# Board of Directors Public Meeting - Items for Assurance - 4 May 2023 - Review Room

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

## Documents for Review

# 1. MINUTES OF BOARD COMMITTEES

Calderdale and Huddersfield NHS Foundation Trust

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

**PRESENT**

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|---|---|
| Andy Nelson | Non-Executive Director (Chair) |
| Nigel Broadbent | Non-Executive Director |
| Kirsty Archer | Acting Director of Finance |

**IN ATTENDANCE**

| | |
|---|---|
| Andrea McCourt | Company Secretary |
| Rochelle Scargill | PA to Director of Finance (Minutes) |
| Brian Moore | Public Elected Governor |
| Robert Markless | Public Elected Governor |
| Peter Keough | Assistant Director of Performance |
| Philippa Russell | Acting Deputy Director of Finance |
| Isaac Dziya | Public Elected Governor |
| Adam Matthews | Business Manager - HR |
| Jonathan Hammond | Acting Chief Operating Officer |
| Lisa Whiteley | HR Business Partner- Medicine |
| Helen Rees | Acting Director of Operations - Medicine |
| Rob Aitchison | Deputy Chief Executive |

**ITEM**

**191/22 WELCOME AND INTRODUCTIONS**

The Chair welcomed attendees to the meeting.

**192/22 APOLOGIES FOR ABSENCE**

Apologies were received from Vicky Pickles, Gary Boothby and Anna Basford

**193/22 DECLARATIONS OF INTEREST**

There were no declarations of interest.

**194/22 MINUTES OF THE MEETING HELD 1st NOVEMBER 2022**

The minutes of the last meeting were approved as an accurate record.

**195/22 MATTERS ARISING**

**196/22 ACTION LOG**

The Action Log was reviewed as follows:
Change actions marked as JF to JH.
180/21The new format IPR will not be in draft form by January. There is a substantial change to the format including using some of the layout used by Leeds. Once the draft is in an acceptable position it will be brought to this committee.
133/22 The minutes for all meetings have now been received and summary sheets have been requested from the administrators.
144/22 Terms of reference to be brought to January committee for approval.

Workforce deep dives will no longer take place at this committee as this is covered by the workforce committee. Adam Matthews will be regularly attending this meeting to answer any workforce questions raised.

For any deep dives the HR business partner for that division will also be invited to attend.

**197/22 TERMS OF REFERENCE**

To avoid too much restriction a suggestion to change Executive Directors to Directors. This would provide more flexibility as some attendees are Directors but not Executive directors.
Section 4.3 – Relating to Business and Commercial Development – There is a historic reference to Treasury Management which is no longer applicable.
The Commercial Investment and Strategy group is referenced but no longer exists and has been replaced with the Business Case Approvals Group.
Clarity required on which meetings report to this committee and for what purpose to be reviewed.

**ACTION**: A separate meeting to take place between AN, AM, KA and PR to review the Terms of Reference and agree the changes to be made.

**198/22 ED DEEP DIVE**

A clear definition of the information required within deep dives has been discussed for future deep dives.

The Acting Director of Operations for Medicine presented. 2019/20 has been used a base year for data as it was the last year pre-covid. Towards the end of the year covid cases started to impact.

The average daily attendance in ED across both sites this financial year is 473 compared to 422 in 2019/20. There have been days in November where the number has been above 600 with one day reaching 652. Four-hour breeches have increased in 2022/23 with the average per day being 133. This compares to 53 in 2019/20.
Performance year to date is 74.74% for Calderdale and 69.36% for Huddersfield. The overall performance is at 72.1% which is a decrease from 80.39%. Twelve-hour breeches used to be rare except for Winter. Since August 2021 there have been a substantial number with 420 in November and 424 in October.

The increase in number of attendances has not been reflected in the number of admissions from ED. The increase in attendances is expected to be partially due to patients who would have attended Primary Care, being unable to obtain a GP appointment and presenting at ED instead. There is now an Urgent Care Hub in place. The flipside are patients presenting who are more acutely ill due to delays in seeking care.

Ambulance handovers prior to covid, anything over 60minutes was minimal. However, there was an increase in Summer 2021 which reduced towards the end of the year. There are measures in place. Benchmarked against other Trusts in the region, CHFT is not an outlier and benchmarks well. The RAG rating which

was received after the presentation was put together, shows an increase of 26% in ambulance attendances. CHFT were rating as Green for ambulance handovers of over 30 minutes at 4.59%.
Benchmarking - Comparing ED performance over the last two months with other Trusts in the region, CHFT is one of the best performing Trusts in the area for ED even taking into account the dip in performance.
Patients treated by a doctor within 60 minutes reached 49% and patients who are treated and admitted or discharged within 12 hours was scored at 97%. The national picture shows a deterioration.

Average unit of price of direct costs (no overheads) has increased from an average of £109 per attendance in 2019/20 to £138 per attendance in 2022/23. Average unit cost has increased by 27% driven primarily by use of agency staff but also extra staffing to minimise ambulance handover times. .

ED reduction in performance is due to the following:

- Increased attendances
- Reduced access to primary care
- Acuity of patients
- Workforce capacity
- Space
- Flow into hospital for admissions – bed availability.

Plans are in place to improve performance including, the mapping of the medical workforce staffing to cover peak attendance times and recruitment of 3 speciality doctors and one Trust doctor which will reduce the reliance on agency and bank staff. The new ED from Summer 2023 is expected to assist with recruitment, as colleagues choose to work in a modern, purpose-built facility as well as being designed to be a more efficient and effective space in which to work.

Workforce – Sickness absence is consistently over 7%. HR are working closely with the team to put preventative measures in place.

**FINANCE & PERFORMANCE**

**199/22 MONTH 7 FINANCE REPORT (Including High Level Risks and Efficiency Performance)**

The Acting Deputy Director of Finance presented the Month 7 Finance Report. Year to date the trust is reporting a £13.10m deficit, a £1.76m adverse variance from plan. The in-month position is a deficit of £1.90m, a £0.88, adverse variance. The adverse variance in month is driven by inflationary pressures and staffing costs, in particular the impact of Enhanced Bank rates, (£0.83m in Month 7), high cost Agency staff, and the HPS loss of contribution from wholesaling.

In the first part of the year the variance was offset by the underspend on recovery costs. These are now back on track. There have been a high number of vacancies in FSS and Community divisions which are partially offsetting the pressures.

£820k was spent on the enhanced bank rate in month. The scheme ended on the 6th November and became a more targeted approach which will hopefully reduce costs.

CIP – Still ahead of plan year to date with just under £11m delivered which is £550k better than planned. Forecast is to deliver the full £20m and there is a small gap of £220k to be identified but his is achievable. Agency costs continue to be a concern and showing no sign of reducing. Activity reached 99% for inpatient activity which equates to 103% against 19/20 levels.

Use of Resources score is currently at level 4 which is the lowest level due to the adverse variance to plan and agency spend. Cash currently at £50m and slightly below plan. There has been an improvement in aged debt which has reduced by £3m and is back on trajectory. Capital is underspent at £5.7m against a plan of £17.6m on plan. Forecasting to be above plan by the end of the year which will be a challenge.

Achieving plan is reliant on a number of items. Withdrawal of the 50% enhanced bank rate. The super surge capacity is constantly being used which costs money and could affect recovery performance. The ICB could retain recovery funding if targets were not met.

At the point of reporting month 7 the forecast was officially on plan with a likely risk of £5.5m. Since that point there have been two or three positive moves and CHFT are working with system partners looking to share risk. There is potential for some system support to help our position. We are now looking to report the position as on plan and flag a risk of £1.5m.

Conversation is taking place within CHFT, around moving back to a turnaround approach which has happened in the past. This is in initial discussions and more details to come. This will move away from the weekly ERG held currently and help to prepare for expected further scrutiny. The 2023/24 position is expected to be more challenging. The turnaround executive would build on what we are currently doing with 70-80% of existing projects to continue.

Agency spend is being monitored on the ICB, not individual Trusts. Currently there is an adverse variance to the £99.3m overall agency target. The ICB Director of Finance asked all sectors to report into the ICS forecast forum listing the issues and drivers behind the spend and what is being done to improve. This was done on a sector basis to identify themes which are all very similar.

The Committee **RECEIVED** the Month 7 Financial Update.

**200/22 FINANCIAL RECOVERY UPDATE**

A guidance document has been issued, which specifies the protocol for any changes to financial forecasts. A copy was included within the meeting papers in the Convene Reading Room. If anyone is to report an overall financial position which has an adverse variance from their original plan which was signed off for the year, then additional measures will be put in place.

This includes additional approval limits put in place. If an organisation went off plan in forecast terms, then ICB approval will be required for any investment over £50k. This effectively equates to one post. If the whole ICB goes off plan, a national approval system will come into place for investments over £100k.

The crucial point will be month 9. The guidance makes clear that it is expected that any changes to forecast will have gone through a rigorous process before being declared. Any adverse plan declarations would reflect badly on the organisation. The ICB DoF has encouraged CHFT to enact the t rigour discussed within the document. This ties in with the decision to move to the Turnaround Executive process.

The new workforce enhancement scheme has had very few applications so far. A task and finish group has been created to help us move away from use of Tier 3 agencies. It is a challenge to recruit from the agencies who pay a lower rate of pay.

A Joint Financial Recovery group has been created which includes all system partners and aims to drive efficiencies across the whole system.

The Committee **RECEIVED** the Financial Recovery Update

**201/22 INTEGRATED PERFORMANCE REVIEW – OCTOBER 2022**

The Assistant Director of Performance gave an update.

Key headlines – Reporting on the October position. There has been deterioration overall compared to September. Unusually in month we had the first MRSA case for some time.

Safe domain - indicators have seen their best position this year.

Caring domain - has improved with 2 of the 5 friends and family tests (Inpatients and Community) achieving target. Complaints have had a lot of work to improve the position. Only a small improvement has been seen against targets, but we have closed the most complaints within month this financial year. Dementia screening not performing well as required but plans have been put in place. MRSA occurrence in medicine, the investigation has been completed and an action plan circulated. Fractured neck of femur still struggling to meet target and further work going on.

Responsive domain – Continued to achieve key cancer targets. Struggling to maintain improvement in stroke due to fluctuation in month, those scanned and thrombolysed within 1 hour of arrival has improved. ED performance was at 68.44 which is lowest performance ever by CHFT. This had an impact on 12 hour waits which were also the highest in month. There is still a high level of attendances.

The percentage of diagnostics seen within 6 weeks has improved and at 95.82% was the best performance in over 12 months. 52 week waits for treatment have not reduced in month for the first time since December 2021.

None covid related short term sickness is at its highest since January. Lot of work being done around Return to Work interviews which at its lowest position since December.

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

**202/22 RECOVERY UPDATE**

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

Currently delivering 103.1% of 2019/20 activity versus a plan of 102.9% for planned inpatient spells and 103.7% of 2019/20 activity versus a plan of 104.5% for Outpatient first attendances.

Some areas are overperforming against the planned 104% performance, but this needs to be maintained to support the areas that are not yet on plan. The main area exceeding plan are Medical Oncology and Chemotherapy who are reaching 120% of 2019/20 levels. The main area below plan is Gynaecology at 89% of 2019/20 levels. Key targets now need to be hit on a monthly basis.

CHFT is performing well in comparison with other organisations. Focussing extra effort on 52 week waits to mitigate the risk of breaching 78 week targets.

Each speciality has plans in place, and when CHFT is benchmarked against local trusts it is the only Trust reducing its waiting lists across all wait times.

ASI's – Internal target and no requirement to report centrally. Not seeing a reduction in overall numbers. Further work is being done including a lot of triage to transfer some back to GP's.

Cardiology and Gastroenterology ASI's. Waiting for paper for detailed plans. Will need further funding and external support which needs to be agreed.

Follow ups no great reduction.

Harm Review process and task and finish group created looking at clinical validation work.

Diagnostics lot more positive and at their highest level of performance for 12 months of 95.82%. ECHO, Neurophysiology and MRI have all improved following previous backlogs. MRI to be removed from future updates as they are now back on track.

The Committee **NOTED** the Recovery Update for October

**203/22 ONE CULTURE OF CARE (OCOC)**

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

**204/22 DRAFT MINUTES FROM SUB-COMMITTEES**

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

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

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

**205/22 WORKPLAN – 2022/23**

The workplan for 2022/23 was reviewed.

- Deep dives to be reviewed if any follow up is required – AN / JH
- The financial plan for 2023/24 needs to be brought to F&P. A planning update to be brought to the January meeting with more detail in February when the guidance has been issued.

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

**206/22 ANY OTHER BUSINESS**

Deep dives take a substantial amount of time and going forward the assumption will be that the presentation has been read and key highlights and questions will be covered in the meeting.

**207/22 MATTERS TO CASCADE TO BOARD**

The financial position remains challenging but has seen some improvement. Performance recovery positive although the scale of the backlogs on ASIs and Follow-Up Appointments remains a concern – will it lead to greater pressure on 52-week waits.

**DATE AND TIME OF NEXT MEETING:**

Tuesday 10th January 2023, 10:00 – 12.00 MS Teams

Calderdale and Huddersfield NHS Foundation Trust

# Minutes of the Finance & Performance Committee held on Tuesday 10th January 2023, 10.00am – 12.00noon Via Microsoft Teams

**PRESENT**

| | |
|---|---|
| Andy Nelson | Non-Executive Director (Chair) |
| Nigel Broadbent | Non-Executive Director |
| Kirsty Archer | Acting Director of Finance |

**IN ATTENDANCE**

| | |
|---|---|
| Andrea McCourt | Company Secretary |
| Rochelle Scargill | PA to Director of Finance (Minutes) |
| Brian Moore | Public Elected Governor |
| Robert Markless | Public Elected Governor |
| Peter Keogh | Assistant Director of Performance |
| Philippa Russell | Acting Deputy Director of Finance |
| Adam Matthews | Business Manager - HR |
| Jonathan Hammond | Acting Chief Operating Officer |
| Lisa Whiteley | HR Business Partner- Medicine |
| Stuart Baron | Associate Director of Finance |
| Rob Birkett | Managing Director, The Health Informatics Service |
| Anna Basford | Director of Transformation and Partnerships |
| Vicky Pickles | Director of Corporate Affairs |
| Maureen Overton | Lead Cancer Manager |

**ITEM**

**001/23 WELCOME AND INTRODUCTIONS**

The Chair welcomed attendees to the meeting.

**002/23 APOLOGIES FOR ABSENCE**

Apologies were received from, Gary Boothby

**003/23 DECLARATIONS OF INTEREST**

Stuart Baron registered his Declaration of Interest as a Director of CHS.

**004/23 MINUTES OF THE MEETING HELD 6th December 2022**

The minutes of the last meeting were approved as an accurate record.

**005/23 MATTERS ARISING**

**006/23 ACTION LOG**

The Action Log was reviewed as follows:

133/22 The minutes for all meetings have now been received and summary sheets have been requested from the administrators. Action to be closed. The Urgent Emergency Care Delivery Group is currently under review and will relaunch in February.

**007/23 TERMS OF REFERENCE**

AN, AM, KA and PR met to review the terms of reference. These had been updated and were brought to this meeting for approval.

The governance schedule has also been aligned.

**ACTION**: The workplan needs to be reviewed to match the ToR's.

The committee **APPROVED** the Terms of Reference

**008/23 CANCER DEEP DIVE**

AN has had discussions with Denise Sterling (chair of Quality Committee) and Karen Heaton (chair of Workforce Committee) and agreed this committee will take the lead on deep dives into specialities. In February there will be one on Elective Recovery and in March a follow-up review of the actions from the previous deep dives into Stroke and Neck of Femur.

The Lead Cancer Manager gave a presentation on the Trust cancer performance. Data presented was from October 2022. A comparison was shown between local Trusts all of which are struggling with screening. CHFT doing well in comparison. Where the tumour is sited can mean targets are harder to meet and therefore some have quicker pathways than others.

CHFT introduced the 28-day tracked target in 2019 but this became a national target from last year. This target is when a patient has to be told within 28days if they have cancer. Some tumour sites never meet this but most do. For example Lower GI is difficult to meet due to the diagnostics involved.

Treatment by day 31 target is achieved constantly, except for a dip in October 2021. Treatment by day 62 has consistently met target even during Covid but the Lead Cancer Manager emphasised the focus remains on patients and not targets.

CHFT does struggle to meet the 62day screening target although ot wasachieved last month. The numbers of patients that come through screening are low and the target is 90% unlike others which are at 85%. One breech and the target is not reached. The screening team are doing everything that it is possible to meet this target.

Best practice time pathways are national initiatives that have been brought in and look at how quickly each stage of the pathways are completed. For example: an ultrasound in Gynae should be completed by day 7. Conversations are taking place with all teams to find the best way to implement these. For example Radiology are looking into the possibility of being able to refer patients for CT directly instead of back to the GP for them to refer. All of this feeds into national outcomes but nothing specific to CHFT. AN asked if it was possible to have some overall outcome measures for Cancer. The Lead Cancer Manager made clear that the aim is to see and treat patients as soon as possible as research

shows this leads to better outcomes – hence the use and focus on the measures we have today. However, the Acting Chief Operating Officer agreed it would be worth looking at to see if some outcome measures could be developed.

CHFT is leading the way in Prehabilitation work. This is providing support when patients have just received the diagnosis. There is also a non-site specific team where patients can be referred when the diagnosis might not be a cancer. Working closely with GP's to highlight the services on offer. Not everyone can afford to travel to reach the GP or have a blood test.

NCPES – Is a national report around quality improvement and initiatives. Patients feedback on their experience but the survey responses are 18 months out of date once received. CHFT did not receive good feedback for providing long-term support. Work is being done to improve these areas.

Looking to the future – Currently for Dysphagia patients are referred straight to test. It may be possible to roll this out to other groups of patients who meet certain criteria. Succession planning has commenced as anumber of senior nurses are expected to retire in next few years.

A Cancer app is now available for patients to use. Created by the service improvement person. The average reading age for the region is 8-9 years old, in line with the UK as a whole,so the app contains lots of animation for patients so they can see what to expect.

**FINANCE & PERFORMANCE**

**009/23 INTEGRATED PERFORMANCE REVIEW – NOVEMBER 2022**

The Assistant Director of Performance gave an update.

November was a difficult month for performance due to pressures which are continuing in December. Very high numbers of patients are presenting at ED. It is fortunate that to date, this had not impacted the recovery programme which continues to perform well and we are still seeing excellent cancer performance.

Safe domain – Still performing well but continue to see patients with Category 4 pressure ulcers. Actions have been put in place to improve this.

Caring domain – Now seeing the impact of work carried out by colleagues around complaints with an improvement in month. Best performance in response to complaints since December 2021 and the number complaints closed is the highest number in over 12 months. Two of the five areas for the friends and family test are now meeting target. Dementia screening is still not improving.

Effective domain – Work to be done around HSMR/ SHMI, MRSA screening and Neck of Femur. Changing the way that HSMR and SHMI updates are issued to Trusts. Nationally CHFT is ranked 77$^{th}$ out of 123 so there is more work to be done. More work going on around specific diagnosis looking at coding.

Responsive domain – Overall Cancer targets are being reached. In month Cancer 31 Day Subsequent Surgery Treatment target was missed for the first time

since January. For stroke patients 3 out of 4 targets were missed in November. ED performance at 66.37% was the lowest monthly performance seen at CHFT which has also meant the highest number of 12 hour waits in the department. We are also continuing to see a small number of 12-hour trolley waits from Decision to Admit. Compared to others CHFT is in a relatively good position.

New planning guidance has been issued with the 4-hour target now set at 76% (down from 95%) and to be achieved by the end of 2023-24.

Percentage of Diagnostics seen within 6 Weeks has improved again and at 96.9% it was its best performance in over 12 months. Numbers waiting over 52 weeks for treatment continue to reduce as part of our Recovery Programme.

Workforce - Non covid absence, highest since December.

Recovery in general 104, 78 and 52 weeks in a good position. Respiratory medicine has seen a 47% increase in non-elective admissions since pre-Covid.

**ACTION**: PK to do an update on new targets against existing targets.

Ambulance wait times. Figures for CHFT quite good. Going forward we are moving to a different template for the IPR, examples of which were included in the papers for the meeting, which will use SPC charts and will include ambulance wait times.

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

**010/23 RECOVERY UPDATE**

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

Activity has increased in some areas and reduced in others. Plan is to review the action plans created in October. At the end of month 8 we are forecasting to deliver by year end 103.3% of 2019 activity for day cases and elective work and 105.6% for outpatients.

The Access Delivery Group is scheduled to meet next week and will review to see if that end-year forecast position can be improved to meet the overall 104% target. Doing well against the 104, 78, 52-week targets. Stretch target is to reach zero for 52-week waiters by the end of 2022/23 versus the national target is to reach zero by March 2025. CHFT is currently planning to have circa 1000 patients over 52weeks at the end of March 2023. Benchmarking against other Trusts CHFT compares very well, and are currently the only trust improving all time bands over 18 weeks.

Total ASI’s there is not as much movement as we would like although 22- week waits are seeing a reduction. Neurology have 133 patients on the 22-week list

whereas other specialities are around the 30 mark. Looking at weekend work and external support for neurology.

Diagnostics – We are now seeing improvements from the action plans put in place. MRI, ECHO and Neurophysiology are all improving, with the expectation they will be back on target by the end of March.

Included in the pack is a detailed medicine action plan. Surgery are working on doing the same. These will continue to be reviewed by speciality at the Access Delivery Group.

The Committee **NOTED** the Recovery Update for November

**011/23 MONTH 8 FINANCE REPORT (Including High Level Risks and Efficiency Performance)**

The Acting Deputy Director of Finance presented the Month 8 Finance Report.

Year to date the Trust is reporting a £14.99m deficit, a £1.78m adverse variance from plan. The in-month position is a deficit of £1.89m, a £0.02m adverse variance. The adverse variance is driven by inflationary pressures, the costs of opening additional capacity and the associated premium rate staffing costs, in particular the impact of the revised medical bank rates and high cost agency staff.

Some mitigation was deployed in Month 8 to reach this position. Note that the underlying run rate is still around a £3-£3.5m deficit per month.

Agency spend has bypassed the ceiling of £6.9m currently at £8.9m which was a variance from plan of £4.9m year to date. The bank premium in its previous form ended on 6th November which reduced bank spend in month to just an additional £0.02m. There is a new agreement with medical staffing which will incur additional cost.

Increased pay expenditure is also offset by some significant vacancies in maternity and community.

CIP slightly above plan year to date with £12.5m delivered and we are on track to achieve £20m. There was a £170k shortfall in month 8 shortfall but hoping this won't be an issue. Capital spend is significantly behind plan but still forecasting to achieve the full year plan.

Cash balance is £7.77m above plan at £50.5m primarliyl due to lower capital spend.

Aged debt increased in month 8 by £1.42m taking it to £4.68m versus a plan of £3m with the biggest movement around THIS SLA agreements related to the ICB. Some old invoices not paid and new ones not paid. Outside a block agreement. There is also an increase related to Calderdale council who are not paying in as timely a manner as they have previously.

Use of Resources score still at level 4 which is the worst position it can be driven by agency overspend and variance from the overall financial plan. Still forecasting to achieve level 3.

Forecasting to deliver the revised plan of £17.5m deficit. There are risks and potential benefits to deliver this.

- Forecast assumes achievement of the requirements for the Maternity Incentive Scheme for Trusts (CNST).
- Enhanced pay being agreed only on an exceptional basis.
- ICB as a whole planning to break even.
- Non pay inflation around £3.6m manly from PFI contracts and utilities, but now starting to see other inflationary pressures.
- The pay award created a funding gap. National insurance decision reversed.
- Additional capacity is forecast at £8.6m for full year. Includes ED and flow pressures.
- Huddersfield Pharmacy Specials has not delivered the planned surplus in the year to date and is forecasting an adverse variance of £1.57m.

Most of positive variances are non-recurrent. Some of negative ones are recurrent. Some challenges in current year will become a bigger challenge for next year.

The Committee **RECEIVED** the Month 8 Financial Update.

**012/23 2023 / 2024 FINANCIAL PLANNING**

The National planning guidance was issued on the Friday before Christmas. The timetable is compressed at both sides as we are awaiting allocations information from the ICB. Plans must be submitted to the ICB prior to national submission so will need to allow time for this extra stage.

The timetable was anticipated, and preparatory work had commenced prior to receiving the guidance. Board approval for the plan needs to be obtained before final submission at the end of March, but the board meeting is scheduled for early March so there may be a need to delegate approval authority for any final changes before submission to a sub-group of the Board. A near final/complete plan will be ready for board to review early March and prior to this F&P will have had the chance to review early versions of the plan at its meetings in February.

There are three key tasks:

- Recovering our core services and productivity
- Making progress in delivering the key ambitions in the long term plan
- Continue transforming the NHS for the future.

These have then been broken down into more specific KPI’s some of which have been covered elsewhere in the meeting.

Note - the target of financial balance is at a system/ICB level rather than an organisational level. Some organisations will need to plan for a surplus to level out those who are planning for a deficit.

Elective recovery funding – each Commissioner will be set an individual activity target as opposed to a blanket target for every organisation. Re-introduction of a payment by results scheme (cost per case) instead of block payments. More detail required to understand fully the impact of this change.

Planning guidance has some detail but the detail will be clearer once the system allocations are known. An NHS Payment Scheme (NHSPS) efficiency factor of 1.1% has been set but the overall efficiency requirement is expected to be higher but is to be achieved outside of NHSPS.

Likely to see some pressure against inflationary funding. Currently running higher than the figures within the guidance. The PFI for example is based on the retail price index. Funding will not specifically allow for this.

Commenced some work ahead of guidance to create a picture of the financial challenge. This year there was a reliance on non-recurrent solutions. An initial view of the challenge for 2023/24 is that we are forecasting to be circa £62m above break even.

This does not include new developments and will limit our ability to take on new developments. This figure assumes Elective Recovery Funding is equal to activity with no assumption of gain or loss until more information is available. Significant work will be required to mitigate this funding gap. The Use of Resources group has been replaced with a Turnaround Executive with a heightened level of focus on efficiency. Stretch targets have been set at for the 2023/24 CIP at £32m and split against individual portfolios. This still leaves a deficit based on initial figures.

Capital and Cash – Capital position is currently unknown until ICB have allocated. CHFT have some pre commitments to specific schemes such as the multi storey car park. Will wait for allocation before firming up any plans.

There appears to be a change in the guidance around cash with a new facility to allow for cash transfers between system partners. Some organisations have significant cash balances and others have deficits. Transfer would allow cash rich partners to transfer cash to the ICB to be reallocated to a trust who is struggling. CHFT are planning for a £20m cash balance at the beginning of the year, but with a deficit plan this would soon be consumed. More technical guidance expected this week and local decisions to be made.

The Committee **RECEIVED** the 2023 /2024 Financial planning information and noted the scale of the potential efficiency requirement.

**013/23 HUDDERSFIELD PHARMACY SPECIALS BOARD REPORT**

HPS Board report included within the papers. Two elements included, 2021 /2022 and current year. The report flagged financial challenges in the current year particular relating to wholesale activity and inflationary pressures.

Revised updated HPS Commercial strategy will be brought to this committee in February.

**014/23 ONE CULTURE OF CARE (OCOC)**

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

**015/23 DRAFT MINUTES FROM SUB-COMMITTEES**

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

- Access Delivery Group
- Business Case Approvals Group
- Capital Management Group
- CHFT / CHS Joint Liaison Committee
- THIS Executive Board
- Urgent and Emergency Care Group
- THIS Contract Review Meeting

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

**016/23 WORKPLAN – 2022/23**

The workplan for 2022/23 was reviewed.

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

**017/23 ANY OTHER BUSINESS**

None.

**018/23 MATTERS TO CASCADE TO BOARD**

Cancer review – Positive story. Learn from their success.

Performance – Challenging times but seeing improvements.

Finance – Continuation of previous months performance in terms of pressures and gains. More confident that the adverse variance can be closed by year end.

2023/24 Planning – Very early days but there is a risk with the degree of stretch in the plan.

**DATE AND TIME OF NEXT MEETING:**

Tuesday 7th February 2023, 9:30 – 12.00 MS Teams

Calderdale and Huddersfield NHS Foundation Trust

**Minutes of the Finance & Performance Committee held on Tuesday 7th February 2023, 09.30am – 12.00noon Via Microsoft Teams**

**PRESENT**

| | |
|---|---|
| Andy Nelson (AN) | Non-Executive Director (Chair) |
| Nigel Broadbent (NB) | Non-Executive Director |
| Gary Boothby (GB) | Director of Finance |

**IN ATTENDANCE**

| | |
|---|---|
| Kirsty Archer (KA) | Director of Finance |
| Andrea McCourt (AM) | Company Secretary |
| Rochelle Scargill (RS) | PA to Director of Finance (Minutes) |
| Brian Moore (BM) | Public Elected Governor |
| Robert Markless (RM) | Public Elected Governor |
| Peter Keogh (PK) | Assistant Director of Performance |
| Philippa Russell (PR) | Deputy Director of Finance |
| Adam,Matthews (AMa) | Business Manager - HR<br>Associate Director of Finance |
| Stuart Baron (SB) | Director of Operations – Surgery – Present for deep dive only. |
| Thomas,Strickland (TS) | |

**ITEM**

**019/23 WELCOME AND INTRODUCTIONS**

The Chair welcomed attendees to the meeting.

**020/23 APOLOGIES FOR ABSENCE**

Apologies were received from, Rob Aitchison, Jonathan Hammond, Vicky Pickles, Anna Basford, Rob Birkett.

**021/23 DECLARATIONS OF INTEREST**

Stuart Baron registered his Declaration of Interest as a Director of CHS.

**022/23 MINUTES OF THE MEETING HELD 10th January 2023**

AN to clarify what was suggested re regarding outcome measures post the cancer deep dive. Subject to this point (which was addressed after the meeting) the minutes of the last meeting were approved as an accurate record.

**023/23 MATTERS ARISING**

**024/23 ACTION LOG**

The Action Log was reviewed as follows:

007/22 The workplan has been updated in line with the changes to the Terms of Reference. Close the action.

**025/23 RECOVERY DEEP DIVE**

Presented by the Director of Operations for Surgery (TS), the key points to note were:

- CHFT continues to reduce the elective backlog faster than all the Trusts in WYAAT.
- Going beyond national targets in terms of 52 weeks and making good progress vs CHFT internal target. Working to reach zero, if possible, by 31st March 2023.
- Vacancies in theatres post Covid have been filled.
- Cancer targets, CHFT is the second-best performing trust in the country.
- CHFT has been chosen to be one of 8 trusts taking part in the national getting it right first time (GIRFT) surgical hub accreditation pilot.
- Regarding theatre activity and the measure capped utilisation CHFT reached 85% in December making it a top 10 performer nationally.
- Challenges on Appointment Slot Issues (ASI's), Follow-up backlogs and Harm review process, and in some specialities including Maxillofacial, Gastroenterology, Neurology, General and Colorectal Surgery. Within Ophthalmology there are currently medical vacancies.
- Making some good progress on validation with admin validation reducing the pressure on clinical validation. Developing a more effective harm review process
- As of December 2022 the Trust was achieving 103.5% against a national target of 104% for day case and inpatient. For outpatients we were achieving 105.3%.
- This performance has come at a cost which will need to be considered as part of the planning process for 2023/24.
- Referral to Treatment (RTT) - The national standard states that by the 31st March 2023 there will be zero 78 week waiters. These are being man managed at individual patient level to meet this target. 52 weeks are also reducing. Wait time is monitored from the patient being referred by their GP.
- Diagnostics have a national target of 99% of patients should have their diagnostic procedure within 6 weeks. MRI, CT and Endoscopy are around the target. Neurophysiology however are at 61%. Both Neurophysiology and Echocardiography had action plans in place but were impacted by specific issues over the Xmas period. Echocardiography is now back on target. Plans are in place to improve Neurophysiology performance.

AN questioned if there are extra actions in place to improve the areas that have been challenging this year to a point where they revert back to a more standard way of working. The internal targets are much tighter than the national ones. TS stated that the planning assumption for 23/24 is that a 40-week target will be implemented alongside a maximum 18 week wait for outpatients, but decisions will need to be made around balancing this with the financial pressures.

RM asked what the timescale is for the new community diagnostic centre (CDC) is and what the plan is for staffing it. GB said the plan is to have the CDC up and running by 2025 and funding has been awarded for this. This timeline allows time

for recruitment and working alongside the university. The idea is to have services located in areas where people are not accessing them. SB currently exploring the possibility of putting some interim capacity arrangements in place before 2025.

**FINANCE & PERFORMANCE**

**026/23 INTEGRATED PERFORMANCE REVIEW – DECEMBER 2022**

The Assistant Director of Performance (PK) gave an update. The key points to note were:

- December was a very challenging month in ED particularly the three weeks around the 10th.
- Patients were very unwell which contributed to the acuity of the patients and impacted length of stay.
- Moved to OPEL 4 at the end of December along with all West Yorkshire acute trusts. This did not prevent CHFT from treating clinically urgent patients.
- Ambulance handovers were better in CHFT than some other areas. This was due in part to a significant number of actions put in place at Place level which were used to manage demand. A full list of these actions are available within the report.
- All cancer targets were achieved in December despite the operational pressures.
- Peaks were seen in 12,10 and 8 hour emergency department waits which led to a small number of 12 hour trolley waits. These were kept to a minimum. We have also had a mixed sex breach, another MRSA outbreak and seen our 4th Never Event of the financial year.
- Non-Covid staff sickness both long and short term peaked in December which resulted in more bank and agency staff being used.
- There are still a number of areas where we have action plans in place and are yet to see some traction in terms of performance improvement including stroke, neck of femur and dementia screening.
- December also saw a peak in the number of non-Covid deaths and crude mortality reflecting the acuity of the patients presenting at CHFT. There is a deep-dive planned to look at mortality within the Trust including (Summary Hospital Level Mortality Indicator (SHMI) and Hospital Standardised mortality Ratios (HSMR) although we did see an improvement in the 12-month position for HSMR to October.
- Significant work has gone into improving our Complaints system and yet again we have seen this come to fruition with our best performance in responding to complaints within timeline since November 2021.
- Currently in the middle of the annual planning process for 2023/24. Will be confirming some of the targets covered in the deep dive.

NB noted the good news on theatres and surgery. Within the meeting pack, it is shown that for elective surgery there has been a dip in the number of theatre sessions completed. PK responded that during the Christmas period elective work is at a minimum. This is a seasonal fluctuation.

RM asked if mortality rates are in line with national figures? PK – SHMI has been on a gradual increase since covid, comparatively to other organisations we have been in a worse position. For IMD 1's and 2's(Indices of multiple deprivation) we are an outlier. More work needs to be done to understand the reasons why better. There are 20-25% more sicker patients post Covid particularly in respiratory.

AN commented that he has spoken to Denise Sterling regarding the Quality Committee looking at mortality rates and the results of the deep dive – this is something there are planning to do. A follow up deep dive is due next month at this committee on Neck of Femur

AN asked AMa if sickness levels have increased and all the pressures within the Trust, how is this being reflected in staff wellbeing? AMa responded that there are hotspots for stress, anxiety and depression. The wellbeing team have gone out to those areas and offered support. Availability of staff is showing an improvement at the end of January and beginning of February.

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

**027/23 MONTH 9 FINANCE REPORT (Including High Level Risks and Efficiency Performance)**

The Deputy Director of Finance presented the Month 9 Finance Report.

Year to date position at month 9, the Trust is reporting an 18.06m deficit which is a £2.8m adverse variance from plan. The in-month position is a deficit of £3.07m, a £1m adverse variance. These figures are a result of operational pressures in month 9 plus inflationary and agency costs which increased in month due to working at OPEL 4 status and all available surge capacity being open. Agency spend reached over £1m in month and year to date is now reached over £10m which is an adverse variance of £5.4m. Month 9 saw a reduction in bank costs following the decisions made around enhanced bank rates. There are still a number of vacancies in some areas particularly Community and Maternity which is partially offsetting the pressures and recovery costs. There have been lower than planned pay costs in elective recovery but outsourcing in elective recovery has increased.

CIP is still on track with £14.17m of savings delivered year to date which is a favourable variance of £400k. On track to deliver the full £20m CIP with a small gap to close before year end. Use of Resources (UoR) at level 4 which is the lowest level. Two metrics are off track, agency spend and the fact that we are off plan. Neither of these two things are going to change until month 12 when we are expected to be back on track in terms of financial plan which will lead to a UoR score of 3.

Still forecasting a £17.4m deficit as planned. At the point of reporting a worsening in the divisional forecast position was seen as the in month position was worse than expected. At that point there was a gap of £2.7m unidentified mitigation, but month 10 appears to have been less pressured and some of the gap has closed. The gap is now expected to be nearer £1-1.5m maximum. Some non-recurrent support has been received from one of our system partners.

There has been a reduction in the Capital forecast which is now down to £34.5m which is £7.5m lower than planned. The biggest change is in the reconfiguration forecast which is now forecast to be £9.9m lower than planned. This has been offset by some additional funding for diagnostic, digital capability funding and frontline digitisation.

Cash was at £27.2m which is slightly above plan. The reduction on previous months is because of the faster closedown process which meant that the reporting is completed before payroll goes out of the system. In months 9 and 12 a full accounting process takes place so the closedown is later, the difference is due to timing. The ICB has moved to paying CHFT on the 1st of the month which is beneficial as it will enable us to pay less in PDC dividend.

Aged debt has increased in month to £5.3m. The majority is within THIS and relates to ICB invoices, which were delayed, so this is not considered high risk.

NB asked if there is a level of confidence that the agency costs will decline over the remainder of the year as forecasted. Secondly is there a level of confidence that the capital allocation will have been spent before year end.

PR – Regarding agency spend, there is little confidence that the forecast will come to fruition. However, as divisions have been optimistic on the amount of recruitment they intended to do this will hopefully offset the agency costs and not massively impact the bottom line overall. KA commented that the CHFT target for agency spend was low based on previous good performance. Currently, while our agency spend target has been exceeded, we are in a very comparable position with similar sized organisations.

SB – The report covers month 9 but since we are currently in month 10 the capital forecast is already reducing. Reconfiguration will reduce by a further £1m as a result of the delays in terms of approval. The CDC spend of £3m that was forecast has been pushed back. A significant amount of spend on new HRI Emergency Department is imminent. Currently in the process of man marking each capital scheme to follow up that orders are in place for every line item. This is giving assurance that we will spend to latest forecast. Some of the additional monies for additional schemes have been released very late in the year which has not helped with forward planning.

RM asked where we are we up to with treasury approval for the reconfiguration? Approval has not been received as yet. Everyone is aware of the impact of the delay which will mean the end of the programme is delayed.

AN asked why the pay expenditure is set so low in month 12. This is the assumption around the annual leave accrual. Part of the plan was that

colleagues have been taking more annual leave this year to use up their excess that has been carried over due to Covid. The full detail of this will not be available until month 12.

GB stated that one of the risks on the BAF relates to achieving the 22/23 financial plan. This has been given a score of 20. As the year is coming to an end there is confidence that the score on this can now be reduced to 15/16.

The Committee agreed the score can now be reduced.

The Committee **RECEIVED** the Month 8 Financial Update.

**028/23 REVIEW TREASURY MANAGEMENT**

Most of the current treasury information is included in the month 9 report. A complete report will return to this meeting once the planning for 2023/24 has been completed.

**ACTION**: Report for the end of April

**029/23 TURNAROUND EXECUTIVE**

Majority already covered. Plan to achieve £20m CIP. This consists of a significant amount of non-recurrent savings.

**030/23 2023 / 2024 FINANCIAL PLANNING**

Slides were shared by KA at the meeting due to the tight planning deadlines. A detailed review of divisional plans for 23/4 has taken place through the Divisional Performance Review Meetings. That information has been collated into this presentation and underpins the current draft 23/4 plan.

An informal submission to the ICB had taken place this week with a full draft submission to the ICB due on the 15th February. The draft plan will then be submitted to NHSE on the 23rd February. This leaves a very short window between the submission on the 23rd, the next meeting of this committee on the 28th and the following board meeting on the 2nd March. Dependent on any feedback from the ICB, it may be necessary to request board approval outside of the board timetable, closer to the late March deadline for the final plan to NHSE.

**ACTION**: Update on timetable and approval schedule at next meeting.

The financial plan and the operational plan are interlinked as the operational assumptions affect the financial planning. Key points to note against National targets:

- Bed occupancy is to be reduced to 92% or below – CHFT are currently at 98-99%. In order to reduce to 92% we would be required to increase our bed base by 29 beds. This would be a challenge from both a financial point of view and workforce. The plan is to perform better on other metrics, such as length of stay, and achieve 96% bed occupancy

- Electives – performance has been strong this year. The current trajectory is to have minimal waits over 52 weeks by the end of March. The National target is to have no waiters over 65 weeks by March 2024. Our plan assumes no waits over 40 weeks
- The recovery target which was set at 104% of 19/20 performance for this year, has been set at 108% for the ICB. CHFT is currently modelling at less than 108% but delivering no waits over 40 weeks. Target to be confirmed but may have a bearing on any recovery funding if 108% is not achieved.
- Plan to achieve Cancer and diagnostics targets based on the strong performance seen this year.
- Draft plan to be submitted will be a deficit plan which is against the national target to deliver a balanced plan. Other trusts in West Yorkshire are having similar challenges.

