# Public Board of Directors

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| **Schedule** | Thursday 5 May 2022, 9:00 — 12:00 BST |
| **Venue** | Microsoft Teams |
| **Organiser** | Amber Fox |

## Agenda

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| | Presented by Jenny Dyson, Lead Nurse for High Intensity Users and Matron Alistair Christie and Sarah Wilson<br>To Note | |
| 9:36 | 9. Health Inequalities Update<br>To Note - Presented by Ellen Armistead | 25 |
| | APP C1 - HI Cover sheet May 2022.docx | 26 |
| | APP C2 - HI paper Board paper May 2022.docx | 28 |
| 9:46 | 10. Place Based Working in Kirklees<br>To Approve - Presented by Anna Basford | 33 |
| | APP S1 - Kirklees Place Based Working - Trust Board 5 May 2022.doc | 34 |
| | APP S2 - Kirklees Place Agreement_4.0.docx | 36 |
| | Sustainability | 59 |
| 9:51 | 11. Annual Plan<br>To Approve - Presented by Gary Boothby | 60 |
| | APP D1 - 2022-23 Financial Plan Budget Book_cover_sheet_05May_2022.docx | 61 |
| | APP D2 - Budget Book 2223 Trust Final.pdf | 62 |
| 10:01 | 12. Recovery Update<br>To Note - Presented by Jo Fawcus | 72 |
| | APP E - Recovery update_BoD050522.pptx | 73 |
| 10:11 | 13. Month 12 Financial Summary<br>To Note - Presented by Gary Boothby | 80 |
| | APP F1 - Month 12 Finance Report_cover sheet_5 May 22.docx | 81 |
| | APP F2 - Month 12 Finance Report for Board.pdf | 83 |
| 10:21 | 14. CHFT Green Plan (Climate Change)<br>To Note | 88 |
| | APP G1 - Green Plan Update April 2022 Cover Sheet.docx | |

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| 12:01 | 24. | Review of Board Sub-Committee Terms of Reference<br>a) Finance and Performance Committee<br>b) Transformation Programme Board<br>To Approve | 333 |
| | | APP Q1 - Cover Sheet for F and P Terms of Reference May 2022.docx | 334 |
| | | APP Q2 - Version 6.1 - FP TORs Reviewed November 2021.docx | 335 |
| | | APP Q3 - Cover Sheet for TPB Terms of Reference for Trust Board May 2022.docx | 340 |
| | | APP Q4 - Revised Programme Board Terms of Reference 2022 Approved by TPB 22.3.22 (showing all changes).docx | 341 |
| 12:06 | 25. | Board Sub-Committee Chair Highlight Reports (Minutes in the Review Room)<br>• Finance and Performance Committee<br>• Quality Committee<br>• Audit and Risk Committee<br>• Workforce Committee<br>To Note - Presented by Richard Hopkin, Denise Sterling, Andy Nelson and Karen Heaton | 348 |
| | | APP R1 - F and P Chair's Highlights April 4 2022.doc | 349 |
| | | APP R2 - Chair Quality Committee Highlight Report March, April 2022 (1).doc | 350 |
| | | APP R3 - ARC Highlight report April 2022.doc | 352 |
| | | APP R4 - Workforce Committee Chair's Highlight Report April 2022.doc | 353 |
| 12:11 | 26. | Items for Review Room<br>1. Calderdale and Huddersfield Solutions Managing Directors Report – April 2022<br>2. West Yorkshire Association of Acute Trusts (WYAAT) & West Yorkshire and Harrogate (WY&H) Partnership Reports<br>To Note - Presented by Stuart Sugarman and Philip Lewer | 354 |
| 12:13 | 27. | Date and time of next meeting<br>Date: Thursday 7 July 2022<br>Time: 9:00 am<br>Venue: Microsoft Teams<br>To Note - Presented by Philip Lewer | 355 |

# 1. Welcome and Introductions:

To Note

Presented by Philip Lewer

## 2. Apologies for absence:

To Note

Presented by Philip Lewer

# 3. Declaration of Interests

To Note

# 4. Minutes of the previous meeting held on 3 March 2022

To Approve

Presented by Philip Lewer

# Draft Minutes of the Public Board Meeting held on Thursday 3 March 2022 at 9:00 am via Microsoft Teams

**PRESENT**

| | |
|---|---|
| Philip Lewer | Chair |
| Brendan Brown | Chief Executive |
| David Birkenhead | Medical Director |
| Ellen Armistead | Director of Nursing/Deputy Chief Executive |
| Gary Boothby | Director of Finance |
| Suzanne Dunkley | Director of Workforce and Organisational Development |
| Jo Fawcus | Chief Operating Officer |
| Alastair Graham **(AG)** | Non-Executive Director |
| Peter Wilkinson **(PW)** | Non-Executive Director |
| Andy Nelson **(AN)** | Non-Executive Director |
| Karen Heaton **(KH)** | Non-Executive Director |
| Richard Hopkin **(RH)** | Non-Executive Director |
| Denise Sterling **(DS)** | Non-Executive Director |

**IN ATTENDANCE**

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| Stuart Sugarman | Managing Director, Calderdale and Huddersfield Solutions Ltd (CHS) |
| Jim Rea | Managing Director, Digital Health |
| Andrea McCourt | Company Secretary |
| Amber Fox | Corporate Governance Manager (minutes) |
| Karen Spencer | Associate Director of Nursing / Head of Midwifery **(for item 50/22)** |
| Andrea Dauris | Associate Director of Quality and Safety **(for items 45/22 and 46/22)** |

**OBSERVERS**

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| Christine Mills | Public Elected Governor |
| Gina Choy | Public Elected Governor |
| Nicola Seanor | Associate Non-Executive Director |
| Shahida Iqbal | Associate Non-Executive Director, CHS |
| Sarah Wallwork | Eye Clinic Service Manager |
| Karen Lord | Sister/Charge Nurse, Ophthalmology |
| Natalie Rice | Healthcare Assistant, Ophthalmology |

## 32/22 Welcome and Introductions

The Chair welcomed everyone to the public Board of Directors meeting, in particular Sarah Wallwork, Karen Lord and Natalie Rice from Ophthalmology who were in attendance to share a staff story.

The Chair also welcomed invited governors and observers to the meeting.

The Board meeting took place virtually and was not open to members of the public in light of NHS Infection Prevention and Control requirements in healthcare settings. The meeting was recorded, and the recording will be published on our website shortly after the meeting. The agenda and papers were made available on our website.

## 33/22 Apologies for absence

Apologies were received from Anna Basford.

## 34/22 Declaration of Interests

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

Alastair Graham, Stuart Sugarman and Shahida Iqbal declared an interest in Calderdale and Huddersfield Solutions Ltd (CHS).

**35/22 Minutes of the previous meeting held on 13 January 2022**

The minutes of the previous meeting held on 13 January 2022 were approved as a correct record.

**OUTCOME**: The Board **APPROVED** the minutes from the previous meeting held on 13 January 2022.

**36/22 Action log and matters arising**

The action log was reviewed and updated accordingly, noting action 157/21, a Board session on the caring domain / patient experience was being arranged with the Board for June 2022.

**Post meeting note:** The session focused on the caring domain / patient experience has been arranged for Thursday 9 June 2022. Action closed.

**OUTCOME:** The Board **NOTED** the updates to the action log.

**37/22 Chair's Report**

The Chair informed the Board that he continued to attend regular meetings of the Integrated Care System (ICS) on behalf of the Trust. The Chair offered 1-1 meetings outside of the meeting for anyone who would like an update on the ICS designate appointments. The Chair reported the statutory legislation for the ICS has not yet been approved by Parliament and is expected in July 2022.

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

**38/22 Chief Executive's Report**

The Chief Executive formally thanked communities for their tolerance and patience during the pandemic, adding that restrictions have been difficult and it's important to thank the community and colleagues for their support.

The Chief Executive reported the Trust are tackling the next stage of elective recovery, which includes outpatients. Further work is taking place with primary care colleagues to look at the impact and risks for our patients due to the backlog, he added the Trust remains agile in its leadership approach for this.

The Chief Executive informed the Board many positive conversations are taking place between Treasury and NHS England/Improvement (NHS E/I) regarding reconfiguration with lots of ongoing work taking this forward.

The Chief Executive acknowledged the efficiency and financial situation is incredibly challenging and our people, performance and the public pound remain a key focus.

The Chief Operating Officer updated the Board on the position regarding a boiler pipe incident on Tuesday 1 March 2022 at Huddersfield Royal Infirmary. The pressure in the boiler was high and five wards were smoothly and swiftly evacuated. She confirmed patients and staff were safe and the standing operating procedure was put into action. A debrief has taken place on what went well and learning. The Chief Operating Officer re-assured the Board on the steps which took place with system partners and the fire service who were on site, with mutual aid offers from other hospitals. The incident was stood down within two hours and the Trust returned to business as usual. She explained this was a good test of escalation processes with a quick response. It was noted the incident was

publicised on social media quickly by the press; however, she confirmed there was no fire or explosion.

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

**39/22 Staff Story – 'Engage, Support, Reenergise - Our One Culture of Care Experience.... So Far!'**

Sarah Wallwork, Eye Clinic Service Manager, Karen Lord, Sister/Charge Nurse and Natalie Rice, Healthcare Assistant in Ophthalmology presented their 'One Culture of Care Experience' staff story.

Sarah Wallwork explained she joined the Eye Clinic in 2020 during the middle of the pandemic which had impacted on colleague experience. She shared details of work that has taken place to engage, support and re-energise the team, noting how this leads to a good experience for patients. As a new manager to the team, Sarah undertook engagement sessions with the team, including a Working Together to Get Results (WTGR) session with Nikki Hosty, Assistant Director of Human Resources. As a result of the WTGR session, the team reviewed the workforce model and restructured this to build in some absence assumption in the team. The team introduced a wobble room for staff and a weekly department newsletter with regular covid updates, a wellbeing and engagement item, shout outs to the team and a "meet our team" section to introduce newly recruited colleagues. She added the team participated in a listening event with Jill Palmer from the wellbeing team which was very encouraging.

It was noted the Department have a new sensory room to support patients with a learning disability which was funded through charitable funds.

Karen Lord shared her experience, having joined the eye clinic team 12 months ago. She explained the support is brilliant within the team who are all looking out for one another. The team are looking at undertaking Nursing Associate roles in the Department and staff training is being encouraged which has led to staff feeling more supported, valued, and progressing well. As a result, there has been an improvement in patient care and colleague absence and morale in the Department.

Natalie Rice, a technician in the eye clinic, joined the team for a better work life balance having had a healthcare issue last year. She noted that Sarah and Karen are Trust ambassadors for 'One Culture of Care' managers as this has been a real success story, as colleagues in the team gave her so much support during her phased return and showed her compassionate care.

KH thanked Ophthalmology colleagues for sharing their emotive personal story. and commented it is good to know there are strong leaders who expound 'One Culture of Care' naturally. She asked what the team are doing to ensure this continues and is not a short term solution. Natalie Rice responded that the team continue to support an open door policy and work through issues together as a team. She added it is important to use the services that the Trust offers. KH congratulated the team for their work.

The Director of Nursing echoed the comments and stated Sarah Wallwork and Karen Lord shine like stars, and she is very proud.

The Chair thanked the team for sharing their personal experience which was humbling to hear.

**OUTCOME**: The Board **NOTED** the staff story from Ophthalmology in relation to One Culture of Care.

**40/22 Health Inequalities Progress Report**

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

The key points noted from the workstreams were:

- External environment: how we connect with our communities – A nurse specialist for high intensity users and people who are homeless and users with mental health has progressed well with worked linked in with local authority colleagues. It was suggested that the nurse specialist be invited to talk about this work at a future meeting. The Trust are currently recruiting for a mental health consultant to focus on the needs of service users with mental health conditions
- The lived experience – At the end of December, 65% of women from a BAME background have been booked onto a Continuity of Carer pathway
- Overcoming language barriers – a number of workstreams are being progressed to support those whose first language is not English
- Smoking in pregnancy – clear link with Index of Multiple Deprivation (IMD) groups – a new 'Smokefree Pregnancy Pathway' has been introduced
- Obesity and diabetes are linked to deprivation and lots of work is being undertaken with women who are at a higher risk of developing diabetes
- A Health Inequalities dashboard is being further developed and a meeting with the Chief Operating Officer, Director of Nursing, the Health Informatics Services and public health colleagues took place to ensure mapping of elective waiting lists across to IMD and protected characteristic groups continues
- Diverse and Inclusive workforce – CHFT Pride Network has a new Executive Sponsor, Jo Fawcus, Chief Operating Officer
- A public health specialist registrar has commenced in post for a 6-12 months secondment and Peter Wilkinson, as Chair of the Health Inequalities Group will be meeting with the registrar in the next few weeks

AG commended the report and said it was positive to see work continuing in this field which shows CHFT as a leader. He added it was positive to see the sensory room in the staff story and pointed out it is important to incorporate these ideas in reconfiguration plans. AG highlighted the Trust are working with the ICS on this and the care navigator roles which could play an important part in tackling inequalities. He asked what the care navigators do and how their work will be assessed and appraised. The Director of Nursing responded there are two groups of co-ordinators, one for learning disability working with Amanda McKie, and the other care co-ordinator is working alongside high intensity user specialities i.e., mental health, vulnerable patients. The role of the care co-ordinators is about care management and a single point of contact. AG asked if more can be employed with other groups if successful and the Director of Nursing confirmed the work of the roles will be monitored before further roles are developed.

DS commended the work around continuity of carer and with 65% of patients on a continuity of carer pathway it shows the Trust are the highest performer in the Local Maternity System (LMS). She explained there is a high percentage of mistrust from the BAME community and asked what work the Trust are doing to increase dialogue and engagement with community and voluntary services. The Director of Nursing responded that part of the role of the public health midwife is engaging with local communities and the Trust continue with the discovery interviews with patients and staff.

KH stated it was a positive report, very important to measure the social value impact of the work (described in the paper) and commented that reconfiguration provides an opportunity to reduce health inequalities.

The Chief Executive explained the longevity to this work for our communities that should be considered in the forward plan, working in partnership.

AN asked about the uptake in the use of the patient portal and if the Trust are trying to improve this as a tool for patient initiated follow up. The Director of Nursing responded the patient initiated follow up is part of the elective recovery plans and 'My Planned Care' will work alongside the patient portal. The Trust are leading on digital access in conjunction with local authority colleagues as part of the work of the Health Inequalities Group.

The Chair stated he is proud of what the Trust has achieved and it's good to see the progress the Trust are making on this journey.

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

**41/22 2021/22 Strategic Objectives Update**

The Director of Nursing presented an update on progress to the annual strategic plan for the period ending February 2022.

In November 2021 the Trust Board approved an 'annual' strategic plan describing the key objectives to be progressed during the period November 2021 to March 2023 that will support delivery of the Trust's 10-year strategy. Each of the objectives has a named Director lead accountable and responsible for delivery.

This report highlights that of the 19 objectives:

- 0 are rated red
- 5 are rated amber
- 13 are rated green
- 1 have been fully completed

An update on the five areas rated amber was provided by the lead Director:

- Population health data to address health inequalities – linked to the Health Inequalities paper, work is ongoing to ensure there is granular detail around protected characteristics
- Stabilisation of delivery of services in response to the Covid-19 pandemic – to reflect the dynamic of non-elective demand and elective recovery
- Maintain the CQC rating of 'Good' overall – This has been rated cautiously as there has been a different level of scrutiny seen from the regulator, the Trust have introduced journey to outstanding (J2O) reviews and external assurance mechanisms
- Work with system partners to achieve key performance metrics for urgent and emergency care and elective recovery – processes are in place with partners, this is a significant challenge and there is further work to do to improve delayed transfers of care and support processes for new ways of working with our system partners moving forward
- Inclusive recruitment – extensive work taking place on inclusive recruitment panels and processes, including the gender and ethnicity balance of the Board and Senior Team, with the aim of having a Board reflective of the workforce and communities we serve. Further work on inclusive recruitment training and inclusive stories led by the wellbeing and engagement team is ongoing to ensure appropriate questions at interview

Discussion took place on the strategic objective regarding the CQC rating given operational pressures and it was noted there is ongoing work regarding leadership assurance. DS recognised the journey to outstanding reviews have been reinstated with a roll out plan and asked the Director of Nursing where she expects the Trust to be by the end of the year in terms of wards and departments. The Director of Nursing confirmed the Trust will stay on track with the reviews and she is confident most of the ward areas will have been undertaken in the next 12 months with local processes in place for key lines of

enquiry. She added the reviews will cover all areas such as the Emergency Departments, Elderly and Medical wards as there is rapid learning from the journey to outstanding reviews and best practice is shared with all other areas. The Director of Nursing clarified these reviews highlight areas for improvement and identify good practice.

AN asked the Chief Operating Officer if the critical issue relating to delayed transfer of care is the support of partners. The Chief Operating Officer recognised the challenge through January and February was impacted by high levels of staff isolation due to covid and recruitment. The discharge teams are supporting wards in a different way by having conversations with families and there is focus internally to get patients onto different pathways based on the level of input they require. The Trust are also working with partners on how capacity is used and the urgent care response in the community.

The Director of Nursing asked for an update on the talent management launch in 2021. The Director of Workforce and OD stated she is pleased this work has continued and not been impacted by Covid-19. The Trust are supporting a leadership programme with succession planning of entry level roles into senior level roles in the Trust. This includes an exciting piece of work with Calderdale College on place based working.

In relation to the population health data strategic objective, PW stated that given the considerable work to date on population health data this objective could be rated green, and confirmed the amber rating is not because the Trust are behind plan, rather there is further work to do. The Director of Nursing highlighted the opportunity with having a public health specialist working with the Trust in terms of validation and fresh pair of eyes. PW confirmed the public health specialist attended the Health Inequalities Group and is already getting involved.

The Chair thanked the Executive team for assuring the Board on the sustainable progress against the 2021/23 annual strategic plan.

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

**42/22 Operational and Financial Annual Plan 2022/23**

The Director of Finance presented the draft operational and financial plans for 2022/23 for approval which had been reviewed by the Finance and Performance Committee. The Chair explained Chairs' approval processes may be required due to the timetable for submission.

The key points to note from the operational plan were:

- Zero waits over 104 weeks with a plan to achieve this by the end of March 2022
- The scale of challenge for the operational teams in terms of delays to patient care
- Delivery of 104% of 2019/20 elective and day case inpatient levels
- Further opportunity through changes to infection prevention and control guidelines
- The number of patients on the appointment slot issue (ASI) list
- Significant follow up backlog –the Trust are looking at how to undertake follow ups differently i.e., telephone appointments
- Plan to clear the MRI backlog by the end of May 2022, the demand for MRI is significant

The key points to note from the financial plan were:

- Risks regarding non pay inflation, Elective Recovery Funding flow (the Trust's share of ICS monies is £14m), enhanced pay and the Cost Improvement Programme (CIP) scale and acceptance of the plan
- No assumption for additional winter funding with £1m contingency, lower than previous years
- £43m challenge for 2022/23 of which £20m is an efficiency challenge (CIP), leaving a £23m deficit

The Chief Executive asked that anyone who has any concerns from a patient or service perspective on the backlog position to contact any of the Directors.

PW asked if the efficiency target position aligns with the plan. The Director of Finance explained an annual planning day took place on Tuesday 2 March 2022 and the Trust are currently in the process of collating the responses for efficiency. He noted this was a positive session which focused on where to eliminate waste in pathways. A total of 150 colleagues took part in the virtual annual planning day and Directors are collating ideas for the Efficiency Group by the end of the week.

In terms of the ICS position by provider AG commented that given the deficit position it was appropriate for CHFT to have the biggest CIP challenge. He added the Efficient and Effective Use of Resources Group has new governance arrangements and suggested it needs to think about the cultural impact, for example, star awards to staff who have made a contribution not only to patient care, but efficient use of resources.

In response to a comment from the Director of Finance regarding £50m additional spend over two years, KH queried whether this is related to the way the Trust have responded to the pandemic. The Director of Finance agreed and explained all Trusts are incurring greater costs and the NHS as a whole is costing more. KH suggested there is an opportunity to do things differently and more efficiently.

RH stated that the Finance and Performance Committee were supportive of the plan, encouraged the Board to not underestimate the challenge and confirmed the Chief Operating Officer and Director of Finance consider the challenge is achievable.

The Chief Executive recognised the size of the challenge and there is a level of confidence in that the Trust have been planning for this. He added it is important not to underestimate that the Trust are still in a global pandemic and it will remain challenging moving forward.

The Director of Finance sought support for the recommendations.

**OUTCOME**: The Board **APPROVED** the draft operational and financial plans for 2022/23 and **NOTED** the scale of potential efficiency requirement.

**43/22 Recovery Update**

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

- On track to recover 104 week position
- Overall position on P2s (treated within 4 weeks) is good
- 18 week challenge – would be at 55% for target with average wait of 22 weeks
- Concerns regarding diagnostics with the biggest concern in MRI partly due to a delay in static scanners
- Back-up plan in mobile capacity and backlogs will be cleared by May 2022
- Significant backlog in Outpatients
- A different formal reporting process through to the Finance and Performance Committee every month to monitor recovery is being introduced via the Access Committee with terms of reference being developed
- Cancer Committee and Emergency Care Committee terms of reference are being revised and will formally report to the Finance and Performance Committee in the next financial year

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

**44/22** **Month 10 Financial Summary 2021/22**

The Director of Finance presented the month 10 financial summary and highlighted the key points below:

- On plan at end of month 10
- Forecasting to deliver plan for year
- Expenditure is higher in month 10 linked to workforce challenges
- Additional pay enhancements in year was above plan
- Efficiency delivered this year tends to be non-recurrent, which is part of the challenge

**OUTCOME**: The Board **NOTED** the Month 10 Finance Report and the financial position for the Trust as at 31 January 2022.

**45/22** **Safeguarding Bi-Annual Update: Adults and Children**

Andrea Dauris, Associate Director of Nursing gave a presentation detailing an overview of the national and local context of safeguarding and areas of best practice included in safeguarding across the Trust. Key achievements and priority areas were highlighted for Prevent, Safeguarding during Covid, Hidden Harms, Mental Capacity Act and Deprivation of Liberty / Liberty Protection Safeguards, Training Compliance, Adult Safeguarding, Children Safeguarding, Mental Health Act, Children Looked After, Maternity Safeguarding, The Trust continued to support the safeguarding agenda during the pandemic.

**OUTCOME**: The Board **NOTED** the key activity of the Safeguarding Team for the reporting period April 2021 – September 2021.

**46/22** **Nursing and Midwifery Staffing Hard Truths Requirement**

Andrea Dauris, Associate Director of Nursing presented the Nursing and Midwifery Safer Staffing report which provided an overview of nursing and midwifery capacity and compliance with NICE Safe staffing, National Quality Board Standards and the NHS Improvement Workforce Safeguards guidance from August 2021 to January 2022.

It was noted that falls remained at their highest period during the months of August – October 2021 which reflects a challenging fill rate position which dropped to its lowest point in October to 84.5%. This is consistent with care hours per patient day with an ongoing shortfall between August – October 2021, followed by an additional dip in January 2022 which identified a further upward trend in falls in the same month. Andrea Dauris shared details of short term, medium and long term actions being undertaken in response which included a seven day senior nurse leadership rota, twice daily staffing reviews with escalation processes, an enhanced dashboard which gives clear visibility of the workforce position, success in recruitment to nursing and midwifery vacancies (reduced from 150 to 60 full time equivalent posts at January 2022), a robust and aspirational international nurse programme, development of internal career pathways and health and well-being support. It was noted that workforce establishment reviews focus on the recovery agenda, the staffing establishment and absence combined impact on unmet patient need and close monitoring of nurse sensitive indicators continues.

RH asked if the lower quartile position on care hours per patient day is a surprise and if the Trust is expecting the position to improve. The Director of Nursing confirmed the Trust anticipate an improvement given the plans in place which were scrutinised at Workforce Committee on 15 February 2022.

**OUTCOME**: The Board **NOTED** the Nursing and Midwifery Staffing Hard Truths Requirement.

**47/22 Learning from Deaths Q3 Report**

The Medical Director presented the Learning from Deaths report for Q3 from 1 October to 31 December 2021. The key points to note were:

- Work to modify the initial screening tool to be speciality specific
- 31% of all in-hospital deaths have been reviewed using the initial screening tool which is an improvement on previous months
- The majority of initial screening reviews are rated as good or excellent
- 24 structured judgement reviews in Q2 – six deemed to be poor or very poor care and three were referred to incident panels for further review
- Learning from reviews feed into the Trust's quality improvement programme – Care of the Acutely Ill Patient

AG welcomed the improving position and asked if deaths of people with a learning disability are all subject to an initial review or are included in the overall percentage. The Medical Director responded all patients should have a review and the team prioritise patients who are at an increased risk or have a protected characteristic, with deaths of people with learning disabilities going through the Learning Disability Mortality Review process.

AN asked what processes would be used to make sure learning from reviews is embedded. The Medical Director confirmed the initial clinician will share learning and a summary report is taken through Divisional Patient Safety Quality Boards (PSQB) and the quality improvement programme. The Medical Director added that newsletters are going out which summarise the key themes and ongoing work.

RH asked if the external review by Professor Mohammed in response to movements in mortality metrics (SHMI, summary hospital-level mortality indicator and HSMR, hospital standardised mortality rate) is still happening and the timescale for the findings. The Medical Director confirmed the first report from Professor Mohammed on community deaths within 28 days post discharge has been received and this report can be shared outside of the meeting. He explained the review indicated it is an artefact of where people are dying rather than a reflection of poor care. A further piece of work is taking place to understand why SHMI and HSMR is increasing (noting this has been seen across many organisations) which will be reported back at a future date.

**OUTCOME**: The Board **NOTED** the Learning from Deaths Q3 Report.

**48/22 Risk Management Strategy and Policy**

The Director of Nursing presented the refreshed Risk Management Strategy and Policy for approval with the key changes described in the cover sheet, which has been reviewed by the Audit and Risk Committee.

**OUTCOME**: The Board **APPROVED** the updated Risk Management Strategy and Policy.

**49/22 Board Assurance Framework**

The Company Secretary presented the third and final update of the Board Assurance for the 2021/22 financial year. The Board Assurance Framework was approved at the Audit and Risk Committee on 25 January 2022.

Further work has taken place to identify risks and actions and move the risk score towards the target score.

Lead Directors have identified a reduction in scores for three risks. Two risks with reduced scores have met their target scores, 03/20 and 14/19. One risk is proposed for removal, risk 03/20 Business Better Than Usual Service Transformation as it has met its target risk

score. This will be removed from the BAF in April 2022 as agreed by Directors. With this risk removed the total number of risks on the BAF will be 21. The capital funding (14/19) risk score has reduced from 16 to 12; however, it has been agreed this will remain on the BAF following discussion at the Finance and Performance Committee, as this has potential to increase. The third reduced risk is the 7/20 Health Inequalities risk with a reduced score from 16 to 12 reflecting the progress in this area which has been reported to the Board.

AN informed the Board he met with the Company Secretary to review the Board Assurance Framework in detail, thanked Directors and the Company Secretary for their work and confirmed the BAF is in good shape.

**OUTCOME**: The Board **APPROVED** the updated Board Assurance Framework as at 18 February 2022, the removal of risk 03/20 Business Better Than Usual and **NOTED** the movement in risk scores and areas of risk exposure.

**50/22 Ockenden Review of Maternity Services – End of Year Progress Report**

Karen Spencer, Head of Midwifery presented the Ockenden review of maternity services report. In June 2021 maternity services were asked to submit specific evidence to NHS E/I to provide assurance of compliance and received feedback in November 2021. The Head of Midwifery shared the action plan with the Board and confirmed the Trust are not an outlier.

The ensuing action plan has identified two areas for significant improvement, a coproduced work plan with the Maternity Voices Partnership (MVP) and ensuring that personal care and support plans are in place for each patient.

Close working with the Maternity Voices Partnership has proved challenging due to the Covid pandemic though
there is a new Chair in place and regular meetings have been reinstated.

As part of the review, the service submitted workforce plans and the service remain committed to advertising and recruiting to all vacant posts when they become available; however, it acknowledged the difficulty recruiting midwives due to a shortage of midwifes nationally.

The service does not currently have a Director of Midwifery; however, plans are in place for the role to replace the Head of Midwifery within the Families and Specialist Services Division from May 2022 onwards.

Nationally there is a requirement for more Consultant Midwives. The service does not currently have a Consultant Midwife; however, there is a joint post in conjunction with Huddersfield University of a Professor of Midwifery Practice. This helps bridge the gap translating research into practice and helps operational teams deliver research into care.

In terms of leadership development all Band 7 Midwives and above have access to CHFT's online Leadership Development Programme.

The Head of Midwifery shared the phase two results of the audit action plan, from December 2021 to March 2022 which evidenced ongoing work. The areas highlighted in red and amber are still being worked on and some relate to work ongoing across the maternity network and region wide pathways.

The action plan will be shared through the Maternity Forum and Quality Committee and circulated to the Board. The Head of Midwifery informed the Board the CQC report into East Kent's maternity services is due to be released.

KH, Maternity Board Safety Champion congratulated the Head of Midwifery and the midwifery team for the tremendous work, sustained during the pandemic and strong team approach.

DS stated a useful update on the audits being undertaken on personal care and support plans was provided to the Quality Committee. The Head of Midwifery confirmed she will continue to include these reports as appendices for Quality Committee.

**OUTCOME**: The Board **NOTED** the update on the Ockenden Review of Maternity Services.

**51/22 Quality Report**

The Director of Nursing presented the Quality Report. The key updates are:

- Journey 2 Outstanding Reviews (J2O) full review programme has relaunched
- Dementia care and screening – CHFT has been working closely with colleagues in Bradford to develop comprehensive care plans for patients with a diagnosis of dementia. There has been a decline in dementia screening compliance; therefore, this has been added onto the risk register. The Medical Director added it was disappointing to see the figures reduce from October 2021 (44%) and targeted work took place between September and November regarding the importance of undertaking dementia screening. The Medical Director re-assured the Board the dementia scores are better than captured due to free text boxes being used in Cerner which is not captured in the electronic audits. This remains a challenge and is discussed at Induction and during doctors changeover in August and February. An MPage (customised page) has been developed for medical and nursing tasks in the admission documentation to make it clear dementia screening needs to be completed. This will hopefully improve the position. Whiteboards are also being introduced which will make it clearer when dementia screens have not been completed. These actions will hope to improve the position; however, as a final resolution, this can become a mandatory field in EPR; however, this comes with risks and would need to be a joint agreement with Bradford Teaching Hospitals NHS Trust.
- Making Complaints Count collaborative work continues actively addressing the backlog and reporting arrangements in Divisions has been strengthened
- Acting Head of Legal Services is progressing work with the Coroner's Office and agree a more productive and efficient relationship moving forward
- Incorporated learning from the Getting it Right First Time Programme (GIRFT)
- Incidents – increase in total incidents reported in January 2022
- Medication Safety and Compliance Group (MSCG) continue to raise awareness of the importance of safe storage, prescribing and administration of medication and active monitoring of fridges, the terms of reference of this group are being reviewed
- Currently six open Healthcare Safety Investigation Branch (HSIB) investigations relating to maternity services, the service is awaiting the final reports from these
- Staffing remains challenging in maternity; however, CHFT compares favourably with other Local Maternity System (LMS) maternity services
- Figures for one to one care in labour have been maintained
- Quality priorities – regular round of deep dive reviews has taken place into each of these priorities
- Reduction in the incidence of hospital-acquired pressure ulcers from November – December 2021, the Tissue Viability Nurse has been tasked to review pressure ulcer actions to address the high numbers of patients with pressure ulcers during December 2021
- Clinical documentation – driving improvements around this with the Medical Director and the Managing Director of Digital Health, the Chief Nursing Information Officer and Graham Walsh as medical clinical lead
- Improvement in terms of sepsis identification

DS recognised the challenge in dementia screening and asked if the multi-disciplinary team and other members such as Allied Healthcare Professionals, Occupational Therapists could provide additional capacity to support the completion of this screening. The Medical Director responded that it does not take long to complete the screen and is more about highlighting the importance of it.

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

**52/22 Integrated Performance Report (IPR) – January 2022**

The Chief Operating Officer presented the performance position for the month of January 2022 highlighting the key points which were:

- Performance dropped to 64% in January – responsive and workforce domain were red
- Safe was the only green domain
- Complaints dipped again following improvement last month
- Effective domain was amber – SHMI and HSMI and neck of femur targets missed
- Main challenges are the stroke indicators alongside the underperformance in the main planned access indicators and the Emergency Department
- Cancer - CHFT was second out of 127 Trusts for performance which is fantastic news for patients
- Emergency Care Standard – CHFT was 14th nationally of 111 Trusts
- Electives – Emergency Department numbers have increased throughout January

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

**53/22 Non-Executive Director Champion Roles**

The Company Secretary presented a paper which detailed the new approach to Board oversight by Non-Executive Director champion roles following guidance issued from NHSE/I in December 2021.

The guidance recommends that five NED champion roles be retained because they are either a statutory requirement, the function requires a named individual to discharge or NHS E/I consider that having an individual NED is the most effective way of delivering the changes that are needed.

The five core Non-Executive Director champion roles are:

1. Maternity Board Safety Champion – Karen Heaton
2. Wellbeing Guardian – Richard Hopkin
3. Freedom to Speak Up – Karen Heaton
4. Doctors Disciplinary – All Non-Executive Directors
5. Security Management – Andy Nelson

The rationale for each of these roles was noted. The Company Secretary highlighted it will be made clear in the relevant minutes who is the NED Champion for these roles.

There are 13 other roles referenced in the guidance and as the Quality Committee takes on the highest number of these roles, the terms of reference for the Quality Committee are proposed for change.

AN explained the cyber security piece reports through to the Audit and Risk Committee who will escalate to the Board if required. AM agreed that she would amend the paper to reflect cyber security reporting to the Audit and Risk Committee.

**OUTCOME:** The Board **NOTED** the new approach to Board oversight by Non-Executive Director Champion roles and **APPROVED** the changes to the Quality Committee Terms of Reference at section 4.8 in line with national guidance.

**54/22 Governance Report**

The Company Secretary presented the governance items for approval and noted the March 2022 year end processes.

The Company Secretary explained the Board of Directors Terms of Reference, Standing Orders and Trust Constitution are presented for approval which have been updated to include the new pilot Associate Non-Executive Director role.

The Board were asked for delegation for the sign off of the 2021/22 Annual Report and Accounts to the Audit and Risk Committee which has been managed this way for the previous two years due to the national timeframe to sign these off in June which does not align with Board meeting dates.

**OUTCOME:** The Board **APPROVED** the Board of Directors Terms of Reference, Workplan for 2022/23, Standing Orders, Constitution additions and the delegation to the Audit and Risk Committee for the approval of the 2021/22 Annual Report and Accounts.

**OUTCOME:** The Board **NOTED** the Declarations of Interest Register, Fit and Proper Persons Self-Declaration Register and the recruitment process for the Chair and two Non-Executive Directors.

**55/22 Annual / Bi-Annual Reports**

**Public Sector Equality Duty (PSED) Annual Report**

The Director of Workforce and OD presented the Public Sector Equality Duty (PSED) Annual Report for approval which provides evidence of positive joint working across the Place with good outcomes.

**OUTCOME**: The Board **APPROVED** the Public Sector Equality Duty (PSED) Annual Report.

**56/22 Board Sub-Committee Chair Highlight Reports**

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

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

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

**57/22 Items for Review Room**

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

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

- Finance and Performance Committee minutes of the meetings held 06.01.22 and 31.01.22
- Quality Committee minutes of the meeting held 05.01.22
- Audit and Risk Committee minutes of the meeting held 25.01.22
- Charitable Funds Committee minutes of the meeting held 22.11.21 and 08.02.22

- Council of Governors minutes of the meeting held 27.01.22
- Organ Donation Committee minutes of the meeting held 05.01.22 – The Chair reported the Organ Donation Committee has performed brilliantly during the pandemic and he is very proud of the staff.

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

**58/22 Any Other Business**

The Chair formally thanked the Board of Directors, colleagues and governors for their attendance and closed the meeting at approximately 12:01 pm.

**59/22 Date and time of next meeting**

**Date:** Thursday 5 May 2022
**Time:** 9:00 – 12:30 pm
**Venue:** Microsoft Teams

# 5. Action Log and Matters Arising

To Note

Presented by Philip Lewer

# ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC) 2022

Position as at: 03.03.22

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

| DATE DISCUSSED | AGENDA ITEM | LEAD | CURRENT STATUS / ACTION | DUE DATE | RAG RATING | DATE ACTIONED & CLOSED |
|---|---|---|---|---|---|---|
| 04.11.21 157/21 | Quality Report<br>Director of Nursing to plan and lead a caring domain session focused on patient experience for a future Board Development Session. | EA | The session focused on the caring domain / patient experience has been arranged for Thursday 9 June 2022. Action closed. | 03.03.22 | | 08.03.22 |

# 6. Chair’s Report

To Note

Presented by Philip Lewer

# 7. Chief Executive’s Report

To Note

Presented by Brendan Brown

# Transforming and Improving Patient Care

## 8. Patient Story – "The High Intensity User Service and our impact on Patient Care" Presented by Jenny Dyson, Lead Nurse for High Intensity Users and Matron Alistair Christie and Sarah Wilson

To Note

# 9. Health Inequalities Update

To Note

Presented by Ellen Armistead

| | |
|---|---|
| **Date of Meeting:** | Thursday 5 May 2022 |
| **Meeting:** | Public Board of Directors |
| **Title:** | Health Inequalities Progress Report |
| **Authors:** | Ellen Armistead, Director of Nursing / Deputy CEO<br>Anna Basford, Director of Transformation and Partnerships<br>Suzanne Dunkley, Director of Workforce and OD<br>Jo Fawcus, Chief Operating Officer |
| **Sponsoring Director:** | Ellen Armistead, Executive Director of Nursing / Deputy CEO |
| **Previous Forums:** | Health Inequalities Group |

**Purpose of the Report**

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

**Key Points to Note**

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

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

CHFT has been invited to present at the NHS Expo in Liverpool in June regarding the waiting list Health Inequalities work done at CHFT. The title is: *Inclusive recovery: Tackling health inequalities when bringing down the elective backlog*

Health Inequalities group have asked public health registrar to work on a strategy and update the plan on a page.

**External environment: how we connect with our communities**:
Work is being undertaken with Calderdale Council and local system Partners to engage staff, communities, private and Voluntary and Community Sector (VCS) to address inequality during the pandemic, focusing on groups that have been impacted the most.

**The lived experience, initial focus on maternity services:**
There has been good progress in terms with Smoking cessation, during the past year Midwives have significantly increased the number of electronic referrals to external stop smoking services by 67%. A number of discovery interviews were completed during February

and March. Mostly the women were happy with their care and gave the usual feedback about visiting arrangements, car parking etc. Working with the public health registrar we have the identified Cultural Competency Training package on e-Learning for healthcare (eLfh) uploaded onto ESR for roll out across Maternity. The staff survey will be repeated four weeks after the package is made available on Electronic Staff Record (ESR).

**Continuity of carer (CoC):** 26% of women have been booked onto a CoC pathway, 76% of women from BAME backgrounds have been booked onto a CoC pathway. The Trust approach to CoC is currently being reviewed in line with the expectation of the Ockenden review.

**Using our data to inform stabilisation and reset:**

Significant progress has been made on waiting time differential, detail in the main body of the report.

**Diverse and Inclusive workforce:** Staff survey data relating to equality, diversity and inclusion (EDI) is currently being interrogated and shared with the relevant networks in order that the networks can develop objectives to maintain the positive areas and enhance support in the hot spot areas

**EQIA – Equality Impact Assessment**

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

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

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

**Recommendation**

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

**HEALTH INEQUALITIES PROGRESS REPORT**

**5th May 2022**

## 1. Introduction

Health Inequalities are defined as:

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

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

## 2. Background and Context

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

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

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

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

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

## 3 Workstream Updates

CHFT has been invited to present at the NHS Expo in Liverpool in June regarding the waiting list Health Inequalities work done at CHFT. The title is:

- Inclusive recovery: Tackling health inequalities when bringing down the elective backlog

Health Inequalities Group have asked public health registrar to work on a strategy and update the plan on a page

External environment: how we connect with our communities.

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

- Improving the experience in Accident and Emergency Department for people that have experienced trauma and adversity to sign-post and enable their access to a range of community support available.
- Work undertaken with Calderdale Council and local system Partners to engage staff, communities, private and Voluntary and Community Sector (VCS) to address inequality during the pandemic, focusing on groups that have been impacted the most. A video describing this work and implementation of the agreed action plan is attached https://youtu.be/cTGm9_5Gqlo
- Supporting work on a project with Calderdale CCG and in collaboration with Huddersfield University. The aim of the project is to understand what might be the reasons why people who are from the most deprived communities experience inequality in accessing hip replacement surgery. (This national inequality is summarised in a report from the Nuffield Trust attached here https://www.nuffieldtrust.org.uk/resource/deprivation-and-access-to-planned-surgery). The aim of the project is to understand why people locally not seek referral or may decline services – and therefore what actions might be helpful to address this inequality.

The lived experience, initial focus on maternity services

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

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

**Discovery Interviews:** Eight discovery interviews were completed during February and March. Mostly the women were happy with their care and gave the usual feedback about visiting arrangements, car parking etc. Two women where their first language was not English were offered translators at all appointments.

**Staff Training and Cultural Awareness:** Working with the public health registrar we have the identified Cultural Competency Training package on eLfh uploaded onto ESR for roll out across Maternity. The staff survey will be repeated four weeks after the package is made available on ESR.

**Smoking cessation:** Work is in progress to establish two maternity support workers and deliver nicotine replacement treatment for pregnant women. New carbon monoxide monitors have been received by the Trust. Work has begun to prepare for the enhanced data collection and metrics required for reporting across the Trust.

**Smoking Referrals:** during the past year Midwives have significantly increased the number of electronic referrals to external stop smoking services by 67%. This is further reflected by a reduction in SATOD (smoking at the date of delivery) year to date 9.64%.

**Continuity of Carer (CoC):** 26% of women have been booked onto a CoC pathway, 76% of women from BAME backgrounds have been booked onto a CoC pathway. The Trust approach to CoC is currently being reviewed in line with the expectation of the Ockenden review.

Using our data to inform stabilisation and reset

We continue to review the waiting list data and we want to prioritise based on different risks factors. The three areas currently in focus are patients by index of multiple deprivation (IMD); patients with a learning disability and patients from a BAME background.

Latest progress on waiting time equity:

- For P2, BAME patient waits have reduced over time and now wait 0.2 weeks more than white patients compared to an extra 7.2 weeks in March
- For P2, IMD 1&2 patients now have just a 0.4 week longer wait than IMD 9&10.
- For P2, P3, P4 combined BAME patient waits have reduced over time and now wait just 1.2 weeks longer than white patients compared to an extra 5.1 weeks in May.
- For P2, P3, P4 combined, IMD 1&2 patient waits have reduced over time and now wait just 1 week longer than IMD 9&10 patients compared to an extra 5.6 weeks in May.

**Progress by Division**

**Community**

Health Inequalities – IMD incorporated into waiting list and Knowledge Portal Plus (KP+) reviews. Also incorporated into new anticipatory care services and close working with each Primary Care Network (PCN) to tailor those services to population and neighbourhood need

**Medicine**

In addition to review, monitoring and acting on health inequality information for elective pathways, health inequality information in relation to acute pathways has been analysed and shared with Directorates. This information will help inform divisional and directorate priorities for 2022/23

**Surgery**

**Divisional Priorities for Patients with a Learning Disability**

**Identification**

- Learning Disability (LD) Every contact counts - Audits being completed in Audiology and Endoscopy and other high Did Not Attend (DNA) rate areas.
- Use of flags on ESR - information about learning needs and vulnerability documented in the Electronic Patient Record (EPR). This information should be stratified based on their needs into a prioritised group for early treatment and harm prevention.

**Easy Read /Signposting**

- Principles of 10 steps to… Display boards and easy read patient information – sharing learning from Paediatrics into adult areas.
- Patient impact stories.
- Reviewing of patient leaflets

**Supporting Transition between children's and adult services.**

- Specific focus on Audiology to aim to imbed complex clinics for LD patients.
- Shared learning with other specialties.

**Staff Training and Awareness**

- Increase number of LD champions in the Division
- Promotion of e-learning package for LD with teams

**FSS**

Continue to adopt the principle of a clinical needs approach but take account of health inequalities where possible. Some of the key initiatives are described below:

- Appointment booking – Flag on KP+ and Appointment Slot Issues (ASI) to enable LD patients booked first
- Ethnicity status of 'not stated' and 'unknown' reset back to blank in EPR
- Ethnicity capture in Intouch Kiosks now has direct feed linking back into EPR
- Children's, work on prioritising patients with learning disabilities is ongoing – consultant checklist planned
- Recruited Transition Clinical Nurse Specialist (CNS) and start date confirmed
- Diabetes patient advocates presented quality improvement project at the Royal College of Paediatrics and Child Health
- An inequalities and wellbeing group has been set up in Radiology. Conducting a gap analysis of all parts of current service. Once areas have been identified these will be pulled together into an action plan.
- Maternity working with Amanda McKie, Matron to add LD Care Plan to Athena
- Maternity undertaking cultural competency survey as precursor to specific training offer
- COC 2 teams locality based mixed risk team in areas of high IMD code.
- ISHS – Individualised integrated sexual health services in areas of high deprivation e.g., North and Central Halifax
- Working with partners voluntary and statutory to ensure service delivered to hard to reach client base Outreach Services – Ebenezer - homeless shelter, Brunswick Centre Outreach – drop-in service with substance misuse vulnerable women and sex workers Tailored 1:1 care for patients with learning disabilities

Radiology KP+ model now published and being used by the service. Endoscopy pathway model almost ready for publication, this will allow users to see the endoscopy pathway right from waiting list, through pre-op appointments right through to the endoscopy being carried out via a health inequality and LD lens and to help identify any potential inequities of service.

Meetings have taken place with General Managers in numerous services to health inequality and LD KP+ models are available and to give them a route to feedback suggestions and requests

Outpatient DNA rate data added to Activity by IMD KP+ model shows a higher rate of DNAs for more deprived areas, this is an area to further interrogate.

<u>Diverse and Inclusive Workforce.</u>

Wellbeing– April is stress awareness month. The wellbeing team hosted a number of stalls across the CHFT footprint to share material and resources to support wellbeing and signpost colleagues to the support they need

Disability – Community Disability Action Group (CDAG) meeting held 21.4.22 to share staff survey results and develop objectives to connect with and support colleagues with a disability. Management disability toolkit developed in consultation with network members and distributed to the management population

Womens Network – International Womens Day event generated interesting debate and increased membership of the network. Gender Pay Gap report was submitted the figure for the median pay gap is usually considered to be more representative of gender pay gap across the workforce, for CHFT this increased from 18.7% in 2019 to 20.1% in 2020 and has since decreased again to 19.2% in 2021. Action Plan is currently being developed in consultation with the Womens Network.

Staff survey data relating to EDI is currently being interrogated and shared with the relevant networks in order that the networks can develop objectives to maintain the positive areas and enhance support in the hot spot areas

**Summary**

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

**Ellen Armistead**
**Executive Director of Nursing/Deputy CEO**
**May 2022**

# 10. Place Based Working in Kirklees

To Approve

Presented by Anna Basford

Calderdale and Huddersfield NHS Foundation Trust

| | |
|---|---|
| **Date of Meeting:** | Thursday 5 May 2022 |
| **Meeting:** | Public Board of Directors |
| **Title of report:** | Place Based Working in Kirklees |
| **Authors:** | Anna Basford – Director of Transformation and Partnerships |
| **Sponsor:** | Brendan Brown – Chief Executive |
| **Previous Forums:** | Previous discussions have taken place at Trust Board development workshops regarding the white paper published by the Department of Health and Social Care in February 2021 that sets out the key components of a statutory integrated care system ("ICS"). One of these components is "*strong and effective place-based partnerships*" in local places between the NHS, local government and key local partners, interfacing with a statutory ICS. |

**Purpose of the Report**

The purpose of this report is to provide an update on progress to develop the place based partnership agreement in Kirklees and seek

A draft of the collaboration agreement was discussed at the Kirklees Partnership Forum on 7 April 2022 and been updated to incorporate comments from partners.

The Trust Board is now requested to formally confirm agreement to approve the enclosed Kirklees Place-Based Partnership Collaboration Agreement.

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

**Key Points to Note**

The West Yorkshire and Harrogate Health and Care Partnership (ICS) has been progressing work to develop future governance arrangements to implement the legislative changes set out in the Health and Care Act 2022 which puts integrated care systems on a statutory footing from 1st July 2022.

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

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

| |
|---|
| agreement that partner organisations in each place will sign up to.<br><br>In Kirklees work has been progressed to develop the place based working arrangements and a collaboration agreement to describe this. CHFT has been involved and had input to these discussions in recent months through representation. The collaboration agreement document is attached at Appendix S2. |
| **EQIA – Equality Impact Assessment** |
| The proposed legislative changes to partnership working outlined in this paper seek to address the needs of the whole population thought enhanced partnership working to reduce health inequalities.<br><br>At WY and place based level there is commitment that future governance arrangements must improve the diversity and inclusivity of our leadership at every level and ensure meaningful representation across all places and communities in WY. |
| **Recommendation** |
| The Board is asked to **APPROVE** the Kirklees Place Based Partnership Collaboration Agreement |

Insert Kirklees Health and Care Partnership branding/logo

# KIRKLEES HEALTH AND CARE PARTNERSHIP

# COLLABORATION AGREEMENT

| No | Date | Version Number | Author | Status |
|---|---|---|---|---|
| 1 | 25.11.21 | 1 | Hill Dickinson | Initial draft |
| 2 | 01.12.21 | 2 | Hill Dickinson | Draft |
| 2.1 | 02.03.22 | 3 | Kirklees – Laura Ellis | Draft |
| 3 | 28.03.22 | 4 | Hill Dickinson | Draft |
| 3.1 | 28.03.22 | 5 | Kirklees – Laura Ellis | Draft |
| 3.2 | 31.03.22 | 6 | Kirklees – Laura Ellis | Final Draft |
| 4.0 | 22.04.22 | 7 | Kirklees – Laura Ellis | Final |

## BACKGROUND

(A) The white paper published by the Department of Health and Social Care in February 2021[1] (the "White Paper") builds on the NHS Long Term Plan vision of integrated care and sets out the key components of a statutory integrated care system ("ICS"). One of these components is "*strong and effective place-based partnerships*" in local places between the NHS, local government and key local partners, interfacing with NHS Integrated Care Boards and wider ICS and provider collaboratives established on a broader sector-based footprint. The Health and Care Act 2022 looks to implement, from 1 July 2022, the proposals from the White Paper.

(B) The partner organisations ("**Partners**") who are signatories to this Collaboration Agreement have been working collaboratively across Kirklees to integrate services and provide care at or closer to home for local people for some time. This Agreement sets out the vision, objectives and shared principles of the Partners in establishing a place-based partnership for Kirklees (the "**Partnership**") and further developing place-based health and care provision for the people of Kirklees, building on the progress achieved by the Partners to date. The Agreement also sets out how the Partners will work together as participants in the Partnership, including the governance arrangements. The signatories to this Agreement are those partners with a

[1] *Integration and Innovation: working together to improve health and social care for all* (Integration and Innovation: working together to improve health and social care for all (publishing.service.gov.uk)

seat on the ICB Committee; the wider place based partnership also includes many other partners.

(C) The Partners will work together to deliver the Kirklees Health and Wellbeing Plan (as amended from time to time) and to achieve the Kirklees Shared Outcomes. Further focus areas may be agreed by the Partners during the term of this Agreement as required to further the collaborative work of the Partners for the benefit of the population of Kirklees.

(D) The Partners will undertake a programme of work from the Commencement Date through the Partnership governance arrangements set out in this Agreement including receiving and discharging delegated functions from the NHS West Yorkshire Integrated Care Board ("ICB") and broader activity for the benefit of the Kirklees population. This programme of work is set out, in outline terms, in the Kirklees Health and Wellbeing Plan.

(E) The Partners acknowledge that the success of the Partnership will rely on the Partners working collaboratively rather than separately to plan financially sustainable methods of delivering integrated, population-focused services in furtherance of the Kirklees Health and Wellbeing Plan.

(F) This Agreement is intended to supplement and work alongside the Partners' respective governance arrangements and, in the case of provider Partners, their services contracts with the ICB, NHS England and the Council, whilst respecting their individual sovereignty.

## 1. DEFINITIONS AND INTERPRETATION

1.1 In this Agreement, capitalised words and expressions shall have the meanings given to them in Schedule 1.

1.2 In this Agreement, unless the context requires otherwise, the following rules of construction shall apply:

1.2.1 a person includes a natural person, corporate or unincorporated body (whether or not having separate legal personality);

1.2.2 unless the context otherwise requires, words in the singular shall include the plural and in the plural shall include the singular;

1.2.3 a reference to a Partner includes its personal representatives, successors or permitted assigns;

1.2.4 a reference to a statute or statutory provision is a reference to such statute or provision as amended or re-enacted. A reference to a statute or statutory provision includes any subordinate legislation made under that statute or statutory provision, as amended or re-enacted;

1.2.5 any phrase introduced by the terms "**including**", "**include**", "**in particular**" or any similar expression shall be construed as illustrative and shall not limit the sense of the words preceding those terms; and

1.2.6 a reference to writing or written includes emails.

## 2. STATUS AND PURPOSE

2.1 The Partners have agreed to work together on behalf of the people of Kirklees to establish the Partnership through which to identify and respond to the health and care needs of the Kirklees population, and deliver integrated health, support and community care to reduce health inequalities and improved health and care outcomes for the people of Kirklees (the "**Purpose**").

2.2 This Agreement sets out the key terms that the Partners have agreed, including:

2.2.1 the vision of the Partners, and key objectives for the development and delivery of the Kirklees Health and Wellbeing Plan;

2.2.2 the key principles that the Partners will comply with in working together through the Partnership; and

2.2.3 the governance structures underpinning the Partnership as at the Commencement Date.

2.3 This Agreement is not intended to be legally binding, and no legal obligations or legal rights shall arise between the parties from this Agreement. The parties enter into the Agreement intending to honour all their obligations.

2.4 Each of the Partners agrees to work together in a collaborative and integrated way on a Best for Kirklees basis. This Agreement is not intended to conflict with or take precedence over any statutory duties or the terms of any Services Contracts or any Section 75 Agreement unless (and to the extent permitted in law) expressly agreed by the Partners.

## 3. APPROVALS

Each Partner acknowledges and confirms that as at the date of this Agreement, it has obtained all necessary authorisations to enter into this Agreement and that (where relevant) its own organisational leadership body has approved the terms of this Agreement.

## 4. DURATION AND REVIEW

4.1 This Agreement will take effect on the Commencement Date and will expire on 30 June 2025 (the "**Initial Term**"), unless and until terminated in accordance with the terms of this Agreement.

4.2 At the expiry of the Initial Term this Agreement will expire automatically without notice unless the Partners agree in writing that the term of the Agreement shall be extended for a further term to be agreed between the Partners.

4.3 The Partners will review progress made against the Kirklees Health and Wellbeing Plan and the terms of this Agreement by 1 January 2023 and by 30 June 2023 and annually thereafter. The Partners may agree to vary the Agreement to reflect developments as appropriate in accordance with Clause 17 (*Variations*).

## SECTION A: VISION, OBJECTIVES AND PRINCIPLES

### 5. THE VISION

5.1 The Partners have agreed to work towards a common vision for the Partnership as follows:

*No matter where they live, people in Kirklees live their lives confidently and responsibly, in better health, for longer and experience less inequality.*

### 6. THE OBJECTIVES

6.1 The Partners have agreed to work together and to perform their duties under this Agreement in order to achieve the following Objectives:

6.1.1 Reduce health inequalities;

6.1.2 Manage unwarranted variations in care;

6.1.3 Use our collective resources wisely; and

6.1.4 Secure the wider benefits of investing in health and care.

6.2 The Partners will aim to achieve the Kirklees Shared Outcomes identified in the Kirklees Health & Wellbeing Strategy (as amended from time to time):

6.2.1 Children - children have the best start in life;

6.2.2 Healthy - people in Kirklees are as well as possible for as long as possible;

6.2.3 Achievement - people in Kirklees have aspiration and achieve their ambitions through education, training, employment and lifelong learning;

6.2.4 Safe & Cohesive - people in Kirklees live in cohesive communities, feel safe and are safe / protected from harm;

6.2.5 Economic - Kirklees has sustainable economic growth and provides good employment for and with communities and businesses;

6.2.6 Clean & Green – people in Kirklees experience a high quality, clean and green environment; and

6.2.7 Independent - people in Kirklees live independently and have control over their lives.

6.2.8 Shaped by people – we make our places what they are.

6.3 The Partners acknowledge that they will have to make decisions together in order for the Partnership arrangements to work effectively. The Partners agree that they will work together and make decisions on a Best for Kirklees basis in order to achieve the Objectives.

## 7. THE PRINCIPLES

7.1 The Principles set out below underpin the delivery of the Partners' obligations under this Agreement and set out key factors for a successful relationship between the Partners for the delivery of the Partnership.

7.2 The Partners agree that the successful delivery of the Partnership operating model will depend on their ability to effectively co-ordinate and combine their expertise and resources in order to deliver an integrated approach to the planning, provision and use of assets and services across the Partners.

7.3 The Partners will work together in good faith and, unless the provisions in this Agreement state otherwise, the Partners will adhere to the following principles:

7.3.1 We will be ambitious for the people we serve and the staff we employ;

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

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

7.3.4 We will undertake shared analysis of problems and issues as the basis of taking action; and

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

7.3.6 The Partners agree to behave consistently as leaders and colleagues in ways which model and promote the West Yorkshire Integrated Care System shared values:

(a) We are leaders of our organisation, our place and of West Yorkshire;

(b) We support each other and work collaboratively;

(c) We act with honesty and integrity, and trust each other to do the same;

(d) We challenge constructively when we need to;

(e) We assume good intentions; and

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

7.4 The foundation of the Kirklees Health and Care Partnership approach is to:

7.4.1 Work with nine local communities in Kirklees;

7.4.2 Focus on prevention and early intervention;

7.4.3 Empower people to stay independent;

7.4.4 Deliver high quality acute and specialist services;

7.4.5 Do work once, avoiding duplication and make sure things are strong-seamed; and

7.4.6 Commit to openness, transparency and involvement,

and, together with the principles set out in Clause 7.3, these are the "**Principles**".

## 8. PROBLEM RESOLUTION AND ESCALATION

8.1 The Partners agree to adopt a systematic approach to problem resolution which recognises the Objectives and the Principles set out in Clauses 6 and 7 above and which:

8.1.1 seeks solutions without apportioning blame;

8.1.2 is based on mutually beneficial outcomes;

8.1.3 treats the Partners as equal parties in the dispute resolution process; and

8.1.4 contains a mutual acceptance that adversarial attitudes waste time and money.

8.2 If a problem, issue, concern or complaint comes to the attention of a Partner in relation to any matter in this Agreement such Partner shall notify the other Partners in writing. The Partners shall then try to resolve the issue in a proportionate manner within 20 Operational Days of written notification. If they are not able to do this, the matter will be resolved in accordance with Schedule 3 (*Dispute Resolution Procedure*).

8.3 If any Partner receives any formal enquiry, complaint, claim or threat of action from a third party relating to this Agreement (including, but not limited to, claims made by a supplier or requests for information made under the Freedom of Information Act relating to this

Agreement) the receiving Partner will liaise with the other Partners as to the contents of any response before a response is issued.

## SECTION B: OPERATION OF AND ROLES IN THE PARTNERSHIP

## 9. OBLIGATIONS AND ROLES OF THE PARTNERS

9.1 Each Partner will:

9.1.1 act collaboratively and in good faith with each other Partner in accordance with the Law and Good Practice to achieve the Objectives, having at all times regard to the best interests of the Population;

9.1.2 co-operate fully and liaise appropriately with each other Partner in order to ensure a co-ordinated approach to promoting the quality of patient care and so as to achieve continuity in the provision of services;

9.1.3 through high performance and collaboration, unlock and generate enhanced innovation and better outcomes and value for the Population in line with the Objectives;

9.1.4 remain responsible for complying with its statutory duties, performing its obligations and functions and complying with all relevant regulatory requirements; and

9.1.5 remain accountable to its board/cabinet/governing body (or equivalent) and all applicable regulatory bodies.

## 10. TRANSPARENCY

10.1 Subject to compliance with the Law and contractual obligations of confidentiality, the Partners will provide to each other all information that is reasonably required in order to achieve the Objectives and Purpose and deliver the Kirklees Health and Wellbeing Plan in line with the Principles.

10.2 The Partners will ensure that appropriate information barriers are set up between them to ensure that any confidential information is only available to those Partners who need to see it to achieve the Objectives and for no other purpose whatsoever.

10.3 It is accepted by the Partners that the involvement of provider Partners in the governance arrangements for the Partnership is likely to give rise to situations where information will be generated and made available to the provider Partners which could give the provider Partners an unfair advantage in competitions or which may be capable of distorting such competitions (for example, disclosure of pricing information or approach to risk may provide one provider Partner with a commercial advantage over another provider Partner). Any provider Partner will have the opportunity to demonstrate to the reasonable satisfaction of the ICB and/or the Council (where acting as a commissioner) in relation to any competitive

procurements that the information it has acquired as a result of its participation in the Partnership, other than as a result of a breach of this Agreement, does not preclude the ICB and the Council (where acting as a commissioner) from running a fair competitive procurement in accordance with their legal obligations. A provider Partner shall not be obliged to provide any information which in its reasonable opinion would provide any other Partner with an unfair advantage in any competition or would distort competition.

## SECTION C: GOVERNANCE ARRANGEMENTS

### 11. PARTNERSHIP GOVERNANCE

11.1 In addition to the Partners' own Board / Cabinet / Governing Body (or equivalent) which shall remain accountable for the exercise of each of the Partners' respective functions, the governance structure for the Partnership arrangements will include:

11.1.1 the Kirklees Partnership Forum;

11.1.2 the Kirklees ICB Committee ("ICB Committee");

11.1.3 the Kirklees Quality Sub-Committee; and

11.1.4 the Kirklees Finance and Performance Sub-Committee; and

11.1.5 the Kirklees Health and Well-being Board

11.2 The diagram in Schedule 2 (*Governance*) sets out the governance structure and the links between the various groups in more detail.

*Kirklees Partnership Forum*

11.3 The Kirklees Partnership Forum is a consultative and collaborative group to inform and support the work of the decision taking roles of the Kirklees ICB Committee and the Health and Wellbeing Board. It will help to ensure that a broad range of Partner organisations are actively involved in place-based decision making arrangements in Kirklees.

11.4 The Forum will support system development by establishing a shared culture where Partner staff adopt common sets of values and behaviours. It will help to oversee activities that will help the Partner organisations to do this.

11.5 The Forum will help to oversee and support the development of shared partnership infrastructure that may be required to support the work of the Partnership. In doing this it will consider the progress made in existing areas of joint working and consider any further areas where shared partnership infrastructure may be helpful.

11.6 The Forum will act in accordance with its terms of reference, a copy of which is set out in Part 1 of Schedule 2.

*Kirklees ICB Committee*

11.7 The ICB Committee reports to the ICB and is the group responsible for:

11.7.1 making decisions in respect of certain ICB functions as set out in the ICB scheme of reservation and delegation (as may be amended from time to time);

11.7.2 reporting to the ICB and Partner organisations on progress against the Objectives;

11.7.3 reporting to the Kirklees Health and Wellbeing Board on progress against the Joint Health and Wellbeing Strategy for Kirklees; and

11.7.4 liaising where appropriate with:

(a) national stakeholders (including NHS England and NHS Improvement); and

(b) the West Yorkshire ICB Board

(c) other key stakeholders

to communicate the views of the Partnership on matters relating to integrated care in Kirklees.

11.8 The ICB Committee will discharge the functions set out in its terms of reference, a copy of which is set out in Part 2 of Schedule 2.

11.9 The ICB has delegated to the ICB Committee the matters set out in the ICB scheme of reservation and delegation. The ICB Committee is established as a committee of the ICB Board, in accordance with the ICB's Constitution, Standing Orders and Scheme of Delegation. Members of the ICB Committee agree to act in accordance with the Committee's terms of reference, published on the ICB website. These set out the remit, responsibilities, membership and reporting arrangements of the ICB Committee and may only be changed with the approval of the ICB Board. The ICB Committee has no executive powers, other than those specifically delegated to it from the ICB Board.

11.10 The Partners acknowledge that their employees may be appointed as members of the ICB Committee. The Partners agree to support their employees in doing so in line with the aims and objectives of the ICB Committee. The Partners acknowledge that any individual who is nominated as a member of the of the ICB Committee or sub-committee of the ICB Committee understands and agrees to bring knowledge and perspective from their sector but not be delegates or carry agreed mandates from that sector or from their Partner organisation.

11.11 Each Partner will use reasonable endeavours to ensure that its appointed members of the ICB Committee (or their appointed deputies/alternatives) attend at least 75% of scheduled meetings each year and participate fully on a Best for Kirklees basis and in accordance with Clause 6 (*Objectives*) and Clause 7 (*Principles*) and the terms of reference.

11.12 The Partners will review and develop the governance arrangements for the Partnership during 2022/23 to strengthen joint decision-making between the Partners in line with the relevant provisions of the Health and Care Act 2022.

*Kirklees Health and Wellbeing Board*

11.13 The Kirklees Health and Wellbeing Board is a committee of the Council, charged with promoting greater health and social care integration in Kirklees. The Health and Wellbeing Board will receive reports from the ICB Committee as to the development of the Partnership arrangements under this Agreement and progress against the Joint Health & Wellbeing Strategy and the Health and Wellbeing Plan.

## 12. CONFLICTS OF INTEREST

12.1 Subject to compliance with Law and contractual obligations of confidentiality the Partners agree to share all information relevant to the achievement of the Objectives in an honest, open and timely manner.

12.2 The Partners will:

12.2.1 disclose to each other the full particulars of any real or apparent conflict of interest which arises or may arise in connection with this Agreement or the operation of the Partnership governance immediately upon becoming aware of the conflict of interest whether that conflict concerns the Partner or any person employed or retained by them for or in connection with the performance of this Agreement;

12.2.2 not allow themselves to be placed in a position of conflict of interest in regard to any of their rights or obligations under this Agreement (without the prior consent of the other Partners) before they participate in any decision in respect of that matter; and

12.2.3 use best endeavours to ensure that their appointed members on the Forum, the ICB Committee and any sub-committee of the ICB Committee also comply with the requirements of this Clause 12 as relevant when acting in connection with this Agreement.

12.3 The ICB has made arrangements to manage any actual and potential conflicts of interest to ensure that decisions made by committees or sub-committees of the ICB will be taken and seen to be taken without being unduly influenced by external or private interest and do not, (and do not risk appearing to) affect the integrity of the ICB's decision-making processes. These arrangements apply to the ICB Committee and any sub-committees of the ICB Committee.

12.4 The ICB has agreed policies and procedures for the identification and management of conflicts of interest which are published on the website (include link)

12.5 The Partners shall ensure that all ICB Committee and sub-committee members comply with the ICB policy on conflicts of interest in line with their terms of office. This will include but not be limited to declaring all interests on a register that will be maintained by the ICB.

12.6 The Partners shall ensure that all ICB Committee and sub-committee members comply with the ICB Standards of Business Conduct policy (include link)

## SECTION D: FINANCIAL PLANNING

### 13. FINANCIAL PRINCIPLES

13.1 The Partners will continue to be paid in accordance with the mechanism set out in their respective Services Contracts or other agreements (if any).

13.2 The Partners will work together during the Initial Term to develop system financial principles for the allocation of resources within Kirklees including the potential development of risk/reward sharing mechanisms with the aim of achieving the Objectives.

## SECTION E: GENERAL PROVISIONS

### 14. EXCLUSION AND TERMINATION

14.1 A Partner may be excluded from this Agreement on notice from the other Partners (acting in consensus) in the event of:

14.1.1 the termination of their Services Contract; or

14.1.2 an event of Insolvency affecting them.

14.2 A Partner may withdraw from this Agreement by giving not less than 6 months' written notice to each of the other Partners' representatives.

14.3 A Partner may be excluded from this Agreement on written notice from all of the remaining Partners in the event of a material or a persistent breach of the terms of this Agreement by the relevant Partner which has not been rectified within 30 operational days of notification issued by the remaining Partners (acting in consensus) or which is not reasonably capable of remedy. In such circumstances this Agreement shall be partially terminated in respect of the excluded Partner.

14.4 The Partners may agree in writing to terminate this Agreement in whole where:

14.4.1 a Dispute cannot be resolved pursuant to the Dispute Resolution Procedure; or

14.4.2 where the Partners agree for this Agreement to be replaced by a formal legally binding agreement between them.

14.5 Where a Partner is excluded from this Agreement, or withdraws from it, the excluded or withdrawing (as relevant) Partner shall procure that all data and other material belonging to any other Partner shall be delivered back to the relevant Partner or deleted or destroyed (as instructed by the relevant Partner) as soon as reasonably practicable.

## 15. INTRODUCING NEW PARTNERS

Additional parties may become parties to this Agreement on such terms as the Partners shall jointly agree in writing, acting at all times on a Best for Kirklees basis and upon agreement in writing to the terms of this Agreement before admission.

## 16. LIABILITY

The Partners' respective responsibilities and liabilities in the event that things go wrong with the Services will be allocated under their respective Services Contracts and not this Agreement.

## 17. VARIATIONS

Any amendment to this Agreement will not be effective unless set out in writing and signed by or on behalf of each of the Partners.

## 18. CONFIDENTIALITY AND FOIA

18.1 Each Partner shall keep confidential all confidential information that it receives from the other Partners except to extent such confidential information is required by Law to be disclosed or is already in the public domain or comes into the public domain otherwise than through an unauthorised disclosure by a Partner to this Agreement

18.2 To the extent that any confidential information is covered or protected by legal privilege, then disclosing such confidential information to any Partner or otherwise permitting disclosure of such confidential information does not constitute a waiver of privilege or of any other rights which a Partner may have in respect of such confidential information.

18.3 The Partners agree to procure, as far as is reasonably practicable, that the terms of this Clause 18 (*Confidentiality and FOIA*) are observed by any of their respective successors, assigns or transferees of respective businesses or interests or any part thereof as if they had been party to this Agreement.

18.4 Nothing in this Clause 18 (*Confidentiality and FOIA*) will affect any of the Partners' regulatory or statutory obligations, including but not limited to competition law of any applicable jurisdiction.

18.5 The Partners acknowledge that some of them are subject to the requirements of the FOIA and will facilitate each other's compliance with their information disclosure requirements,

including the submission of requests for information and handling any such requests in a prompt manner and so as to ensure that any Partner which is subject to FOIA is able to comply with their statutory obligations.

## 19. GENERAL

19.1 Any notice or other communication given to a Partner under or in connection with this Agreement shall be in writing, addressed to that Partner at its principal place of business or such other address as that Partner may have specified to the other Partner in writing in accordance with this Clause, and shall be delivered personally, or sent by pre-paid first class post, recorded delivery or commercial courier.

19.2 A notice or other communication shall be deemed to have been received: if delivered personally, when left at the address referred to in Clause 19.1 above; if sent by pre-paid first class post or recorded delivery, at 9.00 am on the second Operational Day after posting; or if delivered by commercial courier, on the date and at the time that the courier's delivery receipt is signed.

19.3 Nothing in this Agreement is intended to, or shall be deemed to, establish any partnership between any of the Partners, constitute any Partner the agent of another Partner, nor authorise any Partner to make or enter into any commitments for or on behalf of any other Partner except as expressly provided in this Agreement.

19.4 This Agreement may be executed in any number of counterparts, each of which when executed and delivered shall constitute an original of this Agreement, but all the counterparts shall together constitute the same agreement. The expression "counterpart" shall include any executed copy of this Agreement scanned into printable PDF, JPEG, or other agreed digital format and transmitted as an e-mail attachment. No counterpart shall be effective until each Partner has executed at least one counterpart.

19.5 A person who is not a Partner to this Agreement shall not have any rights under or in connection with it.

Signed by [ insert ]

for and on behalf of **NHS WEST YORKSHIRE INTEGRATED CARE BOARD**

.....

[ ]

Signed by [ insert ]

for and on behalf of **THE COUNCIL OF THE BOROUGH OF KIRKLEES**

.....

[ ]

Signed by [ insert ]

for and on behalf of **MID YORKSHIRE HOSPITALS NHS TRUST**

.....

[ ]

Signed by [ insert ]

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

.....

[ ]

Signed by [ insert ]

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

.....

[ ]

Signed by [ insert ] .....

for and on behalf of **LOCALA CIC** [ ]

Signed by [ insert ] .....

for and on behalf of **HEALTHWATCH KIRKLEES** [ ]

Signed by [ insert ] .....

for and on behalf of **THIRD SECTOR LEADERS** [ ]

Signed by [ insert ] .....

for and on behalf of **GENERAL PRACTICE** [ ]

## SCHEDULE 1

### Definitions and Interpretation

1. The following words and phrases have the following meanings:

| | |
|---|---|
| **Best for Kirklees** | best for the achievement of the Vision, Objectives and Outcomes for the Kirklees population on the basis of the Principles. |
| **Collaboration Agreement** | this collaboration agreement incorporating the Schedules. |
| **Commencement Date** | 1 July 2022. |
| **Dispute** | any dispute arising between two or more of the Partners in connection with this Agreement or their respective rights and obligations under it. |
| **Dispute Resolution Procedure** | the procedure set out in Schedule 3 for the resolution of disputes which are not capable of resolution under Clause 8 (*Problem Resolution and Escalation*). |
| **Forum** | the Kirklees Partnership Forum, the terms of reference for which are set out in Schedule 2 Part 1. |
| **Good Practice** | has the meaning set out in the NHS Standard Contract |
| **Health and Wellbeing Plan** | the Kirklees Health and Wellbeing Plan 2018 – 2023 (as amended from time to time) |
| **ICB** | NHS West Yorkshire Integrated Care Board. |
| **ICB Committee** | the Kirklees ICB Committee, the terms of reference for which are set out in Schedule 2 Part 2. |
| **Initial Term** | the period from and including the Commencement Date until 30 June 2025. |
| **Insolvency** | (as may be applicable to each Partner) a Partner taking any step or action in connection with its entering administration, provisional liquidation or any composition or arrangement with its creditors (other than in relation to a solvent restructuring), being wound up (whether voluntarily or by order of the court, unless for the purpose of a solvent restructuring), having a receiver appointed to any of its assets or ceasing to carry on business. |
| **Law** | a) any applicable statute or proclamation or any delegated or subordinate legislation or regulation; |

| | |
|---|---|
| | b) any applicable judgment of a relevant court of law which is a binding precedent in England and Wales;<br>c) Guidance (as defined in the NHS Standard Contract);<br>d) National Standards (as defined in the NHS Standard Contract); and<br>e) any applicable code. |
| **NHS Standard Contract** | the NHS Standard Contract for NHS healthcare services as published by NHS England from time to time. |
| **Objectives** | the objectives for the Partnership set out in Clause 6.1. |
| **Operational Days** | a day other than a Saturday, Sunday or bank holiday in England. |
| **Outcomes** | the outcomes for the Partnership set out in Clause 6.2. |
| **Population** | the population of Kirklees covered by the Council. |
| **Principles** | the principles for the Partnership set out in Clause 7. |
| **Purpose** | The purpose of the Partnership set out in Clause 2.1. |
| **Section 75 Agreement** | An agreement entered into by the Commissioners under section 75 of the National Health Service Act 2006 to commission the services listed in the Schedules to that agreement. |
| **Service Users** | people within the Kirklees population served by the Commissioners and who are in receipt of the Services. |
| **Services** | the services provided, or to be provided, by each provider Partner to Service Users pursuant to its respective Services Contract. |
| **Services Contract** | a contract entered into by one of the ICB or the Council (as commissioner) and a provider Partner for the provision of Services, and references to a Services Contract include all or any one of those contracts as the context requires. |
| **Vision** | the vision of the Partnership, as set out in Clause 5. |

## SCHEDULE 2

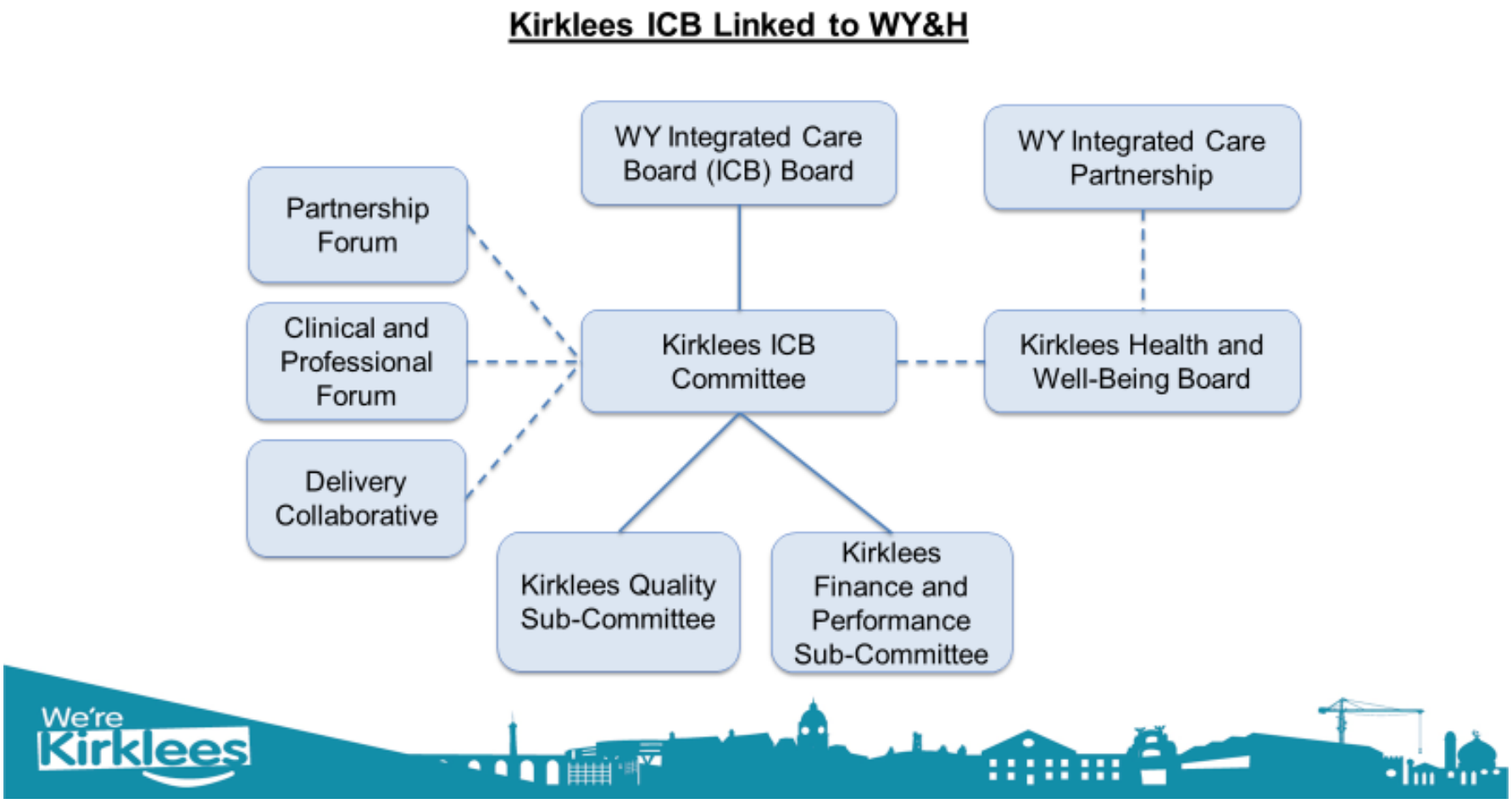
## Governance

This Schedule 2 sets out the core governance arrangements for the Partnership under this Agreement.

The diagram below summarises the governance structure which the Partners have agreed to establish and operate from the Commencement Date, to provide oversight of the development and implementation of the Partnership approach and the arrangements under this Agreement.

This Schedule also contains the terms of reference for the Partnership Forum (Part 1) and the ICB Committee (Part 2).

**Overview of the Kirklees Partnership governance model**



## Part 1 – Kirklees Partnership Forum - Terms of Reference

[TO BE INSERTED]

## Part 2 – Kirklees ICB Committee - Terms of Reference

**[TO BE INSERTED]**

## SCHEDULE 3

### Dispute Resolution Procedure

### 1. Avoiding and Solving Disputes

1.1 The Partners commit to working cooperatively to identify and resolve issues to the Partners' mutual satisfaction so as to avoid all forms of dispute or conflict in performing their obligations under this Agreement. Accordingly the Partners will look to collaborate and resolve differences under Clause 8 (*Problem Resolution and Escalation)* of this Agreement prior to commencing this procedure.

1.2 The Partners believe that by focusing on their agreed Objectives and Principles they are reinforcing their commitment to avoiding disputes and conflicts arising out of or in connection with the Partnership arrangements set out in this Agreement.

1.3 The Partners shall promptly notify each other of any dispute or claim or any potential dispute or claim in relation to this Agreement or the operation of the Partnership (each a '**Dispute**') when it arises.

1.4 In the first instance the relevant Partners' representatives shall meet with the aim of resolving the Dispute to the mutual satisfaction of the relevant Partners. If the Dispute cannot be resolved by the relevant Partners' representatives within 10 Operational Days of the Dispute being referred to them, the Dispute shall be referred to senior officers of the relevant Partners, such senior officers not to have had direct day-to-day involvement in the matter and having the authority to settle the Dispute. The senior officers shall deal proactively with any Dispute on a Best for Kirklees basis in accordance with this Agreement so as to seek to reach a unanimous decision.

1.5 The Partners agree that the senior officers may, on a Best for Kirklees basis, determine whatever action it believes is necessary including the following:

1.5.1 If the senior officers cannot resolve a Dispute, they may agree by consensus to select an independent facilitator to assist with resolving the Dispute; and

1.5.2 The independent facilitator shall:

(i) be provided with any information he or she requests about the Dispute;

(ii) assist the senior officers to work towards a consensus decision in respect of the Dispute;

(iii) regulate his or her own procedure;

(iv) determine the number of facilitated discussions, provided that there will be not less than three and not more than six facilitated discussions, which must take place within 20 Operational Days of the independent facilitator being appointed; and

(v) have its costs and disbursements met by the Partners in Dispute equally.

1.5.3 If the independent facilitator cannot resolve the Dispute, the Dispute must be considered afresh in accordance with this Schedule 3 and only after such further consideration again fails to resolve the Dispute, the Partners may agree to:

(i) terminate this Agreement in accordance with Clause 14.4.1; or

(ii) agree that the Dispute need not be resolved.

# Sustainability

# 11. Annual Plan

To Approve

Presented by Gary Boothby

NHS
Calderdale and Huddersfield
NHS Foundation Trust

| | |
|---|---|
| **Date of Meeting:** | Thursday 5 May 2022 |
| **Meeting:** | Public Board of Directors |
| **Title of report:** | 2022/23 Financial Plan: Budget Book |
| **Author:** | Philippa Russell, Assistant Director of Finance |
| **Sponsor:** | Gary Boothby, Director of Finance |
| **Previous Forums:** | N/A |

**Purpose of the Report**

To update the Board on the final financial plan and to gain approval of the budget for 2022/23.

**Key Points to Note**

Headlines

- The Trust is planning an overall £20.1m deficit position for 2022/23
- This position incorporates a planned £20m efficiency programme and the exit from a further £5.25m of Covid costs

Key assumptions and risks

- The financial plan incorporates additional expenditure in relation to the recovery of planned clinical activity in line with national expectations of achieving 104% of 2019/20 activity levels. It is assumed that Elective Recovery Funding will be secured in support of this.
- Bed numbers and associated costs are planned based upon Summer 2021 Covid inpatient numbers, in line with national guidance.
- There is a risk that inflationary pressures exceed planned levels based upon the wider economic position.
- The scale of the efficiency programme is challenging but schemes have been outlined for the majority of the planned value.

