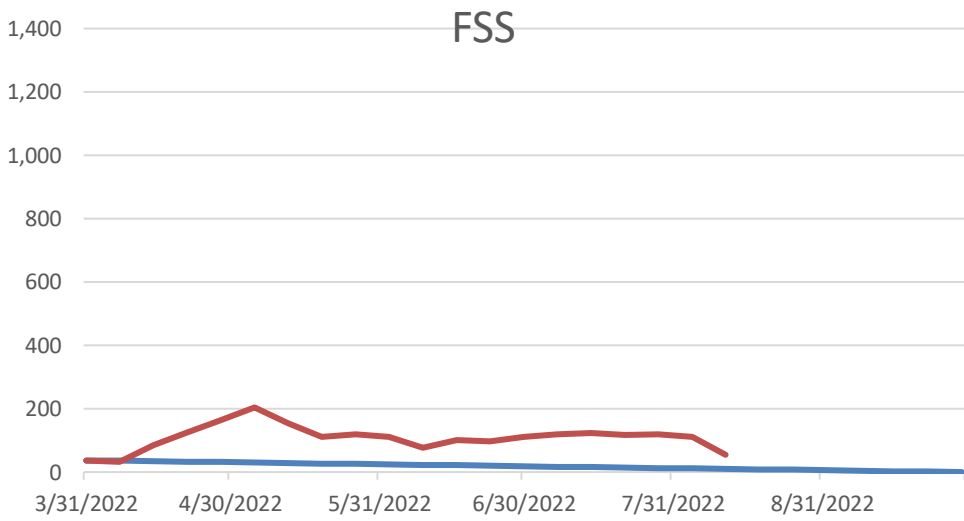
# ASIs over 22 Weeks Divisional Breakdown



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# ASIs over 22 Weeks Key Specialties

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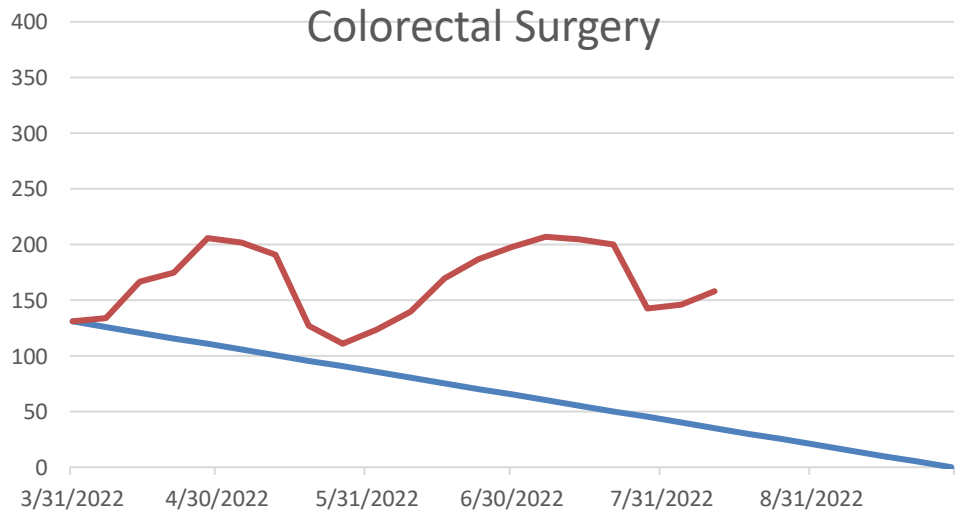


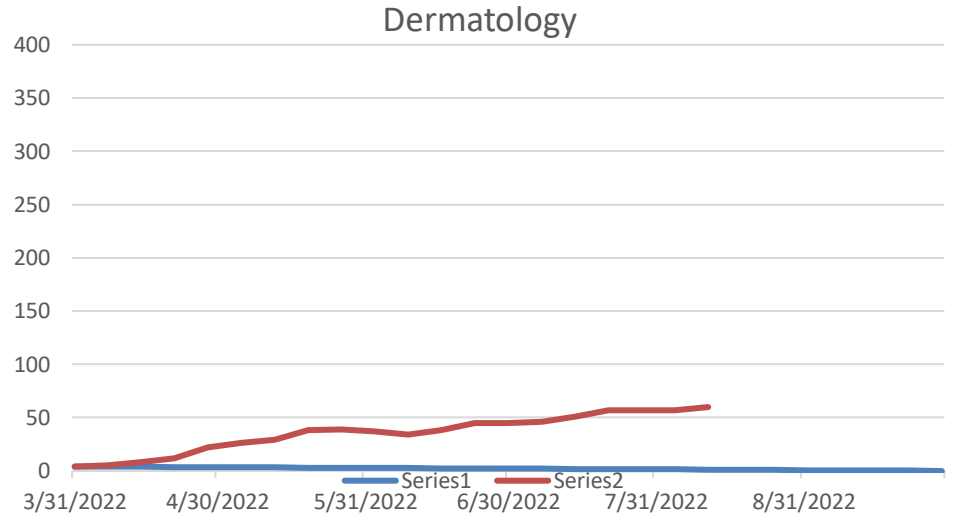


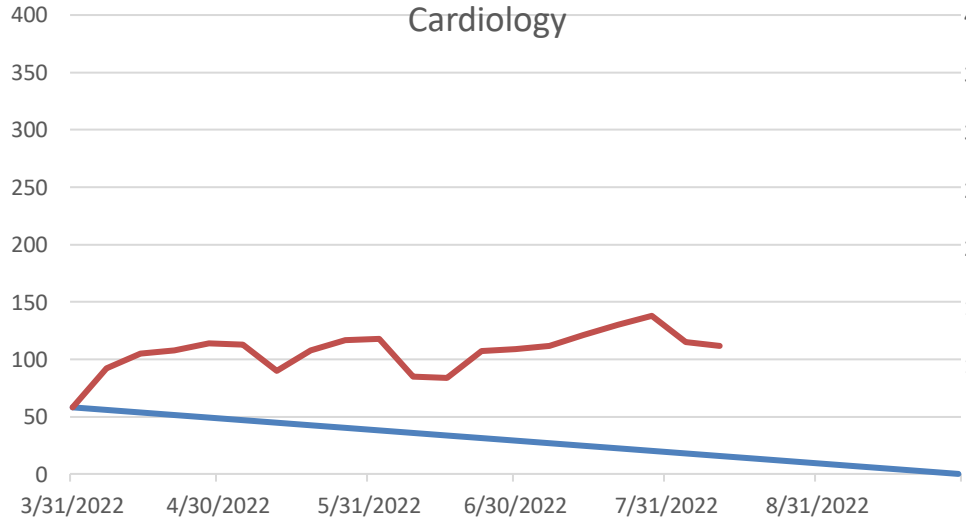


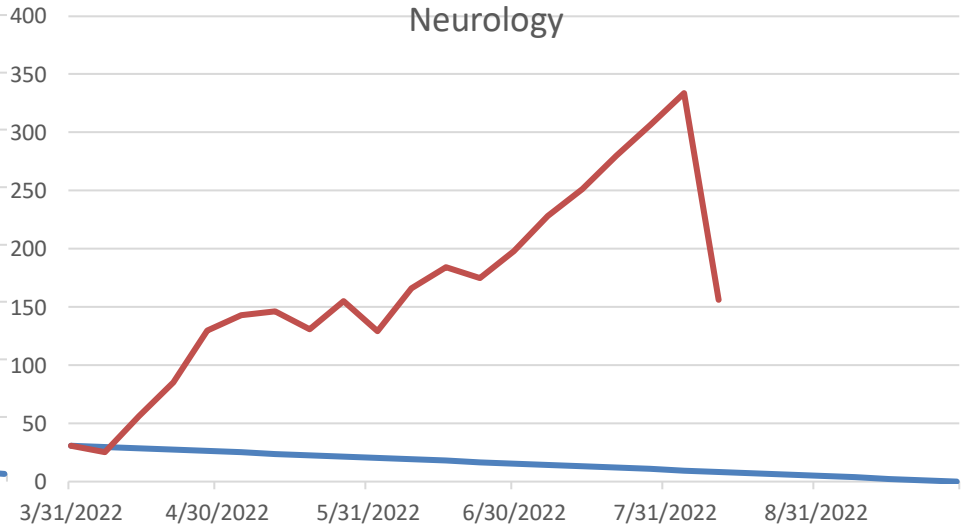

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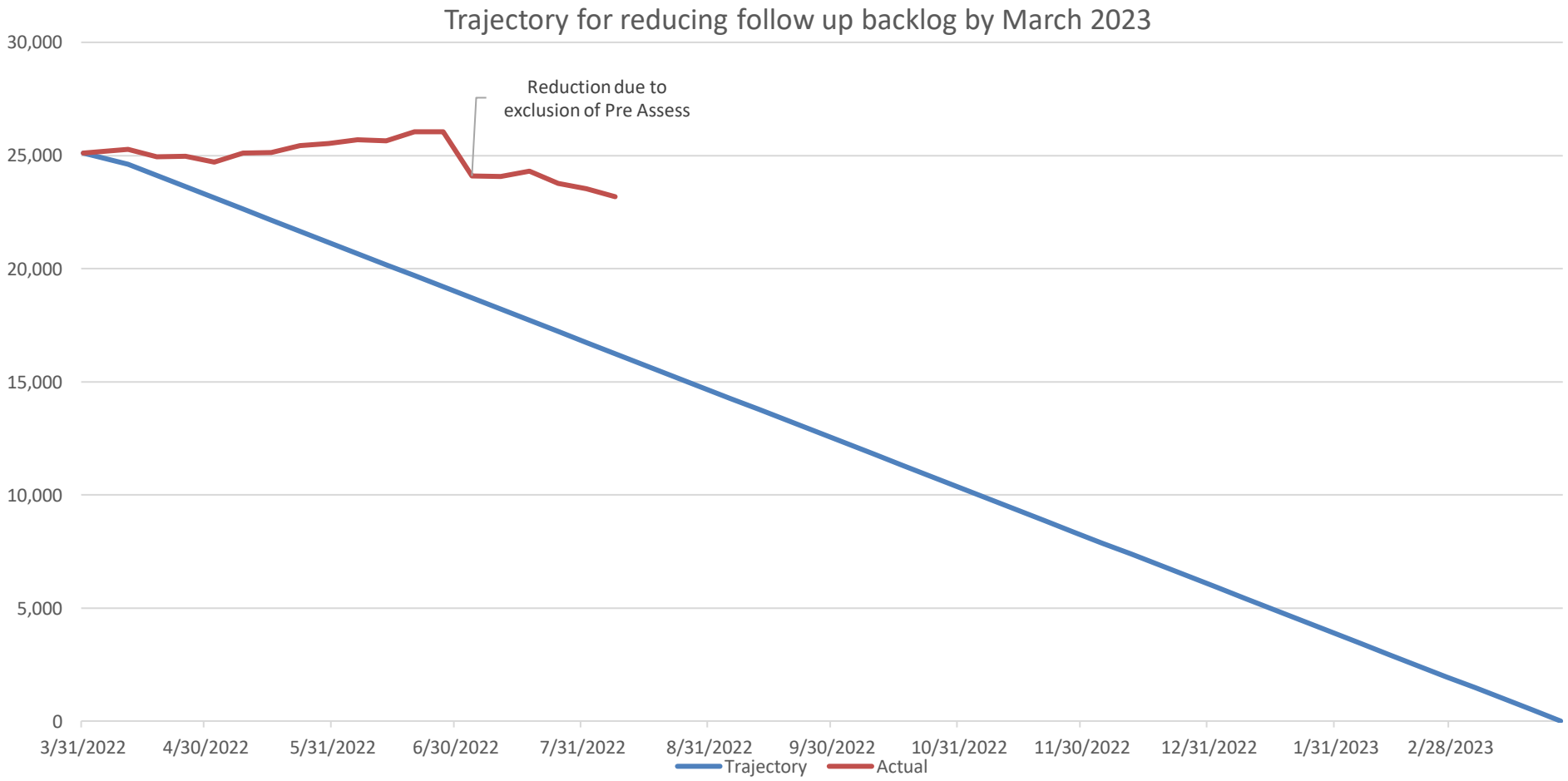
# Follow up Backlog Trust Position



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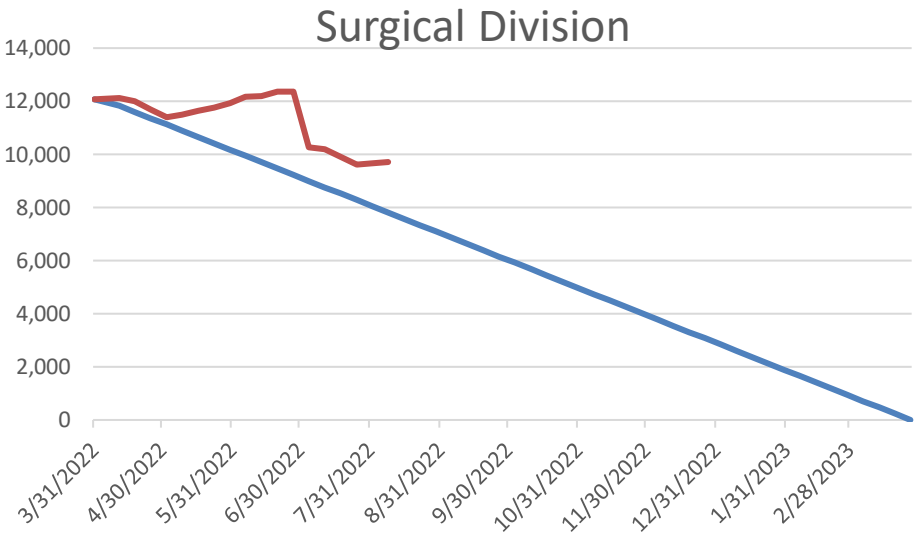
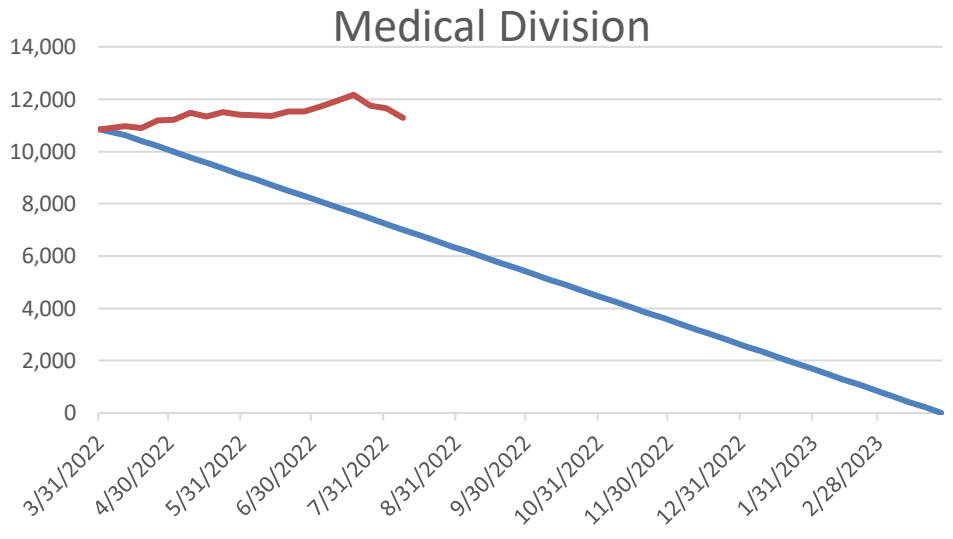
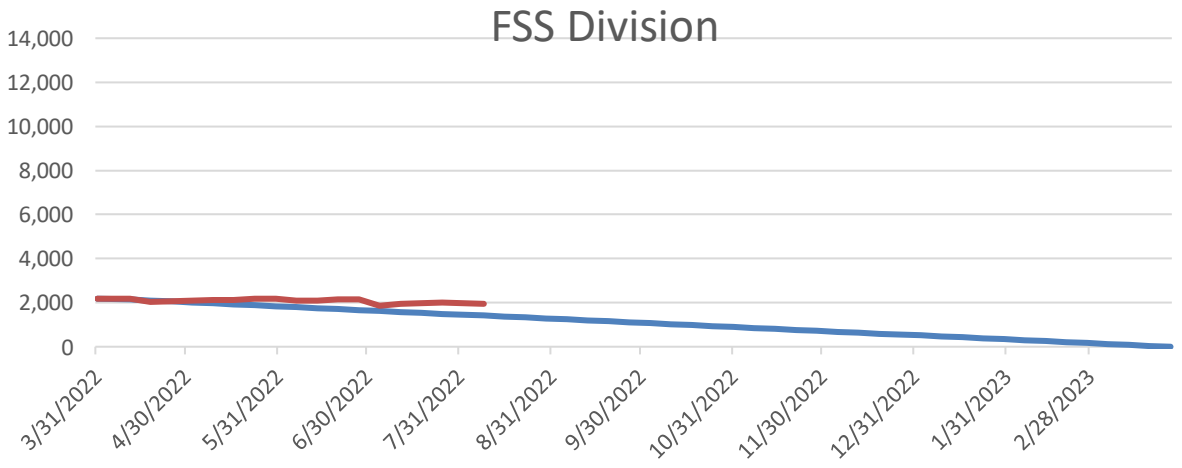
# Follow Up Backlog Divisional Breakdown



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# Diagnostics

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# Performance

| July 2022 | Diagnostic Test | Number of Patients <6 Wks | Number of Patients >6Wks | Number of Patients Total | % achieved | >13 Weeks | % from Last Month | Variance Current Mth vs Last Mth |
|---|---|---|---|---|---|---|---|---|
| Imaging | Magnetic Resonance Imaging | 1987 | 428 | 2415 | 82.28% | 172 | 71.95% | 10.33% |
| | Computed Tomography | 772 | 36 | 808 | 95.54% | 1 | 94.15% | 1.39% |
| | Non-obstetric ultrasound | 2789 | 24 | 2813 | 99.15% | 0 | 98.92% | 0.23% |
| | Barium Enema | 0 | 0 | 0 | N/A | 0 | N/A | - |
| | DEXA Scan | 555 | 3 | 558 | 99.46% | 0 | 99.60% | -0.14% |
| Physiological Measurement | Audiology - Audiology Assessments | 118 | 0 | 118 | 100.00% | 0 | 94.85% | 5.15% |
| | Cardiology - echocardiography | 729 | 274 | 1003 | 72.68% | 2 | 63.30% | 9.38% |
| | Cardiology - electrophysiology | 0 | 0 | 0 | N/A | 0 | N/A | - |
| | Neurophysiology - peripheral neurophysiology | 642 | 196 | 838 | 76.61% | 19 | 71.87% | 4.74% |
| | Respiratory physiology - sleep studies | 70 | 0 | 70 | 100.00% | 0 | 95.16% | 4.84% |
| | Urodynamics - pressures & flows | 18 | 0 | 18 | 100.00% | 0 | 100.00% | - |
| Endoscopy | Colonoscopy | 343 | 1 | 344 | 99.71% | 0 | 100.00% | -0.29% |
| | Flexi sigmoidoscopy | 115 | 0 | 115 | 100.00% | 0 | 100.00% | - |
| | Cystoscopy | 190 | 0 | 190 | 100.00% | 0 | 98.05% | 1.95% |
| | Gastroscopy | 460 | 5 | 465 | 98.92% | 0 | 98.84% | 0.08% |
| | Total Diagnostics | 8788 | 967 | 9755 | 90.09% | 194 | 85.80% | 4.29% |

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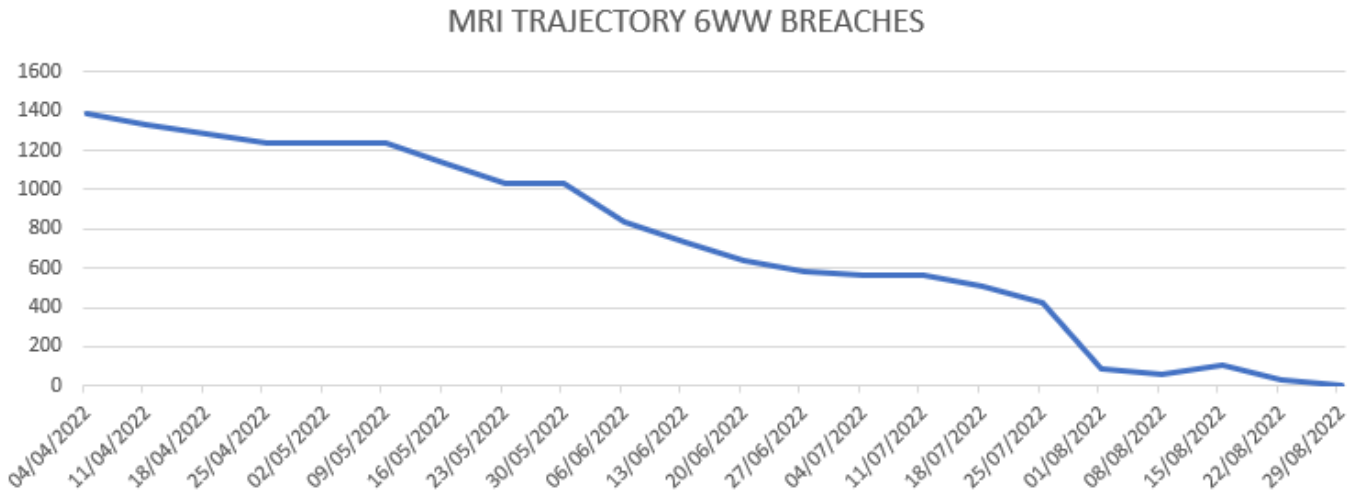
# MRI Trajectory




Previous assumptions around staff availability for new CRH scanners and machine downtime had been optimistic. Therefore, earlier iterations of the recovery trajectory have not been met. The above is a revised trajectory. Key assumptions / considerations are:

- Current demand outstrips capacity (due to staff training on new scanners – expect complete end of Aug)
- Continued mobile hire was not considered cost effective once new scanners live but unable to get sufficient trained staff to clear the backlog in a reasonable timeframe, even after considering agency staffing
- Additionality is assumed to be delivered via:
    - CHFT staffing – 36hrs (based on current uptake)
    - SG (mobile provider) staff – 216hrs
    - Mobile hire – 12 days (216hrs) from 20th July
    - Costs of above are within existing budgets / expected credits

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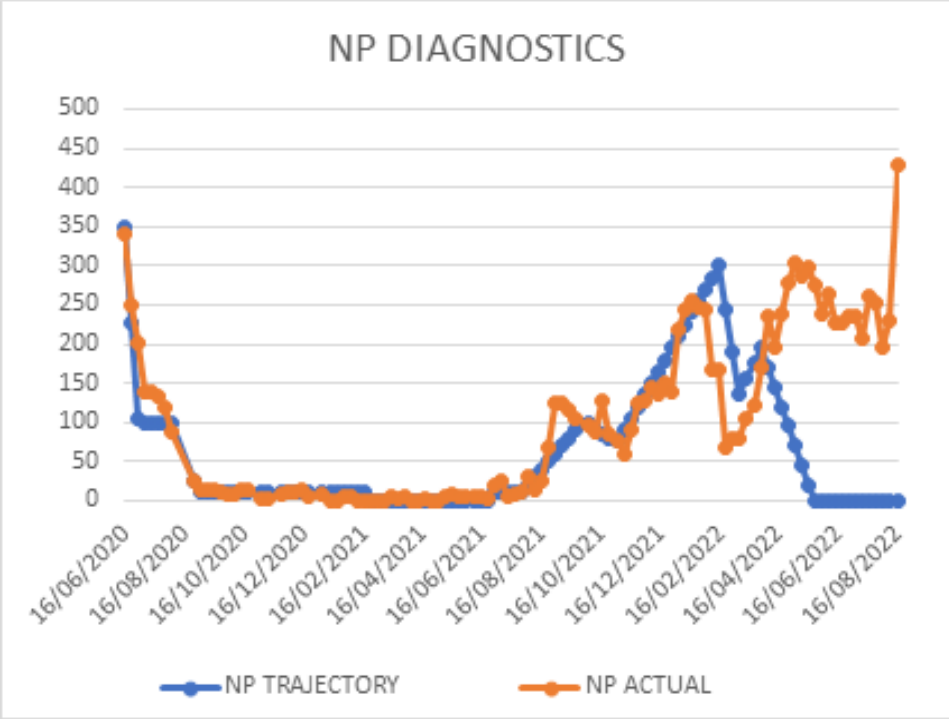
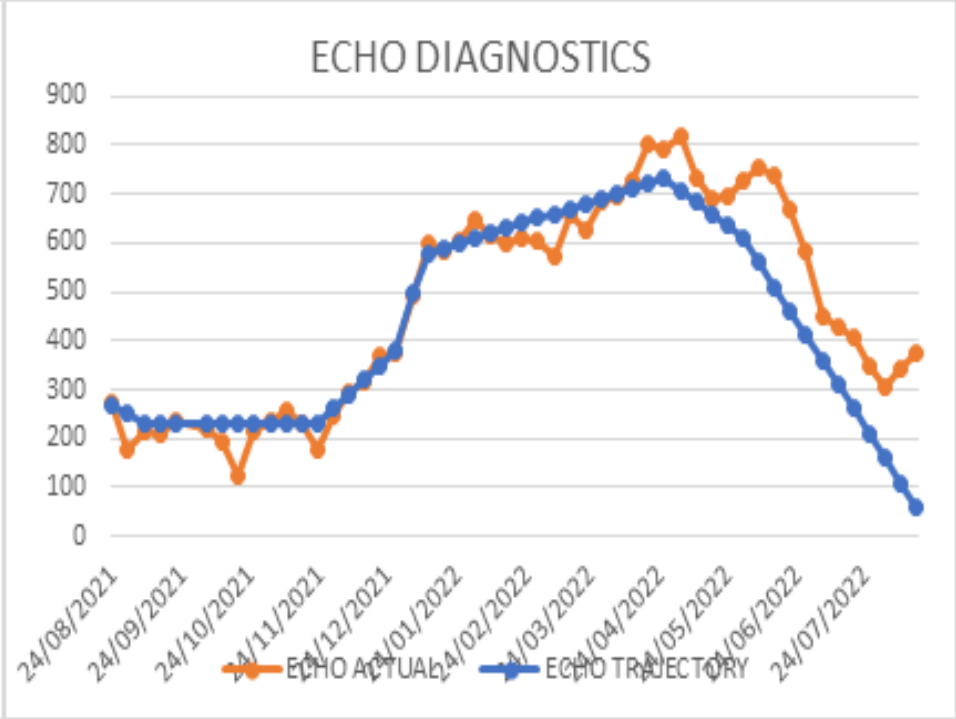
# Echo & Neurophysiology Trajectory



# 11. Month 4 Financial Summary

To Note

Presented by Gary Boothby

| | |
|---|---|
| **Date of Meeting:** | Thursday 1 September 2022 |
| **Meeting:** | Public Board of Directors |
| **Title:** | Month 4 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 4 (July 2022).

**Key Points to Note**

**Year to Date Summary**

Year to date the Trust is reporting an £8.44m deficit, a £0.46m favourable variance from plan. The in month position is a deficit of £1.52m, a £0.34m adverse variance. The Trust has delivered additional efficiencies Year to Date of £1.34m. Operational pressures, including additional capacity requirements, continue to drive additional costs, offsetting the CIP benefit year to date and presenting a significant risk to the forecast delivery of the 22/23 financial plan.

- Funding for 22/23 is based on an Aligned Payment Incentive (API) approach with a fixed element based on agreed activity levels and a variable element to support recovery of elective services. £11.94m of Elective Recovery Funding (ERF) has been assumed in the plan but is subject to delivery of 104% of 19/20 elective activity. ERF of £3.40m has been assumed in the year to date position in line with plan. Indications are that ERF will not be clawed back for the first half of the year (H1), but this remains a risk going into H2, as activity year to date was below the planned level and some claw back might be required if the Trust is unable to catch up this activity in future months.
- The Trust has been allocated block funding of £5.9m for the year to support Covid-19 costs by the Integrated Care System (ICS) and subject to approval continues to have access to funding for Covid-19 costs that are considered to be outside of the System Envelope: Vaccinations and Covid-19 Testing. Requirements for additional funding for testing have reduced as national procurement has expanded and future vaccination programmes are expected to be funded on a fixed cost per vaccine basis.
- Year to date the Trust has incurred costs relating to Covid-19 of £6.36m, £3.21m higher than planned. Covid-19 activity remains higher than planned driving additional staffing costs and consumables, with some extra capacity opened that was planned to be closed by this point in the year.
- Year to date the Trust has delivered efficiency savings of £5.76m, £1.38m higher than planned.
- Agency expenditure year to date is £3.95m, £1.97m higher than planned. It is expected that the NHS Improvement Agency expenditure ceiling will be set at our existing planned level based on the latest guidance.

- Total planned inpatient activity, for the purpose of Elective Recovery, was only 95% of the activity planned year to date.

**Key Variances**

- Income is £0.35m above the planned year to date. Higher than planned NHS Clinical income is offset by lower than planned funding for 'outside of envelope' Covid-19 due to a reduction in testing costs now that most testing consumables have moved to a national procurement mechanism.
- Pay costs are £1.41m below the planned level year to date but were again slightly above plan in month. The underspend is primarily linked to vacancies, particularly in Community and FSS Divisions and lower than planned Recovery costs. In Month 4 the Trust continues to be unable to move to the summer bed plan, with more beds open than planned due to Covid-19 and other operational pressures. This is driving adverse variances in both Medical and Corporate Divisions of around £0.8m in month.
- Non-pay operating expenditure is £1.41m higher than planned year to date with pressure on consumable costs due to additional capacity requirements and inflationary pressures, (in particular on the PFI contract), due to the growth in RPI.

**Forecast**

The Trust has a revised plan to deliver a £17.35m deficit for the year and whilst forecasting to deliver this planned deficit, this is looking increasingly challenging and significant mitigation will be required to offset the ongoing operational pressures that have continued into the summer period. The Trust had planned to close most of the additional capacity wards used over winter by the 1st of June. This capacity remains open, and this will continue to drive additional costs over the next few months unless operational pressures ease. The forecast assumes full delivery of a challenging £20m efficiency target and elements of this plan are also increasingly high risk, particularly those schemes reliant on the exit of Covid-19 costs. The forecast continues to assume that the Trust will deliver its elective activity plan and secure in full £11.9m of Elective Recovery Funding.

Attachment: Month 4 Finance Report

**EQIA – Equality Impact Assessment**

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

**Recommendation**

The Board is asked to receive and **NOTE** the Finance Report and note the financial position for the Trust as at 31 July 2022.

# EXECUTIVE SUMMARY: Total Group Financial Overview as at 31st Jul 2022 - Month 4

## KEY METRICS

| | M4 | | | | YTD (JUL 2022) | | | | Forecast 22/23 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Plan | Actual | Var | | Plan | Actual | Var | | Plan | Forecast | Var | |
| | £m | £m | £m | | £m | £m | £m | | £m | £m | £m | |
| **I&E: Surplus / (Deficit)** | (£1.18) | (£1.52) | (£0.34) | | (£8.91) | (£8.44) | £0.46 | | (£17.35) | (£17.34) | £0.01 | |
| **Agency Expenditure (vs Ceiling)** | (£0.48) | (£1.12) | (£0.64) | | (£1.98) | (£3.95) | (£1.97) | | (£6.03) | (£10.20) | (£4.17) | |
| **Capital** | £2.58 | £1.85 | £0.73 | | £8.29 | £2.57 | £5.72 | | £41.99 | £42.26 | (£0.27) | |
| **Cash** | £58.62 | £52.04 | (£6.58) | | £58.62 | £52.04 | (£6.58) | | £19.26 | £16.64 | (£2.62) | |
| **Invoices paid within 30 days (%)** (Better Payment Practice Code) | 95.0% | 91.4% | -4% | | 95.0% | 90.5% | -4% | | | | | |
| **CIP** | £1.69 | £1.58 | (£0.10) | | £4.38 | £5.76 | £1.38 | | £20.00 | £20.00 | (£0.00) | |
| **Use of Resource Metric** | 3 | 3 | | | 3 | 3 | | | 3 | 3 | | |

**Year to Date Summary**

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# Total Group Financial Overview as at 31st Jul 2022 - Month 4

## INCOME AND EXPENDITURE COMPARED TO PLAN SUBMITTED TO NHS IMPROVEMENT

## YEAR TO DATE POSITION: M4

### CLINICAL ACTIVITY

| | M4 Plan | M4 Actual | Var |
|---|---|---|---|
| Elective | 1,879 | 1,467 | (412) |
| Non-Elective | 19,679 | 17,293 | (2,386) |
| Daycase | 16,693 | 15,882 | (811) |
| Outpatient | 144,750 | 142,021 | (2,729) |
| A&E | 59,301 | 58,999 | (302) |
| Other NHS Non-Tariff | 619,989 | 643,094 | 23,105 |
| **Total** | **862,291** | **878,757** | **16,465** |

### TOTAL GROUP: INCOME AND EXPENDITURE

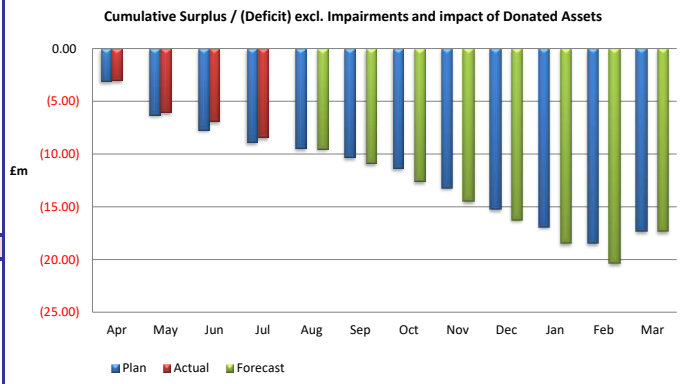
| | M4 Plan | M4 Actual | Var |
|---|---|---|---|
| | £m | £m | £m |
| Elective | £7.50 | £5.80 | (£1.70) |
| Non Elective | £44.26 | £41.76 | (£2.50) |
| Daycase | £11.71 | £11.18 | (£0.52) |
| Outpatients | £13.09 | £13.94 | £0.85 |
| A & E | £9.96 | £10.27 | £0.32 |
| Other-NHS Clinical | £56.77 | £61.18 | £4.41 |
| CQUIN | £0.00 | £0.00 | £0.00 |
| Other Income | £17.90 | £17.41 | (£0.49) |
| **Total Income** | **£161.19** | **£161.54** | **£0.35** |
| Pay | (£107.33) | (£105.92) | £1.41 |
| Drug Costs | (£15.34) | (£14.58) | £0.76 |
| Clinical Support | (£12.74) | (£12.34) | £0.40 |
| Other Costs | (£19.16) | (£21.65) | (£2.48) |
| PFI Costs | (£4.77) | (£4.87) | (£0.10) |
| **Total Expenditure** | **(£159.35)** | **(£159.35)** | **(£0.00)** |
| **EBITDA** | **£1.84** | **£2.19** | **£0.35** |
| Non Operating Expenditure | (£10.75) | (£10.64) | £0.11 |
| **Surplus / (Deficit) Adjusted*** | **(£8.91)** | **(£8.44)** | **£0.46** |

* 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

| | M4 Plan | M4 Actual | Var |
|---|---|---|---|
| | £m | £m | £m |
| Surgery & Anaesthetics | (£33.34) | (£32.38) | £0.96 |
| Medical | (£40.08) | (£42.41) | (£2.33) |
| Families & Specialist Services | (£28.99) | (£27.85) | £1.14 |
| Community | (£8.96) | (£8.73) | £0.23 |
| Estates & Facilities | £0.00 | (£0.00) | (£0.00) |
| Corporate | (£17.72) | (£18.15) | (£0.44) |
| THIS | £0.40 | £0.43 | £0.03 |
| PMU | £0.81 | £0.20 | (£0.61) |
| CHS LTD | £0.14 | £0.03 | (£0.12) |
| Central Inc/Technical Accounts | £119.92 | £120.83 | £0.91 |
| Reserves | (£1.09) | (£0.40) | £0.69 |
| **Surplus / (Deficit)** | **(£8.91)** | **(£8.44)** | **£0.46** |

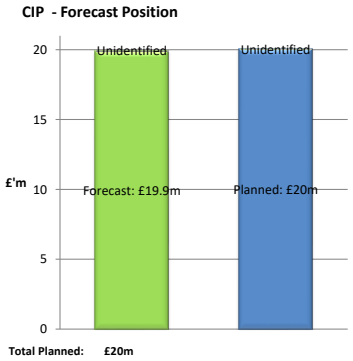
### TOTAL GROUP SURPLUS / (DEFICIT)

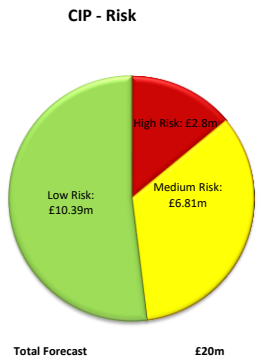



### KEY METRICS

| | Year To Date | | | Year End: Forecast | | |
|---|---|---|---|---|---|---|
| | M4 Plan | M4 Actual | Var | Plan | Forecast | Var |
| | £m | £m | £m | £m | £m | £m |
| I&E: Surplus / (Deficit) | (£8.91) | (£8.44) | £0.46 | (£17.35) | (£17.34) | £0.01 |
| Capital | £8.29 | £2.57 | £5.72 | £41.99 | £42.26 | (£0.27) |
| Cash | £58.62 | £52.04 | (£6.58) | £19.26 | £16.64 | (£2.62) |
| Invoices Paid within 30 days (BPPC) | 95% | 91% | -4% | | | |
| CIP | £4.38 | £5.76 | £1.38 | £20.00 | £20.00 | (£0.00) |
| | Plan | Actual | | Plan | Forecast | |
| Use of Resource Metric | 3 | 3 | | 3 | 3 | |

### COST IMPROVEMENT PROGRAMME (CIP)




## YEAR END 22/23

### CLINICAL ACTIVITY

| | Plan | Actual | Var |
|---|---|---|---|
| Elective | 5,774 | 4,574 | (1,200) |
| Non-Elective | 58,360 | 52,034 | (6,327) |
| Daycase | 50,173 | 48,380 | (1,793) |
| Outpatient | 436,084 | 453,214 | 17,130 |
| A&E | 170,928 | 170,704 | (225) |
| Other NHS Non- Tariff | 1,867,647 | 1,943,726 | 76,079 |
| **Total** | **2,588,966** | **2,672,631** | **83,665** |

### TOTAL GROUP: INCOME AND EXPENDITURE

| | Plan | Actual | Var |
|---|---|---|---|
| | £m | £m | £m |
| Elective | £23.05 | £17.71 | (£5.34) |
| Non Elective | £123.29 | £117.89 | (£5.40) |
| Daycase | £31.95 | £30.53 | (£1.42) |
| Outpatients | £32.67 | £37.04 | £4.37 |
| A & E | £28.76 | £29.92 | £1.16 |
| Other-NHS Clinical | £195.88 | £204.52 | £8.65 |
| CQUIN | £0.00 | £0.00 | £0.00 |
| Other Income | £49.67 | £51.96 | £2.29 |
| **Total Income** | **£485.26** | **£489.57** | **£4.30** |
| Pay | (£318.79) | (£318.17) | £0.62 |
| Drug Costs | (£45.79) | (£43.99) | £1.79 |
| Clinical Support | (£38.80) | (£43.82) | (£5.02) |
| Other Costs | (£52.67) | (£56.41) | (£3.74) |
| PFI Costs | (£14.31) | (£14.60) | (£0.30) |
| **Total Expenditure** | **(£470.36)** | **(£477.00)** | **(£6.63)** |
| **EBITDA** | **£14.90** | **£12.57** | **(£2.33)** |
| Non Operating Expenditure | (£32.25) | (£29.91) | £2.34 |
| **Surplus / (Deficit) Adjusted*** | **(£17.35)** | **(£17.34)** | **£0.01** |

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

### DIVISIONS: INCOME AND EXPENDITURE

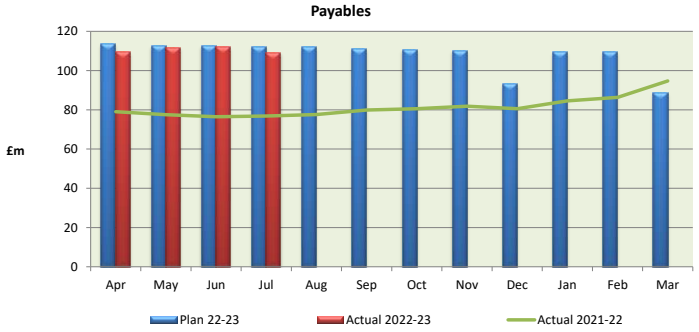
| | Plan | Forecast | Var |
|---|---|---|---|
| | £m | £m | £m |
| Surgery & Anaesthetics | (£100.69) | (£99.41) | £1.27 |
| Medical | (£121.61) | (£130.12) | (£8.51) |
| Families & Specialist Services | (£88.20) | (£85.12) | £3.08 |
| Community | (£27.23) | (£26.84) | £0.39 |
| Estates & Facilities | £0.00 | (£0.00) | (£0.00) |
| Corporate | (£53.03) | (£53.67) | (£0.65) |
| THIS | £1.25 | £1.19 | (£0.07) |
| PMU | £2.43 | £1.23 | (£1.20) |
| CHS LTD | £0.54 | £0.29 | (£0.25) |
| Central Inc/Technical Accounts | £367.18 | £371.21 | £4.02 |
| Reserves | £1.99 | £3.91 | £1.91 |
| **Surplus / (Deficit)** | **(£17.35)** | **(£17.34)** | **£0.01** |

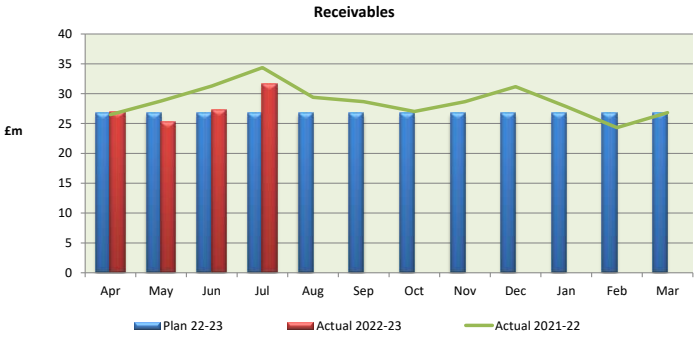
# Total Group Financial Overview as at 31st Jul 2022 - Month 4

## CAPITAL AND CASH COMPARED TO PLAN SUBMITTED TO NHS IMPROVEMENT

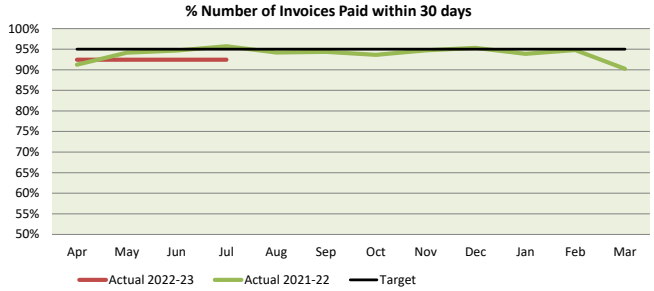
### WORKING CAPITAL

| | M4 Plan £m | M4 Actual £m | Var £m | M4 |
|---|---|---|---|---|
| Payables (excl. Current Loans) | (£112.22) | (£108.96) | (£3.26) | |
| Receivables | £26.70 | £31.64 | (£4.94) | |



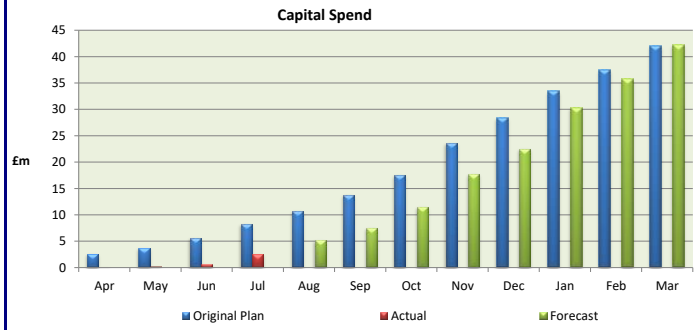




### BETTER PAYMENT PRACTICE CODE



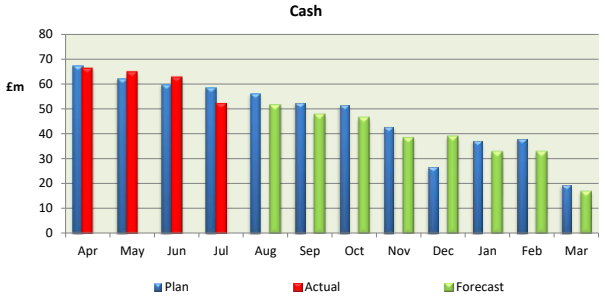

### CAPITAL

| | M4 Plan £m | M4 Actual £m | Var £m | M4 |
|---|---|---|---|---|
| Capital | £8.29 | £2.57 | £5.72 | |

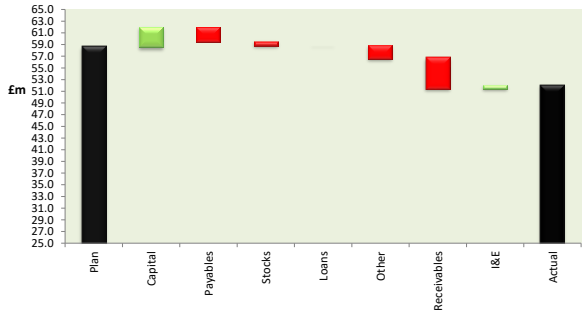



### CASH

| | M4 Plan £m | M4 Actual £m | Var £m | M4 |
|---|---|---|---|---|
| Cash | £58.62 | £52.04 | (£6.58) | |
| Loans (Cumulative) | £16.57 | £16.57 | £0.00 | |




### CASH FLOW VARIANCE




### SUMMARY YEAR TO DATE

- Year to date the Trust is reporting an £8.44m deficit, a £0.46m favourable variance from plan.
- The Trust has delivered additional efficiencies Year to Date of £1.38m, offset to some extent by operational pressures, including additional capacity requirements.
- Funding for 22/23 is based on an Aligned Payment Incentive (API) approach with a fixed element based on agreed activity levels and a variable element to support recovery of elective services. £11.94m of Elective Recovery Funding (ERF) has been assumed in the plan, but is subject to delivery of 104% of 19/20 elective activity.
- £3.40m of ERF has been assumed in the year to date position as planned. Indications are that ERF will not be clawed back for the first half of the year (H1), but this remains a risk going into H2.
- Total planned inpatient activity for the purposes of Elective recovery was 95% of the activity planned year to date.
- Year to date the Trust has incurred costs relating to Covid-19 of £6.36m, £3.21m higher than planned

- Capital expenditure is lower than planned at £2.57m against a planned £8.29m. Capital plans now also including any new leases.
- Year to date the Trust has delivered efficiency savings of £5.76m, £1.38m more than planned.
- NHS Improvement performance metric Use of Resources (UOR) stands at 3 as planned, but the Agency metric is currently worse than planned.

### NOTES

- The Trust plans to deliver a £17.35m deficit for the year. Whilst the Trust is forecasting to deliver this planned deficit, this is looking increasingly challenging and significant mitigation will be required to offset the ongoing operational pressures that have continued into the summer period. The forecast assumes that mitigation of £8.3m is identified to offset these ongoing financial pressures.
- The forecast position assumes full delivery of a challenging £20m efficiency target. At the end of June 22, £19.90m of efficiency had been identified and is forecast to deliver.
- The forecast assumes that the Trust will deliver it's elective activity plan and secure in full £11.9m of Elective Recovery Funding.

- The total loan balance is £16.57m as planned. No further loans are planned for this financial year.
- The Trust is forecasting to spend £42.26m on Capital programmes in this financial year including £2.92m on leases. The £0.27m adverse variance to plan is due to an increase in forecast donated assets (funded through charitable funds).

- The Trust has a cash balance of £52.04m, £6.58m 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 |

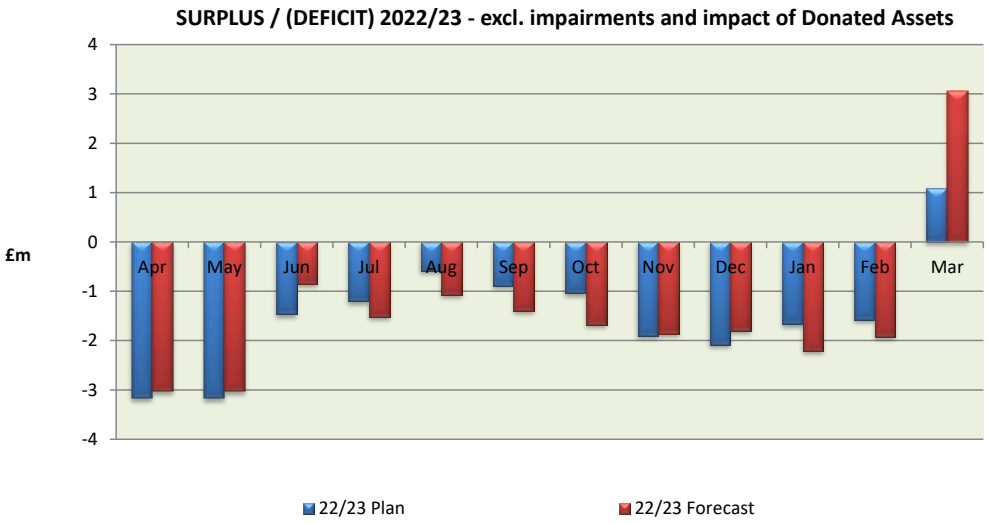
# FORECAST POSITION 22/23

## 22/23 Forecast (31 Mar 23)

| Statement of Comprehensive Income | Plan[2] £m | Forecast £m | Var £m | |
|---|---|---|---|---|
| Income | £485.35 | £489.93 | £4.58 | |
| Pay expenditure | (£318.79) | (£318.17) | £0.62 | |
| Non Pay Expenditure | (£151.58) | (£158.83) | (£7.25) | |
| Non Operating Costs | (£32.68) | (£30.44) | £2.24 | |
| **Total Trust Surplus / (Deficit)** | **(£17.69)** | **(£17.51)** | **£0.18** | |
| Deduct impact of: | | | | |
| Impairments (AME)[1] | £0.00 | (£0.00) | (£0.00) | |
| Donated Asset depreciation | £0.43 | £0.53 | £0.10 | |
| Donated Asset income (including Covid equipment) | (£0.08) | (£0.36) | (£0.28) | |
| Net impact of donated consumables (PPE etc) | £0.00 | £0.00 | £0.00 | |
| Gain on Disposal | £0.00 | £0.00 | £0.00 | |
| **Adjusted Financial Performance** | **(£17.35)** | **(£17.34)** | **£0.01** | |

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

## MONTHLY SURPLUS / (DEFICIT)




- The Trust is forecasting to deliver the revised plan of a £17.35m deficit.
- Both plan and forecast reflect the revised plan that was submitted to NHS Improvement on the 20th June. Additional funding for inflation will flow in the form of an increase in Tariff (additional income).
- Whilst forecasting to deliver this planned deficit, this is looking increasingly challenging and mitigation will be required to offset the ongoing operational pressures that have continued into the summer period. The Trust had planned to close most of the additional capacity wards used over winter by the 1st of June. This capacity remains open and this will continue to drive additional costs over the next few months unless operational pressures ease.
- The additional funding for inflation was required to flow in full to improve the Trust overall financial position and assumed that plans included sufficient funding to cover any pressures. The increase in RPI since March 22 is driving additional inflationary pressures over and above the planned level, particular in relation to Energy costs and the PFI contract. It is also impacting on the ability to achieve planned procurement savings.
- The forecast assumes full delivery of a challenging £20m efficiency target and elements of this plan are also increasingly high risk, particularly those schemes reliant on the exit of Covid-19 costs.
- The Pharmacy Manufacturing Unit did not deliver the planned surplus in the first third of the year and there is a significant risk that the organisation is not successful in recovering this position.
- Vacancies have driven underspends in Community and FSS Divisions in the year to date. A continuation of this position may mitigate the risks above to some extent.
- The forecast continues to assume that the Trust will deliver it's elective activity plan and secure in full £11.9m of Elective Recovery Funding.
- Divisional forecasts suggest that mitigation of £8.3m will have to be identified to offset these operational pressures.

**Risks and Potential Benefits**

- The forecast assumes full delivery of a challenging £20m efficiency target. As at the end of July 22, £19.90m of efficiency has been identified, but around £2m has been flagged as at very high risk of not delivering.
- Indications are that ERF will not be clawed back for H1, but it is not yet clear whether there will be any changes to the current guidelines for H2. Based on current under delivery of Recovery, this remains a risk.
- The details of the funding mechanism for the recently announced pay award have now been released and are being assessed to see if there is any likely shortfall in funding.
- There is a further risk that staffing shortages result in an increase in Bank or Agency rates.
- The Forecast assumes that the current Covid-19 wave peaks in August and that the impact reduces in the early Autumn. There is a risk that Covid-19 impact over the Autumn and Winter period is more severe than expected.

