Calderdale and Huddersfield NHS Foundation Trust

Public Board of Directors

Schedule	Thursday 7 November 2024, 9:00 — 12:00 GMT
Venue	Rooms 3 & 4, Acre Mills Outpatients
Organiser	Amber Fox

Agenda

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10:24	13. Quality Committee Chair Highlight Report – 3 September 2024 - Director of Infection Prevention Control Q2 Report To Note - Presented by Denise Sterling	122
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11:59	24.	Governance Report a) Use of Trust Seal b) West Yorkshire Association of Acute Trusts (WYAAT) Memo of Understanding c) Board of Directors Workplan for 2024/2025 To Approve - Presented by Andrea McCourt	375
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12:04	25.	Items to receive and note 1. Minutes of Board Committees - Finance and Performance Committee, 3 September 2024 & 1 October 2024 - Quality Committee, 3 September 2024 - Audit and Risk Committee, 22 October 2024 2. Partnership papers: - Kirklees Health and Care Partnership https://www.kirkleeshcp.co.uk/about-us/kirklees-icb-committee/kirklees-icb-committee-meetings/ - Calderdale Cares Partnership https://www.calderdalecares.co.uk/about-us/meeting-papers/ To Receive	438
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		APP T3 - FINAL Quality Committee minutes - Tue 3 September 2024 (Approved 15 Oct 2024).docx	454

	APP T4 - Chair Approved Minutes Audit and Risk Committee Meeting held on 22 October 2024.docx	463
26.	DATE AND TIME OF NEXT MEETING Date: Thursday 16 January 2025 Time: 9.00 – 12.00 pm Venue: Rooms 3 & 4, Acre Mills Outpatients To Note - Presented by Helen Hirst	473

1. Welcome and Introductions:

To Note

Presented by Helen Hirst

2. Apologies for absence:

Jonathan Hammond, Chief Operating Officer

Peter Wilkinson, Non-Executive Director

Sheila Taylor, Public Elected Governor

To Note

Presented by Helen Hirst

3. Declaration of Interests

To Receive

STRATEGY: TRANSFORMING AND IMPROVING PATIENT CARE

4. Patient Story – Mental Health

Presented by Ian Noonan, Consultant Nurse - Mental Health

To Note

5. Clinical Strategy

Presented by Catherine Riley, Associate Director of Strategy

To Approve

Date of Meeting:	Thursday 7 November 2024
Meeting:	Public Board of Directors
Title:	Refresh of the Clinical Strategy 2024-2029
Author:	Catherine Riley, Associate Director of Strategy
Sponsoring Director:	Neeraj Bhasin, Medical Director. Lindsay Rudge, Chief Nurse.
Previous Forums:	Executive Board. Staff Partnership Forum. Expert by Experience group. Public Council of Governors.
Purpose of the Report	The purpose of this report is to present to the Board of Directors the refreshed Clinical strategy, for their approval.
Key Points to Note	The Trust Clinical Strategy was most recently reviewed in 2021. At this stage the focus was on lessons learned from the pandemic and recovery from this period. Much has been achieved in this period, some of these achievements have been listed on page 6 of the refreshed strategy and include Non Surgical Oncology partnership working with our colleagues at Mid-Yorks, our Elective Care Transformation Programme, the development of two Community Diagnostic Centres, a new Emergency Department in Huddersfield and becoming an national exemplar of the benchmarking and improvement programme Getting it Right First Time. The refresh of the Clinical Strategy has taken place over six months in 2024 and has included: • Bottom up - engagement with all management teams in the Trust both through the Weekly Executive Board meeting and through direct attendance at team meetings, identifying clinical priorities for the next five years for all the divisions • Opportunity for all staff in the Trust to engage directly with the Clinical Strategy Review. Comments from service areas were fed back to management teams for consideration and inclusion. • Top down - review of the Trust's Five Year Strategy (see page 3 of The Clinical Strategy) ensuring The Clinical Strategy is integrated into all plans, and especially supports the delivery of The Five Year Strategy

	• Review of national plans such as the Darzi Report and West Yorkshire ICB Strategy and Place based plans. • A review of engagement with patients undertaken by the Trust and by Healthwatch on behalf of the Trust, ensuring any learning is included in the strategy. • Identification of the enablers that will support the delivery of the Clinical Strategy. These are identified on page 6 of the Clinical Strategy, and in more detail from page 14. Through this work the Clinical Strategy describes four key deliverables to be achieved over the next five years. These are: • **High quality care** We will provide the most effective clinical care for patients. This will enable us to achieve optimal health outcomes for our community including reducing health inequalities – The Trust's vision is that we will deliver outstanding compassionate care to the communities we serve. • **Service Resilience** We will continuously improve service resilience and patient outcomes by delivering the most effective clinical service configurations and collaborative working arrangements • **Highly skilled workforce** We will provide colleagues with support and opportunities for clinical skills learning, development and research. • **Effective recruitment and retention** We will offer career opportunities and support that will attract and retain clinical colleagues to work at CHFT Each of these deliverables is described in more detail in The Clinical Strategy, please refer to pages 9-12. In addition to this there are specific service level objectives included, these are available from page 19 to the end of the report at page 32. Examples of service specific objectives include: • Cardiology – twin catheter and day case unit development. Work towards a weekend Percutaneous Coronary Intervention (PCI) service. Begin progress towards primary PCI • Respiratory – Sleep service development, bringing care closer to home for patients who currently attend Leeds for management • Stroke – increase use of community services for care of stroke patients supporting further early supported discharge and enhancements to community rehabilitation services • Care of the elderly and Orthopaedic trauma – Develop an orthogeriatric led fracture neck of femur model of care supported by Orthopaedic in-reach

	• Emergency Medicine – specialist paediatric and frailty ED departments with a skilled workforce • Women's – Embed the service user voice into the directorate by making sure all service improvements have been co-designed and sharing lived experience is embedded in key forums • Women's - Implement and monitor the agreed model of delivery for all four birth options, continuing to ensure safety, sustainability and choice • Surgery - To maintain the award winning 24/7 consultant delivered acute surgical service • Surgery – all minimally invasive colorectal surgery to involve robotic surgery Once a first draft of The Clinical Strategy was completed we engaged with all of our stakeholders in the system. Engagement included: Discussion with: • Expert by Experience Forum • Council of Governors • Staff Partnership Forum Sharing The Clinical Strategy, offering the opportunity for a meeting and inviting feedback from: • All of the staff networks within the Trust • All WYAAT partners • West Yorkshire ICB, Calderdale ICB, Kirklees ICB • Calderdale and Kirklees Local Authorities • Healthwatch • Community and mental health networks • Local provider partners including Locala, SWYPFT • Local provider partners in primary care • Third sector partners including the two local hospices • Partners in education including the local colleges and Huddersfield University The delivery of The Clinical Strategy will be incorporated into the annual plans for each division. There will be no additional plan for delivery. Monitoring will be undertaken through existing performance reviews to avoid layering an extra element of monitoring onto an already pressurised management team. The strategy will be reviewed regularly and refreshed in due course.

EQIA – Equality Impact Assessment	The Trust's approach to Health Inequalities plays an important role in reducing the impact that inequalities have on access to, experience of, and outcomes from care. Specific initiatives within The Clinical Strategy will continue to be reviewed to ensure they do not disadvantage individuals or groups negatively and that wherever possible actions maximise positive impact on protected characteristic groups. Reducing inequalities is one of the key enablers to this strategy.
Recommendation	The Board is asked to **APPROVE** The Clinical Strategy 2024-2029.

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Clinical Strategy

2024 - 2029

compassionate care

June 2024

Contents

Strategic plans and development

The clinical strategy is one component of CHFT's Five Year Strategic Plan that is supported by the detailed enabling strategies shown.

Clinical Strategy | Five Year Strategic Plan | Enabling Strategies

one culture of care

Purpose of the clinical strategy

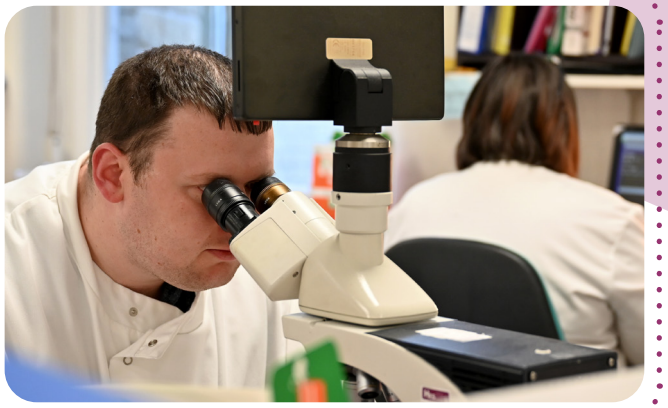
The clinical strategy describes our clinical priorities for the next five years. It states what is important to us, and our broad direction of travel. Our clinical strategy will enable us to:

- provide the most effective clinical care for patients. This will enable us to achieve optimal health outcomes for our community including reducing health inequalities
- continuously improve service resilience and patient outcomes by delivering the most effective clinical service configurations and collaborative working arrangements with partners
- provide colleagues with support and opportunities for clinical skills learning, development and research
- offer career opportunities and support in line with One Culture of Care, making CHFT a great place to work and that attracts and retains colleagues.

The delivery of the clinical strategy supports the delivery of the Trust's overall 5 Year Strategy.

The clinical strategy drives our clinical direction. We will prioritise investment to deliver the clinical strategy.

The clinical strategy provides information to potential employment candidates and to our patients.



The clinical strategy has been developed in partnership with our colleagues through divisions and through Trust-wide surveys. As part of the development, we have shared it with partners in Place, across West Yorkshire and with service users.

CHFT and the clinical strategy

Calderdale and Huddersfield NHS Foundation Trust (CHFT) delivers compassionate care from our two main hospitals, Calderdale Royal Hospital and Huddersfield Royal Infirmary, as well as in community sites, health centres and in patients' homes.

We provide healthcare and specialist services for people living in Calderdale, Huddersfield and beyond.

We work closely with our health, social care, voluntary sector, and academic partners in the Integrated Care System (ICS) across West Yorkshire, and in our local places as a member of the Calderdale Cares Partnership and Kirklees Health and Care Partnership.

We are committed to integrated working to progress our shared ambitions, to:

- Improve health outcomes for people
- Reduce health inequalities
- Support social and economic development
- Enhance productivity and value for money.

Our Vision

"Together with partners, we will deliver outstanding compassionate care to the communities we serve."

This clinical strategy sits alongside several other Trust strategy documents. This includes: Our five year strategy; Digital Strategy; the Green Plan; our Service Reconfiguration Plans; the Quality Plan; the Research and Development Strategy; the Health and Inequalities Strategy; and our Workforce and Organisational Development Plan.

This Clinical Strategy builds on our previous strategy written in 2021, and sets out our ambitions of strengthening patient care, and supporting colleagues to deliver the most effective clinical services. Our focus remains on delivering high quality, compassionate care, where and when our patients need it. Colleagues across the health and care system work incredibly hard in the face of extraordinary challenges to deliver compassionate and safe healthcare and we will support their development, value their diversity, and ensure they are listened to and have a sense of belonging in our local places.

CHFT and the clinical strategy

Some of our successes over the last four years include:

- Non-Surgical Medical Oncology service provision and the hosting of network services
- Our Elective Care Transformation Programme
- Funding for Community Diagnostic Centres (CDC) in Halifax and Huddersfield
- Application of artificial intelligence (AI) in Radiology
- A new Emergency Department (ED) in Huddersfield
- The use of robotics in surgery
- Installation of pharmacy robot
- Consensus Agreement with Primary Care
- National exemplar of the benchmarking and improvement programme Getting It Right First Time (GIRFT)
- Development of new Learning Development Centres at both CRH and HRI
- Digitalised Same Day Emergency Care department (SDEC)
- Neurology transformation through partnership working.

The delivery of excellent care will be facilitated by eight significant enablers. These are:

- One Culture of Care
- Being a learning and improvement organisation
- Working in Partnership at Place and delivering Regional Networks
- The delivery of Target Operating Models
- Service reconfiguration
- A digitally-enabled organisation
- CHFT as an anchor partner
- Reducing health inequalities.

The Trust – what we do

Our Performance

CHFT has continued to perform well in its key metrics during 2023/24, despite unprecedented levels of attendances at both emergency departments and with industrial action taking place at several points during the year.

- From April 2023 to March 2024 month-on-month CHFT was the best performing acute Trust (out of 119) in England for Cancer 62-day referral to treatment for 9 out of 12 months (2nd best in other 3 months).
- The Trust met the four hour emergency care standard during the month of March 2024 with 76.79% of patients admitted, transferred or discharged within four hours - 6th out of 119 acute Trusts for type 1 attendances.
- Our Recovery Programme meant that no patients were waiting over 52 weeks by March 2024 and 40-week waits were amongst the best in the country.
- In 2024/25 we have already seen an improvement in diagnostic waiting times, with over 90% seen within 6 weeks.

Our Financial Performance

- In 2023/24 the Trust successfully delivered a year-end deficit position of £13.4m, a £7.6m favourable variance from plan. This position included delivery of £27.3m of efficiency savings.
- For 2024/25 the Trust, and Calderdale and Kirklees systems, have significant financial challenges with drivers including delayed transfers of care, social care capacity and funding, increasing demand and inflationary costs.
- Longer term financial sustainability of the Trust will be supported by our major service reconfiguration plans to reduce structural costs associated with dual site working and to ensure value for money from the estate. These plans are in progress.
- CHFT is working closely with Kirklees and Calderdale Place leaders and partners from the West Yorkshire Association of Acute Trusts (WYAAT) to deliver system-wide joint financial recovery plans.

A typical day at CHFT

112 ambulance attendances

486 A&E attendances

69 surgeries in theatre

12 babies born

1,217 diagnostic scans

913 community therapy contacts

656 home nursing visits

642 inpatients

1,849 outpatients

2,932 calls to switchboard

14,966 pathology samples tested

The Trust – what we do

The population we serve

- The resident population of Huddersfield and Calderdale is approximately 458,000. People in Calderdale and Huddersfield are living longer lives than in the past, however more people are likely to have multiple long-term conditions, thereby increasing demands on the health and social care system. As a result, there is a growing population of people older than 65 with the younger population remaining stable, thereby leading to an increase in the dependency ratio. These patients have more complex health needs, placing greater demands on healthcare services.
- Our population is very varied and diverse and there are also significant areas of deprivation resulting in a significant difference in life expectancy of approximately 7.5 years from the most to least deprived areas, with an even greater variance in the number of years lived in good health of approximately 11 years. In Kirklees 21% of the population is from an ethnic minority background whilst in Calderdale approximately 10%, the largest minority ethnic groups across both authorities are Asian/Asian British comprising 15% and 8% of the population respectively.
- CHFT has worked hard to reduce the waiting times for treatment that occurred as a result of the Covid pandemic. Providing treatment for people that have had their care delayed is a top priority for the Trust. We will use Health Inequalities data to complement clinical prioritisation to continue to inform our system's post Covid-19 recovery to minimise the risk of treatment delays widening health inequalities in our communities.

The partners we work with

- The Trust is a member of the West Yorkshire Health and Care Partnership (Integrated Care System - ICS) which is the second largest ICS in the country, covering a population of 2.6 million people and a budget of over £5 billion. The purpose of the partnership is to deliver the best possible health and care for everyone living in the areas of: Calderdale, Kirklees, Bradford District and Craven, Leeds and Wakefield. The Partnership is made up of care providers, commissioners, voluntary organisations and Councils working closely together to plan health and care.
- The Trust plays a major role in the West Yorkshire Association of Acute Trusts (WYAAT) established in 2016 as an acute collaborative provider network comprising six local Trusts which are engaged in a number of provider to provider arrangements. The vision of WYAAT is to create a region-wide efficient and sustainable healthcare system that embraces the latest thinking and best practice consistently delivering the highest quality care and outcomes for patients. The purpose of the collaborative programme is to reduce variation and deliver sustainable services to a standardised model which are efficient and of high quality.
- In Calderdale and Kirklees CHFT works closely with local system partners at both the Integrated Care Partnerships and the Primary Care Networks.

The clinical strategy – deliverables

We will provide the most effective clinical care for patients. This will enable us to achieve optimal health outcomes for our community including reducing health inequalities – The Trust's vision is that we will deliver outstanding compassionate care to the communities we serve.

We will know we have delivered this by:

- delivery of our performance measures in emergency care, cancer, elective and diagnostic waiting times
- our SHMI/HSMR mortality metrics will remain within the expected range
- a reduction in clinical incidents
- a reduction in inequalities in access to care and ensure prioritisation promotes equitable access and outcomes
- our patient and staff feedback will tell us that care is outstanding
- the Trust being recognised for the delivery of "outstanding" care by our regulators and achieving CQC rating of Outstanding
- we will be accredited by other external bodies
- we will continue to deliver on the performance metrics focused on prompt access to care
- CHFT will be seen as an employer of choice and a reduction in the number of vacant clinical posts
- the Trust being recognised by our patients and their families for delivering effective and responsive care with an improvement in our Friends and Family results and being the place of choice for their healthcare needs
- a reduction in our formal complaints.

We will do this by:

- reducing variation (GIRFT)
- development of workforce, giving the workforce the opportunity to develop and grow in their roles
- focus on being a learning and improvement organisation
- maintaining a continuous drive for improvement, being innovative in our approach and continuing to engage in national quality improvement collaboratives including NHS Quest and the NHS Improvement Quality, Service Improvement and Redesign Programme
- ensuring compliance with NICE and other national guidance
- continuing our focus on the delivery of the Health and Inequalities Strategy, including ensuring all people are treated with respect at all times
- implementing the Medical Examiner role
- harness our role as an anchor institution and connect with our communities and partners to promote health and equity in the local population
- ensure all patients experience high-quality, compassionate, and holistic care to improve outcomes and reduce inequalities, including availability of translation services when required
- promote a diverse and inclusive workforce which reflects the populations we serve and where everyone feels valued
- and working towards a position where holistic view of mental health and psychological wellbeing is everyone's business.

The clinical strategy – deliverables

We will continuously improve service resilience and patient outcomes by delivering the most effective clinical service configurations and collaborative working arrangements.

We will know we have delivered this by:

- opening of the new A&E at HRI
- redevelopment of the Calderdale Royal site including the construction of a new clinical wing, the development of the learning centre and the addition of new car parking
- implementation of the Targeting Operating Models
- collaborative working with all our partners in the places of Kirklees and Calderdale and with our colleagues across West Yorkshire.

We will do this by:

- investing in both our hospitals to provide state-of-the-art healthcare facilities that will enable essential clinical adjacencies to improve quality and safety
- delivery of the TOMs. Eight future Target Operating Models (TOMs) for inpatient hospital pathways have been agreed. The TOMs provide clarity on the clinical and operating model we aspire to deliver that will transform services and enable each speciality to provide outstanding compassionate care. The TOMs are a blueprint that are an enabler for delivery of CHFT's 5 Year Strategy and the Clinical Strategy
- working with our own Community Division to be an exemplar for care in the community and adopt innovative practice
- increasing the use of technology to offer virtual consultations and review
- reducing the number of appointments each patient needs to attend by offering one-stop clinic models combining diagnostics and management in the same visit or by implementing patient initiated follow up models
- positive patient and carer feedback on their experience of services
- making every contact count. This approach enables the delivery of consistent and concise health and wellbeing information and encourages individuals to engage in conversations about their health at scale across organisations and populations
- continue to support work in priority areas for lived experience: learning disability, maternity and mental health.

The clinical strategy – deliverables

We will provide colleagues with support and opportunities for clinical skills learning, development and research.

We will know we have delivered this by:

- using our redeveloped learning centre at CRH to support staff in all development areas
- developing a dedicated research hub to expand our research capability, capacity and delivery
- expanding our commercial research portfolio of studies
- increasing our number of clinical staff as Principal and Chief Investigators
- increasing the number of patients able to access and participate in clinical trials
- forging greater collaboration with our academic and industry partners to generate successful research grants.

We will do this by:

- Providing a bespoke research hub with a robust infrastructure to deliver research.
- Widening the research base by setting up research in new clinical specialities.
- Placing emphasis on research when appointing to new clinical posts.
- Re-investing research income for continuous research improvement
- Meeting high level objectives for performance and delivery thereby growing our reputation as a centre for excellence
- Pro-actively engaging with academia and industry partners to explore opportunities for research and joint appointments as part of the hub model.

This will result in:

- Greater access and opportunity for our patients to participate in research studies.
- Offering cutting-edge treatments, therapy and access to novel trial drugs for our patients.
- Attracting and retaining high quality and expert staff.
- Attracting new research sponsors by creating a strong base for delivery via the hub model.
- The Trust's reputation and performance as a centre for research excellence.
- Improved measurable outcomes for all our patients.

The clinical strategy – deliverables

We will offer career opportunities and support that will attract and retain clinical colleagues to work at CHFT.

We will know we have delivered this by:

- staff surveys consistently demonstrate CHFT as a place where people are pleased to work, and where they recommend family and friends receive medical treatment
- CHFT becomes a place where colleagues aim to work
- reduction in number of colleagues leaving the organisation
- increase in applications working in the organisation.

Our priorities are:

- to achieve compliance with Royal College of Emergency Medicine workforce recommendations and the standards for Children and Young People in Emergency Care settings with regards to having ready access to paediatric specialist trained staff
- to achieve compliance with Guidelines for the Provision of Intensive Care Services 2015 (GPICS) standards
- to strengthen clinical rotas and enable specialised rotas to be provided
- to provide models of service that are attractive to staff and will improve recruitment and retention reducing the Trust's reliance on locum and agency staff (particularly in Emergency Medicine, Gastroenterology, Urology, Radiology, Dermatology, Rheumatology, Ophthalmology, Critical Care, and Acute Medicine)
- to provide models of service that support community pathways of care and the recruitment of colleagues providing care in community settings
- to separate unplanned inpatient care from planned services to make it easier to run efficient surgical services.

We will do this by

- investing in both our hospitals to provide state-of-the-art healthcare facilities that will enable essential clinical adjacencies to improve quality and safety
- delivering recruitment and retention strategies to facilitate staff choosing CHFT as a place to work
- we have meaningful clinical career pathways for all professional groups and consider how professional diversity at board level can support CHFT in navigating the health complexities we often face.

The clinical strategy – enablers

The following enablers will support the delivery of the clinical strategy:

One Culture of Care

- We will work together to create an organisation that is known for one culture of care: that means we care for colleagues in the same way we care for our patients. This will also help us ensure that colleagues are able to develop as professionals throughout their career at the Trust, with opportunities for gaining new skills and taking on new roles and responsibilities.
- We have meaningful clinical career pathways for all professional groups and consider how professional diversity at board level can support CHFT in navigating the health complexities we often face.
- We recognise the growing issue of poverty in the workplace. We will support the financial wellbeing of our staff, including through providing financial advice and support where appropriate.
- We use development tools such as Working Together to Get Results (WTGR) and Team Engagement and Development (TED) to empower our teams to develop and support each other.

Working in partnership at Place and delivering regional networks

- We collaborate with partners across West Yorkshire through WYAAT to improve the resilience of acute hospital services, patient safety and clinical outcomes through the establishment of speciality clinical networks and centres of excellence.
- We also collaborate vertically through place, through partnerships with primary care, community and mental health providers, social care providers and third sector organisations including local hospices and other charities supporting specific population groups.
- We work in partnership with local colleges, schools and universities ensuring education programmes for our local populations and developing the healthcare providers of the future. Through this work we provide social value for the local population, creating opportunity for meaningful careers in the local community.
- We work with partners across the system focusing on preventative healthcare, providing social value, and supporting public health.

The clinical strategy – enablers

The following enablers will support the delivery of the clinical strategy:

A learning and improvement organisation

- CHFT is a learning and improvement organisation. We will build on our strong track record of research (in particular our award-winning work on the Covid-19 Recovery Trials) to make the Trust a national exemplar for applying research findings to clinical practice and in improving the health of our population.
- Through this research and also our review of operational and strategic planning we will ensure our preparedness for another pandemic or catastrophic event.
- The Trust Quality Strategy 24/25 describes that together we will deliver the best quality and safest care to the communities we serve.
- CHFT use the Patient Safety Incident Response Framework (PSIRF) that sets out the Trust's approach to developing and maintaining effective systems and processes for responding to patient safety events and issues for the purpose of learning and improving patient safety.
- The PSIRF advocates a co-ordinated and data-driven response to patient safety events. It embeds patient safety event responses within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.
- We continue to learn from complaints and from staff and patients' views.
- We will continue to embed the "Getting it Right First Time" (GIRFT) programme at CHFT and also use Model Hospital to benchmark our services against peers. The GIRFT programme has been highly successful and CHFT is a recognised national thought-leader. The programme is clinically led and involves doctors, nurses and therapists in peer review to identify and reduce unwarranted variation in working practices and apply evidence-based practice to their clinical care to achieve improvements in clinical quality.

The clinical strategy – enablers

The following enablers will support the delivery of the clinical strategy:

Target Operating Models (TOMs)

An extensive process has been carried out to engage and involve clinical colleagues in the design of the future operating model across CHFT. Eight future Target Operating Models (TOMs) for in-patient hospital pathways have been agreed. The TOMs provide clarity on the clinical and operating model we aspire to deliver that will transform services and enable each speciality to provide outstanding compassionate care. The TOMs are a blueprint that are an enabler for delivery of CHFT's 5 Year Strategy and the Clinical Strategy.

Service Reconfiguration

We will invest at CRH to expand the hospital providing additional wards, theatres and a new emergency department including a special paediatric A&E. At HRI investment has already enabled the build of a new A&E department and the adaptation of existing buildings. These developments will provide state-of-the-art healthcare facilities and enable essential clinical adjacencies to improve quality and safety.

CHFT as an anchor partner

CHFT is a major employer in Calderdale and Kirklees, both through its own workforce and through its partnership with other organisations including the public sector, private sector and third sector. As such its focus is:

- To harness our role as an anchor institution and connect with our communities and partners to promote health and equity in the local population
- To reduce inequalities in access to care and ensure prioritisation promotes equitable access and outcomes
- To ensure all patients experience high-quality, compassionate, and holistic care to improve outcomes and reduce inequalities
- To promote a diverse and inclusive workforce which reflects the populations we serve and where everyone feels valued.

The clinical strategy – enablers

The following enablers will support the delivery of the clinical strategy:

Digitally Enabled

- We will ensure that data and decision support tools are available at the fingertips of our doctors, nurses and therapists to drive safety, quality improvement, and research. We will also use data to gain insight into the way people access services and use this to inform how we can make care more personalised and relevant to individual patients and communities to reduce health inequalities. Examples include e-consent, MEWs, sCDR, Discharge mPage to improve discharges, SDEC will improve visibility to patients, virtual wards, remote monitoring.
- We will use digital services to facilitate patient access to services, their knowledge about their healthcare and ensure we prioritise patients with greatest need. Examples include both the introduction of digital outpatients, the patient portal and also our use of KP+ and Cerner Millenium. Whilst doing this we remain mindful of the public who do not routinely access technology, and ensure they are not disadvantaged by our adoption of advances in technology and in fact benefit from our strategy.
- We will ensure we use all up to date technology to improve patient care and the experience of both our patients and staff. For example our work in introducing Artificial Intelligence (AI) into diagnostics is leading the acute hospital sector.
- We recognise it is critical our digital journey is in partnership with our local healthcare providers both in primary care, community services and other acute trusts. This is how we will ensure delivery of outstanding care to our patients.

Reduce Health Inequalities

Health inequalities are not inevitable; they are preventable. These inequalities can be reduced but doing so requires deliberate and sustained action from all parts of society and public services, not least the NHS. We will work with partners and communities and use population health data to understand and take action that will reduce health inequalities. We will:

- Reduce inequalities in access to care and ensure prioritisation promotes equitable access and outcomes.
- Play a leading role locally in improving population health and tackling inequalities, taking bold action, and working with our partners to deliver impactful change for the communities we serve.
- Deliver the four priority areas for action in our Population Health and Inequalities Strategy 2022-2024. These are:
  - Connecting with our communities and partners
  - Access and prioritisation
  - Lived experience and outcomes
  - Diverse and inclusive workforce

Clinical networks and host services

Listed below are services where there is opportunity to work in clinical networks or for CHFT to host services. These include the potential for CHFT to provide a centre of excellence delivery model for the following specialist services.

- Bariatric Surgery
- Primary Percutaneous Coronary Intervention (PPCI)
- Non-Surgical Medical Oncology service provision and the hosting of network services
- Hyper acute stroke services and the hosting of network services
- Revision joint surgery and ambulatory day case arthroplasty
- Development of Respiratory Medicine to include centres of excellence for sleep
- Complex asthma and idiopathic pulmonary fibrosis
- Development of Community Diagnostic network Hub and Spoke models
- Huddersfield Pharmacy Specials (HPS)

Bibliography

- CHFT 5 year strategy 2023-2028
- Health Inequalities strategy 22-24
- Digital Strategy
- Target Operating Models

Clinical strategy objectives by specialty

Community services

Division-wide

We will optimise delivery of planned and unplanned care services, ensuring every contact counts, across our acute footprint (Calderdale and Huddersfield), our place (Calderdale) and our 5 neighbourhoods.

We will focus on use of risk stratification to support crisis prevention and admissions avoidance across our communities.

We will work with partners, to explore learning from within the UK and Internationally to identify community health and care models that deliver against the strategic health and care challenges evident within our communities (ageing populations, lack of resilience in primary care and adult social care models, rising urgent and emergency care demand, health and education inequalities).

We will continue to engage with Journey to Outstanding (J2O), supporting refresh of our quality strategy internally and externally with partners. We will also work with partners on upcoming SEND and OFSTED inspection to ensure we deliver quality children's and young people's services to our communities

We will continue to supplement our performance KPIs in Knowledge Portal Plus with quality indicators (i.e. functional, activation, outcomes, experience) across service level dashboards).

We will embed nursing and AHP workforce manager, clinical practice education and legacy mentorship roles into business as usual quality improvement across our services. We will also focus in 24/25 of non-clinical career pathways across our operational and admin teams in division.

We will alongside the workforce, educator and mentor roles to create an identity around CHFT Community as a place to be, to work and to be fulfilled in your career.

Therapies

We will continue to focus on our 'grow our own' workforce strategy by embedding and expanding apprenticeship, preceptorship and advancing practice models across all our services. With a focus in 24/25 on clarifying advanced practice opportunities for community (i.e. community specific ACPs, nurse/AHP consultant roles).

We will empower individuals to self-manage their condition, remaining as healthy as possible in their own home. Focusing our specialist resource and capacity on those individuals with higher levels of need and complexity but lower levels of activation. We will also work with referrers to reduce unwarranted demand across services.

We will work closely with corporate colleagues to capture learning needs analyses and conversion of those needs into a clear development plan across services, professions and colleagues. Ensuring all therapy colleagues are competent and empowered to deliver care to our patients that is of optimal clinical standards.

We will continue to expand our research portfolio by working with trust, academic and system partners. Focusing in 24/25 on therapy specialties with limited engagement to date in formal research and audit experience. Embedding research and best practice for the ongoing improvement of clinical care across therapy services and linked into all patient focussed pathways.

Clinical strategy objectives by specialty

Community services

Nursing
We will optimise self-care and patient activation across our community nursing services. Focusing on areas of unsustainable growth in demand initially but rolling out as a principle across our services. We will also work with referrers to reduce unwarranted demand across services.
We will implement safer care and safe staffing insights via Allocate and incorporate insights from national audit and benchmarking of caseload levels across DN services. Working with e-roster and corporate nursing teams to operationalise use of those insights across services.
We will embed nursing and AHP workforce manager, clinical practice education and legacy mentorship roles into business as usual quality improvement across our services. We will also focus in 24/25 of non-clinical career pathways across our operational and admin teams in division.
We will continue to focus, alongside the community nursing workforce on our 'grow our own' community nursing workforce strategy by embedding and expanding apprenticeship, preceptorship and advancing practice models across all our community nursing services. With a focus in 24/25 on clarifying advanced practice opportunities for community (i.e. community specific ACPs, nurse consultant roles).
We will continue to focus on wider recruitment and retention of our community nursing workforce by ensuring we have a voice in all recruitment forums with additional focus in 24/25 on our next generation of community nursing workforce through engagement with local schools and colleges.
We will continue to expand our research and audit portfolio by working with trust, academic and system partners. Focusing in 24/25 on community nursing teams and specialties with limited engagement to date in formal research and audit experience.
We will in reviewing pathway transformation opportunities look to optimise community nursing skill mix across planned and unplanned care services. Ensuring specialist skills are sustainable across footprint, place and neighbourhood services and all opportunities for optimising utilisation of non-clinical and non-specialist capacity are explored and implemented.

Clinical strategy objectives by specialty

Medicine services

Cardiology

- Twin catheter lab and daycase unit development. Work towards a weekend PCI service. Begin progression towards primary PCI.
- Implement and establish CPAP provision on CCU.
- Development of community services such as Arrhythmia clinics.
- Development of stress cardiac MR service.
- Development of combined physiologist and heart failure specialist nurse-led service for Cardiac Resynchronisation Therapy.
- Enhancement of allied health professionals led services.
- Virtual ward and CDC pathway developments.

Respiratiory

- Establishment of ARCU in line with trust reconfiguration plans.
- Sleep service development, bringing care closer to home for patients who currently attend Leeds for management.
- Establish biologics service at CHFT for ILD patients who are currently managed at Leeds.
- Pleural service development.
- Best practice time pathway – Lung Cancer.
- Virtual ward and CDC pathway developments.

Nephrology

- Expansion of workforce.
- Development of acute renal services.
- Collaboration with WYAAT AKI networks.
- Virtual ward and CDC pathway developments.

Stroke

- Increase use of community services for care of stroke patients supporting further early supported discharge and enhancements to community rehab services.
- Review workforce to establish substantive workforce.
- Development of specialist roles i.e. therapists, thrombolysis nurses and leadership roles.
- Stroke hub development.
- Best practice time pathway – Lung Cancer.
- Virtual ward and CDC pathway developments.

Clinical strategy objectives by specialty

Medicine services

Diabetes and Endocrinology

- Regional work linked to increased availability and rollout of CGM and insulin pump technology.
- Enhanced specialist training within existing workforce to support advances in technology and diabetes management.
- Capacity and demand review of elective work.
- Merge multi-skilled team together rather than working in silos.
- Link to COW modelling for general medicine.

Gastroenterology

- EUS Progression and development towards FNA and therapeutics.
- Development of hepatology pathway.
- Explore CDC options and potential for fibro scanning.
- Aim to recruit 11th consultant.

Acute & Care of the Elderly

- Continue DTOC ward project and progress the 100 beds piece.
- Continue enhancement of SDEC services with direct links to ED such as pathways, capacity & demand review and improved community access.
- Expansion of virtual and remote services within frailty, elderly, acute and general medicine.
- To develop an orthogeriatric led fracture neck of femur model of care supported by Orthopaedic Surgery in-reach.

Palliative medicine

- Recruit to the vacant consultant post.
- Improve links between inpatient and hospice work - joint collaboration.
- Integration between palliative and other specialties - increase senior palliative leadership within bedbase.
- Improve use of technology around remote reviews.

Neurology

- Service redesign and continuing to engage in WYAAT service reconfiguration.
- Work towards collaborative approach Focusing on joint posts.
- Take staff through CESR programme where possible.
- Establish condition specific clinics.

Neurophysiology

- Ensure full substantive workforce to deliver 6 week diagnostic services.
- Work towards reinstating regional trainees within the department
- Look into new treatment/clinic options such as ophthalmology links
- Maintain IQIPS accreditation

Clinical strategy objectives by specialty

Medicine services

Emergency medicine

Provide 24/7 consultant-led A&E services across both sites as part of the reconfiguration.

Specialist Paeds and frailty ED departments with a skilled workforce.

Improve our staff survey and ensure a trauma-informed approach is used for staff to ensure physical and psychological needs are met.

Through colocation and workforce we will optimise SDEC services.

Be innovative with the patient portal towards patient feedback and learning.

Rheumatology

Continue to develop specialist pharmacy services.

Expand the workforce to deliver new specialist services.

Dermatology

Develop consistent substantive workforce including both medical and nursing.

Develop CESR posts.

Teledermatology/AI – 2/3 year aim to implement.

Oncology

Operational/governance structure review.

Workforce review.

Work towards implementation of NSO model supporting the wider programme to implement a strong governance structure.

Haematology

Strategy for increasing non medical workforce.

High risk specialty - cancer, outpatients, inpatient etc.

Continue to develop and improve specialist pharmacy services.

Continue work towards 6th consultant.

Clinical psychology

Adopt a prioritised strategic development approach with 3 phases:
1. Paeds, neurophysiology and ICU
2. Cardiology, chronic pain and HIV
3. Adult diabetes, paeds diabetes, gastroenterology, bariatric surgery, stroke, respiratory, oncology and long covid.

To promote the development and provision of psychological care as a routine part of a patients physical health care.

To address issues of parity of esteem.

To promote and enhance physical health outcomes through supporting psychological needs.

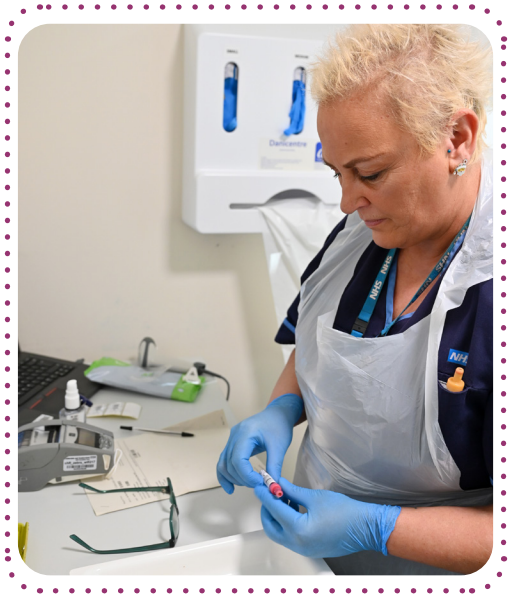
To ensure equity of access for patients of C&H.

To reduce the inequalities in care currently faced by patients at C&H whereby there are many areas in which patients at CHFT have no access to clinical health psychology that is available across the rest of WYAAT e.g. neuropsychology; paediatrics; chronic pain; ICU; neonates etc.

Clinical strategy objectives by specialty

Families and specialist services

Women's
Ensure as a Directorate we meet Local and National KPIs for screening and Cancer pathways.
Ensure we have the right staff in the right place to deliver the right care at the right time across nursing, midwifery, medical and allied health professional pathways.
Embed the service user voice into the directorate by making sure all service improvements have been co-designed and sharing lived experience is embedded in key forums.
Continue on the Directorates digital journey to ensure that digitalisation is an enabler to safer more efficient care.
Continue to meet the safety and Quality actions that form the Maternity, Neonatal and women's transformational plan ensuring a two-way floor to board culture.
Maintain and work as an MDT to ensure CQC preparedness for all services including NICU Gynaecology and TOP.
Develop plans for delivering continuity of carer to most vulnerable group working with the MNVP and internal and external partners.
Implement and monitor the agreed model of delivery for all 4 birth options, continuing to ensure safety, sustainability and choice.
Be proactive and collaborate internally within the Trust and with partners across the region to provide equitable and seamless patient pathways.
Implement a Same Day Emergency Care (SDEC) model for gynaecology services.



Clinical strategy objectives by specialty

Families and specialist services

Radiology

Together with imaging departments across WYAAT, we will develop future models of service delivery, enabled through digital technology and shared information systems.

CHFT's establishment of 2 Community Diagnostic Centres, one in Halifax town centre and one in Huddersfield town centre, will:
1.provide additional capacity for planned diagnostic services
2.enable improvements in patient pathways
3.ensure better access to acute diagnostics
4.enable the creation of dynamic hybrid roles.

Radiographic workforce transformation will take place through collaboration with our local higher education institute, creating new diagnostic radiography courses and associated placements.

Detailed planning for all service delivery developments and all capital replacement schemes will tie in with trust wide reconfiguration plans.

The service will consistently retain accreditation through the Quality Standards for Imaging scheme by establishing optimum levels of safety and quality.

Children and Young People

Work collaboratively with all other Trust Divisions to progress efficient and clear pathways of care for children and young people.

Review and embed SDEC working across Paediatric assessment unit and outpatients.

Review 'virtual ward' model to enable more children and young people to be cared for in the community.

Ensure equity of service for all children and young people who travel through our outpatient service in hospital or in the community and help to address health inequalities.

Continue to work in partnership with children, young people, their families and carers to understand their individual needs and to advocate on their behalf to improve the care that we provide. Developing family friendly methods to capture feedback.

Ensure improved advanced care planning/end of life care for children's young people and their families.

Ensure equity in out of hours access to senior decision making clinical staff for in patients as defined in National standards (facing the future) without delay and also have access for appropriate second opinion if needed (Martha's rule).

Ensure workforce models are used effectively to reflect national standards and support the safety and efficiency of Children's services.

Progress our journey to outstanding to ensure CQC preparedness for all services through the CYP Transformation plan, Children's Board and a two-way floor to board culture.

Clinical strategy objectives by specialty

Families and specialist services

Pathology
Development and implementation of the joint WYATT Pathology LIMS.
Implement NICE guidelines for patient testing pathways include M. genitalium/TV testing and the implementation of NT proBNP.
To develop new models of delivering phlebotomy services to our ward, out-patient and community outreach services.
Delivering on the NHSI data collection requirements including Pathology Quality Assurance Board (PQAD). Working with our WYAAT Pathology network to develop common approaches to data collection.
Interfacing results from Point of Care Testing devices into patient records.
Addition of batched products to our Haemonetics Blood Track system, ensuring all products have full traceability.
Maintain UKAS accreditation against IS015189:2012 for all our Pathology Network and foster collaborative working.

Pharmacy
Finalise the implementation of robotic and digital solutions for dispensing of medications and electronic controlled drug recording. We will work towards closed loop administration of medication.
Continue to work with WYAAT colleagues to deliver aseptic service transformation and as a trailblazer site, establish aseptic hub and spoke model.
Support development and employment of ICS-based consultant pharmacist and advanced practice pharmacist and tech roles.
Strengthen 7-day pharmacy service, review weekend pharmacy workforce provision and consider additional ODP opening hours and additional inpatient pharmacy staffing.
Scope options for prescription collection medication lockers to improve patient experience and reduce parking issues.
Develop WY South Sector pharmacy service and governance systems to optimise medicines usage for non-surgical oncology patients utilising non-medical roles for pharmacy staff to work at the top of their registration.
To meet new initial education and training standards for undergraduate pharmacists and provide designated prescribing practitioner capacity to support WY ICS to enable all pharmacists to qualify as prescribers.
To strive towards the expansion of pharmacy services to meet the needs of our patient population, workforce challenges and to: Enhance roles of non-registrants / Optimise use of registered staff to their top of their registration. Adapt to propose change to pharmacy supervision legalisation.
Ensure appropriate use of clinical / non clinical waste streams and optimise recycling.

Clinical strategy objectives by specialty

Surgery

Ear, Nose and Throat (ENT) & Head and Neck Cancer

To continue working collaboratively with our WYAAT partners.

To ensure that patients are seen at the right time, by the most appropriate clinicians and practitioners.

Create Same Day Emergency Care capacity for the ENT team to enable prompt assessment.

Develop workforce modelling to encourage career progression with core trainees and specialty doctors.

Clinical review of medical staff model to reduce outsourcing of services and improve continuity of care.

Develop the role of the Clinical Nurse Specialist in Aural care and development opportunities and improve patient pathways.

To continue providing a Head and Neck Cancer service for CHFT population.

Continue to adapt and deliver in line with GIRFT and Further Faster recommendations.

Audiology

Improve our offer for patients with learning disabilities, delirium and dementia.

Reinstate balance testing pathways led by the audiology team.

Implementing direct access tinnitus clinics.

To integrate the Audiology patient information system onto EPR.

To review and improve paediatric clinics.

To attain IQIPS (improving quality in physiological services) accreditation.

To implement recall (for hearing aids) for vulnerable patient cohorts.

Oral Surgery

Separate the service from maxillofacial surgery including coding for better evaluation of services and understanding of demand.

CHFT to provide estate and surgical support to community services for paediatric dentistry and dental services for patients with Special Needs.

Relaunch and improve sedation service for anxious dental patients.

To improve the estate, resources and staff to make this area more flexible, with staff of transferable skills and efficient.

Referrals to the service will need to be via an electronic portal.

Making CHFT Oral surgery a centre of excellence for West Yorkshire with links to the Leeds School of Dentistry.

CHFT oral surgeons will provide training and support to community and Tier 2 dental services.

To strengthen links with other medical specialities eg Cardiology and ENT to optimise patient outcomes.

Continue to adapt and deliver in line with GIRFT.

Clinical strategy objectives by specialty

Surgery

Maxillofacial surgery

Maxillofacial surgery services are to focus on Head and Neck Fast track cancers in 2 week wait capacity and to support skin cancer services with 30 and 62 day targets.

Maxillofacial surgery consultants to support the oral surgery team with reviewing Head and Neck Cancers.

Ophthalmology, Orthoptics, Optometry

Improved data sharing and transparency with primary care (GPs and OPtoms) across Trusts (IPTs) and patients through further digital transformation.

Development and encourage of current workforce to provide a sustainable workforce for the future. Internal support for competencies and promotions to improve retention.

CHFT aims to maintain or improve where possible quality assurance standards.

Continue to adapt and deliver in line with GIRFT and Further Faster recommendations.

Develop workforce modelling to encourage career progression with core trainees and specialty doctors.

Clinical review of medical staff model to reduce outsourcing of services and improve continuity of care.

Trauma and Orthopaedics

To create a regional centre of excellence for elective orthopaedic care with a dedicated outpatient setting that is ring fenced from A+E pressures. A ring fenced elective unit with high proportion of same day surgery. An ability to evidence the high quality care we provide by truly integrating PROMs feedback within EPR e.g. on initial referral registration process a baseline Oxford score must be completed by patient to allow an appointment to be booked; subsequent 6 and 12month PROMs to be collected using automated system - this should facilitate a true transformation of OP services by providing a route for truly digitised elective follow up.

To have an acute on call T&O service in the fracture clinic where all the on call staff are with x ray and plaster room and treatment room with supporting staff in the same area.

To develop an orthogeriatric led fracture neck of femur model of care supported by Orthopaedic Surgery in-reach.

To create a Same Day Emergency Care model.

Clinical strategy objectives by specialty

Surgery

Plastics and Breast Services
Single site breast service
Develop lipoedema/ lymphoedema pathway and research with nursing services in plastic services.
Develop workforce modelling to encourage career progression to include nursing workforce.
Continue to adapt and deliver in line with GIRFT and Further Faster recommendations.
Review Genomics pathways for breast services
Increase of workforce to meet demand at consultant level by introducing specialist registrar posts.
To introduce new pathways, techniques, and technologies to improve patients' outcomes.

General surgery, Colorectal, Bariatric Services, Paediatrics and Endoscopy
To continue working collaboratively with our WYATT partners
To provide acute upper GI and colorectal services across the network as a cancer centre in west Yorkshire.
The trust aspires to be the centre of excellence for Bariatric services.
CHFT to maintain, has an award winning 24/7 consultant delivered acute service.
To ensure that patients are seen at the right time, by the most appropriate clinicians and practitioners.
Develop workforce modelling to encourage career progression to include nursing workforce.
Continue to adapt and deliver in line with GIRFT and Further Faster recommendations.
All minimally invasive colorectal surgery to involve robotic surgery.
All laparoscopic consultants to be trained in robotic service
Build and expand our robotic systems
Continue to improve with post op rehabilitation and discharges from ward areas.
To introduce new pathways, techniques, and technologies to improve patient care and outcomes.
Introduce digital processes to improve clinical validations.

Clinical strategy objectives by specialty

Surgery

Urology
Expand the Urology diagnostic unit.
To introduce new pathways, techniques, and technologies to improve patient care and outcomes.
All laparoscopic consultants to be trained in robotic service.
To improve the estate, resources, and staff to make this area more flexible, with staff of transferable skills and efficient.
To continue working collaboratively with our WYAAT partners.
Introduce one stop clinics for LUTS working with LMC to improve referral.
Continue to adapt and deliver in line with GIRFT and further faster recommendations.
Develop workforce modelling to encourage career progression to include nursing workforce.
Maintain fertility services.
Provide cystoscopy procedures in an outpatient setting where possible.
Consider expanding less invasive daycase procedure into the Urology diagnostic unit.
Introduce digital processes to improve clinical validations.
Explore opportunity for community-based care for catheters.

Vascular
Ensure we continue to contribute to the continuous improvement of care delivered at the arterial centre for patients from our catchment, including clinical and operational elements.
Expand the delivery of OPD clinics in line with reconfiguration.
Consider expanding the remit of our day lists to prevent the transfer of patients to BRI and cancellations.
Expand the scope of vascular access (fistula formation) procedures we can offer at HRI.
Continue to adapt and deliver in line with GIRFT and Further Faster recommendations. One stop MDT joint clinics with Medicine / community (leg ulcer clinics).

Clinical strategy objectives by specialty

Surgery

Operating Services (Theatres and Pre-Assessment)

Acute Theatres

Further development of our STUGs (Speciality Theatre User Groups) for CEPOD.

Elective Theatres

Enhanced processes and mechanisms which support and enable highly efficient and productive use of our theatres using our 6-4-2 model.

Pre-assessment

- Further development of digital transformation to enable more efficient patient appointments and processing of information to and from patients.
- Linking in with local Community Diagnostic Centres to deliver pre-assessment services close to home.

Critical Care, CVAD (central venous access devices) and pain

Critical Care

- To achieve GPICS/ACSA accreditation.
- To prepare our service and our workforce for reconfiguration our service onto a single site.

CVAD

- To develop a robust Vascular Access Service, which supports base ward staff to safely manage and access lines.
- To review the Vascular access service to incorporate increasing the PICC insertion capacity to 5 days cross site, supporting base ward staff to safely manage and access lines.
- Increasing the PICC insertion capacity will improve patient experience, aim to reduce LOS and improve patient flow and limit impact on theatre time.

Chronic Pain

- To maintain our position of delivering treatment to our patients which meets the 18 week RTT target
- To develop further digital transformation to aid in the delivery of appointments and information to patients

Clinical strategy objectives by specialty

Operational Management

Operational Site Management

Patient Flow

- Enhanced processes and mechanisms which support and enable highly efficient patient flow, maintaining performance and quality metrics.
- Develop digital capabilities to support and enhance efficiencies in patient flow.
- Maintain senior on-site presence 24/7 at a tactical command level.
- Challenge clinical decision making to maintain patient safety.

Discharge Lounge

- Promote early discharge and create good patient flow.
- To maintain safety during the discharge process by checking appropriate provisions have been made for a patient going home.
- To provide an appropriate environment whilst patients are waiting to go home.

Acute Response Team

- To respond to the need of the deteriorating patient and improve clinical outcomes.
- To work alongside clinical colleagues supporting education and training for staff.
- To provide knowledge and expertise and maintain critical friend relationships.
- To deliver Martha's Rule objectives.

Integrated Flow Hub

- Create co-located facilities, a discharge lounge, Medical SDEC, Frailty SDEC and Digital Command Centre.
- Increasing the ability to manage non-elective patients without the need for admission.
- To speed up the pathway for patients on discharge releasing beds for new admissions earlier in the day.
- Providing a digital operations hub that enables the site management team to have live data on all key areas of the hospital to support efficient and effective patient flow. It will ensure agreed pathways are complied with and will have early warning of bottlenecks and the tools to enact escalation plans.

6. Minutes of the previous meeting held on 12 September 2024

To Approve

Presented by Helen Hirst

Chair Approved Minutes of the Public Board of Directors Meeting held on Thursday 12 September 2024 at 9.00 am, Rooms 3 & 4, Acre Mills Outpatients, Huddersfield Royal Infirmary

PRESENT

Helen Hirst	Chair
Brendan Brown	Chief Executive
Rob Aitchison	Deputy Chief Executive
David Birkenhead	Medical Director
Gary Boothby	Director of Finance
Lindsay Rudge	Chief Nurse
Nigel Broadbent (NB)	Non-Executive Director
Tim Busby (TB)	Non-Executive Director
Peter Wilkinson (PW)	Non-Executive Director
Vanessa Perrott (VP)	Non-Executive Director

IN ATTENDANCE

Anna Basford	Deputy Chief Executive/Director of Transformation and Partnerships
Jonathan Hammond	Chief Operating Officer
Andrea McCourt	Company Secretary
Jason Eddleston	Deputy Director of Workforce and Organisational Development
Amber Fox	Corporate Governance Manager *(minutes)*
Gemma Puckett	Director of Midwifery and Women's Service **(for item 88/24)**
Julie Mellor	Lead Nurse for Children and Young People **(for item 85/24)**

OBSERVERS

Lorraine Wolfenden	Public Elected Governor **(Lead Governor)**
Chris Roberts	Deputy Director of Operations, Division of Medicine **(Shadow Board)**

80/24 Welcome and Introductions

The Chair welcomed everyone to the Board meeting held in public, in particular Lorraine Wolfenden, Lead Governor and Julie Mellor, Lead Nurse for Children and Young People who was in attendance to present the patient story.

The Board meeting took place face to face. The agenda and papers were made available on the Trust website.

81/24 Apologies for absence

Apologies were received from Suzanne Dunkley, Jo Wass, Victoria Pickles, Robert Birkett and Denise Sterling.

82/24 Declarations of Interest

There were no declarations of interest and the Board were reminded by the Chair to declare interests at any point in the agenda should any arise.

83/24 Minutes of the previous meeting held on 4 July 2024

The minutes of the previous meeting held on 4 July 2024 were approved as a correct record.

OUTCOME: The Board **APPROVED** the minutes from the previous meeting held on 4 July 2024 as a correct record.

84/24 Matters Arising and Action Log

The action log was reviewed and all actions were completed.

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

85/24 **Patient Story – Children and Young People Strategy**

The Chief Nurse introduced Julie Mellor, Lead Nurse for Children and Young People, who presented a child's patient story together with the Children and Young People Strategy 2024 – 2029 which launched in July 2024.

Julie Mellor described how they are making the strategy 'live', with the voice of children and young people heard and shared data on the numbers of children using a wide range of services, up to the age of 24. She explained the Strategy provides a plan of our 'journey to outstanding' for the care of children and young people in the Trust, the vision and ambition of the Strategy and how they plan to deliver it, providing compassionate high-quality care for children and young people in a suitable child friendly environment.

Four key messages from the strategy were:

1. Listen and engage me in decisions about my care.
2. Be welcoming: attitude and communication play a big part in how I respond.
3. Respect my rights and remember it can be a scary situation that I am in.
4. Create an environment that builds trust and keeps me safe.

Julie Mellor shared a patient story of a young girl's journey of care with chronic asthma, describing how the team introduced her to the spiromac trial which recognises when an asthma attack is going to happen and reduces the risk of asthma attacks in children. The patient and her family explained how this felt for them personally, how the team supported them which enabled her to go back to normal life and enjoy her activities again. A second story was shared, 'Sophie's legacy', to have enhanced provision of play and distraction, improvements to food for children in hospital and parents to have a hot meal when staying with their child with a 'pay what you can' scheme.

The strategy is supported by the CHFT Charity through the ray of sunshine fundraising campaign to help brighten the care and experience of children, young people and families who access services across CHFT.

TB asked for more detail on delivery of the strategy, particularly in terms of access where there are health inequalities. Julie Mellor gave details of service investments in the CORE20 PLUS 5 key clinical areas, such as an asthma specialist nurse in communities sharing training on inhaler techniques, and focused work around end of life care, with a key worker for childhood death and epilepsy. She described work she was involved in as a member of the Health Inequalities Group and a Champion for Children and Young People, such as promoting a one off payment for families with a child in hospital for 21 days and a poverty proofing project.

Lorraine Wolfenden welcomed the co-production of the strategy and use of language that resonates with them.

PW highlighted the reduction in the number of attendances from areas with a higher level of deprivation over the last few years and asked if this was due to the interventions from the team.

Julie Mellor explained the Directorate are focusing on 'was not brought' from a child's point of view and an audit was taking place. Was not brought rates (currently 8%) are monitored through the FSS Divisional Board meetings. The Chief Operating Officer added there was a national drive around elective recovery for children and young people which the Access Delivery Group was focussing on. An analysis of recently shared data showed a disproportionate volume of children

waiting longer compared to adults, in several specialties such as ENT which is a challenge and to address this, they are outsourcing work to providers. Julie Mellor was invited to attend future CYP waiting list meeting held by the surgical division to support review and appropriate action planning to address. Julie Mellor is working with Mark Butterfield to develop a CYP dashboard on KP+ and this will be presented at a future Children's Board.

VP thanked Julie Mellor for bringing the voice of children and young people into the strategy and asked how they will address other areas in the strategy such as obesity reduction. Julie Mellor responded there are patient advocates for children's diabetes who focus on engagement with young people and the strategy includes feedback from lots of different avenues. VP asked if they have worked with primary care. Julie Mellor responded the focus was introducing this as a CHFT strategy and the plan is to build in more partnership working and improved engagement with primary care as a joint approach. The Chief Nurse shared that a discussion took place at the Children and Young People Board on the need to have a strategic dashboard to take into the system through the partnership structure.

Chris Roberts shared feedback from Shadow Board was how clear it was that children have been involved in the development of the Strategy and how important this is. He shared an example of using the children's A&E at HRI which is a specific unit designed for children which is secure at both sides and helps children and young people feel safe.

OUTCOME: The Board **NOTED** the patient story supported by the Children and Young People Strategy.

86/24 Chair's Report including the Charitable Funds Committee Terms of Reference and Organ Donation Principles

The Chair's report was received which details the actions and activity of the Chair since July 2024.

As Corporate Trustee, the Charitable Funds Committee Terms of Reference were presented for approval.

Paul Knight, Jayne Greenhalgh, Specialist Nurse and the Chair have been reviewing the guidelines in use at the Trust to support organ and tissue donation and requested the Board to endorse the principles and guidance which were attached to the Chair's report. The Chair recognised the work of the Organ and Tissue Donation Engagement Group which received 100% compliance in training in the last quarter.

OUTCOME: The Board **NOTED** the Chair's Report and **APPROVED** the Charitable Funds Committee Terms of Reference as Corporate Trustee and **ENDORSED** the Organ Donation Guidance and Principles.

87/24 Chief Executive's Report

The Chief Executive presented the report which provided a focused update on the Trust's response to specific elements of its service delivery and the evolving health and care landscape. The key points noted were:

- Lord Darzi has published the findings of his investigation of the NHS in England which informs the NHS 10 year plan and is the most significant review in the past five years of the NHS. Headlines include moving care out of acute hospitals into community so that hospitals can function properly and the need to invest in more management and leadership.
- A significant event has been the period of civil unrest, it is important to review what impact this has left on our colleagues and celebrate our diversity in the organisation. This is an ongoing response and one we will continue to pay leadership attention to.

- CHFT is one of the top two Trusts in the country for cancer performance, top six for elective recovery and top 25 for A&E performance.
- The Chief Executive has written to the Secretary of State setting out our position as a Trust, the fact that we are halfway through an ambitious programme of reconfiguration and invited him to see our plans and the work that takes place in a productive, good district general hospital that serves as an anchor partner across two communities.
- We also have five new Members of Parliament representing the communities we provide services to, and meetings have taken place with three and meeting the other two members after the Board meeting.
- The Community Diagnostic Centre in Halifax opened in July and is working well. The official opening event was held on 11 September. The Chief Executive gave credit to our people who are committed and dedicated and saw this facility open in a year and invited colleagues to go and see it. Feedback from patients interviewed by Sky news said it is the right environment and it doesn't feel clinical and is about care closer to home.
- The reconfiguration plans continue and is 50% of the way through with a new Emergency Department at HRI, new Community Diagnostic Centre (CDC) open with another underway, new Childrens' Rainbow Centre, new Learning and Development Centre (L&DC) at HRI and a new L&DC at CRH about to open in Autumn. Enabling work has commenced on the the multi-storey car park at CRH.
- WYAAT commissioned a review by PWC that links to the Lord Darzi report and Secretary of State manifesto around collective productivity and delivery.
- David Birkenhead, the Medical Director, for whom this was his last formal Board of Directors meeting before retirement was thanked for his commitment to patient care and strategic leadership over the last ten years through some significant challenges including the global pandemic, recent industrial action, and the public consultation on the reconfiguration of our services.

Action: Corporate Governance Manager to correct page 2 of the CEO report, section 2.3 – we are one of very few Trusts with no patients waiting over 65* weeks and no patients waiting over 52* weeks.

PW thanked the Chief Executive for the clear and informative written report and the Chief Executive acknowledged the work of the Director of Corporate Affairs in writing the report.

The Chair confirmed the Board will reflect on the government changes and national developments at the October Board Development session.

OUTCOME: The Board **NOTED** the Chief Executive's Report.

STRATEGY: TRANSFORMING AND IMPROVING PATIENT CARE

88/24 Maternity and Neonatal Oversight Report

The Chief Nurse introduced the report and explained there is a vast amount of information in the report designed to cover national expectations. However, a clearer format for the Board report will be produced in the next three months, involving Vanessa Perrott as Non-Executive Director maternity champion, which will support the Board's understanding of key issues and risks. The three key points highlighted from the report were:

- Maternity incentive scheme is on track for compliance.
- Successful midwifery recruitment programme, with plans in place to support their retention.
- Further focused work is taking place to reduce the stillbirth rate at the Trust, with a number of actions being taken, including at system and partnership level such as public health, the Integrated Care Board, primary care, communities, family hubs and engaging in a particular postcode area.

Gemma Puckett, Director of Midwifery and Women's Services provided a further overview, the key points noted were:

- Two years into the three year delivery plan, working hard to bring the voice of the service user into everything to keep it central and the team are working well with the Maternity Voices Partnership Chair
- Further work to do to improve patient experience and reflecting this accurately in the clinical record.
- The large cohort of midwives joining the Trust should reduce the vacancy rate to less than 10% which is significant, with the wider team supporting the new cohort and retention.
- Further work is required to meet compliance of a minimum of 70% in neonatal nursing.
- Diversity – the Local Maternity System (LMS) have included in their workplan a system review in response to diversity and how this could be improved. The Director of Midwifery and Women's Services has linked with the University of Huddersfield about student retention and understanding why students drop out of the course and how representation from BME communities can be improved.
- Thirlwall enquiry has commenced and it is important to support staff and patients.
- A "positive pants week" held in July on the back of national thank you day was well received by staff.
- There have been some complex and unusual cases this year; some of which resulted in life saving treatment by the teams across the Trust. The Director of Midwifery and Women's explained she is proud of how the teams responded and dealt with this.

In response to a question from VP, maternity champion, about scope of the perinatal culture survey, the Director of Midwifery and Women's Services confirmed the survey was across the maternity, neonatal and anaesthetic teams. VP asked what was being done to respond to staff burnout and the Director of Midwifery and Women's Services responded shortage of workforce and the shift pattern were issues which the new cohort of midwives should help with. She explained there is good teamwork and the department layout which is spread across the hospital was a factor and the reconfiguration will help this by having two obstetric theatres based on labour ward which will help teamwork. Their aim is to see burnout reduce over the next 12 months and conversations are being held with staff about their wellbeing at work.

VP queried, following her 15 steps quality visit to the labour ward where there were three bereavements that day, the accuracy of the data in the report on the number of stillbirths and asked about actions in relation to stillbirths. The Director of Midwifery and Women's Services responded the data looks different as some bereavements do not meet the criteria for reporting. She explained some of the internal actions being taken around clinical pathways for ultrasound and implementation of new software that will automate growth charts and a move to population based charts as advised by the LMS. The social vulnerability tool is progressing, and they are validating its use in clinical practice. Another area being considered is whether a multi-disciplinary team review takes place for the top 20% of high risk DNA rates to put in early intervention support. The team are also looking at how they track and manage the diabetes case load which is increasing, particularly Type 2 and obesity and how system working can support this.

The Chief Nurse explained they are meeting with Bradford colleagues who have undertaken lots of work with their population and primary care to see what learning can be shared.

Action: Gemma Puckett, Lindsay Rudge, Vanessa Perrott and Vicky Pickles to agree what the future maternity report to Board will look like.

Discussion took place about timing of surveys and the opportunities to implement actions which could impact future surveys. The Chief Nurse suggested a conversation with ED colleagues and their experience around the staff survey as they had undertaken work on staff engagement which had been positive for staff.

Action: Gemma Puckett to speak to Jason Bushby about actions in response to staff survey. Jason Eddleston to explore adding the perinatal culture survey to OD tools with Gemma Puckett.

The Chair asked what the team are doing now to make sure the new cohort are welcomed into CHFT prior to their October start date. The Director of Midwifery and Women's Services gave details of pre-work with new starters including bespoke sessions and welcome events and personal email contact, the Trust has to date retained almost all new midwives who have been offered a post to start in October.

OUTCOME: The Board **APPROVED** the Maternity and Neonatal Oversight Report.

INTEGRATED PERFORMANCE

89/24 **Quality Committee Chair Highlight Report – 2 July 2024**

The Chief Nurse presented the Chair's highlight report from the Quality Committee meetings of 2 July 2024. The key points noted were:

- Strong progress is being made against the objectives in the Trust's research strategy.
- Assurance from the Medical Gas Group and Hospital Transfusion Service, including the proactive management of three Serious Hazards of Transfusion (SHOT) incidents and targeted training that has reduced the number of rejected blood samples in midwifery.
- Stroke admissions to an acute unit within four hours fell below 30%, steps are being taken to improve stroke care and assurance was provided there was some improvement undertaken. A deep dive will take place at Finance and Performance Committee in October.
- Two deep dives took place on acute kidney injury (AKI) and ward assurance was provided.
- CQC Group – a comprehensive review of all the must do and should do actions and closed 11 of the recommendations down with evidence.
- National concerns about the quality and safety of paediatric audiology services, led to a review of the services provided by the Trust. The Medical Director explained they are working towards an accreditation for audiology with a target of the next two years. A number of cases have been reviewed externally.
- The Medical Director explained there has been a rise in both SHMI / HSMR (mortality metrics) which raised some concerns regarding the new Same Day Emergency Care (SDEC) reporting, this is largely down to coding of pneumonia and the document hadn't fully recognised the comorbidities of these patients. He explained a further rise in the metrics as a result of the SDEC work was likely but confirmed he had sought assurance that there was not a quality of care issue.
- Director of Infection Prevention and Control report shows a slightly improved position for Q1 compared to last year. Deep cleans have been helpful. Thresholds show a slight increase however this is a positive start to the year.

OUTCOME: The Board **NOTED** the contents of the Quality Committee Chair Highlight Report and **NOTED** the Q1 Infection, Prevention and Control Report and the Learning from Deaths Annual Report.

90/24 **Workforce Committee Highlight Report – 15 August 2024**

JE presented the Workforce Committee Chair's highlight report for the meeting held on 15 August 2024 which focused on Talent Management. The key points noted were:

- Focus was on recruitment, the Committee heard from a range of colleagues participating in internal and external leadership programmes who shared their experiences. There is a commitment to put learning into practice.

- Received information on the anticipated employment changes as a result of the new Labour government such as removing the two year qualifying period for unfair dismissal, imposing stricter probation rules, the right to disconnect from work and mandatory reporting on ethnicity and disability pay gaps.
- New legislation in October protecting individuals from sexual harassment in the workplace.
- Report received on ethnicity and disability.
- AI in recruitment – discussed the use of tools available in managing applicants and AI technology used by applicants which is evident by the same narrative text from applications. This makes shortlisting difficult and will result in a significant change in the way we recruit and select in future.
- Approved the Trust gender pay gap analysis and Workforce Race Equality Scheme and Workforce Disability Equality Scheme 2024/25 action plans.
- Detailed workforce report – strong performance in retention, turnover, training and agency and bank use.
- Weakness identified in completion of appraisals – as close to 90% target as possible.
- Deep dive of BAF 10a Medical Staffing risk has been completed and approved the retained risk rating of 16.

PW shared it was powerful hearing from colleague experience on the leadership programmes.

OUTCOME: The Board **NOTED** the contents of the Workforce Committee Chair Highlight Report.

91/24 **Finance and Performance Committee Chair Highlight Report – 3 September 2024**

VP provided an update from the Finance and Performance Committee meeting held on 3 September 2024. The key points noted were:

- Diagnostic target is a challenge for neurophysiology achieved 95% for the first time in 18 months.
- Lots of quality improvement on care of the acutely ill patient.
- Most cancer targets are still performing well, early diagnosis remains a challenge.
- Elective recovery and Referral to Treatment (RTT) consistently remains above target and CHFT is currently in the top 30 Trusts in the country for RTT data quality assurance, this is a credit to the teams.
- There is an improvement in identification of Cost Improvement Programme (CIP) efficiency plans.
- Deep dive into the Emergency Department (ED) and Same Day Emergency Care (SDEC) took place in September, this was a follow up from a deep dive from February and brought in light of the new ED opening at HRI in July. It was interesting to see the impact of the new ED opening and the review of staff survey feedback was largely positive.
- Difference in performance between HRI and CRH – largely due to higher bed occupancy at HRI still being challenging – performance hasn't improved since new ED opening at HRI due to high demand and bed base.
- Ambulance target of waiting 30 mins has increased (also impacted by flow)
- SDECs are generally working well, ongoing work on best modelling. Opening of medical same day emergency care at CRH has been successful. Looking to open SDECs in Paediatrics and Gynaecology.
- Review the audit the West Yorkshire Association of Acute Trusts had commissioned by Price Waterhouse Coopers LLP (PWC) with recommendations. Reviewing the detail at the next meeting.
- Reviewed and accepted the national cost submission.
- Forecasting to deliver the planned £26.26m deficit, the likely scenario suggests a gap of £5.58m due to likely slippage on delivery of efficiencies.
- Virtual ward was discussed, 55% utilisation against a target of 80% partly due to 5 day limit of consultant cover.

TB highlighted the good news on cancer targets and elective recovery and raised two areas of concern, the percentage in the right to reside in hospital and utilisation of the virtual ward and

asked what the key drivers were. VP responded almost 20% of patients no longer meet the criteria to reside in hospital. The Chief Operating Officer explained they are working with community colleagues and the CRH offer is much smoother in the transition back to the community. He recognised the challenge and explained they are working on this on a day to day basis with robust actions for each patient. He added it is fairly static and they are not at the target of 14% and fluctuate around 18-20%. The transfer of care (TOC) list is at 120-130 which was around 100 this time last year.

The Chief Executive suggested the Trust take a lead role and commit some resource, bringing partners with us. The Chief Operating Officer added there has been a complexity of patients in ED which drives admissions and complexities on the wards which add to the TOC list.

The Deputy Chief Executive provided assurance there was a discussion on virtual ward at the Community Collaborative Forum on the West Yorkshire position and the deterioration at the Trust matches the national position. The service at CRH is more utilised than HRI and further work is needed. He explained the urgent community response (UCR) service and the virtual ward service works is two different metrics and two different teams which needs a focus.

OUTCOME: The Board **NOTED** the contents of the Finance and Performance Committee Chair Highlight Report.

92/24 **Month 4 Financial Summary**

The Director of Finance presented the financial position as reported at the end of Month 4, and provided a further update as of month 5, the key points noted were:

- £300k overspent at month 4 – covering strike costs which will be funded and improve the position.
- £200k shortfall on cost improvement programme (CIP). Just over £1m still to identify compared to a £32m target.
- At month 4, West Yorkshire was presenting a £12m adverse position, £64m deficit compared to a planned deficit forecast for the year of £50k. Exceeded by £14m.
- In context to the WY position, CHFT are performing well compared to partners at £350k overspend at month 5 compared to the £14m West Yorkshire shortfall.
- There are risks to the position; however, the Trust are forecasting to deliver the plan.
- Risks – gradually closing the £1m gap to the CIP risk. Biggest risk is bed base, an additional £700k was spent over the last two months due to extra beds open over the summer. Need to address this with partners and focus on the right to reside.
- The Trust are in a positive position on metrics that are reviewed at a West Yorkshire level – the Trust has spent less on agency than plan and CHFT are one of two, out of eleven Trusts with a positive trend on overall pay expenditure (pay run rate).

NB asked what the potential impact is on the wider system if it overspends and should it materialise for CHFT based on the new financial guidelines. The Director of Finance responded all Trusts agreed a plan to deliver based on the financial guidelines, if any systems are in breach of the plan guidelines, it suggests there are restrictions on the system's capital for future years. Further discussion is required on how capital would be allocated differently if some partners meet plan and others don't. The rules suggest any systems that start to deteriorate an external consultancy is brought in to review. The Director of Finance explained it would be at worst 5% reduction to the overall capital programme.

TB asked how much of the £5/6m is due to industrial action. The Director of Finance responded it is suggested nationally the direct costs incurred will be funded on a formula basis, with no funding for lost activity which is part of the challenge of why income is down.

OUTCOME: The Board **NOTED** the Month 4 Financial position for the Trust as at the end of July 2024.

93/24 **Audit and Risk Committee Chair Highlight Report – 23 July 2024 and Committee Annual Reports 2023/24**

NB presented an update from the Audit and Risk Committee meeting held on 23 July, the key points noted were:

- Only 3 recommendations overdue from the 111 recommendations issued.
- Limited assurance reports had previously been received from Internal Audit on the Mental Health Act and management of contractors. Most of the actions in response to the audit of the Mental Health Act had already been implemented and would be completed by August. It is intended that a re-audit will be undertaken in October to provide the assurance required. Actions had also been implemented on the management of contractors and it was agreed that further discussion would take place with the Fire Safety Officer about the arrangements for fire safety when contractors are working in Trust premises.
- One limited assurance report had been issued in 2024/25 which was a follow up on the Naso gastric tube processes. It was agreed that the Executive lead would be invited to the October Audit and Risk Committee (ARC) meeting to contribute to a deep dive into this audit following two never events.
- A risk management deep dive will take place at the October meeting following the new system InPhase being introduced.
- A deep dive into the work of the Data Quality Board took place in July. This identified the work of the Data Quality Board, its successes over the last 12 months and its plans over the next year. The Committee took assurance from this presentation but also the external sources such as the Analytical Maturity Adoption Model where the CHFT is the only Trust in Europe to achieve level 6 rating.
- An updated version of the Board Assurance Framework (BAF) Standard Operating Procedure was approved which now incorporates reference to the arrangements within the ICS.
- The Committee recommended that responsibility for the BAF risk in relation to cyber security be transferred to ARC and that the wording of the risk in relation to the clinical strategy be updated to reflect the recent change to the risk scoring. A review of the cyber security risk in relation to third party suppliers will take place at the next meeting in October.

Committee Annual Reports 2023/24

NB presented the Annual Reports from Finance and Performance Committee, Quality Committee, Workforce Committee and the Transformation Programme Board for 2023/24 which were approved by Audit and Risk Committee in July. This is a change from previous practice where these would have been reviewed at Board; however, the Audit and Risk Committee will now triangulate the work of the Committees and use the annual reports to inform its view on the Annual Governance Statement. NB highlighted the consistencies within the annual reports in terms of inclusion of the terms of reference, information on the review of committee's effectiveness, details of membership and attendance and confirmation that each committee had achieved its purpose. Further work to attempt more consistency in the format of the annual reports to include a requirement to review the relevant BAF risks, areas of focus over the next 12 months and co-ordinating workplans will be brought forward for next year.

OUTCOME: The Board **NOTED** the contents of the Audit and Risk Committee Highlight Report and **NOTED** the Committee Annual Reports for 2023/24.

94/24 **Integrated Performance Report**

The Chief Operating Officer presented the Integrated Performance Report for July 2024. The key points noted were the positive elective activity undertaken compared to plan, first attendances are

high which is positive and drives income. The total waiting list hasn't reduced, and they are seeing an increase in demand in a number of specialities which is being managed by increasing new patient appointments which is driving follow ups. A detailed piece of work on follow ups is taking place and additional access meetings have been arranged to address this, anticipating follow ups to come down over the next few months. In terms of productivity, day case rates are high and cap theatre utilisation is at 85%.

TB asked for an update on mortality statistics with reference to a reclass from April 2024 which makes the trend analysis hard to read. He asked if a historical trend analysis can be made on the same basis to see the changes in relation to SDEC. The Chief Operating Officer agreed to take this forward and explained as patients have been pulled out it impacted on length of stay.

Action: Chief Operating Officer to discuss SDEC reporting with the Assistant Director of Performance.

The Chair highlighted complaints performance has steadied at 70% having shown improvement over the past two years. The Chief Nurse responded this relates to a focus on getting responses right first time and not creating extensions in the response time. They have introduced more challenge and have seen a dip which is expected until we get this right.

OUTCOME: The Board **NOTED** the Integrated Performance Report for July 2024.

KEEPING THE BASE SAFE

95/24 Guardian of Safe Working Hours Quarterly Report

The Medical Director presented the quarterly Guardian of Safe Working Hours report covering the period 1 April – 30 June 2024.

VP asked why the exception reporting was greater from general medicine and the voice of the junior doctor about why this was happening. The Medical Director responded the largest number of trainees sit in medicine, rather than other departments and the greatest pressures of work are seen in medicine i.e. extra beds and high acuity. The Medical Director explained less experienced doctors have been struggling to cope with the workload. Overall, the total number of exception reports compared to the total number of doctors is relatively small, 48 exception reports compared to 400 doctors and a 20% vacancy rate. He added there is a good fill rate; however, there are still times when a doctor isn't in place and pressures are seen.

The Deputy Director of Workforce and OD added it will be interesting how the report changes when the junior doctors pay deal ballot closes on 15 September 2024. The Medical Director confirmed this also includes the impact on training, experience and opportunity. The Guardian of Safe Working Hours when he attends a future Board of Directors will be asked to share some of the impact of these changes.

Action: Guardian of Safe Working Hours to share the impact of the pay deal ballot in relation to junior doctors at a future meeting.

OUTCOME: The Board **NOTED** the contents of the Guardian of Safe Working Hours report covering the period 1 April to 30 June 2024.

96/24 Medical Revalidation and Appraisal Annual Report

The Medical Director updated the Board on the General Medical Council (GMC) revalidation and appraisal compliance for non-training grade medical staff for the appraisal and revalidation year 2023/2024. The Medical Director highlighted the positive appraisal compliance at 99.5%.

NB asked for feedback on the training programme and highlighted a difference between the numbers which states 58 undertook four or more appraisals through the year and 74 are identified as assessors. He stated this suggests there are some who don't undertake four appraisals per year. The Medical Director confirmed appraisal training should be undertaken every three years and they should be doing a minimum of 4-5 appraisals per year. The Medical Director agreed to understand what the accessors are and provide feedback.

Action: Medical Director to understand the assessors in relation to medical appraisals and feedback to NB.

The Chief Executive commented the idea of a peer review and 'go see' was positive and asked what the Trust could gain from this. The Medical Director confirmed they are encouraged to link with one or two other organisations and when he first started as the Responsible Officer, they commissioned an external review on our processes which was really positive and the internal audit report last year was supportive of the processes in place. The peer review provides a further level of scrutiny of the processes in place. The Medical Director acknowledged the work of Sue Burton and Sudhi Ankarath who do a great job making sure everyone stays on track.

OUTCOME: The Board **NOTED** the Revalidation and Appraisal of Non-Training Grade Medical Staff.

97/24 **Risk Appetite Statement**

The Company Secretary presented the Trust risk appetite statement following an annual review of the existing risk appetite. It is proposed that an additional risk appetite category of environmental sustainability is added, reflecting that this is key to our five year strategy and operating environment.

The wording was revised for the Quality and Improvement and Digital Innovation/New Technology to differentiate them clearly.

TB said he expected the environmental sustainability risk appetite to be similar to new technology, where we look to embrace new technology and move to net zero and invest ahead of the curve and recognise some of this investment won't realise benefit. The Company Secretary commented further discussion can take place and this is a lower category of risk. The Chief Executive commented there is a lower risk tolerance for innovation.

The Director of Transformation and Partnerships shared there have been a few examples where new green technology has been implemented which had a detrimental impact against some other compliance factors or running costs and affordability to maintain this.

The Chair suggested a future Board development session is focused on the risk appetite statement. The Company Secretary explained a full Board Development Session focused on risk appetite in previous years.

NB suggested the use of the risk appetite is included in the discussion, to not just agree the wording but how to use if afterwards.

Action: Company Secretary to add the Risk Appetite Statement to the Board Development Programme.

OUTCOME: The Board **APPROVED** the updated risk appetite and agreed it will be added to the Board Development Programme.

98/24 High Level Risk Register

The Company Secretary presented the report which gave an overview of risks scoring 15 or above.

The new system, provided by InPhase, will replace the current Datix system/Bespoke Risk Register, and will provide a more comprehensive reporting structure to Board and its committees in line with the new Patient Safety Incident Reporting Framework. A data cleansing exercise is currently taking place to ensure all risks are reviewed and either updated or closed prior to the transfer to the new InPhase system at the end of September. There will be a period of data quality checking to ensure migration has been successful and we will then test the new reporting functionality.

The Chief Nurse provided assurance the divisional teams are now reviewing their risks and keeping them up to date and the way they are updating them is much better embedded with more assurance in place.

The Chief Operating Officer commented the way the risks are written are very specific, for example, individual gaps on rota levels, he suggested the risks are broader which would be easier to review as it would be difficult to keep it accurate.

OUTCOME: The Board **CONSIDERED** and discussed risks scoring 15 or more report and **NOTED** the ongoing work to strengthen the management of risks.

99/24 Green Plan Annual Report

The Managing Director for CHS presented the annual progress update relating to the Green Plan and Sustainability Action Plan (SAP).

The CHFT Green Plan outlines the Trust's ambition for sustainability to 2026. The Green Plan was developed alongside a corresponding Sustainability Action Plan (SAP), which spans ten key themes to address the Trust's carbon reduction commitments while ensuring integration with corporate objectives. The Green Plan was first approved by Transformation Programme Board (TPB) in March 2021, and delivery has since been managed by CHS. Progress against the SAP is monitored through the Green Planning sub-group.

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

Delivering and monitoring the Green Plan will help CHFT to:

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

The report shared the key progress for 2023/24 against 200+ actions on the sustainability action plan and key achievements of the Green Plan. Since the baseline year 2013/14, there has been 41.6% reductions in Co2e, 285 tonnes of waste recycled and 308 unnecessary waste collection journeys prevented since installation of compactors, having a financial benefit saving £47,000 each year.

On 20th June 2024, CHFT celebrated national Clean Air Day by giving away surplus tree saplings following the planting regime at HIR earlier in the year.

VP commented she was surprised to not see medications, such as medicines waste and processing as a key area. The Managing Director for CHS responded there are gaps and there needs to be more focus on this area; however, it is not on the green planning agenda within the next 12 months.

VP asked if GPs undertake a quality improvement project annually. The Medical Director responded they undertake an audit on an annual basis. VP is going to suggest as part of PWC report to get clinicians more involved.

TB said there is great momentum and asked if there was a net zero roadmap that covers the Trust, not just CHS. The Managing Director for CHS confirmed the Green Plan is Trust wide and involves the emergency group, green planning committee with members from Engie and ISS. He added there is still more work to do on the roadmap for achieving net zero on both sites.

OUTCOME: The Board **NOTED** the Green Plan progress in relation to the accompanying Sustainability Action Plan.

GOVERNANCE

100/24 Governance Report

The Company Secretary presented the following governance items to the Board:

a. Governance Structure

The Board was asked to note there are additional groups reporting to the Quality Committee which have been added to the Governance structure. These are:

- Learning Forum – this is a quality and safety learning forum chaired by the Chief Nurse or Deputy Chief Nurse responsible for providing assurance that there is effective monitoring and oversight of lessons learnt from patient safety events.
- The Maternity and Neo Natal Board, with the Board receiving a regular report on progress with the three year plan for maternity and neo-natal services.

b. Board of Directors Workplan for 2024 – 2025

The Board of Directors workplan for 2024/25 was presented for approval.

c. Board of Directors Meeting Dates 2025/2026

The proposed Board of Directors and Board Development meeting dates for the period April 2025 – March 2026 was shared for approval.

The Chair reminded the Board there will be four Board Development sessions and the August date can be taken out of diaries. Once the Board Development Plan is agreed a further date will be removed.

OUTCOME: The Board **APPROVED** the Board of Directors Workplan for 2024-2025 and Board of Directors meeting dates for the period April 2025 – March 2026 and **NOTED** the Governance Structure with the additions of the Learning Forum and Maternity and Neo Natal Board reporting to the Quality Committee.

101/24 Review Board Committee Terms of Reference

The following annual review of Committee Terms of Reference were shared for approval:

- Quality Committee
- Audit and Risk Committee
- Transformation Programme Board

OUTCOME: The Board **APPROVED** the Quality Committee, Audit and Risk Committee and Transformation Programme Board Terms of Reference.

102/24 **Items to receive and note**

The following minutes were provided for assurance:

- Finance and Performance Committee – 2 July 2024
- Audit and Risk Committee – 23 July 2024
- Charitable Funds Committee – 6 August 2024
- Quality Committee – 3 June & 2 July 2024
- Workforce Committee – 12 June 2024

A link to the Kirklees Health and Care Partnership papers and Calderdale Cares Partnership papers was included for information.

