Public Board of Directors - Items for Board Assurance - 12 January 2023

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

1. Workforce Equality, Diversity and Inclusion Update - Appendix 4-6

Calderdale and Huddersfield NHS Foundation Trust

2022/3 WRES Action Plan

Workforce Committee

7 December 2022

One Culture of care

compassionate care

What is the Workforce Race Equality Standard (WRES)?

The WRES focuses on enabling people to work comfortably with race equality. Through communications and engagement, work will be undertaken to change the deep rooted cultures of race inequality in the system, learn more about the importance of equity, to build capacity and capability to work with race.

Continuous embedding of accountability to ensure key policies have race equality built into their core, so that eventually workforce race becomes everyday business.

The WRES will continue to work to evidence the outcomes of the work that is done, publishing data intelligence and supporting the system by sharing replicable good practice.

With over one million employees, the NHS is mandated to show progress against a number of indicators of workforce equality, including a specific indicator to address the low numbers of BME board members across the organisation.

Alongside WRES, NHS organisations use the Equality and Diversity Systems (EDS2) to help in discussion with local partners including local populations, review and improve their performance for people with characteristics protected by the Equality Act 2010. By using the EDS2 and the WRES, NHS organisations can also be helped to deliver on the Public Sector Equality Duty.

Workforce Race Equality Standard (WRES) Action Plan (22/23)

Appendix 4

Calderdale and Huddersfield NHS Foundation Trust

	Indicator	Narrative – the implications of the data and any additional background explanatory narrative	Action
1	**Percentage of staff in each of the AfC Bands 1-9 OR Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce**	• Overall, the Trust has 20.6% of its workforce from a BME background compared to 18.0% in the previous year, an increase of 2.6%. • The report this year shows a further decrease in the number of people who had not declared their ethnicity. Reducing from 4.0% last year to 3.4% as at the 31 March 2022. This indicates an overall data quality improvement. • Within the non-clinical group, the largest increases of BME staff were in Band 8c (+7.1%), Under Band 1 (+5.7%) apprentices, and Band 5 (+3.1%). • The largest decreases of BME staff within the non-clinical group were within VSM (-11.1%), Band 8b (-7.1%), and Band 1 (-4.2%). • Within the clinical group, the largest increases of BME staff were in Band 8c (+16.7%), Under Band 1 (+6.4%), and Band 5 (+5.9%). • The largest decreases of BME staff within the clinical group were within Band 8d (-11.1%), and Band 4 (-1.5%). • Within the Medical group all grades have seen an increase in BME staff. Consultants an increase of +1.3%, Career an increase of 1.2%, and Trainees an increase of 3.4%.	• Inclusive Recruitment implemented and embedded (opportunities truly accessible for all). • Ensure the Recruitment and Job Matching Panellists are representative. • Review Job Matching Process • We have a strong REN network and steering group, who meet regularly • Require VSMs and board members to mentor/reverse mentor and sponsor at least one talented ethnic minority staff at AfC band 8d or below • ED&I Education Programme for all

Workforce Race Equality Standard (WRES) Action Plan (22/23)

	Indicator	Narrative – the implications of the data and any additional background explanatory narrative	Action
2	Relative likelihood of staff being appointed from shortlisting across all posts.	The data shows that in a 12-month period (April 2021 to March 2022) the likelihood of being appointed decreased for both White and BME staff. More colleagues being shortlisted and interviewed therefore the ratio to appointment has decreased Overall, white staff remain slightly more likely to be appointed than BME staff.	• Talent management – Concrete measures to remove barriers for our most talented BME staff • Inclusive Recruitment (ensuring vacancy advertisements are widely promoted) • Batch interviews should be considered ie more than one applicant to be shortlisted • Build confidence in BAME colleagues by mentoring, shadowing, development programmes, career conversation and interview and application form skills dev
3	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. Based on snapshot data as at 31.3.22 for the previous year.	The overall **number of disciplinaries recorded by the Trust remains very low**, as such even small changes can cause dramatic shifts in the reported ratios. However, based on current year information the **likelihood of a BME colleague entering the disciplinary process is now 3 times as likely** than a white colleague; this is an increase from the previous year.	• Undertake analysis – discover the key themes • Gain a good understanding from live cases – how can we take proactive measure to think about what happens pre disciplnary action • Benchmark CHFT against other organisations

Workforce Race Equality Standard (WRES) Action Plan (22/23)

Appendix 4

Calderdale and Huddersfield NHS Foundation Trust

	Indicator	Narrative – the implications of the data and any additional background explanatory narrative	Action
4	Relative likelihood of staff accessing non-mandatory training and CPD.	The data shows that during 2021-22 the uptake of non-mandatory training has increased for both BME and White staff, and both groups are now equally as likely to access non-mandatory CPD.	• Open Learning Culture – accessible development programmes, educational resources ie webinars, conferences, etc • Shadowing programme • Promote stretch opportunities
5	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.	The latest survey shows that the percentage of BME staff experiencing harassment, bullying or abuse from patients, relatives, or the public in last 12 months has seen a decrease when compared to the previous year. The average benchmark (median) for BME staff within Acute Trusts is 28.8%. In comparison the Trusts ranking is better than the average. Rates for white staff have remained the same compared to the previous and remain above (worse than) the benchmark median average for Acute Trusts (26.5%).	• Undertake a root cause analysis review of harassment, bullying, abuse cases • Review current arrangements around how we are supporting colleagues who have had this experience

Workforce Race Equality Standard (WRES) Action Plan (22/23)

	Indicator	Narrative – the implications of the data and any additional background explanatory narrative	Action
6	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.	BME staff have seen a significant decrease in this metric, moving from 33.2% to 23.9%. The average (median) for BME staff within acute Trusts is 28.5%. In comparison the Trusts ranking is better than the average. White staff have reported a slight decrease when compared to the previous year from 21.7% to 21.1%. This is a favourable position and is below the benchmark average of 23.6%	• Undertake a root cause analysis review of harassment, bullying, abuse cases • Review current arrangements around how we are supporting colleagues who have had this experience
7	Percentage believing that trust provides equal opportunities for career progression or promotion.	BME staff have seen improvement in this metric when compared to the previous year moving from 50.2% to 51.5%. The benchmark average (median) for BME staff within Acute Trusts is 44.6%. In comparison the Trusts ranks better than the average. The average (median) for white staff within Acute Trusts is 58.6%. In comparison the Trusts ranking of 60.8% is better than the average.	• Send a OCOC support pack to unsuccessful applicants • Monitor progress of unsuccessful applicants • Develop a 'How to give supportive feedback document' for recruiting managers • More work to do to justify why a colleague did not get the role

Workforce Race Equality Standard (WRES) Action Plan (22/23)

Appendix 4

Calderdale and Huddersfield NHS Foundation Trust

	Indicator	Narrative – the implications of the data and any additional background explanatory narrative	Action
8	In the last 12 months have you personally experienced discrimination at work from any of the following? - Manager/team leader or other colleagues	White staff have seen a small increase in discrimination from colleagues. While BME staff report a decrease in discrimination of -3.3% within the reporting year. However, the likelihood of a BME staff member experiencing discrimination remains over twice as likely than a white colleague. The benchmark average (median) for BME staff within acute Trusts is 17.3%. In comparison the Trusts rate of 13.9% is much better than the average. The average (median) for White staff within acute Trusts is 6.7%. In comparison the Trusts ranking is better than the average at 5.8%	• Consider how we can provide feedback to colleagues who have raised a concern in this area • Undertake a root cause analysis review of harassment, bullying, abuse cases • Review current arrangements around how we are supporting colleagues who have had this experience

Workforce Race Equality Standard (WRES) Action Plan (22/23)

	Indicator	Narrative – the implications of the data and any additional background explanatory narrative	**Action**
9	Percentage difference between the organisations' Board membership and its overall workforce.	The Board BME rate has decreased due to staffing changes over the year. This combined with an overall increase in BME rate for the Trust has led to an increase in the difference between BME representation of the board and the Trust by 9.7%.	• Focus on encouraging diverse high calibre candidates for board and senior leadership level roles. • Consider candidates for board and senior leadership appointments from a wide pool. • Ensure board and senior leadership appointment 'long lists' include diverse candidates. • Report against these objectives and other initiatives to promote diversity annually. • Report annually on the outcome of the evaluation including the diversity of the composition of the senior team. • Require VSMs and board members to mentor/reverse mentor and sponsor at least one talented ethnic minority staff at AfC band 8d or below • Recruitment drive on BME non-executive directors (NEDs) • Existing NEDs will be encouraged to play an active role in mentoring and sponsoring BME staff that have the potential to get to an executive role within three years. • Work closely with ICB • Shadow Board

Calderdale and Huddersfield NHS Foundation Trust

2022/3 WDES Action Plan

Workforce Committee

7 December 2022

One Culture of care

compassionate care

What is the Workforce Disability Equality Standard (WDES)?

- The main purpose of the WDES is to help local and national NHS organisations to review their workforce data against ten indicators and to produce an action plan to improve workplace experiences of disabled colleagues
- The WDES also places an obligation on NHS organisations to improve overall representation at Board level
- WDES reporting links into the mandated Equality Delivery System (EDS) goals. EDS is an equality performance and evaluation tool to help improve equality performance across 4 goals:-
    1. Better health outcomes 2. Improve patient access and experience 3. A represented and supported workforce
    4. Inclusive leadership
- WDES relates directly to all goals but specifically directly to EDS goals 3 and 4
- This report describes CHFT performance and sets out the action plan to address the gaps in data
- The action plan will be shared with all relevant departments
- An end of year ED&I report to capture the progress made in 2022 will be shared at Workforce Committee
- Provides a real impetus for NHS organisations to improve workforce equality for the benefit of colleagues and patients.
- This document has been co produced with Colleague Disability Equality Group members
- This document has been produced with support from the North East and Yorkshire Diversity Team and Action Plan Guidance document.

Workforce Disability Equality Standard (WDES) Action Plan (2022/2023)

	Indicator	Narrative – the implications of the data and any additional background explanatory narrative	Action Plan
1	Percentage of staff in each of the AfC Bands 1-9, medical and dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. This metric is a snapshot as at 31 March 2022.	• Overall, 4.51% of the Trust workforce has declared they have a disability. An increase on the 4.22% reported in the previous year. • The report this year shows there has been an increase in the non-stated category. Up slightly from 4.10% last year to 4.40% as at the 31 March 2022. Indicating a reduction in data quality. • Non-clinical Band 1,2,3,4,6,8b,8d, and VSM all have disability rates higher than the Trust average. • Clinical Bands 2,6,8b have disability rates higher than the Trust average.	• Review of recruitment practices, align work with the published inclusive recruitment toolkits and implement values based recruitment • Audit of hybrid working implementation upon recruitment • Continue to grow membership of the CDAG (Colleague Disability Action Group) network – flyers /posters/screensavers/comms campaign • Communication campaign to improve self declaration rates inc guidance on how to self report your disability status • Continue to promote the importance of an appraisal conversation • Continue to host values and behaviours charter workshops including focus on ED&I and belonging • People strategy refresh with a chapter dedicated to ED&I • ED&I Education and Awareness programme content developed by CDAG members • Staff survey outputs shared with each equality network and each equality network then has the opportunity to build objectives to improve colleague experience • Health Academy – partnering with the council and the local colleges / universities to ensure we implement effective talent pipelines • CDAG noticeboard at both hospital sites • CDAG to work with the unions • Best Practice to be shared between all Equality Groups at CHFT Inclusion Group meeting

Workforce Disability Equality Standard (WDES) Action Plan (2022/2023)

Appendix 5

Calderdale and Huddersfield NHS Foundation Trust

	Indicator	Narrative – the implications of the data and any additional background explanatory narrative	Action Plan
2	Relative likelihood of disabled colleagues compared to non-disabled colleagues being appointed from shortlisting across all posts.	**Data for previous year** Disabled = 0.45 / Non-disabled = 0.47 **Data for reporting year** Disabled = 0.48 / Non-disabled = 0.41 In the current reporting year disabled colleagues are more likely to be appointed from shortlisting across all posts compared to non disabled.	• Interview/Application form workshops • Reciprocal mentoring • Shadowing opportunities • Empower programme – Season 3 • Development for all – self directed learning dependent on what your ambitions are • Stepping into Leadership – for colleagues who want to be a leader in the future but want to start to understand leadership now. • Equality Groups and Wellbeing support promoted during recruitment
3	Relative likelihood of staff entering the formal capability process, as measured by entry into a formal capability procedure. (non-sickness related only)	Numbers of staff entering the formal capability process for non-sickness related reasons are very low within the Trust. As such the number of staff entering the formal capability process is a very small fraction compared to the workforce as a whole.	• Freedom to Speak up Guardian and network attend CDAG so they can hear lived experiences • Compassionate Leadership programme • Ensure network members have access to senior leadership allies • Refreshed appraisal – discussing problem areas early and upward feedback

Appendix 5

Workforce Disability Equality Standard (WDES) Action Plan (2022/2023)

	Indicator	Narrative – the implications of the data and any additional background explanatory narrative	Action Plan
4	Indicator 4a. Percentage of staff experiencing harassment, bullying or abuse in the last 12 months from. Indicator 4b. Percentage of disabled colleagues compared to non-disabled colleagues saying the last time they experienced harassment, bullying, abuse at work they or a colleague reported it.	**Data for previous year** **Patients and service users** Disabled = 34.2%/Non-Disabled = 28.6% **Managers** - Disabled = 13.7%/Non-Disabled = 9.7% **Colleagues** - Disabled = 23.4%/Non-Disabled = 16.6% **Reported it in the last 12 months** - Disabled = 47.8%/Non-Disabled = 42.7% **Data for Reporting Year** **Patients and service users** - Disabled = 35.6%/Non-Disabled = 26.1% **Managers** - Disabled = 14.1%/Non-Disabled = 7.4% **Colleagues** - Disabled = 25.6%/Non-Disabled = 14.8% **Reported it in the last 12 months** - Disabled = 52.5%/ Non-Disabled = 46.4% The percentage of staff experiencing harassment, bullying and abuse in the last year has increased in all categories for disabled collea. Disabled colleagues continue to be more likely to experience harassment, bullying or abuse than non-disabled colleagues. Disabled colleagues are more likely to report than non-disabled colleagues.	• Education and awareness programme to be 'live' January 2023 • Allyship model in development for 22/23 • WDES being a standing agenda item at CDAG and Inclusion Group • Hard hitting communications campaign • Freedom to Speak up promoted at CDAG • International Recruit safe space sessions • Link in with work undertaken at ICB level • Compassionate Leadership programme • Values and behaviours refresh • Values and behaviours charter

Workforce Disability Equality Standard (WDES) Action Plan (2022/2023)

Appendix 5

Calderdale and Huddersfield NHS Foundation Trust

	Indicator	Narrative – the implications of the data and any additional background explanatory narrative	Action Plan
5	Indicator 5. Percentage of disabled colleagues believing the Trust provides equal opportunities for career progression or promotion	**Data for previous year** Disabled = 56.3% / Non-Disabled = 61.8% **Data for reporting year** Disabled = 52.0%/Non-Disabled = 61.7% 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.	• Regular discussions around development opportunities at CDAG meetings • Interview/application form coaching • Coaching and mentoring programmes • Shadowing opportunities
6	Indicator 6. Percentage of disabled colleagues compared to non-disabled colleagues saying they have felt pressure from their manager to come to work despite not feeling well enough to perform their duties.	**Data for previous year** Disabled = 35.0% / Non-Disabled = 24.3% **Data for reporting year** Disabled = 35.9% / Non-Disabled = 25.1% Disabled colleagues feel more pressured to come to work despite not feeling well enough to perform duties, than non-disabled colleagues. The position has worsened from the previous year for both disabled and non-disabled staff.	• Reasonable Adjustments Management Toolkit – Disability Guide made for managers to access (Page Tiger) • Hybrid working model – feeling of belonging • Case studies through CDAG group • 1 to 1's / Appraisal should give both parties the opportunity to review the workload and discuss support available • Accessible wellbeing support • Health and Wellbeing risk assessment

Workforce Disability Equality Standard (WDES) Action Plan (2022/2023)

	Indicator	Narrative – the implications of the data and any additional background explanatory narrative	Action Plan
7	Indicator 7. Percentage of disabled colleagues compared to non-disabled colleagues saying they are satisfied with the extent to which their organisation values their work.	**Data for previous year** Disabled = 36.5% / Non-Disabled = 47.0% **Data for reporting year** Disabled = 30.0% / Non-Disabled = 40.0% This metric has decreased for both disabled and non-disabled groups indicating that a higher proportion of colleagues are less satisfied with the extent the organisation values their work.	• Work with Clinically Extremely Vulnerable Group to understand their experiences • Learn from the above and develop a plan to build on strengths and take action on area for development

Workforce Disability Equality Standard (WDES) Action Plan (2022/2023)

	Indicator	Narrative – the implications of the data and any additional background explanatory narrative	Action Plan
8	Indicator 8. Percentage of disabled colleagues saying that their employer has made adequate adjustments to enable them to carry out their work	**Data for previous year** 73.3% **Data for reporting year** 68.0% This metric has seen a decrease of 5.3% compared to the previous reporting year and is below the benchmark average of 70.9%.	• Reasonable Adjustment guide to develop with contribution on content from CDAG • ED&I Education and Awareness Programme • Include a section on reasonable adjustments Leadership Development Programme • Effective signposting on the intranet to tools on how to access support for both colleagues and managers

Workforce Disability Equality Standard (WDES) Action Plan (2022/2023)

	Indicator	Narrative – the implications of the data and any additional background explanatory narrative	Action Plan
9	Indicator 9a. The staff engagement score for disabled staff compared to non-disabled staff and the overall engagement score for the organisation Has your Trust taken action to facilitate the voices of disabled staff in your organisation to be heard?	**Data for previous year** Disabled = 6.6/Non-Disabled = 7.0 **Data for reporting year** Disabled = 6.3 / Non-Disabled = 6.9 The engagement score for disabled staff remains lower than that of non-disabled colleagues. Both disabled and non-disabled colleagues saw reductions in their engagement scores during 2021-22, with the disabled staff colleagues worsening to a greater extent.	• Reach out to disable colleagues and ask for colleagues to share experiences positive or negative • Use these experiences in Leadership Development programmes • Refresh the 'lived experience' suite of videos • More work to do to promote development and career pathways for disabled colleagues

Workforce Disability Equality Standard (WDES) Action Plan (2022/2023)

	Indicator	Narrative – the implications of the data and any additional background explanatory narrative	Action Plan
10	Difference between the organisations' Board voting membership and its overall workforce	**Data for previous year** 11% **Data for reporting year** 10% The difference in disability compared to the overall workforce has decreased slightly in the 2021-22 reporting year.	• Board to review their representation in 22/23 • Action Plan to address representation

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

WORKFORCE COMMITTEE

16 AUGUST 2022

GENDER PAY GAP

1. INTRODUCTION

Gender Pay Gap (GPG) reporting legislation requires employers with 250 or more employees to publish statutory calculations every year showing the pay gap between male and female employees.

The gender pay gap shows the difference in average earnings between all male full-pay relevant employees and all female full-rate relevant employees in the organisation. It is important to highlight the difference between equal pay and gender pay gap. Equal pay deals with the pay differences between men and women who carry out the same jobs, similar jobs or work of equal value. It is unlawful to pay people unequally because they are a man or a woman. The gender pay gap shows the difference in the average pay between all men and women in a workforce. It is entirely possible to have a significant gender pay gap whilst having complete pay equality.

2. THE 2022 GENDER PAY GAP DATA

The Trust is required to report data in six different ways:

- the mean gender pay gap;
- the median gender pay gap;
- the mean gender bonus gap;
- the median gender bonus gap;
- the proportion of men and women who received bonuses; and
- the number of men and women according to quartile pay bands

Reported figures exclude pay data in respect of the colleagues that are now employed by Calderdale and Huddersfield Solutions Ltd.

The pay data analysed to produce this submission is obtained from the Electronic Staff Record (ESR) Business Intelligence reporting suite using gender pay gap dashboards constructed nationally. Long service award monetary values are calculated outside of ESR.

Should further guidance be issued prior to the next reporting date of March 2023 this may cause the data to change.

The table below shows the figures for March 2022 that will be submitted in March 2023. Please note, a positive figure in metrics 1-4 indicates that men receive a higher rate than women.

1. Difference in hourly rate of pay - mean	28.9%
2. Difference in hourly rate of pay - median	19.2%
3. Difference in bonus pay - mean	55.0%
4. Difference in bonus pay - median	96.7%
5. Percentage of employees receiving a bonus	
Male	6.8%
Female	1.8%
6. Employees by quartile	
Upper Quartile - Male	32.8%
Upper Quartile - Female	67.2%
Upper Middle Quartile - Male	15.5%
Upper Middle Quartile - Female	84.5%
Lower Middle Quartile - Male	13.5%
Lower Middle Quartile - Female	86.5%
Lower Quartile - Male	14.3%
Lower Quartile - Female	85.7%

The final gender pay gap data for March 2022 will be shared again prior to publication on the Government online reporting service in March 2023.

In the context of the wider NHS workforce; CHFT is typical of most NHS Trust's, in that it has a higher number of females than males in its workforce – of the 6225 employees counted as part of the gender pay gap reporting, 5040 were female 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.

The pay gap data along with the staff survey results was discussed by the Women's Voices colleague network in April 2022.

It has been identified through the network that a key driver in the overall gender pay gap is the medical and dental staff group.

Although as at 31 March 2022 CHFT employed 101 female consultants and 178 male, because the Trust employs fewer men overall, the number of male consultants as a proportion of the overall male workforce is 15.6% and 2.9% of the overall workforce. Compared to female consultants who make up 2.0% of the overall female workforce and 1.6% of the overall workforce. This demonstrates that the male consultant workforce will significantly contribute to the pay gap for CHFT. The Bonus pay gap is also driven by the higher proportion of males in receipt of CEA's as well as the fact they are traditionally in receipt of the higher level CEA's.

Appendix 1 is the action plan.

Appendix 2 outlines further analysis of the Gender pay gap within the Trust as at 31 March 2022.

Appendix 3 includes a comparison between the Trust's gender pay gap submissions for 2021 and 2022. It also shows the comparison with CHS included and excluded from the data.

Appendix 4 outlines Gender pay gap benchmarking across WYAAT organisations.

3. REDUCING THE GENDER PAY GAP

We are committed to being an inclusive employer and taking positive steps to reduce the pay gap. Activities that have taken place in 2022 include:

- Women's Voices networked developed
- Menopause Group developed – 8 point action plan developed
- Carers network formed
- New appraisal paperwork and Talent Toolkit developed – each manager to use this tool to support career conversations with colleagues
- Empower programme / Stepping into Leadership Programme
- Widening Participation team supporting hard to reach communities and encouraging younger demographic into NHS careers

The Trust has a Women's Voices colleague network and we are actively encouraging medical colleagues to participate in the group discussions. At the April 2022 meeting of the Women's Voices network a number of areas were identified as areas where action is required. It is recognised that the actions required will be long term and are likely to span a number of years before the full impact will be seen. The areas of focus identified included:

- Access to leadership roles – shadowing / reverse mentoring
- Management of Clinical Excellence Awards
- Interview coaching/Career pathway transparency – available through the talent toolkit discussions
- Colleague Development
- Colleague Experience

In order to drive improvements an action plan focused around the above identified areas has been developed and included as appendix 1. This action plan will be monitored through the Women's Voices network.

4. CONCLUSION

The Trust is committed to positively responding to the matters identified within the gender pay gap reporting, it is recognised that this will require action over a number of years with key areas of immediate focus identified through the proposed action plan.

5. RECOMMENDATIONS

The Workforce Committee are asked to

a) Review and discuss the content of the proposed action plan
b) Identify and suggest any further areas for inclusion within the action plan
c) To approve the ongoing monitoring of the relevant actions through the Women's Voices staff network

Appendix 1 – proposed action plan

Action	Timescale	Who
Management of clinical excellence awards		
Review of internal CEA process to discuss innovative ways to address barriers	Autumn 2022	AD of HR (Medical Workforce)
Offer mentoring for female CEA applicants	Autumn 2022	AD of HR (Inclusion & Development)
Monitor the gender split of CEAs in future rounds	Periodically	Women's Voices network
All Consultants to be written to by the Medical Director to be encouraged to apply for CEA if eligible. Support to be offered to all doctors in submitting their applications by Medical Director / Medical Staffing Lead.	4 weeks prior to submission	AD of HR (Medical Workforce)
Access to leadership roles		
Roll out of reverse mentoring	Autumn 2022	AD of HR (Inc & Dev)
Development Programmes - mentoring	Autumn 2022	AD of HR (Inc & Dev)
Shadowing Programme	Autumn 2022	AD of HR (Inc & Dev)
Commission a piece of work to understand barriers to leadership roles, with a particular focus on medical leadership roles	Autumn 2022	AD of HR (Medical Workforce)
Interview Coaching		
Mirror external interview coaching offering internally	Autumn 2022	AD of HR (Inc & Dev)
Lunch & Learn workshops – career pathways	Autumn 2022	AD of HR (Inc & Dev)
Colleagues sharing their progression stories (podcasts, videos etc)	Autumn 2022	AD of HR (Inc & Dev)
Development		
Leadership development offer to include inclusive leadership support, covering key inclusion topics	Implemented Jan 2022 and monitoring how the learning is applied practically in the workplace	AD of HR (Inc & Dev)
Unconscious bias and inclusion covered in workshops for recruiting managers – discussions to take place quarterly regarding fairness in the process	Implemented and monitoring how the learning is applied practically in the workplace	AD of HR (recruitment)
Colleague Experience		

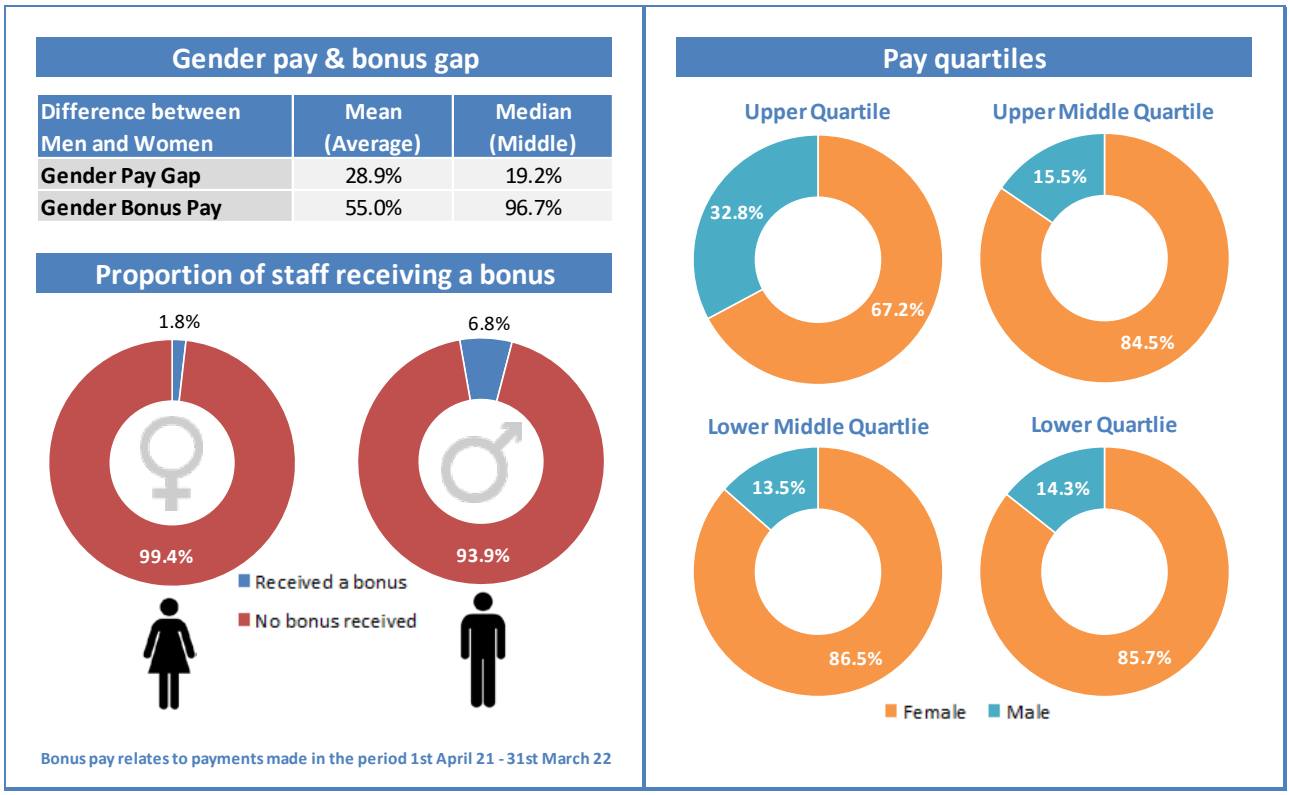
Women's Voices to understand key issues and host periodic discussions to support change	Implemented and monitoring how the learning is applied practically in the workplace	Women's Voices network
Engage allies to support change	Autumn 2022	Women's Voices network

APPENDIX 2

GENDER PAY GAP DATA ANALYSIS – (As at 31 March 2022)

The key themes to note from the gender pay gap data are as follows:-

As at 31 March 2022, 81% of the Trust's workforce was female and 19% of the Trust's workforce was male.



The gender pay gap (difference in hourly rate of) as a mean is 28.9% and a median of 19.2%.

Calderdale and Huddersfield Solutions Ltd (CHS) colleagues are excluded from this analysis.

Appendix 3 shows the comparison of March 2022 data with the submitted position for 31 March 2021 both with and without CHS employees included. This shows that the mean gender pay gap has decreased by 1.3% while the median remains unchanged.

The Medical and Dental staff group has a major impact on the gender pay gap. Excluding Medical and Dental staff from the calculation significantly decreases the pay gap, to the extent that the overall mean pay gap changes from 28.9% in favour of men to 5.7%, and the median from 19.2% to 2.7%.

The mean bonus pay gap between men and women is 55.0%, and the median is 96.7%. 6.8% of males received a bonus payment, compared to 1.8% of females.

Long service awards are included in the bonus payment calculation.

72 long service awards were given during the 2021-22 reporting year compared to 21 in 2020-21.

The table below outlines the numbers of employees, broken down by gender, who received Long Service Awards in 2021-2022. 81.9% of Long Service Awards went to female colleagues in 2021-22.

	25 Years	40 Years
Male	8	5
Female	40	19

This increased number of lower value long service award bonus payments has caused a substantial rise in the difference in bonus pay by both mean (24.2% increase) and median (91.8% increase).

The payments for Clinical Excellence Awards have a much higher value than Long Service Awards. Only 31.7% of the higher value CEA payments went to females.

To note, Clinical Excellence Awards are limited to Consultant employees within the Medical and Dental staff group.

Year on year comparison

A comparison between the snapshot gender pay gap position for 31 March 2021 and the snapshot position for 31 March 2022, which will not be submitted until March 2023.

	As at 31 March 2021	As at 31 March 2022	Difference
1. Difference in hourly rate of pay - mean	30.2%	28.9%	-1.3%
2. Difference in hourly rate of pay - median	19.2%	19.2%	0.0%
3. Difference in bonus pay - mean	30.8%	55.0%	+24.2%
4. Difference in bonus pay - median	4.9%	96.7%	+91.8%
5. Percentage of employees receiving a bonus			
Male	7.1%	6.8%	-0.3%
Female	1.1%	1.8%	+0.7%
6. Employees by quartile			
Upper Quartile - Male	32.6%	32.8%	+0.2%
Upper Quartile - Female	67.4%	67.2%	-0.2%
Upper Middle Quartile - Male	13.6%	15.5%	+1.9%
Upper Middle Quartile - Female	86.4%	84.5%	-1.9%
Lower Middle Quartile - Male	13.6%	13.5%	-0.1%
Lower Middle Quartile - Female	86.4%	86.5%	+0.1%
Lower Quartile - Male	13.3%	14.3%	+1.0%
Lower Quartile - Female	86.7%	85.7%	-1.0%

Please note: Data does not include CHS colleagues.

Comparisons with CHS

A comparison between the snapshot gender pay gap position for 31 March 2022 for CHFT, CHS and the two combined.

	CHFT	CHS	CHFT & CHS
1. Difference in hourly rate of pay - mean	28.9%	-0.8%	24.5%
2. Difference in hourly rate of pay - median	19.2%	-4.6%	9.3%
3. Difference in bonus pay - mean	55.0%	26.5%	52.5%
4. Difference in bonus pay - median	96.7%	46.7%	93.4%
5. Percentage of employees receiving a bonus			
Male	6.8%	11.2%	7.5%
Female	1.8%	7.5%	2.1%
6. Employees by quartile			
Upper Quartile - Male	32.8%	41.6%	31.8%
Upper Quartile - Female	67.2%	58.4%	68.2%
Upper Middle Quartile - Male	15.5%	43.4%	15.1%
Upper Middle Quartile - Female	84.5%	56.6%	84.9%
Lower Middle Quartile - Male	13.5%	45.4%	17.0%
Lower Middle Quartile - Female	86.5%	54.6%	83.0%
Lower Quartile - Male	14.3%	43.2%	19.0%
Lower Quartile - Female	85.7%	56.8%	81.0%

West Yorkshire Association of Acute Trusts (WYAAT) Gender Pay Gap Benchmarking

A comparison of the Trust's previously reported pay gap submission and that of other WYAAT Trusts is provided.
In addition, clarification on the inclusion of bonus payments for WYAAT Trusts is set out.

	Calderdale & Huddersfield March 2022	Calderdale & Huddersfield March 2021	Airedale March 2021	Bradford Teaching March 2021	Harrogate March 2021	Leeds Teaching March 2021	Mid Yorkshire March 2021
1. Difference in hourly rate of pay - mean	28.9%	30.2%	27.6%	23.6%	27.6%	21.3%	26.8%
2. Difference in hourly rate of pay - median	19.2%	19.2%	30.3%	6.9%	14.5%	21.2%	16.7%
3. Difference in bonus pay - mean	55.0%	30.8%	33.9%	34.6%	19.5%	36.3%	32.8%
4. Difference in bonus pay - median	96.7%	4.9%	20.9%	33.3%	33.1%	38.5%	69.9%
5. Percentage of employees receiving a bonus							
Male	6.8%	7.1%	4.9%	6.4%	13.3%	5.4%	10.0%
Female	1.8%	1.1%	0.8%	0.9%	6.1%	0.9%	1.5%
6. Employees by quartile							
Upper Quartile - Male	32.8%	32.6%	32.7%	32.9%	26.6%	37.2%	33.0%
Upper Quartile - Female	67.2%	67.4%	67.3%	67.1%	73.4%	62.8%	67.0%
Upper Middle Quartile - Male	15.5%	13.6%	14.1%	15.8%	8.9%	22.0%	13.3%
Upper Middle Quartile - Female	84.5%	86.4%	85.9%	84.2%	91.1%	78.0%	86.7%
Lower Middle Quartile - Male	13.5%	13.6%	13.0%	19.0%	12.8%	20.2%	17.4%
Lower Middle Quartile - Female	86.5%	86.4%	87.0%	81.0%	87.2%	79.8%	82.6%
Lower Quartile - Male	14.3%	13.3%	11.4%	23.5%	13.3%	21.7%	15.2%
Lower Quartile - Female	85.7%	86.7%	88.6%	76.5%	86.7%	78.3%	84.8%

Airedale	Bonus pay only includes Consultants Clinical Excellence Awards (CEAs) and discretionary points.
Bradford	Bonus pay only includes Consultants Clinical Excellence Awards (CEAs).
Harrogate	Bonus pay only includes Consultants Clinical Excellence Awards (CEAs) and Long Service Awards.
Leeds Teaching	Bonus pay only includes Consultants Clinical Excellence Awards (CEAs). Discussions with Payroll confirmed Leeds Teaching Hospitals NHS Trust do not have long service awards. Percentage of employees receiving a bonus has only shown the % of consultants receiving a CEA.
Mid Yorkshire	No report available for March 2021 data. Previous report indicates only CEAs contributing to bonus pay calculations.

2. MIS submission and approval process

NHS Resolution

Maternity incentive scheme – year four

Conditions of the scheme

Ten maternity safety actions with technical guidance

Questions and answers related to the scheme

October 2022

Contents

Introduction

NHS Resolution is operating year four of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care.

The maternity incentive scheme applies to all acute Trusts that deliver maternity services and are members of the CNST. As in previous years, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund.

The scheme incentivises ten maternity safety actions as referenced in previous years' schemes. Trusts that can demonstrate they have achieved **all** of the **ten** safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds.

Trusts that **do not meet** the ten-out-of-ten threshold will **not** recover their contribution to the CNST maternity incentive fund, but may be eligible for a small discretionary payment from the scheme to help to make progress against actions they have not achieved. Such a payment would be at a much lower level than the 10% contribution to the incentive fund.

Maternity incentive scheme year four: conditions

In order to be eligible for payment under the scheme, Trusts must submit their completed Board declaration form to NHS Resolution (nhsr.mis@nhs.net) by 12 noon on Thursday 2 February 2023 and must comply with the following conditions:

- Trusts must achieve **all** ten maternity safety actions.
- The declaration form is submitted to Trust Board with an accompanying joint presentation detailing position and progress with maternity safety actions by the Director of Midwifery/Head of Midwifery and Clinical Director for Maternity Services
- The Board declaration form must be signed and dated by the Trust's **Chief Executive Officer** (CEO) to confirm that:
  - The Trust Board are satisfied that the evidence provided to demonstrate achievement of the ten maternity safety actions meets the required safety actions' sub-requirements as set out in the safety actions and technical guidance document included in this document.
  - There are no reports covering either year 2021/22 or 2022/23 that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration (e.g. Care Quality Commission (CQC) inspection report, Healthcare Safety Investigation Branch (HSIB) investigation reports etc.). All such reports should be brought to the MIS team's attention before Thursday 2 February 2023.
- The Board must give their permission to the CEO to sign the Board declaration form prior to submission to NHS Resolution. Trust Board declaration form must be

signed by the Trust's CEO. If the form is signed by another Trust member this will not be considered.

- In addition, the CEO of the Trust will ensure that the Accountable Officer (AO) for their Integrated Care System (ICB) is apprised of the MIS safety actions' evidence and declaration form. The CEO and AO must both sign the Board declaration form as evidence that they are both fully assured and in agreement with the compliance submission to NHS Resolution

Note: CCG functions will be subsumed into integrated care systems, with CCGs ceasing to exist as statutory organisations by July 2022.

- Trust submissions will be subject to a range of external validation points, these include cross checking with: MBRRACE-UK data (safety action 1 standard a, b and c), NHS England & Improvement regarding submission to the Maternity Services Data Set (safety action 2, criteria 2 to 7 inclusive), and against the National Neonatal Research Database (NNRD) and HSIB for the number of qualifying incidents reportable (safety action 10, standard a)). Trust submissions will also be sense checked with the CQC, and for any CQC visits undertaken within the time period, the CQC will cross-reference to the maternity incentive scheme via the key lines of enquiry.
- The Regional Chief Midwives will provide support and oversight to Trusts when receiving Trusts' update at Local Maternity and Neonatal System (LMNS) and regional meetings, focusing on themes highlighted when Trusts have incorrectly declared MIS compliance in previous years of MIS.
- NHS Resolution will continue to investigate any concerns raised about a Trust's performance either during or after the confirmation of the maternity incentive scheme results. Trusts will be asked to consider their previous MIS submission and reconfirm if they deem themselves to be compliant. If a Trust re-confirm compliance with all of the ten safety actions then the evidence submitted to Trust Board will be requested by NHS Resolution for review. If the Trust is found to be non-compliant (self-declared non-compliant or declared non-compliant by NHS Resolution), it will be required to repay any funding received and asked to review previous years' MIS submissions.
- NHS Resolution will publish the outcomes of the maternity incentive scheme verification process, Trust by Trust, for each year of the scheme (updated on the NHS Resolution Website).

Evidence for submission

- The Board declaration form must not include any narrative, commentary, or supporting documents. Evidence should be provided to the Trust Board only, and will not be reviewed by NHS Resolution, unless requested as explained above.
- Trusts must declare YES/NO or N/A (where appropriate) against each of the elements within each safety action sub-requirements.
- The Trust must also declare on the Board declaration form whether there are any external reports which may contradict their maternity incentive scheme submission and that the MIS evidence has been discussed with commissioners.

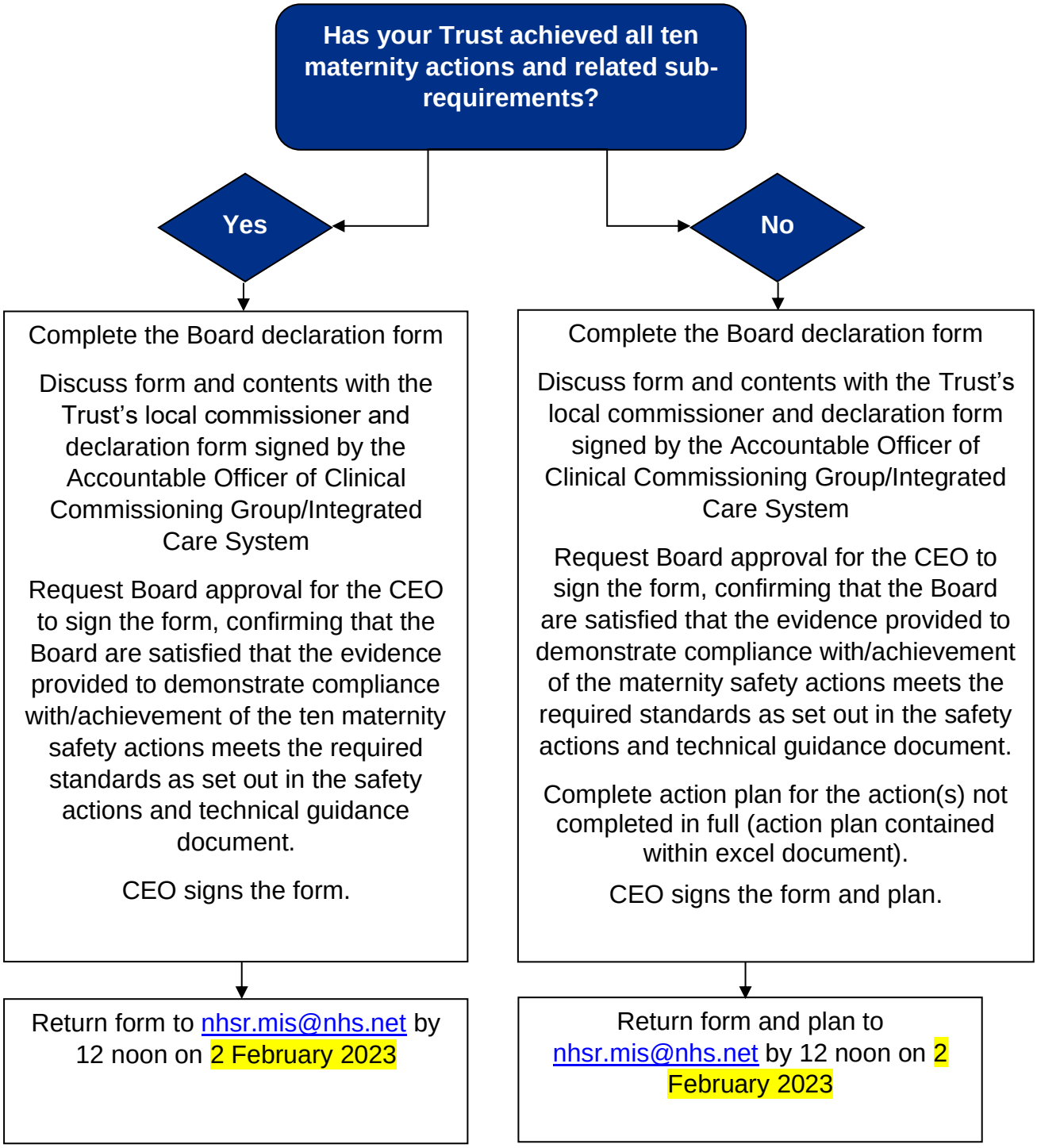
- Trusts will need to report compliance with MIS by Thursday 2 February 2023 at 12 noon using the Board declaration form, which will be published on the NHS Resolution website in the forthcoming months.
- The Trust declaration form must be signed by the Trust's CEO, on behalf of the Trust Board and by Accountable Officer (AO) of Clinical Commissioning Group/Integrated Care System.
- Only for a set amount of safety action requirements, Trusts will be able to declare N/A (not applicable) against some of the sub requirements.
- The declaration form will be available on the MIS webpage at a later date.

Timescales and appeals

- Any queries relating to the ten safety actions must be sent in writing by e-mail to NHS Resolution (nhsr.mis@nhs.net) prior to the submission date.
- The Board declaration form must be sent to NHS Resolution (nhsr.mis@nhs.net) between Thursday 26 January 2023 and Thursday 2 February 2023 at 12 noon. An electronic acknowledgement of Trust submissions will be provided within ten working days from submission date.
- Submissions and any comments/corrections received after 12 noon on Thursday 2 February 2023 will not be considered.
- Further detail on the results publication, appeals and payments process will be communicated at a later date

For Trusts who have not met all ten safety actions

Trusts that have not achieved all ten safety actions may be eligible for a small amount of funding to support progress. In order to apply for funding, such Trusts must submit an action plan together with the Board declaration form by 12 noon on 2 February 2023 to NHS Resolution (nhsr.mis@nhs.net). The action plan must be specific to the action(s) not achieved by the Trust and must take the format of the action plan template which will be provided within the Board declaration form. Action plans should not be submitted for achieved safety actions.

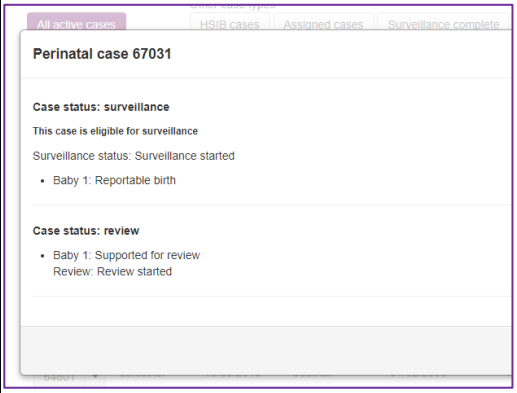

Has your Trust achieved all ten maternity actions and related sub-requirements?
Yes
No
Complete the Board declaration form
Discuss form and contents with the Trust's local commissioner and declaration form signed by the Accountable Officer of Clinical Commissioning Group/Integrated Care System
Request Board approval for the CEO to sign the form, confirming that the Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the ten maternity safety actions meets the required standards as set out in the safety actions and technical guidance document.
CEO signs the form.
Return form to nhsr.mis@nhs.net by 12 noon on 2 February 2023
Complete the Board declaration form
Discuss form and contents with the Trust's local commissioner and declaration form signed by the Accountable Officer of Clinical Commissioning Group/Integrated Care System
Request Board approval for the CEO to sign the form, confirming that the Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets the required standards as set out in the safety actions and technical guidance document.
Complete action plan for the action(s) not completed in full (action plan contained within excel document).
CEO signs the form and plan.
Return form and plan to nhsr.mis@nhs.net by 12 noon on 2 February 2023
Send any queries relating to the ten actions to NHS Resolution (nhsr.mis@nhs.net) prior to the submission date

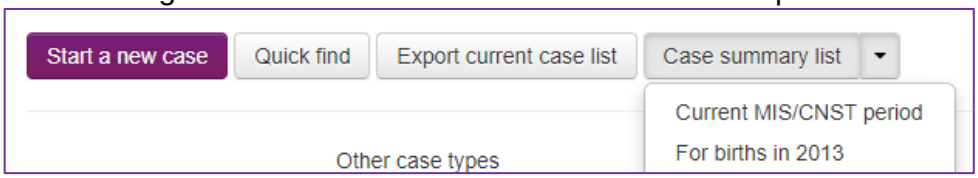
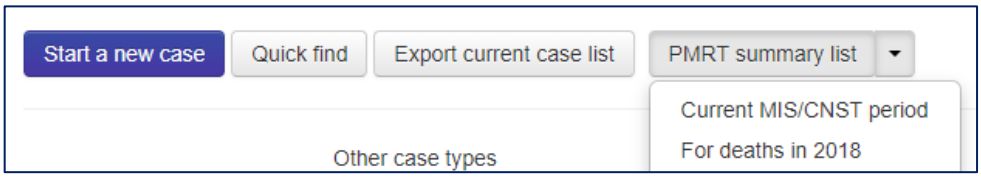
Safety action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?

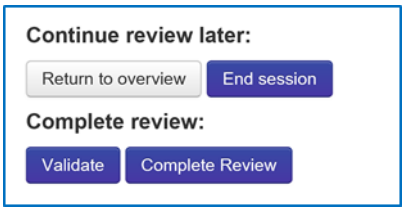
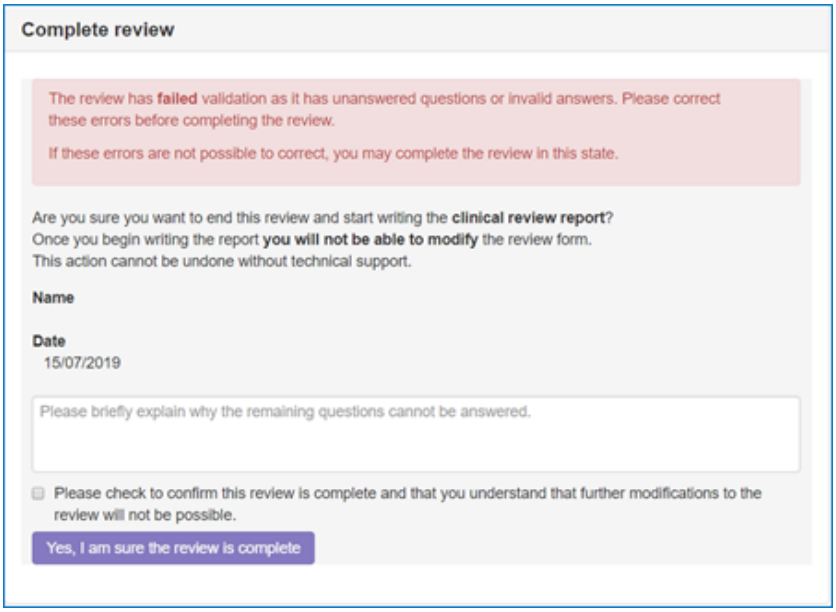
Required standard	a) i. All perinatal deaths eligible to be notified to MBRRACE-UK from 6 May 2022 onwards must be notified to MBRRACE-UK within seven working days and the surveillance information where required must be completed within one month of the death. Deaths where the surveillance form needs to be assigned to another Trust for additional information are excluded from the latter. ii. A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 6 May 2022 will have been started within two months of each death. This includes deaths after home births where care was provided by your Trust. b) At least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, from 6 May 2022 will have been reviewed using the PMRT, by a multidisciplinary review team. Each of these reviews will have been completed to the point that at least a PMRT draft report has been generated by the tool within four months of each death and the report published within six months of each death. c) For at least 95% of all deaths of babies who died in your Trust from 6 May 2022, the parents will have been told that a review of their baby's death will take place, and that the parents' perspectives and any questions and/or concerns they have about their care and that of their baby have been sought. This includes any home births where care was provided by your Trust staff and the baby died either at home or in your Trust. If delays in completing reviews are anticipated parents should be advised that this is the case and be given a timetable for likely completion. Trusts should ensure that contact with the families continues during any delay and make an early assessment of whether any questions they have can be addressed before a full review has been completed; this is especially important if there are any factors which may have a bearing on a future pregnancy. In the absence of a bereavement lead ensure that someone takes responsibility for maintaining contact and for taking actions as required.

	d) Quarterly reports will have been submitted to the Trust Board from 6 May 2022 onwards that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety and Board level safety champions.
Minimum evidential requirement for Trust Board	Notifications must be made and surveillance forms completed using the MBRRACE-UK reporting website. The perinatal mortality review tool must be used to review the care and reports should be generated via the PMRT. A report has been received by the Trust Board each quarter from 6 May 2022 onwards that includes details of the deaths reviewed and the consequent action plans. The report should evidence that the PMRT has been used to review eligible perinatal deaths and that the required standards a), b) and c) have been met. For standard c) for any parents who have not been informed about the review taking place, reasons for this should be documented within the PMRT review.
Validation process	Self-certification by the Trust Board and submitted to NHS Resolution using the Board declaration form. NHS Resolution will use data from MBRRACE-UK/PMRT, to cross-reference against Trust self-certifications.
What is the relevant time period?	From 6 May 2022 until 5 December 2022
What is the deadline for reporting to NHS Resolution?	Thursday 2 February 2023 at 12 noon

Technical guidance for safety action 1

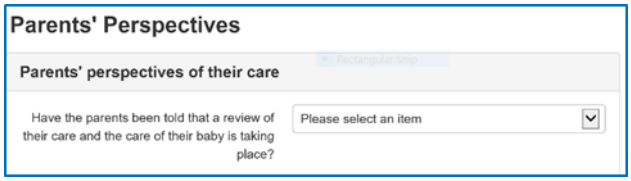
Technical guidance	
Which perinatal deaths must be notified to MBRRACE-UK?	Details of which perinatal death must be notified to MBRRACE-UK are available at: https://www.npeu.ox.ac.uk/mbrrace-uk/data-collection
What is the time limit for notifying a perinatal death?	All perinatal deaths eligible to be reported to MBRRACE-UK from 6 May 2022 must be notified to MBRRACE-UK within seven working days. When a notification is complete the notification status will show whether surveillance (and review) is required for each case. This is available from the case management screen by clicking on the Case ID and selecting Notification status.  Following notification within seven working days of the perinatal death, the surveillance form, where required, must be completed within one month of the death. If at that stage post-mortem or other investigations are not available and the final cause of death is not confirmed, indicate this in the “Cause of Death/Confirmation of cause of death” section, complete the rest of the information, and close the surveillance form. Once the additional information and the final cause of death is known and confirmed as part of the PMRT review discussion, the reporter should re-open the case, update the relevant sections and close it again. You can reopen the surveillance form from the case management screen. If you need to assign the surveillance form to another Trust for additional information then that death will be excluded from the standard validation of the requirement to complete the surveillance data within one month of the death.

What are the statutory obligations to notify neonatal deaths?	The Child Death Review Statutory and Operational Guidance (England) sets out the obligations of notification for neonatal deaths. This guidance is available at: https://www.gov.uk/government/publications/child-death-review-statutory-and-operational-guidance-england MBRRACE-UK are working with the National Child Mortality Database (NCMD) team to provide a single route of reporting for neonatal deaths which will be via MBRRACE-UK. Once this single route is established MBRRACE-UK will be the mechanism for directly notifying all neonatal deaths to the local Child Death Overview Panel (CDOP). At that stage, for any Trust not already doing so, a review completed using the PMRT will be the required mechanism for completing the local review for submission to CDOP. This will also be the required route for providing additional information about the death required by the NCMD. Work is underway to provide this single route of reporting with plans to have this in place in the forthcoming months.
How can we keep a check on which of our deaths require surveillance?	There is a report under 'Case summary list' on the MBRRACE-UK case management screen entitled 'Current MIS/CNST period'.  This includes ALL deaths in the Trust which have been notified to MBRRACE-UK and shows the status of the surveillance if required. This will also indicate if surveillance is required and not started/completed.
Which perinatal deaths must be reviewed to meet safety action one standards?	The following deaths should be reviewed to meet safety action one standards: •All late miscarriages/ late fetal losses (22+0 to 23+6 weeks' gestation) •All stillbirths (from 24+0 weeks' gestation) •Neonatal death (up to 28 days after birth) While it is possible to use the PMRT to review post neonatal deaths (from 29 days after births) this is NOT a requirement to meet safety action one.
How can we keep a check on which of our deaths are suitable for review using the PMRT and their review status?	Within the PMRT authorised users of the PMRT can generate a report for your Trust under 'PMRT summary list' entitled 'Current MIS/CNST period'. This list includes those deaths notified by your Trust which are suitable for review using the PMRT at the point when the report is generated.  This is a list of those deaths notified by your Trust which are suitable for review using the PMRT **at the point when the report is**

	generated. This report is of ALL deaths in the Trust which have been notified to MBRRACE-UK some of which (for example terminations of pregnancy) are not suitable for review using the PMRT.
What is meant by "starting" a review using the PMRT?	Starting a review in the PMRT requires the death to be notified to MBRRACE-UK for surveillance purposes, and the PMRT to have been used to complete the first review session (which might be the first session of several) for that death. At a minimum all the 'factual' questions in the PMRT should be completed for the review to be regarded as started; it is not sufficient to just open the PMRT tool, this does not meet the criterion of having started a review.
What is meant by "completing a review to the point that at least a draft report has been generated"?	A multidisciplinary review team should have used the PMRT to review the death, then the review progressed to at least the stage of writing a draft report by pressing 'Complete review'.  The tool may raise validation errors at this point. If validation errors appear you need to deal with these in one of two ways: (i) resolve them and then press the 'Complete Review' button again OR (ii) complete the text box with an explanation of why the remaining questions cannot be validated (for example, the mother's hand held notes were lost). Confirm that the review is complete by ticking the box and pressing the button **'Yes I am sure that the review is complete'**.  The report entitled 'PMRT summary list' includes the status of the review, which should be 'Writing report' or 'Review complete'.

What does multi-disciplinary review mean?	The team conducting the review should include at least one and preferably two professionals relevant to the care of the woman and her baby. Ideally the team should include a member from a relevant professional group who is external to the unit who can provide peer review as part of the PMRT review team. It may not be possible to include an 'external' member for all reviews and you may need to be selective as to which deaths are reviewed by the team including an external member. Where a HSIB investigation has been carried out the external member could be one or more of the HSIB reviewers involved in the HSIB investigation. Further guidance about multidisciplinary review can be found on the PMRT website at: https://www.npeu.ox.ac.uk/pmrt/implementation-support
Review assignment	A feature available in the PMRT is the ability to assign reviews to another Trust for review of elements of the care if some of the care for the women and/or her baby was provided in another Trust. For example, if the baby died in your Trust but antenatal care was provided in another Trust you can assign the review to the other Trust so that they can review the care that they provided. Following their review the other Trust reassigns the review back to your Trust. You can then review the subsequent care your Trust provided Issues with care identified are 'owned' by the Trust which identified them as are the related action plans, but a single report is generated. This ensures that when the report is discussed with the parents all aspects of the care they received can be covered; this should avoid potentially contradictory findings being conveyed and inappropriate advice being given regarding their next pregnancy.
Can the PMRT help by providing a quarterly report which can be presented to the Trust Board?	Reports for your Trust, summarising the results from completed reviews over a period, can be generated within the PMRT by authorised PMRT users for user-defined periods of time. These are available under the 'Your Data' tab in the section entitled 'Perinatal Mortality Reviews Summary Report and Data extracts'. These reports can be used as the basis for your quarterly Board reports and should be discussed with your Trust maternity safety champion.
What deaths should we review outside the relevant time period for the safety action validation process?	We recommend Trusts review all eligible deaths using the PMRT as a routine process, irrespective of the MIS timeframe and validation process.
What should we do if our post-mortem	For deaths where a post-mortem (PM) has been requested (hospital or coronial) and is likely to take more than four months for the results

service has a turn-around time in excess of four months?	to be available, the PMRT team at MBRRACE-UK advise that you should start the review of the death and complete it with the information you have available. When the post-mortem results come back you should contact the PMRT team at MBRRACE-UK who will re-open the review so that the information from the PM can be included. Should the PM findings change the original review findings then a further review session should be carried out taking into account this new information. If you wait until the PM is available before starting a review you risk missing learning opportunities earlier, especially if the turn-around time is considerably longer than four months. Where the post-mortem turn-around time is quicker than this information from the post-mortem can be included in the original reviews.
What should we do if we do not have any eligible perinatal deaths with the relevant time period?	If you do not have any babies that have died between 6 May 2022 and 5 December 2022 then you should partner up with a Trust with which you have a referral relationship to participate in case reviews.
How does the involvement of the Healthcare Safety Investigation Branch (HSIB) in investigations impact on meeting safety action one?	It is recognised that for a small number of deaths (term intrapartum stillbirths and early neonatal deaths of babies born at term) investigations will be carried out by HSIB. Your local review using the PMRT should be started but not completed until the HSIB report is complete. You should consider inviting the HSIB reviewers to attend these reviews to act as the external members of the review team, thereby enabling the learning from the HSIB review to be automatically incorporated into the PMRT review. Depending upon the timing of the HSIB report completion achieving the standards for these babies may therefore be impacted by timeframes beyond the Trust's control. For an individual death you can indicate in the MBRRACE-UK/PMRT case management screen that an HSIB INVESTIGATION is taking place and this will be accounted for in the external validation process.
How does "assigning a review" impact on safety action 1, especially on starting a review?	It is recognised that if you need to assign a review to another Trust this may affect the ability to meet some of the deadlines for starting, completing and publishing that review. This will be accounted for in the external validation process.
We have informed parents that a local review will take place and they have been asked if they have any	In order to address any questions that parents have about their care and why their baby died, parents need to be informed that a review will take place and be given the opportunity to provide their perspective about their care and raise any questions that they have. In order that parents' perspectives and questions can be considered this information needs to be incorporated as part of the review and

reflections or questions about their care. However, this information is recorded in another data system and not the clinical records. What should we do?	entered into the PMRT. So if this information is held in another data system it needs to be brought to the review meeting, incorporated into the PMRT and considered as part of the review discussion. Materials to support parent engagement in the local review process are available on the PMRT website at: https://www.npeu.ox.ac.uk/pmrt/parent-engagement-materials 
We have contacted the parents of a baby who has died and they don't wish to have any involvement in the review process, what should we do?	Following the death of their baby, before they leave the hospital, all parents should be informed that a local review of their care and that of their baby will be undertaken by the Trust. In the case of neonatal deaths parents should also be told that a review will be undertaken by the local CDOP. Verbal information can be supplemented by written information. The process of parent engagement should be guided by the parents. Not all parents will wish to provide their perspective of the care they received or raise any questions and/or concerns, but all parents should be given the opportunity to do so. Some parents may also change their mind about being involved and, without being intrusive, they should be given more than one opportunity to provide their perspective and raise any questions and/or concerns they may subsequently have about their care. Materials to support parent engagement in the local review process are available on the PMRT website at: https://www.npeu.ox.ac.uk/pmrt/parent-engagement-materials See especially the notes accompanying the flowchart.
Parents have not responded to our messages and therefore we are unable to discuss the review – what should we do?	As stated above, following the death of their baby, before they leave the hospital, all parents should be informed that a local review of their care, and that of their baby, will be undertaken by the Trust (as above). If this does not happen for any reason and parents cannot be reached after three phone/email attempts, send parents a letter informing them of the review process and inviting them to be in touch with a key contact, if they wish. In addition, if causes for concern for the mother's wellbeing were raised during her pregnancy consider contacting her GP/primary carer to reach her. If parents do not wish to input into the review process ask how they would like findings of the perinatal mortality review report communicated to them. Materials to support parent engagement in the local review process, including an outline of role of key contact, are available on the PMRT website at: materials to support parent engagement in the local review process are available on the PMRT website at: https://www.npeu.ox.ac.uk/pmrt/parent-engagement-materials

	See notes accompanying the flowchart as well as template letters and ensure engagement with parents is recorded within the parent engagement section of the PMRT.
Is the quarterly review of the Board report based on a financial or calendar year?	This can be either a financial or calendar year. Reports for your Trust summarising the results from reviews over a period time which have been completed can be generated within the PMRT by authorised PMRT users for a user-defined periods of time. These are available under the 'Your Data' tab and the report is entitled 'Perinatal Mortality Reviews Summary Report and Data extracts'. These reports can be used as the basis of your quarterly reports to your Trust Board and should be discussed with your Trust maternity safety champion. Please note that these reports will only show summaries, issues and action plans for reviews **that have been published** therefore the time period selected may need to relate to an earlier period than the current quarter and may lag behind the current quarter by up to six months.
The scheme was paused on 23 December 2021. Trusts were asked to continue to report eligible cases to MBRRACE-UK during the pause. Will the safety action 1 standards be applied to the deaths occurring before the pause date?	Trusts were asked to continue to report eligible cases to MBRRACE-UK during MIS year 4 pause. However, Standard 1 requirements will only be validated for the period after the pause that is, from 6 May 2022 until 5 December 2022.
What should we do if we experience technical issues with using PMRT?	All Trusts are reminded to contact their IT department regarding any technical issue in the first instance. If this cannot be resolved, then the issue should be escalated to MBRRACE-UK as soon as possible. This can be done through the 'contact us' facility within the MBRRACE-UK/PMRT system or by emailing us at: mbrrace.support@npeu.ox.ac.uk
If there are any updates on PMRT for the maternity incentive scheme where will they be published?	Any updates on the PMRT or the MBRRACE-UK notification and surveillance in relation to the maternity incentive scheme safety action, will be communicated via NHS Resolution email and will also be included in the PMRT "message of the day".

Safety action 2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

Required standard	This relates to the quality and completeness of the submission to the Maternity Services Data Set (MSDS) and ongoing plans to make improvements. 1. By 31st October 2022, Trusts have an up to date digital strategy for their maternity services which aligns with the wider Trust Digital Strategy and reflects the 7 success measures within the What Good Looks Like Framework. The strategy must be shared with Local Maternity Systems and be signed off by the Integrated Care Board. As part of this, dedicated Digital Leadership should be in place in the Trust and have engaged with the NHSEI Digital Child Health and Maternity Programme. 2. Trust Boards to assure themselves that at least 9 out of 11 Clinical Quality Improvement Metrics (CQIMs) have passed the associated data quality criteria in the "CNST Maternity Incentive Scheme Year 4 Specific Data Quality Criteria" data file in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2022. The data for July 2022 will be published during October 2022. 3. July 2022 data contained height and weight data, or a calculated Body Mass Index (BMI), recorded by 15+0 weeks gestation for 90% of women reaching 15+0 weeks gestation in the month. 4. July 2022 data contained Complex Social Factor Indicator (at antenatal booking) data for 95% of women booked in the month. 5. July 2022 data contained antenatal personalised care plan fields completed for 95% of women booked in the month. (MSD101/2) 6. July 2022 data contained valid ethnic category (Mother) for at least 90% of women booked in the month. Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001) 7. Trust Boards to confirm to NHS Resolution that they have passed the associated data quality criteria in

	the "CNST Maternity Incentive Scheme Year 4 Specific Data Quality Criteria" data file in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2022 for the following metrics: **Midwifery Continuity of carer (MCoC)** i. Over 5% of women who have an Antenatal Care Plan recorded by 29 weeks and also have the CoC pathway indicator completed. ii. Over 5% of women recorded as being placed on a CoC pathway where both Care Professional ID and Team ID have also been provided. iii. At least 70% of MSD202 Care Activity (Pregnancy) and MSD302 Care Activity (Labour and Delivery) records submitted in the reporting period have a valid Care Professional Local Identifier recorded. Providers submitting zero Care Activity records will fail this criterion. Criteria i and ii are the data quality metrics used to determine whether women have been placed on a midwifery continuity of carer pathway by the 28 weeks antenatal appointment, as measured at 29 weeks gestation. Criteria iii are fundamental building blocks and a necessary step towards measuring whether or not women have received midwifery continuity of carer (though it is not the complete measurement). The data for July 2022 will be published in October 2022. If the data quality for criteria 7 are not met, trusts can still pass safety action 2 by evidencing sustained engagement with NHS Digital which at a minimum, includes monthly use of the Data Quality Submission Summary Tool supplied by NHS Digital (see technical guidance for further information).
Minimum evidential requirement for Trust Board	1) Criteria 1 will be reported to NHS Resolution as part of trusts' self-declaration using the Board declaration form. For criteria 2 to 7, the "CNST Maternity Incentive Scheme Year 4 Specific Data Quality Criteria" data file in the Maternity Services Monthly Statistics publication series displays whether trusts have passed the requisite data quality thresholds.

