Public Board of Directors - Items for Board Assurance - 10 November 2022

Organiser	Deborah Melia	
Reviewers	David Birkenhead	Pending
	Gary Boothby	Pending
	Kirsty Archer	Pending
	Suzanne Dunkley	Pending
	Anna Basford	Pending
	Karen Heaton	Pending
	Andy Nelson	Pending
	Denise Sterling	Pending
	Stuart Sugarman	Pending
	Peter Wilkinson	Pending
	Andrea McCourt	Pending
	Brendan Brown	Pending
	Tim Busby	Pending
	Lindsay Rudge	Pending
	Victoria Pickles	Pending
	Helen Hirst	Pending
	Robert Birkett	Pending
	Nigel Broadbent	Pending
	Nicola Seanor	Pending
	Jonathan Hammond	Pending
	Rob Aitchison	Pending

Documents for Review

- EPRR Annual Report
- Fire Safety Annual Report

1. Integrated Performance Report (full version) Sept 2022

compassionate care

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Integrated Performance Report

September 2022

Report Produced by : The Health Informatics Service

Data Source : various data sources syndication by VISTA

Contents

RAG Key	
Not achieving target or threshold	
Achieving target	
Between target and threshold	

Key Indicators

	21/22	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	YTD	Performance Range		
SAFE																			Green	Amber	Red
Never Events	2	1	0	0	0	0	0	0	0	0	1	0	1	1	1	0	**0**	**3**	0		>=1
CARING																			Green	Amber	Red
% Complaints closed within target timeframe	63.61%	100.00%	69.44%	55.10%	71.43%	58.82%	94.29%	70.73%	37.50%	44.44%	29.41%	27.08%	48.98%	28.57%	44.64%	55.32%	**45.45%**	**42.29%**	100%	86% - 99%	<=85%
Friends & Family Test (IP Survey) - % Positive Responses	96.91%	97.00%	96.38%	96.61%	97.33%	98.26%	97.47%	97.35%	97.10%	97.36%	96.36%	97.57%	97.14%	97.60%	98.27%	98.02%	**in arrears**	**97.68%**	>=90% / >=95% from September		<=79%
Friends and Family Test Outpatients Survey - % Positive Responses	92.16%	92.29%	91.88%	91.77%	91.49%	91.51%	92.45%	93.02%	93.20%	92.15%	93.71%	91.82%	92.24%	90.33%	92.02%	90.48%	**in arrears**	**91.46%**	>=90% / >=93% from September		<=79%
Friends and Family Test A & E Survey - % Positive Responses	82.76%	82.98%	78.53%	81.33%	80.85%	81.01%	82.39%	84.40%	86.40%	84.69%	76.52%	83.18%	81.09%	79.94%	79.63%	83.03%	**in arrears**	**81.33%**	>=80% / >=85% from September		<=69%
Friends & Family Test (Maternity) - % Positive Responses	94.64%	91.23%	97.53%	95.19%	97.69%	93.98%	93.20%	98.33%	92.30%	91.00%	95.12%	96.74%	97.92%	95.90%	93.48%	93.48%	**in arrears**	**95.26%**	>=90% / >=95% from September		<=79%
Friends and Family Test Community Survey - % Positive Responses	92.44%	93.37%	87.74%	92.52%	94.27%	91.12%	95.86%	93.68%	95.50%	91.21%	98.32%	94.79%	94.52%	88.96%	92.73%	94.51%	**in arrears**	**92.80%**	>=90% / >=95% from September		<=79%
EFFECTIVE																			Green	Amber	Red
Number of MRSA Bacteraemias – Trust assigned	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**	0		>=0
Preventable number of Clostridium Difficile Cases	5	0	1	0	1	0	0	1	1	0	0	2	1	1	0	1	**0**	**5**	<3		>=3
Local SHMI - Relative Risk (1 Yr Rolling Data)	106.36	105.07	105.49	105.91	105.39	106.60	106.99	106.36	104.79	104.38	104.58	105.39	107.98	107.85				**107.85**	<=100	101 - 109	>=110
Hospital Standardised Mortality Rate (1 yr Rolling Data)	102.2	90.00	90.56	92.19	93.78	95.20	97.00	99.27	102.20	102.64	104.59	105.86	106.69	107.31	107.98			**107.98**	<=100	101 - 109	>=111
RESPONSIVE																			Green	Amber	Red
Emergency Care Standard 4 hours	78.99%	86.16%	78.59%	79.57%	78.29%	75.97%	76.81%	72.95%	75.70%	73.92%	74.05%	72.64%	75.85%	72.97%	72.52%	73.27%	**75.44%**	**73.79%**	>=95%	81% - 94%	<=80%
% Stroke patients admitted directly to an acute stroke unit within 4 hours of arrival	36.71%	54.90%	42.29%	43.14%	42.00%	33.87%	33.33%	23.19%	16.67%	15.79%	25.45%	25.53%	28.81%	13.33%	24.60%	19.18%	**33.30%**	**23.59%**	>=90%		<=85%
Two Week Wait From Referral to Date First Seen	98.38%	97.82%	97.93%	98.51%	98.80%	98.58%	99.21%	97.96%	98.39%	98.35%	97.56%	97.76%	98.46%	98.03%	97.77%	97.80%	**96.36%**	**97.69%**	>=93%	86% - 92%	<=85%
Two Week Wait From Referral to Date First Seen: Breast Symptoms	97.53%	100.00%	98.68%	100.00%	97.96%	98.45%	96.84%	96.00%	93.84%	97.25%	93.50%	96.92%	96.27%	98.20%	97.83%	100.00%	**100.00%**	**98.22%**	>=93%		<=92%
31 Days From Diagnosis to First Treatment	98.21%	97.63%	98.94%	97.92%	95.88%	94.89%	99.02%	99.37%	98.35%	99.39%	98.31%	97.58%	98.87%	99.00%	99.45%	97.80%	**98.84%**	**98.58%**	>=96%		<=95%
31 Day Subsequent Surgery Treatment	95.43%	100.00%	97.78%	94.44%	84.78%	100.00%	92.59%	100.00%	93.33%	96.55%	94.44%	96.00%	100.00%	100.00%	100.00%	96.77%	**97.22%**	**98.53%**	>=94%		<=93%
31 day wait for second or subsequent treatment drug treatments	99.51%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	95.45%	98.63%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	**98.70%**	**99.76%**	>=98%		<=97%
38 Day Referral to Tertiary	50.00%	50.00%	72.73%	47.06%	52.17%	61.11%	50.00%	37.93%	35.00%	66.67%	30.77%	55.17%	64.71%	40.74%	28.57%	25.00%	**42.86%**	**42.40%**	>=85%		<=84%
62 Day GP Referral to Treatment	90.62%	91.87%	91.23%	91.40%	89.77%	91.51%	93.43%	87.32%	89.59%	86.82%	89.71%	91.63%	87.70%	90.69%	85.32%	84.98%	**87.11%**	**87.81%**	>=85%	81% - 84%	<=80%
62 Day Referral From Screening to Treatment	59.47%	48.48%	32.14%	55.26%	32.00%	55.56%	76.19%	81.25%	62.50%	50.00%	96.30%	92.59%	73.68%	70.37%	87.88%	86.67%	**88.24%**	**83.66%**	>=90%		<=89%
Faster Diagnosis Standard: Maximum 28-day wait to communication of definitive cancer / not cancer diagnosis for patients referred urgently (including those with breast symptoms) and from NHS cancer screening	74.31%	68.93%	73.27%	69.07%	70.56%	76.23%	78.16%	76.82%	76.50%	83.12%	79.54%	77.76%	76.91%	74.07%	76.00%	73.70%	**77.05%**	**75.84%**	>=75%		<=70%
WORKFORCE																			Green	Amber	Red
Sickness Absence rate (%) - Rolling 12m - Non-Covid related	4.83%	4.00%	4.13%	4.23%	4.33%	4.43%	4.49%	4.58%	4.66%	4.63%	4.83%	4.90%	4.91%	4.88%	4.82%	4.77%	**4.73%**	-	<=4.75%	<5.25%	>=5.25%
Long Term Sickness Absence rate (%) -Rolling 12m - Non-Covid related	3.21%	2.85%	2.92%	3.01%	3.07%	3.10%	3.10%	3.12%	3.15%	3.17%	3.21%	3.24%	3.23%	3.20%	3.15%	3.10%	**3.06%**	-	<=3.0%	<3.25%	>=3.25%
Short Term Sickness Absence rate (%) -Rolling 12m - Non-Covid related	1.62%	1.17%	1.21%	1.23%	1.26%	1.33%	1.39%	1.46%	1.52%	1.57%	1.62%	1.66%	1.68%	1.69%	1.68%	1.67%	**1.66%**	-	<=1.75%	<2.00%	>=2.00%
Overall Essential Safety Compliance	92.90%	95.64%	95.48%	93.93%	93.81%	93.22%	93.01%	93.28%	92.50%	92.57%	92.90%	92.54%	92.94%	92.61%	92.63%	91.89%	**90.46%**	-	>=90%	>=85%	<85%
Appraisal (1 Year Refresher) - Non-Medical Staff	69.06%																	-	>=95%	>=90%	<90%
Appraisal (1 Year Refresher) - Medical Staff (Rolling 12mth)	82.43%	12.04%	17.00%	30.80%	44.51%	54.57%	60.90%	61.72%	63.51%	65.54%	69.06%	0.64%	2.79%	5.94%	9.36%	17.18%	**48.64%**	-	>=95%	>=90%	<90%
FINANCE																			Green	Amber	Red
I&E: Surplus / (Deficit) Var £m YTD	2.27	0.28	-0.22	-1.40	-1.62	**0.00**	-0.05	0.17	0.02	-0.06	-0.11	0.11	0.11	0.59	-0.34	-0.83	**-0.51**	**-0.88**			

SWOT Analysis

Strengths

- Agreed Recovery Framework.
- Continuing to focus on Trust agreed priorities for elective patients, e.g. ensuring we prioritise patients with learning disabilities, P2s and long waiters (104 weeks).
- Ongoing comprehensive theatre staff engagement and workforce development programme.
- Progressing installation of two new permanent MRI scanners which are being ramped and shimmed which is the process by which the main magnetic field is made more homogenous.
- Ward 11 back under the surgical team, await the build up of elective lists in the pipeline, utilising for acute surgical patients currently to support the site pressures
- Community Pharmacist roles continue to add significant value in Quality Improvement (identifying and managing medication incidents), supporting effective assessment and care planning across nursing and therapy services and helping manage some of the discharge based risks and issues with handover of medicines management.
- Continue to support Mid Yorkshire Hospital Trust with Non-Surgical Oncology care for Breast and Lung cancer and also now providing some in-reach support to Bradford.
- Focus on recruitment in both clinical and admin roles to support Recovery. Using alternative roles and thinking differently for hard to recruit areas. Also exploring risks and benefits to over recruitment to minimise bank and agency spend.
- Insourcing arrangements in place for ENT (OP & Surgery), Orthopaedics (CHOP LLP) and Ophthalmology (OP, diagnostics & Surgery) to help tackle elective backlogs.
- Automated medicine cabinets installed at HRI and pharmacy robot business case approved.
- CMDU programme started 17th January in collaboration with Locala and Mid Yorkshire to reduce hospital attendances. This funding has now been extended for the whole of 22/23.
- Urgent Community Response 0-2 hour service started 6th December and is being well received and utilised with on average 187 referrals per month and 85 admissions avoided.
- Cost per case model implemented and tested by a number of specialties, to roll out to others and allocate according to backlogs
- Ward 11 back under the surgical team (now ward 14), await the build up of elective lists in the pipeline, utilising for acute surgical patients currently to support the site pressures

Weaknesses

- Bed pressures continue to be significant.
- The staffing position continues to be extremely challenging across all divisions in particular among nursing teams.
- Theatre lists still not up to pre covid numbers but pipeline staffing showing a positive position over the next few weeks and months.
- Some specialties i.e. large complex cases are not recovering at the same pace as others.
- Issue retaining Community Pharmacists in Quest due to conflicting demands with PCN Pharmacists.
- Disparity with availability of clinical educators into Therapy services to support staff retention and education.
- Trust Estate and dual site configuration reduces flexibility.

Opportunities

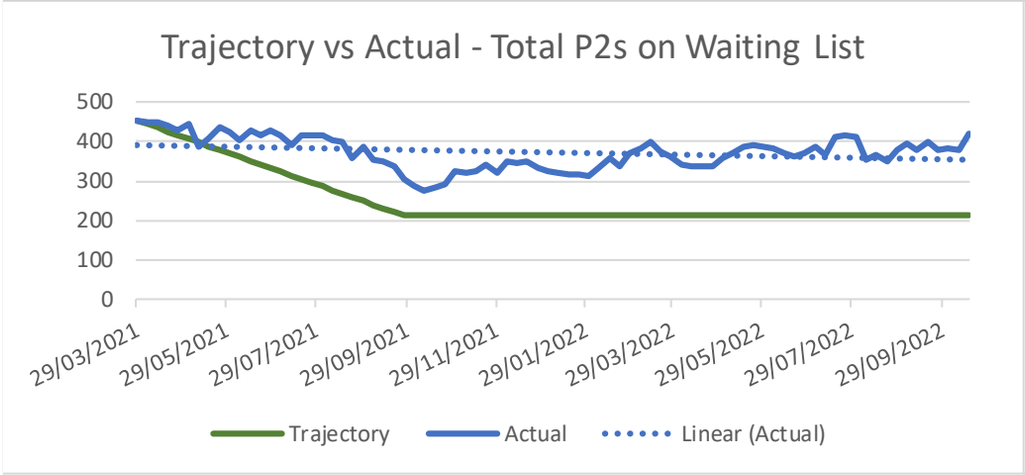
- The SAFER programme continues to pull together existing workstreams and those stopped during the Covid period.
- The Plan for Every Patient roll-out programme is underway with further resource allocated to increase pace and buy-in.
- Medicine is enacting plans to effectively use allocated face to face clinic capacity to ensure this is used effectively across all specialties to ensure patients with the highest priority are seen.
- Pilot Urgent Care Hubs have been established at both HRI and CRH staffed by CHFT colleagues. These are operational Monday-Friday 08.00-18.00 with the service reverting to Local Care Direct outside of these hours.
- Using Myosure in Gynaecology to see and treat patients in an ambulatory setting where previously they would have needed theatre. Supports capacity and improved patient experience.
- Development of workforce plan including ODP apprentices, Nurse Associate role.
- Opportunity to work with NHSE as a part of the pathfinder pilot looking at hospital patient transport (HTCS) for both inpatients and outpatients.
- School aged Immunisations - expression of interest to tender for the Calderdale Immunisations contract for a potential further 5 years completed.
- Patient appliance trustwide budget is to be consolidated into the community division, this will come with a cost pressure but streamlines operational pressures and improves patient pathways.
- Virtual wards - CKW working groups have been established for virtual wards to ensure pathways are streamlined across the CKW footprint. Initial focus pathways are Frailty and Respiratory. Initial VW plans were submitted on w/c 13th June, with further CKW workshops diarised to look at cross patch efficiencies and implementation planning. Plans are now well underway and we have a target bed plan to be staggered over the next 18 months. Recruitment is underway with the aim to have the first VW beds live at the start of November.
- CHFT Community have agreed to work as a pilot site for developing a community currency tool with NHSE
  The Community division are currently working up a number of business cases with external partners to maximise some system money earmarked for innovation. In addition we are submitting a business case to Parkinson's UK for some pump primed funding to enhance the Calderdale Parkinson's service.
- IC Beds current provision extended for a further 12 months under the existing contract but on reduced beds (now 15 in total) and will be re looked at through 3CPB.

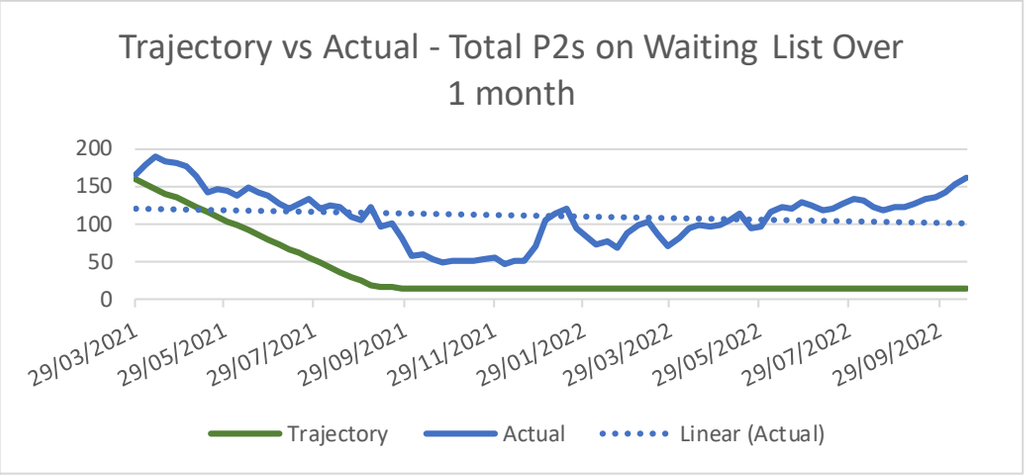
Threats

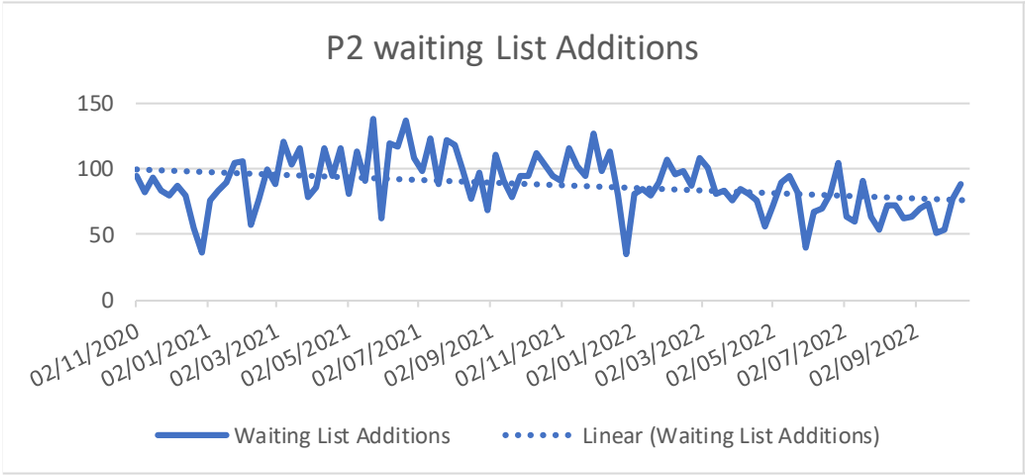
- We continue to see the significant and sustained increase in demand for both our emergency departments which continues to create pressure at the front door and driving ongoing increased staffing.
- Deterioration of Head and Neck service in terms of consultant cover and Speech and Language Therapy, started some WYAAT conversations re: a regional response.
- Significant delay in Theatre refurbishment (theatres 7 & 8), unable to commence as plan, in conversation re: delaying until next year due to threat to recovery.
- Community services are increasingly seeing more complex and acute presentation with impacts on wider anticipatory care and Long Term Condition (LTC) management.
- Patients are presenting with increased acuity and complexity which is resulting in a longer length of stay and challenges around timely discharge into the community.
- Staff fatigue due to ongoing pressures and frustration due to prolonged changing and increasing workloads.
- Potential further covid waves could delay the recovery through sickness or possible deployment
- Increasing number of complaints due to prolonged waits and poor patient experience.
- Significant cost pressure within the division due to Private Ambulance costs over and above CCG YAS commissioned service. This service has moved to the corporate division from May 2022.
- Risk of further vacancies in community nursing due to local organisations rebanding DN roles to Band 7. It has now been agreed to uplift Community DN's to band 7 backdated to January 2022
- Risk around long term funding of Virtual ward, this comes with 1 year pump priming, 1 year match funding and should be sustained through existing resource from 2024/25. Community are working in collaboration with other CHFT divisions as well as across CKW for longer-term efficiencies.
- Risk around recruitment to virtual ward posts as initial plans support recruitment of circa 150 WTE posts across the West Yorkshire footprint.
  Health and safety risks due to ageing estate across the Trust. Working with stakeholders to mitigate risks and explore permanent solutions that align with wider Trust reconfiguration plans.
- There is currently an ongoing exercise to understand procurement options for Intermediate Care Beds in Calderdale. There is a significant risk to the stability of wider intermediate care provision and pathways the beds go out for open procurement.

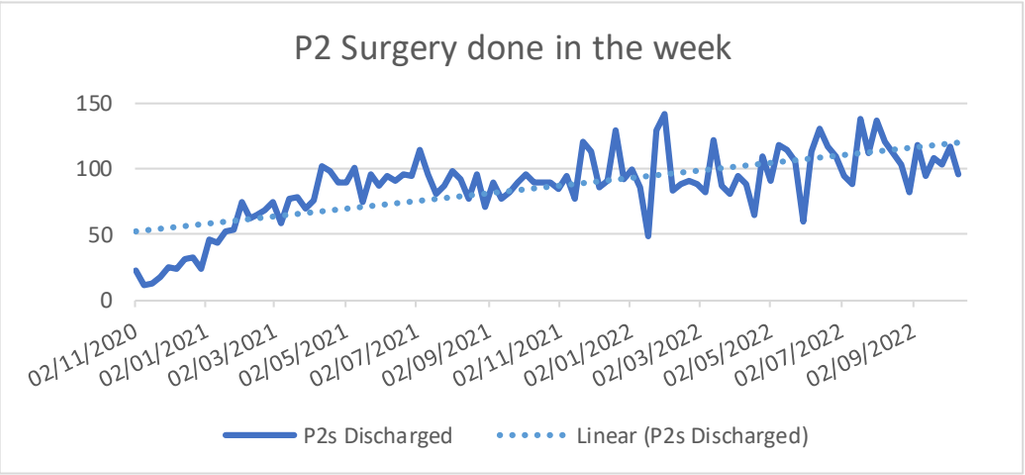
Recovery

INPATIENT WAITING LIST - P2

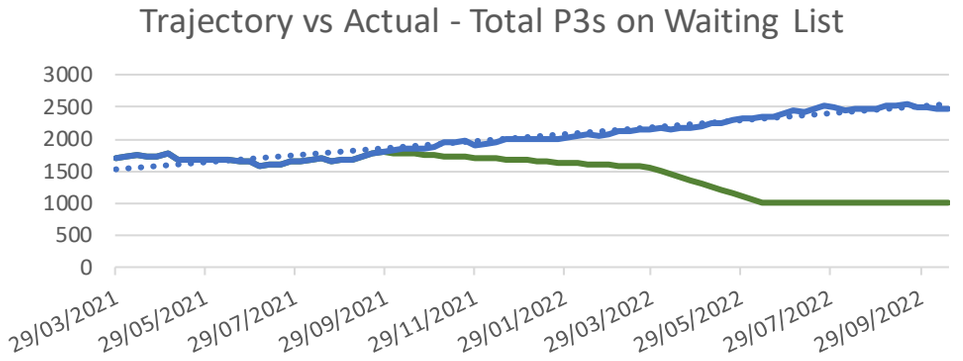


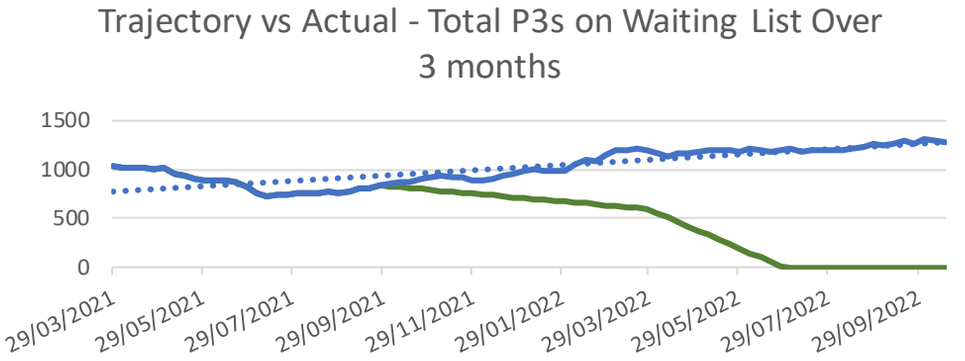


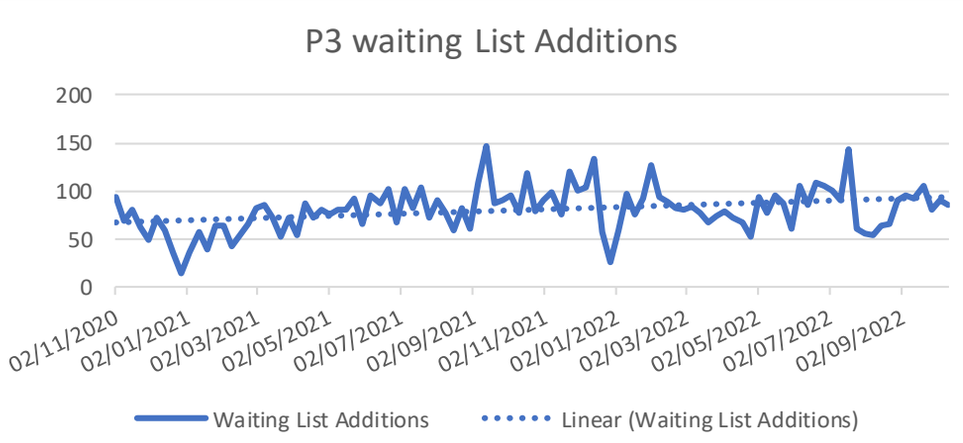


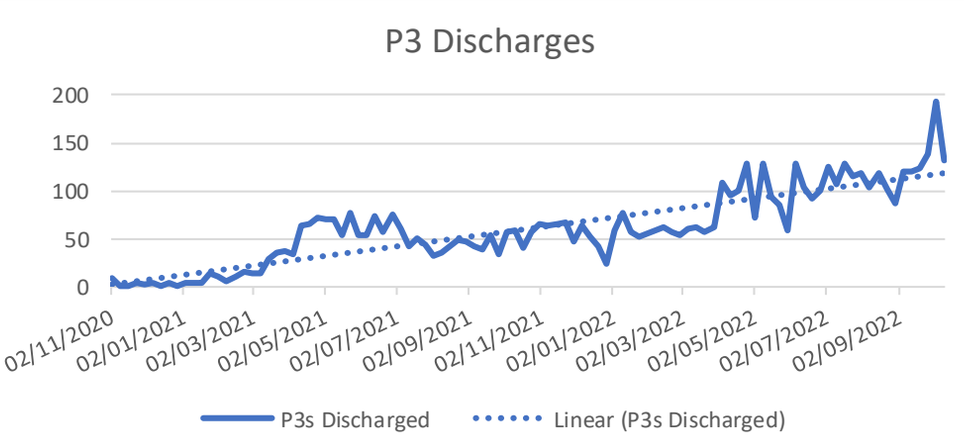


INPATIENT WAITING LIST - P3









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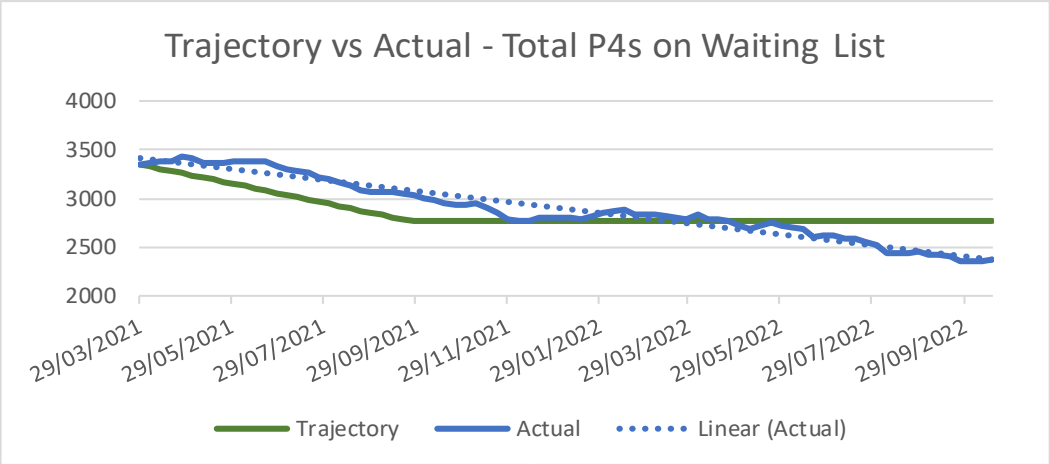
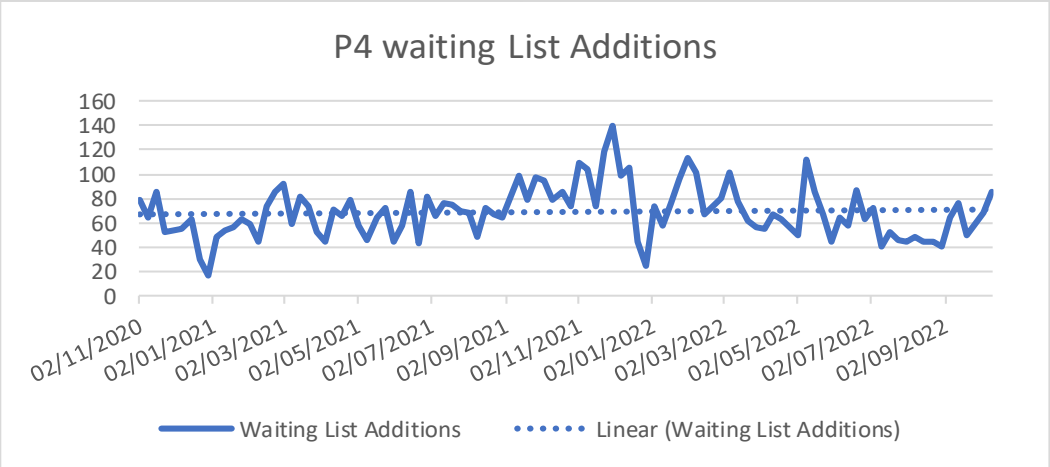
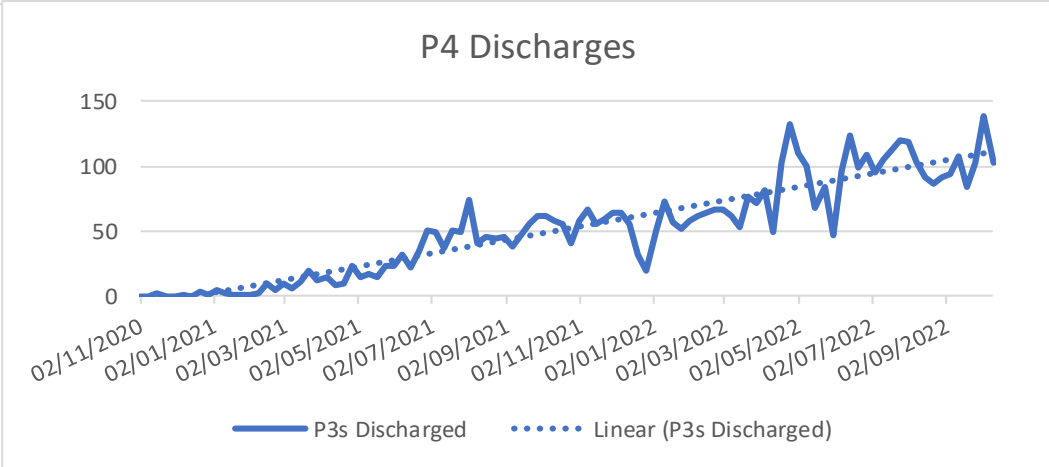
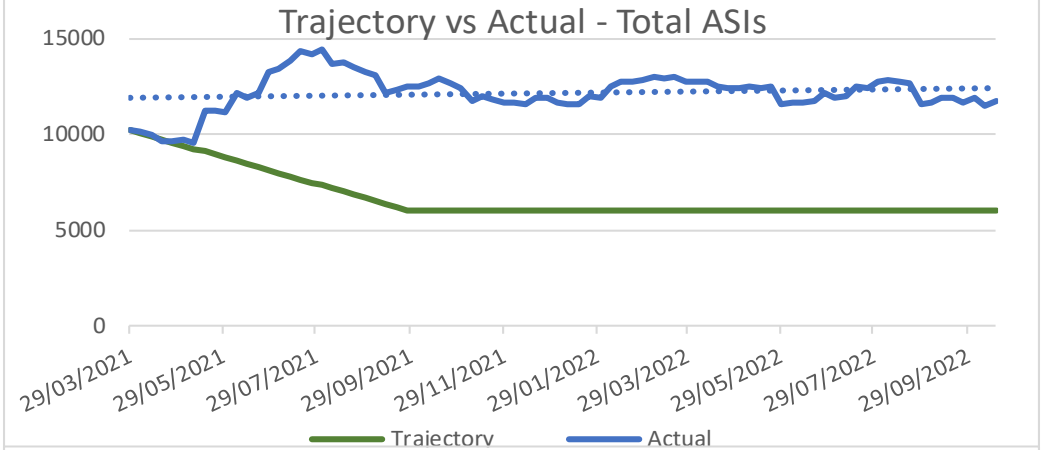
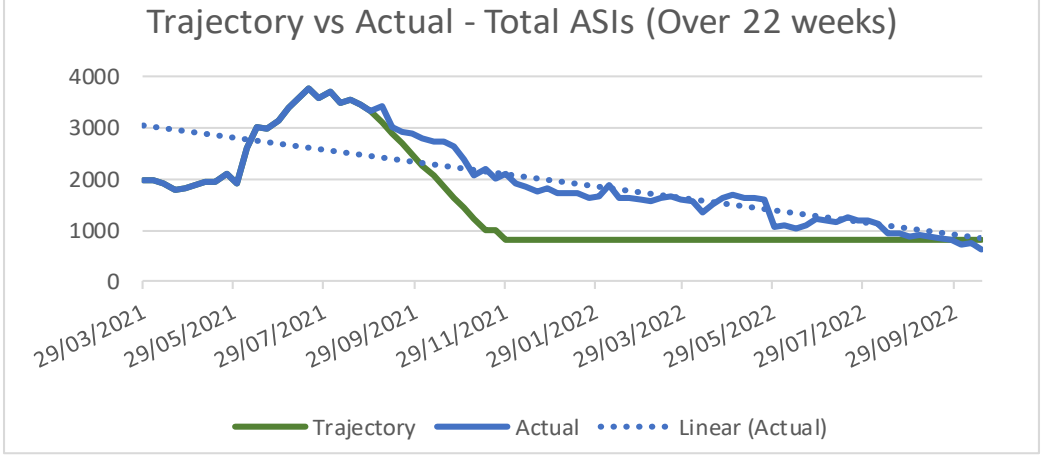






ASIs

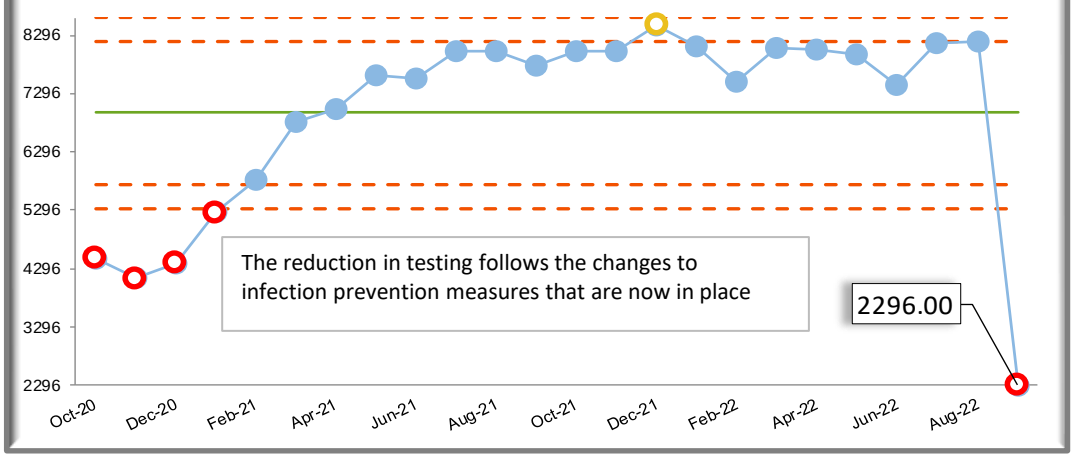

Trajectory vs Actual - Total ASIs
15000
10000
5000
0
29/03/2021
29/05/2021
29/07/2021
29/09/2021
29/11/2021
29/01/2022
29/03/2022
29/05/2022
29/07/2022
29/09/2022
Trajectory
Actual


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

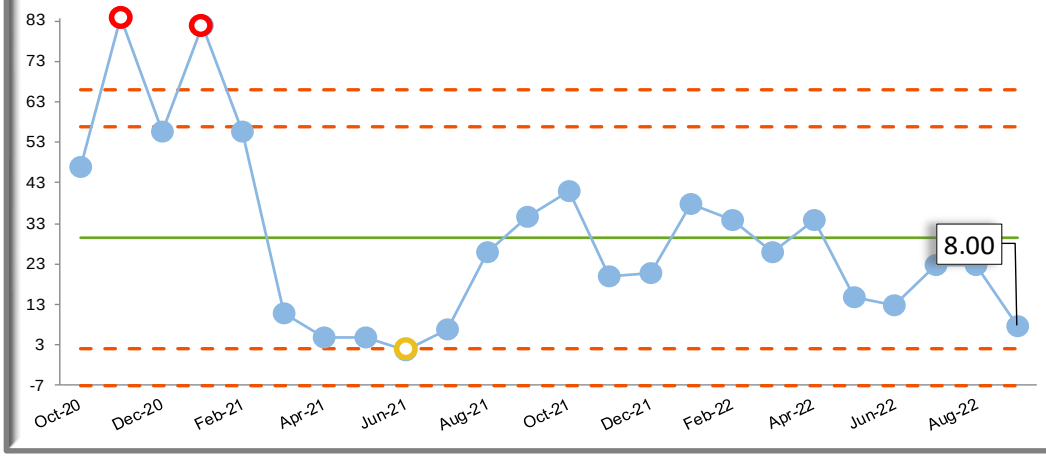
Covid-19 - SPC Charts

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

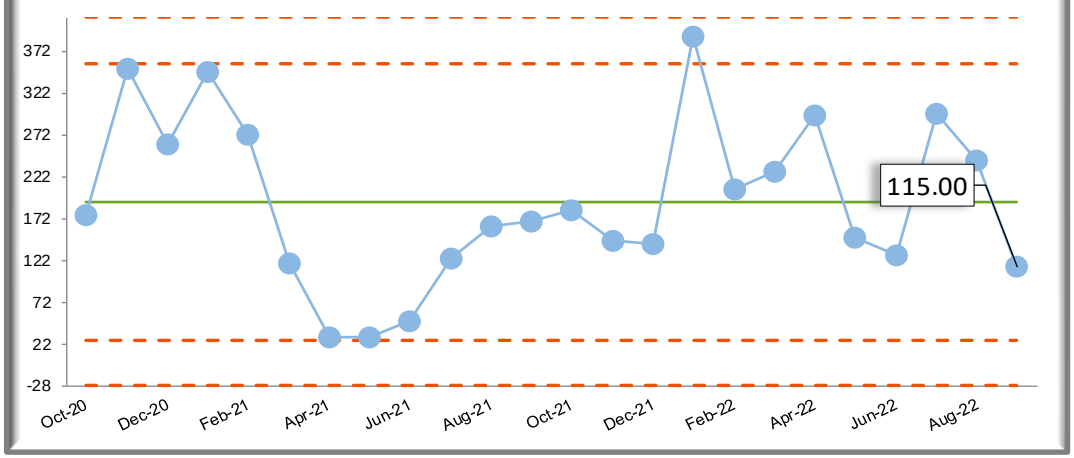
Number of Patients Tested for Covid-19



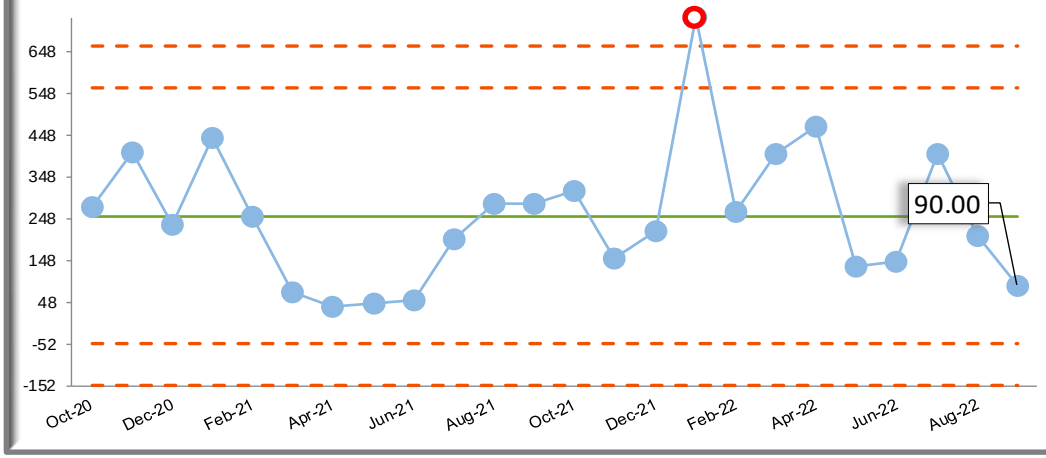
Number of Covid+ Deaths



Number of Covid+ Patients Discharged Well

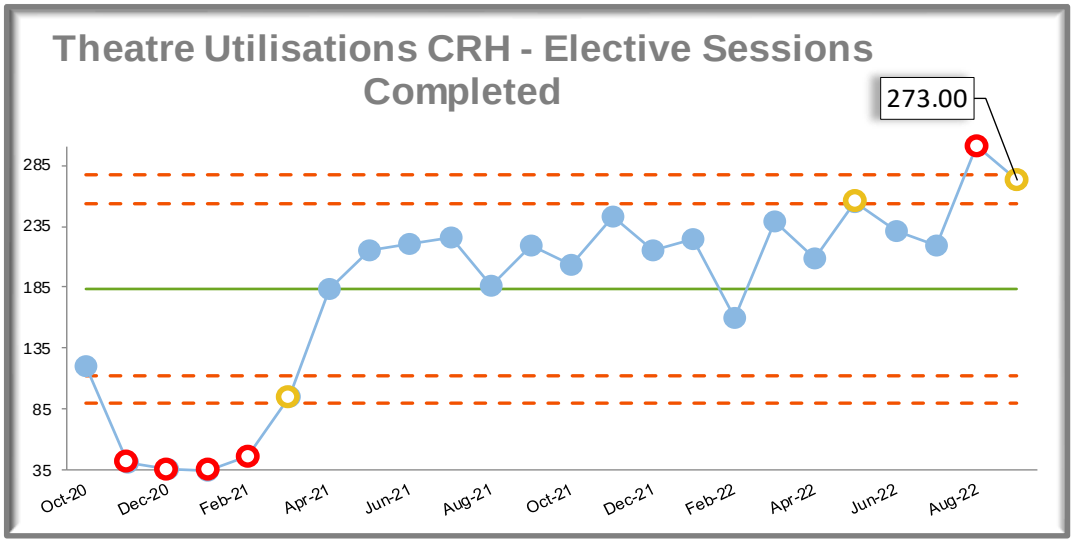


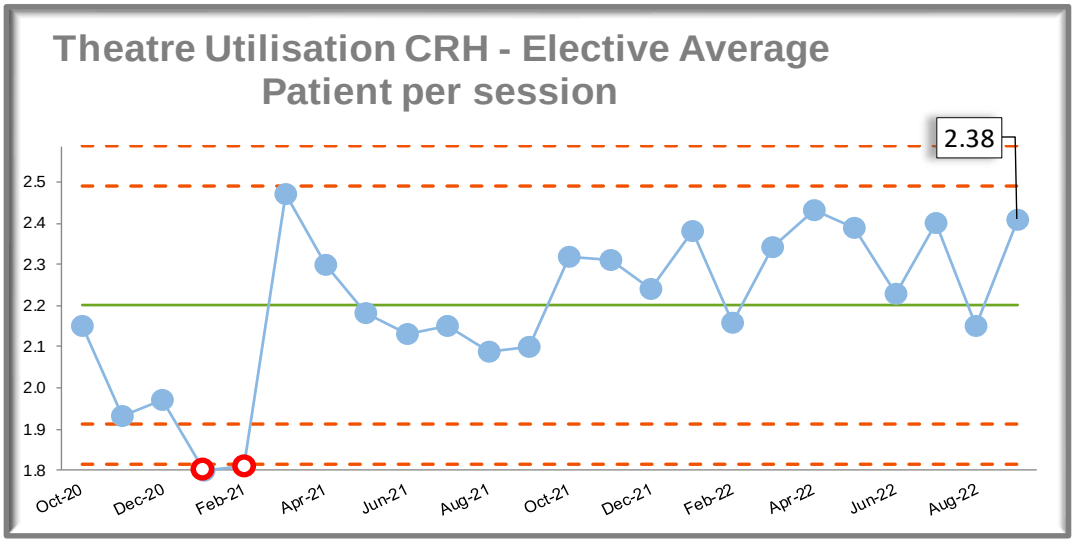
Number of New Covid+

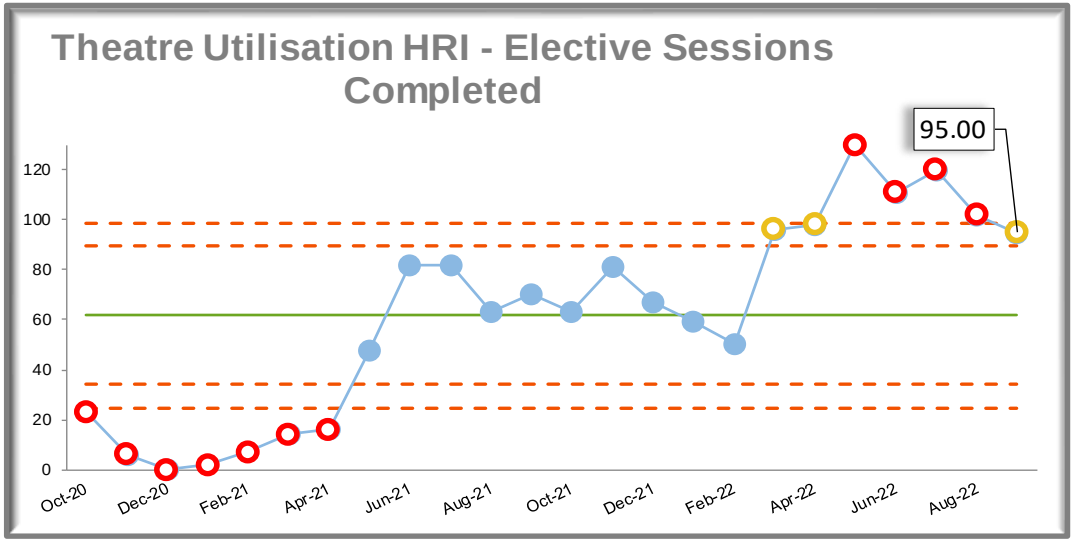


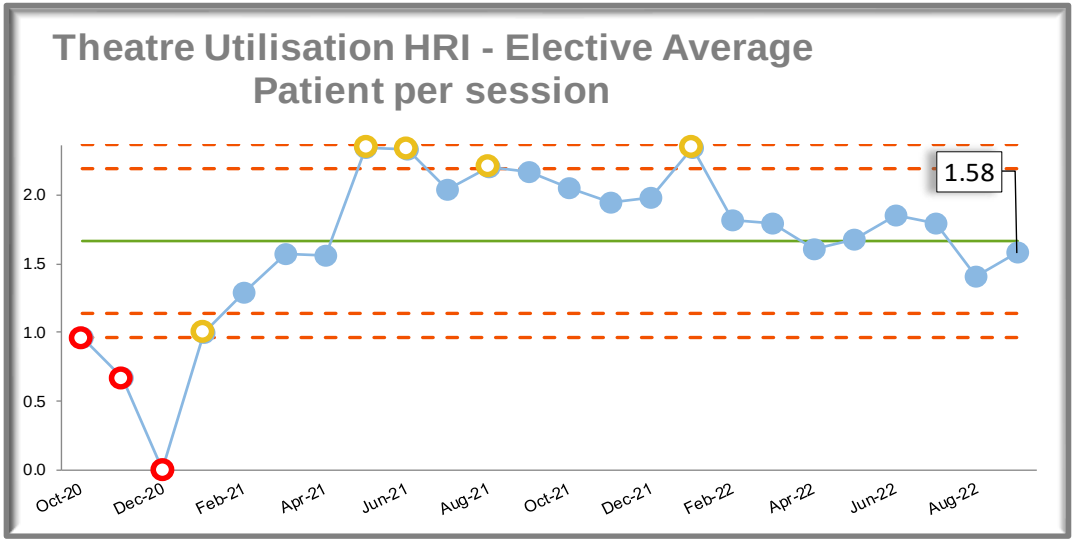
Theatres - SPC Charts

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

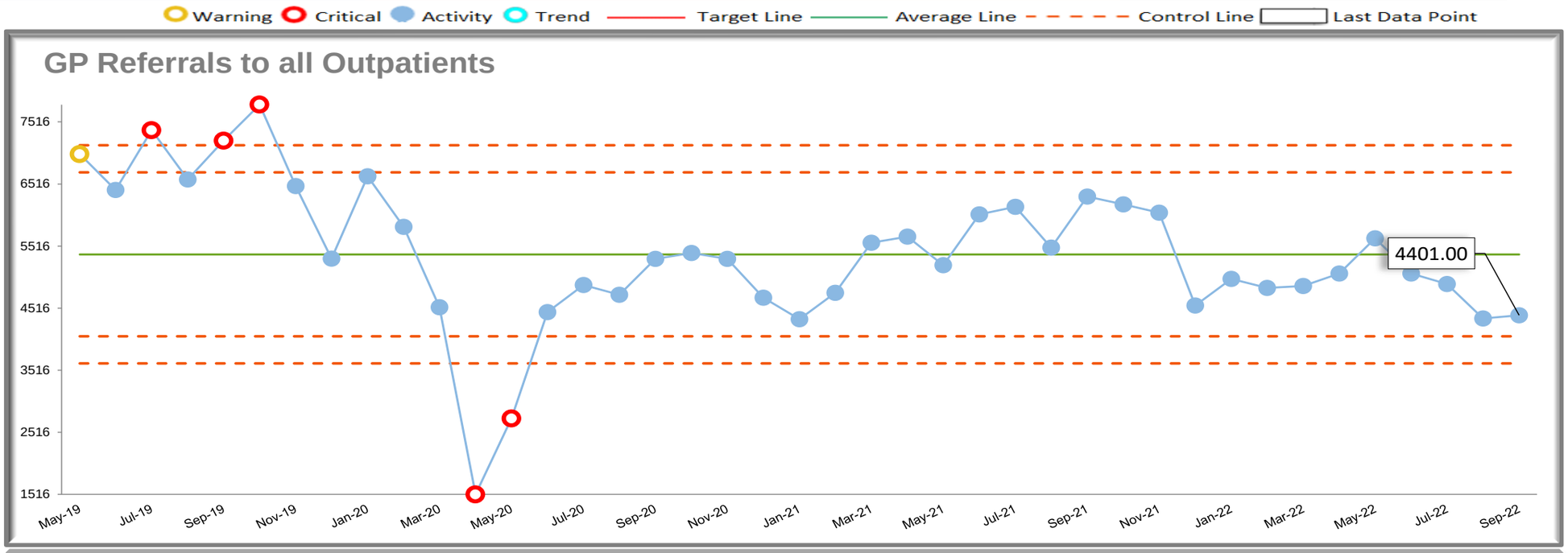


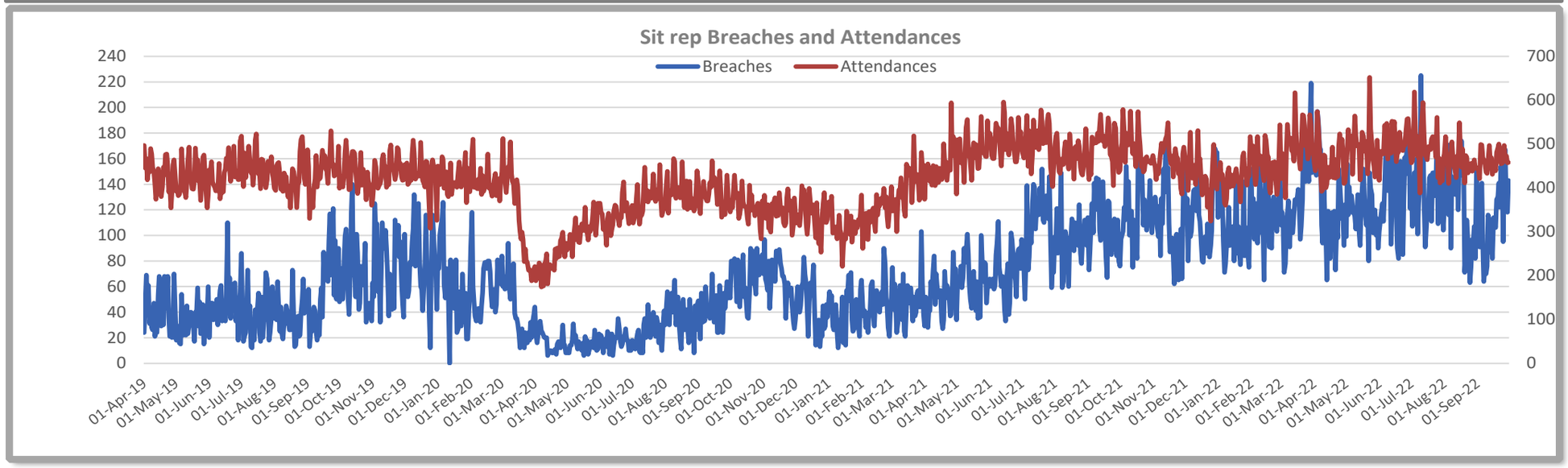






Capacity and Demand

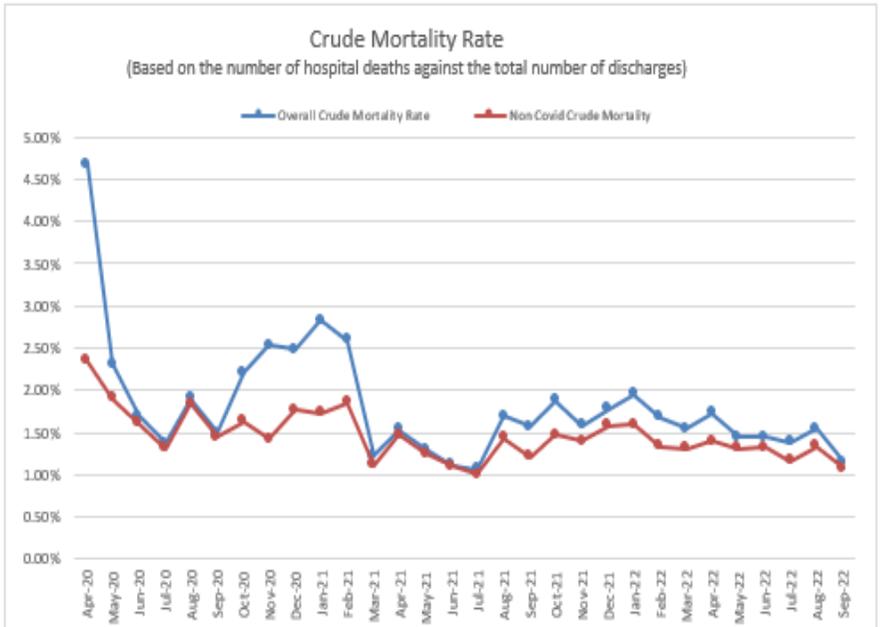


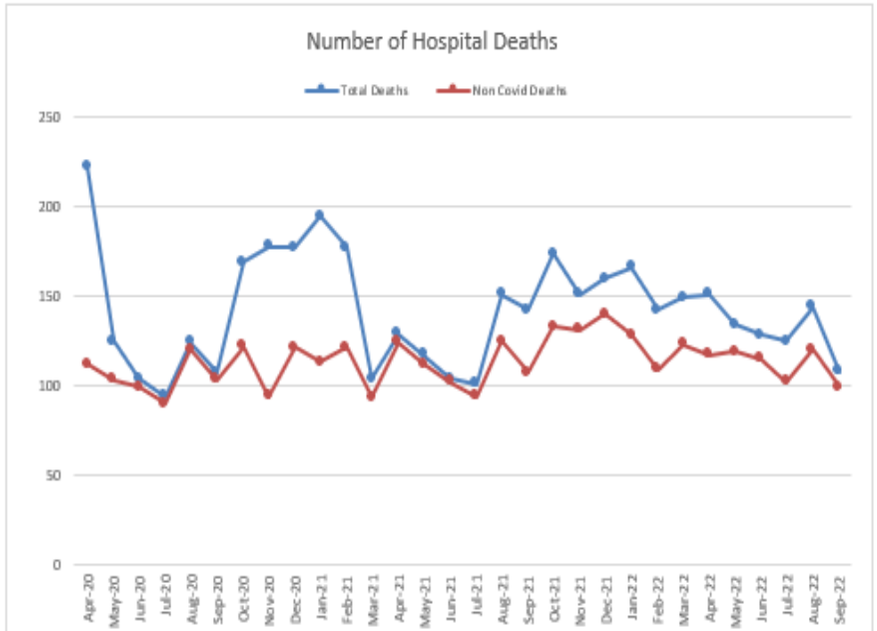


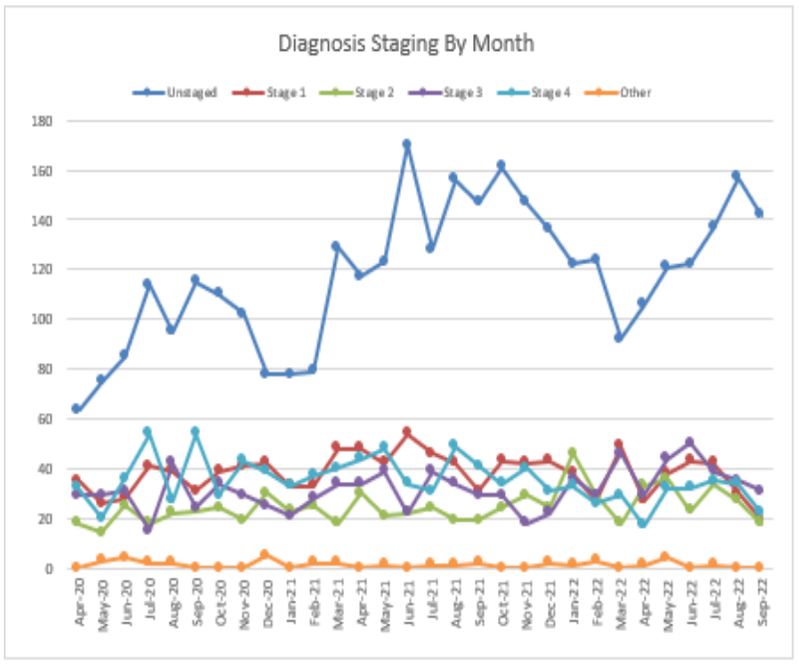
Recovery

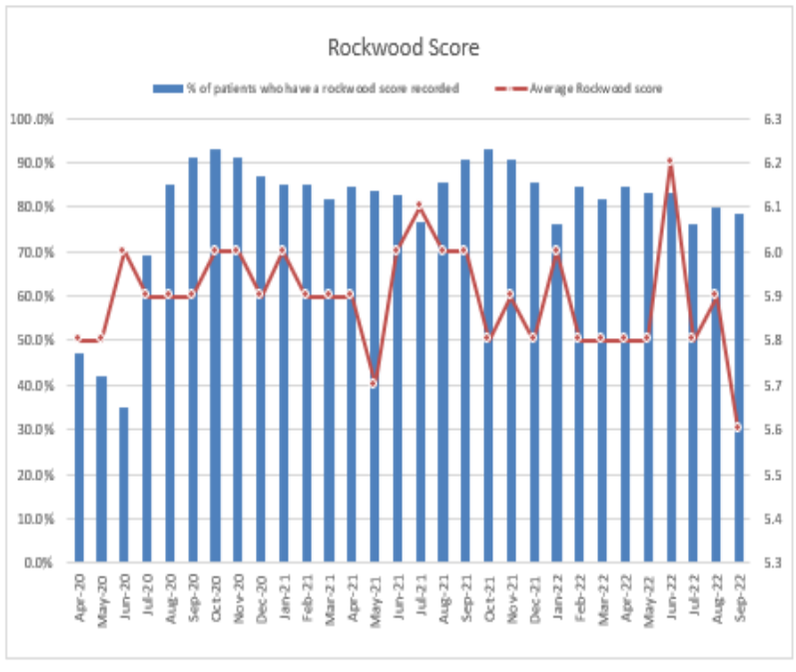
	21/22	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	YTD	Performance Range		
Recovery – Patient Initiated Outpatient Follow-Ups (PIFU)																Green	Amber	Red
Number of episodes moved to Patient Initiated Out-Patient Follow-Up Pathway as an outcome of their attendance	6446	431	329	859	735	859	878	1099	894	1102	908	972	1151	**1196**	**6,223**	Ongoing Monitoring		
% PIFU Delivered as an outcome of their attendance	1.18%	1.08%	0.85%	2.06%	2.04%	2.35%	2.47%	2.71%	2.48%	2.75%	2.39%	2.64%	3.03%	**3.04%**	**2.67%**	>=2.00%		<=1.99%
Number of episodes discharged to Patient Initiated Out-Patient Follow-Up Pathway as an outcome of their attendance	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**	Ongoing Monitoring		
Number of episodes on active Patient Initiated Out-Patient Follow-Up Pathway	40340	3301	3458	5114	5400	4740	5,666	5,886	6,761	6,879	7,508	7,754	8,219	**8,620**	**45,741**	Ongoing Monitoring		
Number of episodes on Patient Initiated Out-Patient Follow-Up Pathway completed	1168	17	24	239	260	272	302	7	281	293	336	223	390	**357**	**1,880**	Ongoing Monitoring		
Number of appointments where the reason for booking was a Patient Initiated Out-Patient Follow Up Appointment	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**	Ongoing Monitoring		
Number of booked appointments where patient failed to attend (attend on time) from a Patient Initiated Out-Patient Follow-Up Pathway	25	5	2	4	2	5	2	2	5	7	1	3	9	**0**	**25**	Ongoing Monitoring		