OUTCOME: The Board **RECEIVED** the items listed above.

103/24 **Any Other Business**

Chris Roberts thanked Anna Basford and Rob Aitchison for their support over the last 12 months at Shadow Board. It was their last development session and he found it a great experience.

Lorraine Wolfenden shared it was a very informative and useful Board meeting to observe.

104/24 **Date and time of next meeting**

The Chair formally thanked the Board of Directors, colleagues and governors for their attendance and closed the meeting at approximately 12.00 pm.

Date: Thursday 7 November 2024
Time: 9.00 am – 12:00 pm
Venue: Rooms 3 & 4, Acre Mills Outpatients

7. Matters Arising and Action Log

To Note

Presented by Helen Hirst

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC) 2024

Position as at: 25.10.24

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

DATE DISCUSSED	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
12.09.24 94/24	Integrated Performance Report Chief Operating Officer to discuss SDEC reporting with the Assistant Director of Performance to see if the historical data can be included in the report to provide a trend analysis.	Jonathan Hammond	Assistant Director of Performance confirmed historical data was available and Chief Operating Officer will review inclusion in future IPR reporting.	07.11.24		29.10.24.
12.09.24 88/24	Maternity and Neonatal Oversight Report Lindsay Rudge and Vicky Pickles to agree what the future maternity report to Board will look like. Include Vanessa Perrott as Maternity NED Champion.	Lindsay Rudge/Vicky Pickles /Vanessa Perrott	The intention is to take a version to Board in the new year and meetings are taking place in November to go through the statutory requirements.	16.01.25		
12.09.24 97/24	Company Secretary to add the Risk Appetite Statement to the Board Development Programme.	Andrea McCourt	Discussion to be had at the December Board Development Session on the 2025 Programme.	16.01.25		
12.09.24 95/24	Guardian of Safe Working Hours to share the impact of the pay deal ballot in relation to junior doctors at a future meeting.	Guardian of Safe Working Hours	To be shared when the Guardian of Safe Working Hours is invited to the Board on 8 May 2025.	08.05.25		
12.09.24 87/24	Corporate Governance Manager to correct page 2 of the CEO report, section 2.3 – we are one of very few Trusts with no patients waiting over 65* weeks and no patients waiting over 52* weeks.	Amber Fox	CEO report corrected. Action closed.	13.09.24		13.09.24

8. Chair’s Report

To Note

Presented by Helen Hirst

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	7 November 2024
Meeting:	Board of Directors
Title:	Chair's Update
Author:	Helen Hirst, Chair
Sponsoring Director:	N/A
Previous Forums:	None
Purpose of the Report	To update the Board on the actions and activity of the Chair.
Key Points to Note	The enclosed report details information on key issues and activities the Trust Chair has been involved in over the past two months within the Trust, with local system partners and regional and national work.
EQIA – Equality Impact Assessment	The attached paper is for information only and does not disadvantage individuals or groups negatively.
Recommendation	The Board is asked to **NOTE** the report of the Chair.

Chair's Report to the Board

This report provides information about key issues and activities I have been involved in over the past couple of months within the Trust, within local systems, regionally and nationally. These present me with opportunities to better understand the excellent work colleagues across the Trust do, the innovation and quality improvement that happens in services routinely, and the challenges faced by our teams. It also helps to develop my understanding of where our Trust contributes to and is impacted by wider system working and decision making. This helps set the context for the discussions and decisions we make during Board meetings.

1. Trust activities

Council of Governors

The Annual Members Meeting was held on 19 September with attendance from current and former governors as well as Trust members. Brian Moore, former lead governor talked of the work of the Council of Governors. We had excellent presentations from Brendan Brown, Mark Davies, Sarah Clenton, Tom Ladlow, Gary Boothby and James Boyle, external auditors KPMG.

An informal development session for the Governors and some Board members brought new and current governors up to speed with reconfiguration plans including the background to the plans and future developments.

Board business

Alongside a number of Board members, I participated in the launch event for the new clinical build at Calderdale Royal Hospital. As well as an opportunity to understand the benefits of the development for our patients and communities it was great the see the ideas and plans being developed and experience a virtual reality tour of what the new build will look and feel like.

Broad Street Plaza Community Diagnostic Centre was officially opened by the Team there in September. It is a great example of what can be achieved and is a credit to the whole team behind the development. The design and creative visuals make for a calm and more relaxing environment that benefits both patients and colleagues.

The Board Strategy session in early October enabled us to reflect on the plans for the NHS from the new Government including the review by Professor Lord Ara Darzi and consider the implications for the Trust's strategy. We had an informative and encouraging session about the extensive use of Artificial Intelligence (AI) within the Trust and its potential for the future. With thanks to Jonathan Cowley, Neil Staniforth, Louise Croxall and Nikhil Bhuskute for their input to the session.

It is always a pleasure to visit some of our services and this last couple of months I have been on a few to hear about some of the fantastic work our colleagues do. Fran Howland, Ward Manager on the Same Day Emergency Care Unit has been recognised by the Trust for her dedication to promoting a kindness culture. She has very clear methods and high standards which ensures both colleagues and patients alike experience one culture of care. I visited the pre-child bereavement team at CRH (Julie, Abbie, Anthony, Rebecca, Gemma, Liz and Mandy) and heard about My Forever Box, a memory box provided for children affected by the death of a loved one. As well as hearing some of the presentation the team

had done as part of being shortlisted for the Nursing Times Award it was good to see the connection with the Trust's Children and Young People Strategy presented at Board last time by Julie Mellor, Lead Nurse. The team from different parts of the organisation have made a huge difference to children and young people through what, on the face of it, is a simple initiative. Funded by the CHFT Charity, the boxes are probably relatively inexpensive when compared to the impact they have not just in the time immediately after someone close has died but in the longer term.

Vanessa Perrot and I met with Lucy and Naomi and colleagues from the Maternity Health Advisory Team, a great public health resource, bursting with ideas and enthusiasm who have had success with stopping smoking during pregnancy amongst other initiatives. I had a great visit with Arley Byrne, Senior Clinical Educator for Allied Healthcare Professionals (AHPs) and Jessica Loam, Occupational Therapy Clinical Educator to discuss their fabulous work on recruitment, team morale, collaboration and workforce development to increase the AHP workforce in the Trust. And last week I had a great hour with Sarah Clenton who showed me around radiology – the new bits and the old bits. The Radiology AI Team showed me the chest x-ray process where it takes seconds to analyse the results and provide immediate feedback.

This last month has been Freedom to Speak Up Month. Brendan and I met with Carol and Caroline our Guardians to receive an update on their work. They have, with the help of Ambassadors, Vicky Pickles (Director of Corporate Affairs) and Jo-Anne Wass (Non-Executive Director) been raising awareness across Calderdale and Huddersfield sites. It was great to visit the stand at HRI last week where Rachel Roberts, Matron and Ambassador, wasn't letting anyone pass by the stand without a conversation!

As part of my personal objectives this year I am undertaking some 'go see' visits to other Trusts to see how their Board meetings function. My first visit was to Harrogate Foundation Trust where Sarah Armstrong, Chair allowed me to attend the People and Culture Committee as well as observe their Board.

I mentioned in my last report Organ Donation Week started on 23 September and to recognise this Team CHFT entered Race for Recipients. The Yorkshire region was third overall with CHFT coming in sixth with a total of 1557.8 miles from our 40 racers of which I managed 37 miles!

2. Health and Care System

Calderdale Cares Partnership Board did two deep dives at their September meeting – one into community mental health transformation and one into integrated services for children and young people. Other items included a refresh of the Calderdale Cares Transformation and Delivery Plan.

West Yorkshire Partnership Board meeting discussed the ambition to reduce stillbirths, neonatal deaths, brain injury and maternal mortality as well as updates on strengthening the local economy, the vision of the West Yorkshire local transport plan and the West Yorkshire Equity, Diversity and Social Justice Strategy. The meeting was preceded by the West Yorkshire Chairs' Forum where I was joined by Denise Sterling, Non-Executive and we had updates on the Chair and Non-Executive Director (NED) talent pipeline and insights from Rob Webster into the plans of the Government for the NHS.

West Yorkshire Association of Acute Trusts (WYAAT) Committee in Common was postponed until next month.

Brendan, Vicky and I attended a roundtable discussion on the future of provider collaboratives alongside colleagues from across Yorkshire and Humber.

The quarterly meeting of the Health Innovation Yorkshire and Humber Strategic Advisory Board was held at the University of Hull. The theme of the meeting was Artificial Intelligence and how it can revolutionise healthcare.

I have had one to one meetings with Councillor Carole Pattison, Leader of Kirklees Council, Keith Ramsey, Chair at Mid Yorkshire Teaching Hospitals Trust, Cathy Elliot, Chair of West Yorkshire Integrated Care Board and Palvinder Singh, Principal of Kirklees College.

3. National

An NHS Providers Chair and Chief Executive Forum was held on 17 September where we heard national policy updates from NHS Providers and presentations about Anchor Institutions as well as updates from Penny Dash (CQC review) and Sally Warren (10 year plan).

Along with other West Yorkshire colleagues I have been involved in the development of the national framework for Board members appraisals.

Helen Hirst
Chair
29 October 2024

9. Chief Executive’s Report

To Note

Presented by Brendan Brown

Date of Meeting:	Thursday 7 November 2024
Meeting:	Public Meeting of the Trust Board
Title of report:	Chief Executive's Report
Authors:	Brendan Brown, Chief Executive Officer and Victoria Pickles, Director of Corporate Affairs
Sponsor:	Brendan Brown, Chief Executive Officer
Previous Forums:	None
Purpose of the Report	This report provides a focused update on the Trust's response to specific elements of its service delivery and the evolving national health and care landscape.
Key Points to Note	1. We continue to live in times of national and global turmoil and conflict. 2. The Chancellor announced further funding for the NHS in her budget this week, although it is not yet clear what this means in terms of performance and productivity expectations. 3. We have continued to see significant pressures in our emergency departments and throughout our hospitals over the last few weeks, which reflects the national picture across acute and integrated Trusts. 4. There have been key reports published reflecting planned changes to the Care Quality Commission, which will have a bearing on the approach to our regulatory performance. 5. The Secretary of State for Health and Social Care launched an appeal for patients and NHS health and care staff to come together and share their ideas for change in the NHS as part of a new 10-Year Health Plan, to which we will be contributing as a Trust and encouraging individuals to share their views.
Regulation	CQC Regulation 17: Good governance
EQIA – Equality Impact Assessment	There are no differential equality impacts resulting from the areas of work highlighted in this report at the point of writing.
Recommendation	The Board of Directors are requested to receive this paper as assurance and progress against both the local and national health and social care agenda, and as an update against leadership responsibilities within the CEO portfolio.

Calderdale and Huddersfield NHS Foundation Trust
Chief Executive's Report
7 November 2024

1. Introduction

1.1. This report aims to provide strategic and delivery context to the items for discussion on the agenda of this Board meeting. It sets out the key challenges and activities happening within the Trust and our partnership arrangements, within the current dynamic and challenging national health and social care agenda, and against each of our strategic objectives.

1.2. We continue to live through times of turmoil and conflict both nationally and internationally. It is now just over 12 months since the Hamas terrorist attacks in Israel, which continue to have serious repercussions in the region, the ripples of which are felt here in England and in the NHS. We are also approaching three years since the start of the war in Ukraine. We must not underestimate the ongoing impact that these international events continue to have on some of our colleagues and communities. The week we meet as a Board, the US will also have been to the polls to elect a new President, with the outcome anticipated across the global political stage.

1.3. Closer to home, the Chancellor has now revealed her long awaited, and much trailed budget. In it she announced:

- £22.6 billion increase in day-to-day health budget this year and next
- £3.1 billion increase in capital budget this year and next
- £1 billion to tackle RAAC (Reinforced Autoclaved Aerated Concrete) issues in health settings, and to address repair backlogs
- £1.5 billion of funding for new surgical hubs and diagnostic scanners

1.4. The NHS is also clearly impacted by the wider announcements about the increase in National Insurance contributions for employers and the increase in the real living wage.

1.5. We are expecting more detail imminently on what this means in terms of the expectations on performance and productivity, and for us as an employer. We are also in the process of understanding and supporting colleagues through the implications of the budget actions for them as individuals.

2. Keeping the base safe – quality and safety of care.

2.1. I wanted to repeat my thanks to colleagues for truly stepping up over the past couple of weeks as we've faced challenging times operationally, as they have gone over and above to ensure our patients have been cared for with compassion in either of our hospitals, in their own homes, or one of our community settings. Their flexibility to work differently and fully use the range of systems we now have in place is to be commended.

2.2. We have been experiencing the bite of winter activity extremely early this year. While the hospitals and our community services have been busy all summer, without that usual seasonal hiatus, the weeks running up to this Board meeting have seen unusually high attendances at both of our emergency departments. A review of activity data has shown that attendances are our emergency departments are up by 20% when compared with pre-pandemic levels, and up by just less than 5% over the same period last year.

2.3. As a result of the ongoing pressures our emergency department performance reduced to 69% in September with a further increase in Trust wide bed occupancy and length of stay. The consequence extends beyond the emergency departments; whilst the number of patients on the transfer of care list reduced, we have seen this increase back up to over 130 in recent days. The number of patients waiting over 12 hours in ED was recorded with its first increase for 5 months, and the proportion of ambulance arrivals delayed over 30 minutes has also increased.

2.4. The recent pressures have been a real test for the effectiveness of our new Integrated Flow Hub, Full Capacity Protocol, and discharge processes across the Trust and in to our community services. However, we are not normalising our response to these pressures, and our Director of Community Services is leading work across Kirklees, working in partnership with Locala, Kirklees Council and Mid Yorkshire Hospitals NHS Teaching Trust to look at discharge pathways to ensure we are maximising all the available services and capacity outside of hospital settings.

2.5. Our Medical Division opened a new Respiratory Support Unit (RSU) last week, which gives acutely unwell patients immediate admission so they can benefit from the specialist care they need more quickly. This is a step towards having a complete Acute Respiratory Care Unit (ARCU) which will be developed as part of the wider reconfiguration programme in the long-term. The unit will provide immediate access to enhanced care for respiratory patients who meet the RSU criteria (including selected level 2 patients, equivalent to HDU). These patients will benefit from closer monitoring, specialist respiratory input and access to care from the wider respiratory multidisciplinary team including input from physiotherapy, occupational therapy, palliative care, psychology, and pharmacy staff. Specialist equipment such as monitoring, workstations, chairs, and NIV machines in line with British Thoracic Society guidelines will be used within this specialist area. The RSU will be introduced in a phased approach with phase one including the provision of four RSU beds. Phase two will see this increase to six RSU beds.

2.6. Despite the urgent, non-elective pressures, we have been able to maintain all our elective, planned care capacity. We continue to make progress in reducing our waiting list with focus on specialties such as Ear, Nose and Throat where waiting times and the size of the list has been longer.

2.7. Unfortunately, we did not meet the 28-day cancer standard in September. This was due to a particular pressure in dermatology. We have since recovered the position and we remain one of the best performing Trusts nationally for cancer performance.

2.8. Cancer care, elective performance, and emergency care are all key deliverables within the Trust's clinical strategy over the next five years, which is at this Board meeting for approval. The strategy describes our commitment to providing the most effective clinical care for patients to enable us to achieve optimal health outcomes for our community including reducing health inequalities. This is an important strategy which sits at the centre of our broader Trust strategy and reflects the work we are doing to describe our target operating models for the reconfiguration.

2.9. Our work on health inequalities is recognised nationally, and Rachel Westbourne, Public Health Lead and Claudia De'Vries, Project Manager for Health Inequalities, were invited to speak at an NHS Providers conference about the use of data and dashboards in reducing health inequalities and the development of the inequalities flag in our systems. Progress in

this work and the wider health inequalities agenda is also included on the agenda for this meeting.

2.10. Health inequalities also a key area of focus in the Care Quality Commission's (CQC) recently published State of Care Report for 2023/24. This report describes issues in specific services, such as mental health, maternity and children and young people's care. It also recognises the key role of local systems in addressing inequalities and joining up care. The report also considers in depth areas of specific concern, including maternity care, Black men's mental health, care for autistic people and people with dementia, and places significant emphasis on the need to improve services for children and young people. It is timely that, in addition to the reports on the agenda for this meeting, Board colleagues will hear from Ian Noonan, our Nurse Consultant for Mental Health, about the work we have been doing to strengthen how we care for patients with a mental health condition.

2.11. In my last report, I referenced the publication of the interim review of the operational effectiveness of the CQC by Dr Penny Dash. The full report has now been published alongside the findings of Sir Mike Richards' independent review of the regulator's single assessment framework and its implementation. You can read a summary of them here.

2.12. The two reports make complementary recommendations on how the regulator can restore its credibility, effectiveness, and its ability to ensure the safety and quality of care of services in England. These include:

- A fundamental reset of the organisation, reverting to its previous model of three chief inspectors.
- Abandoning the concept of a 'single assessment framework' covering all sectors regulated by CQC, while retaining existing key questions and quality statements.
- Improving operational performance, including the quality and timeliness of reports.
- Rebuilding expertise within the organisation, and its relationships with providers.
- Fixing technical issues with the provider portal and addressing registration backlogs.
- Working closely with providers to improve its approach to assessment and inspection.

2.13. Sir Julian Hartley has been announced as the new Chief Executive of the CQC. As a Trust we continue to have good engagement and relationships with the CQC and work closely with them while recognising their organisation is going through a significant period of change.

2.14. Earlier this month the Secretary of State for Health and Social Care launched an appeal for patients and NHS health and care staff to come together and share their ideas for change in the NHS as part of a new 10-Year Health Plan. It is absolutely right that with a lived experience of working in, or being a patient of the NHS, we contribute. There will be more information coming from NHS England soon as we're likely to be asked to support engagement sessions, as well as run some of our own, but in the meantime everyone can get involved online

2.15. We have been strengthening our patient and public involvement and engagement arrangements over the last year. In addition to our experts by experience, we have also

established an involvement panel to test and advise teams on their plans for engagement on service changes and developments.

2.16. In addition, a range of colleagues have engaged with patients, carers, and other colleagues to understand what person-centred care means to people and to capture why it is so critical to providing high-quality care and a positive experience. This has led to the development of a shared definition of what person-centred care at the Trust means, and a promotional video 'Together we can make patient-centred care everyone's experience.' Led by Vicki Drummond, Patient Experience Lead this work has been praised by local and national partners including the National Institute of Clinical Excellence, Calderdale Council, HealthWatch and the Integrated Care Board. You can watch the video here.

2.17. We have also held our first Parent and Carer Forum for the parents and carers of children and young people who use any of our services. The forum enables us to gather feedback to help improve our services. Topics discussed included: Martha's Law (providing patients, families, carers and staff with round-the-clock access to a rapid review from a separate care team if they are worried about a person's condition), for which the Trust is a pilot site; the Children and Young People's Trust-wide strategy; visiting times; and Sophie's Legacy (created in memorial of Sophie Fairall and the legacy of change she wanted to create for children and their families during hospital stays).

2.18. The Forum also discussed our Charity's Ray of Sunshine Campaign for Children and Young People. Launched to support the delivery of the Children and Young People's Strategy, the Campaign aims to raise funds for several key areas, which include: Help me to sleep well; keep me entertained and distracted; provide me with a homely and visually appealing environment; offer me peer support and social activities; help me to stay calm and comfortable; provide me with play therapy support; help my parents or carers feel welcome and cared for. Many of these areas meet the requests set out in Sophie's Legacy. Using the new 'Bee Mascot' the Charity team are working with local community groups, schools, and partners.

3. Inclusive workforce and local employment

3.1. I want to welcome Neeraj Bhasin to his first Board meeting as Medical Director. Neeraj has worked for the Trust as a Consultant Vascular Surgeon since 2011 and has held the positions of Associate Medical Director and Deputy Medical Director. Neeraj was also the regional clinical director for vascular services across West Yorkshire. Nationally he chairs The Circulation Foundation, a UK based charity, dedicated to vascular health.

3.2. As senior leaders within the NHS it is important that we continue to ensure that we create a safe place where colleagues come to work every day to provide compassionate care and support to others. This has been important when considering the incidences of racism and hate that occurred over the summer, and when considering the recent reports nationally of sexual misconduct within the NHS. Last month NHS England published a new national policy framework on sexual misconduct. This builds on the sexual safety charter the NHS launched last year, which we, along with all other NHS organisations signed up to. The national policy introduces the option of anonymous reporting to make it easier for colleagues

to come forward to report serious issues. We are currently working on a local campaign, using learning from other organisations, which we will be rolling out later this month.

3.3. Of course, there are already several ways in which colleagues can raise concerns within the Trust, and October saw Freedom to Speak Up month promoted across the Trust. We now have more Freedom to Speak Up ambassadors, and from a wider range of services and professions, than ever before. The ambassadors joined our Guardians and colleagues from Yorkshire Ambulance Service, to promote speaking up safely.

3.4. The NHS National Staff Survey is another way for colleagues to provide feedback on the organisation. The 2024 Survey is currently live and closes on 29th November. In addition, doctors in training posts (junior doctors now referred to as resident doctors) are surveyed separately as part of the National General Medical Council Training survey. The survey for doctors in training has questions grouped under 4 headings: Learning Environment and Culture, Educational Governance and Leadership, Developing and Supporting Learners and Delivering Curricula and Assessments. There are also voluntary questions on burnout and discriminatory behaviours. The most recent survey results were published in July and were considered at the Workforce Committee last month. CHFT was ranked 222nd out of 229 organisations with postgraduate doctors in training. While the margin between the highest and lowest ranked trust is small, this is clearly disappointing and will be a key priority for the Medical Director and Executive Team over the next six months.

3.5. I was delighted to join colleagues from our Shadow Board for their last session in October. During this session, focussing on Health Inequalities, the group were joined by Dr Bola Owolabi, National Lead for Health Inequalities. I had the chance to hear from members of the Shadow Board about their experiences and the learning they have taken during from last 12 months including what they will take into their roles in future. This is the first time the organisation has run a Shadow Board – it has been a great success and has provided learning, not only for those participating in it, but also for us as a Board and the wider organisation. The Shadow Board will take a pause for now, as I review with colleagues and consider how this offer fits with our wider development, inclusivity and talent offers, and response to what our colleagues tell us in the staff survey over the next year.

3.6. I hope Board colleagues had an opportunity to see the film created to showcase the nine Allied Health Professions here at the Trust. It is part of a suite of films we are developing which has included midwifery, children's services, and the wider organisation, to show people planning a potential career with us that there are a real range of vocations on offer.

4. Financial, economic, and environmental sustainability

4.1. The finance report at this meeting shows a year-to-date deficit position of £3.68m, a £0.25m adverse variance to plan. The in-month position is a surplus of £10.33m, a £0.10m positive variance.

4.2. The Trust is forecasting to deliver the (revised) planned £1.26m deficit, but the 'likely case' scenario suggests a gap of £4.92m due to: potential pay award pressures, potential pressures on Advice and Guidance and increased bed capacity needs. Of the £32.18m CIP target for the year, £0.65m is not yet fully identified. Detail of the reasons for the current position and forecast are included in the finance report to this Board and the highlight report from the Finance and Performance Committee held on 29 October.

5. Transforming services and population outcomes

5.1. In the private meeting today, the Board will be asked to approve the business case for the internal changes that need to take place at Calderdale Royal Hospital as we progress our reconfiguration plans. The changes include moving the birth centre from the ground floor; additional plant to support the larger footprint post clinical build; and an expanded entrance that will accommodate the additional footfall through the hospitals front entrance once the multi-storey car park is built.

5.2. In October, our new A&E at HRI was Highly Commended at the Institute of Healthcare Engineering and Estate Management (IHEEM) Awards in the New Build Project of the Year category. A huge well done to the project team - it is a real achievement to receive national recognition for what has been a huge piece of work in our transformation and reconfiguration journey.

5.3. Last month we began rolling out Patient Knows Best (PKB), an online service for our patients that gives them secure access to their personal health record. PKB enables access to NHS services and information via a website and the NHS App using the NHS login. All information is securely stored in one place with instant notifications when new information is made available. All patients for whom we had an email address received details of how to register with PKB and how to opt out should they not wish to use PKB. This is part of the national move, referenced in the 10-year plan to increased digital access for individuals to their health information.

5.4. NHS Providers have published a report exploring how NHS trusts' ability to go further and faster to digitally transform NHS services is being hindered by funding and financial constraints, operational pressures and inadequate infrastructure. This is an interesting read and reinforces our position as a digitally advanced Trust, and the decisions we have made and continue to make to invest in our digital infrastructure. Our teams are currently supporting Airedale NHS Foundation Trust who are due to go live on the same instance of Oracle Cerner EPR later this month.

5.5. As part of our development as an anchor partner organisation in challenging financial times, we will be undertaking a self-assessment against the NHS Confederation social and economic potential maturity framework. The framework provides a practical tool for Integrated Care Boards and Trusts to review current system working practice and areas for improvement. A copy of the assessment will be shared with the Board.

6. Recommendations

6.1. The Board is asked to receive this paper as assurance and progress against both the local and national agenda, and as an update against leadership responsibilities within the CEO portfolio.

10. Maternity and Neonatal Oversight Report

Presented by the Chief Nurse and Gemma Puckett, Director of Midwifery & Women's Services

To Approve

Date of Meeting:	Thursday 7 November 2024
Meeting:	Board of Directors
Title of report:	Maternity and Neonatal Oversight report
Author:	Gemma Puckett, Director of Midwifery and Women's Services
Sponsoring Director:	Lindsay Rudge, Chief Nurse, Executive Director Maternity Safety Champion
Previous Forums:	Maternity and Neonatal Transformation Board October 2024 Quality Committee 15 October 2024
Purpose of the Report	This report aims to provide assurance to the Board of Directors that there are effective systems of control in place to monitor and continuously improve maternity services at Calderdale and Huddersfield NHS Foundation Trust.
Key Points to Note	The position and data contained in this report is for the Trust position at the end of August 2024 unless otherwise specified. A bi-monthly maternity and neonatal transformation board is held which reviews all data in line with the perinatal quality surveillance model and maternity incentive scheme requirements. A detailed report is submitted to the Quality Committee (QC) following this for oversight and scrutiny of the perinatal services. QC also receive a report into progress against each theme of the Three-year delivery plan for maternity and neonatal services in the alternate months. This ensures that there is a timely and structured reporting mechanism of maternal and neonatal outcomes including learning from incidents and ensures Trust Board can receive assurance from the Quality Committee of an open and transparent oversight and scrutiny of perinatal (maternity and neonatal) services. Further to the Quality committee scrutiny, the Board is asked to specifically note the following areas which are detailed in this report. Assure: • The Maternity Incentive Scheme is currently on track for compliance against all ten safety actions with a monthly oversight of evidence collation. • Local maternity and neonatal system (LMNS) data has shown 100% retention of newly qualified midwives across cohorts from 2022 and 2023. CHFT is one of only two organisations within the LMNS to achieve this. • Neonatal Medical workforce is compliant with the minimum standards for British Association of Perinatal Medicine (BAPM). • A CQC engagement visit took place in maternity in August 2024 with positive feedback on the day on the progress

	made with the recommendations. No further feedback or concerns have been shared following the visit. Advise: • The engagement event with women in HX1 will take place between 14th October 2024 and 15th November 2024. A 15 steps review led by the Maternity Voices partnership (MVP) will take place on 13th November 2024. (section 1.2 of the report). • 30.4 WTE midwives will join the Trust between October - December 2024. This will reduce vacancy to circa 7%. (section 2.1 of the report). • A neonatal Operational Delivery Network (ODN) peer review visit took place on 18th September 2024 with positive feedback on the new leadership structure for oversight of the neonatal service (section 5.0 of the report). Alert: • Neonatal Nursing workforce does not currently meet the minimum standard of BAPM for 70% of nurses to be qualified in specialty (QIS). (Section 2.2 of the report). • Further obstetric workforce planning is required to ensure there is adequate cover for all clinical and non-clinical activities. (section 2.3 of the report). • The rate of stillbirths at CHFT is more than the national average. There were clear health inequalities and clinical complexity evident for many women who presented to the service. System response workstreams have been identified and a stillbirth task and finish group are in place to monitor progress against these (section 3.4 and 3.5 of the report). • A thematic review of postpartum haemorrhage rates was commissioned due to rates flagging on the dashboard on more than 3 months (section 4.5 of the report).
EQIA – Equality Impact Assessment	There is noteworthy evidence which demonstrates that the experiences and outcomes of mothers and babies from BAME groups and those from the areas of highest levels of deprivation are more likely to be poor. Maternity and neonatal services are working with Directors of Public Health, local authority, ICB colleagues, local maternity, and neonatal system (LMNS), maternity voices partnership (MVP) and voluntary sector organisations to identify and close the gap in health inequalities.
Recommendation	The Board of Directors is asked to **APPROVE** the report.

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1.0 Listening to and working with women and families with compassion.

1.1 Lived Experience: Engagement Events

Women and families in HX1 ward were disproportionately represented in the stillbirth data during the first six months of 2024. Women in this locality also present later in pregnancy (>10 weeks gestation) to book for their maternity care.

A joint bespoke engagement event has been planned by CHFT and the ICB to better understand the experiences of women and families in this area.

The event is targeted at women and families in HX1 but may incorporate some women who live in the immediate surrounding areas and are cared for by the same community midwifery team. The results will be able to be analysed by postcode locality.

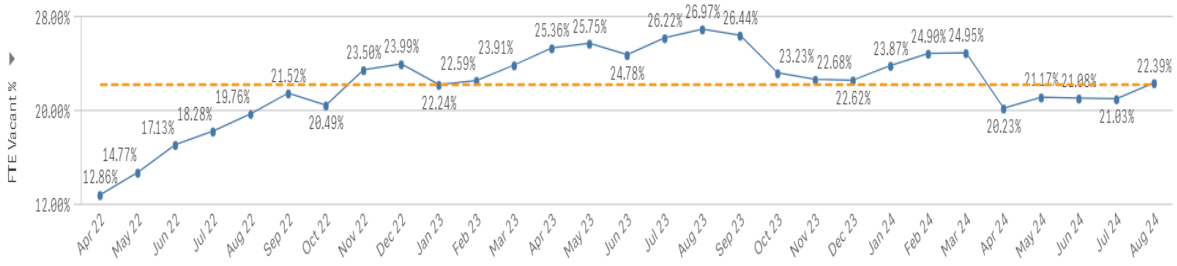
The questions have been co-produced with voluntary services and maternity voices partnership (MVP) and there has been a robust engagement strategy in place. The engagement is being led by community-based engagement champions, MVP, and insight peer support workers within the family hub.

The engagement will take place Monday 14 October to 15 November 2024.

A 15 steps review has been organised to take place on 13 November 2024 and will be led by the MVP with service users attending to support.

2.0 Growing retaining and supporting our workforce.

2.1 Midwifery Staffing



The full time equivalent (FTE) vacancy rate has increased slightly from 21.03% in July to 22.39% in August 2024.

Posts were offered in April to student midwives due to qualify in October resulting in an ongoing impact of vacancy over the summer period. An ongoing rolling recruitment programme is also in place for experienced midwives.

These recruitment programmes will result in 30.4 WTE midwives commencing in post between October and December 2024. Vacancy will therefore reduce to <10% in the coming months.

Local Maternity and Neonatal system (LMNS) data shows 100% retention of newly qualified midwives since 2022 with CHFT being 1 of only 2 organisations that have achieved this.

2.2 Neonatal Nursing

The current level of QIS nurses in the neonatal service does not meet the BAPM minimum requirement of 70%, the current level is 60%. Three nurses commenced the QIS foundation course in September 2024.

It has also been identified there are at least five nurses who have completed the foundation level of the course but not gone on to complete the full course. These staff have been prioritized for completion of the course with the next cohort to commence in March 2025.

In line with maternity incentive scheme (MIS) requirements for safety action four an action plan to address this shortfall has been developed and this can be found in Appendix one.

2.3 Medical staffing Obstetrics and Neonates

Currently the Directorate has a mixed obstetrics and gynaecology consultant rota, The directorate has been actively recruiting for consultants over the last 6-8 months. This has resulted in the appointment of three consultant roles however pressures on the rota remain due to leavers and career break.

A further round of recruitment took place with interviews taking place for a substantive post in October 2024 and a successful appointment following this.

The maternity safety champion raised concern to the maternity and neonatal transformation board that the consultant workforce is not sufficient to cover all clinical and non-clinical activities and is leading to the potential for harm and personal burnout.

There is no evidence through Datix of any harm caused or near misses. Gaps in the rota are mitigated through cover by existing consultant colleagues or use of locum cover. Concerns over personal burnout have been raised in the consultant meetings with the clinical director.
The clinical director and obstetric consultant team have been asked to better define any potential harm and frequency this may occur. It has also been advised to capture when nonclinical activity to support the quality and safety of the service has been impacted and for this to be reflected in the risk register with appropriate and timely escalation to the divisional director.

A business case for additional workforce to enable a split of the obstetrics and gynaecology on call rota was submitted last year but was unsuccessful. The clinical director has been further reviewing the current funded establishment, the requirement and therefore any gap. This will be presented to the divisional management team at the next performance and quality review meeting and a refreshed business case prepared.

There have been no changes to the medical workforce for neonates and this does meet the minimum standards in line with BAPM guidance.

Action Plans to support the development of the medical workforce can be found in appendix two.

2.4 Safety Champion engagement

You said / we did activity:

The Chief Nurse who holds the role of Board Executive Director Maternity Safety Champion has included the following:

Discussed with the community midwifery team the current accommodation arrangement which are suboptimal for the team, having an impact professionally and a wellbeing perspective - because of this feedback and discussion the board level maternity safety champion has secured them additional office space at HRI.

The board level maternity safety champion has escalated concerns to the divisional senior leadership team regarding medical input into the Maternity and Neonatal Transformation Board and asked for support from them in securing this.

The board level maternity safety champion has spent time across the unit following an incident talking to colleagues and offering any further support.

3.0 Developing and sustaining a culture of safety, learning and support

3.1 Incidents

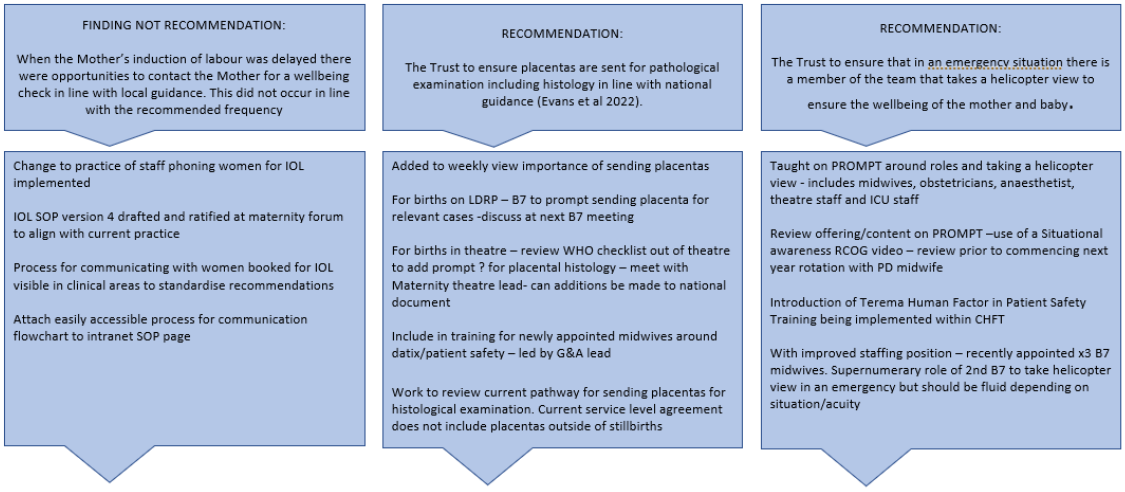
Incidents are reviewed at a weekly maternity governance multi-disciplinary team meeting. All incidents are reported via Datix.

Governance	Number	Themes & Trends / Actions being taken
Incidents logged as moderate or above	12	- Actions ongoing around Cardiac Arrest calls summoning correct personnel in Maternity / Neonates - OASI teaching and competency assessment for newly rotated doctors
Serious Incidents / PSII Reported	New cases: 1 Open Cases: 4 No. Closed in Reporting period: 1	- 1 additional SI signed off at panel early September awaiting return to division for circulation and learning
MNSI Cases	New cases Referred: 0 Open cases: 7 No. Closed in reporting period: 0	6 of the 7 cases are reports returned and in action plan stage for implementation 1 report at draft stage
PMRT / MBRACE	New cases Referred: 3 (+supporting input in 4 other trusts) Open cases: 9 No. Closed in reporting period:4	Compliance with MIS 1/10: Yes Task and finish group set meeting to review and strengthen PMRT processes External peer review of completed investigation
PSIRF:	No. Thematic Reviews in progress: 1	PPH review ongoing over last year
Inquests /Claims / Coroner Regulation 28	24 Open Early Notification Cases 7 Open Claims	

Trust top recommendations*

28 completed reports.
8 reports *did not have* recommendations for the primary provider.

Trust improvements from MNSI cases



3.2 Perinatal Mortality & Morbidity – National Maternity safety Ambitions

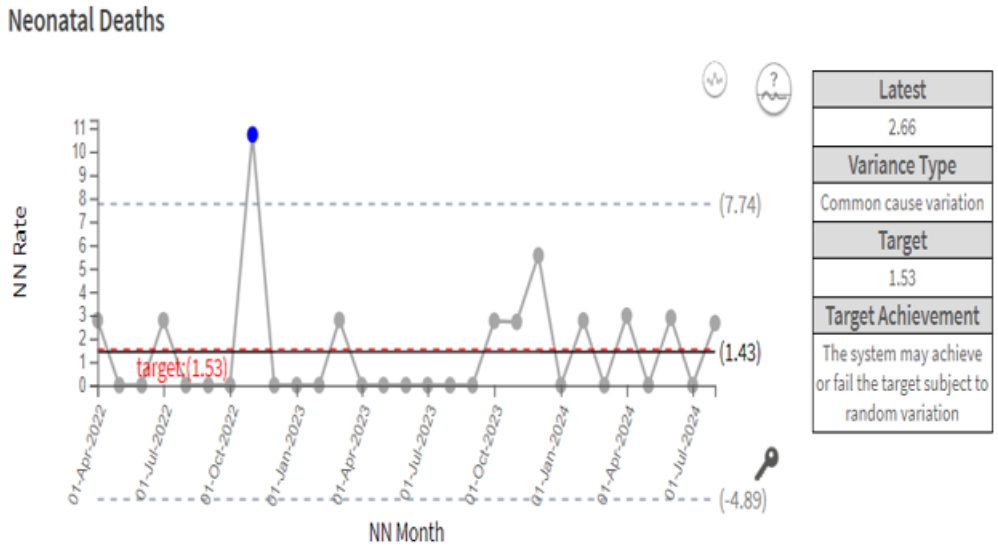
The Long Term plan committed the NHS to accelerate achievement of the national maternity safety ambition of 50% reductions in stillbirth, maternal mortality, neonatal mortality, and serious brain injury by 2025. CHFT's position against these is reported in the Trust Integrated Performance Report monthly.

Maternity and Children's Health:

Metric	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Neonatal deaths per 1,000 total live births	August 2024	2.66	1.53			1.43	0	7.74
Stillbirths per 1,000 total births	August 2024	2.65	3.33			4.3	0	15.1
Maternity Workforce	August 2024	151.31	195			153.6	147.7	159.4
Maternal Mortality	August 2024	0	0			0.07	0	0.45
Pre-Term Births	August 2024	8.2%	8%			6.8%	2.0%	11.7%
Brain Injuries	August 2024	0	2.2			0.34	0	1.77

3.3 Neonatal Deaths

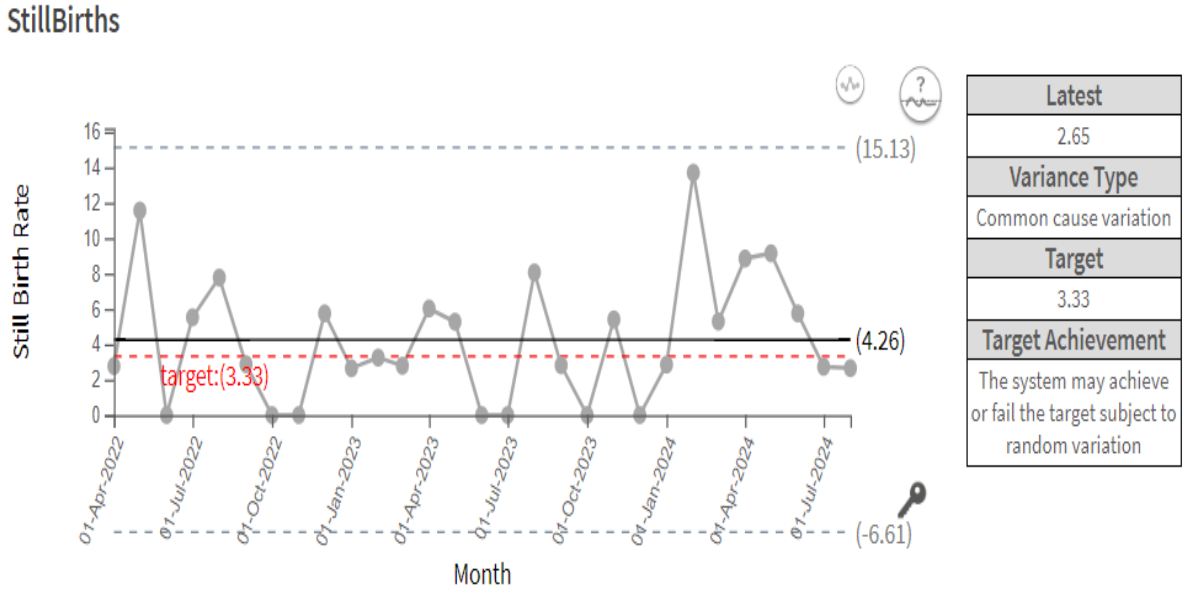
Target:
1.53 deaths within 28 days of birth per 1,000 live births. (MBRRACE-UK)



There was one Neonatal death in August 2024.

An ODN Peer review visit took place on 18th September 2024 and included a review of mortality data and learning.

Stillbirths



There were two stillbirths in August 2024. There were no stillbirths in September and there have been 2 stillbirths in October at the time of this report. This brings the calendar year total to 21 stillbirths.

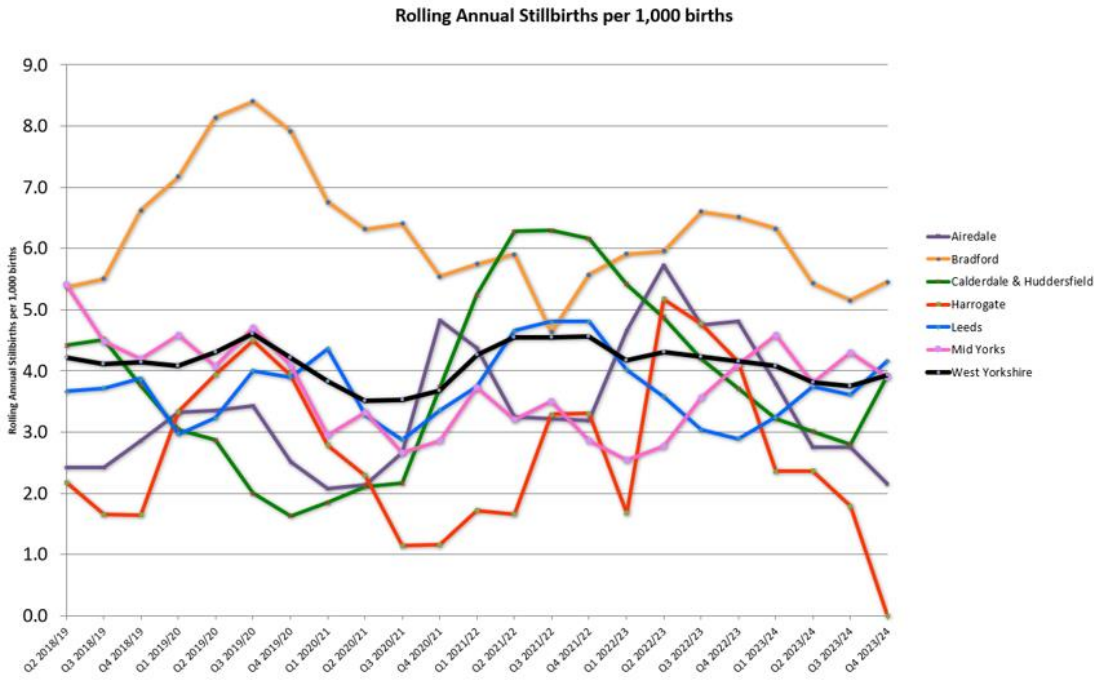
Women who have experienced a loss have multiple complexities, both social and clinical. There is a disproportionate representation of women who are BAME, English is not their first language and live in IMD codes 1-4. This is reflective of the national picture and there is a national task group taking place to better understand why these women experience poorer outcomes.

CHFT highest impact areas have been identified as:

- Small for gestational age pathways.
  - Implementation of viewpoint software.
  - Alignment of growth charts to population based (to implement alongside viewpoint software).
  - Audit programme of scan images.
- Diabetes Pathway
  - Caseload tracking.
  - Clinic capacity and delivery model.
  - Alignment of guidance against national best practice (NICE).
- Reduced fetal movements.
  - Bitesize videos in top 5 languages.
  - Access to MAC using feedback from engagement event.
- Vulnerability tool.
  - Application to inform personalised care pathways.
  - Review of clinical dashboard data though health inequality lens.
  - Cultural competency of workforce.

LMNS stillbirth data for quarter 4 23-24 was presented at the LMNS Board in October 2024.

Indicators	Latest period	LMS Value	Previous Value	Variance
Rolling Annual Stillbirths per 1,000 births	Q4 2023/24	3.9	3.7	↑ 0.18



3.5 System response to stillbirths at CHFT

A system wide stillbirth summit was held in July 2024 including Directors of Public Health, ICB, LMNS and safeguarding colleagues.

Main workstreams identified following this are:

- Primary care Interface: GP / Women's services.
- Obesity Pathway: Prevention, Preconception, pregnancy management.
- Safety culture: Learning across the system and from all review processes.
- Access to care: Transport, location, contact with services, enhanced continuity of carer.
- Diabetes Pathway: Prevention, pre-conception, pregnancy, and postnatal management.
- Smoking Pathway: Prevention, reduction, stop.

Underpinning and informing the actions for these workstreams will be the lived experiences of women and families, and the workforce both in number and skill required to close the gap in health inequalities and reduce the rate of stillbirth across the CHFT footprint.

The next CHFT stillbirth task and finish meeting has been scheduled for 4th November 2024 and will take place monthly. This will include public health representation, LMNS representation and ICB representation.

3.7 Perinatal Mortality Review Tool (PMRT)

This tool provides a standardised approach to reviewing cases of stillbirth and neonatal death.

There have been no cases where care has been graded as directly contributing to the outcome. The learning from the closed cases formed part of the externally supported thematic review.

A multidisciplinary meeting to review the current process for undertaking PMRT reviews and to benchmark against the national guidance took place in October 2024. Priority areas to address following this review are quoracy, family engagement and receipt of the outcome of the review.

All reportable PMRT CRHT cases from the 8 December 2023 to 30 November 2024 where there was a late fetal loss, stillbirth or neonatal death should be notified to PMRT within 7 working days. CHFT is compliant with this at the time of this report.

100% of all deaths of babies suitable for review using the PMRT occurring from 8 December 2023 to 30 November 2024 should be started within two months of each death. CHFT is compliant with this at the time of this report.

This is compliant with MIS safety action 1.

Placenta histology is taking up to 6 months to be finalised because they are analysed at Manchester Foundation Trust which is the only Trust offering this service. This can affect the final cause of death being reported via the tool but not the timely completion of the PMRT.

PMRT recommends that final reviews of the case are done with an external Trust. This can be challenging due to capacity issues from our partner Trust. To increase the likely hood of an external reviewer being present requests have been made to other organisations across the LMNS.

4.0 Standards and structures that underpin safer, more personalised, and more equitable care.

4.1 Maternity Incentive Scheme (MIS)

Maternity Incentive Scheme Year 6	
Date Submission due	February 2025
Compliance Status	In Progress - all safety actions on track
Escalations	None

4.2 CQC

CQC Maternity ratings	
Date Inspection	June 2023

Overall Rating	Good

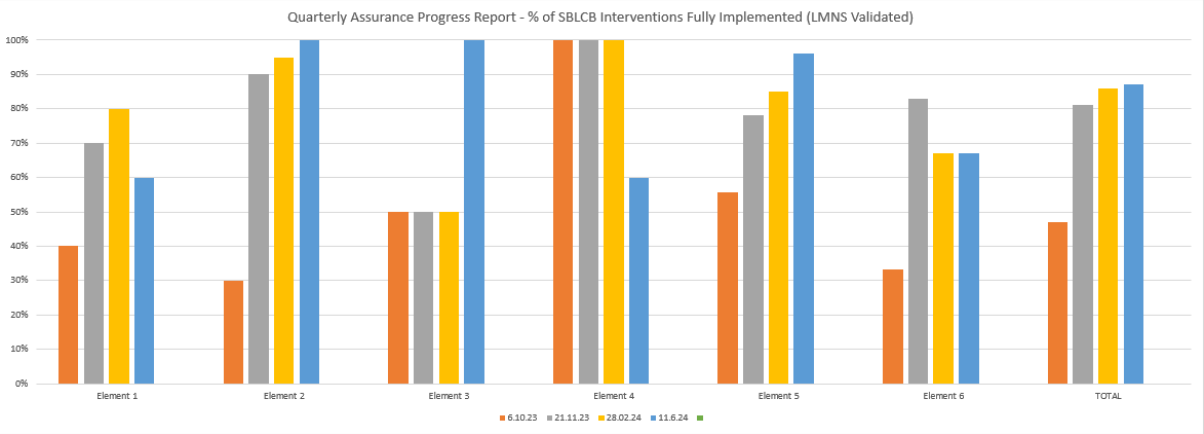
CQC Neonatal ratings	
Date Inspection	Not yet inspected as core service
Overall Rating	N/A

4.3 Regulatory Actions

Regulatory Escalations:	
Coroner 28 Regulations:	None
MNSI / NHSR / CQC or other organisation with a concern or request for action made directly to the Trust	None

4.4 Saving Babies Lives Care Bundle version 3.

Saving babies Lives evidence review in September 2024 confirmed Trust compliance at 86% overall with more than 50% in every element. This is a decrease in overall compliance of 1% and this is due to performance against target in some metrics.



4.5 Dashboard

Key Indicators	Thresholds			Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	YTD
	Green	Amber	Red													
Total Bookings <13 Weeks	>90%	-	<90%	86.8%	90.44%	91.08%	90.00%	88.63%	90.31%	92.31%	86.45%	89.10%	89.20%	89.32%	90.86%	88.9%
Total Births within Service	Monitoring Only			355	363	371	360	350	365	378	339	328	348	364	377	1756
Bookings <10 weeks	>90%	-	<90%	60.3%	64.7%	66.0%	67.5%	57.1%	66.4%	77.2%	63.2%	67.6%	67.9%	68.0%	70.6%	67.3%
Normal births	>57%	-	<57%	55.2%	57.0%	50.7%	48.3%	55.4%	47.4%	50.5%	51.0%	47.6%	51.4%	55.5%	53.3%	69.14%
Assisted vaginal births	<12.4%	-	>12.4%	7.61%	8.82%	8.63%	9.17%	8.86%	10.96%	10.05%	12.09%	11.59%	9.20%	9.34%	5.57%	9.45%
Elective C/S deliveries	Monitoring Only			11.61%	13.89%	16.30%	15.69%	15.16%	16.90%	15.55%	14.67%	17.39%	13.41%	13.19%	14.29%	14.53%
Emergency C/S deliveries	Monitoring Only			24.93%	19.17%	22.93%	26.05%	20.41%	24.65%	22.79%	21.56%	24.22%	25.07%	21.15%	25.88%	23.59%
3rd/4th degree tear - normal birth	<2.8%	-	>2.8%	0.3%	1.9%	0.8%	0.8%	0.3%	0.6%	0.0%	0.3%	0.6%	1.5%	0.8%	0.3%	3.5%
3rd/4th degree tear - assisted birth	<6.05%	-	>6.05%	3.7%	9.4%	15.6%	0.0%	0.0%	0.0%	7.9%	7.3%	2.6%	0.0%	0.0%	4.8%	3.0%
PPH ≥ 1500ml	<3%	3%-3.5%	>=3.5%	2.0%	1.4%	3.0%	3.4%	3.8%	3.0%	3.8%	3.3%	2.5%	2.9%	4.4%	2.7%	3.2%
Total stillbirths	0	<3	>=3	1	0	1	0	1	5	2	3	3	2	1	1	10
Perinatal and Neonatal Deaths	0	<3	>=3	0	1	1	2	0	1	0	1	0	1	0	1	3
Total stillbirths and Perinatal /Neonatal Deaths	0	<3	>=3	1	1	2	2	1	6	2	4	3	3	1	2	13
Low birth weight at term - live births - % of live babies at term < 2200g	0%	-	>=1%	1.22%	0.29%	1.18%	0.00%	0.93%	0.30%	0.28%	0.96%	0.31%	0.00%	0.88%	0.87%	0.61%
1:1 Care in Labour	>=98%	>=97%	<97%	99.7%	99.7%	99.4%	99.2%	100.0%	98.6%	99.5%	98.8%	99.7%	99.4%	99.4%	99.7%	98.7%
Induction Rate	Monitoring Only			38.5%	38.4%	35.0%	40.5%	44.0%	33.7%	40.3%	50.5%	47.7%	42.4%	36.7%	41.8%	43.6%
Planned Home Birth	Monitoring Only			1.98%	1.67%	1.93%	2.52%	1.46%	0.83%	0.00%	1.20%	0.93%	2.33%	1.10%	1.35%	0.56%
Smoking at Delivery	< 11%	-	> 11%	7.93%	6.94%	9.39%	7.00%	8.16%	8.31%	5.09%	6.59%	7.76%	6.41%	6.04%	12.1%	7.84%
Smoking at Delivery (Not recorded)	3%		>3%	5.9%	5.3%	2.49%	5.6%	2.92%	5.8%	2.1%	5.1%	4.0%	4.4%	8.5%	7.8%	6.1%
CO tested at booking	Monitoring Only			97.5%	95.1%	93.7%	98.9%	98.9%	99.3%	98.9%	99.8%	98.3%	98.6%	97.1%	98.0%	98.4%
No. Mothers breastfeeding as First Feed	≥ 74.4%	-	< 74.4%	63.4%	65.0%	65.4%	66.7%	66.1%	62.6%	70.4%	68.0%	71.8%	69.5%	64.5%	60.8%	66.7%
No. Mothers breastfeeding as First Feed Not Recorded	Monitoring Only			25	20	25	22	23	37	23	19	15	26	26	26	112
CO testing at 36 weeks (35-36.6 days)	≥ 80%	-	< 70%	87.13%	80.48%	84.10%	86.14%	83.83%	90.39%	76.81%	95.41%	94.01%	94.74%	94.58%	94.82%	94.71%

Areas to note include:

- The number of stillbirths reported for August has been identified as incorrect and should read as 2. This has been alerted to the Business intelligence team to investigate and correct.
- The smoking at delivery data is of concern therefore the Public Health midwife will undertake a review to better understand, and the actions needed to address this.
- There has been a sustained improvement over the last fourth months in 3rd and 4th degree tear rates.
- Under the PSIRF framework a thematic review of Postpartum Haemorrhage (PPH) cases is under way given seven of the last 12 months have flagged either amber or red. This review was commissioned in July 2024 but has been delayed due to capacity in team. PPH cases are all reported through Datix and reviewed at the weekly governance meeting for the clinical response to, and management of, the haemorrhage and no concerns have been identified through this. These reviews however do not currently include if there was antenatal optimization. CHFT are to participate in the Obs UK research project with a consultant obstetrician identified as principal investigator (PI). This project is the implementation of best practice for prevention and management of obstetric haemorrhage.

5.0 Neonatal ODN Peer Review Visit.

The neonatal ODN were invited by CHFT to undertake a peer review visit as a proactive mechanism to support preparation for a CQC inspection.

- Initial feedback was that there have been positive changes with the move to place neonates under the same leadership as the maternity services with the Calderdale leadership team enthusiastic to understand the requirements of a large local neonatal unit within the ODN and implement different ways of working.
- CHFT should progress work to meet the 4 family centered care priorities (parental access, parental presence on ward rounds, cot side reclining chairs, BFI / BLISS accreditation.
- CHFT should use ODN network dashboards and National Neonatal Audit Programme (NNAP) data to inform service developments.

- CHFT should ensure workforce meets the needs of the service including Allied Healthcare Professionals and specialist roles.
- Recommend review and streamline the mortality review processes across the perinatal service and ensure timely escalation and involvement of the ODN where there may be concerns.

Appendix One: Neonatal nurse staffing Action Plan

Neonatal Nurse Staffing Action Plan October 2024

Lead/s: Jo-Ann Cornelly

Summary of issue: Ability to meet BAPM standard for Qualified in Speciality (QIS) in the neonatal unit.

Governance: Reported through Neonatal Forum

On the basis that some actions have already been started / completed the following delivery rating is applied:

	Action complete: evidence available
	Action complete: evidence being compiled
	Action on track: will progress to timescale
	Action off track: subject to executive escalation

Successful delivery of the plan will require the action plan lead to provide robust evidence as assurance that:

- The action has been completed.
- The action has achieved the intended impact.
- There is evidence of ongoing monitoring where appropriate.
- Any identified risks are captured on the risk register.

Recommendation		Current position	Further action required	Lead	Completion date	Ongoing assurance / success	RAG
1.	To ensure that the neonatal unit has the correct number registered nurses to meet the required workforce model for the bed base.	Unclear on actual workforce model against requirement, therefore unclear on vacancy position.	Review of workforce with ODN to understand our current position. Review workforce model (WFM) to ensure appropriate for bed base. Discuss at hard truths any potential changes for WFM.	Fozia Arshad Laura Douglas	31.10.24 31.12.24 April 2025		
Comments/update: 23.10.24 – Review of workforce data submission with ODN completed and discussed further at ODN peer review visit. Discussed at hard truths WF to be reviewed.							
2.	To ensure that sufficient nurses are trained in QIS to consistently achieve BAPM standards for QIS of 75%	Current ratio of QIS trained nurses is 57.1%	Review of all nurses and current training position Plan to facilitate additional QIS training on a rolling basis.	Jo-Ann Cornelly Jo-Ann Cornelly	7.10.24 31.10.24		

			Complete trajectory for training completion to outline when we will achieve 75% QIS. Ensure robust plan for onward training once compliance achieved to maintain this position (succession planning)	Jo-Ann Cornelly Jo-Ann Cornelly	31.10.24 31.12.24		
Comments/update: 23.10.24 – 3 foundation trained nurses commenced QIS Oct 24 and are due to complete Jan 25 Further 3 due to commence QIS March 25 and due to complete July 25. Additional places requested for January course but awaiting reply.							

Appendix Two: Medical Workforce Action Plans – page 17 – 21

ACTION PLAN in relation to Obstetric Workforce			
Action Reference:			
	Obstetric medical workforce 1. 1.NHS Trusts/organisations should ensure that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas: a. currently work in their unit on the tier 2 or 3 rota or b. have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP) or c. hold an Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums. 2. Trusts/organisations should implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings. rcog-guidance-on-the-engagement-of-long-termlocums-in-mate.pdf 3. Trusts/organisations should implement RCOG guidance on compensatory rest where consultants and senior Speciality and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day. Services should provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings. rcog-guidance-on-compensatory-rest.pdf 4. Trusts/organisations should monitor their compliance of consultant attendance for the clinical situations 27 listed in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service https://www.rcog.org.uk/en/careerstraining/workplace-workforce-issues/rolesresponsibilities-consultant-report/ when a consultant is required to attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance. Trusts' positions with the requirement should be shared with the Trust Board, the Board-level safety champions as well as LMNS. Current position Dec 2023 /24 1. SOP for agency doctors in place – Flexible workforce aware and utilising, need to audit the compliance of agency doctors against the SOP. 2. No long-term locums currently employed for obstetrics services, 3. Meeting on compensatory rest within obstetrics RCOG guidance on an ad hoc basis – see associated action plan. 4. Currently audit consultant compliance in clinical situation, SOP in place This is reviewed at the weekly Governance meeting. Mitigation 1. Discussion with Flexible workforce HR department to set up and audit Programme of the compliance of agency doctors against the SOP to be set up- audit programme set up on a quarterly basis. 2. To devise a pre boking checklist to ensure that any doctors for both O and G have the appropriate relevant in date training and registered with RCOG platform. **Update 24/25 (4/09/24) Please see updated action plan for status.**		
Executive Lead:		**Senior Responsible Officer:**	Gavin Boyd/Gemma Puckett
Monitoring Forum:	Maternity Forum/ Women's and Families Directorate/Mat neo board	**Assurance Forum:**	Divisional Board

Approval	Approval by:	**Evidence of approval**	

Overall Status:		**Date of Report Update:**	**1st Dec 23**
		Version	1.0
Key Outcome Metric:	To ensure safe Obstetric staffing		

Action Ref.	Action	Action Owners	Target Date	Current Status	Evidence/ Outcome Metrics	Update
1	Audit Programme to be set up by Flexible workforce regarding the compliance of agency doctors against the SOP.	Gill Harries	April 24		Quarterly audit in place that assesses Locums against the required requirements for an individual working on bank or agency as a short-term locum	Sept 24 SOP in place. Audit in place and action taken appropriately with doctors who do not have the appropriate up to date training for safe Maternity care
2	Benchmarking against the RCOG compensatory rest guidance for both SAS and	Tahira Naeem	Feb 25		Compensatory rest implemented into the on-call rota in a planned manner	Sept 24 Work underway regarding looking at the on-call rota and ensuring that compensatory rest can be taken in line with job plan responsibilities Awaiting exercise to be completed and new consultants to start – revised target date to Feb 25
3	Case for split rota being put forward for business planning this will have requirement for compensatory rest included	Gill Harries/Tahira Naeem	March 24		Split rota case not agreed at 24/25 business planning	Capacity and demand work undertaken to ensure a clear case of need submitted for next business planning round
4						

ACTION PLAN in relation to the Neonatal Medical Workforce meeting BAPM standards	
Action Reference:	Y&H Neonatal ODN: Neonatal Medical Workforce
	To declare full compliance with MIS Year 3/4/5 - Safety Action 4 units are required to submit 2 reports to the Neonatal ODN. The CHFT Neonatal unit has been asked whether it meets the BAPM national standards of junior medical staffing. If the answer is 'no', the Trust have been asked to submit a Trust Board approved action plan to the Neonatal ODN. There should also be an indication whether the standards not being met is due to insufficient funded posts or no trainee or/suitable applicant for the post (rota gap). There should also be a record of the rota tier affected by the gaps. **Tier 1 (in line with BAPM national standards)** • 24/7 SHO cover (long day and night SCBU shifts) • Monday – Friday – daytime designated postnates SHO **Tier 2 (not in line with BAPM national standards as a Tier 2 practitioner should be immediately and solely available to the neonatal service and labour ward)** • Monday – Sunday – designated SCBU Registrar from 08:30 – 21:00 • Monday – Friday – Twilight Registrar until 22:00 • Monday – Sunday – one Registrar split between the ward and SCBU. **Mitigation** • **Sept 21/22progress update-** From September 2021 the service introduced a Twilight Registrar shift (rather than the previous long day shift) to support in the evening. This is now rostered for most evenings and enables the night Registrar to focus on either Neonates or Paediatrics • The Directorate recognised only having 1 night Registrar as a risk and this is on the risk register (score of 20). A case was presented as part of business planning regarding funding to support having a 2nd night Registrar. This has been agreed for 6 months as part of winter funding and we are currently awaiting the outcome of 2 interviews. • **June 22/23 progress update** Further mitigation provided in June 22 partial funding received for 2nd registrar at night from Network, rota to be amended at next change over to ensure further compliance. Risk reg amended accordingly to reflect current risk. • **Nov 23/24 progress update –** further funding from LMNS/ODN has been received on a recurrent basis to support a second nighttime registrar to cover the service. This means that funding for about 1.5 FTE posts on a permanent basis is now available leaving us with only a 1.2 FTE funding gap to achieve a rota that allows for a permanent second nighttime registrar. Plan for the winter period was to use this money to ensure two registrars are on each night to support both neonates and paediatrics during their winter surge period this has proved to be extremely beneficial for both services. Further work to be undertaken to incorporate the Advanced Neonatal nurse practitioner role to support neonates during both the day and night – further work to be completed – additional funding also requested through Trust business planning process. • **Sept 24/25 progress update (4/9/24)** from winter 23/24 funds were used received from the network to ensure we had a dedicated reg for both paed and nicu overnight in our busiest period this proved to be very successful from a safety perspective but also from a wellbeing perspective for the registrars. We have continued with two regs post winter and have secured funds from the trust for an additional Trust grade doctor as well as the 1.8 funded by Neonatal Network. Currently we have 1.8 Trust Grade Regs in post and two additional recruited who are starting in Oct (I for rota gaps) this all improves are current position, less reliance on bank and has played out in the positive GMC survey results just published. We are currently reviewing are ANNP workforce to ensure we utilise them appropriately and effectively.

Executive Lead:		**Senior Responsible Officer:**	Gavin Boyd
Monitoring Forum:	Neonatal Forum / Maternity Forum /Mat Neo Board	**Assurance Forum:**	Divisional Board
Approval	Approval by:	**Evidence of approval**	

Key Outcome Metric:	To ensure safe neonatal staffing. To meet British Association of Perinatal Medicine (BAPM) medical staffing standard.

Action Ref.	Action	Action Owners	Target Date	Current Status	Evidence/ Outcome Metrics	Update
1	Introduce a Twilight Registrar shift (rather than a long day shift) to support Tier 2 staffing across Neonates and Paediatrics in the evening.	Matthew Taylor, Venkat Thiyagesh, Elena Gelsthorpe-Hill	September 2021		Rota available. Improved bleep response times and general medical support across Neonates, the labour ward, and ED. Improved patient experience. Improved staff morale.	Twilight Registrar now available)
2	As part of the winter bidding process, bid for an additional night Registrar across Neonates and Paediatrics. This is in relation to risk 8072 (score of 20)	Elena Gelsthorpe-Hill, Venkat Thiyagesh	December 2021		Improved bleep response times and general medical support across Neonates, the labour ward, and ED. Improved patient experience. Improved staff morale and trainee placement reputation.	22/23 Bidding successful to secure funding for 6 months as part of winter funding. To update risk reg with progress 24/251.8 WTE funding received from network 1 WTE received internally from Trust

Action Ref.	Action	Action Owners	Target Date	Current Status	Evidence/ Outcome Metrics	Update
3	Secure funding for the Neonatal unit to have a dedicated night Registrar on a permanent basis.	Elena Gelsthorpe-Hill, Venkat Thiyagesh	April 2022		Improved bleep response times and general medical support across Neonates, the labour ward, and ED. Improved patient experience. Improved staff morale and trainee placement reputation.	June 22 progress additional funding received from the network/LMS for one WTE Reg this means that on a significant number of nights that there are two regs – to continue to look for further funding both internal and external to ensure a split reg rotas overnight. 24/251.8 WTE funding received from network 1 WTE received internally from Trust (2 WTE joining Oct 24)
4	Using budget differently to support key seasonal pressures	Gill Harries Venkat Thiyagesh	Feb 24		Using funding to employ bank staff to ensure two reg available over the winter period	Successful implementation of this plan further works to be undertaken to utilise ANNP on both days and nights to support the reg rota for neonates

11. Health Inequalities Update

To Note

Presented by Rob Aitchison

Date of Meeting:	Thursday 7 November 2024
Meeting:	Public Board of Directors
Title:	Health Inequalities Update
Author:	Rachel Westbourne, Public Health Lead
Sponsoring Director:	Rob Aitchison, Deputy Chief Executive
Previous Forums:	Trust Health Inequalities Group
Purpose of the Report	The purpose of this report is to: • update the Board on relevant activity and work undertaken to progress the Trust's Health Inequalities priorities, as set out in the Population Health and Inequalities Strategy (2022–24) • inform Board on plans to refresh the Population Health and Inequalities Strategy
Key Points to Note	**1. Population Health and Inequalities Strategy update** • The Health Inequalities Group continues to meet on a monthly basis with representation across service areas and the corporate division, and work continues to progress the delivery of the strategy. • There are activity updates and positive progress against all four of the workstreams: connecting with our communities and partners, equitable access and prioritisation, lived experience and outcomes, diverse and inclusive workforce. • Some key highlights include: o Over the past 12 months, the BLOSM service has developed and evolved, supporting 1000 vulnerable young people and working with partners to ensure they are given the right care and support. o The Health Inequalities team have recently presented at a number of national forums and webinars on the work in the Trust to understand and address inequalities, including for NHS Providers and NHS England's (NHSE) Healthcare Inequalities Improvement Forum.

- A successful pilot in the Appointments Centre has reduced missed appointments and inequalities in 'Did Not Attend' rates for patients living in the most deprived areas.
- Use of the Health Inequalities Matrix and Inequality Flag is being explored and operationalised in more areas and specialities; using data to understand inequalities in access and outcomes and proactively identify and support patients at the greatest risk of experiencing inequalities. This includes work in Maternity, Clinical Psychology, and Outpatients access.
- In July, the new Community Diagnostics Centre opened in Halifax, with plans for the Huddersfield Community Diagnostics Centre to open in 2026. Community Diagnostic Centres provide opportunities to address health inequalities by enabling easier and quicker access to diagnostics.

2. Plans to update the strategy in 2025

- The Population Health and Inequalities Strategy was adopted to cover an initial time period of 2022-24. We are beginning work to evaluate and update the strategy, which will be relaunched in 2025. The strategy has provided important focus and accountability to the work to address health inequalities at CHFT, and the overarching aims and priority areas of the strategy remain relevant.
- Since the strategy was approved in November 2022, there has been progress in all these areas, but there is still more work we can do to make addressing and preventing health inequalities and promoting population health part of our core business.
- An updated strategy will be developed to cover a longer period of time, reflect our progress to date, and establish key objectives we will achieve in the future. Board will be engaged as part of the development process before receiving the final updated strategy for approval in 2025.
- Updating the strategy provides an opportunity to reflect on our progress to date and establish future priorities, including how to ensure we can go further on our work to address health inequalities and achieve sustained impact.
- As we redevelop the strategy, guiding principles and priorities will include:
  - Engagement with our workforce, patients, and partners on a coproduced strategy.
  - Emphasising our role as an anchor partner and the importance of systems leadership.
  - The use of data, intelligence, and digital solutions.
  - Equity and proportional universalism.
  - Opportunities to create savings and reduce demand through addressing inequalities.

	○ Focusing on few key deliverables to achieve real impact. ○ Ensuring national policy priorities and the changing context are reflected where appropriate, particularly in light of the Darzi Review and expected 10 Year Health Plan from government.
EQIA – Equality Impact Assessment	The Trust's approach to Health Inequalities plays an important role in reducing the impact that inequalities have on access to, experience of, and outcomes from care. Specific initiatives within this work will continue to be reviewed to ensure they do not disadvantage individuals or groups negatively and that wherever possible actions maximise positive impact on protected characteristic groups.
Recommendation	The Board is asked to **NOTE** the updates on progress on action to support the Population Health and Inequalities Strategy. The Board is asked to **NOTE** plans to update the Population Health and Inequalities strategy in 2025.

Health Inequalities Update Report – covering the period May 2024 to November 2024

1. Population Health and Inequalities Strategy – activity and action

The Health Inequalities Group continues to meet on a monthly basis with representation across service areas and the corporate division. Key pieces of work for delivering the Health Inequalities strategy and highlights of the last quarter have included:

1.1. Connecting with our communities and partners:

- **The BLOSM service** has developed and evolved over the previous 12 months, culminating in the recruitment of our own Youth Navigators who started in post at the start of September 2024. Recruiting our own team has allowed us to provide a much more consistent approach for how we support vulnerable young people who are attending the Emergency Department (ED) and the wider hospital. The service has worked hard to build strong relationships with community partners to allow for appropriate referrals to be made from the BLOSM team and our nursing and medical colleagues. An example of this has been our close work with drug and alcohol services in both Kirklees and Calderdale. In Calderdale Royal, we now have a full-time Substance Liaison Practitioner who is working within the hospital supporting adults who have attended with issues relating to substance use. Through proactive identification and engagement, we are improving the experiences of vulnerable people who are attending our Emergency Departments and building effective pathways out into community services. Around 1000 young people have been seen by BLOSM over the past 12 months and supported or enabled to access to appropriate services, instead of falling through the cracks. The BLOSM Service Lead and Public Health Lead are currently working together on evaluation of impact of the service, including through reducing repeat ED attendances and attendances related to violence and drug and alcohol misuse. There are also plans in development to host a Partnership Summit event, bringing together key partners in the local system to discuss the impact of the service and its future.

  The BLOSM service continues to receive regional and national recognition for its excellent work and has recently been shortlisted for a prestigious Nursing Times Award for the second year running. Funding for the service is currently due to end in March 2025.

- The Health Inequalities team have recently **presented at a number of national forums and webinars** on the work in the Trust to understand and address inequalities, including for NHS Providers and NHSE's Healthcare Inequalities Improvement Forum. We have subsequently been invited to present at the Health Inequalities Improvement Network, chaired by Professor Bola Owolabi, the Director of the National Healthcare Inequalities Improvement Programme at NHSE.

- We are working with **Active Calderdale** to support a bid to Sport England for funding to continue the Active Calderdale programme, which works across local anchor partners and communities to increase physical activity across Calderdale. If successful, the expansion of Active Calderdale will include supporting CHFT to become an "active hospital", enabling us to maximise our opportunities as a care provider and anchor partner to encourage our patients and workforce to be physically active. This would support our work to improve population health outcomes as physical inactivity is a leading risk factor for chronic conditions and premature mortality. This work would also be targeted to reduce inequalities, as we know that more than 1 in 3 people in the local population have very low levels of physical activity, and levels are lowest in the most deprived and ethnic minority communities.

- A number of colleagues recently attended the **Kirklees Director of Public Health Annual Report launch**, where we engaged in discussions around the findings of the report and next steps for the local system. The report is focused on inequalities in the experience of death and dying and can be found on the Kirklees Council website (Director of public health annual report 2023/24: Death and Dying matters). Following this, CHFT colleagues in public health, mental health, learning disability, integrated comprehensive care, and palliative care are looking at how we can respond to the findings at CHFT and opportunities for Quality Improvement.

1.2. Equitable access and prioritisation

- A pilot has been undertaken to test an **intervention in the Appointments Centre to reduce Did Not Attends (DNAs) and inequalities in DNAs**, particularly to reduce the gap in DNAs seen between the most and least deprived communities (Index of Multiple Deprivation (IMD) quintile 1 compared the IMD quintile 5). Patients on the holding list waiting for a follow-up appointment, living in IMD quintile 1, and with a high risk of missing their appointment (based on our DNA predictor tool) were targeted in the pilot and offered a more flexible, patient-centred approach to booking to increase accessibility. Findings from the initial pilot have been very positive, with a 25% reduction in the DNA rate for those

targeted with the intervention. Based on this, it is estimated that if scaled up the intervention could give a 1:9 Return on Investment. A second stage pilot is now being planned.

- In late July, the **Halifax Community Diagnostic Centre** (CDC) opened at the Broad Street Plaza in Halifax. The vision is for CDCs to move diagnostics closer to home for patients and provide multiple diagnostic services out of one convenient hub. Alongside increasing diagnostic capacity and enabling earlier diagnosis, part of the purpose of CDCs is to address inequalities in health care access. To support this, work has been undertaken to understand who is most likely to use are diagnostic services and where current inequalities are and identify opportunities to address these inequalities as part of the CDCs offer. Performance metrics will be monitored to understand what impact the CDC is having on inequalities in accessing diagnostics and identify opportunities to do more to address inequalities. The Huddersfield Community Diagnostic Centre is due to open in 2026.

- Use of the **Health Inequalities Vulnerability Matrix** (a tool which combined data to identify patients at the greatest risk of experiencing inequalities) continues to expand. An **Inequality Flag** has been developed to highlight patients at the greatest risk of experiencing inequalities or worse health care access and outcomes. The flag can be incorporated into current clinical and operational systems, and we are exploring with how it might be used to target interventions to reduce and prevent inequalities. The tool is now also being used within Clinical Psychology and Maternity to understand inequalities experienced by patients, the impact these have on patient outcomes, and how we might tailor services to address these.

- A large-scale project to review all outpatient communication and letters in order to **improve accessibility** is ongoing. We have recently introduced a new process that will enable letters to be automatically sent to patients in a range of accessible formats: easy read, large print, large print yellow background, braille, audio (sent by email). Work now needs to be done to increase the documenting of patient communication needs and preferences in patient records. This will mean a better experience and improve communication and access for any patient with a particular communication need.

1.3. Lived experience and outcomes

- **The Clinical Health Psychology department now have a Health Inequalities Matrix** set up for their service. A psychology department meeting in December will be used to focus in on the population being referred to and attending

psychology services in CHFT, using the data to start to address areas where Health Inequalities negatively impact access to psychological support.

- The **Children's Therapy Services** team recently had a learning and development session on Health Inequalities with the Public Health Lead. Further work is planned to understand if there are any inequalities in access or outcomes in the service and what opportunities there may be to do more to understand, address, and prevent inequalities.

- The **community health clinics / service continues to provide vital access to health care for homeless and socially vulnerable populations**. The service currently has 126 active patients that attend in the drop-in sessions twice a week, has received 18 New referrals over the last 3 months, and has carried out 149 face-to-face contacts over the last 3 months.

- On 21 October 2024, **Sophie's Legacy launched in our Children's Service**. Sophie's Legacy is a campaign to offer support to parents with children who are resident in hospital / staying in hospital for a long time. The Children's team were awarded £5000 from Sophie's Legacy to kickstart a pilot to offer a free hot meal for parents to particularly support low-income families, with the option for all parents to access the meals and pay what they can to generate funds back into charitable funds and the ongoing funding of the meals.

- **Patient experience insight** recently identified that fewer patients / families from ethnically diverse backgrounds were accessing the Trust's reablement service. Following this, we worked with Healthwatch to undertake surveys to better understand the experience of intermediate care and reablement for ethnically diverse people. Some key findings and recommendations included lack of awareness of the service, and the need for more information and more information available in a range of languages. Structured interviews will be undertaken to build better understanding before the full findings are reviewed by the Discharge Quality Group and Patient Experience and Insight Group.

- There is a **range of ongoing work to promote mental health and better identify and support patients with mental health problems**, in recognition of the fact that people with mental health problems are also at greater risk of physical health problems and inequalities in access and outcomes. This includes screening all adult admissions, hosting placements for mental health and learning disability nursing students, and the rollout of Making Every Contact Count for Mental Health training across CHFT staff (over 100 colleagues now trained).

- The Health Inequalities Group recently discussed **unpaid carers** and the inequalities they face. Unpaid carers report having worse health and facing

barriers to accessing health care. Work is being explored to improve access and experience for our patients that are unpaid carers, beginning with increased identification of unpaid carers on Electronic Patient Record through increased promotion and awareness of the ability to do this on EPR. This will enable quick signposting to the Support for Unpaid Carers service.

1.4. Diverse and inclusive workforce

- A **wide range of work continues within the Workforce and Organisational Development team** to progress objectives on equality, diversity, and inclusion, and maximising on our role as an employer to reduce inequalities for our staff and local communities.

- **October was Black History Month** and the flag was flying at both hospital sites. Events in the community have been promoted and the Race Equality Network chairs have been engaging with colleagues regarding this year's theme of 'Reclaiming Narratives'.

- The **Widening Participation programme** continues to support employment routes into the Trust and provide a "getting employment ready" offer to the local community, with a significant proportion of those supported coming from the most deprived local areas and ethnic minority communities. The Widening Participation programme are also working with organisations representing refugees looking for employment or volunteering opportunities.

- In July, six young people with a learning disability graduated from the **Project SEARCH apprenticeship programme**. Since the programme started in 2017, 80 young people have enrolled and graduated, with 22 gaining meaningful employment, many within CHFT. Nine young people have now started on this year's programme in September.

- In October, the **Shadow Board** had a development session on Health Inequalities, which included focused discussions on the role of the Trust in addressing and preventing health inequalities for our patients and communities.

- We continue to offer a **wide financial wellbeing package for staff**, including Wagestream, which CHFT uses to offer access to earned pay at any point during the month. This service supports colleagues who are struggling with the cost of living. The funds they can access are a portion of what they've actually earned that month to date. Access to earned wages allows employees with varying income to ensure cashflow problems do not impact their financial health and wider wellbeing. This benefit was launched seven months ago and within that

time period 12% of colleagues have enrolled (923 colleagues) to access this benefit and £784,000 has been advanced to colleagues within that time period. Alongside Wagestream, the other benefits we offer to support colleagues with the cost of living include: “top up shops” (at both HRI and CRH) where colleagues can pick up clothing, toiletries and nonperishables discreetly without submitting any applications or grants; an employee assistance programme available 24/7, 365 to support colleagues with advice, guidance, counselling and information; salary sacrifice schemes and promoting access to discounts and benefits as an NHS Employee.

2. Plans to update the Population Health and Inequalities Strategy

The Population Health and Inequalities Strategy was adopted to cover an initial time period of 2022-24. We are beginning work to evaluate and update the strategy, which will be relaunched in 2025. The strategy has provided important focus and accountability to the work to address health inequalities at CHFT, and the overarching aims and priority areas of the strategy remain relevant.

The Strategy outlined that our vision for population health and inequalities is:

“CHFT will play a leading role locally in improving population health and tackling inequalities, taking bold action, and working with our partners to deliver impactful change for the communities we serve. We will ensure equitable access and excellent experience of care to improve outcomes for everyone.”

And set out four key aims and areas for action:

1. To harness our role as an anchor institution and connect with our communities and partners to promote health and equity in the local population.

2. To reduce inequalities in access to care and ensure prioritisation promotes equitable access and outcomes.

3. To ensure all patients experience high-quality, compassionate, and holistic care to improve outcomes and reduce inequalities.

4. To promote a diverse and inclusive workforce which reflects the populations we serve and where everyone feels valued.

Since the strategy was approved in November 2022, there has been progress in all these areas, but there is still more work we can do to make addressing and preventing health inequalities and promoting population health part of our core business.

As we update and redevelop the strategy, priorities and principles for the process will include:

- Engaging with the workforce, patients, our communities, and partners to understand what matters to them and how we can work together, so we can have a strategy that is coproduced.
- Emphasising our role as an anchor partner in place and the importance of systems leadership in addressing health inequalities.
- Embedding action on health inequalities and health promotion into systems and processes so it is part of “business as usual”.
- Equity and proportional universalism – delivering compassionate, high-quality care for all of our patients and ensuring we provide appropriate services proportionate to the need to achieve equitable access and outcome.
- Continuing to use data, intelligence, and digital solutions to drive improvements and target in a way that achieves maximum impact.
- Maximising opportunities to reduce inequalities while also creating potential efficiencies and savings (such as reducing missed appointments and preventing future demand).
- Focusing on a few key deliverables where we can achieve and demonstrate impact.
- Ensuring national and regional priorities are reflected, including NHSE’s CORE20Plus5 approach to reducing inequalities and the West Yorkshire Integrated Care Partnership’s Strategy.
- Responding to the changing national context and priorities, particularly in light of the Darzi Review and expected 10 Year Health Plan from government.

An updated strategy will be developed to cover a longer period of time, reflect our progress to date, and establish key objectives we will achieve in the future. Board will be engaged as part of the development process before receiving the final updated strategy for approval next year.

12. 2024-2025 Strategic Objectives Progress Report

To Note

Presented by Anna Basford

Date of Meeting:	7 November 2024
Meeting:	Public Meeting of the Trust Board
Title of report:	2024-25 Annual Strategic Plan – Progress Report
Author:	Anna Basford, Deputy Chief Executive / Director of Transformation and Partnerships (with input from all Executive Directors)
Sponsor:	Brendan Brown, Chief Executive
Previous Forums:	None
Purpose of the Report	Provide an update on progress against the 2024-25 annual strategic plan.
Key Points to Note	In March 2024 the Trust Board approved the 2024-25 annual strategic objectives to be delivered in year 2 of CHFT's five year strategic plan (2023-28). The strategic plans describe the Trust's ambitions across the four goals: • To transform patient care and population health outcomes • To provide the best quality and safety of care • To be the best place to work, supporting a workforce for the future • To be sustainable in our use of financial and environmental resources This report provides an update on progress to implement the 2024-25 annual strategic objectives.
EQIA – Equality Impact Assessment	For each objective described in the annual strategic plan the lead Director is responsible for ensuring that a Quality and Equality Impact Assessment is undertaken and where possible that this follows best practice to involve patients, public and colleagues in the process of assessment and the agreement of any required actions to mitigate risks or negative impacts.
Recommendation	The Board is requested to **NOTE** the assessment of progress against the 2024-25 strategic plan.