Non-elective activity has been modelled on the current run rate of around 98% occupancy with an average of 95 transfer of care patients in beds. The plan does not assume extra beds to achieve the target. Currently there is no bed capacity funding available for next year. The plan does allow for the same level of beds seen this year to continue into next year. The extra bed capacity comes at a cost of £10.8m before seeking to address through efficiencies. There will be a focussed programme to target efficiencies through the Turnaround Executive.

Elective activity – Overall target for ICB of 108% of pre covid levels however, chemotherapy will not be measured as part of the recovery unlike this year. Instead, chemotherapy cases will be paid on a cost per case basis outside of these percentage targets. Other changes to the way procedures are measured and coded mean that instead of the 103.4% performance we are planning for, 100.5% would be the plan.

Financial plan – Elective Recovery Funding (ERF) will be different to this year. Nationally each commissioner will be set an individual activity target. Providers will be paid on a level of activity delivery. Further work to be done to understand the detail around this. The ICB have submitted a proposal for them to take a different approach on the national plan and use the funding in a more targeted way around waiting time targets. No response as yet from NHSE on this.

The NHS's overall efficiency requirement will be higher, to be achieved through measures outside of the NHS Payment Scheme and allocative efficiency / productivity gains:

- Covid-19 funding for ICB reduced by c.90%
- ICB Convergence adjustment -0.71%, plus potential for further local adjustment.

At the draft submission stage, the ICB have asked for plans to be submitted excluding elective recovery, growth, covid and bed capacity funding. Therefore, there are some significant areas of expenditure not currently covered by funding.

Growth funding is a risk as there is no guarantee that funding will be allocated in full.

**ACTION**: Slides to be shared after the meeting – complete.

All of this leaves CHFT with a proposed deficit plan of £43m after achieving a £25m proposed efficiency target (CIP). Due to the funding streams, such as elective recovery, from the ICB being unconfirmed, a further £25m will need to be deducted which would leave a proposed deficit of £68m.

Capital and Cash - Working on an allocation of £16.2m which would be the CHFT “fair share” of the ICB funding. This would bring the total capital plan to just below £32m. From this some projects have been pre-committed.

Cash is forecast to have an opening balance of £20m. The current planned deficit position will affect this and currently exceeds £20m. This would result in a requirement for additional funding from the Public Dividend Capital which is non-repayable but would incur an annual interest charge of 3.5%.

Recommendations to this committee is for approval of the draft plan for submission, noting our position against performance targets, the challenging efficiency requirement, and the residual deficit position. Consider the timing implications mentioned previously for the final submission.

NB – Asked for clarification of the bed base plan for next year? KA stated that in the plan it has been assumed a continuation of the average beds seen this year including a seasonal allowance. The Turnaround Executive will look at the bigger picture which may or may not result in a reduction of beds.

NB – Risk on ERF in plan based on ERF activity. What are the risks to CHFT if the ICB decide to remove funding due to not reaching 108% target? KA stated that conversations still to be had, but CHFT are unable to deliver 108% as we do not have the volume of patients to achieve 108%. Questions may be around why should CHFT have funding to reduce to waits to 40 weeks when others haven’t yet reached 52 weeks.

PK – Diagnostics are heading toward 99% and have reached this target in most areas. The plan is suggesting reducing the target to 95%. So far there has not been a conversation around the change of performance. Do we intend to continue as are with a target of 99% and the known costs associated with achieving this? GB stated the ICB so far have focussed on financial performance and not overall performance. Ideally, CHFT would not want to reduce our performance but discussions may need to take place if performance can be maintained financially.

AN commented that it was helpful to see what had driven the performance this year. What is being assumed for next year around Covid, flu levels etc. It would be useful to see these assumptions in future plan submissions and when talking about extra activity versus extra capacity to know what this means. PR responded that additional capacity talks about the bed base. Additional beds opened or extra ED requirements to support an increased number of patients.

Activity is where certain specialities are doing more. More to do with the volume of patients rather than beds.

With the high CIP target it is difficult to know which areas to target until some of the funding decisions are clearer. The vacancy factor also needs more work.

**ACTION**: Approval of final plan and deadlines to be discussed at board.

The Committee **APPROVED** the 2023 /2024 draft financial plan and noted the scale of the potential efficiency requirement.

**031/23 BAF Risks**

The Company secretary explained that this is the third and final update of the BAF risks for this year. All of the risks for review by this committee have been updated by the directors.

Risk 5/20 is due to be audited as part of the testing of the Board Assurance Framework (BAF).

Performance risk 5/20 and 8/19, the thought is that these two are converging. In the next financial year, in line with new guidance, they will be combined into one risk.

Recovery and long term financial sustainability risks remain at a score of 16.

7/19 compliance with NHS England. This risk has been left on the BA register but will be reviewed in the new year when the new targets are available. 2023/24 will there be different targets.

AN - Commercial one risk. Leave the score as is. HPS are not hitting their targets but performance in THIS and CHS are performing better.

AN – Long term financial sustainability is a score of 16 still correct? KA responded that it used to be higher. It was reduced when we reached a stage of approval for the reconfiguration business case. Status remains so reasonable to leave the score as is. Once the wider context for next year is understood look at this one again.

**ACTION**: AM to take ensure key points from this discussion are presented to Board

The Committee **APPROVED** the changes to the BAF risks.

**032/23 ONE CULTURE OF CARE (OCOC)**

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

**033/23 DRAFT MINUTES FROM SUB-COMMITTEES**

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

- Access Delivery Group
- Business Case Approvals Group
- Capital Management Group

The Chair sent an email to the chairs of the sub committees asking for consistency on how the cover sheets are put together. Capital Planning Group and Capital Management Group are used interchangeably. Capital Management Group is the correct name. On Capital AN requested that a review of the capital plan and how it has been spent is presented to F&P at a future meeting.

**ACTION:** review of 2023/24 capital to come to a future F&P meeting

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

**034/23 WORKPLAN – 2022/23**

The workplan for 2022/23 was reviewed.

The layout has been updated to separate out the different areas or review and assurance the committee undertakes.

**ACTION**: More time on the next agenda for the 23/24 plan

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

**035/23 ANY OTHER BUSINESS**

None.

**036/23 MATTERS TO CASCADE TO BOARD**

- Despite operational pressures performance remaining strong in most areas
- Elective recovery on track to meet or exceed all national targets
- On track to deliver this year's financial plan
- The financial plan for 2023/4 is very challenging with a projected deficit plan of £43m

**DATE AND TIME OF NEXT MEETING:**

Tuesday 28th February 2023, 9:30 – 12.00 MS Teams

Calderdale and Huddersfield NHS Foundation Trust

**Minutes of the Finance & Performance Committee held on Tuesday 28th February 2023, 10.00am – 12.00noon Via Microsoft Teams**

**PRESENT**

| | |
|---|---|
| Andy Nelson (AN) | Non-Executive Director (Chair) |
| Nigel Broadbent (NB) | Non-Executive Director |
| Kirsty Archer (KA) | Director of Finance |

**IN ATTENDANCE**

| | |
|---|---|
| Andrea McCourt (AM) | Company Secretary |
| Rochelle Scargill (RS) | PA to Director of Finance (Minutes) |
| Brian Moore (BM) | Public Elected Governor |
| Robert Markless (RM) | Public Elected Governor |
| Peter Keogh (PK) | Assistant Director of Performance |
| Philippa Russell (PR) | Deputy Director of Finance |
| Adam Matthews (AMa) | Business Manager - HR |
| Thomas Strickland (TS) | Director of Operations – Surgery – Present for deep dive only. |
| Christopher Roberts (CR) | Deputy Director of Operations - Medicine |
| Rob Aitchison (RA) | Deputy Chief Executive |
| Vicky Pickles (VP) | Director of Corporate Affairs |
| Helen Rees (HR) | Director of Operations - Medicine |
| Rob Birkett (RB) | Managing Director of Digital Health |

**ITEM**

**037/23 WELCOME AND INTRODUCTIONS**

The Chair welcomed attendees to the meeting.

**038/23 APOLOGIES FOR ABSENCE**

Apologies were received from, Anna Basford and Gary Boothby.

**039/23 DECLARATIONS OF INTEREST**

**040/23 MINUTES OF THE MEETING HELD 7th February 2023**

The minutes were approved as an accurate record.

**041/23 MATTERS ARISING**

**042/23 ACTION LOG**

The Action Log was reviewed as follows:

190/21 and 126/22 IPR – Timeline for the new format IPR is in place and the format has been agreed. The format has received positive feedback and is largely based on the report used by Leeds Trust. THIS have been particularly helpful in producing the data for the new format as the data required has proved more challenging to access. The plan is to complete the draft IPR by 10th March, share it with the Executives and Non-Executives and go live in April. The first report in the new

format will be at the May meeting showing April data. "Making data count" training sessions are running in support. The next sessions are for Executives and Non-Executives. Training has also been planned for the governors further down the line.

009/23 IPR compare targets – This will be done as part of the new IPR looking at the oversight and planning guidance for 2023/24. Close Action.

030/23 2023/2024 Financial Planning – Update on the timetable is on the agenda. Close Action.

030/23 2023/2024 Financial Planning – Approval of final plan and deadlines from board discussion included on the agenda. Close Action.

034/23 Workplan – Bring to next meeting at beginning of April as a full workplan for 2023/24.

**043/23 STROKE DEEP DIVE – FOLLOW UP**

The Medical Deputy Director of Operations covered the key points from the stroke deep dive. The full deep dive was shared with the committee in October 2022.

- There was a downwards trend in performance during 2021/22. This was due in part to Covid but also staffing challenges.
- The most recent SSNAP performance is from January 2023. The majority of the performance charts are moving in the right direction.
- There was a recap of the actions and key challenges for the Stroke service as presented in October 2022.
- The SSNAP position for the 1st and 2nd quarter of 2022 were presented to show the direction of travel. The 3rd quarter results have not yet been published. The overall SSNAP score has shown improvement from a rating of C in the 1st quarter to a rating of B in the 2nd.
- Multidisciplinary team working has also improved from C to B but there is still a challenge with therapy staff with a 40% vacancy rate currently. Changes to ways of working have made a significant impact.
- There has been an increased demand on the stroke service with a 42% increase presenting compared with figures prior to covid. January 2023 saw the highest number of ED attendances for stroke at 184, which when compared to 2018 data shows an increase of 70 per month.
- Increased length of stay is gradually coming down. Additional workforce in the form of ACP's leading on ward 7D is having a significant impact. Also managed to reinforce the stroke medical workforce. Jan 22 – Mar 22 started to reduce the length of stay despite the numbers presenting at ED. Recently opened 7A to reduce bed pressures which has also contributed to this improvement, along with additional work in the community.
- The increased numbers attending are diluting the improvements made.
- Summary of challenges, the biggest challenge is managing the acute demand. Work continues to try to recruit suitable candidates. A registrar has

been recruited which will enable us to build the workforce and plan for retirements in one years' time.

- Actions completed – The vacancy rate in stroke consultants made it difficult to achieve the SSNAP targets. We have now managed to recruit so reach 5 stroke consultants however some of these are locum posts.
- With the support of radiology a deep dive has taken place looking at where we were failing to complete CT scans within one hour. Two easy fixes that came out of that were, when the CT scans are requested, they are not being identified as potential stroke. This has now been addressed. The second fix is that physically transferring patients from ED to the CT scanner was incurring delays. This is being flagged.
- A nurse consultant job description is currently going through a matching panel.
- Fully recruited to the thrombolysis team to safeguard and improve resilience of timely access 7days / week.
- Recruited a registrar to ensure succession planning.

HR commented that the service had been able to provide a better response with the extra bed base on ward 7A. a lot of work has been done around modernising the workforce and how we can work differently. Currently working with Community around what the community bed base will look with an aim of reducing length of stay.

JH Mentioned that work was being done to put a business case together, that looked at the whole pathway. The overall case became very expensive to put a stoke hub in at the same time as enhancing the stroke department. Discussions have taken place and Michael Folan is bringing the case to be reviewed alongside other cases at Business Case Approvals Group. Medicine and Community to work together on KPI's.All must be triangulated so that the information is clear in the case. Actions have been put in place which have improved the service, including an improved therapy provision. To be noted that there are still challenges around speech therapy.

Discussion was held with the Committee on the content of the deep dive report.

**044/23 NECK OF FEMUR DEEP DIVE – FOLLOW UP**

The key points presented by the Director of Operations for Surgery were: -

- Jane Peacock attended this committee last year and presented an update on the Neck of Femur (NoF). The key issue was around patients access to theatres within the 36 hour standard and the action plan that was put in place, which included putting a new Trauma only Consultant post in place.
- The Consultant Trauma post was self-funded within division and as part of the business case, very clear KPI's were requested. One of these was to improve the 36 hour standard.
- The performance against the target is not yet consistently above 70% with full year performance in 2022 of 60.64% for 2022 compared to 57.03% in 2021.
- Continue to see an increase year on year on the number of admissions with NoF or Fractures where the best practice tariff applies, with an increase in the number of admissions of around 33% since 2019.

- Mortality is positive with a reduction to 5.5% which means CHFT remain below the national average and has one of the best performances in the region.
- 36 hours standard – whilst this improved in 2022 to just over 60% from 57% in 2021 that is not where we were intending to be. The target was set at 70% with a stretch of 85%.
- In the presentation last year there was reference to investigating the possibility of creating a fracture liaison service (FLS) which is in place with some other trusts. The fracture liaison service is the gold standard for DXA scanning for osteoporosis which can highlight the risk of NoF. However, the cost of this is £1m.
- Conversations with directorate colleagues revolve around increased demand and the need for more staff and theatre capacity. While this would help, conversations within division have been very clear that there is a need to look at other things. Agreed to re-orientate our approach and not just focus on more theatre capacity.
- Agreed as a division to set up a trauma improvement programme commencing March 2023 to look at improving performance. There are a number of workstreams which will look at plans to reduce length of stay. Will also look at theatre utilisation and improving productivity.
- Over the next three months, three “Go Sees” have been arranged to visit other trusts that have been having more success. What are they doing that CHFT can learn from?

AN asked how do we benchmark against others? What does good look like? Is there a national target.

TS The CHFT target is 70-85%. There is no national standard.

AN Are staffing levels a problem?

TS More capacity would be useful, but the go sees are about facts. Will be looking at other factors than capacity.

NB questioned if the “Go See” visits include a mixture of those who have a fracture liaison service and those who don’t to see if it makes a difference?

TS Approximately 50% of services have a fracture liaison service. For the “Go see” visits the preference is that they don’t have an FLS as that will been seen as the solution.

JH FLS would be a System commissioning discussion not just CHFT, and we would expect to see a reduction in NoF. It is worthwhile seeing what others do with the resources available then see what can be used within CHFT. Explore all other options then revisit LFS if required.

**FINANCE & PERFORMANCE**

**045/23 MONTH 10 FINANCE REPORT (Including High Level Risks and Efficiency Performance)**

The Deputy Director of Finance presented the Month 10 Finance Report

Key points

- Year to date the Trust is reporting a deficit of £20.4m which is a £3.48m adverse variance from plan. The in month position is a £2.33 deficit in month 10 which is a adverse variance of £0.69m.
- A lot of operational pressures at the beginning of January and remained at OPEL 4 for a number of weeks in month 10 which resulted in some high levels of bank and agency pay.
- Agency spend year to date is £11.73m which is £6.12m higher than planned. The ICB set the Trusts agency expenditure at £6.9m for the full year. We aer still seeing a continued high level of nursing agency.
- Overall pay costs had a underlying variance of £600k in month. This is despite recovery costs being below plan and vacancy factors in FSS and Community etc still high.
- There was a slight improvement in non-pay spend in Month 10 following a spike December however, it is still above plan. There are some significant inflationary pressures which are having an impact.
- On track to deliver CIP with £15.97m delivered year to date. This is heavily reliant on non-recurrent benefits.
- Capital – year to date we have delivered £13.8m of our £33.4m plan. The forecast plan has now changed to deliver £30.6m this is due in part to slippage in reconfiguration plans.
- Cash on track with a £40.8m balance at the end of the month which was higher than planned but is linked to the capital underspend.
- Aged debt currently above the target but this is in relation to THIS system contracts so is deemed low risk.

A waterfall diagram showing the forecast variances was shared.

- Items which are driving the variances from a negative perspective include, Non-pay inflation which is now over £6m. Additional capacity is over £7m, though now the approach has been changed some of the pay enhancements have reduced. HPS is an ongoing pressure. Most will continue into the new financial year.
- Items with a positive variance include a lot of non-recurrent mitigation. Bed capacity funding received this year has not been confirmed for next year. Additional funding has been secured from the ICB. Elective recovery costs are lower than planned. This has also been reflected in the plan for 2023/24. Technical benefits are £1m less than expected following receipt of a full valuation, which adds some risk to month 12. The level of vacancy has reduced since the beginning of the year.

KA The aged debt referenced above, related in part to Bradford Place. This has been escalated and has been resolved. The delay related to a misunderstanding as to what was billed outside the block.

RB Notes that support from KA and GB has been important in resolving some of the aged debt.

AN Is there confidence that Capital will reach the forecast plan by the end of March?

PR A verbal update this week has state that in month capital spend was £5m. The normal spend is around the £1m mark. So progress is being made.

AN The finance report and the IPR are showing different figures for agency spend.

PR This is more than likely a typo. IPS shows £17.73m which should read £11.73m.

**ACTION:** AM asked to raise with Mark Bushby.

The Committee **RECEIVED** the Month 10 financial report.

**046/23 TURNAROUND EXECUTIVE**

Most of the detail covered in the financial report. TE are still monitoring this year's CIP but the focus is now the identification of schemes for the new year.

**047/23 2023 / 2024 FINANCIAL PLANNING**

Slides were shared by KA at the meeting. Key points to note;

- Crucial decisions are still awaited so there are minimal changes on the presentation from last month.
- Operational and financial assumptions remain the same.
- Governance and sign off process – It was hoped sign off would be possible at Board this week but the funding information has still not come through so an additional exceptional meeting has been arranged towards the end of March for sign off. This will allow the maximum time possible to achieve the most developed plan.
- There has been an addition to the planning timetable which now includes a deep dive session from the ICB. An additional slide in the pack which shows the overall ICB financial position. All the Places are currently presenting a deficit position. Each Place is being challenged and the CHFT session is scheduled for tomorrow as part of the Kirklees Place.
- Still awaiting further information on funding from the ICB. It is not clear how some funding streams will be allocated. There are some conversations around growth funding and what the levels of allocation will be. There is a challenge from providers that the funding needs to flow.
- There is a national change to elective recovery funding. The West Yorkshire ICB has submitted a counter proposal to focus more on waiting times as the key measure of performance as opposed to volumes and to fix the funding on that basis. The feedback to this seems to be positive with the possibility of the West Yorkshire ICB and one other ICB trialling this.
  For CHFT this would be a positive as it would lead to funding being allocated. An agreed wait target would most likely a positive as would get funding. Currently CHFT is assuming a reduction to a 40 week wait but the national target is 65 weeks.
- Capital plan was previously described as £30.9m plan but is now £37.1m due to the inclusion of leases which ow have to be included in Capital to comply

with the IFRS standard. Capital allocation is in excess of what current plans would require so conversations are ongoing with both Place and ICB.
- Cash as described last month as plans currently stand, CHFT would require cash support next year. Again conversations are taking place with the ICB.

AM asked if prior to the meeting to the 28th March if any delegation was required from next week's board meeting for the annual plan sign off

KA / AN To provide clarity this will need to be arranged.

NB asked what the ICB deep dive were expected to challenge CHFT on.

KA The email invite talks about clarity on additional investment, consistency checking, assurance, and an opportunity to highlight opportunities where support is required. Brendan has suggested using the opportunity to ask for more clarity and pace around funding decisions.

NB How fixed is the agency plan mentioned on one of the slides? Currently suggesting £1.5m less than has been spent in this financial year. Would this affect CIP for example?

PR The plan is to stick to the 3.7% target given which seems reasonable. Plans need to be put in place to achieved this. There are also some specific CIP plans to reduce Tier 3 agency spend. This year's costs have been driven by price rather than just volume. Working through a strategy including negotiating with the agencies.

The Committee **NOTED** the Financial Planning update

**048/23 INTEGRATED PERFORMANCE REVIEW – JANUARY 2023**

The Assistant Director of Performance (PK) gave an update. The key points to note were:

- January saw an improvement in emergency pressures with less attendances at both EDs resulting in better 4-hour performance, shorter ambulance handovers, less patients spending over 12 hours in ED and smaller numbers of 12-hour trolley waits.
- We must achieve the 76% target for ED 4-hour performance by March 2024. We have not achieved this since 2021 in any month. Starting to see more pressures in February and attendances have increased.
- Ambulance waits during early December were up with 30 over 60 minutes at HRI and 21 waits over 60 minutes at CRH. In January this was reduced to 1 at CRH and 1 at HRI.
- Bed occupancy is still high at 98%. The bed base was reduced in January.
- Unusually three cancer targets were missed. 28 day faster diagnosis, 31 day subsequent surgery and 62 day referral from screening to treatment. Regularly have good results but still have some tumour sites that struggle to meet them. Ongoing work with those specialities.
- Another never event in January.
- Dementia screening has an action plan in place which is a work in progress

- HSMR decreased in November to below 100 for the first time in over 12 months. HSMR and SHIMI work on going.
- Following significant work, 94% of complaints were responded to in January. Which is the best performance in a number of years.

JH Decision has been made operationally in planning for 2023/24 not to aim for the recommended bed plan of 92% CHFT going for a more realistic 96% but there is work to be done around patient flow and length of stay to get to that point. Today there are 145 transfer of care patients which is double what the target was. There has not been less than 120 for last 10 days.

VP Two challenges in regards to complaints, maintain existing performance and learning from the complaints. Have looked at the themes of the complaints which are very broad. There is a need to look at the detail which is currently underway.

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

**049/23 RECOVERY UPDATE**

The Assistant Director of Performance (PK) gave an update. The key points to note were:

- Reiterate the excellent work that has been done in the organisation to get to the current position on waitlists, which is better than our peers.
- 104 waits currently have zero. One patient currently at 103 weeks but has a date to attend.
- RTT 78 weeks are now at minimal numbers. ENT have the most with 9 patients.
- RTT 52 weeks internal target to reach zero by March 2023. Consistently reducing and will achieve target in most specialities. Planning to reduce to below 40 weeks next year.
- Outpatients ASI's small reduction overall. Three main specialities now have patients waiting over 22 weeks.
- The main concern is around follow-ups. The harm review process will be in place moving forward. These are covered as a regular agenda item at PRM's and the access delivery group.
- Diagnostics - Echocardiography and neurophysiology have had a dip in performance but plans are in place and confident they will be back on track.
- Overall excellent position with some concern over follow ups.

AN Commented that overall, it was a good news story in terms of what has been achieved. The positive result is due several different actions.

PK Excellent data has been provided from THIS that is shown in all meetings.

JH Follow ups are challenging. ASI's are also challenging. The closer we can get to the waiting times seen pre Covid, it will allow us to reassess new patient and follow up appointments. There have been some good conversations around transformation work which will help to manage our patients differently. The outpatient transformation group is relaunching in the new financial year which will draw in the GIRFT recommendations.

The Committee **NOTED** the Recovery update

**050/23 HPS COMMERCIAL STRATEGY**

The Deputy Chief Executive as Chair of the HPS Board, highlighted the points of note:

- The plan for 2022/23 was for HPS to make a £2.9m contribution.
- HPS have ceased wholesaling within this year which has impacted the amount of contribution.
- The commercial strategy reflects a decrease in contribution of under £1m.
- Ongoing risks which could affect the contribution, include a drug which could become licensed which would prevent HPS from manufacturing it. This is a £300k contribution risk on a single product.
- Aged debt - £780k over 60 days from a wholesale customer. Speaking to the customer involved.
- From the commercial strategy are two main streams of business the manufacture of specials medicines and repacking and labelling of tablets. Considerable time is being dedicated to developing products that HPS can licence and therefore become the exclusive manufacturer of.
- Conversations taking place at HPS board around Investment versus payoff. Further development plan for 2033/24. Any business cases which are submitted must be rigorous. There is a need to balance risk and opportunity.

KA To be noted that there is a planned reduction in contribution from this year to next year, but that follows a reduction in contribution from last year to this year. Overall reduction is important to note since overall compared to pre-pandemic there has been an overall reduction in contribution of over £2m.

VP Asked that since HPS is not the only NHS pharmacy manufacturing unit, would it be possible for them to perform “Go sees” and visit other units?

The Committee **RECEIVED** the HPS Commercial Strategy.

**051/23 DRAFT MINUTES FROM SUB-COMMITTEES**

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

- Access Delivery Group
- Business Case Approvals Group – The group will not be approving cases at this time. They will be picked up as part of the broader planning. Developments on the table current at £11-£12m but only £2m has been set aside as a contingency.
- Capital Management Group – Asked for end of year review at the May meeting.
- Cash Committee

- CHFT / SPC Quarterly Meeting

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

**052/23 WORKPLAN – 2022/23**

The workplan for 2022/23 was reviewed.

Work through and bring an updated version for 2023/24 to the next F&P meeting.

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

**053/23 ANY OTHER BUSINESS**
None.

**054/23 MATTERS TO CASCADE TO BOARD inc. ONE CULTURE OF CARE**

- Follow up deep dives. Positives and challenges.
- Confidence we will deliver the 2022/23 plan.
- 2023/24Planning update
- IPR key headlines
- Recovery – challenges next year but YTD great story.

**DATE AND TIME OF NEXT MEETING:**
Tuesday 4th April 2023, 9:30 – 12.00 MS Teams

Calderdale and Huddersfield NHS Foundation Trust

**Minutes of the Finance & Performance Committee held on Tuesday 4th April 2023, 09.30am – 12.00noon Via Microsoft Teams**

**PRESENT**

| | |
|---|---|
| Andy Nelson (AN) | Non-Executive Director (Chair) |
| Nigel Broadbent (NB) | Non-Executive Director |
| Gary Boothby (GB) | Director of Finance |

**IN ATTENDANCE**

| | |
|---|---|
| Andrea McCourt (AM) | Company Secretary |
| Rochelle Scargill (RS) | PA to Director of Finance (Minutes) |
| Brian Moore (BM) | Public Elected Governor |
| Peter Keogh (PK) | Assistant Director of Performance |
| Rob Aitchison (RA) | Deputy Chief Executive |
| Vicky Pickles (VP) | Director of Corporate Affairs |
| Helen Rees (HR) | Director of Operations - Medicine |
| Stuart Baron (SB) | Associate Director of Finance |
| Anna Basford (AB) | Director of Transformation and Partnerships |

**ITEM**

**055/23 WELCOME AND INTRODUCTIONS**

The Chair welcomed attendees to the meeting.

**056/23 APOLOGIES FOR ABSENCE**

Apologies were received from, Rob Birkett, Jonathan Hammond, Robert Markless, Adam Matthews, Kirsty Archer, and Philippa Russell.

**057/23 DECLARATIONS OF INTEREST**

Stuart Baron registered his Declaration of Interest as a Director of CHS.

**058/23 MINUTES OF THE MEETING HELD 28th February 2023**

The minutes were approved as an accurate record.

**059/23 MATTERS ARISING**

Figures are now aligned in the IPR and Finance report for agency spend.

**060/23 ACTION LOG**

The Action Log was reviewed as follows:

0180 /21 IPR – The new draft version has been circulated to the operational directors. Vicky Pickles to share more widely with governors etc. Further training to be rolled out colleagues which has been linked on the intranet to view and book.
**ACTION**: PK to share with AN and NB

031/23 BAF risks – key points to be presented at Board. Complete.

**061/23 URGENT AND EMERGENCY CARE**

The Director of Operations for Medicine presented the highlights of the Urgent and Emergency Care Recovery Plan. The full presentation was included in the meeting pack.

ED attendances have increased beyond pre-pandemic levels since April 2021. ED Performance dropped slightly in February to 67.5% in month from 70.9% in January. Against the performance target for 2023/24 of 76% ED is currently performing on average in the late 60% - early 70's%. ED attendances are up but admissions are down. However, Acuity has increased which has an impact on length of stay which has increased from 3.8 to 4.4 days and bed occupancy remains high at between 98-100%.

Transfer of care have been increasing since 10th February and peaked at 154 w/c 24th February. The target in 2022/23 was 70 or below and this has only been achieved on three or four occasions. The average is 120 with discussions ongoing to reduce these to 50 in this financial year.

The Urgent and Emergency Care Delivery group (UECDG) is meeting on a monthly basis to review the performance of Urgent and Emergency Care. From this there are two focussed improvement groups, Same Day Emergency Care (SDEC) and Length of Stay (LOS).

Currently the SDEC service is only available at HRI but the team are currently looking at the possibility of opening SDEC at CRH.

GB – Noted that good data is now being provided around length of stay which demonstrates that it is not solely driven by external partners. By working at ward level, it gives the ward ownership to reduce length of stay.

Discussion was held with the Committee on the content of the urgent and emergency care report.

**FINANCE & PERFORMANCE**

**062/23 MONTH 11 FINANCE REPORT (Including High Level Risks and Efficiency Performance)**

The Director of Finance presented the Month 11 Finance Report.

Key points-

- No key changes in the themes from previous reports so close to year end. On track to deliver the plan.
- Extra beds open in February and March created extra pressures.
- Colleagues currently performing the financial year end closedown.
- The full CIP program will be delivered
- The internal Capital plan will be delivered.

NB Asked if the use of resources metric will change in 2023/24 as seems to be fixed at level 4.

GB responded that this is something that used to have to be reported monthly. This is no longer a “must do” but CHFT are still reporting it as it is linked to some of the longer term risks and our strategy. Some metrics are no longer correct but next year for example we are expected to have a more realistic target around agency spend. This along with income and expenditure, should see the score reduce to a level 3 next year.

The Committee **RECEIVED** the Month 11 financial report.

**064/23 PLANNING 2023/24 and DEEP DIVE ANALYSIS**

The Director of Finance shared the 2023/24 financial plan presentation that had been used for the recent deep dive with ICB and NHSE colleagues. Due to the scale of our deficit, it was decided by the ICS that a deep dive should take place on our plans for next year.

An NHSE colleague was scheduled to attend but had to withdraw due to circumstances beyond their control. The deep dive was attended by Mike Savage – Director of Finance at Airedale, and Alison Needham – Director of Finance for Kirklees ICB.

The session started by looking at CHFT’s plan for this year, which had concluded that our pay growth was in line with peers and there was nothing out of the ordinary on any other areas, but our income 2019/20 to 2021/22 was less than others. The challenge was pushed back to the ICB that we were not receiving a fair share of the income.

It was highlighted that CHFT has delivered the 2022/23 plan unlike other Trusts in the area and the level of productivity in comparison to 2019/20 was better than peers.

A financial bridge linking 2022/23 – 2023/24 had to be submitted to the ICB which shows that expenditure has grown more than income. Julian Kelly has given some clarity to the income position and has said that it should demonstrate a 1.8% flat growth. The bridge demonstrates that whilst we have additional income coming in, it is not the 1.8% we should be receiving.

The fact that CHFT is in voluntary turnaround was also highlighted at the session.

Feedback from Mike and Alison at the end of the meeting:

- Challenge the income.
- Consider some unpalatable challenges. The CHFT elective activity plan for example, delivers better than is required vs the national target. Could we go in line with the target? Challenge of volume of outpatient follow ups.
- Inconsistency identified around funding assumed for Capacity pot 2.
- CHFT do not have a financial contingency. Question if others within the ICS have.

CHFT are expecting a second deep dive from NHSE.

CHFT are the best performing in West Yorkshire for implementing alternative pathways to reduce follow up attendances, with the patient initiated follow ups (PIFU). We are also held up as an exemplar for targeting patients who have gone beyond their targeted follow up.
Following a meeting last week, it is expected that there will be an additional submission of plans in April. There are still question over the pay award as anything over 2% cannot be funded by NHS without reducing services.

In relation to the CIP target, attendance and engagement is good for the Turnaround Executive which is at the early stage of scoping schemes to reach Gateway one by the middle of April and Gateway 2 by middle of May. There is currently £2.25m of unidentified schemes against the overall target of £25m of savings. The plans will be interrogated, and deep dives performed where deemed necessary. ED, workforce and length of stay are the three biggest areas.

**063/23 TURNAROUND EXECUTIVE**

Most of the detail covered in above report.

**ACTION**: RA to give one page update on TE each month.

**065/23 INTEGRATED PERFORMANCE REVIEW – FEBRUARY 2023**

The Assistant Director of Performance (PK) gave an update. The key points to note were:

- February saw a return to increased emergency pressures and more patients spending over 12 hours in ED however we managed to have zero 12-hour trolley waits following decision to admit. We also managed to have shorter ambulance handovers.
- We are confident that we will achieve 104-week and 78-week challenge for the end of March with minimal 52-week waits too.
- Cancer performance was back on track with only 31-Day Subsequent Surgery Treatment missing its target in month.
- Our achievements in cancer were noted recently in the Guardian where we were 1 of only 3 Trusts nationally to regularly achieve the 14-day and 62-day referral to treatment targets.
- There are still a number of areas where we have action plans in place and are still not seeing improvement including stroke, #neck of femur and dementia screening.
- HSMR 1 year rolling position has gone above 100 as expected following the high number of deaths in December following the increase in acuity and numbers through ED.
- Although not quite as good performance as last month the improvement in responding to complaints needs to be noted.
- We experienced extreme pressures on our services during the last week of March and went into Operational Pressures Escalation Level (OPEL) 4 for a few days.

- There were high attendances through ED and a limited number of beds available for admissions.
- Moving to new format in the new financial year

There has been no feedback on the HSMR reviews that were scheduled to be carried out. PK will speak to Neeraj Bhasin who was leading on these and include the information for the committee next month.

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

**066/23 RECOVERY UPDATE**

The Assistant Director of Performance (PK) gave an update. The key points to note were:

- CHFT continues to reduce its elective backlog faster than all Trusts across WYATT. There have been improvements in most categories.
- When benchmarked with other Trusts in West Yorkshire, CHFT is in a very positive position.
- 104% Elective Recovery is on plan as of February however the Junior Doctors strike could have an impact.
- RTT 78 week – There are zero patients waiting more than 78 weeks.
- RTT 52 weeks – In April 2022 there were 2500 patients waiting over 52 weeks. Against our internal target of Zero we have 135 patients. The national expectation is to reach zero by March 2025 – a target we almost reached by March 2023.
- Outpatients is not seeing the same decrease with total ASI's increasing compared to 12 months ago. There is no external target to report but the CHFT internal target is to reach pre-covid levels.
- ASI's over 22 weeks – the plan is to reduce these to 18 weeks. The number has reduced from 2000 to just over 500.
- Outpatient Follow ups – The harm review process in place.
- Diagnostics – The 99% target has been reached in most areas. Going forward the target will be 95% which ECHO and Neurophysiology are not quite reaching due to known problems around staffing and pressures. Hopeful to reduce over the next couple of months.

New targets will be in place in the new year. CHFT has been looking at different ways of working and have put plans in place to achieve those. New trajectories will be introduced for all aspects of Elective Recovery.

The Committee **NOTED** the Recovery update

**067/23 DRAFT MINUTES FROM SUB-COMMITTEES**

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

- Access Delivery Group
- Capital Management Group
- Cash Committee
- CHFT / SPC Quarterly Meeting

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

**068/23 WORKPLAN – 2022/23**

This workplan for the new year will be finalised.

ACTION: Plan to be finalised and approved at the next meeting.

**069/23 ANY OTHER BUSINESS**
None.

**070/23 MATTERS TO CASCADE TO BOARD inc. ONE CULTURE OF CARE**
Nothing to cascade at this time due to the next committee meeting taking place before the next board meeting.

**DATE AND TIME OF NEXT MEETING:**
Wednesday 26th April 2023, 9:30 – 12.00 MS Teams

Calderdale and Huddersfield NHS Foundation Trust

# QUALITY COMMITTEE

**Monday, 16 January 2023**

## STANDING ITEMS

### 01/23 WELCOME AND INTRODUCTIONS

**Present**

| | |
|---|---|
| Denise Sterling **(DS)** | Non-Executive Director **(Chair)** |
| Dr David Birkenhead **(DB)** | Medical Director |
| Mr Neeraj Bhasin **(NB)** | Deputy Medical Director |
| Gina Choy **(GC)** | Public Elected Governor |
| Sharon Cundy **(SC)** | Head of Quality and Safety |
| Richard Dalton **(RD)** | Head of Risk and Compliance |
| Jason Eddleston **(JE)** | Deputy Director of Workforce & Organisational Development |
| Jonathan Hammond **(JH)** | Deputy Chief Operational Officer |
| Karen Heaton **(KH)** | Non-Executive Director |
| Joanne Middleton **(JMidd)** | Deputy Chief Nurse |
| Victoria Pickles **(VP)** | Director of Corporate Affairs |
| Lindsay Rudge **(LR)** | Chief Nurse |
| Kim Smith **(KS)** | Assistant Director for Quality and Safety |
| Elisabeth Street **(ES)** | Clinical Director of Pharmacy |
| Michelle Augustine **(MA)** | Governance Administrator **(Minutes)** |

**In attendance**

| | |
|---|---|
| Helen Barker **(HB)** | Operations Director - Reconfiguration **(item 07/23)** |
| Laura Douglas **(LDou)** | Deputy Head of Midwifery **(for Diane Tinker and item 08/23)** |
| Dr Elizabeth Loney **(EL)** | Associate Medical Director **(item 06/23)** |
| Lucy Raine **(LRa)** | Student Nurse on Placement **(Observing)** |
| Debbie Winder **(DW)** | Deputy Director of Quality – NHS West Yorks ICB **(for LD)** |
| Tracy Wood **(TW)** | Interim Research and Development Lead **(item 10/23)** |

**Apologies**

| | |
|---|---|
| Rob Aitchison **(RA)** | Deputy Chief Executive |
| Lucy Dryden **(LD)** | Quality Manager for Calderdale Integrated Care Board |
| Jo Kitchen **(JK)** | Staff Elected Governor |
| Diane Tinker **(DT)** | Director of Midwifery |

Lindsay Rudge was congratulated on her appointment in the substantive role as Chief Nurse.

Jonathan Hammond and Joanne Middleton were welcomed to their first meeting of the Quality Committee.

### 02/23 DECLARATIONS OF INTEREST

There were no declarations of interest.

### 03/23 MINUTES OF THE LAST MEETING AND ACTION LOG

The minutes of the last meeting held on Monday, 14 November 2022 were approved as a correct record.

The scheduled meeting for Wednesday, 22 December 2022 was cancelled.

The action log can be found at the end of these minutes.

**04/23 MATTERS ARISING**

**Care Quality Commission (CQC) Action Plan Review**

Victoria Pickles presented the action plan as circulated at appendix B.

A detailed review of the original 'must do' and 'should do' CQC actions was undertaken with divisions to ensure actions were still progressing. The report shows the current position of the 63 actions and details how the seven progressing actions (one 'must do' and six 'should do') will be monitored going forward.

**VP** also noted the restructuring of the CQC and compliance Group, which have now been separated. The CQC Group will focus on the preparedness for any CQC inspection and ongoing levels of quality and safety and any required trustwide actions.

**KH** asked for clarification on the critical care action (MD 8) which states that it is embedded, and also in progress. VP clarified that the embedded rating was carried out before the detailed review, and the in progress rating is the current position.

**JE** asked whether the CQC are aware of the internal position and appreciative of the work delivered or ongoing, in order to attain compliance or mitigate risks when not fully compliant. **VP** stated that the Trust is clear with the CQC of our current position, and will be on-site for a deep dive into Critical Care on 1 February 2023. There is honest dialogue on the position, and are aware that some actions will take place post-reconfiguration. **LR** also added that a number of deep dives have taken place with the CQC during normal relationship meetings and also through wanting to look at key services. **LR** suggested that the presentations which took place with the Emergency Department (ED), Children's Services and End of Life Care are shared with the Committee to clarify what has been shared with the CQC, and feedback received.

**Action**: Presentations from previous deep dives to be shared with the Committee.

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

## SPECIFIC REPORTS

**05/23 QUALITY AND SAFETY STRATEGY**

Kim Smith provided an update on the Quality and Safety strategy as circulated at appendix C.

**KH** asked if there was an opportunity for Governors to be referenced as setting the quality priorities; and in relation to the quality ambitions, it was asked if there is an intention to have milestones set against those ambitions. **KS** stated that governors can be referenced, and milestones will be included.