Validation process	All criteria to be self-certified by the Trust Board and submitted to NHS Resolution using the Board declaration form. NHS England and Improvement will cross-reference self-certification of criteria 2 to 7 (inclusive) against NHS Digital data
What is the relevant time period?	From 6 May 2022 until 5 December 2022
What is the deadline for reporting to NHS Resolution?	Thursday 2 February 2023 at 12 noon

Technical guidance for safety action 2

Technical guidance	
Regarding criteria 1, we have not started a digital strategy for our maternity service. What support is available?	NHSEI will not be reviewing individual strategies. Support on how to write a strategy can be sought within your own Trust, ICS and Regional Digital Midwife Expert Reference Groups (see below for further information).
Regarding criteria 1, what is meant by having digital leadership in place?	By digital leadership, we mean that the maternity service should have at least 1 person who is dedicated towards working on the digital strategy and improving digital maturity within maternity services. The digital lead does not have to be a clinical member of staff, and could, for example, be a project manager, however they must report to or work alongside a clinician.
Regarding criteria 1, what is meant by engaging with the Digital Child Health and Maternity Programme?	By engaging with the programme, we mean that the digital lead should have made contact and be known to the Regional Digital Midwives Expert Reference group (or equivalent). For further information regarding the Expert Reference Group, please email england.digitalmaternitynhsx@nhs.net
Regarding criteria 1, our Integrated Care Board is unable to sign off our digital strategy. What are the alternative options?	If a Trust already have a pre-existing digital strategy for maternity that aligns with the What Good Looks Like Framework which has been signed off by the appropriate governance, then no further action is needed to meet this criteria. If it is not possible to obtain Integrated Care Board sign-off for new strategies, then sign-off by another appropriate governance board will be acceptable (e.g. LMNS Board).
My maternity service has currently suspended Midwifery Continuity of Carer pathways. How does this affect my data submission for CNST safety action 2?	If your maternity service has suspended Midwifery Continuity of Carer (MCoC) pathways, in your MSDS submission you should report that women are not being placed on these pathways in MSDS table MSD102. This is a satisfactory response for safety action 2 criteria 7i. Consequently, criteria 7ii would not be applicable to your CNST submission as it relates only to women placed on MCoC pathways, and no further action from you would be necessary. However, criteria 7iii does still apply to all maternity services, even if they have suspended MCoC pathways, as we would expect all services to report Care Professional Local Identifier data

Where can I find out further technical information on the above metrics?	Technical information, including relevant MSDSv2 fields and data thresholds required to pass CQIMs and other metrics specified above can be accessed on NHS Digital's website In the "Meta Data" file (see 'construction' tabs) available within the Maternity Services Monthly Statistics publication series: https://digital.nhs.uk/data-and-information/publications/statistical/maternity-services-monthly-statistics
The following CQIMs use a rolling count across three separate months in their construction. Will my Trust be assessed on these three months? • **Proportion of babies born at term with an Apgar score <7 at 5 minutes** • **Women who had a postpartum haemorrhage of 1,500ml or more** • **Women who were current smokers at delivery** • **Women delivering vaginally who had a 3rd or 4th degree tear** • **Women who gave birth to a single second baby vaginally at or after 37 weeks after a previous caesarean section** • **Caesarean section delivery rate in Robson group 1 women** • **Caesarean section delivery rate in Robson group 2 women** • **Caesarean section delivery rate in Robson group 5 women**	No. For the purposes of the CNST assessment trusts will only be assessed on July 2022 data for these CQIMs. Due to this, trusts are now directed to check whether they have passed the requisite data quality required for this safety action within the "CNST Maternity Incentive Scheme Year 4 Specific Data Quality Criteria" data file in the Maternity Services Monthly Statistics publication series, as the national Maternity Services Dashboard will still display these data using rolling counts. NHS E&I will externally verify Trust' compliance with criteria 2 to 7.
Will my Trust fail this action if women choose not to receive continuity of carer or a Personalised Care and Support Plan?	**No. This action is focussed on data quality only and therefore Trusts pass or fail it based upon record completeness for each metric and not on the proportion (%) recorded as the metric output.**

The metrics for Midwifery Continuity of Carer appear to have changed. Why is this?	In the last version, there was a metric for placement of women onto midwifery continuity of carer pathways. This has not changed and has simply been broken down into the 2 required data quality measures (see i and ii), to provide more clarity on what is required. The last version also contained a metric to demonstrate evidence of receipt of continuity of carer by women. Current national data quality levels suggest there is much further work to be done for all Trusts to achieve this. Therefore, this has been replaced with a metric (see iii) containing important elements needed to improve the overall data.
The metric for Personalised Care and Support Plans (PCSP) has changed. Why is this?	NHSEI has taken on board feedback that reporting of the PCSP metrics as given previously in this action were not sufficiently aligned to the policy or clinical practice. In addition, we were informed that, as a consequence, Maternity Information Systems had not been appropriately configured to record PCSPs in the way suggested. The replacement metric is the same as that used in last year's MIS, which Trusts successfully reported on. The only difference is that we have increased the reporting threshold from 90 to 95% for the proportion of women with the antenatal PCSP field completed ('yes' or 'no') who were booked in the month. This data still provides useful insight and will contribute towards a more refined measure for PCSPs in future.
What is the Data Quality Submission Summary Tool? How does my Trust access this?	The Data Quality Submission Summary Tool has been developed by NHS Digital specifically to support this safety action. The tool provides an immediate report on potential gaps in data required for CQIMs and other metrics specified above after data submission, so Trusts can take action to rectify them. It is intended to be used alongside other existing reports and documentation in order for providers to be able to create a full and detailed picture of the quality of their data submissions. Further information on the tool and how to access it is available on NHS Digital's website: https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/maternity-services-data-set/data-quality-submission-summary-tool

For the Data Quality Submission Summary Tool, what does "sustained engagement" mean for the purposes of passing criteria 7?	By "sustained engagement" we mean that Trusts must show evidence of using the tool for at least three consecutive months prior to the submission of evidence to the Trust Board. For example, for a submission made to the Board in November, engagement should be, as a minimum, in August, September and October. This is a minimum requirement and we advise that engagement should start as soon as possible. To evidence this, Trusts should save the Excel output file after running the report for a given month. Three files representing each of the three consecutive months should be provided to your Trust Board as part of the assurance process for MIS. Note – this only becomes a requirement in the event your Trust fails the requisite data quality for the continuity of carer metrics. Also note – in the last version of this action we had asked for evidence of 4 months' use of the tool which included the assessment month. This is no longer the case – any 3 consecutive months before submission of evidence to your Trust Board is sufficient.
The monthly publications and Maternity Services Dashboard states that my Trusts' data has failed for a particular metric. Where can I find out further information on why this has happened?	Details of all the data quality criteria can be found in the "Meta Data" file (see 'CQIMDQ/CoCDQ Measures construction' tabs) which accompanies the Maternity Services Monthly Statistics publication series (https://digital.nhs.uk/data-and-information/publications/statistical/maternity-services-monthly-statistics). The scores for each data quality criteria can be found in the "Measures" file within the same publication series.
The monthly publications and national Maternity Services Dashboard states that my Trusts' data is 'suppressed'. What does this mean?	Where data is reported in low values for clinical events, the published data will appear 'suppressed' to ensure the anonymity of individuals. However, for the purposes of data quality within this action, 'suppressed' data will still count as a pass.

Where can I find out more about MSDSv2?	https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/maternity-services-data-set
Where should I send any queries?	**On MSDS data** For queries regarding your MSDS data submission, or on how your data is reported in the monthly publication series or on the Maternity Services Dashboard please contact NHS Digital at maternity.dq@nhs.net. **For any other queries**, please email nhsr.mis@nhs.net

Safety action 3: Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?

Required standard	a) Pathways of care into transitional care have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care. b) The pathway of care into transitional care has been fully implemented and is audited quarterly. Audit findings are shared with the neonatal safety champion, LMNS, commissioner and Integrated Care System (ICS) quality surveillance meeting each quarter. c)A data recording process (electronic and/or paper based for capturing **all** term babies transferred to the neonatal unit, regardless of the length of stay, is in place. d) A data recording process for capturing existing transitional care activity, (regardless of place - which could be a Transitional Care (TC), postnatal ward, virtual outreach pathway etc.) has been embedded. If not already in place, a secondary data recording process is set up to inform future capacity management for late preterm babies who could be cared for in a TC setting. The data should capture babies between 34+0-36+6 weeks gestation at birth, who neither had surgery nor were transferred during any admission, to monitor the number of special care or normal care days where supplemental oxygen was not delivered. e) Commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data set (NCCMDS) version 2 are available to be shared on request with the operational delivery network (ODN), LMNS and commissioners to inform capacity planning as part of the family integrated care component of the Neonatal Critical Care Transformation Review and to inform future development of transitional care to minimise separation of mothers and babies. f) Reviews of babies admitted to the neonatal unit continue on a quarterly basis and findings are shared quarterly with the Board Level Safety Champion. Reviews should now include all neonatal unit transfers or admissions regardless of their length of stay and/or admission to BadgerNet. In addition, reviews should report on the number of transfers to the neonatal unit that would have met current TC admissions criteria but were transferred or admitted to the neonatal unit due to capacity or staffing issues. The review should also record the number of babies that were transferred or admitted or remained on Neonatal Units because of their need for nasogastric tube feeding, but could have been

	cared for on a TC if nasogastric feeding was supported there. Findings of the review have been shared with the maternity, neonatal and Board level safety champions, LMNS and ICS quality surveillance meeting on a quarterly basis. g) An action plan to address local findings from the audit of the pathway (point b) and Avoiding Term Admissions Into Neonatal units (ATAIN) reviews (point f) has been agreed with the maternity and neonatal safety champions and Board level champion. h) Progress with the revised ATAIN action plan has been shared with the maternity, neonatal and Board level safety champions, LMNS and ICS quality surveillance meeting.
Minimum evidential requirement for Trust Board	Local policy/pathway available which is based on principles of British Association of Perinatal Medicine (BAPM) transitional care where: **Evidence for standard a) to include:** • There is evidence of neonatal involvement in care planning • Admission criteria meets a minimum of at least one element of HRG XA04 but could extend beyond to BAPM transitional care framework for practice • There is an explicit staffing model • The policy is signed by maternity/neonatal clinical leads and should have auditable standards. • The policy has been fully implemented and quarterly audits of compliance with the policy are conducted.
	Evidence for standard b) to include: • An audit trail is available which provides evidence that ongoing audits from year 3 of the maternity incentive scheme of the pathway of care into transitional care are being completed as a minimum of quarterly. If for any reason, reviews have been paused, they should be recommenced using data from quarter 1 of 2022/23 financial year. • Audit findings are shared with the neonatal safety champion on a quarterly basis. Where barriers to achieving full implementation of the policy are encountered, an action plan should be agreed and progress overseen by both the board and neonatal safety champions.
	Evidence for standard c) to include: • Data is available (electronic and/or paper based) on all term babies transferred or admitted to the neonatal unit. This will include admission data captured via Badgernet as well as transfer data which may be captured on a separate paper or electronic system.

	• If a data recording process is not already in place to capture all babies transferred or admitted to the NNU this should be in place no later than **Monday 18 July 2022.**
	Evidence for standard d) to include: • Data is available (electronic or paper based) on transitional care activity (regardless of place - which could be a TC, postnatal ward, virtual outreach pathway etc.). • Secondary data is available (electronic or paper based) on babies born between 34+0-36+6 weeks gestation at birth, who did not have surgery nor were transferred during any admission, to monitor the number of special care or normal care days where supplemental oxygen was not delivered to inform future capacity management for late preterm babies who could be cared for in a TC setting.
	Evidence for standard e) to include: • Commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data Set (NCCMDS) version 2 are available to share on request, for example to support service development and capacity planning, with the LMNS, ODN and/or commissioner.
	Evidence for standard f) to include: • An audit trail is available which provides evidence that ongoing reviews from year 3 of the maternity incentive scheme of term admissions are being completed as a minimum of quarterly. If for any reason, reviews have been paused, they should be recommenced using data from quarter 1 of 2022/23 financial year. • If not already in place, an audit trail is available which provides evidence that reviews from Monday 18 July 2022, now include **all** term babies transferred or admitted to the NNU, irrespective of their length of stay, are being completed as a minimum of quarterly. If your reviews already included all babies transferred or admitted to the NNU then this should continue using data from quarter 1 of 2022/23 financial year. • Evidence that the review includes: the number of transfers or admissions to the neonatal unit that would have met current TC admission criteria but were transferred or admitted to the neonatal unit due to capacity or staffing issues and the number of babies that were transferred or admitted to, or remained on NNU because of their need for nasogastric tube feeding, but could have been cared for on a TC if nasogastric feeding was supported there.

	• Evidence that findings of all reviews of term babies transferred or admitted to a neonatal unit are reviewed quarterly and the findings have been shared quarterly with the maternity and neonatal safety champions and Board level champion, the LMNS and ICS quality surveillance meeting.
	Evidence for standard g) and h): • An audit trail is available which provides evidence and rationale for developing the agreed action plan to address local findings from the pathway audit (point b) and the ATAIN reviews (point f).Evidence that progress with the action plan has been shared with the neonatal, maternity safety champion, and Board level champion, LMNS and ICS quality surveillance meeting each quarter.
	• Self-certification by the Trust Board and submitted to NHS Resolution using the Board declaration form
Validation process	Self-certification by the Trust Board and submitted to NHS Resolution using the Board declaration form
What is the relevant time period?	a) The expectation is that the pathway has been in place since year 2 of the scheme and should now be business as usual. If for any reason this is not in place it should be by Thursday 16 June 2022 at the very latest. b) The expectation is that the audits have been in place since year 3 of the scheme and should now be business as usual. If for any reason, audits have been paused, they should be recommenced, using data from quarter 1 of 2022/23 financial year and be completed on a quarterly basis. There should be evidence that audit findings are shared with the neonatal safety champion each quarter. c) Reviews of babies transferred to the neonatal unit, including those not captured on BadgerNet and regardless of length of stay should be in place from no later than Monday 18 July 2022. d) Data collection process should have been met and in place in year 3 of the scheme. If for any reason it was not, this should be achieved by no later than 16 June 2022. Secondary data collection process for late pre-terms in place by no later than 16 June 2022. e) Commissioner returns on request – as per ODN request f) The expectation is that the reviews have been in place since year 3 of the scheme and should now be business as usual. If for any reason, reviews have been paused, they should be recommenced using data from quarter 1 of 2022/23 financial year and be completed on a quarterly basis.

	Reviews of babies transferred to the neonatal unit, including those not captured on BadgerNet and regardless of length of stay, should be included from Monday 18 July 2022. If your reviews already included all babies transferred or admitted to the NNU then this should continue using data from quarter 1 of 2022/23 financial year. There should be evidence that review findings have been shared quarterly with the maternity and neonatal safety champions and Board level champion, the LMNS and ICS quality surveillance meeting. g) Evidence of an action plan (to address points b, and f) being agreed with the maternity and neonatal safety champions and Board level champion and signed off by the Board no later than 29 July 2022. h) Evidence of progress with the action plan being shared with the neonatal, maternity safety champion, Board level champion and LMNS and ICS quality surveillance meeting each quarter following sign off at the Board.
What is the deadline for reporting to NHS Resolution?	Thursday 2 February 2023 at 12 noon

Technical guidance for safety action 3

Technical guidance	
Does the data recording process need to be available to the ODN/LMNS/ commissioner?	The requirement for a data recording process has been carried over from year three of the maternity incentive scheme as a means of informing future capacity planning as part of the family integrated care component of the Neonatal Critical Care Transformation Review and to inform future development of transitional care to minimise separation of mothers and babies. This could be captured through existing systems such as BadgerNet or alternatives such as paper based or electronic systems. These returns do not need to be routinely shared with the ODN, LMNS and/or commissioner but must be readily available should it be requested.
What members of the MDT should be involved in Atain reviews?	The expectation is that this is a multi-professional review, as a minimum the care should be reviewed by representation from both maternity and neonatal staff groups. This should include as a minimum; a member of the maternity team (a midwife and / or obstetrician and /or trainee from maternity services) and a member of the neonatal team (neonatal nurse and / or neonatologist/paediatrician and/or trainee from neonatal services).
Why has the standard now been changed to include all babies transferred and admitted to a NNU?	Feedback from regional maternity colleagues identified variation in ATAIN reviews being undertaken, with some units reviewing all babies admitted and transferred to the NNU and some only reviewing those admitted onto Badgernet. There is valuable learning in both and to avoid unwarranted variation and maximise the opportunity to learn, ATAIN reviews must include **all babies transferred or admitted to the NNU for any period of time**. As a minimum, a high-level review of the primary reasons for all transfers and admissions should be completed, with a focus on the most frequent reason(s) for transfer or admission through a deep dive to determine relevant themes to be addressed.
What do you mean by ‘transferred to the NNU’	This is when a baby is transferred to the NNU for any period of observation and / or intervention, regardless of whether this was recorded on Badgernet. **We are fully supportive of this practice and would not discourage perinatal services from doing this as this might impact on safe care being provided.**
We have undertaken some reviews for term	Maintaining oversight of the number of term babies admitted to a Neonatal Unit (NNU) is an important component of sustaining the

admissions to NICU, do we need to undertake more and do all babies admitted or transferred to the NNU need to be included?	ATAIN work to date. The expectation is that reviews have been continued from year 3 of the scheme. If for any reason, reviews have been paused, they should be recommenced using data from quarter 1 of the 2022/23 financial year (beginning 1 April 2022). **This may mean that some of the audit is completed <u>retrospectively</u>.** For units where previous reviews have not included term babies transferred to the NNU with a short stay, or babies not admitted on BadgerNet, reviews must now include these babies no later than Monday 18 July 2022. If your reviews already included all babies transferred or admitted to the NNU then this should continue using data from quarter 1 of 2022/23 financial year. We recommend **ongoing reviews, at least quarterly** of unanticipated term admissions to the NNU to determine whether there were modifiable factors which could be addressed as part of an action plan. A high-level review of the primary reasons for all transfers and admissions should be completed, with a focus on the most frequent reason(s) for transfer or admission through a deep dive to determine relevant themes to be addressed. For example, if 60% of babies are transferred or admitted for respiratory problems, then focus on this cohort of babies and complete a deep dive into identified themes or if 40% of babies were transferred or admitted due to observation for hypoglycaemia and 35% of with hypothermia then focus on these two cohorts of babies. **It is important to monitor emerging trends in transfers and admissions and these should also be factored into the quarterly review. For example, if there is an increasing number of babies transferred each month due to hypothermia, or to receive IV antibiotics, even if this is not the most frequent reason, a deep dive should be performed so that actions are put in place to mitigate any future separation of mother and baby.** In addition to this the number of babies transferred or admitted to the NNU that would have met current TC admission criteria but were transferred to the NNU due to capacity or staffing issues and the number of babies that were transferred or admitted to, or remained on NNU because of their need for nasogastric tube feeding, but could have been cared for on a TC if nasogastric feeding was supported there should be reported on.
Do we include babies that were transferred to the NNU rather than TC	No, these babies do not need to be captured.

due to the parents declining to stay for TC, but not due to staffing or capacity issues?	
What do mean by quarterly?	Occurring every three months. This would usually mirror the 4 quarters of the financial year, for example quarter 1 covering 01/04/2022-30/06/2022).
ATAIN audit – what should the audit include and is there a standard audit tool?	An audit tool can be accessed below as a baseline template, however the audit needs to include aspects of the local pathway. The audit tool can be found here https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-Trusts/maternity-incentive-scheme/ We recommend that Trusts refer to the auditable standards included in their local TC pathway guideline/policy.
What "*nor were transferred during any admissions*" mean?	This refers to babies that are transferred between Units of a Trust (e.g. if they needs an uplift in care).
"If not already in place, a secondary data recording process is set up to inform future capacity management for late preterm babies who could be cared for in a TC setting. The data should capture babies between 34+0 - 36+6 weeks gestation at birth, who neither had surgery nor were transferred during any admissions, to monitor the number of special care or normal care days where supplemental oxygen was not delivered" **FAQ - If women are booked at another hospital and come in for delivery at our hospital and deliver**	The statement refers only to neonatal transfers (not to e.g. an ex-utero transfer).

here, does this count as a transfer as well as an ex-utero transfer as mum was transferred in not the baby?	
If not already in place, a secondary data recording process is set up to inform future capacity management for late preterm babies who could be cared for in a TC setting. The data should capture babies between 34+0 - 36+6 weeks gestation at birth, who neither had surgery nor were transferred during any admissions, to monitor the number of special care or normal care days where supplemental oxygen was not delivered" **If a baby is transferredfor ITU or HD care initially and subsequently to TC, do we exclude them completely, or just count the special care days they have?**	The aim of this requirement is to count all babies who would be fit for TC when they get to that point- either directly at birth, or subsequently (as this is still mother/baby separation, which is what we are aiming to reduce). If Badgernet/NNAP data is used, it would include babies initially transferredto ITU/HDU. **<u>These babies should be captured as a number but do not need to be included in a detailed review.</u>**
How long have the neonatal safety champions been in place for?	Trust board champions were contacted in February 2019 and asked to nominate a neonatal safety champion. The identification of neonatal safety champions is a recommendation of the national neonatal critical care review and have been in place since February/March 2019.
What is the definition of transitional care?	Transitional care is not a place but a service and can be delivered either in a separate transitional care area, within the neonatal unit and/or in the postnatal ward setting. Principles include the need for a multidisciplinary approach between maternity and neonatal teams; an appropriately skilled and trained workforce, data collection with regards to activity, appropriate admissions as per HRGXA04 criteria and a link to community services.

Where can we find additional guidance regarding this safety action?	https://www.bapm.org/resources/80-perinatal-management-of-extreme-preterm-birth-before-27-weeks-of-gestation-2019 https://www.bapm.org/resources/24-neonatal-transitional-care-a-framework-for-practice-2017 https://improvement.nhs.uk/resources/reducing-admission-full-term-babies-neonatal-units/ https://www.e-lfh.org.uk/programmes/avoiding-term-admissions-into-neonatal-units/ https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/04/Illness-in-newborn-babies-leaflet-FINAL-070420.pdf Implementing-the-Recommendations-of-the-Neonatal-Critical-Care-Transformation-Review-FINAL.pdf (england.nhs.uk)

Safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?

Required standard	a) Obstetric medical workforce 1. The obstetric consultant team and maternity senior management team should acknowledge and commit to incorporating the principles outlined in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service: https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/ 2. Units should monitor their compliance of consultant attendance for the clinical situations listed in this document when a consultant is required to attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance. Trusts' positions with the requirement should be shared with the Trust board, the board-level safety champions as well as LMNS. **b) Anaesthetic medical workforce** A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients (ACSA standard 1.7.2.1) **c) Neonatal medical workforce** The neonatal unit meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing. If the requirements **had not been met** in both year 3 and year 4 of MIS, Trust Board should evidence progress against the action plan developed in year 3 of MIS as well include new relevant actions to address deficiencies.

	If the requirements **had been met** in year 3 without the need of developing an action plan to address deficiencies, however they are not met in year 4, Trust Board should develop an action plan in year 4 of MIS to address deficiencies. **d) Neonatal nursing workforce** The neonatal unit meets the service specification for neonatal nursing standards. If the requirements **had not been met** in both year 3 and year 4 of MIS, Trust Board should evidence progress against the action plan developed in year 3 of MIS as well include new relevant actions to address deficiencies. If the requirements **had been met** in year 3 without the need of developing an action plan to address deficiencies, however they are not met in year 4, Trust Board should develop an action plan in year 4 of MIS to address deficiencies and share this with the Royal College of Nursing, LMNS and Neonatal Operational Delivery Network (ODN) Lead.
Minimum evidential requirement for Trust Board	**Obstetric medical workforce** Sign off at Trust Board level acknowledging engagement with the RCOG document along with an action plan to review any non-attendance to the clinical situations listed in the document. Trusts should evidence their position with the Trust Board, Trust Board level safety champions and LMNS meetings at least once from the relaunch of MIS year 4 in May 2022. **Anaesthetic medical workforce** The rota should be used to evidence compliance with ACSA standard 1.7.2.1. **Neonatal medical workforce** The Trust is required to formally record in Trust Board minutes whether it meets the recommendations of the neonatal medical workforce. If the requirements are not met, Trust Board should evidence progress against the action plan developed in year 3 of MIS to address deficiencies. **Neonatal nursing workforce** The Trust is required to formally record to the Trust Board minutes the compliance to the service specification standards annually using the neonatal clinical reference group nursing workforce calculator. For units that do not meet the standard, the Trust Board should evidence progress against the action plan developed in year 3 of MIS to address deficiencies.

	A copy of the action plan, outlining progress against each of the actions, should be submitted to the Royal College of Nursing (cypadmin@rcn.org.uk), LMNS and Neonatal Operational Delivery Network (ODN) Lead.
Validation process	Self-certification by the Trust Board and submitted to NHS Resolution using the Board declaration form
What is the relevant time period?	**a) Obstetric medical workforce** 1. By 16 June 2022 2. By 29 July 2022 and monitored **monthly** from then. **b) Anaesthetic medical workforce** Any six month period between August 2021 and 5 December 2022 **c) Neonatal medical workforce** A review has been undertaken any 6 month period between August 2021 and 5 December 2022. **d) Neonatal nursing workforce** Nursing workforce review has been undertaken at least once during year 4 reporting period (August 2021 and 5 December 2022).
What is the deadline for reporting to NHS Resolution?	Thursday 2 February 2023 at 12 noon

Technical guidance for safety action 4

Technical guidance	
Obstetric workforce standard and action	
How can the Trust board evidence that the department has acknowledged and committed to incorporating the principles of the RCOG document?	Documented evidence of discussion at relevant meetings e.g. consultant meeting, divisional governance meetings, new consultants' induction etc. Circulation to all staff who work in maternity and Gynaecology. Mandatory consultant attendance list to be included in departmental escalation policies.
How can the Trust monitor adherence with the standard?	For example, departments can audit consultant attendance for clinical scenarios or situations mandating their presence in the guidance. Departments may also wish to monitor adherence via incident reporting systems. Feedback from departmental or other surveys may also be employed for triangulation of compliance.
What should a department do if there is non-compliance with attending mandatory scenarios/situations?	Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance.
Can we self-certify compliance with this element of safety action 4 if consultants have not attended clinical situations on the mandated list?	Trusts can self-certify compliance with safety action 4 provided they have agreed strategies and action plans implemented to prevent subsequent non-attendances. These can be signed off by the Trust Board.
RCOG "Roles & Responsibilities" - Are we required to evidence compliance with the obstetric attendance requirements or also the Gynae ones included in the RCOG list?	Trusts should monitor their compliance against the RCOG standards in relation to Consultants with any obstetric commitment to intrapartum care.
What period is the audit to cover and is it a snapshot or day by day audit?	Trusts should monitor their compliance day by day on a monthly basis from 29 July 2022

Where can I find the roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology RCOG workforce document?	https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/

Anaesthetic medical workforce

Technical guidance	
Anaesthesia Clinical Services Accreditation (ACSA) standard and action	
1.7.2.1	A duty anaesthetist is immediately available for the obstetric unit 24 hours a day. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patient in order to be able to attend immediately to obstetric patients.

Neonatal medical workforce

Technical guidance	
Neonatal Workforce standards and action	
Do you meet the BAPM national standards of junior medical staffing depending on unit designation?	If no, Trust Board should outline progress with the action plan developed in year 3 of MIS and submit this to the Neonatal ODN. There should also be an indication whether the standards not being met is due to insufficient funded posts or no trainee or/suitable applicant for the post (rota gap). There should also be a record of the rota tier affected by the gaps.
BAPM **"Optimal Arrangements for Neonatal Intensive Care Units in the UK. A BAPM Framework for Practice" 2021** **or** **"Optimal arrangements for Local Neonatal Units and Special Care Units in the UK including guidance on their staffing: A Framework for Practice" 2018**	
NICU **Neonatal Intensive Care Unit**	Staff at each level should only have responsibility for the NICU and Trusts with more than one neonatal unit should have completely separate cover at each level of staff during office hours and out of hours. **Tier 1**

	Resident out of hours care should include a designated tier one clinician - Advanced Neonatal Nurse Practitioner (ANNP) or junior doctor ST1-3 NICUs co-located with a maternity service delivering more than 7000 deliveries per year should augment their tier 1 cover at night by adding a second junior doctor, an ANNP and/or by extending nurse practice **Tier 2** A designated experienced junior doctor ST 4-8 or appropriately trained specialty doctor or ANNP NICUs with more than 2500 intensive care days should have an additional experienced junior doctor ST4-8 or appropriately trained specialty doctor or ANNP. (A consultant present and immediately available on NICU in addition to tier 2 staff would be an alternative) **Tier 3** Consultant staff in NICUs should be on the General Medical Council specialist register for neonatal medicine or equivalent and have primary duties on the neonatal unit alone NICUs undertaking more than 4000 intensive care days per annum with onerous on call duties should consider having a consultant present in addition to tier 2 staff and immediately available 24 hours per day. NICUs undertaking more than 2500 intensive care days per annum should consider the presence of at least 2 consultant led teams during normal daytime hours. NICUs undertaking more than 4000 intensive care days per annum should consider the presence of three consultant led teams during normal daytime hours.

LNU **Local Neonatal Unit**	**Tier 1** At least one resident tier 1 practitioner immediately available dedicated to providing emergency care for the neonatal service 24/7 In large LNUs (>7000 births) there should be two dedicated tier 1 practitioners 24/7 to support emergency care, in keeping with the NICU framework **Tier 2** An immediately available resident tier 2 practitioner dedicated solely to the neonatal service at least during the periods which are usually the busiest in a co-located Paediatric Unit e.g. between 09.00 - 22.00, seven days a week LNUs undertaking either >1500 Respiratory Care Days (RCDs) or >600 Intensive Care (IC) days annually should have immediately available a dedicated resident tier 2 practitioner separate from paediatrics 24/7 **Tier 3** Units designated as LNUs providing either >2000 RCDs or >750 IC days annually should provide a separate Tier 3 Consultant rota for the neonatal unit LNUs providing >1500 RCDs or >600 IC days annually should strongly consider providing a dedicated Tier 3 rota to the neonatal unit entirely separate from the paediatric department; a risk analysis should be performed to demonstrate the safety & quality of care if the Tier 3 is shared with paediatrics at any point in the 24 hours in these LNUs. All LNUs should ensure that all Consultants on-call for the unit also have regular weekday commitments to the neonatal service. This is best delivered by a 'consultant of the week' system and no consultant should undertake fewer than 4 'consultant of the week' service weeks annually No on-call rota should be more onerous than one in six and all new appointments to units with separate rotas should either have a SCCT in neonatal medicine or be a general paediatrician with a special interest in neonatology or have equivalent neonatal experience and training
SCU **Special Care Unit**	**Tier 1** A resident tier 1 practitioner dedicated to the neonatal service in day-time hours on weekdays and a continuously immediately available resident tier 1 practitioner to the unit 24/7. This person could be shared with a co-located Paediatric Unit out of hours.

	Tier 2 A resident tier 2 to support the tier 1 in SCUs admitting babies requiring respiratory support or of very low admission weight <1.5kg. This Tier 2 would be expected to provide cover for co-located paediatric services but be immediately available to the neonatal unit **Tier 3** In SCUs there should be a Lead Consultant for the neonatal service and all consultants should undertake a minimum of continuing professional development (equivalent to a minimum of eight hours CPD in neonatology)
Our Trust do not meet the relevant neonatal medical standards (Tier 1, 2 and/or 3) and in view of this an action plan, ratified by the Board has been developed. Can we declared compliance with this sub-requirement?	If the requirements are not met, Trust Board should outline progress against the action plan developed as part of year three of MIS in order to meet the recommendations. Action plan and related progress details should be shared with the Neonatal ODN. This will enable Trusts to declare compliance with this sub-requirement.
When should the review take place?	The review should take place at least once during the MIS year 4 reporting period.
Please access the followings for further information on Standards	BAPM Optimal Arrangements for Neonatal Intensive Care Units in the UK (2021) A BAPM Framework for Practice https://www.bapm.org/resources/296-optimal-arrangements-for-neonatal-intensive-care-units-in-the-uk-2021 Optimal arrangements for Local Neonatal Units and Special Care Units in the UK (2018). A BAPM Framework for Practice https://www.bapm.org/resources/2-optimal-arrangements-for-local-neonatal-units-and-special-care-units-in-the-uk-2018

Neonatal nursing workforce

Technical guidance
Neonatal nursing workforce

Where can we find more information about the requirements for neonatal nursing workforce?	Between 8 August 2021 until 5 December 2022, each neonatal unit should perform a nursing workforce calculation using the CRG work force staffing tool. Units that do not meet the service specification requirement for nursing workforce should have an action plan signed off by their Trust board, as per MIS year 3 requirements. Trust Board should evidence progress against the action plan and share those with the RCN, LMNS and Neonatal ODN.
Our Trust does not meet the relevant nursing standards and in view of this an action plan, ratified by the Board has been developed. Can we declare compliance with this sub-requirement?	If the requirements are not met, Trust Board should evidence progress against the action plan developed in year 3 of MIS to meet the recommendations. The action plan and related progress, signed off by the Trust Board, should be shared with the Royal College of Nursing (cypadmin@rcn.org.uk) and Neonatal ODN Lead. This will enable Trusts to declare compliance with this sub-requirement.

Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

Required standard	a) A systematic, evidence-based process to calculate midwifery staffing establishment is completed. b) Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above. c) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service d) All women in active labour receive one-to-one midwifery care e) Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year four reporting period.
Minimum evidential requirement for Trust Board	The report submitted will comprise evidence to support a, b and c progress or achievement. It should include: • A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated • In line with midwifery staffing recommendations from Ockenden, Trust Boards must provide evidence (documented in Board minutes) of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations. • Where Trusts are not compliant with a funded establishment based on BirthRate+ or equivalent calculations, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls. • The plan to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent undertaken, where deficits in staffing levels have been identified must be shared with the local commissioners. • Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall in staffing. -The midwife to birth ratio -The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not

	included in clinical numbers. This includes those in management positions and specialist midwives. • Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator status and the provision of one-to-one care in active labour. Must include plan for mitigation/escalation to cover any shortfalls.
Validation process	Self-certification to NHS Resolution using the Board declaration form
What is the relevant time period?	From 6 May 2022 until 5 December 2022
What is the deadline for reporting to NHS Resolution?	Thursday 2 February 2023 at 12 noon

Technical guidance for Safety action 5

Technical guidance	
What midwifery red flag events could be included in six monthly staffing report (examples only)? **We recommend that Trusts continue to monitor the red flags as per previous year and include those in the six monthly report to the Trust Board, however this is currently not within the minimal evidential requirements but more a recommendation based on good practice**.	• Redeployment of staff to other services/sites/wards based on acuity • Delayed or cancelled time critical activity. • Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing). • Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication). • Delay of more than 30 minutes in providing pain relief. • Delay of 30 minutes or more between presentation and triage. • Full clinical examination not carried out when presenting in labour. • Delay of two hours or more between admission for induction and beginning of process. • Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output). • Any occasion when one midwife is not able to provide continuous one-to-one care and support to a woman during established labour. Other midwifery red flags may be agreed locally. Please see the following NICE guidance for details: www.nice.org.uk/guidance/ng4/resources/safe-midwifery-staffing-for-maternity-settings-pdf-51040125637
Can the labour ward coordinator be considered to be supernumerary if for example they had to relieve staff for breaks on a shift?	The Trust can report compliance with this standard if this is a one off event and the coordinator is not required to provide 1:1 care for a woman in established labour during this time. If this is a recurrent event (i.e. occurs on a regular basis and more than once a week), the Trust should declare non-compliance with the standard and include actions to address this specific requirement going forward in their action plan mentioned in the section above. The role of the co-ordinator includes providing oversight of the labour ward and support and assistance to other midwives. For example: providing CTG 'fresh eyes', giving second opinion and reviews, providing assistance to midwives at birth when required, supporting junior

	midwives undertaking suturing etc. This should not be counted as losing supernumerary status. Supernumerary status will be lost if the labour ward coordinator is required to be solely responsible for any 1:1 care for a labouring woman or relieve for break, (or any short period of time) a midwife who is providing 1:1 care for a high risk woman requiring constant observation. This includes supervising a student midwife providing 1:1 care.
What if we do not have 100% supernumerary status for the labour ward coordinator?	An action plan detailing how the maternity service intends to achieve 100% supernumerary status for the labour ward coordinator which has been signed off by the Trust Board, and includes a timeline for when this will be achieved. As stated above, completion of an action plan will not enable the Trust to declare compliance with this sub-requirement in year 4 of MIS.
What if we do not have 100% compliance for 1:1 care in active labour?	An action plan detailing how the maternity service intends to achieve 100% compliance with 1:1 care in active labour has been signed off by the Trust Board, and includes a timeline for when this will be achieved. Completion of the action plan will enable the Trust to declare compliance with this sub-requirement.

Safety action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version two?

Required standard	1. Trust Board level consideration of how its organisation is complying with the Saving Babies' Lives care bundle version two (SBLCBv2), published in April 2019. Note: Full implementation of the SBLCBv2 is included in the 2020/21 standard contract. 2. Each element of the SBLCBv2 should have been implemented. Trusts can implement an alternative intervention to deliver an element of the care bundle if it has been agreed with their commissioner (CCG). It is important that specific variations from the pathways described within SBLCBv2 are also agreed as acceptable clinical practice by their Clinical Network. 3. The quarterly care bundle survey should be completed until the provider Trust has fully implemented the SBLCBv2 including the data submission requirements. The survey will be distributed by the Clinical Networks and should be completed and returned to the Clinical Network or directly to England.maternitytransformation@nhs.net from May 2022 onwards. Evidence of the completed quarterly care bundle surveys should be submitted to the Trust board.
Minimum evidential requirement for Trust Board	**Element one** Process indicators: A. Percentage of women where Carbon Monoxide (CO) measurement at booking is recorded. B. Percentage of women where CO measurement at 36 weeks is recorded. Note: The relevant data items for these process indicators should be recorded on the provider's Maternity Information System (MIS) and included in the MSDS submissions to NHS Digital in an MSDSv2 Information Standard Notice compatible format, including SNOMED-CT coding. The Trust board should receive data from the organisation's MIS evidencing an average of 80% compliance over a four month period (i.e. four consecutive months in during the MIS year 4 reporting timeframe). If there is a delay in the provider Trust's ability to submit these data to MSDS then compliance can be determined using their interim data recording method. The denominator should still be the total number of women at booking or 36 weeks gestation, as appropriate for each process indicator. If the provider Trust is unable to record these data on their maternity information system an audit of 60 consecutive cases

	would be acceptable evidence to demonstrate >80% of women having a CO measurement recorded at 36 weeks. The denominator for the audit should be 60 consecutive women at 36 weeks gestation, whereas the denominator for the electronic audit would be the total number of women at 36 weeks gestation. In addition to this, the audit should be accompanied by a brief description of the stop smoking strategy within the Trust and any plans for improvement. **A Trust will fail Safety Action 6 if the process indicator metric compliance is less than 80%.** **If the process indicator scores are less than 95% Trusts must also have an action plan for achieving >95%.** In addition, the Trust board should specifically confirm that within their organisation they: 1) Pass the data quality rating on the National Maternity Dashboard for the 'women who currently smoke at booking appointment' Clinical Quality Improvement Metric. 2) Have a referral pathway to smoking cessation services (in house or external). 3) Audit of 20 consecutive cases of women with a CO measurement ≥4ppm at booking, to determine the proportion of women who were referred to a smoking cessation service. 4) Have generated and reviewed the following outcome indicators within the Trust for four consecutive months within the MIS year 4 reporting period: • Percentage of women with a CO measurement ≥4ppm at booking. • Percentage of women with a CO measurement ≥4ppm at 36 weeks. • Percentage of women who have a CO level ≥4ppm at booking who subsequently have a CO level <4ppm at the 36 week appointment. **Additional information** If your Trust is planning on using the maternity dashboard to evidence an average of 80% compliance over four months, please be advised that there is a three month delay with MSDSv2 data, for example data submitted at the end of August 2022 will be published on the dashboard at the end of November 2022. If your Trust does not have an in house stop smoking service or a pathway to an external service, please contact your local authority stop smoking service or escalate to your local maternity system to enable the Trust to ensure provision is in place.

	***Percentage of women where Carbon Monoxide (CO) measurement at booking is recorded*.** **Women declining CO testing at booking / 36 weeks appointment** Standard A and B of element 1 require Trusts to demonstrate that 80% of women had CO testing at booking and at 36 weeks respectively and that this is recorded in the Trusts' information system. In the event of a high number of women declining CO testing a Trust would be at risk of failing standard A and B by not reaching the 80% testing rate. We suggest Trusts proactively monitor their testing rate and consider interventions to maintain adequate compliance.
	Element two **Process indicator:** 1) Percentage of pregnancies where a risk status for fetal growth restriction (FGR) is identified and recorded using a risk assessment pathway at booking and at the 20 week scan (e.g. Appendix D). Note: The relevant data items for these indicators should be recorded on the provider's Maternity Information System and included in the MSDS submissions to NHS Digital in an MSDSv2 Information Standard Notice compatible format, including SNOMED-CT coding. The Trust board should receive data from the organisation's MIS evidencing 80% compliance. If there is a delay in the provider Trust Maternity Information System's ability to record these data at the time of submission an in house audit of 40 consecutive cases of women at 20 weeks scan using locally available data or case records should have been undertaken to assess compliance with this indicator. **A Trust will fail Safety Action 6 if the process indicator metric compliance is less than 80%.** **If the process indicator scores are less than 95% Trusts must also have an action plan for achieving >95%.** In addition the Trust board should specifically confirm that within their organisation: 2) Women with a BMI>35 kg/m^2 are offered ultrasound assessment of growth from 32 weeks' gestation onwards

	3) In pregnancies identified as high risk at booking uterine artery Doppler flow velocimetry is performed by 24 completed weeks gestation 4) There is a quarterly audit of the percentage of babies born <3rd centile >37+6 weeks' gestation. 5) They have generated and reviewed the percentage of perinatal mortality cases for 2021 where the identification and management of FGR was a relevant issue (using the PMRT). 6) Their risk assessment and management of growth disorders in multiple pregnancy complies with NICE guidance or a variant has been agreed with local commissioners (CCGs) following advice from the Clinical Network. 7) They undertake a quarterly review of a minimum of 10 cases of babies that were born <3rd centile >37+6 weeks' gestation. The review should seek to identify themes that can contribute to FGR not being detected (e.g. components of element 2 pathway and/or scanning related issues). The Trust board should be provided with evidence of quality improvement initiatives to address any identified problems. Trusts can omit the above mentioned quarterly review of a minimum of 10 cases of babies that were born <3rd centile >37+6 weeks' gestation for quarter 3 of this financial year (2021/22) if staffing is critical and this directly frees up staff for the provision of clinical care.
	Element three Process indicators: A. Percentage of women booked for antenatal care who had received reduced fetal movements leaflet/information by 28+0 weeks of pregnancy. B. Percentage of women who attend with RFM who have a computerised CTG (a computerised system that as a minimum provides assessment of short term variation). Note: The SNOMED CT code is still under development for RFM and therefore an in-house audit of two weeks' worth of cases or 20 cases of women attending with RFM whichever is the smaller to assess compliance with the element three process indicators. **A Trust will fail Safety Action 6 if the process indicator metric compliance is less than 80%.** **If the process indicator scores are less than 95% Trusts must also have an action plan for achieving >95%.**
	Element four There should be Trust board sign off that staff training on using their local CTG machines, as well as fetal monitoring in labour are

	conducted annually. The fetal monitoring sessions should be consistent with the Ockenden Report recommendations, and include: intermittent auscultation, electronic fetal monitoring with system level issues e.g. human factors, escalation and situational awareness. The Trust board should specifically confirm that within their organization 90% of eligible staff (see Safety Action 8) have attended local multi-professional fetal monitoring training annually as above. Please refer to safety action 8 for more information re training.
	Element five Process indicators: A. Percentage of singleton live births (less than 34+0 weeks) receiving a full course of antenatal corticosteroids, within seven days of birth. B. Percentage of singleton live births occurring more than seven days after completion of their first course of antenatal corticosteroids. C. Percentage of singleton live births (less than 30+0 weeks) receiving magnesium sulphate within 24 hours prior birth. D. Percentage of women who give birth in an appropriate care setting for gestation (in accordance with local ODN guidance). Note: The relevant data items for these process indicators should be recorded on the provider's Maternity Information System and included in the MSDS submissions to NHS Digital in an MSDSv2 Information Standard Notice compatible format, including SNOMED-CT coding. If there is a delay in the provider Trust MIS's ability to record these data then an audit of 40 cases consisting of 20 consecutive cases of women presenting with threatened preterm labour before 34 weeks and 20 consecutive cases of women who have given birth before 34 weeks using locally available data or case records should have been undertaken to assess compliance with each of the process indicators. **The Trust board should receive data from the organisation's Maternity Information System evidencing 80% compliance with process indicators A, C and D. The percentage for process indicator B should be as low as possible and can be reported as the proportion.**

	A Trust will not fail Safety Action 6 if the process indicator scores are less than 80%. However, Trusts must have an action plan for achieving >80%. In addition, the Trust board should specifically confirm that within their organisation: • They have a dedicated Lead Consultant Obstetrician with demonstrated experience to focus on and champion best practice in preterm birth prevention. (Best practice would be to also appoint a dedicated Lead Midwife. Further guidance/information on preterm birth clinics can be found on https://www.tommys.org/sites/default/files/2021-03/reducing%20preterm%20birth%20guidance%2019.pdf • Women at high risk of preterm birth have access to a specialist preterm birth clinic where transvaginal ultrasound to assess cervical length is provided. If this is not the case the board should describe the alternative intervention that has been agreed with their commissioner (CCG) and that their Clinical Network has agreed is acceptable clinical practice. • An audit of 40 consecutive cases of women booking for antenatal care has been completed to measure the percentage of women that are assessed at booking for the risk of preterm birth and stratified to low, intermediate and high risk pathways, and the percentage of those assessed to be at increased risk that are referred to the appropriate preterm birth clinic and pathway. The assessment should use the criteria in Appendix F of SBLCBv2 or an alternative which has been agreed with local CCGs following advice from the Clinical Network. • Their risk assessment and management in multiple pregnancy complies with NICE guidance or a variant that has been agreed with local commissioners (CCGs) following advice from the provider's clinical network.
Validation process	Self-certification to NHS Resolution using the Board declaration form.
What is the relevant time period?	Trusts should be evidencing the position as of 2 February 2023 at 12 noon

Technical guidance for Safety action 6

Technical guidance	
Where can we find guidance regarding this safety action?	SBL care bundle: https://www.england.nhs.uk/publication/saving-babies-lives-version-two-a-care-bundle-for-reducing-perinatal-mortality/ The SBLCB v2 Technical Glossary which includes the numerators and denominators for all of the process indicators can be found on the NHS Digital webpages here: https://digital.nhs.uk/binaries/content/assets/website-assets/data-and-information/data-sets/maternity-services/sblcbv2-msds-v2.0-technical-glossary-for-publication.xlsx Any queries related to the **digital aspects** of this safety action can be sent to NHS Digital mailbox maternity.dq@nhs.net For any other queries, please email nhsr.mis@nhs.net
Further guidance regarding element 2 of the SBL care bundle V2	Compliance with the intervention for surveillance of low-risk women does not mandate participation in the Perinatal Institute's Growth Assessment Protocol (GAP) or the use of customised fundal charts. Providers should however ensure that for low risk women, fetal growth is assessed using antenatal symphysis fundal height charts by clinicians trained in their use. All staff must be competent in measuring fundal height with a tape measure, plotting measurements on charts, interpreting appropriately and referring when indicated. All women should have a risk assessment for FGR at booking. It should be appreciated that some women will develop additional risk factors after the booking appointment such as significant bleeding or risk factors that will only be evident after the mid-trimester anomaly scan, such as echogenic bowel or EFW <10th centile. When these risk factors are identified their clinical pathway will change as per SBLCBv2 Figure 6 in Appendix D. If a Trust chooses to meet this standard using an electronic audit which is unable to capture risk factors after booking then the Trust should include a brief description of how women with significant bleeding after booking, echogenic bowel or EFW <10th centile are triaged to the appropriate pathway described in fig. 6 of appendix D in SBLCBv2. There will be a variety of ways Trusts choose to do this, but what is important is that women with these risk factors receive the appropriate care.

	An example might be that when a risk factor is identified at the mid-trimester scan the ultrasonographer alerts the antenatal clinic midwife who then arranges obstetric review and the additional scans indicated. A similar process of escalation should be described for significant bleeding after booking. Confirmation by the Trust Board that the Trust has implemented the Tommy's Centre Clinical Decision Tool within a research programme will meet the requirement that standard 1-2 above have been implemented.
What is the deadline for reporting to NHS Resolution?	2 February 2023 at 12noon

Safety action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?

Required standard	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?
Minimum evidential requirement for Trust Board	**Evidence should include:** • Terms of Reference for your MVP. They reflect the core principles for Terms of Reference for a MVP as outlined in annex B of Implementing Better Births: A resource pack for Local Maternity Systems • Minutes of MVP meetings demonstrating how service users are listened to and how regular feedback is obtained, that actions are in place to demonstrate that listening has taken place and evidence of service developments resulting from coproduction between service users and staff. • Written confirmation from the service user chair that they are being remunerated as agreed and that this remuneration reflects the time commitment and requirements of the role given the agreed work programme. Remuneration should take place in line with agreed Trust processes. • The MVP's work programme, minutes of the MVP meeting which agreed it and minutes of the LMNS board that ratified it • Written confirmation from the service user chair that they and other service user members of the MVP committee are able to claim out of pocket expenses, including travel, parking and childcare costs in a timely way. • Evidence that the MVP is prioritising hearing the voices of women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation, given the findings in the MBRRACE-UK reports about maternal death and morbidity and perinatal mortality. • Evidence that the MVP Chair is invited to attend maternity governance meetings and that actions from maternity governance meetings, including complaints' response processes, trends and themes, are shared with the MVP.

Validation process	Self-certification to NHS Resolution using the Board declaration form.
What is the relevant time period?	From 6 May 2022 until 5 December 2022
What is the deadline for reporting to NHS Resolution?	Thursday 2 February 2023 at 12 noon

Technical guidance for Safety action 7

Technical guidance	
What is the Maternity Voices Partnership?	A Maternity Voices Partnership is a multidisciplinary NHS working group for review and coproduction of local maternity services. For more information see: • Implementing Better Births: A resource pack for Local Maternity Systems Chapter 4 and Annex B • National Maternity Voices
How often should the Maternity Voices Partnership meeting be held?	MVP should meet "no less than four times per year" in line with MVP Terms of Reference template, available here: https://nationalmaternityvoices.org.uk/toolkit-for-mvps/ This should include meeting with Maternity Leadership to ensure progression of the work plan.
We are unsure about the funding for Maternity Voices Partnerships	The maternity commissioner is responsible for facilitating and organising any agreed funding, this may be provided by the commissioner alone or in conjunction with local providers. Local discussions will need to take place to agree how the costs of the Maternity Voices Partnership will be shared between commissioner and provider organisations

Safety action 8: Can you evidence that a **local training plan** is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4?

In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', **one-day, multi-professional training day** which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and newborn life support, starting from the launch of MIS year 4?

Required standard and minimum evidential \requirement	Can you evidence that: a) **A local training plan** is in place to ensure that all six core modules of the Core Competency Framework, will be included in your unit training programme over 3 years, starting from the launch of MIS year 4 in August 2021. b) 90% of each relevant maternity unit staff group have attended an 'in house' one day multi-professional training day, that includes maternity emergencies starting from the launch of MIS year four in August 2021? c) 90% of each relevant maternity unit staff group have attended an 'in-house' one day multi-professional training day that includes antenatal and intrapartum fetal monitoring, starting from the launch of MIS year four in August 2021. d) Can you evidence that 90% of the team required to be involved in immediate resuscitation of the newborn and management of the deteriorating newborn infant have attended in-house neonatal life support training or a Newborn Life Support (NLS) course starting from the launch of MIS year four in August 2021.
Validation process	Self-certification to NHS Resolution using the Board declaration form.
What is the relevant time period?	Any 12 consecutive months within the period: 1st August 2021 until 5th December 2022

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Technical guidance	
What training should be covered in the local training plan to cover the six modules of the Core Competency Framework?	A training plan should be in place to cover all six core modules of the Core Competency Framework. The training plan will span a 3-year time period and should include the following 6 core modules: • Saving Babies Lives Care Bundle • Fetal surveillance in labour • Maternity emergencies and multi-professional training. • Personalised care • Care during labour and the immediate postnatal period • Neonatal life support
Core competency framework-maternal critical care What is the expectation of those unit that don't provide enhanced maternal critical care in the maternity setting?	This should relate to recognition of deterioration, escalation, stabilisation and monitoring of the woman until transfer takes place
Core competency framework – which modules should our unit focus on?	For MIS year 4, Trusts only need to focus on the 6 core elements – and do not require the 2 modules relating to directly to COVID care (core modules 7 and 8).
Covid-19 impact on training. **Does 'in-house' training have to be face to face?**	We encourage the reinstatement of face to face training wherever possible, however where this is not possible hybrid and/or remote training formats that meet the requirements of the safety actions, can all be counted to meet the proportion of staff attending training.

What training should be covered for the one-day multi-professional training? **What should be covered in the training programme?**	The one-day training programme should include: • Antenatal and Intrapartum Fetal monitoring • 4 Maternity emergencies • Neonatal life support Local maternal and neonatal outcomes should be provided on the training days, ideally benchmarked against other organisations with a similar clinical profile. These data may be local, drawing on learning from case studies, local incidents and/or exemplars or from National programmes e.g. National Maternity Perinatal Audit (NMPA), Getting It Right First Time (GIRFT) and others. **Fetal monitoring and surveillance (in the antenatal and intrapartum period)** Should be consistent with the Ockenden Report (2021) recommendations, and include as a minimum: • Risk assessment • Intermittent auscultation • Electronic fetal monitoring • System level issues e.g. human factors, classification, escalation and situational awareness • Use of local case histories • Using their local CTG machines **Multi-professional maternity emergencies training** • The training day should include 4 of the minimum requirements for multi-professional maternity emergency scenarios, as set out in the Core Competency Framework, with the aim that all scenarios will be covered over a 3-year period. • The 4 scenarios will be based on locally identified training needs, drawing on learning from local serious incidents, near misses and local reviews. • At least one scenario should include a *'learning from excellence'* case study where care was excellent. • Ideally, at least one of the four emergency scenarios should be conducted in a clinical area, ensuring full attendance from the relevant wider multi-professional team. This will enable local system and environmental factors within the clinical setting to be identified with an action plan developed to address issues identified. **Neonatal life support** • All staff in attendance at births should attend local neonatal life support training every year.

	• Attendance on separate certified NLS training for maternity staff should be locally decided but this would be the gold standard. • Those attending a NLS programme every 4 years will attend annual local neonatal life support training in between. Training should include as a minimum: • Preparing for neonatal resuscitation, including suitability of the clinical environment, and preparing the resuscitation device(s) • Identification of a baby requiring resuscitation after birth • Knowledge and understanding of the NLS algorithm, annual updates should be following the latest NLS edition. • The timing and how to call for help within the organisation • Situation, Background, Assessment Recommendation (SBAR) or equivalent communication tool handover on arrival of help.
How do maternity units include the remaining components of the Core Competencies Framework that are not listed above? **The remaining 2 components are:** • **Personalised care** • **Care during labour and the immediate postnatal period**	For the remaining 2 components of the Core Competencies Framework, maternity teams should choose 2 subjects per year from those listed in each of these core competencies, and these should be based on identified unit priorities, audit report findings and locally identified learning (e.g. ATAIN reviews) involving aspects of care which require reinforcing and national guidance. The aim is that all subjects within the Core Competencies Framework will be covered over the three-year period.
Which maternity staff attendees should be included for the 'in house' maternity emergencies multi-professional training day?	Maternity staff attendees should include 90% of each of the following groups: • Obstetric consultants • All other obstetric doctors (including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows and foundation year doctors contributing to the obstetric rota • Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives) • Maternity support workers and health care assistants (to be included in the maternity skill drills as a minimum) • Obstetric anaesthetic consultants

	• All other obstetric anaesthetic doctors (staff grades and anaesthetic trainees) contributing to the obstetric rota
Training timeframe - What if we had a large number of staff trained in July/ and August 2021– do we then have to have these staff do their training again before 12 months are up?	The MIS year 4 reporting timeframe referred in safety action 8 is between the launch of MIS year 4 in August 2021 and 5th December 2022 with a submission deadline of 2nd February 2023. Trusts should assess their compliance based on the proportion of staff trained in 12 consecutive months within the reporting period. 90% compliance should be demonstrated by the end of the 12 month period.
Should the anaesthetic and maternity support workers (MSWs) attend fetal surveillance in labour and neonatal life support training?	Anaesthetic staff and MSWs are not required to attend fetal monitoring. The staff groups below are not required to attend neonatal resuscitation training: • All obstetric anaesthetic doctors (consultants, staff grades and anaesthetic trainees) contributing to the obstetric rota and • Maternity critical care staff (including operating department practitioners, anaesthetic nurse practitioners, recovery and high dependency unit nurses providing care on the maternity unit)
What compliance is required for maternity theatre staff?	Maternity theatre staff are a vital part of the multidisciplinary team and are encouraged to attend the one-day maternity emergencies and multi-professional training, however they will not be required to meet MIS year four compliance assessment.
Which staff should be included for immediate neonatal life support training?	Staff in attendance at births should be included for immediate neonatal life support training - listed below: • Neonatal Consultants or Paediatric consultants covering neonatal units • Neonatal junior doctors (who attend any births) • Neonatal nurses (Band 5 and above) • Advanced Neonatal Nurse Practitioner (ANNP) • Midwives (including midwifery managers and matrons, community midwives, birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives) and Maternity theatre midwives who also work outside of theatres.
Which maternity staff attendees should be included for the local intrapartum fetal	Maternity staff attendees should be 90% of each of the following groups: • Obstetric consultants

surveillance in line with Saving Babies Lives Care Bundle (SBLCBv2)?	• All other obstetric doctors (including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows and foundation year doctors contributing to the obstetric rota • Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives). Maternity theatre midwives who also work outside of theatres.
Fetal monitoring training- Should GP trainees attend fetal monitoring training as stated in safety action 6/8 even though our unit has a protocol that GP rotational doctors do not undertake CTG reviews in any circumstances?	GP trainees should also attend the fetal monitoring training session if they have any obstetric commitment to intrapartum care.
What if staff have been booked to attend training after (add in date) for the 'in-house' multi-professional training day?	Only staff who have attended the training will be counted toward overall percentage. If staff are only booked onto future training sessions and/or have not attended training, they cannot be counted towards the overall percentage.
Will we meet the action if one of our staff group is below the 90% threshold for the 'in-house' maternity emergencies and multi-professional training day?	No, you will need to evidence to your Trust Board that you have met the threshold of 90% for each of the staff groups by 5th December 2022.
Training compliance - breakdown by staff groups	Compliance should be presented by staff group mentioned e.g. obstetric consultants 90%, obstetric trainees 89%, anaesthetic consultants 92% etc.
What if Covid-19 restrictions are still in place for in house training?	If social distancing guidelines preclude face to face training then remote or hybrid formats will be acceptable.
I am a NLS instructor, do I still need to attend neonatal resuscitation annual training?	If you have taught on a NLS course at least once during that year, you do not need to attend local neonatal resuscitation training as well
I am a Medical Obstetric Emergencies and Trauma (MOET) instructor, do I still need to attend the emergency training session?	MOET instructors do not need to attend annual training if their NLS instructor status is still valid.

I have attended my NLS training, do I still need to attend neonatal resuscitation annual training?	For MIS purposes, not during the same year that you completed NLS training, but you will need to attend neonatal resuscitation training annually for the 3 years in-between each NLS course.
Which members of the team can teach in house neonatal resuscitation training?	Best practice would be for this training to be delivered by a trained NLS instructor. The minimum standard would be for training to be provided by staff who hold an in-date NLS provider certificate and have a teaching role such as a clinical skills facilitator.
Who should attend certified NLS training in maternity?	Attendance on separate certified NLS training for maternity staff should be locally decided but this would be the gold standard.
What is the required timeframe?	One day training on multi-professional, maternity emergencies, including a learning from excellence case study and intrapartum fetal surveillance should be undertaken by each staff group within the MIS reporting period.
Where can I find the Core Competencies Framework and other additional resources?	• NHS England and NHS Improvements Core Competency Framework (December 2020) https://www.england.nhs.uk/publication/core-competency-framework/ • https://www.resus.org.uk/library/2021-resuscitation-guidelines/newborn-resuscitation-and-support-transition-infants-birth • All link to forthcoming national intrapartum fetal surveillance programme • Toolkit for high quality neonatal services (October 2009) http://www.londonneonatalnetwork.org.uk/wp-content/uploads/2015/09/Toolkit-2009.pdf

Safety action 9: Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?

Required standard	a) The pathway developed in year 3, that describes how safety intelligence is shared from floor to Board, through local maternity and neonatal systems (LMNS), and the Regional Chief Midwife has been reviewed in line with the implementing-a-revised-perinatal-quality-surveillance-model.pdf (england.nhs.uk) The revised pathway should formalise how Trust-level intelligence will be shared with new LMNS/ICS and regional quality groups to ensure early action and support is provided for areas of concern or need. b) Board level safety champions present a locally agreed dashboard to the Board quarterly, including; the number of incidents reported as serious harm, themes identified and actions being taken to address any issues; staff feedback from frontline champions and walk-abouts; minimum staffing in maternity services and training compliance are taking place at Board level no later than 16 June 2022. NB, The training update should include any modifications made as a result of the pandemic / current challenges and a rough timeline of how training will be rescheduled later this year if required. This additional level of training detail will be expected by 16 June 2022. c) Trust Boards have reviewed current staffing in the context of the letters to systems on 1 April 2022 and 21 September 2022 regarding the roll out of Midwifery Continuity of Carer as the default model of care. A decision has been made by the Board as to whether staffing meets safe minimum requirements to continue rollout of current or planned MCoC teams, or whether rollout should be suspended d) Board level and maternity safety champions are actively supporting capacity and capability building for staff to be involved in the Maternity and Neonatal Safety Improvement Programme (MatNeoSIP)

Minimum evidential requirement for Trust Board	**Evidence for points a) and b)** • Evidence of a revised pathway which describes how frontline midwifery, neonatal, obstetric and Board safety champions share safety intelligence between a) each other, b) the Board, c) new LMNS/ICS quality group and d) regional quality groups involving the Regional Chief Midwife and Lead Obstetrician to ensure early action and support is provided for areas of concern or need in line with the perinatal quality surveillance model. • Evidence that a clear description of the pathway and names of safety champions are visible to maternity and neonatal staff. • Evidence that discussions regarding safety intelligence, including; the number of incidents reported as serious harm, themes identified and actions being taken to address any issues; staff feedback from frontline champions and engagement sessions; minimum staffing in maternity services and training compliance are taking place at Board level no later than 16 June 2022 NB- The training update should include any modifications made as a result of the pandemic / current challenges and a rough timeline of how training will be rescheduled later this year if required. This additional level of training detail will be expected by 16 June 2022. • Evidence of the engagement sessions (e.g. staff feedback meeting, staff walkaround sessions etc.) being undertaken by a member of the Board. • Evidence of progress with actioning named concerns from staff workarounds are visible to both maternity and neonatal staff and reflects action and progress made on identified concerns raised by staff and service users. • Evidence that the Trust's claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level safety champions to help target interventions aimed at improving patient safety at least twice in the MIS reporting period at a Trust level quality meeting. This can be a board or directorate level meeting. **Evidence for point c):** This is to be evidenced by a minuted Board level discussion and decision since 1 April 2022 on how a Trust's current workforce position should determine current and future rollout of MCoC. Where more than one discussion has taken place, the most recent evidence should be submitted.

	Evidence for point d): Evidence of how the Board and Safety Champions have supported staff involved in part d) of the required standard and specifically in relation to: • active participation by staff in **contributing to the delivery** of the collective aims of the MatNeo Patient Safety Networks, and undertaking of specific improvement work aligned to the MatNeoSIP national driver diagram and key enabling activities • **engagement** in relevant improvement/capability building initiatives nationally, regionally or via the MatNeo Patient Safety Networks, of which the Trust is a member • support for clinicians identified as MatNeoSIP Improvement Leaders to facilitate and lead work through the MatNeo Patient Safety Networks and the National MatNeoSIP network • utilise insights from culture surveys undertaken to inform local quality improvement plans • maintain oversight of improvement outcomes and learning, and ensure intelligence is actively shared with key system stakeholders for the purpose of improvement
Validation process	Self-certification to NHS Resolution using the Board declaration form
What is the relevant time period?	**Time period for points a and b)** • Evidence of a revised written pathway, in line with the perinatal quality surveillance model, that is visible to staff and meets the requirements detailed in part a) and b) of the action is in place no later than 16 June 2022. The expectation is that work has already commenced on this in line with the Ockenden response (Ockenden, 2021). • Evidence that discussions regarding safety intelligence, including; the number of incidents reported as serious harm, themes identified and actions being taken to address any issues; staff feedback from frontline champions and walk-abouts; minimum staffing in maternity services and training compliance are taking place at Board level no later than 16 June 2022. NB, The training update should include any modifications made as a result of the pandemic / current challenges and a rough timeline of how training will be rescheduled later this year if

	required. This additional level of training detail will be expected by 16 June 2022. • The expectation is that quarterly engagement sessions have continued from year 3 of the scheme. If for any reason these have been paused, they should be recommenced no later than 16 June 2022. The reason for pausing feedback sessions should be captured in the minutes of the Board meeting, detailing mitigating actions to prevent future disruption to these sessions. • Progress with actioning named concerns from staff engagement sessions are visible to both maternity and neonatal staff and reflects action and progress made on identified concerns raised by staff and service users from no later than 16 June 2022. • Evidence that the Trust's claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level safety champions at a Trust level (board or directorate) quality meeting each quarter, beginning no later than quarter 2 of 2022/23 (July 2022). **Time period for points c)** • Board level discussion and decision since 1st April 2022 on how a trust's current workforce position should determine current and future rollout of MCoC. Where more than one discussion has taken place, the most recent evidence should be submitted. **Time period for points d)** • Attendance or representation at a minimum of two engagement events such as Patient Safety Network meetings, MatNeoSIP webinars and/or the annual national learning event by 5th December 2022. • Evidence that insights from culture surveys undertaken have been used to inform local quality improvement plans by 5th December 2022.
What is the deadline for reporting to NHS Resolution?	By Thursday 2 February 2023 at 12 noon
Where can I find additional resources?	implementing-a-revised-perinatal-quality-surveillance-model.pdf (england.nhs.uk)

	Measuring culture in maternity services: Add in link to Safety Culture Programme for Maternal and neonatal services: https://drive.google.com/file/d/1bzAqOcf5A5XHR8HWBZnLzH6qsG_SgXoa/view?usp=sharin Maternity and Neonatal Safety Champions Toolkit September 2020 (england.nhs.uk) NHS England » Maternity and Neonatal Safety Improvement Programme

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Technical guidance	
What is the expectation around the Perinatal Quality Surveillance Model?	The Perinatal Quality Surveillance Model must be reviewed and the local pathway for sharing intelligence updated. This revised pathway should: - Describe the local governance processes in place to demonstrate how intelligence is shared from the floor to Board - Formalise how Trust-level intelligence will be shared with the LMNS/ICS quality group and regional quality groups involving the Regional Chief Midwife and Lead Obstetrician
What do we need to include in the dashboard presented to Board each month?	The dashboard can be locally produced and must include; the number of incidents reported as serious harm, themes identified and actions being taken to address any issues; staff feedback from frontline champions' engagement sessions; minimum staffing in maternity services and training compliance. The dashboard can also include additional measures as agreed by the Trust.
We had not continued to undertake monthly feedback sessions with the Board safety champion what should we do?	Parts a) and b) of the required standards build on the year three requirement of the maternity incentive scheme in building visibility and creating the conditions for staff to meet and establish a relationship with their Board safety champions in order to raise concerns relating to safety. The expectation is that Board safety champions have continued to undertake quarterly engagement sessions as described above. Part b) requires that progress with actioning named concerns from staff feedback sessions are visible. This builds on requirements made in year three of the maternity incentive scheme and the expectation is that this should have been continued. If these have not been continued, this needs to be reinstated by no later than 16 June 2022.
We are a Trust with more than one site. Do we need to complete the same frequency of engagement sessions in each site as a Trust on one site?	Yes. The expectation is that the same number of engagement sessions are completed at each individual site on a quarterly basis.