**EQIA – Equality Impact Assessment**

Any decisions taken in support of the overall financial plan will be subject to Equality Impact Assessment and Quality Impact Assessment on a case by case basis, for examples changes linked to the efficiency programme.

**Recommendation**

The Board is asked to **APPROVE** the 2022/23 plan and associated budget.

compassionate care

NHS
Calderdale and Huddersfield
NHS Foundation Trust

# BUDGET BOOK
# 2022-23

**2022/23 Financial Plan - Overview**

The Trust's financial plan for 2022/23 is for a £20.1m deficit. This is a £3m improvement compared to the Draft Plan and is expected to be achieved through the release of part of the Annual Leave Accrual.

**Planning Assumptions:**

**Income Changes:**

- Block Contract allocations uplifted by 3.8%:
  - + 1.7% Tariff uplift (2.8% inflation less 1.1% efficiency requirement)
  - + 2.1% Growth
- Allocations adjusted to reflect 'Convergence Adjustment' of -0.6%
- Share of local Convergence Adjustment (CCCG) -£0.44m
- Covid-19 funding reduced by 57%
- Includes Elective Recovery Funding of £11.7m.

**Cost Changes:**

- Includes recovery costs to achieve 104% of 19/20 activity:
  - £8.6m to support 19/20 activity levels plus growth (including £5.3m Independent Sector support)
  - A further £9.38m to support stretch to 104% activity target (net of planned efficiency)
- Covid-19 costs reflect National guidance activity assumptions and assumes £5.25m improvement compared to 21/22 cost due to reduced Covid-19 cases / capacity requirements.
- Pay inflation included as per national guidance.
- Non Pay inflation includes estimated impact of current RPI on PFI / B Braun contracts and expected pressure on Utilities. Offset to some extent by better than national average improvement in CNST costs for 22/23.
- Assumes delivery of £20m efficiency (4.35%) plus the £5.25m Covid-19 efficiency: Total efficiency requirement of £25.25m

**Risks**

- Assumes achievement of 104% activity target to secure full allocation of Elective Recovery Funding (ERF). Missing this target could result in a 75% reduction in ERF funding regardless of the additional costs incurred.
- As per national planning guidance, the plan assumes a low number of Covid-19 patients allowing at least a £5m reduction in Covid-19 costs compared to levels reported in 21/22, based on assumption that additional capacity requirements will be lower.
- Assumes that DTOC levels reduce to an average of 70
- Risk of further inflationary pressures above planned level, particularly March RPI based contracts and utilities.
- Plans assume Agency and Bank premium payments are only required to deliver additional recovery.
- Scale of CIP challenge with a residual gap to close and some schemes still being developed.
- Risk that winter costs exceed available funding.

**22/23 Plan (CHFT Group): Income & Expenditure**

| Income & Expenditure | 20/21 Actual | 21/22 Actual | 22/23 Plan (Excl. Efficiency) | 22/23 Efficiency | 22/23 Total Plan |
|---|---|---|---|---|---|
| | £'m | £'m | £'m | £'m | £'m |
| NHS Clinical Income | 422.23 | 453.68 | 432.39 | 0.06 | 432.45 |
| Other Income[1] | 57.71 | 54.36 | 49.43 | 0.72 | 50.15 |
| TOTAL INCOME | 479.94 | 508.04 | 481.82 | 0.77 | 482.60 |
| Medical | (84.45) | (94.85) | (93.03) | 3.52 | (89.51) |
| Nursing | (83.29) | (87.35) | (94.30) | 2.10 | (92.20) |
| Sci Tech & Ther | (35.04) | (37.02) | (41.24) | 0.00 | (41.24) |
| Support to clinical staff | (45.08) | (49.06) | (50.34) | 1.11 | (49.24) |
| Any Other Spend[1] | (1.61) | (1.53) | (1.52) | 0.52 | (1.00) |
| Managers and infrastructure support | (40.87) | (43.77) | (46.98) | 1.38 | (45.60) |
| PAY EXPENDITURE | (290.35) | (313.57) | (327.41) | 8.63 | (318.79) |
| Drugs | (40.96) | (43.09) | (46.59) | 0.80 | (45.79) |
| Clinical Supplies & Services | (30.47) | (39.34) | (43.29) | 4.49 | (38.80) |
| Other Costs | (91.09) | (84.50) | (72.10) | 5.12 | (66.98) |
| NON PAY EXPENDITURE | (162.52) | (166.93) | (161.99) | 10.41 | (151.58) |
| TOTAL EXPENSES | (452.87) | (480.50) | (489.40) | 19.04 | (470.36) |
| **EBITDA** | **27.07** | **27.54** | **(7.58)** | **19.81** | **12.23** |
| Non Operating Expenditure | (36.47) | (27.84) | (32.88) | 0.20 | (32.68) |
| **TOTAL SURPLUS/(DEFICIT)** | **(9.40)** | **(0.30)** | **(40.45)** | **20.01** | **(20.44)** |
| Less: Items excluded from Control Total[2] | 9.75 | 0.34 | 0.34 | 0.00 | 0.34 |
| **TOTAL SURPLUS/(DEFICIT) on a Control Total Basis** | **0.36** | **0.04** | **(40.11)** | **20.01** | **(20.10)** |

**Overview:**

- Total deficit improved from £23.1m Draft Plan. £3m improvement expected to be linked to a release of the Annual Leave Accrual.
- 22/23 Budget includes planned income and expenditure linked to Elective Recovery and achieving the 104% of 2019/20 activity target.
- 22/23 Budget includes both the funding and expenditure for expected Covid costs that are considered to be outside of system envelope (eg Testing and Vaccinations).
- System Envelope funded Covid-19 costs have been included in Divisional budgets.
- Efficiency requirement for 22/23 is £20m plus a further embedded efficiency on Covid-19 costs (vs 21/22 expenditure) of £5.25m. Total efficiency requirement as reported to NHSI is £25.25m.
- Position includes inflation, growth, and approved pressures and developments.
- Contingency of £1m held to cover any in year developments approved through the Business Case Approval Group.

**22/23 Plan (CHFT Group): Statement of Financial Position**

| Statement of Financial Position | 21/22 Budget As at 31 Mar 22 £'m | 21/22 Actual As at 31 Mar 22 £'m | 22/23 Plan As at 31 Mar 23 £'m |
|---|---|---|---|
| **Non Current Assets** | | | |
| Property, Plant & Equipment | 116.07 | 121.00 | 150.35 |
| On B/S PFI Assets | 59.98 | 62.20 | 60.20 |
| Right to Use Leases[1] | | | 22.30 |
| Investment in Joint Venture | 3.91 | 4.18 | 4.38 |
| Other | 3.99 | 3.90 | 2.49 |
| | 183.94 | 191.27 | 239.71 |
| **Current Assets** | | | |
| Inventories | 7.46 | 7.61 | 7.61 |
| Receivables | 21.88 | 22.30 | 22.17 |
| Other | 5.13 | 4.80 | 4.80 |
| Cash | 38.75 | 54.65 | 14.43 |
| | 73.21 | 89.36 | 49.02 |
| **Current Liabilities** | | | |
| Loans | (1.21) | (2.21) | (2.21) |
| Deferred Income | (9.68) | (7.45) | (7.45) |
| Payables | (53.56) | (76.25) | (68.86) |
| Provisions | (3.43) | (7.52) | (5.45) |
| Leases (Incl PFI) | (0.75) | (3.48) | (6.60) |
| | (68.63) | (96.92) | (90.57) |
| **Non Current Liabilities** | | | |
| Loans | (16.46) | (15.46) | (13.25) |
| Leases (Incl PFI) | (67.14) | (64.39) | (78.81) |
| Provisions | (1.18) | (1.12) | (1.12) |
| Other | (0.99) | (0.89) | (0.80) |
| | (85.77) | (81.87) | (93.99) |
| | | | |
| **TOTAL ASSETS EMPLOYED** | **102.75** | **101.85** | **104.17** |
| **Taxpayers Equity** | | | |
| Public Dividend Capital | 291.90 | 289.87 | 312.63 |
| Income & Exp Reserve | (191.88) | (191.78) | (212.23) |
| Revaluation Reserve | 2.72 | 3.76 | 3.76 |
| **TOTAL TAXPAYERS EQUITY** | **102.75** | **101.85** | **104.17** |

1. New accounting standard IFRS 16 relating to leases implemented for 22/23

**Key Assumptions:**

- No asset valuation adjustments are assumed.

**22/23 Plan (CHFT Group): Statement of Cash Flow**

| Statement of Cash Flow | 21/22 Budget £'m | 21/22 Actual £'m | 22/23 Plan £'m |
|---|---|---|---|
| **Surplus/(deficit) from Operations** | **0.46** | **(0.30)** | **(20.44)** |
| **non-cash flows in operating surplus/(deficit)** | | | |
| Non-cash donations/grants credited to income | (0.08) | (0.20) | (0.08) |
| Depreciation and amortisation | 14.33 | 13.49 | 16.75 |
| Other operating non-cash (income)/ expenses | 14.49 | 11.90 | 15.86 |
| Impairments | 0.00 | 0.32 | 0.00 |
| Gain on disposal of assets | 0.00 | | 0.00 |
| | **28.74** | **25.51** | **32.53** |
| **Operating Cash flows before movements in working capital** | **29.20** | **25.21** | **12.08** |
| **Movement in working capital** | **(3.12)** | **9.70** | **(5.98)** |
| **Net cash inflow/(outflow) from operating activities** | 26.08 | 34.91 | 6.11 |
| **Net cash inflow/(outflow() from investing activities** | | | |
| Capital Expenditure | (18.99) | (22.09) | (39.08) |
| Proceeds on disposal of property, plant and equipment | 0.28 | 0.01 | 0.00 |
| Increase/(decrease) in Capital Creditors | (8.00) | 4.04 | (5.98) |
| Other cash flows from investing activities | 0.14 | 0.08 | 0.32 |
| | **(26.58)** | **(17.95)** | **(44.73)** |
| **Net cash inflow/(outflow) before financing** | **(0.49)** | **16.96** | **(38.63)** |
| **Net cash inflow/(outflow) from financing activities** | | | |
| Public Dividend Capital Received | 10.90 | 8.85 | 22.77 |
| Drawdown of Loans | 0.00 | 0.00 | 0.00 |
| PDC Dividends paid | (0.92) | (1.04) | (1.63) |
| Repayment of Loans | (2.21) | (2.21) | (2.21) |
| Financing | (15.95) | (15.99) | (20.52) |
| Non-Current Movements | 0.00 | (0.15) | 0.00 |
| | **(8.18)** | **(10.53)** | **(1.59)** |
| **Net increase/(decrease) in cash** | **(8.67)** | **6.42** | **(40.21)** |
| **Opening cash** | 48.22 | 48.22 | 54.65 |
| **Closing cash** | **39.55** | **54.65** | **14.43** |

**Key Assumptions:**

- Capital Plan totals £39.08m, including £22.77m assumed to be externally funded:
  * 21.840m PDC funding for Reconfiguration
  * £0.866m PDC funding for Scan4Safety
  * £0.063m PDC funding for Critical cybersecurity infrastructure risks

- Cash balances as at 31st March 22 were higher than planned due to high levels of accrued expenditure, both Capital and Revenue - it is assumed that these payments will catch up to some extent during 22/23 reducing the total cash balance.
- Cash balance is also adversely impacted by the £20.1m planned deficit and the scale of Capital commitments.

**22/23 Plan by Division: Income & Expenditure**

| Division | 21/22 Contribution Actual £'m | 22/23 Income Plan £'m | 22/23 Pay Plan £'m | 22/23 Non Pay Plan £'m | 22/23 Contribution Plan £'m |
|---|---|---|---|---|---|
| Medical Division | (119.93) | 7.30 | (94.52) | (35.09) | (122.31) |
| Surgical Division | (94.55) | 2.69 | (72.37) | (26.10) | (95.77) |
| Families & Specialist Services | (86.16) | 8.21 | (68.45) | (26.75) | (86.99) |
| Community Division | (25.50) | 4.24 | (28.93) | (2.62) | (27.30) |
| Corporate Division | (53.17) | (1.20) | (22.50) | (28.34) | (52.03) |
| Estates & Facilities | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| Health Informatics | 1.98 | 19.16 | (10.55) | (7.23) | 1.38 |
| PMU | 2.05 | 11.82 | (2.63) | (6.55) | 2.64 |
| CHS LTD* | 0.41 | 61.00 | (11.06) | (49.40) | 0.54 |
| Central Inc/ Technical Accounts* | 361.09 | 421.45 | (0.63) | (65.41) | 355.40 |
| Trust Reserves | 13.80 | 11.55 | (7.15) | (0.05) | 4.35 |
| **Surplus / (Deficit)*** | **0.04** | **546.23** | **(318.79)** | **(247.54)** | **(20.10)** |
| **LESS Inter-company payments** | **0.00** | **(63.63)** | **0.00** | **63.63** | **0.00** |
| **GROUP Surplus / (Deficit)** | **0.04** | **482.60** | **(318.79)** | **(183.91)** | **(20.10)** |

* Includes inter-company transactions

**Notes:**

• The planned income and expenditure totals shown above include inter-company payments of £63.63m between the Trust and its subsidiary company (CHS Ltd). These payments are excluded when reporting the Income & Expenditure position for the Group (as required by NHS Improvement).

**22/23 Plan: Activity & Income**

| Activity | 20/21 Actual [1] | 21/22 Actual [1] | 22/23 Plan (Excl. CIP) | 22/23 CIP | 22/23 Total Plan |
|---|---|---|---|---|---|
| | Spells | Spells | Spells | Spells | Spells |
| NHS Clinical Income | | | | | |
| Elective | 1,704 | 4,219 | 5,776 | 0 | 5,776 |
| Non Elective | 46,717 | 52,398 | 58,360 | 0 | 58,360 |
| Daycase | 20,401 | 46,870 | 50,173 | 0 | 50,173 |
| Outpatients | 156,157 | 406,236 | 436,084 | 0 | 436,084 |
| A & E | 125,522 | 172,928 | 170,928 | 0 | 170,928 |
| Other-NHS Clinical | 1,450,732 | 1,763,234 | 1,873,315 | 0 | 1,873,315 |
| | | | | | |
| | | | | | |
| | | | | | |
| TOTAL SPELLS | 1,801,233 | 2,445,886 | 2,594,636 | 0 | 2,594,636 |

| Income | 20/21 Actual | 21/22 Actual | 22/23 Plan (Excl. CIP) | 22/23 CIP | 22/23 Total Plan |
|---|---|---|---|---|---|
| | £'m | £'m | £'m | £'m | £'m |
| NHS Clinical Income | | | | | |
| Elective | 18.01 | 11.35 | 22.92 | 0.00 | 22.92 |
| Non Elective | 114.89 | 112.77 | 129.01 | 0.00 | 129.01 |
| Daycase | 30.72 | 25.27 | 34.79 | 0.00 | 34.79 |
| Outpatients | 46.12 | 34.83 | 39.45 | 0.00 | 39.45 |
| A & E | 23.16 | 23.15 | 28.56 | 0.00 | 28.56 |
| Other-NHS Clinical | 185.54 | 242.95 | 177.66 | 0.06 | 177.72 |
| CQUIN | 3.79 | 3.37 | 0.00 | 0.00 | 0.00 |
| Other Income | 57.71 | 54.36 | 49.43 | 0.72 | 50.15 |
| TOTAL INCOME | 479.94 | 508.04 | 481.82 | 0.77 | 482.60 |

**Key Assumptions:**

• Contract Income based on Aligned Payment Incentive (API) approach: fixed element based on agreed level of activity and variable element to support recovery of elective services.

• Overall Income envelope has now been finalised, but contract negotations with CCGs are ongoing regarding the pricing of activity and may result in some minor changes to the income allocation across Points of Delivery (POD).

• CQUIN is operating but is now embedded within POD rather than shown as a seperate income stream.

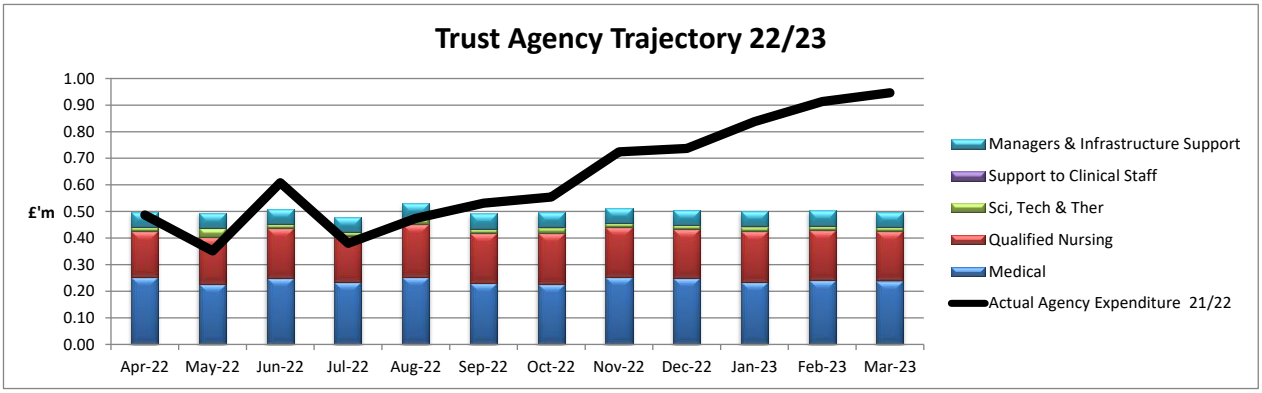
• System block Covid-19 funding significantly reduced compared to last year. Central reimbursement of Testing and Vaccination costs will continue.

• Income plan assumes full achievement of activity plan to deliver 104% of 2019/20 activity in order to secure full allocation of Elective Recovery Funding.

**22/23 Plan: Agency Trajectory**

| Agency Trajectory 22/23 | Apr-22 £'m | May-22 £'m | Jun-22 £'m | Jul-22 £'m | Aug-22 £'m | Sep-22 £'m | Oct-22 £'m | Nov-22 £'m | Dec-22 £'m | Jan-23 £'m | Feb-23 £'m | Mar-23 £'m | Total £'m |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Medical | 0.25 | 0.23 | 0.25 | 0.23 | 0.25 | 0.23 | 0.23 | 0.25 | 0.25 | 0.24 | 0.24 | 0.24 | 2.90 |
| Qualified Nursing | 0.17 | 0.18 | 0.19 | 0.17 | 0.20 | 0.19 | 0.19 | 0.19 | 0.18 | 0.19 | 0.19 | 0.19 | 2.22 |
| Sci, Tech & Ther | 0.02 | 0.04 | 0.02 | 0.02 | 0.02 | 0.02 | 0.02 | 0.02 | 0.02 | 0.02 | 0.02 | 0.02 | 0.22 |
| Support to Clinical Staff | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| Managers & Infrastructure Support | 0.06 | 0.06 | 0.06 | 0.06 | 0.06 | 0.06 | 0.06 | 0.06 | 0.06 | 0.06 | 0.06 | 0.06 | 0.69 |
| **Total** | 0.50 | 0.50 | 0.51 | 0.48 | 0.53 | 0.49 | 0.50 | 0.51 | 0.51 | 0.50 | 0.50 | 0.50 | 6.03 |

| | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Actual Agency Expenditure 21/22** | 0.49 | 0.35 | 0.61 | 0.38 | 0.47 | 0.53 | 0.55 | 0.72 | 0.74 | 0.84 | 0.91 | 0.95 | 7.55 |




**Key Assumptions:**

- NHS Improvement agency ceiling has not yet been set for 22/23.

**22/23 Plan: Reserves**

| Reserves Summary | 22/23 Plan £'m | Notes |
|---|---|---|
| **Uncommitted Reserves** | | |
| Contingency Reserve | 1.00 | Assumed as Pay in Plan |
| Winter Contingency Reserve | 0.00 | No Contingency held - budgets allocated recurrently in 21/22 |
| | 1.00 | |
| **Planning Gap** | | |
| Unidentified CIP - Planning Gap | (0.96) | Savings Gap to £20m requirement |
| Identified CIP not yet allocated | (4.72) | To be allocated once plans are fully developed |
| | (5.68) | |
| **Committed Reserves** | | |
| Covid-19 Reserve | (5.90) | Covid-19 block funding held centrally |
| Income Reserve | (5.05) | Capacity funding and Spec Comm Top Up pending allocation |
| Recovery Reserve | 9.38 | Elective Recovery plans net of CIP pending approval |
| Clinical Excellence Awards | 1.20 | 21/22 awards yet to be paid |
| Approved Business Cases / funding | 0.21 | To be transferred to Divisions once costs are incurred |
| Reconfiguration | 0.26 | To be transferred to Divisions once costs are incurred |
| Pressures / Developments not yet approved | 0.22 | To be transferred to Divisions once approval confirmed |
| | 0.33 | |
| | | |
| **TOTAL RESERVES** | **(4.35)** | |

**Key Assumptions:**

- Covid-19 budgets fully allocated in 22/23.
- Recovery costs to deliver 104% activity have been identified but allocation of budget is subject to final approval of plans.

**22/23 Plan: Capital**

| Scheme Category | Capital Schemes | 22/23 Plan £'m |
|---|---|---|
| **IT** | Digital Strategy | 1.06 |
| | Clinical Systems | 0.20 |
| | Other IT | 1.20 |
| | | 2.46 |
| **Built Environment** | | 2.97 |
| **Equipment** | Non Medical HPS | 1.05 |
| | Surgical | 0.88 |
| | FSS | 1.99 |
| | Community | 0.02 |
| | Medical | 0.97 |
| | Other | 1.75 |
| | | 6.65 |
| **Other** | Car Park | 1.00 |
| | Contingency | 3.14 |
| | | 4.14 |
| **Total Internally Funded** | | **16.22** |
| **Funded by Public Dividend Capital (DHSC)** | Reconfiguration of Services | 21.84 |
| | Scan4Safety | 0.87 |
| | Critical cybersecurity infrastructure risks | 0.06 |
| **Donated Assets** | | 0.09 |
| **TOTAL CAPITAL EXPENDITURE** | | **39.08** |

**Key Assumptions:**

• Internally generated funds from Depreciation (£16.8), are also required to cover the cost of repayments on the PFI (£3.5m) and Capital Loans (£2.2m), leaving £11.1m available for Capital Expenditure. £16.2m has been planned as shown above. Cash Reserves of £5.1m will be required to cover the shortfall.

• Capital plans as reported to NHSI now also includes Right of Use Leases previously expensed as operating expenditure, following changes to accounting standards (IFRS 16).

# 12. Recovery Update

To Note

Presented by Jo Fawcus

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NHS Foundation Trust

# Board of Directors

## 5th May 2022

## Recovery Trajectory

# Inpatients/Day Cases

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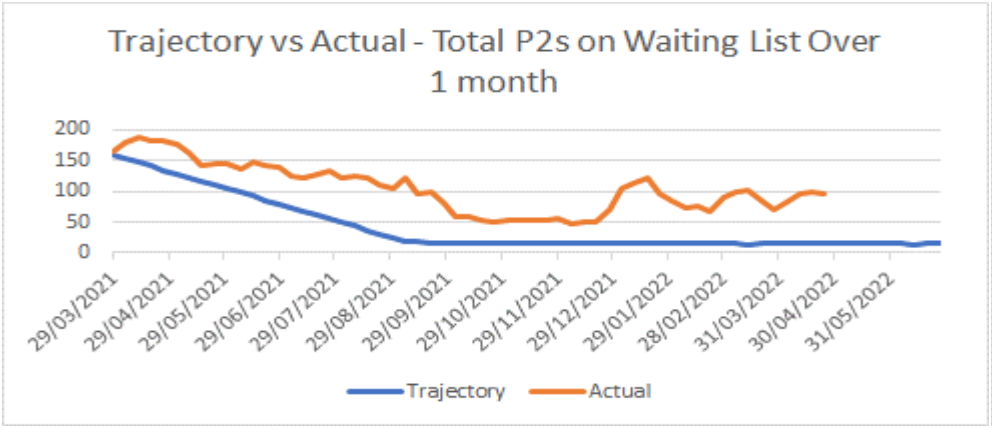
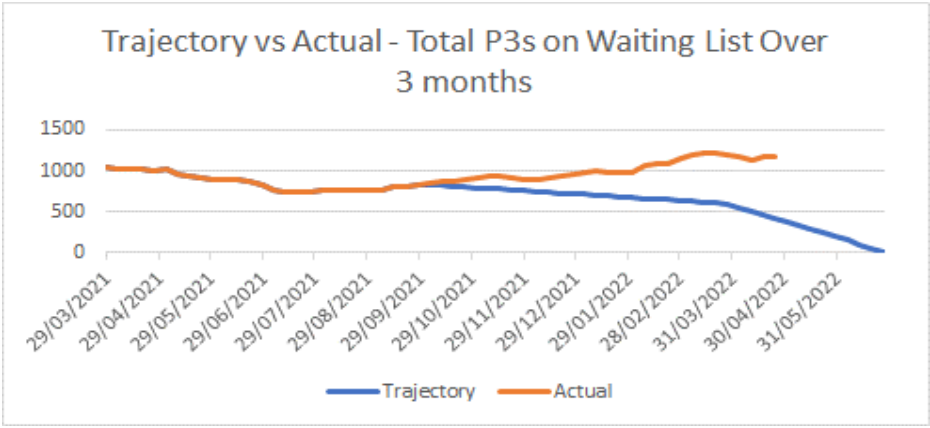
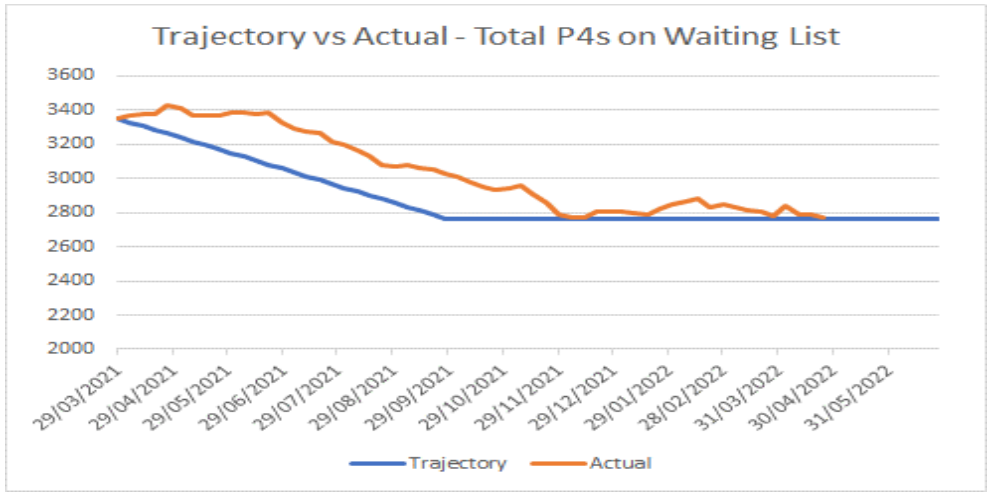
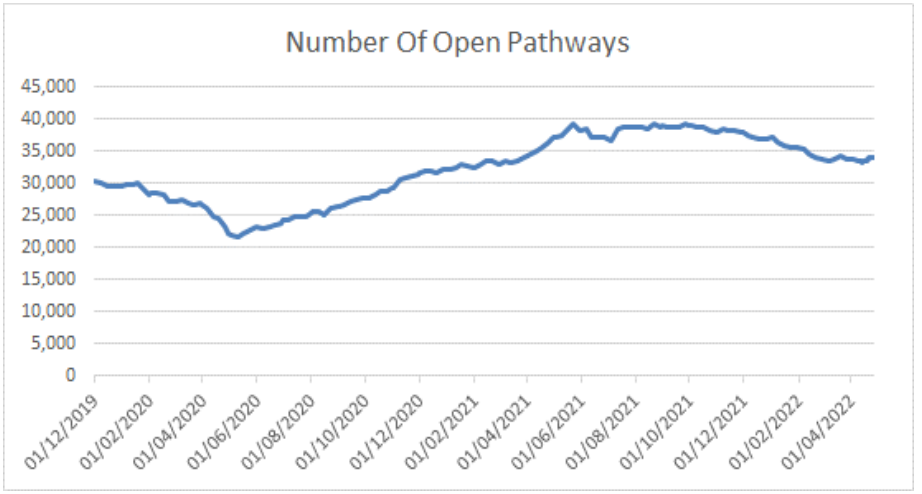
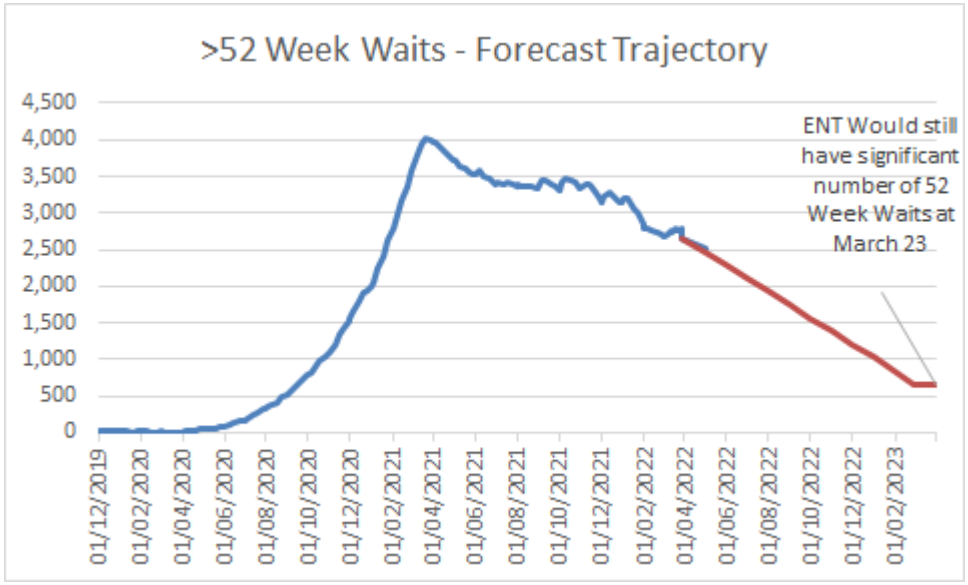


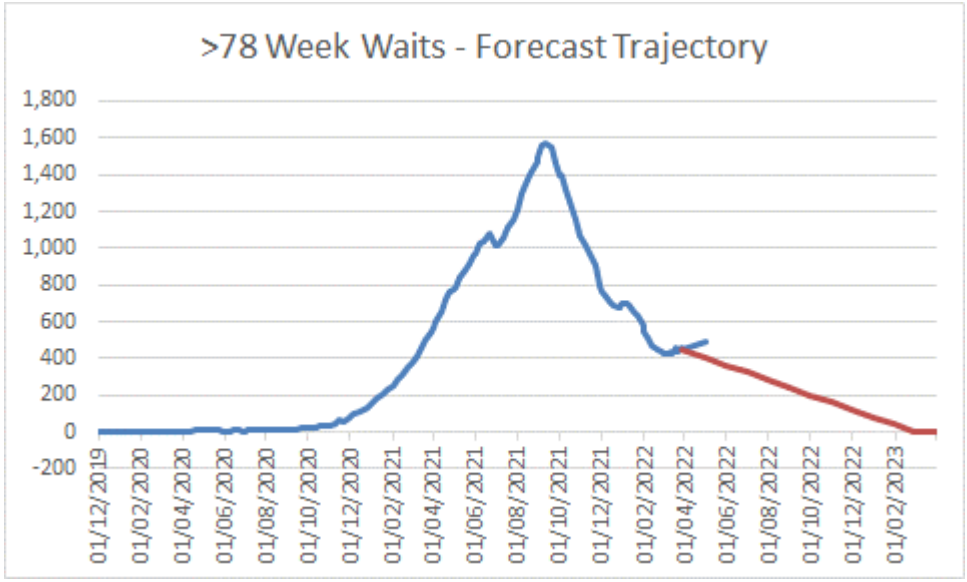



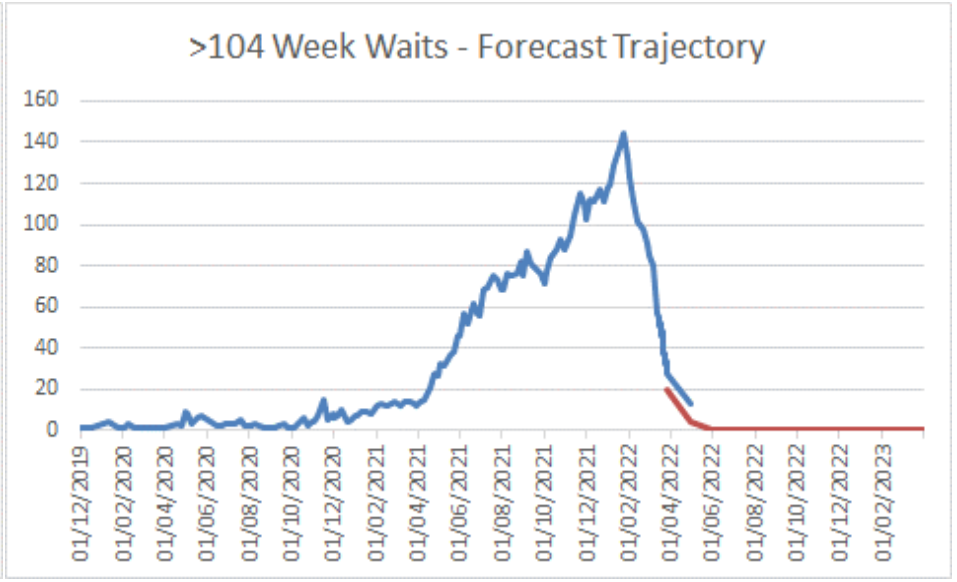



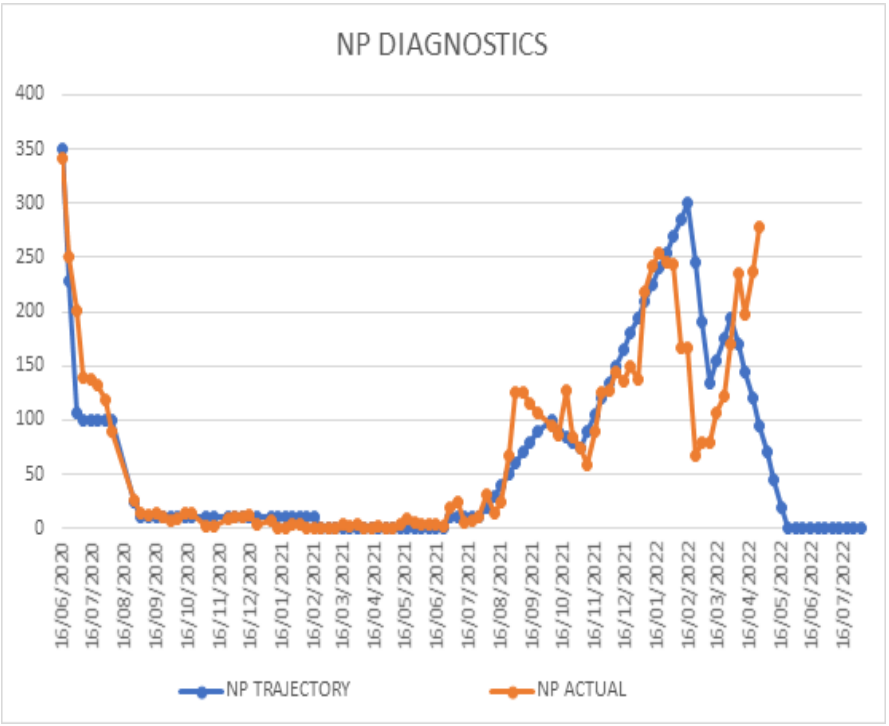
# Inpatients/Day Cases

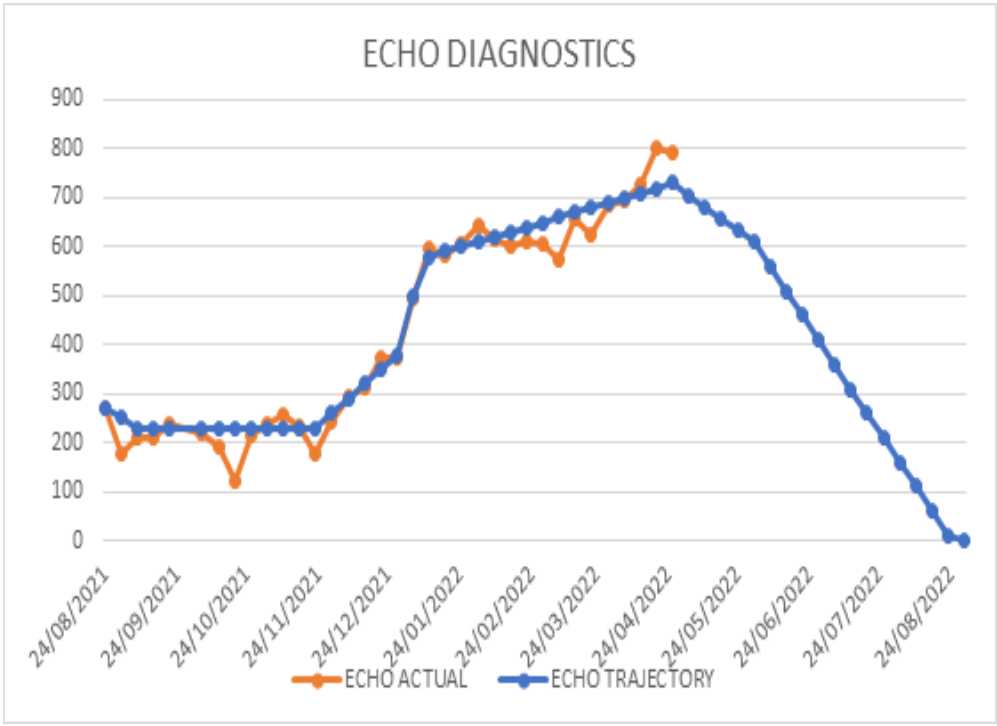


# Diagnostics



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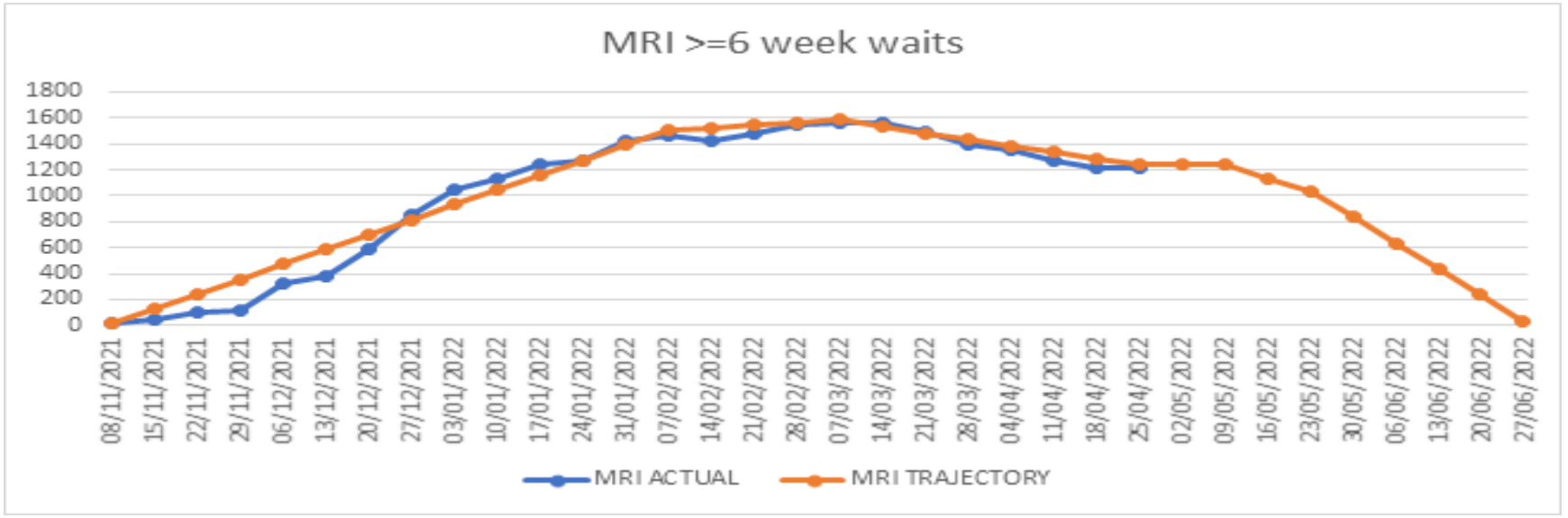
# MRI Backlog Recovery (June 2022, £333k)




**Return to 6WW 99% performance by end June 2022 (£333k)**

- Delay in delivery of new scanners
- Build works at HRI having impact on static scanners (increased downtime)
- Mobile MRI usage until end of May 22 at cost of £333k
- Position may recover sooner if downtime can be reduced

# Outpatients

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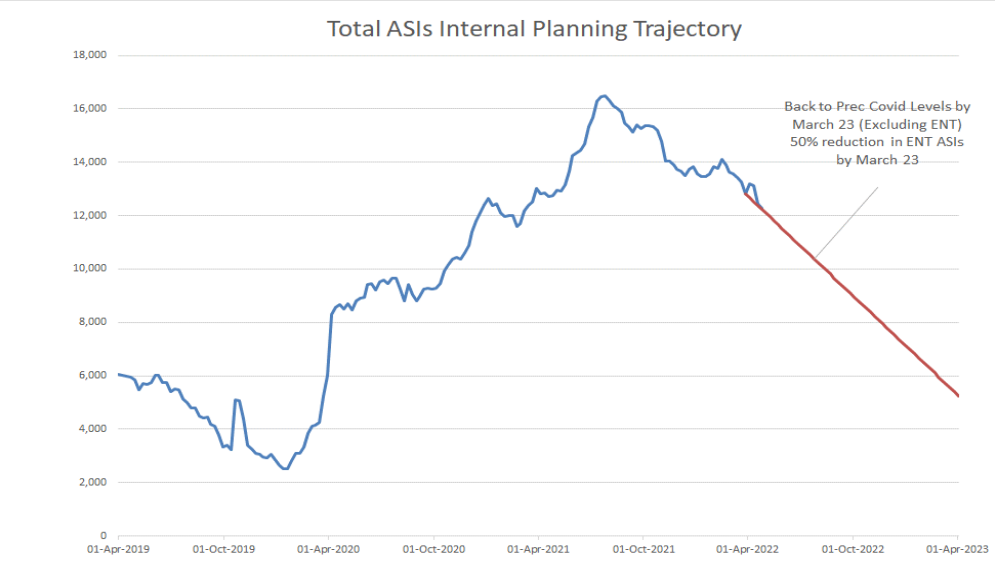
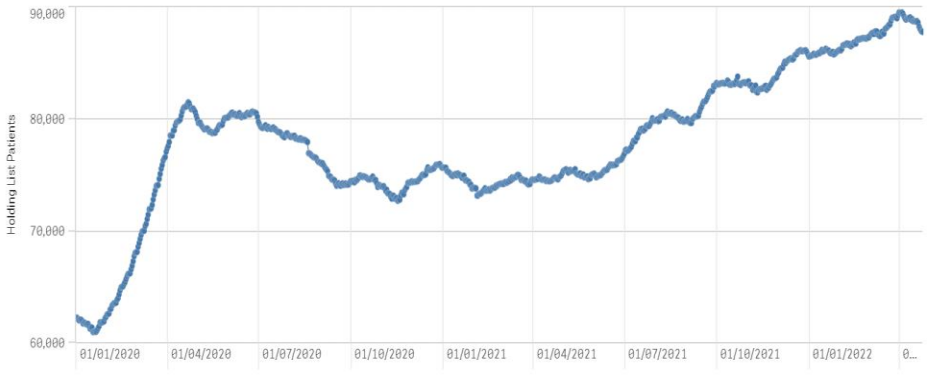



compassionate care

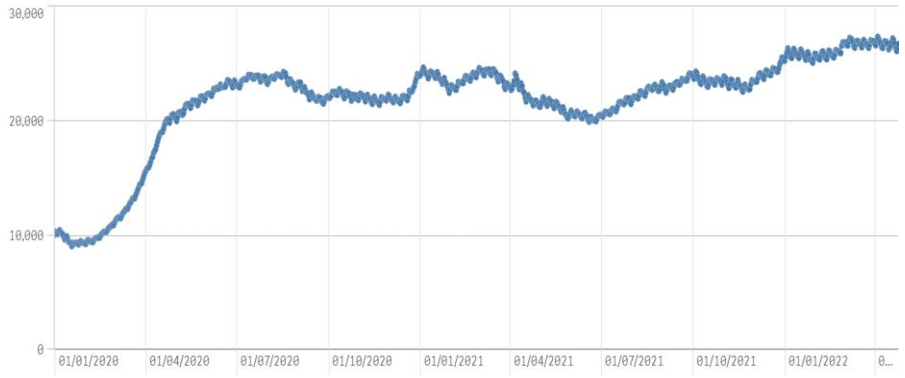
# Follow Up Trends

Calderdale and Huddersfield NHS Foundation Trust

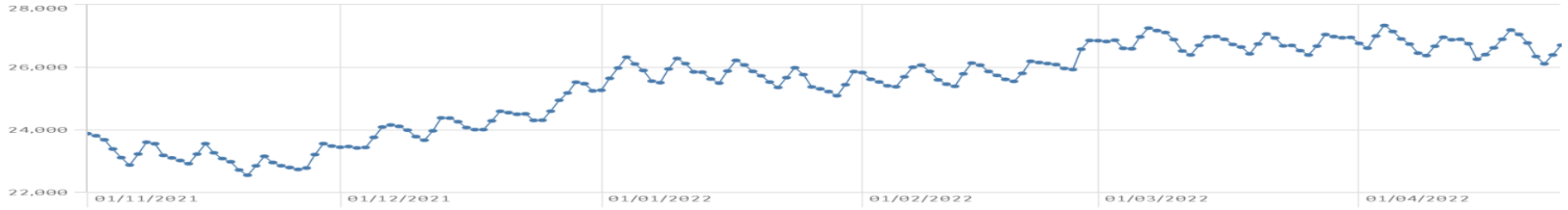
**Total Follow-up Appt Trend**




**Follow-Up Appt Past Due Date Trend**




**Follow-Up Appt Past Due Date Trend – Last 6 Months**




There are 79,400 patients on the follow-up waiting list and 24,981 have exceeded their appointment due date.
The trend analysis shows that the overall volume on the waiting list rose sharply January – April 2020 then started to reduce as phone appointments and some F2F activity recommenced. The volume of f/up appts on the holding list then started to rise again from July 2021 however we are now seeing this reduce again and this is reflected in the trend.

# 13. Month 12 Financial Summary

To Note

Presented by Gary Boothby

| | |
|---|---|
| **Date of Meeting:** | Thursday 5 May 2022 |
| **Meeting:** | Public Board of Directors |
| **Title:** | Month 12 Finance Report |
| **Author:** | Philippa Russell – Assistant Director of Finance |
| **Sponsoring Director:** | Gary Boothby - Director of Finance |
| **Previous Forums:** | Finance and Performance Committee |

**Purpose of the Report**

To provide a summary of the financial position as reported at the end of Month 12 (March 2022).

**Key Points to Note**

**2021/22 Year End Summary**

The Trust is reporting a £0.04m surplus, in line with the planned position. The financial position has been adjusted for elements excluded for the purposes of assessing System financial performance: Donated Asset Income, Donated Asset Depreciation, donated equipment and consumables (PPE), Impairments and Gains on Disposal. Achieving this break-even position has been challenging with the Trust experiencing a number of significant financial pressures, in particular the growing cost of temporary staffing (enhanced bank rates and high cost agency), the ongoing pressure on capacity due to Covid-19 and the cost of Recovery. H2 also included a significant efficiency requirement of £6.7m, of which only £3.54m has been delivered. However, the Trust successfully bid for additional Elective Recovery Funding in support of schemes to increase capacity, and also secured some additional non-recurrent funding allocations from both local Commissioners and the Integrated Care System (ICS), which between them have mitigated these additional cost pressures.

- The Trust continues has continued to have access to funding for Covid-19 costs that are considered to be outside of the System Envelope and has accounted for £7.02m of additional funding to cover costs incurred for Vaccinations, Covid-19 Testing, 3rd Year Student Nurse contracts and Isolation Hotels for overseas recruits. Income up to the end of M9 has now been approved and received, Q4 funding remains subject to final approval but has been provisionally confirmed.
- In total the Trust has incurred costs relating to Covid-19 of £23.00m. Costs were driven by: Covid-19 virus testing, vaccinations (on hospital site and for local vaccination centre), the segregation of patient pathways (particularly within the Emergency Department), ICU staffing models and remote management of patients.
- The Trust has delivered efficiency savings of £6.54m, but largely on a non-recurrent basis.
- Agency expenditure year to date is £7.64m, £1.19m lower than the NHS Improvement Agency expenditure ceiling. However, agency costs have increased significantly in the last few months and there has also been a large increase in Bank costs over the last 9 months due to the enhanced pay agreement.
- Total planned inpatient activity was 115.9% of the month 12 2019/20 baseline, within this total Elective inpatient activity was 90.1%. For H2 £0.98m of Elective Recovery Funding (ERF) has been allocated by the ICS to the Trust.

**Key Variances**

- Income is £39.82m higher than planned. This includes £12.14m to support pensions contributions paid in year by NHS England, £3.57m income to support the unplanned and backdated 21/22 pay awards. Additional income to offset outside of system envelope Covid-19 costs is £4.54m higher than planned. ERF is above the planned level at £4.65m, a favourable variance of £0.34m year to date. The Trust has also received £4.52m additional Elective Recovery+ funding, £6.00m of reallocated System funding and a further £3.40m of additional CCG / Trust income to support capacity.
- Pay costs are £25.48m above the planned level. This includes the requirement to account for additional employer pension contributions of £12.14m in Month 12 and £3.57m of H1 backdated pay awards which are funded, leaving an underlying variance of £9.77m adverse. Includes £1.06m of Covid-19 costs that are outside of envelope and therefore offset by additional income and an accrual of £1.45m for Consultant Study leave not taken as planned this year and carried forward due to the operational situation. The remaining overspend is linked to pressures as a result of the unavailability of staff, including the impact of enhanced pay rates for bank staff (50%) of £6.31m, an adverse variance to plan of £3.04m and a significant increase in both the volume and cost of Agency staffing.
- Non-pay operating expenditure is higher than planned by £15.70m. This variance includes Covid-19 related expenditure of £3.26m for H1 vaccination costs and Covid-19 testing that were not budgeted and are offset by income. The remaining overspend is driven by unidentified efficiencies, High Cost Drugs growth, an increase in provisions, as opposed to the planned decrease, and a pressure on the Clinical Negligence Scheme for Trusts (CNST).

**EQIA – Equality Impact Assessment**

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

**Recommendation**

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

# EXECUTIVE SUMMARY: Total Group Financial Overview as at 31st Mar 2022 - Month 12

## KEY METRICS

| | M12 | | | | YTD (MAR 2022) | | | | Forecast 21/22 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Plan | Actual | Var | | Plan | Actual | Var | | Plan | Forecast | Var | |
| | £m | £m | £m | | £m | £m | £m | | £m | £m | £m | |
| **I&E: Surplus / (Deficit)** | £2.67 | £2.56 | (£0.11) | | £0.00 | £0.04 | £0.04 | | £0.00 | £0.04 | £0.04 | |
| **Agency Expenditure (vs Ceiling)** | (£0.74) | (£0.95) | (£0.22) | | (£8.82) | (£7.64) | £1.19 | | (£8.82) | (£7.64) | £1.19 | |
| **Capital** | £3.07 | £12.60 | (£9.53) | | £18.99 | £24.37 | (£5.37) | | £18.99 | £24.37 | (£5.37) | |
| **Cash** | £38.75 | £54.65 | £15.90 | | £38.75 | £54.65 | £15.90 | | £38.75 | £54.65 | £15.90 | |
| **Invoices paid within 30 days (%)** (Better Payment Practice Code) | 95.0% | 90.2% | -5% | | 95.0% | 94.0% | -1% | | | | | |
| **CIP** | £1.31 | £0.80 | (£0.51) | | £9.70 | £6.54 | (£3.16) | | £9.70 | £6.54 | (£3.16) | |
| **Use of Resource Metric** | 1 | 2 | | | 2 | 2 | | | 2 | 2 | | |

**2021/22 Year End Summary**

The Trust is reporting a £0.04m surplus, in line with the planned position. The financial position has been adjusted for elements excluded for the purposes of assessing System financial performance: Donated Asset Income, Donated Asset Depreciation, Donated equipment and consumables (PPE), Impairments and Gains on Disposal. Achieving this break-even position has been challenging with the Trust experiencing a number of significant financial pressures, in particular the growing cost of temporary staffing (enhanced bank rates and high cost agency), the ongoing pressure on capacity due to Covid-19 and the cost of Recovery. H2 also included a significant efficiency requirement of £6.7m, of which only £3.54m has been delivered. However, the Trust successfully bid for additional Elective Recovery Funding in support of schemes to increase capacity, and also secured some additional non-recurrent funding allocations from both local Commissioners and the Integrated Care System (ICS), which between them have mitigated these additional cost pressures.

• The Trust continues has continued to have access to funding for Covid-19 costs that are considered to be outside of the System Envelope and has accounted for £7.02m of additional funding to cover costs incurred for Vaccinations, Covid-19 Testing, 3rd Year Student Nurse contracts and Isolation Hotels for overseas recruits. Income up to the end of M9 has now been approved and received, Q4 funding remains subject to final approval but has been provisionally confirmed.
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• Agency expenditure year to date is £7.64m, £1.19m lower than the NHS Improvement Agency expenditure ceiling. However agency costs have increased significantly in the last few months and there has also been a large increase in Bank costs over the last 9 months due to the enhanced pay agreement.
• Total planned inpatient activity was 115.9% of the month 12 2019/20 baseline, within this total Elective inpatient activity was 90.1%. For H2 £0.98m of Elective Recovery Funding (ERF) has been allocated by the ICS to the Trust.

**Key Variances**

• Income is £39.82m higher than planned. This includes £12.14m to support pensions contributions paid in year by NHS England, £3.57m income to support the unplanned and backdated 21/22 pay awards. Additional income to offset outside of system envelope Covid-19 costs is £4.54m higher than planned. ERF is above the planned level at £4.65m, a favourable variance of £0.34m year to date. The Trust has also received £4.52m additional Elective Recovery+ funding, £6.00m of reallocated System funding and a further £3.40m of additional CCG / Trust income to support capacity.
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• Non-pay operating expenditure is higher than planned by £15.70m. This variance includes Covid-19 related expenditure of £3.26m for H1 vaccination costs and Covid-19 testing that were not budgeted and are offset by income. The remaining overspend is driven by unidentified efficiencies, High Cost Drugs growth, an increase in provisions, as opposed to the planned decrease, and a pressure on the Clinical Negligence Scheme for Trusts (CNST).

# Total Group Financial Overview as at 31st Mar 2022 - Month 12

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

### YEAR TO DATE POSITION: M12

#### CLINICAL ACTIVITY

| | M12 Plan | M12 Actual | Var |
|---|---|---|---|
| Elective | 3,958 | 4,219 | 261 |
| Non-Elective | 58,213 | 52,398 | (5,815) |
| Daycase | 47,497 | 46,870 | (627) |
| Outpatient | 409,301 | 406,236 | (3,065) |
| A&E | 164,537 | 172,928 | 8,391 |
| Other NHS Non-Tariff | 1,650,603 | 1,675,187 | 24,584 |
| Other NHS Tariff | 92,256 | 88,028 | (4,228) |
| **Total** | **2,426,366** | **2,445,866** | **19,500** |

#### TOTAL GROUP: INCOME AND EXPENDITURE

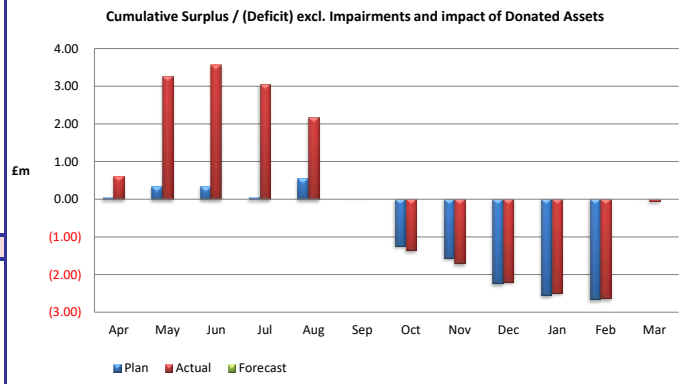
| | M12 Plan | M12 Actual | Var |
|---|---|---|---|
| | £m | £m | £m |
| Elective | £11.39 | £11.35 | (£0.04) |
| Non Elective | £112.76 | £112.77 | £0.01 |
| Daycase | £25.29 | £25.27 | (£0.02) |
| Outpatients | £34.85 | £34.83 | (£0.02) |
| A & E | £23.16 | £23.15 | (£0.02) |
| Other-NHS Clinical | £171.08 | £211.75 | £40.66 |
| CQUIN | £3.37 | £3.37 | (£0.00) |
| Other Income | £52.88 | £52.12 | (£0.76) |
| **Total Income** | **£434.78** | **£474.60** | **£39.82** |
| Pay | (£300.23) | (£325.71) | (£25.48) |
| Drug Costs | (£42.56) | (£43.09) | (£0.53) |
| Clinical Support | (£39.79) | (£39.34) | £0.45 |
| Other Costs | (£54.13) | (£69.75) | (£15.62) |
| PFI Costs | (£13.03) | (£13.03) | £0.00 |
| **Total Expenditure** | **(£449.74)** | **(£490.92)** | **(£41.18)** |
| **EBITDA** | **(£14.96)** | **(£16.32)** | **(£1.36)** |
| Non Operating Expenditure | (£28.38) | (£26.98) | £1.40 |
| **Surplus / (Deficit) Adjusted*** | **(£43.34)** | **(£43.30)** | **£0.04** |
| System Top Up Funding | £43.34 | £43.34 | £0.00 |
| **Surplus / Deficit*** | **£0.00** | **£0.04** | **£0.04** |

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

#### DIVISIONS: INCOME AND EXPENDITURE

| | M12 Plan | M12 Actual | Var |
|---|---|---|---|
| | £m | £m | £m |
| Surgery & Anaesthetics | (£91.55) | (£94.55) | (£3.00) |
| Medical | (£109.88) | (£119.93) | (£10.04) |
| Families & Specialist Services | (£86.35) | (£86.16) | £0.19 |
| Community | (£26.56) | (£25.50) | £1.06 |
| Estates & Facilities | £0.00 | £0.22 | £0.22 |
| Corporate | (£53.13) | (£53.39) | (£0.26) |
| THIS | £1.61 | £1.98 | £0.37 |
| PMU | £2.60 | £2.05 | (£0.55) |
| CHS LTD | £0.81 | £0.41 | (£0.39) |
| Central Inc/Technical Accounts | £359.25 | £365.06 | £5.81 |
| Reserves | £3.20 | £9.82 | £6.62 |
| **Surplus / (Deficit)** | **£0.00** | **£0.04** | **£0.04** |

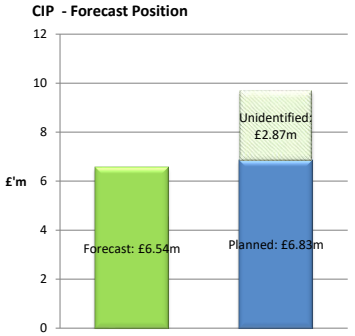
### TOTAL GROUP SURPLUS / (DEFICIT)

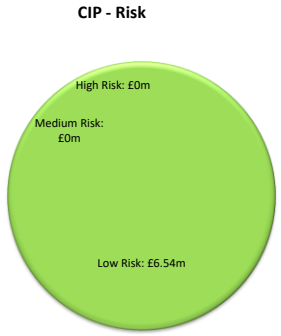



### KEY METRICS

| | Year To Date | | | Year End: Forecast | | |
|---|---|---|---|---|---|---|
| | M12 Plan | M12 Actual | Var | Plan | Forecast | Var |
| | £m | £m | £m | £m | £m | £m |
| I&E: Surplus / (Deficit) | £0.00 | £0.04 | £0.04 | £0.00 | £0.04 | £0.04 |
| Capital | £18.99 | £24.37 | (£5.37) | £18.99 | £24.37 | (£5.37) |
| Cash | £38.75 | £54.65 | £15.90 | £38.75 | £54.65 | £15.90 |
| Invoices Paid within 30 days (BPPC) | 95% | 94% | -1% | | | |
| CIP | £9.70 | £6.54 | (£3.16) | £9.70 | £6.54 | (£3.16) |
| | Plan | Actual | | Plan | Forecast | |
| Use of Resource Metric | 2 | 2 | | 2 | 2 | |

### COST IMPROVEMENT PROGRAMME (CIP)




**Total Planned: £9.7m[1]**

**Total Forecast £6.54m**

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

### YEAR END 21/22

#### CLINICAL ACTIVITY

| | Plan | Actual | Var |
|---|---|---|---|
| Elective | 3,958 | 4,219 | 261 |
| Non-Elective | 58,213 | 52,398 | (5,815) |
| Daycase | 47,497 | 46,870 | (627) |
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| Other NHS Tariff | 92,256 | 88,028 | (4,228) |
| **Total** | **2,426,366** | **2,445,866** | **19,500** |

#### TOTAL GROUP: INCOME AND EXPENDITURE

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| Other Costs | (£54.13) | (£69.31) | (£15.18) |
| PFI Costs | (£13.03) | (£13.46) | (£0.44) |
| **Total Expenditure** | **(£449.74)** | **(£490.92)** | **(£41.18)** |
| **EBITDA** | **(£14.96)** | **(£16.32)** | **(£1.36)** |
| Non Operating Expenditure | (£28.38) | (£26.98) | £1.40 |
| **Surplus / (Deficit) Adjusted*** | **(£43.34)** | **(£43.30)** | **£0.04** |
| System Top Up Funding | £43.34 | £43.34 | £0.00 |
| **Surplus / Deficit*** | **£0.00** | **£0.04** | **£0.04** |

* Adjusted to exclude forecast £5m non-recurrent accounting adjustment and all items excluded for assessment of System financial performance: Donated Asset Income, Donated Asset Depreciation, Donated equipment and consumables (PPE), Impairments and Gains on Disposal

#### DIVISIONS: INCOME AND EXPENDITURE

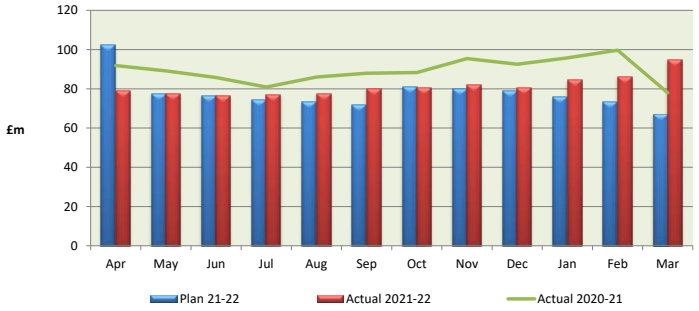
| | Plan | Forecast | Var |
|---|---|---|---|
| | £m | £m | £m |
| Surgery & Anaesthetics | (£91.55) | (£94.55) | (£3.00) |
| Medical | (£109.88) | (£119.93) | (£10.04) |
| Families & Specialist Services | (£86.35) | (£86.16) | £0.19 |
| Community | (£26.56) | (£25.50) | £1.06 |
| Estates & Facilities | £0.00 | £0.22 | £0.22 |
| Corporate | (£53.13) | (£53.39) | (£0.26) |
| THIS | £1.61 | £1.98 | £0.37 |
| PMU | £2.60 | £2.05 | (£0.55) |
| CHS LTD | £0.81 | £0.41 | (£0.39) |
| Central Inc/Technical Accounts | £359.25 | £365.06 | £5.81 |
| Reserves | £3.20 | £9.82 | £6.62 |
| **Surplus / (Deficit)** | **£0.00** | **£0.04** | **£0.04** |

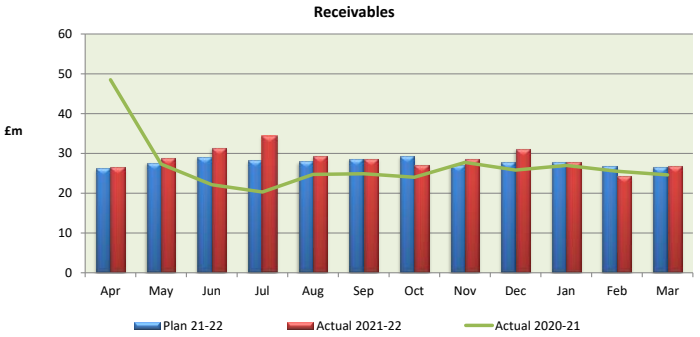
# Total Group Financial Overview as at 31st Mar 2022 - Month 12

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

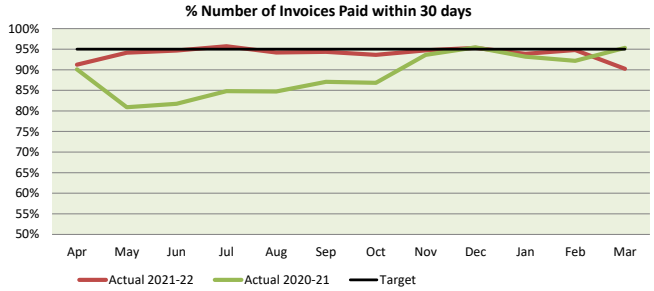
### WORKING CAPITAL

| | M12 Plan £m | M12 Actual £m | Var £m | M12 |
|---|---|---|---|---|
| Payables (excl. Current Loans) | (£67.42) | (£94.71) | £27.29 | |
| Receivables | £26.73 | £26.83 | (£0.10) | |



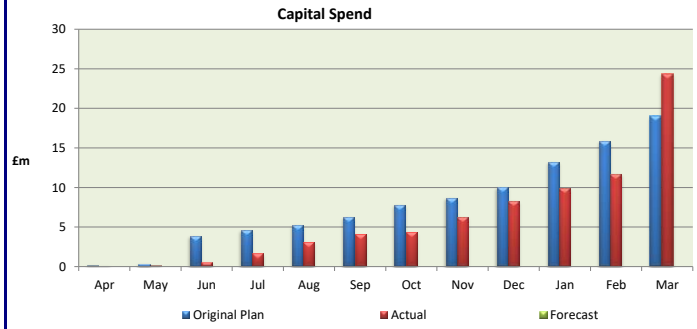




### BETTER PAYMENT PRACTICE CODE



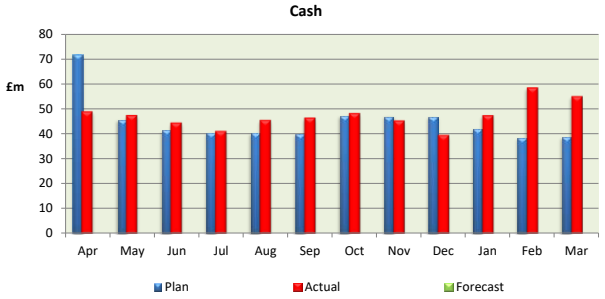

### CAPITAL

| | M12 Plan £m | M12 Actual £m | Var £m | M12 |
|---|---|---|---|---|
| Capital | £18.99 | £24.37 | (£5.37) | |

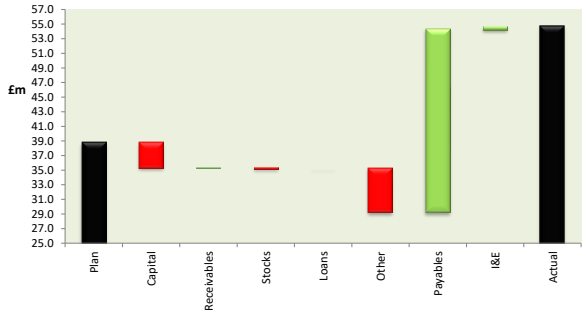



### CASH

| | M12 Plan £m | M12 Actual £m | Var £m | M12 |
|---|---|---|---|---|
| Cash | £38.75 | £54.65 | £15.90 | |
| Loans (Cumulative) | £17.67 | £17.67 | £0.00 | |




### CASH FLOW VARIANCE




### SUMMARY YEAR TO DATE

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- Total planned inpatient activity was 115.9% of the month 12 2019/20 baseline, within this total Elective inpatient activity was 90.1%. For H2 £0.98m of Elective Recovery Funding (ERF) has been allocated by the ICS to the Trust.
- The Trust has incurred costs relating to Covid-19 of £23.00m, of which £7.02m are considered as 'outside of system envelope' and for which additional funding is available.
- Capital expenditure is higher than planned at £24.37m against a planned £18.99m.
- The Trust has delivered efficiency savings of £6.54m, but largely on a non-recurrent basis.
- NHS Improvement performance metric Use of Resources (UOR) stands at 2 as planned.

### NOTES

- The planned financial position shown here excludes a one off financial accounting adjustment of £5m that has been delayed to the new financial year
- The total loan balance is £17.67m as planned.
- The Trust has a cash balance of £54.65m, £15.90m 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 |

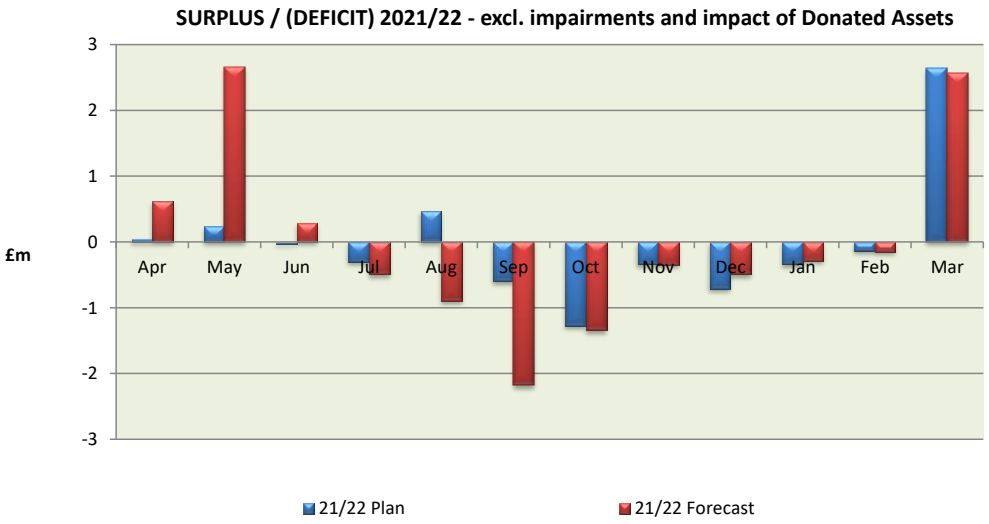
# YEAR END POSITION 21/22

## H2 Position (31 Mar 22)

| Statement of Comprehensive Income | Plan[2] £m | Actual £m | Var £m | |
|---|---|---|---|---|
| Income | £478.21 | £520.18 | £41.97 | |
| Pay expenditure | (£300.23) | (£325.71) | (£25.48) | |
| Non Pay Expenditure | (£149.51) | (£166.93) | (£17.42) | |
| Non Operating Costs | (£28.81) | (£27.84) | £0.97 | |
| **Total Trust Surplus / (Deficit)** | **(£0.34)** | **(£0.30)** | **£0.04** | |
| Deduct impact of: | | | | |
| Impairments (AME)[1] | £0.00 | £0.32 | £0.32 | |
| Donated Asset depreciation | £0.43 | £0.43 | £0.00 | |
| Donated Asset income (including Covid equipment) | (£0.08) | (£2.24) | (£2.15) | |
| Net impact of donated consumables (PPE etc) | £0.00 | £1.83 | £1.83 | |
| Gain on Disposal | £0.00 | (£0.01) | (£0.01) | |
| **Adjusted Financial Performance** | **£0.00** | **£0.04** | **£0.04** | |

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

## MONTHLY SURPLUS / (DEFICIT)




**NHSI reported position:**

Total reported Trust year end position is a £0.30m deficit. This includes a number of items that are excluded for the purposes of monitoring financial performance. These adjustments are shown in the table to the left. Excluding these items, the Trust delivered a £0.04m surplus and favourable variance and therefore achieved the financial plan for both H2 and the full year ending 31 March 2022.

# COVID-19 & Recovery

| Covid-19 Expenditure YTD MAR 2022 | Pay £'000 | Non-Pay £'000 | Total £'000 |
|---|---|---|---|
| Expand NHS Workforce - Medical / Nursing / AHPs / Healthcare Scientists / Other | 1,256 | 0 | 1,256 |
| Remote management of patients | 529 | 871 | 1,400 |
| Support for stay at home models | 57 | 0 | 57 |
| Increase ITU capacity (incl Increase hospital assisted respiratory support capacity, particularly mechanical ventilation) | 998 | 190 | 1,188 |
| Segregation of patient pathways | 9,248 | 215 | 9,463 |
| Existing workforce additional shifts | 999 | 67 | 1,066 |
| Decontamination | 0 | 281 | 281 |
| Backfill for higher sickness absence | 305 | 2 | 307 |
| Remote working for non patient activities | 0 | 0 | 0 |
| PPE - other associated costs | 0 | 1 | 1 |
| Sick pay at full pay (all staff types) | 2 | 0 | 2 |
| Other COVID-19 virus / antibody (serology) testing (not included elsewhere) | 855 | 5 | 860 |
| Enhanced PTS | 0 | 415 | 415 |
| COVID-19 virus testing - rt-PCR virus testing | 243 | 3,847 | 4,090 |
| COVID-19 - Vaccination Programme - Provider/ Hospital hubs | 623 | 3 | 626 |
| COVID-19 - Vaccination Programme - Vaccine centres | 0 | 1,653 | 1,653 |
| COVID-19 - Vaccination Programme - Vaccination of Healthy 12-15s (via SAIS) | 11 | 88 | 99 |
| NIHR SIREN testing - antibody testing only | 25 | 4 | 29 |
| COVID-19 - International quarantine costs | 0 | 23 | 23 |
| COVID-19 - Deployment of final year student nurses | 182 | 0 | 182 |
| **Total Reported to NHSI** | **15,332** | **7,666** | **22,998** |
| PPE - locally procured | 0 | -22 | -22 |
| Internal and external communication costs | 0 | 1 | 1 |
| **Grand Total** | **15,332** | **7,645** | **22,976** |

| Recovery Costs YTD MAR 2022 | Pay £'000 | Non-Pay £'000 | Total £'000 |
|---|---|---|---|
| Independent Sector | 0 | 6,023 | 6,023 |
| Additional Staffing - Medical | 1,243 | 0 | 1,243 |
| Additional Staffing - Nursing | 447 | 0 | 447 |
| Additional Staffing - Other | 587 | 0 | 587 |
| Non Pay | 0 | 1,291 | 1,291 |
| Enhanced Payment Model - Medical | 1,374 | 124 | 1,499 |
| Enhanced Payment Model - Nursing | 1,640 | 0 | 1,640 |
| **Total** | **5,291** | **7,438** | **12,729** |

**Covid-19 Costs**

The Trust has incurred £22.98m 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 cost is £16.27m versus a plan of £13.27m. The overspend on Covid-19 is therefore £3.04m, driven by the continuation of some enhanced workforce models on wards and in ICU, a continuation of Emergency Department segregation and enhanced Bank pay rates. Outside of envelope costs are highlighted in the table to the left and total £7.02m.

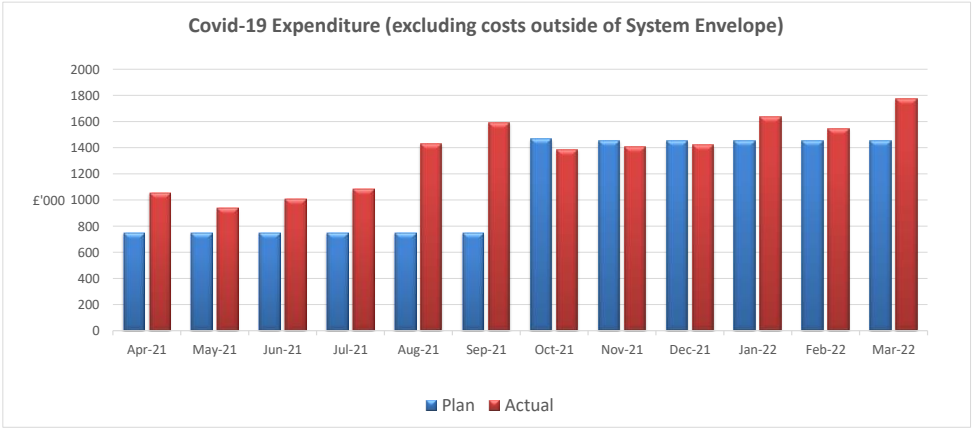
**Covid-19 Funding**

The Trust has been allocated block funding by the ICS to cover any ongoing Covid-19 costs and associated impacts totalling £30.02m year to date, (including £6m of additional allocations agreed in Q4 to support Covid and Recovery pressures). In addition the Trust has requested retrospective Covid-19 funding of £7.02m to cover outside of envelope costs: Vaccinations, Covid-19 Testing, 3rd year student nurses and Isolation Hotels for overseas recruits.

**Recovery**

Recovery costs totalling £7.01m for H2 were approved in conjunction with the Trust's activity plan.

- Actual Recovery costs were £12.73m.
- A significant proportion of the costs incurred related to use of the Independent Sector for outsourcing and insourcing. The Trust agreed outsourcing contracts with Optegra, BMI, Spire and 'This Is My', as well as insourcing arrangements with Remedy, Ormis and Pioneer.
- The Trust has also been allocated Elective Recovery Fund (ERF) Funding of £0.96m for H2.
- The Trust did also receive additional funding via the Elective Recovery Fund for Quarter 1 as the thresholds agreed for April, May and June activity were exceeded and £3.69m of income has been received.
- The Trust was also successful in two separate bids for Elective Recovery+ funding to support schemes in the Trust aimed at increasing capacity, additional income has been received totalling £4.42m.



# 14. CHFT Green Plan (Climate Change)

To Note

Calderdale and Huddersfield NHS Foundation Trust

| | |
|---|---|
| **Date of Meeting:** | Thursday 5 May 2022 |
| **Meeting:** | Public Board of Directors |
| **Title:** | CHFT Green Plan Update |
| **Author:** | Grace Barrett |
| **Sponsoring Director:** | Stuart Sugarman, Managing Director, CHS |

**Purpose of the Report**

This report provides an update regarding progress in relation to the CHFT Green Plan.

**Key Points to Note**

The CHFT Green Plan outlines the Trust's ambition for sustainability across the next five years. The Green Plan was developed alongside a corresponding Sustainability Action Plan (SAP), which spans ten key themes to address the Trust's carbon reduction commitments while ensuring integration with corporate objectives. The Green Plan was first approved by Transformation Programme Board (TPB) in March 2021, and delivery has since been managed by CHS. Progress against the SAP is monitored through the Green Planning sub-group.

This update report describes each SAP theme and outlines the key progress and next steps subsequently.

**What is a Green Plan?**

A Green Plan is a Board approved, current live strategy document outlining the organisation's aims, objectives, and delivery plans for sustainable development. This includes implementation of the NHS Long Term plan deliverables.

Delivering and monitoring the Green Plan will help the CHFT to:

1. Deliver on its Long-Term plan
2. Improve the health of the local community
3. Achieve its financial goals
4. Meet its legislative requirements.

A Green Plan may be valid for 3 to 5 years and should be reviewed at least once in the interim period. To ensure a Green Plan has impact and progress against the commitments set out, plans are expected to be reported to the Board or Governing Body on an annual basis. Progress against this plan is reviewed on a regular basis at TPB. The Green Plan has been submitted to relevant partners and communicated to staff and the public via intranet, newsletters and the organisation's website. It's important to note that the SAP is a live document and will continue to be developed as the strategy is delivered.

| EQIA – Equality Impact Assessment |
| --- |
| The Green Plan proposes a range of key aspirations to address socio-economic issues in and around our local areas. It identifies several targets which include a focus on sustainable procurement. Through this objective the Trust will promote local sourcing and ethical purchases, ensuring that future Capital projects invest funds within our surrounding community. More broadly speaking targets for ethical procurement also reduce the risk of Modern Slavery / child labour and enforce fair employment standards within construction.<br><br>The key themes behind the Green Plan are also aligned with the Trust's Care Models and our plans for Governance and adaptation. The SAP allows the Trust to assess risks associated with climate change and identify ways to mitigate these risks. The SAP encourages the development of adaptation and resilience strategies and a review of our Heatwave Plans, Cold weather Plans and Flood Management Plans.<br><br>The Green Plan is also aligned with the Trusts aspirations for Corporate Social Responsibility and promotes further engagement with voluntary organisations. This ensures that the Trust is acting as a responsible corporate citizen and helps to increase the social value that we provide as an organisation. |
| **Recommendation** |
| The Board are asked to **NOTE** the Green Plan progress in relation to the accompanying Sustainability Action Plan. |

Integrated Facilities Management

# Green Plan Progress Update

**Author: Grace Barrett**

**Sponsor: Andy Nelson & Stuart Sugarman**

**April 2022**

Calderdale and Huddersfield Solutions Ltd
Huddersfield Royal Infirmary · CHS Headquarters ·
Acre Street · Huddersfield · HD3 3EA
Web: www.chs-limited.co.uk
Company registration number 11258001 · VAT number 293 0609 00

Working in partnership with

NHS
Calderdale and Huddersfield
NHS Foundation Trust

**Executive summary**

This paper provides a progress update relating to the Calderdale and Huddersfield Foundation Trust (CHFT) Green Plan and Sustainability Action Plan (SAP). The SAP outlines individual actions across 10 key themes. In total there are 191 interventions proposed, of which 110 are designated as complete. Figure 1 (page 3) provides a summary of progress across each of the core SAP themes.

**Key progress to April 2022**

- Audit Yorkshire feedback confirms that CHFT is demonstrating a commitment to minimising its adverse impacts on the environment.
- Following engineering visits by Inenco, Calderdale & Huddersfield Solutions (CHS) have received heat decarbonisation reports for both hospital sites which will inform long term decarbonisation plans.
- An application for Salix funding has been made which if successful would finance air source heat pumps, Solar PV and Low Loss Transformers across Huddersfield Royal Infirmary (HRI), Huddersfield Pharmacy Specials (HPS) and Calderdale Royal Hospital (CRH).
- Biodiversity Action Plan approved by Transformation Programme Board (TPB).
- LED lighting scheme due to commence at CRH in May 2022.
- CHS Managing Director designated as Net Zero Lead.

**Key Next Steps**

- Funding priorities for the Biodiversity Action Plan (BAP) to be determined.
- Stericycle contract due for renewal in June 2022. Offers to be considered for procurement through other providers for instance SharpSmart.
- Second Green Champions group meeting due to take place in April 2022.
- Further work around site capacity for additional Electric Vehicle Charging Points (EVCPs) at HRI needed.
- Consistent Trust wide Switch off campaign to reduce energy wastage and address rising costs and carbon emissions.

**Key issues**

- Ongoing cost pressures for financial year 2022/23 as a result of rising unit prices for gas and energy.
- Further support needed from Trust communications to ensure effective Green Plan communication and engagement across workforce.