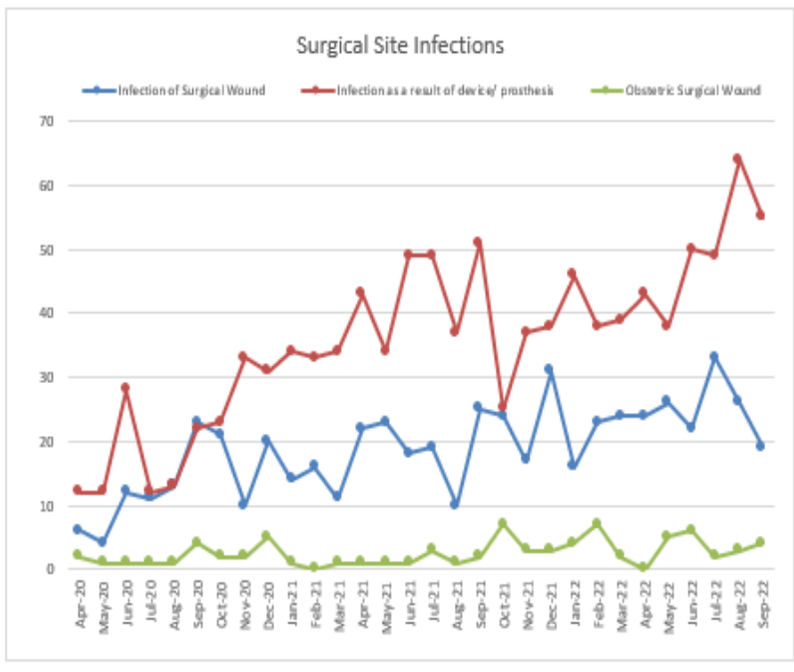
Outcome Measures





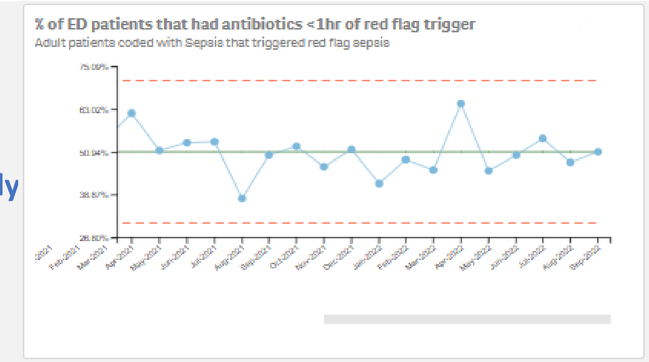


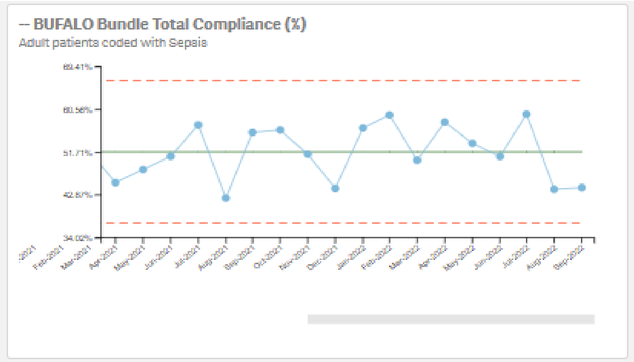




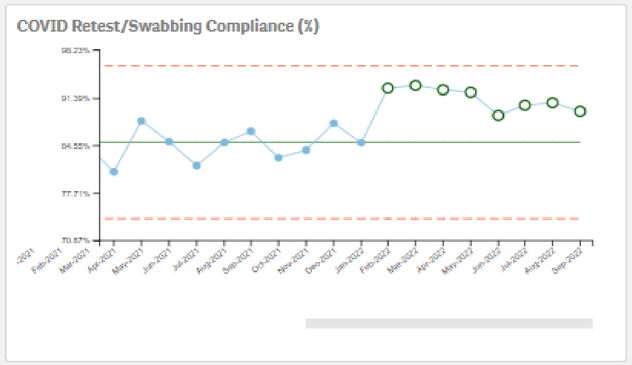
Quality Priorities - Quality Account Priorities

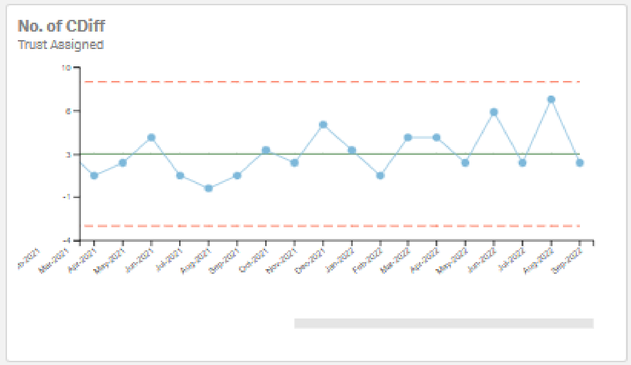
Priority 1
Recognition and timely treatment of Sepsis

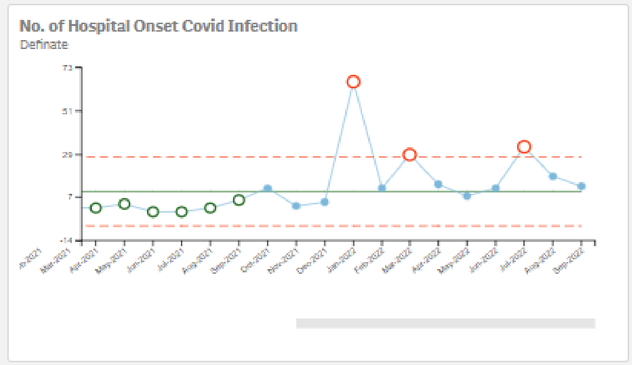




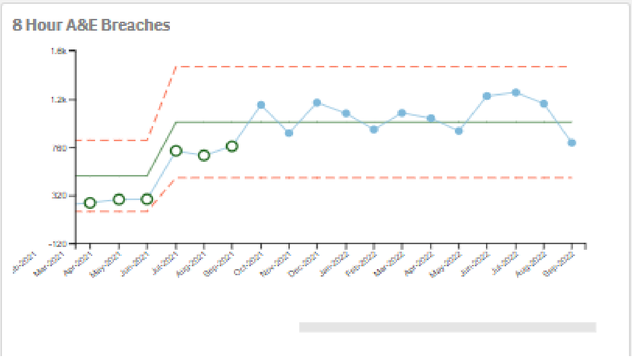
Priority 2
Reduce number of hospital acquired infections including COVID-19

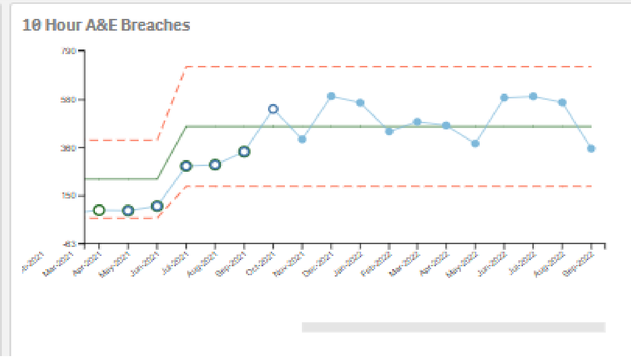


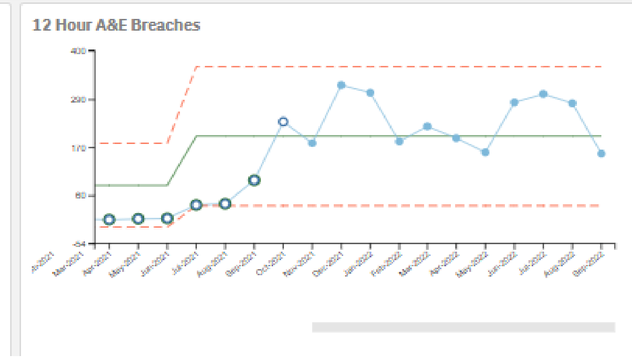




Priority 3
Reduce waiting times for individuals in the Emergency Department

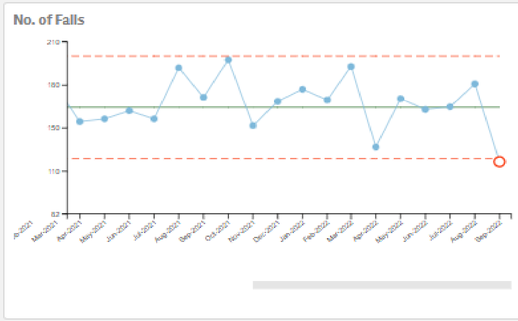


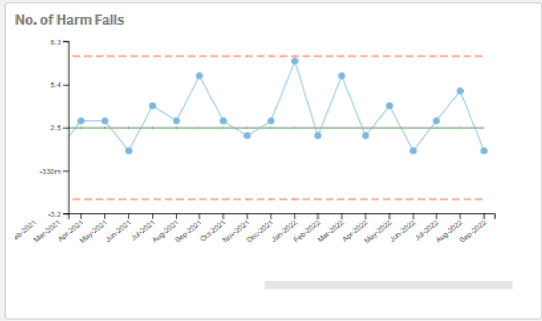




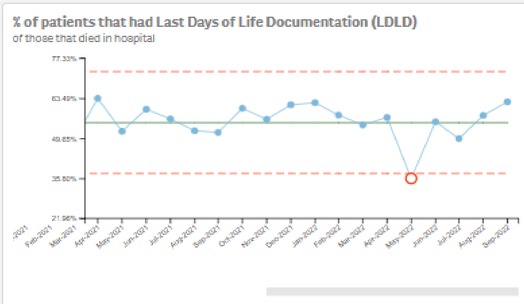
Quality Priorities - Focused Priorities

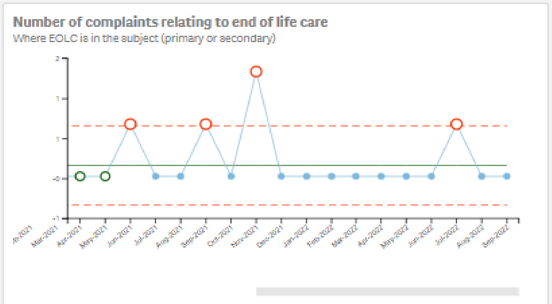
Priority 1
Reducing the number of falls resulting in harm

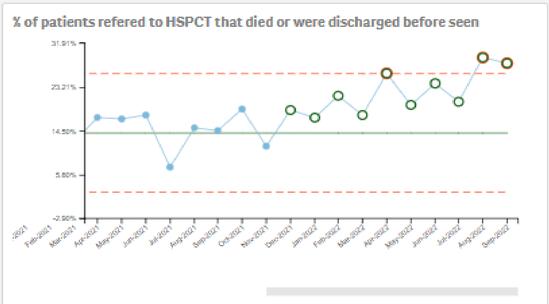




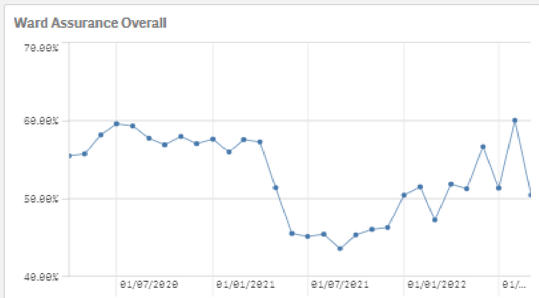
Priority 2
End of Life Care

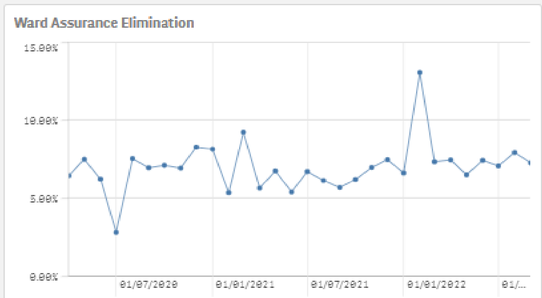


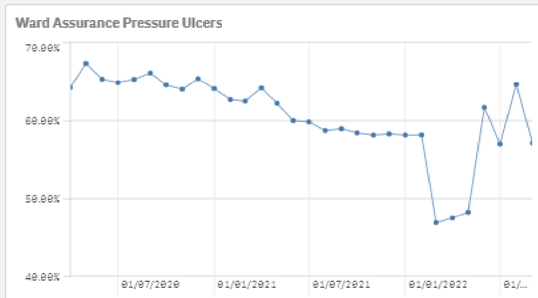




Priority 3
Clinical Documentation





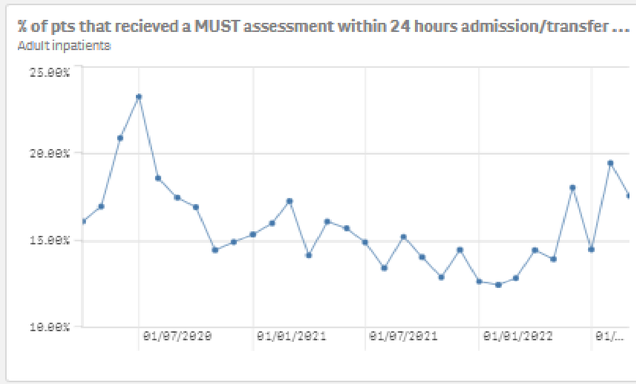


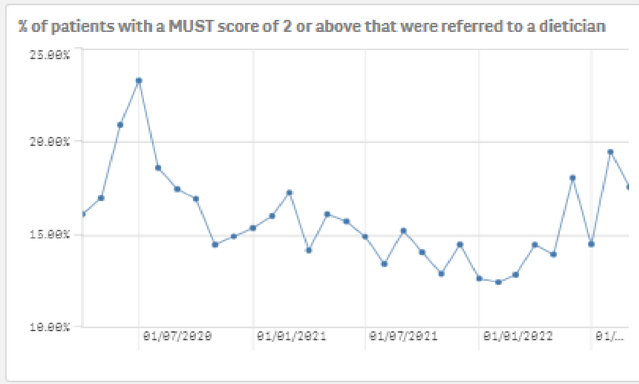
Priority 4
Clinical Prioritisation

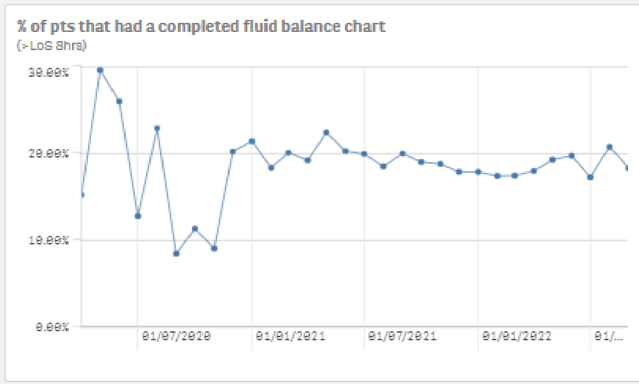
Not Yet Available

Quality Priorities - Focused Priorities

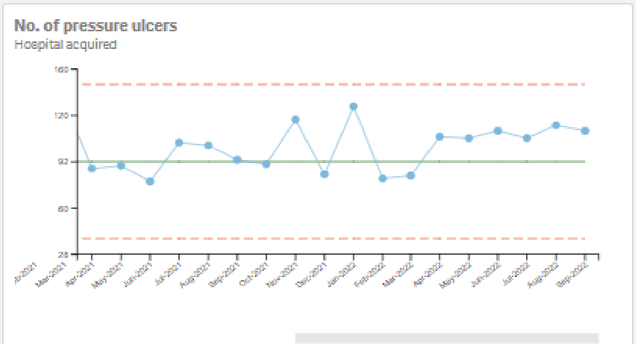
Priority 5
Nutrition and Hydration



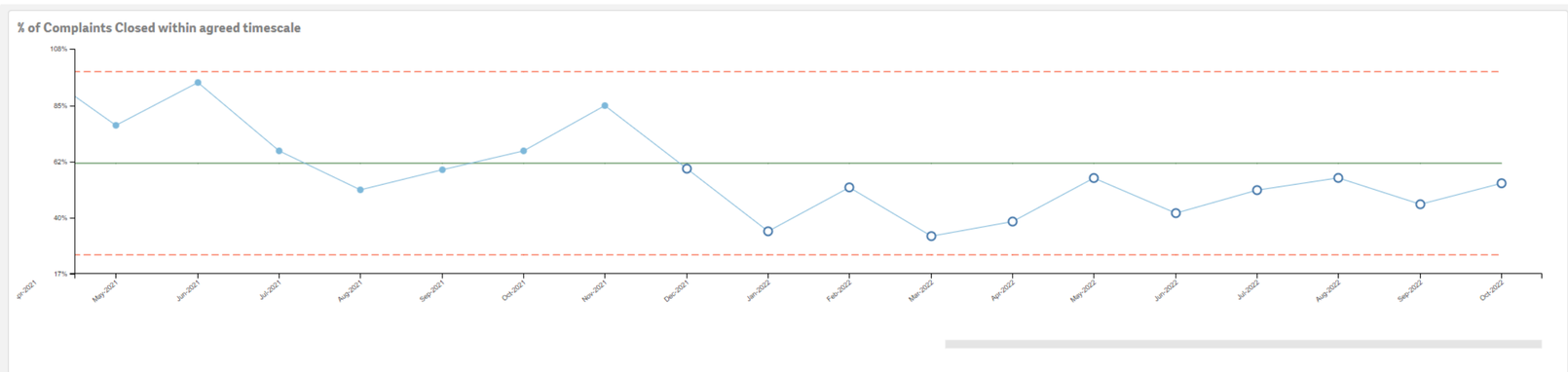




Priority 6
Reduction in the number of CHFT acquired pressure ulcers



Priority 7
Making complaints count



CQUIN - Key Measures

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

CQUIN - Key Measures

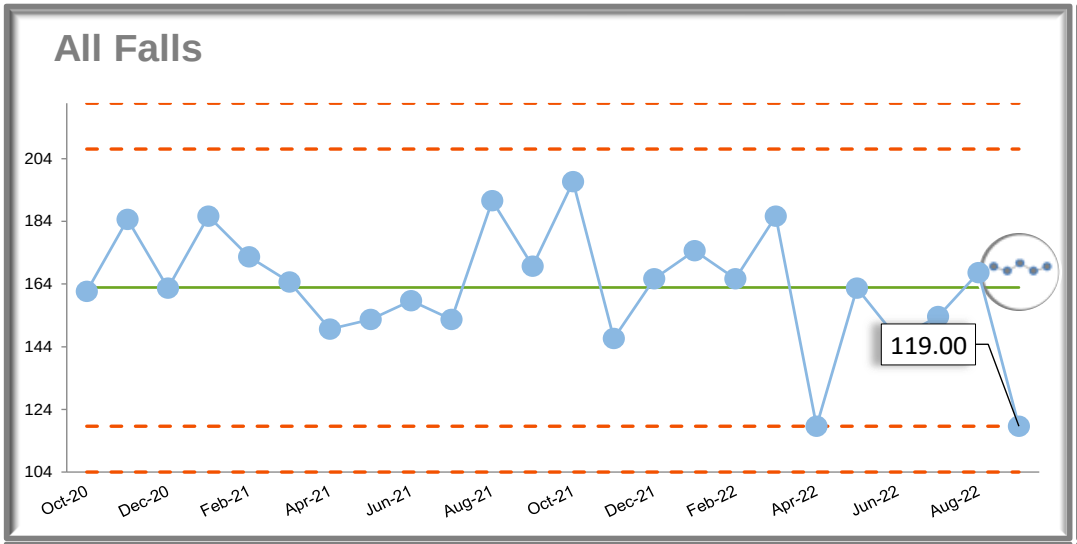
Indicator Name	Reality	Response	Result
CCG2: Appropriate antibiotic prescribing for UTI in adults aged 16+	Achievement of the 5 elements of the UTI Diagnosis/Management CQUIN requires overall compliance of >60% to receive full payment. After 1st quarter we are achieving 57% overall compliance. The element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

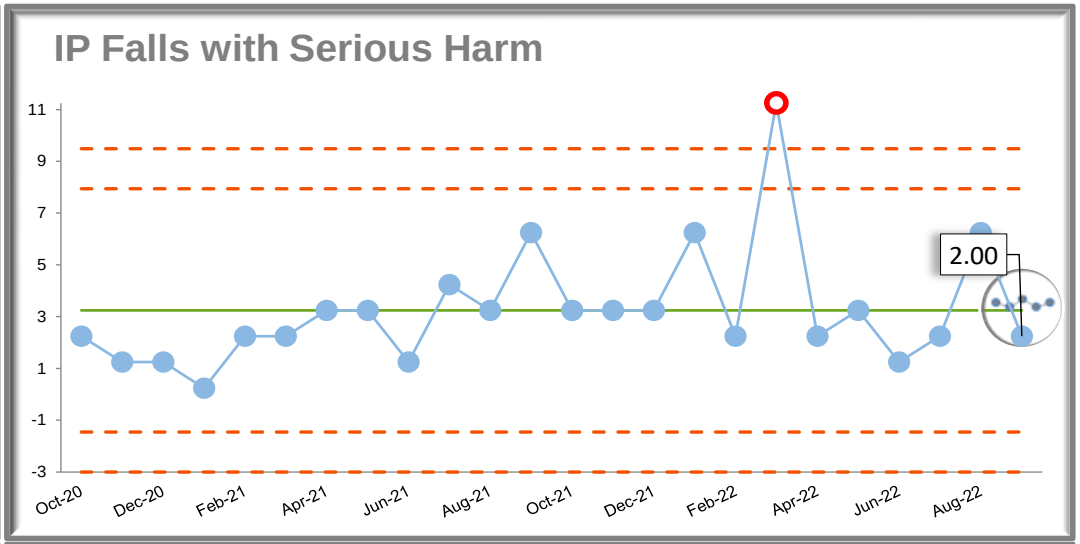
Safe - Key measures

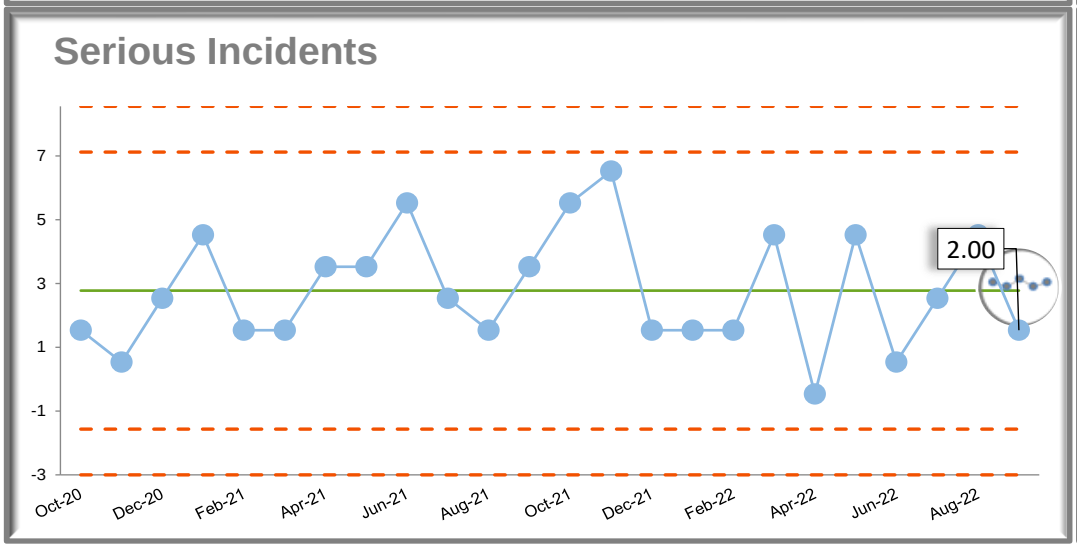
	21/22	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	YTD	Performance Range		
Falls / Incidents and Harm Free Care																Green	Amber	Red
All Falls	2013	170	197	147	166	175	166	186	119	163	147	154	168	**119**	**870**	Ongoing Monitoring		
Inpatient Falls with Serious Harm	48	6	3	3	3	6	2	11	2	3	1	2	6	**2**	**16**	Ongoing Monitoring		
Falls per 1000 bed days	8.95	8.98	10.04	7.48	8.28	8.77	9.02	9.1	6.2	8.22	7.6	7.69	8.39	**6.11**	**7.38**	Ongoing Monitoring		
Number of Serious Incidents	47	4	6	7	2	2	2	5	0	5	1	3	5	**2**	**16**	Ongoing Monitoring		
Number of Incidents with Harm	2934	246	275	274	254	340	240	301	293	294	261	286	221	**273**	**1,628**	Ongoing Monitoring		
Harm Falls per 1000 bed days	0.18	0.32	0.15	0.11	0.15	0.36	0.11	0.3	0.1	0.16	0.05	0.1	0.3	**0.11**	**0.14**	Ongoing Monitoring		
Percentage of Duty of Candour informed within 10 days of Incident	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%**	100%	96 - 99%	<=95%
Never Events	2	0	0	0	0	0	0	1	0	1	1	1	0	**0**	**3**	0		>=1
Percentage of SIs investigations where reports submitted within timescale – 60 Days	26.30%	25.00%	100.00%	0.00%	33.30%	60.00%	50.00%	33.00%	0.00%	none to report	none to report	0.00%	25.00%	**0.00%**	**26.30%**	Ongoing Monitoring		
% Emergency Sepsis patients receiving antibiotic treatment within 1 hour of diagnosis	92.49%	97.87%	98.00%	98.11%	100.00%	71.05%	82.76%	78.79%	84.85%	77.14%	76.32%	76.67%	89.19%	**in arrears**	**80.92%**	>=90%	86% - 89%	<=85%
% Inpatient Sepsis patients receiving antibiotic treatment within 1 hour of diagnosis	84.06%	94.87%	88.89%	91.43%	96.00%	55.17%	53.57%	60.00%	70.00%	52.17%	70.00%	66.67%	58.62%	**in arrears**	**63.91%**	>=90%	86% - 89%	<=85%
Maternity																		
% PPH ≥ 1500ml - all deliveries	2.21%	2.39%	2.57%	2.68%	2.60%	2.74%	1.45%	2.35%	2.79%	2.33%	2.60%	3.40%	2.61%	**2.59%**	**2.72%**	<= 3.0%	3.1% - 3.4%	>=3.5%
Antenatal Assessments < 13 weeks	90.35%	90.10%	90.10%	90.20%	90.40%	90.12%	90.22%	90.00%	90.01%	87.36%	89.80%	87.60%	89.20%	**88.80%**	**88.80%**	>90%	81% - 89%	<=80%
Maternal smoking at delivery	9.49%	7.66%	6.50%	9.50%	8.98%	9.12%	10.14%	7.83%	12.01%	9.62%	11.90%	9.90%	9.90%	**11.80%**	**10.85%**	<=12.9%		>=13%
Pressure Ulcers/VTE Assessments																		
Number of Trust Pressure Ulcers Acquired at CHFT	1069	82	79	109	82	130	85	82	102	107	111	105	108	**under validation**	**533**	Refer to SPC charts		
Pressure Ulcers per 1000 bed days	2.17	1.90	1.68	2.41	1.93	2.94	2.35	1.56	2.55	1.71	1.87	2.18	2.38	**under validation**	**2.23**	Refer to SPC charts		
Number of Category 2 Pressure Ulcers Acquired at CHFT	513	34	40	53	34	53	52	46	38	51	58	55	46	**under validation**	**248**	Refer to SPC charts		
Number of Category 3 Pressure Ulcers Acquired at CHFT	34	7	3	2	1	4	1	4	4	4	3	0	2	**under validation**	**13**	Refer to SPC charts		
Number of Category 4 Pressure Ulcers Acquired at CHFT	13	2	0	2	1	2	0	3	1	2	0	0	0	**under validation**	**3**	0		>=1
Number of Deep Tissue Injuries	354	26	32	36	29	47	21	19	44	32	38	33	49	**under validation**	**196**	<=26.583 & YTD <=319		
Number of Unstageable Pressure Ulcers	155	13	4	16	17	24	11	10	15	18	12	17	11	**under validation**	**73**	<=11.667 & YTD <=140		
Number of patients with a Pressure ulcer	861	65	67	83	72	95	71	72	75	84	92	90	86	**under validation**	**427**	Refer to SPC charts		
% of leg ulcers healed within 12 weeks from diagnosis	81.60%	61.50%	87.50%	81.30%	89.50%	53.80%	85.70%	77.80%	80.00%	96.00%	96.88%	93.98%	98.25%	**92.90%**	**93.40%**	>=90%	86% - 89%	<=85%
Percentage of Completed VTE Risk Assessments	96.29%	95.93%	96.37%	96.27%	96.06%	96.32%	96.60%	95.98%	95.35%	95.03%	95.69%	96.30%	97.13%	**97.23%**	**95.90%**	>=95%	86% - 89%	<=85%
Health & Safety Incidents																		
Health & Safety Incidents	269	23	28	18	25	13	28	21	20	22	18	17	27	**14**	**118**	Ongoing Monitoring		
Health & Safety Incidents (RIDDOR)	7	2	0	0	1	0	0	2	1	0	2	0	2	**1**	**6**	0		>=1
Reconciliation of Medicines																		
Medical Reconciliation within 24 hours (excluding Children)	52.90%	49.00%	50.50%	46.60%	57.50%	58.80%	53.30%	62.50%	53.30%	58.10%	56.40%	63.30%	51.90%	**48.90%**	**55.50%**	>=68%		<=67%
Electronic Discharge																		
% Complete EDS	94.46%	94.22%	94.01%	92.10%	92.46%	91.61%	93.70%	91.70%	95.42%	96.43%	94.75%	94.01%	95.49%	**in arrears**	**95.22%**	>=95%	91% - 94%	<=90%

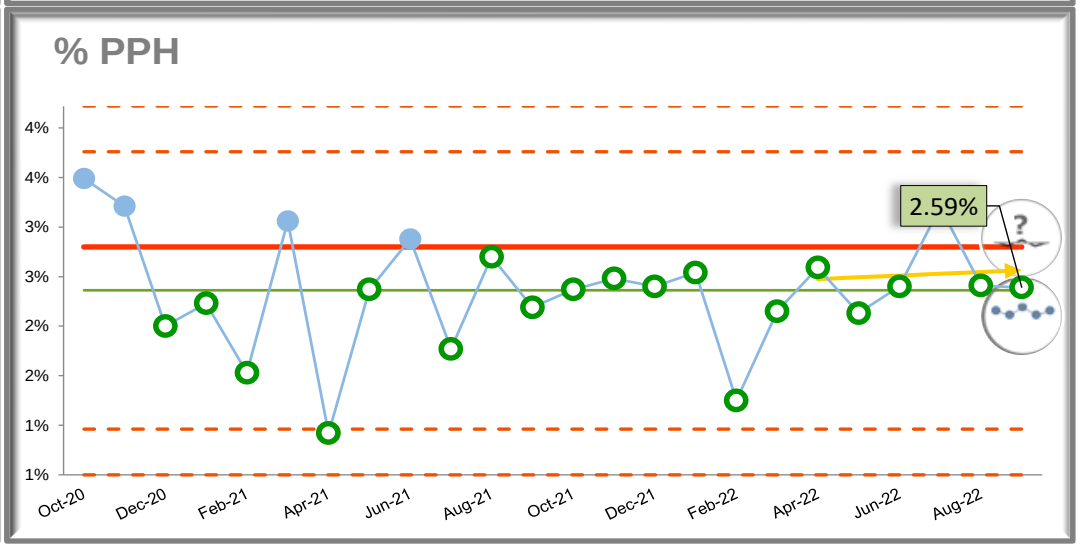
Safe - SPC Charts

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









Safe - Key messages

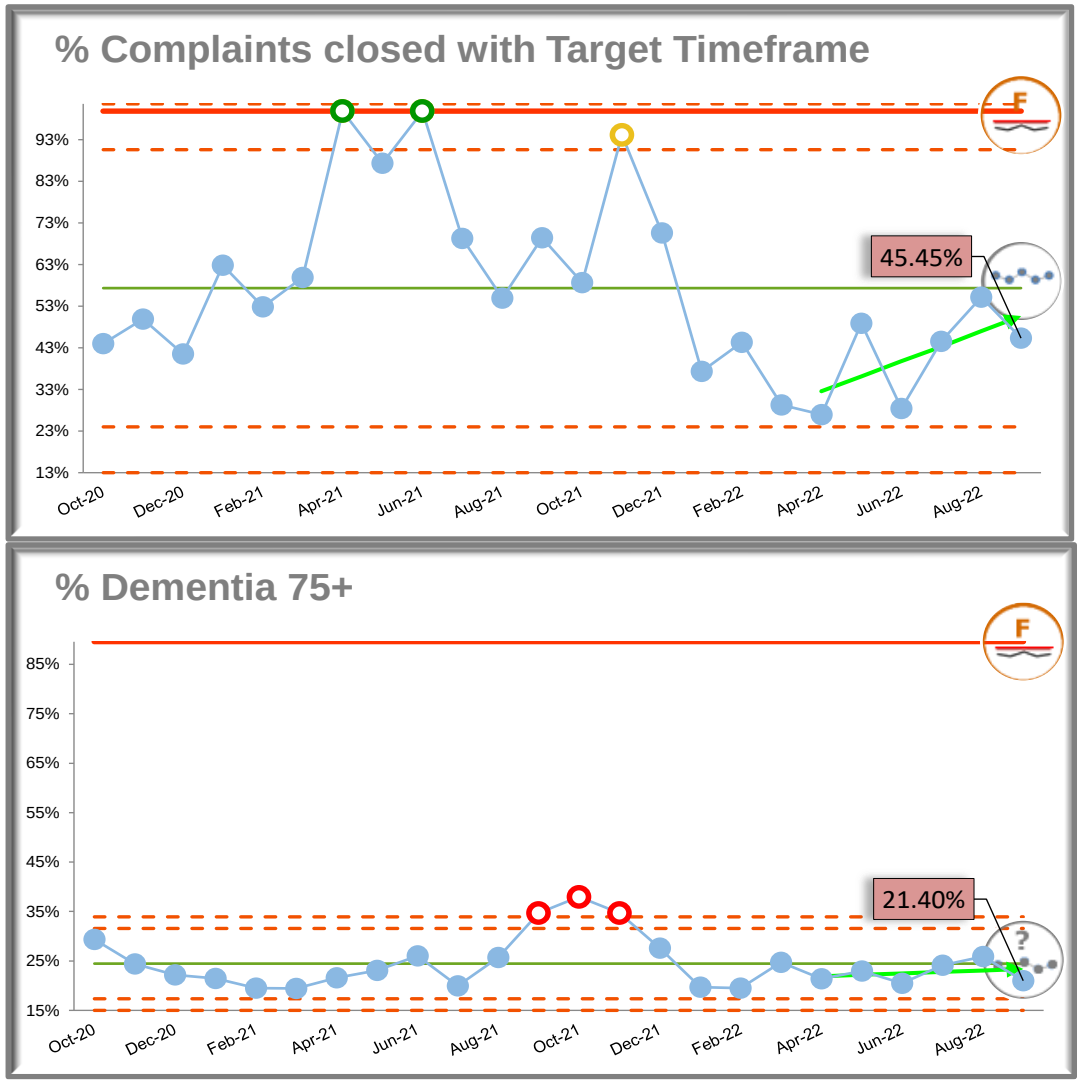
Area	Reality	Response	Result
Number of Deep Tissue Injuries	We have had 49 deep tissue injuries in August. This is an increase on previous months and above the ceiling of 26.5.	The Trust is implementing a new pressure ulcer risk assessment tool called PURPOSE T in September 2022. This will replace Water low. KP+ now has a dedicated pressure ulcer page and senior nurses now have relevant information on performance to share and use as appropriate. Matrons are undertaking audits of pressure ulcer practice on a regular basis. Daily virtual safety huddles between Matrons and Tissue Viability Nurses. Tissue Viability Nurse / Matron Leadership walkabouts have commenced. These allow a sense check of pressure ulcer standards and discussions with frontline staff.	Total YTD to be below 319. Accountable: ADNs
Medical Reconciliation within 24 hours (excluding Children)	Performance for Med Rec within 24 hours in September is 48.9%, which is below the 68% target.	The target has not been achieved in the last 24 months – there is only one month – April 2020 due to reduced attendances at the hospital that a result of 73% was achieved. In the last 27 months; there have only been 6 occasions when the figure has been above 58%. The HRI dedicated ward Pharmacy team continue to contribute to the improvement in medicines reconciliation for newly admitted medical patients (98% within 24 hours in that area). We hope to get business case approval to roll this service out at CRH in the next 12 months which will have a significant positive impact on our rates.	We have seen a significant increase in this figure in the last 6 months however due to some changes in practice and the current aim is to keep the figure at a consistent 60% level.
% Emergency & Inpatient Sepsis patients receiving antibiotic treatment within 1 hour of diagnosis	For patients in the emergency department performance in August was 89.19% which is just below the 90%, but higher than previous months. For inpatients performance in August was 58.62% which is well below the 90% target.	The sepsis collaborative has implemented multiple actions to improve overall concordance of antibiotic treatment through a multidisciplinary team approach. This includes focussed priority of timely patient assessment and treatment through improved communication networks, timely patient assessments, education and ensuring accurate data results.	Improved performance by September 2022 Accountable: Quality Priority Lead
Antenatal Assessments < 13 weeks	Booking <13 weeks is 88.8% for September which is a slight deterioration in month from 89.2% in August. This is the 5th consecutive month where rates have fallen below the target of 90%.	Work ongoing with community teams to ensure timely bookings when referrals made. Some additional clinics added to address outstanding bookings but impacted by midwifery staffing pressures. Noted some increase in late bookings / self referrals. Women are now able to self refer for pregnancy bookings. Plan to continue close observation and timely management of referrals.	To work with community teams to undertake targeted piece of work on supporting improved compliance and rates achieved within targeted range Accountable: General Manager
Health & Safety Incidents (RIDDOR)	1 RIDDOR incidents for the month of September.	The incident has been investigated and will be responded to accordingly.	Remind staff to be vigilant at all times. Accountable: Head of Health & Safety

Caring - Key measures

	21/22	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	YTD	Performance Range		
Complaints																Green	Amber	Red
% Complaints closed within target timeframe	63.61%	69.57%	58.82%	94.29%	70.73%	37.50%	44.44%	29.41%	27.08%	48.98%	28.57%	44.64%	55.32%	**45.45%**	**42.29%**	100%	86% - 99%	<=85%
Total Complaints received in the month	492	50	47	60	38	44	43	31	30	47	51	49	58	**36**	**271**	no target		
Complaints re-opened	86	8	8	13	5	6	7	9	5	9	6	12	12	**8**	**52**	no target		
Inpatient Complaints per 1000 bed days	1.39	1.8	1.63	1.78	1.42	1.52	1.42	1.03	1.15	1.81	1.61	1.67	1.74	**1.21**	**1.53**	no target		
No of Complaints closed within Timeframe	243	16	20	33	29	12	20	10	13	24	10	25	26	**20**	**118**	Refer to SPC charts in Appendix		
Total Complaints Closed	382	23	34	35	41	32	45	34	48	49	35	56	47	**44**	**279**	no target		
Friends & Family Test																		
Friends & Family Test (IP Survey) - % Positive Responses	96.88%	97.33%	98.26%	97.47%	97.35%	97.10%	97.36%	96.36%	97.57%	97.14%	97.60%	98.27%	98.02%	**in arrears**	**97.68%**	>=90% / >=95% from September 21 onwards		<=79%
Friends and Family Test Outpatients Survey - % Positive Responses	92.23%	91.49%	91.51%	92.45%	93.02%	93.20%	92.15%	93.71%	91.82%	92.24%	90.33%	92.02%	90.48%	**in arrears**	**91.46%**	>=90% / >=93% from September 21 onwards		<=79%
Friends and Family Test A & E Survey - % Positive Responses	82.53%	80.85%	81.01%	82.39%	84.40%	86.40%	84.69%	76.52%	83.18%	81.09%	79.94%	79.63%	83.03%	**in arrears**	**81.33%**	>=80% / >=85% from September 21 onwards		<=69%
Friends & Family Test (Maternity) - % Positive Responses	94.66%	97.69%	93.98%	93.20%	98.33%	92.30%	91.00%	95.12%	96.74%	97.92%	95.90%	93.48%	93.48%	**in arrears**	**95.26%**	>=90% / >=95% from September 21 onwards		<=79%
Friends and Family Test Community Survey - % Positive Responses	92.46%	94.27%	91.12%	95.86%	93.68%	95.50%	91.21%	98.32%	94.79%	94.52%	88.96%	92.73%	94.51%	**in arrears**	**92.80%**	>=90% / >=95% from September 21 onwards		<=79%
Caring																		
Number of Mixed Sex Accommodation Breaches	0	0	0	0	0	0	0	0	0	0	0	2	0	**0**	**2**	0		>=1
% Dementia patients screened following emergency admission aged 75 and over	26.57%	35.11%	38.37%	35.11%	28.03%	20.14%	19.92%	25.13%	21.81%	23.35%	20.88%	24.56%	26.34%	**21.40%**	**23.09%**	>=90%	88% - 89%	<=87%

Caring - SPC Charts

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



Caring - Key messages

Area	Reality	Response	Result
% Complaints closed within target timeframe	Performance in September is 45.45% which is well below the 100% target. YTD 42.29%.	The number of complaints closed within timeframe has decreased this month and performance is less than hoped for. Specific focus on complaints continues with weekly oversight and scrutiny within Divisions and alongside the Corporate Team.	An increase in performance moving forward. Accountable : Head of PALS and Complaints
% Dementia patients screened following emergency admission aged 75 and over	% Dementia patients screened following emergency admission aged 75 and over was 21.4% in September compared with 26.34% in August.	Despite introducing several initiative to increase compliance in this indicator, compliance remains very low. The dementia lead has now developed an options appraisal which is being taken through the weekly executive board for executive sign off. This is expected to recommend that this task moves from a medical task to a nursing task.	To improve dementia compliance Accountable: Director of Operations
Friends and Family Test Community Survey - % Positive Responses	Performance in August is at 94.51% this is an increase from July at 92.73% .	Communication to Team Leads and managers is ongoing, reminding them to access KP+ and monitor their service's FFT collection	Improved FFT submission. By when: October 2022 Accountable: Director of Operations
Friends and Family Test A & E Survey - % Positive Responses	Performance in August is 83.03% which is an increase from July at 79.63%	There is going to be an increased focus in divisional PSQB on patient experience going forward, with the head of PALS presenting this and guiding discussion on a quarterly basis.	The Trust continues to score above the national average. Accountable : ADN

Caring - What our Patients are saying

Impact Story October 2022
MRI – Ambient Experience

RESULT:
Transformation of the traditional MRI scanning which has improved the patient experience

Type of Event:
New experiment and improved environment

Event (REALITY):

Most patients who undergo an MRI scan experience some level of anxiety. As a result, some move so much that they cause motion artifacts which often meant images became destroyed and invalid. Sometimes our Radiographers were unable to complete the scan, or patients did not attend their appointment because of the fear of the MRI. This all results in increased health risks and additional costs for the Trust.
Previously, addition challenges arose when scanning some of our paediatric patients, those living with a learning disability and those who suffer from claustrophobia.
For some patients simply coming into hospital felt scary. So, image have an MRI scan, for whom this may have needed to be completed in an emergency unplanned situation, in an extremely noisy and alien environment.
In the past it was common practice for patients to be sedated for this procedure, should they present with the challenges mentioned.

Actions (RESPONSE):

With the support of the Calderdale and Huddersfield NHS charity the Trust has been able to purchase the technology needed for our patients to experience an ambient MRI scan.
This has been clinically proven to decrease anxiety and increase patient well-being.
The ambient MRI provides patients with a multi-sensory experience. The patient has a choice one of many themes, allowing them to personalise their experience through sound, lighting, and projection, this has given the patients a sense of control of the procedure which provides a positive distraction and reduces stress. This has also resulted in less patients requiring general anaesthetic or sedation.
During October 2022 our first paediatric patients were able to have their scans done using the distraction techniques of the ambient MRI.
Our Radiographers have told us that YouTube has been a particular favourite amongst teenagers.
All patients who can be offered the ambient MRI are given this as our preferred option for MRI scanning.