What is the rationale for the Board level safety champion safety action?	It is important to ensure all staff are aware of who their frontline and Board safety champions are if concerns are to be actively shared. Sharing of insights and good practice between providers, their LMNS, ICS and regional quality groups should be optimised. The development of a local pathway which describes these relationships, how sharing of information will take place and names the relevant leaders will support this standard to realise its aims. The guidance in the link below will support the development of this pathway. Maternity-and-Neonatal-Safety-Champions-Toolkit--2020.pdf
Where can I find more information re my Trust's scorecard?	More information regarding your Trust's scorecard can be found here https://resolution.nhs.uk/2021/10/28/2021-scorecards-launch/?utm_medium=email&utm_campaign=Resolution%20Matters%20October%202021&utm_content=Resolution%20Matters%20October%202021+CID_ac638a61c8ce1ac278298e3233f234af&utm_source=Email%20marketing%20software&utm_term=2021%20Scorecards%20launch https://resolution.nhs.uk/2020/10/27/claims-scorecards-for-2020/
What are the expectations of the Board safety champions in point d) as it asks that all Trust safety champions are supporting MatNeoSIP?	The Board safety Champions will be expected to continue their support for quality improvement by working with the designated improvement leads to participate and mobilise improvement via the MatNeo Patient Safety Networks. Trusts will be required to undertake improvement including data collection and testing work aligned to the national driver diagram and key enablers. The Board level safety champion will continue to support staff as detailed in the minimum evidential requirements for Trust Board.
What is the expectation for Trusts to utilise previous SCORE culture surveys?	Whilst it is recognised that some Trusts SCORE culture surveys were completed several years ago, identified themes from the surveys are likely to still be relevant as it changes a number of years to change culture. This would include leadership and team dynamics. These insights, and any recent work in these areas should still be used to inform improvement work.
Evidence or representation at a minimum of two engagement events such as Patient Safety Network meeting,	MatNeoSIP Patient Safety Network events have continued during year 4 of MIS with good engagement. Recordings have and can be made available to listen to and feedback regarding the content. PSC also have attendance lists for the events.

MatNeoSIP webinars and/or the annual learning event.	There are PSN events planned for each quarter of 2022/23. The expectation is that Trusts still engage with a minimum of two of these.

Safety action 10: Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) Scheme from 1 April 2021 to 5 December 2022?

Required standard	A) Reporting of all qualifying cases to HSIB from 1 April 2021 to 5 December 2022 B) Reporting of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 1 April 2022 until 5 December 2022 C) For all qualifying cases which have occurred during the period 1 April 2021 to 5 December 2022, the Trust Board are assured that: 1. the family have received information on the role of HSIB and NHS Resolution's EN scheme; and 2. there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.
Minimum evidential requirement for Trust Board	**Trust Board** sight of Trust legal services and maternity clinical governance records of qualifying HSIB/EN incidents and numbers reported to HSIB and NHS Resolution. **Trust Board** sight of evidence that the families have received information on the role of HSIB and EN scheme. **Trust Board** sight of evidence of compliance with the statutory duty of candour.
Validation process	Self-certification to NHS Resolution using Board declaration form. Trusts' reporting will be cross-referenced against the HSIB database and the National Neonatal Research Database (NNRD), and NHS Resolution database for the number of qualifying incidents recorded for the Trust and externally verify that standard a) and b) have been met in the relevant reporting period. In addition, for standard C1 there is a requirement to complete field on the Claims Reporting Wizard (CMS), whether families have been informed of NHS Resolution's involvement, completion of this will also be monitored, and externally validated.
What is the relevant time period?	Reporting to HSIB – from Wednesday 1 April 2021 to 5 December 2022

	Reporting period to HSIB **and** to NHS Resolution - from 1 April 2022 to 5 December 2022
What is the deadline for reporting to NHS Resolution?	By 2 February 2023 at 12 noon

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Technical guidance	
Where can I find information on HSIB?	Information about HSIB and maternity investigations can be found on the HSIB website https://www.hsib.org.uk/
Where can I find information on the Early Notification scheme?	Information about the EN scheme can be found on the NHS Resolution's website • EN main page • Trusts page • Families page
What are qualifying incidents that need to be reported to HSIB?	Qualifying incidents are term deliveries (≥37+0 completed weeks of gestation), following labour, that resulted in severe brain injury diagnosed in the first seven days of life. These are any babies that fall into the following categories: • Was diagnosed with grade III hypoxic ischaemic encephalopathy (HIE) [0r] • Was therapeutically cooled (active cooling only) [Or] • Had decreased central tone AND was comatose AND had seizures of any kind Once HSIB have received the above cases they will triage them and advise which investigations they will be progressing for babies who have clinical or MRI evidence of neurological injury.
Changes in the EN reporting requirements for Trust from 1 April 2021 to 31 March 2022	Between 1 April 2021 to 31 March 2022, all qualifying cases should still be reported to HSIB. HSIB will then inform NHS Resolution of the case. Should you wish to discuss further, please contact HSIB at maternity@hsib.org.uk
Changes in the EN reporting requirements for Trust from 1 April 2022 going forward	With effect from 1 April 2022, Trusts will be required to continue to report their qualifying cases to HSIB via the electronic portal. In addition, Trusts' will need to notify NHS Resolution, via the Claims Reporting Wizard, of qualifying EN cases once HSIB have confirmed they are progressing an investigation due to clinical or MRI evidence of neurological injury. The Trust must share the HSIB report with the EN team within 30 days of receipt of the final report by uploading the HSIB report to the corresponding CMS file via DTS. Trusts are advised they should avoid uploading HSIB reports in batches (e.g. waiting for a number of reports to be received before uploading).

	Once the HSIB report has been shared by the Trust, the EN team will triage the case based on the MRI findings and then confirm to the Trust which cases will proceed to a liability investigation.
Changes in the Outstanding 2021/22 cases to be reported	If there are any outstanding cases which occurred from 1 April 2021 to 31 March 2022, Trust should report them as soon as possible to HSIB, following the process outlined above.
What qualifying EN cases need to be reported to NHS Resolution?	• Trusts are required to report cases to NHS Resolution where HSIB are progressing an investigation i.e. those where there is clinical or MRI evidence of neurological injury. • Where a family have declined a HSIB investigation, but have requested an EN investigation, the case should also be reported to NHS Resolution.
Cases that do not require to be reported to NHS Resolution	- Cases where families have requested an investigation - Cases where Trusts have requested an investigation - Cases that HSIB are not investigating
What if we are unsure whether a case qualifies for referral to HSIB or NHS Resolution?	For cases from 1 April 2022, if the baby has a clinical or MRI evidence of neurological injury and the case is being investigated by HSIB because of this, then the case should also be reported to NHS Resolution via the claims wizard along with the HSIB reference number (document the HSIB reference in the “any other comments box”). Please select Sangita Bodalia, Head of Early Notification (legal) at NHS Resolution on the Claims Reporting Wizard Should you have any queries, please contact a member of the Early Notification team to discuss further (nhr.enteam@nhs.net) or HSIB maternity team (maternity@hsib.org.uk).
How should we report cases to NHS Resolution?	Trusts’ will need to notify NHS Resolution, via the Claims Reporting Wizard, of qualifying EN cases once they have been confirmed by HSIB as under investigation.
What happens once we have reported a case to NHS Resolution?	On receipt of the HSIB report, following triage, NHS Resolution will overlay an investigation into legal liability. Where families have declined an HSIB investigation, no EN investigation will take place, unless the family requests this.
Candour	Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 provides that a health service body must act in an open and transparent way with relevant persons in relation to care and treatment provided. https://www.legislation.gov.uk/ukdsi/2014/9780111117613/regulation/20

	In accordance with the statutory duty of candour, in all relevant cases, families should be 'advised of what enquiries in relation to the incident the health body believes are appropriate' – 20(3)(a) and details of any enquiries to be undertaken (20)(4)(b). This includes details of enquiries undertaken by HSIB and NHS Resolution. Assistance can be found on NHS Resolution's website, including the guidance 'Saying Sorry' as well as an animation on 'Duty of Candour' Trust Boards should be aware that if a breach of the statutory duty of candour in relation to a qualifying case comes to light which calls the validity of certification into question this may result in a review of the Trust submission and in addition trigger escalation to the CQC.
Will we be penalised for late reporting?	Trusts are strongly encouraged to report all incidents to HSIB as soon as they occur and to NHS Resolution as soon as HSIB have confirmed that they are taking forward an investigation. Trusts will meet the required standard if they can evidence to the Trust Board that they have reported all qualifying cases to HSIB and where applicable to NHS Resolution and this is confirmed with data held by NNRD and HSIB and NHS Resolution. Where qualifying cases are not reported within two years from the date of the incident, these cases will no longer be eligible for investigation under the Early Notification scheme.

FAQs for year four of the maternity incentive scheme

Does 'Board' refer to the Trust Board or would the Maternity Services Clinical Board suffice?	**We expect Trust Boards to self-certify the Trust's declarations following consideration of the evidence provided.** It is recommended that all executive members e.g. finance directors are included in these discussions. If subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of governance which we may escalate to the appropriate arm's length body/NHS system leader. We escalate these concerns to the Care Quality Commission for their consideration if any further action is required, and to the NHS England and NHS Improvement regional director, the Deputy Chief Midwifery Officer, regional chief midwife and DHSC for information. In addition, we now publish information on the NHS Resolution website regarding the verification process, the name of the Trusts involved in the MIS re-verification process as well as information on the outcome of the verification (including the number of safety actions not passed).
Do we need to discuss this with our commissioners?	Yes, the CEO of the Trust will ensure that the Accountable officer (AO) for their ICB is apprised of the MIS safety action evidence and declaration form. The CEO and AO must both sign the Board declaration form as evidence that they are both fully assured and in agreement with the evidence to be submitted to NHS Resolution The declaration form must be signed by both CEO and the Accountable Officer of Clinical Commissioning Group/Integrated Care System before submission.
Our current commissioning systems are changing, what does this mean in terms of sign off?	There have been structural changes for NHS Commissioning as a result of 2022 Health and Care Act. Where this has caused significant reconfiguration and adjustment of commissioning systems, sign off by the accountable lead for commissioning maternity services can be considered
Will NHS Resolution cross check our results with external data sources?	Yes, we will cross reference results with external data sets from: MBRRACE-UK data (safety action 1 point a, b, c), NHS England& Improvement regarding submission to the Maternity Services Data Set (safety action 2, sub-requirements 2 and 3), and against the National Neonatal Research Database (NNRD) and HSIB for the number of qualifying incidents reportable to HSIB (safety action 10,

	standard a)). Your overall submission may also be sense checked with CQC maternity data, HSIB data etc. For more details, please refer to the conditions of the scheme.
What documents do we need to send to you?	The Board declaration form will need to be sent to NHS Resolution. Ensure the Board declaration form has been approved by the Trust Board, signed by the CEO and, where relevant, an action plan is completed for each action the Trust has not met. **Please do not send your evidence or any narrative related to your submission to us.** Any other documents you are collating should be used to inform your discussions with the Trust Board.
Where can I find the Trust reporting template which needs to be signed off by the Board?	The Board declaration Excel form will be published on the NHS Resolution website in 2022. **It is mandatory that Trusts use the Board declaration Excel form when declaring compliance to NHS Resolution. If the Board declaration form is not returned to NHS Resolution by 12 noon on Thursday 2 February 2023, NHS Resolution will treat that as a nil response.** **The declaration form will be published later in 2022.**
Will you accept late submissions?	We will not accept late submissions. The Board declaration form and any action plan will need to be submitted to us no later than **12 noon on Thursday 2 February 2023**. If not returned to NHS Resolution by 12 noon on Thursday 2 February 2023, NHS Resolution will treat that as a nil response.
What happens if we do not meet the ten actions?	Only Trusts that meet all ten maternity safety actions will be eligible for a payment of at least 10% of their contribution to the incentive fund. Trusts that do not meet this threshold need to submit a completed action plan for each safety action they have not met. Trusts that do not meet all ten safety actions may be eligible for a small discretionary payment to help them to make progress against one or more of the ten safety actions.
Our Trust has queries, who should we contact?	Any queries prior to the submission date must be sent in writing by e-mail to NHS Resolution via nhsr.mis@nhs.net
Please can you confirm who outcome letters will be sent to?	The maternity incentive scheme outcome letters will be sent to Trust's nominated MIS leads.

What if Trust contact details have changed?	It's the responsibility of the Trusts to inform NHS Resolution of the most updated link contacts via link on the NHS Resolution website. https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-Trusts/maternity-incentive-scheme/maternity-incentive-scheme/
What if my Trust has multiple sites providing maternity services?	Multi-site providers will need to demonstrate the evidential requirements for each individual site. The Board declaration should reflect overall actions met for the whole Trust.
Will there be a process for appeals this year?	Yes, there will be an appeals process and Trusts will be allowed 14 days to appeal the decision following the communication of results.
Merging Trusts	Trusts that will be merging during the year four reporting period (August 2021 to February 2023) must inform NHS Resolution of this via nhsr.mis@nhs.net so that arrangements can be discussed. In addition, Trust's Directors of Finance or a member of the finance team must make contact with the NHS Resolution finance team by email at nhsr.contributions@nhs.net as soon as possible to discuss the implications of the changes in the way maternity services are to be provided. This could have an impact on the contributions payable for your Trust in 2022/23 and the reporting of claims and management of claims going forward.

Q&A regarding Maternity Safety Strategy and CNST maternity incentive scheme

Q1) What are the aims of the maternity incentive scheme?

The Maternity Safety Strategy sets out the Department of Health and Social Care's ambition to reward those who have taken action to improve maternity safety.

Using CNST to incentivise safer care received strong support from respondents to our *2016 CNST consultation* where 93% of respondents wanted incentives under CNST to fund safety initiatives. This is also directly aligned to the Intervention objective in our *Five year strategy: Delivering fair resolution and learning from harm.*

Q2) Why have these safety actions been chosen?

The ten actions have been agreed with the national maternity safety champions, Matthew Jolly and Jacqueline Dunkley-Bent, in partnership with NHS Digital, NHS England, NHS Improvement, the Care Quality Commission (CQC), Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE-UK), Obstetric Anaesthetists Association, Royal College of Anaesthetists, HSIB, Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives.

The Collaborative Advisory Group (CAG) previously established by NHS Resolution to bring together other arm's length bodies and the Royal Colleges to support the delivery of the CNST maternity incentive scheme has also advised NHS Resolution on the safety actions.

Q3) Who has been involved in designing the scheme?

The National Maternity Safety Champions were advised by a group of system experts including representatives from:

- NHS England & Improvement
- NHS Digital
- MBRRACE-UK
- Royal College of Obstetricians and Gynaecologists
- Royal College of Midwives
- Royal College of Anaesthetists
- Royal College of Paediatrics and Child Health
- Care Quality Commission
- Department of Health and Social Care
- NHS Resolution
- Clinical obstetric, midwifery and neonatal staff
- HSIB

Q4) How will Trusts be assessed against the safety actions and by when?

Trusts will be expected to provide a report to their Board demonstrating achievement (with evidence) of each of the ten actions. The Board must consider the evidence and complete the Board declaration form for result submission.

Completed Board declaration forms must be discussed with the commissioner(s) of the Trust's maternity services, signed off by the Board and then submitted to NHS Resolution (with action plans for any actions not met) at nhsr.mis@nhs.net **by 12 noon on 2 February 2023**.

Please note:

- Board declaration forms will be reviewed by NHS Resolution and discussed with the scheme's Collaborative Advisory Group.
- NHS Resolution will use external data sources to validate some of the Trust's responses, as detailed in the technical guidance above.
- If a completed Board declaration form is not returned to NHS Resolution by 12 noon on Thursday 2 February 2023, NHS Resolution will treat that as a nil response.

3. Integrated Performance Report (full version) November 2022

compassionate care

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Integrated Performance Report

November 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	Oct-22	Nov-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	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%	49.12%	**66.67%**	**46.97%**	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%	97.62%	98.23%	98.23%	98.38%	97.97%	**in arrears**	**97.84%**	>=90% / >=95% from September 21		<=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%	91.75%	91.91%	**in arrears**	**91.54%**	>=90% / >=93% from September 21		<=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%	83.06%	84.64%	76.60%	**in arrears**	**81.18%**	>=80% / >=85% from September 21		<=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%	95.92%	93.09%	93.75%	93.26%	94.24%	**in arrears**	**94.91%**	>=90% / >=95% from September 21		<=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%	92.77%	94.51%	92.20%	96.27%	**in arrears**	**93.13%**	>=90% / >=95% from September 21		<=79%
EFFECTIVE																					Green	Amber	Red
Number of MRSA Bacteraemias – Trust assigned	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	**0**	**1**	0		>=0
Preventable number of Clostridium Difficile Cases	5	0	1	0	1	0	0	1	1	0	0	2	1	1	0	0	0	0	**0**	**7**	<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	108.15					**108.15**	<=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	106.74				**106.74**	<=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%	68.44%	**66.37%**	**72.15%**	>=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%	26.15%	**31.30%**	**24.95%**	>=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%	97.76%	97.79%	96.20%	96.74%	**98.22%**	**97.62%**	>=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%	98.56%	**99.32%**	**98.42%**	>=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%	98.86%	99.00%	99.45%	97.84%	98.90%	99.01%	**98.53%**	**98.64%**	>=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%	96.97%	97.44%	97.22%	**90.32%**	**97.45%**	>=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%	98.75%	98.85%	**98.98%**	**99.50%**	>=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%	35.00%	24.00%	38.46%	56.52%	**33.33%**	**43.60%**	>=85%		<=84%
62 Day GP Referral to Treatment	90.62%	91.87%	91.23%	91.40%	89.77%	91.51%	93.43%	87.32%	89.59%	86.82%	89.71%	91.63%	87.70%	90.69%	85.32%	85.43%	85.96%	90.53%	**92.37%**	**88.68%**	>=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%	88.24%	88.89%	70.37%	**78.57%**	**81.69%**	>=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%	74.06%	75.88%	73.65%	77.44%	78.17%	**76.85%**	**76.29%**	>=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%	**4.71%**	**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%	**3.06%**	**3.08%**	-	<=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%	**1.65%**	**1.65%**	-	<=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%	**91.68%**	**92.38%**	-	>=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%	**59.23%**	**66.77%**	-	>=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**	**-0.02**	**-1.78**			

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 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.
- 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.
- 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 2022/23.
- 3 Colleagues in Community division have just been awarded the Queens Nurse accreditation, taking the number of accreditations within Division to 6 serving as leaders and role models within Community nursing.
- Improving AHP workforce planning capability through extension of project roles to deliver outputs of initial review findings.
- E-Job rollout almost complete for AHP and next for specialist nursing.

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.
- 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.
- 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. The first VW beds went live in 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.
- The school aged Immunisations tender has been released to start a new contract from 1st September 2023. Community division are looking at submitting a collaborative tender with Locala for CHFT to continue to provide this service.

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.
- 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.
- We are still not clear on the match funding requirements for virtual ward in 2023/24, we continue to submit our forecast costs for 2022/23 and have submitted a plan for 2023/24 to NHSE and await further guidance.
- 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

104% Elective Recovery – Position to Nov and Forecast

Point of Delivery	YTD Performance Against 2019/20 and 104% Target				Performance Against 2022/23 Plan				Forecast Performance Against 2019/20 and 104% Target			
	2019/20 Baseline YTD	2022/23 Actual YTD	Variance YTD	% of 2019/20 Baseline Delivered YTD	2022/23 Plan YTD - activity	2022/23 Plan YTD - % of 2019/20 baseline	Variance YTD - activity	Variance YTD - % of 2019/20 baseline	2019/20 Baseline Full Year	2022/23 Actual Forecast	Variance Forecast	% of 2019/20 Baseline Delivered Forecast
Daycase	32,093	33,631	1,538	104.8%					48,300	50,593	2,293	104.7%
Elective	3,550	3,053	- 497	86.0%					5,285	4,766	- 519	90.2%
Sub-total Planned Inpatient	**35,644**	**36,684**	**1,040**	**102.9%**	**36,650**	**102.8%**	**34**	**0.1%**	**53,585**	**55,359**	**1,774**	**103.3%**
Outpatient First Attendances*	**97,071**	**102,175**	**5,104**	**105.3%**	**102,002**	**105.1%**	**172**	**0.2%**	**143,668**	**151,697**	**8,029**	**105.6%**
Outpatient Follow-ups	175,067	199,457	24,390	113.9%	190,661	108.9%	8,796	5.0%	270,804	297,321	26,517	109.8%

* actual outpatient first activity includes an estimate of 926 attendances for OMNES (ENT) and 642 attendances for Pioneer (ENT, Ophthalmology & Neurology) not yet input into EPR for Oct & Nov

- **Planned inpatient spells**
  - Currently delivering **102.9% of 2019/20 levels**.
  - Planned to be delivering 102.8% and therefore **0.1% (34 spells) ahead of plan**
  - **Forecasting to deliver 103.3% of 2019/20 levels** and therefore 0.7% (369 spells) below 104% target.
  - This is inclusive of further elective recovery agreed at ERG of 397 day case spells, reflecting an increased run-rate for endoscopy, oral surgery and pain in Jan-Mar.

- **Outpatient first attendances**
  - Currently delivering **105.3% of 2019/20 levels**.
  - Planned to be delivering 105.1% and therefore **0.2% (172 attendances) ahead of plan**
  - **Forecasting to deliver 105.6% of 2019/20 levels** and therefore 1.6% (2,282 spells) above 104% target
  - This is inclusive of further elective recovery agreed at ERG of 2,640 attendances, predominantly due to further use of insourcing providers.

Planned Inpatient Recovery - Position to Nov and Forecast

Planned Inpatient (Day case and Elective)	Performance Against 2019/20 and 104% Target				Performance Against 2022/23 Plan				Forecast Performance Against 2019/20 and 104% Target			
	2019/20 Baseline YTD	2022/23 Actual YTD	Variance YTD	% of 2019/20 Baseline Delivered YTD	Plan YTD - activity	Plan YTD - % of 2019/20 baseline	Variance YTD - activity	Variance YTD - % of 2019/20 baseline	2019/20 Baseline Full Year	2022/23 Actual Forecast	Variance Forecast	% of 2019/20 Baseline Delivered Forecast
Surgery	12,367	12,078	- 289	97.7%	12,386	100.2%	- 308	-2.5%	18,706	18,701	- 4	100.0%
Medicine	11,062	12,706	1,644	114.9%	11,776	106.5%	930	8.4%	17,014	19,105	2,090	112.3%
FSS	1,940	1,859	- 81	95.8%	2,072	106.8%	- 213	-11.0%	2,899	2,859	- 39	98.6%
Sub-total by Division (excluding Endoscopy)	**25,369**	**26,643**	**1,274**	**105.0%**	**26,234**	**103.4%**	**409**	**1.6%**	**38,619**	**40,665**	**2,046**	**105.3%**
Endoscopy	10,275	10,040	- 235	97.7%	10,417	101.4%	- 377	-3.7%	14,966	14,692	- 274	98.2%
Total Planned Inpatient	**35,644**	**36,683**	**1,039**	**102.9%**	**36,650**	**102.8%**	**33**	**0.1%**	**53,585**	**55,357**	**1,773**	**103.3%**

Non-endoscopy Day case and Elective:

- Activity is currently at **105% of 2019/20 levels**
- Planned to be at 103.4% of 2019/20 levels and are **therefore 1.6% ahead of plan**.
- Main area **exceeding is Medical Oncology and Chemotherapy at 123%** of 2019/20 levels (1,306 spells). This is in-part due to additional Mid Yorkshire Hospitals activity. Demand predicted to continue.
- Main area below is Gynaecology, at 91% of 2019/20 levels (94 spells) and 88% of plan (205 spells). This is mainly due to a lack of outsourcing provider activity.
- Activity if forecast to be at **105.3% of 2019/20 levels.**

Endoscopy:

- Activity is currently at **97.7% of 2019/20 levels.**
- We planned to be at **101.4% of 2019/20 levels and are therefore 3.7% behind plan**. This is more materially below plan within Bowel Cancer Screening due to lower than anticipated demand.
- Activity is forecast to be at **98.2% of 2019/20 levels.**

Outpatient First Recovery – Position to Nov and Forecast

Outpatient First	Performance Against 2019/20 and 104%				Performance Against 2022/23 Plan				Performance Against 2019/20 and 104%			
	2019/20 Baseline YTD	2022/23 Actual YTD	Variance YTD	% of 2019/20 Baseline Delivered YTD	Plan YTD - activity	Plan YTD - % of 2019/20 baseline	Variance YTD - activity	Variance YTD - % of 2019/20 baseline	2019/20 Baseline Full Year	2022/23 Actual Forecast	Variance Forecast	% of 2019/20 Baseline Delivered Forecast
Surgery*	45,237	42,531	- 2,706	94.0%	45,010	99.5%	- 2,480	-5.5%	66,199	60,796	- 5,403	91.8%
Medicine	32,088	34,754	2,666	108.3%	33,186	103.4%	1,568	4.9%	47,928	53,100	5,172	110.8%
FSS	14,844	19,318	4,474	130.1%	18,498	124.6%	820	5.5%	22,066	29,599	7,533	134.1%
Community	4,901	5,572	671	113.7%	5,308	108.3%	264	5.4%	7,474	8,201	727	109.7%
Total Outpatient First	**97,071**	**102,175**	**5,104**	**105.3%**	**102,002**	**105.1%**	**172**	**0.2%**	**143,668**	**151,697**	**8,029**	**105.6%**

* actual outpatient first activity includes an estimate of 926 attendances for OMNES (ENT) and 642 attendances for Pioneer (ENT, Ophthalmology & Neurology) not yet input into EPR for Oct & Nov

- **Outpatient first attendances are at 105.3% of 2019/20 levels. We planned to be at 105.1% and so are 0.2% above plan.**
- This is inclusive of further elective recovery within a number of specialties.
- The main specialties forecasting to be away from plan are ENT, Oral Surgery, Ophthalmology, Neurology and Rheumatology.

Outpatient Follow-ups – Position to Nov and Forecast

Outpatient Follow-up	Performance Against 2019/20 and 104%				Performance Against 2022/23 Plan				Performance Against 2019/20 and 104%			
	2019/20 Baseline YTD	2022/23 Actual YTD	Variance YTD	% of 2019/20 Baseline Delivered YTD	Plan YTD - activity	Plan YTD - % of 2019/20 baseline	Variance YTD - activity	Variance YTD - % of 2019/20 baseline	2019/20 Baseline Full Year	2022/23 Actual Forecast	Variance Forecast	% of 2019/20 Baseline Delivered Forecast
Surgery	89,078	109,470	20,392	122.9%	102,182	114.7%	7,288	8.2%	141,157	161,989	20,832	114.8%
Medicine	59,889	65,788	5,899	109.9%	64,093	107.0%	1,695	2.8%	90,769	98,356	7,587	108.4%
FSS	20,370	18,278	- 2,092	89.7%	19,909	97.7%	- 1,631	-8.0%	30,159	28,167	- 1,992	93.4%
Community	5,731	5,921	190	103.3%	4,477	78.1%	1,444	25.2%	8,719	8,810	90	101.0%
Total Outpatient Follow-up	**175,067**	**199,457**	**24,390**	**113.9%**	**190,661**	**108.9%**	**8,796**	**5.0%**	**270,804**	**297,321**	**26,517**	**109.8%**

- Outpatient follow-up attendances are at 113.9% of 2019/20 levels. We planned to be at 108.9% and so are 5% higher from plan.
- The main areas of increase are within Ophthalmology, due to changes in pathway and Colorectal.
- The overdue follow-up backlog, however, has not materially changed.
- National target to reduce by 25% by March 23 – didn't commit to

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Summary

		As of 09/12/2022	Current Trajectory as	Variance to trajectory	Meeting Trajectory	Variance against trajectory				Main areas above Trajectory
						Medical	Surgical	FSS	Community	
Elective Backlogs	104 Weeks RTT	0	0	0	Yes	0	0	0	-	-
	78 Weeks RTT	128	113	15	Yes	3	10	3	-	Max Fax, General Surgery
	52 Weeks RTT	1280	2187	-907	Yes	-121	-738	-46	-	Max Fax, ENT, Gastroenterology, Colorectal Surgery & General Surgery
	Total ASI's	12059	6752	5307	No	2241	1892	1185	-11	Neurology, Max Fax, Gynaecology & Cardiology
	ASIs over 22 weeks	606	212	394	No	418	-67	34	5	Neurology - much smaller numbers in Max Fax, Gynaecology & Cardiology
	Holding List overdue	23900	7876	16024	No	8450	5896	1243	-	Urology, Cardiology, Dermatology, Gastro, Neurology & Respiratory Med, T&O, Ophthalmology & Gynaecology

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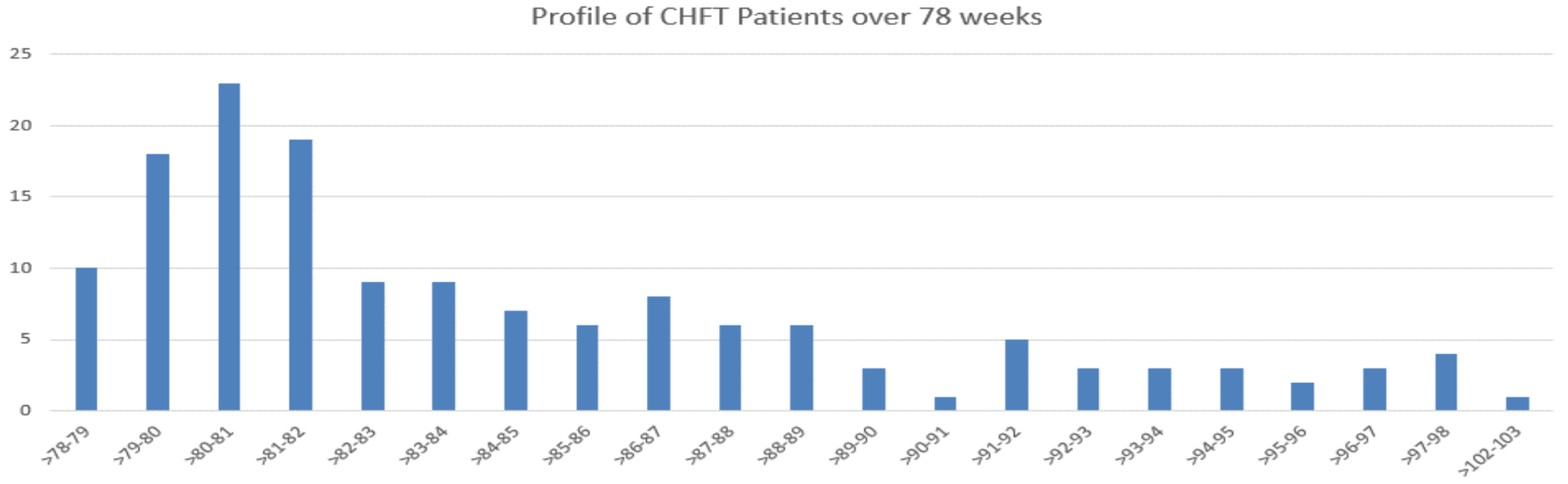
Current 104 week wait Position

- As of 9th December, we currently have 0 patients waiting over 104 weeks.



RTT – 78 Weeks

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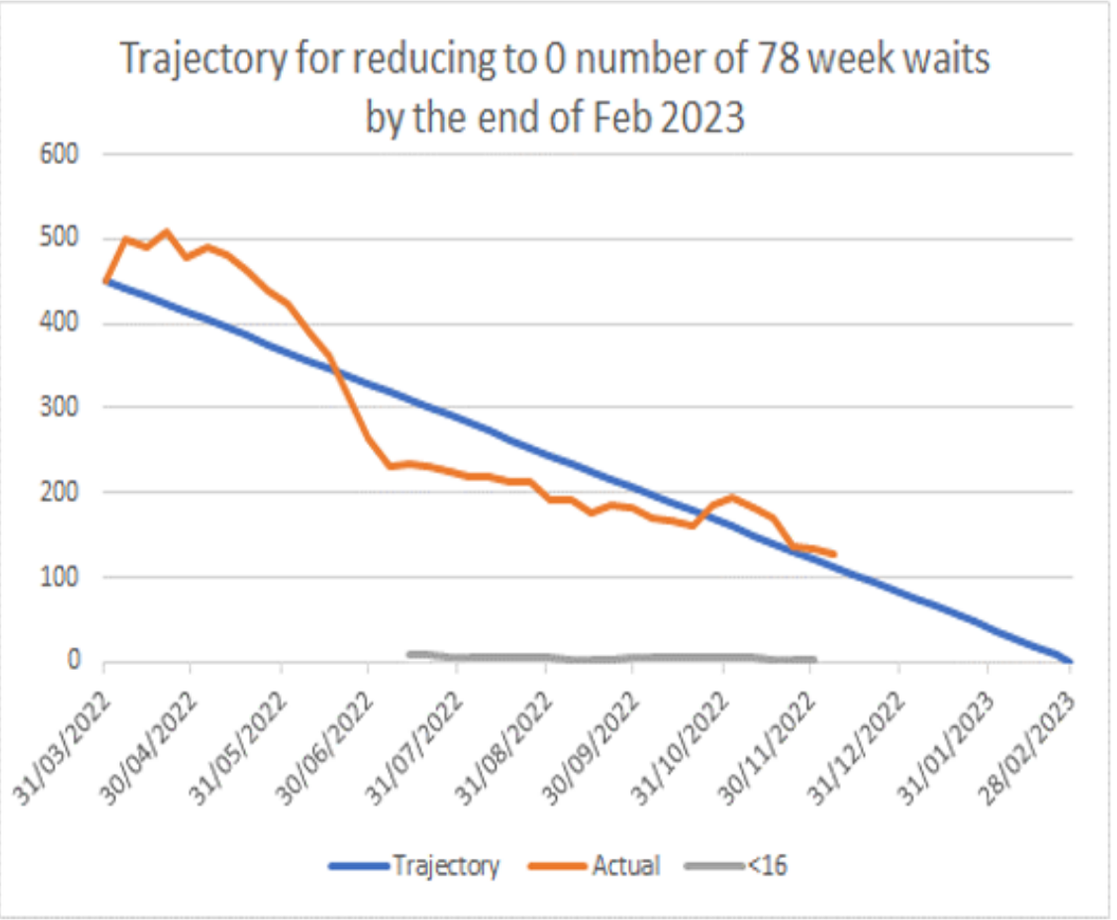

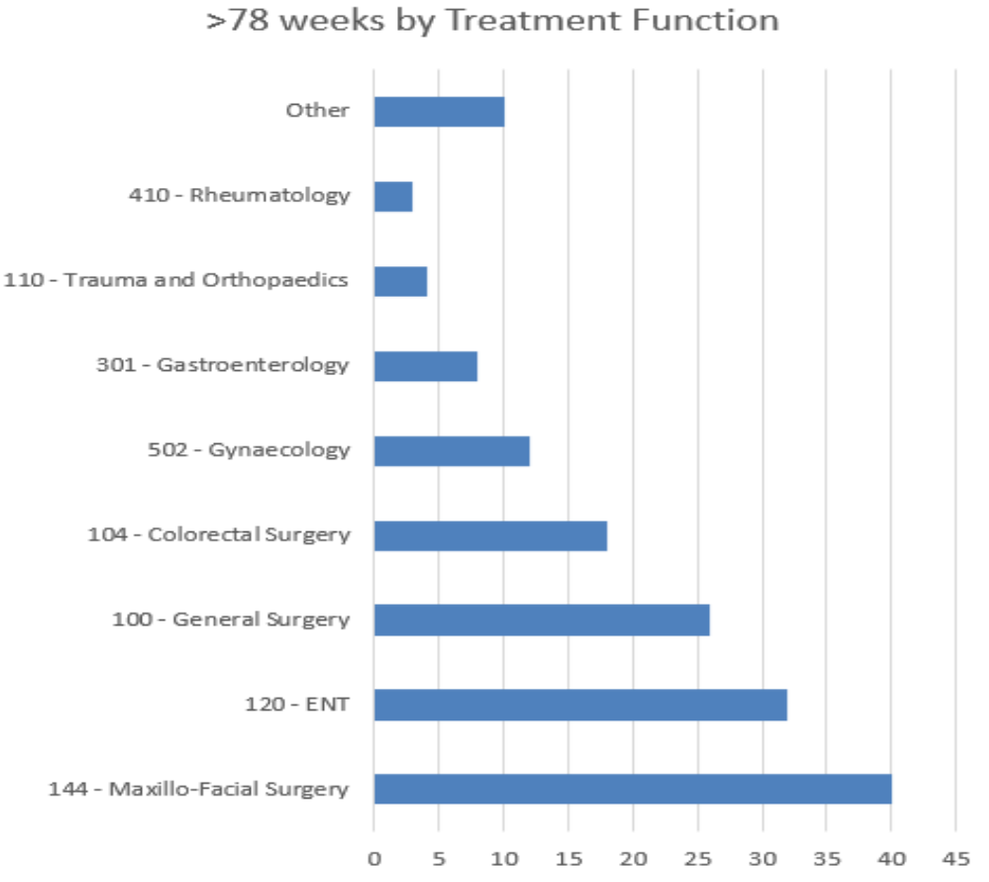

National expectation to be at zero by end of March 2023, on track to deliver.

RTT – 52 Weeks

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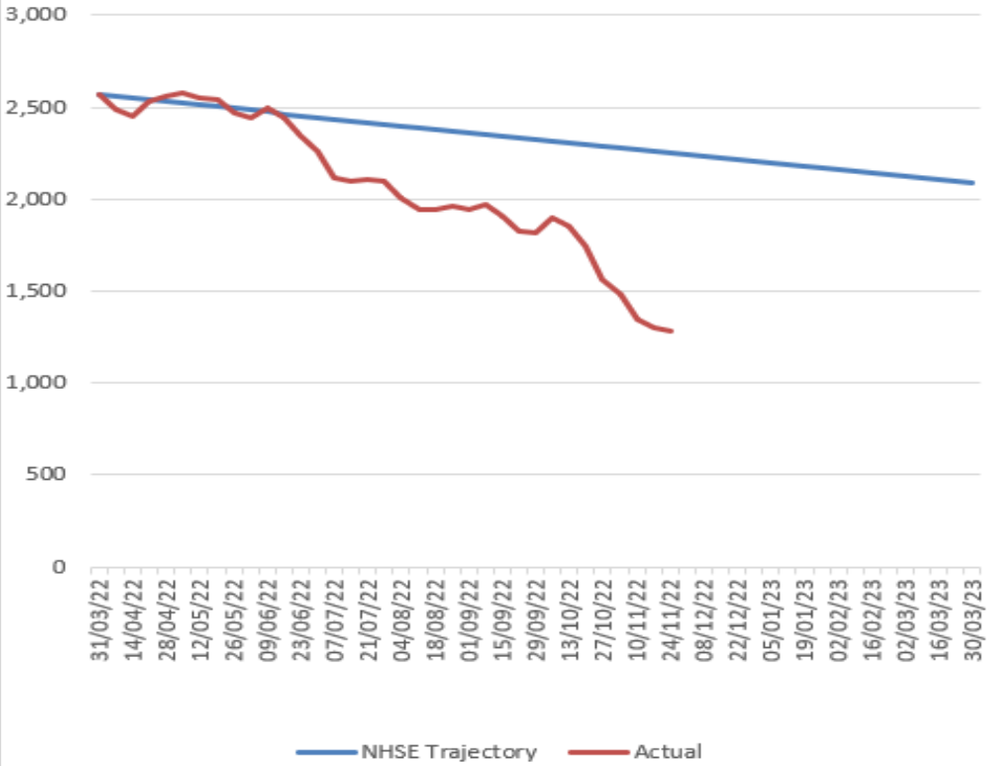
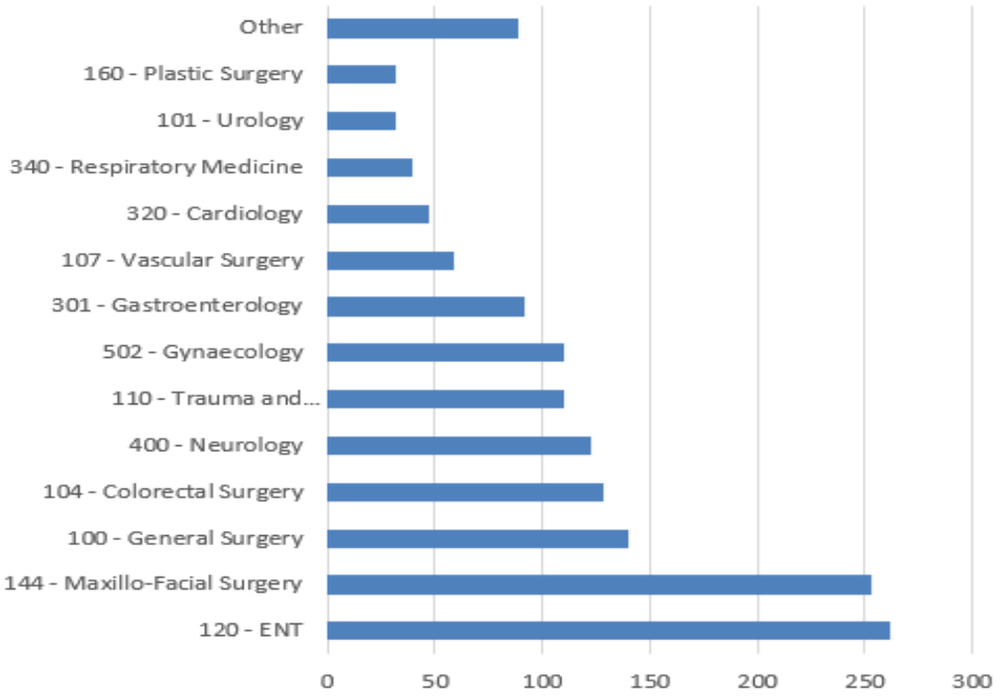
Trajectory for reducing 52 week waits by the end of March 23



>52 Weeks by Treatment Function



National expectation to be at zero by end of March 2025, on track to deliver NHSE ask.

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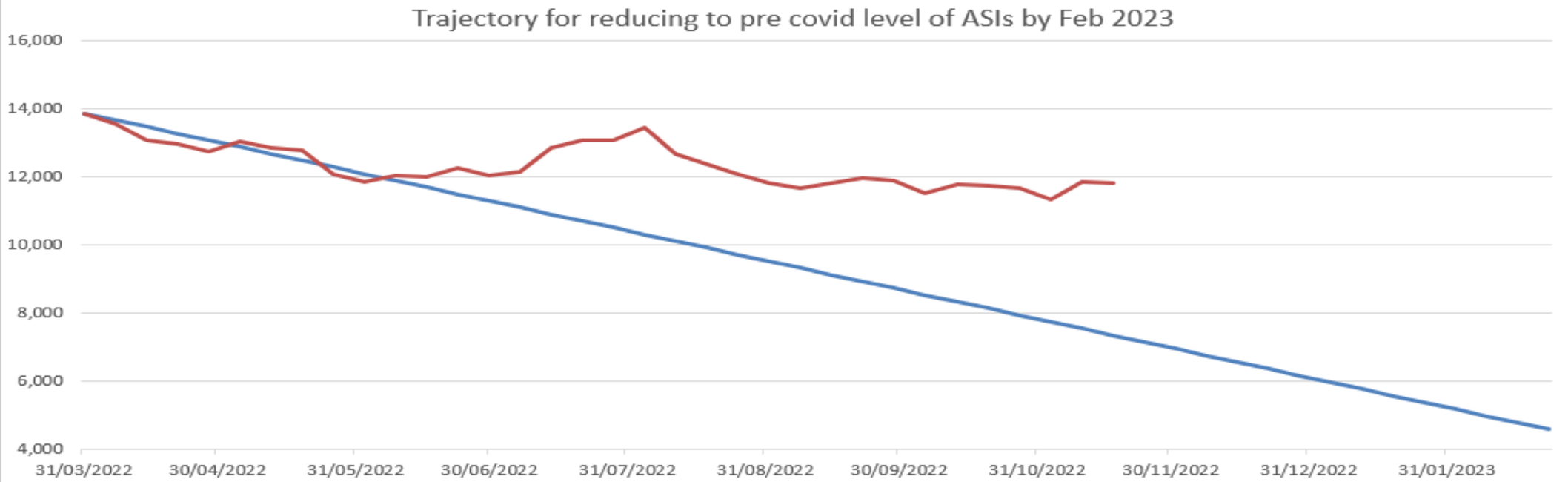
Outpatients – New (total ASIs)



- No external target and no requirement to report centrally. Internal target to get back to pre-covid levels.
- Current ASIs = reduced by 8.4% (1,100) from 13,141 in April to 12,059 December
- Risk of not addressing is on overall length of RTT pathways

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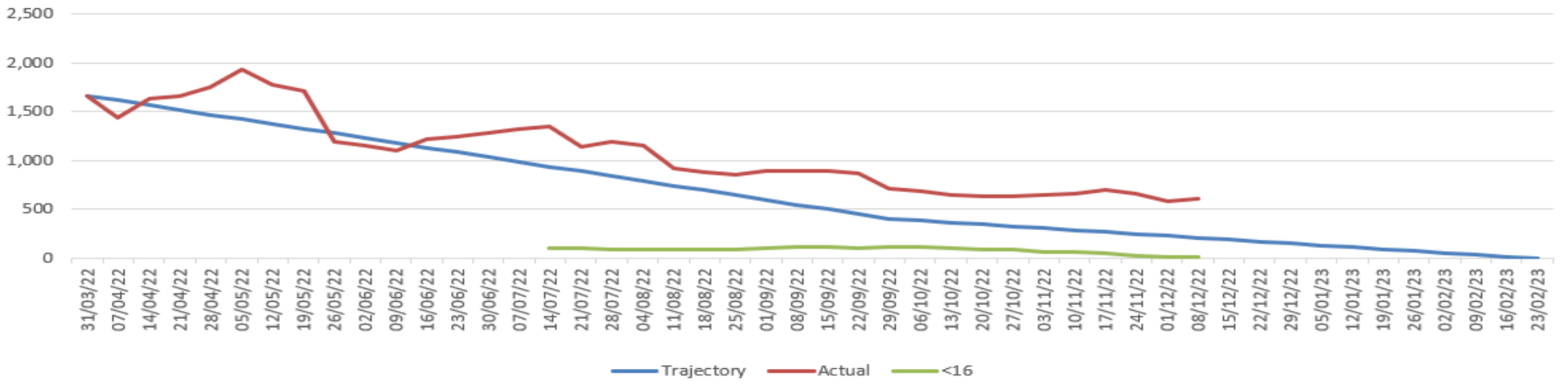
Outpatients – New (ASI > 22 weeks)

Trajectory for reducing to 0 number of ASI over 22 weeks by the end of Feb 2023)



- Our trajectory is a locally set target that will help achieve a reduction in 52/78 week RTT Waits. ENT ahead of plan. Other specialties behind plan, leading to the gap.
- Remaining ASIs over 22 weeks:
  - 272 in Neurology
  - 52 in Max Fax
  - 32 in Gynaecology and 32 in Dermatology
  - 43 in Gastroenterology

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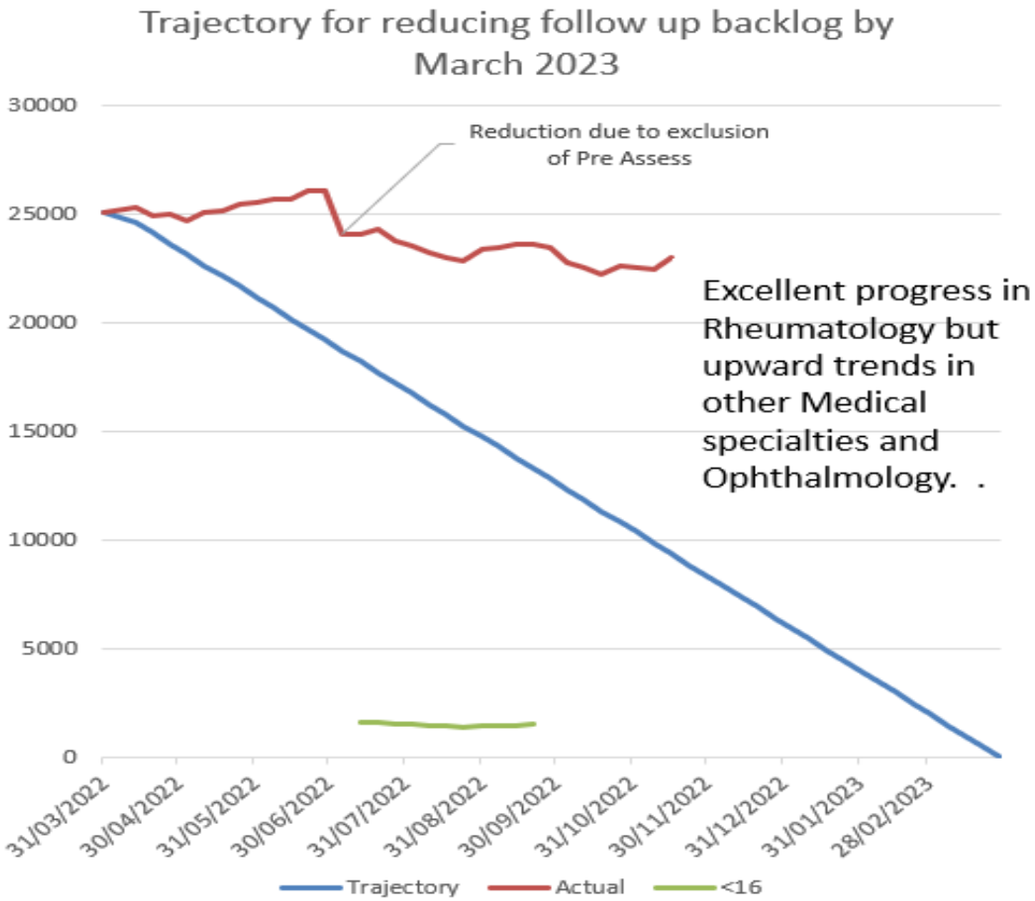
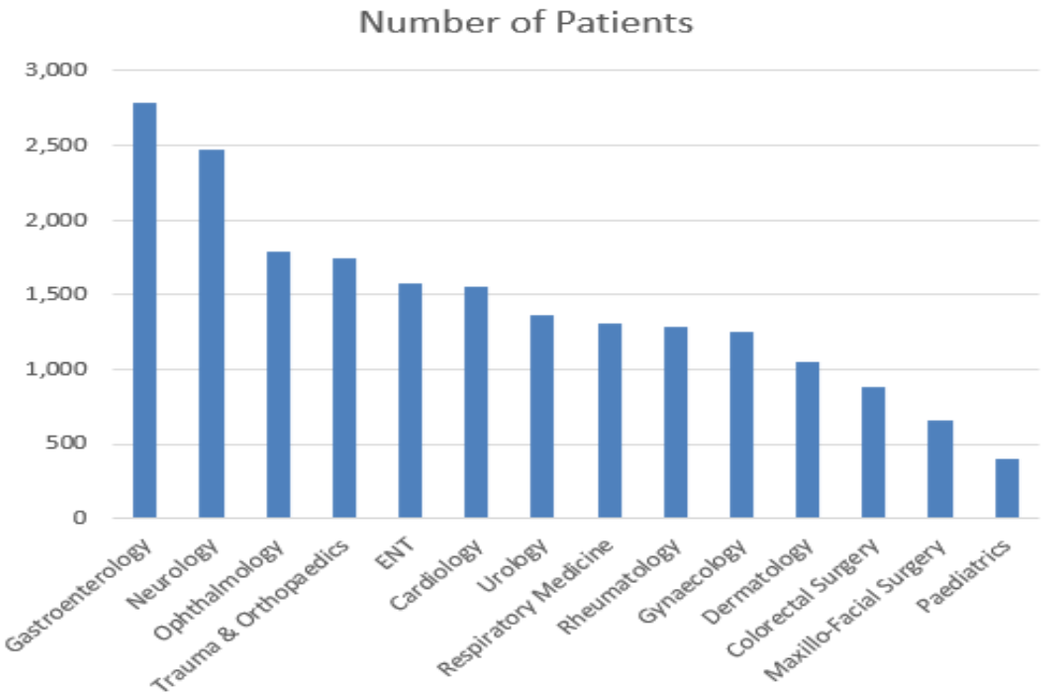
Outpatients – Follow Up



Excellent progress in Rheumatology but upward trends in other Medical specialties and Ophthalmology. .

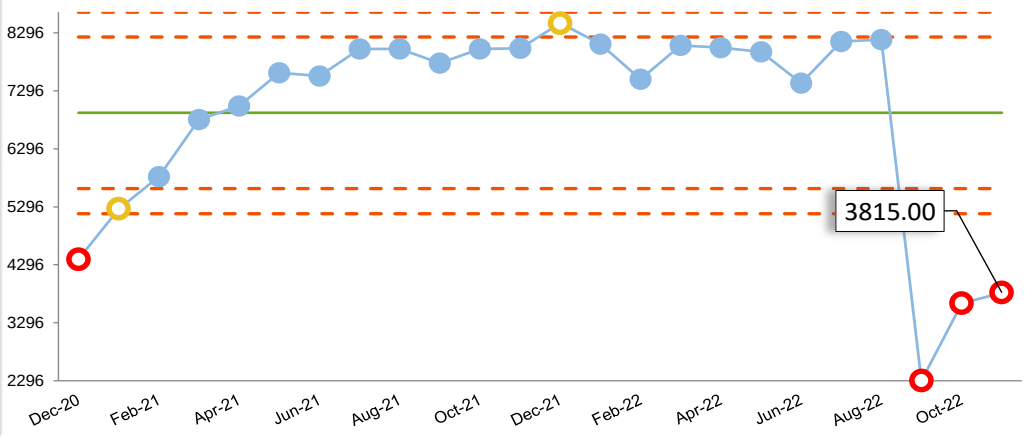


- No external target or requirement to report externally
- Internal target to reduce to 0, currently 23,900
- Transformation and clinical buy-in is the way forward