*Figure 1 - Sustainability Action Plan – Summary Table*

| Calderdale & Huddersfield Green Plan Sustainable Action Plan | | | | |
|---|---|---|---|---|
| **Module** | **Reference** | **Nominated Lead** | **Number of Actions** | **Completed Actions** |
| Corporate Approach | CA | Stuart Sugarman/ Kelly Sanders | 18 | 12 |
| Asset Management & Utilities | AM | Tom Donaghey/ Grace Barrett | 11 | 7 |
| Travel & Logisitics | TL | Andy Mould/ Stuart Sugarman | 21 | 15 |
| Adaptation | AD | Ian Kilroy/ Gemma Berrimen | 19 | 14 |
| Capital Projects | CP | Tom Donaghey | 14 | 13 |
| Greenspace & Biodviersity | GS | Jammal Mohammed/ Dan Smith/ Grace Barrett | 24 | 14 |
| Sustainable Care Models | SC | Sarah Rothery/ Ian Kilroy/ Nicola Bailey/ Anna Basford | 10 | 7 |
| Our People | OP | Sarah Rothery/ Ian Kilroy/ Nicola Bailey/ Anna Basford | 15 | 7 |
| Sustainable Use of Resources | SU | Nigel Murphy/ Cheryl Gibbons | 31 | 11 |
| Carbon & GHGs | CG | Tom Donaghey/ Grace Barrett | 28 | 10 |

## 1. Introduction and Background

The purpose of this report is to update the Public Board of Directors on progress in relation to the Trust's Green Plan and the delivery of the accompanying SAP.

The Green Plan was first approved by TPB in March 2021. Delivery has since been managed by the CHS and progress against the SAP is monitored through the Green Planning sub-group.

The Green Plan is a Board approved document which is submitted at ICS level. There are ten themes in the SAP which have been described in subsequent paragraphs. A progress update is provided for each.

## 2. Updates on Sustainable Action Plan

### 2.1. Corporate Approach

**Overview**

Focuses on governance and Board level support within the Trust. There are 18 actions within this section. These actions aim to embed sustainability throughout the Trust's policies and services.

**Key progress**

- Environment and sustainability reporting is included in the Trust's Annual Report, as required by NHS standard contract.
- Workforce engagement campaign- 'Green Hero's'- established with Public Relations company Prime Creative. Consistent promotion across the Trust via posters & banners, website banners, email footers and Teams backgrounds.
- First Green Newsletter Published by CHS in January 2022.
- Green plan included on CHFT and CHS Intranet. CHS Intranet also includes an additional dedicated Green Plan and Sustainability page.
- Procurement Policy Note (PPN) 06/20 adopted by the Trust in April 2022. This encourages 10% weightings for net zero and social value.
- The Board nominated sustainability lead, Stuart Sugarman, named as Kirklees Climate Commissioner.

**Key next steps**

- Further support from internal Trust communications needed to increase engagement with green agenda. Workforce Engagement Calendar to be approved.
- Identification of volunteer opportunities for staff and any further opportunities to collaborate with CHFT Charity.

### 2.2. Asset Management & Utilities

**Overview**

We recognise that energy consumption is the greatest contributor to carbon emissions within the Trust. There are 11 actions within this section many of which are linked to the Trusts ambition for carbon net-zero targets.

**Key progress**

- Electricity supplied to the Trust is 100% certified renewable energy
- Inenco contract extended to 2027 to protect the Trust from future cost increases.
- Water bills are currently contracted through Business Stream however the Trust is due to join Inenco's water procurement framework.
- 'Switch -off' messages have been included in information packs for THIS new starters and staff returning to site at Elland and communicated to staff at Broad Street Plaza, in response to an observed rise in electricity consumption at both sites.
- Heat decarbonisation planning with Inenco (*see section 2.10 Carbon and Greenhouse Gasses*).

**Key next steps**

- The Triad Building Management System (BMS) contract is currently up for renewal and there are plans to change the specification of the contract to include more regular reviews of system performance and optimisation to improve energy efficiency.

- Proposal received from Triad to install sensors to switch off air handling units when not in use. Further assessment and consultation with clinicians needed to assess clinical risk and determine feasibility.
- In light of rising fuel costs, a significant Trust-wide switch off campaign may be needed to reduce energy wastage, especially at the main hospital sites. This will need substantial backing and support from the Trust and internal communications.

### 2.3. Travel and Logistics

**Overview**

As staff, patient, visitor and supplier travel at the Trust contributes to carbon emissions, the 21 actions within this section aim to reduce the impacts of travel and transport, thereby reducing the Trust's contribution to air pollution.

**Key progress**

- Improvement to cycle storage made at HRI. 10 new secure, covered cycle lockers have been installed in the main car park and outside the Spring Cottage Nursery, and 2 (short stay) Sheffield stands installed outside the hospital main entrance and CHS Estates.
- EVCPs in the Acre Mill Car Park have been replaced. There are now 4 working EVCPs for use by staff and visitors.
- External banners in key locations further promote active travel in the spring.
- An Active Travel notice board has been installed outside the Ingleton Falls restaurant at CRH and HRI General Office. Free walking maps continue to be provided at both hospital sites.
- Active travel and public transport information is included in new starter information packs.
- The CHFT shuttle is now back to running at full capacity due to the removal of some Infection Prevention and Control (IPC) measures.
- 94% of the CHS fleet are now ultra-low emissions vehicles. This exceeds our target of 90% by 2028.

**Key next steps**

- Park and Ride initiative delayed due to funding pressures. Commencement rescheduled for early 2023. Staff have been informed of delay via Trust communications.
- Development and promotion of a Liftshare Platform delayed due to conflicting messages regarding social distancing. Further investigation into feasibility and costs is needed.
- Decisions regarding supplier and location of additional EVCPs for staff and visitors at HRI to be made before installation can take place. Additional work around site capacity needed.

### 2.4. Adaptation

**Overview**

The Trust recognises that it is well placed as a health and care organisation to address

the health-related impacts relating to climate change – the greatest threat to public health. There are 19 actions within this section.

**Key progress**

- Development of an Environmental Aspects and Impacts (A&I) Register following external audit by Adler and Allan which outlines the main environmental risks for the CHS and sites under our operations.
- Flood, heat and winter plans are incorporated into Trust emergency and business continuity strategy.
- Bi-monthly meetings attended by the Trust to local authority emergency planning and resilience governance groups. Trust also linked to local Clinical Commissioning Group meetings.

**Key Next Steps**

- Ensure mitigation measures outlined on the A&I Register are implemented and maintained through regular audits.
- Adaptation plans to be reviewed to ensure alignment with Dec-21 NHS health and adaptation report.

### 2.5. Capital Projects

**Overview**

Identifying the Trust ambition to achieve estate-wide efficiency through reconfiguration. There are 14 actions within this section. Actions include ensuring that all new builds achieve a minimum Building Research Establishment Environmental Assessment Method (BREEAM) rating of "Excellent".

**Key Progress**

- Reconfiguration projects presently prioritise Brownfield sites for new builds.
- Modular design for CRH learning centre promoted to ensure sustainability and waste minimisation.
- Embodied carbon addressed in reconfiguration through BREEAM aspiration- all new builds above a value of £2.5 million are aiming for BREEAM excellent.

**Key Next Steps**

- Site of recently demolished Nurse's Residence at HRI will be used as Green Space. Plans to be confirmed.
- Spend to save projects to be prioritised through critical works register.

### 2.6. Greenspace & Biodiversity

**Overview**

Protecting and enhancing greenspace and biodiversity is hugely beneficial for the environment and can positively impact wellbeing. Planted trees will likely play a crucial role in offsetting future carbon emissions. There are 24 actions within this section.

**Key Progress**

- Biodiversity Action Plan (BAP) approved by the TPB.
- Tree survey carried out by Nurture Landscapes at HRI.
- Tree works including crown lifting have been carried out along the HRI south boundary wall at Saville Road in March 2022. The chippings will be used by the groundskeeper as mulch and there is an opportunity to use larger branches to create habitat piles. This supports biodiversity and reduces wastage.
- Tree works have taken place during the spring to keep disruption to bird populations on site at a minimum.
- CHFT Charity has submitted a successful bid to fund a wellbeing garden in the newly demolished Nurses Residence green space at HRI.
- Engie/Equans are working with The Dales at CRH to create a wellbeing garden.
- New catering specification at HRI successfully promotes sustainability. CHS coffee shops and restaurants actively promote sustainably procured products and endeavor to minimise reliance on single use items.
- Woodland Trust 'Trees for communities' application successful. Tree packs will be delivered around November 2022 and planted/ maintained by CHS Groundskeepers.

**Key Next Steps**

- Meadow management and mowing regimes to promote and enhance biodiversity to be implemented by the Groundskeeper in the spring/ summer.
- Following successful charity bid for funding to create a wellbeing green space on the site of the demolished Nurse's Residence at HRI, planning may commence.
- Funding priorities for the Biodiversity Action Plan to be determined.
- Equans to adopt recommendations from the BAP Management Plan.
- Emerging recommendations from NHS food review to be adopted.

### 2.7. Sustainable Care Models

Ingraining sustainability into our clinical care models is a vital consideration if the Trust is to become carbon net-zero. There are 10 actions within this section.

**Key progress**

- Target of 25% virtual outpatient appointments for 2022/23 is expected to be met.
- Anaesthetic Gases Task and Finish group report that average CO2 emissions as a result of Desflurane, Sevoflurane and Isoflurane combined have decreased by 45.5%.
- Between the previous and current financial year, average monthly Desflurane use has dropped by 67%.
- Pharmacy and Theatres are actively engaged in agenda to continue to promote use of low carbon medical gases.
- Pharmacy department engaged with intervention to replaced metered dose inhalers across the Trust.

**Key next steps**

- Continued engagement with clinicians to further promote sustainable procurement and limit the use of single use materials where possible and appropriate.
- Nitrous Oxide consumption still to be addressed. An investigation into the feasibility of gas capture technology is needed.
- Greater clinical representation needed at Green Planning Committee meetings.

### 2.8. Our People

**Overview**

This section includes 15 actions which recognise that as people are at the heart of our organisation, it is crucial for the Trust to maintain a positive and inclusive work environment, protect staff wellbeing and provide the best care for our patients.

**Key progress to date**

- The Trust is now smoke free as of 1st April, 2022.
- Promotion of Cycle to Work salary sacrifice scheme in Trust News/ comms as an alternative mode of travel in light of rising fuel costs.
- Audit Yorkshire feedback concluded that the Green Plan aligns with the Trust's aspiration to be a responsible 'green corporate citizen'.
- Environment Coordinator has received Carbon Literacy training.

**Key next steps**

- The second quarterly Green Champions meeting is due to take place in April 2022.
- Audit Yorkshire feedback recommends the Trust seek to include a greater range of staff disciplines, including increased clinical representation, at Green Planning Committee meetings.
- Review waste and sustainability training to identify areas for improvement. Carbon literacy training to be delivered to initial pilot group.

### 2.9. Sustainable use of Resources

**Overview**

A significant amount of waste is produced by the Trust to deliver our services. Through improving waste management, the Trust can reduce the amount of waste produced, reduce carbon emissions, and save money. There are 31 actions in this section.

**Key Progress**

- As of January 2022, recycling rates in community settings are upwards of our 40% target.
- 'Dump the Junk' campaign has seen requests for 534 items to be removed from 61 locations across the Trust. These items are to be triaged for storage or skipping and stock is to be catalogued and managed accordingly. Stock that is catalogued for storage may be used elsewhere across the Trust when needed- this promotes recycling and reuse where appropriate and reduces waste.
- The Waste Management Officer is working with supply chain to provide boxes to be used as receptacles for glass recycling. This will take heavy glass out of the general waste stream and increase our recycling tonnage.

- The Waste Management Officer has held Toolbox talks with Domestic Supervisors at HRI about the importance of correct waste segregation and ensuring this is cascaded to all Domestic Staff.
- At CRH, the Waste Management Officer will have monthly meetings ISS supervisors to walk round waste yard and ensure that ISS domestic staff are adhering to correct waste segregation and housekeeping of the yard is up to standard.

**Key next steps**

- Ward bins are to be replaced with soft closing bins. This will free up existing bins to be repurposed as recycling bins, creating an opportunity to increase recycling efforts across non-clinical departments.
- Depending on quantity available, boxes to be used as glass recycling receptacles will be labelled and distributed across ward and department kitchens throughout the Trust. If Supply Chain is unable to provide the quantity of boxes required for glass recycling, then options to obtain from an alternative source or purchase may need to be explored.
- Further support from Trust Communications is required to promote correct waste segregation and ensure that messages are communicated effectively.
- Stericycle contract due for renewal in June 2022. Offers to be considered for procurement through other providers for instance SharpSmart.

### 2.10. Carbon & Greenhouse Gases (GHGs)

**Overview**

Reducing our emissions to carbon net-zero requires effort from all departments at the Trust. There are 28 actions within this section.

**Key Progress**

- LED lighting scheme due to commence at CRH in May 2022.
- Carbon calculations are conducted for properties managed by CHS through annual Streamlined Energy and Carport Reports (SECR).
- Carbon impacts are measured annually and reported through Estates Return Information Collection (ERIC) returns.
- Following Salix payment received in January 2022, engineering visits by Inenco have taken place in March 2022 at CRH and HRI as part of heat decarbonisation planning.
- CHS have received 2 heat decarbonisation reports for CRH and HRI from Inenco. The reports set out a plan as to how both sites can be decarbonised by 2040, and the findings can be used to develop a long-term decarbonisation strategy which supports our emissions reduction targets.
- An application for further Salix funding has been made which if successful would finance air source heat pumps, Solar PV and Low Loss Transformers across HRI, HPS and CRH.
- The Trust contributes to Greener NHS quarterly reporting which feeds into the Greener NHS dashboard.

**Key Next Steps**

- Further work to be carried out to develop a consistent Trust-Wide 'Switch off' Campaign.

- Embodied carbon to be addressed via reconfiguration through BREEAM aspiration and local sourcing policy.

# A Workforce for the Future

# 15. Workforce and Organisational Development Strategy including Staff Survey Results and Action Plan

To Note

Presented by Suzanne Dunkley

NHS
Calderdale and Huddersfield
NHS Foundation Trust

| | |
|---|---|
| **Date of Meeting:** | Thursday 5 May 2022 |
| **Meeting:** | Public Board of Directors |
| **Title:** | 2021 Staff Survey Results |
| **Authors:** | Nikki Hosty, Assistant Director of Human Resources<br>Jason Eddleston, Deputy Director of Workforce and Organisational Development |
| **Sponsoring Director:** | Suzanne Dunkley, Executive Director of Workforce and Organisational Development |
| **Previous Forums:** | Workforce Committee March 2022<br>Executive Board March 2022 |

**Purpose of the Report**

The report (via a slide deck presentation) provides the Board of Directors with feedback from the 2021 national staff survey and the Trust's survey response.

**Key Points to Note**

- The 2021 survey is now aligned with the NHS People Promise, comparisons against 2020 survey data is limited
- Nationally, staff survey scores have deteriorated, they indicate colleague 'burn out'
- One Culture of Care is our guiding principle and drives our response
- Board and senior leader responsibilities in effecting positive cultural change consistent with our values and behaviours are identified
- Staff survey actions are principally leader and manager owned within our organisational structures
- Primary Board oversight for our response is through the Workforce Committee.

**EQIA – Equality Impact Assessment**

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

**Recommendation**

The Board is asked to **NOTE** the contents of the report.

NHS
Calderdale and Huddersfield
NHS Foundation Trust

# Staff Survey Results 2021
# Board of Directors

5 May 2022

One Culture of care

compassionate care

# National Overview

Calderdale and Huddersfield NHS Foundation Trust

- Over 1.3 million NHS employees in England were invited to participate in the survey, 280 NHS organisations took part, including all 217 trusts in England
- Where questions can be compared between 2020 and 2021 they generally worsened, and there were notable increases in work pressure, negative staff experiences, and a decline in health and wellbeing measures.
- The 2021 survey is now aligned with the NHS People Promise and therefore comparisons against 2020 data is limited
- Staff engagement and morale have worsened between 2020 and 2021.
  Morale fell from 6.1 to 5.8 and staff engagement fell from 7.0 to 6.8 (scored out of a possible 10)
- CHFT is benchmarked against 128 Acute and Acute Community Trusts, the median response rate was 46% and the average engagement score was 6.8%

**People Promise Scores**

| | |
|---|---|
| We are compassionate and inclusive | 7.2 |
| We are recognised and rewarded | 5.9 |
| We each have a voice that counts | 6.7 |
| We are safe and healthy | 6.0 |
| We are always learning | 5.3 |
| We work flexibly | 6.0 |
| We are a team | 6.6 |

**Participation**

**648,594**
staff responded
(up from 595,270 in 2020)

**594,974**
online responses
(up from 543,105 in 2020)

**53,620**
paper responses
(up from 52,165 in 2020)

**48%**
response rate
(up from 47% in 2020)

**Note:** These are overall figures which include trusts and non-trust organisations.

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# CHFT Overview

Calderdale and Huddersfield NHS Foundation Trust

**48%** response rate

*-2% from 2020*

**2,802** responses

*+3 from 2020*

**6.7** engagement score

*-0.2 from 2020*

## Common Themes for Improvement

- ***Pharmacy Manufacturing Unit scored below the organisation average on 8 questions***
- ***Medical Division scored below the organisation average on 5 question.***

- Effectiveness of appraisals
- scores
- Burn Out/Stress/Frustration
- **PMU and Medical Division**

## Lowest Scores Breakdown (Engagement)

| Staff Group | | Movement from 2020 |
|---|---|---|
| Nursing & Midwifery Registered | 6.6 | -0.3 |
| Additional Clinical Services | 6.5 | -0.2 |
| Add Prof Scientific & Technical | 6.4 | -0.2 |
| Healthcare Scientists | 6.1 | -0.4 |

| Division | | Movement from 2020 |
|---|---|---|
| Families & Specialist Services | 6.5 | -0.2 |
| Medical | 6.4 | -0.4 |
| Pharmacy Manufacturing Unit | 6.1 | -0.1 |

| Directorate | | Movement from 2020 |
|---|---|---|
| Emergency Care | 6.5 | -0.3 |
| Medical Specialties | 6.4 | -0.3 |
| Radiology | 6.1 | -0.3 |
| Womens | 6.3 | -0.5 |
| Operating Services | 6.2 | -0.4 |
| Orthopaedics | 6.0 | -0.7 |

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# People Promise Themes

Calderdale and Huddersfield NHS Foundation Trust

| | CHFT | National |
|---|---|---|
| We are compassionate and inclusive | 7.2 | 7.2 |
| We are recognised and rewarded | 5.7 | 5.9 |
| We each have a voice that counts | 6.7 | 6.7 |
| We are safe and healthy | 5.8 | 6.0 |
| We are always learning | 5.1 | 5.3 |
| We work flexibly | 5.8 | 6.0 |
| We are a team | 6.5 | 6.6 |

| | Engagement | | National | |
|---|---|---|---|---|
| | 2020 | 2021 | 2020 | 2021 |
| Staff engagement | 6.9 | 6.7 | 7.0 | 6.8 |
| Morale | 5.9 | 5.6 | 6.1 | 5.8 |

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# Equality, Diversity and Inclusion

Calderdale and Huddersfield NHS Foundation Trust

## Age

Most engaged

**66+** and **16-20** with 7.5 and 7.2 respectively.

Least engaged

**21-30** with 6.5

## Disability

Overall engagement score 0.6 points lower than colleagues that do no consider themselves to have a disability.

## Ethnicity

The engagement score for BAME colleagues is 0.3 higher than for White colleagues.

## Gender

The engagement score dropped by 0.2 points for both men and women. Engagement for colleagues that stated they 'prefer not to say' dropped 0.6 points to 5.7.

## Sexuality

LGBTQ+ colleagues score for a negative experience is 0.7 lower than the organisation overall.

## Religion

Colleagues that have stated they 'prefer not to say' what their religion is, are the least engaged group at 6.1. Buddhist colleagues also had a low engagement score at 6.2

# CHFT Positives

Calderdale and Huddersfield NHS Foundation Trust

Organisation definitely takes positive action on health and wellbeing – increase of 28.1% from 32% to 60.1% (national score – 57%)

Opportunities to show initiative frequently in my role – increase of 2.8% from 70.7% to 73.5% (national score – 72.3%)

Immediate managers asks for my opinions before making decisions that affect my work – increase from 51% to 53.5% (national score – 57%)

Would feel secure raising concerns about unsafe clinical practice – increase from 73.9% to 76.1% (national score 74.9%)

Always know what work responsibilities are – increase from  85.1% to 87% (national score – 85.7%)

Community scored better than average against 8 of the questions

BAME overall engagement score 7.0, which is 0.3 higher than white colleagues who scored 6.7, BAME colleagues score higher for motivation 7.3 and are more likely to recommend the organisation as a place to work, scoring 6.7, BAME involvement score has improved from 6.6 in 2020 to 6.8 in 2021

| Top 5 scores vs Benchmark Average | Trust | Bench Avg |
|---|---|---|
| q11a. Organisation takes positive action on health and well-being | 60% | 57% |
| q15. Organisation acts fairly: career progression | 59% | 56% |
| q17a. Would feel secure raising concerns about unsafe clinical practice | 76% | 74% |
| q14b. Not experienced harassment, bullying or abuse from managers | 91% | 88% |
| q16b. Not experienced discrimination from manager/team leader or other colleagues | 93% | 91% |

| Bottom 5 scores vs Benchmark Average | Trust | Bench Avg |
|---|---|---|
| q2a. Often/always look forward to going to work | 45% | 52% |
| q10c. Don't work any additional unpaid hours per week for this organisation, over and above contracted hours | 39% | 43% |
| q13d. Last experience of physical violence reported | 62% | 67% |
| q7b. Team members often meet to discuss the team's effectiveness | 51% | 56% |
| q11c. In last 12 months, have not felt unwell due to work related stress | 49% | 53% |

| Most improved scores | Trust 2021 | Trust 2020 |
|---|---|---|
| q14d. Last experience of harassment/bullying/abuse reported | 48% | 44% |
| q3c. Opportunities to show initiative frequently in my role | 73% | 71% |
| q9c. Immediate manager asks for my opinion before making decisions that affect my work | 53% | 51% |
| q17a. Would feel secure raising concerns about unsafe clinical practice | 76% | 74% |
| q3a. Always know what work responsibilities are | 87% | 85% |

| Most declined scores | Trust 2021 | Trust 2020 |
|---|---|---|
| q3i. Enough staff at organisation to do my job properly | 23% | 33% |
| q21c. Would recommend organisation as place to work | 55% | 64% |
| q2a. Often/always look forward to going to work | 45% | 53% |
| q21d. If friend/relative needed treatment would be happy with standard of care provided by organisation | 64% | 72% |
| q11d. In last 3 months, have not come to work when not feeling well enough to perform duties | 45% | 53% |

**Areas where our scores reduced by 6% or more were:**

Q2a. Often/always look forward to going to work – decreased by 8.2% from 53.4% to 45.2%

Q2b. always/often enthusiastic about my job – decreased by 6.2% from 70.7% to 64.5%

Q3i. Enough staff at organisation to do my job properly – decreased by 10.2% from 33.3% to 23.1%

Q11d. In last 3 months, have not come to work when not feeling well enough to perform duties – decreased by 7.6% from 52.8% to 45.2%

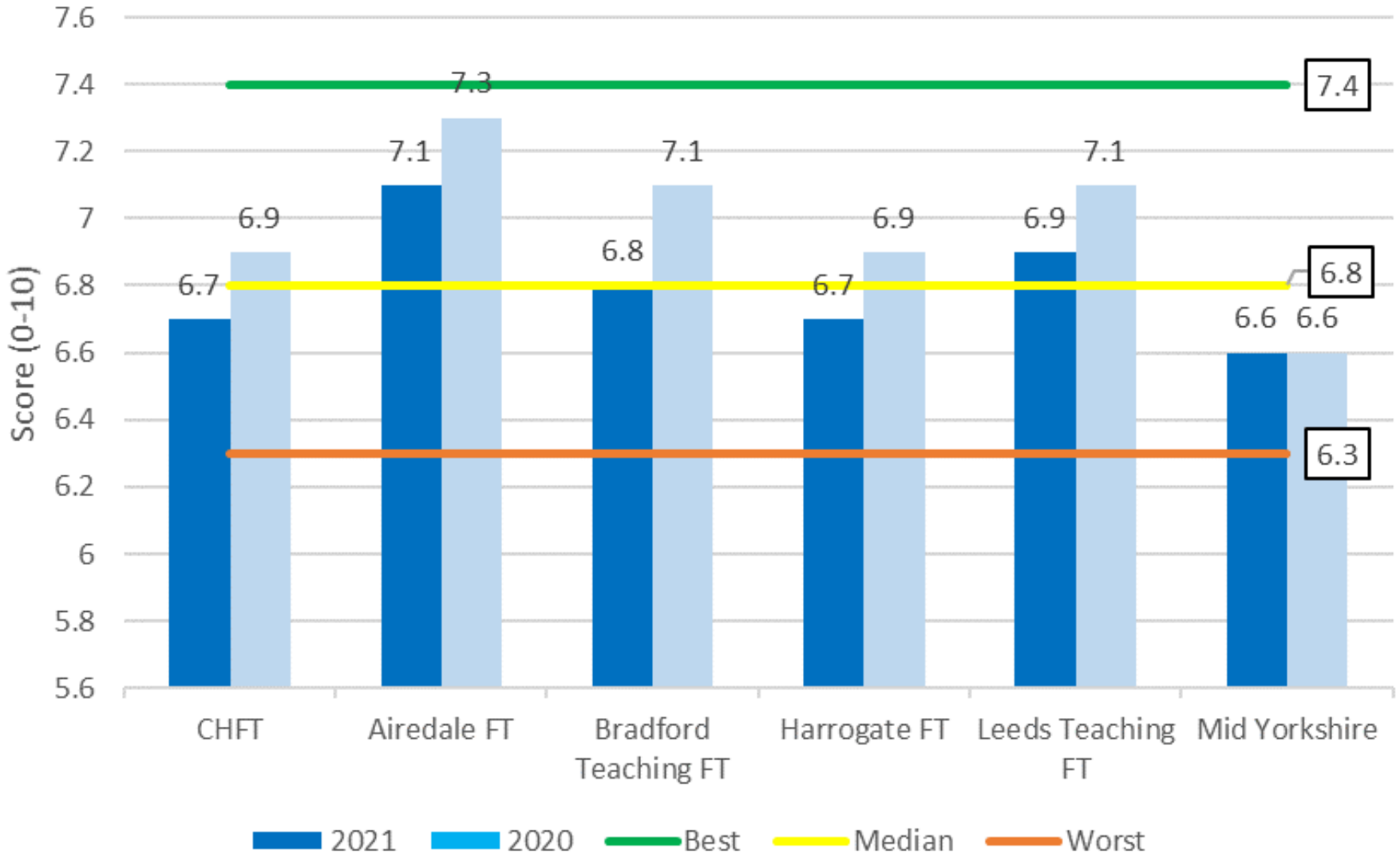
Q21c. Would recommend organisation as place to work – decreased by 8.8% from 63.8% to 55%

Q21d. If friend/relative needed treatment would be happy with standard of care provided by organisation – decreased by 7.9% from 71.6% to 63.7%

**NB:** All CHFT scores, score below the National score for these questions. Nationally all scores in relation to these questions have comparatively fallen

# Engagement Scores

Calderdale and Huddersfield NHS Foundation Trust

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# Key Priorities

Calderdale and Huddersfield NHS Foundation Trust

- One Culture of Care
- Wellbeing
- Change and improvement
- Engagement
- Authentic speech
- Appraisal and development
- Leadership visibility
- Inclusion and teamwork

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# Values & Behaviours

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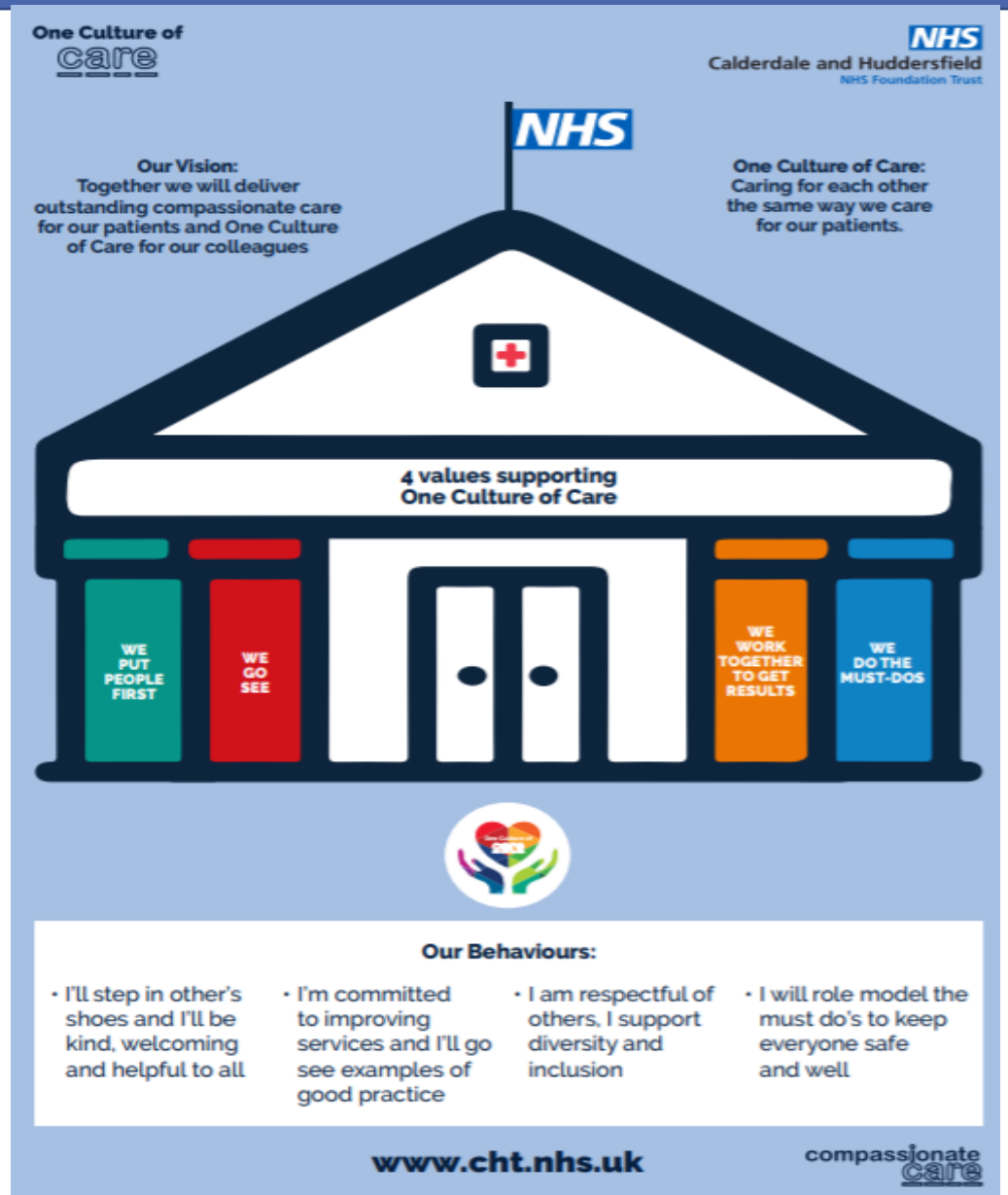


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# People Strategy Refresh

Calderdale and Huddersfield NHS Foundation Trust


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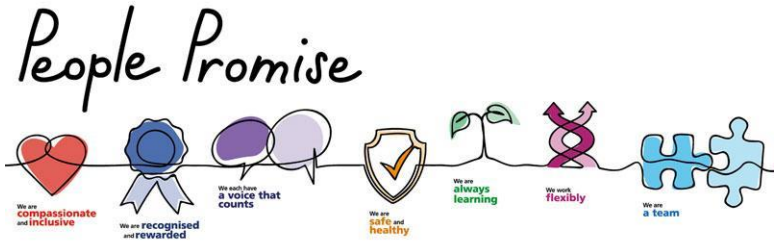
People Promise

# Action Plans



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# Governance



- Workforce Committee interrogation of progress against action plan

- Monthly discussion at divisional performance review meetings. Divisional Directors and Directors of Operations are responsible owners for making improvement for their staff survey results

# Monitoring Progress and Gaining Assurance



- People Pulse
- Engagement team collecting you said/we did output for the you said/we did promotional campaign
- Tea trolley
- Team Engagement and Development diagnostic and work together/get results workshops
- Engagement Board – mix of people, get out there, hearing evidence about whether things are changing on the ground
- Team values and behaviour charter – collecting evidence from colleagues of positive practice

# Actions

Calderdale and Huddersfield NHS Foundation Trust

One Culture of Care – people strategy refresh, promote a fresh start, promote values and behaviours, management and engagement toolkits, one culture of care charters

Wellbeing - leadership development (wellbeing at the heart of conversations), appraisal refresh will enable regular wellbeing dialogue, continue with wellbeing hour

Change and improvement - the ability to 'bounce back' and learn after adversity, using work together / get results and team engagement and development diagnostic we will co create the plan, to deliver the change we want to see, mini hot house toolkits

Engagement – opening up channels to understand what colleagues really want from their workplace – engagement walkrounds, tea trolleys values and behaviours charter, you said/we did

Authentic speech – leadership role modelling the values and behaviours, colleagues feeling valued and recognised – appreciation day, celebrating success, monthly star award, local CHuFT appreciation kits

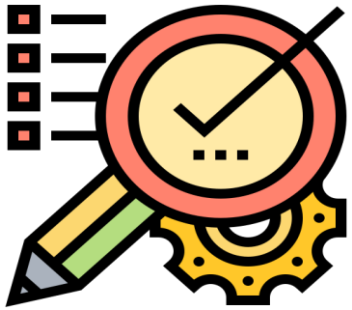
Appraisal and development - improve tools for managers to host quality appraisals, host appraisal workshops, 'how to' appraisal video, development for all approach communicated widely

Leadership visibility – increase number of leaders volunteering for care club and refresh tea trolley campaign, collect evidence to demonstrate we hear you, we care, we act on our promises

Inclusion and teamwork - spend time understanding differences, building and sustaining positive workplace, improve connectivity and dialogue between equality group members and leaders/teams, EDI education and awareness

# Actions

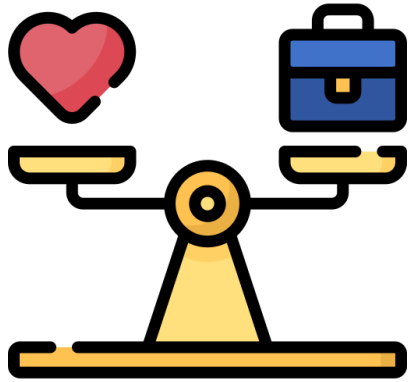
Calderdale and Huddersfield NHS Foundation Trust



## Workforce Priorities

1. Development for all.
2. Inclusive approach to recruitment.
3. Enhance our leadership and management development programmes.
4. Develop a Trust approach to workforce design
5. Consolidate our health and wellbeing offer

*"You said, we did!"* campaign



*Helping colleagues balance work priorities with looking after themselves*

**Management comms and engagement toolkit!**


*Managers working together with colleagues.*


**Appreciation**

# Board Response

Calderdale and Huddersfield NHS Foundation Trust

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

# Summary



- Nationally staff survey scores has seen a decrease - colleagues are burnt out
- We can re-set and re-energise
- We need leaders who role model One Culture of Care and the values and behaviours
- We all need to pull together as one team - lets work together to get results, respecting and appreciating each others point of view
- We need to start having quality conversations between manager and colleague – the new approach to appraisals will do this (with supporting resources and toolkits)
- Let's add One Culture of Care on each meeting agenda so we can make it real and share examples of good practice

Please click on the link below to access the full 2021 staff survey scores from a national and local perspective

https://www.nhsstaffsurveys.com/results/

# Keeping the Base Safe

# 16. Director of Infection, Prevention and Control Q4 Report

To Approve

Presented by David Birkenhead

| | |
|---|---|
| **Date of Meeting:** | Thursday 5 May 2022 |
| **Meeting:** | Public Board of Directors |
| **Title:** | Quarterly Director of Infection Prevention and Control (DIPC) report Q4 – 1st January 2022 to 31st March 2022 |
| **Authors:** | Gillian Manojlovic - Senior IPC Nurse<br>Lindsay Rudge - Deputy Director of Nursing / Assistant DIPC |
| **Sponsoring Director:** | David Birkenhead, Medical Director |
| **Previous Forums:** | None |

**Purpose of the Report**

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

**Key Points to Note**

The revised version of the Infection Prevention and Control Board Assurance Framework (BAF) has been reviewed following publication. A further updated BAF is expected to be published following updated guidance.

CDifficile objective for 2021/22 breached.

Significant effect of the Omicron variant on the Trust reflected in the Hospital Onset Covid-19 Infections (HOCI) and outbreak data.

MRSA bacteraemia – zero cases in year.

**EQIA – Equality Impact Assessment**

This report relates performance information relating to Infection Prevention and Control. It is not expected that the performance metrics reported will be significantly affected by ethnicity, however disability may predispose individuals to certain infections.

**Recommendation**

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

# DIPC Report to Board of Directors
# 1st January to 31st March 2022

## 1. Introduction

This report covers the period from 1st January – 31st March 2022 unless otherwise noted. Calderdale and Huddersfield Foundation Trust recognises that effective infection prevention practice, underpinned by the implementation and audit of evidence-based policies, guidelines and education are fundamental to the reduction of risk and patient harm from Healthcare Associated Infections (HCAI). The report will provide assurance against key infection prevention and control performance and quality indicators.

## 2. Performance targets

| Indicator | End of year ceiling 2021/2022 | End of year performance | Actions/Comments |
|---|---|---|---|
| MRSA bacteraemia (trust assigned) | 0 | 0 | |
| C.difficile (trust assigned) | Objective = 22 | 37 | 27 HOHA = 5 preventable, 18 unpreventable, 4 pending<br><br>10 COHA = 10 unpreventable |
| MSSA bacteraemia (post admission) | None set | 19 | |
| E. coli bacteraemia | Objective = 91 | 72 | 33 HOHA cases<br>39 COHA cases |
| MRSA screening (electives) | 95% | 70% | Work ongoing to improve data quality, which is expected to improve reported compliance. |
| ANTT Competency assessments (medical staff) | 90% | 79.5% | 10% increase in medical staff compliance |
| ANTT Competency assessments (nursing and AHP) | 90% | 93% | |
| Hand hygiene | 95% | 99.6% | |
| Level 2 IPC training (Doctors | 90% | 88.7% | This continues as an e-learning package. |
| Level 2 IPC training (nursing and AHP) | 90% | 89.8% | |

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

## 3. Quality Indicators

| Indicator | Year-end agreed target | YTD performance | Comments |
|---|---|---|---|
| MRSA screening (emergency) | 95% | 91% | |
| Isolation breaches | Non set | Not recorded this quarter | COVID-19 patients remain priority for side room isolation |
| Cleanliness | Non set | 97.1% | |

## 4. MRSA bacteraemia:

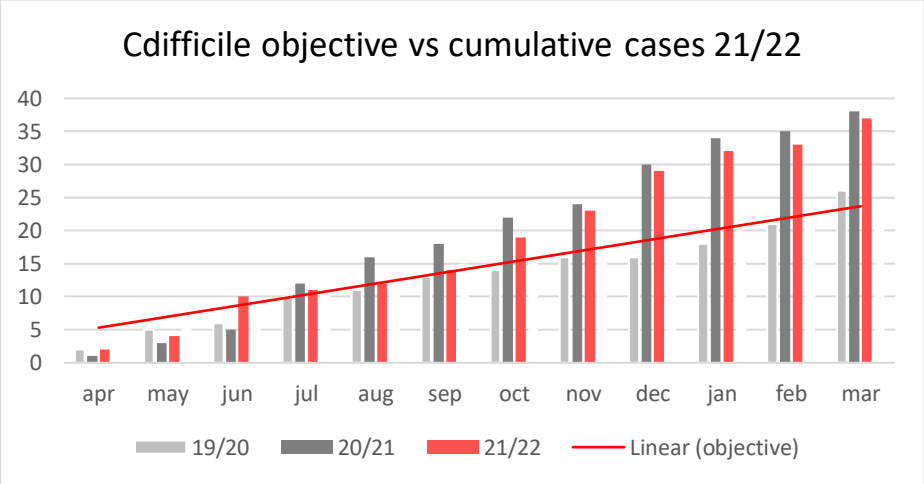
No cases to report during the current reporting period. There have been no MRSA bacteraemia cases this year.

## 5. MSSA bacteraemia:

There have been 7 post-admission MSSA bacteraemia cases during the current reporting period with a total of 19 cases at year end. The IPC team continue to review these cases.

## 6. Clostridium difficile:

The objective for 2021-22 was 22 cases, a reduction of 1 case on the 2019 data (calendar year). The objective includes both HOHA cases (hospital onset, healthcare associated) plus COHA (community onset, healthcare associated) infections where there has been an inpatient episode within the previous 28days. There have been a total of 37 cases against the objective of 22 cases at year end. The objective breached in November 21.




All cases are subject to an investigation of which:

- 5 deemed as preventable,
- 28 unpreventable
- 4 outcomes pending.

## 7. E. coli bacteraemia:

There have been 3 post-admission *E. coli* bacteraemia cases plus 6 COHA cases during the reporting period with a total of 73 cases year to date (not ratified due to a data issue). This is well within the objective of 91 cases at year end.

## 8. Outbreaks & Incidents:

### 8.1 Outbreaks

There have been 3 norovirus outbreaks reported during Q4 affecting wards H6, H17 and H11.

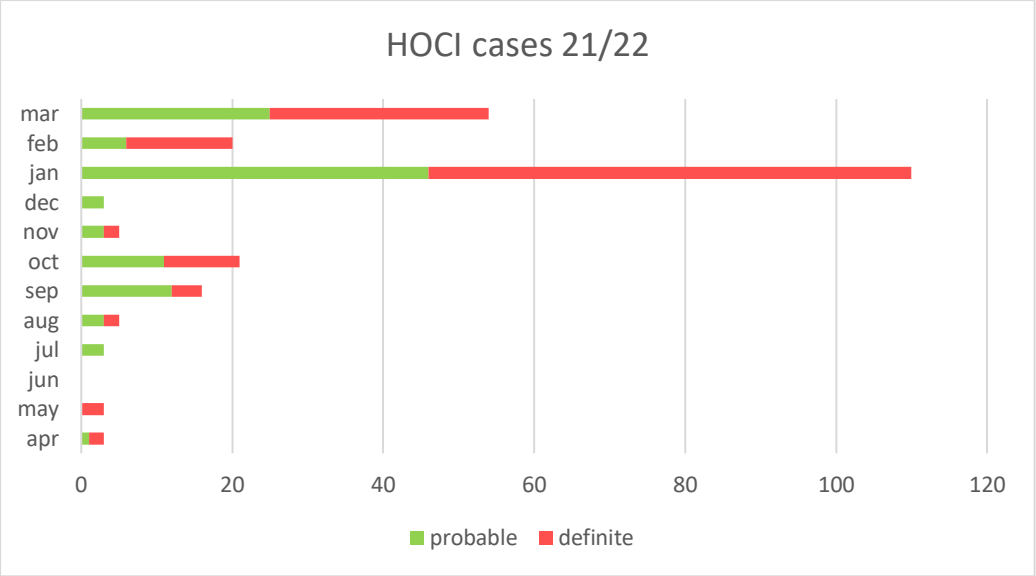
In addition, there have been 21 Covid19 outbreaks recorded during the reporting period; with wards C5B, C6C, C6AB, CCU, C4D, C7's, H5, H6, H11, H17, H19, H21, H22 affected on one or more occasions plus one staff outbreak.

All Covid-19 outbreaks are managed in line with Covid19 outbreak management guidelines and are monitored for 28 days. Issues identified included:

- Mobile patients with cognitive impairment
- Patient cooperation with the wearing of masks and social distancing.
- Visitor compliance with mask wearing.

### 8.2 Healthcare associated Covid19 Infections (HOCI's)

All probable and definite HOCIs are investigated at CHFT following a process agreed with the divisions and the risk team. Any immediate learning is also discussed at the IPC gold meeting and communicated where relevant. For this reporting period there have been 184 HOCI cases (107 definite, 77 probable).




### 8.3 Staff Covid19

Covid-19 has had an ongoing affect on staffing. Further detail and vaccine update will be outlined in the Occupational Health report.

## 9. FFP3 (Protective Respiratory Face Mask) Use

The National programme to build resilience in the supply chain and reduce reliance on 3M as a manufacturer requires staff to be fit tested to at least 2 masks. In addition, 2 yearly fit testing is being implemented. Long term planning for the ongoing provision of fit testing to be agreed.

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

## 10. Audits

**COVID Assurance audits including:**

- Infection Prevention Control Board Assurance Framework self-assessment – new framework released 24/12/21 and updated
- Daily must do compliance by ward managers
- Weekly leadership walkround every Wednesday
- Weekly IPC Covid 19 assurance – completed by the Matrons
- 2 weekly front line ownership (FLO) audits
- Night matron's assurance audit to monitor compliance out of hours to IPC and social distancing recommendations

- 7 day on site Senior Leadership rota

**Quality Improvement Audits**
The programme was once again put on hold during the reporting period, this has been reviewed and was planned to recommence in January 2022. However, due to the effect of the Omicron variant on the workload of the IPC team, matrons and service performance this was delayed until March 22. So far, 5 quality improvement audits have been completed.

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

## 11. Recommendations

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

# 17. Guardian of Safe Working Hours Annual Report (Including Q4 Report) - Devina Gogi, Guardian of Safe Working Hours

To Note

NHS
Calderdale and Huddersfield
NHS Foundation Trust

| | |
|---|---|
| **Date of Meeting:** | Thursday 5 May 2022 |
| **Meeting:** | Public Board of Directors |
| **Title:** | Annual Report (April 2021- March 2022) from the Guardian of Safe Working Hours, CHFT |
| **Author:** | Ms Devina Gogi |
| **Sponsoring Director:** | Dr David Birkenhead, Medical Director |
| **Previous Forums:** | None |

**Purpose of the Report**

In line with Terms & Conditions of Service for NHS Doctors & Dentists in Training (England) 2016. The purpose of the report is to provide an overview and assurance of the Trust's compliance with safe working hours for Junior doctors across the Trust and to highlight any area of concern or commendation.

**Key Points to Note**

1. Decrease in exception reports in 2021-2022.
2. Efficient filling the of rota gaps.
3. Successful hosting of junior doctors' awards in May 2021 which recognised the hard work and compassionate care delivered by junior doctors during the pandemic.
4. Improved Trust and Guardian of Safe Working Hours (GOSHW) engagement with the junior doctor workforce.
5. Appointment of new junior doctor lead for training recovery.

**EQIA – Equality Impact Assessment**

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

**Recommendation**

The Board is asked to **RECEIVE** and **NOTE** the report.
To acknowledge the need for extra support & flexibility with training and rota for junior doctors in the training recovery phase.

**ANNUAL REPORT: (1st April 2020 to 31st March 2022)**

**GUARDIAN OF SAFE WORKING HOURS (GOSWH) CHFT**

## EXECUTIVE SUMMARY

The purpose of the annual report is to provide assurance to the Board that junior doctors are safely rostered and enabled to work hours that are safe and in compliant with the Terms & Conditions of Service (TCS) for NHS Doctors and Dentists in Training (England) 2016, version 9.

**The period covered in this report is from April 2021 to March 2022.**

This year saw a decrease in the exception reports (ER) compared to previous years. There was submission of ER from a wide variety of specialities, suggesting that the process of exception reporting is embedded across the trust. There was an increase in ER from within the Medical Division reflecting the higher clinical workload, increased patient acuity and staffing issues during recurring COVID peaks.

There was no ER logged for immediate safety concern this year.

The rota gaps were efficiently filled by bank & agency locum.

'Normal' rotas have been in place since mid-March 2021. There was no need to introduce any escalated COVID rotas in any speciality this year despite recurring COVID peaks and staff shortages.

During this year of post COVID pandemic recovery phase, there has been improved engagement by the Trust and GOSWH with the junior doctors, which was encouraged through successful Junior Doctors Forum meetings and trust induction. A new junior doctor lead for training recovery was appointed to focus on ways to improve training opportunities for junior doctors during these challenging times.

## ESSENTIAL DATA

| Trainee Type | Budget | Full Time | | Part Time | | Vacancies |
|---|---|---|---|---|---|---|
| | FTE | FTE | Headcount | FTE | Headcount | FTE |
| Core Trainee | 37 | 33 | 34 | 3.56 | 5 | 0.44 |
| Foundation Year 1 | 47 | 45 | 46 | 0.65 | 1 | 1.35 |
| Foundation Year 2 | 55 | 35 | 35 | 1.58 | 2 | 18.43 |
| GP Trainee - Trust Based | 38 | 30 | 30 | 8.31 | 10 | -0.31 |
| Specialty Trainee | 97.56 | 76 | 76 | 25.74 | 34 | -4.18 |

| Trainee Type | Budget | Full Time | | Part Time | | Vacancies |
|---|---|---|---|---|---|---|
| | FTE | FTE | Headcount | FTE | Headcount | FTE |
| GP Trainee - Practice Based | N/A | 43 | 43 | 22.56 | 31 | N/A |

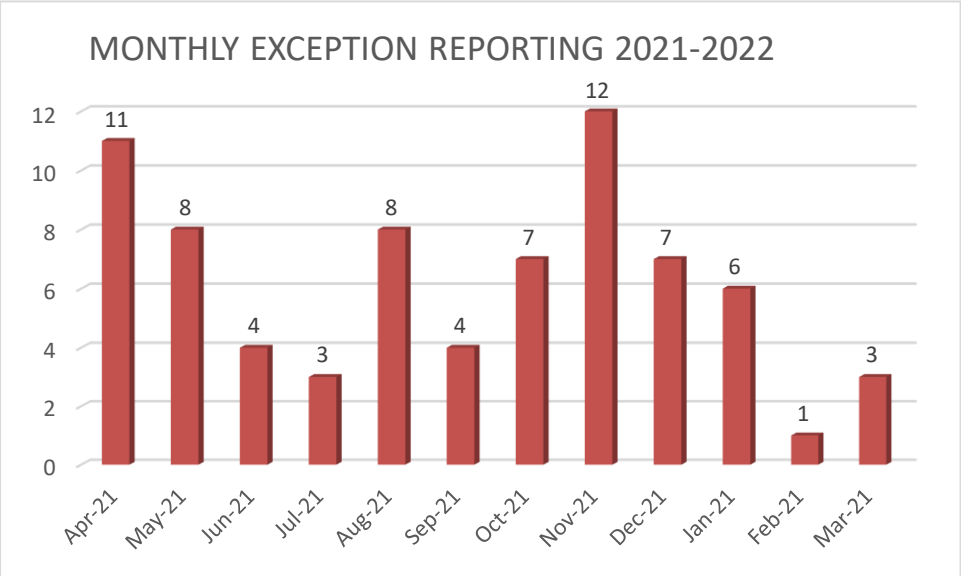
| Trainee Type | Budget | Full Time | | Part Time | | Vacancies |
|---|---|---|---|---|---|---|
| | FTE | FTE | Headcount | FTE | Headcount | FTE |
| Medical Training Initiative (Royal College Approved) | 0 | 1 | 1 | 0.00 | 0 | -1.00 |
| Trust Doctor | 9.94 | 40 | 40 | 3.38 | 5 | -33.44 |

## 1. EXCEPTION REPORTING (ERs)

Total number of exception reports received per quarter this year.

| | Immediate Safety Concerns | Total hours of work &/ or pattern | Educational opportunities/ support | Service Support available | Total |
|---|---|---|---|---|---|
| **Q1** | 0 | 13 | 2 | 0 | 15 |
| **Q2** | 0 | 24 | 0 | 2 | 26 |
| **Q3** | 0 | 9 | 0 | 1 | 10 |
| **Q4** | 0 | 21 | 0 | 2 | 23 |
| **Total** | 0 | 67 | 2 | 5 | **74** |

Number of monthly ER (April 2021- Mar 2022)

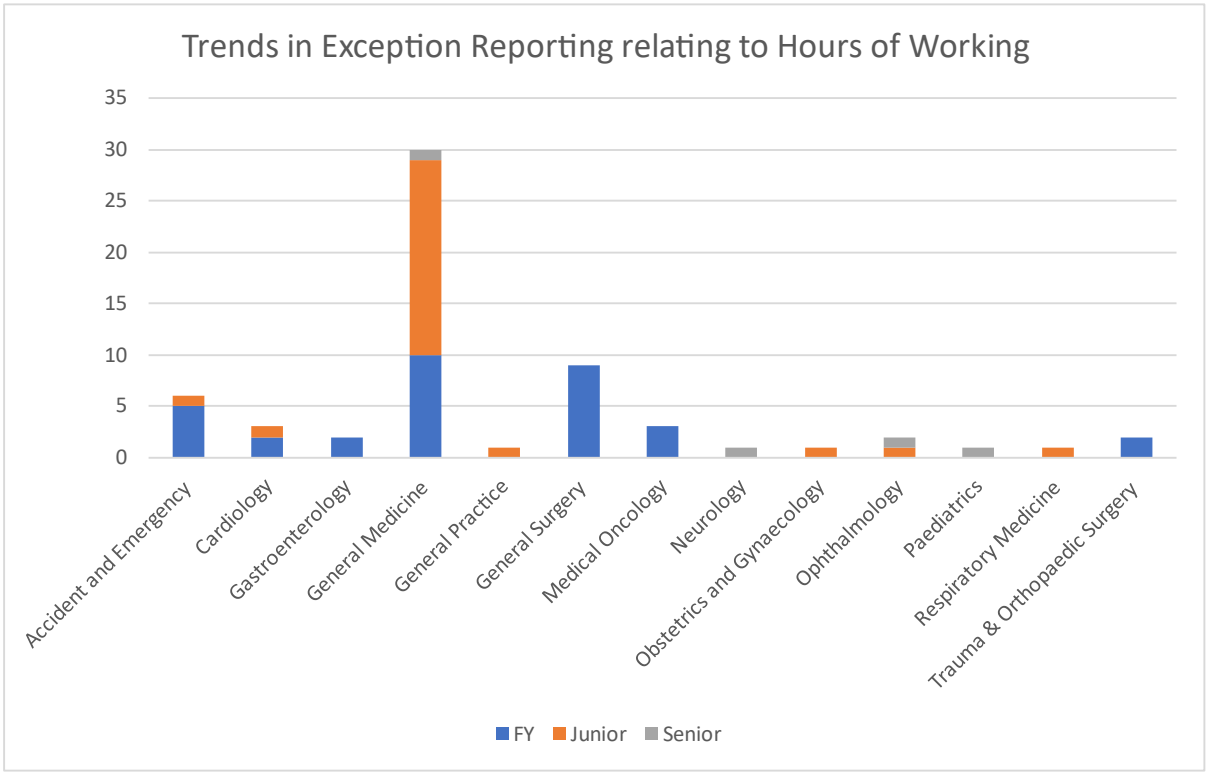



### Trends in Exception Reporting

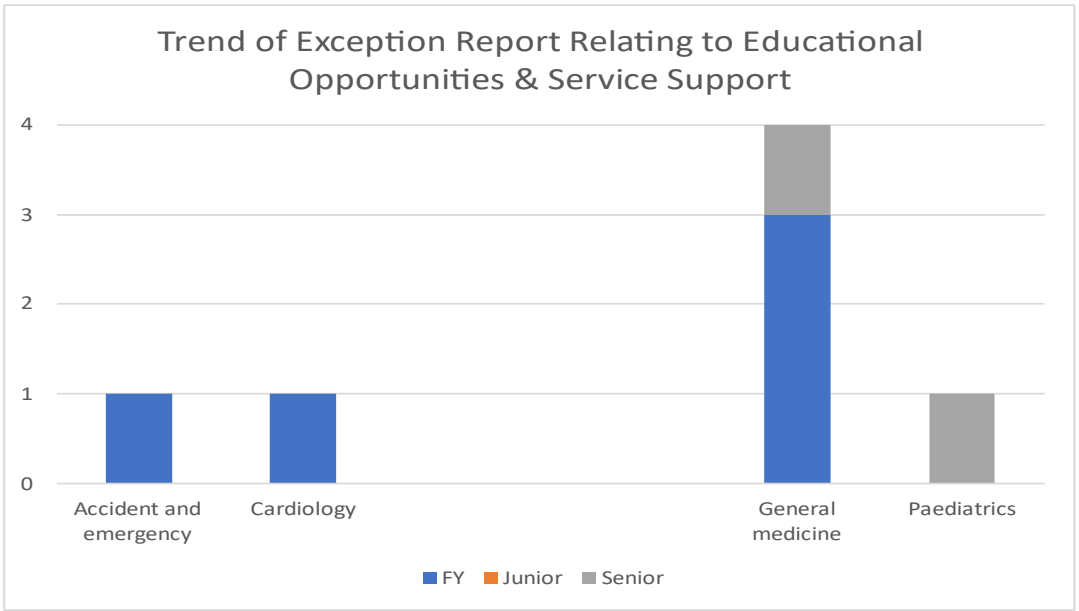
There has been a total of 74 exception report (ER) this year, with the majority being submitted in Quarter 2 and Quarter 4. Whilst the process of exception reporting was available throughout, there was a significant decrease in the reports submitted in Quarter 3.

The majority of the ERs were submitted by foundation trainees, which is similar to previous years, but the trend of increased ERs from junior & senior trainees is continuing. Submission of ERs from a wide variety of specialities, suggests that the process of exception reporting is embedded across the trust.

There was an increase in ER from Medical division reflecting the higher clinical workload, increased patient acuity & staffing issues during recurring COVID peaks.

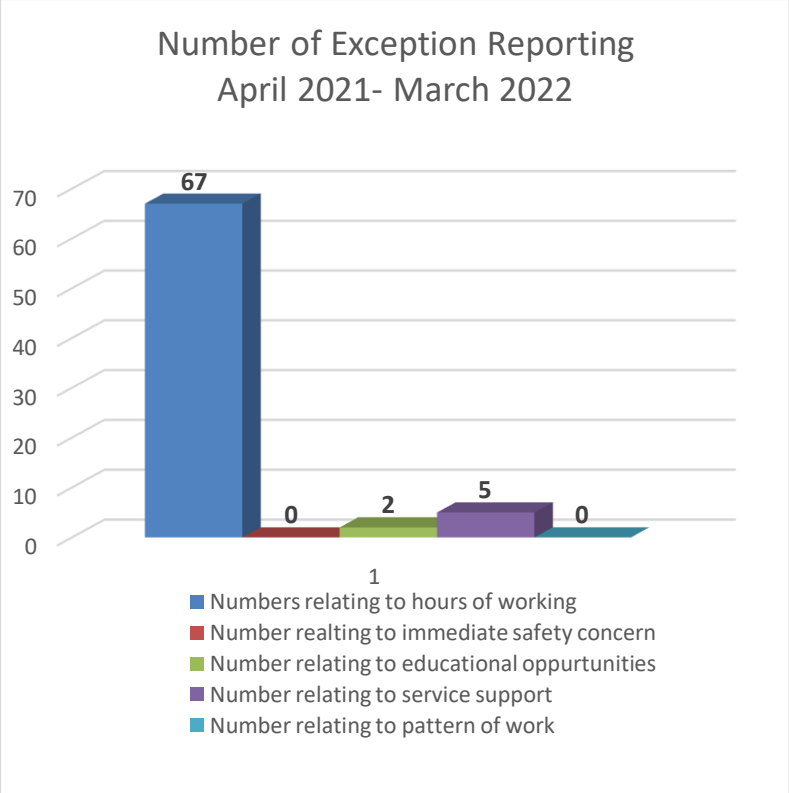



There was limited ER's related to educational opportunities signifying that training & teaching were protected for trainees during this challenging recovery period.




**Types of Exception Reports (ERs) & Outcomes**

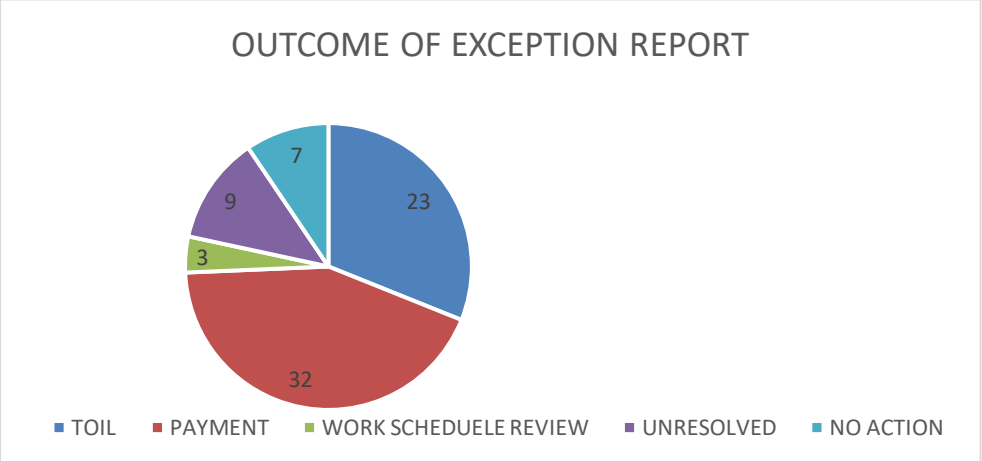
Approximately 90% of ERs submitted this year were because of working overtime & this was due to higher patient acuity & staffing shortages due to COVID peaks during the year.




Most ERs have resulted in time off in-lieu or payment. There were a few work schedule reviews which were sorted by timely intervention & meeting with the concerned parties involved.

The work schedule review was related to 2 ER on 2 consecutive days by an FY1 in General Medicine which led to discussing the Oncology helpline and the staffing rota. This highlighted that there wasn't a doctor undertaking a twilight shift, therefore that was a regular issue of patients arriving at the end of day, with no specific person to handover to. This led to changes looking at the staffing at the end of the day or not accepting patients via helpline after certain time.

A few ER are currently unresolved due to a delay with trainee agreement about the outcome. Medical HR continues to communicate with trainees to close the report when the outcome is agreed.



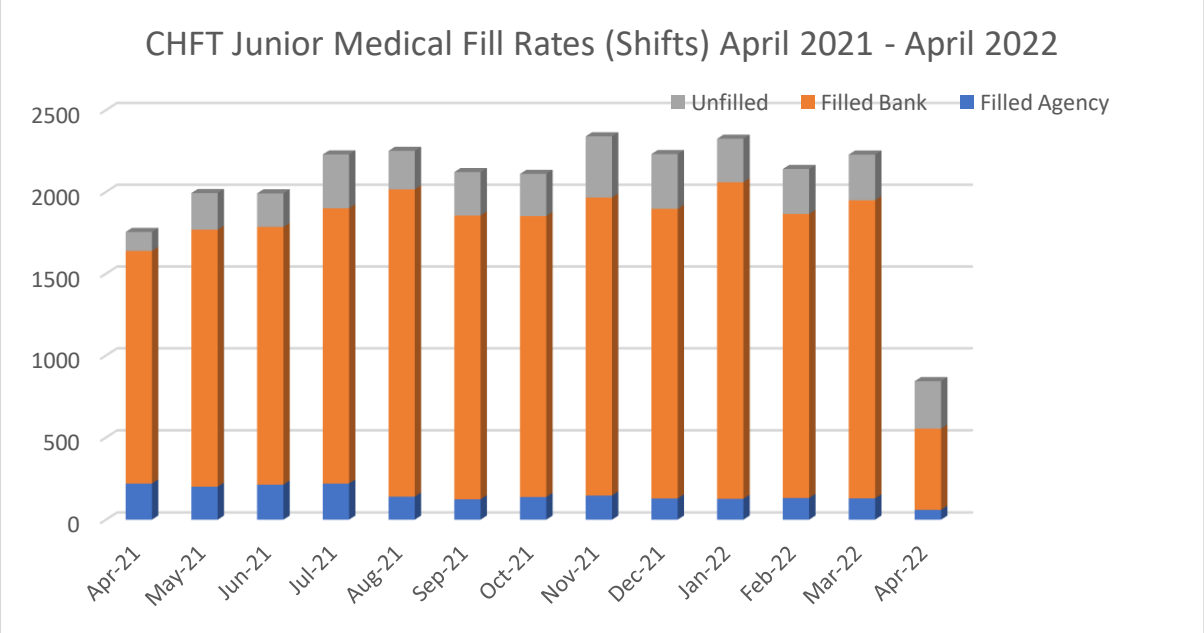
**Immediate Safety Concern**

No ER was flagged as immediate safety concern this year.

**2. ROTA GAPS & LOCUM FILL RATES**

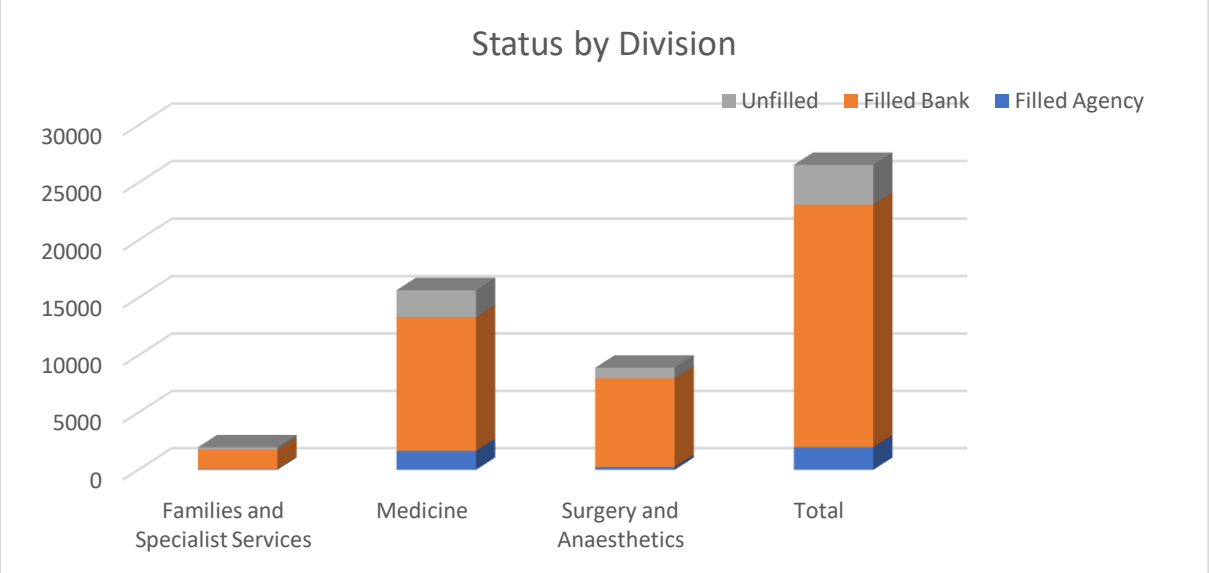
The detailed rota gaps per speciality have been included in Appendix 1.

This graph shows the rota gaps per month




The gaps were greatest in the medical division but the use of bank & agency locums, reduced the total unfulfilled shifts to approximately 5%.

The on call covers in all specialities with rota gaps were covered with ad-hoc locums. We tried to advertise trust doctor posts in some specialities to cover the rota gaps.



## 3. JUNIOR DOCTOR's ROTA CHANGES

'Normal' rotas have been in place since mid-March 2021. There was no need to introduce any escalated COVID rotas in any speciality this year despite recurring COVID peaks & staff shortages.

In December 2021, changes were made to the start and end time of the Long Day and Night Shifts when on call in Medicine. The biggest driving factor in initiating these changes was feedback from the GMC survey. The changes were discussed and agreed to improve patient care as it enables a longer morning handover.

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

## 4. JUNIOR DOCTORS AWARDS 2021

In May 2021 we hosted the 3rd 'CHFTs Got Medical Talent Awards ceremony. Due to COVID-19 the ceremony was held online, and the attendance rate was excellent.

All doctors employed by the Trust and working at a junior level could be nominated, as could teams of junior doctors, anyone could make a nomination. Approximately, 280 doctors were eligible, and we received 80 nominations.

The categories were:

- Rewarding excellence in compassionate care
- Rewarding excellence in clinical leadership
- Rewarding excellence in medical education
- Rewarding excellence in research, audit and quality improvement
- Going above and beyond the call of duty.

We were not surprised that after a very challenging 12 months the 'compassionate care' and 'going above and beyond' categories received the highest number of nominations and the judges commented on how apparent it was that they juniors had really 'stepped up to the mark'. What was also impressive was that despite the necessary focus on clinical work there were still excellent nominations for those who had established education programmes, supported medical students, and become involved in research.

The junior doctors were really pleased that despite everything that was happening, the Trust had taken the time to organise and hold the awards.

We plan to hold the 4th CHFT's got Talent Awards ceremony virtually this year in May again. It has been advertised on CHFT web portals and nominations for the same categories are open now for the junior doctors.

## 5.APPOINTMENT OF NEW JUNIOR DOCTOR LEAD FOR TRAINING

Dr Louise Finn has been appointed as a junior doctor lead for Training recovery. Her appointment is a positive step towards active involvement of the junior doctors in the training recovery programme that has started in the trust.

## 6. ACTIVE PARTICIPATION IN TRUST INDUCTION

The GOSWH was ardently involved in trust induction in August and advocated the importance of junior doctors' participation as representatives in junior doctor forums so that we can strive to learn about and resolve issues, creating a better work environment for them. The process and importance of Exception Reporting was also highlighted in the trust induction.

## 7. JUNIOR DOCTOR FORUM (JDF)

The JDF was held on 30th September 2021 & 20th January 2022. This was chaired by the GOSWH. Whilst there were some junior doctor representatives that attended, there were fewer than expected in attendance at the forum. The GOSWH highlighted the importance of better engagement by junior doctors in this forum.

The junior doctors emphasised updating the "DOCTOR TOOLBOX" with important information, so that it can be a useful resource by junior doctors to carry out their routine clinical activities properly. The lack of availability of rooms for junior doctors to attend meetings due to the closure of the postgraduate centre in HRI, was expressed and various possible solutions were explored.

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

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

We are holding the next JDF on 28th April 2022.

## 8.FINES LEVIED

No Fines have been levied this year.

## 9.TRAINEE DOCTORS EXCEPTION REPORT EQUALITY IMPACT ASSESSMENT (EQIA)

The junior doctor workforce is highly mobile & constantly changes within the trust which means that monitoring needs to be regularly reviewed. The exception reports submitted by our junior doctors during this year have been split by ethnicity, gender & disability.

There is no statistically significant difference in the ER submitted by the White & BAME group.

More females filled the ER, but this is representative of the junior doctor population of the trust.

| Ethnicity | Exceptions | Trainee Doctors | Trust |
|---|---|---|---|
| White | 41.10% | 44.28% | 75.79% |
| BAME | 49.32% | 51.66% | 20.74% |
| Unknown | 9.59% | 4.06% | 3.47% |
| **Gender** | **Exceptions** | **Trainee Doctors** | **Trust** |
| Female | 64.38% | 53.51% | 79.64% |
| Male | 35.62% | 46.49% | 20.36% |
| **Disability** | **Exceptions** | **Trainee Doctors** | **Trust** |
| No | 83.56% | 84.50% | 90.96% |
| Yes | 1.37% | 1.48% | 4.57% |
| Not Declared | 6.85% | 14.02% | 4.23% |
| Unspecified | 8.22% | 0.00% | 0.14% |
| Prefer Not to Answer | 0.00% | 0.00% | 0.11% |

**SUMMARY**

This year showed a decrease in exception reports compared to previous years. There was no ER logged for immediate safety concerns and the majority of ER were closed with time off in lieu or agreed locum payments.

The rota gaps were effectively filled by agency & bank locums.

During this year of post COVID pandemic recovery phase, improved engagement by the trust & GOSWH with the junior doctors was encouraged through successful JDF meetings & trust induction. A new junior doctor lead for training recovery was appointed to outline ways to improve training opportunities for junior doctors during these challenging times.

**RECOMMENDATION**

The Board of Directors is requested to receive and note the Guardian of Safe Working Hours Annual Report for 2021-22.

**Devina Gogi**
**Guardian of Safe Working Hours**
**April 2022**

**APPENDIX 1**

**A&E**

HRI

3 ST4 Gaps April 2021 – June 2022

2 ST4 Gaps June 2021 – September 2022

1 ST3 Gap April 2021 – May 2021

3 ST3 Gaps May 2021 – August 2021

CRH

1 ST4 Gap April 2021 – June 2021

2 ST4 Gaps June 2021 – August 2021

1 ST4 Gap August 2021 – September 2021

2 ST3 Gaps April 2021 – May 2021

1 ST3 Gap May 2021

2 ST3 Gaps May 2021 – August 2021

1 FY2 Gap April 2021 – August 2021

HRI

1 ST4 Gap August 2021

1 ST4 Gap 10th Jan 2022 – 20th Jan 2022

2 ST3 Gaps August 2021 – January 2022

1 ST3 Gap February 2022 – March 2022

1 ACP Gap December 2021 – January 2022

2 ACP Gaps January 2022

2 ACP and 2 GPST Gaps February 2022

1 ACP and 1 GPST Gap February 2022 – March 2022

CRH

2 ST4 Gaps August 2021 – December 2021

1 ST4 Gaps December 2021 – January 2022

1 ST3 Gap August 2021 – September 2021

1 ST3 Gap November 2021 – December 2021

2 ST3 Gaps December 2021 – March 2022

1 ACP and 1 GPST Gap February 2022 – March 2022

1 FY2 Gap December 2021 – February 2022

**Medicine**

**CRH**

GPST Aug 21- Feb22 20% x2 Stroke, Cardio

GPST Aug 21- Feb22 50% x1 AAU

GPST Feb22- March 22 20% x1 AAU

Registrar Aug 21-March 22 20% x1 Cardio

Registrar Oct 21-March 22 full gap x1 Resp

**HRI**

GPST Feb22- March 22 20% x1 Gastro

GPST Feb22- March 22 full gap x1 AAU

Registrar April 21-Oct 21 20% x2

**General Surgery**

Surgery

FY1

April – July 2021 = 1 LTFT 60% no nights. 1 LTFT 80%

July – Dec 2021 = None

Dec 2021 – April 2022 = 1 LTFT 60% no nights

All on-calls covered with ad hoc locums.

FY2 / CT / GPST

April – Aug 2021 = 1 GPST vacancy

Aug – Dec 2021 = 1 Trust CT (started Oct Visa delay)

Feb 2022 – April 2022 = 1 CT vacancy. 1 CT LTFT 80% no nights. 1 Trust CT vacancy.

All on-calls covered with ad hoc locums.

Registrar

April – Oct 2021 = 1 SpR

Jan – May 2022 = 1 Trust SpR

All on-calls covered with ad hoc locums.

**Urology**

FY1

Dec 2021 – April 2022 = 1 vacancy

All on-calls covered with ad hoc locums.

Registrar

April – Oct 2021 = LTFT 60%

Feb – April 2022 = LTFT 60%

All on-calls covered with ad hoc locums.

**Obs and Gynae**

| Vacancy period | Grade (FY, CT, ST3+, SAS, GPST) | Number of Gaps | Reason for gap | Cover arrangements |
|---|---|---|---|---|
| **Apr-21** | FY2-ST2/ST3+/ SPR | 1.2 ST3+ and 0 FY2-ST2 | Deanery gap and 1 on Maternity leave | On-calls to be covered by locum |
| **May-21** | FY2-ST2/ST3+/ SPR | 2.2 ST3+ and 0 FY2-ST2 | Deanery gap and 2 on Maternity leave | On-calls to be covered by locum |
| **Jun-21** | FY2-ST2/ST3+/ SPR | 2.2 ST3+ and 0 FY2-ST2 | Deanery gap and 2 on Maternity leave | On-calls to be covered by locum |
| **Jul-21** | FY2-ST2/ST3+/ SPR | 2.2 ST3+ and 0 FY2-ST2 | Deanery gap and 2 on Maternity leave | On-calls to be covered by locum |
| **Aug-21** | FY2-ST2/ST3+/ SPR | 4.4 ST3+ and 0 FY2-ST2 | Deanery gap, SPR gap, LTFT, Maternity leave | On-calls to be covered by locum |
| **Sep-21** | FY2-ST2/ST3+/ SPR | 4.4 ST3+ and 0 FY2-ST2 | Deanery gap, SPR gap, LTFT, Maternity leave | On-calls to be covered by locum |
| **Oct-21** | FY2-ST2/ST3+/ SPR | 4.4 ST3+ and 0 FY2-ST2 | Deanery gap, SPR gap, LTFT, Maternity leave | On-calls to be covered by locum |
| **Nov-21** | FY2-ST2/ST3+/ SPR | 3.4 ST3+ and 0 FY2-ST2 | Deanery gap, LTFT, Maternity leave | On-calls to be covered by locum |
| **Dec-21** | FY2-ST2/ST3+/ SPR | 3.4 ST3+ and 0 FY2-ST2 | Deanery gap, LTFT, Maternity leave | On-calls to be covered by locum |

| | | | | |
|---|---|---|---|---|
| **Jan-22** | FY2-ST2/ST3+/ SPR | 2.4 ST3+ and 0 FY2-ST2 | Deanery gap, LTFT, Maternity leave | On-calls to be covered by locum |
| **Feb-22** | FY2-ST2/ST3+/ SPR | 2 ST3+ and 0 FY2-ST2 | Deanery gap, LTFT, Maternity leave | On-calls to be covered by locum |
| **Mar-22** | FY2-ST2/ST3+/ SPR | 2 ST3+ and 0 FY2-ST2 | Deanery gap, LTFT, Maternity leave | On-calls to be covered by locum |

**T&O**

| Vacancy period | Grade (FY, CT, ST3+, SAS, GPST) | Number of Gaps | Reason for gap | Cover arrangements (incl MT1s/ACPs/PAs) |
|---|---|---|---|---|
| **Apr-21** | CT + SpR | 1x CT + 1x SpR | Deanery gap | On-calls to be covered by locum |
| **May-21** | CT + SpR | 1x CT + 1x SpR | Deanery gap | On-calls to be covered by locum |
| **Jun-21** | CT + SpR | 1x CT + 1x SpR | Deanery gap | On-calls to be covered by locum |
| **Jul-21** | CT + SpR | 1x CT + 1x SpR | Deanery gap | On-calls to be covered by locum |
| **Aug-21** | CT + SpR | 1x CT + 1x SpR | Deanery gap | On-calls to be covered by locum |
| **Sep-21** | CT + SpR | 1x CT + 1x SpR | Deanery gap | On-calls to be covered by locum |
| **Oct-21** | CT | 1x CST | Deanery gap | On-calls to be covered by locum |
| **Nov-21** | CT | 1x CST | Deanery gap | On-calls to be covered by locum |
| **Dec-21** | CT | 1x CST | Deanery gap | On-calls to be covered by locum |
| **Jan-22** | CT | 1x CST | Deanery gap | On-calls to be covered by locum |
| **Feb-22** | CT | 1x CST | Deanery gap | On-calls to be covered by locum |
| **Mar-22** | CT | 1x CST | Deanery gap | On-calls to be covered by locum |

**Paeds**

| Vacancy period | Grade (FY, CT, ST3+, SAS, GPST) | Number of Gaps | Reason for gap | Cover arrangements (incsACPs) |
|---|---|---|---|---|
| **Apr-21** | FY1/ FY2-ST3/ ST4+ | 0.2 FY2-St3 | Deanery gap LTFT | On-calls to be covered by locum |
| **May-21** | FY1/ FY2-ST3/ ST4+ | 0.2 FY2-St3 | Deanery gap LTFT | On-calls to be covered by locum |
| **Jun-21** | FY1/ FY2-ST3/ ST4+ | 0.2 FY2-St3 | Deanery gap LTFT | On-calls to be covered by locum |

| | | | | |
|---|---|---|---|---|
| **Jul-21** | FY1/ FY2-ST3/ ST4+ | 10.2 FY2-St3 | Deanery gap LTFT | On-calls to be covered by locum |
| **Aug-21** | FY1/ FY2-ST3/ ST4+ | 10.2 FY2-St3 | Deanery gap LTFT | On-calls to be covered by locum |
| **Sep-21** | FY1/ FY2-ST3/ ST4+ | 1 FY2-ST3 2 ST4+ | Deanery gap and 2 on Mat leave | On-calls to be covered by locum |
| **Oct-21** | FY1/ FY2-ST3/ ST4+ | 1 FY2-ST3 2 ST4+ | Deanery gap and 2 on Mat leave | On-calls to be covered by locum |
| **Nov-21** | FY1/ FY2-ST3/ ST4+ | 1 FY2-ST3 2 ST4+ | Deanery gap and 2 on Mat leave | On-calls to be covered by locum |
| **Dec-21** | FY1/ FY2-ST3/ ST4+ | 1 FY2-ST3 2 ST4+ | Deanery gap and 2 on Mat leave | On-calls to be covered by locum |
| **Jan-22** | FY1/ FY2-ST3/ ST4+ | 1 FY2-ST3 2 ST4+ | Deanery gap and 2 on Mat leave | On-calls to be covered by locum |
| **Feb-22** | FY1/ FY2-ST3/ ST4+ | 1 FY2-ST3 2 ST4+ | Deanery gap and 2 on Mat leave | On-calls to be covered by locum |
| **Mar-22** | FY1/ FY2-ST3/ ST4+ | 1 FY2-ST3 2 ST4+ | Deanery gap and 2 on Mat leave | On-calls to be covered by locum |

**Ophthalmology**

| Vacancy period | Grade (FY, CT, ST3+, SAS, GPST) | Number of Gaps | Reason for gap | Cover arrangements (incl MT1s/ACPs/PAs) |
|---|---|---|---|---|
| **Apr-21** | SAS Doctor | 1 | trust gap | On-calls to be covered by locum |
| **May-21** | SAS Doctor | 1 | trust gap | On-calls to be covered by locum |
| **Jun-21** | SAS Doctor | 1 | trust gap | On-calls to be covered by locum |
| **Jul-21** | SAS Doctor | 1 | trust gap | On-calls to be covered by locum |
| **Aug-21** | SAS Doctor | 1 | trust gap | On-calls to be covered by locum |
| **Sep-21** | SAS Doctor | 1 | trust gap | On-calls to be covered by locum |
| **Oct-21** | SAS Doctor | 1 | trust gap | On-calls to be covered by locum |
| **Nov-21** | SAS Doctor | 1 | trust gap | On-calls to be covered by locum |
| **Dec-21** | SAS Doctor | 1 | trust gap | On-calls to be covered by locum |
| **Jan-22** | SAS Doctor | 1 | trust gap | On-calls to be covered by locum |
| **Feb-22** | SAS Doctor + SpR | 1x SAS + 1x SpR | trust gap + deanery gap | On-calls to be covered by locum |
| **Mar-22** | SAS Doctor + SpR | 1x SAS + 1x SpR | trust gap + deanery gap | On-calls to be covered by locum |

# 18. Health and Safety Update

To Note

Presented by Suzanne Dunkley

| | |
|---|---|
| **Date of Meeting:** | Thursday 5 May 2022 |
| **Meeting:** | Public Board of Directors |
| **Title:** | Health and Safety Update |
| **Author:** | Richard Hill, Head of Health and Safety |
| **Sponsoring Director:** | Suzanne Dunkley, Executive Director of Workforce and Organisational Development |
| **Previous Forums:** | CHFT Health and Safety Committee |

**Purpose of the Report**

To provide the Board with an overview of the health and safety activities during 2021/2022 and the progress against the Health and Safety action plan.

**Key Points to Note**

A summary of the main activities and updates for the 12-month reporting period to 31st March 20 22, and progress against the action plan monitored at the Health and Safety Committee to date.

**EQIA – Equality Impact Assessment**

All Health and Safety guidance and advice is provided in language that is appropriate for all colleagues, including those who are neuro diverse. Throughout COVID, place based risk assessments have been designed to be clear, easy to read and understand.

**Recommendation**

The Board of Directors is asked to **NOTE** the progress made against the action plan presented and receive the Health and Safety Update.