RESULT

- ✓ Improved patient, family and carer experience as they have less anxiety
- ✓ Earlier diagnosis for patients
- ✓ Reduced number of rescans
- ✓ Less need for general anaesthetics or sedation
- ✓ No recovery time following completion of the scan
- ✓ Significantly reduced waiting times
- ✓ Quicker on the day appointment times
- ✓ Less staffing resources needed
- ✓ Potential life-changing treatment sooner
- ✓ Improved staff experience for our Radiographic teams as they have an improved work experience
- ✓ Financial savings

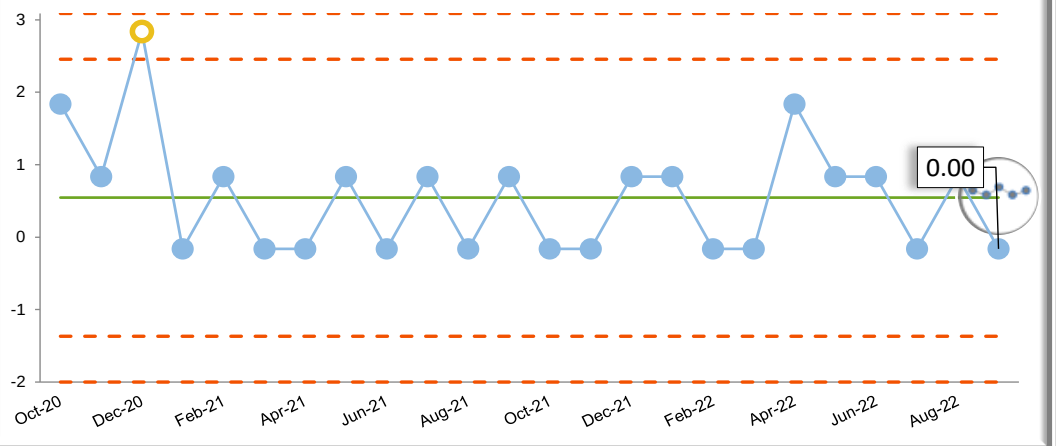
Effectiveness - Key measures

	21/22	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	YTD	Performance Range Green	Amber	Red
Infection Control																		
Number of MRSA Bacteraemias – Trust assigned	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**	0		>=0
Total Number of Clostridium Difficile Cases - Trust assigned	27	1	3	2	5	3	1	4	4	2	6	2	7	**1**	**22**	<=3.1667 & YTD <=38		
Preventable number of Clostridium Difficile Cases	5	1	0	0	1	1	0	0	2	1	1	0	1	**0**	**5**	No target		
Number of MSSA Bacteraemias - Post 48 Hours	16	5	2	1	0	2	2	0	2	4	1	3	1	**2**	**13**	No target		
Number of E.coli - Post 48 Hours	30	3	3	1	6	2	0	0	1	5	5	9	1	**4**	**25**	<=5.9167 & YTD <=71		
Number of P. Aeruginosa - Post 48 Hours	6			1	0	0	0	0	0	0	0	0	0	**0**	**0**	<=0.9167 & YTD <=11		
MRSA Elective Screening – Percentage of Inpatients Matched	70.66%	74.12%	68.42%	72.73%	68.69%	71.64%	71.18%	70.87%	66.70%	69.95%	67.19%	65.11%	66.30%	**70.42%**	**67.63%**	>=95%	94% - 93%	<=92%
Number of Klebsiella - Post 48 Hours	16			2	1	1	2	2	1	3	0	2	0	**1**	**7**	<=1.5834 & YTD <=19		
Mortality																		
Stillbirths Rate (including intrapartum & Other)	0.62%	0.95%	0.92%	0.48%	0.47%	**0.00%**	1.10%	0.26%	0.28%	0.87%	0.00%	0.55%	0.77%	**0.29%**	**0.65%**	<=0.47%		>=0.48%
Perinatal Deaths (0-7 days)	0.13%	0.00%	0.00%	0.00%	0.47%	0.30%	0.29%	0.26%	0.28%	0.00%	0.00%	0.00%	0.00%	**0.00%**	**0.14%**	<=0.1%		>=0.11%
Neonatal Deaths (8-28 days)	0.00%	0.00%	0.00%	0.00%	0.00%	0.30%	0.00%	0.00%	0.28%	0.00%	0.00%	0.28%	0.00%	**0.00%**	**0.14%**	<=0.1%		>=0.11%
Local SHMI - Relative Risk (1 Yr Rolling Data)	104.58	105.39	106.60	106.99	106.36	104.79	104.38	104.58	105.39	107.98	107.85				**107.85**	<=100	101 - 109	>=110
Hospital Standardised Mortality Rate (1 yr Rolling Data)	104.59	93.78	95.20	97.00	99.27	102.20	102.64	104.59	105.86	106.69	107.31	107.98			**107.98**	<=100	101 - 109	>=111
Crude Mortality Rate	1.58%	1.60%	1.91%	1.57%	1.81%	1.96%	1.73%	1.53%	1.76%	1.47%	1.45%	1.41%	1.57%	**1.14%**	**1.46%**	No target		
Coding and submissions to SUS																		
% Sign and Symptom as a Primary Diagnosis	7.77%	8.65%	7.79%	7.30%	7.19%	7.15%	7.44%	7.20%	6.67%	6.60%	6.35%	6.23%	7.72%	**6.39%**	**6.66%**	<=8.3%	8.4% - 9.4%	>=9.5%
Average co-morbidity score	5.83	5.79	5.69	5.76	6.09	6.05	5.97	6.11	6.33	6.15	6.01	6.21	6.34	**6.30**	**6.22**	>=5.08 / >=5.30 from April 20		<=4.7
Average Diagnosis per Coded Episode	6.9	6.89	6.96	6.8	6.95	7.29	7.22	7.29	7.59	7.55	7.28	7.31	7.53	**7.37**	**7.44**	>=6.14 / >=6.48 from April 20		<=5.8
Recruitment to Time and Target (Research)	81.63%	80.25%	81.94%	79.73%	79.22%	83.10%	83.56%	83.33%	80.30%	80.28%	81.82%	80.26%	80.30%	**83.78%**	**81.12%**	>=80%	76% - 79%	<=75%
Best Practice Guidance																		
Percentage Non-elective #NoF Patients With Admission to Procedure of < 36 Hours - BPT based on discharge	59.62%	67.57%	41.67%	57.45%	63.64%	60.00%	68.18%	64.62%	70.83%	60.78%	53.49%	81.08%	53.70%	**61.22%**	**62.77%**	>=85%	84% - 83%	<=82%
Breastfeeding - First Fed	68.70%	74.40%	72.60%	71.40%	70.60%	67.20%	68.30%	64.40%	63.30%	68.70%	65.00%	67.60%	68.20%	**in arrears**	**55.60%**	>=70%	66% - 69%	<=65%
Community																		
% Readmitted back in to Hospital within 30 days for Intermediate Care Beds	2.73%	0.00%	5.10%	1.60%	4.70%	2.00%	0.00%	2.30%	13.80%	2.90%	3.30%	6.30%	0.00%	**5.90%**	**5.20%**	No target		
Hospital admissions avoided by Community Nursing Services	2815	207	249	236	256	181	184	168	137	110	98	114	103	**86**	**648**	>=233 & YTD <=2796		

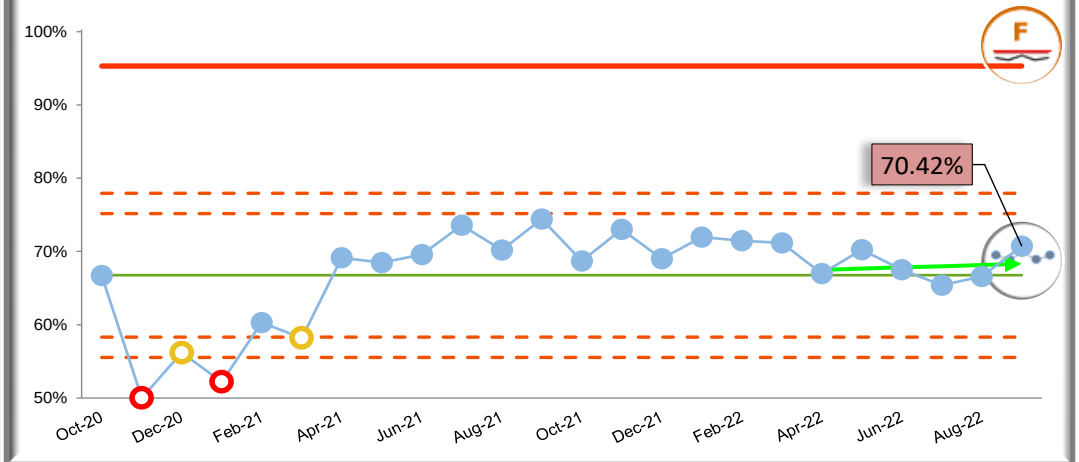
Effective - SPC Charts

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

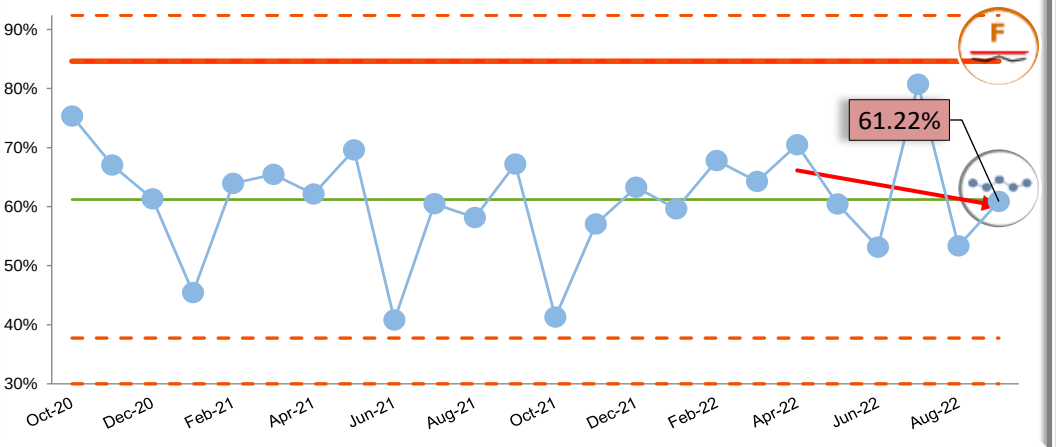
Preventable C-difficile



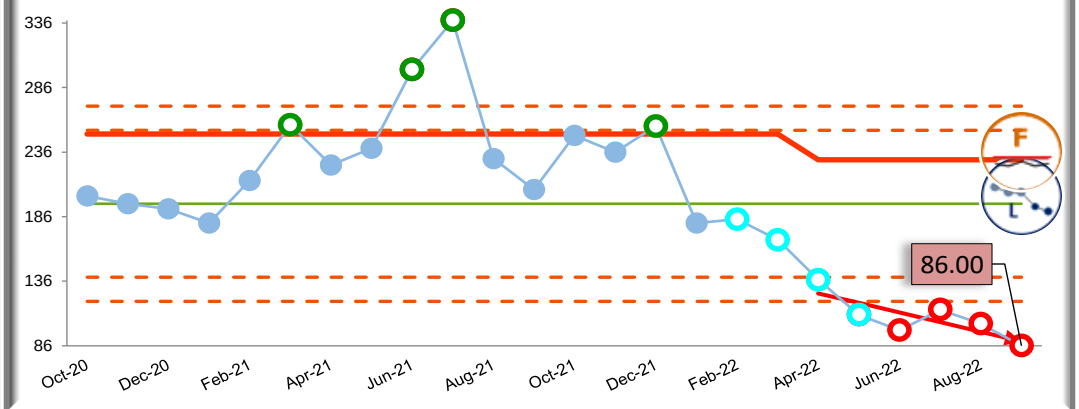
MRSA Elective Screening



FNoF< 36hrs BPT



Hospital Admissions avoided by Community Intervention



Effectiveness - Key messages

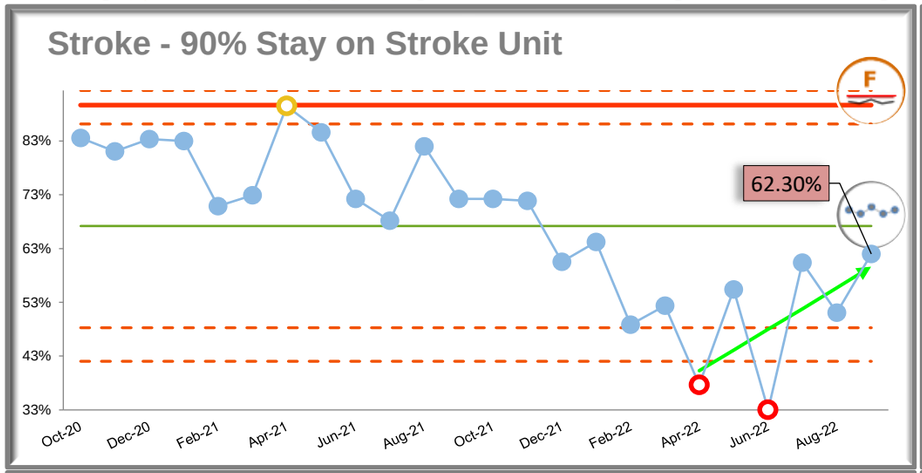
Area	Reality	Response	Result
Percentage Non-elective #NoF Patients With Admission to Procedure of < 36 Hours - BPT based on discharge	< 36 hour to theatre performance 61.22% in September 2022 YTD 62.77%	Continued in month to have a number of surges of admissions and a number of cancelled Trauma 2 lists.	Monitoring of performance at Directorate PRM with Division/Directorate DMT & #NOF MDT to review and assess performance Accountable: General Manager
Number of Hospital admissions avoided by Community Nursing services	86 hospital admissions were avoided as a result of intervention from Community nursing and Crisis intervention teams.	This has decreased from last month and is still below target. Continue to build upon existing admission avoidance capability and capacity including but not exclusive to acceleration of UCR project.	Reduction in Admissions to hospital of community patients. By when: October 2022 Accountable: Director of Operations
MRSA Elective Screening – Percentage of Inpatients Matched	MRSA Elective Screening is 70.42% for September, this is an increase from 66.30% in August but is below the 95% target.	A deep dive has been completed and has identified a cohort of patients that are not being screened, further clarification is required to establish if they require screening and therefore remain in the data or if they need to be excluded. Further work is ongoing with the data team and IPC to look into rectifying this.	Improvement should be seen by October data. Accountable: Infection Control Lead

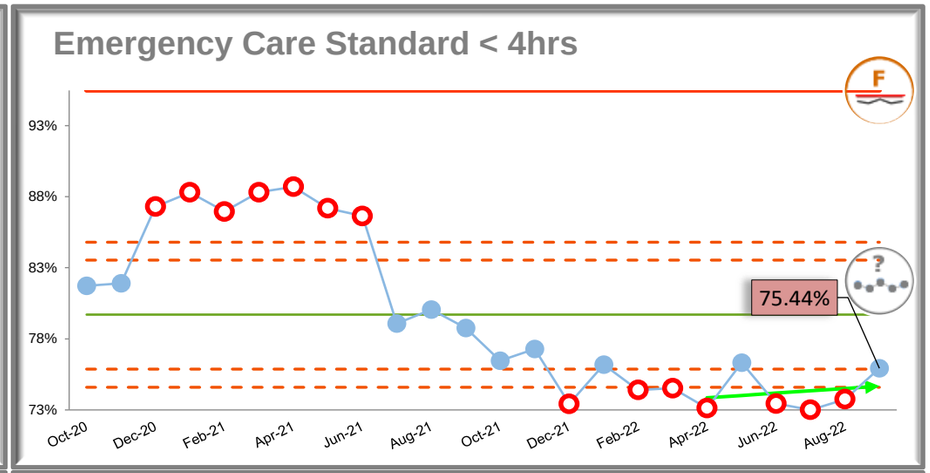
Responsive - Key measures

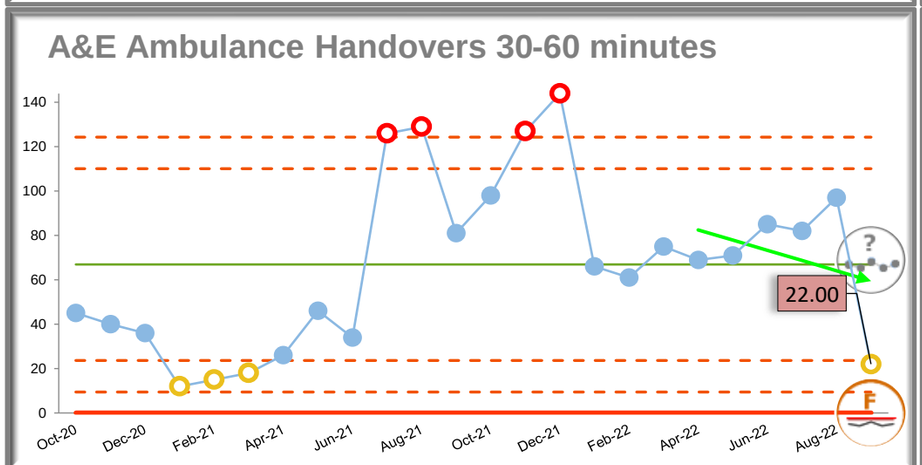
	21/22	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	YTD	Performance Range		
																Green	Amber	Red
Accident & Emergency																		
Emergency Care Standard 4 hours	78.99%	78.29%	75.97%	76.81%	72.95%	75.70%	73.92%	74.05%	72.64%	75.85%	72.97%	72.52%	73.27%	**75.44%**	**73.79%**	>=95%		<95%
Emergency Care Standard 4 hours inc Type 2 & Type 3	80.04%	79.30%	77.13%	78.15%	74.31%	76.83%	75.23%	75.42%	73.97%	77.08%	74.27%	73.93%	74.76%	**76.84%**	**75.14%**	>=95%		<95%
A&E Ambulance Handovers 15-30 mins (Validated)	6402	473	514	547	639	631	649	636	633	610	500	557	571	**539**	**3,410**	0		>=1
A&E Ambulance Handovers 30-60 mins (Validated)	1013	81	98	127	144	66	61	75	69	71	85	82	97	**22**	**426**	0		>=1
A&E Ambulance 60+ mins	430	30	94	44	79	52	27	17	26	15	30	27	32	**11**	**141**	0		>=1
A&E Trolley Waits (From decision to admission)	11	0	2	0	2	4	1	1	0	1	2	2	0	**2**	**7**	0		>=1
Proportion of patients spending more than 12 hours in an emergency department	1766	101	251	194	358	313	221	248	217	175	309	317	304	**196**	**1518**	0		>=1
Patient Flow																		
Right to Reside	55.19%	57.44%	55.23%	55.88%	55.12%	56.11%	56.11%	62.27%	64.46%	67.18%	67.35%	65.63%	65.41%	**64.37%**	**65.72%**	No target		
Coronary Care Delayed Discharges	248	15	not available	24	19	25	34	34	31	45	27	30	43	**17**	**193**	No target		
Green Cross Patients (Snapshot at month end)	845	79	89	81	53	79	54	87	78	64	69	86	80	**73**	**73**	<=40	41 - 45	>=45
Advice & Guidance responded within 48 hours	77.60%	78.80%	77.40%	75.40%	77.00%	76.50%	75.90%	74.30%	71.90%	71.80%	75.00%	70.40%	71.50%	**74.40%**	**72.50%**	>=80%	71% - 79%	<=70%
Stroke																		
% Stroke patients spending 90% of their stay on a stroke unit	69.87%	72.55%	72.58%	72.22%	60.87%	64.58%	49.15%	52.73%	38.00%	55.74%	33.33%	60.70%	51.39%	**62.30%**	**50.13%**	>=90%	89% - 86%	<=85%
% Stroke patients admitted directly to an acute stroke unit within 4 hours of hospital arrival	36.71%	42.00%	33.87%	33.33%	23.19%	16.67%	15.79%	25.45%	25.53%	28.81%	13.33%	24.60%	19.18%	**33.30%**	**23.59%**	>=90%		<=85%
% Stroke patients Thrombolysed within 1 hour	74.19%	33.33%	87.50%	100.00%	80.00%	80.00%	63.64%	83.33%	45.50%	70.00%	50.00%	42.90%	60.00%	**80.00%**	**60.38%**	>=55%		<=50%
% Stroke patients scanned within 1 hour of hospital arrival	44.67%	41.18%	38.71%	41.67%	42.25%	38.78%	44.07%	34.55%	52.00%	44.26%	37.33%	51.60%	36.99%	**47.50%**	**44.24%**	>=48%		<=45%
Cancellations																		
% Last Minute Cancellations to Elective Surgery	0.49%	0.61%	0.43%	0.84%	0.91%	0.56%	0.34%	0.54%	0.32%	0.80%	0.58%	1.00%	0.67%	**0.43%**	**0.63%**	<=0.6%		>=0.8%
Breach of Patient Charter (Sitreps booked within 28 days of cancellation)	8	0	0	1	2	4	0	0	0	0	0	0	0	**0**	**0**	0		>=2
No of Urgent Operations cancelled for a second time	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**	0		>=2
18 week Pathways (RTT)																		
18 weeks Pathways >=26 weeks open	9,383	11,695	11,568	11,189	11,480	10,485	8,853	9,383	9,928	9,549	8,714	8,171	8,211	**7,889**	**7,889**	0		>=1
RTT Waits over 52 weeks Threshold > zero	2,454	3211	3182	3062	3103	2667	2,609	2,454	2,503	2,326	2,052	1,957	1,920	**1,782**	**1,782**	0		>=1
% Diagnostic Waiting List Within 6 Weeks	80.78%	88.43%	90.99%	92.82%	81.59%	76.76%	79.46%	80.78%	79.30%	82.09%	85.80%	90.09%	88.41%	**93.45%**	**93.45%**	>=99%		<=98%
Cancer																		
Two Week Wait From Referral to Date First Seen	98.38%	98.80%	98.58%	99.21%	97.96%	98.39%	98.35%	97.56%	97.75%	98.46%	98.03%	97.76%	97.79%	**96.21%**	**97.65%**	>=93%	86% - 92%	<=85%
Two Week Wait From Referral to Date First Seen: Breast Symptoms	97.53%	97.96%	98.45%	96.84%	96.00%	93.84%	97.25%	93.50%	96.92%	96.27%	98.20%	97.83%	100.00%	**100.00%**	**98.22%**	>=93%		<=92%
31 Days From Diagnosis to First Treatment	98.21%	95.88%	94.89%	99.02%	99.37%	98.35%	99.39%	98.31%	97.56%	98.87%	99.00%	99.45%	97.80%	**98.84%**	**98.58%**	>=96%		<=95%
31 Day Subsequent Surgery Treatment	95.43%	84.78%	100.00%	92.59%	100.00%	93.33%	96.55%	94.44%	96.00%	100.00%	100.00%	100.00%	96.77%	**97.22%**	**98.53%**	>=94%		<=93%
31 day wait for second or subsequent treatment drug treatments	99.51%	100.00%	100.00%	100.00%	100.00%	95.45%	98.63%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	**98.70%**	**99.76%**	>=98%		<=97%
38 Day Referral to Tertiary	50.00%	52.17%	61.11%	50.00%	37.93%	35.00%	66.67%	30.77%	55.17%	64.71%	40.74%	28.57%	25.00%	**42.86%**	**42.40%**	>=85%		<=84%
62 Day GP Referral to Treatment	90.62%	89.77%	91.51%	93.43%	87.32%	89.59%	86.82%	89.71%	91.46%	87.70%	90.69%	85.32%	85.10%	**86.73%**	**87.76%**	>=85%	81% - 84%	<=80%
62 Day Referral From Screening to Treatment	59.47%	32.00%	55.56%	76.19%	81.25%	62.50%	50.00%	96.30%	92.59%	73.68%	70.37%	87.88%	87.50%	**87.50%**	**83.77%**	>=90%		<=89%
104 Referral to Treatment - Number of breaches - Patients Treated	23	1.5	1.5	1.5	1	1.5	4	6.5	0.5	3	3.5	5.5	2.5	**3.5**	**18.5**	0		>=1
104 Referral to Treatment - Number of breaches - Patients Still waiting	9	3	5	2	5	9	7	2	3	9	10	6	9	**9**	**9**	0		>=1
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%	70.56%	76.23%	78.16%	76.82%	76.50%	83.12%	79.54%	77.76%	76.91%	74.04%	75.88%	73.67%	**77.37%**	**75.87%**	>=75%		<=70%

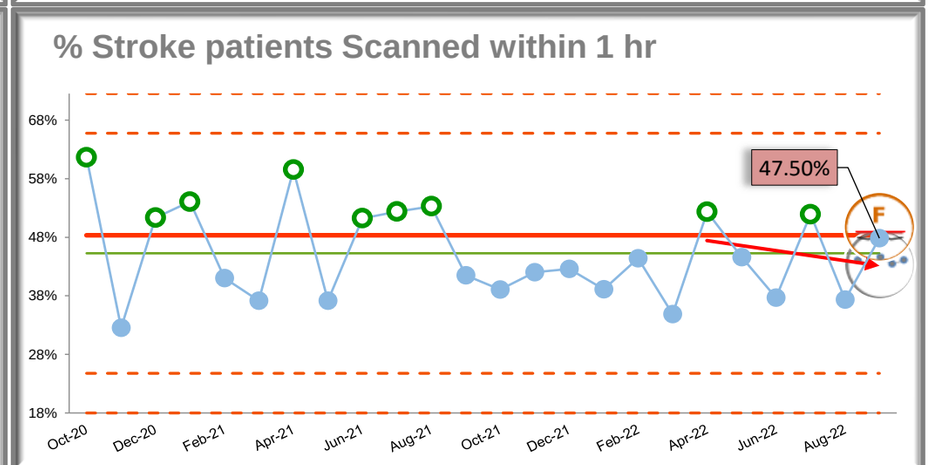
Responsive - SPC Charts

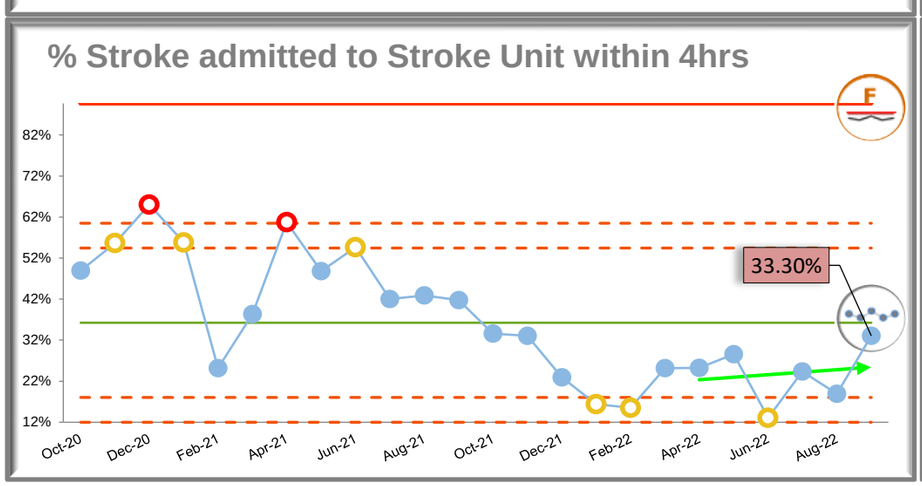
Warning | Critical | Activity | On Target | Trend | Target Line | Average Line | Control Line | Last 6 Points Directional Flow | RAG Rated Last Data Point

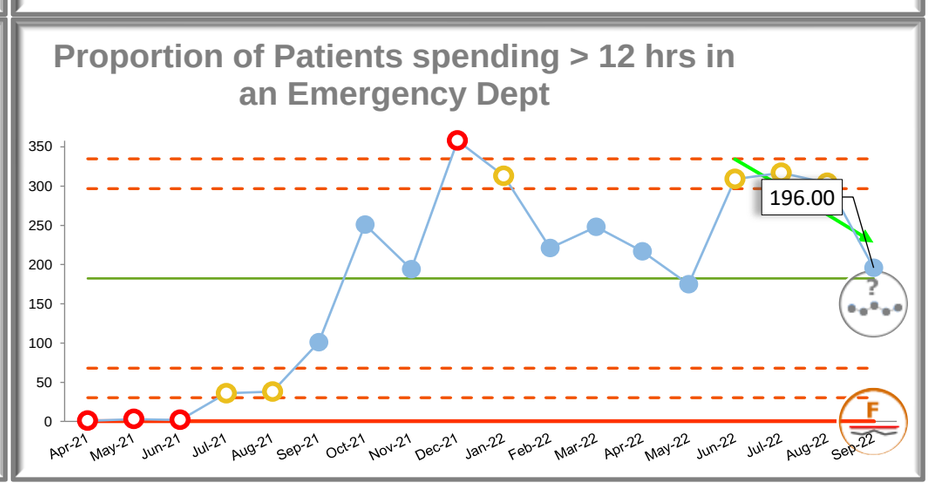








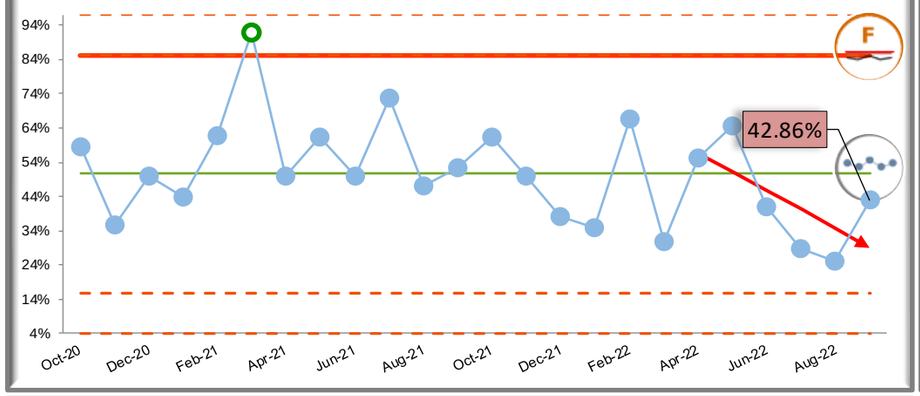




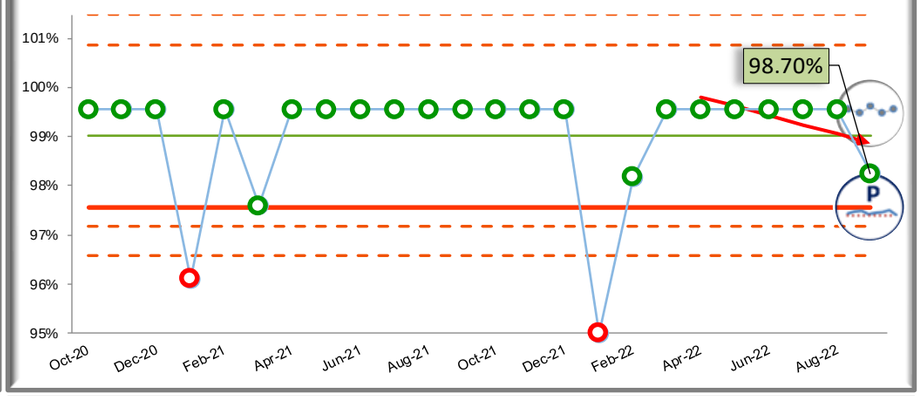
Responsive - SPC Charts

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

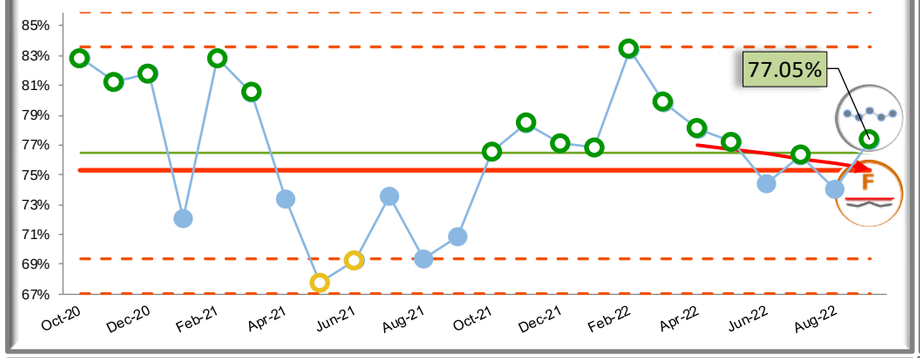
38 Day Tertiary Referral



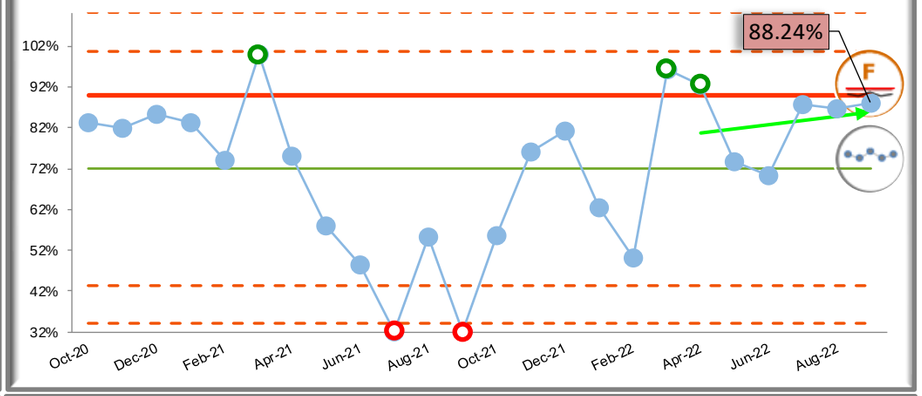
31 day 2nd or Subsequent drug Treatment



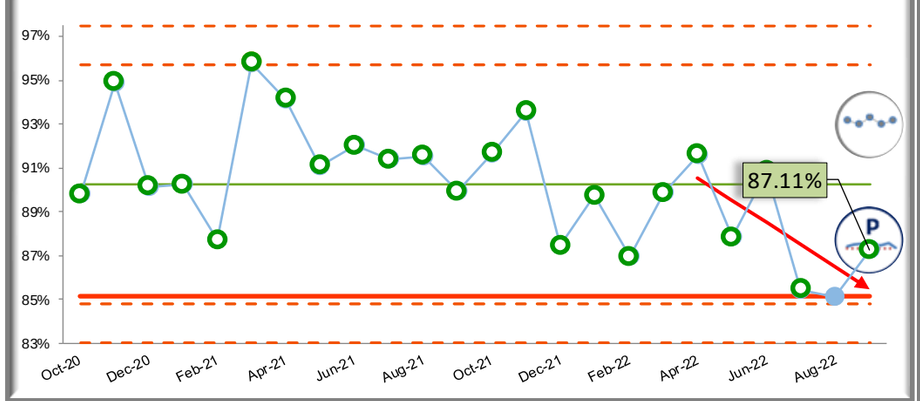
Faster Definitive Cancer Diagnosis within 28 days



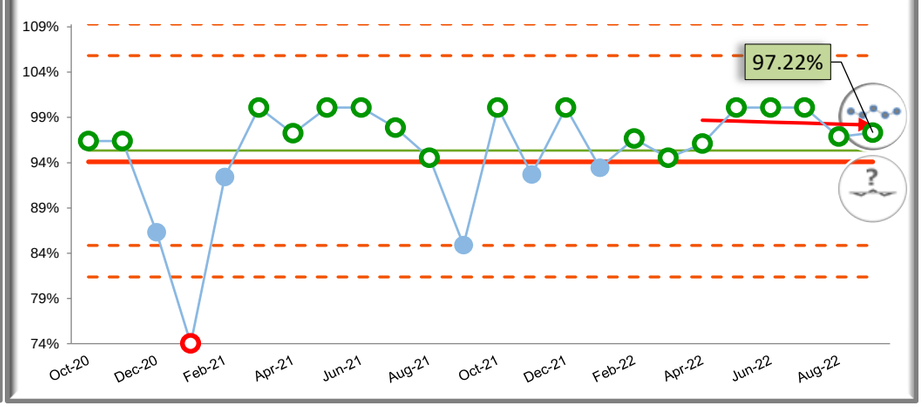
62 day Referral to Screening



62 day GP referral to Treatment



31 day Surgery to Treatment



Responsive - Key messages

Area	Reality	Response	Result
Emergency Care Standard 4 hours	ECS - <4 hours performance - 75.44% in month which is a slight improvement from 73.27% in August. A&E Ambulance Handovers 30-60 mins - 22 in month which is a significant improvement from 97 in August. A&E Ambulance Handovers over 60 mins - 11 in month which is improved from 32 in August. A&E Trolley Waits (from decision to admit) - 2 in September compared to 0 in August.	We continue to see an increased demand through both emergency departments. The medical bed base remains in an escalated position and super surge planning for winter for both emergency departments and the inpatient bed base has commenced. Further progress and development of the Paediatric area at the CRH site is underway with the £250k investment. A band 7 and band 5 have now been recruited and the paediatric ED will start to be implemented as the new recruits come on board.	Delivery of safe and effective patient flow with an outstanding patient experience. Appropriate capacity in place for each patient group attending ED and waiting times consistent with new national standards. A project plan has been put together which details a programme of improvement work over the next 2 years.
Stroke	% Stroke patients spending 90% of their stay on a stroke unit has increased in month to 62.3% from 51.39% the previous month. This remains below the 90% target. % Stroke patients admitted directly to an acute stroke unit within 4 hours of hospital arrival was 33.3% in month compared to 19.18% in August. This remains below the 90% target. % Stroke patients Thrombolysed within 1 hour was 80% in month which is an improvement from 60% in August. This is above the 55% target. % Stroke patients scanned within 1 hour of hospital arrival increased in month to 47.5% from 36.99% previous month. This remains very slightly below the 48% target.	There continues to be significant pressures on the service during September with performance extremely challenged. There continues to be an increased number of outliers due to a lack of capacity both in the inpatient bed base and community therapy. We are continuing to see increased demand through ED with monthly admissions increasing year on year: Average length of stay has also increased significantly since 2019. These two factors are meaning that performance against the four hour target and discharge into the community are both extremely challenging. The key action is now to complete and gain sign-off for the overall stroke business case which seeks to redesign both the inpatient service and the community offering. Approval has been given to developing a stroke assessment area on the stroke floor in the interim and work to implement this is underway.	Sustainable recovery of SSNAP A standard for Stroke services. Accountable: Divisional Director Medicine

Responsive - Key messages

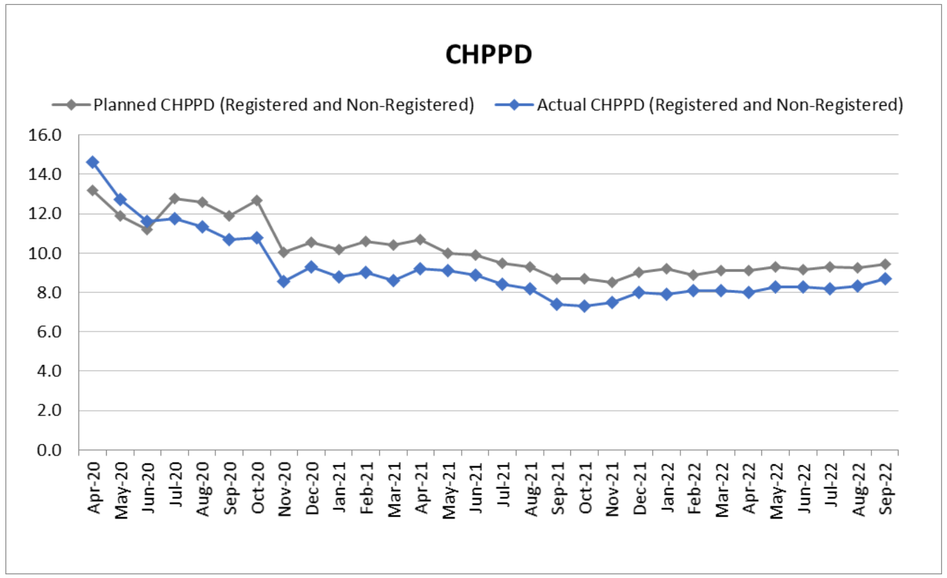
Area	Reality	Response	Result
38 Day Referral to Tertiary	This relates to clinic capacity running near day 14, then the ability of receiving timely diagnostics, which at this point is taking up to 3 weeks with reports. Therefore, patients can already be on day 35 before MDT.	There has been a high number of breaches. Changes have been made in clinics to see patients quicker, this has started to see an improvement. Diagnostics as with 62 days diagnostics has an impact on 38 days.	All patients sent to Tertiary centre by day 38 Accountable: General Manager
104 Day Referral to Treatment	Delays remains due to Covid and diagnosis delays with complex pathways.	Patient compliance at the beginning of the pathway can be difficult and work is ongoing with GPs and patient Navigators to try to improve this. The main reasons for delays as stated: diagnostics timely, Face to Face and theatre capacity. The 104 datix's process is being reviewed so that changes can be implemented and any learning needs to be shared.	Reduce number of patients waiting 104 days Accountable: General Manager
62 Day Referral From Screening to Treatment	Late referrals from screening and waits for MRI scans.	The issues with regards to capacity within LGI are the main concerns, due to face to face capacity and theatre demand.	Meet the screening Target Accountable: General Manager
Advice & Guidance responded within 48 hours	There has been an improvement in advice and guidance acted on within 48 hours. The current compliance for September being 74.4% with a Trust target of 80%.	This has been due to significant gaps in the rota due to leave and sickness so there has been a reliance on locums. Continue to monitor weekly, ensure A & G is allocated on rota when locum consultant is working.	Ensure the A&G target of 80% is met. Accountable: General Manager

Hard Truths: Safe Staffing Levels

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

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

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



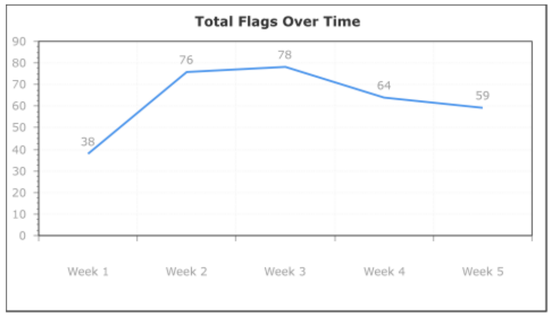
CHPPD provides a single, consistent and nationally comparable way of recording and reporting deployment of staff to provide care on inpatient wards. CHPPD is not a stand alone measure and should be used alongside clinical quality and safety outcome measures.

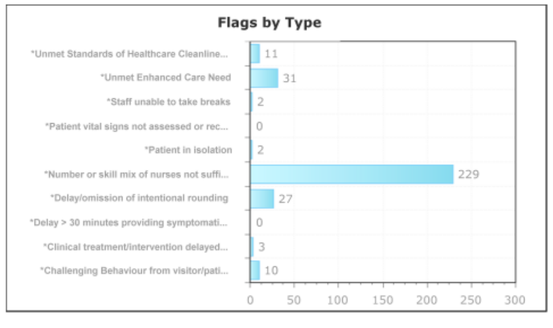
A review of September data indicates that the combined RN and non-registered clinical staff metrics resulted in 23 of the 28 clinical areas having fewer CHPPD than planned, with a total deficit of 0.7 CHPPD across the Trust compared to the planned position. The gap in CHPPD is at its broadest within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

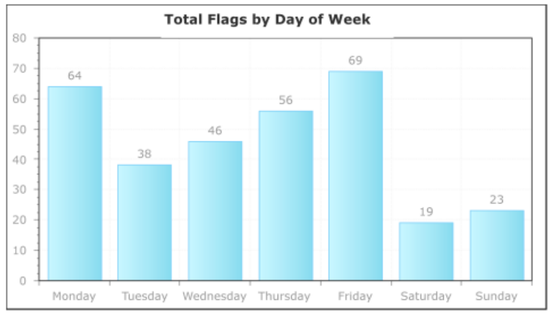
The 2021 successful recruitment to HCA roles has enabled increased shift fill to provide support to the reduced RN availability. However adjustment to workforce models and attrition has now created a vacancy pressure in this workforce group, which is being addressed by central recruitment. Professional judgement is used daily to redeploy staff on a shift basis and establish the safest staffing possible in all areas.
Challenges of the requirement to staff additional capacity areas continue to impact on the ability to staff all areas according to workforce model.

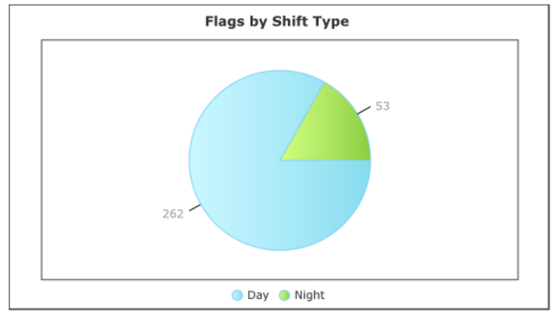
A review of the nurse sensitive indicators demonstrates incidence of falls within normal variation whilst pressure ulcer prevalence is slightly elevated in the medical division. This is being addressed through increased training.

STAFFING RED FLAG INCIDENTS









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

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

Hard Truths: Safe Staffing Levels (2)

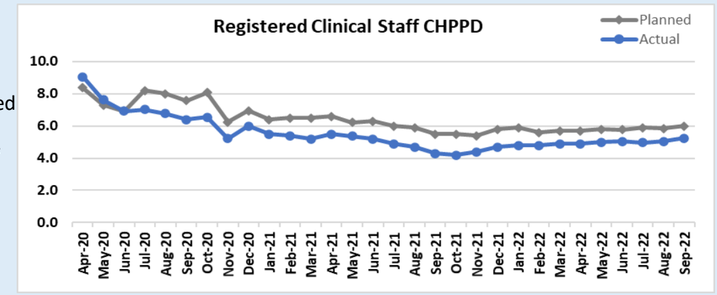
Aggregate Position **Trend** **Result**

CHPPD BY STAFF TYPE

Registered Clinical Staff

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

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

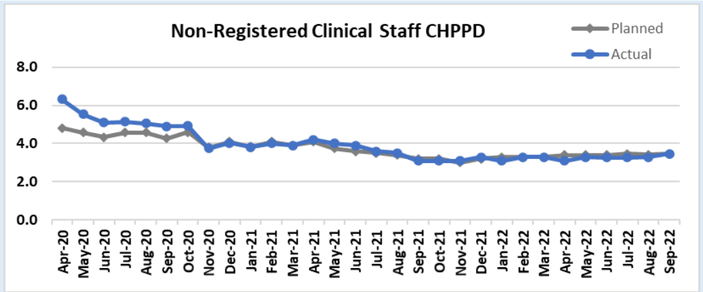


Overall there is a shortfall of 0.8 CHPPD against an overall requirement of 6.0 CHPPD for registered staff. Professional judgement informs decision-making at the twice daily staffing meetings to mitigate the risk across the clinical areas, and staff are redeployed to optimise safety. A suite of nurse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

Non-Registered Clinical Staff

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

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



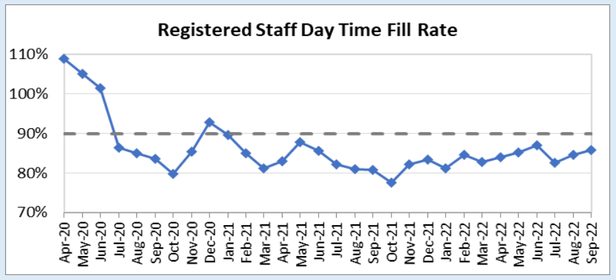
Overall the CHPPD delivered by non-registered clinical staff was as planned. The day time fill-rate percentage of non-registered clinical staff (table below) shows a slight increase on the previous two months and is attributed to the recruitment drive for this staff group.
Nightshift fill is prioritised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

FILL RATES BY STAFF AND SHIFT TYPE

Registered Clinical Staff Day

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

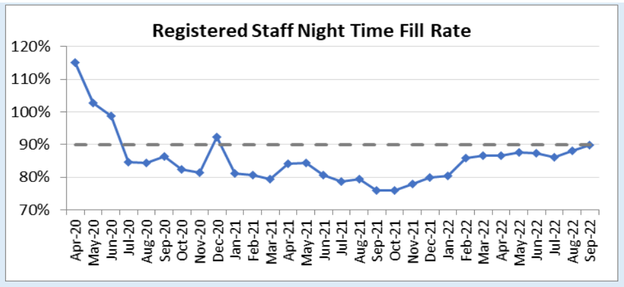
85.85% of expected Registered Clinical Staff hours were achieved for day shifts.



Registered Staff Night

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

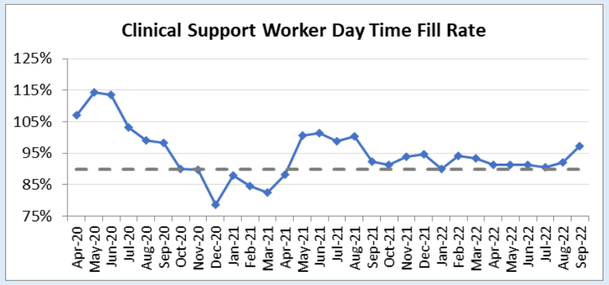
89.78% of expected Registered Clinical Staff hours were achieved for night shifts.



Non-Registered Clinical Staff Day

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

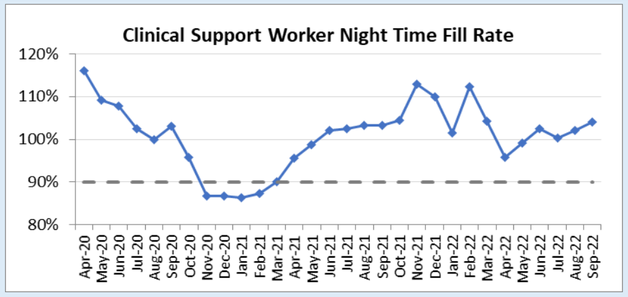
97.25% of expected Non-Registered Clinical Staff hours were achieved for Day shifts.