**ES** asked how the Commissioning for Quality and Innovation (CQUINs) fit into the strategy. **KS** stated that the 2023/24 CQUINs are still being discussed and not yet been agreed, but will be part of the strategy. There has been some challenge on which CQUINs are chosen and work has taken place across the integrated care board looking at shared quality priorities and CQUINs.

**DS** asked about the implementation of the revised strategy. **KS** stated that it would be a soft launch with feedback at early stages. The implementation of the effectiveness of the strategy will also need to be monitored throughout the year with regular reports back to the Committee on progress. **LS** stated that the measurement framework within the dashboard needs to be clear, relevant and match national metrics.

OUTCOME: **KS** was thanked for the update and the Quality Committee approved the timeline.

## 06/23 HOSPITAL STANDARDISED MORTALITY RATIO UPDATE

Dr Elizabeth Loney was in attendance to provide a verbal update.

**EL** reported that both the Hospital Standardised Mortality Ratio (HSMR) and the Summary Hospital-level Mortality Indicator (SHMI) have improved. The HSMR data up to the end of October 2022 was at 102.26 and previously at 103.96. The SHMI data up to the end of September 2022 shows an improvement from 106.65 to 105.86. Nationally, CHFT is ranked 48th and within the green section of the chart. Some of the improvement in the HSMR is due to an increased number of palliative care discharges. Looking at the data between now and October 2022, the crude in-hospital mortality increased, and the out-of-hospital mortality reduced in December. The first question is whether people have been dying in hospital because they have not been able to go back out into the community, and secondly, whether the spike in Emergency Department (ED) mortality of 25 deaths, had anything to do with the increase in number of patients in ED, delayed transfers of care, patients not being able to get a bed, patients who were not expected to die in the ED, etc. This data does not count toward CHFT's HSMR or SHMI, therefore, an audit has been requested. There have been no new alerts.

**JH** mentioned some work done with the Health Informatics Team on demand through the EDs over the last three to four weeks, as well as acuity information of patients, which will be shared with EL.

**DW** stated that it is important to learn from deaths and how the ICB can support with any learning outside of the organisation to ensure a place-based approach.

OUTCOME: **EL** was thanked for the update.

## 07/23 REVIEW OF FOLLOW-UP APPOINTMENT CONCERNS REPORT

Helen Barker was in attendance to present the above report as circulated at appendix D.

In summary, **HB** stated that there is not a systemic issue with the Electronic Patient Record (EPR), however, there are improvements which can be made to the functionality of the EPR to provide assurance on the follow-up pathway management. **HB** thanked the members of the task and finish group on the amount of work achieved in six weeks.

It was suggested that the Quality Committee receive an update on the recommendations on a quarterly basis, which have been agreed by the Executive Board.

**DS** asked about the EPR training, what needs to change, and whether this is part of ongoing work. **JH** stated that EPR training is available, however, there is an opportunity to see how effective it is. This is being led by Neil Staniforth.

**NB** stated that generic baseline training is provided, however, the nuances of what to do for which speciality when in clinic regarding the different surveillance is required, and would benefit from the additional training. It was also noted that Jonathan Cowley (Chief Clinical Information Officer) and Louise Croxall (Chief Nursing Information Officer) will be picking up some of this work regarding awareness around the optimisation of the training and how to most effectively use EPR.

OUTCOME: **HB** was thanked for the update and the Quality committee noted the rapid response to concerns and process entered.

**SAFE**

## 08/23 MATERNITY REPORT AND MATERNITY INCENTIVE SCHEME SUBMISSION

Laura Douglas was in attendance to provide an update on the Maternity report as circulated at appendix E1, highlighting:

- Maternity Transformation Plan – Monthly confirm and challenge meetings continue to review the plan, with the current position table included in the report. A weekly maternity improvement huddle also takes place, which the plan is fed into.
- Maternity Incentive Scheme – the additional paper provided with the report as circulated at appendix E2 details the 10 safety actions and progress against them. In preparation for the submission, there have been divisional check and challenge meetings to review the actions and evidence. As a result, it was agreed that nine out of the 10 safety actions were compliant. Work is ongoing with the one outstanding safety action - action six - which relates to the Saving Babies' Lives care bundle. The action has two elements; one is the percentage of women where Carbon Monoxide (CO) measurement at booking is recorded, and the other element is percentage of women where CO measurement at 36 weeks is recorded. An update on the compliance figure within the report was provided. As of December 2022, there was an overall average of 88%.
- Healthcare Safety Investigation Branch (HSIB) Investigations – At the time of the report, there were two active ongoing cases, with a summary provided for each.
- Maternity incidents – The summary of a maternal death which occurred in December 2022 was provided.

**LR** reported that the Board of Directors accepted the Maternity Incentive Scheme position last Thursday.

**LR** also commented on the incident data and the higher reporting around postpartum haemorrhage and term admission to the neonatal unit, and asked whether any deep dives have been carried out on both to look for any reasons or mitigations that can be put in place. **LDou** stated that postpartum haemorrhage is monitored on the dashboard and if there are consecutive months where it is an outlier, then a deep dive would be carried out. In terms of admissions to the neonatal units, a deep review is done as part of the ATAIN (Avoiding Term Admissions Into Neonatal units) work, audited and presented to the ATAIN meetings within the Local Maternity System. **LR** stated that it would be helpful to appendix the maternity dashboard to this report in order for the Committee to see local data and benchmarks.

**LR** also asked about the significant increase in delays to emergency caesarean sections between the November and December's positions. **LDou** stated that the November data was noted as a partial review, however, all delays in caesarean sections are reviewed through the weekly governance meeting. **LDou** asked for a review of December's data regarding the delays and whether any harm occurred. It was also suggested that this is added to a dashboard in order to see data over time.

**DS** stated that in previous reports, reference has been made to work being done on a national and regional level with teams on new trajectories and plans in regard to maternity continuity of carer, and asked about the progress of this. **LDou** stated that the formal outcome and recommendations from the Ockenden 2 and East Kent reports are being awaited, therefore a confirmed trajectory or target dates are not yet known.

**DW** stated that the planning guidance around maternity is expected in January to pull together those action plans. In relation to the governance of the Maternity Incentive Scheme, there is a requirement for a Place assurance and a statement that it has been signed off by the ICS accountable officer. **DW** is working through the evidence with **DT** to be able to support the collation in a timely manner.

OUTCOME: **LDou** was thanked for the update.

### 09/23 TRUST PATIENT SAFETY AND QUALITY BOARD REPORT

Kim Smith provided an update on the above report as circulated at appendix F.

**KS** reported on the lengthy narrative in the report, and asked that the Quality Committee supports the work going forward into the new financial year, that there is a process for oversight and scrutiny from divisional level into Trust Patient Safety and Quality Board for increased level of assurance into Quality Committee. The process will link into work around the Quality Strategy, Quality Priorities and outcome measures.

**DS** mentioned the items for escalation to Quality Committee and asked if there was any actions expected of the Committee. **KS** stated that terms of references of both the Trust PSQB and sub-groups have been reviewed, and that there have been challenges from the last few months with acuity and operational issues, however, once there is a change in focus and reports are in a more robust place, it may be easier for attendance.

**LR** asked that it be referenced that during the time of the reporting, CHFT was fluctuating between Opel 3 and 4, and the organisation took the decision to stand a number of meetings down, which may have impacted on attendance.

OUTCOME: **KS** was thanked for the update.

## WELL-LED

### 10/23 RESEARCH AND INNOVATION COMMITTEE REPORT

Tracy Wood was in attendance to provide an update on the above report as circulated at appendix G.

**KH** commented on the R&D department's success story which goes from strength to strength. **LD** thanked **TW** for putting CHFT on the map with the national nursing lead who recently visited CHFT.

**DS** commented on how the Quality Committee can assist in getting more coverage for the R&D department. **NB** stated that alternatives have been sought, and thanked **JH** for allowing the R&D team to present at the Wednesday morning leadership briefings. There is an aspiration to go into new services, specialties, or forums to potentially look at job plans to attract and recruit Physician Associates, nurses and Allied Health Professionals to have an element of research, therefore any suggestions on areas where research can be championed were welcomed.

OUTCOME: **TW** and **NB** were thanked for their update.

## RESPONSIVE

### 11/23 QUALITY REPORT

Kim Smith provided an update on the above report as circulated at appendix H.

**KS** noted that the majority of CQUINs are on track, however, the report shows two amber and one red CQUIN: CCG2 – Appropriate antibiotic prescribing for UTI in adults aged 16+; CCG9 – Cirrhosis and fibrosis tests for alcohol dependent patients, and CCG14 – Assessment, diagnosis and treatment of lower leg wounds.

**ES** commented that although CCG7 – Timely communication of changes to medicines to community pharmacists via the Discharge Medicines Service - was not prioritised for the organisation, it was very specific to pharmacy around referrals to community pharmacy when patients have several medication changes, to ensure they are informed. The target was 1.5% of all discharges, and Pharmacy achieved 3.19% for the latest quarter, and the highest

performing Trust in North East and Yorkshire. It is hoped that this carried through into the final quarter.

In relation to the expected CQC maternity services inspection, **KH** commented on the incredible work undertaken in the service on their thorough and detailed action plan, and good feedback from the assurance visit last year.

**DS** commented on the ED quality priority and the increasing numbers of patients in ED who are breaching the eight, 10 and 12 hour targets, however, was pleased to see that no patients were coming into any harm, however, the pressure ulcer data states that there is an increase in hospital acquired Pressure Ulcers due to long waits and time spent on trollies. **DS** asked how reviews in ED are linking to ward level. **LR** stated that it cannot be said that patients are not coming to any harm on the long waits, as there are some serious incidents regarding delay in treatment. It was suggested that a review of the incidents related to ED over the Christmas period is carried out.

**Action**: Report of a review of incidents relating to the ED over the Christmas period to return to a future meeting, and triangulating data of increased acuity and admissions into the bed base as discussed at item 06/23.

OUTCOME: **KS** was thanked for the update.

### 12/23 INTEGRATED PERFORMANCE REPORT

David Birkenhead presented an update to the report as circulated at appendix I, highlighting key points and noting the cancer performance which remains really positive and good progress made on the long waiters.

There has been significant pressure with the organisation being in Opel 4 through much of December and the first part of January.

OUTCOME: The Quality Committee noted the report.

## ITEMS TO RECEIVE AND NOTE

### 13/23 CLINICAL OUTCOMES GROUP MINUTES

A copy of the minutes were available at appendix J.

**KH** noted from the minutes of the lack of a report from the End of Life Care Group.

**DB** reported following this up as a report has been expected and awaiting a response. **LR** stated that for assurance, **JM** will now be chairing the Group and having a stronger assurance role.

OUTCOME: DB was thanked for the update.

### 14/23 MINUTES FROM KIRKLEES PLACE

A copy of the minutes were available at appendix K for information.

**DS** asked if there are any queries from the Quality Committee, how will these be fed back? **LR** stated that a report by exception would be completed. It was noted that an issue has been raised on the need for a risk register representative of Place. As of yet, a quality dashboard has not yet been agreed, however, at the last integrated care board quality committee, a range of quality metrics were discussed and it is hoped that a review of the dashboard can take place with agreed metrics, and a sub-group for risk which reviews the risk register.

### 15/23 ANY OTHER BUSINESS

**DS** mentioned the notification of the change of dates to the Quality Committee from April 2023, to ensure alignment with other Board sub-committees. It was acknowledged that some members may now be unable to attend Quality Committee due to conflicting commitments, however, this will be managed throughout the year.

**DS** also mentioned discussions about the length of Board sub-committee meetings. There may be recommendations to extend the meetings by 30 minutes in order to get through the agenda and to ensure there is appropriate time given to agenda items and time for discussions to take place.

### 16/23 MATTERS FOR ESCALATION TO THE BOARD OF DIRECTORS

**DS** mentioned changes at Board level in terms of how sub-committee Chairs report, therefore, this will now be a broader report provided to the Board, which will include most of the Quality Committee agenda.

### 17/23 QUALITY COMMITTEE ANNUAL WORK PLAN

The workplan was available at appendix L for information.

There is still some work to be done on the workplan, and the finalised agreed workplan will hopefully be able to be shared by March 2023 at the latest.

## POST MEETING REVIEW

### 18/23 REVIEW OF MEETING

A good overview of quality from all aspects of the organisation, and acknowledgement of challenges, not just assurances.

## NEXT MEETING

Monday, 20 February 2023
3:00 – 5:00 pm
Microsoft Teams

# QUALITY COMMITTEE ACTION LOG

## Following meeting on Monday, 16 January 2023

Overdue | New / Ongoing | Closed | Going Forward

| MEETING DATE AND REF | AGENDA ITEM | LEAD | CURRENT STATUS / ACTION | RAG RATING |
|---|---|---|---|---|
| **NEW / ONGOING ACTIONS** | | | | |
| 14.11.22 (193/22)<br><br>16.01.23 (04/23) | **BAF Risk 4/20 – CQC**<br><br>**CQC action plan review** | | At the last CQC meeting, a complete review of all the must-do and should-do actions from the last inspection took place to create a more realistic position.<br>**Action**: Report detailing review of all must and should-do actions to be submitted to the next Quality Committee for sign-off.<br>**Update Jan 2023**: See agenda item 04/23<br>**Action Jan 2023**: Presentations from previous deep dives to be shared with the Committee (also see end of combined pack for full presentations)<br>EoLC Focus CQC Visit - MASTER Template.p; FINAL JSS Vaccination Centre CQC TMA Pres; Maternity Services CQC presentation.ppt; Medicine CQC Slides May 2022 final.pptx; Patient FIRST - Presentation V5.pptx | **DUE FOR CLOSURE** |
| 16.05.22 (80/22) | **Split Paediatric Service** | **J Mellor / S Riley-Fuller / S Cartwright** | **Action 16 May 2022**: That the original escalation process is revisited.<br>**Update**: Options to return to Quality Committee in September and October have been provided and awaiting response from division.<br>**Update Oct 2022**: See item 168/22<br>**Action 24.10.22:** A focus on the children and young people standards to return to Quality Committee. | **See agenda item 22/23** |
| 20.06.22 (84/22) | **Annual Patient Experience Report** | **Nicola Greaves** | **OUTCOME**: To be deferred<br>**Update**: The report is awaiting approval at the Patient Experience and Caring Group before ratification at Quality Committee<br>**Update Oct 2022**: Deferred to a future meeting – date TBC | **See agenda item 35/23** |
| **UPCOMING ACTIONS** | | | | |
| 16.01.23 (1/23) | **Quality Report** | **Kim Smith** | **DS** commented on the ED quality priority and the increasing numbers of patients in ED who are breaching the eight, 10 and 12 hour targets, however, was pleased to see that no patients were coming into any harm, however, the pressure ulcer data states that there is an increase in hospital acquired Pressure Ulcers due to long waits and time spent on trollies. **DS** asked how reviews in ED are linking to ward level. **LR** stated that it cannot be said that patients are not coming to any harm on the long waits, as there are some serious incidents regarding delay in treatment. It was suggested that a review of the incidents related to ED over the Christmas period is carried out.<br>**Action 16.01.23**: A report of a review of incidents relating to the ED over the Christmas period to return to a future meeting, and triangulating data of increased acuity and admissions into the bed base as discussed at item 06/23. | **March 2023** |
| 16.05.22 (80/22) | **Split Paediatric Service** | **Lindsay Rudge** | **LR** commented on the risk relating to the APNP model at Huddersfield, which is at a score of 16 on the risk register, stating that Simon Riley-Fuller (ADN in FSS) has been asked to review this. It was also noted that the Emergency Department (ED) are also looking at the impact of any incidents or near misses that have occurred as a result of the described risk, the results of which can be returned to a future Quality Committee for oversight and assurance to ensure that the risk is not tolerated.<br>**Action 24.10.22**: For any results of the review of the risk and impact of incidents and near misses to be returned to the Quality Committee | **TBC** |
| 24.10.22 (171/22) | **Integrated Performance Report** | **Lindsay Rudge** | **LR** also stated that it would be helpful to bring a presentation on the data to see the broader impact of all the increased activity and that expanded bed base to see what that means in terms of harm and incidence.<br>**Action**: Presentation to be requested for Quality Committee | **TBC** |

| CLOSED ACTIONS | | | | |
|---|---|---|---|---|
| 24.10.22 (176/22) | **Medical Gases and Non-Invasive Ventilation (NIV) Group** | **Lindsay Rudge / Nicholas Scriven** | **LR** asked if there were any solutions to the issues raised or whether any support was required from the Committee. **NSc** stated that in terms of attendance at the meeting, divisional representation has been sought, however, this is challenged due to turnover, and not being certain on who the correct representative is, therefore any help would be appreciated on identifying the correct people to target to attend the meeting.<br>**Action 24.10.22: LR** agreed to meet with **NSc** outside of the meeting to logically go through the issues raised.<br>**Update**: Vanessa Dickinson met with **NSc** and Lis street on 16 November 2022 to discuss the various issues regarding the NIV/O2/Medical gases meeting and lack of divisional representation, the following were agreed:<br>• NIV/O2 and Medical Gases will be split into two separate meetings again – (identified by all parties that joining them has increased the problems)<br>• Pull sub-groups back into the main meeting to reduce number of meetings and increase divisional representation<br>• Vanessa has introduced a buddy system in medicine for the medical matrons regarding all meetings, which should also improve attendance and is happy to share with other divisions. | **CLOSED Jan 2023** |
| 16.05.22 (80/22) | **Split Paediatric Service** | **David Birkenhead** | The Chair also mentioned the key risk in regard to staffing and asked if there was any business planning taking place or a business case, and whether this would be a long-term risk.<br>**Action 24.10.22: DB** agreed to liaise with Venkat Thiyagesh for further detail on the above and feedback to the Quality Committee.<br>**Update**: The Division produced an options paper to manage the risk. This went to Weekly Executive Board, and the option to move Paediatric A&E patients to CRH in line with the reconfiguration model was supported.<br>**Update Jan 2023: DB** reported that a paper was taken through to the Weekly Executive Board for consideration. There were a number of options, including moving to a model where most children would be cared for in Calderdale. This has since moved on and now potentially looking to recruit additional paediatric nurses for the HRI site. This will return to the WEB this week, with plans to mitigate the risks | **CLOSED** |

Calderdale and Huddersfield NHS Foundation Trust

# QUALITY COMMITTEE

**Monday, 14 November 2022**

## STANDING ITEMS

### 182/22 WELCOME AND INTRODUCTIONS

Present

| | |
|---|---|
| Denise Sterling **(DS)** | Non-Executive Director **(Chair)** |
| Rob Aitchison **(RA)** | Deputy Chief Executive |
| Gina Choy **(GC)** | Public Elected Governor |
| Sharon Cundy **(SC)** | Head of Quality and Safety |
| Richard Dalton **(RD)** | Head of Risk and Compliance |
| Andrea Dauris **(AD)** | Deputy Chief Nurse |
| Karen Heaton **(KH)** | Non-Executive Director |
| Victoria Pickles **(VP)** | Director of Corporate Affairs |
| Lindsay Rudge **(LR)** | Chief Nurse |
| Elisabeth Street **(ES)** | Clinical Director of Pharmacy |
| Michelle Augustine **(MA)** | Governance Administrator **(Minutes)** |

In attendance

| | |
|---|---|
| Helen Hirst **(HH)** | CHFT Chair **(Observing)** |
| Richard Hill **(RH)** | Head of Health and Safety **(item 185/22)** |
| Lucy Dryden **(LD)** | Quality Manager for Calderdale Integrated Care Board |
| Helen Rees **(HR)** | Director of Operations – Medical Division **(item 185/22)** |
| Nicola Greaves **(NG)** | Quality Improvement Manager - Patient Experience **(item 189/22)** |
| Christopher Roberts **(CR)** | Deputy Director of Operations – Medical Division **(item 185/22)** |
| Diane Tinker **(DT)** | Director of Midwifery **(item 175/22)** |
| Debbie Winder **(DW)** | Deputy Director of Quality – NHS West Yorks ICB **(item 186/22)** |

Apologies

| | |
|---|---|
| Mr Neeraj Bhasin **(NB)** | Deputy Medical Director |
| Dr David Birkenhead **(DB)** | Medical Director |
| Jason Eddleston **(JE)** | Deputy Director of Workforce & Organisational Development |
| Jonathan Hammond **(JH)** | Chief Operational Officer |
| Jo Kitchen **(JK)** | Staff Elected Governor |
| Kim Smith **(KS)** | Assistant Director for Quality and Safety |

Rob Aitchison was welcomed to his first Quality Committee meeting as Deputy Chief Executive.

### 183/22 DECLARATIONS OF INTEREST

There were no declarations of interest.

### 184/22 MINUTES OF THE LAST MEETING AND ACTION LOG

The minutes of the last meeting held on Monday, 24 October 2022 were approved as a correct record, with the exception that an action is made in conjunction with the last paragraph of item 176/22 in relation to the Medical Gases and Non-Invasive Ventilation (NIV) Group. The action log can be found at the end of these minutes.

## 185/22 MATTERS ARISING

**Stroke Deep Dive**

Christopher Roberts was in attendance to present the update as circulated at appendix B.

The Sentinel Stroke National Audit Programme (SSNAP) allows for CHFT to monitor performance against national targets for stroke, and historically, CHFT have performed at a rating of 'A', however, during COVID and over more recent months, there has unfortunately been a deteriorating position. The current performance of a 'C' rating is due to a number of challenges, one of which is the closure of nine beds prior to COVID, with a view to delivering increased care in the community. This took place with an early supported discharge service which increased capacity, however, there was also a significant increase of stroke patients presenting at the Emergency Department (ED), as well as increased acuity and dependency, which has led to increased outliers with patients not being seen as quickly by the Stroke team, which in turn led to increased lengths of stay.

Some of the challenges have been mitigated, with nurse vacancies now being fully recruited to, and other actions taken have seen a continued improvement in the SSNAP scores, with increases from 'C' to 'A' ratings in some of the individual measures in the last couple of months. Further actions completed and ongoing actions were also detailed in the presentation.

The stroke service are aware of the challenges and have addressed them as much as possible, however, an ongoing challenge is the medical workforce and not able to successfully recruit into those posts.

**KH** commented on the increase in the number of patients being seen and asked if there was anything specific around this. **CR** stated that COVID and an aging population have impacted on the increase, and also mentioned that there tends to be a pattern of an increase of stroke patients every six weeks or so into the bed base, and trying to understand this is also a challenge. **LR** stated that the issue of the increase in stroke patients was taken to the Clinical and Professional forums at Calderdale, and one of the responses were people not accessing their regular screenings throughout COVID as normal, and there is an expectation that this impact will continue. **KH** asked how CHFT's performance compares to others in the region. **CR** stated that CHFT is not a significant outlier.

**LR** asked if there was any harm or outcomes being seen as a result of not being able to meet the SSNAP and performance targets. **CR** stated that the prevention of harm is the main focus. Practice was changed during COVID to facilitate early discharge, and the outcomes are now being seen on the ongoing quality of life, as not being able to rehabilitate patients as quickly and challenges with therapy staffing.

**VP** stated that a decision was made at a point in time to remove beds from the acute stroke ward, and asked what would trigger a different decision to put the capacity back in. **CR** stated that it is believed that there is a cohort of patients that could be rehabilitated in the community bed base and this is being worked towards. In terms of triggers to open up additional capacity, this would be determined on the number of outliers, and the number of attendances in a day which require the additional beds being opened. The biggest trigger is at what point, for example, ten outliers are reached, and to also understand the impact on the wider Trust, as staffing also needs to be considered.

**LR** stated being involved in the stroke task and finish groups, and understood from an integrated care board perspective, that there was a commitment to fund additional inpatient beds to cope with demand. It was asked if this is still the case. **HR** stated that as part of the winter funding, four additional beds have been supported, as well as support for early supported discharge.

**ES** mentioned enhanced roles for pharmacists and Advanced Clinical Practitioners, and asked if there was anything which the service could provide, in terms of workforce support. **CR** welcomed the support and agreed to follow this up with **ES** outside of the meeting.

**LR** stated that clarity is required on which forum this item will be monitored, Finance and Performance or Quality Committee, to ensure there is no duplication.

OUTCOME: CR was thanked for the update and would be kept informed of which forum any follow-ups would be required.

**Health and Safety Assurance Report**

Richard Hill was in attendance to provide an update on health and safety assurances, as circulated at appendix C, in light of changes made to the Quality Committee terms of reference for the Committee being cited on employee safety issues.

**RH** stated that there were five projects:

- NHS Workplace Health and Safety Standards – Compliance is being demonstrated against the majority of the required legislation, with those partially demonstrated due to be fully compliant by December 2022.
- Management of the most common risk of injuries:
  - slips, trips and falls injuries are the most frequent type of injury, and has been on a steady decline since 2017. Over the last 12 months, **RH** has been working with PFI partners and CHS to review the risk assessments, policies, procedures and method statements. The majority of injuries are connected to the cleaning processes and winter weather conditions.
  - Needlestick injuries are the second most frequent type of injury, and several improvement plans are taking place. In the next 4-6 months, a further measure of incidents will take place to reflect on the work which has been done.
  - Moving and handling injuries – since 2017, there has been a steady decline in the number of injuries, due to the work of the moving and handling team.
- Handling and control of exposure to hazardous chemicals – a review of the 8000 assessments on the database has been done, and a review of current users is taking place in December 2022.
- Controlling the risk to new and expectant mothers – a review of the maternity assessment content has taken place, with a planned implementation of the refreshed assessment due in November 2022.
- Direct working arrangements between the Head of Health and Safety and Occupational Health Team – Work undertaken by **RH** is closely aligned with Occupational Health and Human Resources, and over the next six months, meetings will take place to review issues on work-related loss-time injuries; stress management; DSE referrals and needlestick injury referrals, and some measures put in place to reduce where there are increases in those areas.

**RH** stated that these areas of work have been represented over the last six months, with much more work which will be included in the end of year report to the Board of Directors.

**KH** asked about the progress of the assessment for controlling the risk to new and expectant mothers. **RH** stated that this was completed four weeks ago.

**ES** asked about a refresh of the Control of Substances Hazardous to Health (COSHH) training. **RH** stated that within the employee staff record (ESR), there are different types of health and safety modules and a PowerPoint presentation on COSHH will be added at the beginning of next year. **DS** asked if there have been any incidents relating to COSHH. **RH** stated that there have not been any incidents at the moment.

**DS** asked about the Display Screen Assessments, response rates so far, and what was coming through in relation to colleagues working from home, and the plans to address any issues. **RH** started the assessments are based on office-based colleagues, and assessments for homeworking colleagues is work in progress through Human Resources and agile working. There are currently 120 desk-based users with 80% compliance of completing the assessment, with around 12 colleagues who have raised issues relating to the ergonomics and position and setup of chairs; aches, pains, back injuries and historic medical conditions. **RH** has been working with a company in Sowerby Bridge who are DSE specialists, who will be giving a free of charge in-depth assessment for those individuals.

OUTCOME: RH was thanked for the update.

## AD HOC REPORTS

### 186/22 PLACE-BASED ARRANGEMENTS FOR QUALITY ASSURANCE

Debbie Winder was in attendance to provide an update on the integrated quality framework for Place-based arrangements, as circulated at appendix D.

The framework contains the principles of how quality oversight, surveillance and assurance will take place in Calderdale in an integrated way and the opportunities for quality improvement.

The relationships between the Integrated Care Board place and the programmes of work was highlighted at appendix 1 within the paper. The proposed principles for the Calderdale Place Integrated Quality Group (IQG) was also highlighted, and the proposed IQG model for delivery.

In relation to the governance structure within appendix 1, **VP** asked whether the structure was the same for both Kirklees and Calderdale places, and how duplication and consistency of information is managed, as Trusts do not have representation on the system quality group in terms of membership. It was also asked how this feeds into the Quality integrated care board Committee. **DW** stated that this is an emergent process, and that the current arrangement is that Penny Woodhead as the Executive Lead represents and takes information into the high-level committee, in agreement with partners. In terms of duplication, **DW** stated that this is something which is being mindful of, but does not have a definitive answer as yet. **VP** asked how CHFT will be appropriately represented, and how data that is being used is accurately reflective. **LR** stated that there is further work to be done on the data that is represented, and requested that data is brought through the CHFT Quality Committee before being submitted externally. **KH** asked about the role of the CHFT Quality Committee into the structure, and how it would receive and have the opportunity to feed information into. **DW** stated again that this is an emergent process, and hopes that definitive answers will be available soon, and is happy to return to update.

**LR** assured the Quality Committee that it was recognised at the Kirklees place that further work is needed on the risk register. A sub-group will be set up to work through what would be expected on the register, and it was agreed that this is fast-tracked through this Committee, as well as the minutes from the meetings.

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

### 187/22 SAFER STAFFING REPORT

Andrea Dauris was in attendance to present the report as circulated at appendix E, which provided an overview of Nursing, Midwifery and Allied Health Professional (AHP) staffing capacity and compliance within CHFT in line with the National Institute for Excellence (NICE) Safe Staffing, National Quality Board (NQB) and the NHS Improvement Workforce

Safeguards guidance. The report has previously been through the Workforce Committee and also the Board of Directors.

The key points to note were highlighted.

**GC** noted speech and language therapists, and concerns about whether or not there is capacity in the Community for this to be delivered. **LR** stated that work has been done with Jenny Clark, Associate Director of Therapy Services, to support speech and language therapists, by creating some nurse specialist roles around dysphagia management and screening, which will provide more capacity. This is a hard to recruit service, however, there are things which can be done differently which will remove some of the tasks which can be performed by another professional.

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

## 188/22 EXTERNAL REVIEWS REPORT

Sharon Cundy presented an update as circulated at appendix F.

Three external reviews had not yet started, one review completed and one review in progress. One review not yet started was the onsite Healthcare Safety Investigation Branch inspection, where the final report is still awaiting publication. The other review not yet started was the Ockenden regional maternity team assurance visit, where a mock inspection has been carried out with positive feedback received. One of the recommendations was that Julie Mellor's role is reviewed, as she is the only lead nurse for children in the organisation. **LR** stated that this is to ensure that Julie has the correct capacity to carry out her role across the organisation, with further matron roles being put into paediatrics.

**LR** stated that from a Quality Committee perspective, there is a commitment to carry out a development session with Board members around the children and young people's strategies, which will be taken forward over the next couple of months.

**VP** asked about the status columns within the update which state 'not yet started'. **SC** agreed to come back to **VP** with a response, as the template was not populated by herself.

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

# CARING

## 189/22 LEARNING FROM PATIENT STORY

Nicola Greaves was in attendance to share a patient story as circulated at appendix G on motor neurone disease (MND), with an opportunity for the Committee to look at the learning.

The presentation highlighted the patient voice, the initiating of the MND steering group, the reality, response and result of the steering group, and benefits of the learning.

**VP** agreed that this was something which the community requires, however, was not clear on the learning from the presentation. The benefits of having an MND nurse and the steering group were evident, however, the learning as an organisation, on how patients' voices are listened to, about the service developments that may be required within the organisation were not outlined. **NG** stated that work on an engagement toolkit will refine more about the listening to voices, and learn about when it is appropriate and how to make that judgement of putting the steering group in place.

**DS** asked where the information is captured from patients and carers who are stating that their needs are not met. **NG** stated that Friends and Family Test results, appreciations and complaints are now being triangulated, with some themes emerging, especially within maternity. A specific patient experience group has been set up to look at the issues.

In terms of carers, work is ongoing and increasing awareness such as the John's campaign, with better conversations with dementia carers, and targeting the carers' lanyard across more carers. There are also good mechanisms for engaging with carers once they have been provided with a lanyard, and working with carers' agencies across the health economy about carers being signposted for additional support.

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

## SAFE

### 190/22 MATERNITY REPORT

Diane Tinker provided a brief update on the report as circulated at appendix H, highlighting the key points, including the publication of the East Kent report. The report identified six areas for concern, which were submitted to the Board of Directors for discussion.

**DS** asked about the complaints, which are not seeing an increase in the numbers, although, with the additional scrutiny within maternity, it was asked if any changes were noted in the themes coming though. **DT** was not concerned about any themes, but stated that a piece of work on themes and relating to clinical incidents is being carried out as well as triangulating that with the maternity scorecard, which will be part of next months' report.

**LR** stated that following agreement at Board, a more detailed report on the East Kent report will also be submitted to the Quality Committee.

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

## EFFECTIVE

### 191/22 CLINICAL OUTCOMES GROUP MINUTES AND DASHBOARD

Sharon Cundy briefly presented an update from the Clinical Outcomes Board, as circulated at appendix I, which included items for escalation to Quality Committee of:

- ReSPECT (Recommended Summary Plan for Emergency Care) update, which will hopefully be rolled out in early 2023
- Concerns from the Care of the Acutely Ill Patient (CAIP) Programme included sepsis and the administration of antibiotics in ED within 60 minutes; the percentage of stroke patients spending 90% of their length of stay on a dedicated stroke unit; and the AKI business case not progressing as expected due to the interface between Cerner and Electronic Patient Record, and the risk of losing funding.
- Mental Health Strategy to be ratified at the Clinical Outcomes Group before submission to the Quality Committee, and a Mental Health Nurse in now in post.
- Maternity is being removed from the risk assessment compliance data for pressure ulcers, KP+ and Datix are generating different data. Data is being captured on Athena instead
- The COG dashboard shows that the administration of antibiotics for in the ED for sepsis has decreased; in harm falls have decreased, and a positive is that hospital mortality ratio is at its lowest since the start of the pandemic.

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

## RESPONSIVE

### 192/22 INTEGRATED PERFORMANCE REPORT

Lindsay Rudge presented an update to the report as circulated at appendix J.

It was noted that there is an improvement in the Quality Priority for 'Recognition and timely treatment of Sepsis' with challenges for the remaining quality priorities for 'Reduction in the number of hospital-acquired infections including COVID-19' due to continued COVID waves and 'Reducing waiting times for individuals attending the Emergency Department' due to continued ED positions.

The surgical site infection data looks to be increasing, with a possible update required going forward on the actions being taken and what it means in practice.

**LR** also noted that at the last weekly executive board (WEB) meeting, there was a deep dive into the Hospital Standardised Mortality Ratio.

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

## WELL-LED

### 193/22 BOARD ASSURANCE FRAMEWORK (BAF) RISK 4/20 – CQC RATING

Victoria Pickles presented the report as circulated at appendix K.

Key points to note were:

- The Trust continues to make good progress in assessing key service areas
- All board members recently took part in a 'well led' conversation individually with an external assessor. Feedback from this will be shared and actions to address any areas of development put in place.
- The learning from recent and upcoming webinars on the new approach to inspection to understand how this will affect us will be shared
- Children's services recently had an independent assessment by external facilitator. Report due in December 2022.
- The rating for the risk remains the same at a score of 12.

It was noted that the CQC and Compliance Group is now being restructured to only focus on CQC, which will be included on the new governance structure. The compliance element of the meeting will be monitored elsewhere. At the last CQC meeting, a complete review of all the must-do and should-do actions from the last inspection took place to create a more realistic position.
**Action**: Report detailing review of all must and should-do actions to be submitted to the next Quality Committee for sign-off.

## ITEMS TO RECEIVE AND NOTE

### 194/22 QUALITY COMMITTEE ANNUAL REPORT ACTION PLAN

A copy of the Quality Committee Annual Report action plan was available at appendix L for information. There were no questions from the Committee in relation to the action plan.

### 195/22 MEDICINES MANAGEMENT COMMITTEE MINUTES

A copy of the Medicines Management Committee minutes were available at appendix M for information. There were no questions from the Committee in relation to the minutes.

### 196/22 ANY OTHER BUSINESS

Integrated Care Board report

**LD** asked the Committee if there was anything of focus for the report, which is due to be drafted this week. Any comments which would like to be added, to be emailed to LD.

### 197/22 MATTERS FOR ESCALATION TO THE BOARD OF DIRECTORS

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

- Productive conversation with Debbie Winder in terms of place working arrangements
- Health and Safety highlight report with good assurance on appropriate processes and systems in place for patient and employee safety
- External Reviews Report
- Surgical Site Infections
- Safer Staffing Report

### 198/22 QUALITY COMMITTEE ANNUAL WORK PLAN

The workplan was available at appendix N for information.

## POST MEETING REVIEW

### 199/22 REVIEW OF MEETING

This item was not taken due to time constraints.

## NEXT MEETING

Monday, 16 January 2023
3:00 – 5:00 pm
Microsoft Teams

The meeting scheduled for Wednesday, 21 December 2022 was cancelled.

# QUALITY COMMITTEE ACTION LOG

## Following meeting on Monday, 14 November 2022

| Overdue | New / Ongoing | Closed | Going Forward |
|---|---|---|---|

| MEETING DATE AND REF | AGENDA ITEM | LEAD | CURRENT STATUS / ACTION | RAG RATING |
|---|---|---|---|---|
| **NEW / ONGOING ACTIONS** | | | | |
| 14.11.22 (193/22) | **BAF Risk 4/20 – CQC** | **Victoria Pickles** | At the last CQC meeting, a complete review of all the must-do and should-do actions from the last inspection took place to create a more realistic position.<br>**Action**: Report detailing review of all must and should-do actions to be submitted to the next Quality Committee for sign-off. | **Due 16 January 2023** |
| 24.10.22 (176/22) | **Medical Gases and Non-Invasive Ventilation (NIV) Group** | **Lindsay Rudge / Nicholas Scriven** | **LR** asked if there were any solutions to the issues raised or whether any support was required from the Committee. **NSc** stated that in terms of attendance at the meeting, divisional representation has been sought, however, this is challenged due to turnover, and not being certain on who the correct representative is, therefore any help would be appreciated on identifying the correct people to target to attend the meeting.<br>**Action 24.10.22: LR** agreed to meet with **NSc** outside of the meeting to logically go through the issues raised.<br>**Update**: Vanessa Dickinson met with **NSc** and Lis street on 16 November 2022 to discuss the various issues regarding the NIV/O2/Medical gases meeting and lack of divisional representation, the following were agreed:<br>• NIV/O2 and Medical Gases will be split into two separate meetings again – (identified by all parties that joining them has increased the problems)<br>• Pull sub-groups back into the main meeting to reduce number of meetings and increase divisional representation<br>• Vanessa has introduced a buddy system in medicine for the medical matrons regarding all meetings, which should also improve attendance and is happy to share with other divisions. | |
| 16.05.22 (80/22) | **Split Paediatric Service** | **David Birkenhead** | The Chair also mentioned the key risk in regard to staffing and asked if there was any business planning taking place or a business case, and whether this would be a long-term risk.<br>**Action 24.10.22: DB** agreed to liaise with Venkat Thiyagesh for further detail on the above and feedback to the Quality Committee.<br>**Update**: The Division produced an options paper to manage the risk. This went to Weekly Executive Board, and the option to move Paediatric A&E patients to CRH in line with the reconfiguration model was supported. | |
| **UPCOMING ACTIONS** | | | | |
| 16.05.22 (80/22) | **Split Paediatric Service** | **Lindsay Rudge** | **LR** commented on the risk relating to the APNP model at Huddersfield, which is at a score of 16 on the risk register, stating that Simon Riley-Fuller (ADN in FSS) has been asked to review this. It was also noted that the Emergency Department (ED) are also looking at the impact of any incidents or near misses that have occurred as a result of the described risk, the results of which can be returned to a future Quality Committee for oversight and assurance to ensure that the risk is not tolerated.<br>**Action 24.10.22**: For any results of the review of the risk and impact of incidents and near misses to be returned to the Quality Committee | **TBC** |
| 24.10.22 (171/22) | **Integrated Performance Report** | **Lindsay Rudge** | **LR** also stated that it would be helpful to bring a presentation on the data to see the broader impact of all the increased activity and that expanded bed base to see what that means in terms of harm and incidence.<br>**Action**: Presentation to be requested for Quality Committee | **TBC** |
| 16.05.22 (80/22) | **Split Paediatric Service** | **J Mellor / S Riley-Fuller / S Cartwright** | **Action 16 May 2022**: That the original escalation process is revisited.<br>**Update**: Options to return to Quality Committee in September and October have been provided and awaiting response from division.<br>**Update Oct 2022**: See item 168/22<br>**Action 24.10.22:** A focus on the children and young people standards to return to Quality Committee. | **Due 20 February 2023** |
| 20.06.22 (84/22) | **Annual Patient Experience Report** | **Nicola Greaves** | **OUTCOME**: To be deferred<br>**Update**: The report is awaiting approval at the Patient Experience and Caring Group before ratification at Quality Committee<br>**Update Oct 2022**: Deferred to a future meeting – date TBC | |

Calderdale and Huddersfield NHS Foundation Trust

# QUALITY COMMITTEE

**Monday, 20 February 2023**

## STANDING ITEMS

### 19/23 WELCOME AND INTRODUCTIONS

**Present**

| | |
|---|---|
| Denise Sterling **(DS)** | Non-Executive Director **(Chair)** |
| Dr David Birkenhead **(DB)** | Medical Director |
| Mr Neeraj Bhasin **(NB)** | Deputy Medical Director |
| Gina Choy **(GC)** | Public Elected Governor |
| Sharon Cundy **(SC)** | Head of Quality and Safety |
| Jason Eddleston **(JE)** | Deputy Director of Workforce & Organisational Development |
| Alison Edwards | |
| Jonathan Hammond **(JH)** | Deputy Chief Operational Officer |
| Karen Heaton **(KH)** | Non-Executive Director |
| Joanne Middleton **(JMidd)** | Deputy Chief Nurse |
| Victoria Pickles **(VP)** | Director of Corporate Affairs |
| Kim Smith **(KS)** | Assistant Director for Quality and Safety |
| Elisabeth Street **(ES)** | Clinical Director of Pharmacy |
| Michelle Augustine **(MA)** | Governance Administrator **(Minutes)** |

**In attendance**

| | |
|---|---|
| Gemma Hinchliffe **(GH)** | Quality Manager – NHS West Yorks ICB **(for LD and DW)** |
| Dr Tim Jackson **(TJ)** | Lead Medical Examiner **(item 27/23)** |
| Dr Elizabeth Loney **(EL)** | Associate Medical Director **(item 06/23)** |
| Julie Mellor **(JM)** | Student Nurse on Placement **(Observing)** |
| Liz Pepper **(LP)** | Senior Medical Examiner Officer **(item 27/23)** |
| Diane Tinker **(DT)** | Director of Midwifery **(item 29/23)** |

**Apologies**

| | |
|---|---|
| Rob Aitchison **(RA)** | Deputy Chief Executive |
| Lucy Dryden **(LD)** | Quality Manager for Calderdale Integrated Care Board |
| Lindsay Rudge **(LR)** | Chief Nurse |
| Debbie Winder **(DW)** | Deputy Director of Quality – NHS West Yorks ICB |

### 20/23 DECLARATIONS OF INTEREST

There were no declarations of interest.