**BOARD OF DIRECTORS**

**5th May 2022**

# HEALTH AND SAFETY UPDATE

## 1. Introduction

This paper presents updates against actions carried out since the last review and includes an update to the Health and Safety Annual Plan (Appendix A). Good progress is being made towards the development and implementation of the NHS Workplace Health and Safety Standards and these are on track toward a phase of auditing and monitoring. COVID compliance workplace checking continues in collaboration with IPC leads. In terms of personal safety for colleagues working in the community, there has been a strong focus upon making improvements, with action plans being developed and the formation of a Task and Finish Group.

## 2. CHFT Health & Safety Action Plan

Progress against the CHFT Health and Safety Annual Plan is identified in Appendix (A).

## 3. Quadriga Health & Safety Review Update

In 2019 Quadriga Ltd were appointed to carry out a review of the policies status, including aspects of governance arrangements in place. The review generated 15 recommendations and work has taken place to address each of them. See Appendix (B).

## 4. COVID-19 Compliance

The Trust has implemented measures to provide a secure environment for colleagues and patients. The Incident Management Team introduced a social distancing group, PPE group meeting and IPC Gold meetings. The output from these meetings have helped strengthen the Trust's Environmental Risk Assessment which is being updated and republished to all colleagues by the IPC team. Spot checking of conditions continue across the Trust to ensure standards remain in place, including occupancy levels, PPE wearing and social distancing.

## 5. Huddersfield Pharmacy Specials

Since the last update, good progress has been made in the development of policies, procedures, and risk assessments and action plans have been developed to track progress with regular update given to the SMT. Bi-monthly health and safety meetings take place with good representation by management and the operational teams.

## 6. The Health Informatics Service

At the start of 2022, bi-monthly health and safety meetings were formed with representation from management and non-management. Action plans have been developed and good progress is being made to demonstrate compliance.

## 7. Accident Preventative Initiatives

We have placed a focus upon the most common risk, which is sharps injuries and slips, trips and falls injuries that has led to the formation or integration of these matters into compliance meetings.

(a) Slips, Trips and Falls - A review has now taken place of the Management of Falls Policy that now takes account of floorplate conditions and work upon the development of new floorplate risk assessments has been completed in partnership with EQUANS, ISS and CHS Ltd. The result of this means a closer scrutiny and future review opportunities of the control measures, that includes entrance surface floor conditions, and the re-establishment of the building condition surveys by the Performance and Contracts Team. These remain a standing agenda at future meetings so that CHFT have good oversight of conditions and the risk of patient and non-patient falls is reduced so far as is reasonably practicable.

(b) Sharps Injuries – since the last update a group has been set-up to help monitor DATIX incidents and put in plans to manage the risk. The group includes representation from clinical and divisions and continues to function successfully. Action this year is taking place to provide more awareness to colleagues about sharps prevention injuries and there are plans to introduce extra training to junior doctors who are showing to be at greater risk of sharps related injuries when carrying out clinical procedures (reference DATIX incidents).

## 8. Community Division

Work has started to review and improve upon colleague's personal safety and wellbeing when working in the community and visiting patient's homes. This means that a new Task and Finish Group has been formed with representation from all services and these meetings continue with action plans being developed.

## 9. Control of Substances Hazardous to Health (COSHH) Group

A sub-group has been set-up to ensure the storage, handling and disposal of hazardous chemicals is correctly managed. This includes representation from all relevant stakeholders and the aim is to make improvements and re-establish legacy arrangements.

## 10. Air Monitoring of Clinical Areas

Following last year's successful project, Entonox environmental monitoring is planned to be repeated in 2022 by Peritus Ltd. These actions provide assurance to colleagues working in those departments, where this gas is often used, so that their own wellbeing is protected.

## 11. NHS Workplace Health and Safety Standards

The NHS Workplace Health and Safety standards were published to all NHS Trusts in 2013 and endorsed by the Health and Safety Executive (HSE), they provide simple and straightforward guidance to achieve compliance. Each is accompanied by guidance on how to meet the requirements of legislation. The objective is to have the Standards in place that can give firm assurance to colleagues, HSE and CHFT insurance underwriter. Good progress is being made towards achieving assurances in all areas of risk. Appendix C identifies the stages of development towards final implementation of the standards.

**Appendix A**

**Progress Against the CHFT Health and Safety Annual Plan**

| | | | Target for completion 2022yr | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Ref** | **Action** | **Progress** | **June** | **July** | **Aug** | **Sept** | **Oct** | **Nov** |
| 1.0 | A review of the CHFT Health and Safety Policy which includes a review of the roles, responsibilities, and arrangements across the organisation with a focus also upon developing a 'statement of intent' which highlights commitment for a safe environment by the CEO. | The revised policy is now displayed on the Intranet. The 1-page 'statement of intent' is now to be displayed on notice boards. Policy being updated with new CEO signature | X | | | | | |
| 2.0 | To produce a CHFT slips, trips, and falls policy which will place focus upon managing the risk of injuries by non-patient movement across the hospital and community hubs | A pragmatic decision has been agreed to review the existing clinical Falls Collaborative Policy by including non-clinical references into it. The revision has been shared with the Falls Collaborative Group Lead Person and they are adding updates. | X | | | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 3.0 | To develop the risk assessment process as a stand-alone document and to introduce a new risk assessment template | A re-think upon this based on achieving better oversight of completion oversight by the end user. An on-line risk assessment form to be designed which will have 100% central oversight/quality checked from the Head of Health and Safety, when completed by the end user. | X | | | | | |
| 4.0 | To review the staff incident report and change into a quarterly report, with reference to the top 3 staff causes of incidents (slips, trips and falls / moving and handling / sharps reduction | Each subject is now a standing agenda item at all H/S Committee Meetings | **Completed** | | | | | |

| | | | Target for completion 2022yr | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Ref** | **Action** | **Progress** | **June** | **July** | **Aug** | **Sept** | **Oct** | **Nov** |
| 5.0 | To support the PPE and Social Distancing Groups in the development of COVID secure measures | A revised environmental risk assessment has been produced and will be shared by IPC team. The social distancing notices on all entry doors are being refreshed to allow for 1m distancing in the non-clinical areas. | | x | | | | |
| 6.0 | To support the wellbeing of staff working from home and using a display screen, workstation set-up | On-line guidance has been produced and shared with all home-workers. The guidance is to help individuals reduce the risk of ergonomic related posture. Plans are in place to roll out the DSE assessment to home working colleagues. | | x | | | | |
| 7.0 | To collaborate with partner organisations which provide support services to ensure there is equal understanding of health and safety measures for staff and patients. | Attendance takes place at each of the partner health and safety meetings which allows for alignment of thinking and understanding on subject related matters. | **Completed** | | | | | |
| 8.0 | To help carry out COVID secure walkarounds so measures are in place to help protect staff and patients | Walkabouts continue monthly on the wards and community sites with engagement by IPC team. | **Completed** | | | | | |
| 9.0 | To review and reconvene the sharps reduction group, including a reset of the terms of reference | A sharps reduction injury group has now been set-up with meetings taking place to review DATIX incidents and actions | **Completed** | | | | | |

## Appendix B

## Quadriga Health and Safety Review

| | Action | Tasks | Target Date | Progress/Action to progress |
|---|---|---|---|---|
| 1 | **Review of Health and Safety Arrangements** | a. Assess and review health and safety governance arrangements between CHFT and CHS | N/A | **Complete**<br>Robust governance structures in place between CHFT and CHS. |
| | | b. Advertise and appoint Trust Health and Safety Manager | N/A | **Complete**<br>Richard Hill in post Sept 20. |
| | | c. Review Trust Health and Safety Policy to create clarity on roles and responsibility within CHFT (referencing relevant support from CHS) stating how competent support is provided at strategic level. | N/A | **Complete**<br>The policy has now been approved and uploaded to the Intranet policy pages |
| 2. | **Review of Risk Assessments** | a. Introduce Risk Assessment Policy / Protocol | June 2021 | **Completed**<br>The Group Risk Management Policy has been reviewed and is now a live document. The policy cross-references clearly to risk assessment process/protocols. |
| | | b. Review Risk Assessment scoring matrix | n/a | **Completed**<br>Scoring matrix to remain as is following discussions with Risk. This is because to alter the scoring matrix would interfere with the entire scoring matrix within the risk management policy, used by other departments. |
| | | c. Review effectiveness of Risk Assessment Training | N/A | **Ongoing**<br>A new risk assessment on-line training package has been developed. This allows for control and quality of the end assessment which is essential. The completion records can be held securely and easily made availble upon request by a 3rd party. We now have a full list of non-clinical lead persons upon which the training will be given. This will take place in April-June 2022. |

| | Action | Tasks | Target Date | Progress/Action to progress |
|---|---|---|---|---|
| 3 | **Develop Specific Risk Related policies** | a. Review and, where appropriate, create individual policies on specific risk areas namely: -<br><br>• Dangerous Substances and Explosive Atmosphere Regs (2002)<br>• Control of Noise at Work Regs (2005)<br>• Control of vibration at Works Regs (2005<br>• Control of Electromagnetic Fields at Work Regs (2006) | n/a | **Completed**<br>A position statement written by the Head of Health and Safety on rejection of the requirements.<br>**DSEAR** – equal measures already in place.<br><br>**Noise** – not applicable to current clinical and non-clinical activities<br><br>**Vibration** – tools used in theatre/plaster room no vibration risk<br><br>**Electromagnetic fields** – consultation with Fergus Dunn (IRS Ltd) = no risk within the Trust but could apply to CHS operations |
| 4 | **Ensure compliance with Construction (Design & Management) Regs 2015** | a) CHFT to clarify appointments in writing including the HTM roles and responsibilities and CDM 2015 appointments. | July 2021 | **Completed**<br>As required by the HTMs, the appointment of AEs have been made by the Designated Person (Gary Boothby), together with further appointments of DPs.<br><br>CHFT have appointed CHS, as required by the CDM Regulations for Planned & Reactive Maintenance, Minor & Small Works & Variations |
| | | b) HTM roles clearly defined in letters of appointment and acceptance letters at both CRH & HRI including respective AP structures | n/a | **Completed**<br>All HTM appointment letters / acceptance letters in order and available for audit. |
| | | c) CDM 2015 Principal Contractor and Principal De-signer appointments will be project specific on a case by case basis. Clearly defined in H&S construction phase plans for all such minor works | July 2021 | **Completed**<br>The arrangement for larger projects is included in the latest update of the SLA. Appointments to be made based on the individual roles and responsibilities carried out by CHS and designer and contractor parties (if required |

| | | | | |
|---|---|---|---|---|
| 5. | **Ensure compliance with the Fire Safety (Regulatory Reform) Order and supporting HTM 05** | a. Appoint Director with overall responsibility for Fire Safety | n/a | **Completed**<br>Jo Fawcus replaces Helen Barker as the AD |
| | | b. Review Fire Safety Service Level Agreement between CHFT and CHS. | n/a | **Completed**<br>CHS SLA with Fire Committee approved. |
| | | c. Review Trust Fire Policy ensuring clarity on roles, responsibilities, and arrangements with CHS and clarity on training requirements. | n/a | **Completed**<br>Fire Policy Agreed at Fire Committee |
| | | d. Develop 5-year Fire Strategy considering capital works / reconfiguration and compartmentation. | n/a | **Completed**<br>Fire Strategy Agreed |
| 6 | **Reduce the number of Needle-stick, Sharps and Splash incidents.** | a. Update Health & Safety Committee terms of reference incorporating the role and responsibility of Divisional Reps | n/a | **Completed**<br>TORS discussed at Oct H&S Committee and approved at Dec meeting. Lead sourced for this group |
| | | b. Measure the number of incidents on a quarterly basis. | n/a | **Completed**<br>Quarterly report provided which is aligned with Occ. Health data. Shared at H&S Committee |
| | | c. Develop and share innovative learning across Trust | n/a | **Complete**<br>Forms part of 6a; H&S Committee /Sharp Group Sub-Group TORs agreed and sent to new chair. |
| 7 | **Provide a robust COSHH management system Trust wide** | a. Carry out a review of current COSHH system within Trust recognizing: -<br>• Number of Super users<br>• Number of Staff Trained<br>• Up to date COSHH folders available<br>• Knowledge of colleagues in Divisions | July 2021 | **Ongoing**<br>A task and finish group has been set-up with regular meetings taking place in 2022. A third meeting is planned in April 2022, and it is hoped another 2 or 3 meetings more will be enough to fulfil the aim of achieving compliance, so by October 2022 the final meeting should take place |

| | | | | |
|---|---|---|---|---|
| 8 | **Monitor reporting of Slips, Trips & Falls** | a. Monitor the number of incidents on a quarterly basis. | n/a | **Completed**<br>Slips trips and falls (non-clinical) is now integrated into the Falls Collaborative Group as a standing agenda item with representation by the Head of Health and Safety. Data stats will continue to report into health and safety committee meeting |
| | | b. Encourage accurate reporting and learning via Datix | | **Completed**<br>Learning to be established from Sub-Group. Quarterly reports to be discussed at Trust Health and Safety Committee |
| 9 | **Review Health and Safety Training** | a. Monitoring mandatory 3 yearly training | November 2021 | **Ongoing**<br>The national skills framework has been studied and a paper produced, shared with the health and safety committee meeting February 2021. Next steps are work on the recommendations of that paper, which will take place later in 2021 as part of the NHS Workplace Health and Safety Standards implementation – this piece of work has been delayed due to COVID related pressures. The paper recommendations are still ready to be shared and a meeting has taking place with Nikki Hosty April 2022 and a draft version of the training material is now produced with an expectation to make this live in Q4, 2022. |
| | | b. Measure numbers of colleagues receiving risk assessment training | n/a | **Completed**<br>Paper shared with Oct H&S Committee.<br><br>As 2c |
| | | c. Reviewing effectiveness of risk assessment training | n/a | **Completed**<br>Paper shared with Oct H&S Committee. As 2c |
| 10 | **Wards / Departments to achieve Medical Devices training target** | a. Monitor and report medical device training statistics at health and safety committee | n/a | **Completed**<br>Regular reports feature at Health & Safety Committee |
| | | b. Escalate areas of concern to Audit & Risk Committee | n/a | **Completed**<br>SOAP template designed for escalation of Health and Safety Committee issues to Audit and Risk |

| | | | | |
|---|---|---|---|---|
| 11. | **CHS & CHFT Risk Registers** | a. Cross reference CHS and CHFT applicable risks | n/a | **Completed**<br>Agenda Item at Joint Liaison Committee and TORs |
| | | a. Ensure Joint Liaison Committee (CHS/CHFT) periodically review whether risk controls in place are considered acceptable and are working. | n/a | **Completed**<br>Risk controls reviewed and challenged at regular intervals |
| | | a. Where risks are registered as falling into the significant risk category on either CHS or CHFT register, and are reported to the JLC Committee, that the immediate actions being taken to mitigate the risk are also outlined in the same report. This should be supplemented by the planned timescale for implementation. | n/a | **Completed**<br>action plans considered at JLC. |
| 12. | **Improvement of reporting arrangements of RIDDORs incidents to HSE** | a. Review RIDDOR reporting arrangements for interfacing with the Health and Safety Executive and submitting reports under RIDDOR to the HSE | September 2021 | **Completed**<br>Awareness concerning the importance of RIDDOR reporting has been shared via the Intranet and a section added to the health and safety page to remind colleagues. |
| | | b. Monitor and report RIDDOR incident and trends at health and safety committee | n/a | **Completed**<br>RIDDOR incidents included in incident reporting |

**Appendix C**

**NHS Workplace Health and Safety Standards**

| Ref | Title | Lead Person | Review of Policy content | Development of Policy | Implementation of Policies |
|---|---|---|---|---|---|
| | | | **Jan-March 2021** | **June-December 2021** | **Jan-March 2021** |
| **1.0** | Incident Reporting Compliance | Lisa Cook | Completed | Completed | Completed |
| **2.0** | Occupational Health Compliance | Christine Bouckley | Completed | On-going | Ongoing |
| **3.0** | Slips, Trips and Falls Compliance | Abhijit Chakraborty | Completed | Completed | Carried forward to Q3, 2022yr |
| **4.0** | Radiology Compliance | Claire Gruszka | Completed | Completed | Completed |
| **5.0** | Musculoskeletal Disorders, Moving and Handling Compliance | Mandy Tanyan | Completed | Completed | Completed |
| **6.0** | Electrical Profiling Beds Compliance | Rob Ross | Completed | Completed | Completed |
| **7.0** | Violence and Aggression/Challenging Behaviour | Ian Kilroy | Carried forward to Q4, 2022yr | Carried forward to Q4, 2022yr | Carried forward to Q4, 2022yr |
| **9.0** | Management of Work-Related Stress Compliance | Nicola Hosty | Carried forward to Q4, 2022yr | Carried forward to Q4, 2022yr | Carried forward to Q4, 2022yr |

| Ref | Title | Lead Person | Review of Policy content | Development of Policy | Implementation of Policies |
|---|---|---|---|---|---|
| | | | **Jan-March 2021** | **June-December 2021** | **Jan-March 2021** |
| **10.0** | Management of Bullying & Harassment Prevention Compliance | TBC | Carried forward to Q4, 2022yr | Carried forward to Q4, 2022yr | Carried forward to Q4, 2022yr |
| **11.0** | Hazardous Substances Compliance | TBC | Sub-group established in February 2022 and working through the key areas of compliance. Policy to be finalised circa November 2022 | Sub-group established in February 2022 and working through the key areas of compliance. Policy to be finalised circa November 2022 | Carried forward to Q4, 2022yr |
| **12.0** | Management of Sharps Compliance (Prevention and Management of Clinical Injuries and Exposure to Blood and High-Risk Body Fluids Policy) | Gill Manojlovic | Completed | Completed | Completed |
| **13.0** | Work Equipment Compliance | Rob Ross | Completed | Completed | Completed |
| **14.0** | Display Screen Equipment Compliance | Diane Marshal | Completed | Policy reviewed in February 2022 | Carried forward to Q4, 2022 until a review of home working numbers is confirmed |
| **15.0** | Legionella Compliance | Ian Rawson | Completed | Completed | Completed |

| | | | | | |
|---|---|---|---|---|---|
| **16.0** | Asbestos Compliance | Ian Rawson | Completed | Completed | Completed |
| **17.0** | Room Temperature Conditions Compliance | Ian Rawson | Planned | Requirements to be considered by AE and the Water and Air Quality Group | Carried forward to Q3, 2022 |
| **18.0** | Transport Compliance | Andrew Mould | Completed | Completed | Completed |
| **19.0** | Electricity Compliance | Ian Rawson | Completed | Completed | Completed |
| **23.0** | Competency | Richard Hill | Completed | No specific policy required because after more scrutiny this subject is embedded in the key policies which are reviewed/being reviewed | No specific policy required because after more scrutiny this subject is embedded in the key policies which are reviewed/being reviewed |
| **24.0** | Risk Profiling Assessment | Richard Hill | Completed | No specific policy required because after more scrutiny this subject is embedded in the key policies which are reviewed/being reviewed | No specific policy required because after more scrutiny this subject is embedded in the key policies which are reviewed/being reviewed |

| | | | | | |
|---|---|---|---|---|---|
| **25.0** | Measuring Compliance Performance | Richard Hill | Completed | No specific policy required because after more scrutiny this subject is embedded in the key policies which are reviewed/being reviewed | No specific policy required because after more scrutiny this subject is embedded in the key policies which are reviewed/being reviewed |
| **26.0** | Lessons Learnt | Richard Hill | Completed | No specific policy required because after more scrutiny this subject is embedded in the key policies which are reviewed/being reviewed | No specific policy required because after more scrutiny this subject is embedded in the key policies which are reviewed/being reviewed |
| **27.0** | Policy Planning | Richard Hill | Completed | No specific policy required because after more scrutiny this subject is embedded in the key policies which are reviewed/being reviewed | No specific policy required because after more scrutiny this subject is embedded in the key policies which are reviewed/being reviewed |
| **28.0** | Roles and Responsibilities | Richard Hill | Completed | No specific policy required because after more scrutiny this subject is embedded in the key policies which are reviewed/being reviewed | No specific policy required because after more scrutiny this subject is embedded in the key policies which are reviewed/being reviewed |

| | | | | | |
|---|---|---|---|---|---|
| **29.0** | Cooperation and Communication | Richard Hill | Completed | No specific policy required because after more scrutiny this subject is embedded in the key policies which are reviewed/being reviewed | No specific policy required because after more scrutiny this subject is embedded in the key policies which are reviewed/being reviewed |
| **30.0** | First Aid | Richard Hill | Completed | Policy development delayed until extra first aid emergency training has been delivered. The review will take place in May 2022 | Policy development delayed until extra first aid emergency training has been delivered. The revised policy will be shared at the health and safety committee, May 2022 |

NHS
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NHS Foundation Trust

# Health and Safety Update

## Board of Directors

## 5 May 2022

One Culture of care

compassionate care

# Key Activities over next 5 years

| Ref | Priorities | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|
| 1 | Development and Implementation of the NHS Workplace Health and Safety Standards across all departments which include reference to risk assessment review. Outcome is a reliable and measurable management systems in place, providing a safe environment for everyone. Update: Good progress being made on the development of these across each relevant department/area | x | x | x | | |
| 2 | COVID-19 Compliance Review and Monitoring Standards. Outcome = a safe environment for everyone entering and using CHFT services. Update: Covid compliance random checks of wards and community hubs continue and findings shared with IPC | x | x | x | x | x |
| 3 | Community Division Compliance Project Improvement Plan and Collaborative Working with subject matter experts. Outcome is safer environment and stronger oversight of standards for colleagues and service users. Update: community compliance set-up, reference prevention and management of violence and aggression | x | x | | | |
| 4 | Accident Reduction Planning/Initiatives. Outcome is a firmer grip and ability to identify upward trends and early intervention. Update: sharps management group, collaboration taking place with EQUANS/ISS/CHS Ltd reference floorplate conditions. | x | x | x | x | x |
| 5 | Developing Health and Safety Training and Collaborative Working with Training Lead. Outcome is an improvement in the content quality which is relevant to CHFT. Update: Update: gap-analysis completed and new material produced | x | x | | | |
| 6 | Collaborative working with CHS Ltd and ENGIE/ISS Ltd on building compliance matters, including floorplate safety. Outcome is direct oversight of the compliance data produced by our partners, including risk assessments and inspections. Update: relaunch of floor inspections started and new floorplate risk assessments completed | x | x | | | |
| 7 | Networking across NHS Trusts to benchmark and share best practice . Outcome is to learn from the experiences of other Trusts and use that knowledge to help develop and improve within CHFT Update:: Membership and attendance at the NHS 3 monthly networking meetings continues with 48 other NHS members | | x | | | |
| 8 | RIDDOR reporting awareness campaigns. Outcome is to develop the culture of reporting so that the Board has as a true picture and reduction plans can be developed and mobilised. Update: Plans are in place for May/June 2022 to relaunch awareness upon RIDDOR reporting requirements with a target audience of Band 7/8's. This follows last years awareness piece that was shared Trust-wide | x | x | x | | x |
| 9 | Engagement with the reconfiguration building plan meetings for CRH and HRI. Outcome is to monitor risk and provide relevant input when necessary. Update: Meeting invitations reserved for the future planned meetings | x | x | x | x | x |

# Health and Safety Update

NHS
Calderdale and Huddersfield
NHS Foundation Trust

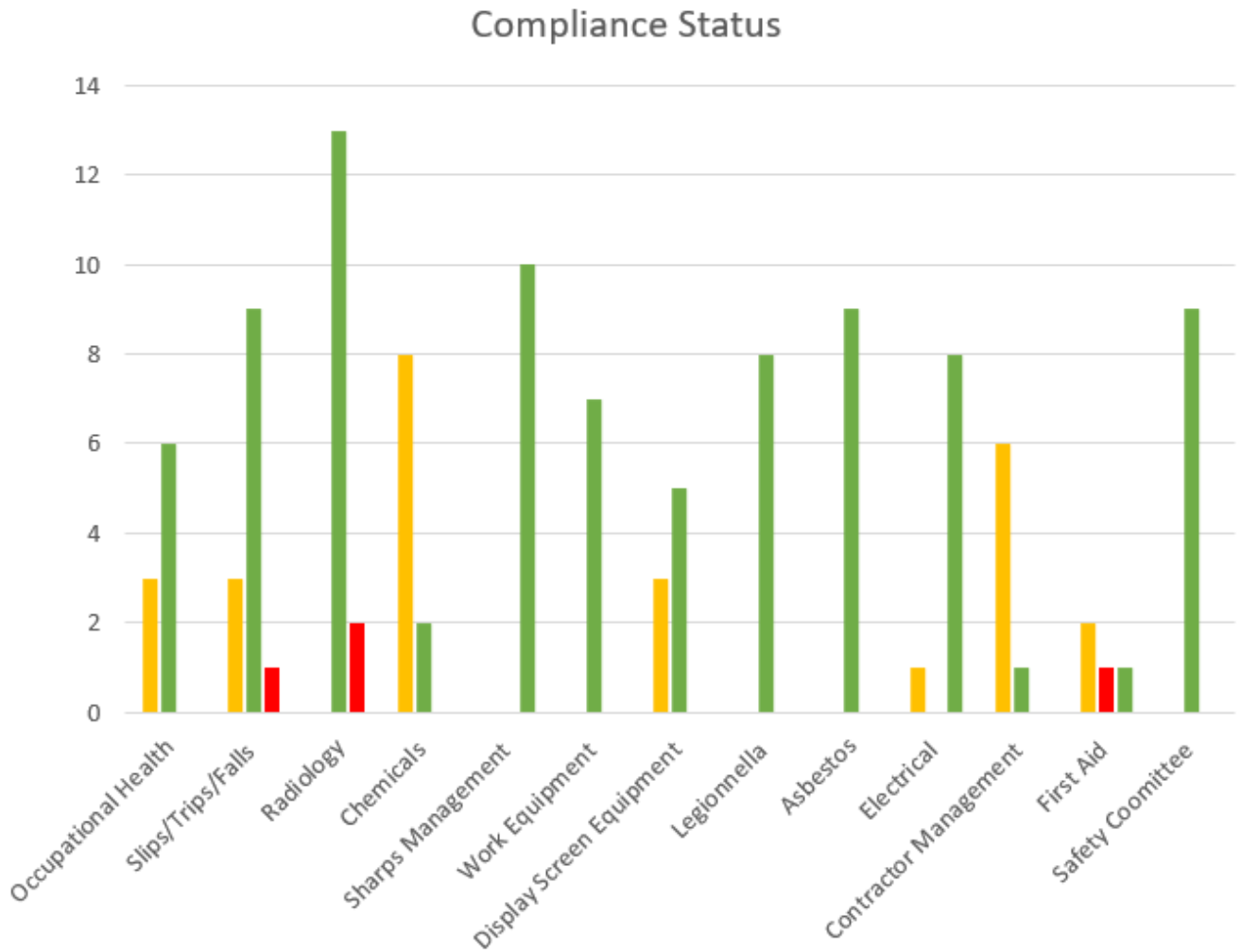
1. NHS Workplace Health and Safety Standards
2. Community Division Update
3. Accident Reduction Initiative
4. Incident reporting  improvements (RIDDOR's)
5. Improving the learning content within ESR

# Implementation of the NHS Workplace Health and Safety Standards

Calderdale and Huddersfield NHS Foundation Trust

A recent review has taken place of the evidence in place regarding the prevention and management of violence and aggression and action plans have been developed to make improvements.

The aim is to achieve GREEN and start the process of periodic auditing and the production of dashboards for SMT's.




One Culture of care

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# Community Division #[1]

Calderdale and Huddersfield NHS Foundation Trust

A Task and Finish Group has been set-up **to make changes to the arrangements in place concerning personal safety** for front-line colleagues who are working directly within the community.

- Phlebotomy
- Community Nursing Team (District Nursing, Community Matrons, Quest)
- Specialist Teams ( incorporating Cardiac Rehabilitation Team)
- Heart failure Specialist Team
- Pulmonary Rehabilitation Team
- Lymphedema Team
- Bladder and Bowel Team
- TB Team
- Specialist Palliative Care Team
- Parkinson Team)
- Urgent Care Response/Crisis Team
- Community Rehabilitation Team
- Stroke Early Supported Discharge Team
- Intermediate Care Beds
- Podiatry Team
- Children Therapy Team

# Community Division #2



**Ligature Prevention Risk Reduction**.

- **440 colleagues** have been given ligature prevention  training across each hospital in the high risk areas.
- Plans are in place to repeat the above for the bases in the community, where there is patient waiting areas and ligature release kits are being supplied for trained staff members.

# Community Division #3



## COVID Assurance Audits

1. Room occupancy door notices displayed on every door.
2. Touch-point cleaning records are up to date.
3. Hand-gels provided and face mask wearing is in place.
4. The seating for patients is configured to be socially distance.

| Audit Number | COVID Compliance |
|---|---|
| 1 | 100% |
| 2 | 75% |
| 3 | 80% |

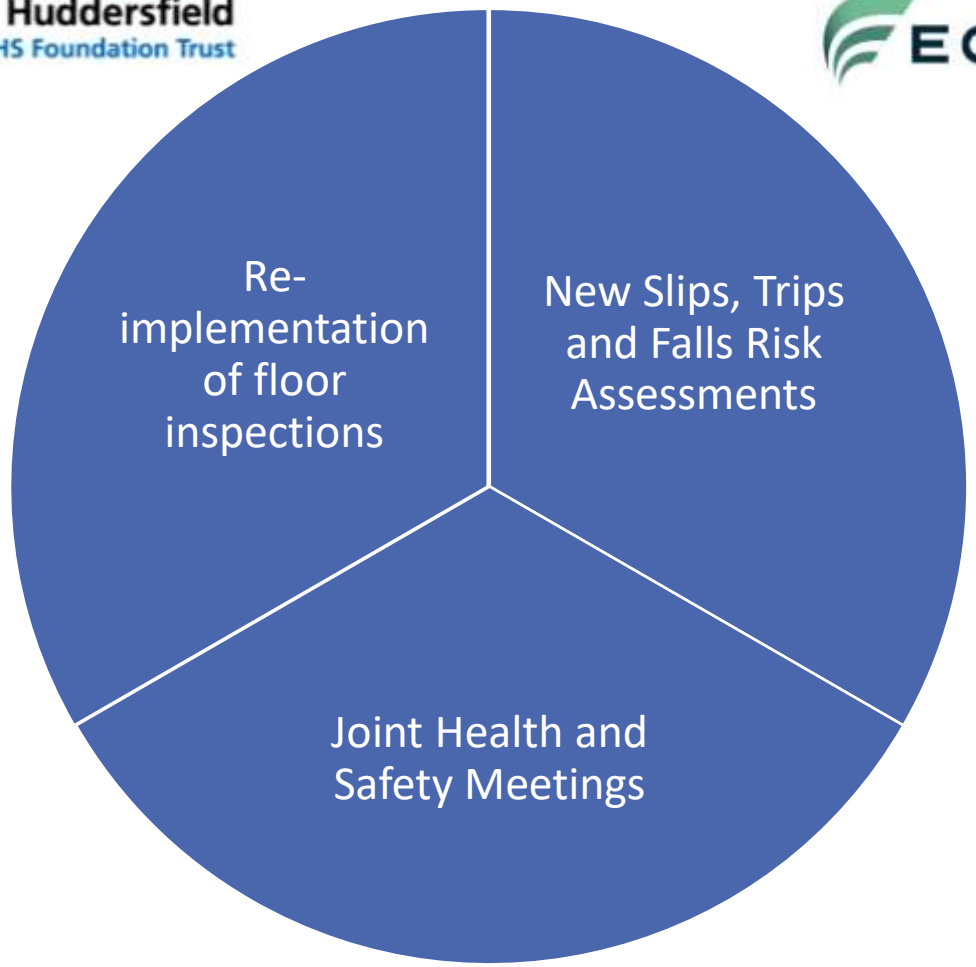
# Accident Reduction Initiatives



- A **sharps management  sub-group** has been developed to help reduce the number of sharps injuries.
- **Awareness posters have been developed** and shared in 2021yr in targeted areas  Plans are in place to repeat this in 2022yr
- Plans to provide **extra training to junior doctors** to reduce sharps injuries amongst this group is planned for 2022yr.
- The sharps group continues to meet every 3 months in order to monitor the DATIX results and agree any next steps, when needed.

# Floor safety conditions

Collaborative work has been taking place with a **new slips, trips and falls risk assessment** and improvements in the related policy

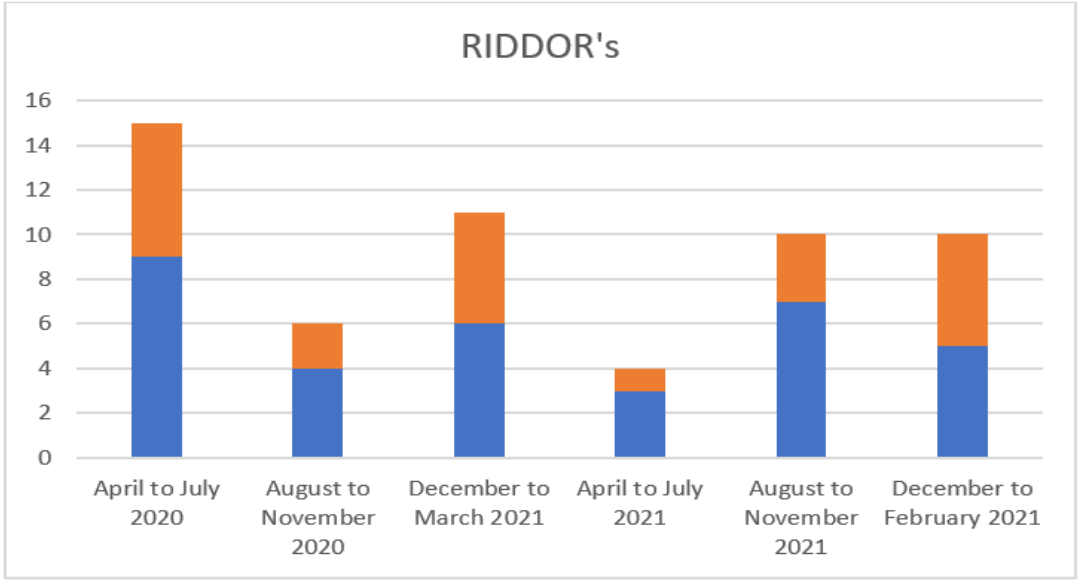


# Reporting of Accidents (RIDDOR's)



- An awareness piece had been written and shared last year on the intranet about the importance of reporting accidents. There are plans to repeat this, but to focus Bands 7/8's who hold responsibility for reporting.

- The aim is to avoid future incorrect reporting.

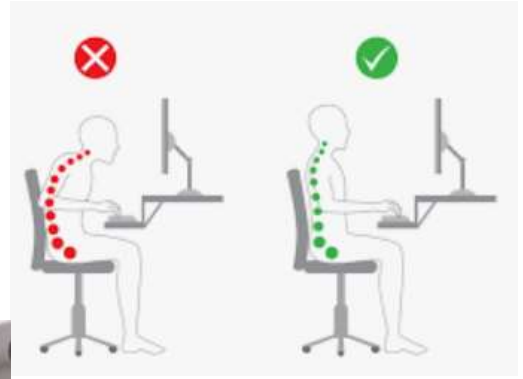


# Improving the health and safety training content for learners

Calderdale and Huddersfield NHS Foundation Trust

A **gap analysis** of health and safety training has been completed and work has been completed to  strengthen the learning material related to:

1. safe handling of hazardous handling of chemicals
2. ergonomic comfort in front of the computer screens
3. accident reporting improvements.



# 19. CHFT Response to the Ockenden Review

To Note

Presented by Ellen Armistead

| | |
|---|---|
| **Date of Meeting:** | Thursday 5 May 2022 |
| **Meeting:** | Public Board of Directors |
| **Title of report:** | Findings, Conclusions and Essential Actions from the Independent Review of Maternity Services at Shrewsbury and Telford NHS Trust – Overview Report |
| **Author:** | Karen Spencer, outgoing Head of Midwifery, Diane Tinker Interim Head of Midwifery |
| **Sponsor:** | Ellen Armistead, Executive Director of Nursing, Deputy Chief Exec, Board Maternity Safety Champion |
| **Previous Forums:** | None |

**Purpose of the Report**

- To provide an overview of the final report into the independent review of maternity services at Shrewsbury and Telford NHS Trust (the Ockenden report).
- To provide WEB with the maternity services self- assessment against the 15 Immediate and Essential Actions within the report.
- To provide WEB with a recommendation taking into account the current staffing position regarding the continuance of Midwifery Continuity of Carer (MCoC) in response to the letter to all Trusts of the 1st April.

**Key Points to Note**

- The final Ockenden report builds upon upon the first report in that all the Immediate and Essential Actions within that report remain important and must be progressed; the second report has identified a number of new themes which have translated into a number of immediate and essential actions for Trusts.
- The investigation team heard evidence from 1486 families throughout their review of services. Families who wanted to understand what had happened during their care but also wanted the system to learn.
- The team considered all aspects of clinical care in maternity services including antenatal (pre-birth), intrapartum (care during labour and birth) and postnatal (care following birth), obstetric anaesthesia and neonatal care.
- The investigation team identified thematic patterns in the quality of care and investigation procedures carried out by the Trust, and identified where opportunities for learning and improving the quality of care have been missed.
- 3 avoidable baby deaths, 12 maternal deaths and 498 cases of stillborn babies were reviewed. In these cases the review concluded that if guidance had been followed and cases managed differently the outcome may have been different.
- The review team found failures in governance and leadership, failure to follow national guidelines, failure to escalate and work collaboratively across disciplines.
- In terms of clinical governance investigatory processes were not followed, and were not to a standard that would have been expected at the time. Reviews were not multidisciplinary and maternity governance teams down graded serious incidents to local investigations to avoid external scrutiny.
- The Trust Board did not have oversight or a full understanding of the issues and concerns within the maternity service, and there was a lack of oversight by the Trust Board when investigations took place.
- On the 1st April Trusts received instruction to immediately assess the midwifery staffing position and make a decision about the continuation or suspension of MCoC. This paper provides a recommendation to WEB.

| **EQIA – Equality Impact Assessment** |
| --- |
| There is significant evidence which demonstrates that the experiences and outcomes of mothers and babies from BAME groups and those from the areas of highest levels of deprivation are more likely to be poor.<br><br>Maternity services have an active Health Inequalities work stream to drive improvement work for those most at risk. CHFT's midwifery reader has produced a cultural survey that has been shared with staff to understand knowledge gaps ahead of developing training opportunities for midwives and obstetricians. |
| **Recommendation** |
| The Board of Directors is asked to **NOTE** the contents of this paper. |

Findings, Conclusions and Essential Actions from the Independent Review of Maternity Services at Shrewsbury and Telford NHS Trust – Overview Report

## Introduction

On the 30th March 2022, the Secretary of State for Health and Social Care published Dame Donna Ockenden's final report from the independent review of maternity services at Shrewsbury and Telford Hospital NHS Trust. This second report builds upon the first report in that all the Immediate and Essential Actions within that report remain important and must be progressed; the second report has identified a number of new themes which have translated into a number of immediate and essential actions for Trusts.

The investigation team heard evidence from 1486 families throughout their review of services. Families who wanted to understand what had happened during their care but also wanted the system to learn from what had happened at Shrewsbury and Telford.

The investigation team interviewed 60 current and former members of staff to gain their opinion on the services they worked within and 84 staff completed a questionnaire for the review.

The team considered all aspects of clinical care in maternity services including antenatal (pre-birth), intrapartum (care during labour and birth) and postnatal (care following birth), obstetric anaesthesia and neonatal care.

## Report Overview

Throughout the review of 1486 families' care the investigation team identified thematic patterns in the quality of care and investigation procedures carried out by the Trust, and identified where opportunities for learning and improving the quality of care have been missed.

In the 9 months preceding the avoidable death of Kate Stanton- Davies (whose parents instigated the independent review) the review team identified two further babies who had died in similar circumstances. The review found evidence of poor investigation of these cases and a lack of transparency with families which resulted in missed opportunities for learning and lost opportunities to prevent further baby deaths.

12 maternal deaths were considered by the review team. They concluded that none of the mothers received care in line with best practice at the time. Only 1 maternal death was investigated by external clinicians and the internal investigations were rated as poor. The investigations did not recognise system and service wide failings to follow appropriate procedures and guidance.

498 cases of stillborn babies were reviewed and graded. One in four cases were found to have significant or major concerns which if managed appropriately might or would have resulted in a different outcome.

The review team found failures in governance and leadership, failure to follow national guidelines, failure to escalate and work collaboratively across disciplines. The report describes a culture of “them and us” between midwives and obstetricians leading to a fear amongst midwives to escalate concerns to obstetricians, which led to a lack of psychological safety in the workplace and an inability to make positive change.

In terms of clinical governance investigatory processes were not followed, and were not to a standard that would have been expected at the time. Reviews were not multidisciplinary and maternity governance teams down graded serious incidents to local investigations to avoid external scrutiny.

The review found that the Trust board did not have oversight or a full understanding of the issues and concerns within the maternity service, and there was a lack of oversight by the Trust board when investigations took place.

Immediate and Essential Actions

The review team have identified the following 15 Immediate and Essential Actions which they recommend should be considered by all Trusts providing maternity care.

- Workforce Planning and Sustainability
- Safe Staffing
- Escalation and Accountability
- Clinical Governance and Leadership
- Clinical Governance and Leadership – Incident Investigation and Complaints
- Learning from Maternal Deaths
- Multi-Disciplinary Training
- Complex Antenatal Care
- Pre-term Birth
- Labour and Birth
- Obstetric Anaesthesia
- Postnatal Care
- Bereavement Care
- Neonatal Care
- Supporting Families

Maternity Services have undertaken a self-assessment against all the immediate and essential actions. The service has taken the learning from the submission requirements for the 7 Immediate and Essential Actions of the first Ockenden report and ensured that the self-assessment against the 15 IEA’s within the final report has included that there is assurance that we can provide evidence that we are either fully or partially compliant with each element of the IEA. (Appendix 1).

Midwifery Continuity of Carer (MCoC)

On the 1st April 2022, Trusts received a letter from the NHS Chief Executive, Chief Nursing Officer and National Medical Director in response to the publication of Dame Donna Ockenden's review.

The letter made particular reference to the Trusts submissions of their MCoC plans; in line with the national maternity transformation programme; by the 15th June, which must take now take account of the requirement within immediate essential action (IEA) 2 Safe staffing: *"All trusts must review and suspend if necessary, the existing provision and further roll out of Midwifery Continuity of Carer (MCoC) unless they can demonstrate staffing meets safe minimum requirements on all shifts."*

The letter asks trusts to immediately assess their staffing position and make one of the following recommendations:

- Trusts that can demonstrate staffing meets safe minimum requirements can continue existing MCoC provision and continue to roll out
- Trusts that cannot meet safe minimum staffing requirements for further roll out of MCoC, but can meet safe minimum staffing requirements for existing MCoC provision should cease further roll out and continue to support at the current level of provision or only provide services to existing women on MCoC pathways and suspend new women being booked into MCoC provision
- Trusts that cannot meet safe minimum staffing requirements for further roll out of MCoC and for existing MCoC provision should immediately suspend existing MCoC provision and transfer them to alternative maternity pathways of care.

CHFT maternity currently has 4 COC teams who each month book approximately 25% of all women onto a COC pathway and 50% of all BAME women. The Community Midwifery Matron and the midwives within the teams have worked hard since 2020 to maintain the current position, however due to vacancy levels and staff unavailability both in the COC teams and across maternity services it is becoming increasingly difficult to maintain this position and maintain safe maternity services for all women.

The maternity service is currently working through an options appraisal to inform a recommendation for Board to consider the most appropriate actions for CHFT in terms of Midwifery Continuity of Carer.

**Ockenden 2 Report Recommendations April 22 - RAG rated self assessment**

| 1. WORKFORCE PLANNING AND SUSTAINABILITY | | RAG RATING | COMMENTS |
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| Essential action - financing a safe maternity workforce<br><br>The recommendations from the Health and Social Care Committee Report. The safety of maternity services in England must be implemented. | • The investment announced following our first report was welcomed. However to fund maternity and neonatal services appropriately requires a multi-year settlement to ensure the workforce is enabled to deliver consistently safe maternity and neonatal care across England. | | The Local Maternity System (LMS) have provided us with the information re Ockenden funding for next year a fair shares approach has been taken across the system |
| | • Minimum staffing levels should be those agreed nationally, or where there are no agreed national levels, staffing levels should be locally agreed with the LMNS. This must encompass the increased acuity and complexity of women, vulnerable families, and additional mandatory training to ensure trusts are able to safety meet organisational CNST and CQC requirements. | | |
| | • Minimum staffing levels must include a locally calculated uplift, representative of the three previous years' data, for all absences including sickness, mandatory training, annual leave and maternity leave. | | |
| | • The feasibility and accuracy of the BirthRate Plus tool and associated methodology must be reviewed nationally by all bodies. These bodies must include as a minimum NHSE, RCOG, RCM, RCPCH. | | |
| Essential action – training<br><br>We state that the Health and Social Care Select Committee view that a proportion of maternity budgets must be ring-fenced for training in every maternity unit should be implemented. | • All trusts must implement a robust preceptorship programme for newly qualified midwives (NQM), which supports supernumerary status during their orientation period and protected learning time for professional development as per the RCM (2017) position statement for this. | | We have a robust preceptorship programme both trust wide and local. NQMW's receive 4 weeks supernumerary status within this is protected time for learning and they are all assigned a preceptor. |
| | • All newly Qualified Midwives must remain within the hospital setting for a minimum period of one year post qualification. This timeframe will ensure there is an opportunity to develop essential skills and competencies on which to advance their clinical practice, enhance | | Currently rostered to all areas awaiting further regional guidance |

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| | professional confidence and resilience and provide a structured period of transition from student to accountable midwife. | | |
| | • All trusts must ensure all midwives responsible for coordinating labour ward attend a fully funded and nationally recognised labour ward coordinator education module, which supports advanced decision-making, learning through training in human factors, situational awareness and psychological safety, to tackle behaviours in the workforce. | | No nationally recognised education module |
| | • All trusts to ensure newly appointed labour ward coordinators receive an orientation package which reflects their individual needs. This must encompass opportunities to be released from clinical practice to focus on their personal and professional development. | | No current orientation package – development in progress |
| | • All trusts must develop a core team of senior midwives who are trained in the provision of high dependency maternity care. The core team should be large enough to ensure there is at least one High Dependency Unit (HDU) trained midwife on each shift, 24/7. | | MAIMS training offered. Need to review which midwives have undertaken training and ensure LDRP (labour ward) staff prioritised moving forwards |
| | • All trusts must develop a strategy to support a succession-planning programme for the maternity workforce to develop potential future leaders and senior managers. This must include a gap analysis of all leadership and management roles to ensure those held by specialist midwives and obstetric consultants. This must include supportive organisational processes and relevant practical work experience. | | Succession planning trust wide documents in Cupboard<br><br>Need to undertake gap analysis |
| | • The review team acknowledges the progress around the creation of Maternal Medicine Networks nationally, which will enhance the care and safety of complex pregnancies. To address the shortfall of maternal medicine physicians, a sustainable training programme across the country must be established, to ensure the appropriate workforce long term. | | Ongoing regional work that is being undertaken through the LMS with Leeds as the lead provider |
| **2. SAFE STAFFING** | | | **COMMENTS** |

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| Essential action<br><br>All trusts must maintain a clear escalation and mitigation policy where maternity staffing falls below the minimum staffing levels for all health professionals. | • When agreed staffing levels across maternity services are not achieved on a day-to-day basis this should be escalated to the services' senior management team, obstetric leads, the chief nurse, medical director, and patient safety champion and LMS. | | Maternity bleep holder each shift to oversee staffing Maternity staffing discussed at twice daily safe staffing meeting and would be added to the Matron daily report if appropriate. Obstetric and Maternity staffing flows through Trust tactical command (5 meeting per day). Daily LDRP safety briefing. Daily escalation report to LMS,<br><br>Obstetric leads/ chief nurse. / Medical director etc not informed directly on a daily basis However midwifery staffing is included in maternity report to Quality Committee. Obstetric staffing to be also included |
| | • In trusts with no separate consultant rotas for obstetrics and gynaecology there must be a risk assessment and escalation protocol for periods of competing workload. This must be agreed at board level. | | Need to undertake risk assessment and review split obstetric and Gynae rotas, cost and how this would reduce risk. Escalation protocol to be reviewed |
| | • All trusts must ensure the labour ward coordinator role is recognised as a specialist job role with an accompanying job description and person specification. | | Specific LDRP Coordinator job description |
| | • All trusts must review and suspend if necessary the existing provision and further roll out of Maternity Continuity of Carer (MCoC) unless they can demonstrate staffing meets safe minimum requirements on all shifts. This will preserve the safety of all pregnant women and families, which is currently compromised by the unprecedented pressures that MCoC models place on maternity services already under significant strain. | | Paper developed awaiting trust response |
| | • The reinstatement of MCoC should be withheld until robust evidence is available to support its reintroduction. | | As above |
| | • The required additional time for maternity training for consultants and locally employed doctors must be provided in job plans. The protected time required will be in addition to that required for generic trust mandatory training and | | Job plans compliant and include both CTG and prompt lead, this is included in Job plans. However additional time for role specific and essential safety training is not currently added |

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| | reviewed as training requirements change. | | to job plans for Doctors not in a training post |
| | • All trusts must ensure there are visible, supernumerary clinical skills facilitators to support midwives in clinical practice across all settings. | | 2 band 6 midwives recruited as part of central funding of £50k. this is likely to be approved for the year 22/23 |
| | • Newly appointed Band 7/8 midwives must be allocated a named and experienced mentor to support their transition into leadership and management roles. | | This is something that is done on a more add hoc manner, need a formal process. |
| | • All trusts must develop strategies to maintain bi-directional robust pathways between midwifery staff in the community setting and those based in the hospital setting, to ensure high quality care and communication. | | End to end maternity record, polices and guidelines span all areas, out of criteria pathway for women. |
| | • All trusts should follow the latest RCOG guidance on management of locums. The RCOG encourages the use of internal locums and has developed practical guidance with NHS England on the management of locums. This includes support for locums and ensuring they comply with recommended processes such as pre-employment checks and appropriate induction. | | The RCOG guidance will be reviewed and a bench marking process undertaken. The service tends not to use many external locums and use internal locums in the main. If using an external locum they tend to be one of 3 who work for us on a regular basis |
| **3. ESCALATION AND ACCOUNTABILITY** | | | **COMMENTS** |
| Essential action<br><br>Staff must be able to escalate concerns if necessary.<br><br>There must be clear processes for ensuring that obstetric units are staffed by appropriately trained staff at all times.<br><br>If not resident there must be clear guidelines for when a consultant obstetrician should attend. | • All trusts must develop and maintain a conflict of clinical opinion policy to support staff members in being able to escalate their clinical concerns regarding a woman's care in case of disagreement between healthcare professionals. | | Trust wide action |
| | • When a middle grade or trainee obstetrician (non-consultant) is managing the maternity service without direct consultant presence trusts must have an assurance mechanism to ensure the middle grade or trainee is competence for this role. | | Trainees are not able to go onto nights without things signed off in their logbook. We have two trainees on each night one for Gynae and one for obs with the plan to pair up with a senior and a junior. We do have a significant bank doctors who we have worked with previously. On the occasion we use an agency doctor college tutor and Clinical Director check CV . No current formal guidance in place |
| | • Trusts should aim to increase resident consultant obstetrician presence where this is achievable. | | We currently have a consultant resident 08.00- 21.00 Mon-Fri, 8.30 -18.00 Sat/ Sun BH |
| | • There must be clear local guidelines for when consultant | | Duties of the Hot Week Consultant SOP |

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| | obstetricians' attendance is mandatory within the unit. | | |
| | • There must be clear local guidelines detailing when the consultant obstetrician and the midwifery manager on-call should be informed of activity within the unit. | | Region wide escalation policy |

| 4. CLINICAL GOVERNANCE LEADERSHIP | | | COMMENTS |
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| Essential action<br><br>Trust boards must have oversight of the quality and performance of their maternity services.<br><br>In all maternity services the Director of Midwifery and Clinical Director for obstetrics must be jointly operationally responsible and accountable for the maternity governance systems. | • Trust boards must work together with maternity departments to develop regular progress and exception reports, assurance reviews and regularly review the progress of any maternity improvement and transformation plans. | | Current position monthly maternity report to Quality Committee. Maternity report added to bi monthly Board report.<br>Monthly Perinatal Quality Surveillance meetings with Board Safety Champions |
| | • All maternity service senior leadership teams must use appreciative inquiry to complete the National Maternity Self-Assessment Tool if not previously done. A comprehensive report of their self-assessment including governance structures and any remedial plans must be shared with their trust board. | | Self-assessment ongoing but then needs to be presented to Division and Board |
| | • Every trust must ensure they have a patient safety specialist, specifically dedicated to maternity services. | | Trust action |
| | • All clinicians with responsibility for maternity governance must be given sufficient time in their job plans to be able to engage effectively with their management responsibilities. | | Hours allocated in job plans/specific job description |
| | • All trusts must ensure that those individuals leading maternity governance teams are trained in human factors, causal analysis and family engagement. | | Human Factors included in PROMPT,<br>No training in family engagement, maternity patient safety quality lead undertaken baby Lifeline Investigation training. |
| | • All maternity services must ensure there are midwifery and obstetric co-leads for developing guidelines. The midwife co-lead must be of a senior level, such as a consultant midwife, who can drive the guideline agenda and have links with audit and research. | | Obstetrics lead for Guideline is the safety champion. One of the Maternity governance team leads on guidelines with a monthly guideline group in place that feeds into Maternity forum Consultant audit lead in place |
| | • All maternity services must ensure they have midwifery and obstetric co-leads for audits. | | Obstetric Audit lead<br>No co-leads for all audit |

| 5. CLINICAL GOVERNANCE – INCIDENT INVESTIGATION AND COMPLAINTS | | | COMMENTS |
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| Essential action<br><br>Incident investigations must be meaningful for families and staff and lessons must be learned and implemented in practice in a timely manner. | • All maternity governance teams must ensure the language used in investigation reports is easy to understand for families, for example ensuring any medical terms are explained in lay terms. | | All complaints and investigation reports reviewed through trust processes. Divisional sign off for maternity complaints is the HOM. Incidents signed off at Orange Panel – HOM sits at Panel. |
| | • Lessons from clinical incidents must inform delivery of the local multidisciplinary training plan. | | Not consistently, but we do send a weekly brief to all staff and lessons learn across the trust through Patient Safety Quality Board (PSQB) |
| | • Actions arising from a serious incident investigation which involve a change in practice must be audited to ensure a change in practice has occurred. | | Action plan produced and actions completed managed through Datix.<br>Any changes not currently audited |
| | • Change in practice arising from and SI investigation must be seen within 6 months after the incident occurred. | | Action plan produced and actions completed managed through Datix.<br>Any changes not currently audited |
| | • All trusts must ensure that complaints which meet SI threshold must be investigated as such. | | Complaints graded red are reviewed against recorded incidents and senior decision to manage as complaint/ incident. Check trust policy. |
| | • All maternity services must involve service users (ideally via their MVP – Maternity Voices Partnership) in developing complaints response processes that are caring and transparent. | | All trust complaints managed through wider trust processes. |
| | • Complaints themes and trends must be monitored by the maternity governance team. | | Need to ensure this happens and is reported through forum/Directorate and key themes to PSQB |
| **6. LEARNING FROM MATERNAL DEATHS** | | | **COMMENTS** |
| Essential action<br><br>Nationally all maternal post-mortem examinations must be conducted by a pathologist who is an expert in maternity | • NHS England and Improvement must work together with the Royal Colleges and the Chief Coroner for England and Wales to ensure that this is provided in any case of a maternal death. | | Awaiting confirmation of this from a national perspective |
| | • This joint review panel/investigation must have an | | Awaiting confirmation of this from a national |

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| physiology and pregnancy related pathologies.<br><br>In the case of a maternal death a joint review panel/investigation of all services involved in the care must include representation from all applicable hospitals/clinical settings. | independent chair, must be aligned with local and regional staff and seek external clinical expert opinion where required. | | perspective |
| | • Learning from this review must be introduced into clinical practice within 6 months of the completion of the panel. The learning must also be shared across the LMS. | | Awaiting confirmation of this from a national perspective |
| **7. MULTIDISCIPLINARY TRAINING** | | **RAG RATING** | **COMMENTS** |
| Essential action<br><br>Staff who work together must train together.<br><br>Staff should attend regular mandatory training and rotas. Job planning needs to ensure all staff can attend.<br><br>Clinicians must not work on labour ward without appropriate regular CTG training and emergency skills training. | • All members of the multidisciplinary team working within maternity should attend regular joint training, governance and audit events. Staff should have allocated time in job plans to ensure attendance, which must be monitored. | | PROMPT and audit attendance monitored |
| | • Multidisciplinary training must integrate the local handover tools (such as SBAR) into the teaching programme at all trusts. | | Escalation, communication and SBAR is an integral part of PROMPT |
| | • All trusts must mandate annual human factor training for all staff working in a maternity setting; this should include the principles of psychological safety and upholding civility in the workplace, ensuring staff are enabled to escalate clinical concerns. The content of human factor training must be agreed with the LMS. | | Human Factors included in PROMOT await further guidance from LMS |
| | • There must be regular multidisciplinary skills drills and on-site training for the management of common obstetric emergencies including haemorrhage, hypertension and cardiac arrest and the deteriorating patient. | | Need to increase frequency and debrief documented as evidence |
| | • There must be mechanisms in place to support the emotional and psychological needs of staff, at both an individual and team level, recognising that well supported staff teams are better able to consistently deliver kind and compassionate care. | | Trust wide health and wellbeing agenda |
| | • Systems must be in place in all trusts to ensure that all | | K2 and PROMPT attendance logged and |

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| | staff are trained and up to date in CTG (fetal heart rate monitoring) and emergency skills. | | audited |
| | • Clinicians must not work on labour wards or provide intrapartum care in any location without appropriate regular CTG training and emergency skills training. This must be mandatory. | | K2 and PROMPT attendance logged and audited |
| **8. COMPLEX ANTENATAL CARE** | | | **COMMENTS** |
| Essential action<br><br>Local Maternity Systems, Maternal Medicine Networks and trusts must ensure that women have access to pre-conception care.<br><br>Trusts must provide services for women with multiple pregnancy in line with national guidance.<br><br>Trusts must follow national guidance for managing women with diabetes and hypertension in pregnancy. | • Women with pre-existing medical disorders, including cardiac disease, epilepsy, diabetes and chronic hypertension, must have access to preconception care with a specialist familiar in managing that disorder and who understands the impact that pregnancy may have. | | We do have this informally if there is a referral from a GP this would be done as an office appointment (this is included in guidelines for high-risk pts). There is currently no preconception clinics, but all referrals from a GP will be contacted - |
| | • Trusts must have in place specialist antenatal clinics dedicated to accommodate women with multifetal pregnancies. They must have a dedicated consultant and have dedicated specialist midwifery staffing. These recommendations are supported by the NICE Guideline Twin and Triplet Pregnancies 2019. | | No specific multi fetal clinics or specialist midwifery staffing. We have lead consultant for monochorionic twin pregnancy (Roy Abraham and Fi Shamsudin. Specialist scan slots would also need to be available and NICE guidance suggests a specialist sonographer |
| | • NICE Diabetes and Pregnancy Guidance 2020 should be followed when managing all pregnant women with pre-existing diabetes and gestational diabetes. | | Guideline, written by lead obstetrician follows NICE guidance and is in date |
| | • When considering and planning delivery for women with diabetes, clinicians should present women with evidence-based advice as well as relevant national recommendations. Documentation of these joint discussions must be made in the woman's maternity records. | | Guideline, written by lead obstetrician follows NICE guidance and is in date- audit to be undertaken to demonstrate compliance |
| | • Trusts must develop antenatal services for the care of women with chronic hypertension. Women who are identified with chronic hypertension must be seen in a special to treatment. Women must be commenced on Aspirin 7 ist consultant clinic to evaluate and discuss risks and benefits 5-150mg daily, from 12 weeks gestation in accordance with the NICE Hypertension and Pregnancy | | We don't have a specific clinic for Hypertension as these patients are managed routinely in a standard high-risk clinic. Aspirin usage advice is included as a mandatory risk assessment for pre- eclampsia risk –completed by community midwifery |

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| | Guideline (2019). | | audit to be completed |
| **9. PRETERM BIRTH** | | | **COMMENTS** |
| Essential action<br><br>The LMNS, commissioners and trusts must work collaboratively to ensure systems are in place for the management of women at high risk of preterm birth.<br><br>Trusts must implement NHS Saving Babies Lives Version 2 (2019). | • Senior clinicians must be involved in counselling women at high risk of very preterm birth, especially when pregnancies are at the thresholds of viability. | | This happens would only be able to evidence through records. Need to check what our guideline says would a standard operating procedure be better? |
| | • Women and their partners must receive expert advice about the most appropriate fetal monitoring that should be undertaken dependent on the gestation of their pregnancies and what mode of delivery should be considered. | | As above |
| | • Discussions must involve the local and tertiary neonatal teams so parents understand the changes of neonatal survival and are aware of the risks of possible associated disability. | | How would we evidence this – sure it happens |
| | • There must be a continuous audit process to review all in utero transfers and cases where a decision is made not to transfer to a Level 3 neonatal unit and when delivery subsequently occurs in the local unit. | | Need to commence an audit |
| **10. LABOUR AND BIRTH** | | | **COMMENTS** |
| Essential action<br><br>Women who choose birth outside a hospital setting must receive accurate advice with regards to transfer times to an obstetric unit should this be necessary.<br><br>Centralised CTG monitoring systems should be mandatory in obstetric units. | • All women must undergo a full clinical assessment when presenting in early or established labour. This must include a review of any risk factors and consideration of whether any complicating factors have arisen which might change recommendations about place of birth. These must be shared with women to enable an informed decision re place of birth to be made. | | See Ockenden 1 |
| | • Midwifery-led units must complete yearly operational risk assessments. | | New action, need to understand if a national tool is being developed |
| | • Midwifery-led units must undertake regular | | Needs to be more frequent and we need to |

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| | multidisciplinary team skills drills to correspond with the training needs analysis plan. | | be able to evidence |
| | • It is mandatory that all women who choose birth outside a hospital setting are provided accurate and up to date written information about the transfer times to the consultant obstetric unit. Maternity services must prepare this information working together and in agreement with the local ambulance trust. | | Need to check and update what we give to women and work with YAS.<br>This should include Huddersfield Birth Centre |
| | • Maternity units must have pathways for induction of labour, (IOL). Trusts need a mechanism to clearly describe safe pathways for IOL if delays occur due to high activity or short staffing. | | Guidelines and SOP in place |
| | • Centralised CTG monitoring systems must be made mandatory in obstetric units across England to ensure regular multi-professional review of CTGs. | | In place |
| **11. OBSTETRIC ANAESTHESIA** | | | **COMMENTS** |
| Essential action<br><br>In addition to routine inpatient obstetric anaesthesia follow-up, a pathway for outpatient postnatal anaesthetic follow-up must be available in every trust to address incidences of physical and psychological harm.<br><br>Documentation of patient assessments and interactions by obstetric anaesthetists must improve. The determination of core datasets that must be recorded during every obstetric anaesthetic intervention which result in record-keeping that more accurately reflects events.<br><br>Staffing shortages in obstetric anaesthesia must be highlighted and updated guidance | • Conditions that merit further follow-up include, but are not limited to, postdural puncture headache, accidental awareness during general anaesthesia, intraoperative during obstetric interventions, neurological injury relating to anaesthetic interventions, and significant failure of labour analgesia. | tbc | To be benchmarked by anaesthetics lead |
| | • Anaesthetists must be proactive in recognising situations where an explanation of events and an opportunity for questions may improve a woman's overall experience and reduce the risk of long-term psychological consequences. | tbc | To be benchmarked by anaesthetics lead |
| | • All anaesthetic departments must review the adequacy of their documentation in maternity patient records and take steps to improve this where necessary as recommended in Good Medical Practice by the GMC. | tbc | To be benchmarked by anaesthetics lead |
| | • Resources must be made available for anaesthetic professional bodies to determine a consensus regarding contents of core datasets and what constitutes a satisfactory anaesthetic record in order to maximise | tbc | To be benchmarked by anaesthetics lead |

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| for the planning and provision of safe obstetric anaesthesia services throughout England must be developed. | national engagement and compliance. | | |
| | Obstetric anaesthesia staffing guidance to include:<br>• The role of consultants, Specialist and Associate Specialist doctors and doctors-in-training in service provision, as well as the need for prospective cover, to ensure maintenance of safe services whilst allowing for staff leave. | tbc | To be benchmarked by anaesthetics lead |
| | • The full range of obstetric anaesthesia workload including, elective caesarean lists, clinic work, labour ward cover, as well as teaching, attendance at multidisciplinary training, and governance activity. | tbc | To be benchmarked by anaesthetics lead |
| | • The competency required for consultant staff who cover obstetric services out-of-hours, but who have no regular obstetric commitments. | tbc | to be benchmarked by anaesthetics lead |
| | • Participation by anaesthetists in the maternity multidisciplinary ward rounds as recommended in the first report. | tbc | |
| **12. POSTNATAL CARE** | | | **COMMENTS** |
| Essential action<br><br>Trusts must ensure that women readmitted to a postnatal ward and all unwell postnatal women have timely consultant review.<br><br>Postnatal wards must be adequately staffed at all times. | • All trusts must develop a system to ensure consultant review of all postnatal readmissions, and unwell postnatal women, including those requiring care on a non-maternity ward. | | Need to review our guideline, however all postnatal readmissions admitted to LDRP |
| | • Unwell postnatal women must have timely consultant involvement in their care and be seen daily as a minimum. | | All unwell postnatal women managed on LDRP |
| | • Postnatal readmissions must be seen within 14 hours of readmission or urgently if necessary. | | As above |
| | • Staffing levels must be appropriate for both the activity and acuity of care required on the postnatal ward both day and night, for both mothers and babies. | | Await national guidance on staffing |

| **13. BEREAVEMENT CARE** | | **RAG RATING** | **COMMENTS** |
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| Essential action | • Trusts must provide bereavement care services for | | 1 part time bereavement midwife |

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| Trusts must ensure that women who have suffered pregnancy loss have appropriate bereavement care services. | women and families who suffer pregnancy loss. This must be available daily, not just Monday to Friday. | | however all staff receive bereavement training in PROMPT day 2 |
| | • All trusts must ensure adequate numbers of staff are trained to take post-mortem consent, so that families can be counselled about post-mortem (PM) within 48 hours of birth. They should have been trained in dealing with bereavement and in the purpose and procedures of post-mortem examinations. | | 10 midwives have received training to undertake PM consent. |
| | • All trusts must develop a system to ensure that all families are offered follow-up appointments after perinatal loss or poor serious neonatal outcome. | | Follow up is on checklist and perinatal loss contacted by bereavement midwife |
| | • Compassionate, individualised, high quality bereavement care must be delivered for all families who have experienced a perinatal loss, with reference to guidance such as the National Bereavement Care Pathway. | | Need to assess against Pathway |
| **14. NEONATAL CARE** | | | **COMMENTS** |
| Essential action<br><br>There must be clear pathways of care for provision of neonatal care.<br><br>This review endorses the recommendations from the Neonatal Critical Care Review (December 2019) to expand neonatal critical care, increase neonatal cot numbers, develop the workforce and enhance the experience of families. This work must now progress at pace. | • Neonatal and maternity care providers, commissioners and networks must agree on pathways of care including the designation of each unit and on the level of neonatal care that is provided. | | In place - designated level 2 status. |
| | • Care that is outside this agreed pathway must be monitored by exception reporting (at least quarterly) and reviewed by providers and the network. The activity and results of the reviews must be reported to commissioners and the Local Maternity Neonatal Systems (LMS/LMNS) quarterly. | | Performing out of scope - exception reports go to the network - all babies who are delivered locally outside our care criteria are reported to the network. This is completed by Karin Schwarz.<br>2) How many babies we haven't accepted.<br><br>To be included in Neonatal report to Divisional Board and PQSB |
| | • Maternity and neonatal services must continue to work towards a position of at least 85% of births at less than 27 weeks gestation taking place at a maternity unit with an onsite Newborn Intensive Care Unit (NICU). | | Reported monthly to LMS and at PSQM |
| | • Neonatal Operational Delivery Networks must ensure that staff within provider units have the opportunity to | | Medical-Occasional teaching ward round attendance at Bradford for consultants. |

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| | share best practice and education to ensure units do not operate in isolation from their local clinical support network. For example senior medica, ANNP and nursing staff must have the opportunity for secondment to attend other appropriate network units on an occasional basis to maintain clinical expertise and avoid working in isolation. | | Junior doctor rotation. Sam Oddie (Bradford Consultant) - dedicated support for CHFT team.<br>Nursing<br>Discussions have taken place with the network. |
| | • Each network must report to commissioners annually what measures are in place to prevent units from working in isolation. | | Action for the network |
| | • Neonatal providers must ensure that processes are defined which enable telephone advice and instructions to be given, where appropriate, during the course of neonatal resuscitations. When it is anticipated that the consultant is not immediately available (for example out of hours), there must be a mechanism that allows a real-time dialogue to take place directly between the consultant and the resuscitating team if required. | | Need for equipment and further discussion at Neonatal Forum. |
| | • Neonatal practitioners must ensure that once an airway is established and other reversible causes have been excluded, appropriate early consideration is given to increasing inflation pressures to achieve adequate chest rise. Pressures above 30cmH2O in term babies, or above 25cmH2O in preterm babies may be required. The Resuscitation Council UK Newborn Life Support (NLS) Course must consider highlighting this treatment point more clearly in the NLS algorithm. | | |
| | • Neonatal providers must ensure sufficient numbers of appropriately trained consultants, tier 2 staff (middle grade doctors or Advanced Neonatal Nurse Practitioner (ANNPs)) and nurses are available in every type of neonatal unit (NICU, LNU and Special Care Baby Unit (SCBU)) to deliver safe care 24/7 in line with national service specifications. | | **Consultants** -The neonatal on call rota is supported by 7 consultants but 4 also cover Paediatrics COTW but not paeds on call<br>**The tier 2 rota**, we do not have a 2 registrars across Paediatrics and Neonates at night. There is a requirement for funding 1.4 WTE additional registrars at night. Risk currently on risk reg with score of 20<br>Mitigation |

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| | | | 1. Short term funding secured last year but delay in recruitment due to covid<br>2. Bid for permanent funding (business planning 22) not yet approved –<br>3. Night registrar supported by on-call consultant<br>4. A twilight consultant is resident 2-4 afternoons/evenings per week to support activity at peak times<br>5. September 2021, tier 2 rota amended, so that most evenings a twilight registrar is available<br>Nursing<br>Neonatal workforce tool (NWT) completed in 2020- 49.38WTE required to provide direct patient care only – current budget April 2022 45.18WTE, in post 36.43WTE, however 6WTE recruited awaiting start dates (Recurrent funding from the ODN). Variance 4.20WTE from NWT to budgeted WTE. |
| **15. SUPPORTING FAMILIES** | | | **COMMENTS** |
| Essential action<br><br>Care and consideration of the mental health and wellbeing of mothers, their partners and the family as a whole must be integral to all aspects of maternity service provision.<br><br>Maternity care providers must actively engage with the local community and those with lived experience, to deliver services that are informed by what women and their families say they need from their care. | • There must be robust mechanisms for the identification of psychological distress, and clear pathways for women and their families to access emotional support and specialist psychological support as appropriate. | | Currently don't have this in place although do have a mental health specialist midwife |
| | • Access to timely emotional and psychological support should be without the need for formal mental health diagnosis, as psychological distress can be a normal reaction to adverse experiences. | | Currently don't have this in place although do have a mental health specialist midwife |
| | • Psychological support for the most complex levels of need should be delivered by psychological practitioners who have specialist expertise and experience in the area of maternity care. | | Currently don't have this in place although do have a mental health specialist midwife |

# 20. Quality Report

To Note

Presented by Ellen Armistead

| | |
|---|---|
| **Date of Meeting:** | Thursday, 5 May 2022 |
| **Meeting:** | Board of Directors |
| **Title:** | Quality Report<br>(Reporting period February to March 2022) |
| **Author:** | Kim Smith, Assistant Director for Patient Safety |
| **Sponsoring Director:** | Lindsay Rudge, Deputy Director of Nursing |
| **Previous Forums:** | None |

**Purpose of the Report**

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

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

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

**Key Points to Note**

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

**Care Quality Commission (CQC)**

During February & March 2022, the CQC workstreams have continued to be guided by the continuous engagement with the Trusts CQC Relationship Managers, Trust's recovery plan, and national guidance.

*Journey 2 Outstanding Review (J2O)* - In February and March 4 full comprehensive reviews took place across the Trust, any areas of non-compliance continue to be actioned at Ward Level with Divisional monitoring and oversight.

Divisional bi-monthly updates are presented at the CQC & Compliance Group for ongoing oversight, scrutiny, and assurance

*Integrated Care Services Inspection* – During April CQC will be conducting inspections across the West Yorkshire Integrated Care Services focusing on Urgent & Emergency Care pathways across acute, primary, and adult social care. The aim is to support improvement in patient experience and the quality of care received when accessing these services,

To achieve this, CQC will coordinate activity where appropriate to positively influence the system wide response to the challenges across urgent and emergency care pathways and

drive system wide accountability.

CHFT were made aware that CQC would be visiting Mid Yorkshire NHS Foundation Trust as part of the Integrated Care Services Urgent & Emergency Care review and therefore there was possibility that the Trust may also be inspected. Therefore, CHFT are using the Journey 2 Outstanding methodology to carry out focused reviews across these pathways as part of the internal assurance process.

*CQC Insight Report* - CQC were due to publish their next CQC Insight report in March to date this has not been published due to a delay with CQC. Therefore, nothing further to report.

**Dementia Care and Screening**

CHFT has been working closely with colleagues in Bradford to develop comprehensive care plans for colleagues to follow for patients with a diagnosis of dementia. Separate delirium care plans are also being developed. This will be link with dementia screening compliance to ensure a robust process in place as well as additional training and guidance being implemented for new medical staff.

The dementia screening compliance has begun to improve slightly, to 24.66% in March 2022 from 19.20% in January 2022. however, the compliance rate of 90% has not yet been meet therefore it remains on the risk register to ensure there is a process for oversight and scrutiny. Actions continue to address this include a Standard Operating Procedure (SOP) has been circulated to the new rotational medical colleagues, which contains guidance about the process and why, as well as educational packages. Consultants are ensuring dementia screening is completed as part of board rounds

The dementia Lead Practitioner has met with Bradford Dementia Lead to create a more in-depth care plan for staff to follow for patients with a diagnosis of dementia. Separate delirium care plan also in process of being developed.

**Patient Experience, Participation, Equalities**

*Friends and Family Test* (FFT) - Except for In-patients, we have seen a significant reduction in the number of FFT's being completed. The low response rates this means the data is less representative of the patient group and less useful Divisional teams have been reminded of the importance of patients completing the FFT. The Trust also have a volunteer who has been recruited specifically to focus on increasing responses in low response rate areas, this will commence from April 2022. It should be noted that NHS England have reported that this has been an issue nationally, with other Trusts seeing an average reduction of 10-22%.

*Volunteer Service* -Volunteers have made a significant improvement to the "front of house" at both HRI and CRH. Evidence has shown us that volunteers help on average 100 patients per shift, with a focus on areas such as:

- Helping patients navigate around the hospital grounds to their appointments
- Reminding patients and visitors about the importance of wearing masks
- Conveying patients in their wheelchairs to their appointments (this is following training) freeing up porting staff.

*Carers strategy* - Our Carers strategy was presented to the Patient Experience and Caring Group (PEG) in March 2022. It is intended to ensure that carers and the role that they have

in caring for someone is valued, that they are involved in a way they wish to be involved and supported in their role. It fits with the Trust's vision of delivering compassionate care that puts our patients and community first.

Caring for patients with visual impairments - Visual Awareness training for staff is being developed, so they understand the challenges patients with a visual impairment face when in our hospitals, Service users have been involved with the co-design of this as well as Improvements being made to signage across the Trust.

**Patient Advice and Complaints Service (PACS)**

The Task and Finish Group are continuing to review the process for complaints, the outcomes from this so far are the implementation of a training needs analysis, as well as a specific intranet page which will contain "how to guides" to support teams with completing complaint responses. This will also include patient centred standard statements to ensure consistency of approach.

Key performance indicators (KPI's) have also been agreed to focus on performance, quality (re-opened complaints) and escalation of concerns to complaints, to enable the Trust to measure these areas effectively and make improvements where required. Learning from complaints is a priority for the Trust with a group planning to be established to enable the triangulation of learning in relation to Complaints, Incidents, Inquests, Mortality and Compliments.

The service continues to receive a high number of contacts from patients and their families and continues to strive to provide a responsive and quality service.

**Legal Services**

A full review of the claim's portfolio is currently underway and has allowed for the implementation of case plans, which are being reviewed and approved by the Head of Legal. This has allowed for deeper scrutiny of claims and escalation to the Divisions, Finance and the executive teams where organisational risk is identified.

In relation to Inquests there still remains backlog of inquest and some challenges when working with the Bradford Coroner's Office, which impact on the ability of the Trust to prepare for inquests and can increase the pressure on divisional colleagues. A meeting between the Acting Head of Legal, Executive Medical Director and Executive Director of Nursing and Senior Coroner is planned to establish a line of communication with the Coroner's Office and agree a more productive and efficient working relationship moving forward.

Legal are looking to incorporate learning from Inquest and Claims and Getting It Right First Time (GIRFT) into the new processes. Legal Services are planning to link in with Speciality GIRFT Leads and Divisions across the Trust on a quarterly basis in relation to claims and inquests. Whilst there are already established links in some areas, the aim is to standardise this engagement so that no clinical/divisional areas are excluded.

**Incidents**

There have been 755 incidents total reported in March 2022, which is a decreased from 718 reported in February 2022. Fourteen incidents resulted in severe harm or death in March 2022 compared to eight incidents in February 2022, with five incidents meeting the threshold for reporting externally on StEIS (Strategic Executive Information System) in March 2022 and three in February meeting the threshold, giving a total of 8 StEIS (Strategic

Executive Information System) incidents reported.

Never Events

One Never Event was reported in March 2022 in relation to wrong site surgery.

Summary of Progress with Serious Incident Actions

The Risk team continues to review the management of serious incidents and has incidents where outstanding actions have been evidence.

The Risk team continue to provide support to clinical teams. The risk team effective oversight of serious incidents and continue to work closely with the divisions to support a consistent process across the Trust and ensure all actions are responded to in a timely manner, with robust evidence to support this

**Lesson Learnt from Serious Incidents**

Specific themes and trends from serious incidents are identified as: -

A robust handover between the mental health team and the physical health team to take place to ensure that all Mental Health Act (MHA) documentation is completed correctly and that this is contained within the patients notes.

Staff to be made aware of the needs of confused/visually impaired patients and use the Mental Capacity Act (MCA) and the Best Interests decision-making process to record the decisions which are made in the patient's best interests

**Medicine Safety**

Medicine Safety Compliance Group Attendance -Quoracy of the group remains a challenge however the group is making progress in increasing engagement. A patient representative and junior doctor are now part of the meet with next steps include a junior pharmacist is to attend on rotational basis to help with understanding and supporting medicine safety agenda and regular feedback from specialist medicines groups/leads

The group are also working with IT colleagues to develop a medicines management dashboard. This will help provide assurance for compliance of medicine management standards and also track improvements following any changes in guidance or practice.
Considered for installation of electronic cabinets to support with medication storage compliance taking place

**Maternity Services**

*Ockenden report* - The service received Dame Donna Ockenden's final report into maternity services at Shrewsbury and Telford NHS Trust on the 30 March 2022. This is a far-ranging report with actions not only for maternity services but also for Obstetric Anaesthetic and Neonatal services at provider levels long with wider system and national actions to improve all actions of maternity care.

There are 15 Immediate and Essential Actions described in the report and maternity services are currently undertaking a robust self- assessment of their current position and will provide Quality Committee, Board and the Local Maternity System with a robust action plan to achieve compliance with this landmark review of maternity services.
The service continues to work towards achieving full compliance with the action of the first

Ockenden report and is expecting an assurance visit from regional colleagues on the 28 June 2022 this year to review our current position.

*NHS Resolution Maternity Incentive Scheme*- In response to the on- going COVID-19 pandemic and the pressures currently being experienced across all areas of healthcare NHS resolution suspended year 4 of the Maternity Incentive scheme in December for a period of three months initially. The service however continues to work towards the current trajectories and have not paused any internal on-going work to meet year 4 of the scheme. At the time of writing year 4 of the scheme has not been reinstated however an update version of year 4 is expected imminently.

**Quality Priorities**

The Trust has continued to focus on its quality priorities. There has been an increased focus on ensuring that there is evidence are supported the implementation of action and progress report are provided. The following updates are provided:

- *Recognition and timely treatment of Sepsis.* - The Emergency Department consultants are continuing to analyse red flag patient (sickest sepsis patients.) The Sepsis nurse providing increased training within the department and additional sepsis trolleys available

- *Reduce number of Hospital Acquired Infections including COVID-19* - The new National Standards of Healthcare Cleanliness 2021 to be reviewed and implemented. CHFT are compliant with the minimal national patient testing regime and also include additional tests as part of our local guidance. Covid immunisation history is part of routine pre-employment health check. The Trusts remains consistent in position that masks are required within the healthcare setting.

- *Reduce waiting times for individuals in the Emergency Department (ED)* – CHFT continue to capture any length of stay over 12 hours. The Redesign of OPEL process that captures ED internal process. New datix format for 12-hour LOS implemented to ensure consistency of data collection.

Focused Quality Priorities:

- *Making complaints count* -Equality monitoring data is now captured as part of the service user survey and at the point of access into the service. Complaint's training has been reviewed to ensure it meets service needs. A revised training package to be developed and offered. All complaint responses have a quality assurance check.

- *End of Life Care* - Consultation and staff engagement meetings have taken place and it is now planned for the inpatient acute palliative care service to move to 7 day working from September 2023. Increase skill mix to enable an increase in bereavement calls and also in reach into ward areas. Bereavement support service now work closely with the medical examiners team to prioritise relatives who they feel may need extra support

- *Reducing the number of Falls resulting in harm* - Falls prevention intervention care plans have been created and disseminated across the wards. The Falls policy has been updated to reflect specific timeframes for assessments. Patient and carer falls leaflet has been updated

- *Nutrition and Hydration for in-patient adult and paediatric patients* - Observation of mealtimes during Observe and Act framework. The Medical Matrons have been asked to encourage and support all areas in completing Malnutrition Universal Screening Tool

(MUST) training. Discussions around monthly metrics being printed for each ward so that clinical areas can see and improve their compliance in relation to MUST assessments

- *Increase the quality of clinical documentation across CHFT* - Digital white boards have been produced. First trial area identified for the ward assurance tool in place and divisions now monitoring compliance and improvements. Training in use of Ward Assurance Tool rolled out to Managers and Matrons

- *Clinical Prioritisation (Deferred care pathways)* - Review of health inequalities data to compliment clinical prioritisation and our post COVID-19 delivery model for both planned and unplanned care has taken place. A Clinical Reference Group on Health Inequalities was established to steer this element of recovery. A new pathway from referral is being developed to ensure ongoing prioritisation of patients with a Learning Disability.

- *Reduction in the number of CHFT acquired pressure ulcers* - Daily safety huddles now taking place between Tissue Viability team and Matrons to discuss high risk patients with pressure damage and moisture damage and to allow for rapid escalation of omissions in care. Successful 'Minimise Moisture' week held in March 2022 to raise awareness of good practice in skin, continence and moisture care. Tissue Viability Nurse is attending national training event on pressure ulcer prevention in patients with dark skin tones. Joined up working between CHFT BAME team and Tissue Viability.

**EQIA – Equality Impact Assessment**

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

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

It is not anticipated that the contents within this report will have a detrimental impact on any of the protected characteristics but seeks to give the assurances that as a Trust we are doing everything in our power to reduce risk and ensure high quality and safe care for all to include improvements for dementia screening for our patients aged 75 and over.