Non-Registered Clinical Staff Night

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

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



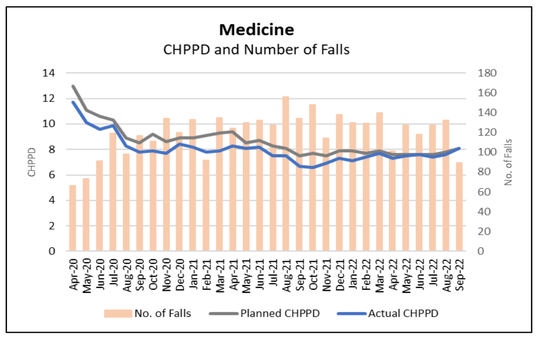
Safe | Caring | Effective | Responsive | Workforce | Efficiency/Finance | Activity | CQUIN

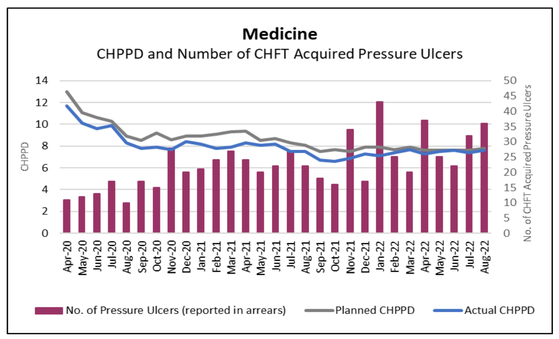
Hard Truths: Safe Staffing Levels (3)

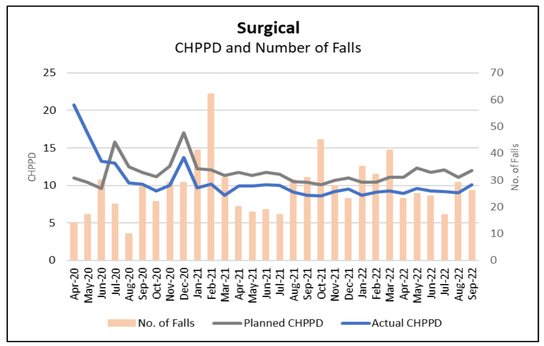
NURSING QUALITY INDICATORS AND FILLRATES BY WARD AND DIVISION

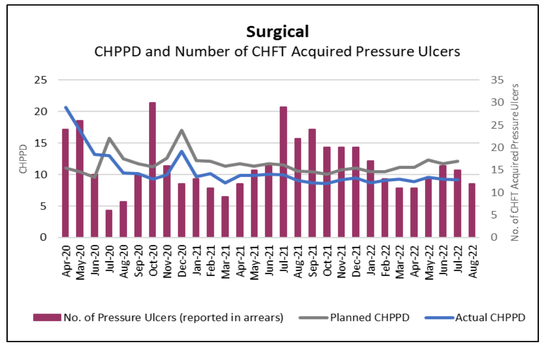
Ward	Average Fill Rates: DAY - Registered Clinical Staff (%)	DAY - Non Registered Clinical Staff (%)	NIGHT - Registered Clinical Staff (%)	NIGHT - Non Registered Clinical Staff (%)	CHPPD: Total PLANNED CHPPD	Total ACTUAL CHPPD
CRH ACUTE FLOOR	90.4%	91.1%	100.6%	97.1%	8.4	7.9
HRI ACUTE FLOOR	93.6%	91.3%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

Nursing Quality Indicators









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

Hard Truths: Safe Staffing Levels (4)

Conclusions and Recommendations

Conclusions

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

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

Workforce - Key Metrics

	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	YTD	Target	Threshold/Monthly
Staff in Post																
Staff in Post Headcount	6009	6083	6127	6127	6164	6146	6170	6109	6109	6101	6094	6087	6129	-	-	
Staff in Post (FTE)	5326.86	5400.30	5441.13	5437.83	5471.83	5451.37	5473.01	5411.91	5404.28	5399.06	5397.81	5368.15	5435.91	-	-	
Vacancies																
Establishment (Position FTE)**	5461.62	5527.50	5556.86	5556.33	5554.69	5582.19	5588.27	-	5814.35	5835.60	5837.38	5840.51	5855.60	-	-	
Vacancies (FTE)**	134.76	127.20	115.73	118.50	82.86	130.82	115.26	-	410.07	436.54	439.57	472.36	419.69	-	-	*April data has not been included due to issues with the Establishment which have been corrected for May 2022
Vacancy Rate (%)**	2.47%	2.30%	2.08%	2.13%	1.49%	2.34%	2.06%	-	7.05%	7.48%	7.53%	8.09%	7.17%	-	-	
Staff Movements																
Turnover rate (%) - in month	0.55%	0.60%	0.62%	0.68%	0.50%	0.49%	1.21%	0.63%	0.80%	0.77%	0.72%	0.85%	0.89%	-	-	
Executive Turnover (%)	0.00%	33.33%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-	-	
Turnover rate (%) - Rolling 12m	7.74%	7.89%	7.91%	7.94%	7.83%	7.90%	8.28%	8.59%	8.52%	8.71%	8.63%	8.93%	9.23%	-	**11.50%**	<=11.5% Green, <=12.5 >11.5% amber, >12.5% Red
Retention/Stability Rate (%) - rolling 12m	89.29%	89.15%	89.14%	88.94%	88.77%	87.85%	88.44%	87.17%	87.46%	87.26%	87.25%	87.02%	86.75%	-	-	
Sickness Absence - Rolling 12 month																
Sickness Absence rate (%) - rolling	4.89%	5.00%	5.01%	5.12%	5.43%	5.45%	5.77%	5.96%	6.00%	6.01%	6.06%	6.03%	5.98%	-	**4.00%**	=< 4.0% - Green 4.01% -4.5% Amber >4.5% Red
- Of which Covid related absence	0.56%	0.57%	0.52%	0.54%	0.77%	0.82%	0.94%	1.06%	1.09%	1.13%	1.23%	1.26%	1.26%	-	-	
- Of which Non Covid related absence	4.33%	4.43%	4.49%	4.58%	4.66%	4.63%	4.83%	4.90%	4.91%	4.88%	4.82%	4.77%	4.73%	-	**4.75%**	=< 4.75% Green, >4.75% - <5.25% Amber, =>5.25% Red
Long Term Sickness Absence rate (%) - rolling	3.36%	3.39%	3.38%	3.38%	3.40%	3.42%	3.46%	3.50%	3.49%	3.45%	3.39%	3.34%	3.30%	-	**2.50%**	=< 2.5% Green 2.5% -2.75% Amber >2.75% Red
- Of which Covid related absence	0.29%	0.29%	0.28%	0.26%	0.25%	0.25%	0.25%	0.26%	0.26%	0.26%	0.25%	0.25%	0.24%	-	-	
- Of which Non Covid related absence	3.07%	3.10%	3.10%	3.12%	3.15%	3.17%	3.21%	3.24%	3.23%	3.20%	3.15%	3.10%	3.06%	-	**3.00%**	=< 3.00% Green, >3.00% - <3.25% Amber, =>3.25% Red
Short Term Sickness Absence rate (%) - rolling	1.53%	1.61%	1.63%	1.74%	2.04%	2.14%	2.31%	2.46%	2.51%	2.56%	2.66%	2.69%	2.68%	-	**1.50%**	=< 1.5% - Green 1.5% -1.75% Amber >1.75% Red
- Of which Covid related absence	0.27%	0.28%	0.24%	0.28%	0.52%	0.57%	0.69%	0.80%	0.83%	0.87%	0.99%	1.01%	0.24%	-	-	
- Of which Non Covid related absence	1.26%	1.33%	1.39%	1.46%	1.52%	1.57%	1.62%	1.66%	1.68%	1.69%	1.68%	1.67%	1.66%	-	**1.75%**	=< 1.75% Green, >1.75% - <2.00% Amber, =>2.00% Red
Attendance rate (%) - rolling	95.11%	95.00%	94.99%	94.88%	94.57%	94.55%	94.23%	94.04%	95.09%	93.99%	93.94%	93.97%	94.02%	-	**96.00%**	
Sickness Absence - Monthly																
Sickness Absence rate (%) - in month	5.59%	5.74%	5.54%	6.35%	8.74%	6.08%	6.35%	6.36%	4.90%	5.14%	6.06%	5.30%	5.21%	-	-	
- Of which Covid related absence	0.57%	0.65%	0.45%	1.05%	3.66%	1.32%	1.65%	1.71%	0.62%	0.82%	1.69%	0.82%	0.51%	-	-	
- Of which Non Covid related absence	5.02%	5.10%	5.09%	5.30%	5.08%	4.76%	4.70%	4.66%	4.28%	4.32%	4.37%	4.49%	4.70%	-	-	
Long Term Sickness Absence rate (%) - in month	3.62%	3.35%	3.35%	3.59%	3.58%	3.38%	3.23%	3.25%	3.13%	3.08%	3.02%	3.33%	3.29%	-	-	
- Of which Covid related absence	0.25%	0.20%	0.24%	0.25%	0.38%	0.33%	0.27%	0.31%	0.28%	0.19%	0.15%	0.17%	0.13%	-	-	
- Of which Non Covid related absence	3.37%	3.15%	3.11%	3.34%	3.20%	3.05%	2.96%	2.93%	2.85%	2.90%	2.87%	3.06%	3.16%	-	-	
Short Term Sickness Absence rate (%) - in month	1.97%	2.39%	2.19%	2.76%	5.16%	2.70%	3.12%	3.12%	1.77%	2.06%	3.04%	1.97%	1.92%	-	-	
- Of which Covid related absence	0.33%	0.44%	0.21%	0.80%	3.28%	1.00%	1.37%	1.39%	0.34%	0.63%	1.54%	0.65%	0.38%	-	-	
- Of which Non Covid related absence	1.64%	1.95%	1.98%	1.96%	1.88%	1.70%	1.75%	1.73%	1.43%	1.43%	1.50%	1.32%	1.54%	-	-	
Attendance rate (%) - in-month	94.41%	94.26%	94.46%	93.65%	91.26%	93.92%	93.65%	93.64%	95.10%	94.86%	93.94%	94.70%	94.8%	-	**96.00%**	
Attendance Management																
Sickness Absence FTE Days Lost -in month	8852.57	9527.81	8956.75	10627.70	14727.34	9276.14	10745.12	10297.59	8185.08	8303.94	10112.80	8881.89	8881.89	-	-	
Average days lost (FTE) per FTE - Rolling 12 month	17.57	17.87	17.92	18.36	19.51	19.96	20.75	21.51	21.69	21.78	21.96	21.88	21.85	-	-	
Sickness Absence Estimated Cost (£) - month	£0.86M	£0.85M	£0.92M	£0.85M	£0.99M	£0.87M	£0.89M	£1.00M	£0.74M	£0.76M	£0.94M	£0.83M	£0.79M	-	-	
Return to work Interviews (%)	66.83%	68.50%	64.70%	53.48%	62.05%	60.67%	64.85%	73.12%	70.97%	68.13%	65.02%	60.32%	57.19%	-	**80.00%**	=>90% Stretch Blue, 80% Green, 65%-79% Amber, <65% Red
Health & Wellbeing Risk Assessment																
Percentage completion	51.88%	52.17%	52.70%	52.94%	53.18%	47.37%	47.37%	48.53%	48.80%	49.23%	49.23%	49.23%	51.17%			
Spend																
Substantive Spend (£)	£24.95M	£22.14M	£22.40M	£21.61M	£22.61M	£22.53M	£34.68M	£22.97M	£23.15M	£24.43M	£22.85M	£22.41M	£26.14M	-	-	*Increase in Sept due to pay award
Bank Spend (£)	£3.42M	£3.36M	£3.44M	£3.37M	£3.89M	£3.42M	£5.71M	£2.34M	£2.54M	£1.18M	£2.41M	£3.26M	£3.77M	-	-	
Agency Spend (£)	£0.54M	£0.55M	£0.73M	£0.66M	£0.84M	£0.91M	£0.95M	£0.87M	£0.92M	£0.47M	£1.12M	£1.16M	£1.20M	-	-	
Agency Ceiling (£)	£0.74M	£0.74M	£0.74M	£0.74M	£0.74M	£0.74M	£0.74M	£0.50M	£0.50M	£0.51M	£0.48M	£0.53M	£0.49M	-	-	
Variance from Ceiling (£)	£0.20M	£0.19M	£0.00M	£0.07M	-£0.11M	-£0.17M	-£0.22M	-£0.37M	-£0.43M	£0.04M	-£0.64M	-£0.63M	-£0.70M	-	-	
Total Spend (£)	£28.91M	£26.06M	£26.57M	£25.64M	£27.35M	£26.86M	£41.34M	£26.19M	£26.61M	£26.08M	£26.38M	£26.82M	£31.10M	-	-	
Proportion of Temporary (Agency) Staff	1.87%	2.10%	2.76%	2.59%	3.09%	3.38%	2.30%	3.32%	3.47%	1.79%	4.23%	4.32%	3.84%	-	-	
Essential Safety (12m rolling)																
Overall Essential Safety Compliance	93.81%	93.22%	93.01%	93.28%	92.50%	92.57%	92.90%	92.54%	92.94%	92.61%	92.63%	91.89%	90.46%	-	**90.00%**	>=90% Green >=85%<90% Amber <85% Red
Conflict Resolution (3 Year Refresher)	95.22%	94.36%	92.45%	90.21%	92.02%	91.84%	92.48%	91.88%	91.37%	91.49%	91.59%	91.10%	91.51%	-	**90.00%**	>=90% Green >=85%<90% Amber <85% Red
Data Security Awareness (1 Year Refresher)	90.45%	89.77%	90.22%	88.61%	88.88%	89.50%	89.83%	88.94%	89.59%	89.00%	89.30%	88.84%	88.14%	-	**95.00%**	>=95% Green >=85%<95% Amber <85% Red
Dementia Awareness (No Renewal)	97.02%	96.93%	96.93%	95.78%	96.81%	97.07%	97.14%	97.36%	97.26%	97.48%	97.45%	96.23%	95.79%	-	**90.00%**	>=90% Green >=85%<90% Amber <85% Red
Equality and Diversity (3 Year Refresher)	94.45%	93.07%	92.92%	91.40%	93.40%	93.90%	94.45%	94.12%	94.56%	94.51%	94.61%	93.88%	93.89%	-	**90.00%**	>=90% Green >=85%<90% Amber <85% Red
Fire Safety (1 Year Refresher)	91.65%	90.60%	90.79%	90.53%	89.55%	89.74%	90.66%	88.57%	88.36%	85.54%	84.98%	85.08%	86.21%	-	**90.00%**	>=90% Green >=85%<90% Amber <85% Red
Health and Safety (3 Year Refresher)	94.63%	93.27%	93.10%	91.56%	92.66%	92.62%	93.17%	93.71%	94.42%	94.77%	94.88%	93.79%	94.05%	-	**90.00%**	>=90% Green >=85%<90% Amber <85% Red
Infection Control (1 Year Refresher)	91.72%	91.43%	91.36%	90.68%	90.14%	90.77%	90.49%	90.46%	91.30%	90.41%	90.46%	89.65%	89.16%	-	**90.00%**	>=90% Green >=85%<90% Amber <85% Red
Manual Handling (2 Year Refresher)	92.95%	92.70%	92.12%	92.75%	91.60%	90.57%	91.09%	91.26%	91.77%	92.70%	92.99%	92.30%	91.72%	-	**90.00%**	>=90% Green >=85%<90% Amber <85% Red
Safeguarding (3 Year Refresher)	93.40%	93.41%	93.31%	92.52%	93.26%	92.81%	93.05%	92.53%	92.93%	93.41%	92.51%	91.95%	91.42%	-	**90.00%**	>=90% Green >=85%<90% Amber <85% Red
Learning Disabilities Awareness (No renewal)									40.54%	57.57%	66.46%	72.60%	77.18%	-	90.00%	>=90% Green >=85%<90% Amber <85% Red
Appraisal																
Appraisal (1 Year Refresher) - Non-Medical Staff	44.51%	54.57%	60.90%	61.72%	63.51%	65.54%	69.06%	0.64%	2.79%	5.94%	9.36%	17.18%	48.64%	-	**95.00%**	>=95% Green >=90%<95% Amber <90% Red
Appraisal (1 Year Refresher) - Medical Staff (Rolling 12mth)	62.67%	67.79%	69.10%	70.31%	72.91%	74.86%	82.43%	82.31%	81.50%	82.97%	83.79%	83.15%	82.47%	-	**95.00%**	>=95% Green >=90%<95% Amber <90% Red

** Vacancy information is updated monthly and is based on the funded establishment held in ESR, this is updated monthly by Finance colleagues based on the establishment information stored in the Trust's financial systems.

- Sickness absence reporting has been enhanced to provide a clear split of the overall sickness rate composition by COVID / Non-COVID related absence, this will allow for post-COVID comparison to a non-COVID absence rate indicator
- 12 month rolling absense has been RAG rated using the 2022/2023 targets. While it wasn't in use last year the current targets have been applied to the data for reference and ease of comparison. *blue was previous years target for reference
- Sickness absence data does not include self / household / shielding isolation due to COVID-19.
- The RTW compliance position reported reflects activity data held in ESR as of 18 October 2022. This can change as activity is continued to be recorded within ESR for the reporting period 1 September 2022 to 30 September 2022, beyond the report production date of 21 October 2022. The final monthly compliance figure will be updated in next month's report.

Workforce Key Metrics

Workforce - Key Metrics

**April figures have not been included due to issues with Establishment data. These have been corrected for May 2022.

WORKFORCE	Current Month Score	Previous Month	Trend	Change	NHSi Submitted Position
Staff In Post (Headcount)	**6129**	6087	↑	42	-
Staff In Post (FTE)	**5435.9**	5368.2	↑	67.76	-
Establishment (FTE)**	**5855.6**	5840.5	↑	15.09	-
Starters	**59.59**	**73.79**	↓	-14.21	-
Leavers	**45.93**	**43.61**	↓	2.32	-
Vacancies (FTE) **	**419.69**	472.4	↑	-52.67	-
Vacancies (%) **	**7.17%**	8.09%	↑	-0.92%	-
Turnover Rate (rolling 12 month) (%)	**9.23%**	8.93%	↓	0.30%	*11.5%

ATTENDANCE MANAGEMENT	Current Month Score	Previous Month	Trend	Change	Target
Non Covid Sickness Absence Rate (rolling) (%)	**4.73%**	**4.77%**	↑	-0.04%	4.75%
Non Covid Long Term Sickness Absence Rate (rolling) (%)	**3.06%**	**3.10%**	↑	-0.04%	3.00%
Non Covid Short Term Sickness Absence Rate (rolling) (%)	**1.66%**	**1.67%**	↑	-0.01%	1.75%
Non Covid Sickness Absence Rate (month) (%)	**4.70%**	**4.49%**	↓	0.21%	4.75%
Non Covid Long Term Sickness Absence Rate (month) (%)	**3.16%**	**3.06%**	↓	0.10%	3.00%
Non Covid Short Term Sickness Absence Rate (month) (%)	**1.54%**	**1.32%**	↓	0.22%	1.75%
Return to work interviews completed (%)	**57.2%**	**60.3%**	↓	-3.13%	80.00%

*The RTW compliance position reported reflects activity data held in ESR as of 18 October 2022. This can change as activity is continued to be recorded within ESR for the reporting period 1 September 2022 to 30 September 2022, beyond the report production date of 21 October 2022. The final monthly compliance figure will be updated in next month's report.

APPRAISAL	Current Month Score	Previous Month	Trend	Change	Target
Appraisal (YTD)	**48.64%**	17.18%	↑	31.46%	95.00%
Medical Appraisal (YTD)	**82.47%**	83.15%	↓	-0.68%	95.00%

ESSENTIAL SAFETY TRAINING	Current Month Score	Previous Month	Trend	Change	Target
Data Security Awareness (1 Year Refresher)	**88.14%**	88.84%	↓	-0.70%	95.00%
Infection Control (1 Year Refresher)	**89.16%**	89.65%	↓	-0.48%	90.00%
Fire Safety (1 Year Refresher)	**86.21%**	85.08%	↑	1.12%	90.00%
Manual Handling (2 Year Refresher)	**91.72%**	92.30%	↓	-0.58%	90.00%
Safeguarding (3 Year Refresher)	**91.42%**	91.95%	↓	-0.53%	90.00%
Conflict Resolution (3 Year Refresher)	**91.51%**	91.10%	↑	0.41%	90.00%
Equality & Diversity (3 Year Refresher)	**93.89%**	93.88%	↑	0.02%	90.00%
Health, Safety & Wellbeing (3 Year Refresher)	**94.05%**	93.79%	↑	0.26%	90.00%
Dementia Awareness (No Renewal)	**95.79%**	96.23%	↓	-0.44%	90.00%
Learning Disabilities Awareness***	**77.18%**	72.60%	↑	4.57%	90.00%

↔	No movement from previous month	*	Internal target rather than NHSi Submitted Position
↑	Improvement from previous month		Not achieving target
↓	Deterioration from previous month		Achieving target

***Learning Disabilities Awareness EST commenced from 10 May 2022, however is not included in Overall EST Compliance score or Domain Score totals

* The recruitment data has been realigned to take into account the National Streamlining agenda and targets set locally. Data shows agenda for change (AFC) recruitment and Medical and Dental (M&D) only and excludes recruitment activity relating to deanery doctors, retirement, volunteers and rolling adverts.

** Current figures exclude non-clinical and corporate vacancies which are subject to a vacancy freeze from May 2022 to October 2022

	AfC		Medical		All				
RECRUITMENT**	Current Month Avg Days	Previous Month	Current Month Avg Days	Previous Month	Current Month Avg Days	Previous Month	Trend	Change	Target (Days)
Vacancy approval to advert placement	9.8	7.8	14.7	3.8	**10.0**	7.8	↓	2.2	8
Shortlisting to interview	3.4	3.6	9.6	5.1	**3.9**	3.8	↓	0.1	12
Interview to conditional offer	2.8	2.1	1.4	0.7	**2.6**	2.0	↓	0.6	6
Pre employment to unconditional offer	21	23.2	9	54.0	**20.7**	24.1	↑	-3.4	18
Unconditional Offer to Acceptance	2.8	0.00	1.4	4.0	**2.6**	4.0	↑	-1.4	3

Vacancy approval to advert placement-The average number of days between a vacancybeing submitted for approved and the advert being placed.

Shortlisting to interview- The average number of days between date vacancy closed and date invited to interview

Interview to conditional offer- The average number of days between the interview date and the date of informing of a decision.

Pre employment to unconditional offer -The average number of days between the date Conditional Offer letter sent & the date Unconditional Offer letter sent

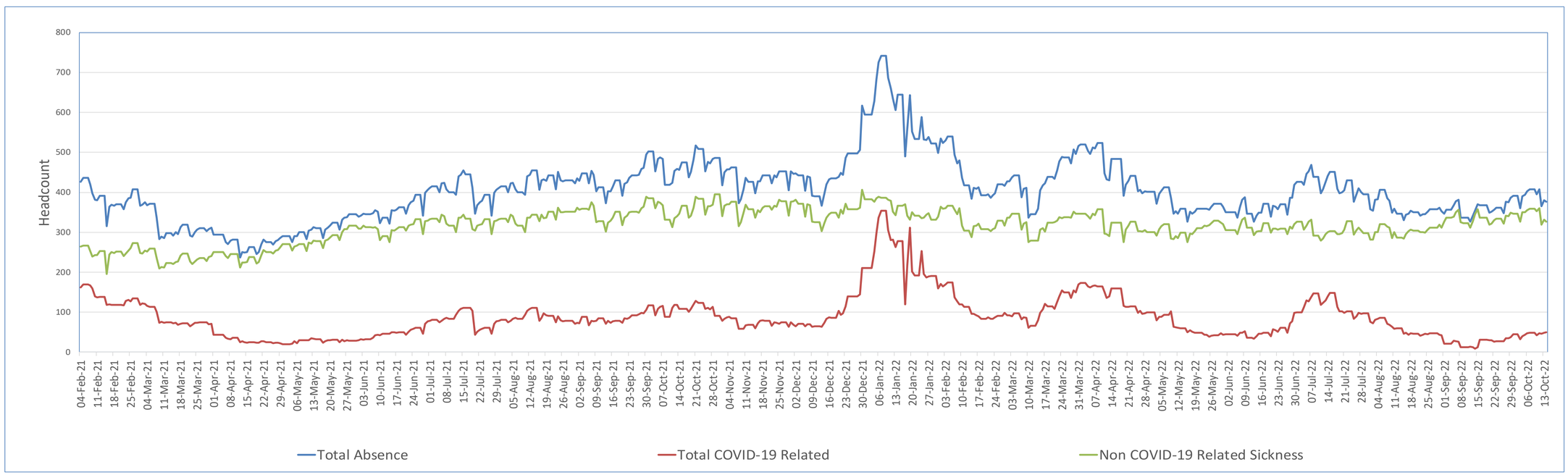
Unconditional Offer to Acceptance - The average number of days for Unconditional Offer to Acceptance

PAY	Current Month Spend	Previous Month	Trend	Change	Target (Budget)
Substantive Expenditure	**£26.14M**	£22.41M	↓	£3.73M	£26.14M
Agency Expenditure	**£1.20M**	£1.16M	↓	£0.04M	£1.20M
Agency Ceiling Cap	**£0.49M**	**£0.53M**	-	-	-
Variance from Ceiling	**£0.70M**	£0.63M	↓	-	-
Bank Expenditure	**£3.77M**	£3.26M	↓	£0.52M	£3.77M

** Current month spend for September includes pay rise award back payments

COVID-19 - Key Metrics

ABSENCE



Workforce Absence	@ 16 Sept 2022	
	Headcount	% of workforce
Absence - COVID-19 Related	31	0.5%
Absence - Sickness (Non COVID-19 Related)	337	5.1%
Total Absence	368	5.6%

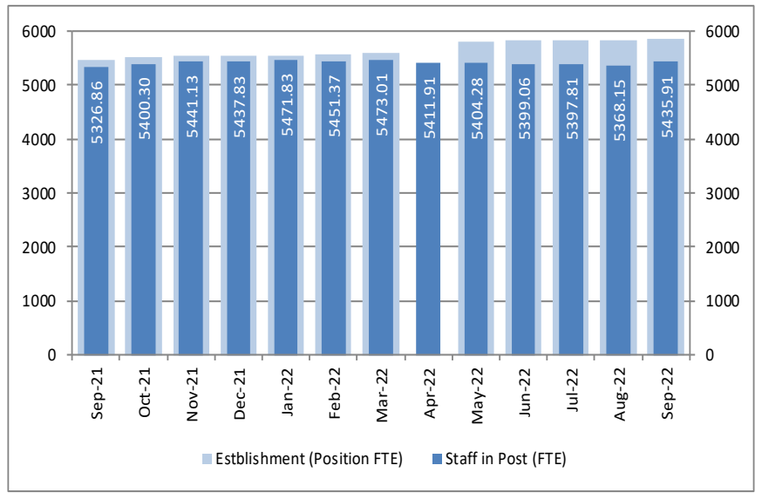
Workforce Absence	@ 14 Oct 2022	
	Headcount	% of workforce
Absence - COVID-19 Related	50	0.8%
Absence - Sickness (Non COVID-19 Related)	376	5.7%
Total Absence	426	6.4%

6617

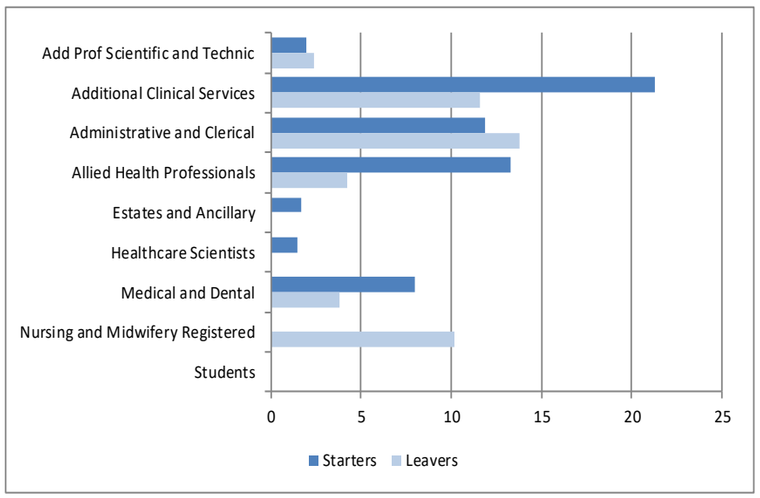
Covid Related Key Metrics

Reality

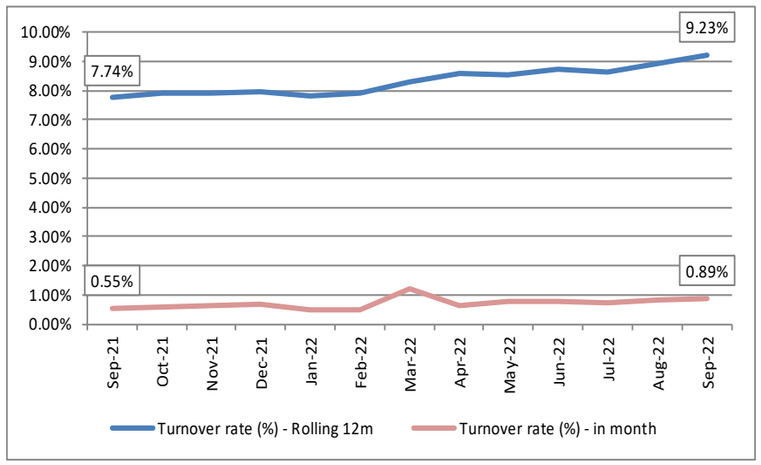
Staff in Post (FTE) v Establishment (FTE)



Starters & Leavers (FTE) by Staff Group - September 2021



Turnover



Turnover by Staff Group

Staff Group	In-Month	Rolling
Add Prof Scientific and Technic	1.50%	10.48%
Additional Clinical Services	0.97%	9.98%
Administrative and Clerical	1.26%	11.53%
Allied Health Professionals	0.92%	14.16%
Estates and Ancillary	0.00%	10.37%
Healthcare Scientists	0.00%	7.33%
Medical and Dental	0.99%	8.76%
Nursing and Midwifery Registered	0.60%	5.97%

Result

Have a Retention Strategy with interventions aimed at key staff groups which currently have a high turnover.

Response

Retention

The Trust has recently relaunched it's People Strategy.

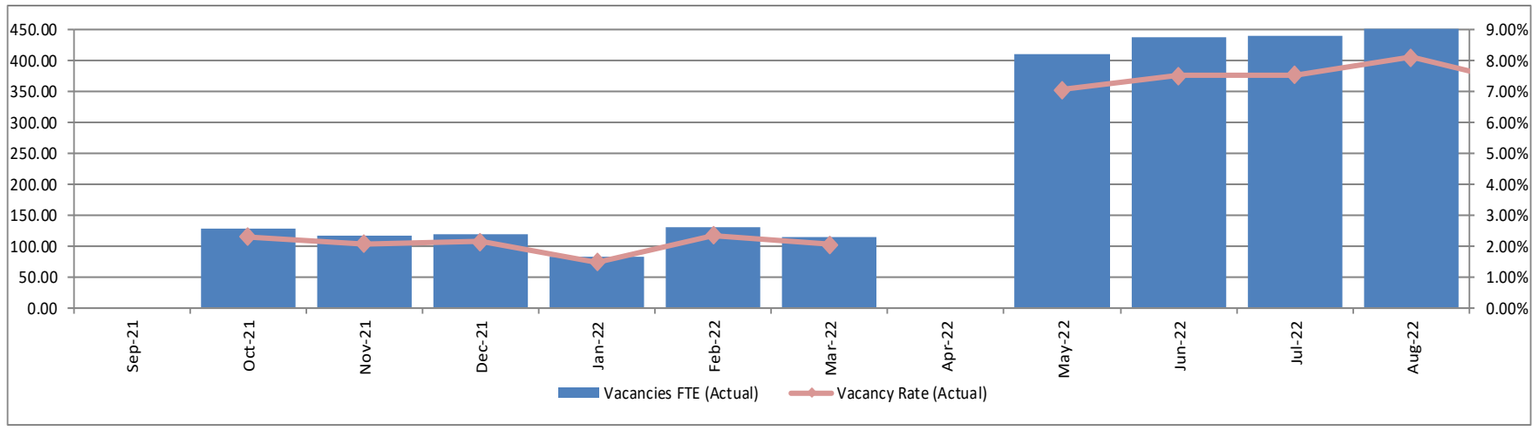
A focused piece of work to undertake a self-assessment against the Nursing and Midwifery Retention Tool is underway and an action plan will be developed to address this.

HCSW retention review is underway and actions to address an increasing number of leavers is being developed.

Staff in Post / Starters & Leavers / Turnover

Reality

Vacancies



**April figures have not been included due to issues with Establishment data. These have been corrected for May 2022. Between year end March 2022 and May 2022 there has been a decrease of 68.73 FTE Actual and and increase of 226.08 FTE Establishment leading to an overall increase in vacancies of 294.81 FTE

Vacancies by Staff Group

Staff Group	Establishment (FTE)	Actual (FTE)	Vacancies (FTE)
Add Prof Scientific and Technic	182.98	159.60	23.38
Additional Clinical Services	1243.91	1200.18	43.73
Administrative and Clerical	1185.39	1095.09	90.30
Allied Health Professionals	496.90	460.36	36.54
Estates and Ancillary	54.42	56.63	-2.21
Healthcare Scientists	133.10	129.99	3.11
Medical and Dental	710.09	648.63	61.46
Nursing and Midwifery Registered	1848.81	1685.44	163.37
Students	0.00	0.00	0.00
Total	**5855.60**	**5435.91**	**419.69**

Additional Clinical Services Breakdown

Role	Establishment (FTE)	Actual (FTE)	Vacancies (FTE)
Asst./Associate Practitioner Nursing	1.93	2.43	-0.50
Health Care Support Worker	43.84	44.95	-1.11
Healthcare Assistant	771.66	690.28	81.38
Nursery Nurse	1.76	1.76	0.00
Nursing Associate	51.20	57.49	-6.29
Trainee Nursing Associate	1.00	52.72	-51.72
Total (Unregistered Nursing)	**871.39**	**849.63**	**21.76**

Other Additional Clinical Service	372.52	350.55	21.97

Recruitment:
Recruitment of Newly Qualified Nurses from September 2022 is now complete. There are currently 69 new graduates, the majority starting their positions on 26 September and will be delivering patient care as part of the rostered shifts by the end of October in most areas. This will contribute significantly to our commitment to retract from the use of agency staff to provide patient care.
International recruitment at the Trust continues to provide a second pipeline of recruits throughout the year. We are on plan to meet the ambitious target of 100 international RN recruits during 2022, and are now in receipt of an offer from NHS England to bid for funds to secure further recruitment of international nurses by the end of March 2023.
Recruitment of the next cohort of apprentices to top-up from Nursing Associate to Registered Nurses (NA to RN) is complete with 7 nursing associates commencing the programme 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. Further work is underway to evaluate how this route to recruitment of registered nurses could be used to target 'hard to recruit to' specialisms and support the 'grow our own' strategy.
This year CHFT are also supporting the introduction of degree apprenticeships in Physiotherapy and Occupational Therapy alongside Operating Department Practitioners
Actions to mitigate staffing risks:
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.
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.
Work continues to maximise the use of Health Roster 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 head-rooms. The summer round of the bi-annual staffing review, known as 'Hard Truths', is now complete with some slight adjustments to a minority workforce models informed by patient dependency using the validated Safer Nursing Care Tool as well as review of the nursing quality indicators with professional judgement.

Result

CHFT to be the employer of choice in a competitive environment through a recruitment strategy which includes candidate attraction to the Trust.

Response

Medical Recruitment

A 'Welcome to UK Practice' session was held 8th September for some of our international graduates who are new to the UK. This is delivered by the General Medical Council, as a training opportunity which highlights some of the differences in health care settings within the NHS compared to those of other countries. There is an overview of different pamphlets and guidance that are available from the GMC and provides an opportunity to consider responses to different scenarios that are often experienced in day-to-day work. For example, maintaining patient confidentiality whilst being co-operative with police investigations, as well as duties of a doctor in accordance with Good Medical Practice. There is another session scheduled for late October as a number of new international doctors are due to commence in post over the next few weeks. The attendees also get the opportunity to build networks and for some peer support from colleagues in different specialties. Feedback from delegates is always really positive.

The new cohort of trainees commenced in post in September without any delays. These were predominantly higher trainees rotating from other Trusts. Medical Education arranged an induction, and the new Guardian of Safe Working Hours attended to talk about the 2016 contract and exception reporting. The Guardian also invited trainees to attend the Junior Doctor Forum so that they can contribute to discussions about any issues or changes that trainees would wish to address. Dr Sukumar also talked about the Junior Doctors Awards for 2023, as previous awards have been received so positively. A new cohort of trainees are due to commence in post in early October, and induction is being arranged for them. Work is still ongoing to complete pre-employment checks to ensure that they can all commence as expected without delay.

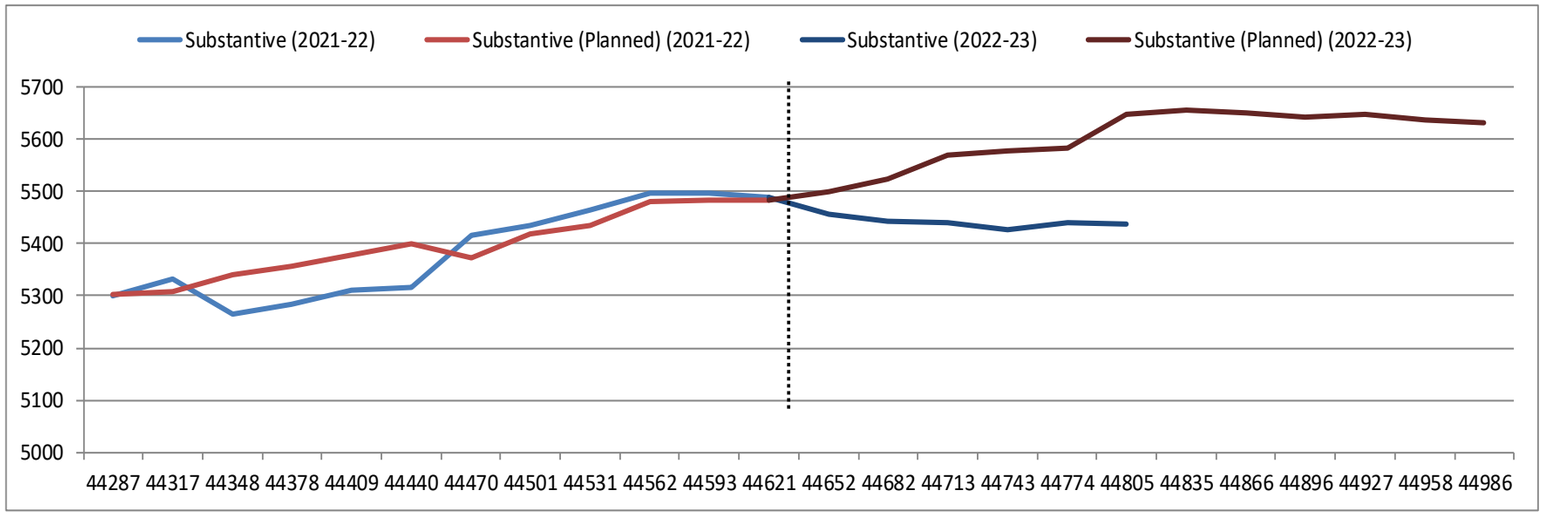
A number of new SAS/Trust doctors are due to commence during September and early October in Anaesthesia, ENT, Oral and Maxillo-facial Surgery in addition to 1 x ED Consultant, 2 Consultant Anaesthetists, and a Uro-gynaecology Consultant.

Agreement has been reached in principle with the LNC and BMA regarding the approach to the Local Clinical Excellence Awards for 2022/2023 and we are working towards making payments to those eligible in November 2022

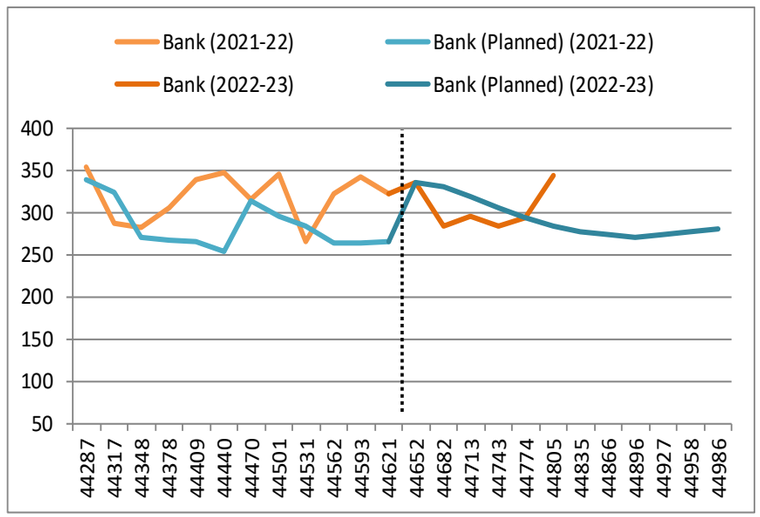
Vacancies

Reality

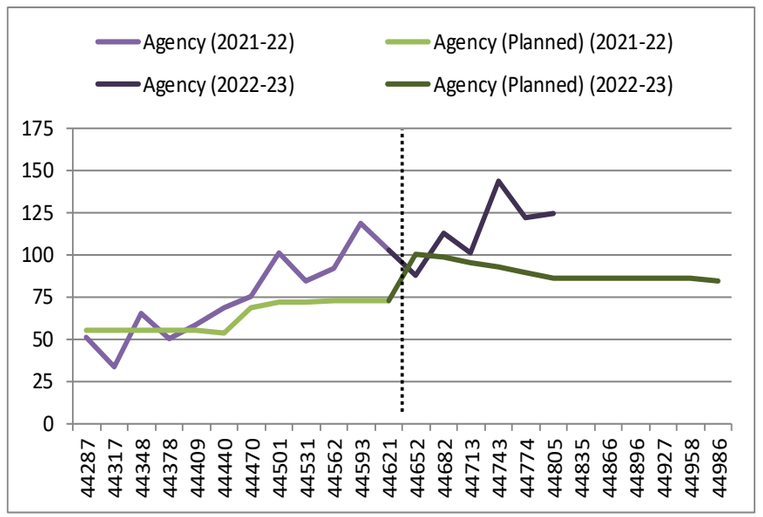
Substantive



Bank



Agency



Result

Increasing the substantive workforce whilst reducing the reliance on bank and agency usage.

These graphs show the FTE worked in-month for substantive, bank and agency workers, against the planned figures submitted to NHSi at the start of the financial year.

Response

These graphs show the contracted hours for substantive staff, and the hours worked in-month for bank/agency workers converted to FTE, against the most recent planned workforce figures submitted to NHSE/I.

The full year plan for 2022-23 has been submitted to the ICS in April 2022.

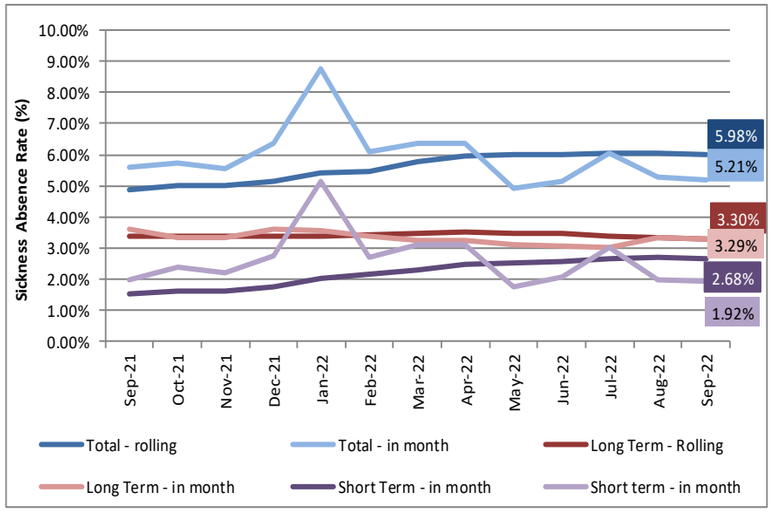
The ICS now requires a multi-year workforce plan to be developed, separate from the normal NHSI operational planning. The Trust submission has been submitted for combining into a place based workforce plan.

Substantive actuals are currently 211 FTE below the planned position for September 2022. Some of this difference will be attributable to the freeze on A&C recruitment and an increased level of turnover. The substantive gap along with ongoing availability, recovery and covid staffing requirements will adversely affect required bank and agency usage as it evident by continuing increased bank and agency use and the Trust not meeting the agency ceiling target.

Workforce Plan

Reality

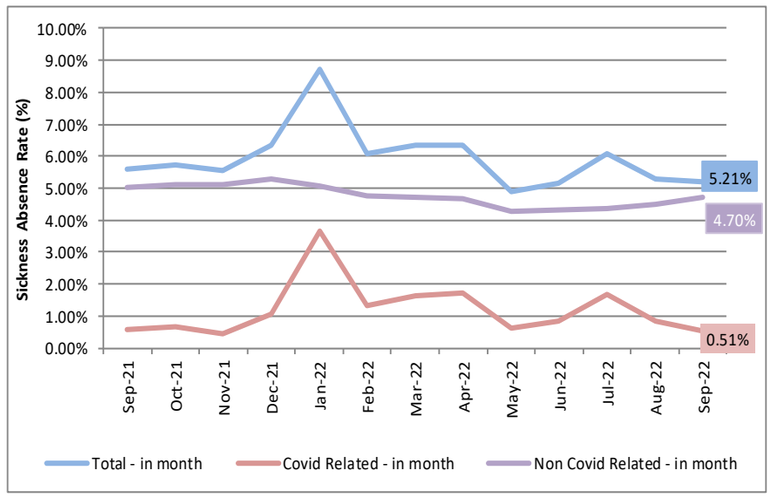
Sickness Absence



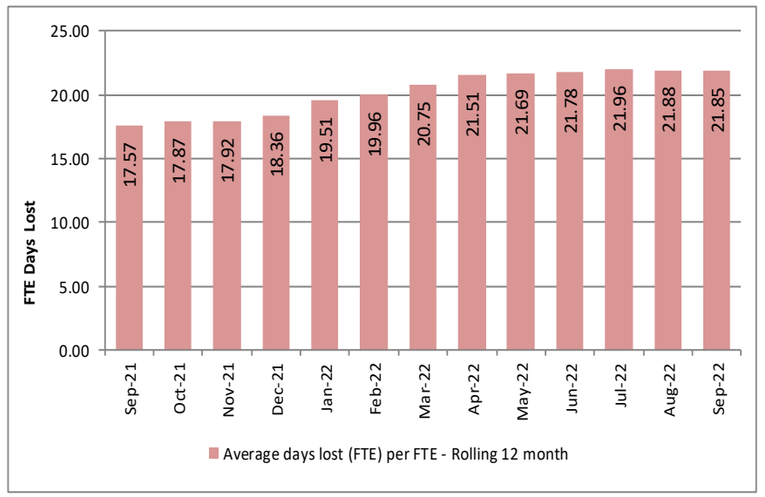
Sickness Absence Reasons - September 21

Reason	FTE Days Lost	%
S10 Anxiety/stress/depression/other psychiatric illnesses	2884.28	34.13%
S15 Chest & respiratory problems	959.56	11.36%
S12 Other musculoskeletal problems	844.28	9.99%
S25 Gastrointestinal problems	711.57	8.42%
S28 Injury, fracture	543.26	6.43%
S13 Cold, Cough, Flu - Influenza	524.79	6.21%
S11 Back Problems	319.95	3.79%
All Other Reasons	1662.45	19.67%

Covid / Non-Covid Related Sickness Absence (monthly)



Average Days Lost Per FTE - rolling 12 month



Result

Robust attendance management is in place to ensure rolling 12 month attendance rates achieve the 96% target.

Response

Sickness absence data does not include self / household / shielding isolation.

Colleagues continue to follow revised Covid guidance for employees as per DOH guidance. Singular lateral flow tests kits are available from the site Commanders on each hospital site.

Health and wellbeing questionnaires continue to be submitted to the department, although only 5 were received during September. Assessments for Covid Age and pregnancy concerns with letters of recommendations to managers are provided where required by the individual.

Throughout September the Occupational Health department issued 238 appointments, 29 of which were DNAs. 75 Colleagues attended for vaccinations / vaccination checks. A further 12 did not attend for their appointments. In addition 77 management referral appointments for first assessment were successfully completed. A further 13 booked appointments resulted in DNA. Nurses carried out a further 38 follow up review appointments during September, 2 of which were not attended. Key reasons for management referrals continue to be for mental health and musculoskeletal reasons.

The covid booster programme for Trust employees commenced as planned on the 12.09.22. This is being led by Carol Pinder with OH taking a supportive role due to staffing challenges. The clinics are being alternated on a weekly basis between CRH and HRI.

The immunisation of clients with the monkey pox vaccine attending the Sexual health service continues. This is reported on a daily basis by the sexual health team into NHS England.

Sickness Absence

Reality

Sickness Absence - in-month

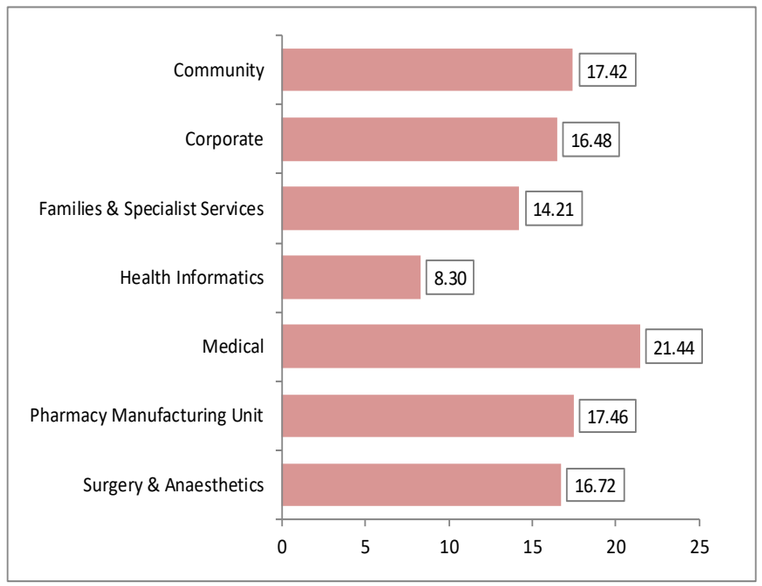
Division	Aug-22	Sep-22
Community	3.89%	4.77%
Corporate	3.51%	4.52%
Families & Specialist Services	3.94%	3.89%
Health Informatics	2.85%	2.27%
Medical	5.41%	5.87%
Pharmacy Manufacturing Unit	4.65%	4.78%
Surgery & Anaesthetics	4.89%	4.58%

* April 2022+ reported figure for Non Covid Absence

Sickness Absence by Staff Group - rolling 12 month

Staff Group	Short Term	Long Term	Total
Add Prof Scientific and Technic	1.60%	4.06%	5.66%
Additional Clinical Services	2.48%	4.96%	7.43%
Administrative and Clerical	1.10%	2.09%	3.20%
Allied Health Professionals	1.43%	1.87%	3.30%
Estates and Ancillary	2.30%	8.30%	10.60%
Healthcare Scientists	2.22%	2.30%	4.52%
Medical and Dental	0.92%	1.02%	1.94%
Nursing and Midwifery	1.75%	3.25%	5.00%
Students	0.00%	0.00%	0.00%

Average Days Lost Per FTE - rolling 12 month



Response

*The National Workforce Data set which is maintained by NHS Digital has been updated and version 3.2 was approved and published by the Data Alliance Partnership Board. Following this update the Job Role of Operating Department Practitioner has changed Staff Group from Additional Professional Scientific and Technical to Allied Health Practitioner. This change is reflected within the data following the ESR June system update.

The **Medicine** division reported no change to the overall absence total in month. Sickness remains above trust target at 6.50% with the Acute Medical Directorate being a hotspot area. Management of long term sickness continues and the HRA liaises with the Wellbeing Team on a weekly basis to ensure appropriate interventions are in place for those that need it. RTWI compliance is noted to have decreased again from 53.82% to 53.54% and the divisions appraisal compliance rate is currently 38.17%.

In **Community**, all long term absence cases have a plan is in place for all colleagues which has resulted in an overall decrease in total sickness absence to 3.8% below Trust target. Particular focus has been placed on colleagues absent with Stress, Anxiety and Depression, our highest reason for absence. Colleagues have been made aware of the support available from the Trust and regular reviews meetings are been held. Community Nursing has an overall sickness absence rate of 5.18% and a deep dive will be undertaken to ensure the reasons for absence and support and support and a management plan are in place. Return to work compliance remains a concern with compliance decreasing to 50% a 10% reduction from last month. Specific work continues with line mangers regarding the importance of recording RTW interviews and HRA's continue to identify those line managers who consistently fail to record their RTW Interviews All elements of EST remain over 90% compliance and non-complaint colleagues are identified to line managers. . Over 50% of appraisals have been completed.

Result

Robust attendance management is in place to ensure rolling 12 month attendance rates achieve the 96% target.

Response

The **Surgery & Anaesthetics** Division have seen a continued decrease in absence to 4.58% for October2022. Support remains in place for managers to continue managing any sickness effectively, and targeted work continues from the wellbeing team. Operating Services and Critical Care remain the areas experiencing the highest level of absence but additional support remains to try and decrease and sustain this. The RTW has increased this month to 66.31% and work will continue to promote the importance of conducting a good RTW and the benefits of this.

In **THIS**, the total absence has again decreased and remains below target with overall absence at 3.14%. Return to work interviews have decreased from 88.902% to 60.23% and focus will be placed on the importance of recording this month

Total Absences in **Corporate** remains below target at 3.51%. HRA's continue to ensure colleagues are supported and a regular meetings are in place to support a return to work. RTW compliance has decreases significantly from 71.935 to 33% and as a result HRA's will contact line managers who are non-compliant to discuss what is preventing RTW interviews being recorded.

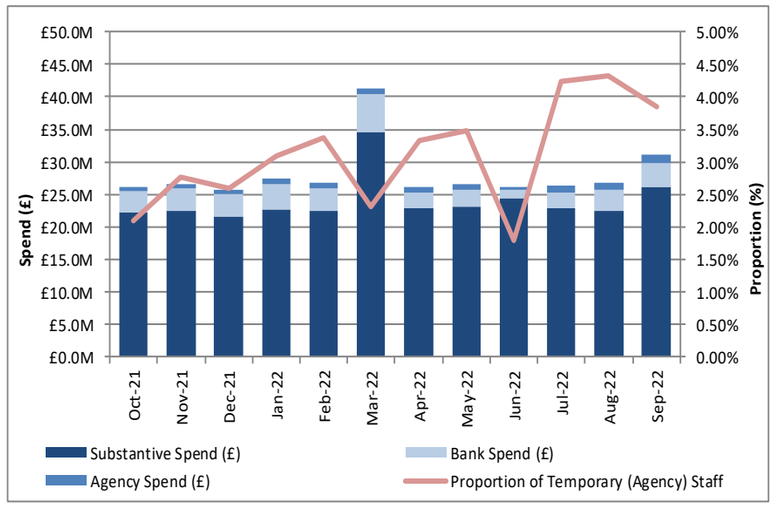
In **PMU** the total absence has increased for the second month from 5.46% to 6.61%. Long term has increased from 3.93% to 5.05% however short term has decreased slightly from 1.63% to 1.56%. A series of Attendance Management sessions have been held in September and were well attended by PMU line mangers. RTW compliance has improved significantly to 57.14%.

Absence in **FSS** has decreased again and remains below trust target 4.55% in month and 4.5% for the rolling 12 months. Return to work interview compliance continues to maintain around 60%, work continues to ensure colleagues are aware of gaps and the need to record information within ESR or the roster system as appropriate.

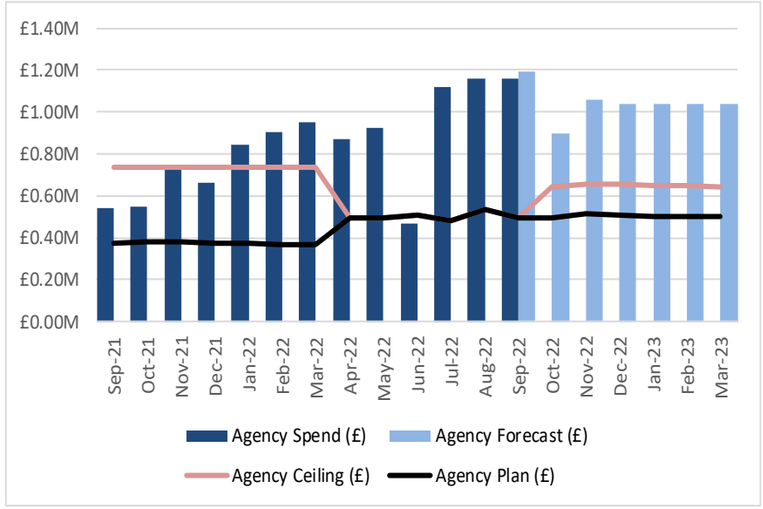
Sickness Absence - Divisional/Staff Group

Reality

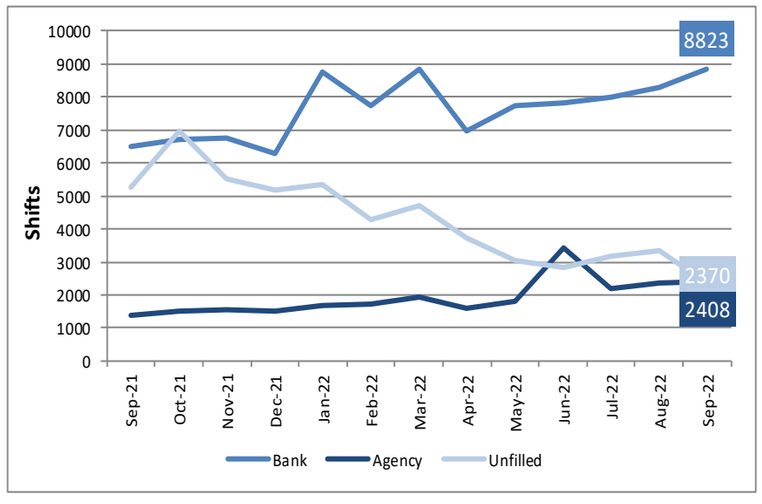
Workforce Spend



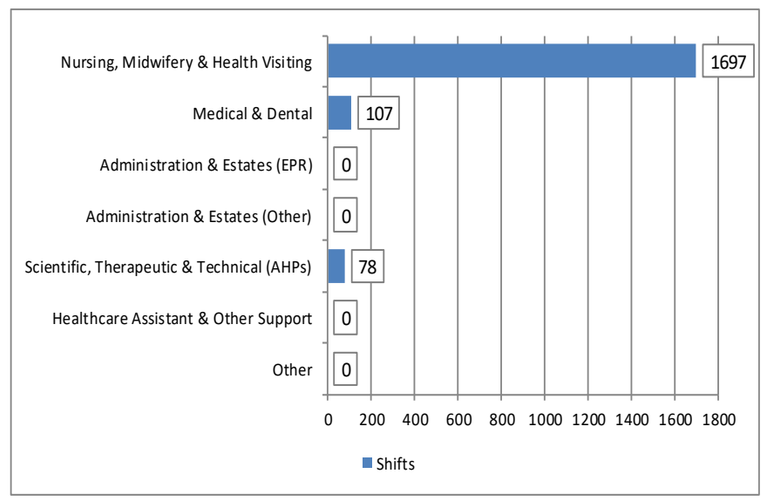
Agency Ceiling



Agency, Bank and Unfilled Shifts



Number of shifts that broke the agency cap - September 2021



Result

Continue to reduce the use of agency colleagues and reduce the bank paybill in 2022/2023.

Response

Workforce Spend

March 2022 substantive spend includes year end pension contributions of 6.3% (£11.2M). These contributions are paid by NHSE. As such while substantive spend shows a marked increase this is offset by an increase in income of the same amount.

Bank/Agency

A total of 1795 shifts broke the agency cap in September 2022, this is a decrease on 2061 in August 2022.
The high cost agency withdrawal plan was paused from May 2022 but recommenced from October 2022.
For Nursing & Midwifery, of all requests 46.06% were filled by Bank and 33.95% by Agency. with an overall fill rate of 80.02%
For Medics, of all requests 84.30% were filled by Bank and 7.7% by Agency, with an overall fill rate of 92.0%

Agency Ceiling

As of 1 September 2022 NHSE have re-introduced agency staffing performance & monitoring within the Oversight Framework.

NHSE will monitor performance against existing requirements on agency shifts within national capped rates & establish expenditure limits at system level with trusts mapped to ICBs in line with financial planning.