### 21/23 MINUTES OF THE LAST MEETING AND ACTION LOG

The minutes of the last meeting held on Monday, 16 January 2023, circulated at appendix A1, were approved as a correct record. The action log can be found at the end of these minutes.

### 22/23 TERMS OF REFERENCE

A copy of the terms of reference were circulated at appendix A2 for revision and approval by the Quality Committee, prior to submission to the next Trust Board.

Changes made during the last year have been incorporated into the revised terms of reference. It was asked that the organogram within the terms of reference is amended to highlight changes to chairs of sub-group meetings.

**Action**: The organogram to be updated, and the amended terms of reference to be re-circulated.

## SPECIFIC REPORTS

### 23/23 CQC CHILDREN AND YOUNG PEOPLE SURVEY ACTION PLAN

Julie Mellor was in attendance to present the above, circulated at appendix B.

**JM** assured the Committee that the action plan has now been built into the overarching transformation plan, which will continue to be presented to the Committee.

**KH** asked about the timeframe for having volunteers in place. **JM** stated that confirmation from Infection Control is needed for the additional volunteers who will be actively involved in play sessions with children. This is being worked through by matrons at this time and envisaged to be in place in the next four weeks.

**SC** asked whether the clinical governance board is a divisional or trustwide initiative. **JM** stated that is a staff-facing board which was developed locally, and not in the public domain. It is a board in the medicines room with readily available information.

**DS** commented that it was encouraging to see the amount of work completed since the last Quality Committee update, and asked that thanks are conveyed to the key individuals who have been pushing this work forward.

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

## WELL-LED

### 24/23 GETTING IT RIGHT FIRST TIME (GIRFT)

Mr Neeraj Bhasin presented the above report, circulated at appendix C.

**DS** commented on the tracking of the benefits of GIRFT across the organisation and asked how this will be done, due to the team not yet being at full complement. **NB** stated that the reason for the new team composition is to try to enable that. One of the difficulties is double counting, as some of the benefits from the urology work, for example, are also captured in the outpatient transformation programme and divisional plans. One of the areas which needs to be more rigorous in capturing the benefits, is the refreshed reporting system. The GIRFT reports are monitored through the Performance Review Meetings, however, there should also be a view to quality, via Patient Safety and Quality Board meetings, in order for divisions to have an oversight and understanding of GIRFT in order to facilitate it.

**KH** reported that this continues to be a good story with a good track record, and looking forward to the new team being established quickly in order to not lose the successful momentum, as this is now embedded in the Trust and continues to be useful and helpful.

**JH** mentioned the benefits of GIRFT and trying to embed it as business as usual in divisions and directorates. An example of this is through the elective transformation programme, and trying to build on work already done, particularly around outpatients, and bring to the forefront by using the GIRFT outpatient recommendations as a menu of what each specialty could do if they followed the GIRFT process, with a structured approach and support from the GIRFT team.

**DS** commented on positive feedback received in terms of the training provided to increase colleagues' awareness of GIRFT.

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

### 25/23 BOARD ASSURANCE FRAMEWORK (BAF) RISK 3/19 – SEVEN-DAY SERVICES

Mr Neeraj Bhasin presented the above report, circulated at appendix D.

**NB** noted that this is particularly around the medical staffing and medical reviews defined by NHS England audit, rather than the broader provision of seven-day services, which is an operational and Multi-disciplinary Team approach.

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

## EFFECTIVE

### 26/23 LEARNING FROM DEATH (LfD) REPORT

Dr Elizabeth Loney was in attendance to present the above report, circulated at appendix E.

**EL** reported on highlights not included in the report, including community services now being part of the electronic initial screening review process; work ongoing on a new tool to bring the emergency department to electronic initial screening reviews, and then finally working with critical care to bring them online to use standardised initial screening review templates.

**EL** commented that the Hospital Standardised Mortality Ratio has gone below 100 for the first time in some time, and dropped to 99.98%. The Summary Hospital-level Mortality Indicator has dropped from 105.86 to 104.66.

**ES** asked about the three medicine-related incidents identified via the structured judgement reviews process, and queried whether the medication safety officers were cited on them, as part of the process. **EL** stated that one of the problems is that once the incidents go into the Datix process, they are lost sight of within the Mortality Surveillance Group, unless a colleague goes back into the individual Datix incident to get the feedback. **EL** reported liaising with the Risk Management department in order to join up the process, however, a response is yet to be received.

**DS** asked how we ensure that outcomes and messages are shared widely across the divisions, as necessary. **EL** stated that as part of the mortality review process, many specialties have a mortality/morbidity meeting, where their specialty mortalities are discussed. The surgery and anaesthetic division does this particularly well, however, there is room for improvement at better sharing learning from deaths, and an opportunity to link with the acute medical team to provide some learning sessions for junior doctors. Learning is circulated through different routes, for example, through Patient Safety and Quality Board meetings, however, more joined up learning, linking complaints, incidents, etc is required, which may be further improved with the introduction of Patient Safety Incident Response Framework, which will be reviewing themes.

On behalf of the Committee, **DS** thanked **EL** for her contributions over the last three years, which have always been positively received. This was the last meeting for **EL** as Associate Medical Director.

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

### 27/23 MEDICAL EXAMINER REPORT

Dr Tim Jackson and Liz Pepper were in attendance to present the above report, circulated at appendix F.

**DS** thanked **TJ** for the comprehensive update on the work of the Medical Examiners' Office and good to see the service moving forward, despite the challenges. In terms of the planned national rollout of Medical Examiner (ME) scrutiny to include community deaths, **DS** asked whether the ME Office will be in a position to do so by April 2023. **TJ** stated that between all

the services in the region, lead Medical Examiners are not in a position to 100% complete the community rollout.

**JE** commented on the helpful paper and comprehensive data sets which show impressive performance, and asked that future reports highlight where CHFT are in relation to partners in the West Yorkshire footprint. **TJ** stated that previous reports included regional data, however, data was not forthcoming for this report due to instability in the regional leadership team. **TJ** agreed to include comparative data in future reports.

OUTCOME: **TJ** and **LP** were thanked for the update, and the Quality Committee noted the report.

### 28/23 CLINICAL OUTCOMES GROUP REPORT

Dr David Birkenhead presented the above report, circulated at appendix G.

It was also noted that the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) process is being rolled out with CHFT and Mid-Yorks collaboratively, and across the health economy.

OUTCOME: **DB** was thanked for the update.

## SAFE

### 29/23 MATERNITY SAFETY REPORT

Diane Tinker presented the above report, circulated at appendix H.

The report also includes sections requested at the last meeting on the maternity dashboard, a review of the December 2022 cases postpartum haemorrhage and delay in emergency caesarean sections.

**DT** asked for comments on how the Perinatal Mortality Review Tool updates are reported. It was suggested that once the cases are reported as green, they are then taken off the subsequent report and a summary at the end of the year states the amount. DT also noted that through doing the Perinatal Mortality Review, there was an increase in neonatal deaths from 10 in 2021, to 25 in 2022, and a thematic review is being undertaken, with a view that the results are reported at a later meeting.

**KH** commented on the comprehensive report and good to see the progress against the detailed transformation plan. In terms of recruitment, **KH** also asked how many international midwife posts were expected to be filled. **DT** stated that there will be an over-offer of 10 posts, in order to recruit to five.

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

### 30/23 SAFEGUARDING BI-ANNUAL REPORT

Alison Edwards presented the above report, circulated at appendix I.

**DS** thanked **AE** for the comprehensive report and asked what the biggest challenge for the team was at the moment. **AE** stated that there have been several vacancies, and recruitment into safeguarding is difficult, with a lack of staff with appropriate skills to fill vacancies. One of the biggest challenges is in relation to the Mental Capacity Act (MCA) and colleagues' understanding. The audit results were of concern, and targeted work is planned over the next few months to address and improve colleague confidence in relation to their understanding, as the transition to the Liberty Protection Safeguard (LPS) will not be achieved.

**DS** asked whether there is enough support in place in order to deliver what is required. **AE** stated that there is support from the Safeguarding Team, the Learning Disability matron and the new lead for mental health, and will also look at having some MCA champions to get learning embedded within departments in the organisation.

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

### 31/23 Q3 INFECTION PREVENTION AND CONTROL REPORT

Dr David Birkenhead presented the above report, circulated at appendix J.

The Infection Prevention and Control Board Assurance Framework self-assessment was also appended to the report, which was rated with reasonable assurance.

**JE** asked that given CHFT have breached the Clostridium difficile ceiling, what are the regulatory implications and/or sanctions that flow from that, if any. **DB** stated that there are no sanctions, however, there is a visit from the regional Infection Prevention and Control team to review what is being done at CHFT, however, it is not anticipated that there will be anything suggested which is not already being carried out. With breaching the Clostridium difficile ceiling, there may be some attention from a CQC point of view, however, there are no particular concerns around the numbers, and CHFT is performing well in relation to peer Trusts.

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

## CARING

### 32/23 PATIENT EXPERIENCE AND CARING GROUP REPORT

Kim Smith presented the above report, circulated at appendix K.

In relation to the 52 complaints, **DS** asked how representative were the category of complainants. **KS** stated that there was good representation across the demographic, however, the challenge is that people who have responded well were those who were likely to respond anyway.

**VP** stated that equality data is not collected well enough about complainants and who make complaints, which can be done better. This is difficult, as it involves going back to complainants to ask to complete a form, which they are not always willing to do. The data is currently as representative as it can be, based on what is already known about complainants at this time, however, there is more which can be done. **KS** also stated that it is also around how the questions are asked, and also the timeliness of the questions.

**DS** commented on the principles of John's campaign being used in other areas.

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

## RESPONSIVE

### 33/23 QUALITY REPORT

Sharon Cundy presented the above report, for the period of January 2023, circulated at appendix L.

**DS** noted that an end of year summary for all the quality priorities is hoped to be brought to a next meeting, as some are still recording as amber or red. **KS** stated that this would need to be done in April, as the end of March 2023 data will be required to do a close-off summary. The introduction of the new quality priorities can also be done at the same time.

**VP** queried the Friends and Family Test, and asked whether there was a decline in the number of people completing, or a decline in the scores. **SC** stated that there was a decline in the number of people completing, as the process is partly done electronically, and partly done on paper, and those being completed on paper, are not being filled in.

**VP** commented on being interested in what the Friends and Family Test results were saying rather than the numbers being completed. **SC** stated that this was rather difficult to determine at the moment, as the Patient Safety Incident Response Framework task and finish group is currently looking at various types of data to ascertain what themes and trends would be in order to choose the Patient Safety Incident Response Framework categories, however, the Friends and Family Test data has so many elements to it, that it is hard to collate. The Health Informatics Team are currently working on a report; however, the majority of results say that good care is being provided. The difficulty is currently in the theming of the results. **KS** stated that the feedback that is being received is genuinely positive, however, due to the numbers being received, it is difficult to analyse.

**JMidd** shared that there may be a system to easily pull the themes from the Friends and Family Test systems, and agreed to liaise with **SC** outside of the meeting.

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

## 34/23 QUALITY ACCOUNTS TIMELINE

Kim Smith presented the above report, circulated at appendix M, which outlined the timeline and requirements to ensure ethe Quality Account for April 2022 to March 2023 are prepared and submitted to the Quality Committee.

The date of 2 March 2023 was confirmed as to when the Trust Board would be agreeing delegated authority to Quality Committee for sign off the Quality Accounts.

OUTCOME: **KS** was thanked for the update, and the Quality Committee noted and were agreement to the timeline.

## 35/23 INTEGRATED PERFORMANCE REPORT

Dr David Birkenhead presented the above report, circulated at appendix N.

**VP** mentioned a previous deep dive into stroke services; however, figures continue to be low, and asked when it was expected that actions would begin to make a difference. **DB** stated that it is challenging, with things not improving at this point in time, and in some ways, the pressures are increasing with staffing. Medical Directors of the Integrated Care Board raised the issue of stroke performance across CHFT and the ICBs, and whether the Stroke network can help in terms of stroke performance overall. **JH** stated that workforce challenges became more significant over the last couple of months, despite using outside agencies, looking across the country and abroad for additional Consultants. Two locum consultants have been agreed in order to ensure that the service is covered, however, this is fragile. From a workforce perspective, this is not limited to the medical workforce, this also applies to the therapy workforce, with challenges around therapy provision, particularly in occupational therapy and speech and language therapy. Business cases have been worked up looking at the pathway, which was prohibitively expensive, and broken down, and the community division plan to take the case through the Business Case Approvals Group, looking at an extended early supported discharge (ESD) service. Further work is required to understand the benefits. **JH** also added that some actions have been taken over the last couple of months to expand the stroke ward to manage patients at the front end as opposed to having outliers. Ward 7A has been opened up using nurses from across the stroke floor to staff the ward, however, this is not without challenge, in terms of a staffing position.

**DS** stated discussion took place at a previous Quality Committee regarding further investigation into long trolley waits and further information and assurance that patients had

not come to harm, particularly during the December 2022 and January 2023 timeframes of being in Opel 4. **JMidd** stated that Thomas Ladlow (ED Head Nurse) has started to review this, which can hopefully be brought to the next meeting.

OUTCOME: The Quality Committee noted the report.

## ITEMS TO RECEIVE AND NOTE

### 36/23 SUB-GROUP TERMS OF REFERENCE

Copies of the Quality Committee sub-groups' terms of reference were circulated at appendix O, for ratification, as part of recommendations from the Quality Structure Internal Audit. These included Research and Development; Mental Health Operational Group; Medical Gases and Non-invasive Ventilation Group; Trust Patient Safety and Quality Board and Clinical Effectiveness and Audit Group.

OUTCOME: All terms of reference were signed off by the Quality Committee.

### 37/23 ANNUAL PATIENT EXPERIENCE REPORT

A copy of the annual patient experience report 2021-2022 was circulated at appendix P for information.

OUTCOME: The Quality Committee noted the report.

### 38/23 MEDICINES MANAGEMENT COMMITTEE MINUTES

A copy of the above minutes were circulated at appendix Q for information. No comments were made.

### 39/23 ANY OTHER BUSINESS

There was no other business.

### 40/23 MATTERS FOR ESCALATION TO THE TRUST BOARD

The reports received include:

- Children and Young People Survey and Action plan
- Getting It Right First Time
- Board Assurance Framework – Seven-Day Services
- Learning from Deaths Report
- Medical Examiner Report

### 41/23 QUALITY COMMITTEE ANNUAL WORK PLAN

A copy of the above was available at appendix R for information.

## POST MEETING REVIEW

### 42/23 REVIEW OF MEETING

- Good reports
- Briefing to presenters to only provide highlights of reports
- One of the recommendations from the internal audit report was to review the reporting structure below the Quality Committee. **LR**, **VP**, **KS**, **SC** and **JMidd** met a few weeks ago, and are in the process of finalising what that structure may look like, and will return to a future Quality Committee meeting. Alongside that, the Committee needs to receive highlight reports from sub-groups rather than minutes, to either provide assurance or no assurance.

## NEXT MEETING

Monday, 20 March 2023
2:30 – 5:00 pm
Microsoft Teams

# QUALITY COMMITTEE ACTION LOG

## Following meeting on Monday, 20 February 2023

Overdue | New / Ongoing | Closed | Going Forward

| MEETING DATE AND REF | AGENDA ITEM | LEAD | CURRENT STATUS / ACTION | RAG RATING |
|---|---|---|---|---|
| **NEW / ONGOING ACTIONS** | | | | |
| 20.02.23 (22/23) | **Quality Committee terms of reference** | **All** | A copy of the terms of reference were circulated at appendix A2 for revision and approval by the Quality Committee, prior to submission to the next Trust Board.<br>Changes made during the last year have been incorporated into the revised terms of reference. It was asked that the organogram within the terms of reference is amended to highlight changes to chairs of sub-group meetings.<br>**Action 20 Feb 2023**: The organogram to be updated, and the amended terms of reference to be re-circulated.<br>**Update**: The revised terms of reference were re-circulated on 20 February 2023, with a deadline for comments to be received by 23 February. Comments received were incorporated into the final copy of the terms of reference, which were submitted to Trust Board on 2 March 2023 and approved. | **DUE FOR CLOSURE**<br>2023 (Feb) - Quality Committee Terms of R |
| **UPCOMING ACTIONS** | | | | |
| 16.01.23 (1/23) | **Quality Report** | **Kim Smith/ Jonathan Hammond / THIS** | **DS** commented on the ED quality priority and the increasing numbers of patients in ED who are breaching the eight, 10 and 12 hour targets, however, was pleased to see that no patients were coming into any harm, however, the pressure ulcer data states that there is an increase in hospital acquired Pressure Ulcers due to long waits and time spent on trollies. **DS** asked how reviews in ED are linking to ward level. **LR** stated that it cannot be said that patients are not coming to any harm on the long waits, as there are some serious incidents regarding delay in treatment. It was suggested that a review of the incidents related to ED over the Christmas period is carried out.<br>**Action 16.01.23**: A report of a review of incidents relating to the ED over the Christmas period to return to a future meeting, and triangulating data of increased acuity and admissions into the bed base as discussed at item 06/23.<br>**Update**: Information to be triangulated with the more detailed analysis carried out in relation to demand. This will help frame the improvement work in ED.<br>**March Update:** To be presented at the April meeting. | **Monday, 17 April 2023** |
| 24.10.22 (168/22) | **Split Paediatric Service** | | **LR** commented on the risk relating to the APNP model at Huddersfield, which is at a score of 16 on the risk register, stating that Simon Riley-Fuller (ADN in FSS) has been asked to review this. It was also noted that the Emergency Department (ED) are also looking at the impact of any incidents or near misses that have occurred as a result of the described risk, the results of which can be returned to a future Quality Committee for oversight and assurance to ensure that the risk is not tolerated.<br>**Action 24.10.22**: For any results of the review of the risk and impact of incidents and near misses to be returned to the Quality Committee<br>**March Update**: Followed-up with **SRF** as to whether the risk reviews have taken place, and also with the Risk Management Team as to whether there have been any reports from ED in relation to the impact of incidents or near misses as a result of the above risk. Awaiting responses on both. | **TBC** |
| 24.10.22 (171/22) | **Integrated Performance Report** | **Lindsay Rudge** | **LR** also stated that it would be helpful to bring a presentation on the data to see the broader impact of all the increased activity and that expanded bed base to see what that means in terms of harm and incidence.<br>**Action**: Presentation to be requested for Quality Committee<br>**Update**: Charlotte Anderson (Performance and Intelligence Lead) will attend the April meeting to present. | **Monday, 17 April 2023** |
| **CLOSED ACTIONS** | | | | |
| 14.11.22 (193/22)<br><br>16.01.23 (04/23) | **BAF Risk 4/20 – CQC**<br><br>**CQC action plan review** | | At the last CQC meeting, a complete review of all the must-do and should-do actions from the last inspection took place to create a more realistic position.<br>**Action**: Report detailing review of all must and should-do actions to be submitted to the next Quality Committee for sign-off.<br>**Update Jan 2023**: See agenda item 04/23<br>**Action Jan 2023**: Presentations from previous deep dives to be shared with the Committee (also see end of combined pack for full presentations) | **CLOSED** |

| | | | | |
|---|---|---|---|---|
| 16.05.22 (80/22) | **Split Paediatric Service** | | **Action 16 May 2022**: That the original escalation process is revisited.<br>**Update**: Options to return to Quality Committee in September and October have been provided and awaiting response from division.<br>**Update Oct 2022**: See item 168/22<br>**Action 24.10.22:** A focus on the children and young people standards to return to Quality Committee.<br>**Update**: See agenda item 23/23 | **CLOSED** |
| 20.06.22 (84/22) | **Annual Patient Experience Report** | | **OUTCOME**: To be deferred<br>**Update**: The report is awaiting approval at the Patient Experience and Caring Group before ratification at Quality Committee<br>**Update Oct 2022**: Deferred to a future meeting – date TBC<br>**Update**: See agenda item 37/23 | **CLOSED** |

Calderdale and Huddersfield NHS Foundation Trust

# QUALITY COMMITTEE

**Monday, 20 March 2023**

## STANDING ITEMS

### 43/23 WELCOME AND INTRODUCTIONS

**Present**

| | |
|---|---|
| Denise Sterling **(DS)** | Non-Executive Director **(Chair)** |
| Dr David Birkenhead **(DB)** | Medical Director |
| Mr Neeraj Bhasin **(NB)** | Deputy Medical Director |
| Gina Choy **(GC)** | Public Elected Governor |
| Lucy Dryden **(LD)** | Quality Manager for Calderdale Integrated Care Board |
| Sharon Cundy **(SC)** | Head of Quality and Safety |
| Joanne Middleton **(JMidd)** | Deputy Chief Nurse |
| Andy Nelson **(AN)** | Non-Executive Director |
| Victoria Pickles **(VP)** | Director of Corporate Affairs |
| Lindsay Rudge **(LR)** | Chief Nurse |
| Emma Sattler **(ES)** | Directorate Secretary **(Facilitating)** |

**In attendance**

| | |
|---|---|
| Nicola Greaves **(NG)** | Quality Improvement Manager – Patient Experience |
| Diane Tinker **(DT)** | Director of Midwifery **(item 29/23)** |

**Apologies**

| | |
|---|---|
| Jason Eddleston **(JE)** | Deputy Director of Workforce & Organisational Development |
| Jonathan Hammond **(JH)** | Deputy Chief Operational Officer |
| Kim Smith **(KS)** | Assistant Director for Quality and Safety |
| Karen Heaton **(KH)** | Non-Executive Director |
| Elisabeth Street **(ES)** | Clinical Director of Pharmacy |
| Michelle Augustine **(MA)** | Governance Administrator **(Minutes)** |

### 44/23 DECLARATIONS OF INTEREST

There were no declarations of interest.

### 45/23 MINUTES OF THE LAST MEETING AND ACTION LOG

The minutes of the last meeting held on Monday, 20 February 2023, circulated at appendix A, were approved as a correct record. The action log can be found at the end of these minutes.

## SPECIFIC REPORTS

### 46/23 LEARNING FROM PATIENT STORY - CARERS

Nicola Greaves was in attendance to present the above presentation circulated at appendix B.

The patient story, associated with John's Campaign, was Linda's story. The video of the story, told by her daughter, was played during the meeting.

**NG** reported how John's Campaign is being accredited to some of the reductions in complaints, with a deep dive on this taking place. **NG** stated that that the medical division have reflected on no longer seeing the volume of issues for visitation being an issue for carers.

**AN** asked about the carers organisations mentioned which provide further support, and asked where people would look for this and what support would be provided. **NG** stated that the main organisation - Carers Count - have monthly drop-ins at the main hospital sites, and

provide bereavement support, benefits advice, peer support, moving and handling support, and respite care.

**DS** commented on the local care organisations mentioned in the presentation, and asked whether they were reflective of the different communities which the Trust serves. **NG** stated that the organisations are a range of registered charities and self-made carers organisations for the most vulnerable groups, including refugee carers, and strategy groups across Calderdale and Kirklees, which feed into the health and wellbeing boards. Carers are being given a voice within the hospitals, as well as within their communities and on a larger scale.

**LR** acknowledged David Britton's (Associate Director of Nursing – Medical Division) leadership of this campaign across the medical division, and who continues to be an ambassador. This is a good example of improvement that does not require a collaborative, and as a result, could be used as an approach to doing quality priorities differently.

**DS** asked about the implementation and roll-out of the campaign into the community. **NG** reported that it is being well-received, and being able to connect carers to their local resources and empowering them to have a voice.

OUTCOME: **NG** was thanked for the presentation and story and the Quality Committee noted the report, and look forward to the next steps of sustainable improvement.

## 47/23 PUBLIC SECTOR EQUALITY DUTY (PSED) ANNUAL REPORT

**LR** reported that the PSED report was received at the Trust Board, with a request to strengthen the patient element. It was agreed that contributions to the PSED annual report in relation to patients should be presented periodically throughout the year to Quality Committee, in order to help populate the information for the annual report throughout the year. This will form part of the workplan going forward, which will cover patient experience and public engagement. **LR** also stated that this will be built into the patient experience and caring group's strategy.

Agreement is needed on whether this will come through the Patient Experience report, and also the frequency of the discussions.
**Action**: To be agreed at agenda-setting meeting

## SAFE

## 48/23 MATERNITY SAFETY REPORT

Diane Tinker presented the above report, circulated at appendix D. The report also included an additional ATAIN (Avoiding Term Admission to Neonatal Units) report, transitional care audit and the NHFT NHS maternity services survey benchmark report 2022.

**LR** asked where CHFT benchmarks across West Yorkshire. **DT** reported that the Trust benchmarks well with most areas, and agreed to include this data in subsequent reports. **LR** also asked about what specific work is being done to improve the booking targets. **DT** stated that the Local Maternity System are doing work on early booking as it was found from a deep dive that some communities were not accessing care early, despite being asked to. **LR** stated that this needs to be formally added to the health inequalities action plan, due to a health equity issue around booking.

**AN** asked whether bullet points can be provided on the areas of red on the dashboard to indicate what is being done.

In terms of the maternity transformation plan and Ockenden 2, there were two areas of concern. **DS** asked what mitigations have been put in place to reduce the concerns, whilst awaiting the outcome of the business plan. **DT** stated that the two areas are the split rota and having two registrars at night for paediatrics. In relation to the split rota, Consultants who are

predominantly gynaecologists do 'hot-weeks' three times a year, and they are supported with their training. In terms of the registrars, there is now external funding to cover three nights, plus there is access to the Consultant on call for senior backup.

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

## RESPONSIVE

### 49/23 INTEGRATED PERFORMANCE REPORT

Dr David Birkenhead presented the above report, circulated at appendix E.

**LR** mentioned that along with the report at the next meeting on the review of the ED, there has also been a report by **JH** around the acuity into the bed base, which will describe why there is complexity regarding performance indicators.

In terms of dementia, the switch to nurses carrying out assessments is underway, with a plan to go live in April. This will be more than just registered nurses, but also therapists, and who is the best person to carry out the assessment at the time. **DS** agreed that this should be a multi-disciplinary team approach, with the most appropriate member of the team at that point to carry out the screening.

In response to the nurse training workforce position, there has been some late national funding to increase the international recruitment capacity. Regarding infection, prevention and control essential safety training, there is a deep dive and plans in place to improve the indicator.

In relation to Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI), **AN** asked what has been done to get the Trust back to a better performing position. **DB** stated that the Trust was in the best quartile for HSMR and SHMI for a period of time, however, this began to increase through COVID. It is not known exactly why there was an increase, as there has not been an obvious theme. It was rebased at one point and decreased, but still remained above 100. Through that period of time, the Trust was not outlying, and remained within the expected range. Other Trusts also saw an increase during COVID, and CHFT were not unique in relation to the metrics. Work to improve has included general quality improvement work, focusing on care of the deteriorating patient and rapid identification and implementation of remedial actions for those patients and acuity of patients on discharge. Advice was to focus on quality improvement, rather than the data, which has been taking place, and numbers have now steadily started to reduce.

In relation to CHPPD (Care hours per patient day), **AN** asked if this was a national measure, or an internal plan. **LR** stated that it calculates what is planned, and also calculates what is done against plan – the need versus the actual, however, it is also an internal plan. CHFT used to benchmark quite high, but have since come down to slightly lower than mid-range, and need to better understand that which will come through the safer staffing report.

**DS** asked about the decisions taken last week with cancelled appointments, and what approach is being used for those group of patients going forward. **DB** stated that they would be prioritised and brought forward, and extra capacity has been put into theatres.

In relation to the improvement in responding to complaints within the timeline, **DS** asked if there was a reduction in the number of reopened complaints. **LR** stated that there are better responses to complaints first time, however, the re-opened data can be brought back. It was noted that the quality of the complaints responses are very good, and not a high number are referred onto the Ombudsman.

OUTCOME: The Quality Committee noted the report.

## ITEMS TO RECEIVE AND NOTE

### 50/23 CLINICAL OUTCOMES GROUP MINUTES

A copy of the above minutes were circulated at appendix F for information. No comments or were made.

### 51/23 QUALITY COMMITTEE ANNUAL WORK PLAN

A copy of the above was available at appendix G for information.

Following discussions, the frequency of the PSED will be added to the workplan.

### 52/23 ANY OTHER BUSINESS

**LD** shared a good experience following two visits to CHFT for herself and her daughter. **LD** fed back that the care received on the two visits, was absolutely phenomenal, especially the care in the Emergency Department for her daughter, as well as the follow-up from the orthopaedic team.

### 53/23 MATTERS FOR ESCALATION TO THE TRUST BOARD

The highlight report will include most of which was captured in the meeting.

It was also noted that the quality and safety strategy, which was due to be at this month's meeting, has been deliberately deferred, due to alignments required with the one and five year plan, which will also be included.

## POST MEETING REVIEW

### 54/23 REVIEW OF MEETING

There were no comments raised.

## NEXT MEETING

Monday, 17 April 2023
2:30 – 5:00 pm
Microsoft Teams

# QUALITY COMMITTEE ACTION LOG

## Following meeting on Monday, 20 March 2023

Overdue | New / Ongoing | Closed | Going Forward

| MEETING DATE AND REF | AGENDA ITEM | LEAD | CURRENT STATUS / ACTION | RAG RATING |
|---|---|---|---|---|
| **NEW / ONGOING ACTIONS** | | | | |
| 20.03.23 (47/23) | **Public sector equality duty (PSED) annual report** | **Chair / L.Rudge / V.Pickles** | Agreement is needed on whether this will come through the Patient Experience report, and also the frequency of the discussions.<br>**Action**: Frequency of reporting to be agreed at agenda-setting meeting | **Tuesday, 18 April 2023** |
| 16.01.23 (1/23) | **Quality Report** | **Kim Smith/ Jonathan Hammond / THIS** | **DS** commented on the ED quality priority and the increasing numbers of patients in ED who are breaching the eight, 10 and 12 hour targets, however, was pleased to see that no patients were coming into any harm, however, the pressure ulcer data states that there is an increase in hospital acquired Pressure Ulcers due to long waits and time spent on trollies. **DS** asked how reviews in ED are linking to ward level. **LR** stated that it cannot be said that patients are not coming to any harm on the long waits, as there are some serious incidents regarding delay in treatment. It was suggested that a review of the incidents related to ED over the Christmas period is carried out.<br>**Action 16.01.23**: A report of a review of incidents relating to the ED over the Christmas period to return to a future meeting, and triangulating data of increased acuity and admissions into the bed base as discussed at item 06/23.<br>**Update**: Information to be triangulated with the more detailed analysis carried out in relation to demand. This will help frame the improvement work in ED.<br>**March Update:** To be presented at the April meeting.<br>**Update: A deep dive of the incidents over the Christmas period was carried out, and triangulated with the information at item 58/23. It should be noted that only 4 incidents were reported, 1 x severe and 3 x catastrophic. On review of the four incidents, any harm caused was not directly related to increased acuity or admissions.**<br>**Just to note we are currently looking at any incidents that are reported during the industrial action and reviewing to ascertain if any learning is required from these.** | **Monday, 17 April 2023** |
| 24.10.22 (171/22) | **Integrated Performance Report** | | **LR** also stated that it would be helpful to bring a presentation on the data to see the broader impact of all the increased activity and that expanded bed base to see what that means in terms of harm and incidence.<br>**Action**: Presentation to be requested for Quality Committee<br>**Update: Charlotte Anderson (Performance and Intelligence Lead) will attend the April meeting to present.** | **See agenda item 58/23** |
| 24.10.22 (168/22) | **Split Paediatric Service** | | **LR** commented on the risk relating to the APNP model at Huddersfield, which is at a score of 16 on the risk register, stating that Simon Riley-Fuller (ADN in FSS) has been asked to review this. It was also noted that the Emergency Department (ED) are also looking at the impact of any incidents or near misses that have occurred as a result of the described risk, the results of which can be returned to a future Quality Committee for oversight and assurance to ensure that the risk is not tolerated.<br>**Action 24.10.22**: For any results of the review of the risk and impact of incidents and near misses to be returned to the Quality Committee<br>**March Update**: Followed-up with **SRF** as to whether the risk reviews have taken place, and also with the Risk Management Team as to whether there have been any reports from ED in relation to the impact of incidents or near misses as a result of the above risk. Awaiting responses on both.<br>**Update: Risk 7776 was originally scoring 20, and reduced to a 16 as there are not gaps every day for the PNP cover. Of note, a trainee has handed in their final dissertation and if successful, will be able to add as part of the PNP rota later this year. It is anticipated at this point, that the risk score will reduce further. The Children's Directorate and ED team have collated a paper that has been presented to WEB in terms of plans for urgent care delivery for CYP on both hospital sites. If approved this will cumulate in the APNP's being based on the CRH site. Dr Morris, Tom Ladlow, Fiona Stuttard, Chloe Gough and Julie Mellor are aiming to meet to try to progress this work.** | |

| CLOSED ACTIONS | | | | |
|---|---|---|---|---|
| 20.02.23 (22/23) | **Quality Committee terms of reference** | **All** | A copy of the terms of reference were circulated at appendix A2 for revision and approval by the Quality Committee, prior to submission to the next Trust Board.<br>Changes made during the last year have been incorporated into the revised terms of reference. It was asked that the organogram within the terms of reference is amended to highlight changes to chairs of sub-group meetings.<br>**Action 20 Feb 2023**: The organogram to be updated, and the amended terms of reference to be re-circulated.<br>**Update**: The revised terms of reference were re-circulated on 20 February 2023, with a deadline for comments to be received by 23 February. Comments received were incorporated into the final copy of the terms of reference, which were submitted to Trust Board on 2 March 2023 and approved. | **CLOSED 20 Feb 2023**<br>2023 (Feb) - Quality Committee Terms of R |

Calderdale and Huddersfield NHS Foundation Trust

**Draft Minutes of the Audit and Risk Committee Meeting held on Tuesday 31 January 2023 commencing at 10:00 am via Microsoft Teams**

**PRESENT**

| | |
|---|---|
| Nigel Broadbent (The Chair) | Chair, Non-Executive Director |
| Denise Sterling (DS) | Non-Executive Director |
| Peter Wilkinson (PW) | Non-Executive Director |

**IN ATTENDANCE**

| | |
|---|---|
| Andrea McCourt | Company Secretary |
| Kirsty Archer | Director of Finance |
| Shaun Fleming | Local Counter Fraud Specialist, Audit Yorkshire |
| Leanne Sobratee | Internal Audit Manager, Audit Yorkshire |
| Liam Stout (LS) | Staff Elected Governor |
| Kim Smith | Assistant Director of Patient Safety |
| Chris Boyne | Audit Yorkshire |
| Philippa Russell | Acting Deputy Director of Finance |
| Richard Lee | KPMG |
| Heather Moore | Audit Yorkshire |
| Richard Hill | Head of Health and Safety – from 11am |

**01/23 WELCOME AND INTRODUCTIONS**

The Chair welcomed everyone to the Audit and Risk Committee.

**02/23 APOLOGIES FOR ABSENCE**

There were no apologies received.

**03/23 DECLARATIONS OF INTEREST**

The Chair reminded Committee members to declare any items of interest.

**04/23 MINUTES OF THE MEETING HELD ON 25 OCTOBER 2022**

The minutes of the meeting held on 25 October 2022 were approved as a correct record.

**OUTCOME:** The Committee **APPROVED** the minutes of the previous meeting held on 25 October 2022.

**05/23 MATTERS ARISING AND ACTION LOG**

The action log was reviewed and updated accordingly. It was noted that the action relating to item 52/22 internal audit follow up report regarding delegated consent was on the agenda.

**OUTCOME:** The Committee **NOTED** the updates to the Action Log.

**06/23 EXECUTIVE DIRECTOR OF FINANCE'S BUSINESS**

**1. Review of Losses and Special Payments**

The Director of Finance presented a report summarising the losses and special payments for quarter 3 2022/23 totalling £142K. The increase in quarter 3 compared to the prior

quarter, quarter 2 was noted, which it was confirmed relates primarily to the write off of bad debts at circa £60K. The losses of patient property, including cash, was noted in terms of poor patient experience which is likely impacted by recent capacity challenges with Matrons taking a special interest to reduce these incidents.

DS commented that she was pleased to note that there was not an acceptance of the increase in loss of patient items and steps were being taken to reduce these and monitor it. The Director of Finance highlighted a change in how such costs are allocated previously the losses were charged centrally but are now being charged to the service area where the loss was incurred to highlight the issue operationally.

NB questioned the financial thresholds within the Standard Financial Instructions, that determines what is reported to this Committee. The Director of Finance responded that everything over £1000, the limit of bad debt that can be written off at the discretion of the Director of Finance is reported to the Committee. Each transaction is reviewed individually, rather than aggregated across the quarter.

**OUTCOME**: The Committee **NOTED** the Review of Losses and Special Payments report.

**2. Review of Waiving of Standard Orders**

The Director of Finance presented the quarter report showing 138 waivers during quarter 3, 2022/23 at a total cost of £8,715,468.45.

The report reflects several changes within Procurement Contract Regulations and procurement. The new electronic system Atamis is tracking in more sophisticated ways and reporting different categories.

It was noted there had been a focus on single source tenders over the allowable threshold where there was no competition. Only one single source waiver was reported as being over the threshold which was a contract value of £120K for radiation protection services. Investigations as to whether this service can be brought in house to CHS are underway.

Single source tenders were reported under the threshold total at a value of £329K, which were made up of smaller values. Of the single source tenders £202K were in-house, ie exempt from the regulations, such as contracts between CHFT and other NHS Trusts.

**OUTCOME**: The Committee **NOTED** the updated Waiving of Standing Orders report for quarter 3, 2022/23.

**3. Debts Proposed for Write Offs**

The Director of Finance noted that having fully exhausted options around debt recovery, the debt identified in this paper totalling £134.6k was now recommended for write-off, with provision made in the Trust's financial statements, with the exception of the payroll overpayments which were included in the Trust's pay position in 2021/22.

The Director of Finance gave the history relating to an old debt of circa £100K for one overseas visitor who had spent an extended time in ICU, which had been previously brought to the Committee. The patient was complying with a monthly payment plan until their death, and there is no estate to claim from. It had been initially planned to write off this debt at the end of 2021/22 as the patient was deceased. However a cautious approach was taken and checks were made at a national level to see if a threshold had been breached which required the amount to be reported nationally. It had been

confirmed that £300K was the threshold for national level reporting and this applied only to special payments, not a bad debt such as this one. This bad debt was presented once again to this Committee to seek approval to write off this debt.

There is a further £26k of overseas debt spread across nine invoices. Circumstances are similar in that patients are deceased or destitute.

The proposed debts to write off relating to payroll were very specific cases where four apprentices were overpaid with full details given in the report.

PW requested clarification that overseas debt is beyond the control of CHFT and we are not able to prevent such instances. The Director of Finance gave assurances that systems are in place to seek payment for elective procedures via the Overseas Visitors team and that bad debts usually relate to non-elective procedures. It was noted that the volumes of overseas visitors are low compared to other Trusts. Non -payment can be escalated to the level of the patient being prevented from entering the UK if deemed necessary.

In terms of the apprentice overpayments, NB asked if there is a general policy in regard to salary overpayment and whether the write off was consistent with the policy. The Director of Finance confirmed there is a policy in place. In the first instance CHFT would usually seek to reclaim the overpayment from the individual. The policy allows for discretion if individuals would be in hardship as a result of repaying the overpay. This case is unusual in that it was not the fault of individuals, rather CHFT by using the incorrect start point. The colleagues concerned are paid at a low rate which would create financial hardship if deductions were to be made.