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

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

**Recommendations**

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

# Contents

**Bi-monthly reports** *(February to March 2022)*



**Quality Account Priorities:**



**Focussed Quality Priorities**

## 1. Introduction

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

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

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

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

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

## 2. Care Quality Commission (CQC) workstreams

During February and March 2022, the CQC workstreams have continued to be guided by the continuous engagement with the Trusts CQC Relationship Managers, Trust's recovery plan, and national guidance.

**2021/22 CQC Exceptions Action Plan – Update on 'Must Do' & 'Should Do' Actions**

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

**"*MD1* - *The Trust must improve its financial performance to ensure services are sustainable in the future*"**

The current progress and position against the remaining open recommendation was presented by the Deputy Director of Finance at the March CQC and Compliance Group. A full roundup of all the actions undertaken to support the Trust's Use of Resources (UOR) position was received by Finance and Performance Committee in early 2021/22. Consideration was also given to closure of this action given the successful delivery of an improved financial position in line with targets over several years and the progress made to advance the reconfiguration. However, given the scale of the challenge for 2022/23 a decision was made to keep the action open to ensure this has optimum and ongoing monitoring and oversight.

**CQC Engagement Meeting**

Regular catch-up meetings between CQC and CHFT have continued to take place throughout the COVID-19 pandemic with both the Acute and Community Healthcare Services. These catch-ups are scheduled to continue quarterly with the last full engagement meeting taking place on 18th March 2022. This was the first official engagement meeting with the new CQC Inspection Manager and Relationship Manager.

The meeting was led by CQC and focused on:

- Current COVID-19 Position
- Recovery Plans
- Must Do's
- Elective Waiting Times
- Serious Incidents
- Complaints
- Staff Health & Well-being

There was also an opportunity for CHFT to share some successes and positive news stories. CQC were assured by the Trust updates and no further requests for assurance were requested.

Discussions at the engagement meeting also took place regarding a notification which was received informing that CHFT could possibly be inspected as part of the West Yorkshire Integrated Care System (ICS), with a focus on Urgent & Emergency Care pathways - see below for CHFTs Response.

**Journey 2 Outstanding Review**

The full Journey 2 Outstanding 2022 inspection programme was relaunched in February.

In February and March, four full comprehensive reviews took place across the Trust, the table below sets out the reviews and overall compliance of the 2022 reviews undertaken to date.

| Site | Division | Speciality | Ward | Overall Compliance |
|---|---|---|---|---|
| CRH | Medicine | Acute Medicine | Ward 6A/B | **76%** |
| CRH | Family Specialist Services | Paediatrics | Ward 3 A/B/C/D | **90%** |
| HRI | Surgery & Anaesthetics | Orthopaedics | Ward 21 | **89%** |
| HRI | Medicine | Elderly Care | Ward 15 | **93%** |

Any areas of non-compliance continue to be actioned at Ward Level with Divisional monitoring and oversight.

Divisional bi-monthly updates are presented at the CQC and Compliance Group for ongoing scrutiny and assurance.

**Challenges**

There continues to be ongoing challenges to ensure medical colleagues are involved in the J2O reviews both from a review team perspective and to be interviewed as part of the inspection. This is mainly due to operational pressures.

**J2O Review Next Steps**

The J2O Review process is now embedded across the Trust. The 2022 inspection regime is in place, with two reviews taking place per calendar month.

Areas to visit will continue to be guided by risks, concerns, and intelligence of areas.

It is recommended that all wards and departments use the J2O Review Toolkit to self-assess and peer review across divisions.

All tools are available for colleagues to access on the CQC Intranet Page: CQC J2O INSPECTION PREPARATION TOOLS - CHFT Intranet (cht.nhs.uk)

**CQC Insight Report**

CQC were due to publish their next CQC Insight report in March 2022, to date this has not been published due to a delay with CQC. Therefore, nothing further to report.

**West Yorkshire Integrated Care System Inspection**

During April, CQC will be conducting inspections across the West Yorkshire ICS focusing on Urgent and Emergency Care (U&EC) pathways across acute, primary, and adult social care.

The aim is to support improvement in patient experience and the quality of care received when accessing services and pathways across urgent and emergency care.

To achieve this, CQC will coordinate activity where appropriate to positively influence the system-wide response to the challenges across urgent and emergency care pathways and drive system wide accountability.

CQC will regulate services across the urgent and emergency care pathway by:

- Responding to existing concerns and risk in urgent and emergency care services whilst testing a coordinated, multidisciplinary approach across systems, where appropriate, to fully understand the challenges which may result in poor patient experience
- Keeping patients at the centre of their approach and understanding their experience of urgent and emergency care regardless of the point of access
- Using data and intelligence to focus activity and remain proportionate in approach
- Engaging with system partners and providing feedback to drive improvement

Intelligence was received on Monday 28th March 2022 informing that CQC would be visiting Mid Yorkshire NHS Foundation Trust as part of the ICS U&EC Review.

Initial feedback from Mid Yorkshire set out the below key points for consideration:

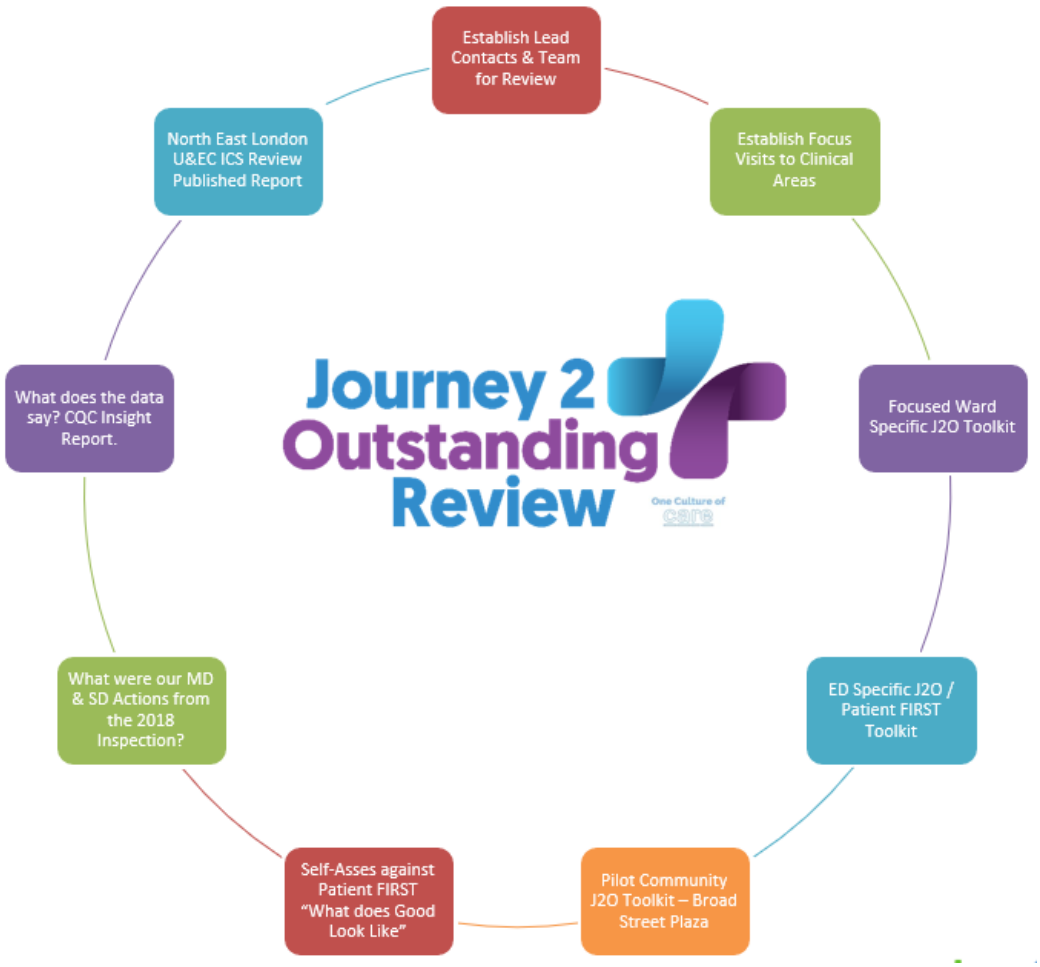
- Mid Yorkshire were advised by CQC of a visit Monday evening with arrival Tuesday morning.
- 20 CQC Inspectors were onsite for three days.

- Out of Hours services were also inspected as part of the review.
- 200 data requests were received on the first day.
- Feedback so far suggests the lines of enquiry are very thorough.
- Mid Yorkshire were also being re-inspected (rated), alongside the WY ICS U&EC review (this is not rated).

**CHFT Response to CQC Inspection Activity Notification**

In response to the possible CQC inspection activity, CHFT coordinated an initial project plan to prepare for any possible activity. Image 1 sets out the key stages of preparation.

**Image 1.**




It was agreed that both a Ward Based, Community and Emergency Department (ED) specific J2O Toolkit would be developed for use to aid with the Trusts CQC Prepartion.

These toolkits are focused and specifically inlcude key lines of enquiry which we use as part of the Urgent & Emergency Care Pathways and also areas in which the Trust had specific Must Do & Should Do recommendations at the last CQC Inspection in 2018.

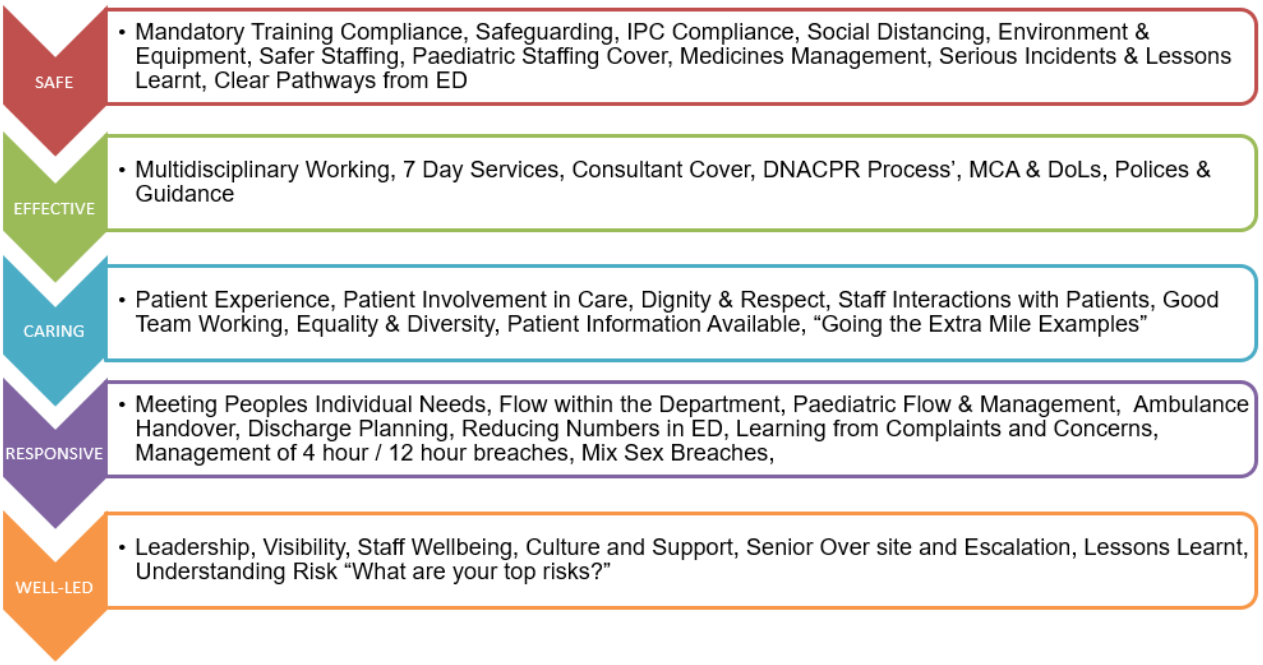
The J2O CQC preparation Toolkits include:

- Observations of all staff and roles at ward level and in the Emergency Departments.
- Enviroment and Equipment Observations
- Testining Staff Knowledge

The ED Specific toolkit also includes recommendations as set out in the Patient FIRST CQC ED publication.

The toolkit  frameowrks include Key Lines of Enquiry as set out in image 2.

**Image 2.**




The Trust is planning coordinated unannounced visits to Ward, Community & Emergency Departments throughout April to ensure CQC inspection readiness.

**CQC and Compliance Group**

The CQC and Compliance Group continues to meet monthly; the meetings terms of reference are now due for annual review, giving the opportunity to relook at the meetings attendees, purpose, reporting and function within the CHFT governance structure.

The review of the groups terms of reference links to two other key workstreams which are the review the organisations Divisional Compliance Registers and External Inspection and Review policy.

The plan is to review the three workstreams as a whole to ensure robust processes, reporting and governance are in place to ensure Compliance and Assurance is embedded across the organisation.

## 3. Dementia Screening

| | Month | Annual | Mar-22 | Feb-22 | Jan-22 | Dec-21 | Nov-21 | Oct-21 | Sep-21 | Aug-21 | Jul-21 | Jun-21 | May-21 | Apr-21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Division | Ward | | | | | | | | | | | | | |
| Trust | Totals | 27.80% | 24.66% | 19.46% | 18.36% | 27.39% | 34.39% | 38.89% | 35.60% | 24.89% | 19.26% | 25.78% | 22.74% | 21.48% |
| FSS | Totals | 40.00% | - | 100.00% | 0.00% | - | 0.00% | - | - | - | 0.00% | - | 100.00% | - |
| Medicine | Totals | 26.54% | 18.65% | 19.76% | 19.20% | 27.99% | 36.00% | 39.08% | 39.90% | 27.34% | 19.87% | 27.36% | 24.48% | 22.25% |
| | 2A CRH | 29.97% | 11.76% | 47.06% | 30.77% | 35.71% | 31.58% | 35.29% | 35.71% | 58.82% | 9.09% | 33.33% | 25.00% | 25.00% |
| | 2BCD CRH | 34.90% | 12.09% | 26.17% | 23.23% | 41.00% | 50.00% | 49.49% | 61.80% | 42.70% | 26.92% | 27.78% | 28.81% | 32.97% |
| | 6 HRI | 52.79% | 50.00% | 29.63% | 20.69% | 36.73% | 54.55% | 60.00% | 60.47% | 37.50% | 66.67% | 63.27% | 69.57% | 64.00% |
| | AF HRI | 22.65% | 20.50% | 19.78% | 16.75% | 23.04% | 33.69% | 40.46% | 39.08% | 22.78% | 11.06% | 21.39% | 14.94% | 12.62% |
| Surgical | Totals | 22.66% | 55.21% | 17.05% | 13.95% | 24.51% | 26.25% | 38.04% | 12.00% | 11.43% | 16.28% | 18.48% | 14.29% | 16.67% |
| | 19 HRI | 16.81% | 60.00% | 17.65% | 4.76% | 20.69% | 18.18% | 20.00% | 0.00% | 4.76% | 10.34% | 31.25% | 6.90% | 15.79% |
| | 21 HRI | 19.51% | 66.67% | 18.75% | 10.00% | 18.18% | 16.67% | 40.00% | 0.00% | 0.00% | 0.00% | 20.00% | 28.57% | 16.67% |
| | SAU HRI | 28.19% | 61.54% | 20.00% | 20.00% | 33.33% | 32.35% | 45.76% | 20.00% | 19.44% | 25.64% | 14.04% | 16.28% | 17.65% |

Dementia screening has been added onto the risk register (risk no 8093). As screening compliance is improving, the risk will be reviewed accordingly. However, the risk remains as compliance is not yet near the 90% target. Screening compliance has dropped recently, this may be linked to staffing levels.

To improve compliance, the below have been implemented:

- A Standard Operating Procedure (SOP) has been circulated to the new rotational medical colleagues and has been added onto Padlet for medics to review in their own time. The SOP has also been uploaded onto the Dementia intranet page for all staff to view.
- A daily email of the list of patients with an overdue dementia screen is sent out to consultants/ward managers/ward sisters and matrons of the assessment units, Ward 19 and Ward 21 to prompt medical staff to complete.
- A “Dementia Screening – What is it and why do we do it?” educational package has been developed for medical colleagues to support them to understand the importance of dementia screening and impact on patient experience. This has been presented at the induction for all new rotational medics and is uploaded on the Intranet for staff to view.
- Attended the most recent induction for medics and presented the above dementia screening educational package. This has been recorded and will be presented to all future medics.
- Dementia screening is requested by consultants in board round to be completed.

Compliance is not improving despite the above interventions. Discussions held with medical staff on Acute floor and Surgical Assessment Unit (SAU) found that the assessment is a lower priority in comparison to other medical tasks and identified that the assessment should be done as part of clerking process, or during the daily ward round. However, due to the assessment not being easily accessible on the Electronic Patient Record (EPR) when clerking, it is often not completed.

Planned actions:

- Focussed work with the ward matrons and medical teams to identify how to support them to complete
- Electronic whiteboard implementation to provide a visual reminder to medical staff regarding dementia screening.
- Review with EPR team regarding Clinician workflow and establish if Dementia Screening can be added or prompted. Have attempted to have a pop-up visual prompt on EPR however, this was identified as not appropriate.

**Dementia / Delirium Care Plan**

The Dementia Lead Practitioner has met with the Bradford Dementia Lead Nurse to create a more in-depth care plan for staff to follow for patients with a diagnosis of dementia. A separate delirium care plan is also in process of being developed. The aim is for care plans to be triggered through Dementia, Delirium and Depression screen. This is ongoing as it needs to be linked with dementia screening compliance. Meeting with Bradford Dementia Lead re this 22nd March to review.

**Enhanced Care Team**

Risk 7998 – Recent success of three new recruits into the team, interviewing for three band 2 positions week. Ongoing with long term sickness and recruitment.

There is a high caseload with more complex patients being referred. This is having a significant impact on the wards. Increased number of patients with challenging behaviour being seen. A review of training is taking place to support staff with this including breakaway training and enhanced Conflict Resolution Training. The Team manager and Practitioner for Enhanced Care are reviewing the enhanced care team and role, scope of service and ways to support the wards. This will include educational sessions, workshops and ad-hoc training on the wards. Educational plan is in the process of being drafted.

**Dementia Operational Group**

Last meeting took place in February 2022, with a plan to relaunch. The next meeting is planned for beginning of May 2022. The Dementia Operational Group is reviewing the Dementia Strategy in line with the quality priorities, with the request for senior support to embed the group.

The plan to use Dementia Operational Group to develop and implement Dementia Link Practitioners across the wards. First training session will follow the next Dementia Operational Group.

There is also a plan to link in with ward managers to identify staff that want to lead with dementia care on their wards.

**Community**

Working with Kirklees Dementia Hub, Gateway to Care and Admiral Nurses to develop a hospital admission pack for people with dementia. Aim is to provide people with dementia at point of diagnosis, so that they can keep the pack and add to it prior to any admission. Included in this will be the 'See Who I Am' care plan to support the wards with caring for a patient with dementia.

Post-diagnostic support for people with dementia in Calderdale has been up for tender. Calderdale Dementia Hub has been successful in winning the bid. Calderdale and Kirklees will be consistent with their information and support provided. Introductory meeting planned with Calderdale Dementia Hub manager in next four weeks to plan how to work together.

**Dementia Lead Role**

Reviewing patients daily on elderly care wards who have delirium and dementia in relation to their care needs, Deprivation of Liberty Safeguards (DoLS), capacity assessments and discharge planning, providing advice and guidance to staff where required. It has been

noted an increased number of referrals have been received which is positive. Feedback received so far has been positive, the aim is to increase the number of referrals received.

## Dementia Training Compliance

| Division | Assignment Count | Required | Achieved | Outstanding | Compliance % |
|---|---|---|---|---|---|
| 372 Pharmacy Manufacturing Unit L3 | 68 | 68 | 68 | 0 | 100.00% |
| 372 Health Informatics L3 | 237 | 237 | 236 | 1 | 99.58% |
| 372 Corporate L3 | 478 | 478 | 470 | 8 | 98.33% |
| 372 Community L3 | 684 | 684 | 672 | 12 | 98.25% |
| 372 Families & Specialist Services L3 | 1415 | 1415 | 1382 | 33 | 97.67% |
| Calderdale & Huddersfield Solutions Ltd L3 | 450 | 450 | 439 | 11 | 97.56% |
| 372 Surgery & Anaesthetics L3 | 1258 | 1258 | 1210 | 48 | 96.18% |
| 372 Medical L3 | 1577 | 1577 | 1513 | 64 | 95.94% |
| 372 Central & Technical L3 | 16 | 16 | 14 | 2 | 87.50% |
| **Grand Total** | **6183** | **6183** | **6004** | **179** | **97.10%** |

## Dementia Diagnosis in Hospital

The pathway has been set up and provisionally agreed with Memory Services. Pathway development on hold until February 2022, due to staffing in MHLT. In process of liaising with Dr Thomas (Consultant Psychiatrist) to review pathway.

## 4. Patient Experience, Participation and Equalities Programme

<table>
<tr><th>Project</th><th>Summary</th><th>Current position March 2022</th><th>RAG rating</th></tr>
<tr>
<td>1. Friends and Family Test (FFT) changes:<br><br>Project leads: Quality Improvement Manager and FFT divisional leads<br><br>Evidence for change: Revised question and restart following suspension</td>
<td>• The national FFT question was due to change on 1st April 2020, with the question being revised from a one which asked whether patients would recommend the service to friends and family to one which asks how patients would ‘rate’ the care they received.<br>• However, notification was received 30th March 2020 to advise that in order to reduce the burden and release capacity to manage the COVID-19 pandemic that the submission of FFT data to NSHE&I was to be suspended from all settings until further notice.<br>• Where SMS messaging was used to capture responses (OPD and ED) this could be continued. In these areas, useful feedback was received to indicate whether changes implemented to address the pandemic were providing an experience that met patient needs<br>• Notification was received from NHSE&I that the submission of FFT data was to recommence with effect from December 2020<br>• The reporting format has moved away from response rates with a greater focus on driving improvement, supporting comments of what went well and what can we do better will help to inform the improvements<br>• Numbers of responses have been low for inpatient, community and maternity services, low figures relate to staffing pressures and priorities, along with adapting to new processes; higher numbers achieved in the ED and OPD where SMS messaging is the main method of response</td>
<td>With the exception of In-patients, we have seen a significant reduction in the number of FFT’s being completed. This is disappointing as with low response rates this means the data is less representative of the patient group and less useful. The narrative, if it has been provided, can still help us understand what patients value and what they feel we can improve.<br><br>NHS England have reported that this has been an issue nationally, with other Trusts seeing an average reduction of 10-22%.<br><br>Positive Responses by %
<table>
<tr><th></th><th>January</th><th>February</th><th>March</th></tr>
<tr><td>In-Patients</td><td>97.4%</td><td>97.3%</td><td>96.4%</td></tr>
<tr><td>Outpatients</td><td>93.2%</td><td>92.1%</td><td>92.3%</td></tr>
<tr><td>A&E</td><td>86.9%</td><td>84.4%</td><td>77.0%</td></tr>
<tr><td>Maternity</td><td>93.2%</td><td>91.0%</td><td>95.0%</td></tr>
<tr><td>Community</td><td>95.5%</td><td>91.5%</td><td>89.3%</td></tr>
</table>
Number of completed FFT for Feb and March
<table>
<tr><th></th><th>Feb</th><th>March</th><th>% Difference</th></tr>
<tr><td>In-Patients</td><td>1172</td><td>1219</td><td>+4%</td></tr>
<tr><td>Outpatients</td><td>1795</td><td>392</td><td>-78%</td></tr>
<tr><td>A&E</td><td>790</td><td>283</td><td>-64%</td></tr>
<tr><td>Maternity</td><td>200</td><td>139</td><td>-30.5%</td></tr>
<tr><td>Community</td><td>329</td><td>225</td><td>-31%</td></tr>
</table>
Through visiting Wards and clinics, it has been highlighted that there are some mixed messages with regards to the CHFT FFT. When staff have been asked about how they are approaching their FFT many have reported that it has been</td>
<td>Reasonable Assurance</td>
</tr>
</table>

| Project | Summary | Current position March 2022 | RAG rating |
|---|---|---|---|
| | | suspended, or they are no longer doing it. Many display boards are no longer showing their results, or they are showing extremely outdated information. Feedback also highlighted that staff felt it difficult to ask patients with dementia about their time in hospital. It is likely that with the increasing visiting hours family members, Carers and loved ones will be able to help support the patient share their experience with us.<br><br>  <br><br><br>Divisional teams have been reminded of the importance of patients completing the FFT.<br><br>In addition to this, the Trust now has over 120 new ward volunteers who have now been trained on FFT, through their induction. We also have a volunteer who has been recruited specifically to focus on increasing responses in low response rate areas, this will commence from April 2022.<br><br>Increasing the numbers of patients completing the FFT and learning from the feedback will continue throughout 2022/2023 | |

| Project | Summary | Current position March 2022 | RAG rating |
|---|---|---|---|
| **2. Reducing noise at night (from staff):**<br><br>***Project leads:*** Felicity Austin<br><br>***Evidence for change:*** National inpatient survey, Exemplar ward audit, Joint research project with university of Huddersfield | The results of the 2020 inpatient survey (patients discharged in July 19) identified the following question about noise at night as scoring low, when benchmarked with other Trusts was 'Were you ever bothered by noise at night by hospital staff'<br><br>The Trust had previously collaborated with the University of Huddersfield on a joint research project to explore the characteristics of night-time noise levels and in-patients' self-reported sleep. An opportunity was taken to use this knowledge to develop an improvement package, which included:<br>• Educational online resource<br>• Presentations at key meetings<br>• Posters for wards<br>• Ward based 'sleep champions'<br>• Resources promoted through Trust 'comms'<br>• Clinical waste bin selection (soft-close)<br>• Looking into use of noise metre<br>• Adding information to elective surgery letters about ear plugs<br><br>The Professor of Nursing leading the research influenced a revision to the National survey question, changing to one that is more focused on sleep:<br><br>Were you ever prevented from sleeping at night by any of the following?<br>• Noise from other patients<br>• Noise from staff<br>• Noise from medical equipment<br>• Hospital lighting<br>• Something else<br>• None of these | Bin Evaluation: At both hospital sites to obtain feedback from clinical staff regarding 3 different models of bins, that are improved design than the current Wybone bins that are<br><br>The task group have made significant progress towards addressing this issue, not only for adults, but also children and young people. With some great examples of best practice being applied.<br><br>The priority is to now translate the research into improvement.<br><br>The role of Sleep Champions depleted during the high of Covid, but it is recognised in our new reality we now need to bring back this role.<br><br>We can measure that 70% of our nursing staff have now watched the education online resource, which is extremely positive.<br><br>**Plans for 2021/22**<br><br>• Work with individual ward managers and the nominated sleep champions to fully embed the improvement package, to include measurement of compliance and impact.<br><br>• A business case will be submitted for the provision of soft-close bins<br><br>• Reducing Noise at Night will feature of the 'Shine a spotlight' section of the next Patient Experience & Caring Group | **Substantial Assurance** |

| Project | Summary | Current position March 2022 | RAG rating |
|---|---|---|---|
| **3. Volunteer work - Front of House** – meet and greet service and safety guardian (NHSEI funded projects<br><br>***Project leads:*** to be revised due to new accountability structure with the Quality and Safety Team<br><br>***Evidence for change:*** Patient feedback | • Successful bids made to the NHSE&I 'winter and covid 19 volunteering programmes', has created an opportunity to fund temporary co-ordinator project posts within the Quality Directorate.<br>• The purpose of the NHSE&I funding is to support the use of volunteer services in order to reduce pressure on NHS staff and services.<br>• The project incorporates a detailed induction and on-boarding programme in line with the Trust's additional governance requirements for voluntary services to maintain safety of the volunteers. This includes monitoring progress, evaluating impact, and identifying emerging volunteer leaders.<br><br>Volunteer roles that form part of the project are:<br><br>- Establishing and embedding a robust front of house / meet and greet service (to include monitoring of covid 19 requirements (use of hand gel, wearing a face covering, maintaining social distancing). This role will also support the 'Belongings to Loved Ones' service, once a full rota is in place<br>- Exploring how the service can maximise the opportunities to support patients and carers on discharge from hospital<br>- Introducing ward based 'safety guardians' to work as part of the clinical team to provide 'eyes on' support<br><br>• The pilot Front of House rotas have now commenced, running over four mornings, the volunteers are providing feedback after each session based on reflection at the end of their shift re their observations of good practice, along with any concerns they encountered / noted | The Volunteers have made a significant improvement to the front of house at both HRI and CRH. Evidence has shown us that volunteers help on average 100 patients per shift.<br><br>**Volunteers have helped with:**<br><br>• Helping patients navigate around the hospital grounds to their appointments<br>• Reminding patients and visitors about the importance of wearing masks<br>• Signposting patients<br>• Conveying patients in their wheelchairs to their appointments (this is following training) freeing up porting staff.<br>• Collecting equipment for wards<br><br>**Insight shared from Volunteers**:<br><br>• If department moves/ closures happen, this information is not always cascaded onto volunteers and/or reception staff<br>• Appointment letters do not always make it clear where a patient should go on their appointment, this could result in patients arriving late for appointments<br>• Changes in relation to Covid visiting arrangements should be made clear to volunteers<br><br>The Volunteer programme has now been completed and handed over to Workforce & Development. | **Substantial assurance** |

| Project | Summary | Current position March 2022 | RAG rating |
|---|---|---|---|
| **8a. Volunteer bid – Ward Volunteers**<br><br>***Project leads:*** Liam Whitehead<br><br>***Evidence for change:*** Staffing levels / workforce data | The role of the 'Ward Volunteers" s' has been explored with ward managers to gain an agreement of suitable tasks, these include answering telephones, sitting with patients, supporting mealtimes and being involved in the 'time to clean' sessions<br><br>**Plans for 2021/22:**<br><br>• Commence a recruitment campaign for new volunteers, along with revisiting the readiness for existing volunteers who are currently not back in the Trust to return as government restriction are relaxed. All placements are based on an advanced safety check and Occupational Health agreement.<br><br>• Align the services with the existing volunteering services in the trust, embedding and sustaining the volunteer role – develop processes that will enable the project co-ordinators to walk away from the project with the volunteer positions functioning effectively within the trust and being recognised as an essential part of the ward's workforce model | Workforce and Development continue to roll-out Ward Volunteers. The Trust now has over 120 volunteers who have been deployed to priority areas where there are acute pressures. This provides hands on ward experience for those interested in careers in the NHS, reduces pressure on CHFT colleagues and has a positive impact on patient experience. Volunteers.<br><br>Demand for volunteer resource has been phenomenal. 75 x Volunteers working an average of 5 hours each week will bring over 19,500 additional hours with a cost benefit of £185K into CHFT.<br><br>The blueprint is in place for this project to be expanded and to incorporate other volunteer roles. Current funding ends in July 2022 and after this time there will be no designated resource for volunteering at CHFT. Funding opportunities are currently being explored.<br><br>**Feedback example:**<br>*''The care club have supported us in paediatrics for over a month with the Ward Volunteers, we have a fabulous range of volunteers who work various hours Monday to Sunday. The volunteers bring a smile to the teams faces and offer additional support to patients and their family. They have become an invaluable resource within our wards. The volunteers assist with nutritional needs, IPC compliance, patient experience and staff wellbeing. In addition, we have offered volunteers placements with us to enhance their career now and in the future and encourage long term recruitment. I am so thankful to each and every one of the team who tirelessly provide this support in their own free time, we couldn't do without them.''* | **Substantial assurance** |

<table>
<tr><th>Project</th><th>Summary</th><th>Current position March 2022</th><th>RAG rating</th></tr>
<tr>
<td>4. Making complaints count<br><br>Project leads: Emma Catterall/ Divisional complaint leads<br><br>Evidence for change: Local reviews / PHSO standards</td>
<td>Plans for 2021/22<br>Initial project milestones are focused on:<br><br>• Gathering user experience and feedback<br>• Capturing a wider data set of patient characteristics – to better understand the differing needs of our communities<br>• Improving data quality, including a staff education programme, improved internal communications, and improving the quality of complaint responses<br>• Developing a standard operating procedure for the complaint’s pathway in line with the Parliamentary and Health Service Ombudsman (PHSO) standards</td>
<td>The trust currently has 194 open complaints. (Figures taken from KP+)<br><br>
<table>
<tr><td></td><td>Total 194</td><td>Within time</td><td>In Breech of agreed timescale</td></tr>
<tr><td>Community</td><td>5</td><td>3</td><td>2</td></tr>
<tr><td>Corporate</td><td>2</td><td>0</td><td>2</td></tr>
<tr><td>FSS</td><td>21</td><td>14</td><td>7</td></tr>
<tr><td>Medicine</td><td>136</td><td>51</td><td>84</td></tr>
<tr><td>SAS</td><td>28</td><td>22</td><td>6</td></tr>
</table>
<br>Task and finish groups have set up to help address the following:<br><br>• Quality<br>• Learning<br>• Performance<br><br>Since the last report the task and finish groups have not taken place. However, learning tools with real examples of responses for divisional teams have been developed and are now available on the intranet. It is hoped that this will help raise the quality of the response letters to complainants.<br><br>Learning from complaints is still an area that requires development. The Risk & Quality team have set up learning groups to look at triangulation and implementation. This have been scheduled to commence from April 2022,<br><br>Making Complaints Count will continue to be a Trust Quality Priority for 2022/2023.</td>
<td>Reasonable Assurance</td>
</tr>
</table>

| Project | Summary | Current position March 2022 | RAG rating |
|---|---|---|---|
| **5. Commitment to Carers**<br><br>***Project leads:*** Quality Improvement Manager<br><br>***Evidence for change:*** National guidance | An assessment of the NICE guidance - supporting adult carers, has been used to direct the priorities for the Trust, which includes developing processes to involve carers more fully and for them to be seen as partners in care:<br><br>• Identifying unpaid carers<br>• Referring carers to 3rd sector carer support organisations (who will take responsibility to refer for formal carer assessments and signpost carers to information and support<br>• Recognising carers in the Trust (via a lanyard and ID card) and providing them with support such as reduced parking rates, refreshments, discounted meals and access to the ward. Also agreeing involvement in care and treatment discussions (with patient consent)<br><br>Contacts have been made from within the local community to explore more effective ways of working together:<br><br>- West Yorkshire and Harrogate Health and Care Partnership carers leads<br>- Local Authority carer leads and commissioners<br>- Local 3rd sector service providers<br><br>**Plans for 2021/22**<br>• Set up a carers collaborative group, with champions from services such as Frailty, End of life care, Discharge, Dementia, Learning Disability, Cancer, Stroke<br>• Review the involvement of carers post covid<br>• Identify test wards for the project<br>• Increase awareness in the Trust<br>• Co-design a carers charter | Our Carers strategy was presented and accepted at our Patient Experience and Caring Group (PEG) in March 2022. It is intended to ensure that carers and the role that they have in caring for someone is valued, that they are involved in a way they wish to be involved and supported in their role. It fits with the Trust's vision of delivering compassionate care that puts our patients and community first.<br><br>Our vision is for our staff to be carer aware and understand carers' rights. We will recognise, value, involve and support the role carers play in working with us to deliver patient-centred care. We will also recognise, value, and support the role of carers when they are patients themselves or are our colleagues.<br><br>**The CHFT Carers Strategy Themes:**<br>The Strategy's there are taken from the NHS England's Commitment to Carers:<br>1. Raising the profile of Carers<br>2. Education, training and information<br>3. Service development<br>4. Person-centred, well-coordinated care<br>5. CHFT as an employer<br><br>Objectives of the CHFT Carers Strategy:<br>• To ensure our staff are 'carer aware'<br>• To identify carers and support them with new and changing caring roles<br>• To value carers in their caring role when the person they care for is admitted to hospital<br>• To involve carers as valued partners<br>• To support and signpost carers to sources of support<br>• To have due consideration for carers when they are our | **Reasonable Assurance** |

| Project | Summary | Current position March 2022 | RAG rating |
|---|---|---|---|
| | | patients<br>• To have carer-friendly policies and practices in place for our staff<br>This will continue to me monitored through the Patient Experience & Caring Group. | |
| **6. Caring for patients with visual impairments**<br><br>***Project leads:*** Janette Cockroft / Disability Partnership Calderdale<br><br>***Evidence for change:*** Feedback from Disability Partnership Calderdale, Learning from patients and carers, SI | Group established and met via Teams – Ophthalmic colleagues, Disability Partnership Calderdale, Halifax Society for the Blind. Creating links with Kirklees visual impairment network. Propose as core project 2021/22<br><br>We started this collaborative working with Disability Partnership Calderdale, after they shared a story with us about an experience of one of their visually impaired members. We have had one meeting with them, following which they have undertaken some further engagement with visually impaired members and also with Halifax Society for the Blind.<br><br>They are bringing feedback from this engagement to a meeting this Thursday (happy for someone to join if they are free (12 – 1:30 via Teams)<br><br>Our aim is to identify where improvements can be made, prioritise issues raised and work together on solutions.<br><br>From the Trust we have myself, one of our corporate Matrons (Janette), Sister and Matron for eye clinic and eye clinic liaison officer<br><br>Also got Kirklees Visual Impairment Network attending the meeting | The group continues to meet.<br><br>Visual Awareness training for staff is being developed, so they understand the challenges patients with a visual impairment face when in our hospitals, Service users have been involved with the co-design of this. This was updated at the January meeting and comments have been invited for when the group next meets in April 2022.<br><br>Improvements have been made to signage.<br><br>The project lead has continued to raise the profile of the group through the transformation group, who are responsible for shaping the new building,<br><br>**Pete Hoey – Halifax Blind Society** '*I am really impressed with the work you are doing. This is going to make a massive difference for hundreds of patients. It is great to have conversations at the right time, rather than just being an afterthought'.* | **Work ongoing** |
| **7. Observe and Act**<br><br>***Project leads:*** Janette Cockroft / Andy Nelson | • Project work commenced in 2020 to introduce 'Observe and Act' within the trust. This national 'through the patient eyes' observation / improvement tool is to be utilised virtually as part of the focussed support framework approach. | CHFT continues to be the only organisation to use this approach in the country. The onsite clinical facilitator is supported by governors, members and Non-Executive Directors who view the environment through a patient's eyes and are involved in discussions with patients and staff | **Substantial assurance** |

| Project | Summary | Current position March 2022 | RAG rating |
|---|---|---|---|
| ***Evidence for change:*** Capturing real time feedback from patient perspective | • CHFT is currently testing this approach using virtual mechanisms and is the first trust in the country to test this approach.<br>• This module will be predominately supported/ delivered by volunteers, governors, members and non-executive directors.<br>• One of the key elements of this module relates to observing how our patients and carers with accessibility, inclusion and diversity needs are cared for.<br>• Key findings at each observation then drives local improvement at ward level in the trust.<br><br>**Plans for 2021/22**<br>Following the initial Train the Trainer training the aim is to build capacity and capability within the trust. Further recruitment of volunteers and governors to support will be happening. Ongoing evaluation is informing implementation in the Trust and this learning is being shared nationally. | members.<br><br>Key findings at each observation then drives local improvement at ward level in the Trust.<br><br>CHFT have been involved in sharing this concept with the national team and in recent months have been involved in the review work of the existing framework which is being introduced later this year through the national HOPE patient experience platform.<br><br>Further steps are being taken to adapt the framework and patient questions to use in our community hubs and provide patients with the opportunity to share their feedback on experience with community-based care. This is due to be piloted in Spring 2022. | |
| **Arts council** | Working with communities to coproduce a solution that enables communities and individuals to tell their story in a way that meets their cultural background / preferred medium for storytelling. The people that will be supporting the storytelling to happen practically will be from our local communities e.g. local students, local businesses. Focus On: health inclusion communities<br><br>**Next steps:** Meet with Arts & Health Programme Manager – South West Yorkshire Trust to scope the project | Funding has been secured to complete this.<br><br>Areas to develop further:<br>End of Life<br>Carers Choir<br>Children & Young People<br><br>We have undertaken 5 scoping exercises.<br>Awaiting next stages and South West Yorkshire Trust decision moving forward, but all engagement requirements have been fulfilled by CHFT to date.<br><br>We are awaiting further development from the Arts Council | **Reasonable Assurance** |

## 5. Patient Advice and Complaints Service (PACS)

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

### Key Objectives

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

| Objective | Current level of assurance | Comments |
|---|---|---|
| **1.** Working with the divisions effectively to deliver strong complaints performance and user centric service | **REASONABLE Assurance** | Progress continues and implementation of new processes is underway. Intranet page updated to ensure Divisions are aware of our processes and template letters are available to refer to. Improvement is required on responding within timeframes and work is continuing with Divisions to ensure improvement. |
| **2.** Making Complaints Count & Working Together to Get Results: Delivering on collaborative action plan/quality priority | **REASONABLE Assurance** | Task and Finish Group met to discuss Quality, Learning and Performance. Some progress was made to ensure we are meeting our KPI's and are able to measure these effectively. Further work is required on learning aspect and plans in place to set up a group to focus on this and share learning. |

### Progress against key objectives

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

| | February 2022 | March 2022 |
|---|---|---|
| Complaints received | 44 | 36 |
| Complaints closed | 44 | 34 |
| Complaints closed outside of target timeframe | 24 | 15 |
| % of complaints closed within target timeframe | 45% | 56% |
| Complaints reopened *1 | 8 | 9 |
| *1 Work is ongoing to validate this figure due to informal methods of handling further contacts on Datix | | |
| PALS contacts received | 180 | 162 |
| Compliments received | 47 | 38 |
| PHSO complaints received | 1 | 0 |
| PHSO complaints closed | 0 | 0 |
| Complaints under investigation with PHSO (total) | 5 | |

**Making Complaints Count Collaborative**

The Making Complaints Count (MCC) steering and operational groups have been reviewed to ensure effective use of colleague input across both groups. As mentioned in table above, a Task and Finish Group was identified and six sessions scheduled to focus on Quality, Performance and Learning, these commenced early January. Progress was made on 'quality' with discussions and agreements around expected response standards from Divisions. Intranet page updated to encourage divisional staff to refer to, including templates and examples of good responses.

Key Performance Indicators (KPI's) have also been agreed to focus on performance, quality (re-opened complaints) and escalation of concerns to complaints, to enable the Trust to measure these areas effectively and make improvements where required. Learning from complaints is a priority for the Trust with a group planning to be established to enable the triangulation of learning in relation to Complaints, Incidents, Inquests, Mortality and Compliments.

## 6. Legal Services

### Introduction

Calderdale and Huddersfield NHS Foundation Trust is committed to:

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

### Synopsis / Present position

Sarah Mather continues in the seconded role as Acting Head of Legal from Weightmans LLP (NHS Panel Solicitors) until a permanent placement is confirmed.

### Claims

There continues to be operational pressure around claims particularly due to new NHSR investigation processes and increased activity around claims. A new Legal standard operating procedure (SOP) is currently being worked on to streamline the claims process. The Divisions will be included in the drafting of this process to ensure an efficient and consistent approach across all Divisions.

In the interim, Paralegal assistance has been sought via a secondment with Weightmans LLP. This has allowed for additional support within the claim portfolio where we are experiencing high volumes of work (to handler ratio). A full review of the claims portfolio is currently underway and has allowed for the implementation of case plans, which are being reviewed and approved by the Head of Legal. This has allowed for deeper scrutiny of claims and escalation to the Divisions, Finance and the executive teams where organisational risk is identified.

The claims portfolio has so far reduced from 203 to 177.

A new SOP and escalation process for Calderdale and Huddersfield Solutions (CHS) Claims is currently in place to ensure the files are being dealt with correctly and efficiently. Legal are continuing to provide a Quarterly Report to CHS (by 1st March, June, September, December) with the Head of Legal or representative to attend the CHS Patient Safety Quality Board on a quarterly basis.

### Inquests

The backlog and difficulties at Bradford Coroner's Office continue to impact upon our ability to prepare for inquests and divisional pressure. A meeting between the Acting Head of Legal, Executive Medical Director and Executive Director of Nursing and Senior Coroner is planned to establish a line of communication with the Coroner's Office and agree a more productive and efficient working relationship moving forward.

We are slowly working to be more proactive and have better oversight of the risks within the inquest portfolio. Case plans have been fully implemented and include a risk rating of each

inquest case. The inquest portfolio has reduced to 72 (provisional assessment confirms 22 moderate, 33 low and 17 minimal risk inquests).

Moving forward, moderate and high-risk inquests will include executive and divisional awareness and include strategy meetings between panel solicitors, legal and senior leads from the divisional and assurance teams to discuss planning for the inquest, witness support and mitigation.

**Medical records disclosure**

Several issues have been identified within Legal and Patient Advice and Liaison Service (PALS) and Complaints Teams relating to the disclosure of patient records including the risk of duplication across various services. There also appears to be a disproportionate number of emails from claimant's solicitors / HMC advising that records released by Legal are incomplete and a separate process has become necessary to deal with locating missing records. This has been placed on the risk register.

A SOP is already in place however, further measures have been implemented including a system of cross checking of the medical and tailoring of record requests to limit the scope of disclosure (and likelihood of missing records). Staff access in being looked in to and an electronic learning package that gives full training, record of training and a place staff can refer to for updates is being considered.

**Statement disclosure**

Legal Services are currently trialling a new workstream in which all safeguarding and Police requests for information will come via Legal Services. This will allow Legal to review and facilitate formal requests as well as quality checking the statements prior to disclosure.

**Recent Data**

This report covers the period **1 February – 31 March 2022**.

**Clinical Negligence**

- 144 active clinical negligence claims
- 11 new clinical negligence claims were received
- 60 clinical negligence claims were concluded
- Damages totalled £8,023,609.05 (Obstetric claim settled for £6.5 million)

**Employers' and Public Liability (EL/PL) Claims**

- 23 active EL/PL claims
- 2 EL/PL claims were received
- 0 EL/PL claims were concluded

**Lost Property**

- 14 active lost property claims
- 3 lost property claims were received
- 0 lost property claims were concluded

**Inquests**

- 72 active inquests
- 16 inquests were opened
- 12 inquest files were closed

| Objective | Q2 | Q3 | Q4 | Assurance |
|---|---|---|---|---|
| **System in place to ensure effective communication within the Legal Services Department** | Snapshot service review completed. New Head of Legal Services to review further on commencement. | Acting Head of Legal to incorporate communication and sharing procedures within new Legal SOP. This is to be implemented by March 2022.<br><br>An escalation process has been agreed with the Divisions for triangulation and efficiency. | **This is ongoing. The proposed claims and inquest process is to be shared with the Division.**<br><br>**We are currently working on Claims and Inquest reports to be shared with the Executive and Divisional Teams.** | **Reasonable assurance** |
| **Datix Module for Legal Services reviewed and updated** | New Head of Legal Services to review further on commencement. | This has stalled in the absence of a Datix Manager. It is noted steps have been taken to recruit for this role.<br><br>Acting Head of Legal to incorporate into SOP to be implemented by March 2022.<br><br>Case Plans have already been implemented in the Inquest portfolio to record salient information. This is to be rolled out in Claims shortly. | **This continues as the new Datix Manager is yet to be appointed.**<br><br>**Further fields have been added to Datix including Trust risk probability and financial reserving. In addition, case plans have been implemented to record salient information.** | **Reasonable assurance** |
| **Audit of Legal Services files on Datix** | File audit continues in association with quarterly and bi-monthly reporting, plus ad hoc sampling, therefore more regularly than quarterly. | File audit continues in association with quarterly and bi-monthly reporting, plus ad hoc sampling, therefore more regularly than quarterly.<br><br>This is supported by the introduction of Case Plans to ensure accurate and up to date information is maintained on file. | **This continues. Learning is to be communicated at weekly portfolio meetings and discussed as part of monthly technical training sessions.** | **Reasonable assurance** |
| **SOP for DP7 requests** | Access to Health Data is updating the main Access to health records policy, of which this forms a part. | A finalised SOP from Access to Health Data has been received.<br><br>The Medical Records disclosure process is currently being reviewed. This has been added to the Risk Register given the operational, financial and reputational risk. | **As detailed above.** | **Reasonable assurance**. |

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

Legal are looking to incorporate learning from Inquest and Claims and Getting It Right First Time (GIRFT) into the new processes. Legal Services are planning to link in with Speciality GIRFT Leads and Divisions across the Trust on a quarterly basis in relation to claims and inquests. Whilst there are already established links in some areas, the aim is to standardise this engagement so that no clinical/divisional areas are excluded.

There will be two strands to this engagement. The first will be to ensure that all Divisional and Speciality Leadership, as well as individual clinicians involved in providing care, are sighted on all claims and inquests at the relevant stages. As above, this has been implemented.

The second strand of improved engagement will be with Speciality Leadership. Legal Services will arrange to meet with each Speciality, once a quarter, to review their new, on-going, and closed claims and inquests.

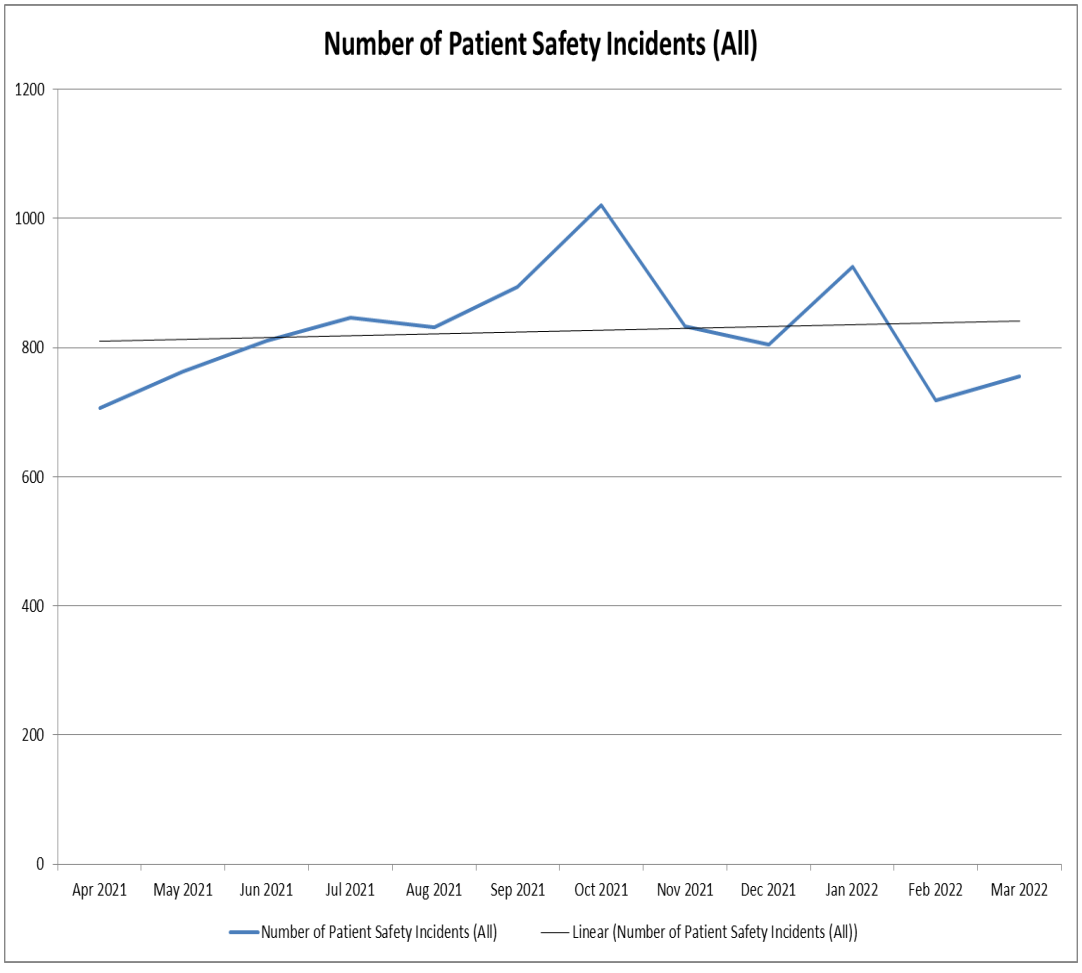
Reporting of this information is currently being reviewed as well as appropriate forums; however, it is anticipated this will be aimed at lower to senior levels and clinical forums. This will ensure oversight and awareness by the Speciality and improve identifying and acting on any learning in real time, rather than when a claim has concluded, which traditionally has been the case. This will also ensure that the 5 Point Action Plan recommended by GIRFT can be achieved on a continual basis, rather than once a year with the release of the Data Pack.

## 7. Incidents

Below is a summary of patient safety incidents and incidents with severe harm or death, for the year April 2021 to March 2022, and number of serious incidents (SIs) reported by month.

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

| Month reported | Number of Patient Safety Incidents reported (all) | Number of Patient Safety Incidents of severe harm or death | Serious Incidents by the month externally reported on StEIS |
|---|---|---|---|
| Apr 2021 | 707 | **3** | 4 |
| May 2021 | 763 | **5** | 2 |
| Jun 2021 | 811 | **7** | 6 |
| Jul 2021 | 846 | **4** | 3 |
| Aug 2021 | 831 | **7** | 2 |
| Sept2021 | 894 | **11** | 4 |
| Oct 2021 | 1020 | **9** | 6 |
| Nov 2021 | 833 | **10** | 7 |
| Dec 2021 | 804 | **3** | 1 |
| Jan 2022 | 925 | **11** | 2 |
| Feb 2022 | 718 | **8** | 3 |
| Mar 2022 | 755 | **14** | 5 |



**Never Events**

One Never Event was reported in March 2022 in relation to wrong site surgery.

**Summary of Progress with Serious Incident Actions**

The Risk team continues to review the management of serious incidents and has incidents where outstanding actions have been evidence.

The Risk team continue to provide support to clinical teams. The risk team effective oversight of serious incidents and continue to work closely with the divisions to support a consistent process across the Trust and ensure all actions are responded to in a timely manner, with robust evidence to support this

A total of eight StEIS (Strategic Executive Information System) incidents were reported; three for February 2022 and five in March 2022.

**Learning from Serious Incidents**

Specific themes and trends from serious incidents are identified as: -

- A robust handover between the mental health team and the physical health team to take place to ensure that all MHA documentation is completed correctly and that this is contained within the patients notes.

- Staff to be made aware of the needs of confused/visually impaired patients and use the Mental Capacity Act (MCA) and the Best Interests decision-making process to record the decisions which are made in the patient's best interests.

Serious incident reports submitted to the Clinical Commissioning Group (CCG) in February 2022 and March 2022 are as follows:

| Incident Summary | Learning Need and Organisational Learning |
|---|---|
| Unknown / unbooked pregnancy | • The sepsis and AKI bundle to be reviewed to include that in women of childbearing age with abdominal distension, an ultrasound scan to rule out possible pregnancy should always be considered even if the woman denies that a pregnancy is possible.<br>• Radiologist enlarges any scanograms prior to proceeding to a computerised tomography (CT) scan on patients who are of childbearing age where there is a CT request to exclude intra-abdominal sepsis in order to identify any foetus and to reduce the risk of carrying out a CT scan on a unknown pregnancy |

| Incident Summary | Learning Need and Organisational Learning |
|---|---|
| Missed / failed diagnosis by outsourcing company | • It is noted that from the external reporting company that the individual concerned as undertaken personal reflection/learning from this incident: In addition, the reporting Radiologist has undertaken a personal reflection and learning on clinical aspect of reporting for internal purposes, which our Clinical Lead has reviewed and confirmed that the appropriate learning has been recognized and will be applied to their reporting.<br>• As with all discrepancy cases, this case was shared at our own Trusts Radiology Departments REALM (learning) meeting to enable wider learning. |
| Patient was unlawfully detained | • All details of patients sectioned under the mental health act on both acute floors to be emailed to the matron for awareness- check of paperwork then to be done for completeness. Information has been cascaded to all ward sisters.<br>• All senior ward staff band 8,7 and 6 to do the in-house training for receipt and scrutiny process. A robust handover between the mental health team and the physical health team must take place to ensure that all MHA documentation is completed correctly and that this is contained within the patients notes, this included all sections of the H3 form<br>• A process (checklist) should be in place to ensure that the patient is given their section 132 rights and it is documented that they have understood these<br>• Any error / omission in completing any part of the MHA documentation during any stage of the patient's admission should be escalated to the Matron and the safeguarding team so that this can be rectified in a timely manner |
| Complication of treatment resulting in episode of care | • Assess each patient for the appropriate site for central line insertion prior to procedure<br>• The operator must satisfy themselves that the line is correctly placed intravenously<br>• All central lines to be checked with pressure transduction prior to use<br>• If pressure transduction is unavailable, blood gas analysis confirming venous placement to be demonstrated prior to use<br>• A team approach to ensuring correct checks have taken place to confirm venous placement<br>• If a central line is inadvertently placed in the arterial system, to consult vascular surgeons to advise best course of action<br>• Highlight potential for misinterpretation of Chest X-rays and aspiration of dark non-pulsatile blood<br>• Chest X-ray teaching of unusual line appearances<br>• Case Presentation to ICU and anaesthetic team |

| Incident Summary | Learning Need and Organisational Learning |
|---|---|
| Hospital Acquired Pressure Ulcer Category 4 | • Comprehensive risk assessment tools support identification of potential risk and in the planning to mitigate this risk<br>• Having clear roles and responsibilities ensures colleagues understand their role in patient care<br>• Best practice guidance and national guidelines give us an evidence-based upon<br>• which to align care planning and documentation |
| Patient Fall | • The role of the LADO / PIPOT can support with the managing allegations against staff policy and when to notify an incident for advice and support<br>• Be aware of the needs of confused/visually impaired patients and use the MCA and the Best Interests decision-making process to record the decisions which are being made in the patient's best interests<br>• Be aware of the changing legal status of patients in relation to MCA / DoLS, particularly how it is recorded within the EPR<br>• Be cognisant of carrying forward or replicating information regarding the legal status of a patient and always check first<br>• Body Worn Video Camera recordings provide an additional contemporaneous record of events to support the patient and staff |
| Patient admitted with sepsis found unresponsive. | • Initiation of Sepsis 6 with the early establishment of an alternative suitable viable intravenous access considered and urinary catheter insertion to maintain accurate monitoring of urine output.<br>• Consideration of early escalation to the critical care outreach team / HOOP for a patient with an elevated NEWS prior to transfer from the emergency department to ward to provide additional support at ward level.<br>• Clear documentation of the patient's care pathway and information cascaded to the clinical teams caring for the patient to avoid misinterpretation of information.<br>• Sensitive discussion regarding ceiling of care, prognosis and Do Not Attempt Resuscitation (DNAR) with the patient. |

| Incident Summary | Learning Need and Organisational Learning |
|---|---|
| Complication from treatment resulting in death | • Shared learning with Leeds Renal service Ward 50 and the Renal Consultant who has assisted in fact finding re learning from the investigation.<br>• A Trust wide review of the current policy Guidelines for the management of electrolyte imbalance in adults July 2020 is required to incorporate the recommendations of the Renal Association Clinical Practice Guidelines Treatment of Acute Hyperkalaemia in adults (2020).<br>• internal and external communication regarding patient management - including transferring to other care facilities - are to have an allocated clinical team member to take responsibility for relevant actions including communication with all appropriate clinical personnel involved in the patient care, acute floor coordinator and if required clinical coordinator, in case escalation is required for inter hospital transfers. Progress of actions are to be documented clearly in the patient's electronic patient records (EPR) |
| Treatment / Care delivery- Ventilator placed on standby | • Placing Hamilton S1 ventilator into 'standby' should be avoided. If required, then verbalisation of the action must be undertaken, and distraction avoided until ventilation resumed<br>• Minimum monitoring standards should be placed into the guidelines for arterial line insertion<br>• The case should be discussed at the ICU mortality and morbidity meeting |

## 8. Medicines Safety

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

**Medicine Safety Compliance Group Attendance**

Quoracy remains a challenge however, the group is making progress in increasing engagement. A patient representative and junior doctor joined the last meeting. Next steps include the following:

- Junior Pharmacist to attend on rotational basis to help with understanding and supporting medicine safety agenda.
- Regular Feedback from specialist medicines groups/leads

The group are working with IT colleagues to develop a medicines management dashboard. This will help provide assurance for compliance of medicine management standards and also track improvements following any changes in guidance or practice.

**Electronic Controlled Drugs Register (eCDR) Development**

User Acceptance Testing (UAT) is underway with the eCDR over the next 2 weeks, and we have a planned roll this out to wards if the UAT proves to be successful.

Once finalised and implemented the eCDR will reduce Controlled Drug (CD) incidents related to documentation for example crossing outs, ambiguous entries and provide greater visibility with the reporting functionality of CD management in clinical areas.

**Medical Gases**

The DNO/DMO Forum did not go ahead due to Trust Opel 3 levels of activity. Instead, a briefing to Senior Managers and Ward Managers was provided in relation to key messages and risks which impact on medicine and patient safety, this included:

- Availability of CD Oxygen cylinders
- Correct storage and transfer when using CD oxygen cylinders
- Correct operation of CD oxygen cylinders linked to training
  Appropriate management of faulty cylinders

| Issue | Update | Risks | Mitigations | Next steps | Assurance |
|---|---|---|---|---|---|
| **Non-compliance of the medicines management 'must do's**<br><br>**Ongoing objective requiring continual monitoring** | Electronic meds management audit tool developed and being rolled out to ward managers. To be completed by November 2022<br><br>Spot checks have not demonstrated improvements.<br>Added to Medication Safety and Compliance Group (MSCG) workstreams a review of current Medicines management training module making it more reflective of CHFT medication safety issues. Lead Medicines management nurse is leading on this review.<br>Deep dive of training issues due to be presented at weekly Executive Board (WEB) but this has been cancelled twice.<br>Only 1612 staff are registered for this training and 1251 have completed it. 1612 does not equate to the total number of RNs / RMs / ODPs / NAs, Prescribers & AHPs who handle medicines at the Trust. | Audits only give a snapshot of routine practice<br><br>It appears there is a difference in the results seen on planned visits when the ward is informed in advance they are being audited compared to ad hoc/ unannounced visits indicating the planned audits may not be seeing the true picture<br><br>As the current medicines management training does not reflect our medication safety issues, we risk staff not being aware of the required standards and how to mitigate these risks. | Ward managers and senior nurses reminded of the core standards and their professional responsibility to adhere to them<br><br>Pharmacy teams supporting wards to alert senior nurses if standards aren't being met. To offer support when capacity to do so in terms of emptying returns bin/ putting deliveries away/ removing expired medication from fridge<br><br>Training to be reviewed and updated. Divisions to be made aware of which staff need to complete this training. | Where spot checks have highlighted issues / concerns, reported to ward manager and action plan agreed.<br><br>Areas with poor medication storage facilities e.g paediatrics being considered for installation of electronic cabinets to support with medication storage compliance. This is unlikely to be until 22/23. Paediatrics informed that the cabinets do not currently interface with Cerner.<br><br>Some areas: ED and the ward 6's asking for additional pharmacist support due to medication governance issues in those areas. Whilst short term support is being provided (where possible), a long term solution i.e. business case needs to be considered.<br><br>Discuss with the Web team about building bespoke CHFT medicines management training that is reflective of current local and national medication safety issues. Review if which staff requires this training and how compliance can be improved. Still awaiting timescales from web team regarding approximate timescales for completion of this meds management training development work. | **LIMITED ASSURANCE** |

| Issue | Update | Risks | Mitigations | Next steps | Assurance |
|---|---|---|---|---|---|
| **Annual medication fridge temperature monitoring audit highlighted only 39% of all areas 100% compliant. Repeated audits continue to show poor compliance.**<br><br>**Go live for Stanley Active temperature monitoring system- target completion date delayed from Aug 21 to April 22** | Review of in hours and out of hour's escalation process as switchboard staff will now be part of this process. SOP needs amending to reflect this change and then recirculated to staff who have already been trained on the original escalation process. Go live for active fridge temperature monitoring is on hold until the Switchboard process is confirmed. | Audits show that staff are not acting on temperature deviations<br><br>Staff may tamper with new temperature devices as they may not know what they are<br><br>Staff have turned off current' traditional' fridge thermometer alarms (reliant on for manual monitoring of fridges until the active system go live). This results in no audible alarm i.e., when fridge door left<br><br>Once Go Live for fridge monitoring, aim go live with ambient temperature monitoring and there is a financial risk for any areas whose temperature is consistently above 25 degrees Celsius as they may need air con installing | Screensaver and comms issued to clinical staff showing pictures of monitoring devices including instruction stating not to tamper with devices<br><br>Daily manual recording of fridge temperatures continues until active system Go Live<br>Pharmacy audits continue to check 'traditional' fridge monitor alarm correctly switched on and daily monitoring of temperatures is recorded<br><br>For any areas storing meds at higher than recommended temperatures, there is a pharmacy led process of reducing expiring dates (depending on exposure length and temp reached). This carries the added risk of increased waste of medication/ cost | SOP updated to include Switchboard escalation.<br><br>Ward managers reminded of must do's /manual fridge temperature monitoring requirements (until Go live with active temperature monitoring system)<br><br>Comms to nursing teams of active temp system, Go Live date and requirement to complete training<br><br>Relevant staff to complete training and informed of switchboard escalation process. | **Reasonable assurance** |

## 9. Maternity Services

### Ockenden report

The service received Dame Donna Ockenden's final report into maternity services at Shrewsbury and Telford NHS Trust on the 30th March. This is a far-ranging report with actions not only for maternity services but also for Obstetric Anaesthetic and Neonatal services at provider levels long with wider system and national actions to improve all actions of maternity care.

There are 15 Immediate and Essential Actions described in the report and maternity services are currently undertaking a robust self- assessment of their current position and will provide Quality Committee, Board and the Local Maternity System with a robust action plan to achieve compliance with this landmark review of maternity services.

The service continues to work towards achieving full compliance with the action of the first Ockenden report and is expecting an assurance visit from regional colleagues on the 28 June 2022 this year to review our current position.

### Better Births – Continuity of Carer (COC)

Within Immediate and Essential Action 2 (Safe Staffing) of the final Ockenden report is an action for all trusts to review and suspend, if necessary, the existing provision and further roll out of Midwifery Continuity of Carer (MCoC) unless they can demonstrate staffing meets safe minimum requirements on all shifts.

This is in response to the report author's acknowledging that "this will preserve the safety of all pregnant women and families, which are currently compromised by the unprecedented pressure that MCoC models place on maternity services already under significant strain."

On the 1st April all trusts received a letter from the NHS Chief Executive, Chef Nursing Officer and National Medical Director that trusts should immediately assess their staffing position and make one of the following decisions:

- Trusts that can demonstrate staffing meets safe minimum requirements can continue existing MCoC provision and continue to roll out MCoC provision
- Trusts that cannot meet minimum safe staffing requirements for further roll out of MCoC, but can meet safe staffing requirements for existing MCoC provision, should cease further roll out and continue to support at the current level of provision, or only provide services to existing women on MCoC pathways and suspend new women being booked into MCoC provision
- Trusts that cannot meet safe minimum staffing requirements for further roll out of MCoC and for existing MCoC provision should immediately suspend existing MCoC provision and ensure women are transferred to alternative maternity pathways, taking into consideration their individual needs.

At the time of writing maternity services are assessing their position against the above in order to inform Executive Board.

### NHS Resolution Maternity Incentive Scheme

In response to the on- going COVID-19 pandemic and the pressures currently being experienced across all areas of healthcare NHS resolution suspended year 4 of the Maternity Incentive scheme in December for a period of three months initially. The service

however continues to work towards the current trajectories and have not paused any internal on-going work to meet year 4 of the scheme.

At the time of writing year 4 of the scheme has not been reinstated however an update version of year 4 is expected imminently.

**Healthcare Safety Investigation Branch (HSIB)**

As of the 4th April 2002 the position is:

| Cases to date | |
|---|---|
| Total referrals | 36 |
| Referrals / cases rejected | 11 |
| Total investigations to date | 25 |
| Total investigations completed | 21 |
| Current active cases | 4 |
| Exception reporting | 0 |

Of the current cases the position is:

**HSIB case number: MI-004891**
**HSIB criteria:** HIE / Cooling
**Trust site:** Calderdale Royal Hospital
**Incident date:** 03/11/21
**Referral date:** 11/11/21
**Consent date:** 16/11/21
**Six-month deadline:** 03/05/22
**Update:**
- 29 March 2022: Draft report shared with the Trust.

**Next steps:**
- Following responding to the Trust comments, the draft report will be shared with the family.

**Key lines of enquiry:**
- Escalation process for cat1 caesarean sections.

**HSIB case number: MI-005708**
**HSIB criteria: Neonatal Death**
**Trust site:** Calderdale Royal Hospital - Home
**Incident date:** 15/12/21
**Referral date:** 29/12/21
**Consent date:** 31/12/21
**Six-month deadline:** 29/06/22
**Update:**
- Staff interviews complete.
- Additional information requests received with thanks.
- 28.03.22: Additional neonatal surgical review completed.
- Draft report and analysis underway.

**Next steps:**
- 20.04.22: Second subject matter review panel.

**Key lines of enquiry:**
- Management of antenatal Vitamin D.
- Induction of labour following SROM.
- Neonatal care at Trust A and Trust B.

**HSIB case number: MI-005964**
**HSIB criteria:** HIE / Cooling (neonatal death)
**Trust site:** Calderdale Royal Hospital – Birth centre
**Incident date:** 13/01/22
**Referral date:** 17/01/22
**Consent date:** verbal consent 20/01/22
**Six-month deadline:** 17/07/22
**Update:**

- 31/03/22: Staff interviews completed.
- Progress to analysis and prepare for HSIB obstetric and neonatal clinical panel meetings.

**Next steps:**

- 04/05/22: scheduled second HSIB neonatal clinical panel meeting.
- 05/05/22: scheduled second HSIB clinical panel meeting.

**Key lines of enquiry:**

- Risk assessment of pregnancy and the management plan.
- Care in latent phase of labour.
- Assessment of maternal and fetal wellbeing in labour.
- Resuscitation of the baby.

**HSIB case number: MI-006831**
**HSIB criteria:** HIE (NND at 7 days of age)
**Trust site:** Calderdale Royal Hospital
**Incident date:** 20/02/22
**Referral date:** 22/02/22
**Consent date:** 03/03/22
**Six-month deadline:** 22/08/22
**Update:**

- Emailed governance department re funeral date and provisional interviews- await response.
- 05/04/22: SMART 1 rescheduled.

**Next steps:**

- Terms of reference to agree at SMART 1; share with the Trust and family
- Undertake family and staff interviews.

**Key lines of enquiry:** To be confirmed.

**Perinatal Mortality Review Tool (PMRT) Quarter 4 Report**

Quarter 4 PMRT reportable cases

| Date | Gestation | Stillbirth (SB) or Late fetal Loss (LFL) | Brief Summary |
|---|---|---|---|
| 4.1.22 | 23 | LFL | Reduced fetal movements for 24 hours prior to attending |
| 4.2.22 | 39+2 | SB | No fetal movements for 24 hours, prior to attending |
| 14.2.22 | 24+4 | SB | Attended Antenatal clinic no fetal heart heard |
| 18.2.22 | 26+2 | SB | Attended MAc with reduced feta movements no fetal heart heard |
| 9.3.22 | 29+6 | SB | Twin pregnancy this baby twin 1 known to have demised at 27 weeks of pregnancy. Spontaneous labour and twin 2 born alive and transferred to NICU |

Neonatal Deaths in Quarter 3

| Date of death | Gestation / Age | Brief Summary |
|---|---|---|
| 14.1.22 | 22+5 | Spontaneous labour at 22 weeks of pregnancy parents opted for no resuscitation due to extreme prematurity |
| 21.1.22 | 9 days | Overlay at home will be followed up via Child Death Overview Panel |
| 22.1.22 | term | Unexpected poor outcome at birth HSIB investigating |
| 15.2.22 | 22+2 | Admitted in labour |
| 21.2.22 | 29 days | Unexpected death at home will be followed un by Child Death Overview Panel |
| 4.2.22 | 24+4 | Spontaneous labour baby transferred to Sheffield |
| 27.2.22 | 37+3 | Twin pregnancy twin 1 born alive twin 2 born in poor condition transferred to Tertiary Neonatal Unit. Referred to HSIB |
| 17.3.22 | 28+5 | Known preterm ruptured membranes since 24 weeks, spontaneous labour baby in poor condition transferred to NICU. |

**Maternity Incidents**

Maternity incidents reviewed at weekly maternity governance MDT meeting. All incidents are reported via Datix and coded as maternity incidents. The data for February and March are described below.

| | Total Feb | Total (to 24.3.22) |
|---|---|---|
| PPH- no adverse outcome | 6 | 5 |
| Shoulder Dystocia | 3 | 2 |
| Unexpected admission to the Neonatal Unit | 16 | 15 |
| 2nd Theatre opened | 7 | 2 |
| 3rd or 4th Degree perineal tear | 2 | 3 |
| Delay in Emergency Caesarean Section | 9 | 5 |
| **Total** | **53** | **32** |

**Maternity Complaints**

Maternity services currently have 3 open complaints as of 29th March 2022 under investigation all of these within timescale.

**Maternity Staffing**

In line with nursing at CHFT midwifery staffing allocation is managed through the Allocate e-rostering system and Safecare safer nursing care acuity and dependency tool. However, to note Safecare is not a recognised tool for maternity acuity so the Birth Rate Plus acuity tool is used in both Labour, Delivery, Recovery and Postpartum (LDRP) and the Birth Centre.

**Local Midwifery Metrics**

The LDRP coordinator completes the Birth Rate Plus acuity tool every four hours. The tool assesses each patient on the ward at the time of the census against specific criteria relating to their pregnancy risk and status, whether they are antenatal, in labour or postnatal. The number of midwives on duty is also taken into account. The tool assesses the number of

midwives available against the acuity and demand of the patients and calculates the excess or deficit of midwives available in that time period.

This is then RAG rated:

- Red more than 3 midwives short in the census period
- Amber up to 3 midwives short in the census period
- Green number of midwives available meets the acuity

In the February and March 2022, the acuity was:

| Week | %Census periods RAG rated Red | %Census period RAG rated Amber | %Census periods RAG rated Green |
|---|---|---|---|
| 7.2.22 | 0% | 40% | 60% |
| 14.2.22 | 2% | 40% | 57% |
| 21.2.22 | 7% | 36% | 56% |
| 28.2.22 | 0% | 24% | 76% |
| 7.3.22 | 7% | 48% | 45% |
| 14.3.22 | 2% | 49% | 49% |
| 21.3.22 | 5% | 57% | 38% |
| 28.3.22 | 2% | 31% | 67% |

Whilst the table above describes the weekly position, it is important to note that the acuity fluctuates as activity on the labour ward ebbs and flows therefore the daily review of acuity is a more sensitive metric as it captures the peaks and troughs directly related to the number of women in labour at any one time and their individual acuity. It is this metric that the senior maternity leadership team use to deploy midwives to match the acuity, this period of deployment can range from a whole shift to a few hours and the acuity changes.

1:1 care in labour is reported both internally and externally on the maternity Dashboard.
The previous six months data for CHFT is:

| Month | Sep | Oct | Nov | Dec | Jan | February |
|---|---|---|---|---|---|---|
| % women received 1:1 care in labour | 98.8% | 98.4% | 96.6% | 98.1% | 99.7% | 98.8% |

Quarterly LMS and Yorkshire and the Humber data for 1:1 care in labour

| 1:1 care in labour | Q1 21/22 | Q2 21/22 | Q3 21/22 |
|---|---|---|---|
| CHFT % | 98.5% | 97.2% | 96.8% |
| West Yorkshire and Harrogate LMS | 95.38% | 94.6% | 94.7% |
| Yorkshire and The Humber % | 91% | 94.3% | 94.7% |

**Labour Ward Coordinator Supernumerary**

NHS Resolution's Maternity Incentive Scheme describes that the midwifery coordinator in charge of labour ward must have supernumerary status, which is defined as having no caseload of their own during their shift to ensure there is an oversight of all birth activity within the service.

The assessment of supernumerary status is a subjective assessment undertaken by the coordinator and recorded each census period within the Birth Rate Plus acuity tool. For the period 1.2.22 to 31.3.22 there were 354 census periods and only 2 consecutive 4 hour periods (99.54% time Coordinator supernumerary) where the LDRP Coordinator was not supernumerary.

## 10. Quality Priority updates

The report details each priority and the measures to be monitored and reported into the Quality Committee this coming year.