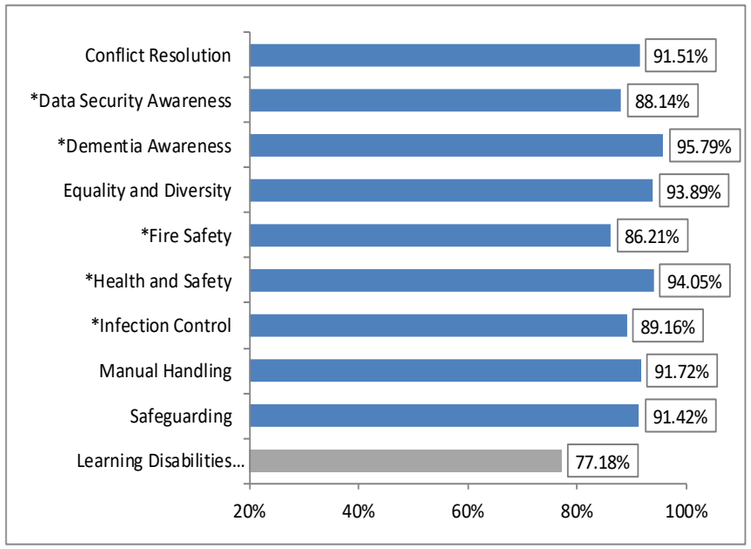
Limits are based on planned reductions & set to reduce by at least 10% compared to 2021/22. Performance on agency spend limit will be considered along with agency spend as a proportion of total pay bill, compliance with agency price caps and useage of off-framework agency staff.
The ICB ceiling for the Trust is £9.9M and for West Yorkshire in total it is £99.8M
Year to date in September 2022 the Trust breached the agency ceiling with a spend of £6.31m, a £3.30m adverse variance

The first phase of project outcomes will be delivered through the plans below:-
Stop use of Thornbury, a high cost agency Thornbury currently fill at short notice within 24 hours and removing this option may cause issues within some hot spot areas/extreme circumstances. Proposal to offer an enhancement to substantive & bank/bank only staff if fill shifts within same lead time as Thornbury within extreme circumstances. Move from using Tier 3 by increasing use of Tier 1. Progress will be monitored through Nursing and

Workforce Spend / Agency Usage

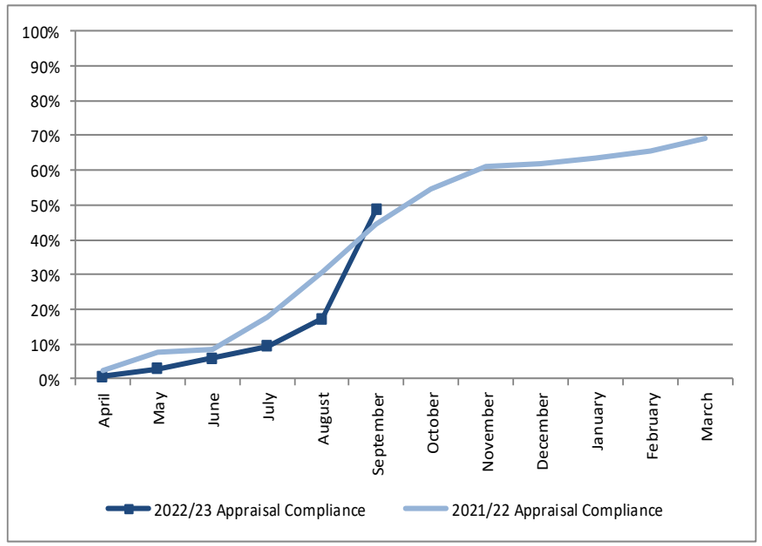
Reality

Essential Safety Training

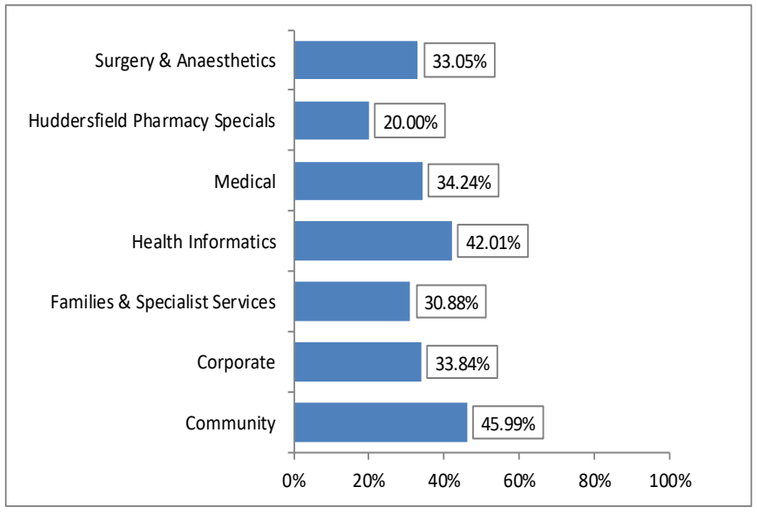


* Essential Safety Training elements that are covered at Corporate Induction.

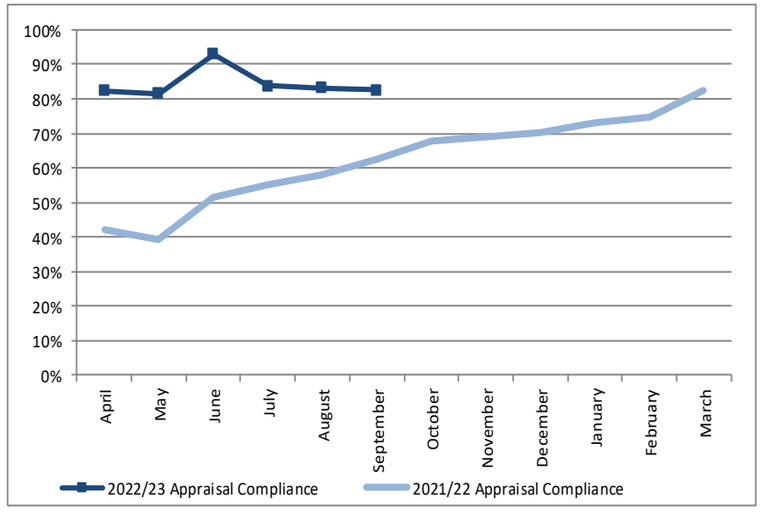
Non-Medical Appraisal Compliance



Non-Medical Appraisal Compliance by Division



Medical Appraisal Compliance



Result

Appraisal compliance is consistently above 95%.

Essential safety training compliance is consistently above 90% stretching to 95%.

Response

Essential Safety Training
A paper is presented weekly to Executive Board highlighting the compliance figures for all EST including role specific training.

The focus remains on improving role specific subjects with less than 85% compliance.

Appraisal
The Trust now adopts an appraisal season approach. The appraisal season ran from 1 July to 31 October last year The final position for the 2020/21 appraisal season was 95.15%.

The appraisal season for 2022/23 will run from 1 July 2021 until 31 October 2022.

As a result of COVID-19 the Medical appraisal process was suspended by NHSE on 19th March 2020.

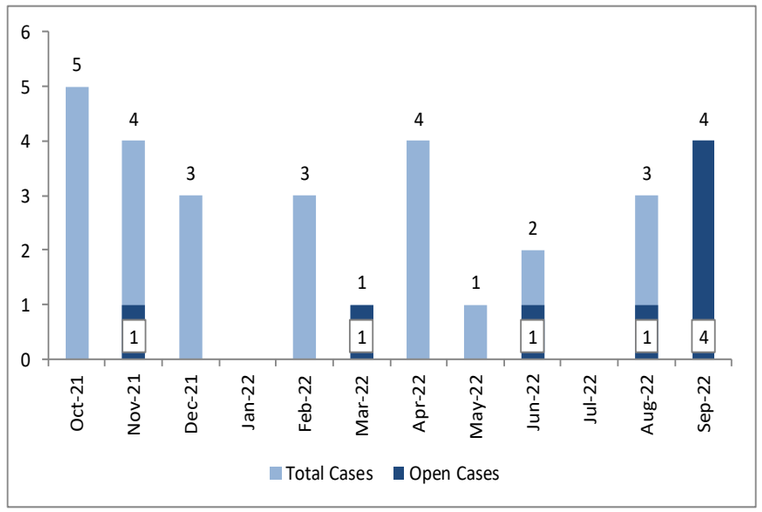
The process was restarted on 1st October using a temporary revised appraisal format, however the need to complete an appraisal was not mandated. From April 2021 Medical appraisals have been reinstated.

Learning Disabilities Awreness EST commenced from 10 May 2022, however is not included in Overall EST Compliance score or Domain Score totals

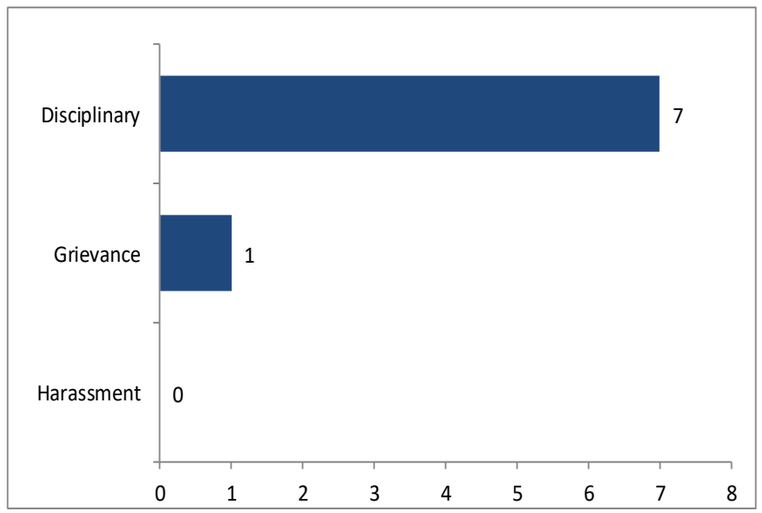
Essential Safety Training / Appraisals

Reality

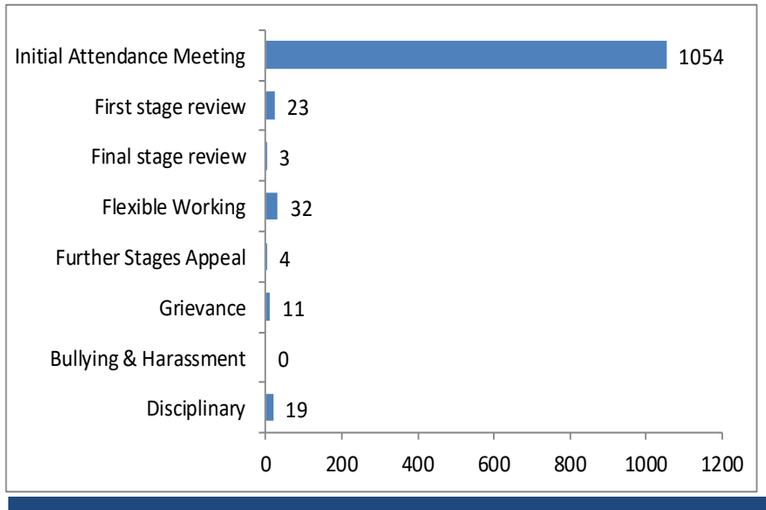
Disciplinary, Grievance, Harassment cases opened last 12 months



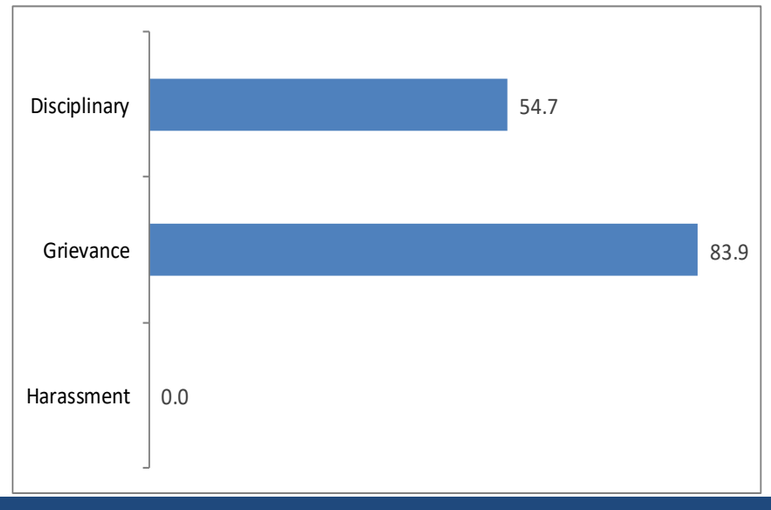
Open Disciplinary, Grievance, Harassment cases by type



All cases opened in the last 12 months by case type



Average number of days to close cases



Result

Maintain a robust capturing process.

Response

Following a deep dive into employee relations cases, the HR Team reviewed the way in which employee relations cases were been recorded and updated. This has resulted in a number of changes which will ensure consistency and enable automated reporting of case management.

- ESR will now be the sole recording system for employee relations cases. Previously the HR Team had been trying to maintain two different systems which led to discrepancies.

- If the employee has a registered disability, absence management cases will now be recorded under 'Capability UHR'. All other absence management cases will be recorded under 'Capability No UHR'.

- Long term sickness absence will now be captured on ESR.

- Unsatisfactory performance during a probationary period will now be captured on ESR.

Employee Relations

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

KEY METRICS

	M6				YTD (SEP 2022)				Forecast 22/23			
	Plan	Actual	Var		Plan	Actual	Var		Plan	Forecast	Var	
	£m	£m	£m		£m	£m	£m		£m	£m	£m	
I&E: Surplus / (Deficit)	(£0.87)	(£1.38)	(£0.51)		(£10.33)	(£11.21)	(£0.88)		(£17.35)	(£17.35)	£0.00	
Agency Expenditure (vs Ceiling)	(£0.49)	(£1.20)	(£0.70)		(£3.01)	(£6.31)	(£3.30)		(£6.90)	(£12.41)	(£5.51)	
Capital	£3.06	£0.48	£2.58		£13.80	£4.33	£9.47		£41.99	£42.71	(£0.72)	
Cash	£52.51	£53.04	£0.53		£52.51	£53.04	£0.53		£19.26	£18.88	(£0.38)	
Invoices paid within 30 days (%) (Better Payment Practice Code)	95.0%	91.5%	-4%		95.0%	90.6%	-4%					
CIP	£2.02	£1.47	(£0.55)		£8.42	£9.07	£0.65		£20.00	£20.00	£0.00	
Use of Resource Metric	3	4			3	4			3	3		

Year to Date Summary

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

• Funding for 22/23 is based on an Aligned Payment Incentive (API) approach with a fixed element based on agreed activity levels and a variable element to support recovery of elective services. £11.94m of Elective Recovery Funding (ERF) has been assumed in the plan, but is subject to delivery of 104% of 19/20 elective activity. ERF of £5.46m has been assumed in the year to date position in line with plan. It has been confirmed that ERF will not be clawed back for the first half of the year (H1), but this remains a risk going into H2, as activity year to date was below the planned level and some claw back might be required if the Trust is unable to catch up this activity in future months.
• The Trust has been allocated block funding of £5.9m for the year to support Covid-19 costs by the Integrated Care System (ICS) and subject to approval continues to have access to funding for Covid-19 costs that are considered to be outside of the System Envelope: Vaccinations and Covid-19 Testing. Requirements for additional funding for testing have reduced significantly as national procurement has expanded and the Autumn vaccination programme is funded differently, on a fixed cost per vaccine basis.
• Year to date the Trust has incurred costs relating to Covid-19 of £9.88m, £4.91m higher than planned. Covid-19 activity remains higher than planned driving additional staffing costs and consumables, with extra capacity opened that was planned to be closed by this point in the year.
• Year to date the Trust has delivered efficiency savings of £9.07m, £0.65m higher than planned.
• Agency expenditure year to date is £6.31m, £3.30m higher than planned. The Integrated Care Board has set the Trust's Agency expenditure ceiling for the full year at £6.9m, at the Trust is already close to exceeding that ceiling.
• Total planned inpatient activity, for the purpose of Elective Recovery, was only 96% of the activity planned year to date.

Key Variances

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

Forecast

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

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

INCOME AND EXPENDITURE COMPARED TO PLAN SUBMITTED TO NHS IMPROVEMENT

YEAR TO DATE POSITION: M6

CLINICAL ACTIVITY

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

TOTAL GROUP: INCOME AND EXPENDITURE

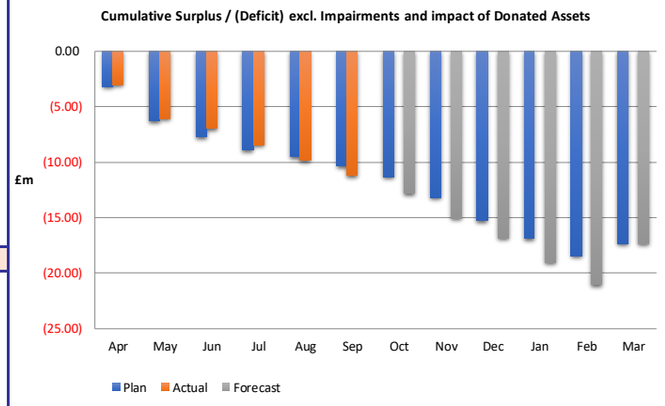
	M6 Plan	M6 Actual	Var
	£m	£m	£m
Elective	£11.37	£8.62	(£2.75)
Non Elective	£64.72	£62.10	(£2.62)
Daycase	£17.48	£16.77	(£0.71)
Outpatients	£19.80	£21.50	£1.70
A & E	£14.88	£15.36	£0.47
Other-NHS Clinical	£86.93	£96.52	£9.59
CQUIN	£0.00	£0.00	£0.00
Other Income	£26.86	£27.75	£0.89
Total Income	**£242.06**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

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

DIVISIONS: INCOME AND EXPENDITURE

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

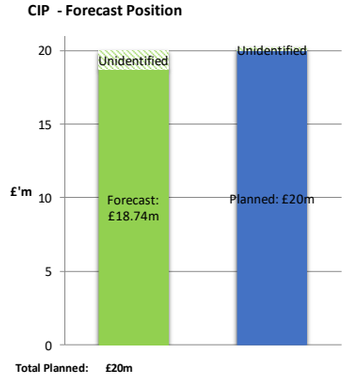
TOTAL GROUP SURPLUS / (DEFICIT)

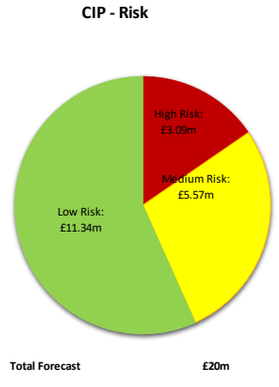


KEY METRICS

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

COST IMPROVEMENT PROGRAMME (CIP)





YEAR END 22/23

CLINICAL ACTIVITY

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

TOTAL GROUP: INCOME AND EXPENDITURE

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

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

DIVISIONS: INCOME AND EXPENDITURE

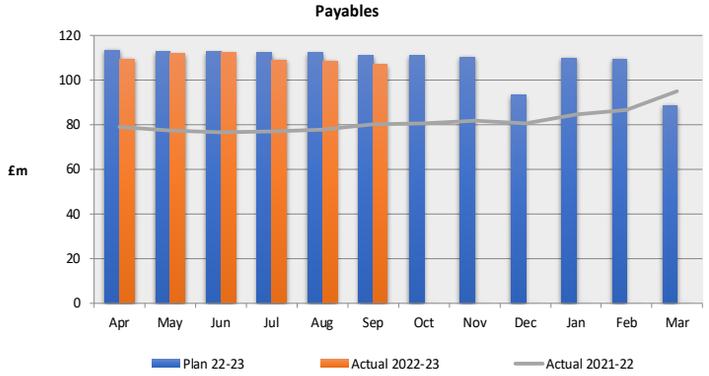
	Plan	Forecast	Var
	£m	£m	£m
Surgery & Anaesthetics	(£102.25)	(£101.79)	£0.45
Medical	(£124.40)	(£131.67)	(£7.27)
Families & Specialist Services	(£89.70)	(£87.84)	£1.85
Community	(£27.98)	(£27.47)	£0.51
Estates & Facilities	£0.00	(£0.00)	(£0.00)
Corporate	(£53.65)	(£54.09)	(£0.44)
THIS	£0.95	£0.79	(£0.16)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

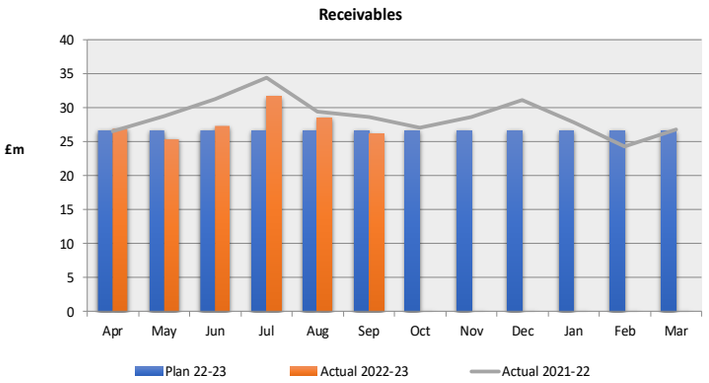
Total Group Financial Overview as at 30th Sep 2022 - Month 6

CAPITAL AND CASH COMPARED TO PLAN SUBMITTED TO NHS IMPROVEMENT

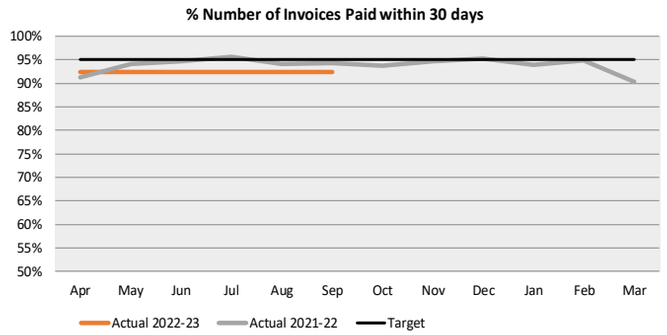
WORKING CAPITAL

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



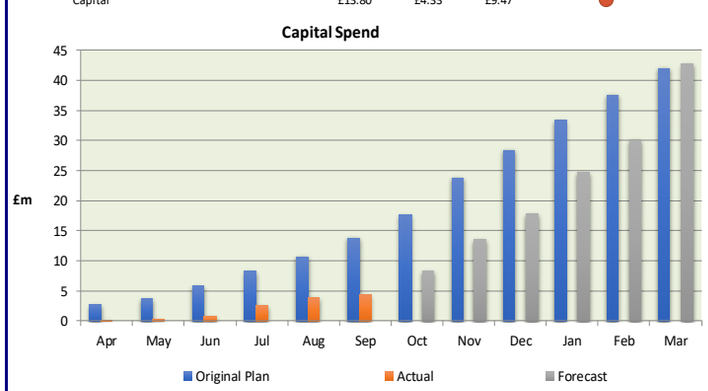


BETTER PAYMENT PRACTICE CODE



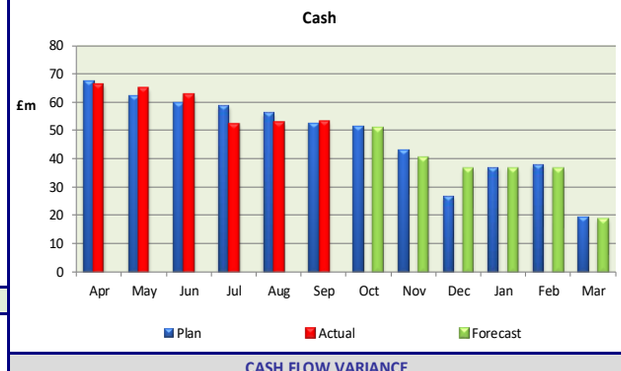
CAPITAL

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

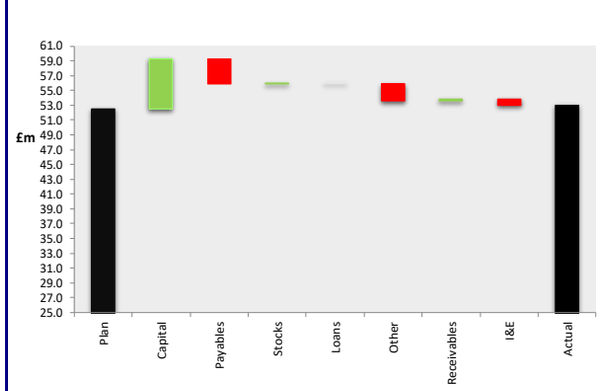


CASH

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



CASH FLOW VARIANCE



SUMMARY YEAR TO DATE

- Year to date the Trust is reporting an £11.21m deficit, a £0.88m adverse variance from plan.
- Operational pressures, including additional capacity requirements, continue to drive additional costs including the impact in month of Enhanced Bank rates.
- Funding for 22/23 is based on an Aligned Payment Incentive (API) approach with a fixed element based on agreed activity levels and a variable element to support recovery of elective services. £11.94m of Elective Recovery Funding (ERF) has been assumed in the plan, but is subject to delivery of 104% of 19/20 elective activity.
- £5.46m of ERF has been assumed in the year to date position as planned. It has been confirmed that ERF will not be clawed back for the first half of the year (H1), but some potential clawback remains a risk for H2.
- Total planned inpatient activity for the purposes of Elective recovery was 96% of the activity planned year to date.
- Year to date the Trust has incurred costs relating to Covid-19 of £9.88m, £4.91m higher than planned.
- Capital expenditure is lower than planned at £4.33m against a planned £13.80m. Capital plans now also include any new leases.
- Year to date the Trust has delivered efficiency savings of £9.07m, £0.65m more than planned.
- NHS Improvement performance metric Use of Resources (UOR) stands at 4, worse than planned, with 2 metrics currently away from plan.

NOTES

- The Trust plans to deliver a £17.35m deficit for the year. The risk to delivery of this forecast remains significant due to inflationary impacts, a Pay Award funding shortfall of £0.84m and Bank and Agency staffing pressures.
- The forecast position assumes full delivery of a challenging £20m efficiency target. At the end of September 22, £18.74m of efficiency has been identified and is forecast to deliver.
- The forecast assumes that the Trust will deliver it's elective activity plan and secure in full £11.9m of Elective Recovery Funding.
- The total loan balance is £16.57m as planned. No further loans are planned for this financial year.
- The Trust is forecasting to spend £42.71m on Capital programmes in this financial year including £2.92m on leases. The £0.72m adverse variance to plan is due to an increase in forecast donated assets (funded through charitable funds) and additional PDC funded Reconfiguration expenditure.
- The Trust has a cash balance of £53.04m, £0.53m higher than planned.

RAG KEY: (Excl: UOR)		Actual / Forecast is on plan or an improvement on plan
		Actual / Forecast is worse than planned by <2%
		Actual / Forecast is worse than planned by >2%

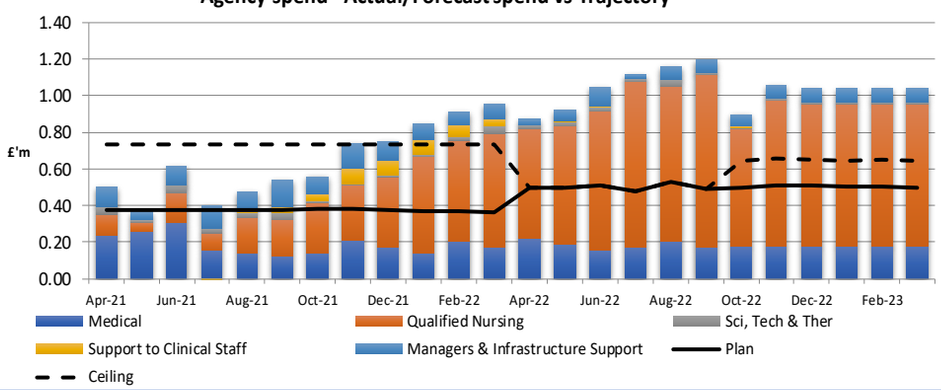
NB. In addition to the above rules, if Capital expenditure <85% of that planned then Red, (per NHSI risk indicator).

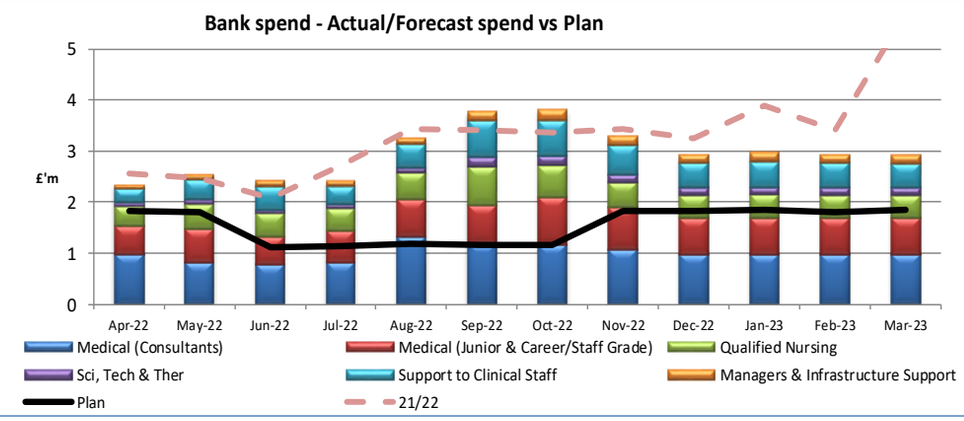
RAG KEY: UOR		All UOR metrics are at the planned level
		Overall UOR as planned, but one or more component metrics are worse than planned
		Overall UOR worse than planned

WORKFORCE

Vacancies

	Sci, Tech & Ther	Admin & Estates	Medical	Nursing	Support to Clinical	Total
Vacancies (WTE)	63	91	61	163	43	421
Staff in post (WTE)	750	1,512	649	1,685	1,201	5,798
% Vacancies	8%	6%	9%	9%	3%	7%





Cumulative Agency and Bank Spend	Plan	Actual	Var		NHSI Ceiling	Var from Ceiling	
	£'m	£'m	£'m		£'m	£'m	
Agency Year to Date	(£3.01)	(£6.31)	(£3.30)		(£3.01)	(£3.30)	
Agency Forecast	(£6.03)	(£12.41)	(£6.38)		(£6.90)	(£5.51)	
Bank Year to Date	(£8.22)	(£16.75)	(£8.53)				
Bank Forecast	(£18.54)	(£35.62)	(£17.08)				

Vacancies

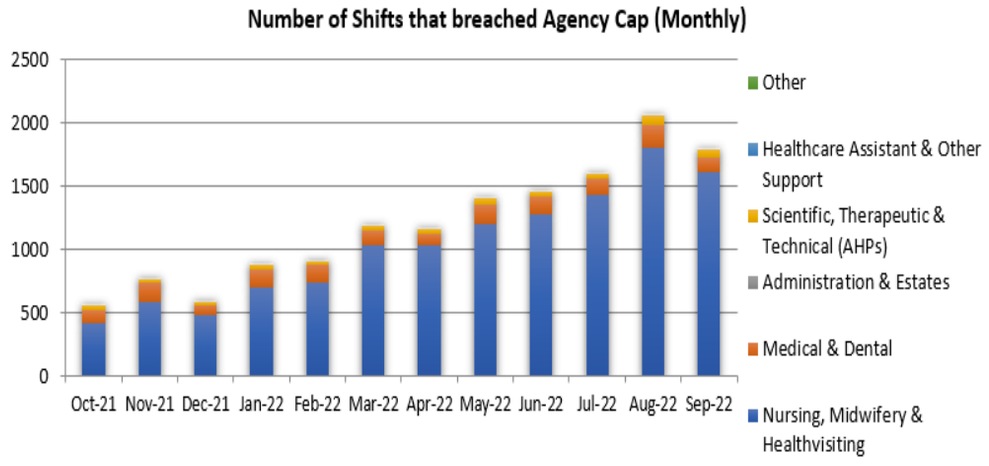
- Total vacancies: 421 or 7% of baseline establishment, a reduction of 62 WTE compared to Month 5.
- The vacancies include additional capacity linked to Recovery and ongoing Covid-19 costs have been non-recurrently funded in budgets this year resulting in an increase to Establishment - in many cases these will be filled using temporary staffing due to the temporary nature of the staffing requirement.
- Total Staff in Post has increased since Month 5 by 44 to 5,798
- Medical vacancies have remained static at 9%.
- Nursing vacancies have reduced by 2% to 9%.

Agency Expenditure

- Agency expenditure year to date is £6.31m; £3.30m higher than planned.
- The Agency Ceiling for the Trust has been set at £6.90m for the year, slightly higher than the planned level of £6.03m for the year. This represents a 10% reduction compare to 21/22 levels in line with recently revised guidance. As with many targets this year, the ceiling will be set at Integrated Care Board (ICB) level and there will be a collective responsibility to achieve the target across the System.
- Higher than planned agency costs due to additional capacity requirements, vacancies and higher than planned levels of staff sickness (Covid-19 and other).
- The use of Agency Healthcare Support Workers has been eliminated since April 22.
- Increasing Nursing Agency costs are due to an increase in the average hourly rate, due to increasing use of Tier 3 Agencies, as well as an increase in volume required.

Bank usage

- Expenditure on Bank staff year to date is £16.75m, £8.53m higher than planned.
- The overspend is linked to operational pressures, vacancies and unavailability of staff, and has increased further in September due to the introduction of 50% enhanced pay rates for bank staff at a cost of £0.89m for the month, (£1.12m year to date impact).



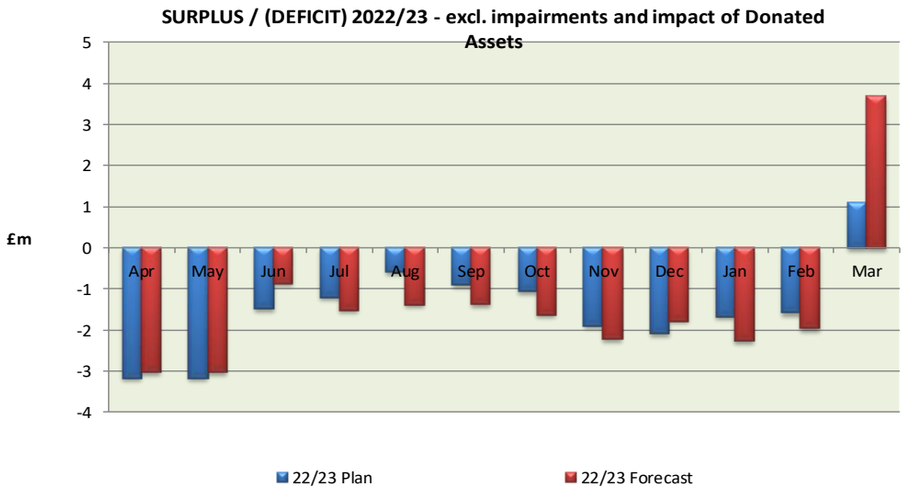
FORECAST POSITION 22/23

22/23 Forecast (31 Mar 23)

Statement of Comprehensive Income	Plan[2] £m	Forecast £m	Var £m	
Income	£485.35	£500.72	£15.37	
Pay expenditure	(£318.79)	(£329.61)	(£10.83)	
Non Pay Expenditure	(£151.58)	(£158.85)	(£7.28)	
Non Operating Costs	(£32.68)	(£29.69)	£2.98	
Total Trust Surplus / (Deficit)	**(£17.69)**	**(£17.44)**	**£0.25**	
Deduct impact of:				
Impairments (AME)[1]	£0.00	(£0.00)	(£0.00)	
Donated Asset depreciation	£0.43	£0.53	£0.10	
Donated Asset income (including Covid equipment)	(£0.08)	(£0.44)	(£0.35)	
Net impact of donated consumables (PPE etc)	£0.00	£0.00	£0.00	
Gain on Disposal	£0.00	£0.00	£0.00	
Adjusted Financial Performance	**(£17.35)**	**(£17.35)**	**£0.00**	

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

MONTHLY SURPLUS / (DEFICIT)



- The Trust is forecasting to deliver the revised plan of a £17.35m deficit.
- Whilst forecasting to deliver this planned deficit, this remains challenging and mitigation will be required to offset the ongoing operational pressures that have continued throughout the summer period. Capacity requirements continue to be above the planned level due to higher than planned Covid-19 activity, Delayed Transfers of Care and other operational pressures. This is driving additional costs, particularly in relation to bank and agency expenditure.
- The additional funding for inflation was required to flow in full to improve the Trust overall financial position and assumed that plans included sufficient funding to cover any pressures. The increase in RPI since March 22 is driving additional inflationary pressures over and above the planned level, particular in relation to Energy costs and the PFI contract. It is also impacting on the ability to achieve planned procurement savings.
- The forecast assumes full delivery of a challenging £20m efficiency target and elements of the plan are no longer expected to deliver, particularly those schemes reliant on the exit of Covid-19 costs. However, work is already underway to identify additional schemes to mitigate this slippage and the expectation is that sufficient opportunities have been identified to close this gap.
- The Pharmacy Manufacturing Unit has not delivered the planned surplus in the year to date and there is a significant risk that the organisation is not successful in recovering this position.
- Vacancies have driven underspends in Community and FSS Divisions in the year to date. A continuation of this position may mitigate the pressures above to some extent.
- The forecast continues to assume that the Trust will deliver it's elective activity plan and secure in full £11.9m of Elective Recovery Funding.
- Whilst some potential mitigation has been identified to offset Divisional forecast pressures of around £8.5m, a gap remains and the current 'likely case' forecast is an adverse variance of £5.5m.

Risks and Potential Benefits

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

Appendices

Appendices

COVID-19 & Recovery

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

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

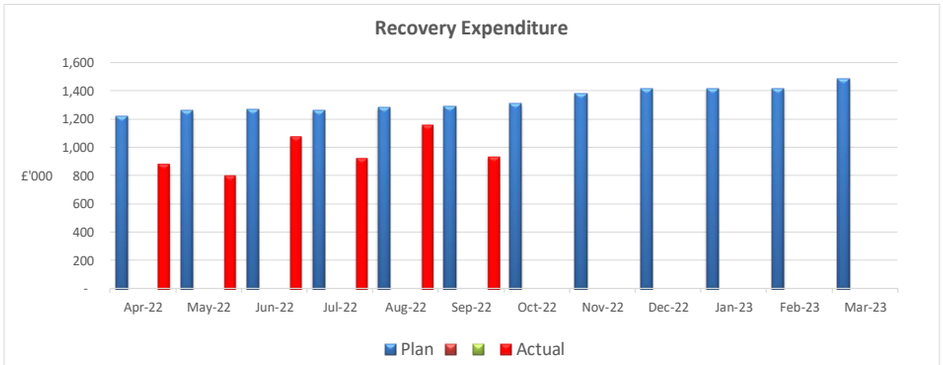
Covid-19 Costs
Year to date the Trust has incurred £9.88m of expenditure relating to Covid-19. Excluding Covid-19 costs that were outside of System envelope and for which funding can be claimed retrospectively, the year to date cost is £9.51m versus a plan of £4.61m, an adverse variance of £4.91m. This overspend was driven by higher than planned Covid-19 related activity leading to higher staffing and consumables costs and delays in closing additional Medical capacity. Outside of envelope costs are highlighted in the table to the left and total £0.37m year to date.

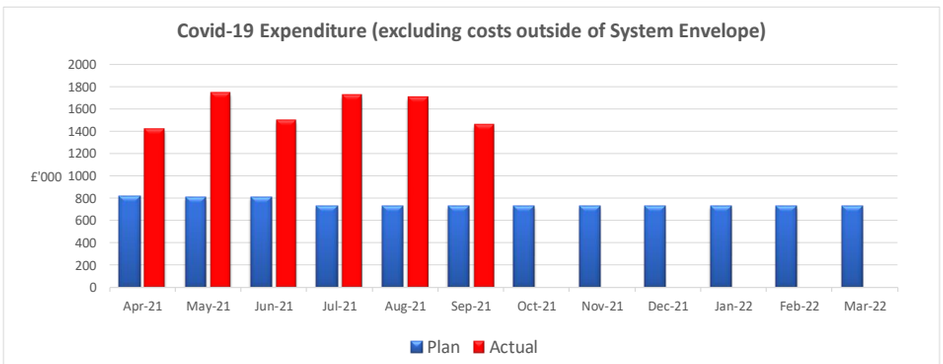
The Autumn Covid-19 vaccination programme has started and funding will be provided on a fixed cost per vaccine basis.

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

Recovery
- Year to date Recovery costs are £5.79m, £1.78m lower than planned.
- Total planned Recovery costs for the year are £15.97m to deliver the required 104% of 19/20 activity.
- Funding of £11.9m of Elective Recovery Funding (ERF) is assumed for the year, receipt of which is reliant on the Trust achieving it's activity targets as planned. £5.46m of ERF has been assumed in the year to date position as planned, (profiled in line with activity plans). ERF will not be clawed back for the first half of the year (H1), but this remains a risk going into H2, as activity year to date was below the planned level and some claw back might be required if the Trust is unable to catch up this activity in future months.

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



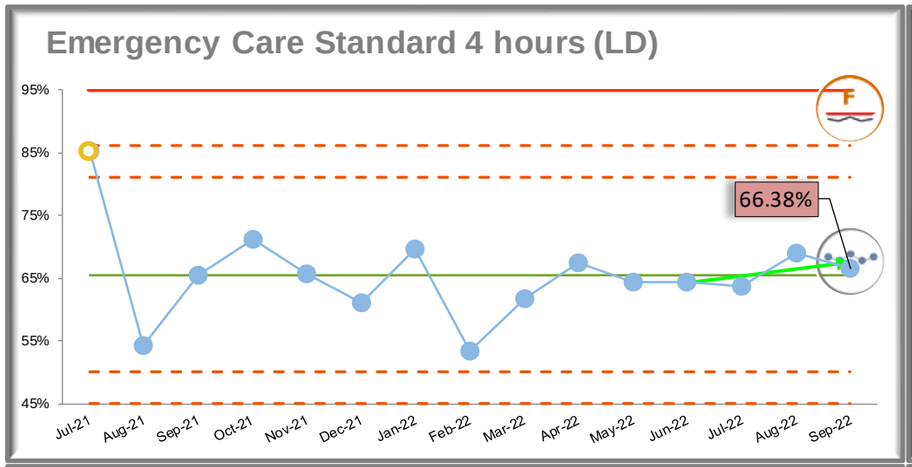


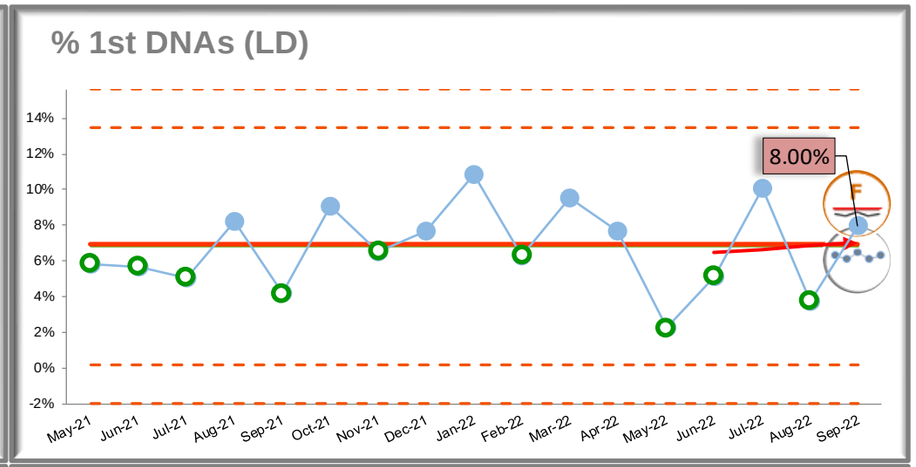
LD - Key measures

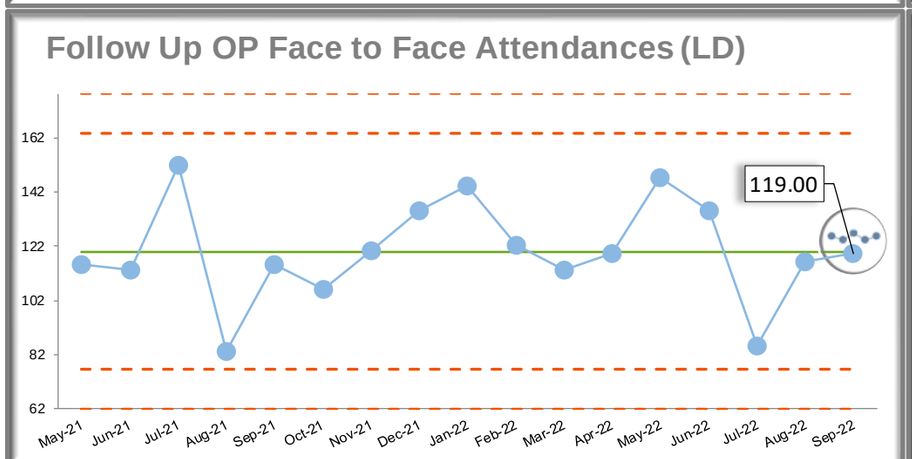
	21/22	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	YTD	Performance Range		
																Green	Amber	Red
Recovery																		
Total P2 on Waiting List (LD)	32	4	2	3	4	3	2	4	1	11	7	4	4	**6**	**33**	No target		
Total P3 on Waiting List (LD)	119	13	10	10	7	8	11	11	14	16	12	9	10	**10**	**71**	No target		
Total P4 on Waiting List (LD)	58	9	9	3	3	2	1	1	2	3	4	4	2	**2**	**17**	No target		
Emergency Care																		
Emergency Care Standard 4 hours (LD)	65.74%	65.31%	71.05%	65.65%	61.02%	69.57%	53.33%	61.62%	67.26%	64.23%	64.35%	63.54%	68.93%	**66.38%**	**65.77%**	>=95%		<95%
Waiting Times																		
18 weeks Pathways >=26 weeks open (LD)	569	54	56	58	69	61	63	54	50	47	54	41	35	**37**	**264**	0		>=1
RTT Waits over 52 weeks Threshold > zero (LD)	409	41	37	41	45	41	47	38	35	38	42	30	16	**27**	**188**	0		>=1
% Diagnostic Waiting List Within 6 Weeks (LD)	83.63%	0.851	0.8713	84.85%	84.97%	90.43%	73.54%	68.48%	82.40%	84.64%	83.19%	85.63%	79.51%	**87.80%**	**83.56%**	>=99%		<=98%
Cancer																		
Two Week Wait for Referral to Date First Seen (LD)	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	**100.00%**	**100.00%**	>=93%	86% - 92%	<85%
31 Days From Diagnosis to First Treatment (LD)	100.00%	not applicable	not applicable	not applicable	100.00%	not applicable	not applicable	not applicable	100.00%	not applicable	100.00%	not applicable	not applicable	**100.00%**	**100.00%**	>=96%		<95%
31 Day Subsequent Surgery Treatment (LD)	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	**not applicable**	**not applicable**	>=94%		<93%
38 Day Referral to Tertiary (LD)	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	**not applicable**	**not applicable**	>=85%		<84%
62 Day GP Referral to Treatment (LD)	100.00%	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	100.00%	not applicable	not applicable	**100.00%**	**100.00%**	>=85%	81% - 84%	<80%
62 Day Referral From Screening to Treatment (LD)	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	**not applicable**	**not applicable**	>=90%		<89%
Activity - Number of Attendances																		
New Outpatient Attendances - Face to Face (LD)	366	26	34	33	38	38	24	31	37	38	41	40	48	**53**	**257**	No target		
New Outpatient Attendances - Non Face to Face (LD)	256	18	26	19	25	18	16	18	12	20	15	9	11	**15**	**82**	No target		
Follow up Outpatient Attendances - Face to Face (LD)	1426	115	106	120	135	144	122	113	119	147	135	85	116	**119**	**721**	No target		
Follow up Outpatient Attendances - Non Face to Face (LD)	845	60	69	74	47	45	56	67	54	60	61	41	48	**49**	**313**	No target		
Activity - % DNAs																		
% 1st DNAs (LD)	7.22%	4.23%	9.09%	6.58%	7.69%	10.87%	6.35%	9.59%	7.69%	2.30%	5.19%	10.14%	3.80%	**8.00%**	**6.12%**	<=7.0%	7.1% - 7.9%	>=8.0%
% Follow Up DNAs (LD)	5.72%	6.17%	8.30%	5.93%	8.10%	5.79%	6.13%	5.39%	6.58%	7.24%	3.72%	4.52%	6.52%	**9.20%**	**6.42%**	<=7.0%	7.1% - 7.9%	>=8.0%

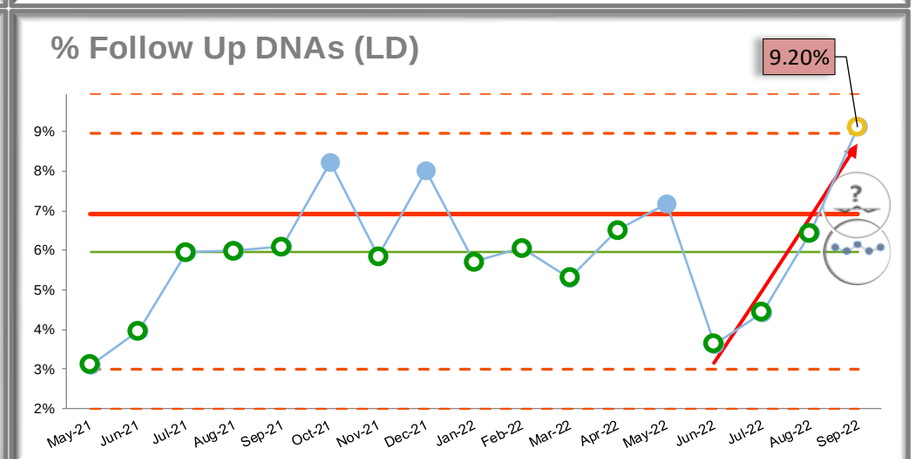
LD - SPC Charts

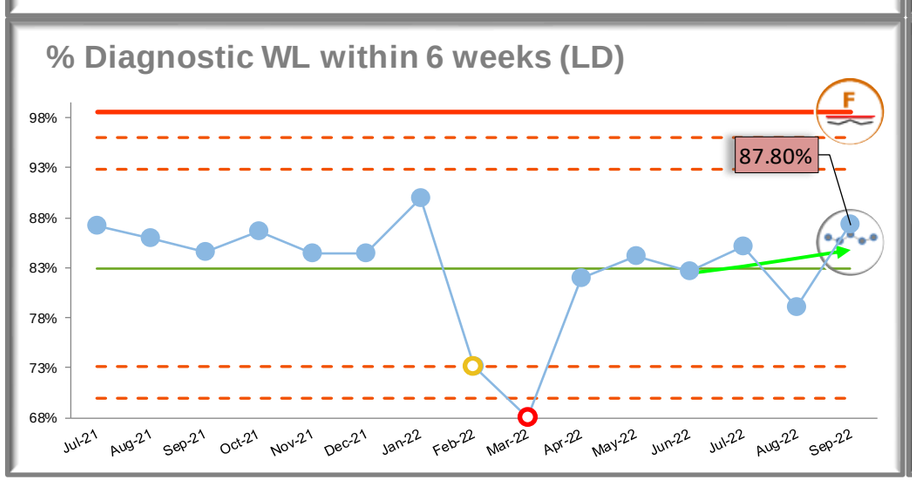
Warning | Critical | Activity | On Target | Trend | Target Line | Average Line | Control Line | Last 6 Points Directional Flow | RAG Rated Last Data Point

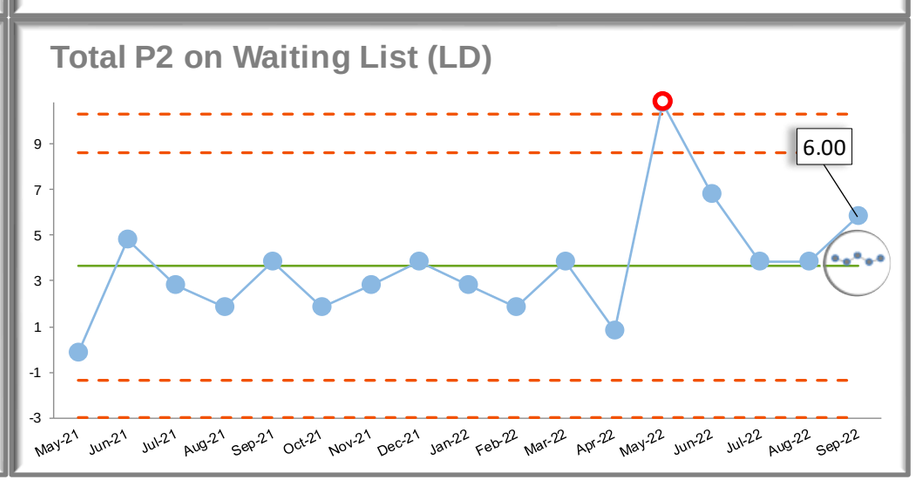




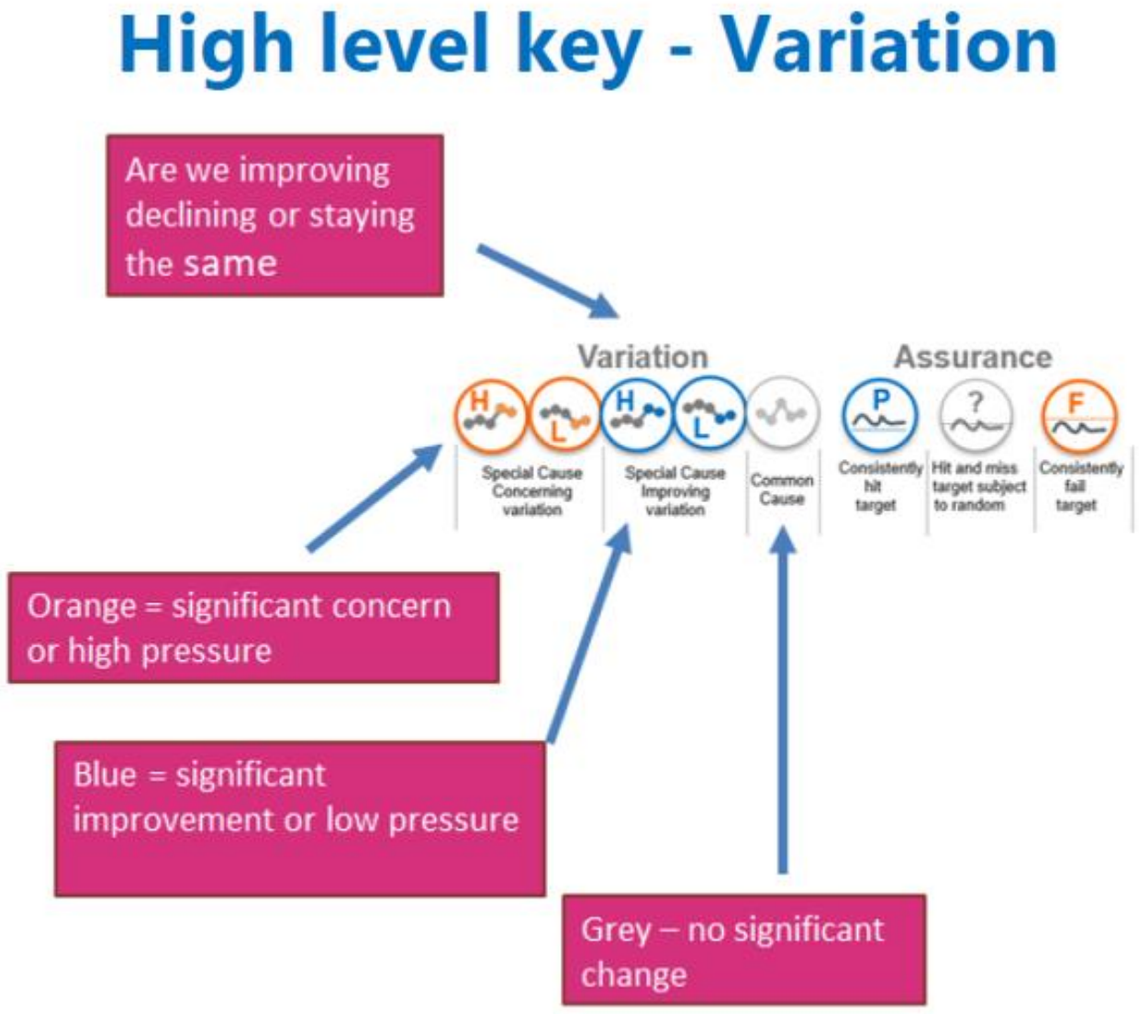








A note on SPC Charts



Variation			Assurance		
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

2. Quality Committee

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

Date of Meeting:	**10 November 2022**
Meeting:	**Board of Directors**
Title:	**Quarterly Director of Infection Prevention and Control (DIPC) report Q2 – 1st July 2022 to 30th September 2022**
Authors:	**Gillian Manojlovic – Lead Nurse IPC** **Lindsay Rudge - Director of Nursing / Deputy DIPC**
Sponsoring Director:	**David Birkenhead, Medical Director / DIPC**
Previous Forums:	**None**

Key Points to Note

Clostridium difficile prevention and control remains a challenge. The number of *C. difficile* infections have increased over the past 2 years. The increase in *C. difficle* 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 in November. Actions completed to date are identified.