# COVID-19 & Recovery

| Covid-19 Expenditure YTD JUL 2022 | Pay £'000 | Non-Pay £'000 | Total £'000 |
|---|---|---|---|
| Expand NHS Workforce - Medical / Nursing / AHPs / Healthcare Scientists / Other | 438 | 0 | 438 |
| Remote management of patients | 75 | 141 | 215 |
| Increase ITU capacity (incl Increase hospital assisted respiratory support capacity, particularly mechanical ventilation) | 0 | 44 | 44 |
| Segregation of patient pathways | 5,044 | 137 | 5,181 |
| Existing workforce additional shifts | 56 | 0 | 56 |
| Decontamination | 0 | 6 | 6 |
| Backfill for higher sickness absence | 1 | 0 | 1 |
| Remote working for non patient activities | 0 | 0 | 0 |
| PPE - other associated costs | 0 | 0 | 0 |
| Sick pay at full pay (all staff types) | 0 | 0 | 0 |
| Enhanced PTS | 0 | 161 | 161 |
| COVID-19 virus testing - rt-PCR virus testing | 111 | 174 | 285 |
| COVID-19 - Vaccination Programme - Provider/ Hospital hubs | 0 | 0 | 0 |
| COVID-19 - Vaccination Programme - Vaccine centres | 74 | 0 | 74 |
| COVID-19 - Vaccination Programme - Vaccination of Healthy 12-15s (via SAIS) | 0 | 0 | 0 |
| NIHR SIREN testing - antibody testing only | 5 | 1 | 7 |
| COVID-19 - International quarantine costs | 0 | 0 | 0 |
| COVID-19 - Deployment of final year student nurses | 0 | 0 | 0 |
| **Total Reported to NHSI** | **5,804** | **663** | **6,467** |
| PPE - locally procured | 0 | -16 | -16 |
| Other COVID-19 virus / antibody (serology) testing (not included elsewhere) | 268 | -5 | 264 |
| Support for stay at home models | 0 | 10 | 10 |
| Internal and external communication costs | 0 | -1 | -1 |
| **Grand Total** | **6,072** | **651** | **6,723** |

| Recovery Costs YTD JUL 2022 | Pay £'000 | Non-Pay £'000 | Total £'000 |
|---|---|---|---|
| Independent Sector | 710 | 4 | 714 |
| Additional Staffing - Medical | 0 | 675 | 675 |
| Additional Staffing - Nursing | 0 | 98 | 98 |
| Additional Staffing - Other | 0 | 355 | 355 |
| Non Pay | 1,622 | 0 | 1,622 |
| Enhanced Payment Model - Medical | 0 | 0 | 0 |
| Enhanced Payment Model - Nursing | 0 | 231 | 231 |
| **Total** | **2,332** | **1,363** | **3,695** |

**Covid-19 Costs**

Year to date the Trust has incurred £6.72m 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 £6.36m versus a plan of £3.15m, an adverse variance of £3.21m. This overspend was driven by higher than planned Covid-19 related activity leading to higher staffing and consumables costs and delays in closing additional Medical capacity. Outside of envelope costs are highlighted in the table to the left and total £0.37m year to date.

Planning is underway for the Autumn Covid-19 vaccination programme and it has been indicated that funding will be provided on a fixed cost per vaccine basis.

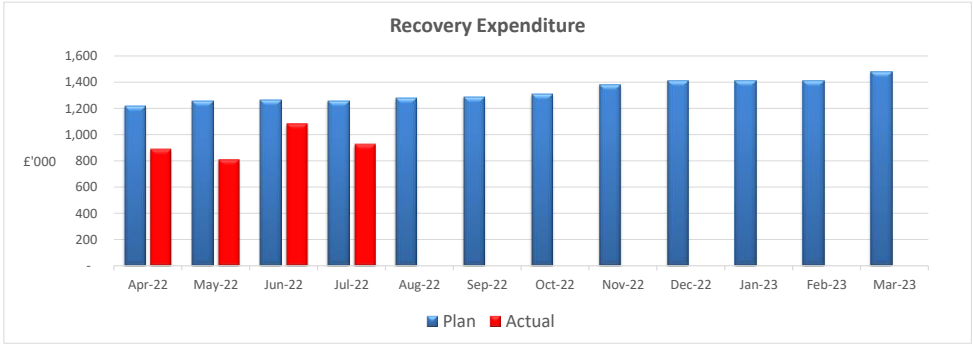
**Covid-19 Funding**

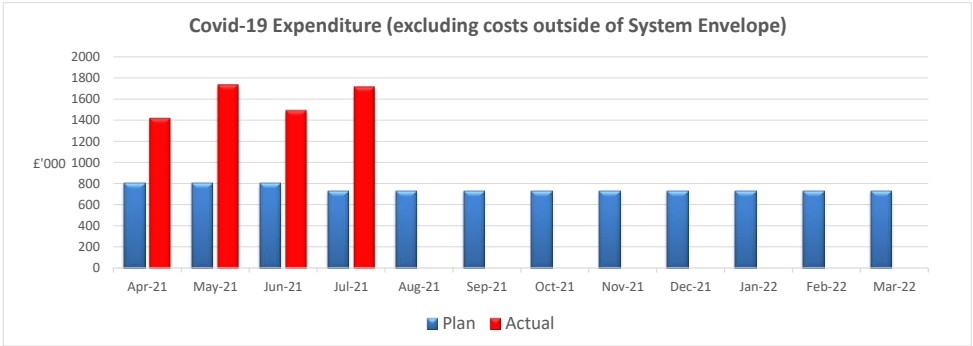
The Trust has been allocated block funding by the ICS to cover any ongoing Covid-19 costs and associated impacts totalling £5.90m for the year (£1.97m year to date).

**Recovery**

- Year to date Recovery costs are £3.70m, £1.30m lower than planned.
- Total planned Recovery costs for the year are £15.97m to deliver the required 104% of 19/20 activity.
- Funding of £11.9m of Elective Recovery Funding (ERF) is assumed for the year, receipt of which is reliant on the Trust achieving it's activity targets as planned. £3.40m of ERF has been assumed in the year to date position as planned. This income has been assumed as instructed by the Integrated Care Board (ICB) in order to ensure a consistent approach across Providers and Commissioners. Indications are that ERF will not be clawed back for the first half of the year (H1), but this remains a risk going into H2, as activity year to date was below the planned level and some claw back might be required if the Trust is unable to catch up this activity in future months.

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



# A Workforce for the Future

# 12. Progress with Staff Survey Action Plan

To Note

Presented by Suzanne Dunkley and Jason Eddleston

Calderdale and Huddersfield NHS Foundation Trust

| | |
|---|---|
| **Date of Meeting:** | Thursday 1 September 2022 |
| **Meeting:** | Public Board of Directors |
| **Title:** | Staff Survey/Board One Culture of Care Commitments Review |
| **Author:** | Jason Eddleston, Deputy Director of Workforce and Organisational Development |
| **Sponsoring Director:** | Suzanne Dunkley, Executive Director of Workforce and Organisational Development |
| **Previous Forums:** | None |

**Purpose of the Report**

This paper provides an opportunity for the Board of Directors to review progress in implementing the actions identified in response to the Trust's 2021 staff survey results and the leadership commitments it made at its meeting on 5 May 2022 to embedding One Culture of Care.

**Key Points to Note**

- The Trust's 2021 staff survey results were received by the Board at its meeting on 5 May 2022.
- The Board considered its leadership role in driving improvements to the colleague Experience and agreed a number of commitments to help embed One Culture of Care.
- The commitments to One Culture of Care made by the Board have been translated into practical actions through a 'how to' guide.
- High impact actions were identified to respond to the colleague feedback offered through the staff survey.
- The actions are identified in a 'plan on a page' and align to the Trust's refreshed People Strategy received by Board at its July meeting.
- The significant majority of actions have been completed or initiated.
- A more detailed action plan is overseen by the Workforce Committee
- Additionally, divisional focused responses to our survey feedback are received by the Executive Board at its 'people' theme meetings.
- Our core approach to facilitating a positive colleague experience is described in the People Strategy, the annual staff survey results (and quarterly People Pulse survey feedback) inform the approach to what we do and tell us our people strategy is relevant focusing on and dealing with what matters most to our colleagues and if we are making a positive difference to their work life experience.
- Improvements/activities set out in the People Strategy will take 3 to 5 years to embed and impact our staff survey scores.
- The activity identified in the plan on a page helps provide clarity to our leaders and managers about the importance of leadership visibility, colleague engagement, health and wellbeing and inclusion.
- The next staff survey is launched in September 2022 and preparations have been made to encourage participation and celebrate success and improvement since the 2021 survey.
- Significant operational service delivery challenge post-pandemic and impacts on the cost of living of higher levels of inflation which will undoubtedly influence how colleagues feel a bout their employment and experience in the Trust.

| EQIA – Equality Impact Assessment |
| --- |
| The equality impact for specific actions will be assessed, considered and mitigated as appropriate. |
| **Recommendation** |
| The Board of Directors is asked to **NOTE** the content of the paper and to consider if it is progressing, individually and collectively, the commitments it made at its meeting on 5 May 2022. |

**CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST**

**BOARD OF DIRECTORS**

**1 SEPTEMBER 2022**

**STAFF SURVEY/BOARD ONE CULTURE OF CARE COMMITMENTS REVIEW**

## 1. PURPOSE

This paper provides an opportunity for the Board of Directors to review progress in implementing the actions identified in response to the Trust's 2021 staff survey results and the leadership commitments it has made to embedding One Culture of Care.

## 2. INTRODUCTION

The Trust's 2021 staff survey results were received by the Board at its meeting on 5 May 2022. In the proposed response, the Board considered its leadership role in driving improvements to the colleague experience and agreed the following:-

- One Culture of Care – only show in town. As a Board let's be clear what we're asking our senior leader to focus on.
- Every Board member to be a sponsoring director for a service or a clinical division ie mentor, critical friend, working alongside the Divisional Directors and Directors of Operations.
- If not us, who? Hold ourselves/each other to account, with a governance framework wrapped around that.
- The people agenda is not solely owned by Workforce and Organisational Development, how can you hold your leaders to account for balancing operational/financial challenges with the people experience challenge.
- Add One Culture of Care to meeting agenda as a standing item - discuss and provide examples of how people are feeling/and hold our leaders to account to drive fundamental change in 'hot spot' areas.
- Values and Behaviours – get behind them, make them real, praise good examples/call out poor examples.
- Visibility - ie general walkarounds, Back to the Floor, tea trolley enabling an understanding of the pressures first hand.
- Leadership conference – this is a 'must do'. Are our current leaders up for the challenge? If not, is CHFT the place for them?

## 3. 2021 STAFF SURVEY RESULTS RESPONSE

When reviewing the feedback from colleagues secured through the survey consideration was given to how the Trust improves its staff engagement score, a significant 'workforce health check' in the survey. A response designed as a plan on a page was developed to capture high impact actions. This is at Appendix 1. The significant majority of actions/ activities identified have been completed or initiated. A more detailed action plan is overseen by the Workforce Committee. Additionally, divisional focused responses to our survey feedback are received by the Executive Board at its 'people' theme meetings.

All the actions align to our People Strategy centred around One Culture of Care, a 5-year plan with a formal review each year overseen by the Workforce Committee. The Board received the 'refreshed' strategy at its meeting in July 2022. The strategy will be reviewed by the Committee in June 2023 when it assesses progress towards a survey staff

engagement score of 7. Our core approach to facilitating a positive colleague experience is described in the strategy, the annual staff survey results (and quarterly People Pulse survey feedback) will inform the approach to what we do and tell us our people strategy is relevant focusing on and dealing with what matters most to our colleagues and if we are making a positive difference to their work life experience.

The survey enables a regular touch point with colleagues to track the progress of our commitments and priorities in the People Strategy. The Board acknowledges the improvements/activities set out in the People Strategy will take 3 to 5 years to embed and impact our staff survey score. The engagement activity identified in the plan on a page helps provide clarity to our leaders and managers about the importance of leadership visibility, colleague engagement, health and wellbeing and inclusion. The backdrop for this is significant operational service delivery challenge post-pandemic and impacts on the cost of living of higher levels of inflation which will undoubtedly influence how colleagues feel about their employment and experience in the Trust.

The next staff survey is launched in September 2022 and preparations have been made to encourage participation and celebrate success and improvement since the 2021 survey.

## 4. BOARD ONE CULTURE OF CARE COMMITMENTS

The commitments to One Culture of Care made by the Board at its meeting on 5 May 2022 have been translated into practical actions through a 'how to' guide. This is at Appendix 2. The guide enables a simple assessment of whether the Board is leading One Culture of Care in the way it anticipated/planned to and to evolve/refine the approach/actions based on its experience.

## 5. CONCLUSION

The Board of Directors is asked to note the content of the paper and to consider if it is progressing, individually and collectively, the commitments it made at its meeting on 5 May 2022.

**Suzanne Dunkley**
**Director of Workforce and Organisational Development**

**17 August 2022**

# How do we improve our Staff Survey Engagement Score?

6.7 → 7.0

Appendix 1

Calderdale and Huddersfield NHS Foundation Trust

Our people strategy is a 5-year plan with a formal review overseen by the Workforce Committee each year. Progress will next be formally assessed by it in June 2023 when we review our progress towards a staff engagement score of 7. A full refresh review will be undertaken at year 3. We will regularly monitor a range of indicators so that the 'people health' of the organisation is tested. Our annual staff survey results and quarterly People Pulse survey results will inform our approach to what we do and tell us our people strategy is relevant focusing on and dealing with what matters most to our colleagues. It will tell us if we are making a positive difference to their work life experience

## REALITY

## RESPONSE

## RESULT

| WHAT ARE THE 7 HIGH IMPACT ACTIONS THAT WILL IMPROVE OUR SURVEY SCORE? | THIS MEANS WE STILL HAVE WORK TO DO TO… | THE SPECIFIC ACTIONS TO DELIVER ARE….. | WHEN WILL THE ACTIONS BE DELIVERED BY? | HOW WILL WE ENSURE A GOLDEN THREAD OF ACTIVITY? | WHAT IS OUR END GOAL / PURPOSE? |
|---|---|---|---|---|---|
| 1. Embed One Culture of Care (OCOC) | • Challenge behaviour<br>• Develop OCOC in all we do<br>• Develop clear ✓ and X of behaviours | • Refresh Values and Behaviours<br>• Develop OCOC Charters (in ALL teams and services)<br>• Ensure OCOC is discussed in all meetings by having a standard agenda item<br>• Refresh our People Strategy to make a firm commitment to OCOC<br>• Refresh our Wednesday morning leadership sessions giving more focus to OCOC leadership and expectations | • May 2022 ✓<br>• July 2022 ✓<br>• July 2022 ✓<br>• May/June 2022 ✓<br>• June 2022 ✓ | | To provide compassionate care to the communities we serve |
| 2. Develop a sense of team, maximising engagement, and collaboration with colleagues | • Roll out more Work Together Get Results (WTGR) training<br>• Facilitate WTGR sessions across services and staffing groups<br>• Hold more Trust wide events | • Trust choir<br>• Wellbeing Festival including a wellbeing hour 'vote'<br>• Hot House and mini (DIY) Hot House<br>• Executive and senior team WTGR training<br>• Team Engagement and Development (TED) diagnostic roll out<br>• Fast-track to Occupational Health for unwell colleagues (Health and Wellbeing Risk Assessment) | • June 2022 ✓<br>• 27-31 May 2022 ✓<br>• April 2022 – March 2023<br>• May 2022 – April 2023 | | **HOW WILL WE MEASURE OUR PROGRESS?**<br>• Workforce Committee<br>• Performance Review Meetings<br>• Staff Survey/Pulse<br>• Absence<br>• Turnover<br>• Compliance<br>• Workforce Race Equality Standard (WRES)<br>• Workforce Disability Standard (WDES)<br>• Freedom to Speak Up (FTSU)<br>and ultimately ……<br>• Accident & Emergency performance<br>• Friends and Family test<br>• Referral to Treatment Time (RTT)<br>• Cancer |
| 3. Invest in colleague health and wellbeing and encourage self-care | • Wellbeing events<br>• Appraisal refresh - owned by colleague | • Welfare packs<br>• Appraisal quality audit and relaunch<br>• 24/7 helpline<br>• Bespoke wellbeing sessions and programmes in each team<br>• Bespoke 'wrap around' programmes | • In place ✓<br>• June 2022 ✓<br>• In place ✓<br>• In place ✓<br>• In place ✓ | | |
| 4. Invest in leadership and management development and service improvement, confirming clear expectations of leadership behaviour | • Improve our leadership visibility<br>• Develop people skills of managers<br>• Focus on compassionate leadership<br>• Roll out Executive development<br>• Roll out Board development | • Launch a series of management guides to assist with key people management issues (visibility, wellbeing, inclusive leadership, what is a leader/manager, what does OCOC mean for leaders/managers)<br>• A leadership conference focused on commitments required from leaders and managers<br>• Leadership Development programme and coaching relaunched<br>• Leadership walk rounds – clear management requirements including framework for walkarounds<br>• Launch an engagement calendar focused on key dates around staff survey launch<br>• WTGR training | • July 2022 ✓<br>• Spring/Autumn<br>• In place ✓<br>• July ✓<br>• June ✓<br>• In place ✓ | All activities are aligned with our People Strategy, One Culture of Care and A workforce fit for the future CHFT 10-year plan | |
| 5. Create opportunities for all colleagues to develop and learn | • Improved learning and coaching opportunities for all colleagues | • Relaunch Leadership/Management development programme<br>• Empower programme<br>• Talent Toolkit<br>• Compassionate leadership module<br>• 'Development for All' reference guide to learning opportunities<br>• WTGR training for all<br>• Equality, Diversity and Inclusion educational/awareness resources, toolkits and workshops | • In place ✓<br>• In place ✓<br>• June 2022 ✓<br>• In place ✓<br>• In place ✓<br>• In place ✓<br>• October 2022 | | |
| 6. Celebrate achievements and show appreciation | • Celebration events across the Trust | • Wellbeing event focused on support on offer and wellbeing hour 'vote'<br>• Appreciation event (1)<br>• Appreciation event (2)<br>• Annual awards ceremony<br>• Local 'CHuFT' appreciation toolkit | • 27-31 May 2022 ✓<br>• 29 June – 1 July 2022 ✓<br>• September 2022<br>• November 2022<br>• June 2022 ✓ | | |
| 7. Adopt a positive and proactive approach to the management and communications of the staff survey | • Roll out of staff survey and comms<br>• Underperforming teams – key focus and/or ask to fill Team Engagement and Development (TED) instead | • 'Your opportunity to shine as a team'<br>• Further thank you event<br>• 'You said we did' campaign<br>• Appraisal and burn out specific comms and activity<br>• OCOC 'takeover' brand immersion<br>• Board sponsor for each service in need | • June 2022 ✓<br>• December 2022<br>• In place ✓<br>• June 2022 ✓<br>• July 2022 ✓<br>• May/June/July 2022 ✓ | | |

One Culture of care

Appendix 2

NHS
Calderdale and Huddersfield
NHS Foundation Trust

# Board Of Directors One Culture Of Care 'How To Guide'

## (Translating commitments to One Culture of Care into action)

For more information please contact:

| | |
|---|---|
| **Email** | ODTeam@cht.nhs.uk |

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Appendix 2

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NHS Foundation Trust

**Our Vision:**
Together we will deliver outstanding compassionate care for our patients and One Culture of Care for our colleagues

**One Culture of Care:**
Caring for each other the same way we care for our patients.


**Our Behaviours:**

- I'll step in others' shoes and I'll be kind, welcoming and helpful to all
- I'm committed to improving services and I'll go see examples of good practice
- I'm respectful of others. I'll support diversity and inclusion
- I'll role model the must dos to keep everyone safe and well

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Appendix 2

NHS Calderdale and Huddersfield NHS Foundation Trust

**BOARD OF DIRECTORS ONE CULTURE OF CARE 'HOW TO GUIDE'**
**(translating commitments to One Culture of Care into action)**

| **Commitment** | **Action** | **What's expected?** | RAG |
|---|---|---|---|
| One Culture of Care – only show in town. As a Board let's be clear what we're asking our senior leader to focus on. | Each Board of Directors meeting to include a One Culture of Care agenda item.<br><br>Board to consider and measure activity against a One Culture of Care Well Led checklist in its discussions.<br><br>The Board to support the Team Engagement and Developlement (TED) diagnostic tool.<br><br>The Board to support the Work Together to Get Results (WTGR) toolkit | • A full discussion at each Board of Directors meeting about progress to embed One Culture of Care. The agenda item to focus on enquiry to determine if Board members have observed evidence regarding the following:-<br>There are cooperative, supportive and appreciative relationships where colleagues and teams work collaboratively and share responsibility (Culture).<br>There are mechanisms for providing all colleagues at every level with organisation 'need to know' news (Communications).<br>There is accountability at all levels for ensuring compassionate, inclusive and effective leadership (Leadership and management).<br>• The Board to adopt and utilise the One Culture of Care Well Led checklist.<br>• The Board to complete the TED survey and design a response plan against which progress will be monitored.<br>• Board members to participate (new or as a refresh) in the WTGR learning programme. | |
| Every Board member to be a sponsoring Director for a service or a clinical division ie mentor, critical friend, working alongside the Divisional Directors and Directors of Operations | Each Board member with the exception of Chair and Chief Executive will partner with a service area (eitheer hotspot of division) as follows:-<br><br><u>Hotspot areas</u><br>Emergency Care Lindsay Rudge<br>HPS Vicky Pickles<br>Medical Specialities Gary Boothby<br>Operating Services Jo Fawcus<br>Orthopaedics Suzanne Dunkley<br>Radiology Anna Basford<br>Womens David Birkenhead | • A minimum of 3 walkarounds (general visit/walkaround, planned visit/walkaround, tea trolley, back to the floor session) every 6 months.<br>• A critical review against progress of the the 2021 staff survey information pack for the area the Board colleague is partnering.<br>• An initial meeting with the divisional/service senior team to review the 2021 staff survey response plan and discuss how the Board colleague will work with them.<br>• A contract between the two parties regarding what support is required and what action will be taken to deliver the survey response.<br>• The Board memberto use the One Culture of Care Well Led checklist during walkarounds.<br>• Board members will share what they have observed with the senior team to support improvements and celebrate successes. | |

| | | | |
|---|---|---|---|
| | <u>Divisions</u><br>FSS Denise Sterling<br>Medical Andy Nelson<br>Community Karen Heaton<br>S&A Peter Wilkinson<br>Corporate (Workforce and OD, THIS, Finance, Quality) Richard Hopkin | | |
| If not us, who? Hold ourselves each other to account, with a governance framework wrapped around that. | Board of Directors One Culture of Care agenda item<br><br>One Culture of Care Well Led Checklist<br><br>Appraisal | • In the course of discussing this agenda item Board members to feedback on whether One Culture of Care was demonstrated within the meeting and what could be improved.<br>• A One Culture of Care Well Led checklist to be submitted for each formal Board meeting capturing activity, feedback collated during the course of walkrounds, discussions with the senior team on how they can work together and prompt discussion at the Board.<br>• One Culture of Care values and behaviours to be an essential feature of Board member appraisal conversations. An assessment to be made within the conversation in relation to delivery against the Board commitments. | |
| The people agenda is not solely owned by Workforce and Organisational Development, how can you hold your leaders to account for balancing operational/financial challenges with the people experience challenge | An annual Board One Culture of Care self-assessment. | • A self-assessment to be completed by Board members (reflection over the past 12 months – has the Board done enough to balance the three challenges? Has one area of focus been a priority over another? Why? What consequence has this had? What learning can be taken and applied to improve Board performance over the next 12 months?).<br>• A Board development session to be scheduled to consider the self-assessment responses and a response plan agreed.<br>• Monitoring of the response plan at formal Board meetings. | |

| | | | |
|---|---|---|---|
| Add One Culture of Care to meeting agenda as a standing item - discuss and provide examples of how people are feeling/and hold our leaders to account to drive fundamental change in 'hot spot' areas | One Culture of Care agenda item.<br><br>Intensive care wraparound support for 'hot spot' service areas | • A minimum of 3 walkarounds (general visit/walkaround, planned visit/walkaround, tea trolley, back to the floor session) every 6 months.<br>• A critical review against progress of the the 2021 staff survey information pack for the area the Board colleague is partnering.<br>• An initial meeting with the divisional/service senior team to review the 2021 staff survey response plan and discuss how the Board colleague will work with them.<br>• Board member to sponsor adoption of the TED diagnostic tool (results from the diagnostic to be shared with the team, a development plan created and the diagnostic to be run again in 12 weeks to determine areas of improvement/deterioration.<br>• Board members to review TED results prior to the launch of the 2022 staff survey. | |
| Values and Behaviours – get behind them, make them real, praise good examples/call out poor examples | Tea Trolley/walkrounds.<br><br>Values and Behavious charter visible and discussed at senior meetings | • Board members to initiate/host general discussion with colleagues regarding the values and behaviours<br>• Board members to check to see if a values and behaviours charter is visible<br>• Board members to check-in with senior leaders that meeting agenda celebrate and cascade good practice examples and review examples of poor practices and drive improvement. | |
| Visibility - ie general walkarounds, Back to the Floor, tea trolley enabling you to understand the pressures first hand | Tea Trolley/Back to the Floor/general visibility /walkrounds | • Board members to check-in/engage with colleagues using the One Culture of Care Well Led checklist. Examples of areas for discussion to initiate feedback include:-<br>What does a good day look like?<br>What does a not so good day look like?<br>Why is CHFT a great place to work?<br>What could make it even better?<br>What is stopping us from making this place a great place to work?<br>What support do they need from you to make that happen? | |
| Leadership conference, this is a 'must do'. Are our current leaders up for the challenge? If not, is CHFT the place for them? | Establish a Spring/Autumn Leadership conference programme. | • Board member attendance and participation in Spring and Autumn leadership conference as speakers, delegates and/or facilitators. | |

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# WELL LED CHECKLIST

## Engaging with our colleagues to promote our vision, values and behaviours to support One Culture of Care.

For more information please contact:


| Email | ODTeam@cht.nhs.uk |
|---|---|

Appendix 2

**One Culture of care**

**Calderdale and Huddersfield NHS Foundation Trust**

**Our Vision:**
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NHS Foundation Trust

Date of Visit:

Service area:

No of colleagues spoken to:

Summary:

| Task | Comments | Action | RAG |
|---|---|---|---|
| | | | |
| **Culture** | | | |
| Are colleagues aware of the values and behaviours and do they have a charter? | | | |
| Are colleagues aware of the CHuFT channels to recognise one another? | | | |
| Are colleagues aware of appraisals and access to development? | | | |
| Do colleagues have access to opportunities to further develop their role? | | | |
| Do colleagues regularly see the vacancies on offer at CHFT | | | |
| Are colleagues aware of the wellbeing support available and how to access this? | | | |
| Do colleagues believe that they 'belong' and feel part of the team? | | | |
| Do colleagues believe they can make improvements, contribute to change, speak up? | | | |
| Are colleagues able to participate in networks ie equality networks/wellbeing networks outside their day to day role? | | | |
| | | | |
| **Communications & Engagement** | | | |
| Do regular team briefs/huddles take place and do colleagues find them valuable? | | | |
| Board to ward comms – are colleagues aware of general organisation news updates? | | | |
| Do colleagues get a chance to see CHFT Live, CHFT news, Brendan Brown's Friday blog? | | | |
| | | | |
| **General Management** | | | |
| Do colleagues regularly see their leaders and do leaders engage or pass through? | | | |
| Do managers speak about the values and behaviours? | | | |
| Do colleagues have opportunity to take regular breaks? | | | |
| Do colleagues receive ongoing feedback from managers regarding their performance | | | |
| Do colleagues generally leave on time? | | | |
| Do managers hold regular appraisals and have they discussed the development for all offer? | | | |

# 13. Health and Wellbeing Update

To Note

Presented by Suzanne Dunkley

NHS
Calderdale and Huddersfield
NHS Foundation Trust

| | |
|---|---|
| **Date of Meeting:** | Thursday 1 September 2022 |
| **Meeting:** | Public Board of Directors |
| **Title:** | Colleague Health and Wellbeing Update |
| **Author:** | Nikki Hosty, Assistant Director of Human Resources |
| **Sponsoring Director:** | Suzanne Dunkley, Executive Director of Workforce and Organisational Development |
| **Previous Forums:** | None |

**Purpose of the Report**

This paper provides an opportunity for the Board of Directors to review colleague health and wellbeing activity undertaken since January 2022 and be sighted on the continued approach to support One Culture of Care.

**Key Points to Note**

- The Trust's enhanced colleague health and wellbeing support focuses on mental, physical, social and financial aspects
- A first wellbeing festival was held in May/June 2022 connecting with 400 colleagues
- An appreciation event was held in July 2022, 572 colleagues said thank you and/or confirmed their appreciation of others
- Through the wellbeing festival colleagues shared views about and confirmed they wish to retain the wellbeing hour
- Simplified guidelines to support wellbeing hour implementation are to be issued 5 September 2022
- The Trust wellbeing offer is being strengthened, it is aligned to our refreshed People Strategy.

**EQIA – Equality Impact Assessment**

The equality impact for specific actions will be assessed, considered and mitigated as appropriate.

**Recommendation**

The Board of Directors is asked to **NOTE** the content of the paper and continue its support for colleague health and wellbeing.

**CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST**

**BOARD OF DIRECTORS**

**1 SEPTEMBER 2022**

# COLLEAGUE HEALTH AND WELLBEING UPDATE

## 1. PURPOSE

This paper provides an opportunity for the Board of Directors to review colleague health and wellbeing activity undertaken since January 2022 and be sighted on the continued approach to support One Culture of Care.

## 2. INTRODUCTION

In 2020, the Trust committed to establishing enhanced health and wellbeing support for our colleagues, ensuring One Culture of Care is at the heart of the approach.

The approach focuses on 4 areas:-

- Mental
- Physical
- Social
- Financial

The case for supporting colleague wellbeing is well established - people are more likely to remain in their employment, recruiting talent is easier, individuals are engaged in what the organisation is about, and colleagues are more content and productive at work. The Trust's approach is to co-produce our offer with our colleagues, to understand what matters and what is important to them and importantly, what will have the biggest positive impact. There is also recognition that social and economic factors outside of the Trust's direct control impacts our colleagues and the approach adopted to date is cognisant of that. Our People Strategy has been refreshed, it includes a dedicated wellbeing chapter and identifies wellbeing as a core theme in its overall content. Our values and behaviours refresh includes a fundamental shift to 'we put people first' to ensure we retain a focus on our colleagues' wellbeing in its widest sense.

## 3. HEALTH AND WELLBEING/ENGAGEMENT EVENTS

The Trust has held two events so far in 2022 to engage colleagues in appreciation, celebration and health and wellbeing including hosting virtual events dedicated to our homeworking colleagues.

The events focused attention on face to face and virtual positive connectivity, signposting colleagues to support, asking for suggestions regarding what support colleagues need going forward and having some fun along the way. Headlines from the events include:-

- Our wellbeing festival in May/June connected with 400 colleagues including a session for homeworkers
- It enabled a discussion regarding the future of the wellbeing hour, with 370 colleagues voting on it
- Discussion about the content of our refreshed People Strategy and our values and behaviours sharing how we aim to embed a positive, inclusive and healthy culture

- Festival focused attention on our four primary themes (physical, mental, social, financial) with significant signposting for colleagues to the available services and support
- Our Appreciation event generated participation from 575 colleagues including a session for homeworkers
- The event focused attention on appreciating colleagues in the here and now and sharing information about how to nominate a colleague for the CHuFT Star and Annual awards
- Engaged with colleagues asking for suggestions regarding what we can do better, having some fun along the way, with colleagues loving the thank you cards
- 287 hard copy thank you cards posted, 292 appreciation messages sent via email.

## 4. WELLBEING HOUR

The wellbeing hour was launched during the first year of the pandemic, principally to give those colleagues who had limited flexibility an opportunity to recharge and focus on wellbeing. The hour is popular with colleagues albeit some service areas have experienced significant difficulties in implementing it. At our Health and Wellbeing Festival, colleagues voted on whether to keep the wellbeing hour. The outcome of the vote was to keep it. Changes to the approach were suggested by colleagues that should mean more people can benefit from it. We continue to engage with leaders and managers to work together to deploy the wellbeing hour, so it is accessible to as many as our colleagues as possible. Simplified guidelines, operational from 5 September 2022, have been designed that support the following:-

- It is inclusive to all
- The hour is available for 1 hour per week (pro rata for less than full time colleagues)
- There can be no 'banking' of time or carry over
- The hour is not rostered/job planned or contractual and flexes with the needs of the service
- The wellbeing hour will not generate a cost and will not be costed the principal benefits of the hour come from the discussion between both parties and the ability to be flexible.

The intention is to support access irrespective of role, service or location.

## 5. STRENGTHENING OUR HEALTH AND WELLBEING OFFER

Our offer is at Appendix 1. All our health and wellbeing activities align to the People Strategy.

Current activities include:-

- Leaders actively leading wellbeing, equipping managers with the right skills and capabilities to support their own wellbeing and that of those around them
- Leadership visibility, create time and space to talk, positive behaviours, understanding impact, be present, authentic and empathetic
- Refreshed appraisal approach including wellbeing check-in including improved conversations regarding colleague development
- Local appreciation toolkits, tools and resources to thank people in the 'here and now'
- Values and behaviours charters to support a happy and healthy team where we work together to get results
- Engaging, clear communications designed with the colleague in mind, with input from the workforce psychologist
- Wellbeing and engagement calendar of events
- Enhance top up shops and support for financial wellbeing

- Our leaders have participated in wellbeing into the heart of conversations awareness sessions and a management guide has been produced
- We have worked with the 150 colleagues volunteering as Wellbeing Ambassadors in 2020. Supportive dialogue has taken place with each volunteer and 53 colleagues wish to continue in the role. All 53 have undertaken 'recognising signs of trauma training' delivered by Socrates, an external psychology service
- All leadership development programmes include a 'wellbeing' module
- Financial education
- Friendly ear service well utilised with support from our partners West Yorkshire Mental Health and Wellbeing Hub, Care First, our Employee Assistance Programme provider and Socrates.

Our activity plans for the future include:-

**Mental**
- Workforce psychologist working closely with service/line managers to support debriefs, bereavements, suicide intervention, communications and complex cases
- Career guidance sessions
- Debrief and listening ear sessions
- Podcasts
- Halsa on-line wellbeing sessions.

**Physical**
- Ergonomic guidance and advice for homeworkers
- On site massage, reflexology, wellness kiosk ('Let's get healthy' stalls)
- Dance/exercise classes (every Tuesday evening 5pm to 6pm)
- Infuse your water (handing out lemons, oranges, mint to give water a refreshing lift)
- Great Wall of China/Kilimanjaro /Ben Nevis step challenge (or a local landmark)/UK cycle challenge
- Sports day/football tournament (2 September 2022)
- Meatless Monday in our on-site restaurants.

**Financial**
- Salary Finance partnership
- Financial education stalls (supported by Salary Finance and local financial organisations)
- Financial webinars supported by our Employee Assistance Programme provider, Care First
- Increase communications around workplace benefits
- Top Up Shop
- Clothing banks.

**Social**
- Volunteering in the local community (offer 1 day a year to all colleagues to support local organisations)
- Create a healthy workplace cookbook (published recipes will receive a £5 gift voucher)
- Art classes (engage local artists to pop in and meet the team)
- Crochet/knitting classes (led by the Pride network)
- Film/Book clubs
- Cooking classes (engage local restaurants).

## 6. CONCLUSION

The Board of Directors is asked to note the content of the paper and continue its support for colleague health and wellbeing.

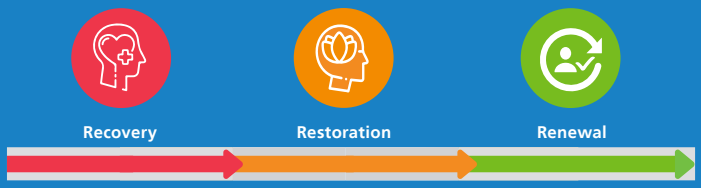
**Suzanne Dunkley**
**Director of Workforce and Organisational Development**

**19 August 2022**

Appendix 1

Calderdale and Huddersfield NHS Foundation Trust

# Health and Wellbeing Strategy




## Colleagues may be feeling

| Recovery | Restoration | Renewal |
|---|---|---|
| Tired and exhausted, mentally and physically | Unprepared to move forward or desperate to move forward | Hopeful |
| Anxious of things outside their control – fuel and energy costs | Continuing need to discuss the impact of the last few years on them | Afraid of change |
| Angry, demoralised and hard done to I/me not we/us – assess the difference in perceived contribution | Mismatch with colleagues feelings – some may be excited, others may be fearful of change | Team focused |
| Requiring clarity and direction | Requiring a 'new start' change of role/career/ way of life | |
| Owed recompense for their loss/pain | Inpatient with the pace of change<br>Excited, engaged | |
| Low levels of energy and enthusiasm | 'Left behind' | |
| Desperate to move forward | Resurgence of concentration on patient and compassion and care | |
| Resigned to how things are | Divergence in colleagues opinions on the future direction of services | |
| Thankful for relationships and teams | Weary – have seen change before | |
| Some may not be troubled at all and become frustrated with those that are | | |
| **What should our response be?**<br>• Connectivity & Engagement Events ie Festivals/Stalls<br>• Leadership visibility, create time and space to talk, positive behaviours, understanding impact, be present, authentic and empathetic<br>• Dedicated wellbeing sessions for homeworkers ie ergonomics for homeworkers | **What should our response be?**<br>• Work Together Get Results approach<br>• Compassionate leadership activity/sessions<br>• Leaders leading wellbeing, equipping managers with the right skills and capabilities to support their own wellbeing and that of those around them<br>• Engaging, clear communications designed with the colleague in mind, with input from the workforce psychologist<br>• Focus on personal development | **What should our response be?**<br>• Celebration and appreciation events<br>• Partnership/Community Engagement - Volunteering in the local community - Give 1 day a year to all colleagues to support local organisations<br>• Workforce psychologist working closely with line managers to support with debriefs, bereavements, suicide intervention, communications and complex cases |
| **Support on offer**<br>• Refreshed People Strategy<br>• Refreshed appraisal approach including wellbeing check-in including improved conversations regarding colleague development<br>• Wellbeing ambassadors<br>• All leadership development programmes include a 'wellbeing' module<br>• Friendly ear service well utilised with support from our partners West Yorkshire Mental Health and Wellbeing hub, Care First (Employee Assistance Programme) and Socrates<br>• Halsa on line wellbeing sessions<br>• Top up shops<br>• Wellbeing Hour<br>• Financial Education & support around Financial<br>• Salary Finance Partnership | **Support on offer**<br>• Our leaders have participated in wellbeing into the heart of conversations awareness sessions and a Mini-Hot House toolkit has been produced<br>• Development for all offer<br>• Empower<br>• Career guidance workshops inc. interview and application form connect and learn sessions<br>• Wellbeing & Engagement calendar of events<br>• Maths and English workshops<br>• Debrief & Listening ear sessions<br>• Dance/Exercise classes - every Tuesday evening 5 – 6pm<br>• Sports Day/Football Tournament - 2nd September 2022<br>• Clothing top up shops<br>• Podcasts<br>• Equality Networks | **Support on offer**<br>• Regular celebration events<br>• Local Appreciation toolkits, tools and resources to thank people in the 'here and now'<br>• Organisation wide appreciation/thank you events<br>• Values and Behaviours charters to support a happy and healthy team where we work together to get results<br>• On site massage, reflexology, wellness kiosk (Lets get healthy stalls)<br>• Meatless Monday in the restaurants<br>• Create a healthy workplace cookbook – any recipes published in the book will receive a £5 gift voucher<br>• Cooking/Art classes – engage local people from the community to pop in and meet the team |

# Keeping the Base Safe

# 14. Freedom to Speak Up Annual Report Presented by Andrea Gillespie, Freedom to Speak Up Guardian

To Note

Presented by Suzanne Dunkley

| | |
|---|---|
| **Date of Meeting:** | Thursday 1 September 2022 |
| **Meeting:** | Public Board of Directors |
| **Title:** | Freedom to Speak Up Annual Board Report |
| **Author:** | Andrea Gillespie, Freedom to Speak Up Guardian |
| **Sponsor:** | Suzanne Dunkley, Director of Workforce and Organisational Development |
| **Previous Forums:** | Workforce Committee 6 June 2022 |

**Purpose of the Report**

This paper provides information to the Board in respect of the Freedom to Speak Up (FTSU) arrangements at CHFT and FTSU activity in the Trust from the 1st April 2021 to the 31st March 2022.

**Key Points to Note**

- There has been a very minimal decrease in the number of concerns raised by colleagues in 2021/2022 when compared with previous years
- 56% of concerns raised in 2021/2022 were raised anonymously. This percentage remains static in comparison to previous years
- The Registered Nurses and Midwives staff group has submitted the highest number of concerns in 2021/2022
- No CHFT colleagues have reported suffering any detriment or demeaning treatment as a result of speaking up
- The main themes of concerns are related to colleague attitudes and behaviours
- Multiple concerns have been raised around maternity and HRI theatre services
- Many actions are being undertaken to create a culture where staff feel safe to speak up and make FTSU business as usual at CHFT

**EQIA – Equality Impact Assessment**

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

**Recommendation**

The Board of Directors is asked to **NOTE** the contents of the report, the number of concerns raised in 2021/2022 and the work of the FTSU Guardian and Ambassadors.

**CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST**

**BOARD OF DIRECTORS**

**1 SEPTEMBER 2022**

# FREEDOM TO SPEAK UP ANNUAL REPORT

## 1. PURPOSE

This paper provides information to the Board of Directors in respect of the Freedom to Speak Up (FTSU) arrangements at CHFT and FTSU activity in the Trust from the 1st April 2021 to the 31st March 2022.

## 2. BACKGROUND

Freedom to Speak Up is vital in healthcare if we are to continually improve patient safety, patient experience and the working conditions for colleagues. The National Guardian's Office (NGO) believes a positive speaking up culture makes for a safer workplace, for workers, patients, and service users. At CHFT we are working towards making speaking up business as usual.

Effective speaking up arrangements help to protect patients and improve the experience of NHS workers. Having a healthy speaking up culture is an indicator of a well-led Trust. The Care Quality Commission (CQC) assesses a Trust's speaking up culture during inspections within its Key Line of Enquiry (KLOE) approach as part of a Well-Led review.

## 3. PROGRESS UPDATE

### 3.1 The FTSU Network at CHFT

The Trust appointed a new FTSU Guardian (FTSUG), Andrea Gillespie in September 2021 who currently works 22.5 hours per week. She came to the role with some experience of FTSU, reviewed our existing processes and documentation with 'fresh eyes' and created an opportunity for a FTSU refresh. The FTSUG attends the FTSU Yorkshire and Humber network monthly meeting where there is attendance from the NGO and buddy's the FTSU Guardian at Bradford Teaching Hospitals. Both Guardians meet monthly via MS Teams for peer support.

Suzanne Dunkley, Director of Workforce and Organisational Development, is the Executive Sponsor for FTSU and there are 23 FTSU Ambassadors. The Ambassadors promote the FTSU agenda in their areas of work and are a point of contact and source of support for any colleague who wants to raise and escalate a concern. The Ambassadors currently have no protected time to dedicate to FTSU within their substantive roles.

The FTSU network meets bi-monthly. The meetings are chaired by the FTSUG, and regular agenda items include updates and minutes from the Regional Meetings, data submissions and National reviews, i.e., case reviews performed by the NGO.

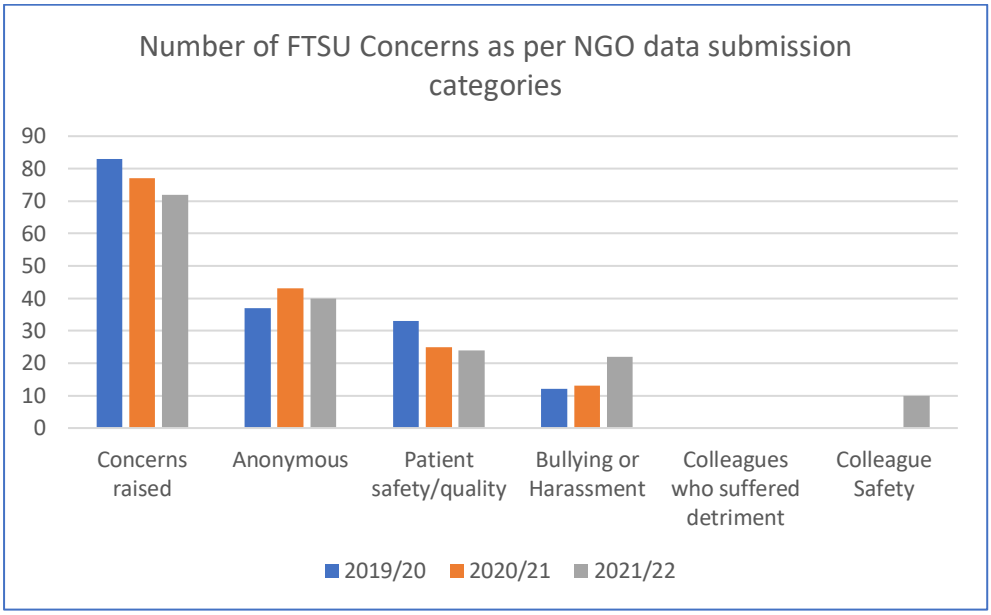
Recently drop-in support clinics have been introduced to create a regular opportunity for the FTSU Ambassadors to speak with the FTSUG in a 1:1 situation and an opportunity for the FTSU Guardian to provide advice, help and wellbeing support for the FTSU Ambassadors.

### 3.2 FTSU concerns raised from the 1st April 2021 to the 31st March 2022

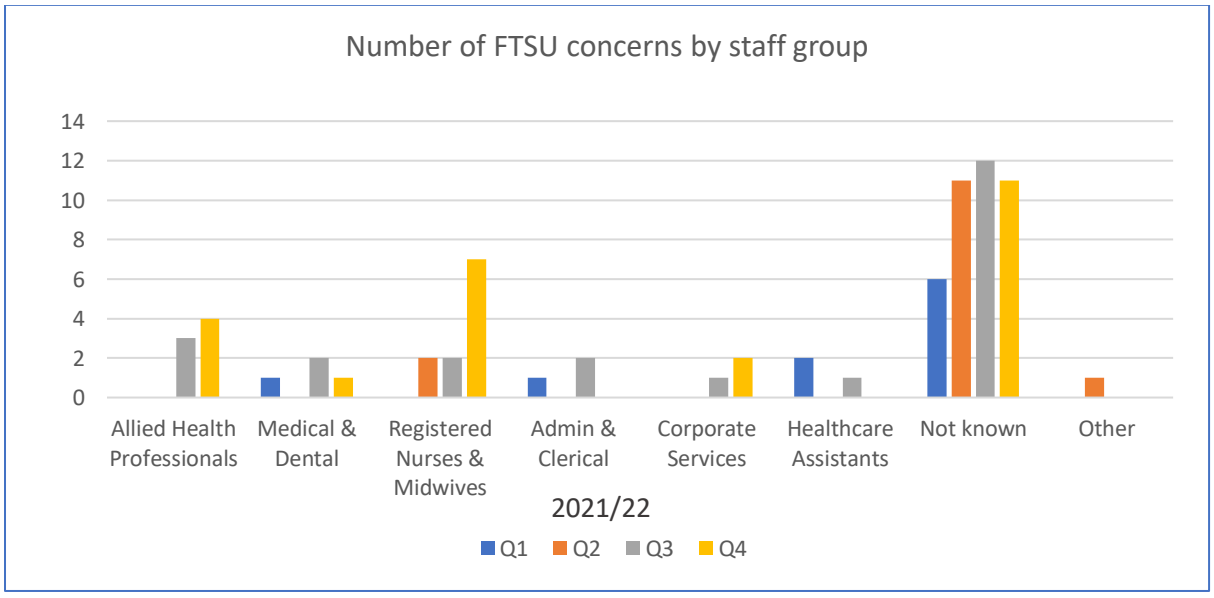
The graph below shows the total number of concerns raised in 2021/2022 and the number of concerns raised as per the NGO's submission categories. Data for 2019/2020 and 2020/2021 have been added to provide a comparison.

No colleagues have reported suffering any detriment or demeaning treatment as a result of speaking up.

There is only data for 2021/2022 in the colleague safety category as it was introduced in March 2021.




Colleagues raising FTSU concerns are requested to indicate which professional/ worker group (as defined by the NGO) that they belong to. The graph below indicates the number of concerns raised per quarter by staff group at CHFT. Registered nurses and midwives have submitted the highest number of concerns. The data is utilised to identify staff groups where more FTSU promotion and education is required. The 40 'not known' are the colleagues who have raised their concerns anonymously.




The subjects of the concerns raised are extremely varied however there are common themes. The main themes are related to colleague attitudes and behaviours with several references made specifically to the behaviours of managers and leaders. Colleagues describe a lack of understanding for their personal situations, and a lack of kindness, compassion and support.

Multiple concerns have been raised around maternity and theatre services. The concerns raised around maternity are being addressed as part of the Maternity Improvement plan. The Maternity Improvement plan will bring together the themes of the FTSU concerns with the findings and recommendations of the Ockenden Final report from the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust. The concerns raised around theatre services at Huddersfield Royal Infirmary (HRI) are being addressed divisionally using several actions being monitored by the Executive Lead for FTSU, Suzanne Dunkley and the FTSUG.

In May 2022 an FTSU escalation process was developed and communicated to senior leaders. It includes criteria for when the FTSUG should escalate concerns to the FTSU Executive sponsor and criteria for when the FTSUG Executive sponsor should escalate concerns to the Executive Board.

As a result of concerns raised many actions have been taken which have led to learning and improvement. Examples include:

- As a result of a concern several actions were taken to improve the safety and experience of patients being nursed in an area which was opened during Covid for extra capacity.
- As a result of a concern raised in relation to an unsafe discharge of a patient from the Emergency Department, an investigation was conducted by a nurse and occupational therapist to identify potential learning for both staff groups.
- As a result of a concern raised in relation to colleague safety the security team have joined up with the communications team to develop an infographic highlighting what support is available for colleagues. A colleague engagement group where security issues are discussed is also being planned.

The FTSUG uses opportunities during discussions to share the learning from concerns. In addition, a template for a quarterly FTSU newsletter is in development where learning will be shared also.

Nationally there are now over 800 Freedom to Speak Up Guardians in more than 400 organisations (50% of which are NHS Trusts) which submit quarterly data to the NGO. All of the submitted data is published on the NGO website and in the Culture and Engagement compartments of the Model Health system which enables each organisation to benchmark against similar types and sizes of organisations. The data is varied, however on average at CHFT (classified as a medium sized Trust using the NGO data set) the data is consistent with other medium sized Trusts.in our region. At a number of Trust's including CHFT, the number of concerns raised per quarter fluctuate and are gradually increasing in number and/or complexity.

| ORGANISATION | SIZE | Q1 | Q2 | Q3 | Q4 | **TOTAL 21/22** |
|---|---|---|---|---|---|---|
| **Calderdale & Huddersfield NHS FT** | **Medium** | **10** | **14** | **22** | **26** | **72** |
| Airedale NHSFT | Small | 3 | 8 | 6 | 5 | **22** |
| Barnsley Hospital NHSFT | Small | 32 | 21 | 24 | 12 | **89** |
| Bradford Teaching Hospital NHSFT | Medium | 19 | 13 | 18 | 10 | **60** |
| Doncaster & Bassetlaw Teaching Hospital NHSFT | Medium | 21 | 16 | 27 | 33 | **97** |
| Leeds Teaching Hospitals NHST | Large | 26 | 9 | 29 | 8 | **72** |
| Sheffield Teaching Hospitals NHSFT | Large | 6 | 10 | 10 | 9 | **35** |
| The Mid Yorkshire Hospitals NHST | Medium | 45 | 45 | 39 | 93 | **222** |
| Harrogate & District NHSFT | Small | 3 | 4 | 8 | 9 | **24** |

*As per NGO guidance:
Small organisation – up to 5,000 workers
Medium organisation – between 5,000 and 10,000 workers
Large organisation – more than 10,000 workers

Data published on the NGO webpages can be accessed via this link:
https://nationalguardian.org.uk/learning-resources/speaking-up-data/

In April 2022 an updated version of the CHFT FTSU portal went live. The portal has undergone many improvements to make it more user friendly and to ensure that all the data required by the NGO is easily accessible.

Colleagues who have raised their concerns anonymously can now re-access the portal to view what actions have been taken in response to their concern, monitor progress and add more detail if they wish to do so. Similarly, the FTSUG can now request more detail, make enquiries re the colleague's wellbeing, and provide information about the support they can access if required.

Improvements to the portal have also simplified the way in which colleagues can give feedback. Subsequently more responses to the NGO feedback question, 'Given your experience, would you speak up again?' and feedback comments are being received.

Feedback received in Quarter 1 2022/23 has been very positive. Here are some examples:

- 'Thank you again for your support and for caring. I would definitely speak up again if I felt I needed to'.

- 'I felt supported throughout the whole process, and I would use the service again. I have encouraged members of my team to use it too'.

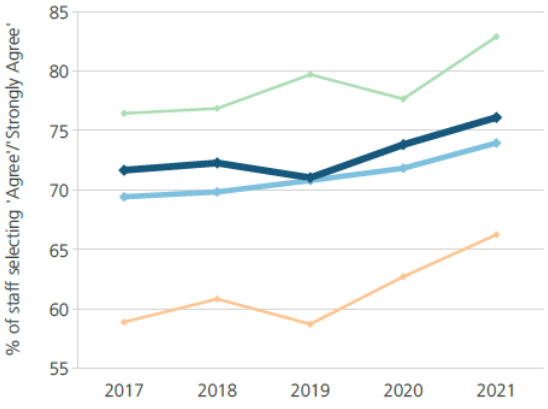
- 'FTSU is a means of addressing concerns that involve processes and culture in a manner that is challenging but non-confrontational'.