### Quality Account Priorities

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

### Focussed Quality Priorities

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

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

**Operational Leads** – Dr Rob Moisey and Paula McDonagh

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

| What do we aim to achieve? | February to March 2022 Update | Progress rating |
|---|---|---|
| **QP1.** Increase our concordance with the administration of intravenous antibiotics in the emergency depts. within 60minutes of recognition of sepsis to 80% for the severely septic patient.<br><br>This will be measured by using the Red Flag Criteria for severe sepsis recognition. Concordance is captured by the timing from the earliest suspected sepsis alert to the administration of the first intravenous antibiotic through the electronic patient record system. | **1) All patients coded with sepsis-February 2022- 62.1%**<br>**March 2022-57.3 %**<br><br>**2) Red flag patients- February 2022- 59.3%**<br>**March 2022- 46.8 %**<br><br>The above percentages are based on 1) all patients coded with suspected sepsis in the Emergency Department (ED) at both sites.2) all patients admitted to EDs with Red Flag sepsis.<br><br>**Progress work**<br><br>- Sepsis trollies in use at both ED sites.<br>- Macoset device introduced to assist with mixing the antibiotic Pip Tazocin<br>- Mobile phones for ED Registrar sepsis reviews now delivered and SOP set up.<br>- Rob Moisey and Huw Masson met with informatics 30/3/22 to finalise parameters for red flag data pull. This was then tested for accuracy.<br>- Sepsis nurse delivering training and liaising with ED sepsis champions. Sepsis boards in place and display monthly data results and sepsis press.<br>- Sepsis nurse identified on each shift in ED, awaiting delivery of Tabbards.<br>- ED sepsis lead clinician updating actions from red flag data at daily handovers.<br><br>**Risks and mitigation's**<br><br>- Continued use of sepsis trolleys being monitored.<br>- Not all staff using Macoset device to mix Pip Tazocin ED HRI so further communication re usage given, **Action** sepsis nurse will monitor, and check stock levels are sufficient. Sepsis nurse overseeing commencement of trial of device in ED at CRH. Use of Macoset device introduced to acute floors and Frailty due to success in ED, positive feedback on reducing preparation times and support of good practice re ANTT.<br>- Patients admitted to Resus with sepsis do not always have their IV antibiotics signed for in timely way due to time critical administration, sepsis nurse looking at improving this issue. Possible effect of data compliance results.<br>- Compliance of sepsis training reduced due to staffing shortages and vacancies. **Action-**Sepsis nurse | **Reasonable Assurance** |

| What do we aim to achieve? | February to March 2022 Update | Progress rating |
|---|---|---|
| | delivering training to RNs and noted to have improved attendance in March.<br>- Staffing shortages have been affecting patient reviews and treatment times. **Action –** ED teams initiated cross site staffing support lead by lead nurse each site, use of flexible workforce and extra duty payments.<br><br>**<u>Successes</u>**<br><br>Category 2 patients in the emergency department are being seen in rapid assessment at HRI rather than waiting for a cubicle. This has improved treatment times for patients with sepsis.<br><br>Mobile phones delivered and SOP set up.<br><br>Recruitment of sepsis champions in both EDs.<br><br>Agreed that further purchase of sepsis trolleys required as part of reconfiguration plan.<br><br>Sepsis boards in both EDs | |
| **QP2.** Compliance of all elements of the sepsis 6 (BUFALO) to be improved to 50% **single elements to be improved to 90%** | **Feb2022** **March 2022** | |
| **B**lood cultures | 82.8%. 72.5% | **Reasonable** |
| **U**rine output | 75.3% 73.5% | **Reasonable** |
| **F**luids | 97.8% 99.0% | **Substantial** |
| **A**ntibiotics | 97.8% 99.0% | **Substantial** |
| **L**actate | Unable to add Lactate to EPR | |
| **O**xygen | 92.5% 90.2% | **Substantial** |
| **TOTAL %** | **60.2%** **50.0%** | |
| Each element will be measured (with exception of Lactate) from the sepsis screening tool and power plan within the electronic patient record. | **<u>Progress work</u>**<br><br>- Element for blood culture has been confirmed as being measured accurately, sepsis nurse actioning drop ins to clinical areas to remind clinicians about taking blood cultures within red flag sepsis criteria.<br>- Sepsis screening tool now live on Athena, informatics are now able to gain compliance data.<br>- Point of Care Testing Business case funding now agreed and waiting next stage to initiate the reporting of blood gas and urinalysis results from Lab to EPR. Aim is for this to be completed by 31/03/2022. Working groups in place. **No update available.**<br><br>**<u>Risks and mitigation's</u>**<br><br>- Not all Red flag sepsis patients are receiving blood cultures when sepsis six care bundle requests this, this is more prevalent in ward areas. **Action-** sepsis collaborative members to media the requirement through | |

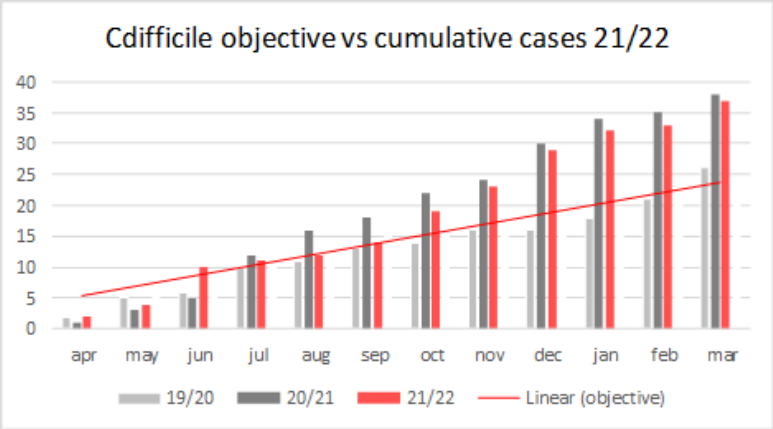
| What do we aim to achieve? | February to March 2022 Update | Progress rating |
|---|---|---|
| | their work channels, sepsis nurse to visit clinical areas and remind clinicians, action group to be set up by sepsis nurse, article added to sepsis press re importance of this element measure. Additionally, sepsis 6 education now on junior doctors induction training. Noted that nurses within ward based areas do not take blood cultures so added to agenda on IV working group for discussion/action.<br><br>**Successes**<br><br>Target of total (50%) compliance achieved<br>Oxygen element changed to measure target saturation compliance resulting in more accurate recording.<br>Consistent month on month substantial progress reporting fluid and antibiotics.<br>PCOT funding agreement to report arterial and venous blood gas results (Lactate). | |
| **QP3.** Establish sepsis skills training as part of essential safety training and achieve 40% concordance for eligible staff in year 1.<br><br>This will be measured by training compliance records extracted from ESR and Lead Sepsis Nurse presentations. | Business intelligence have now provided the training numbers:<br>- Consultants (except Obstetrics and Gynaecology) 250<br>- Foundation years (except Obstetrics and Gynaecology) 82<br>- CT (except Obstetrics and Gynaecology) 31<br>- ST (except Obstetrics and Gynaecology) 69<br>- Clinician Total **432**<br>- Registered Nursing Total **672**<br><br>**Progress work**<br><br>- Sepsis training continuing on Teams and face to face with 20 eligible staff being trained in last 4 weeks. **Total so far 260**<br>- Sepsis presentation now separated into clinician and registered nurse. RN approved at January's sepsis collaborative meeting now to be approved at nursing and midwifery group on 20/4/2022. Clinician training approved at the sepsis collaborative and approved by Cornelle Parker. Both to be added to EST in next 4 weeks.<br>- Sepsis champions supporting the training of registered nurses in clinical areas.<br><br>**Risks and mitigations**<br><br>- Sepsis recognition and treatment not currently part of essential safety training. **Action-** agreed at sepsis collaborative that training should be mandatory and with a 3-year update.<br>- Access to training staff proving difficult at times due to ward/dept pressures and movement of staff to support staffing shortages particularly in last 2 months. **Action-** sepsis nurse providing access to training evening and weekends and utilising sepsis champions to assist where possible. Attendance improvement noted in March 2022. | **Limited assurance** |

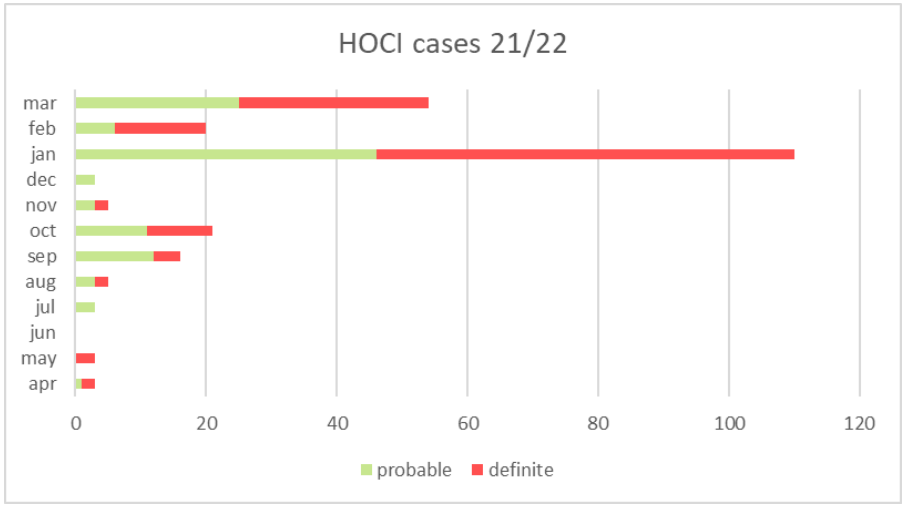
## 10.2 Reduce number of Hospital Acquired Infections including COVID-19 (Quality Account Priority)

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

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

| What do we aim to achieve? | February to March 2022 Update | Progress rating |
|---|---|---|
| **QP1.** Through the testing workstream we will ensure that all CHFT patient and colleague testing strategies are compliant with National and Local guidance. This will be measured by performance against patient testing regimes. | CHFT are compliant with the minimal national patient testing regime and also include additional tests as part of our local guidance | **Full assurance** |
| | Covid testing compliance data issue within KP+ – escalated. Unable to provide an accurate position. | **Limited Assurance** |
| | Lateral Flow Device (LFD) testing is in place as per national guidance for staff. This is to be encouraged with staff but is not mandated. We are no longer able to track this data due to staff being instructed to upload results onto the National portal. Continuing actions taken to promote LFD uptake include communication via leadership briefings and the MUST Do messages. | **Limited Assurance** |
| **QP2.** Support a system wide approach to Covid-19 vaccination programme through CHFT vaccine centres and support to the national programme. | No further clinic sessions booked for staff. Should staff want to access vaccination, this is available via the government booking system. Planning for 2022 Autumn/Winter C19 and influenza vaccination is in the planning stage. | **Substantial assurance** |
| 2a Establish specialised vaccine clinics for people with Learning Disabilities (LD) | Specialised clinics have been established to support people with a learning disability to receive their vaccines and will be included in future planning | **Substantial assurance** |
| 2b Establish clinics for people with allergies | All future allergy referrals for the whole of West Yorkshire where there is the need to administer the vaccine in an acute setting will be managed at Airedale Hospital. | **Full Assurance** |
| 2c Community teams support the vaccine programme across Calderdale | The community healthcare division has proactively supported the vaccination programmes across Calderdale place and has included this in the system wide winter planning. | **Substantial assurance** |

| What do we aim to achieve? | | February to March 2022 Update | Progress rating |
|---|---|---|---|
| | 2d Through our partnerships support the vaccine programme across Kirklees | CHFT have remained an active partner on the Executive Partnership meeting for Kirklees and have contributed both in leadership activities and resource support to the programme | **Substantial assurance** |
| | This will be measured as a narrative against the indicators and numbers of people vaccinated where data is available | Staff vaccination position = 73.3% fully vaccinated including booster as of 3/4/22 | **Reasonable Assurance** |
| **QP3.** | Reduce the number of preventable Clostridium Difficile infections<br>This will be measured by ensuring we do not exceed the threshold of 22 cases set in 20/21 | The 21/22 objective for C.difficile is 22 cases which is a reduction of one case based on the 2019 data of 18 HOHA cases plus 5 COHA cases. This will be monitored in the Integrated Performance Report (IPR).<br>The objective was breached in November 21, and there have been 37 cases at year end.<br>  | **Limited assurance** |

| What do we aim to achieve? | February to March 2022 Update | Progress rating |
|---|---|---|
| **QP4.** Ensure strategies are in place to minimise Hospital Onset Covid-19 Infection (HOCI)<br>This will be measured by the rate of HOCI each month. | COVID patient pathways are in place to minimise the risk.<br>Hospital-Onset COVID-19 Infections (HOCI) are reported immediately, and an RCA completed. HOCIs are reported to IPC tactical meeting and monthly to IPC Performance Board.<br>'Every action counts' tools are being used to support alongside the updated IPC guidance.<br>Lessons learnt from HOCI are shared to support organisational learning.<br>The IPC Board Assurance Framework (BAF) is reviewed within the governance structures.<br><br>There was an extensive increase seen in January and again in March with the Omicron variant and associated outbreaks. The CHFT experience of the Omicron variant has not been different to that of other Trusts.<br>  <br> | **Reasonable Assurance** |

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

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

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

| What do we aim to achieve? | February to March 2022 update | Progress rating |
|---|---|---|
| **QP1.** Implement and monitor effectiveness of the standard operating procedure to prevent any 12-hour breaches within the ED department<br><br>This will be measured by:<br>• Number of (NHSE/I) reportable 12-hour breaches | Presented to DQB in June that new reporting mechanism (on discharge) implemented April 2021 ensures that all length of stay (LOS) in the ED are captured and reported accurately. **No change still capturing any LoS >12 hours and no reportable 12 LOS have ensued** | **Reasonable Assurance** |
| • Internal standard: Number of patients who waited >12 hour within the department from time of arrival | Zero tolerance as reportable.<br>There were two patients over 12-hour breaches last month discharged home non-reportable. **This has increased to 131 patients having a LoS over 12 hours non-reportable in March all patients have been risk assessed and RCA completed on datix** | **Limited assurance** |
| • Training delivered for on call teams to support implementation of the SOP | Surge and escalation document in use ensuring wide communication between all on call elements and tactical leads. **In use and distributed to clinical commanders / night matrons and on call managers session delivered by ED consultant. Redesign od OPEL process that captures ED internal OPEL process this has been cascaded to On Call management teams.** | **Limited assurance** |
| **QP2.** To align reporting systems with Cerner and the DATIX incident reporting system.<br><br>This will be measured by<br><br>• Establishment of >12hr DTA breach report from Cerner that matches incident reporting | New datix format for 12-hour LOS implemented by risk | **Substantial assurance** |

| What do we aim to achieve? | February to March 2022 update | Progress rating |
|---|---|---|
| **QP3.** Improved documentation of Intentional care rounds to ensure patients are receiving effective pressure area care, nutrition and hydration.<br><br>This will be measured through:<br>• No of colleagues who undertake training for intentional care rounds | Documentation audit in place to provide assurance to lead nurses that standards are met. Requires further monitoring to establish success. **Ongoing** | **Reasonable Assurance** |
| • Monthly audit of patient cases to review compliance with clinical documentation | Care is reviewed via datix | **Reasonable Assurance** |

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

**Operational Leads** – Dr Abhijit Chakraborty, Lauren Green and Charlotte Anderson

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

### Falls per 1000 bed days

| Month | Apr-2021 | May-2021 | Jun-2021 | Jul-2021 | Aug-2021 | Sep-2021 | Oct-2021 | Nov-2021 | Dec-2021 | Jan-2022 | Feb-2022 | Mar-2022 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Falls per 1000 bed days | 9.3 | 8.9 | 9.4 | 8.1 | 9.9 | 8.9 | 10.2 | 7.5 | 8.4 | 9.0 | 9.3 | 9.4 |

### Falls by month/division

| | Apr 2021 | May 2021 | Jun 2021 | Jul 2021 | Aug 2021 | Sep 2021 | Oct 2021 | Nov 2021 | Dec 2021 | Jan 2022 | Feb 2022 | Mar 2022 | Apr 2022 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Community | 3 | 4 | 1 | 1 | 2 | 3 | 0 | 3 | 3 | 1 | 2 | 7 | 0 | 30 |
| Corporate | 0 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 3 |
| FSS | 0 | 1 | 7 | 8 | 3 | 1 | 3 | 1 | 0 | 3 | 0 | 1 | 1 | 29 |
| Medical | 123 | 129 | 132 | 126 | 156 | 133 | 148 | 117 | 140 | 134 | 130 | 141 | 28 | 1637 |
| Surgical | 24 | 18 | 19 | 18 | 30 | 32 | 46 | 27 | 23 | 35 | 35 | 43 | 6 | 356 |
| Total | 150 | 153 | 159 | 153 | 191 | 170 | 197 | 148 | 166 | 174 | 167 | 192 | 35 | 2055 |

### Medicine falls – level of harm

| | Apr 2021 | May 2021 | Jun 2021 | Jul 2021 | Aug 2021 | Sep 2021 | Oct 2021 | Nov 2021 | Dec 2021 | Jan 2022 | Feb 2022 | Mar 2022 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| No Harm | 97 | 107 | 97 | 90 | 120 | 95 | 111 | 90 | 99 | 105 | 102 | 99 | 1212 |
| Minor Harm | 26 | 19 | 32 | 32 | 34 | 29 | 34 | 25 | 35 | 23 | 25 | 33 | 347 |
| Moderate harm | 0 | 3 | 2 | 2 | 2 | 7 | 3 | 2 | 6 | 4 | 3 | 4 | 38 |
| Severe harm | 0 | 0 | 0 | 1 | 0 | 2 | 0 | 0 | 0 | 2 | 0 | 2 | 7 |
| Catastrophic or Death | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3 | 4 |
| Death - not caused/related to incident | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| Total | 123 | 129 | 132 | 126 | 156 | 133 | 148 | 117 | 140 | 134 | 130 | 141 | 1609 |

### Surgery falls – level of harm

| | Apr 2021 | May 2021 | Jun 2021 | Jul 2021 | Aug 2021 | Sep 2021 | Oct 2021 | Nov 2021 | Dec 2021 | Jan 2022 | Feb 2022 | Mar 2022 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| No Harm | 18 | 15 | 14 | 12 | 24 | 27 | 38 | 20 | 18 | 28 | 30 | 36 | 280 |
| Minor Harm | 3 | 3 | 5 | 6 | 5 | 5 | 7 | 7 | 5 | 6 | 5 | 5 | 62 |
| Moderate harm | 3 | 0 | 0 | 0 | 1 | 0 | 1 | 0 | 0 | 1 | 0 | 2 | 8 |
| Total | 24 | 18 | 19 | 18 | 30 | 32 | 46 | 27 | 23 | 35 | 35 | 43 | 350 |

Medicine has had two severe harm falls and three catastrophic or fatal falls. This is a significant change and actions are being implemented to improve this position, detailed below. Number of falls have increased; this is likely to be linked to recent low staffing levels, increase in number of patient transfers due to ward changes and the bed base working at extra capacity.

Actions to mitigate risk:

- Falls Collaborative continues to meet every 6 weeks.
- The Lead is leading with the falls EPR workstream and has identified the current falls assessment tool and falls care plan as requiring improvement. Work is ongoing with Bradford falls lead to adapt falls assessment tool on EPR. Positive feedback received from Bradford to change the assessment tool used – waiting to meet with EPR team following next Falls Collaorative to agree and implement changes.

- Patient and carer falls leaflet updated, this has been agreed and finaled through the Falls Collaborative – this will be uploaded onto the intranet for staff to access and hand out to all patients/carers
- Falls intranet in the process of being developed, and liaising with THIS to create. The Falls Intranet page will have all information for Falls Link Practitioners, resources, learning from Serious Investigations, best practice guidelines, link to updated falls policy, link to EPR SOP, updated bed rail guidance, QI projects and outcomes, video demonstrations how to use equipment to support a patient who has fallen. This will be regularly reviewed.
- A Falls prevention intervention care plan has been created and will be disseminated across the wards. The interventions have been added into the updated falls policy. This care plan will be uploaded onto EPR however until then the wards will be informed via their matrons, ward managers and senior nurses.
- Bed rail risk assessment in process of being updated, bed rail flow chart drafted up and has be finalsed the most recent Falls Collaborative
- Falls and Fragility Fracture Audit Programme (FFFAP) Quality Improvement project underway. Aim identified: 80% of patients admitted onto the Acute Floors (CRH & HRI) over age of 65 to have a Lying and Standing blood pressure recorded within 48 hours of admission, documented in the appropriate section on EPR.
- All wards are now compliant with the Sure Falls Devices and Stealth Mats. The ward managers have been informed of how to order the falls devices once their reach their compliance rate. The wards do not need to purchase their falls alarms, there is a central stock in medical devices.
- Falls policy has been updated to reflect specific timeframes for assessments, fall prevention interventions and bed rail guidance flowchart. The policy will be renamed to allow staff to find it on the intranet easier, it is currently named Slips, Trips and Falls Group Policy. Propose change – Falls, Slips and Trips group policy.
- Learning from Serious Investigations will be disseminated through the Falls Collaborative. SI recently completed and action plan in place.
- In process of mapping out wards to identify high fall risk areas, W6, 6AB and HRI acute floor mapped out. This will support managers/nurses in charge with their decision making as to where a patient will be placed on a ward. I.e. in a visible bed/bay/cohorting patients/use of side rooms.
- Falls Link Practitioners – initial education session drafted. First session planned for 28th April following the Falls Collaborative meeting. Names are still being collected and a role specification has been drafted
- Audit completed of harm falls across trust. Identified themes and generated an action plan following audit:
    - Mapping floors to identify high risk areas. Utilising ward staff and remote laptop stands – wards mapped to date – W6, HRI Acute floor and CRH 6AB. Working with Neil Staniforth re laptop provision.
    - Developing a risk assessment to support nursing staff with their decision making as to where patients are placed on a ward upon admission depending on their level of falls risk. This is awaiting agreement from Falls Collaborative:

Risk assessment for transfer onto ward:

- Has patient been admitted following a fall?; Is the patient at risk of a fall?; Has the patient fallen within the last 6 months?; Has the patient been referred into Enhanced Care for 1:1 support?; Is the patient confused/disorientated?

**If YES – the patient needs to be placed in a high visibility bed with appropriate falls prevention interventions until a full falls risk assessment has been completed.**

Risk: 5862 – No change. Current staffing levels are challenging, Difficult to release staff to provide education/learning. See plans above.

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

**Operational Leads** – Mary Kiely, Christopher Roberts and Christopher Button

**We will this year undertake quality improvements to:**

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

| What do we aim to achieve? | February to March 2022 update | Progress rating |
|---|---|---|
| **QP1.** Implement a 7-day service within the inpatient areas<br>Measure impact of 7 day working across the Key Performance Indicators EoL dashboards | Consultation and staff engagement meetings have taken place and it is now planned for the inpatient acute palliative care service to move to 7 day working from September 2023. | |
| **QP2.** Increasing the number of advance care plans for all appropriate patients across the CHFT and community footprint | Improve access to EPaCCs – Currently there is limited staff within the acute trust who have access to see or document on EPaCCs template through system one<br><br>Project underway to increase the number of people to have access to system one and training on EPaCCs.<br><br>This will be measured through an audit of records every quarter | Update required |
| **QP3.** Further develop a service that will improve a person's experience pre and post bereavement delivered by the ward teams | The bereavement service will feed back qualitative narrative and improvements to the End-of-Life Care Steering Group quarterly.<br><br>The bereavement service will act on negative and positive experiences gained from the bereavement telephone service. Currently the EOLC Facilitator and colleague work with wards and groups to improve overall care but specific areas are targeted | Awaiting funding decision at end of Jan 22 re permanent funding |

| What do we aim to achieve? | February to March 2022 update | Progress rating |
|---|---|---|
| | based on feedback from the bereavement service where necessary. The Bereavement service is now also recording compliments/concerns via Datix to enable the team to monitor areas of need and excellence to ensure suitable support is available.<br><br>CHFT Charitable funds have funded the bereavement support service for 12 months to employ a Band 6, 5 and 3 to enable increase in bereavement calls and also in reach into ward areas.<br><br>Review Visitors guidance in line with national guidance and monitor compliance | |

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

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

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

| What do we aim to achieve? | February to March 2022 Update | Progress rating |
|---|---|---|
| **QP1.** Optimise the Clinical Record<br><br>1a. Complete the in-depth analysis | Company identified – stuck in the procurement process at the moment.<br>July 21 – Meeting arranged with company 20.07.21<br>Sept 21 – Meeting took place with the company new Chief Nursing Informatics Officer (CNIO) needs to become up to date with background and then drive this forward to bring a plan back to next meeting.<br>Dec 21- New CIO looking at ways of optimisation currently the external review has been paused.<br>Feb 22- New CIO has assessed the original optimisation plan in conjunction with colleagues and a new plan has been put in place to base line re- education and a separate technical silver service. Nursing documentation is being looked at alongside Bradford CNIO.<br>March 22- Work ongoing regarding admission documentation for both clinicians and nursing. Meetings scheduled for April to assess current workflow and need for change and improvement. | **Reasonable Assurance** |
| 1b. Benchmark | Subject to the outcome of the in-depth analysis | **Reasonable Assurance** |
| 1c. Set local standards | Subject to the outcome of the benchmarking | **Reasonable Assurance** |

| What do we aim to achieve? | February to March 2022 Update | Progress rating |
|---|---|---|
| **QP2. Trial the use of the Digital White Board**<br>Identify areas to trial over a 4-week period - implement the white boards identifying data that can be pulled and measured to determine progress and future planning. | Trial period commenced – end date 15th June 21.<br>July 21 – evaluation of the trial underway.<br>Sept 21 – trial completed and CNIO and Chief Clinical Informatics Officer (CCIO) to meet to review feedback and discuss future innovations with Cerner.<br>Dec 21- Further meetings taken place with Cerner re: White board and working with Director of Operations (DOP) for medicine to configure the white boards to CHFT needs and work alongside plan for every patient. Task and finish group taken place and electronic patient record (EPR) team building a mock board in cert to review and start a trial.<br>Feb 22- Meetings have taken place with the DOP for medicine, QI manager and EPR workstream lead to map out what the board needs to include and how the board will work in clinical practice. Needs to go to Change and Prioritisation board and CNIO and CCIO have asked for a project manager to be assigned to the project to drive and coordinate the implementation.<br>March 22- Board has been produced and demo provided to project team. First trial area identified on ward 5 and awaiting another area to be identified by the division of Medicine to provide a trial from two different areas to gain compare different areas with different needs. Trial expected to start in April 22. | **Substantial assurance** |

| What do we aim to achieve? | February to March 2022 Update | Progress rating |
|---|---|---|
| **QP3. Carry out a full review of the Ward Assurance within the KP+.**<br>3a. Look at current data captured with service users | This will be reviewed by the subject matter experts (SMEs) and Ward Managers following the Work Together Get Results (WTGR) piece.<br>Work to commence July 202.<br>July 21 – Task and Finish Groups to be formed now WTGR completed to look at data capture.<br>Sept 21- Task and finish groups under way. All first ones undertaken and SME's reviewing the documentation to bring back to next meeting.<br>Dec 21- Task and finish groups completed and CNIO and corporate matron meeting with Robert Cox and team to make sure all areas are pulling from the correct place.<br>Feb 22- Task and finish groups complete.<br>March 22- All changes in place in data quality team. Paediatrics has also been included. | **Substantial assurance** |
| 3b. Assess whether data relevant | Full review of data to be carried out regarding not only relevance, but also how staff can make it more meaningful to them in addressing shortfalls.<br>July 21 – Task and Finish Groups to be formed now WTGR completed to assess whether data relevant.<br>Sept 21 – SME's reviewing documentation bring back to task and finish groups.<br>Dec 21- All key metrics have been agreed by SME's and are all in line with national guidance. Some questions modified and removed.<br>Feb 22- As Above<br>March 22 – No change. | **Substantial assurance** |

| What do we aim to achieve? | February to March 2022 Update | Progress rating |
|---|---|---|
| 3c. Agree metrics for collection | Metrics already agreed upon – review of data being extracted.<br>Sept 21- Metrics may change according to task and finish group decisions.<br>Dec 21 – As above meeting with data team and ward assurance team to improve data collection.<br>Feb 22- Awaiting all data quality messages to be completed to pull information from relevant and correct areas within EPR. This should be completed by 14th Feb.<br>March 22- All completed. | **Substantial assurance** |
| **QP4. Ensure Ward Managers and Matrons own their own ward data using KP+**<br>4a. Ensure that all Ward Managers and Matrons have access to KP+ | Staff groups contacted already – awaiting feedback. Aim to complete this by end of June 2021.<br>July 21 – engaged with Matrons and Managers – access arranged for those who did not have access.<br>Sept 21- This has been put on hold until task and finish groups complete there woke to train all staff the correct way.<br>Dec 21- Meeting with CNIO and data quality team to make sure all the data is pulling correctly in ward assurance to give the wards the correct data.<br>Feb-22 All ward managers have been issued with the individualised care document to issue to all nurses in ward areas of what assessments are expected.<br>March 22- Divisions to now monitor compliance and improve ward assurance. | **Substantial Assurance** |

| What do we aim to achieve? | February to March 2022 Update Required | Progress rating |
|---|---|---|
| 4b. Provide training in the use of KP+ for Ward Managers and Matrons | This was carried out in November 2020 – further engagement with staff on the 6th August 2021 through Chief Nurse's briefing.<br>Sept 21- All ward managers have been asked to make sure they have access to KP+<br>Dec 21- Plan to roll out in January 2022.<br>Feb 22- All ward managers should have access this needs to be managed in divisions to make sure ward managers are using and providing assurance.<br>March 22- Divisions to monitor. | **Reasonable Assurance** |
| 4c. Embed review of KP+ into daily practice | This will be an action from the WTGR – start end of July '21<br>July 21 – further training 6th August 2021 at Chief Nurse's briefing.<br>Sept 21- Once task and finish groups completed this will be a session on Chief Nurse's briefing.<br>Dec 21- Review of KP+ and to work with senior nursing leaders to improve dashboards for ward managers/ Matrons<br>Feb 22- Strategy to be formed on how this can be achieved and completed and reviewed within divisions.<br>March 22- Divisions to follow up and monitor. | **Reasonable Assurance** |

| What do we aim to achieve? | February to March 2022 Update Required | Progress rating |
|---|---|---|
| **QP5. Audit clinical records using an audit tool.**<br>Audit 5 sets of records per week by Ward Manager reporting and act upon findings. | Audit to be carried out by Matrons – one per month per each of their wards – to start end of July 2021.<br>July 21 – roll out delayed due to delay in completion of WTGR<br>Sept 21- As above.<br>Dec 21- Individualised care document to be updated and distributed to Matron's and ward managers. Changes implemented on feedback from ward 5 pilot making it easier for staff to access certain areas of the notes. This then needs to be driven by Associate Directors of Nursing (ADN)<br>Feb 22- Sat within divisions.<br>March 22 – Sat with divisions CNIO happy to assist where needed. | **Reasonable Assurance** |
| **QP6. Identify and establish a project team that can drive the improvement of data entry into EPR across the Trust.**<br>6a. Identify the team | This will include Associate Director of Nursing, Matron and Ward Managers across the Trust. | **Substantial assurance** |
| 6b. Identify outcomes wanting to achieve | Working Together Get Results completed at the end of July, face to face to ensure optimum engagement obtained. Action Plan to be completed from the results of the WTGR.<br>Sept 21- Task and finish groups have been established. Which are being led by the subject matter experts<br>Dec 21 – Clinical Records and Optimisation group will drive this forward in the future alongside ward Assurance tool.<br>Feb 22- Clinical Records group will continue to drive forward and ward assurance will be covered in quality committee and through WEB.<br>March 22- As above | **Reasonable Assurance** |

| What do we aim to achieve? | February to March 2022 Update Required | Progress rating |
|---|---|---|
| 6c. Agree defined goals and action plan that reflects this | Outcome of the WTGR will determine the action plan – aim for this to be available by the end of July 2021.<br>July 21 - Sessions completed end of July – working towards action plan middle of August 2021.<br>Sept 21-. Subject matter experts leading the review of assessment documentation within EPR. Amendments can then be made to extract data at the backend of EPR<br>Dec 21- Review of the ward assurance will continue.<br>Feb 22- Review of ward assurance continues.<br>March 22 – ward Assurance reviews continue. | **Reasonable Assurance** |
| **QP7. Ensure training in the use of EPR reflects the standards laid down by the Trust and that it reflects training needs of the staff**<br>7a. Support the Training team to ensure training meets the needs of the service user – fully aligned to roles and responsibilities | Task and Finish Group set up 2/12 ago to review the training plans for medical, nursing and HCA groups as a priority. Some representation from nursing but not medical teams – seeking support from them.<br>July 21 - Progressing well with projected completion by the end of August 2021.<br>Sept 21- Training team for digital health are attending ward areas also with set goals to achieve. CNIO working with Matrons and ward manager for the area to make sure correct goals are set. Ward 5 identified as first ward.<br>Dec 21- Supporting the training team to introduce working again in the trust from being at home throughout the pandemic. Further areas identified for them to work in in coming months.<br>Feb 22- Review and working alongside training team and looking at how can support the clinical groups working everyday supporting the teams. Review of training material planned with EPR team and training team.<br>March 22- First meeting planned for April with junior doctors, workstream leads and training team to review training and workflows. | **Reasonable Assurance** |

| What do we aim to achieve? | February to March 2022 Update Required | Progress rating |
|---|---|---|
| 7b. Encourage Training Team to explore ways in which service users can be supported e.g. online, face to face, digitally | This is being reviewed within THIS. Initial plans e-Learning developer starting in post on 21.06.21 with an immediate action to create e-Learning modules for medical, nursing and HCA roles for August 2021.<br>July 21 – E Learning Developer now in post and e learning sessions already underway.<br>Sept 21- Training team attending ward areas for 3 weeks at a time working with nurses on the ward making sure EPR is being used to its most effective and documentation is all in the correct place.<br>Dec 21 –New E-Learning modules have been produced and are currently in the testing phase.<br>Feb 22- Training teams have been supporting the CNIO with ward visits supporting nurses and student nurses. Monthly meetings have been set up between the CHFT digital health team and the training lead to make sure expectations are laid out and key deliverables achieved. Also reviewing the training and different ways to support clinical staff across all roles.<br>March 22- Meetings continue and how we can support staff on the ward to achieve their training needs. Training team is now fully recruited, and 2 new members of staff commence in post end of March meaning in a few months there will be a lot more resource to support the wards. | **Substantial assurance** |

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

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

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

| What do we aim to achieve? | February–March 2022 | Progress rating |
|---|---|---|
| **1.** A minimum of 90% of staff required to complete Malnutrition Universal Screening Tool (MUST) training will be compliant | For the month of February-March all Divisions remain above 90% compliance except for Medicine at 86.3%.<br><br>**Action:**<br>The Medical Matrons have been asked to encourage and support all areas in completing this training. If compliance doesn't improve individual letters will be sent out to the staff not compliant encouraging them to complete.<br><br>There is currently an issue with Community data – they are showing as 100% compliant but with only 3 members of staff registered as needing the training.<br><br>**Action:**<br>Community teams are looking into this with the IT/ESR team to rectify | **Substantial assurance** |
| **2.** A minimum of 90% of staff required to complete Screening Tool for the Assessment of Malnutrition in Paediatrics (STAMP) training will be compliant | Compliance 80% | **Reasonable assurance** |
| **3.** 100% of adult in-patients will have a MUST assessment within 24 hours of admission/transfer | Jan 2022= 12.6%<br>Feb 2022= 12.4%<br>March 2022= 12.8%<br><br>**Mitigation**<br>▪ Safety huddle inclusion within clinical areas as prompt for completion for clinical staff.<br>▪ Inclusion within Journey to Outstanding clinical area reviews. | **Limited assurance** |

<table>
<tr><th>What do we aim to achieve?</th><th>February–March 2022</th><th>Progress rating</th></tr>
<tr><td></td><td>Actions<ul><li>WTGR improvement work ongoing with regards clinical documentation. It has been agreed that we will remove the need for a MUST assessment completing on Transfer. This should improve compliance. Meeting scheduled with Interface & Intelligence Lead –to discuss as this has not been removed yet.</li><li>Discussions around monthly metrics being printed for each ward so that clinical areas can see and improve their compliance. Information to be displayed on ward.</li><li>Changes are live and staff are being reminded during other training sessions</li></ul></td><td></td></tr>
<tr><td>4. Trust aspiration to achieve 100% of paediatric in-patients having a STAMP assessment within 24 hours of admission & weekly thereafter</td><td>This data isn’t currently available on the ward assurance dashboard on K+, a request has been made to include this and is underway.</td><td>Reasonable assurance</td></tr>
<tr><td>5. 100% of adult in-patients with a MUST score of 2 or above will be referred to the dietetic service</td><td>56.8%<br><br>The above figure is starting to reflect the work completed in EPR with Bradford.</td><td>Reasonable assurance</td></tr>
<tr><td>6. 100% of paediatric in-patients with a STAMP score of 4 or above will be referred for nutritional support (i.e., dietician, nutritional support team or consultant)</td><td>This data is not currently available on the ward assurance dashboard on K+, a request has been made to include this and is being progressed.</td><td>Limited assurance</td></tr>
<tr><td>7. A minimum of 90% of staff from wards that are regular users or high users of nasogastric tube feeds will be compliant with nasogastric training</td><td>High Users Regular Users
<table>
<tr><th>17</th><th>ICU</th><th>Peads</th><th>Comm Peads</th><th>Hoop</th><th>Resp</th><th>6AB</th><th>8C</th><th>Stroke</th><th>20</th></tr>
<tr><td>56.2%</td><td>76.3%</td><td>75%</td><td>100%</td><td>100%</td><td>85.9%</td><td>35.3%</td><td>71.4.7%</td><td>78.9%</td><td>70.9%</td></tr>
</table>
NG Tube training has been offered on a more frequent basis and the dates for sessions more widely advertised and emailed to all ward managers.<br>6AB’s compliance has improved from last month.<br>17 have seen a drop in compliance which reflects staff recruitment/ retention.<br>Action: Ward manager and matron have been contacted by the lead nurse for nutrition to arrange training. Places available on Respiratory for 6AB to join also.<br>Individual letters will be sent out to staff encouraging them to arrange training.</td><td>Reasonable assurance</td></tr>
</table>

| What do we aim to achieve? | February–March 2022 | Progress rating |
|---|---|---|
| **8.** Nasogastric and STAMP training will be added to the electronic staff record (ESR) platform to enable monitoring by ward managers & matrons | Nasogastric tube training data is available via education and learning dashboard of Business Intelligence spine of ESR<br><br>3.6.21 update - ESR compliance is based on the target audiences on position not on an individual level. It must be everyone in that position as they do the same job.<br><br>Option: To try to put through the essential safety training (EST) proforma and ask it to be set up as an EST role specific course.<br>3.6.21 update - STAMP training has been requested via EST process to be reported.<br><br>There is currently a delay with changes on ESR due to the system having an update. This action will be revisited in January 2022. | **Limited assurance** |
| **9.** Meal service will be safe, organised, and well led on all wards at CHFT | Divisional actions plan and observation of service delivery in ward areas.<br>Patient feedback collated by ISS and Calderdale and Huddersfield Solutions (CHS) catering depts.<br><br>Feedback through patient discussions and complaints/incidents<br><br>Observation of mealtimes during Observe and Act framework, practice will be monitored through this process and shared at ward level.<br><br>There is currently a new process being trailed on ward 5 HRI which includes protected mealtimes for patients. The plan is to now introduce this to ward 17 and a medical ward at CRH.<br><br>A routine has been developed regarding preparing patients for meals (cleaning tables, sitting patients up or out in a chair if needed, providing hand hygiene wipes).<br><br>All tests/discussions with patients unless urgent to be carried out before or after meals this releases all staff to have involvement in meal delivery<br><br>Medications to be administered after patients have eaten.<br>A new SOP to reflect this work is currently being developed and will be shared when completed.<br><br>Leadership observations at ward level | **Reasonable assurance** |

| What do we aim to achieve? | February–March 2022 | Progress rating |
|---|---|---|
| **10.** The red tray/lid and jug lid alert system will be used consistently and appropriately on all adult in-patient wards | Trust wide initiative not consistently utilised in all ward areas.<br>The use of Red Trays/Lids will be encouraged in each ward area by matrons.<br>Patients with additional nutritional needs will be discussed daily in the ward safety huddles.<br>The use of magnets behind the beds will also be reviewed by the matrons and support given to the wards to ensure correct use.<br>Question included within Observe and Act observation tool to monitor local compliance (Theme D. Food and drink)<br>Key themes to date (3 wards)-preparation and assistance at mealtimes and utilisation of red trays and red jugs lids | **Reasonable assurance** |
| **11.** CHFT guidelines, policies, strategies, pathways, decision making tools will reflect current NHS guidelines & NICE guidance | CHFT Policies and guidance is reviewed against current NHS guidelines & NICE guidance via the nutrition operational meeting. Includes:<br>• Nutrition and hydration policy (including allergen management)<br>• Food hygiene policy<br>• Parenteral nutrition policy<br>Reviews undertaken as new guidance released and via CHFT policy review process. | **Substantial assurance** |
| **12.** The ward assurance indicators for nutrition and hydration will be reviewed for appropriateness and accurate affiliation with CHFT's nutritional policies, guideline etc. | Ward assurance documentation indicators reflect the current guidance within the current Nutrition and hydration policy.<br>Further actions-for discussion of ward assurance indicators at WTGR. There is currently work being carried out on EPR with regards to Must assessments and the requirements for compliance. Some sections to be removed. | **Reasonable assurance** |
| **13.** A staff education plan to be developed and actioned to ensure staff know when a fluid balance chart is indicated and understand the importance of monitoring and recording correctly within EPR | The group have investigated the Fluid balance charts on EPR.<br>All patients must have a fluid balance chart initiated within 8 hours of admission regardless of need.<br>Work is ongoing regarding trying to identify some triggers for the initiation of the fluid balance chart. As it has been recognised that a fluid balance may not be required for all patients.<br>MUST competency updated for CSW competency document. | **Limited assurance** |

| What do we aim to achieve? | February–March 2022 | Progress rating |
|---|---|---|
| | Trust compliance with clinical recording of fluid balance on EPR remains static **17.4%**<br><br>Risks<br>Inaccurate monitoring and recording of fluid balance chart on EPR impacting on patient's clinical outcome and patient experience.<br>Mitigation of risks<br>Clinical based actions-requests via medical team with clear guidance as to rationale for FBC.<br>Accuracy of monitoring/compliance through ward assurance documentation<br>Further Actions<br>NVQ team to make additions to HCA competencies.<br>Review process of indication/recording/monitoring requirement through WTGR workshop. | |
| **14.** Theme D (Food & Drink) of Observe & Act reports to be monitored at monthly Nutrition Operational group meetings for information, discussion, and potential shared learning | Multiple areas completed utilising Observe and Act framework completed.<br><br>Further actions<br>Monthly agenda item for discussion and shared learning at nutrition operational meeting. | **Substantial assurance** |
| **15.** A CHFT Food & Drink strategy to be developed to sit alongside the comprehensive CHFT Nutrition and Hydration policy (recommendation of the 2014 Hospital Food Standard panel report DoH) | Strategy to be developed with identified lead- New Lead identified work will now commence of developing a CHFT Food & Drink strategy | **Reasonable assurance** |

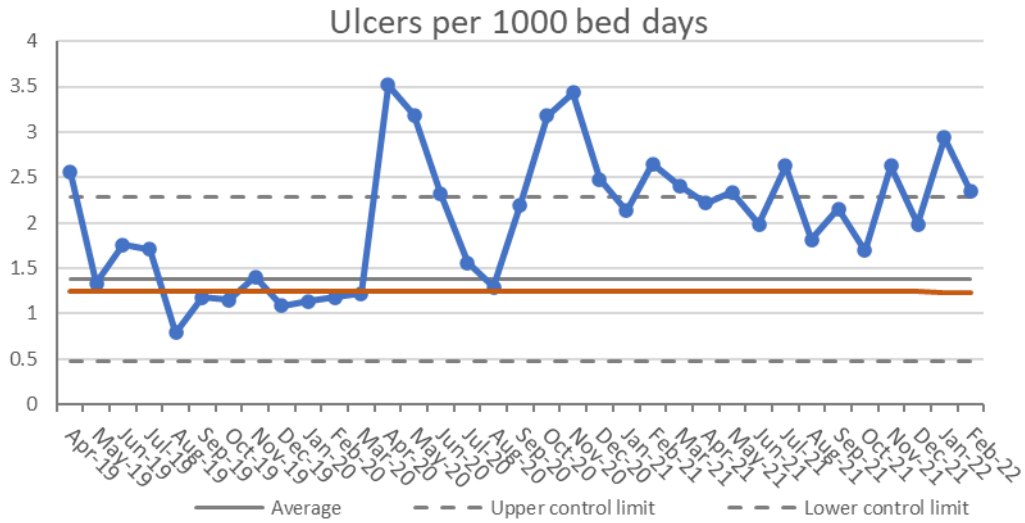
## 10.8 Reduction in the number of CHFT acquired pressure ulcers (Focused Quality Priority)

**Operational Lead** – Judy Harker

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

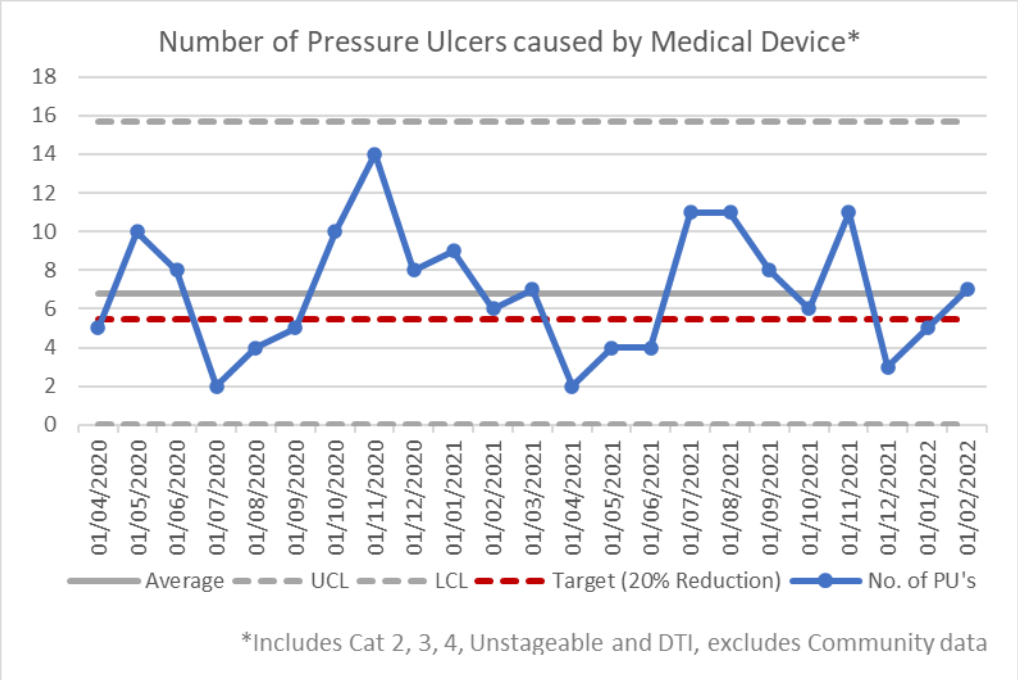
**We will this year undertake quality improvements to:**

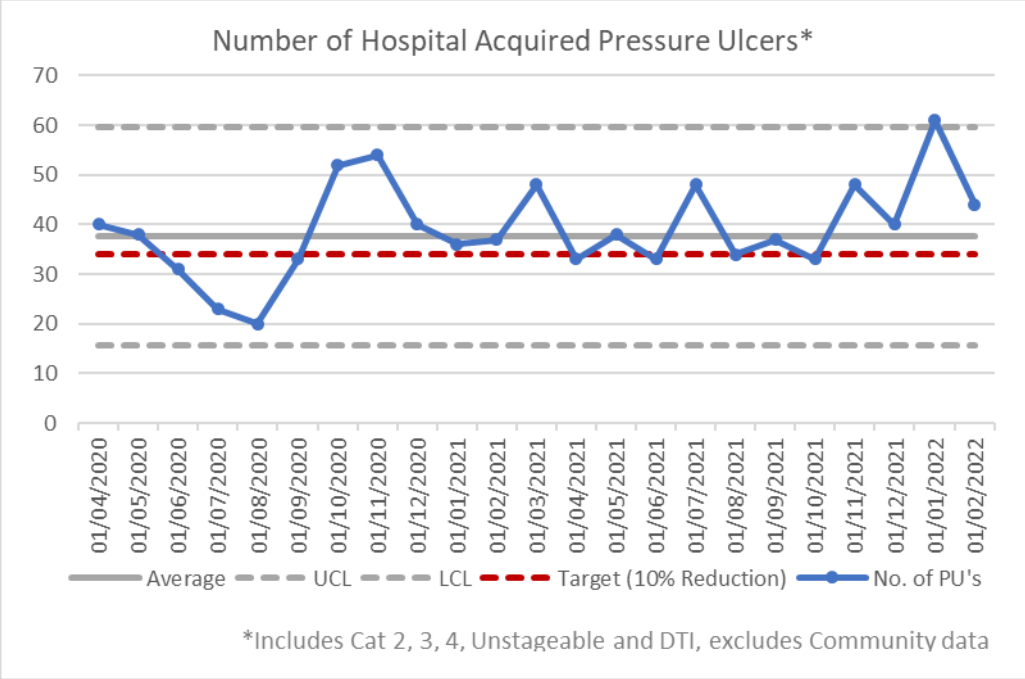
- Reduce the occurrence of pressure ulcers and improve healing rates for existing pressure ulcers. In doing so we can reduce harm and spend, while improving the quality of healthcare experience of our most vulnerable patients.

| What do we aim to achieve? | Current Update – January / February 2022 | Progress rating | Next period |
|---|---|---|---|
| Reduction in the Incidence* of hospital-acquired pressure ulcers by 10%. This will be measured by incident data |  | **Limited assurance** | Continue to monitor and validate March data<br><br>Launch of new pressure ulcer policy<br><br>Pressure ulcer checklist to be embedded into Datix<br><br>Roll out of Pressure ulcer KP+ to Matrons, Ward Managers. |

| What do we aim to achieve? | Current Update – January / February 2022 | Progress rating | Next period |
|---|---|---|---|
| | **Risk**<br><br>No sustained reduction in incidence of hospital acquired pressure ulcers.<br><br>January and February have been very challenging months for pressure ulcers. The Trust has witnessed high patient acuity and frailty, high numbers of patients with pressure ulcers at end of life and high levels of moisture associated skin damage which places an individual at greater risk of pressure damage. There have been reported long trolley waits in ED and ongoing staffing challenges. The demand for dynamic / air mattresses in hospital setting had been unprecedented.<br><br>Further hospital acquired category 4 pressure ulcer in March 2022.<br><br>There have been instances where wards have failed to Datix hospital acquired pressure ulcers. There is a risk that the data may not be providing a true reflection of the current position on pressure ulcers.<br><br>**Mitigation**<br><br>Daily safety huddles now taking place between Tissue Viability team and Matrons to discuss high risk patients with pressure damage and moisture damage and to allow for rapid escalation of omissions in care<br><br>New build of pressure ulcer section in KP+. This will provide live data on the Trust's current position with pressure ulcers according to Datix reporting. It will allow identification of patients who have not received a risk assessment within 6 hours of admission.<br><br>Datix training delivered by Quality and Safety Team. Divisions to ensure that Datix reporting is included in Quality Priority action plans.<br><br>Due to the increase in CHFT acquired category 4 pressure ulcers, divisions are providing enhanced focus and scrutiny on pressure area care | | Utilisation of Todays Patient Data on KP+ to identify patients without a risk assessment |

| What do we aim to achieve? | Current Update – January / February 2022 | Progress rating | Next period |
|---|---|---|---|
| | Focused pressure ulcer session at Ward Manager meeting has taken place in April 2022. Presentations from Professor Ousey, TV service and divisions on national and local positions. Future events planned to explore barriers to implementation of pressure area care.<br><br>Divisional ADNs are reviewing all pressure ulcers acquired on enhanced ward dashboards on a weekly basis<br><br>PURPOSE T pressure ulcer risk assessment tool endorsed by NHS England now built on Cerner. Testing underway.<br><br>Improvements in incident reporting of moisture associated skin damage.<br><br>Targeted documentation audit on orthopaedic wards of pressure area care standards<br><br>Orthopaedic Practitioners to start ward rounds for patients in casts.<br><br>Pressure ulcer collaborative has secured Clinical Governance support to conduct improvement work including audits on wards where incidence of pressure ulcers is high. Targeted support to selected wards to identify barriers to implementation of pressure area care standards<br><br>The new Policy for the Prevention and Management of Pressure Ulcers is awaiting executive level approval.<br><br>Successful 'Minimise Moisture' week held in March 2022 to raise awareness of good practice in skin, continence and moisture care.<br><br>A bid for a further £65k to purchase alternating pressure mattresses has been approved. This will equip the hospitals with sufficient high risk devices to meet the increasing demand.<br><br>Tissue Viability Nurse is attending national training event on pressure ulcer prevention in patients with dark skin tones. Joined up working between CHFT BAME team and Tissue Viability. | | |

| What do we aim to achieve? | Current Update – January / February 2022 | Progress rating | Next period |
|---|---|---|---|
| Reduction in the incidence* of hospital-acquired medical device related pressure ulcers by 20%. This will be measured by incident data |  <br>There has been an increase in the number of device related pressure ulcers from December 2021 to February 2022.<br><br>Devices causing pressure damage in the last 3 months include naso-gastic tube, endotracheal tube, off-loading heel device, oxygen tubing, walker boot, bowel management system, urinary catheter, tracheostomy tube, bed rail, backslab.<br><br>**Risk**<br>Lack of sustained reduction in medical device related pressure ulcers. | **Reasonable assurance** | Continue to monitor and validate March data.<br><br>Sustain strong culture of reporting device related pressure ulcers. |

| What do we aim to achieve? | Current Update – January / February 2022 | Progress rating | Next period |
|---|---|---|---|
| | **Mitigation**<br>Surgical division matrons have carried out a 'Go See' visit at BHFT orthopaedic department to learn about improvements used to reduce incidence of cast-related pressure ulcers. | | |
| Reduction in the incidence* of hospital-acquired heel pressure ulcers by 20%. This will be measured by incident data |  <br><br>Please note, graph provided above includes number of pressure ulcers and not incidence of pressure ulcers per 1,000 bed days.<br><br>No sustained reduction in number of heel pressure ulcers.<br><br>All relevant wards have inflatable heel devices on top up via Materials Management. Training video disseminated widely.<br><br>Heel inspection mirrors are being promoted and distributed across Trust. | **Reasonable assurance** | Continue to monitor and validate March data<br><br>Heel Device Selection Guide to be devised by Podiatry Team<br><br>Explore feasibility of using QR codes on plaster casts to provide pressure ulcer information<br><br>Spread QI from Orthopaedic OPD to Orthopaedic wards in relation to heel pressure ulcer prevention |

| What do we aim to achieve? | Current Update – January / February 2022 | Progress rating | Next period |
|---|---|---|---|
| Reduction in the number of Orange harm pressure ulcers by 50% | Data not available<br>**Risk**<br>Unclear how many moderate pressure ulcer incidents we have in the Trust due to backlog.<br><br>**Mitigation**<br>There is a need to understand the journey of an incident and identify who is responsible for updating Datix at different stages of an investigation.<br><br>Additional Orange Panels have been organised to reduce backlog. | **Reasonable assurance** | Datix checklist to be merged into Datix and enable causal omissions and contributory factors to be identified. Medical division is developing a SOP for Orange Panel to improve attendance, quality of investigations and learning. Once completed this will be shared across the organisation. |
| No Red serious pressure ulcer incidents | There has been a further red serious incident in March 2022. This is a category 4 pressure ulcer to the natal cleft. Themes from red incidents have been very similar. They include gaps in skin inspection and repositioning, provision of incorrect pressure redistributing equipment, inconsistent documentation and incorrect or late risk assessment. These all constitute the fundamentals of pressure area care. | **Limited assurance** | |

| What do we aim to achieve? | Current Update – January / February 2022 | Progress rating | Next period |
|---|---|---|---|
| 95% or more of patients in hospital will have a pressure ulcer risk assessment within 6 hours of admission to Trust / transfer to ward. This will be measured by ward assurance | At February 2022 30% of patients in hospital received a risk assessment within 6 hours of admission/transfer. There has been no improvement on this measure.<br>**Risk**<br>Data would indicate that 98% of patients have received a risk assessment within 7 days. Analysis of data would suggest that whilst risk assessments are being carried out in ED, they are not consistently being repeated once a patient has transferred to a new ward. This results in a failure to implement or delayed implementation of preventative interventions.<br>**Mitigation**<br>Audit support provided for this quality priority. Identification of barriers to completing risk assessments will be focus of enquiry.<br>Meeting arranged with Information Management and Tissue Viability to undertake sense check of data.<br>KP+ Pressure Ulcer data will support this KPI as discussed | **Limited assurance** | |
| 95% or more of at-risk patients in hospital will have a sskin bundle identified and completed. This will be measured by ward assurance | Data incomplete.<br>**Risk**<br>Gaps in skin bundles poses risk for pressure ulcer development.<br>**Mitigation**<br>Guidelines for Documenting Individualised Care through EPR now published and circulated to clinical areas. Informatics are building a live dashboard on KP+ to help identify patients who have not received necessary risk assessments. | **Limited assurance** | Skin bundle fields on EPR being reviewed jointly with BHFT.<br><br>Changes to EPR to require ED to initiate skin bundles. Meeting with ED staff to understand how sskin bundles will fit with patient pathways on EPR. |

| What do we aim to achieve? | Current Update – January / February 2022 | Progress rating | Next period |
|---|---|---|---|
| 95% or more of at-risk patients in hospital will have a pressure ulcer care plan initiated. This will be measured by ward assurance | All patients with a Waterlow of 10 > had a pressure ulcer prevention care plan initiated.<br>Joint work underway with BHFT in developing a new suite of pressure ulcer care plans.<br><br>Guidelines for Documenting Individualised Care through EPR now published and circulated to clinical areas. | **Substantial assurance** | Finalise revisions to BHT / CHFT care plan. |
| 95% or more of patients will have a completed Waterlow pressure ulcer risk assessment within 7 days of admission to District Nursing caseload. This applies to patients who have been on caseload for more than 28 days. This will be measured by SystmOne audit. | Data not available<br><br>Risk<br><br>Difficulties in extracting data from Systmone due to diverse patient caseload and activity. Early data needs to be interpreted with caution.<br><br>Mitigation<br>Data to be interrogated further for next report. Timing and accuracy of risk assessments are reviewed in Orange Panel. | | |

| What do we aim to achieve? | Current Update – January / February 2022 | Progress rating | Next period |
|---|---|---|---|
| 95% of relevant staff (RNs, Nursing Associates and HCAs) will have completed React To Red Pressure or equivalent Pressure Ulcer training in last 2 years. This will be measured by Essential Safety Training (EST) compliance data | 79% of staff have completed React To Red Training. Additional virtual and ward-based training has been provided on pressure ulcer prevention to support staff.<br><br>Bite-sized training delivered to target medical / surgical wards and community nursing teams.<br><br>Going forward, new Pressure ulcer build on KP+ will include EST training compliance which can be drilled down to division and ward / team level.<br><br>National pressure ulcer e learning tool will replace Trust's e learning resource once the new pressure ulcer risk assessment tool is implemented across the organisation. | **Reasonable assurance** | Divisions to continue to address non-compliance<br><br>Screensaver to raise to promote new national e-learning module once PURPOSE T risk assessment tool launched. |

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

**Operational Leads** – Head of Complaints

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

| What do we aim to achieve? | Current update | Progress rating |
|---|---|---|
| **QP1.** Through the MCCC operational group and tactical meetings we will ensure that CHFT is compliant with National regulations.<br><br>This will be measured by aligned performance reporting. | A Task & Finish group was established in January 2022 to focus on key aspects of this priority, which included Quality, Performance & Learning. The group met a number of times and agreed actions for Quality and Performance – including sharing good examples of response to ensure the standard is achieved for every response prior to Divisional/Executive sign off. Actions have also been agreed for Learning and another group has been formed to triangulate lessons learnt and cross-divisional sharing of these lessons. KPI's have been agreed to focus on Performance, Quality (re-opened complaints), and escalation of concerns to complaints. This will be measured moving forward. | **Reasonable Assurance** |
| **1.5** Seek feedback from those who raise complaints (as well as staff involved) on their experience | Service users surveys have been sent to obtain feedback from complainants responded to in Q1 & Q2 – we have yet to receive feedback and are currently looking at more proactive methods of gathering feedback. | **Reasonable Assurance** |
| **2.7** Every stage of concerns / complaints meets the needs of minority and vulnerable groups and makes reasonable adjustments where required. | • Using the Ethnic Diversity Index (EDI), the indication is that BAME communities are accessing the service above the current %population figures.<br>• Equality monitoring data is now captured as part of the service user survey and at the point of access into the service – this is sporadic and needs to be further embedded into process. | **Reasonable Assurance** |

| What do we aim to achieve? | Current update | Progress rating |
|---|---|---|
| | • Access to reasonable adjustment services are in place e.g., interpreting for the spoken language and BSL<br>• Support is also available via Healthwatch for anyone requiring support to submit a complaints<br>• Exploration of mapping complaints to the IMD groups has begun to enable this information to be captured. | |
| **2.9** Staff make sure they respond to concerns and complaints at the earliest opportunity - clear timeframes given | The service continues to negotiate timeframes, the majority of which are 40 working days, with the more complex cases taking 60 days and can be up to 6 months. Due to competing demands operationally, adhering to timeframes has been challenging and improvement is required to ensure performance is optimal. | **Limited Assurance** |
| **3.1** Staff are properly trained and have the appropriate level of experience and authority | • An investigation training programme is ongoing - the focus for this is serious incident investigation, but the theory is transferable to a complaint investigation.<br>• Complaints training is currently being reviewed to determine if this will be offered "in-house" or externally to support staff in the investigation of and responding to complaints. A training package will be developed and offered. | **Limited Assurance** |
| **3.2** Staff have the appropriate resources, support and protected time | • Divisions continue to feel challenged to respond to complaints, particularly at the current time when staffing levels are extremely challenged.<br>• External resources were sourced and utilised to assist in the drafting of complaint responses once investigations had been completed divisionally, to ease the pressure on operational staff – this is a short term action put in place. | |

| What do we aim to achieve? | Current update | Progress rating |
|---|---|---|
| **3.3** Assign complaints to staff who have had no prior involvement or who have no actual or perceived conflict of interest. | • Assigning complaints to staff who have had no prior involvement / conflict of interest is not currently happening – however they are ***usually*** assigned to a more senior member of staff within the same team.<br>• All complaint responses are reviewed by a senior member of the Division and again by the Head of Complaints and therefore would be assessed to ensure a fair and just response has been made<br>• A check-list has been developed to complete during various stages of the complaints process, an element of this is to determine who has had senior oversight of complaint investigations and responses and enables challenge where required. | |

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

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

# 21. High Level Risk Register

To Approve

Presented by Ellen Armistead

Calderdale and Huddersfield NHS Foundation Trust

| | |
|---|---|
| **Date of Meeting:** | Thursday 5 May 2022 |
| **Meeting:** | Board of Directors |
| **Title:** | High Level Risk Register |
| **Author:** | Lisa Cook, Head of Risk and Compliance |
| **Sponsoring Director:** | Ellen Armistead, Executive Director of Nursing |
| **Previous Forums:** | Risk Group |

**Purpose of the Report**

To provide an overview of the highest risks and related ongoing actions.

To provide an overview of the movement of risk scores.

**Key Points to Note**

The number of very high and high risks across the organisation has reduced.

There is ongoing work with the divisions to link risk descriptors to measurable outcomes. This will support a clear link with risk scores and the effectiveness of mitigating actions as well as the impact of any gaps.

**EQIA – Equality Impact Assessment**

As part of its role and function, the Risk Group will ensure that in reviewing risks across the Trust, patients are not negatively impacted, and in doing so, seeks to give the assurances that as a Trust, we are doing everything in our power to reduce risks associated with or impact on the protected characteristics, and ensure high quality safe care for all.

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

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

**Recommendation**

The Board is asked to **APPROVE** the high level risk register and note the ongoing work to strengthen the management of risks.

NHS
Calderdale and Huddersfield
NHS Foundation Trust

# High Level Risk Register – March 2022

| HLRR | Risks Rated Last Report | Risks Rated Latest Report |
|---|---|---|
| Very high risks (20-25) | 10 | <9 |
| High risks (15-16) | 10 | <9 |
| Total Active Risk | 20 | <18 |

| Symbols Key | > Increased | Decreased < | No change = |
|---|---|---|---|

## EXISTING TOP RISKS (20 and above)

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

**There is a risk** of being unable to deliver timely clinical activity
**Due to** a lack of capacity (theatre and clinic)
**Resulting in** potentially poor outcomes for patients and a poor experience.
**Current Update: March 2022**
Theatre staffing challenges remain in theatres. A new cost-per-case model for additionality in theatres will be implemented from April (pick-up unknown at this point). Recruitment has been successful into theatres so there is a pipeline of staff coming in during 22/23
**Identified Lead** – T Strickland

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

**There is a risk** that patients may have to wait for outpatient appointments, diagnostic tests or routine operations
**Due to** cancellations of routine surgery and rescheduling of clinics
**Resulting in** patients waiting longer than is best practice for outpatient appointments, their condition deteriorating, with a potential impact on treatment options available and a less positive outcome
**Current Update: February 2022**
Increasing number of clinics cancelled over the last few weeks due to increasing pressures within CHFT. Bookings still in priority order after Clinical Validation has been completed. Insourcing in key areas to reduce ASIs. Recovery plans still ongoing
**Identified Leads** – T Strickland, S Shepley

**6453 – Fractured Neck of Femur (NOF) - repair within 36 hours (C4 x L5 = 20)**

**There is risk** of poor patient experience, safety, quality of care, extended length of stay due to failure to undertake surgical repair of #NOF within 36 hours of admission and maintain BPT in 85% of patients.
**Due to** availability of surgeons with appropriate skills to undertake THR and surge in activity of #NOF & general trauma.
**Resulting in** extended length of stay and increased mortality in this patient group.
**Latest update: January 2022**
Risk score remains at 20. had 22 Tr 2 theatre lists cancelled due to staffing issues since May 2021, but equally we have also had some extras provided during time of trauma surge especially in Dec 2021, which was a very busy month with a record 61 NOF admitted.
**Identified lead** – Simon Sturdee

**7078 - Medical staffing risk (C4 x L5 =20) Corporate**

**There is a risk** of not being able to deliver safe, effective and high quality care
**Due to** difficult to recruit to consultant posts in Gastroenterology, Radiology, Dermatology and Ophthalmology,
**Resulting in** increase clinical risk and patient safety
**Current Update: February 2022**
**February 2022**
Our new rotational doctors in training arrived safely without delay in February, and attended a bespoke induction organised by the Medical Education Team. We are expecting two new overseas qualified trainees to arrive in the first week in March to join the Emergency Medicine department. The trainees are part of a new scheme in collaboration with Doncaster and Bassetlaw Trust and the Royal College of Emergency Medicine, known as HIEM (Hybrid International Emergency Training). The trainees will be arriving from Nepal and will be supernumary for the first six weeks in post, whilst undertaking a structured induction programme.
Shadowing periods are also being introduced by Health Education England to support GP trainees who are new to the NHS. In August 2021 we had several new GP Trainees join the training scheme from overseas. When they were due to rotate into the Acute setting in February some of them spent two weeks prior to the rotation within the placement shadowing existing colleagues. GP training programmes are being modified and in future GP trainees will spend less time in the Acute setting during their placements. Work is commencing to understand the impact that this will have on existing placements and rotas.
Our new Specialists in Anaesthetics are due to commence in March and there are interviews arranged to appoint Specialty Doctors who will backfill their posts and other existing gaps. The Emergency Medicine department are reviewing their workforce model to assess how Specialists may be of benefit in the future.
**Identified Lead** – Pauline North

**7454 - Radiology Staffing Risk (C4 x L5 =20) FSS**

**There is a risk** to Radiology service provision capacity
**Due to** a reduction in Radiology Consultants
**Resulting in** reduced capacity to cover in some specialist areas with the potential to breach national targets
**Current update: March 2022**
Risk reviewed, all areas updated as required. Position remains the same as December 2020 update.
**Identified Lead** – Sarah Clenton

**7474 - Medical devices (C4 x L5 =20) Trust wide**

**There is a risk** of out of service medical devices being in circulation and in use across CHFT
**Due to** the lack of assurance about the Trust Asset Register being up to date as it doesn't include equipment which has been gifted or bought without CHS involvement and wards/departments not managing their equipment effectively
**Resulting in** potential patient harm to patients.
**Current Update: March 2022**
High risk risen (from 801 to 859), Medium fallen (from 3149 to 2506), Low risen (from 1711 to 1753) a total of (from 5661 to 5118). The second round of assets have been deactivated and decommissioned as can be seen in the numbers with a reduction of 934 assets outstanding maintenance, this demonstrates that the current plan is working, but needs more time to reduce risk to required level in order to justify reduction in risk, it is now evident that we will not meet target date and need an extension. Ability to achieve plan been impacted by Covid isolation of staff, retirement/departure of staff and gaps caused by recruitment, plan to engage bank staff will not mitigate before target date, therefore plan to extend target date by 6 months. Admin resource is now in post to aid with process, new staff have been recruited to replace some gaps, but some recruitment is still ongoing and am expecting to need to replace more staff as we are expecting another departure imminently.
**Identified Lead** – Robert Ross

**7479 – Caring for young people with acute mental health issues (C4 x L5=20) FSS**

**There is a risk** that young people will be managed on the paediatric ward for an extended period of time waiting for a specialist bed or Children's Social care management
**Due to** a National shortage of inpatient provision for young people with acute Mental health issues
**Resulting in** staff caring for vulnerable young people in not an appropriate environment and without the appropriate skill set or professional training to manage patients safely, resulting in potential harm to the patient with mental health needs, other patients, carers and staff.
**Latest update: December 2021**
Anti-ligature risk assessment completed for the children's ward (3, CRH)
**Identified Leads** – Elena Gelsthorpe-Hill/Julie Mellor/Louise Riby

**7615 – not meeting the four hour emergency care standard (C4 x L5 =20) Medical**

**There is a risk of** not meeting the four hour emergency care standard
**Due to** increasing demand on Emergency Care, patient flow issues, delays in assessment and discharge due to lack of social care staffing (hospital based social work team), lack of timely domiciliary care in community
More recently there have been increasing demand for side rooms due to the need to isolate patients with possible COVID-19, this has caused increasing delays.
**Resulting in** poor patient experience, patient harm, increased scrutiny and reputational damage
**Latest update November 2021:** Risk score increased and agreed at PSQB

| NEW RISKS (proposed for acceptance) |
|---|
| **None** |

| INCREASED RISKS |
|---|
| **None** |

| RISKS WITH REDUCED SCORE |
|---|
| **6345 - Nurse staffing risk (C5 x L5) reduced to (C4 x L5 =20) Corporate**<br>**There is a risk** of not being able to deliver safe, effective and high quality care<br>**Due to** a lack of nursing staffing<br>**Resulting in** an increase in clinical risk to patient safety due to reduced level of service / less specialist input. Negative impact on staff morale and patient experience. Impact on sickness and absence. Impact on staff mandatory training and appraisal and financial implications due to an increased costs of interim and agency staffing.<br>**Reason for reduction:**<br>This risk was reviewed at the Nursing and Midwifery Workforce Steering Group on the 16th March 2022. Those present agreed the risk should be reduced based on the following factors:-<br>A current vacancy position of 78:02WTE which is also supported by 21.80 WTE Nursing Associates that supports the workforce models within clinical areas.<br>A reduction in the OPEL safer staffing score from 4 to a 3, which also included an episode of a high level 2 in February.<br>This risk has been reviewed alongside divisional risks specifically related to Nursing and Midwifery workforce risks.<br><br>**7328 - Uncovered tier one non-resident ENT (C4 x L5 =20) reduced to (C4 x L4=16) SAS**<br><br>**There is a risk of** uncovered tier one non-resident ENT on-call rota gaps<br>**Due to** only 4 out of 6 posts currently filled. |

**Resulting in** staff burn out and risk of uncovered on-call shifts. Possible knock-on effect includes impact on outpatient clinics and theatre lists activity post busy on-call if consultants end up covering the gap. This also adds a financial pressure.
**Reason for reduction:**
Team recruited to establishment. However, one member of team to go on unpaid leave for 3 months (enforced) leaves one gap on the 1 in 6 rota.
Notified that one middle grade is intending leaving to take up GP training role in August 2022.

**8196 – colon capsule service (C4 x L4=16) reduced to (C3 x L3 =9) SAS**
**There is a risk of** being unable to develop an additional ERCP list and colon capsule service
**Due to** not having a budget to increase the current workforce model
**Resulting in** longer stays, delay in patient flow and being unable to provide a colon capsule service that is sustainable.
**Reason for reduction:**
Final decision to increase workforce model awaited but 5 staff have been trained

**6596 – Delay in SI investigations (C4 x L4=16) reduced to (C4 x L3 = 12) Corporate**
**There is a risk of** not complying with the national SI framework March 2015
**Due to** not conducting timely investigations into serious incidents (SIs)
**Resulting in** delays to mitigate risk, to realise learning from incidents and share the findings with those affected.
**Reason for Reduction:**
Improved position with 38 open investigations. SI investigation progress flow chart now in place to support timely investigations. Serious incident report to Quality Committee for oversight 21/2/22. Risk score reviewed and reduced due to systems and processes now in place.

| CLOSED |
| --- |
| **None** |

## TRUST RISK PROFILE AS AT 31/03/2022

**KEY:** = Same score as last period ↓ decreased score since last period
! New risk since last period ↑ increased score since last period

| LIKELIHOOD (frequency) | CONSEQUENCE (impact/severity) | | | | |
|---|---|---|---|---|---|
| | Insignificant | Minor | Moderate (3) | Major (4) | Extreme (5) |
| Highly Likely (5) | | | = 6715 Poor quality / incomplete documentation | = 7078 Medical Staffing<br>= 7454 Radiology staffing<br>= 7689 Diagnostics, OPD, operations<br>= 7474 Medical Devices<br>= 7479 Caring for young people with acute mental health issues<br>= 7615 Emergency care standard<br>↓6345 Nurse Staffing | =7809 Theatre and clinical capacity |
| Likely (4) | | | | = 7634 Vacancies in theatre<br>= 2827 Over reliance on locum middle grade doctors in A&E<br>= 7683 Isolation facilities<br>= 7678 Covid impact on medical staffing<br>= 7834 Elective orthopeadic theatre capacity<br>↓7328 ENT Staffing Shortage | = 6453 Delay of surgical report #NOF |
| Possible (3) | | | ↓8196 colon capsule service | ↓6596 Delay in SI investigations | = 5747 Vascular /interventional radiology service<br>= 7413 Fire compartmentation HRI |
| Unlikely (2) | | | | | |
| Rare (1) | | | | | |

| | Risk No | Div | Dir | Dep | Opened | Status | Objective | Risk Description plus Impact | Existing Controls | Gaps In Controls | Initial | Current | Target | Action Plans | Progress Update | Review | Target | Tolerate | RC | Exec Dir | Lead |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Very High | 7809 | Surgery & Anaesthetics | All Directorates S&A | All Departments/Wards | Jun-2020 | Active | Keeping the base safe | There is a risk of being unable to deliver timely clinical activity due to a lack of capacity (theatre) resulting in a potentially poor outcomes for patients and a poor experience. | Patients are being reviewed and allocated P values.<br><br>Theatre lists being allocated according to the trust's priority criteria.<br><br>Enhanced payments have been approved to support additionality for elective activity. | Elective theatres are running on both sites but not at full pre-covid capacity yet due to lower staffing levels in theatres. | 16 4 x 4 | 25 5 x 5 | 3 1 x 3 | Each directorate team is managing their waiting lists and backlogs. | Mar 2022: theatre staffing challenges remain in theatres. A new cost-per-case model for additionality in theatres will be implemented from April (pick-up unknown at this point). Recruitment has been successful into theatres so there is a pipeline of staff coming in during 22/23 | Apr-2022 | Jun-2022 | | PSQB | William Ainslie | Thomas Strickland |
| Very High | 7078 | Corporate | Medical Director's Office | Operational | Oct-2017 | Active | Keeping the base safe | Medical Staffing Risk (see also 6345 nurse staffing, 2827 A&E middle grade, 7454 radiology, 5747 interventional radiology)<br><br>Risk of not being able to deliver safe, effective and high quality care with a positive experience for patients due to difficult to recruit to Consultant posts in Gastroenterology, Radiology, Dermatology and Ophthalmology, and dual site working which impacts on medical staffing rotas resulting in:<br>- increase in clinical risk to patient safety due to reduced level of service / less specialist input<br>- negative impact on staff morale, motivation, health and well-being and ultimately patient experience<br>- negative impact on sickness and absence<br>- negative impact on staff mandatory training and appraisal<br>- cost pressures due to increased costs of interim staffing<br>- delay in implementation of key strategic objectives | Medical Staffing<br><br>Job planning established which ensures visibility of Consultant activity.<br>E-rostering roll out commenced to ensure efficient use of Consultant time<br>Establishment of staff bank to ensure vacant posts filled<br>WYAAT networked approach to pressured specialties<br><br>Medical Workforce Group chaired by the Medical Director.<br>Active recruitment activity including international recruitment at Specialty Doctor level<br>- new electronic recruitment system implemented (TRAC)<br>- HR resource to manage medical workforce issues.<br>- Identification of staffing gaps within divisional risk registers, reviewed through divisional governance arrangements | Medical Staffing<br><br>Risk of pensions issue impacting on discretionary activity<br>National shortage in certain medical specialties<br>Regional re-organisation could potentially de-stabilise the workforce<br>E-rostering partially implemented for doctors (expected by Sept 2020)<br><br>- centralised medical staffing roster has commenced but not fully integrated into the flexible workforce team<br>- measure to quantify how staffing gaps increase clinical risk for patients | 20 4 x 5 | 20 4 x 5 | 9 3 x 3 | • Monitored by Medical Workforce Programme Steering Group<br>• Active recruitment including international | February 2022<br><br>Our new rotational doctors in training arrived safely without delay in February, and attended a bespoke induction organised by the Medical Education Team. We are expecting two new overseas qualified trainees to arrive in the first week in March to join the Emergency Medicine department. The trainees are part of a new scheme in collaboration with Doncaster and Bassetlaw Trust and the Royal College of Emergency Medicine, known as HIEM (Hybrid International Emergency Training). The trainees will be arriving from Nepal and will be supernumary for the first six weeks in post, whilst undertaking a structured induction programme.<br><br>Shadowing periods are also being introduced by Health Education England to support GP trainees who are new to the NHS. In August 2021 we had several new GP Trainees join the training scheme from overseas. When they were due to rotate into the Acute setting in February some of them spent two weeks prior to the rotation within the placement shadowing existing colleagues. GP training programmes are being modified and in future GP trainees will spend less time in the Acute setting during their placements. Work is commencing to understand the impact that this will have on existing placements and rotas.<br><br>Our new Specialists in Anaesthetics are due to commence in March and there are interviews arranged to appoint Specialty Doctors who will backfill their posts and other existing gaps. The | Mar-2022 | Mar-2022 | | WF | David Birkenhead | Pauline North |

| | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | Emergency Medicine department are reviewing their workforce model to assess how Specialists may be of benefit in the future.<br><br>The SAS Advocate post is open for applications, with interviews scheduled for the beginning of March. This is a new role and as the SAS Tutor role is also about to be advertised it may present a new opportunity to improve engagement with our SAS doctors. | | | | | | T Strickland, S Shepley, A Ameen, L Willia |
| Very High | 7689 | Trustwide | All Divisions | All Departments/Wards | Mar-2020 | Active | Keeping the base safe | There is a risk that patients may have to wait for outpatient appointments, diagnostic tests or routine operations<br>Due to cancellations of routine surgery and rescheduling of clinics<br>Resulting in their condition deteriorating, potential impact on treatment options available and a less positive outcome | EPR booking and validation processes<br>Urgent fast-track processes in place<br>Risk assessment for re-prioritisation of appointments<br>Virtual appointments commenced in some prioritised areas | Unable to meet target KPI's for RTT and diagnostics, and that patients will wait longer than is best practice for outpatient appointments with an increase in the ASI list and holding list. | 20<br>4<br>x<br>5 | 20<br>4<br>x<br>5 | 4<br>2<br>x<br>2 | Clinical review and prioritisation of essential patients<br>Medicine: risk assessment of booked and due, consider remote or delay 3-6 months.<br>Working up CAS model and recovery plan.<br>Incident reporting for identifying patient harm or impact on prognosis or outcome<br>Complaints and PALS Team logging enquiries and concerns re waits for appointments, and patients not wishing to attend for appointments | Feb 22 - Increasing number of clinics cancelled over the last few weeks due to increasing pressures within CHFT. Bookings still in priority order after Clinical Validation has been completed. Insourcing in key areas to reduce ASIs. Recovery plans still ongoing | Mar-2022 | Mar-2023 | | NA | Helen Barker | T Strickland, S Shepley, A Ameen, L Willia |
| Very High | 6345 | Corporate | Workforce & Organisational Development | Resourcing / Recruitment | Jul-2015 | Active | Keeping the base safe | There is a risk of not being able to deliver safe, effective and high quality care with a positive experience for patients due to:<br>- insufficient availability of nursing and nursing support staff, ( i.e. not achieving minimum nurse staffing levels (as per Establishment reviews/CHPPD and national workforce models)<br>- Inability to adequately staff additional capacity ward areas<br><br>resulting in:<br>- increase in clinical risk to patient safety due to inability to deliver required level of care, reduced level of service and less specialist input<br>- negative impact on staff morale, motivation, health and well-being and ultimately patient experience<br>- negative impact on sickness and absence<br>- negative impact on staff mandatory training and appraisal<br>- cost pressures due to increased costs of interim staffing<br><br>Nurse Staffing Risk (see also medical staffing risk 7078 and therapy staffing risk 7077). Risk was also referenced in Risk 5937 - this has now been merged to Risk 6345. | Nurse Staffing<br>To ensure safety across 24 hour period:<br>- use of electronic duty roster to set nurse staffing within agreed workforce models, approved by Matron and general managers<br>- risk assessment of nurse staffing levels for each shift reviewed at least three times each 24 hour period using the Safer Care tool with formal escalation to Director of Nursing to agree mitigating actions.<br>- staff redeployment where necessary<br>- nursing retention strategy<br>- flexible workforce used for shortfalls (bank/nursing, internal, agency) and weekly report as part of HR workstream<br>- active recruitment activity, including international recruitment<br>- Introduction of new roles eg Nurse associate<br>- Identification and training of volunteers to meet and additional surge demand<br>- Implementation of NHSE Winter Planning Guidance and Associated Assurance Framework, including OPEL escalation triggers and actions, and twice daily senior safer staffing meeting. | Low numbers of applications to nursing posts across grades and specialities<br>National shortage of RGN's<br>Large numbers of staff sick or isolating due to Covid 19. | 16<br>4<br>x<br>4 | 20<br>4<br>x<br>5 | 9<br>3<br>x<br>3 | • Local/domestic recruitment<br>• International recruitment project<br>• Nursing associate role development and deployment of graduating cohorts<br>• Workforce transformation (NA's, TNA's and ACP's)<br>• Developing nursing retention strategy<br>• Use of flexible workforce<br>• Utilisation of nursing workforce using safe care live<br>• Response to the NHS interim people plan - significantly grown the number of undergraduate Health students to improve the pipeline of nurses to recruit | March 2022.<br><br>This risk was reviewed at the Nursing and Midwifery Workforce Steering Group on the 16th March 2022. Those present agreed the risk should be reduced based on the following factors:-<br><br>An current vacancy position of 78:02WTE which is also supported by 21.80 WTE Nursing Associates that supports the workforce models within clinical areas.<br><br>A reduction in the OPEL safer staffing score from 4 to a 3, which also included an episode of a high level 2 in February.<br><br>This risk has been reviewed alongside divisional risks specifically related to Nursing and Midwifery workforce risks. | Apr-2022 | Sep-2022 | | WF | Ellen Armistead, Suzanne Dunkley | Janet Youd |

| | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Very High | 6453 | Surgery & Anaesthetics | Orthopaedics | All wards/departments Orthopaedic | Sep-2018 | Active | Transforming and improving patient | Risk of poor patient experience, safety, quality of care, extended length of stay due to failure to undertake surgical repair of #NOF within 36 hours of admission and maintain BPT in 85% of patients. | - Senior clinical review of patients waiting for surgery<br>- Anaesthetic pathways of care embedded<br>- Job plans to provide cross cover for THR surgeon availability<br>- Discuss with theatres the need for additional trauma lists as and when needs arise | - Availability of surgeons with appropriate skills to undertake THR<br>- Surge in activity of #NOF & general trauma overwhelming capacity to treat within 36 hours of admission. This has now been further compounded due to Covid 19 pandemic and lack of theatre capacity for trauma.<br>- No additional trauma theatre sessions in place 3 per week to keep up with demand following second wave of Covid-19 pandemic | 16 4 x 4 | 20 4 x 5 | 9 3 x 3 | Enhanced monitoring and escalation as required. | 25/03/2022 There has been some job plan changes that will take full affect from 1st April. This means there will be better provision of THR for NOF which will help the 36 hr to theatre metric. | Apr-2022 | Aug-2022 | | DB | Jo Fawcus | Simon Sturdee |
| Very High | 7454 | Family & Specialist Services | Radiology | Main X-Ray | Apr-2019 | Active | Keeping the base safe | Service Delivery Risk<br><br>There is a risk to Radiology service provision due to a reduction in Consultant capacity resulting in a reduction of cover in some specialist areas and overall general capacity with the potential for breaching national targets. | - Agency Sonographer cover.<br>- NHS Locum cover.<br>- IR: Daytime support from neighbouring organisation (1 day per week); reconfiguration completed in November and now sharing OOH cover with WYVAS.<br>- NHS locum and Bank locum in place providing block cover (x weeks on/ x weeks off).<br>- Head & Neck - part time consultant in post, US scanning supported by locum sonographer<br>- Additional reporting support from external providers.<br>- Neuro: Additional reporting support from external providers and temporary change to job plans.<br>- General on-call: Increase in use of external provider cover and existing Consultants picking up additional stand-by shifts.<br>- Global Fellow in place (Paeds).<br>- Support from BHFT and Mid Yorks in exceptional circumstances (e.g. NAI's/reporting). | Vacancies in all areas, including:<br>- Intervention: Gap when contracted NHS Locum is on annual leave/other leave.<br>- Neuro: Reduced capacity and no capacity during annual leave/other leave.<br>- Paediatrics.<br>- Head and Neck (i.e. biopsies). | 15 3 x 5 | 20 4 x 5 | 1 1 x 1 | - Actively seeking recruitment in all areas including use of introduction agencies.<br>- Actively seeking NHS and agency locum for all required areas.<br>- Existing consultants working through competencies to enable coverage of gaps.<br>- Outsourcing increased to free up capacity where possible.<br>- Locum support employed when available e.g. breast radiologists<br>- Appointed a NHS Locum Chest Radiologist.<br>- Chest substantive starting in ?April 2022.<br>- New starters join on-call rota.<br>- Recruited an additional Global Fellow with an additions due to start in 2022. | Earlier updates saved in File Notes.<br><br>March 2021 Update: Risk reviewed, all areas updated as required. Position remains the same as December 2020 update.<br><br>July 2021 Update: Position remains the same as March 2021. We are currently in the process of recruiting new Radiologists.<br><br>November 2021 Update: A number of new Radiologists have come into post in October/November.<br><br>February 2022 Update: Risk reviewed and changes in workforce reflected. Overall Consultant numbers have increased. | Mar-2022 | Oct-2022 | | DB | Stephen Shepley | Sarah Clenton |
| Very High | 7474 | Trustwide | All Divisions | All Departments/Wards | May-2019 | Active | Keeping the base safe | There is a risk to the organisation of out of service medical devices being in circulation and in use across CHFT due to the lack of assurance about the Trust Asset Register being up to date as it doesn't include equipment which has been gifted or bought without CHS involvement resulting in potential patient harm to patients. This is also due to wards/departments not managing their equipment effectively, those which are out of service date and have not been seen for extended periods of time and are in use or available for use within CHFT for patient care, there is risk of patient harm.<br>CHS Risk 7438 | CHS Medical Engineering are attempting to rectify the problem and identify all devices in the high, medium and low risk category to provide an up to date register. To check if devices have a date on when they were last inspected as this would assist CHFT colleagues to identify equipment out of date.<br><br>CHFT staff are aware of the need to report medical devices requiring maintenance/repair however a reminder is deemed appropriate to ensure colleagues follow this process which will support CHS achieve their objectives.<br><br>Equip database enabled providing increased divisional control and | Failure to manage, maintain and service medical devices which are both know/unknown to EBME | 5 5 x 1 | 20 4 x 5 | 6 3 x 2 | Schedule the maintenance of those devise identified prioritising high risk devices first<br>2021/03/01-Update- working with divisions to audit asset register and ensure devices are in correct locations, adding assets to asset tracking system and to allocated ward areas.<br>2021/04/01-Update- Audits ongoing will continue and be in progress for the next few months will also be aligning with Theatre audit days. Staff recruitment ongoing to mitigate lack of staff relative to increased asset base.<br>2021/07/01-Update- Audits ongoing contracts compliance at highest level, staff recruited and | 2022/03/01-Update High risk risen (from 801 to 859), Medium fallen (from 3149 to 2506), Low risen (from 1711 to 1753) a total of (from 5661 to 5118). The second round of assets have been deactivated and decommissioned as can be seen in the numbers with a reduction of 934 assets outstanding maintenance, this demonstrates that the current plan is working, but needs more time to reduce risk to required level in order to justify reduction in risk, it is now evident that we will not meet target date and need an extension. Ability to achieve plan been impacted by Covid isolation of staff, retirement/departure of staff and gaps caused by recruitment, plan to engage bank staff will not mitigate before target date, therefore plan to extend target | Apr-2022 | Oct-2022 | | RC | Ellen Armistead | Robert Ross |