Covid-19 has continued to have a significant impact on the Trust and the work of the IPC team, even though there has been a reduction of cases towards the end of the quarter.

A new Board Assurance Framework has been published and is under review.

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

Calderdale and Huddersfield NHS Foundation Trust

Quarterly Director of Infection Prevention and Control (DIPC) report
Q2 – 1st July 2022 to 30th September 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	34	Objective is 1 case above the 21/22 outturn 23 HOHA and 11 COHA
MSSA bacteraemia (post admission)	None set	14	
E. coli bacteraemia	Objective = 71	40	Objective is down 20 on 21/22 26 HOHA and 14 COHA.
Pseudomonas aeruginosa	11	0	New objective for 22/23
Klebsiella spp.	19	11	New objective for 22/23 7 HOHA and 4 COHA
MRSA screening (electives)	95%	70.5%	Down 0.5%
ANTT Competency assessments (medical staff)	90%	64%	Significant decrease – (Nursing 10%, Medical 20%)
ANTT Competency assessments (nursing and AHP)	90%	83%	
Hand hygiene	95%	99.5%	
Level 2 IPC training (Medical staff)	90%	88%	Down 1%
Level 2 IPC training (nursing and AHP)	90%	88%	

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%	90.8%	Down 1%
Isolation breaches	Non set	Not recorded this quarter	COVID-19 patients remain priority for side room isolation

3. MRSA bacteraemia:

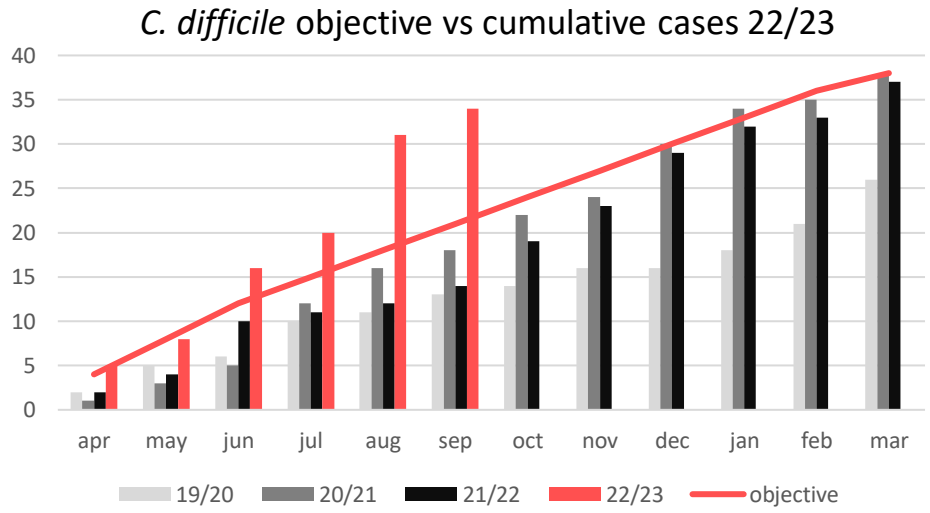
The objective for MRSA cases in year remains at zero. No cases to report during the current reporting period/year to date.

4. MSSA bacteraemia:

There have been 14 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 34 cases year to date. Each case is being investigated. The system for investigation has been reviewed and will be led by the IPC team for the rest of the year.



A review of 16 *C. difficile* cases for this quarter has identified 12 patients where antibiotics prescribed were not in accordance with local antibiotic guidelines. There was also an issue identified regarding appropriate samples to aid antibiotic de-escalation in 12 of 16 patients.

The *C. difficile* Improvement Plan (Aug 22) has been implemented and is monitored through IPC Tactical and Performance Board. Actions completed to date include:

- *C.difficile* weekly ward rounds with the Infection Control Doctor and IPC Nurse
- Antimicrobial prescribing remote ward rounds by the Antimicrobial Management Team.
- Review and implementation of changes to the investigation process
- Review of *C. difficile* policy
- HPV deep clean of all elderly medicine wards, with a further deep clean planned for the rest of the in-patient areas in Spring.

6. E. coli bacteraemia:

There have been 40 post-admission *E. coli* bacteraemia cases to date. This is over the planned trajectory and therefore a risk that the objective of 72 will be breached.

7. Outbreaks & Incidents:

Norovirus: There has been 1 norovirus outbreak reported during Q2 affecting wards C5D.

Covid-19: There have been 10 Covid19 outbreaks recorded during the reporting period on Yorkshire Fertility Clinic (staff), CTheatres (staff) and wards C7C, C7D, H19, H20, H21, H15 (twice), H17, and H22. 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)
For this reporting period there have been 111 HOCI cases (75 definite, 36 probable). HOCI cases with significant symptoms (respiratory support/ICU etc) are reported and investigated via Datix.

9. Covid-19 management

Throughout the reporting period management of Covid-19 has continued to dominate the work of the IPCT and colleagues across the Trust. No significant changes were made during the reporting period and the number of cases admitted to hospital continued to decrease throughout.

10. Audits

IPC Board Assurance framework: The IPC BAF self-assessment framework has been Reissued and is currently being reviewed.

Quality Improvement Audits: The programme has resumed, though continues to be disrupted due to Covid19 and staffing pressures.

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 99%.

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.

Internal audit have assessed the processes and report that the system is well designed. The controls in the system are clear and the audit has been able to confirm that the system (if followed) would work effectively in practice. There are no significant flaws in the design of the system. They have identified areas to improve assurance and these will be addressed and reported via Performance Board.

11. Recommendations

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

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 10 November 2022
Meeting:	Board of Directors
Title of Report:	Learning from Deaths Report 2022/23
Author:	Mandy Hurley, Clinical Governance Support Manager
Presenter of report: (if different from author)	David Birkenhead, Executive Medical Director
Sponsoring Director:	David Birkenhead, Executive Medical Director
Previous Forums:	None

Purpose of the Report

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

Key Points to Note
(Include any legal, financial implications; human resources / diversity implications; strategic and any key risks)

In Quarter 1 (April – June 2022), there were 411 adult inpatient deaths. 152 (**37%**) of these have been reviewed using the initial screening tool. This falls short of the 50% target; however, the board is reminded of the lag between issuing cases for review and completion of the reports MSG have allocated mortalities up to July 2022.

Previous support was offered by 8 of our Trust CT trainees. Trainees were provided with confirmation of completion for their portfolios once they had undertaken 10 completed ISRs.
Extra support is being discussed with the Junior Doctor MSG representative to undertake this process again.

A total of **76** SJRs were requested in Quarter 1 (April to June) of 2022/23 of which **72** 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
(confirmation this has been completed and summary if any significant issues from this)

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

Additional aspects of EQIA include:

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

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

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

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

Recommendation

The Board is asked to **NOTE** the Learning from Deaths Q2 Report

3. Audit and Risk Committee

- EPRR Annual Report
- Fire Safety Annual Report

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Tuesday 25 October 2022
Meeting:	Audit and Risk Committee
Title of report:	Annual Report: Emergency Preparedness Resilience and Response / Security Risk Management / Business Continuity Management Systems
Author:	Sarah Rothery, General Manager - Corporate Division
Sponsor:	Jonathan Hammond (to be briefed due to date stating in role)
Previous Forums:	

Purpose of the Report

The purpose of the report is to detail the work undertaken by the Resilience and Security Management team and the Security and Resilience Governance Group for the period 1st Aug 2021 to 1st Aug 2022. It provides the Committee with an update on the Trust's position in relation to Emergency Preparedness, Resilience and Response, Security Risk Management and Business Continuity Management Systems. The report highlights key achievements, key risks and informs of the priority areas to address.

The report has been prepared by the General Manager, Corporate Division due to the long-term absence of the Security and Resilience Manager.

Key Points to Note

Emergency Preparedness, Resilience and Response (EPRR) is a key Trust priority alongside the safety and security of staff, patients, visitors, and property. The delivery of high standards of emergency preparedness ensures staff and organisational resilience.

Business Continuity Management Systems is a process that seeks to ensure that there is minimal disruption to critical services, information assets and core business in the event of major disruption, incident or breakdown, and to reinstate business as quickly as possible.

Safety and security work is critical to supporting the delivery of the highest possible standards of clinical treatment and care to our patients. Calderdale and Huddersfield NHS Foundation Trust (CHFT) is committed to improving the environment and personal security for those who access our services and for those who provide our services.

NHS providers must plan for, and respond to, a wide range of incidents and emergencies that could affect patient health and delivery of care. EPRR is a programme of work that is underpinned by a set of a core standards. Demonstrating a level of compliance to the core standards gives assurance that the Trust is prepared to respond to incidents whilst maintaining services.

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All staff working within the Trust have a responsibility to be aware of potential security issues and to assist in prevention of security related incidents and losses. We are always accountable for the security of ourselves and patients, visitors and colleagues and the property around us. Working to reduce violence and aggression, theft or damage across the Trust will lead to resources being released for the delivery of clinical care, contributing to the production and maintenance of a safe environment for the delivery of our services.

CHFT is a category 1 responder under the Civil Contingencies Action 2004 (CCA 2004) so that it can perform its critical activities in the event of an emergency or business interruption. CCA 2004 states Categorised 1 responders are required to: -

- Assess the risk of emergencies occurring and use this to inform contingency planning.
- Put in place emergency plans.
- Put in place a business continuity management led process to identify and mitigate risks.
- Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency. Share information with other local responders to enhance co-ordination.
- Co-operate with other local responders to enhance co-ordination and efficiency.

The contents of this report reflect the commitment of the Trust to achieving the safest possible environment from which to deliver high quality health and care services.

EQIA – Equality Impact Assessment

The Annual Report aims to implement measures that meet the diverse needs of our service, population and workforce ensuring that none are placed at a disadvantage over others. We therefore aim to ensure that in both employment and services no individual is discriminated against by reason of their gender race, disability, age, sexual orientation, religion or religious/philosophical belief or marital status.

Recommendation

The Committee is asked to **NOTE** the information provided within the Annual Report.

NHS providers must plan for, and respond to, a wide range of incidents and emergencies that could affect patient health and delivery of care. Emergency Preparedness, Resilience and Response (EPRR) is a programme of work that is underpinned by a set of a core standards. Demonstrating compliance to the core standards gives assurance that the Trust is prepared to respond to incidents whilst maintaining services.

This report summarises the structures and governance in place to ensure we are ready and able to respond to any emergency, the key activities that have taken place and our compliance with the core standards

1. GOVERNANCE

To ensure a safe and responsive environment for the delivery of our healthcare services, the Trust has security and resilience governance arrangements in place.

Accountable Emergency Officer (AEO): The Trust's Chief Operating Officer is the Accountable Emergency Officer with strategic responsibility and ultimate accountability for EPRR across the Trust and for providing assurance to the Trust Board that the organisation continues to meet its statutory and legal requirements.

Non-Executive Director: The Chairperson of the Security and Resilience Governance Group (SRGG), with EPRR within their portfolio.

Director of Operations, Corporate Division: Strategic responsibility for the Corporate Division.

General Manager for Central Operations: Strategic responsibility for the Central Operations Team Directorate and accountability for the Resilience and Security Management Specialist team within the Directorate.

Resilience and Security Management Specialist: The tactical lead for resilience and security preparedness programmes and emergency planning. Informs the AEO, Director of Operations and General Manager of Trust compliance to core standards and ability to respond to emergencies.

Resilience and Security Support Officer: Supports the Resilience and Security Management Specialist to deliver specialist security and resilience programmes across the Trust, and the provision of administrative support.

Security and Resilience Governance Group (SRGG):
The Security & Resilience Governance Group (SRGG) meets six times annually (bi-monthly) and is in place to ensure that the Trust complies with the legal requirements of the Civil Contingencies Act as well as fulfilling its non-statutory obligations under NHS England's Core Standards for EPRR. The SRGG routinely escalates or refers information through the Health & Safety Committee and to the Trust Board.

The SRGG reports directly in to the Health and Safety Committee and a number of key pieces of work have been ratified by both groups this during the last year.

The EPRR team has had support from a locum EPRR Manager since late January 2022 (working remotely). Initially the role was to support the review and completion of the out of date Incident Response Plans and Policies, guidance and procedures. Following the completion and approval of a number of these Plans, the role has concentrated on the review and improvements of the Business Continuity Arrangements across departments.

2. COVID-19 GLOBAL PANDEMIC

2.1 Incident Control Centre

In response to the Covid-19 pandemic, the Trust's Incident Control Centre (ICC) has continued to operate. The ICC inbox and mobile telephone was managed by the Resilience and Security specialist team in accordance with the requirements set out in national guidance over the reporting period. The inbox is the allocated single point of contact for Covid-19 related communications and a 'guidance log' monitors the incoming and outgoing communications as well as providing assurance on the completion of any required actions.

Any urgent information is also delivered in the daily Site Management Meetings, Tactical (Silver) command and Strategic (Gold) command meetings.

3. EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE (EPRR)

3.1 NHS Core Standards for EPRR

As part of the NHS England Emergency Preparedness, Resilience and Response (EPRR) Framework, providers and commissioners of NHS funded services must show they can effectively respond to major, critical, and business continuity incidents whilst maintaining services to patients. The NHS Core Standards for EPRR set out the minimum requirements expected of providers of NHS funded services in respect of EPRR.

The purpose of the NHS Core Standards for EPRR are to enable healthcare provider organisations across the country to share a common approach to EPRR. The standards allow co-ordination of EPRR activities according to the organisation's size and scope, providing a consistent and cohesive framework for EPRR activities.

Providers of NHS funded care must provide an annual assurance return for their compliance against the NHS Core Standards for EPRR. In October 2021, there was a total of 48 core standards applicable for Acute Trusts to report against and an additional 7 standards in the Deep Dive section. The Deep Dive in the 2021 submission was on the provision of medical gasses and therefore CHFT as a provider of this was required to report against the Deep Dive standards.

The Trust reported an overall 81.25% compliance against the 2021 core standards which equated to 'partial compliance'. On the Deep Dive section, the Trust reported 100%, 'full compliance'. Table 1 displays the 2021 compliance by domain category.

Table 1 – 2021 Core Standards Compliance (October 2021 submission)

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Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	5	5	0	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	9	5	4	0
Command and control	1	1	0	0
Response	5	5	0	0
Warning and informing	3	3	0	0
Cooperation	4	4	0	0
Business Continuity	7	5	2	0
CBRN	12	9	3	0
Total	48	39	9	0

Overall assessment:	81.25% - Partial

Deep Dive	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Oxygen Supply	7	7	0	0
Ambulance Resilience	0	0	0	0
Total	7	7	0	0

3.2 Training

Following a reduced number of training and exercises taken place during the height of the Covid-19 pandemic (2020-21, part of 2021-22), there has recently been a focus on reintroducing training and exercises. Exercises have taken place with Pathology, Medical Engineering and Estates (CHS); two community exercises with the Community Healthcare Division, a maternity abduction exercise and counter terrorism exercise with the security teams (CRH and HRI). A procurement exercise covered the loss of supplies due to Fire, IT failure and loss of the network / server.

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Engagement sessions with the Clinical Site Matrons and Clinical Commanders on communication chain of cascade and introduction to METHANE reporting has also taken place, with On Call training sessions in the planning.

A training and exercise schedule been developed to support the scheduling of training and exercises across the year and will continue to be used in to future years.

3.3 EPRR Strategy

The revised EPRR Strategy document has been reviewed during the reporting period and was approved in January 2022, with a next review date of January 2024.

The strategy document covers the EPRR team commitment to maintaining and exercising plans and having oversight of emergency planning at local, system and national level.

3.4 Specialist Incident Response Plans

Calderdale and Huddersfield NHS Foundation Trust is a Category 1 Responder (Cat 1) under the UK's Civil Contingency Act (CCA) 2004. The Act imposes a clear set of roles and responsibilities on organisations with a key role to play in preparing for and responding to emergencies. As a Cat 1 responder the Trust is subject to the full set of civil protection duties and is required to prepare for emergencies in line with its responsibilities under the Act. This includes assessing local risks, implementing emergency plans and collaborating with other local responders to enhance the co-ordination and efficiency of emergency response. The SRGG governs the activity that the Trust carries out in relation to the development, monitoring and testing of incident response plans to keep it compliant and resilient as a Cat 1 responder.

Several Incident Response Plans (IRPs) that have previously been out of date have been reviewed and approved during the reporting period, these are:

1. **Major Incident Plan** – September 2022 (next review September 2023)
2. **Evacuation Plan** – September 2022 (next review September 2023)
3. **Critical Incident Plan** – January 2022 (next review date January 2023)
4. **Flood Plan** – March 2022 (next review date March 2024)
5. **Fuel Disruption Plan** - March 2022 (next review date March 2024)
6. **HAZMAT / CBRNe** - March 2022 (next review March 2024)
7. **Heatwave Plan** – March 2022 (next review March 2024)
8. **Lockdown Plan** – March 2022 (next review March 2024)
9. **Surge and Escalation Plan OPEL** – October 2022 (annual review)
10. **VIP / Celebrity Visitors** – March 2022 (next review March 2024)
11. **Winter Response Plan** – Autumn 2021 (annual review)

All approved IRPs will be formally reviewed at the next review date, or sooner following the need for any significant changes, or gaps identified through testing / exercising.

The Major Incident Plan (MIP) has undergone a full and comprehensive review as the published version was last reviewed in 2018. The reviewed Plan has been presented at SRGG and now requires testing and exercising.

The Evacuation and Shelter Plan has also undergone a full and comprehensive re-write as the published version was last reviewed in 2018. The reviewed Plan has been presented at SRGG and now requires testing and exercising.

The Lockdown Plan has been fully reviewed and has been presented at the SRGG and ratified at Board. It now requires testing and exercising.

A main priority of the team has been to review out of date Plans, policies and procedures. The next priority is to begin testing and exercising and making any changes as required.

4. SECURITY RISK MANAGEMENT (SRM)

4.1 Security Strategy and Policy

The revised Security Strategy and Policy is a combined policy document to set out the Trust's commitment and duty to security policy and strategy. This has been revised and agreed through SRGG, with a next review date of February 2024.

4.2 Security Policies and Guidance

5 security policy and guidance documents have been reviewed and approved in the last reporting period, including:

1. **Audio Visual Recording of Staff** – October 2021
2. **Search Guidance** – March 2022
3. **Counter Terrorism Guidelines** – January 2022
4. **Restrictive Physical Intervention Guidelines for Adults** – January 2022
5. **Abduction Guidelines** (Maternity owned document – reviewed by SRGG)

All approved policies and guidance documents will be formally reviewed at the next review date, or sooner following the need for any significant changes, or gaps identified through testing / exercising.

The Prevention and Management of Violence and Aggression Group Policy is currently undergoing a full and comprehensive review by the General Manager of Central Operations. A strategy paper is due for presentation in Autumn 2022 to Weekly Executive Board.

The Lone Worker Guidance is being reviewed through a Lone Worker Task and Finish group.

Violence Marker Procedure Guidance and CCTV Guidance are due for development.

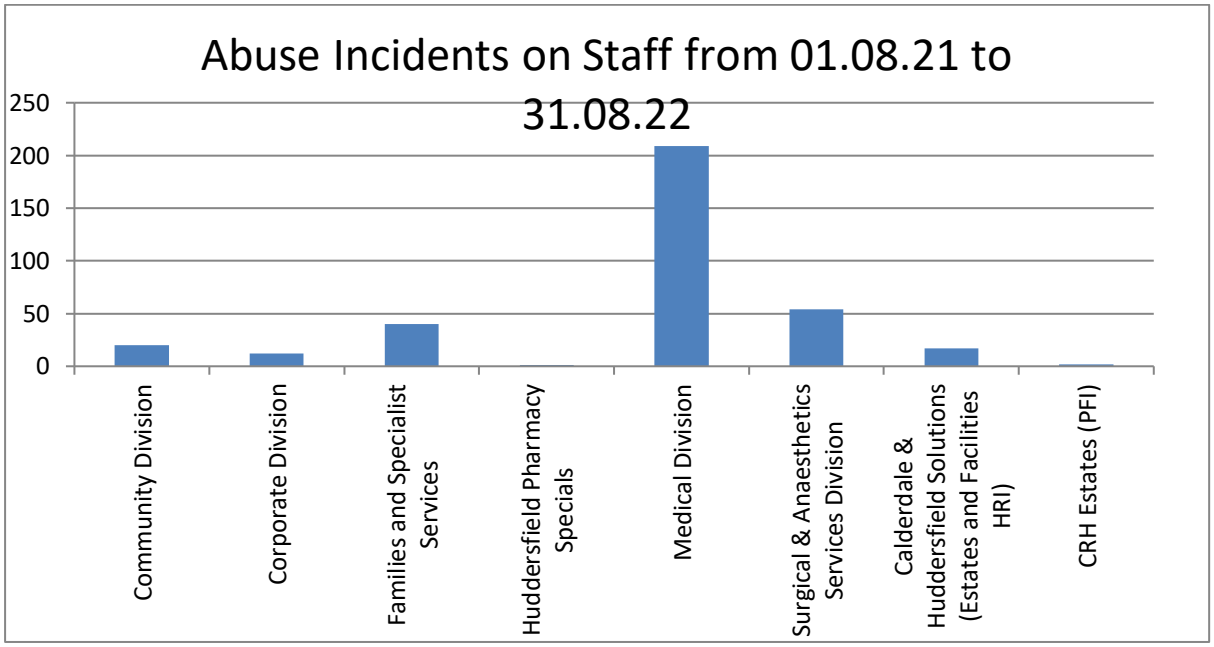
4.3 Prevention and Management of Violence and Aggression

As a Trust, we are experiencing a rising number of incidents relating to violence, aggression and abuse across our services. Data supported by intelligence shows that this is an issue that we must address as a matter of urgency to ensure staff attend to work feeling safe in

their environment and are supported by resources to help in times of conflict. Data from Datix reports demonstrates that abuse related incidents have been reported on average 25 times a month, with a total of 298 abuse-related incidents reported over the last year (Aug 2021 - Aug 2022). In August 2022, a total of 39 abuse incidents were reported which was the highest number over the last 12 months.

The data shows that the problem spans all Divisions in both inpatient and outpatient areas. Graph 1 shows the number of abuse related incidents reported by Division over the last 12 months. The Medical Division reported the highest number of incidents over the last year with 209 abuse related incidents reported.

Graph 1: Abuse Incidents on Staff from 01/08/2022 to 31/08/2022



Headline data shows that over the last 12 months;

- 158 incidents WERE reported under ‘physical abuse, assault or violence’
- 39 incidents of ‘verbal abuse or disruption’
- 31 incidents of ‘threats to harm / threatening behaviour’

Contributory factors to the increased tensions and anti-social behaviour have been reported as;

- Excessive waiting times
- Asking people to wear face masks
- Asking people to social distance
- Managing visiting restrictions
- Drink or drug fuelled incidents
- Mental health care
- Resorting to the premises for shelter

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NHS Violence Reduction Standard

NHS employers have a duty of care to protect staff from threats and violence at work. In January 2021, NHS England in conjunction with the Social Partnership Forum published the new Violence Reduction and Prevention Standard, which complements existing health and safety legislation. In June 2022, NHS England published guidance notes to support organisations to perform a self-assessment. The Standard is a risk framework made up of multiple indicators, not a compliance tool.

A self-assessment has been completed in draft by the Security & Resilience Manager, and next steps will be addressed in the recently established Prevention and Management of Violence and Aggression Steering Group. The team are working in collaboration with the Trauma and Adversity project at the NHS West Yorkshire Integrated Care Board to develop benchmarking and identify common areas for additional support requirements across West Yorkshire.

NHS Workplace Health and Safety Standards – Health and Safety Executive (HSE)

The NHS Workplace Health and Standards published by the Health and Safety Executive (HSE) cover violence and aggression, lone working, risk profiling, measure and policy. A template self-assessment has been completed with an action plan against each indicator.

A key piece of work derived from this assessment is the completion of violence and aggression environmental based risk assessments, starting with the highest risk areas: Acute Floors, Emergency Departments, Paediatrics and moving to inpatient base wards. The Resilience and Security Manager is currently completing the risk assessments with the Matron in each area. An action plan can be formed from the finings with key themes being identified to help improve the safety of our environment.

Ligature Policy and Ligature Risk Assessments

A Ligature Policy has been developed and implemented (December 2021 – next review 2024) to communicate ligature awareness to staff at Calderdale and Huddersfield Foundation Trust (CHFT) and Calderdale & Huddersfield Solutions (CHS) to safeguard patients within the Trust in compliance with CQC guidance.

Environmental risk assessments regarding ligature risks and ligature anchor points have been completed and ligature rescue packs are available on all crash trollies. The audit of ligature risk assessments, training and inpatient areas to be completed has been added to annual audit plan for Trust.

Partnership Work - CHFT and West Yorkshire Police

The Trust has re-commissioned the services of a Police Community Support Officer (PCSO) from West Yorkshire Police to support CHFT staff in making the environment safe for staff and patients. The PCSO has a presence across both hospital sites, frequently attends incidents and provides debrief and education to staff. The Trust also engages with the Violence Reduction Unit at West Yorkshire Police to share known risks, build on improving partnership communication and helping to keep the base safe.

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CHFT Security Training Programmes

Enhanced Conflict Management training has been delivered to groups of staff working in areas at higher risk of experiencing challenging behaviours, such as the Emergency Department reception staff. These sessions concentrate on identifying triggers, behaviour mechanisms and legal restraint. Concerns are discussed and specialist advice is given on the handling of difficult situations.

A strategy paper to Weekly Executive Board in Autumn 2022 sets out a request for support towards commissioning enhanced training in the form of de-escalation, conflict resolution, breakaway and restraint.

CHFT Security Projects

As part of CHFT's reconfiguration plan to develop the new Emergency Department (ED) at HRI, key areas of consideration include CCTV, automatic access control systems (AACS) and lockdown principles with a focus on increasing security and safety within the department. The project also has a focus on the implementation of a safe room, a key management system and a 'staff attack' alarm system to keep staff safe. A recent business case has approved the costings for the inclusion of a partial Emergency Department lockdown capability to control movement to and from the department in the event of a security / crime / emergency threat or incident. This will provide the lockdown capacity of all external doors.

The update and expansion of the use of CCTV camera system at HRI has increased recording capacity and provided more footage in previous 'blind spots' at the site. The monitoring and capture of CCTV footage helps to assist the security team and the police to work to deter and prevent crime happening at our hospital sites keeping staff and service users safe.
Following the terrorist incident at Liverpool Women's Hospital in November 2021, NHS England issued advice to all NHS Trusts to review security arrangements. A team including the Resilience and Security Manager, security team representatives, and Estates (Calderdale and Huddersfield Solutions Ltd and ISS/Equans) conducted security reviews at both hospital sites and community sites.

Communications

Following a Freedom to Speak Up report, a CHFT personal safety poster was developed with support of the Communication team to highlight the personal safety and security support available to staff, how to access it and highlight recent improvements made to increase security across the Trust.

5. BUSINESS CONTINUITY MANAGEMENT

The Trust has a statutory duty under the Civil Contingencies Act 2004, to have Business Continuity Plans (BCPs) in case of serious business disruptions which threaten the provision

of the Trust's services. It is recognised good practice that BCPs are formulated from an in-depth Business Impact Analysis (BIA) of each department delivering services.

Business Continuity Management Policy

The Policy setting out the Trust's approach to Business Continuity Management has been reviewed and approved during the reporting period, with a next review date of November 2023.

Business Continuity Plan and Business Impact Analysis Review Guidance

Guidance has been developed to support individual departments to review their Business Continuity Plans and Business Impact Analysis to ensure the content within is comprehensive and relevant. The guidance document has recently been circulated to all Business Continuity Leads with an ask to review BCPs and BIAs.

A recent desktop audit review of all published BCPs and BIAs with the aim to identify where good practice in business continuity arrangements exist within the Trust and to identify where there are gaps and vulnerabilities. The review found that the Trust had 55 Business Continuity Plans completed and 58 Business Impact Analysis. The majority of the documents were found to be completed to a high standard. The Health Informatics Service (THIS) has a BCP which includes BIAs for 18 areas of delivery. This BCO is audited through ISO27001/9001 as well as internal audit.

17 departments were found to not have completed a Business Impact Analysis, which included three departments for which there were Business Continuity Plans.

14 departments were found to not have completed a Business Continuity Plan.

Recommendations from the desktop audit included the development of Corporate Business Continuity Plan and for all departments to review their BCPs and BIAs.

Departmental Reviews

All Trust Business Continuity Leads have been asked to review and/or complete a BCP and BIA for their department by the end of August 2022, using the new support guidance document, and submit to the Security and Resilience team. Upon return, the Plans will be checked and where additional support is required, this will be provided.

A follow up review audit will take place to demonstrate the increase in compliance in this area.

6. PRIORITY AREAS - AUGUST 2022 to AUGUST 2023

1. Business Continuity Plans / Business Impact Analysis

The direction to complete a review of all Business Continuity Plans and Business Impact Analysis by end August 2022 will help to mitigate this risk.

The development of new Business Continuity Plans and Business Impact Analysis for departments that do not have them at present will also mitigate this risk.

2. **Violence and Aggression**

The Trust is committed to minimising the risk of physical and non-physical assaults against its staff. The Resilience & Security Team will focus efforts on compliance against the Violence Reduction Standard and the NHS Workplace Health and Safety Executive Standard. The comprehensive review of the Violence and Aggression Group Policy will help to empower staff to manage violent and aggressive incidents. De-escalation training will help to improve staff skills and also the completion of the environmental violence and aggression risk assessments.

3. **Training and Drill / Exercises**

Training and exercise will continue to be prioritised to ensure the Trust is prepared in its response to incidents and emergencies. A training and exercise schedule has been

4. **Outstanding Plans, Guidance and Policies**

The completion of the few outstanding response Plans, guidance and polices will take place, with approval through the correct governance route.

7. Summary

The work programmes associated with emergency preparedness, emergency planning, security and business continuity are vast. They are critical activities to ensure the safety and compliance of the Trust for all.

A supportive work plan has been developed and helps the team to track progress, highlight gaps and plan exercise programmes.

All activities have now been restarted, clear plans are in place and the structures in place will ensure delivery of any outstanding policies or guidance and the ongoing training of colleagues.

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Date of Meeting:	Tuesday 25 October 2022
Meeting:	Audit and Risk Committee
Title of report:	Annual Fire Safety Report
Author:	Keith Rawnsley, Trust Fire Officer Edited and contributed to by Sarah Rothery, General Manager
Sponsor:	Jo Fawcus, Chief Operating Officer
Previous Forums:	Fire Safety Response Committee

Purpose of the Report

The purpose of the Annual Fire Safety Report is to provide the Board of Directors with a comprehensive review of the management and activities relating to fire safety at Calderdale and Huddersfield NHS Foundation Trust.

The report covers the period of 1st April 2021 to 31st March 2022 and includes a workplan forecast into the year ahead, to meet the requirements of the Regulatory Reform (Fire Safety) Order 2005 (RRO) and the Health Technical Memorandum (HTM) 05 – Managing Healthcare Fire Safety.

Key Points to Note

Fire Safety is a key Trust priority to ensure the safety of patients, staff and public. The delivery of a high standard of fire safety is critical to ensuring that our premises remain as safe as possible and staff are trained to be able to deal with any emergency situation that may arise.

Healthcare providers have a duty of care to ensure that appropriate governance arrangements are in place and are managed effectively. The Health Technical Memorandum (HTM) series provides best practice engineering standards and policy to enable management of this duty of care. Calderdale and Huddersfield NHS Foundation Trust (CHFT) is committed to improving and protecting the environment for those who access our services and for those who provide our services and is guided by the HTM series.

The contents of this report reflect the commitment of the Board to achieving the safest possible environment from which to deliver high quality health and care services. It details the work conducted by the Fire Safety team in collaboration with other members and teams within the organisation for the period 1st April 2021 to 31st March 2022.

EQIA – Equality Impact Assessment

The Annual Report aims to implement measures that meet the diverse needs of our service, population and workforce ensuring that none are placed at a disadvantage over others. We therefore aim to ensure that in both employment and services no individual is discriminated against by reason of their gender race, disability, age, sexual orientation, religion or religious/philosophical belief or marital status.

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Recommendation
It is recommended that the Board of Directors: 1) **NOTE** the content of the Annual Fire Safety Report 2) **APPROVE** the report for publication

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1. INTRODUCTION

This report has been prepared by the Trust Fire Officer to provide the Calderdale and Huddersfield NHS Foundation Trust (CHFT) Board of Directors with a comprehensive review of the management and activities relating to fire safety for the period of 1st April 2021 to 31st March 2022. The report includes a workplan forecast into the year ahead, to meet the requirements of the Regulatory Reform (Fire Safety) Order 2005 (RRO) and the Health Technical Memorandum (HTM) 05 – Managing Healthcare Fire Safety.

Individual responsibilities of designated persons in relation to fire safety are outlined in the Trust Fire Safety Group Policy. The Chief Operating Officer is the Executive Director with delegated strategic responsibility for fire safety across the organisation assumes responsibility at board level for all Fire Safety Policy matters.

The organisation employs a Trust Fire Officer who is supported by a Trainee Fire Officer who work as a team to carry out the operational requirements of fire safety activity across the organisation. The Fire Safety Response Committee meets monthly with a broad membership including colleagues from Calderdale and Huddersfield Solutions Ltd (CHS), and Equans.

2. EXECUTIVE SUMMARY

The Regulatory Reform (Fire Safety) Order (RRO) provides the legal framework for the implementation of fire safety in organisations and the HTM (Health Technical Memorandum) provides guidance on how to manage fire safety in healthcare premises, detailing the responsibilities placed upon the Trust and its employees. Fire safety advice, support and training is provided by the Trust's Fire Officer and Trainee Fire Officer. The Trust also commissions independent advice from a formally appointed Authorising Engineer (AE) Fire, as required by HTM 05 – Managing Healthcare Fire Safety. A 5 year Fire Strategy commissioned in 2020 and signed off by the Trust Board in March 2021 confirms the understanding and direction that has been recommended by the Trust Fire Officer and the Fire Safety Response Committee.

In 2021-22, a funding allocation of £400,000 was awarded for fire safety projects across the Trust. £252,000 of the allocation was spent on fire safety capital projects during the reporting period which is attributed in part to access restrictions to ward areas during the Covid pandemic. Major capital works undertaken at Huddersfield Royal Infirmary (HRI) have included fire safety improvements for the new Learning Centre areas and focused improvement works to upgrade the fire alarm panels.

The improvement works on the fire alarm panels has seen the replacement of the old fire panels with the new EN 54 version. This improvement gives a greater reliability of the system and allows for further upgrades to be possible in the future. The replacement EN 54 fire panels enables the fire alarm to sound only in the block where the sensor is activated, minimising the disturbance across other areas of the building. The installation has allowed for the lowering of the height of the panels allowing them to be more easily accessible for staff as they were initially installed too high.

The fire alarm system at CRH is being upgraded in line with the life cycle programme, with the majority of the site being complete with the exception of block N. There has been an agreement to not update the system in block Q as the Learning Centre will be demolished as part of the reconfiguration plan. A meeting was held with the PFI partners (SPC Albany, EQUANS and the Trust Fire Officer) to agree this stance and it was agreed that this risk is low.

Compartmentation works have been progressed at HRI. Compartmentation is the sub-division of a building into smaller sections or units in order to withstand or limit the growth or spread of a fire, through the use of fire resisting construction such as fire doors. 60 minute compartmentation works have been carried out and architectural drawings have been commissioned to show the current compartmentation of up to 30 minute and 60 minutes. The drawings will indicate the current standard of compartmentation and identify the gaps in compliance. This improvement work is being planned through a 3-phase approach: drawings, surveys and works. Surveys and improvement works will require access to ward areas. Clarity around the areas due for demolition within the Trust's reconfiguration plans is required to ensure funds and resources to improve compartmentation can be allocated most effectively. Compartmentation at Calderdale Royal Hospital (CRH) is to a good standard.

Mandatory fire training has been delivered through an updated online package, accessed via the ESR system. The Trust did not meet its overall target for fire training compliance during 2021-22 and therefore action is being taken to address the importance of completing this. An On Call Manager and Director fire exercise was carried out in October 2021 along with well attended face to face Fire Warden training and fire extinguisher training. The Trust now has over 1000 trained Fire Wardens covering all departments. A Fire Warden must be on duty whilst a department is operational and there are currently discussions underway to determine how a Fire Warden identifier can be integrated into the e-rostering system.

Construction work has now commenced for the new Emergency Department at Huddersfield Royal Infirmary and the refurbishment of the MRI area at Calderdale Royal Hospital. These capital projects require regular input from the Trust Fire Officer to ensure that plans and proposals are fire safe. The buildings works is being closely monitored by the Fire Team as not to compromise the current means of escape from Block 1.

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3. GOVERNANCE

Fire Safety Response Committee

The reporting of the Trust's fire safety compliance with current fire legislation, fire safety regulations and the Trust Fire Safety Group Policy is structured through the Fire Safety Response Committee which meets on a monthly basis.

The reporting methodology includes a presentation of a Fire Officer Report which includes a review of any incidents or fire alarms. The Committee reviews fire safety action plans, priorities contained within the Fire Strategy and reviews risks on the risk register.

It is Chaired by the Director of Operations (Corporate) and reports directly in to the Health and Safety Committee, and up to Board.

Fire Safety Group Policy

The Trust Fire Safety Group Policy underwent a review following the recommendations made in the Fire Strategy. It is currently under review again to keep it compliant and relevant, and seeks now to include a new protocol for identifying and recording colleagues who require a Personal Emergency Evacuation Plan (PEEP).

4. COVID-19 PANDEMIC

The Covid-19 pandemic required the Trust to respond to the Covid guidance to keep staff, patients and visitors safe; and this in turn has had an impact on fire safety management. The pandemic presented many fire safety challenges and fire risk factors not previously encountered, impacting on the ability to carry out some fire-related capital investment projects.

Challenges included oxygen enriched environments due to the unprecedented amount of oxygen being delivered to patients with Covid-19. Daily monitoring and on occasions twice daily checks were carried out. High readings were recorded, (above 23%) but action was taken quickly to reduce this level Only Ward 18 at HRI has full mechanical ventilation to support high oxygen delivery safely. Across other wards, windows are not usually opened in the winter months or during building works due to aspergillus and this caused oxygen enrichment risks resulting in the requirement for daily monitoring of levels and on occasions twice daily checks were carried out by the Trust Fire Officers. The dangers posed by oxygen enrichments has been published on the intranet and is now incorporated into the Fire Warden training. Staff will also be educated about the dangers in the new fire training package that is due to be launched soon.

In response to the social distancing requirements, a direct impact was the need to remove from use furniture including some waiting room chairs, desk spaces and beds. High volumes of furniture and equipment needed to be stored elsewhere causing some ongoing fire safety concerns. The storage of bulky items on corridors presents a risk to evacuation and fire loading significantly increases particularly in fire sterile environments. These storage concerns are being addressed by the Trust Fire Officers and is now documented on the risk register. It is also a standing item on the Fire Safety Response Committee.

Staff working from home had a major impact on some departments thorough departments not being covered by fire wardens whilst operational and colleague's own personal safety (home fire safety). Additional checks have been carried out and where gaps were found, contact was made with managers of these areas to address and put mitigating actions in to place. Additional Fire Warden courses were delivered to assist in this deficiency. The issue of home fire safety is addressed in the new annual fire training.

5. FIRE STRATEGY 2021 – 2026

Fire Strategy Priorities

A Fire Strategy commissioned in 2020 and signed off by the Trust Board in March 2021 confirms the understanding and direction that has been recommended by the Trust Fire Officer and the Fire Safety Response Committee. The strategy follows the guidance set out in 'Firecode – Fire safety in the NHS: HTM 05-03: Operational provisions' sets out the contents for a model fire strategy document. It seeks to inform the Trust Fire Safety Group Policy and acts as the primary control point for each of the individual building Fire Risk Assessments.

The overall objective of this Fire Strategy is to create one single and coherent approach to fire safety principles within the Trust. The strategy was performed by Mott MacDonald in accordance with BS 9997 (Fire risk management systems – Requirements with guidance for use) and makes recommendations to improve fire safety across CHFT, including some community sites. These recommendations have been prioritised over a five year period with progress against the action plan monitored at the Fire Safety Response Committee.

6. FIRE SAFETY - PERFORMANCE

Fire Risk Assessments

Fire Risk Assessments (FRA) are a legal requirement and have been carried out for all CHFT premises. The Authorising Engineer (Fire) undertakes the FRAs for the Trust by doing this it enables an independent overview on how well the Trust is progressing with fire safety. The Trust Fire Officer is in regular contact with the Trust Authorising Engineer (Fire) on related matters.

The Trust Fire Committee reports to the Trust Health and Safety Committee
Review of the assessments is managed in a rolling programme. Each FRA is reviewed by the Trust Fire Officers and then reviewed by the Fire Safety Response Committee.

The Trust currently holds 127 FRAs. This includes FRAs for CHFT, Calderdale and Huddersfield Solutions Ltd (CHS) and The Health Informatics Service (THIS). ISS and Equans hold their own FRAs.

One of the main areas for improvement is the 30 minute fire compartmentation works at HRI. Other common findings include concerning storage of items including beds, mattresses, consumables and other equipment being located in inappropriate areas such as corridors. Electrical risks include insufficient electrical socket outlets resulting in the use of extension leads which can be dangerous. The NHS has a policy of one plug, one socket. Where electrical concerns are identified, the Trust Fire Officers are asking department managers to ensure the safe use of electrical sockets which may require a reduction in the number of electrical appliances being used. Or the advice to request for the installation of additional sockets which will incur a departmental cost. Wedging open of fire doors is another concerning issue and funding is needed to allow some doors to be held on 'hold open' devices linked to the fire alarm.

The movement of departments and staff to different locations does not always necessitate the need for a review of the fire risk assessment.

Fire Risk Assessments are followed up with an action plan and a review.

Fires and Fire Alarms

No major fires occurred at CHFT during the reporting period.

In November 2021, a small printer fire occurred in Pathology at CRH. The incident was dealt with promptly and safely by a staff member using a CO^2 extinguisher. An incident report was filed and discussed at the Fire safety Response Committee.

In March 2022, there was a steam leak incident in the boiler house at HRI. Estates staff activated the fire alarm as means of giving warning and alerting staff. This initially caused confusion because staff were being asked to evacuate even though no fire was detected. A live evacuation process started to take place from which

some learning was identified. The Director of Operations Corporate Division held a debrief of this incident and learning was documented and shared at various forums.

Two small fire occurred in The Dales Unit. This is operated and managed by South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) and both fires were dealt with by SWYPFT staff and had no impact on CHFT.

False Alarms

The Trust is required to monitor fire alarm activations to ensure they are kept to a reasonable level and determine the reason for the activation putting in actions or to prevent a reoccurrence.

An unwanted fire signal (UFS) is a fire alarm where the fire service attend site and there is no fire. West Yorkshire Fire and Rescue Authority charge organisations £450 for each UFS. Their objective is to reduce the number of UFS ensuring fire tenders / appliances are available for actual fire calls. The Trust Fire Officer and Authorised Engineer continue to work closely with the Fire Authority, CHS,ISS and Equans to ensure, where possible, we manage UFS internally and are not subjected to charges.

Table 1 shows the number of fire alarm activations at HRI over the last two years: 2020-21 and 2021-22

Table 1

Year	Location	Actuations	Fires	False Alarms	Unwanted Fire Signals
2021 /22	HRI	21	0	20	0
2020 /21	HRI	37	0	33	0

NB. Additional 1 activation at Acre Mill ODP, which was a false alarm.
Table 2 shows the number of fire alarm activations at CRH over the last two years: 2020-21 and 2021-22

Table 2

Year	Location	Actuations	Fires	False Alarms	Unwanted Fire Signals
2021/ 22	CRH	29	1	28	0
2020/ 21	CRH	11	0	11	0

NB. An additional 19 activations within The Dales at CRH, 2 of which were fires.

Calderdale and Huddersfield NHS Foundation Trust

Fire Safety Training

Mandatory training during the reporting period was delivered via an ESR online training module. The Trust achieved 87.67% compliance for completion of mandatory fire safety training, against a target figure of 90%.

Although the Trust recognises that colleagues have generally been under significant operational pressure during the Covid-19 pandemic, the completion of fire safety training remains a mandatory requirement for staff. In the coming year 2022-23 the Trust Fire Officers are making changes to the online fire safety training package following feedback from staff.

Fire Warden Training

Fire Warden training continued throughout the reporting period and was conducted face to face however delegate numbers were limited due to Covid-19 restrictions. The Trainee Fire Officer delivered Fire Warden training to 488 colleagues, over double the number the previous year.
Available training facilities with sizeable rooms were limited due to vaccinations programs, social distancing, limited staff and staff working from home.

Table 3 shows the number of staff trained in mandator fire safety training and Fire warden training

Table 3

Year	Mandatory Fire Safety Training (individuals)	Fire Warden Training (individuals)
2021/22	5361	488
2020/21	5500	221

The numbers above account for Trust and CHS staff. It si estimated that around another 800 staff trained in Fire Safety in ISS, Engie, Renal, Locala, Social Services, etc.

Fire Response Team Training

Fire response team training was reduced due to Covid restrictions; however security teams and Porters at HRI have had additional training on the dry risers.

Trust Induction

Induction training is carried either by online training or by using MS Teams dependent on who the induction is for.

Fire Evacuation Training
The majority of training was suspended due to social distancing requirements, however training is expected to re-commence this coming year.

Evacuation training using the evacuation aids has also been undertaken when requested, using Evacpads and the Bariatric devices, but reduced due to Covid. A tabletop exercise was held for on call managers and directors for a fire in ED at CRH, this mirrored an incident which occurred at Leeds.

7. WEST YORKSHIRE FIRE & RESCUE SERVICE/BUILDING CONTROL

There is a sustained and open dialogue between the Trust Fire Officer, the AE Fire and the Fire Service, both in terms of building work and in conjunction with building control. We also liaise with operational crews for site visits and training by allowing use of our premises where appropriate. Site visits have unfortunately reduced due to availability of fire crews and Covid restrictions.

8. WORK PLAN 2022 – 23

Fire Safety Response Committee Annual Work Plan
The Trainee Fire Officer has developed an annual Work Plan for review at the Fire Safety Response Committee to ensure progress stays on track. The Work Plan structures work programmes in to monthly, quarterly, six monthly or annual updates in to the Fire Safety Response Committee and covers all aspects of fore safety related programmes including training, estates plans and funding, FRAs and policy reviews.

Work Schedule
The work schedule for 2022 – 23 is guided by the recommendations made in the Fire Strategy, the mitigating works to lower risks on the risk register and the findings made in Fire Risk Assessments.

The outstanding priority 2 recommendations that are behind schedule for completion need to continue to be addressed and aim for completion in 2022 – 23. Progress to achieve the priority 3 recommendations must take place alongside the completion of the priority 2 actions to ensure that the work schedule for 2022-23 is delivered.

Table 4 below indicates a range of priority work schedules in 2022 – 23.

Table 4

	Item	Lead	Status
1	**Fire Risk Assessments**		
1.1	Ongoing assessment on risks within the Trust	AE (Fire)	On-going

1.2	Work towards completion of actions from Fire Risk Assessments	KR / KZ and Fire Committee	On-going
2	**Training**		
2.1	Annual Fire Training Monitor progress to ensure suitable levels of understanding and compliance	Fire Officer	On-going
2.2	Fire Warden Provide both new and refresher training	Fire officer	On-going
2.3	Deliver Fire Extinguisher Training (practical)	Fire Officer	On-going
2.4	Deliver Evacuation Training	Fire Officer	On-going
2.5	Develop training package for 2022/23/24	Fire Officer	On-going
3	**Capital Works**		
3.1	Ensure any works carried out complies with Fire regulations	Fire Officer	On-going
3.2	Give fire safety advice on reconfiguration projects	Fire Officer	On-going
3.3	Fire Door Replacement & Maintenance Ensure work carried out is to comply with standard	Fire Officer/ CHS/ EQUANS	On-going
3.4	Continue to oversee the fire alarm up grades at both CRH and HRI	Fire Officer/ CHS/ EQUANS	On-going
3.5	Compartmentation works at CRH – drawings, survey, works		
4.	**Fire Fighting Equipment**		
4.1	Ensure Fire extinguisher are appropriate for the fire risks they cover	Fire Officer/ CHS/ EQUANS	On-going
5	**Fire Alarm Activations**		
5.1	Continue to work to reduce the number of fire alarm activations across CHFT	Fire Officer/ CHS/ EQUANS	On-going

Calderdale and Huddersfield NHS Foundation Trust

9. REFERENCES

CHFT Fire Strategy

Health Technical Memorandum 05-02: Firecode Guidance in support of functional provisions (Fire safety in the design of healthcare premises) 2015 edition

4. Governance Report

- Going Further on Winter Resilience Plans

Classification: Official

Publication reference: PR2090

To:
- ICB chief executives
- All NHS Foundation Trust and Trust:
  - Chief executives
  - Medical directors
  - Chief nursing officers
  - Chief people officers and HR directors
- All GP practices
- PCN Clinical Directors

cc.
- ICB chairs
- NHS Foundation Trust and Trust Chairs
- All local authority chief executives
- NHS regional directors

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

18 October 2022

Dear colleagues,

In August we set out a number of steps to boost capacity and resilience, with funding ahead of winter, including providing extra bed capacity and better support for staff. Thank you to you and your teams for the incredible hard work that is ongoing to make progress and deliver these focused actions, which remain crucial.

More than eight million people have already had their autumn booster COVID-19 vaccination in just over a month. However, we continue to be in a Level 3 incident, and services are under continued, significant pressure, with challenges including timely discharge of patients impacting on patient flow within hospitals, alongside ongoing pressures in mental health services.

Over the past few weeks this has been exacerbated by an increase in the number of COVID-19 inpatients and related staff absences. We continue to prepare for the possibility of high prevalence of flu, based on the evidence from other countries and advice from public health experts.

We therefore all need to be prepared for things to get even tougher over the coming weeks and months. We will support you in doing your best under these very difficult circumstances, including as you work with and support clinical leaders to ensure risk is managed appropriately across local systems. We are working with the relevant regulators to support this.

This clinical risk management is especially important to support the ongoing work to improve ambulance handovers and response times. Many of you already have access to the data platforms that you will need to drive performance or will be getting access in the coming weeks. These data platforms will inform national, regional, and local oversight, including the NHS Oversight Framework.

Going further on our winter resilience plans

In August we set out key actions to improve operational resilience, built in partnership with you. Following further engagement with systems over recent weeks we are now setting out a necessary expansion of these plans. These actions have been co-created with systems and clinical leaders and build on best practice that you have shared with us. They have been selected based on this evidence showing that they will make the biggest additional impact. In particular we want to work with you to ensure the NHS can:

- **Better support people in the community** – reducing pressures on general practice and social care, and reducing admissions to hospital by:
    - Putting in place a community-based falls response service in all systems for people who have fallen at home including care homes
    - Maximising the use of virtual wards, and actively considering establishing an Acute Respiratory Infection (ARI) hub to support same day assessment
    - Providing additional support for care homes through reducing unwarranted variation in ambulance conveyance rates

- **Deliver on our ambitions to maximise bed capacity and support ambulance services** – bed occupancy continues to be at all-time highs, and we need to take all opportunities to make maximum use of physical and virtual ward capacity to increase resilience and reduce delays elsewhere in the system. This includes:
    - Supporting delivery of additional beds including previously moth-balled beds
    - All systems setting up a 24/7 System Control Centre to support system oversight and decision making based on demand and capacity across sites and settings
    - Ensuring all ambulance services deploy 24/7 mental health professionals in emergency operation centres and on-scene

- **Ensure timely discharge and support people to leave hospital when clinically appropriate** – more than 10,000 people a day are clinically ready to leave hospital but can’t be discharged, and this causes significant and fundamental issues for patient flow. In addition to maintaining focus on the high impact actions from the 100 day challenge, the Government recently announced £500m to support social care to speed up discharge across mental and physical health pathways. More details about distribution of this fund will be shared with you when available.