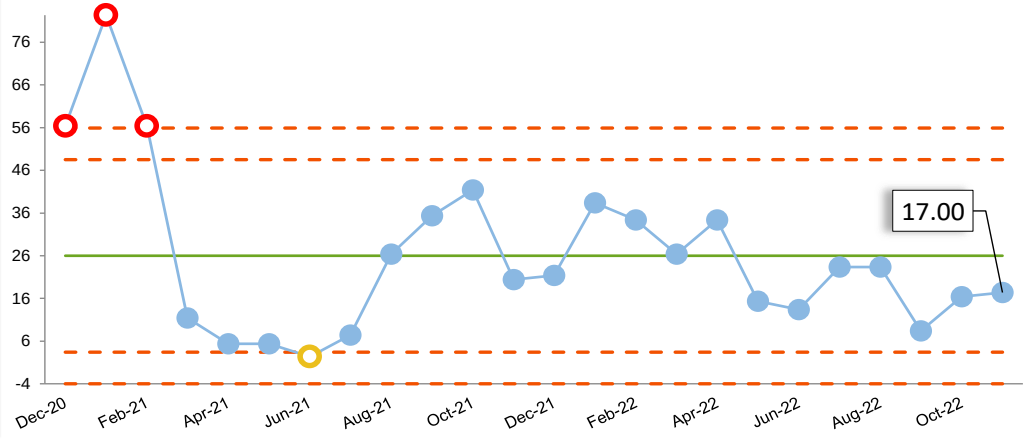
Covid-19 - SPC Charts

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

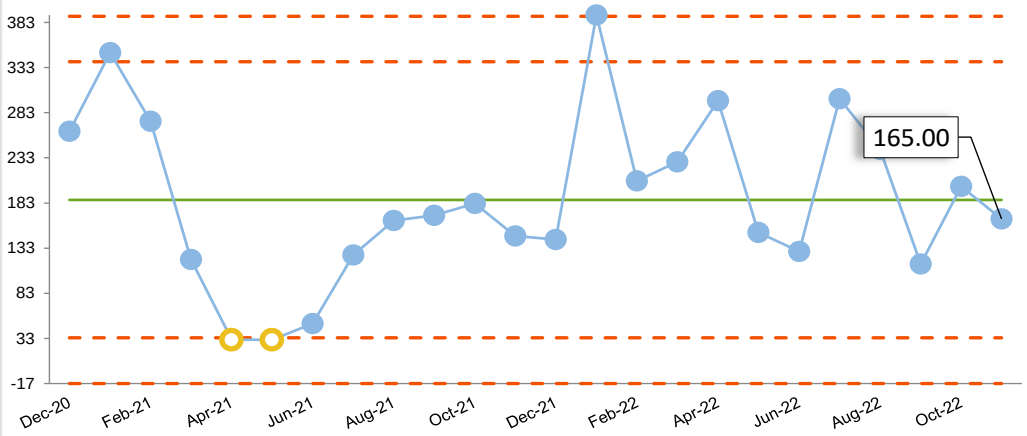
Number of Patients Tested for Covid-19



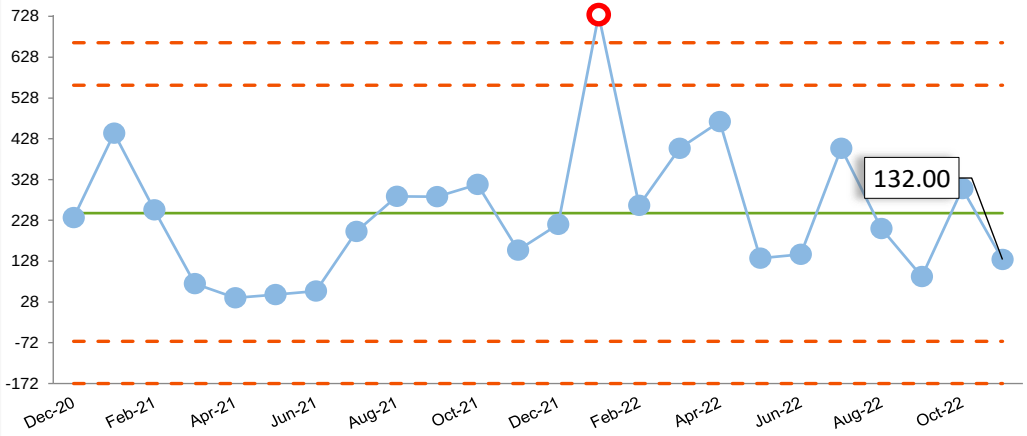
Number of Covid+ Deaths



Number of Covid+ Patients Discharged Well

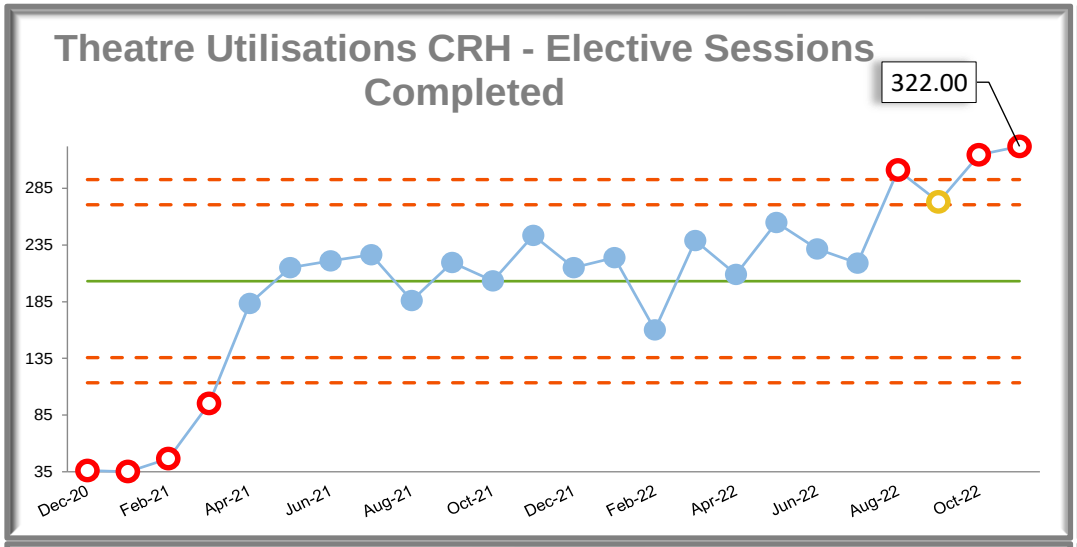


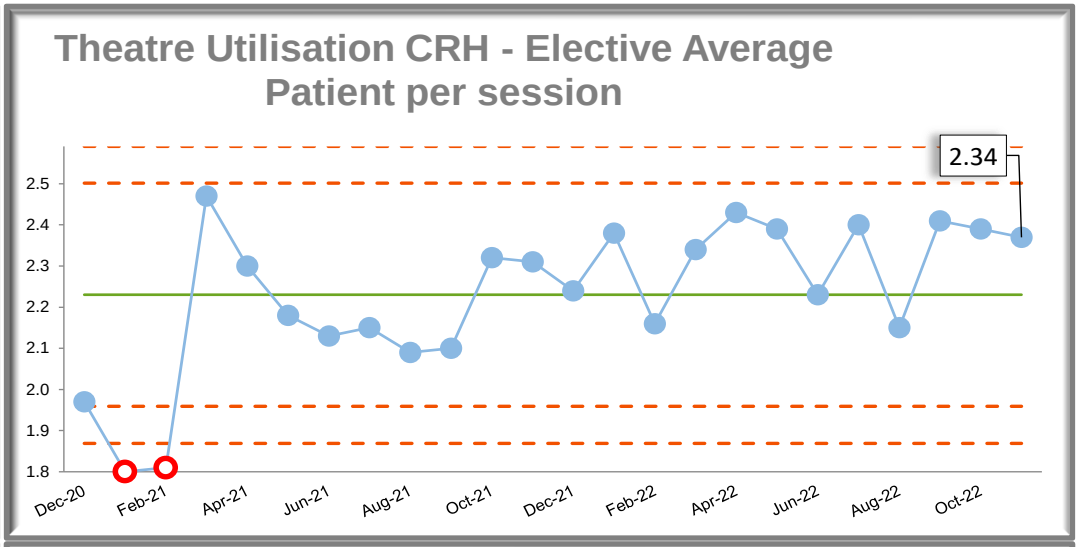
Number of New Covid+

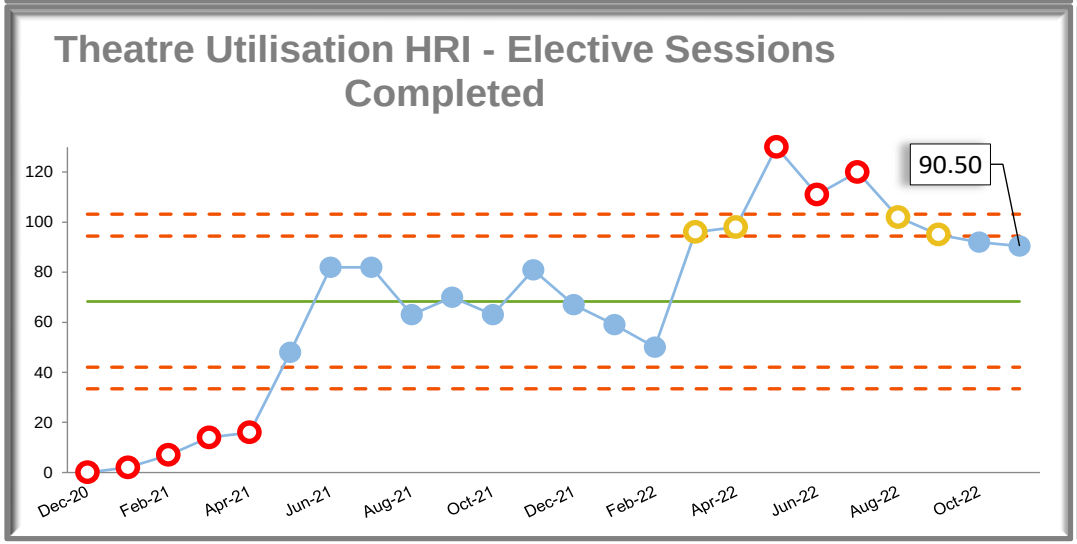


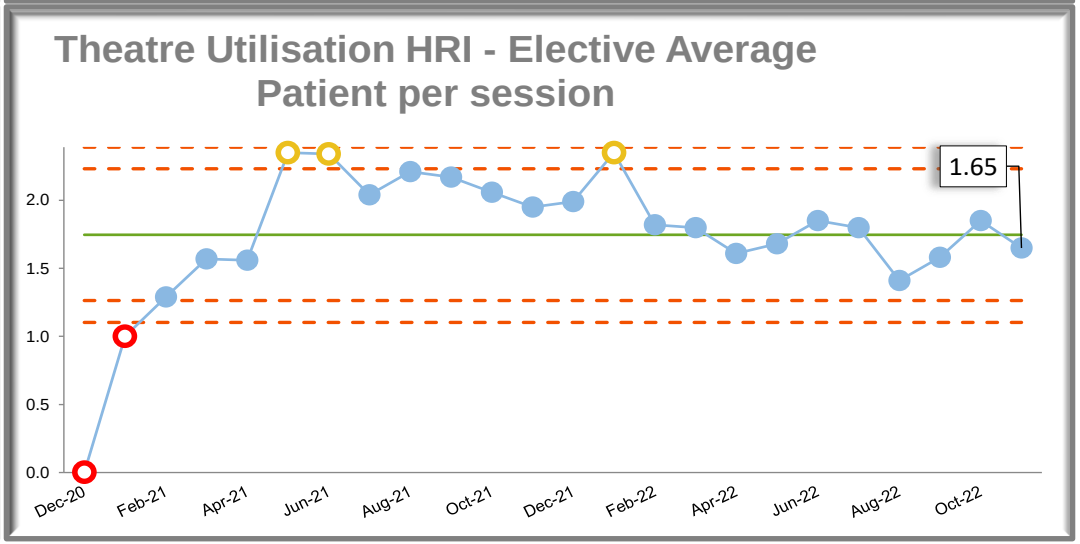
Theatres - SPC Charts

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

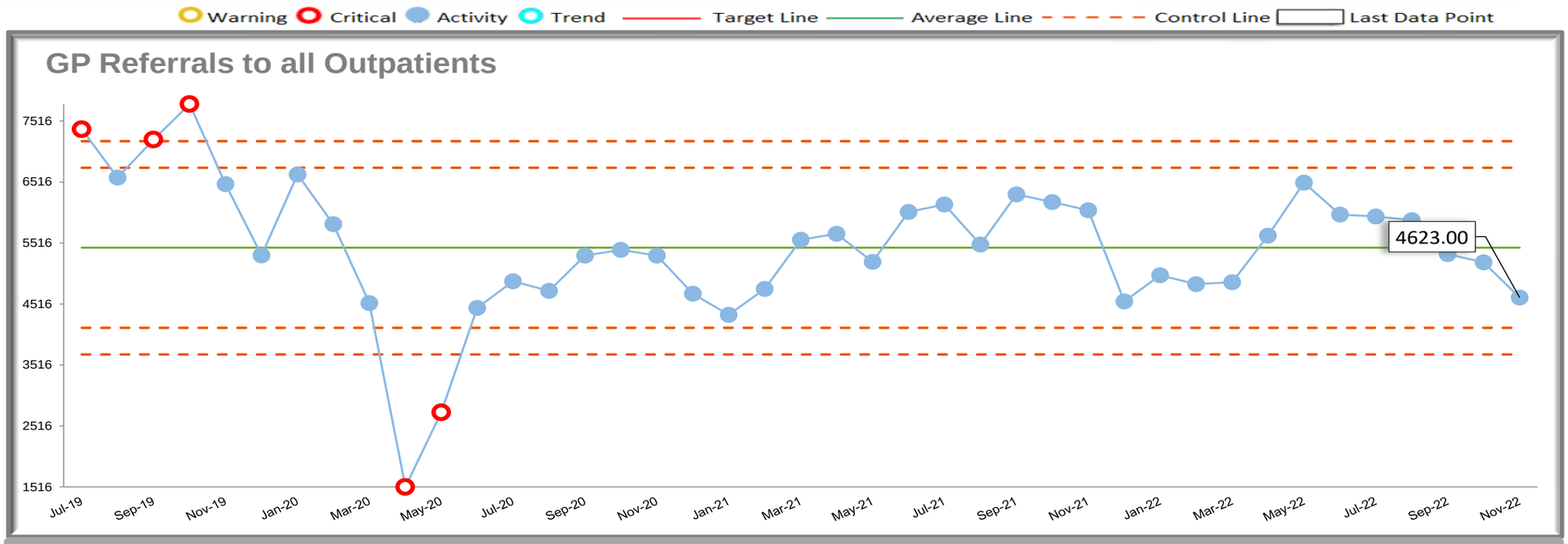


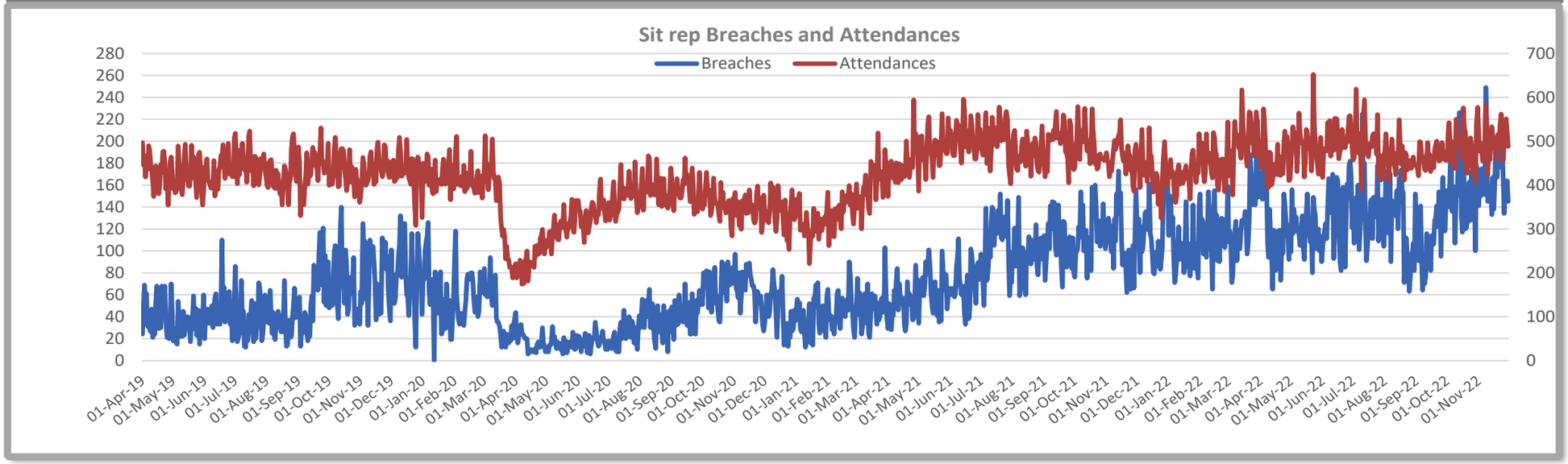






Capacity and Demand

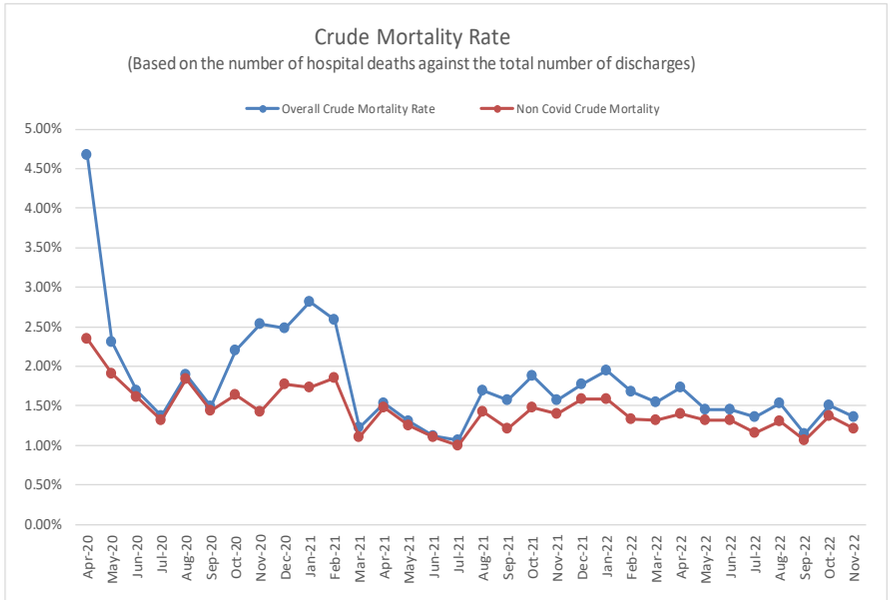


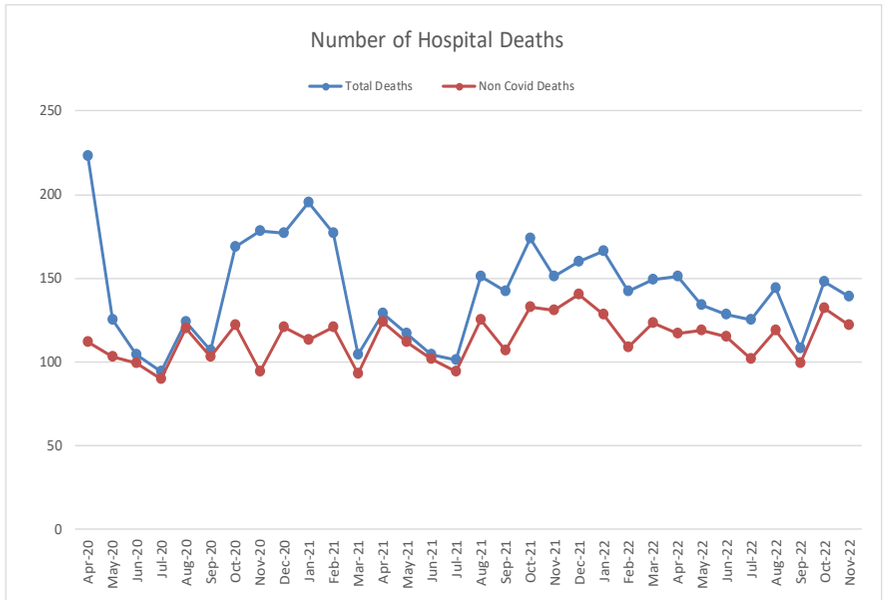


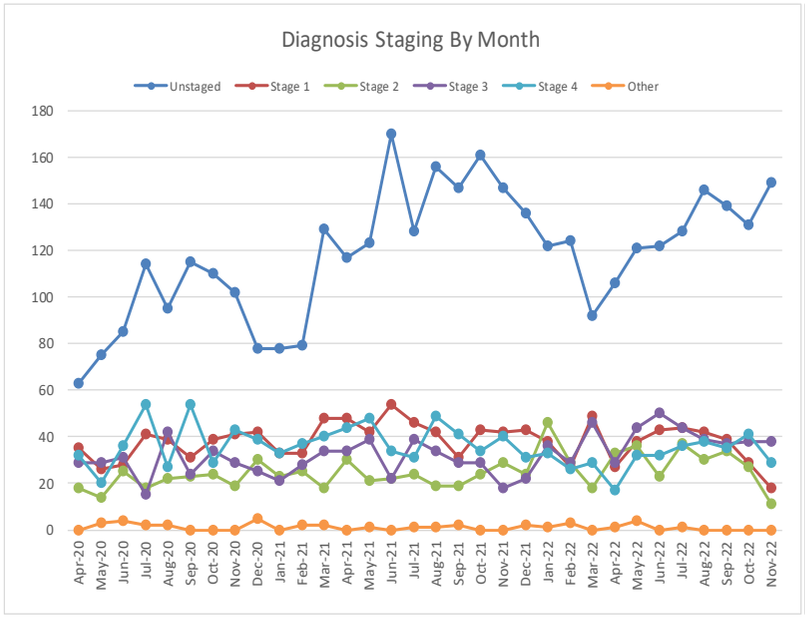
Recovery

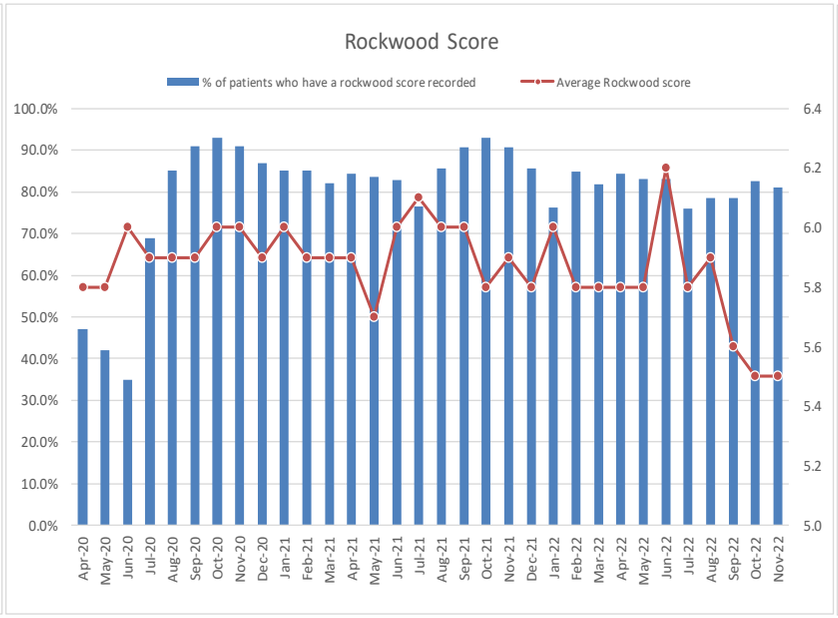
	21/22	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	YTD	Performance Range		
Recovery – Patient Initiated Outpatient Follow-Ups (PIFU)																Green	Amber	Red
Number of episodes moved to Patient Initiated Out-Patient Follow-Up Pathway as an outcome of their attendance	6446	859	735	859	878	1099	894	1102	908	972	1151	1196	1232	**1334**	**8,789**	Ongoing Monitoring		
% PIFU Delivered as an outcome of their attendance	1.18%	2.06%	2.04%	2.35%	2.47%	2.71%	2.48%	2.75%	2.39%	2.64%	3.03%	3.04%	3.20%	**3.10%**	**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	5114	5400	4740	5666	5886	6,761	6,879	7,508	7,754	8,219	8,620	9,043	**9,452**	**64,236**	Ongoing Monitoring		
Number of episodes on Patient Initiated Out-Patient Follow-Up Pathway completed	1168	239	260	272	302	7	281	293	336	223	390	357	394	**499**	**2,773**	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	4	2	5	2	2	5	7	1	3	9	0	6	**4**	**35**	Ongoing Monitoring		

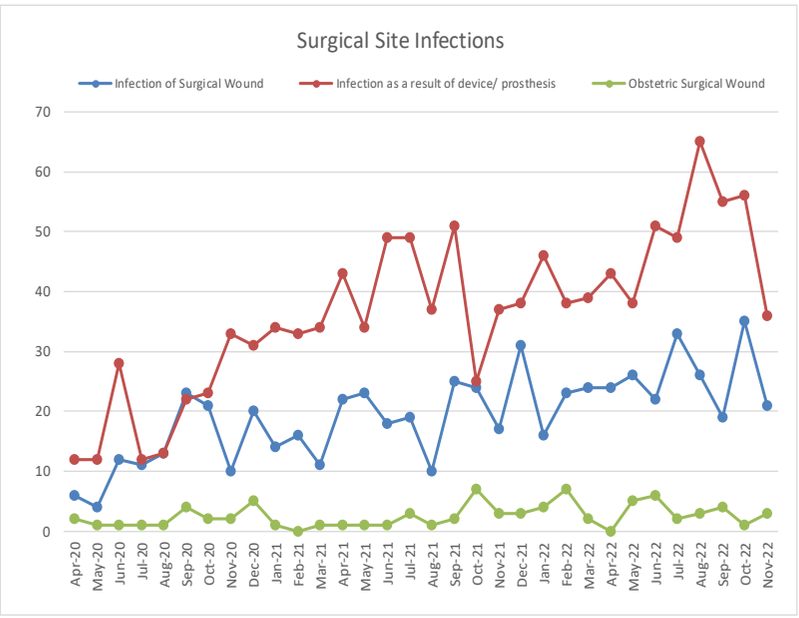
Outcome Measures









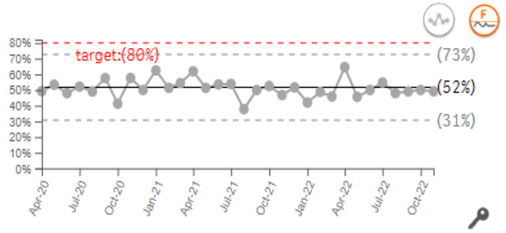


Graphs produced by the Quality Performance Team

Quality Priorities - Quality Account Priorities

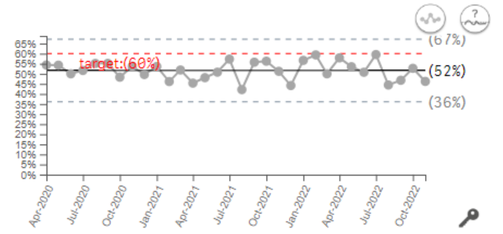
Priority 1
Recognition and timely treatment of Sepsis

% of ED patients that had antibiotics <1hr of red flag trigger
Adult patients coded with Sepsis that triggered red flag sepsis



Latest
49.15%
Variance Type
Common cause variation
Target
80%
Target Achievement
The system is expected to consistently fail the target

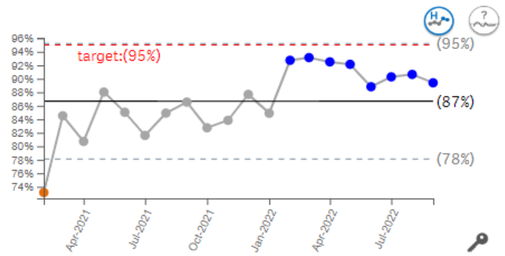
BUFALO Bundle Total Compliance (%)
Adult patients coded with Sepsis



Latest
46.22%
Variance Type
Common cause variation
Target
60%
Target Achievement
The system may achieve or fail the target subject to random variation

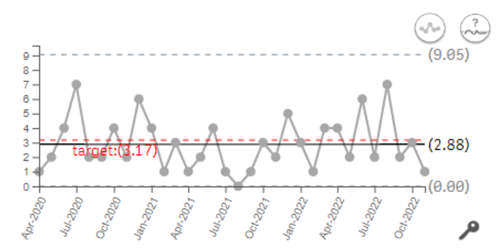
Priority 2
Reduce number of hospital acquired infections including COVID-19

COVID Retest/Swabbing Compliance (%)



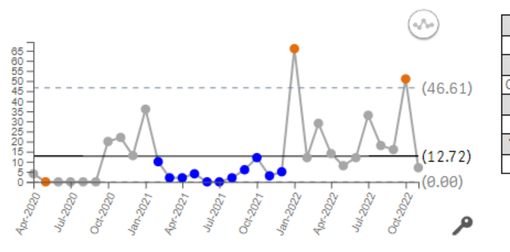
Latest
89.41%
Variance Type
Special cause variation - improvement (indicator where high is good)
Target
95%
Target Achievement
The system may achieve or fail the target subject to random variation

No. of CDiff
Trust Assigned



Latest
1
Variance Type
Common cause variation
Target
3.17
Target Achievement
The system may achieve or fail the target subject to random variation

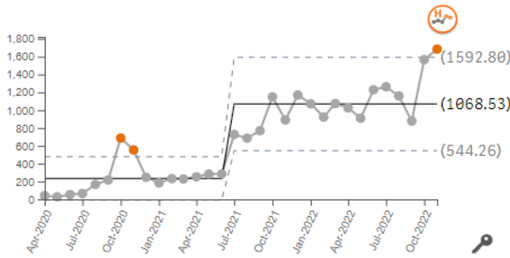
No. of Hospital Onset Covid Infection
Definate



Latest
7
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

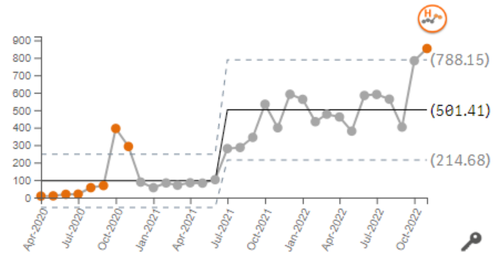
Priority 3
Reduce waiting times for individuals in the Emergency Department

8 Hour A&E Breaches



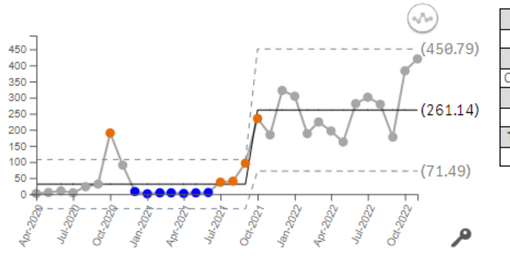
Latest
1685
Variance Type
Special cause variation - cause for concern (indicator where high is a concern)
Target
N/A
Target Achievement
N/A

10 Hour A&E Breaches



Latest
853
Variance Type
Special cause variation - cause for concern (indicator where high is a concern)
Target
N/A
Target Achievement
N/A

12 Hour A&E Breaches



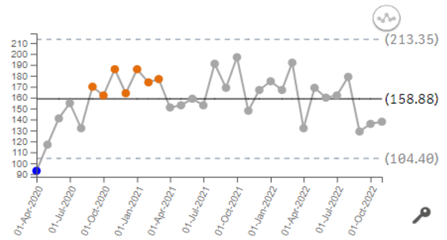
Latest
420
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Graphs produced by the Quality Performance Team

Quality Priorities - Focused Priorities

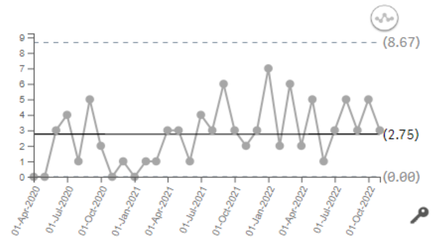
Priority 1
Reducing the number of falls resulting in harm

No. of Falls



Latest
138
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

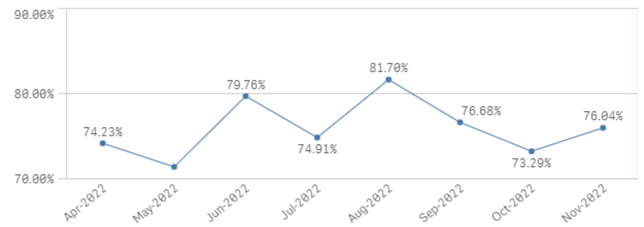
No. of Harm Falls



Latest
3
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

% of pts that had a falls risk assessment on adm/trans to the ward

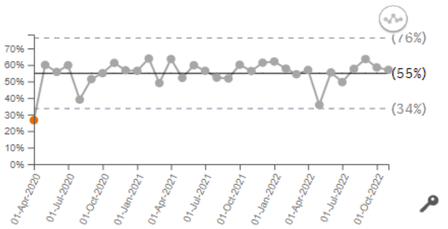
Adult inpatients



Priority 2
End of Life Care

% of patients that had Last Days of Life Documentation (LDLD)

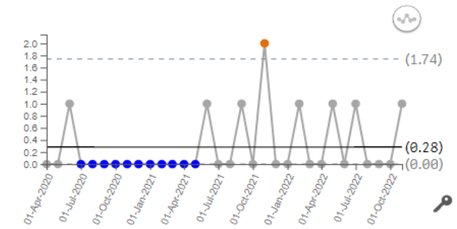
of those that died in hospital



Latest
57.04%
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

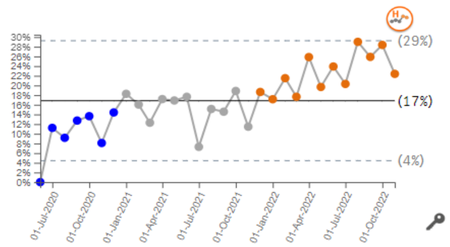
Number of complaints relating to end of life care

Where EOLC is in the subject (primary or secondary)



Latest
1
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

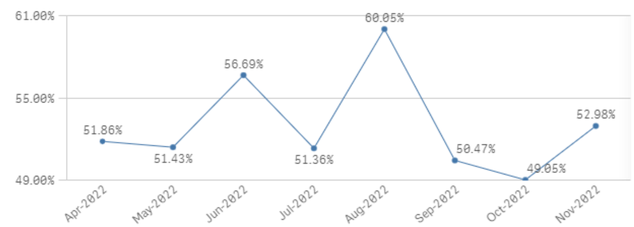
% of patients refered to HSPCT that died or were discharged before seen



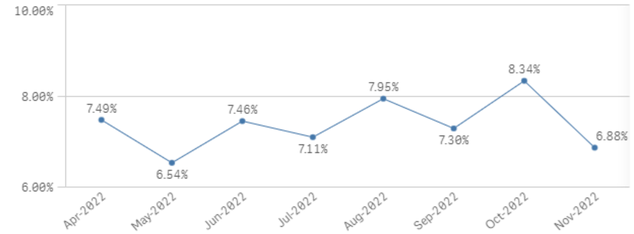
Latest
22.39%
Variance Type
Special cause variation - cause for concern (indicator where high is a concern)
Target
N/A
Target Achievement
N/A

Priority 3
Clinical Documentation

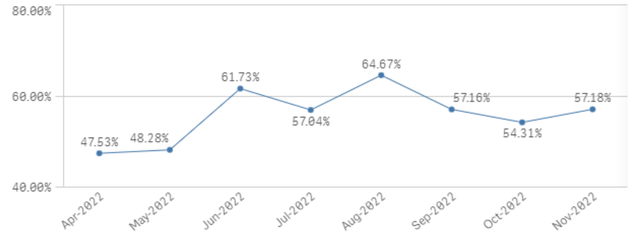
Ward Assurance Overall



Ward Assurance Elimination



Ward Assurance Pressure Ulcers



Priority 4
Clinical Prioritisation

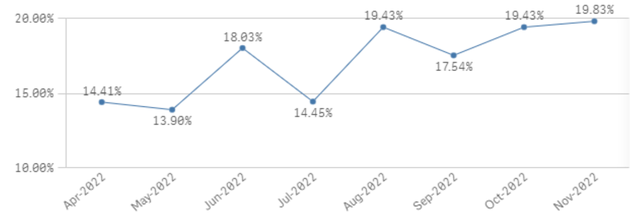
Not Yet Available

Graphs produced by the Quality Performance Team

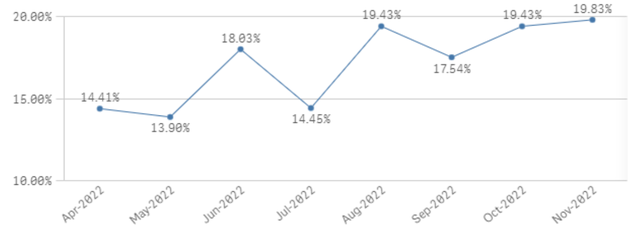
Quality Priorities - Focused Priorities

Priority 5
Nutrition and Hydration

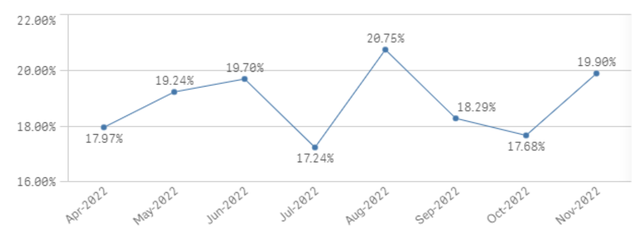
% of pts that recieved a MUST assessment within 24 hours admission/transfer to t...
Adult inpatients



% of patients with a MUST score of 2 or above that were referred to a dietician

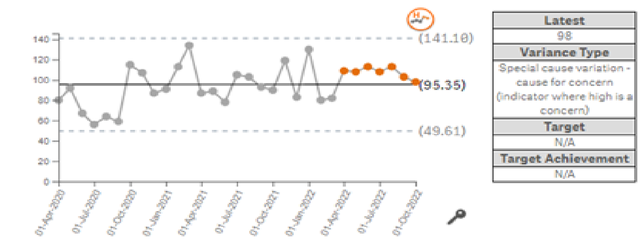


% of pts that had a completed fluid balance chart
(>LoS 8hrs)



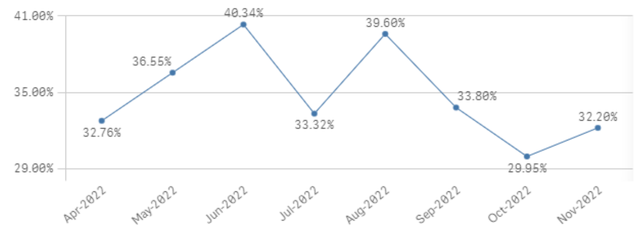
Priority 6
Reduction in the number of CHFT acquired pressure ulcers

No. of pressure ulcers
Hospital acquired



Latest
98
Variance Type
Special cause variation - cause for concern (indicator where high is a concern)
Target
N/A
Target Achievement
N/A

% of inpatients that received a pressure ulcer risk assessment within 6 hrs of admis...



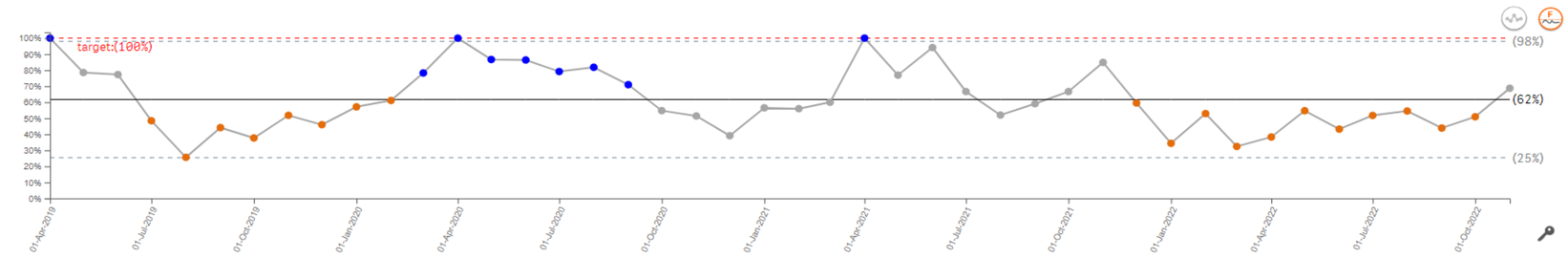
95% of relevant staff* will have completed Pressure Ulcer training in last 2 years.
*(RNs, Nursing Associates and HCAs)

Trust Compliance

86.28%

Priority 7
Making complaints count

% of Complaints Closed within agreed timescale



Latest
69%
Variance Type
Common cause variation
Target
100%
Target Achievement
The system is expected to consistently fail the target

Graphs produced by the Quality Performance Team

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%	59.00%			59.00%								
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%	100.0%	84.6%	75.0%	84.4%	100.0%	42.9%	100.0%	66.7%								
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%	8.04%	4.84%	4.21%	5.60%	7.15%	7.24%	9.75%	8.00%								
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%	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%	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%	16.00%	15.70%	12.60%	14.90%	14.60%	15.50%	15.60%	15.20%								
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%	88.00%	90.00%	88.89%	89.00%								
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%	12.90%	4.23%	3.77%	6.99%	4.29%	6.17%	1.75%	4.33%								
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%	43.50%			43.50%								

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. Q2 data is still being verified.	A campaign is being prepared to improve urine sampling for launch early in Q3.	Aiming for overall >60% compliance for the 5elements of the CQUIN.
CCG4: Compliance with timed diagnostic pathways for cancer services	In Q2 we achieved 8% compliance, which is a small improvement from Q1 but still well below the 65% target.	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 second 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	Performance for Q2 is 4.33% which is below the 35% target.	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 28.4% compliance, the reason for low compliance this quarter is due to the data collection framework not being in place. Q2 data is still being validated.	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.

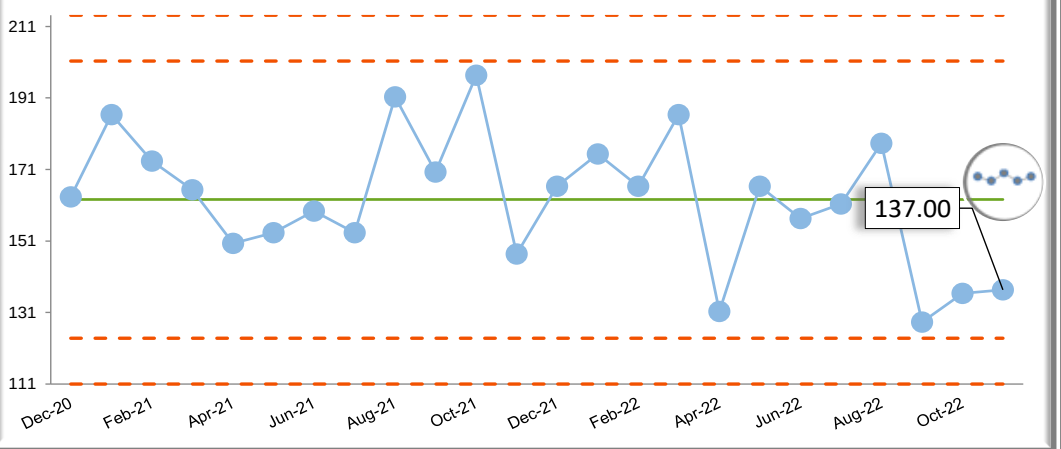
Safe - Key measures

	21/22	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	YTD	Performance Range		
																Green	Amber	Red
Falls / Incidents and Harm Free Care																		
All Falls	2013	147	166	175	166	186	131	166	157	161	178	128	136	**137**	**1,194**	Ongoing Monitoring		
Inpatient Falls with Serious Harm	48	3	3	6	2	11	2	4	1	3	5	3	4	**3**	**25**	Ongoing Monitoring		
Falls per 1000 bed days	8.95	7.48	8.28	8.77	9.02	9.1	6.79	8.4	8.09	8.08	8.96	6.43	6.45	**6.8**	**7.49**	Ongoing Monitoring		
Number of Serious Incidents	47	7	2	2	2	5	0	5	1	3	5	2	4	**4**	**24**	Ongoing Monitoring		
Number of Incidents with Harm	2934	274	254	340	240	301	293	294	261	286	221	273	292	**261**	**2,181**	Ongoing Monitoring		
Harm Falls per 1000 bed days	0.18	0.11	0.15	0.36	0.11	0.3	0.1	0.21	0.05	0.15	0.25	0.15	0.19	**0.15**	**0.16**	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	1	0	1	1	1	0	0	0	**0**	**3**	0		>=1
Percentage of SIs investigations where reports submitted within timescale – 60 Days	26.30%	0.00%	33.30%	60.00%	50.00%	33.00%	0.00%	none to report	none to report	0.00%	25.00%	0.00%	0.00%	**0.00%**	**26.30%**	Ongoing Monitoring		
% Emergency Sepsis patients receiving antibiotic treatment within 1 hour of diagnosis	92.49%	98.11%	100.00%	71.05%	82.76%	78.79%	84.85%	77.14%	76.32%	76.67%	89.19%	82.22%	in arrears	**in arrears**	**80.92%**	>=90%	86% - 89%	<=85%
% Inpatient Sepsis patients receiving antibiotic treatment within 1 hour of diagnosis	84.06%	91.43%	96.00%	55.17%	53.57%	60.00%	70.00%	52.17%	70.00%	66.67%	58.62%	64.29%	in arrears	**in arrears**	**63.91%**	>=90%	86% - 89%	<=85%
Maternity																		
% PPH ≥ 1500ml - all deliveries	2.21%	2.68%	2.60%	2.74%	1.45%	2.35%	2.79%	2.33%	2.60%	3.40%	2.61%	2.59%	2.27%	**3.25%**	**2.73%**	<= 3.0%	3.1% - 3.4%	>=3.5%
Antenatal Assessments < 13 weeks	90.35%	90.20%	90.40%	90.12%	90.22%	90.00%	90.01%	87.36%	89.80%	87.60%	89.20%	88.80%	87.90%	**88.30%**	**88.60%**	>90%	81% - 89%	<=80%
Maternal smoking at delivery	9.49%	9.50%	8.98%	9.12%	10.14%	7.83%	12.01%	9.62%	11.90%	9.90%	9.90%	11.80%	10.80%	**8.10%**	**10.50%**	<=12.9%		>=13%
Pressure Ulcers/VTE Assessments																		
Number of Trust Pressure Ulcers Acquired at CHFT	1069	109	82	130	85	82	103	100	93	99	106	99	90	**under validation**	**690**	Refer to SPC charts		
Pressure Ulcers per 1000 bed days	2.17	2.41	1.93	2.94	2.35	1.56	2.82	1.66	1.67	2.03	2.34	2.18	1.88	**under validation**	**2.08**	Refer to SPC charts		
Number of Category 2 Pressure Ulcers Acquired at CHFT	513	53	34	53	52	46	39	48	39	47	50	52	30	**under validation**	**305**	Refer to SPC charts		
Number of Category 3 Pressure Ulcers Acquired at CHFT	34	2	1	4	1	4	0	0	3	0	0	0	0	**under validation**	**3**	Refer to SPC charts		
Number of Category 4 Pressure Ulcers Acquired at CHFT	13	2	1	2	0	3	1	2	0	0	1	3	1	**under validation**	**8**	0		>=1
Number of Deep Tissue Injuries	354	36	29	47	21	19	46	32	39	33	44	32	37	**under validation**	**263**	<=26.583 & YTD <=319		
Number of Unstageable Pressure Ulcers	155	16	17	24	11	10	17	18	12	19	11	12	22	**under validation**	**111**	<=11.667 & YTD <=140		
Number of patients with a Pressure ulcer	861	83	72	95	71	72	76	78	80	85	85	82	80	**under validation**	**566**	Refer to SPC charts		
% of leg ulcers healed within 12 weeks from diagnosis	81.60%	81.30%	89.50%	53.80%	85.70%	77.80%	80.00%	96.00%	96.88%	93.98%	98.25%	92.90%	86.30%	**91.20%**	**91.90%**	>=90%	86% - 89%	<=85%
Percentage of Completed VTE Risk Assessments	96.29%	96.27%	96.06%	96.32%	96.60%	95.98%	95.35%	95.03%	95.69%	96.30%	97.13%	97.23%	96.32%	**not available**	**95.94%**	>=95%	86% - 89%	<=85%
Health & Safety Incidents																		
Health & Safety Incidents	269	18	25	13	28	21	20	22	18	17	27	19	26	**24**	**173**	Ongoing Monitoring		
Health & Safety Incidents (RIDDOR)	7	0	1	0	0	2	2	0	3	0	3	2	1	**0**	**11**	0		>=1
Reconciliation of Medicines																		
Medical Reconciliation within 24 hours (excluding Children)	52.90%	46.60%	57.50%	58.80%	53.30%	62.50%	53.30%	58.10%	56.40%	63.30%	51.90%	48.90%	53.70%	**48.00%**	**54.00%**	>=68%		<=67%
Electronic Discharge																		
% Complete EDS	94.46%	92.10%	92.46%	91.61%	93.70%	91.70%	95.59%	96.60%	95.27%	95.05%	95.92%	95.59%	94.50%	**in arrears**	**95.50%**	>=95%	91% - 94%	<=90%

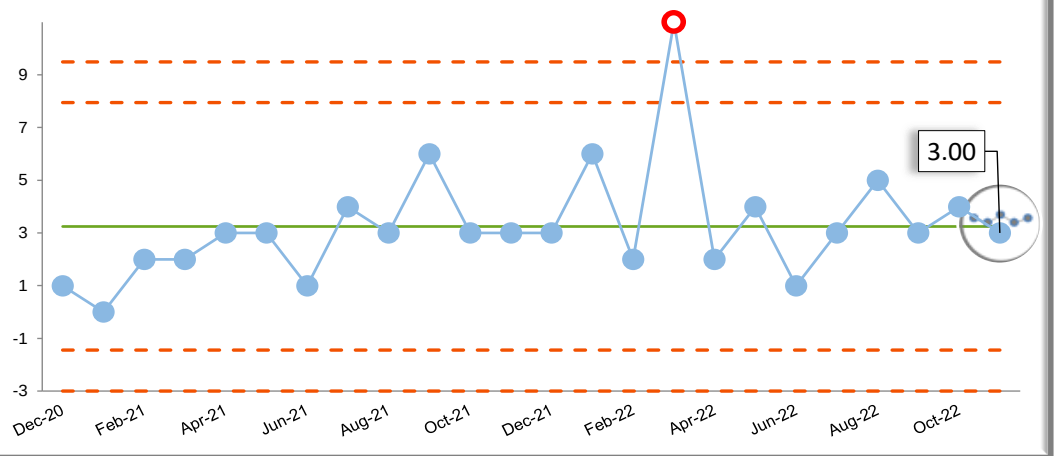
Safe - SPC Charts

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

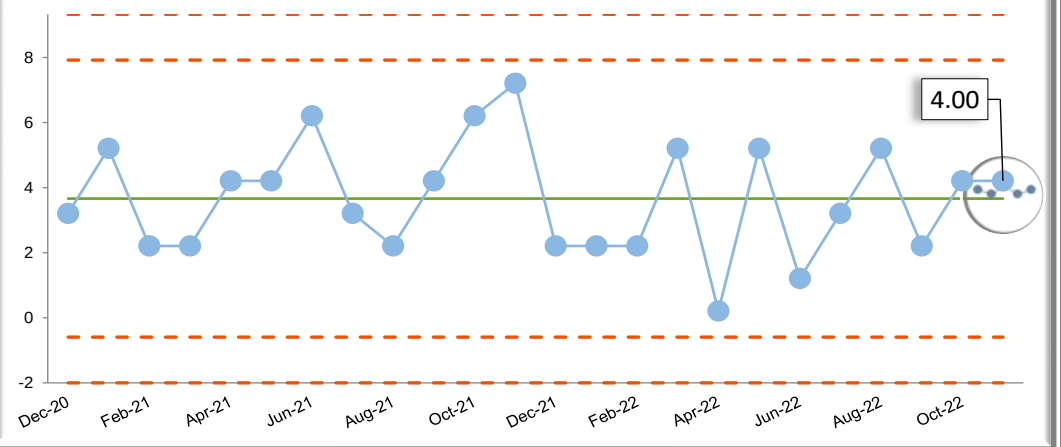
All Falls



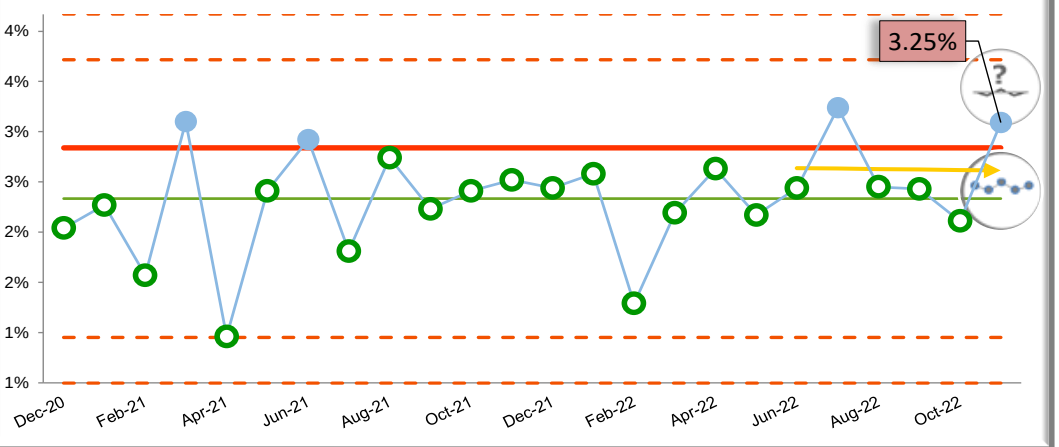
IP Falls with Serious Harm



Serious Incidents



% PPH



Safe - Key messages

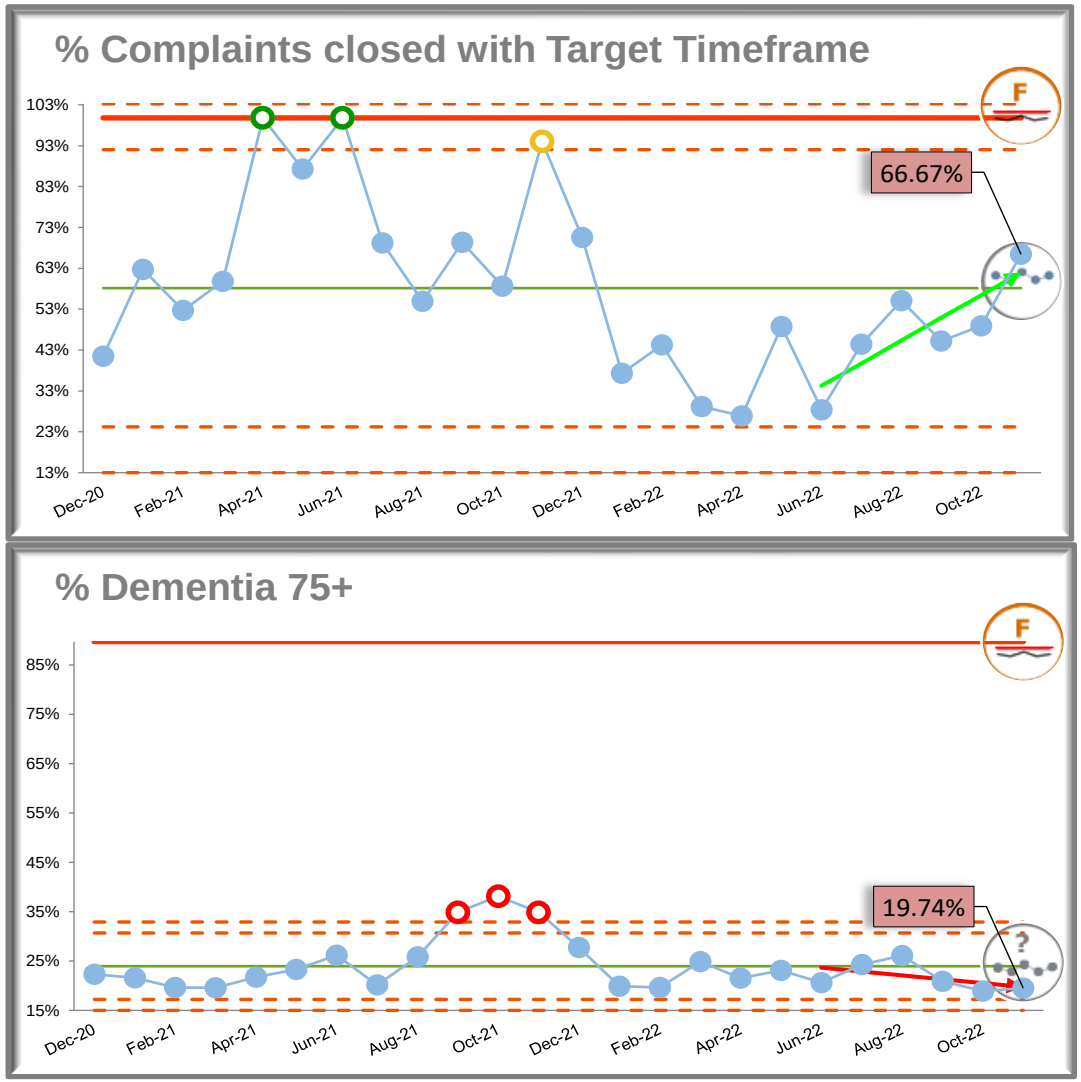
Area	Reality	Response	Result
Number of Deep Tissue Injuries	We have had 37 deep tissue injuries in October. This is above the ceiling of 26.5.	The Trust is implementing a new pressure ulcer risk assessment tool called PURPOSE T which will replace Waterlow. Roll-out has been delayed due to the e-learning package not being ready but should be implemented early in the new year. 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 November is 48%, 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. Staffing mix reviewed and more response deployed to CRH from HRI on a Saturday and Sunday to try and impact and improve the figure due to an increased bed base at CRH	We have seen a significant increase in this figure in the last 6 months, however, due to some changes in practice, the current aim is to keep the figure at a consistent 60% level. Accountable: Director of Pharmacy
% Emergency & Inpatient Sepsis patients receiving antibiotic treatment within 1 hour of diagnosis	For patients in the emergency department performance in September was 82.22% which is just below the 90%,. For inpatients performance in September was 64.292% 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 December 2022 Accountable: Quality Priority Lead
Antenatal Assessments < 13 weeks	Booking <13 weeks is 88.3% for November which is an increase in month from 87.9% for October. This is the 7th 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. EPR midwife asked to review bookings as on small snapshot some appear to be transfers of care rather than 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

Caring - Key measures

	21/22	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	YTD	Performance Range		
Complaints																Green	Amber	Red
% Complaints closed within target timeframe	63.61%	94.29%	70.73%	37.50%	44.44%	29.41%	27.08%	48.98%	28.57%	44.64%	55.32%	45.45%	49.12%	**66.67%**	**46.97%**	100%	86% - 99%	<=85%
Total Complaints received in the month	492	60	38	44	43	31	30	47	51	49	58	36	37	**30**	**338**	no target		
Complaints re-opened	86	13	5	6	7	9	5	9	6	12	12	8	7	**11**	**70**	no target		
Inpatient Complaints per 1000 bed days	1.39	1.78	1.42	1.52	1.42	1.03	1.25	1.92	1.78	1.73	1.85	1.12	0.91	**1.25**	**1.47**	no target		
No of Complaints closed within Timeframe	243	33	29	12	20	10	13	24	10	25	26	20	28	**40**	**186**	Refer to SPC charts in Appendix		
Total Complaints Closed	382	35	41	32	45	34	48	49	35	56	47	44	57	**60**	**396**	no target		
Friends & Family Test																		
Friends & Family Test (IP Survey) - % Positive Responses	96.88%	97.47%	97.35%	97.10%	97.36%	96.36%	97.57%	97.14%	97.62%	98.23%	98.23%	98.38%	97.97%	**in arrears**	**97.84%**	>=90% / >=95% from September 21 onwards		<=79%
Friends and Family Test Outpatients Survey - % Positive Responses	92.23%	92.45%	93.02%	93.20%	92.15%	93.71%	91.82%	92.24%	90.33%	92.02%	90.48%	91.75%	91.91%	**in arrears**	**91.54%**	>=90% / >=93% from September 21 onwards		<=79%
Friends and Family Test A & E Survey - % Positive Responses	82.53%	82.39%	84.40%	86.40%	84.69%	76.52%	83.18%	81.09%	79.94%	79.63%	83.06%	84.64%	76.60%	**in arrears**	**81.18%**	>=80% / >=85% from September 21 onwards		<=69%
Friends & Family Test (Maternity) - % Positive Responses	94.66%	93.20%	98.33%	92.30%	91.00%	95.12%	96.74%	97.92%	95.92%	93.09%	93.75%	93.26%	94.24%	**in arrears**	**94.91%**	>=90% / >=95% from September 21 onwards		<=79%
Friends and Family Test Community Survey - % Positive Responses	92.46%	95.86%	93.68%	95.50%	91.21%	98.32%	94.79%	94.52%	88.96%	92.77%	94.51%	92.20%	96.27%	**in arrears**	**93.13%**	>=90% / >=95% from September 21 onwards		<=79%
Caring																		
Number of Mixed Sex Accommodation Breaches	0	0	0	0	0	0	0	0	0	2	0	0	0	**0**	**2**	0		>=1
% Dementia patients screened following emergency admission aged 75 and over	26.57%	35.11%	28.03%	20.14%	19.92%	25.13%	21.81%	23.35%	20.88%	24.56%	26.34%	21.13%	19.16%	**19.74%**	**21.68%**	>=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 October is 66.67% which is an increase on last month, but below the Trust's target. YTD 46.97%	The Trust's overall performance is moving in the right direction with a 16pp improvement on last month's data, increasing to 67%, with all Divisions seeing an improvement since last month. We continue to work collaboratively with Divisions to ensure this improvement is maintained and if possible increases further.	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 19.55% in November compared with 16.73% in October.	Despite introducing several initiatives 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 A & E Survey - % Positive Responses	Friends & Family Test (A&E) - Positive responses is 76.6% in month compared with 84.64% during October.	There has been a decrease in positive responses for A&E which is in line with the increased demand we are seeing which is leading to longer waiting times. FFT continues to be reviewed at PSQB with learning shared appropriately.	The Trust continues to score above the national average. Accountable : ADN
Friends and Family Test Maternity Survey - % Positive Responses	Performance in October is 94.24% which is just below the 95% target. YTD 94.91%	The Trust has recently re-introduced a Womens Patient Experience working group to look through the triangulated themes from our PALS, Appreciations, Complaints FFT results and newly introduced Healthwatch intelligence. Where our FFT may be slightly below the national average, we have, however, seen an increase in the narrative provided from our patients, which gives us a real opportunity to understand what is valued and identified areas for improvements.	Improved FFT submission. Accountable : ADN

Caring - What our Patients are saying

Impact Story December 2022:
Recognising Deterioration at End of Life

RESULT:
Improvement in staff recognising patient deterioration when they approaching end of life

Type of Event:
Staff training and engagement as a result of patient/carer feedback

Event (REALITY):
Through various strands of intelligence there has been a sense that at times staff struggled to identify when a patient in deteriorating at and of life.
Intelligence has been received through our NACEL audit feedback and complaints.
By recognising symptoms of deterioration early this allows for timely intervention and treatment, which improves care and enables more efficient use of resources. It also gives family members and carers more opportunity to be involved in decisions about their loved ones, making sure their wishes are respected.

Improvement needed (RESPONSE):
- Improved staff awareness
- Training delivered in a way that staff easily access
- Training outside of office hour, to ensure staff working late shifts could have first-hand information
- Relationship building between the ward staff and the EOL Team

Result:
With a recently extended End of Life (EOL) Team they have been able to provide more bespoke training and support to staff. This was recently highlighted through their response to family/carer feedback from ward 15.
Through engaging with the staff on the ward they were able to provide training that fit in with the operational demands of delivering patient care,
Moving away from the more typical training approach, The EOL team attended various Board Rounds, engaged with staff to understand their challenges to identifying when a patient is deteriorating at EOL, and provided teams training and drop-in sessions. This approach was aimed at reaching all staff delivering care.
Staff have become more confident in recognising the signs of a deteriorating patient and are more aware of the importance of involving family members, carers and loved ones when a patient approaches this stage.
Due to the success of the training and engagement with staff, more EOL champions have been recruited, these staff will help support those they are working alongside and drive the quality of the patient and carer experience. The course the EOL Champions complete is deigned to develop the confidence and skills of those who care for and support patients in their last year of life.

RESULTING IMPACT STORY:

Increase in the number of EOL Champions

Staff aware of the support available by the EOL Team

Changing practice

Developing skills

Earlier family/ carer involvement

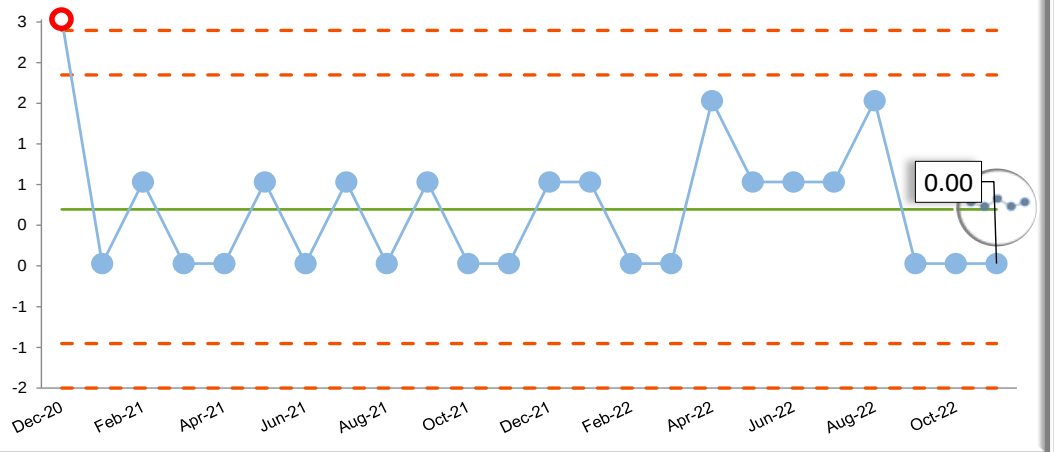
Effectiveness - Key measures

	21/22	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-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	1	**0**	**1**	0		>=0
Total Number of Clostridium Difficile Cases - Trust assigned	27	2	5	3	1	4	4	2	6	2	7	1	2	**1**	**25**	<=3.1667 & YTD <=38		
Preventable number of Clostridium Difficile Cases	5	0	1	1	0	0	2	1	1	1	2	0	0	**0**	**7**	No target		
Number of MSSA Bacteraemias - Post 48 Hours	16	1	0	2	2	0	2	4	1	3	1	2	1	**0**	**14**	No target		
Number of E.coli - Post 48 Hours	30	1	6	2	0	0	1	5	5	9	1	4	4	**6**	**35**	<=5.9167 & YTD <=71		
Number of P. Aeruginosa - Post 48 Hours		6		0	0	0	0	0	0	0	0	0	0	**0**	**0**	<=0.9167 & YTD <=11		
MRSA Elective Screening – Percentage of Inpatients Matched	70.66%	72.73%	68.69%	71.64%	71.18%	70.87%	82.46%	83.08%	82.33%	81.64%	79.16%	83.26%	81.29%	**82.99%**	**82.02%**	>=95%	94% - 93%	<=92%
Number of Klebsiella - Post 48 Hours		16		1	2	2	1	3	0	2	0	1	0	**0**	**7**	<=1.5834 & YTD <=19		
Mortality																		
Stillbirths Rate (including intrapartum & Other)	0.62%	0.48%	0.47%	0.00%	1.10%	**0.26%**	0.28%	0.87%	0.00%	0.55%	0.77%	0.29%	0.00%	**0.00%**	**38.00%**	<=0.47%		>=0.48%
Perinatal Deaths (0-7 days)	0.13%	0.00%	0.47%	0.30%	0.29%	0.26%	0.28%	0.00%	0.00%	0.00%	0.00%	0.00%	0.25%	**1.07%**	**0.21%**	<=0.1%		>=0.11%
Neonatal Deaths (8-28 days)	0.00%	0.00%	0.00%	0.30%	0.00%	0.00%	0.28%	0.00%	0.00%	0.28%	0.00%	0.00%	0.00%	**0.00%**	**0.07%**	<=0.1%		>=0.11%
Local SHMI - Relative Risk (1 Yr Rolling Data)	104.58	106.99	106.36	104.79	104.38	104.58	105.39	107.98	107.85	108.15					**108.15**	<=100	101 - 109	>=110
Hospital Standardised Mortality Rate (1 yr Rolling Data)	104.59	97.00	99.27	102.20	102.64	104.59	105.86	106.69	107.31	107.98	106.74				**106.74**	<=100	101 - 109	>=111
Crude Mortality Rate	1.58%	1.57%	1.81%	1.96%	1.73%	1.53%	1.76%	1.47%	1.45%	1.41%	1.57%	1.14%	1.47%	**1.35%**	**1.46%**	No target		
Coding and submissions to SUS																		
% Sign and Symptom as a Primary Diagnosis	7.77%	7.30%	7.19%	7.15%	7.44%	7.20%	6.68%	6.60%	6.35%	6.22%	7.71%	6.30%	6.33%	**7.33%**	**6.70%**	<=8.3%	8.4% - 9.4%	>=9.5%
Average co-morbidity score	5.83	5.76	6.09	6.05	5.97	6.11	6.33	6.15	6.01	6.21	6.33	6.29	6.22	**6.00**	**6.19**	>=5.08 / >=5.30 from April 20		<=4.7
Average Diagnosis per Coded Episode	6.9	6.8	6.95	7.29	7.22	7.29	7.59	7.55	7.28	7.31	7.52	7.38	7.48	**7.36**	**7.43**	>=6.14 / >=6.48 from April 20		<=5.8
Recruitment to Time and Target (Research)	81.63%	79.73%	79.22%	83.10%	83.56%	83.33%	80.30%	80.28%	81.82%	80.26%	80.30%	83.78%	84.28%	**83.82%**	**81.86%**	>=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%	57.45%	63.64%	60.00%	68.18%	64.62%	70.83%	60.78%	53.49%	81.08%	53.70%	60.78%	55.36%	**59.09%**	**61.08%**	>=85%	84% - 83%	<=82%
Breastfeeding - First Fed	68.70%	71.40%	70.60%	67.20%	68.30%	64.40%	63.30%	68.70%	65.00%	67.60%	68.20%	69.70%	64.20%	**in arrears**	**58.10%**	>=70%	66% - 69%	<=65%
Community																		
% Readmitted back in to Hospital within 30 days for Intermediate Care Beds	2.73%	1.60%	4.70%	2.00%	0.00%	2.30%	13.80%	2.90%	3.30%	6.30%	0.00%	5.90%	3.10%	**10.70%**	**5.60%**	No target		
Hospital admissions avoided by Community Nursing Services	2815	236	256	181	184	168	137	110	98	114	103	86	88	**83**	**819**	>=233 & YTD >=2757		

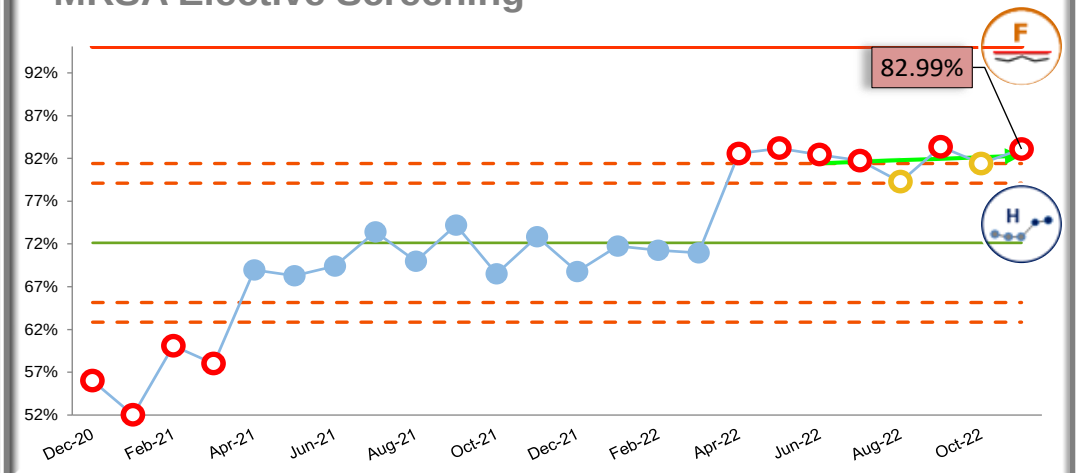
Effective - SPC Charts

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

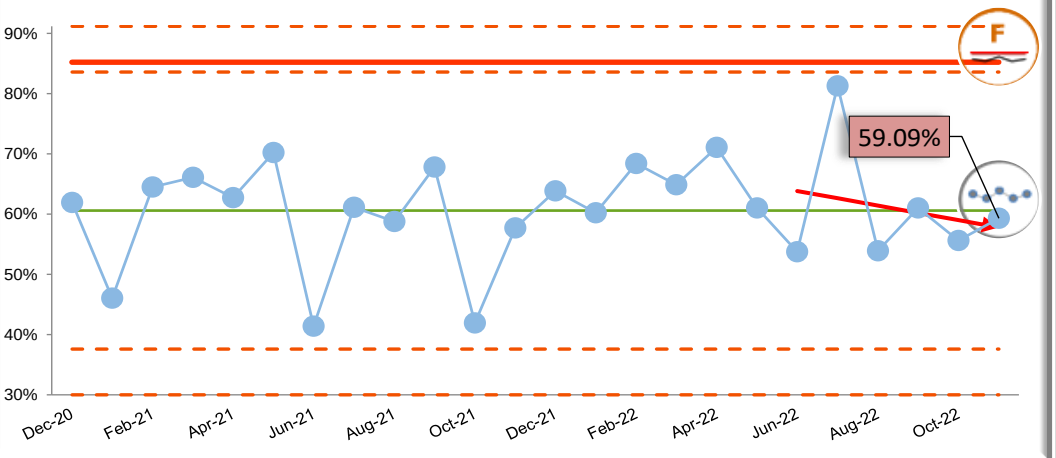
Preventable C-difficile



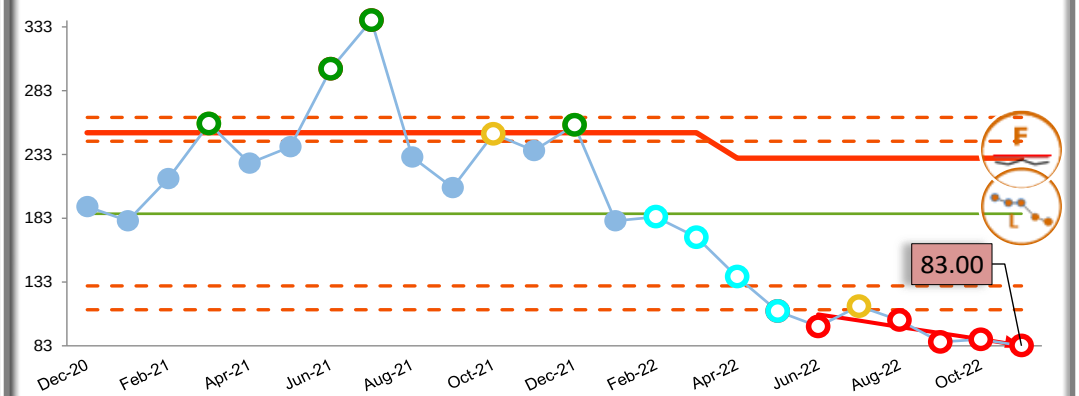
MRSA Elective Screening



FNoF< 36hrs BPT



Hospital Admissions avoided by Community Intervention



Effectiveness - Key messages

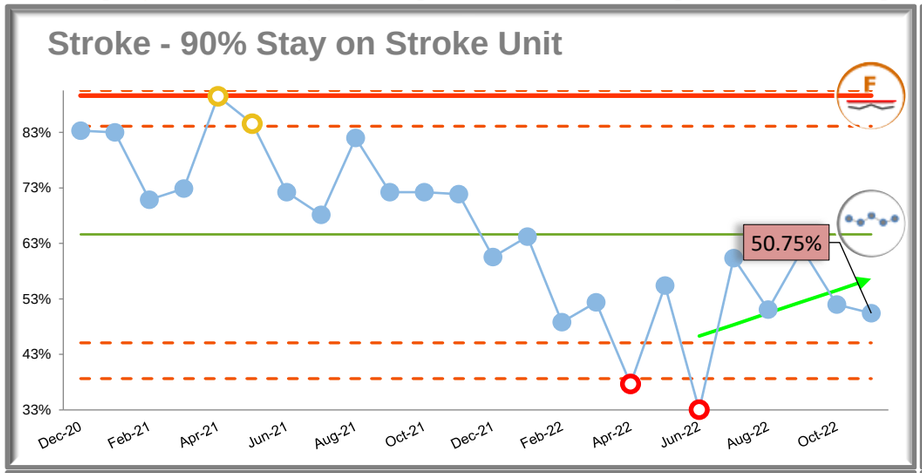
Area	Reality	Response	Result
Percentage Non-elective #NoF Patients With Admission to Procedure of < 36 Hours - BPT based on discharge	< 36 hour to theatre performance slightly better than October at 59.09%. YTD 61.08%	Continue to see month on month increases in number of #NOF's including surges. Additional Trauma 2 lists given and using capacity at CRH elective lists for any trauma that is suitable to increase capacity Monitoring of performance at Directorate PRM with Division/Directorate DMT & #NOF MDT to review and assess performance. Commenced Trauma Improvement Programme to look at ways to improve performance.	Consistently achieve target. Accountable: General Manager
Number of Hospital admissions avoided by Community Nursing services	83 hospital admissions were avoided as a result of intervention from Community nursing and Crisis intervention teams. 32 of these were due to interventions by Quest Matrons in care homes and 28 due to interventions by IMC/Crisis. 17 were due to interventions by the respiratory team.	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. Accountable: Director of Operations
MRSA Elective Screening – Percentage of Inpatients Matched	MRSA Elective Screening is 82.99% for November, this is below the 95% target but a slight increase from the 81.29% in	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 December data. Accountable: Infection Control Lead
Perinatal Deaths (0-7 days)	The Perinatal death rate for November is 1.07 % which is an increase in month from October which was 0.25% , this is above the threshold of 0.1%.	All stillbirths and perinatal deaths are reviewed at weekly governance meeting and a timeline completed and presented to orange panel for identification of any learning.	To see a reduction in the number of stillbirths and perinatal deaths each month. Where there is an increasing trend in the number to undertake a review for any trends and required actions. Accountable: Head of Midwifery
Breastfeeding - First Fed	The number of women breastfeeding at first feed was below target 70% in November 2022	It is not possible to address First Feed in isolation as it is recognised that improving skin to skin contact following birth is likely to increase the number of women offering a breast feed as a first feed. CHFT has been an accredited UNICEF Baby Friendly Hospital (BFI) since 2002. As such we are subjected as a minimum to triennial site visits by a team of external UNICEF assessors. In the interim it is a requirement to provide a written Audit Report of standards annually to UNICEF. The audit data includes Skin to Skin contact and First Feed. Following review of the BFI Audit data there appears to be a mismatch between the reported standard of care when mothers are interviewed face-to face and the data collected through the Trust Information Technology System. A thorough review to ensure the systems and processes for collecting this data are an accurate reflection of the care provided. Increase awareness of staff of the importance of correctly recording skin-to-skin contact and first feed. With particular attention on the process of recording in Maternity Recovery. Training of additional Breastfeeding Champions to encourage prompting of accurate documentation in the clinical areas. Repeat face-to-face interviews with mothers using the CQC questionnaire format. Provide an awareness campaign through the Better Births at Calderdale and Huddersfield Facebook page on the benefits of Skin-to -Skin Contact and offering a first breastfeed,.	Accountable: Head of Midwifery
Number of E.coli - Post 48 Hours	Total number of E.Coli post 48 hours has increased to 6.	There has been a HPV cleaning programme in place for wards 15, ward 20 and ward 5 as these are the hotspot areas in terms of infections over the last few months. This programme is now complete.	Accountable: Medical Director