3.3 Staff survey results

The annual staff survey provides an opportunity to monitor how CHFT is performing in relation to other organisations classified as the best, average, and worst performing in respect to raising concerns.

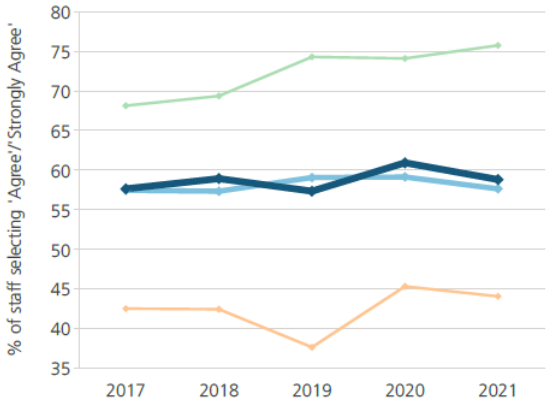
The graphs below illustrate a steady increase in CHFT colleagues feeling safe to raise their concern about unsafe clinical practice since 2019 and a decrease in confidence that their concern would be addressed since 2020.

**Q17a**
I would feel secure raising concerns about unsafe clinical practice



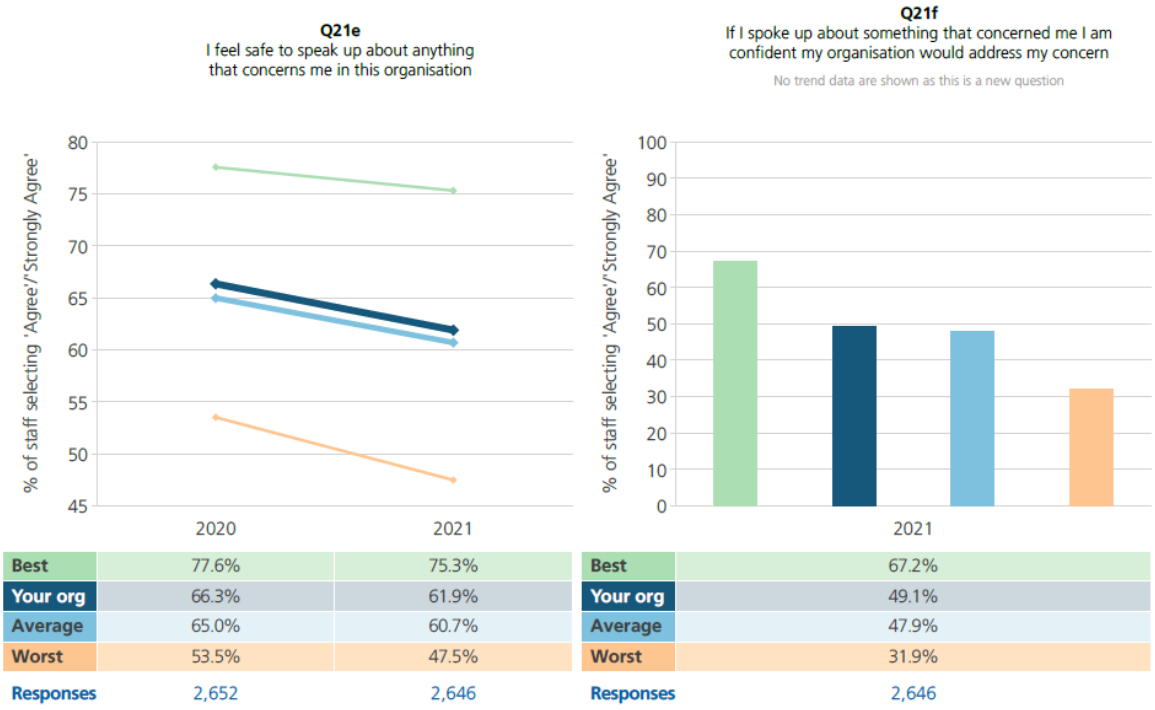

| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| Best | 76.4% | 76.9% | 79.7% | 77.7% | 82.9% |
| Your org | 71.7% | 72.3% | 71.0% | 73.8% | 76.1% |
| Average | 69.4% | 69.8% | 70.8% | 71.8% | 73.9% |
| Worst | 58.9% | 60.8% | 58.7% | 62.7% | 66.2% |
| Responses | 2,348 | 2,640 | 2,473 | 2,663 | 2,675 |

**Q17b**
I am confident that my organisation would address my concern




| | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|
| Best | 68.1% | 69.4% | 74.3% | 74.1% | 75.7% |
| Your org | 57.6% | 58.9% | 57.3% | 60.9% | 58.8% |
| Average | 57.4% | 57.3% | 59.1% | 59.1% | 57.6% |
| Worst | 42.5% | 42.4% | 37.6% | 45.3% | 44.1% |
| Responses | 2,343 | 2,632 | 2,475 | 2,659 | 2,676 |

The graphs below illustrate a decrease in CHFT colleagues feeling safe to raise their concerns about anything and 49.1% of colleagues having confidence that CHFT would address their concern.




| | 2020 | 2021 |
|---|---|---|
| Best | 77.6% | 75.3% |
| Your org | 66.3% | 61.9% |
| Average | 65.0% | 60.7% |
| Worst | 53.5% | 47.5% |
| Responses | 2,652 | 2,646 |

| | 2021 |
|---|---|
| Best | 67.2% |
| Your org | 49.1% |
| Average | 47.9% |
| Worst | 31.9% |
| Responses | 2,646 |

## 4. NGO UPDATE

In November 2021 a new National Guardian was appointed, Dr. Jayne Chidgey-Clark who is a registered nurse.

In February 2022 the NGO published new guidance, 'Recording Cases and Reporting Data' to be implemented on the 1st of April 2022. The key changes are:

- A new category, 'An element of other inappropriate attitudes or behaviours' has been introduced.
- The category, 'An element of worker safety' has been extended to include wellbeing.
- The definitions of bullying and harassment published by the Advisory, Conciliation and Arbitration Service have been introduced.
- The professional/worker group category has been updated.

In April 2022 the NGO launched FTSUG Foundation training which all Guardians must complete by October 2020. It consists of e-learning divided into two parts; part one to be undertaken by established Guardians and part two for new Guardians. Alongside the training a mentor scheme has also been developed where established Guardians will mentor new Guardians.

During the last 12 months the NGO, in collaboration with Health Education England has developed and launched three e-learning modules:

- Speak Up – This core training is for all workers including volunteers, students, and those in training. It will help colleagues understand how to speak up and what to expect when they do.
- Listen Up - This training is for all line and middle managers and is focussed more on listening up and the barriers that can get in the way of speaking up.
- Follow Up - This training is aimed at all senior leaders including executive board members (and equivalents), Non-Executive Directors, and Governors to help them understand their role in setting the tone for a good speaking up culture and how speaking up can promote organisational learning and improvement.

The Speak Up and Listen Up training modules are on the Trust's e-learning platform and Follow Up will be available in the next 2-4 weeks. The FTSUG is working with the Communications team to plan a launch of the training and add details of the training to the Training section of the intranet. Colleagues will access the modules on their ESR using a simple link or a QR code.

## 5. FTSU COMMUNICATIONS & ENGAGEMENT

The overarching objective of all communications and engagement will be to make FTSU business as usual at CHFT and create an open and honest culture where colleagues feel safe to raise their concerns.

The FTSU intranet pages and the CHFT FTSU policy were reviewed and updated in January 2022. The NGO is currently revising the FTSU policy guidance and when available the policy will be reviewed and renewed in line with this.

Promotional materials have been updated and are currently being distributed across all wards and departments including community settings. The new resources include a QR code which when scanned takes colleagues directly to the FTSU intranet pages where they can raise their concerns.

FTSU information and updates feature regularly in CHFT news and as screensavers. FTSU at CHFT is incorporated in to Trust induction, included in the induction resources for students and the FTSUG delivers an interactive teaching session at preceptorship days. Arrangements for FTSUG to attend medical staff induction are in progress.

## 6. RISK ASSESSMENT

Regular evaluation of the number and complexity of concerns received is essential for assurance that the resource available to lead, manage and co-ordinate FTSU at CHFT ensures a timely, appropriate, and supportive response for colleagues raising a concern and enables a full and proper enquiry and resolution of the concern. A sudden increase in the number and/or complexity of concerns or an increasing trend that is not appropriately considered and attended to could create risk to the integrity and credibility of FTSU at the Trust. FTSU activity is reviewed regularly by the FTSUG in conversation with others and any additional resource requirements are considered. Expansion and further development of the Ambassador network is a key component of the FTSU publicity and colleague engagement plan in the Trust and will help mitigate any immediate requirement for support to the FTSUG.

## 7. CONCLUSION

Moving forward in to 2022/2023, the priorities are to increase the promotion of FTSU and ensure the learning and improvements produced as a result of the concerns are captured and shared widely.

Data will be used to identify where barriers may exist, and a communication strategy will be developed and implemented. The communication strategy will ensure all the different channels of communication available are utilised and barriers to speaking up are addressed.

Additional routes for the sharing of learning and improvements will be explored and utilised if attainable.

Both priorities will be progressed with the support of the CHFT Communications team.

The Board of Directors is asked to note the contents of the report, the number of concerns raised in 2021/2022 and the work of the FTSU Guardian and Ambassadors.

**Andrea Gillespie**
**Freedom to Speak Up Guardian**
**August 2022**

# 15. Director of Infection, Prevention and Control Q1 Report

To Approve

Presented by David Birkenhead

| | |
|---|---|
| **Date of Meeting:** | Thursday 1 September 2022 |
| **Meeting:** | Public Board of Directors |
| **Title:** | Quarterly Director of Infection Prevention and Control (DIPC) report Q1 – 1st April 2022 to 30th June 2022 |
| **Authors:** | Gillian Manojlovic – Lead Nurse IPC<br>Lindsay Rudge - Director of Nursing / Deputy DIPC |
| **Sponsoring Director:** | David Birkenhead, Medical Director / DIPC |
| **Previous Forums:** | Quality Committee |

**Purpose of the Report**

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

**Key Points to Note**

Clostridium difficile prevention and control remains a challenge. The number of CDifficile infections have increased over the past 2 years. The increase in CDifficle is not limited to CHFT but is being seen across many NHS Trusts. This may be due to the increase in and therefore treatment of respiratory infections associated with the Covid-19 pandemic. Current data suggests the objective for 22/23 will be breached. A CDifficile improvement plan is in development and progress will be reported on in the next quarter.

Covid-19 has continued to have a significant impact on the Trust and the work of the IPC team.

**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.

**Recommendation**

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

NHS
Calderdale and Huddersfield
NHS Foundation Trust

# Director of Infection Prevention and Control (DIPC) report
# Q1: 1st April 2022 to 30th June 2022

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.

## 1. Performance targets

| Indicator | Objective 2022/23 | Year to date performance | Actions/Comments |
|---|---|---|---|
| MRSA bacteraemia | 0 | 0 | |
| C.difficile (HOHA and COHA) | Objective = 38 | 16 | Objective is 1 case above the 21/22 outturn<br>12 HOHA and 4 COHA |
| MSSA bacteraemia (post admission) | None set | 8 | |
| E. coli bacteraemia | Objective = 71 | 16 | Objective is down 20 on 21/22<br>12 HOHA and 4 COHA. |
| Pseudomonas aeruginosa | 11 | 0 | New objective for 22/23 |
| Klebsiella spp. | 19 | 5 | New objective for 22/23<br>4 HOHA and 1 COHA |
| MRSA screening (electives) | 95% | 71% | Improvement of 1% |
| ANTT Competency assessments (medical staff) | 90% | 84% | Further increase in medical staff compliance |
| ANTT Competency assessments (nursing and AHP) | 90% | 92% | |
| Hand hygiene | 95% | 99.85% | |
| Level 2 IPC training (Medical staff) | 90% | 89.4% | Continued improvement seen. |
| Level 2 IPC training (nursing and AHP) | 90% | 90.3% | |

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

## 2. Quality Indicators

| Indicator | Year-end agreed target | YTD performance | Comments |
|---|---|---|---|
| MRSA screening (emergency) | 95% | 92.4% | Improvement of 1.4% |
| Isolation breaches | Non set | Not recorded this quarter | COVID-19 patients remain priority for side room isolation |

## 3. MRSA bacteraemia:

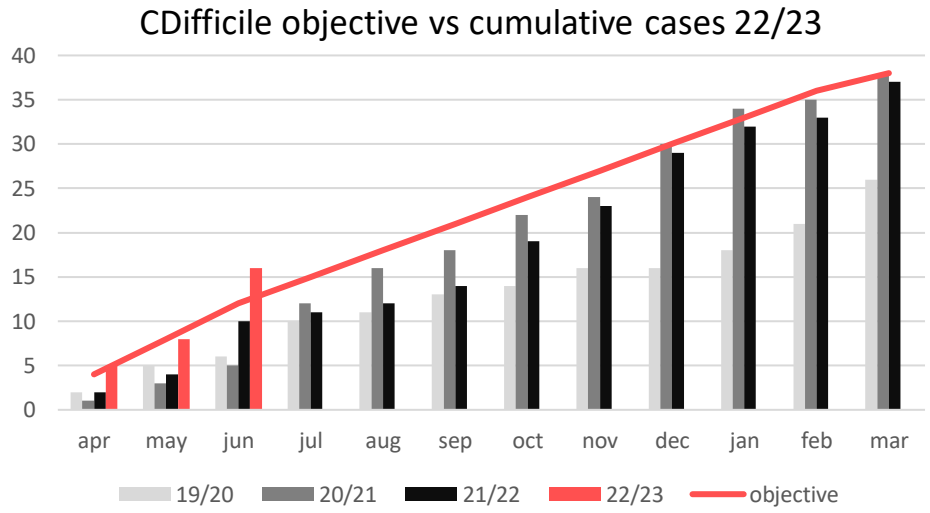
The objective for MRSA cases in year remains at zero. No cases to report during the current reporting period/year to date.

## 4. MSSA bacteraemia:

There have been 8 post-admission MSSA bacteraemia cases during the current reporting period. The IPC team continue to review these cases. There is no objective set for MSSA.

## 5. Clostridium difficile:

The objective for 2022-23 is 38 cases, an increase of 1 case on outturn from 21/22. The objective includes both HOHA cases (hospital onset, healthcare associated) plus COHA (community onset, healthcare associated) infections where there has been an inpatient episode within the previous 28days. There have been a total of 16 cases year to date. Each case is being investigated. 4 preventable cases have been identified to date this quarter, with 6 investigations pending.




## 6. E. coli bacteraemia:

There have been 12 post-admission *E. coli* bacteraemia cases plus 4 COHA cases during the reporting period.

## 7. Outbreaks & Incidents:

**CDifficile:** There has been a cluster of CDifficile cases affecting 3 patients caused by ribotype 106 with a connection noted between the case 1 and case 2 in January on ward 22 and connection between case 1 and case 3 identified in April 22 on ward 15. No further 106 cases have been reported with a connection to the outbreak. The incident was managed in line with the Trust outbreak policy.

**Vancomycin Resistant Enterococci (VRE):** There has been a incidence of VRE cross infection reported on ICU HRI in April. Investigation identified that the patients had consecutively occupied the same sideroom and the first patient was subsequently identified as VRE positive. The HPV clean normally completed following a VRE case was not completed as the index patient was not known to have VRE at the time of transfer.

**Meticillin Resistant Staphylococcus aureus (MRSA):** There has been a cluster of MRSA colonisation affecting 4 infants in the neonatal unit. Investigation through WGS has identified that there was evidence of transmission but all environmental and staff screening was negative.

**Norovirus:** There have been 3 norovirus outbreaks reported during Q1 affecting wards H6, H5 and C5D.

**Covid-19:** Finally, there have been 8 Covid19 outbreaks recorded during the reporting period on wards H15, H22, C6B, C6C, C7C, C4D, C7B and C7D. All Covid-19 outbreaks are managed in line with Covid19 outbreak management guidelines and are monitored for 28 days.

**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 tactical meeting and communicated where relevant. For this reporting period there have been 76 HOCI cases (35 definite, 41 probable).

## 9. Covid-19 management

Throughout the reporting period work has been undertaken to implement the national guidance for the management of respiratory infections, changes to testing regimes and step back from some of the other mitigations in place. These changes were implemented on the 20th June following a long period of consultation and communication. Unfortunately, mask use has had to be reintroduced due to increased staff sickness. All other changes remain.

## 10. Audits

**COVID Assurance audits:** The IPC BAF self-assessment framework is continually reviewed

- Daily must do compliance by ward managers
- Weekly IPC Covid 19 assurance – completed by the Matrons

**Quality Improvement Audits:** The programme has resumed. 6 QI audits have been completed in this reporting period.

**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 and include elements of Covid-19 mitigations. Current scores are showing in-patient areas at 91% and community bases at 97%.

**National Standards of Cleanliness:** Implementation of the new National Standards of Cleanliness (2021) which will replace the National Specifications for Cleanliness in the NHS (2007) has begun. This is applicable to all Healthcare settings and has several mandatory elements:

- Functional risk categories
- Elements, frequencies and performance parameters
- Cleaning responsibilities
- Audit frequency
- Star ratings
- Efficacy checks
- Commitment to cleanliness charter

Audit frequency depends on the functional category of an area. The higher the risk, the higher the score to be achieved and the more frequent the audits. Areas will be issued a star rating.

## 11. Recommendations

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

# 16. Medical Revalidation and Appraisal Annual Report

To Approve

Presented by David Birkenhead

Calderdale and Huddersfield NHS Foundation Trust

| | |
|---|---|
| **Date of Meeting:** | Thursday 1 September 2022 |
| **Meeting:** | Public Board of Directors |
| **Title:** | Revalidation and Appraisal of Non Training Grade Medical Staff |
| **Author:** | Sue Burton, Medical Education |
| **Sponsoring Director:** | Dr David Birkenhead, Executive Medical Director |
| **Previous Forums:** | None |

**Purpose of the Report**

To update the Board on the General Medical Council (GMC) revalidation and appraisal compliance for non-training grade medical staff for 2021/2022.

**Key Points to Note**

GMC revalidation recommendations were reintroduced following a suspension for 12 months due to COVID-19. Likewise, appraisals became mandatory once more from 1st April 2021, again having been temporarily suspended as a result of COVID-19.

The report also includes Annex D, Statement of Compliance - A Framework of Quality Assurance for Responsible Officers and Revalidation (NHS, July 2021) which requires Board approval.

**EQIA – Equality Impact Assessment**

The completion of appraisals and the GMC revalidation process make an overall positive contribution to advancing quality in relation to colleague/patient safety across the NHS. The revalidation and appraisal process does not have a negative impact on equality for people with protected characteristics.

**Recommendation**.

This report is submitted to the Board with the assurance that the agreed processes for GMC revalidation and appraisal have been adhered to.

The Board is asked to **APPROVE** Annex D – Statement of Compliance - A Framework of Quality Assurance for Responsible Officers and Revalidation (NHS, July 2021) and **NOTE** the contents of the report.

Calderdale and Huddersfield NHS Foundation Trust

**BOARD OF DIRECTORS – 1st SEPTEMBER 2022**

**REVALIDATION AND APPRAISAL OF NON TRAINING GRADE MEDICAL STAFF 2021/2022**

## 1. Executive Summary

The purpose of this report is to update the Board on the progress of the Trust's management of medical appraisal and revalidation. The report will also cover the 2021/2022 appraisal and revalidation year (1st April 2021 – 31st March 2022).

Summary of key points:

- As of 31st March 2022, 431 doctors had a General Medical Council (GMC) prescribed connection to Calderdale and Huddersfield NHS Foundation Trust (as compared to 437 on 31st March 2021).
- From March 2021 it was possible to make revalidation recommendations once more following the one-year recommendation suspension introduced by the GMC due to COVID-19.
- In the 2021/22 revalidation year 91 non-training grade medical staff had been allocated a revalidation date by the GMC.
- Mandatory appraisals for non-training grade medical staff were reintroduced from 1st April 2021 following a period from 23rd March 2020 when NHS England (NHSE) and the GMC did not require them to be completed due to COVID-19.
- Based on headcount, 93.96% of non-training grade appraisals were completed and submitted in the 2021/2022 appraisal year). It is important to note that 5.34% of non-training grade medical staff were not required to complete an appraisal for a verified reason (recently joined the Trust, long term ill health, maternity leave, recent return from secondment etc).
- The completion rate for all appraisals which were required to be completed in the appraisal year was 99.3%. For information our appraisal compliance from 2017/2018 is shown below:

| Appraisal Year | Appraisal Completion Rate | Number of Missed Appraisals |
|---|---|---|
| 2021/2022 | 99.3% | 3 |
| 2019/2020 | 100%* | 0 |
| 2018/2019 | 99.7% | 1 |
| 2017/2018 | 99.7% | 1 |

* This 100% compliance rate comes with a warning. Appraisals were suspended due to COVID-19 on 23rd March 2020. We were asked by NHSE to record the 16 appraisals which had not been completed by 23rd March 2020 as 'approved missed appraisals'. It is likely that some of those appraisals would not have been completed regardless of COVID-19.

## 2. Background

2.1 Medical revalidation was launched in December 2012 to strengthen the way that doctors are regulated with the aim of improving the quality of care provided to patients. Revalidation is the process by which licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practice.

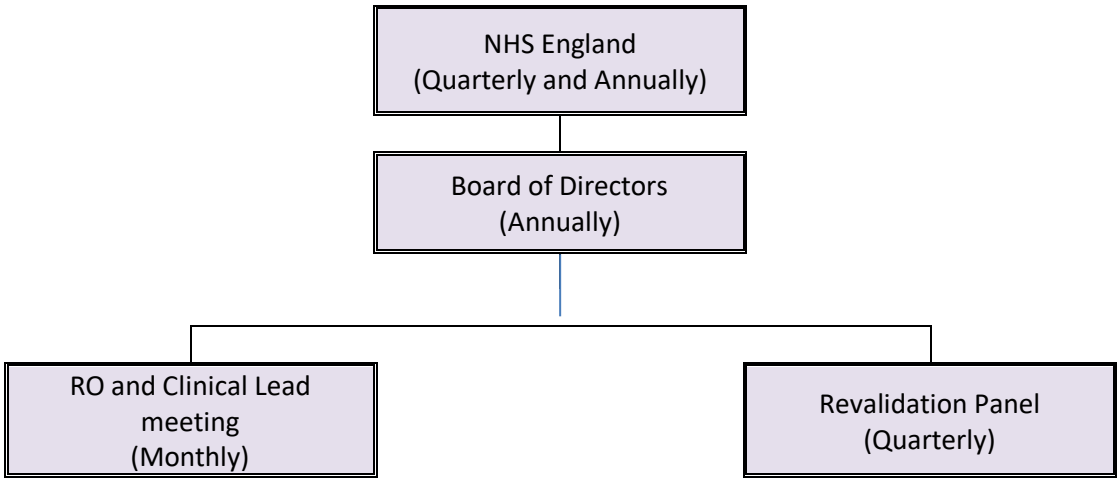
2.2 The Trust has a statutory duty to support the Responsible Officer (Executive Medical Director) in discharging their duties under Responsible Officer Regulations and is expected that the board will oversee compliance by:

- monitoring the frequency and quality of medical appraisals in their organisations;
- checking there are effective systems on place for monitoring the performance and conduct of their doctors;
- confirming that feedback from patients and colleagues is sought periodically so that their views can inform the appraisal and revalidation process;
- ensure that appropriate pre-employment checks are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

2.2 Revalidation is the process by which licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practice.

## 3. Governance Arrangements

3.1 The Trust's governance reporting structure for medical appraisal and revalidation is shown below:



3.2 **GMC Connect**

GMC Connect is the GMC database used by Designated Bodies (ie Calderdale and Huddersfield NHS Foundation Trust) to view and manage the list of doctors who have a prescribed connection with the Trust.

GMC is managed by the revalidation administration team on behalf of the Responsible Officer. The Trust's Electronic Staff Record (ESR) is used as the main source in relation to starters and leavers.

## 4. Medical Appraisal and Revalidation Performance Data for 2021/2022

### Revalidation Cycles

4.1 The first revalidation cycle started in January 2013. The majority of doctors (with the exception of new starters and those whose revalidation has been put on hold by the GMC) completed their first revalidation cycle by 31st March 2018 and will have had a recommendation made about their fitness to practise by a Responsible Officer (for this Trust this is the Medical Director).

4.2 In the 2021/2022 revalidation year (Year 9) the Responsible Officer has made recommendations for doctors as follows: (see also Appendix A: Audit of Revalidation Recommendations).

| Revalidation Cycle (Year 9) | Positive Recommendations | Recommendation Deferred ** |
|---|---|---|
| Year 9, Quarter 1 (April 2021 – June 2021) | 32 | 0 |
| Year 9, Quarter 2 (July 2021 – September 2021) | 13 | 0 |
| Year 9, Quarter 3 (October 2021 – December 2021) | 28 | 2 |
| Year 9, Quarter 4 (January 2022 – March 2022) | 16 | 0 |
| **Total:** | **89** | **2** |

** The reasons for the deferrals were insufficient evidence being presented for a revalidation recommendation to be made. This was usually due to the fact the doctors were relatively new to the organisation and did not provide sufficient or relevant evidence from previous employers for a recommendation to be made.

### Medical Appraisal

4.3. Medical Appraisal underpins the revalidation process. Doctors are expected to complete five appraisals within the revalidation cycle.

4.4 The appraisal year runs from 1st April – 31st March. The table below shows the compliance rate at the end of the 2021/2022 appraisal year on 31st March 2022 (see also Appendix B – Audit of all missed or incomplete appraisals).

| Grade | Number of doctors with prescribed connection to CHFT | ***Completed Appraisals | Approved incomplete or missed appraisal | Unapproved incomplete or missed appraisal |
|---|---|---|---|---|
| Consultants (permanent) | 275 | 267 | 10 | 0 |
| Staff Grade, Associate Specialist, Specialty Doctor (permanent) | 75 | 67 | 4 | 2 |
| Temporary or short term contract holders (all grades) | 81 | 71 | 9 | 1 |
| **Total** | **431** | **405** | **23** | **3** |

*** Appropriate appraisals can be transferred between organisations. This figure will include appraisals/ARCPs which may have been completed at other organisations but are within the timescale and acceptable of standard.

*(Doctors with a GMC prescribed connection to CHFT on 31st March 2022*)

## 5. Allocation of Appraisers

5.1 The revalidation administration team allocates appraisers to appraisees and allocates the month the appraisal should take place.

## 6. Quality Assurance of the Process

6.1 The process used to monitor the quality of the medical appraisers is for the doctors to rate their appraisal experience in relation to:

- The organisation of the appraisal;
- The appraiser;
- The appraisal discussion.

All appraisals submitted as part of the revalidation process are reviewed thoroughly by the Clinical Lead for Revalidation and Appraisal. This involves a comprehensive review of the appraisal form (appraisal inputs and supporting information).

6.2 The Clinical Lead for Revalidation and Appraisal also routinely quality assures a sample of appraisals submitted (see Appendix C which shows the framework for quality assurance used) in addition to appraiser feedback which is completed by appraisers on the PReP electronic appraisal system.

**6.3 Access, security and confidentiality**

Historical appraisal folders, supporting information and all correspondence relating to the revalidation processes are stored on the Trust network drive. Access to the drive is restricted to the Responsible Officer, the Clinical Lead for Appraisal and Revalidation, the Revalidation Panel clinical members and the Revalidation administrative support. All appraisals since 2017 and supporting information are stored on the PReP system which is ISO27001 accredited, GDPR compliant, 100% IG Toolkit compliant. Access to appraisals is in line with the Appraisal Policy for non-training grade medical staff.

6.5 **Clinical Governance**

Data is provided annually by the Trust to each appraisee to assist with the appraisal process. The DATIX incident reporting system provides basic information relating to serious incidents, complaints and claims where the doctor is named. The Health Informatics department also provide information relating to CHFT activity data, benchmarking data and attendance at audit.

**7. Update**

a) PReP – Appraisal Form

The PReP e-appraisal form was amended in light of NHSE guidance during COVID-19 with , greater emphasis being placed on providing support in light of COVID-19, and to offer an opportunity for a confidential discussion to explore the personal and professional experiences of COVID-19 for the appraisee. NHSE are retaining some of these elements in a revised form being introduced in Autumn 2022.

b) Audit of Revalidation and Appraisal Processes

The Trust is currently working with Audit Yorkshire who are reviewing the processes and procedures in place for revalidation and appraisal.

c) Framework of Quality Assurance for Responsible Officers (NHS)

This report also includes as an attachment, 'A Framework of Quality Assurance for Responsible Officers and Revalidation' (NHS, July 2021) which requires Board approval.

**8 Action Required of the Board**

The report is provided for assurance purposes.

Dr David Birkenhead
Medical Director/Responsible Officer
August 2022

**Appendix A**

**Audit of Revalidation Recommendations (1st April 2021 - 31st March 2022)**

**(Template taken from 'A Framework of Quality Assurance for Responsible Officers and Revalidation – Annex D Annual Board Report Template – June 2014)**

**Revalidation Recommendations made between 1st April 2021 and 31st March 2022**

| | **Number** |
|---|---|
| Recommendations completed on time (within the GMC recommendation window) | 91 |
| Late recommendations (completed but after GMC recommendation window closed) | 0 |
| Missed recommendations (not completed) | 0 |
| **TOTAL** | **91** |
| Primary reason for late/missed recommendations<br>For late or missed recommendations only one primary reason may be identified | |
| No responsible officer in post | 0 |
| New starter/new prescribed connection established within 2 weeks of revalidation due date | 0 |
| Unaware the doctor had a prescribed connection | 0 |
| Unaware of the doctors revalidation due date | 0 |
| Administrative error | 0 |
| Responsible officer error | 0 |
| Inadequate resources or support for responsible officer role | 0 |
| Other | 0 |
| **TOTAL SUM OF LATE AND MISSED RECOMMENDATIONS** | **0** |

**Appendix B**

**Audit of all missed or incomplete appraisals audit (1st April 2021 - 31st March 2022)**

**(Template taken from 'A Framework of Quality Assurance for Responsible Officers and Revalidation – Annex D Annual Board Report Template – June 2014)**

| **Doctors Factors (Total)** | **Number** |
|---|---|
| Maternity leave during the majority of the 'appraisal due window' | 1 |
| Sickness absence during the majority of the 'appraisal due' window' | 0 |
| Prolonged leave during the majority of the 'appraisal due window' | 0 |
| Suspension during the majority of the 'appraisal due window' | 0 |
| New starter within 3 months of appraisal due date | 22 |
| New starter more than 3 months from the appraisal due date | 0 |
| Postponed due to incomplete portfolio/insufficient reporting information | 0 |
| Lack of time of doctor | 0 |
| Lack of engagement of doctor | 3 |
| Other doctors' factors (describe) | 0 |
| | **26** |
| **Appraiser Factors (Total)** | |
| Unplanned absence of appraiser | 0 |
| Lack of time of appraiser | 0 |
| Other appraiser factors (describe) | 0 |
| **Organisational Factors (Total)** | |
| Administration or management factors | 0 |
| Failure of electronic information systems | 0 |
| Insufficient numbers of trained appraisers | 0 |
| Other organisational factors (describe) | 0 |

Classification: Official

Publications approval reference: B0614

# A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1, July 2021

# Contents

# Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and seven annexes A – G.

In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded with a slimmed down version of the AOA (Annex C) and a revised Board Report template (Annex D), which was combined with the Statement of Compliance (previously listed as Annex E) for efficiency and simplicity.

**Annual Organisational Audit (AOA):**

At the end of April 2021, Professor Stephen Powis wrote to Responsible Officers and Medical Directors in England letting them know that although the 2020/2021 AOA exercise had been stood down, organisations will still be able to report on their appraisal data and the impact of adopting the Appraisal 2020 model, for those organisations who have, in their annual Board report and Statement of Compliance.

**Board Report template:**

Following the revision of the Board Report template in June 2019 to include the qualitative questions previously contained in the AOA, the template has been further updated this year to provide organisations with an opportunity to report on their appraisal data as described in the letter from Professor Stephen Powis.

A link to the letter is below:

https://www.england.nhs.uk/coronavirus/publication/covid-19-and-professional-standards-activities-letter-from-professor-stephen-powis/

The changes made to this year's template are as follows:

Section 2a – Effective Appraisal

Organisations can use this section to provide their appraisal information, including the challenges faced through either pausing or continuing appraisals throughout and the experience of using the Appraisal 2020 model if adopted as the default model.

Section 2b – Appraisal Data

Organisations can provide high level appraisal data for the period 1 April 2021 – 31 March 2022 in the table provided. Whilst a designated body with significant groups of doctors (e.g. consultants, SAS and locum doctors) will find it useful to maintain internal audit data of the appraisal rates in each group, the high-level overall rate requested is enough information to demonstrate compliance.

With these additional changes, the purpose of the Board Report template is to help the designated body review this area and demonstrate compliance with the responsible officer regulations. It simultaneously helps designated bodies assess their effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance.[1] This publication describes a four-point checklist for organisations in respect of good medical governance, signed up to by the national UK systems regulators including the Care Quality Commission (CQC). The intention is therefore to help designated bodies meet the requirements of the system regulator as well as those of the professional regulator. Bringing these two quality strands together has the benefits of avoiding duplication of recording and harnessing them into one overall approach.

The over-riding intention is to create a Board Report template that guides organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,

b) provide the necessary assurance to the higher-level responsible officer, and

c) act as evidence for CQC inspections.

[1] Effective clinical governance for the medical profession: a handbook for organisations employing, contracting or overseeing the practice of doctors GMC (2018) [https://www.gmc-uk.org/-/media/documents/governance-handbook-2018_pdf-76395284.pdf]

**Statement of Compliance:**

The Statement Compliance (in Section 8) has been combined with the Board Report for efficiency and simplicity.

# Designated Body Annual Board Report

## Section 1 – General:

The Board of Directors of Calderdale and Huddersfield NHS Foundation Trust can confirm that:

**1.** An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Yes, Dr David Birkenhead (Executive Medical Director)

**2.** The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes
Action from last year: No specific actions
Comments: None
Action for next year: No specific actions

**3.** An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Yes
Action from last year: No specific actions
Comments: None
Action for next year: No specific actions

**4.** All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Yes
Action from last year: No specific actions
Comments: None
Action for next year: No specific actions

**5.** A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

| |
|---|
| Actions from last year: No specific actions<br>Comments: None<br>Action for next year: We are currently participating in an audit co-ordinated by Audit Yorkshire which is reviewing the Trusts appraisal and revalidation processes. |

**6.** A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

| |
|---|
| Yes<br>Action from last year: No specific actions<br>Comments: The Revalidation Office offer one to one support and guidance for short term placement doctors. This includes an initial meeting and follow up support.<br>Action for next year: To continue as present. |

## Section 2a – Effective Appraisal

**7.** All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes. For organisations that have adopted the Appraisal 2020 model, there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet used the Appraisal 2020 model may want to consider whether to adopt the model and how they will do so.

| |
|---|
| Yes |

Action from last year:: The Trust adopted the Appraisal 2020 mode and continues to use this at present with a view to introducing the revised NHSE appraisal recommendations in Autumn 2022

Comments: None

Action for next year: To ensure all non training grade medical staff are aware of the revisions to the appraisal form.

**8.** Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Not applicable

**9.** There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Yes

Action from last year: No specific actions

Comments: None

Action for next year: No specific actions

**10.** The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Yes

Action from last year: No specific actions

Comments: Appraiser training sessions for new appraisers are arranged.

Action for next year: To continue to recruit new appraisers as required.

**11.** Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Yes

Action from last year: No specific actions

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/

Comments: Refresher training sessions for existing appraisers are held on a regular basis.

Action for next year: To continue hosting refresher sessions and providing support to appraisers as required.

**12.** The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Yes

Action from last year: No specific actions

Comments: None

Action for next year: No specific actions

## Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

| **Name of organisation:** | |
|---|---|
| **Total number of doctors with a prescribed connection as at 31 March 2022** | **431** |
| **Total number of appraisals undertaken between 1 April 2021 and 31 March 2022** | **405** |
| **Total number of appraisals not undertaken between 1 April 2021 and 31 March 2022** | **3** |
| **Total number of agreed exceptions** | **23** |

## Section 3 – Recommendations to the GMC

**13.** Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Yes

Action from last year: We restarted making recommendations following the temporary suspension due to COVID-19

Comments: None

Action for next year: No specific actions

**14.** Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Yes

Action from last year: No specific actions

Comments: None

Action for next year: No specific actions

## Section 4 – Medical governance

**15.** This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: No specific actions

Comments: The Trust has robust clinical governance processes (eg supporting doctors with revalidation and appraisal, continuous learning and improvement using mechanisms such as audit/review, patient feedback, investigating concerns, promoting freedom to speak, duty of candour etc)

Action for next year: To continue to improve existing processes

**16.** Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: No specific actions

Comments: All doctors are informed in advance of their appraisal month, appraiser allocated. They are provided with clinical activity data available

and details of any complaints, SUI's or incidents they may have been involved in.

Action for next year: To continue with existing processes.

**17.** There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: No specific actions

Comments: The Trust has a robust policy in place which complies with national and local MHPS processes.

Action for next year: To continue with existing processes.

**18.** The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[3]

Action from last year: No specific actions

Comments: The Board and Workforce Committee (a main Board sub-Committee) receives a regular performance report that captures employees where concerns are raised and formal processes instigated. The Board of Directors receive formal reports where individual doctors are excluded from the workplace. The Trust is compliant with national and local MHPS processes with the Medical Director providing oversight. The Trust is assisting the Practitioner Performance Advice (PPA) service to develop a dashboard that captures individual NHS organisation engagement with it in relation to case management. The Trust has assessed its formal processes in accordance with the May 2019 'Improving People Practices' letter from the Chair of NHS Improvement, Dido Harding and has made changes, primarily the support offered to employees, to its formal processes.

Action for next year: To continue with existing processes

[3] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

**19.** There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[4]

| |
|---|
| Action from last year: No specific action |
| Comments: We use the MPIT transfer from designed by NHSE for transferring information between Responsible Officers. |
| Action for next year: No specific action |

**20.** Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

| |
|---|
| Action from last year: No specific action |
| Comments: Safeguards are in place |
| Action for next year: No specific action |

## Section 5 – Employment Checks

**21.** A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

| |
|---|
| Action from last year: No specific actions |
| Comments: There are systems in place to ensure all appropriate pre-employment checks are undertaken. This is managed by the Workforce and Organisational Development team |
| Action for next year: No specific action |

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

## Section 6 – Summary of comments, and overall conclusion

It was good that appraisal and revalidation processes were restarted following the temporary suspension as a result of COVID-19. It was pleasing to note that our doctor re-engaged with the processes immediately.

## Section 7 – Statement of Compliance:

The Board / executive management team – [*delete as applicable*] of [*insert official name of DB*] has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: Calderdale and Huddersfield NHS Foundation Trust

Name: Brendan Brown Signed: _ _ _ _ _ _ _ _ _ _

Role: Chief Executive

Date: _ _ _ _ _ _ _ _ _ _

NHS England and NHS Improvement
Skipton House
80 London Road
London
SE1 6LH

This publication can be made available in a number of other formats on request.


Publication approval reference: PAR614

# 17. Learning from Deaths Q1 Report

To Note

Presented by David Birkenhead

Calderdale and Huddersfield NHS Foundation Trust

| | |
|---|---|
| **Date of Meeting:** | Thursday 1 September 2022 |
| **Meeting:** | Public Board of Directors |
| **Title of Report:** | Learning from Deaths Q1 Report 2022/23 |
| **Author:** | Elizabeth Loney, Trust Mortality Lead<br>Mandy Hurley, Clinical Governance Support Manager |
| **Sponsoring Director:** | David Birkenhead, Executive Medical Director |
| **Previous Forums:** | Quality Committee |

**Purpose of the Report**

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

To provide an update against agreed recommendations in relation to LfD approved in the annual report July 2022.

**Key Points to Note**

In Quarter 1 (April – June 2022), there were 411 adult inpatient deaths. 73 (**18%**) of these have been reviewed using the initial screening tool. This falls short of the 50% target; however, the committee is reminded of the lag between issuing cases for review and completion of the reports MSG have allocated mortalities up to May 2022 only.

Extra capacity for completion of ISRs was offered by 8 of our Trust CT trainees. Trainees were provided with confirmation of completion for their portfolios once they have undertaken 10 completed ISRs.

A total of **73** SJRs were requested in Quarter 1 (April to June) of 2022/23 of which **62** have been completed. The findings from SJRs are shared with the speciality mortality leads and appropriate Clinical Directors.

9 SJRs undertaken in Q1 of 2022/23 have been escalated to divisions via the Datix reporting process and taken through orange panels for further investigation.

**EQIA – Equality Impact Assessment**

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

Additional aspects of EQIA include:

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

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

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

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

**Recommendation**

The Board is asked to **NOTE** the Learning from Deaths Q1 Report.

**Learning from Deaths Report Quarter 1 2022/2023**

In Quarter 1 (April – June 2022), there were 411 adult inpatient deaths at CHFT recorded on Knowledge Portal.

**Initial Screening Reviews (ISR)**

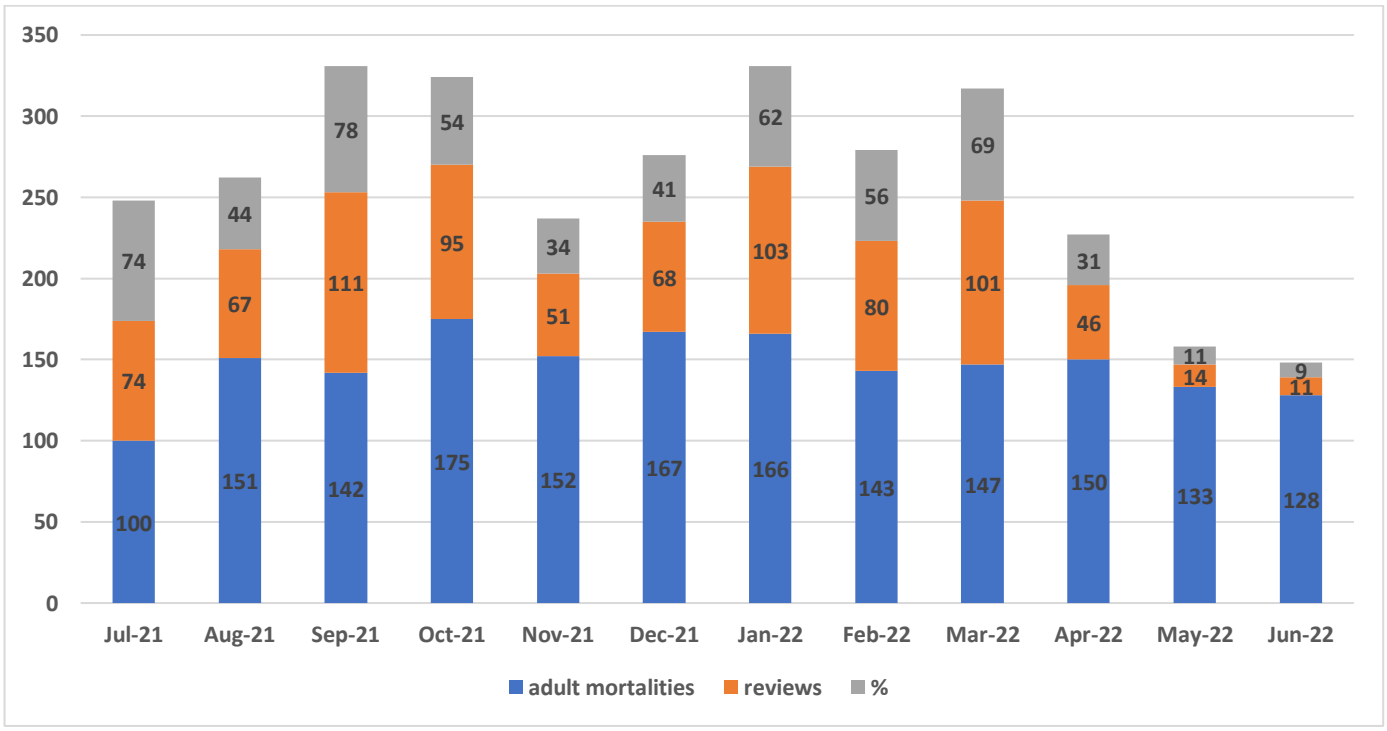
The online initial screening review tool focuses primarily on initial assessment, ongoing care, and end of life care. Reviewers are asked to provide their judgement on the overall quality of care. Specialities have been given the opportunity to identify additional specific questions to enhance the information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

Of the **411** adult inpatient deaths recorded in Quarter 1 of 2022/2023, **73** (**18%**) have been reviewed using the initial screening tool. This falls short of the 50% target; however, the committee is reminded of the lag between issuing cases for review and completion of the reports (MSG have allocated mortalities up to May 2022).

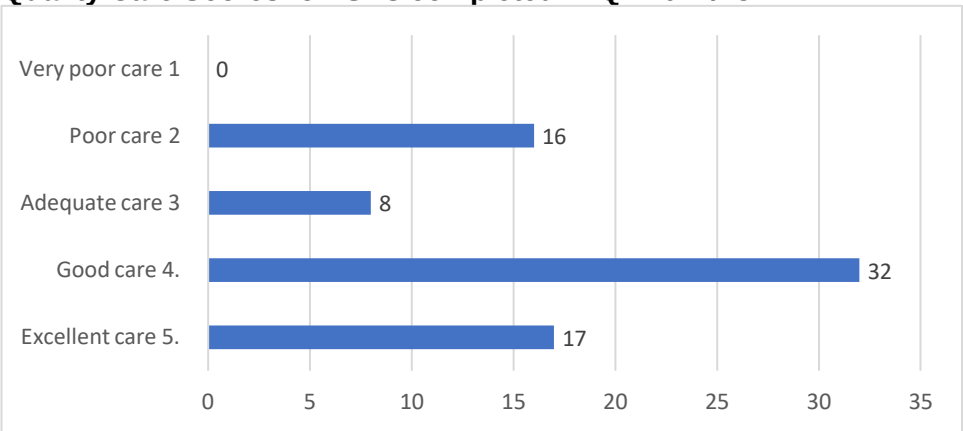
By comparison in the LfD annual report for 2021/22 mortalities demonstrated a review rate of **50.5%** for the year.

The table below shows the number of adult inpatient deaths reviewed by ISR by month over the last 12 months.

N.B. time lag from May 2022



**Quality Care Scores for ISRs completed in Q1 2022/23**




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

## Structured Judgement Reviews

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

| | Escalated from ISR | Escalated by ME | 2nd opinion | SI Panel | Elective | LD | Complaint | Coroner | other | Total |
|---|---|---|---|---|---|---|---|---|---|---|
| **April 21** | 0 | 0 | 2 | 0 | 0 | 0 | 0 | | **18 *** | **20** |
| **May 21** | 0 | 2 | 3 | 0 | 0 | 1 | 0 | 1 | 0 | **7** |
| **June 21** | 2 | 10 | 4 | 0 | 0 | 1 | 0 | 0 | 2 | **19** |
| **July 21** | 1 | 3 | 0 | 0 | 2 | 0 | 0 | 0 | 0 | **6** |
| **Aug 21** | 1 | 8 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | **11** |
| **Sept 21** | 0 | 6 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | **7** |
| **Oct 21** | 4 | 1 | 6 | 0 | 0 | 1 | 0 | 0 | 0 | **12** |
| **Nov 21** | 1 | 3 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | **6** |
| **Dec 21** | 12 | 3 | 4 | 0 | 0 | 0 | 0 | 0 | **19 *** | **38** |
| **Jan 2022** | 6 | 6 | 5 | 0 | 0 | 0 | 0 | 0 | **2 *** | **19** |
| **Feb 2022** | 7 | 4 | 5 | 0 | 0 | 2 | 0 | 0 | 0 | **18** |
| **March 22** | 4 | 3 | 3 | 1 | 0 | 1 | 0 | 0 | 0 | **12** |
| **Total** | **38** | **49** | **35** | **1** | **2** | **8** | **0** | **1** | **41** | **175** |

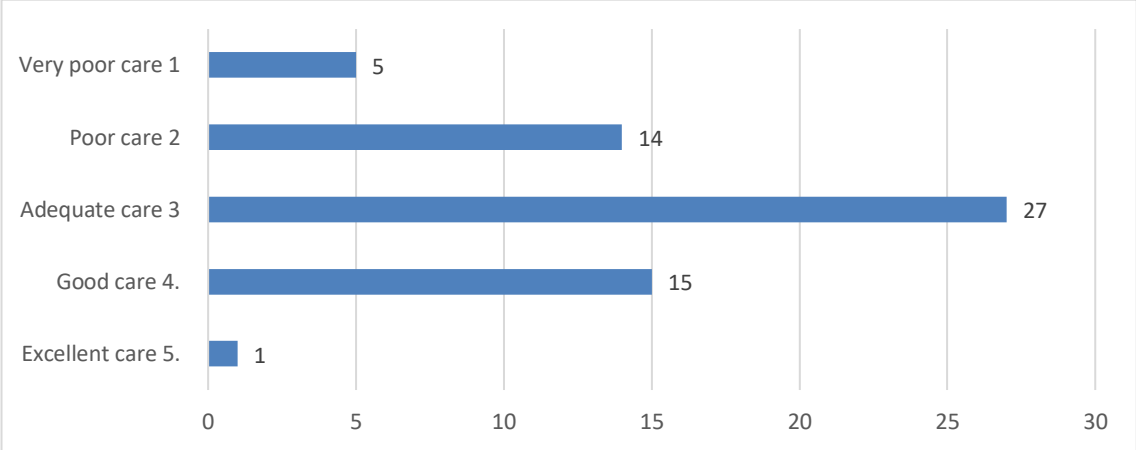
*spike in deaths August 2021 and SHMI alerts = 41 SJRs

175 SJRs were requested in the last 12 months. An increasing proportion of SJR's have been requested through the Medical Examiner's Office. This is to be expected and is a positive development. Early case

review by an experienced medical practitioner which is intrinsic to the process, flags clinical concerns more promptly.

A total of **73** SJRs were requested in Quarter 1 (April to June) of 2022/23 of which **62** have been completed. The findings from SJRs are shared with the speciality mortality leads and appropriate Clinical Directors.

**Quality of Care score distribution for 62 completed SJRs**




Of the 62 SJRs completed in Quarter 1 2022/2023 the following learning themes and concerns were identified:

**The following good practice was identified:**

- Prompt ED and medical review
- Good family communication and MDT involvement
- The first 24 hours of care was excellent with appropriate management of a significant variceal bleed.

**The following poor practice was identified:**

- The care received at the end of life was poor – the patient missed prescribed medication for two days, which may have allowed her to go home to die, which were her wishes.
- A significant lack of being able to recognise that this patient had been hypotensive since admission
- Missed opportunity to diagnose pulmonary embolism in a high-risk patient
- Lack of senior medical review on admission
- Poor family communication
- Potassium treatment, especially lack of checking the results of the treatment, could have been managed better
- lack of ICU decision justification in not admitting patient
- Poor care for a GI bleed. Missed treatment for more than 48 hours, despite seeing multiple senior doctors
- New oxygen requirement was not investigated in a timely manner
- Failure to assess the patient after the CT scan despite her having a NEWS of 9 pre-scan.
- The escalation decision could have been considered sooner and formal end of life care initiated before death

**Learning from Deaths Annual Report 2021/22**

**The following areas for improvement were identified**

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

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

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

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

   **Response**

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

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

- The End-of-Life Steering Group has recently been re-established. This group will identify and triangulate concerns and learning from Serious Incidents and Structured Judgment Reviews
- Through the CAIP programme we can now identify frailer patients, at greater mortality risk through their admission Rockwood scores and institute earlier advanced care planning

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

**LfD Recommendations for 22/23**

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

**Recommendation**

The Board is asked to note the Learning from Deaths Quarter 1 report.

# 18. Safeguarding Adults and Children Annual Report

To Note

Presented by Lindsay Rudge

| | |
|---|---|
| **Date of Meeting:** | Thursday 1 September 2022 |
| **Meeting:** | Public Board of Directors |
| **Title:** | Safeguarding Adults and Children Annual Report |
| **Authors:** | Andrea Dauris, Associate Director of Nursing – Corporate<br>Alison Edwards, Head of Safeguarding |
| **Sponsoring Director:** | Lindsay Rudge, Chief Nurse |
| **Previous Forums:** | Safeguarding Committee - 25 July 2022<br>Quality Committee - 17 August 2022 |

**Purpose of the Report**

This report provides an overview of the national and local context of safeguarding and areas of practice included in safeguarding across the Trust for the reporting period April 2021 March 2022.

The report provides assurance to the Quality Committee highlighting key performance activity and information of how its statutory responsibilities are being met, and of any significant issues or risks, and how these are mitigated.