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| | | | | | | | | | ability to see which items of equipment are overdue. | | | | | in post to aid maintenance and mitigate risk, overtime authorised to rectify position.<br>2021/10/01- Update- We have been completing the audits within ward/department areas, and additionally we have been targeting Theatres as part of the audit days, however we are now at the point where we need to propose at the next Medical Device Procurement & Management Group, that the route forward is to compile a compliance report for Divisions on a monthly basis where we drill down to a ward/ department areas outstanding work, this will come as a percentage and compliance target.<br>Green will require;<br>• >95% High Risk assets.<br>• >90% Medium Risk.<br>• >85% Low Risk.<br>Amber will be:<br>• 90% to 95% High.<br>• 85% to 90% Medium..<br>• 80% to 85% Low.<br>Red will be:<br>• <90% High.<br>• <85% Medium.<br>• <80% Low.<br>Any assets listed as out of compliance to be presented/identified in month to Medical Engineering for maintenance, if not found by the Ward/Department in month these assets are to be written off by the Division, these assets will then be archived within eQuip, which will remove them from the compliance targets, but will enable them to be reactivated if found at a later date once outstanding maintenance has been completed. | date by 6 months. Admin resource is now in post to aid with process, new staff have been recruited to replace some gaps, but some recruitment is still ongoing and am expecting to need to replace more staff as we are expecting another departure imminently. | | | | | | |
| Very High | 7479 | Family & Specialist Services | Children's Services | Children's Ward CRH (3) | Jun-2019 | Active | Keeping the base safe | There is risk that young people with acute mental health needs will managed on the paediatric ward for an extended period by staff that do not have the appropriate skillset. There is a significant concern around children and young people with self-harm, suicidal ideation, eating disorders, and the increased complexities associated.<br><br>Due to a national shortage of inpatient provision for young people with acute mental health issues there waiting for a specialist bed or Children's Social care management. | 1. Agreed joint admissions guidance with CAMHS provider<br>2. Restrictive holding policy in place<br>3. Mental health awareness training undertaken for key staff<br>4. All incidents investigated<br>5. Paediatric representation at the mental health operational group<br>6. All requested for one to one shifts immediately escalated<br>7. Paediatric/CAMHS partnership meetings commenced<br>8. Clear escalation plans formulated<br>9. CAMHS hot and cold debriefs instigated<br>10. Clinically related challenging behaviour guidelines | Skill set of staff to care for children with complex psychological needs<br>Inability to provide a one to one support from staff with the correct skill set and experience<br>Consistency of escalation during out of hours periods<br>Lack in joint pathway agreement between social care, CAMHS and CHFT | 20 4 x 5 | 20 4 x 5 | 4 2 x 2 | December 2021<br>- Joint job descriptions for mental health liaison nurse to be agreed and go for job matching<br>- Ongoing strategic and operational meetings with CCGs, CAMHS and Social Care. Moving forward meetings are to be split into strategic and operational<br>- Awaiting outcome on Youth Music and Arts Project (due February 2022)<br>- Anti-ligature training to be fully implemented<br>- Anti-ligature risk assessment to be completed for ward 4<br><br>Historic | December 2021 - Anti-ligature risk assessment completed for the children's ward (3, CRH)<br>November 2021 - Initial joint meeting with Camhs, CCG to sope new ways of working and channels for escalation. and with key stakeholders - | Mar-2022 | Dec-2023 | | HSC | Nikhil Bhuskute | Elena Gelsthorpe-Hill/Julie Mellor/Louise Riby |

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| | | | | | | | | Resulting in potential harm to the patient, other patients, carers and staff.<br><br>COVID-19 has had a significant detrimental impact on the number of acutely unwell children and young people with mental health conditions. This increase has been seen both locally and nationally, in numbers and acuity. | 11. Restraint and use of force guidance<br>12. Clinical PEARLS | | | | | Two orange incidents to be investigated further<br>MDT approach to one case arranged - with mulit professional attendance<br>We can Talk QI project<br>Wider roll out of We can Talk training for all staff<br>Ian Kilroy in discussions with SWYFT to design physical intervention training package for high risk areas within CHFT.<br>Plan to deliver training to all band 6 clinical paediatric colleagues in receipt and scrutiny.<br>Joint training delivery with CAMHS<br>Community Registrar reviewed recent cases and incidents to identify key learning/trends.<br>To review policy guidance around detention and custody restraint policy | | | | | | |
| Very High | 7615 | Medical | All Directorates Medical | All Departments/Wards Medical | Dec-2019 | Active | Keeping the base safe | There is a risk of not meeting the four hour emergency care standard<br><br>Due to increasing demand on Emergency Care, patient flow issues, delays in assessment and discharge due to lack of social care staffing (hospital based social work team), lack of timely domiciliary care in community<br>More recently there have been increasing demand for side rooms due to the need to isolate patients with possible COVID-19, this has caused increasing delays.<br><br>Resulting in poor patient experience, patient harm, increased scrutiny and reputational damage | Operational procedures to improve patient experience and flow are in place and reviewed at 3 hourly bed meetings<br>Ambulance hand over time<br>Time to triage<br>Seen in 60 minutes by a medic<br>Digital - manages time and RAG rates<br>Clinical site commanders<br>KPI - refer for inpatient bed before 3 hours<br>Coordinators managing ED<br>Matrons in place at both EDs<br>Urgent care action cards direct staff<br>Housekeepers providing fundamental care<br>External support for dept in times of pressure - eg gynae, paeds<br>Surge and Escalation plan - OPEL<br>Training of on call managers and teams<br>Skill mix- training for newly qualified nurses<br>Streaming from the fron tdoor and admission avoidance services - frailty, streaming,<br>Covid IMT and tactical oversight of patient flow<br>ED improvement plan is being monitored through Gold as part of the flow "must do" | Partners not being able to deliver<br>YAS - transport - escalation and response times and transfer to bed base<br>Interruption of the Local Care Direct Service, GP closures for training<br>Vacancy<br>Non compliance with action cards and process without escalation<br>Engagement and understanding of the risk at ward level and across teams<br>Continued increase in demand in ED<br>High bed occupancy levels due to increased demand and restricted social care services | 15<br>3<br>x<br>5 | 20<br>4<br>x<br>5 | 1<br>1<br>x<br>1 | Patient Flow action plan in place<br>Governance - reported monthly at WEB<br>Patient Flow one of the 4 core must do's is being monitored at gold. owner – DOP for medicine<br>Accountability- Directors<br>Relaunch of the safer project<br>System wide working action owner is John Parnoby | November 2021 - Risk score increased and accepted at PSQB<br><br>October 21 - Plan for every patient program relaunched with additional resource to accelerate role out. ED improvement plan is being monitored through Gold as part of the flow "must do" System wide working action owner is John Parnoby. (Updated by L Taylor following a risk meeting with J Hammond) | Dec-2021 | Dec-2021 | | WEB | Ellen Armistead | Jonathan Hammond |

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| High | 7634 | Surgery & Anaesthetics | Theatres & Operating Services | Theatres CRH | Jan-2020 | Active | Keeping the base safe | There is a risk of theatre lists being cancelled due to the volume of staff vacancies (Band 5/6 leaving and retiring between December 2019 and October 2020), resulting in a loss of specialist skills and reduction in theatre activity. | Band 6 vacancies currently being advertised with divisional board approval to over recruit suitable candidates as part of succession planning Weekly staffing meetings with matron and clinical operations manager,s to review theatre lists by case and staffing requirements, identification of where staff can be released and redeployed cross site. Theatre lists and staff allocations reviewed daily by the theatre co-ordinator. Potential risks are escalated to the matron, inpatient operational manager and GM.<br>All unfilled shifts are sent to bank following roster final approval and to agency 21 days prior to the list date.<br>Review and postpone all non essential training.<br><br>October 2021 - 2 weekly meetings & theatre recruitment meeting.<br>December 2021 2 weekly meeting continue<br>January 2022 updated twice weekly meeting continue & theatre recruitment. | Pace of recruitment<br>Unfilled agency shifts<br>Not all remaining staff have transferable skills for each speciality.<br>Currently high levels of staff sickness<br><br>October 2021 - some agency lost due to other trust offering different pay<br>December 2021 updated<br>January 2022 updated | 9 3 x 3 | 16 4 x 4 | 4 2 x 2 | Plan to implement Band 6 development programme in all theatre areas, with clinical educator responsible for delivery of theatre specific competencies.<br>SOP -Procedure to follow prior to request to cancel theatre list due to unsafe staffing levels to be agreed at February DMT. | January 2022 - recruitment still continues, 5 new starters starting within the next 5 weeks 14 vacancies still remain.<br><br>. | Feb-2022 | Mar-2022 | | DB | Thomas Strickland | Sarah Bray |
| High | 7678 | Trustwide | All Divisions | All Departments/Wards | Mar-2020 | Active | Keeping the base safe | There is a risk of reduction in safe Medical staffing levels below the minimum required to maintain safety<br>Due to the impact of Covid-19 on capacity particularly in Critical Care, Respiratory Medicine, Acute Medicine, Elderly Medicine and Emergency Department<br>Resulting in unsafe levels of patient care<br><br>In addition, because Covid-19 directly impacts sickness absence and self-isolation of the medical workforce, a reduction in the medical workforce is to be expected.<br><br>Outside of surges of COVID-19 impact is reduced but non-COVID activity remains high. | Options implemented during COVID surges and episodes of high activity and stood down when activity and staffing pressures lessen<br>Identified lead for Medical redeployment (CP)<br>Covid Incident Control meetings and governance arrangements<br>Staffing Incident Command once or twice-daily meetings<br>Cancellation of annual leave<br>Cancellation of study leave<br>Suspension of appraisal<br><br>Tools used<br>Guidance on shaping the Medical Workforce<br>Staffing framework for ICU used<br>Developed acuity tool to inform doctor deployment | SPA time for revalidation and appraisal<br>Do not have all staff on e-rostering<br>Reporting of sickness absence and self-isolation is not consistent for medical staffing<br>Overseas recruited medical staff cannot travel to UK to commence work - anaesthetics, gastro, ED, Radiology | 20 4 x 5 | 16 4 x 4 | 6 3 x 2 | Work with regional partners to mitigate impacts on smaller services<br>Staff testing to identify those safe to return to work<br>Redeployment of staff to critical areas<br>Return to Practice Doctors being approached by Health Education England<br>Bank adverts across grades and specialties<br>Continue recruitment as usual<br>Consolidated junior doctor rotas<br>New rotas for middle grade (start 6.4.20) and consultant on-site 24/7 cover (start 13.4.20) - second phase start 9 November 2020<br>Mapping capacity against minimum and strech levels in non-high and intensity areas<br>Skilllsets - Physician CPAP trained, non-physician trianing package for high intensity areas | 16.7.21 COVID-19 activity has reduced but is climbing again, non-COVID activity is high with rising attendances in ED and increased medical admissions. Plans to clear extensive elective backlog underway. Current medical staffing pressures occurring as a result of staff being infected with COVID-19 and requirement to isolate/childcare. Gaps being covered through increased flexibility and movement of trainees and increased bank activity.<br>Proposals being considered for increasing and standardising additional duty payments.<br>Acuity tool developed and on KP+ to help support trainee placement.<br>EST paused | Aug-2021 | Nov-2021 | | WF | David Birkenhead | Cornelle Parker, Pauline North |

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| High | 7683 | Trustwide | All Divisions | All Departments/Wards | Aug-2020 | Active | Keeping the base safe | There is a risk of not having adequate isolation (Side room) facilities<br>Due to an increase in demand and initiation of testing of asymptomatic patients<br>Resulting in failure to safety isolate patients and further transmission of Covid-19 to vulnerable patients and impacting patient flow | Infection Control policies and procedures<br>PHE guidance<br>In-house testing of patients.<br>Daily IMC VC meetings.<br>SITREPS<br>Monitored by Tactical with reporting and escalation into Covid re bed capacity and patient flow.<br>Reason to Reside reviewed on a daily basis and meeting arranged with GP, CCG and social care partners<br>Discharge team working with consultants to expedite discharges<br>Strategic Command | One platform for testing and if this goes down will need to revert for testing to Leeds with results taking longer to receive<br><br>Aerosol generating respiratory interventions should be in single side rooms or require all in the area to wear PPE. | 12<br>4<br>x<br>3 | 16<br>4<br>x<br>4 | 6<br>3<br>x<br>2 | In-house testing to move negative out of isolation - in place<br>POC testing in place to reduce the need to admit directly to a side room and reduce risk to other patients on the ward.<br>Review anti-microbial protocols for antibiotic prescribing to reduce patient contact and move to early discharge<br>Plan for commencement of testing of asymptomatic patients - in place<br>Manage patient flow, discharge planning, admission avoidance, reason to reside assessment | August 2021- Ward 18 HR remains open with Covid positive and Covid contact patients placed on this ward unless their clinical need necessitates them staying in speciality. POC testing in place for all patients admitted to the wards from ED. This is carried out by a dedicated swabbing team on both sites. All patients requiring admission to speciality beds from Ed or clinics are POC tested before admission. Resp floor at CRH is currently open with 3 wards specifically for Covid positive patients with all AGPs on ward 5B where staff are in full PPE and access is prohibited to other staff to reduce the risk of transmission.<br>March 2021- Ward 18 remains open and currently all Covid positive patients are placed on this ward. POC testing in place to ensure that patients are placed in side rooms appropriately and to move patients out of side rooms when necessary. POC testing reduces the risk to other patients when placed in bays on wards All patients requiring admission to speciality beds eg CCU, Cardiology or stroke have a POC test to establish Covid status before admission. Reducing the risk of transmission to other patients on the ward. | Sep-2021 | Sep-2021 | | NA | David Birkenhead | Claire Speight, Bev Walker |
| High | 2827 | Medical | Emergency Care | Accident & Emergency CRH/HRI | Apr-2011 | Active | Developing our workforce | Risk of poor patient outcomes, safety and efficiency due to the inability to recruit sufficient middle grade emergency medicine doctors to provide adequate rota coverage results in the reliance of locum doctors to fill gaps.<br>Risks:<br>1. Risk to patient safety using staff unfamiliar with department processes and systems, results in complaints and clinical incidents<br>2. Risk to the emergency care standard due to risk above and increased length of stay<br>3. Risk of shifts remaining unfilled by flexible workforce department<br>4. Risk to financial situation due to agency costs<br><br>***It should be noted that risk 6131should be read in conjunction with this risk. | Associated Specialist in post and Regular locums used for continuity appointed<br>Middle Grade Doctors moved within sites to respond to pressures<br>Part-time MG doctors appointed<br>Consultants act down into middle grade roles to fill gaps temporarily<br>4 weeks worth of rota's requested in advance from flexible workforce department<br>Expansion of CESR programme<br>Ongoing ACP development<br>Weekly meeting attended by flexible workforce department, finance, CD for ED and GM<br>EMBeds website for induction of locum staff.<br>Allocated a further 10 Senior ED trainee placements by School of EM | Difficulty in recruiting Middle Grade and longer term locums<br>Variable quality of locum doctors<br>Relatively high sickness levels amongst locum staff.<br>Flexible Workforce not able to fill all gaps<br>ACP development will take 5 yrs from starting to achieve competence to support the middle grade level<br>Inability to recruit to CESR posts.<br>CESR training will extend time to reach Consultant level with no guarantee of retention<br>Inability of School of EM to allocate trainees. | 20<br>4<br>x<br>5 | 16<br>4<br>x<br>4 | 12<br>4<br>x<br>3 | 1. Recruitment including overseas and part time positions<br>2. Increase to senior ED trainee placement | March 22-Rota coordination to ensure equal balance of grades across each shift<br>Jan 22 Advert out to recruit 10 ST4-8 following gap analysis<br>July 2020<br>Clinical fellows have now started in the depatment<br>Continue to support and recruit ST 3 & 4s | Apr-2022 | Apr-2022 | | WEB | David Birkenhead | Amjid Mohammed |

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| High | 7328 | Surgery & Anaesthetics | Head and Neck | Ear, Nose and Throat | Sep-2018 | Active | Keeping the base safe | There is a risk of uncovered non-resident ENT Middle Grade on-call rota (1 in 6) gaps due pending resignations could result in staff burn out and risk of uncovered on-call shifts. Possible knock-on effect includes impact on outpatient clinics. It could also result in loss of theatre activity post busy on-call if consultants end up covering the gap (this also adds a financial pressure.) | Previous employee is being supported to join staff bank - application sent<br>All current staff are signed up on bank to help cover gaps<br>Jobs will be advertised on TRAC when resignations submitted | 19.3.22 one of the current team is on an enforced period of unpaid leave for 3 months. This person should be back before the other resignations (as notifications not received as at 16.3.22) | 12 3 x 4 | 16 4 x 4 | 1 1 x 1 | Advertise vacancies on TRAC to fill substantive posts<br><br>Recruit more ENT doctors (Nov 2018)- completed | 16.3.22 - one member of team to go on unpaid leave for 3 months (enforced) leaves one gap on the 1 in 6 rota. Notified that one middle grade is intending leaving to take up GP training role in August 2022. | Apr-2022 | Sep-2022 | | PSQB | Thomas Strickland | Sharon Berry |
| High | 7834 | Surgery & Anaesthetics | Orthopaedics | All wards/departments Orthopaedic | Jul-2020 | Active | Keeping the base safe | There is a risk that Orthopaedic elective patients are unable to have surgery within timescale, due to their being no availability of elective theatres or ward staff resulting in lengthily delays and poor patient outcomes.<br><br>There is currently no elective Orthopaedic inpatient theatre capacity at CHFT. | A number of Elective Day case lists have been sourced in the independent sector at the Spire and BMI hospitals up to 24 December 2020. After this the NHSE IS contract finishes and there is currently no agreement in place for IS theatre capacity thereafter.<br><br>All Consultants are reviewing their current waiting lists and telephone clinics have been established for review and stratification of the patients on the waiting lists. Following clinical validation the patients are clinically prioritised and categorised from 1 (that being the must urgent) - 4 (being the least urgent) according to Royal College guidance on clinical prioritisation of surgical patients. | There is currently no elective Orthopaedic inpatient theatre capacity at CHFT.<br><br>Limitations of IS criteria for patient cohort dependent on co-morbidties. A lot of our patients don't fit the criteria for surgery in the independent sector.<br><br>The nursing staff from the Orthopaedic elective ward at CRH have been redeployed during the Covid-19 pandemic to the acute respiratory floor and there are no current plans for their return into Orthopaedics.<br><br>A number of patients that were risk stratified in May/June time at a certain level (1-4) are now moving in to the lower more urgent categories with no plan to operate. | 16 4 x 4 | 16 4 x 4 | 9 3 x 3 | There is currently reduced elective orthopaedic inpatient theatre capacity at CHFT and there are no actions we can take to illeviate this. | 25/03/2022 - No real improvement in amount of elective lists at CRH. We are certainly below 50% of normal activity due to staff shortages amongst theatre staff. Since Aug 2021 we have had 133 theatre lists cancelled because of staffing issues and this is with trying to run two theatres a day at CRH rather than three so actual figure is much higher that this. Probably > 400 lists cancelled. | Mar-2022 | Dec-2022 | | PSQB | William Ainslie | Simon Sturdee |
| High | 7413 | Corporate | Finance and Procurement | Corporate Finance | Feb-2019 | Active | Keeping the base safe | There is a risk of fire spread at HRI due to insufficient fire compartmentation in areas which could result in fire spread / damage to buildings / equipment and harm to staff, patients and visitors. | Following a fire compartmentation undertaken in 2014 capital funding has been made available to improve compartmentation and fire safety across HRI Site.<br><br>Fire committee has been established in November 2019 where fire safety is discussed and any risks escalated. Chief Operating Officer, is the nominated executive lead for fire safety<br><br>Works undertaken by CHS includes:-<br><br>• Replacement of fire doors in high risk areas<br>• Replacement fire detection / alarm system compliant to BS system installed<br>• Fire Risk Assessments complete<br>• Decluttering of wards to support | Number of areas awaiting fire compartmentation works Consequence of decanting ward area to carry out risk prioritised compartmentation works | 15 5 x 3 | 15 5 x 3 | 1 1 x 1 | May 2021 The fire strategy has been produced by outside consultants and a work plan is being developed. The fire policy is ready to be approved by the fire committee.<br><br>Dec 2019 - CHFT Fire Committee established with involvement from CHS and PFI. Fire Strategy to be developed to provide a short, medium and long term plan aligning with Trusts reconfiguration plans. Fire Committee to review fire risks.<br><br>July 2019: NHSI capital bid for 19/20<br><br>June 2019: Fire risk assessments, installation of sockets | June 2021<br>Position still the same, we need the awareness of what building stock is to stay and what is removed, so we can target work to fit the reconfiguration. | Jul-2021 | Mar-2022 | | FIREC | Helen Barker | CHS / CHFT |

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| | | | | | | | | | ensure safe evacuation<br>• Improved planned preventative maintenance regime on fire doors<br>• Regular planned maintenance on fire dampers<br><br>Fire Safety Training continues throughout CHFT via CHS Fire Safety Office<br>• Face to face<br>• Fire marshal<br>• Fire evacuation<br>• Fire extinguisher | | | | | May 2019: Delivery of fire training<br><br>Feb 2019: Walk around on wards between CHS, CHS Fire Officer and Matrons with the aim of de-cluttering wards to ensure a safe and effective evacuation.<br><br>Feb 2018 The Trust has bid to NHSI for early release of capital monies to support further fire compartmentation work. However, in order for CHS to manage this in a prioritised risk based approached it is essential the Trust are able to decant areas to enable CHS to complete building works to a satisfactory standard. | | | | | | | |
| High | 5747 | Family & Specialist Services | Radiology | Angiography & Fluoroscopy | Mar-2013 | Active | Keeping the base safe | Service Delivery Risk<br><br>There is a risk of patient harm due to challenges recruiting to vacant interventional radiologist posts resulting in an inability to deliver OOH vascular cover as part of the WYVAS committment and in hours on site cover. | - 1 NHS Locum in post due to be renewed in the Summer).<br>- 1 NHS (Bank) Locum supporting the service in tandem with the above.<br>- 1 day per week support from a neighbouring organisation.<br>- Working closely with WYVAS to plan and secure adequate cover. | - Reconfiguration of services completed in November 2020 | 16<br>4<br>x<br>4 | 15<br>5<br>x<br>3 | 6<br>2<br>x<br>3 | 1. Continue to try to recruit to the vacant post, advertising for joint post with Bradford Teaching TH.<br>2. Working with WYVAS to progress a regional approach. | Earlier updates saved into File Notes.<br><br>March 2021 update - current cover is via temporary arrangements but cover is stable. Working with WYVAS colleagues to plan future strategy/joint cover. | Mar-2022 | Oct-2022 | | DB | Stephen Shepley | Sarah Clenton |
| High | 6715 | Corporate | Corporate Nursing | Workforce and Clinical Development | Apr-2016 | Active | Keeping the base safe | There is a risk to patient safety, outcome and experience due to inconsistently completed documentation on EPR.<br><br>This has the potential to result in a negative impact for the patient in increasing their length of stay, lack of escalation should deterioration occur, poor communication both internally and externally and difficulties with efficient multidisciplinary working.<br><br>In addition to this, inaccurate coding and submissions, appropriate remuneration for care delivered and the inability to be able to be able to establish the correct patient pathway in response to review, complaints, serious incidents and legal requirements. | Structured documentation within EPR as per induction training.<br><br>Training and education around documentation within EPR - development of E Learning Modules for training.<br><br>KP+ Model regarding monthly and weekly ward assurance.<br><br>Doctors and nurses EPR guides and SOPs.<br><br>Datix reporting<br><br>Relevant Boards and specialist groups that support clinical documentation which include<br>-Clinical Records Group<br>-Clinical Outcomes Group<br>-Information Governance and Record Strategy Group<br>-Deteriorating Patient<br>-Pressure Ulcer Collaborative<br>-Nutrition and Hydration<br><br>Quality Priority for 2021/22 in | Remaining paper documentation not built in a structured format in EPR which has been a challenge to the organisation since go live of the electronic patient record due to<br><br>KP+ reporting tool does not provide assurance around documentation - requires review of components being extracted.<br><br>There are gaps in recruitment currently within the nursing, training and EPR Change Team which would support an improved electronic record.<br><br>Not all SOP's are in date. | 20<br>4<br>x<br>5 | 15<br>3<br>x<br>5 | 6<br>3<br>x<br>2 | September 2020 - Action plan to review current status and progress improvement<br>- Clinical Records Group - review attendance and TOR<br>- Review data extraction for clinical records relating to Ward Assurance in KP+ model to ensure accuracy.<br>- Roll out White Board Functionality in EPR - identify areas to formulate improvement before roll out across the organistion<br>- Support improvement at ward level in improvement of key metrics - promote ward ownership<br>- Implementation of Optimisation Strategy in stages - Stage 1 In-depth Analysis of current working practices amongst staff working in the trust - OPD and In-patient services. Stage 1 results will determine Stage 2 relating to recommendations and development of Digital Champions | March 2022: Training team continue to visit wards and review currently underway as to how training can look in the future with more focus on 1:1 support in the clinical area. CNIO and CCIO are liaising with Cerner regarding how the admission process can be more streamlined and focus on completing the must do assessments while also not making it more cumbersome for staff. This is feeding into Clinical Records group. | Apr-2022 | Dec-2022 | | WEB | Ellen Armistead | Louise Croxall/Graham Walsh |

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| | | | | | | | | relation to strengthening record keeping within the Trust. | | | | | - Explore Training and Support - alternative methods of delivery and at the elbow support<br>- Work Together Get Results - Workshops to collectively discuss and promote digital record keeping within the work environment - understand barriers for failure to comply and put measures in to support change as a result | | | | | | | |

# 22. Integrated Performance Report – March 2022

To Note

Presented by Jo Fawcus

Calderdale and Huddersfield NHS Foundation Trust

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| **Date of Meeting:** | Thursday 5 May 2022 |
| **Meeting:** | Public Board of Directors |
| **Title:** | QUALITY & PERFORMANCE REPORT |
| **Authors:** | Peter Keogh, Assistant Director of Performance, Kirsty Archer Deputy Director of Finance, Andrea Dauris Associate Director of Nursing, Jason Eddleston Deputy Director of Workforce and OD, Cornelle Parker Deputy Medical Director |
| **Sponsoring Director:** | Jo Fawcus, Chief Operating Officer |
| **Previous Forums:** | Quality Committee, Finance & Performance Committee |

**Purpose of the Report**

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

**Key Points to Note**

Trust performance for March 2022 was 64% with the following areas to note. There was a never event in March, HSMR finally went above 100 as expected however we did manage to achieve all our key cancer targets which was excellent news.

The **SAFE** domain is now amber following a never event in March. The **CARING** domain remains amber with 2 of the 5 FFT areas now green but maintaining performance in Complaints is still a challenge. Dementia screening has improved slightly to 25%. **EFFECTIVE** domain remains amber as HSMR has risen above 100. #Neck of Femur is still a challenge at 64%. The **RESPONSIVE** domain remains amber with all key cancer targets achieved for March which is an excellent achievement. Stroke indicators alongside the underperformance in the main planned access indicators and ED remain a challenge moving forward. **WORKFORCE** remains amber and there is a peak in the 12-month running total for both long-term and short-term sickness with an increase in Covid related sickness in March when compared to February though not at the same level as seen in January. Return to Work Interviews have improved in month. **FINANCE** domain remains amber whilst Use of Resources indicator has returned to green.

Due to operational pressures IPR (Integrated Performance Report) only contains narratives for Key Indicators that are not achieving target.

*Just to note as agreed at March FSS Performance Review meeting we will no longer report performance against Caesarean Section rates within the IPR but this will continue to be monitored as part of a wider selection of indicators within the Maternity dashboard.*

**EQIA – Equality Impact Assessment**

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

**Recommendation**

The Board of Directors is asked to **NOTE** the narrative and contents of the report and the overall performance score for March 2022.

**Performance**
**March 2022**

**Elective Care**
At the end of March there were 23,281 patients waiting over 2 years for treatment nationally. At CHFT we had single figures which is a fantastic achievement bearing in mind some of our neighbouring West Yorkshire Trusts had numbers in the hundreds.

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

ED attendances for both hospital sites continue to increase since Christmas, however Covid cases where a patient needs to be admitted continue to fall with numbers now down to approximately 30 patients across both hospital sites. Acuity/dependency is still significantly high and has led to some very challenging operational issues, this has had an impact on the 4-hour ECS performance over recent months although this has seen some improvement over the last few weeks and continues to perform better than other Trusts in West Yorkshire. We have continued to see long waits in both emergency departments which is an extremely poor patient experience, and we know increases risk for patients in terms of outcomes.

Hospital Acquired Covid numbers continue to drop, and outbreaks are becoming less frequent. We are still seeing some asymptomatic positive cases though within ward areas. Other infections such as norovirus and flu have not been seen over the last few months and this has helped with patient flow across both our sites.

There continues to be approximately 100 patients on the Transfer of Care list which means keeping the extra capacity areas open and using discharge lounge at HRI and Ambulatory at CRH as inpatient ward areas on many occasions. This is a feature usually at the beginning of the week following low discharges during the weekends and it normally takes until Wednesday to recover this position.

HSMR is deteriorating from having been a positive outlier to the current rolling position of 102.2 which is classed ‘as expected’ range.

Having examined the data in detail, we have identified the issue as being a reduction in those patients receiving specialist palliative care input and a reduction in the utilisation of the corresponding code. The reason for this is a combination of staffing vacancies and sickness within the specialist palliative care team and increasing complexity of patients.

The Medical Director and Deputy Medical Director have discussed this with the specialist palliative care team, who are now are working with Informatics to proactively identify those patients who may benefit from specialist palliative care input and providing in-reach into those ward areas via their MDT meetings.

From a financial point of view, the Trust is reporting a year end £0.04m surplus, in line with

the planned operational breakeven position. Achieving this breakeven position has been challenging with the Trust experiencing a number of significant financial pressures, in particular the growing cost of temporary staffing (enhanced bank rates and high cost agency) linked to the ongoing pressure on capacity due to Covid and the cost of Recovery. The letter half of the year also included a significant efficiency requirement of £6.7m, of which only £3.54m has been delivered. However, the Trust successfully bid for additional Elective Recovery Funding in support of schemes to increase capacity and also secured some additional non-recurrent funding allocations from both local Commissioners and the Integrated Care System (ICS), which between them have mitigated these additional cost pressures.

We continue to monitor One Culture of Care must-do activity including colleague rest and recuperation for wellbeing, health and wellbeing risk assessments, clear access points for our internal Listening Ear service and external psychologist-led employee assistance programme provided by CareFirst, refreshed leader/manager guides and ensuring there is an understanding of the opportunities to raise concerns through our Speak Up processes. The 12-month rolling sickness absence rate is at 5.77%, the in-month rate for March is at 6.35% albeit a reduction from an exceptional high of 8.74% in January due directly to a spike in Covid related absence.

A review of March 2022 data indicates that the combined RN and non-registered clinical staff metrics resulted in 20 of the 27 clinical areas having fewer CHPPD than planned, with a total deficit of 1.0 CHPPD across the Trust (a slight deterioration on the previous month). The gap in CHPPD is at its broadest with the RN workforce representing 0.8 deficit. This deficit is managed through twice daily staffing meetings which are chaired by the Associate Directors of Nursing and supported by mitigations reported within the Safecare system and the use of professional judgement to redeploy staff on a shift basis and establish the safest staffing possible in all areas.

compassionate care

NHS
Calderdale and Huddersfield
NHS Foundation Trust

# Integrated Performance Report

March 2022

Report Produced by : The Health Informatics Service

Data Source : various data sources syndication by VISTA

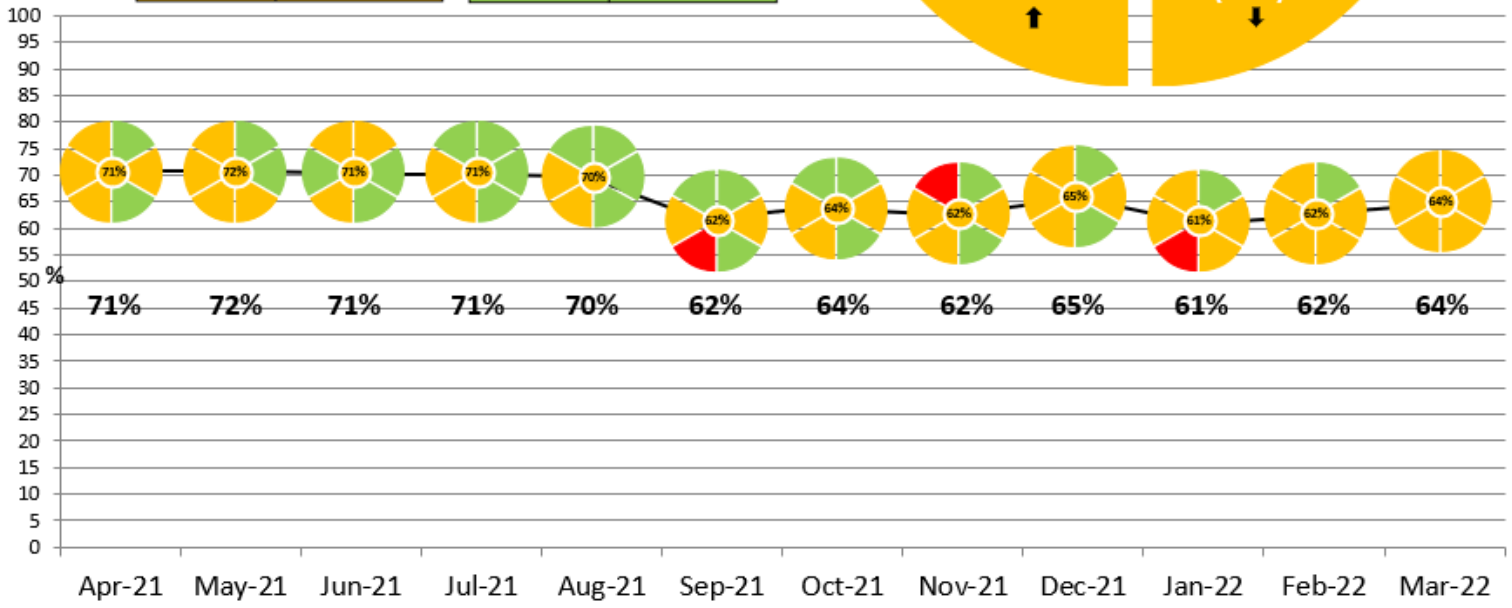
## Performance Summary

# March 2022

SYSTEM OVERSIGHT FRAMEWORK

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

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

## Key Indicators

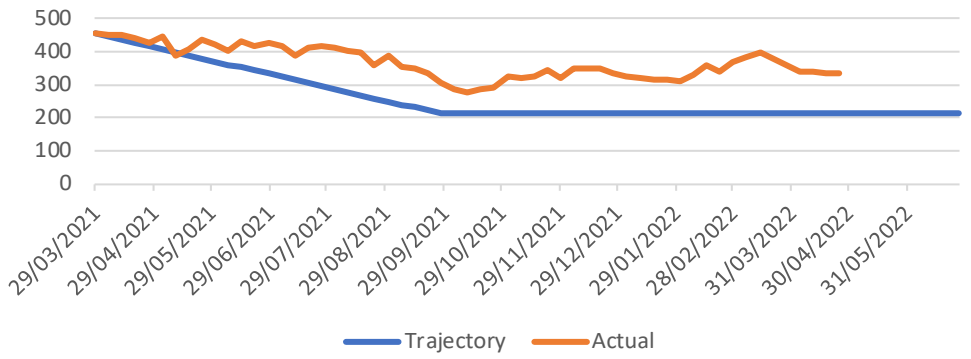
| | 20/21 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Mar-22 | YTD | Performance Range | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **SAFE** | | | | | | | | | | | | | | | | | | | | | | | | | | | Green | Amber | Red |
| Never Events | 2 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 2 | 0 | | >=1 |
| **CARING** | | | | | | | | | | | | | | | | | | | | | | | | | | | Green | Amber | Red |
| % Complaints closed within target timeframe | 60.07% | 93.8% | 81.8% | 80.0% | 69.6% | 71.4% | 53.9% | 44.1% | 50.0% | 41.7% | 63.0% | 52.9% | 60.00% | 100.00% | 87.50% | 100.00% | 69.44% | 55.10% | 71.43% | 58.82% | 94.29% | 70.73% | 37.50% | 44.44% | **29.41%** | **63.61%** | 100% | 86% - 99% | <=85% |
| Friends & Family Test (IP Survey) - % Positive Responses | 91.09% | COVID | COVID | COVID | COVID | COVID | COVID | COVID | COVID | 93.63% | 93.46% | 88.32% | 96.82% | 96.75% | 95.62% | 97.00% | 96.38% | 96.61% | 97.33% | 98.26% | 97.47% | 97.35% | 97.10% | 97.36% | **96.43%** | **96.91%** | >=90% / >=95% from | | <=79% |
| Friends and Family Test Outpatients Survey - % Positive Responses | 93.27% | COVID | COVID | COVID | COVID | COVID | COVID | COVID | COVID | 93.37% | 93.10% | 93.28% | 92.38% | 92.45% | 92.20% | 92.29% | 91.88% | 91.77% | 91.49% | 91.51% | 92.45% | 93.02% | 93.20% | 92.15% | **92.26%** | **92.16%** | >=90% / >=93% from | | <=79% |
| Friends and Family Test A & E Survey - % Positive Responses | 90.16% | COVID | COVID | COVID | COVID | COVID | COVID | COVID | COVID | 90.38% | 90.91% | 89.37% | 90.48% | 85.13% | 85.90% | 82.98% | 78.53% | 81.33% | 80.85% | 81.01% | 82.39% | 84.40% | 86.40% | 84.69% | **77.05%** | **82.76%** | >=80% / >=85% from | | <=69% |
| Friends & Family Test (Maternity) - % Positive Responses | 98.86% | COVID | COVID | COVID | COVID | COVID | COVID | COVID | COVID | 98.00% | 100.00% | 100.00% | 91.89% | 85.71% | 90.00% | 91.23% | 97.53% | 95.19% | 97.69% | 93.98% | 93.20% | 98.33% | 92.30% | 91.00% | **95.10%** | **94.64%** | >=90% / >=95% from | | <=79% |
| Friends and Family Test Community Survey - % Positive Responses | 100.00% | COVID | COVID | COVID | COVID | COVID | COVID | COVID | COVID | 100.00% | 100.00% | 100.00% | 100.00% | 99.50% | 93.80% | 93.37% | 87.74% | 92.52% | 94.27% | 91.12% | 95.86% | 93.68% | 95.50% | 91.21% | **88.99%** | **92.44%** | >=90% / >=95% from | | <=79% |
| **EFFECTIVE** | | | | | | | | | | | | | | | | | | | | | | | | | | | Green | Amber | Red |
| Number of MRSA Bacteraemias – Trust assigned | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** | **0** | 0 | | >=0 |
| Preventable number of Clostridium Difficile Cases | 6 | 1 | 1 | 2 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 0 | 1 | 0 | 0 | 1 | 1 | 0 | **0** | **5** | 4 | | 3.4 |
| Local SHMI - Relative Risk (1 Yr Rolling Data) | 100.94 | 98.4 | 98.68 | 99.05 | 99.74 | 100.88 | 101.31 | 102.27 | 102.71 | 100.94 | 104.11 | 103.15 | 102.26 | 104.83 | 104.78 | 105.07 | 105.49 | 105.91 | 105.39 | 106.60 | 106.99 | 106.36 | | | | **106.36** | <=100 | 101 - 109 | >=110 |
| Hospital Standardised Mortality Rate (1 yr Rolling Data) | 90.49 | 91.32 | 91.56 | 92.39 | 91.88 | 92.85 | 93.32 | 93.3 | 92.98 | 90.32 | 90.49 | 90.76 | 89.46 | 88.24 | 88.99 | 90.00 | 90.56 | 92.19 | 93.78 | 95.20 | 97.00 | 99.27 | 102.20 | | | **102.20** | <=100 | 101 - 109 | >=111 |
| **RESPONSIVE** | | | | | | | | | | | | | | | | | | | | | | | | | | | Green | Amber | Red |
| Emergency Care Standard 4 hours | 88.81% | 92.59% | 95.24% | 94.76% | 93.72% | 90.65% | 88.93% | 81.25% | 81.42% | 86.82% | 87.82% | 86.48% | 87.83% | 88.22% | 86.70% | 86.16% | 78.59% | 79.57% | 78.29% | 75.97% | 76.81% | 72.95% | 75.70% | 73.92% | **74.05%** | **78.99%** | >=95% | 81% - 94% | <=80% |
| % Stroke patients admitted directly to an acute stroke unit within 4 hours of arrival | 65.30% | 71.43% | 71.93% | 67.24% | 54.41% | 58.33% | 50.94% | 49.18% | 55.90% | 65.30% | 56.06% | 25.42% | 38.60% | 61.02% | 49.06% | 54.90% | 42.29% | 43.14% | 42.00% | 33.87% | 33.33% | 23.19% | 16.67% | 15.79% | **25.45%** | **36.71%** | >=90% | | <=85% |
| Two Week Wait From Referral to Date First Seen | 98.74% | 98.24% | 99.02% | 98.52% | 98.92% | 99.65% | 97.85% | 99.04% | 98.50% | 98.91% | 98.55% | 98.80% | 98.76% | 98.30% | 99.08% | 97.82% | 97.93% | 98.51% | 98.80% | 98.58% | 99.21% | 97.96% | 98.39% | 98.35% | **97.56%** | **98.38%** | >=93% | 86% - 92% | <=85% |
| Two Week Wait From Referral to Date First Seen: Breast Symptoms | 97.86% | 100.00% | 100.00% | 97.70% | 95.87% | 100.00% | 99.27% | 100.00% | 94.78% | 98.70% | 97.35% | 96.45% | 97.34% | 98.28% | 98.68% | 100.00% | 98.68% | 100.00% | 97.96% | 98.45% | 96.84% | 96.00% | 93.84% | 97.25% | **93.50%** | **97.53%** | >=93% | | <=92% |
| 31 Days From Diagnosis to First Treatment | 98.08% | 99.42% | 97.37% | 98.26% | 97.83% | 97.69% | 100.00% | 98.67% | 96.23% | 96.71% | 96.82% | 98.55% | 99.22% | 99.46% | 99.41% | 97.63% | 98.94% | 97.92% | 95.88% | 94.89% | 99.02% | 99.37% | 98.35% | 99.39% | **98.31%** | **98.21%** | >=96% | | <=95% |
| 31 Day Subsequent Surgery Treatment | 90.99% | 96.88% | 96.00% | 69.57% | 86.84% | 91.30% | 100.00% | 96.30% | 96.30% | 86.21% | 73.91% | 92.31% | 100.00% | 97.14% | 100.00% | 100.00% | 97.78% | 94.44% | 84.78% | 100.00% | 92.59% | 100.00% | 93.33% | 96.55% | **94.44%** | **95.43%** | >=94% | | <=93% |
| 31 day wait for second or subsequent treatment drug treatments | 99.15% | 100.00% | 100.00% | 97.87% | 97.83% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 96.55% | 100.00% | 98.04% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 95.45% | 98.63% | **100.00%** | **99.51%** | >=98% | | <=97% |
| 38 Day Referral to Tertiary | 54.64% | 76.00% | 45.45% | 40.00% | 65.00% | 47.06% | 39.13% | 58.33% | 35.71% | 50.00% | 43.75% | 61.54% | 91.67% | 50.00% | 61.11% | 50.00% | 72.73% | 47.06% | 52.17% | 61.11% | 50.00% | 37.93% | 35.00% | 66.67% | **30.77%** | **50.00%** | >=85% | | <=84% |
| 62 Day GP Referral to Treatment | 91.47% | 93.61% | 91.41% | 85.59% | 91.72% | 91.16% | 93.03% | 89.67% | 94.76% | 90.00% | 90.10% | 87.58% | 95.65% | 94.00% | 90.95% | 91.87% | 91.23% | 91.40% | 89.77% | 91.51% | 93.43% | 87.32% | 89.59% | 86.82% | **89.71%** | **90.62%** | >=85% | 81% - 84% | <=80% |
| 62 Day Referral From Screening to Treatment | 63.98% | 72.22% | 37.50% | 0.00% | 0.00% | 33.33% | 0.00% | 83.33% | 81.82% | 85.19% | 83.33% | 73.91% | 100.00% | 75.00% | 57.89% | 48.48% | 32.14% | 55.26% | 32.00% | 55.56% | 76.19% | 81.25% | 62.50% | 50.00% | **96.30%** | **59.47%** | >=90% | | <=89% |
| Faster Diagnosis Standard: Maximum 28-day wait to communication of definitive cancer / not cancer diagnosis for patients referred urgently (including those with breast symptoms) and from NHS cancer screening | 79.84% | 70.98% | 85.89% | 73.70% | 80.21% | 83.19% | 82.94% | 82.52% | 80.91% | 81.48% | 71.76% | 82.50% | 80.21% | 73.04% | 67.41% | 68.93% | 73.27% | 69.07% | 70.56% | 76.23% | 78.16% | 76.82% | 76.50% | 83.12% | **79.54%** | **74.31%** | >=75% | | <=70% |
| **WORKFORCE** | | | | | | | | | | | | | | | | | | | | | | | | | | | Green | Amber | Red |
| Sickness Absence rate (%) - Rolling 12m | 4.52% | 4.12% | 4.23% | 4.25% | 4.25% | 4.24% | 4.24% | 4.30% | 4.41% | 4.46% | 4.53% | 4.59% | 4.52% | 4.37% | 4.35% | 4.44% | 4.61% | 4.76% | 4.89% | 5.00% | 5.01% | 5.12% | 5.43% | 5.45% | 5.77% | - | <=4% | <=4.5% | >4.5% |
| Long Term Sickness Absence rate (%) -Rolling 12m | 3.07% | 2.61% | 2.69% | 2.72% | 2.73% | 2.73% | 2.73% | 2.78% | 2.86% | 2.93% | 2.99% | 3.07% | 3.07% | 3.01% | 2.99% | 3.07% | 3.17% | 3.29% | 3.36% | 3.39% | 3.38% | 3.38% | 3.40% | 3.42% | 3.46% | - | <=2.5% | <=2.75% | >2.75% |
| Short Term Sickness Absence rate (%) -Rolling 12m | 1.45% | 1.51% | 1.54% | 1.53% | 1.52% | 1.51% | 1.52% | 1.52% | 1.55% | 1.52% | 1.54% | 1.52% | 1.45% | 1.36% | 1.35% | 1.38% | 1.44% | 1.48% | 1.53% | 1.61% | 1.63% | 1.74% | 2.04% | 2.14% | 2.31% | - | <=1.5% | <=1.75% | >1.75% |
| Overall Essential Safety Compliance | 94.90% | 93.61% | 94.11% | 94.24% | 95.85% | 94.42% | 95.28% | 95.51% | 95.18% | 95.16% | 95.02% | 94.86% | 94.90% | 94.85% | 94.68% | 95.64% | 95.48% | 93.93% | 93.81% | 93.22% | 93.01% | 93.28% | 92.50% | 92.57% | 92.90% | - | >=90% | >=85% | <85% |
| Appraisal (1 Year Refresher) - Non-Medical Staff | 95.15% | | | | | | | | | 95.15% | 95.15% | 95.15% | 95.15% | | | | | | | | | | | | | - | >=95% | >=90% | <90% |
| Appraisal (1 Year Refresher) - Medical Staff (Rolling 12mth) | 41.05% | | | | | | | | | | | | | | | | | | | | | | | | | - | >=95% | >=90% | <90% |
| **FINANCE** | | | | | | | | | | | | | | | | | | | | | | | | | | | Green | Amber | Red |
| I&E: Surplus / (Deficit) Var £m YTD | 2.27 | (0.00) | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.95 | 0.16 | -1.00 | 0.41 | 0.58 | 1.18 | 0.55 | 2.39 | 0.28 | -0.22 | -1.40 | -1.62 | 0.00 | -0.05 | 0.17 | 0.02 | -0.06 | **-0.11** | **0.04** | | | |

## SWOT Analysis

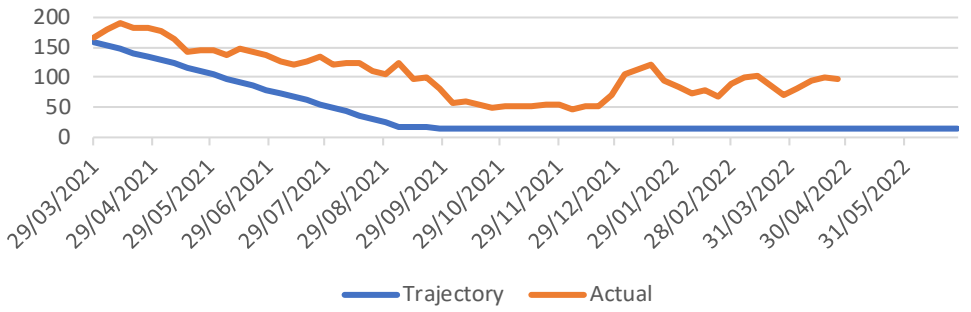
| | |
|---|---|
| Strengths | • Agreed Recovery Framework.<br>• Continuing to focus on Trust agreed priorities for elective patients, e.g. ensuring we prioritise patients with learning disabilities, P2s and long waiters (104 weeks).<br>• Ongoing comprehensive theatre staff engagement and workforce development programme.<br>• 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.<br>• Covid Vaccination Programme 12-15 yr old requirements including the 2nd dose, working in partnership with Pharmacy 2 U completed.<br>• 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.<br>• 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.<br>• Have introduced a locally developed acuity and complexity score for District Nursing caseloads which is adding value in weighting caseload management but also evidencing increased acuity in demand.<br>• Insourcing arrangements in place for ENT (OP & Surgery), Orthopaedics (CHOP LLP) and Ophthalmology (OP, diagnostics & Surgery) to help tackle elective backlogs.<br>• Automated medicine cabinets installed at HRI and pharmacy robot business case approved.<br>• Have demonstrated ability to deliver significant change in the delivery of the Urgent Community Response and wider 0-72 hour integrated team on schedule and in advance of national expectations.<br>• Community 7-day on-call manager rota in operation to respond to and support pressures in the system. |
| Weaknesses | • Bed pressures continue to be significant. Continued sustained pressure on ICU.<br>• The staffing position continues to be extremely challenging across all divisions in particular among nursing teams and is being closely monitored and managed on a daily basis through the Gold meetings.<br>• Ward 11 is now a 24/7 medical ward but with an establishment only for Monday-Friday<br>• Staffing shortages in theatres leading to continued reduced capacity to operate on patients.<br>• Having to pull outsourced patients back from BMI and Spire due to not being dated within current local waiting time targets.<br>• Issue retaining Community Pharmacists in Quest due to conflicting demands with PCN Pharmacists.<br>• Disparity with availability of clinical educators into Therapy services to support staff retention and education.<br>• MRI downtime in Radiology due to equipment issues. ED and IP prioritised to ensure flow was not compromised.<br>• 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.<br>• The Plan for Every Patient roll-out programme is underway with further resource allocated to increase pace and buy-in.<br>• 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.<br>• Pilot Urgent Care Hubs have been established at both HRI and CRH staffed by CHFT colleagues. These are operational Monday-Friday 08.00-18.00 with the service reverting ` to Local Care Direct outside of these hours.<br>• Developing SOP to stop mandatory 3-day isolation for low-risk pathways - will help reduce health inequalities and help backfill late notice cancellations.<br>• 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.<br>• Development of workforce plan including ODP apprentices, Nurse Associate role.<br>• Opportunity to work with NHSE as a part of the pathfinder pilot looking at hospital patient transport (HTCS) for both inpatients and outpatients.<br>• Money received from HEE for Allied Health Professions Workforce Supply Strategy Planning project work.<br>• 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.<br>• Recruitment in process for Clinical Educator role (Nursing). Will support development of competencies and aim to improve performance against key quality KPIs i.e. medication incidents. |
| 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.<br>• Staff being stretched due to increased number of Delayed Transfers of Care.<br>• Community services are increasingly seeing more complex and acute presentation with impacts on wider anticipatory care and Long Term Condition (LTC) management.<br>• 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.<br>• Staff fatigue due to ongoing pressures and frustration due to prolonged changing and increasing workloads.<br>• Cost pressures increasing dependencies on overtime and bank.<br>• Amendments to pay enhancement scheme for elective recovery could risk losing more theatre capacity<br>• Increasing number of complaints due to prolonged waits and poor patient experience.<br>• Significant cost pressure within Community due to Private Ambulance costs over and above CCG YAS commissioned service.<br>• Risk of further vacancies in community nursing due to local organisations rebanding DN roles to Band 7.<br>• Health and safety risks due to ageing estate across the Trust. Working with stakeholders to mitigate risks and explore permanent solutions that align with wider Trust reconfiguration plans. |

## INPATIENT WAITING LIST - P2

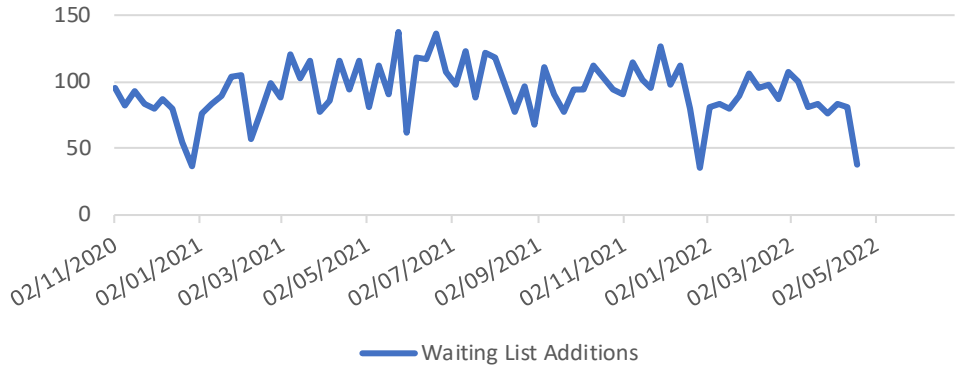
### Trajectory vs Actual - Total P2s on Waiting List



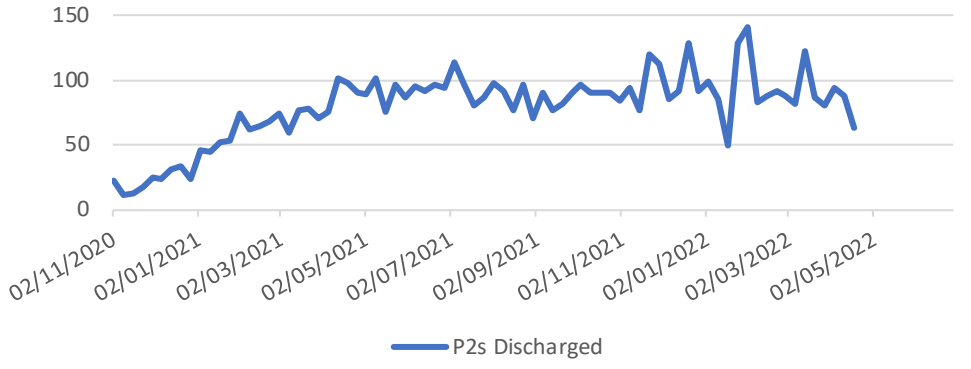

### Trajectory vs Actual - Total P2s on Waiting List Over 1 month




### P2 waiting List Additions

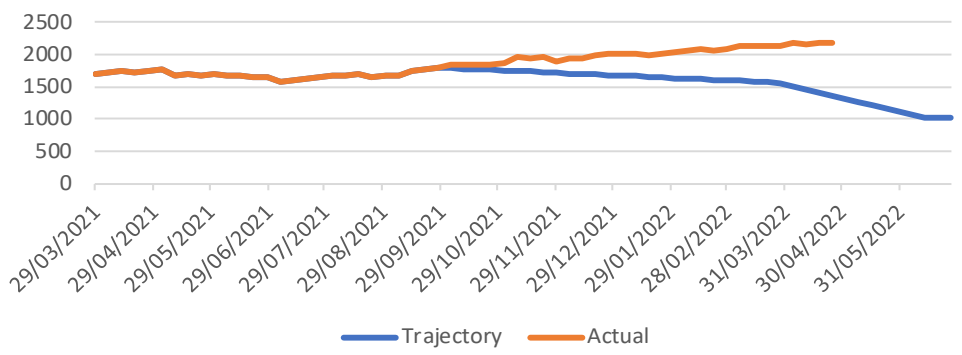



### P2 Surgery done in the week

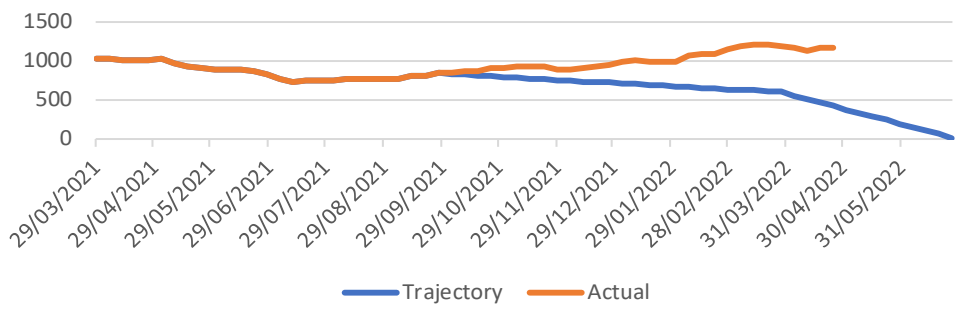


## INPATIENT WAITING LIST - P3

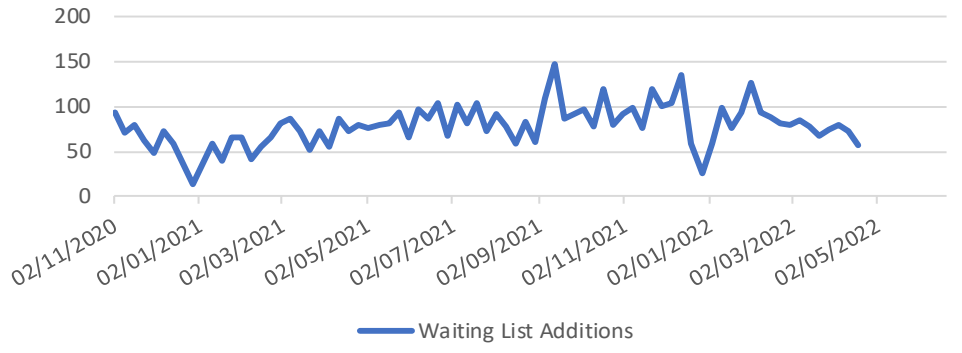
### Trajectory vs Actual - Total P3s on Waiting List



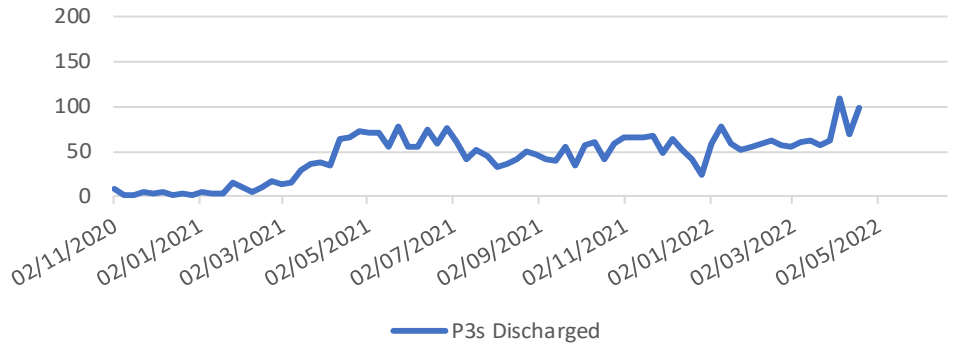

### Trajectory vs Actual - Total P3s on Waiting List Over 3 months



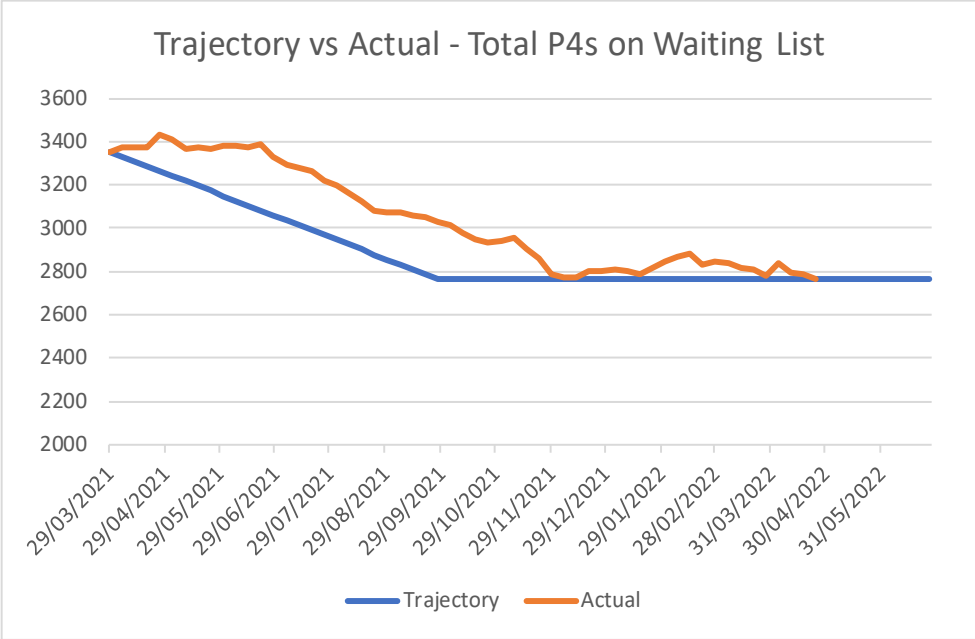

### P3 waiting List Additions

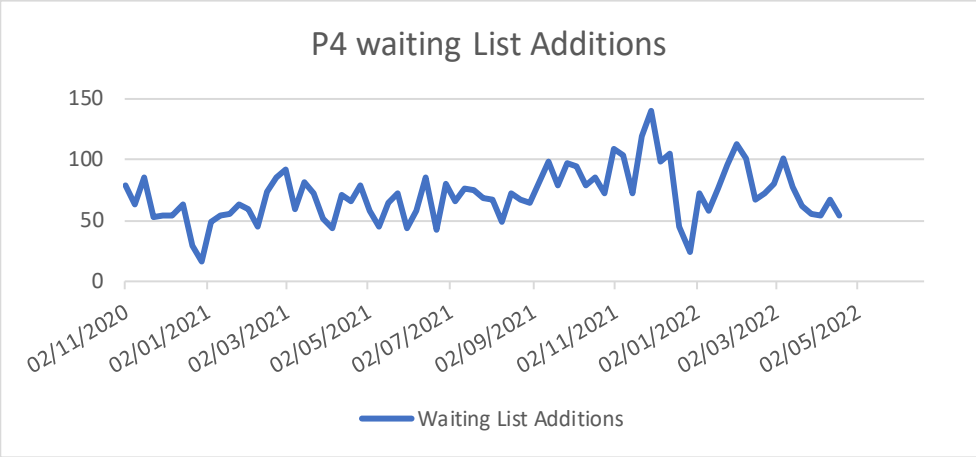


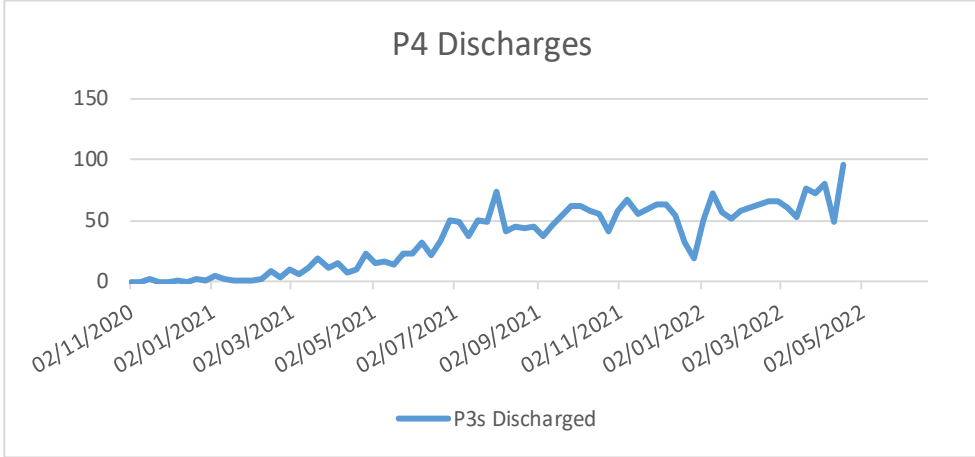

### P3 Discharges



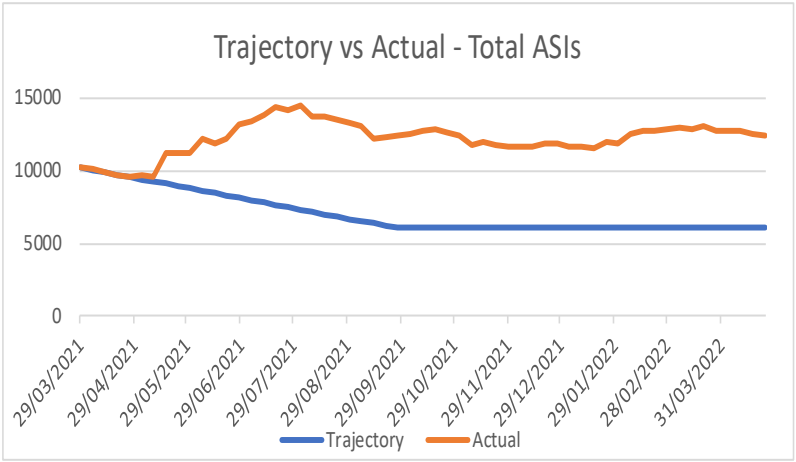
## INPATIENT WAITING LIST - P4

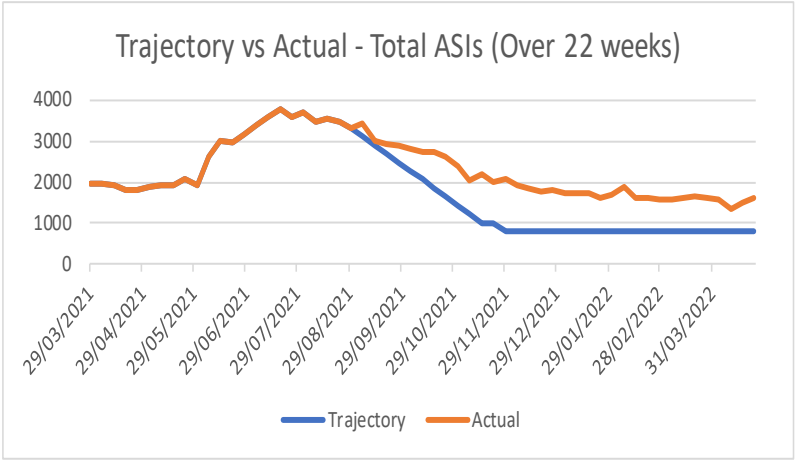


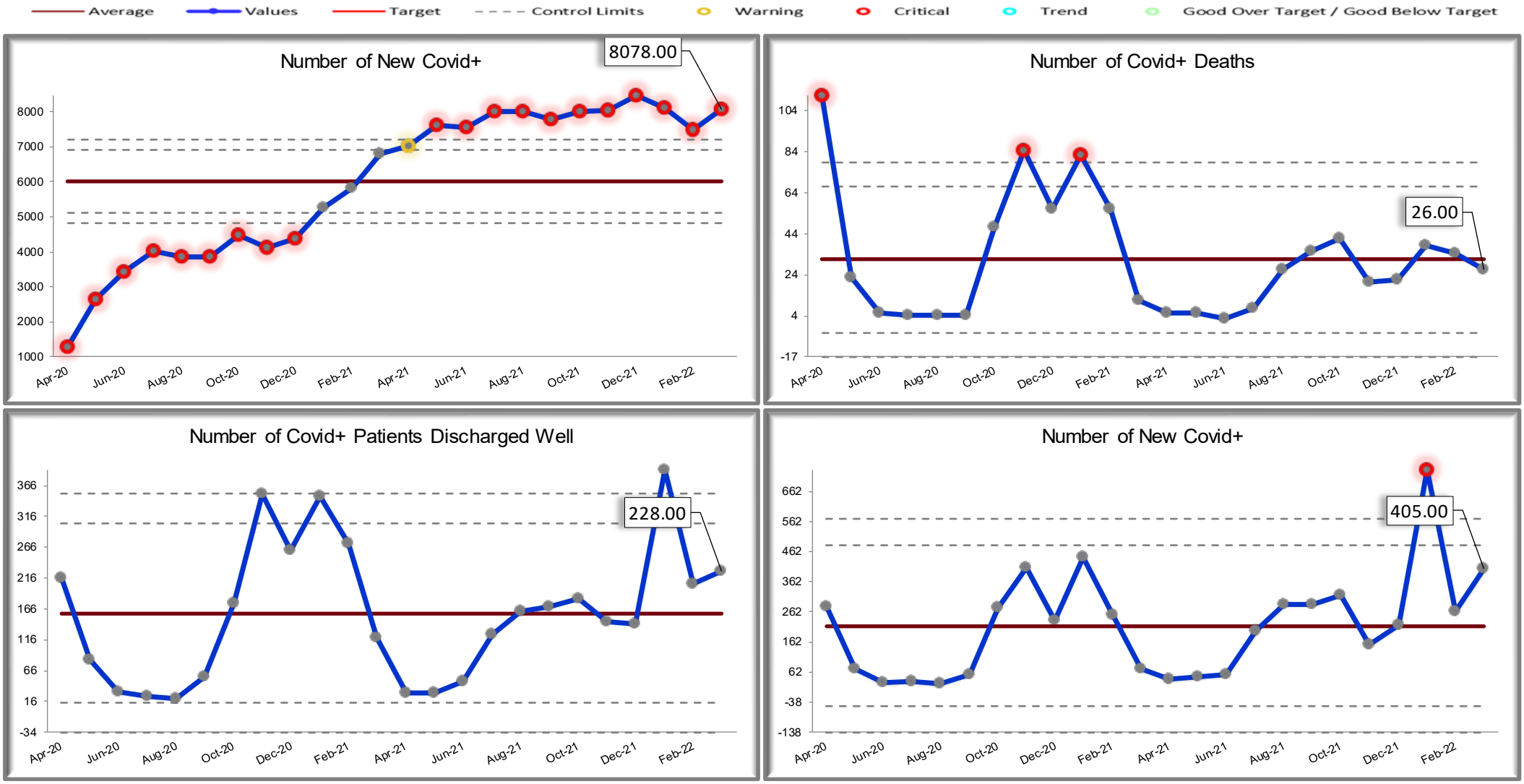



## ASIs


Trajectory vs Actual - Total ASIs
15000
10000
5000
0
29/03/2021
29/04/2021
29/05/2021
29/06/2021
29/07/2021
29/08/2021
29/09/2021
29/10/2021
29/11/2021
29/12/2021
29/01/2022
28/02/2022
31/03/2022
Trajectory
Actual

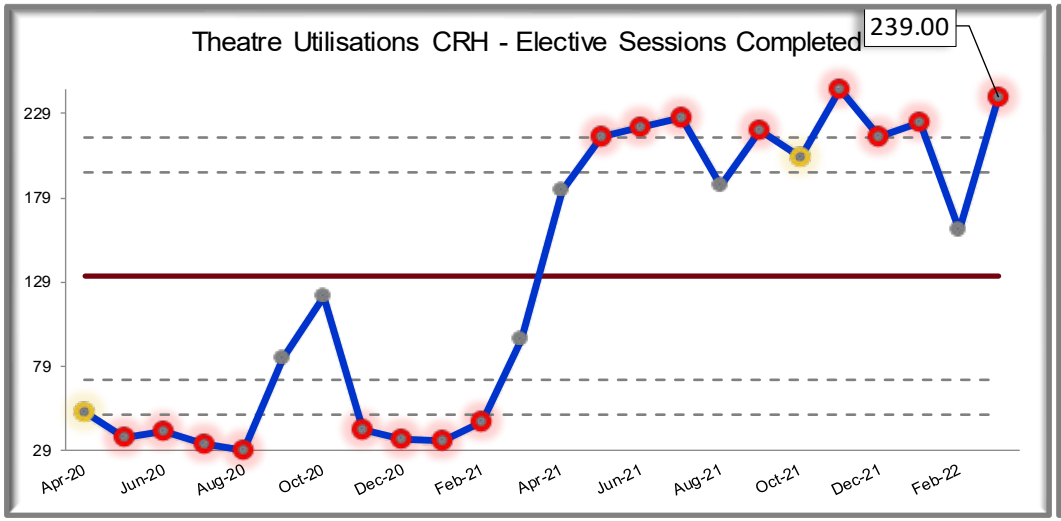

Trajectory vs Actual - Total ASIs (Over 22 weeks)
4000
3000
2000
1000
0
29/03/2021
29/04/2021
29/05/2021
29/06/2021
29/07/2021
29/08/2021
29/09/2021
29/10/2021
29/11/2021
29/12/2021
29/01/2022
28/02/2022
31/03/2022
Trajectory
Actual

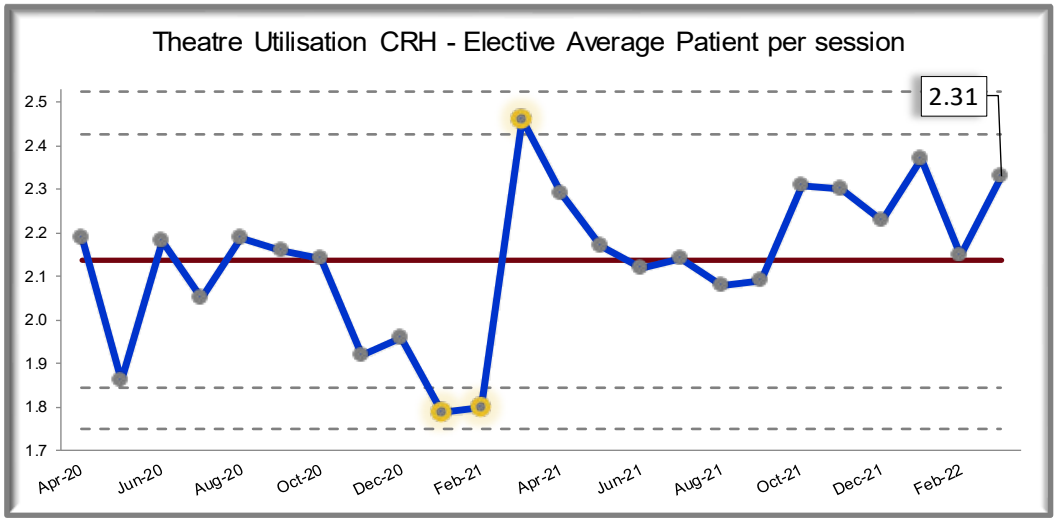
# Covid-19 - SPC Charts

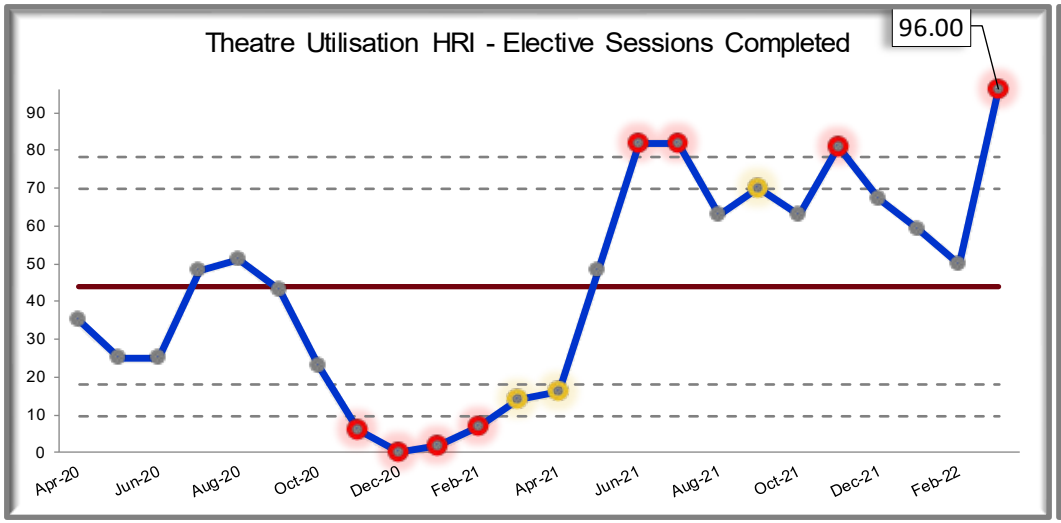


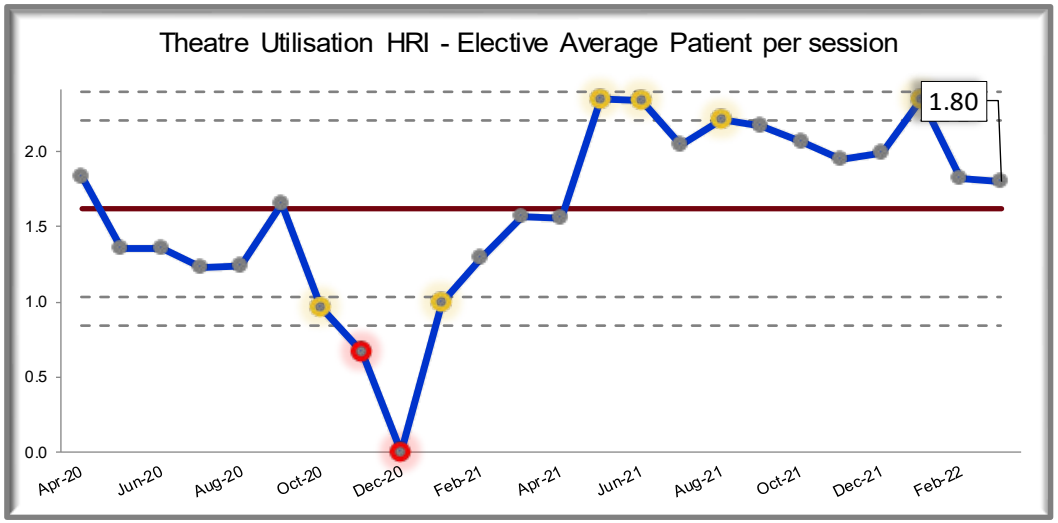
# Theatres - SPC Charts

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

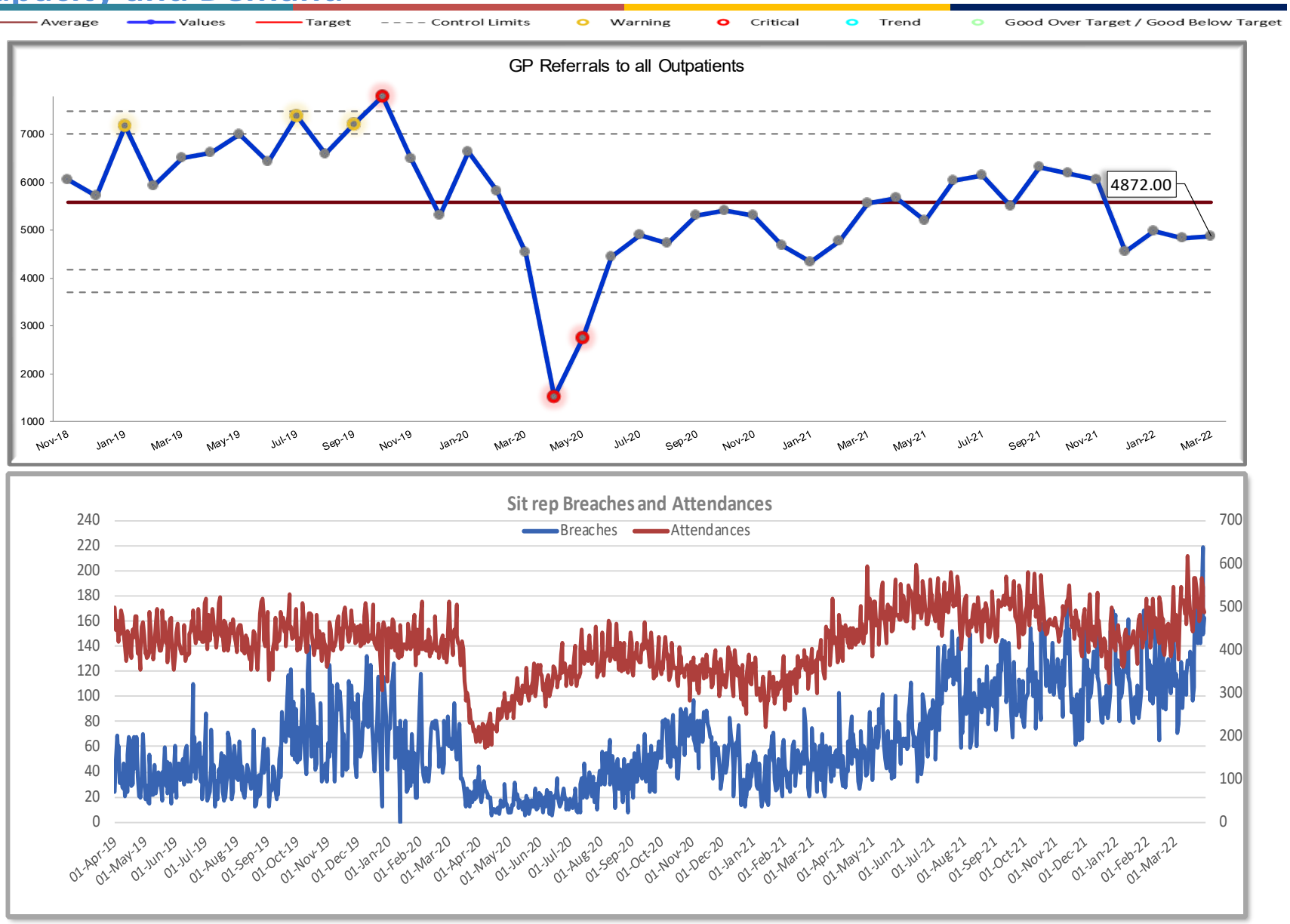


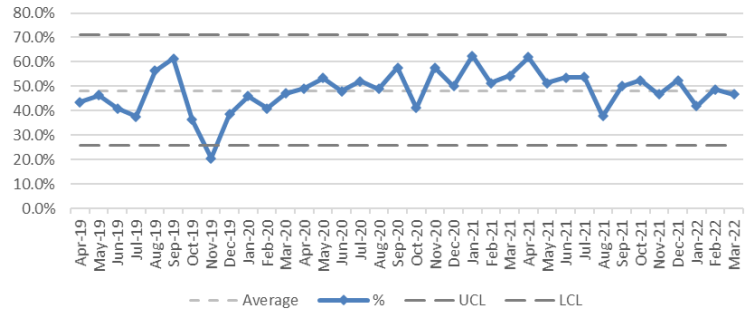
# Capacity and Demand



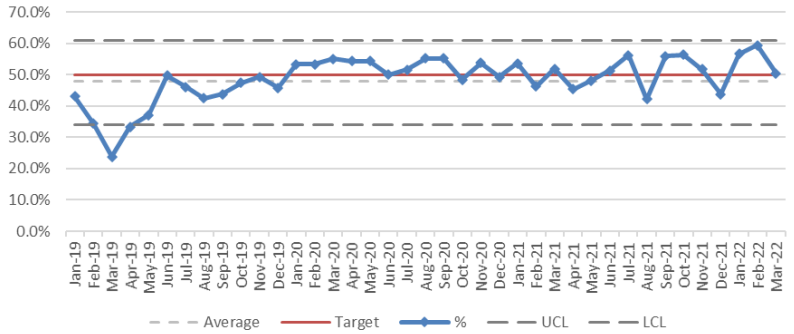
# Quality Priorities - Quality Account Priorities

**1. Recognition and timely treatment of Sepsis**

% of adult patients that triggered in ED for red flag Sepsis had antibiotics administered <1 hour of the trigger

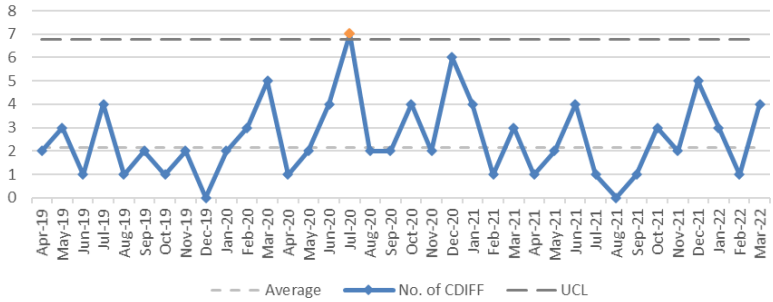



% of patients coded with Sepsis that received all elements of the BUFALO bundle (exc. lactate) - Trust

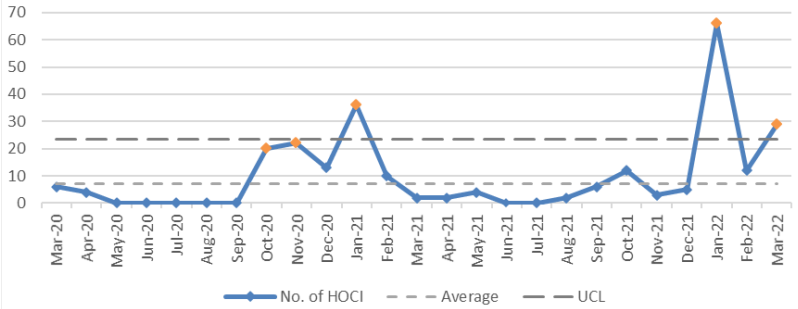



**2. Reduce number of Hospital Acquired Infections including Covid 19**

Number of C Diff Cases - Trust Assigned - Trust

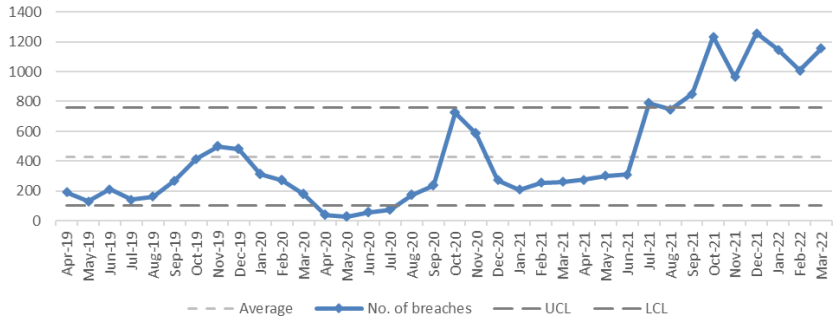



Number of Hospital Onset COVID Infections (HOCI) - Trust

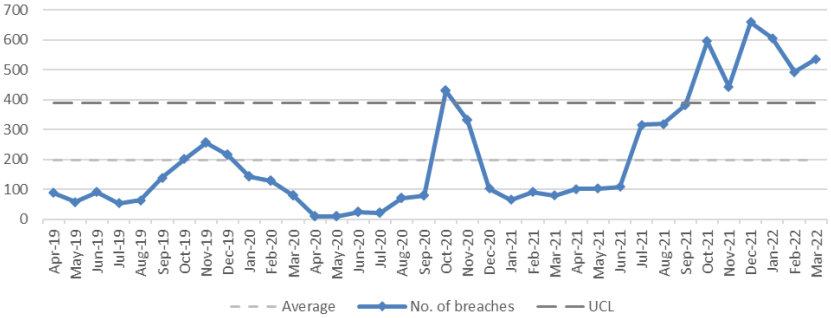



**3. Reduce waiting times for individuals attending the ED**

8 Hour A&E Breaches based on checkout time

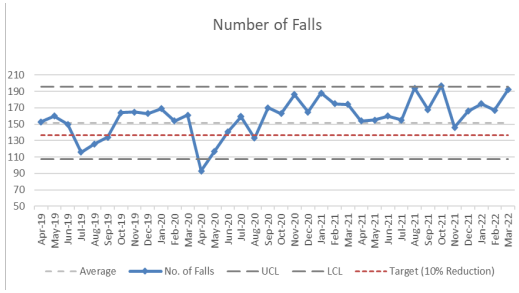



10 Hour A&E Breaches based on checkout time

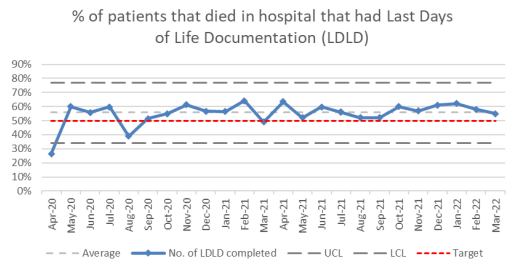


# Quality Priorities - Focussed Quality Priorities

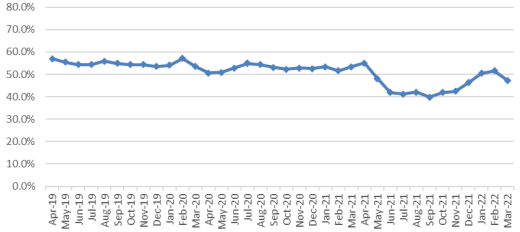
**1. Falls Resulting in Harm**



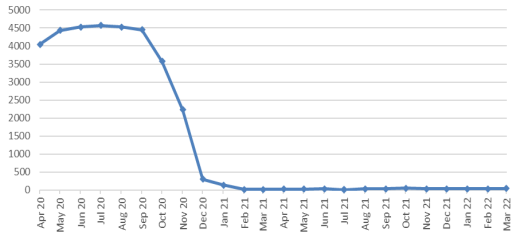

**2. End of Life Care**



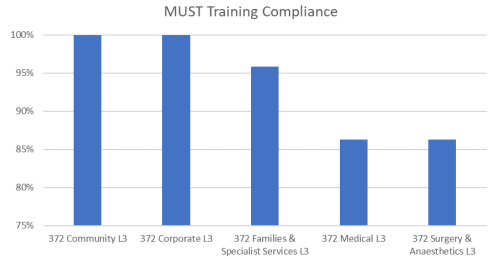

**3. Clinical Documentation**

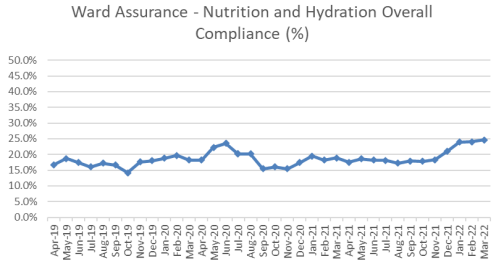



**4. Clinical Prioritisation (Deferred care pathways)**



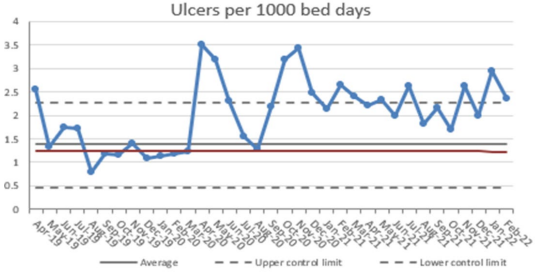

**5. Nutrition and Hydration**

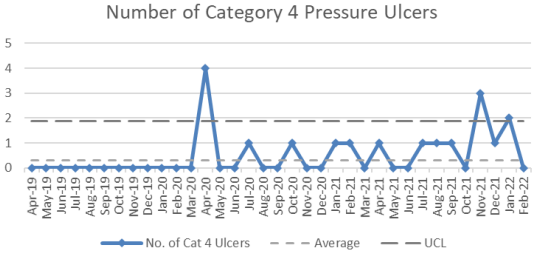



**6. Pressure Ulcers**

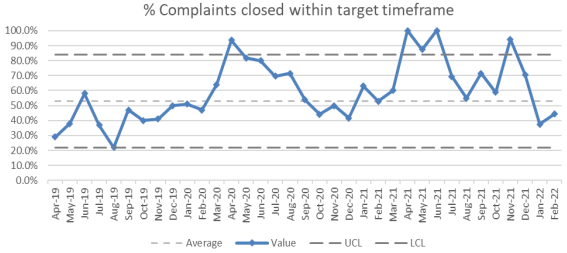
(Reported a month in areas)




**7. Making Complaints Count**

(Reported a month in areas)

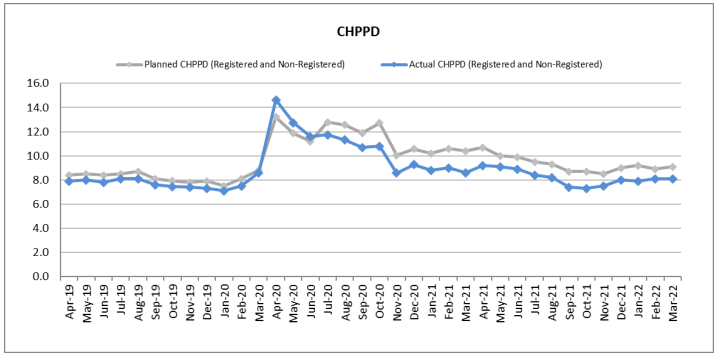


# Hard Truths: Safe Staffing Levels

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

| | Jan-22 | Feb-22 | Mar-22 |
|---|---|---|---|
| FILL RATES - DAY (REGISTERED & NON REGISTERED CLINICAL STAFF) | 85.6% | 89.5% | 88.1% |
| FILLRATES - NIGHT (REGISTERED & NON REGISTERED CLINICAL STAFF) | 91.0% | 99.1% | 95.5% |

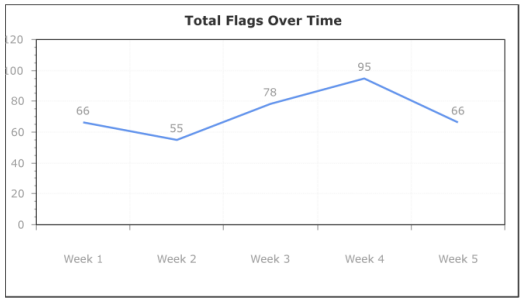
| | | | |
|---|---|---|---|
| PLANNED CHPPD (REGISTERED & NON REGISTERED CLINICAL STAFF) | 9.2 | 8.9 | 9.1 |
| ACTUAL CHPPD (REGISTERED & NON REGISTERED CLINICAL STAFF) | 7.9 | 8.1 | 8.1 |

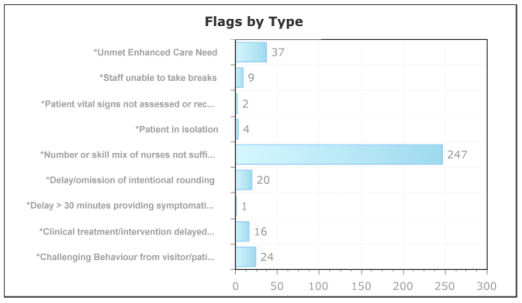


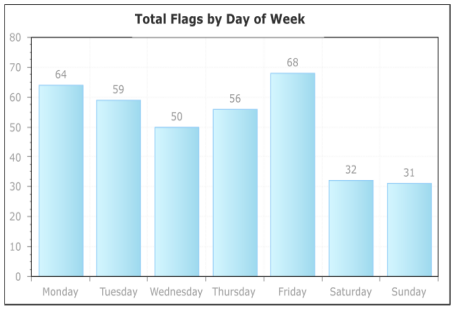

CHPPD provides a single, consistent and nationally comparable way of recording and reporting deployment of staff to provide care on inpatient wards. CHPPD is not a stand alone measure and should be used alongside clinical quality and safety outcome measures.