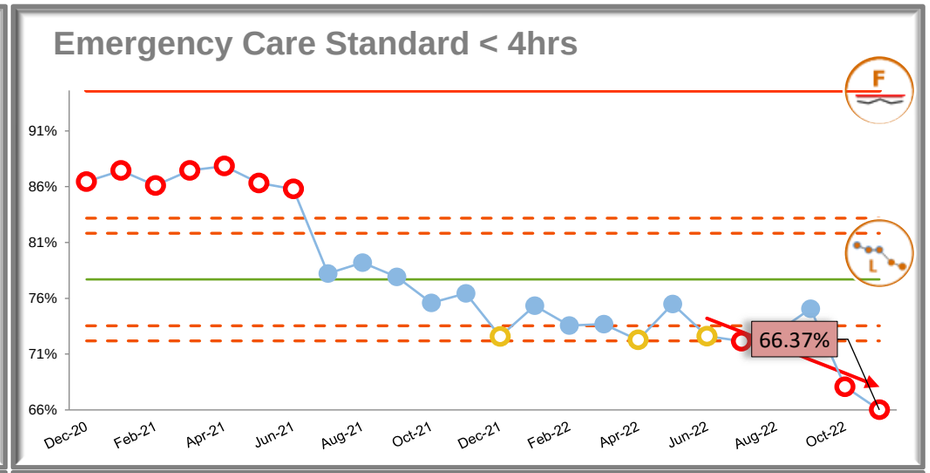
Responsive - Key measures

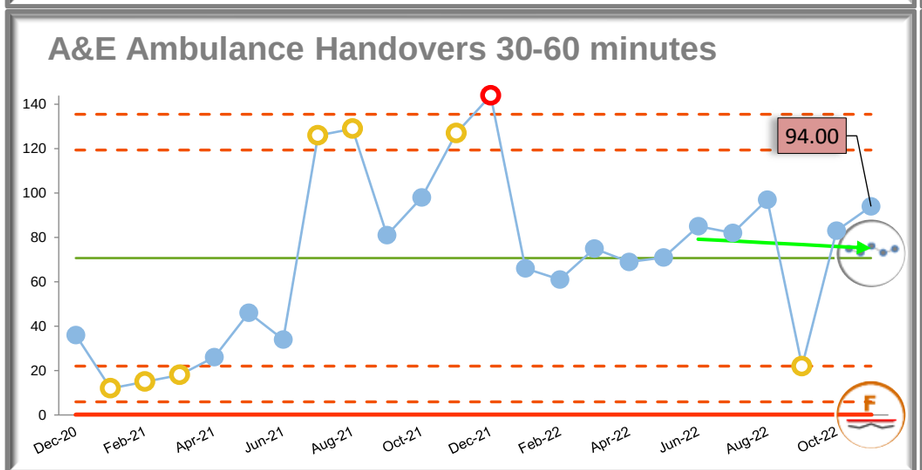
	21/22	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	YTD	Performance Range		
																Green	Amber	Red
Accident & Emergency																		
Emergency Care Standard 4 hours	78.99%	76.81%	72.95%	75.70%	73.92%	74.05%	72.64%	75.85%	72.97%	72.52%	73.27%	75.44%	68.44%	**66.37%**	**72.15%**	>=95%		<95%
Emergency Care Standard 4 hours inc Type 2 & Type 3	80.04%	78.15%	74.31%	76.83%	75.23%	75.42%	73.97%	77.08%	74.27%	73.93%	74.76%	76.84%	70.10%	**67.73%**	**73.56%**	>=95%		<95%
A&E Ambulance Handovers 15-30 mins (Validated)	6402	547	639	631	649	636	633	610	500	557	571	539	605	**663**	**4,678**	0		>=1
A&E Ambulance Handovers 30-60 mins (Validated)	1013	127	144	66	61	75	69	71	85	82	97	22	83	**94**	**603**	0		>=1
A&E Ambulance 60+ mins	430	44	79	52	27	17	26	15	30	27	32	11	18	**16**	**175**	0		>=1
A&E Trolley Waits (From decision to admission)	11	0	2	4	1	1	0	1	2	2	0	2	3	**2**	**12**	0		>=1
Proportion of patients spending more than 12 hours in an emergency department	1766	194	358	313	221	248	217	175	309	317	304	196	441	**474**	**2,433**	0		>=1
Patient Flow																		
Right to Reside	55.19%	55.88%	55.12%	56.11%	56.11%	62.27%	64.46%	67.18%	67.35%	65.63%	65.41%	64.37%	66.44%	**66.66%**	**65.85%**	No target		
Coronary Care Delayed Discharges	248	24	19	25	34	34	31	45	27	30	44	17	25	**41**	**260**	No target		
Green Cross Patients (Snapshot at month end)	845	81	53	79	54	87	78	64	69	86	80	73	95	**63**	**63**	<=40	41 - 45	>=45
Advice & Guidance responded within 48 hours	77.60%	75.40%	77.00%	76.50%	75.90%	74.30%	71.90%	71.80%	75.00%	70.40%	71.50%	74.40%	72.20%	**70.50%**	**72.10%**	>=80%	71% - 79%	<=70%
Stroke																		
% Stroke patients spending 90% of their stay on a stroke unit	69.87%	72.22%	60.87%	64.58%	49.15%	52.73%	38.00%	55.74%	33.33%	60.70%	51.39%	62.30%	52.31%	**50.75%**	**50.49%**	>=90%	89% - 86%	<=85%
% Stroke patients admitted directly to an acute stroke unit within 4 hours of hospital arrival	36.71%	33.33%	23.19%	16.67%	15.79%	25.45%	25.53%	28.81%	13.33%	24.60%	19.18%	33.30%	26.15%	**31.30%**	**24.95%**	>=90%		<=85%
% Stroke patients Thrombolysed within 1 hour	74.19%	100.00%	80.00%	80.00%	63.64%	83.33%	45.50%	70.00%	50.00%	42.90%	60.00%	80.00%	83.33%	**88.89%**	**66.18%**	>=55%		<=50%
% Stroke patients scanned within 1 hour of hospital arrival	44.67%	41.67%	42.25%	38.78%	44.07%	34.55%	52.00%	44.26%	37.33%	51.60%	36.99%	47.50%	47.69%	**39.13%**	**43.99%**	>=48%		<=45%
Cancellations																		
% Last Minute Cancellations to Elective Surgery	0.49%	0.84%	0.91%	0.56%	0.34%	0.54%	0.32%	0.80%	0.58%	1.00%	0.67%	0.43%	0.71%	**0.60%**	**0.64%**	<=0.6%		>=0.8%
Breach of Patient Charter (Sitreps booked within 28 days of cancellation)	8	1	2	4	0	0	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	11,189	11,480	10,485	8,853	9,383	9,928	9,549	8,714	8,171	8,211	7,889	7,726	**6,923**	**6,923**	0		>=1
RTT Waits over 52 weeks Threshold > zero	2,454	3062	3103	2667	2609	2454	2,503	2,326	2,052	1,957	1,920	1,782	1,783	**1,295**	**1,295**	0		>=1
% Diagnostic Waiting List Within 6 Weeks	80.78%	92.82%	81.59%	76.76%	79.46%	80.78%	79.30%	82.09%	85.80%	90.09%	88.41%	93.45%	95.82%	**96.87%**	**96.87%**	>=99%		<=98%
Cancer																		
Two Week Wait From Referral to Date First Seen	98.38%	99.21%	97.96%	98.39%	98.35%	97.56%	97.75%	98.46%	98.03%	97.76%	97.79%	96.20%	96.74%	**98.22%**	**97.62%**	>=93%	86% - 92%	<=85%
Two Week Wait From Referral to Date First Seen: Breast Symptoms	97.53%	96.84%	96.00%	93.84%	97.25%	93.50%	96.92%	96.27%	98.20%	97.83%	100.00%	100.00%	98.56%	**99.32%**	**98.42%**	>=93%		<=92%
31 Days From Diagnosis to First Treatment	98.21%	99.02%	99.37%	98.35%	99.39%	98.31%	97.56%	98.86%	99.00%	99.45%	97.84%	98.90%	99.01%	**98.53%**	**98.64%**	>=96%		<=95%
31 Day Subsequent Surgery Treatment	95.43%	92.59%	100.00%	93.33%	96.55%	94.44%	96.00%	100.00%	100.00%	100.00%	96.97%	97.44%	97.22%	**90.32%**	**97.45%**	>=94%		<=93%
31 day wait for second or subsequent treatment drug treatments	99.51%	100.00%	100.00%	95.45%	98.63%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	98.75%	98.85%	**98.98%**	**99.50%**	>=98%		<=97%
38 Day Referral to Tertiary	50.00%	50.00%	37.93%	35.00%	66.67%	30.77%	55.17%	64.71%	40.74%	35.00%	24.00%	38.46%	56.52%	**33.33%**	**43.60%**	>=85%		<=84%
62 Day GP Referral to Treatment	90.62%	93.43%	87.32%	89.59%	86.82%	89.71%	91.46%	87.70%	90.69%	85.32%	85.43%	85.96%	90.53%	**92.37%**	**88.68%**	>=85%	81% - 84%	<=80%
62 Day Referral From Screening to Treatment	59.47%	76.19%	81.25%	62.50%	50.00%	96.30%	92.59%	73.68%	70.37%	87.88%	88.24%	88.89%	70.37%	**78.57%**	**81.69%**	>=90%		<=89%
104 Referral to Treatment - Number of breaches - Patients Treated	23	1.5	1	1.5	4	6.5	0.5	3	3.5	5.5	2.5	3.5	1.5	**2.5**	**22.5**	0		>=1
104 Referral to Treatment - Number of breaches - Patients Still waiting	9	2	5	9	7	2	3	9	10	6	9	9	8	**7**	**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%	78.16%	76.82%	76.50%	83.12%	79.54%	77.76%	76.91%	74.06%	75.88%	73.65%	77.44%	78.17%	**76.85%**	**76.29%**	>=75%		<=70%

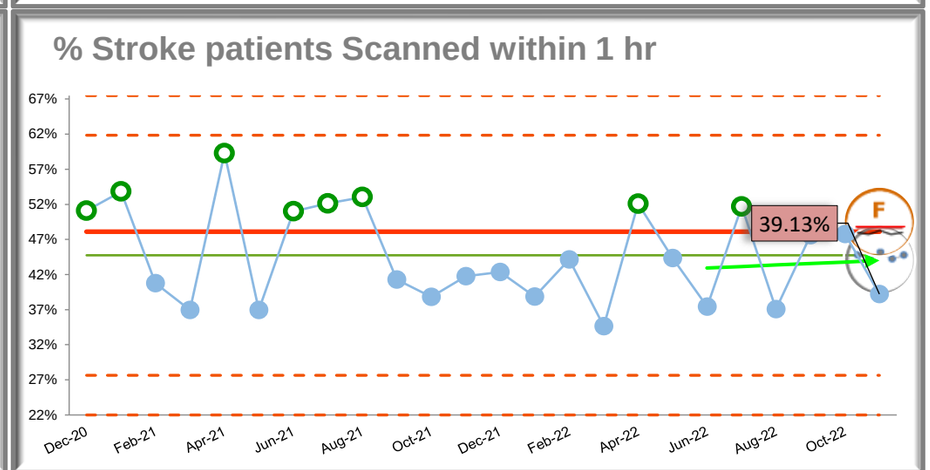
Responsive - SPC Charts

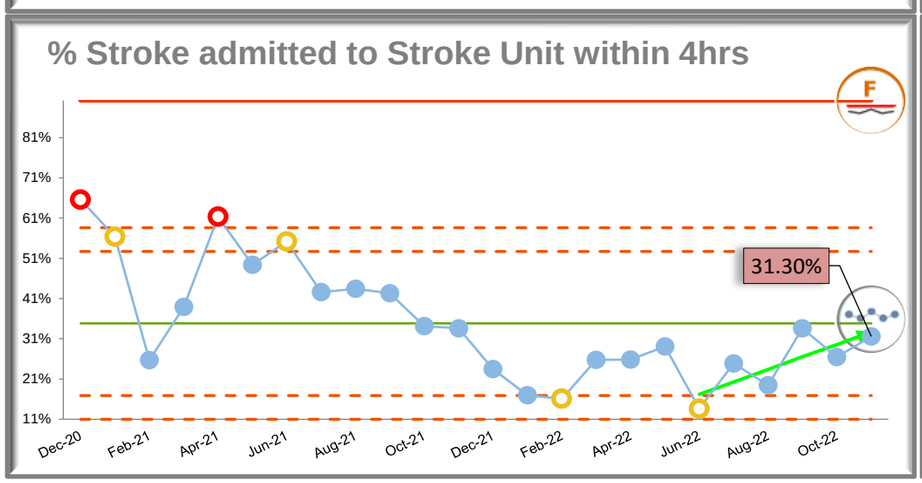
Warning | Critical | Activity | On Target | Trend | Target Line | Average Line | Control Line | Last 6 Points Directional Flow | RAG Rated Last Data Point

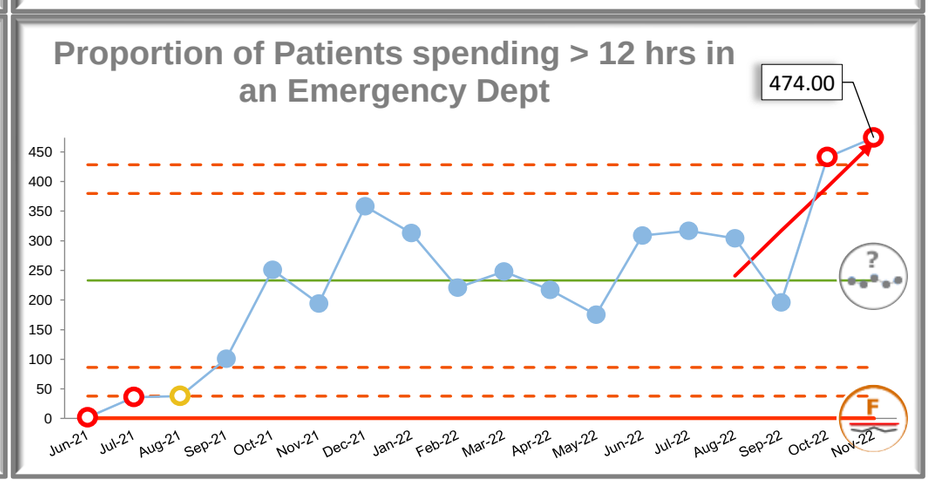






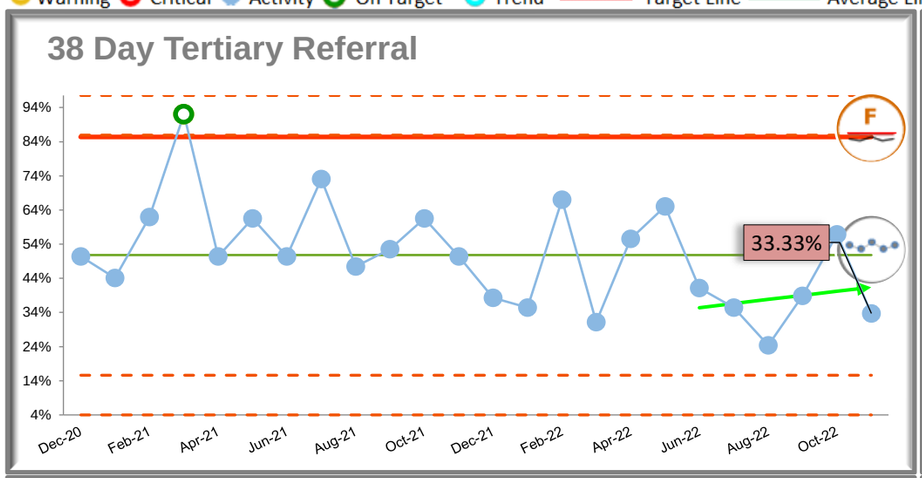


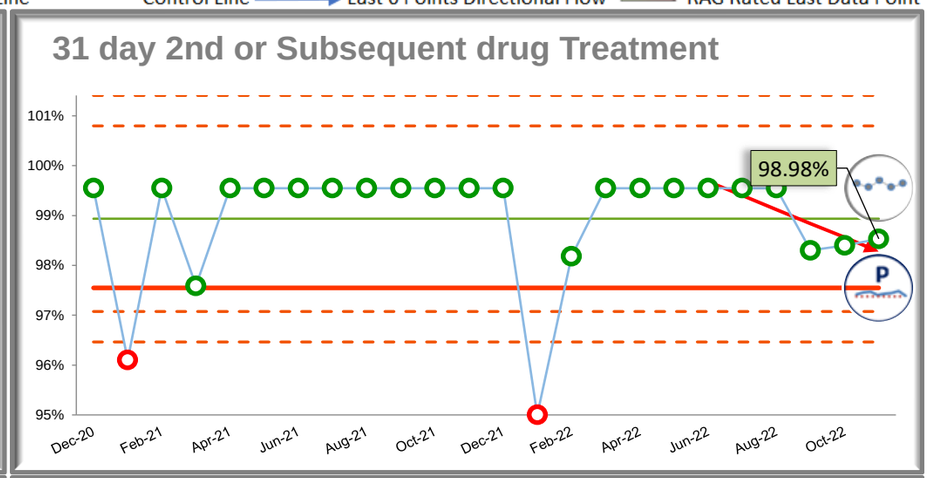


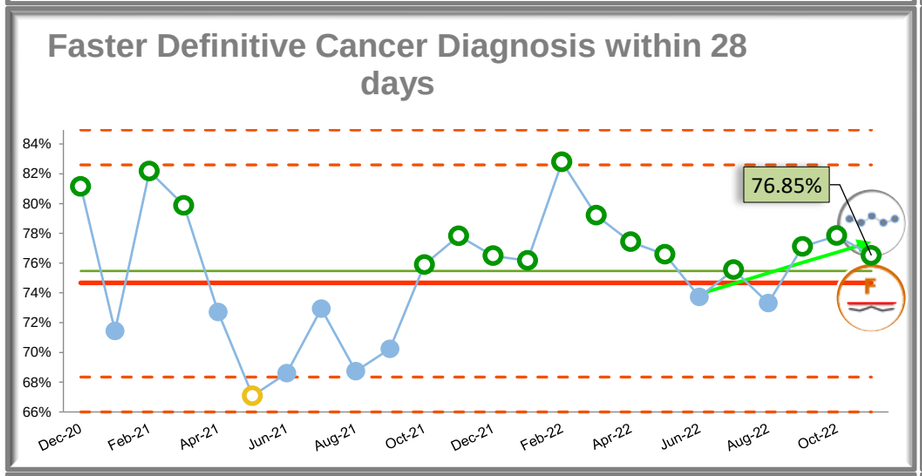


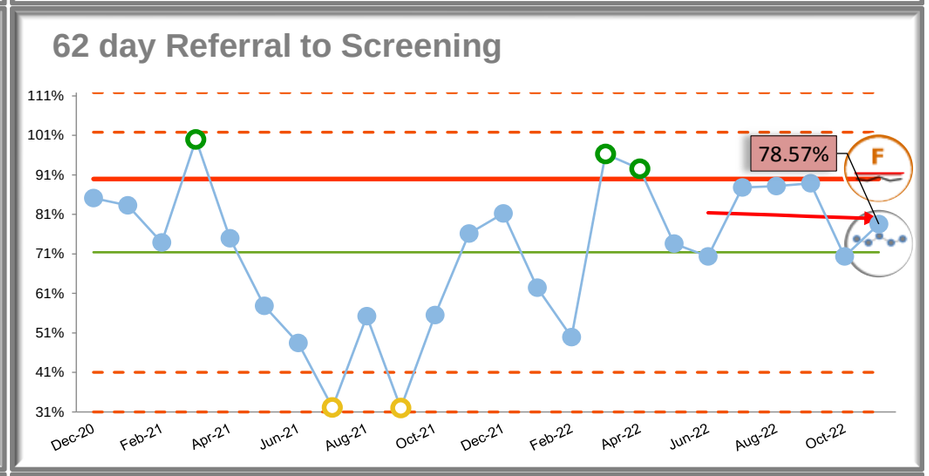
Responsive - SPC Charts

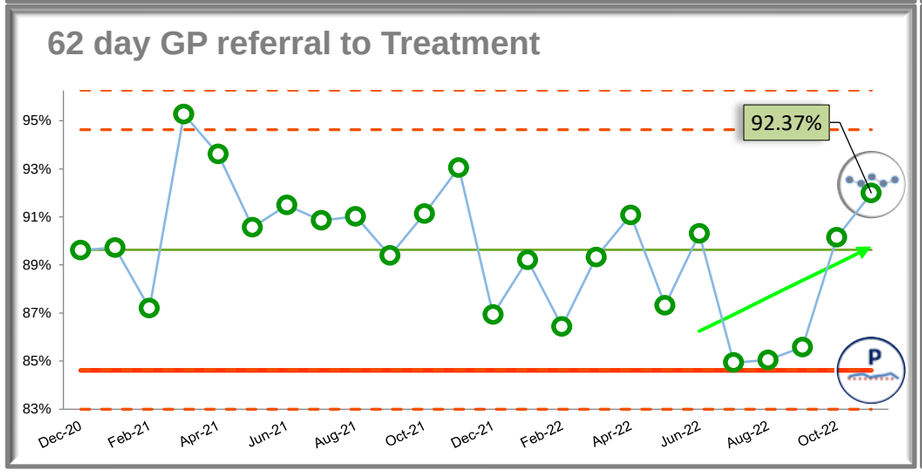
Warning | Critical | Activity | On Target | Trend | Target Line | Average Line | Control Line | Last 6 Points Directional Flow | RAG Rated Last Data Point

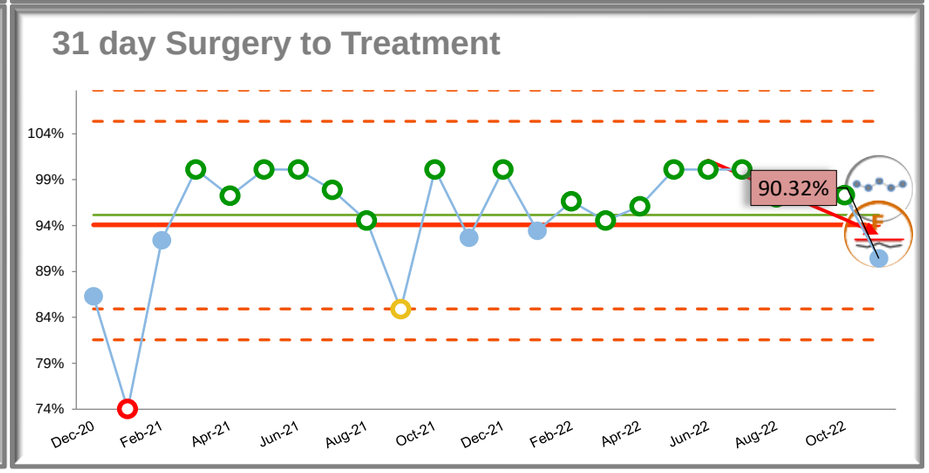












Responsive - Key messages

Area	Reality	Response	Result
Emergency Care Standard 4 hours	ECS - <4 hours performance - 66.37% in month which is a decrease from 68.44% in October. A&E Ambulance Handovers 30-60 mins - 94 in month which is an increase from 83 in October. A&E Ambulance Handovers over 60 mins - 16 in month compared to 18 in October. A&E Trolley Waits (from decision to admit) - 2 in month compared to 3 in October.	We continue to see very high demand through both emergency departments with some exceptionally busy days. Flow into the community has remained challenging causing a lack of flow out of the emergency departments. The medical bed base has escalated into a "super surge" position. Specifically in relation to ambulance handovers, there are surge SOPs in place for each site which tie into the department surge and review. YAS have also done a walk around and identified areas on each site that they would use in escalation where they would send a member of staff to care for 3 patients, releasing the crews.	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 decreased in month to 50.7% from 52.3% 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 31.3% in month compared to 19.18% in October. This remains below the 90% target. % Stroke patients Thrombolysed within 1 hour was 88.9% in month which is an improvement from 80% in October. This is above the 55% target. % Stroke patients scanned within 1 hour of hospital arrival decreased in month to 39.1% from 47.7% previous month. YTD we remain at 44% which remains very slightly below the 48% target.	There continued to be significant pressures on the service during November with performance extremely challenged. There continued to be an increased number of outliers however to manage this ward 7a has been opened to a capacity of 10 beds to ensure outliers are now in a stroke bed base. It is expected that the admission within 4 hours and percentage stay in a stroke bed will improve as a result in December. This has also supported the wider bed base with recent pressures. We are continuing to see increased demand through ED with monthly admissions increasing year on year and a comparison of April- August 2022 to the same time period in 2019 there has been a **27% increase** in the number of stroke patients presenting at ED and a **13% increase** of compared to 2021. The service is also facing medical recruitment challenges with 2 consultants due to leave in January. To date despite utilisation of specialist recruitment agencies and regular recruitment drives these have not delivered a sustainable solution. A high-cost agency doctor has been recruited but the risk remains in January that we are 1 consultant below the required establishment. The key action is now to review the overall stroke business case as the financial requirement of £2.7m to redesign both the inpatient service and the community offering. To note this is not affordable and workforce requirements are to be amended.	Sustainable recovery of SSNAP A standard for Stroke services. Accountable: Divisional Director Medicine

Responsive - Key messages

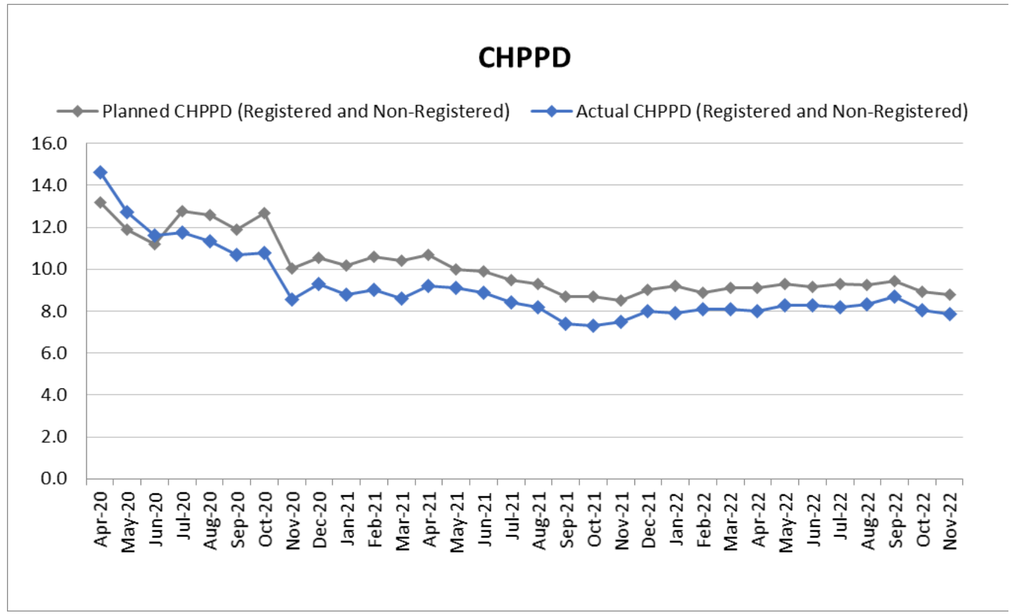
Area	Reality	Response	Result
38 Day Referral to Tertiary	Clinic capacity running near day 14 then impacts on the ability of receiving timely diagnostics. Currently taking up to 3 weeks with reports. Therefore, patients can already be on day 35 before MDT.	Diagnostics at the beginning of the pathway is being reviewed to see if any patients can be referred straight to test. Diagnostics as with 62 days diagnostics has an impact on 38 days. Continue with weekly monitoring of high risk pathways, ensuring robust process of escalation are in place. Fast track pathway work under way (funding gained from alliance to triage all fast tracks). The new triage process is supporting the 38 day target and we continues to man mark all patients who are requiring to be managed at Tertiary centre.	All patients sent to Tertiary centre by day 38 Accountable: General Manager
104 Day Referral to Treatment	Delays remains due to:- Covid Diagnosis delays with complex pathways Capacity issues Endoscopy Preparations Complications due to co-morbidities	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. Communication with patients to see if they realise why they have been referred and if they wish to undergo the necessary diagnostics tests. Pathways will be reviewed from Datix at MDTs and recommendation for learning will be agreed and discussed at CDG	Reduce number of patients waiting 104 days and achieve the 104 for patients. 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
31 Day Subsequent Surgery Treatment	The current compliance for November is 90.32%, with YTD at 97.45% Delays due to theatre capacity issues.	Review capacity for patients within the scope of all surgical targets.	Meet the 31 day target Accountable: General Manager
Advice & Guidance responded within 48 hours	The current compliance for November is 70.5%, with the Trust target of 80%.	Significant gaps in the rota due to leave and sickness so there has been a reliance on locums. Continue to monitor Consultants on Hot weeks' completion of A&G and chase where required. Allocate and ensure ownership of A&G to locum consultants ensuring all users have no Smartcard /access issues .	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)

	Sep-22	Oct-22	Nov-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)	9.4	8.9	8.8
ACTUAL CHPPD (REGISTERED & NON REGISTERED CLINICAL STAFF)	8.7	8.0	7.9

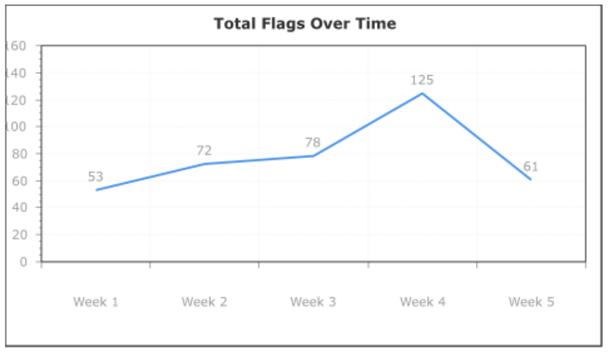


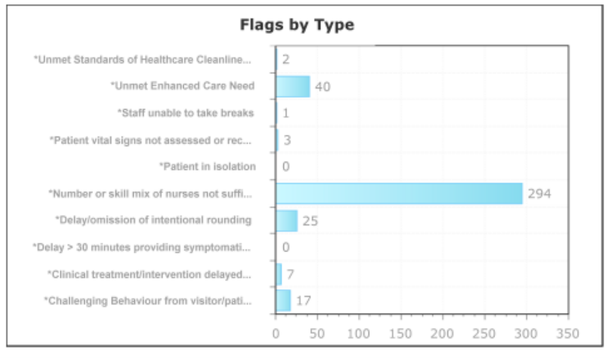
CHPPD provides a single, consistent and nationally comparable way of recording and reporting deployment of staff to provide care on inpatient wards. CHPPD is not a stand alone measure and should be used alongside clinical quality and safety outcome measures.

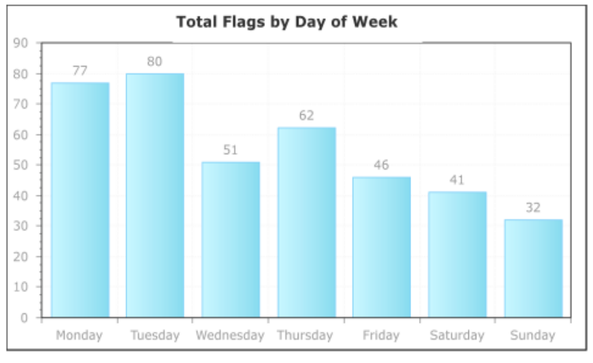
A review of November 2022 data indicates that the combined RN and non-registered clinical staff metrics resulted in 23 of the 28 clinical areas having fewer CHPPD than planned, with a total deficit of 0.9 CHPPD across the Trust. Despite consistency in shift fill rates, the requirement to move staff to cover additional capacity areas means the 'base area' resulted in reduced CHPPD.
The CHPPD planned vs actual gap is most prominent in the Surgical division (2.1 CHPPD deficit). This is largely attributable to the staffing in ICU which planned a rich model due to the temporary move to ward 10 as a result of the refurbishment of the existing unit. The 'Actual' levels represent the staffing required to care for the patients each shift according to professional judgement and GPICS ratios. In reality, these staff were able to assist with patient care on surgical ward 10 when ICU patient numbers were low.

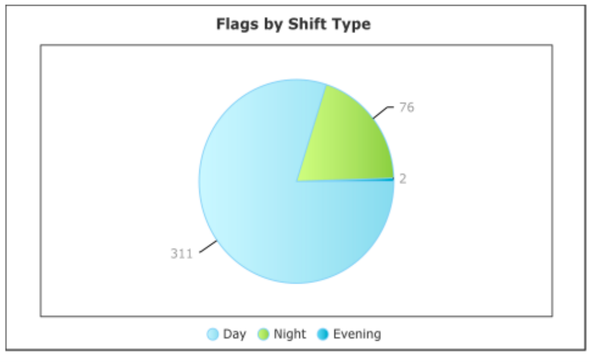
The apparent overstaffing in some wards for HCSW reflect the high number of patients requiring 1:1 care which is not 'planned' in the rosters.
A review of the nurse sensitive indicators demonstrates incidence of falls and pressure ulcers to be within normal variation.

STAFFING RED FLAG INCIDENTS









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

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

Hard Truths: Safe Staffing Levels (2)

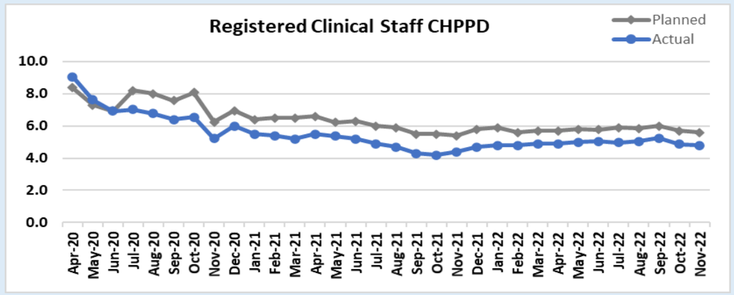
	Aggregate Position	Trend	Result

CHPPD BY STAFF TYPE

Registered Clinical Staff

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

CHPPD was 5.6 for planned and 4.8 For actual for Registered Clinical Staff

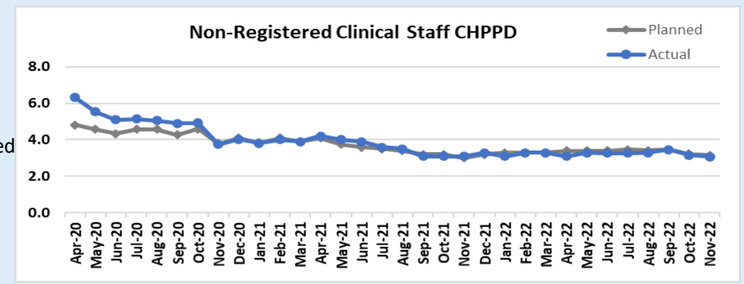


Overall there is a shortfall of 0.8 CHPPD against an overall requirement of 5.6 CHPPD for registered staff. Professional judgement informs decision-making at the twice daily staffing meetings to mitigate the risk across the clinical areas, and staff are redeployed to optimise safety. A suite of nurse 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. Both falls and pressure ulcer prevalence remain within normal variation in month.

Non-Registered Clinical Staff

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

CHPPD was 3.2 for planned and 3.1 for actual for Non-Registered Clinical Staff



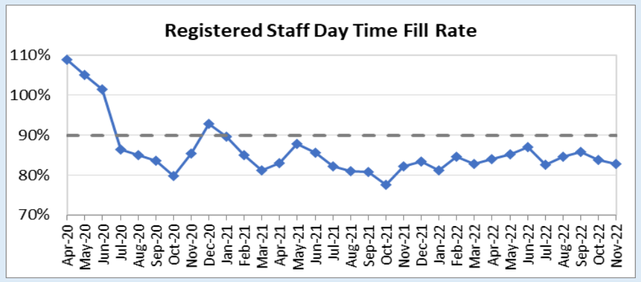
There was a shortfall in the planned CHPPD provided by non-registered clinical staff of 0.1CHPPD
Nightshift fill is prioritised over day shift due the increased vulnerability of patients and having fewer health professionals on the wards and the need to mitigate against reduced RN availability.

FILL RATES BY STAFF AND SHIFT TYPE

Registered Clinical Staff Day

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

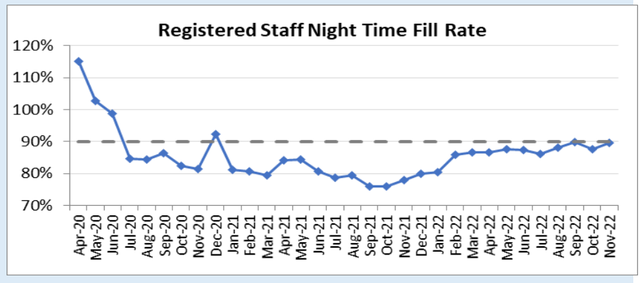
82.76% of expected Registered Clinical Staff hours were achieved for day shifts.



Registered Staff Night

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

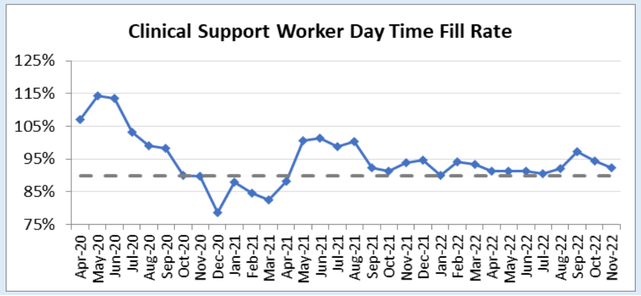
89.48% of expected Registered Clinical Staff hours were achieved for night shifts.



Non-Registered Clinical Staff Day

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

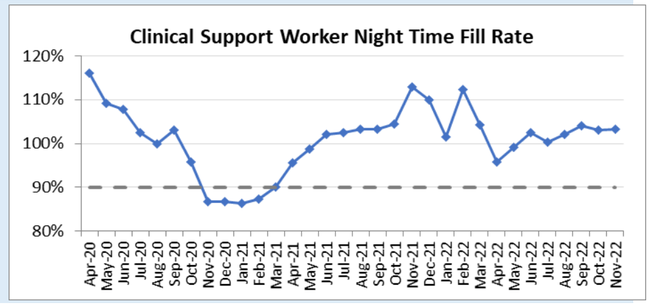
92.47% of expected Non-Registered Clinical Staff hours were achieved for Day shifts.



Non Registered Clinical Staff Night

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

103.34% of expected Non-Registered Clinical Staff hours were achieved for night shifts.



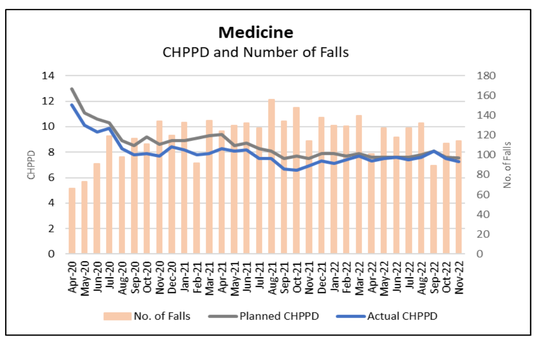
Safe | Caring | Effective | Responsive | Workforce | Efficiency/Finance | Activity | CQUIN

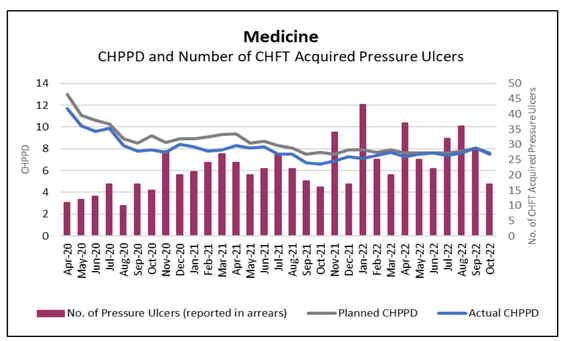
Hard Truths: Safe Staffing Levels (3)

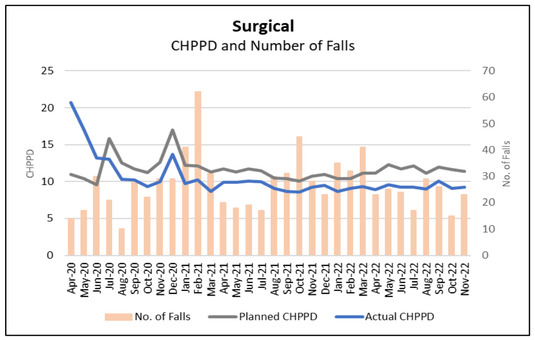
NURSING QUALITY INDICATORS AND FILLRATES BY WARD AND DIVISION

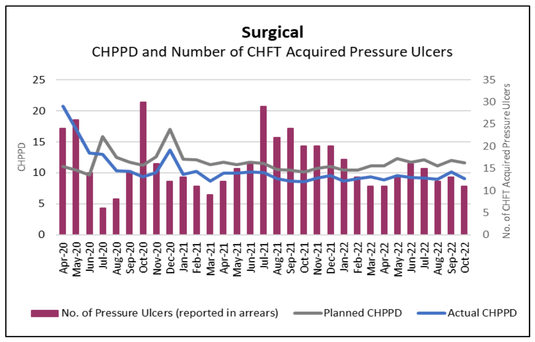
Ward	Average Fill Rates: DAY - Registered Clinical Staff (%)	DAY - Non Registered Clinical Staff (%)	NIGHT - Registered Clinical Staff (%)	NIGHT - Non Registered Clinical Staff (%)	CHPPD: Total PLANNED CHPPD	Total ACTUAL CHPPD
CRH ACUTE FLOOR	112.6%	116.0%	129.7%	127.1%	6.3	7.6
HRI ACUTE FLOOR	90.9%	91.3%	103.1%	96.8%	8.3	7.9
RESPIRATORY FLOOR	66.2%	83.9%	85.4%	88.6%	9.1	7.1
WARD 5	86.9%	119.0%	100.8%	135.5%	6.7	7.3
WARD 6	77.8%	68.0%	98.1%	116.1%	4.0	3.4
WARD 6C	83.9%	94.0%	103.5%	116.6%	12.7	12.4
WARD 6AB	83.9%	94.0%	103.5%	116.6%	6.4	6.2
WARD CCU	78.8%	72.0%	89.1%		8.3	7.1
STROKE FLOOR (INC AHP)	111.0%	110.9%	95.3%	99.0%	7.6	7.9
STROKE FLOOR (EXC AHP)	94.8%	98.5%	95.3%	99.0%	7.6	7.3
WARD 12	94.4%	74.5%	100.0%	95.0%	7.2	6.4
WARD 15	81.5%	119.8%	96.0%	110.0%	7.1	7.2
WARD 17	77.3%	88.7%	95.2%	110.0%	7.0	6.2
WARD 18	66.6%	107.5%	76.7%	168.3%	9.7	9.3
WARD 20	77.4%	100.3%	96.1%	101.0%	7.2	6.7
Medicine	**84.82%**	**98.16%**	**98.60%**	**110.54%**	**7.5**	**7.3**
WARD 21	83.9%	83.3%	95.9%	92.7%	7.7	6.8
WARD 22	90.4%	109.7%	92.6%	129.2%	6.9	7.0
ICU	72.2%	43.0%	69.9%	54.2%	95.7	63.6
WARD 8A	79.6%	66.9%	68.5%	89.4%	13.5	10.0
WARD 8C	100.5%	76.1%	99.9%	96.7%	7.7	7.2
WARD 10	74.8%	87.2%	81.5%	92.4%	9.2	7.6
WARD 14	51.3%	63.6%	60.1%	74.0%	14.0	8.5
WARD 19	85.6%	98.1%	98.7%	119.9%	7.5	7.4
SAU HRI	97.7%	92.6%	99.2%	98.8%	7.5	7.3
Surgical	**79.0%**	**79.0%**	**81.0%**	**92.8%**	**11.4**	**9.3**
WARD LDRP	75.7%	85.0%	75.1%	94.0%	21.2	16.4
WARD NICU	102.3%	77.4%	104.0%	84.2%	11.5	11.5
WARD 3ABCD	74.1%	94.5%	75.5%	108.9%	9.8	7.7
WARD 4ABC	88.0%	92.0%	83.1%	93.3%	5.5	4.8
Ward 1D	97.7%	75.0%	100.4%	71.8%	14.1	12.8
FSS	**82.7%**	**88.2%**	**81.6%**	**96.2%**	**10.3**	**8.7**
TRUST	**82.76%**	**92.47%**	**89.48%**	**103.34%**	**8.8**	**7.9**

Nursing Quality Indicators









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

Hard Truths: Safe Staffing Levels (4)

Conclusions and Recommendations

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. Future 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 73 recruits of the planned 100 resident in the UK to the end of November. The remaining 27 are in pipeline. Further funding has been secured to recruit an additional 20 International Nurses between January and March 2023. CHFT were also 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

	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	YTD	Target	Threshold/Monthly
Staff in Post																
Staff in Post Headcount	6127	6127	6164	6146	6170	6109	6109	6101	6094	6087	6129	6193	6209	-	-	
Staff in Post (FTE)	5441.13	5437.83	5471.83	5451.37	5473.01	5411.91	5404.28	5399.06	5397.81	5368.15	5435.91	5493.14	5507.52	-	-	
Vacancies																
Establishment (Position FTE)**	5556.86	5556.33	5554.69	5582.19	5588.27	-	5814.35	5835.60	5837.38	5840.51	5855.60	5944.40	5969.73	-	-	
Vacancies (FTE)**	115.73	118.50	82.86	130.82	115.26	-	410.07	436.54	439.57	472.36	419.69	451.26	462.21	-	-	*April data has not been included due to issues with the Establishment which have been corrected for May 2022
Vacancy Rate (%)**	2.08%	2.13%	1.49%	2.34%	2.06%	-	7.05%	7.48%	7.53%	8.09%	7.17%	7.59%	7.74%	-	-	
Staff Movements																
Turnover rate (%) - in month	0.62%	0.68%	0.50%	0.49%	1.21%	0.63%	0.80%	0.77%	0.72%	0.85%	0.89%	0.34%	0.53%	-	-	
Executive Turnover (%)	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	33.33%	0.00%	-	-	
Turnover rate (%) - Rolling 12m	7.91%	7.94%	7.83%	7.90%	8.28%	8.59%	8.52%	8.71%	8.63%	8.93%	9.23%	8.95%	8.86%	-	**11.50%**	<=11.5% Green, <=12.5 >11.5% amber, >12.5% Red
Retention/Stability Rate (%) - rolling 12m	89.14%	88.94%	88.77%	87.85%	88.44%	87.17%	87.46%	87.26%	87.25%	87.02%	86.75%	86.82%	86.66%	-	-	
Sickness Absence - Rolling 12 month																
Sickness Absence rate (%) - rolling	5.01%	5.12%	5.43%	5.45%	5.77%	5.96%	6.00%	6.01%	6.06%	6.03%	5.98%	5.97%	5.99%	-	4.00%	=< 4.0% - Green 4.01% -4.5% Amber >4.5% Red
- Of which Covid related absence	0.52%	0.54%	0.77%	0.82%	0.94%	1.06%	1.09%	1.13%	1.23%	1.26%	1.26%	1.26%	1.27%	-	-	
- Of which Non Covid related absence	4.49%	4.58%	4.66%	4.63%	4.83%	4.90%	4.91%	4.88%	4.82%	4.77%	4.73%	4.71%	4.73%	-	**4.75%**	=< 4.75% Green, >4.75% - <5.25% Amber, =>5.25% Red
Long Term Sickness Absence rate (%) - rolling	3.38%	3.38%	3.40%	3.42%	3.46%	3.50%	3.49%	3.45%	3.39%	3.34%	3.30%	3.29%	3.30%	-	2.50%	=< 2.5% Green 2.5% -2.75% Amber >2.75% Red
- Of which Covid related absence	0.28%	0.26%	0.25%	0.25%	0.25%	0.26%	0.26%	0.26%	0.25%	0.25%	0.24%	0.23%	0.23%	-	-	
- Of which Non Covid related absence	3.10%	3.12%	3.15%	3.17%	3.21%	3.24%	3.23%	3.20%	3.15%	3.10%	3.06%	3.06%	3.08%	-	**3.00%**	=< 3.00% Green, >3.00% - <3.25% Amber, =>3.25% Red
Short Term Sickness Absence rate (%) - rolling	1.63%	1.74%	2.04%	2.14%	2.31%	2.46%	2.51%	2.56%	2.66%	2.69%	2.68%	2.68%	2.69%	-	1.50%	=< 1.5% - Green 1.5% -1.75% Amber >1.75% Red
- Of which Covid related absence	0.24%	0.28%	0.52%	0.57%	0.69%	0.80%	0.83%	0.87%	0.99%	1.01%	1.02%	1.03%	1.04%	-	-	
- Of which Non Covid related absence	1.39%	1.46%	1.52%	1.57%	1.62%	1.66%	1.68%	1.69%	1.68%	1.67%	1.66%	1.65%	1.65%	-	**1.75%**	=< 1.75% Green, >1.75% - <2.00% Amber, =>2.00% Red
Attendance rate (%) - rolling	94.99%	94.88%	94.57%	94.55%	94.23%	94.04%	95.09%	93.99%	93.94%	93.97%	94.02%	94.03%	94.01%	-	**96.00%**	
Sickness Absence - Monthly																
Sickness Absence rate (%) - in month	5.54%	6.35%	8.74%	6.08%	6.35%	6.36%	4.90%	5.14%	6.06%	5.30%	5.21%	5.70%	5.69%	-	-	
- Of which Covid related absence	0.45%	1.05%	3.66%	1.32%	1.65%	1.71%	0.62%	0.82%	1.69%	0.82%	0.51%	0.81%	0.50%	-	-	
- Of which Non Covid related absence	5.09%	5.30%	5.08%	4.76%	4.70%	4.66%	4.28%	4.32%	4.37%	4.49%	4.70%	4.89%	5.19%	-	-	
Long Term Sickness Absence rate (%) - in month	3.35%	3.59%	3.58%	3.38%	3.23%	3.25%	3.13%	3.08%	3.02%	3.33%	3.29%	3.27%	3.47%	-	-	
- Of which Covid related absence	0.24%	0.25%	0.38%	0.33%	0.27%	0.31%	0.28%	0.19%	0.15%	0.17%	0.13%	0.16%	1.90%	-	-	
- Of which Non Covid related absence	3.11%	3.34%	3.20%	3.05%	2.96%	2.93%	2.85%	2.90%	2.87%	3.06%	3.16%	3.11%	3.28%	-	-	
Short Term Sickness Absence rate (%) - in month	2.19%	2.76%	5.16%	2.70%	3.12%	3.12%	1.77%	2.06%	3.04%	1.97%	1.92%	2.43%	2.22%	-	-	
- Of which Covid related absence	0.21%	0.80%	3.28%	1.00%	1.37%	1.39%	0.34%	0.63%	1.54%	0.65%	0.38%	0.65%	0.31%	-	-	
- Of which Non Covid related absence	1.98%	1.96%	1.88%	1.70%	1.75%	1.73%	1.43%	1.43%	1.50%	1.32%	1.54%	1.78%	1.91%	-	-	
Attendance rate (%) - in-month	94.46%	93.65%	91.26%	93.92%	93.65%	93.64%	95.10%	94.86%	93.94%	94.70%	94.79%	94.30%	64.3%	-	**96.00%**	
Attendance Management																
Sickness Absence FTE Days Lost -in month	8956.75	10627.70	14727.34	9276.14	10745.12	10297.59	8185.08	8303.94	10112.80	8881.89	8881.89	9670.16	9397.84	-	-	
Average days lost (FTE) per FTE - Rolling 12 month	17.92	18.36	19.51	19.96	20.75	21.51	21.69	21.78	21.96	21.88	21.85	21.85	21.90	-	-	
Sickness Absence Estimated Cost (£) - month	£0.92M	£0.85M	£0.99M	£0.87M	£0.89M	£1.00M	£0.74M	£0.76M	£0.94M	£0.83M	£0.79M	£0.96M	£0.94M	-	-	
Health & Wellbeing Risk Assessment																
Percentage completion	52.70%	52.94%	53.18%	47.37%	47.37%	48.53%	48.80%	49.23%	49.23%	49.23%	51.17%	47.99%	48.28%			
Spend																
Substantive Spend (£)	£22.40M	£21.61M	£22.61M	£22.53M	£34.68M	£22.97M	£23.15M	£24.43M	£22.85M	£22.41M	£26.14M	£23.37M	£23.79M	-	-	*Increase in Sept due to pay award
Bank Spend (£)	£3.44M	£3.37M	£3.89M	£3.42M	£5.71M	£2.34M	£2.54M	£1.18M	£2.41M	£3.26M	£3.77M	£3.02M	£2.61M	-	-	
Agency Spend (£)	£0.73M	£0.66M	£0.84M	£0.91M	£0.95M	£0.87M	£0.92M	£1.04M	£1.12M	£1.16M	£1.20M	£1.28M	£1.33M	-	-	
Agency Ceiling (£)	£0.74M	£0.74M	£0.74M	£0.74M	£0.74M	£0.50M	£0.50M	£0.51M	£0.48M	£0.53M	£0.49M	£0.64M	£0.66M	-	-	
Variance from Ceiling (£)	£0.00M	£0.07M	-£0.11M	-£0.17M	-£0.22M	-£0.37M	-£0.43M	-£0.53M	-£0.64M	-£0.63M	-£0.70M	-£0.64M	-£1.99M	-	-	
Total Spend (£)	£26.57M	£25.64M	£27.35M	£26.86M	£41.34M	£26.19M	£26.61M	£26.08M	£26.38M	£26.82M	£31.10M	£27.67M	£27.74M	-	-	
Proportion of Temporary (Agency) Staff	2.76%	2.59%	3.09%	3.38%	2.30%	3.32%	3.47%	1.79%	4.23%	4.32%	3.84%	4.64%	4.81%	-	-	
Essential Safety (12m rolling)																
Overall Essential Safety Compliance	93.01%	93.28%	92.50%	92.57%	92.90%	92.54%	92.94%	92.61%	92.63%	91.89%	90.46%	91.68%	92.38%	-	**90.00%**	>=90% Green >=85%<90% Amber <85% Red
Conflict Resolution (3 Year Refresher)	92.45%	90.21%	92.02%	91.84%	92.48%	91.88%	91.37%	91.49%	91.59%	91.10%	91.51%	91.86%	92.74%	-	**90.00%**	>=90% Green >=85%<90% Amber <85% Red
Data Security Awareness (1 Year Refresher)	90.22%	88.61%	88.88%	89.50%	89.83%	88.94%	89.59%	89.00%	89.30%	88.84%	88.14%	87.90%	88.69%	-	**95.00%**	>=95% Green >=85%<95% Amber <85% Red
Dementia Awareness (No Renewal)	96.93%	95.78%	96.81%	97.07%	97.14%	97.36%	97.26%	97.48%	97.45%	96.23%	95.79%	95.67%	96.38%	-	**90.00%**	>=90% Green >=85%<90% Amber <85% Red
Equality and Diversity (3 Year Refresher)	92.92%	91.40%	93.40%	93.90%	94.45%	94.12%	94.56%	94.51%	94.61%	93.88%	93.89%	94.07%	94.98%	-	**90.00%**	>=90% Green >=85%<90% Amber <85% Red
Fire Safety (1 Year Refresher)	90.79%	90.53%	89.55%	89.74%	90.66%	88.57%	88.36%	85.54%	84.98%	85.08%	86.21%	86.55%	87.53%	-	**90.00%**	>=90% Green >=85%<90% Amber <85% Red
Health and Safety (3 Year Refresher)	93.10%	91.56%	92.66%	92.62%	93.17%	93.71%	94.42%	94.77%	94.88%	93.79%	94.05%	94.23%	95.13%	-	**90.00%**	>=90% Green >=85%<90% Amber <85% Red
Infection Control (1 Year Refresher)	91.36%	90.68%	90.14%	90.77%	90.49%	90.46%	91.30%	90.41%	90.46%	89.65%	89.16%	88.88%	89.75%	-	**90.00%**	>=90% Green >=85%<90% Amber <85% Red
Manual Handling (2 Year Refresher)	92.12%	92.75%	91.60%	90.57%	91.09%	91.26%	91.77%	92.70%	92.99%	92.30%	91.72%	91.34%	91.89%	-	**90.00%**	>=90% Green >=85%<90% Amber <85% Red
Safeguarding (3 Year Refresher)	93.31%	92.52%	93.26%	92.81%	93.05%	92.53%	92.93%	93.41%	92.51%	91.95%	91.42%	90.14%	90.06%	-	**90.00%**	>=90% Green >=85%<90% Amber <85% Red
Learning Disabilities Awareness (No renewal)							40.54%	57.57%	66.46%	72.60%	77.18%	79.97%	82.58%	-	90.00%	>=90% Green >=85%<90% Amber <85% Red
Appraisal																
Appraisal (1 Year Refresher) - Non-Medical Staff	60.90%	61.72%	63.51%	65.54%	69.06%	0.64%	2.79%	5.94%	9.36%	17.18%	48.64%	59.23%	66.77%	-	**95.00%**	>=95% Green >=90%<95% Amber <90% Red
Appraisal (1 Year Refresher) - Medical Staff (Rolling 12mth)	69.10%	70.31%	72.91%	74.86%	82.43%	82.31%	81.50%	82.97%	83.79%	83.15%	82.47%	76.57%	76.57%	-	**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 16 December 2022. This can change as activity is continued to be recorded within ESR for the reporting period 1 November 2022 to 30 November 2022, beyond the report production date of 22 December 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)	**6209**	6193	↑	16	-
Staff In Post (FTE)	**5507.5**	5493.1	↑	14.38	-
Establishment (FTE)**	**5969.7**	5944.4	↑	25.33	-
Starters	**46.23**	**95.77**	↓	-49.53	-
Leavers	**28.04**	**17.27**	↓	10.77	-
Vacancies (FTE) **	**462.21**	451.3	↓	10.95	-
Vacancies (%) **	**7.74%**	7.59%	↓	0.15%	-
Turnover Rate (rolling 12 month) (%)	**8.86%**	8.95%	↑	-0.09%	*11.5%

ATTENDANCE MANAGEMENT	Current Month Score	Previous Month	Trend	Change	Target
Non Covid Sickness Absence Rate (rolling) (%)	**4.73%**	**4.71%**	↓	0.02%	4.75%
Non Covid Long Term Sickness Absence Rate (rolling) (%)	**3.08%**	**3.06%**	↓	0.02%	3.00%
Non Covid Short Term Sickness Absence Rate (rolling) (%)	**1.65%**	**1.65%**	↔	0.00%	1.75%
Non Covid Sickness Absence Rate (month) (%)	**5.19%**	**4.89%**	↓	0.30%	4.75%
Non Covid Long Term Sickness Absence Rate (month) (%)	**3.28%**	**3.11%**	↓	0.17%	3.00%
Non Covid Short Term Sickness Absence Rate (month) (%)	**1.91%**	**1.78%**	↓	0.13%	1.75%

*The RTW compliance position reported reflects activity data held in ESR as of 16 December 2022. This can change as activity is continued to be recorded within ESR for the reporting period 1 November 2022 to 30 November 2022, beyond the report production date of 22 December 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)	**66.77%**	59.23%	↑	7.54%	95.00%
Medical Appraisal (YTD)	**76.57%**	76.57%	↔	0.00%	95.00%

ESSENTIAL SAFETY TRAINING	Current Month Score	Previous Month	Trend	Change	Target
Data Security Awareness (1 Year Refresher)	**88.69%**	87.90%	↑	0.79%	95.00%
Infection Control (1 Year Refresher)	**89.75%**	88.88%	↑	0.87%	90.00%
Fire Safety (1 Year Refresher)	**87.53%**	86.55%	↑	0.98%	90.00%
Manual Handling (2 Year Refresher)	**91.89%**	91.34%	↑	0.55%	90.00%
Safeguarding (3 Year Refresher)	**90.06%**	90.14%	↓	-0.08%	90.00%
Conflict Resolution (3 Year Refresher)	**92.74%**	91.86%	↑	0.88%	90.00%
Equality & Diversity (3 Year Refresher)	**94.98%**	94.07%	↑	0.91%	90.00%
Health, Safety & Wellbeing (3 Year Refresher)	**95.13%**	94.23%	↑	0.90%	90.00%
Dementia Awareness (No Renewal)	**96.38%**	95.67%	↑	0.71%	90.00%
Learning Disabilities Awareness***	**82.58%**	79.97%	↑	2.61%	90.00%

↔ No movement from previous month

↑ Improvement from previous month

↓ Deterioration from previous month

* Internal target rather than NHSi Submitted Position

Not achieving target

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	9.1	9.5	7.6	18.5	**9.1**	9.8	↑	-0.7	8
Shortlisting to interview	3.8	4.3	8.8	12.7	**3.9**	5.1	↑	-1.2	12
Interview to conditional offer	1.8	3.6	8.5	2.0	**2.3**	3.6	↑	-1.3	6
Pre employment to unconditional offer	16.7	14.8	34.2	57.9	**17.8**	19.0	↑	-1.2	18
Unconditional Offer to Acceptance	0.0	0.00	1.0	2.3	**1.0**	2.3	↑	-1.3	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

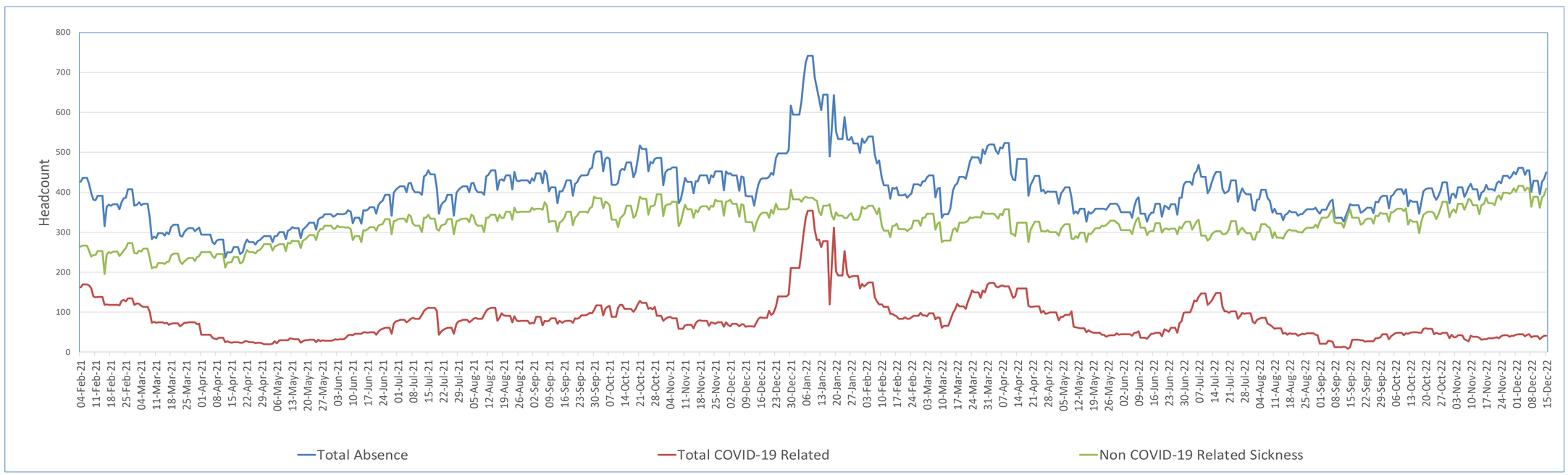
Unconditional Offer to Acceptance - The average number of days for Unconditional Offer to Acceptance

PAY	Current Month Spend	Previous Month	Trend	Change	Target (Budget)
Substantive Expenditure	**£23.79M**	£23.37M	↓	£0.43M	£24.71M
Agency Expenditure	**£1.33M**	£1.28M	↓	£0.05M	£0.51M
Agency Ceiling Cap	**£0.66M**	**£0.64M**	-	-	-
Variance from Ceiling	**£1.99M**	£0.64M	↓	-	-
Bank Expenditure	**£2.61M**	£3.02M	↑	-£0.41M	£1.83M

Page 1 - Workforce Key Metrics

COVID-19 - Key Metrics

ABSENCE



Workforce Absence @ 14 Nov 2022	Headcount	% of workforce
Absence - COVID-19 Related	36	0.5%
Absence - Sickness (Non COVID-19 Related)	345	5.2%
Total Absence	381	5.7%

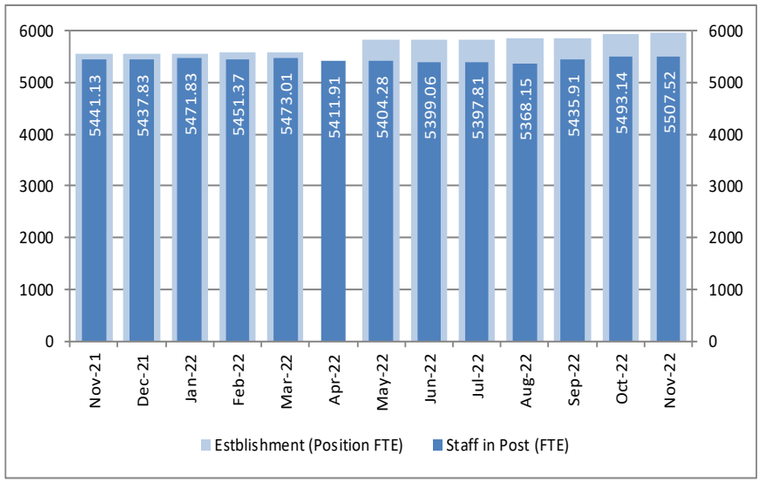
Workforce Absence @ 15 Dec 2022	Headcount	% of workforce
Absence - COVID-19 Related	41	0.6%
Absence - Sickness (Non COVID-19 Related)	409	6.1%
Total Absence	450	6.8%

6663

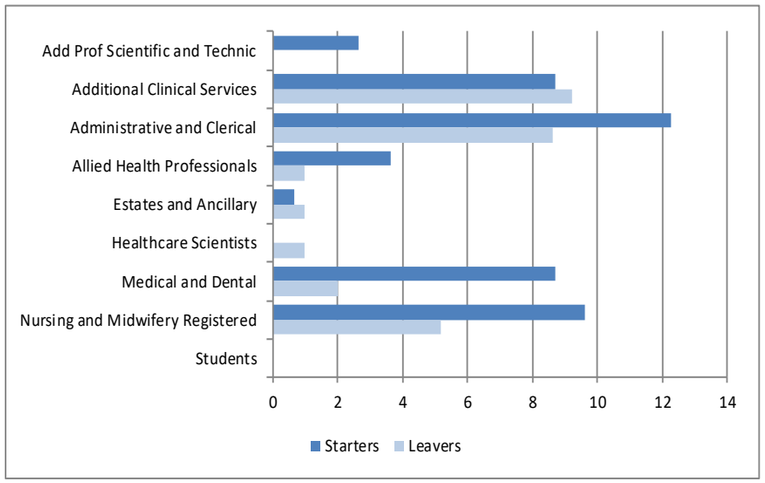
Covid Related Key Metrics

Reality

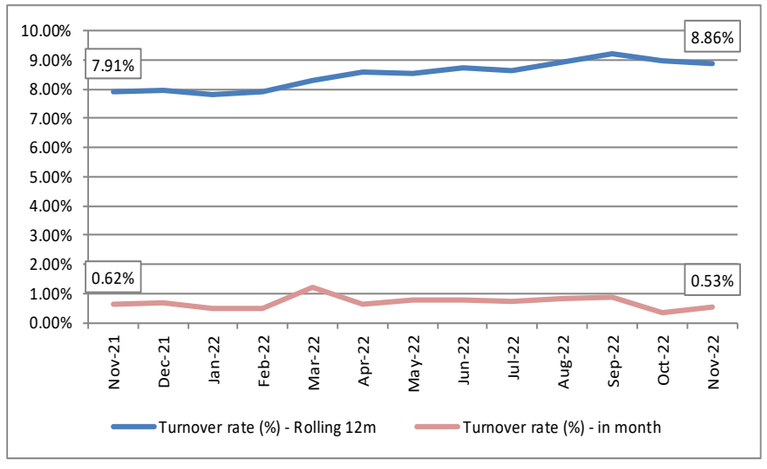
Staff in Post (FTE) v Establishment (FTE)



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



Turnover



Turnover by Staff Group

Staff Group	In-Month	Rolling
Add Prof Scientific and Technic	0.00%	10.48%
Additional Clinical Services	0.76%	9.86%
Administrative and Clerical	0.79%	11.29%
Allied Health Professionals	0.21%	12.06%
Estates and Ancillary	1.75%	11.90%
Healthcare Scientists	0.78%	7.32%
Medical and Dental	0.49%	8.21%
Nursing and Midwifery Registered	0.30%	5.70%

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.