**OUTCOME:** The Committee **APPROVED** the debt right off as set out in the paper

**4. Final Accounts Process and Plans**

The Director of Finance noted that the 2022/23 final accounts will follow the same process and timeline as previous years. Dates for the 2022/23 audit cycle and timetable are published in the KPMG audit planning paper which was on the agenda. Two colleagues have attended a two-day accounts planning workshop in preparation.

**OUTCOME:** The Committee **NOTED** the Final Accounts Process and Plans.

**07/23 Local Counter Fraud:**

The Local Counter Fraud Specialist, SF from Audit Yorkshire, presented the Local Counter Fraud progress report and provided an update on current investigations. The key points to note were:

- Newsletter is sent out on a monthly basis.
- QR code to be added to posters and leaflets for further information to encourage engagement.
- Presentations made to Finance team and Freedom to Speak Up guardians since the last meeting.
- 12 scams of Christmas document sent out, highlighting potential scams at both home and work.
- Fraud prevention masterclass sessions have been delivered covering a selection of topics.
- Survey of all attendees of masterclasses to gauge the effectiveness
- There have been various fraud alerts with a theme of mandate fraud usually cyber enabled.

- The National Fraud Initiative (NFI) exercise that takes place every two years has commenced. The date has been downloaded and matches are coming out in next few months
- In the hold to account section, there are two investigations. One from last year relating to vaccinations is now closed as the evidence asked for was not available. A new investigation which began just before Christmas is ongoing regarding an employee and secondary working whilst on sick leave.
- Referral benchmarking across all Trusts for quarter 3 2022/23 is the same as usual, with two main themes of staff and computer fraud noted.
- Strategic Governance - over the next few months work on a compliance exercise on performance against national counter fraud standards will commence. 124 fraud risks have been reviewed and risk assessed. These will be shared with the risk owners and measures put in place to alleviate the risk. This should enable an improved rating of amber for requirement 3, first introduced in 2021/22, regarding risk assessment methodology
- Progress with the 2022/23 Counter Fraud Plan is on target. There have been more referrals and investigations this year indicating improving awareness of fraud.

PW asked if there was any data showing the benefits of the colleague training, eg by increased referrals. SF noted that it was difficult to assess as increased referrals show greater awareness. SF noted work continues to increase more awareness via face to face training. There has been a low response rates to previous surveys, but results have always shown a good level of awareness.

The Director of Finance commented that training to increase awareness is targeted to areas where colleagues may spot potential fraud.

AM, as the counter fraud champion for CHFT, queried if there had been activity nationally regarding this role and SF advised nothing has been done centrally since the initial guidance was issued, with individual organisations to communicate how this role should work.

DS commented on the positive news around training resulting in awareness and queried the level of take up of training compared to other Trusts and whether more promotion is needed. SF replied that CHFT engagement is on the low side but the Trust is in the same position as other comparative Trusts. The training is constantly advertised. New subjects might encourage colleagues to take up.

NB noted that this Committee could have a role in promoting to the right audience the masterclasses, newsletter and encourage engagement with the survey and training as he would like CHFT to be on a par with the best of the other Trusts.

**OUTCOME:** The Committee **NOTED** the Local Counter Fraud Progress Report.

**08/23 INTERNAL AUDIT**

**1. Internal Audit Follow Up Report**

The Internal Audit Manager presented an update to the circulated Follow-Up Report which covers the period Q3 2022/23

It was noted that Internal Audit had completed and finalised 12 audit reports within the last quarter as follows:

- 2 High assurance reports

- 7 Significant assurance reports
- 1 No opinion report
- 2 Limited assurance reports

A total of 268.5 days have been delivered; this represents 72% of planned audit days. The team is currently on track to complete work on the plan by 30 April 2023, with the 2023/24 plan commencing on 1 May 2023.

**2. Internal Audit Progress Report**

The Internal Audit Manager, LS, presented a report which details the progress made by Internal Audit in completing the Internal Audit Plan for 2022/23.

It has not been possible to start two audits as yet: the implementation of a new stock system in theatres has been delayed so will now be scheduled in the 2023/24 plan and a system upgrade at HPS has also been delayed and is under discussion as to whether it will form part of the 2023/24 plan.

The Quality Governance audit which had received a limited assurance opinion was discussed, noting that structures and escalations channels were found to be in place. KS commented that the report was helpful in reviewing ward to Board assurance and that the intention is to complete all recommendations by the end of this week, with terms of reference having been updated with the correct names of Committees.

DS asked whether audits relating to “Medical” had been cancelled or were on hold as only 15 of the 40 planned days for such audits had taken place. LS advised the dementia screening audit had been cancelled as the responsibility for the screening is moving from doctors to nurses and the Safer Procedures (LOCSSIPS) audit was underway but had been delayed as in-house work had been needed prior to the audit commencing.

The Sickness Absence audit report which had received a limited assurance opinion was discussed, noting there had been issues with members of staff and line managers recording sickness, in terms of not always following the process when trigger points are reached. It was noted there is work to do to complete return to work interviews within 72 hours and make sure triggers are being monitored.

AM advised the report should be shared with the Workforce Committee and progress monitored through there.

**ACTION**: DS to take to workforce committee.

**OUTCOME:** The Committee **NOTED** the Internal Audit Follow Up Report and Progress Report.

**3. Follow up of Internal Audit Recommendations.**

LS presented the outstanding recommendations report for the period 20 January 2022 – 19 January 2023. At the time of issue of Committee papers, the report stated there were 27 outstanding recommendations. As of 31 January 2023 that position has improved with 22 outstanding. Of the 22, two are overdue and 20 have been given a revised target date. In total 106 recommendations have been completed in the last 12 months with 45 which are due before 31 March 2023 and work is required to make sure as many of these have been closed as possible.

A full list of the outstanding actions will be shared with NB. LS advised that individual responsible officers will receive their next reminders from the audit system on 3 February 2023.

LS has been training some of the secretarial PA's on the system so they can assist Directors with signing off actions.

AM requested it be noted that the actions are on the Executive Directors radar. It has been agreed that some colleagues can email through their responses rather than using the system which is helpful.

NB commented that there are good processes in place and recommend that the Executive Board (WEB) continue the process to support completion of as many recommendations as possible by the end of March 2023.

DS asked if some of the significantly overdue actions had been closed. LS advised that some recommendations from 2019/20 have been closed, however, there is one from 2018 relating to the study leave policy which remains open. The policy has been written but not enacted due to ongoing discussions with Local Negotiating Committee. As study leave was cancelled for the last few years due to the pandemic this has not been deemed a risk.

In terms of the delegated consent audit it was noted that CHFT has implemented a new electronic system for e-consent but it does not have all the functionality expected which is impacting on completing the recommendations.

**ACTION**: LS circulate the updated report post meeting - Complete
**ACTION**: Update required on long standing actions from responsible officers with commitment to achieve the revised dates. NB to follow up with Brendan.

**OUTCOME:** The Committee **NOTED** the Internal Audit Follow Up Report and Progress Report.

**09/23 EXTERNAL AUDIT**

**1. Sector Update**

RL presented the sector update for information and noted the general theme in the paper regarding the changes from Clinical Commissioning Groups to Integrated Care Boards in light of statutory changes.

The following were highlighted: financial reporting, guidance around the deterioration of the financial position in the context of system working, updated code of governance and duties for governors around roles and responsibilities in a system working arrangement.

PW commented the sector update was well put together.

**OUTCOME:** The Committee **NOTED** the External Audit Report.

**2. Draft External Audit Plan**

The draft audit plan was presented by RL. Audit planning and risk assessment has been undertaken for 2023 and risks have been identified where KPMG will focus their work.

- Page 4 shows a summary of the initial assessment of risk.

- The risk assessment for 2023 is stable compared to the previous year.
- A specific risk assessment relating to value for money will be brought to this Committee at the next meeting.
- Materiality – as the Trust is continuing to forecast expenditure and income around the £500m threshold this puts CHFT on the radar of an AQR (Audit Quality Review) scope audit, where the Financial Reporting Council (FRC) and audit quality review team review the audits performed. This results in additional procedures for KPMG, particularly around documentation, and a second level review takes place before the issue of audit opinions.
- the headline materiality threshold has been increased because of some of the challenge through the audit review process. Headline materiality based on revenue and income of the Trust is between 0.5% and 3%, a prudent level within a stable environment. Any misstatements identified above £300k will be reported to this Committee.
- KPMG will continue to audit Calderdale and Huddersfield Solutions whose timeline will be in line with the Trust annual accounts sign off. A new audit team from KPMG with greater experience of the NEP ledger system is now in place with more on site audit planned.
- Risk around expenditure were noted, including cost improvement programmes (CIP). Valuations of land and buildings was highlighted as a risk, as this is subject to judgement. This year is a full valuation year for land and buildings at CHFT; this was last done in 2018.
- The impact of the new auditing standards ISA 315 revised was highlighted with an enhanced planning and risk assessment approach which reflects an increasing dependence by organisations on digital systems. Further work by KPMG's digital team will be done to understand the processes around key risks.
- The audit cycle and timetable was shown, with finalisation of accounts in June. The plan is for the subsidiaries audit work to be signed off earlier this year than last.
- The proposed fees for 2022/23 were shared which are based on contract, inflation and impact of ISA 315 revised. NB questioned the allowance for inflation and when the fee for ISA315 would be determined. The final fees will be agreed with the Director of Finance before these are charged.

.
PW queried if the risk re land and property valuation was due to the valuation exercise and not market movement. RL confirmed this was correct as the risk was due to the value of land and buildings (£130M) and reliance on a third party valuer. RL commented that a full valuation is usually more accurate and can significantly impact on the accounts.

The Director of Finance detailed the significant amount of work in the Trust undertaken for the Value For Money(VFM) process and noted that good progress has been made in last few weeks with supporting evidence shared with KPMG, much of which crosses over with evidence provided for the financial sustainability checklist. In regard to the new ISA 315 revised, CHFT use the same ledger system as most Trusts in WYAAT and if we are unable to answer questions, we would have support from those Trusts and the supplier NEP.

The Director of Finance noted that further conversations are to be had around fees, given the considerable increase in fees at the start of the renewed contract with KPMG in 2021/22.

The Committee formally delegated further discussion of fees to the Director of Finance.

**10/23 BOARD ASSURANCE FRAMEWORK (BAF)**

The Company Secretary presented the 2022/23 third and final version of the BAF update.

The top three risks are consistent with previous reports. The workforce nurse staffing risk continues to be the biggest risk. The risk details are to be audited as part of internal audit testing of the Board Assurance Framework. The second risk is around progression of the reconfiguration, which at present is outside of the control of CHFT.

The only risk to have its score changed is Health and Safety risk to reduce from a score of 9 to 6 based on the advice of the Head of Health and Safety, who commented that the plan is to reduce the risk score further over the next 6-12 months towards the target risk score of 3.

AM noted the new deputy CEO has taken the Director lead on the health inequalities risk and refreshed this.

NB asked if the sickness report limited assurance should be referenced in the BAF. AM agreed to review this in relation to workforce risks prior to the paper going to the Board.

NB queried if the Board is satisfied that any new risks around Place or systems sustainability are reflected in the framework. AM fedback that a desktop review of some other BAFS highlighted that some Trusts had one individual system risk on the BAF but that it had been concluded that this was not helpful. AM advised that specific BAF risks had PLACE/ system references where appropriate to the risk, which was more meaningful than having a separate overarching systems risk. Further national guidance regarding BAFs and system risks is awaited.

PW Commented that the top three risks are not obvious within the BAF report. AM agreed to review the presentation of the paper with a view to adding a summary page for the top three risks for the next Board report.

**OUTCOME:** The Committee noted the reduced risk score for risk 16/19 health and safety and **APPROVED** the updated BAF and **RECOMMEND** this to the Board.

**11/23 COMPANY SECRETARY'S BUSINESS**

**1.1 Review Standing Orders**

AM advised that a scheduled review had taken place and updates mainly include legislation and guidance updates which reflect system working. Definitions had been added to, more information had been included on Director roles and a revision to give the Chair the casting vote in the event of an equal result. Information has been added to clarify which are mandatory Committees, and which are non-mandatory. Reference to the Standards of Public Life are now included.

NB advised that he would raise minor points on the Standing Orders with AM outside of meeting.

**OUTCOME:** The Committee **APPROVED** the updated Standing Orders and **RECOMMEND** this to the Board.

**1.2 Standing Financial Instructions (SFIs)**

PR advised that there had been a number of updates to the SFIs as part of this regular review, none of which were major. Future proofing terms had been added e.g. using "regulator" instead of a specific organisation named. Additions include budget holders to sign off budgets at the beginning of the financial year. This is required and any non-compliance will be reported to this Committee. The Online banking section had been updated. The biggest change was in the procurement section which the Head of Procurement and Supplies has rewritten. Reference to EU guidelines has been removed and updated. A paragraph has been added in section 14 with reference to the HM Treasury managing public money guidance.

PR noted a further piece of work is required to update the two appendices which are around authorisation limits.

**ACTION**: Bring back review of Appendices to July Committee meeting.

**OUTCOME:** The Committee **APPROVED** the updated Standing Financial Instructions and **RECOMMEND** this to the Board.

**1.3 Scheme of Delegation**

AM presented this item and noted this was a scheduled review with housekeeping and amends to reflect new Director roles and changed portfolios. The material change relates to delegated authority to the Charitable Funds Committee to approve the charities annual report on annual accounts.

Should the updated appendices of the SFIs impact the scheme of delegation, then this will be returned to this Committee at the same time.

**OUTCOME:** The Committee **APPROVED** the revised Scheme of Delegation and **RECOMMEND** this to the Board.

**1.4 Self-Assessment of Committee Effectiveness**

AM advised this would be circulated for completion and return by Word version to be distributed. Checklist one is only to be completed by the meeting Chair and Director of Finance. The form should be returned by 17 February 2023 and will be fedback with an action plan to the April meeting.

**1.5 Draft Annual Accounts Timetable**

AM advised that the official Foundation Trust accounting manual for 2022/23 has not yet been issued. The timetable is based on the two key dates known. The draft annual accounts are due for submission on 27 April 2023, Trust sign off date is planned for the 27 June 2023 with final submission of accounts planned for 30 June 2023

NB noted sufficient time was needed to review the accounts in advance of the Committee meeting reviewing the accounts and asked if these could be shared at the earliest opportunity.

**ACTION**: Director of Finance and Zoe Quarmby to arrange a meeting with NB after the draft submission and after audit have completed a significant part of their review.

**OUTCOME:** The Committee **NOTED** the annual accounts timetable for 2022/23.

### 1.6 Audit and Risk Committee Workplan 2023

Risk management review deferred to the next meeting.

**OUTCOME:** The Committee **NOTED** the Audit and Risk Workplan for 2023.

## 12/23 APPROVAL OF STRATEGY AND POLICIES

**1.Health and Safety Strategy 2023 – 2028**
RH presented this noting the alignment towards the NHS workplace safety, health and safety standards. The Trust's ambition is to achieve the requirements of ISO 45001 which is the gold standard of assurance. The strategy has been written with these points in mind and is now at the review stage. For the next five years focus will be on monitoring those standards to make sure CHFT continues to meet them.

Other work to be done involves networking with third party organisations and better sharing of information between occupational health and the moving and handling team. This strategy has been to the Health and Safety Committee.

**OUTCOME:** The Committee **APPROVED** the health and safety strategy.

**2.Health and Safety Policy**
RH advised the policy has been reviewed by the Health and Safety Committee. Key points:

- Signature from the current Chief Executive added.
- New polices have been created over the last two years with new risks around ligature, which are now cross referenced in the policy.
- Re-written to make it easier to read and for the reader to access associated information.

NB asked whether it is clear that health and safety is everyone's responsibility. The statement of intent lists the Chief Executive and Board responsibility. RH responded that key responsibilities are noted in the paper at senior levels, which is an NHS requirement. Further down the structures there is less specific detail, but re-iterated health and safety is everyone's responsibility.

**OUTCOME:** The Committee **APPROVED** the Health and Safety Policy.

**3.Conflicts of Interests Policy**
AM presented the revised policy following a routine scheduled review. The main changes highlighted were that the nil return process has been made clearer for decision making staff. CHFT have a lower threshold of decision making staff, at band 7, than the national requirement of band 8 and above. AM advised that NHS Contracts guidance required the Trust to publish details of decision -makers that had not made a nil return. The counter fraud contacts have been updated.

**OUTCOME:** The Committee **APPROVED** the Conflicts of Interest Policy

**4.Treasury Management Policy**

The Director of Finance and PR had to leave the meeting The updated policy within the meeting pack was approved with any comments to PR.

**ACTION** Any comments sent to KA and PR copy in NB.

**OUTCOME:** The Committee **APPROVED** the Treasury Management policy.

**13/23 REVIEW OF SUB-COMMITTEE TERMS OF REFERENCE**

**1.Health and Safety Committee**
RH advised that over the last 18 months new subgroups have been created to tackle some of the key issues. These have now been reflected in terms of reference. The membership of the committee has been updated.

NB commented that there was no section detailing quoracy of the meetings. RH advised the meeting must have 75% attendance to achieve quoracy. RH agreed to add quoracy information to the terms of reference

AM highlighted a correction under escalation – the name of this Committee is Audit and Risk Committee and advised that the terms of reference should state that the Audit and Risk Committee also provide health and safety assurance.

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

**2. Compliance Group**
KS advised that the terms of reference were presented as the Compliance Group has been separated out from the CQC and Compliance group. The Director of Corporate Affairs is chairing both meetings and taking the Director lead. The terms of reference have been re-written to show clear lines of accountability. The new meetings allow them to be clear about the appropriateness of the membership and are able to focus on separate agenda items and give more scrutiny to those items.

**3.Risk Group**
KS advised the Risk Group terms of reference had been reviewed.

**4.Information Governance and Records Strategy Group**
No colleague present to discuss.

**OUTCOME**: The Committee **RATIFIED** the Terms of Reference for the above sub-groups.

**14/23 SUMMARY REPORTS**

A summary report of work undertaken since April 2022 was provided for the following sub-committees and minutes of these meetings were made available in the review room:

- Risk Group
- Information Governance and Records Strategy Group
- Health and Safety Committee
- Data Quality Board
- CQC and Compliance Group – Stood down due to operational pressures.

**OUTCOME**: The Committee **NOTED** the summary reports for the above sub-groups.

**15/23 ANY OTHER BUSINESS**

No other business was raised.

**16/23 MATTERS TO CASCADE TO BOARD OF DIRECTORS**

- Policies and strategies approved. Referred to Board on Standing Orders, Standing Financial Instructions and Scheme of Delegation.
- Promoting counter fraud awareness programme
- Follow up of internal audit actions.
- Refer to BAF update.

**17/23 DATE AND TIME OF THE NEXT MEETING**

Tuesday 24 April 2023 10:00 – 12:15 pm Microsoft Teams

**ACTION**: Two deep dives on agenda, consider deferring one**.** Arrange agenda so that items requiring formal approval are at the top of agenda for next meeting. AM

**18/23 REVIEW OF MEETING**

The meeting closed at approximately 12.15.

Appendix A

**CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST**

**Minutes of the WORKFORCE COMMITTEE**

**Held on Tuesday 14 February 2023, 3.00pm – 5.00pm**
**VIA TEAMS**

**PRESENT:**

| | | |
|---|---|---|
| David Birkenhead | (DB) | Medical Director |
| Suzanne Dunkley | (SD) | Director of Workforce and OD |
| Karen Heaton | (KH) | Non-Executive Director (Chair) |
| Lindsay Rudge | (LR) | Chief Nurse |
| Denise Sterling | (DS) | Non-Executive Director |

**IN ATTENDANCE:**

| | | |
|---|---|---|
| Jason Eddleston | (JE) | Deputy Director of Workforce and Organisational Development |
| Nikki Hosty | (NH) | Assistant Director of HR (for items 11/23, 12/23 and 13/22) |
| Tegan Joseph | (TJ) | Race and Inclusion Engagement Partner (for item 10/23) |
| Tina Knight | (TK) | Chair, Disability Network (for item 10/23) |
| Adam Matthews | (AM) | WOD Business Manager (for item 06/23) |
| Andrea McCourt | (AM) | Company Secretary (observing) |
| Keith Rawnsley | (KR) | Fire Safety Officer (for item 06/23) |
| Jackie Robinson | (JR) | Assistant Director of HR (for item 07/23) |
| Helen Senior | (HS) | Staff Side Chair |
| Lisa Whiteley | (LW) | HR Business Partner (for items 08/23 and 09/23) |

01/23 **WELCOME AND INTRODUCTIONS**

The Chair welcomed members to the meeting.

02/23 **APOLOGIES FOR ABSENCE**

Rob Aitchison, Deputy Chief Executive
Peter Bamber, Governor
Mark Bushby, Workforce Business Intelligence Manager
Sarah Eastburn, Governor
Jonny Hammond, Chief Operating Officer
Vicky Pickles, Director of Corporate Affairs

03/23 **DECLARATION OF INTERESTS**

There were no declarations of interest.

04/23 **MINUTES OF MEETING HELD ON 7 DECEMBER 2022**

The minutes of the Workforce Committee held on 7 December 2022 were approved as a correct record.

KH brought to the attention of the Committee that clarification is required in terms of what capacity colleagues are attending the meeting. This will be reviewed outside of the meeting for future accurate note recording and the terms of reference will be updated accordingly.

05/23 **ACTION LOG – FEBRUARY 2023**

The action log was received.

06/23 Matters Arising

**EST – Fire Safety Training**

KR summarised the last 12 months fire safety training activity. KR commented on the inflexibility of the current e-learning programme which had been developed largely in response to pandemic restrictions. KR expressed his preference for a combination of face to face and e-learning that can be modified and adapted to suit both hospital and community premises and can also provide awareness to partner colleagues working from Trust sites. A new software system is being procured by the Trust that will facilitate customised e-learning programmes.

SD asked about immediate plans to drive compliance. KR responded that managers and fire wardens are targeted as often in a ward area for example there is more than one non-compliant colleague. DS asked if there was any indication when face to face training might commence and what support is needed to update the e-learning package. KR stated the Fire Safety Committee isn't currently supportive of returning to a face to face approach albeit Fire Warden training is face to face as this is site specific. The e-learning material is finalised in readiness for uploading to the new software system. LR commented on instances when colleagues have been unable to register completion of the training on ESR. JR advised the Workforce BI team can record compliance should colleagues experience any difficulties. Discussion took place about engagement with colleagues, role of the Fire Warden and how the Trust benchmarks across other organisations.

KH recapped the points outlining a number of actions to be brought back to the next Committee meeting:-

- Current compliance rates
- Activity taken place since today's Workforce Committee meeting
- Alternative training considered and implemented
- Increase in face to face training trial
- Number of team training sessions delivered
- Consideration of fire wardens training their teams

**ACTION: KR to attend April meeting to present the above actions.**

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

**SHADOW BOARD**

AD informed the Committee that a recent audit recommended that by 2025 our senior leadership team should match the Trust's diverse community. As a result, an action highlighted in the Board's representation action plan is to develop and implement a Shadow Board in 2023/2024. The intention is for the Shadow Board to serve for 12 months in role, meeting monthly; comprising of 6 meetings in line with Board meetings plus 6 development sessions. The Shadow Board will receive papers at the same time as the Board and will be chaired by the Deputy Chief Executives who will feedback to the Board. The Shadow Board is a fundamental part of our wider talent management offer presenting development opportunities for aspirant directors and senior leaders. A comms launch piece is being developed.

**OUTCOME:** The Committee **NOTED** the establishment of a Shadow Board.

Appendix A

07/23 **QUALITY AND PERFORMANCE REPORT (WORKFORCE) – JANUARY 2023**

JR presented the report.

Summary
Performance on workforce metrics is now back to amber and the Workforce domain has decreased to 62.5% in December 2022. This is due to the inclusion of the non-medical colleague appraisal compliance. 7 of the 14 current metrics that make up the Workforce domain score are not achieving target - Non Covid Long Term Sickness, Non Covid Total sickness absence, Data Security Awareness EST compliance, Fire Safety EST Compliance, Infection Control EST Compliance, and Medical and Non-Medical appraisals.

Workforce – December 2022
Staff in Post has decreased slightly at 6191, which, is due, in part to 23.61 FTE leavers in December 2022. FTE in the Establishment was 5964.6, and along with student nurses. Turnover decreased to 8.56% for the rolling 12-month period January 2022 to December 2022. This is a decrease on the figure of 8.85% for November 2022.

Sickness absence – December 2022
The in-month Non Covid sickness absence increased to 6.08% in December 2022. However, the rolling 12-month rate for Non Covid sickness also increased to 6.02% from 5.99% in November. Stress, anxiety, and depression problems were the highest reason for sickness absence, accounting for 25.97% of sickness absence in December 2022, with cold, cough, and flu the second highest at 19.14% in December 2022.

Essential Safety Training – December 2022
Performance has increased in all 10 of the core suite of essential safety training. With 6 out of 10 above the 90% target with 3 achieving the 95% 'stretch' target. Data security awareness target has been amended to fall in line with national guidelines and is now 95%. Learning Disabilities Awareness EST commenced from 10 May 2022, however is not included in Overall EST Compliance score or Domain Score totals. Overall compliance increased to 92.74% from 92.38% and is the third increase month on month. It is however no longer above the stretch target of 95%.

Workforce Spend – December 2022
Agency spend increased for the month to £1.41M, whilst bank spend decreased in month by £0.29M to £2.32M.

Recruitment – December 2022
4 of the 5 recruitment metrics reported reached target in December 2022. The time for Unconditional offer to Acceptance in November 2022 decreased to 1.0 days.

KH noted her concern about the increasing sickness absence levels. The report shows more starters than leavers and noted the high vacancies in nursing. LR responded the nursing vacancies aren't a worsening position and explained that vacancies are tracked against the extra additional bed plan which is a raised whole time equivalent base.

DS asked if there was a potential risk regarding the number of colleagues requiring an immunisation update. SD advised there is a post-pandemic backlog and a summary paper will accompany this meeting's notes that describes the current position and forward actions.

**ACTION: Immunisation Update paper to attach to April Committee notes (SD).**

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

08/23 **QUARTERLY VACANCY DEEP DIVE QUARTER 3**

LW presented the vacancy deep dive report highlighting the following key points:-

- Planned vacancy position over the last quarter 347.81 full time equivalent (fte)
- Medicine and FSS divisions have majority of vacancies, consistent with previous quarters.
- Community vacancies increased over last quarter by 24.25 fte .
- Turnover increased by 0.51%, now at 8.65%
- Continued focus on hotspot areas in each division, linking in with apprenticeships, widening participation, international recruitment team for nurses, midwives and radiographers.
- Generic Recruitment events for all vacancies plus bespoke event for paediatric recruitment.
- Focus on growing our own for hard to recruit vacancies, e.g. physiologists.
- 194 live vacancies.
- Hotspots – a number of specialty doctors in ED confirmed they wish to progress through the CESR programme to specialist registration. Specialist doctor commencing in 2 months. Advert out for substantive consultant posts.
- Successful recruitment to paediatric radiologist commencing in May.
- Actively recruiting for Stroke physicians.
- Contact made with overseas Neurology specialist who is willing to gain specialist registration through the CESR programme who would work as an interim consultant whilst going through the programme.

LR added further explanation and detail to elements of the report. SD suggested it would be useful for the Committee to have sight of Divisional recruitment action plans, particularly hot spot areas. JE advised the NHSE published workforce plan should be available ahead of the next Committee meeting and highlighted the need to check in on programmes intended to support recruitment and retention. We need to be cognisant of regional hotspots and ensure that our position isn't falling back against partners locally.

**ACTION: Divisional recruitment plans to be shared with the Committee (LW).**

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

09/23 **ABSENCE MANAGEMENT (SICKNESS ABSENCE) AUDIT RECOMMENDATIONS**

LW presented a paper that set out the findings of an audit conducted by Audit Yorkshire in November 2022 in relation to the Trust's arrangements for the effective management of sickness absence. The overall audit opinion was 'Limited Assurance'. 5 recommendations for action were highlighted, 3 major, 1 moderate and 1 minor. 11 actions were agreed in response to the audit findings. 8 actions are complete with 1 to be completed in March 2023 and 2 in April 2023. The action plan is at Appendix 2 of the report.

SD thanked LW for a comprehensive report. SD stated absence is under increased scrutiny. Checks will be made to ensure colleagues are in the appropriate process to be supported to return to work or exit colleagues that have no prospect of returning to work. SD recognises absence sits at the root of a lot of our workforce issues adding that this is an action in both our CIP and Availability work.

HS asked about attendance management training for managers commenting that she has experience of managers not understanding the process. LW confirmed the training is voluntary. JE added the work around management fundamentals will not only support new colleagues in leadership and management roles but also existing managers.

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

10/23 **EQUALITY NETWORK GROUPS UPDATE**

Disability Group Action Plan
TN recently took over as Chair of Disability Network Group and has joined the development programme for the Disability Chair Network benefitting from structure and interaction with regional colleagues. TN described the 7 high impact action areas aligned to the People Strategy to improve colleague experience at CHFT. NH added that engagement with colleagues through a range of channels will continue, we listen to lived experiences and balance with education across the Trust around invisible disabilities.

SD observed the plan is at the raising awareness phase and stated that 16 to 19% of the population have a disability with less than 4% of colleagues declaring they have a disability. SD stated it is important to give colleagues confidence to come forward recognising the challenges .

KH commented on the commendable programme and gave encouragement on what is known to be a difficult journey.

Race Equality Network
TJ advised the REN was established in 2016. There are currently two groups; a steering Group comprising a selection of colleagues, chaired by Neeraj Bhasin, who meet monthly and a wider group for all colleagues chaired by Polly Shunje and Deehan Mair. 78 new colleagues have joined the wider network. As part of the Root Out Racism campaign 98 pledges were signed within 2 weeks and in recognition of this CHFT featured in the WY Health and Care Partnership weekly briefing shared widely across West Yorkshire.

SD asked if there is an action plan that the Committee can support with. TJ responded the action plan will be shared as soon as it is finalised. DS recently attended a walkaround and commented on TJ's positivity and enthusiasm. DS is a sponsor for the network and remarked on the great work and is confident we will see a significant move forward this year.

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

11/23 **DEVELOPMENT FOR ALL**

NH presented an update on the Development For All programme which is embedded in the Talent Management Chapter of the People Strategy. NH provided examples of partnership working, apprenticeship successes, tools to engage colleagues and the CHFT Leadership Offer. The presentation summarised areas for focus in 2023.

KH stated this is excellent work, a well thought through programme with powerful messages demonstrating a commitment to grow your own. DS echoed the comments made by KH and added the development of the programme clearly displays response to feedback and gives potential for increased engagement and more people wanting to get on board.

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

12/23 **STAFF SURVEY RESULTS**

NH presented on screen the high level survey results. The Committee noted the results are embargoed with benchmark results available on 21 February 2023 and comprehensive results embargoed until 9 March 2023.

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

13/23 **GENDER PAY GAP (6 MONTH UPDATE ON ACTION PLAN)**

The paper had been circulated.

**OUTCOME:** The Committee **NOTED** the progress made on the action plan.

14/23 **BOARD ASSURANCE FRAMEWORK**
**RISK 10/19 MEDICAL STAFFING**

DB presented the deep dive into the Medical Staffing Risk. Progress in key areas were noted:-

- Recruitment
- Engagement Activity
- Flexible Workforce
- E Job Planning
- E-Rostering
- Policy development
- 'Grow our Own'
- Engagement with the GMC

DB added that external factors such as industrial relations with medical staff, BMA rate cards for consultants, specialty doctors and junior doctors and pensions impact on the ability to manage the risk.

KH thanked DB for the detailed report. She noted there are challenges however felt the report did provide assurance.

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

15/23 **INTERNAL AUDIT REPORT FOR CHFT: MEDICAL REVALIDATION CH/15/2023**

DB presented the findings of an audit of medical revalidation in November/December 2022. The report carries a high assurance opinion for each of the domains. Audit Yorkshire state this reflects the effective systems and processes in place for medical revalidation. Consequently no recommendations have been made.

KH congratulated everybody involved, an outstanding report.

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

16/23 **WORKFORCE COMMITTEE SELF ASSESSMENT ACTION PLAN REVIEW**

**OUTCOME:** The Committee **ACCEPTED** the progress on actions.

17/23 **WORKFORCE COMMITTEE WORKPLAN**

KH had recently discussed with SD the time constraints for deep discussion of agenda items. KH proposed to schedule a dedicated meeting in May to discuss diversity and inclusion. A date will be confirmed in diaries.

In addition to workplan business items, it was felt the Committee should have a systematic approach to discussing the 6 Chapters of the People Strategy. One Chapter per meeting will be listed for discussion which aligns well to the Committee meeting 6 times per year. This approach will allow balance in hearing about positive progress and grasping hot spot areas. There will be an emphasis on Divisions/leads attending Committee meetings to present their

key priorities and action plans in response to hot spot areas.

The Committee's workplan and terms of reference will be refreshed accordingly.

**OUTCOME:** The Committee **SUPPORTED** and **AGREED** the proposed approach.

18/23 **ONE CULTURE OF CARE – MEETING REVIEW**

LR commented the theme ran through all elements of the meeting.

19/23 **ANY OTHER BUSINESS**

No other business was discussed.

20/23 **MATTERS FOR ESCALATION TO THE BOARD OF DIRECTORS**

KH will present the highlight report to the Board capturing the topics discussed highlighting:-

Fire Safety
Vacancy Deep Dive
Audits
Staff Survey
Health and Wellbeing

21/23 **DATE AND TIME OF NEXT MEETING:**

24 April 2023, 2pm – 4.30pm

# Immunisation Update for Workforce Committee

## 1. Background

There is a risk that colleagues who have commenced employment at CHFT since March 2020 may not be fully protected against risks associated with contracting blood borne viruses (BBVs).

Due to restrictions associated with the Covid-19 pandemic and periods of vaccine shortages, plus a need to recruit staff to clinical posts swiftly during this period there is now a backlog of colleagues who potentially have never attended occupational health for an immunisation assessment appointment*

Unfortunately, due to a change in electronic Occupational Health (OH) system and the fast pace at which new colleagues were recruited (and in some cases have now left), the Trust does not hold fully accurate records of who is affected by the above.

The OH system in place does not currently have an interface with ESR presenting further challenges around maintaining records that are accurate in terms of current staff and the roles they are in.

## 2. Current Position

Workforce BI have provided details of all new hires into clinical roles since March 2020 and who were still in post as of 31 December 2022. This is a total of 1595 colleagues.

Of these, 1086 are medical staff or professionally registered practitioners such as RN's, AHPS etc. for whom it is reasonable to assume have been vaccinated during their training. Efforts are therefore initially being focussed upon the remaining 509 colleagues who commenced in support roles during the period of time in question.

Unfortunately, there is the requirement to check every individual OH record for each of the new hires to ascertain what, if any OH intervention is required. This is a time consuming and laborious process and therefore will be addressed in stages commencing with colleagues who work in higher risk areas. As a need for assessment appointments are identified these will be issued and colleagues will be notified via text and email.

A further assessment of the remaining 1084 needs to be carried out to determine what , if any OH intervention is required for each individual given that it is anticipated that the majority are likely to have been immunised elsewhere.

Addressing the backlog needs to take place alongside current activity for those undergoing a series of vaccinations and immunisation appointments for current new starters. Failure to do so will result in an increase of unvaccinated colleagues, further compounding the problem.

Capacity to offer appointments is limited to two band 5 staff nurses, providing 69 immunisation related appointments each week. At present, the majority of these 69 appointments are for newly appointed colleagues, however, it has been determined that the backlog of the priority 509 colleagues will be cleared between April 2023 and March 2024.

## 3. Actions Implemented since January 2023

- Text messaging has now been enabled within our system meaning colleagues can be notified of appointments via text. A standardised text and email is sent for all OH appointments.

- Colleagues can now book and manage their own appointment via a newly introduced booking page. This is in addition to being able to call OH to book over the telephone.

- A weekly vaccination clinic is now held on the HRI site to make attending appointments more accessible especially during working hours for those based at HRI. If this proves successful, a second day will be added.

- Using the monthly new starters list, all new starters into a role where risk has been identified are sent an appointment for an immunisation assessment. This is sent via email and text.

- New starters who commence in cohorts such as international nurses and clinical apprentices are booked to attend during their induction before they commence in the clinical area.

- Appointments are confirmed via text and email. Reminder emails are sent 2 days before the appointment to help reduce the number of DNAs

## 4. Future Planned Actions

- New hires into specific clinical roles will be required to provide evidence of their immunisation history as part of the pre-employment checks. Unconditional offer letters will not be issued until this has been received (effective from 01.04.23).

- OH will attend the fortnightly Corporate induction sessions when they return to face to face (scheduled to commence 24 April 2023) to book in appointments for immunisation assessments directly with each applicable new starter.

- A bi-directional ESR to Cohort interface has been designed. This will automatically update OH records with any changes to staff details / position etc and any leavers. It will also allow for transfer of immunisation data via IAT into the OH record in Cohort, reducing the need for colleagues to provide this themselves (implementation anticipated December 2023).

**Pamela Wood, Head of Occupational Health**
**Workforce & OD Directorate**
**March 2023**

**Emergency Department – Response to Vacancy Pressure**

**March 2023**

| | |
|---|---|
| **Staff Group** | Medical / Nurse recruitment |
| **Vacancy Pressure** | National shortage of ED medical staff in the context of strong competition for those that are in the employment market from local Trusts perceived as preferred employers.<br><br>Difficulty in recruiting paediatric trained nurses for the HRI ED |
| **CHFT ED Response** | |
| **Grow our own** | Improving colleague retention with inclusive leadership from GM/Operational Manager engaging colleagues in decision making and changing rota which offers an improved work/life balance.<br><br>Success of CESR programme with 3 specialist doctors successfully moving to consultant roles<br><br>ST6's – 3 offered opportunity to develop to Consultants<br><br>Funding secured to train all senior nurses to Advanced Paediatric Life Support (APLS) level to mitigate the risk.<br><br>Development of an in-house Paediatric training course delivered by the ED Clinical Educators, this course provides RNs with the knowledge around recognising the deteriorating Paediatric patients and the management of common Paediatric presenting complaints. |
| **External recruitment drive** | Positioning CHFT ED department as an employer of choice to new applicants on the basis of working within a new ED department at HRI 2023 onwards and being part of that journey moving forward.<br><br>Job descriptions and adverts modernised to be reflective of the role and showcase the move to the new ED department as part of the reconfiguration.<br><br>Innovative recruitment campaign planned – ED working with Comms Manager to produce a recruitment video to include ED CD and consultants showcasing CHFT ED department an opportunities. |

| | |
|---|---|
| | Trialed utilising ACP's to develop to ST3 level currently achieving SHO competency<br><br>Proactive plan to move away from reliance on locums and replace them with substantive Consultants.<br>Aim to move to the WFM of 16 Consultants.<br><br>Current recruitment activity<br><br>o Consultants x5 (On TRAC)<br>o ST4+ x5 (On TRAC)<br>o ST3 x2<br>o Junior x10 (these can be ST1-2 or Physician Associates)<br>o ACP x8 (preferably already qualified band 8a)<br><br>Funding agreed £1,216,608 to meet increase in MWFM, Consultant and Junior rota agreed in medical division.<br><br>ED nursing presence at CHFT recruitment events, specifically those aimed at the recruitment of Paediatric trained nurses. |
| **Reconfiguration** | Rota review utilising the ED activity heatmap to ensure safer staffing levels resulting in a revised rota that had been in place for 17 years. This is a significant shift requiring consultant cover over weekends and to participate on the on call rota ensuring senior clinical support for team when operational pressures are at the highest.<br><br>Using the reconfiguration as a driver to attract new staff particularly show casing the new Paediatric ED area in light of this being a notoriously difficult area to recruit Paediatric nurses to. |

Appendix A

**Surgery and Anaesthetics - Response to Vacancy Pressures**

**March 2023**

| | |
|---|---|
| **Staff Group** | Medical recruitment |
| **Vacancy Pressure** | Difficulty in recruiting Medical Staff into Anaesthetics and Eyes.<br><br>National shortage of specialists- (Anaesthetists and critical care) |
| **Grow our own** | |
| **Response** | Eyes is a close network across the UK. GM in touch with consultant colleagues regarding trainees who are coming through in the UK, and Doctors abroad who are looking to come to the UK.<br><br>We are also constantly looking at our non-medical workforce to see what we can do differently.<br><br>In addition the eye department work with other trusts to see what they can do to streamline services - and share our transformation work with them. Louise Corp (former Eye Services GM is currently on secondment with the ICB leading the transformation project. |

| | |
|---|---|
| **Staff Group** | Medical recruitment |
| **Vacancy Pressure** | Difficulty in recruiting into Anaesthetics<br><br>National shortage of specialists, eg Glaucoma |
| **Grow our own** | Over recruiting into lower grades to retain and support to Consultant level |
| **Response** | Tried high cost agencies which has not been effective. Plan is to over recruit on Speciality Drs which has been really successful<br><br>There is a confirmed Locum Consultant starting later this year and interviews for substantive posts later this month (March 2023) with potential further interests later this year as well. |
| **Staff Group** | Nursing and ODPs in Theatres |

| | |
|---|---|
| **Vacancy Pressure** | Difficulty in recruiting into Theatres, with retention issues. |
| **Grow our own** | Continued recruitment into Theatre workforce, including ODP apprenticeships and nursing associates, which have been really successful and lead to more robust, resilient workforce |
| **Response** | Implemented various workforce initiatives to increase retention and improve working environment. Specific Theatre induction implemented with SMT input. Clinical Educator post to ensure Colleagues access the right training, and have the opportunity to progress.<br><br>Recruitment keeping in touch evenings for staff who have secured a role, but awaiting uni results/ working notice period. This allows opportunity to meet the team, walk around the department and familiarise themselves with their surroundings.<br><br>ESU accreditation and networking across WYATT have also greatly helped in increasing the department's reputation and making it a place where people want to work. |

Calderdale and Huddersfield NHS Foundation Trust

| | |
|---|---|
| **Date of Meeting:** | 4th May 2023 |
| **Meeting:** | Board of Directors |
| **Title:** | Annual report (1 April 2022 to 28 February 2023) from the Guardian of Safe Working Hours, CHFT |
| **Author:** | Dr Shiva deep Sukumar |
| **Sponsoring Director:** | Dr David Birkenhead, Medical Director |
| **Previous Forums:** | None |

**Purpose of the Report**

To provide an overview and assurance of the Trusts compliance with safe working hours for doctors/dentists in training across the Trust, and to highlight any areas of concern

**Key Points to Note**

1. Increase in exception reports since August 2022 with the new cohort of trainees
2. Successful delivery of the presentation about Exception reporting at induction.
3. Information about cover arrangements for out of hours rota gaps
4. Junior Doctors Forum Meeting
5. Junior doctors' strike
6. Improvements in induction for our Junior Doctors.