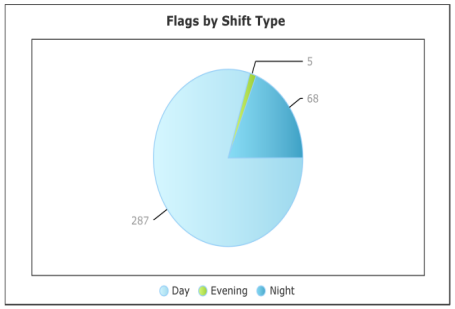
A review of March data indicates that the combined RN and non-registered clinical staff metrics resulted in 20 of the 27 clinical areas having fewer CHPPD than planned, with a total deficit of 1.0 CHPPD across the Trust (a slight deterioration on the previous month). The gap in CHPPD is at its broadest with the RN workforce representing 0.8 deficit. This deficit is managed through twice daily staffing meetings which are chaired by the Associate Directors of Nursing and supported by mitigations reported within the Safecare system and the use of professional judgement to redeploy staff on a shift basis and establish the safest staffing possible in all areas.

## 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 mitigation put in place as required.

# Hard Truths: Safe Staffing Levels (2)

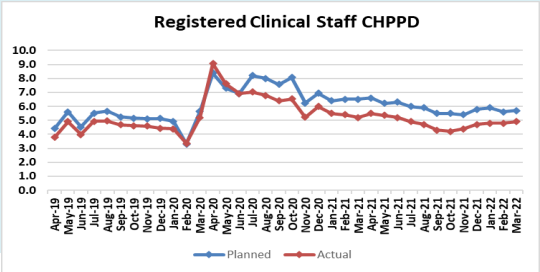
Aggregate Position | Trend | Result

## CHPPD BY STAFF TYPE

**Registered Clinical Staff**

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

CHPPD was 5.7 for planned and 4.9 For actual for Registered Clinical Staff

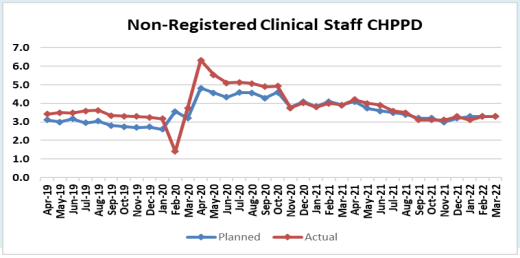



Overall there is a shortfall of 0.8 CHPPD against an overall requirement of 5.6 CHPPD for registered staff. Professional judgement informs decision-making at the twice daily staffing meetings to mitigate the risk across the clinical areas, and staff are redeployed to optimise safety. A suite of nurse 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. For those indicators reported the number of falls reported in March remains relatively unchanged to the incidence of falls reported in February where the gap in CHPPD was also 0.8.

**Non Registered Clinical Staff**

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

CHPPD was 3.3 for planned and 3.3 for actual for Non-Registered Clinical Staff




There is no shortfall in the CHPPD for non-registered clinical staff. This is reflective of an increasing demand for 1:1 care and a skill-mix response to mitigate the risk to meet the needs of patients due to the shortfall in Registered Clinical Staff CHPPD.

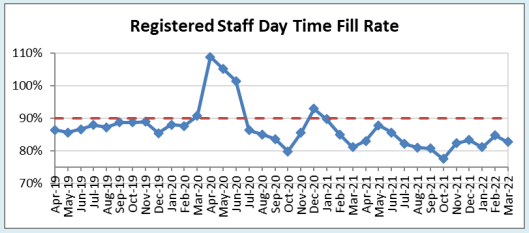
The fill-rate percentage of non-registered clinical staff (table below) remains above the 90% threshold which is responding to the ongoing demand in the requirement for 1:1 care needs and the need for additional staff due to the increased bed base capacity.

## 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.

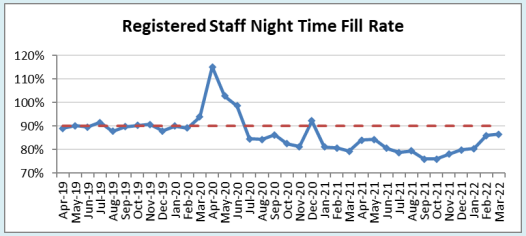
82.78% of expected Registered Clinical Staff hours were achieved for day shifts.




**Registered Staff Night**

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

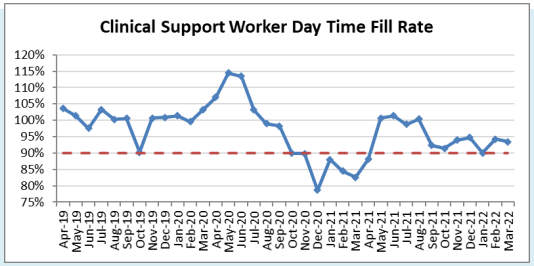
86.61% of expected Registered Clinical Staff hours were achieved for night shifts.




**Non Registered Clinical Staff Day**

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

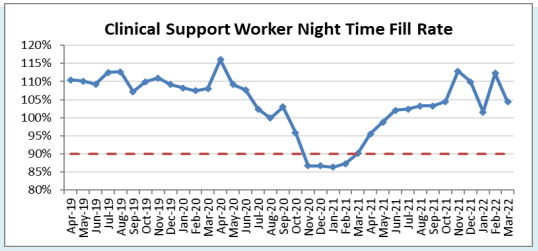
93.46% of expected Non-Registered Clinical Staff hours were achieved for Day shifts.




**Non-Registered Clinical Staff Night**

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

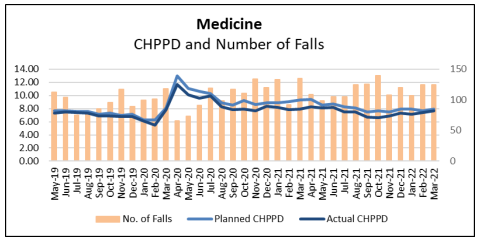
104.34% of expected Non-Registered Clinical Staff hours were achieved for night shifts.

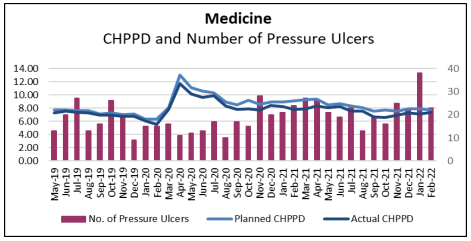


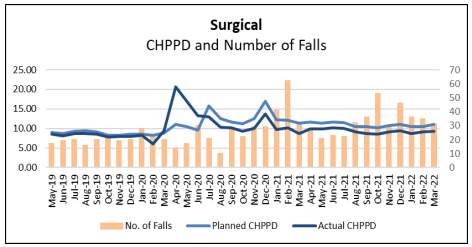
## Hard Truths: Safe Staffing Levels (3)

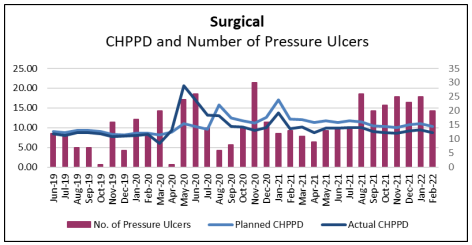
### NURSING QUALITY INDICATORS AND FILLRATES BY WARD AND DIVISION

| Ward | Average Fill Rates | | | | Care Hours Per Patient Day | | Nursing Quality Indicators | | | | | Safecare | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | DAY - Registered Clinical Staff (%) | DAY - Non Registered Clinical Staff (%) | NIGHT - Registered Clinical Staff (%) | NIGHT - Non Registered Clinical Staff (%) | Total PLANNED CHPPD | Total ACTUAL CHPPD | MRSA Bacteraemia (post cases) | Pressure Ulcer (Month in Areas) | Falls | Staffing Red Flags | Ward Assurance | Number of red shifts | Number of amber shifts |
| **Medicine** | **91.3%** | **97.1%** | **95.6%** | **109.3%** | **7.9** | **7.7** | **0** | **23** | **125** | **221** | **54%** | **612** | **80** |
| CRH ACUTE FLOOR | 121.8% | 109.5% | 125.1% | 110.4% | 8.5 | 10.0 | | 1 | 20 | 33 | 53.3% | 78 | 4 |
| HRI ACUTE FLOOR | 83.0% | 78.5% | 92.7% | 91.8% | 9.0 | 7.7 | | 3 | 16 | 21 | 52.6% | 80 | 7 |
| RESPIRATORY FLOOR | 73.4% | 71.7% | 82.8% | 90.0% | 9.3 | 7.3 | | 5 | 9 | 17 | 51.6% | 52 | 13 |
| WARD 5 | 79.1% | 90.9% | 103.4% | 109.1% | 6.8 | 6.4 | | 1 | 8 | 17 | 48.8% | 52 | 7 |
| WARD 6 | 78.1% | 67.4% | 100.1% | 109.8% | 4.2 | 3.5 | | 1 | 12 | 18 | 57.3% | 46 | 7 |
| WARD 6C | 96.6% | 106.6% | 102.4% | 128.4% | 12.7 | 13.7 | | 1 | 6 | 2 | 53.7% | 11 | |
| WARD 6AB | 96.6% | 106.6% | 102.4% | 128.4% | 5.9 | 6.4 | | 1 | 9 | 26 | 54.7% | 41 | 6 |
| WARD CCU | 73.7% | 78.0% | 88.8% | | 8.8 | 7.2 | | | 1 | 2 | 63.2% | 2 | |
| STROKE FLOOR | 157.7% | 132.0% | 98.7% | 116.2% | 7.4 | 9.5 | | 2 | 17 | 38 | 53.4% | 7 | 5 |
| WARD 12 | 91.5% | 69.8% | 108.6% | 102.0% | 8.8 | 7.9 | | 2 | 3 | 4 | 48.2% | 16 | 5 |
| WARD 15 | 74.8% | 129.8% | 82.7% | 129.7% | 7.3 | 7.5 | | 1 | 6 | 12 | 56.6% | 45 | 10 |
| WARD 17 | 66.4% | 95.8% | 79.5% | 102.7% | 7.1 | 5.7 | | 1 | 5 | 16 | 52.6% | 53 | 11 |
| WARD 18 | 74.5% | 127.9% | 81.8% | 145.9% | 8.8 | 8.8 | | | 6 | 6 | 59.9% | 57 | 1 |
| WARD 20 | 80.6% | 108.2% | 94.4% | 99.3% | 6.8 | 6.4 | | 4 | 2 | 9 | 55.1% | 72 | 4 |
| **Surgical** | **74.4%** | **91.3%** | **79.6%** | **103.6%** | **11.1** | **9.3** | | **18** | **31** | **33** | **48.0%** | **166** | **50** |
| WARD 21 | 80.3% | 95.5% | 94.6% | 115.7% | 8.2 | 7.8 | | 2 | 10 | | 53.6% | 15 | 5 |
| WARD 22 | 83.8% | 96.3% | 95.1% | 103.5% | 6.8 | 6.3 | | | 5 | 1 | 46.2% | 47 | 10 |
| ICU | 62.7% | 60.7% | 66.2% | 54.4% | 61.5 | 38.8 | | 4 | | | 60.9% | | |
| WARD 8AD | 54.5% | 49.7% | 50.1% | 100.0% | 20.5 | 11.2 | | 1 | 1 | | 53.9% | 9 | 2 |
| WARD 8B | 99.9% | 80.0% | 100.1% | 93.7% | 9.3 | 8.7 | | | 2 | | 57.8% | 8 | 6 |
| WARD 10 | 74.0% | 100.0% | 77.9% | 83.8% | 9.9 | 8.1 | | | 1 | 1 | 64.2% | 31 | 5 |
| WARD 11 | 77.9% | 134.5% | 99.9% | 128.9% | 7.9 | 8.4 | | | 1 | 20 | 39.9% | 14 | 1 |
| WARD 19 | 80.5% | 100.0% | 101.2% | 113.6% | 7.6 | 7.4 | | 5 | 8 | 1 | 58.1% | 12 | 5 |
| SAU HRI | 92.1% | 104.9% | 83.8% | 131.8% | 8.4 | 8.1 | | 6 | 3 | 10 | 45.0% | 30 | 16 |
| **FSS** | **78.2%** | **77.8%** | **79.0%** | **83.0%** | **11.2** | **8.9** | **0** | **0** | **0** | **11** | **15.8%** | **25** | **13** |
| WARD LDRP | 74.4% | 71.0% | 70.8% | 73.8% | 26.3 | 19.1 | | | | 10 | 15.8% | | |
| WARD NICU | 80.1% | 75.6% | 86.8% | 74.2% | 11.5 | 9.4 | | | | | 14.1% | | |
| WARD 3ABCD | 75.7% | 77.4% | 76.6% | 88.6% | 12.0 | 9.3 | | | | 1 | 18.7% | | |
| WARD 4ABC | 86.1% | 88.1% | 92.7% | 91.9% | 5.3 | 4.8 | | | | | 14.6% | 25 | 13 |
| **TRUST** | **82.78%** | **93.46%** | **86.61%** | **104.34%** | **9.1** | **8.1** | | | | | | | |



# Hard Truths: Safe Staffing Levels (4)

## Conclusions and Recommendations

-

**Conclusions**

The Trust remains committed to achieving safe staffing levels in all clinical areas. Where shortfalls have been identified clear governance processes have been established to respond to both the on-day challenges alongside more medium to long-term recruitment and retention strategies.

1.The use of the Enhanced Metrics Dashboard is embedded in the weekly senior safer staffing review meeting. Areas with less than 85% shift fill rate are scrutinised with a suite of nurse sensitive indicators. Matrons from affected clinical areas present their analysis of indicators at the Nursing and Midwifery Safer Staffing forum where recommendation and actions are agreed to respond to the current position.

2. The Nursing and Midwifery Workforce Steering Group agenda has been re-established to focus upon medium to long-term strategies to support the Nursing, Midwifery and AHP workforce requirements. This includes an ongoing review of the current Nursing and Midwifery vacancy position and workforce plans reviewing directorate specific pressures to inform recruitment strategies.

4. Work continues to maximise the use of HealthRoster and the confirm and challenge process, to ensure a reduction of planned variability of shift fill across weekdays and weekends, as well as ensuring Annual Leave and Study leave is planned within agreed headrooms.

5. A piece of work has just been completed and has been rolled out to key Nursing and Midwifery forums to support the principles of effective rostering and annual leave management.

6. Work at CHFT is in progress to meet our ambitious target of 80 international recruits during 2022, we continue to adopt a varied approach to securing applicants, including the use of agencies and an international nurse specific job advert in which nurses can apply direct to Trust via our recruitment system. There is an interview schedule across the year to support this strategy with arrivals expected from May through to December 2022.

23. Governance Report

a) Compliance with License Conditions

b) Delegation for Quality Account Approval

c) Update on Non-Executive Director Appointments

d) Board of Directors Attendance Register – for the Annual Report and Accounts 2021/22

e) Board of Directors 2022-2023 Workplan

To Approve

Presented by Andrea McCourt

NHS
Calderdale and Huddersfield
NHS Foundation Trust

| | |
|---|---|
| **Date of Meeting:** | Thursday 5 May 2022 |
| **Meeting:** | Public Board of Directors |
| **Title of report:** | Governance Report |
| **Author:** | Andrea McCourt, Company Secretary |
| **Sponsor:** | Brendan Brown, Chief Executive |
| **Previous Forums:** | None |

**Purpose of the Report**

This paper presents the following governance items to the Board:

a) Compliance with the Trust's provider licence conditions
b) Request for delegation of 2021/22 Quality Accounts approval to the Quality Committee
c) Update on Non-Executive Director Appointments
d) Board of Director Attendance Register 2021/22
e) Board of Directors 2022-2023 Workplan

**Key Points to Note**

**a) Self-certification of Compliance with Licence Conditions**

Each year NHS England / Improvement (NHS E/I) requires all Foundation Trusts to complete a number of self-certifications to provide assurance that the Trust is compliant with the conditions of their NHS provider licence or provide explanatory text where this is not the case.

The purpose of this paper is to seek Board approval of the enclosed self–certification schedules for 2021/22 at Appendix P2 and P3. Self -certification relates to the following three conditions:

- *Compliance with governance requirements* - condition FT4 (8) relates to compliance with systems and processes for good governance and forward compliance with the governance condition for the 2022/23 financial year and any risks. Compliance is confirmed in Appendix Q2.

- *Compliance with provider licence* - the Trust is confirming compliance with condition G6 (3) which relates to effective systems to ensure compliance with the conditions of the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009, the Health and Social Care Act 2012 and have regard to the NHS Constitution) - this is detailed at Appendix Q3.

- *Available resources if providing commissioner requested services* - condition S7 (CoS7 (3)) relates to continuity of service and having the required resources available for the next 12 months. The Trust is confirming that it has a reasonable expectation that resources will be available for 2022/23 subject to the factors detailed in the return which is enclosed at Appendix Q3. This is because the Trust remains in breach of its licence, for the availability of resources certification (CoS7) the Trust is declaring that it has a reasonable expectation to have the required resources available (declaration 3b) and the factors relating to this are stated in the return. This is consistent with the response that the Trust has given over the previous financial years whilst in breach of the licence.

The self-certification documents confirms Trust compliance with governance (FT4) and the provider licence condition G6 (3).

| Condition | Description | Internal Assurance Process |
|---|---|---|
| FT4 (8) | Compliance with systems and processes for good governance and forward compliance with the governance condition for the 2020/21 financial year and any risks. | Confirmed - compliance is confirmed in the attached Appendix Q2.<br><br>Evidence of compliance with Code of Governance reviewed at Audit and Risk Committee 21 April 2022.<br><br>Governor training confirmed by lead governor on behalf of the Council of Governors |
| G6 (3) | Trust compliance with its NHS provider licence, NHS acts and NHS constitution. | Confirmed - see Appendix Q3 |
| G6 (4) Publication | Publication of condition G6(3) self certification | To be added to Trust website by 30 June 2022 |
| Condition CoS7(3) | Continuity of Service and having the required resources available for the next 12 months for providing commissioner requested services | Narrative based on 2022/23 position and ongoing oversight of financial position by Finance and Performance Committee (see Q3) |

**RECOMMENDATION:** The Board is asked to **APPROVE** the content of the self-certification documents for the signature of declarations.

**b) Request for Delegation of authority to the Quality Committee for sign off of Quality Account 2021/22**

The Department of Health and Social Care (DHSC) has confirmed that the deadline to publish 2020/21 Quality Accounts is 30 June 2022. The process is the same as for 2020/21 Quality Accounts, in that the Quality Account is no longer part of the Trust's Annual Report, with a requirement for Trusts to publish a separate Quality Account for 2021/22. There is also no requirement for external auditor assurance on the Quality Account.

The Trust does not have a Board meeting to approve the Quality Accounts within this timeframe, with the Trust Board meeting on 5 May 2022 being too early given the need for consultation with stakeholders and the 7 July 2022 Board meeting too late. The Quality Committee has a meeting scheduled for 20 June 2022 where it would review the Quality Accounts with a view to approving these to enable approval and submission within the deadline date and publication of the Quality Accounts on the Trust website by 30 June 2022.

It is recommended that the Trust Board agree delegation of authority to the Quality Committee for the approval of the 2021/22 Quality Accounts.

**RECOMMENDATION:** The Board is asked to **APPROVE** the delegation of authority to the Quality Committee to approve on behalf of the Board, at its meeting of 20 June 2022, the 2021/22 Quality Account.

**c) Update on Non-Executive Director Appointments**

Following a recruitment process and ratification by the Council of Governors the following two Non-Executive Director appointments have been made:

- Tim Busby, who will also chair the Board of Calderdale and Huddersfield Solutions Limited
- Nigel Broadbent, who has financial experience and qualifications

Start dates have been agreed and induction planning is underway to enable handover from current Non-Executive Directors prior to the end of their appointments. Tim Busby formally takes up his appointment from 1 June 2022 and Nigel Broadbent from 1 September 2022, following completion of the induction and handover periods for these roles.

Thanks to Alastair Graham who will stand down as Non-Executive Director at the end of May 2022 for his contribution since he joined the Trust as a Non-Executive Director on 1 October 2017.

**RECOMMENDATION:** The Board is asked to **NOTE** the appointments of Tim Busby and Nigel Broadbent as Non-Executive Directors.

**d) Board of Directors Attendance Register for the Annual Report and Accounts 2021/22**

The attendance of Directors at Board of Directors meetings during 2021/22 is detailed within the annual report for 2021/22.

The Board of Directors attendance is attached at Appendix P4. Any changes to this should be notified to the Company Secretary.

**RECOMMENDATION:** The Board is asked to **APPROVE** the Board of Directors Attendance Register for 2021/22.

**e) Board of Directors 2022-2023 Workplan**

The Board workplan provides the basis for the preparation of Board agendas for the coming year. Ad-hoc items and reports will be included on meeting agendas as necessary. The 2022/23 workplan at Appendix P5 is presented for approval.

**RECOMMENDATION:** The Board is asked to **APPROVE** the Board of Directors workplan for 2022-2023.

**EQIA – Equality Impact Assessment**

The content of this report does not adversely affect people with protected characteristics.

**Recommendation**

The Board is asked to **APPROVE** the:

- the content of the self-certification documents for the signature of declarations for 2021/22
- Delegation to the Quality Committee for the approval of the 2021/22 Quality Accounts
- Board of Directors Attendance Register for 2021/22
- Board of Directors Workplan for 2022-2023

The Board is asked to **NOTE** the appointments of Tim Busby and Nigel Broadbent as Non-Executive Directors.

**APPENDIX P2 - SELF-CERTIFICATION TEMPLATE**

This template may be used by Foundation trusts and NHS trusts to record the self-certifications that must be made under their NHS Provider Licence.
You do not need to return your completed template to NHS Improvement unless it is requested for audit purposes.

**Self-Certification Template - Condition FT4**

**Calderdale and Huddersfield NHS Foundation Trust**

*Insert name of organisation*

Foundation Trusts and NHS trusts are required to make the following self-certifications to NHS Improvement:

*Corporate Governance Statement - in accordance with Foundation Trust condition 4 (Foundations Trusts and NHS trusts)*

*Certification on training of Governors - in accordance with s151(5) of the Health and Social Care Act (Foundation Trusts only)*

These self-certifications are set out in this template.

**How to use this template**

1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

**APPENDIX P2 - SELF-CERTIFICATION TEMPLATE**

**Worksheet "FT4 declaration"**

**Financial Year to which self-certification relates** | **2021/2022** | Please Respond

## Corporate Governance Statement (FTs and NHS trusts)

Calderdale and Huddersfield NHS Foundation Trust

*The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one*

| | Corporate Governance Statement | Response | Risks and Mitigating actions |
|---|---|---|---|
| 1 | The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS. | Confirmed | The Trust monitors and reviews its systems and processes to ensure they comply with good governance, having received a CQC good rating at a well-led inspection in April 2018, with a "requires improvement" rating for use of resources. The Trust has completed an externally commissioned a well-led development governance review. |
| 2 | The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time | Confirmed | The Trust pays due regard to guidance when issued by NHS England / NHS Improvement and liaises through national and regional networks.<br><br>NHS England / NHS Improvement guidance is also noted through the Trust's external audit technical updated reported each quarter to the Audit and Risk Committee with a similar report shared via internal auditors. Compliance with the Code of Governance is reviewed annually by the Audit and Risk Committee. |
| 3 | The Board is satisfied that the Licensee has established and implements:<br>(a) Effective board and committee structures;<br>(b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and<br>(c) Clear reporting lines and accountabilities throughout its organisation. | Confirmed | The Trust has a robust Board and Board Committee governance structure which is reviewed annually and depicted within the Risk Management Strategy and Policy, approved by the Board in March 2022.<br><br>Each committee has a terms of reference reviewed annually, assesses it's effectiveness on an annual basis and develops an action plan. |
| 4 | The Board is satisfied that the Licensee has established and effectively implements systems and/or | Confirmed | Board Committees give assurance to the Board that the Trust is operating effectively. These include Board Committees |

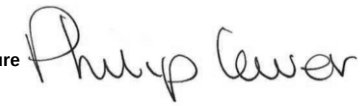
**APPENDIX P2 - SELF-CERTIFICATION TEMPLATE**

| | | | |
|---|---|---|---|
| 5 | The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure:<br><br>(a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;<br>(b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;<br>(c) The collection of accurate, comprehensive, timely and up to date information on quality of care;<br>(d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;<br>(e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and<br>(f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate. | **Confirmed** | There is an effective objective setting and performance review process in place for Board members and a Board skills competency assessment is completed periodically. A fit and proper person declarations register is maintained and reported to the Board.<br><br>. Quality account priorities (agreed with governors) and quality focused priorities have been agreed and reported, along with other quality metrics, to the Quality Committee and Board, with a detailed quality report presented to each Board meeting. The Trust has a Quality Strategy in place and engages in a wide range of quality improvement collaboratives to improve patient care.There is a robust quality impact assessment process in place for service changes. |
| 6 | The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence. | **Confirmed** | The Trust has in place a fomal appointment process to the Board overseen by a Nominations and Remuneration Committee which ensures that appropriately qualified Board members are recruited and appointed, with appraisal processes in place to review existing Board members. These processes were used during the year to make appointments to the Board of Directors.<br>A fit and proper person declarations register is maintained and reported to the Board. |

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, h Calderdale and Huddersfield NHS Foundation Trust

**Signature** 

**Name** Brendan Brown, Chief Executive

**Signature** 

**Name** Philip Lewer, Chair

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A N/A

OK

# APPENDIX P2 - SELF-CERTIFICATION TEMPLATE

**Worksheet "Training of governors"** | **Financial Year to which self-certification relates** | **2020/21** | Please Respond

## Certification on training of governors (FTs only)

Calderdale and Huddersfield NHS Foundation Trust

*The Board are required to respond "Confirmed" or "Not confirmed" to the following statements. Explanatory information should be provided where requ*

**Training of Governors**

| | | | |
|---|---|---|---|
| 1 | The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role. | **Confirmed** | OK |

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

| **Signature** | | **Signature** | |
|---|---|---|---|
| **Name** | Brendan Brown | **Name** | Philip Lewer |
| **Capacity** | Chief Executive | **Capacity** | Chair |
| **Date** | 05 May 2022 | **Date** | 05 May 2022 |

Further explanatory information should be provided below where the Board has been unable to confirm declarations under s151(5) of the Health and Social Care Act

A N/A

**APPENDIX N3 - SELF-CERTIFICATION TEMPLATE - CONDITIONS G6 AND CoS7**

This template may be used by NHS foundation trusts and NHS trusts to record the self-certifications that must be made under their NHS provider licence.
You do not need to return your completed template to NHS Improvement unless it is requested for audit purposes.

# Self-Certification Template - Conditions G6 and CoS7

## Calderdale and Huddersfield NHS Foundation Trust

Foundation Trusts and NHS trusts are required to make the following self-certifications to NHS Improvement:

*Systems or compliance with licence conditions - in accordance with General condition 6 of the NHS provider licenc*
*Availability of resources and accompanying statement - in accordance with Continuity of Services condition 7 of the*

These self-certifications are set out in this template.

**How to use this template**

1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

## Worksheet "G6 & CoS7"

# Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

*The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.*

**1 & 2 General condition 6 - Systems for compliance with license conditions (FTs and NHS trusts)**

| | | |
|---|---|---|
| 1 | Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution. | Confirmed |

**3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)**

**EITHER:**

| | | |
|---|---|---|
| 3a | After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. | |

**OR**

| | | |
|---|---|---|
| 3b | After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services. | Confirmed |

**OR**

| | | |
|---|---|---|
| 3c | In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate. | |

**Statement of main factors taken into account in making the above declaration**

remove watermark

Given the underlying deficit position and the planned deficit for 2022/23, the Trust has given this due consideration and notes the following:

Fixed block funding for the Trust's services will be received from commissioners in this period, incorporating additional Covid funding and embedding historic levels of Financial Recovery Funding (FRF). The Trust will work with partners across the Integrated Care System to manage elective recovery plans and access associated funding.

The Trust has sufficient cash holdings at the outset of 2022/23 to support the cash flow forecast to manage the deficit plan without recourse to in-year borrowing.

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

| | | | |
|---|---|---|---|
| **Signature** | | **Signature** | |
| **Name** | Philip Lewer | **Name** | Brendan Brown |
| **Capacity** | Chair | **Capacity** | Chief Executive |
| **Date** | 05 May 2022 | **Date** | 05 May 2022 |

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

A

**Appendix P4**

## Attendance at Board of Directors meetings

The attendance of members of the Board during 2021/2022 is given below:

| Name | Role | Date Commenced in CHFT | Board of Director Meetings Attended |
|---|---|---|---|
| **EXECUTIVE DIRECTORS** | | | |
| **Professor Brendan Brown** | Chief Executive | 04.01.2022 | 2/2 |
| **Dr Owen Williams** | Chief Executive | 14.05.2012 | 5/5 |
| **Jo Fawcus** | Chief Operating Officer | 08.11.2021 | 2/2 |
| **Helen Barker** | Chief Operating Officer | 01.01.2016 | 5/5 |
| **David Birkenhead** | Executive Medical Director | 01.12.1999 | 7/7 |
| **Gary Boothby** | Executive Director of Finance | 07.03.2016 | 6/7 |
| **Ellen Armistead** | Executive Director of Nursing / Deputy Chief Executive | 01.07.2019 | 7/7 |
| **Suzanne Dunkley** | Executive Director of Workforce and Organisational Development | 01.02.2018 | 7/7 |
| **NON-VOTING DIRECTORS** | | | |
| **Jim Rea** | Managing Director – Digital Health | 02.08.2021 | 3/3 |
| **Mandy Griffin** | Managing Director – Digital Health | 19.01.2009 | 3/4 |
| **Anna Basford** | Director of Transformation and Partnerships | 15.07.2013 | 5/7 |
| **Stuart Sugarman** | Managing Director – Calderdale and Huddersfield Solutions Limited | 30.09.2019 | 7/7 |
| **NON-EXECUTIVE DIRECTORS** | | | |
| **Philip Lewer** | Chair | 01.04.2018 | 7/7 |
| **Richard Hopkin** | Non-Executive Director / Senior Independent Non-Executive Director * | 01.03.2016 | 6/7 |

| | | | |
|---|---|---|---|
| **Andy Nelson** | Non-Executive Director / Chair of Audit and Risk Committee | 01.10.2017 | 6/7 |
| **Alastair Graham** | Non-Executive Director / Chair of Calderdale and Huddersfield Solutions Limited | 01.12.2017 | 6/7 |
| **Karen Heaton** | Non-Executive Director / Chair of Workforce Committee | 01.03.2016 | 6/7 |
| **Denise Sterling** | Non-Executive Director / Chair of Quality Committee | 01.10.2019 | 5/7 |
| **Peter Wilkinson** | Non-Executive Director / Chair of Transformation Project Board | 01.10.2019 | 7/7 |

**ATTENDANCE REGISTER – PUBLIC BOARD OF DIRECTORS**
**1 APRIL 2021 – 31 MARCH 2022**

| Attendance | ✓ | Apologies | × | Not in post | |
|---|---|---|---|---|---|

| DIRECTOR | 6.5.21 | 1.7.21 | 2.9.21 | AGM 28.07.21 | 4.11.21 | 13.1.22 | 3.3.22 | TOTAL |
|---|---|---|---|---|---|---|---|---|
| Philip Lewer (Chair) | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 7/7 |
| Alastair Graham | ✓ | ✓ | ✓ | × | ✓ | ✓ | ✓ | 6/7 |
| Andy Nelson | ✓ | ✓ | × | ✓ | ✓ | ✓ | ✓ | 6/7 |
| David Birkenhead | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 7/7 |
| Denise Sterling | ✓ | ✓ | ✓ | ✓ | × | × | ✓ | 5/7 |
| Ellen Armistead | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 7/7 |
| Gary Boothby | ✓ | ✓ | × | ✓ | ✓ | ✓ | ✓ | 6/7 |
| Helen Barker | ✓ | ✓ | ✓ | ✓ | ✓ | | | 5/5 |
| Jo Fawcus | | | | | | ✓ | ✓ | 2/2 |
| Karen Heaton | ✓ | ✓ | ✓ | × | ✓ | ✓ | ✓ | 6/7 |
| Owen Williams | ✓ | ✓ | ✓ | ✓ | ✓ | | | 5/5 |
| Brendan Brown | | | | | | ✓ | ✓ | 2/2 |
| Peter Wilkinson | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 7/7 |
| Richard Hopkin | ✓ | ✓ | ✓ | ✓ | × | ✓ | ✓ | 6/7 |
| Suzanne Dunkley | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 7/7 |
| Anna Basford | ✓ | ✓ | ✓ | × | ✓ | ✓ | × | 5/7 |
| Mandy Griffin | ✓ | ✓ | ✓ | × | | | | 3/4 |
| Jim Rea | | | | | ✓ | ✓ | ✓ | 3/3 |
| Stuart Sugarman | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 7/7 |

# PUBLIC BOARD WORKPLAN 2022-2023

| DATE OF MEETING | 5 May 2022 | 7 July 2022 | 1 Sep 2022 | 3 Nov 2022 | 12 Jan 2023 | 2 Mar 2023 |
|---|---|---|---|---|---|---|
| Date of agenda setting/Feedback to Execs | 4 April 2022 | TBC | TBC | TBC | TBC | TBC |
| Date final reports required | 22 April 2022 | 24 June 2022 | 19 August 2022 | 21 October 2022 | 30 December 2022 | 17 February 2023 |
| **STANDING AGENDA ITEMS** | | | | | | |
| Introduction and apologies | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Declarations of interest | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Minutes of previous meeting, matters arising and action log | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Patient/Staff Story | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Chair's report | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Chief Executive's report | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Integrated Performance report (Inc: Quality, Finance, Workforce) | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Recovery Update | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| **Financial Update** | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| **Health Inequalities** | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Quality Committee Chair's Highlight Report & Minutes | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Audit and Risk Committee Chair's Highlight Report & Minutes | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Finance and Performance Committee Chair's Highlight Report & Minutes | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Workforce Committee Chair's Highlight Report & Minutes | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Charitable Funds Committee Minutes | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Council of Governors Meeting Minutes | ✓ | ✓ | ✓ | | ✓ | |
| **STRATEGY AND PLANNING** | | | | | | |
| Strategic Objectives – 1 year plan / 10 year strategy | | ✓ *- 2021-2023 Strategic Objectives Progress Report* | | ✓ | | ✓ |
| Digital Health Strategy | | ✓ | | | | |

| DATE OF MEETING | 5 May 2022 | 7 July 2022 | 1 Sep 2022 | 3 Nov 2022 | 12 Jan 2023 | 2 Mar 2023 |
|---|---|---|---|---|---|---|
| Workforce OD Strategy | ✓ | | | | | |
| Risk Management Strategy | | | | | | ✓ |
| Annual Plan | ✓ | ✓ | | | | ✓ |
| Capital Plan | | | | | ✓ | |
| Winter Plan | | | ✓ | | | |
| Green Plan (Climate Change) | ✓ | | | | | |
| **QUALITY** | | | | | | |
| Quality Board update | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Director of Infection Prevention Control (DIPC) quarterly report | ✓Q4 | | ✓Q1 | ✓Q2 | ✓Q3 | |
| DIPC Annual Report | | ✓ | | | | |
| Learning from Deaths Quarterly Report | | ✓Q4 (Annual Report) | ✓Q1 | ✓Q2 | | ✓ Q3 |
| Safeguarding update – Adults & Children | | | (Annual Report) | | | ✓ |
| Safeguarding Adults and Children Annual Report | | | ✓ | | | |
| Complaints Annual Report | | | ✓ | | | |
| **WORKFORCE** | | | | | | |
| **Staff Survey Results and Action Plan** | ✓ | ✓ | | | | ✓ |
| **Health and Well-Being** | | | ✓ | | | |
| Nursing and Midwifery Staffing Hard Truths Requirement | | | | ✓ Bi-Annual | | |
| **Guardian of Safe Working Hours (quarterly)** | ✓Q4 | | ✓Q1 | ✓Q2 | ✓Q3 | |
| Guardian of Safe Working Hours Annual Report | ✓ | | | | | |
| Diversity | | | | | | ✓ |
| Medical Revalidation and Appraisal Annual Report | | | ✓ Annual Report | | | |
| Freedom to Speak Up Annual Report | | | ✓ Annual Report | | ✓ 6 month report FTSU themes | |

| DATE OF MEETING | 5 May 2022 | 7 July 2022 | 1 Sep 2022 | 3 Nov 2022 | 12 Jan 2023 | 2 Mar 2023 |
|---|---|---|---|---|---|---|
| Workforce Committee Annual Report | | ✓ 2021/2022 | | | | |
| Public Sector Equality Duty (PSED) Annual Report | | | | | | ✓ |
| **GOVERNANCE & ASSURANCE** | | | | | | |
| **Health and Safety Update** | ✓ | ✓ | | | ✓ | |
| **Health and Safety Policy** (May 2023) | | | | | | |
| Health and Safety Annual Report | | | | | ✓ | |
| Board Assurance Framework | | ✓ 1 | | ✓ 2 | | ✓ 3 |
| Risk Appetite Statement | | | ✓ | | | |
| High Level Risk Register | ✓ | | ✓ | | ✓ | |
| Calderdale Huddersfield Solutions Managing Directors Report | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Standing Orders/SFIs/SOD review | ✓ *(TBC)* | | | | | |
| Non-Executive appointments | | | | ✓ | | ✓ |
| Annual review of NED roles | | | ✓ | | | |
| Board workplan | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Board meeting dates | | ✓ | | | | |
| Use of Trust Seal | | ✓ | | ✓ | | ✓ |
| Council of Governor elections | | | | | | ✓ timetable |
| **Declaration of Interests – Board of Directors (annually)** | | | | | | ✓ |
| **Attendance Register – (annually)** | ✓ | | | | | |
| **Fit and Proper Person Self-Declaration Register** | | | | | | ✓ |
| Seek delegation from Board to ARC for the annual report and accounts 2021/22 | | | | | | ✓ |
| BOD Terms of Reference | | | | | | ✓ |
| Sub Committees Terms of Reference | ✓ QC<br>✓ F&P<br>✓ TPB | ✓ Workforce | ✓ARC | | | ✓QC<br>✓ NRC BOC |

| DATE OF MEETING | 5 May 2022 | 7 July 2022 | 1 Sep 2022 | 3 Nov 2022 | 12 Jan 2023 | 2 Mar 2023 |
|---|---|---|---|---|---|---|
| Constitutional changes (+as required) | ✓ | | | | | ✓ |
| Compliance with Licence Conditions | ✓ | | | | | |
| Huddersfield Pharmaceuticals Specials (HPS) Annual Report | | | | ✓ | | |
| Fire Safety Annual Report | | ✓ | | | | |
| Fire Strategy 2021-2026 and Fire Policy Update | | | | | | ✓ |
| Emergency Planning Annual Report (Bev Walker/Ian Kilroy/Karen Bates) | | | ✓ | | | |
| Charitable Funds Report 2021-22 and Accounts (Audit Highlights Memorandum) | | | | | ✓ | |
| Committee review and annual reports | | ✓ | | | | |
| Audit & Risk Committee Annual Report 2021/2022 | | ✓ | | | | |
| Finance & Performance Committee Annual Report 2021/2022 | | ✓ | | | | |
| Quality Committee Annual Report 2021/22 | | ✓ | | | | |
| WYAAT/WY&H Partnership Reports | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| WYAAT Annual Report and Summary Annual Report | | | | | ✓ | |

| Colour Key to agenda items listed in left hand column: | |
|---|---|
| Items for approval | To formally receive a report or strategy for discussion and particularly approve recommendations or a particular course of action |
| Items to receive | To discuss in depth, noting the implications for the Board or Trust without formal approval |
| Items to note | For the intelligence of the Board without in-depth discussion |
| Items for assurance | To assure the Board that effective systems of internal control are in place (see Review Room papers) |

# 24. Review of Board Sub-Committee Terms of Reference

a) Finance and Performance Committee

b) Transformation Programme Board

To Approve

NHS
Calderdale and Huddersfield
NHS Foundation Trust

| | |
|---|---|
| **Date of Meeting:** | Thursday 5 May 2022 |
| **Meeting:** | Public Board of Directors |
| **Title of report:** | Annual Review of Terms of Reference – Finance and Performance Committee |
| **Author:** | Gary Boothby, Director of Finance |
| **Previous Forums:** | Finance and Performance Committee – November 2021 |

**Purpose of the Report**

The Terms of Reference for the Finance and Performance Committee requires that an annual review is undertaken to refresh and confirm the scope of work. This review has been undertaken and the revised Terms of Reference are attached.

**Key Points to Note**

The Terms of Reference were reviewed and approved by the Finance and Performance Committee in November 2021 and are presented to the Board of Directors for approval. The following additions / changes have been made which are highlighted in red on the attached document:

Version 6.1 – Section 5.3 added to allow for quoracy:

5.3. If a Non-Executive Director or Executive Director is unable to attend a meeting, they should nominate a deputy, subject to the agreement with the Trust Chair and Chief Executive, and that deputy will be counted for the purpose of quoracy.

**EQIA – Equality Impact Assessment**

There is no adverse equality impact as a result of this change.

**Recommendation**

It is recommended that the Board **APPROVE** the updated Terms of Reference for the Finance and Performance Committee.

Calderdale and Huddersfield NHS Foundation Trust

# FINANCE & PERFORMANCE COMMITTEE

# TERMS OF REFERENCE

| | |
|---|---|
| **Version:** | 1.1 - first draft circulated for review to Chair / CE / DoF / DDof<br>1.2 - comments received OW / CB / AH<br>1.3 - Amendments from the Board of Directors<br><br>2.1 – Reviewed and updated for membership and to reflect planning cycle<br><br>3.1 – Reviewed and updated to include a Performance Delivery and Assurance Section<br><br>4.1 – Reviewed and updated – March 2019<br><br>5.1 – Reviewed and updated – June 2020<br><br>6.1 – Reviewed and section 5.3 added to allow for quoracy. November 2021 |
| **Approved by:** | Board of Directors |
| **Date approved:** | |
| **Date issued:** | |
| **Review date:** | |

# FINANCE & PERFORMANCE COMMITTEE – TERMS OF REFERENCE

## 1. Constitution

The Trust Board hereby resolves to establish a Committee to be known as the Finance and Performance Committee. The Committee has no executive powers, other than those specifically delegated in these Terms of Reference.

## 2. Purpose

The Finance and Performance Committee has delegated authority from the Board to oversee, coordinate, review and assess the financial and performance management arrangements. This includes monitoring the delivery of the 5 Year Plan and supporting Annual Plan decisions on investments and business cases.

The Committee will assist in ensuring that Board members have a sufficiently robust understanding of key performance, financial and investment issues to enable sound decision-making.

## 3. Authority

The Finance and Performance Committee is authorised by the Board, to which it is accountable, to investigate or approve any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request for such information.

## 4. Role and duties of the Committee

The Finance and Performance Committee will provide the Board with assurance that finance and performance is being monitored and managed across the organisation and that progress is being made in the implementation of the Annual Plan. The Committee will also make recommendations on investment.

The duties of the Committee can be categorised as follows:

### 4.1. **Finance and Financial Performance**

- Provide assurance that the finances and financial performance reporting systems of the organisation are robust through detailed review of the Monthly Financial Report.
- Seek assurance from the executive that any appropriate management action has been taken to return the Trust's financial performance to plan and that any such actions or recovery plans are in place are adequately resourced, implemented and monitored.
- Provide assurance to the Board that cost improvement plans to support organisational changes are being delivered
- Review the Trust's Long Term Financial Model and any NHS Improvement submissions to test assumptions and provide assurance that the returns represent a true and fair view of the financial performance for the period under review.
- Review all significant financial risks on the high level risk register and the Board Assurance Framework.
- Review the finance elements of the Single Oversight Framework and Use of Resources metric.
- Examine any matter referred to the Committee by the Trust Board.

### 4.2 **Performance Delivery and Assurance**

- Provide assurance that the performance reporting systems of the organisation are robust through detailed review of the regulatory performance and other KPIs as they relate to resource utilisation and income through Integrated Board Report on a monthly basis.

# FINANCE & PERFORMANCE COMMITTEE – TERMS OF REFERENCE

- Keep the content of the Trust's Integrated Board Report under review, ensuring that it includes appropriate performance metrics and detail of exceptions to provide assurance to the Board on all aspects of organisational performance against its Strategic Objectives.
- If and when necessary, seek assurance from the executive that any appropriate management action has been taken to return the trust performance to plan and that any such actions or recovery plans are in place are adequately resourced, implemented and monitored and that appropriate EQIA has been completed.
- Provide assurance to the Board that the performance of Clinical Divisions and corporate teams are in line with agreed annual plans and receive escalation where recovery plans do not resolve any adverse variance
- Review all significant operational and strategic risks as they pertain to financial and regulatory standards on the high level risk register and the Board Assurance Framework.

**4.3 Business and commercial development**

- Ensure compliance with the Treasury Management guidance.
- Approve and set control limit for capital
- Review the Trust's Annual Business Plan, 5 Year Plan, 5 Year Capital Plan and Financial Model and recommend to the Board for approval.
- Approve capital programme under discrete headings (based on high level business case proposals from divisions):
  - Equipment replacement
  - Unavoidable major schemes
  - IM&T
  - Significant strategic importance
  - Estates (maintenance/ upgrades)
  - Aspirational
- Understand and agree revenue consequences of major schemes (in line with SFIs) and monitor cash flow implications, and also ensure that appropriate EQIA has been completed.
- Receive an update from Commercial Investment Strategy Group on business case approvals ensuring that outcomes and benefits are clearly defined, are measurable and support the delivery of key objectives for the Trust. Ensuring only those below £2.5M are approved by the Group and those above £2.5M are recommended to the Board for approval.
- *this is under treasury management*Periodically review the market share analysis for the Trust.
- Approve the establishment of joint ventures or other commercial partnerships/relationships including the incorporation of start-up companies. Make recommendations to the Trust Board in relation to any due diligence, warranties, assignments, investment agreements, etc. related to joint ventures, commercial partnerships or incorporation of start-up companies.
- Agree investment / dis-investment in services (with full understanding of financial and service implications of these decisions e.g. overheads)

**4.4 Treasury Management**

- Maintain an oversight of the Trust's Treasury Management activities, ensuring compliance with Trust's policies.
- Review borrowing arrangements and liabilities
- Review and monitor the Trust's Treasury Management Policy *(approval is through the Audit & Risk Committee)*.

# FINANCE & PERFORMANCE COMMITTEE – TERMS OF REFERENCE

- Review the activities undertaken at Cash Management Committees

4.5 **Procurement**

- Review the activities undertaken by Procurement and the contributions made along with performance against key national metrics.

## 5. Membership and Attendees

5.1. The Committee shall consist of the following members:

- Non – Executive Director (Chair)
- Non – Executive Director (Vice Chair)
- Chief Executive
- Executive Director of Finance
- Chief Operating Officer
- Director of Transformation and Partnerships.

5.2. The Deputy Director of Finance and the Company Secretary will regularly attend. All other non-executive and executive directors will be invited to attend along with a Governor representative. Executive Directors and other senior management staff may be required to attend discussions when the Committee is discussing areas of performance or operation that are their responsibility.

5.3. If a Non-Executive Director or Executive Director is unable to attend a meeting, they should nominate a deputy, subject to the agreement with the Trust Chair and Chief Executive, and that deputy will be counted for the purpose of quoracy.

## 6. Attendance

6.1. Attendance is required by members at 75% of meetings. Members unable to attend should indicate in writing to the Committee secretary, at least 7 days in advance of the meeting and nominate a deputy except in extenuating circumstances of absence. In normal circumstances, any members who are unable to attend must nominate a deputy who is appropriately briefed to participate in the meeting.

6.2. A register of attendance will be maintained and the Chair of the Committee will follow up any issues related to the unexplained non-attendance of members. Should continuing non-attendance of a member jeopardies the functioning of the Committee, the Chair will discuss the matter with the member and, if necessary, seek a substitute or replacement.

## 7. Administration

7.1. The Committee shall be supported by the Secretary to the Executive Director of Finance, whose duties in this respect will include:

- In consultation with the Chair develop and maintain the reporting schedule to the Committee
- Collation of papers and drafting of the agenda for agreement by the Chair of the Committee;
- Taking the minutes and keeping a record of matters arising and issue to be carried forward;
- Advising the group on scheduled agenda items;
- Agreeing the action schedule with the Chair and ensuring circulation within 48 hours of each meeting; and
- Maintaining a record of attendance.

# FINANCE & PERFORMANCE COMMITTEE – TERMS OF REFERENCE

## 8. Meetings

8.1. Meetings will be held on a monthly basis and arranged to meet the requirements of the corporate calendar;

Meetings could be held either in person or using virtually using digital technology

8.2. Items for the agenda must be sent to the Committee Secretary a minimum of 8 days prior to the meeting: urgent items may be raised under any other business;

8.3. An action schedule will be circulated to members 48 hours following each meeting and must be duly completed and returned to the Secretary for circulation with the agenda and associated papers; and

8.4. The agenda will be sent out to the Committee members one week prior to the meeting date, together with the updated action schedule and other associated papers.

## 9. Reporting

9.1. The minutes of the Committee meetings formally recorded by the Committee Secretary will be submitted to the Trust Board when approved.

9.2. The Chair of the Finance and Performance Committee shall, at any time, draw to the attention of the Trust Board any particular issue which requires their attention.

9.3. The Capital Management Group, the Commercial Investment Strategy Group, Cash Committee, Hospital Pharmacy Specials, Joint Liaison Committee, Strategic PFI Partner meeting, THIS Executive Board and A&E Delivery Board will provide minutes of its meetings to the Committee along with reports as agreed.

## 10. Quorum

A quorum is determined as being four of the members in attendance but must include the Chair or Vice-Chair and one Executive Director.

## 11. Review

The Terms of Reference shall be reviewed on an annual basis and ratified by the Board.

## 12. Monitoring Effectiveness

In order that the Committee can be assured that it is operating at maximum effectiveness in discharging its responsibilities as set out in these terms of reference and, if necessary, to recommend any changes to the Board, the Chair will ensure that once a year a review of the following is undertaken and reported to the next meeting of the Committee:

- The objectives set out in section 3 were fulfilled;
- Members attendance was achieved 75% of the time;
- Agenda and associated papers were distributed 7 days prior to the meetings;
- The action schedule was circulated within 3 working days of the meeting, on 80% of occasions.

NHS
Calderdale and Huddersfield
NHS Foundation Trust

| | |
|---|---|
| **Date of Meeting:** | Thursday 5 May 2022 |
| **Meeting:** | Public Board of Directors |
| **Title of report:** | Annual Review of Terms of Reference - Transformation Programme Board |
| **Author:** | Anna Basford - Director of Transformation and Partnerships |
| **Previous Forums:** | Transformation Programme Board 22 March 2022 |

**Purpose of the Report**

The Terms of Reference for the Transformation Programme Board (TPB) requires that an annual review is undertaken to refresh and confirm the scope of work. This review has been undertaken the revised Terms of Reference are attached.

**Key Points to Note**

The Terms of Reference have been reviewed and the following additions / changes incorporated which are highlighted in red on the attached document:

1. That the purpose of the Transformation Programme Board will include ensuring the learning from the Covid-19 Pandemic continues to feed into the transformational changes in future service deliver models following the closure of the "Business Better Than Usual" Programme.
2. That the purpose of the Transformation Programme Board will include ensuring the Trust continues to engage and involve colleagues and key partners as well as the other stakeholders listed in the previous terms of reference.
3. That the Committee shall be supported by the Transformation Programme Governance Lead following the retirement of the Committee Administrator and the recruitment of the Programme Governance Lead.
4. Reference to the Chair's Highlight Report produced upon approval of the Transformation Programme Board minutes and reported into Trust Board.
5. Inclusion of the Organ Donation Committee on the Governance Structure at Appendix A.
6. That the duties of the Transformation Programme Board will include awareness and response to changes in statutory governance arrangements within the local health and social care system.

**EQIA – Equality Impact Assessment**

The Terms of Reference include specific responsibility of the Transformation Programme Board to ensure that assessment of the Equality and Quality Impact and Data Protection Impact of the Transformation Programme is undertaken and kept up to date and that any necessary mitigation plans are in place.

**Recommendation**

It is recommended that the Board **APPROVE** the updated Terms of Reference for the Transformation Programme Board.

Calderdale and Huddersfield
NHS Foundation Trust

# TRANSFORMATION PROGRAMME BOARD TERMS OF REFERENCE

## 1. Constitution

1.1 The Trust Board hereby resolves to establish a Committee to be known as the Transformation Programme Board. The Transformation Programme Board has no executive powers, other than those specifically delegated in these Terms of Reference. The governance structure is at Appendix A.

## 2. Authority

2.1 The Transformation Programme Board is constituted as a Standing Committee of the Trust Board. Its constitution and terms of reference are subject to amendment by the Trust Board.

2.2 The Committee derives its power from the Trust Board and has no executive powers, other than those specifically delegated in these terms of reference. The Committee will comply with the Trust's Standing Orders and Standing Financial Instructions and schemes of delegation.

2.3 The Committee is authorised by the Trust Board to investigate any activity within its terms of reference – it is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

2.4 The Committee is authorised by the Trust Board to request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary.

## 3. Purpose

3.1. The purpose of the Transformation Programme Board is to oversee the development and delivery of complex transformation programmes in the Trust, and to provide assurance on these matters to the Trust.

3.2. The responsibilities of the Transformation Programme Board include:

- To set and ensure delivery of the key milestones for the reconfiguration of services and ensure that service delivery plans are based on new ways of working including the optimised use of digital technology.
- To set and ensure delivery of the key milestones for the capital investment and estate development at Huddersfield Royal Infirmary and Calderdale Royal Hospital to enable service reconfiguration. This will include major

capital schemes identified by the Transformation Programme Board that are high risk, high value and of significant strategic importance.

- To ensure the Trust has secured through appropriate commercial arrangements an effective supply chain with the necessary specialist skills and capacity to deliver the reconfiguration of services and associated estate development.
- To ensure that the Programme produces viable and affordable business cases that are supported by local CCGs and the West Yorkshire Health and Care Partnership and approved by NHSE&I, DHSC and HM Treasury. This includes the Strategic Outline Case, the Outline Business Case and the Full Business Case.
- To ensure the Trust's existing PFI contract for Calderdale Royal Hospital is renegotiated - and subsequently ensure there is effective dialogue and relationship management with the PFI provider to enable the required estate developments on the CRH site.
- To ensure delivery of the Programme within the agreed and available capital and revenue resource budgets.
- To ensure that the risks associated with the Transformation Programme are managed appropriately.
- To ensure that benefits realisation associated with the Transformation Programme are managed, reported or delivered. To ensure independent review of benefits realisation is undertaken through-out the programme.
- ~~To ensure the Business Better than Usual Programme, that will progress learning from the Covid-19 Pandemic to incorporate transformational changes in future service delivery models, is led and reports into the Transformation Programme Board.~~
- To ensure the learning from the Covid-19 Pandemic continues to feed into the transformational changes in future service deliver models.
- To ensure that assessment of the Equality and Quality Impact and Data Protection Impact of the Transformation Programme is undertaken and kept up to date and that any necessary mitigation plans are in place.
- To ensure the Trust continues to engage and involve colleagues, local people, key partners, stakeholders and the Joint Health Scrutiny Committee in the Transformation Programme.
- To ensure the Programme proactively responds to climate emergency in Calderdale and Kirklees and enables an improvement in CHFT contribution to environmental sustainability. The Trust's Green Planning Committee will report to and provide regular updates to the Transformation Programme Board on these matters.
- To review and provide and assurance to the Trust Board on the following items included on the Board Assurance Framework:
    - Trust estate
    - Service reconfiguration
    - Digital transformation
    - ~~Business better than usual – learning from the pandemic~~
    - Sustainability
    - Clinical strategy

## 4. Duties

4.1 The Programme Board will approve and manage the programme plan and sign off the key outputs and decisions at each stage of the programme. This includes:

- Monitoring and ensuring delivery of the overall plan of key activity, milestones and critical path.
- Patient and colleague communications and engagement.
- Procurement and commercial processes and decisions.
- Review of all the key deliverables and the activities required to deliver them
- The activities required to validate the quality of the deliverables.
- The resources and time needed for all activities and any need for people with specific capabilities and competencies.
- The dependencies between activities and any associated constraints when activities will occur.
- The points at which progress will be monitored, controlled and reviewed.
- The provision of regular reports, updates and assurance to CHFT Board, NHSE&I, DHSC and HM Treasury.
- Maintenance of a detailed risk registers and mitigation of risk factors affecting the successful delivery of the project.
- Maintenance of a benefits realisation registers and monitoring of delivery.
- Considering and recommending to the Trust Board any changes to the project scope, budget or timescale if required.
- Review of serious issues, which have reached threshold level.
- Brokering relationships with stakeholders within and outside the project to maintain positive support for the programme.
- Being aware of and responding to any changes in statutory governance arrangements within the local health and social care system (for example the establishment of Integrated Care Boards locally) which may impact the programme.
- Maintaining awareness of the broader strategic perspective advising the SRO on how it may affect the project.
- Approving the design brief, appointment of external consultant team and approving the programme of work and the critical path.

## 5. Membership and attendance

5.1 The Transformation Programme Board shall consist of the following members:

- Three Non-Executive Directors, one of whom will Chair the Committee and one of whom will be the Deputy Chair of the Committee (the Trust Board may also choose to appoint an independent Lay Chair)
- Chief Executive / Senior Responsible Officer (SRO)
- Chief Operating Officer
- Medical Director & Director of Infection Prevention and Control
- Director of Nursing

- Director of Workforce and Organisational Development
- Director of Finance
- Director of Transformation and Partnerships (Programme Director)
- Managing Director – Digital Health
- Managing Director – Calderdale and Huddersfield Solutions.

5.2 The following shall be required to attend all meetings of the Committee:

- Transformation Programme Manager
- Transformation Programme ~~Administrator~~ Governance Lead (notes)
- Associate Director of Finance

5.3 Other attendees may be co-opted or requested to attend as considered appropriate and may include external advisors. The Trust's Lead Governor will be invited to attend all meetings.

5.4 A quorum will be four members of the Committee and must include at least three board members of which one must be a Non-Executive and one an Executive Director.

5.5 Attendance is required at 75% of meetings. Members unable to attend should indicate in writing to the Committee Administrator of the meeting and nominate a deputy except in extenuating circumstances of absence. In normal circumstances any members who are unable to attend must nominate a deputy who is appropriately briefed to participate in the meeting.

5.6 A register of attendance will be maintained, and the Chair of the Transformation Programme Board will follow up any issues related to the unexplained non-attendance of members. Should continuing non-attendance of a member jeopardise the functioning of the Committee, the Chair will discuss the matter with the member and, if necessary, select a substitute or replacement.

## 6. Administration

6.1 The Committee shall be supported by the ~~Administrator~~ Transformation Programme Governance Lead, whose duties in this respect will include:

- In consultation with the Chair ~~to~~ develop and maintain the reporting schedule to the Committee.
- Collation of papers and drafting of the agenda for agreement by the Chair of the Committee.
- Taking the minutes and keeping a record of matters arising and issues to be carried forward.
- Advising the group of scheduled agenda items,
- Agreeing the action schedule with the Chair and ensuring circulation.
- Maintaining a record of attendance.

**Frequency of Meetings**

7.1 The Committee will meet monthly. Additional meetings may be scheduled if required in relation to the Transformation Programme of work and timelines.

## 8. Reporting

8.1 The Transformation Programme ~~Administrator~~ Governance Lead will produce and maintain a standard agenda; any additional agenda items must be sent to the ~~Secretary~~ Governance Lead no later than 10 working days prior to the meeting, urgent items may be raised under any other business.

8.2 An action schedule will be articulated to members following each meeting and must be duly completed and returned to the ~~Administrator~~ Governance Lead for circulation with the agenda and associated papers.

8.3 The agenda will be sent out to the Transformation Programme Board members 5 working days prior to the meeting date, together with the updated action scheduled and other associated papers.

8.4 Formal minutes shall be taken of all committee meetings. Once approved by the committee, the minutes will inform the Chair's highlight report which will go to the next Trust Board of Directors meeting.

8.5 In considering reporting to the Trust Board, the Transformation Programme Board will consider Guidance for Reserving Matters to a Private Session of the Board of Directors

## 9. Review

9.1 As part of the Trust's annual committee effectiveness review process, the Committee shall review its collective performance.

9.2 The terms of reference of the Committee shall be reviewed by the Trust Board of Directors at least annually.

## 10. Monitoring effectiveness

10.1 In order that the Committee can be assured that it is operating at maximum effectiveness in discharging its responsibilities as set out in these terms of reference and, if necessary, to recommend any changes to the Senior Management Team, the Chair will ensure that once a year a review of the following is undertaken and reported to the next meeting of the Committee:

- The objectives set out in section 3 were fulfilled
- Members' attendance was achieved 75% of the time
- Agenda and associated papers were distributed 5 working days prior to the meetings

- The action points from each meeting are circulated within two working days, on 80% of occasions.

10.2 These Terms of reference will be reviewed after three years to determine if there is a continued need for the Transformation Programme Board.

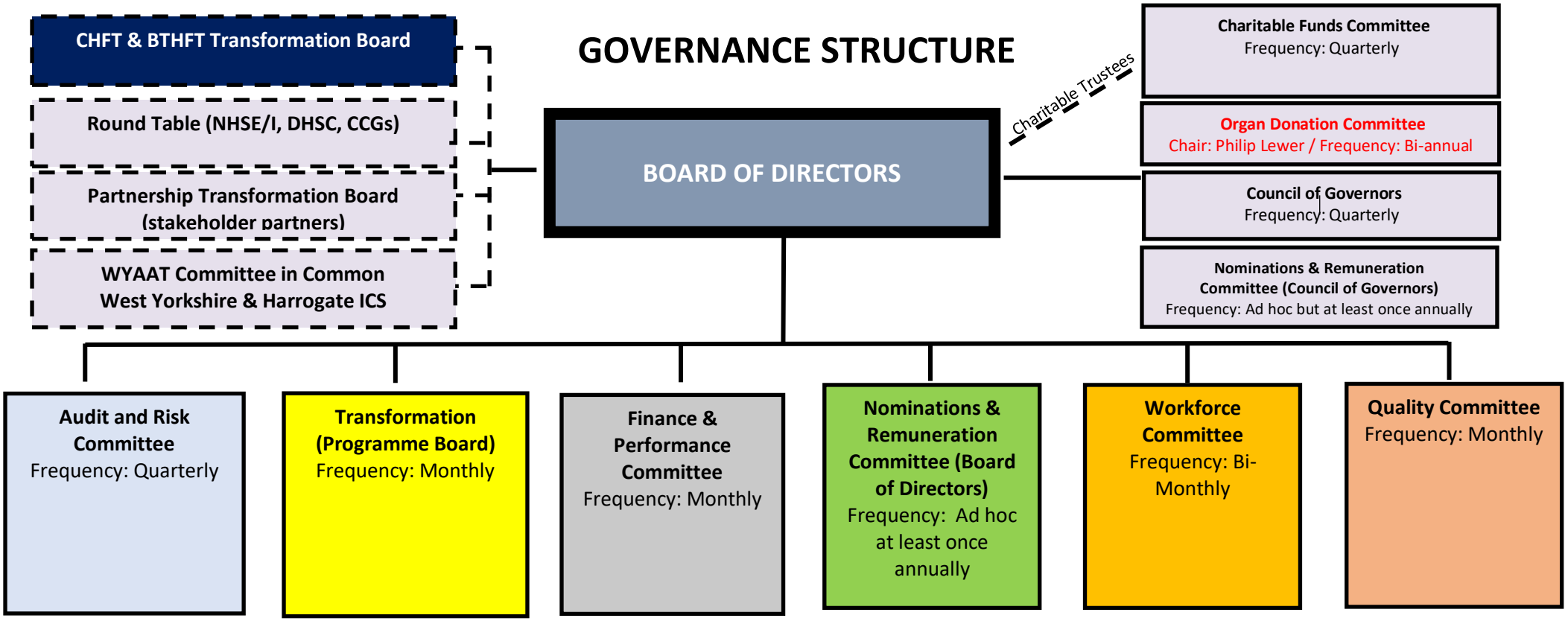
**Date Approved by Transformation Programme Board: 22 March 2022**

**Date Approved by Trust Board:**

**Review Date:**

APPENDIX A

# GOVERNANCE STRUCTURE



## 25. Board Sub-Committee Chair Highlight Reports (Minutes in the Review Room)

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

To Note

Presented by Richard Hopkin, Denise Sterling, Andy Nelson and Karen Heaton

Calderdale and Huddersfield NHS Foundation Trust

# CHAIR'S HIGHLIGHT REPORT
# to the Board of Directors

| | |
|---|---|
| **Committee Name:** | Finance and Performance Committee |
| **Committee Chair:** | Richard Hopkin, Non-Executive Director |
| **Date of meeting:** | 4 April 2022 |
| **Date of Board meeting this report is to be presented:** | 5 May 2022 |

**ACKNOWLEDGE**

- Recovery performance still largely on track with strong achievement on P2s and 104 week waiters and improved position on endoscopy
- Continuing good performance on cancer metrics despite operational challenges
- Expecting to deliver 21/22 Financial Plan based on M11 YTD performance and forecast for March
- Aged debt fell by £1.3m in February and year end target of less than £3m will be achieved
- Good progress in identifying efficiency opportunities for 22/23 (£16.6m of schemes identified to date) following successful workshop and close scrutiny of ERG and Executive team

**ASSURE**

- Review of Recovery Performance to end of March against revised trajectories
- Review of changes to 22/23 Operational and Financial Plans and approval of latest version of Plans with £23m deficit, after CIP/Covid cost reduction of £25m
- Review of external deep dive into 22/23 Plans carried out by NHSEI and peers (from Airedale/ICS)
- Review of approach to 22/23 efficiency target from Effective Resources Group ('ERG'), including major event involving 100+ colleagues to develop schemes
- Work Plan for 22/23 approved

**AWARE**

- Overall IPR performance still down at 62% with continuing key issues including – stroke indicators, #neck of femur, dementia screening, complaints closure, FFT, DTOC and mortality indicators
- High volumes and acuity of attendances in ED; only 74% achieved in February against 4 hour standard.
- Overall waiting list backlog and average wait times still a major challenge.
- Key risks identified in relation to CHFT 22/23 Plans including (i) achievement of 104% elective activity (v 2019/20 base) (ii) £5m Covid cost reduction target (iii) DTOC reduction to 70 days (iv) Gazprom exit costs – up to £3m
- Significant challenge across the ICS in relation to overall 22/23 financial plans and underlying efficiency requirement

Calderdale and Huddersfield NHS Foundation Trust

# CHAIR'S HIGHLIGHT REPORT
# to the Board of Directors

| | |
|---|---|
| **Committee Name:** | Quality Committee |
| **Committee Chair:** | Denise Sterling, Non-Executive Director |
| **Dates of meetings:** | 21st March 2022, 20th April 2022 |
| **Date of Board meeting this report is to be presented:** | 5th May 2022 |

## ACKNOWLEDGE

Updates received:

- Dementia screening, compliance remains below target, committee noted actions in place to increase compliance. Monitoring will continue as concerns remain regarding slow rate of sustained improvement.
- The no of falls have increased and likely to be linked to reduced staffing levels on the wards. Committee assured a wide range of falls prevention actions in place
- Deteriorating patient - work undertaken in response to a cluster of serious incidents regarding the management of the deteriorating patient across specialties. Recommendations from a quality summit have been implemented and to be reviewed for impact. 62% of incidents occurred in Nov/Dec2021 reduced to 15% since the summit.

## ASSURE

- Updated Quality Committee terms of reference approved.
- Maternity report received and progress is being made on the Ockenden review action plan. The CHFT results from 2021 CQC maternity survey shows an increase in the response rate from previous survey. Two areas highlighted were CHFT performing worse than expected, action plan in development and to be brought to QC.
- Report on the work undertaken in response to the Children and Young People Survey, new risk added to risk register regarding play and distraction and engagement with families Comprehensive action plan presented and Committee noted progress.
- The Q4 IPC Board Report performing quite well against targets, no MRSA cases reported for 2021/22.
- FocussedJ20 reviews undertaken in preparation for CQC ICS inspection, immediate learning from the reviews being disseminated across the organisation.
- IPR- Achieved all cancer standards in March , second highest performing trust against cancer targets. Stroke indicators remain a concern working with partners to look at stroke capacity.
- Reviewed the HLR and noted the reduction in the number of very high and high risks and the work on cross divisional risks.
- The Legal report provided reasonable assurance on the legal services improvement programme, review of the claims portfolio is currently underway and 60 clinical negligence claims closed in Q4. All open inquests have been risk assessed

| **AWARE** |
| --- |
| • Trust received a Prevention of Future Deaths Report (Regulation 28) as Coroner felt there were several issues that had not been appropriately addressed by the Trust investigation. Compiling a response which will address the concerns and provide information on the measures that have been put in place.<br>  • Never Event reported in March in relation to wrong site surgery. |

Calderdale and Huddersfield NHS Foundation Trust

# CHAIR'S HIGHLIGHT REPORT
# to the Board of Directors

| | |
|---|---|
| **Committee Name:** | Audit and Risk Committee (ARC) |
| **Committee Chair:** | Andy Nelson, Non-Executive Director |
| **Date of meeting:** | 26th April 2022 |
| **Date of Board meeting this report is to be presented:** | 5th May 2022 |

**ACKNOWLEDGE**

- ARC had a presentation on work being done to improve our risk management processes and the committee was encouraged by the progress made in addressing such issues as:
    - Inconsistent approaches across divisions
    - Longstanding risks
    - Setting risk scores appropriately based on actions taken

**ASSURE**

- ARC approved the updated terms of reference for the Data Quality Board and Risk Management Group
- The formal Value For Money Assessment for 2021/22 undertaken by the external auditors KPMG has not identified any significant risks regarding the three domains of financial sustainability, governance and improving economy, efficiency and effectiveness
- The Counter Fraud and Internal Audit plans for 2022-23 were approved
- Although it has not been possible to complete the internal plan this year (and 9 audits are still to be completed and 6 audits have been cancelled or postponed to 2022-23) the Head of Internal Audit assured the committee she will still be able to issue a Head of Internal Audit opinion which she currently expects to be positive with a rating of 'Significant'

**AWARE**

- Although some progress has been made in clearing Internal Audit recommendations there are still 35 overdue versus 44 in the report in January. The chair of the committee and the Finance Director will follow up with relevant executive directors
- Internal Audit have found it is taking much longer to complete audits than in previous years – often months instead of weeks. Although it is recognised that the pressures brought on by Covid have been a key factor in such delays we need to find an approach where, in future, audits can be completed in a timelier manner.

Calderdale and Huddersfield NHS Foundation Trust

# CHAIR'S HIGHLIGHT REPORT
# to the Board of Directors

| | |
|---|---|
| **Committee Name:** | Workforce and Organisational Development Committee |
| **Committee Chair:** | Karen Heaton, Non-Executive Director |
| **Date(s) of meeting:** | Tuesday 12 April 2022 |
| **Date of Board meeting this report is to be presented:** | Thursday 5 May 2022 |

## ACKNOWLEDGE

The following points are to be noted by the Board following the meeting of the Committee on 12 April 2022.

- Recruitment Strategy is well presented and clear. Further work is being undertaken to develop an action plan and milestones. This was welcomed by the Committee.
- The Committee recognised the excellent work in defining a new approach – Development for All, including a Colleague Engagement Plan and Team Engagement and Development (TED).
- Assurance provided to the Committee through the Nursing Workforce Programme update and recruitment continues to be strong.
- IPR- concern over the level of short term sickness absence which is now showing signs of levelling off and the number of return to work interviews remains below target with further work planned to improve this. Sickness absence targets have been revised upwards to reflect reality which has the support of the Committee.
- A refresh and refocus on the Trusts' People Strategy is underway with alignment to the West Yorkshire and Harrogate People Plan
- Board Assurance Framework- Risk10b/19 Nurse Staffing. The level of risk remains unchanged and the Quality Committee will also discuss any gaps in control and assurance.
- Update from BAME Chair was well received and the Committee welcomed the interaction with colleagues and extended an invitation to attend the committee to other staff networks.

## ASSURE

The Committee continues to keep a close watch on the level of sickness absence and expects a continued improvement in the number of RTWs undertaken. BAF risk remains unchanged for Nurse Staffing. It was noted that the Committee felt assured by the actions underway as presented in the detailed report.

## AWARE

- Workforce metrics remain amber and concerns remain over the sickness absence rate, return to work interviews (RTW) and Data Security Awareness EST compliance. The wellbeing of the workforce is of continuing concern.
- Excellent work being undertaken to improve engagement with the workforce and their development.

# 26. Items for Review Room

## 1. Calderdale and Huddersfield Solutions Managing Directors Report – April 2022

## 2. West Yorkshire Association of Acute Trusts (WYAAT) & West Yorkshire and Harrogate (WY&H) Partnership Reports

To Note

Presented by Stuart Sugarman and Philip Lewer

## 27. Date and time of next meeting

Date: Thursday 7 July 2022

Time: 9:00 am

Venue:  Microsoft Teams

To Note

Presented by Philip Lewer