The report provides a focus on the work and commitment to safeguarding children and adults provided by the Safeguarding Team referring to: -

- Prevent
- Safeguarding and Covid
- Hidden Harms
- Mental Capacity Act and Deprivation of Liberty Safeguards/Liberty Protection Safeguards
- Training
- Safeguarding Supervision
- Adult Safeguarding
- Children's Safeguarding
- Mental Health
- Children Looked After Calderdale
- Maternity Safeguarding

**Key Points to Note**

- We have achieved 90% compliance in levels of safeguarding Adults/Children/Prevent/ MCA/DoLS training
- Training compliance is below 90% for Female Genital Mutilation (FGM- 87%) and Receipt and Scrutiny Training (68%)
- Safeguarding supervision is reported at 56% and work continues in partnership with the Divisions to look at how we can support to increase compliance.
- We continue to maintain a business-as-usual functionality continuing with day-to-day op erations and attendance at multi-agency virtual Safeguarding Adults Board meetings and Children's Partnership meetings for Calderdale and Kirklees and their sub-groups.
- We have reviewed and refreshed the Safeguarding Strategy (2022-2024) to reflect the Boards/Partnerships priorities and support the safeguarding workplan
- Discharge quality improvement work with partner agencies (under the SAFER service im provement agenda) is ongoing to support the improvement of the quality of hospital disc harges.
- The service level agreement with SWYPFT has been updated to ensure that mental health services provided to CHFT continue effectively.
- CHFT staff have continued to make Deprivation of Liberty applications throughout this period ensuring the rights of our patients are safeguarded. These have continued to increase in 2021-2022 showing a maintained awareness amongst staff to ensure the Human Rights of patients are protected.
- We have successfully recruited to all our vacant posts and are inducting our new team members into their roles.
- Initial and Review Health Assessments carried out by the Children Looked After Team in Calderdale have continued and a contingency plan has been implemented to address the backlog of review health assessments for children out of area placed in Calderdale.
- Calderdale Safeguarding Adults Board have recognised and commended the work in relation to the CHFT wound clinics/sexual health clinics at the Gathering Place and the High Intensity User Group that has taken place in response to the Burnt Bridges Thematic Review.

**EQIA – Equality Impact Assessment**

Equality impact assessment forms the basis of much of the work of the Safeguarding Team. The role of the team is to ensure that those in the most vulnerable groups are protected from harm.

**Recommendation**

The Board is asked to **NOTE** the key activity of the Safeguarding Team for the reporting period April 2021-March 2022.

## 1. INTRODUCTION

This report is the Safeguarding Adults and Children Annual Report for the Trust Board, for the reporting period April 2021 – March 2022.

The report provides an overview of activity and outlines key achievements and developments on both the progress against the annual report priorities and our safeguarding strategy for 2020-2022. The report also outlines our priorities in line with our refreshed strategy for 2022-2024.

The report will focus upon our consistent safeguarding response during the Covid-19 pandemic and the challenges it has posed, whilst providing assurance that Calderdale and Huddersfield Foundation Trust (CHFT) has fulfilled its statutory safeguarding responsibilities.

## 2. PREVENT

The Counterterrorism and Security Act (2015) places a duty on CHFT to have; *'due regard to the need to prevent people from being drawn into terrorism.'*

CHFT Safeguarding Team undertakes regular patient information requests regarding potentially high-risk individuals and shares these with PREVENT partner agencies. We also attend Channel panel meetings to discuss individual cases to understand their vulnerability to being drawn into terrorism activities, as well as engaging with the person and partner agencies (e.g., Child and Adolescent Mental Health Service (CAMHS), (Housing, Social Care) to support these vulnerable individuals to consider how they can make positive changes to their lives.

PREVENT training is now available by Government PREVENT wrap training. We are working with the PREVENT lead in the local authority and the BAME network to address some issues that have been highlighted in relation to this training. In response to the concerns raised; there has been contact with the Department of Health and Social Care who are keen to receive feedback in relation to the concerns raised about the content of this training. Further meetings are planned to provide this. The BAME network are receiving updates in relation to any progress with this work. Further work is required to develop a network of PREVENT Safeguarding Champions within CHFT.

CHFT has met its statutory responsibilities with the key achievements set out below: -

**Key Achievements**

- All staff receive the Government approved Prevent e-learning training.
- Our training compliance has remained consistently above 90% throughout the year.
- Prevent activity and information is shared quarterly with NHSE and our Designated Safeguarding Nurses in the CCG.
- CHFT Safeguarding Team attend Channel panel meetings where partner agencies discuss individuals in the pre-radicalisation phase to prevent them being drawn into terrorism.

**Priorities 2022-2023 (including actions from 2022-2024 Safeguarding Strategy workplan)**

- Explore the role of Prevent Champions and increase numbers if required.
- Continue to work with the BAME network and Channel co-ordinator to explore the concerns raised regarding the PREVENT training

## 3. SAFEGUARDING AND COVID

The Coronavirus Act 2020 did not suspend professionals' duties to safeguard children and adults or their responsibility to comply with the Mental Capacity Act/Deprivation of Liberty Safeguards during this challenging time.

The Safeguarding Team have maintained the safeguarding service consistently throughout the pandemic, ensuring our key statutory roles were maintained. There have been several further changes to the team with the recruitment of a new 1.0 whole time equivalent (wte) Named Nurse for Safeguarding Children; 0.8wte Named Nurse for Safeguarding Children Looked After and Care Leavers; 1.0wte Specialist Advisor in Children's Safeguarding and Maternity and 1.0wte Paediatric Liaison Sister.

Given the gap in cover arrangements the team have prioritised essential safeguarding work and informed key partners of the staffing position.

Feedback regarding adult safeguarding initial investigations to the Local Authority, is that CHFT are not meeting the multi-agency agreed timeframes which are defined in the multi-agency safeguarding adult's policy. We are continuing to work with the Local Authority to improve this process, however due to the impact of staffing within the Local Authority due to the ongoing pandemic this work is progressing slowly.

- In response to this, there has been ongoing work with the Risk Management Team to align Trust and safeguarding processes and increase understanding between the two teams of how this can be addressed. The Risk Management Team are meeting regularly to review incidents and the Safeguarding Team feed into these huddles. A dashboard has been developed to identify open cases and meetings are planned with the Local Authority to manage open cases.
- This risk has now been reduced from 12 to 9.

The Safeguarding Boards and Partnerships have been kept fully briefed and updated throughout this period. The Safeguarding Team have fulfilled all partnership requests for information and have contributed towards several safeguarding and domestic homicide reviews during this period. We have developed a process with the Risk Management Team to ensure the Serious Incident Panel have oversight of the safeguarding review process. Significantly, in Burnt Bridges, a Safeguarding Adult Review (SAR) report, the health issues of people with multiple and complex needs, including those leading street-based lives were identified. The multi-agency work streams arising from this report, along with the Making Every Adult Matter (MEAM) and trauma informed practice approaches, should improve the health outcomes of patients with such complex needs and may address some local health inequalities. Calderdale Safeguarding Adults Board have recognised and commended the work in relation to the CHFT wound clinics/sexual health clinics at the Gathering Place and High Intensity User Group that has taken place in response to the Burnt Bridges Thematic Review. Work is ongoing to support the Trauma Navigator Pilot within our Emergency Departments.

Self-neglect has been a significant theme in SARS during this period and the self-neglect pathways and risk escalation conferences are in regular use. Other SAR reports have identified the use of the Mental Capacity Act (MCA) with patients who may have difficulties with their executive functioning (such as those with substance misuse problems, head injuries and phobias etc). We have updated the MCA policy to reflect this area and have input into various groups (such as the High Intensity User Group) to ensure that recent case law is drawn to the attention of staff working with people with complex needs. The bespoke face to face training programme also includes this area. Self-Neglect/MCA/DoLS will be one of the key areas highlighted during Safeguarding Week 2022.

We have seen several complex mental health patients (adults and children) over the last year and continued to be involved pro-actively with Divisions. The Safeguarding Team have prioritised essential safeguarding work and maintained the key health practitioner role in the Domestic Abuse Hub.

In line with the national trend during the pandemic there has been an increase in children admitted with non-accidental injury, particularly in the under 1's. In response to this CHFT has been involved in the roll out of the ICON programme (I-Infant crying is normal; C- Comforting methods can help; I- It's ok to walk away; N- Never shake a baby). CHFT are contributing towards a serious practice review in relation to non-accidental injury in a baby under the age of 1. The learning from this review and the National Panel Thematic Review on Non-Accidental Injury to Under One Year Olds identifies hidden males/significant others as a key area of learning and this will help inform in safeguarding practice going forward. Safeguarding children training has been updated to reflect this. Hidden males/significant others will be one of the key areas highlighted during Safeguarding Week 2022.

**Key Achievements**

- We have carried out business as usual within the team and continued to maintain our operational service throughout.
- We have continued to ensure our safeguarding training is in line with restrictions in place during the pandemic, with our packages and videos being available for staff to complete on the intranet.
- We have sent our Kirklees and Calderdale partners assurances regarding our business continuity arrangements.
- We have continued to attend virtual Safeguarding Adults Board meetings and Children's Partnership meetings for Kirklees, and their safeguarding subgroups.
- Maintained our mandatory FGM and PREVENT reporting responsibilities and submissions to NHSE.
- Collaboratively our Mental Health Liaison Team (SWYPFT) has worked in partnership with CHFT to reduce prolonged waits in the Emergency Department during this unprecedented time.
- Safeguarding supervision is being delivered remotely as are our internal and multi-agency meetings.
- Worked collaboratively with Joint Security Operations Group, the security teams, and the Resilience & Security Management Specialist to consider issues such as restraint of vulnerable patients, manging patients with behaviours that challenge others and to consider the Violence Protection Standards.
- Provided the CCG with safeguarding provider assurance in relation to the Children Looked After and Safeguarding Inspections 2016/2018 through position statement mechanism.
- Supported completion for a multi-agency health audit reviewing communication between health agencies when a case has been referred to the DA Hub

**Priorities 2022-2023 (including actions from 2022-2024 Safeguarding Strategy workplan**

- Continue to learn about the impact of the Covid 19 pandemic in relation to safeguarding children and adults at risk and how this is influencing safeguarding practice.
- Continue to support the learning from safeguarding and domestic homicide reviews influences our safeguarding practice.
- Publicise the safeguarding strategy and monitor our progress in relation to this.

### 3.1 Hidden Harms

Crimes such as child abuse, child sexual exploitation, domestic abuse (including "honour" based abuse), sexual violence and modern-day slavery, typically take place behind closed doors, hidden away from view. The pandemic has caused hidden harms to children and adults, and this has increased the complexity of the needs of families requiring effective early intervention and help. The Coronavirus measures; resulted in these crimes being more prevalent and less visible.

In April 2021 the Domestic Abuse Act was passed by Parliament and for the first time in history there is a wide-ranging legal definition of domestic abuse which incorporates a range of abuses beyond physical violence, and this includes emotional, coercive or controlling behaviour, and economic abuse.

The Domestic Abuse Policy was updated in 2021 to reflect the publication of the Domestic Abuse Act 2021. The CHFT Maternity Domestic Abuse guideline was incorporated into the policy following a recommendation from a Domestic Homicide Review.

### 3.2 Health based Independent Domestic Violence Advisor (IDVA):

In 2021 CHFT were successful in receiving funding from the West Yorkshire Combined Authority to employ a health based IDVA to work in Huddersfield with victims from a BAME background. CHFT recruited to the role and our IDVA commenced in post 24.01.2022.

The role of the health IDVA is first line contact for patients who are victims, offering refuge, emergency accommodation, support, liaison with police and establishing links for individuals and their families to longer term community based support. This now occurs often whilst the victim is in hospital or in the Emergency Department (ED).

The role includes accessing and screening the referrals made by the ED and then referring into either the DA Hub (Calderdale) or DRAMM (Kirklees) daily multi-agency meetings.
Proactively the health IDVA service aims to improve the training and education of front-line staff to develop understanding and confidence in responding to domestic abuse. From September 2022 the IDVA is going to re-introduce bespoke training in addition to the level 2 and level 3 training looking at identifying and responding to domestic abuse. The impact of the training with be evaluated 3 months after the training commences.

Funding for the IDVA post has been extended until 2025.
With the funding for 2021-2022 we were able to fund the IDVA to complete the Women's Aid IDVA training and the Domestic Abuse Specialist Advisor to complete the Saving Lives IDVA training. The IDVA commenced in post in January 2022 with no previous experience of working as an IDVA therefore the priority was to complete the training.

The number of new referrals received by the IDVA since commencing in post from 24.01.2022 until 31.03.2022 were 12 with 3 victims being supported to report a crime to the police. The age range of victims supported is between 13 and 64 years.
Initial feedback from the victims supported by IDVA submitted to the MOJ is:

**It was good that I can speak to someone face to face on the same day as the appointment, without the hassle of booking 2 appointments.*
**Speaking to someone who can speak in my language and can understand me has really help me to talk.*
**You are approachable and easy to talk to especially as this is the first time, I have met you.*

We secured 100 training packages for CHFT safeguarding team, and staff working in frontline roles in ED, Maternity and Acute floor medical and surgical areas. This is the Homicide timeline training by Professor Jane Monckton-Smith which lays out her ground-breaking research on coercive relationships and detectable signs that lead to domestic abuse and homicide. This will assist frontline practitioners to recognise and respond to domestic abuse and recognise the risk of homicide to assist with the quality of referrals into MARAC.

### 3.3 Calderdale Domestic Abuse Services

Safe Lives have been commissioned to undertake a whole system review by operationalising a Public Health approach. Using systems thinking methodology and through the lens of the whole family this will identify opportunities for improving the risk led response, early intervention, and prevention of domestic abuse. This includes a systems-wide assessment of the current local landscape, identifying data and ongoing monitoring opportunities, consulting with service users and providers to understand risk and protective factors.

Early recommendations identified that the current Domestic Abuse Hub was not aligned to the 10 principles of an effective Multi Agency Risk Assessment Conference (MARAC). As a result of the report a review of the current Domestic Abuse Hub was undertaken benchmarking this against other Daily Risk Assessment Meetings (DRAM)/Domestic Abuse HUB (DA Hub) meetings across West Yorkshire. The proposal is to move to a daily DRAM and a bi-monthly MARAC meeting of 4 hours.

CHFT currently employ the Domestic Abuse Specialist Practitioner who will continue to work with the daily DRAM meetings sharing health information from CHFT, LOCALA and SWYPFT.

The expectation is that CHFT will provide a MARAC service representation in a senior role and this will be undertaken by the Named Midwife Safeguarding/Domestic Abuse Lead. It is anticipated that this will require 12-14 hours in time to meet this commitment. We are developing plans for the Safeguarding Advisor for Children and Maternity and Domestic Abuse Specialist Practitioner to be able to support maternity supervision to support this proposal.

**Key Achievements**

- We continue to promote the use of the Partnership Intelligence Portal for staff to feed in soft intelligence to the Police in relation to gangs/County Lines and Modern Day Slavery.
- We continue to support local partnership meetings for children and young people at risk of exploitation.
- We flag hospital records of children/young people at risk of exploitation.
- We have successfully used the under 18 and adults at risk CHFT bespoke proforma that has key questions in place in relation to vulnerability in gynaecology, sexual health and midwifery. This has now been built into EPR.
- We continue to link in with National Safeguarding Children Professional meetings to benchmark other regional trends in safeguarding children.
- We have monitored our safeguarding data closely throughout the year and noted increases in children on a child protection plan and those coming into care. Whilst noting these increases, we have continued to carry out safeguarding children medicals and initial and review health assessments by our Children Looked After Team.
- Reviewed the Domestic Abuse Policy
- Appointment of a Health Based IDVA
- Increased access to Domestic Abuse training

**Priorities 2022-2023 (including actions from 2022-2024 Safeguarding Strategy workplan)**

- Continue to review the impact that the Covid 19 Pandemic has had upon the emotional wellbeing of pregnant women.
- Continue to raise awareness of the complex issues relating to contextual safeguarding and the use of multiagency meetings to share intelligence around this.
- Develop awareness and training regarding the under 18's and adults at risk safeguarding proforma.
- Raising awareness of the Making Every Adult Matter (MEAM) agenda in conjunction with partner agencies.
- Raising awareness of the Trauma Informed approach to working with patients and their families.
- Support staff to identify and provide support for those who have multi-complex needs; are homeless or display signs of self-neglect.
- Review the impact of the Health Based IDVA.

## 4 MENTAL CAPACITY ACT (MCA) AND DEPRIVATION OF LIBERTY SAFEGUARDS (DoLS)

The Department of Health and Social Care issued guidance in April 2020 emphasising that the principle of the MCA and the safeguards provided by DoLS still apply during the Covid 19 pandemic.

Work continues to promote the principles of the MCA and in particular supporting staff in considering the importance of the executive functioning of a patient.

All CHFT DoLS applications continue to be quality assured by the Adult Safeguarding Team providing evidence that the restrictions on the patient, that amount to a deprivation of liberty, are the least restrictive and in the patient's best interests, in addition to meeting the statutory requirement for an urgent DoLS authorisation and an application for a Standard Authorisation. Once the Standard Authorisation has been granted, the team ensure that any conditions on CHFT are complied with and that the Relevant Persons Representative (RPR) or paid RPR is identified in the patient's records. We continue to work closely with the Independent Mental Capacity Advocate (IMCA) Service.

### 4.1 DoLS Data in Q1, Q2, Q3 and Q4

| | Number of Urgent DoLS Authorisations | Number of Standard Authorisations | Average p/month |
|---|---|---|---|
| 2018/19 | 219 | 27 | 18 |
| 2019-20 | 186 | 20 | 15 |
| 2020-21 | 191 | 0 | 16 |
| 2021-22 | 350 | 3 | 29 |

The number of Urgent Authorisations reflects CHFT staff commitment to protecting the Human Rights of their patients and has risen significantly over the past 12 months. Patients have not usually been assessed for a Standard Authorisations (by the Supervisory Body) as either the patient has been discharged, successfully treated, or have regained the mental capacity to consent to their care and treatment arrangements. In some situations, staff have been able to use less restrictive care practices to prevent the patient being deprived of their liberty.

### 4.2 The Mental Capacity (Amendment) Bill

The Mental Capacity (Amendment) Act received Royal Assent in May 2019 and introduces the Liberty Protection Safeguards to replace DoLS. The purpose of the Bill is to provide a simplified legal framework and authorisation process which is accessible, clear, delivers improved outcomes for people deprived of their liberty and places the person at the heart of decision making. Because of the Covid-19 pandemic, the Minister for Care has deferred the implementation of the LPS, with no identified date for implementation. However, CHFT must continue to work towards preparing staff and the organisation for its implementation.

**Implications for CHFT**
This is a significant piece of statutory work which will include several departments to ensure the implementation is effective. There will be a transition period during which existing Authorisations will remain valid.

Hospitals will become the responsible body and will be responsible for authorising the deprivation of liberty (it will no longer be the Local Authorities responsibility, but the Hospital Manager). To ensure CHFT meets it statutory and legal responsibilities and to guarantee the deprivation is lawful, referral pathways and the authorisation process will need to be considered and agreed within the organisation.

For the responsible body to authorise any deprivation of liberty, it needs to be clear that:

- The person lacks capacity to consent to the care arrangements
- The person is of unsound mind
- The arrangements are necessary and proportionate

Under Liberty Protection Safeguards (LPS), the Authorisation can be used in a variety of settings (i.e.) those who live at home and have respite care and a day centre. Staff will need to be trained and aware of what the new LPS encompasses, as well as what an objection is including how to refer to an Approved Mental Capacity Practitioner (AMCP) when the patient is objecting to the arrangements. The role of the AMCP is to carry out a pre-authorisation review and to determine whether to approve the arrangements.

LPS will apply to children aged 16 and 17.

An initial paper has been presented to WEB explaining 3 options the Trust will need to consider for successful implementation. Option 1 – How the Board will manage its function as a responsible body; Option 2 – How CHFT will manage their responsibility in relation to s12 doctors; Option 3 – How CHFT will manage their responsibility in relation to AMCP's. A further paper has now been presented to WEB in March to provide a more detailed appraisal of option 1.

The MCA code of practice/regulations was released for consultation in March 2022. The consultation period ends on the 14/07/2022. The Safeguarding Team is collating the consultation response from CHFT and has sent out requests for staff to consider and respond to the changes. Once the consultation period has closed, the Government will need to consider its response and it is anticipated that this will take place over the winter of 2022-2023. Following this period of consideration, with possible further amendments to the code of practice/regulations and its transition to law, it is expected that LPS will not come into force until October 2023 and possibly April 2024.

CHFT are ensuring that the implementation of the LPS is a smooth process for staff, patients and their families. The Local Implementation Network (LIN) is being re-established and there are regular meetings with the CCG lead, and an internal draft action plan has been developed. The internal steering group is currently being set up.

As part of the commissioning process, ICB's (formerly CCG's) will reasonably expect to see evidence of the LPS working effectively and the MCA LPS is likely to be included in the NHS standard contract.

**Key Achievements**

- Referrals during the period April 2021-March 2022 have increased showing an awareness with staff to ensure the Human Rights of our patients are maintained.
- Provided a detailed report to the Executive Board regarding the Liberty Protection Safeguards, implications of the Bill and Codes of Practice.
- We continue to quality assure all referrals made by CHFT staff.
- We have developed a digital mental capacity assessment form.
- Developed and delivered bespoke training sessions in response to identified gaps in knowledge and skills.

**Priorities 2022-2023 (including actions from 2022-2024 Safeguarding Strategy workplan)**

- Develop a strategic implementation plan and continue to work towards the implementation of LPS with digitised documentation.
- Continue to update the Trust Board regarding progress in relation to LPS.
- Continue to ensure that all staff are trained in the Mental Capacity Act according to their role.
- Continue to work with our local networks and partners to ensure successful implementation of LPS.
- Audit the use of the MCA in relation to DoLS.
- Deliver bespoke MCA training to those who work with children to ensure a foundation for LPS implementation.

## 5 TRAINING

The Covid-19 pandemic infection control changes meant that CHFT stopped face to face training. To ensure we maintained safeguarding/MCA/DoLS competencies with staff, it was moved to an e-learning package, available on the Safeguarding intranet pages enabling staff to complete these and self-declare their compliance. We supplemented this training through regular updates and briefings though divisional Patient Safety and Quality Board meetings, supervision sessions and bespoke training. During this period, we have developed and worked on an alternative approach which will include e-learning and face to face training. This will ensure our compliance with the Intercollegiate documents for adults, children and children looked after and care leavers, MCA training competencies and prepare our workforce for the implementation of Liberty Protection Safeguards. This has now been approved at the Safeguarding Committee, Nursing and Midwifery Council and WEB. Face to face training will recommence during 2022.

Figure 1 indicates the year end Trust position for Safeguarding training compliance. Compliance data is monitored in the Safeguarding Committee. As of March 2022, overall compliance was at 92.89%.

| | 31.03.21 | | | | | 31.03.22 | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Assignment Count | Required | Achieved | Outstanding | Compliance % | | | | | | % Deviation |
| | 6063 | 23284 | 21618 | 1666 | 92.84% | 6176 | 24091 | 22378 | 1713 | 92.89% | 0.05% |
| | | | | | | | | | | | |
| Competence Name | | | | | | | | | | | |
| NHS\|MAND\|Mental Capacity Act - 3 Years\| | 237 | 237 | 208 | 29 | 87.76% | 202 | 202 | 184 | 18 | 91.09% | 3.33% |
| NHS\|MAND\|Mental Capacity Act Level 2 - 3 Years\| | 3312 | 3312 | 3081 | 231 | 93.03% | 3329 | 3329 | 3144 | 185 | 94.44% | 1.41% |
| 372\|LOCAL\|Mental Capacity Act Level 3 - 3 Years\| | 648 | 648 | 592 | 56 | 91.36% | 776 | 776 | 727 | 49 | 93.69% | 2.33% |
| NHS\|CSTF\|Safeguarding Adults - Level 1 - 3 Years\| | 1686 | 1686 | 1642 | 44 | 97.39% | 1750 | 1750 | 1654 | 96 | 94.51% | -2.88% |
| NHS\|MAND\|Safeguarding Adults Level 2 - 3 Years\| | 3661 | 3661 | 3415 | 246 | 93.28% | 3807 | 3807 | 3608 | 199 | 94.77% | 1.49% |
| NHS\|MAND\|Safeguarding Adults Level 3 - 3 Years\| | 553 | 553 | 518 | 35 | 93.67% | 537 | 537 | 519 | 18 | 96.65% | 2.98% |
| 372\|LOCAL\|Female Genital Mutilation\| | 509 | 509 | 466 | 43 | 91.55% | 606 | 606 | 529 | 77 | 87.29% | -4.26% |
| NHS\|MAND\|Prevent WRAP - No Renewal\| | 6063 | 6063 | 5649 | 414 | 93.17% | 6176 | 6176 | 5784 | 392 | 93.65% | 0.48% |
| NHS\|CSTF\|Safeguarding Children - Level 1 - 3 Years\| | 1683 | 1683 | 1638 | 45 | 97.33% | 1747 | 1747 | 1647 | 100 | 94.28% | -3.05% |
| NHS\|MAND\|Safeguarding Children Level 2 - 3 Years\| | 3654 | 3654 | 3408 | 246 | 93.27% | 3755 | 3755 | 3561 | 194 | 94.83% | 1.56% |
| NHS\|MAND\|Safeguarding Children Level 3 - 3 Years\| | 561 | 561 | 538 | 23 | 95.90% | 590 | 590 | 562 | 28 | 95.25% | -0.65% |
| 372\|LOCAL\|Mental Health Act Receipt and Scrutiny Training\| | 86 | 86 | 56 | 30 | 65.12% | 82 | 82 | 56 | 26 | 68.29% | 3.17% |
| 372\|LOCAL\|Safeguarding Supervision\| | 631 | 631 | 407 | 224 | 64.50% | 727 | 727 | 397 | 330 | 54.61% | -9.89% |
| **Grand Total** | **6063** | **23284** | **21618** | **1666** | **92.84%** | **6176** | **24091** | **22378** | **1713** | **92.89%** | 0.05% |

Key

Aspirational Target >95%
On target 90% - 94.0
ear Target 85% - 89.9%
Below Target<85%

(Figure 1)

## 5.1 Exception reporting: Receipt and Scrutiny Training and Safeguarding Children Supervision.

Mental Health Act Receipt and Scrutiny training has been delivered virtually over Microsoft Teams by SWYPFT MHA administrators to CHFT senior nurses who would accept MHA section papers on behalf of the Trust until December 2021. Due to retirement of the post holder SWYFT are reviewing delivery of this training and from December 2021-March 2022 no further training has been received for CHFT. This has been escalated to the SWYFT Mental Health Act Committee in March 2022.

The levels of Receipt and Scrutiny (of statutory Mental Health Act documentation) training is below 90% however compliance will not increase until further training is available.

Safeguarding Children's Supervision is delivered virtually though Microsoft Teams and compliance remains significantly below 90%. Compliance continues to be monitored via the Safeguarding Operational Group and Safeguarding Committee and the plan to increase compliance is to adopt a targeted approach by working more directly with line managers to identify challenges in relation to attendance and recording compliance. Safeguarding supervision has been available to the children's and maternity workforce for several years. We are also starting to embed safeguarding supervision within the adult workforce to further strengthen our approach to supporting all staff who manage safeguarding cases, and as a way of maintaining their own wellbeing in recognition of the emotional impact of this work.

CHFT has invested in training safeguarding champions as facilitators to support increasing safeguarding supervision compliance in line with the CHFT Safeguarding Supervision Policy.

**Key Achievements**

- We continue to engage and share training compliance with Divisions bi-monthly.
- High levels of MCA/DoLS and safeguarding training have been maintained throughout the year.
- Bespoke training sessions through teams in relation to the MHA and MCA have been delivered.
- Reviewed delivery and updated the content of the Level 3 Safeguarding Training/MCA/ DoLS packages.
- We have updated level 2 Safeguarding Families Children's and Adults combined E-learning package which includes MCA and DoLS basic awareness.
- A national E-learning package for MCA DoLS has been identified and with additional bespoke sessions it was agreed via the Safeguarding Committee that some staff groups will need to complete this further training, to ensure they are adequately equipped with the foundation for the effective implementation of the Liberty Protection Safeguards.
- Updated the Safeguarding Supervision Policy.

**Priorities 2022-2023 (including actions from 2022-2024 Safeguarding Strategy workplan)**

- Implementation of safeguarding training to ensure ongoing compliance with the Intercollegiate documents and the re-introduction of face-to-face training.
- Continue to develop a more targeted approach to increase safeguarding supervision compliance.
- Continue to work with SWYFT to support attendance at the Receipt & Scrutiny training.

## 6. ADULT SAFEGUARDING

Safeguarding adults is a statutory requirement under the Care Act (2014). Safeguarding adult's means protecting a person's right to live in safety and free from harm, abuse and neglect.

Ineffective or unsafe discharges remain an issue for safeguarding; this position continues to be shared at Safeguarding Committee meetings which has representation from the four divisions. The Safeguarding Team continue to work with local authority partners to ensure oversight and investigation of all these cases. Kirklees Local Authority have previously agreed that poorly managed discharges can be managed by a different approach to Calderdale and that some of these can be managed as quality-of-care concerns. In Calderdale all ineffective discharges are managed as S42 investigations under the Care Act 2014. To date this process remains unchanged.

The strategic transformation programme has been addressing continual improvement and the Trust now has in place the Safari programme whereby pharmacists are working directly with discharges to ensure that the patient fully understands their medication use, potential side effects and that they have the correct medication for their discharge. The initial safeguarding data appears to confirm that the medication issues on discharge have decreased, and we anticipate this improvement will be sustained. Additionally, the Standard Operating Procedure (SOP) introduced in ED has made some improvements with the quality of discharges from ED.

Data relating to discharges is now received onto the Enhanced Dashboard Metric and early data highlights a reduction in discharge related incidents. This measure is now being monitored on a weekly basis going forward. The Clinical Governance Support Mangers have submitted a separate report to Divisional PSQB's identifying trends in incidents related to

discharges. A response to this position is expected to be reported through the corporate PSQB meeting.

**Key Achievements**

- Management of Patients Not Brought for Appointments Policy now includes adults with vulnerabilities/adults at risk.
- Missing Persons Policy has been reviewed.
- Adult Safeguarding continue to work closely with Kirklees Local Authority to agree that the increased number of ineffective discharges could be managed internally by CHFT as opposed to formal individual Care Act (2014) Section 42 investigations.

- **Priorities 2022-23 (including actions from 2022-24 Safeguarding Strategy workplan)**
- Streamline safeguarding processes and investigations.
- Systems approach to embed learning (i.e. Multi Agency Audit programmes)
- Working with the new Lead Nurse Children to progress the embedding of the Transition Policy.
- To contribute to support Divisions and the ongoing work to drive quality improvements in relation to hospital discharges.
- To work alongside and support Divisions with regard to providing timely feedback to the local authority.

## 7. CHILDREN SAFEGUARDING

CHFT is fully committed to the principles set out in the government guidance 'Working Together to Safeguard Children – 2018, the Children Act 1989/2004" and to joint working with both the Calderdale and Kirklees Safeguarding Children Partnerships. The Trust works within the West Yorkshire Safeguarding Children Policies and Procedures for the protection of all children who attend CHFT.

**Key Achievements**

- Recruitment of a safeguarding children's/maternity advisor.
- Process established for identifying where 16 to 17 year olds are admitted, training undertaken and SOP developed to support.
- Safeguarding supervision being offered to departments where young people aged 16 to 17 are admitted with presentations of concern.
- Developed a pathway with Locala (Community Services) for direct referral into Paediatric/ED services for children requiring hospital assessments.
- Introduction of the electronic ED Paediatric Liaison Notification form.
- Paediatric Sit Rep embedded into core safeguarding work, children and young people reviewed and supported by the team.
- Developed a Children Mental Health Policy with CAMHS and Paediatric Services
- Robust oversight of paediatric patients who have mental health concerns and closer working with the paediatric department. MDT meetings established, with safeguarding representation to support paediatric department. Ongoing utilisation of the Children Mental Health Policy and documentation.
- ED bespoke training reviewed.

**Priorities 2022-23 (including actions from 2022-24 Safeguarding Strategy workplan)**

- Paediatric Liaison Sister and Safeguarding Advisor to establish links with the Trauma Navigators once in post.

- Ongoing training to support teams to undertaken safeguarding supervision within own departments via the safeguarding champions arena and safeguarding team members.
- Map other areas that may need review of safeguarding supervision processes and include establishing robust safeguarding children's champions.
- Continue to support inclusion of the child's voice/lived experience of the child in safeguarding practice.
- Audit introduction of the electronic paediatric liaison notification form.
- Progress the ongoing work relating to the improvement of the quality of the paediatric discharge summaries.

## 8. MENTAL HEALTH

CHFT works in partnership with SWYPFT formally through the service level agreement and the clinical working protocol. We are using the values described in our 4 pillars in developing a mental health strategy with our partners though the Mental Health Operational Group. There are reciprocal representatives and papers shared at SWYPFT's Mental Health Act Committee and CHFT's Safeguarding Committee meeting, and we continue to work in close partnership to meet the needs of our patients.

The Mental Health Liaison Team (MHLT) support and work with CHFT trust staff to ensure that all patients who are referred are reviewed and supported in a timely way.
Around one in four women experience mental health problems in pregnancy and during 12 months after giving birth. If left untreated, mental health issues can have a significant negative and long lasting effects on the woman, the child and the wider family. CHFT Maternity Services continue to work with SWYFT, Locala and the voluntary sector to provide services for pregnant and post-natal women who have mental health concerns, including those who may have experienced baby loss/removal at birth/birth trauma.

An adult safeguarding team representative attends the Mental Health Operational Group and the multi-agency Suicide Prevention Action Group.

**Key Achievements**

- The Department of Health and Social Care (DHSC) and NHS England (NHSE) have provided guidance to professionals on the use of the Mental Health Act during the pandemic. The Court and Tribunals Department instructed the MHA office to carry out their functions remotely during the Coronavirus period. The Mental Health Act Tribunals and Hospital Managers hearings which are co-ordinated by the MHA Office have continued remotely, ensuring our patients' rights to appeal have been discharged throughout this period.
- The Safeguarding Team have continued to support the MHA Office with their scrutiny and reporting mechanism.
- The Service Level Agreement between SWYPFT and CHFT has been re-reviewed and signed for a further 12 months.
- There are honorary contracts in place for Consultants who work for SWYPFT and based in the Mental Health Liaison Team.
- Additional training dates provided to improve compliance with Receipt and Scrutiny training.
- The Joint Working Protocol has been reviewed in line with changes to the working arrangements in the Mental Health Liaison Team.

**Priorities 2022-23 (including actions from 2022-24 Safeguarding Strategy workplan)**

- Reforming the Mental Health Act' White Paper Consultation took place and the Government has now published its response to the Consultation. When more information

becomes available, CHFT will consider the proposals and ensure that policies and procedures are updated accordingly. There may be changes to the Mental Capacity Act Policy and Procedures that will need to be implemented.
- Embedding of new processes for electronic submission of forms related to detaining and serving of MHA papers.
- Ongoing promotion of MHA receipt and scrutiny training to improve compliance.

## 9. CHILDREN LOOKED AFTER AND CARE LEAVERS (CALDERDALE)

Our Children Looked After Team, work in partnership with Calderdale Metropolitan Borough Council (CMBC) to ensure that the health needs of children who are looked after (CLA) and young people in Calderdale are met. The team provides advice and support to health and social care practitioners to improve health outcomes for CLA and young people. A Looked After Child is subject to a care order (placed into the care of local authorities by order of a court), and children accommodated under Section 20 (voluntary) of the Children Act 1989.

Looked after children may live in foster homes, residential placements or with family members (connected carer's).

Following the Covid- 19 Prioritisation of Community Services document issued by the Government in March 2020, Review Health Assessments (RHA) completed by the team were initially stopped. Three members of the CLA team were initially redeployed frontline to support the delivery of acute nursing services in Paediatrics and the PPE team, leaving an Administrator and the Named CLA Nurse to carry on essential functions of the service. Our Consultant Paediatrician and Designated Doctor for Children Looked After were also re-deployed to support the Paediatric Service in the hospital and continued to undertake Initial Health Assessments (IHA) virtually and adoption medicals face to face as highlighted in the prioritisation document. The team recommenced face to face visiting in March 2021.

**Initial Health Assessments** (IHA) completed by the Designated Doctor are completed face to face at Brighouse Health Centre following PHE guidance and use of appropriate PPE.

Data - During the reporting period (1/4/21-31/3/22):
92 Initial Health Assessments (IHAs) completed for Calderdale children: 79 completed in timescales = 86%
35 under age 5 (38%)
57 age 5 and over (62%)
13 IHA not completed in timescales (8 were due to delayed notifications from the LA). 7 were completed with health timescales once received the notification. CLA Named Nurse continues to work closely with the local authority to further understand the reason behind the delayed notifications
10 unaccompanied asylum-seeking children were received in to care

**Review Health Assessments** were initially carried out virtually either via teams/phone and returned to face-to-face contacts around March 2021

Data:
354 Review Health Assessments (RHA's) completed (35% increase from 2020-2021)
Done in timescales: 329 (92%)
5 refused their health assessment to be undertaken
68% completed within Calderdale
29% completed outside Calderdale but within 50 miles
3% completed by other CLA health team for Calderdale children placed outside 50-mile radius

93% are up to date for Immunisations
Number of CLA with Child Exploitation concerns: 3

**Key Achievements**

- Further development of electronic records to support with data collection & analysis.
- Audit to review children placed in Calderdale from out of area and the impact this has on their unmet health needs, Calderdale Health Service provision and to highlight any gaps.
- CLA health team group supervision to look at team development/new ways of working.
- CLA implementation of processes to support externally placed children/young people.
- Review of the recommendations from the 2016 Children's Looked After and Safeguarding CQC inspection and provide assurance to the CCG in relation to embedding and monitoring of these.

**Priorities 2022-23 (including actions from 2022-24 Safeguarding Strategy workplan)**

- Continue to support links for care leavers over 18.
- Explore use of continued virtual assessments (to prevent breeches or when attempting to engage with a YP).
- Working with Calderdale Children's Services to improve completion of SDQ's (Strengthening Difficulties Questionnaire).
- To continue to develop Standard Operation Procedures to ensure a consistent approach is used team members so that children and young people receive an equitable service.
- To conduct monthly quality assurance audit of a sample of Initial Health Assessments/Review Health Assessments.

Case Study 1-
Young person aged 15 years old, was placed in Calderdale from an external local authority and living in a specialist residential setting. The young person was feeling suicidal and attended A&E on three occasions within the same week and was discharged home following assessment with CAMHS. CAMHS were unable to offer any support and signposted the young person to local services whom he could approach for support
CLA Nurse received notifications from paediatric liaison to inform of attendances to A&E. CLA Nurse liaised with CAMHS to understand the reason for not being able to offer any support.

Following this the CLA Nurse rang the residential setting and spoke with the young person. He engaged and was open about how he was feeling. He said he didn't feel listened to and that no one cared about him.
The CLA Nurse arranged to visit the young person who asked that he could be seen at home with a staff member to support him. This was the first time that the CLA Nurse had met this young person. During the visit the young person shared that it was the first time he felt someone cared and has listened to how he was feeling
It was identified that the young person needing further specialist support from CAMHS
Outcome: following further support and assessment from CAMHS, this young person was moved to be placed in a specialist provision for young people who have a diagnosis of autism.

**This case demonstrates:**
CLA health team working in a collaborative way with other clinical specialists in the best interest of the child
Voice of the child is paramount to good outcomes
Every contact counts
CLA Nurse being a strong advocate for the young person

## 10. Maternity Safeguarding

Within maternity services, safeguarding from early intervention to child protection is a key factor. Babies can be particularly vulnerable to abuse, and early assessment, intervention and support provided during the antenatal period can help minimise any potential risk of harm. Issues that can impact on parenting ability are parental substance misuse, perinatal mental illness, domestic abuse, where a member of a household poses risk or potential risk to children, parents known to services because of historical concerns i.e. neglect, child protection planning or removal of children and parents who are or was looked after children and parents under the age of 18 though this list is not exhaustive (West Yorkshire Consortium Inter Agency Safeguarding and Child Protection Procedures).

Where it has been identified that the woman or her family have safeguarding concerns and more detail is required, practitioners document this information within the confidential element of the electronic maternity patient record (Athena). This ensures that all maternity staff have a clear overview of the concerns within the pregnancy as well as the plan for the unborn if the case is open to children's social care.

CHFT maternity service have a specialist midwifery panel that meets once a week. The purpose of this panel is to ensure that there is a robust review process in place for referrals to the Specialist Midwives with a clear rationale for outcome of the referral based on criteria and a follow up process if cases need review.

The panel reviews all referrals to ascertain whether the pregnant woman would benefit from additional support or case loading by the Substance Misuse Specialist Midwife or Early Intervention Midwives or additional support and caseload supervision by the Perinatal Mental Health Lead (Midwifery Services).

### 10. 1 Swans (supporting women in antenatal services)

Within Kirklees key agencies such as children's social care, MARAC (Multi-agency risk assessment conference – domestic abuse), West Yorkshire Police, CHFT Midwifery services, Mid Yorkshire Midwifery services, SWYPFT Perinatal Mental Health, Pennine Domestic Abuse Service (PDAP), Integrated Sexual Health Service and Drug and Alcohol Service work together to provide holistic health care and safety planning to ensure the safety of adults, children and the unborn.

This meeting is organised and managed by LOCALA, but the meeting is chaired by the Named Midwife Safeguarding from CHFT and MYHT and is held monthly to have a coordinated approach to safeguarding and assessing the health and social needs of 'vulnerable' pregnant women and the unborn who are affected by substance misuse, domestic abuse, poor physical, sexual and mental health, homelessness, poverty, involvement in sex work, criminal justice system, multiple removal of previous children and possible concealed pregnancy.

During 2021-2022 there were 31 new referrals made for woman being cared for by CHFT maternity services, and 109 review cases discussed.

### 10.2 MAPLAG (Multi agency pregnancy liaison advisory group)

The MAPLAG was established within Calderdale following a Serious Case Review in 2007. This meeting is organised and led by CHFT Named Midwife Safeguarding where assessment of risk to the unborn is discussed. The meetings are attended by Children's Social Care and Family Intervention Team, CHFT Maternity services, CHFT perinatal mental health lead, SWYFPT perinatal mental health, LOCALA perinatal health visitor, domestic abuse health practitioner, Calderdale Drug and Alcohol Service.

The cases have increased for 2021-2022 with 38 new referrals and an audit of cases heard in MAPLAG will be completed in 2022 to assess the outcome for women and babies heard in the MAPLAG meeting. The audit will be presented to Maternity Forum, Safeguarding Operational Group prior to being presented at the Calderdale Safeguarding Children Health Assurance & Improvement Group (CHAIG).

**Key Achievements**

- Ensured that mandatory FGM reporting responsibilities are maintained with the submissions to NHSE.
- Ensured processes in place for the Trust to ensure all female children born to FGM survivors, records are flagged with the female genital mutilation information sharing (FGM-IS) flag.
- CHFT is continuing to participate with the Children Partnership Board within Calderdale and Kirklees in relation to FGM. This is to represent health and help to reduce the risk to children in our local area.
- Provided external FGM training with Karma Nirvana.
- Reviewed MAPLAG and SWANS process to ensure enhanced risk assessment processes are in place within the multi-agency arena.
- We have successfully used the under 18 and adults at risk CHFT bespoke proforma that has key questions in place in relation to vulnerability in gynaecology, early pregnancy assessment unit (EPAU). This has been built into EPR.
- Developed a pathway with Locala for direct referral into Paediatric/ED services for children requiring hospital assessments.
- Delivered ICON training.
- Review purpose and scope of the Specialist Midwifery Panel.
- FGM audit.
- Audit transfer of antenatal/ postnatal information.

**Priorities 2022-23 (including actions from 2022-24 Safeguarding Strategy workplan)**

- To work with both local authorities in developing a robust pathway for referring female children/new-born babies into children's social care.
- To update CHFT FGM policy.
- To ensure a think family approach is embedded in Maternity to include robust risk assessments into partners/fathers and significant others.
- To develop a robust mechanism for recording safeguarding referrals to the Local Authority.

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# Safeguarding Adults and Children Annual Report April 2021- March 2022

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# Prevent

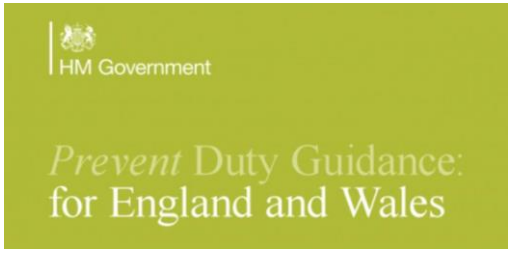
***Prevent is about safeguarding people and communities from the threat of terrorism***

**Key Achievements**

- Our training compliance has remained consistently above 90% throughout this period.
- Prevent activity and information is shared quarterly with NHSE and our Designated Safeguarding Nurses in the CCG.
- CHFT Safeguarding Team attend Channel panel meetings where partner agencies discuss individuals in the pre-radicalisation phase to prevent them being drawn into terrorism.

**Priorities 2022-23 (including actions from 2022-24 Safeguarding Strategy workplan)**

- Further explore the role of Prevent Champions.
- Continue the work with the BAME network/ Channel co-ordinator responding to the concerns raised by the BAME network relating to Prevent training



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# Safeguarding and Covid

***The Coronavirus Act 2020 did not suspend safeguarding duties and responsibilities***

**Key Achievements**

- Continue to work closely with and support the work of the Safeguarding Boards/ Partnerships virtually.
- Provided the CCG with safeguarding provider assurance in relation to the Children Looked After and Safeguarding Inspections 2016/2018 through position statement mechanism
- Worked collaboratively with the Joint Security Operations Group, security teams and the Resilience & Security Management Specialists to consider issues of restraint and challenging behaviours to consider the Violence Protection Standards.

**Priorities 2022-2023 (including actions from 2022-24 Safeguarding Strategy workplan)**

- Continue to learn from the effects of the pandemic on families, influencing safeguarding practice with what we have learned.
- Continue to support the learning from safeguarding and domestic homicide reviews
- Publicise the safeguarding strategy and monitor our progress in relation to this

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# Hidden Harms

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***Hidden Harms take place behind closed doors or away from view eg domestic abuse, sexual abuse, child sexual abuse and modern slavery.***

**Key Achievements**

- Under 18/ adults at risk proforma built into EPR to support identification of contextual safeguarding
- Appointment of the Health Based Independent Domestic Violence Advocate (IDVA)
- Increased access to Domestic Abuse training

**Priorities 2022-23 (including actions from 2022-24 Safeguarding Strategy work plan)**

- Continue to support awareness of the Making Every Adult Matter agenda and trauma informed approach
- Supports staff to identify and provide support for those who have multi-complex needs; are homeless and display signs of self neglect
- Review the impact of the Health Based IDVA

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# MCA and DoLS/ Liberty Protection Safeguards

***The MCA protects and restores power to vulnerable people who may lack capacity to make decisions***

## Key Achievements

- Provide detailed report to the Executive Board regarding the Liberty Protection Safeguards, implications of the Bill and Codes of Practice.
- Update the Board in relation to appraisal of the options for the implementation of liberty protection safeguards
- Developed and delivered bespoke training sessions in response to identified gaps in knowledge and skills base.

## Priorities 2022-23 (including actions from 2022-24 Safeguarding Strategy workplan)

- Audit the use of the MCA and DOLS
- Continue to work with our partners to support a smooth transition to LPS
- Continue to ensure that all staff are trained in the Mental Capacity Act according to their role

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# Training Compliance

| | 31.03.21 | | | | | 30/09/2021 | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Assignment Count | Required | Achieved | Outstanding | Compliance % | Assignment Count | Required | Achieved | Outstanding | Compliance % | % Deviation |
| | 6063 | 23284 | 21618 | 1666 | 92.84% | 6011 | 23418 | 21817 | 1601 | 93.16% | 0.32% |
| **Competence Name** | | | | | | | | | | | |
| NHS\|MAND\|Mental Capacity Act - 3 Years\| | 237 | 237 | 208 | 29 | 87.76% | 219 | 219 | 205 | 14 | 93.61% | 5.85% |
| NHS\|MAND\|Mental Capacity Act Level 2 - 3 Years\| | 3312 | 3312 | 3081 | 231 | 93.03% | 3314 | 3314 | 3123 | 191 | 94.24% | 1.21% |
| 372\|LOCAL\|Mental Capacity Act Level 3 - 3 Years\| | 648 | 648 | 592 | 56 | 91.36% | 708 | 708 | 658 | 50 | 92.94% | 1.58% |
| NHS\|CSTF\|Safeguarding Adults - Level 1 - 3 Years\| | 1686 | 1686 | 1642 | 44 | 97.39% | 1684 | 1684 | 1644 | 40 | 97.62% | 0.23% |
| NHS\|MAND\|Safeguarding Adults Level 2 - 3 Years\| | 3661 | 3661 | 3415 | 246 | 93.28% | 3762 | 3762 | 3549 | 213 | 94.34% | 1.06% |
| NHS\|MAND\|Safeguarding Adults Level 3 - 3 Years\| | 553 | 553 | 518 | 35 | 93.67% | 499 | 499 | 482 | 17 | 96.59% | 2.92% |
| 372\|LOCAL\|Female Genital Mutilation\| | 509 | 509 | 466 | 43 | 91.55% | 504 | 504 | 448 | 56 | 88.89% | -2.66% |
| NHS\|MAND\|Prevent WRAP - No Renewal\| | 6063 | 6063 | 5649 | 414 | 93.17% | 6011 | 6011 | 5615 | 396 | 93.41% | 0.24% |
| NHS\|CSTF\|Safeguarding Children - Level 1 - 3 Years\| | 1683 | 1683 | 1638 | 45 | 97.33% | 1679 | 1679 | 1634 | 45 | 97.32% | -0.01% |
| NHS\|MAND\|Safeguarding Children Level 2 - 3 Years\| | 3654 | 3654 | 3408 | 246 | 93.27% | 3701 | 3701 | 3486 | 215 | 94.19% | 0.92% |
| NHS\|MAND\|Safeguarding Children Level 3 - 3 Years\| | 561 | 561 | 538 | 23 | 95.90% | 569 | 569 | 539 | 30 | 94.73% | -1.17% |
| 372\|LOCAL\|Mental Health Act Receipt and Scrutiny Training\| | 86 | 86 | 56 | 30 | 65.12% | 78 | 78 | 58 | 20 | 74.36% | 9.24% |
| 372\|LOCAL\|Safeguarding Supervision\| | 631 | 631 | 407 | 224 | 64.50% | 672 | 672 | 379 | 293 | 56.40% | -8.10% |
| **Grand Total** | **6063** | **23284** | **21618** | **1666** | **92.84%** | **6011** | **23418** | **21817** | **1601** | **93.16%** | 0.32% |

Key

| |
|---|
| Aspirational Target >95% |
| On target 90% - 94.0 |
| ear Target 85% - 89.9% |
| Below Target<85% |

The chart above indicates the year end Trust position for Safeguarding training compliance. Compliance data is monitored in the Safeguarding Committee.

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# Adult Safeguarding

***Is protecting a person's rights to live in safety, free from abuse and neglect***

**Key Achievements**

- Management of Patients Not Brought for Appointments Policy now includes adults with vulnerabilities/ adults at risk
- Adult safeguarding have continued to work closely with Kirklees LA to agree that ineffective discharges could be managed internally by CHFT. Initial data re. medication errors on discharge demonstrates an improving picture.
- Data relating to discharges monitored via Enhanced Dashboard metric

**Priorities 2022-23 (including actions from 2022-24 Safeguarding Strategy workplan)**

- Systems approach to embed learning (i.e. Multi Agency Audit programmes).
- To contribute to support Divisions and the work to drive quality improvements in relation to hospital discharges
- To work alongside and support Divisions with regard to providing timely feedback to the local authority

Kirklees Safeguarding Adults Board

Partners in preventing abuse and neglect

Calderdale Safeguarding Adults Board

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# Safeguarding Children

***Working together to protect the welfare of children and protect them from harm***

**Key Achievements**

- Successful recruitment of safeguarding children's/ maternity specialist advisor
- Process identified to identify where 16-17 year olds are cared for, training undertaken with staff and development of a SOP to support, including safeguarding supervision.
- Robust oversight of paediatric patients who have mental health concerns (MDT meetings; MH documentation).

**Priorities 2022-23 (including actions from 2022-24 Safeguarding Strategy workplan)**

- Ongoing training to support teams to undertake safeguarding supervision with own departments via the safeguarding team champions and safeguarding team
- Continue to support the inclusion of the child's voice/ lived experience of the child in safeguarding practice
- Ongoing work to progress the improvement of the quality of the paediatric discharge summaries

Kirklees Safeguarding Children Board

Calderdale Safeguarding Children Partnership

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# Mental Health Act

***The Mental Health Act covers the assessment, treatment and rights of people with a mental health disorder.***

**Key Achievements**

- Service level agreement between SWYPFT and CHFT reviewed and signed
- The safeguarding team have continued to support the MHA Office with their scrutiny and reporting mechanisms
- Joint Working Protocol has been reviewed in line with the changes to the working arrangements in the Mental Health Liaison team

**Priorities 2022-23 (including actions from 2022-224 Safeguarding Strategy) work plan**

- Review policy and procedure in response to the proposals following the consultation process reforming the Mental Health Act
- Embedding of new processes for electronic submission of forms related to detaining and serving of MHA papers.
- Ongoing promotion of MHA receipt and scrutiny training to improve compliance once the new training module is available.

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# Children Looked After (CLA)

***Children and Young people in the care of the Local Authority. The CLA team works with Calderdale Council to ensure the health needs of looked after children in Calderdale are met***

**Key Achievements**

- Audit to review out of area children placed in Calderdale – impact on health needs; gaps in Calderdale service provision
- Implementation of processes to support externally placed children/ young people
- Further development of electronic patient records to support with data collection and analysis

**Priorities 2022-23 (including actions from 2022-24 Safeguarding Strategy workplan)**

- Continue to support links for care leavers over 18.
- Working with Calderdale Children's Services to improve completion of SDQ's (Strengthening Difficulties Questionnaire).
- Development of Standard Operating Procedure to ensure consistency and children and young people receive an equitable service.