Calderdale and Huddersfield NHS Foundation Trust
2024-25 Strategic Plan – Progress Report November 2024

Purpose of Report

The purpose of this report is to provide an update on progress made against the Trust's 2024-25 strategic annual plan (Appendix 1).

Structure of Report

The report provides an overview of progress against key objectives, and this is rated using the following categories:

1. Completed (blue)
2. On track (green)
3. Off track – with plan (amber)
4. Off track – no plan in place (red)

For each objective the following information is provided:

- a summary narrative of the progress to date
- the measure(s) to assess delivery
- reference to the to the Board Assurance Framework (BAF) and details of where the Board can receive further assurance.

Summary

This report highlights that of the 15 objectives:

0	are rated red
0	are rated amber
15	are rated green
0	has been completed

Recommendation

Note the assessment of progress against the 2024-25 objectives.

Goal: Transforming and improving patient care					
Deliverable	**Progress rating**	**Progress summary**	**Outcome Measure & Assurance route**	**Board Assurance Framework – Risk Score**	**Indicative Measure of Delivery**
We will have opened the new A&E at HRI and reported on benefits realised, completed build and opened the new Learning and Development Centre (LDC) at CRH, commenced construction of the Multi-storey Car Park (MSCP) at CRH.	**GREEN** on track	• The new A&E at HRI opened in May 2024. Benefits realisation / post project evaluation is being undertaken and a report will be prepared in November. • Construction of the new learning and development centre at CRH is nearing completion. • Enabling ground works for the MSCP at CRH are in progress and construction is planned to commence in April 2025.	**We will have built new 'state of the art' hospital buildings that will enable delivery of the best safety, outcomes and experience of care for people.** **Lead: AB** Transformation Programme Board , Trust Board ICS, NHSE, DHSC	20 BAF Risk 1/19 Reconfiguration	• Open the new A&E and confirm benefits in post project evaluation report. • Open the new LDC and confirm benefits in post project evaluation report. • Construction underway of MSCP and on track for planned completion in 2026.
We will deliver our 12-month digital programme in line with our Trust Digital Strategy. Maintaining a robust and secure infrastructure, developing our digital systems (inc our EPR) in line with our clinical and operational needs (e.g. Patient Portal, Paediatric SDEC); alongside ensuring access to accurate and timely data in order to improve outcomes, operational effectiveness and help	**GREEN** on track	Following achieving HIMSS stage 6 for Adoption Model for Analytics Maturity (AMAM) in May, work continues towards achieving this in all 3 HIMSS models in 24/25. Progress against the digital strategy continues in line with clinical and operational priorities, some key milestones are provision of KP+ modules to support the Integrated Care Hub, further development of the patient portal functionality and continued work to develop closed loop medication provision across the wards. Digital Maturity Assessment (DMA) has been completed for both Acute and Community provision. THIS have been successful in recertification for all 3 ISO standards 9001, 20000 and 27001.	**Patients and colleagues will be digitally enabled to provide and receive care wherever this is needed.** **Lead: RB** Divisional digital boards Divisional Operational Boards Data Quality Board Digital Executive Board. Report to Board and Finance and Performance Committee by exception.	12 BAF risk 02/20 Digital Strategy	• HIMSS level (Achieve level 6 in 24/25) · • Progress against CHFT Digital Strategy (e.g. continual delivery of our digital roadmap/plan) · • NHSE Digital Maturity Assessment (DMA) · • Maintain 3 ISO Standards (27000/9001/20000)

shape service redesign.					
We will deliver Year 2 of the Trust's Health Inequalities Strategy using the four key areas of Communities, Lived Experience, Data and Diversity & Inclusion as our delivery framework. We will provide updates to the Board on a regular basis.	**GREEN** on track	The Health Inequalities strategy is now coming to the end of year 2 with milestones progressing and on-track. This includes: • Use of the "Health inequalities vulnerability index" to identify patients at increased risk of experiencing inequalities. The tool is now being used within outpatient services, maternity and cancer services to prioritise support to those who need it most. • Continuing to prioritise care for people with a learning disability. Qualitative audit undertaken and actions in response underway. • Implemented improved communications for patients including those who require additional support. • Continued delivery of the BLOSM service within our emergency departments to tackle health inequalities and engage with vulnerable service users attending ED. • Use of the revised health inequalities reporting to understand where inequalities in service provision exist and need to be acted upon • The Trust's Health Inequalities strategy will be refreshed during 2025 informed by input from patients, carers and colleagues across the organisation.	**Working with partners we will use population health data to prevent ill health and reduce health inequalities.** **Lead: RA** Health Inequalities Group Executive Board Board of Directors Health Inequalities Oversight Group (England)	12 BAF risk 07/20 Health Inequalities	• Continued delivery of actions within the Trust's approved Health Inequalities strategy 2022-2025 • Act on the health inequalities indicators within the Trust Integrated Performance Report. • Maintain equality of elective care access for different protected groups including an initiative supporting those groups most likely to not attend (DNA) for contacts with the organisation.
We will collaborate with external partners, to offer research to our patients & deliver this safely.	**GREEN** on track	• The R&D restructure has been approved and is now in process of implementation. • We have strengthened collaborative working across place and networks,	**We will participate in research and innovation to improve patient care, prevent ill-health, and achieve**	12 BAF risk 01/20 Clinical Strategy	• C&K Research Group Shared goals and terms of reference

We will establish a Calderdale & Kirklees research Group. Survey the CHFT workforce in regard to clinical research to provide us with evidence to enable improvements. Continue to promote the work of Ethnic Minority Research Inclusion (EMRI) group and reverse mentoring to improve uptake of research in ethnic groups Support and guide our CHFT workforce to design and lead research as Chief Investigators To enable this growth, we will review the R&D structure to ensure we are fit for purpose, resilient and safe.		illustrated in our recent CHFT Research Event. • The inaugural Calderdale & Kirklees Research Collaborative took place in Sept. Meetings with external partners will continue quarterly to achieve the collaborative vision. • CHFT will submit a bid with Bradford Teaching Hospital to be a spoke, with MYHT, in a Commercial Research Delivery Centre. If supported this will provide income and support to further develop a commercial research work portfolio in addition to the NIHR funded portfolio. • We continue to increase the number of different roles leading research, e.g. specialist pharmacists, dietitians, physiotherapy and physician associate colleagues. • 20 CHFT colleagues have completed the NIHR trainee Associate PI scheme with another 10 in progress. • 13 members of the research team have completed reverse mentoring.	**better outcomes and faster recovery for patients.** **Lead: NB** Research Group Executive Board Quality Committee		• Monitor studies we enable as part of this collaboration • Review and act on survey results to make improvements to enable research • Complete the pilot for NIHR reverse mentoring scheme within CHFT research team. • Increase of CHFT chief investigators • R&D structure review complete
Goal: Keeping the base safe					
Deliverable	**Progress rating**	**Progress summary**	**Outcome Measure & Assurance route**	**Board Assurance Framework – Risk Score**	
We will continue implementing the National Patient Safety Incident Reporting Framework (PSIRF) and develop the roles of Patient Safety Partners and Experts by Experience.	**GREEN** on track	• Progress continues with the PSIRF framework the Trust SI panel terms of reference have been updated to reflect this. The Trust Quality & Safety Lessons Learnt Forum has been established to support the ongoing progression of the PSIRF framework	**We will be delivering and enabling outstanding quality, safety and experience of care for people needing hospital and**	12 BAF risk 04/20 CQC rating	• Continued delivery of actions within the Trust's Patient Experience Strategy 2024/25 and the Trust Quality Strategy 2024/25. • Monitor key performance indicators within the Trust

We will implement the Inphase digital system. We will set the Trust Quality priorities to support delivery of the Trust Quality Strategy. Prepare and support for CQC within the new single assessment framework we will align our internal inspection framework (J2O) with the new CQC quality impact statements. Publish a revised Clinical Strategy and Quality & Safety strategy Revision of the Nursing & Midwifery Strategy to reflect the newly published national strategy.		• The first meeting of the Patient Safety Partners and Experts by Experience panel was held in June. The Involvement Forum (with representation from Healthwatch and ICB) to engage and involve our local population / groups in planning and developing services held its first meeting in October • The implementation of Inphase remains on plan. The full testing of the incident reporting platform and training has commenced. • The Trust Quality and Safety Strategy has been approved by the Quality Committee and the quality priorities have been selected and approved. • Progress is being made in 2 of the Quality Priorities, and a deep dive into the Stroke Priority has been commissioned where performance is not improving. • The Nursing and Midwifery Ambition 2025-2029 has been launched. • Ongoing progression of the Clinical strategy is underway. The Clinical Strategy has been completed and will be presented at the BOD in November. • The CQC have visited the HRI Emergency Department as part of the ongoing planned visits, and we will respond to further changes of the framework as these emerge.	**community services.** **Lead: LR** Quality Committee Executive Board		Integrated Performance Report. • Continued monitoring of regulatory standards via the Trust J2O and internal and external inspections/reviews
Working within the resources available we will meet national standards in relation to elective recovery. We will meet priority KPIs for cancer services.	**GREEN** on track	We continue to meet key Cancer KPIs. Elective recovery waiting times continue to reduce. There are challenges in a few specialties linked to staffing gaps, however specific action plans are in place and the expectation is still to meet	**We will be consistently achieving key performance targets that matter most to patients.**	20 BAF risk 1/23	• Elective backlog • 28,31 and 62 day cancer targets. • Diagnostic DMO1 performance target. • ED four hour target.

We will maintain our position within the top quartile of diagnostic performance. We will maintain our position within the top quartile nationally of ED performance, with a focus on ambulance waits over 30 minutes and over 12 hour ED waits.		the waiting list reductions planned by year end. Diagnostic performance is on track. Type 1 ED 4 hour performance remains in the top quartile. Meeting the Type 1 and 3, 4 hour target remains challenging primarily driven by high bed occupancy and challenges discharging in to the community. The move to a new ED at HRI was successful and performance in relation to ambulance handover remains within the agreed target and compares well to peers and nationally. Proportion of over 12 hour waits has reduced over May, June, July and August 24 and is significantly lower than Oct 23-Jan 24.	**Lead: JH** Integrated Board Report Executive Board Audit and Risk Committee Finance and Performance Committee Access Delivery Group	Demand and capacity	• Volume of patients with 12 hour length of stay in ED. • Average ambulance wait times.
We will review the governance arrangements against the GGI / HFMA framework in line with good financial controls and complete a well led review. We will also undertake the full self-assessment of compliance with the new CQC Inspection Framework at both Board and Divisional levels.	**GREEN** on track	We have continued with positive engagement meetings with CQC colleagues and are working with them to understand the likely changes to the inspection framework. In the meantime divisional teams have been working through the fundamental standards and ensuring compliance – reported through divisional patient safety and quality boards and performance review meetings. Following the West Yorkshire Association of Acute Trusts external financial review, we have an action plan that we are working through with divisions. A full external well led review is not due until 25/26.	**We will be 'well-led' and governed and compliant with our statutory duties.** **Lead: VP** Executive Board Trust Board	6 BAF risk 16/19 Health & Safety 12 BAF risk 4/20 CQC rating	• Review undertaken and recommended actions implemented. • Self-assessment complete across all domains including Board well led assessment
Review the Patient experience and involvement strategy to ensure service planning and developments consider the diverse needs of the local population.	**GREEN** on track	Revision of the strategy is underway. The first meeting of the Patient Safety Partners and Experts by Experience panel was held in June. They were involved in • Patient Correspondence • Patient Portal • Cardiology Services	**Patients will be able to shape decisions about service developments and their personal care based on 'what matters' to them and their individual strengths and needs.**	6 BAF risk 04/19 Patient and Public Engagement	• Continued delivery of actions within the Trust's Patient Experience Strategy 2024/25 and the Trust Quality Strategy 2024/25. • Patient Survey Reports • Friends and Family test results

Initiate two new workstreams for the Patient Experience Involvement Group**:** person centred care and strengthening working in partnership with people and communities. Continue work within the patient experience and Involvement strategy to inform priorities and Keep Carers Caring. Introduce Experts by Experience and Patient Safety Partners. Develop actions across the local system to support identification of unpaid carers, improve their involvement and support their health and wellbeing.		Keep carers caring remains embedded in the Trust, however from feedback received we have refreshed our information for carers, and it is now called Support for Unpaid Carers The Patient Experience Team have supported the Transformation team to ensure that patient correspondence includes a clear statement, supporting people to know that they are welcome to be accompanied by a person of their choice when they attend appointments. We have commenced work with partners including Calderdale Local Authority and Kirklees Local Authority to develop a carers charter which will support unpaid carers across the geographical patch. CHFT has been successful in bidding to be one of the first provider sites to implement Martha's Rule. We continue to work closely with NHSE to implement Martha's rule across the trust and good progress is being made. Work has taken place to develop a promotional film to support person centred care across CHFT. We have engaged with patients, carers and other colleagues to understand what person-centred care means to people and to capture why it is so critical to providing high-quality care and a positive experience. We have produced a film and the captions in it have all been informed by patients, carers and colleagues. The trust has received the inpatient survey results and has maintained the previous overall score. The Involvement Forum (with representation from Healthwatch and ICB) to engage and involve our local	**Lead: LR** Quality Committee Executive Board		• CHFT compliance with statutory guidance "Working in Partnership with People and Communities" • Healthwatch reports • We will continue to monitor assurance via the Trust CQC Compliance Group. In addition, we will ensure regular engagement meetings continue with our CQC Relationship Owner. • Maternity Incentive Scheme and Ockenden Assurance compliance

		population / groups in planning and developing services held its first meeting in October CHFT continues to address inequalities for people with Mental Health who access services and improve people's experience of our services. The Nurse Consultant for MH will provide an update to the November BOD			
Goal: A workforce fit for the future					
Deliverable	**Progress rating**	**Progress summary**	**Outcome Measure & Assurance route**	**Board Assurance Framework – Risk Score**	
We will increase emphasis on appreciation and recognition culminating in a successful CHuFT awards event.	**GREEN** on track	• CHuFT awards scheduled for June 2025 (following feedback on the operational pressures in the winter months) the event will be combined with an afternoon tea to recognise colleagues' long service. We will be working with Calderdale College to deliver this event. • Colleague Appreciation Week commencing 21 October 2025. • We have enhanced the colleague recognition and appreciation toolkit and promoting this resource so that teams can utilise this locally.	**We will be widely known as one of the best places to work through an embedded one culture of care - supporting the health and wellbeing of all colleagues.** **Lead: SD** Workforce Committee	12 BAF risk 1/24 Recruitment and Retention (leadership)	• Increase CHuFT nominations • appreciation weeks in engagement calendar
We will continue to improve and promote our internal development offer, with a strong focus on leadership.	**GREEN** on track	• Leadership conference is planned in December 2024 with a focus on Quality Improvement methodology. • 2024 Empower and New to Manager cohorts have graduated with great results/feedback. • The next cohort of Empower and New to Manager participants are being sought for the Autumn 2024 through to Autumn 2025 programme with a targeted communications campaign to all BAME colleagues.	**We will foster an open learning culture that demonstrates lessons learnt, and actively seeks and celebrates best practice.** **Lead: SD** Workforce Committee	12 BAF risk 1/24 Recruitment and Retention (leadership)	• Succession plans in place for all Divisions to tier 3 • 2 leadership conferences per annum • 10% of managers having completed WTGR training • 10% increase in cohort of empower graduates

		• Civility and Respect session held in Pharmacy. Session was well received. Train the Trainer sessions are being held so that all teams within pharmacy can participate. • Proud2bOps monthly development workshops are planned in the diary and sessions delivered by the operational colleague community. • A Place wide HR Practitioner conference was held in September 2024. A second event is scheduled in December 2024 and a 2025 programme is in development. • A customer service training programme will be piloted in Autumn 2024 within Workforce and OD. • A WTGR diagnostic tool has launched in October 2024 to measure team engagement and effectiveness.			• management fundamentals rolled out across the Trust
We will implement an inclusive recruitment approach aligned to our values and behaviours and increase internal mobility for under-represented groups.	**GREEN** on track	• Inclusion Strategy (2025 – 2028) development session scheduled for 28 October 2024. Workforce data analysis to inform approach and areas of focus. • Careers events held both within the Trust and across the local community to promote our Widening Participation approach. • Outreach work planned throughout 2024 is targeting under-represented groups including Looked after Children, refugees and long term unemployed. • Enhanced communications and engagement with under-represented groups regarding the development offer.	**We will have a diverse and inclusive workforce of the right shape, size and flexibility to deliver care that meets the needs of patients.** **Lead: SD** Workforce Committee	12 BAF risk 1/24 Recruitment and Retention (leadership)	• Increased internal mobility for BAME colleagues to band 6 and above roles.-

We will develop bespoke learning pathways and curriculums to develop a pipeline of local talent into health and social care vacancies	**GREEN** on track	• Review and reset of Widening Participation strategy underway. • Widening Participation programmes to support pipelines into the Trust and to support the local community in preparing people for work including Princes Trust, T Levels, Project Search and St Johns Cadets. • Development of new pathways including refugees. • Apprenticeship levy spend has increased by 7.5% from 2023/2024. • CHFT is in the top 10% of employer provider performance in the UK for apprentice achievement rates. • 48.59% of apprentices recruited from IMD 1 to 4. • Tracking of colleagues from Widening Participation programmes into employment.	**We will work with partners to create local employment, career and development opportunities for people.** **Lead: SD** Workforce Committee	12 BAF risk 1/24 Recruitment and Retention (leadership)	• Increase of number of colleagues recruited from IMD 1-4 • Increase our apprenticeship levy spend by 5% • We will co-launch a health and social care Academy for Calderdale
Goal: Sustainability					
Deliverable	**Progress rating**	**Progress summary**	**Outcome Measure & Assurance route**	**Board Assurance Framework – Risk Score**	
Deliver the ICB and NHSE approved financial plan. Benchmark favourably across both West Yorkshire and Nationally against the National Productivity Metrix	**GREEN** on track	• At month 6 the Trust continues to forecast delivery of the 2024/25 plan. • Latest productivity benchmarking data has been issued which shows a significantly deteriorated position for CHFT. This relates to inconsistent recording of activity. When adjusted, CHFT remains more productive than national average and WYAAT peers. CHFT have met with the national team to suggest improvements to the tool as they recognise existing flaws. • Further new benchmarking has been issued regarding pay expenditure. The latest data shows that CHFT is one of only 2 providers across WY	**We will be consistently delivering our annual financial plans and demonstrating value for money.** **Lead: GB** Reported to Finance & Performance Committee Monthly regulator discussions	16 BAF risk 18/19 Financial Sustainability	• Deliver approved plan. • Productivity Benchmarks

		(out of 10), where pay bill is lower this year than last after considering pay awards.			
Deliver a calendar of sustainability engagement events for 2024/25; achieve a minimum recycling target of 40% for non-clinical waste streams; work to reduce single occupancy vehicle journeys by 5% by 2026; make progress towards our targets of a 100% reduction in emissions by 2040 and to convert 90% of our fleet to low, ultra-low and zero emissions vehicles by 2028	**GREEN** on track	• Of the 207 actions proposed in our green plan 165 of these are complete. We continue to deliver a calendar of sustainability engagement events. • The Trust has reported a 1.33% reduction in carbon emissions since 2023/24 and 41.6% reduction since (2013/14) • Over 800 efficient LED light fittings installed • 400 tree saplings planted at HRI • Nitrous oxide manifold has been decommissioned • 10 new EV charging points were installed at HRI and Acre Mill to help facilitate the transition to zero carbon travel • CHFT celebrated national Clean Air Day by giving away surplus tree saplings	**We will have taken action to reduce our impact on the environment and will be on track to achieve targets for carbon net zero.** **Lead: SS** Transformation Programme Board Trust Board	8 BAF risk 06/20 Climate Action	• a 100% reduction in direct (scope 1) carbon dioxide equivalent emissions by 2040. An 80% reduction will be achieved by 2032 • convert 90% of our fleet to low, ultra-low and zero emissions vehicles by 2028 • a minimum recycling target of 40% for non-clinical waste streams • a 5% reduction in single occupancy journeys by 2026
During 2024-25 we will work with our Construction Partner for the new Clinical Build at CRH and with local partners and communities to agree a Social Value action plan that will enable and measure delivery of economic and social benefits for people in Calderdale and Kirklees.	**GREEN** on track	Laing O'Rourke has been appointed as the design and construction partner for the new clinical build at CRH. The Trust has commenced working with them to progress next stage designs and plans that includes the development of a social value action plan.	**Our investments and use of resources will be generating Social Value to support economic recovery in Calderdale and Kirklees Places.** **Lead: AB** Transformation Programme Board Trust Board	-	• Agreed Social Value Action Plan with quantified measures.

INTEGRATED PERFORMANCE

13. Quality Committee Chair Highlight Report – 3 September 2024

- Director of Infection Prevention Control Q2 Report

To Note

Presented by Denise Sterling

Calderdale and Huddersfield NHS Foundation Trust

CHAIR'S HIGHLIGHT REPORT
to the Board of Directors

Committee Name:	Quality Committee
Committee Chair:	Denise Sterling
Date(s) of meeting:	3 September 2024
Date of Board meeting this report is to be presented:	12 September 2024
ACKNOWLEDGE	• Amendments to Quality Committee Terms of Reference approved
ASSURE	• The Patient Experience and Involvement Group (PEIG) reports progress in four key areas: person-centred care, community partnerships, insights for improvement, and carer support. Key initiatives shared included a patient-centred care film, engagement sessions, and the recruitment of Experts by Experience and Patient Safety Partners, boosting patient and carer involvement in Trust committees. • Engagement in the Clinical Outcomes Group has improved, with increased assurance levels. The areas of limited assurance include the End-of-Life Care strategy, which needs improvement in advance care planning and care coordination, as well as stroke, Acute Kidney Injury, dementia. • The Medication Safety and Compliance Group Q1 report outlined ongoing efforts and initiatives to enhance medication safety, including revising medication incident review processes in line with Patient Safety Incident Response Framework principles and improving ward controlled drugs audit compliance • Infection Control Report Q1 provided assurance against the key performance targets, the Trust being in a better position compared to Q1 in 2023/2024. There were reduced cases of Clostridium difficile, E. coli and other infections. Ward closures due to Norovirus persist and efforts were underway to strengthen fit testing and vaccination campaigns for COVID-19, influenza, and other respiratory viruses ahead of winter. • Quarter 4 Learning from Deaths and Annual Report 2023/24 showed an improvement in the percentage of Initial Screening Reviews (ISRs) conducted, covering 48% of deaths. Significant areas of focus

	include structured judgement reviews (SJRs) for learning disability and maternity deaths, with key themes of communication, documentation, and deteriorating patient management being addressed through ongoing actions and improvements. • Theme 3 of the Maternity & Neonatal three-year delivery plan was presented and a summary of the current position on the objectives: developing a positive safety culture, learning and improving; and support and oversight. In response to the stillbirths, there has been a decline in numbers this year despite a cluster in February, but further efforts, including a focus on obesity and concealed pregnancies, are necessary. Positive developments include patient experience feedback, a national review of the Matron's Handbook involving a CHFT matron, leadership and positive feedback from the CQC visit. .
AWARE	• The Clinical Outcomes Group dashboard showed a rise in mortality metrics (Summary Hospital level Mortality Indicator (SHMI) and HSMR) due to under-recorded comorbidities in two respiratory episodes, no significant care quality issues were found. Concerns were raised about comparisons with London hospitals, as SHMI does not account for regional health inequalities, and CHFT's position will remain negatively impacted until all Trusts align with new benchmarking in March 2025. • The Medical Examiner (ME) report provided an update on the Parliamentary sign-off for the commencement of the legislation for the Death Certification Reforms, which took effect from Monday, 9 September 2024. The ME service has reviewed its processes and was in a good position to meet the start date. One aspect that has to change is the referral pathway for certification within CHFT along with a newly developed escalation process for timely submissions. • Board Assurance Framweowrk Risks, 4/19 – Public and patient involvement • 6/19 – Compliance with quality and safety standards, and 4/20 – CQC were received and there are no changes to the risk ratings since last presented to the Quality Committee.

ONE CULTURE OF CARE	• One Culture of care is considered as part of the quality reports and in discussions where the considerable staff contribution to safe quality care and quality improvement initiatives are acknowledged.

CHAIR'S HIGHLIGHT REPORT
to the Board of Directors

Committee Name:	Quality Committee
Committee Chair:	Denise Sterling
Date(s) of meeting:	15 October 2024
Date of Board meeting this report is to be presented:	7 November 2024
ACKNOWLEDGE	• Medicine Division Patient Safety Quality Board reviewed terms of reference approved. • The first biannual report of the Children and Young People's Board (CYP) was received. Key achievements as a result of the Board were the strong multidisciplinary engagement and robust governance oversight of the care of children and young people within CHFT. The recently launched CYP strategy that has been co-produced with CYP, families and staff emphasises compassionate care and ongoing quality improvement. A live transformation plan is being used for action planning and to ensure progress aligns with best practices and key standards.
ASSURE	• The Stroke Deep Dive was initially reviewed by the Finance and Performance Committee and subsequently brought to the Quality Committee to look at stroke service performance in regards to quality of care, outcomes, risks, and patient experience. Key findings from the Sentinel Stroke National Audit Programme (SSNAP) identified areas requiring sustained improvement to align with high standards of stroke care. Significant challenges were noted, including increased emergency department demand, higher stroke acuity, limited access to acute beds, prolonged lengths of stay, and workforce shortages. Response strategies to these challenges were discussed and the Committee will continue to monitor SSNAP performance, patient outcomes, and overall service. • The Quarter 2 quality reports were presented from all the Divisions Patient Safety and Quality Boards (PSQB) The comprehensive reports show that the

	Divisions are actively managing their key risks and have strengthened risk management. Divisions are progressing quality priorities for 2024/25, continuing to focus on CQC preparedness and evidencing good compliance with NICE guidance. Two Divisions shared the Freedom to Speak up concerns that have been raised and actions taken. It was noted that Family and Specialist Services (FSS) have stood down the PSQB and information will be going into performance review meetings. FSS to feedback how this new approach is working and how accountability for patient safety and quality outcomes are being maintained across departments. • The maternity and neonatal services received positive feedback during the CQC visit in August. Compliance with the Maternity Incentive Scheme's 10 safety actions was on track. In response to findings highlighting the disproportionate representation of women and families in the HX1 ward concerning still birth rates and early pregnancy care access an engagement event is being organised by CHFT in collaboration with the Integrated Care Board (ICB) between October and November 2024. It will focus on gathering insights from women and partners who accessed antenatal maternity care in the past year. .
AWARE	• The Q2 Infection Prevention Control (IPC) report highlighted the new objective targets for 2024/25 and the current performance against these targets including Hospital-onset Healthcare Associated (HOHA) and Community-onset Healthcare Associated (COHA) cases. There has been a decline in the training compliance figures for medical staff in Aseptic Non touch technique (ANTT) and Level 2 IPC training
ONE CULTURE OF CARE	• One Culture of care is considered as part of the quality reports and in discussions where the considerable staff contribution to safe quality care and quality improvement initiatives are acknowledged.

Date of Meeting:	**Tuesday, 15 October 2024**
Meeting:	**Quality Committee**
Title of Report:	**Q2 Infection Control**
Author:	**Belinda Russell, Matron Lead IPC**
Presenter of report: (if different from author)	**Dr David Birkenhead**
Sponsoring Director:	**Dr David Birkenhead**
Previous Forums:	**ICC**

Actions Requested: To note

Purpose of the Report

The report provides an update on Infection, Prevention and Control (IPC) performance and activity for the second quarter of 24/25.

Key Points to Note

Targets have now been received for 2024/25 which now include both HOCI and COHA cases.
Hospital-onset healthcare associated (HOHA)
Community-onset healthcare associated (COHA)

EQIA – Equality Impact Assessment

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

Recommendation

The Committee is asked to note the content of the report

IPC Report Q4 1st July– 30th September 2024

Calderdale and Huddersfield Foundation Trust recognises that effective infection prevention practice, underpinned by the implementation and audit of evidence-based policies, guidelines and education are fundamental to the reduction of risk and patient harm from Healthcare Associated Infections (HCAI). The report will provide assurance against key infection prevention and control performance and quality indicators. The objective targets for 24/25 have now been published PRN00150-nhs-standard-contract-24-25-minimising-clostridioides-gram-negative-bloodstream-infections-v2 (1).pdf. The objective includes both HOHA cases (hospital onset, healthcare associated) plus COHA (community onset, healthcare associated) infections where there has been an inpatient episode within the previous 28 days.

1. Performance targets

2. Indicator	Objective new target set 24/25	CHFT Year to date performance	Actions/Comments
C.difficile (HOHA & COHA)	57	26	16 HOHA 10 COHA (11 COCA) (Q1 HOHA 2 April 2May 4June =8)
E. coli bacteraemia	70	35	18 HOHA 17 COHA (116 COCA)
Pseudomonas aeruginosa	5	2	2 HOHA 0 COHA (4 COCA)
Klebsiella spp.	37	13	8 HOHA 5 COHA (25 COCA)
MRSA bacteraemia	No target set	3	Not mentioned on this year's targets continue to be monitored by IPC team. 1 HOHA 2 COHA (1 COCA)
MSSA	No target set	12	Not mentioned on this year's targets continue to be monitored by IPC team. 6 HOHA 7 COHA (29 COCA)
ANTT Trust overall competency assessments	90%	90.15 %	
ANTT Competency assessments (medical staff)	90%	77.54%	Decreased compliance, despite assessing all New to the trust Medical staff.
ANTT Competency assessments (nursing and AHP)	90%	93.39%	Increased compliance on last year.
Hand hygiene	95%	100%	Audit process renewed in 24/25
Level 2 IPC Training Trust overall		89.39%	Decreased compliance
Level 2 IPC training (Medical staff)	90%	66.10%	Decreased compliance on last year
Level 2 IPC training (nursing and AHP)	90%	93.83%	Increased compliance on last year.

HOHA = hospital onset, healthcare associated: COHA = community onset, healthcare associated COCA = Community-onset, community associated

3. Quality Indicators

MRSA screening (emergency)	95%	92.07%	Increased 5.8% on last year
Isolation breaches	Non set	Not recorded this quarter	COVID-19 patients remain priority for side room isolation

4. MRSA bacteraemia:

No objective for MRSA cases set in year. **1 HOHA** and **2 COCA** case to report during the current year.

5. MSSA bacteraemia:

There is no objective set for MSSA. 6 HOHA and 7 COHA cases in the year. The IPC team continue to review these cases.

6. Clostridium difficile:

The objective for 2024/25 57 cases,
There are a total of 26 cases year to date: 16 HOHA cases and 10 COHA cases

7. E. coli bacteraemia:

Objective 24/25 target 70 cases: **18 HOHA cases and 17 COHA year** to date. The Trust is participating in regional improvement work in relation to gram negative bacteraemia.

8. Pseudomonas aeruginosa:

Objective 24/25 target 5 cases: **2 HOHA cases 0 COHA**

9. Klebsiella spp.:

Objective 24/25 target 37 cases: **8 HOHA cases 5 COHA**

Outbreaks & Incidents:

Areas closed due to outbreaks in Q2: The IPC team have monitored and advised on outbreaks throughout the quarter. All outbreak areas were monitored by the IPC team for staff compliance, patient symptoms, positive results and reopened at the earliest safe opportunity. ALL areas remained open to visitors with advisory signage in place at entrances.

HRI wards	CRH wards
	27.09.24 6C Covid 19 ward closed
27.08.24 H6 restricted VGE	
24.09.24 H21B Covid 19 ward closed	

Increased incidence Covid-19: the Government guidance now asks that covid is managed in line with other known respiratory illnesses: where there has been an increase in Covid19 cases recorded mitigations have been put in place: including mask use.

Outbreaks have been recorded where 2 or more positive cases related to time and place.

Audits

IPC BAF: the self-assessment framework is continually reviewed, and a revised version has recently been adopted this is an ongoing review.

Quality Improvement Audits: QI audits are on an 18-month rolling programme and continued to be completed in this reporting period, these are dependent on a whole team approach to go ahead due to Dr's Strikes there have been some which are delayed but have been re arranged and will be completed within the next quarter.

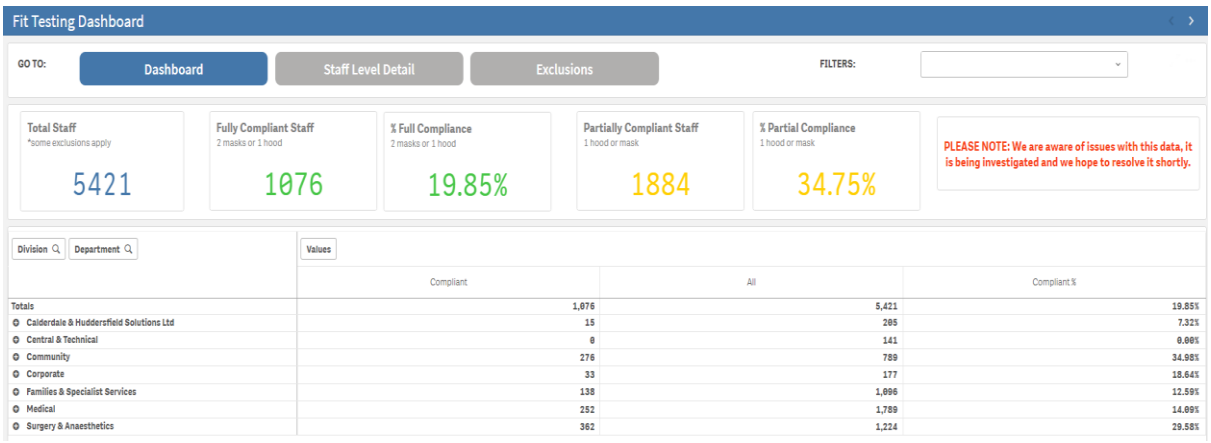
FLO (Front Line Ownership) audits: These are carried out by clinical areas to confirm compliance with set elements of staff and patient safety indicators, teams identify where good practice and areas where standards need improving. These audits are ongoing across all clinical areas The acute ward environment version has now been updated to a new format which now feeds into KP+.

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

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

Audit frequency depends on the functional category of an area. The higher the risk, the higher the score to be achieved and the more frequent the audits. Areas are issued a star rating. This has now also rolled out into community bases.

Fit testing: Data can now be seen on KP+ and drilled down to compliance for 1mask or hood **or** for 2 masks or 1 hood, this will help ward managers raise compliance across the Trust, in line with national guidance. The respiratory support worker within the IPC team continues to support this agenda across the Trust and is currently working to cleanse the data and work with divisions to support frontline staff and has seen good improvements within some areas.



11. Recommendations

The Committee is asked to note the performance against key IPC targets and in particular to note the training figures for Medical staff against both ANTT and Level 2 IPC training and approve the report.

14. Workforce Committee Chair Highlight Report – 17 October 2024

To Note

Presented by Jo-Anne Wass

Calderdale and Huddersfield NHS Foundation Trust

CHAIR'S HIGHLIGHT REPORT
to the Board of Directors

Committee Name:	Workforce Committee
Committee Chair:	Jo-Anne Wass, Non-Executive Director
Date(s) of meeting:	Thursday 17 October 2024
Date of Board meeting this report is to be presented:	Thursday 7 November 2024
ACKNOWLEDGE	At each committee meeting, we concentrate on one of the themes from the Trust's People Strategy. This meeting was looking in detail at **workforce design** -- both at the Trust-wide strategies in place to support workforce design, and how these are being applied within specific projects. We were pleased to note the following positive achievements: **Community Diagnostic Centres (CDCs):** The committee was joined by Sarah Clenton (Deputy Director of Operations, Families and Specialist Services division), who delivered an impressive presentation on the workforce planning and design underpinning the new CDCs. It was obvious that a great deal of thought and planning had gone into the design of the patient pathway and the roles needed to support it. This has resulted in a structure which maximises recruitment opportunities by creating interesting jobs and providing career pathways for colleagues. This work has supported the successful opening of the Halifax CDC. Most **workforce metrics** continue to hit or exceed targets (data presented was from the end of August 2024). Notably: • Our **sickness absence** rate is the lowest of all acute trusts across West Yorkshire. It was 4.21% in month. The rolling 12-month rate is 4.73%. • Apprenticeship Levy spend continues to improve, an increase of 7.5% on 23/24 is predicted during 24/25, this equates to £1.508 million. • The Trust has recently recruited an additional 24 new healthcare support worker apprentices, who started in September 2024, with the next cohort due to start in November.

ASSURE	The committee received the following assurances in line with its terms of reference: • **Workforce design tool:** members of the workforce and OD team presented an interactive 'how to' guide which identifies six practical steps to workforce design, aimed at supporting leaders and managers in their change activity. The guide was developed through a series of 'sprint' sessions (short, focussed meetings held on a regular basis to work through an issue to deliver an outcome). The tool captures the Trust's improvement methodology, Work Together to Get Results, and presents this alongside other methodologies that can help managers and leaders. The tool is comprehensive and brings a whole host of useful information together into one place for ease of access. • The committee were joined by Mark Davies (project lead for the new CRH clinical build) and Ria Green (workforce reconfiguration lead); and Jules Hoole (non-surgical oncology programme director) to talk us through their own **workforce design challenges**. There were themes in common between these two presentations, and indeed between these and the earlier one delivered by Sarah Clenton – eg all involved proactively engaging colleagues in service redesign; the mapping of patient pathways against competencies; creative and innovative design of new roles; ensuring colleagues are supported to achieve the full potential of their roles and levels of ability; providing opportunities for career growth; the importance of strong partnerships with local colleges and universities; supporting pathways with appropriate technology. • This provided us with assurance that Trust wide tools and support and local change activity are aligned and mutually reinforcing. • We received a detailed **vacancy report** highlighting hotspot areas, where recruitment is difficult, often due to national workforce shortages. We were able to triangulate this with discussions at the quality committee, held earlier in the week, and specifically probed plans to improve recruitment in stroke services and for speech and language therapists. • **Turnover continues to reduce** and stands at 6.54%. All divisions and staff groups are now under a rolling average of 10%. • **Bank usage** is tracking against the planned rate of reduction. • **Agency usage** has dropped faster and further than forecast. • **Overall Essential Safety Training compliance is 93.1%.** The Trust's target is 90%.

AWARE	The Committee: • Discussed the **new government's plans** to make changes to employment legislation – for example, the right to claim unfair dismissal from day one of employment and new probationary arrangements – and how these and other changes might impact on the Trust as a large employer. • Considered **Board Assurance Framework risk 1/24.** This is a new risk (bringing together two previous ones) which demonstrates the link between the actions of managers and leaders and our ability to recruit and retain colleagues. **The committee accepted the recommendation that this risk score be set at 12.** Although turnover and vacancies are relatively low at the moment, compared to historical trends, some gaps in controls had been identified. • Was informed that colleague **appraisals** for 2024-25 were due to be completed by the end of September with a 90% season end target. In August 2024, only 46.6% had been completed and this target is therefore likely to be missed. • Discussed at some length the results of the **2024 GMS National Training Survey** for doctors in training. The committee was concerned to see that results have been deteriorating over recent years to the extent that the Trust is now ranked 222 out of 229 Trusts nationally. Members of the medical education team, who attended the committee, presented the survey results and an action plan. The committee welcomed the honest appraisal of team members; encouraged them to ensure they had real clarity on the root causes of the deterioration; to engage doctors in training in identifying and testing solutions; and to seek support from the Deanery as appropriate. The committee asked the team to return with progress reports against the action plan at the next two committee meetings (December and February) as the next survey is in March 2025. • Asked for an annual presentation, bringing together in summary form the **experience of all students** undertaking clinical placements at the Trust. As our potential future workforce, we are interested in hearing and acting on their feedback. • **Noted that vacancies are up slightly**, at 7.87 per cent. This is due to current cost control measures. Headcount and full time equivalent (FTE) are also down.
ONE CULTURE OF CARE	One Culture of Care is considered as part of the workforce reports and in discussions.

15. Finance and Performance Chair Highlight Report – 1 October 2024

To Note

Presented by Vanessa Perrott

Calderdale and Huddersfield NHS Foundation Trust

CHAIR'S HIGHLIGHT REPORT
to the Board of Directors

Committee Name:	Finance and Performance Committee
Committee Chair:	Vanessa Perrott, Non-Executive Director
Date of meeting:	1 October 2024
Date of Board meeting this report is to be presented:	7 November 2024
ACKNOWLEDGE	**PERFORMANCE** • Continued good performance in elective recovery and most cancer targets, and Diagnostics remains high (>90%). • Outpatient follow-up backlog has several specialty specific actions in place whilst first attendances have a low DNA rate (<6%). • Percentage of complaints closed within agreed timescales has improved (common variance). • Proportion of urgent community responses has improved and achieved the target for a 2-hour response. • Rate of inpatient falls is lowest recorded since September 2022; Turnover and sickness absence are the lowest rates seen for more than 3 years; Maternal mortality remains a special cause for improvement with no maternal deaths since December 2022. **FINANCE MONTH 5** Year to date, the Trust is reporting a deficit position of £14.01m, £0.35m adverse to plan. • Agency spend remains below plan • Elective recovery activity to plan remains above the plan, however the funding value attached to this is lower than originally assumed.
ASSURE	At our October meeting we: • Did a deep dive into Stroke performance. Stroke is a quality priority - % of stroke patients admitted directly to an acute stroke unit within 4 hours of hospital admission, currently failing the target of 90% (40%). Some areas of improvement within this (CT scan and discharge). Challenges include: workforce vacancies in medical and Speech and Language Therapy; available beds for stroke admission and care; and differences between the 2 sites. There is ongoing work to address these. This will be presented again at the Finance and Performance Committee in around 6 months' time. • Financial status against the plan for a £26.26m deficit was discussed. • The in-month position is a deficit of £1.87m, £0.05m adverse to plan. The Trust is forecasting to deliver the planned £26.26m deficit, but the 'likely case' scenario suggests a gap of £5.35m. • We reviewed the actions against the recommendations and financial improvement opportunities made following the report

	commissioned by PWC and will see further reporting on progress with this in January. • We reviewed and accepted the updated position on those Board Assurance Framework risks which the Committee has oversight over. It was agreed that due to improved performance the BAF risk 4/23 in relation to failure to achieve national and local performance targets would be removed.
AWARE	**PERFORMANCE** • There are some areas which remain a special cause for concern. Some relate to the significant operational pressures experienced at present (e.g. proportion of ambulances waiting more than 30 minutes). Virtual ward occupancy has deteriorated (65% against 80% target) and summary hospital-level mortality indicator (SHMI) remains an outlier. • The 3 quality priorities of Care of the acutely ill patient, personalisation of care (screening for dementia) and Stroke were all failing their targets. However, personalisation of care has been shown statistically to be an area of special cause for improvement. **FINANCE** • Cost improvement programme (CIP) target is now £32.18m (£30m new schemes plus £2.18m Full Year Effect of 2023/24 schemes). Year to date, the CIP has delivered slightly lower improvements than planned (£0.09m). The CIP challenge will increase as the year progresses due to its weighted plan but nearly all the CIP has been identified. • CHFT is to receive £25m of the total £50m given to the West Yorkshire Association of Acute Trusts (WYAAT) following the submission of the cash support plan. This is non-recurrent funding and does not alter the financial challenge. Based on this additional cash support is provided and CHFT does not intend to submit any further cash support drawdown requests in the remainder of this financial year.
ONE CULTURE OF CARE	One Culture of Care considered as part of the performance and finance reports.

CHAIR'S HIGHLIGHT REPORT
to the Board of Directors

Committee Name:	Finance and Performance Committee
Committee Chair:	Vanessa Perrott, Non-Executive Director
Date(s) of meeting:	29 October 2024
Date of Board meeting this report is to be presented:	7 November
ACKNOWLEDGE	**PERFORMANCE** • Continued good performance in Elective recovery and Diagnostics (achieving 95% target for second time in 3 months) • Rate of inpatient falls sustained as very low and is lowest recorded since September 2022 • Percentage of complaints closed within agreed timescales has improved (91% vs 95% target) • Capped Theatre Utilisation has been recognised as the best performance in WYAAT just below the 85% target. • Maternal mortality remains a special cause for improvement with no maternal deaths since December 2022. **FINANCE MONTH 6** • The Trust is forecasting to deliver the revised financial plan, and year to date the Trust is reporting a deficit of £3.68m, a £0.25m adverse variance to plan. • The Trust deficit position has been significantly improved by receiving a portion of Deficit Support Funding from NHSE to West Yorkshire ICS (£25m). The expectation is that no further Revenue Support Public Dividend Capital will be drawn down.
ASSURE	We had two Deep Dives scheduled in our October meetings: 1. A deep dive into Stroke performance. Stroke is a quality priority, currently failing the target of 90% (40%). Some areas of improvement within this (CT scan and discharge). Challenges include: workforce vacancies in medical and SALT; available beds for stroke admission and care; and differences between the 2 sites. There is ongoing work to address these. This will be presented again to the Committee. 2. A deep dive in the Length of Stay improvement / Pathways 0 – 3. Slides were prepared. Colleagues were unable to attend due to operational pressures (Opel 4). Questions were written and will be addressed within the next meeting (3 December).

	• Out of the CIP target of £32.18m only 0.08m is unidentified. Planning is underway to identify CIP for next year and the aspiration is to increase the percentage of schemes which deliver recurrent savings (55% of schemes in this financial year are recurrent). • The Trust is forecasting to deliver the (revised) planned £1.26m deficit, but the 'likely case' scenario suggests a gap of £4.92m due to: potential pay award pressures, potential pressures on Advice and Guidance and increased bed capacity needs. • The Huddersfield Pharmacy Specials (HPS) Annual report which included a number of financial and operational performance improvements was noted. • £8.8m of capital investment in areas of greatest need in the Trust has been approved and will be brought forward from 2025/26 into the current year to manage the capital resource available.
AWARE	**PERFORMANCE** • The 3 quality priorities of Care of the acutely ill patient, personalisation of care (screening for dementia) and Stroke are all failing their targets. However, there have been some improvements in % of patients screened with dementia; and improved percentage of patients admitted directly to a stroke unit within 4 hours. • Operational pressures remain high. Emergency Department (ED) performance reduced to 69% in September with a further increase in bed occupancy and length of stay for pathway 0 patients. The number of patients waiting over 12 hours in ED increased and proportion of ambulance arrivals delayed over 30 minutes has increased. **FINANCE** • Financial status against the revised deficit plan from £26.26m to £1.26 m light of the £25 m received was discussed. This is non recurrent cash funding which reduces the amount of borrowing required by the Trust but does not materially alter the financial plan. • The key focus for the Trust continues to be delivery of the plan for this year, whilst planning is underway for next year.

16. Month 6 Financial Summary

To Note

Presented by Gary Boothby

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Date of Meeting:	7 November 2024
Meeting:	Public Board of Directors
Title:	Month 6 Finance Report
Author:	Kirsty Archer - Deputy Director of Finance
Sponsoring Director:	Gary Boothby - Director of Finance
Previous Forums:	Finance & Performance Committee
Purpose of the Report	The purpose of this report is to provide a summary of the financial position as reported at the end of Month 6 (September 2024)
Key Points to Note	**Year To Date Summary** The Trust is reporting a year to date deficit position £3.68m, (excluding the impact of Donated Assets, Impairments and the PFI remeasurement due to IFRS16), a £0.25m adverse variance to plan. The in-month position is a surplus of £10.33m, a £0.10m positive variance. The year to date and forecast deficit position have been significantly improved by the agreed distribution of £50m of Deficit Support Funding from NHSE to West Yorkshire ICS. It has been agreed that CHFT will receive £25m of this funding in the full year and the year to date proportion of this has been recognised at Month 6 (pending final confirmation on timing). The main reason for this distribution is to support organisations with a cash shortfall. This is a non-recurrent allocation. The key focus for the Trust continues to be delivery in line with plan (now revised for this allocation). **Key Variances** • Income is £1.10m lower than planned due to: lower than planned Elective Recovery / Advice and Guidance income of £1.22m, lower than planned Depreciation funding £0.89m (matched to lower than planned Depreciation cost) and slippage on the implementation of Community Diagnostic Centres (CDCs £1.75m), offset to some extent by higher than planned commercial income from both Huddersfield Pharmacy Specials (HPS) and Research and Development. • Pay costs are in line with the planned level year to date with compensating variances due to slippage on the implementation of CDCs (£0.65m offset by lower than planned income), higher than planned vacancies (vacancy freeze and midwifery vacancies) and lower than

	planned Elective Recovery costs. These underspends were offset to some extent by the impact of Strike action in June / July, a cost of £0.45m. • Non-pay operating expenditure is £0.73m higher than planned year to date including non-recurrent legal costs (£0.91m) and higher than planned Independent Sector spend for Elective Recovery. **Forecast** The Trust is forecasting to deliver the (revised) planned £1.26m deficit, but the 'likely case' scenario suggests a gap of £4.92m due to: potential pay award pressures, potential pressures on Advice and Guidance and increased bed capacity needs. Of the £32.18m CIP target for the year, £0.65m is not yet fully identified, (scoping or unidentified). Attached: Month 6 Finance Report
Regulation	Regulation 13: Financial position
EQIA – Equality Impact Assessment	The attached paper is for information only. Where this information is used to inform changes to services, policies or procedures, an Equality Impact Assessment will first be completed to assess the effects that it is likely to have on people from different protected groups, as defined in the Equality Act 2010.
Recommendation	The Board is asked to **RECEIVE** the Finance Report and note the financial position for the Trust as at the end of September 2024.

EXECUTIVE SUMMARY: Total Group Financial Overview as at 30th Sep 2024 - Month 6

KEY METRICS

	M6				YTD (SEP 2024)				Forecast 24/25			
	Plan	Actual	Var		Plan	Actual	Var		Plan	Forecast	Var	
	£m	£m	£m		£m	£m	£m		£m	£m	£m	
I&E: Surplus / (Deficit)	£10.23	£10.33	£0.10		(£3.43)	(£3.68)	(£0.25)		(£1.26)	(£1.26)	(£0.00)	
Agency Expenditure (vs Plan)	(£0.76)	(£0.45)	£0.30		(£4.54)	(£3.58)	£0.95		(£9.07)	(£5.92)	£3.15	
Capital	£4.14	£2.62	£1.52		£20.09	£12.80	£7.29		£54.58	£57.38	(£2.80)	
Cash	£19.53	£30.38	£10.85		£19.53	£30.38	£10.85		£10.78	£18.76	£7.98	
Invoices paid within 30 days (%) (Better Payment Practice Code)	95.0%	93.7%	-1%		95.0%	92.5%	-3%					
Cost Improvement Plans (CIP)	£2.77	£3.53	£0.76		£12.62	£13.30	£0.68		£32.18	£32.18	(£0.00)	
Use of Resource Metric	2	2			3	3			2	2		

Year To Date Summary

The Trust is reporting a year to date deficit position £3.68m, (excluding the impact of Donated Assets, Impairments and the PFI remeasurement due to IFRS16), a £0.25m adverse variance to plan. The in-month position is a surplus of £10.33m, a £0.10m positive variance.

- The year to date and forecast deficit position have been significantly improved by the agreed distribution of £50m of Deficit Support Funding from NHSE to West Yorkshire ICS. It has been agreed that CHFT will receive £25m of this funding in the full year and the year to date proportion of this has been recognised at Month 6 (pending final confirmation on timing). The main reason for this distribution is to support organisations with a cash shortfall. This is a non-recurrent allocation. The key focus for the Trust continues to be delivery in line with plan (now revised for this allocation).
- Delivery of planned care activity in Month 6 was above plan. Challenges remain with the national measurement of Advice and Guidance performance which are being worked through with the regional and national team to minimise the adverse income impact as far as possible.
- £13.30m of CIP delivered at Month 6, £0.68m higher than planned.
- Bed capacity continues to drive an expenditure pressure of c.£0.9m. This has been largely offset by mitigations including higher bank interest and lower agency staffing costs and over delivery of CIP year to date. The industrial action direct costs of £0.45m in the year to date position will be partially covered by £0.38m of funding to be received in October.
- The Trust is forecasting to deliver the revised planned £1.26m deficit (£26.26m original plan adjusted for £25m Deficit Support), but the 'likely case' scenario suggests a gap of £4.9 due to: bed capacity pressures, potential Advice and Guidance funding shortfall and an emerging risk on a pay award funding shortfall.

Key Variances

- Income is £1.10m lower than planned due to: lower than planned Elective Recovery / Advice and Guidance income of £1.22m, lower than planned Depreciation funding £0.89m (matched to lower than planned Depreciation cost) and slippage on the implementation of Community Diagnostic Centres (CDCs £1.75m), offset to some extent by higher than planned commercial income from both Huddersfield Pharmacy Specials (HPS) and Research and Development.
- Pay costs are in line with the planned level year to date with compensating variances due to slippage on the implementation of CDCs (£0.65m offset by lower than planned income), higher than planned vacancies (vacancy freeze and midwifery vacancies) and lower than planned Elective Recovery costs. These underspends were offset to some extent by the impact of Strike action in June / July, a cost of £0.45m.
- Non-pay operating expenditure is £0.73m higher than planned year to date including non-recurrent legal costs (£0.91m) and higher than planned Independent Sector spend for Elective Recovery.

Forecast

The Trust is forecasting to deliver the (revised) planned £1.26m deficit, but the 'likely case' scenario suggests a gap of £4.92m due to: potential pay award pressures, potential pressures on Advice and Guidance and increased bed capacity needs.

Of the £32.18m CIP target for the year, £0.65m is not yet fully identified, (scoping or unidentified).

Total Group Financial Overview as at 30th Sep 2024 - Month 6

INCOME AND EXPENDITURE COMPARED TO PLAN SUBMITTED TO NHS ENGLAND

YEAR TO DATE POSITION: M6

CLINICAL ACTIVITY

	M6 Plan	M6 Actual	Var
Elective	2,060	2,119	59
Non-Elective	19,164	21,788	2,624
Daycase	24,469	26,163	1,694
Outpatient	224,102	226,012	1,910
A&E	88,472	93,052	4,580
Other NHS Non-Tariff	1,196,109	1,151,405	(44,704)
Total	**1,554,376**	**1,520,538**	**(33,837)**

TOTAL GROUP: INCOME AND EXPENDITURE

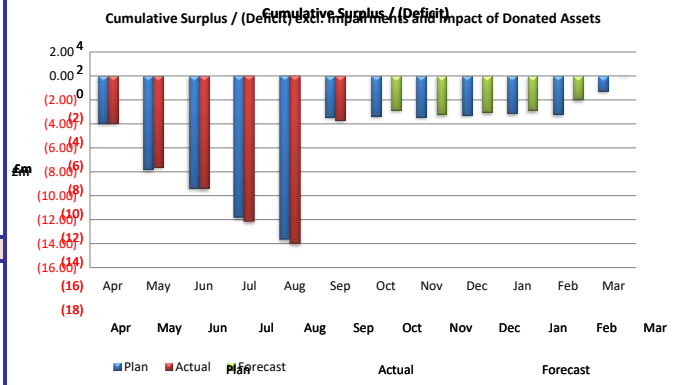
	M6 Plan	M6 Actual	Var
	£m	£m	£m
Elective	£8.67	£8.80	£0.13
Non Elective	£59.93	£63.57	£3.65
Daycase	£18.15	£19.80	£1.65
Outpatients	£24.16	£24.54	£0.38
A & E	£16.68	£17.43	£0.75
Other-NHS Clinical	£134.33	£122.83	(£11.50)
CQUIN	£0.00	£0.00	£0.00
Other Income	£28.25	£32.08	£3.83
Total Income	**£290.16**	**£289.06**	**(£1.10)**
Pay	(£183.74)	(£183.71)	£0.03
Drug Costs	(£24.95)	(£24.19)	£0.76
Clinical Support	(£19.53)	(£19.35)	£0.19
Other Costs	(£36.07)	(£37.48)	(£1.41)
PFI Costs	(£8.68)	(£8.63)	£0.05
Total Expenditure	**(£272.97)**	**(£273.36)**	**(£0.39)**
EBITDA	**£17.19**	**£15.69**	**(£1.50)**
Non Operating Expenditure	(£20.62)	(£19.38)	£1.24
Surplus / (Deficit) Adjusted*	**(£3.43)**	**(£3.68)**	**(£0.25)**

* Adjusted to exclude items excluded for assessment of System financial performance: Donated Asset Income, Donated Asset Depreciation, Donated equipment and consumables (PPE), Revaluations and Impairments & PFI remeasurement

DIVISIONS: INCOME AND EXPENDITURE

	M6 Plan	M6 Actual	Var
	£m	£m	£m
Surgery & Anaesthetics	(£53.06)	(£52.62)	£0.45
Medical	(£72.71)	(£74.33)	(£1.62)
Families & Specialist Services	(£48.69)	(£47.56)	£1.14
Community	(£17.39)	(£16.86)	£0.53
Estates & Facilities	£0.00	£0.00	£0.00
Corporate	(£29.87)	(£29.21)	£0.66
THIS	£0.64	£0.96	£0.32
PMU	£1.27	£1.70	£0.44
CHS LTD	£0.56	£0.61	£0.05
Central Inc/Technical Accounts	£216.76	£213.59	(£3.17)
Reserves	(£1.38)	£0.03	£1.41
Surplus / (Deficit)	**(£3.89)**	**(£3.68)**	**£0.21**

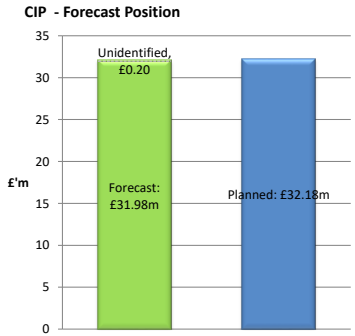
TOTAL GROUP SURPLUS / (DEFICIT)

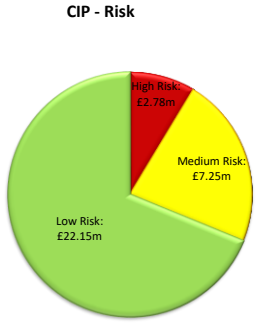


KEY METRICS

	Year To Date			Year End: Forecast		
	M6 Plan	M6 Actual	Var	Plan	Forecast	Var
	£m	£m	£m	£m	£m	£m
I&E: Surplus / (Deficit)	(£3.43)	(£3.68)	(£0.25)	(£1.26)	(£1.26)	(£0.00)
Capital	£20.09	£12.80	£7.29	£54.58	£57.38	(£2.80)
Cash	£19.53	£30.38	£10.85	£10.78	£18.76	£7.98
Invoices Paid within 30 days (BPPC)	95%	92%	-3%			
CIP	£12.62	£13.30	£0.68	£32.18	£32.18	(£0.00)
	Plan	Actual		Plan	Forecast	
Use of Resource Metric	3	3		2	2	

COST IMPROVEMENT PROGRAMME (CIP)





YEAR END 24/25

CLINICAL ACTIVITY

	Plan	Actual	Var
Elective	4,170	4,316	146
Non-Elective	38,535	43,860	5,325
Daycase	49,622	53,273	3,651
Outpatient	452,467	457,251	4,784
A&E	176,460	185,621	9,161
Other NHS Non- Tariff	2,408,522	2,318,790	(89,731)
Total	**3,129,776**	**3,063,111**	**(66,665)**

TOTAL GROUP: INCOME AND EXPENDITURE

	Plan	Actual	Var
	£m	£m	£m
Elective	£17.53	£17.98	£0.45
Non Elective	£119.60	£127.15	£7.55
Daycase	£36.94	£40.51	£3.57
Outpatients	£48.78	£49.72	£0.94
A & E	£33.27	£34.76	£1.49
Other-NHS Clinical	£267.85	£250.21	(£17.63)
CQUIN	£0.00	£0.00	£0.00
Other Income	£56.58	£64.62	£8.04
Total Income	**£580.54**	**£584.95**	**£4.42**
Pay	(£365.09)	(£368.05)	(£2.96)
Drug Costs	(£50.08)	(£48.96)	£1.11
Clinical Support	(£37.73)	(£39.23)	(£1.50)
Other Costs	(£70.25)	(£74.34)	(£4.08)
PFI Costs	(£17.36)	(£17.27)	£0.09
Total Expenditure	**(£540.52)**	**(£547.85)**	**(£7.33)**
EBITDA	**£40.02**	**£37.11**	**(£2.91)**
Non Operating Expenditure	(£41.27)	(£38.36)	£2.91
Surplus / (Deficit) Adjusted*	**(£1.26)**	**(£1.26)**	**(£0.00)**

* Adjusted to exclude all items excluded for assessment of System financial performance: Donated Asset Income, Donated Asset Depreciation, Donated equipment and consumables (PPE), Impairments and Revaluations & PFI remeasurement

DIVISIONS: INCOME AND EXPENDITURE

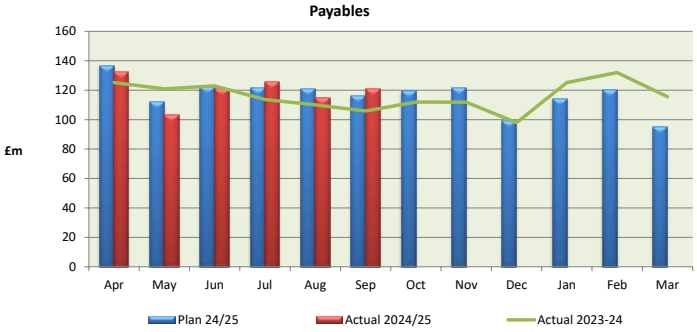
	Plan	Forecast	Var
	£m	£m	£m
Surgery & Anaesthetics	(£105.85)	(£105.54)	£0.31
Medical	(£145.43)	(£147.91)	(£2.48)
Families & Specialist Services	(£96.85)	(£94.55)	£2.30
Community	(£35.08)	(£34.43)	£0.65
Estates & Facilities	£0.00	£0.00	£0.00
Corporate	(£60.21)	(£59.97)	£0.23
THIS	£1.27	£1.42	£0.15
PMU	£2.53	£2.53	£0.00
CHS LTD	£0.70	£0.70	(£0.00)
Central Inc/Technical Accounts	£437.53	£437.52	(£0.00)
Reserves	(£0.89)	£0.29	£1.18
Surplus / (Deficit)	**(£2.28)**	**£0.06**	**£2.33**

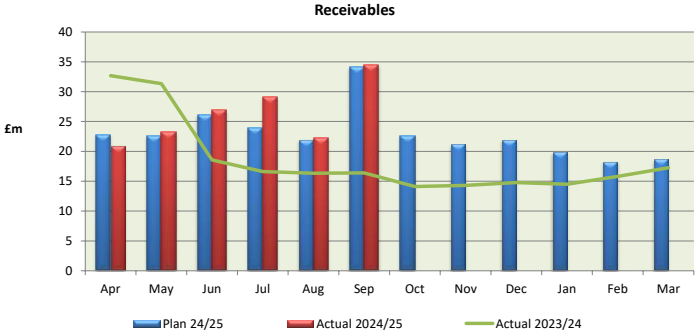
Total Group Financial Overview as at 30th Sep 2024 - Month 6

CAPITAL AND CASH COMPARED TO PLAN SUBMITTED TO NHS IMPROVEMENT

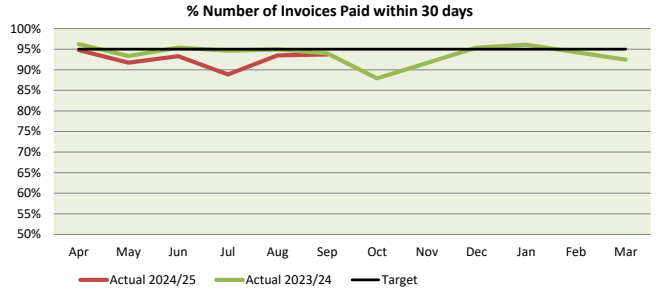
WORKING CAPITAL

	M6 Plan £m	M6 Actual £m	Var £m	M6
Payables (excl. Current Loans)	(£116.24)	(£120.69)	£4.45	
Receivables	£34.21	£34.49	(£0.28)	





BETTER PAYMENT PRACTICE CODE

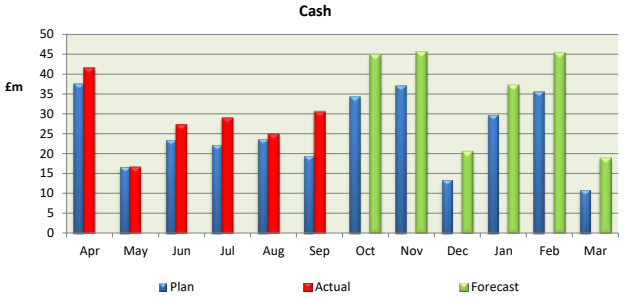


CAPITAL

	M6 Plan £m	M6 Actual £m	Var £m	M6
Capital	£20.09	£12.80	£7.29	

CASH

	M6 Plan £m	M6 Actual £m	Var £m	M6
Cash	£19.53	£30.38	£10.85	
Loans (Cumulative)	£12.15	£12.15	£0.00	



CASH FLOW VARIANCE

SUMMARY YEAR TO DATE

- The Trust is reporting a £3.68m deficit, (excluding the impact of Donated Assets and PFI remeasurement IFRS16), £0.25m adverse variance to plan.
- The Trust incurred additional direct costs of £0.45m in the year to date due to the Junior Doctors Strike. Elective Recovery / Advice and Guidance Funding is £0.99m lower than plan, including c. £0.30m impact of the Industrial Action. These adverse variances have been offset by other mitigations in the year-to-date position including higher than planned commercial income and additional income from interest.
- In 2024/25 the Trust is operating under the National Payment by Results (PBR) funding mechanism for activity within the scope of Elective Recovery.
- Delivery of planned care activity in the year to date is broadly in line with plan.
- Year to Date the Trust has delivered efficiency savings (CIP) of £13.30m, £0.68m higher than planned.
- The Trust has a cash balance of £30.38m, £10.85m higher than planned.
- Capital expenditure is lower than planned at £12.80m against a planned £20.09m.
- NHS Improvement performance metric Use of Resources (UOR) stands at 3, as planned, with 4 out of 5 metrics at the planned level.
- The Trust is forecasting a UOR of 3 as planned.

NOTES

- The Trust is forecasting to deliver the revised planned £1.26m deficit, but the 'likely case' scenario suggests a gap of £4.92m due to: likely slippage on the delivery of efficiencies; potential Elective Recovery Funding loss; and the emerging pay award funding shortfall risk.
- CIP Target is £32.18m (£30m new schemes plus £2.18m Full Year Effect of 23/24 schemes), of which £2.87m is not yet fully identified (scoping or unidentified).
- The Capital forecast is to spend £57.38m, £2.80m more than planned due to confirmation of additional PDC funding for Reconfiguration and additional lease charges
- The Trust is forecasting to end the year with a cash balance of £6.26m, higer than the revised plan and reflects changes in the profiling of the Public Dividend Capital Funding plan / Deficit Support Funding allocation. This includes £2.92m of Capital PDC awarded for 24/25 where the cash payment is expected next year.
- The total loan balance is £12.15m as planned.
- The Trust's reliance on Revenue Support Public Dividend Capital (PDC) was planned at £30.91m for the full year. Year-to-date to August £9.69m had been drawn down under this regime. In September, Deficit Support Funding of £25m has been allocated to the Trust with the expectation that no further Revenue Support Public Dividend Capital will be drawn down.

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

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

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

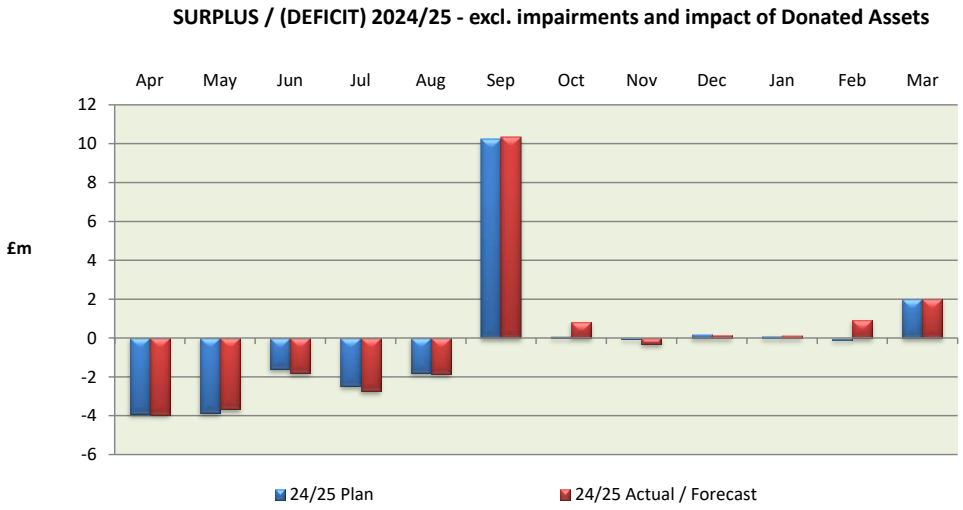
FORECAST 2024/25

24/25 Forecast (31 Mar 25)

Statement of Comprehensive Income	Plan £m	Forecast £m	Var £m	
Income	£580.62	£585.04	£4.42	
Pay expenditure	(£365.09)	(£368.05)	(£2.96)	
Non Pay Expenditure	(£175.43)	(£179.80)	(£4.37)	
Non Operating Costs	(£38.48)	(£45.46)	(£6.99)	
Total Trust Surplus / (Deficit)	**£1.62**	**(£8.27)**	**(£9.90)**	
Deduct impact of:				
Impairments & Revaluations (AME)[1]	£0.00	£9.92	£9.92	
Remeasurement of PFI (IFRS16)[2]	(£3.47)	(£3.49)	(£0.02)	
Donated Asset depreciation	£0.68	£0.68	£0.00	
Donated Asset income (including Covid equipment)	(£0.08)	(£0.08)	£0.00	
Net impact of donated consumables (PPE etc)	£0.00	£0.00	£0.00	
Gain on Disposal	£0.00	£0.00	£0.00	
Adjusted Financial Performance	**(£1.26)**	**(£1.25)**	**£0.00**	

Notes:
1. AME - Annually Managed Expenditure - spend that is unpredictable and not easily controlled by departments
2. Adjustment also removes the benefit of a reduction in PDC Dividend due to the PFI remeasurement

MONTHLY SURPLUS / (DEFICIT)



The Trust's submitted a revised plan for a £26.26m deficit, reflecting an improvement of £12.3m from the earlier plan submission: £5m stretch CIP target; £5.6m additional ICS funding allocation; and £1.7m additional funding to support the pressure arising from the PFI remeasurement (technical adjustment). Budgets were realigned in M3 to reflect this revised plan.

In September, the Trust has been allocated £25m of Deficit Support Funding from NHSE on agreement that the annual plan is revised to a deficit of £1.26m. This is a non-recurrent allocation given to the Trust to support a cash shortfall. The key focus for the Trust is to deliver in line with the plan now revisied for the allocation.

The Trust is forecasting to deliver the planned £1.26m deficit, but the 'likely case' scenario suggests a gap of £4.92m due to: likely slippage on the delivery of efficiencies; potential Elective Recovery / Advice and Guidance Funding loss; the emerging pressure on a shortfall of pay award funding; high cost drugs and bed capacity pressures.

17. Audit and Risk Committee Chair Highlight Report – 22 October 2024 - Health and Safety Annual Report

To Note

Presented by Nigel Broadbent

Calderdale and Huddersfield NHS Foundation Trust

CHAIR'S HIGHLIGHT REPORT
to the Board of Directors

Committee Name:	Audit and Risk Committee (ARC)
Committee Chair:	Nigel Broadbent, Non-Executive Director
Date of meeting:	22 October 2024
Date of Board meeting this report is to be presented:	7 November 2024
ACKNOWLEDGE	• 7 internal audit reports have been finalised for 2024/25 and only one of these had resulted in a limited assurance opinion. The benchmarking provided by Audit Yorkshire (AY) suggested that CHFT had a below average proportion of limited assurance reports last year relative to other AY clients. • There have been 127 recommendations resulting for internal audit reports over the last 12 months and only one was currently overdue. The Committee noted however that there were 20 recommendations with revised target dates. • AY have implemented a new process for verifying that recommendations have been implemented and the sample that they have tested showed all to be complete.
ASSURE	• The Committee received an update on progress with the actions being taken following the internal audit of Naso Gastric tube processes. The follow up audit on this had also received a limited assurance opinion but the Committee received assurances about the new actions which had been implemented and that ongoing monitoring would be continued through the nutrition and hydration group and the Quality Committee. • Deep dives were also undertaken by the Committee on risk management and cyber security. Risk management had previously received a limited assurance audit report, but the Committee was provided with a progress update with actions on the outstanding recommendations including the review of risks and timelines for further progress. In particular it was noted that the transfer over to the new Inphase system would be complete by March 2025. • The deep dive on cyber security was undertaken to provide an update on the cyber security arrangements in place within the organisation but also to consider how we obtain assurance about the cyber security arrangements of third-party suppliers. The Committee was provided with information about the controls in place and assured that

	further investment had been agreed to upgrade the backup facilities as one of the mitigation measures. • The second update of the Board Assurance Framework (BAF) was approved by the Committee which included the removal of three risks which are now at their target score (partnership governance, impact as an anchor organisation and national and local performance targets) and the merging of two recruitment and retention risks into a new risk around the upskilling of managers. AY had provided a benchmarking report which showed that CHFT has more risks (22 risks) on their BAF than other clients and that Department of Health recommends that Trusts should concentrate on between 6 and 12 key risks. The Committee agreed that it would consider this recommendation, but the current coverage of the Trust BAF was appropriate at this stage for the organisation. • The Committee approved the update of the Conflicts of Interests and Business Conduct Policy and the updated Counter Fraud Policy. A progress report was also considered on the counter fraud plan including an update on the investigations which had been carried out and information on criminal investigation processes and the fraud risk assessment. • The Committee received and noted the annual Health and Safety Security report for 2023/24. The content of the annual report will be reviewed in advance of the 2024/25 report to give it a more strategic focus and to incorporate some key performance indicators (KPIs). There was some discussion about attendance at role specific training (e.g. moving and handling and medical devices) and how to balance the need to improve attendance at training sessions against the operational pressures which exist. The Committee also considered whether Mental Health should also be included within this annual report. • Of the 20 internal audit recommendations which have missed their original target date but not their revised target date, 8 of these relate to the consultant job planning audit. The Committee agreed to review progress against the outstanding recommendations on consultant job planning at the next meeting in January and consider whether to ask the responsible officer or audit sponsor to attend the Committee to provide assurances about implementation of the recommendations.

AWARE	• The Committee approved the updated terms of reference for the Risk and Compliance Group. • The Committee received a report from AY about how the Audit Committees in other Trusts use the annual reports from Committees to triangulate information and assurances across the organisation, including the use of the reviews of effectiveness of each committee. One Trust undertakes the effectiveness reviews in a more interactive and discussive way and the Committee agreed that it would look at this approach in more detail for consideration at a future meeting of the Audit & Risk Committee.
ONE CULTURE OF CARE	• The Committee thanked everyone involved in the deep dive discussions at the meeting.

Date of Meeting:	7 November 2024
Meeting:	Board of Directors
Title:	Health, Safety and Security Annual Report – 1 April 2023-31 March 2024
Authors:	Richard Hill – Head of Health, Safety and Security Gemma Berriman – Director of Ops for Resilience, Acute Flow and Transformation
Sponsoring Director:	Jonathan Hammond – Chief Operating Officer and Accountable Emergency Officer
Previous Forums:	Resilience and Safety Group – 22 October 2024 Audit and Risk Committee – 22 October 2024
Purpose of the Report	The purpose of this report is to provide the Board with an update of the key areas of security, health and safety compliance across Calderdale and Huddersfield NHS Foundation Trust during the fiscal year 2023/24. This report provides a description of the requirements of legislation which the Trust must meet and highlights how these are being achieved.
Key Points to Note	This report provides an analysis of the Health, Safety and Security compliance across the Trust between April 2023 to March 2024. It is benchmarked against the Health and Safety at Work Act 1974, which is the overarching legislation describing what is required to meet Health, Safety and Security law. The Act is supported by regulations that are listed below (1-7). 1. Management of Health and Safety at Work Regulations. 2. Manual Handling Operations Regulations. 3. Display Screen Equipment Regulations. 4. Provision and Use of Work Equipment Regulations (Medical Equipment). 5. Health and Safety (Sharps Instruments in Healthcare) Regulations. 6. Control of Substances Hazardous to Health Regulations. 7. Artificial Optical Radiation Regulations. Further down this report, the reader will see a description of each regulation and an insight into how CHFT is meeting compliance.

	This report will also contain key information regarding the below areas (8-14). 8. The Health Informatics Service (THIS) 9. Huddersfield Pharmacy Specials (HPS) 10. Governance 11. The Prevention and Management of Violence and Aggression 12. Security Information and Instruction 13. Community Hubs 14. Enforcement Action and Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR's **<u>Next Steps</u>** The next steps are to continue putting in measures across 2024/2025 with special attention given to the prevention and management of violence and aggression training to colleagues, a de-escalation of sharps injuries, an improvement of compliance towards moving and handling training and medical equipment training.
EQIA – Equality Impact Assessment	Health, Safety and Security are key Trust priorities to support the safety and security of staff, patients, visitors, and property. The delivery of high standards of Health, Safety and Security ensures staff safety and organisational resilience. Health, Safety and Security Standards aims to implement measures that meet the diverse needs of our service, population and workforce ensuring that none are placed at a disadvantage over others. We therefore aim to ensure that in both employment and services no individual is discriminated against by reason of their gender race, disability, age, sexual orientation, religion or religious/philosophical belief or marital status.
Recommendation	The Board is is asked to **RECEIVE** and **NOTE** the Health, Safety and Security Annual Report for 2023/2024.

Introduction

This report is a description of the work completed across the 12-month period of this report to ensure security, health and safety compliance is demonstrated and a safe environment continues to be provided for colleagues and patients. There are several pieces of legislation which help CHFT meets health and safety legislation and these are explained within the body of this report, and this is complimented by the NHS Workplace Health and Safety Standards which the Trust continues to use.

1. Management of Health and Safety at Work Regulations

This piece of legislation is about ensuring there are workplace risk assessments in place for the wards and departments and these have now been done and available for colleagues to read from the intranet and are held on the health and safety management pages. The aim of the risk assessments is to identify the significant risks of harm to individuals from the working environmental conditions and describe the measures which help eliminate or reduce the possibility of harm. The structure of the risk assessments follows the structure and content required by the Health and Safety Executive which provides confidence they are written in a style that meets expectations. To make sure the measures continue to be effective, regular meetings across the year take place between the Head of Security, Health and Safety and the estates and facilities team because they are responsible for many of the measures that are contained in the risk assessments e.g. legionella, asbestos, electrical, gas, etc. Table 1 below provides the reader with an insight into the type of meetings which take place across the year between the Head of Security, Health and Safety and the estates and facilities team and these are facilitated by the Performance and Contracts Manager.

Table 1 – this table shows the types of meetings across the year between the Head of Security, Health and Safety and the estates and facilities team.

Name of Meeting	Frequency of meetings in 2023/2024
HTM Ventilation Group Meeting	Annual Meeting
HTM Asbestos Management Meeting	Annual Meeting
HTM Water Quality Meeting	Annual Meeting
HTM Electrical Safety Meeting	Annual Meeting

The table above shows the frequency of meetings that have taken place across the year and each forms part of the healthcare technical memorandum requirements (HTM). The healthcare technical memorandums are interpretations by the NHS of the law.

Another part of Management of Health and Safety at Work Regulations is about making sure that volunteers and students from the schools/colleges seeking work experience have received a health and safety induction. Any harm to colleagues is of equal importance but there is a level of special importance given to students and volunteers and the Health and Safety Executive expect a higher level of attention.

Over the last year the Head of Security, Health and Safety has been working with the human resource department to ensure measures continue to be robust and maintained, so that the students and volunteers continue to work without a risk to themselves or others. An important change to the process has been moving away from paper-based induction forms/risk assessment and transferring these to Microsoft E-Form so there is central oversight and the ability for the Head of Security, Health and Safety to monitor compliance. Equally this change

will allow any future changes to the induction to be done simply and quickly without searching for paper copies.

2. Manual Handling Operations Regulations

This piece of legislation is about ensuring there are risk assessments for moving and handling operational activities so that the risk of injury to colleagues is reduced as far as is reasonably practicable. CHFT have a small team of moving and handling leads that are supported by moving and handling training facilitators who deliver training and help in the completion of the risk assessments.

Training

There has been a drop in the number of colleagues attending the face to face moving and handling training sessions across the year and after further conversations with the moving and handling lead, the feedback which has been received suggests that operational pressures on the wards and departments have made it hard to find enough time to attend the training sessions. Due to these pressures faced by colleagues, the moving and handling team are looking at different ways of being able to deliver the training and have already increased the number of courses on offer, but the team maintain the importance that these must be face-to-face sessions.

Table 2 Attendance at Face-to-Face Training (2023/2024)

The table shows the level of attendances at the moving and handling (face-to-face) training sessions and these are shown as percentage attendances.

Divison	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Surgical	77	78	79	82	81	82	81	82	79	77	83	85
Medical	72	71	73	74	79	78	77	76	74	71	75	75
Community	78	79	85	86	88	87	87	86	83	79	89	88
Corporate	74	68	71	76	77	79	78	79	73	79	82	78
FSS	75	78	80	83	83	83	82	82	73	83	81	82

(target = 90%, or stretch = 95%)

The data in the above table shows that across most of the year, attendance at the training sessions was below the (90% target) and following conversations between the Head of Security, Health and Safety and the moving and handling lead, operational pressures on the ward/departments s is often acting as a barrier to attendance. During the later part of 2023yr, more training courses were provided in anticipation that attendance would improve, however a different way of delivering the course is being explored so that attendance at the face-to-face training sessions can improve. What the reader will notice later within this report is an increase in the number of moving and handling injuries across the year, which could be related to a drop in receiving the training.

Risk Assessments

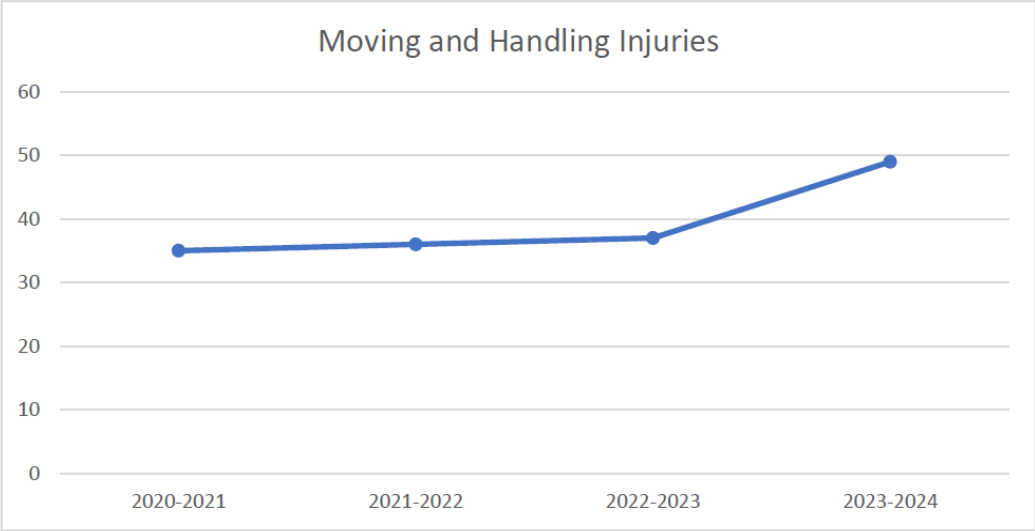
Under the Manual Handling Operations Regulations it is mandatory that risk assessments of moving and handling activities are completed. Following several enquiries by the moving and handling lead, it has become apparent the introduction of a new adult nursing document has changed the clinical instructions given to colleagues to complete moving and handling risk

assessments which is at odds with the opinion of the moving and handling lead and there is a speculation, the change has led to a drop in the number of completed moving and handling risk assessments. The Chief Nurse Information Officer has confirmed that during 2024yr, there has been some new online functionality that have been constructed in the background which may have distorted the true story behind the reality of compliance and therefore the Chief Nurse Information Officer is carrying out enquiries into this matter and has given an instruction to the facilitators team to carry out an audit to determine how many moving and handling may have been missed and if needed an education piece will be developed and shared with stakeholders so compliance improves. Moving forward the EPR compliance records will show completed risk assessment compliance data.

Moving and Handling Injuries

It is essential the likelihood of moving and handling injuries is reduced as far as is reasonably practicable. Through the combination of risk assessment, training and the availability of patient lifting equipment, the risk is reduced to the lowest possible level. The graph below, shows the trend of injuries that have been reported on DATIX across the year and it is clear to see there has been an upward movement of injuries reported in 2023/2024yr.

Graph 1 – This graph shows the number of moving and handling injuries between 20020 and 2024yr.



The direction of the line in the graph shows that before 2022yr there was only a slight increase in the number of injuries, however this changed in 2023yr with a higher number of reported incidents. The Moving and Handling Lead has studied the DATIX incidents and concluded that patients acting out of character, operational pressures experienced by front-line colleagues and the issue about risk assessments (which has already been noted earlier) are underlying factors.