**EQIA – Equality Impact Assessment**

The opportunity to exception report is available for all doctors in training and Trust doctors on the 2016 Contract irrespective of any protected characteristics.

**Recommendation**

Board is asked to

1. Note and approve the report.
2. Continue to support the Guardian of Safe Working Hours.
3. Note updates regarding the Trust's compliance with revised 2016 TCS.

**GOSWH Annual report – 04.05.2023**

**Introduction:**

The purpose of this report is to give assurance to the Board that our doctors in training are safely rostered and that their working hours are compliant with the Junior doctor's contract rota rules and in accordance with the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016.

The report includes the data from April 2022 to February 2023.

After the previous Guardian, Ms Devina Gogi left the Trust, Dr Shiva deep Sukumar became the Guardian of Safe Working Hours (GOSWH), and commenced in role from September 2022.

**Executive summary:**

The trust has used Allocate software since August 2017 to enable trainees to submit exception reports. All doctors in training and locally employed Trust doctors employed on the 2016 Terms and Conditions have an Allocate account. Educational supervisors and clinical supervisors also have access to this software. The software will send them a message to alert them to any issues raised by trainees, and to capture a summary of their discussion with the trainee and agreed response, whether that is time off in lieu, payment, or some other solution.

Exception reports help the supervisors, Guardian and DME to know the problems faced by junior doctors. Remedies are reached based on the discussion with junior doctors following the exception reports.

All our junior doctor rotas are fully compliant with the 2016 TCs. Rota gaps remain a challenge, when/where Health Education England don't provide a trainee, however a number of Trust doctors are recruited to cover wherever possible. Where there are out of hours gaps the flexible workforce team work to cover these shifts with bank/agency locums, with the junior doctor's cross-covering during the day.

**High level Data:**

Number of doctors / dentists in training (total): 260

Number of doctors / dentists in training on 2016 TCS (total): 260

Amount of time available in job plan for guardian to do the role: 2 PAs

Administrative support is provided to the guardian by the Medical HR and Medical Education teams.

The Medical HR team manage the payment for exception reports wherever this is agreed and create Allocate accounts for all those that need access. They also do initial prompts to clinical supervisors and educational supervisors regarding exception reports. There is a regular meeting scheduled with the GOSWH and the Medical HR Manager for additional support if required.

The Medical Education team manage the invites, agenda, and minutes for the quarterly Junior Doctors Forum meeting.

Support is also given by consultant colleagues wo have the initial discussion with trainees who raise exceptions.

Time within the Job Plan is identified to undertake this support. Educational Supervisors, are allocated0.25 PAs per trainee as per Health Education England recommendations

Clinical Supervisors have job-planned time within their core SPA allocation.

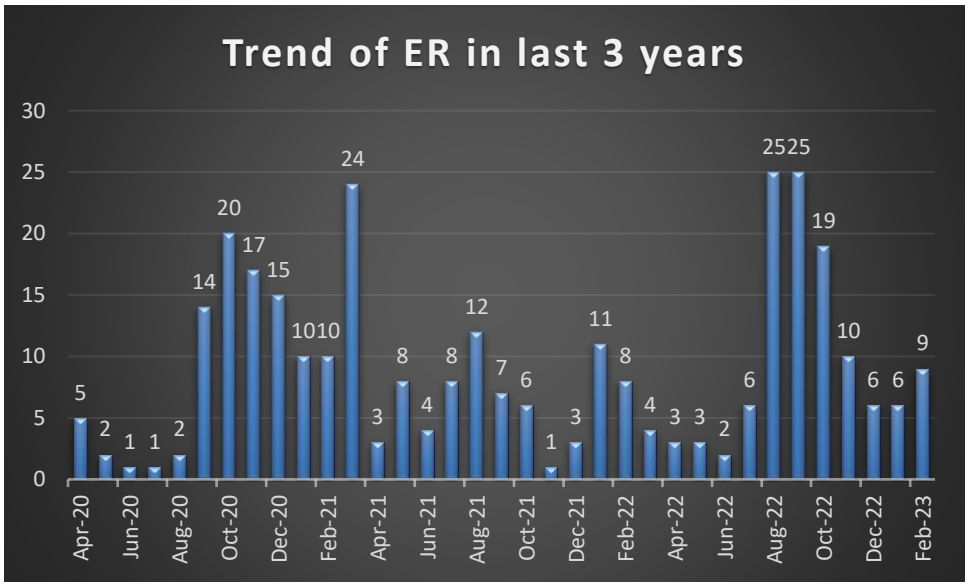
**Exception reports:**

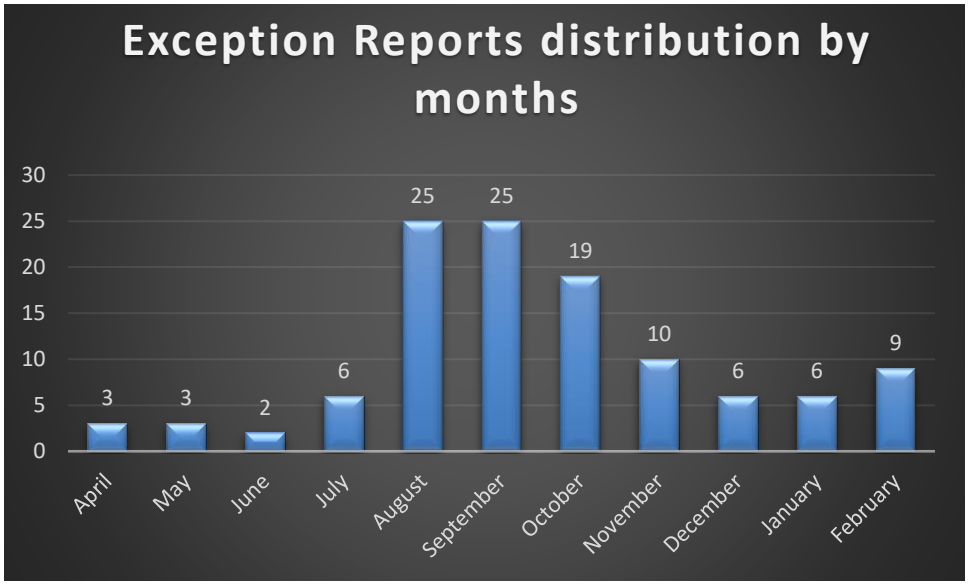
ER from April 2022 – February 2023= 114

The number of exception reports (ERs) shows that Foundation year doctors still account for the highest number submitted. This is a pattern that has been seen before and is due to several factors. Also, more reports are submitted in August-September period.

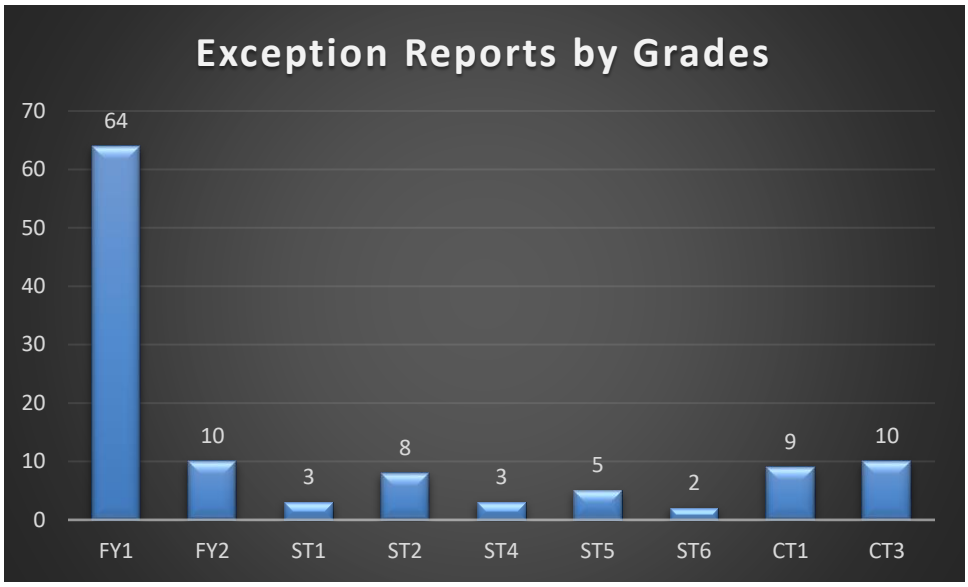
For Foundation Year 1 trainees that commence in August, this is their first experience of working in the NHS. They may take longer than colleagues to undertake some tasks, which, with practice will reduce time pressures. They are gaining an understanding of protocols and working practices and may initially be more reluctant to hand over jobs that have not been completed.

It may also reflect the successful induction programme when exception reporting is discussed, and a presentation is given.



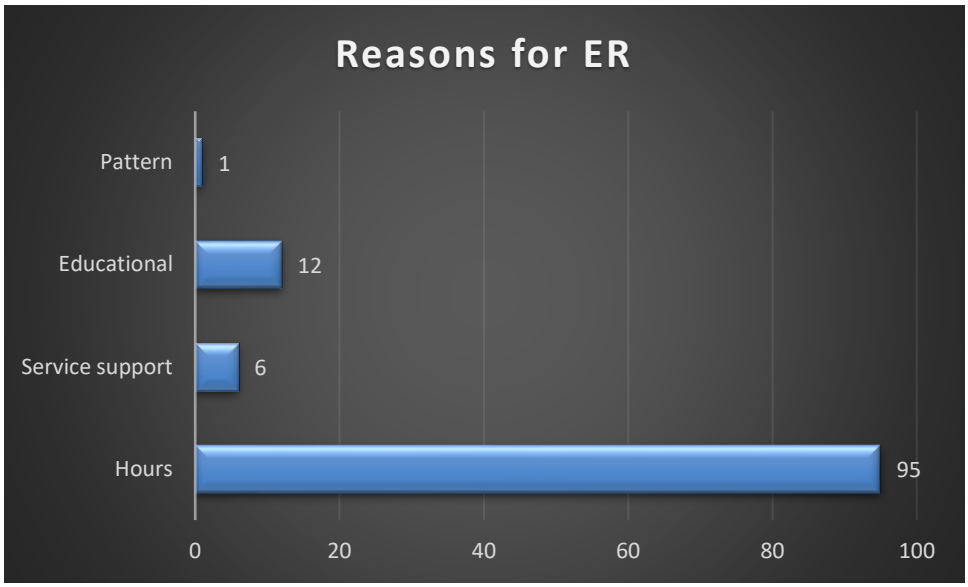



**Exception report by Grades**




More reports were submitted by FY1 doctors.

**Distribution of exception reporting in relation to various reasons**

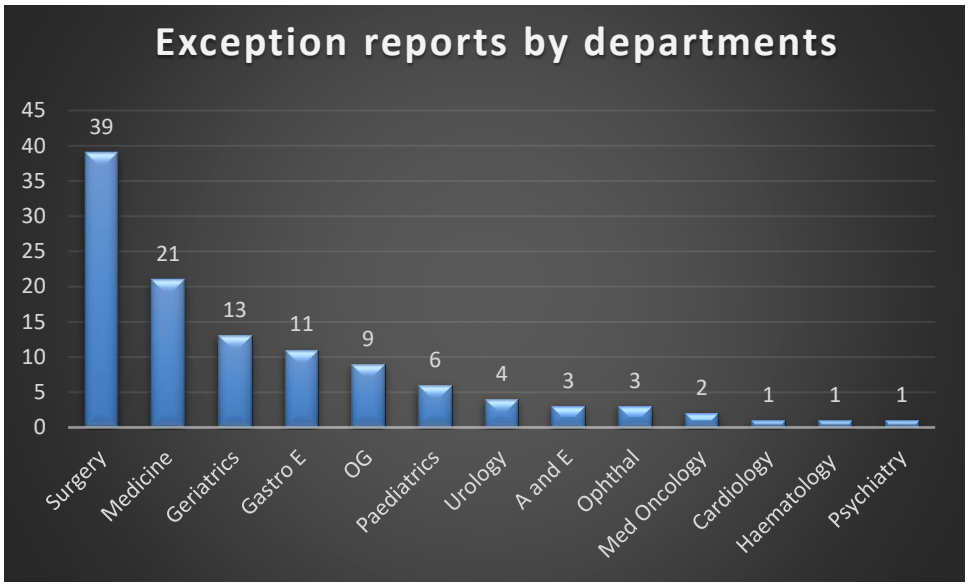



Most of the ER that were submitted were in relation to extra hours worked. This in some cases were due to less doctors rostered. ER in such cases helped the supervisors and rota coordinators to help plan the rota in a better way.

**Exception reports by Departments**

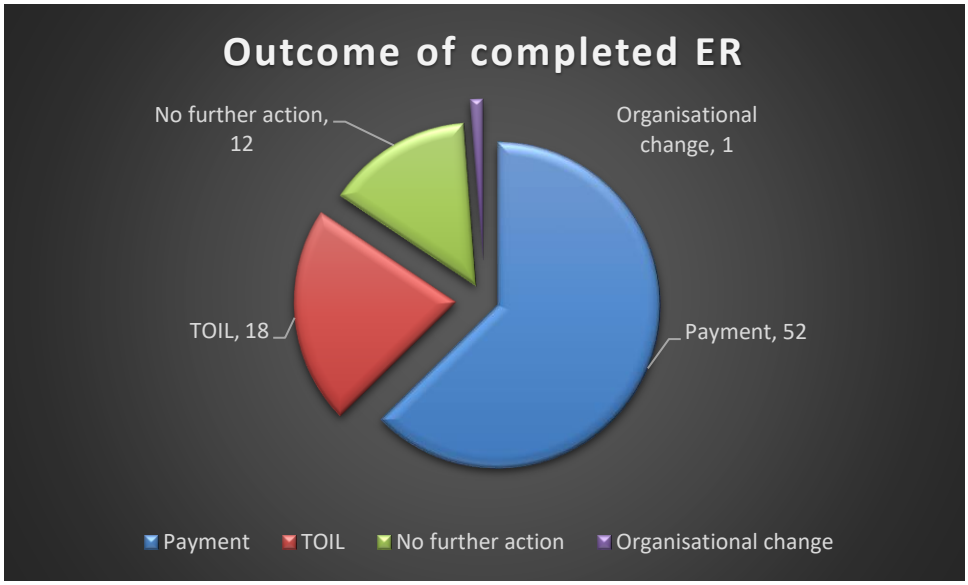
We see that ER were submitted predominantly in the surgery department. The ER from surgery were more in Q3.

The Divisional Director of Surgery and Anaesthesia, was alerted to this, and he provided assurance that the issues would be raised with his colleagues. This was for awareness and to resolve issues, particularly with those who are currently responsible for the management of the rota. Since then, we see that the number of ER have decreased significantly in the surgery department.




There are some ERs that were completed but the junior doctors did not close the reports. Of those completed reports, the majority were given payments and some were given TOIL.

**Outcome of resolved exception reports**




Organizational change was made in terms of change in rota pattern in an ER.

**Safety concern raised through Exception Report:**

There was a safety concern that was raised by a Junior Doctor working in Geriatric medicine. They had stayed late, without breaks, to respond to the needs of patients and the service. There was a new GP trainee, working alongside the Geriatric trainee, however, due to the complex illnesses of some of the patients more support was needed.

The issues that were raised through the exception report were escalated to the management team and discussed in the geriatric medicine department meeting. It was agreed by the division that the minimum number of staffing by juniors on ward 20 should be increased to 3 as there are 30 patients, most of whom are complex cases. There is always a consultant available for decision making too, but the increase in available staff should help more junior trainees and reduce any risk of delays in treatment to patients.

**Work Schedule review has been undertaken:**

1 FY1 personalised work schedule review was requested in General Medicine which took place on 11th April 2022 by the previous GOSWH. Another FY1 personalised work schedule review was undertaken in the Cardiology department. It was based on educational opportunity missed. Recommendations were given and agreed.

**Fines:**

There haven't been any fines issued.

**Other Salient ER investigation:**

There was one ER submitted by a ST4 registrar from with the medicine department in March 2023, which will be covered in the next quarterly report.

**Payment for Untaken Annual Leave**

A Junior doctor has raised a query regarding payment for unused holidays if they are unable to take leave due to rota issues. Whilst it is recommended that the trainees take leave to rest and recuperate at regular intervals, the Trust can pay trainees for untaken annual leave if the department has not been able to give the leave when they rotate to another training placement. However, this does not happen routinely, but is reviewed on a case-by-case approach after discussion.

## Post-Shift rest facilities:

It is challenging to always have rooms available due to reconfiguration and the removal of some of the buildings that we may have used in the past. Gina Davies and her team do their upmost to monitor and provide rooms wherever possible.

A PDF giving information about how to access accommodation was created and has been circulated to doctors in training and is held within the 'Doctors Toolbox' for reference. It is discussed at induction for the trainees as they tend to be less aware due to rotating frequently.

**Trainee Vacancies:**

Data on Rota gaps is challenging to obtain, as most rosters up to the Consultant level are covered by a combination of doctors in training, Trust doctors and specialty doctors. When Allocate E rostering is fully rolled out, this data will become easier to access.

Where there are trainee vacancies, a Trust doctor may be recruited for a fixed term to cover that gap. Or alternative cover may be arranged for out of hours commitments. As can be seen from the data held within ESR most of our training posts are filled currently. As referenced above, as all Rota's are populated by different Medics there may still be gaps in cover.

| April 2022 to September 2022 | | | |
|---|---|---|---|
| | Budgeted FTE | Actual FTE | Vacancies by FTE |
| Foundation Year 1 | 48 | 52.5375 | -4.5375 |
| Foundation Year 2 | 36 | 32.64375 | 3.35625 |
| Specialty Registrar | 176.76 | 174.89375 | 1.86625 |
| Total | 260.76 | 260.075 | 0.685 |

| | October 2022 | | | November 2022 | | |
|---|---|---|---|---|---|---|
| | Budgeted FTE | Actual FTE | Vacancies by FTE | Budgeted FTE | Actual FTE | Vacancies by FTE |
| Foundation Year 1 | 48 | 52.54 | -4.54 | 48 | 52.54 | -4.54 |
| Foundation Year 2 | 36 | 32.64 | 3.36 | 36 | 33.64 | 2.36 |
| Specialty Registrar | 138.76 | 133.9 | 4.86 | 139.76 | 133.82 | 5.94 |
| Trust doctor – FY level | 18 | 12 | 6 | 18 | 17 | 1 |
| Trust doctor – SpR level | 26.94 | 39.24 | -12.32 | 26.94 | 39.22 | -12.28 |
| GP trainees – trust based | 39 | 31.46 | 7.54 | 39 | 32.46 | 6.54 |

| | Dec-22 | | | Jan-23 | | | Feb-23 | | |
|---|---|---|---|---|---|---|---|---|---|
| Role | Budgeted FTE | Actual FTE | Vacancies by FTE | Budgeted FTE | Actual FTE | Vacancies by FTE | Budgeted FTE | Actual FTE | Vacancies by FTE |
| Foundation Year 1 | 48.00 | 53.49 | -5.49 | 48.00 | 53.49 | -5.49 | 48.00 | 52.89 | -4.89 |
| Foundation Year 2 | 36.00 | 32.64 | 3.36 | 36.00 | 33.41 | 2.59 | 36.00 | 32.48 | 3.53 |
| General Medical Practitioner | 0.00 | 0.20 | -0.20 | 0.00 | 0.20 | -0.20 | 0.00 | 0.20 | -0.20 |
| Specialty Doctor | 112.93 | 86.03 | 26.90 | 112.93 | 82.73 | 30.20 | 115.22 | 86.03 | 29.19 |
| Specialty Registrar | 140.76 | 134.21 | 6.55 | 139.76 | 134.71 | 5.05 | 139.76 | 135.58 | 4.19 |
| GP Trainees - Trust Based (Specialty Registrar) | 39.00 | 35.46 | 3.54 | 39.00 | 36.28 | 2.72 | 39.00 | 40.35 | -1.35 |
| Staff Grade (Closed to new entrants) | 1.00 | 1.00 | 0.00 | 1.00 | 1.00 | 0.00 | 1.00 | 1.00 | 0.00 |
| Trust Grade Doctor - Foundation Level | 18.00 | 16.00 | 2.00 | 18.00 | 18.00 | 0.00 | 18.00 | 22.00 | -4.00 |
| Trust Grade Doctor - Specialty Registrar | 26.94 | 36.62 | -9.68 | 26.94 | 38.62 | -11.68 | 26.94 | 35.62 | -8.68 |
| **TOTAL** | **422.63** | **395.65** | **26.98** | **421.63** | **398.44** | **23.19** | **423.92** | **406.14** | **17.78** |

In addition to those trainees captured above we have on an average of 80 GP trainees in post, working off-site in Primary care settings at anu given time.

**Shifts covered by Bank and Agency:**

Out of hours shifts on trainee rotas can arise for a number of reasons. There may be a vacancy, sickness absence, restrictions on working hours for health reasons, maternity leave, less-than full-time working in a full-time rota slot. In all of these examples the flexible workforce team will work to arrange alternative cover through offering bank shifts or by booking an agency locum. As you can see from the table below, most shifts are filled with alternative cover.

| **Bank and Agency fill rates by division- April 2022 to February 2023** | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |
| | | April 2022 to September 2022 | | October 2022 to November 2022 | | | December 2022 to February 2023 | | |
| | % Unfilled hours | % Filled Bank hours | % Filled Agency hours | % Unfilled hours | % Filled Bank hours | % Filled Agency hours | % Unfilled hours | % Filled Bank hours | % Filled Agency hours |
| FSS | 1.79 | 90 | 8.21 | 5.47 | 72.74 | 21.80 | 8.17 | 89.57 | 2.26 |
| Medicine | 1.49 | 74.10 | 12.30 | 10.08 | 74.47 | 11.58 | 13.08 | 73.68 | 13.24 |
| Surgery and Anaesthetics | 12.77 | 84.77 | 2.47 | 0.57 | 99.43 | 0 | 9.83 | 83.33 | 6.84 |

**Communication with trainees:**

I have a regular slot at the junior doctor induction days and my presentation includes the key changes in the new contract, rota rules, work schedules, exception reporting and the role of the GOSWH and the junior doctor forum. So far 4 inductions have taken place in last 1 year.

I email the trainees and supervisors as and when needed in relation to the exception report submitted.

**Junior Doctors forum (JDF)**

A JDF meeting was held on 12th December 2022. At the meeting the GOSWH updates those present on the details of the most recent report and any relevant comments from the previous board meeting. In the last Board meeting we discussed about the spike in ER in the month of August. This was discussed in the JDF and the reason was that the rise is because the cohort is new to the NHS system was confirmed after discussion. From the trend of gradual decrease in ER in October and November, it is again evident.

Members from the Medical division and the BMA representative attended the meeting. Training recovery money and the plans on how to spend this were discussed by the medical education team with the trainees present. Teaching opportunities for junior doctors were also discussed. The next JDF was planned for 9th March 2023. 0

**Sharps Reduction action plan:**

I took an active participation in the meetings held by the Head of Health and safety regarding Sharps incidents and plans to reduce the incidence. A suggestion was made to have awareness posters and to give handouts within the welcome pack for the junior doctors when they join the trust.

**Regional GOSWH conferences and webinars:**

I attended the regional GOSWH virtual conference on 25th November 2022. It was useful and gave me an opportunity to interact with other GOSWHs.

I attended the webinar for GOSWH arranged by the British Medical Association on 7th December 2022 which, helped me to gain a greater understanding of their view of the role of the GOSWH in relation to the implementation of the 2016 Contract.

I am a member of an online GOSWH Network via WhatsApp which has been set up so that Guardians can share information and advice.

I will be attending the two hours webinar on E-rostering delivered as part of enhancing junior doctors working lives (EJDWL) event hosted by NHS England on 25th April 2023.

I will also be attending one day Yorkshire and the Humber Annual GOSWH meeting by HEE Health Education, England on 3rd May 2023.

**H) Talent awards:**

CHFT's Got Medical Talent Awards was provisionally arranged for 25th May 2023. I'll update more on this in the next report. We have not determined whether it will happen due to various reasons. There is a 'Farewell and Thank You' event scheduled for trainees in late July 2023.

**Industrial Action:**

On Friday 24 February the British Medical Association confirmed that doctors in training along with locally employed doctors engaged on mirror terms and conditions would be undertaking industrial action for 72 hours commencing at 6.59am Monday 13 March through to 7am Thursday 16 March 2023. Additionally, the Hospital Consultants and Specialists Association confirmed strike action on Wednesday 15 March 2023.

The industrial action was confirmed as a full stoppage of work, with no derogations agreed locally or nationally during the strike period. In the event of a major unpredictable incident the Trust could call for doctors to return as long as the nationally agreed process was followed.

Whilst not obliged to inform the Trust about whether there was an intention to strike, many of our colleagues did let their operational management teams know so that plans could be put in place.

The Medical Director wrote to all medical and dental staff to confirm the details of the action, to remind colleagues to be respectful of others' views and to share a document with frequently asked questions. Well-being support was available to all and regularly referenced in Trust updates.

Additional strike action by the same eligible group happened for 4 days from Tuesday 11th April to Saturday 15th April 2023. The industrial action was again a full stoppage of work

Further details of the impact and how the industrial action was managed will be provided in the next Guardians report which covers March and April.

**Summary:**

The trainees here at CHFT all have Allocate accounts to enable them to raise an exception report if they work outside of their agreed rota, or there are any issues that they wish to escalate, including gaps in educational support. Training is given on how and when to exception report when they first start in post and representatives have been sought for the Junior Doctor Forum. The rotas that are in place are all fully compliant with the rules of the 2016 contract and there is scope to review these where feedback highlights when changes may be needed. Whilst there are some exceptions that are still open on the system, they were resolved prior to the trainee leaving the organisation so I will work with Allocate to close these.

As GOSWH I look forward to working with the trainees and other colleagues to minimise issues, and to ensure that any problems that are highlighted are resolved as quickly as possible.

| | Risk No | Div | Dir | Dep | Opened | Status | Objective | Risk Description plus Impact | Existing Controls | Gaps In Controls | Initail | Current | Target | Action Plans | Progress Update | Review | Target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| High | 8473 | Family & Specialist Services | Children's Services | All Departments | Dec-2022 | Active | Keeping the base safe | There is a risk of insufficient WTE of matron leadership to support the children's directorate due to the size of the portfolio for the role (Children's inpatients, Outpatients, Child development Centre, Diabetes, Epilepsy, Specialist Nurses, Transition, Special Schools and Children's Community Nursing Team). This results in sporadic leadership to provide quality and safety assurance for patient care and support for the clinical managers and wider MDT teams. This also results in concerns for the inability to deliver key strategic agenda items for CYP from the Long-Term Plan (NHSE), RCPCH Standards and Journey to Outstanding reviews are likely to remain limited with the current structure. There is also no defined Clinical Governance support for the Directorate. There has also been two Serious Incidents (Nov, Dec 2022) which in part can be attributed to the need for more visible senior leadership. | NHSE Regional Lead for CYP peer review visit.<br>0.8wte recruited to cover substantive 1.0wte Matron Maternity Leave<br>CQC CYP Transformation meetings<br>ADN/Lead Nurse for CYP supporting with Operational workload. | | 16<br>4 x 4 | 16<br>4 x 4 | 0 0<br>x 0 | ADN /Chief Nurse - consideration of additional Matron for community & Band 7 leadership as part of hard truths process<br>Review of WFM with separate safe staffing for each clinical area - PAU, HDU, POD's and Ward 4.<br>Shelford acuity data collection in progress January 2023 with a plan to repeat in June 2023<br>Recruitment to Governance lead for CYP | | Apr-2023 | |
| High | 8483 | Family & Specialist Services | Children's Services | Neonates | Jan-2023 | Active | Keeping the base safe | There is a risk to insufficient substantive funding of senior leadership for neonates to support the children's directorate agenda due to this not been part of the workforce model for Neonates. This results in sporadic senior oversight of neonatal care and concerns for the inability to deliver key strategic agenda items for the Neonatal agenda, for example the GIRFT Neonates, Ockendon and Long Term Plan. Progress to meet the is are likely to remain limited with the current structure. There is also no defined Clinical Governance support for the Directorate. | Temporary uplift of existing Band 7 clinical manager into Matron role due to end March 2023<br>Review of existing WFM as part of hard truths process<br>Clinical Manager linking with regional ODN Neonatal network | | 16<br>4 x 4 | 16<br>4 x 4 | 0 0<br>x 0 | ADN/Lead Nurse to review as part of staffing Workforce models.<br>To be considered as part of Directorate business planning process 2023 | | Apr-2023 | Jun-2023 |

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| High | 8439 | Family & Specialist Services | Women's Services | All Departments | Oct-2022 | Active | Keeping the base safe | The Women's Directorate is a risk in not meeting the Ockenden 2 recommendation of in a trusts with no separate consultant rota for obstetrics and Gynaecology medical staff this can have an impact on the meeting of the RCOG guidance. The lack of a Obstetrics and Gynaecology rota may result in suboptimal care for local women and their families and loss of reputation | Datix trigger list for Obstetric and Gynaecology<br>Duties of the hot week consultant guidance in place<br>extended resident consultant hour on labour ward to ensure 2nd ward round with MDT | A fully functioning split rota<br>Additional funding post Ockenden 2 lack of risk assessment and escalation protocol for periods of competing workload, with a mandate for this to be agreed at board level.<br>Meeting of the RCOG guidance re role of the hot week consultant for O and G<br>Capacity impacted in ANC due to lack of cover for hot week | 16 4 x 4 | 16 4 x 4 | 4 4 x 1 | Paper completed outlining | March 23 reviewed by GH and LD we are currently waiting for a final decision from execs regarding funding<br><br>Feb 23 LD DT review - continue to await case outcome for split rota and additional recruitment of consultants to be completed.<br><br>Jan 23 DT, GH, LD review - case for additional consultants to support split rota submitted to division awaiting approval. | Apr-2023 | |
| High | 8416 | Family & Specialist Services | Radiology | All Radiology | Sep-2022 | Active | Keeping the base safe | Financial Risk:<br><br>There is risk of an increase in expenditure relating to reporting of images due to a significant increase in the imaging requiring reporting (linked to increase in demand) and the increased cost in reporting costs which will result in an overspend of the Radiology Directorate budget. | - Regular monitoring of reporting backlogs<br>- Daily allocation of images for reporting<br>- Regular liaison with external reporting company re: capacity, allocation, turnaround times etc. | - Inability to control demand for imaging which in turn creates reporting<br>- Inability to control reporting capacity for external reporting companies | 16 4 x 4 | 16 4 x 4 | 9 3 x 3 | - To continue to monitor reporting needs on a daily basis<br>- To continue to liaise with external reporting companies to maximise reporting<br>- Offer of additional reporting to in-house Radiologists at a premium rate for a short period of time to help reduce backlogs<br>- Consider other options for increasing in-house reporting capacity | November 2022 Update: Recent tendering exercise has ensured all providers are from an appropriate framework and two new providers have been identified/contracts entered into. Backlogs experienced in the Summer due to reduced capacity are much improved. This is due to premium payments for in-house Radiologist insourcing which meant better uptake by CHFT Consultants. Utilisation of premium rate outsourcing 24hr turnaround also helped to reduce backlogs. There continues to be a direct correlation between high Emergency Department attendances and high levels of out of hours reporting and associated costs. Increased spend on reporting has been forecast to the end of the financial year. | Apr-2023 | Mar-2024 |
| High | 8358 | Surgery & Anaesthetics | Head and Neck | Ophthalmology | Jul-2022 | Active | Keeping the base safe | There is a risk of significant harm due to insufficient corneal appointments available to cope with demand due to increasing patient numbers and inability to recruit substantive consultant. This will result in existing routine patients having to be moved to accommodate more urgent appointments on a weekly basis. Many appointments falling outside the recommended guidelines due to capacity issues. Delays in treatment could lead to clinical incidents including increase of complaints and permanent sight loss if patients are not seen in a timely manner. | Risk stratification of waiting lists<br>Micromanagement of clinics and utilisation of slots by existing consultant and failsafe<br>Pathways to ensure efficient and correct requests<br>Weekly WLI by consultant<br>No of overdue f/up patients: 396 with the longest waiter being from Feb 2022 this excludes clinically validated patients that have been moved on. This include high risk urgent patients.<br>No of overdue new patients: 18, Next available slots are in sept 2022 (9-10 weeks away) | Lack of medical staff, optometry support, clinical capacity and clinical space to see the required demand resulting in an increase in holding lists.<br>Single point of failure to service if one of existing consultants should be off.<br>Further cancellation of clinics to enable theatre sessions. | 16 4 x 4 | 16 4 x 4 | 0 5 x 0 | Job advert for additional substantive or locum consultant with a special interest in cornea<br>Business case for additional optometry hours to enable low risk caseload to be moved away from consultant clinics<br>Identify and develop areas that may be suitable for diagnostic or virtual pathways | 13/04/23 - Substantive post back out to recruitment on Trac. Close Date May with aim to interview in June.<br><br>09/02/2023 Optometry business case rejected. Virtualizing low risk patients identified and transformation project discussed. Needs escalating<br><br>Recruited consultant withdrawn due to 'a better job offer'<br><br>08/08/22 Holding list validation 530 overdue pts, 48 of which are high risk, booked until end of sept with no capacity to see the high risk pts.<br><br>08/12/22 525 pts past end date 27 urgent | May-2023 | |

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| High | 8277 | Medical | Integrated Medical Specialties | Neurology | Mar-2022 | Active | Keeping the base safe | "There is a potential risk to patient care and treatment as not sustaining the day to day delivery of the Neurology service due to the depletion of the medical workforce, and not being to recruit replacement Consultants, will result in an unsustainable service.<br><br>Broad overview of service requirements:<br><br>- 70 new outpatient referrals per week<br>- 25 inpatient referrals per week<br>- Current backlog ASI's 979<br>- Holding list over 12 weeks 847<br>- Validation - 2300 to complete " | Reducing inpatient cover to 3 days a week.<br><br>Clinics have been stepped down to provide time for validation to ensure we fully understand the service risk and patient impact.<br><br>Additional bank shifts offered. | Explored joint working with Leeds not possible until August 2022 at the earliest due to their current gaps.<br><br>Approached Mid Yorks/Bradford to understand ability to offer mutual aid however, they are also under resourced and cannot support.<br><br>Outsourcing in place but limited capacity.<br><br>Looking to maintain rotational reg placement however, with reduced medical workforce and supervisory capacity this is a risk of being removed, reducing capacity further.<br><br>Locum Agency's approached but no | 20 4 x 5 | 16 4 x 4 | 6 3 x 2 | Ongoing recruitment - interview of one candidate on 8th April.<br>Discussions with deanery to maintain rotational registrar.<br>Implemented different ways of working to mitigate risk (see existing controls). | 22/07/2022 - Risk accepted at PSQB<br><br>21/06/2022 - Risk accepted at Directorate Board. Now needs presenting at PSQB in July<br><br>12/9/2022 - Clinics stepped down effective from beginning of September releasing consultant capacity to facilitate inpatient reviews as a result of a reduced medical workforce due to retirements, people leaving and an inability to recruit<br><br>21/10/2022 - Reduction in risk score accepted at PSQB<br><br>27/3/2023 - Leeds support is now in place for A&G and a third party from April will be involved in triaging all new referrals to reduce outpatient demand which is currently being managed via insourcing, However we still have reduced capacity | Apr-2023 | Sep-2023 |
| High | 8290 | Community Healthcare | Inpatient Therapies | Inpatient Speech and Language | Mar-2022 | Active | Keeping the base safe | There is a risk that inpatients requiring speech and language therapy intervention will be delayed due to significant decrease in staffing levels due to vacancies within the team and lack of dysphagia trained staff. Resulting in decreased capacity to meet the referral demand to the service and staff sickness due to pressure on service and staff. | Vacant posts advertised<br>Workload prioritised<br>Bank hours | Vacant post being advertised but struggling to attract candidates or the candidates are 3rd year students and will not be able to start until qualify in the summer of 2022.<br>National issue for recruitment of speech and language therapists<br>Update Oct 2022 - 2 new band 5 graduates started (not dysphagia trained as yet) however 2 WTE band 6 vacancies, 0.72 on career break until early Dec 2022 and 1 WTE going on mat leave in early 2023 | 15 3 x 5 | 16 4 x 4 | 1 1 x 1 | Speech and language team are prioritising referrals so that urgent and priority patients receive assessment/treatment.<br>Use of bank staff and out to agency<br>Discussion with regional SALT leads re their experience and how managed<br>Discussions with procurement re outsourcing support | April 2023 - risk continues, some sickness which affecting further. In discussion with procurement re outsourcing service support<br>March 2023 - risk continues<br>Jan 2023 - risk continues<br>Nov 2022 - risk remains the same<br>August 2022 - risk remains the same<br>May 2022 - remains the same<br>Oct 2022 - 2 new band 5s in post however they are not dysphagia trained and 2 WTE band 6 posts remain vacant and out to advert, 0.72 WTE band 7 on career break until early Dec 2022 and mat leave coming up early in 2023 so going out to advert for | Apr-2023 | Jun-2023 |
| High | 8088 | Community Healthcare | Community Therapies | Whole Directorate | Jul-2021 | Active | Keeping the base safe | There is a risk that patients on the therapy caseload in all 3 therapy directorates (adults and children) will not receive timely care<br>Due to the current deficit in the therapies workforce (Vacancies, recruitment challenges, long term sickness, maternity leave and phased returns)<br>Resulting in potential developments of harm and unidentified deterioration of conditions leading to an increase in incidents and a negative impact on the credibility of the Trust.<br>Areas with a high impact are dysphagia in acute and community settings due to lack of dysphagia trained speech and language therapists, the voice provision to patients at CHFT (no therapist in post). | Staff bank/requests for locum staff<br>Recruitment ongoing | Deficits:<br><br>B5 B6 B7 B8a<br>Dietitians 19% 5.20% 6.52%<br>OT 38% 27.80% 10.80%<br>Physio 9.20% 11.30% 11.30% 12.50%<br>Podiatry 12%<br>SALT 30% 25% 4.40%<br><br>Additionally across the whole of therapy services there is the following gap for:<br>Band 2 = 5%, Band 3 = 19% and Band 4 = 3.5% | 12 3 x 4 | 16 4 x 4 | 0 0 x 0 | Prioritising workload<br>Recovery posts agreed<br>Workforce modelling<br>Skill mix review of vacant posts<br>Request for bank / private providers to support - working through with procurement | October 22 - risk remains the same<br>June 2022 - risk remains the same<br>Jan 22 - risk remains the same<br><br>Feb 22 - Vacancy levels persist - Dietitians, SALT and OT professions are of particular concern - ability to attract and retain an issue<br><br>April 2022- significant vacancies in Dietetics. Band 5 80% reduction and 32% for Band 6. Priority working in place<br><br>August 2022. vacancies remain high especially Dietetics (26%),SALT (16%) and OT (13%). Vacancies remain at advert however support worker posts considered and out to advert following review of skill mix<br><br>September 2022. Vacancies persist however posts for support workers being filled, new models of care being developed with change in skill mix. Interviews undertaken and some new starters now in post. However this has minimal impact on staffing risk | Jul-2023 | Aug-2023 |