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# Maternity Safeguarding

***Within maternity services, safeguarding from early intervention to child protection is a key factor in keeping the unborn and pregnant women safe***

## Key Achievements

- Review the purpose and scope of the specialist Midwifery Panel
- Reviewed Multi Agency Pregnancy Liaison Advice Group (MAPLAG) and Supporting Women in Ante Natal Services (SWANS) process to ensure multi-agency risk assessment processes are in place
- Maintained mandatory reporting mechanisms for FGM

## Priorities 2022-23 (including actions from 2022-24 Safeguarding Strategy workplan)

- Collaborative working with the local authorities in developing a robust pathway for referring female children/ new born babies into children's social care
- Embed think family approach to support robust risk assessments into partners and significant others
- Review the FGM policy

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# Safeguarding is Everyone's Responsibility

# 19. Quality Report

To Note

Presented by Lindsay Rudge

| | |
|---|---|
| **Date of Meeting:** | Thursday 1 September 2022 |
| **Meeting:** | Public Board of Directors |
| **Title:** | Quality Report<br>(Reporting period June to July 2022) |
| **Author:** | Kim Smith - Assistant Director for Patient Safety |
| **Sponsoring Directors:** | Lindsay Rudge - Chief Nurse<br>Dr David Birkenhead - Medical Director |
| **Previous Forums:** | Quality Committee – Wednesday, 17 August 2022 |

**Purpose of the Report**

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

It is to ensure that the 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**

See separate PowerPoint Executive Summary.

**EQIA – Equality Impact Assessment**

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

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

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

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

In ensuring the above as a Trust we well be well placed to respond positively to external

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| scrutiny from the Commission for Equality & Human Rights, the Care Quality Commission, and the Audit Commission. |
| **Recommendations** |
| The Board of Directors are asked to **NOTE** the content of the report and the ongoing activities across the Trust to improve the quality and safety of patient care. |

## 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 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 June and July 2022: the progress updates for the Quality Account Priorities and the Focussed Quality Account Priorities for 2022/2023.

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

## Contents

## 2. Care Quality Commission (CQC) workstreams

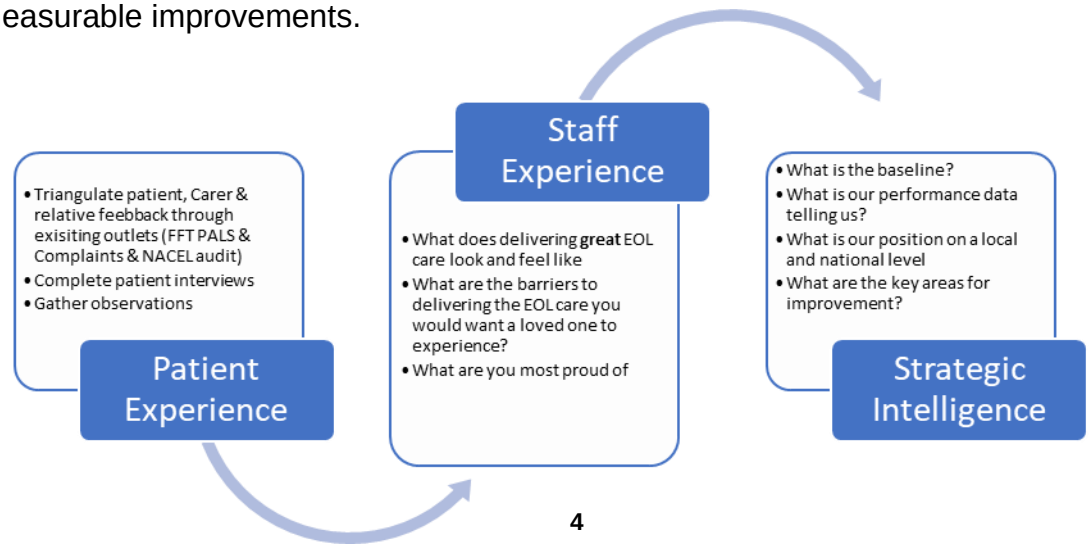
Key highlights are included within the PowerPoint slides at appendix D1.

## 3. Patient Experience, Participation and Equalities Programme

### End-of-Life (EoL) Experience Based Design Project:

Commencing in July 2022 a plan was implemented to support the gathering of intelligence, mapping challenges to overcome and work on developing sustainable improvements.


The patient and staff feedback will be used alongside strategic intelligence to drive measurable improvements.



## 4. Patient Advice and Complaints Service (PACS)

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

**Key Objectives**

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

| Objective | Current level of assurance | Comments |
|---|---|---|
| **1.** Working with the divisions effectively to deliver strong complaints performance and user centric service | **REASONABLE Assurance** | Standard Operating Procedure currently being drafted to ensure all Divisions are following same process. Escalation process has been agreed when complaint response are outside of timeframe (letter from Interim Chief Nurse to be sent to Investigating Officer. Weekly separate meeting with all Divisions is now taking place lead by Head of Complaints to assess complaint position and those that are in the pipeline. Weekly meeting including all Divisions is also being held, chaired by Associate Director of Quality & Safety to discuss up to date positions and any that require escalation to Chief Nurse and Chief Operating Officer. |
| **2.** Making Complaints Count & Working Together to Get Results: Delivering on collaborative action plan/quality priority | **REASONABLE Assurance** | Work is on-going to embed learning and the process surrounding this. Support is being offered to Divisions regarding quality of complaint responses. |

## 5. Legal Services

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.

**Key Objectives**

The Legal Services team's main objectives are:

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| Objective | Q4 | Q1 | Q2 | Assurance |
|---|---|---|---|---|
| **System in place to ensure effective communication within the Legal Services Department** | This is ongoing. The proposed claims and inquest process is to be shared with the Division.<br><br>We are currently working on Claims and Inquest reports to be shared with the Executive and Divisional Teams. | New Legal SOP is being trialled. This includes communication and escalation procedures to senior, executive and divisional levels.<br><br>Strategy meetings are also being trialled for an any moderate or high risk inquest/claim to ensure effective planning and triangulation of information.<br><br>Legal are also participating in the new Mortality (SJRS) Incidents, Complaints claims and Inquest (MICCI) meetings to share pertinent information.<br><br>A new executive fortnightly inquest dashboard report has been created. Divisional Leads also receive a fortnightly inquest schedule confirming listings by directorate and witness involvement. | **This continues however, due to a reduction in staff it is expected this will be impacted in the following months.**<br><br>**A legal restructure review is underway however, a comparison with neighbouring Trusts with similar portfolio sizes suggests the Trust Legal Services Team is understrength.**<br><br>**The Head of Legal is also working operationally to assist with claims, inquests and court hearings.** | **Reasonable assurance** |
| **Datix Module for Legal Services reviewed and updated** | This continues as the new Datix Manager is yet to be appointed.<br><br>Further fields have been added to Datix including Trust risk probability and financial reserving. In addition, case plans have been implemented to record salient information. | No major changes. This continues as the new Datix Manager is to start shortly. A meeting has been scheduled to discuss changes required.<br><br>Further fields have been added to Datix including Trust risk probability and financial reserving. In addition, case plans have been implemented to record salient information.<br><br>Once Datix is reconfigured for legal case management use, further reporting will be explored via KP+. | **The new Datix Manager has started and a mapping exercise has taken place. The Datix Manager is to work on the proposed changes. In the interim, case plans have been implemented to record salient information.**<br><br>**Once Datix is reconfigured for legal case management use, further reporting will be explored via KP+.** | **Reasonable assurance** |

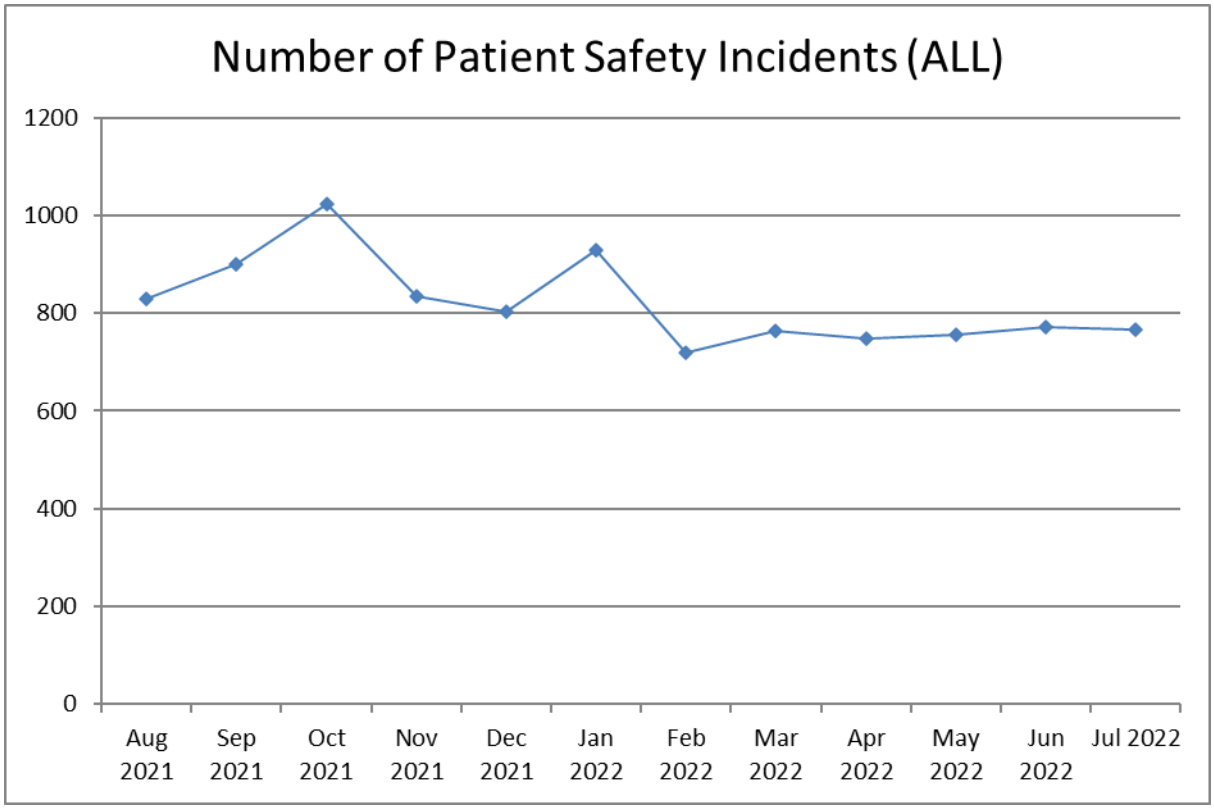
| Objective | Q4 | Q1 | Q2 | Assurance |
|---|---|---|---|---|
| **Audit of Legal Services files on Datix** | This continues. Learning is communicated at weekly portfolio meetings and will be feedback in 1-1's. | This continues. Learning is communicated at weekly portfolio meetings and will be feedback in 1-1's. | **File audit continues in association with quarterly and bi-monthly reporting, plus ad hoc sampling, therefore more regularly than quarterly.**<br><br>**This is supported by the introduction of Case Plans to ensure accurate and up to date information is maintained on file.** | **Reasonable assurance** |
| **SOP for DP7 requests** | A finalised SOP from Access to Health Data has been received.<br><br>The Medical Records disclosure process is currently being reviewed. This has been added to the Risk Register given the operational, financial and reputational risk. | A new SOP for statement requests (including DP7) is in the process of drafting.<br><br>Disclosure of medical records is also currently being reviewed Trust wide as part of a Task & Finish Group led by Louise Croxall, Neil Staniforth and Graham Walsh. | **This continues.** | **Reasonable assurance**. |

## 6. Incidents

Below is a summary of patient safety incidents and incidents with severe harm or death, for the year August 2021 to July 2022, and number of serious incidents (SIs) reported by month.

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

| Month reported | Number of Patient Safety Incidents reported (all) | Number of Patient Safety Incidents of severe harm or death | Serious Incidents by the month externally reported on StEIS |
|---|---|---|---|
| Aug 2021 | 813 | 7 | 2 |
| Sept 2021 | 847 | 11 | 4 |
| Oct 2021 | 830 | 10 | 4 |
| Nov 2021 | 901 | 11 | 7 |
| Dec 2021 | 1024 | 4 | 1 |
| Jan 2022 | 834 | 13 | 2 |
| Feb 2022 | 804 | 8 | 3 |
| Mar 2022 | 928 | 13 | 5 |
| Apr 2022 | 720 | 4 | 2 |
| May 2022 | 763 | 11 | 2 |
| June 2022 | 749 | 7 | 1 |
| July 2022 | 756 | 14 | 6 |



**Summary of Progress with Serious Incident Actions**

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

A total of seven StEIS (Strategic Executive Information System) incidents were reported; one for June 2022 and six in July 2022.

**Learning from Serious Incidents.**

Two Serious incident reports submitted to the Clinical Commissioning Group (CCG) for June 2022 and July 2022 which are as follows:

| Incident Summary | Learning Need and Organisational Learning |
|---|---|
| Cancer - Dx failed or delayed | The Vague Symptom Service team has already reflected on this and learning, and development has been led by those within the team. The developments focus – particularly - on the recommendations made in actions 2,3 and 4 below. |
| Test results/reports - failure/delay to report test results | 1. Endorsement and reviews of investigation reports should take place at allocated times when other priorities are not causing distraction or fatigue.<br><br>2. A failsafe system should be introduced to ensure appropriate action has happened on any ** alert result.<br><br>3. A failsafe process has been developed to ensure that any suspected cancers have been acted upon following endorsement and review of flagged CT scan results.<br><br>4. This could be that clinicians contact the secretarial team to confirm that they have actioned any recommendations made in ** alert reports forwarded to them .If this is not received then the secretary would send a reminder to the doctor asking for confirmation.<br><br>5. Patients should be informed about the results of their CT scans whether it is good or bad news. The “No news is good news” approach should not be used as this gives patients and GPs no incentive to chase up their results. |

## 7. Medicines Safety

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

Medicine Safety Compliance Group Attendance

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

Electronic Controlled Drugs Register (eCDR) Development

User Acceptance Testing (UAT) for the new eCDR software is due to start in September 2022 with roll out to wards to start from end of October 2022. Initially this will be to wards at HRI and then roll out at CRH from February 2023. Superusers are required to be identified for each clinical area. These superusers will be required to support on their wards during initial roll out of this new system and assist with training of new staff. Pharmacy and the software design team trainers will also be supporting. The training will include both face to face/ train the trainer sessions, support on wards and e-learning videos. RNs, RMs, anaesthetists and ODPs will be required to complete this training which is likely to take approximately 1 hour. This training will be a 'must do' to ensure we continue to have a legal record of all controlled drugs supplied and administered.

Parkinson's medicines

Following a pledge made by Brendan Brown, our Chief Executive Officer, to support a national campaign for the timely administration of Parkinson's drugs, pharmacy and nursing are working together to develop an action plan to improve the timely administration of these medicines. Missing even one dose of a patients Parkinson's medication can lead to an increased length of their hospital stay. In 2018-2019 an audit showed that this caused an extra 28,500 nights in hospital in NHS Trusts in England and Wales. Many patients do not return fully to their normal as a result. A recent CHFT audit by Dr Bell and colleagues showed the following results for delayed administration of Parkinson's disease (PD) medications for nine of our patients.

| Number of hours delay | Number of patients |
|---|---|
| <30 mins | 1 (self-administered) |
| 1 to 5 hours | 5 |
| 6-15 hours | 1 |
| 16-24 hours | 2 |

Only one patient had their initial dose on time (<30 mins from when due) - they had self-administered it even though it was not yet prescribed.

*On average there was a delay of **7.8 hours** in getting PD meds from when the first dose was due.*

To raise awareness of how critical it is to administer Parkinson's drugs on time, Dr Andrew Perkins, a retired GP who is himself suffering from Parkinson's disease attended the CHFT

senior nurse and matron huddle to promote awareness and share his story of his treatment as an inpatient at Leeds Teaching Hospital.

Our next steps are to formulate a PD medication action plan to improve our timeliness of administration. This is being supported by the specialist Parkinson's nurse and Dr Bell.

Active Temperature Monitoring

At the point of writing this report, only 33 out of 51 wards and clinical areas had gone live with the Stanley active temperature monitoring system for their ward medicines fridges. The system allows real time alerting to any fridge temperature deviations, ensuring ward staff can respond to these alerts in a timely way. During the recent heatwave, medical engineering produced a report from the Stanley system to check the temperatures of all CHFT medicines fridges. This report identified that several ward fridges had gone out of range (above 8 degrees) but because the staff in those areas had not completed the required training, they were not aware of the alerts or how to action them. This is obviously a risk for the safe storage of medicines and result in potential degradation/ reduced efficacy of medicines stored in fridges.

Associate Directors of Nursing (ADN) and matrons have been asked to support to ensure their teams complete this training as soon as possible.

This system replaces the requirement to manually record daily temperatures on a log sheet. Training on the new system takes approximately 10 minutes to complete. Previously, compliance with manual temperature monitoring was poor, hence, ward / clinic managers are encouraged to adopt this new system as soon as possible to improve compliance to correct fridge temperature monitoring and response time to deviations. Divisions have been asked to add this issue to their risk registers.

Medication shortages

There are currently 3 significant national medication shortages affecting CHFT patients:

- Alteplase; Pharmacy procurements are working with clinical teams to centralise stock. The regional procurement team are supporting oversight of all Trusts stock and coordinating mutual aid between organisations
- Moviprep; This has the potential to significantly impact our ability to for bowel screening. Endoscopy are aware and working with the pharmacy to consider alternatives.
- Remifentanil 1mg; pharmacy procurement are working with anaesthetists to identify alternative opioids for use in sedation

## Quality Priority updates

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

**Quality Account Priorities:**

- Recognition and timely treatment of Sepsis
- Reduce the number of Hospital-acquired infections including COVID-19
- Reduce waiting times for individuals attending the Emergency Department

**Focussed Quality Priorities**

- 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 inpatient adults and paediatric patients
- Reduction in the number of CHFT-acquired pressure ulcers
- Making Complaints Count

**Quality Priority** (2022-2023)


**Recognition and timely treatment of Sepsis**

**Executive Lead**

Dr Elizabeth Loney

**Operational Leads**

Dr Rob Moisey
Paula McDonagh

**Reporting**

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

| What do we aim to achieve? | **Update** (June and July 2022) | Progress rating |
|---|---|---|
| **Aim 1**<br>Percentage of adult patients that triggered in ED for red flag Sepsis that had antibiotics administered within 1 hour of trigger | **Red flag patients ED, patients who have triggered one or more red flags at each site**<br><br>**June 2022 = 46.7%**<br>**July 2022 = 50.0%**<br><br>**All patients coded with sepsis ED**<br><br>**June 2022 = 63.4%**<br>**July 2022 = 66.7%**<br><br>**External reporting compliance (within hour of clinical assessment)**<br><br>**85%**<br><br>**Progress work**<br><br>▪ Sepsis trollies in use.<br>▪ Use of sepsis write back to ensure accuracy of non-compliant patients (those exceeding the 60-minute antibiotic administration target)<br>▪ Feedback of write back findings given at Dr handovers<br>▪ Introduction of ED Registrar carrying phone so can be contacted quickly to review and prescribe sepsis | **Reasonable Assurance** |

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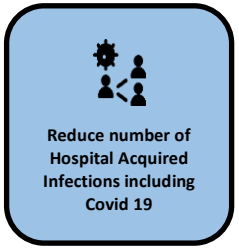
|---|---|---|
| | treatment.<br>▪ Trial of shift sepsis nurse who oversees time critical assessments and treatment.<br>▪ ED sepsis champion, clinician and nurse feeding back audit results.<br>▪ Sepsis info boards in central areas.<br><br>**Risks and mitigations**<br><br>▪ Continued use of sepsis trolleys being monitored.<br>▪ Registrar sepsis/high risk phone not always being used, sepsis nurse discussed with clinicians and will send Comms out on SOP. Issue with phone at CRH so another purchased. Use at HRI more consistent than CRH.<br>▪ Patients admitted to Resus with sepsis do not always have their IV antibiotics signed for in timely way due to time critical administration, sepsis nurse looking at improving this issue. Possible effect of data compliance results. Discussions at sepsis collaborative taken place, ED band 7s to more closely response times. Options to sign for antibiotics retrospectively discussed (in resus only)<br>▪ 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.<br>▪ Duty sepsis nurse role not always being filled due to RN staffing gaps.<br><br>**Successes**<br><br>▪ Category 2 patients in the ED are being seen in rapid assessment at HRI rather than waiting for a cubicle. This has improved treatment times for patients with sepsis.<br>▪ Mobile phones delivered and SOP set up.<br>▪ Recruitment of sepsis champions in both EDs. | |

| | | |
|---|---|---|
| | ▪ Agreed that further purchase of sepsis trolleys required as part of reconfiguration plan.<br>▪ Sepsis boards in both EDs | |
| **Aim 2**<br>BUFALO Bundle Total Compliance (%) | **June 2022** **July 2022** | |
| **B**lood Cultures | 83.8% 81.9% | **Reasonable Assurance** |
| **U**rine output | 66.9% 72.3% | **Reasonable Assurance** |
| **F**luids | 99.2% 96.4% | **Substantial Assurance** |
| **A**ntibiotics | 100.0% 96.4% | **Substantial Assurance** |
| **L**actate (waiting adding to EPR) | Unable to add Lactate to EPR | |
| **O**xygen | 90.0% 92.8% | **Substantial Assurance** |
| **TOTAL** | **50.0%** **61.4%** | |
| Each element will be measured (with exception of Lactate) from the sepsis screening tool and power plan within the electronic patient record. | **<u>Progress work</u>**<br>▪ Element for blood culture has been confirmed as being measured accurately, sepsis nurse actioning drop ins to clinical areas to remind clinicians about taking blood cultures within red flag sepsis criteria.<br>▪ Sepsis screening tool now live on Athena, informatics are now able to gain compliance data for maternity patients.<br>▪ Point of Care Testing Business case funding now agreed and waiting next stage to initiate the reporting of blood gas and urinalysis results from Lab to EPR. Working groups in place.<br>▪ Blood culture 3Rs meeting taken place to initiate blood culture compliance improvement work in the EDs. Band 7 coordinator to oversee response to sepsis treatment during shift.<br>▪ Media of importance of blood culture collection in Red Flag sepsis placed into sepsis press.<br>▪ Gavin Boyd joined sepsis collaborative and is looking at Blood culture volume and contamination rates.<br>▪ Sepsis collaborative reviewing new blood culture guidance | |

| | | |
|---|---|---|
| | on our current position.<br><br>**Risks and mitigation's**<br><br>▪ Not all Red flag sepsis patients are receiving blood cultures. **Action-** sepsis collaborative members to continue to media the requirement through their work channels, sepsis nurse to visit clinical areas and remind clinicians, action group to be set up by sepsis nurse, article added to sepsis press re importance of this element measure. Additionally, sepsis 6 education now on junior doctors' induction training. Noted that nurses within ward-based areas do not take blood cultures so added to agenda on IV working group for discussion/action, no date for group reconvening available at this time. Investigate a Regional well performing ED which could be used as a 'Go see' exercise.<br><br>**Successes**<br><br>▪ Target of total (60%) compliance<br>▪ Oxygen element changed to measure target saturation compliance resulting in more accurate recording.<br>▪ Consistent month on month substantial progress reporting fluid and antibiotics.<br>▪ Point of Care Testing (POCT) funding agreement to report arterial and venous blood gas results (Lactate).<br>▪ Introduction of high-risk phones for middle grade doctor at each site, this is to assist in speeding up reviews and prescriptions for antibiotics, fluids and oxygen | |

| | | |
|---|---|---|
| **Aim 3**<br>Sepsis ESR Training Compliance (%)<br>(Not Yet Available) | Business intelligence have now provided the training numbers:<br><br>▪ Consultants (except Obstetrics and Gynaecology) 250<br>▪ Foundation years (except Obstetrics & Gynaecology) 82<br>▪ CT (except Obstetrics and Gynaecology) 31<br>▪ ST (except Obstetrics and Gynaecology) 69<br>▪ Clinician Total **550**<br>▪ Registered Nursing Total **900**<br><br>**Progress work**<br><br>Sepsis recognition and treatment Essential training for eligible Clinicians and registered nurses now on CHFT staff ESR accounts (added 25/7/22). Training update is 3 yearly. Informatics will now be able to pull the compliance figures. Staff (450) who have received training in last 12 months from sepsis nurses may self-declare.<br><br>**Risks and mitigations**<br><br>Delays in staff completing training due to staffing pressures. **Action-** sepsis nurse to communicate need to complete training through meeting channels, sepsis press and ward/dept visits. | **Reasonable Assurance** |

## Quality Priority (2022-2023)




**Reduce the number of Hospital-acquired infections including COVID-19**

**Executive Lead**

Dr David Birkenhead

**Operational Leads**

Dr Vivek Nayak
Gillian Manojlovic

**Reporting**

- Infection Control Performance Board
- Infection Control Committee
- Quality Committee

| What do we aim to achieve? | **Update** (June to July 2022) | Progress rating |
|---|---|---|
| **Aim 1**<br><br>COVID 19 in patient testing compliance (%) | The current schedule of in-patient testing is days 0, 1, 3, 5 & 7. This was introduced on 20/06/22. Currently testing is supported by the swabbing team and all tests (other than day 0) are done by lab PCR.<br>**The data will be available on KP+ and is in development and is planned to be available for the next report.** | **Limited Assurance** |
| **Aim 2**<br><br>Number of c. diff: Trust-assigned (not to breach the 22/23 objective of 38 cases) | The number of C. difficile infections is monitored nationally, reported via the UKSHA HCAI data capture system. The number of C. difficile infections have increased over the past 2 years. The increase in C. difficile is not limited to CHFT but is being seen across many NHS Trusts. This may be due to the increase in and therefore treatment of respiratory infections associated with the Covid-19 pandemic. An SPC of both the C. difficile cases and the antimicrobial prescribing will be presented in the next report.<br>**Currently, there are 20 cases reported including 6 Community onset, healthcare associated cases. This is over the trajectory for the year.** | **Reasonable Assurance** |

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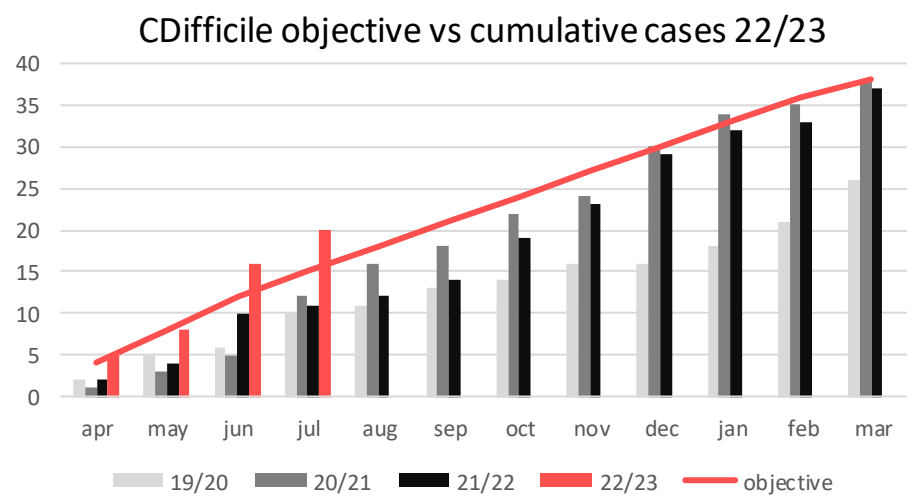
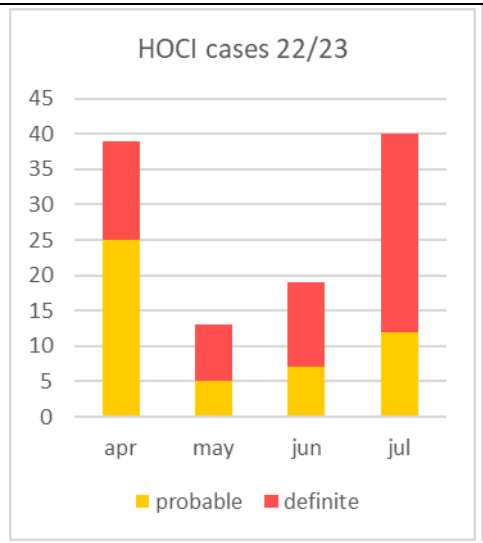
| |  | |
| **Aim 3**<br><br>Number of Hospital Onset Covid-19 Infections (surveillance) | Hospital Onset Covid-19 infection (HOCI) increases and decreases in line with that seen in the wider population. This data provides an overview of the numbers of HOCI year to date.<br>The Covid-19 control measures were changed in June 22 in line with national guidelines. Masks were reintroduced shortly afterwards following an increase in staff sickness.<br>Whether the changes had a significant influence on the increase in HOCI is not known as the rise mirrored that seen in the wider population.<br><br>**The following charts include the data to date for definite and probable HOCI and the distribution across the two sites. This reflects the outbreaks experienced at HRI in the orthopaedic and elderly medicine wards during the current wave. The open nature of some of the ward environments makes outbreak control more of a challenge.** | **Substantial assurance** |


HOCI cases 22/23
45
40
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15
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apr
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jun
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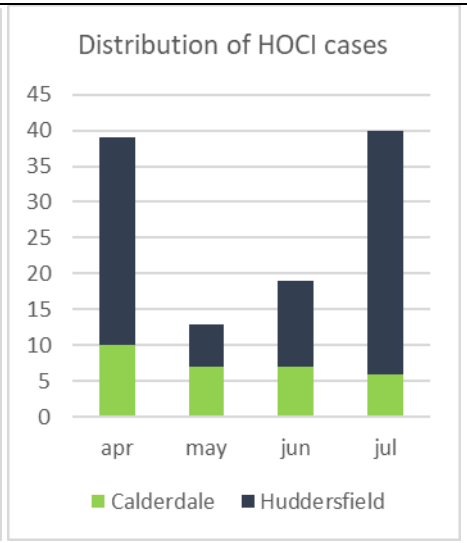
probable
definite


Distribution of HOCI cases
45
40
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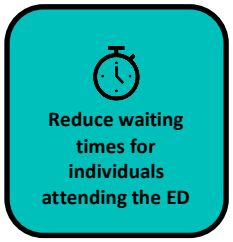
0
apr
may
jun
jul
Calderdale
Huddersfield

## Quality Priority (2022-2023)




**Reduce waiting times for individuals attending the Emergency Department**

**Executive Lead**

Jo Fawcus (Chief Operating Officer)

**Operational Leads**

Jason Bushby
Dr Amjid Mohammed
Jayne Robinson

**Reporting**

- Medical Division PSQB
- Trust PSQB
- Quality Committee

| What do we aim to achieve? | **Update** (June 2022) | Progress rating |
|---|---|---|
| **Aim 1**<br>Monitor 8 Hour A&E Breaches and ensure timely escalation and prevention of patients remaining in the department longer than the national / local standards | June 2022 -15,162 attendances in month<br><br>670 patients had length of stay (LoS) between 8-10 hours of which 374 patients were admitted<br>No patients came to harm<br>Further review of non-admitted patients to be completed | **Reasonable assurance** |
| **Aim 2**<br>Monitor 10 Hour A&E Breaches ensure timely escalation and prevention of patients remaining in the department longer than the national / local standards | June 2022 – 15,162 attendances in month<br><br>374 patients had LoS between 10–12 hours of which 256 patients were admitted<br>No patients came to harm and care needs met | **Reasonable assurance** |
| **Aim 3**<br>Monitor 12 Hour A&E Breaches ensure timely escalation and prevention of patients remaining in the department longer than the national / local standards | June 2022 – 15,162 attendances in month<br><br>286 patients had LoS above 12 hours of which 241 patients were admitted<br>3 decision to admit (DTA) breaches (MH patients) waiting for MH bed<br>98.8% achieved Emergency Care Standard (ECS) 100% | **Reasonable assurance** |

## Focused Quality Priority (2022-2023)


**Reducing the number of falls resulting in harm**

**Executive Lead**

Lindsay Rudge

**Operational Leads**

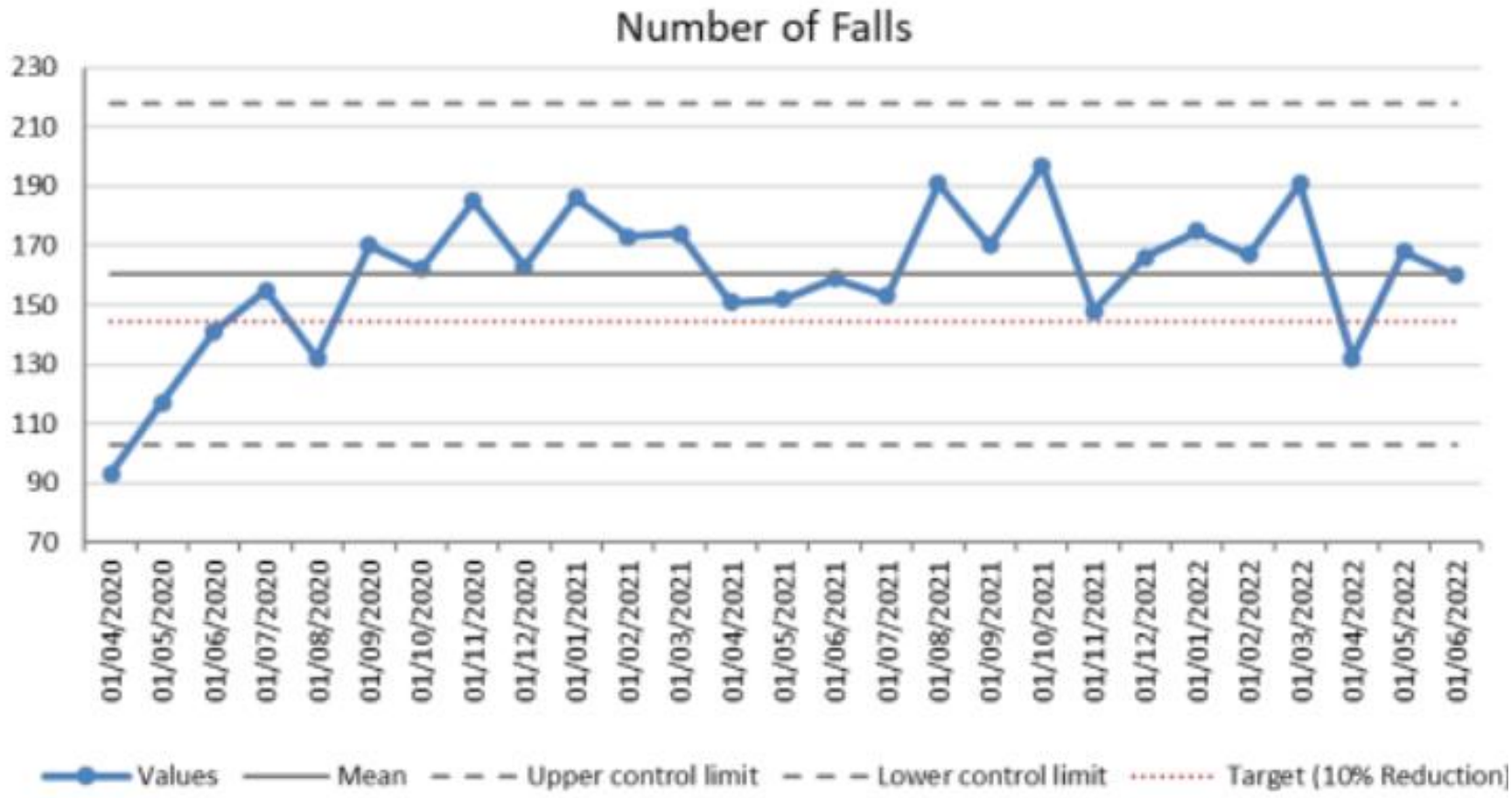
Dr Abhijit Chakraborty
Lauren Green
Helen Hodgson

**Reporting**

- Falls Collaborative
- Clinical Outcomes Group
- Quality Committee

| What do we aim to achieve? | **Update** (June to July 2022) | Progress rating |
|---|---|---|
| **Aim 1**<br><br>Monitor the total number of falls and implement actions to reduce these | Falls dashboard updated monthly and fed back through the Falls Collaborative. The total number of falls have varied over the last 6 months, June 2022 saw a slight decrease in the number of falls from May, however this is still a significant amount more than April 2022. See below action plan in relation to risk mitigations<br>**(See chart 1 – Number of falls)** | **Reasonable assurance** |
| **Aim 2**<br><br>Monitor the total number of Number of falls resulting in harm and implement actions to reduce these | Falls dashboard updated monthly and fed back through the falls collaborative. Number of harm falls have been variable since November 2021, linking in with staffing levels and ward acuity. June 2022 saw a decrease in harm falls across the trust, with two reported during the month. | **Reasonable assurance** |
| **Aim 3**<br><br>Ensure all adult inpatients will receive a falls risk assessment on admission/ transfer to the ward (ward assurance) | The data shows an improvement in patients receiving a falls risk assessment upon admission. Work is ongoing via the Falls Link Practitioners and electronic patient record (EPR) team to improve this. | **Reasonable assurance** |

**Chart 1 – Number of Falls**



## Focused Quality Priority (2022-2023)


**End of Life Care**

**Executive Lead**

Lindsay Rudge

**Operational Leads**

Mary Kiely
Gillian Sykes
Christopher Button

**Reporting**

- EoLC Steering Group
- Clinical Outcomes Group
- Quality Committee

| What do we aim to achieve? | **Update** (June 2022) | Progress rating |
|---|---|---|
| **Aim 1**<br><br>To monitor the number of patients referred to HSPCT who die or are discharged from hospital before an encounter with the team to identify themes and trends | There were 95 referrals in June 2022, of whom 18 died before they were seen, and 4 were discharged. Level 1 advice was given on 25 patients, and 45 patients were seen face to face. The mean length of stay prior to referral was 7.2 days.<br>KPS (modified performance status) was 10-20 (moribund/unconscious) in 25 of those seen face to face, and 30-50 (bedbound/needing assistance or nursing care) in 17. | **Limited Assurance** |
| **Aim 2**<br><br>That 50% of patients seen in the frailty service identified at Rockwood 8 are offered the opportunity to create an advance care plan | June - July 2022<br>• Met with frailty team to review how as a team this could be delivered. Met with The Kirkwood and Overgate Hospice to understand if there is anything they could do to support this in the persons pathway. 6 weekly meeting have now been set up to work through this.<br>• The advance care planning facilitator in frailty post is now vacant and is now under review | **Limited Assurance** |
| **Aim 3**<br><br>Monitor and report the number of complaints, concerns and compliments related to end-of-life care to identify themes and trends to implement lessons learned | June - July 2022<br>• Performance and Intelligence Lead is developing an EOLC dashboard that will contain complaints, compliments and concerns, in order to monitor trends, areas of excellent and concerns.<br>• Head of Complaints is going to pull together themes from EOLC complaints over the last 6 months for analysis<br>• Quality Improvement Manager for Patient Experience has | **Limited Assurance** |

| | | |
|---|---|---|
| | triangulated data from the National Audit of Care at the End of Life (NACEL) bereavement survey, Friends and Family Tests and concerns, complaints and compliments. This will be presented at the EOLC steering group to share the findings.<br>• Bereavement Service – We have now appointed three new members of staff that will support the bereavement service and EOLC education team to work closely with bereaved relatives and wards to support end of life care. | |

## Focused Quality Priority (2022-2023)


**Increase the quality of clinical documentation across CHFT**

**Executive Lead**

Dr David Birkenhead

**Operational Leads**

Louise Croxall
Mr Graham Walsh

**Reporting**

- Clinical Outcomes Group
- Quality Committee

| What do we aim to achieve? | Update (July 2022) | Progress rating |
|---|---|---|
| **Aim 1** Optimise the Clinical Record by improving the workflows and making it easier to achieve the Must do's | Task and finish groups completed for nursing workforce on admission process. CNIO at CHFT and BTHFT have requested from the head of EPR costings to complete the work over the next 12 months. To improve care plans, admissions, discharge etc.<br>New doctors training is ready to be rolled out at the new intake. Feedback requested from divisions through digital boards. | **Substantial assurance** |
| **Aim 2** Making sure assessments are achieved within a timely manner on admission and throughout the hospital stay as needed. | More work ongoing with data quality team re: ward assurance. Completion of assessments will tie in with work mentioned above. | **Substantial assurance** |
| **Aim 3** Implement the hospital white board across the trust to assist in completion of accurate documentation and assessments | Successful pilot on Acute floor at HRI and ward 5. Plans to roll out to SAU and Respiratory however awaiting business case for funding for equipment. No more spare screens available so will need to procure further equipment. | **Reasonable Assurance** |
| **Aim 4** Improve overall performance on documentation by assisting ward managers and matrons to access information and report figures monthly into their quality boards. | New dashboard being created with the data quality team on KP+ making it easier for ward managers, matrons to access their data. Liaising with quality team and other areas so there is one source of the truth for ward managers to use not multiple different platforms. | **Reasonable Assurance** |

## Focused Quality Priority (2022-2023)


**Clinical Prioritisation (deferred care pathways)**

**Executive Lead**

Dr David Birkenhead

**Operational Leads**

Divisional Directors
Directors of Operation
Kimberley Scholes

**Reporting**

- Recovery Framework Board
- Quality Committee

| What do we aim to achieve? | **Update** (Please indicate reporting period) | Progress rating |
|---|---|---|
| **Aim 1**<br><br>Number of validations in month | The Trust currently has 15,644 outstanding clinical validations. This comprises 6,512 incomplete order patients and 9,132 holding list patients. The incomplete order patients do not have an order on the system therefore will never receive an appointment until clinically validated. Of the outstanding validations 9,118 patients have been waiting >90 days to be reviewed. The target is for no patient to wait more than 30 days. The longest wait currently stands at 558 days. | **Limited Assurance** |
| **Aim 2**<br><br>Number of prioritisations in month | The number of clinical prioritisations given in month are as follows June 1,409, July 1,608. This indicates the number of prioritisations being completed is not sufficient to reduce the backlog. | **Limited Assurance** |
| **Aim 3**<br><br>% of prioritisations that resulted in discharge | Since Mpage go live 21,404 patients have been recorded as already having an appointment before they could be clinically validated indicating a significant wait for prioritisation. The monthly breakdown is as follows June 1,466, July 1,442. This number is expecting to increase due to the backlog and delay in validation. A number of patients are discharged following clinical validations, had these patients been validated some would have been discharged and therefore the capacity could have been used for other patients needing to be seen. | **Limited Assurance** |

## Focused Quality Priority (2022-2023)

Pressure Ulcers

**Reduction in the number of CHFT-acquired pressure ulcers**

**Executive Lead**

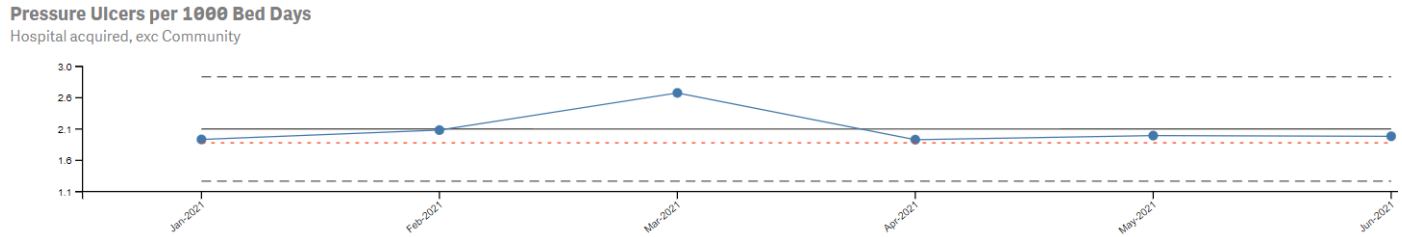
Lindsay Rudge

**Operational Lead**

Judy Harker

**Reporting**

- Pressure Ulcer Collaborative
- Clinical Outcomes Group
- Quality Committee

| What do we aim to achieve? | **Update** (April to June 2022) | Progress rating |
|---|---|---|
| **Aim 1**<br><br>10% reduction in the incidence of hospital acquired pressure ulcers per 1,000 bed days | **Hospital acquired pressure ulcers per 1,000 bed days**<br><br>The graph shows the target was met both in May and June 2022. Stable performance with incidence remaining well within upper control limits.<br><br>  <br><br><br>**Numbers of CHFT acquired pressure ulcers**<br>This table shows that the majority of CHFT acquired pressure ulcers occur in the community division. Medicine has witnessed a sharp reduction since January 2022. | **Reasonable assurance** |

| | Jan-2022 | Feb-2022 | Mar-2022 | Apr-2022 | May-2022 | Jun-2022 |
|---|---|---|---|---|---|---|
| COMMUN | 64 | 41 | 47 | 49 | 64 | 59 |
| FSS | 1 | - | 1 | - | 2 | 1 |
| MED | 41 | 24 | 20 | 43 | 20 | 19 |
| SAS | 17 | 12 | 10 | 11 | 14 | 12 |

**Categories of CHFT acquired pressure ulcers**

The majority of pressure ulcers are category 2 and deep tissue injury, followed by unstageable and category 3 / 4. As deep tissue injuries and unstageable pressure ulcers resolve / evolve over time, incidents are updated.

Note: If a pressure ulcer deteriorates, it is reported again as a separate incident to capture any learning. Therefore, the data below may include some pressure ulcers which have been counted twice. This issue has been escalated to the quality and Safety Team.

In Q1, 1 patient developed 2 category 4 CHFT acquired pressure ulcers in the community setting. No lapses in care identified at Orange Panel.

| | Jan-2022 | Feb-2022 | Mar-2022 | Apr-2022 | May-2022 | Jun-2022 |
|---|---|---|---|---|---|---|
| Total number of CHFT acquired pressure ulcers | 123 | 77 | 78 | 103 | 100 | 91 |
| Category 2 | 54 | 48 | 46 | 39 | 48 | 39 |
| Category 3 | 4 | 2 | 1 | 0 | 0 | 2 |
| Category 4 | 1 | 0 | 3 | 0 | 2 | 0 |
| DTI's | 43 | 18 | 19 | 46 | 32 | 39 |
| Unstageables | 21 | 9 | 9 | 18 | 18 | 11 |

**Medical Device Related Pressure ulcers**

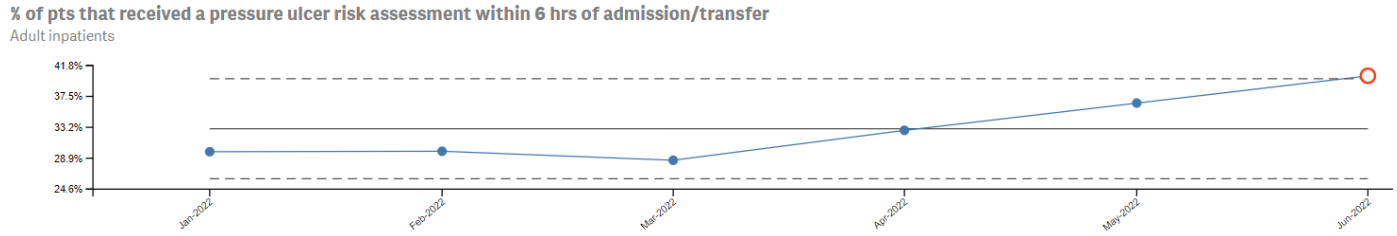
Approximately 10% of CHFT acquired pressure ulcers are caused by medical devices according to the data for May and June 2022. Devices include oxygen masks, faecal management systems, orthopaedic devices, compression hosiery, saturation probes, endotracheal tubes.