3. Display Screen Equipment Regulations

This piece of legislation is about ensuring colleagues are given the opportunity to complete a workstation self-assessment for the desk/chair/computer configuration. The aim of the legislation is to ensure all reasonable measures have been taken to prevent the individual from experiencing discomfort and eye-strain that would otherwise cause symptoms including

back ache, neck pain and visual problems and therefore a display screen equipment assessment provides guidance and advice on how to ensure all of these matters can be reduced by the individual.

Risk Assessment

The Head of Security, Health and Safety has produced a risk assessment for colleagues to complete and this is shared with them on the occupational health intranet page via a microsoft e-form link so that completed assessments are easily monitored and action can be taken to provide help and support to colleagues who declare they need more advice and guidance. Sometimes this is because they have explained on their assessment some complex medical conditions such as spinal and hip conditions. In such situations CHFT work with Virgo Ltd which is a local consultancy that specialise in bespoke work equipment to suit the needs of the individual e.g. a modified chair to support the needs of the individual's posture requirements etc.

Table 3 – This table shows total number of display screen equipment assessments completed by colleagues who are desk-based.

Total number of display screen equipment assessments	Total number of referrals for support and help to Virgo Ltd
368	27

The table above shows that 14% of the number of assessments completed by colleagues required further help and support so they could address discomfort issues and therefore gives the reader an impression of the size of the complex needs. The majority of these required specialist advice and equipment by Virgo Ltd to help improve their posture, often because some of them presented with complex medical conditions.

4. Provision and Use of Work Equipment Regulations

This piece of legislation requires the Trust to demonstrate that colleagues responsible for using medical device equipment have received training on its use, and this continues to be a mandatory requirement. The training is provided by the medical device training team who give sessions across the year for colleagues.

Table 4 – This table shows the percentages of staff that have attended the medical device equipment trainng sessions in (2023/2024)

	95%>
	75-95%
	<75%

Dated	Percentage of Staff that have recived training upon medical devices
Mar-23	78%
Apr-23	78%
May-23	78%
June-23	79%
Jul-23	80%
Aug-23	80%
Sep-23	81%
Oct-23	78%
Nov-23	79%
Dec-23	81%
Jan-24	81%
Feb-24	82%
Mar-24	81%

Source: CHS (Medical Device Training Team)

The table above shows there were 13 training sessions provided to colleagues across the year and across each month between 75%-95% of attendance was achieved. The Head of

Security, Health and Safety has held conversations with the medical device training team leader and the attendance rates is a reflection of the operational demands placed on colleagues that is sometimes preventing them from attending the sessions, and this means that they do not receive the certified competency for medical device equipment. In the meantime the medical device equipment team leader continues to advertise the training session so that colleagues are reminded and this is listed more here;

- A reminder to attend the trainng has been placed on the notice board at HRI and in the equipment pool at CRH.
- A reminder to attend the training has been added to the intranet page.
- A reminder to attend the training has been sent by emails sent to the ward managers/ link trainers in department regularly.
- A reminder to attend the training has been added to the screensavers.

5. Health and Safety (Sharps Instruments in Healthcare) Regulations

This piece of legislation is about preventing colleagues suffering sharps injuries from medical devices including sharps needles and blades. Sharp needle injuries can result in the requirements for immediate treatment to prevent the spread of potentially infectious and life changing infections. The legislation is specific in its demands and colleagues must be provided with training, information, instructions and risk assessments. All of this is available

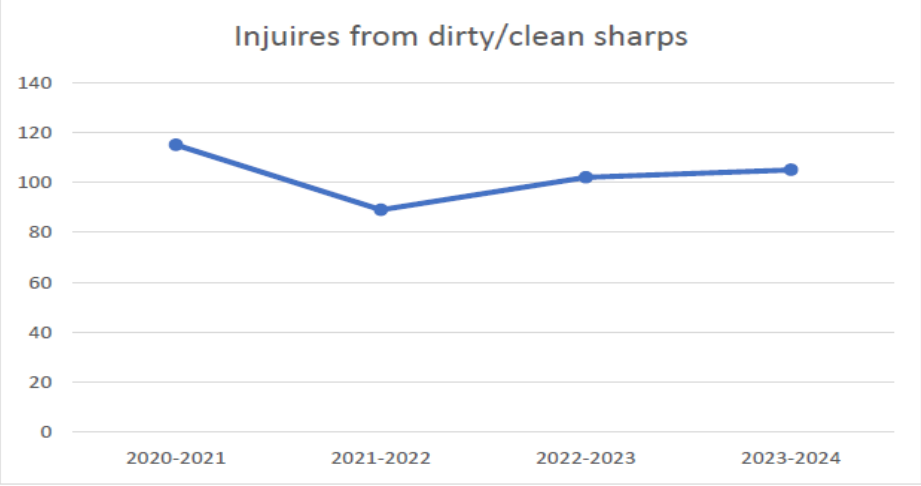
on the intranet, and in 2023yr thirty-three new risk assessments of the sharps medical devices was completed between the Head of Security, Health and Safety and the corporate matron.

Every three months a CHFT Sharps Meeting takes place and is held by the Head of Security, Health and Safety with representation by each division, occupational health team and the IPC team. This is an opportunity to spend quality time looking at the DATIX incidents and searching for trends and patterns so that actions can be agreed to help reduce or eliminate these.

Table 5 – The table below shows the number of sharps group meetings and is represented by clinical and non-clinical representation

Period	Number of meetings held in the month
March 2023	1
June 2023	1
September 2023	1
December 2023	1
March 2024	1
Total number of meetings	5

Graph 2 – This graph shows the number of injuries from using dirty/clean needles/blades between (2020 and 2024yr)



The graph above shows the number of injuries which colleagues have experienced when administrating treatment to patients. There are several factors that contribute to these incidents, including unexpected movements of the patient, but the overwhelming common factor is 'human – error' and the descriptions given on the DATIX, reflect this opinion. There are many reasons for human error and this could include fatigue, concentration, distractions, speed, tiredness and method of application.

Following conversations between the Head of Security, Health and Safety and the clinical educator lead, there is an understnding that over the last 3 years, CHFT have appointed a cohort of newly qualified colleagues with little experience of using the medical devices and this may be a leading factor together with the possiblities of the pace of work and the multitude of different medical sharps device design features. Although not descied in the graph above, what should be noted is an impressive decline in the number of insulin needle injuries and this is a credit to the diabetic team who have carried out a lot of hard work on risk reduction.

Following a meeting in 2024yr, between the Head of Health and Safety, IPC Lead and the clincial educator lead there are plans to explore additional training for colleagues and this will include the production of new training modules and working in partnership with the supplier of the medical devices to deliver some new training. The key areas where there is a high number of incidents is within the emergency department, acute wards and theatres which will be the focus of the training that is being explored.

In the meantime, the image below has been displayed as a screensaver to help remind colleagues to protect themselves, and this has been displayed as a poster in many of the wards and departments.

6. Control of Substances Hazardous to Health Regulations

This piece of legislation is about ensuring the Trust has measures in place to reduce the likelihood of harm to colleagues when handling chemicals which are hazardous in nature. There are several routes of harm into the body that could lead to advese health effects, and these include substances that can absorb into the bloodstream, ingestion and inhalation of airbourne gasses. The legislation is specific in its demands that the organisation must ensure there is training, information, instruction and risk assessments for each chemical.

Information/Instruction/Risk Assessment/Training

A small team has been provided to support the Head of Security, Health and Safety so that CHFT can achieve much better compliance than before, and underpinning the abiity to do this has been the use of a third party software portal, SYPOL. This is a computer system which has the ability to hold a singificant number of risk assessments. The computer system is also designed to be an interactive tool to help a colleague complete a risk assessment. SYPOL also has the function to store the safety data sheet for each substance, which is the background information and advice on how to use, store and dispose of the substance.

As part of a multi-discplinary team, SYPOL has now been re-designed and made easier to use. During 2024, each department has nominated a lead person to begin using SYPOL. Longer-term there is a plan for the Head of Security, Health and Safety to carry out audits, so

compliance is maintained and the results will be shared with a wider audience. In the meantime, background work is taking place to ensure all colleagues have access to the safety data sheets via their devices and laptops, which will be helpful if they need information quickly in an emergency.

A review by the Head of Security, Health and Safety of the training provided to trust-wide colleagues on the safe use of hazardous chemicals has been carried out and the current material which is provided on the NHS National ESR Training Framework is limited, so work has been carried out to provide more material for colleagues. A brand new training module has been produced and this is will be added as an ESR mandatory course in 2024yr.

On a last point the pharmacy leads are working in collaboration with Peritus Ltd (air monitoring consultancy) to carry out annual air monitoring of gasses, so that the risk to colleagues continues to be kept under control. This will be focused on the departments which use Entonox gas so that levels of exposure from second-hand gas is controlled.

Pathology – Category 3

The pathology department conduct high risk procedures that requires the containment of category three pathogens, and these requires a series of recorded balances and checks to prevent exposures. This is achieved by using mechanical, engineering controls, and administrative measures.

In the future, a section of this report will be committed to giving a summary on category three. Equally the department is in the process of appointing a new laboratory health and safety officer who will attend future resilience and safety group meetings. During 2024yr the Head of Security, Health and Safety will consult directly with a new laboratory health and safety officer to conduct a health and safety audit.

7. Artificial Optical Laser and Non-Ionising Radiation Compliance

There is a requirement for the Trust to have in place checks and balances to prevent exposure to radiation particles. The Trust has in place relevant policies to help support the due diligence measures needed and this includes the appointment of a Radiation Protection Advisor which is a contract agreement with IRS Ltd who are highly qualified and specialists in this field. They conduct the audits to ensure the right measures continue to be in place.

Table 6 – showing the number of audits completed by IRS ltd during the period of this report.

Date of audit	Department	Compliant
17-04-2023	South Drive MRI	MR23-0878 – Full Compliance
17-04-2023	South Drive MRI	MR23-0901 – Full Compliance
03-03-2023	Eye Clinic	LS23-0876, LS23-0883 – Recommendation given
02-03-2023	Theatres	LS23-0904, LS23-0905 – Recommendation given
02-03-2023	Oral/Maxillofacial	LS23-0906 – Full Compliance
08-03-2023	MRI Unit 1	MR23-0579 – Full Compliance
08-03-2023	MRI Unit 2	MR23-0580 – Full Compliance

8. The Health Informatics Service (THIS)

The Head of Security, Health and Safety continues to give advice and support to the Health Informatics Service, and this includes its own health and safety committee meetings which take place every 3 months. A significant amount of work has been conducted over the last 3 years to help improve the compliance requirements and following a health and safety audit by the Head of Security, Health and Safety in January 2024 compliance continues to be strong.

Table 7 – This table shows the level of compliance within Health Informatics Service and is benchmarked against specific pieces of health and safety legislation.

Subject	RAG Rating Status
First aid compliance	
Electrical safety compliance	
Asbestos management compliance	
legionella management compliance	
Moving and handling compliance	
Workplace risk assessments	
Gas safety management compliance	
Driver risk management compliance	
Display screen equipment compliance	
Health and safety training compliance	
Warehouse safety compliance	
Health and safety inspection compliance	
Goods lift compliance	
Lone Working compliance	

The above table shows the level of health and safety compliance within the Health Informatics Service. Over the last couple of years the business has been implementing a health and safety framework which has twenty-seven individual health and safety standards that have been created specifically by the Head of Security, Health, and Safety for the business. The final piece of work left is upon lone working measures and a few other smaller tasks, which will be completed during 2024yr.

9. Huddersfield Pharmacy Specials (HPS)

The Head of Security, Health and Safety continues to provide advice and guidance to the business and across the year and attendance at the HPS health and safety committee that take place every 3 months.

Table 8 – This table shows the level of compliance within HPS and is benchmarked against specific pieces of health and safety legislation.

Subject	Rag Rating Status
Manual handling risk assessments	
Pressure systems compliance	

First aid compliance	
Electrical safety compliance	
Asbestos management compliance	
legionella management compliance	
Lifting equipment compliance	
Gas safety management compliance	
Moving and handling trainers compliance	
Health and safety inspection compliance	
Task specific risk assessments compliance	
COSHH compliance	

The above table shows the level of compliance within HPS, which is benchmarked against twenty health and safety standards which have been created specifically by the Head of Security, Health and Safety for the business. Over the last 3 years work has taken place between the Head of Security, Health and Safety and the local management team to help put in place the evidence so that the organisation can meet legislation requirements.

There is a focus around compliance of equipment risk assessments, management of the hazardous substances and the implementation of workplace health and safety inspections which will see further improvements across 2024yr. There are further plans later in 2024yr, for the Head of Health and Safety to complete a health and safety audit which will help maintain the focus.

10. Governance

It is important that there is a structure to allow a process of consultation between management, workforce, and the union health and safety representative. Under law, this is made clear within the Safety Representatives and Safety Committees Regulations 1977 and The Health and Safety (Consultation with Employees) Regulations 1996. As a result CHFT have a structure which allows opportunities for consultation, and this is shown in the chart below.

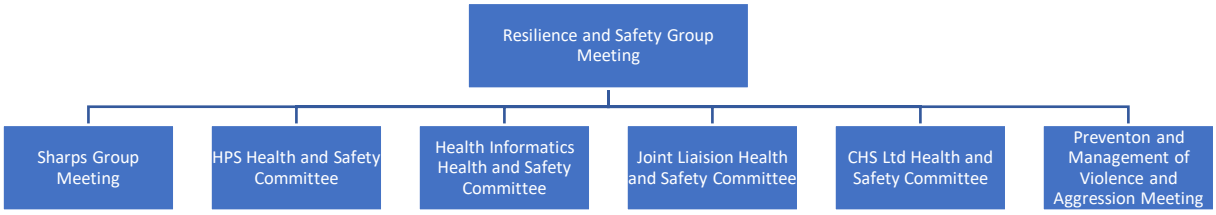


Table 9 – this table shows the different health and safety meetings across the year.

Meeting	Frequency of Meetings
Resilience and Safety Group Meeting	Bi-monthly
Sharps Group Meeting	3- month
HPS Health and Safety Meeting	2- month
HPS Health and Safety Meeting	3-month
Joint Liaison Health and Safety Meeting	Monthly
CHS Health and Safety Meeting	Bi-monthly
Prevention and Management of Violence and Aggression Meeting	Monthly

11. The Prevention and Management of Violence and Aggression

Under the Health and Safety at Work Act 1974, the Trust has a responsibility to provide a safe environment, and this requires the importance of making sure there are relevant policies, training, information, and risk assessments in place.

Policy

A new Management and Prevention of Violence and Aggression Behaviour Policy has been written in 2023yr. The aim of the policy is to ensure that all colleagues are aware of measures in place to help in the prevention or management of poor patient behaviour. The policy provides advice and guidance about how to deal with physical and verbal aggression and includes an escalation process for colleagues to use, if needed. A Security Management Policy has also been produced and this provides an overarching insight into the arrangements to ensure security of the building, assets, and people and finally during the course of 2024yr, a new Lone Working Policy has been produced. Each of these policies are being operationalised in 2024yr and measured to produce performance data at the end of the year.

Training

The Head of Security, Health and Safety has been working in collaboration with clinical leads and an external training consultancy to provide colleagues with breakaway/conflict resolution training, so they feel empowered and have the confidence when dealing with challenging patient behaviour. In 2023yr funding was provided and training was delivered to some colleagues which is shown in table (7).

Table 10 – this table shows the departments that have received training in breakaway/conflict resolution techniques in 2023yr.

Department	Total Number of Colleagues
Emergency Department	24
Acute Wards	28
Paediatric Ward	3
Radiology Department	24

The above table shows that some colleagues received face to face training, however looking forwards into the future, the Head of Security, Health and Safety is seeking a longer-term strategy which will mean that colleagues working in all the higher risk wards and departments continue to receive the training that is over and above a basic ESR conflict awareness training.

Table 11 – this table shows the list of wards and departments where there is higher incidents of reported violence and aggression (2023yr-2024).

Name	Number of incidents
Acute Wards	77
Stroke Ward	15
Emergency Department	39
Trauma & Orthopaedic Ward	13

Elderly	61
Respiratory	17
Paediatric Ward	15

The table above provides a list of wards and departments where there is a higher number of violence and aggression by patients (reference DATIX 2023/2024). These wards/departments continue to be given attention towards the delivery of the forementioned training and security officer priorities.

Prevention and Management of Violence and Aggression Risk Assessments

There is a legal requirement to ensure documented risk assessments are completed for each ward and department. The aim of the people orientated risk assessment is to identify the triggers that cause patient behaviours and equally closely match appropriate control measures to help mitigate the risk. These measures include things like dementia training and learning disability training for colleagues. Other control measures include security officer attendance, clinical interventions and in some cases post-incident support to colleagues. The assessments have been completed by the Head of Security, Health, and Safety in collaboration with human resources, safeguarding, matrons. There has also been another bundle of assessments that are environmental orientated and these account for the physical security measures such as door locking mechanism, room security, protection of medication etc.

12. Security Information and Instruction

Over the last 12 months, the Head of Health and Safety has developed the security page which is available on the intranet, and this includes a new Prevention and Management of Violence and Aggression Reduction Strategy 2024/2025. There is also lots of guidance and advice on the intranet page which colleagues will find helpful.

It is important that patients are engaged and have some understanding of the importance of acceptable behaviour towards colleagues, so during 2023yr, a lot of thought was given by the Head of Security, Health and Safety about the best way to communicate effectively with patients in a respectful and engaging manner. In collaboration with the Communication Team, a series of colourful and eye-catching posters were displayed across the hospital, which are shown here.

13. Community Hubs

It is essential the security of the community hubs across the community benefits from a professional security assessment, so that the risk of criminal damage, loss of assets and business disruption is reduced as far as is reasonably practicable. The Head of Health and Security, Health and Safety arranged for each of the buildings to receive a security risk assessment and in partnership with West Yorkshire Police Service, this was done free of charge. The reports have now been shared with each of the business/divisional lead persons.

14. Enforcement Action and Reporting of Injuries Diseases and Dangerous Occurrences Regulations (RIDDOR's)

There has not been any enforcement action or visits conducted during the period of this report, apart from an enquiry by a local Environmental Health Officer which was quickly and satisfactorily resolved after a report of an accident during the winter of 2024yr.

The legislation requires specific types of incidents to be reported to the Health and Safety Executive, and these are reported under the Reporting of Injuries of Diseases and Dangerous Occurrences Regulations. This gives the Health and Safety Executive (HSE) an understanding of the number and type of incidents so they can either conduct their own enquiries or plan future national accident reduction campaigns.

Table (12) – This table shows the number of incidents that were reported to the Health and Safety Executive in 2023/2024

Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec
0	1	0	1	3	2	2	2	0	0	0	0

The table above shows the number of incidents across the year which were reported to the Health and Safety Executive via completion of the DATIX form. Most of the incidents in table (9) have been minor in nature but led to the individual taking more than 7 days of work that qualifies the submission of a RIDDOR.

Conclusion

The patient operational pressures across the year have placed demands on colleagues and this is reflected in the body of this report in terms of the levels of compliance. To help mitigate these pressures, a series of measures have been developed to help drive down injuries and improve compliance. These measures include the formation of a prevention and management of violence and aggression collaborative group meeting that is taking place every month, the continuation of the sharps injury prevention group, appointment of a new Police Constable Support Officer and the engagement with an external trainer to do deliver local bespoke training upon reducing the impact of violence and aggression towards staff members by patients.

18. Integrated Performance Report

To Note

Presented by Jonathan Hammond

Date of Meeting:	Thursday 7 November 2024
Meeting:	Public Board of Directors
Title:	QUALITY & PERFORMANCE REPORT
Author:	Peter Keogh, Assistant Director of Performance
Sponsoring Director:	Jonny Hammond, Chief Operating Officer
Previous Forums:	Finance & Performance Committee, Executive Board

Actions Requested: To note.

Purpose of the Report

To provide the Board of Directors with a single combined narrative that seeks to triangulate current performance for the month of September 2024.

Key Points to Note

Performance Summary

Quality indicators: Summary Hospital-level Mortality Indicator (SHMI) is still special cause for concern but has seen a decrease in-month to 112.35. The latest national SHMI position stands at 100.2 and CHFT now sits above this national position.

Falls per 1,000 bed days for September was still below target and similar to last month at the lowest rate recorded Trust-wide since September 2022.

There was 1 never event declared by the Trust Patient Safety Event Review Panel in September.

There were 6 severe harm incidents reported in September. 1 incident has been downgraded after investigation, 2 incidents have been validated as severe harm and 3 remain under investigation.

% of complaints closed on time (target 95%) has improved again to 91% in September. Performance has improved by 7 percentage points this month which highlights the actions are taking effect. There are still a number of draft responses that are not of the quality expected and therefore have to be returned to Division for further information which is unfortunately causing delays.

Quality Priorities - % of patients that have been screened for dementia has improved over the last 7 months. Stroke - % of stroke patients admitted directly to an acute stroke unit within 4 hours of hospital admission continues to improve at 46% against its 90% target.

Improvement work is being undertaken to increase the % of patients who are admitted within 4 hours, and an expectation is that this will be seen over the coming weeks as the data is collected at the point of discharge.

Care of the acutely ill patient (% of patients with a NEWS2 of 5+ will not have a higher score during their episode of care) – performance is still around 60% in September against a target of 70%.

We continue to perform well in terms of **elective recovery** with 52-week waits in September at 41 (ENT 24) however we did see an increase in numbers to 916 40-week waits particularly in ENT.

For **diagnostics** we achieved the 95% target for the second time in 3 months with further improvement in Echocardiography which is expected to be back on track by the end of October.

Capped Theatre Utilisation at 84% has also been recognised as the best performance in WYAAT just below the 85% target. Currently in performance quartile 4 of 4 (Highest 25% performance bracket).

Cancer performance continues to be excellent in September although the 28-day faster diagnosis performance dipped below the 75% target. There are issues with a small number of cancer sites including Head & Neck, Lower GI and Gynaecology with actions in place. Referrals have increased by 8% compared to last year for faster diagnosis pathways.

ED performance reduced to 69% in September with a further increase in bed occupancy and length of stay for pathway 0 patients. TOC numbers reduced to 109. The number of patients waiting over 12 hours in ED had its first increase for 5 months.

Proportion of **ambulance arrivals** delayed over 30 minutes has increased again due to the pressures seen in ED.

The full capacity plan has been enacted as required to respond to high OPEL scores within the ED and an assessment against nationally published guidance on temporary escalation spaces is being undertaken.
In **Community** % of 2-hour UCR referrals that achieved the 2-hour response standard continues to improve and achieve target. Virtual Ward occupancy has deteriorated in month to 57% against the 80% target although looking at the position over the last 12 months 80% was achieved due to the peaks and troughs in seasonal trends.

Workforce – Turnover and Sickness Absence lowest rates for over 3 years.

Performance Matrix Metrics Changes *(green improvement, purple deterioration).*

- *Proportion of Urgent Community Response referrals reached < 2 hours*
- *Hospital Discharge Pathway Activity*
- *Day Case Rates*

EQIA – Equality Impact Assessment

The IPR does not report performance with a breakdown of Protected Characteristics either for workforce or patient data. Workforce equality monitoring is conducted at Workforce Committee via WRES, WDES and Staff Survey. The Public Sector Equality Duty annual report is presented to Board annually, as well as our gender pay gap report.

Recommendation

The Board of Directors is asked to **NOTE** the narrative and contents of the report for September 2024.

Calderdale and Huddersfield NHS Foundation Trust

Integrated Performance Report September 2024

Report produced by this

Contents:

Performance Matrix Summary:

Note:
Improvement in matrix position
Deterioration in matrix position

Matrix Key
- High Improvement
- Improvement
- Neutral
- Concern
- High Concern

VARIANCE	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT	• Staff Movement (Turnover)	• Diagnostic activity undertaken against activity plan • Non-site-specific cancer referrals • Maternal Mortality • Sickness Absence (Non-Covid)	• Personalisation of care - % of patients that have been screened for dementia • % of patients that receive a diagnostic test within 6 weeks • Day Case Rates • % of beds occupied by patients who no longer meet the criteria to reside
COMMON CAUSE/NATURAL VARIATION	• % of incidents where the level of harm is severe or catastrophic • Total RTT Waiting List • Brain Injuries (maternity) • Patients dying within their preferred place of death • Core EST Compliance	• Hospital Standardised Mortality Ratio (HSMR) • Falls per 1,000 Bed Days • CHFT Acquired Pressure Ulcers per 1,000 Bed Days • C. Difficile Infection Rate • E. Coli Infection Rate • P. aeruginosa Infection • Klebsiella SPP Infections • % of complaints within agreed timescale • Total Patients waiting >40 weeks • Total Patients waiting >52 weeks • Capped Theatre utilisation • Proportion of patients meeting the 62-day cancer standard • Proportion of patients meeting the faster diagnosis standard • ED Proportion of patients seen within 4 hours • Proportion of patients spending more than 12 hours in ED • Neonatal Deaths per 1,000 total • Stillbirths per 1,000 total births • Pre-Term Births • Proportion of Urgent Community Response referrals reached < 2 hours	• % of patients with a NEWS2 of 5+ that do not go on to have a higher score • % of stroke patients admitted directly to an acute stroke unit within 4 hours of hospital admission • Early Cancer Diagnosis • Bed Occupancy • Transfers of Care • Maternity Workforce
SPECIAL CAUSE CONCERN		• Summary Hospital-level Mortality Indicator • Hospital Discharge Pathway Activity • Virtual Ward	• Proportion of ambulance arrivals delayed over 30 minutes

Not included in table – Number of Never Events, Care Hours per Patient Day (CHPPD), MRSA, Number of Patient Safety Incident Investigations (PSII), elective activity, First attendance, Follow Up activity, Community WL, Appraisal Compliance, Bank and Agency Spend, Finance, HI metrics

Safe, High Quality Care

Metric	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Summary Hospital-level Mortality Indicator (SHMI)	June 2024	114.09 (Rolling 12 month)	100			106.67	85.53	127.81
Hospital Standardised Mortality Ratio (HSMR)	July 2024	101.68 (Rolling 12 month)	100			98.47	62.45	134.50
Care Hours Per Patient Day (CHPPD)	September 2024	8.8/7.8	-	-	-	-	-	-
Falls per 1000 Bed Days	September 2024	6.6	7.08			7.68	5.53	9.83
CHFT Acquired Pressure Ulcers per 1000 Bed Days	August 2024	0.84	1.49			1.61	0.77	2.45
MRSA Bacteraemia Infection	September 2024	0	0	-	-	-	-	-
C.Difficile Infection	September 2024	3	4.75			4.53	0	12.51
E.Coli Infection	September 2024	8	5.83			5.91	0	11.99
P.aeruginosa Infection	September 2024	0	0.42			0.33	0	1.80
Klebsiella SPP Infections	September 2024	1	3.08			2.53	0	6.57

Safe, High Quality Care

Metric	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Number of Never Events	September 2024	1	0	-	-	-	-	-
Number of Patient Safety Incident Investigations (PSII)	September 2024	1	0	-	-	-	-	-
% of incidents where the level of harm is severe or catastrophic	September 2024	0.88%	2%			0.65%	0%	1.35%
% of complaints within agreed timescale	September 2024	91%	95%			87.53%	68.96%	100%

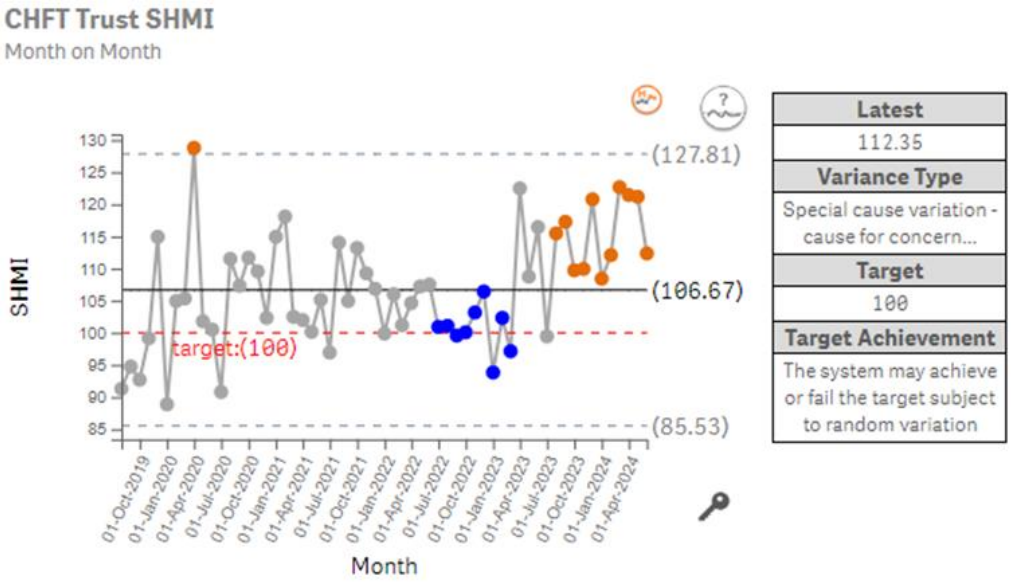
Summary Hospital-level Mortality Indicator

Calderdale and Huddersfield NHS Foundation Trust

Executive Owner: David Birkenhead Clinical Lead: Nikhil Bhuskute Business Intelligence Lead : Oliver Hutchinson

Rationale:
This is to monitor the ratio between the actual number of patients who die following hospitalisation at the Trust and within 30 days of discharge plus the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated here.

Target:
100



What does the chart show/context:
- CHFT SHMI performance has remained stable for the latest 12 month rolling release and shows performance of 114.09.
- Month on Month performance has improved in June performance standing at 112.35.
- Performance remains within the expected range in the latest release.
- The latest national SHMI position stands at 100.20 and CHFT now sits above this national position.

Underlying Issues:
- This position in CHFT's performance remains largely been driven by performance within the 122 – Pneumonia CCS group. A review was undertaken to establish any quality-of-care concerns. There were 2 cases that were assigned as 'poor' care, these were incident reported.
- There has been a reduction in observed deaths on a national basis this does not seem to have been replicated within the CHFT datasets. Therefore, this is affecting CHFT's expected deaths figures.
- The annual national rebasing exercise has now been completed and is reflected in these figures.
- From April 2024 CHFT has reclassified SDEC activity as national required with this activity now being captured within the A&E datasets. This has therefore removed these admissions from this dataset. CHFT are amongst the first organisations in the country to make this change. It is expected that this change will have an initial negative impact on mortality indicators until all organisations make this change. This is because this change has removed a high volume of patients with a low 'mortality risk' from the dataset resulting in the expected deaths for the organisation reducing in number however the observed deaths remaining stable, this therefore increases the SHMI ratio performance.

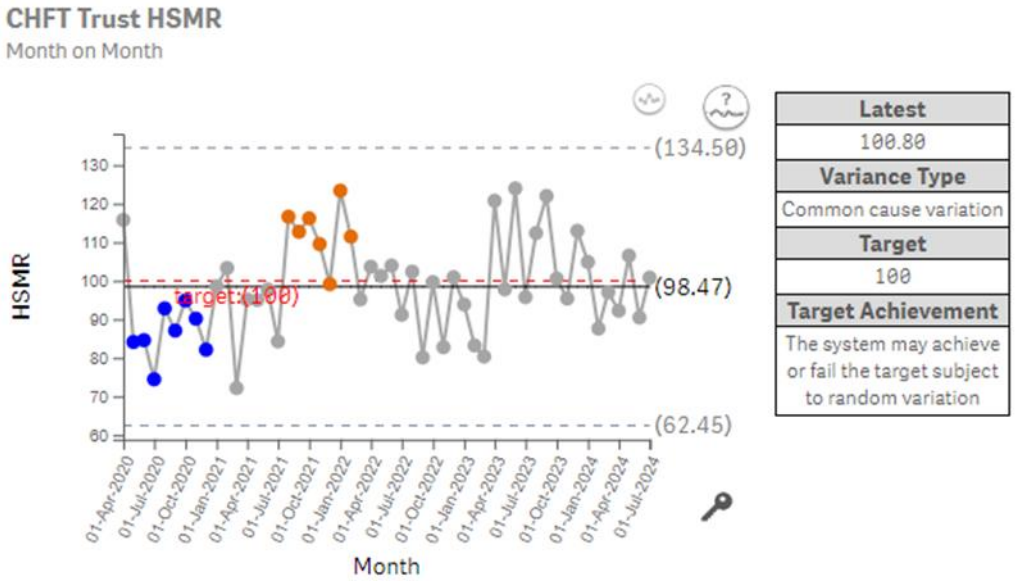
Actions:
- Clinical Lead has contacted all mortality leads in all specialties to communicate the need to increase the level of mortality reviews being carried out monthly and the timeliness of these reviews being improved.
- A new 'mortality prediction' tool has been developed to closely replicate the HSMR calculation for live Trust data. This can be used to help forecast where CHFT's HSMR performance is likely to go in the coming data releases and would give a heads up 3 months in advance of national releases.
- Proposed changes in the way CHFT conduct mortality reviews. A proposal is in place to change the way that CHFT assign and review mortalities internally. Moving away from the fixed 50% target for all deaths to a more targeted review process based on the information within the new mortality prediction tool in KP+, targeting those patients that have died with a low predicted mortality %.

Hospital Standardised Mortality Ratio (HSMR)

Executive Owner: David Birkenhead Clinical Lead: Nikhil Bhuskute Business Intelligence Lead : Oliver Hutchinson

Rationale:
This is to monitor the ratio between the actual number of patients who die following hospitalisation at the Trust against those that would be expected to die on the basis of average England figures, given the characteristics of the patients treated here.

Target:
100



What does the chart show/context:
- CHFT HSMR has remained stable with the latest 12-month rolling figure standing at 101.68.
- The site breakdown shows HRI at 107.66 and CRH 95.92.
- Month on Month performance has declined slightly in the latest reporting month of July 2024 with performance standing at 100.80 for the in-month figure.
- Performance remains within the expected range in the latest release.

Underlying Issues:
- This position in CHFT's performance remains largely been driven by performance within the 122 – Pneumonia CCS group. A review was undertaken to establish any quality-of-care concerns. There were 2 cases that were assigned as 'poor' care, these were incident reported.
- There are also reviews taking place in the CCS groups of UTI and COPD, these are not showing excessive excess deaths however it was felt these should be investigated.
- There has been a reduction in observed deaths on a national basis this does not seem to have been replicated within the CHFT datasets. Therefore, this is affecting CHFT's expected deaths figures.
- From April 2024 CHFT has reclassified SDEC activity as national required with this activity now being captured within the A&E datasets. This has therefore removed these admissions from this dataset. CHFT are amongst the first organisations in the country to make this change. It is expected that this change will have an initial negative impact on mortality indicators until all organisations make this change.

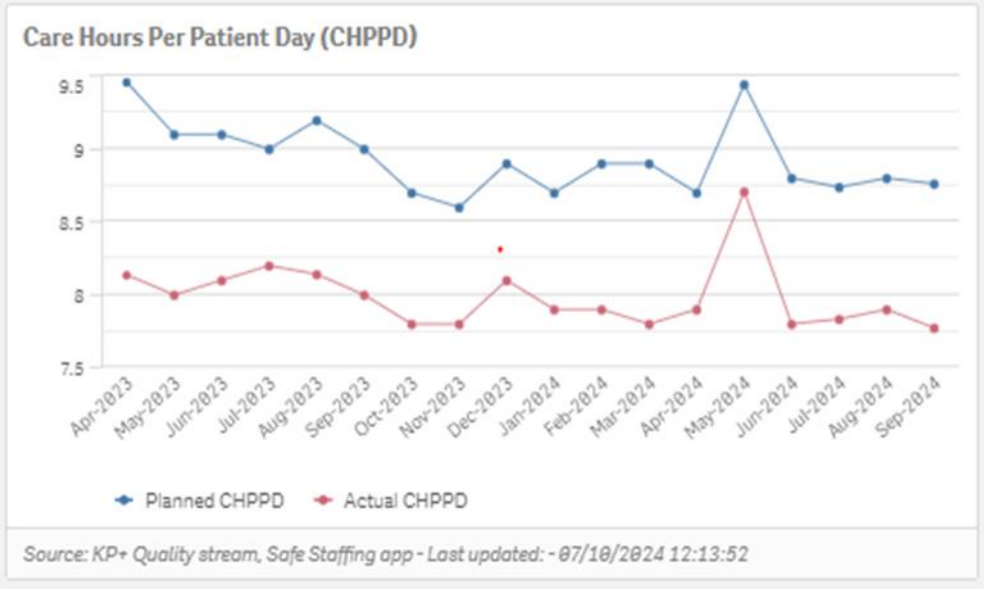
Actions:
- Clinical Lead has contacted all mortality leads in all specialties to communicate the need to increase the level of mortality reviews being carried out monthly and the timeliness of these reviews being improved.
- A new 'mortality prediction' tool has been developed to closely replicate the HSMR calculation for live trust data. This can be used to help forecast where CHFT's HSMR performance is likely to go in the coming data releases and would give a heads up 3 months in advance of national releases.
- Changes in the way CHFT conduct mortality reviews. A proposal is in place to change the way that CHFT assign and review mortalities internally. Moving away from the fixed 50% target for all deaths to a more targeted review process based on the information within the new mortality prediction tool in KP+, targeting those patients that have died with a low predicted mortality %. This work has now started for mortality reviews.

Care Hours Per Patient Day

Executive Owner: Lindsay Rudge Clinical Lead: Andrea Dauris Business Intelligence Lead: Kelley Wilcock

Rationale:
CHPPD is the national benchmark measure for safer staffing and provides a single consistent way of recording and reporting deployment of staff working on inpatient wards/units.

Target:
There is no 'correct' number of CHPPD to be achieved. However, variation between the actual and planned CHPPD should warrant further investigation.



What does the chart show/context:
- The actual CHPPD is less than the planned by a deficit of 1.0 care hour per patient day.
- The latest data in Model Hospital (July 2024 Data) reports CHFT providing 7.8 CHPPD against a peer median 8.2 and national median 8.7 with CHFT remaining in the middle of quartile 1 for that month.

Underlying issues:
- The CHPPD deficit reflects unfilled shifts of both the registered and unregistered workforce. It is also aligned to bed occupancy at midnight. With staffing at workforce model, fewer patients increases planned CHPPD, whilst more patients reduces actual CHPPD
- When staffing is reduced due to the requirement to staff extra capacity areas, CHPPD in substantive areas is reduced.
- Reducing the CHPPD deficit is dependent on having the right workforce to meet the patient requirements.

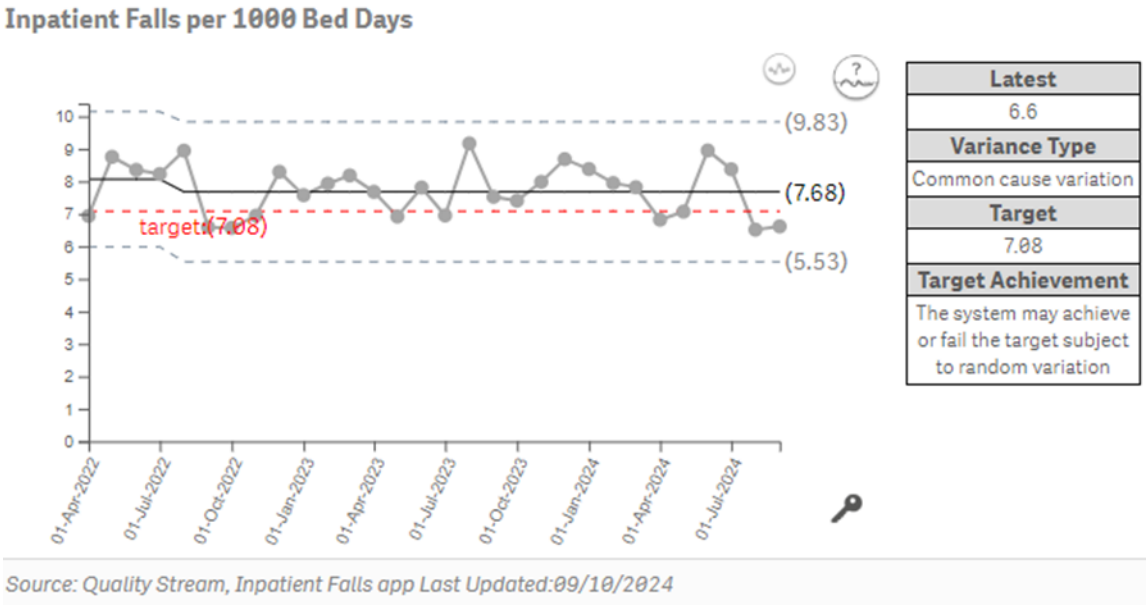
Actions:
- Undertake bi-annual Safer Staffing review. This process provides assurance of the correct workforce models based on an evidence-based methodology. The next bi-annual review will commence with acuity data collection in November 2024 and progress to Chief Nurse panels in February 2025.
- Ongoing monthly reviews of recruitment strategies, including employment of new graduates, midwives, Allied Healthcare Professionals (AHPs) and apprenticeships by the Nursing, Midwifery and AHP Workforce Steering Group (NMAHPWSG).The intention is to recruit to the estimated attrition over the coming months to prevent the opening of new vacancies.
- Review and refresh of the Retention strategy by the NMAHPWSG.
- Monthly review of nurse sensitive indicators triangulated to nurse staffing levels.
- Strong roster management maximises efficiency of the available workforce. Continue monthly roster scrutiny.
- Ongoing twice-daily staffing meetings chaired by Divisional Matrons to review any red flags and required care hours determined by Safecare, to ensure real-time safe-staffing across the hospital sites.

Falls per 1,000 Bed Days

Executive Owner: Lindsay Rudge Clinical Lead: Rhys Edwards Business Intelligence Lead: Keziah Bentley

Rationale:
Inpatient falls are the most frequently reported safety incident in hospital. Not all falls are preventable but 20–30% of falls can be prevented by assessing risks and intervening to reduce these risks.

Target:
10% reduction from 2023/24



What does the chart show/context:
- The rate of inpatient falls for September was 6.5, which is below the target of 7.08
- Currently performance can be expected to vary from 5.53 to 9.81.
- Performance is within the expected range.

Underlying issues/Updates:
- Awaiting EPR bed rail risk assessment build of signed-off version with Bradford and Airedale – confirmation that EPR build is happening WC 16/9/24. *Please note CHFT remain non-compliant with national alert.- this is now complete*
- The Falls policy was reviewed and signed off by the Clinical Outcomes Group in September and will be presented at the November Quality Committee for approval.
- Falls Collaborative looking to launch improvement work concerning Moving and Handling Assessment compliance
- We are currently working to standardise the post falls assessment proforma and a draft has been circulated for comment

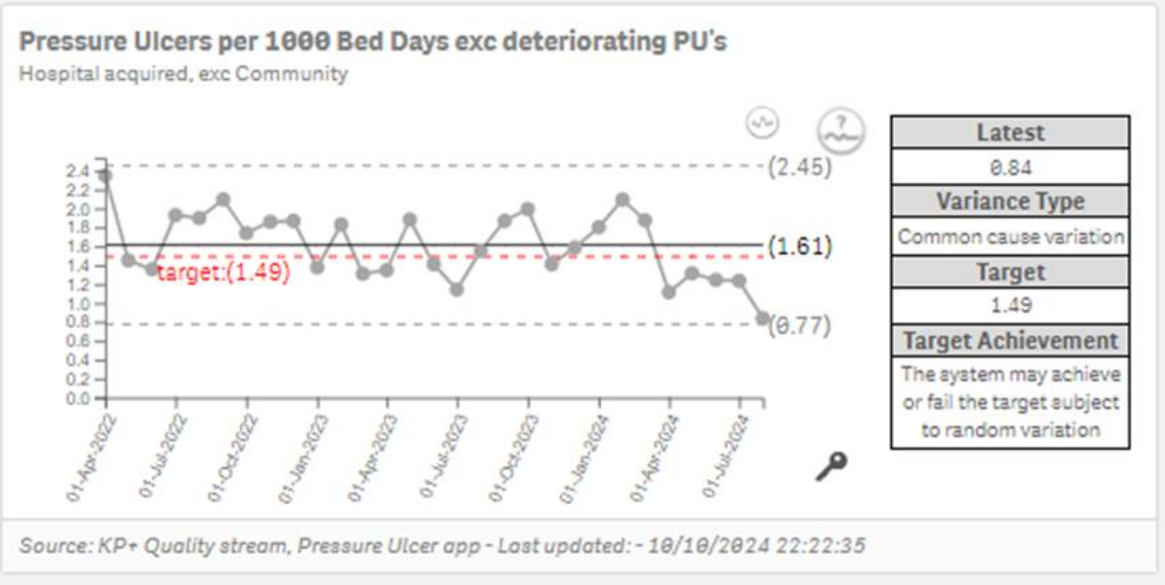
Actions:
- Await sign-off of falls policy.
- Use the dashboard to support focussed work in areas/better understand position.

Hospital Acquired Pressure Ulcers per 1,000 Bed Days

Executive Owner: Lindsay Rudge Clinical Lead: Alison Ward Business Intelligence Lead: Kelley Wilcock

Rationale:
Pressure ulcers (PUs) remain a concerning and often avoidable harm for the patients who develop them, and the healthcare professionals involved in their prevention and management. PU are in the 'top ten harms' in the NHS in England. Investigations into the causes of pressure ulcers frequently show that unwarranted variation from evidence-based practice contributes to the development of pressure ulcers.

Target:
10% reduction from 2022/23, still awaiting target for 2024/2025.



What does the chart show/context:
- The data continues to exclude deteriorating pressure ulcers to ensure data accurately reflects current position.
- The incidence of Hospital Acquired Pressure Ulcers (PU) excluding deteriorating PU for August was 0.84. Currently performance can be expected to vary from 0.77 to 2.45.
- KPI for reduction in pressure ulcers remains at 10%.

Underlying issues:
- PU risk assessment within 6 hours of admission has sustained improvement at 87.7%.
- Performance around PU risk assessment being completed every 7 days has low compliance at 39%

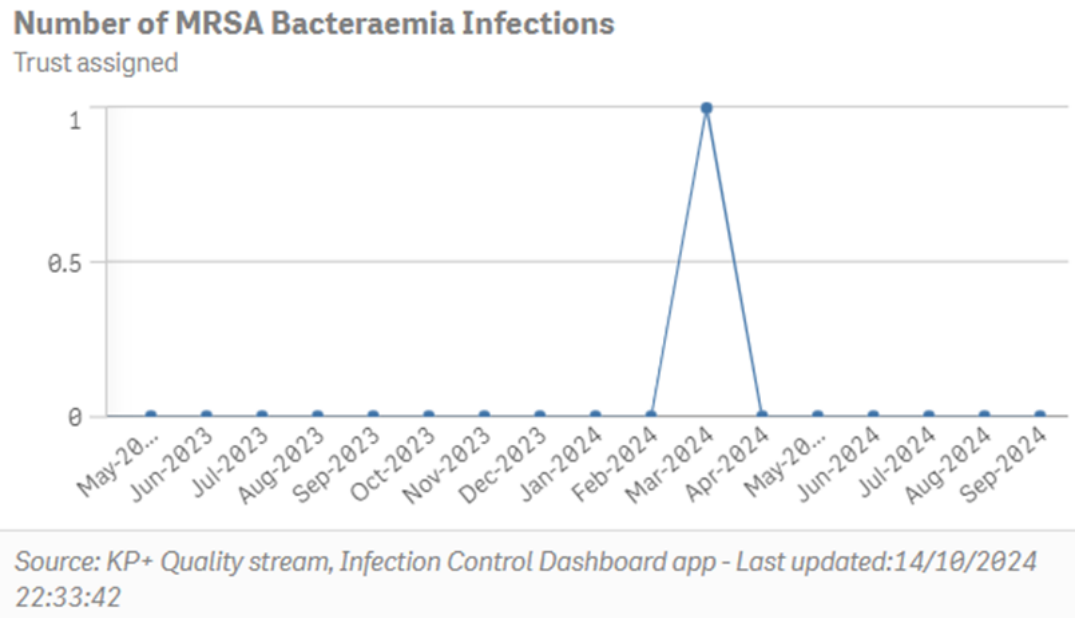
Actions:
- Targeted improvement continues for the low performing wards via the Pressure Ulcer Collaborative.
- Updated SSKIN bundle went live on 30/10/2024 in collaboration with Bradford Teaching Hospital and Airedale General Hospital.
- Patient Safety Incident Response Framework (PSIRF) Thematic Analysis of Pressure Ulcer Incidents trialled. Meeting with head of Patient Safety & Quality has taken place to map out process and gain buy-in from divisions.
- PSIRF Pressure Ulcer checklist and After-Action Reviews (AAR) continue to be embedded in Acute and Community.
- Quality Assurance Must Dos now includes weekly mattress check and will be captured on KP+ to improve mattress management.
- Tissue Viability are working with informatics team to create an electronic audit template for ward areas to use, this will feed directly into KP+ for monthly mattress audits.
- Community Division holistic assessment template has been updated align PU risk assessment to the aSSKINg framework.

MRSA Bacteraemia Infections

Executive Owner: David Birkenhead Clinical Lead: Belinda Russell Business Intelligence Lead: Kelley Wilcock

Rationale:
HCAIs pose a serious risk to patients, clients, staff and visitors to health and social care premises. They can cause significant morbidity and mortality risk for those infected.

Target: 2024/25 Targets have not been released yet- our previous target was-
To have no cases of MRSA Bacteraemia infections that are Trust-Assigned in 2023/24.



Source: KP+ Quality stream, Infection Control Dashboard app - Last updated:14/10/2024 22:33:42

What does the chart show/context:
- There were 0 MRSA Bacteraemia infections in September.
- YTD 2024/25 – 0.

Underlying issues:
- Colonisation suppression prescribing is via a POWERPLAN in EPR.
- ANTT and IPC level2 training is mandated for clinical staff and both require improvement.

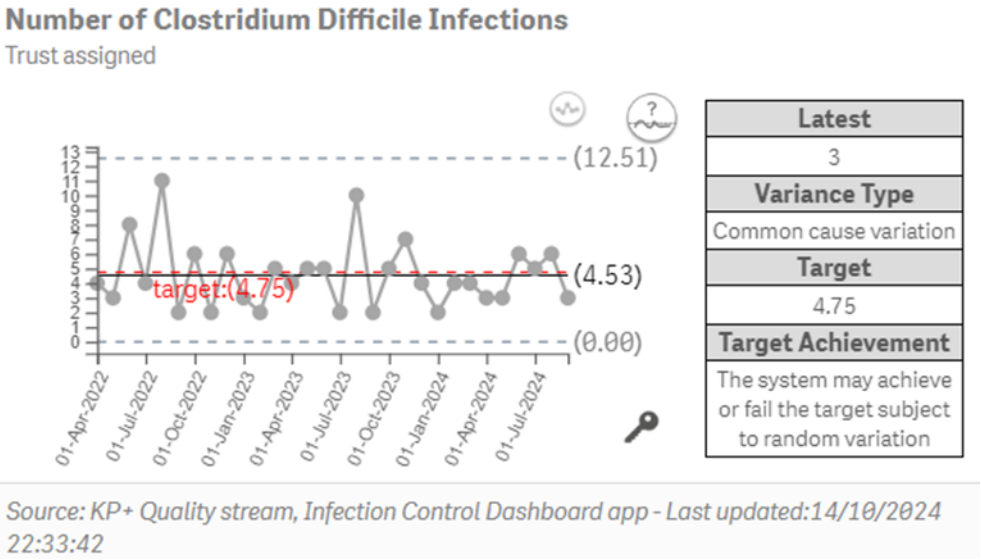
Actions:
- Colonisation suppression visual user guides have been provided to patients to ensure correct application.
- Mandatory training to be monitored through IPC Performance Board on a monthly basis.
- Any infections are investigated and discussed at panel, this infection was discussed at SI panel and downgraded to Orange. Further learning will be presented at IPC Performance Board and patient safety meetings.

C.difficile Infections

Executive Owner: David Birkenhead Clinical Lead: Belinda Russell Business Intelligence Lead: Kelley Wilcock

Rationale:
HCAIs pose a serious risk to patients, clients, staff and visitors to health and social care premises. They can cause significant morbidity and mortality risk for those infected.

Target: 2024/25 target threshold 57 cases (COHA and HOHA).



What does the chart show/context:
- There were 3 C.diff infections in September.
- Currently performance can be expected to vary from 0 to 12.51.
- YTD 2024/25 – 26 against a ceiling of 57.

Underlying issues:
- The number of C.diff infections has increased over the past 2 years and this increase is not limited to CHFT but is being seen across many NHS Trusts.
- The first 6 months' data reviewed and risks of acquisition of C.diff are as per known norms (Older age/antibiotics/hospital stay/PPIs etc).
- Antimicrobial prescribing, diagnostic sampling to inform antibiotic choices and isolation delays have been identified as issues in the prevention and management of C.diff in the investigations carried out over the past 12 months.

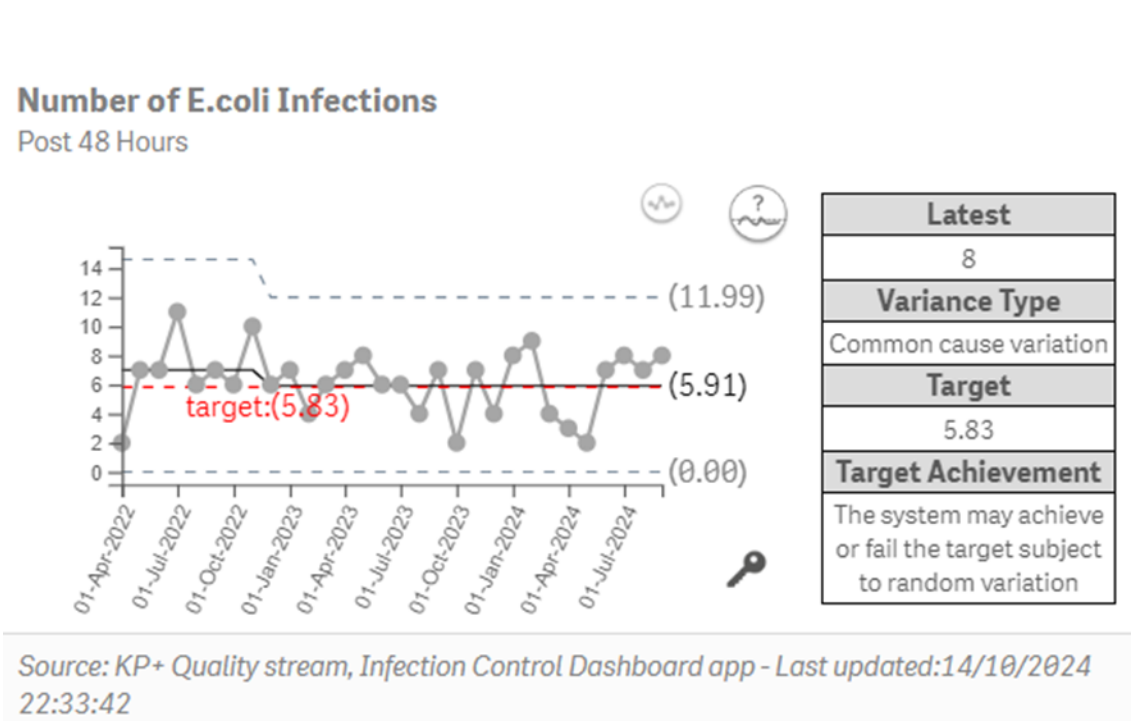
Actions:
- The Trust has implemented an improvement plan including a deep cleaning programme of HPV cleaning, this has been completed at the CRH site and will then continue at HRI.
- C.diff ward rounds / antimicrobial ward rounds are on a weekly basis and review all known cases.
- NHSEI recommendations inform the improvement plan which is monitored at IPC Performance Board.
- The PSIRF approach for investigating C.diff cases is now in place. Divisions are undertaking a review of cases and the first 6-monthly thematic review has been completed with learning incorporated into the improvement plan.
- Relaunch of champions network has been well received with a revised approach to hand hygiene audits. The frequency of champions meetings has been increased to quarterly to support delivery of this agenda.
- A review of the Frontline Ownership Tool is ongoing with Associate Directors of Nursing shadowing Matron audits.

E.coli Bacteraemia Infections

Executive Owner: David Birkenhead Clinical Lead: Belinda Russell Business Intelligence Lead: Kelley Wilcock

Rationale:
HCAIs pose a serious risk to patients, clients, staff and visitors to health and social care premises. They can cause significant morbidity and mortality risk for those infected.

Target: 2024/25 target threshold 70 cases (HOHA and COHA).



What does the chart show/context:
- There were 8 E.coli infections in September.
- Currently performance can be expected to vary from 0 to 11.99.
- YTD 2024/25 – 35 infections against a ceiling of 70.

Underlying issues:
- The focus on reducing the incidence has focused predominantly on the management of in-dwelling urinary catheters and wider prevention of UTI.
- The majority of E.coli bacteraemia occur in the community.

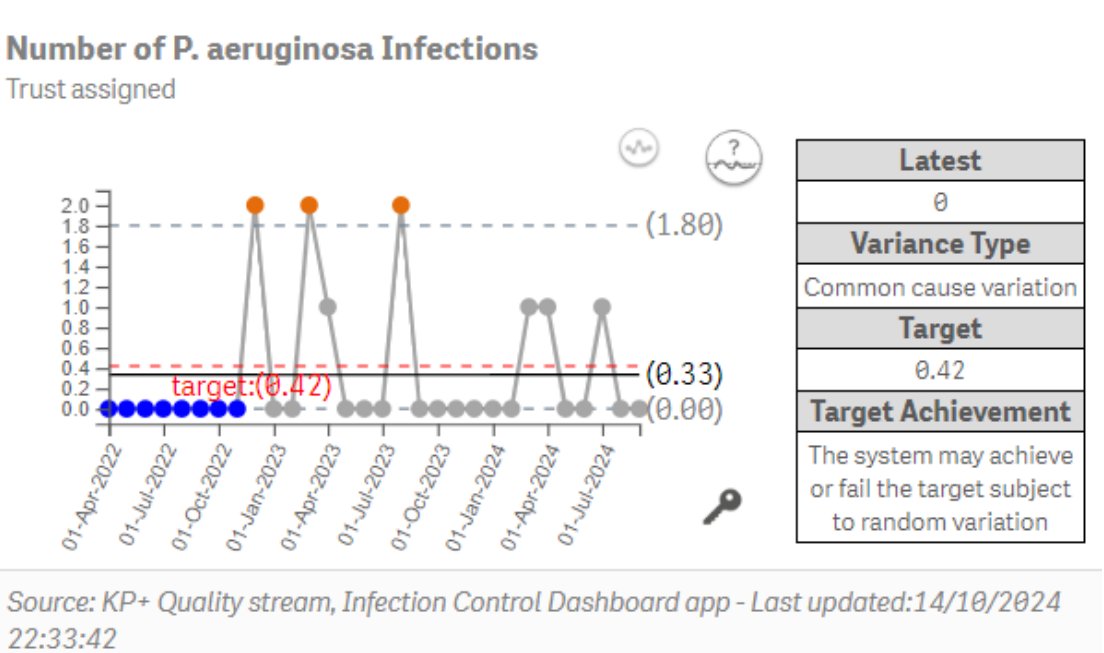
Actions:
- Extended surveillance of all the cases is conducted and uploaded to the UKHSA DCS system for national analysis.
- As part of the workplan of the IPCT, an annual audit of catheter management has been completed and recommendations shared with the divisions for implementation.
- A regional working group (WY) is focusing on hydration and community delivery of subcutaneous fluids to avoid hospital admissions.
- A CKW reduction plan is in development. CHFT are engaged in both groups.

P. aeruginosa Infections

Executive Owner: David Birkenhead Clinical Lead: Belinda Russell Business Intelligence Lead: Kelley Wilcock

Rationale:
HCAIs pose a serious risk to patients, clients, staff and visitors to health and social care premises. They can cause significant morbidity and mortality risk for those infected.

Target: 2024/25 target threshold 5 cases (HOHA and COHA).



Source: KP+ Quality stream, Infection Control Dashboard app - Last updated:14/10/2024 22:33:42

What does the chart show/context:
- There were 0 P. aeruginosa infections in September.
- Currently performance can be expected to vary from 0 to 1.80.
- YTD 2024/25 – 2 infections against a ceiling of 5.

Underlying issues:
- Gram-negative bloodstream infections are now monitored more closely to support the delivery of the Antimicrobial resistance (AMR) national Action Plan 2024-29, by preventing any increase in all GNBSIs
- Aging profile of the population and the requirement to see a 17% reduction in current underlying trends

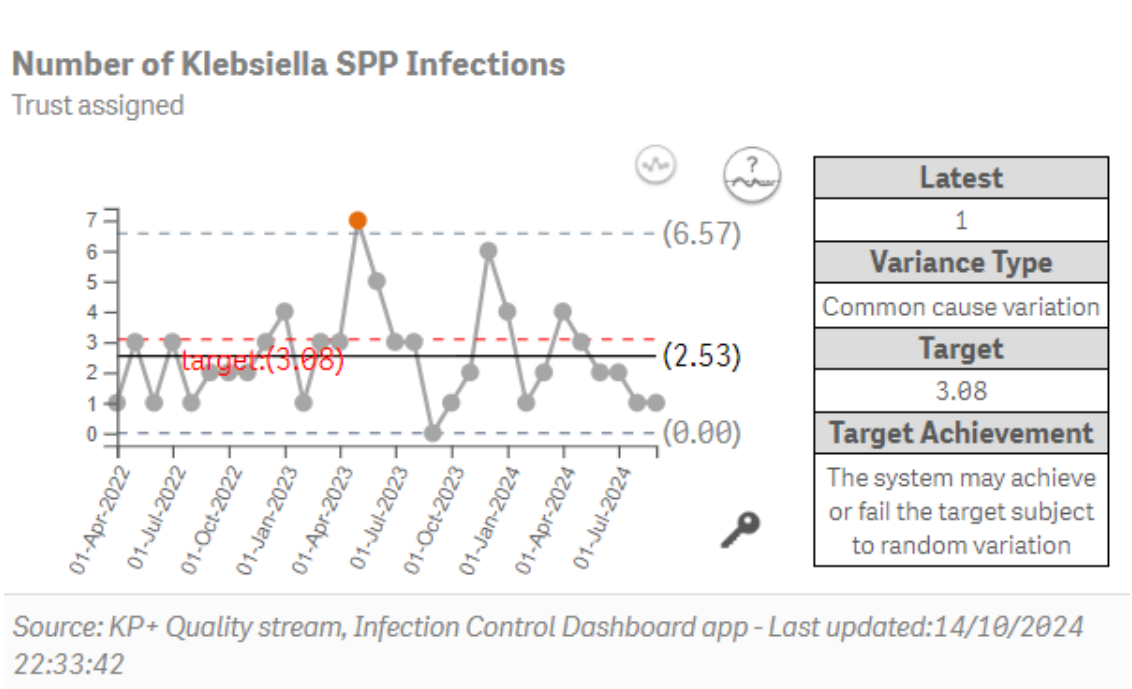
Actions:
- Support AMR through a range of actions including following the Trust prescribing formulary.
- AMR targets to be met.

Klebsiella SPP Infections

Executive Owner: David Birkenhead Clinical Lead: Belinda Russell Business Intelligence Lead: Kelley Wilcock

Rationale:
HCAIs pose a serious risk to patients, clients, staff and visitors to health and social care premises. They can cause significant morbidity and mortality risk for those infected.

Target: 2024/25 target threshold 37 cases (HOHA and COHA).



What does the chart show/context:
- There was 1 Klebsiella SPP infection in September.
- Currently performance can be expected to vary from 0 to 6.57.
- YTD 2024/25 – 13 infections against a ceiling of 37.

Underlying issues:
- Gram-negative bloodstream infections (GNBSI) are now monitored more closely to support the delivery of the AMR national Action Plan 2024-29, by preventing any increase in all GNBSIs.
- Aging profile of the population and the requirement to see a 17% reduction in current underlying trends.

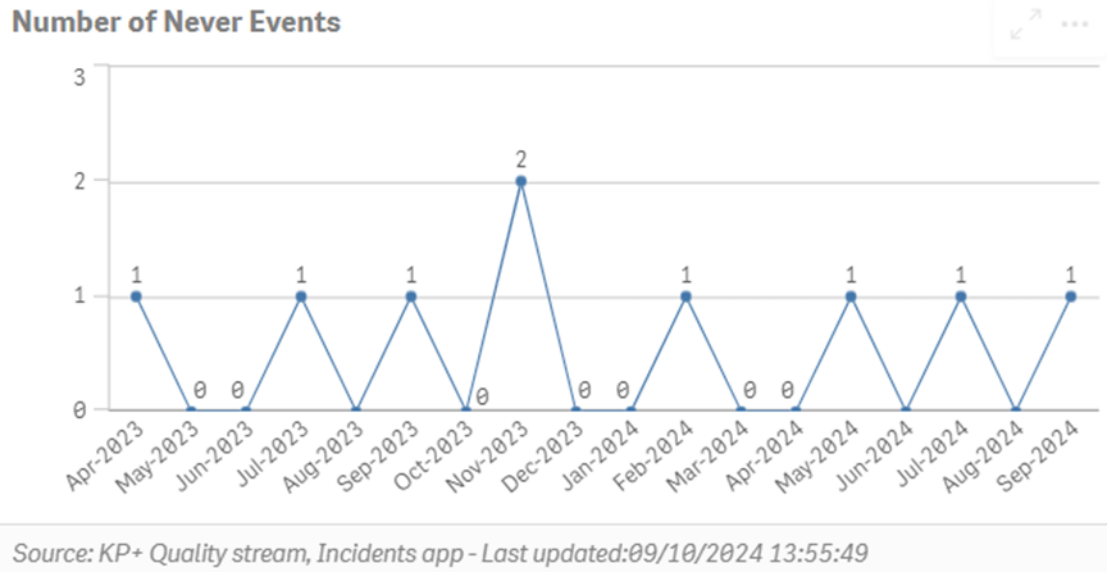
Actions:
- Support AMR through a range of actions including following the Trust prescribing formulary.
- AMR targets to be met.

Number of Never Events

Executive Owner: Lindsay Rudge Operational Lead: Sharon Cundy Business Intelligence Lead: Charlotte Anderson

Rationale:
To identify areas where CHFT can reduce risks and prevent harm, the reporting of all near misses and serious incidents is imperative to ensure we improve safety and learn from these events to prevent recurrence. Promoting a positive reporting culture is essential to CHFT's learning success for all our patients, families and staff.

Target:
To have no never events



What does the chart show/context:
- There was 1 never event declared by the Trust Patient Safety Event Review Panel in September.

Underlying issues:
- This was in relation to retained swab.

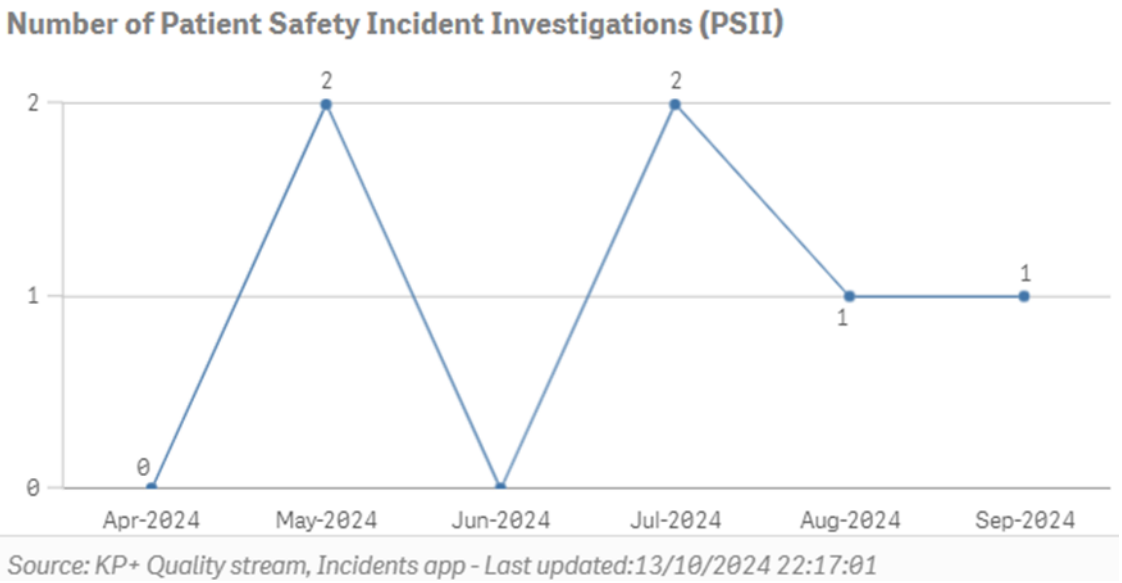
Actions:
- The Trust will continue to hold SWARM huddles as required to ensure learning is identified to keep our patients and staff safe.

Number of Patient Safety Incident Investigations (PSII)

Executive Owner: Lindsay Rudge Operational Lead: Sharon Cundy Business Intelligence Lead: Charlotte Anderson

Rationale:
To identify areas where CHFT can reduce risks and prevent harm, the reporting of all near misses and serious incidents is imperative to ensure we improve safety and learn from these events to prevent recurrence. Promoting a positive reporting culture is essential to CHFT's learning success for all our patients, families and staff.

Target:
To have no Patient Safety Incident Investigations (PSII)



What does the chart show/context:
- There was 1 PSII commissioned in September 2024 which has been declared and validated at the Trust Patient Safety Event Review Panel.

- An Incident declared on StEIS in March 2024 with an outcome of requiring an After-Action Review (AAR) was brought back to Patient safety event panel in September for a review .There is a concern that the AAR has not fully addressed the concerns raised and it was brought back to panel for a decision on level of investigation. Panel decision was for PSII to be commissioned. This is not included in the September figure for PSII as the incident had been already reported on StEIS as a serious incident investigation and will be double counted.

Underlying issues:
- The PSII commissioned was validated as a minor harm incident.
- This was under the Families and Specialist Services.
- This PSII is currently under investigation.

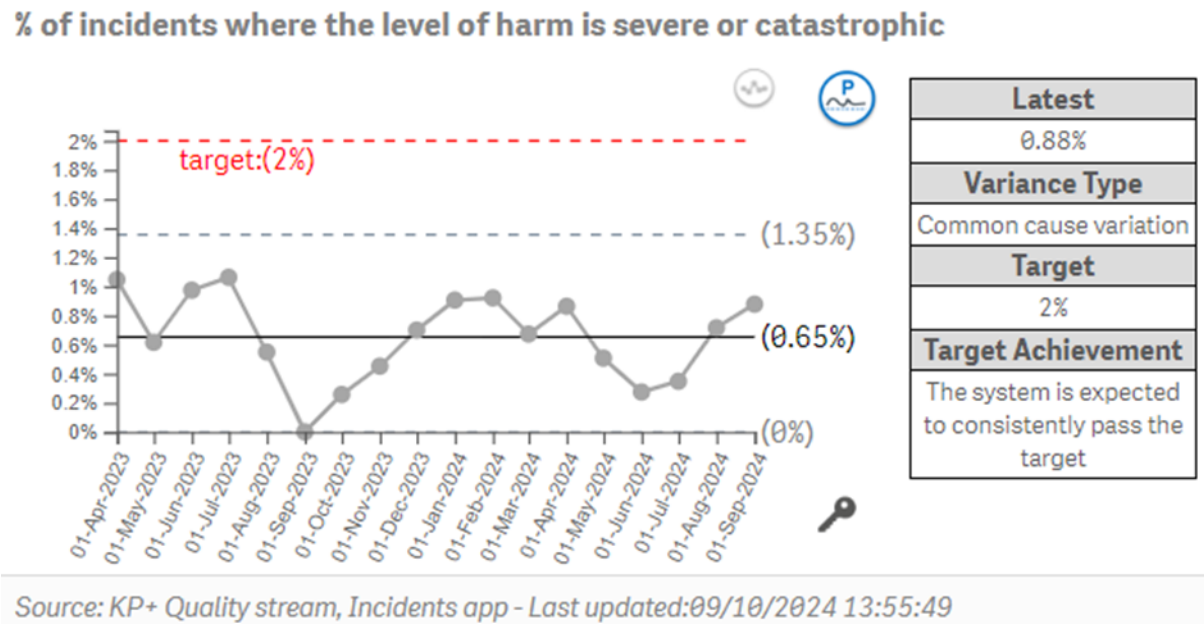
Actions:
- The Senior PSIRF Investigator is currently working with designated PSII investigators on this report.
- The Risk management Team and the Quality Governance Leads will continue to support the Divisions to triangulate and review data for learning.
- Learning will be shared once the PSIIs are complete.

% of incidents where the level of harm is severe or catastrophic

Executive Owner: Lindsay Rudge Operational Lead: Sharon Cundy Business Intelligence Lead: Charlotte Anderson

Rationale:
To identify areas where CHFT can reduce risks and prevent harm, the reporting of all near misses and serious incidents is imperative to ensure we improve safety and learn from these events to prevent recurrence. Promoting a positive reporting culture is essential to CHFT's learning success for all our patients, families and staff.

Target:
2% or less



What does the chart show/context:
- The percentage of incidents where the level of harm was severe or catastrophic was 0.88% in September 2024.
- Currently performance is subject to common cause variation and can be expected to vary from 0% to 1.35%.

Underlying issues:
- There were 6 severe harm incidents reported within this period (2 severe harm and 4 deaths).
- These incidents were recorded as 1 Appointment/Admission/Transfer/Discharge, 2 Assessment/Treatment/Diagnosis, 1 Maternity Incidents and 2 in relation to slip trip and fall.
- 1 incident has been downgraded after investigation, 2 incidents have been validated as severe harm and 3 remain under investigation.

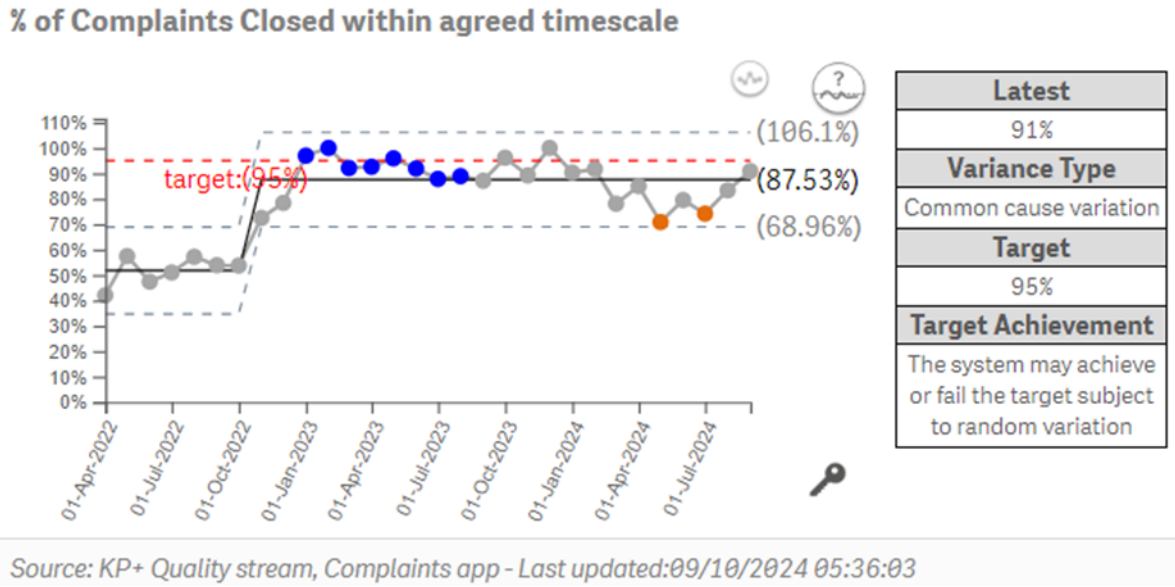
Actions:
- SWARMs and hot debriefs continue to be held to identify learning and immediate actions.
- The Risk Management Team and the Quality Governance Leads continue to work with clinical teams/departments to identify and triangulate themes and trends for implementation of quality improvement initiatives and shared learning Trust-wide.
- To continue to monitor the trend within the upper controls limits to ascertain reasons for variation.

% of complaints within agreed timescale

Executive Owner: Lindsay Rudge Operational Lead: Emma Catterall Business Intelligence Lead: Charlotte Anderson

Rationale:
CHFT views any complaint as an extension of our service user's care and the Trust is committed to moving towards a user centric service. Effective processes and procedures for handling concerns, feedback, stories, compliments, and complaints are pivotal to organisational learning success

Target:
95% of complaints to be closed on time.



What does the chart show/context:
- In September 2024 91% of complaints were closed within the agreed timescale.
- We may fail or achieve the target subject to random variation.
- Currently performance can be expected to vary from 68.96% to 100%.

Underlying issues:
- Performance has improved again, by 7 percentage points this month which is positive and highlights the actions taken are taking effect.
- There are still a number of draft responses that are not of the quality expected and therefore have to be returned to Division for further information which is unfortunately causing delays

Actions:
- Regular catch ups with ADNs alongside the weekly complaint meetings continue with good attendance from all Divisions to ensure responses are of good quality and within timeframes.
- Continue to monitor Trust performance daily and meet with Divisions on a weekly basis to maintain oversight of performance.

Quality Priorities:

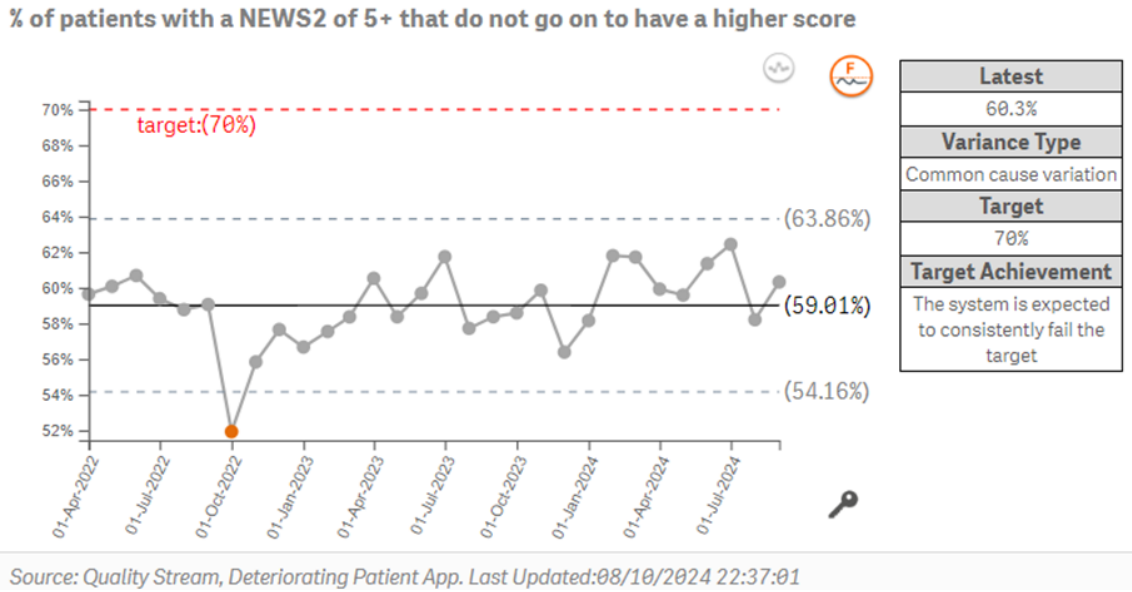
Metric	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Care of the acutely ill patient - % of episodes scoring NEWS of 5 or more not going on to score higher	September 2024	60.3%	70%			59.01%	54.16%	63.86%
Personalisation of care - % of patients that have been screened for dementia	September 2024	62.14%	90%			47.27%	35.26%	59.28%
Stroke - % of stroke patients admitted directly to an acute stroke unit within 4 hours of hospital admission	September 2024	45.95%	90%			33.39%	14.90%	51.89%

Care of the Acutely Ill Patient

Executive Owner: David Birkenhead Clinical Lead: Elizabeth Dodds Business Intelligence Lead: Charlotte Anderson

Rationale:
The identification and recording of deterioration, enabling swifter response, which will reduce the rate of preventable deaths. Reducing the need for higher levels of care will free up capacity particularly in ICU by avoiding admissions and reducing length of stay, both of which are significant factors in the NHS's recovery efforts.

Target:
70% of patients with a NEWS2 of 5+ will not have a higher score during their episode of care



Source: Quality Stream, Deteriorating Patient App. Last Updated:08/10/2024 22:37:01

What does the chart show/context:
- Performance was 60.3% in September 2024.
- The Trust is unable to meet the target of 70% and will consistently fail the target.
- Currently performance is subject to common cause variation
- Performance can be expected to vary from 54.16% to 63.86%.

Underlying Issues:
- There is a high volume of Nervecentre alerts requiring review, filtering and redistribution by the ART team (up to 2,260 per month). This can result in delays to responding to patients with a raised NEWS score.
- Medical Registrars do not carry Nervecentre devices at present, relying on bleeps for tasks, which may delay the response or result in more junior staffing reviewing NEWS 7 or more.
- Some of the patients with NEWS 5 or more who go on to score higher will include patients nearing the end of life who are appropriately palliated. This will be captured in the audit.

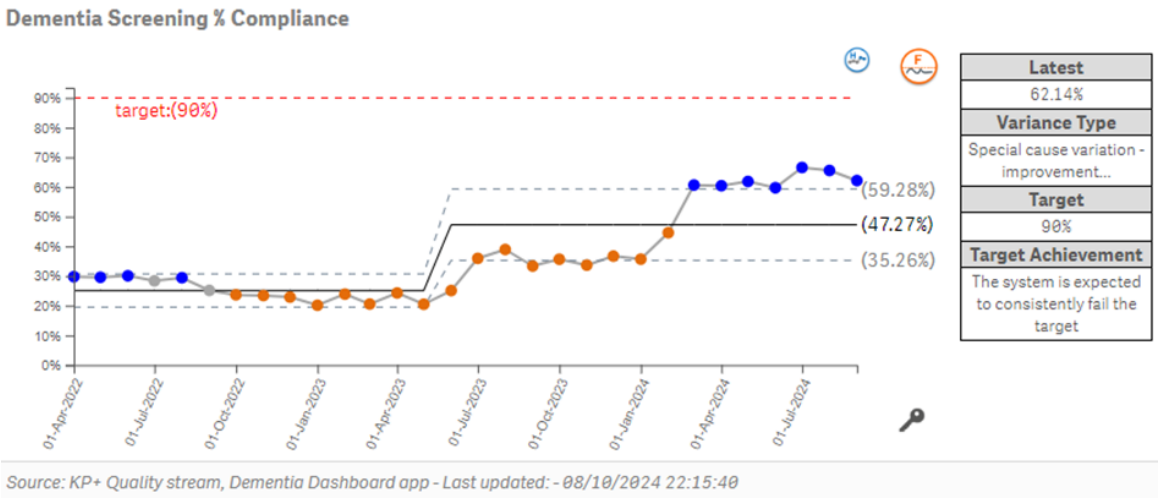
Actions:
- Nervecentre data shows there is a high volume of repeat alerts for NEWS7+ with some weeks up to 29 alerts per night shift generated for around 10 patients with a new deterioration per shift.
- Medical rotas are under review by the medical management team to ensure appropriate staffing skill mix reflecting the acuity of the Nervecentre
- A new task and finish group has been created to address these challenges.
- The medical teams will be the initial focus, before looking at the different challenges faced by the surgical teams and other departments. Surgical representatives are joining the meeting to facilitate collaboration from inception.

Personalisation of Care

Executive Owner: Lindsay Rudge | Clinical Lead: Laura Doyle | Business Intelligence Lead: Keziah Bentley

Rationale:
Dementia is a significant challenge and a key priority for the NHS, when people with dementia come into acute care, their length of stay is longer than people without dementia. Recognition of dementia also allows for improved care during the hospital admission.

Target:
To ensure 90% of admitted patients receive screening as per guidance



What does the chart show/context:
- Performance was 62.14% in September.
- The Trust is unable to meet the target of 90% and will consistently fail the target.
- Currently performance is subject to special cause indicating improvement.
- Performance can be expected to vary from 35.26% to 59.28%.

Underlying issues:
- Dementia screening assessments remain an area of priority with areas identified for further training as compliance is not yet meeting the national standard of 90% - there has however been an improvement in compliance, but this will continue to remain an area of priority.