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| High | 8132 | Family & Specialist | Women's Services | Gynaecology | Aug-2021 | Active | Keeping the base safe | Health and Saftey Recovery risk - There is a risk to patient saftey due to longer than normal waits for Elective surgery due to the reduction of routine elecive surgery capcacity during the covid pandemc, reduced theatre capacity and the shortfalls in theatre staffing resulting in poor patient experience impacting on patient saftey and prompt care. | P value validation process<br>Prioritisination of P2 and long waiters<br>Weekly recovery data<br>out sourcing to private sector<br>weekly theatre scheduling meetings | A robust comunication process with patients<br>Surgeons operating less frequently that could impact on skills<br>Short notice multiple cancelaltions following cancelled theatres due to staffing shortfalls can impact on care pathways ( including fast tracks) | 16 4 x 4 | 16 4 x 4 | 4 2 x 2 | 1. Monitor theatre activiy weekly<br>2. review KP plus waiting list | march 23 GH and LD Reviewed significant progress with long waiters hope to be in a position where there are minimal 52 week wait's by the 31st March - to review score next month<br><br>Feb 23 reviewed by GH still working on scheduling long waiters, reviewed weekly at the data meeting<br><br>Jan 23 GH, LD, DT review - starting to see some improvement with women awaiting significant time for surgery. Working on trajectory to have no | Apr-2023 | |
| High | 8161 | Family & Specialist Services | Radiology | CT | Sep-2021 | Active | Keeping the base safe | Service Delivery Risk:<br>There is a risk of being unable to provide a CT scanning service in the event of a fatal breakdown of the CT scanner at CRH due to the age of the equipment (9 years old, lease expires 2022) which may result in the inability to scan patients and a failure to meet national standards (i.e. Stroke). | - Scanner regularly serviced<br>- Maintenance and Service contract in place<br>- Current use of mobile CT scanner in the event of a breakdown (at an additional cost)<br>- Ability to scan patients at HRI if needed | - No cover when the mobile scanner leaves site (planned to leave March 2022)<br>- Our staff are not trained to use the mobile scanner (the scanner is provided by a private company and is manned by their staff). | 9 3 x 3 | 16 4 x 4 | 4 2 x 2 | - CT scanner to be included within the new MES<br>- To utilise the mobile unit where ever possible<br>- To transfer to HRI, if appropriate.<br>- CHFT staff now training to use the mobile scanner.<br>- Replacement scanner included in equipment replacement scheme planning. | Discussed at Radiology October Board - risk to remain as proposed for the time being, to update when all CHFT staff have been trained on the mobile unit scanner.<br><br>November 2021: Radiology Board agreed to approve this risk, additional risk linking to financial impact to also be added.<br><br>February 2022: Cancellation of use of mobile scanner presented at EQUIA Panel who did not approve the scheme. Funding to keep the mobile | Jul-2023 | Mar-2024 |
| High | 8197 | Surgery & Anaesthetics | Theatres & Operating Services | All Theatres | Nov-2021 | Active | Keeping the base safe | There is a risk of delayed surgical treatment for Ophthalmic conditions due to shortage of Ophthalmic trained theatre staff resulting in the inability to open a second theatre. This will impact on clinical outcomes and patient safety due to continual rise in surgical waiting lists and delays in treatment. | Rolling trac advert for ophthalmic theatre staff.<br>Use of Pioneer (insourcing) on weekends<br>Oursourcing - Optegra for Cataract surgery | Continual staff vacancies for ophthalmic specific theatre staff<br>Gaps in competencies and training support across the range of sub-speciality provision.<br>No dedicated Ophthalmic clinical educator to lead training of current and new staff<br>Ophthalmic on call provision reduced to 9pm 6 months ago - on | 16 4 x 4 | 16 4 x 4 | 0 0 x 0 | Recruitment fair - Ophthalmic stall 14/11/21<br>Rolling trac advert - reviewed November 21<br>Zoe Matthewman to support competencies and training<br><br>Scope - ophthalmic theatre specialist role to support new workforce | September 2022 - Staff are still gaining competency sign off. Number of lists for Ophthalmology have increased in line with pipeline and based on staff available.<br><br>June 2022 - Staff reaching competencies, ongoing. looking to to be able to work in numbers July/August<br><br>April 2022 - Ophthalmic theatre staff under | Oct-2022 | Feb-2023 |

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| High | 7776 | Family & Specialist Services | Children's Services | All Paediatric inpatients | Apr-2020 | Active | Keeping the base safe | Due to 2 WTE difficult to fill Advanced Nurse Practitioner posts there is an inability to cover the 24 hour rota on the HRI site. There are also often gaps within the tier 1 medical rota at CRH, meaning sometimes a decision has to be taken to pull the PNP to CRH to support this gap.<br><br>This results in non-resident paediatric cover/paediatric APLS on the HRI site at times.This results in poor staff experience and may result in further staff leaving. This may impact on patient safety in the emergency department and onsite paediatric cover for children on ward 4. | Current rota does allow for the APNP to work some shifts on the CRH site<br>protective CPD time<br>Supervision<br>Regular team meetings<br>5.24 required to cover 24/7 - 7.29 WTE in post, of which 3.0 are in training (not part of rota)<br>use of technology to access training and attendance at meeting<br>APNP escalation process in place<br>Training 2wte APNPs -start date September 2020 and a further 1wte from September 2021<br>Lead Consultant for APNPs identified.<br>Ensuring APLS cover in ED when there are gaps<br>Roll out of paediatric positive Internal training for ED staff and Care of acutely ill child via University | Opportunity to work regular hours on the CRH site<br>Portfolio development - offered but not accepted<br>Lack of fill rate for gaps despite use of bank/locum cover | 9 | 3 x 3 | 16 | 4 x 4 | 6 | 3 x 2 | February 2023<br>Children's Directorate and ED team have collated a paper that has been presented to WEB in terms of plans for urgent care delivery for CYP on both hospital sites. If approved this will cumulate in the APNP's been based on the CRH site. Awaiting approval and Executive sponsorship<br><br>November 2022<br>ED & Children's directorate discussion at SI panel 4.11.22 - agreed for directorate teams to meet to agree next steps with executive team oversight.<br>ED to potential scope recruiting Paediatric trained staff/APNP's for ED specifically.<br><br>October 2022<br>-Divisional team/Directorate management team discussion re role and meeting in place. Also impact of shortfall in junior medical cover for CRH site - PNP's integral to keeping the paediatric base safe. Plan to meet with ED Colleagues end October<br><br>September 2022<br>- Divisional team chased for meeting regarding PNPs - following this meeting there will be wider discussion with Medicine as to plan for PNPs.<br><br>July 2022<br>- Consideration of line | February 2023<br>As above<br><br>November 2022<br>As above<br><br>September 2022<br>- As above.<br><br>July 2022<br>- As above.<br><br>March 2022<br>- Progress on Paeds ED business case, being led by the Medicine Division. Awaiting Board sign off and potential timescales.<br>- PNP role went back out to advert twice but with no success. Meeting in late April 2022 with new ADN to discuss nursing workforce strategy.<br><br>December 2021 - Paeds ED business case agreed in principle - further work to be done on workforce model<br>- Readvertise posts in January/February 2022<br><br>November 2021 - Ongoing gaps in service cover which is managed closely between ED and Paediatric team with support of flexible workforce. Ensuring APLS cover in place for ED 24/7<br><br>September 2021 - Additional 0.2 WTE (7.5 hour) reduction in APNP hours for the next 6 months.<br><br>August 2021 Additional 1wte recruited to start ACP training Sept 2021. A number of complex cases in HRI ED when there has been gaps. Consultant on call from CRH pulled to cover which causes risk to CRH site.<br><br>July 2021 - Advert on hold. Consideration to train further APNPs - awaiting outcome of ED business case/Trust decision re. ACPs<br><br>April 2021 - Advert refreshed and re-advertised | Mar-2023 | Nov-2023 |

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| High | 7955 | Family & Specialist Services | Radiology | Main X-Ray | Dec-2020 | Active | Keeping the base safe | Service Delivery Risk:<br>There is a risk that we will be unable to deliver plain film services from three plain film rooms at Calderdale Royal Hospital (CRH) due to the rooms becoming obsolete due to their age (these rooms are 20 years old and are beyond their normal life span and no longer have maintenance cover due to the lack of parts and qualified engineers). This would result in the rooms no longer being in use and disruption to all acute (including the Emergency Department) and main x-ray services.<br><br>The equipment includes, for example, the rooms, the retrofit units and peripheral kit such as printers, CR readers and consoles.<br><br>Also refer to risk 7581 in relation to the financial impact of a breakdown. | - Maintenance cover*.<br>- Datix reporting of breakdowns.<br>*Whilst we have maintenance cover we are experiencing difficulties in sourcing replacement parts. On a previous occasion a replacement part has had to be made as the part was no longer available. This is resulting in longer periods of downtime and eventually parts will not not be able to be replaced. | - Continued maintenance cover due to age and lack of available parts. | 12<br>4 x<br>3 | 16<br>4 x<br>4 | 4 2<br>x 2 | - Plan for MES.<br>- Equipment on the 5 year capital plan. | August 2022 - Position remains the same, gaps updated Earlier entries moved to "File notes" section.<br><br>September 2022 - 3 x plain films at HRI and 3 x plain film rooms at CRH have been approved by capital for replacement in 23/24.<br><br>October 2022 - OPT (Dental) machine at CRH is now out of use due to age and is no longer supported. Funding was approved in September for replacement 22/23. Meetings with procurement have started regarding all room replacements and plans.<br><br>November 2022 - Equipment replacement process with procurement. Sign off for manufacturer choice should be 11th Nov 2022. Awaiting start dates for estates work and new build to be complete at HRI.<br><br>Divisional Risk Register confirm and challenge update 8/12/22<br>Present: SC, GE, NB, NV, SS, SRF, LH, LR<br>Risk score may reduce once the ED Xray kit goes in<br><br>January 2023 Update: The risk remains the same.<br><br>February 2023 Update: The risk remains the same | May-2023 | Mar-2024 |
| High | 6035 | Medical | All Directorates Medical | All Departments/Wards Medical | Jun-2014 | Active | Keeping the base safe | There is a risk that Medicine division has a higher prevalence of C.Diff infections, which is greater than the agreed acceptable tolerance levels for 2021/2022<br>due to gaps in assurance measures around cleaning<br>Resulting in the increased number of patient contracting C.Diff. | Established infection control measures to minimise the occurrence of C. Diff infections:<br>Monthly hand hygiene compliance monitoring<br>Early patient risk assessment as deemed appropriate<br>Antibiotic prescribing and ongoing monitoring in line with current policy<br>Standard isolation precautions and infection control guidelines with | Gaps in assurance measures around cleaning and FLO audits, highlighted to Ward managers/ sisters that all High Impact Interventions should include robust documentation of any failures in compliance.<br><br>Risk of inappropriate prescritption of antibiotics particularly out of hours | 16<br>4 x<br>4 | 16<br>4 x<br>4 | 4 2<br>x 2 | Share learning<br>Monitor incidents<br>Deliver RCAs and identify contributory factors to address | May 2020 update:<br>Have had 2 CDiff cases in the months of Jan, Feb, Mar, & April. RCA's undertaken and discussed.<br>Rates and learning continued to be monitored via Divisional IPC meetings which are currently being re-instated and the corporate IPC performance board.<br><br>Learning from RCA and areas of substandard or good practice shared and disseminated via PSQB<br>Improved screening with prompt isolation | Aug-2022 | Feb-2023 |

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| High | 7672 | Trustwide | All Divisions | All Departments/Wards | Mar-2020 | Active | Keeping the base safe | There is a risk of reduction in safe Medical staffing levels below the minimum required to maintain safety Due to the impact of Covid-19 on capacity particularly in Critical Care, Respiratory Medicine, Acute Medicine, Elderly Medicine and Emergency Department Resulting in unsafe levels of patient care<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 | October 2020: Notifications to junior doctors and registrars regards new rota changes to be miplemented from 9.11.2020, Fully compliant with rules set out in 2016 junior doctor contract. Medical Workforce briefings in place, doctor representatives publicised. Message to consultants regards rota changes effective 9.11.2020.<br><br>01.05.2020 IMT risk review<br>20.04.2020 As of 13.4.20 nearly 200 training grade doctors, physician associates and 14 ACP's on same compliant rota pattern. Majority still working in their base area until step change in demand. Consultant Acute Physicians working a 24/7 onsite rota joined by resp physicians working till midnight and contactable thereafter and elderly medicine now doing twilight rotas until midnight. General Surgeons already work this shift pattern which continues. Three senior medical registrars on site overnight<br>Anaesthetists are providing direct support to the Critical care expansion plans<br>Twice daily medical deployment meetings, 7 days a week chaired by Deputy Medical Director with DD's, and other colleagues incl. junior doctor input. Activity, sickness and acuity reviewed.<br>T&O supporting ED with management of the Minors workflow<br>Training grade doctors WhatsApp for communication. Core group of senior colleagues and 11 junior doctor/physician associate leaders | Aug-2021 | Nov-2021 |
| High | 8009 | Medical | Integrated Medical Specialties | All Departments | Feb-2021 | Active | Keeping the base safe | There is a risk of outpatient capacity not being sufficient to ensure timely appointments for both new and follow up patients across IMS. This is exacerbated by the restriction of face to face appointments that are required although this is partially mitigated through video and phone clinics. For specialties such as Neurology physical examination is more likely and face to face appointments required following an initial telephone appointment or video call and therefore adding additional pressure to already stretched capacity.<br><br>This risk is due to the size of the backlog that has built up during the covid pandemic.<br><br>This is resulting in delayed appointments and ultimately the risk of not diagnosing a patient and seeing and treating then within the 18 week RTT pathway. | CAS clinic and advice and guidance to manage referrals into the trust | Capacity to deliver against the demand for Neurology with upcoing staffing issues - adverts for recruitment have been completed | 16 4 x 4 | 16 4 x 4 | 2 1 x 2 | Looking to increase the medical workforce where budget allows and as short term mitigation increasing the number of clinics run through waiting list initiatives. | 30/6/2021 - A change in the set up of outpatient clinics for both face to face and telephone has allowed increased face tro face capacity to start to address the ASI backlog. Additionally work is underway with CCG to look at possibilities of outsourcing to increase capacity<br><br>21/05/2021 - Risk accepted at PSQB<br><br>05/10/21<br>Neurology: Outsourcing of new referrals starting with Pioneer. Interview for joint consultant post- not appointed. interview for vacant middle grade post-appointed, currently going through HR process. Specialty Doctor returned from long term sickness. To review position in 2 months.<br><br>Rheumatology: Middle grade returned from Egypt and now working full time. Appointed band 8 nurse-nurse led clinics to start when in post. Advertising for 1.8 Band 6 posts. Business case for oncology pharmacist which would free up additional 4 nursing and 2 consultant sessions per week- currently with SMT.<br><br>Dermatology: Middle grade vacancy filled and applicant started 27th September. Received | Apr-2023 | Mar-2024 |

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| High | 8034 | Medical | All Directorates Medical | All Departments/Wards Medical | Apr-2021 | Active | Keeping the base safe | There is a risk of not being able to reduce the acute inpatient bed base due to rising patient acuity, non-elective demand and challenges in community bed and social care provision resulting in a potential delay to Covid recovery plans and reduction in the bed base. | • Admission avoidance through the Emergency Department and Ambulatory areas<br>• Trust wide work on discharge planning - plan for every patient and R2R<br>• Linking with Community colleagues to support earlier discharge and TOC list<br>• Developing clinical pathways to support outreach clinical service (Covid Community clinics)<br>• SAFER programme - P4EP | • Capacity in Community services<br>• Workforce gaps<br>• Delay in presentation of certain patient groups due to not proactively seeking out medical services during the pandemic<br>• Continued increase in acute demand<br>• Increased acuity of patients impacting on LOS | 12 4 x 3 | 16 4 x 4 | 2 2 x 1 | • Trust wide discussions regarding IPC restrictions of bed base<br>• Continued review of recovery plans in the event that acute pressure increases<br>• Balance of workforce distribution to elective and acute work<br>• SAFER program and system wide program of improvement work (perfect storm)<br>• Continued review of bed base to best manage demand<br>• Clear bed plan worked up which includes the order of retraction out of extra capacity beds | 24 March 2023 - Risk updated by David Britton. We remain in extra capacity areas and have been in OPEL 4 recently. Unable to retract out of AF CRH beds currently to put SDEC back in. 4D and 8b also open at CRH along with extra beds on the RF and 6ab.<br><br>November 21 - Risk updated by L Taylor on behalf of DOP - Balance of workforce distribution to elective and acute work.<br>SAFER program and system wide program of improvement work (perfect storm)<br>Continued review of bed base to best manage demand<br>Score increased and accepted at PSQB<br><br>23/04/2021 - Risk accepted at PSQB<br>19/05/2021 - Risk reviewed at the Acute Directorate risk review meeting. No change to the risk currently<br>30/03/2021 - Risk reviewed by ADN, extra capacity beds remain open on 4d, 6ab and flex beds on the | Apr-2023 | Apr-2023 |
| 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- | 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 2023 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. | March 23 - last few vacancies left, working on supernumerary status and skills<br><br>November 22 - November: there has been slippage in the theatre recruitment position due to some future staff pulling out. Currently on track to now be fully established by late January 2023.<br><br>September 2022 -Ffrom Monday 19 September staffing levels in theatres will rise to enable us to provide more theatre lists to treat our patients. In mid-November we will see another increase in | Apr-2023 | Apr-2023 |
| High | 7637 | Family & Specialist Services | Children's Services | Paediatric Medical Staff | Jan-2020 | Active | Keeping the base safe | There is a risk that, due to regular sickness and isolation across the Tier 1 and Tier 2 medical staffing rota, the delivery of safe care for the Paediatric and Neonatal unit may be compromised.<br><br>There is currently reliance on existing staff and bank and agency staff to fill shifts at both tier levels. If gaps are not filled there is a risk to patient safety. There's also an impact on the Consultant workforce, who may need to cover Tier 2 gaps, which can impact on other workload.<br><br>This risk is ongoing and will be reviewed as part of rotations. | 1. Fixed-term tier 2 post filled (historic)<br>2. Tier 2 6 month fixed-term (winter funding) post filled (historic)<br>3. Calculating additional funding required as part of business planning (some pressure accepted, however development not accepted) - looking at 23/24<br>4. Regular weekly meetings with medical staffing commenced in May 2021 to ensure gaps are picked up with as much notice as possible, with all possible options for cover explored. | Adequate workforce to enable an adequate rota. | 16 4 x 4 | 16 4 x 4 | 6 2 x 3 | 1. Rotas monitored on a weekly basis, with daily escalation plans in place.<br>2. Continue work with HR to ensure rotational doctor information/updates in received in good timeframes.<br>3. Continue to seek recruitment for 2 x qualified APNPs. 2 trainee APNPs in post since Autumn 2020 and a 3rd trainee to start in Autumn 2021. Out to advert x4 times. No applicants.<br>4. Utilise existing APNPs/ANNPs to support medical rotas when able to. Engage with ED regarding gaps to ensure appropriate mitigation. | Update March 2023<br>- Development submitted relating to registrar staffing on pause (plus all developments trust wide) - escalated concerns regarding this to the division on 3/3/23 - asked to escalate this at the next PRM (31/3/23) for their escalation at divisional PRM<br>- Pressure relating to tier 1 and 2 sickness accepted - this will support the bottom line<br>- Reduced number of trainees on current rotation<br>- Ops Manager starting on 28/3/23 which will support day-to-day management of the trainees and HR follow up<br><br>January 2023<br>- 0.8 WTE tier 2 permanent funding - post recruited to - awaiting start date.<br>- Update from Division on Ockenden paper still awaited - informed it was going to Divisional PRM on 28/11.<br>- Concern re. number of gaps for next rotation (Feb/March 2023 onwards). Some posts out to advert/being interviewed for. Medical HR out to agency.<br>- Concern re. time to approve posts on TRAC (5 | Jun-2023 | Sep-2023 |

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| 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 be 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 they are waiting for a specialist bed or Children's Social care management.<br><br>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.<br><br>As an example, from January 2022 to June 2022, there were 80 admissions of CYP in crisis to the children's ward. | 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<br>11. Restraint and use of force guidance<br>12. Clinical PEARLS | 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<br>Clarity of escalation pathway to ensure awareness and timely transfer of patients to inpatient mental health settings external to the trust | 20 | 4 x 5 | 16 | 4 x 4 | 4 2 x 2 | February 2023<br>Mental Health Liaison Nurse in post<br>Review of mental health guidelines in progress<br>MH liaison nurse shared<br>Training opportunities shared with children's ward team<br><br>November 2022<br>Induction plan for Band 6 liaison nurse jointly developed between Paediatrics and Camhs.<br>Aiming for CAMHS team to allocated band 3 to the children's ward following their recruitment.<br>Linking with CHFT Nurse Consultant for Mental health re training plan and oversight.<br>Paediatric attendance at Mental Health Operational group<br><br>October 2022<br>Band 6 Mental Health liaison nurse appointed.<br>Debrief sessions for team following complex cases.<br>Task and finish group in place to develop Multi agency protocol for escalation and removing barriers to discharge.<br><br>July 2022<br>- Band 6 Mental Health Nurse post out to advert (funding via CCG)<br>- CYP barriers to discharge workshop completed on 20/07 | February 2023 as above<br>October 2022 -as above<br>July 2022 - as above<br>March 2022 - as above<br>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.<br>Sept 21 - Escalation at PSQB, PRM, Tactical, and externally to the Division as required. Escalation to CCG, CAMHS, Social Care, and ODN. Escalated concern regarding lack of 1:1s to CCG - CCG coordinating CAMHS supporting this.<br>July 2021 - The situation continues to be challenging. Daily MDTs to support patients continue, however there have been issues with attendance from Social Care. Good support from CAMHS. Plan to get an escalation process in place across teams.<br>April 2021 The situation has worsened due to the pandemic and not having access to school etc. Also Calderdale has a high number of children in care that have been relocated and the private providers are unable to deal with the behaviours and therefore they present at ED<br>Dec 20 Aiming to roll out We can Talk Mental Health training in CHFT in new financial year. When young people admitted and there are delays in Tier 4 beds -Daily professional meetings are now instigated and this has improved management plans and appropriate timely escalation to internal and external partners. CHFT seeing a similar picture to what is happening regionally and nationally.<br>Sept 20 Draft children's and young people guidance being worked on - Directorate feel not to reduce score currently<br>June 2020 - issues remain, no incidents or escalations currently noted<br>April 2020 work has been underway to review policies and procedures to ensure that the service we offer is safe . | Mar-2023 | Dec-2023 |

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| High | 7092 | Trustwide | All Divisions | All Departments/Wards | Oct-2017 | Active | Keeping the base safe | Medication Safety - risk of incorrect prescription details<br><br>This may be due to selection errors, untrained users in EPR users not responding to decision support alerts , or users not following SOPS.<br><br>This may result in incorrect drug details -eg selection of drug , incorrect drug doses , frequencies and durations. Incorrect information could be sent to the GP regarding drugs stopped , amended or new drugs started during hospital admission. | Training and SOPs are available<br>Medications Safety Group reviews incidents of incorrect prescribing.<br>Order sentences are built - which filters drugs and dosage by age/weight and gives a suggested dose<br>Pharmacy / senior doctor review and feedback to junior prescribers<br>Guided prescribing through care plans<br>Critical incident / complaints reviews<br>Training and education before access is granted<br>Role based access control within EPR<br>Audit of drug errors leading to design | Training could be improved and refresher sessions offered.<br>EPR SOPS are available but staff often unaware and dont follow- leading to errors<br><br>Reducing the number of paper drug charts and paper outpatient prescribing.<br><br>Not all prescriptions are verified by a pharmacist before administration<br><br>Supervision of junior medical staff and adoption of good practice needs reviewing | 9 | 3 x 3 | 16 | 4 x 4 | 6 | 3 x 2 | Escalate to Division - training and supervision of prescribing staff is required | March 2019 - This risk is a prescribing issue and needs to be held by the Prescribers - so the risk needs to be held by the divisions rather than pharmacy<br>October 2020 - risk to be held by divisions and not pharmacy | Dec-2020 | Feb-2021 |
| High | 6078 | Family & Specialist Services | Appointment and Records | Appointments Service | Aug-2014 | Active | Keeping the base safe | There is a risk of being unable to provide sufficient appointment slots to manage demand. Due to an increase in referrals to services/reduced available capacity to manage demand.<br><br>Resulting in:<br>- poor patient experience<br>- increased administration (reliance on spreadsheets to track capacity requirements)<br>- risk to failure of RTT targets<br>- impact on contract income targets | Process: Fortnightly communication to Clinical Divisions highlighting capacity requirements. Regular communications with Ops managers / GMs.<br><br>KP+ system allows for real time monitoring of slots, waiting lists and canx/DNA rates.<br><br>All GP referrals are now referred via ERS. Worklists include ASIs, enabling review of the referral prior to offering appointment including the | Variations in capacity and demand plans.<br><br>Consultant vacancy factor.<br><br>Not all services review referrals prior to offering an appointment.<br><br>Lack of monitoring of no AC relevant slot utilisation | 16 | 4 x 4 | 16 | 4 x 4 | 3 | 3 x 1 | Monitor ASI position at customer contact meetings.<br><br>CAS/RAS service operating in some services.<br><br>Insourcing work on-going to help reduce ASI numbers. | July No change in risk- Discussed at PSQB<br><br>ASI action plan developed which includes trajectories at specialty level<br><br>Further actions planned to improve the position including weekly cross-divisional access meetings to monitor performance, development of a capacity management team within appointment centre, development of the Knowledge portal as a capacity planning tool to assist directorates.<br><br>Further action to confirm full divisional recovery plans to reduce ASI list further. Review at weekly | May-2023 | Dec-2023 |

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| High | 6109 | Family & Specialist Services | Children's Services | Paediatric Medical Staff | Sep-2014 | Active | Keeping the base safe | There is a risk...<br>- The paediatric department is not fully complying with the Royal College of Paediatrics and Health (RCPCH) paediatric acute medical standards. One example is paediatric consultant (or equivalent) presence at peak times of activity (17:00 - 22:00), leading to delays in senior review. All examples can be shown on the RCPCH action plan. This could result in delays in care and diagnosis and poor patient outcomes. 2 additional consultants are needed to support this rota.<br>- The neonatal department not fully complying with BAPM standards. The neonatal unit should have 7 consultants. 1 additional consultant is needed to support this.<br>- A lack of resource to ensure children and young people are seen in appropriate time-frames in outpatient clinics.<br><br>The above results in a greater number of incidents and an impact on flow, both impacting the medical care of children and young people. | 24/7 on call Consultant cover (17:00 - 22:00) for days of peak activity in winter. Twilight consultant cover around 2-4 evenings per week.<br><br>24/7 Tier 2 rota (resident) - however, there are often gaps.<br><br>24/7 Paediatric Nurse Practitioner support at HRI. 4 hourly acuity and capacity risk assessment using RCN standards with escalation policy if demand compromises safe nursing care. However, there are often gaps due to sickness and vacancies.<br><br>Minimum roster standard - 1 APLS trained nurse on each inpatient area 24/7.<br><br>High levels of workforce compliance with HDU training and sepsis awareness training.<br><br>Matron daily sit rep provides daily focus on staffing, workload and risks.<br><br>Consultants completing some additional clinics. 6 month recovery locum starting March 2023.<br><br>December 2022 - ad hoc support | The paediatric consultant workforce is flexible and proactive in putting the needs of patients first. There is acknowledgement that the safety of the service is enhanced by their flexibility and this can impact on service delivery the next day. This is not sustainable.<br><br>Gap in budget. | 12 | 3 x 4 | 16 | 4 x 4 | 3 | 3 x 1 | 1. Rapid access clinics established once per week.<br>2. Winter resilience plan established in summer 2021 (also considering COVID-19 related factors). OPEL plan in place. OPEL plan being reviewed December 2022.<br><br>See progress update for further action plan updates. | Update March 2023<br>- PCC funding has enabled the service to have a twilight consultant every week night until 31/3/23 (this means we are meeting standards but it's also helped with winter pressures). This is not a sustainable model with continuing elective activity with the same number of consultants<br>- Developed raised to increase the consultant workforce to enable the service to meet standards, however all developments across the Trust have been paused. Escalation raised with the division on 3/3/23 - asked to take this to PRM on 31/3/23 so the divisional team can raise this at the divisional PRM<br><br>Update January 2023<br>- Challenging paediatric winter has been evident. Additional (internal) consultant twilight shifts in place every week day evening from the start of December 2022 until the end of January 2023. Already realised in the budget by the Senior Finance Manager and General Manager<br>- 3 x additional consultants put forward as part of business planning - awaiting outcome<br><br>Update December 2022<br>- Significant surge evident in late November/early December 2022. Some divisional agreement to support greater twilight shifts, however this is only temporary.<br>- Increase in incidents. 2 SIs being taken to red panel on 2/12/22.<br>- 3 x additional consultants to be put forward as part | Jun-2023 | Oct-2023 |

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| 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 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 | Number of areas awaiting fire compartmentation works<br>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<br><br>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 | March 23 Survey by CHS to understand the scale of the works required on the compartmentation is being carried out,<br>Sept 2022 Drawings continue to be reviewed<br>May 2022 AFL architects have been updating the drawings, once received we will cross reference what we should have and what we actually have to identify gaps.<br>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.<br>May 2021<br>60 minute fire compartmentation completed along with ward 18. Some areas have not been addressed, but guidance on what building stock is being kept or demolished will help with planning further work.<br>30 minute sub-compartmentation is still outstanding, but this will require a lot of work and cause major disruption as wards will need to be vacated for a considerable amount of time.<br><br>December 2020<br>60 minute Fire Door replacement scheme nearing completion and Ward 18 now fully compartmentalised. 30 minute sub compartmentation still outstanding<br><br>April 2020<br>additional fire risks due to impact of Covid-19, fire loading, increased use of oxygen, increased storage of supplies and equipment, movement of staffing, utilisation of theatres as critical care wards, fire evacuation routes altered. Full risk impact scoped and added to Covid risk register.<br><br>MARCH 2020<br>Fire Committee reviewing Fire Risk to ensure appropriate risks identified and sufficient controls are in place. Fire Committee meeting 8th April 2020 and will review / approve all Fire related risks.<br><br>FEBRUARY 2020 | Apr 2023 | Sept 2023 |

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| 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 relation to strengthening record keeping within the Trust. | Remaining paper documentation not built in a structured format in EPR which has been a challenge to the organisation since go live of the electronic patient record due to<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 | 4 x 5 | 15 | 3 x 5 | 6 | 3 x 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<br>- 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 | April 2024: Work is still ongoing to review wokrflows and over the next 12 months there will be a programme to re train the wokrforce in the correct wokrflows. Change facilitators commenced in post 17th April 2023.<br>Feb 2023: Work commenced on improving the nursing clinical record and pharmacy drug catalogue. The training team continues to teach new doctors workflow and evaluations underway with CCIO.<br>Nov 22: CV's obtained for developers to be employed by the trust to improve some of the work within workflows. Training team continue to work on wards and support staff. Junior doctor training complete training team now moving on to senior doctor grades.<br>Sept 22: Work still ongoing to priorities work and fund the additional resource needed. Training team evaluating impact of new doctor training to feedback to CNIO and CCIO.<br>August 2022: Work on going with Bradford and CHFT head of EPR has been asked by CNIO's for both trust to provide a quote for the resource needed to complete this work and improve workflows for both nursing and clinical. Task and finish groups completed and all the information gathered.<br>June 2022: CNIO still attending weekly quality reviews looking at why documentation is limited in some areas and why assessments are missed. Doctors training being relooked at and workshops taking place. Admission task and finish group still going ahead making good progress with what is needed to complete a full and comprehensive admission document.<br>April 2022: Task and finish group set up to look at clinician training and review the whole process. These are being led by the training team and are underway. Nursing admission task and finish group set up first meeting on 29th April to review admission process and what works for the areas. CNIO attending weekly quality reviews looking at why documentation is limited in some areas and | May-2023 | Apr-2024 |

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| High | 7649 | Family & Specialist Services | Pharmacy | Pharmacy | Feb-2020 | Active | Keeping the base safe | There is a risk that patients do not receive appropriate medication because of the the current staffing which results in a lack of assurance that patients are receiving an appropriate level of pharmacy input. Pharmacy service to ITU is not compliant with national standards for provision of intensive care services. We have 1.0 WTE B8a pharmacist in post (approx 0.7 WTE of time is dedicated to ICU delivery). There is reduced cover from existing band 7 pharmacists due to current vacancies.<br><br>In the NHS England Critical Care specification document it states that pharmacy cover should be provided: "Clinical pharmacists supporting delivery of medicines optimisation in critical care areas must provide patient-centred care, including: medicines reconciliation (on admission and discharge), independent patient medication review with attendance of multi-professional ward rounds and professional support activities, including: clinical guidelines, medication-related clinical incident reviews and clinical audit and evaluation."<br><br>In The Intensive Care Society and the Faculty of Intensive Care Medicine Version 2.1 of the Guidelines for the Provision of Intensive Care Services (GPICS); it states the following - CHFT data include below each standard:<br><br>1. There must be a designated intensive care pharmacist for every | A number of experienced pharmacists are available to provide cover to ITU on both sites - and there is some ward round attendance. | We do not meet the national standard outlined above.<br>Additional resource required with reconfiguration and the planned bed new bed base.<br>Lack of resilience to meet any COVID surge<br>Limited cover available for sickness/leave without impacting on other service areas | 6 | 2 x 3 | 15 | 3 x 5 | 1 | 1 x 1 | See details in risk above.<br>Business case for expanded service to be submitted to BCAG early 2023 (when considering cases) | Update March 2020: No fully compliant in the past but situation is currently worse because the two substantive ITU pharmacists are currently in a new position and on secondment till end June 2020<br><br>Update April 2020 - due to current Covid situation and significant increase in ITU beds there is increased input to ITU and additional pharmacists are being trained up to a minimum standard<br><br>May 20 - vacancy control now put on TRAC - awaiting approval and then can close risk<br><br>Sept 20 - risk to remain open whilst we are unable to provide 7 day service to ITU.<br><br>Jan 22 - Still unable to provide a 7 day service to ITU. Senior ITU pharmacist currently undergoing training and development to be at the advance level required.<br><br>**********<br>STANDARDS<br>1. There must be a designated intensive care pharmacist for every critical care unit.<br>2. The critical care pharmacist must have sufficient job time within which to do the job. There should be 0.1 whole time equivalent (WTE) pharmacist for every Level 3 bed and for every two Level 2 beds for a 5/7 a week service.<br>3. Clinical pharmacy services should be available seven days per week. However, as a minimum, the service must be provided five days per week (Monday-Friday) with plans to extend the ward service to seven days a week before 2020.<br>4. The most senior pharmacist within a healthcare organisation who works on a daily basis with critically ill patients must be competent to at least Advanced Stage II (excellence level) in adult critical care pharmacy.<br>5. Other clinical pharmacists who provide a service to intensive care areas and have the minimum competencies to allow them to do so (Advanced Stage I) must have access to an Advanced Stage | Jun-2023 | Jun-2023 |
| High | 8228 | Medical | Acute Medicine | Acute Floor - HRI | Jan-2022 | Active | Keeping the base safe | There is risk of a security breach due to unsafe storage of medication in the treatment room on ward 9 due to the keypad lock is not fit for purpose, resulting in uncontrolled access to the treatment room and potential access to intravenous fluids and medications. | The treatment room has a keypad lock that functions intermittently.<br>The intravenous fluids although not stored in a locked cabinet are stored (in theory) behind a locked door.<br>Laminated red signage used to identify fluids with potassium.<br>Domestic cleans the treatment room daily.<br>Surface spillages are cleaned by the nursing team as they occur.<br>Controlled drugs are locked within the CD cabinet with keys and access restricted to registrants only. | The lock on the door is a manual door keypad, this is not secure and has intermittent faults.<br>The code on the treatment room door is not regularly changed again resulting in potential uncontrolled access.<br>The treatment room is unfit for purpose with inadequate strorage space and lockable units.<br>Indequate workspace to prepare aseptic non touch techinique procedures.<br>Awaiting quote and authorisation for room refit. | 15 | 3 x 5 | 15 | 3 x 5 | 1 | 1 x 1 | We are in the process of obtaining quotes through estates and facilities for a treatment room refit to resolve the above safety and security issues.<br>This incusive of an electronic ID access system to gain entry to the treatment room and will monitor the access of persons including date and time if required. | No update provided by estates at present<br><br>May 22 - Risk reworded and accepted at April's PSQB | Feb-2022 | Apr-2023 |

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| High | 8294 | Community Healthcare | Inpatient Therapies | Inpatient Speech and Language | Mar-2022 | Active | Keeping the base safe | There is a risk that speech and language therapists will not be able to provide the required amount of time with stroke patients to meet the requirements of SSNAP audit due to staff vacancies resulting in SSNAP target of A or B score not being achieved for the Trust | Vacancies advertised<br>Bank staff usage<br>Prioritising workload across acute and stroke wards | National issue for recruitment of speech and language therapists | 15 3 x 5 | 15 3 x 5 | 1 1 x 1 | Use of Bank staff<br>Prioritise workload | April 2023 - no change, some sickness in team affecting position further.<br>March 2023 - no change, posts remain out to advert<br>Jan 2023 - no change, posts remain out to advert<br>Dec 22 - no change, posts remain out to advert<br>Nov 22 - identified as a possible risk that could be combined with staffing SALT risk at Oct risk group. Response from lead - both risks are on priority service as a result of vacancies the timelines for | May-2023 | Jul-2023 |
| High | 8315 | Surgery & Anaesthetics | Head and Neck | Ophthalmology | Apr-2022 | Active | Keeping the base safe | There is a risk of significant of increasing waiting lists and delays to new and follow up appointments in the ophthalmology paediatric service as well as delays in improvement, quality assurance, staff development and pressure on the service due to not having enough substantive Paediatric Consultants. This could result in catastrophic or significant harm to the patient. | One FT substantive consultant with 3x Paeds sessions a week<br>Job to be advertised for substantive paediatric consultant<br>Collaboration with locum consultants<br>Utilisation of existing orthoptic and optometry skills<br>Links with admin staff regarding pending lists, ASI's<br>Regular validation | Lack of capacity<br>Lack of additional substantive consultant<br>Lack of speciality middle grade | 15 5 x 3 | 15 5 x 3 | 0 0 x 0 | Validation of waiting lists<br>Advertise attractive substantive Paeds Consultant vacancy<br>Collaborative working amongst AHP's regarding service improvement and working differently<br>Service improvement<br>Review of the pathway / AHP and nursing training<br>Paediatric leads orthoptic/ optom and also Paediatric ACP<br>Quality assurance systems to ensure patients are seen by the right clinician at the right time<br>Opportunities to work differently to optimise capacity | 01/09/22 Locum Paeds consultant to start 2 days a week in October, Job advert out for substantive position.<br><br>03/11/22 Only candidate for interview was not successful. Job is back out to advert.<br><br>08/12/22 Locum Dr given 4 weekend clinic dates, lack of uptake from support staff 358 pts past end date. 33 high risk<br><br>13/04/2023 - Locum post back out to advert on Trac | May-2023 | Jul-2023 |
| High | 8344 | Family & Specialist Services | Women's Services | Maternity | Jun-2022 | Active | Keeping the base safe | There is a potential risk that the lack of a Maternity Reporting Software may lead to human error in interpretation of Doppler waveforms this has come to light following an increased scan requirement due to NICE guidance (UID) This may lead to an error in identifying women at risk of severe growth restriction or incorrect management of growth restricted fetuses - both of which may result in stillbirths | 1. Doppler waveform results are produced on the scan report and staff have to manually plot using a ruler and then make a decision of care based on this result | Incorrect manual plotting on graph has the risk to result in incorrect management and has the potential to result in stillbirth or a poor outcome | 15 5 x 3 | 15 5 x 3 | 4 4 x 1 | 1.review of current provision<br>2. develop a case for maternity scanning reporting software. | March 23 -reviewed by GH and LD awaiting for full business case to be completed as cost has exceeded capital allocation<br><br>Feb 23 - Review LD / GH - no change from last update. Work underway assessing full costs<br>Jan 23 - DT, GH, LD review - task and finish group in progress reviewing procurement options<br><br>Divisional Risk Register confirm and challenge update 8/12/22<br>Present: GH, LD, NV, SS, SRF, LH, LR | Apr-2023 | May-2023 |
| High | 8398 | Surgery & Anaesthetics | General and Specialist Surgical Services | Colorectal | Aug-2022 | Active | Keeping the base safe | There is currently a risk of high volumes of patients awaiting a follow up appointment within Colorectal surgery due to increased referrals post covid and historical patients waiting for their appointments, resulting in patients waiting longer for their appointments which will delay treatment and care for these patients. | Clinicians have prioritised work to ensure long waiters have been treated for surgery, along with the cancer patients.<br>Currently as of 16/08/2022 922 patients are over due appointments, of which 118 patients are overdue 52 + weeks and 141 overdue 39+ weeks | There has been a 30% increase in demand with no increase in resources to see more patients.<br>There is no failsafe officer. | 15 3 x 5 | 15 3 x 5 | 6 2 x 3 | Clinicians have sight of the patients that are overdue , to implement plans to mitigate and clinically validate these patients as not all patients require follow up appointments.<br>To write a business case for an additional Colorectal Consultant. | 20/03 Current position statement, still with high volumes of patients awaiting validations. Appointed additional consultant due to start July 2023. Work ongoing with admin teams to see if can validate using trends to present at the consultant meeting once work has been completed.<br>07/02/2023- Current position statement.<br>1103 patients overdue for follow up appointment of which<br>112 52+ weeks<br>121 over 39 weeks | May-2023 | Jun-2023 |

| | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| High | 8453 | Family & Specialist Services | Pharmacy | Pharmacy | Nov 2022 | Active | Keeping the base safe | There is a risk that patients may receive incorrect or delayed medicines due to a shortage of Pharmacist and Pharmacy Technicians and Pharmacy ATOs. There is a 20% vacancy in the Clinical Pharmacist workforce and in the Pharmacy Dispensary Team. This shortage means that there can be delays or omissions in medication drug history checks, reconciliation, screening of inpatient medicine orders and follow up of pharmacy interventions, coupled with an impact on the dispensing and release of medication for inpatient and at discharge. | Prioritization of core medicines areas (1) discharge turnaround (2) medicine supplies.<br>Prioritization of DWP and Safari cover to support patient flow.<br>Staff with substantive posts undertaking additional hours as bank staff.<br>Use of bank Pharmacist and Pharmacy technician where available to support gaps in the rota<br>Staff recruitment to vacant posts.<br>Training for new starters which priorities roles.<br>Flexible working with the Pharmacy Team to priorities patient facing roles. | Cannot resource all available vacancies even with bank staff | 15<br>3 x<br>5 | 15<br>3 x<br>5 | 1 1<br>x 1 | Recruitment Plan to address vacancies<br>Discussion of stepping down functions and activities<br>Discussion re restriction of leave /study time<br>Review of co-coordinator Roles to support junior work force and patient flow<br>Testing of a different weekend model of working across CRH and HRI sites | 19 Jan 23: Accepted risk by Pharmacy Board KC<br>March 23: Recruitment ongoing. Risk remains | Jun-2023 | Jul-2023 |

| Lead | Exec Dir | RC | Tolerate |
|---|---|---|---|
| Julie Mellor | Simon Riley Fuller | PSQB | |
| Julie Mellor/Wendy Kilner | Simon Riley Fuller | PSQB | |

| | | | | |
|---|---|---|---|---|
| | PSQB | Stephen Shepley | Gill Harries | |
| | DB | Prof. Bhuskute | Sarah Clenton | |
| | PSQB | Aletta Carbone | Natalka Drapan | |

| | | | |
|---|---|---|---|
| | PSQB | Michael Folan | Debbie Wolfe |
| | PSQB | Michael Folan | Jennifer Clark |
| | PSQB | Purav Desai | Chris Roberts /Andy Hardy |

| | | | |
|---|---|---|---|
| | PSQB | Stephen Shepley | Gill Harries |
| | PSQB | Stephen Shepley | Lucy Thomson |
| | PSQB | Ruth Lush | Sarah Bray |

| | | | |
|---|---|---|---|
| | PSOB | Simon Riley-Fuller | Julie Mellor |

| | | | |
|---|---|---|---|
| | ICPB | David Birkenhead | Chris Lord-Tyrer |
| | PSCB | Stephen Shepley | Emma Hurst |