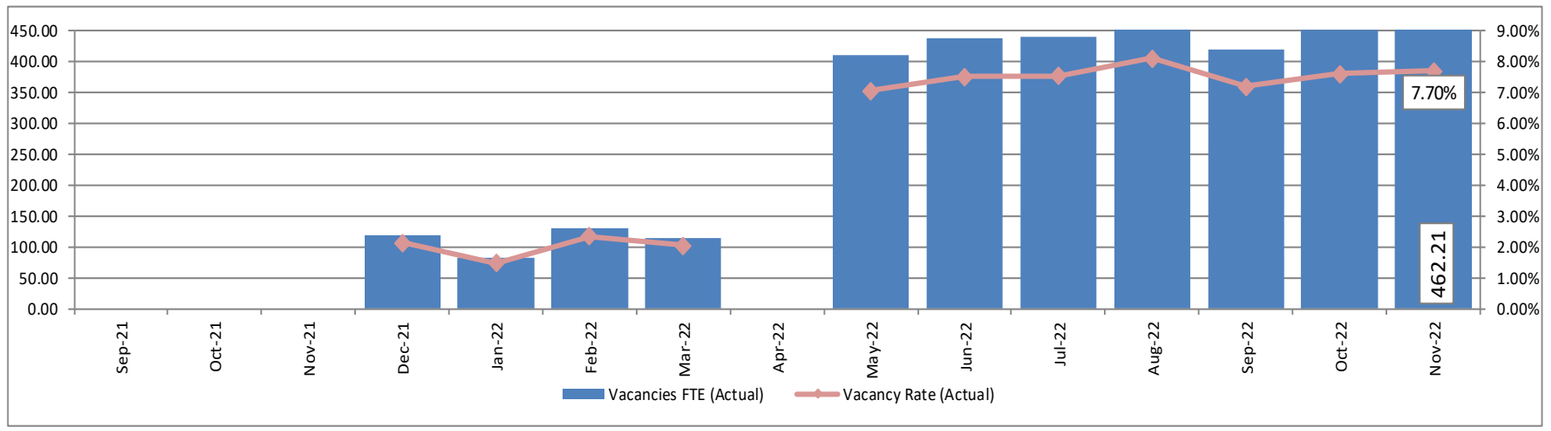
A self-assessment against the national Nursing and Midwifery Retention Tool has been undertaken and an action plan developed to address this.

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	195.23	162.35	32.88
Additional Clinical Services	1273.97	1206.29	67.68
Administrative and Clerical	1187.64	1101.90	85.74
Allied Health Professionals	499.23	475.01	24.22
Estates and Ancillary	53.62	56.29	-2.67
Healthcare Scientists	137.40	128.19	9.21
Medical and Dental	713.99	664.62	49.37
Nursing and Midwifery Registered	1908.65	1712.86	195.79
Students	0.00	0.00	0.00
Total	**5969.73**	**5507.52**	**462.21**

Additional Clinical Services Breakdown

Role	Establishment (FTE)	Actual (FTE)	Vacancies (FTE)
Asst./Associate Practitioner Nursing	33.55	38.35	-4.80
Health Care Support Worker	51.55	42.16	9.39
Healthcare Assistant	794.13	694.43	99.70
Nursery Nurse	1.76	1.76	0.00
Nursing Associate	52.20	57.65	-5.45
Trainee Nursing Associate	0.00	52.00	-52.00
Total (Unregistered Nursing)	**933.19**	**886.35**	**46.84**
Other Additional Clinical Service	340.78	319.94	20.84

Recruitment:

Recruitment of Newly Qualified Nurses from September 2022 is now complete. Close scrutiny of the health roster is being conducted to ensure staff are moved from supernumerary status to shift-fill in a timely way. Any staff requiring additional supernumerary time have a clear action plan in place. 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. In the calenda r year to date we have employed 72 International Nurses with a further 34 in pipeline. We are now recruiting to enable a further 20 nurses to arrive before the end of March 2023 following successful securing of additional funds from NHS England.
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. To complement the recruitment strategy, the Nursing and Midwifery Workforce Steering Group has initiated a robust retention strategy based on the principles set out by NHSE.

*The **AHP** workforce leaver rate has increased from 8 – 14% over the past 12 months. We recognise that this is similar across other NHS organisations. In an effort to improve retention we have recruited a clinical educator to embed preceptorship and manage the postgraduate training needs and an AHP workforce manager who is focussing on:*
Working with local HEIs to promote CHFT as a place to work. Expanding the student training offer and improve the placement experience to promote applications for newly qualified AHPs
International recruitment for AHPs and ensure Trust readiness and capacity which builds on that currently offered to nurses. Promote the return to practice offer across the Calderdale and Kirklees locality to encourage those with previous HCPC registrations to access CHFT for their training and future employment opportunities. Develop the AHP support workforce to maximise their potential and support work previously undertaken by registered colleagues. Increase the degree apprenticeship programme both in quantity and professions. Increase the AHP bank through liaison with local HEIs.

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

In December internal rotations took place for the Foundation Year 1 and 2 doctors in training. This consisted of 51 FY1 trainees, 28 FY2 trainees and 9 CT1/2 trainee doctors who all rotated within CHFT to their second placement. This all took place without delay and all trainees were able to start their new placement on 7th December.

Data from Health Education England for Junior Doctors in training changeover for February 2023 and March 2023 (Paediatrics and O&G) has all now been received and pre-employment checks are underway within the team to ensure that all doctors are ready to start in February. There are a number of trainee gaps that have been noted on the higher Paediatrics data from Health Education England for March 2023. These have been flagged and meetings held with the divisional team. Trust grade adverts are currently out to recruit to fill these posts by March 2023. This has also been escalated to the TPD.

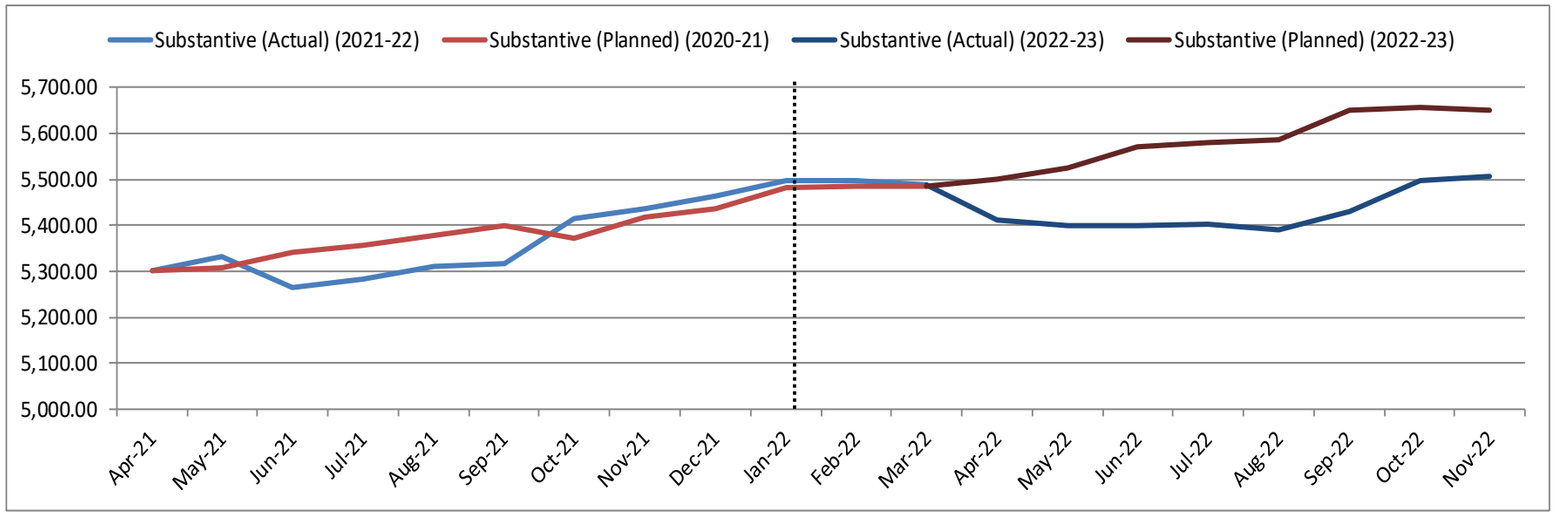
As detailed on the previous report updated there have been a number of delays in visa applications being completed over the last few months due to the situation in the Ukraine and the prioritisation of processing Ukrainian nationals. Frequent contact is being maintained and the Trust contact with the Home Office is making regular contact with the NHS UK Visa and Immigration Team to try and expedite applications wherever possible.

There were a number of new starters that commenced in post during December including a Locum Consultant in Geriatric Medicine, several Trust doctors in Acute Medicine, General Surgery and Ophthalmology. Our first Medical Support Worker role within Acute Medicine also started in post. To note there are also a number of doctors in the pipeline still to commence this month including several Specialty Doctors within Emergency Medicine, Ophthalmology and ENT and a further trust grade doctor in Emergency Medicine. There are also a couple of new Specialty Drs who are interested in progressing through CESR to a consultant level post. These are in Neurophysiology, Gastroenterology and possibly ENT

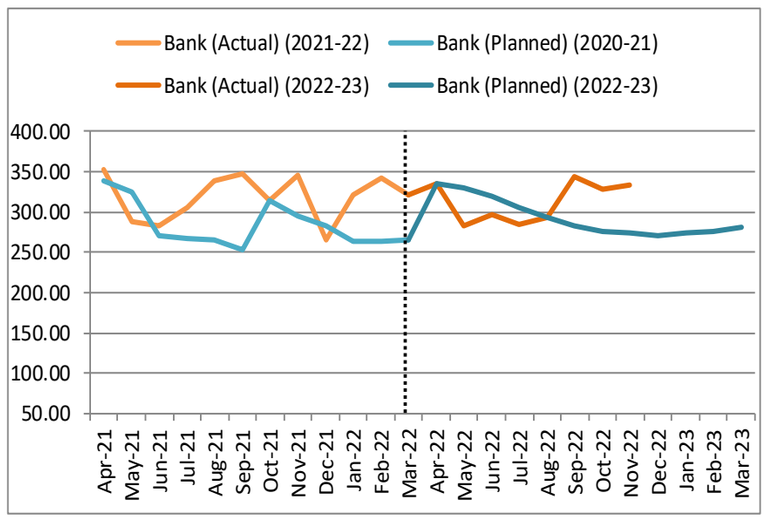
Vacancies

Reality

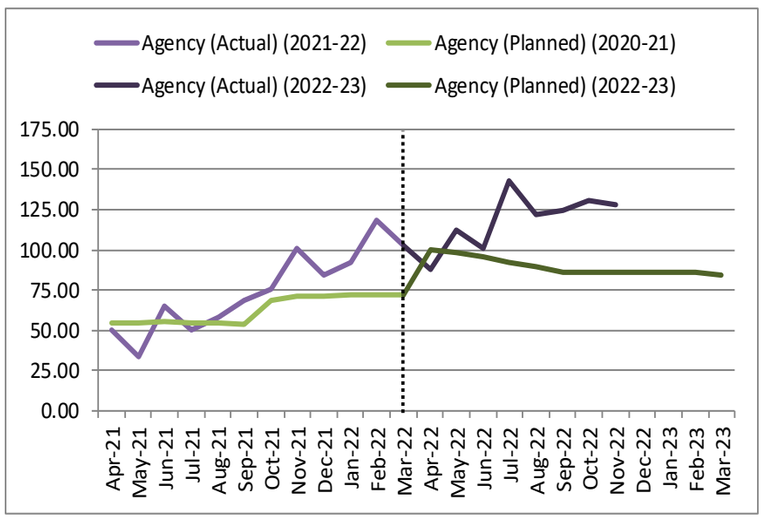
Substantive



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 FTE 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.

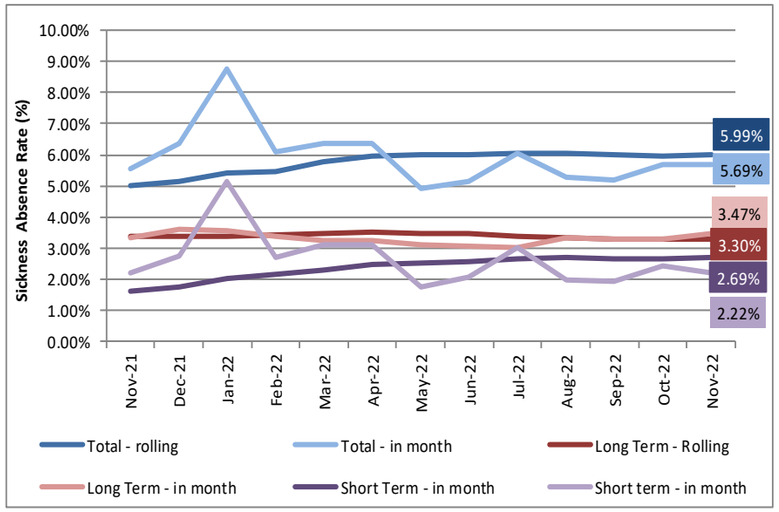
Substantive actuals are currently 158 FTE below the planned position for October 2022. This has reduced in part due to graduate and international nurse recruitment through September and October.

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

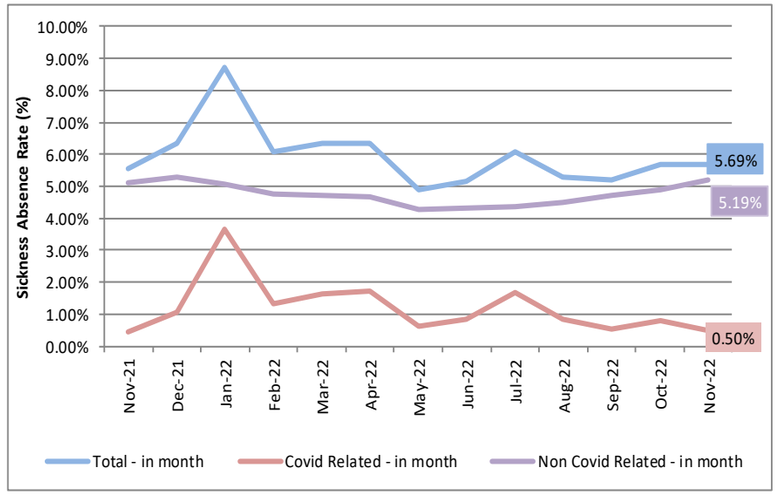
Sickness Absence



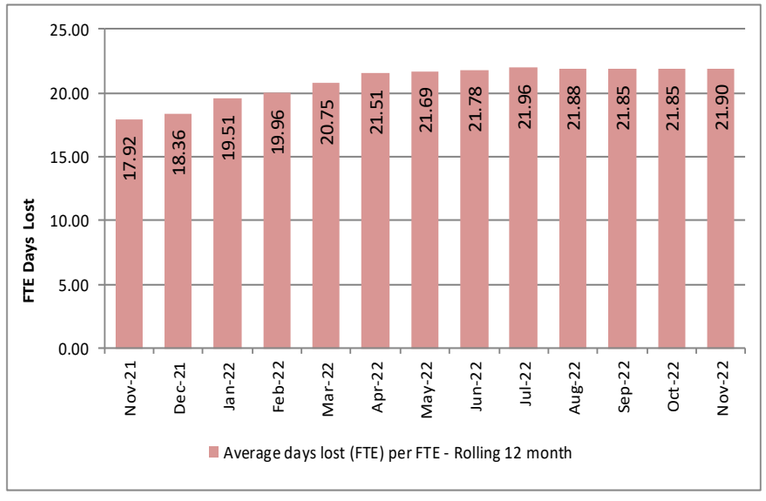
Sickness Absence Reasons - November 21

Reason	FTE Days Lost	%
S10 Anxiety/stress/depression/other psychiatric illnesses	3029.44	32.24%
S15 Chest & respiratory problems	1122.99	11.95%
S13 Cold, Cough, Flu - Influenza	1007.75	10.72%
S12 Other musculoskeletal problems	886.61	9.43%
S25 Gastrointestinal problems	697.47	7.42%
S28 Injury, fracture	592.15	6.30%
S11 Back Problems	424.24	4.51%
All Other Reasons	1637.18	17.42%

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, 17 were received during November. Assessments for Covid Age and pregnancy concerns with letters of recommendations to managers are provided where required by the individual.

Throughout November the Occupational Health department issued 320 appointments.
127 immunisation appointments were issued – 97 of these were attended but 30 resulted in DNA or cancellation.

129 management referral appointments for first assessment were successfully completed. A further 26 booked appointments resulted in DNA or cancellation. Practitioners carried out a further 37 follow up review appointments during November, 4 of which were not attended.

Key reasons for management referrals continue to be for mental health and musculoskeletal reasons. There are a significant number of colleagues who have immunisations outstanding. Occupational Health will be launching a scheme to address this in the New Year. This will include offering a vaccine clinic on the HRI site to improve uptake and attendance.

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

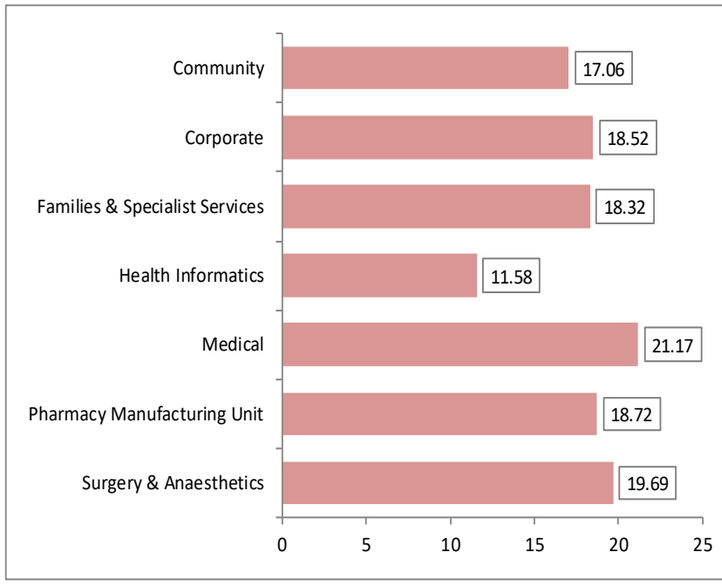
Division	Oct-22	Nov-22
Community	4.15%	4.67%
Corporate	4.89%	5.07%
Families & Specialist Services	4.57%	5.02%
Health Informatics	2.26%	3.17%
Medical	6.18%	5.80%
Pharmacy Manufacturing Unit	4.62%	5.13%
Surgery & Anaesthetics	4.54%	5.40%

* 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	1.53%	3.87%	5.40%
Additional Clinical Services	2.39%	4.91%	7.30%
Administrative and Clerical	1.14%	2.26%	3.40%
Allied Health Professionals	1.41%	1.78%	3.19%
Estates and Ancillary	2.27%	8.81%	11.08%
Healthcare Scientists	2.04%	2.83%	4.87%
Medical and Dental	0.87%	0.92%	1.80%
Nursing and Midwifery	1.78%	3.23%	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.

Absence in the **Medicine** division has seen a decrease in month to 6.40% from 7.45% with a reduction to both short term and long term absence. Management of long term sickness continues and the HRA liaises with the Wellbeing Team on a weekly basis with particular focus on our ASD cases to ensure that support is in place for those that need it. 26% of the total sickness absence is attributed to ASD. RTWI compliance has increased to 62.05% in month although this remains below Trust target. The HRA continues to work with the division to focus on increasing RTWI compliance going forward.

In **Community**, all long term absence cases have a plan is in place for all colleagues. Colleagues and line managers are regularly reminded of the support available from the Trust and regular reviews meetings are been held. HRA will contact all line manager to ensure to assess what further support can be put in place.

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 an increase in sickness absence to 5.77% for November 2022, which was anticipated due to an increased level of conduct issues being addressed across the division, and an increase in colleagues experiencing cold and flu symptoms. Covid related absence is having a minimal impact on absence at present, with stress and anxiety remaining the main reason. Alternative support has been sought from the Trust's new Occupational Health Psychologist who has agreed to carry out a piece of work with the division and focus on supporting the most affected areas with some alternative ways not yet tried. RTW has decreased to 59.91% but operational pressures and an increase in colleague sickness absence has impacted completion rates.

In **THIS**, short term absence has increased resulting in an increase in the Total absence. The total percentage remains below Trust Target. The Senior Management team are informed of the absence percentages on a monthly basis and regular contact is maintained with line managers.

In **Corporate** there has been a further increase in total absence to 5.51%. Specific HRA support will continue to be targeted to areas of concern and assurance that a management plan is in place for all colleagues.

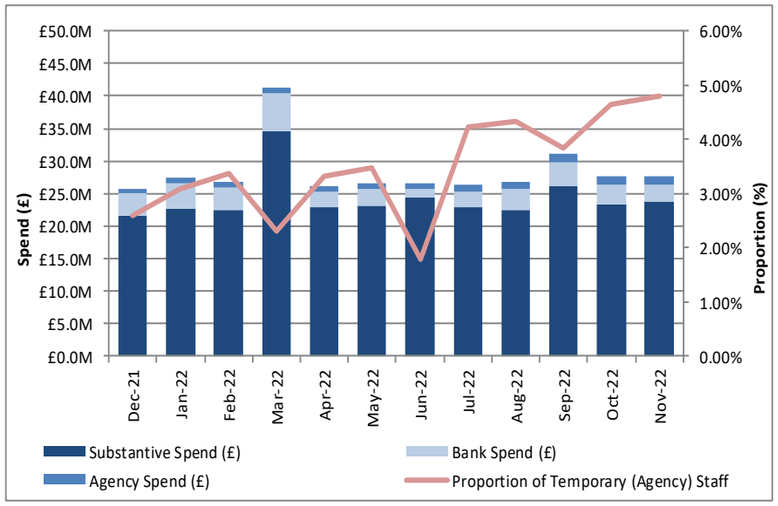
In **PMU** the total absence has increased slightly to 5.13%. Specific support continues to be provided by the HRA.

Absence in **FSS** has increased to 5.02% however the rolling 12 month % remains below trust target. Regular reviews of absence are in place to ensure that LT absence cases are managed as effectively as possibly. LT deep dive to be undertaken early January. ST absence remains a difficulty due to volume of cases to manage, plan to undertake directorate based deep dives on ST absence throughout 2023. RTW compliance has increased since the previous month to 65% however remains under the target.

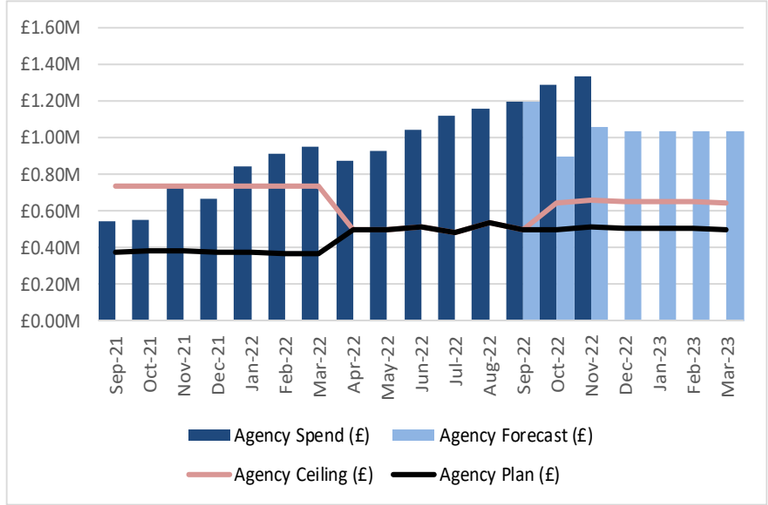
Sickness Absence - Divisional/Staff Group

Reality

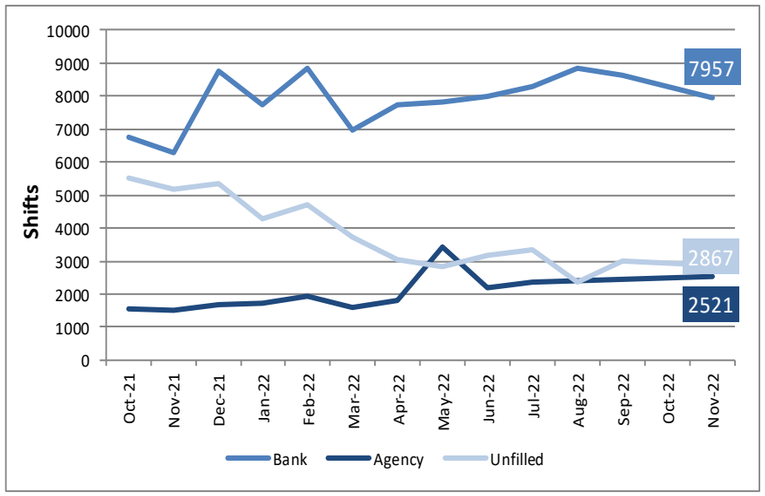
Workforce Spend



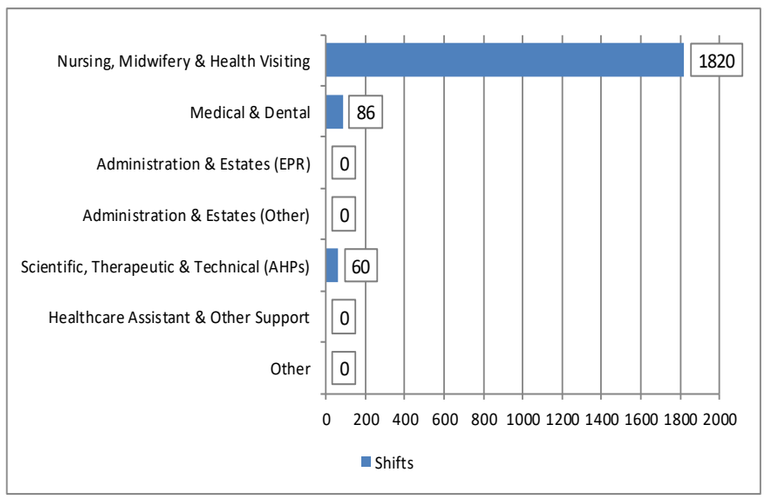
Agency Ceiling



Agency, Bank and Unfilled Shifts



Number of shifts that broke the agency cap - November 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 1822 shifts broke the agency cap in November 2022, this is an decrease on 2233 in October 2022.
The high cost agency withdrawal plan was paused from May 2022 but recommenced from October 2022.
For Nursing & Midwifery, of all requests 40.6% were filled by Bank and 36.5% by Agency. with an overall fill rate of 77.2%
For Medics, of all requests 77.9% were filled by Bank and 9.4% by Agency, with an overall fill rate of 87.3%

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.

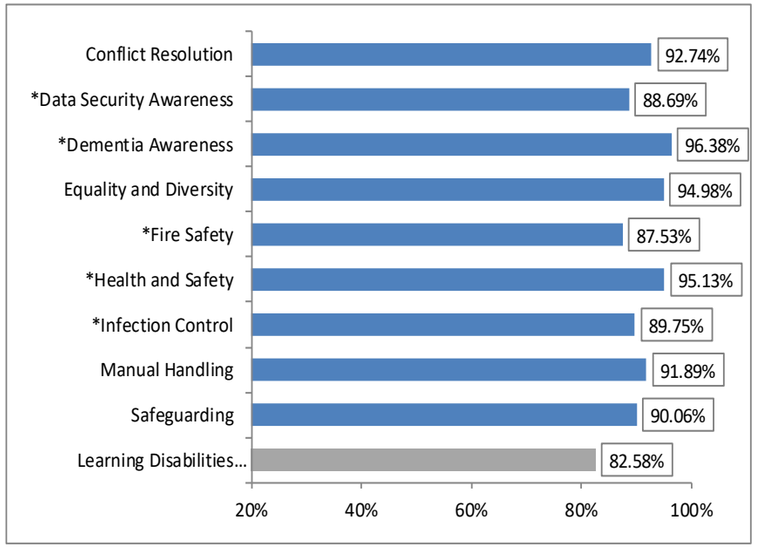
Limits are based on planned reductions & set to reduce by at least 10% compared to 2021/22. Performance on agency spend limit will be considered along with agency spend as a proportion of total pay bill, compliance with agency price caps and useage of off-framework agency staff.
The ICB ceiling for the Trust is £9.9M and for West Yorkshire in total it is £99.8M
Year to date in November 2022 the Trust breached the agency ceiling with a spend of £8.9m, a £4.62m 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

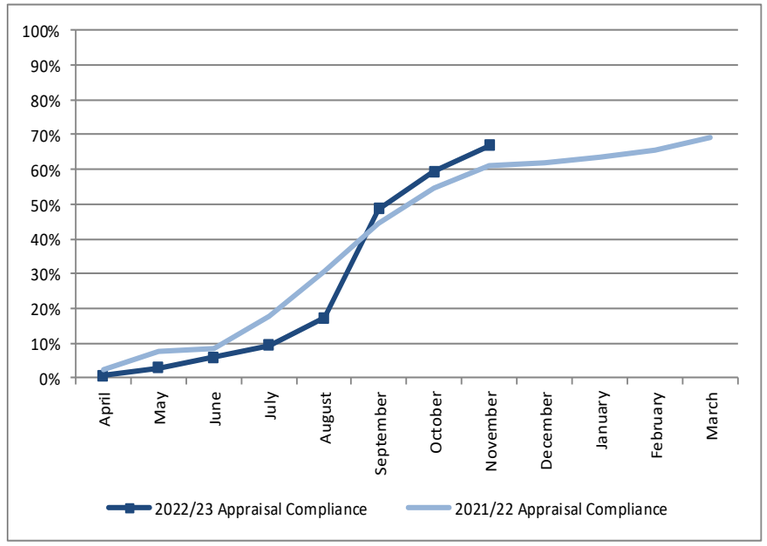
Reality

Essential Safety Training

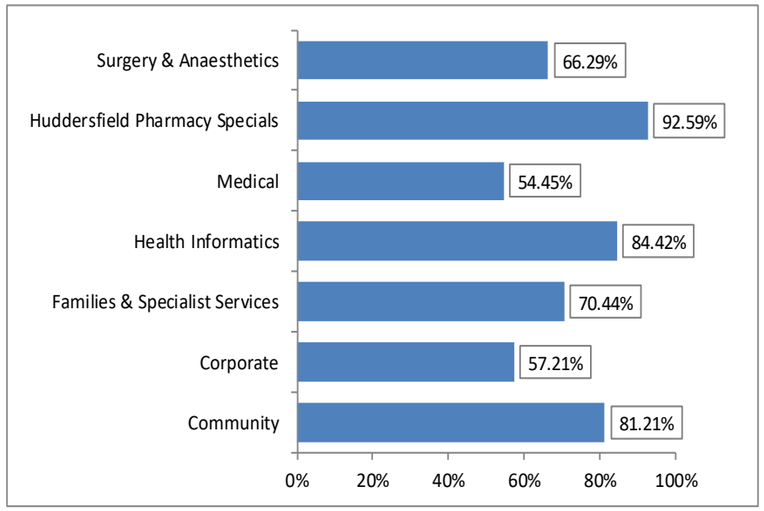


* Essential Safety Training elements that are covered at Corporate Induction.

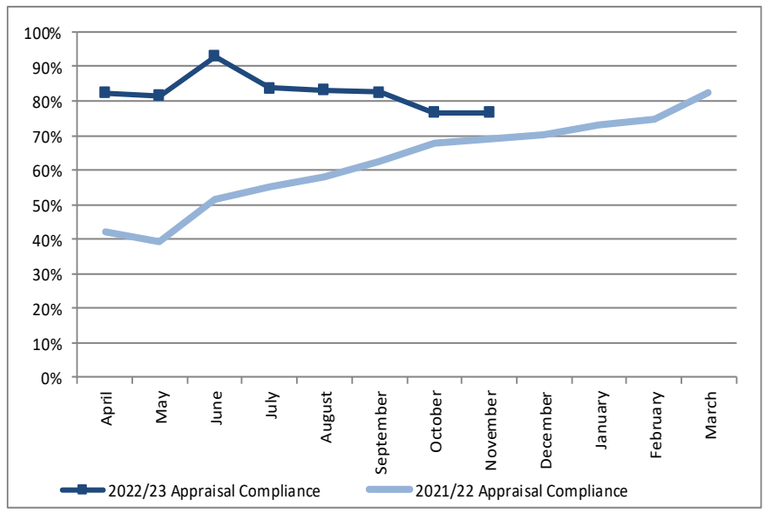
Non-Medical Appraisal Compliance



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 has been extended and will run from 1 July 2021 until 31 December 2022 .

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

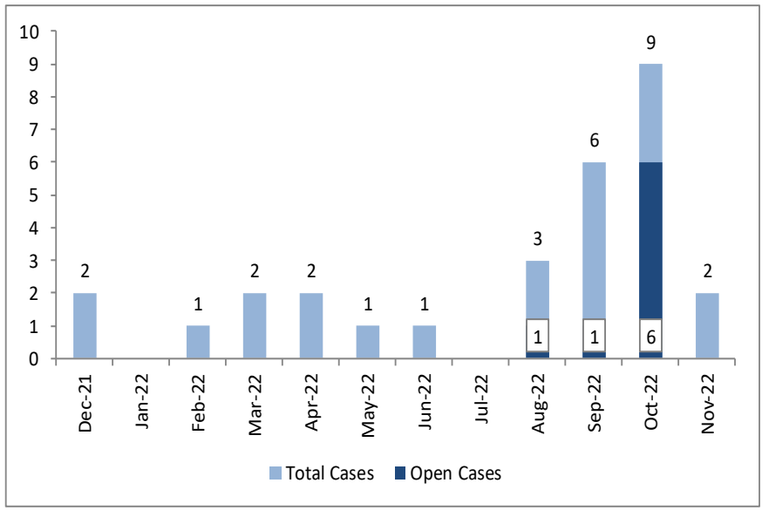
The process was restarted on 1st October using a temporary revised appraisal format, however the need to complete an appraisal was not mandated. From April 2021 Medical appraisals have been reinstated.

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

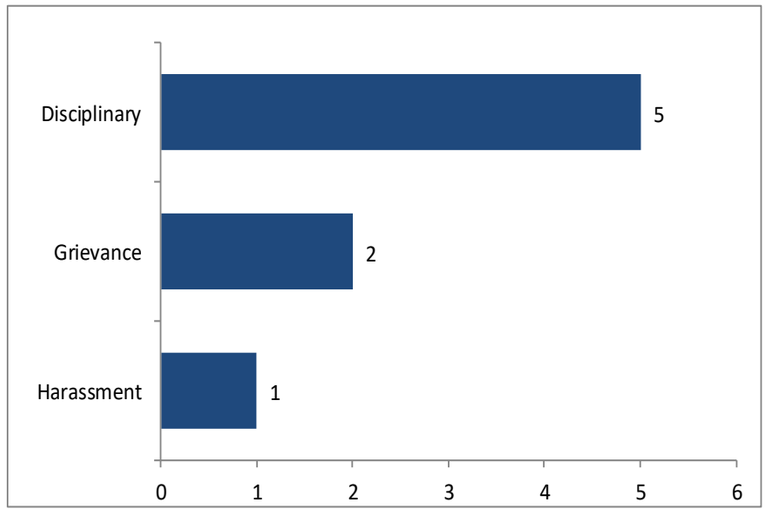
Essential Safety Training / Appraisals

Reality

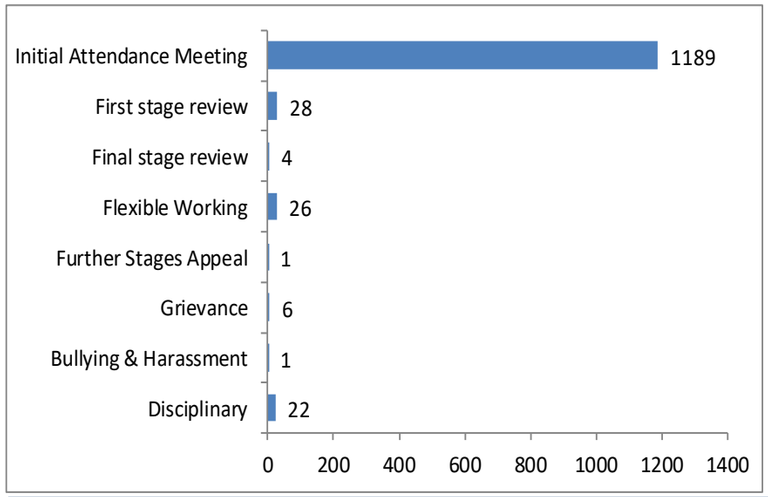
Disciplinary, Grievance, Harassment cases opened last 12 months



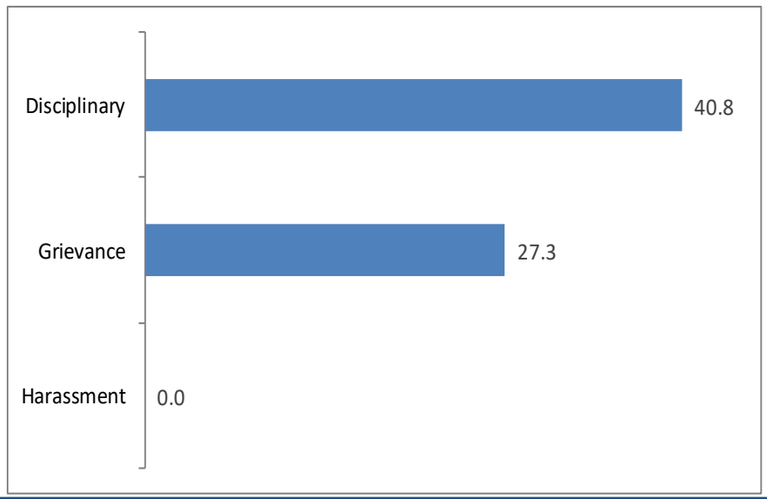
Open Disciplinary, Grievance, Harassment cases by type



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

Workforce Metrics

November 2022

NHS Calderdale and Huddersfield NHS Foundation Trust

The Cupboard One Culture of care

Target:
Vacancies (NHSi submitted position) – 230.08 FTE

Workforce

Headcount	6209
Actual FTE	5507.52
Establishment FTE	5969.76
Vacancies FTE	462.21

Most Vacancies:
Nursing and Midwifery **(195.79 FTE)**
Admin & Clerical **(85.74 FTE)**
Additional Clinical Services **(67.68 FTE)**

Target:
Overall - 4.75%
Long Term – 3.0%
Short Term – 1.75%

Non Covid- Sickness Absence

Rolling 12 month	4.73%
In-month	5.19%
FTE days lost per FTE (Rolling)	21.90

Main Reason (in-month):
Anxiety, stress, and depression **(32.24%)**

Highest Staff Groups (in-month):
Estates & Ancillary **(11.08%)**
Additional Clinical Services **(7.30%)**

Target:
Rolling – 11.5%

Turnover

Rolling 12 month	8.86%
In-month	0.53%
Leavers FTE	28.04

Highest Staff Groups:
Allied Health Professionals **(12.06%)**
Administrative & Clerical **(11.29%)**
Add Prof Scientific & Technical **(10.48%)**

Target:
EST - 90%
Appraisal – 95%

Essential Safety Training & Appraisal

Overall EST Compliance	92.38%
Appraisal Compliance*	66.77%

*69.06% at the end of appraisal season 2021/2022.
** Appraisal season for 2022/23 moved & extended to July to December 2022

Lowest EST Core Suite Elements:
Fire Safety **(87.53%)**
Data Security **(88.69%)**

Targets:
Advised by WYATT Streamlining
1 8 days
2 45 days
3 3 days

Recruitment

Vacancy approval to advert placement 1	9.1
Interview to conditional offer 2	2.3
Unconditional offer to acceptance 3	1.0

Forecast Budget (YTD):
Substantive - £197.8M
Agency - £4.0M
Bank - £11.2M

Spend (YTD)

Substantive	£189.1M
Agency	£8.93M
Bank	£19.8M

Highest Agency Spend:
Medical and Dental **(£1.54M)**
Nursing and Midwifery **(£6.8M)**

All data correct as at 30 November 2022

Directorate Health Heatmap

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Directorate	Division	NHS SS Response Rate 2022 (Early Data)	Engagement Score 2021	EST (Nov 2022)	AfC Appraisal 2022-23 (YTD)	Sickness (Non-Covid) (12m)	Annual Leave Usage Apr-Oct 2022	Turnover (12m)	Vacancy Rate (Nov 2022)	Health Score
Finance	Corporate	82.2%	8.0	99.0%	90.2%	0.89%	55.62%	2.3%	-5.3%	88.9%
Community Management	Community	58.8%	7.4	97.6%	91.3%	1.72%	60.97%	7.9%	-2.5%	88.9%
Information	Health Informatics	85.5%	7.8	96.3%	76.6%	2.11%	57.58%	6.5%	0.5%	83.3%
Workforce and Organisational Development	**Corporate**	81.0%	7.6	90.5%	90.1%	2.40%	58.10%	13.5%	1.1%	72.2%
Critical Care	Surgery & Anaesthetics	51.2%	6.5	97.8%	52.4%	6.03%	62.41%	7.0%	-15.1%	72.2%
General Surgery	Surgery & Anaesthetics	34.5%	6.9	92.4%	86.0%	3.23%	60.79%	6.1%	2.6%	72.2%
Head & Neck	Surgery & Anaesthetics	37.8%	6.7	95.6%	81.7%	4.76%	61.18%	9.1%	5.8%	72.2%
Outpatients & Records Services	Families & Specialist Services	57.8%	6.5	99.7%	99.3%	5.12%	65.01%	13.0%	16.2%	66.7%
Surgical Medical Secretaries	Surgery & Anaesthetics	58.1%	6.9	98.5%	53.5%	4.93%	59.87%	9.1%	12.2%	66.7%
Medical Divisional Management	Medical	54.5%	7.4	91.0%	55.2%	3.84%	30.51%	3.2%	1.2%	66.7%
Community Therapies	Community	51.0%	7.0	95.5%	84.3%	3.92%	61.98%	14.9%	5.7%	66.7%
Quality	Corporate	59.0%	7.3	93.4%	47.6%	4.85%	52.64%	10.0%	-8.9%	61.1%
Corporate Services	Corporate	70.4%	8.1	93.6%	55.3%	1.52%	46.19%	18.5%	-1.2%	61.1%
Surgical Divisional Support	Surgery & Anaesthetics	68.9%	7.8	91.3%	59.4%	3.87%	31.72%	10.1%	6.4%	61.1%
FSS Management	Families & Specialist Services	56.7%	7.2	96.3%	72.4%	2.77%	57.61%	12.6%	3.3%	61.1%
Pathology	Families & Specialist Services	39.1%	6.4	98.5%	86.6%	5.12%	55.83%	10.7%	9.3%	55.6%
Corporate & Operations	Health Informatics	64.0%	7.1	96.0%	87.3%	1.59%	50.93%	13.8%	8.9%	55.6%
Community Nursing	Community	33.8%	7.1	91.3%	73.4%	6.78%	60.63%	7.5%	5.8%	55.6%
Pharmacy	Families & Specialist Services	46.9%	6.7	96.6%	77.3%	3.79%	61.98%	18.6%	10.3%	55.6%
Childrens	Families & Specialist Services	40.8%	6.9	90.1%	47.3%	4.27%	54.05%	6.7%	9.0%	55.6%
Orthopaedics	Surgery & Anaesthetics	25.7%	6.0	90.4%	62.4%	4.10%	60.31%	10.2%	7.5%	50.0%
Radiology	Families & Specialist Services	43.0%	6.3	96.1%	65.3%	2.80%	37.10%	11.7%	9.6%	50.0%
Womens	Families & Specialist Services	44.1%	6.3	92.8%	45.2%	5.30%	56.43%	8.4%	17.6%	44.4%
Operating Services	Surgery & Anaesthetics	31.6%	6.2	89.8%	48.7%	5.75%	61.99%	6.3%	1.5%	44.4%
Medical Specialties	Medical	32.1%	6.3	87.8%	42.7%	5.10%	45.22%	6.2%	13.0%	38.9%
Integrated Medical Specialties	Medical	30.3%	6.8	89.2%	55.6%	5.17%	53.13%	10.4%	8.1%	33.3%
Pharmacy Manufacturing Unit	Pharmacy Manufacturing Unit	62.3%	6.1	92.5%	90.9%	6.48%	53.41%	18.7%	12.3%	33.3%
Acute Medical	Medical	27.1%	6.4	89.8%	51.0%	6.67%	54.25%	5.5%	13.2%	33.3%
Emergency Care	Medical	28.4%	6.3	86.3%	72.1%	4.97%	54.31%	4.4%	7.7%	33.3%
Corporate Central Operations	Corporate	28.8%	-	90.2%	8.5%	7.38%	57.15%	6.0%	14.5%	31.3%
Service Delivery	Health Informatics	-	-	88.6%	42.9%	12.52%	54.78%	33.3%	6.7%	21.4%

One Culture of care

compassionate care

EXECUTIVE SUMMARY: Total Group Financial Overview as at 30th Nov 2022 - Month 8

KEY METRICS

	M8				YTD (NOV 2022)				Forecast 22/23			
	Plan	Actual	Var		Plan	Actual	Var		Plan	Forecast	Var	
	£m	£m	£m		£m	£m	£m		£m	£m	£m	
I&E: Surplus / (Deficit)	(£1.87)	(£1.89)	(£0.02)		(£13.22)	(£14.99)	(£1.78)		(£17.35)	(£17.35)	£0.00	
Agency Expenditure (vs Ceiling)	(£0.66)	(£1.33)	(£0.68)		(£4.31)	(£8.93)	(£4.62)		(£6.90)	(£13.23)	(£6.33)	
Capital	£6.07	£2.09	£3.98		£23.67	£7.79	£15.88		£41.99	£42.81	(£0.82)	
Cash	£42.73	£50.50	£7.77		£42.73	£50.50	£7.77		£19.26	£25.08	£5.82	
Invoices paid within 30 days (%) (Better Payment Practice Code)	95.0%	92.6%	-2%		95.0%	90.9%	-4%					
CIP	£1.79	£1.67	(£0.12)		£11.98	£12.37	£0.39		£20.00	£20.00	£0.00	
Use of Resource Metric	3	3			3	4			3	3		

Year to Date Summary

Year to date the Trust is reporting an £14.99m deficit, a £1.78m adverse variance from plan. The in month position is a deficit of £1.89m, a £0.02m adverse variance. The adverse variance is driven by inflationary pressures, the costs of opening additional capacity and the associated premium rate staffing costs, in particular the impact of the revised medical bank rates 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. £12.13m of Elective Recovery Funding (ERF) was assumed in the plan, but is subject to delivery of 104% of 19/20 elective activity. ERF of £7.57m 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). National guidance suggests that ERF is not likely to be clawed back in the second half of the year, but this has not been formally confirmed and there remains some risk, as activity year to date remains below the planned level.
• The Trust has been allocated block funding of £6.0m 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 £12.02m, (excluding costs outside of System Envelope), £5.60m higher than planned. Covid-19 activity remains higher than planned and is one of a number of factors driving additional staffing costs and consumables, with extra capacity opened over and above the planned level and ongoing Emergency Department segregation.
• Year to date the Trust has delivered efficiency savings of £12.37m, £0.39m higher than planned.
• Agency expenditure year to date is £8.93m, £4.62m higher than planned. The Integrated Care Board has set the Trust's Agency expenditure ceiling for the full year at £6.9m, and the Trust has already exceeded that ceiling.
• Total planned inpatient activity, for the purpose of Elective Recovery, was 99% of the activity planned year to date, (103% of 19/20 activity levels).

Key Variances

• Income is £7.98m above the planned year to date due to changes to Tariff based funding (£4.26m YTD) to support changes to pay (pay award / National Insurance changes) 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 £6.25m above the planned level year to date, including £5.08m 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 £1.17m above the planned level, with an adverse variance in Month 8 of £0.18m. This overspend was primarily linked to pressures associated with the opening of additional capacity in excess of the winter plan, driving higher than planned Bank and Agency costs including £0.30m due to the revised medical bank rates.
• Non-pay operating expenditure is £6.01m higher than planned year to date with pressure on consumable costs due to additional capacity requirements, higher than planned insourcing / outsourcing costs associated with Elective Recovery and inflationary pressures in particular on utilities and the PFI contract.

Forecast

Whilst the reported year end forecast continues to be in line with the planned £17.35m deficit, the underlying position would drive a significantly bigger deficit, which is largely mitigated by additional non recurrent funding, technical flexibilities, and system support. A mitigation gap of c.£1.8m remains to be identified. The forecast assumes full delivery of a challenging £20m efficiency target and that the Trust will deliver it's elective activity plan and secure £11.63m of Elective Recovery Funding, delivering 104% of 19/20 activity levels within the planned funding envelope.

Total Group Financial Overview as at 30th Nov 2022 - Month 8

INCOME AND EXPENDITURE COMPARED TO PLAN SUBMITTED TO NHS IMPROVEMENT

YEAR TO DATE POSITION: M8

CLINICAL ACTIVITY

	M8 Plan	M8 Actual	Var
Elective	3,840	3,053	(787)
Non-Elective	38,422	35,679	(2,743)
Daycase	33,289	33,631	342
Outpatient	292,663	301,631	8,968
A&E	118,145	117,733	(412)
Other NHS Non-Tariff	1,248,811	1,318,600	69,789
Total	**1,735,170**	**1,810,327**	**75,157**

TOTAL GROUP: INCOME AND EXPENDITURE

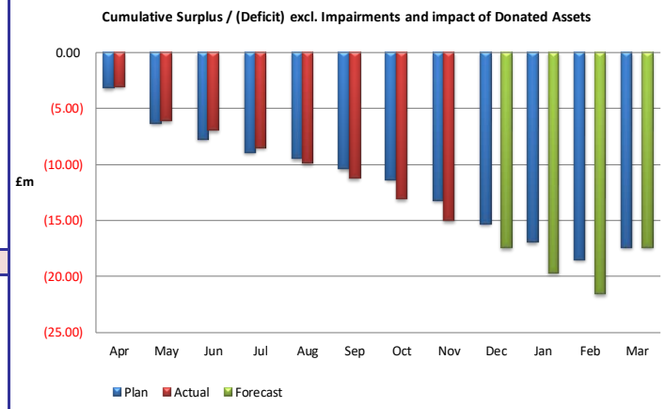
	M8 Plan	M8 Actual	Var
	£m	£m	£m
Elective	£15.41	£11.80	(£3.61)
Non Elective	£86.14	£84.44	(£1.69)
Daycase	£23.49	£23.51	£0.02
Outpatients	£26.67	£29.21	£2.55
A & E	£19.75	£20.61	£0.87
Other-NHS Clinical	£115.77	£125.08	£9.31
CQUIN	£0.00	£0.00	£0.00
Other Income	£35.82	£38.40	£2.58
Total Income	**£323.04**	**£333.06**	**£10.02**
Pay	(£213.00)	(£219.26)	(£6.25)
Drug Costs	(£30.45)	(£29.82)	£0.63
Clinical Support	(£25.67)	(£25.44)	£0.23
Other Costs	(£36.10)	(£42.76)	(£6.66)
PFI Costs	(£9.54)	(£9.74)	(£0.20)
Total Expenditure	**(£314.76)**	**(£327.02)**	**(£12.26)**
EBITDA	**£8.28**	**£6.04**	**(£2.24)**
Non Operating Expenditure	(£21.50)	(£21.03)	£0.47
Surplus / (Deficit) Adjusted*	**(£13.22)**	**(£14.99)**	**(£1.78)**

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

DIVISIONS: INCOME AND EXPENDITURE

	M8 Plan	M8 Actual	Var
	£m	£m	£m
Surgery & Anaesthetics	(£68.15)	(£66.94)	£1.21
Medical	(£81.22)	(£86.38)	(£5.16)
Families & Specialist Services	(£59.57)	(£57.93)	£1.65
Community	(£18.58)	(£18.02)	£0.56
Estates & Facilities	£0.00	(£0.00)	(£0.00)
Corporate	(£35.74)	(£36.44)	(£0.71)
THIS	£0.83	£0.86	£0.03
PMU	£1.59	£0.70	(£0.89)
CHS LTD	£0.29	£0.14	(£0.15)
Central Inc/Technical Accounts	£247.52	£249.66	£2.14
Reserves	(£0.18)	(£0.64)	(£0.46)
Surplus / (Deficit)	**(£13.22)**	**(£14.99)**	**(£1.78)**

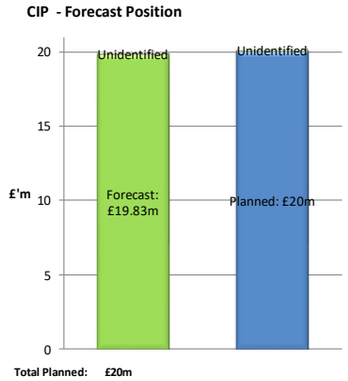
TOTAL GROUP SURPLUS / (DEFICIT)

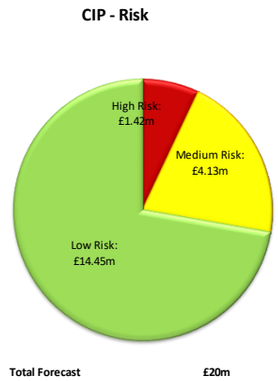


KEY METRICS

	Year To Date M8 Plan	Year To Date M8 Actual	Year To Date Var	Year End: Forecast Plan	Year End: Forecast Forecast	Year End: Forecast Var	
	£m	£m	£m	£m	£m	£m	
I&E: Surplus / (Deficit)	(£13.22)	(£14.99)	(£1.78)	(£17.35)	(£17.35)	£0.00	
Capital	£23.67	£7.79	£15.88	£41.99	£42.81	(£0.82)	
Cash	£42.73	£50.50	£7.77	£19.26	£25.08	£5.82	
Invoices Paid within 30 days (BPPC)	95%	91%	-4%				
CIP	£11.98	£12.37	£0.39	£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	4,766	(1,008)
Non-Elective	58,360	54,168	(4,192)
Daycase	50,173	50,593	420
Outpatient	436,084	449,018	12,934
A&E	170,928	171,915	987
Other NHS Non- Tariff	1,867,647	1,979,082	111,435
Total	**2,588,966**	**2,709,543**	**120,577**

TOTAL GROUP: INCOME AND EXPENDITURE

	Plan	Actual	Var
	£m	£m	£m
Elective	£23.08	£18.53	(£4.55)
Non Elective	£123.29	£122.22	(£1.07)
Daycase	£35.10	£35.85	£0.74
Outpatients	£40.60	£45.46	£4.85
A & E	£28.76	£30.43	£1.67
Other-NHS Clinical	£180.77	£191.34	£10.57
CQUIN	£0.00	£0.00	£0.00
Other Income	£53.66	£57.63	£3.97
Total Income	**£485.26**	**£501.46**	**£16.19**
Pay	(£318.79)	(£329.15)	(£10.36)
Drug Costs	(£45.79)	(£44.43)	£1.35
Clinical Support	(£38.80)	(£40.30)	(£1.50)
Other Costs	(£52.67)	(£61.37)	(£8.70)
PFI Costs	(£14.31)	(£14.60)	(£0.30)
Total Expenditure	**(£470.36)**	**(£489.86)**	**(£19.50)**
EBITDA	**£14.90**	**£11.60**	**(£3.30)**
Non Operating Expenditure	(£32.25)	(£28.95)	£3.30
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

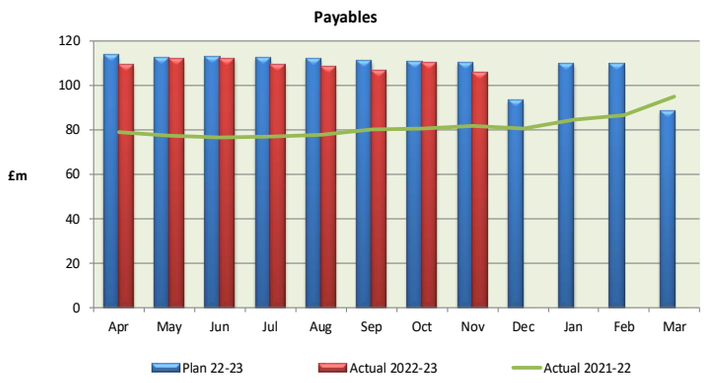
	Plan	Forecast	Var
	£m	£m	£m
Surgery & Anaesthetics	(£102.29)	(£101.79)	£0.50
Medical	(£124.34)	(£131.08)	(£6.74)
Families & Specialist Services	(£89.56)	(£87.85)	£1.71
Community	(£27.87)	(£27.33)	£0.55
Estates & Facilities	£0.00	(£0.00)	(£0.00)
Corporate	(£53.61)	(£54.38)	(£0.77)
THIS	£1.28	£1.11	(£0.17)
PMU	£2.39	£0.82	(£1.57)
CHS LTD	£0.54	£0.26	(£0.28)
Central Inc/Technical Accounts	£375.16	£378.57	£3.41
Reserves	£0.95	£4.32	£3.37
Surplus / (Deficit)	**(£17.35)**	**(£17.35)**	**£0.00**

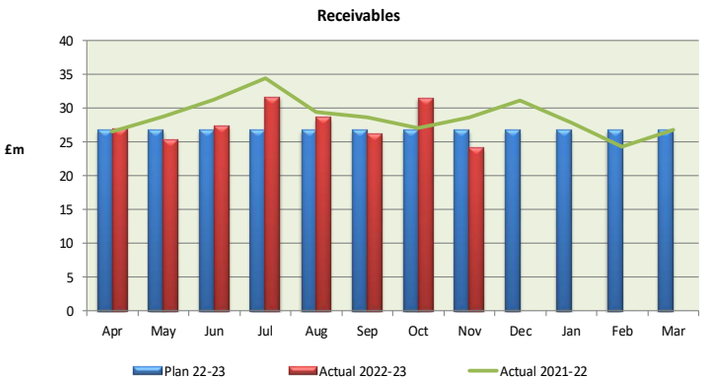
Total Group Financial Overview as at 30th Nov 2022 - Month 8

CAPITAL AND CASH COMPARED TO PLAN SUBMITTED TO NHS IMPROVEMENT

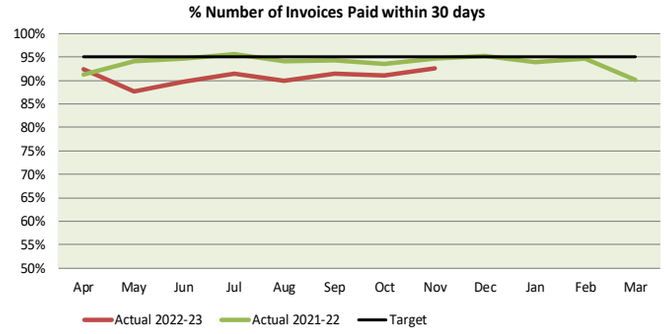
WORKING CAPITAL

	M8 Plan £m	M8 Actual £m	Var £m	M8
Payables (excl. Current Loans)	(£110.27)	(£106.02)	(£4.25)	
Receivables	£26.70	£24.05	£2.65	



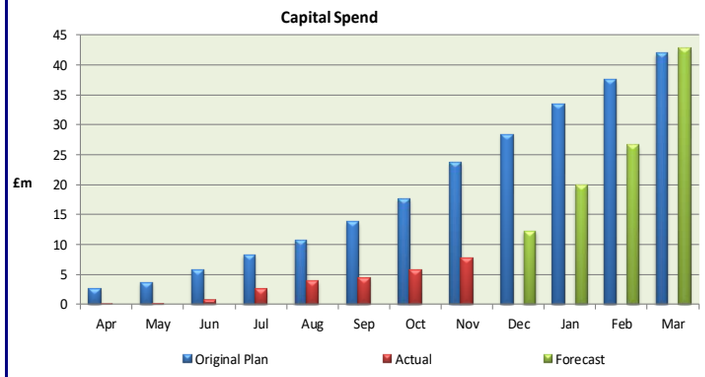


BETTER PAYMENT PRACTICE CODE



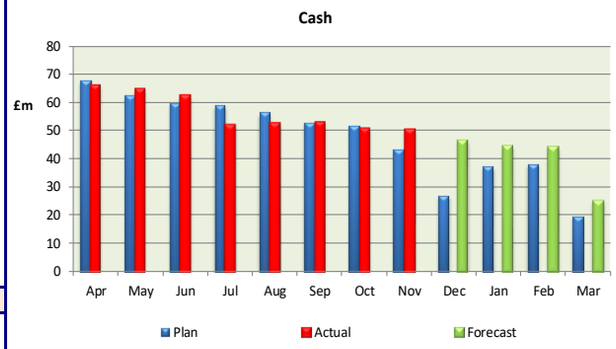
CAPITAL

	M8 Plan £m	M8 Actual £m	Var £m	M8
Capital	£23.67	£7.79	£15.88	

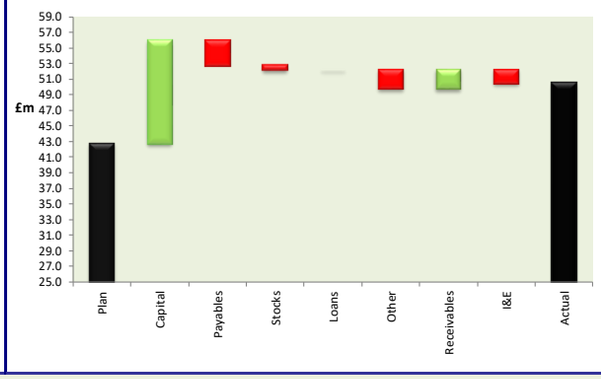


CASH

	M8 Plan £m	M8 Actual £m	Var £m	M8
Cash	£42.73	£50.50	£7.77	
Loans (Cumulative)	£15.46	£15.46	£0.00	



CASH FLOW VARIANCE



SUMMARY YEAR TO DATE

- Year to date the Trust is reporting an £14.99m deficit, a £1.78m adverse variance from plan.
- The adverse variance is driven by inflationary pressures, the costs of opening additional capacity and the associated premium rate staffing costs.
- 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. £12.13m of Elective Recovery Funding (ERF) was assumed in the plan, subject to delivery of 104% of 19/20 elective activity.
- £7.57m 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 99% of the activity planned year to date, (103% of 19/20 activity levels).
- Year to date the Trust has incurred costs relating to Covid-19 of £12.02m, (excluding testing and vaccination costs funded outside of System envelope), £5.60m higher than planned.
- Capital expenditure is lower than planned at £7.79m against a planned £23.67m. Capital plans now also include any new leases.
- Year to date the Trust has delivered efficiency savings of £12.37m, £0.39m 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

- Whilst the reported year end forecast continues to be in line with the planned £17.35m deficit, the underlying position would drive a significantly bigger deficit, which is largely mitigated by additional non recurrent funding, technical flexibilities, and system support. A mitigation gap of c.£1.8m remains to be identified.
- The forecast position assumes full delivery of a challenging £20m efficiency target. At the end of November 22, £19.83m 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 £11.73m of Elective Recovery Funding.
- The total loan balance is £15.46m as planned. No further loans are planned for this financial year.
- The Trust is forecasting to spend £42.81m on Capital programmes in this financial year including £2.92m on leases. The £0.82m adverse variance to plan is due to an increase in forecast donated assets (funded through charitable funds), additional PDC funded Reconfiguration expenditure and Endoscopy equipment.
- The Trust has a cash balance of £50.50m, £7.77m 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%

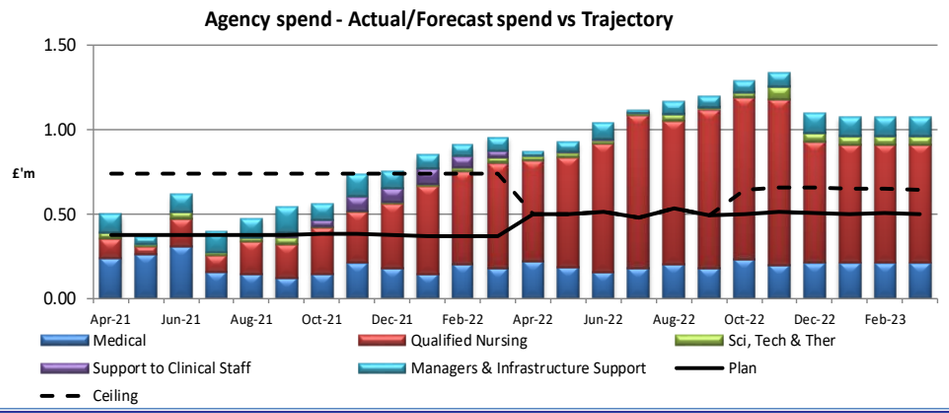
NB. In addition to the above rules, if Capital expenditure <85% of that planned then Red, (per NHSI risk indicator).