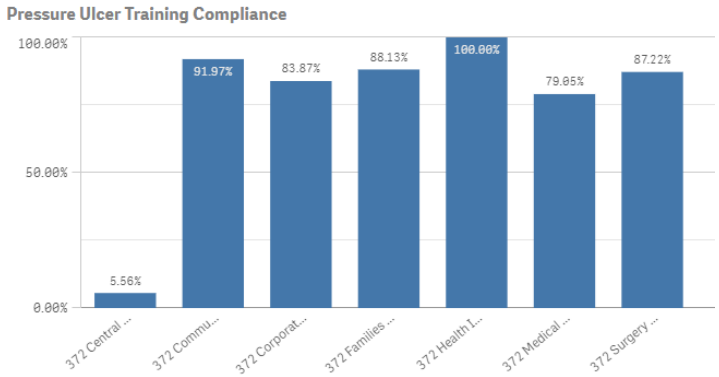
| | Jan-2022 | Feb-2022 | Mar-2022 | Apr-2022 | May-2022 | Jun-2022 |
|---|---|---|---|---|---|---|
| Total number of CHFT acquired pressure ulcers | 7 | 6 | 5 | 9 | 11 | 11 |
| Category 2 | 5 | 7 | 5 | 6 | 8 | 7 |
| Category 3 | 0 | 1 | 0 | 0 | 0 | 2 |
| Category 4 | 0 | 0 | 0 | 0 | 0 | 0 |
| DTI's and Unstageables | 2 | 0 | 0 | 3 | 3 | 5 |

**Level of investigation for CHFT acquired pressure ulcers**

A large proportion of incidents are found to have no ommissions in care.

| Level of Investig... | Month | | | | | |
|---|---|---|---|---|---|---|
| | Jan-2022 | Feb-2022 | Mar-2022 | Apr-2022 | May-2022 | Jun-2022 |
| Green - Local review (no omissions) | 72 | 49 | 51 | 54 | 66 | 64 |
| Orange - Divisional level investigation | 9 | 3 | 1 | 10 | 6 | 1 |
| Red - Serious incident investigation | - | - | 2 | - | - | - |
| Yellow - Local level investigation | 42 | 25 | 24 | 39 | 28 | 26 |

| | | |
|---|---|---|
| | **Improvement Work**<br><br>▪ New Community Nursing Pressure Ulcer Safety Huddles taking place weekly.<br>▪ Trust working on skin tone bias in pressure ulcer prevention. Dark skin training models on order which will enhance awareness of different techniques required to detect early signs of pressure damage.<br>▪ Learning from a recent serious incident has resulted in a number of improvements around escalating patients with a raised BMI to the Moving and Handling Team. Tissue Viability Nurses are being requested to undertake skin assessments on the larger patient to ensure the correct management plan is in place.<br>▪ ED senior nurses to alert Manual Handling and Tissue Viability in a timely manner at start of admission.<br>▪ Flag alerts on EPR have been optimised.<br><br><u>Next steps:</u><br><br>Set up a task and finish group to review pressure area care in Emergency department in response to long trolley / stretcher waits.<br><br>Work with new Datix Manager to review thematic analysis of causal omissions and contributory factors. | |
| **Aim 2**<br><br>**2a.** 95% of inpatients receive a pressure ulcer risk assessment within 6 hrs of admission/transfer | The graph demonstrates improvement for three consecutive months in the proportion of patients receiving a pressure ulcer risk assessment within six hours of admission or transfer. As of June 2022, this stands at 40%. Quality Priority Divisional Leads complete ward audits to review compliance. Risk assessment highlighted on aSSKINg care bundle action cards. Risk assessment is going to be focus of Worldwide Stop The Pressure week in November 2022. The Trust will renew its focus on risk assessment when launching new risk assessment tool, PURPOSE T. PURPOSE T new pressure ulcer risk assessment tool and a suite of care plans have been built for Cerner. The tool already exists on SystmOne. Implementation is due in the autumn.<br><br>  <br> | **Limited assurance** |

| | | |
|---|---|---|
| **2b**. 95% of patients have a PU risk assessment within 7 days of admission to DN caseload | 42% compliance for May 2022. Data collection issues. Actions in place to support Systmone data extraction. Data currently being manually reviewed to determine compliance.<br><br>Rated as limited assurance in terms of progress due to lack of evidence that outcome is being met. | |
| **Aim 3**<br><br>95% of relevant staff will have completed Pressure Ulcer Prevention training | 84% of staff have completed React To Red Training as of July 2022. Data available on KP+. Training provided to all Pressure Ulcer Collaborative members on how to review data. Good evidence of divisions targeting key wards to improve performance. Best performing division is community showing 92% compliance with pressure ulcer training. Medicine 79%, SAS 87% and FSS 88%.<br><br>  <br><br><br>Additional virtual and ward-based training has been provided on pressure ulcer prevention to support staff.<br><br>Bite-sized training delivered to target medical / surgical wards and community nursing teams.<br><br>Face to face training has recommenced.<br><br>National pressure ulcer e learning tool will replace Trust's e learning resource once the new pressure ulcer risk assessment tool is implemented across the organisation in the autumn. | **Reasonable assurance** |

## Focused Quality Priority (2022-2023)


**Nutrition and Hydration for inpatient adult and paediatric patients**

**Executive Lead**

Lindsay Rudge

**Operational Leads**

Vanessa Dickinson
Jonathan Wood
Dr Mohamed Yousif

**Reporting**

- Nutrition Operational Group
- Quality Committee

| What do we aim to achieve? | **Update** (July 2022) | Progress rating |
|---|---|---|
| **QP1** . % of adult patients that received a MUST assessment within 24 hours admission/ transfer to the ward | The operational group has removed the condition for MUST to be repeated on transfer to the ward as this is not a national requirement and will unnecessarily skew the figures.<br>18%. This is the highest for over 12 months. Work is being carried out via the operational group to cascade the need down to the wards through the safety huddle. Work needs to be instigated with the acute admissions wards to see any major impact. | **Limited Assurance** |
| **QP2** % of patients with a MUST score of 2 or above that were referred to a dietician | 63%. Although unsure how this figure is so low as all patients with a recorded MUST of 2 have an automatic referral sent to the dietitians.<br>Ongoing work with IT to identify where the discrepancy lies. | **Substantial Assurance** |
| **QP3.** % of patients (>LoS 8hrs) that had a completed fluid balance chart | 29.2%. This is improving.<br>Not all admitted patients will require a fluid balance chart.<br>How this is to be undertaken and who will be identified has yet to addressed. | **Reasonable Assurance** |

## **Focused Quality Priority** (2022-2023)


**Making Complaints Count**

**Executive Lead**

Lindsay Rudge

**Operational Lead**

Emma Catterall

**Reporting**

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

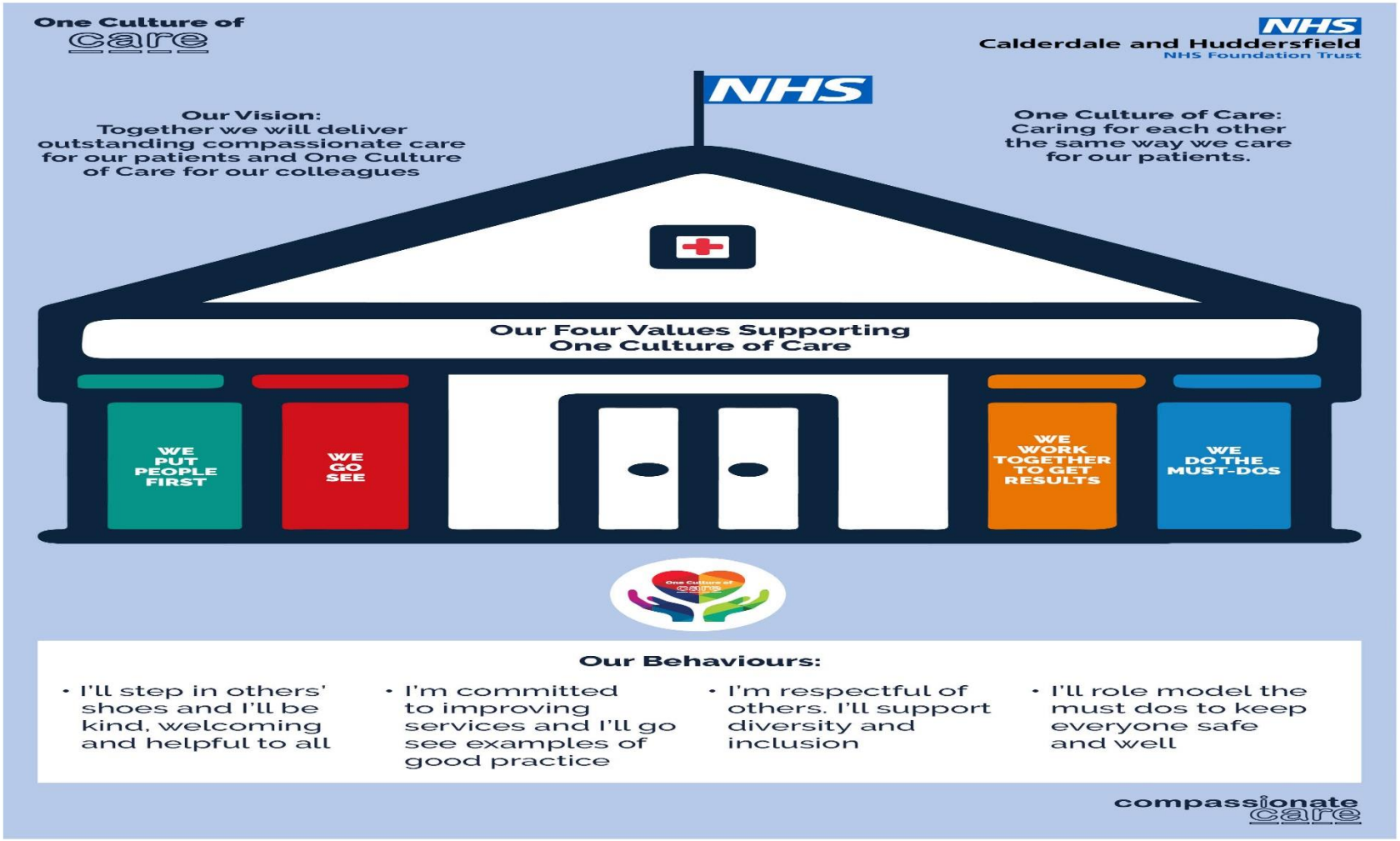
| What do we aim to achieve? | **Update** (June to July 2022) | Progress rating |
|---|---|---|
| **Aim 1**<br><br>% of Complaints Closed within agreed timescale | Meetings have been taking place weekly individually with Divisions led by Head of Complaints to understand the current position, any concerns which require escalation and which responses are in the pipeline. To further support this, a weekly meeting is taking place with all Divisions, chaired by the Associate Director of Quality & Safety to reaffirm the current position and discuss any potential issues arising. This is working well and the frequency of it is useful in escalating issues quickly. | **Reasonable Assurance**<br>Since these meetings have been implemented – performance has improved and communication between Divisions and the corporate team is more effective. Operational representation (triumvirate team) is required to ensure these meetings are as effective as possible. |
| **Aim 2**<br><br>Number of reopened complaints | The quality of complaint responses continues to be a priority – a rota has been established within the Executive Team to approve and sign complaint responses to ensure a varied oversight is achieved. 18 complaints have been re-opened from 1/06/2022 – 31/07/2022 out of 90 that were closed (20%), which is higher than hoped for – a number of local resolution meetings have been requested/suggested. | **Limited assurance**<br>Due to number re-opened, however continues to be our priority to respond to complaints effectively first time round. |
| **Aim 3**<br><br>Number of concerns that escalate into complaints | This is currently being monitored and usually occurs when Division have not been pro-active in responding to low-level concerns due to operational pressures. Over the coming months, work will take place with Divisions to reiterate the importance of responding to concerns as quickly and effectively as possible to avoid them escalating to complaints. | **Reasonable Assurance**<br>In this reporting time period 7 concerns have escalated to a formal complaint. This will continue to be monitored, however all 7 appear to be genuine formal complaints that need a level of investigation and response. |

## Appendix 1 – Report BRAG rating assurance table

| RAG RATING | Evidence of fulfilling RAG rating |
|---|---|
| **WHITE** | • Not yet started |
| **Substantial assurance** | • Progressing to time, evidence of progress<br>• Full assurance provided over the effectiveness of controls.<br>• No action required<br>• This would normally be triggered when performance is currently meeting the target or on track to meet the target.<br>• 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.<br>• Impact on people who use services, visitors or staff is low.<br>• Action required is minimal<br>• Some assurances in place or controls are still maturing so effectiveness cannot be fully assessed at this moment but should improve.<br>• 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.<br>• 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<br>• Cause for concern. No progress towards completion. Needs evidence of action being taken<br>• Close monitoring or significant action required. This would normally be triggered by any combination of the following:<br>• Performance is currently not meeting the target or set to miss the target by a significant amount.<br>• 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.<br>• The issue requires further attention or action |
| **Full assurance** | • Completed with documented evidence<br>• Evidence of compliance with standards or action plans to achieve compliance. |

# Calderdale and Huddersfield NHS Foundation Trust

## Quality Report - Executive Summary - Reporting Period June 2022 to July 2022



# Purpose

The purpose of these slides are to provide key updates and assurance to the Board of Directors in relation to the core quality work streams of the Trust.

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

The update will focus on key workstreams as well as three Quality Account Priorities and Focused Quality Priorities including:

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

# Quality Priorities

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

**Recognition and timely treatment of Sepsis**

- Oxygen element changed to measure target saturation compliance resulting in more accurate recording.
- Consistent month-on-month substantial progress reporting of fluid balance and antibiotics.
- Sepsis 6 education now on junior doctors' induction training to ensure the process is embedded
- Category 2 patients in the Emergency Department are being seen in rapid assessment at HRI rather than waiting for a cubicle. This has improved treatment times for patients with sepsis.

# Quality Priorities

**Reduce the number of Hospital-acquired infections including COVID-19**

The number of C. difficile infections have increased over the past two years. The increase in C. difficile is not limited to CHFT but is being seen across many NHS Trusts. This may be due to the increase in and therefore treatment of respiratory infections associated with the COVID-19 pandemic. Currently, there are 20 cases reported including six Community-onset, healthcare associated cases. This is over the trajectory for the year. A comparison of C. difficile cases and the antimicrobial prescribing will be presented in the next report for analysis.

Hospital-Onset COVID-19 infection (HOCI) increases and decreases in line with that seen in the wider population.

The COVID-19 control measures were changed in the Trust in June 2022 in line with national guidelines.

Whether the changes had a significant influence on the increase in HOCI is not known as the rise mirrored that seen in the wider population.

# Quality Priorities

## Reduce waiting times for individuals attending the Emergency Department

In June 2022, the Trust experienced 15,162 attendances to the Emergency departments in month. Of these, 670 patients had length of stay (LoS) between 8-10 hours of which 374 patients were admitted.
None of the patients came to harm. Further review of non-admitted patients is to be completed to identify lessons learnt.

It should be noted 286 patients had LoS above 12 hours of which 241 patients were admitted and of these there were three patients requiring mental health specialist beds.

# Focused Quality Priorities

Examples of progress against the priorities are shown below, with further details contained within the body of the report:

**End of Life Care (EoLC)** - Performance and Intelligence Lead is developing an EoLC dashboard which will contain complaints, compliments and concerns, in order to monitor trends, areas of excellent and concerns.

**Increase the quality of clinical documentation across CHFT -** New dashboard being created with the data quality team on Knowledge Portal+ (KP+) making it easier for ward managers and matrons to access their data. Successful implementation of white board across the Trust.

**Clinical Prioritisation (deferred care pathways) -** A number of patients are discharged following clinical validations, had these patients been validated some would have been discharged and therefore the capacity could have been used for other patients needing to be seen.

**Making Complaints Count -** In this reporting time period, seven concerns have escalated to a formal complaint. This will continue to be monitored, however, all seven appear to be genuine formal complaints that need a level of investigation and response.

## Focused Quality Priorities

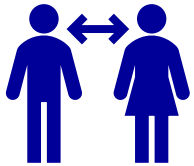
Examples of progress against the priorities are shown below , with further details contained within the body of the report:

**Reducing the number of falls resulting in harm -** Falls dashboard is updated monthly and fed back through the falls collaborative for assurance. Number of harm falls have been variable since November 2021, linking in with staffing levels and ward acuity. June 2022 saw a decrease in harm falls across the Trust, with two reported during the month.

**Reduction in the number of CHFT-acquired pressure ulcers -** Learning from a recent serious incident has resulted in a number of improvements around escalating patients with a raised BMI to the Moving and Handling Team.

**Nutrition and hydration for inpatient adult and paediatric patients -** The operational group has removed the condition for the Malnutrition Universal Screening Tool (MUST) to be repeated on transfer to the ward as this is not a national requirement and will unnecessarily skew compliance rates.

# Care Quality Commission



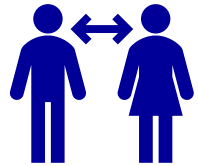
## 2018 CQC Action plan

A review of all ‘Must Do’ & ‘Should Do’ actions is underway to ensure progress has been maintained and identify any potential gaps . This will be monitored by CQC and Compliance group.

The Trust has one action to complete. *MD1 - The Trust must improve its financial performance to ensure services are sustainable in the future* This action will continue to be monitored to ensure full scrutiny and oversight.

The focused Journey to Outstanding (J20) process continues across the Trust, with themes and trends which are identified escalated and monitored via the weekly Trust CQC & Improvement huddle. This maintains engagement across all services and assurance can be sought that outstanding areas of compliance are progressing in line with expectations.

# Care Quality Commission



As part of the regular engagement between CHFT and the CQC, a planned visit to Maternity services took place on Friday, 8th July 2022. An overview of services was shared with CQC as well as a ‘walk around’ to clinical areas. The Trust received positive feedback from this informal visit.

No formal engagement meetings with CQC has taken place within the reporting period.

# Patient Experience, Participation, Equalities

## Commitment to Carers

CHFT is now part of the partnership ‘All age Carers strategy’ which is supported by West Yorkshire Integrated Care Board, Calderdale Council and VSI alliance. Our participation and involvement will be use as part of the first draft of a regional Carers strategy, which will be fed into the national framework for Carers.

## End-of-Life (EoL) Experience Based Design Project

To improve the EoL experience for our patients, their relatives and Carers, the Trust plan to undertake an Experienced Based Design (EBD) approach project. EBD is an approach that enables staff and patients (Carers and relatives included) to co-design services and/or care pathways, together in partnership. This will be valuable in shaping the way we deliver EoL care. A plan was implemented in July 2022 to support the gathering of intelligence, mapping challenges to overcome and work on developing sustainable improvements.

# Patient Experience, Participation, Equalities

## The National Audit of Care at the End of Life (NACEL) Triangulation

In response to the 2021 findings of the Trust's NACEL audit, the data has been triangulated, alongside feedback from the Patient Advice and Liaison Service (PALS), complaints and Friends and Family Test (FFT). It should be recognised the NACEL audit findings only relate to in-patient experience.

The top three themes of positive feedback related to:

- Compassionate care
- Relatives Line
- Follow-up support

# Patient Experience, Participation, Equalities

With the three areas requiring most improvement related to:

- Hospital visiting
- Family involvement in decision making
- Attitude of staff

A NACEL audit steering group has been established to look at the key findings, and strengthen the intelligence to feedback across all divisions

# Patient Advice and Complaints Service (PACS)

| PERFORMANCE SUMMARY | June 2022 | July 2022 |
|---|---|---|
| Complaints received | 48 | 49 |
| Complaints closed | 33 | 57 |
| Complaints closed outside of target timeframe | 19 | 32 |
| % of complaints closed within target timeframe | 33% | 44% |
| Complaints reopened *1 | 6 | 12 |
| *1 Work is ongoing to validate this figure due to informal methods of handling further contacts on Datix | | |
| PALS contacts received | 154 | 163 |
| Compliments received | 2 | 19 |
| PHSO complaints received | 3 | 0 |
| PHSO complaints closed | 0 | 1 |
| Complaints under investigation with PHSO (total) | 6 | |

*Please note that the figures for compliments are not accurate as there is a number which still requiring logging for each of the above months.

# Legal Services

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

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

This will ensure oversight and awareness by the Speciality and improve identifying and acting on any learning in real time, rather than when a claim has concluded. It will also ensure that the five 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.

# Legal Services

A new report will be trialled at this month's Families and Specialist Services (FSS) Patient Safety and Quality Board (PSQB) meeting.

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

Learning will therefore be recorded on each case and circulated for wider sharing.

# Incidents and Lesson Learnt from Serious Incidents

## Never Events

There were two never events reported for the period of June and July 2022. One reported in June 2022 related to Prescribing Wrong Dose or Strength of medication and one in July 2022 in relation to wrong-site surgery. This procedure happened three years ago. This was identified when the patient re-presented unwell. Any immediate actions / learning from these are disseminated from the Serious Incident panel to be shared across all services.

CQC and the ICS have been made aware of both of the never events as part of the regulatory compliance process.

Specific learning from incidents can be found in the body of the report , key themes relate to ensuring patients are made aware of tests results and ensuring failsafe systems are in place to follow up test results

A summary of patient safety incidents and incidents with severe harm or death are included in the body of the report, which does show a minimal increase in the number of Patient Safety Incidents of severe harm or death month on month.

# 20. Integrated Performance Report – July 2022

To Note

Presented by David Birkenhead and Lindsay Rudge

Calderdale and Huddersfield NHS Foundation Trust

| | |
|---|---|
| **Date of Meeting:** | Thursday 1 September 2022 |
| **Meeting:** | Public Board of Directors |
| **Title:** | Quality and Performance Report |
| **Authors:** | Peter Keogh, Assistant Director of Performance, Kirsty Archer, Deputy Director of Finance, Andrea Dauris, Interim Deputy Director of Nursing, Elizabeth Morley, Interim Deputy Director of Nursing, Jason Eddleston, Deputy Director of Workforce and OD, Neeraj Bhasin, Deputy Medical Director, Kim Smith, Assistant Director of Quality |
| **Sponsoring Director:** | Jo Fawcus, Chief Operating Officer |
| **Previous Forums:** | Executive Board, Finance & Performance Committee |

**Purpose of the Report**

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

**Key Points to Note**

July's Performance Score is at 58% with 2 domains (Safe and Caring) now RED. There has been a further never event which makes it 5 in 5 months and is a cause for concern.

The **SAFE** domain is now red due to the never event and missing other standard targets. The **CARING** domain is now red as only 1 of the 5 FFT areas is now green. In addition there were 2 mixed sex breaches in month. There has been a small improvement in both complaints and dementia screening. The **EFFECTIVE** domain remains amber with #Neck of Femur improving significantly in month and only just missing the target. The **RESPONSIVE** domain remains amber with improvement in Cancer 28-day faster diagnosis performance. 3 of the 4 stroke indicators missed target whilst the underperformance in the main planned access indicators and ED remain a challenge moving forward. **WORKFORCE** remains amber with a peak in the 12-month running total for short-term Covid related sickness. Return to Work Interviews have fallen to their lowest position since February. **FINANCE** domain remains amber.

Action plans and deep dives are in place to tackle those areas that have been underperforming for some time e.g., Complaints, Dementia Screening, Stroke, #Neck of Femur.

**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 July 2022.

Calderdale and Huddersfield NHS Foundation Trust

**Performance**
**July 2022**

**Recovery**
At the end of July there were no patients waiting over 104 weeks at CHFT which is a great achievement.

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

ED attendances for both hospital sites continue to increase with a 12% rise in numbers attending on previous years, however Covid cases where a patient needs to be admitted has fallen. Along with increased attendances, acuity/dependency is still significantly high and has led to some very challenging operational issues, this has had an impact on the 4-hour ECS performance. We have had sustained periods in OPEL 3 with some days where we have nearly verged into OPEL 4. Predominantly this is due to increasing needs to keep extra capacity open, outlying patients into the surgical bed base and a TOC list that has been high at over 100 for a sustained length of time. Despite this we continue to perform well within the region and outperform a number of other Trusts in West Yorkshire. We have continued to see long waits above 8 and 12 hours in both emergency departments which is an extremely poor patient experience, and we know increases risk for patients in terms of outcomes.

Hospital Acquired Covid numbers continue to drop, and outbreaks are becoming less frequent, although we are still seeing some asymptomatic positive cases within ward areas and these do cause some outbreaks. Those patients being treated in hospital with Covid also continue to fall and we have been able to retract some of the Covid capacity.

Responding to complaints in a timely fashion continues to be a challenge, however it should be noted that there has been some improvement in complaints closed in line with the target timeframe in July to 45%. There is an increased level of oversight and scrutiny at both divisional level and corporate level which will help us to continue on this trajectory. We are also aiming to ensure that all complaint responses are 'first-time right' and all concerns raised by the complainant have been addressed and responded to.

The current rolling position for HSMR is 106.69 which has moved CHFT above the 'as expected' range. SHMI has stabilised in the expected range, and crude mortality benchmarking is also stable.
Having examined the HSMR data in detail, we have identified the requirement for review of clinical coding in general after any deaths, more specifically we also need to review coding and clinical input in relation to the specialist palliative care team. There is some apparent outlying mortality in the sepsis group and investigation and response will come through the Clinical Care Standards Group. Finally we will be reviewing deaths through stroke.

From a financial point of view, in the year to date the Trust is reporting an £8.44m deficit, a £0.46m favourable variance from plan. The in-month position is a deficit of £1.52m, a £0.34m adverse variance. The Trust has delivered additional efficiencies Year to Date of £1.34m. Operational pressures, including additional capacity requirements, continue to drive additional costs, offsetting the CIP benefit year to date and presenting a significant risk to the forecast delivery of the 2022/23 financial plan.

Agency staffing expenditure year to date is £3.95m, £1.97m higher than planned. It is expected that

the NHS Improvement Agency expenditure ceiling will be set at our existing planned level based on the latest guidance. Total planned inpatient activity, for the purpose of Elective Recovery Funding (ERF), was only 95% of the activity planned year to date. Indications are that ERF will not be clawed back for the first half of the year, but securing the full year funding remains a risk going into the latter half if the Trust is unable to catch up this activity in future months.

The Trust has a revised plan to deliver a £17.35m deficit for the year and whilst forecasting to deliver this planned deficit, this is looking increasingly challenging and significant mitigation will be required to offset the ongoing operational pressures that have continued into the summer period. The Trust had planned to close most of the additional capacity wards used over winter by 1st June. This capacity remains open and this will continue to drive additional costs over the next few months unless operational pressures ease. The forecast assumes full delivery of a challenging £20m efficiency target and elements of this plan are also increasingly high risk, particularly those schemes reliant on the exit of Covid costs. The forecast continues to assume that the Trust will deliver its elective activity plan and secure in full £11.9m of Elective Recovery Funding.

An increase in Covid related absence generated by a further peak in the local prevalence of the virus combined with service challenges has meant a significant focus on sustaining/enhancing colleague availability so that we continue to provide safe, high-quality care to our patients. We continue to focus on the health and wellbeing of colleagues, so they feel appropriately supported whilst at work. This means concentrating attention on One Culture of Care must-do activity including colleague rest and recuperation, hydration and nutrition, use of the wellbeing hour, health and wellbeing risk assessments and clear access points for our internal Listening Ear service and external psychologist-led employee assistance programme provided by CareFirst. We continue to strengthen our wellbeing offer by developing a suite of activities to tailor opportunities that support the individual needs of each team.

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

A review of the July 2022 data indicates that the combined RN and non-registered clinical staff metrics resulted in 22 of the 28 clinical areas having fewer CHPPD than planned, with a total deficit of 1.1 CHPPD across the Trust. The gap in planned vs actual CHPPD is at its broadest with the RN workforce representing 0.9 deficit with HCSW showing 0.2 deficit. The CHPPD planned vs actual gap is most prominent in the Surgical division (2.9 CHPPD deficit). This is largely attributable to the staffing in ICU which continues to report the planning for a Covid escalation workforce model. 'Actual' levels represent the staffing required to care for the patients each shift according to GPICS ratios. The CHPPD gap in FSS (2.7) is mostly attributable to midwifery absence and vacancies. This pressure on service provision is managed according to local and regional OPEL escalation plans to ensure safety of women and babies is maintained.

The 2021 successful recruitment to HCA roles has enabled increased shift fill to provide support to the reduced RN availability. However, some attrition and adjustment to workforce models has now created a small vacancy pressure in this workforce group which is being addressed by central recruitment. Professional judgement is used daily to redeploy staff on a shift basis and establish the safest staffing possible in all areas.

Challenges of the requirement to staff additional capacity areas, combined with increased Covid prevalence in July, continue to impact on the ability to staff all areas according to workforce model.

compassionate care

NHS
Calderdale and Huddersfield
NHS Foundation Trust

# Integrated Performance Report

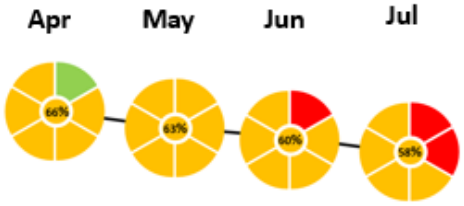
July 2022

Report Produced by : The Health Informatics Service

Data Source : various data sources syndication by VISTA

## Performance Summary

# July 2022





**SYSTEM OVERSIGHT FRAMEWORK**

| | |
|---|---|
| **SAFE** | |
| VTE Assessments | Never Events |
| **CARING** | |
| Mixed sex accommodation breaches | % Complaints closed |
| FFT Inpatients | FFT A&E<br>FFT Community<br>FFT Outpatients<br>FFT Maternity |
| **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 |

July's Performance Score is at 58% with 2 domains (Safe and Caring) now RED. There has been a further never event which makes it 5 in 5 months and is a cause for concern.

The **SAFE** domain is now red due to the never event and missing other standard targets. The **CARING** domain is now red as only 1 of the 5 FFT areas is now green. There has been a small improvement in both complaints and dementia screening. The **EFFECTIVE** domain remains amber with #Neck of Femur improving significantly in month and only just missing the target. The **RESPONSIVE** domain remains amber with improvement in Cancer 28-day faster diagnosis performance. 3 of the 4 stroke indicators missed target whilst the underperformance in the main planned access indicators and ED remain a challenge moving forward. **WORKFORCE** remains amber with a peak in the 12-month running total for short-term Covid related sickness. Return to Work Interviews have fallen to their worst position since February. **FINANCE** domain remains amber.

Action plans and deep dives are in place to tackle those areas that have been underperforming for some time e.g. Complaints, Dementia Screening, Stroke, #Neck of Femur.

## Key Indicators

| | 21/22 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Mar-22 | Apr-22 | May-22 | Jun-22 | Jul-22 | YTD | Performance Range | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **SAFE** | | | | | | | | | | | | | | | | | Green | Amber | Red |
| Never Events | 2 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 2 | 1 | **1** | **4** | 0 | | >=1 |
| **CARING** | | | | | | | | | | | | | | | | | Green | Amber | Red |
| % Complaints closed within target timeframe | 63.61% | 100.00% | 69.44% | 55.10% | 71.43% | 58.82% | 94.29% | 70.73% | 37.50% | 44.44% | 29.41% | 27.08% | 48.98% | 28.57% | **44.64%** | **38.30%** | 100% | 86% - 99% | <=85% |
| Friends & Family Test (IP Survey) - % Positive Responses | 96.91% | 97.00% | 96.38% | 96.61% | 97.33% | 98.26% | 97.47% | 97.35% | 97.10% | 97.36% | 96.36% | 97.57% | 97.25% | 97.55% | **in arrears** | **97.45%** | >=90% / >=95% from September | | <=79% |
| Friends and Family Test Outpatients Survey - % Positive Responses | 92.16% | 92.29% | 91.88% | 91.77% | 91.49% | 91.51% | 92.45% | 93.02% | 93.20% | 92.15% | 93.71% | 91.81% | 92.24% | 89.78% | **in arrears** | **91.75%** | >=90% / >=93% from September | | <=79% |
| Friends and Family Test A & E Survey - % Positive Responses | 82.76% | 82.98% | 78.53% | 81.33% | 80.85% | 81.01% | 82.39% | 84.40% | 86.40% | 84.69% | 76.52% | 83.18% | 81.09% | 77.36% | **in arrears** | **81.33%** | >=80% / >=85% from September | | <=69% |
| Friends & Family Test (Maternity) - % Positive Responses | 94.64% | 91.23% | 97.53% | 95.19% | 97.69% | 93.98% | 93.20% | 98.33% | 92.30% | 91.00% | 95.12% | 96.67% | 97.87% | 95.38% | **in arrears** | **96.42%** | >=90% / >=95% from September | | <=79% |
| Friends and Family Test Community Survey - % Positive Responses | 92.44% | 93.37% | 87.74% | 92.52% | 94.27% | 91.12% | 95.86% | 93.68% | 95.50% | 91.21% | 98.32% | 94.74% | 94.50% | 88.78% | **in arrears** | **92.43%** | >=90% / >=95% from September | | <=79% |
| **EFFECTIVE** | | | | | | | | | | | | | | | | | Green | Amber | Red |
| Number of MRSA Bacteraemias – Trust assigned | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** | **0** | 0 | | >=0 |
| Preventable number of Clostridium Difficile Cases | 5 | 0 | 1 | 0 | 1 | 0 | 0 | 1 | 1 | 0 | 0 | 2 | 1 | 1 | **0** | **4** | <3 | | >=3 |
| Local SHMI - Relative Risk (1 Yr Rolling Data) | 106.36 | 105.07 | 105.49 | 105.91 | 105.39 | 106.60 | 106.99 | 106.36 | 104.79 | 104.38 | 104.58 | 105.39 | | | | **105.39** | <=100 | 101 - 109 | >=110 |
| Hospital Standardised Mortality Rate (1 yr Rolling Data) | 102.2 | 90.00 | 90.56 | 92.19 | 93.78 | 95.20 | 97.00 | 99.27 | 102.20 | 102.64 | 104.59 | 105.86 | 106.69 | | | **106.69** | <=100 | 101 - 109 | >=111 |
| **RESPONSIVE** | | | | | | | | | | | | | | | | | Green | Amber | Red |
| Emergency Care Standard 4 hours | 78.99% | 86.16% | 78.59% | 79.57% | 78.29% | 75.97% | 76.81% | 72.95% | 75.70% | 73.92% | 74.05% | 72.64% | 75.85% | 72.97% | **72.52%** | **73.52%** | >=95% | 81% - 94% | <=80% |
| % Stroke patients admitted directly to an acute stroke unit within 4 hours of arrival | 36.71% | 54.90% | 42.29% | 43.14% | 42.00% | 33.87% | 33.33% | 23.19% | 16.67% | 15.79% | 25.45% | 25.53% | 28.81% | 13.33% | **24.60%** | **22.50%** | >=90% | | <=85% |
| Two Week Wait From Referral to Date First Seen | 98.38% | 97.82% | 97.93% | 98.51% | 98.80% | 98.58% | 99.21% | 97.96% | 98.39% | 98.35% | 97.56% | 97.76% | 98.46% | 98.04% | **97.59%** | **97.97%** | >=93% | 86% - 92% | <=85% |
| Two Week Wait From Referral to Date First Seen: Breast Symptoms | 97.53% | 100.00% | 98.68% | 100.00% | 97.96% | 98.45% | 96.84% | 96.00% | 93.84% | 97.25% | 93.50% | 96.92% | 96.27% | 98.17% | **97.65%** | **97.16%** | >=93% | | <=92% |
| 31 Days From Diagnosis to First Treatment | 98.21% | 97.63% | 98.94% | 97.92% | 95.88% | 94.89% | 99.02% | 99.37% | 98.35% | 99.39% | 98.31% | 97.58% | 98.88% | 98.99% | **99.36%** | **98.71%** | >=96% | | <=95% |
| 31 Day Subsequent Surgery Treatment | 95.43% | 100.00% | 97.78% | 94.44% | 84.78% | 100.00% | 92.59% | 100.00% | 93.33% | 96.55% | 94.44% | 96.00% | 100.00% | 100.00% | **100.00%** | **99.26%** | >=94% | | <=93% |
| 31 day wait for second or subsequent treatment drug treatments | 99.51% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 95.45% | 98.63% | 100.00% | 100.00% | 100.00% | 100.00% | **100.00%** | **100.00%** | >=98% | | <=97% |
| 38 Day Referral to Tertiary | 50.00% | 50.00% | 72.73% | 47.06% | 52.17% | 61.11% | 50.00% | 37.93% | 35.00% | 66.67% | 30.77% | 55.17% | 64.71% | 42.31% | **36.36%** | **50.60%** | >=85% | | <=84% |
| 62 Day GP Referral to Treatment | 90.62% | 91.87% | 91.23% | 91.40% | 89.77% | 91.51% | 93.43% | 87.32% | 89.59% | 86.82% | 89.71% | 91.63% | 87.90% | 90.53% | **82.91%** | **88.35%** | >=85% | 81% - 84% | <=80% |
| 62 Day Referral From Screening to Treatment | 59.47% | 48.48% | 32.14% | 55.26% | 32.00% | 55.56% | 76.19% | 81.25% | 62.50% | 50.00% | 96.30% | 92.59% | 73.68% | 70.37% | **72.73%** | **77.89%** | >=90% | | <=89% |
| Faster Diagnosis Standard: Maximum 28-day wait to communication of definitive cancer / not cancer diagnosis for patients referred urgently (including those with breast symptoms) and from NHS cancer screening | 74.31% | 68.93% | 73.27% | 69.07% | 70.56% | 76.23% | 78.16% | 76.82% | 76.50% | 83.12% | 79.54% | 77.90% | 76.97% | 74.23% | **75.45%** | **76.09%** | >=75% | | <=70% |
| **WORKFORCE** | | | | | | | | | | | | | | | | | Green | Amber | Red |
| Sickness Absence rate (%) - Rolling 12m - Non-Covid related | 4.83% | 4.00% | 4.13% | 4.23% | 4.33% | 4.43% | 4.49% | 4.58% | 4.66% | 4.63% | 4.83% | 4.90% | 4.91% | 4.88% | 4.82% | - | <=4.75% | <5.25% | >=5.25% |
| Long Term Sickness Absence rate (%) -Rolling 12m - Non-Covid related | 3.21% | 2.85% | 2.92% | 3.01% | 3.07% | 3.10% | 3.10% | 3.12% | 3.15% | 3.17% | 3.21% | 3.24% | 3.23% | 3.20% | 3.15% | - | <=3.0% | <3.25% | >=3.25% |
| Short Term Sickness Absence rate (%) -Rolling 12m - Non-Covid related | 1.62% | 1.17% | 1.21% | 1.23% | 1.26% | 1.33% | 1.39% | 1.46% | 1.52% | 1.57% | 1.62% | 1.66% | 1.68% | 1.69% | 1.68% | - | <=1.75% | <2.00% | >=2.00% |
| Overall Essential Safety Compliance | 92.90% | 95.64% | 95.48% | 93.93% | 93.81% | 93.22% | 93.01% | 93.28% | 92.50% | 92.57% | 92.90% | 92.54% | 92.94% | 92.61% | 92.63% | - | >=90% | >=85% | <85% |
| Appraisal (1 Year Refresher) - Non-Medical Staff | 69.06% | | | | | | | | | | | | | | | - | >=95% | >=90% | <90% |
| Appraisal (1 Year Refresher) - Medical Staff (Rolling 12mth) | 82.43% | 12.04% | 17.00% | 30.80% | 44.51% | 54.57% | 60.90% | 61.72% | 63.51% | 65.54% | 69.06% | 0.64% | 2.79% | 5.94% | 9.36% | - | >=95% | >=90% | <90% |
| **FINANCE** | | | | | | | | | | | | | | | | | Green | Amber | Red |
| I&E: Surplus / (Deficit) Var £m YTD | 2.27 | **0.28** | **-0.22** | **-1.40** | **-1.62** | **0.00** | **-0.05** | **0.17** | **0.02** | **-0.06** | **-0.11** | **0.11** | **0.11** | **0.59** | **-0.34** | **0.46** | | | |

## SWOT Analysis

### Strengths

- Agreed Recovery Framework.
- Continuing to focus on Trust agreed priorities for elective patients, e.g. ensuring we prioritise patients with learning disabilities, P2s and long waiters (104 weeks).
- Ongoing comprehensive theatre staff engagement and workforce development programme.
- Progressing installation of two new permanent MRI scanners which are being ramped and shimmed which is the process by which the main magnetic field is made more homogenous.
- Ward 11 back under the surgical team, await the build up of elective lists in the pipeline, utilising for acute surgical patients currently to support the site pressures
- Community Pharmacist roles continue to add significant value in Quality Improvement (identifying and managing medication incidents), supporting effective assessment and care planning across nursing and therapy services and helping manage some of the discharge based risks and issues with handover of medicines management.
- Continue to support Mid Yorkshire Hospital Trust with Non-Surgical Oncology care for Breast and Lung cancer and also now providing some in-reach support to Bradford.
- Focus on recruitment in both clinical and admin roles to support Recovery. Using alternative roles and thinking differently for hard to recruit areas. Also exploring risks and benefits to over recruitment to minimise bank and agency spend.
- Insourcing arrangements in place for ENT (OP & Surgery), Orthopaedics (CHOP LLP) and Ophthalmology (OP, diagnostics & Surgery) to help tackle elective backlogs.
- Automated medicine cabinets installed at HRI and pharmacy robot business case approved.
- Urgent Community Response 0-2 hour service started 6th December and is being well received and utilised with 132 referrals in April primarily from CHFT services, other HCP's GP's and YAS.
- Community virtual noticeboard re-launched and receiving excellent feedback.
- Audit of patient feedback across the division has been extremely positive and seen as an exemplar across the organisation and reflected in low number of complaints within the division.
- Community 7-day on-call manager rota in operation to respond to and support pressures in the system.

### Weaknesses

- Bed pressures continue to be significant.
- The staffing position continues to be extremely challenging across all divisions in particular among nursing teams.
- Theatre lists still not up to pre covid numbers but pipeline staffing showing a positive position over the next few weeks and months.
- Some specialties i.e. large complex cases are not recovering at the same pace as others.
- Issue retaining Community Pharmacists in Quest due to conflicting demands with PCN Pharmacists.
- Disparity with availability of clinical educators into Therapy services to support staff retention and education.
- Trust Estate and dual site configuration reduces flexibility.

### Opportunities

- The SAFER programme continues to pull together existing workstreams and those stopped during the Covid period.
- The Plan for Every Patient roll-out programme is underway with further resource allocated to increase pace and buy-in.
- Maternity team working to review the Ockenden report recommendations and developing action plan.
- Medicine is enacting plans to effectively use allocated face to face clinic capacity to ensure this is used effectively across all specialties to ensure patients with the highest priority are seen.
- Pilot Urgent Care Hubs have been established at both HRI and CRH staffed by CHFT colleagues. These are operational Monday-Friday 08.00-18.00 with the service reverting to Local Care Direct outside of these hours.
- Using Myosure in Gynaecology to see and treat patients in an ambulatory setting where previously they would have needed theatre. Supports capacity and improved patient experience.
- Development of workforce plan including ODP apprentices, Nurse Associate role.
- Opportunity to work with NHSE as a part of the pathfinder pilot looking at hospital patient transport (HTCS) for both inpatients and outpatients.
- Money received from HEE for Allied Health Professions Workforce Supply Strategy Planning project work started and planned to be undertaken between December 2021 and June 2022.
- School aged Immunisations - expression of interest to tender for the Calderdale Immunisations contract for a potential further 5 years completed.
- Patient appliance trustwide budget is to be consolidated into the community division, this will come with a cost pressure but streamlines operational pressures and improves patient pathways.
- Virtual wards - CKW working groups have been established for virtual wards to ensure pathways are streamlined across the CKW footprint. Initial focus pathways are Frailty and Respiratory. Initial Virtual Ward plans were submitted w/c 13th June, with further CKW workshops diarised to look at cross-patch efficiencies and implementation planning. Plans are now approved and posts are starting to go out to recruitment.
- CHFT Community have agreed to work as a pilot site for developing a community currency tool with NHSE.
- IC Beds current provision extended for a further 12 months under the existing contract but on reduced beds (now 15 in total) and will be re looked at through 3CPB.

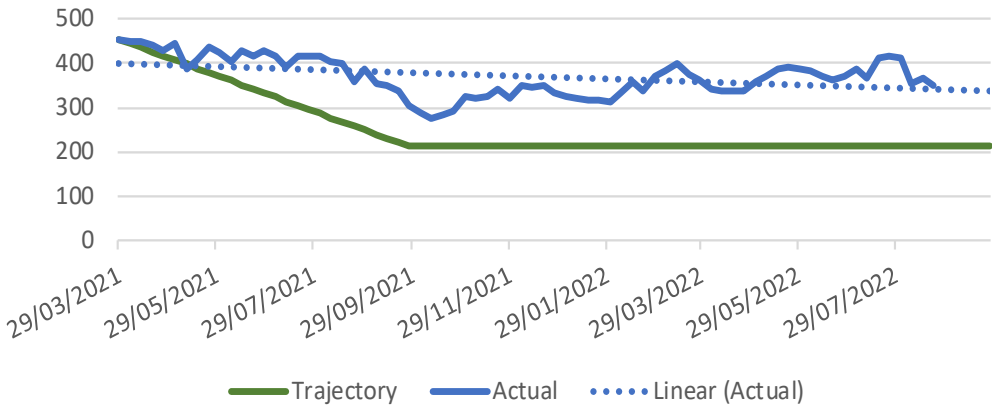
### Threats

- We continue to see the significant and sustained increase in demand for both our emergency departments which continues to create pressure at the front door and driving ongoing increased staffing.
- Deterioration of Head and Neck service in terms of consultant cover and Speech and Language Therapy, started some WYAAT conversations re: a regional response.
- Significant delay in Theatre refurbishment (theatres 7 & 8), unable to commence as plan, in conversation re: delaying until next year due to threat to recovery.
- Community services are increasingly seeing more complex and acute presentation with impacts on wider anticipatory care and Long Term Condition (LTC) management.
- Patients are presenting with increased acuity and complexity which is resulting in a longer length of stay and challenges around timely discharge into the community.
- Staff fatigue due to ongoing pressures and frustration due to prolonged changing and increasing workloads.
- Potential further covid waves could delay the recovery through sickness or possible deployment
- Increasing number of complaints due to prolonged waits and poor patient experience.
- Significant cost pressure within the division due to Private Ambulance costs over and above CCG YAS commissioned service. This service has moved to the corporate division from May 2022.
- Risk of further vacancies in community nursing due to local organisations rebanding DN roles to Band 7. It has now been agreed to uplift Community DN's to band 7 backdated to January 2022
- Risk around long term funding of Virtual ward, this comes with 1 year pump priming, 1 year match funding and should be sustained through existing resource from 2024/25. Community are working in collaboration with other CHFT divisions as well as across CKW for longer-term efficiencies.
- Risk around recruitment to virtual ward posts as initial plans support recruitment of circa 150 WTE posts across the West Yorkshire footprint.

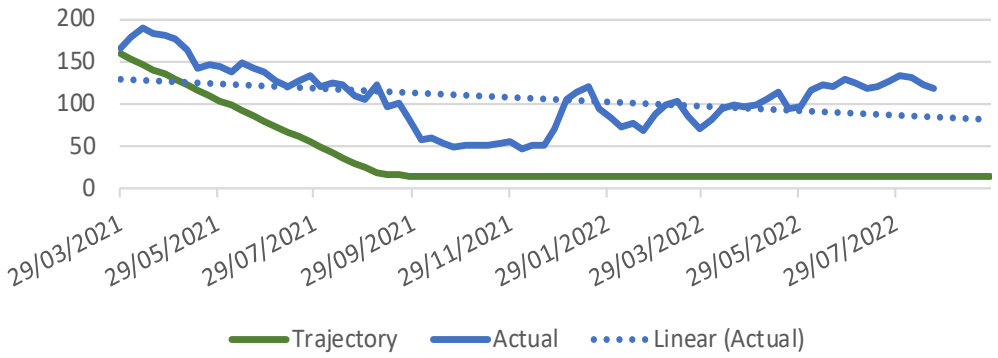
Health and safety risks due to ageing estate across the Trust. Working with stakeholders to mitigate risks and explore permanent solutions that align with wider Trust reconfiguration plans.

## INPATIENT WAITING LIST - P2

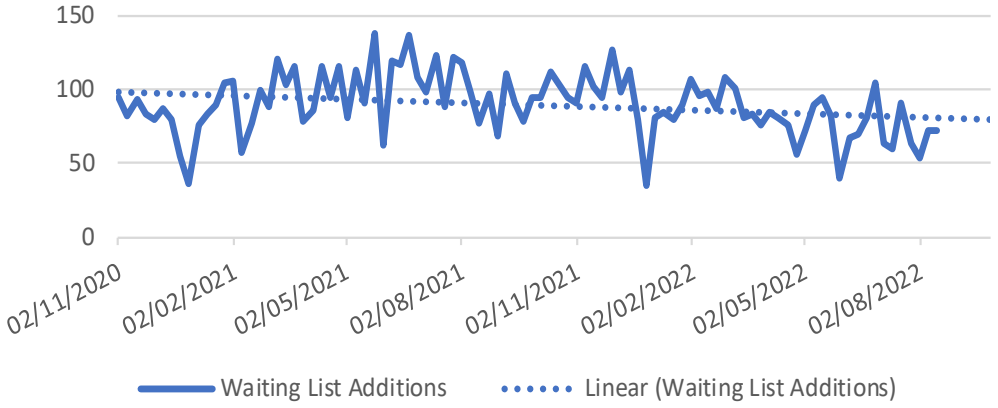
### Trajectory vs Actual - Total P2s on Waiting List



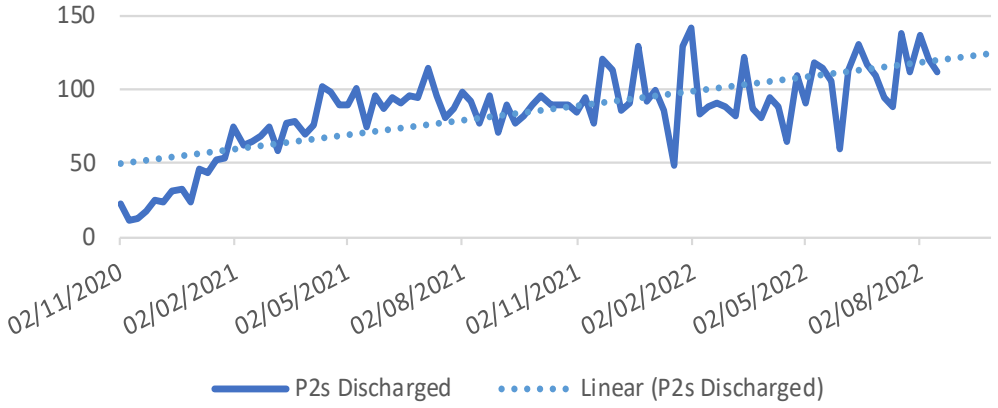

### Trajectory vs Actual - Total P2s on Waiting List Over 1 month




### P2 waiting List Additions

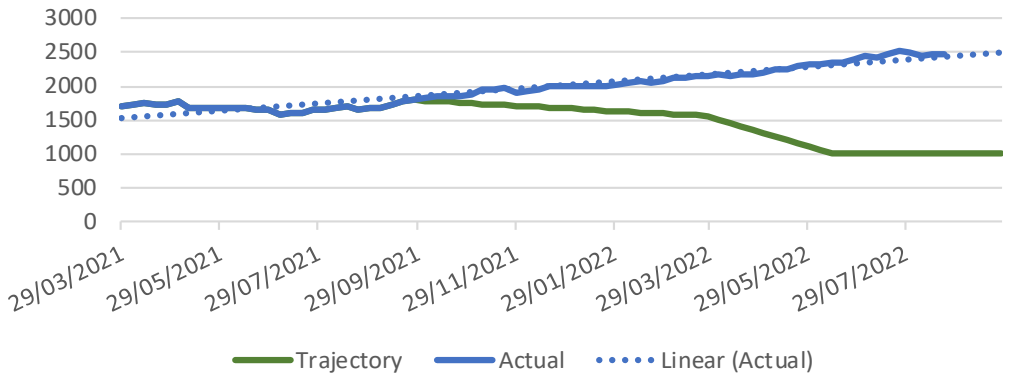



### P2 Surgery done in the week

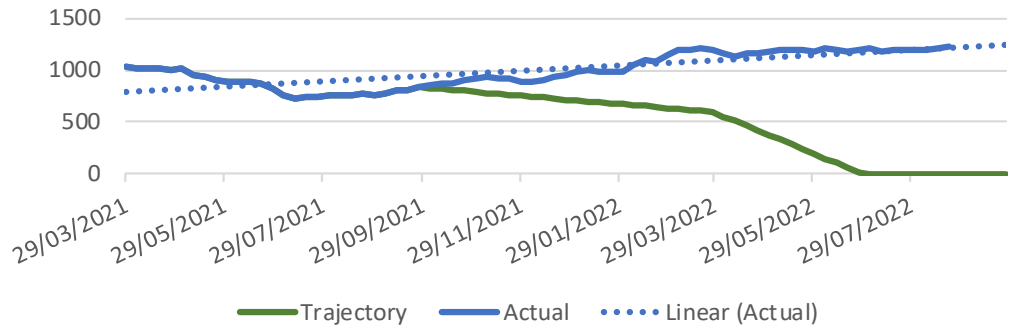


## INPATIENT WAITING LIST - P3

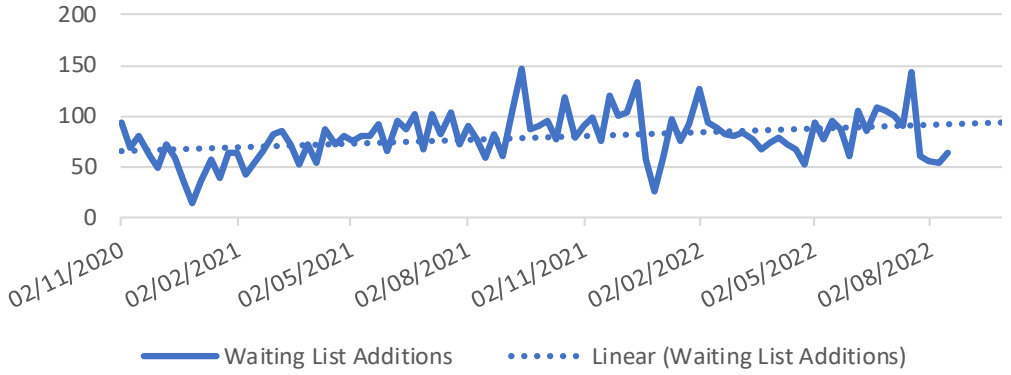
### Trajectory vs Actual - Total P3s on Waiting List