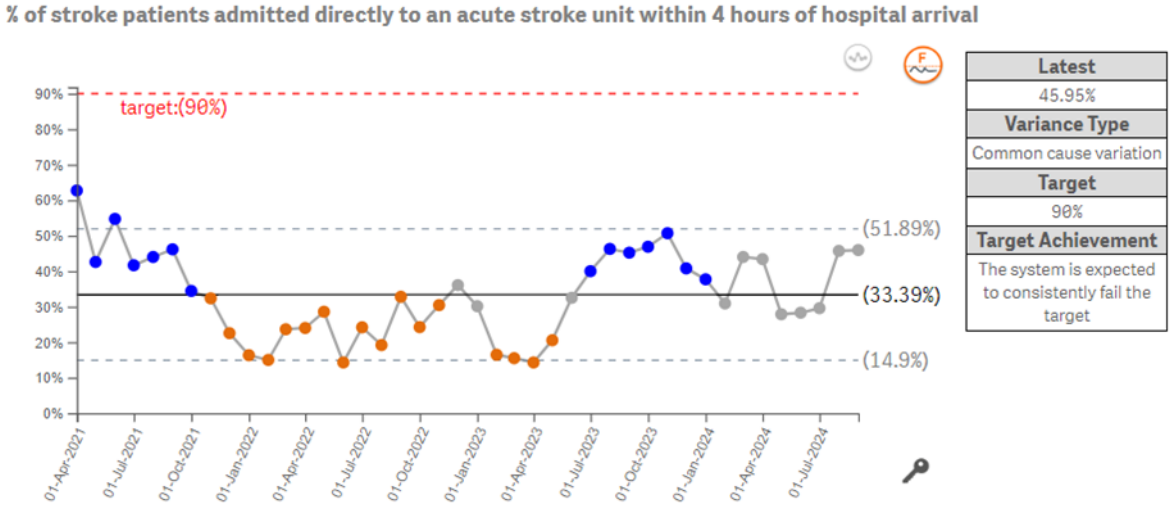
Actions
- The dementia operational group met on 17th September 2024 the dementia screening assessment compliance will be promoted and audited through this group.
- The enhanced care team are providing training to ward areas on how to complete the tool and the importance of its use, this has also been incorporated into the new dementia training package which is available for all staff, there are sessions available across sites, places can be booked via the enhanced care team.

Stroke

Executive Owner: David Birkenhead Clinical Lead: Karthik Viswanathan Business Intelligence Lead: Charlotte Anderson

Rationale:
This measure is looking at the % of stroke patients admitted directly to an acute stroke unit within 4 hours of hospital admission. This is the national standard, with direct admission to a stroke unit within 4 hours being a large driver for patient outcomes.

Target:
90%.



What does the chart show/context:
- Performance was 45.95% in September 2024 which is in expected range.
- The Trust is unable to consistently meet the target of 90% and is showing a performance level that is shown to statistically fail this target with the current process.
- Currently performance can be expected to vary from 14.0% to 51.89%.

Underlying Issues:
- High level of demand
- Availability of beds across Stroke Floor.
- Main driver is lack of HASU bed availability.
- Level of therapy input has decreased impacting negatively on the length of stay (LoS) and delays discharge.
- Outlier numbers remain high to create bed capacity across the Acute Stroke Unit (ASU).
- Patients admitted to ASU via Acute Floor due to capacity constraints as a result of increased length of stay.

Actions:
- WTGR Session 22nd October with representatives from Stroke, ED and Patient Flow/Site teams to work through HASU bed availability issue.
- Agreement for change of process whereby the portering team will be contacted with an ETA for arrival of stroke patients to A&E. Porter will meet patient and stroke team to escort patient to CT and back.
- Ward 8B now being used to cohort outliers from stroke rehab wards with early identification of patients who can outlie.
- Stroke and Frailty matrons reviewing pathways.

Elective Care:

Metric	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Total Patients waiting >40 weeks to start treatment	September 2024	916	0			-	-	-
Total Patients waiting >52 weeks to start treatment	September 2024	41	0			-	-	-
Total RTT Waiting List	September 2024	35,830	36,538			35,361	34,370	36,351
Total elective activity undertaken compared with 2023/24 activity plan	September 2024	100.3%	100%	-	-	-	-	-
Percentage of patients waiting less than 6 weeks for a diagnostic test	September 2024	95.1%	95%			89.0%	83.3%	94.7%
Diagnostic Activity undertaken against activity plan	September 2024	14,905	14,547			14,223	12,111	16,336
Total First attendances and procedures undertaken compared with 2024/25 activity plan	September 2024	102.1%	100%	-	-	-	-	-
Total Follow-Up activity undertaken compared with 2023/24 activity plan	September 2024	94.9%	100%	-	-	-	-	-
Day Case Rates	June 2024	82.9%	85%			81.4%	80.1%	82.7%
Capped Theatre Utilisation	September 2024	83.7%	85%			81.8%	73.6%	90.0%

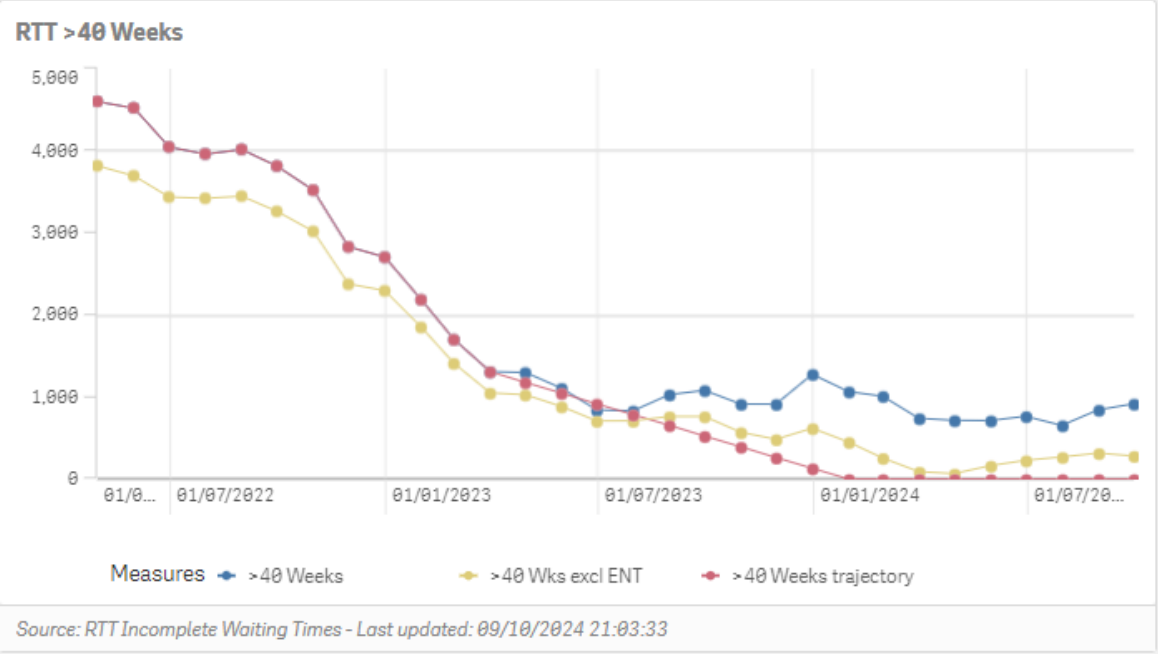
Total Patients waiting more than 40 weeks to start consultant-led treatment

Calderdale and Huddersfield NHS Foundation Trust

Executive Owner: Jonathan Hammond Operational Lead: Thomas Strickland Business Intelligence Lead: Fiona Phelan

Rationale:
To measure and encourage compliance with recovery milestones for the RTT waiting list.

Target:
Aim to have 0 patients waiting more than 40 weeks by January 2025 (excluding ENT)



What does the chart show/context:

- Our 40-week position stands at 916 at the end of September against the target trajectory of 0 (282 excluding ENT).
- Most of our remaining patients who are waiting over 40 weeks are in ENT (634), General Surgery (49), MaxFax (71), Plastic Surgery (24), Gynaecology (48),Gastroenterology (22) and Cardiology (28). All other specialties have 12 or fewer. Most specialties have deteriorated.

Underlying issues:

- A growing ASI list (especially in ENT) represents a risk to the continuing reduction in list size.
- Cancelled lists/appointments due to strike action have resulted in a delay in reducing the 40-week position.

Actions:

- Operational teams to be tracking patients to at least 26 weeks.
- KP+ writeback model being used by all operational teams to ensure that tracking actions are transparent and cannot be overwritten by Validation teams.
- ENT Task and Finish Group concluded with actions in place.
- Actions have been identified in 3 cohort areas:
    - Demand management
    - Increasing internal capacity
    - Increasing external capacity
- Number of >40 week waits impacted by Industrial action is being tracked.
- To support 40-week delivery additional Access meetings have been put in for Cardiology, Gynaecology, Dermatology and Gastroenterology and Max Fax specialties.

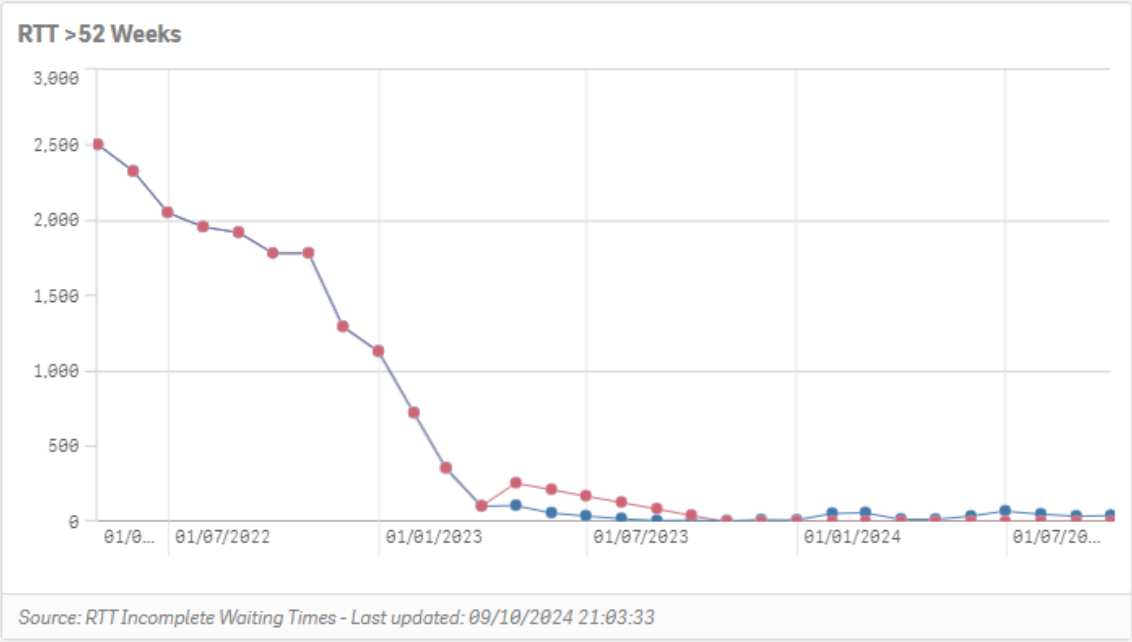
Total Patients waiting more than 52 weeks to start consultant-led treatment

Calderdale and Huddersfield NHS Foundation Trust

Executive Owner: Jonathan Hammond Operational Lead: Thomas Strickland Business Intelligence Lead: Fiona Phelan

Rationale:
To measure and encourage compliance with recovery milestones for the RTT waiting list.

Target:
Aim to have 0 patients waiting more than 52 weeks by November 24.



What does the chart show/context:
- Our 52-week position now stands at 41 (27 in ENT, 4 in MaxFax, 2 each Gastroenterology and Ophthalmology, 1 each in Medical Other, Cardiology, Dermatology, General Surgery, Urology and Plastic Surgery.
- There are 192 patients waiting between 46 and 52 weeks, mainly ENT (150 – up from 102), MaxFax (12), Gynaecology and Cardiology (10 each) and General Surgery (5).
- All other specialties (5) have 2 or fewer patients waiting between 46 and 52 weeks.
- There are 0 patient over 65 weeks.
- There are 7 patients who have been waiting between 60 and 65 weeks (4 in ENT), 1 each in Dermatology, Ophthalmology and Plastic Surgery.

Underlying issues:
- The longer-term risk to the 52-week position is specifically from ENT ASIs.
- The non-ENT patients have treatment plans in place.

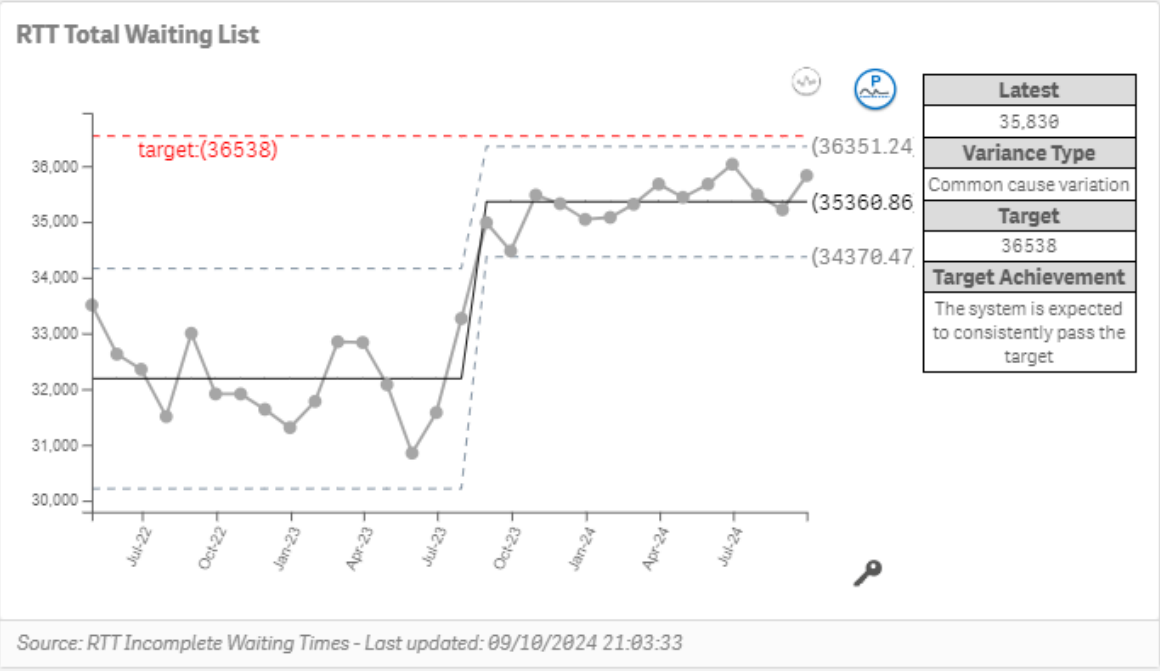
Actions:
- Operational teams to be tracking patients to at least 26 weeks.
- To support 52-week delivery and maintain delivery from May onwards - S&A have restructured A&C resource to enable greater tracking of ENT's RTT position.
- KP+ writeback model being used by all Operational teams to ensure that tracking actions are transparent and cannot be overwritten by Validation teams.
- ENT Task and Finish Group concluded with actions in place and are working to 52-week compliance.
- Actions have been identified in 3 cohort areas:
    - Demand management
    - Increasing internal capacity
    - Increasing external capacity

Total RTT Waiting List

Executive Owner: Jonathan Hammond Operational Lead: Kim Scholes Business Intelligence Lead: Fiona Phelan

Rationale:
To measure the size of the Referral to Treatment (RTT) incomplete pathways waiting list.

Target:
36,538 (activity plan 2024/25)



What does the chart show/context:
- The list remains high and stands at 35,830 at the end of September, although it is below the target and represents normal variation.

Underlying issues:
- We currently have a relatively stable RTT Waiting list position which is below the target for 2024/25 of 36,538.
- For ENT and Gynaecology, we have seen an increase in ASIs (ENT is a capacity issue whilst Gynaecology has seen an increase in demand and reduced capacity).
- Ophthalmology has increased due to an improvement in data quality which means the inclusion of pathways for those on the portal (EyeV) awaiting triage.
- The national position continues to grow monthly. The ICS position suggests we are the only Trust in the region currently not seeing a 20% increase in pathways over the last 12 months.

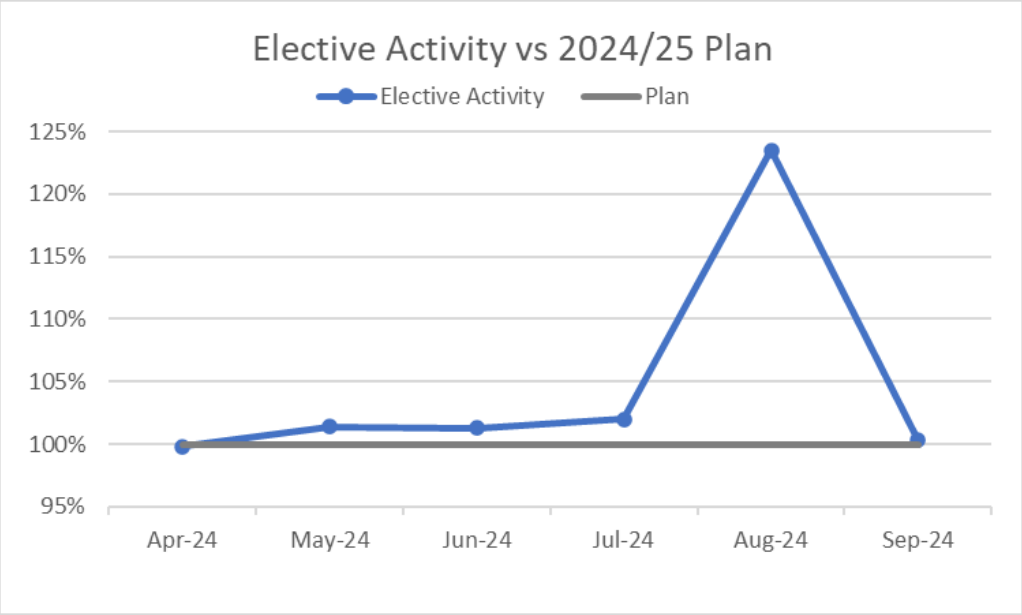
Actions:
- Validation team to monitor LUNA (National DQ RTT Benchmarking tool – currently in top 10 Trusts in the country for RTT DQ Assurance).
- Meet the trajectory for no ASIs over 18 weeks.
- Meet the trajectory for 40/52 weeks.
- Operational teams to be tracking patients to at least 32 weeks.
- Validation team to use KP+ RTT model that identifies where RTT Pathways have been created inappropriately or user has selected status code of 99 Not Known that suggests a training issue.

Total elective activity undertaken compared with 2024/25 activity plan

Executive Owner: Jonathan Hammond Operational Lead: Kim Scholes Business Intelligence Lead: Oliver Hutchinson
Finance Lead: Helen Gaukroger

Rationale:
Recover elective activity levels to meet the National Elective Recovery target.

Target:
Recover elective (day cases/elective inpatients) services so that activity levels are at least 100% of 2024/25 activity plan



What does the chart show/context:
- CHFT has exceeded the 2024/25 overall elective activity plan in September 2024 with performance standing at 100.3% when compared to the September 2024 plan.
- Elective inpatient activity exceeded the in-month plan showing performance against plan of 106.8%, with Day case performance standing at 99.6% for September in month.
- The year-to-date position for elective activity overall is at 104.0% of plan, equating to 845 spells above plan.

Underlying issues:
- This data is performance against the original CHFT Plan.
- The day case and elective position excludes ‘planned procedures not carried out’ as these are not in scope for Elective Recovery Funding.

Actions:
- There has been a KP+ Contract Monitoring Report model set up for 2024/25 to break this data down to specialty level. Finance leads to work with divisional GMs and Ops managers to ensure awareness of this position at specialty and divisional level.

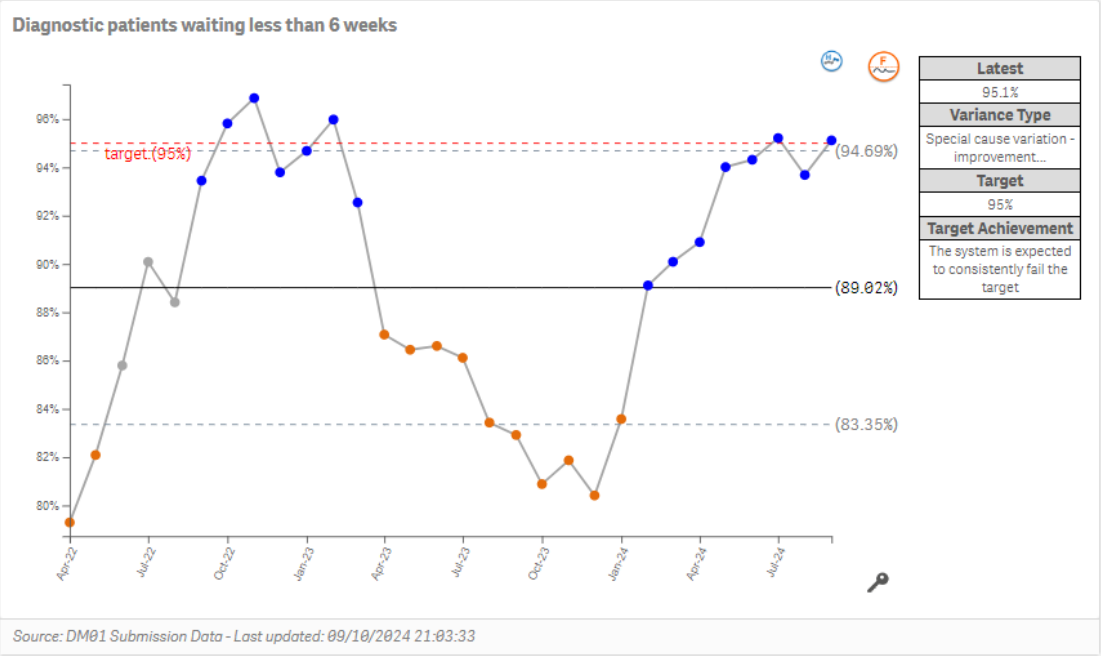
Percentage of patients waiting less than 6 weeks for a diagnostic test

Executive Owner: Jonathan Hammond
Business Intelligence Lead: Fiona Phelan

Operational Leads: Thomas Strickland/Stephen Shepley/Helen Rees
Finance Lead: Helen Gaukroger

Rationale:
Maximise diagnostic activity focused on patients of highest clinical priority.

Target:
Increase the percentage of patients that receive a diagnostic test within 6 weeks in line with the March 2025 ambition of 95%.



What does the chart show/context:
- The Trust achieved the 95% target in September (95.1%).

Underlying issues:
- Echocardiography still has significant numbers of pathways >6 weeks.
- The Cystoscopy backlog position has now recovered to a normal level (96.9%).
- Whilst the Trust performance is meeting the 95% target in most modalities, we are still consistently below this for Echocardiography (74.4% up from 69.4 %).

Actions:
Echocardiography
- Rate of recovery has increased in line our goal to recover by the end of October
- Weekend clinics planned and CDC activity has increased from 2 to 5 days.
- Reporting backlog now at manageable levels.
- Trainee templates now amended giving us 12 additional scans per week per trainee which is giving us 150 additional slots a month.
- Once recovered, plan to stop weekend clinics and gradually reduce bank in core hours as able whilst ensuring performance targets are met.

Total Diagnostic Activity undertaken against the activity plan

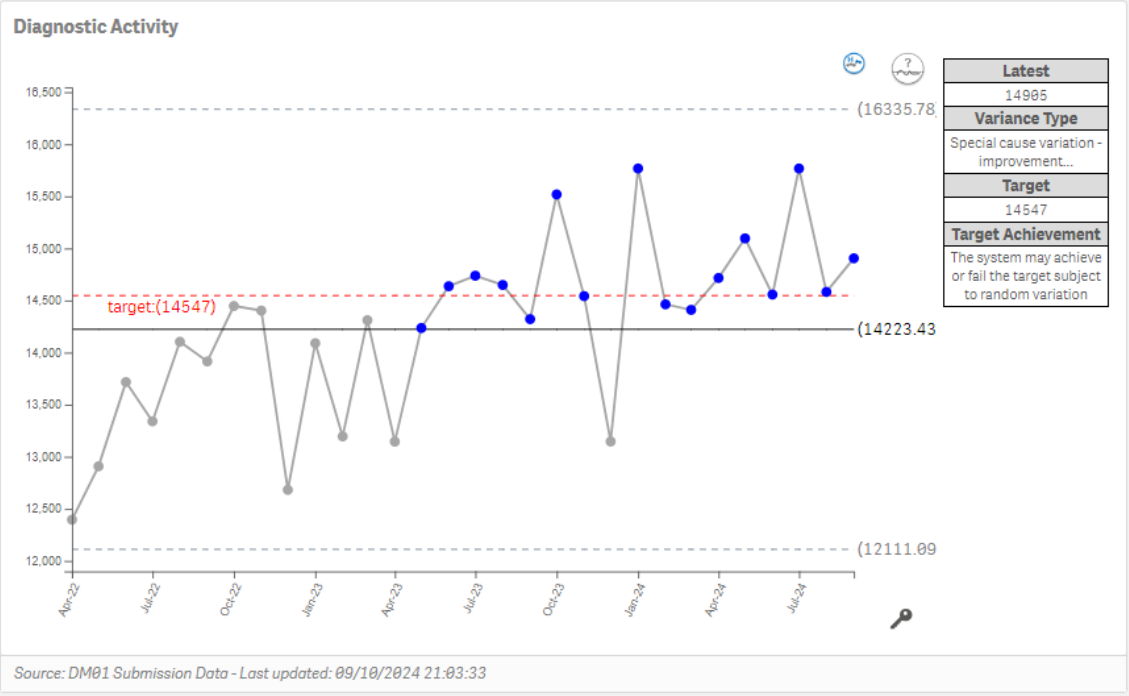
Calderdale and Huddersfield NHS Foundation Trust

Executive Owner: Jonathan Hammond
Business Intelligence Lead: Fiona Phelan

Operational Lead: Thomas Strickland/Stephen Shepley/Helen Rees
Finance Lead: Helen Gaukroger

Rationale:
Maximise diagnostic activity focused on patients of highest clinical priority.

Target:
Recovery of diagnostic testing is key to wider elective recovery, including RTT performance. Target 14,547 (activity plan 2023/24)



What does the chart show/context:

- The Trust has been achieving levels around the target of 14,547 since May 2023, but it may achieve or fail the target subject to random variation. The activity for September 2024 is above the target at 14,905.
- Performance can be expected to vary between 12,111 and 16,336. Activity is similar to pre-Covid levels.

Underlying issues:

- Overall, we have been performing around the target level, but since some modalities are already operating at 6 weeks or less from a diagnostic waiting time perspective, additional activity is not currently needed as per the planning submission made at the start of the year.
- Echocardiography is the main area where activity is below the plan and is materially off target against 95% of patients being seen within 6 weeks.

Actions:
Echocardiography

- Rate of recovery has increased in line our goal to recover by the end of October
- Weekend clinics planned and CDC activity has increased from 2 to 5 days.
- Reporting backlog now at manageable levels.
- Trainee templates now amended giving us 12 additional scans per week per trainee which is giving us 150 additional slots a month.
- Once recovered, plan to stop weekend clinics and gradually reduce bank in core hours as able whilst ensuring performance targets are met.

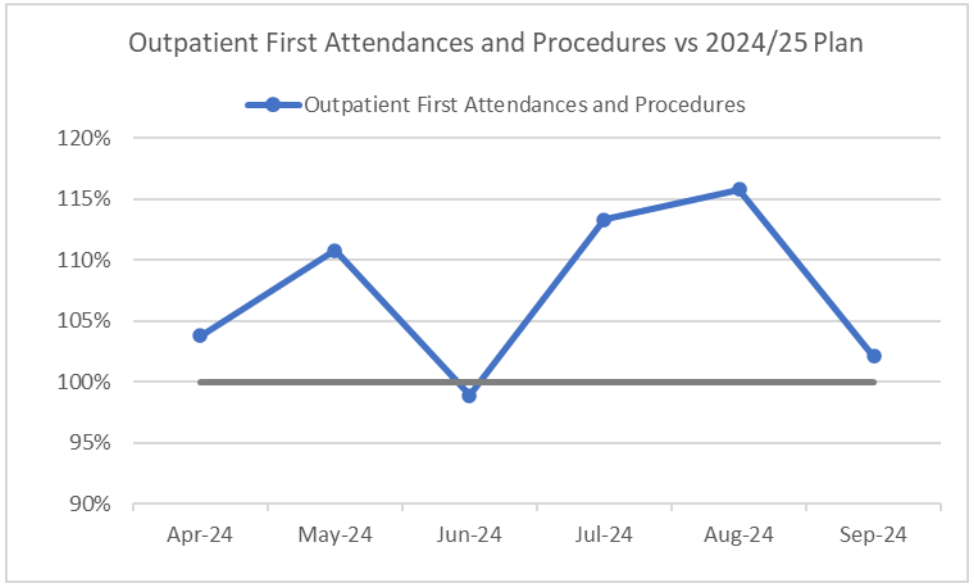
Total First attendances and procedures undertaken compared with 2024/25 activity plan

Calderdale and Huddersfield NHS Foundation Trust

Executive Owner: Jonathan Hammond Operational Lead: Kim Scholes Business Intelligence Lead: Oliver Hutchinson
Finance Lead: Helen Gaukroger

Rationale:
Recover first attendance and procedure levels to meet the National Elective Recovery target.

Target:
100% of 2024/25 activity plan (source: activity plan 2024/25)



What does the chart show/context:

- Outpatient first attendance and procedure (first and follow-up) activity has decreased in month 6 compared to the 2024/25 activity plan however remains above planned position delivering 102.1% of plan in month. First attendances have delivered to 102.0% of plan and procedures delivered 103.4% of plan.
- The year-to-date position is at 108.8% of plan equating to 6,437 outpatient first attendances and procedures above plan.
- Work is ongoing to improve the capture the coding of outpatient procedures and this has seen a positive shift from outpatient attendances to procedures in the year-to-date position within Gynaecology and Urology.

Underlying issues:

- With the increase in outpatient first attendances seen in month 6 the ASI list does still remain at 17,338, this is a decrease of 800 from the previous month.
- There has been an increase in incomplete outcomes in the first 6 months of 2024/25, this is causing some activity to not make it through to this position. This is being closely monitored and picked up in Outpatient Access meetings with all areas.

Actions:

- Cardiology have plans in place to run some extra clinics for first waiters to address the growing ASI list.
- Gynaecology have been running some ‘Super Saturday Clinics’ for extra first capacity with another clinic taking place this month, there are plans in place for further clinics in the coming months.
- ENT continue to work with Pioneer to support with the management of the waiting list.

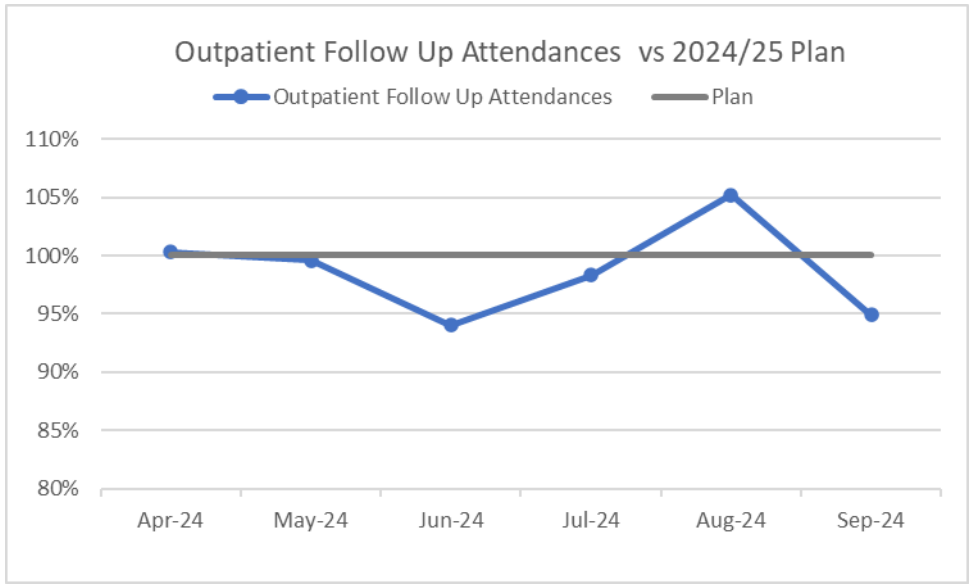
Total Follow-Up attendances undertaken compared with 2024/25 activity plan

Calderdale and Huddersfield NHS Foundation Trust

Executive Owner: Jonathan Hammond Operational Lead: Kim Scholes Business Intelligence Lead: Oliver Hutchinson
Finance Lead: Helen Gaukroger

Rationale:
To measure the relative reduction in follow-up outpatient attendances (consultant and non-consultant led) in 2023/24 compared to 2023/24 activity plan

Target:
100% of 2024/25 activity plan (source: activity plan 2024/25)



What does the chart show/context:
- CHFT made the decision at the start of 2022/23 to not adopt the 25% reduction in Outpatient follow-up activity, this has continued for 2024/25.
- Activity has moved below the planned position in September 2024 standing at 94.9% of the in-month plan.
- The year-to-date position is at 98.3% of plan. This represents a total of 1,986 attendances below the planned position to date.

Underlying issues:
- 40% of the backlog has been waiting less than 12 weeks.
- Work progressing through the Outpatient Access meetings has led to a positive reduction in the Trauma and Orthopaedics follow up waiting list perspective, with a reduction of 400 in month.

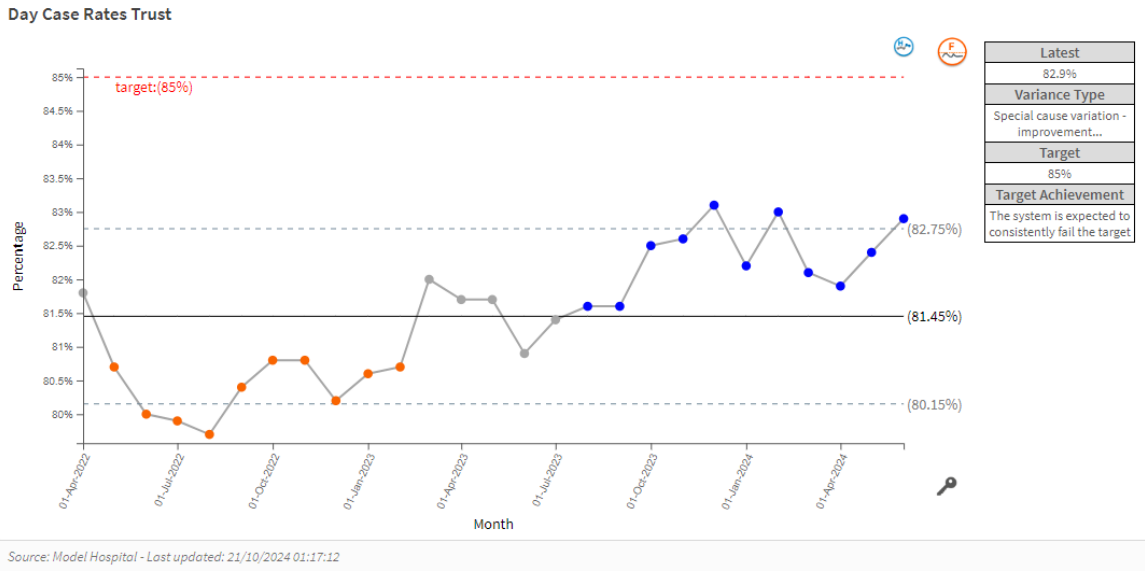
Actions:
- There are currently 6k (of the 32k backlog) records that are awaiting a clinical prioritisation within CHFT's MPage system. This remains static but is a direct result of a reduction in admin validation due to focusing on more productive validation work utilising data science. WTGR workshops have been held in August and September with a final session planned for October. A WTGR has been planned for November to focus on booking.
- We now have 32,076 follow-up patients past see by date, and this is gradually increasing weekly.
- A regular 'Outpatient Access' meeting focussing on the follow-up backlog and capacity management has been established. There has also been a waiting time target for each specialty area introduced to track improvement work.

Day Case Rates

Executive Owner: Jonathan Hammond Operational Lead: Tom Strickland Business Intelligence Lead: Inderjit Singh

Rationale:
To measure the relative increase

Target: Over 85%



What does the chart show/context:

- In September 2024 Model health amended how they calculated organisational day case rates for BADS procedures to include those BADS procedure completed in an outpatient setting.
- The report shown being 3 months to the end of June 2024 – performance at 82.9% against an 85% target – currently in performance quartile 2 of 4.

Underlying issues:

- Data quality challenges around “intended management”. Cases are being listed on Bluespier and completed as day case however these are not counted due to PM office amendments not being made.
- Reverse conversion are not counted – If a patient is listed for an inpatient stay but is completed as day case this is not reflected in our day case rate.

Actions:

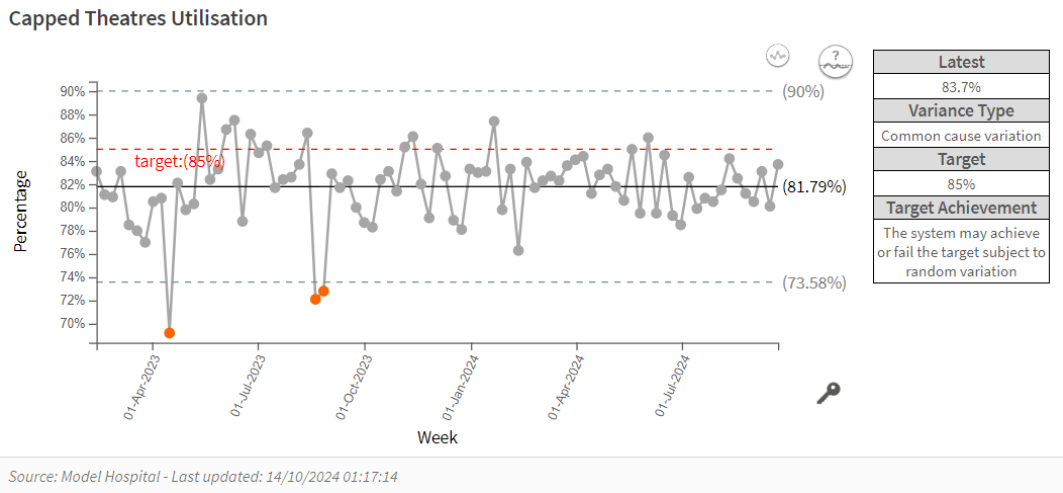
- Day case rates are monitored at a specialty level through the monthly STUG meetings.
- Procedure specific data reviewed each month to identify improvement opportunities or data quality challenges.
- Specific actions in development for procedures where CHFT are identified as true outliers
- Working with THIS team to ensure data quality gives us accurate DC rates.

Capped Theatre Utilisation

Executive Owner: Jonathan Hammond Operational Lead: Gemma Pickup Business Intelligence Lead: Inderjit Singh

Rationale:
To measure the relative increase

Target: Over 85%



Source: Model Hospital - Last updated: 14/10/2024 01:17:14

What does the chart show/context:

- Model Hospital Capped theatre utilisation is reported on a weekly basis and only reports 1 week at a time.
- The report shown being w/e 22nd September 2024 – performance at 83.7% against an 85% target – currently in performance quartile 4 of 4 (Highest 25% performance bracket).

Underlying issues:

- Regional Go Sees have identified inconsistencies as to how organisations record 'Start' times.
- Lots of work done to improve intercase downtime however there are often large gaps between AM & PM patients due to breaks and staff changes. Identified that one regional trust has an extra member of staff in theatre to support collecting next patient to ensure quick turnaround.
- MH unable to explain how they account for 60 min lunchtime despite this being reported as an 'allowed' gap. Negatively impacts CHFT as other trusts in region still operate on an AM/PM model.

Actions:

- Utilisation is monitored at a specialty list level through the monthly STUG meetings to identify improvement opportunities or data quality challenges. Work with the STUG to identify themes and concerns.
- Issue with scheduling in some specialties. Working to review amount of time being allocated to specific procedures
- Weekly 6-4-2 Scheduling meetings with specialties now working well. Working towards better communication around utilisation and scheduling.
- Trialling new start times in Orthopaedics to see if this improves.

Cancer:

Metric	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Proportion of patients meeting the 62-Day standard	September 2024	85.90%	85%			88.64%	82.78%	94.41%
Proportion of patients meeting the faster diagnosis standard	September 2024	74.53%	75%			76.84%	69.39%	84.28%
Non-Site-Specific Cancer Referrals	September 2024	28	27			23.93	10.73	37.13
Early cancer diagnosis: 75% of cases diagnosed at stage 1 or 2 by 2028	September 2024	50.50%	75%			48.72%	34.64%	62.80%

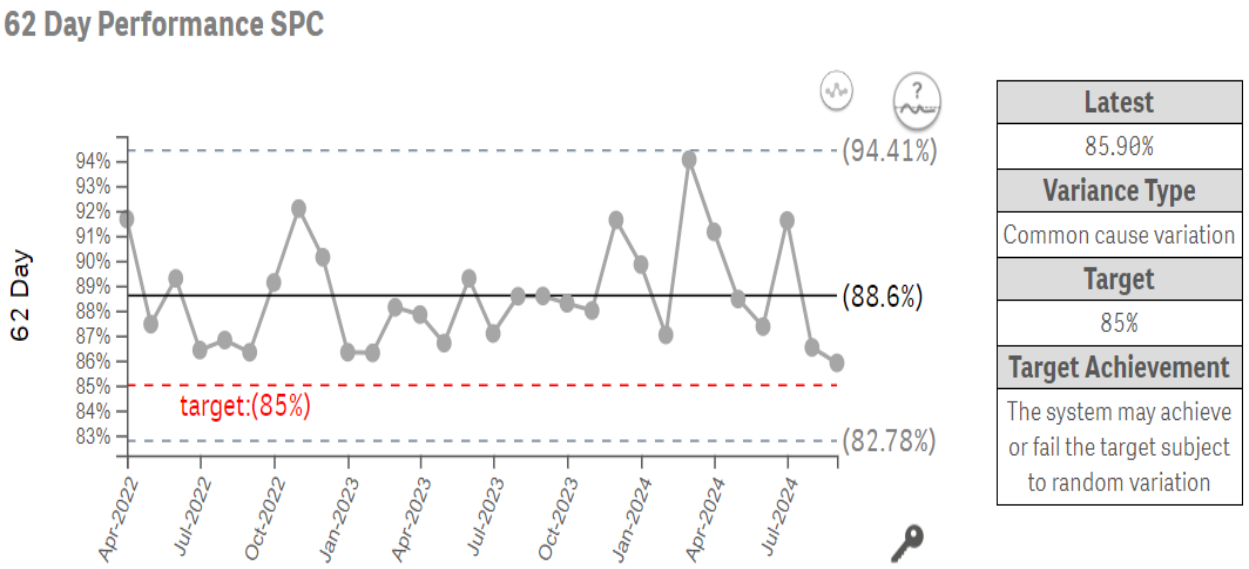
Proportion of patients meeting the 62-day cancer referral to treatment standard

Calderdale and Huddersfield NHS Foundation Trust

Executive Owner: Jonathan Hammond Operational Lead: Maureen Overton Business Intelligence Lead: Courtney Burkinshaw

Rationale:
The NHS Constitution outlines what patients can expect and their rights when they are referred on a cancer diagnosis and treatment pathway. Patients who receive a cancer diagnosis after an urgent suspected cancer referral, referral for breast cancer symptoms, or via cancer screening should start treatment within 62 days of that initial referral.

Target: 85%



Latest
85.90%
Variance Type
Common cause variation
Target
85%
Target Achievement
The system may achieve or fail the target subject to random variation

What does the chart show/context:
- This chart shows number of patients who have been given their first treatment within 62 days.
- The Trust consistently hits this target, and current performance stands at 85.9%

Underlying issues:
- Lack of capacity at first seen.
- 28-day target performance due to delay in first seen, diagnostic capacity, radiology. Repeat tests.
- H&N at 14% in September. Issues with Thyroid surgery
- SKIN still delays in pathway with diagnostic biopsies, late referral to Max/Fax and plastics
- Lower GI and Bowel Screening, capacity for clinic and theatre.
- 104-day pathways – this is a concern patients as a higher proportion of patients at this point in the pathways, some due to complexity, change in treatment plans, long waiting times for Radiotherapy at Leeds. Though our IPT to Tertiary centres are late in the pathway
- Referrals have increased resulting in 27% (311) more allocated 62-day pathways year to date compared to last year.

Actions:
- Teams need to review their pathways from beginning to end.
- Escalation of risk at weekly meeting with PPC's, Opps/GM's
- Continue to monitor patients on PTL between day 48 and day 62 and prevent patients reaching over 104. Daily checks and weekly meeting to review these patients.
- Capacity to be reviewed alongside other completing pressures.
- Competing capacity for theatres with other Trust targets.

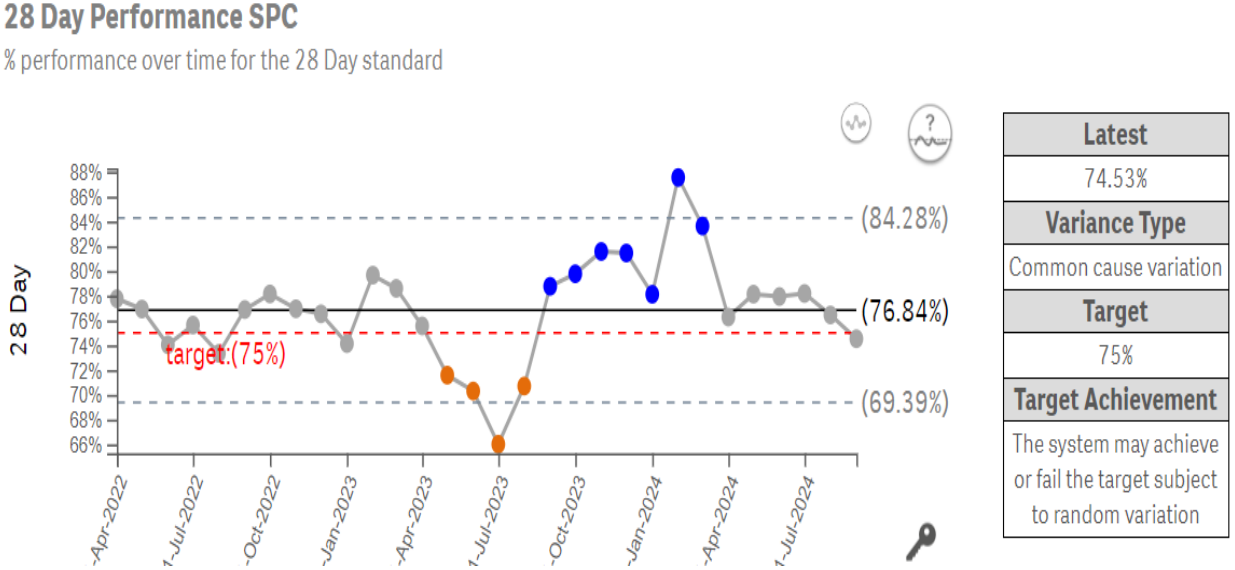
Proportion of patients meeting the faster diagnosis standard

Calderdale and Huddersfield NHS Foundation Trust

Executive Owner: Jonathan Hammond Operational Lead: Maureen Overton Business Intelligence Lead: Courtney Burkinshaw

Rationale:
Faster Diagnosis will facilitate an improvement in the Cancer early detection rate and thereby increase the chances of patients surviving.

Target:
Maximum four weeks (28 days) from receipt of referral, to point at which patient is told they have cancer, or cancer is definitely excluded. Target 75% (77% by March 2025).



Latest
74.53%
Variance Type
Common cause variation
Target
75%
Target Achievement
The system may achieve or fail the target subject to random variation

What does the chart show/context:
- Latest monthly performance stands at 74.53% which is below the National target
- National performance tends to be under the 75% target.
- The Trust is expected to meet or fail the target of 75% subject to random variation. Performance can be expected to vary between 69% and 84%

Underlying issues:
- Lower GI - 48% in September. Some improvement with Lower GI although we are working hard in this area as we still do not achieve day 28, factors preventing this are diagnostic tests turn around for actual test and results. Endoscopy capacity for deep sedation colons. Results Admin clinics delaying pathways in results being received by patients.
- H&N (71% in September) we are frequently chasing results letters/appointments for results. Slight improvement here as the CNS team are helping with calls to patients to give benign diagnosis.
- Gynae has seen a drop in performance due to Capacity for FT OPA, reinstate regular FT meetings, and delayed Outpatient hysteroscopies
- Referrals have increased resulting in 8% (1,300) more faster diagnosis standard pathways year to date compared to last year.

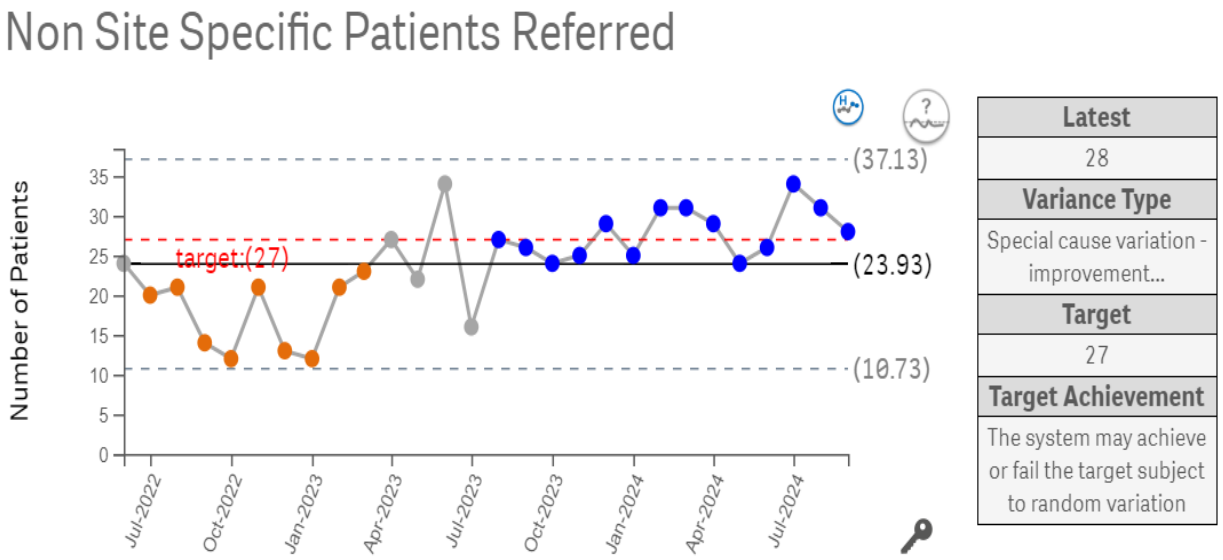
Actions:
- Lower GI trialling “Perfect week” to see effect on 28 days and further pathway. Monitoring of Admin clinics for results making sure enough capacity is put in.
- H&N work ongoing with team and closely monitoring of patients at weekly risk meeting
- Gynae reviewing outpatient Hysteroscopy capacity and monitoring at a fortnightly cancer meeting. Gynae will also review 28 days performance at the weekly risk meeting to try and challenge some of the current issues.

Non-Site-specific Cancer Referrals

Executive Owner: Jonathan Hammond Operational Lead: Maureen Overton Business Intelligence Lead: Courtney Burkinshaw

Rationale:
The non-specific symptoms (NSS) pathway provides a route for patients presenting with vague symptoms who may have a serious illness.

Target: 27 as per activity plan for 2024/25



Latest
28
Variance Type
Special cause variation - improvement...
Target
27
Target Achievement
The system may achieve or fail the target subject to random variation

What does the chart show/context:
- The Trust is unable to consistently meet the target of 27 and may achieve or fail the target subject to random variation. Performance can be expected to vary between 10 and 37.

Underlying issues:
- Referrals continue to be variable.

Actions:
- Looking to set up a GP education session to raise the profile of the service and the links to offering a pathway for FIT negative patients.
- NSS in the community has been rolled out to 4 PCNs across Calderdale and Kirklees.

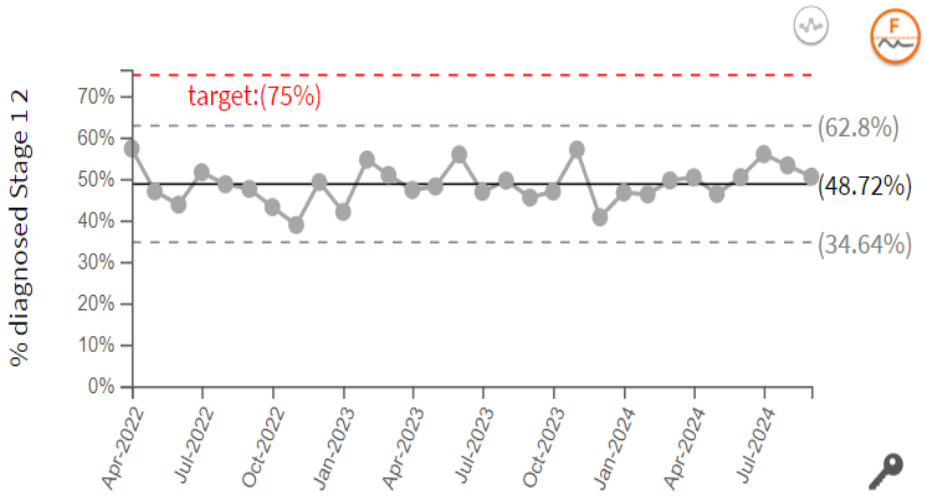
Early cancer diagnosis: 75% of cases diagnosed at stage 1 or 2 by 2028

Executive Owner: Rob Aitchison Operational Lead: Maureen Overton Business Intelligence Lead: Courtney Burkinshaw

Rationale:
Cancer is one of the biggest contributors to inequalities in life. Early presentation, referral, screening and diagnosis are key to addressing the health inequalities around diagnosis of cancer.

Target:
75% of all diagnosed cancer to be stage 1 or 2 by 2028.

Cancers Diagnosed by Stage 1 and 2



Latest
50.5%
Variance Type
Common cause variation
Target
75%
Target Achievement
The system is expected to consistently fail the target

What does the chart show/context:
- The Trust is expected to consistently fail the target of 75%.
- Performance can be expected to vary between 34% and 63%.
- Nationally this metric stands at 54%

Underlying issues:
- This metric is an area where CHFT need to work with partners to raise awareness and ensure that ICB colleagues are addressing the issues.

Actions:
- Metric rolled out alongside a series of NHSE pilots, including FIT testing.
- The Faster Diagnostic Framework will also support this unit of work..

Urgent and Emergency Care and Flow:

Metric	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Proportion of patients admitted, transferred or discharged within 4 hours	September 2024	68.88%	78%			68.74%	60.77%	76.72%
Proportion of ambulance arrivals delayed over 30 minutes	September 2024	16.6%	0%			10.07%	5.54%	14.6%
Proportion of patients spending more than 12 hours in an emergency department	September 2024	3.78%	2%			3.42%	0.92%	5.92%
Adult G & A acute bed occupancy adjusted for void beds (Type 1 Acutes Only)	September 2024	97.80%	96%			98.14%	96.48%	99.80%
% of beds occupied by patients who no longer meet the criteria to reside	September 2024	18.4%	16%			20.8%	17.4%	24.2%
Hospital Discharge Pathway Activity – AvLOS pathway 0	September 2024	4.9	4.56			4.3	3.9	4.8
Transfers of Care*	September 2024	109	50*			108	68	147

* Note TOC target for 2024/25 to be agreed

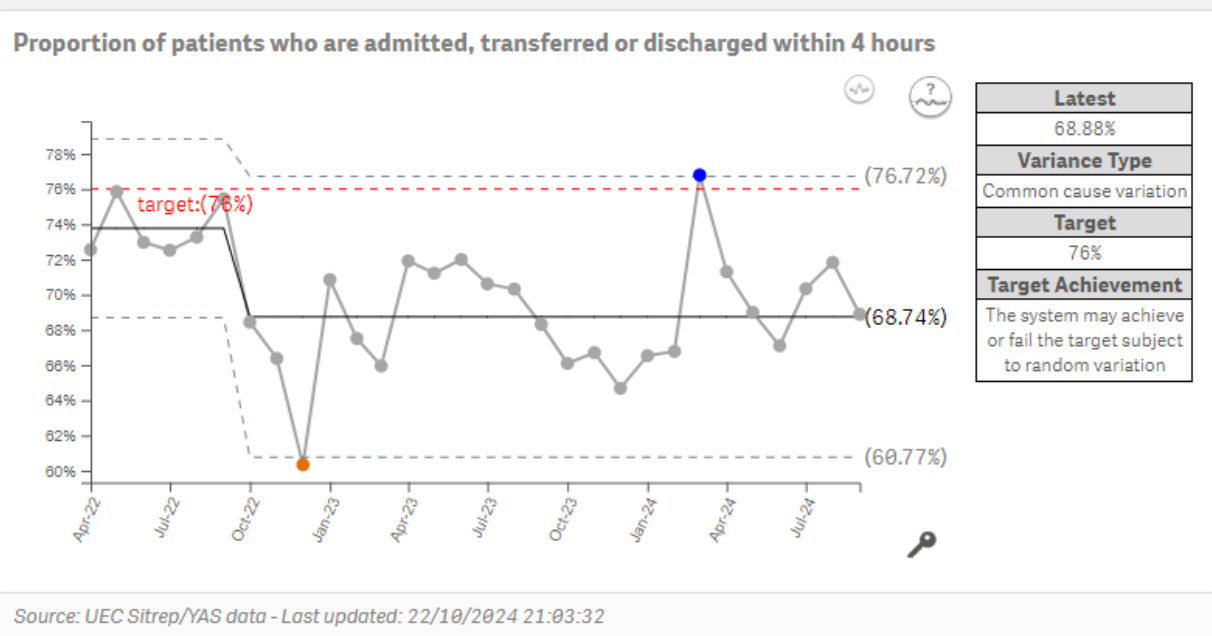
Proportion of patients admitted, transferred or discharged within 4 hours

Calderdale and Huddersfield NHS Foundation Trust

Executive Owner: Jonathan Hammond Operational Lead: Jason Bushby Business Intelligence Lead: Alastair Finn

Rationale:
To monitor waiting times in A&E.

Target:
NHS Objective to improve A&E waiting times so that no less than 78% of patients are admitted, transferred or discharged within 4 hours by March 2025.



What does the chart show/context:
- The performance for September was 68.9%.
- The performance for CRH was 73.1% and HRI was 64.3%.

Underlying issues:
- Increase in occupied beds - long wait for beds.
- Increase in acuity.
- TOC numbers still high.

Actions:.
- Evenings into nights is problematic and breach review identifies poor skill/seniority mix in employed medical workforce. Now addressed with 2 ST4+ on nights and evening consultant staying on until department is clear.
- We are monitoring our admitted and non-admitted performance daily to try improve the overall 4-hour standard performance. We have changed the rag rating on these KPIs to factor in the changing of SDEC recording.
- Testing of full capacity protocol is underway, aimed at supporting reducing long waits in ED.
- Increased ED Consultant presence 08:00-00:00 cross site 7 days per week, hope to expand this to 24 hours provision at the HRI site, discussions on going.
- Breach validation SOP completed – will ensure consistent validation process
- Engaging with colleagues within CHFT and ICB around potential presence of GP within the ED on bank holidays.
- Work ongoing with CHFT SDEC in relation to streaming.

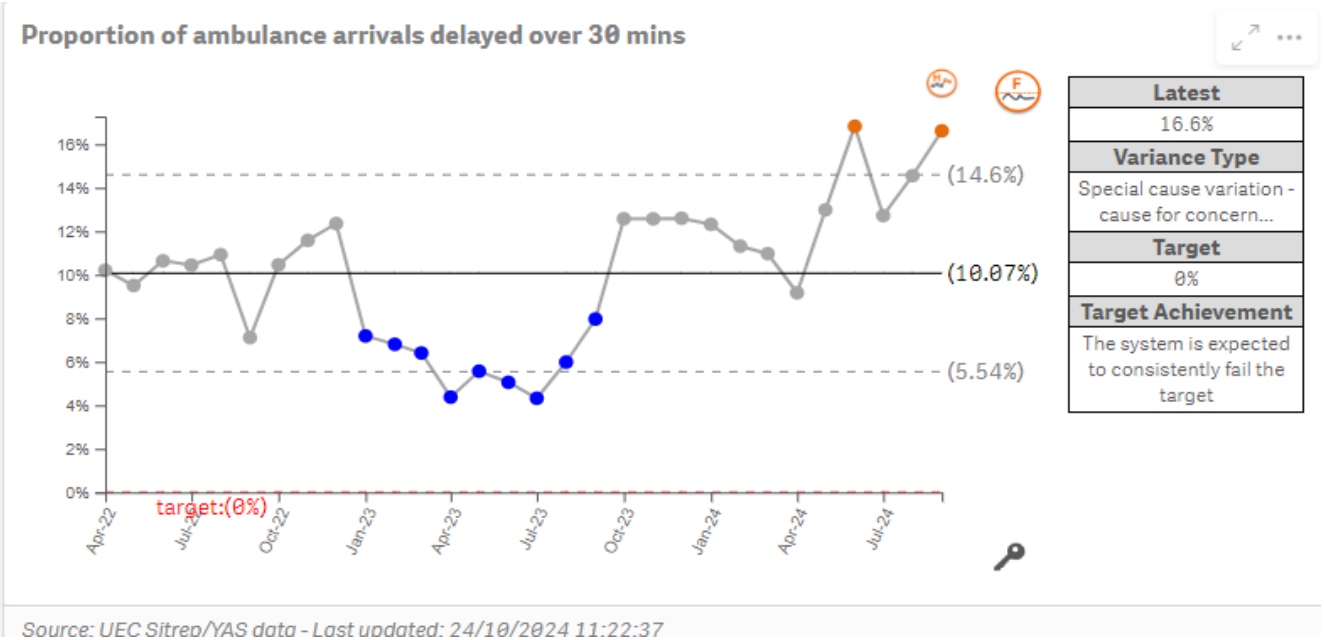
Proportion of ambulance arrivals delayed over 30 minutes

Calderdale and Huddersfield NHS Foundation Trust

Executive Owner: Jonathan Hammond Operational Lead: Jason Bushby Business Intelligence Lead: Alastair Finn

Rationale:
Proportion of ambulances which experience a delay (by more than 30 minutes) in transferring the patient over to the care of ED staff.

Target:
Patients arriving via an ambulance should be transferred over to the care of hospital staff within 15 minutes of arrival at an Emergency Department (ED). 0% should wait over 30 minutes to handover (NHS Standard Contract 2023/24).



What does the chart show/context:
- The performance for September was 16.6%.
- The Trust is expected to consistently fail the target of 0%. Performance can be expected to vary between 5.54% and 14.6%.
- *The chart has been changed for this month to show the unvalidated position (External figures on Daily Ambulance Collection). The change was made as from August 2024 we stopped revalidating 30-60 minute handovers and therefore the data was skewed.*

Underlying issues:
- We have seen a deterioration in performance from October 2023 and this will continue as the reporting for YAS handovers has changed. The key change is the use of arrival destination as the trigger for when the clock starts. This removes any notify times previously used and as a result we have seen an increase in handover times.
- Stopped revalidating the 30 to 60 minute handovers which has led to an increase. These numbers are internal as external numbers come straight from YAS.
- Increase in attendances.
- Increase in bed occupancy – long waits for beds.
- Increased LOS in ED means the departments can become bed blocked.
- Increased acuity (less fit to sit patients).

Actions:
- Testing of full capacity protocol is underway, aimed at supporting reducing long waits in ED.
- Meeting YAS management on site to identify and resolve issues in handovers through collaboration.

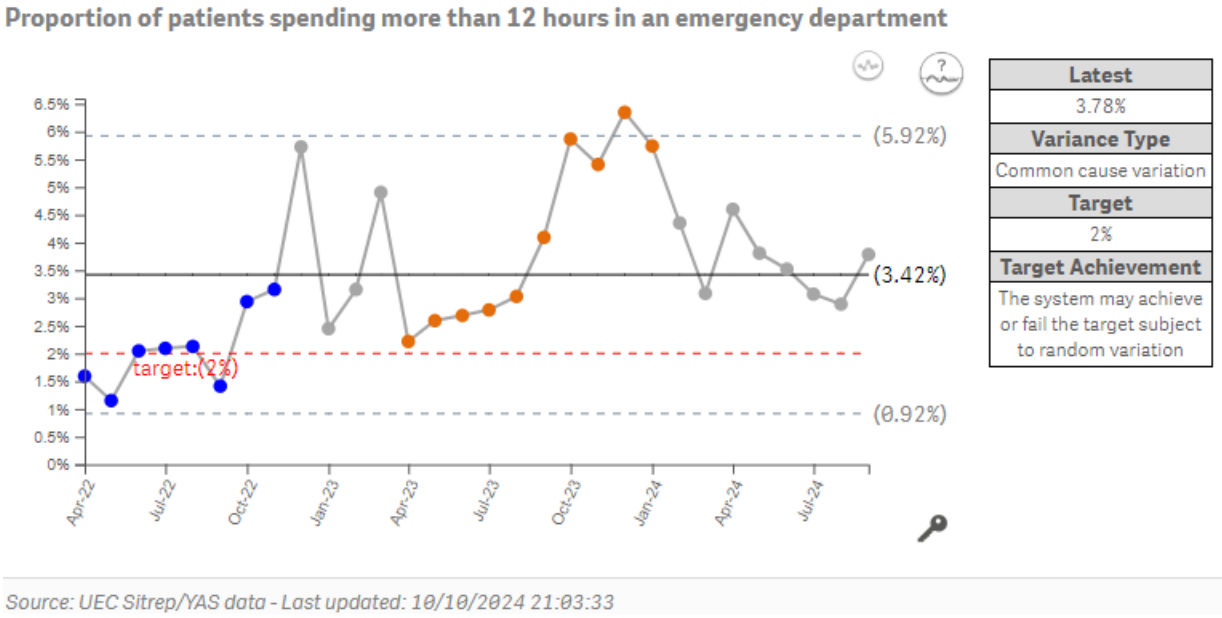
Proportion of patients spending more than 12 hours in an emergency department

Calderdale and Huddersfield NHS Foundation Trust

Executive Owner: Jonathan Hammond Operational Lead: Jason Bushby Business Intelligence Lead: Alastair Finn

Rationale:
To monitor long waits in A&E.

Target:
The number of patients that spend more than 12 hours between arrival and admission, transfer or discharge, as a proportion of total attendances. Less than 2% of patients should wait more than 12 hours (NHS Standard Contract 2023/24).



What does the chart show/context:
- Performance for September was 3.78% with 563 over 12-hour breaches.

Underlying issues:
- Increase in demand
- Wait for beds
- Increase in acuity

Actions:
- Evenings into nights is problematic and breach review identifies poor skill/seniority mix in employed medical workforce. Now addressed with 2 ST4+ on nights and evening consultant staying on until department is clear.
- We are monitoring our admitted and non-admitted performance daily to try improve the overall 4-hour standard performance. We have changed the rag rating on these KPIs to factor in the changing of SDEC recording.
- Testing of full capacity protocol is underway, aimed at supporting reducing long waits in ED.
- Increased ED Consultant presence 08:00-00:00 cross-site 7 days per week, hope to expand this to 24 hours provision at the HRI site, discussions are ongoing.
- Breach validation SOP completed – will ensure consistent validation process
- Engaging with colleagues within CHFT and ICB around potential presence of GP within the ED on bank holidays.
- Work on-going with CHFT SDEC in relation to streaming.

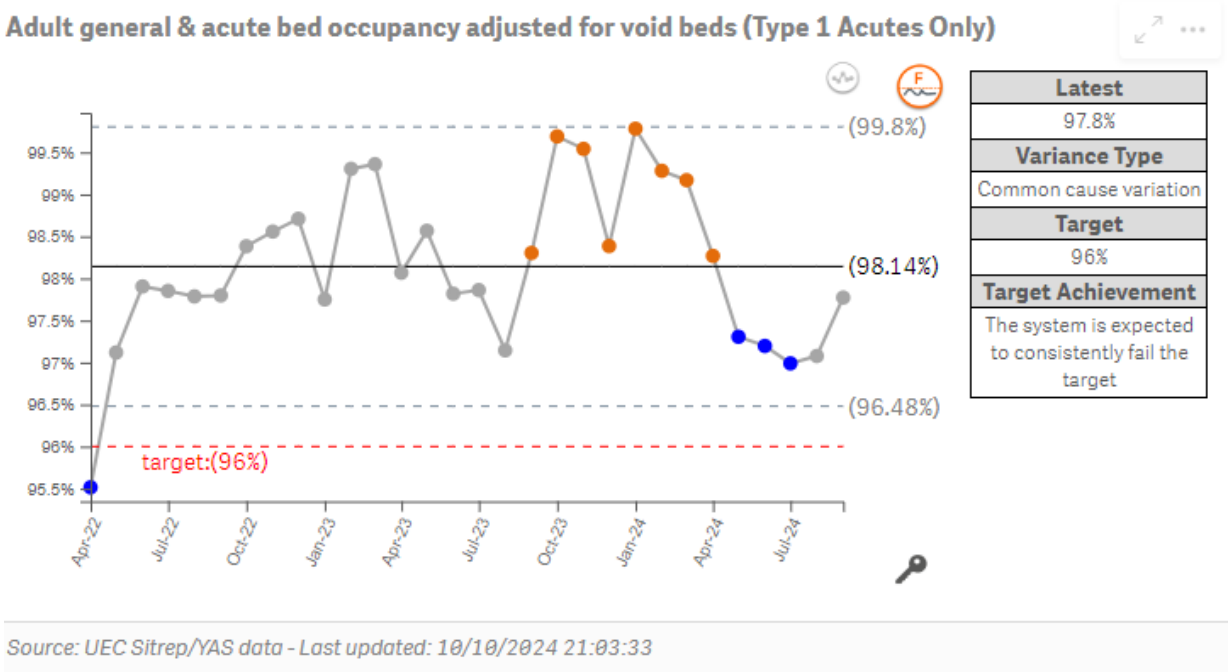
Adult general & acute bed occupancy adjusted for void beds (Type 1 Acutes Only)

Calderdale and Huddersfield NHS Foundation Trust

Executive Owner: Jonathan Hammond Operational Lead: Gemma Berriman Business Intelligence Lead: Alastair Finn

Rationale:
Understand the proportion of adult general and acute beds that are occupied.

Target:
Target 96% or less.



What does the chart show/context:
- Adult bed occupancy in September was 97.8%. The Trust is expected to consistently fail the target of 96%.
- It is important to factor in the bed base when analysing this graph.

Underlying issues:
- Large numbers of surge and super surge beds remain open as well as flexed capacity across the Acute Floor, Respiratory floor and other wards.
- Extra capacity opened to improve ECS and prevent long waits within the Emergency Department.
- Increased acuity increasing LOS.
- High TOC numbers and delays into care homes and EMI beds.

Actions:
- Funded and unfunded bed base now established.
- Working with operational site teams to maintain capacity and drop occupancy levels.
- Long length of stay work continues.
- Trajectory for reducing TOC numbers.
- WOW improvement project has established KPIs reporting into Urgent and Emergency Care Delivery Group.

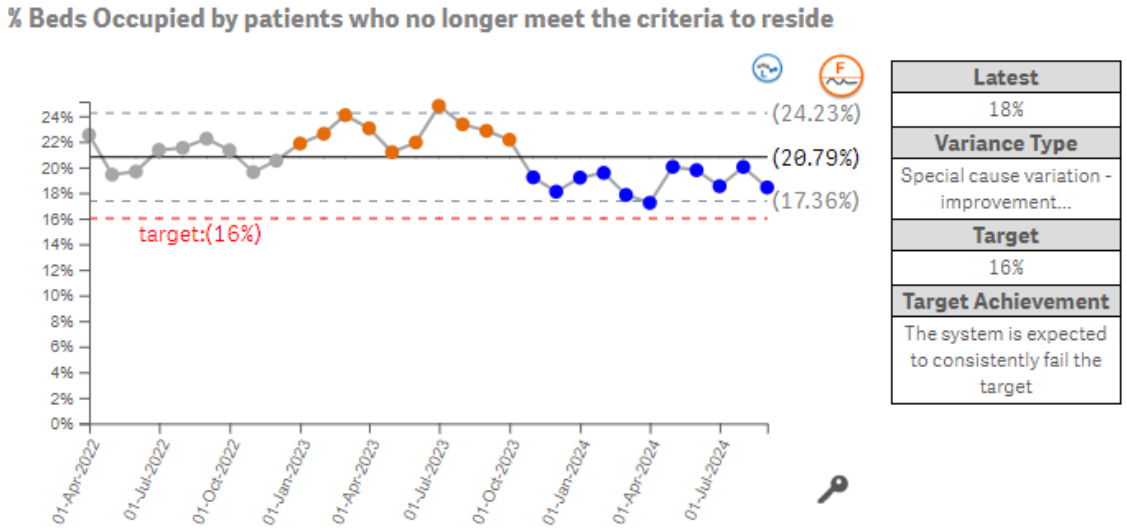
Percentage of beds occupied by patients who no longer meet the criteria to reside

Calderdale and Huddersfield NHS Foundation Trust

Executive Owner: Jonathan Hammond | Operational Lead: Michael Folan | Business Intelligence Lead: Alex King

Rationale:
Understand the numbers of beds which are not available for patients who do meet the criteria to reside and therefore points to resources which are unavailable due to discharge issues.

Target: Less than 16% as per activity plan (by March 2025).



Source: KP+ Information Team stream R2R IPR app - Last updated: 22/10/2024 21:03:32

What does the chart show/context:

- In September 18.4% of patients had no reason to reside.
- Fewer beds were occupied in September, but this was still in line with the number of patients with no reason to reside, hence the percentage remaining similar to previous months.
- The Trust will consistently fail the target of 16% and performance can be expected to vary between 17% and 25%.

Underlying issues:

- Increases in acuity across our ward areas.
- Patients not transferred onto the TOC list in a timely manner despite wards waiting for a pathway 1-3 outcome.
- The criteria to reside not being managed at ward and department level in the board and ward rounds.
- Confusion around utility and operational use of criteria to reside and relationship to discharge ready date and entry onto TOC.

Actions:

- Incorporating in well organised ward work a clear strategic steer around the operational use of discharge ready date for
    1. Identifying patients ceasing to have a reason to reside.
    2. Clarifying roles and responsibilities for using reason to reside information on wards and within flow teams.
    3. 'Starting' the clock to drive out unwarranted LOS across pathways 0-3.
    4. To support accurate reporting of discharge ready date (at the moment using referral date on TOC as a proxy for DRD but not accurate and only covers a subset of patients).
- Joint CHFT, Community and Local Authority dashboard under development which will give greater visibility and focus on the delays to discharge for patients on TOC.
- Agreed at UECB to incorporate TOC dashboard and performance targets for P1-3 into its governance structure for 2024/25. Those targets link to reducing LOS post discharge ready and will feed into NR2R performance.

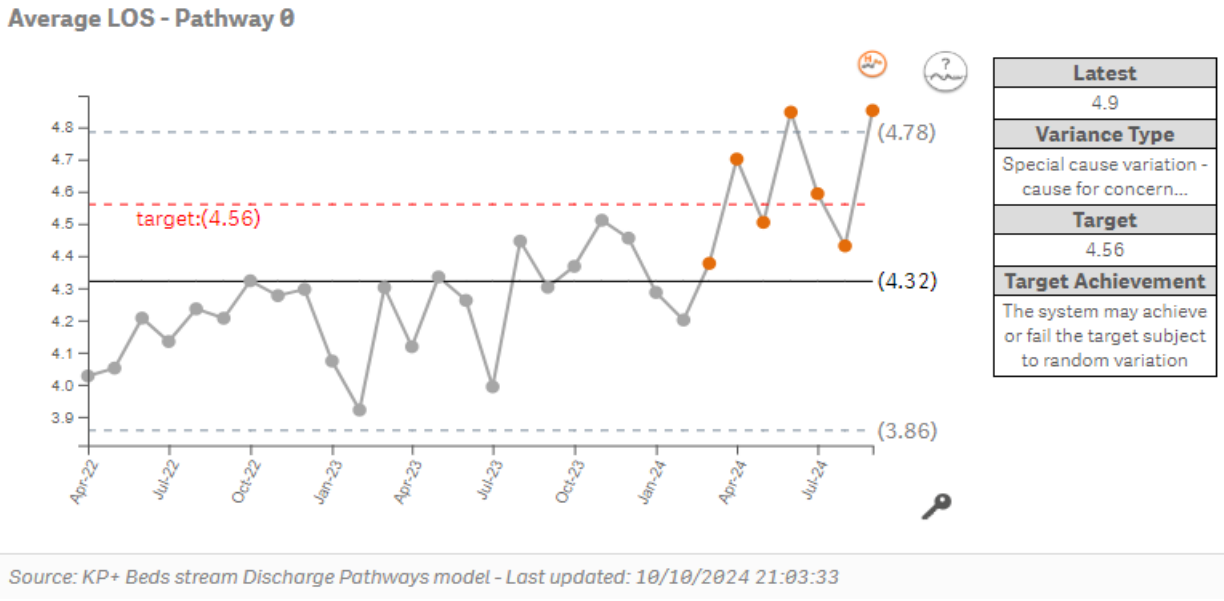
Hospital Discharge Pathway Activity

Calderdale and Huddersfield NHS Foundation Trust

Executive Owner: Jonathan Hammond Operational Lead: Renee Comerford Business Intelligence Lead: Alastair Finn

Rationale:
A reduction in average length of stay for pathway 0 (less complex patients who do not require input from Health and Social care) releases capacity, gives a better patient experience and reduces possible exposure to hospital infections. Pathway 0 patients make up the majority of hospital discharges.

Target:
Average Length of Stay for pathway 0 patients to 4.56 days.



Source: KP+ Beds stream Discharge Pathways model - Last updated: 10/10/2024 21:03:33

What does the chart show/context:
- In September the average length of stay for pathway 0 patients was 4.9 days.
- Performance can be expected to vary between 3.86 and 4.78 days.

Underlying issues:
- Increasing attendances to ED
- Increasing acuity
- Delays in discharging

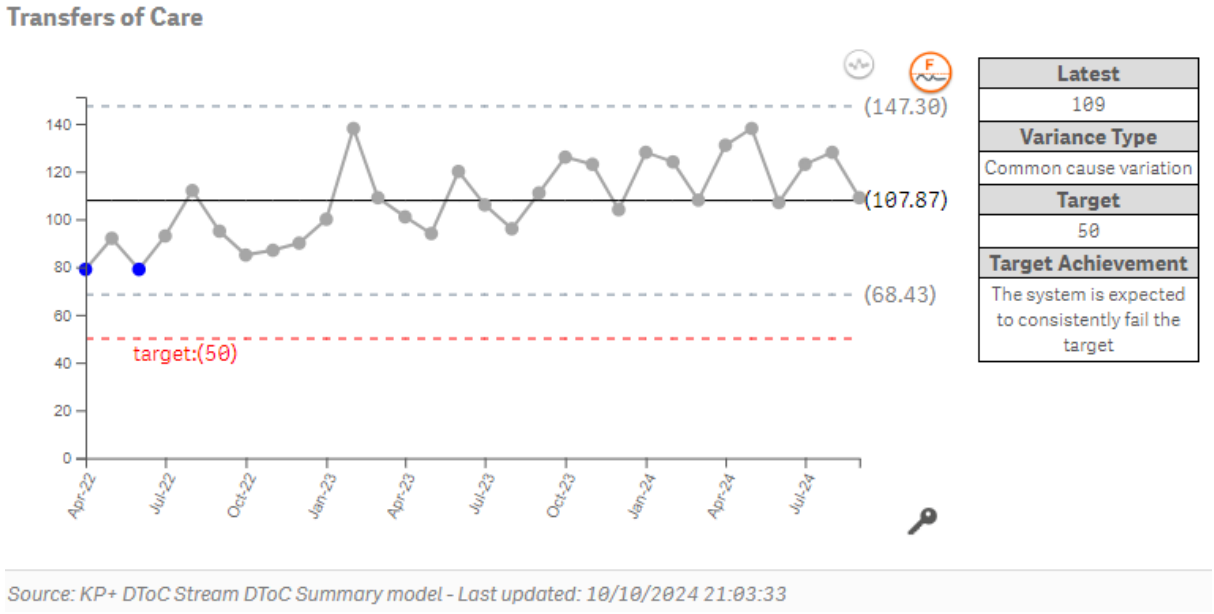
Actions:
- Improvement groups continue with PMO support to develop and improve groups.
- Launch of the Well Organised Ward (WOW) Programme.
- Approval of funding to reablement and trusted assessors.
- New pack for UECDG to help support improvements.
- Governance structures defined within the divisions and through PRMs.

Transfers of Care

Executive Owner: Jonathan Hammond Operational Lead: Michael Folan Business Intelligence Lead: Alastair Finn

Rationale:
Delayed transfer of care occurs when a patient is ready to leave a hospital but is still occupying a bed. Delays can occur when patients are being discharged home or to a supported care facility, such as a residential or nursing home, or are awaiting transfer to a community hospital or hospice. Delayed transfers can cause considerable distress and unnecessarily long stays in hospital for patients. They also affect waiting times for NHS care as delayed transfers reduce the number of beds available for other patients.

Target: 50



What does the chart show/context:
- The snapshot for the end of September was 109 patients on the TOC list.

Underlying issues:
- Increasing numbers on TOC.
- Increasing referrals to TOC.
- Resources to manage TOC have remained the same.
- Increasing need for discharge support due to aging population and increasing dependency.

Actions:
- Ward LOS trajectories in place and a reporting mechanism designed.
- Weekly Long LOS reviews undertaken for those patient over 60 days.
- Weekly LOS Meetings with system flow coordinator.
- Training package for complex discharges with legal team.
- System meeting to discuss TOC.
- Joint CHFT, Community and Local Authority dashboard under development which will give greater visibility and focus on the delays to discharge for patients on TOC.

Maternity and Children's Health:

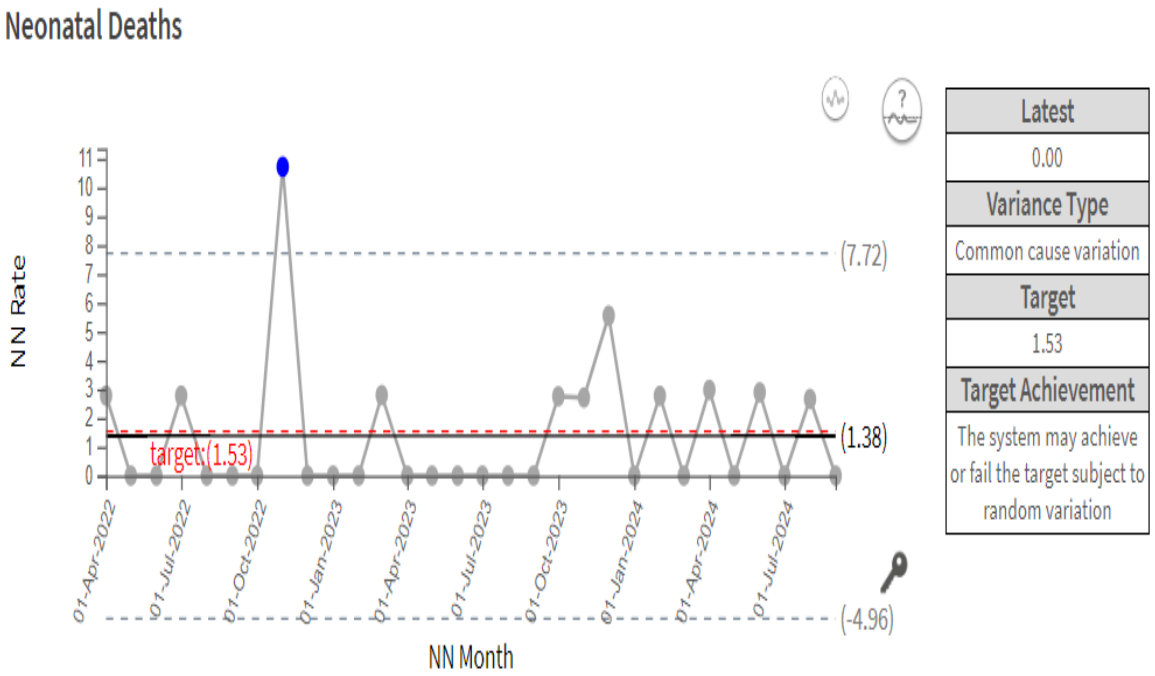
Metric	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Neonatal deaths per 1,000 total live births	September 2024	0	1.53			1.38	0	7.72
Stillbirths per 1,000 total births	September 2024	0	3.33			4.12	0	14.86
Maternity Workforce	September 2024	151.4	195			153.5	147.8	159.2
Maternal Mortality	September 2024	0	0			0.07	0	0.43
Pre-Term Births	September 2024	6.4%	8%			6.8%	2.0%	11.6%
Brain Injuries	September 2024	0	2.2			0.33	0	1.71

Neonatal deaths per 1,000 total live births

Executive Owner: David Birkenhead Clinical Lead: Gemma Puckett Business Intelligence Lead: Saima Hussain

Rationale:
The Long-Term Plan committed the NHS to accelerate action to achieve the national maternity safety ambition of 50% reductions in stillbirth, maternal mortality, neonatal mortality and serious brain injury by 2025.

Target:
1.53 deaths within 28 days of birth per 1,000 live births. (MBRRACE-UK)



What does the chart show/context:
- There was no neonatal deaths in September.