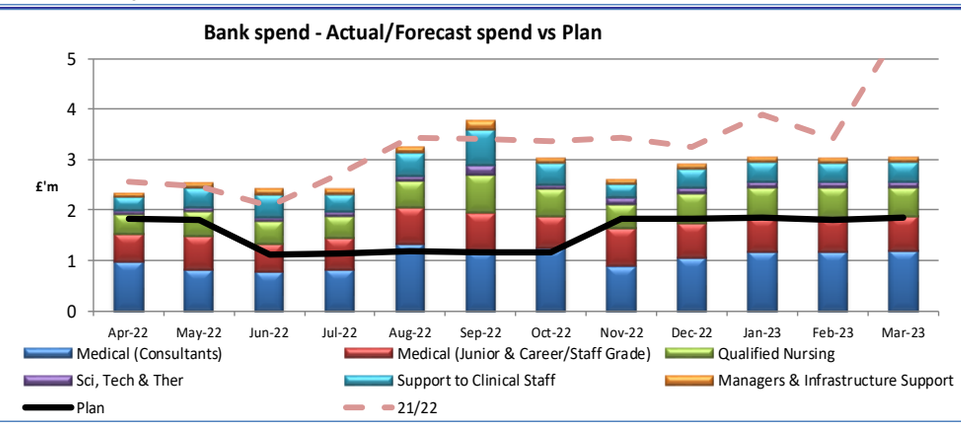
RAG KEY: UOR	
	All UOR metrics are at the planned level
	Overall UOR as planned, but one or more component metrics are worse than planned
	Overall UOR worse than planned

WORKFORCE

Vacancies

	Sci, Tech & Ther	Admin & Estates	Medical	Nursing	Support to Clinical	Total
Vacancies (WTE)	66	81	49	196	68	460
Staff in post (WTE)	766	1,521	665	1,713	1,206	5,870
% Vacancies	8%	5%	7%	10%	5%	7%





Cumulative Agency and Bank Spend	Plan	Actual	Var		NHSI Ceiling	Var from Ceiling	
	£'m	£'m	£'m		£'m	£'m	
Agency Year to Date	(£4.02)	(£8.93)	(£4.91)		(£4.31)	(£4.62)	
Agency Forecast	(£6.03)	(£13.23)	(£7.21)		(£6.90)	(£6.33)	
Bank Year to Date	(£11.21)	(£22.38)	(£11.18)				
Bank Forecast	(£18.54)	(£34.39)	(£15.85)				

Vacancies

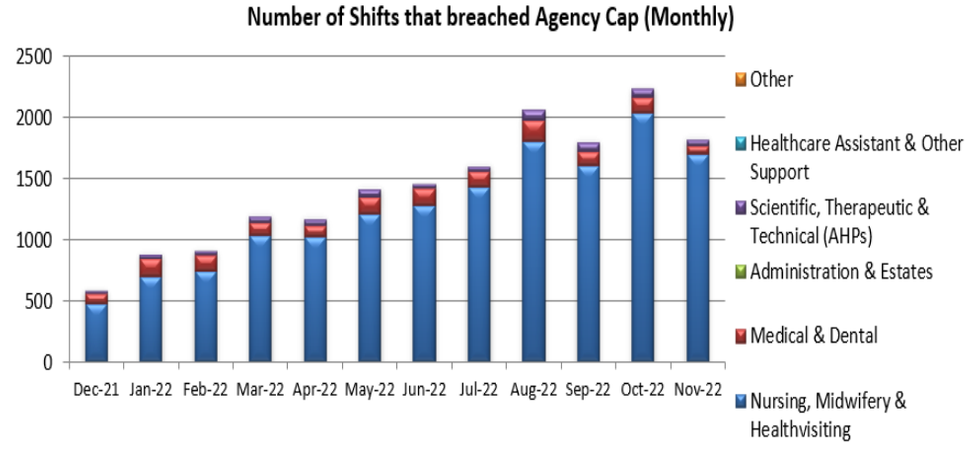
- Total vacancies: 460 or 7% of baseline establishment, an increase of 27 WTE compared to Month 7.
- The vacancies include additional capacity linked to Recovery and ongoing Covid-19 costs have been non-recurrently funded in budgets this year resulting in an increase to Establishment - in many cases these will be filled using temporary staffing due to the temporary nature of the staffing requirement.
- Total Staff in Post has increased since Month 7 by 14 to 5,870
- Medical vacancies have remained static at 7%.
- Nursing vacancies have increased by 1% to 10%.

Agency Expenditure

- Agency expenditure year to date is £8.93m; £4.91m higher than planned and above the annual ceiling for the full year.
- 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.
- Plans are being progressed to reduce visibility of shifts for Tier 3 agencies with the aim of reducing the cost impact.

Bank usage

- Expenditure on Bank staff year to date is £22.38m, £11.18m higher than planned.
- The overspend is linked to operational pressures, vacancies and unavailability of staff, and the 50% enhanced pay rates for bank staff that were in place between August and early November, (£1.95m impact), c. £0.70m a month.
- A new more targeted scheme started in November incurring a lower monthly cost of £0.30m.



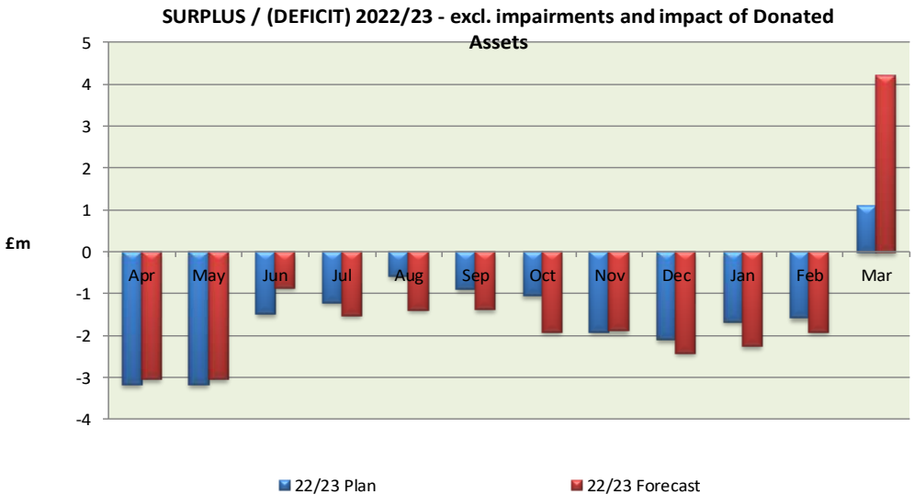
FORECAST POSITION 22/23

22/23 Forecast (31 Mar 23)

Statement of Comprehensive Income	Plan[2] £m	Forecast £m	Var £m	
Income	£485.35	£501.78	£16.44	
Pay expenditure	(£318.79)	(£329.15)	(£10.36)	
Non Pay Expenditure	(£151.58)	(£160.71)	(£9.14)	
Non Operating Costs	(£32.68)	(£29.48)	£3.20	
Total Trust Surplus / (Deficit)	**(£17.69)**	**(£17.56)**	**£0.14**	
Deduct impact of:				
Impairments (AME)[1]	£0.00	(£0.00)	(£0.00)	
Donated Asset depreciation	£0.43	£0.53	£0.11	
Donated Asset income (including Covid equipment)	(£0.08)	(£0.32)	(£0.24)	
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, the year to date deficit shows how challenging this will be and the identification of further mitigation will be required to offset the ongoing operational pressures. Capacity requirements have further increased and 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. Additional schemes have been identified to offset slippage on the original plan, leaving just a small gap yet to be identified. The expectation is that closing the remaining gap is feasible and full delivery of the target is expected.
- The Pharmacy Manufacturing Unit has not delivered the planned surplus in the year to date and is forecasting an adverse forecast variance of £1.57m by year end.
- 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 within the planned financial envelope and secure £11.73m of Elective Recovery Funding.
- The forecast assumes that the more targeted Bank rate enhancement scheme introduced from the 6th of November is a cheaper option than the previous 50% Bank enhancement scheme and costs no more than £417k per month as modelled.
- Further mitigation has been identified to offset Divisional forecast pressures, but a gap of £1.8m remains. However, given the reduced scale of the challenge, the current 'likely case' forecast as reported to the Integrated Care Board is delivery of the planned financial position.

Risks and Potential Benefits

- The forecast assumes full delivery of a challenging £20m efficiency target.
- The combined impact of the funded pay award and the changes to National Insurance rates is a £0.60m shortfall in funding.
- There is a risk that the revised scheme for Bank enhancements proves more expensive than expected or an expansion of the scheme is required due to operational pressures.
- 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.
- Opportunities to reduce Agency costs are being considered including a scheme to retract from Tier 3 Nursing Agency rates.
- The forecast assumes achievement of the requirements for the Maternity Incentive Scheme (Clinical Negligence Scheme for Trusts (CNST)), securing the £0.86m rebate.

Appendices

Appendices

COVID-19 & Recovery

Covid-19 Expenditure YTD NOV 2022	Pay £'000	Non-Pay £'000	Total £'000
Expand NHS Workforce - Medical / Nursing / AHPs / Healthcare Scientists / Other	724	0	724
Remote management of patients	139	0	139
Increase ITU capacity (incl Increase hospital assisted respiratory support capacity, particularly mechanical ventilation)	0	58	58
Segregation of patient pathways	9,466	253	9,719
Existing workforce additional shifts	159	0	159
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	265	265
COVID-19 virus testing - rt-PCR virus testing	183	83	266
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	0	0	0
Total Reported to NHSI	**10,766**	**665**	**11,431**
COVID-19 - Vaccination Programme - Vaccine centres (Locally Funded)	47	0	47
COVID-19 - Vaccination Programme - Provider/ Hospital hubs (Locally funded)	70	0	70
PPE - locally procured	0	-16	-16
Other COVID-19 virus / antibody (serology) testing (not included elsewhere)	471	0	471
Support for stay at home models	0	19	19
Internal and external communication costs	0	-1	-1
Grand Total	**11,354**	**668**	**12,022**

Recovery Costs YTD NOV 2022	Pay £'000	Non-Pay £'000	Total £'000
Independent Sector	8	4,659	4,667
Additional Staffing - Medical	1,485	0	1,485
Additional Staffing - Nursing	270	0	270
Additional Staffing - Other	770	0	770
Non Pay	0	1,222	1,223
Enhanced Payment Model - Medical	0	0	0
Enhanced Payment Model - Nursing	546	0	546
Total	**3,079**	**5,882**	**8,960**

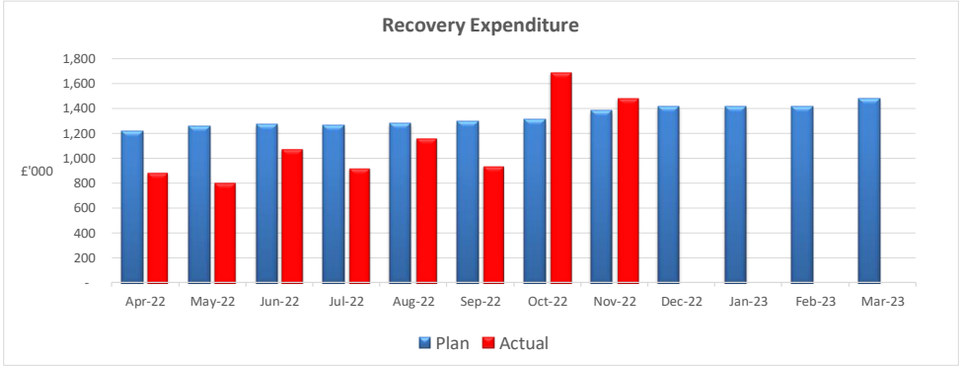
Covid-19 Costs
Year to date the Trust has incurred £12.02m of expenditure relating to Covid-19. Excluding Covid-19 costs that were outside of System envelope and for which funding can be claimed retrospectively, the year to date cost is £11.66m versus a plan of £6.06m, an adverse variance of £5.60m. This overspend was driven by higher than planned Covid-19 related activity leading to higher staffing and consumables costs and contributing to the requirement for additional Medical capacity. Outside of envelope costs are highlighted in the table to the left and total £0.36m year to date.

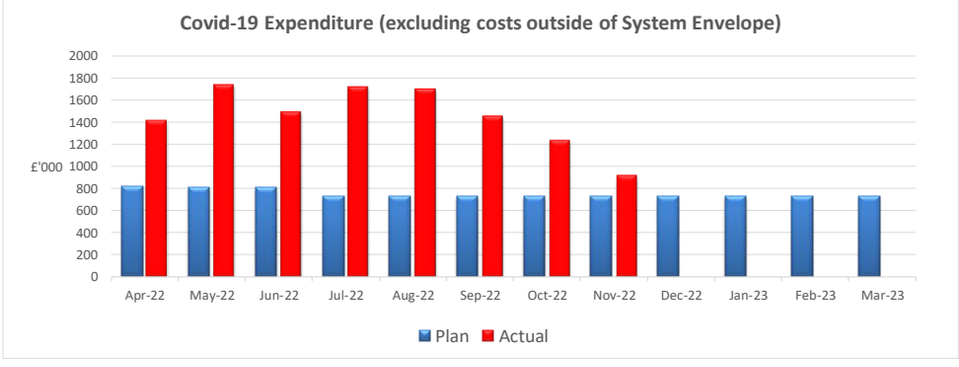
The Autumn Covid-19 vaccination programme has started and funding will be provided on a fixed cost per vaccine basis.

Covid-19 Funding
The Trust has been allocated block funding by the ICS to cover any ongoing Covid-19 costs and associated impacts totalling £6.00m for the year (£4.00m year to date).

Recovery
- Year to date Recovery costs are £8.96m, £1.30m lower than planned.
- Total planned Recovery costs for the year are £15.97m to deliver the required 104% of 19/20 activity.
- Funding of £12.13m 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. £7.57m of ERF has been assumed in the year to date position as planned, (profiled in line with activity plans). Funding has been secured for H1 and National guidance suggests that ERF is not likely to be clawed back in the second half of the year, but there is a local agreement to return £0.40m of the planned ERF to the Integrated Care Board (ICB) to support Independent Sector overspends in Kirklees Place.

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





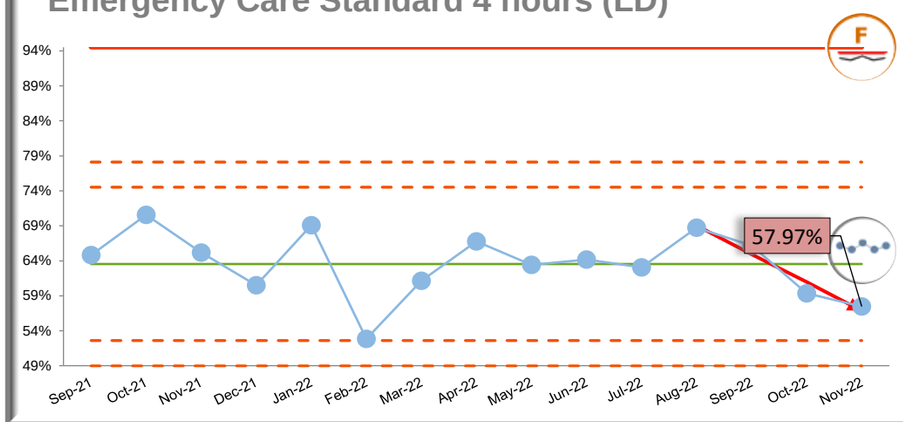
LD - Key measures

	21/22	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	YTD	Performance Range		
																Green	Amber	Red
Recovery																		
Total P2 on Waiting List (LD)	32	3	4	3	2	4	1	11	7	4	4	7	4	**1**	**1**	No target		
Total P3 on Waiting List (LD)	119	10	7	8	11	11	14	16	12	9	10	10	10	**7**	**7**	No target		
Total P4 on Waiting List (LD)	58	3	3	2	1	1	2	3	4	4	2	2	3	**4**	**4**	No target		
Emergency Care																		
Emergency Care Standard 4 hours (LD)	65.74%	65.65%	61.02%	69.57%	53.33%	61.62%	67.26%	63.93%	64.66%	63.54%	69.23%	66.67%	59.84%	**57.97%**	**63.83%**	>=95%		<95%
Waiting Times																		
18 weeks Pathways >=26 weeks open (LD)	569	58	69	61	63	54	50	48	55	41	36	38	36	**34**	**34**	0		>=1
RTT Waits over 52 weeks Threshold > zero (LD)	409	41	45	41	47	38	10	8	8	5	4	6	5	**3**	**49**	0		>=1
% Diagnostic Waiting List Within 6 Weeks (LD)	83.63%	0.8485	0.8497	90.43%	73.54%	68.48%	82.40%	84.64%	83.68%	85.80%	79.51%	87.80%	92.61%	**89.63%**	**85.38%**	>=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	100.00%	not applicable	not applicable	not applicable	100.00%	not applicable	100.00%	not applicable	not applicable	100.00%	100.00%	**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	100.00%	not applicable	not applicable	100.00%	not applicable	**not applicable**	**100.00%**	>=85%	81% - 84%	<80%
62 Day Referral From Screening to Treatment (LD)	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	not applicable	100.00%	**not applicable**	**100.00%**	>=90%		<89%
Activity - Number of Attendances																		
New Outpatient Attendances - Face to Face (LD)	366	33	38	38	24	31	37	40	41	40	48	59	38	**51**	**354**	No target		
New Outpatient Attendances - Non Face to Face (LD)	256	19	25	18	16	18	11	20	15	9	13	16	18	**12**	**114**	No target		
Follow up Outpatient Attendances - Face to Face (LD)	1426	120	135	144	122	113	119	149	137	86	117	123	132	**128**	**991**	No target		
Follow up Outpatient Attendances - Non Face to Face (LD)	845	74	47	45	56	67	56	61	61	41	48	50	55	**74**	**446**	No target		
Activity - % DNAs																		
% 1st DNAs (LD)	7.22%	6.58%	7.69%	10.87%	6.35%	9.59%	7.79%	3.33%	5.19%	10.14%	4.82%	7.41%	2.53%	**9.57%**	**6.35%**	<=7.0%	7.1% - 7.9%	>=8.0%
% Follow Up DNAs (LD)	5.72%	5.93%	8.10%	5.79%	6.13%	5.39%	6.53%	7.14%	4.07%	4.95%	6.44%	9.70%	7.66%	**6.25%**	**6.67%**	<=7.0%	7.1% - 7.9%	>=8.0%

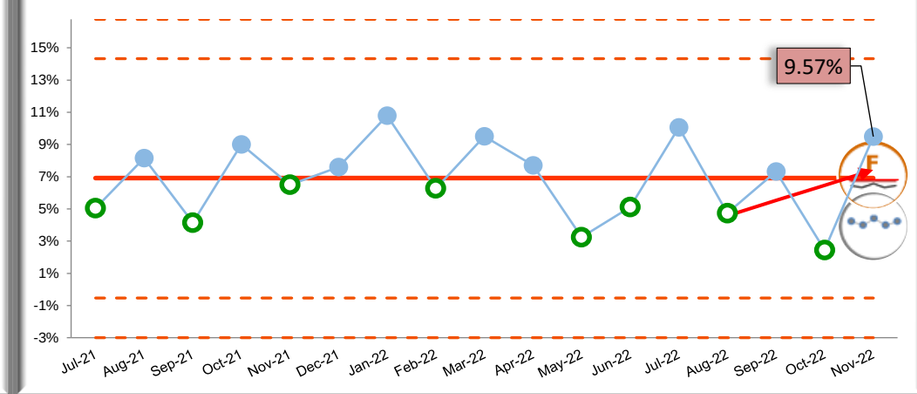
LD - SPC Charts

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

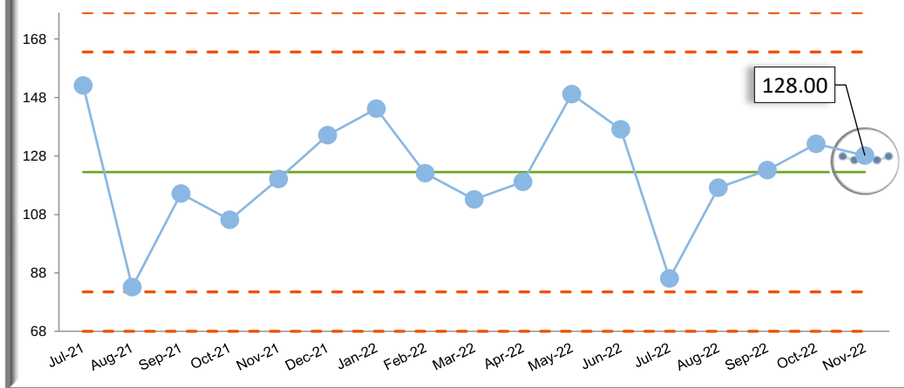
Emergency Care Standard 4 hours (LD)



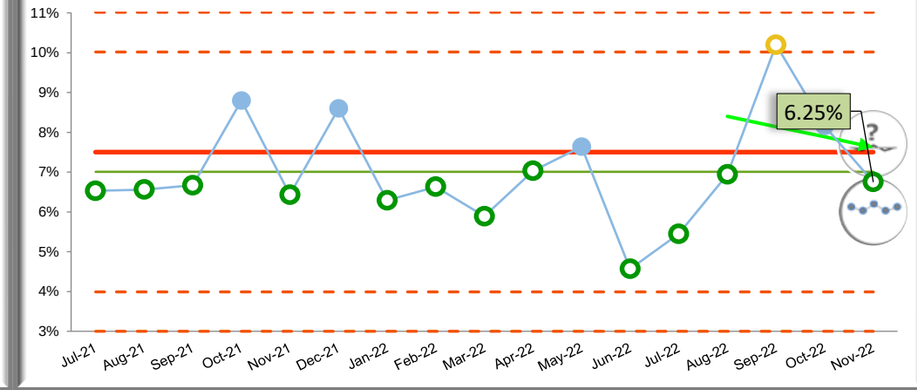
% 1st DNAs (LD)



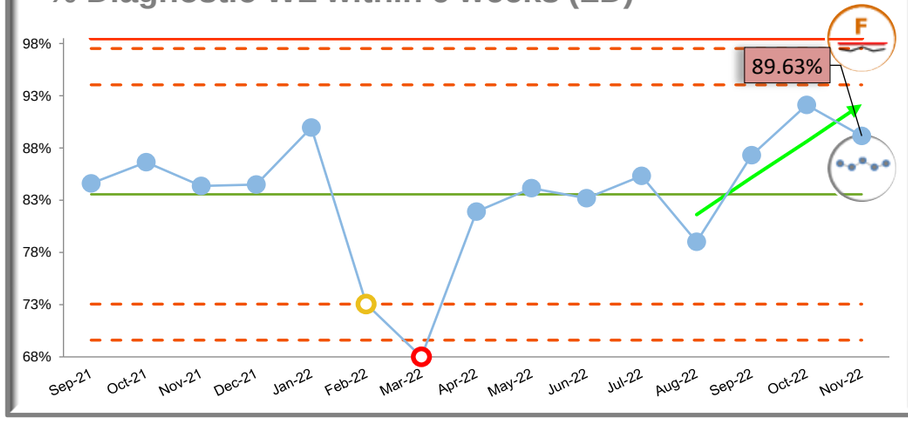
Follow Up OP Face to Face Attendances (LD)



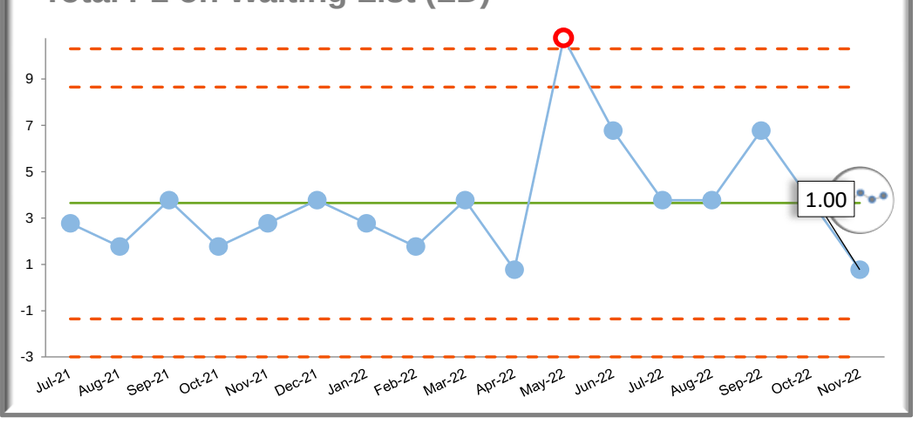
% Follow Up DNAs (LD)



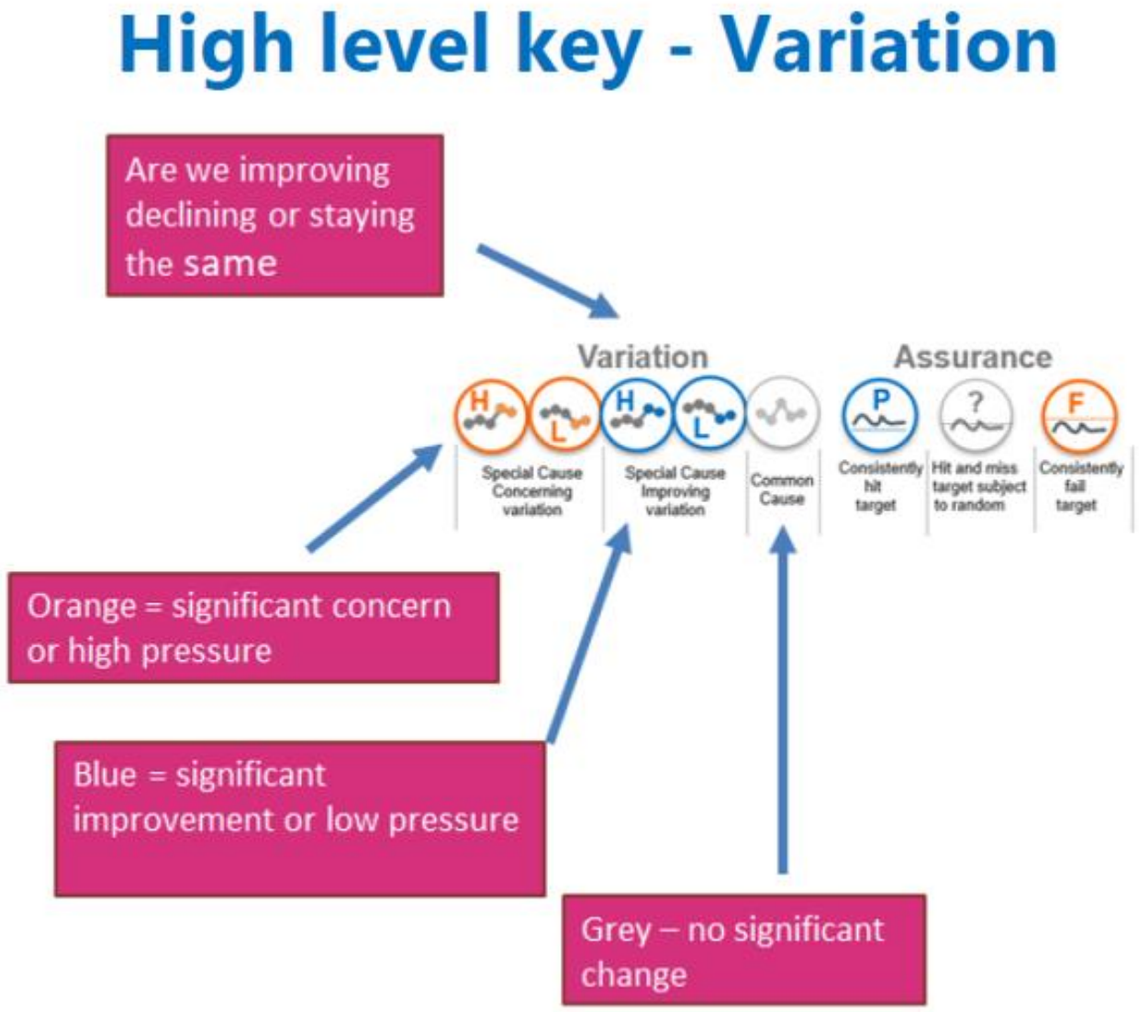
% Diagnostic WL within 6 weeks (LD)



Total P2 on Waiting List (LD)



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

4. Quality Committee

- Learning from Deaths Q2 Report

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	12 January 2023
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:	Mortality & Surveillance Group January 2023

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

In Quarter 2 (July – September 2022), there were 383 adult inpatient deaths at CHFT recorded on Knowledge Portal.

Of the **383** adult inpatient deaths recorded in Quarter 2 of 2022/2023, **119** (**31%**) have been reviewed using the initial screening tool. This falls short of the 50% target; however, the committee is reminded of the slight lag between issuing cases for review and completion of the reports (MSG have allocated mortalities up to September 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 Initial Screening Reviews. Extra support has been identified within our new cohort of Junior Doctors via the MSG Junior doctor representative

A total of **38** Structured Judgement Reviews (SJR) were requested in Quarter 2 (July to Sept) of 2022/23 of which **34** have been completed. The findings from SJRs are shared with the speciality mortality leads and appropriate Clinical Directors.
6 of the 34 structured judgement reviews were deemed poor care and reported to Datix.

EQIA – Equality Impact Assessment

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

Additional aspects of EQIA include:

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

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

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

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

Recommendation

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

Learning from Deaths Report Q2 data

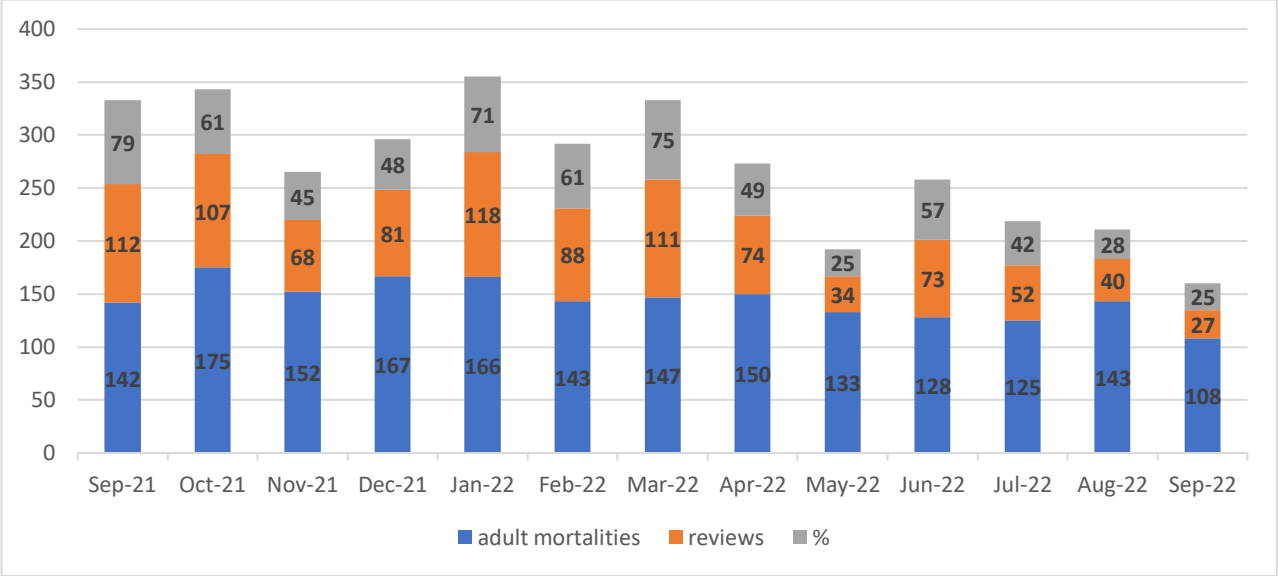
In Quarter 2 (July – September 2022), there were 383 adult inpatient deaths at CHFT recorded on Knowledge Portal.

Initial Screening Reviews (ISR)

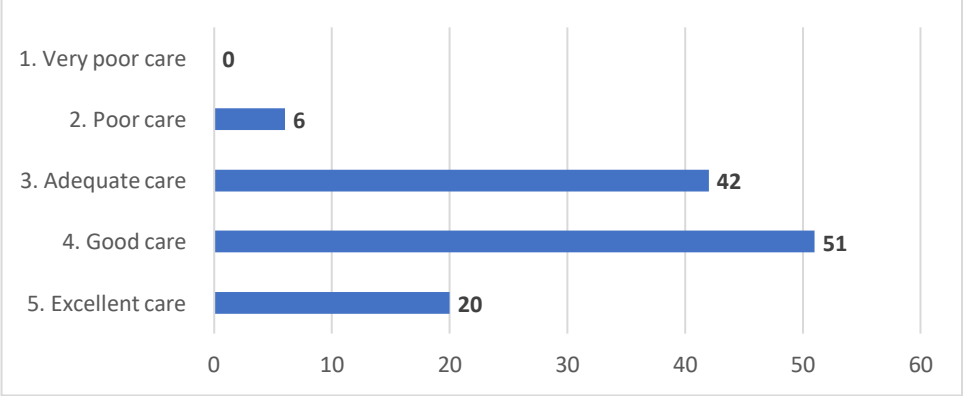
The online initial screening review tool focuses primarily on initial assessment, ongoing care, and end of life care. Reviewers are asked to provide their judgement on the overall quality of care. Specialities have been given the opportunity to identify additional specific questions to enhance the information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

Of the **383** adult inpatient deaths recorded in Quarter 2 of 2022/2023, **119** (**31%**) have been reviewed using the initial screening tool. This falls short of the 50% target; however, the committee is reminded of the slight lag between issuing cases for review and completion of the reports (MSG have allocated mortalities up to September 2022).

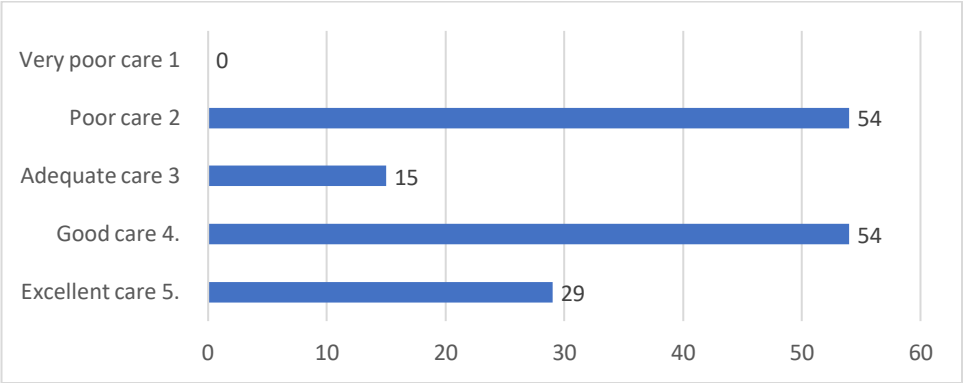
The table below shows the number of adult inpatient deaths reviewed by ISR by month over the last 12 months



Quality Care Scores for 119 ISRs completed in Q2 2022/23



Quality Care Scores ISRs completed in Q1 2022/23



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

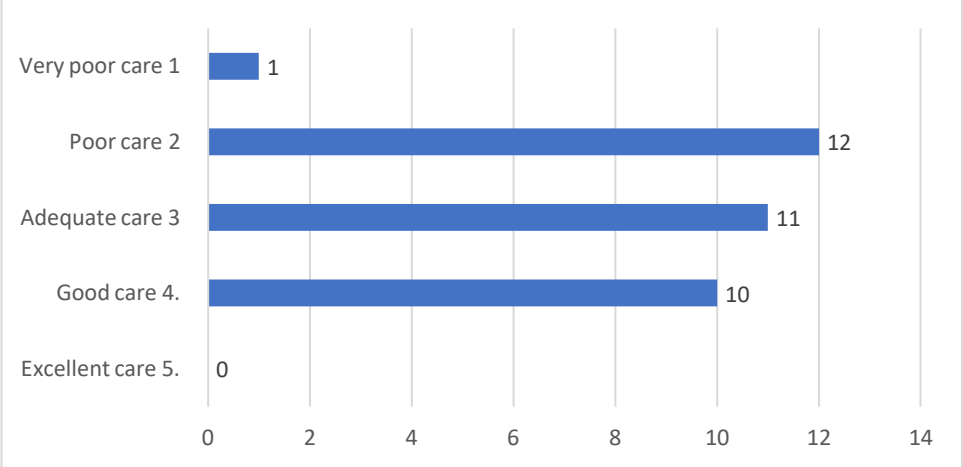
Structured Judgement Reviews Overview

219 SJRs were requested in the last 12 months. An increasing proportion of SJR's have been requested through the Medical Examiner's Office. This is to be expected and is a positive development. Early case review by an experienced medical practitioner which is intrinsic to the process, flags clinical concerns more promptly.

	Escalated from ISR	Escalated by ME	2nd opinion	SI Panel	Elective	LD	Complaint	Coroner	HED Alerts & Spike in deaths	Total
Oct 21	4	1	6	0	0	1	0	0	0	**12**
Nov 21	1	3	1	0	0	1	0	0	0	**6**
Dec 21	12	3	4	0	0	0	0	0	19	**38**
Jan 2022	6	6	5	0	0	0	0	0	2	**19**
Feb 2022	7	4	5	0	0	2	0	0	0	**18**
March 22	4	3	3	1	0	1	0	0	0	**12**
April 22	3	6	2	1	0	1	0	0	0	**13**
May 22	8	10	6	0	1	0	0	0	1	**26**
June 22	5	3	4	1	0	0	0	0	24	**37**
July 22	6	0	1	0	1	0	0	0	0	**8**
Aug 22	8	3	2	0	0	1	0	0	1	**15**
Sept 22	7	0	6	1	0	1	0	0	0	**15**
Total	**71**	**42**	**45**	**4**	**2**	**8**	**0**	**0**	**47**	**219**

A total of **38** SJRs were requested in Quarter 2 (July to Sept) of 2022/23 of which **34** have been completed. The findings from SJRs are shared with the speciality mortality leads and appropriate Clinical Directors.

Quality of Care score distribution for 34 completed SJRs



Of the 34 SJRs completed in Quarter 2 2022/2023 the following learning themes and concerns were identified:

The following good practice was identified:

- Excellent family communication
- The palliative care team reviewed the patient on the day of the decision to palliate
- Good timely assessment of severity of clinical condition and multidisciplinary involvement in important decision making.
- Good communication with the family in a timely fashion.
- Treatment started promptly led by senior team and decisions made appropriately
- Clear documentation of ceiling of care by Critical care
- DNACPR documentation completed in a timely manner
- Gastro advice sought regarding plan of care in a timely manner
- Family discussion and communication within MDT and family were of high standard.

The following poor practice was identified:

- Poor documentation i.e., lack of
- Operation carried out without vascular surgeons on site.
- There is a missed opportunity to review the patient when the NEWS score is 6, no review requested via HOOP
- Delays in appropriate speciality reviews
- More focus on End-of-Life care ought to have taken place.

Incidents identified via the Structured Judgement Review process

6 of the 34 structured judgement reviews were deemed poor care and reported to Datix. Details as follows:

213822 – Surgery & Anaesthetics Orange Investigation – difficult operation, patient suffered cardiac arrest – still under investigation.

216255 – Medicine Red Incident – Delay in treatment – still under investigation

219073 – Medicine Orange Incident – Delay in Treatment – Still under investigation
212163 – Medicine Incident downgraded to yellow following panel – Delay to monitor deteriorating patient – still under investigation
219333 – Medicine Incident – in the holding area awaiting review – reported 09/12/22
219335 – Medicine Incident – Delay in Treatment – under investigation

Recommendation to Quality Committee

Quality Committee is asked to note the Learning from Deaths Quarter 2 report.

5. Finance and Performance Committee - Huddersfield Pharmaceuticals Specials (HPS) Annual Report - To Follow

6. Minutes of Board Committees

- Finance and Performance Committee 1 November 2022
- Quality Committee 12 September 2022 and 24 October 2022
- Workforce Committee 11 October 2022
- Charitable Funds Committee 23 November 2022

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Minutes of the Finance & Performance Committee held on
Tuesday 1st Novmeber 2022, 13.00pm – 15.00pm
Via Microsoft Teams

PRESENT

Andy Nelson	Non-Executive Director (Chair)
Nigel Broadbent	Non-Executive Director
Kirsty Archer	Acting Director of Finance
Anna Basford	Director or Transforamtion and Partnerships

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
Philippa Russell	Acting Deputy Director of Finance
Vicky Pickles	Director of Corporate Affairs
Peter Howson	Commercial Director THIS
Rob Birkett	Managing Director THIS

ITEM

174/22 WELCOME AND INTRODUCTIONS
The Chair welcomed attendees to the meeting.

175/22 APOLOGIES FOR ABSENCE
Apologies were received from Jonathan Hammond

176/22 DECLARATIONS OF INTEREST
There were no declarations of interest.

177/22 MINUTES OF THE MEETING HELD 7th October 2022
Brian Moore was listed as both in attendance and as giving apologies. Brian was not present at the meeting. The minutes were then approved as an accurate record.

178/22 MATTERS ARISING
Since the last meeting the director team have carried out a Board Assurance Framework (BAF) review. A couple of the risks that this committee has responsibility for will look different in future when a revised BAF goes to Board.
Unable to maintain current levels of service due to COVID – the score has been reduced with mitigations in place
Not delivering the necessary improvements required to achieve full compliance with NHS EI. - the score has been reduced.

179/22 ACTION LOG

The Action Log was reviewed as follows:
Change actions marked as JF to JH.
180/21 Should be ready to review a draft at January 2023 meeting of this committee.
113/22 The ED deep dive has been deferred to December.
133/22 Summary sheets for minutes from other meetings. Not all minutes are yet being received.
143/22 AN and SD to meet to discuss workforce deep dive content. Meeting arranged. Close action.
143/22 Apprenticeship statistics to be requested from Suzanne. Requested but not received. AN to pick up at separate meeting with Suzanne.
144/22 Terms of reference to be brought to December committee for approval.
166/22 – Forecast Scenarios is an agenda item. Close action.

180/22 REVIEW OF THIS COMMERCIAL STRATEGY

The Commercial Director from THIS presented an update of the commercial strategy. The strategy was presented to this committee in September 21. At the point of the report THIS are now in month 6 of the first year of the strategy. The presentation was shared prior to this meeting. The aim was to give the committee assurance about progress regarding the strategy.

THIS's income comes from three main sources.

- SLA with CHFT £12.83m
- Contracts with 55 external partners and customers £4.7m
- A continued ad hoc target to achieve each year £1.6m

The strategy considers 13 objectives to be focussed on for the next three years. These include: Pricing, Investment in profitable areas, Opportunities with existing customers, New customers, Marketing and Promotion, ICB collaboration and Commercial collaborations.

MEASURING OF PERFORMANCE –

- Increase in the contract length of existing customers – Target 70% of customers to have contracts in place longer than one year. Currently at 60%.
- Increase in additional business value from existing customer base – Target growth of 5%. Currently at 4%
- Continued contribution to CHFT – on target. Planned to deliver
- Recurrent new business – Target for 2022/23 £250k. Currently £60k confirmed to date.
- Expand commercial collaboration portfolio – Target for 2022/23 – 1 new agreement. Currently 1 agreement confirmed and 2 others pending.
- Procurement framework – THIS to successfully be added to procurement frameworks. So far this has been unsuccessful due to the process involved.

SUMMARY THIS continues to be on target to meet its first year commercial targets. ICS and collaborative working is becoming a reality offering opportunities. Commercial versus partnership working is becoming more and more of an important conversation.

The committee asked how THIS were dealing with the challenges of recruiting and retaining staff. Different routes are being tried. Developing existing colleagues to promote from within. Trying different ways of recruiting. Also offering flexible working options to compete with other employers. Good track record of developing internally. There are currently five students on placement. There is a good engagement from Huddersfield University which is being expanded on.

THIS are working with Procurement to have everything in place in preparation for applying to be on the government frameworks. Previously missed out due to a combination of timing, and the fact that since THIS are part of CHFT, all CHFT's relevant paperwork has to be submitted alongside THIS.

Good lines of communication have been put in place with the ICB with the ICB approaching THIS for their input.

The Committee **ACKNOWLEDGED** the good progress made.

181/22 REVIEW OF THIS DIGITAL STRATEGY

The THIS Managing Director presented the annual review of the Digital Strategy initially presented to Board in July 2020. This is the second annual review and the strategy is in its third year. The update covers changes since the last update in July 2021.

Key points to note:

Point of care testing has gone live recently and involved some significant work on integrating these results into EPR. This has reduced transcription errors and allowing results to be accessed quickly. The Pharmacy EPR integration is the first of its kind between EMIS and Cerner and improved patient safety by reducing errors.

Microsoft Azure cloud platform – Historically new server rooms would have been requested as part of the reconfiguration work. Now that the cloud provision is in place the physical server footprint required is much smaller. Services will increasingly be moved into the cloud.

Allocated part of the technical budget to allow teams to be trained and enable them to deliver the services into the System. Capability, skills and capacity have been increased by recruiting new specialist roles.

Three key areas to be looked at moving forward:

Five years into EPR there are some improvements on the basics that need to be addressed.

A number of projects have been started and THIS are committed to completing them. Further progression around integration, core progression updates etc.

There is a wealth of data now available. Over the next 12-18 months will be assessing what can be done with the data and what it can tell us. Can it be used to predictively analyse services and patient pathways.

The committee asked for confidence around security of the systems. THIS have made significant investment in cyber security and protection around different types of cyber attack. Also audited and accredited on the ISO standards one of which includes information security.

There is reference to engaging with people with learning difficulties in the submitted paper but is consideration being given to other groups within the community who may struggle to access IT systems? Further work is required around access to systems within the community. Trying to increase engagement through patient groups.

The Optimisation plan referred to is what we could do if the resource is available.

THIS good new stories and successes need to be shared internally. The Trust is one of the leaders for implementing technology being one of the first regionally and nationally on occasion, with more to come. Possibility of using the screen savers to advertise more internally.

Work has been completed to allow GP surgeries to have visibility of patients records and vice versa. Easy to see how much has been achieved with very positive feedback. Regional integration programmes on patient records are planned within the next couple of years which may supersede this work.

The Committee **ACKNOWLEDGED** the good progress made.

FINANCE & PERFORMANCE

182/22 MONTH 6 FINANCE REPORT (Including High Level Risks and Efficiency Performance)

The Acting Deputy Director of Finance presented the Month 6 Finance Report. The Trust is reporting a £11.21m deficit, a £0.88m adverse variance from plan. The reasons behind this are similar to previous months – Inflation, additional capacity, impact of enhanced bank rates. Agency expenditure continues to be high reaching £940k in month 6 on nursing which was higher than seen in previous years. That takes the position to £3.3m above our agency plan year to date. Currently at £6.31m year to date with an ICB allocated ceiling of £6.9m for the full year. It is inevitable that this will be breached.

Funding was received towards the pay award, but it left a shortfall of £840k This will be a recurrent impact. Planned inpatient activity was behind plan at 96% which equates to 101% of the 19/20 plan. All Elective Recovery Funding (ERF) was secured for the first half of the year. Expectation is that the funding for the second half of the year will not be reclaimed but the funding is Place based funding so may not be wholly allocated to CHFT.

CIP position is positive year to date with just over £9m being delivered which is £650k better than plan.

Capital spend year to date shows just over £4m has been spent which is a £9.5m underspend. There has been slippage on reconfiguration, IT expenditure and lease expenditure for example. However, the expectation remains that the full capital plan will be delivered.

Aged debt is high in month 6 due to provider-to-provider invoices which were not received by some of our NHS partners due to a technical problem. These were settled early October.

Our use of resources metric is currently at level 4 which is the lowest level. The plan was to achieve level 3 but due to the agency position and year to date variance to plan we have slipped to 4. If our plan is delivered at the end of the year then we will reach Level 3.

In the year end forecast we are reporting externally a £17.35m deficit but there is risk particularly around inflation and the continuing staffing pressures. Predicting a mid-case scenario of an adverse variance from plan £5.5m. Changes have been made to the enhanced bank rate and there is an agency spend reduction plan underway to try to move away from the Tier 3 agency staff.

The Acting Director of Finance explained that at the recent West Yorkshire (WY) ICS finance forum it was discussed that several organisations are significantly over trajectory on agency spend. The difference being that the ceiling given to CHFT was lower than others due to previous years relatively low spend.

The members of the WY ICS reported having similar challenges to CHFT with staffing, inflation, and capacity.

There has been an acknowledgment of Covid numbers not reducing as expected. Funding of £2.28m referred to as bed capacity funding has been received which recognises that trusts have to have extra bed capacity in place. This does not remove the full pressure of extra costs and within ED specifically it does not cover the full pressure. Growth in demand and Covid difficult to separate especially in ED.

Regarding capital funding, divisions are being encouraged to submit agreed orders as soon as possible, but it was known that the plan would be to spend more towards year end as projects progressed.

The Committee **RECEIVED** the Month 6 Financial Update.

183/22 FINANCIAL RECOVERY PLANS – INCLUDES EFFECTIVE USE OF RESOURCES UPDATE

The Acting Director of Finance gave an update following the Forecast Scenarios shared at the last meeting. The best-case scenario remains the same which would be a nil variance to plan. Terminology has changed from last month with the likely case scenario now being described as “mid-case”. Assumptions made in the mid-case remain the same as last month but the projected adverse

variance has been reduced from £7.6m to £5.5m. This is due to progress having been made in closing the CIP gap as a result of hard work from colleagues.

Risks and opportunities include: ERF, Operational pressures, winter, covid, flu and the impact on staff. In addition trade union activity could lead to strike action and there is continuing political uncertainty but there are also opportunities for collaborative working with partners.

Action is being taken to mitigate these risks and explore the opportunities and is being managed through the Effective Use of Resources Group (ERG). This includes reviewing the enhanced pay.

Met with council officers from both Places so they are fully sighted on CHFT risks and to understand the risks across the ICB Places. A joint recovery group is currently being formed with system partners.

The ERG is now forward looking and putting plans together into next year and beyond. Distinct actions have been noted in ERG which look at future operating models. These have been given timetabled expectations

The Committee **RECEIVED** the Financial Recovery Plans.

184/22 INTEGRATED PERFORMANCE REVIEW – SEPTEMBER 2022

The Assistant Director of Performance gave an update. September had a positive in month performance with improvement in several domains. The Trust is in the best overall position since May and benchmarks well nationally. Emergency sepsis patients receiving antibiotic treatment within one hour of diagnosis is just now just below target. The cancer 28 day target was achieved again. CHFT is one of only three organisations to consistently achieve the 2-week wait target since August 2019.

Stroke struggled with the targets but in month there has been an improvement in those scanned within one hour. Starting to see the results of action plans put in place. ED performance at 75.44% was the third best performance in this calendar year.

Diagnostics was the best performance in 12 months with ECHO, MRI and Neurophysiology giving a better performance in month and aiming to reach 99% in the next three months.

In elective recovery numbers of patients waiting over 52 weeks are continuing to decrease. Workforce rolling 12-month non covid absence at 4.7%; lowest since March.

HMSR and SHMI presentation made to the Weekly Executive Board around actions to address the high scores. Past four months HSMR scores have been lower in month than the position at the end of 2021/ beginning of 2022. The expectation is that the rolling position will improve in the coming months. More detailed narrative in report.

The Committee **NOTED** the Integrated Performance Review.

185/22 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.

Slides included in the meeting pack for information. One patient who had been waiting over 104 weeks was discovered through validation and they now have a date in November. The 78-week and 52-week statistics show the breakdown by speciality.

The Access Delivery Group have an action plan in place for any areas going off track. A comparison slide is in the pack showing how CHFT compare in West Yorkshire. In General Surgery the most concerning area is maxillio-facial where mutual aid is being sought so a working group has been set up and data being reviewed weekly. Confidence that this will reduce.

ASI's – There is no external target but the Trust want to reduce numbers to pre-covid level. Work is ongoing with a paper around Cardiology and Gastroenterology going to the Medicine senior management team to look at the next steps for those specialities. 22 weeks slightly above trajectory.

Follow up back log – Excellent progress in Rheumatology but other specialities are showing an increase. Looking at the best approach to deal with this and will be followed up at the Access Delivery Group in a few weeks.

The Committee **NOTED** the Recovery Update for September.

186/22 ONE CULTURE OF CARE (OCOC)

Chairs highlight report will refer to any items linked to one culture of care.

187/22 DRAFT MINUTES FROM SUB-COMMITTEES

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

- THIS Executive Board
- Access Delivery Group
- Capital Management Group

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

188/22 WORKPLAN – 2022/23

The workplan for 2022/23 was reviewed.

- Fitting the deep dives in alongside the standing agenda items is proving challenging. The next three have all been moved to prevent more than one at each meeting.

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

189/22 ANY OTHER BUSINESS

The Chair asked the committee their opinion on extending this meeting given the challenges in getting the agenda completed in the time. There is some potential duplication between this and other Board sub-committees such as the Workforce Deep Dive. Deep dives may need to be better co-ordinated with with the Quality Committee.

The Chair concluded that the meeting would only be extended by exception to accommodate required deep dives when this committee is the correct place for it, with preparation of the deep dive before this meeting between the Chair and the team presenting. Meetings not to be extended to longer than 2.5 hours in these circumstances.

190/22 MATTERS TO CASCADE TO BOARD

Positives from IPR and recovery and the challenges that remain.

DATE AND TIME OF NEXT MEETING:

Tuesday 6th December 2022, 13:00 – 15.00 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)**	Chief Nurse
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

Monday, 24 October 2022

STANDING ITEMS

165/22 WELCOME AND INTRODUCTIONS

Present

Denise Sterling **(DS)**	Non-Executive Director **(Chair)**
Mr Neeraj Bhasin **(NB)**	Deputy Medical Director
Dr David Birkenhead **(DB)**	Medical Director
Gina Choy **(GC)**	Public Elected Governor
Andrea Dauris **(AD)**	Deputy Chief Nurse
Jason Eddleston **(JE)**	Deputy Director of Workforce & Organisational Development
Karen Heaton **(KH)**	Non-Executive Director
Lindsay Rudge **(LR)**	Chief Nurse
Elisabeth Street **(ES)**	Clinical Director of Pharmacy
Michelle Augustine **(MA)**	Governance Administrator **(Minutes)**

In attendance

Christopher Button **(CB)**	Lead Cancer Nurse **(item 170/22)**
Lucy Dryden **(LD)**	Quality Manager for Calderdale Integrated Care Board
Elena Gelsthorpe-Hill **(EG-H)**	General Manager – Children & Young People **(item 168/22)**
Nicola Greaves **(NG)**	Quality Improvement Manager - Patient Experience **(item 170/22)**
Julie Mellor **(JM)**	Lead Nurse – Children and Young People **(item 168/22)**
Dr Nicholas Scriven **(NSc)**	Consultant in Acute & Gen Med / Medical Examiner **(item 176/22)**
Diane Tinker **(DT)**	Director of Midwifery **(item 175/22)**

Apologies

Sharon Cundy **(SC)**	Head of Quality and Safety
Richard Dalton **(RD)**	Head of Risk and Compliance
Jonathan Hammond **(JH)**	Chief Operational Officer
Jo Kitchen **(JK)**	Staff Elected Governor
Victoria Pickles **(VP)**	Director of Corporate Affairs
Christopher Roberts **(CR)**	Deputy Director of Operations – Medical Division
Nicola Seanor **(NS)**	Associate Non-Executive Director
Kim Smith **(KS)**	Assistant Director for Quality and Safety

The Chair stated that the date of the meeting scheduled for 17 October 2022 was changed to 24 October 2022 at short notice due to a clash with another Executive meeting and thanked those in attendance for changing diary commitments to attend this meeting.

166/22 DECLARATIONS OF INTEREST

There were no declarations of interest.

167/22 MINUTES OF THE LAST MEETING AND ACTION LOG

The minutes of the last meeting held on Monday, 12 September 2022 were approved as a correct record. The action log can be found at the end of these minutes.

168/22 MATTERS ARISING

Split Paediatric Service Update

Elena Gelsthorpe-Hill and Julie Mellor were in attendance to present the above update, which was tabled at the meeting. The presentation will be circulated after the meeting (see end of minutes).

EGH provided some background to the previous paper presented to the Quality Committee in May 2022 on the paediatric split-site service, and the actions/next steps in relation to the paediatric escalation process and model to support Huddersfield.

As a result of reconfiguration in 2017, there is currently no resident paediatrician on the Huddersfield site, with a tolerated risk added to the risk register in June 2019, at a score of 12. In terms of current mitigation, there is an escalation process in place for sick and deteriorating children at Huddersfield (Escalation Process – Care of sick or deteriorating child on ward 4); an advanced paediatric nurse practitioner (APNP) based at Huddersfield 24/7 (SOP for APNP role in ED at HRI), and an APLS trained nurse on ward 4.

The paediatrician model across CHFT was shown, highlighting that a consultant is available remotely 24/7 and will attend Huddersfield for serious emergencies. However, unless there is a twilight consultant in place, which is two to four evenings per week from 2:00 – 10:00 pm, based on the current job planning, this leaves Calderdale without cover if they have to go to Huddersfield for those emergencies.

The current standards which the service is benchmarking themselves against were shown, with three based in the Children's Directorate and one within the Medical division. The service are currently focused on reviewing their standards against the acute paediatric care standards and taking those through the Directorate divisional processes.

The next steps are to revisit the paediatric escalation process as the risk cannot be mitigated with the current staffing model, and two to three additional consultants would be required to have resident cover at Huddersfield; finalise the current benchmarking against acute paediatric care standards, and to continue with the CQC transformation plan.

JM stated that Alison Smith, the regional lead for NHS England for children and young people, has joined the service to provide support over the last few weeks, and will have some formal feedback of her findings. **LR** stated that further work will be done at a system and regional level in developing a peer review framework, using our Journey to Outstanding (J2O) framework, as well as working with CQC, NHS England. A link to a tertiary centre is also proposed to further develop the model.

The Chair asked for confirmation that work around the escalation process is underway. **EGH** stated that the process is ongoing, however, as part of the wider work around the CQC transformation, the service want to review the Royal College of Paediatrics and Child Health (RCPCH) standards and incorporate those into the model and benchmark themselves again. **LR** stated that a meeting is held with the team on a weekly basis around the key children and young people standards which are expected to be monitored against, and also stated that this could be returned to the Quality Committee for a further focus.
Action: A focus on the children and young people standards to return to Quality Committee.

LR commented on the risk relating to the APNP model at Huddersfield, which is at a score of 16 on the risk register, stating that Simon Riley-Fuller (ADN in FSS) has been asked to review this. It was also noted that the Emergency Department (ED) are also looking at the impact of any incidents or near misses that have occurred as a result of the described risk, the results of which can be returned to a future Quality Committee for oversight and assurance to ensure that the risk is not tolerated.
Action: For any results of the review of the risk and impact of incidents and near misses to be returned to the Quality Committee

In terms of safe risk assessment, **JM** stated ongoing day-to-day work and moving of colleagues to work flexibly across-site to try to mitigate the fact that there is no on-site consultant cover at Huddersfield. There is a general consensus across paediatrics, orthopaedics and surgical specialties that the absolute focus is for a single-site paediatric service. The directorate, along with ED colleagues are questioning whether or not certain aspects of the original business case could be brought forward, rather than waiting until 2025

when the new ED is built. **DB** stated that in terms of reconfiguration and providing a solution, this is an ongoing challenge, as it would probably be beyond 2025 before there is a fully reconfigured service.

NB stated that in terms of escalation outside of ED, ward 4 patients at HRI are generally under an alternative specialty (general surgery, orthopaedics, etc.), and therefore in terms of risk assessment, it is expected that any deterioration or complications in those patients are more likely, in the first instance, to be secondary to either the orthopaedic or general surgery pathology that they have presented with, rather than something truly paediatric. **NB** asked whether it could be considered as part of the mitigation, that the general surgery orthopaedic team who are on site could respond to that in the first instance, because it would be around the surgical condition rather than requiring a paediatrician on-site specifically. **JM** stated that the standard operating procedure for Escalation Process – Care of sick or deteriorating child on ward 4 and Paediatric Surge and Escalation Plan (OPEL) were developed and shared with surgical and orthopaedic colleagues and relates to the deteriorating surgical orthopaedic patient as opposed to general paediatric medical patients. **DB** accepted that surgical patients on ward 4 should be a surgeons first port of call, however, this does not resolve the issues through ED, and stated that a paediatrician on-site would be helpful, however, this is currently a challenge and will need to be mitigated. The Chair also mentioned the key risk in regard to staffing and asked if there was any business planning taking place or a business case, and whether this would be a long-term risk.
Action: DB agreed to liaise with Venkat Thiyagesh for further detail on the above and feedback to the Quality Committee.

OUTCOME: **EGH** and **JM** were thanked for their updates.

Annual Complaints Report

Lindsay Rudge presented the report as circulated at appendix C, highlighting the key points to note, which included an increase in both Patient Advice and Liaison Service (PALS) concerns and formal complaints; the most prevalent theme across both concerns and complaints being communication; Complaint performance overall decreased in comparison to the previous year, and actions have been implemented to ensure an improvement in both quality of responses and performance.

The Chair noted communication being the most prevalent theme for complaints and asked how colleagues across the Trust were being made aware that communication and patients not feeling that they were being listened to was a theme. **LR** stated that this has been a real problem and is one of the impacts that COVID has had where people and families have not been able to come into the hospital, and some of the skills around effective and compassionate communication with families and carers is something that is being focused on and will be one of the improvement priorities for next year.

The Chair referenced the data about complaints from various groups and agreed for the need to review the data in more detail as the percentage of complaints from patients and carers from a black, Asian and minority ethnic (BAME) background seems to be very low. The Chair was pleased to note the increase in the number of face-to-face meetings as an approach to resolve complaints.

JE queried how the 2021-2022 report compared with previous years' reports, particularly those years prior to COVID. **JE** also asked whether there was a different range of themes being identified, and/or whether the shift within the range of themes were less staff attitude and more about communication, or vice versa. **LR** stated that there had been a shift, particularly around patient care, which was not previously in the top three prior to COVID. The report will also be submitted to the Board of Directors, and **LR** agreed to include an addendum to the report which includes the information.

OUTCOME: **LR** was thanked for the update and the Committee approved the report.

RESPONSIVE

169/22 QUALITY REPORT

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

The key messages around the quality and focussed priorities were provided, and it was noted that there has been progress with some, however, there was a difficult position in the three quality account priorities, namely, with reducing waiting times for individuals attending the ED. There had been increased activity in the ED, therefore achieving the priority is a significant risk; recognition and timely treatment of sepsis is improving; however, the reducing the number of hospital-acquired infections priority is challenging in terms of the changing of guidance and the testing regimes.

The Chair commented on the work done by the sole sepsis nurse and asked if there was any resource or support for when she was not available. **LR** stated that the sepsis nurse supports teams around their improvement activity, and her role is to build capability, capacity and sustainable processes in other colleagues to meet the target. **DB** stated that the work is led by the sepsis nurse, however, there is an approach that is developing and improving, with colleagues involved in managing sepsis throughout the organisation. **LR** also stated that the Quality directorate has earmarked for a Project Lead post which will oversee all projects around quality priorities and support clinical experts who support work streams. A job description has been drafted, and hopefully, a new Project Lead will be available from quarter four.

LR also noted that the end of life care section of the report will be updated prior to the report being submitted to the Board of Directors.

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

170/22 END OF LIFE CARE CQC REPORT

Christopher Button and Nicola Greaves were in attendance to provide an update on the CQC engagement visit which took place on 5 October 2022.

During the delivery of the presentation to the CQC, **CB** stated that the end of life care team provided assurance by identifying and addressing areas of weakness which were highlighted to the CQC as concerns.

The end of life care service is around providing care for patients within the last 12 months of their life, including those where death is expected to be imminent. The end of life care service and strategy fit with the national ambitions framework, with priorities which include identification of people in the last 12 months of life and high quality communication with them; coordinated, timely and equitable access to good care, and exemplary care in the last hours and days of life. The end of life care quality priority also helps address some of the issues, and the key focus within the priority are to increase the number of advanced care plans for all appropriate patients across the CHFT and community footprint; to further develop a service that will improve a person's experience pre- and post-bereavement, delivered by the ward teams, and to measure the impact of the seven-day working of our specialist palliative care service across the key performance indicators in the end of life care dashboard.

The National Audit of Care at the End of Life (NACEL) was published last year, with a monthly task and finish group taking place, working on key findings from the report and a number of key actions.

Patient experience intelligence across the Trust was presented which is now embedded within the quality priority, the patient experience group, the NACEL and the end of life care steering group. The challenges and successes of the service were also identified.

NSc asked whether the end of life care service receive information or feed into what medical examiners do, as medical examiners also talk to all bereaved next of kin for hospital deaths, and from next year, all deaths, usually within the first 24 hours after death, and also receive feedback from next of kin. **CB** stated that part of the work being done around the bereavement service is linking in with both the general office and medical examiners, as it is important that all three areas communicate for consistent discussions. **LR** also stated that it is important how the learning is triangulated.

The Chair asked about trustwide engagement and senior support at divisional and corporate level for the end of life care group, and whether there was any progress. **CB** stated that at times, there are still some issues with engagement, generally across the medical division due to 70% or more of deaths happening within the medical division, and engagement in the last six months has been lacking, however, the engagement within the monthly NACEL audit action group has been tremendous from the medical division, and likewise, for the CQC presentation. It felt that the team came together very cohesively, and that this will hopefully continue with future work on key actions. **LR** also stated that the Deputy Chief Nurse commences in post from 21 November 2022, and end of life care will be part of her portfolio which will help with senior leadership support.

OUTCOME: **CB** and **NG** were thanked for the update.

171/22 INTEGRATED PERFORMANCE REPORT

Lindsay Rudge and Dr David Birkenhead presented the integrated performance report as circulated at appendix E.

August's performance score was at 59% with the Finance domain now red. The safe domain improved to amber as there were no never events. The caring domain was amber with only one of the five Friends and Family Test areas green. There were further small improvements in both complaints and dementia screening. The effective domain remained amber, unfortunately fractured neck of femur deteriorated following good performance in July. Both Hospital Standardised Mortality Ratio and Summary Hospital-level Mortality Indicator continued to deteriorate with scores around 107. The responsive domain remained amber with cancer 28-day faster diagnosis performance just below target. Three of the four stroke indicators missed target whilst the underperformance in the main planned access indicators and ED remained a challenge moving forward. Workforce remained amber with non-Covid long-term absence increasing slightly in month. Return to Work Interviews fell to their worst position since December. Finance is now red with a deterioration in Use of Resources and I&E: surplus/deficit. Action plans and deep dives are in place to tackle those areas that have been underperforming for some time e.g. Complaints, Dementia Screening, Stroke, fractured neck of femur.