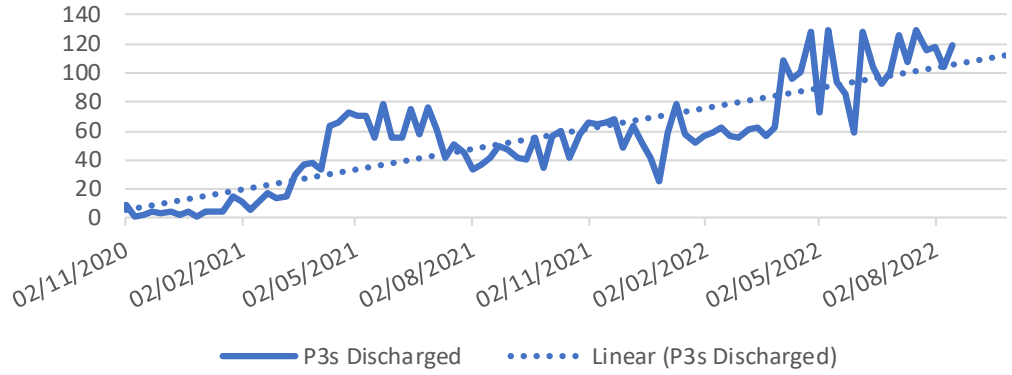

### Trajectory vs Actual - Total P3s on Waiting List Over 3 months



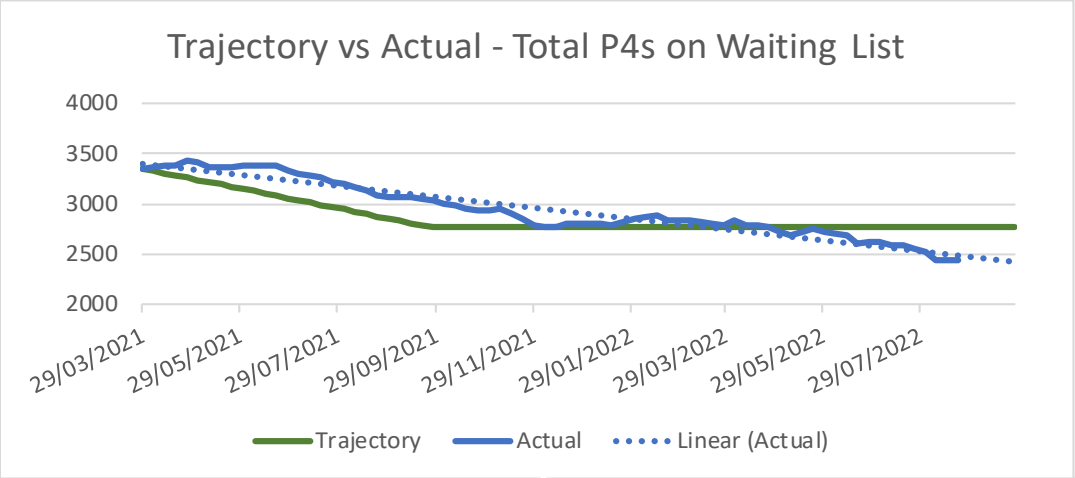

### P3 waiting List Additions

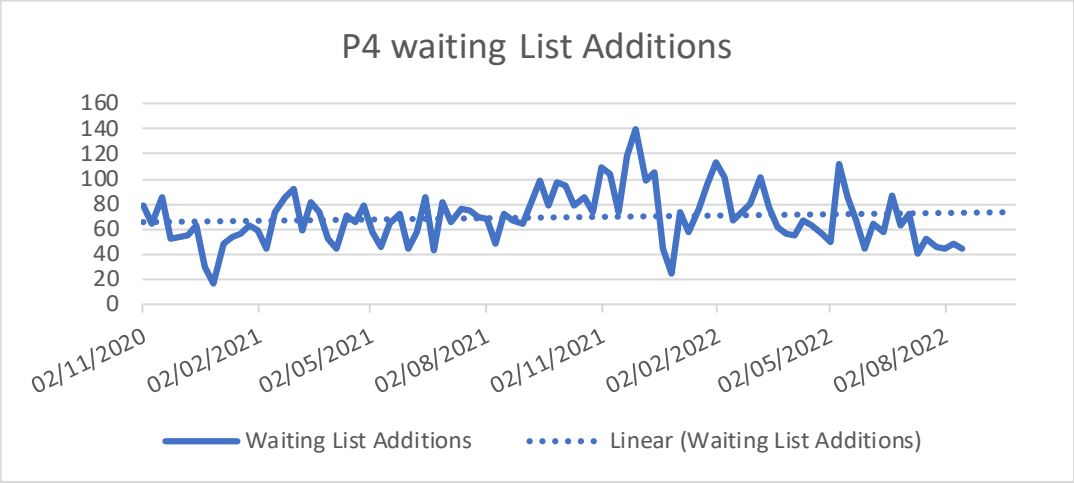


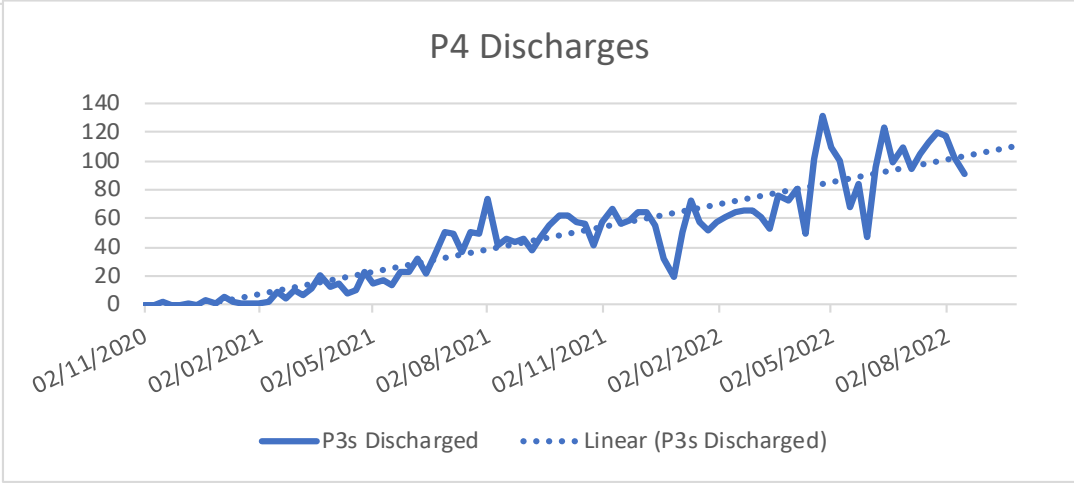

### P3 Discharges



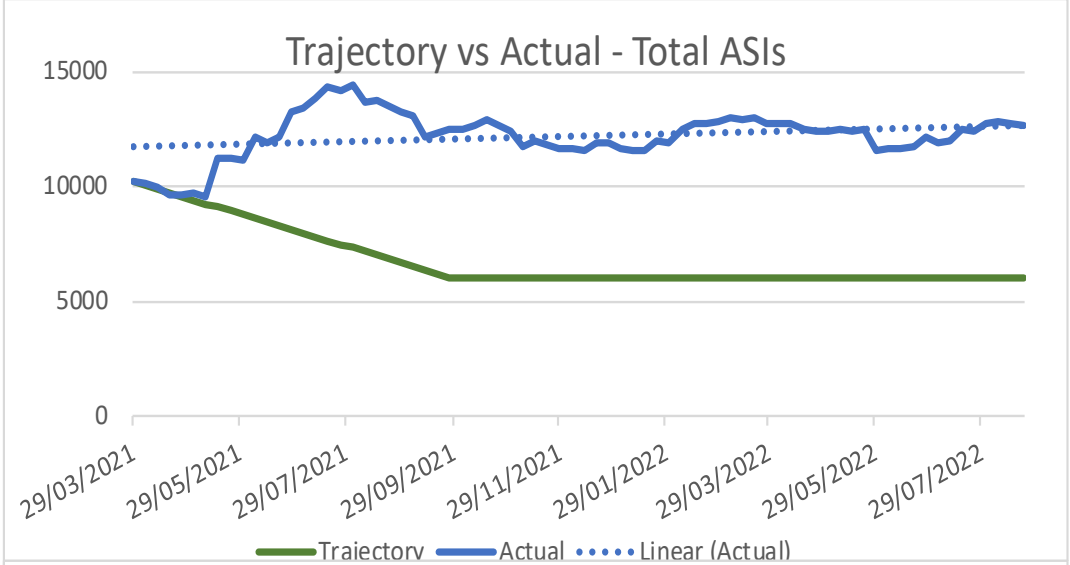
## INPATIENT WAITING LIST - P4

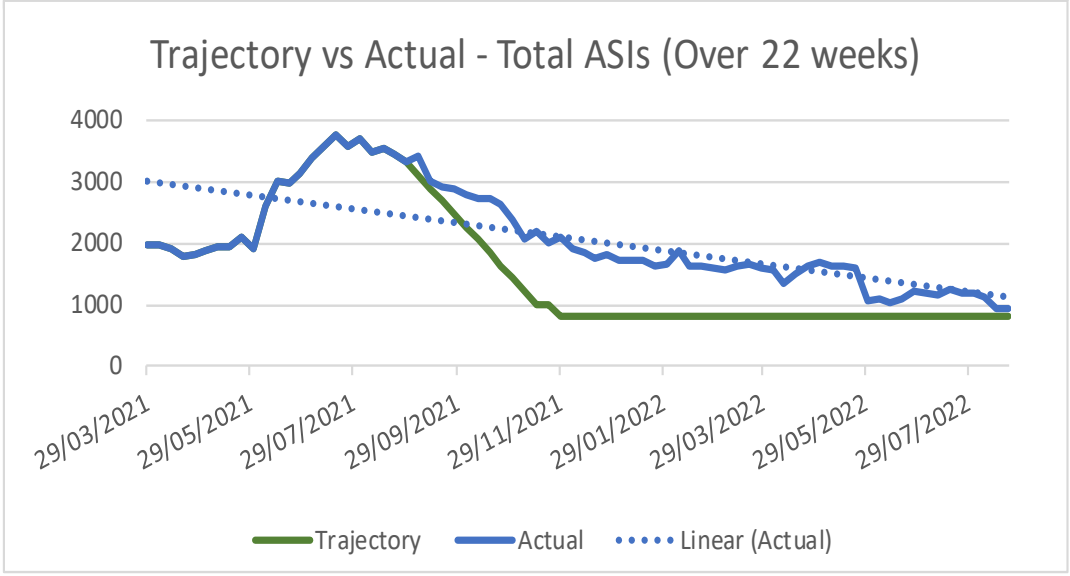


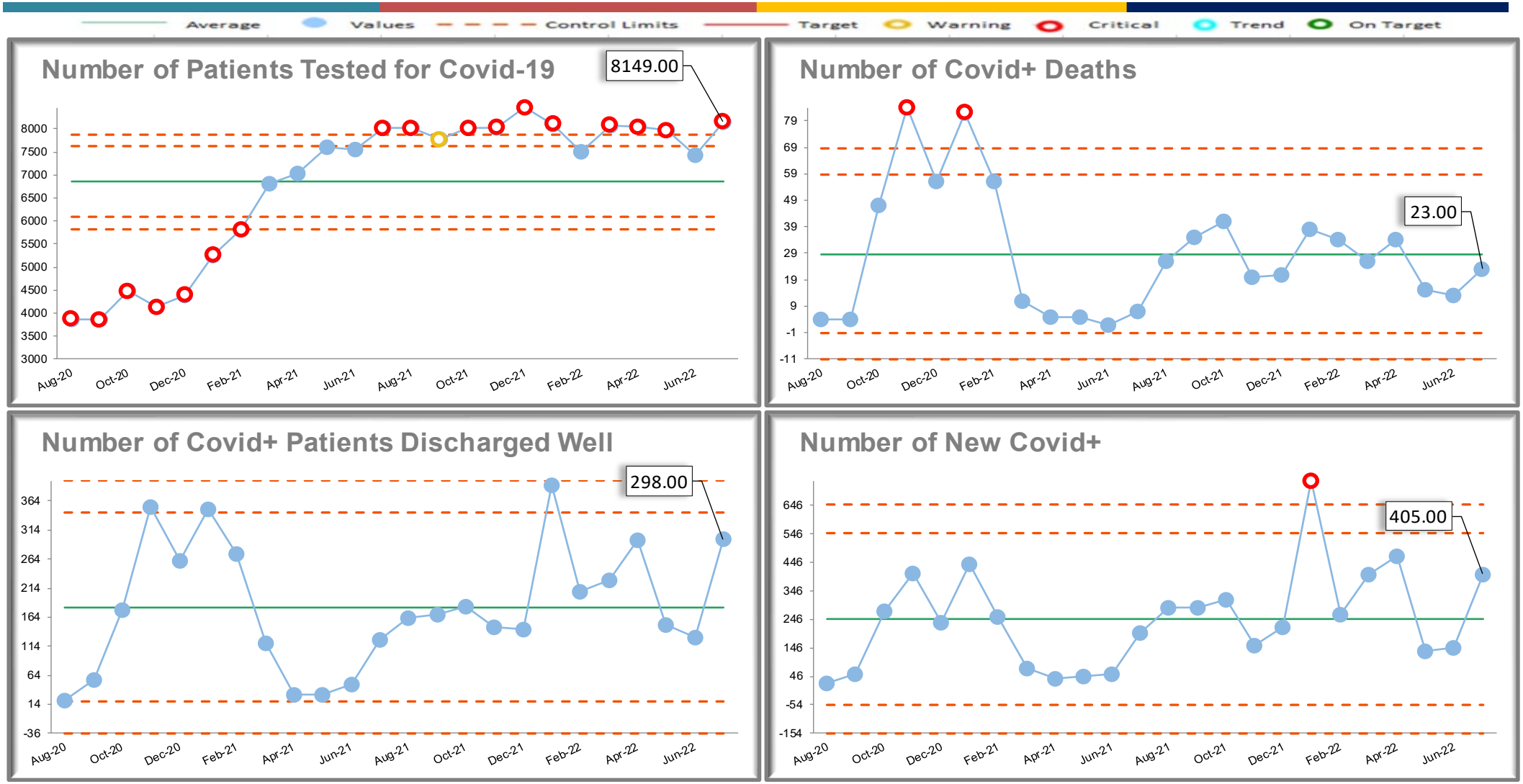



## ASIs

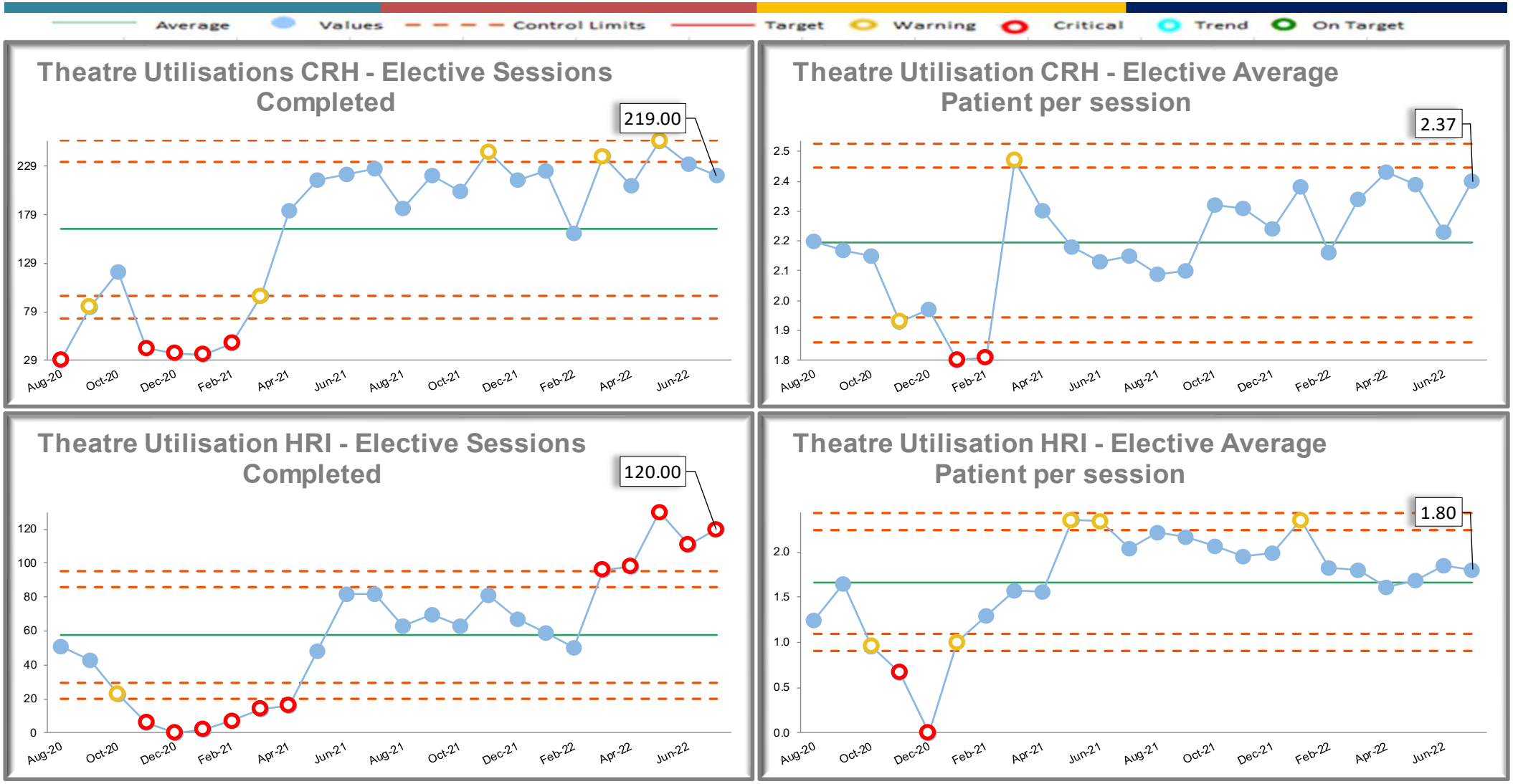

Trajectory vs Actual - Total ASIs
15000
10000
5000
0
29/03/2021
29/05/2021
29/07/2021
29/09/2021
29/11/2021
29/01/2022
29/03/2022
29/05/2022
29/07/2022
Trajectory
Actual
Linear (Actual)


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

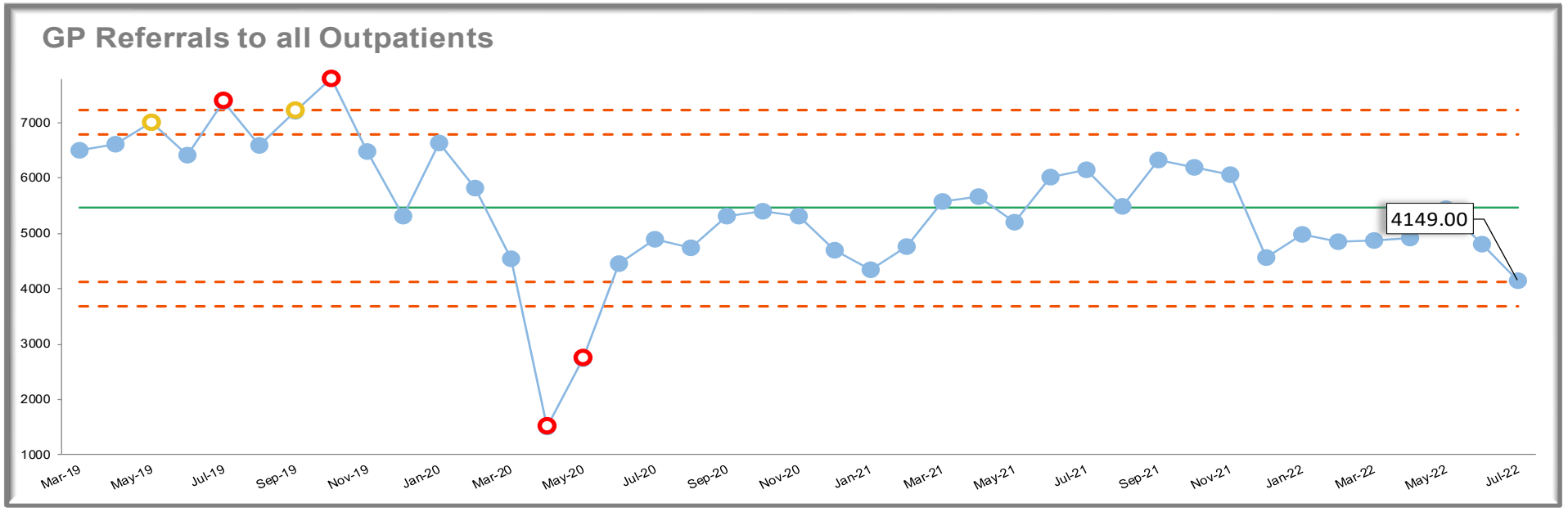
# Covid-19 - SPC Charts

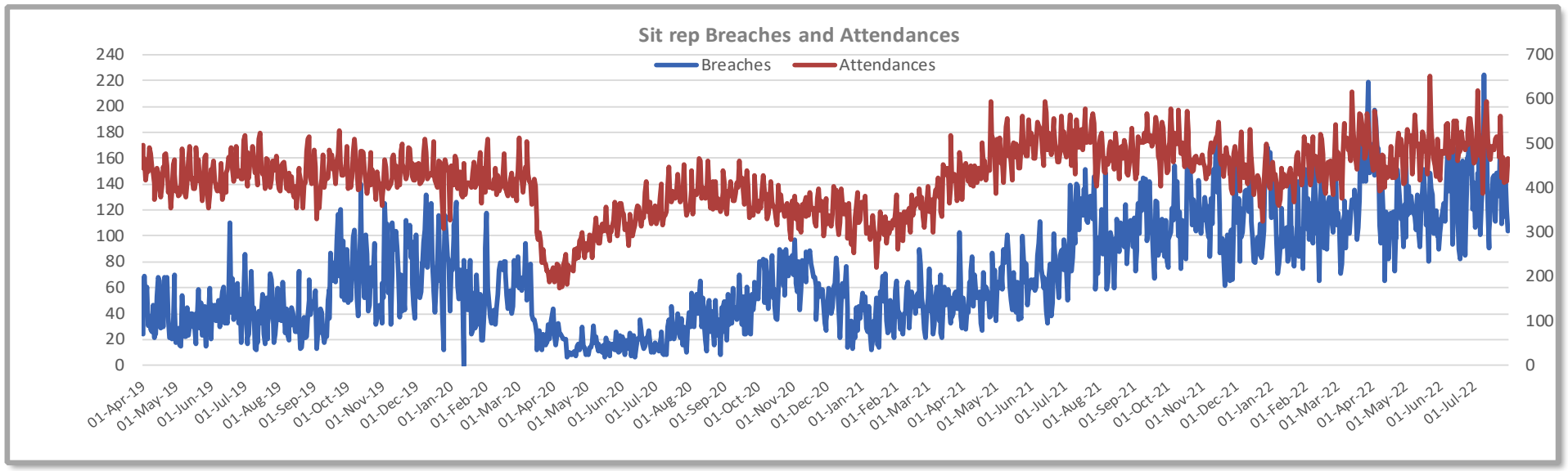


# Theatres - SPC Charts



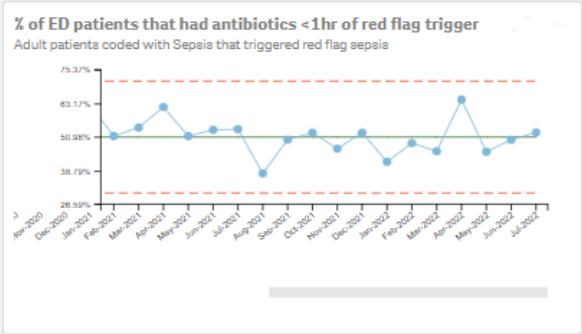
# Capacity and Demand

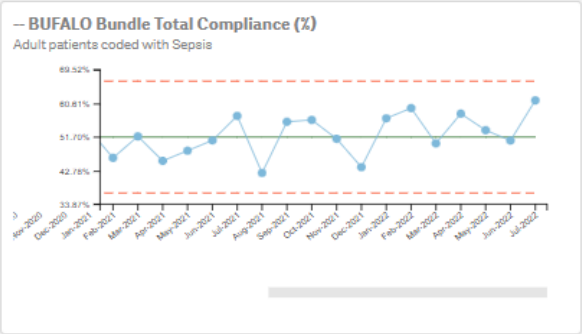


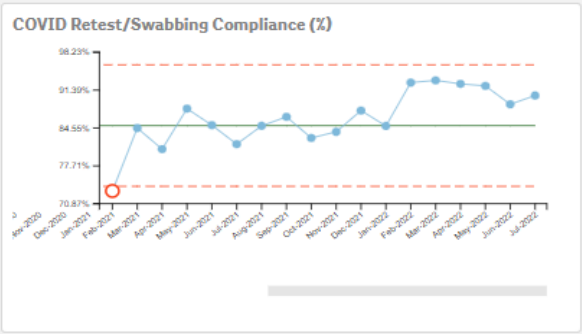
# Quality Priorities - Quality Account Priorities

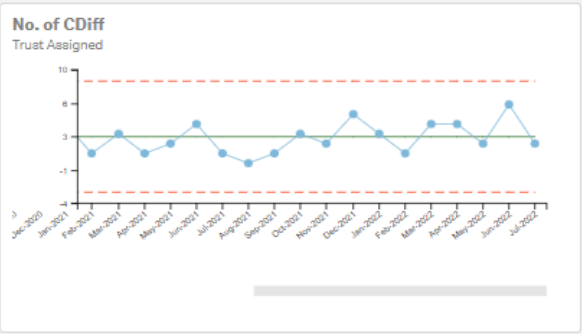
**Priority 1**
Recognition and timely treatment of Sepsis

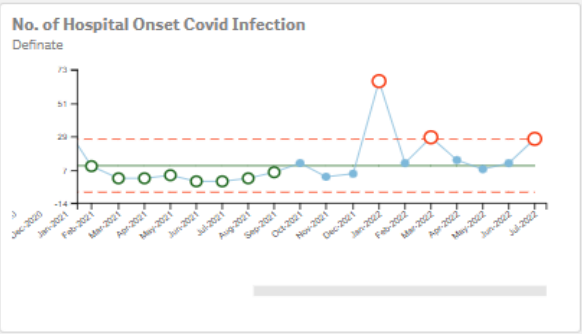


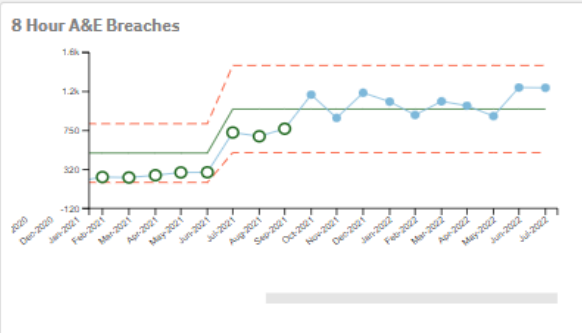

**Priority 2**
Reduce number of hospital acquired infections including COVID-19

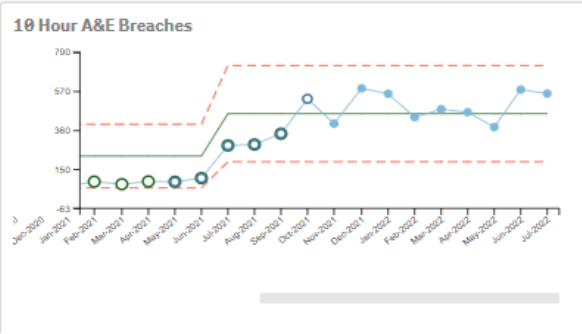


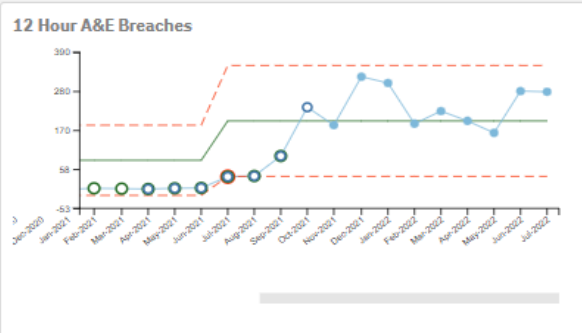




**Priority 3**
Reduce waiting times for individuals in the Emergency Department



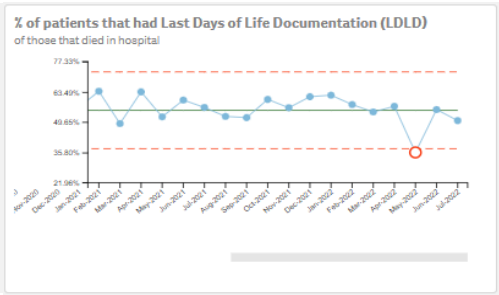



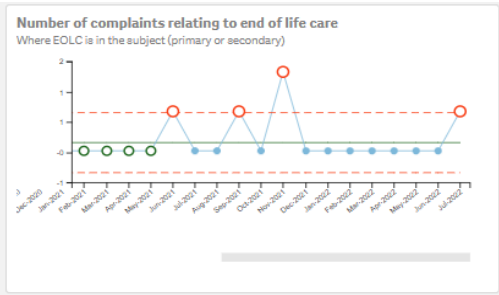
## Quality Priorities - Focused Priorities

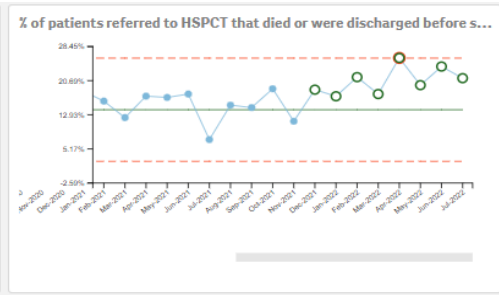
**Priority 1**
Reducing the number of falls resulting in harm



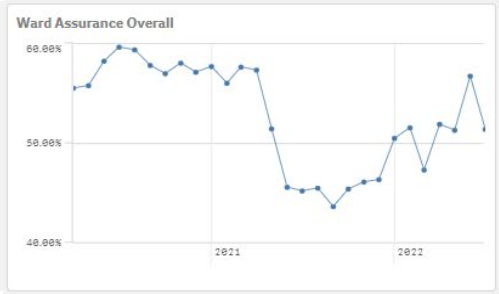

**Priority 2**
End of Life Care

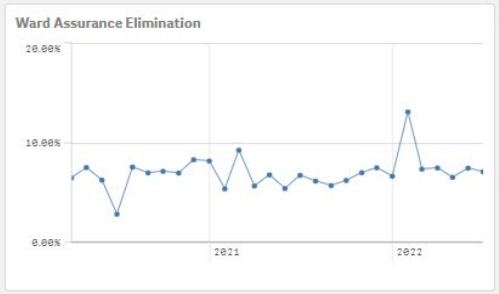


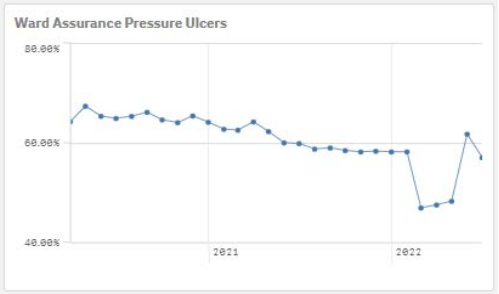




**Priority 3**
Clinical Documentation



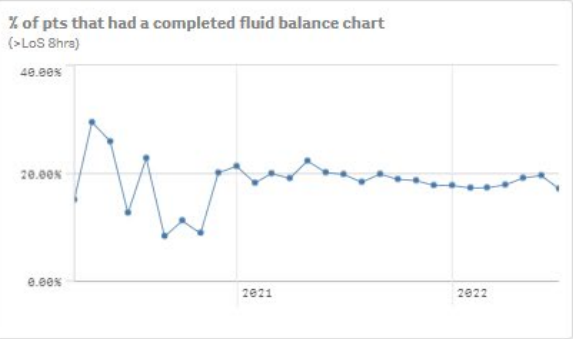

**Priority 4**
Clinical Prioritisation

Not Yet Available

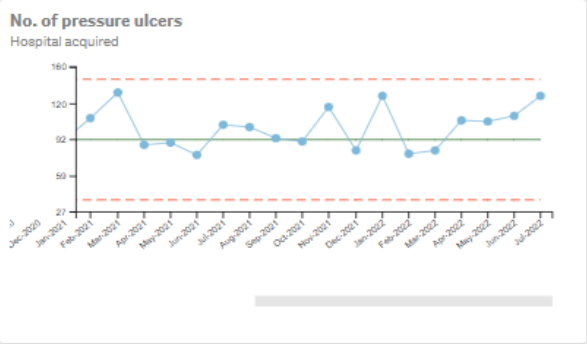
# Quality Priorities - Focused Priorities

**Priority 5**
Nutrition and Hydration

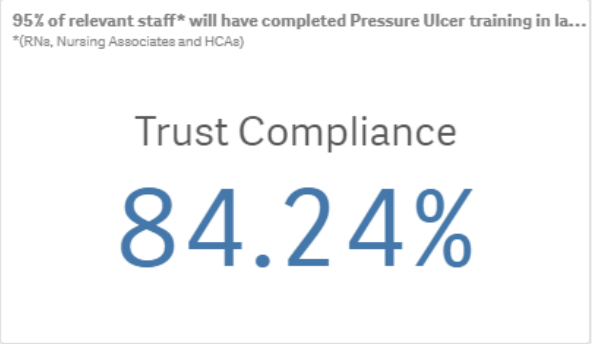




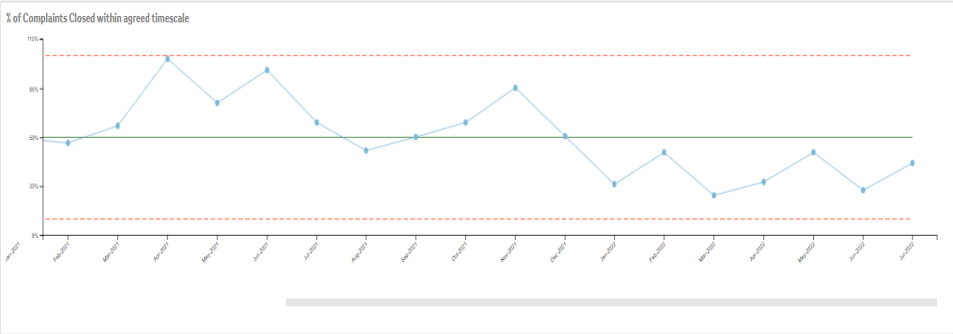

**Priority 6**
Reduction in the number of CHFT acquired pressure ulcers








**Priority 7**
Making complaints count

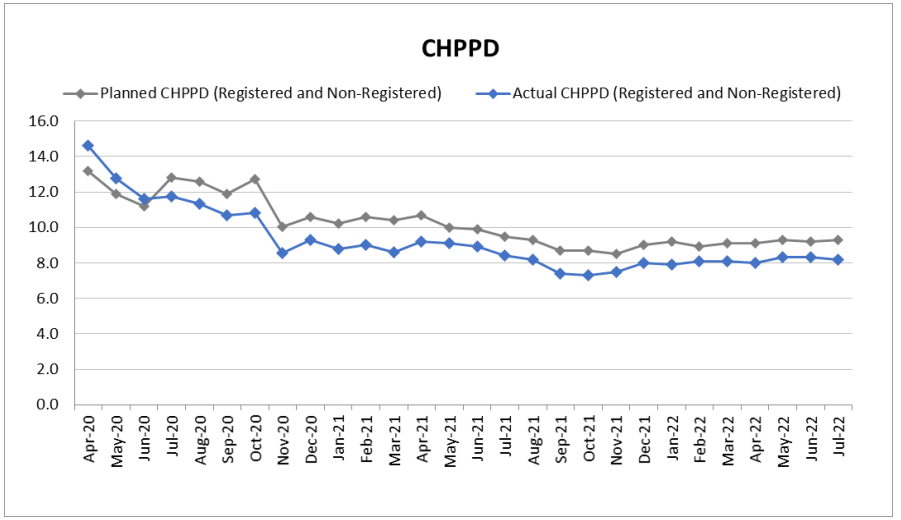


# Hard Truths: Safe Staffing Levels

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

| | May-22 | Jun-22 | Jul-22 |
|---|---|---|---|
| FILL RATES - DAY (REGISTERED & NON REGISTERED CLINICAL STAFF) | 87.6% | 88.6% | 88.6% |
| FILLRATES - NIGHT (REGISTERED & NON REGISTERED CLINICAL STAFF) | 91.7% | 92.7% | 92.7% |

| | | | |
|---|---|---|---|
| PLANNED CHPPD (REGISTERED & NON REGISTERED CLINICAL STAFF) | 9.3 | 9.2 | 9.3 |
| ACTUAL CHPPD (REGISTERED & NON REGISTERED CLINICAL STAFF) | 8.3 | 8.3 | 8.2 |

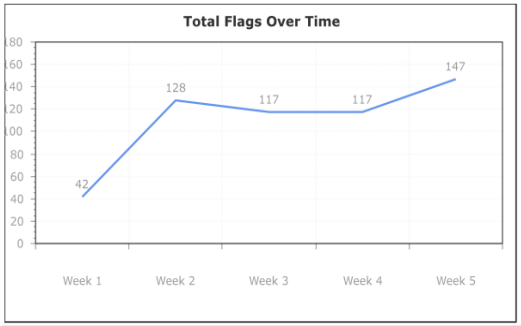


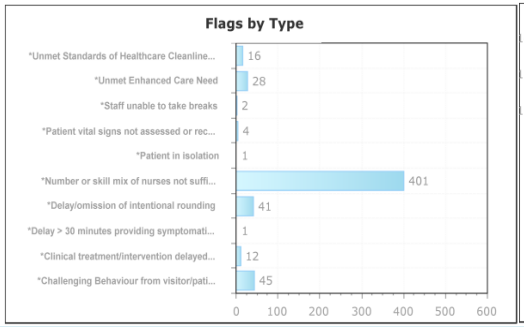

CHPPD provides a single, consistent and nationally comparable way of recording and reporting deployment of staff to provide care on inpatient wards. CHPPD is not a stand alone measure and should be used alongside clinical quality and safety outcome measures.

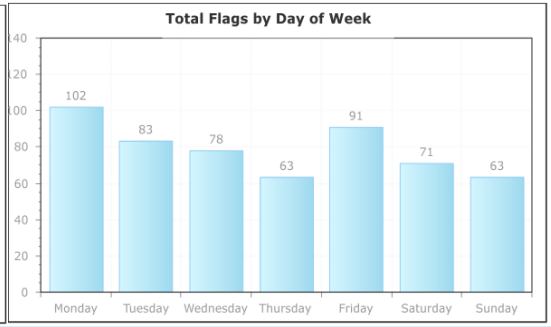
A review of the July 22 data indicates that the combined RN and non-registered clinical staff metrics resulted in 22 of the 28 clinical areas having fewer CHPPD than planned, with a total deficit of 1.1 CHPPD across the Trust. The gap in planned v actual CHPPD is at its broadest with the RN workforce representing 0.9 deficit with HCSW showing 0.2 deficit. The CHPPD planned v actual gap is most prominent in the Surgical division (2.9 CHPPD deficit) This is largely attributable to the staffing in ICU which continues to report the planning for a COVID escalation workforce model. 'Actual' levels represent the staffing required to care for the patients each shift according to GPICS ratios. The CHPPD gap in FSS (2.7) is mostly attributable to midwifery absence and vacancies. This pressure on service provision is managed according to local and regional OPEL escalation plans to ensure safety of women and babies is maintained.

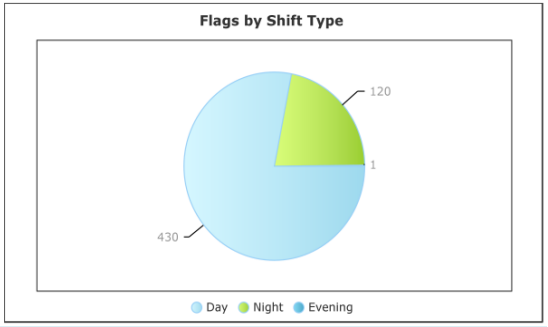
The 2021 successful recruitment to HCA roles has enabled increased shift fill to provide support to the reduced RN availability. However some attrition and adjustment to workforce models has now created a small vacancy pressure in this workforce group which is being addressed by central recruitment. Professional judgement is used daily to redeploy staff on a shift basis and establish the safest staffing possible in all areas.
Challenges of the requirement to staff additional capacity areas, combined with increased Covid prevalence in July, continue to impact on the ability to staff all areas according to workforce model.

## STAFFING RED FLAG INCIDENTS




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

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

# Hard Truths: Safe Staffing Levels (2)

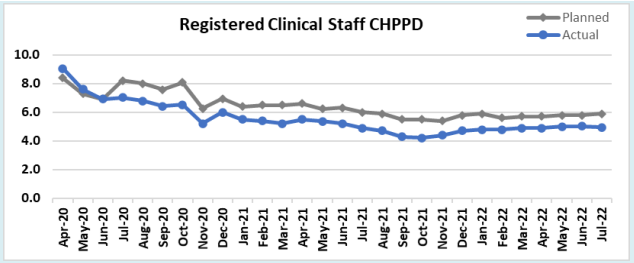
Aggregate Position | Trend | Result

## CHPPD BY STAFF TYPE

**Registered Clinical Staff**

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

CHPPD was 5.9 for planned and 5.0 For actual for Registered Clinical Staff

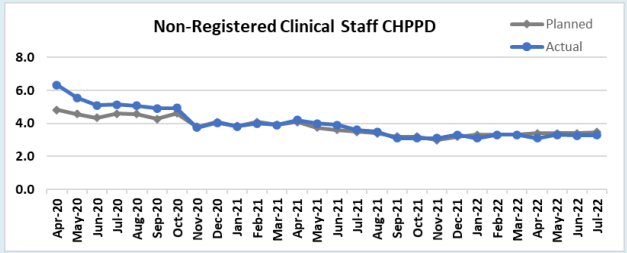



Overall there is a shortfall of 0.9 CHPPD against an overall requirement of 5.9 CHPPD for registered staff. Professional judgement informs decision-making at the twice daily staffing meetings to mitigate the risk across the clinical areas, and staff are redeployed to optimise safety. A suite of nurse sensitive indicators have also been incorporated into this section of the report to monitor for any correlations alongside the CHPPD in line with national recommendations.
Continued training is being promoted to prevent falls and improve pressure area care. These indicators remain within normal variation in month.

**Non Registered Clinical Staff**

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

CHPPD was 3.5 for planned and 3.3 for actual for Non Registered Clinical Staff



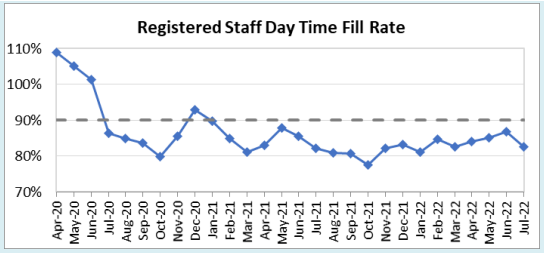

Overall there is a shortfall in the CHPPD of 0.2 for non-registered clinical staff. Nightshift fill is prioritised over day shift due the increased vulnerability of patients overnight and having fewer health professionals on the wards. Where RN numbers fall below planned, non-registered clinical staff numbers are often increased to mitigate for patient safety risks.

## 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.

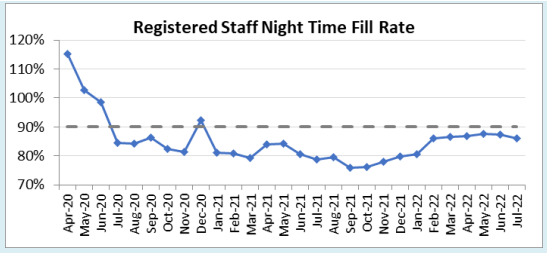
82.66% of expected Registered Clinical Staff hours were achieved for day shifts.




**Registered Staff Night**

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

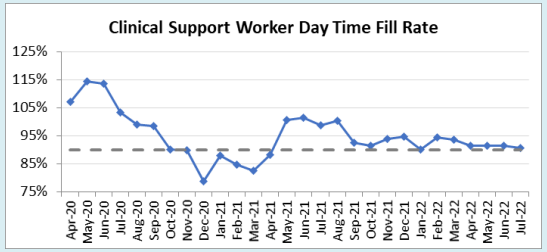
86.06% of expected Registered Clinical Staff hours were achieved for night shifts.




**Non Registered Clinical Staff Day**

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

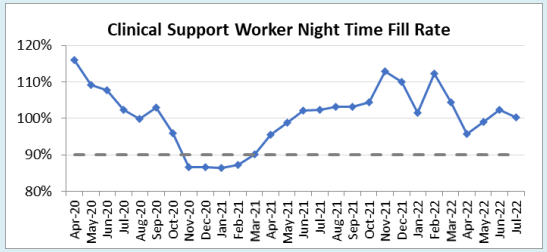
90.66% of expected Non Registered Clinical Staff hours were achieved for Day shifts.




**Non Registered Clinical Staff Night**

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

102.24% of expected Non Registered Clinical Staff hours were achieved for night shifts.

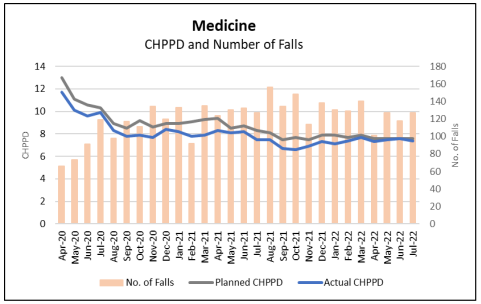


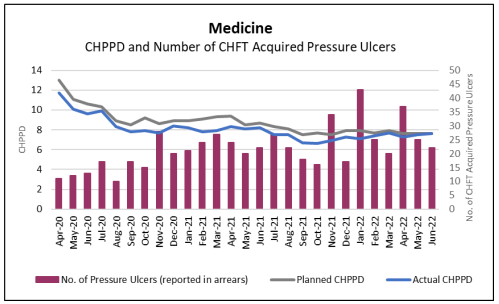
## Hard Truths: Safe Staffing Levels (3)

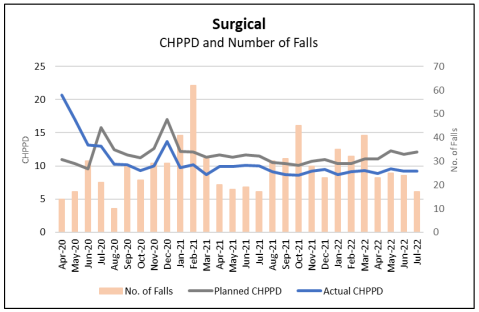
### NURSING QUALITY INDICATORS AND FILLRATES BY WARD AND DIVISION

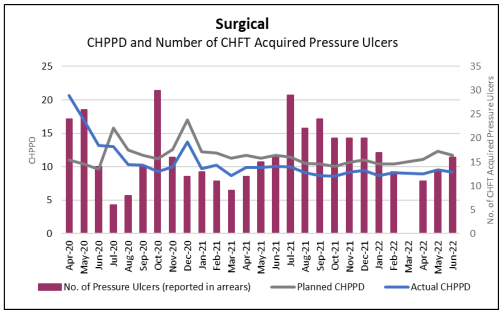
| Ward | Average Fill Rates | | | | CHPPD | |
|---|---|---|---|---|---|---|
| | DAY - Registered Clinical Staff (%) | DAY - Non Registered Clinical Staff (%) | NIGHT - Registered Clinical Staff (%) | NIGHT - Non Registered Clinical Staff (%) | Total PLANNED CHPPD | Total ACTUAL CHPPD |
| **Medicine** | **91.3%** | **97.2%** | **95.4%** | **105.7%** | **7.6** | **7.4** |
| CRH ACUTE FLOOR | 96.5% | 82.8% | 100.8% | 87.6% | 8.5 | 7.8 |
| HRI ACUTE FLOOR | 90.2% | 92.6% | 98.6% | 100.9% | 8.3 | 7.9 |
| RESPIRATORY FLOOR | 75.1% | 84.2% | 88.3% | 88.6% | 8.4 | 7.0 |
| WARD 5 | 78.7% | 95.1% | 101.4% | 144.0% | 6.7 | 6.8 |
| WARD 6 | 75.1% | 58.1% | 98.4% | 100.0% | 4.2 | 3.3 |
| WARD 6C | 96.2% | 82.4% | 104.3% | 92.6% | 11.8 | 11.1 |
| WARD 6AB | 96.2% | 82.4% | 104.3% | 92.6% | 6.3 | 5.9 |
| WARD CCU | 79.1% | 71.7% | 89.6% | | 8.4 | 7.1 |
| STROKE FLOOR | 151.6% | 163.8% | 97.7% | 122.6% | 7.5 | 10.1 |
| WARD 12 | 90.4% | 78.4% | 96.8% | 100.8% | 7.5 | 6.7 |
| WARD 15 | 79.6% | 122.4% | 87.2% | 132.8% | 7.2 | 7.6 |
| WARD 17 | 71.7% | 91.8% | 93.5% | 124.6% | 7.0 | 6.2 |
| WARD 18 | 92.3% | 110.7% | 77.5% | 142.9% | 8.7 | 8.9 |
| WARD 20 | 85.5% | 114.8% | 98.0% | 111.4% | 6.5 | 6.7 |
| **Surgical** | **72.0%** | **75.8%** | **76.2%** | **89.7%** | **12.1** | **9.2** |
| WARD 21 | 82.5% | 105.2% | 91.3% | 132.9% | 8.7 | 8.8 |
| WARD 22 | 87.1% | 99.4% | 94.1% | 103.2% | 6.9 | 6.5 |
| ICU | 67.1% | 48.9% | 69.0% | 39.8% | 58.4 | 37.0 |
| WARD 8AD | 39.1% | 38.6% | 37.9% | 99.8% | 25.6 | 10.7 |
| WARD 8B | 98.2% | 71.1% | 98.4% | 96.8% | 8.4 | 7.6 |
| WARD 10 | 73.9% | 92.8% | 74.5% | 90.2% | 9.7 | 7.8 |
| WARD 11 | 52.8% | 54.2% | 62.0% | 69.8% | 11.7 | 6.8 |
| WARD 19 | 79.2% | 88.5% | 95.7% | 97.8% | 8.4 | 7.5 |
| SAU HRI | 93.6% | 95.1% | 97.8% | 99.2% | 8.4 | 8.1 |
| **FSS** | **79.6%** | **76.9%** | **80.6%** | **87.9%** | **13.8** | **11.1** |
| WARD LDRP | 77.8% | 57.8% | 79.2% | 87.2% | 30.4 | 23.5 |
| WARD NICU | 83.3% | 63.7% | 84.9% | 90.3% | 18.2 | 15.1 |
| WARD 3ABCD | 75.4% | 96.0% | 75.5% | 79.0% | 16.0 | 12.4 |
| WARD 4ABC | 85.4% | 89.8% | 89.2% | 94.8% | 5.7 | 5.1 |
| Ward 1D | 92.8% | 64.2% | 90.5% | 80.7% | 20.4 | 17.4 |
| **TRUST** | **82.66%** | **90.66%** | **86.06%** | **100.24%** | **9.3** | **8.2** |

**Nursing Quality Indicators**




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

# Hard Truths: Safe Staffing Levels (4)

## Conclusions and Recommendations

**Conclusions**

The Trust remains committed to achieving its nurse and midwifery staffing establishments and developing the workforce as part of the Time to Care strategy. Delivery of actual CHPPD, whilst still fewer than planned, equates to the national median.

On-going activity:

1.The use of the enhanced metrics dashboard is embedded in the weekly senior safer staffing review meeting. Areas with less than 85% shift fill rate are scrutinised with a suite of nurse sensitive indicators. Matrons from affected areas present their analysis of indicators at the Nursing and Midwifery Safer Staffing forum where recommendations and actions are agreed to respond to the current position.

2. The Nursing and Midwifery Workforce Steering Group agenda has been re-established to focus upon medium to long-term strategies to support the Nursing, Midwifery and AHP workforce requirements. This includes an ongoing review of the current and projected Nursing and Midwifery vacancy position and workforce plans reviewing directorate specific pressures to inform recruitment strategies.

3. Work continues to maximise the use of HealthRoster and the 'confirm and challenge' process to ensure a reduction of planned variability of shift fill across weekdays and weekends, as well as ensuring Annual Leave and Study leave is planned within agreed headrooms.

4. Active recruitment of final year students to be employed as Newly Qualified Nurses in September 2022 is underway through recruitment fayres as well as generic job advertisements with 64 newly qualified nurses in the pipeline. This primary pipeline of staff are due to commence their induction on 26 September and are expected to be delivering patient care as part of the rostered shifts by the end of October in most areas.

5. International recruitment at CHFT continues to provide a second pipeline of recruits through the year. We are on plan to meet the ambitious target of 80 international RN recruits during 2022 (with 30 already in the UK and a further 50 in pipeline), and have submitted a bid to secure financial support from NHSE to recruit a further 20 (total 100) by December 2022, which we are confident of achieving.

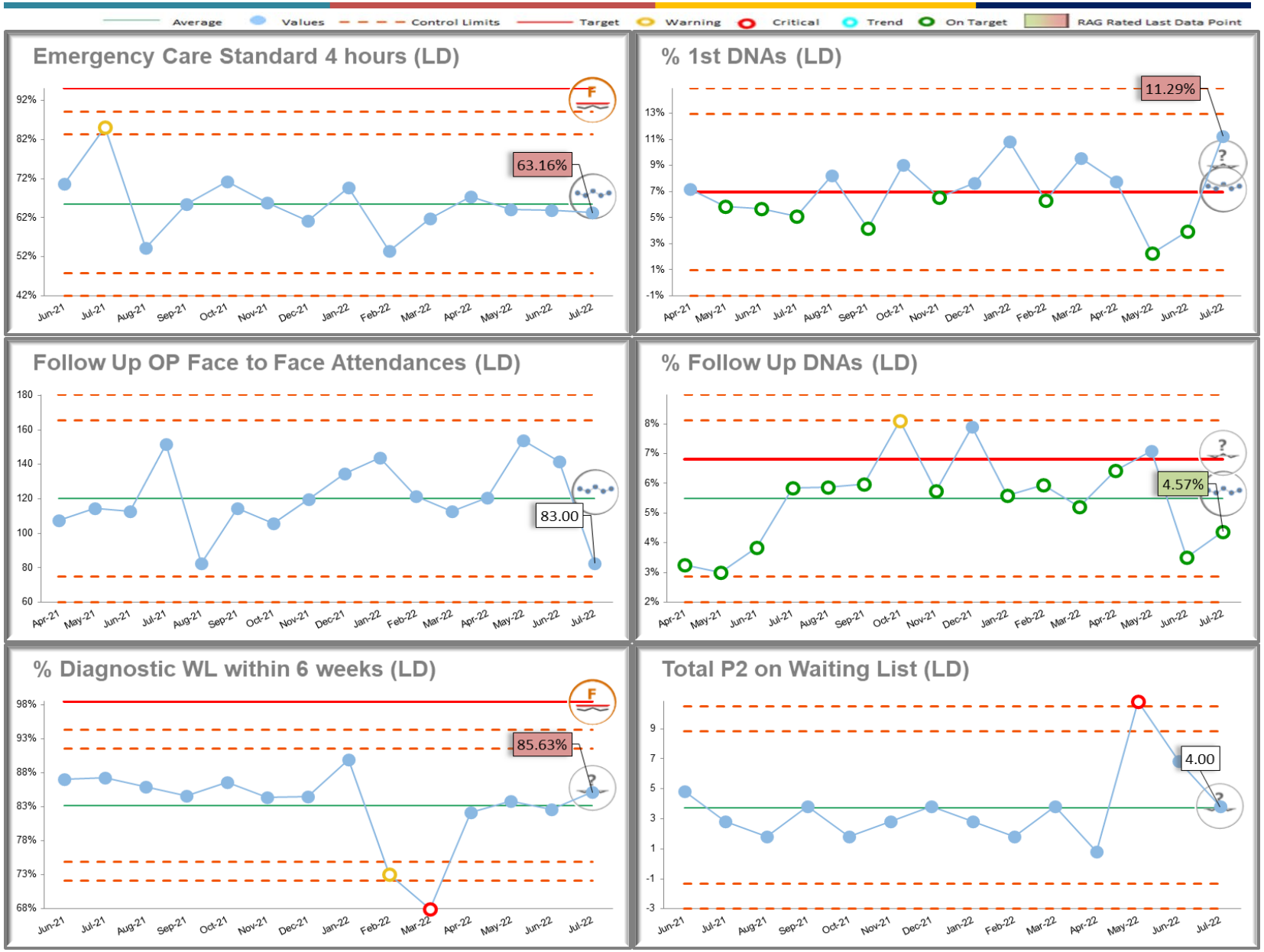
6. Patient dependency data for the next round of the bi-annual establishment reviews (Hard Truths) has been collected. Analysis of this data has been conducted through July with proposed establishment changes being presented to panel by early September.

7. Recruitment of the next cohort of apprentices to top-up from Nursing Associate to Registered Nurses(NA to RN) has begun with 7 places to commence in October 2022. This route to registration allows career progression for those unable to access traditional undergraduate courses and forms part of our offer to promote equitable and levelling up opportunities.