Underlying issues:
- Currently no underlying issues identified.
- Deaths will continue to be monitored and investigated as required. Actions below will ensure performance is maintained.

Actions:
- All early neonatal deaths reviewed at Orange Panel and weekly governance meeting.
- All neonatal deaths MDT PMRT (perinatal mortality review tool) completed.
- All term-early neonatal deaths referred to MNSI (The Maternity and Newborn Safety Investigations Programme).
- Regular quarterly stillbirth/neonatal audit undertaken.
- MDT with tertiary fetal medicine centre for known fetal anomalies.
- Work to develop the maternity and neonatal dashboard is underway including availability on KP+, use of SPC charting and benchmarking against the national maternity ambition.
- ODN Peer review visit has taken place on 18th September 2024 and included a review of mortality data and learning.

Stillbirths per 1,000 total births

Executive Owner: David Birkenhead Clinical Lead: Gemma Puckett Business Intelligence Lead: Saima Hussain

Rationale:
The government's National Ambition is to halve the rate of stillbirths from a 2010 baseline by 2025, with a 20% reduction by 2020, reducing the rate from 5.1 per 1,000 births in 2010 to 4.1 in 2020 and 2.5 in 2025.
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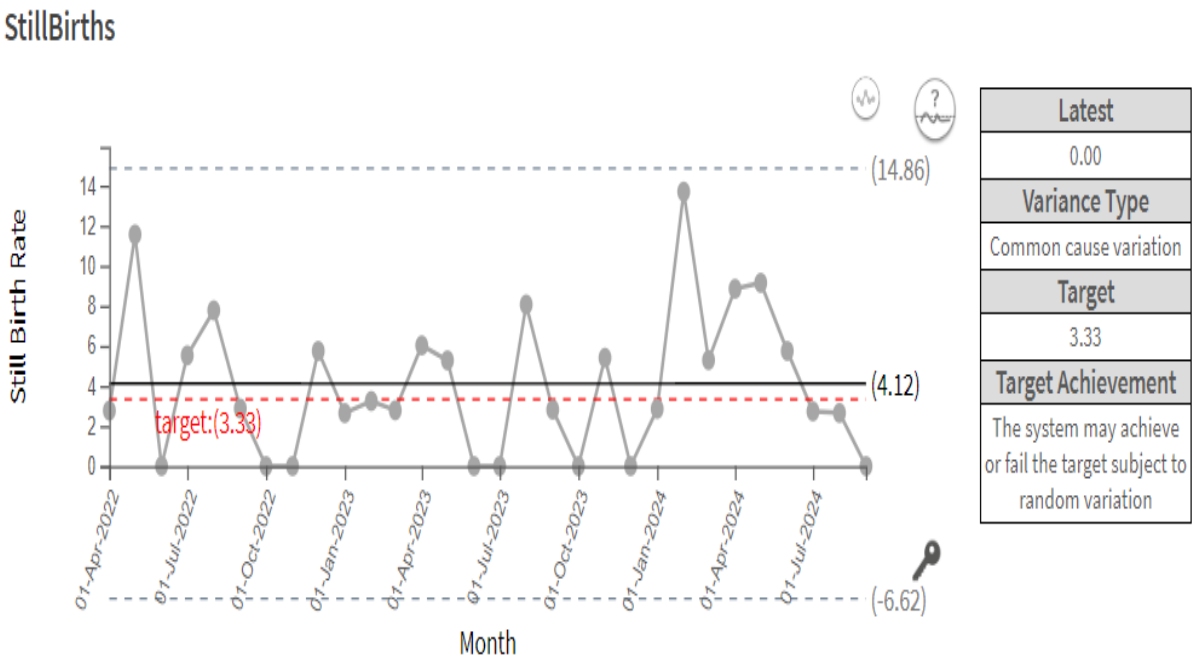
Target:
3.33 deaths per 1,000 live births. MBRRACE-UK



What does the chart show/context:
- There were no stillbirths in September.

Underlying issues:
- There is a disproportionate representation of women who are BAME, English is not their first language and live in IMD codes 1-4. This is reflective of the national picture and there is a national task group taking place to better understand why these women experience poorer outcomes.
- There are no continuity of carer teams currently in place, implementing an interim model of enhanced antenatal and postnatal care for women from this cohort will be a priority. Once the workforce has reached an appropriate level this should be further developed to a full continuity of carer model.
- Deaths will continue to be monitored and investigated.

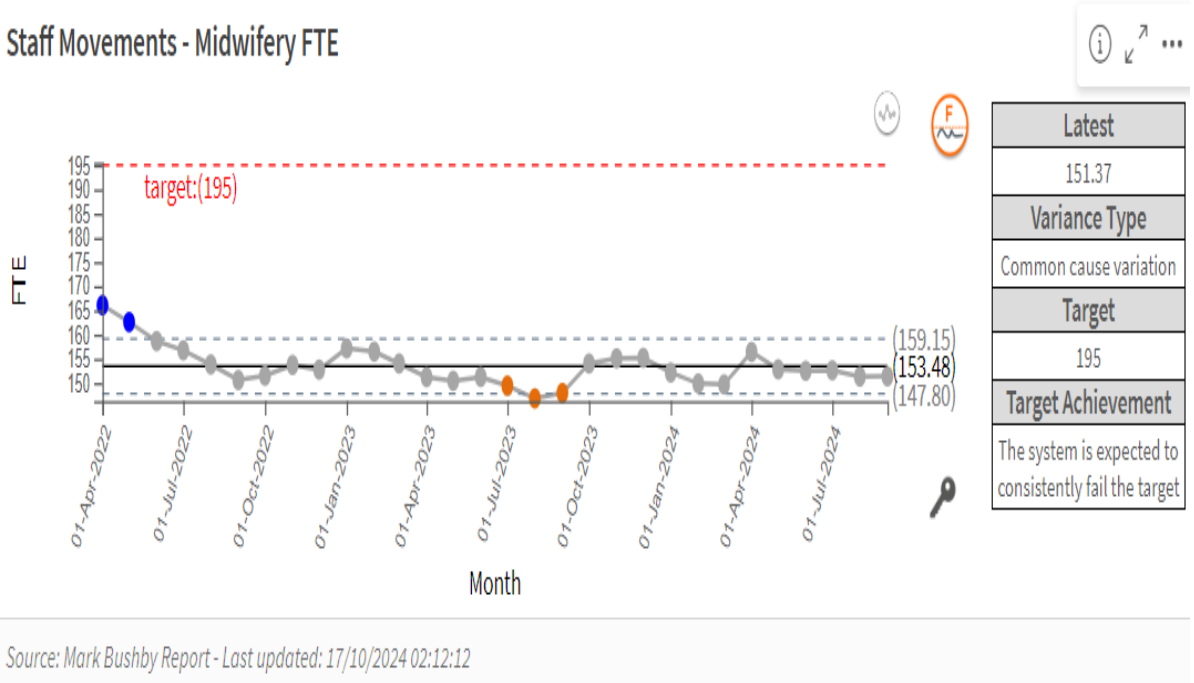
Actions
- All stillbirths are reviewed at the divisional patient safety panel and weekly governance meeting, health inequalities are considered.
- All stillbirths have an MDT PMRT completed (Perinatal Mortality Review Tool - a structured national tool that is used to review all deaths).
- All term intrapartum stillbirths are referred to MNSI.
- Regular quarterly stillbirth/neonatal audit is undertaken.
- An LMNS supported thematic review of the 2024 stillbirth cases took place on 3rd June 2024.
- A system stillbirth summit took place on 29th July 2024 and a stillbirth reduction programme will take place following this.

Maternity Workforce

Executive Owner: Lindsay Rudge Clinical Lead: Gemma Puckett Business Intelligence Lead: Saima Hussain

Rationale:
To ensure the right numbers of the right staff are available to provide safer, more personalised, and more equitable care

Target:
195 FTE (current funded establishment)



What does the chart show/context:
- The FTE rate is 151.37 in September

Underlying issues:
- National Shortage of midwives
- Attrition rate of student midwives
- Intense scrutiny of maternity services

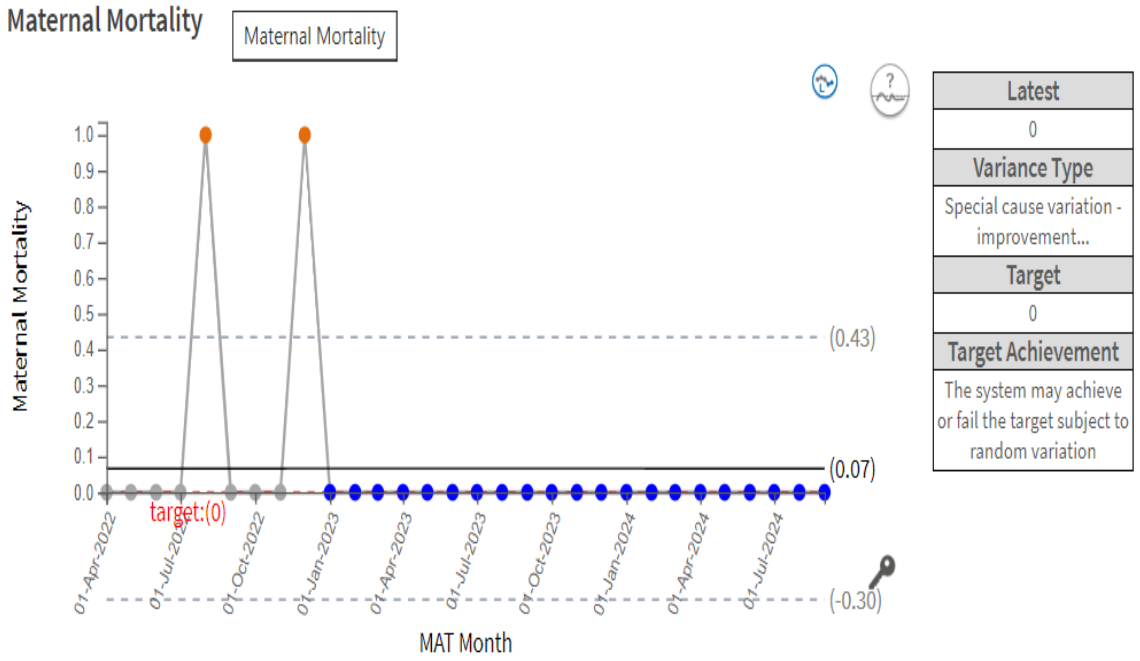
Actions:
- Birthrate plus report commissioned and report received at end of April 2024, currently being reviewed through divisional governance.
- Recruitment and retention strategy being refreshed.
- Rolling recruitment programme.
- Grow your own workforce pathways: Midwifery apprenticeship, shortened programme
- Recruitment and retention midwife employed to work alongside and support new midwives in clinical practice.
- Stay conversations implemented.
- DoM/DDoM undertaking all exit interviews, retention has improved over last 6 months.
- Recruitment films commissioned and released on social media and being used in adverts and recruitment open days.
- Use of alternative roles such as registered nurses in maternity service.
- Circa 31 WTE offered to newly qualified midwives to commence in October 2024 – 20wte commenced on 14th October, some late attrition and some delayed starts due to registration delays.
- 4 WTE Band 6 midwives offered posts following interviews in July 2024.
- Robust preceptorship programme.

Maternal Mortality

Executive Owner: Lindsay Rudge Clinical Lead: Gemma Puckett Business Intelligence Lead: Saima Hussain

Rationale: The government's National Ambition is to halve the rate of maternal deaths from a 2010 baseline by 2025,. with a 20% reduction by 2020, reducing the rate from 10.6 per 100,000 maternities in 2010 to 8.5 in 2020 and 5.3 in 2025

Target: 0



What does the chart show/context:

- There have been no maternal deaths since December 2022.

Underlying issues:

- Timely recognition of a deteriorating pregnant or postnatal patient outside of the maternity setting.

Actions:

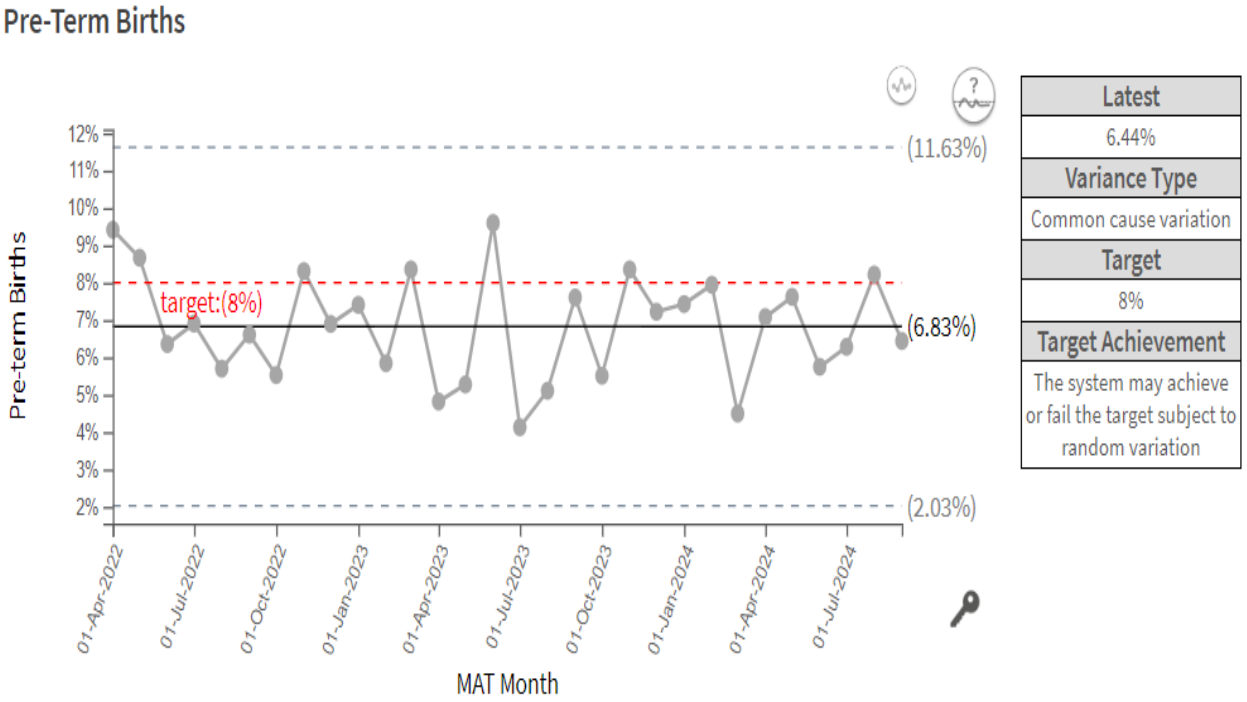
- Implementation of MEOWS score for pregnant or postnatal women who are being cared for outside of the maternity setting.
- Training sessions for key clinical areas outside of maternity setting.
- Strengthening of pathway for management of pregnant or postnatal women who present to ED.

Pre-Term Births

Executive Owner: Lindsay Rudge Clinical Lead: Gemma Puckett Business Intelligence Lead: Saima Hussain

Rationale: The government's national ambition for pre-term birth rate is to achieve a 25% reduction from an 8% baseline in 2015 to 6% by March 2025.

Target:
Reduce all Preterm births (delivery < 37 weeks) from 8% to 6% by March 2025



What does the chart show/context:
- The target has been met in September.

Underlying issues:
- There is increased pressure in the system for level 3 NNU units leading to difficulty in transferring babies when required or requests from the network to accept babies outside of criteria.

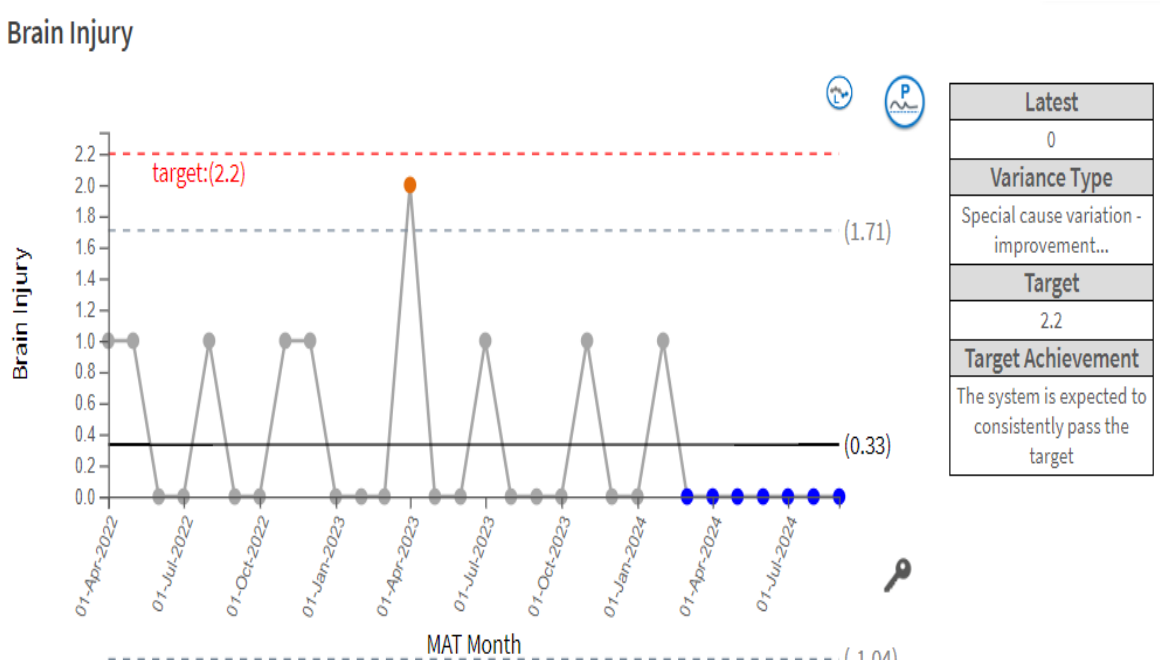
Actions:
- Continue to fully implement element 5 of Saving Babies Lives Bundle version 3.
- Continue review of all pre-term births where babies are born in a unit without the correct level of neonatal unit support.
- Continue to participate in LMNS pre-term birth workstream.
- Develop in-utero transfer guidance to support being able to accept requests for transfer from across the region in line with network recommendations.

Brain Injuries

Executive Owner: Lindsay Rudge Clinical Lead: Gemma Puckett Business Intelligence Lead: Saima Hussain

Rationale: The government's National Ambition is to halve the rate of intrapartum brain injuries from a 2010 baseline by 2025.

Target:
Reducing the rate from 4.3 per 1,000 live births in 2010 to 3.5 in 2020 and 2.2 in 2025.



What does the chart show/context:
- There have been no brain injuries since February 2024.

Underlying issues:
- Timely escalation in an emergency.
- Loss of situational awareness.

Actions:
- Change of ward layout to support.
- Each Baby Counts Teach and Treat re-launch.
- Maternity and Neonatal safety critical training includes escalation and use of SBAR.

Community Services:

Metric	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Proportion of Urgent Community Response referrals reached within 2 hours	September 2024	74.1%	70%			67.6%	51.9%	83.2%
Community Waiting List – over 52 weeks	September 2024	1,238	1,142 (Mar25)	-	-	-	-	-
Virtual Ward	September 2024	57%	80%			82.1%	47.9%	116.3%
Patients dying within their preferred place of death	September 2024	100%	80%			94.7%	85.1%	100.0%

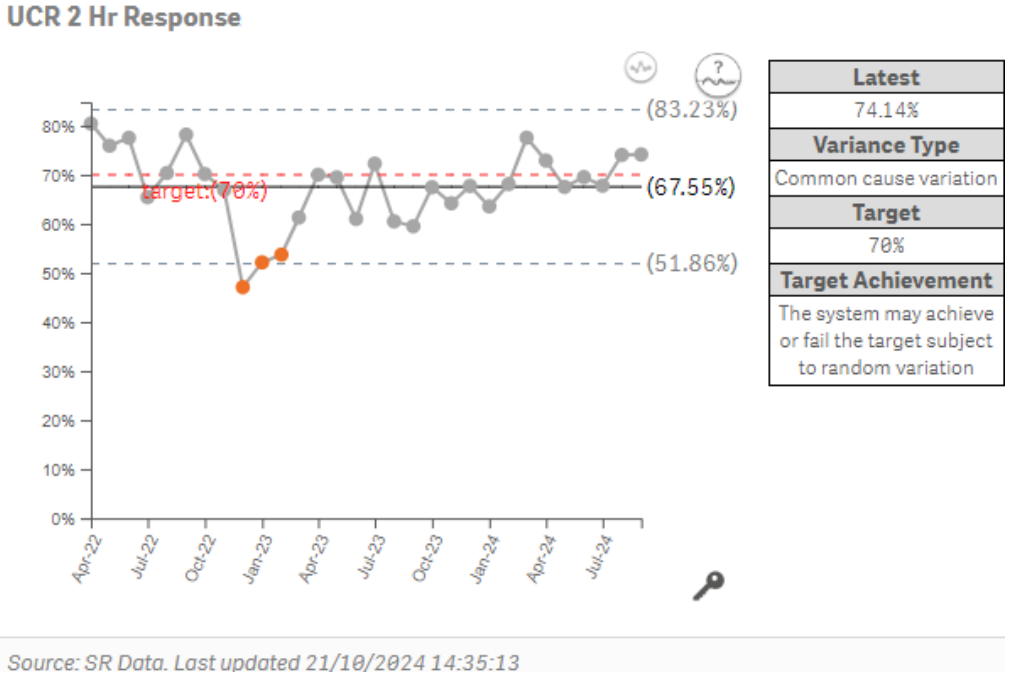
Proportion of Urgent Community Response referrals reached within two hours

Calderdale and Huddersfield NHS Foundation Trust

Executive Owner: Rob Aitchison Operational/Clinical Lead: Michael Folan/Hannah Wood Business Intelligence Lead: Gary Senior

Rationale:
Urgent Community Response services are a commitment in the NHS Long-Term Plan to provide urgent care to people in their homes if their health or wellbeing suddenly deteriorates.

Target:
% of 2-hour UCR referrals that achieved the 2-hour response standard. Clinical contact within 2 hours of referral into service. Target: 70%.



What does the chart show/context:
- Current position for September 2024 is at 74.1%.

Underlying issues:
- Logging time of arrival is improving and less cases of obvious errors that affect data reporting, but reminders sent to team again as they are still occurring. Manual review of breached being completed every month to support accuracy or reporting into IPR.
- Complexity with LCD where their triage may mean that we have little time to get out to the properties – also some providers feeling it is a difficult and time-consuming process to do this and triage at LCD is taking too much time.
- Workshop completed with LCD and pathways reviewed. Changes made to streamline triage for referrers and also enable more discussion between teams to accept more referrals.

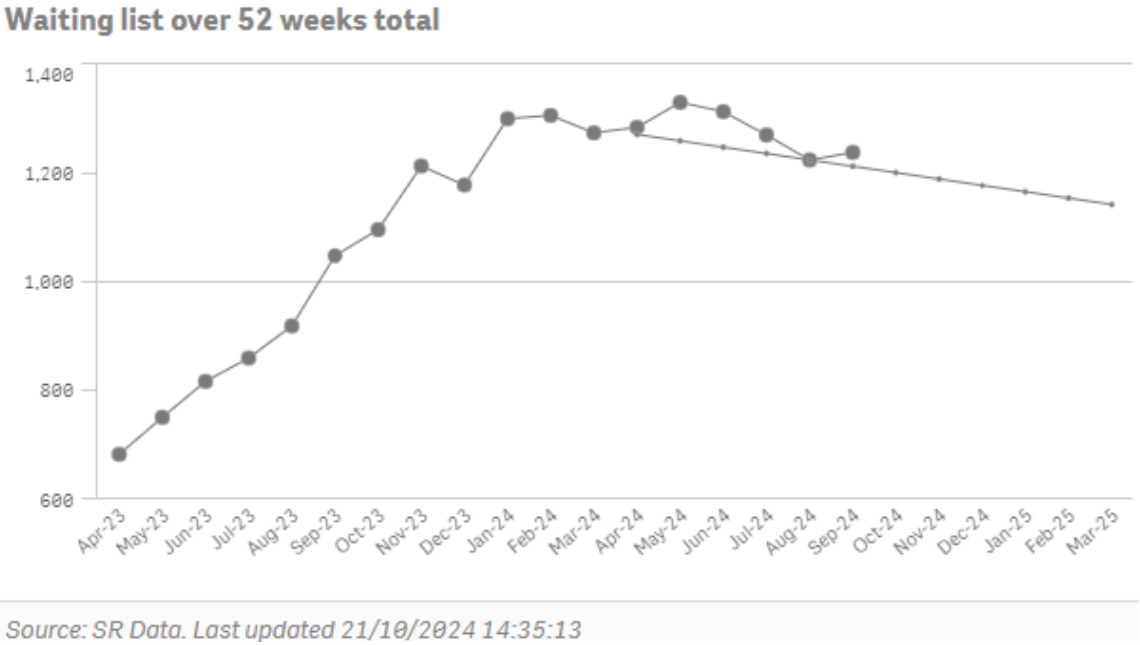
Actions:
- Communications to whole team around accurate data recording.
- Ongoing cases where 2 hours' time is taken by LCD to triage due to their processes therefore is out of the 2-hour window prior to reaching UCR – audit tool capturing these.
- Manual audit completed to examine the different elements of the 2-hour response – meeting arranged with LCD and primary care to go through the results.
- Continuing to attempt to increase referrals into the service and working with LCD and primary care to do this – strategy now agreed with primary care and some new processes for them to commence approx. November to try to enhance referrals. To also use this is a first step to build on for the future of referrals possibly going to trusted assessor in the future.
- Looking at "trusted" routes for other professionals into UCR to make the triage quicker when another healthcare professional had already assessed the patient – agreed that these now include AVS service as trusted assessors.

Community Waiting List - over 52 weeks

Executive Owner: Rob Aitchison Operational Lead: Michael Folan/Carly Hartshorn Business Intelligence Lead: Gary Senior

Rationale:
Understand resilience amongst providers of community health services and provide valuable data on waiting times and waiting list information.

Target:
The total number of patients (Adults and Children) on community waiting lists waiting over 52 weeks at a given time.
Target 1,142 by March 2025 (as shown in Trajectory below).



What does the chart show/context:
- 1,238 total in September 2024.

Underlying issues:
- Children's SALT is our main concern.
- Children's SALT workforce issues remain difficult, we currently have 1.2 band 6 vacancies in that team having recruited to other outstanding vacancies as well as 2x WTEs on maternity leave. Recent recruitment should support this position but will take a number of months until in post. 1x WTE B7 post to advert and staff member has finished with the Trust. Team Lead has also reduced hours at financial year end. Locum has also finished with the Trust.

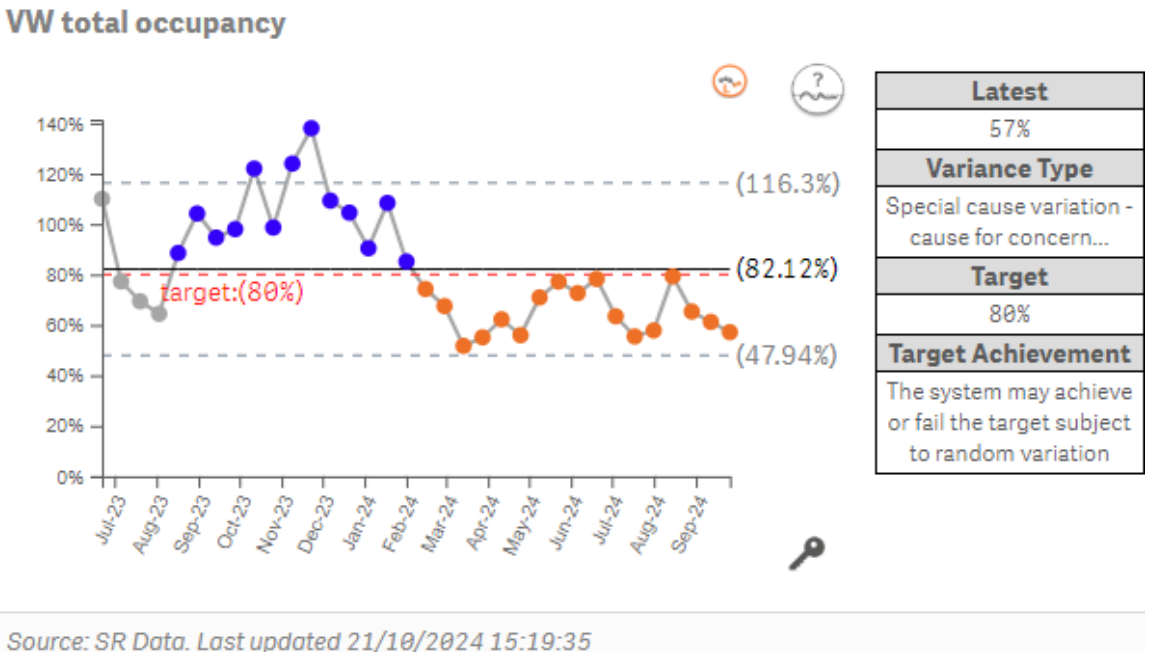
Actions:
- SALT recruitment pressures – 2x recruits with start dates, ongoing B7 recruitment, looking for locum support
- Transition to new SALT service structure has begun with percentage increase in wait list reducing since this point.
- Service now in a sustainable position with number of referrals added each month also being removed – backlog still being addressed.
- Share KP+ model to assist in management of patients.

Virtual Ward

Executive Owner: Rob Aitchison Operational Lead: Michael Folan/Hannah Wood Business Intelligence Lead: Gary Senior

Rationale:
Monitor occupancy rate of Virtual Wards - Respiratory and Frailty services. The CHFT plan currently has a bed base of 42

Target:
Number of patients on the Virtual Ward caseload compared to the number of beds available/allocated. Target 80%.



Source: SR Data. Last updated 21/10/2024 15:19:35

What does the chart show/context:
- Current combined position for September 2024 is 57% - 12-month average position is 80%
- Not achieving target since February 2024 - Special cause variation.
- Frailty admissions remaining relatively consistent but there is clear patterns developing in respiratory admissions and in recent months there has been a significant deterioration in those which is playing out in the occupancy position.

Underlying issues:
- Currently there is only a 5-day consultant offer for frailty virtual ward as 7-day cover is not funded. This limits referrals towards the end of the week due to concern they may need consultant input over a weekend.

Actions:
- Medical division reviewing medical cover to support a 7-day Multi Discipline Team meeting for Frailty virtual ward. Other organisations have not all been able to recruit consultants but backfilled with a registrar.
- Advanced Clinical Practitioner working on Frailty Same Day Emergency Care on a weekend is supporting Kirklees virtual Frailty service with advice and guidance.
- Kirklees are reviewing the urgent community response service to establish if they can be aligned with the virtual ward.
- Frailty criteria have been amended to ensure we can take more frail and older people from across areas.
- Further work with Acute visiting service and GPs for VW and UCR referrals and how we streamline this and ensure the patient gets to the right service.
- Respiratory - criteria now changed to include patients requiring oxygen weaning.
- Attendance at June's medical division meeting to do some training about virtual ward.

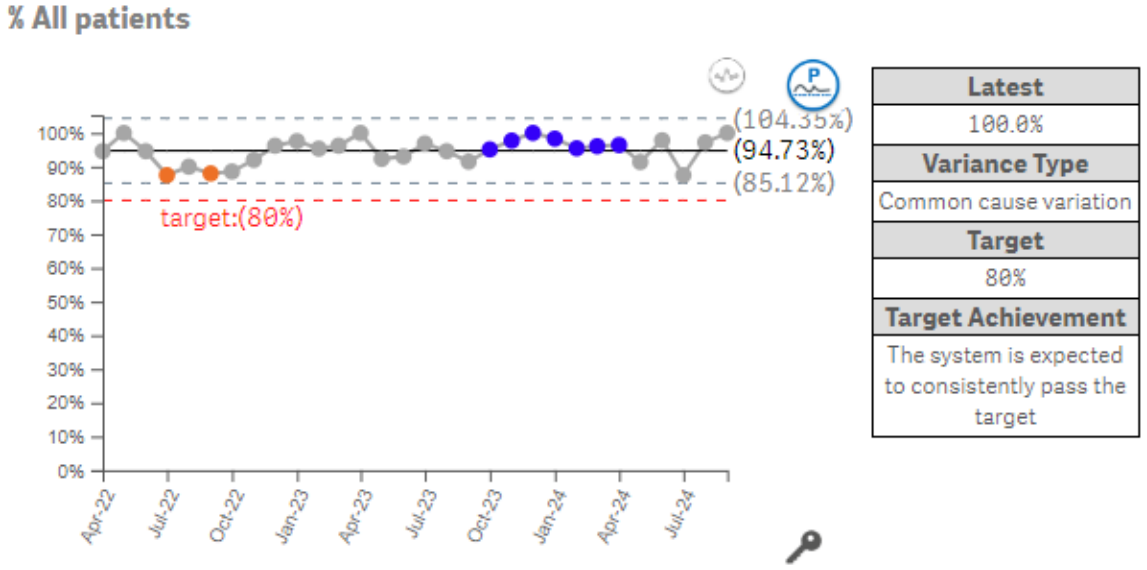
Patients dying within their preferred place of death

Calderdale and Huddersfield NHS Foundation Trust

Executive Owner: Lindsay Rudge Operational Lead: Michael Folan/Abbie Thompson Business Intelligence Lead: Gary Senior

Rationale:
% of patients dying within their preferred place of death – Community Palliative Care.

Target: Over 80%



Latest
100.0%
Variance Type
Common cause variation
Target
80%
Target Achievement
The system is expected to consistently pass the target

Source: SR Data. Last updated 21/10/2024 14:35:13

- CSPCT – Calderdale Specialist Palliative Care Team
- PPD – Preferred place of death
- CNS – Clinical Nurse Specialist
- WFM – Work Force Model

What does the chart show/context:
- Consistently above 80% target
- September 2024 total 100% (Out of Hours End of Life care 100% and Palliative 100%)
  100% died at 'home'.

Underlying issues:
- Workload pressures – high referral numbers and staff vacancies across all teams
- Acuity and complexity of need – patients are increasingly in urgent need of specialist intervention due to late presentation / diagnosis or multiple comorbidity.
- CSPCT continue to work additional hours to keep patients safe – limiting GP call-outs by utilising Independent Prescribing / assessment skills and coordinating care with Acute hospital teams to streamline patient interventions / reduce length of hospital stay (avoiding ED wherever possible).
- OOH EoLC – currently working extended hours for a further 12 months (March 2025) as result of successful Innovation bid. Need to secure funding to facilitate the new Workforce Model to include (in conjunction with existing joint service agreement with Marie Curie) from April 2025.
- HSPCT – significant staffing depletion requiring review of WFM to enable prompt review of patients to facilitate discharge to home / care home / hospice– Dashboard development ongoing.
- HSPCT In-Reach project funded by Calderdale ICB Innovation Bid commenced December 2023 – awaiting dashboard data – significant impact on facilitating patients back to home / care home or hospice – reduced in-patient admission and reduced length of stay improves achieving PPD.
- Care Home Palliative CNS project funded by Cald ICB Innov Bid commenced July 2023 –working in collaboration with QUEST - has improved patient safety and outcomes in ensuring patients not inappropriately admitted to hospital and supported to remain in care home setting.

Actions:
- To ensure continued funding for all teams (with review of WFM for HSPCT) to maintain this strong position of achieving preferred place of death, facilitating the vast majority to die at home, appropriate admission to hospice and reducing avoidable admissions and deaths in the acute hospital setting.

Workforce:

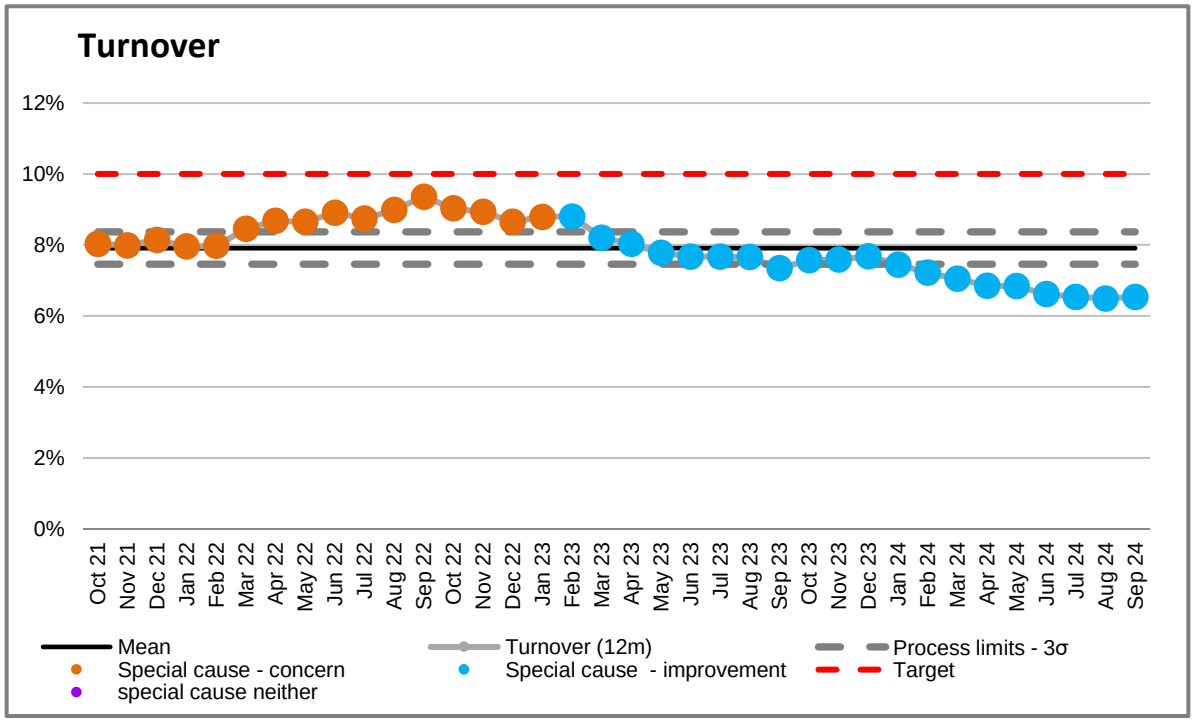
Metric	Latest Month	Measure	Target / Ceiling	Variation	Assurance	Mean	Lower process limit	Upper process limit
Staff Movement (Turnover)	September 2024	6.53%	10.00%			7.91%	7.45%	8.37%
Sickness Absence	September 2024	4.45%	4.50%			5.32%	3.97%	6.68%
Appraisal Compliance (YTD)	September 2024	75.88%	90.00%	-	-	-	-	-
Core EST Compliance	September 2024	92.43%	90.00%			93.49%	92.37%	94.60%
Bank Spend	September 2024	£2.64M	-		-	£3.11M	£2.13M	£4.10M
Agency Spend	September 2024	£0.45M	£0.76M		-	£0.79M	£0.44M	£1.15M

Staff Movement (Turnover)

Executive Owner: Suzanne Dunkley Lead: Adam Matthews Business Intelligence Lead: Mark Bushby

Rationale:
It is healthy for an organisation to have a reasonable level of staff turnover, there is a balance between losing valuable, knowledgeable staff and bringing in new colleagues with fresh ideas and ways of working.

Ceiling: 10.00% **Current: 6.53%**



What does the chart show/context:
- Total FTE lost due to colleagues leaving all employment with the Trust against the average headcount of the reporting period.
- Turnover is consistently below the Trust ceiling of 10.00%.
- Current turnover rate is below the mean average at 6.53%.
- The Trust benchmarks well against other WYAAT organisations.

Underlying issues:
- Directorates with turnover above the 10% ceiling include Surgical Divisional Support (17.6%), Workforce and OD (12.1%) and Quality (11.3%).
- Phlebotomists and Trust Grade Doctors also have turnover rates above the ceiling rate.

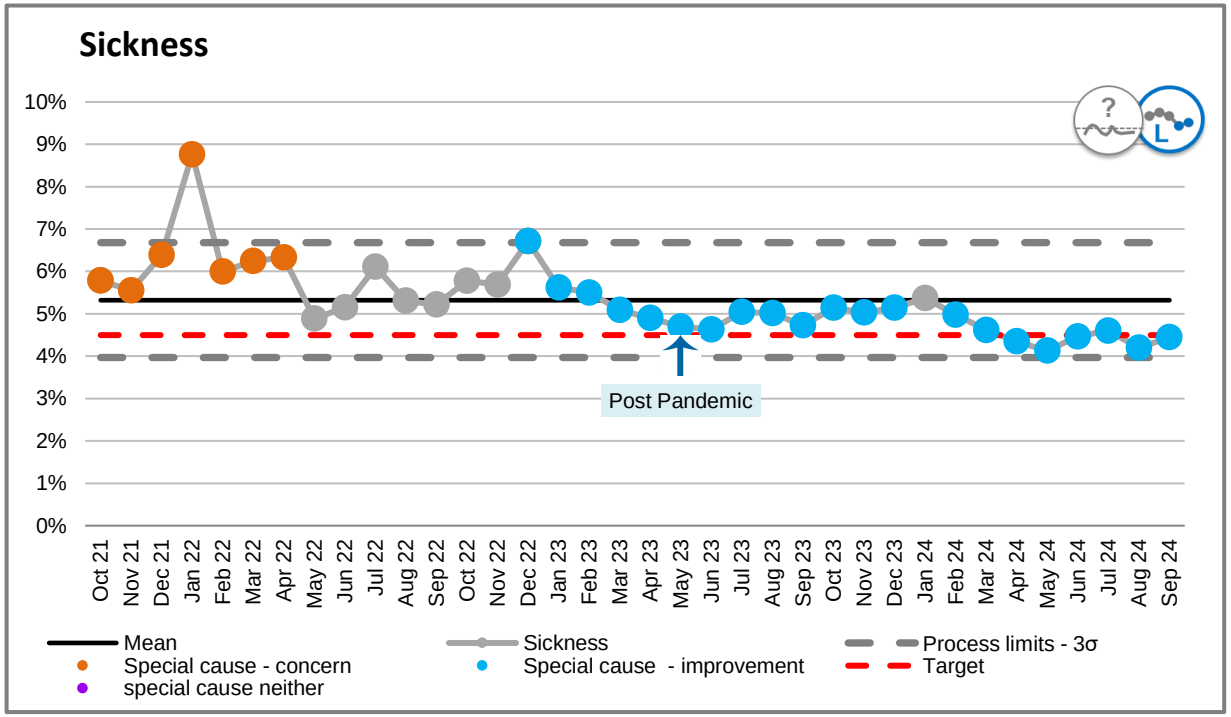
Actions:
- Trust level and local level activities continue to improve the Trust retention, turnover and stability rates. These actions include:-
  - Task and finish group to review approach to exit interviews and questionnaires.
  - Review and improve ‘stay conversation.
  - Review of workforce metrics to identify gaps in retention activity for certain groups
  - Review of recruitment process to embed inclusive recruitment.
  - Communication of revised national approach to retirement options.

Sickness Absence

Executive Owner: Suzanne Dunkley Lead: Azizen Khan Business Intelligence Lead: Mark Bushby

Rationale:
It is important for the Trust to monitor sickness absence levels to ensure any trends are investigated to inform future planning around availability.

Ceiling: 4.50%	**Current:**	**Total**	**4.45% (in month)**	**4.70% (12m)**
		Long	**2.49% (in month)**	**2.82% (12m)**
		Short	**1.96% (in month)**	**1.88% (12m)**



What does the chart show/context:

- The target for absence is close to the mean and falls between the upper and lower process limits, as such compliance will be unpredictable on a month-by-month basis due to common cause variation.
- From April 2024, the Trust ceiling for sickness absence has been reduced from 4.75% to 4.50% which is shown across all months for reference.
- From April 2024, Covid Sickness is now included in the absence data.

Underlying issues:

- Top 3 reasons for sickness in September 2024 – Anxiety/Stress/Depression, Other musculoskeletal problems and Gastrointestinal problems.

Actions:

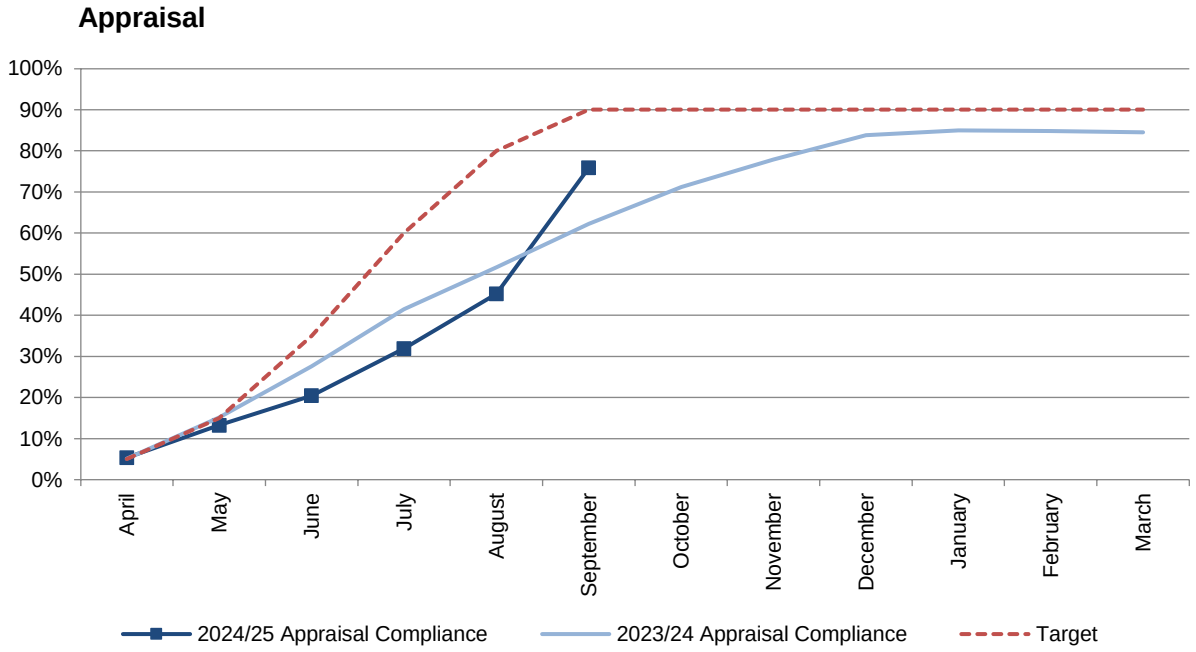
- HR teams regularly review all open ended LTS cases to ensure timely actions are taken and that where for example cases relate to an MSK issue that colleagues are aware of self-referral options for in-house Physiotherapy.
- Any identified hotspot areas undertake a deep-dive to review cases and where any training needs are identified this is managed.
- Absence data remains a key item on directorate and divisional meetings and teams are asked to provide updates via a plan on a page to address areas with absence above target or where absence is increasing.
- Knowledge Portal+ has been rolled out across all divisions to allow easier access to absence data and the use of SPC charts is now part of absence reporting within directorate meetings.
- Updated guidance for H&WB support has been shared across divisions to ensure colleagues are aware of the new employee assistance programme.
- Corporate WOD colleagues are leading workforce redesign workshops with stakeholders to improve processes around attendance management. Two workshops have taken place with further workshops scheduled.
- Corporate WOD are analysing and reviewing hotspot areas on a monthly basis. A number of areas have been identified which would give the greatest return if there is focussed attention from divisions.
- 3 Rs sessions to be held within Directorates across all Divisions who are high performers around absence management processes and those with support requirements.

Appraisal

Executive Owner: Suzanne Dunkley Lead: Nicola Hosty Business Intelligence Lead: Mark Bushby

Rationale:
A performance appraisal is a regular assessment of how an individual is performing in their job role. It can have many benefits in practice, being used to identify individual learning needs, identify continuing development needs of employees and demonstrate competency in practice. The appraisal season runs from 1 April 2024 to 30 September 2024.

Target: 90.00% (Annual), 90.00% (in month) **Current: 75.88% (in month)**



What does the chart show/context:
- Appraisal compliance is below the in-month planned position with 75.88%, an increase of 30.66 percentage points from the previous month.
- Appraisal compliance is performing above the rate of the previous year at the same point in time.

Underlying issues:
- Time and availability of colleagues to undertake appraisal.
- Accurate and timely recording of appraisal conversations on ESR.
- Challenge to colleagues around appraisal being a “tick box” exercise.
- Seasonal variance especially during the summer and winter holidays.
- Regular strike action impacting priorities.

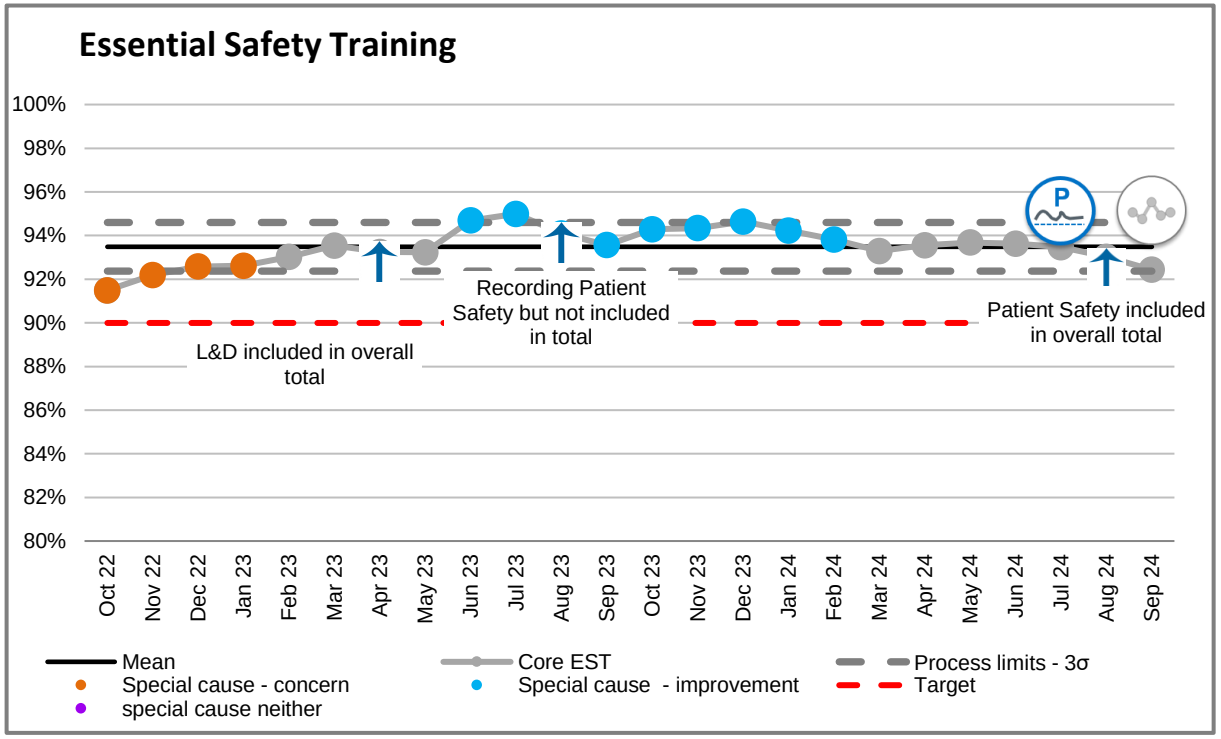
Actions:
- ‘How to’ guide to appraisals video now available as part of our management fundamentals offer, to make it a more people centred conversation.
- New to manager programme launch features appraisals in content.
- ESR recording guidance produced to support managers to ensure all activity is captured.
- Targeted approach to support hotspot areas including Connect & Learn sessions (managers’ and appraisees’ guides) to improve the quality of conversations.
- Recent audit from NHS England completed showcasing best practice, impact data and general process.
- Hotspot areas targeted via OCOC charter support workshops that includes appraisal management.
- Final month in the appraisal season, big push on communications and engagement through a variety of channels including the line manager bulletin, meetings with matrons, DPp and HE Ops engagement sessions, Equality group meetings and updates via screensavers and other CHFT communication channels

Core EST Compliance

Executive Owner: Suzanne Dunkley | Lead: Nicola Hosty | Business Intelligence Lead: Mark Bushby

Rationale:
Training staff is important in health and social care to ensure the safety of people receiving and giving care and to maintain high standards of care quality. It ensures that colleagues in the Trust are following up-to-date procedures and reduces the risk of errors and prevents accidents. This means they and our patients can be safe in the workplace

Target: 90.00% **Current: 92.43%**



What does the chart show/context:
- The Trust is consistently achieving the 90% target; EST compliance is below the 95% stretch target at 92.43%

Underlying issues:
- Safeguarding Adults and Childrens compliance has dropped below 90%, this is likely due to a review of RST as safeguarding is tiered learning.

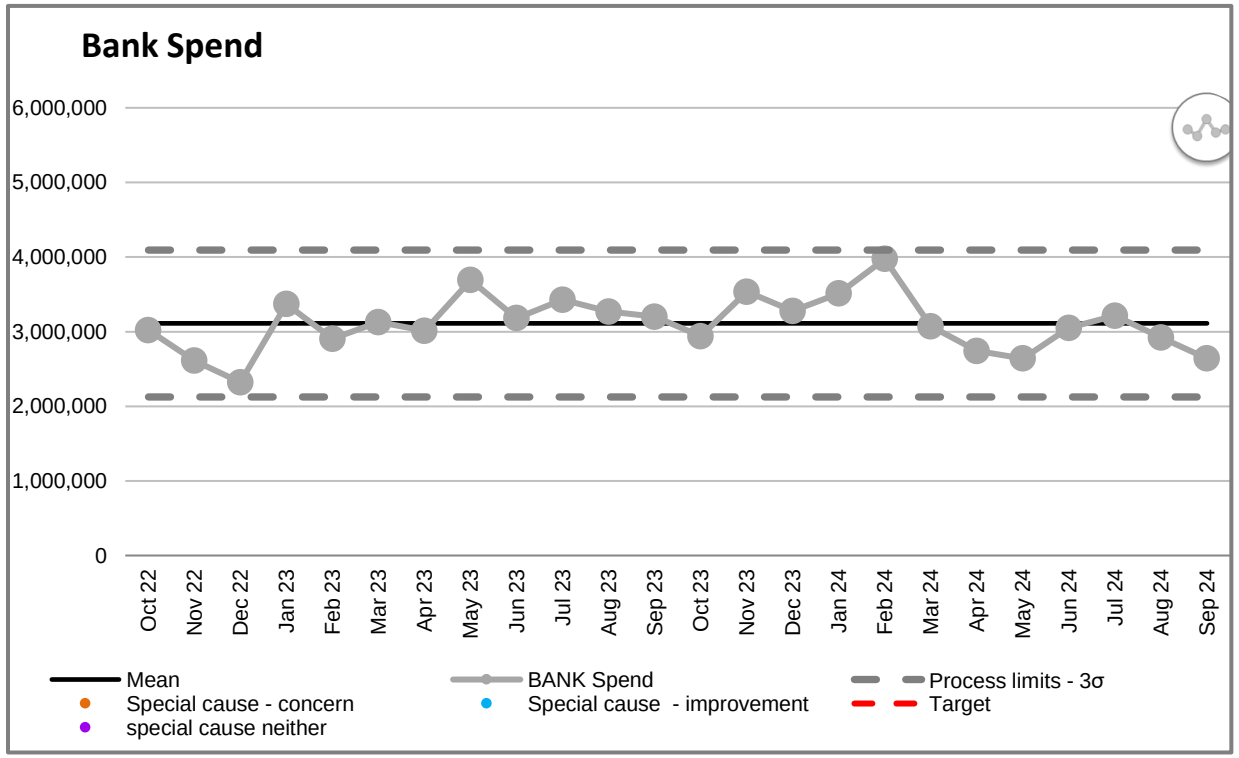
Actions:
- Compliance rates are shared with Directorates on a weekly basis.
- Enhanced Divisional accountability.
- Local campaigns to focus on mandatory learning in Divisions.
- Task and Finish group is being formed to review RST and progress will be fed back to the Education Committee.

Bank Spend

Executive Owner: Suzanne Dunkley | Lead: Samuel Hall | Business Intelligence Lead: Mark Bushby

Rationale:
It is important for the Trust to monitor Bank staff spend as it can help to minimise temporary staffing costs ensuring value for money and compliance.

Current: £2.6M



What does the chart show/context:
- An increase in May 2023 is due to the 5% pay award for April 2023 and May 2023.
- An increase in February 2024 can be attributed to back-pay of WTD % that was not accurately applied
- Bank spend is currently £2.64M in September 2024, a decrease from £2.92M in August.

Underlying issues:
- There is a dependency on bank to support the running of extra capacity areas that flex open and closed.
- Bank and Agency workers support in covering unplanned absences (sickness etc.).

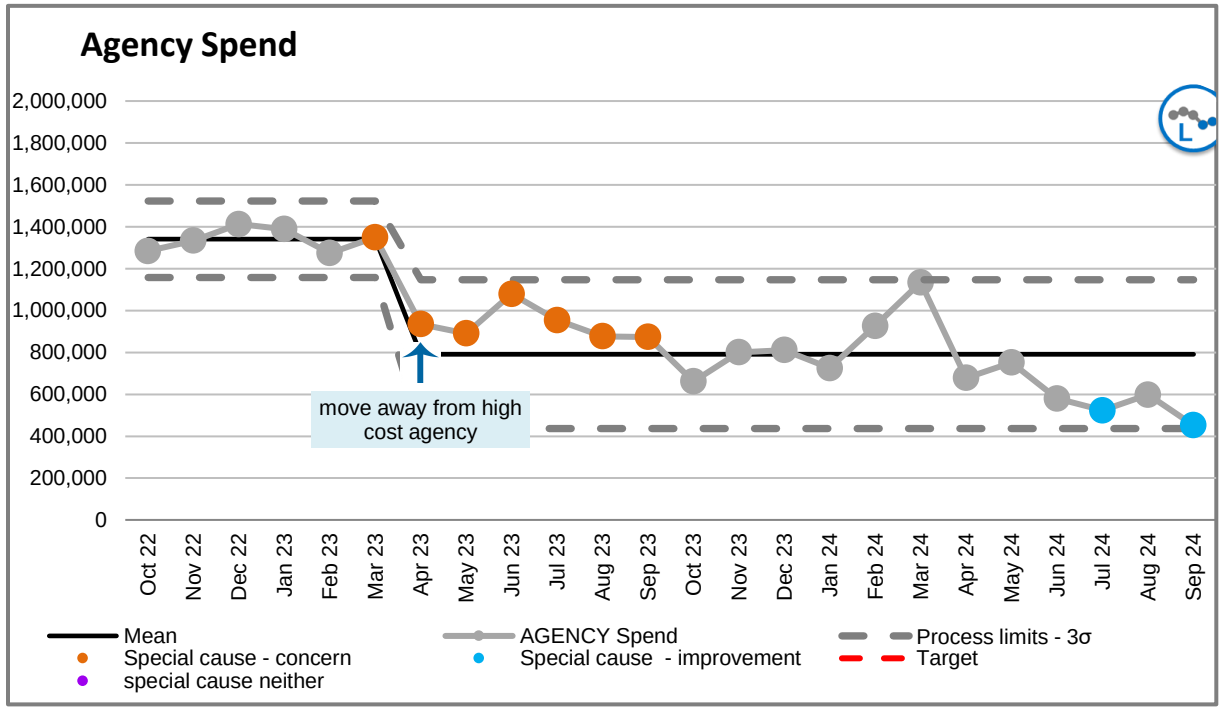
Actions:
- Bank and Agency CIP group established and closely monitoring Temporary Staffing usage throughout the organisation.
- Checklist of enablers for managing bank and agency use has been implemented in divisions.
- Bank & agency activity and spend dashboards and trackers are embedded in divisions to support targeted approach to removal.

Agency Spend

Executive Owner: Suzanne Dunkley | Lead: Samuel Hall | Business Intelligence Lead: Mark Bushby

Rationale:
It is important for the Trust to monitor Agency staff spend as it can help to minimise temporary staffing costs ensuring value for money and compliance and can encourage the recruitment and retention of staff.

Target: £0.76M **Current: £0.45M**



What does the chart show/context:
- The Trust moved away from high-cost agency during April 2023.
- Agency spend is now following normal cause variation from October 2023.
- Spend in September 2024 at £0.45M.
- Agency usage in September 2024 is at its lowest point in 2 years.

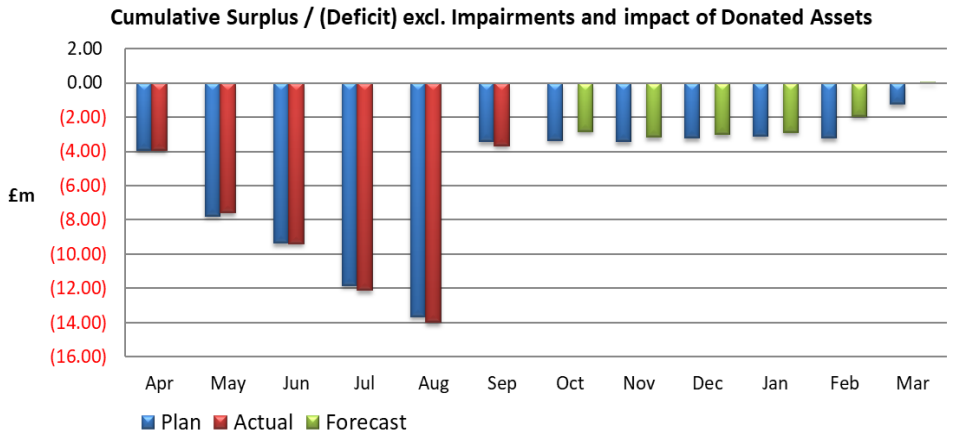
Underlying issues:
- Bank and Agency workers support in covering unplanned absences (sickness etc.).

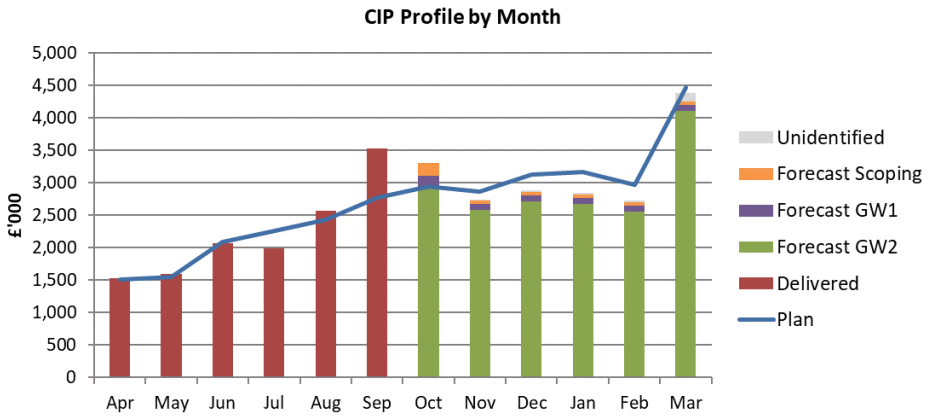
Actions:
- Bank & Agency CIP Workstream meets weekly to review bank and agency use across all divisions.
- Checklist of enablers for managing bank and agency use has been implemented in divisions.
- Bank & agency activity and spend dashboards and trackers are embedded in divisions to support targeted approach to removal.
- Consideration of Direct Engagement model to generate saving for agency medical staff
- Nursing agency review meetings to be scheduled to renegotiate agency rates of pay.
- High-cost/high usage Locum in Stroke Medicine ended engagement, costs should lower pending replacement being sourced.

Financial Performance

Executive Owner: Gary Boothby

Finance Lead: Adrienne Lake





Rationale:

- To monitor year to date and forecast performance against the 2024/25 financial plan and efficiency target

Target:

- The Trust has a revised annual plan for a £1.26m deficit (the original £26.26m deficit plan has improved due to the non-recurrent Deficit Support Funding of £25m allocated to the Trust). CIP Target is £32.18m (£30m new schemes plus £2.18m Full Year Effect of 2023/24 schemes.

What do the charts show/context:

- The Trust is reporting a year-to-date deficit of £3.68m, an adverse variance to plan of £0.25m. The Trust has delivered efficiency savings of £13.30m year-to-date, £0.68m higher than planned.

Underlying issues:

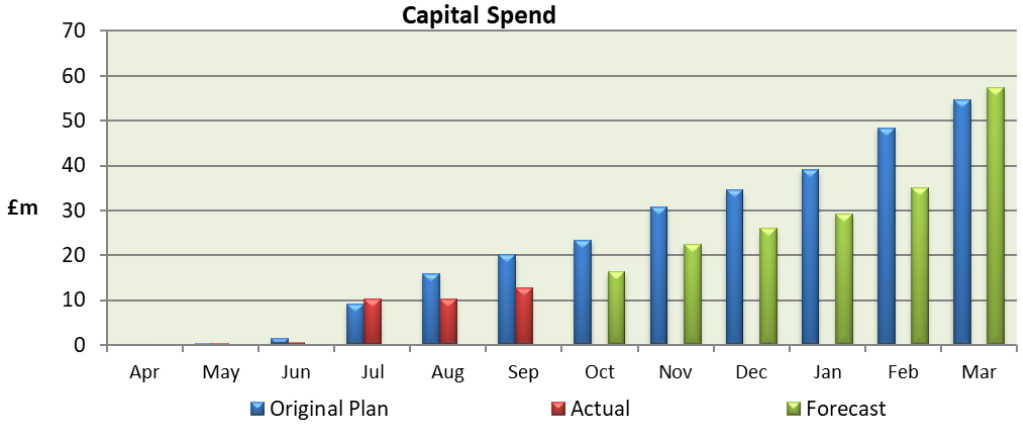
- The Trust incurred additional direct costs of £0.45m in June / July due to the Junior Doctors' Strike. Elective Recovery / Advice and Guidance funding is £1.18m lower than the stretch target assumed in planning, including c.£0.30m impact of the Industrial Action. These issues were compounded by additional bed capacity open above planned levels driving £0.9m pressure and high-cost drugs spend in excess of plan. These adverse variances have been largely offset by mitigations in the year-to-date position including higher commercial income, additional bank interest, lower agency staffing costs and over delivery of CIP year-to-date.
- The CIP challenge will increase significantly in future months due to the profiling of planned savings. Achievement of the 2024/25 plan, will require a significant improvement in the run-rate through full delivery of targeted savings.

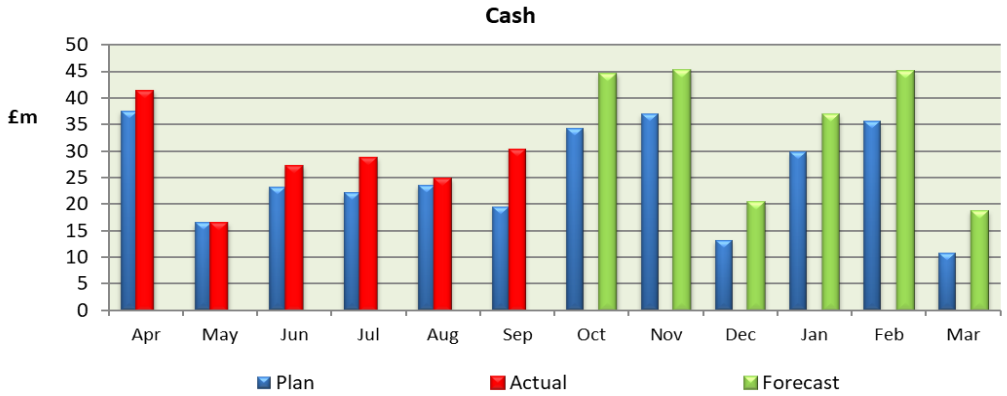
Actions:

- The focus is on implementing plans to secure CIP, delivering the 2024/25 financial plan and maintaining strengthened grip and control measures including: Headcount reduction plans; Bank and Agency expenditure reduction; and Non-Pay expenditure controls.

Financial Performance: Capital, Cash and Use of Resources

Executive Owner: Gary Boothby Finance Lead: Adrienne Lake





Use of Resources Metric:	24/25 Plan: 3	24/25 Actual: 3

Rationale:

- To monitor year to date and forecast Capital expenditure, Cash balance and Use of Resources metric against the 2024/25 financial plan.

Target:

- The Trust Capital Plan for 2024/25 is £54.58m. The planned Revenue Support Public Dividend Capital request for the year was £30.91m. Year-to-date to August £9.69m had been drawn down under this regime. In September, Deficit Support Funding of £25m has been allocated to the Trust with the expectation that no further Revenue Support Public Dividend Capital will be drawn down. This total level of cash support will be required to support the revised deficit plan of £1.26m, the internally funded capital plan which exceeds internal funding sources by £4.49m and an element of working capital movement that relates to the previous year's deficit.
- The Use of Resources metric is the financial element of the National Oversight Framework, with one overall score derived from the average score across 5 separate metrics: Liquidity, Capital Servicing Capacity, Income & Expenditure (I&E) Margin, Variance from I&E plan and Agency expenditure. A score of 1 is the most favourable and 4 the least favourable. Planned UOR for 24/25 is level 3.

What do the charts show/context:

- The Trust has spent £12.80m on Capital programmes year-to-date, £7.29 less than planned. At the end of September, the Trust had a cash balance of £30.38m, £10.85m higher than planned. Use of Resources (UOR) stands at 3, as planned.

Underlying issues:

- The cash balance was £10.85m higher than planned at the end of September. This variance is due to the combination of a favourable variance in cash flow year to date of £1.59m, supported by lower capital spend, plus a higher than forecast closing cash balance in the prior year (£9.27m).
- The Trust's capital forecast has increased by £2.80m to £57.38m since the plan submission, this is due to increased PDC funding being received above the planned value in relation to reconfiguration at CRH and an increase on the lease forecast of £1m.

Appendix A – Variation and Assurance Icons

Calderdale and Huddersfield NHS Foundation Trust

Variation Icons:

Icon	*Technical Description*	*What does this mean?*	*What should we do?*
	Common cause variation, NO SIGNIFICANT CHANGE.	This system or process is **currently not changing significantly**. It shows the level of natural variation you can expect from the process or system itself.	**Consider if the level/range of variation is acceptable**. If the process limits are far apart you may want to change something to reduce the variation in performance.
	Special cause variation of a CONCERNING nature where the measure is significantly HIGHER.	**Something's going on!** Your aim is to have low numbers but you have some high numbers – something one-off, or a continued trend or shift of high numbers.	**Investigate** to find out what is happening/ happened. Is it a one-off event that you can explain? Or do you need to change something?
	Special cause variation of a CONCERNING nature where the measure is significantly LOWER.	**Something's going on!** Your aim is to have high numbers but you have some low numbers - something one-off, or a continued trend or shift of low numbers.	**Investigate** to find out what is happening/ happened. Is it a one-off event that you can explain? Or do you need to change something?
	Special cause variation of an IMPROVING nature where the measure is significantly HIGHER.	**Something good is happening!** Your aim is high numbers and you have some - either something one-off, or a continued trend or shift of low numbers. Well done!	Find out what is happening/ happened. **Celebrate** the improvement or success. Is there **learning** that can be shared to other areas?
	Special cause variation of an IMPROVING nature where the measure is significantly LOWER.	**Something good is happening!** Your aim is low numbers and you have some - either something one-off, or a continued trend or shift of low numbers. Well done!	Find out what is happening/ happened. **Celebrate** the improvement or success. Is there **learning** that can be shared to other areas?

Assurance Icons:

Icon	*Technical Description*	*What does this mean?*	*What should we do?*
	This process will not consistently HIT OR MISS the target as the target lies between the process limits.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **within** those limits then we know that the target may or may not be achieved. The closer the target line lies to the mean line the more likely it is that the target will be achieved or missed at random.	Consider whether this is acceptable and if not, you will need to change something in the system or process.
	This process is not capable and will consistently FAIL to meet the target.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **outside of those limits in the wrong direction** then you know that the target cannot be achieved	**You need to change something in the system or process if you want to meet the target.** The natural variation in the data is telling you that you will not meet the target unless something changes.
	This process is capable and will consistently PASS the target if nothing changes.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **outside of those limits in the right direction** then you know that the target can consistently be achieved.	**Celebrate the achievement**. Understand whether this is by design (!) and consider whether the target is still appropriate; should be stretched, or whether resource can be directed elsewhere without risking the ongoing achievement of this target.

Appendix B (i) – Metrics Rationale and Background

Calderdale and Huddersfield NHS Foundation Trust

Metric	Details
Total Patients waiting >40, 52 weeks to start treatment and Total RTT Waiting List	Waiting times matter to patients. Most patients want to be referred, diagnosed and treated as soon as possible. To measure and encourage compliance with recovery milestones for the RTT waiting list.
Total elective activity undertaken compared with 2023/24 activity plan	A key planning requirement for 2023/24 is to recover elective activity levels to above those seen in the pre-Covid period, to order to address the growing elective care waiting list.
Percentage of patients waiting less than 6 weeks for a diagnostic test	Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%.
Diagnostic Activity undertaken compared with 2019/20 baseline	Maximise diagnostic activity focused on patients of highest clinical priority. Recovery of diagnostic testing is a key NHS objective and critical to wider elective recovery, including RTT performance.
Total Follow-Up activity undertaken compared with 2023/24 activity plan	To measure the relative reduction in follow-up outpatient attendances (consultant and non-consultant led) in 2023/24 compared to 2023/24 activity plan
Proportion of patients meeting the 62-day cancer referral to treatment standard	The NHS Constitution outlines what patients can expect and their rights when they are referred on a cancer diagnosis and treatment pathway. Patients who receive a cancer diagnosis after an urgent suspected cancer referral, referral for breast cancer symptoms, or via cancer screening should start treatment within 62 days of that initial referral.
Proportion of patients meeting the faster diagnosis standard	Faster Diagnosis will facilitate an improvement in the Cancer early detection rate and thereby increase the chances of patients surviving. Expectation is that 75% or more of patients will a maximum four weeks (28 days) from receipt of urgent GP (GMP, GDP or Optometrist) referral for suspected cancer, breast symptomatic referral or urgent screening referral, to point at which patient is told they have cancer, or cancer is definitely excluded.
Non-Site-Specific Cancer Referrals	The non-specific symptoms (NSS) pathway provides a route for patients presenting with vague symptoms who may have a serious illness. Measure is number of non-site-specific referrals received in a month against target from operational plan for 2024/25
Day Case Rates	Day case surgery, where the patient is admitted, undergoes intervention and is discharged on the same day, is an important aspect of service provision in the NHS. Day case surgery brings recognised benefits for both patients and system-wide efficiencies related to patient quality and experience, reduced waiting times and release of valuable bed stock.

Appendix B (ii) – Metrics Rationale and Background

Calderdale and Huddersfield NHS Foundation Trust

Metric	Details
Capped Theatre Utilisation	Capped theatre utilisation is a metric used to measure how well the allocated planned theatre session time has been utilised in an individual theatre list. It is calculated by taking the total needle to skin time of all patients within the planned session time and dividing it by the session planned time. High capped utilisation signifies that the allocated planned session time has been well utilised.
Early cancer diagnosis: 75% of cases diagnosed at stage 1 or 2 by 2028	Cancer is one of the biggest contributors to inequalities in life expectancy with people from the most deprived communities more likely to get cancer, be diagnosed at a late stage for certain types of cancer and to die from the disease. Early presentation, referral, screening and diagnosis are key to addressing this.
Proportion of patients admitted, transferred or discharged within 4 hours	Monitor waiting times in A&E. Longer waits associated with poorer patient outcomes. NHS Objective to improve A&E waiting times so that no less than 76% of patients are admitted, transferred or discharged within 4 hours by March 2024 with further improvement in 2024/25.
Proportion of ambulance arrivals delayed over 30 minutes	Proportion of ambulances which experience a delay (by more than 30 minutes) in transferring the patient over to the care of ED staff. Patients arriving via an ambulance should be transferred over to the care of hospital staff within 15 minutes of arrival at an Emergency Department (ED). Handover delays can be detrimental to the health of the patient and can have a knock-on impact on the ambulance service (crews are unable to attend to other potentially life-threatening calls). Such delays at the front door of ED can also be a sign of potential overcrowding within the ED.
Proportion of patients spending more than 12 hours in an emergency department	To monitor long waits in A&E which could indicate overcrowding in ED and can cause poor patient experience. The number of patients that spend more than 12 hours between arrival and admissions, transfer or discharge, as a proportion of total attendances.
Neonatal deaths per 1,000 total live births	The Long-Term Plan committed the NHS to accelerate action to achieve the national maternity safety ambition of 50% reductions in stillbirth, maternal mortality, neonatal mortality and serious brain injury by 2025. The number of neonatal deaths is influenced by a number of factors, including the quality of care delivered to the mother and baby and appropriate surveillance for all women. The rate of deaths within 28 days of birth per 1,000 live births. A neonatal death is defined as a live born baby born at 24 weeks gestational age or later, or with a birthweight of 400g or more, who died before 28 completed days after birth.
Stillbirths per 1,000 total births	The focus of this indicator is to measure progress in reducing the rate of stillbirths against the trajectory towards the 2025 ambition. Measures the rate of stillbirths per 1,000 live births and stillbirths. A stillbirth is defined as a baby delivered at or after 24 weeks gestational age showing no signs of life, irrespective of when the death occurred.
% of patients dying within their preferred place of death – Community Palliative Care.	The focus of this indicator is to measure the proportion of patients who die in their preferred place of death. Everyone deserves the best possible experience at the end of their lives. The place where someone's cared for at the end of their life and whether this matches what they want – is an important part of this experience.

Appendix B (iii) – Metrics Rationale and Background

Calderdale and Huddersfield NHS Foundation Trust

Metric	Details
Proportion of Urgent Community Response referrals reached within 2 hours	Urgent Community Response services are a commitment in the NHS Long Term Plan to provide urgent care to people in their homes if their health or wellbeing suddenly deteriorates. % of 2-hour UCR referrals subject to the 2-hour response standard (as specified in the UCR technical guidance), with an RTT end date in reporting month, that achieved the 2-hour response standard.
Community Waiting List over 52 weeks	Understand resilience amongst providers of community health services and identify specific issues (e.g. changes to activity, the extent of any backlogs). Provide valuable data on waiting times and waiting list information. Data used by national teams and systems to inform recovery plans and reduce waiting lists across community health services.
Virtual Ward	A virtual ward is a safe and efficient alternative to NHS bedded care that is enabled by technology. Virtual wards support patients who would otherwise be in hospital to receive the acute care, monitoring and treatment they need in their own home. This includes either preventing avoidable admissions into hospital, or supporting early discharge out of hospital.
Hospital Discharge Pathway Activity	Monitors discharges from hospital to ensure that patients are discharged safely to the most appropriate place and that they continue to receive the care and support they need after they leave hospital.
Adult G & A acute bed occupancy adjusted for void beds (Type 1 Acutes Only)	Understand the proportion of adult general and acute beds that are occupied. The proportion of adult general and acute beds occupied (adjusted for Covid void beds). Covid void beds are beds that are closed due to Covid, but which are unoccupied. These beds cannot accept new admissions unless the patient is Covid-positive.
% of beds occupied by patients who no longer meet the criteria to reside	Understand the numbers of beds which are not available for patients who do meet the criteria to reside and therefore points to resources which are unavailable due to discharge issues. There is significant interest in discharges and beds due to ongoing pressures which NHS providers face and even more so over the Winter period. This indicator shows the numbers of beds which are not available for patients who do meet the criteria to reside and therefore points to resources which are unavailable due to discharge issues.
Transfers of Care	Counting DTOCs helps whole systems to understand unmet need and identify bottlenecks and ensures that pathways through the system are patient-oriented rather than organisation or service-centred. Helps systems to improve services for patients by reducing situations where people are in hospital longer than they need to be, which can have a detrimental effect on their recovery, rehabilitation and long-term health and well-being.
Maternity Workforce	To ensure the right numbers of the right staff are available to provide safer, more personalised, and more equitable care
Maternal Mortality	The government's National Ambition is to halve the rate of maternal deaths from a 2010 baseline by 2025,. with a 20% reduction by 2020, reducing the rate from 10.6 per 100,000 maternities in 2010 to 8.5 in 2020 and 5.3 in 2025

Appendix B (iv) – Metrics Rationale and Background

Calderdale and Huddersfield NHS Foundation Trust

Metric	Details
Pre-Term Births	The governments national ambition for pre-term birth rate is to achieve a 25% reduction from an 8% baseline in 2015 to 6% in 2025.
Brain Injuries	The government's National Ambition is to halve the rate of intrapartum brain injuries from a 2010 baseline by 2025.
Care Hours Per Patient Day (CHPPD)	CHPPD is the national benchmark measure for safer staffing and provides a single consistent way of recording and reporting deployment of staff working on inpatient wards/units. It is calculated by totalling the number of hours worked by registered nurses, nursing associates, and in some cases allied health professionals, as well as healthcare support workers on each ward for the 24-hour period, then dividing by the number of patients on the ward each day at midnight. There is no 'correct' number of CHPPD to be achieved. However, variation between the actual and planned CHPPD, should warrant further investigation.
Inpatient Falls per 1000 Bed Days	Inpatient falls are the most frequently reported safety incident in hospital. Not all falls are preventable but 20–30% of falls can be prevented by assessing risks and intervening to reduce these risks.
CHFT Acquired Pressure Ulcer per 1000 Bed Days	Pressure ulcers (PUs) remain a concerning and often avoidable harm for the patients who develop them, and the healthcare professionals involved in their prevention and management. PU are in the 'top ten harms' in the NHS in England. Investigations into the causes of pressure ulcers frequently show that unwarranted variation from evidence-based practice contributes to the development of pressure ulcers.
Summary Hospital-level Mortality Indicator	This is to monitor the ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die based on average England figures, given the characteristics of the patients treated here. It covers all deaths reported of patients who were admitted to Non-Specialist Acute Trusts in England and died either while in hospital or within 30 days of discharge.
Hospital Standardised Mortality Ratio	This is to monitor the ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die based on average England figures, given the characteristics of the patients treated here. It covers in-hospital deaths in conditions that account for 80% of in-hospital mortality.
MRSA Bacteraemia Infections	HCAIs pose a serious risk to patients, clients, staff and visitors to health and social care premises. They can cause significant morbidity and mortality risk for those infected.
C.Difficile Infections	HCAIs pose a serious risk to patients, clients, staff and visitors to health and social care premises. They can cause significant morbidity and mortality risk for those infected.
E.Coli Infections	HCAIs pose a serious risk to patients, clients, staff and visitors to health and social care premises. They can cause significant morbidity and mortality risk for those infected.

Appendix B (v) – Metrics Rationale and Background

Calderdale and Huddersfield NHS Foundation Trust

Metric	Details
P.aeruginosa Infection	HCAIs pose a serious risk to patients, clients, staff and visitors to health and social care premises. They can cause significant morbidity and mortality risk for those infected.
Klebsiella SPP Infections	HCAIs pose a serious risk to patients, clients, staff and visitors to health and social care premises. They can cause significant morbidity and mortality risk for those infected.
% of incidents where the level of harm is severe or catastrophic	To identify areas where CHFT can reduce risks and prevent harm, the reporting of all near misses and serious incidents is imperative to ensure we improve safety and learn from these events to prevent recurrence. Promoting a positive reporting culture is essential to CHFT's learning success for all our patients, families and staff.
Number of Patient Safety Incident Investigations (PSII)	To identify areas where CHFT can reduce risks and prevent harm, the reporting of all near misses and serious incidents is imperative to ensure we improve safety and learn from these events to prevent recurrence. Promoting a positive reporting culture is essential to CHFT's learning success for all our patients, families and staff.
Never Events	To identify areas where CHFT can reduce risks and prevent harm, the reporting of all near misses and serious incidents is imperative to ensure we improve safety and learn from these events to prevent recurrence. Promoting a positive reporting culture is essential to CHFT's learning success for all our patients, families and staff.
Complaints	CHFT views any complaint as an extension of our service users' care and the Trust is committed to moving towards a user-centric service. Effective processes and procedures for handling concerns, feedback, stories, compliments, and complaints are pivotal to organisational learning success
Personalisation of Care	Dementia is a significant challenge and a key priority for the NHS, when people with dementia come into acute care, their length of stay is longer than people without dementia. Recognition of dementia also allows for improved care during the hospital admission
Care of the Acutely Ill Patient	The identification and recording of deterioration, enabling swifter response, which will reduce the rate of preventable deaths. Reducing the need for higher levels of care will free up capacity particularly in ICU by avoiding admissions and reducing lengths of stay, both of which are significant factors in the NHS's recovery efforts.
Stroke	This measure is looking at the % of stroke patients admitted directly to an acute stroke unit within 4 hours of hospital admission. This is the national standard, with direct admission to a stroke unit within 4 hours being a large driver for patient outcomes.