Winter Improvement Collaborative

In August we committed to launching new improvement initiatives to support ambulance handover and response times, in addition to the focussed work that we are continuing to do with the 10 most challenged systems and providers.

Providers, systems, and regions have done a significant amount of work on these issues, but we have heard that we need to work with you on a faster way of identifying good practice and helping you to spread it at scale. We will therefore establish a new national Winter Improvement Collaborative by the end of October. We will review the effectiveness of this programme after 10 weeks and are committed to learning and iterating the approach to ensure it has maximum benefit. This will focus on the root causes of delay in each area. It will support teams to identify, evaluate, quantify, and scale innovation and best practice in improving handover delays and response times and reducing unwarranted variation at pace, supported by a single set of metrics.

We wish to learn from providers and systems who are tackling these issues successfully and are asking all systems to participate. The collaborative will be clinically-led, and we will work in partnership with staff using an Adapt and Adopt approach.

Continuing to support elective activity

We have proved we can deliver the ambitions set out in the elective recovery delivery plan with the virtual elimination of 2 year waits in July. Now we are in the second phase of the elective recovery plan, we need to continue to have a strong operational grip across both overall long waits and care for patients with suspected cancer. It is essential that all elective procedures go ahead unless there are clear patient safety reasons for postponing activity. If you are considering cancelling significant levels of elective care you should continue to escalate to your Regional Director for support and mobilisation of mutual aid where possible. We will be writing shortly on the next steps in recovery of elective and cancer services for our most challenged providers.

We are asking every Trust providing elective and cancer services to have their Board review the relevant performance data and delivery plans for the coming months. The Board should reflect on whether the assurance mechanisms are effective and in line with your elective recovery plan. Delivery should be managed in line with the plans and trajectories that have been agreed with NHS England regional teams. These plans should also be shared with your ICB.

On cancer, the key drivers of the cancer 62-day backlog are clear. The hard work of GPs and their teams has meant that the proportion of cancers diagnosed at Stage 1 and 2 has now fully recovered and is higher than pre-pandemic. Urgent cancer referrals are at 118% of pre-pandemic levels, while cancer treatment and diagnostic activity levels are nearer 100% of pre-pandemic levels. Three pathways (Lower GI, Skin and Urology) make up two-thirds of long waiting patients and have seen the largest increases.

Given this context, there are priority actions we are asking you to implement:

1. Faecal Immunochemical Testing (FIT) in the Lower GI pathway including for patients on Endoscopy waiting lists
2. Best Practice Timed Pathway for prostate cancer including the use of mpMRI
3. Tele-dermatology in the suspected skin cancer pathway
4. Greater prioritisation of diagnostic and surgical capacity for suspected cancer.

Infection prevention and control (IPC) measures and testing

Existing UKHSA guidance on the management of COVID-19 patients remains in place, along with the appropriate IPC measures detailed in the IPC Manual. Ahead of winter, providers should self-assess their compliance with this guidance using the IPC board assurance framework.

This guidance will continue to be reviewed based on advice from UKHSA, in line with the latest scientific evidence including the impact of COVID-19 and other respiratory diseases in the coming months. Local healthcare organisations, with clinically appropriate advice, may also continue to exercise local discretion to test specific individuals or cohorts in line with broader IPC measures.

Symptomatic testing is continuing for patients and staff, based on the current list of symptoms. Symptomatic staff should test themselves using LFDs at the earliest opportunity. Staff testing positive should follow UKHSA's return to work guidance.

Staff vaccination

It is important that health and social care workers receive both the COVID-19 and flu vaccines to protect themselves and their patients; the viruses can be life-threatening and getting both flu and COVID-19 increases the risk of serious illness. The vaccines offer the best protection for staff to better support patients and the people we care for.

All frontline healthcare workers should be offered both vaccines by their employer. Employers will confirm where both vaccines can be received, either at place of work, or, at a neighbouring provider. Health and Social Care workers can also book on the National Booking System by visiting www.nhs.uk/get-vaccination or calling 119.

Systems should continue to look at sections of their community where vaccine uptake is lower and focus significant efforts with partners to ensure community-based support is provided, building on approaches that have proved successful in the past. Trusts should also ensure that those attending for other reasons are signposted or offered vaccination.

Oversight and incident management arrangements

We will work with ICBs to ensure that oversight arrangements and associated support are appropriately focused on winter resilience and the delivery of elective recovery, including cancer, as set out above. This includes updating the NHS Oversight Framework metrics to reflect those set out in the Board Assurance Framework.

The NHS continues to operate at Level 3 Incident Response. Local systems will have their own response arrangements in place, and it is important that these continue, with robust escalation processes. There will be an opportunity to test these arrangements with a desktop exercise on winter pressures and escalation planned for November. This will be led by Regions working with ICBs, though participation will be open to all local partners. Seven day reporting against the UEC sitrep will start from Monday 31 October. Arrangements for the COVID-19 sitrep remain unchanged.

Thank you again to you and your teams for your continued hard work, and the leading role ICBs are playing in strong partnership working across the system. Since we published the winter plan in August, you have shared excellent examples of best practice

taking place across the country, and this good work has been used to inform the actions set out in this letter. The coming weeks and months will be difficult, but we will continue to support you in these challenging circumstances to ensure that we collectively deliver for patients and support our staff.

Amanda Pritchard
NHS Chief Executive
NHS England

Julian Kelly
Chief Financial Officer
NHS England

David Sloman
Chief Operating Officer
NHS England

Appendix A – Further Actions Ahead of Winter

Relevant service specifications for the actions outline in the letter can be found here.

New variants of COVID-19 and respiratory challenges

- *Systems should actively consider establishing Acute Respiratory Infection (ARI) hubs as part of preparing for managing increased ARI in the community.*

Demand and capacity

We will work with local systems to:

- *Support delivery of additional beds available to admit patients to across England to reduce the number of patients waiting in ED for a suitable bed, ambulance handover delays, and ambulance response times.*

- *Deliver their agreed contribution to the winter planning ambition of delivering an additional 2,500 Virtual Ward (VW) beds. VW capacity must be included within overall bed capacity plans and monitoring and all local VW providers must submit timely, high-quality data through the national sitrep by 24 October 2022. Systems should ensure that virtual wards are effectively utilised both in terms of addressing the right patient cohort and optimising referrals.*

- *Ensure all systems establish 24/7 System Control Centres (SCCs). SCCs will balance the risk across acute sector, community, mental health, and social care services with an aim of ensuring that clinical risk is appropriately dispersed across the whole ICS during periods of surge. SCCs will need to be supported by senior operational and clinical decision-makers to proactively manage clinical risk across the country in a 24/7 format for 365 days per year. The expectation is that systems will develop the operating model for approval via the BAF and that all systems will have an operational SCC by 1 December 2022.*

- *Improve the accuracy of information provided in the capacity tracker. The accuracy of information submitted to the capacity tracker will be key to ensuring that we can effectively manage demand and capacity at a system, regional and national level. We will work with regional teams to ensure that all providers have plans in place to submit accurate data to the capacity tracker, and that updates are submitted in line with the collection timetable.*

- *Continue to invest into acute-workforce training in managing mental health need (including paediatric acute) and embed the integration framework with associated resources for systems to support children and young people with mental health needs within acute paediatric settings.*

Discharge

- *We know that discharge challenges are causing significant issues for flow and are impacting emergency care for patients. The 100-day challenge work will continue, as local systems continue to embed the 10 best practice interventions. We will work with regions to understand the specific actions where national support is*

required to go further, and a similar programme will be extended to community and mental health trusts. Intensive discharge support will also continue for a small number of our most challenged systems and Trusts. A national data focus, beginning with a drive to improve data quality, will support real-time operational decisions.

- *We are working with cross-government colleagues through the National Discharge Taskforce to explore further options to reduce delays to discharge. This includes supporting the £500m fund to recruit and retain more care workers and speed up discharge. Looking ahead to next year, with colleagues in DHSC and DLUHC we are selecting a number of discharge Frontrunners to identify radical, effective and scalable measures for improving discharge processes and joint working between and adult social care.*

- *Mental health remains a challenge for UEC activity and delayed discharge. It is important that systems continue to invest in mental health as planned in crisis alternatives, community transformation, primary care, and liaison services in acute hospitals, and that 12 hour delays are avoided.*

Ambulance service performance

We will work with local systems to:

- *Ensure all ambulance services deploy 24/7 mental health professionals in emergency operation centres and on-scene and implement new models of improving flow out of emergency departments. Staff may be employed on a rotational or joint basis with mental health trusts. This additional capacity will prevent unnecessary mental health related ambulance trips to A&E and enable more people in mental health crisis to access the right support in their community. Further guidance will be shared shortly.*

Preventing avoidable admissions

All local systems should:

- *Have a community-based falls response service in place between 8am and 8pm for people who have fallen at home including care homes. The service should be in place by 31 December 2022 and be available as a minimum 8am-8pm 7 days per week.*

- *Address unwarranted variation in ambulance conveyance rates in care homes working collaboratively with care homes to identify and access alternative interventions and sources of support.*

- *Consider targeted, proactive support for people who have high probability of emergency admission, sometimes called High Frequency Users. For example, work in one area identified that 1% of people (~600 people) accounted for 1,925 ED attendances and 54,000 GP encounters over a 12 month period.*

Workforce

In July we wrote to you asking you to prioritise five high impact actions to maximise the retention and experience of nursing and midwifery staff. Significant progress has already been made and we are asking you to continue working across key areas, including:

1. **Nursing and midwifery retention self-assessment tool** – completed self-assessment tool and retention improvement plans should be shared with your ICS retention lead or equivalent.
2. **National Preceptorship Framework** went live on 10 October. The framework includes a core set of standards and a gold standard for organisations wanting to further develop their preceptorship programmes.
3. **Flexible working –** Your staff should be made aware and encouraged to explore flexible working options. Information and tools are available on the NHS Futures site.

We are now extending our workforce support by:

- *Re-launching the National NHS reserve campaign to bolster local surge capacity.*
- *Launching a staff offers hub to support spread of local good practice over winter.*
- *Providing a full list of recommended workforce solutions for Integrated Care Boards.*
- *Providing targeted support teams to any region or system that falls into difficulty.*

5. Board Committee Minutes in the Review Room

- Finance and Performance Committee 6 September and 7 October 2022
- Quality Committee 17 August and 12 September 2022
- Workforce Committee 16 August 2022

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

Minutes of the WORKFORCE COMMITTEE

Held on Monday 16 August 2022, 3.00pm – 5.00pm
VIA TEAMS

PRESENT:

Peter Bamber	(PB)	Governor
David Birkenhead	(DB)	Medical Director
Suzanne Dunkley	(SD)	Director of Workforce and OD
Karen Heaton	(KH)	Non-Executive Director (Chair)
Jason Eddleston	(JE)	Deputy Director of Workforce and Organisational Development
Jo Fawcus	(JF)	Chief Operating Officer
Lindsay Rudge	(LR)	Chief Nurse
Helen Senior	(HS)	Staff Side Chair
Denise Sterling	(DS)	Non-Executive Director

IN ATTENDANCE:

Alison Bohannon	(AB)	Workforce Business Intelligence Officer (for item 76/22)	
Will Ainsley	(WA)	Divisional Director, Surgery & Anaesthetics	(for item 78/22)
David Britton	(DB)	Associate Director of Nursing, Medical	
Gill Harries	(GH)	Deputy Director of Operations, Family & Specialist Services	
Caroline Lane	(CL)	Matron, Community	
Rachel Rae	(RR)	Associate Director of Nursing, Surgery & Anaesthetics	
Helen Rees	(HR)	Assistant Director of Finance, Medical	
Tom Strickland	(TS)	Director of Operations, Surgery & Anaesthetics	
Ashwin Verma	(AV)	Divisional Director, Medical	
Debbie Wolfe	(DB)	Head of Therapy Professions	
Nikki Hosty	(NH)	Assistant Director of HR (for items 79/22, 80/22 and 81/22)	
Rachel Newburn	(RN/CB)	LGBT Network Lead (for item /22)	
Catherine Riley Bentley	(CR/CB)	Women's Network Lead/Associate Directorate for Strategy (for item 75/22)	
Alicia Webster	(AW)	HR Business Partner (for item 77/22)	
Jackie Robinson	(JR)	Assistant Director Human Resources (for item 75/22)	

69/22 **WELCOME AND INTRODUCTIONS**

The Chair welcomed members to the meeting.

70/22 **APOLOGIES FOR ABSENCE**

Andrea McCourt, Company Secretary
Gary Boothby, Director of Finance
Mark Bushby, Workforce Business Intelligence Manager

71/22 **DECLARATION OF INTERESTS**

There were no declarations of interest.

72/22 **MINUTES OF MEETING HELD ON 6 JUNE 2022**

The minutes of the Workforce Committee held on 6 June 2022 were approved as a correct record.

73/22 **ACTION LOG – JUNE 2022**

The action log, as at 6 June 2022, was received.

74/22 **MATTERS ARISING**

Admin and Clerical Turnover

AB presented data for the period August 2020 to July 2022. Rolling A&C turnover had increased from 10.21% in July 2021 to 10.68% in July 2022, an increase of 0.47%. Peak in month turnover during the reporting period occurred in March 2022. During the period August 2021 to July 2022 the leaving reason of Work Life Balance dropped by 50%, while Promotion and Better Reward Package saw increases. 24 colleagues declared a destination on leaving as another NHS organisation during the 12-month period, 10 of these returned to CHFT. The remainder moved on to several different Trusts with no clear pattern identified.

DS was pleased to see a higher number of colleagues retiring and returning and asked if there had been a particular campaign to influence this. JE advised there is a recognition of good, skilled colleagues and conversations take place with leavers in order to retain that talent.

KH queried why there was a peak in leavers in March 2022. LR commented in March there is normally a cycle of leavers particularly in nursing. JE felt the financial year influences individuals. KH found the report reassuring and added she would like to see younger workforce numbers on Trust career pathways. Turnover in general will continue to be regularly reported at the Committee.

Infection Control Guidance Prevention

LR reported that new IPC guidance introduced in July 2022 allowed the reduction of mask wearing, however a further wave of covid resulted in the necessity for full precautions. Visiting restrictions were lifted and this has maintained. Nationally an early flu season is predicted and a further covid wave in autumn and January next year, therefore current plans will remain in place throughout the winter period. LR advised of the importance of supporting colleagues whilst wearing PPE particularly during a heat wave.

LR advised the vaccination programme will be rolled out early September. A comms is being developed.

DS commented that she had seen some individuals without masks. LR said that all colleagues are encouraged to challenge. It was noted that there had been an issue with stocking of the mask stations at the HRI main entrance and this would be addressed.

75/22 **UPDATE FROM NETWORK CHAIR – WOMEN'S VOICES**

CR presented an update from the Women's Voices Network. Largely, the network's objectives comprise information sharing, networking and sharing stories. All colleagues who attended the 2021 International Women's Day were invited to join the network. Around 100 people responded with 20-30 people now attending each meeting. Colleagues are invited to suggest topics/speakers and feedback from the meetings has been very positive. The Network praised Carys Bentley's support in organising topics and speakers and is looking forward to LR being the Network's Executive Sponsor. JF commented she had really enjoyed attending the meetings and had promoted the Networks at a recent leadership brief session and would do that again. DS agreed networks take time to grow and acknowledged how much the Women's Voice had developed in a relatively short time. A discussion took place about men attending the Network. CR commented that women are at the centre of the group

and it is not an anti-male environment. DS felt there is more work to do across the equality networks and developing allies would help to bridge the gap.

KH commended CR for the great work and added that CR should be very proud.

OUTCOME: The Committee **NOTED** the update.

76/22 **QUALITY AND PERFORMANCE REPORT (WORKFORCE) – JULY 2022**

AB presented the report.

Summary
Performance on workforce metrics is now amber and the Workforce domain remain at 71.2% in June 2022. This has remained in the amber position for a twelfth month. 6 of the 15 current metrics that make up the Workforce domain score are not achieving target – 'Return to Work interviews recorded', Non Covid Long Term Sickness Absence rate (rolling 12 months) and 'Non Covid Sickness Absence Rate (rolling 12 month)', and Data Security Awareness EST compliance, Fire Safety EST Compliance and Medical appraisals. Non-medical are not included as the appraisal season is running from July to October 2022

Workforce – June 2022
The Staff in Post has reduced slightly at 6101, which, is due, in part to 39.30 FTE leavers in June 2022. FTE in the Establishment was 5835.6. Turnover increased to 8.71% for the rolling 12-month period July 2021 to June 2022. This is a slight increase on the figure of 8.52% for May 2022.

Sickness absence – June 2022
The in-month Non Covid sickness absence increased to 4.32% in June 2022. However, the rolling 12-month rate for Non Covid sickness decreased to 4.88%. Anxiety, Stress and Depression problems were the highest reason for sickness absence, accounting for 25.96% of sickness absence in June 2022, with Chest and Respiratory problems the second highest at 16.94% in June 2022. The RTW completion rate decreased to 65.87% in June (at the first run of data), down from 70.97% in May 2022.

Essential Safety Training – June 2022
Performance has increased in 5 of the core suite of essential safety training with 7 out of 10 above the 90% target, however only 1 achieving the 95% 'stretch' target. Data security awareness target has been amended to fall in line with national guidelines and is now 95%. Learning Disabilities Awareness EST commenced from 10 May 2022, however is not included in Overall EST Compliance score or Domain Score totals. Overall compliance decreased to 92.61% and is the first decrease month on month. It is however no longer above the stretch target of 95%.

Workforce Spend – June 2022
Agency spend decreased for the month to £0.47M, whilst bank spend decreased in month by £1.36M to £1.18M.

Recruitment – June 2022
4 of the 5 recruitment metrics reported reached target in June 2022. The time for Unconditional offer to Acceptance in May 2022 increased and was 2 days.

JR provided more context around the increased vacancy numbers at the start of the year. To enable better planning a different approach to budget setting has been adopted in that the process now accounts for month by month changes such as winter planning, rather than a static forecast throughout the year. JR stated plans for 5 international midwives are being worked up along with 12 radiographers, 3 AHPs and a stretch target of 100 international

nurses. Support is being given to Locala for the recruitment of 10 community nurses and discussions are underway regarding expanding the Community international recruitment offer.

KH commented on the flat domain score and asked what really needs to be essential training. SD recognised the current amount of training required is unrealistic and noted the Education Committee is reviewing the whole EST suite and a proposal for next steps would be brought to a future Workforce Committee.

KH expressed concern regarding RTW interview compliance rates, highlighting the importance particularly in relation to anxiety and stress being a key factor in sickness absence levels. DS agreed with KH concerns. DS also commented on the EST compliance stretch target and asked how realistic it is to retain the 95% stretch for the rest of the year. SD acknowledged the stretch target is unrealistic and added that our compliance rates do compare well with other Trusts. The Education Committee's review will cover length and number of training modules. SD highlighted the challenges using ESR as a learning system.

OUTCOME: The Committee **NOTED** the report.

77/22 **QUARTERLY VACANCY DATA Q1 2022/2023**

AW introduced the vacancy report highlighting the planned vacancy position using the estimated year end budget figure and in month planned actuals was 320.91 FTE (5.45%) in June 2022 and is currently 440.40 FTE (7.54%) when calculated using the actual in month data. The Trust turnover has increased from 7.96% in June 2021 to 8.82% at the end of June 2022 (excludes Trainee Doctor rotations and employee transfers).

Medical and Dental
Budgeted established for medical and dental staff increased further this quarter to 710 FTE. There are currently 25 consultant level vacancies. Turnover had increased from 4% in May 2021 to just over 7% in May 2022. 13 consultants left the Trust between May 2021 and May 2022. 6 substantive appointments are due to commence in the next few months. Significant gaps remain in Surgery & Anaesthetics at Trust doctor and consultant levels.

Nursing and Midwifery
67 newly qualified nurses are in the recruitment pipeline with international recruitment providing a second pipeline of recruits. Recruitment of apprentices to top up from Nursing Associate to Register Nurses has begun. The Medicine division has the majority of nursing vacancies. Midwifery remains in line with the national shortage and funding for the recruitment of 5 international midwives is being explored.

Support to Clinical Staff
Recruitment activity continues to build our Nursing Associate workforce. In Community there continues to be a focus on the recruitment and retention issues within the AHP group. Phlebotomy posts are out to advert, the leadership structure has been fully recruited to.

Infrastructure Support
The Trust has a 6 month non-clinical post vacancy freeze and therefore the vacancy position within this staff group is likely to increase over time. Divisions are undertaking reviews to enable more efficient, effective and resilient services.

Other staff groups (AHPs, Healthcare Scientists, Scientific, Therapeutic and Technical)
Funding is being reviewed to support international recruitment for Radiographer roles. Grow your own model and workforce planning for Radiographers is in place.

KH noted the stretched gap between the planned vacancy position and actual and asked if this was achievable. SD referenced the impact by the way that Finance have set the vacancies for this year. This would be made clearer in the next vacancy report.

DS was pleased to see strong international recruitment and asked if we are retaining colleagues LR stated that in the past we had experienced colleagues recruited from Europe migrating to larger cities. More recently colleagues from India and the Philippines integrate well into the workplace and the local community.

OUTCOME: The Committee **NOTED** the Quarterly Vacancy report.

78/22 **COLLEAGUE AVAILABILITY, AN OVERVIEW OF DIVISIONAL PROCESS PLANNING RESPONSE**

SD introduced this item explaining that the pandemic stimulated a need to look at everything within our control to improve availability. SD felt the Divisions had done enormously well in supporting colleagues to return to work and acknowledged the effort in managing the complexities of workforce availability.

Divisional colleagues attended the meeting to deliver a presentation that added greater detail to the briefing paper. Assurance was provided in respect of:-

- Availability of staffing at safe levels over the summer holiday period for all staff groups (and not solely those with an e-rostering arrangement)
- Identification of any gaps, and mitigation
- Identification of lessons learned from previous peak annual leave periods (for example, Easter 2022)
- Subsequent actions taken by divisional teams to ensure safe staffing levels in peak annual leave periods
- In-division governance processes for safe staffing
- Managing headroom so there are no breaches. – key is cross divisional processes
- Escalation response/deployment plans when dealing with heightened pressures

KH queried the level of vacancies and how to plan for the unforeseen asking if there was any play in the system. WA explained services in Surgery & Anaesthetics are running on a knife edge in a number of specialities highlighting the difficulties in filling long term gaps and there being some reliance on extra contractual work from colleagues. AV acknowledged the same position in Medicine.

KH commented on the challenges and RR responded that colleagues have become skilled enough in each other's areas to know where the hotspots are. SD explained what 'headroom' comprises and RR advised the overall headroom is 22%. LR noted the 22% headroom is below the national recommendation of 25% and felt it important to recognise this in terms of the essential training review. CL explained that dashboards in Community have been devised to reflect small teams and so a safe percentage for a small team would equate to 12-15%.

SD asked what happens when a roster is signed off and then other decisions are made. RR explained any changes are alerted as part of the escalation process and often an honest conversation can address a situation. Some elements are less in control such as sickness. DB added that factoring annual leave is extremely challenging and sometimes difficult conversations are required. As part of the process additional annual leave requests are escalated to the Associate Director of Nursing. LR added there is prospective roster review that looks at KPIs that need to be set for each roster and also a retrospective roster for scrutiny.

KH thanked the Divisions for the comprehensive report and presentation noting the lessons learned and the robust systems across the board.

OUTCOME: The Committee **NOTED** the report.

79/22 **WORKFORCE RACE EQUALITY STANDARDS (WRES)**

The Committee received the WRES annual workforce data and associated action plan. NH provided an overview of improvements:-

- overall BME workforce
- BME in manager pay bands (8a+)
- likelihood of appointment is almost equal between white and BME
- likelihood of accessing further CPD
- decreases in BME staff experiencing harassment/bully/abuse in both categories
- increases in perceived equal opportunities for BME staff progression

Areas of focus for 2022/2023 will be:
- To understand the root cause of BME colleagues experiencing twice the discrimination compared to white staff (although the BME group has reported a drop in discrimination this year compared to last)
- The reduced BME representation at Board compared to the overall Trust workforce
- The likelihood of BME colleague entering the disciplinary process (though the numbers here are very small so it can fluctuate significantly year to year)

NH stated the Chief Executive currently chairs the Race Equality Network supported by some really strong advocates and wished to thank DS for her involvement. NH advised the recently established Inclusion Group would examine all inclusion elements of the WRES to identify how the Group can support areas for improvement.

OUTCOME: The Committee **NOTED** the data and progress made.

80/22 **WORKFORCE DISABILITY STANDARDS (WDES)**

NH presented the WDES annual workforce data and associated action plan. Improvements were highlighted in:-

- Self-declaration rates
- Disabled staff are more likely to be appointed

However the report highlighted areas for improvement as a negative response was seen in the following areas:-

- The percentage of staff experiencing harassment, bullying and abuse in the last year has increased in all categories for disabled staff
- Year on year there has been a decrease in the number of disabled colleagues who believe the Trust provides equal opportunities for progression or promotion
- Disabled colleagues feel more pressured to come to work despite not feeling well enough to perform duties, than non-disabled colleagues.
- Higher proportion of disabled colleagues are less satisfied with the extent the organisation values their work.
- Decrease in adequate adjustments being implemented
- The engagement score for disabled staff remains lower than that of non-disabled colleagues

HS acknowledged reasonable adjustments is being discussed in another forum but asked about training for line managers. NH confirmed an e-magazine line manager guide had been developed that would link in with the leadership development platforms. HS raised concern that often managers don't have the awareness that's required and struggle to locate the Trust's policy via the Intranet. NH encourages colleagues to speak out by attending the Colleague Disability Action Group or to reach out to HS. NH suggested she and HS connect to identify nature of concerns.

DS asked if experiences of discrimination and bullying translate into grievance cases. NH agreed to explore this and feedback into the Inclusion Group.

KH acknowledged the positives in the report however was concerned to hear that some managers lack in understanding what reasonable adjustments in the workplace means. KH also noted her concern around the level of bullying and harassment reports adding this is a big area to push forward one culture of care.

OUTCOME: The Committee **NOTED** the report.

81/22 **GENDER PAY GAP**

NH presented the report which outlined Trust data on the gender pay gap for March 2022 that will be submitted in March 2023. The key points being 5040 female colleagues employed by the Trust compared to 1185 male. The figure for the median pay gap is usually considered to be more representative of gender pay gap across the workforce, for CHFT this decreased from 20.1% in 2020 to 19.2% in 2021 and has since remained at 19.2% in 2022. There has been a continued reduction in the mean GPG from 30.9% in 2020 to 30.2% in 2021 to 28.9% in 2022. In order to drive improvement an action plan has been developed focusing on access to leadership roles, management of clinical excellence awards, colleague development and experience. The action plan will be monitored through the Women's Voices network. Discussion followed around clinical excellence awards being a key feature in disparity. The Committee noted some pay differences are historical and that the specific actions ought to support improvement. KH was interested to see how CHFT compared with other Trusts and requested this data is included in future reports.

OUTCOME: The Committee **NOTED** the report and **APPROVED** the monitoring of actions through the Women's Voices Network

82/22 **PEOPLE STRATEGY REFRESH**

SD provided a verbal update explaining feedback from the July 2022 hot house had been collated and incorporated into the strategy. Some of the amazing ideas will be translated onto posters and QR codes. SD added it's a very coordinated strategy connecting to our celebration and appreciation events planned for September. Next steps are to integrate into everything we do. SD strongly recommended the benefits of a hot house approach and 3Rs methodology.

OUTCOME: The Committee **NOTED** the update.

83/22 **BOARD ASSURANCE FRAMEWORK**
RISK 11/19 RECRUITMENT/RETENTION INCLUSIVE LEADERSHIP

SD presented the deep dive report which outlined the key controls in place to manage and reduce risk. Positive assurance highlights are:-

- Clinicians leading of transformation programmes.
- Recruitment to key roles across the Trust - see BAF risk 10a.
- Workforce Committee reviews key workforce indicators at its meetings.
- CHuFT Awards Recognition programme, 130+ nominations from a range of grades, Divisions and specialisms colleague to colleague nomination.
- Integrated Performance Report and Workforce Committee reports show Turnover of 8.28%.
- Results of Medical turnover review discussed at Executive Board.
- Reduction in vacancies to 115.26.
- Revalidation report to Board.
- Talent Management framework to Board in July 2022.

- GMC survey of trainees is positive, with CHFT having no negatively outlying results in comparison with other WYAAT trusts.

In terms of Gaps in Control the Committee noted a lack of comparative workforce data for medical and AHP staff groups compared to nursing, due to the delayed implementation of e-rostering. A medical roll-out will be completed by March 2023.

The following Gaps in Assurance were noted:-

- Review medical colleague turnover following issue of annual pension statement in October 2021, action survey of consultants early November to assess impact.
- The impact of the 2022 pay award and other pay related developments is as yet unknown. The Trust may see an increase in colleagues who are unwilling to undertake additional work and this will impact on the ability to deliver against targets and potentially again safe patient care.

The risk rating remains at 12.

KH asked if there was any update around the pension scheme. SD responded that the Trust is looking at the pensions recycling scheme again and is committed to undertaking an EQIA. The item will be discussed at the next People themed Executive Board.

OUTCOME: The Committee **NOTED** the updated and the retained score.

84/22 **EDUCATION COMMITTEE UPDATE**

The Education Committee notes had been shared with papers. JE confirmed the Education Committee is making progress notwithstanding the massive agenda. JE confirmed the Education Committee had commenced a radical EST review.

OUTCOME: The Committee **NOTED** the update.

85/22 **WORKFORCE COMMITTEE ANNUAL REPORT ACTION PLAN**

JE presented the Committee's action plan. An action to encourage debate and challenge around agenda items was noted. KH hoped for more responses to next year's self-assessment.

OUTCOME: The Committee **NOTED** the action plan.

86/22 **WORKFORCE COMMITTEE WORKPLAN**

As recent Committee meetings had very full agendas KH highlighted the need to monitor the extent of items for discussion. KH is keen to include updates from the equality network groups and linking in with other equality and diversity work would be good.

OUTCOME: The Committee **NOTED** the workplan.

87/22 **ONE CULTURE OF CARE – MEETING REVIEW**

KH felt the thread of one culture of care was evident in the reports noting that members were mindful of the impacts on the topic being discussed has on one culture of care.

88/22 **ANY OTHER BUSINESS**

No other business was discussed.

89/22 **MATTERS FOR ESCALATION TO THE BOARD OF DIRECTORS**

Women's Voice Network
Quality and Performance Report – EST compliance
Quarterly Vacancy Report
WRES/WDES
Gender Pay Gap
People Strategy
BAF – recruitment and retention/Inclusive leadership
Education Committee
Committee Action Plan

90/22 **DATE AND TIME OF NEXT MEETING:**

11 October 2022, 3pm – 5pm

Calderdale and Huddersfield NHS Foundation Trust

Minutes of the Finance & Performance Committee held on
Friday 7th October 2022, 09.30pm – 11.30pm
Via Microsoft Teams

PRESENT

Nigel Broadbent	Non-Executive Director (Chair)
Karen Heaton	Non-Executive Director

IN ATTENDANCE

Andrea McCourt	Company Secretary
Rochelle Scargill	PA to Director of Finance (Minutes)
Brian Moore	Public Elected Governor
Robert Markless	Public Elected Governor
Peter Keough	Assistant Director of Performance
Kirsty Archer	Acting Director of Finance
Philippa Russell	Acting Deputy Director of Finance
Vicky Pickles	Director of Corporate Affairs
Anna Basford	Director for Transformation and Partnerships
Helen Hirst	CHFT Chair
Chris Roberts	General Manager Medicine
Jonny Hammond	Director of Operations Medicine
Tom Strickland	Director of Operations Surgery
Ruth Lush	General Manager Surgery

ITEM

155/22 WELCOME AND INTRODUCTIONS
The Chair welcomed attendees to the meeting.

156/22 APOLOGIES FOR ABSENCE
Apologies were received from Gary Boothby, Andy Nelson, Andrea McCourt, Brian Moore

157/22 DECLARATIONS OF INTEREST
There were no declarations of interest.

158/22 MINUTES OF THE MEETING HELD 5th August and 5th September 2022
The minutes from the 5th September under matters arising, there was no “r” on the end of matters. Both sets of minutes were then approved as an accurate record.

159/22 MATTERS ARISING
No matters arising.

160/22 ACTION LOG
The Action Log was reviewed as follows:

129/22 The aged debt has now been split into commercial and non-commercial.
180/21 New due date to be provided by PK as this has become a bigger piece of work than originally intended.

143/22 Apprenticeship statistics to be requested from Suzanne.

161/22 STROKE DEEP DIVE

JH and CR gave a presentation to update the committee following the last deep dive in February. The presentation shows the Sentinel Stroke National Audit Programme (SSNAP) performance for August and give a challenging picture. As the 3rd wave of covid reduced in the spring there was an increase in demand for stroke services. SSNAP is an ongoing audit covering different areas that we are measured against. The aim is to be at SSNAP level A for all areas. The presentation showed some achieving level A and some underperforming. The scores are also presented as percentages.

Patients scanned within 1 hour of hospital arrival was rated as C. There is some ongoing work audit work to work on improving this. CR has met with the service managers in Radiology and they are doing a live audit of all the referrals for strokes into CT these are then tracked to see what outcome is. By end of month should have more data to discover what is affecting the SSNAP performance.

Percentage of stroke patients admitted directly to an acute stroke unit within 4 hours of hospital arrival. Over the last year it has been challenging to get patients onto the unit due to demand. This is also affecting the percentage of patients spending 90% of their stay on a stroke unit.

Percentage of patients thrombolysed. A number of audits looking at this in detail have taken place which have given assurance that patients that need to be thrombolysed are being so.

Challenges with workforce in Speech and Language and particularly in Occupation therapy where there is a struggle to recruit.

Quarterly score for SSNAP April to June 2022 the overall rating is at C. CHFT has not been rated at A since June 2021. This is because of several reasons – lots of variables one of which is having the similar recruiting issues as elsewhere. Access to the stroke bed base which has been reflected in the number of outliers within the Trust.

There has been an increased demand in potential strokes. It was consistent until April 2020. Increased in 2021. Then reduced in the second half of the year but significantly increased this year since February. There has been a 27% increase in the number presenting. Even in comparison to 2021 there has been a 13% increase. This has had an impact against the 4 hour target.

Stroke patients' acuity and dependency has increased during 2021 compared to 2020. Awaiting information for 2022. Length of stay has gradually increased since 2019 from 4-12 days to 8-18 days. It was particularly high in March 2022 but has reduced over the last three months.

Dedicated resource has been implemented to reduce length of stay. Advanced Care Practitioners (ACP's) New initiative having significant impact. ACP role extended to support Thombolysis team and lead ward rounds.

A working together to get results session (WTGR) took place and resulted in some actions which have now been completed. A step down criteria has been developed for rehab patients to facilitate an earlier discharge. This is resulting in faster discharge and rehab taking place nearer to patients' homes using community services. A business case covering the full stroke pathway, stroke hub and community beds has been put together but is totalling £2.7m. This is being reworked before presenting to see what can be done differently.

Discussions over last couple of weeks with Michael Folan as to how to use allocated winter monies. Could use to test changes to processes, measure and understand the impact. Successful outcomes could then be built into plans going forward.

162/22 SURGERY AND THEATRE DEEP DIVE

This is the first surgery and theatre deep dive to come to this committee. An in-depth presentation to the impact of the pandemic, current challenges, and actions taken to overcome those challenges.

In March 2020 elective theatre procedures were stood down and staff were redeployed elsewhere within the Trust. Theatre staff have skills that were vital to the dealing with covid e.g Airway management skills. In hindsight decisions made that were felt to be correct at the time were detrimental to the theatre teams. The staff were badly affected. Poor communication while working in teams they had not worked in before. Staff were scared and carrying out practices and dealing with types of patients they do not usually deal with. Sickness levels increased and a high number of theatre staff left the Trust. Left with over 30 vacancies due to colleagues retiring or leaving.

Pre covid, theatres were completing an average of 132 elective lists per week. As elective work re-started this had reduced to an average of 71 lists per week in March and April 2021. Current capacity is around 90 lists per week. The intention is to reach full capacity by December 2022 when staffing levels have increased.

Recruitment – The colleagues that were lost were very experienced and skilled in a number of specialities. There has been an extensive recruitment programme which has resulted in 41 members of staff being employed since August 2021 and 28 in the pipeline who will be in post by April 2023. The new staff do not have the same knowledge and experience as those who have been lost. Excellent training has been put in place to create a multi-skilled team and also to support future planning for retirements. This is also to encourage retention. Operating Department Practice (ODP) apprenticeships have been developed to upskill existing Assistant Theatre Practitioners (ATP) and to "grown our own" as there is a known shortage of ODP's within the region.

There has been a drop in anaesthetists covering theatres and we are currently down by five whole time equivalents. This is due to pay issues. Drop off in surgeons picking up waiting list initiative shifts.

There are a lot of challenges that have had to be dealt with. A speciality user groups have been created to drive improvement. These are positive collaborative conversations. The model is still embedding and not at maturity. Trying to improve business as usual and increase elective activity.

Looking to increase the number of cases per list alongside increasing the number of lists. This will help to clear the elective back log. Slides were shown to demonstrate the average number of cases per list per speciality.

Looked at how to incentivise staff to take on more cases but still achieve a work life balance. From April a cost per case model is being used where the team in theatre is not paid for how long they are in theatre but for how many patients they operate on. 354 additional patients have been treated as a result. This has been recognised both regionally and nationally by Getting it right first time (GIRFT) and NHSE as an innovative exemplar in trying to deliver elective recovery.

Good news – Positive feedback from WYAAT on theatre start times compared to peers across the region.

Blandine Renou staff nurse in operating theatres has been shortlisted for the Nursing times preceptor of the year.

FINANCE & PERFORMANCE

163/22 INTEGRATED PERFORMANCE REVIEW – AUGUST 2022

The Assistant Director of Performance gave an update. The report is in the process of being updated and a new version will be brought to this committee in a few months' time. The August performance score was 59% which was similar to July.

SAFE – Domain is now back in Amber due to there not being a never event in August.

CARING – Now at Amber. No mixed sex breaches, and only one of the 5 friend and family areas is currently green. There has been a small improvement in both dementia screening and stroke.

EFFECTIVE – Remains Amber with Neck of Femur unfortunately deteriorating in month following a good performance in July. Both HSMR and SHMI continue to deteriorate with scores around 107. Further work around this to try and determine what is causing the deterioration.

RESPONSIVE – Remains at Amber with the 28-day cancer faster diagnosis just below target. 3 of the 4 stroke indicators missed target with challenges around ED and elective work remain a challenge.

WORKFORCE - Remains amber with long term non covid absence increasing in month. Return to work interviews have fallen to their lowest position since December.

FINANCE – Now red with a deterioration in the use of resources and I&E.

The Committee **NOTED** the Integrated Performance Report for AUGUST.

164/22 RECOVERY UPDATE

The Assistant Director of Performance gave an update covering Activity (including delivery against the 104% trajectory), risk areas and mitigations, Standards and Diagnostics.

104% activity – Slide shows several areas where achieving. Surgical showing lots of areas not achieving 104% but as discussed in the deep dive, actions are in place. Elective Outpatients is pretty much achieving 104%. Achieving 104% does not automatically equate to all waiting list backlogs being cleared. It will depend on the speciality. Confirmation on if and how elective recovery funding will be allocated for the second half of the year has not yet been confirmed.

RTT – overall summary against key waits. Currently we do not have any 104 week waits. A couple are due in the next few months but his down to patient choice. Within WYATT and the ICB it has been recognised that we are performing well against targets.

78 weeks doing very well and below trajectory along with the external target for 52 week waiters.

Against the internal 52 week trajectory there is some work to do. The target is to breach zero by March 2023.

Within the specialities there are actions are in place. Gynaecology for example was above the trajectory but now a new consultant is due to start and an additional all day theatre session has been added so there is confidence that the target to achieve zero by the end of February will be met

ASI's – Overall there is no downward trend at the moment. Some actions in place with the aim still to reduce the 22weeks to zero by the end of year. There are pressures in certain specialities, but plans are in place.

Follow up backlog Trust position – Excellent progress in Rheumatology but upward trends in other Medical specialities and Ophthalmology.

Diagnostics – Few areas

MRI – The six week wait position is expected to be at 97% by the end of September. There will be around 50-60 patients who have been waiting longer than six weeks but this is because of intervention from other specialities, GA requirements or patient choice.

ECHO and Neurophysiology – Consultants are not willing to work additional sessions currently, so it is proving difficult to put plans in place for all specialities.

Harm review process has been created and is being piloted in Gastroenterology. This is a process where we communicate with patients through texts and letters to check in with them and see if they still need their appointment and to check their condition. Rolling out one speciality at a time.

ACTION: TS to come back to a future meeting and give an update on specialities.

The Committee **NOTED** the Recovery Report for June.

165/22 MONTH 5 FINANCE REPORT (Including High Level Risks and Efficiency Performance)

The Acting Deputy Director of Finance presented the key messages across three core areas of income and expenditure, cash and capital. The Trust is reporting a deficit of £9.4m year to date (YTD) and an adverse variance of £0.37m from plan.

. In month there was a significant adverse variance of £0.83m which eroded the positive position from previous months.. We are still seeing operational pressures and bed capacity is not decreasing but we have received a small amount of funding for that. CIP is still ahead of the plan year to date but in month behind plan which has impacted the position. Certain Covid exits schemes have not commenced and may not happen at all. Also seeing an increase in recovery costs as they return to plan so no longer offsetting some of the pressures seen in previous months. The 50% enhanced bank pay landed for part of August but will hit for the whole of September. Agency costs have been increasing month on month. Inflationary pressures have previously been mentioned for PFI costs and utilities are now starting to hit as the higher rate bills come in. Estates team are looking at what the capped rates mean for the forecast but currently expecting an overspend.

Capital underspent by £7m YTD where the Trust has not yet invested in new leases yet this year. This is thought to be a timing issues and capital spend will return to forecast later in the year. Reconfiguration costs are slightly behind and there are pieces of equipment that needs to be purchased. Cash balance is slightly behind plan at £52.6m. There have been delays in receiving funding from some NHS organisations partly to do with provider to provider invoices being raised late. Also, some technical issues resulted in some organisations not receiving invoices to pay. Expecting an improvement next month.

Aged debt increased but not a risk as mainly due to issues mentioned above. Forecasting to deliver the planned £17.35m deficit for the year which is looking increasing challenging.

ERG looking at alternate schemes to mitigate the CIP deficit. Agency spend CHFT have been giving a low trajectory as historically performed we have performed well. Our target is proportionately the lowest in WYAAT.

The Committee **RECEIVED** the Month 5 Financial report.

166/22 FORECAST SCENARIOS

The Acting Director of Finance gave a presentation based on information requested by the ICB who have requested the best, likely and worst case scenarios around the financial forecast taking into account the risks and budgetary pressures.

The ICB would in the first instance expect each organisation to manage their own risks. They would then look for organisations to have conversations at a PLACE level and seek options locally. The third and final step is looking to see if there is any mitigation at the whole ICB level.

Best case scenario is basically to deliver the planned deficit of £17.35m with a zero variance. This assumes we would be able to bring the pressures back on track.

Likely scenario would go off plan by £7.6m adverse variance on top of the £17.35m. This assumes that various things are not able to be mitigated such as full delivery of the CIP programme, some of the additional operational pressures and a continuation of the pay enhancements until the end of September.. **Worst case scenario** assumes all the risks and challenges happening at once including not receiving ERF for the second half of the year, full year exposure to pay enhancements and covid/winter surges over the winter period. This is the extreme position in the unlikely event that all risks and challenges materialise but demonstrates the extent of risk and challenge in the financial position. **Next steps** – Identify alternative plans to close the CIP gap already identified. Secure savings from gateway 1 schemes, scoping and high risk schemes or mitigate.

Review the impact of the enhanced bank pay and decisions that could be taken around that.

ACTION: Bring back to the committee with an update to the next meeting more detail what action can be taken to mitigate the risks identified in the presentation - KA / PR

167/22 EFFECTIVE USE OF RESOURCES GROUP (ERG) / EFFICIENCY TARGETS

The Acting Director of Finance gave a verbal update. The regular ERG update has been covered during other agenda items.

5 year planning - There have been a series of sessions on the future operating models 5 year planning. Final sessions have focussed on benefits realisation from reconfiguration. The output from these meetings need to be aggregated . The next update is due to the January meeting of this committee.

The Committee **NOTED** the Effective Resources update and the higher risk schemes.

168/22 BAF RISKS

Most remain unchanged in terms of risk. Some narratives updates and marked in the papers.

Committee **APPROVED** the update of risks

169/22 ONE CULTURE OF CARE (OCOC)

Chair highlights report will refer to any items linked to one culture of care.

170/22 DRAFT MINUTES FROM SUB-COMMITTEES

The following minutes and summaries thereof were received by the Committee:

- Business Case Approval Group (BCAG)
- THIS Executive Board
- Access Delivery Group
- Capital Management Group

The Committee **RECEIVED** and **NOTED** the key points from the Sub-Committees.

171/22 WORKPLAN – 2022/23

The workplan for 2022/23 was reviewed.

- The THIS Strategy has been pushed back to the next meeting due to the number of items on today's agenda.

The Committee **APPROVED** the Workplan for 2022/23

172/22 ANY OTHER BUSINESS

173/22 MATTERS TO CASCADE TO BOARD

- Reflect on the two deep dives.
- Key concerns from the IPR

- Finance month 5 still challenging.

DATE AND TIME OF NEXT MEETING:
Tuesday 1st November 2022, 13:00 – 15.00 MS Teams

Calderdale and Huddersfield NHS Foundation Trust

Minutes of the Finance & Performance Committee held on
Tuesday 6th September 2022, 13.00pm – 15.00pm
Via Microsoft Teams

PRESENT

Andy Nelson	Non-Executive Director (Chair)
Nigel Broadbent	Non-Executive Director

IN ATTENDANCE

Helen Rees	Assitant Director of Finance
Andrea McCourt	Company Secretary
Rochelle Scargill	PA to Director of Finance (Minutes)
Brian Moore	Public Elected Governor
Robert Markless	Public Elected Governor
Peter Keough	Assistant Director of Performance
Kirsty Archer	Deputy Director of Finance
Suzanne Dunkley	Director of Workforce and Organisational Development
Adam Matthews	HR Business Manager

ITEM

137/22 WELCOME AND INTRODUCTIONS
The Chair welcomed attendees to the meeting.

138/22 APOLOGIES FOR ABSENCE
Apologies were received from Gary Boothby, Stuart Baron, Jo Fawcus, Rob Birkett, Helen Hirst and Vicky Pickles.

139/22 DECLARATIONS OF INTEREST
There were no declarations of interest.

140/22 MINUTES OF THE MEETING HELD 5th August 2022
The minutes of the last meeting could not be approved due to this meeting not been quorate.

141/22 MATTERS ARISING
No mattes arising.

142/22 ACTION LOG
The Action Log was reviewed as follows:

180/21 – Review of the IPR against the performance accountability framework. A new format has been created and shared with some of the Exec. team for comments and feedback. This will be presented at the Board Development session at the beginning of October.

143/22 WORKFORCE DEEP DIVE

The Director of Workforce and Organisational Development (WOD) gave a verbal update.

The workforce deep dives have taken place quarterly during the pandemic. The teams are looking at availability of staff rather than absence now. Absence has been broken down in term of sickness, annual leave etc. to get an accurate picture of resource available. There have been high volumes through the Emergency Department (ED) most of which genuinely need the ED services. The Delayed Transfer of Care (DTOC) figures are currently above 100 with target of 70.

Covid numbers have reduced but currently experiencing some operational difficulties meaning we have been operating around Operational Pressures Escalation Levels (OPEL) level of 3. Workforce is crucial in responding to this both from a resource point of view and how colleagues are supported. The Trust currently has an absence rate of 5.5% inclusive of Covid which compares favourably across WYATT who area reporting around 6%.

The refresh of the people strategy has been completed and is really clear and easy to understand showing the plans in place for the workforce. One of the main focusses is the “Grow your own” initiative which looks are recruiting staff to develop into the roles that are required. Colleagues are not being redeployed at the same rate as they were during the pandemic, but it is still happening. Where possible we are keeping colleagues on the same site. Elective Recovery is going well.

Underpinning everything is our wellbeing strategy with support for colleagues to increase.

The Covid and Flu Vaccination programme starts on the 12th September with Carol Pinder as project manager. The information being shared on the government website is incorrect as it is advising against pregnant and breastfeeding people having the Covid vaccination. This is going to be updated and awaiting clarity on some other points.

ACTION Andy Nelson and Suzanne Dunkley to meet to discuss the information included in future workforce deep dives.

The funding for Continuing Professional Development (CPD) changed a few years ago. An Education Committee has recently been created to ensure that available resources and funding are allocated to the right areas. Training budgets will be centralised and a new suite of Leadership development has been put together.

The Apprentice team is a jewel in the crown of CHFT. On a recent OFSTED inspection, we were rated Good or Outstanding across the board. They have also been nominated for the regional apprenticeship awards. Currently looking at offering higher level apprenticeships in non-clinical areas.

ACTION: Suzanne Dunkley to arrange for the apprenticeship statistics to be sent to this committee.

144/22 TERMS OF REFERENCE (TOR) FOR THIS COMMITTEE

Approval of the TOR is to be deferred due to the next meeting not being quorate. Comments on the TOR were received.

ACTION: Point 5.2 to be updated to include two governors in attendance from one.
ACTION: Quoracy requirements of meeting to be reviewed. Andy Nelson and Andrea McCourt to discuss.

FINANCE & PERFORMANCE

145/22 INTEGRATED PERFORMANCE REVIEW – JULY 2022

The Assistant Director of Performance gave an update. The Trust has been under extreme pressure for months now which has impacted the performance score. Currently at 58% with two domains, Safe and Caring, at red. There has also been another never event which equates to 5 in 5 months which is concerning but there are no patterns between the events.

SAFE – Domain is now red due to the never event and missing other standard targets.

CARING – Now at red as only one of the friends and family standards is now green where previously we had two. There has been a small improvement in both dementia screening and complaints.

EFFECTIVE – Remains Amber with Neck of Femur improving in month and only just missing the target. Looking ahead August is not looking in as good a position but this may be due to annual leave. Will be reported in depth at the next meeting.

RESPONSIVE – Remains at Amber after achieving the 28-day cancer target which was missed last month. The Emergency Department (ED) has had the most difficult month in terms of performance.

WORKFORCE and FINANCE both remain amber and have been covered in detail elsewhere within this meeting.

Positives – At the end of July there were zero patients waiting 104 weeks. Having reviewed CHFT against national benchmarking for ED performance April to July, CHFT is rated 7th out of over 100 organisations. Only one of the organisations rated higher has more attendances than us.

CHFT is the best performing acute trust for hitting the Cancer 62 days target, comparing April to June figures.

Combining both of those benchmarks, rates CHFT 3rd nationally.

Action plans and deep dives are in place to tackle those areas that have been underperforming for some time e.g. complaints, dementia screening etc.

Additional staff in quality team

HSMR – Current position is now 106.69 which is above the CHFT “as expected” range. Work being done.

SHIMI – This has stabilised within the “expected” range. Ongoing work around outlying mortality in the sepsis group.

The Committee **NOTED** the Integrated Performance Report for July.

146/22 RECOVERY UPDATE

The Assistant Director of Performance gave an update covering Activity (including delivery against the 104% trajectory), risk areas and mitigations, Standards and Diagnostics.

Activity against 104% - There are several areas where we are not meeting the targets in terms of Elective and outpatients. However, in follow ups CHFT is reaching over the 104%. Looking at the national reporting figures only two organisations have achieved 104% across the board.

In comments – Some specialities are not achieving the levels should be doing. ENT, neurology etc. These are being looked at in more detail at the Access Delivery Group meeting. General managers have been asked to provide a verbal or written reports on those specialities not reaching 104% activity. The Access Delivery Group minutes do form part of the papers for this committee.

There are currently no patients waiting 104 weeks. 78 weeks is also doing well and is below the trajectory which aims to reach zero by the end of February 2023. For patients waiting over 52 weeks, the internal target is being achieved without ENT. The aim is to reach zero by March 2023, but we currently have 400 patients more than we would like at this point.

ASI’s (first appointments appointment slot issues.) Surgery is close to their trajectory, but FSS and Medicine are off target but small numbers are involved. Acute specialities are not significantly away from target but plans are in place to put them back on track.

The Committee **NOTED** the Recovery Report for June.

147/22 MONTH 4 FINANCE REPORT (Including High Level Risks and Efficiency Performance)

The Deputy Director of Finance presented the key messages across three core areas of income and expenditure, cash and capital. The Trust is reporting a deficit of £8.44m and a favourable variance of £0.46m.

Contributing to this is the fact that the delivery of the efficiency programme was ahead of plan in year to date. That was offset in part by operational pressures e.g.,

higher Covid numbers and and a higher bed base than assumed in the plan. Assumptions were based on national guidance through the planning stage. The Elective Recovery Funding (ERF) will not operate any clawback based on performance for the first half of the year. This secures the income position for quarters 1 and 2. Guidance is expected for H2 but has not yet been seen.

Agency trajectory was mentioned from the expenditure position. Agency spend is linked to operational capacity pressures as well as elective recovery. Spending on agency is above plan. The CHFT agency trajectory has been confirmed by the ICS and is similar to planned levels. Year to date we are operating above the trajectory and above forecast. This contributes to our use of resources score so is closely monitored.

The overall forecast position for the year continues to be a planned £17.35m deficit. This is looking increasingly challenging but the forecast at month 4 is to achieve this deficit. This figure included full delivery of the £20m CIP target and full receipt of the elective recovery funding. There are a range of risks and potential benefits highlighted within the forecast section of the paper.

Pay award was announced as fully funded but in reality there is a pressure of £800k.

At the end of the month cash in bank of £52m against a plan of £58.6m. The difference is due in the main to the timing of cash payments for capital investments. Cash remains healthy but will reduce towards year end and become more challenging next year. Capital below plan with lower spend on IT and licences. Aim to be back on plan by year end, with teams encouraged to make investments as soon as possible.

The Committee **RECEIVED** the Month 4 Financial report.

148/22 FINANCIAL CHALLENGES WITHIN MEDICINE

A lot the pressures mentioned previously are coming out in Medicine e.g. bed capacity etc. End of month 4, Medicine had a £8.5m overspend against forecast. Year to date medicine is £2.3m overspent against plan.