# LD - Key measures

| | 21/22 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Mar-22 | Apr-22 | May-22 | Jun-22 | Jul-22 | YTD | Performance Range | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | | | Green | Amber | Red |
| **Recovery** | | | | | | | | | | | | | | | | | | |
| Total P2 on Waiting List (LD) | 32 | 3 | 2 | 4 | 2 | 3 | 4 | 3 | 2 | 4 | 1 | 11 | 7 | **4** | **23** | No target | | |
| Total P3 on Waiting List (LD) | 119 | 14 | 18 | 13 | 10 | 10 | 7 | 8 | 11 | 11 | 14 | 16 | 12 | **9** | **51** | No target | | |
| Total P4 on Waiting List (LD) | 58 | 9 | 11 | 9 | 9 | 3 | 3 | 2 | 1 | 1 | 2 | 3 | 4 | **4** | **13** | No target | | |
| **Emergency Care** | | | | | | | | | | | | | | | | | | |
| Emergency Care Standard 4 hours (LD) | 65.74% | 85.05% | 54.21% | 65.31% | 71.05% | 65.65% | 61.02% | 69.57% | 53.33% | 61.62% | 67.26% | 63.93% | 63.72% | **63.16%** | **64.56%** | >=95% | | <95% |
| **Waiting Times** | | | | | | | | | | | | | | | | | | |
| 18 weeks Pathways >=26 weeks open (LD) | 569 | 51 | 48 | 54 | 56 | 58 | 69 | 61 | 63 | 54 | 50 | 47 | 54 | **41** | **192** | 0 | | >=1 |
| RTT Waits over 52 weeks Threshold > zero (LD) | 409 | 38 | 40 | 41 | 37 | 41 | 45 | 41 | 47 | 38 | 35 | 38 | 42 | **30** | **145** | 0 | | >=1 |
| % Diagnostic Waiting List Within 6 Weeks (LD) | 83.63% | 0.8774 | 0.8649 | 85.10% | 87.13% | 84.85% | 84.97% | 90.43% | 73.54% | 68.48% | 82.70% | 84.31% | 83.12% | **85.63%** | **83.83%** | >=99% | | <=98% |
| **Cancer** | | | | | | | | | | | | | | | | | | |
| Two Week Wait for Referral to Date First Seen (LD) | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | **100.00%** | **100.00%** | >=93% | 86% - 92% | <85% |
| 31 Days From Diagnosis to First Treatment (LD) | 100.00% | not applicable | not applicable | not applicable | not applicable | not applicable | 100.00% | not applicable | not applicable | not applicable | 100.00% | not applicable | 100.00% | **not applicable** | **100.00%** | >=96% | | <95% |
| 31 Day Subsequent Surgery Treatment (LD) | not applicable | not applicable | not applicable | not applicable | not applicable | not applicable | not applicable | not applicable | not applicable | not applicable | not applicable | not applicable | not applicable | **not applicable** | **not applicable** | >=94% | | <93% |
| 38 Day Referral to Tertiary (LD) | not applicable | not applicable | not applicable | not applicable | not applicable | not applicable | not applicable | not applicable | not applicable | not applicable | not applicable | not applicable | not applicable | **not applicable** | **not applicable** | >=85% | | <84% |
| 62 Day GP Referral to Treatment (LD) | 100.00% | not applicable | 100.00% | not applicable | not applicable | not applicable | not applicable | not applicable | not applicable | not applicable | not applicable | not applicable | 100.00% | **not applicable** | **100.00%** | >=85% | 81% - 84% | <80% |
| 62 Day Referral From Screening to Treatment (LD) | not applicable | not applicable | not applicable | not applicable | not applicable | not applicable | not applicable | not applicable | not applicable | not applicable | not applicable | not applicable | not applicable | **not applicable** | **not applicable** | >=90% | | <89% |
| **Activity - Number of Attendances** | | | | | | | | | | | | | | | | | | |
| New Outpatient Attendances - Face to Face (LD) | 366 | 34 | 24 | 26 | 34 | 33 | 38 | 38 | 24 | 31 | 36 | 40 | 43 | **34** | **153** | No target | | |
| New Outpatient Attendances - Non Face to Face (LD) | 256 | 23 | 35 | 18 | 26 | 19 | 25 | 18 | 16 | 18 | 12 | 18 | 13 | **8** | **51** | No target | | |
| Follow up Outpatient Attendances - Face to Face (LD) | 1426 | 152 | 83 | 115 | 106 | 120 | 135 | 144 | 122 | 113 | 121 | 154 | 142 | **83** | **500** | No target | | |
| Follow up Outpatient Attendances - Non Face to Face (LD) | 845 | 90 | 81 | 60 | 69 | 74 | 47 | 45 | 56 | 67 | 51 | 51 | 55 | **41** | **198** | No target | | |
| **Activity - % DNAs** | | | | | | | | | | | | | | | | | | |
| % 1st DNAs (LD) | 7.22% | 5.13% | 8.24% | 4.23% | 9.09% | 6.58% | 7.69% | 10.87% | 6.35% | 9.59% | 7.79% | 2.30% | 3.95% | **11.29%** | **5.96%** | <=7.0% | 7.1% - 7.9% | >=8.0% |
| % Follow Up DNAs (LD) | 5.72% | 6.03% | 6.06% | 6.17% | 8.30% | 5.93% | 8.10% | 5.79% | 6.13% | 5.39% | 6.61% | 7.29% | 3.70% | **4.57%** | **5.67%** | <=7.0% | 7.1% - 7.9% | >=8.0% |

# LD - SPC Charts



# 21. Risk Appetite Statement

To Approve

Presented by Andrea McCourt

| | |
|---|---|
| **Date of Meeting:** | Thursday 1 September 2022 |
| **Meeting:** | Public Board of Directors |
| **Title:** | Annual Review of Risk Appetite |
| **Author:** | Andrea McCourt, Company Secretary |
| **Sponsoring Director:** | Victoria Pickles, Director of Corporate Affairs |
| **Previous Forums:** | None |

**Purpose of the Report**

This paper confirms the Trust risk appetite following an annual review of the existing risk appetite.

It also proposes a process for assessing risks against risk tolerance and identifying areas of risk exposure to the Board.

**Key Points to Note**

**1 Risk Appetite**

**1.1 Definition of Risk Appetite**

Risk appetite is "the amount and type of risk that the Trust is prepared to pursue, retain or take" in pursuit of its strategic objectives and is key to achieving effective risk management.

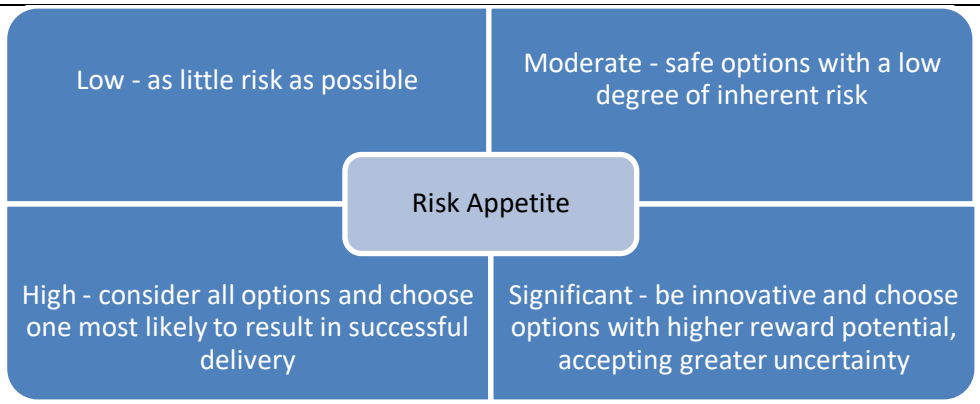
The Board needs to understand, set and apply the risk appetite as a key element of its strategic approach to risk management as it explicitly articulates the Board's attitude to and boundaries of risk. Risk appetite also provides clear expectations for staff and managers regarding the management of risk. It allows for controlled risk taking. The risk appetite also supports the Board by ensuring that they do not expose the Trust to risks it cannot tolerate, it can choose to take opportunities when they arise and the Board is not over cautious or stifles innovation and development.

All risks on the Board Assurance Framework have an identified risk appetite and the Board reviews its risk appetite annually. The amount of risk the Trust is prepared to accept or be exposed to will vary according to the perceived significance of risks, timing and regulatory or legislative constraints. Each risk requires the exercise of judgement and risk appetite levels may need to be re-assessed and amended to reflect new and changing circumstances.

When balancing risks, the Trust will tolerate some risks more than others, for example we have a low appetite for risk relating to harm and safety whereas for quality, innovation and improvement we have a significant risk appetite allowing the Trust to pursue areas with a higher reward potential.

**1.2. Trust Risk Appetite**

The Trust has four levels of risk appetite as depicted below:




### 1.3 Risk Appetite Statement

The Trust has a qualitative risk appetite statement rather than a one-dimensional quantitative statement reflecting the context within which the Trust works and enabling well calculated risks to be taken to improve delivery when opportunities arise.

The risk appetite is based upon the Good Governance Institute (GGI) Risk Appetite for NHS Organisations Matrix.

The Trust's risk appetite is structured around the following key risk categories:

- Strategic / organizational
- Reputation
- Financial/assets
- Regulation
- Legal
- Innovation/technology
- Commercial
- Harm and safety
- Workforce
- Quality, innovation and improvement
- Partnership

**TRUST RISK APPETITE STATEMENT**

| Risk Category / Type | Description | Risk Appetite |
|---|---|---|
| **Strategic / Organisational** | We seek out innovation to deliver higher quality patient care, accepting this brings risk. | **SIGNIFICANT** |
| **Quality innovation and improvement** | We seek innovation in the way we deliver services and employ staff as a key enabler for improving quality, patient safety and experience. | **SIGNIFICANT** |
| **Partnership** | We accept a level of risk in working with partners to support service transformation and operational delivery. | **SIGNIFICANT** |
| **Innovation / Technology** | We change how we deliver care to meet the challenges of the future by actively pursuing digital innovation, while providing safe, effective and efficient care for patients. | **HIGH** |

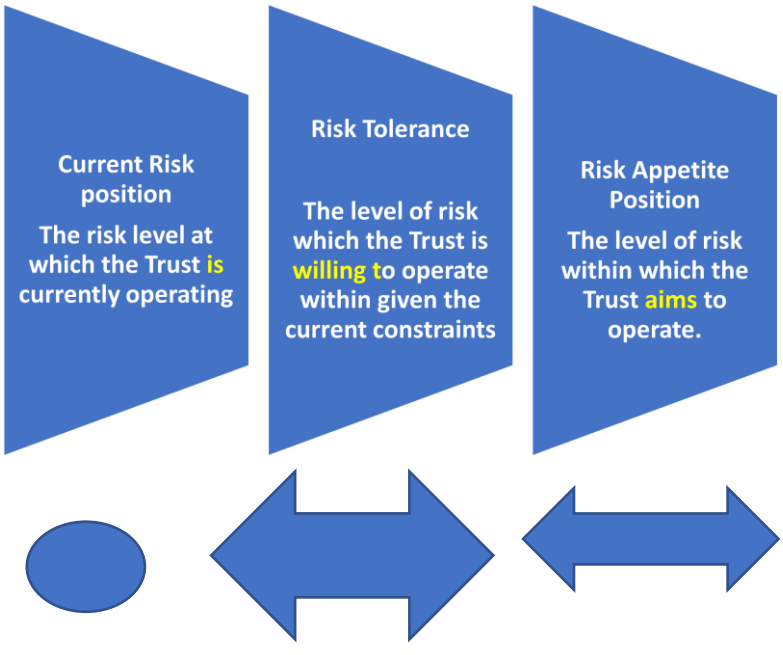
| | | |
|---|---|---|
| **Reputation** | We will not shy away from making difficult decisions in the best interests of patient safety but appreciate this may attract scrutiny / interest from stakeholders | **HIGH** |
| **Commercial** | We will consider new opportunities which will enhance and support our core business and reputation for providing patient care. | **HIGH** |
| **Financial / Assets** | We will invest resources to enable us to deliver improvements in care ensuring rigorous impact assessments. We will resource opportunities and always consider price, value, benefits, and local impact, aiming to deliver our services within our financial plans, retaining flexibility to capitalise on opportunities. | **MODERATE** |
| **Regulation** | We will make every effort to comply with regulation and will explain our approach. | **MODERATE** |
| **Harm and safety** | We take as little risk as possible when it comes to harm and safety to keep our patients safe and achieve the best clinical outcomes. | **LOW** |
| **Workforce** | We have one Culture of Care with colleagues looking after each other as well as the people we care for, ensuring patient safety and promoting the well-being of our staff. | **LOW** |
| **Legal** | We will comply with the law. | **LOW** |

**2. Risk Tolerance**

Risk appetite is about how much risk the Trust is willing to pursue, whereas risk tolerance is about the level of risk the Trust can deal with.

Risk tolerance is a range of acceptable deviation from the risk appetite score from a risk perspective. Exceeding a risk tolerance, e.g., breach of risk appetite or risk exposure, will require notification to the Board and a review of actions.

The diagram below depicts the difference between risk appetite and risk tolerance.



To advise the Board if a risk on the Board Assurance Framework has breached its risk appetite it is proposed that the following process is used.

Using the 5x5 risk scoring matrix, the table below proposes the scores in relation to how risks on the Board Assurance Framework (BAF) are deemed to have breached their risk appetite level and are either within a risk tolerance level or have become areas of risk exposure, requiring greater oversight by the Board and its Committees.

The proposed risk scores for each risk appetite level and risk tolerance and risk exposure levels is given below.

| **Risk Appetite Level** | **Risk appetite** | **Risk Tolerance** | **Identification of Risk Exposure Score according to the 5x5 risk matrix** |
|---|---|---|---|
| Low | 1 - 4 | 5 - 8 | 9 - 25 |
| Moderate | 1 - 8 | 9 - 12 | 15 - 25 |
| High | 1 - 10 | 12 - 15 | 16 - 25 |
| Significant | 1 - 15 | 16 - 25 | |

For example, BAF risk 12/19 regarding engagement with colleagues is a workforce risk with a low risk appetite. The target score for this risk is 4 and the current risk score is 12. Based on the table below this falls into the red category and therefore is an area of risk exposure to be highlighted to the Board for greater oversight by the Board and its Committees.

Appendix 1 provides the risk matrix for each level of risk appetite.

Subject to approval of the above, all BAF risks will be reviewed against the above levels to assess if the target risk score is in line with risk appetite level.

**Recommendation**

The Board is asked to:

i. **APPROVE** the updated risk appetite statement
ii. **APPROVE** the process for determining risk tolerance and risk exposure.

**APPENDIX 1**

**Risk Appetite Low - as little risk as possible**

| Consequence | Low Risk Appetite | | | | |
|---|---|---|---|---|---|
| 5 | 10 | 15 | 20 | 25 |
| 4 | 8 | 12 | 16 | 20 |
| 3 | 6 | 9 | 12 | 15 |
| 2 | 4 | 6 | 8 | 10 |
| 1 | 2 | 3 | 4 | 5 |
| | | Risk Likelihood | | |

| | |
|---|---|
| 1 - 4 | Risk appetite |
| 5 - 8 | Risk tolerance |
| 9-25 | Risk exposure |

**Moderate Risk Appetite - safe options with a low degree of inherent risk**

| Consequence | Moderate Risk Appetite | | | | |
|---|---|---|---|---|---|
| 5 | 10 | 15 | 20 | 25 |
| 4 | 8 | 12 | 16 | 20 |
| 3 | 6 | 9 | 12 | 15 |
| 2 | 4 | 6 | 8 | 10 |
| 1 | 2 | 3 | 4 | 5 |
| | | Risk Likelihood | | |

| | |
|---|---|
| 1 - 8 | Risk appetite |
| 9 -12 | Risk tolerance |
| 15 - 25 | Risk exposure |

**High Risk Appetite -** consider all options and choose one most likely to result in successful delivery

| Consequence | High Risk Appetite | | | | |
|---|---|---|---|---|---|
| 5 | 10 | 15 | 20 | 25 |
| 4 | 8 | 12 | 16 | 20 |
| 3 | 6 | 9 | 12 | 15 |
| 2 | 4 | 6 | 8 | 10 |
| 1 | 2 | 3 | 4 | 5 |
| | | Risk Likelihood | | |

| | |
|---|---|
| 1 - 10 | Risk appetite |
| 12 -15 | Risk tolerance |
| 16 - 25 | Risk exposure |

**Significant Risk Appetite:** be innovative and choose options with higher reward potential, accepting greater uncertainty

| Consequence | Significant Risk Appetite | | | | |
|---|---|---|---|---|---|
| 5 | 10 | 15 | 20 | 25 |
| 4 | 8 | 12 | 16 | 20 |
| 3 | 6 | 9 | 12 | 15 |
| 2 | 4 | 6 | 8 | 10 |
| 1 | 2 | 3 | 4 | 5 |
| | | Risk Likelihood | | |

| | |
|---|---|
| 1 - 15 | Risk appetite |
| 16 - 25 | Risk tolerance |

# 22. High Level Risk Report - TO FOLLOW

To Approve

Presented by Lindsay Rudge

# 23. Governance Report

# a) Non-Executive Directors and Board Committees

# b) Board of Directors Workplan 2022/23

To Approve

Presented by Andrea McCourt

NHS
Calderdale and Huddersfield
NHS Foundation Trust

| | |
|---|---|
| **Date of Meeting:** | Thursday 1 September 2022 |
| **Meeting:** | Public Board of Directors |
| **Title:** | Governance Report |
| **Author:** | Andrea McCourt, Company Secretary |
| **Sponsoring Director:** | Victoria Pickles, Director of Corporate Affairs |
| **Previous Forums:** | None |

**Purpose of the Report**

This paper presents the following governance items to the Board in September 2022:

a) Governance – Non-Executive Directors and Board Committees
b) Board of Directors Workplan 2022/23

**Key Points to Note**

**a) Governance - Non-Executive Directors and Board Committees**

Board Committees are key to the Trust's governance and assurance processes. All Board Committees are chaired by a Non-Executive Director.

There are currently seven NEDs, including the Chair, as follows:

Helen Hirst, Chair
Karen Heaton, Deputy Chair and Senior Independent Non-Executive Director
Andy Nelson
Denise Sterling
Peter Wilkinson
Tim Busby, Chair of Calderdale Huddersfield Solutions (CHS) Ltd. Board
Nigel Broadbent

As part of succession planning the Board of Directors and the Council of Governors, via their respective Nominations and Remuneration Committees, has reviewed Board capacity to ensure it is of sufficient size to deliver its duties and future challenges. Consequently, recruitment for a further Non-Executive Director and Executive Director is underway.

Arrangements for the Chair and membership of Board Committees will be further reviewed in the autumn following a Board discussion on Board governance on 6 October 2022 and once the further NED has been recruited, providing extra capacity for Board Committees.

The NED membership of those Trust Board Committees which report to the Trust public Board, with effect from 1 September 2022, is given below. Board Committee terms of reference will be amended to reflect the changes.

**Table 1: Committee attendance by individual NED**

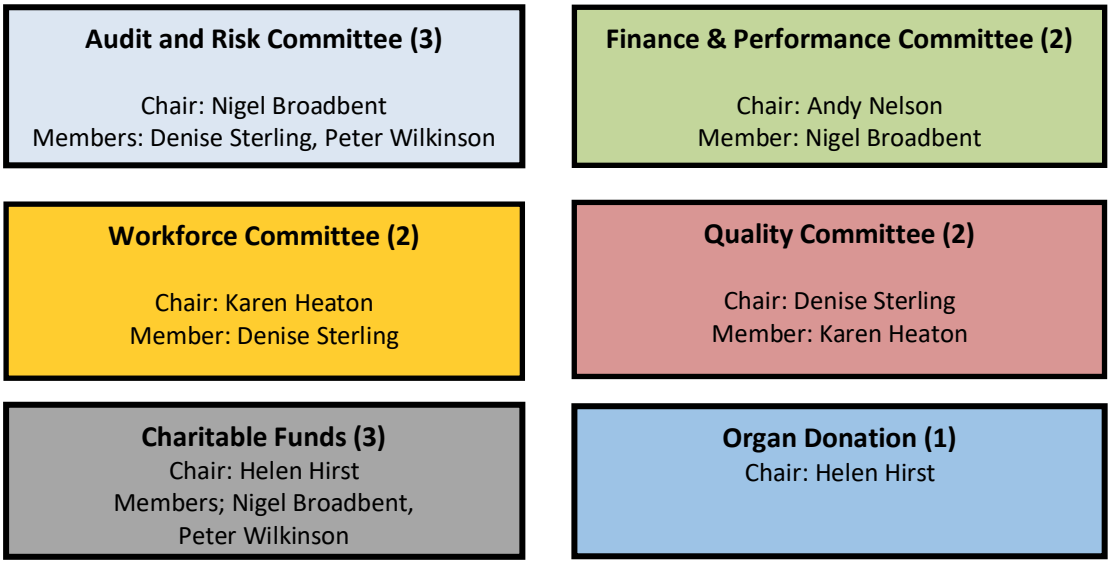
| NED | Chair Role | Board Committee member |
|---|---|---|
| Helen Hirst | Board of Directors<br>Organ Donation Committee | The Chair may attend any Board Committee |
| Karen Heaton* | Workforce Committee | Quality Committee |
| Andy Nelson | Finance and Performance Committee | |
| Denise Sterling | Quality Committee | Workforce Committee<br>Audit and Risk Committee |
| Peter Wilkinson | | Audit and Risk Committee<br>Charitable Funds |
| Nigel Broadbent | Audit and Risk Committee<br>Charitable Funds Committee | Finance and Performance Committee |

***Deputy Chair for Board of Directors**

To note there are other time commitments for certain NEDs, such as reconfiguration of chair of the CHS Board which are not reflected in table 1 as they are not Board Committees reporting to the public Board. All time commitments of NEDs have been shared with the Nomination and Remuneration Committee of the Council of Governors.

The Trust also has an Associate Non-Executive Director, Nicola Seanor, who attends Board meetings and may attend Board Committees.

**NED membership by Board Committee reporting to public Board**




**b) Board of Directors Workplan 2022/23**

The Board workplan provides the basis for the preparation of Board agendas for the coming year. Ad-hoc items and reports will be included on meeting agendas as necessary. The 2022/23 workplan is presented for approval.

The annual cycle of reporting to Board is being reviewed for 2023/24 and the Board workplan for 2023/24 will be presented at the Board meeting on Thursday 10 November 2022 for approval.

**RECOMMENDATION:** The Board is asked to **APPROVE** the Board of Directors workplan for 2022/23 and **NOTE** the Board of Directors workplan for 2023/24 is being reviewed and will be presented at the Board meeting on 10 November 2022.

## Recommendation

The Board is asked to:

a) **NOTE** the Board Committee membership for those Board Committees reporting to the Board with effect from 1 September 2022
b) **APPROVE** the Board of Directors Workplan for 2022/23 and **NOTE** the Board of Directors workplan for 2023/24 is being reviewed and will be presented at the Board meeting on 10 November 2022.

# PUBLIC BOARD WORKPLAN 2022-2023

| DATE OF MEETING | 5 May 2022 | 7 July 2022 | 1 Sep 2022 | 10 Nov 2022 | 12 Jan 2023 | 2 Mar 2023 |
|---|---|---|---|---|---|---|
| Date of agenda setting/Feedback to Execs | 4 April 2022 | 1 June 2022 | 19 July 2022 | 21 September 2022 | 15 November 2022 | 17 January 2023 |
| Date final reports required | 22 April 2022 | 24 June 2022 | 19 August 2022 | 28 October 2022 | 30 December 2022 | 17 February 2023 |
| **STANDING AGENDA ITEMS** | | | | | | |
| Introduction and apologies | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Declarations of interest | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Minutes of previous meeting, matters arising and action log | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| 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 | | ~~✓~~ Deferred to | | ✓ | | |

| DATE OF MEETING | 5 May 2022 | 7 July 2022 | 1 Sep 2022 | 10 Nov 2022 | 12 Jan 2023 | 2 Mar 2023 |
|---|---|---|---|---|---|---|
| | | November | | + Patient Story | | |
| Workforce OD Strategy | ✓ | | | | | |
| Risk Management Strategy | | | | | | ✓ |
| Annual Plan | ✓ | | | | | ✓ |
| Capital Plan | | | | | ✓ | |
| Winter Plan | | | | ✓ | | |
| Green Plan (Climate Change) | ✓ | | | | | |
| **QUALITY** | | | | | | |
| Quality Board update | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Director of Infection Prevention Control (DIPC) quarterly report | ✓Q4 | | ✓Q1 | ✓Q2 | ✓Q3 | |
| DIPC Annual Report | | ✓ | | | | |
| Learning from Deaths Quarterly Report | | ✓Q4 (Annual Report) | ✓Q1 | ✓Q2 | | ✓ Q3 |
| Safeguarding update – Adults & Children | | | (Annual Report) | | | ✓ |
| Safeguarding Adults and Children Annual Report | | | ✓ | | | |
| Complaints Annual Report | | | | ✓ | | |
| **WORKFORCE** | | | | | | |
| **Staff Survey Results and Action Plan** | ✓ | | ✓ | | | ✓ |
| **Health and Well-Being** | | | ✓ | | | |
| Nursing and Midwifery Staffing Hard Truths Requirement | | | | ✓ Bi-Annual | | ✓ |
| **Guardian of Safe Working Hours (quarterly)** | ✓Q4 | | | ✓Q1 & Q2 | ✓Q3 | |
| Guardian of Safe Working Hours Annual Report | ✓ | | | | | |
| Diversity | | | | | | ✓ |
| Medical Revalidation and Appraisal Annual Report | | | ✓ Annual Report | | | |
| Freedom to Speak Up Annual Report | | | ✓ | | ✓ 6 month report | |

| DATE OF MEETING | 5 May 2022 | 7 July 2022 | 1 Sep 2022 | 10 Nov 2022 | 12 Jan 2023 | 2 Mar 2023 |
|---|---|---|---|---|---|---|
| | | | Annual Report | | FTSU themes | |
| Public Sector Equality Duty (PSED) Annual Report | | | | | | ✓ |
| **GOVERNANCE & ASSURANCE** | | | | | | |
| **Health and Safety Update** | ✓ | | | | ✓ | |
| **Health and Safety Policy** (May 2023) | | | | | | |
| Health and Safety Annual Report | | | | | ✓ | |
| Board Assurance Framework | | ✓ 1 | | ✓ 2 | | ✓ 3 |
| Risk Appetite Statement | | | ✓ | | | |
| High Level Risk Register | ✓ | | ✓ | ✓ | ✓ | ✓ |
| Calderdale Huddersfield Solutions Managing Directors Report | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Standing Orders/SFIs/SOD review | ✓ *(TBC)* | | | | | |
| Non-Executive appointments | | | | ✓ | | ✓ |
| Annual review of NED roles | | | | ✓ | | |
| Board workplan | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Board meeting dates | | ✓ | | | | |
| Use of Trust Seal | | ✓ | | ✓ | | ✓ |
| Council of Governor elections | | | | | | ✓ timetable |
| **Declaration of Interests – Board of Directors (annually)** | | | | | | ✓ |
| **Attendance Register – (annually)** | ✓ | | | | | |
| **Fit and Proper Person Self-Declaration Register** | | | | | | ✓ |
| Seek delegation from Board to ARC for the annual report and accounts 2021/22 | | | | | | ✓ |
| BOD Terms of Reference | | | | | | ✓ |
| Sub Committees Terms of Reference | ✓ QC<br>✓ F&P<br>✓ TPB | ✓ Workforce | ✓ARC | | | ✓QC<br>✓ NRC BOC |

| DATE OF MEETING | 5 May 2022 | 7 July 2022 | 1 Sep 2022 | 10 Nov 2022 | 12 Jan 2023 | 2 Mar 2023 |
|---|---|---|---|---|---|---|
| Constitutional changes (+as required) | ✓ | | | | | ✓ |
| Compliance with Licence Conditions | ✓ | | | | | |
| Huddersfield Pharmaceuticals Specials (HPS) Annual Report | | | | ✓ | | |
| Fire Strategy 2021-2026 and Fire Policy Update | | | | | | ✓ |
| Charitable Funds Report 2021-22 and Accounts (Audit Highlights Memorandum) | | | | | ✓ | |
| Committee review and annual reports | | ✓ | | | | |
| Audit and Risk Committee Annual Report 2021/2022 | | ✓ | | | | |
| Workforce Committee Annual Report 2021/22 | | ✓ | | | | |
| Finance and Performance Committee Annual Report 2021/2022 | | ✓ | | | | |
| Quality Committee Annual Report 2021/22 | | ✓ | | | | |
| WYAAT/WY&H Partnership Reports | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| WYAAT Annual Report and Summary Annual Report | | | | | ✓ | |

| Colour Key to agenda items listed in left hand column: | |
|---|---|
| Items for approval | To formally receive a report or strategy for discussion and particularly approve recommendations or a particular course of action |
| Items to receive | To discuss in depth, noting the implications for the Board or Trust without formal approval |
| Items to note | For the intelligence of the Board without in-depth discussion |
| Items for assurance | To assure the Board that effective systems of internal control are in place (see Review Room papers) |

# 24. Review of Board Committee Terms of Reference

## a) Audit and Risk Committee

To Approve

Presented by Andrea McCourt

| | |
|---|---|
| **Date of Meeting:** | Thursday 1 September 2022 |
| **Meeting:** | Public Board of Directors |
| **Title:** | Audit and Risk Committee Terms of Reference |
| **Author:** | Andrea McCourt, Company Secretary |
| **Sponsoring Director:** | Victoria Pickles, Director of Corporate Affairs |
| **Previous Forums:** | Audit and Risk Committee 26 July 2022 |

**Purpose of the Report**

The Terms of Reference for the Audit and Risk Committee requires that an annual review is undertaken to refresh and confirm the scope of work. This review has been undertaken the revised Terms of Reference are attached with no suggested changes.

**Key Points to Note**

**REVIEW OF AUDIT AND RISK COMMITTEE TERMS OF REFERENCE**

The Audit and Risk Committee Terms of Reference are attached at Appendix Q2 for review and comment. These have been reviewed by the Audit and Risk Committee and were approved on 26 July 2022. No changes to the terms of reference are proposed and the Board are asked to note that Nigel Broadbent will take on the role of Audit and Risk Committee Chair from 1 September 2022.

**Recommendation**

The Board is asked to **APPROVE** the Audit and Risk Committee Terms of Reference and **NOTE** that Nigel Broadbent will take on the Audit and Risk Committee Chair role from 1 September 2022.

# AUDIT AND RISK COMMITTEE

# TERMS OF REFERENCE

| | |
|---|---|
| **Version:** | 5 |
| **Approved by:** | Board of Directors |
| **Date approved:** | Audit and Risk Committee – 21 July 2021<br>Board of Directors – 2 September 2021 |
| **Date issued:** | 2 September 2021 |
| **Review date:** | July 2022 |
| **Next review:** | July 2023 |

# AUDIT and RISK COMMITTEE TERMS OF REFERENCE

## 1. Authority

1.1 The Audit and Risk Committee is constituted as a standing sub-committee of the Foundation Trust's Board of Directors. Its constitution and terms of reference shall be as set out below, subject to amendment at future Board of Directors meetings. The Audit and Risk Committee shall not have executive powers in addition to those delegated in these terms of reference.

1.2 The Audit and Risk Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Audit and Risk Committee.

1.3 The Audit and Risk Committee is authorised by the Board of Directors to obtain outside legal or other specialist ad-hoc advice at the expense of the organisation, subject to budgets agreed by the Board. The Committee is authorised by the Board of Directors to request the attendance of individuals and authorities from outside the foundation trust with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions.

## 2. Purpose

2.1 The Audit and Risk Committee will have primary responsibility for monitoring and reviewing financial and other risks and associated controls corporate governance and assurance frameworks of the Trust and its subsidiary(ies).

2.2 The Audit and Risk Committee will have close working relationships with Quality Committee which has responsibility for oversight and monitoring of clinical risks and clinical audit.

2.3 The Board of Directors is responsible for ensuring effective internal control including:

- Management of the foundation trust's activities in accordance with statute and regulations;
- The establishment and maintenance of a system of internal control to give reasonable assurance that assets are safeguarded, waste or inefficiency avoided and reliable financial information produced, and that value for money is continuously sought.

2.4 The Audit and Risk Committee shall provide the Board of Directors with a means of independent and objective review of financial and corporate governance, assurance processes and risk management across the whole of the Foundation Trust's activities both generally and in support of the statement of internal control. In addition, the Audit and Risk Committee shall:

- Ensure independence of External and Internal audit;
- Ensure that appropriate standards are set and compliance with them is monitored, in all areas that fall within the remit of the Audit and Risk Committee; and
- Monitor corporate governance (e.g. Compliance with terms of licence, constitution, codes of conduct, standing orders, standing financial instructions, maintenance of registers of interests).

## 3. Membership

3.1 The Committee shall be composed of not less than three Non-Executive Directors, at least one of whom should have recent and relevant financial experience. The Trust Chair will not be a member of the Audit and Risk Committee.

3.2 A quorum shall be two members.

## 4. Attendance

4.1 Only members of the Committee have the right to attend. The Director of Finance, Deputy Finance Director, Company Secretary, Senior Risk Manager, Head of Internal Audit and the Managing Director for Digital Health of the Foundation Trust shall generally be invited to routinely attend meetings of the Audit and Risk Committee.

4.2 A representative of the External Auditors may normally also be invited to attend meetings of the Audit and Risk Committee.

4.3 The Chief Executive should be invited to attend at least annually to discuss the assurance supporting the Annual Governance Statement and when considering the Internal Audit plan. Other Directors are expected to attend as required by the Audit and Risk Committee and where items relating to their areas of risk or responsibility are being considered.

4.4 The Foundation Trust Chair may be invited to attend meetings of the Audit and Risk Committee as required.

4.5 A representative of the Local Counter Fraud Service is invited to attend all meetings of the Audit and Risk Committee.

4.6 The Chair of the Board of Directors will appoint a Governor to attend the public meetings of the Audit and Risk Committee. The appointment will be reviewed each year.

4.7 Attendance is required by members at 75% of meetings. Members unable to attend should inform the Corporate Governance Manager as soon as possible in advance of the meeting except in extenuating circumstances.

4.8 A register of attendance will be maintained and the Chair of the Committee will follow up any issues related to the unexplained non-attendance of members. Should continuing non-attendance of a member jeopardise the functioning of the Committee, the Chair will discuss the matter with the member and, if necessary, seek a substitute or replacement.

## 5. Administration

5.1 The Corporate Governance Manager shall be the secretary to the Audit and Risk Committee and will provide administrative support and advice. Their duties include but are not limited to:

- Agreement of the agenda with the chair of the Audit and Risk Committee and attendees together with the collation of connected papers;
- Taking the minutes and keeping a record of matters arising and issues to be carried forward;
- Agreeing the action schedule with the Chair and ensuring circulation within 48 hours of each meeting; and
- Maintaining a record of attendance.

## 6. Frequency of meetings

6.1 Meetings shall be held quarterly, with an additional meeting to review the annual accounts, with other meeting arranged where necessary. The Committee must consider the frequency and timing of meetings required to discharge all of its responsibilities on a regular basis.

6.2 The External Auditor shall be afforded the opportunity at least once per year to meet with the Audit and Risk Committee without Trust staff present.

6.3 The Internal Auditor shall be afforded the opportunity at least once per year to meet with the Audit and Risk Committee without Trust staff present.

## 7. Duties

7.1 Governance, internal control and risk management

7.1.1 To ensure the provision and maintenance of an effective system of integrated governance, risk identification and associated controls, reporting and governance of the Trust and its subsidiary(ies), unless otherwise identified in the governance reporting structure.

7.1.2 To maintain an oversight of the Foundation Trust's general risk management structures, processes and responsibilities, including the production and issue of any risk and control-related disclosure statements.

7.1.3 To review processes to ensure appropriate information flows to the Audit and Risk Committee from executive management and other board committees in relation to the Trust's overall internal control and risk management position

7.1.4 To review the adequacy of the policies and procedures in respect of all counter-fraud work.

7.1.5 To review the adequacy of the Foundation Trust's arrangements by which foundation trust staff may, in confidence, raise concerns about possible improprieties in matters of financial reporting and control and related matters or any other matters of concern.

7.1.6 To review the adequacy of underlying assurance processes that indicate the degree of achievement of corporate objectives and the effectiveness of the management of principal risks.

7.1.7 The adequacy of policies and procedures for ensuring compliance with relevant regulatory, legal and conduct requirements. Policies for approval by the Committee are identified in the Audit and Risk Committee annual workplan.

**7.2 Internal audit**

7.2.1 To review and approve the internal audit strategy and programme, ensuring that it is consistent with the needs of the organisation.

7.2.2 To oversee on an ongoing basis the effective operation of Internal Audit including:

- Adequate resourcing;
- Its co-ordination with External Audit;

Complying with the public sector Internal Audit Standards

- Providing adequate independence assurances;
- Having appropriate standing within the Foundation Trust; and
- Meeting the internal audit needs of the Foundation Trust.

7.2.3 To consider the major findings of Internal Audit investigations and management's response and their implications and monitor progress on the implementation of recommendations.

7.2.4 To consider the provision of the Internal Audit Service annually, the cost of the audit and any questions of resignation and dismissal. The appointment/dismissal of Internal Audit remains the responsibility of the Director of Finance.

**7.3 External audit**

7.3.1 To make a recommendation to the Council of Governors in respect of the appointment, re-appointment and removal of an External Auditor. To the extent that that recommendation is not adopted by the Council of Governors, this shall be included in the annual report, along with the reasons that the recommendation was not adopted.

7.3.2 To discuss with the External Auditor, before the audit commences, the nature and scope of the audit, and ensure co-ordination, as appropriate, with other external auditors in the local health economy. This should include discussion regarding the local evaluation of audit risks and assessment of the foundation trust associated impact on the audit fee.

7.3.3 To assess the External Auditor's work and fees on an annual basis and, based on this assessment, make a recommendation to the Council of Governors with respect to the re-appointment or removal of the auditor. This assessment should include the review and monitoring of the External Auditor's independence and objectivity and effectiveness of the audit process in light of relevant professional and regulatory standards.

7.3.4 To oversee the conduct of a market testing exercise for the appointment of an Auditor at least once every five years and, based on the outcome, make a recommendation to the Council of Governors with respect to the appointment of the Auditor.

7.3.5 To review external audit reports, including the annual audit letter, together with the management response, and to monitor progress on the implementation of recommendations.

7.3.6 To develop and implement a policy on the engagement of the External Auditor to supply non-audit services.

7.3.7 To consider the provision of the External Audit Service, the cost of the audit and any questions of resignation and dismissal.

**7.4 Annual accounts review**

7.4.1 To review the annual statutory accounts, before they are presented to the Board of Directors, to determine their completeness, objectivity, integrity and accuracy. This review will cover but is not limited to:

- The meaning and significance of the figures, notes and significant changes;
- Areas where judgment has been exercised;
- Adherence to accounting policies and practices;
- Explanation of estimates or provisions having material effect;
- The schedule of losses and special payments;
- Any unadjusted statements; and
- Any reservations and disagreements between the external auditors and management which have not been satisfactorily resolved.

7.4.2 To review the annual report and annual governance statement before they are submitted to the Board of Directors to determine completeness, objectivity, integrity and accuracy.

7.4.3 Where required by national guidance in the NHS Foundation Trust Annual Reporting Manual, seek assurances regarding scrutiny of Quality Accounts by the Quality Committee and review of specific areas by External Audit

7.4.4 To review all accounting and reporting policies and systems for reporting to the Board of Directors.

**7.5 Standing orders, standing financial instructions and standards of business conduct**

7.5.1 To review on behalf of the Board of Directors the operation of, and proposed changes to, the Standing Orders and Standing Financial Instructions, the Constitution, Codes of Conduct. Standards of Business Conduct and Declarations of Interest; including maintenance of Registers.

7.5.2 To examine the circumstances of any significant departure from the requirements of any of the foregoing, whether those departures relate to a failing, an overruling or a suspension.

7.5.3 To review the Scheme of Delegation.

**7.6 Other**

7.6.1 To review performance indicators relevant to the remit of the Audit and Risk Committee.

7.6.2 To examine any other matter referred to the Audit and Risk Committee by the Board of Directors and to initiate investigation as determined by the Audit & Risk Committee.

7.6.3 To ensure that the Quality Committee performs at least an Annual Review of the clinical audit plan and considers the findings and recommendations of in-year reports, ensuring the plan and extras are consistent with the strategic direction of the Trust.

7.6.4 To develop and use an effective assurance framework to guide the Audit and Risk Committee's work. This will include utilising and reviewing the work of the Internal Audit, External Audit and other assurance functions as well as reports and assurances sought from Directors and Managers and other investigatory outcomes so as fulfil its functions in connection with these terms

of reference.

7.6.5 To consider the outcomes of significant reviews carried out by other bodies which include but are not limited to regulators and inspectors within the health and social care sector and professional bodies with responsibilities that relate to staff performance and functions.

7.6.6 To review the work of all other Board sub-committees as part of the Audit and Risk Committee assurance role. The Audit and Risk Committee will receive a self-assessment and annual report from each of the committees for approval.

## 8. Reporting

8.1 The minutes of all meetings of the Audit and Risk Committee shall be formally recorded and submitted, together with recommendations where appropriate, to the Board of Directors. The submission to the Board of Directors shall include details of any matters in respect of which actions or improvements are needed. This will include details of any evidence of potentially *ultra vires*, otherwise unlawful or improper transactions, acts, omissions or practices or any other important matters. To the extent that such matters arise, the Chair of the Audit and Risk Committee shall present details to a meeting of the Board of Directors in addition to submission of the minutes via the Chair's highlight report.

8.2 The Audit and Risk Committee will report by a Chair's highlight report to the Board of Directors in respect of the fulfilment of its functions in connection with these terms of reference. Such report shall include but not be limited to functions undertaken in connection with the governance statement; the assurance framework; the effectiveness of risk management within the foundation trust; the integration of and adherence to governance arrangements; its view as to whether the self-assessment against standards for better health is appropriate; and any pertinent matters in respect of which the Audit and Risk Committee has been engaged.

8.3 The Foundation Trust's Annual Report shall include a section describing the work of the Audit and Risk Committee in discharging its responsibilities.

8.4 The Committees that report into the Audit and Risk Committee are the Risk Group, Information Governance and Risk Strategy Committee, Data Quality Board, Health and Safety Committee and the CQC and Compliance Group.

## 9. Review

9.1 The effectiveness of the Audit and Risk Committee will be reviewed by members on an annual basis.

9.2 The Terms of Reference of the Audit and Risk Committee shall be reviewed by the Board of Directors at least annually.

## 25. Board Committee Chair Highlight Reports (Minutes in the Review Room)

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

To Receive

Presented by Nigel Broadbent, Denise Sterling and Karen Heaton

Calderdale and Huddersfield NHS Foundation Trust

# CHAIR'S HIGHLIGHT REPORT
# to the Board of Directors

| | |
|---|---|
| **Committee Name:** | Audit and Risk Committee |
| **Committee Chair:** | Andy Nelson, Non-Executive Director |
| **Date(s) of meeting:** | 26th July 2022 |
| **Date of Board meeting this report is to be presented:** | 1st September 2022 |

## ACKNOWLEDGE

- ARC had 'deep dive' presentations on the work of the Data Quality Board (DQB) and the Health and Safety Committee (H&S)
- For the DQB the committee noted the progress made with information on clinical audits and the advent of a new emergency care dataset which will help drive improved performance in emergency care
- For H&S the committee commended the progress made on compliance with the NHS Workplace Health and Safety Standards and were assured by the feedback on place-based safety assessments in community and hospital sites

## ASSURE

- The committee approved changes to the reporting and management of high-level risks and the revised terms of reference for the Risk group
- The committee were pleased to see some better progress on closing overdue Internal Audit recommendations. There are now 24 overdue versus 35 in April. It was also encouraging to see the positive start made to conducting the planned internal audits for this year – a better start than has been seen in recent years
- The Counter Fraud Annual report was approved

## AWARE

- Although better progress has been made in clearing Internal Audit recommendations there is still work to do to ensure there is greater discipline exercised by those responsible for actioning the recommendations in terms of updates for Internal Audit and adherence to dates

## ONE CULTURE OF CARE

- The committee discussed how we ensure One Culture of Care is (OCOC) addressed in the context of the work of this committee. We concluded it could be helpful to address OCOC in the chairs highlight report and to in future to ask those presenting papers to consider how it is addressing OCOC
- This meeting contributed to OCOC through reviewing the work of the H&S Committee particularly the assessment we had asked for about the prevention of accidents and injuries to staff
- In addition, we assured ourselves the strategic risks in the Board Assurance Framework are being managed effectively and that any potential fraud activity by staff is being actioned in the appropriate manner

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:** | 5 August 2022 |
| **Date of Board meeting this report is to be presented:** | 1 September 2022 |

## ACKNOWLEDGE

- Recovery performance still largely on track with strong achievement on 78 and 104 week waiters and improved position on diagnostics
- Continuing strong performance on cancer metrics
- CHFT named as exemplar re theatre productivity based on latest Model Health data
- Quarter 1 result (£6.9m deficit) £800k better than plan and YTD efficiency savings £1.5m better than budget; full payment of ERF confirmed for H1
- Schemes now identified to meet total efficiency target of £20m for 22/23, with £18m fully developed (at Gateway II)

## ASSURE

- Review of Recovery Performance to end of June against revised trajectories
- Review of approach to 22/23 efficiency target from Effective Resources Group ('ERG') and progress to date
- Review of High Level Risks attributable to F&P Committee
- Terms of reference for new Urgent and Emergency Care Delivery Group approved
- Work Plan for 22/23 approved
- Update of # Neck of Femur deep dive presented to the meeting with some improvement noted in mortality rate and achievement of '36 hour' target

## AWARE

- Continuing key performance issues with overall score down at 63% and including issue on stroke indicators, dementia screening, complaints closure, sickness absence and a further never event
- High volumes and acuity of attendances in ED; only 73% achieved in June against 4 hour standard.
- Overall waiting list backlog (including ASIs) and average wait times still a major challenge.
- Covid costs and agency spend ahead of plan in June
- Concerns re 22/23 full year forecast due to ongoing Covid prevalence (and related increase in bed base), inflationary pressures etc
- Possible concerns re future cancer performance due to current lack of 'head and neck' surgeons at CHFT

**ONE CULTURE OF CARE**

- Considered sickness absence and other staffing KPIs as part of IPR review
- Reviewed variances on pay costs including vacancies and use of bank/agency staff as part of Finance Report
- Suzanne Dunkley to attend next F&P Meeting

Calderdale and Huddersfield NHS Foundation Trust

# CHAIR'S HIGHLIGHT REPORT
# to the Board of Directors

| | |
|---|---|
| **Committee Name:** | Quality Committee |
| **Committee Chair:** | Denise Sterling, Non-Executive Director |
| **Date(s) of meeting:** | 18th July 2022, 18th August 2022 |
| **Date of Board meeting this report is to be presented:** | 1st September 2022 |

## ACKNOWLEDGE

- Annual Safeguarding report – assurance provided that the Trust is meeting its statutory responsibilities, the comprehensive report highlighted significant key achievements through the year along with the priorities 2022/23 and a refresh of the strategy 22-24. The team were commended for their work.
- Quality Report June – July 2022 - Good examples provided of progress against the quality priorities however, the focussed quality priorities End of Life Care and Clinical Prioritisation have a progress rating of limited assurance. The committee acknowledged that the Trust is continuing to make every effort to reduce the numbers on the deferred care pathways.

## ASSURE

- BAF Risk 4/19 – Public and Patient involvement has been reviewed, controls now in place has enabled risk rating to reduce to score of 12.
- Received and approved the Learning Disabilities Action Plan developed in response to the Learning Disabilities Mortality report.
- Update received on the Surgical Division's performance against the fractured neck of femur 36hr to surgery best practice tariff, performance is not yet consistently above 70%. There has been a reduction in the performance variation, and this is expected to lead to an overall improvement in performance. The Division is to report back to QC to confirm the final outputs in January 2023.
- End of Life Care (EoL) – Deep Dive - The working group has been re-established with a focus on the Quality priority, key workstreams and the development of the End of Life Care Strategy. Divisional engagement in the EoL working group was highlighted and discussed, the Chief Operating Officer to support the group.
- Good progress has been made on the action plan developed in response to the CQC Children's and Young People Survey and the next steps include a number of initiatives to further improve the patient experience.
- Learning from Deaths Q1 report was noted and the recommendations for 2022/23.
- Received and noted the Medical Examiners Report and the hard work of the team which has seen the service continue to develop and deliver a high level of scrutiny of deaths, future developments include the expansion of the team for the statutory phase implementation in April 2023.
- High level risk report was approved and it was noted that there was a higher number of risks included in this report as validated risks scoring 15 and above are now included and the work ongoing to further strengthen risk management.
- IPR – Brought to the attention of Committee deteriorating position in June with a never event and missed Cancer 28 day faster target, significant demands continuing in ED, increasing acuity of patients leading to increased LOS. Challenge to deliver Head and Neck cancer treatment due to Consultant vacancy, support is currently being provided

by Bradford and plans for additional support from Leeds. Committee noted deep dives and action plans in place for areas underperforming and requested action plans are presented at future meetings

- Good performance on maternity safe staffing indicators in June 2022 with LDRP coordinator being supernumerary on 100% of the shifts and the 1:1 care in labour at 97.4%, also noted was the positive feedback CHFT received on the day of the Regional Maternity Team Assurance visit in June.
- Never Event: Two patients had the same name, one recorded as having a Do Not Resuscitate order (DNR) and the other wasn't. A patient died as a result of the correct patient not being resuscitated. Committee received update on action taken, processes for patient identification and the independent scrutiny of compliance as part of the J20 process. Committee assured of the learning and management of this incident.

**AWARE**

- The medicines reconciliation rates at CHFT have not achieved the target of 68% within the first 24 hours of admission over the past two years. The designated ward pharmacy (DWP) model in place on the acute floor HRI is having a positive impact. The committee approved the recommendations for the business case which would support the DWP being replicated at Calderdale and requested an update in the next 6 months.
- Recent internal audit of the Trust's complaints process provided limited assurance that recommendations made in the previous audit in 2021 has been implemented. An action plan is in place to ensure the recommendations are implemented by Oct 2022. The Committee requested that the various action plans related to complaints are combined and oversight will continue.

Calderdale and Huddersfield NHS Foundation Trust

# CHAIR'S HIGHLIGHT REPORT
# to the Board of Directors

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| **Committee Name:** | Workforce and Organisational Development Committee |
| **Committee Chair:** | Karen Heaton, Non-Executive Director |
| **Date of meeting:** | Tuesday 16 August 2022 |
| **Date of Board meeting this report is to be presented:** | Thursday 1 September 2022 |

## ACKNOWLEDGE

The following points are to be noted by the Board following the meeting of the Committee on 16 August 2022.

- The Committee continues to monitor the turnover for Administration/Clerical Staff. There was a peak in turnover in March but no specific reasons attributable to the month.
- The Committee received an update on Infection Control Guidance Prevention and was assured that full precautions were in place and continue to be monitored.
- A presentation was delivered by the Chair of the Women's Network which is still developing. The Committee wished to receive an update twice a year from the Chairs of all the staff networks.
- IPR- concern remains over the level of short-term sickness absence which is now showing signs of levelling off and the number of return-to-work interviews remains below target with further work planned to improve this. Sickness absence targets have been revised upwards to reflect reality which has the support of the Committee. Fire safety and data security training completion levels are low, and action is underway to address these. A review of all EST is currently underway to ensure we are identifying what is "essential" and this will be considered by the newly formed Education Committee.
- Quarterly Vacancy Report and Depp dive. We are off the planned vacancy target of 320.91 FTE – current position is 440.40 FTE. International recruitment has gone well, and the Committee asked for further information on how the gap will be addressed. It was also noted that consultant turnover was 4% in May 2021 and is 7% in May 2022.-
- Colleague Availability and Overview of Divisional Plans- the Committee heard a presentation from a number of colleagues from differing Divisions and was reassured that staff planning was more tightly controlled and monitored.
- The annual reports covering the Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard (WDES) were presented. There are concerns about staff reporting bullying and harassment. The Committee wishes to see action taken to address the decrease in adequate adjustments being made /considered by managers.

## 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 Recruitment/Retention Inclusive Leadership.

| **AWARE** |
| --- |
| • Workforce metrics remain amber, and concerns remain over the sickness absence rate, return to work interviews (RTW) and Data Security Awareness and fire safety EST compliance. The wellbeing of the workforce is of continuing concern.<br>• Concerns around managers apparent lack of awareness/understanding of the need to consider making reasonable adjustments where appropriate. The Trust has an aging workforce.<br>• The ongoing monitoring the vacancy levels across the workforce. |

# 26. Review of Board Committee Annual Reports 2021/22 (In the Review Room)

## a) Audit and Risk Committee

To Receive

27. Items for Review Room

1. Calderdale and Huddersfield Solutions Managing Directors Report – August 2022

2. Council of Governors minutes of meeting held 14 July 2022

3. Partnership papers: Kirklees and Calderdale Cares Partnership - https://www.calderdalecares.co.uk/about-us/meeting-dates/

To Receive

# 28. One Culture of Care

For Comment

# How do I introduce One Culture of Care as an agenda item?

The CHFT vision is that 'together we will deliver outstanding compassionate care for our patients and One Culture of Care for our colleagues'. One Culture of Care means that we 'care for each other the same way we care for our patients'.

It is essential we embed our One Culture of Care approach into 'how we do things around here' and that includes reviewing what progress we are making. We have committed to include One Culture of Care as a common and recurring item for discussion in all our meetings. Here is how to go about it…

1. Immediate next meeting:-

   To receive and note the refreshed values and behaviours
   To consider how the values and behaviours impact the nature of the business of the meeting
   To consider how group members will support the behaviours in the way they conduct themselves in the meeting
   To resolve to incorporate Once Culture of Care as an agenda item

2. Thereafter, ask these questions/review the situation in the One Culture of Care agenda item:-

   How are we doing in relation to our values and behaviours?
   What's the evidence for our assessment?
   What more as a forum can we do to support/endorse One Culture of Care and our values and behaviours?
   Have we taken into account One Culture of Care in our meeting decisions?

One Culture of care

NHS
Calderdale and Huddersfield
NHS Foundation Trust

**Our Vision:**
Together we will deliver outstanding compassionate care for our patients and One Culture of Care for our colleagues

**One Culture of Care:**
Caring for each other the same way we care for our patients.


## Our Behaviours:

- I'll step in others' shoes and I'll be kind, welcoming and helpful to all
- I'm committed to improving services and I'll go see examples of good practice
- I'm respectful of others. I'll support diversity and inclusion
- I'll role model the must dos to keep everyone safe and well

compassionate care

29. Date and time of next meeting

Date: Thursday 10 November 2022

Time: 9:00 am

Venue:  Venue to be confirmed

To Note

Presented by Helen Hirst