Appendix B (vi) – Metrics Rationale and Background

Calderdale and Huddersfield NHS Foundation Trust

Metric	Details
Health Inequalities: Cancer Faster Diagnosis Standard - Learning Disability, Deprivation and Ethnicity	Faster Diagnosis will facilitate an improvement in the Cancer early detection rate and thereby increase the chances of patients surviving. Expectation is that 75% or more of patients will a maximum four weeks (28 days) from receipt of urgent GP (GMP, GDP or Optometrist) referral for suspected cancer, breast symptomatic referral or urgent screening referral, to point at which patient is told they have cancer, or cancer is definitely excluded.
Health Inequalities: Percentage of patients waiting less than 6 weeks for a diagnostic test - Learning Disability, Deprivation and Ethnicity	Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%. Maximise diagnostic activity focused on patients of highest clinical priority.
Heath Inequalities: Patients waiting more than 40 weeks to start treatment - Learning Disability, Deprivation and Ethnicity	Waiting times matter to patients. Most patients want to be referred, diagnosed and treated as soon as possible. To measure and encourage compliance with recovery milestones for the RTT waiting list for learning disability patients.
Health Inequalities: Emergency Care Standard – Learning Disabilities, Deprivation and Ethnicity	To monitor waiting times in A&E for patients from the most deprived areas (IMD 1 and 2) to ensure equity across all patient groups
Health Inequalities: Outpatients DNA's – Learning Disabilities, Deprivation and Ethnicity	To monitor DNA rates at first and follow-up appointments for patients from most the most deprived areas (IMD 1 and 2) to ensure equity across all patient groups

A WORKFORCE FOR THE FUTURE

19. Leadership Diversity

To Note

Presented by Suzanne Dunkley

20. Guardian of Safe Working Hours Update

To Note

Presented by Neeraj Bhasin

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 7 November 2024
Meeting:	Public Board of Directors
Title:	**Quarter 2 Report 2024/25 (1 July to 30 September 2024)** from the Guardian of Safe Working Hours, CHFT
Author:	Dr Liaquat Ali, Guardian of Safe Working Hours
Sponsoring Director:	Medical Director
Previous Forums:	None
Purpose of the Report	The purpose of this report is to provide an overview and assurance of the Trust 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. Exception reports 2. Information about cover arrangements for out of hours rota gaps 3. Resident doctors' strike 4. Junior Doctors Forum
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	The Board is asked to **NOTE** the contents of the report.

Calderdale and Huddersfield NHS Foundation Trust

Guardian of Safe Working Hours (GOSWH) Quarterly Report

1 July to 30 September 2024 (Quarter 2)

Introduction:

The purpose of this report is to provide assurance to the Board that doctors in the training are safely rostered and that their working hours are compliant with the resident doctor's contract 2016 and in accordance with the resident doctors terms and conditions of service (TCS). The report includes the data from **1 July to 30 September 2024**

Executive Summary:

Trainees to submit exception reports electronically using Allocate software. 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.

Fifty-six exception reports were initiated by the trainees from 1st of July 2024 to 30th of September 2024. Significant numbers of reports were submitted in the month of September 2024 primarily by Foundation Year 1 (FY1) and FY2 grade doctors when compared to more experienced trainees. This trend has been noted in the previous reports and may result from a lack of experience as they take time to get familiar with NHS system. Most of the reports were triggered by resident doctors in the department of medicine. Approximately two thirds (43 out of 56) were related to extra hours of working. Two exception reports were relating to immediate patient safety issues. Both reports were related to missing breaks as required by the resident doctors 2016 contract. Both reports have been resolved after initial review. Currently thirty-four percent of ERs are unresolved these will be carried forward to the next quarter. No exception reports were initiated by locally employed doctors.

All our resident doctor rotas are fully compliant with the 2016 terms and conditions. Rota gaps remain a challenge, when a trainee is not provided by Health Education England, however several 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 resident doctors cross-covering during the day.

Background Data:

Number of doctors / dentists in training (total): 282.9, Non -Training Resident Doctors: 147.2, vacancy:41.24 (as per data by the end of Sep 2024)

Administrative support is provided to the Guardian: 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.

Safety concern raised through Exception Reports:

Two exception reports were recorded about immediate safety issues; both reports were related to missing break and residents' doctors could not manage to take breaks as per resident doctors 2016 contract. Both reports were resolved after initial review.

Work Schedule reviews:

Six exception reports related to patterns of work and four of these were resolved after initial meetings with educational supervisors. These resulted from working extra hours and trainees were compensated by overtime payments.

One concerned redeployment of an acute care common stem trainee from acute medicine to rehabilitation medicine for service provision - causing loss of educational/training opportunities. This was resolved after initial meeting with educational supervisor, the rota coordinator was informed to avoid in future.

Resolution of another report is still pending which concerns non-resident on call shifts. Doctor reported he was unable to sleep at night from 10pm to 7 am (< 5 hours continuous rest). This is still in the process of negotiation and discussion with rota team and Doctor.

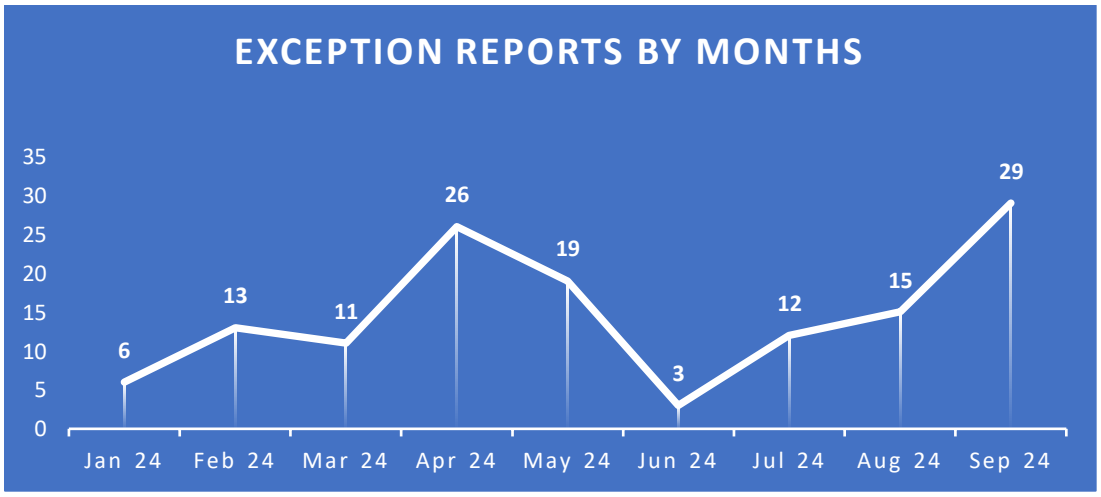
Exception Reports (ER) - details:

Total ER – 56

Distribution of exception reporting in relation to various reasons

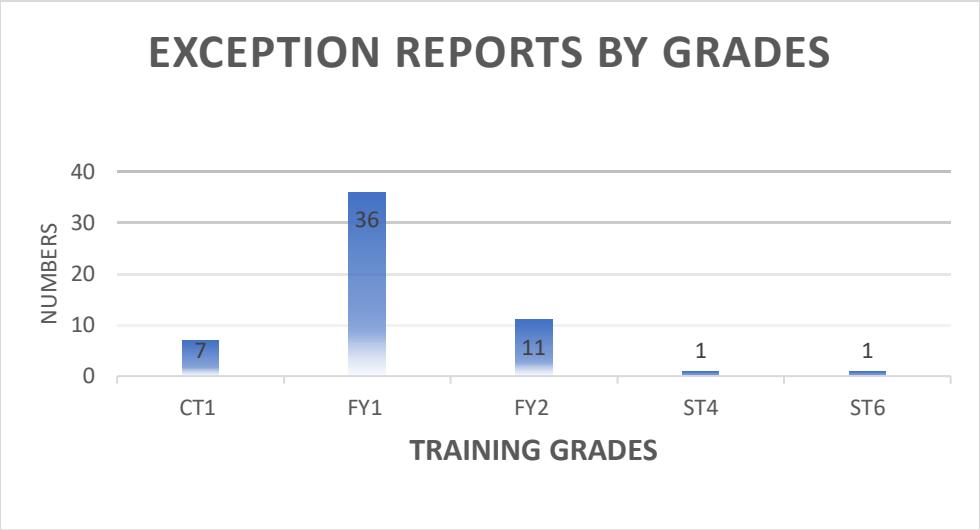
Out of these 56 reports, 43 were related to extra hours of working ,2 relating to immediate patient safety issues and 6 were related to pattern of work. Seven ERs related to missed educational opportunities (missed training day)

Exception Reports (ER) from 1st of July 2024 to 30th of Sep 2024:



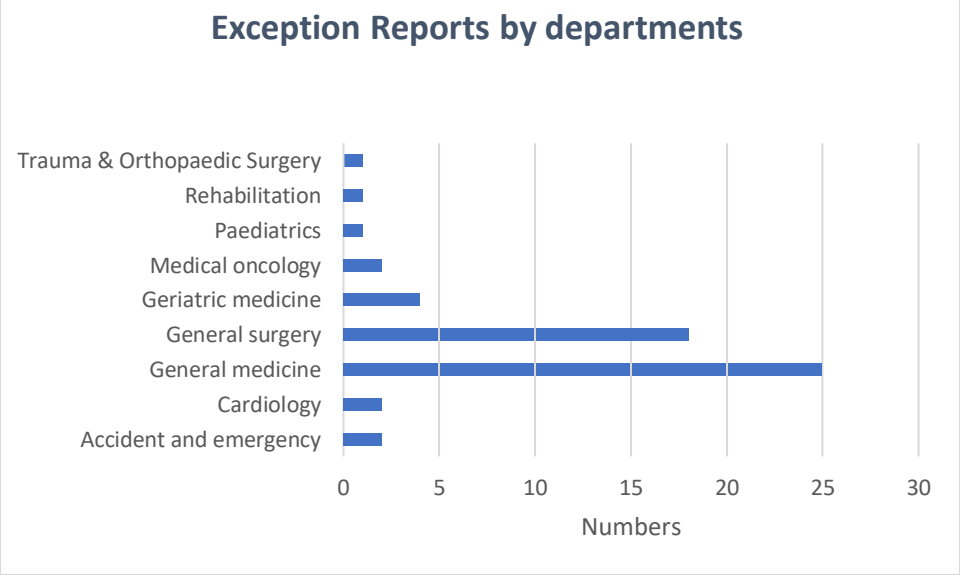
In total 56 reports were submitted over three months. As we can see, the numbers of exception reports are significant higher in September 2024 as compared to other months. This is probably due to change over in the month of August.

Exception reports by Grades:



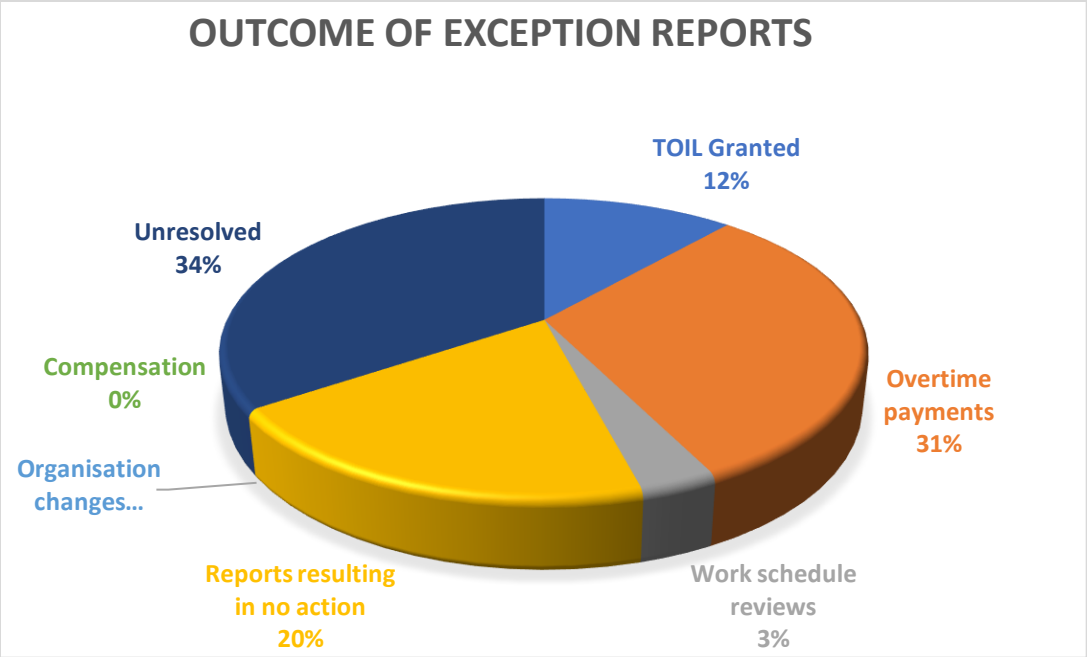
FY1 grade doctors have initiated quite significant numbers of exception reports in contrast to other training doctors. This is expected as the resident doctors are in the first year of working within the NHS and are still getting familiar with how the system works. I have noted few ERs from senior trainees as well.

Exception reports by Departments:



Trainees working in the medical division have generated significant exception reports versus other departments. This is due to indirect impact of on call rota especially at night which requires further investigation.

Outcome of exception reports:



Most of the trainees were given overpayment versus time off in lieu.

Not all ERs were resolved fully. Those shown as no outcome recorded include where the outcome was given by the supervisor after meeting with the trainee, but the doctor has not closed the report. Those shown as unresolved include reports initiated during this quarter were carried forward next month.

Steps from last Board meeting:

Fines:

There have not been any fines issued in last one year.

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. 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 the Electronic Staff Record (ESR) most of our training posts are filled currently.

	Jul-24			Aug-24			Sep-24		
Role	Budg-eted FTE	Actual FTE	Vacan cies by FTE	Budg-eted FTE	Actual FTE	Vacan cies by FTE	Budg-eted FTE	Actual FTE	Vacan cies by FTE
Consultant	333.19	299.47	33.72	328.19	304.39	23.80	329.19	306.64	22.55
Foundation Year 1	48.00	51.66	-3.66	47.00	59.66	-12.66	48.00	60.66	-12.66
Foundation Year 2	37.00	33.49	3.51	35.00	45.49	-10.49	38.00	46.49	-8.49
General Medical Practitioner	0.00	0.20	-0.20	0.00	0.20	-0.20	0.00	0.20	-0.20
Medical Director	1.00	1.20	-0.20	1.00	1.20	-0.20	1.00	1.20	-0.20
Specialty Doctor	127.43	80.12	47.31	125.43	75.12	50.31	130.43	71.12	59.31
Specialty Registrar	144.36	131.96	12.40	143.36	133.58	9.78	143.36	137.39	5.97
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 - Specialist Registrar Level	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Trust Grade Doctor or Dentist - Foundation Level	26.00	12.00	14.00	27.00	11.00	16.00	27.00	11.00	16.00
Trust Grade Doctor or Dentist - Specialty Regis-trar	44.94	61.08	-16.14	44.94	61.08	-16.14	44.94	64.08	-19.14
GP Trainees - Trust Based (Specialty Registrar)	41.00	34.28	6.73	39.00	37.36	1.64	39.00	38.36	0.64
Total	**803.92**	**706.46**	**97.46**	**791.92**	**730.08**	**61.84**	**801.92**	**738.13**	**63.79**

Shifts covered by Bank and Agency:

Out of hours shifts can arise for several reasons. As you can see from the table below, most shifts are filled with alternative cover.

Shifts covered by Bank and Agency: July to 30 Sep 2024 in the following format.

GOSWH Hours report- Bank and Agency fill rates by division. July- September 2024

	FSS	Medi-cine	Surgery and Anaesthetics
Filled shifts	98.06%	93.04%	89.61%
Unfilled hours	1.94%	6.96%	10.39%

This data provide reassurance that bank staff (Trust staff) are used to cover unfilled shifts.

Industrial Action:

Significant planning was done within all divisions to pull together a comprehensive plan with a focus on patient and staff safety protecting critical services to deliver lifesaving care and

maintaining elective care for cancer patients during resident doctor's strike. The strike actions have taken place **7am on 27th June to 7am on 2nd July 2024.**

Significant numbers of doctors participated in strikes as shown by the following data:

	27th June 2024				28th June 2024			
Area Of Work / Specialty	**# Due to Work**	**# Present for work**	**# Absent due to IA**	**% Absent due to IA**	**# Due to Work**	**# Present for work**	**# Absent due to IA**	**% Absent due to IA**
372 Families & Specialist Services L3	36	12	16	44.44%	27	12	8	29.63%
372 Medical L3	142	31	79	55.63%	120	21	70	58.33%
372 Surgery & Anaesthetics L3	61	15	41	67.21%	58	14	37	63.79%
Total	**239**	**58**	**136**	**56.90%**	**205**	**47**	**115**	**56.10%**

	29th June 2024				30th June 2024			
Area Of Work / Specialty	**# Due to Work**	**# Present for work**	**# Absent due to IA**	**% Absent due to IA**	**# Due to Work**	**# Pre sent for work**	**# Ab sent due to IA**	**% Absent due to IA**
372 Families & Specialist Services L3	11	6	4	36.36%	8	4	3	37.50%
372 Medical L3	34	13	25	73.53%	31	8	15	48.39%
372 Surgery & Anaesthetics L3	18	4	14	77.78%	18	3	16	88.89%
Total	**63**	**23**	**43**	**68.25%**	**57**	**15**	**34**	**59.65%**

	1st July 2024			
Area Of Work / Specialty	**# Due to Work**	**# Present for work**	**# Absent due to IA**	**% Absent due to IA**
372 Families & Specialist Services L3	34	11	22	64.71%
372 Medical L3	120	19	74	61.67%
372 Surgery & Anaesthetics L3	59	13	37	62.71%
Total	**213**	**43**	**133**	**62.44%**

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.

The industrial action is confirmed as 'Christmas Day' levels of care. This means that emergency care will continue to be provided, although elective work may need to be cancelled. The medical team was supported by physician associates, pharmacists, trust grade doctors and training doctors who did not participate in the strike action. Fortunately, no unpredictable events took place. ER were recorded during strike action. Adequate support services were available in terms of: The Safari team was available to prescribe for TTOs (take home prescriptions), and a "Floater" prescriber was available as well as Microsoft Team setup (CHFT – Digital Support) to act as a

central resource to facilitate any issues colleagues may have with Cerner, Blood TRACK, ABG (Arterial Blood Gas) machine access and prescribing. There was a significant level of support for industrial action with approximately 90% of those eligible going on strike.

Junior Doctors Forum:

The Junior doctor's forum takes place quarterly, chaired by Deputy Medical Director/Guardian of safe working hours. Members include Director of Medical Education/deputy, Local Negotiating Committee (LNC) chair, resident doctor representatives and medical HR. This provides opportunity for junior doctors to get involved in service improvement (rota masters can be informed prior to ensure attendance). We discuss specialty specific issues, involvement in disbursement of fines, report from GOSWH regarding exception reports and performance manage GOSWH.

This time the meeting took place on 17 September 2024 and audience was informed about post rest facilities, availability of accommodation/taxi services for colleagues finishing on a late shift or too tired to travel home. Medical education department manager updated the forum that 18 doctors have utilised facility of overnight accommodation in approximately two months. She expressed that they are committed to promote and publish about rest facilities for overnight on call team.

Annual summary of exception reports was presented and LNC chair discussed about access of Allocate account to locally employed doctors. HR has confirmed locally employed doctors have been access to initiate exception reporting. HR department has given assurance about allocate account access to locally employed doctors. We have discussed briefly about Government offer to resident doctors and change in nomenclature from junior doctors to resident doctors.

Regional GOSWH conferences and webinars:

Guardians of safe working hours conference has taken place on 8 October 2024 and summary will be discussed in next quarterly meeting.

Summary:

The trainees at CHFT have access to an Allocate account to initiate exception reports and they have the provision if they want to raise any issue regarding safety concern, missed educational opportunities and extra work outside their agreed rota. The rotas that are in the place are fully compliant with the rules of the 2016 contract and there is scope to review these where feedback highlights when change may be needed.

KEEPING THE BASE SAFE

21. Resilience Plan 2024/25

To Approve

Presented by Lindsay Rudge

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Date of Meeting:	Thursday 7 November 2024
Meeting:	Public Board of Directors
Title of report:	Resilience Plan (Including Winter Plan)
Author:	Gemma Berriman, Director of Operations for Resilience, Acute Flow and Transformation
Sponsor:	Jonathan Hammond, Chief Operating Officer
Previous Forums:	Urgent and Emergency Care Delivery Group Finance and Performance Committee Weekly Executive Board
Purpose of the Report	A policy to support operational pressures, including winter plans for Board approval.
Key Points to Note	This is the yearly resilience plan (including winter plan) this is based on the same document that is updated yearly. This plan is used as a framework but is dependent on circumstance. We make different decisions for example, infections on wards, changes in demand surges, medical or surgical. We update the plan yearly however we continue to test different ways of best managing site pressures and as we adapt and find different solutions, we will then roll this into an updated plan in the future in the form of addendums as required. The updates for 2024/25 are: • Integrated Care System (ICS) Updates – Broad assumption changes for 2024/25 • Innovation Schemes for 2024/25 - Integrated Flow Hub - Long Stay Wednesdays • ICS Plan for 2024/25 included. • Decision making in OPEL (operational pressure escalation level) changes, include new language OPEL Site Management meeting, relationship with Control and Command Policy. New language for incidents Operational/Tactical/Strategic. • Action Logs from OPEL Site Management meetings • Vaccination advice and locations. • Wellbeing hour removed from policy. • Colleague Support for Health and Wellbeing updated. • Divisional updates. • Added new Medical SDEC (Same Day Emergency Care) information. • Added Mutual Aid section. There are 16 appendices to the Resilience Plan which are referenced throughout. These appendices are available on request.

EQIA – Equality Impact Assessment	Not required.
Recommendation	The Board of Directors are requested to review and **APPROVE** the Resilience Plan.

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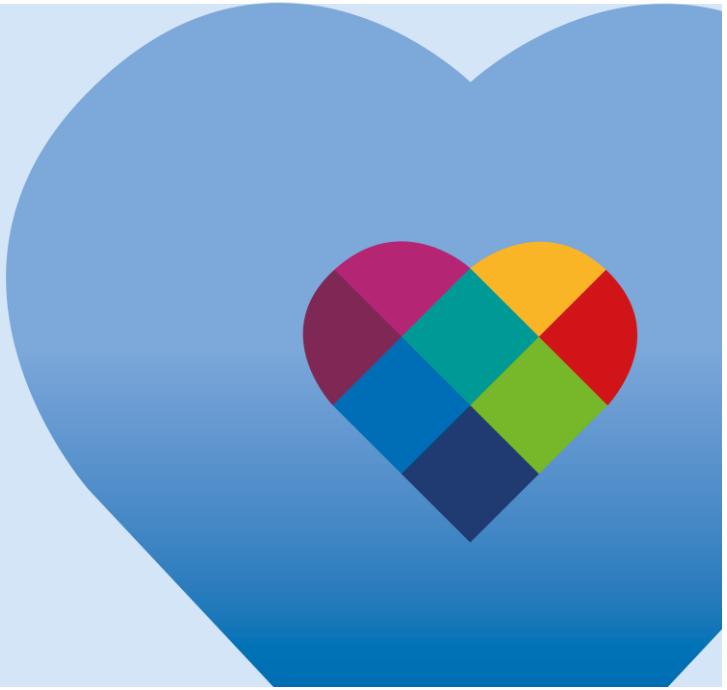
NHS Foundation Trust

Operational Plans 2024-2025

Resilience Plan (Including Winter)

Surge and Escalation Plan (Including Full Capacity Protocol)

October 2024



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How the Plans were Developed

Calderdale and Huddersfield NHS Foundation Trust

- Working with Divisional colleagues
- Working with specific areas such as ED
- Working with system partners across the Local Authority, ICS and ICB
- Sharing and taking comments from all colleagues
- Sharing the information in different forums across CHFT

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Resilience Plan

Calderdale and Huddersfield NHS Foundation Trust

- Previously been described as the Winter Plan.
- Recognising that operational pressure exist throughout the entire year not just during winter and our plans encompass this.

Information in the Plan

- Purpose of the Plan
- CHFTs Resilience & Winter Strategy
- Operational Pressures and Scoring Frameworks
- Communication
- Workforce
- Divisional Level Plans
- Severe Winter Weather
- Escalation and Business Continuity Plans
- Infection Control
- Holiday Periods

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National OPEL Scoring

Calderdale and Huddersfield NHS Foundation Trust

A new OPEL framework was introduced in 2023 and hasn't changed for 2024/25. The framework aims to achieve the following:

- Provide a unified, systematic and structured approach to detect Acute Hospital pressures
- Provide a consistent framework to represent each Acute Trust linking into ICS and NHS regions and nationally.
- Provide guidance to Acute Trusts, ICS and NHSE so a coordinated response to pressures can be sourced
- Provide guidance on the alignment and interaction between the OPEL framework and the National Emergency Preparedness, Resilience and Response (EPRR) framework.

The following benefits should be felt

- Improved patient safety
- Increased efficiency
- Improved communication
- Enhanced decision making

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National OPEL Scoring

Calderdale and Huddersfield NHS Foundation Trust

The following core parameters make up the OPEL assessment for each submission. Each acute hospital with a type 1 ED must complete their own OPEL assessment based on these parameters.

Assessments should be time-cycled as per the OPEL action cards; this calculation should be digitally automated where possible. Scores range from 0 to 44 – with the lowest pressure assessment being 0 and the highest-pressure assessment being 44.

OPEL parameter	Score						
	0	1	2	3	4	5	6
Mean ambulance handover time	<15 min		15–30 min		>30–60 min		>60 min
ED all-type 4-hour performance	>95%	76–95%	60–76%		≤60%		
ED all-type attendances	≤2%	>2–10%	>10–20%		>20%		
Majors and resuscitation occupancy (adult)	≤80%		>80-100%		>100–120%		>120%
Median time to treatment	≤60 min	>60–90 min	90–120 min		>120 min		
% of patients spending >12 hours in ED	≤2%	>2–5%	>5-10%		>10%		
% G&A bed occupancy	≤92%		>92–95%		>95–98%		>98%
% of open beds that are escalation beds	<2%	2–4%	4–6%		>6%		
% of beds occupied by patients no longer meeting criteria to reside	≤10%		>10–13%		>13–15%		>15%

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Key Schemes Underway - Resilience

Calderdale and Huddersfield NHS Foundation Trust

In Hospital

Well Organised Ward (WOW)
Leads
Renee Comerford
David Britton

Well Organised Long Stay Review
Leads
Renee Comerford
Purav Desai

Integrated Flow Hub
Lead
Gemma Berriman

Roles Review
Lead
Gemma Berriman

Same Day Emergency Care (SDEC)
Lead
Helen Rees
Tom Ladlow

Emergency Department Improvement
Lead
Tom Ladlow
Jason Bushby

Out of Hospital

Home First
Lead
Sally Grose

Virtual Ward (CHFT)
Lead
Hannah Wood

Urgent Community Response (UCR) (CHFT)
Lead
Hannah Wood

Single Point of Access
Leads
Michael Folan

Transformation Programme
Kirklees Partnerships
Calderdale Cares
Lead
Michael Folan

Golden Threads

- Admission Avoidance.
- Care in the Community.
- Pulling together the Urgent and Emergency Care (UEC) Pathway.
- Non-elective care pathways joined up working across hospital and community settings.
- Better patient outcomes.

Outcomes

- Reduction in patient harms.
- Reduction in deconditioning.
- Reduction in Hospital Acquired Infections.
- Reduction in pressure sores.
- Better patient experience.
- Increased bed availability.
- Lower waiting times across the UEC pathway.
- Reduction in ambulance waits.
- Decreased Length of Stay (LOS).

Surge Plans - CRH

Calderdale and Huddersfield NHS Foundation Trust

Surge Capacity 2024/25

		Impact/Risks	Medical Cover	Nursing Cover
0	ALREADY ESCALATED CORE BED BASE Outliers on surgical wards and 1D	No additional staffing/equipment	Acute Physcians	No additional need as outliers
1	WARD 1D/4D (16 BEDS on 1D or 10 BEDS on 4D subject to location of FSS GYNAE SDEC)	Additional Staffing/equipment	Acute Physicians	Cohort of substantive staff to be deployed + bank/agency WFM - 2 Qualified, 1 HCAs
2	WARD 8D 15 BEDS	Additional Staffing/equipment	MS Physicians	Cohort of substantive staff to be deployed Bank/agency 2 Qualified plus day coordinator, 2 HCAs
3	WARD 6D 5 BEDS as a start As a min - need 4 bedded bay and SR free for electives	Additional Staffing/equipment Loss of elective activity if more thatn 5 beds used	MS Physicians	Cohort of substantive staff to be deployed Bank/agency 1 RN, 1 HCAs but dependant on beds used
4	WARD 8A 8 BEDS as a start	Loss of elective orthopaedic procedures	Surgery	Surgery plus bank/agency WFM - 2 RN

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Surge Plans - HRI

Calderdale and Huddersfield NHS Foundation Trust

Surge Capacity 2024/25

		Impact/Risks	Medical Cover	Nursing Cover
0	ALREADY ESCALATED CORE BED BAS (Outliers on SAU and ward 14)	Additional Staffing/equipment	SAU - IMS Physcians Ward 14 - Acute Physcians	Ward area covering within WFM and with bank or agency
1	Birth Centre - 5 Beds	Additional Staffing/equipment	Acute Physicians	Covered by bank and agency 1 Qualified - Matron: Surgical Matron

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Surge and Escalation Plan & FCP

Calderdale and Huddersfield NHS Foundation Trust

Purpose

The SEP outlines the key actions to be taken when the Trust is working at increased levels of pressure to effectively managed intense periods of demand. It provides guidance for all colleagues involved in managing patient flow.

The Plan is designed to:

- maintain the operational safety of patients and colleagues
- maintain timely ambulance handovers
- ensure that potential risk to patient safety is not concentrated in one area
- facilitate the admission of patients that come through our emergency departments

Information in the Plan

- Overview, Aim and Purpose
- When and how to activate the plan
- Escalation triggers
- Activation out of hours
- Command and control
- Escalation routes
- Capacity meetings
- Boarding patients and fire safety
- Phasing of the plan (3 Phase)
- De-escalation of the Full capacity protocol
- Action Cards

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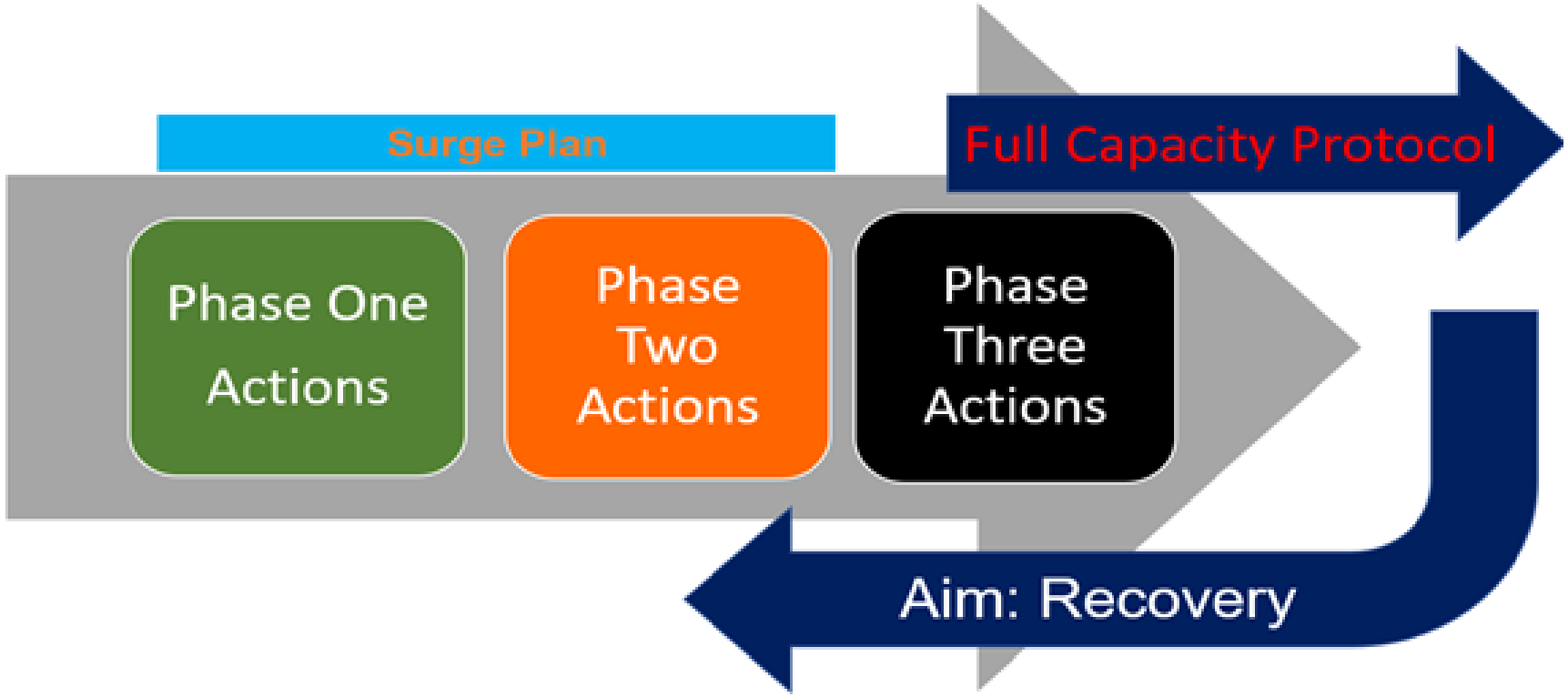
Phases

Calderdale and Huddersfield NHS Foundation Trust

- The Surge & Escalation Plan is broken down into 3 phases, with phase 1 & 2 being the surge and phase 3 being the full capacity protocol.
- Within each phase there are a set of actions to be implemented to ease pressure and improve the operational position.



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Key Points

Calderdale and Huddersfield NHS Foundation Trust

Escalation routes

Flow charts detailing the escalation routes for both in and out-of-hours are detailed within the plan.

- Clear set of action cards to follow
- Clear escalation processes
- Links to OPEL/LOPEL Scoring
- A set of SOPs to support staff in decision making during times of pressure

Phase 3 – Full Capacity Protocol (FCP)

Actions in this phase focus actions being completed alongside each other recognising that moving patients to ward areas can take longer than using agreed expansion space in ED to off load ambulances.

ED

- Using the agreed expansion areas

Designated Wards

- Looking after patients in an area that is not a core bed space. (Boarding)

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Summary of Changes

Calderdale and Huddersfield NHS Foundation Trust

- ICS Updates – Broad assumption changes for 2024/25
- Innovation Schemes for 2024/25
- Integrated Flow Hub
- Long Stay Wednesdays
- ICS Plan for 2024/25 included as an attachment.
- Decision making in OPEL changes include new language OPEL Site Management Meeting, relationship with Control and Command Policy. New language for incidents Operational/Tactical/Strategic.
- Action Logs from OPEL Site Management Meetings and example in appendices.
- Vaccination advice and locations.
- Wellbeing hour removed from policy.
- Colleague Support for Health and Wellbeing updated.
- Divisional updates.
- Added new Medical SDEC information.
- Added Mutual Aid section.

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Calderdale and Huddersfield
NHS Foundation Trust

Resilience Plan 2024/25
(Including Winter Arrangements)

V2

Document Summary Table	
Unique Identification No.	G-136-2023
Status	Draft
Version	2
Implementation Date	October 2023
Current/Last Review Dates	New
Next Formal Review	August 2025
Sponsor	Chief Operating Officer
Author	Director of Operations – Resilience, Acute Flow & Transformation
Where available	Trust Intranet
Target audience	All Staff

Ratifying Committees	
Executive Board	
Finance & Performance Committee	
Resilience, Acute Flow and Transformation Governance Group	

Consultation Committees	
Finance & Performance Committee	
Urgent and Emergency Care Delivery Group	
Resilience and Safety Group	

Other Stakeholders Consulted
Medical Division
Surgical Division
Families and Specialist Services Division
Corporate Teams
NHS England
System Partners

Does this document map to other Regulatory requirements?	
1	New National OPEL Framework
2	Urgent and Emergency Care Recovery Programme
3	EPRR

Document Version Control		
1	Oct 2023	First Version
2	Oct 2024	• ICS Updates – Broad assumption changes for 2024/25 • Innovation Schemes for 2024/25 - Integrated Flow Hub - Long Stay Wednesdays • ICS Plan for 2024/25 included as an attachment.

		• Decision making in OPEL changes include new language OPEL Site Management Meeting, relationship with Control and Command Policy. New language for incidents Operational/Tactical/Strategic. • Action Logs from OPEL Site Management Meetings and example in appendices. • Vaccination advice and locations. • Wellbeing hour removed from policy. • Colleague Support for Health and Wellbeing updated. • Divisional updates. • Added new Medical SDEC information. • Added Mutual Aid section.

Contents

1. Introduction

The Resilience Plan describes the structure within which operational pressures will be anticipated and managed. It includes arrangements for during the winter period and it provides the framework for managers and clinicians in the Trust to work together and with other organisations. The Resilience Plan should be used in conjunction with the Surge and Escalation Plan (SEP) including the Full Capacity Protocol (FCP). This should also be read in conjunction with the Command-and-Control framework that covers during times where incident management may be required.

The Calderdale and Huddersfield NHS Foundation Trust (CHFT) Resilience Plan also forms part of the larger system Resilience Plan pulled together by the Integrated Care System (ICS). (Appendix One)

Preparedness for operational pressures and winter in particular is imperative to ensure we keep our patients and staff safe. We remain resilient as an organisation, as well as continue with our elective recovery programme to reduce backlogs.

Whilst the winter period is normally defined as the period from October through to the end of March the pressures in the NHS remain throughout most of the year, so the Resilience Plan and the Surge and Escalation Plan and Full Capacity Protocol need to be prepared and tested with daily monitoring of data in place to trigger OPEL and associated escalations and actions.

2. Purpose of the Resilience Plan

The objectives of the plan are in line with the
West Yorkshire Integrated Care System (ICS) Operational Pressures and Winter Planning Principles listed below:

- System resilience is 365 days of the year – winter challenges October to March
- Staff Support and Wellbeing arrangements should be in place to enable a resilient workforce.
- Health Inequalities integral to all plans.
- System wide clinical engagement and leadership in the ongoing development of plans and oversight.
- Data trends to inform planning assumptions – including public health.
- Focus on prevention – Vaccination, Infection Prevention Control (IPC).
- Consideration of impact of wider transformational schemes on system plans.
- Early identification of winter schemes through winter learning.
- Robust command and control arrangements to support system escalation.
- Mechanisms in place to ensure systems escalate early in anticipation of demand surges, not in response to them.
- Development of communication plans with system partners and the public to influence behaviour.

The NHS England Winter planning letter 16 September 2024 confirms the requirement to continue with the 2-year Urgent Emergency Care Recovery Programme as well as the following:

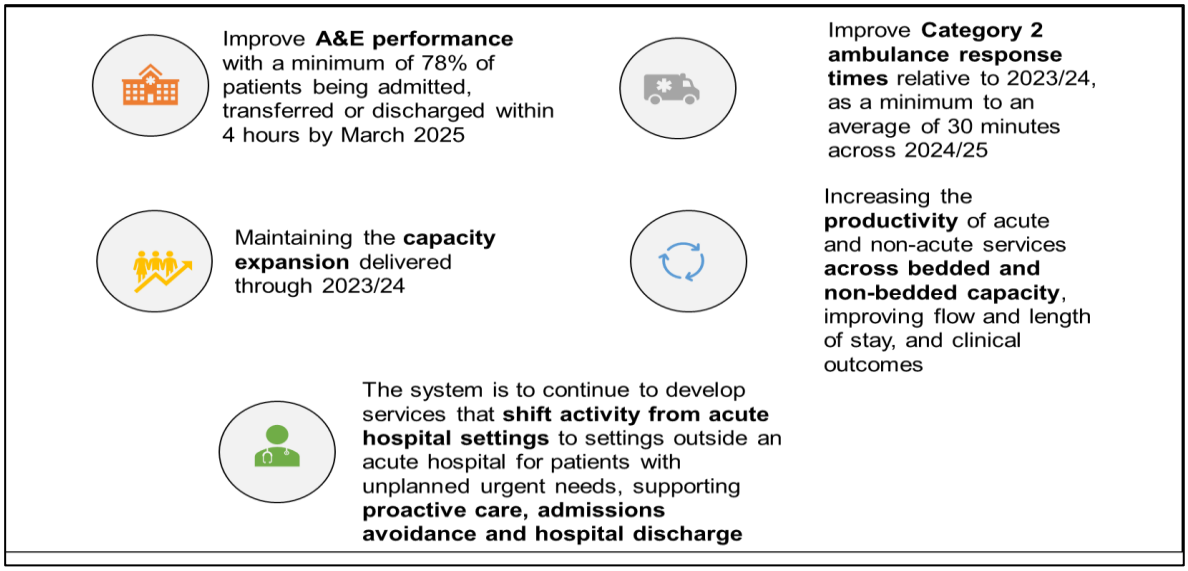
- Supporting people to stay well – preventing illness and improving resilience, both in our population and workforce. There is a particular focus on flu and covid immunisation, alongside the offering of respiratory syncytial virus (RSV) vaccine to those aged 75-79 and pregnant women.
- Maintaining patient safety – ensuring basic standards of care are in place, ensuring patients are treated in the safest possible place as quickly as possible – delivered through system working. This will be support through GIRFT acute data led reviews and the development of improvement resources and expanding OPEL arrangements.

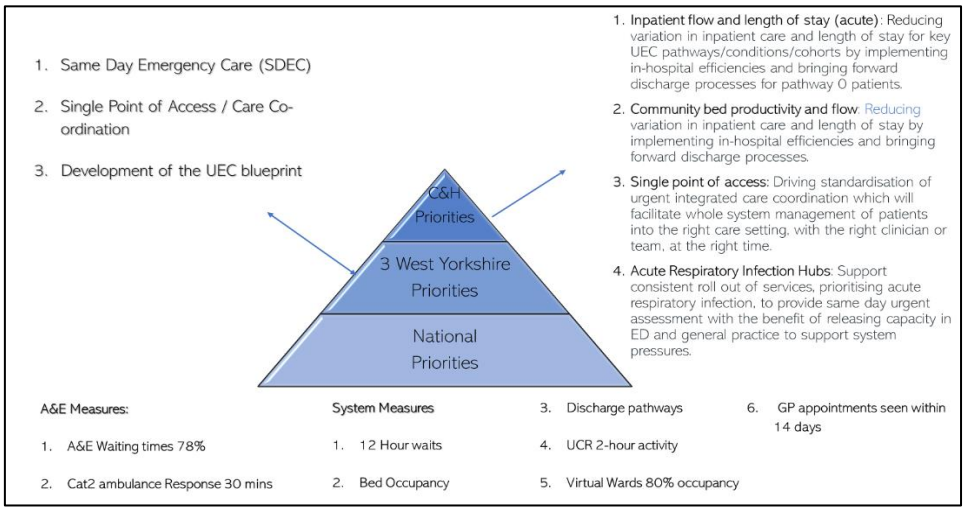
The Department of Health and Social care have also made a commitment to set out priorities for improving service resilience in the short term, ahead of and during the winter period. The principles guiding these short-term priorities are similar to those that will underpin that longer-term reform:

- A 'home first' approach that supports people to live independently for as long as possible.
- A relentless focus on ensuring high-quality care.
- Close involvement of people receiving care and their families and carers

Close partnership working and joint planning between adult social care, the NHS and other community partners is clearly vital to the successful delivery of these priorities. Reconfirmation of these priorities is also consistent with delivery of our priorities at the Acute Trust.

Broad Assumptions





Alongside the above principles and assumptions there is also a regional Urgent Emergency Care Recovery Plan, this is a programme designed to cover a 2-year period (now in year 2) but there are a set of rapid roll out priorities identified to ensure pressures are manageable for the 2024/25 period.

Building on the 3 high level focus areas from 2023/24 further ambitions for 2024/25 are:

- Maintaining the capacity expansion delivered through 2023/24.
- Increasing the productivity of acute and non-acute services across bedded and non-bedded capacity, improving flow and length of stay and clinical outcomes.
- Continuing to develop services that shift activity from the acute hospital settings to settings outside an acute hospital for patients with unplanned urgent needs, supporting proactive care, admissions avoidance, and hospital discharge.

These are committed to deliver the following:

- 78% A&E performance by 31st March 2025.
- Improve Category 2 ambulance response times relative to 2023/24, to an average of 30minutes across 2024/25.

This will be achieved by prioritising the following:

- **Maintain Acute General and Adult beds**:
  At a system level maintaining the growth achieved by Quarter 4 2023/24 on average over the course of the year, adjusting for seasonality.
- **Maintain ambulance capacity and support the development of services to prevent conveyance:**
  Maximising opportunities for call before you convey and community options.
- **Reduction in ambulance handover times:**
  Reducing handover delays will be a key focus and action for systems to deliver in 2024/25 and will remain a metric to better assess flow across Urgent Emergency Care pathways and support improved patient outcomes.
- **Expand bedded and non-bedded intermediate care capacity, to support improvements in hospital discharge and enable community step-up care:**

Working jointly across ICBs and local authorities, ensure that commissioned intermediate care capacity meets projected demand, supported by the additional £400 million in the 2024/25 Discharge Fund. Plans should accurately forecast capacity needs, considering the most appropriate balance between different discharge pathways, and identify the workforce capacity and skill mix changes required to deliver sufficient rehabilitation and reablement activity to support discharge. Plans will be assured through the Better Care Fund (BCF) assurance process. Use the Intermediate care framework for rehabilitation, reablement and recovery following hospital discharge, and the Community rehabilitation and reablement model, to identify how to improve service and workforce models.

- **Improve access to virtual wards:**
  Maintain capacity and improve occupancy of virtual wards, expand access to step-up and step-down capacity, and improve length of stay by pathway, through implementing best practice as set out in the virtual ward framework. Work together locally, including with social care providers, to increase access to virtual ward services that provide an alternative to hospital attendance or admission ('step up' virtual wards) including increasing the home referrals and directing patients from ED and SDEC following initial assessment where appropriate.
- **Focus on reductions in admitted and non-admitted time in ED:**
  Continue to focus on initial assessments, including continuing to increase the proportion received within 15 minutes of arrival, and increase the proportion of patients redirected to alternative services. Work with providers to improve flow into and through acute beds by reducing excess length of stay and variation in high volume, high bed use pathways. Review critical interventions along patient pathways in hospital and ensure they are aligned with best flow practice principles. • Review and audit trust internal professional standards. Reduce mental health patient time in EDs, including reducing length of stay for patients in acute beds waiting for a mental health bed, and in mental health beds. Systems, including local government, should focus on improving whole mental health pathway patient flow.
- **Focus on reductions in the number of patients still in hospital beyond their discharge ready date (DRD)**:
  Continue to improve in-hospital discharge processes. Ensure early discharge planning, including effective involvement of patients, carers, and families, in line with statutory guidance on hospital discharge and community support. Working across the NHS and social care, maximise the effectiveness and maturity of care transfer hubs to improve quality and timeliness of discharge for patients with complex needs. Working across the NHS and local authorities, implement trusted assessments to reduce duplication and ensure information is shared through the pathway.
- **Improve consistency and accuracy of data reporting:**
  Ensure we are consistently and accurately recording key metrics including SDEC activity in ECDS, community discharge information on the community SitRep/SUS, DRD, data on reasons for discharge delays, and the Ambulance Data Set. Ensure system co-ordination centres are fully embedded and made ready for system OPEL. Consider how to disaggregate data based on age, to understand demand and monitor performance for children and young people.

- **Increase referrals to and the capacity of urgent community response (UCR) services:**
  Increase UCR referral volumes and number of patients treated. Explore the use of technologies and point of care testing to optimise existing capacity and consider referral pathways from technology enabled care (TEC) providers and SDEC.
- **Ensure all Type 1 providers have an SDEC service in place for at least 12 hours a day, 7 days a week:**
  Ensure SDEC compliance of 12 hours a day, 7 days a week. Increase utilisation by working with partners (including ambulance trusts) to increase the proportion of patients with direct access, direct referrals from outside the ED (NHS 111, 999 and primary care), and reduce variation in the proportion of ED patients who are treated through the SDEC. Increase productivity by implementing the minimum standards of delivery outlined in the SAMEDAY strategy. Improve consistency of reporting SDEC into the Emergency Care Data Set (ECDS) by March 2025.
- **Ensure all Type 1 providers have an acute frailty service in place for at least 10 hours a day, 7 days a week:**
  Ensure acute frailty service compliance of 10 hours a day, 7 days a week, implementing a comprehensive geriatric assessment at the front door, and the minimum standards in the FRAIL strategy, to increase patient flow and the proportion of patients over 65 with a Clinical Frailty Score. • Understand and work across systems to reduce numbers and variations in care home referrals to ED.
- **Provide integrated care co-ordination services:**
  Work to understand the total demand for services that provide an alternative to an ED attendance for urgent care needs, complemented by a review of capacity holistically across all relevant services. Work with local authorities to link this to BCF demand and capacity planning for intermediate care. Establish core operational integrated care co-ordination structures as a minimum by October 2024, with a focus on paramedic access to clinical advice to support alternative pathways to ED. Ensure surge acute respiratory infection provision, including for children.

The CHFT resilience plan will aim to achieve the following:

- To support existing plans by increasing the operational focus on pressures and winter as an issue that challenges the resilience of the Trust.
- To provide a framework for the management of the operational pressures including winter.
- To provide the basis for agreement and working with other partners and organisations.
- To provide reference material for use in the Trust.
- To set out the information systems to be used to manage the response.

3. Duties (roles and responsibilities)

Chief Operating Officer (COO)

- Responsible officer at Executive level for Resilience and Winter Planning.
- Will represent Trust on the Urgent Care Delivery Board.

Director of Operations for Resilience, Acute Flow and Transformation (DoP RAFT)

- Represent the Trust on the Calderdale and Huddersfield Urgent and Emergency Care Board planning meetings.
- Represent the Trust on the West Yorkshire and Humber (WY&H) ICS System Resilience Workshops.
- Update the divisional leads regarding resilience across the local healthcare system.
- Respond to requests for assurance from the Integrated Care Board (ICB) and NHS England.
- Benchmark and share good practice from partner organisations.
- Ensure that resilience plans are aligned with the Trust Emergency Management Arrangements and associated emergency plans.
- Collate departmental plans for the Christmas and New Year period and ensure they are accessible to staff on-call and on-duty over the period.
- Ensure that contingency plans that are in place for surge in non-elective demand for inpatient capacity, resurgence of COVID-19, outbreaks of winter infectious diseases and severe winter weather are appropriate and will deliver safe patient care and experience and organisational resilience.
- Ensure that the Trust Resilience Plan aligns with those across the local health and social care system.
- Lead in Partnership with the Chief Nurse specific plans to support the organisation to manage resurgence of COVID-19 through the creation of Isolation capacity and new operating model for managing patients with infections that require isolation.

Divisional Directors (DDs)

- Ensure each Division takes responsibility for securing sufficient capacity to meet out of hours demands on a daily basis.
- Ensure collaboration across Divisions.
- Ensure each Division has robust arrangements for escalation and any associated operational and site management meetings.

Chief Nurse

- Ensure each Division has robust arrangements for escalation through the site management meetings.
- Lead in partnership with the Director of Operations for Resilience, Acute Flow and Transformation specific plans to support the organisation to manage resurgence.
- Support the divisional teams to implementation of any new IPC guidance.
- Lead in Partnership with the Director of Operations for Resilience, Acute Flow and Transformation specific plans to support the organisation to manage

resurgence of COVID-19 through the creation of Isolation capacity and new operating model for managing patients with infections that require isolation.

Divisional Directors of Operations (DoPs)

- Ensure that appropriate plans are in place to manage an increase in non-elective activity within the division.
- Ensure that divisional plans are joined up across the organisation.
- Ensure that contingency plans are in place for surge in severe winter weather and outbreaks of winter infectious diseases.
- Ensure that key staff groups are aware of the risks and response arrangements for winter.
- Ensure robust communication of the resilience plan is in place across the divisions.
- Ensure all Business continuity plans are updated following learning from the COVID-19 pandemic.

Calderdale and Huddersfield Solutions (CHS), Clinical Site Matrons (CSM), Commanders Site Commanders (CSC) (Huddersfield Site)

- Initiate and respond to surge following Surge and Escalation procedures and the Operational Escalation Pressures Levels (OPEL) framework.
- Liaise with Local Council Highways departments to clear roads for urgent patient transport requirements.
- Contact alternative transport providers if required.
- Work with IPC to optimise inpatient isolation capacity.
- Liaise with those contracted to arrange access to 4X4 vehicles for transport services if required.

CHS/ EQUANS/ISS (Calderdale Royal Site)

- Ensure that there are sufficient supplies of salt/grit for clearing car parks, pathways, and roads on site and in community buildings where CHFT staff and patients are working/attending.
- Ensure that additional staff accommodation is available if required.
- Be prepared for additional outbreak cleaning and curtain changes as and when required.
- Ensure staffing levels are maintained by calling upon generic pool of bank workers.
- Ensure cleaning requirements are in place to manage infection outbreaks and possible resurgence of COVID-19.

4. The Trust's Resilience and Winter Strategy

The resilience plan is based on the following strategic aims.

- To continue to provide high quality health and social care to the communities of Calderdale and Kirklees.

- To ensure that patients receive treatment in the most appropriate environment at the time most beneficial to their needs.
- To work collaboratively with other health and social care providers to effectively manage capacity.
- To assess risks to continued service provision and put plans in place to mitigate those risks.
- To put in place a communications strategy that assists the public in gaining access to appropriate health and social care services.
- To ensure optimum occupancy and staffing levels during pressures and over the winter period to minimise the risk of harm.
- To ensure patients do not wait in any part of the system unless clinically appropriate.
- To ensure learning from Winter 2023/24, the COVID-19 pandemic and WY&H ICS Resilience Workshops is incorporated into 2024/25 Resilience Plan (Including Winter).

5. Resilience and Winter Planning Arrangements

The Trust Operational Lead for resilience planning is the Director of Operations for Resilience, Acute Flow & Transformation in collaboration with the Divisional Senior Management Teams.

The local Calderdale and Huddersfield Urgent Care Delivery Board has overall responsibility for ensuring that the health and social care service in Calderdale and Huddersfield is adequately prepared to manage an expected increase in activity and acuity during times of pressure and during the winter period. The Urgent and Emergency Care Delivery Group is responsible for assurance regarding resilience planning including winter arrangements. It is responsible for ensuring that the Trust has plans in place for severe winter weather, COVID-19 resurgence, seasonal infectious disease outbreaks and Christmas and New Year bank holidays.

In 2024 the Trust's internal Urgent and Emergency Care Delivery Group with membership of all Clinical Director's, contributed to resilience planning by developing new innovative schemes providing increased resilience and clinical effectiveness. All innovations are being monitored against clear aims and Key Performance Indicators (KPIs):

Work Stream	Description	KPIs
Well Organised Ward (WOW)	Well Organised Ward (WOW). Plan for Every Patient (PFEP). Sessions including standardisation of board rounds and SOPs – linking with improvement projects to reduce ward LOS.	• Releasing time to care. • Adding value to patient journey with clear actions. • Reduction in use of paper-based notes. • Improved dementia screening and VTE screening. • Reduction in LOS.

		• Increased discharges before lunchtime.
Well Organised Long Stay Review	The trust, community partners and local authority propose to implement the weekly Well Organised Long Stay Review process. The trust will adopt a mobile based review process to help understand the root of the cause of delays. This process will review all patients with a LOS 7+ days to support staff with patients who have a criteria or no criteria to reside. It will encompass review of all medical, therapy, social plans.	• Reduction in patients with an LOS greater than 7 days.
Criteria to Reside	A daily review of all patients who do not have a criteria to reside. Information available and live on KP+ with parameters set out by NHS England. Daily meeting to discuss plans and challenge decisions on remaining in hospital. Optimising the use of Virtual Ward OPAT and Urgent Community Response.	• Reduction in LOS. • Clear plans of care. • Utilisation of community services such as virtual ward, UCR and OPAT.
Criteria Led Discharge	Criteria to allow a patient to be discharged should they meet a required set of parameters set by the clinician, without the requirement for a further review.	• Early discharge. • Freeing up of clinician time to see other acutely unwell patients. • Improved discharges at the weekend. •
SDEC Improvement	Improving access to SDECs by • Increased opening hours. • Inclusion criteria based rather than pathway based. • YAS direct referral. • Increasing capacity by moving to integrated flow hub.	• Reduced patients in ED. • Reduced admission and LOS. • Admission avoidance.
Integrated Flow Hub	The Integrated Flow Hub project was commenced in April 2023 to look at how we can use the available footprint left behind by the old Emergency Department and co-locate some of our services to create better flow and better communication.	• Earlier bed availability. • Improved numbers through SDEC • Improved numbers through discharge lounge.

	The new flow hub will be based on the Huddersfield site with the model having four key activities. • Increasing the ability to manage non-elective (unplanned) patients without the need for admission. • Speeding up pathways for patients on discharge releasing beds for new admissions earlier in the day. • Providing a digital operations hub that enables the site management team to have live data on all key areas of the hospital to support efficient and effective flow. • Increasing the numbers of patients through the frailty and medical SDECs. The integrated flow hub will co-locate the following facilities. • Medical Same Day Emergency Care (MSDEC) • Frailty Same Day Emergency Care (FSDEC) • Discharge Lounge • Acute Response Team (ART • Digital Command Centre and Site Management The benefit of this co-location is predicted to have many positives for both patients and staff with some of the key benefits being. • Increased multi-disciplinary team working, reducing duplication, improving communication, and therefore accelerating decision making for patients increasing capacity. • Real time visibility of bottlenecks. • Improved streaming from the Emergency Department to the SDEC facilities. • Improved resilience.	
UCR	The Service Aim for the Calderdale UCR is to provide a 0–2-hour response **for all age adults** to accelerate the treatment of urgent	• Reduction in hospital admissions.

	care needs closer to home and prevent avoidable hospital admissions. These 0-2hour and 2-day urgent response standards are part of a range of commitments which aim to help keep people well at home and reduce pressure on hospital services. In Calderdale, the UCR service will supplement other aspects of the Ageing Well programme such as. • Discharge to assess pathways • Enhanced Health in Care Homes • Anticipatory Care • Frailty Strategy	
Virtual Ward	Early supportive discharge and admission avoidance, providing remote monitoring linking with Urgent Community Response, and Discharge to Assess. Prescribing and offering diagnostics.	• Reduction in LOS. • Reduction in admissions.

Alongside the service development and transformation work a project to look at roles and expectations was also undertaken and can be seen in Appendix Two.

6. Operation Pressures and Scoring Frameworks

All acute Trusts have seen a requirement to respond to an ever-increasing demand for their services. Calderdale and Huddersfield Foundation NHS Trust (CHFT) is committed to providing the highest level of patient care to the public including times when it is experiencing capacity pressures and periods of high demand.

In 2016 NHS England introduced the National Operational Pressures Escalation Framework (OPEL), this was to bring consistency to local and system escalation. The framework was further reviewed in 2018 and released in 2019, however there has been considerable variation to its application and utilisation, in addition there has been changes in services and care since Covid-19. Therefore, a New National OPEL framework has been released in late 2023 implemented in 2024. This framework will remain in place for the 2024/25 period with minimal tweaks.

The New OPEL Framework will be used to support the wider NHS Health and Social Care economy surge and will determine what actions are necessary to protect core services and supply the best possible level of services with the resources available, they also link

with the NHS England Emergency and Preparedness and Resilience framework (Appendix Three)

OPEL is designed to “be informed” by any disruptive challenges and “to inform” internally and to the wider NHS of the pressures facing the organisation. The considerations and actions contained with the OPEL should be viewed as guidance in challenging situations. The OPEL will assist the Trust in operating at a steady state and in proactively managing visible pressures to enable a return to that status as soon as possible.

The new framework aims to achieve the following:

- Provide a unified, systematic, and structured approach to detect Acute Hospital pressures.
- Provide a consistent framework to represent each Acute Trust linking into ICS and NHS regions and nationally.
- Provide guidance to Acute Trusts, ICS and NHSE so a coordinated response to pressures can be sourced.
- Provide guidance on the alignment and interaction between the OPEL framework and the National Emergency Preparedness, Resilience and Response (EPRR) framework.

The following benefits should be felt.

- Improved patient safety
- Increased efficiency
- Improved communication
- Enhanced decision making

6.1. National Operational Pressures Escalation Levels (OPEL)

The OPEL Framework 2023/24 focuses on assessment of an acute hospitals’ operational pressures and how this assessment contributes to the OPEL score of their corresponding NHS trust, ICS and NHSE region, and NHSE nationally. Each acute hospital at CHFT in this case Calderdale Royal Hospital and Huddersfield Royal Infirmary with a Type 1 emergency department (ED) is required to complete an OPEL assessment, this generates an OPEL score. The score from each acute hospital contributes to the acute trust’s OPEL score.

A Type 1 ED is a consultant-led, 24-hour, 7-day service, with full resuscitation facilities, and designated accommodation for the reception of patients receiving 'emergency care' – Emergency care department type (datadictionary.nhs.uk)

The OPEL score must be calculated at a hospital level. Acute trusts with multiple hospitals must use the current proportionate contribution calculations published in the technical guidance issued by NHSE. Subsequently, the acute trust OPEL scores are proportionately aggregated to give the ICS OPEL score. The ICS OPEL scores are aggregated to provide the NHSE region’s OPEL score. In turn, the regional scores are aggregated to produce the national OPEL score and trend analysis.

6.2. OPEL Parameters

The following core parameters make up the OPEL assessment for each submission.

1. Mean ambulance handover time.
2. ED all-type 4-hour performance.
3. ED all-type attendances.
4. Majors and resuscitation occupancy.
5. Time to treatment (TTT).
6. Percentage of patients spending >12 hours in ED.
7. General and Acute (G&A) bed occupancy as a percentage.
8. Percentage of open beds that are escalation beds.
9. Percentage of beds occupied by patients no longer meeting the criteria to reside

Only the core parameters listed above should contribute toward the OPEL score and level for an acute hospital reported through to NHSE. The reported OPEL score for each acute trust, ICS, NHSE region and NHSE nationally is to be based solely on the scores produced for each acute hospital within it.

6.3. How the OPEL Score Works

Table 1 outlines the core OPEL parameters, their thresholds and the scores attributed to each threshold, there descriptors can be found in (Appendix Four). Scores range from 0 to 44 – with the lowest pressure assessment being 0 and the highest-pressure assessment being 44.

Table 1.

OPEL parameter	Score						
	0	1	2	3	4	5	6
Mean ambulance handover time	<15 min		15–30 min		>30–60 min		>60 min
ED all-type 4-hour performance	>95%	76–95%	60–76%		≤60%		
ED all-type attendances	≤2%	>2–10%	>10–20%		>20%		
Majors and resuscitation occupancy (adult)	≤80%		>80-100%		>100–120%		>120%
Median time to treatment	≤60 min	>60–90 min	90–120 min		>120 min		
% of patients spending >12 hours in ED	≤2%	>2–5%	>5-10%		>10%		
% G&A bed occupancy	≤92%		>92–95%		>95–98%		>98%
% of open beds that are escalation beds	<2%	2–4%	4–6%		>6%		
% of beds occupied by patients no longer meeting criteria to reside	≤10%		>10–13%		>13–15%		>15%

OPEL parameters outlined above have been assigned scores within the ranges 0-4 and 0-6, with the score reflecting how far that parameter deviates from the expected standard. The ranges indicate the weighting of those parameters that contribute to the overall OPEL for CHFT. The sum of the score assigned to the 9 parameters gives the

OPEL score. Table 2 indicates the OPEL that is attributed to each range of OPEL score; the indicated risk is also denoted.

Table 2.

Aggregated OPEL Score	OPEL	Clinical Risk	Response
0–11	OPEL 1	Low	**See OPEL action card** (and local policy/ protocols)
12–22	OPEL 2	Medium	
23–33	OPEL 3	High	
34–44	OPEL 4	Very High	

Assessments should be time-cycled as per the OPEL action cards; (Appendix Five) this calculation is digitally automated and managed through Knowledge Portal Plus (KP+) under Command Centre (Appendix Six). The Clinical Site Matrons will share this information with the System Coordination Centre (SCC). An OPEL assessment must be completed as a minimum once per 24-hour period or in response to any changes in OPEL status. The first assessment must be completed no later the 10:00hrs, 7 days per week.

The National OPEL score is available on KP+ within the command centre module, this module updates at 5-minute intervals on the system, however the changes in OPEL scoring every 5 minutes is not required to be reported. The Clinical Site Matrons should use the table below to determine when to check the OPEL score and when to report that score to the SCC. Whilst each site has its own individual OPEL score the overall score for the Trust should be sent to the SCC not the individual site scores.

The intervals for checking and letting the SCC know are as follows:

OPEL Score	Interval for Reporting
OPEL 1	Minimum once every 24hrs and sent by 10:00hrs.
OPEL 2	Every 6hrs 09:00, 15:00, 21:00 and 03:00 The first report should be sent to the SCC by 10:00
OPEL 3	Every 4hrs 09:00, 13:00, 17:00, 21:00 and 01:00 The first report should be sent to the SCC by 10:00

	Every 2hrs 09:00, 11:00, 13:00, 15:00, 17:00, 19:00, 21:00, 23:00, 01:00, 03:00, 05:00 07:00 The first report should be sent to the SCC by 10:00

The SCC will be sent the first report by 10:00hrs daily, following this the OPEL score should be checked by the site matrons following the above chart. The SCC will only need a further report should the OPEL status change. Once the OPEL score has changed the checks on the OPEL score will need to then take place at the intervals prescribed in the above table.

6.4. CHFT Action Triggers

Prior to the introduction of the new National OPEL scoring system CHFT had developed its own OPEL score with a wide-ranging number of parameters and descriptors. These triggers will remain and will produce a score but will no longer produce a local OPEL level meaning only the national OPEL score and level will be quoted. However, the local parameters will be RAG rated so that we can make sure that they trigger required actions. This internal score is currently managed digitally through KP+ and will continue to do so and run alongside the National OPEL scoring system.

6.5. The Triggers

Table 3 outlines the core triggers at CHFT that have attributed actions within the action cards. These triggers will be RAG rated (Appendix Seven) and actions will be discussed in each site management meeting depending on their levels of concern.

Table 3.

Triggers
1. Previous days ambulance turnaround (30-60 mins & 60 mins +).
2. Patients waiting for a bed in ED.
3. Previous day non-elective admissions.
4. Previous days discharges.
5. Previous day SDEC utilisation.
6. Previous day ED attendances.
7. Previous day ECS standard.

9. Current number of patients with a LOS between 6 & 12 hours.
10. Current number of extra beds open.
11. Infection Control Position.
12. Current Number of Patients in ED.
13. Current number of outliers.
14. Critical Care Bed Availability.
15. Bed occupancy levels.
16. Nurse staffing OPEL Score
17. Medical Staffing OPEL Score

6.6. OPEL and Triggers Response

The OPEL framework will recognise operational pressures and the standardised approach with parameters will allow the system to provide a systematic response to aid stabilisation.

The response to both OPEL and CHFT triggers will be conducted using the integrated action cards, these can be seen at Appendix Four. These core actions and any additional actions taken will follow the below guiding principles.

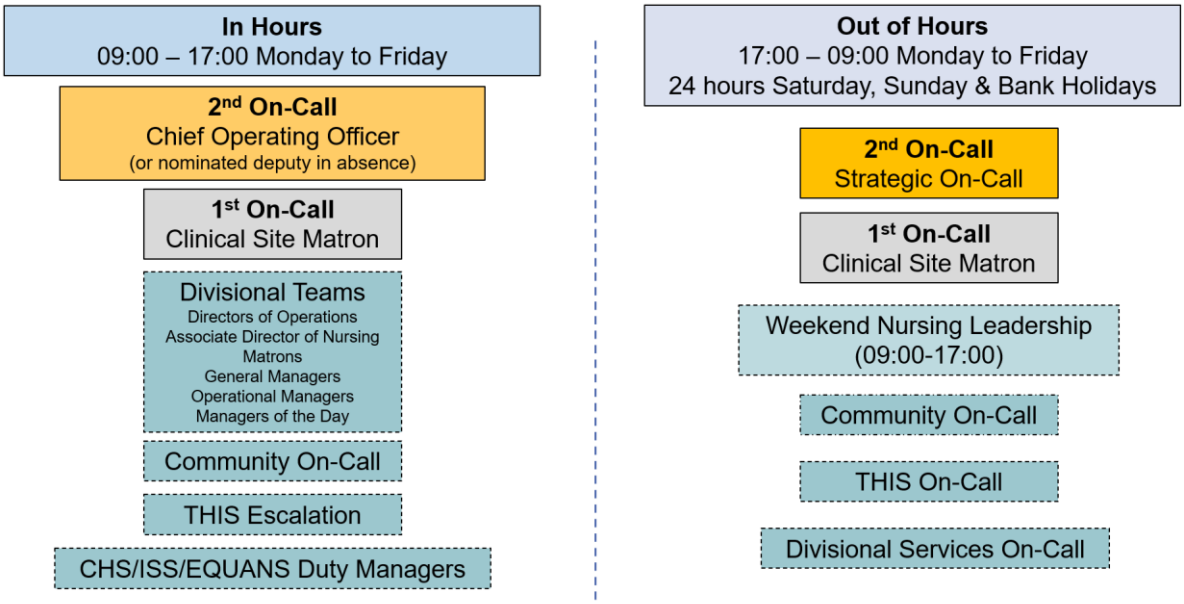
- OPEL actions are grounded by the assessment undertaken, this means the acute trust, ICS and NHS regionally are expected to take OPEL 3 or 4 actions, this is regardless of the aggregated score.
- Making decisions in extremis for crowding and delays will involve risk: it is recognised that actions within this framework would not routinely be taken. Choosing to enact them should reduce a more significant risk in another part of the pathway.
- Risk is dynamic and everyone sees it in different ways: for this reason, a more considered safety decision will result from involving those who can articulate and share insights about the risks and courses of action.
- Decisions about the actions taken should always be recorded: Along with documentation of any anticipated risks, a consideration of how these might be identified and measured and determine the scale of potential harm must be

recorded. This also provides an opportunity for learning and evaluation going forward.

6.7. Decision Making within OPEL

Decision making within OPEL should follow the OPEL Site Management structures already in place see below and are stipulated using the action cards. An action log (Appendix Eight) will be created and will run through each meeting, this will be the focus of the start of each meeting, making sure actions have been undertaken and closed. The action log will be shared via the chat function at the end of each OPEL Site Meeting.

OPEL Site Management Meeting	OPEL 3+ Site Management Meeting	OPEL 4 Escalation Meeting
DAILY IN OPEL 1 & 2 **Operates:** 7 days a week / 365 days a year **Takes Place In Hours:** 09:00 / 13:00 / 16:00 **Takes Place Out of Hours:** 19:00 / 23:30 / 07:00 **Chaired by:** Clinical Site Matron (on a rota basis) **Attended by (suggested list):** • Clinical Site Matron • Clinical Commanders (both sites) • Managers of the Day (all Divisions) • IPC representative • Discharge team representative • Matrons • Ward Managers **Administration:** The meeting is recorded on MS Teams. **Focus:** Operational pressures meeting.	**OPERATES IN OPEL 3 AND OPEL 4** **Operates:** In Hours when in OPEL 3 or OPEL 4 (score 45+) or above **Takes Place In Hours:** 09:00 / 13:00 / 16:00 **Takes Place Out of Hours:** 19:00 / 23:30 / 07:00 **Chaired by:** Clinical Site Matron (on a rota basis) **Attended by (suggested list):** (*In Hours only) • Clinical Site Matron • Clinical Commanders (both sites) • *Deputy Chief Nurse • *Directors of Operations (all Divisions) • *Associate Directors of Nursing (all Divisions) *General Managers (all Divisions) • *Deputy Directors / Heads of • *ED Representative • *Managers of the Day (all Divisions) • *IPC representative • *Discharge team representative • *Matrons • *Ward Managers **Other attendees may include:** Chief Operating Officer Chief Nurse Medical Director **Administration:** The meeting is recorded on MS Teams, and minutes are taken. **Focus:** Operational pressures meeting in times of higher levels of demand.	**TRIGGERED AT OPEL 4 – AT REQUEST OF COO** **Operates:** When required in OPEL 4 **Takes Place:** Usually at 14:00 (or more frequently if required) **Chaired by:** Chief Operating Officer (or nominated Deputy in COO's absence) **Attended by (suggested list):** • Chief Nurse • Medical Director • Director of Workforce and OD • Deputy Chief Nurse • Directors of Operations • Associate Directors of Nursing **Other attendees may include:** • Director of Corporate Affairs • Director of Finance • Divisional, Clinical Directors • Other Directors **Administration:** The meeting is recorded on MS Teams, and minutes are taken. **Focus:** Operational Pressures in times of the highest levels of demand, but pre-critical incident.



The structures beyond business as usual (BAU) should be addressed through the Control and Command Framework. Incident Response Command and Control can be convened in response to an incident, event or emergency that requires Strategic, Tactical and Operational response to be put into place. This may be in response to an incident or to support the response to sustained and escalating operational pressures. Formal Command and Control structures should run alongside the OPEL Site Management structures.

6.8. Recording and Monitoring of OPEL

OPEL scores will be digitally available on KP+ under the Command centre tab (Appendix Six)

All the parameters for OPEL scoring will be retrieved digitally and will be sent directly to the SCC via the digital team, this will be determined based on the OPEL Score

OPEL 1 – Once a day on or before 10:00hrs.
OPEL 2 – Every 6 hours
OPEL 3 – Every 4 Hours
OPEL 4 – Every 2 Hours

The CHFT triggers score will also be available through KP+ under the command centre tab, most of these parameters are retrieved digitally, with a small set of parameters that require writeback.

All site management OPEL Site management meetings are recorded on Microsoft Teams.

7. Performance Metrics

As an organisation we will be measured both regionally and nationally against a set of performance metrics related both to unplanned and elective care, recognising that unplanned activity and performance has a knock-on effect against elective care and elective recovery.

IPR Section	Metric	Target
Elective	Total Patients waiting >40 weeks to start treatment	0
	Total Patients waiting >52 weeks to start treatment	0
	Total Patients waiting >65 weeks to start treatment	0
	Total RTT Waiting List	31,586
	Total elective activity undertaken compared with 2023/24 activity plan	100%
	Percentage of patients waiting less than 6 weeks for a diagnostic test	95%
	Diagnostic Activity undertaken against activity plan	14,547
	Total Follow-Up activity undertaken compared with 2023/24 activity plan	100%

Cancer	Total Patients waiting >62 days to begin cancer treatment compared with February 2020 baseline	35
	Proportion of patients meeting the faster diagnosis standard	75%
	Non-Site-Specific Cancer Referrals	25
	Early cancer diagnosis: 75% of cases diagnosed at stage 1 or 2 by 2028	75%
Urgent and Emergency Care and Flow	Proportion of patients seen within 4 hours	76%
	Proportion of ambulance arrivals delayed over 30 minutes	0%
	Proportion of patients spending more than 12 hours in an emergency department	2%
	Adult G & A acute bed occupancy adjusted for void beds (Type 1 Acutes Only)	96%
	% of beds occupied by patients who no longer meet the criteria to reside	14.21%
	Hospital Discharge Pathway Activity – AvLOS pathway 0	4.1
	Transfers of Care	50
Maternity	Neonatal deaths per 1,000 total live births	1.53
	Stillbirths per 1,000 total births	3.33
Community	Proportion of Urgent Community Response referrals reached within 2 hours	70%
	Community Waiting List	4,387
	Virtual Ward	80%
	OPAT - Outpatient Parenteral Antimicrobial Therapy	N/A
Safe, High-Quality Care	Summary Hospital-level Mortality Indicator	100
	Care Hours Per Patient Day (CHPPD)	-
	Falls per 1000 Bed Days	7.02
	CHFT Acquired Pressure Ulcers per 1000 Bed Days	1.76
	MRSA Bacteraemia Infection	0
	C.Difficile Infection	3.1
	E. Coli Infection	5.6
	Number of Never Events	0
	Number of Serious Incidents	0
	% of incidents where the level of harm is severe or catastrophic	2%
	% of complaints within agreed timescale	95%
Quality Priorities	Alternatives to Hospital Admission – Number of referrals into the Frailty service	TBC
	% of episodes scoring NEWS of 5 or more going on to score higher	30%
	% of adult patients that receive a MUST assessment within 24 hours of admission/transfer to the ward	95%
Health Inequalities - LD	Emergency Care Standard	76%
	Outpatients DNAs	3%
	Cancer Faster Diagnosis Standard	75%
	% of patients waiting less than 6 weeks for a diagnostic test	95%
	Patients waiting more than 40 weeks to start treatment	0
Health Inequalities - IMD	Emergency Care Standard	76%
	Outpatients DNAs	3%
	Cancer Faster Diagnosis Standard	75%

	% of patients waiting less than 6 weeks for a diagnostic test	95%
	Patients waiting more than 40 weeks to start treatment	0
Workforce	Staff Movement (Turnover)	11.50%
	Sickness Absence (Non-Covid)	4.75%
	Appraisal Compliance (YTD)	95.00%
	Core EST Compliance	90.00%
	Bank Spend	£1.60M
	Agency Spend	£0.53M
Finance	Cumulative Surplus	
	CIP Profile	
	Capital Spend	
	Cash Balance	

There will particular scrutiny this year on

- Ambulance delays and the organisation's ability to turn ambulances around to get back on the road and respond to emergency call, a Standard Operating Procedure has been developed to manage this (Appendix Nine).
- Emergency Care 4 Hour Standard
- Elective Recovery

Regionally we are also measured against the following metrics:

- Numbers of patients without a Criteria to Reside (CTR).
- Bed occupancy levels.
- Numbers of patients on Transfer of Care List (TOC).
- Length of Stay LOS at 7 days, 14 days, and 21 days.
- Numbers of patients on Virtual Ward (VW).

8. Communication

Operationally, communication routes will be via the OPEL Site Management Meetings, however there will be a need to be able to communicate with staff in a variety of ways, particularly in times of pressure.

We will continue to effectively use the following internal communication routes to inform and keep staff up to date, as well as provide a way for staff to ask questions.

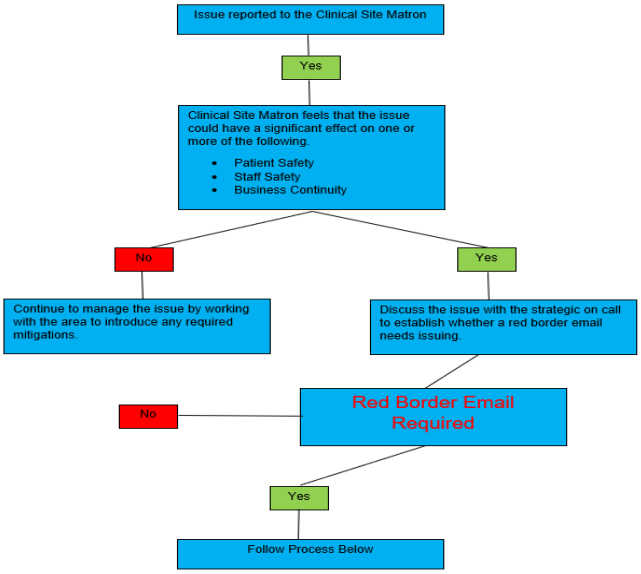
Communication Forum	Style	When
CHFT Live	• Microsoft Teams Live Event. • Information giving. • Questions from staff.	Wednesdays 13:00hrs (plus additional ad hoc sessions when required)
CHFT News	• Web-based newsletter shared by email.	Mondays

	• Information giving.	
Brendan's Update	• Email. • Information giving.	Fridays
Leadership Conversation	• Microsoft Teams Meeting. • Multiway conversation and information giving.	Every other Wednesday
Screensavers	• Screensavers on desktop and laptop computers logged onto the CHFT network. • Information giving.	Continually updates
Intranet latest news	• News article.	Daily
Staff App	• Push notifications and links to content channels above.	As required
All user emails	• Email content with important, but not urgent, information.	As required
Weekend Plan	• Information giving. • Email	Every Friday

8.1. Red Border Emails

As well as the communication routes listed above, we also have the ability to issue 'red border' emails. If a serious issue has occurred or is occurring across the organisation and we need to urgently inform as many people as possible, then a red border email can be issued.

During normal working hours (Monday to Friday 09:00-17:00hrs) this will be discussed and issued by the executive team and the Director of Ops for Resilience Acute Flow and Transformation. It will be issued by the Communications Team on behalf of a director. If a red border email needs issuing out of hours, then the following flow chart should be followed.



Use red border email template and follow instructions in (Appendix Ten).

The Communications Team will issue media statements during times of pressure to reinforce key health messages.

When there is a community outbreak of diarrhoea and vomiting a press release will be issued promoting basic hand hygiene and asking the public to stay away from hospital if possible because they risk passing on an infection to vulnerable patients.

Prior to the Christmas and New Year period a press release will be issued reminding the public them when it is appropriate to use primary care services rather than accident and emergency departments and to stock of home medicines cabinets prior to the holiday.

In the event of a significant infection outbreak the Trust communications team will work with Calderdale and Greater Huddersfield CCG to implement a media and communications strategy utilising key messages which will include advice for visitors.

To support communications in an incident, the Incident Communications Guidance should be referred to.

9. Workforce

9.1. Staffing levels

Agreed workforce plans and skill mix are in place for all inpatient areas and community services. These will be used to assess the risk of reduced staffing due to absence and to assist in the redeployment of staff if necessary. Nurse rosters are signed off by Divisional Matrons to ensure robust cover arrangements especially over holiday periods and to ensure annual leave is managed appropriately over these periods. Staffing gaps should be identified and mitigated by Divisional teams in hours, only last-

minute absences will be actioned by on-call, out of hours teams. Staffing for the weekends will be managed through the week and conveyed onto the weekend plan.

CHFT will run twice daily site staffing meetings 7 days a week and have a clear term of reference Daily Staffing meeting ToR - Hospital - V11 as at 15.06.23.pdf (cht.nhs.uk) these will be chaired by the Divisional Matrons Monday to Friday and the Clinical Site Matrons on a Saturday and Sunday. The use of an OPEL scoring system for staffing (Appendix Four) will be undertaken and the relevant actions undertaken depending on OPEL scoring level.

9.2. Vaccination

The target for Trust staff to have had the 'flu vaccine for this year for Calderdale and Huddersfield the ambition is to achieve 100%of frontline staff. The emphasis will be on staff in clinical frontline roles, but the vaccine will be available to all staff. The campaign this year has been well communicated and information on scheduled sessions, 'myth busting' and league tables of performance have been advertised on the intranet. Additional groups of staff are being trained to administer the vaccine so that it can be more accessible to staff. District nursing services provide flu vaccination to patients on their caseload as well as working with GPs to ensure that all vulnerable people are offered the vaccine.

Vaccinations booster for COVID-19 will be issued alongside flu should frontline staff wish to be vaccinated.

This year's winter vaccination programme will begin on Monday, 7th October. To begin with, there will be a drop-in clinic at both CRH and HRI, where patient-facing colleagues can get their Covid and flu vaccines until Thursday, 31st October.

Sessions will take place between 08:15 and 17:45 Monday to Friday. There is no need to make an appointment. Just pop into one of the two clinics at a time that suits you.

After the 31st of October, our peer immunisers will continue offering flu vaccines only back at their wards and departments.

Vaccinations will be available on both hospital sites:

CRH – Old Rainbow Centre
At CRH the clinic will take place in the old Rainbow Centre. This is now where our Orthopaedics Clinics are based, but the team are kindly allowing us to use two rooms. The Family Room will be clinic waiting area and the Green Room will be the vaccination hub. Both are accessible via the glass corridor entrance to keep disruption to the clinic to a minimum.

HRI – Integrated Flow Hub
The HRI vaccination clinic will be taking place in our Integrated Flow Hub, which used to be the location of our old A&E. The clinic is best accessed from the old walk-in entrance on North Drive. Turn left after the main reception.

9.3. Personal Winter Plan/Engagement Plans

All members of staff have a personal responsibility to ensure that they are available for work and that they have alternative arrangements for carer responsibilities and journeys to work. All staff will be reminded of preparations they should make for winter – seasonal flu vaccination, checking public transport alternative routes, vehicle preparation as well as contingency plans. This will continue to be reinforced through the business continuity management system and staff communications strategy. In severe weather conditions staff in District nursing, community midwifery and other community services will report to their nearest team to their home not necessarily where they usually work. The Trust's attendance management, carer leave, and adverse weather policies will be used to support staff and to maintain service levels.

9.4. Wellbeing Support

Colleague wellbeing remains a priority, the organisation has supported 1000's of colleagues through a range of interventions. Colleagues perform better when they are healthy, energised, fit and well. It is more important than ever that NHS workplaces become environments that encourage and enable staff to lead healthy lives and make choices that support positive wellbeing. Everyone should feel able to thrive at work.

9.5. Colleague Support

Here is a round-up of support for colleagues. You will also find lots of other information and support on these pages.

- **Wellbeing Connect**

Enables CHFT colleagues to access wellbeing advice, information, and guidance via one number and should be your first point of access so that you can be signposted to the most appropriate service.

Wellbeing Connect can be accessed by calling 01484 344 282.

Callers will be able to choose from a variety of options, you will then be prompted to select the most appropriate option and then be forwarded directly to the service that meets your needs.