Recovery funding is currently sat in the medicine management group which is offsetting recovery expenditure in directorates.

Assumptions were made during planning for this year that the usual seasonality on the number of available beds would occur. Unfortunately, this summer has been the same as a winter period which has created extra pressures with extra beds in several areas which require more staff etc.

Some of the hotspots were listed as:

- Acute floor is CRH bed plan 45 but operating all year at 60.
- Ward 6AB CRH 26 beds using 32
- Respiratory CRH 45 beds using 60
- ED Medical staff – The respiratory workstreams are still being treated differently which is leading to a doubling up in some areas of ED.

- Number of vacancies in Medical and nursing staff for ED which is leading to more agency costs.
- Ward 18 HRI – Is being used as an Isolation unit.

When the planning exercise took place for this year the assumptions used were based on national guidance. We have managed to reduce length of stay to below the assumed average figure of 5.07 days to 4.5 days in the Trust and 4.9 days in Medicine.

Bed occupancy was expected to reduce to 92% but we have reached 95.2% over Summer with the birth centre and discharge lounge being used as extra beds. The plan for Summer was to have 403 beds for Medicine but it has reached 476 beds. This has led to an increase in bank and agency spend.

We have secured an additional £2.2m from the bed capacity fund which will help medicines position. It was hoped that the with respiratory pathway segregation in ED would reduce back to a single workstream but with predictions for Covid over winter this is not going to happen and the separate workstream will continue.

At the Hard Truths nursing review, it was agreed to look at more substantive staffing around the increased bed base. Reviewed and agreed workforce models to attract some more substantive staffing in those areas. We would still be using bank and agency but longer-term bookings should lead to better rates.

Neighbouring Trusts are having the same issues.

149/22 EFFECTIVE USE OF RESOURCES GROUP (ERG) / EFFICIENCY TARGETS

The Deputy Director of Finance gave a verbal update. The group has been in receipt of change control notices through ERG, where schemes were planned but are not going to happen. These go through a review process to see if all options have been explored. £1.72m of these schemes were flagged as a risk with 500k mitigated identified.

There were £20m worth of efficiencies identified and we were forecasting accordingly. The schemes that are not going to happen leave a £1.17m financial gap. So alternative plans are required to cover the gap. In the meantime, we will continue to report £20m in efficiencies while trying to identify the £1.17m. The efficiencies identified to cover this are more likely to be non-recurrent.

Some of the efficiencies we were hoping to gain were around Covid but we have not been able to remove the extra measures to the extent expected. Likewise with medical workforce rates of pay for medical bank staffing.

September sees the launch of initiatives to look at identifying efficiencies over the next 5 years. These will link into efficiencies to be gained from the reconfiguration process and what happens between now and reconfiguration being complete.

Appreciation event planned – This is about getting out to say thank you to staff plus ask them for ideas how they want to work and any efficiency ideas they might have.

Give it a go week – Jo Fawcus and Gemma Berriman are leading on this and have been asking for ideas. The focus is on making operational changes. There have been a lot of ideas received which are now being filtered through for a selection to be piloted during the week. Anything that works well will be fed back as an efficiency.

Target operating models (TOM) meetings have commenced which cover a range of topics leading into reconfiguration. These discuss where we are now, where we are going to be and what can we do differently in the meantime. These groups will also pick up the exit from Covid commitments and where they fall into those steams of work.

The Committee **NOTED** the Effective Resources update and the higher risk schemes.

150/22 ONE CULTURE OF CARE (OCOC)

Chair highlights report will refer to any items linked to one culture of care.

- Workforce deep dive most notably our success with apprenticeship schemes

Agency and bank spend

151/22 DRAFT MINUTES FROM SUB-COMMITTEES

The following minutes and summaries thereof were received by the Committee:

- Business Case Approval Group (BCAG) - August 2022
- THIS Executive Board July 2022
- Access Delivery Group July 2022
- HPS Board meeting – August 2022
- CHFT / SPC July 2022
- Cash Committee July 2022

Nigel now attending HPS board - Recovery plan to be pulled together to recover the financial plan as much as possible. To be discussed at next HPS board.

The Committee **RECEIVED** and **NOTED** the key points from the Sub-Committees.

152/22 WORKPLAN – 2022/23

The workplan for 2022/23 was reviewed.

- The HPS Strategy to be pushed back again as the October HPS board meeting has been moved to November.
- There were a lot of deep dives planned for the October meeting. The ED one has been moved to the November meeting. The stroke update is an update

from a previous deep dive and the focus will be on the Surgery/Theatre deep dive.

The Committee **APPROVED** the Workplan for 2022/23

153/22 ANY OTHER BUSINESS

154/22 MATTERS TO CASCADE TO BOARD

- Operational performance remains very challenging
- Benchmarking of key measures against other Trusts.
- Financial pressures putting full year forecast at risk
- Medicine update which exemplifies the types of pressures being faced by the trust as a whole.

DATE AND TIME OF NEXT MEETING:
Friday 7h October 2022, 09:30 – 11.00 MS Teams

Calderdale and Huddersfield NHS Foundation Trust

QUALITY COMMITTEE

Monday, 12 September 2022

STANDING ITEMS

148/22 WELCOME AND INTRODUCTIONS

Present

Denise Sterling **(DS)**	Non-Executive Director **(Chair)**
Mr Neeraj Bhasin **(NB)**	Deputy Medical Director
Dr David Birkenhead **(DB)**	Medical Director
Sharon Cundy **(SC)**	Head of Quality and Safety
Jason Eddleston **(JE)**	Deputy Director of Workforce & Organisational Development
Karen Heaton **(KH)**	Non-Executive Director
Victoria Pickles **(VP)**	Director of Corporate Affairs
Nicola Seanor **(NS)**	Associate Non-Executive Director
Kim Smith **(KS)**	Assistant Director for Quality and Safety
Elisabeth Street **(ES)**	Clinical Director of Pharmacy
Michelle Augustine **(MA)**	Governance Administrator **(Minutes)**

In attendance

Tara Brierley **(TB)**	Patient Experience Team Leader **(Observing)**
Lauren Green **(LG)**	Dementia Lead Practitioner **(item 151/22)**
Onyinye Okafor **(OO)**	Student Nurse on Placement **(Observing)**
Shelley Rochford **(SR)**	CQC Compliance Lead **(Observing)**
Gillian Sykes **(GS)**	End of Life Care Facilitator **(item 156/22)**
Diane Tinker **(DT)**	Director of Midwifery **(item 155/22)**

Apologies

Gina Choy **(GC)**	Public Elected Governor
Jo Fawcus **(JF)**	Chief Operational Officer
Andrea McCourt **(AMcC)**	Company Secretary
Lindsay Rudge **(LR)**	Deputy Director of Nursing
Lucy Walker **(LW)**	Quality Manager for Calderdale Integrated Care Board

149/22 DECLARATIONS OF INTEREST

There were no declarations of interest.

150/22 MINUTES OF THE LAST MEETING AND ACTION LOG

The minutes of the last meeting held on Monday, 17 August 2022 were approved as a correct record. The action log can be found at the end of these minutes.

151/22 MATTERS ARISING

Dementia Options Appraisal

Lauren Green was in attendance to present a dementia options appraisal, as circulated at appendix B.

KH asked about the dementia screening in other Trusts in the region. **LG** stated that there is a mixture where some Trusts use their nursing teams, and some use their medical teams. It was noted that one of the implications of CHFT moving this task from the medical team to the nursing team would be nursing capacity.

NB asked a series of questions, including whether the Advanced Clinical Practitioners (ACPs) were included in the options appraisal; if there is part of the assessment which must be done

by the medical team; whether there was a way of digitally pulling the data onto the discharge summary once screening has been done; and whether a hard stop in the Electronic Patient Record (EPR) notes has been considered, understanding that this has implications in terms of patient safety in a very acute situation.

In relation to the ACPs, **LG** stated that they were considered in the options appraisal, as they support the acute areas, however, other assessment areas such as the surgical assessment unit (SAU), and orthopaedic areas would struggle, as there would not be any consistency across all areas.

Regarding the assessment, **LG** stated that a medic does not necessarily have to complete it, as it is information gathering, however, there are specific parts of the assessment which must be completed in order for it to be pulled through and recorded effectively on EPR for audit purposes.

In terms of the hard stop, this was considered, however, it was felt at the time that due to other visual reminders around Venous Thromboembolism (VTE) and COVID, colleagues would become numb to further reminders. The assessment is mandatory; however, colleagues could still bypass the hard stop, therefore it was not able to be done through EPR.

With regard to digitally pulling the data, a conversation is needed with the EPR team to ascertain whether it can be done, rather than the medical team going into the discharge paperwork and ticking a box for it to be requested through the GP. **LG** stated that this will be taken forward once an outcome of the options appraisal has been confirmed.

SC queried whether Healthcare Assistants and dementia champions could be used to assess, once trained. **LG** stated that there are dementia link practitioners based on wards, however, the assessment needs to be carried out by a registered member of staff.

NS commented on the key performance indicators and the impact of any changes made, ensuring that this is monitored. **NS** suggested placing some targets within the options appraisal of what might be put in place, and to evidence how the changes have or will make a difference.

As the Quality Committee have now set out their expected improvement trajectories, the Chair asked what the next steps were regarding the decision-making for the options appraisals. **LG** had assumed that the Quality Committee would be making a decision, however, **VP** stated that the verdict will need to be an operational decision, to understand the impact on nursing time to care, workflows, etc and would need to return to the operational management structure for nursing input.

LG agreed to discuss the comments and considerations from the Quality Committee with nursing colleagues within the dementia operational group at the end of the month, and also the Clinical Outcomes Group, and a further conversation with the Chief Nurse will also take place.

OUTCOME: **LG** was thanked for the presentation, and the Quality Committee were in support of the preferred option for the task to be moved from medical colleagues to nursing colleagues, however, a swift decision to support the work required will need to be made, in conjunction with nursing input.

Complaints Internal Audit Action Plan

Kim Smith provided an update on further assurance on the recommendations within the complaints internal audit action plan as circulated at appendix C.

Work has taken place since the update at the last meeting, including the appointment of Tara Brierley into the Team Leader post for the Patient Advice and Liaison Service (PALS) and Complaints service, which will provide increased support to the Head of PALS and

Complaints, as well as increased oversight over operational issues. The team are also in the process of advertising a Band 3 PALS support post.

Additional assurance was provided around the complaints process and complaints training, with complaints being triaged on a daily basis and allocated across all divisions for a timelier response. Quality monitoring is also in place with an increased level of scrutiny on a weekly basis. There are still some elements around colleague training in relation to the complaints process, which will be part of the Patient Safety Incident Response Framework presentation later in the meeting. There may be some investigation training for the complaints teams in the short term, while the Patient Safety Incident Response Framework is being implemented.

NS commented on the extensive work done and asked about the role of equality and diversity, as there is not a specific reference in the audit report, and the equality impact assessment section of the report mentions that it is not deemed to have a detrimental impact on the protected characteristics. It was asked that reports provide a breakdown from a protected characteristics perspective to understand on an ongoing basis, who is providing feedback, who is complaining and whether they are representative of the communities served. **KS** agreed to include this in future reports.

OUTCOME: **KS** was thanked for the update and the Committee noted the report.

AD HOC REPORTS

152/22 HEALTH AND SAFETY HIGHLIGHT ASSURANCE REPORT

This is in relation to required changes to our terms of reference, and a requirement for the Committee to receive assurance of health and safety regarding colleague and patient safety, focusing on learning from incidents.
Action: To be deferred to the next meeting.

RESPONSIVE

153/22 INTEGRATED PERFORMANCE REPORT

David Birkenhead presented the integrated performance report as circulated at appendix E, focusing on the quality aspects of the report.

There has been a clear deterioration in performance over a number of months, demonstrating the pressures the NHS is currently under, following COVID and the continued high numbers of COVID patients, at the time of writing, which were in the hospital and also reflecting increased attendances in the Accident and Emergency (A&E) department, and increased morbidity amongst those patients. Pressures are seen through the emergency care standard 4 hour target and general pressures on services through the cancer metrics, however, overall, there has been improvement in the 62-day referral to treatment, despite CHFT providing support into the Bradford and Mid Yorkshire Hospital Trusts.

Complaints is currently challenging for colleagues trying to balance governance activity along with recovery activity, and also recognising higher levels of staff absence.

In relation to the Never Events, since the time of writing the report, one has been downgraded to a serious incident following a review, which involved the retention of part of a gastric band which was being removed. The gastric band was not placed at the time of that surgery, therefore, does not formally fit into the Never Event framework. There is a further serious incident which the Integrated Care Board (ICB) is encouraging to be reported as a Never Event, however, the Trust is confident that it does not meet the framework, therefore there is some challenge to the ICB regarding why it would need to be included as a Never Event. It was noted that the Never Events have been identified over a period of time.

Looking at CHFT performance in comparison to peer organisations, this is still reasonably strong, albeit not as good as it was two years ago.

Issues around data quality was highlighted, namely the screening of emergency patients for Methicillin-resistant staphylococcus aureus (MRSA). It is known that the denominator is incorrect, and whilst the data is helpful in comparing month-on-month, it understates the compliance, as there are patients within the denominator who do not require an MRSA screen. There does not seem to be a simple way of extracting them from data feeds out of the Electronic Patient Record (EPR), which causes an ongoing challenge.

The improved performance in the fractured neck of femur metric was highlighted, as well as challenges around infection control, particularly in relation to C.difficile, where there are higher numbers than previous years, which increased through COVID and an elderly population being in hospital for longer, as well as the use of broad spectrum antibiotics to manage respiratory tract infections. The increase in C.difficile is not unique to CHFT. On a positive note, there have not been any MRSA bacteraemia cases for around 18 months, which is really positive and a testament to colleagues around their hygiene practice.

It was noted that the content of the IPR will be reviewed for a simpler framework.

NS commented on the point made around colleagues finding it difficult to meet the governance requirements as well as operational delivery requirements, and asked what this looks like, as a lot of demands are made for colleagues to attend meetings, to contribute to writing reports, and if that has an impact. **DB** stated that they all have an impact, and the challenge is when in a recovery position and trying to undertake as much clinical work as possible to reduce the risk to patients, colleagues can potentially get distracted from what is good governance. There is a pressure on colleagues' time which needs to be acknowledged by the Committee.

DS asked about the vaccination programme and the targets. **DB** stated that the national targets for COVID and influenza are 80-85%. It is not clear how many colleagues will come forward, however, the information will be provided in order for an informed decision to be made. The COVID vaccination programme started this week, with the influenza vaccines starting in the first week of October, with clinics running on alternate sites.

DS also mentioned the lack of monkeypox vaccines for colleagues, and asked if this was an issue, and whether any colleagues have been infected. **DB** stated that, to the best of his knowledge, no colleagues have been infected, however, some will be at risk if exposed on a regular basis. There have been monkeypox cases through the sexual health clinic, where patients are advised to attend, although it is not necessarily a sexually transmitted infection. Guidance from NHSE was initially that colleagues should be vaccinated, however, the vaccine has not been made available to vaccinate colleagues at this point in time, although a small number have been vaccinated using the stocks held. Further vaccines are expected into the UK at the end of September, and the work ongoing in pilot centres using a diluted vaccine via an intradermal injection, will probably be rolled out, increasing the number of doses per vial from one to five. This will allow more of the vaccine to be available not just to the population but also our colleagues.

OUTCOME: **DB** was thanked for the update and the Quality Committee noted the report

SAFE

154/22 PATIENT SAFETY INCIDENT RESPONSE FRAMEWORK

Kim Smith presented the report as circulated at appendix F on the Patient Safety Incident Response Framework (PSIRF) and how it will be implemented across the organisation.

There is a clear 12-month timeframe for the implementation of this framework, and the Committee were assured that the serious incident investigation process and the orange and red panels will continue, with the two-system process running alongside each other for a

period of time. The key theme to PSIRF is learning from incidents, themes and trends across the health economy, rather than looking at individual incidents.

The PSIRF standards, implementation timeline and next steps were provided, and it was noted that this is a significant piece of work and a significant change for organisations, however, there are some early adopters locally within our networks and 'go-sees' will be undertaken to see how they have adopted this. This is the start of a continuously improving process, with a significant amount of guidance to assist with implementation.

NB asked whether this would require any change or additional training for investigators. **KS** stated that there will be some additional training, however, the basic principles around investigations will be similar.

KH proposed frequent updates to the Committee to see progress and to understand how to overcome any barriers. **KS** stated that updates will form part of the Quality Report on a bi-monthly basis and include some successes as well as any challenges.

In relation to the transition over the next 12 months of this new way of working, **JE** asked what will be done less in the future compared to now, and what more will be done. **KS** stated that there will be fewer individual investigations for individual patient incidents, and more themes and trends, which will hopefully reduce the impact on operational colleagues spending lots of time on similar responses.

VP queried when implementation starts; what will look different for the Trust when the implementation of PSIRF reaches month 9 or 12; and what the implications for other policies and processes across the organisation will be. It was suggested that these are provided through future presentations to the Committee.

KS stated that we are technically in month one of implementation, and noted some challenges, which are still not clear, on information which is shared with coroners and how this might be done, as when incidents take place, coroners request individual action plans for individual patients, however, this is not what it will look like in the future. As part of the education, work with coroner colleagues will be that the information received will be the learning and what has been done to reduce the likelihood of the same event occurring in the future. There will also be implications for other Policies, challenges with different incident management frameworks, etc, however, the first 12 months will be information gathering, and month 13 will be the start of implementation.

DS asked about the capacity within the Quality and Safety team to implement this work in the next 12 months, and whether any support is required. **KS** stated that Sharon Cundy (Head of Quality and Safety) is now in post, as well as Richard Dalton (Head of Risk and Compliance). Increased support may be required; however, this will not be known until the roles and responsibilities are defined.

OUTCOME: **KS** was thanked for the presentation and the Committee noted the report.

155/22 MATERNITY OVERSIGHT REPORT

Diane Tinker presented the report as circulated at appendix G, providing key points including the positive assessment against the seven Immediate Essential Actions (IEAs), with receipt of the full report, which was appended to the paper.

The Chief Nurse and Associate Nurse Director attended the Kirklees Adults Health and Social Care Scrutiny Board on 6 September 2022 to provide an update on the Ockenden and the current Huddersfield Birth Centre, which is currently suspended due to staffing challenges. The outcome of the meeting provided assurance from Ockenden, and different ways of working with Mid Yorkshire Hospital Trusts in providing a low risk birth centre within Kirklees.

The maternity transformation plan includes Ockenden 1 and 2, the maternity incentive scheme, the staff survey and benchmarking. A regular update is provided within the division and directorate; however, a new process of a monthly confirm and challenge meeting has been put in place, led by the Chief Nurse, and external scrutiny carried out by **KS**. Going forward, the transformation plan will indicate improvements over the month, with clear assurance on the number of improved actions.

KH asked about the timescale in relation to the new ways of working regarding maternity staffing. **DT** stated that the new ways of working were approved on 2 September 2022, with the expectation that advertisements are out within the next couple of weeks.

OUTCOME: **DT** was thanked for the update and the Committee noted the report.

CARING

156/22 END OF LIFE CARE ANNUAL REPORT

Gillian Sykes was in attendance to present the report at appendix H, which was agreed at the End of Life Care (EoLC) steering group and at this Committee for information.

GS briefly summarised the report, stating that over the last couple of years with COVID, it has been a challenge for the Trust as a whole, however, for EoLC, there have been some positive achievements, including EoLC education as essential training; a 7-day specialist palliative care service running both in the community and hospital, and the bereavement support service which won the overall Patient Experience Network National Awards (PENNA) award; was shortlisted for the Nursing Times Award, and won the CHuFT Award for team of the year.

For EoLC, there were 1,725 deaths in the acute hospital, and the strategic aims are identifying people in the last 12 months of life, and provide high-quality communication with them; providing coordinated, timely and equitable access to good care; and providing exemplary care in the last hours and days of life. These are all in the context of national priorities and national standards. There are also EoLC quality priorities, which work under the EoLC strategy.

There are some challenges within EoLC, such as embedding change in practice, and the scale of EoLC across the Trust continues to grow. There is a need to increase engagement across all divisions, with a current core group of people who are absolute EoLC champions, as well as a very positive EoLC steering group.

KH commented on the progress and positive work done and stated that this is a very important service which is offered and very much part of our one culture of care, and would like to see additional funding for posts, beyond the 12 months, as it is very important that people get the right level of service and care at the end of their life.

NS commented on the huge amount of progress made since the steering group was set up, and also noted the challenges for the EoLC group around engagement and attendance. **GS** stated that there is now support from divisions but would welcome more engagement.

VP commented on the progress of work and reiterated the importance of getting this right. The new Deputy Director of Nursing will also aide engagement for nursing leaders across the organisation.

NB was in support of this work and in terms of the engagement, stated that there needs to be a cultural shift, as this is everyone's responsibility.

KS mentioned work ongoing around the quality and patient experience strategies which will aid the EoLC team with engagement and become business as usual.

OUTCOME: **GS** was thanked for the update and the Committee noted the report and encouraged the continued fantastic work.

WELL LED

157/22 BOARD ASSURANCE FRAMEWORK RISK 6/19: COMPLIANCE WITH QUALTY AND SAFETY STANDARDS

David Birkenhead presented the report as circulated at appendix I, highlighting that the risk has now been reduced to a score of 12, as a result of an improvement in the key controls, and assurances that are received in a number of groups, including this Committee, around the work ongoing to ensure patients receive high, quality, safe care.

OUTCOME: **DB** was thanked for the update and the Committee supported the reduction in the risk score.

EFFECTIVE

158/22 CLINICAL OUTCOMES GROUP MINUTES AND TERMS OF REFERENCE

David Birkenhead provided an update from the clinical outcomes group via the circulated minutes at appendix J. It was noted that a sub-group report will be provided on a quarterly basis.

The Group is well-attended and looks at a wide range of issues, and now produces a dashboard which summarises the key metrics from each sub-group. There are occasional challenges with data quality from electronic systems into these reports, which will be mentioned later in the meeting. The areas of work of the Group includes the Summary Hospital-level Mortality Indicator (SHMI), which has now stabilised, albeit at a higher rate than previous, and the Hospital Standardised Mortality Ratio (HSMR) which has continued to rise, in part due to the coding and the work of specialist palliative care, which has an adverse impact on the HSMR. It was noted that HSMR has been increasing across a number of organisations and may be at some point that the metrics are rebased. CHFT is not formally an outlier, however, is in the top quartile, but this is not a quality of care issue.

DS made reference to support for the Care of the Acutely Ill Patient (CAIP) Programme and asked if this has been resolved. **DB** stated that this is underway, with new appointments into the Quality and Safety Team, and also Catherine Briggs (Senior Corporate Nurse) now supporting the Deteriorating Patient workstream. **KS** stated that the whole programme is being reviewed in terms of support, governance, the resources and outputs. Discussions are due to be held with the Executive Team, however, reassurance was provided that there will be increased support to the CAIP Programme.

DS also noted the deteriorating position with stroke; however, an update is due at this Committee in October.

A copy of the draft terms of reference were also available for ratification.

OUTCOME: **DB** was thanked for the update, and the Committee noted the minutes and ratified the terms of reference.

ITEMS TO RECEIVE AND NOTE

159/22 MEDICINES MANAGEMENT COMMITTEE MINUTES

Elisabeth Street commented on the intradermal administration for the monkeypox vaccination mentioned earlier at item 153/22. There is a list of competency requirements, which will require a revision to the standard operating procedure. This will be submitted to the next Medicines Management Committee (MMC) meeting for sign-off before use.

The self-prescribing policy has also been updated for colleagues following an incident of inappropriate prescribing. The risk is in relation to general practitioners (GPs) not consistently recording hospital-only drugs. The risk is then if they prescribe drugs themselves, they are not always cited on the fact that a patient is on for example, methotrexate, which has interactions with commonly used antibiotics. This is a concern. Assumptions are made that if a drug is started and continues to be prescribed by hospital, then it would be recorded on the GP system, however, during spot-checks, it was found that this was not the case. There will be some next steps to be devised, which will be taken to the next MMC.

160/22 ANY OTHER BUSINESS

There was no other business.

161/22 MATTERS FOR ESCALATION TO THE BOARD OF DIRECTORS

In terms of the Chair's highlight report to the Board of Directors, the Quality Committee will note receipt of:

- Additional assurance on the action plan in relation to the Internal Audit on complaints
- Introduction to the Patient Safety Incident Response Framework and information provided on how this will be implemented
- The maternity update and the new processes for the maternity transformation plan and a positive outcome from the Regional Maternity Team Assurance visit on 28 June 2022

162/22 COMMITTEE ROLE – ONE CULTURE OF CARE

This is in relation to the Committee's role in ensuring contribution to the embedding of one culture of care in the agenda and discussions.

There has been a theme of one culture of care throughout today's meeting through the understanding of the impact on colleagues with either what is done as a Committee or what is being asked, e.g. Ockenden, dementia screening, and ensuring the impact that is made on colleagues is understood before decisions are made to progress. It's about being mindful that topics discussed do have an impact on colleagues who are already stretched.

JE stated that it would be useful for Committee members to have the agenda guide which was developed for one culture of care. **JE** also stated whether one culture of care is referenced in what is read, what is heard and what is asked to be considered as a Committee. It was asked if we are supporting one culture of care in what we do within the Committee and are we celebrating where one culture of care is evident, and if not, is this being challenged. It was also asked if one culture of care is being demonstrated between each other, for example, in the way we engage with each other, within the conversations where support is offered, and what goes out of the Committee with actions required. All of those have appeared in the dialogue and is important to maintain the check of that.

NS also mentioned the role modelling of behaviours and seeing them evidenced and present in the meeting and challenging when they are not happening.

163/22 QUALITY COMMITTEE ANNUAL WORK PLAN

The workplan was available at appendix L for information. The workplan is reviewed on a monthly basis to review and add. Any views on anything which may be missing are welcomed.

POST MEETING REVIEW

164/22 REVIEW OF MEETING

There was no feedback on the day's meeting, and thanks were conveyed to the Committee for contributions.

NEXT MEETING

Monday, 17 October 2022
3:00 – 5:00 pm
Microsoft Teams

QUALITY COMMITTEE ACTION LOG

Following meeting on Monday, 12 September 2022

Overdue | New / Ongoing | Closed | Going Forward

MEETING DATE AND REF	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	RAG RATING
NEW / ONGOING ACTIONS				
17.08.22 (135/22)	**Annual Complaints Report**	**All**	The Chair stated that the report was unable to be tabled, therefore will be circulated after the meeting for comments before submission to BoD. **Action 17 August 2022**: Committee members asked to comment on report by Tuesday, 23 August 2022. **Update:** The report has been removed from the September Board agenda with changes and comments reflected in a final version to be submitted to the November Board of Directors.	**See agenda item 168/22**
16.05.22 (80/22)	**Split Paediatric Service**	**J Mellor / S Riley-Fuller / S Cartwright**	**Action 16 May 2022**: That the original escalation process is revisited. **Update**: Options to return to Quality Committee in September and October have been provided and awaiting response from division.	**See agenda item 168/22**
20.06.22 (84/22)	**Annual Patient Experience Report**	**Nicola Greaves**	**OUTCOME**: To be deferred **Update**: The report is awaiting approval at the Patient Experience and Caring Group before ratification at Quality Committee	**See agenda item 177/22**
UPCOMING ACTIONS				
12.09.22 (152/22)	**Health & Safety Report**	**Richard Hill**	**Action 12.09.22:** To be deferred to the next meeting. **Update**: Will be presented at the November meeting	**Due Monday, 14 November 2022**
17.08.22 (133/22)	**Integrated Performance Report**	**Jo Fawcus**	**KH** commented on the deep dives and action plans mentioned for the areas around complaints, dementia screening, stroke and neck of femur, and asked if there was a plan for the progress of those to be brought to this meeting. **JF** stated that the stroke deep dive will be going to the Finance and Performance Committee in September 2022 and can be subsequently brought to the Quality Committee. There has also been a deep dive on the neck of femur position, and the action plan can also be brought to this Committee. **Action 17 August 2022**: That the stroke deep dive is shared at the Quality Committee in October. **Update October**: Deferred	**Due Monday, 14 November 2022**
CLOSED ACTIONS				
20.06.22 (96/22)	**Maternity Transformation Plan**	**Gill Harries / Diane Tinker**	**Action 20 June 2022:** KS, GT, DT, LR to meet to discuss the EqIA, project management/ownership, governance and frequency of when the plan will return to Quality Committee. **Update:** a monthly confirm and challenge will be undertaken with the directorate team (Director of Midwifery, General Manager and Clinical Director) and the Assistant Director of Quality and Safety, and an updated position will be shared monthly within the directorate, division and Trust.	**CLOSED 12 Sept 2022**
17.08.22 (133/22)	**Integrated Performance Report**	**Lauren Green**	Dementia- **LR** stated that an option appraisal has been requested. **Action 17.08.22**: That the option appraisal is shared at the next QC. **Update 12 Sept 2022:** See item 151/22.	**CLOSED 12 Sept 2022**
17.08.22 (136/22)	**Complaints internal audit follow-up report**	**Kim Smith**	The Chair noted that the majority of recommendation deadlines and target dates for completion are October 2022 and asked if they will be achieved. **KS** stated that the actions will be achieved, and that some actions have already been addressed, as well as the increased level of oversight and scrutiny. **Action 17.08.22**: **KS** to bring updated action plan to next meeting. **Update 12 Sept 2022:** See item 151/22.	**CLOSED 12 Sept 2022**
17.08.22 (147/22)	**Committee Role – One Culture of Care**	**All**	The Chair stated that all sub-committees of the Board have been asked to consider how Committees ensure that one culture of care is being embedded, and how through our agenda and discussions this can be evidenced. **Action 17.08.22**: To be discussed further at the next meeting. **Update 12 Sept 2022:** See item 162/22	**CLOSED 12 Sept 2022**

Calderdale and Huddersfield NHS Foundation Trust

QUALITY COMMITTEE

Wednesday, 17 August 2022

STANDING ITEMS

128/22 WELCOME AND INTRODUCTIONS

Present

Denise Sterling **(DS)**	Non-Executive Director **(Chair)**
Dr David Birkenhead **(DB)**	Medical Director
Gina Choy **(GC)**	Public Elected Governor
Jo Fawcus **(JF)**	Chief Operational Officer
Karen Heaton **(KH)**	Non-Executive Director
Lindsay Rudge **(LR)**	Deputy Director of Nursing
Nicola Seanor **(NS)**	Associate Non-Executive Director
Kim Smith **(KS)**	Assistant Director for Quality and Safety
Michelle Augustine **(MA)**	Governance Administrator **(Minutes)**

In attendance

Emma Catterall **(EC)**	Head of Complaints **(item 136/22)**
Alison Edwards **(AE)**	Safeguarding Lead **(item 141/22)**
Helen Hirst **(HH)**	Chair **(Observing)**
Dr Tim Jackson **(TJ)**	Lead Medical Examiner **(item #/22)**
Prof. Elizabeth Loney **(EL)**	Associate Medical Director **(item #/22)**
Julie Mellor **(JM)**	Lead Nurse – Children and Young People **(item 132/22)**
Lucy Walker **(LW)**	Quality Manager for CCGs

129/22 APOLOGIES

Mr Neeraj Bhasin **(NB)**	Deputy Medical Director
Jason Eddleston **(JE)**	Deputy Director of Workforce & Organisational Development
Andrea McCourt **(AMcC)**	Company Secretary
Elisabeth Street **(ES)**	Clinical Director of Pharmacy

130/22 DECLARATIONS OF INTEREST

There were no declarations of interest.

131/22 MINUTES OF THE LAST MEETING AND ACTION LOG

The minutes of the last meeting held on Monday, 18 July 2022 were approved as a correct record. The action log can be found at the end of these minutes.

AD HOC REPORTS

132/22 CQC CHILDREN'S YOUNG PEOPLE SURVEY UPDATE

Julie Mellor was in attendance to present the report as circulated at appendix B, providing an update on progress of the action plan.

JM provided some background to the survey which was presented at the previous Quality Committee meeting in March 2022 and stated that an updated action plan is available for anyone who wishes to view it. The summary of progress since March 2022 was described, as detailed in the report.

NS commented on the breadth of work undertaken and noted the value that the service is putting into other workstreams, for example the Patient Experience and Caring Group and the End of Life Care Group. **NS** also mentioned the recruitment of the mental health liaison nurse and the increase in referrals to mental health for children and young people during the

pandemic. It was asked if this has had an impact and whether the liaison nurse role will unblock some of that. **JM** stated that the role is a joint role and will strengthen the working relationship with CHFT and the Child and Adolescent Mental Health Service (CAMHS). Between January and June 2022, there were 80 admissions under CAMHS, and the key role of the mental health liaison nurse is admission avoidance, supporting safe discharge and working with CAMHS to link with agencies, rather than working in isolation. **KH** mentioned the positive feedback received and asked if there were any plans for any pulse surveys. **JM** stated that the core survey is the Friends and Family Test feedback, as well as a survey developed by the Play team. **LR** highlighted future plans around essential training in paediatrics as the mental health element of the service will increase due to the pandemic, and how to train the existing workforce with a skill-set to allow the generic paediatric nursing workforce to manage the complexity of patients that are admitted. **GC** commented on the progress made and queried whether the timescales are included on the detailed action plan. **JM** stated that within the underpinning action plan, all dates have been included.

OUTCOME: **JM** was thanked for the update and the Committee noted the report.

RESPONSIVE

133/22 INTEGRATED PERFORMANCE REPORT

Jo Fawcus presented the integrated performance report at appendix C, highlighting key points.

The safe domain remains amber due to the never event. The caring domain remains amber with two of the five Friends and Family Test areas now green but maintaining performance in Complaints is still a challenge with further deterioration. Dementia screening is now at just 21%. The effective domain remains amber with fractured neck of femur dropping back to 51% after reaching 71% in April. The responsive domain remains amber with cancer 62-day referral from screening to treatment and Cancer 28-day faster diagnosis targets both missed. All Stroke indicators are missing target whilst the underperformance in the main planned access indicators and the Emergency Department (ED) remain a challenge moving forward. It was mentioned that stroke have a bi-weekly meeting to review an action plan to improve the indicators. Workforce remains amber with peaks in the 12-month running total for overall sickness and short-term sickness with a peak in Covid sickness. Return to Work Interviews have fallen a little in month. The finance domain remains amber. Action plans and deep dives are in place to tackle those areas that have been underperforming for some time, for example complaints, dementia screening, stroke and fractured neck of femur.

JF mentioned the 100-day discharge challenge process and action plans around that, as well as the new process for patients with an elongated length of stay who have to be assessed for harm. Cancer has continued to achieve the 62-day referral to treatment standard. The problems in the head and neck service with no consultant to deliver head and neck cancer treatments was raised. The cancer diagnostic pathway can be done, however, there is no consultant to deliver the treatment, nevertheless, there is mutual aid from Bradford, and further aid from Leeds from October. With regard to recovery, the team were congratulated that there are now no patients who have waited over 104 weeks; and appointment slot issues over 22 weeks has reduced significantly.

KH commented on the deep dives and action plans mentioned for the areas around complaints, dementia screening, stroke and neck of femur, and asked if there was a plan for the progress of those to be brought to this meeting. **JF** stated that the stroke deep dive will be going to the Finance and Performance Committee in September 2022 and can be subsequently brought to the Quality Committee. There has also been a deep dive on the neck of femur position, and the action plan can also be brought to this Committee.
Action: That the stroke deep dive is shared at the Quality Committee in October.

In regard to dementia, **LR** stated that an option appraisal has been requested. A review of other West Yorkshire Association of Acute Trust organisations found that where doctors

complete the dementia assessment, the level of performance is similar to CHFT's, however, where nurses complete the assessments, the performance is higher.
Action: That the option appraisal is shared at the next Quality Committee.

In terms of complaints, **LR** stated that there is an action plan and a weekly confirm and challenge process for escalation, with both operational and senior oversight. Meetings were held with divisional colleagues to look at pooling the resource for complaints management to assist in lowering the backlog in the medical division, due to a disproportionate number of complaints. Some additional resource from the corporate nursing team has been arranged, and an update on assurance of the plan in place can be brought to a future meeting.

HH commented on whether there was a systematic analysis for when targets are not achieved. **JF** stated that with cancer performance, if a patient is over 62 or 104 days, there is a root cause analysis (RCA) process with the multi-disciplinary team to decide whether the patient came to harm or not, which will then be taken to the Cancer Delivery Group. In regard to the Emergency Department, any patient that waits over 60 minutes in the back of an ambulance or on an ambulance trolley, or any patient who waits over 12 hours, there is an RCA process that is reviewed within divisions and any harm escalated. **LR** commented on a range of processes around nurse-sensitive indicators and workforce measures, an enhanced dashboard on the Knowledge Portal (KP+) database, as well as a nursing workstream which meets twice a week to review those indicators. If there is an increase in particular areas, matrons are asked to present what is being done to mitigate any further risk. For infection control indicators, RCAs are carried out for any Clostridium difficile and Hospital-Onset COVID-19 Infections. In regard to the narrative at the front of the integrated performance report, the triangulation across nursing, operations, the deputy medical director and assistant director of performance, takes a broad view of key points that impact on each other, and further work is needed before areas of focus can be brought to the Quality Committee. **JF** also mentioned a new process which has started in gastroenterology for outpatient follow-ups, where all patients who are at 52 weeks and not had a follow-up, will go through a harm review process, which will be rolled out over the next nine months and taken through the Access Delivery Group.

OUTCOME: **JF** was thanked for the update and the Quality Committee noted the report.

134/22 QUALITY REPORT

Kim Smith presented the report as circulated at appendix D, providing key updates and assurance in relation to quality and the key workstreams.

It was noted that there have been changes into how the report is being presented to the Committee, and that the deeper level of scrutiny in relation to the work streams will take place at the Trust Patient Safety and Quality Board meeting, with any overarching themes being brought to Quality Committee for assurance.

The key messages around the quality and focussed priorities were provided.

In relation to the clinical prioritisation quality priority, the Chair asked what is being done to address this going forward. **DB** stated that the challenge is how to balance the time needed to do clinical prioritisation versus the time clinicians need to see patients. Work is ongoing to find patients who are at greatest risk and re-prioritising those and working through the others as able to. It is very difficult at the moment, given the current volume, to complete all of those, whilst maintaining current levels of activity, both for emergency care and for progressing with the elective service. There is also a responsibility for colleagues in primary care, and discussions are taking place in terms of what support they can provide for patients who are waiting protracted periods of time. There are real concerns for all in relation to the risk and harm that may be happening to patients who are on long waiting lists.

OUTCOME: **KS** was thanked for the update and the Committee noted the report.

CARING

135/22 ANNUAL COMPLAINTS REPORT

The Chair stated that the report was unable to be tabled, therefore, will be circulated after the meeting for comments before being submitted to the Board of Directors.
Action: Committee members asked to comment on report by Tuesday, 23 August 2022.

136/22 COMPLAINTS INTERNAL AUDIT FOLLOW-UP REPORT

Emma Catterall was in attendance to present the report as circulated at appendix F.

The internal audit which was carried out last year resulted in limited assurance, however, it was positive that some recommendations from the last audit have been actioned and closed.

One of the recommendations from the current audit relatee to improvement with performance and complaint responses, with actions already in place to address, through the weekly meetings mentioned at item 133/22. Another recommendation related to the full complement of staff for the Patient Advice and Liaison Service (PALS) and complaints teams. Unfortunately, there have been a few vacancies for a number of months, however, one of those vacancies has been appointed to, and another is due to go out to advert before the end of this month. A further recommendation included not always recording the method of communication which complainants would like, therefore, actions have been implemented internally to ensure this is being captured. Another recommendation included the categorisation of the severity of complaints. These are being addressed by triaging every complaint received, identifying if there are any clinical incidents relating to that complaint and logged onto Datix. It was noted that the recommendations will be actioned by October 2022.

KS provided further assurance around the recommendation relating to investigation training. The training will follow a similar path to investigation training for incidents, with the introduction of the Patient Safety Incident Response Framework (PSIRF).

KH acknowledged the challenges, however, noted concern that there are still recommendations which have not been implemented and therefore issues are reoccurring. **KH** also asked that the actions arising from the deep dives mentioned at item 133/22 are part of these actions and placed on an overall action plan.

The Chair noted that the majority of recommendation deadlines and target dates for completion are October 2022 and asked if they will be achieved. **KS** stated that the actions will be achieved, and that some actions have already been addressed, as well as the increased level of oversight and scrutiny. Tight deadlines have purposely been put in place in order to get the work completed. An update on the actions can be brought to the next meeting.
Action: **KS** to bring updated action plan to the next meeting for assurance.

GC requested assurance on whether the statement *'This creates a high risk as the complaints department is not adequately operationally managed at a leadership level'* has been addressed, with leadership at an operational level. **EC** stated that this was taken from the audit undertaken last year, and the structure has since changed, and the team is now supported. **LR** provided further assurance of the restructure within the Governance Department and the governance structure review undertaken with the appointment of the Head of Complaints and PALS. The audit mentions vacant positions; however, the Committee was assured that this was part of the corporate vacancy freeze, and costs have now been progressed through to vacancy panels.

OUTCOME: **EC** was thanked for the update and the Quality Committee noted the report.

EFFECTIVE

137/22 QUARTER 1 LEARNING FROM DEATHS REPORT

Elizabeth Loney was in attendance to present the report as circulated at appendix G, providing assurance of the learning from deaths mortality review process.

EL asked the Committee for a change on how the data is reported. At the moment, this report is for quarter one, however, the initial screening reviews have only recently been sent out and results have not yet been received, and it was asked that quarter one data is reported at the end of quarter two. The data reported on the initial screening reviews for quarter one will be incomplete.

All 411 adult inpatient deaths reported in quarter one were subject to an initial structured review, with a target of 50%. To date, 73 (18%) have been carried out. Of the 73, the majority were rated as having good or excellent care, however, 16 had poor care. Going forward, **EL** is keen to know how we learn from deaths. Due to the increasing number of people dying, increased capacity is needed in order to do the initial structured reviews, and one of the ways in which this can be done is by greater involvement of junior doctors. **EL** is planning to roll out the involvement of senior junior doctors doing initial structured reviews and giving them certificates of acknowledgement if a certain number are carried out.

Poor or very poor care triggers further investigation using the structured judgement review (SJR) process. In addition to the SJRs which come through the initial screening reviews, others come through different routes, for example the Medical Examiner's office, serious incident panels, complaints, coroner investigations, etc. Some reviews have resulted in good and bad practice, as detailed in the report.

EL mentioned closing the loop with learning from deaths. Currently, poor care from an initial structured review is escalated to a structured judgement review, and poor care from a structured judgement review is sent through as an incident. Following the report of an incident, the mortality team do not receive an outcome from the serious incident panel, which needs to be addressed via links with the serious incident panel. Other plans for the future involve linking mortality leads via a mortality leads group in order to support one another to better communicate learning from deaths and to be able to report back to this Committee; and to also reinstate the Trust Bulletin on learning from deaths.

DB stated that the focus in the organisation around the mortality review and the quality of care review process does need to be on learning, rather than chasing targets on the number of deaths which need to be reviewed and stated that the reports going forward need to reflect this.

As part of the learning from deaths annual report, the Chair noted the section on learning disability. **EL** stated that learning disabilities has been brought into the Care of the Acutely Ill Patient (CAIP) programme as a workstream, which has key performance indicators including making reasonable adjustments for patients with learning disabilities, which has increased from 20% to 70% in the last audit, and also increasing training are measuring key performance indicators.

OUTCOME: **EL** was thanked for the update and the Quality Committee noted the report and agreed with the proposal to amend the reporting period.

138/22 MEDICAL EXAMINER REPORT

Tim Jackson was in attendance to provide an update on the above report, as circulated at appendix H.

The team continue to scrutinise a high number of cases within the organisation, along with several challenges over the last few months with Medical Examiner availability, conflict with clinical duties, and a period of quite high activity in numbers of deaths occurring.

The Chair asked if there was any further support required from the Committee or the Trust. **TJ** stated that the major challenge is his personal capacity in and amongst his clinical role, however, there is a lot of support from his department and is releasing more clinical time to be able to put more time into the Medical Examiner role, and more Medical Examiners are in the process of being appointed before April 2023. There are open lines of communication with DB, KS, the governance teams and the Chair, therefore if extra support is needed, it is available.

The Chair also asked if the additional recruitment will be a focus and target on General Practitioners (GPs). **TJ** stated that there are currently eight Medical Examiners, with a funding envelope for up to 14 Medical Examiners, and the expectation is that remaining are filled with GPs, assuming there is an interest.

OUTCOME: **TJ** was thanked for the update and the Quality Committee noted the report.

139/22 CLINICAL OUTCOMES GROUP MINUTES

David Birkenhead provided an update from the clinical outcomes group minutes circulated at appendix I.

DB highlighted the progress of work made from the Mental Health Operations Group and the Pressure Ulcer Collaborative. The dementia workstream is also very active, albeit not having the expected outputs in relation to an improvement in the compliance with screening.

The Group is now producing a monthly dashboard which gives a high-level view of how workstreams are progressing. It was suggested that the Committee continue to receive the minutes of the Clinical Outcomes Group on a monthly basis, along with a detailed quarterly report of outputs from the Group, alongside the dashboard.

OUTCOME: **DB** was thanked for the update and the Quality Committee noted the minutes.

SAFE

140/22 Q1 INFECTION PREVENTION AND CONTROL REPORT

David Birkenhead presented the report as circulated at appendix J, highlighting no Methicillin-resistant staphylococcus aureus bacteraemia in over 18 months now, which is a remarkable achievement for the organisation. The MRSA screening (electives) at 71% is an is an under-representation of the true amount of screening taking place, due to the denominator pulling patients through who do not require screening. This may be helpful as a comparator on a month-to-month basis, it does not provide the true extent of the MRSA screen for electives that is taking place. Main concerns remain around Clostridium difficile across the NHS, not just CHFT.

OUTCOME: **DB** was thanked for the update and the Committee noted the report.

141/22 SAFEGUARDING COMMITTEE ANNUAL REPORT

Alison Edwards was in attendance to present the above report as circulated at appendix K, providing an overview of activity provided by the Safeguarding Team including 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 and Maternity Safeguarding.

The report also outlined key achievements and developments on both the progress against the annual report priorities and the safeguarding strategy for 2020-2022, and the priorities in line with the refreshed strategy for 2022-2024.

The Chair asked about receipt and scrutiny training which has not been able to be accessed since March 2022. **AE** mentioned liaison with the mental health trust, who are developing an online package which our colleagues will be able to access, which will hopefully change this position in the near future.

OUTCOME: **AE** was thanked for the update and the Committee noted the report.

142/22 HIGH LEVEL RISK REPORT

The chair asked if there were any comments in relation to the high level risk report circulated at appendix L.

LR noted a change in process of the report and a higher level of scrutiny around the number of risks scoring 15 and above. **KS** provided further assurance that the mitigations and controls of risks will be reviewed as part of Risk Group, whose function has changed from validation to high-level scrutiny around divisional risks for a deeper understanding of the consistency of risk scoring.

LR also stated that Vicky Pickles (Director of Corporate Affairs) and herself met with the Families and Specialist Services (FSS) team following their Performance Review Meeting where a number of risks on their register were scoring 20, and a better understanding was requested as to why they were scoring at such a high level. The reviews being done in the FSS division around consistency of shared lessons will be enacted through the Risk Group. The division will be a pilot for consistent reporting of risks.

143/22 MATERNITY OVERSIGHT REPORT

Lindsay Rudge presented the report as circulated at appendix M, providing key points including a positive maternity review from the Ockenden assurance team and an overarching plan. The report highlights a different way in which the data will be presented to the Committee, which will provide clearer oversight of the maternity action plan, and there will be a further section of the report where the board safety champions describe activity undertaken within their roles.

OUTCOME: **LR** was thanked for the update and the Committee noted the report.

ITEMS TO RECEIVE AND NOTE

144/22 ANY OTHER BUSINESS

Never Event

Kim Smith provided additional level of assurance to the Committee around the never event which took place in relation of the misidentification of a patient regarding do not resuscitate, and the patient subsequently died. This was previously provided to the Committee, however, some of the actions and the implementation of those actions are provided to give a higher level of assurance.

In the case of this never event, immediate learning was identified, and this was communicated to all colleagues via a red border email which included ensuring that:

- All patients must have a wristband in place
- All patients MUST be identified by first and surname on ward patient identification boards (behind patient's bed)
- Writing must be in black and legible - ensuring that all details can be clearly read

- The exceptions to this are paediatric patients or any patient specifically identified as part of clinical risk assessment.

It was also communicated via matrons and ward manager meetings, shared at the CQC and Compliance huddles, and across all divisions via the Patient Safety and Quality Board meetings. The patient identification policy was also reiterated. Points 1, 2 and 3 of the above process are checked by the nurse in charge of each shift, who checks all patients are identified correctly, and this is discussed at the daily huddles and handover. The above steps also have independent scrutiny of compliance as part of the Journey to Outstanding (J2O) process and any actions addressed immediately.

145/22 MATTERS FOR ESCALATION TO THE BOARD OF DIRECTORS

In terms of escalation to the Board of Directors, the Quality Committee noted receipt of:

- Children and Young People's Survey update – evidence of improvement and progress
- Internal Audit of Complaints and action plan in place
- Learning from Deaths report and the plan for increased focus on learning
- Medical Examiner update
- Safeguarding Annual Report
- Integrated Performance Report and concerns in cancer demand

146/22 QUALITY COMMITTEE ANNUAL WORK PLAN

The workplan was available at appendix N for information, with plans to amend.

POST MEETING REVIEW

147/22 COMMITTEE ROLE – ONE CULTURE OF CARE

The Chair stated that all sub-committees of the Board have been asked to consider how Committees ensure that one culture of care is being embedded, and how through our agenda and discussions this can be evidenced.
Action: To be discussed further at the next meeting.

NEXT MEETING

Monday, 12 September 2022
3:00 – 5:00 pm
Microsoft Teams

QUALITY COMMITTEE ACTION LOG

Following meeting on Wednesday, 17 August 2022

Overdue	New / Ongoing	Closed	Going Forward

MEETING DATE AND REF	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	RAG RATING
NEW / ONGOING ACTIONS				
17.08.22 (133/22)	**Integrated Performance Report**	**Lauren Green**	In regard to dementia, **LR** stated that an option appraisal has been requested. **Action 17 August 2022**: That the option appraisal is shared at the next Quality Committee.	**See agenda item 151/22**
17.08.22 (136/22)	**Complaints internal audit follow-up report**	**Kim Smith**	The Chair noted that the majority of recommendation deadlines and target dates for completion are October 2022 and asked if they will be achieved. **KS** stated that the actions will be achieved, and that some actions have already been addressed, as well as the increased level of oversight and scrutiny. Tight deadlines have purposely been put in place in order to get the work completed. An update on actions can be brought to next meeting. **Action 17 August 2022**: **KS** to bring updated action plan to the next meeting for assurance.	**See agenda item 151/22**
17.08.22 (147/22)	**Committee Role – One Culture of Care**	**All**	The Chair stated that all sub-committees of the Board have been asked to consider how Committees ensure that one culture of care is being embedded, and how through our agenda and discussions this can be evidenced. **Action 17 August 2022**: To be discussed further at the next meeting.	**See agenda item 162/22**
20.06.22 (96/22)	**Maternity Transformation Plan**	**Gill Harries / Diane Tinker**	**Action 20 June 2022:** KS, GT, DT, LR to meet to discuss the EqIA, project management/ownership, governance and frequency of when the plan will return to Quality Committee. **Update:** a monthly confirm and challenge will be undertaken with the directorate team (Director of Midwifery, General Manager and Clinical Director) and the Assistant Director of Quality and Safety, and an updated position will be shared monthly within the directorate, division and Trust.	**ONGOING**
UPCOMING ACTIONS				
17.08.22 (133/22)	**Integrated Performance Report**	**Jo Fawcus**	**KH** commented on the deep dives and action plans mentioned for the areas around complaints, dementia screening, stroke and neck of femur, and asked if there was a plan for the progress of those to be brought to this meeting. **JF** stated that the stroke deep dive will be going to the Finance and Performance Committee in September 2022 and can be subsequently brought to the Quality Committee. There has also been a deep dive on the neck of femur position, and the action plan can also be brought to this Committee. **Action 17.August 2022**: That the stroke deep dive is shared at the Quality Committee in October.	**DUE Monday, 17 October 2022**
17.08.22 (135/22)	**Annual Complaints Report**	**All**	The Chair stated that the report was unable to be tabled, therefore the report will be circulated after the meeting for comments before being submitted to the Board of Directors **Action 17 August 2022**: Committee members asked to comment on report by Tuesday, 23 August 2022. **Update: The report has been removed from the September Board agenda with changes and comments reflected in a final version to be submitted to the November Board of Directors.**	**DUE Monday, 17 October 2022**
16.05.22 (80/22)	**Split Paediatric Service**	**Julie Mellor / Simon Riley-Fuller / Stacey Cartwright**	**Action 16 May 2022**: That the original escalation process is revisited. **Update**: Options to return to Quality Committee in September and October have been provided and awaiting response from division.	**DUE Monday, 17 October 2022**
20.06.22 (84/22)	**Annual Patient Experience Report**	**Nicola Greaves**	**OUTCOME**: To be deferred **Update**: The report is awaiting approval at the Patient Experience and Caring Group before ratification at Quality Committee	**DUE Monday, 17 October 2022**

CLOSED ACTIONS				
20.06.22 (85/22)	**Medical Examiner Update**	**Dr Tim Jackson**	**OUTCOME**: To be deferred **Update 17.8.22:** See item 138/22	**CLOSED 17 August 2022**
21.02.22 (23/22) 20.04.22 (60/22)	**Deteriorating patient case note review**	**Risk Team**	A formal report on the issue of deteriorating patients was asked into Quality Committee for April 2022. **ACTION**: Report requested for Quality Committee in April 2022. **Update 20 April 2022**: See agenda item 60/22. **ACTION - 20 April 2022**: Update on case note review requested for three months' time *(Added to workplan to return to Quality Committee in August 2022)* **Update**: An update has been requested from the Deteriorating Patient Workstream to be reported into the Clinical Outcomes Group, then to Quality Committee for assurance.	**CLOSED 17 August 2022**

6. Partnership papers: Kirklees Health and Care Partnership - https://www.kirkleeshcp.co.uk/publications/icb-committee-papers/ and Calderdale Cares Partnership - https://www.calderdalecares.co.uk/about-us/meeting-papers/