LR stated that further work is being done around correlation, as there is a deteriorating position around length of stay and transfers of care which impact the quality and safety performance indicators. Work is ongoing to capture on knowledge portal the impact of harm related to the length of stay, to see the correlation between increased length of stay and the impact that that may have on other metrics such as pressure ulcers, falls and medication incidents. **LR** also stated that it would be helpful to bring a presentation on the data to see the broader impact of all the increased activity and that expanded bed base to see what that means in terms of harm and incidence.
Action: Presentation to be requested for Quality Committee

The Chair mentioned the Commissioning for Quality and Innovation (CQUIN) and asked about the approach used to set the targets for this financial year. **LR** stated that the CQUINs came

with their own set of prescribed targets, and a number of them were selected which was done in partnership with Integrated Care Board (ICB) colleagues.

The Chair also noted the positives from the report on the strong patient story and outlined the work done in ophthalmology for paediatric learning disabilities and the impact from the patient / carer, colleague and Community engagement involvement.

OUTCOME: **DB** and **LR** were thanked for the update and the Quality Committee noted the report.

EFFECTIVE

172/22 QUARTER 2 LEARNING FROM DEATHS REPORT

David Birkenhead presented the above report as circulated at appendix F, highlighting the key point that in terms of the initial screening reviews, there seems to be more reported in the poor care category than in the past, which will require a deep dive to understand why this is, as it is a significant increase in that category, however, when the initial reviews have been submitted for structured judgment reviews, the difference disappears. In terms of overall performance, a significant number of deaths were reviewed from a quality of care perspective, with the learning summarised in the report. Whilst there is data on the themes, further work needs to be done on feeding the data back to individual clinicians. Referrals are also being made to the structured judgment review process from medical examiners, which shows that the process is working well and identifying areas of concern which can then be followed up.

The Chair asked for some assurance on how learning is being disseminated. **DB** stated that the leads for the reviews in each discipline take learning back into the patient safety and quality boards as themes, and possibly missing a more detailed feedback to individual clinicians on an individual case basis from the initial structured reviews and structured judgement reviews.

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

173/22 CLINICAL OUTCOMES GROUP MINUTES AND DASHBOARD

David Birkenhead provided an update from the clinical outcomes group via the circulated minutes and dashboard at appendix G.

The group approved a number of its sub-group terms of reference, and work continues around the Care of the Acutely Ill Patient programme, which will hopefully start to have an impact on Summary Hospital-level Mortality Indicator and Hospital Standardised Mortality Ratio moving forwards.

The Chair noted the mention of excess sepsis deaths and the work being done to look into whether any trends have been identified and asked if they were significant increases. **DB** stated that the alerts are statistically likely to have not happened by chance and is therefore worthy of investigation to ensure there is not a quality of care issue which may need addressing.

OUTCOME: **DB** was thanked for the update, and the Committee noted the minutes.

SAFE

174/22 INFECTION PREVENTION AND CONTROL BOARD REPORT

Dr David Birkenhead presented the report as circulated at appendix H.

The main challenges still relate to COVID and the changes to guidance around testing for COVID, which the Trust implemented, resulting in universal screening of patients on admission to hospital. This testing was withdrawn, and the result of that, in retrospect, is now

outbreaks of COVID within the hospital. CHFT is not unique, as this is taking place across the UK, with a large number of hospital onset COVID infections over the last month, and a number of outbreaks associated with that. CHFT have revised testing guidance accordingly and put control measures in place, and the numbers are starting to reduce.

Clostridium difficile remains a concern, however, CHFT is not unique in seeing increased numbers, and work is being done with antimicrobial prescribing, and the HPV deep clean of wards.

Since the report was written, there was one Methicillin-resistant staphylococcus aureus Bacteraemia case, which was a joint-care patient with Leeds and associated with a line infection.

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

175/22 MATERNITY OVERSIGHT REPORT

Diane Tinker presented the report as circulated at appendix I.

DT commented on the East Kent report which was published last week. There were no immediate actions from the report, however, a national maternity review is being looked into being published, which will pull together all recommendations and actions from all reports to produce a plan that can be delivered against.

In terms of the East Kent report, **LR** stated that going forward, the themes and trends could be included in the report, as well as any Friends and Family Test comments, and freedom to speak up activity.

KH commended **DT** and the team on progress made on the detailed and intense implementation plan.

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

176/22 MEDICAL GASES AND NON-INVASIVE VENTILATION (NIV) GROUP REPORT

Dr Nicholas Scriven was in attendance to present the above report as circulated at appendix J.

Key points to note were lack of engagement in attendance at the meeting and getting divisional colleagues to provide progress on training; the NIV lead stepping down from the role due to lack of time in job plan; and multiple changes in staffing in the medical and non-nursing roles, making it a challenge trying to identify who relevant colleagues are to target for attendance.

Previous ongoing actions in the Group include nitrous oxide and Entonox and desflurane; Oxygen training; Polices being updated; Oxygen audit; incidents being monitored, with the main ones being around patient transfer and a work on the new Transfer Policy; a new NIV Specialist Lead being appointed, and Chief pharmacists requested updates on outstanding actions in relation to security of VIEs and medical gases.

ES commented on the training in terms of designated nursing offices and designated medical officers, with around 50 trained a few years ago, to ensure that colleagues were available 24/7 who had knowledge of medical gases and the pipeline risks, however, the three year refresh timeline has now passed, and compliance has now decreased, which also relates to divisional representation and attendance at the meeting to feed this back into divisions.

LR asked if there were any solutions to the issues raised or whether any support was required from the Committee. **NSc** stated that in terms of attendance at the meeting, divisional representation has been sought, however, this is challenged due to turnover, and not being certain on who the correct representative is, therefore any help would be appreciated on

identifying the correct people to target to attend the meeting. **LR** asked whether a representative could represent all divisions, or whether a divisional lead is required. **NSc** stated that there is good representation from the medical division and critical care, however, there is a challenge with representation from the families and specialist services (FSS) division, surgery and anaesthetics division and paediatrics. It was stated that separate attendance from surgery and maternity were required, due to the use of Entonox in one division and other gases in the other division. **LR** agreed to meet with **NSc** outside of the meeting to logically go through the issues raised.

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

ITEMS TO RECEIVE AND NOTE

177/22 CANCER DELIVERY GROUP MINUTES

A copy of the Cancer Delivery Group minutes were available at appendix K for information. There were no questions from the Committee in relation to the minutes.

178/22 ANY OTHER BUSINESS

There was no other business.

179/22 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:

- Annual Complaints Report
- Update on the split paediatric service
- Update on maternity services

180/22 QUALITY COMMITTEE ANNUAL WORK PLAN

The workplan was available at appendix L for information.

POST MEETING REVIEW

181/22 REVIEW OF MEETING

There was feedback on the good chairing of the meeting and a lot of challenge placed by members, as well as good practice included in reports.

NEXT MEETING

Monday, 14 November 2022
3:00 – 5:00 pm
Microsoft Teams

QUALITY COMMITTEE ACTION LOG

Following meeting on Monday, 24 October 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)	**IPR – Stroke Deep Dive**	**Christopher Roberts / Helen Rees**	**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 to the November meeting.	**See November 2022 agenda item 185/22**
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	**See November 2022 agenda item 185/22**
UPCOMING ACTIONS				
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. **Update Oct 2022**: See item 168/22 **Action 24.10.22:** A focus on the children and young people standards to return to Quality Committee. **Action 24.10.22: DB** agreed to liaise with Venkat Thiyagesh for further detail on the above and feedback to the Quality Committee. **LR** commented on the risk relating to the APNP model at Huddersfield, which is at a score of 16 on the risk register, stating that Simon Riley-Fuller (ADN in FSS) has been asked to review this. It was also noted that the Emergency Department (ED) are also looking at the impact of any incidents or near misses that have occurred as a result of the described risk, the results of which can be returned to a future Quality Committee for oversight and assurance to ensure that the risk is not tolerated. **Action 24.10.22**: For any results of the review of the risk and impact of incidents and near misses to be returned to the Quality Committee	**Date TBC** **DUE 21 December 2022** **DUE 21 December 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 **Update Oct 2022**: Deferred to a future meeting – date to be confirmed	**Due 21 December 2022**
24.10.22 (171/22)	**Integrated Performance Report**	**Lindsay Rudge**	**LR** also stated that it would be helpful to bring a presentation on the data to see the broader impact of all the increased activity and that expanded bed base to see what that means in terms of harm and incidence. **Action**: Presentation to be requested for Quality Committee	**Due 21 December 2022**
CLOSED 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. **Update Oct 2022**: See item 168/22	**CLOSED 24 October 2022**

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Split site paediatric services

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Background

- Julie Mellor (Lead Nurse for Children and Young People), David Britton (ADN, ED) and Stacey Cartwright(Matron, ED) presented a paper outlining the paediatric split site service and ongoing reconfiguration relating to this in May 2022
- Actions/next steps were:
  1) Formalise the governance arrangements of the 2 services within Medicine and FSS– agreed this is the Medicine Division
  2) Work to enhance the service for CYP in ED- Directorate teams)
  3) Work towards a single site paediatric service, in line with reconfiguration plans– Directorate/Divisional teams)
  4) **Revisit the paediatrician escalation process– Children's/FSS**
  5) KS and David Britton to meet to put together 'quality improvement methodology with paediatrics and the ED, which will have external support and produce outcome measures'– Kim Smith/David Britton

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Action 4 – Revisit the paediatrician escalation process

- As a result of reconfiguration in 2017:
  - There is no resident paediatrician at the HRI site– summary of current service model provided in the next slide
  - Risk no. 6916 (score 12, added January 2017 – agreed as a tolerated risk in June 2019) – The paediatric trainee/consultant rota cannot provide resident cover for surgical and orthopaedic inpatient children and young people on the HRI site, leading to the risk of delayed diagnosis and optimal shared decision making about treatment and care. This may result in harm to children and young people. This risk has arisen as a result of early service reconfiguration of paediatric medical services moving to CRH.
- Mitigation
  - Consultant paediatrician model provided in the following slide
  - Escalation process (updated December 2021) in place for the care of a sick or deteriorating child on ward 4, HRI
  - 24/7 APNP on ward 4, with in reach to ED (however, there are 2 vacancies)
  - 24/7 APLS trained nurse on ward 4

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Current model - Consultant Paediatrician cover

Monday - Friday	CRH	HRI - no onsite paediatric medical cover
09:00 – 1300	• Consultant of the week covers ward 3 and emergencies • PAOU consultant answers GP referrals, community midwife queries, A&E referrals, safeguarding referrals, and actions advice and guidance requests	• PAOU consultant cover remotely via telephone- consultant attends HRI for serious emergencies e.g. transfer (not the ideal model)
13:00 – 17:00	• Consultant of the week covers ward 3 and emergencies • Safeguarding consultant completes safeguarding clinic (referrals vary) • Twilight consultant starts 1pm (10pm, 2-4 days per week)	• Safeguarding consultant supports emergencies at HRI, however whilst also covering safeguarding at CRH • Twilight consultant (10pm, 2-4 days per week) – deals with telephone advice and attends HRI for serious emergencies
17:00 – 09:00	• On call consultant • Twilight consultant (10pm) supports paediatric flow 4 days per week	• On call consultant • Twilight consultant (10pm) supports paediatric flow 4 days per week
Weekends/Bank Holidays	**CRH**	**HRI**
09:00 – 17:00	• Consultant covers ward 3 and emergencies	• Consultant available for serious emergencies **but at the cost of CRH ward/A&E being left uncovered**
17:00 – 09:00	• On call consultant	• On call consultant

Action 4 – Revisit the paediatrician escalation process cont.

- Directorate benchmarking against RCPCH Facing the Future standards ongoing:
  - Emergency care
    - 70 standards
    - Governance sits within Medicine
  - **Acute paediatric care**
    - **10 standards and 5 implementation factors**
    - ***In the process of assessing the service against these***
  - Care outside the hospital
    - 11 standards and 4 implementation factors
  - Ongoing needs
    - 11 standards

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Revisiting the paediatrician escalation process- next steps

- Risks cannot be mitigated with the current staffing model
  - Review of number of consultant paediatricians (we would require 2-3 additional consultants to have resident consultant cover at HRI)
- Finalisation of current benchmark against acute paediatric care standards
- Continue with CQC transformation plan – pathways will be captured through this

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CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

Minutes of the WORKFORCE COMMITTEE

Held on Monday 11 October 2022, 3.00pm – 5.00pm
VIA TEAMS

PRESENT:

Peter Bamber	(PB)	Governor
David Birkenhead	(DB)	Medical Director
Mark Bushby	(MB)	Workforce Business Intelligence Manager
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
Andrea McCourt	(AM)	Company Secretary
Lindsay Rudge	(LR)	Chief Nurse
Helen Senior	(HS)	Staff Side Chair

IN ATTENDANCE:

Neeraj Bhasin	(NB)	Deputy Medical Director (observing)
Andrea Dauris	(AD)	Interim Deputy Director of Nursing (for items 97/22, 98/22, 99/22)
Jackie Robinson	(JR)	Assistant Director Human Resources (for item 102/22)

91/22 **WELCOME AND INTRODUCTIONS**

The Chair welcomed members to the meeting.

92/22 **APOLOGIES FOR ABSENCE**

Gary Boothby, Director of Finance
Denise Sterling, Non Executive Director

93/22 **DECLARATION OF INTERESTS**

There were no declarations of interest.

94/22 **MINUTES OF MEETING HELD ON 16 AUGUST 2022**

The minutes of the Workforce Committee held on 16 August 2022 were approved as a correct record.

95/22 **ACTION LOG – OCTOBER 2022**

There were no due or forward actions to note.

96/22 **QUALITY AND PERFORMANCE REPORT (WORKFORCE) – SEPTEMBER 2022**

MB presented the report.

Summary
Performance on workforce metrics is now amber and the Workforce domain has decreased to 67.3% in August 2022. This has remained in the amber position for fourteenth months. 7 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 – August 2022
Staff in Post has reduced slightly at 6087, which, is due, in part to 43.61 FTE leavers in August 2022. FTE in the Establishment was 5840.51, and along with student nurses leaving. Turnover increased to 8.93% for the rolling 12-month period September 2021 to August 2022. This is a slight increase on the figure of 8.63% for July 2022.

Sickness absence – August 2022
The workforce domain 12-month rolling, and in-month absence non-covid target is 4.75%. The target for non-covid long term absence is 3.00% and 1.75% for non-covid short term absence. The compliance rate for return to work interviews has also been refreshed from April 2022 to 80%, a stretch compliance rate of 90% has been retained. The in-month non covid sickness absence increased to 4.49% in August 2022. However, the rolling 12-month rate for non covid sickness decreased to 4.77%. Stress, anxiety and depression was the highest reason for sickness absence, accounting for 30.47% of sickness absence in August 2022, with chest and respiratory problems the second highest at 16.36%. The RTW completion rate decreased from 60.79% in July (at the first run of data), and 65.02% at the final run down to 56.17% in August 2022.

Essential Safety Training – August 2022
Performance has increased in only 2 of the core suite of essential safety training. With 6 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 increased to 92.89% from 92.63% and is the second increase month on month. It is however no longer above the stretch target of 95.00%.

Workforce Spend – August 2022
Agency spend increased for the month to £1.16M, whilst bank spend increased in month by £1.18M to £3.26M.

Recruitment – August 2022
4 of the 5 recruitment metrics reported reached target in August 2022. The time for unconditional offer to acceptance in August 2022 increased to 4.0 days.

KH commented on previous concerns raised regarding RTW compliance and noted the Finance and Performance Committee had recently expressed its concern. JE confirmed a paper would be brought to the December Workforce Committee meeting.

KH remarked on bank and agency spend figures recognising a probable link to the vacancy numbers and turnover.

KH asked about the Education Committee's progress in its review of EST. JE confirmed a stop is in place to prevent further modules being added to the EST suite. Significant work is still to do to alleviate role specific EST. It is unlikely the number of core specific modules will be reduced. A timeline will be confirmed to the next Workforce Committee meeting. KH commented specifically on fire safety training and HS remarked that colleagues had experienced difficulty registering for and recording completion of the training. SD referenced previous efforts to tackle issues and took an action to explore with subject matter experts a way forward to improve colleague learning experience.

Action: Review of EST fire safety training (SD)

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

97/22 **NURSING AND MIDWIFERY SAFER STAFFING REPORT**

AD presented a report that provided an overview for Nursing, Midwifery and AHP staffing capacity and compliance within CHFT in line with the National Institute for Excellence (NICE) Safe Staffing, National Quality Board (NQB) and the NHS Improvement Workforce Safeguards guidance. This is supported by an overview of staffing availability over the reporting period and progress with assessing acuity and dependency of patients on ward areas. The data collection informed the Nursing and Midwifery establishment reviews for 2022-2023.

JE was interested to know what the most significant concern was. AD responded the ongoing position of escalation is a significant challenge as it massively impacts on the vacancy position. An ambitious international recruitment target has been set which is seen as a second pipeline recruitment strategy and added this possibly will become a business as usual model so other strategies need to be explored. LR agreed there is an immediate impact on quality and safety metrics and is pleased to see that colleagues continue to red flag and report incidents. LR also described some of the multi-factorial consequences of the escalator positions for example colleague health and wellbeing and sickness absence. SD stated the WYAAT HR Directors are reporting the same stresses adding that focus on health and wellbeing is vital and explained there is enormous wrap around pastoral care provided to international nurses. SD highlighted the valuable role of volunteers in supporting non-care activities. An unsuccessful funding bid had affected the taking on of additional volunteers. More resources to manage and oversee the volunteer service is needed and SD suggested a workforce and nursing joint bid may be more successful.

KH commented on the thorough report and felt the report provided assurance on the analysis and scrutiny off staffing. She asked how safe is the staffing level and is there a staffing threshold. LR advised the numbers are important but not in isolation. Daily tactical and operational decisions are based upon dependency, acuity and skill mix. The enhanced dashboard is reviewed twice weekly. Safety issues are investigated and actioned.

KH asked for clarification of the additional costs (£1.6m) set out in the report and if the funding had been agreed or if there was a potential impact on budgets. LR responded there are cost neutral workforce changes within the budget and explained the additional monies are linked to escalated capacity. LR agreed to provide more explanation in the report ahead of it being submitted to Board of Directors. PB asked if there was any data available that measures if staffing is getting easier or harder. LR and AD described the metrics and dynamic measures in place emphasising the OPEL escalation action cards.

OUTCOME: The Committee **APPROVED** the report

98/22 **NURSING WORKFORCE PROGRAMME UPDATE**

AD provided an update on the progress of the strategic initiatives to establish safe and effective nurse and midwifery staffing. The report described a number of strategies. AD highlighted:-

- A piece of work that will provide granular detail of the recruitment strategies and projection detail that can objectively inform business cases and proposals going forward.
- Increased uptake in 18 year olds applying to study nursing. The Clinical Education Team are working closely with clinical areas to support students and assist with any day-to-day issues and student assessments. Placement opportunities have been extended over four pilot areas increasing student capacity between 20 to 50%.

- NHSE launched a national retention strategy. CHFT is currently undertaking a self assessment that will help to inform our strategies going forward.

LR wished to acknowledge that over the last couple of years AD has been undertaking the safer staffing fellowship programme. She thanked AD for bringing back to CHFT real evidence of connectivity to the programme. The Trust is in a good position in terms of its workstreams, reporting and assurance mechanisms.

KH was pleased to hear about increased interest in a nursing career path. KH thanked AD for a comprehensive report and the continued hard work.

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

99/22 **DEVELOPING WORKFORCE SAFEGUARDS – NURSING, MIDWIFERY AND MEDICAL**

AD and DB presented an update on the progress against the 14 key recommendations as set out in the developing Workforce Safeguards (2018). The key points to note are:-

- Of the 14 recommendations the Trust continues to maintain compliance with 9 recommendations, and partial compliance with 5 recommendations. However further progress has been made against recommendation 1 and 2 for nursing and midwifery workforce groups, changing this position to green.
- Effective workforce planning has a positive impact on quality of care and patient, service user and staff experience, while ensuring financial resources are used efficiently.
- Accurate plans will help predict the numbers of healthcare workers required to meet future demand and supply and help with improvements in safe and effective care delivery.
- The intended review of the Integrated Performance Report provides to address recommendation 5 and 8.

KH felt it reassuring to note 9 of the recommendations are maintained and progress is expected against other recommendations.

OUTCOME: The Committee **NOTED** the assessment against the 14 recommendations including the revised action plan.

100/22 **MEDICAL WORKFORCE PROGRAMME UPDATE**

DB presented the report, the key points were highlighted:-

- There continue to be challenges following the acute pandemic response whilst moving into the recovery agenda.
- These challenges are potentially compounded by evolving pay and pension issues.
- Medical workforce recruitment and retention continues to be a challenge in certain areas; however, the Trust is being proactive and innovative in terms of recruitment solutions.
- There is continued focused leadership to support this agenda.
- The impact upon quality of care if there is understaffing across clinical areas.
- The current compliance against the Developing Workforce Safeguards (2018) guidance and action plan.

DB thanked the work of the medical workforce teams led by Jackie Robinson and Pauline North and their contribution to this report.
NB informed the Committee that a WTGR programme is being developed around physician associates to tackle long standing junior doctor gaps. A refresh of the medical workforce steering group is also being undertaken and a look at cultural changes to explore how we can do things differently.

JE was pleased to hear of the considerable work and asked if there was anything specific that would make significant improvement. DB stated faster progress of the erostering and job

planning piece would give a better understanding of gaps and would also inform safe staffing levels. Succession planning is also key and KH echoed this.

KH felt the work across all staffing levels is impressive and thanked all staff involved for the joined up work. DB wished to thank Workforce and OD colleagues for their support in this work.

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

101/22 **DIVERSITY PARTNERS PROGRAMMES**

JE presented a paper that showed the Trust's continued commitment to supporting equality, diversity and inclusion (ED&I) by joining the NHS Diversity in Health and Care Partners programme. The Trust is entering into year 3 of its ED&I strategy and the next step is to review the strategy and plans with support from this programme. The programme is underpinned by the NHS values and supports:-

- leaders to integrate the latest sustainable diversity and inclusion practices
- the creation of culturally appropriate and inclusive services to meet the needs of a diverse range of patients and care service users
- organisations to be the best employers and service providers they can be

JE confirmed the Trust participated in the first module in September 2022.

OUTCOME: The Committee **NOTED** the Trust has been accepted onto the Programme.

102/22 **REVIEW PROGRESS ON RECRUITMENT STRATEGY**

JR presented an overview action plan based on the new Recruitment Strategy approved by the Workforce Committee in April 2022. Progress is monitored on a quarterly basis. JR will circulate the more detailed action plan.

JR updated the Committee on values based recruitment. An external company has been identified to work with the Trust. The implementation phase with the company is ensuring our one culture of care and compassionate care branding is across all visuals. The company will provide support in values based scenarios and pre-sifting applications.

JR reported a number of weekend recruitment fairs are taking place and additionally CHFT colleagues are attending job centres and really getting out into the local community.

KH noted the good practice and looked forward to seeing results from these activities.

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

103/22 **BOARD ASSURANCE FRAMEWORK**
RISK 12/19 COLLEAGUE ENGAGEMENT

SD presented the deep dive report which outlined the key controls in place to manage and reduce risk.

SD highlighted the financial impact on colleagues and described activities to provide as much support as possible such as increasing food banks and creation of clothes banks. SD explained that a recent presentation she attended reported that 1 in 9 people are experiencing in work poverty and are having to choose between essentials such as heating or buying toiletries. SD highlighted that operationally led movement of colleagues adds to colleague discontent and we need to do everything possible from a physical and mental point of view. Some indicators show that colleagues are still engaging with us, to date we have a

higher than average staff survey response rate. Appreciation week showed an overwhelming number of thank you's. 282 nominations received for the annual CHuFT awards. SD noted the current trade union activity regarding increased pay being out of our control and hoped that nationally colleagues feel they are being rewarded equitably for their input and effort.

AMc asked for clarification on the staff survey response rate. SD confirmed our response rate is a percentage higher than the average for Trusts this year. SD will ensure the report is made clear on this point.

AMc referred to gaps in control and actions taken and asked if there are any specific actions around leadership and manager visibility that can be articulated. SD responded the quantifiable piece that can be added is the compassionate leadership programme and manager guides that reinstates leadership.

KH thought the paper outlined very well all the activities in place.

OUTCOME: The Committee **NOTED** the report and activity and support being offered to colleagues and the retained score.

104/22 **EDUCATION COMMITTEE UPDATE**

JE highlighted some of the Education Committee's key activity points:-

- Connected with ICB and Place based colleagues to ensure we are properly linked as a provider organisation so we can realise the benefits those connections make in terms of knowledge and funding to invest in educational activity.
- Commissioned a piece of work on how we spend the Apprentice levy
- Soft launch of our learning needs analysis. There is some work to do at Place level before going live proper in April 2023.
- The Education Committee is to sign off the Education Centre Target Operating Model following further socialisation. The Committee had already received representation about the model and following further socialisation it will be received by the Committee for sign off.

KH felt the EC is gathering momentum. JE agreed the Committee is making progress on a few themes and is still on track to deliver its commitments.

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

105/22 **WORKFORCE COMMITTEE WORKPLAN**

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

106/22 **WORKFORCE COMMITTEE 2023 DATES**

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

107/22 **ONE CULTURE OF CARE – MEETING REVIEW**

SD felt the hard edge of one culture of care is covered by making sure we have enough people for it to be manageable and the softer side being engagement. She felt it had been a really good meeting with nursing and medical colleagues doing a phenomenal job and should be very proud. A real teamwork approach. KH endorsed this and felt the one team working comes through very well and the enthusiasm and the commitment comes through very clearly in the reports.

108/22 **ANY OTHER BUSINESS**

No other business was discussed.

109/22 **MATTERS FOR ESCALATION TO THE BOARD OF DIRECTORS**

EST and RTW interview compliance
Nursing and medical workforce reports
Recruitment strategy
BAF – Colleague Engagement
Education Committee

110/22 **DATE AND TIME OF NEXT MEETING:**

7 December 2022, 3pm – 5pm

Minutes of the Charitable Funds Committee meeting held on Wednesday 23 November 2022, 10.30 – 12.00 via Microsoft Teams

PRESENT

Helen Hirst (HH)	Chair
Kirsty Archer (KA)	Acting Director of Finance
Nigel Broadbent (NB)	Non-Executive Director
Jo Kitchen (JK)	Trust Governor

IN ATTENDANCE

Richard Lee (RL)	KPMG
Vicky Pickles (VP)	Director of Corporate Affairs
Emma Kovaleski (EK)	Charity Manager
Carol Harrison (CH)	Charitable Funds Manager (Minutes)
Emily Overend (EO)	Marketing & Communications Assistant
Emma-Leigh Quinn (EQ)	Fundraising & Engagement Coordinator
Lyn Walsh (LW)	Finance Manager
Zoe Quarmby (ZQ)	ADF – Financial Control

Introductions were made at the start of the meeting as there were new attendees.

1. DECLARATION OF INDEPENDENCE

At the beginning of the meeting the Charitable Funds Committee members made their Declaration of Independence.

2. APOLOGIES FOR ABSENCE

Apologies were received from Lindsay Rudge, David Birkenhead, Gary Boothby, Peter Wilkinson, John Gledhill and Adele Roach.

3. MANAGEMENT LETTER, DRAFT LETTER OF REPRESENTATION and DRAFT REPORT & ACCOUNTS 2021/22

RL reported that the audit went smoothly with no issues and that no errors were identified. He was happy, on behalf of KPMG, to give us a clean audit opinion as reflected in the Management Letter.

KA and HH thanked CH and the Finance Team for the quality of the Accounts and thanked EK and the team for making the Annual Report an enjoyable read.

The Letter of Representation was approved and could be signed off and returned to KPMG.

It was also agreed that, pending an amendment being made to the Chair's Message regarding the previous Chair, the Committee approved the Report and Accounts and would be returned to KMPG for their final sign off.

ACTION: EK/LW/CH to arrange for all documentation to be completed and signed off. **23.11.22 – 1**.

4. MINUTES OF MEETING HELD ON 11 MAY 2022

The minutes of the meeting held on 11 May 2022 were approved as an accurate record.

HH noted that, although the August meeting was cancelled, the Committee had approved some General Purpose bids via email.

5. ACTION LOG AND MATTERS ARISING

EK gave an update on the action log and asked that the first two actions be closed as they will be replaced by a new action regarding EK applying to NHS CT for a development grant of £30,000.

It was agreed that the action regarding the Reserves Policy review would be amended in the context of our longer term strategic thinking to ensure the two align. It should be noted that the policy is due for its annual review at the next meeting in February 2023.

ACTION: EK to apply to NHS CT for a development grant. **23.11.22 – 2**.

ACTION: CH to update Action Log re closed items and amendments to Reserves Policy review action. **23.11.22 – 3**.

6. CHARITY MANAGER'S REPORT

EK presented the report showing where the current position and activity within the Charity and future plans. Its contents were NOTED.

Discussions were held around the phasing of the three year refresh strategy starting in 2023 and what were the strategic imperatives. Also discussed were the fundraising strategy and balance between lots of effort and little gain and the risks around finding big potential donors. Other items discussed were a brand refresh, governance (especially around bids) and NB, as a new member, asked for a breakdown of the funds structure to be included.

HH asked for EK to set out the phases and timescales around the strategy to give the Committee clarity and an engagement plan.

ZQ and KA asked about the Imagination Appeal and it was agreed that this appeal would now be closed.

ACTION: EK to draw up a plan showing phases and timescales of the refresh strategy **– 23.11.22 – 4.**

ACTION: CH to close the Imagination Appeal fund and **EK** to close the appeal on JustGiving **– 23.11.22 – 5 and 6.**

7. FINANCE REPORT to end Sept 2022

CH presented this paper and its contents were NOTED.

8. FUNDING AND NEW FUND REQUESTS
General Purpose Bids
Bid 1 – Airvo
Bid 2 – Retinal Camera
Bid 3 – TULA Lasers x 3

The Committee felt it was not able to make decisions regarding these bids as it did not currently have enough information and the correct forms were not completed. It was agreed that EK would go back to the bidders, get the necessary information and recommend to the Committee (in particular, the three General Purpose fund managers – KA (for GB), DB and LR) so that decisions can be made. It was agreed that this would be done via email as soon as possible and recorded formally at the next meeting.

ACTION: EK to gather more information on these bids in order for the Committee to make decisions. **– 23.11.22 – 7.**

New fund request
Enhanced Care Team – this was not covered and will be carried over to the next meeting.

9. GOVERNANCE
Terms of Reference – to review. VP recommended that the Committee agrees to the tweaks that she suggested and that there may be further recommendations after she has carried out some go sees in the spirit of good practice around governance. She will bring back the Terms of Reference for review.

Risk Register – to review. This was NOTED but it was felt that some additional work was needed around the scores which seemed low. It also needed to realign to our strategic objectives. NB offered his help if required.

Work Plan – to be carried forward to next meeting.

ACTION: VP to bring amended Terms of Reference, Risk Register and Work Plan to Feb meeting **– 23.11.22 – 8.**

10. MINUTES OF STAFF LOTTERY COMMITTEE MEETING 14 JUNE and 13 SEP 2022
These papers are for information only and their contents were NOTED.

11. ANY OTHER BUSINESS
EK mentioned funding for Christmas presents and a discussion took place, arising in EK and VP drawing up some guidelines to be published by Comms week commencing 28th November.

DATE AND TIME OF NEXT MEETING:
tbc

7. Health and Safety Annual Report 2021-2022

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

BOARD OF DIRECTORS

12 JANUARY 2023

HEALTH AND SAFETY ANNUAL REPORT – 1 APRIL 2021 – 31 MARCH 2022

1. PURPOSE

The purpose of this report is to provide the Board with information about the levels of compliance across the Trust which includes many improvements. The overarching benchmark to compliance is the NHS Workplace Health and Safety Standards which is underpinning the work completed now and the future. As a helpful reminder, the NHS Workplace Health and Safety Standards describe what is required and the evidence needed, covering 30 different pieces of legislation and an equal number of subordinate regulations. These have been written between the NHS and the Health and Safety Executive and therefore provide a high level of credibility. The level of compliance is shown in (Appendix B). The purpose of sections 2-4 is to give the reader an update on the progress made across the year, including many new initiatives being carried out to further strengthen against risk.

2. PROGRESS AND ACTIONS

Planning Reviews

- A review of the 5-year health and safety strategy has taken place because it was important to reflect the work already completed in the last 18 months and the actions needed for the future (Appendix C).

- A review of the General Health and Safety Policy has been done to ensure attention continues to be given to key areas of risk.

- An ambition to achieve the requirements of ISO-45001 Occupational Health and Safety Management System has started, which will double the level of confidence in compliance, complimenting the NHS Workplace Health and Safety Standards.

Collaboration

- Promotion of incident reporting has taken place with attendance at the Matron and Band 7 Meeting together with advice on the requirements for reporting shared on the health and safety intranet page.

- A joint effort between the Head of Health and Safety and ISS Ltd has taken place, using the time/resources given by ISS Ltd to help promote a health and safety culture. This has centred around a health and safety roadshow, taking place in 2022yr. The aim of the Roadshow was to highlight and champion safe working practices with presentation stalls and activities set-up.

- Directly engaging over 50 practice managers and building operations managers has taken place, because many of the community-based colleagues occupy their buildings. The aim has been to seek confirmation of their due diligence measures, with special attention given to some of the higher risk related matters, including asbestos exposure risks, electrical conditions, gas safety and legionella risks. It is relevant to note that after visiting these buildings during 2022yr, the age/condition of the buildings provided confidence.

- Closer alignment between the Head of Health and Safety, Manual Handling Team, and Occupational Health Team has taken place because of the synergies between risks and workloads prevents duplication and promotes joined-up thinking.

- Collaborative work has taken place with Overgate Hospice to help them strengthen their due diligence measures, including risk assessments, policies, training etc.

Reviews

- All clinical and non-clinical areas across the Trust have now been subject to a workplace health and safety risk assessment. This keeps CHFT in line with regulatory expectations and ensures oversight of any common risks/improvement plans.

- Joint working between the Head of Health and Safety , Head of Nursing and clinical teams has taken place regarding ligature risks. Work has been completed on reducing the risk of patient self-harm by looking at all the potential ligature anchor points across the Trust. This has resulted in the completion of over 50 risk assessments and the roll out of new training to over 900 colleagues with the supply of ligature release devices and available immediately.

- A review of the maternity risk assessment has taken place, in partnership with Workforce and OD/subject matter leads, with improved content and sign-posting information.

- The opportunity to complete a display screen equipment assessment has been offered to all 106 desk-based colleagues who are spending most of their working day in front of a monitor screen inputting data across the different workplaces within CHFT. The use of prolonged data inputting has inherent risks in relation to aches/pains of the upper shoulders, central neck area, eye fatigue and repetitive strain injuries and it is anticipated these actions will reduce any related future sickness levels and increase comfort. The outcome of this project was successful in identifying a small group of colleagues who required adjustments and alterations, due to their medical conditions. Partnership working took place with a local supplier of DSE equipment for those colleagues requiring it.

3. HEALTH AND SAFETY COMMITTEE

The Health and Safety Committee met on the following dates during this reporting period. The aim of the CHFT health and safety committee is to have oversight of compliance across all relevant non-clinical risk areas and to seek assurance/confirmation of measures to reduce or remove the risks.

Dates of meetings

- April 2021
- June 2021
- October 2021
- December 2021
- February 2022

Reporting of Injuries, Diseases and Dangerous Occurrences

This piece of legislation is about those injuries which are the more severe end of the injury spectrum and or include any injury leading to more than 7 days of work. A list of diseases and dangerous occurrences are equally reported to the Health and Safety Executive. There were 15 reported incidents in this period, compared to 19 reported incidents in the previous peiod. This is good news, considering there was a, awareness piece early in the year about the importance of reporting incidents.

It can also be reported, that CHFT hasn't received any enforcement actions or visits by the HSE.

4. INITIATIVES 2021-2022

Partnership working with Occupational Health Team and the Moving and Handling Team

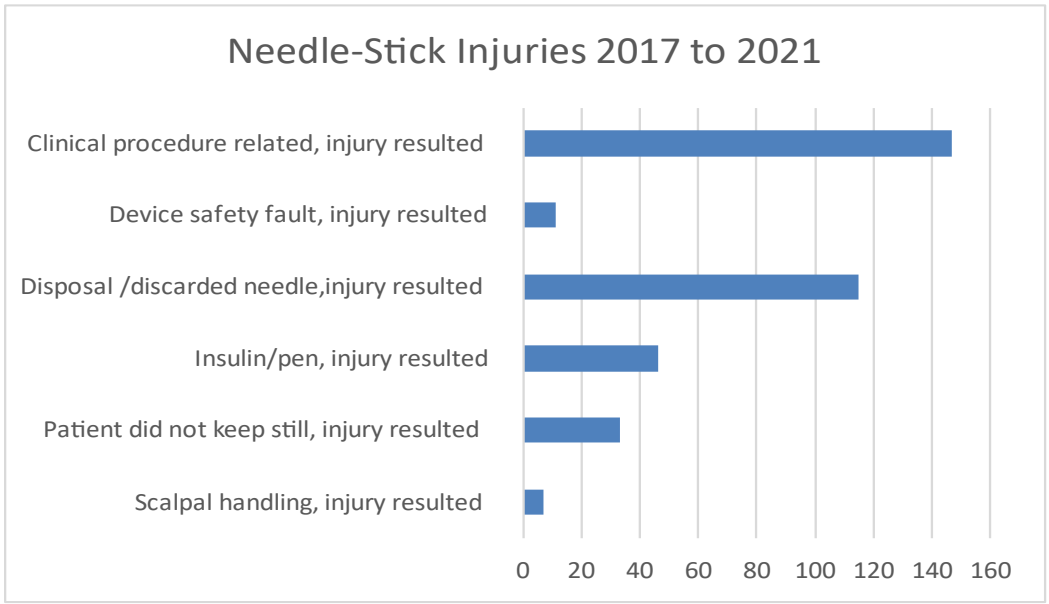
There is an opportunity to work triangularly, between the Head of Health and Safety, Head of Occupational Health and the Moving and Handling Lead. This is because there is shared interest and understanding on some of the risks which appear on DATIX and therefore working smarter together to get results will improve the end outcomes for colleagues. Examples of joint working have included several projects e.g. display screen equipment assessments, appointment of an HSE approved Doctor and sharps reduction activities.

Sharps Injury Reduction Work

Data mining of the underlying causes of sharps injuries has taken place and the DATIX results since 2017yr have shown trends and patterns of interest. As a result, the Head of Health and Safety has been working directly with Matrons, IPC lead, ISS Ltd, CHS Ltd Senior Clinical Educator and others to form a plan of improvements.

The bar chart represent the root causes associated with needle-stick injuries.

Graph (1) Needle-stick Injuries 5-year data



The following table shows existing and extra measures taken to help reduce the number of needlestick injuries experienced by colleagues. The expectation is that these extra measures will take effect during 2022-2023yr.

Sharps Injury Reduction Actions

Legacy measures in place to help reduce needles-stick injuries pre-2022yr	Extra measures implemented to further help reduce injuries
Appointment of Daniels Healthcare to complete an audit of sharps management.	Attendance by IPC at the LIPC meeting to share some of the information and raise awareness around sharps management
FLO audits completed on all wards	A review of the FLO audits has been completed to ensure sharps management is clear.
Band 7 Workshop events	Extra information around sharps management added to the Band 7 Workshop events
IV theory training given on induction to all newly qualifies nurses, midwifes and ODPS. Face to face	5-key messages added to IV theory training to raise awareness of sharps injuries and delivered to newly qualified nurses, midwifes and ODPS, face to face training
	A newsletter (Appendix D) produced and shared Trust wide, includes a section on sharps bin management
	A review of the ANTT training material to ensure sharps management is clear
	A message of the month (Appendix E) added by IPC which refers to 5-key bin management messages
	Extra information added to the Venepuncture and canulation presentations, delivered monthly to substantive staff who require the essential safety training, face to face training
	Extra information added Virtual Student inductions – all learners that attend placement at CHFT – these are delivered x 2 weekly
	Information added to the new Dr Toolbox booklet, produced for Locum Doctors to read and is a fast way for them to be quickly inducted into the Trust, when only doing a couple of shifts

5-key messages added to the Intranet weekly screensaver

Ligature Risks

A task and finish group has been set-up and its aim has been to make sure the risk of an individual attempting to cause themselves life threatening harm is reduced so far as is reasonably practicable. There has been a national upward change in the data from NHS England that has shown increasing attempts of self-harm within hospital environments. In response the following has been done.

- Since the appointment of the new Nurse Consultant for mental health, direct working has started between the Head of Health and Safety, with the aim of working collaboratively upon risk assessment processes.

- Training material has been developed for all clinical colleagues to complete. The content of the material centres around the risks/controls. The training continues to be available and circa 1000 colleagues have now completed it.

- Through teamworking with others, circa 50 ligature prevention risk assessments have been completed across the Trust, with the aim of identifying high risk anchor points, and where possible interventions/removals have been put in place.

- Ligature-release kits have been supplied across wards, which are available in an emergency.

- An audit process is now in place to ensure all the above continues to be in place.

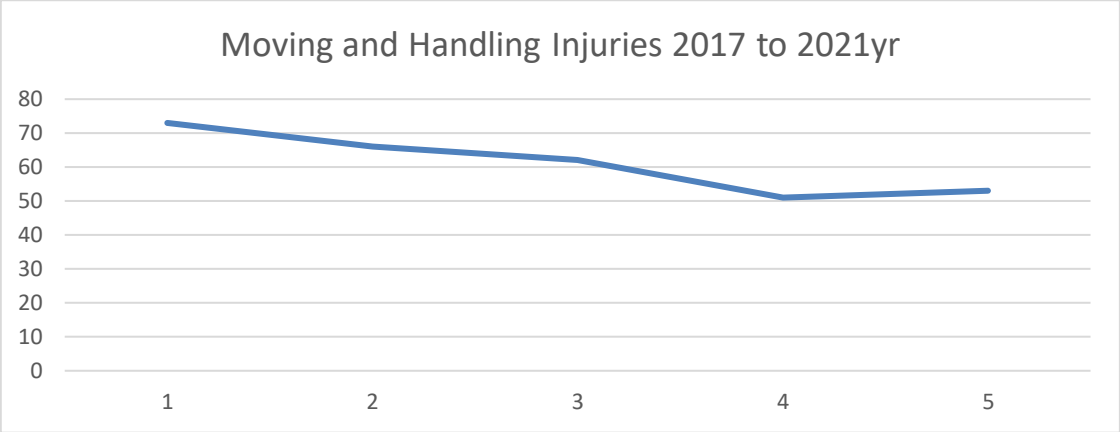
Moving and Handling Injuries

All clinical colleagues entering the Trust, attend the face-to-face training on correct patient and moving/handling techniques. Risk assessments are also completed and monitored with an impressive 80% satisfaction. In terms of injuries, all DATIX incidents are investigated within 48 hours, and help in learning and improving new ways of reducing future incidents.

Over the last five years there has been a decline in injuries, (see line-graph 2) and the correlation between the quality of training and the completion of the risk assessments is thought to be significant contributor to the declining number of injuries.

The completion of training and risk assessment is achieved by Facilitators. A total of 183 Facilitators have been appointed, of those, 42 are based in the community. This is a doubling of the numbers, compared to last year. The facilitator training sessions have a 33% cancellation rate, which is influenced by workload commitments at ward level. Promotion of the sessions continue, and it is hoped that attendance will improve if pressure on services change.

Graph (2) Moving and Handling Injuries 5-year data



The expectation is that these extra measures will take effect during 2022-2023yr.

Measures in place to help reduce the risk of moving and handling injuries	Extra measures implemented to further help reduce injuries
Moving and handling training courses delivered throughout the year	A new bariatric equipment provider has been appointed because the service delivery needed improving
Moving and handling risk assessments completed	A new sling provider is proposed with the aim of improving the safety design features compared to the original offer.
Random audits are carried out by the moving and handling team across the Wards	The moving and handling team have started working collaboratively with the tissue viability practitioner to help with complex patient assessments
	The number of moving and handing facilitators have now been doubled to help increase the availability of places for colleagues
	Promotion of the course are via Intranet and taken to the Band 7 meetings and news-lines on the Intranet

Optical Laser and Non-Ionising Radiation Compliance

Under the current regulations, there is a requirement for the Trust to have in place checks and balances and the appointment of subject matter leads so that the risk of non-ionising radiation and optical laser exposure is reduced so far as is reasonably practicable. The Trust has in place relevant policies to help support the due diligence measures needed. The Trust has appointed a Radiation Protection Advisor (IRS Ltd) to give advice. The Head of Health and Safety is working alongside IRS Ltd in seeking and maintaining compliance. These audits look at the risk assessments, local rules, training records etc.

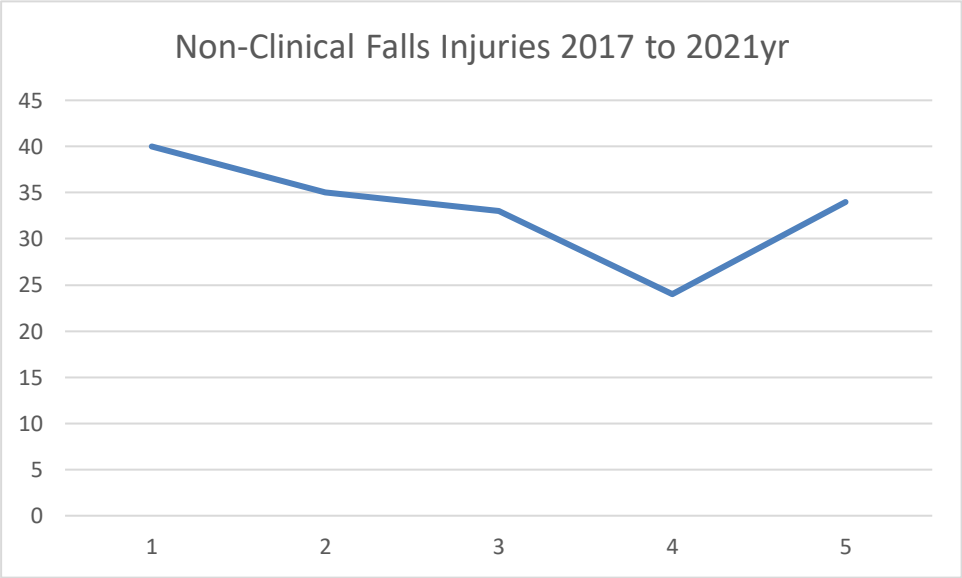
Table – Audits carried out by IRS Ltd during 2022yr

Date of audit	Department	Compliant
07-04-2022	South Drive MRI	Full Compliance
19-04-2022	South Drive MRI	Full Compliance
10-10-2022	South Drive MRI	Minor Contravention with action taken
24-03-2022	Eye Clinic	Minor Contravention with action taken
24-03-2022	Theatres	Minor Contravention with action taken
24-03-2022	Oral/Maxillofacial	Full Compliance
30-05-2022	MRI Unit 2	Minor Contravention with action taken

Slips, Trips and Falls Injuries

The high footfall across the Trust means that the risk of an injury is always possible, but it is important to take every opportunity to reduce that risk by having the right measures in place. The results of the DATIX incidents have shown that some of the contributory factors include winter conditions within the hospital grounds and individuals not following gritted paths, and some colleagues walking across newly cleaned floors, resulting upon injuries being sustained.

Graph (3) Slips, Trips and Falls 5-year data



Contributory factors:
Spillages;
External grounds;
Wires;
Cleaning;
Floor fixtures.

Note:
*2021yr key factor increase = spillages

The expectation is that these extra measures will take effect during 2022-2023yr.

Legacy ideas in place to help reduce slips, trip, fall accidents	New ideas to help reduce accidents
The FLO audit for wards includes a section on floor conditions and the results are monitored centrally.	There is a tenuous link between evacuation and floor conditions and an opportunity to receive compliance. The fire marshal weekly inspections now have a section on the flooring (so that there are no slips/trips/falls hazards) when attempting to evacuate the building and the results are monitored centrally.
The IPC Audits are carried out jointly with the clinical teams, Service Performance and Service Partners (i.e. CHS/ISS/EQUANS). The audits focus on different areas of site in rotation. The checklist considers condition of the flooring and more general infrastructure.	EQUANS have produced new risk assessments which provides assurance of due diligence measures in place to reduce the risk injuries related to slips.
Service performance checks are carried out by Service Performance Team. The checklist considers condition of the flooring and more general infrastructure.	ISS & CHS Ltd are reviewing their floor cleaning risk assessments and method statements
A building safety tour is instigated at CRH by the PFI Provider to provide assurance that their suppliers (ISS and EQUANS) are operating and maintain the building to the required standards.	ISS Ltd completed a health and safety roadshow and a section of that is around slips, trips and falls prevention
	A communication piece has been shared on the Intrant and just before winter begins to increase awareness around taking many of the actions being taken by CHS Ltd/EQUANS to manage ground conditions and gritting
	A newsletter has been produced and there is a section on there around awareness of ground conditions in winter months and gritting of designated paths.
	Attendance by the Head of Health and Safety takes place at the Falls Collaborative, EQUANS/ISS/CHS meetings
	There is a joint risk assessment in place at CRH and HRI. They are due for an annual review in the New Year. Since the RA were carried out action has taken place to address some of the gaps in control. These include: • The replacement of a mat at CRH at the A&E entrance to help quicker drying of shoes

	when entering in wet weather from this direction. • The IPC audits have been reinitiated, with detailed checklists that cover flooring. • toolbox talks are held to remind cleaning staff regarding the correct positioning of wet floor signage. • Wards have had communications shared from Service Performance Team to remind them how to raise jobs for flooring concerns or in the event of spillages when cleaning services are required. • A review of themes of Datix incidents has been carried out and cross checked against current controls.

Revised Health and Safety Policy

A great amount of work has been completed over the last 18 months to improve and change previous ways of getting compliance in place. It is important that the CHFT health and safety policy clearly shows this, and that is why the revision has now taken place.

ISO-45001 Occupational Health and Safety

There is an ambition to meet the requirements of this international standard. The standards match the NHS Workplace Health and Safety Standards but are more inquisitive around granular detail. Traditionally, ISO-45001 is useful to the corporate world to satisfy customer expectations but it can equally be applied to the Trust, albeit without the price of accreditations. Work has started to match/cross reference against IS0-45001 and will act as a second level of assurance.

Message of the Month Calendar

During 2022yr consideration has been given to maintaining the great work which has taken place through the eyes and minds of colleagues, so the importance of health and safety and *One Culture of Care* is never lost. Therefore a 'Message of the Month Timetable' has been produced and its aim is to promote subjects which are pertinent to the conditions/ risks within each month, so for example fire safety during hot weather conditions are intrinsically linked, so it is right to share relevant awareness during the months of summer. Equally, there is a tenuous link between the periods of the year when junior doctors are recruited and needlestick injuries, so awareness/promotional sharps material will be shared at the right time. See Appendix D.

Air Monitoring – Entonox Levels

This gas is used as a pain relief for patients experiencing high levels of discomfort and any unintended exposure to colleagues from the portable/fixed pipeline connections and valves, results in exposure to colleagues and symptoms. This is the second year CHFT have appointed a consultant to carry out these tests and follows the good results of the previous year. Other NHS Trusts plan these tests every 4 years and there is agreement with the medical gas lead, to pause and review following years testing, because CHFT now have good data to show the risk to colleagues is negligible.

Board Health and Safety Legislation Update

A presentation is planned to be delivered to the Board by Weightmans Solicitors and this will take place in 2023yr. The aim of the session is to inform Board members about any emerging risks and to remind the Board about some of the key features of responsibilities.

Health Informatics Service / Huddersfield Pharmacy Specials

Work continues with both business functions and regular health and safety meetings take place with management and staff side. Each business has been given an action plan to work towards.

5. CONCLUSION

This report should give the Board assurance that good progress has been made towards meeting health and safety legislation are now firmly in place and the sub-groups are established to monitor the effectiveness of the policies.

6. RECOMMENDATION

The Board of Directors is asked to note the (2) Progress/Actions, and to approve this Health and Safety Annual Report for 2021/2022.

Richard Hill
Head of Health & Safety

Appendix (A) Timetable – Joint Audit of Compliance Using the NHS Workplace Health and Safety Standards 2023/2024yr

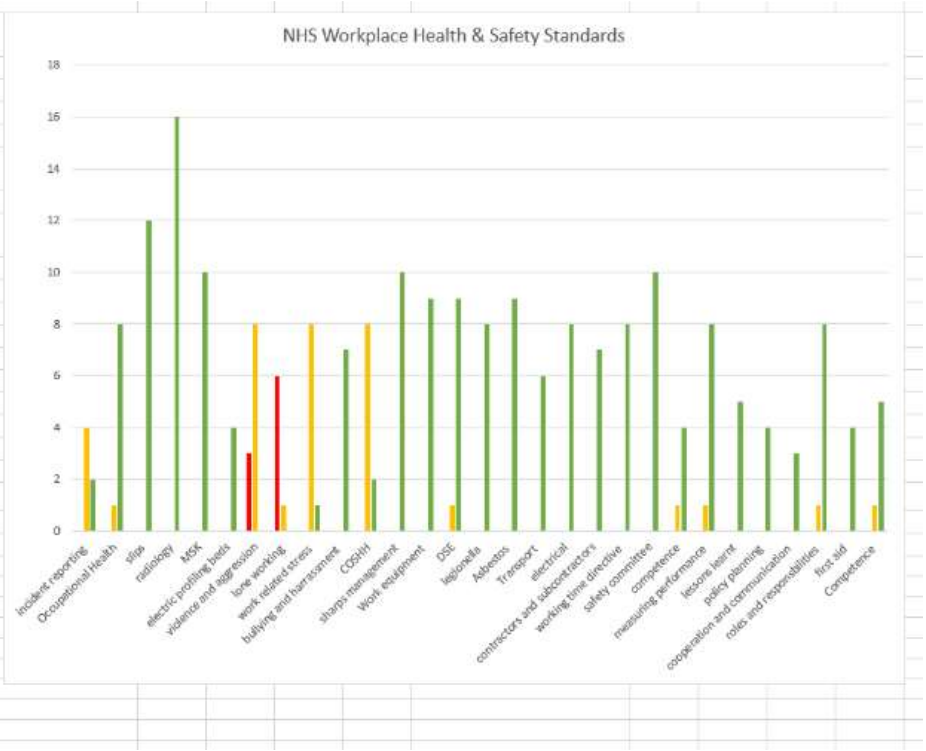
Health & Safety Compliance Review Timetable

The aim is to ensure the NHS Workplace Health and Safety Standard's requirements continue to be achieved. It is a joint piece of work between the Head of Health and Safety and the Subject Matter Leads. The objective is to look at each of the Standard's individual requirements at the intervals given in the table below, and evidence/seek continued assurance, which is shared within the end of year annual health and safety Board reports and submitted at the CHFT health and safety committee meetings/staffside union representative. At the end of each review, a compliance dashboard report will be produced.

Standard	January 23'	February 23'	March 23'	April23'	May23'	June 23'	July 23'	August 23'	September 23'	October 23'	November 23'	December 23'	Joint review to be carried out by
incident reporting			x					x					Richard Dalton/Richard Hill
Occupational Health				x					x				Pamela Wood /Richard Hill
slips		x					x						Ian Rawson / Richard Hill
radiology	x						x						Mark Williams/ Richard Hill
MSK			x							x			Mandy Tanyan / Richard Hill
electric profiling beds			x							x			Rob Ross / Richard Hill
violence and aggression		x				x					x		Ian Kilroy / Richard Hill
lone working		x				x					x		Ian Kilroy / Richard Hill
work related stress					x								Adam Matthews / Richard Hill
bullying and harassment					x								Adam Matthews / Richard Hill
COSHH		x				x					x		Fran Brocklehurst / Richard Hill
sharps management		x				x					x		Maria Ferris / Richard Hill
Work equipment						x							Rob Ross / Richard Hill
DSE							x						Pamela Wood / Amanda Tynan / Richard Hill
legionella												x	Ian Rawson / Richard Hill
Asbestos							x						Ian Rawson / Richard Hill
Transport				x									Ian Rawson / Richard Hill
electrical									x				Ian Rawson / Richard Hill
contractors and subcontractors				x						x			Ian Rawson / Richard Hill
working time directive							x						Azizen Khan
safety committee								x					Helen Senior /Richard Hill
competence													Suzanne Dunkley/Richard Hill
measuring performance											x		Richard Hill
lessons learnt													Richard Dalton/Richard Hill
policy planning			x										Suzanne Dunkley/Richard Hill
cooperation and communication					x								Jacqui Booth / Helen Senior / Richard Hill
roles and responsibilities			x										Adam Matthews/Richard Hill
first aid			x						x				First Department Leads / Richard Hill
Building inspections compliance			x				x			x			Ian Rawson / Charolotte Anderson/Richard Hill

Appendix (B) – Compliance levels against the NHS Workplace Health and Safety Standards

Subject	Red	Amber	Green
incident reporting	0	4	2
Occupational Health	0	1	8
slips	0	0	12
radiology	0	0	16
MSK	0	0	10
electric profiling beds	0	0	4
violence and aggression	3	8	0
lone working	6	1	0
work related stress	0	8	1
bullying and harrassment	0	0	7
COSHH	0	8	2
sharps management	0	0	10
Work equipment	0	0	9
DSE	0	1	9
legionella	0	0	8
Asbestos	0	0	9
Transport	0	0	6
electrical	0	0	8
contractors and subcontractors	0	0	7
working time directive	0	0	8
safety committee	0	0	10
competence	0	1	4
measuring performance	0	1	8
lessons learnt	0	0	5
policy planning	0	0	4
cooperation and communication	0	0	3
roles and responsbilities	0	1	8
first aid	0	0	4
Competence	0	1	5



RAG

1. Green = compliance demonstrated
2. Amber = further work in progress, compliance expected to be demonstrated by February 2023yr
3. Red = work yet to begin to demonstrate compliance but planned for 2023yr

Ps. Due to long term absence of the lone working/violence and aggression lead person, compliance work has been slowed down.

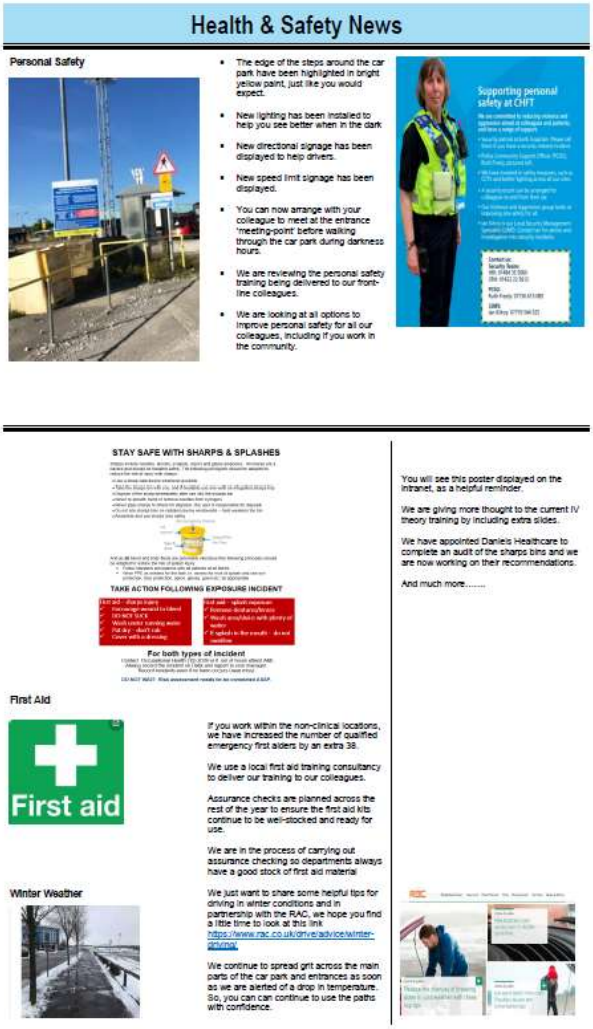
Appendix (C) 5 Year Health and Safety Strategy

	Health & Safety Strategy 2023-2028	yr.	yr.	yr.	yr.	yr.	Is this consistent with the CHFT Health and Safety Policy	Is this measurable or capable of performance evaluation	Are these reflective of risks / opportunities	Are these monitored	Are these communicated	Are these updated regular	Are there resources in place	Is stakeholder responsibility identified	Can the actions achieve CHFT Board Strategy requirements
1	Monitoring of the NHS Workplace Health and Safety Standards using audit options. Outcome is a to ensure the individual standards continue to remain in place and effective.	x	x	x	x	x	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
2	In conjunction with the NHS Workplace Health and Safety Standards, using the ISO 45001 Occupational Health and Safety System and its 10 clauses. Outcome is to achieve over and above just legal compliance, but to forensically examine the effectiveness of policies/roles/responsibly/arrangements/audits	x	x	x	x	x	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
3	Networking across NHS Trusts to benchmark and share best practice by sharing and exchanging new ideas . Outcome is to learn from the experiences of other Trusts and use that knowledge to help benefit each organisation own aim and ambitions.	x	x	x	x	x	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

	Health & Safety Strategy 2023-2028	yr.	yr.	yr.	yr.	yr.	Is this consistent with the CHFT Health and Safety Policy	Is this measurable or capable of performance evaluation	Are these reflective of risks / opportunities	Are these monitored	Are these communicated	Are these updated regular	Are there resources in place	Is stakeholder responsibility identified	Can the actions achieve CHFT Board Strategy requirements
4	Engagement with the reconfiguration meetings for CRH & HRI by attendance at consultation meetings and sharing opinions and ideas. Outcome is to monitor risk and provide relevant input when necessary.	x	x	x	x	x	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
5	Creating a more triangulated direct working arrangement with the Occupational Health /HR/Moving & Handling Team upon issues which triangulate and include subjects such as maternity assessments and referrals, display screen equipment and referrals, sharps prevention projects and finally moving and handling referrals. Outcome is to share data and agree joint plans to help resolve/reduce/eliminate future repeated incidents/requests. Outcome is to work 'SMART'.	x	x	x	x	x	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
6	Supporting the work being carried out to improve personal safety of colleagues and the threat of violence and aggression by attendance at relevant meeting and sharing ideas and opinions. Outcome is to support the efforts taking place to improve personal safety and wellbeing and helping to reduce the number of actual bodily harm experienced by some colleagues	x	x	x	x	x	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

	Health & Safety Strategy 2023-2028	yr.	yr.	yr.	yr.	yr.	Is this consistent with the CHFT Health and Safety Policy	Is this measurable or capable of performance evaluation	Are these reflective of risks / opportunities	Are these monitored	Are these communicated	Are these updated regular	Are there resources in place	Is stakeholder responsibility identified	Can the actions achieve CHFT Board Strategy requirements
7	Working jointly with EQUANS/ISS/CHS Ltd on campaigns/roadshows to promote safe conditions across the estate: Outcome is to to work together common issues that affect both workforces	x		x		x	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
8	Liaising with CHS Ltd to ensure guarantees are in place for colleagues working in 3rd party buildings located across both Kirklees and Calderdale . Outcome is to receive assurance that landlord responsibilities for gas, electrical, asbestos are being met: Outcome is that landlords are taking positive action to provide a safe working environment to colleagues' wellbeing.	x		x		x	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
9	A continued focus upon accident/reductions and working in partnership with the subject matter leads and seeking continuous improvements with the accident/injury reduction frequencies. Outcome is to ensure a firm control of any emerging risks.	x	x	x	x	x	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Appendix (D) Newsletter available for all colleagues to read on the Intranet



Health & Safety News

Personal Safety

- The edge of the steps around the car park have been highlighted in bright yellow paint, just like you would expect.
- New lighting has been installed to help you see better when in the dark
- New directional signage has been displayed to help drivers.
- New speed limit signage has been displayed.
- You can now arrange with your colleague to meet at the entrance 'meeting-point' before walking through the car park during darkness hours.
- We are reviewing the personal safety training being delivered to our front-line colleagues.
- We are looking at all options to improve personal safety for all our colleagues, including if you work in the community.

Supporting personal safety at CHFT

STAY SAFE WITH SHARPS & SPLASHES

TAKE ACTION FOLLOWING EXPOSURE INCIDENT

For both types of incident

You will see this poster displayed on the intranet, as a helpful reminder.

We are giving more thought to the current IV theory training by including extra slides.

We have appointed Daniels Healthcare to complete an audit of the sharps bins and we are now working on their recommendations.

And much more.....

First Aid

First aid

If you work within the non-clinical locations, we have increased the number of qualified emergency first aiders by an extra 38.

We use a local first aid training consultancy to deliver our training to our colleagues.

Assurance checks are planned across the rest of the year to ensure the first aid kits continue to be well-stocked and ready for use.

We are in the process of carrying out assurance checking so departments always have a good stock of first aid material

Winter Weather

We just want to share some helpful tips for driving in winter conditions and in partnership with the RAC, we hope you find a little time to look at this link https://www.rac.co.uk/drive/advice/winter-driving/.

We continue to spread grit across the main parts of the car park and entrances as soon as we are alerted of a drop in temperature. So, you can can continue to use the paths with confidence.

Health & Safety News

Enforce Air Monitoring

Maternity Risk Assessment

Moving and Handling

Do you have any questions for our next health and safety committee?

Appendix E
Message of the Month 2023yr

2023yr Compliance Calendar

Message of the Month

Month	Subject	Lead Sponsor
February	Anti-Ligature	Ian Noonan
September	Suicide Prevention	Ian Noonan
February	Winter Weather Driving for Community Practioners	Sarah Wilson
April / October	Falls Prevention	Ian Rawson
March	Needlestick Injury	Pam Wood/Gill M
TBA	Fire Safety	Sarah Rothery
TBA	Personal Safety Violence and Agression	Sarah Rothery
March / October	Back Awareness	Amanda Tynan
June	Incident Reporting	Richard Hill
November	Display Screen Equipment Assessments	Amanda Tynan/Pam Wood

END

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	12 January 2023
Meeting:	Public Board of Directors
Title:	Annual Health and Safety Report
Author:	Richard Hill, Head of Health and Safety
Sponsoring Director:	Suzanne Dunkley, Executive Director of Workforce and Organisational Development
Previous Forums:	CHFT Health and Safety Committee

Purpose of the Report

To provide the Board with the end of year health and safety report 1 April 2021 – 31 March 2022.

Key Points to Note

The purpose of this report is to provide an update of health and safety compliance within CHFT, during the reporting period stated and since it was last shared with the Board in January 2022. The report incorporates the health and safety framework which is an update to the previous version.

EQIA – Equality Impact Assessment

Calderdale and Huddersfield NHS Foundation Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. We therefore aim to ensure that in the use of the 5-year health and safety strategy no individual is discriminated against by reason of their gender, race, disability, age, sexual orientation, religion or religious/ philosophical belief or marital status, alternatively promoting efforts through the strategy towards inclusion and reducing health inequalities.

Recommendation

The Board of Directors is asked to **NOTE** the progress made against the action plan presented, and to approve this Health and Safety Annual Report for 2021/2022.

8. Partnership papers: Kirklees Health and Care Partnership Kirklees ICB Committee papers - https://www.kirkleeshcp.co.uk/publications/icb-committee-papers/ and Calderdale Cares Partnership - https://www.calderdalecares.co.uk/about-us/meeting-papers/