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|---|---|---|---|
| | WF | David Birkenhead | Corrielle Parker, Pauline North |
| | PSQB | Johnathan Hammond | Chris Roberts |

| | | | |
|---|---|---|---|
| | PSQB | Jonathan Hammond | Helen Rees |
| | DB | Thomas Strickland | Sarah Bray |
| | PSQB | Nikhil Bhuskute/Stephen Shepley | Venkat Thiyagesh/Elena Gelsthorpe-Hill |

| | | | |
|---|---|---|---|
| | HSC | Simon Riley-Fuller | Jen Etchells/Julie Mellor |

| | | | |
|---|---|---|---|
| | QC | David Birkenhead | TBC (Medical education) |
| | PCB | Helen Barker | Nicholas Buckley |

| | | | |
|---|---|---|---|
| | PSOB | Nikita Bhuskute/Stephen Shepley | Venkat Thiyagesh/Elena Gelsthorpe-Hill |

| | | | |
|---|---|---|---|
| | FIR EC | Jonathan Hammond | Keith Rawnsley |

| | | | |
|---|---|---|---|
| | WEB | Ellee Armistead | Louise Croxall/Graham Walsh |

| | | | |
|---|---|---|---|
| | DB | Nikki Bhuskute | Katherine Cullen |
| | PSQB | Helen Rees | Amy Whitehead/Rhys Edwards |

| | | | | | |
|---|---|---|---|---|---|
| Jennifer Clark | Natalka Drapan | Emma Burbidge | Laura Cooper | | |
| Michael Folan | Aletta Carbone | Gill Harries | Thomas Strickland | | |
| PSQB | PSQB | HSC | PCB | | |

| | | | |
|---|---|---|---|
| | PSOB | Elisabeth street | Katherine Cullen |

Calderdale and Huddersfield
NHS Foundation Trust

# FIRE STRATEGY

## 2021 – 2026

Approved by Trust Board of Directors
March 2021

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Calderdale and Huddersfield NHS Foundation Trust

# Calderdale & Huddersfield Foundation Trust

## Fire Strategy 2021-2026

## Document Control

| Document Particulars | |
|---|---|
| Strategy Reference No | XXXXX |
| Executive Director Lead | Jonny Hammond, Chief Operating Officer |
| First Version Issue Date | March 2021 |
| Latest Version Issue Date | March 2021 |
| Review Date | March 2026 |
| Approved By | Trust Board of Directors |

| Change Record | | | |
|---|---|---|---|
| **Date** | **Author** | **Nature of Change** | **Version** |
| 28 October 2020 | Stuart Baron | Draft | 0.1 |
| 22 January 2021 | Phil Redman | Draft to Issue | 0.2 |
| 27 January 2021 | Phil Redman | Update for review comments | 0.3 |
| 28 January 2021 | Helen Barker | Update for final review | 0.4 |
| 28 January 2021 | Stuart Baron | Issue to Fire Committee | 0.5 |
| 06 April 2021 | Chris Davies | Update for review | 0.6 |

Calderdale and Huddersfield
NHS Foundation Trust

# Contents

Calderdale and Huddersfield
NHS Foundation Trust

# Executive Summary

**The Trust Board of Directors of Calderdale and Huddersfield NHS Foundation Trust ("the Trust") recognises the need for strong leadership associated with fire safety and the importance of strong fire management principles. This Fire Strategy document responds to that and seeks to set out those core principles upon which activity and the development of good practice shall be founded.**

The Trust Board of Directors equally recognises the nature of their premises and how they each operate independently of one another, whilst combining to support the clinical care function for the local population. The properties vary in scale, age and condition, yet are each required to perform to a level which maintains safety for staff, patients and visitors.

Furthermore, new accommodation developments (or redevelopments) within the Trust need to conform to agreed standards, which this Fire Strategy seeks to define. Outputs for any and all new developments will include a Fire Risk Assessment undertaken at the design stage.

This Fire Strategy seeks to inform the Trust Fire Policy and acts as the primary control point for each of the individual building Fire Risk Assessments. These risk assessments take the physical and operational specifics of the Trust properties and apply the principles identified in this strategy and Trust Fire Policy.

This Fire Strategy adopts the structure and approach of NHS: HTM 05-03: Operational provisions which defines the national framework for fire safety in healthcare accommodation.

The overall objective of this Fire Strategy is to create one single and coherent approach to fire safety principles within the Trust. As such the document is broken into three core parts:

- The Trusts approach to fire management, identifying those key principles of fire safety;
- The activities which the Trust continue to implement; and
- The recommendations of this strategy to be embedded into the Trust Fire Policy and individual building Fire Risk Assessments.



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Calderdale and Huddersfield
NHS Foundation Trust

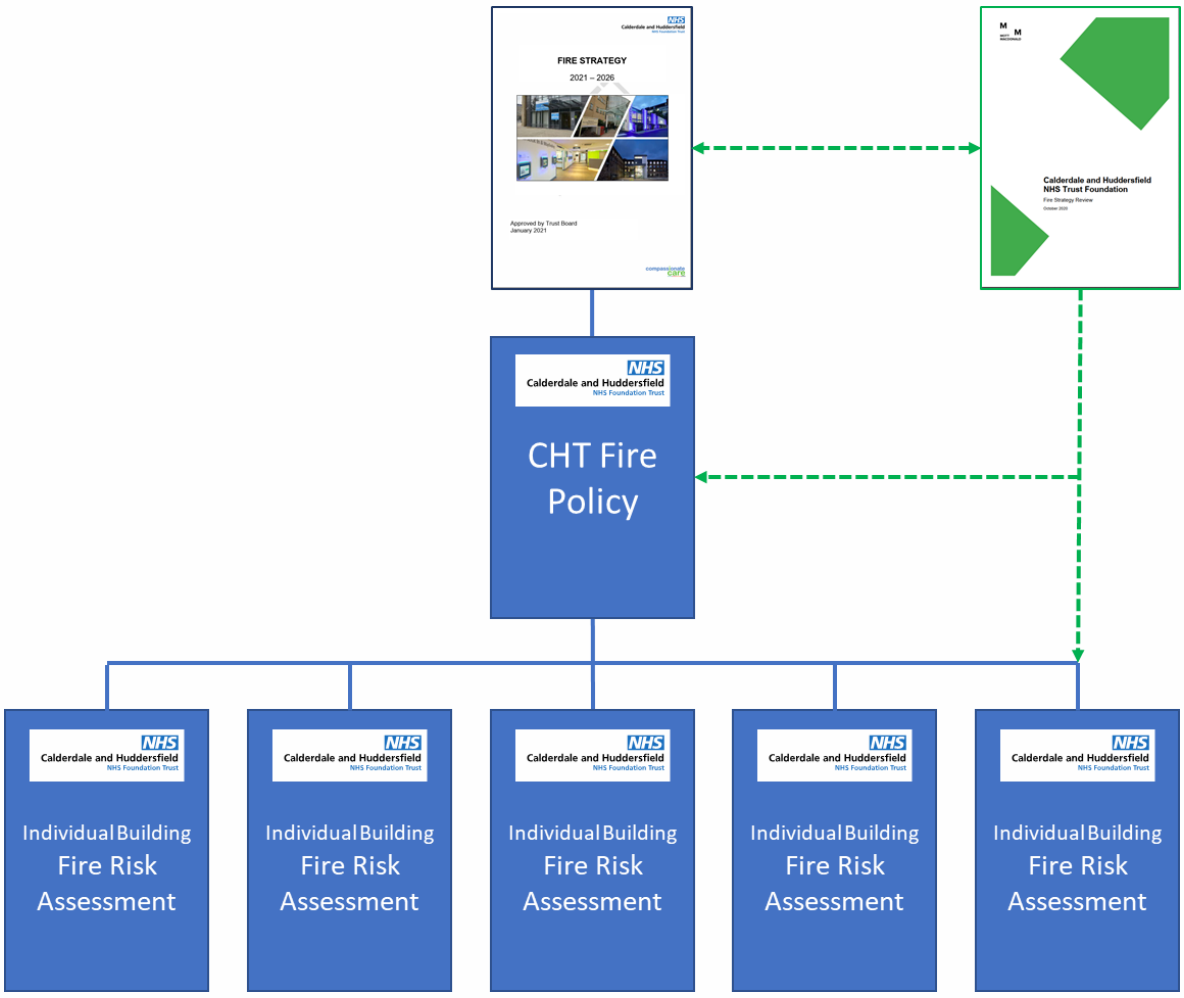
# I. Introduction and overview

The overall aim of this Fire Strategy is to define and highlight the actions which the Trust are taking in order to best ensure that all aspects of Trust fire safety are clearly documented. This will further assist in the ongoing fire safety management of the premises and ensure that any future alterations do not negate the original fire safety objectives.

The Chief Executive (as “Responsible Person”) assumes overall responsibility for all fire safety matters within the Trust. Individual responsibilities of designated persons are outlined in the Trust Fire Policy. The Chief Operating Officer assumes responsibility at board level for all Fire Safety Policy matters.

It forms part of the suite of fire safety documentation developed by the Trust, in broad terms identified below.

**Figure I.1 – Trust Fire Documentation Structure**



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In defining this current position and determining the five-year strategy of the Trust in respect of fire safety, an assessment was performed by Mott MacDonald in accordance with BS 9997 (Fire risk management systems – Requirements with guidance for use). This assessment has helped shape this strategy, will inform the Trust Fire Policy and reinforce the individual building Fire Risk Assessments. It also looks to provide an 'as is' position, an objective, independent review and shapes the next steps of this strategy. It is highlighted in green in Figure I.1

This strategy heads the core principles of fire safety within the Trust and determines actions within the Trust Fire Policy as well as informing the individual building Fire Risk Assessments. All documents are interlinked and derive direction and information from each other.

This strategy follows the guidance set out in 'Firecode – Fire safety in the NHS: HTM 05-03: Operational provisions' sets out the contents for a model fire strategy document. This strategy applies this guidance and tailors this as to how the Trust operates and manages the risk of fire across its estate. The strategy identifies the need for specific overviews of each of our premises, clarity around who occupies the buildings, our evacuation strategy and methodology, our fire detection systems, fire spread, fire rescue service access, ventilation systems, special considerations and fire risk assessments.

From this position this Trust Fire Strategy has been established and key actions identified.

## II. Approach to Fire Management

CHFT is committed to ensuring people's safety whilst on its premises. It will best achieve this by:

a) Providing a safe working environment which, as far as is reasonably practicable, removes or reduces the fire hazards present on site;
b) Provide a safe environment for patients and visitors;
c) Carrying out fire risk assessment to identify, manage and reduce risks;
d) Providing guidance to management and staff on operational requirements relating to fire safety i.e. instructions, training, evacuation drills, plans etc.;
e) Implementing measures to mitigate the impact of fire on life, safety and delivery of service, property and assets; and
f) Creating a 'fire aware' culture across the organisation to minimise the risk of an instance of fire.
g) Horizon scanning of future regulatory changes and ensure building schemes will, where possible, be compliant at opening and in the first 5 years of life.

Our Fire Strategy follows the guidance set out in 'Firecode – Fire safety in the NHS: HTM 05-03: Operational provisions' and covers;

a) Design Codes and Guidance;
b) Overview of Our Premises;
c) Building Occupants;
d) Evacuation Strategy and Methodology;
e) Automatic Fire Systems;
f) Means of Escape;
g) Fire Spread;
h) Fire and Rescue Service Access;
i) Ventilation Systems; and
j) Special Considerations.

The Fire Risk Assessments developed for each Trust facility will provide the specific guidance associated with fire safety in that building. They will be structured in line with HTM 05-03.

Therefore, and as part of this Fire Strategy, each of the sections of the Firecode are included below in order to highlight the key principles which this Fire Strategy seeks to incorporate into the Fire Risk Assessments.

## A. Design Codes and Guidance

This section identifies the design codes and guidance used in the development of the individual fire management strategies within Trust properties. When alternative or fire-engineered solutions have been incorporated, these are outlined in the individual property documentation and, where necessary, justified. As a Trust we have created a position where derogations associated with fire are not considered acceptable. However, where variations or deviations from recognised codes of practice exist, these are fully justified within those individual fire strategies.

The design codes listed below form the basis of this fire strategy and will be those which have and will shape the development of the Fire Risk Assessments at each of the Trust properties.

- NHS 'Firecode' Health Technical Memorandum (HTM's) 05-01; 05-02; 05-03;
- The Regulatory Reform (Fire Safety) Order 2005;
- Guidance for Fire Risk Assessment – Healthcare Premises (Guidance document 10, published by the Department of Communities and Local Governments);
- The Building Act 1984 as amended by Building Regulations 2013 – Approved Document 'B', Fire Safety, , rewritten in 2019 & updated in 2020;
- The Health and Safety at Work Act 1974;
- The Management of Health and Safety at Work Regulations 1992 as amended 1999;
- The Workplace (Health, Safety & Welfare) Regulations 1992; and
- The Health and Safety (Safety Signs and Signals) Regulations 1996.

A full list of reference documents and associated links are provided within the Appendices to this strategy.

## B. Overview of Our Premises

The Overview of Our Premises section shall provide a brief description of the premises included in the plan. This section will also address the Trust's responsibility for its own buildings but also for those properties where our colleagues operate in buildings and facilities that are not Trust owned.

Key elements of this section of the strategy include:

- Trust's responsibilities in owned, leased and accessed buildings;
- The signage in place to notify relevant parties (e.g. Fire Service, staff, patients) of key firefighting notices and equipment;
- The provision of first aid firefighting equipment and facilities;
- Methods of housekeeping across the site; and
- New building projects and major alterations

The detailed management of these are set out within the Trust's Fire Policy however the principles are set within this document.

### *B1 Trust's Responsibility*

CHFT has a responsibility to manage fire safety within all properties belonging to the Trust (either owned or leased) and occupied by Trust staff. Where there are a number of services sharing the same building or site, the management of fire safety is undertaken by local Fire Wardens and managers.

Where there are Trust staff in host buildings (i.e. not managed by the Trust) this fire strategy seeks to best ensure they are familiar with the fire safety systems within the building. This will be achieved through accurate descriptions of those properties within the buildings' Fire Risk Assessment. The Trust will seek to ensure that Trust staff are aware of their own responsibilities when accessing host buildings through fire safety training.

Co-operation and co-ordination between host organisations and staff is important to ensure safe systems are in place in the event of a fire and these are to be identified as part of the building specific documentation.

Furthermore, those individual property Fire Risk Assessments will also contain details around:

a) Localised Emergency Plans;
b) Appropriate fire signage;
c) Provision of first aid firefighting equipment and facilities; and
d) Methods of housekeeping across the site.

### *B2 Trust accessed properties*

In delivering our services the Trust accesses over 120 other properties that the Trust is not responsible for the maintenance and compliance of the building. This Fire Strategy acknowledges the Trust's responsibility as an employer to ensure that these buildings are safe and fit for purpose whilst ensuring that visiting colleagues are aware of their responsibilities upon entering these types of buildings.

It is noted that there are a number of 'outreach areas' which although not owned or leased by the Trust are frequented by staff for business purposes. For these outreach areas, the Trust have no legal obligation for fire safety of these buildings; however, the Trust has a duty of care to colleagues to ensure there are appropriate procedures within those buildings. This is also applicable to the Trust's community services who visit patients' homes.

The Trust shall manage this risk by providing access to annual fire awareness updates for all colleagues which covers individual's responsibilities for safe operation in all

environments. Trust employees have a responsibility to be aware of any local fire safety measures specific to the property they occupy.

### *B3 New building projects and major alterations*

Where proposals for the alteration or change of use of existing Trust buildings, design and construction of new buildings or purchase/lease of additional premises are initiated by the Trust and delivered alongside the Capital Projects and Estates Planning Department of the CHS, the Trust's Estates and Facilities subsidiary and ENGIE for CRH.

The Trust recognises the requirement that adequate fire precaution measures form an essential part of the building management and design. This strategy highlights that the design specifications for the building must fully comply with the requirements of the Building Regulations Approved Document B Fire Safety and NHS Firecode HTM 05-02 Guidance. As identified earlier, where deviations or fire engineering principles are proposed, these shall be fully articulated within the design proposals and derogation schedule subsequently forming part of the stakeholder agreement and sign-off.

The stakeholder agreement process will ensure compliance with the recommendations of NHS Firecode HTM 05-01 together with the Trust Fire Safety Strategy ensuring the Fire Safety Adviser and Authorising Engineer are consulted by the design team as soon as practicable to ensure that appropriate fire safety precautions are considered and included in the scheme before the plans are submitted to Local Authority Building Control or to an Approved Inspector for formal approval under the Building Regulations.

## C. Building Occupants

This section of the Fire Strategy identifies the requirement that the Trust fully consider the type of occupant likely to use the building and as a result, the provisions to be put in place. This includes matters such as training, personnel, fire safety activity and measures around materials stored within the facility (in relation to colleague safety) creating a bespoke 'people centric' approach to fire safety within our premises.

Assessments are to be based on the occupant descriptions contained in Health Technical Memorandum 05-02.

### *C1 Fire Safety Training*

Fire Safety training for all staff is a legal requirement under the Health and Safety at Work Act 1974, the Management of Health and Safety at Work Regulations 1999 and the Regulatory Reform (Fire Safety) Order 2005.

The Trust recognises the importance of regular fire safety training and the Trust Fire Policy makes provision for training all employees. Training will also be provided on request for persons not employed by the Trust but at work on Trust premises (e.g. contractors, volunteers, Local Authority staff etc.)

Each site operates a site induction for contractors and visitors that specifically covers fire safety and reporting mechanisms in the event and/or concern of a fire. Furthermore, each site operates a Hot Works permit system that covers evidence of competency, training, risk assessments and method statements incorporated into the Safe System of Work.

In accordance with HTM 05-01, fire safety training is delivered to all staff at induction when joining the Trust. All staff are then required to undertake annual fire safety awareness training as part of the Essential Training. Local training is the responsibility of the relevant fire warden or line manager however fire safety training is provided tailored to each specific working environment.

Additional Fire Training will be provided to all Fire Wardens to ensure competency to deliver the role.

### *C2 Fire Wardens*

Whilst fire wardens have no enforcing authority they will:

- Act as the focal point on fire safety issues for the local staff;
- Organise and assist in the fire safety regime within local areas;
- Lead the area response to fire or fire drill when warden for that shift;
- Raise issues regarding local fire safety with their line management; and
- Support line managers in their fire safety issues.

With the exception of Building 18 (which is not staffed) every building will have a number of trained Fire Wardens and this Fire Strategy will seek to best ensure that an appropriate amount of Fire Wardens are present across the Trust Estate.

This will be managed through Rostering for ward-based staff and through ensuring enough colleagues are trained as fire wardens in non-ward-based areas.

For information, the table below identifies the number of fire wardens identified within each of the Trust properties.

| Building | Number of Fire Wardens per shift |
|---|---|
| Acre Mills OPD | At least 1 per floor |
| Acre Mills Personnel Building | Minimum of1 per floor |
| Beechwood Medical Centre | At least 1 per floor |
| Broad Street Plaza | At least 1 per floor |
| Building 18 Records Store | N/A |
| Calderdale Royal Hospital | At least 1 per ward/department |

| Building | Number of Fire Wardens per shift |
|---|---|
| Equipment Loan Store and ICT Services (Elland) | Minimum of 1 per floor |
| Huddersfield Royal Infirmary | At least 1 per ward/department |
| Park Valley Mills | At least 1 in the building |
| Pharmacy Manufacturing Unit | Minimum of 1 per floor |
| Spring Cottage Nursery | Responsibility of the Nursery Management Staff |

### *C3 Dangerous Substances*

The risk of storing highly flammable liquids, especially those stored in plastic containers, and the impact for safety of colleagues, can be reduced through careful management. At the time of this strategy the Trust has an increased storage capacity requirement for highly flammable alcohol-based hand sanitiser at CRH and HRI.

From a wider perspective the Trust will seek to:

- Ensure there are no potential ignition sources in the vicinity of the hand sanitiser store.
- Consider whether electrical equipment, including emergency lighting systems and fire alarms, are suitable for use in flammable atmospheres where vapours may accumulate.
- Account for the increased storage capacity through the COSHH risk management system; and
- Ensure stored quantities up to 50 litres are be stored in fire resisting cabinets while quantities greater than 50 litres should be stored in dedicated highly flammable liquids stores.

The Trust shall commission an annual Dangerous Goods audit conducted by the formally appointed dangerous goods safety adviser. This is governed and monitored by the Trust Health and Safety Committee which reports up to the Trust Board of Directors.

## D. Evacuation Strategy and Methodology

This section of the Fire Strategy highlights the necessary principles associated with each of the Trust premises in relation to the evacuation strategies and methodologies that would be employed in the unfortunate event of a fire.

The Trust will ensure reasonable adjustments are made to evacuation methodologies so that no person shall be disadvantaged, to take such steps as it is reasonable to have to take to provide an auxiliary aid.

are made in the form of auxiliary aids

### *D1 Fire Alarm / Evacuation Procedure*

Fundamental to this Fire Strategy is that CHFT can safely respond to the situation, buildings and its occupants in the event of a fire. To facilitate safety of all concerned, all evacuations will be led by Trust staff.

In the event of a fire the following types of evacuation will be adopted:

- **Immediate Evacuation** (used in off-site buildings, Acre Mill Out-patient department and community premises).
- **Progressive Horizontal Evacuation** in the hospital (the movement of patients and staff away from the fire on the same level through fire resisting doors towards a place of relative safety).
- **Delayed Evacuation** in areas where it is not appropriate to evacuate patients due to the level of risk that will be incurred (i.e. Theatres, ICU). In such situations the patients will be prepared for evacuation but only evacuated as a final resort.

Evacuation aids are to be made available in high risk areas where horizontal evacuation cannot be achieved and captured within the building Fire Risk Assessment. 'Ski Pads[1]' or other appropriate measures are to be located in fire escapes and used to aid vertical evacuation of patients down fire escape staircases. If horizontal evacuation is not an option; training in the use of evacuation aids shall be provided.

Each building and distinct area within a building shall complete a local evacuation protocol which defines places of relative safety or local assembly points, fire alarms information, evacuation aids available and requires the fire warden to identify any issues which may delay an evacuation. Methods of overcoming such issues must be agreed with the fire officer and the local fire warden / area.

All colleagues shall be familiar with the location of their assembly point on the site they work or places of relative safety.

### *D2 Fire Evacuation Training*

Unannounced fire drills are to be carried out in areas where it is safe to do this. Where fire drills are not practicable, due to the unacceptable risk to patient care, suitable arrangements to give "effect" of fire drills are practiced by fire wardens and annual fire training is provided to all colleagues.

**Personal Emergency Evacuation Plans (PEEP)**

A PEEP must be documented for any patient group or colleague who has a disability that could affect their ability to evacuate their workplace. For in-patient areas the normal evacuation procedures shall cover the requirement for a PEEP. The PEEP

details what additional measures or assistance is required in order to achieve safe evacuation.

The plans look to ensure the following:

- Hearing impaired individuals: In the event of staff working alone a visual or vibrating method of alert must be considered. This will be complimented by Fire Warden visual inspection of areas in the event of a fire.
- Temporary refuges: places of safety will exist within a building where people can wait for assistance. From here, the individual can be evacuated out of the building in a safe and controlled manner.
- Mobility Equipment: e.g. wheelchairs for ground floor level, vertical evacuation equipment for will be provided for upper floor evacuation.
- Sight impaired individuals: a buddy system to ensure they are accompanied to a place of safety or out of the building.

To ensure understanding and clarity of responsibilities and actions to take place in facilitating evacuation of Persons of Reduced Mobility, the Trust will have formalised arrangements through a Personal Emergency Evacuation Plan (PEEP) for each occupied building (if required).

## E. Automatic Fire Systems

The Automatic Fire Systems section provides details of the fire alarm and detection system, automatic fire suppression systems and means for securing fire doors and exits electronically that are in operation across the estate.

Health Technical Memorandum 05-03 Part B – 'Fire detection and alarm systems' provides general principles and technical guidance on the design, specification, installation, commissioning, testing, operation and maintenance of fire alarm systems in healthcare premises. The Trust shall seek to fully comply with this guidance for the fire systems in place across its properties. Where deviation occurs, this shall be documented with mitigation measures approved by the Trust Fire Officer and ratified by the Fire Committee.

### *E1 Fire Detection and Warning Systems*

Across its sites the Trust has a comprehensive level of detail for the fire alarm systems installed within each property. The following categories of system are in operation within each building:

- Level 1: A system installed throughout all areas of the building to offer the earliest possible warning of fire, so as to achieve the longest available time for escape.
- Level 2: A system designed to give a warning of fire at an early enough stage to enable all occupants, other than possibly those in the room of fire origin, to escape safely, before the escape routes are impassable owing to the presence of fire, smoke

or toxic gases; with the additional objective of affording early warning of fire in specified areas of high fire hazard level and/or high fire risk.

- Level 3: A system designed to give a warning of fire at an early enough stage to enable all occupants, other than possibly those in the room of fire origin, to escape safely, before the escape routes are impassable owing to the presence of fire, smoke or toxic gases.

The Trust will continue to maintain existing fire provision in line with these identified necessary fire detection levels within each of the Trust Properties.

## F. Means of Escape

This section of the Fire Strategy seeks to identify how occupants will exit accommodation in the event of a fire.

Details of specific travel distances shall be as set out in Health Technical Memorandum 05-02 and therefore it is inappropriate for this Fire Strategy to provide arbitrary definition here.

However, where these distances are exceeded a full explanation and justification is included in the property Fire Risk Assessment.

## G. Fire Spread

The design, management and operational policies should allow all occupants to be able to move away from a fire to a place of safety as quickly as possible. As such, the primary provisions are as follows

### *G1 Compartmentation*

Where appropriate and necessary, Trust premises are divided into a number of fire individual compartments; each compartment is designed to contain an outbreak of fire for at least 60 minutes enhancing fire safety for both occupants and accommodation. In some Trust premises, the configuration or use of accommodation may deem that no fire compartmentation is required or practical. These determinations would be highlighted within the building Fire Risk Assessment with any mitigating measures captured there also.

The principles of fire compartmentation would be captured as follows:

- Within each main fire compartment, certain high risk (hazard) rooms and intermediate walls and doors should be designed to contain fire for a period of not less than 30 minutes; and
- This structured fire compartmentation forms the basic fire protection for the occupants and the premises, but it must be emphasised within Fire Risk Assessments that effective compartmentation is dependent upon fire resisting doors being closed, thereby, maintaining integrity.

All parts of the premises are subject to Fire Regulations. Any proposal to materially change the structure, occupancy or use of any part of the premises will be referred to the Fire Officer for review and approval, ratified by the Fire Committee.

Where the Trust has identified areas of improvement to compartmentation in existing buildings they will seek, where able, to address these areas through capital investment. Where this is not possible, following risk assessment, it will ensure sufficient mitigating fire controls are in place, such as for example an L1 Fire Alarm System, additional Fire Wardens, Dry Riser installation, etc..

### *G2 Fire Resisting Doors*

Fire doors are designed to resist the passage of heat and smoke for a specified period (minimum 30 minutes) and have two specific functions:

- To complete the fire resisting enclosure of fire tight compartments; and
- To protect escape routes (e.g. staircases and corridors) along which people may need to travel when evacuating the area.

Fire doors in all occupied buildings across site are to be checked weekly by the Fire Wardens and a more detailed inspection performed annually under the Fire Door Inspection Scheme.

## H. Approach to Fire & Rescue Service Access

This section of the Fire Strategy contains details of the access and facilities for the Fire and Rescue Service. Where variations to the provision of the Firecode exist the Trust shall seek agreement with the West Yorkshire Fire and Rescue Service and these variations be documented within this strategy.

West Yorkshire Fire and Rescue Service (WYFRS) respond to any 999 call and the response is graded as to the information received from the caller, in our case switchboard.

In supporting the quick access for the Fire and Rescue Service will be met by Security or the building Fire Warden who will then take the fire crew to the location internally via the shortest route.

An operational information document is held by WYFRS detailing, access, facilities available, water supplies, fixed installations, etc. Risks are also noted from asbestos containing materials to radiation and MRI scanners, biohazards, medical gases, etc. Operational visits occur at their convenience.

If circumstances change, liaison takes place to update the operational information held.

## I. Ventilation Systems

The Ventilation Systems section shall include information about the operation of the ventilation systems within the Trust premises, where the system should be allowed to continue to operate (for example operating departments) and any cause/effect information.

Each individual Trust premises and building will need to consider the operation of ventilation systems in the event of a fire. Such considerations are necessary to:

a) Prevent the spread of fire or smoke;
b) Prevent the propagation of fire; and
c) Aid the successful evacuation strategy for the building.

Each individual Fire Risk Assessment will seek to identify the specific operational parameters in order to facilitate the above.

## J. Special Considerations

This section of the Fire Strategy seeks to outline any special considerations required.

There will be areas where the complexity of the building or clinical delivery will require a different fire intervention. These tend to be complex areas of estate, or accommodation which has specific needs for patients, staff or visitors. For example, the provision of large atria in buildings. For these a fire-engineered solution (a bespoke solution aimed at responding to a specific situation, approved by the Fire Officer and ratified by the Fire Committee) will be utilised to secure adequate fire safety provision. As such, a bespoke fire engineered solution offers a pragmatic solution to code compliance.

Fire engineering can provide an effective solution to complicated fire compliance activities. As Trust properties can often be complex in their operation, properly developed and implemented fire engineering solutions can provide similar or enhanced solutions to the issue. The Trust will utilise the Authorising Engineer to support this and seek approval from both local Building Control and the local fire authority.

In these circumstances the Trust Fire Officer will oversee the proposed solution in order to best ensure it meets the overarching requirements of this strategy and will reflect this within the localised Fire Risk Assessments.

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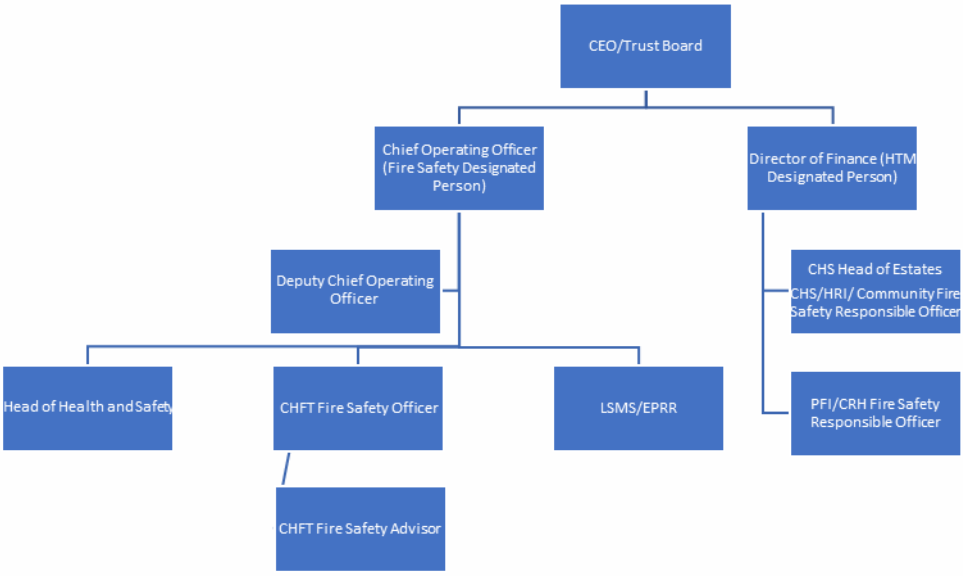
# III. Fire Safety – Trust Enhancement Activity

In this section of the Trust Fire Strategy, the document seeks to identify current activities of the Trust in relation to fire safety measures.

## A. Current Activity

### *A1. Fire Team Structure*

The Trust has established a clear line of command and communication with regard to the maintenance of fire safety measures within Trust premises. An appointed Trust Fire Officer reports via the Deputy Chief Operating Officer into the Chief Operating Officer of the Trust who is the Trust Board of Directors Executive responsible for fire safety.




This structure empowers the Trust Fire Officer to implement measures which directly promote and support fire safety, with the technical competence of CHS to implement.

### *A2. Fire Investment Priorities*

The Trust commissioned a comprehensive baseline audit, undertaken by Mott MacDonald. The recommendations from this will be reviewed by the Fire Committee and a defined schedule of works will be agreed with clarity of risk profile and associated priorities.

An ongoing programme of audits will be carried out by suitably experienced and qualified personnel. They provide a good opportunity for inter Trust collaboration, utilising the expertise and best practice of adjacent Trust to reinforce principles within CHFT. These will inform the annual fire safety capital programme.

## B. New Clinical Infrastructure

As identified in the section “Approach to Fire Management ” above, all new clinical infrastructure will be developed and constructed in accordance to this Fire Strategy and in early consultation with and involvement of the Fire Safety Officer.

Formal horizon scanning of potential regulatory changes to fire safety requirements will be included in large capital schemes and, where possible, changes will be incorporated into the design to ensure compliance once completed.

Subject to the infrastructure under development, the Trust can consider (via the Trust Fire Safety Officer) whether the appointment of a specialist Fire Engineer could provide enhanced facility in conjunction with the infrastructure. With the complexities of clinical delivery, engineered solutions can provide stronger solutions than code or HTM compliance and these should be investigated early.

## C. Adoption of Standards

As with all strategies, they remain constantly under review in order to accommodate new and emerging practices and standards.

The Trust Fire Officer and Fire Committee will be at the front of this ensuring that the Trust documentation is maintained in line with those developing fire management principles.

Amendments to either this strategy or corresponding Fire Policy will need to be approved by the Fire Committee ratified by the Executive Board. If considered appropriate, significant amendments will be brought to the Trust Board of Directors for approval.

## D. Audit

In order to maintain the high standards which this strategy seeks to set, performance against this Fire Strategy will be audited on a bi-annual basis.

The audit will be carried out in line with BS 9997 (Fire risk management systems – Requirements with guidance for use) or any subsequent standards considered appropriate by the Trust Fire Committee.

Audits should be carried out by suitably experienced and qualified personnel and often provide a good opportunity for inter Trust collaboration, utilising the expertise and best practice of adjacent Trust to reinforce principles within CHFT. Additionally the Trust has access to a Fire Authorised Engineer who would be appropriate to carry out such reviews.

# IV. Next Steps

### Summary of Actions and Timescales

The following are the proposed next steps for the Trust to consider in relation to both the adoption of this Fire Strategy as well as other recommendations focused over the next five years:

a) Approve this Fire Strategy and associated Fire Policy.
b) Develop and agree the Fire Investment Priorities to inform the Trust's Capital Programme over the next 5 years.
c) Agree the response to the audit and ensure implementation of any associated Action Plan.

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# Appendix A

**References:**

| Reference | Document/Link |
|---|---|
| Health Technical Memorandum 05-01: Managing healthcare fire safety | https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/192065/HTM_05-01.pdf |
| Health Technical Memorandum 05-02: Firecode Guidance in support of functional provisions (Fire safety in the design of healthcare premises) | https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/473012/HTM_05-02_2015.pdf |
| Firecode – fire safety in the NHS Health Technical Memorandum 05-03: Operational provisions Part A: General fire safety | https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/148476/HTM_05-03_Part_A_Final.pdf |
| Health Technical Memorandum 05-03 Part B – 'Fire detection and alarm systems' | https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/148477/HTM_05-03_Part_B.pdf |



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# Appendix B

Trust owned/leased properties

| No. | Property | Description | Leased/Owned/PFI |
|---|---|---|---|
| 1 | Huddersfield Royal Infirmary, Acre Street, Lindley, Huddersfield HD3 3EA | 1960s NHS Hospital GIFA 65,000m² | Owned |
| 2 | Calderdale Royal Hospital, Salterhebble, Halifax HX3 0PW | 2001 PFI Hospital GIFA 58,000m² | PFI |
| 3 | Acre Mill- Personnel building, Acre Street, Lindley, Huddersfield HD3 3EA | 1900 Office Accommodation | Owned |
| 4 | Unit 17 &18 Acre Street, Lindley, Huddersfield HD3 3EA | 1980s Warehouses | Owned |
| 5 | Huddersfield Pharmacy Specials Gate 2 Acre Mill School Street West Huddersfield HD3 3ET | 2008 Manufacturing Unit | Owned |
| 6 | Park Valley Mills, The Lodge, Park Valley Mills, Meltham Road, Huddersfield HD4 7BH | Office Accommodation | Leased |
| 7 | Broad Street, 51 Northgate, Broad Street Plaza, Halifax, HX1 1UB | Office Accommodation / Health Centre | Leased |
| 8 | Beechwood Health Centre, 60B Keighley Road, Ovenden, Halifax, HX2 8AL | Health center clinic | Leased |
| 9 | Spring Cottage Nursery, Acre Street, Lindley, Huddersfield HD3 3EA | 2004 temp accommodation for third party nursery | Owned |
| 10 | Acre Mill OPD, Z-Block, Acre Street, Lindley, Huddersfield HD3 3EA | Outpatient Facility and Administrative Building | Leased |
| 11 | Equipment Loan Store / THIS, Ainley Bottom, Elland HX5 | Office and warehouse provision | Leased |



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