Elements of this service are accessible 24-hours, 7 days a week, for your convenience and forms part of a range of emotional and financial wellbeing services to support your journey to a healthier and happier you at CHFT.

Details of CHFT colleague health and wellbeing support can be found here: Colleague Health and Wellbeing - CHFT Intranet (cht.nhs.uk) and well as details of our workforce benefits services Financial Support - CHFT Intranet (cht.nhs.uk)

- **VivUp**

Vivup offers a complimentary 24/7, year-round Employee Assistance Programme (EAP).

CHFT colleagues can seek support for mental health and wellbeing. Whether encountering issues in the workplace or personal life, you can access free counselling, unbiased and confidential advice, and information on various matters.

Vivup provides a new additional benefit where colleagues can access an Online GP. Consultations are available via video or phone 7 days a week from 8am-10pm (excluding UK bank holidays).

Call 0800 023 9324 or access a variety of self-help resources at www.vivup.co.uk. You will need to create an account to access the online resources.

Where it says: "If your organisation is already registered with Vivup, you can create an account today" - click into the box and select Calderdale and Huddersfield NHS Foundation Trust and then set up your own account.

- **A Wellbeing Handover**

- **Health and Wellbeing Questionnaires**

All colleagues should be encouraged to complete the health and well-bring questionnaire available on the intranet.

Health and Wellbeing Risk Assessment - CHFT Intranet (cht.nhs.uk)

Further support information is available through the trust's intranet pages, links below.

Colleague support - CHFT Intranet (cht.nhs.uk)

9.6. Managing absence

The Trust's Adverse Weather Policy will be followed at all times to ensure that there is consistency across the organisation in the event that severe winter weather causes staff to be later, absent or work excess hours.

In the event that essential staff have difficulty getting to work and there are no alternate travel options, including car sharing or public transport, it may be possible for the hospital transport team to collect staff from their homes. Where staff have difficulty getting home from work and there are no other options hospital provided transportation is also an option. It may also be possible to provide additional staff overnight accommodation. Requests for additional hospital transport services or accommodation should be made by a matron or general manager to the General Manager of Operations and Facilities.

The adult community nursing team work flexibly in winter. Healthcare workers visit patients closest to their home address and are able to work from an alternative location that is closer to their home address.

10. Divisional Resilience Plans

CHFT's Divisional teams have prepared their resilience plans including winter through analysing their expected demand, using bed modelling tools tracking assumptions against their business plans and understanding the impact transformational work is having.

10.1. Medical Division

The medical division will endeavour to maintain its usual bed base during operational winter by:

- Focusing Same Day Emergency Care pathways – increasing and maximising existing capacity.
- Admission avoidance.
- Working with community services and partners to expedite discharges.
- Maximising the use of community pathways, for example Outpatient Parental Antimicrobial Therapy (OPAT), Virtual wards (VW), Urgent Community Response (UCR).
- Working closely with the site management team on the day-to-day management of the bed capacity.

10.1.1. Medical SDEC

Medical and Frailty SDEC will function from its new base in the Integrated Flow Hub. This area gives increased capacity for SDEC functions allowing use to increase the capacity going through these units.

The increased capacity will also coincide with the increased opening hours starting in November 2024. The SDEC function will be open from:

HRI
Monday-Sunday 08:00-00:00hrs

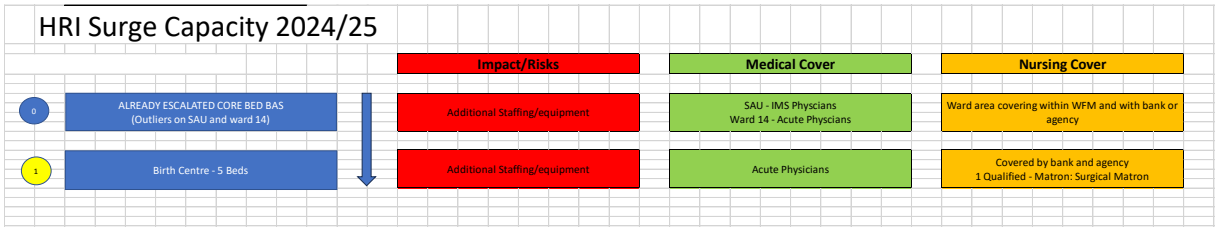
CRH

Monday-Sunday 08:00-18:00hrs

Medical SDEC criteria has been reviewed and expanded to include patients with a projected stay of less than 48 hours. This aims to help alleviate pressure and congestion in the Emergency Department but also to get patients to the right clinician and speciality for their care. This in turn should improve flow and patient experience as well as patient outcomes. The change will also support the clinical management of acute medical patients without the need for admission to the medical Assessment Unit. A Standard Operating Procedure can be seen in Appendix Eleven.

10.1.2. Bed Surge

If all of the above responses are not giving us the flow, we require, and surge capacity is required it will be undertaken in the following order. The decision to open surge capacity will be undertaken via the OPEL Site Management meetings and the opening checklist completed (Appendix Twelve).



10.1.3. Inpatient Length of Stay

All medicine ward areas are engaging with well organised wards programme and are committed to reducing the length of stay of patients.

Where there is a surge in demand for beds then the division will support by:

- All General Managers (GMs), Operational Managers and matrons being deployed to support ward discharges.
- GM's will contact consultants to ensure senior reviews have taken place and patients have plans.

- Using the criteria to reside list, to ensure the 'medically fit' are reviewed and progressed to discharge.
- Standing down non-essential meetings.
- Ensuring senior representation at OPEL Site Management meetings.
- Escalating to standing down elective activity to support ward area reviews.

10.1.4. Cancer Pathway and Elective Pathway

The cancer agenda and targets will be maintained throughout winter. Attendance at Multi-Disciplinary Team (MDT) meetings and performance will be maintained over Christmas time and throughout winter. This will be managed by authorisation/monitoring of the number of consultants that are off at any one time over this period.

10.2. Surgical Division

The Surgical Division has developed plans to be able to respond to increased non-elective demand.

10.2.1. Critical Care

- The escalation plan and standard operating procedure for the demand for critical care exceeding capacity ICU is at Appendix Thirteen.

10.2.2. Trauma & Orthopaedics

- 4 Additional Trauma 2 lists available which in turn can be flipped to a 2nd acute theatre supporting all specialities.
- Acute fracture clinic referrals direct from ED for Consultant led treatment for patients with confirmed fractures are in place maximising virtual fracture clinics and implement a triage of referrals.
- Improved access to theatre will reduce pre-op bed days and overall, LOS for some Minor/intermediate and complex trauma. Performance will continue be monitored regarding delays to theatre.
- The elective inpatient orthopaedic surgery at CRH will continue as per the Phase 3 planning (Appendix Fourteen).
- Christmas day trauma theatre list in place.

10.2.3. General and Specialist Surgery

- Current medical workforce on Surgical Assessment Unit (SAU) will be increased with an additional middle grade to maximise reviews, ambulatory care, and reduced length of stay.
- The elective inpatient surgical theatre capacity at HRI will continue as per the Phase 3 planning due to the ringfenced 'green' nature.
- During high OPEL 3 levels HRI Ward 10 (elective surgical ward) can be used flexibly to accommodate non-elective surgical patients. Strict criteria apply to those non-elective patients who can be admitted to the ward, strictly no medical patients to be admitted.

10.2.4. Inpatient Length of Stay

The Criteria to Reside work is integral in reducing length of stay within all specialties and maximise community pathways with a particular focus on T&O.

Where there is a surge in demand for surgical beds then the divisional plan would be enacted:

- All GM's, Ops managers and matrons are deployed to support ward discharges.
- GMs to contact consultants to ensure senior reviews have taken plan.
- Using the criteria to reside list, to ensure the 'medically fit' are reviewed and progressed to discharge.
- Non-essential meetings would be stood down.
- Ensure senior representation at Flow meetings and tactical command.

10.2.5. Cancer Pathway and Elective Pathway

The cancer agenda and targets will be maintained throughout winter. Elective surgery and cancer have rarely been cancelled due to bed pressures previously (no patients were cancelled during winter 2024/25 due to no bed) – this will continue to be the standard we adhere too. Attendance at MDT's and performance will be maintained over Christmas time and throughout winter. This will be managed by authorisation/monitoring of the number of consultants that are off at any one time over this period.

10.3. Family & Specialist Services Division

There will be daily attendance in the Site Management Meetings of Operational management from FSS to support patient flow, support prioritisation of diagnostics during increased demand. The managers of the day will be based in the digital command centre at HRI.

10.3.1. Paediatrics

- During periods of operational pressure including winter the Matron for the service continues to undertake a twice daily situation report during the week (the nurse in charge on ward 3 will complete twice a day on weekends and bank holidays) and will risk assess situations regarding staffing and activity on the Paediatric ward, to support and underpin this there is an Escalation Plan in place.
- Continued support to the paediatric stream in the Emergency Departments (ED) at peak times in both EDs and planned at Huddersfield Royal Infirmary.
- The Paediatric ward operates on a workforce model that accounts for surge during the winter period which strengthens nurse staffing and leadership during the winter period with the plan to have a senior Nurse Band 6 and 7 working clinically across all shifts.
- The service has introduced rapid access clinic which will support reviewing some patients who had previously been seen in ED or referred via there GP to paediatric assessment.

- From a medical perspective the following actions will be taken between Nov and Feb to support winter pressures: A new rota has been introduced that will ensure that there is a tier one and two doctors on Paediatric assessment to triage and manage flow.
- The Consultant scheduled for Ward 4 HRI will cover in the morning and will if appropriate to undertake a virtual round of ward 4 patients by phone utilising EPR this will ensure they are available to help on the ward round on the Ward 3 CRH – to improve flow and timely discharge at times of peak activity.
- Paediatric Escalation and Surge plan is attached in appendices of this document.
- Advanced Paediatric Nurse Practitioner escalation can also be found in appendices of this documents (Appendix Fifteen).
- Communications are planned to go out to GP services and families residing in Calderdale and Huddersfield to encourage children to present to the CRH site due to paediatric services being on this site. There will also be Telemed services for children who are on the HRI site and require paediatric review to aid discharge.

10.3.2. Neonates

Neonatal services work in partnership with Maternity services as part of a wider network that is managed by transport service Embrace.

During operational pressures and the winter period the Matron for the service continues to undertake a daily situation report during the week and will risk assess situations regarding staffing and activity on the Neonatal unit to support and underpin this there is an Escalation Plan in place (Appendix Sixteen).

10.3.3. Gynaecology

During operational pressure including the winter period the activity theatre plan has been developed to ensure the surge in medical emergency activity is supported.
In addition, prior to transferring to ward 1D the patient must be assessed against essential criteria as outlined below.

CRITERIA FOR MEDICAL TRANSFERS TO: - THE GYNAECOLOGY AREAS

Prior to transferring to ward 1D or GAU the patient must be assessed against essential criteria as outlined below.
If the criteria to outlie are not met please escalate to the Matron for Gynaecology, On Call Duty Matron or Night Matron as appropriate.

- Side room not required.
- No acute delirium, confusion, disorientation.
- Patient is not on the End-of-Life Care Pathway
- Minimal risk of falling.
- Minimal assistance required with mobility.
- For patients requiring reablement, intermediate or 24-hour care section 2 physio and OT referrals must have been completed.
- NEWS within expected limits.

- Patient does not require specialist nursing skills i.e. NIV, Peg feeds, unstable cardiac symptoms, unstable diabetic, active seizures, suspected strokes.
- Patient with a known ongoing complaint/grievance must have Senior review to assure that a move is in the best interest of the patient.
- Patient has not been admitted with a diagnosis of long-term substance misuse.

10.3.4. Maternity

Maternity will need to continue to provide essential services in line with National Institute of Clinical Excellence (NICE) and Royal College of Obstetrics and Gynaecologists (RCOG) guidance.

- During times of operational pressure or during winter period the Clinical Managers/Matrons for the inpatient and Birth Centre services continue to undertake a daily situation report during the week and will risk assess situations regarding staffing and activity throughout the Maternity Unit. This may happen more frequently dependant on the initial sit rep report.
- The Clinical Managers/Matron for community will also review staffing/acuity on a daily or more regular basis as the need requires.
- If weather does not permit home visiting (particularly for postnatal care), the midwife is to contact the woman by telephone/virtual appointment to conduct a review of maternal and baby wellbeing.
- If an essential visit is required, the midwife/manager must undertake a full risk assessment and utilise the 4x4 service if all other options have been explored (i.e. staff members with 4x4's undertaking visit or transporting another member of staff – to go in 2's).
- On call midwifery staff should ensure their vehicle is in a place where easier access is enabled.
- On call midwifery staff should follow the loan worker policy and alert the LDRP Coordinator of being called out and ascertain if safe to do so.
- There is an Escalation Plan in place –that provides information for steps to take dependant on staffing and acuity levels which winter may affect. Escalation Plan can be found on the intranet here: https://documentation.cht.nhs.uk/uploads/715/April%202022%20NEYMaternity%20Escalation%20Policy%20%20Operational%20Pressures%20Escalation%20Levels%Framework.pdf

10.3.5. Radiology

There is a central contact point for in-hours escalation of specific issues – contact details are available to Site Management Teams.

Additional twilight cover is available for the Emergency Department x-ray to enable extra capacity out of hours, during periods of exceptional demand throughout operational pressure and the winter period (November to March; triggers will be agreed with the ED team.

10.3.6. Pathology

Urgent blood sciences results will be available within 60 minutes of receipt in the laboratory. For any escalation of urgent results please contact Haematology or Biochemistry on the relevant site.

In the circumstances of increased demand in the laboratory due to COVID or any other outbreak the service will be flexible to support demand.

10.3.7. Pharmacy

Pharmacy staff will work with medical and nursing staff to prioritise supply of medicines for discharge.

Wards should identify patients due for discharge on all ward areas as soon as possible, and e-discharge should be sent to pharmacy in a timely manner so that these can be processed quickly. Where possible, discharge prescriptions for patients who have monitored dosage systems (MDS) should be sent to pharmacy the day before discharge.

Pharmacy and nursing staff should identify patients who already have sufficient supplies of medicines at home before a request is made for a supply for discharge, which will enable pharmacy to dispense items which are genuinely required more quickly.

At HRI, the Safari discharge team can help write and prescribe TTOs and can be contacted by the following 07503981265. On the Acute floor there is an enhanced pharmacy service covering 08:00-18:00hrs 7 days per week who can also assist with prescribing Tablets to Take Out (TTOs) and medication supply.

If any medication is required urgently and pharmacy is closed, if this medication is not available in the Out of Hours emergency medicines cupboard, then the on-call pharmacist should be contacted.

10.4. Community Division

10.4.1. Discharge Team

- There is daily huddles Monday to Friday with both local authorities at 09:00hrs each morning to discuss all patients on the Transfer of Care List (TOC) and escalations as appropriate where there are delays or no progress.
- Working hours are 8-5 with opportunities to use bank hours to support weekends etc.
- A representative from the discharge team will attend 13:00hrs tactical meeting Monday to Friday.

Contacts for the Discharge Team

Natalie Hinchliffe- Team lead	07769300408
Andrea Liquorish – Clinical lead	07469125526

Christine Bentley – Discharge Sister (part time)	07766905534

10.4.2. Priority 1 Clinical Services

The following services have been deemed as **Priority 1 Clinical Services:**

- District Nursing priority one patients (complex wound care, blocked catheters, administration of medications, OPAT, and palliative care).
- Administration of medications including IV therapy and syringe drivers.
- Palliative Care.
- UCR.
- Intermediate Care bed base/ Discharge to Assess Beds.
- Reablement.
- Palliative care priority one patients.
- Gateway to Care.
- Quest Matron support to Care Homes.
- Community Respiratory Service.
- Community Heart Failure Service.
- Home Enteral Feeding.
- Community Matrons. (if Opel 3 status, then expectation to step into DN service to support)
- Community Rehabilitation Team.
- Stroke ESD

Community Services Available

10.4.3. Gateway to Care

Gateway to care is a hub for health and social care and can take referrals provide advice for professions, patients and public.

Hours of Operation	08.45-17.30hrs Monday to Thursday and 08.45-17.00hrs Friday
Contact Details	01422 393000

10.4.4. Intermediate Care

The intermediate care service is delivered by an integrated partnership of health and independent care home provider, ensuring a multi-disciplinary approach to care. Care is provided at Oak Unit (was Brackenbed View) and has a capacity of 15 beds.

The Service Purpose:

Where people's needs currently exceed what can be safely managed in their own home and they have a rehabilitation need following illness or injury. The service aims to increase function and independence prior to returning home.

Service Criteria:

- Service user/patient must be over 18 years of age.
- Medically stable.
- Be able to consent to referral.
- A resident of Calderdale or Registered with a Calderdale GP.
- Consent to rehabilitation.
- Have an active rehab goal where it is expected that they will achieve this goal in a 6-week period.
- They must require a bed base at this time – if needs can be managed at home, an individual should be referred to a home-based service such as Reablement or package of care.

Hours of Operation	24 hours a day, 7 days a week
Referrals Accepted	Via trusted assessment in to calderdale.integratedcare@nhs.net
Lead Manager	Stef Walker
Contact Details	07471517082 (CHFT therapy team clinical lead)

Transitional Beds

Heatherstones provides temporary accommodation for adults for up to 6 weeks and facilitates early discharge, or prevents the need for admission to hospital, residential or respite care. The service is most appropriate for people who want to live independently but need short-term alternative accommodation or short-term help and support to achieve this.

Service Purpose:

The service aims to reduce individuals' dependency and reliance on direct services and prevent their level of need from increasing with people returning to their own home with the confidence and level of care required to enable them to cope long- term.

Residents are expected to cook their own meals and do their own shopping and laundry. Reablement assistants provide support where needed.

Hours of Operation	Monday to Sunday 08.00a– 21.45hrs 7-day service
Lead Manager	Nicola Gayle
Contact Details	01422 392229

10.4.5. Reablement

The Reablement service provides therapeutic care and support; with therapy care plans provided by CHFT community therapy team and then delivered by social care reablement staff. Access to reablement is via Gateway to Care following an assessment by a social worker.

Reablement is offered for up to 4 visits a day for a period of 6 weeks with the aim to increase function and reduce dependence. If care is required following a period of reablement, a care package will be commissioned, and a means test assessment will

be undertaken to determine what financial contribution will be required by the individual.

Hours of Operation	08.00-21.00hrs, 7-day service
Lead Manager	Tracey Proctor (Council) Emily Sutcliffe (CHFT therapy
Contact Details	07748 797896 (Tracey) 07826535497 (Emily)

Reablement Team	Allocator	Contact number
Lower Valley	Julia Green	01484 728943
Upper Valley	Karen Willows	01422 264640
Central	Jo-Anne Rice	01422 383584

10.4.6. Urgent Community Response Team

Urgent Community Response Team will provide support to someone in crisis in their own home for up to 72 hours. For example, if someone is struggling in their own home after a fall, or discharge from hospital where packages of care cannot start immediately. They are a responsive service and will assess within 2 hours for urgent referrals and 24-72 hours for routine referrals.

The team consists of Advanced Clinical Practitioners (ACPs), Specialist Practitioners (nurses and therapists with blurred boundary training) – response times are between 2hr and 72hrs dependent on the referral that is made. Rehabilitation assistants in the team offer up to 4 visits a day for a period of 72 hours with the aim to increase function and reduce dependence. If further reablement is required after 72 hours, the locality reablement teams continue the care following an onward referral to them, or Independent Living Officers assess for and set up a long-term package of care for the individual on behalf of Calderdale Council.

The Urgent Community Response Service also incorporates the Frailty Virtual Ward and the Home First Pathway.

Referrals are made via Local Care Direct for ACP support and urgent 2hr calls. Referrals can also be made directly to service for example when support is needed for hospital discharge.

The Home first pathway is another element of the UCR service. It facilitates on day or next day discharges from hospital for pathway 1 patients. It can support people at home up to 4 times per day who have a new or additional care need with a rehabilitation need following injury or illness. The aim of the pathway is to allow assessment at home outside of the hospital environment and ensure people regain optimum independence.

Hours of Operation Assessors	08.00–19.00hrs 7 days a week
Reablement Service Work	08.00-21.00hrs 7 days a week
Lead Nurse	Susan Johnson (Manager)
Contact Details	Coordinator on shift: 07785476418

10.4.7. Specialist Palliative Care and End of Life services Out-of-Hours Team

All the clinical services provide responsive action to address complex symptom management and psychospiritual needs, explore advance care planning and treatment escalation plans, and provide holistic patient and family/carer support including pre & post bereavement care, providing individualised care in last days of life.

- The Calderdale Community SPCT work across all community settings, aiming to maintain the patient in their home, transfer to hospice when required and avoid unnecessary hospital admissions.
- The Hospital SPCT works across both HRI and CRH to support ward teams with clinical management plans and facilitate hospital discharge to the patient's own home, or 24hour care setting or hospice if needed.
- The Hospital End of Life Care & Bereavement team support families of patients who have died in our hospital settings, but also provide End of Life Care (EOLC) education to all staff and pastoral care to ward teams (the team do not provide direct clinical care)
- The Calderdale Community End of Life Out-of-Hours team is a collaboration between Overgate Hospice, Marie Curie and CHFT. This small team of a Specialist Palliative Nurse working alongside a Marie Curie Healthcare Assistant provide crisis support to people out of hours who are near the end of their life, to enable the person to remain in their chosen place of care.
- All teams are supported by Consultants in Palliative Medicine during daytime hours, in addition to a rotational on-call consultant providing telephone advice overnight and at weekends.
- Direct admissions to Overgate Hospice in Calderdale and The Kirkwood in Kirklees are facilitated by all clinical SPC teams.

Days of Operation	7-day services
Lead Nurse	Abbie Thompson
Contact Details - **Calderdale Community SPCT (09:00-17:00hrs)** **Hospital SPCT (Mon to Fri 09:00-17:00hrs & weekend 08:00-16:00hrs)** **Out-of-Hours PCT (7pm to 8am)**	 01422 310874 01484 342965 07917 106263
Hospital End of Life & Bereavement service (5-day) Mon- Fri 09:00-17:00hrs	01484 342180

10.4.8. OPAT/ IV Therapy

This team provides antibiotic intravenous therapy to patients in their own homes and in the care home setting. Patients remain under the care of their Physician or Consultant. This prevents some admissions and certainly reduces the LOS for many more.

- Patients have to be medically stable. Need to be under consultant referrals.
- Commissioned for 24 administrations a day.
- Compatible drugs need to be administered within 30 minutes.

Hours of Operation	7-day/24-hour service
Lead Nurse	Helen Muslek
Contact Details	07795 825106

10.4.9. Community Nursing Services

District Nurses visit housebound patients that have complex health care needs. Patients that are able to be transported are expected to attend treatment rooms.

Hours of Operation	7-day/24-hour service
Contact Details Core Hours (08:00-18:00hrs)	01422 652291
Contact Details Evening/Night/Weekends (18:00-08:00hrs)	07917 106263

Out of hours where need is identified for inclusion in out of hours visits all patients are considered however in high demand/high OPEL only **priority 1/urgent patients** are seen at night i.e. palliative care requiring symptom management, blocked catheters and patients requiring prescribed medication at agreed intervals. Less urgent visits will be handed over to the day service.

Quest for Quality Service

CHFT has a well-established multi-disciplinary team consisting of community matrons, pharmacist, therapist, and consultant geriatrician who caseload residents in all residential and nursing homes in Calderdale. The team's main role is to reduce the number of calls made to general practitioners to prevent avoidable admissions. They use Telecare and Tunstall Telehealth to promote health and wellbeing to the residents within the care homes. Throughout the COVID-19 pandemic an enhanced service was implemented. This enhanced service is being commissioned to be in place permanently.

The team have a responsive function to the care homes dealing with calls that would have been received by a General Practitioner (GP) and managing the residents. They also provide support to the care home staff to better manage their residents through training and education. Every Care Home will have a named GP.

The pharmacist role has greatly helped with reviewing patient medication, reduction in polypharmacy and education and training of care home staff.

Hours of Operation	09:00-18:00hrs, 7 days a week
Lead	Emma Vant
Contact Details	07795061342

Community Matron Service

Community Matrons provide a service to people with Long Term Conditions (LTC) who have complex health and social care needs which without effective case management are likely to result in the individual having repeated and avoidable hospital admissions and increased lengths of stay in hospital and frequent contact with primary care services.

They are based in localities with District Nursing Teams.

Hours of Operation	08.30-16.30hrs, Mon-Fri
Lead	Louise Byrom 07919057419

Locality	Base	Matron	Contact Details
Upper Valley	Todmorden Health Centre	Kim Scarlett Debra Priestley	07833353162 07795825211
Lower Valley	Church Lane Surgery	Louise Watson Kay Foley Sarah Jenkins	07717347547 07795603605 07464493519
Calder and Ryburn	Elland and Allan House	Rachel Bulmer Katie Berry	07795825215 07789944447
North Halifax	Beechwood	Sheryl McGinn Louise Nattrass	07769365247 07795825199
Halifax Central	Lister Lane	Vicky Leah Sarah Howden	07768207674 07901518171

Specialist Nursing

There are a range of specialist nursing services that support people in community settings.

Service Area	Hours of Operation	Lead Nurse	Contact Details
Bladder and Bowel	07.00-16:30hrs Mon-Fri	Joanne Hoyle	01422 252086
Respiratory	08.30-16.30hrs 7-days/Week	Gareth McMahon	01422 835195
Heart Failure **Cardiac Rehab**	09.30-17.30hrs Mon-Fri 07.30-16.30hrs Mon-Fri	Clair Jones	01422 224260
Parkinson's	09.00-17.00hrs Mon-Fri	Gloria Tizora	07831120229
Tuberculosis (TB)	09.00-17.00hrs Mon-Fri	Mary Hardcastle	07824 343770
Lymphoedema	09.00am17.00hrs Mon-Fri	Katherine Stubbs	01422 350755

Respiratory Team

During the winter period the Respiratory team will increase their working hours until 8pm and double capacity at the weekend to have two members of staff instead of one. This will enable the team to provide further focus upon key services offered to reduce pressures on the hospital:

- Early Supportive Discharge (ESD) – facilitating patients going home as soon as possible with support from the respiratory team 7 days a week.
- Admission avoidance from ED 7 days a week, 9am-8pm and will also support Kirklees residents to be discharged directly from ED into Locala services.
- Crisis management for community patients via the Single Point of Access (SPA). Direct telephone access for patients 7 days a week
- Admission avoidance from the community 7 days a week

Hours of Operation	08.30-16.30 7 days a week
Lead Nurse	Gareth McMahon
Contact Details	01422 835195

Cardiac Rehabilitation Services

There will be increased capacity which will support extended working hours Monday – Thursday supporting the Cath Lab. This will allow the team to facilitate earlier discharges. When the Cath Lab sessions are scheduled for Saturdays, this will be mirrored by the team facilitating patient flow. In focusing upon facilitating earlier discharges this would also allow the team to offer Cardiac rehab at the weekend which could reduce readmissions.

Early Supported Discharge for Stroke

This team provides support to enable patients who have had a stroke to be supported at home to reduce length of stay and increase function by facilitating people to be as active as possible. An enhanced service will be in place from November as part of the innovation scheme plans.

Hours of Operation	8.30am-5.00pm Mon-Fri
Lead Therapist	Georgina Holt
Contact Details	01422 358146

10.4.10. Therapy Services

Therapy services provide interventions across in-patient, intermediate care and Community Services and will work flexibly across all areas to provide support where pressures manifest during the winter period.

Lead Manager	Debbie Wolfe 07825902363

Community Rehabilitation Team – Calderdale

The Community Rehabilitation Team covers the whole of Calderdale and see any patients with a rehab need and goal over the age of 18 years. This service is not an urgent response service and operates over Monday to Friday. The team cover a vast range of presenting complaints, diagnoses, and reasons for referral. Referrals into the service can come from professionals or self-referrals from patients. The service includes provision for Physio, Occupational Therapy (OT), Speech and Language Therapists (SALT), and dietetics. The team work closely together and have blurred boundary competency training where appropriate. This service sees the vast majority of patients in their own homes.

Hours of Operation	8.00am-5.00pm, 5-day service
Lead Therapist	Dave Nuttall
Contact Details	07785456582

10.4.11. Senior Managers in Community Healthcare Division

Senior Managers on-call rota, contact Calderdale Royal Switchboard on **01422 357171.**

Senior managers contact details are as follows:

Name	Role	Work mobile
Michael Folan	Director of Operations	07785416708
Vicky Hattersley	Assistant Director of Finance	07827 808868
Andrea Dauris	Associate Director of Nursing	07920 251715
Jennifer Clark	Associate Director of Therapies	07500312136
Debbie Wolfe	Head of Therapies and Service Manager for OP Physio, MSK, Podiatry, Orthotics, Speech and Language Therapy, Dietetics Children's Therapies	07825 902363
Sarah Wilson	Head of Nursing	07557157096
Susan Scriven	Matron for Specialist Nursing	07770542879
Hannah Wood	Therapy Services Manager - Community	07584538456
Sally Grose	Therapy Services Manager – Inpatient Therapy and Discharge Coordinators	07881 359250

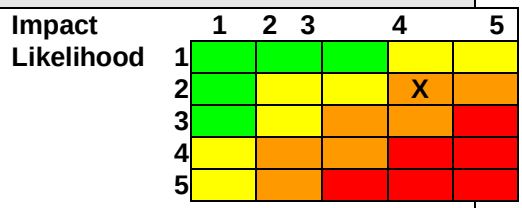
Nicola Glasby	Therapy Services Manager – Outpatients and Children's services	07823 535293
Carly Hartshorn	Therapy Services Manager – Childrens Services	07385400476
Jayne Woodhead	Divisional Matron	07553 970510
Abbie Thompson	Matron EOL	07747472125
Louise Byrom	Matron District Nursing/Community Matrons	07919057419

11. Severe Winter Weather

Overview

Business Impact

- Absence of staff because they cannot get to work.
- Difficulty for staff and patients to travel around and between sites.
- Difficulty for community staff to access patients' homes.
- Increase in minor injuries from slips, trips, and falls.
- Reduced patient transport service.
- Difficulty discharging patients because reduced public transport, patient transport or impassable roads to their homes or other healthcare facilities.
- Difficulty for suppliers to get supplies to hospital.



Proactive strategy

- Adverse winter weather plan in place and reviewed.
- Weather forecasts and gritting information published on the local authority websites.
- Stockpile of salt/grit for car parks and access ways to Hospital sites.
- Access roads to CRH and HRI are on Local Council Highways Priority Gritting Routes.
- Yorkshire Ambulance Service winter plan.
- Secure contingency 4x4 vehicles through voluntary services to transport staff to and from their place of work.
- Community staff advised to work to nearest location to their homes.

Reactive strategy

- Implement flexible working arrangements where possible (adult community nursing)
- Implement the joint surge and escalation plan.
- Contact Local Council Highways to request roads are gritted for essential appointments and discharges (this will not always be possible).
- Provide accommodation for essential staff who cannot get home from work.
- Request that the hospital transport service collect essential staff and bring them to work (this will not always be possible).

Trigger	Received by	Immediate action
Met Office Cold Weather Alert	Incident Control Inbox	• Cold weather alerts will be forwarded to members of the winter (surge) planning group for onward circulation to departments. • Clinical Site Commanders will assess the consequences for discharges.
YAS PTS notification that journeys are affected or have been stopped	Clinical Site Matron	

Significant number of out-patient DNA	Outpatient manager	• The Calderdale & Huddersfield Solutions have a planned process for maintaining the Hospital grounds. • Review by the outpatients and surgical management teams of impact on performance.
Staff absence reporting	Department managers	• All members of staff should make an early assessment of travel plans during inclement weather. It is the responsibility of staff to exhaust every potential transport arrangement that will enable then to attend for duty. • Staff accommodation for inclement weather will be supported by the Trust as in previous years via the Accommodation Manager • All service areas will maintain up-to-date contact lists for all their staff. • Managers will use the Trust's adverse weather policy and the carer leave policy to manage staff absence. • Staff will be reallocated according to service need.

11.1. Cold Weather Alerts

Alert trigger	Trust Actions
OPEL 1 Winter Preparedness.	• Work with partner agencies to co-ordinate cold weather plans. • Work with partners and staff on risk reduction awareness. • Plan for a winter surge in demand for services. • Identify those at risk on your caseload.
OPEL 2 Alert and readiness (60% risk of severe weather).	• Communicate public media messages. • Communicate alerts to staff and make sure that they are aware of winter plans. • Implement business continuity plans. • Identify those most at risk. • Check client's room temperature when visiting.
OPEL 3 Severe Weather Action.	• Communicate public media messages. • Activate plans to deal with a surge in demand for services. • Communicate with those at risk regularly. • Ensure that staff can help and advise clients. • Signpost clients to appropriate benefits. • Maintain business continuity.
OPEL 4 Emergency Response Exceptionally severe weather of threshold temperatures breached >6days.	• Activate emergency management arrangements. • Communicate public media messages. • Activate plans to deal with a surge in demand for services. • Communicate with those at risk regularly. • Ensure that the hospital sites are kept clear and accessible. • Maintain business continuity.

11.2. Road Clearance

Kirklees

In the event of severe winter weather requiring roads to be cleared of snow and ice Kirklees Council will clear the pavement outside HRI to the boundary of the hospital site as part of its planned snow clearance operations. Acre Street and Occupation Road are on priority gritting routes. The access roads to CRH (Dryclough Lane, Godfrey Road, Dudwell Lane and Huddersfield Road) are all on priority gritting routes. Information on the priority gritting routes can be found at:

Winter | Kirklees Council

Winter maintenance is an important role for our Streetscene and Housing Service. We carry out winter maintenance to allow all road users to move about as safely as possible and to help minimise delays caused by adverse weather conditions.

Our winter maintenance service operates 24 hours a day, 7 days a week and is in place whenever the weather demands.

Kirklees Council will do what is possible to help ambulances with gaining access to patients that require urgent treatment / transport to outpatient appointments and hospital discharges. Examples of urgent outpatient treatments include renal dialysis and administration of drugs for life threatening conditions. Any assistance will be on the basis that the hospital confirms that the situation is urgent. Kirklees Council Highways can be contacted 24hours a day on 0800 7318765. Any Trust patient phoning the council to ask for help will be directed to contact the relevant hospital department. The hospital department will inform the Site Management Teams who will be responsible for liaising with Kirklees Council Highways.

Calderdale

Calderdale Council will try to keep the most important roads safe and as free as possible from wintry hazards.

- To do this they have 22 precautionary gritting routes. These cover over 600kms (around 67%) of the Calderdale Road network.
- It is impossible for the gritters to spread salt on every road. Over 600 salt bins are provided at key points throughout the district for use by residents, motorists, and pedestrians.

Information on priority gritting routes can be found at:

Be prepared for winter | Calderdale Council

Calderdale Council Highways commit to responding to requests from the emergency services only but may be able to assist in the event of an urgent request from the Hospital to grit a particular highway. The Calderdale Council Highways can be contacted via the Street Care / Customer Care number 0845 2457000.

There may be occasions in severe winter conditions where the hospital requires urgent deliveries such as medical gases and the site road access is impassable. In these situations, the Local Councils may assist with road clearance where possible.

Both Kirklees and Calderdale Councils will communicate messages regarding road closures and travel issues as well as weather updates via their social media platforms as well as via their websites and local radio stations.

As part of business continuity plans within estates there are processes in place to top up oil and fuel supplies for the boilers and generators to be prepared for any disruption to fuel supplies. Energy suppliers are also contacted to ensure the hospital is a protected site where blackouts are being considered.

11.3. Transportation 4x4

Roads that are impassable to cars due to ice or heavy snow are sometimes accessible to four-wheel-drive vehicles. In the event of disruption to public transport and difficulties in staff getting to work. Minimal availability to a 4x4 will be available.is on standby. The Trust holds an MOU with Yorkshire 4x4 which is a voluntary service, however a fee is incurred for journeys made. All requests must come through the Clinical Site Matrons.

The 4x4 should only be used if there is no public transport running, all other options have been exhausted and the staff member lives more than 3 miles away.

The following voluntary organisations in Yorkshire and the Humber also have access to 4X4 vehicles:

- St John's Ambulance
- British Red Cross
- Yorkshire 4X4 club (4X4 Response)
- Age UK

It is essential that community nursing teams are able to travel to visit service users in their homes. The adult community nursing team managers maintain a list of staff with 4X4 vehicles and ensure that the nursing teams have access to 4X4 vehicles in instances of severe winter weather.

The adult community nursing teams also work closely with Calderdale Council Adult Social Care to make best use of resources.

12. Equipment Ordering and Provision

Patients in the community may require equipment to keep them safe, assist daily living skills and improve mobility/function in their own home.

Physiotherapists, Occupational Therapists, Nursing Teams, and the Crisis Intervention Team are regular referrers to access equipment. Equipment is arranged via the Loan

Stores for Calderdale patients and the service is based at Unit 13, Ainley Top Industrial Estate, Ainley Bottom, Elland, HX5 9PJ.

Kirklees Loan Store

Loan Stores Hours of Operation	8:30am to 5:00pm Monday - Friday Saturday & Sunday priority service
Lead Manager	Mark Rance
Contact Details	01484 221000

Calderdale Loan Store

Loan Stores Hours of Operation	8.30am 4.30pm Monday to Friday, Saturday beds delivery 8.00 - 12.00PM
Lead Manager	Andrew Mould
Contact Details	01422 261396/261399

13. Escalation Plans and Business Continuity Plans

Each clinical division has identified the critical patient services they provide. Directorates have undertaken business impact analysis to identify what service functions can be reduced or suspended and have developed business continuity plans that describe the process for reducing non-critical activity and using the capacity generated to sustain critical patient services.

Below is a list of available and updated Business Continuity Plans:

Outpatient Business Continuity Plans	Emergency Preparedness and Resilience
Childrens Therapies	Critical Care ICU
Community Nursing Clinics	Cardiology
Community Nursing Home Clinics	Estates
Nutrition and Dietetics	General Office
Elective Orthopaedic Rehab	Catering
Intermediate Care Beds & Crisis Intervention	Cleaning
Immunisation Team	Linen
Orthotics	Waste Management
Outpatient Physiotherapy and MSK	Security
Podiatry	Medical Engineering
Specialist Nursing Clinics	Switchboard
Speech and Language Therapy	Equipment
Support and Independence Living Team	Transport
Tuberculosis Team	Portering
	Procurement
Corporate Business Continuity Plan	Appointment Services
Human Resources	Record/Reception Services
Infection Control	Pharmacy
Occupational Health	Pharmacy COVID Vaccine

Payroll	Transfusion
Nerve Centre	Microbiology
	Blood Sciences
	Phlebotomy
	Cellular Pathology
	Mortuary
	Radiology
	SCBU/NICU
	Child Health
	Paediatric wards
	Maternity Services
	Gynaecology
	Outpatient Services
	Endoscopy
	Operating Services
	HRI & CRH ICU
	Emergency Department
	Medical Wards
	Surgical Wards
	Medical SDEC
	Dermatology
	Acute Floor HRI
	Surgical SDEC
	Surgical Pre-Assessment
	Finance
	Communications Team
	EQUANS
	ISS
	Patient Flow

The Trust has a number of policies and plans that would be used in dealing with problems caused by operational pressures and adverse weather. They are both clinical and non-clinical, some are season-specific, and others are for general use. They can be found intranet link below:

Emergency Preparedness, Resilience & Response (EPRR) - CHFT Intranet (cht.nhs.uk)

- Emergency Preparedness, Resilience and Response (EPRR) Policy - Click Here
- Business Continuity Management System Policy - Click Here
- Business Continuity Management Guidance - Click Here
- Command & Control Framework - Click Here
- ICC Set up Guidance - Click Here
- Critical Incident Declaration Guidance - Click Here
- Major Incident Plan - Click Here Role Specific Action Cards - Click Here Communication MI Plan -Click Here
- EPR - Electronic Patient Records - Click Here - currently under review
- Evacuation Shelter Plan - Click here

- Adverse Weather - Click Here
- Fuel Disruption - Click Here
- HAZMAT / CBRN - Click Here
- Lockdown - Click Here
- Pandemic Influenza - Click Here
- VIP / Celebrity Visitors - Click Here
- Resilience Plan - Click Here

14. Infection Control

There is an expected surge of patients with 'flu' and Covid-19 in 2024/25. Guidance will be managed through public health and CHFT internal IPC team.

Point of care testing will be available in both EDs for both COVID-19 testing and flu testing, these tests will be carried out by the teams in ED against a set of criteria, non-urgent samples will be sent to pathology for testing.

Patients who need isolating will have a respiratory isolation sign should be displayed on the side room door (further information on isolation of patients is available in the Isolation policy section K). All staff must wear personal protective clothing (PPE) when entering the side room. When performing aerosolising procedures staff must wear an FFP3 mask and eye protection. Transfer and movement of patients around the hospital should be kept to a minimum, on transfer these patients should be encouraged to wear a surgical face mask wherever possible.

In the event that there are number of admissions with confirmed or suspected influenza it may become appropriate to cohort patients in a single bed bay or ward area. The IPC team will be instrumental in developing the operational plan when cohorting is required.

Some members of staff will be at greater risk from influenza because of a pre-existing medical condition or pregnancy. The risks to staff should already have been identified and managed through existing occupational health protocols.

14.1. Personal Protective Equipment

Wards and departments should ensure that they have sufficient supplies of personal protective equipment including gloves, plastic aprons, and surgical masks.

FFP3 masks or the positive pressure hood are required for specific infectious diseases (MERS and by staff performing cough inducing procedures for patients with suspected or confirmed infectious condition spread via respiratory secretions. FFP3 masks must be worn when performing the following procedures:

- Intubation, extubation and related procedures (e.g., manual ventilation and open suctioning)
- CPR
- Bronchoscopy
- Surgery and post-mortem procedures involving high speed devices.
- Some dental procedures (e.g., drilling).

- Non-invasive ventilation (e.g., bi-level positive airway pressure and continuous positive airway pressure ventilation)
- High-frequency oscillating ventilation; Induction of sputum.

Staff performing these types of procedures will include staff in ED, theatre, respiratory ward, ICU, and the acute floors in addition to staff groups such as Anaesthetists, Intensivists, endoscopists and physiotherapists (chest). Many wards and departments stock these masks, and the following wards are 'top up' areas:

HRI = SAU, acute floor, 18, ICU, Emergency Department

CRH = acute floor, 3, 5, ICU and Emergency Department

14.2. Fit Testing for FFP3 Masks

All staff are required to be fit tested to 2 masks. Prior to using an FFP3 mask the make/model and size of mask MUST be fit tested to the user to ensure a seal can be attained and the member of staff will be safe. Face masks come in various shape sizes so users can determine the most effective.

There are competent 'fit testers' in most clinical areas within the Trust who can carry out the assessment (register held on the intranet). Fit test kits are available from the IPC team for competent fit testers to use. It is the responsibility of the fit testers in each area to fit test their staff and to record the make model and size of mask that they require. Staff who have been fit tested are adding onto the equipment training database by the fit tester or the staff members manager.

Where a member or staff does not successfully fit test with the FFP3 mask used by the Trust, each management team must put in place appropriate risk mitigation measures to protect the member of staff from being exposed to a respiratory infection at work. This may involve:

- Training to use the positive pressure hood.
- Reassigning to an alternative task.

Positive pressure hood systems have been purchased for use across the Trust and are overseen by the IPC Respiratory Support Worker. Training is required prior to use by a competent user.

14.3. Seasonal influenza & Covid-19 Surge

Overview						
Business Impact						
• Absence of staff due to influenza illness and/or Covid-19 • Spread of the virus to frontline staff due to ineffective use of personal protective equipment. • Lack of available supplies of personal protective equipment.	**Impact**	**1**	**2**	**3**	**4**	**5**
	Likelihood					
	1					
	2					
	3					
	4				X	
	5					

• Increase costs of delivering care because of requirement of FFP3 masks and fit testing in some clinical areas. • Lack of available side rooms to isolate infectious patients. • Lack of available capacity on intensive care units to treat flu patients with serious illness. • Closure of ward areas and loss of bed days due to outbreaks of infection. • Increased monitoring and reporting requirements for flu-related activity.		
Proactive strategy		
• Immunise frontline staff for seasonal flu and Covid-19. • Community staff continue support people to stay at home. • Restate the risks and infection control requirements for managing flu patients. • Key messages reinforced by community staff. • Purchase additional supplies of face masks, gowns, and goggles. • Create and manage a stockpile of FFP3 masks. • Fit test staff who may be required to use FFP3 face masks (medical, nursing and physiotherapy staff working in ED, ICU, Respiratory and MAU). • Point of Care Testing (POCT) for ED for patients with suspected seasonal flu.		
Reactive strategy		
• Promote key flu and Covid-19 messages for patients (if you have flu, stay at home) • Follow standard infection control precautions for managing flu and Covid-19 patients. • Reassign or redeploy staff in high-risk groups as appropriate. • Implement the joint surge and escalation plan. • Implement the escalation plan for critical care if required.		
Trigger	**Received by**	**Immediate action**
DH reporting - proactive	DIPC	• Alert forwarded by email rule to Director of Operations, Chief Nurse, Director of Infection Prevention and Control. • Staff in the Emergency Departments and outpatient departments will remind relevant patients to have their flu and Covid-19 jabs if they have not already done so. • Implement management of flu and Covid-19 arrangements.
Surge in flu related activity	ED matron/CD	
Surge in flu admissions	Infection control team	

15. Holiday Periods and Bank Holidays

15.1. Staffing

The clinical divisions will have arrangements in place to ensure staff cover on the bank holidays and during holiday periods, Christmas and New/Year holidays are when there is anticipated surge in emergency/acute demand. There will be senior divisional management cover over the Christmas and New Year period to manage this as well as during other holiday periods.

15.2. Reduced Services

The Christmas and Bank Holiday arrangements for different services will be shared in the weekend pack which will be available in each Digital Command Centre as well as emailed out to all those senior staff working and to switchboards. Copies of the operational arrangements for theatres and clinical support services will be included within this pack.

15.3. Partner organisations

CHFT has worked with our system partners to develop the overall resilience plan, and this aligns with the CHFT plan. On call structures and rotas are available prior to the start of each week and weekend rotas are made available should escalation be required.

Cover arrangements during holiday periods and bank holidays for primary care, social care and safeguarding will be shared with the weekend packs.

15.4 Mutual Aid

The Trust has a Mutual Aid Protocol designed to support the Trust to make or receive mutual aid requests to / from other organisations. The West Yorkshire System Co-ordination Centre (SCC) is the supporting mechanism to manage mutual aid requests on behalf of West Yorkshire Acute Trusts in times of operational pressure. The processes to request mutual aid are set out in the protocol.

Requests from partner organisations for mutual aid should be received via the System Coordination Centre (SCC) and made available to the Chief Operating Officer (in hours) or Strategic on call (out of hours) who should consider the Trusts capacity to be able to offer mutual aid (people, premises, resources, equipment) and risk assess against the safe service delivery to Trust patients' staff and visitors.

Accepting or declining a mutual aid request is at the discretion of the Chief Operating Officer or Strategic On-Call. The decision should be reported back to the SCC for logging purposes.

Mutual aid request may be made to the Yorkshire Ambulance Service and/or West Yorkshire Fire and Rescue Service in the event of a CBRN/HAZMAT event that the Trust requires additional support to respond.

16. Training and Implementation of the Resilience/Winter Plan

The Divisional Director of Operations have overall responsible for ensuring that those with identified roles in the plan are familiar with the protocols set out in this document. This will be achieved by.

- Involvement of leads from each division.
- Discussion at the appropriate divisional committees
- Cascade of messages to key staff groups through email circulation and Trust news.
- Publication of related documents on the Preparing for Emergencies section of the staff intranet.
- Publication of the plan on the Trust intranet.

17. Trust Equalities Statement

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

18. Monitoring Compliance with this procedural document

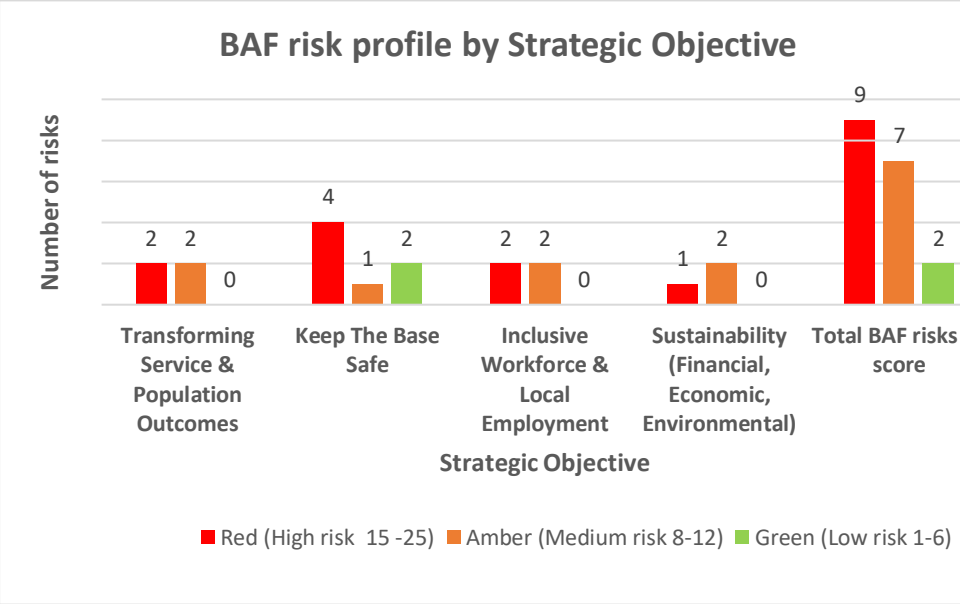
The Deputy Chief Operating Officer and Divisional Director of Operations in collaboration with key service winter leads are responsible for the successful implementation and monitoring of the winter plan. The plan and its effectiveness will be reviewed throughout the winter period and learning shared and acted upon. The Urgent Care Board membership will also play a key role in the review process.

22. Board Assurance Framework – Update 2

To Approve

Presented by Andrea McCourt

Date of Meeting:	Thursday 7 November 2024
Meeting:	Board of Directors
Title:	Board Assurance Framework - Update 2 2024/25
Author:	Andrea McCourt, Company Secretary
Sponsoring Director:	Victoria Pickles, Director of Corporate Affairs
Previous Forums:	Audit and Risk Committee – 22 October 2024
Purpose of the Report	The Board Assurance Framework is the key source of evidence that links the Trust's strategic objectives to risk and assurance. It is the main tool that the Board uses for discharging its overall responsibility for internal control and is presented to the Board three times a year. This report presents for approval the second report of the Board Assurance Framework (BAF) for 2024/25 for approval. The report has been reviewed by the Audit and Risk Committee at its meeting on 22 October 2024.
Key Points to Note	**Risk Profile** The Trust risk profile for risks to its strategic objectives as at 24 October 2024 is given below, with a total of 18 risks, reflecting the proposed closure of four risks for the reasons stated. The closure of these risks was supported by the Audit and Risk Committee. The Keeping the Base Safe goal has the greatest number of risks (7 of 18) and the highest number of red risk scores, at four of the 18 risks on the BAF. **Top Risks** The BAF, via the heat map, shows the top risks for the Board, consistent with those in July 2024 are: • Transforming Services and Population Outcomes - approval relating to hospital services reconfiguration, risk score of 20 • Keeping the Base Safe – demand and capacity (beds), risk score of 20 • Sustainability - risk 18/19 relates to the long term financial sustainability of the Trust and has a risk score of 16.



Risk Movement:

All BAF risks have been reviewed and updated by the lead Director and / or teams with updates shown in red font for ease of reference in the enclosed worksheets within the BAF.

Details of risks for removal from the BAF, merging of risks and changes to risk scores proposed are given below.

Risk Closure – the following risks are recommended for removal by the lead Director and or Committees with oversight for the risk:

3/23 Partnership Governance risk Transforming Services and Population Outcomes	Risk met target risk score of 8 in July 2024. This risk was added at a time of new legislation. Partnership working is part of our business as usual and the risk of impact to decision making processes has not materialised
2/23 Trust impact as an anchor institution Financial, Economic and Environmental Sustainability.	

		partnerships and relationships with wider stakeholders and partners.
	4/23 National and local performance targets Keeping the Base Safe	Risk removed as target score met, approved at Finance and Performance Committee 1.10.24, due to factors below: Industrial action no longer expected by resident doctors due to settlement of pay dispute. Positive performance in cancer and elective care continues. Improved diagnostic performance, over 90%, with particular improvements in neurophysiology and echo. The aspect of the risk relating to the transfer of care list linked to urgent and emergency care has been added to the risk relating to acute pressures, risk 1/23.
	11/19 Recruitment and Retention *1/22 Absence and retention, well - being* Inclusive Workforce and Local Employment	Improvements in people metrics as evidenced in performance report. Risks reviewed, with elements of both risks retained and combined into one risk 1/24 re upskilling of managers, a key priority with a risk score of 12. Reviewed by Workforce Committee 17.10.24. which acknowledged progress on workforce metrics and will monitor this risk closely with a view to reducing the score subject to completion of actions when reviewed at update 3.

There is one risk with downward movement in risk score noted below. The rationale for the movement in risk score is given below.

↓	4/19 Patient Involvement	6 (reduced from 12)

- ***4/19 Patient Involvement*** - risk reduced from a risk score of 12 to 6 due to Patient Experience and Engagement Strategy being in place and progress with engagement, including patient safety partners and experts by experience being in place. Aim to achieve target risk score by March 2025.

Risk Exposure

Where a BAF risk score is higher than the risk appetite (e.g. risk score of 15 or above where risk appetite is moderate) this has been identified as a breach of the risk appetite.

In considering risk exposure the Trust needs to assess whether any further mitigating actions are needed and review the adequacy of information and assurance on the management of risks with risk exposure.

As at 8 October 2024 there are five areas of risk exposure against strategic goals summarised below.

Transforming and Improving Care	**Risk Score**	**Risk Appetite category**	**Risk Appetite**
7/20 Health Inequalities	12 =	Harm and safety	Low
Keeping the Base Safe			
5/23 Cyber Security	15 =	Regulation	Moderate
6/19 Quality and Safety	15 =	Regulation	Moderate
1/23 Demand and capacity (beds)	20 =	Harm and safety	Low
Sustainability			
18/19 Financial sustainability	16 =	Financial/Assets	Moderate

Regulation	CQC Regulation 17: Good Governance
EQIA – Equality Impact Assessment	The BAF has a specific risk, risk 07/20, which relates to the Trust not reducing health inequalities for our most vulnerable patients. The Trust Board receives a report four times a year on progress with health inequalities actions at Board meetings.

	In terms of other risks, should any of the Board Assurance Framework risks materialise and impact people from different protected characteristics the risk owner is accountable for assessing these and determining any proposed actions to mitigate any equality impact arising from the risk.
Recommendations	The Board is asked to: i. **APPROVE** the removal of risks 2/23, 3/23, 4/23 and new Workforce risk (1/24) replacing two previous workforce risks 11/19 and 1/22 and reduction in risk score for 4/19. ii. **APPROVE** the Board Assurance Framework. iii. **CONSIDER** if there are any further risks to the achievement of strategic objectives.

Update 2 - For November 2024 Board
2024/25

Calderdale and Huddersfield
NHS Foundation Trust

BOARD ASSURANCE FRAMEWORK
2024/25 Update 2

Contents:

compassionate care

REF	RISK DESCRIPTION	Initial Score	Current score	Target Score	Lead	Link to High Level Risk Register	Risk Category	Risk Appetite
Transforming Services & Population Outcomes								
01/19	Risk that the Trust does not secure approval of the Hospital Services Reconfiguration, Outline Business Case and Full Business Case resulting in being unable to progress changes to improve quality of care, workforce resilience and mitigate estates risks.	25	**20=**	10	AB	7413, 8528	Strategic/ Organisational	Significant
01/20	Risk of not delivering the ambitions in the Trust clinical strategy due to lack of collaboration due to financial and workforce constraints, delivery of reconfiguration and agreed joint vision for clinical services, delivery of the research and development strategy and the further development of digital health resulting in missed opportunities in terms of quality, efficiency, capacity, patient experience and workforce.	15	**15 =**	10	NB	None	Strategic/ Organisational	Significant
02/20	Risk of not securing appropriate investment to fund the Digital Strategy ambitions, ensuring infrastructure and technology is up to date and future proof due to funding not being available locally and nationally impacting on workforce efficiency and patient experience.	12	**12 =**	9	RB	None	Innovation/ Technology	High
07/20	Risk of slow progress addressing health inequalities in the 20% of the most deprived patients in our communities, due to incomplete population health and patient ethnicity data, healthcare service delivery not matching patient needs in the most deprived areas, lack of quality priorites to advance health equity, lack of resource allocation and programmes for health prevention, ineffective partnership working and lack of sustained focus on actions to address ill health and prevention, resulting in the Trust not reducing health inequalities for our most vulnerable patients with protected characteristics.	16	**12 =**	8	RA	None	Harm and safety	Low
Keeping the base safe best quality and safety of care								
06/19	Risk that patients do not receive high quality, safe care due to poor compliance with internally and externally set standards on quality and safety resulting in patient harm or poor patient experience.	15	**15 =**	10	LR / NB	8528, 6079	Regulation	Moderate
04/19	Risk that patients are not able to shape decisions about their care based on what matters to them due to lack of clear strategy and capacity for patient and service user engagement resulting in not designing services using patient recommendations	12	**6 ↓**	4	VP	None	Regulation	Moderate
09/19	Risk of failure to maintain current estate and equipment and to develop future estates model resulting in patient harm, poor quality patient care or regulatory enforcement.	16	**15 =**	8	GB	7413, 8161, 8562, 7955	Strategic/ Organisational	Significant
16/19	Risk of not being compliant with the Health and Safety at Work Act and regulations due to lack of clarity on roles resulting in harm to staff, patients, the public, visitors, potential regulatory failure and reputational damage.	9	**6 =**	3	JH	7413	Regulation	Moderate
04/20	Risk of not maintaining the Trust CQC overall rating of good and increasing the number of services achieving an outstanding rating as assessed by the new CQC single assessment framework and potential for ratings to be changed by CQC based on other intelligence or data from CQC portal outside of on site inspection of service due to failure to comply with quality statements resulting in a reduction of qualiy of services to patients and an impact on reputation.	12	**12 =**	6	LR	None	Regulation	Moderate
1/23	Risk re demand and capacity requiring additional beds above planned levels resulting in staffing and financial pressures.	16	**20 =**	12	JH	8606, 8528	Harm and safety	Low
5/23	Risk of an impact to the delivery of clinical or corporate services due to reduced or no digital provision resutling from a cyber attack	15	**15**	10	RB	None	Regulation	Moderate

Inclusive workforce and local employment								
10a/19	Risk of not being able to deliver safe and effective high quality care and experience for patients due to insufficient medical staff caused by an inability to attract, recruit, retain, reward and develop colleagues.	16	**16 =**	9	NB	7078, 8315	Quality/Innovation & Improvement	Significant
10b/19	Risk of not being able to deliver safe and effective high quality care and experience for patients due to insufficient nursing staff caused by an inability to attract, recruit, retain, reward and develop colleagues.	16	12 =	9	LR	None	Workforce	Low
6/23	Risk of not being able to deliver safe and effective high quality care and experience for patients due to insufficient midwifery staff caused by an inability to attract, recruit, retain, reward and develop colleagues.	16	**16 =**	9	LR	6911	Workforce	Low
1/24	Risk of not attracting or retaining colleagues if Trust doesn't provide leaders with tools, skills and development opportunities to ensure they are competent to provide compassionate care to their workforce.	12!	**12**	9	SD	None	Workforce	Low
Financial, Economic and Environmental Sustainability								
14/19	Risk that the Trust will not secure sufficient capital funding to maintain facilities over the longer term and meet safety and regulatory standards resulting in patient harm and regulatory intervention.	20	**12 =**	12	GB	None	Financial/Assets	Moderate
18/19	Risk of failure to secure the longer term financial sustainability of the Trust (achieving financial breakeven and providing value for money) due to the size of the underlying and current financial deficit and reliance on cash support.	25 =	**16 =**	12	GB	None	Financial/Assets	Moderate
06/20	Risk of climate action failure and not improving our environmental sustainability	16	**8 =**	8	SS	None	Environment Sustainability	Moderate

New risk
Area of risk exposure

REF	TOP RISKS	Initial Score	Current score	Target Score	Lead	Link to High Level Risk Register	Risk Category	Risk Appetite
TRUST GOAL: TRANSFORMING SERVICES AND POPULATION OUTCOMES								
01/19	Risk that the Trust does not secure approval of the Hospital Services Reconfiguration Outline Business Case and Full Business Case resulting in being unable to progress changes to improve quality of care, workforce resilience and mitigate estates risks.	25	**20=**	10	AB	8528, 7413	Strategic/ Organisational	Significant
TRUST GOAL: 2 KEEPING THE BASE SAFE BEST QUALITY AND SAFETY OF CARE								
1/23	Risk re demand and capacity requiring additional beds above planned levels resulting in staffing and financial pressures.	20	**20**	12	JH	7689, 8283, 8324, 8034	Harm and safety	Low
TRUST GOAL: 4. FINANCIAL, ECONOMIC AND ENVIRONMENTAL SUSTAINABILITY								
18/19	Risk re: longer term financial sustainability of the Trust (as a going concern and providing value for money) due to the size of the underlying financial deficit with the growing level of debt and reliance on borrowing.	25 =	**16 =**	12	GB	8057	Financial/Assets	Moderate

Area of risk exposure

CHFT RISK APPETITE STATEMENT - Revised September 2024

Risk Category	This means	Risk Appetite
Strategic / Organistional	We seek out innovation to deliver higher quality patient care, accepting this brings risk.	**SIGNIFICANT**
Quality innovation and improvement	We seek innovation in the way we develop different models of service delivery and employ staff as a key enabler for improving quality, patient safety and experience.	**SIGNIFICANT**
Partnership	We accept a level of risk in working with partners to support service transformation and operational delivery, withun agreed financial limits.	**SIGNIFICANT**
Digital Innovation / New Technology	We change how we deliver care to meet the challenges of the future by actively pursuing digital innovation and new technologies, while providing safe, effective and efficient care for patients.	**HIGH**
Reputation	Where required we will make difficult decisions in the best interests of patient safety but appreciate this may attract scrutiny / interest from stakeholders.	**HIGH**
Commercial	We explore new opportunities which will enhance and support our core business and reputation for providing patient care.	**HIGH**
Financial / Assets	We will invest resources to enable us to deliver improvements in care ensuring rigorous impact assessments. We will resource opportunities and always consider price, value and benefits, local and system impact, aiming to deliver our services within our ICS approved financial plans, retaining flexibility to capitalise on opportunities.	**MODERATE**
Environmental Sustainability	We are committed to the provision of environmentally sustainable services and having a low carbon footprint and will explore environmentally sustainable developments to deliver improvements.	**MODERATE**
Regulation	We will make every effort to comply with regulation and will explain our approach.	**MODERATE**
Harm and safety	We take as little risk as possible when it comes to harm and safety to keep our patients and colleaguessafe and achieve the best clinical outcomes.	**LOW**
Workforce	We have one Culture of Care with colleagues looking after each other as well as the people we care for, ensuring patient safety, appropraite staffing levels and promoting the well-being of our staff.	**LOW**
Legal	We will comply with the law.	**LOW**

LIKELIHOOD (frequency)	CONSEQUENCE (impact / severity)				
	Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Extreme (5)
High Likely (5)			01/20 Clinical Strategy = 6/19 Compliance with quality standards =	**1/23 Demand and bed capacity =**	
Likely (4)			02/20 Digital Strategy = 1/24! - Recruitment, retention and absence	**18/19 Long term financial sustainability =** 10a/19 Medical Staffing levels = 6/23 Midwifery Staffing levels =	**1/19 Approval of hospital reconfiguration outline business case and full business case =**
Possible (3)				04/20 CQC rating = 14/19 Capital = 07/20 Health Inequalities = 10b/19 Nurse Staffing levels =	5/23 Cyber security = 9/19 HRI Estate fit for purpose =
Unlikely (2)			16/19 Health & Safety = 4/19 Patient & Public Engagement ↓	6/20 Sustainability =	
Rare (1)					

= no change to risk score ! is a new risk ↓ reduced risk score ↑ increased risk score Top 3 risks shown in bold

BOARD ASSSURANCE FRAMEWORK
OCTOBER 2024
TRANSFORMING SERVICES AND POPULATION OUTCOMES

TRUST GOAL: 1. TRANSFORMING SERVICES AND POPULATION OUTCOMES										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING OCTOBER 2024 Risk category: Strategic Risk appetite: Significant**		
1/19	Board of Directors / Transformation Programme Board	Deputy Chief Executive / Director of Transformation & Partnerships	Risk that the Trust does not secure approval of the Hospital Services Reconfiguration Full Business Case (FBC) from NHSE DHSC, Ministers and HM Treasury and as a result the Trust is unable to complete changes that will improve the quality of care, workforce resilience and mitigate estate risks. **Impact** Trust is unable to improve long term clinical quality and deliver compliance with statutory, regulatory and accepted best practice.	Formal governance structures established: - Transformation Programme Board, formal sub-committee of the Trust Board oversees service transformation and reconfiguration plans. - Quarterly review meetings with NHSE, WY ICS, and DHSC colleagues to advise on planning assumptions used in business cases to ensure compliance with HM Treasury and DHSC requirements and facilitate future approval(s). External professional and technical capacity and expertise procured, design partner and Project Director in place. Construction partner in place to manage design and construction of the new clinical build stage at CRH with oversight by Project Board. Close working with: - Joint Health Scrutiny Committee, wider stakeholders and colleagues to ensure full involvement in the development of the plans and business cases. - West Yorkshire Health & Care Partnership and Calderdale Cares Partnership and Kirklees Health and Care Partnership to ensure alignment of the reconfiguration plans with their strategic objectives to facilitate the ICS and Place based formal letters of support for the business cases. A Round Table Board is established that has members from NHSE, WY ICS, DHSC, Calderdale and Kirklees Places and meets quarterly to ensure system alignment and support for business case planning assumptions and development. Clinical protocols agreed with Yorkshire Ambulance Service (YAS) to ensure patients transported to the hospital that meets their clinical needs - refresh protocols nearer to build completion.	<u>First line</u> Transformation Programme Board - oversight of governance and content of business case development including relationship management with Stakeholders and the ICS, NHSE/ DHSC. <u>Second line</u> Trust Board approval of Strategic Outline Case (SOC) and Outline Business Cases (OBC), FBC under development. <u>Third line</u> ICS and NHSE review and approve business cases prior to submission to DHSC and HMT.	• See below for further detail. 1. His Majesty's Revenue and Customs (HMRC) advice on preferred procurement route sought 2. Agreement for development on the CRH site.	None identified.	**Initial** **5x5 = 25**	**Current** **5x4 = 20**	**Target** **5x2 = 10**

Actions	**Timescales**	**Lead**
1. The Trust will have concluded discussions with the PFI Special Purpose Vehicle (SPV) to enable the development on the CRH site. 2. Provision of additional car parking at CRH.	1. An agreement with the PFI Special Purpose Vehicle has been negotiated and is progressing to completion. 2. Build of a Multi-storey car park at CRH to commence in 2024, expected completion 2025/26..	Deputy Chief Executive / Director of Transformation & Partnerships for all actions

Links to risk register from current service configuration:
8528 - ED operational performance
7413 - fire compartmentation risk HRI
Quarterly risk management report on the Reconfiguration Programme Risk Register to Transformation Programme Board

BOARD ASSSURANCE FRAMEWORK
OCTOBER 2024
TRANSFORMING SERVICES AND POPULATION OUTCOMES

TRUST GOAL: 1. TRANSFORMING SERVICES AND POPULATION OUTCOMES										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING OCTOBER 2024 Risk category: Strategic Risk appetite: Significant**		
								Initial	**Current**	**Target**
Ref: 01/20 Added July 2020	Transformation Programme Board (TPB)	Neeraj Bhasin, Medical Director	Risk of not delivering the ambitions described in the Trust clinical strategy due to financial and workforce constraints, delivery of reconfiguration and agreed joint vision for clinical services, delivery of the research and development strategy and further development of digital health, resulting in missed opportunities in terms of quality, efficiency, capacity, patient experience and workforce NB: See 1/19 reconfiguration risk which has signifcant overlap with this risk,18/19 financial risk, 10a/19 medical staffing risk	2024 refresh of current Clinical Strategy (2021-25) underway to describe Trust priorities for the next 5 years. Transformation Programme Board - ensures estate is aligned with the clinical strategy, which informs decisions made to reconfigure services and ensure redesigned hospital model is fit for purpose (see BAF risk 1/19 reconfiguration) ICS - member of the WY& H Partnership Board which agrees service direction, strategy and financial allocations and controls. More effective working relationships with partners and establishment of networked approaches to Pathology and Vascular Surgery. Member of WYAAT which identifies, agrees and manages programms of work targeted to improve services and patient experience across West Yorkshire. WYAAT governance framework with specific forums for acute Trusts including Chief Exec forum, Committeee in Common and programme office with oversight. CHFT Deputy Chief Executive chairs South sector implementation Board for Non Surgical Oncology (NSO) services across MYHT & CHFT. Project Manager support. Target Operating Models agreed.NSO in patient bed base now reconfigured to HRI. West Yorkshire & Humber Diagnostics Board (chaired by MYHT Chief Executive) reviews reports from workstreams on diagnostics (radiology, pathology). Managed Service Contract for Pathology implementation underway- completion by December 2024 Deputy Chief Executive chairing New Pathology Pattnership (NPP) to progress the new network West Yorkshire Imaging Collaborative reports to Diagnostics Board. Continuing to develop longer term model for microbiology and blood sciences. CHFT/ MYHT Partnership Board meets to discuss fragile services and foster closer working relationships Joint working with MYHT to explore partnership working opportunities led by Associate Director of Strategy CHFT partner at Calderdale and Kirklees PLACE level clinical and professional forums**,** Quality Forum and PLACE Boards (sub group of ICB) to agree local health priorities and strategy.	**First Line** Update on review and refresh of clinical strategy shared with WEB (16.5.24.) and signed off draft 11.7.24. Updates on NSO South Sector model to WEB 30.05.24. New in patient unit opened June 2024. WEB review of plans for new clinical build design at CRH 15.8.24. **Second Line (Board / Committee)** Clinical Strategy July 2021 Board approved Refreshed draft clinical strategy discussed by WEB - 16.5.24. WYAAT Strategy approved by Board March 2024 Pathology Partnership Update to January 2023 Board Transformation Programme Board highlight report and minutes to Board. **Third Line** Vascular network established with Bradford WYAAT Pathology Board established. Diagnostics Board and Imaging Collaborative established across West Yorkshire WYAAT / PLACE meetings	LIMS (Laboratory Information System) implemetation delayed until 2025 or beyond, which will delay transfer of Pathology work between network partners. WYAAT and ICS system-wide approaches to reset. Performance of CHFT in relation to Covid backlog position remains focus of work. Awaiting ambitions of government for healthcare post election. CHFT reconfiguration delays impacts timescale for service transformation - action: progressing supporting elements where possible. Trust financial deficit position may limit development of new services -see BAF risk 18/19 long term financial sustainability **Action:** Risk likelihood score increased.	Review and refresh of clinical strategy to ensure it reflects CHFT and system ambitions. Review this risk once refreshed clinical strategy approved. Lead: Medical Director / Associate Director of Strategy. Timescale: Board approval planned for ~~September~~ 7 November 2024	3x5=15	3x5=15 =	3x3=9

Action	**Timescales**	**Lead**
Progress supporting elements of reconfiguration where possible as part of clinical strategy Review and refresh of clinical strategy	Ongoing ~~September~~ November 2024	Medical Director / Deputy Chief Executive and Director of Transformation and Partnerships Medical Director

Links to risk register: None

TRUST GOAL: 1. TRANSFORMING SERVICES AND POPULATION OUTCOMES										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** (*Where are we failing to gain evidence about our system/ controls?)*	**RATING OCTOBER 2024 Risk Category; Innovation/Technology Risk Appetite: High**		
02/20 July 2020	Transformation Programme Board (TPB)	Chief Digital and Information Officer (CDIO)	Risk of not securing appropriate investment to fund and deliver the Digital Strategy ambitions, ensuring infrastructure and technology is up to date and future proof due to funding not being available locally and nationally impacting on workforce efficiency and patient experience	Year 4 of 5 year Digital Strategy and continued review by Weekly Executive Board and annually to Board which will meet the needs and build the foundation for the next 5 year digital strategy Continued central funding available and committed capital funding from the Trust which will enable progression. Director of Digital Operations and Delivery role co-ordinating digital programmes and providing leadership whilst maintaining alignment toTrusts operational needs. Year 4 of the Digital Strategy (24/25 digital/EPR plan) focuses on improving on the digital basics and optimised use of existing systmes where funding may not be available. Governance via Digital WEB and Digital Operations Board.Digital Operations Board chaired by Chief Digital and Information Officer (CDIO), with reviewed terms of reference Monthly meetings with Chief Digital and Information Officer (CDIO) and Director of Finance reviewing progress with digital investment strategy. Divisional Digital Boards ensure appropriate spend of investment and report into the Digital Operations Board which has oversight of investment in line with strategy. EPR team restructured to ensure sufficient capacity and capability, with funding to support third Trust via project. CNIO and CCIO play a key role in the Digital Prioritisation Process (part of the Digital Health Team). COO, Chief Nurse,and Medical Director supporting the direction of digital developments in line with CHFT operational requirements. Clinical Change resource in place to help aid digital adoption and deliver benefits.	**First Line:** Digital Operations Board meeting bi-monthly, programme of work and progress presented at each meeting. **Second Line** Board approved Digital Strategy and associated investment plan (2 July 2020) provides direction . Additional funds for digital capital expenditure for 2023/24 secured. 11 January 2024 Digital Strategy Progress and Update to Board with plan to 2025. Continued optimisation and progress against the Digital Strategy delivered through internal capability with limited funding. 2 September 2021 Board approved THIS Commercial Strategy confirms the Trust contribution target and allows for re-investment into THIS. Review 10 November 2022 Board. BCAG provides assurance that digital benefits are realised and digital business cases are aligned to the Trust Digital Strategy. **Third Line:** WYAAT & WYICS Chief Information Officer meetings ensures alignment of stategy on regional digital deployment as well as availability and eligibility for central digital funding. Good relationship with NHSE digital funding lead, Trust has received limited central funding in 2024/25.	Limited likelihood of securing centralised capital funding (NHS E) as it will be nationally limited in 2024/25. **Action:** Bids prepared to take advantage of any national capital underspend that becomes available in year. Lead: CDIO Timeframe: In Process Limitted funding expected in 2025/26. Potential to close this risk at update 3.	Availability of funding - continual monitoing of central funding available for digital investment. Some funding expected in 2025/26 aligned to digital expecations within the government plan. Lead: CDIO - ongoing	**Initial** **4x3 = 12**	**Current** **4x3 = 12**	**Target** **3x3=9**

Action	**Timescales**	**Lead**
Digital bids prepared and monitoring of availability of central funding for digital investment	Ongoing	Rob Birkett

Links to risk register see linked 1/19 reconfiguration risk

BOARD ASSSURANCE FRAMEWORK
OCTOBER 2024
TRANSFORMING SERVICES AND POPULATION OUTCOMES

TRUST GOAL: 1. TRANSFORMING SERVICES AND POPULATION OUTCOMES											
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING OCTOBER 2024 Risk category: Harm and Safety Risk appetite: low**		
								Initial	**Current**	**Target**
07/20 Added July 2020	Trust Board	Deputy Chief Executive	Risk of failing to respond to the health inequalities that exist within our populations due to lack of quality priorites to advance health equity, incomplete population health and patient ethnicity data, helthcare service delivery not matching patient needs in the most deprived areas or lack of resource allocation and programmes for health prevention, resulting in the Trust not reducing health inequalities for our most vulnerable patients with protected characteristics.	Deputy Chief Executive is the named Board Executive providing accountable leadership for tackling health inequalities. 2022-2024 Population Health and Inequalities Strategy approved at November 2022 Board with updates to Board throughout the year. Strategy focussed around four key areas of priority: Connecting with our communities and partners Access and prioritisation Lived experience and outcomes Diverse and inclusive workforce Health Inequalities Group, chaired by Deputy CEO, ensures oversight of all Trust workstreams in relation to health inequalities. Progress against delivery of Health and Inequalities Strategy reported regularly into the Trust Board. Equality impact assessment (EQIA) process for service and policy changes. Exploring actions to better recognise and address the impacts of poverty on health. Implementation of the Shadow Board - September 2023 Board Diversity Action Plan approved NHS EDI Improvement Plan - 6 high impact actions, one relating to members of Boards having an appraisal objective linked to EDI	**First Line** - Trust-wide health inequalities group meets monthly and oversees the organisations action plan and response to health inequalities. Health inequalities consideration and understanding included as a core element of all services supported by the development of data and performance information to enable greater activity analysis of access and outcomes through routine performance monitoring. **Second Line** - Progress against delivery of Health and Inequalities Strategy reported formally into the Trust Board on a 6 monthly basis. 2023/24 Annual Report reported on the required inequalities indicators and include additional narrative on the Population Health and Inequalities Strategy, our approach to addressing inequalities, and actions undertaken to reduce inequalities in line with NHS England requirements. Approved Board succession plan seeks to ensure clear talent pipelines for each Executive and non Executive roles in the Trust, including actions to ensure inclusive recruitment, and actions to ensure that the Board reflects the gender make up of local communities. EQIA referenced in all Board paper front sheets **Third Line** The Trust is working in collaboration as part of the West Yorkshire (WY) Integrated Care Board, WY Association of Acute Trusts and WY Community Collaborative, as well as continuing to showcase work nationally.	Continue to explore approach to diversity with WYAAT and ICB colleagues to ensure a regional approach. The Trust has delivered a number of successful interventions in respective of equality and diversity including the apprenticeship programme and Project SEARCH. Work continues overseen by the Trust's Inclusion group. Lead: Director of Workforce and Development Timescale: ~~March 2024~~ ~~August 2024~~ March 2025 Update in relation to use of patient level demographic information to prioritise clinical care - methodology trialled and used within cancer pre-habilitation services and outpatient services. Plans to add social vulnerability information to Trust systems. Lead: Deputy Chief Executive Timescale: ~~March 2024~~ ~~August 2024~~ March 2025 Population Health - continue to develop place-based approach to population health information to inform service planning and decision making. Deputy CEO and Managing Director of HIS leading on this work on behalf of CHFT Lead: Deputy CEO and Managing Director of HIS Timescale: ~~March 2024~~ ~~August 2024~~ March 2025	Population Health and Inequalities Strategy (2022-24) now in place. Progress against action plan continues. Policy to be refreshed and relaunched for 2025-27 period. Lead: Deputy Chief Executive ~~June 2024~~ March 2025	4x4=16	4x3=12=	2x4=8

Action	**Timescales**	**Lead**
Action Plan for more diverse Board and senior staffing consistent with local community and explore with WYAAT /ICBs	~~31/03/2024~~ ~~31/08/2024~~ 31/03/2025	Director of Workforce & OD
Development of tool to identify and highlight social vulnerability	~~31/03/2024~~ ~~31/08/2024~~ 31/03/2025	Deputy Chief Executive
Development of Place-based approach to population health information for service planning	~~31/03/2024~~ ~~31/08/2024~~ 31/03/2025	Deputy Chief Executive / Chief Digital and Information Officer

Links to risk register:
None

TRUST GOAL: 2 KEEPING THE BASE SAFE BEST QUALITY AND SAFETY OF CARE										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING OCTOBER 2024 Risk category: Regulation Risk appetite: Moderate**		
								Initial	**Current**	**Target**
04/19	Quality Committee	Director of Corporate Affairs	**Risk** Risk that patients are not able to shape decisions about their care based on what matters to them due to lack of clear strategy and capacity for patient and service user engagement resulting in not designing services using patient recommendations and not meeting statutory requirements **Impact** - poor patient experience - Non delivery of improvements in services - inequitable service / care for patients - Risk of legal challenge - Reputational impact	• Patient Experience and Involvment Group (PEIG) provides strategic leadership and key programmes of work to improve experience of care and support the Trust to involve patients, carers and colleagues. • Governor and Healthwatch are members of PEIG •Dedicated senior leadership post for patient experience, equality and diversity and matron for complex care needs •PEIG work programmes informed by Insight including Person Centred Care; Strengthening working in Partnership with people and communities; Insight to inform Improvement Priorities and Supporting Carers; Divisional PSQB's updated on PEIG programmes of work and requests for support sought. Refresher training to support colleagues on Involvement / working in partnership developed and promoted. PEIG seeks to identify inequalities and barriers to accessing care through insight received and ensures this insight is shared with the Equalities Group. • Observe and Act patient observation tool as part of Journey to Outstanding reviews • Patient Safety Partners and Experts by Experience in place and new patient and public engagement forum set up and testing plans •Ambitions to support Carers at CHFT for 2024 / 2025 informed by carers, partner agencies, insight and colleagues developed. Accessible Information action plan progress reported to PEIG quarterly •Patient Stories widely used across the Trust to share good practice and also areas where experience of care can be improved. 6 CHFT colleagues trained in 2024 to record digital stories (patient, carer or staff experiences) to further amplify the voice of patients and service users and contribute to improvements in experience and service delivery and design • Matron on Reconfiguration Team leads on patient experience • Complaints mapped to IMD (index of multiple deprivation) groupings • Director of Corporate Affairs Chairs Calderdale Place Communications, Involvement and Equality Group and have members on the Kirklees equivalent • Flow chart for patient engagement developed and being tested • Accessible Information Standard Policy developed and approved and being implemented	**First line** Patient Experience Involvement Group Quarterly report on patient experience and involvment to Quality Committee Examples of good practice on patient and public involvement including reconfiguration programme, children's services, carers etc. These are captured in bi monthly divisional highlight reports ; Expert by Experience and Patient Safety Partners recruited and Expert Panel meeting bi-monthly **Second line** Patient Story to PEIG, Quality Committee and Board Governor attends PEIG Director of Corporate Affairs chairs Place Communications, Involvement and Equality Group reporting in to ICB Member of Place Based story tellers network PEIG reporting to Quality Committee quarterly, and Annual Bi monthly Carer meetings with key partners including Local Authority, Healthwatch, ICB **Third line** Quality Accounts, CQC rating of Good - report referenced positive examples of patient engagement. Healthwatch reports, and joint initiatives and positive working relationship Recent external Government led review of accessibility of Trust website led to some actions which are now all complete	1. New Equality Delivery System 22 in place - clarity on the ask of providers versus that of Places. Clarity being sought with NHS England and Place lead 2. Review of translation services contract required following patient feedback. Not clear if meeting KPIs.Review with procurement and bridging contract in place to continue service provision whilst review completed 3. Vacancy in Patient Experience post but filled in interim	Need systematic way of capturing robust assessment of the duty to involve, support for colleagues, including signposting to existing networks through ICB engagement leads and reportiong on patient and public engagement and its link to equality.	3x4 = 12	3x2= 6	1x4 = 4

Actions	**Timescales**	**Lead**
1. Procure new contract for translation services 2. Recruit to Head of Patient Experience 3. Develop database of patient and public involvement activity across the Trust	~~March September 2024~~ March 2025 ~~July 2024~~ March 2025 ~~July 2024~~ March 2025	Head of Procurement Chief Nurse Interim Head of Patient Experience

Links to risk register:
No risks on the high level risk register

BOARD ASSURANCE FRAMEWORK
OCTOBER 2024
KEEPING THE BASE SAFE - BEST QUALITY AND SAFETY OF CARE

TRUST GOAL: 2 KEEPING THE BASE SAFE BEST QUALITY AND SAFETY OF CARE												
Ref	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING OCTOBER 2024 Risk category: Regulation Risk appetite: Moderate**		
								Initial	**Current**	**Target**
06/19	Quality Committee	Chief Nurse/ Executive Medical Director	**Risk** Risk that patients do not receive high quality, safe care due to poor compliance with internally and externally set standards on quality and safety resulting in patient harm or poor patient experience. **Impact** - Quality and safety of patient care and Trust's ability to deliver some services. - Enforcement notices with regulators - Ability to deliver national targets and CQUINS. - Increased risk of litigation and negative publicity. - Poor staff morale	• Quality governance arrangements monitor quality and safety in line with our governance structure approved by the Board of Directors. • Quality and Safety strategy in place and approved by Quality Committee. Divisional reports quarterly to Quality Committee provides oversight of divisional management of quality and safety. • Quality Committee scrutinises quality priorities with specific KPIs in place, and the Maternity Transformation Plan • Serious incident (SI) investigation process currently transferring to the new Patient Safety Incident Investigation (PSII) under the new Patient Safety Incident Response Framework (PSIRF) identifies recommendations to improve care with strong governance in place and process in place to address any immediate learning. • Clinical Effectiveness and Audit Group (CEAG) reviews assurance on guidance and national audits. • Clinical Outcomes Group monitors workstreams for patient safety and quality, reporting into Quality Committee. • Risk management strategy revised and refreshed, strengthened risk management arrangements at divisional level. • Patient Safety Incident Response Framework (PSIRF) and new investigation model that aligns with PSIRF framework being tested, with aligned and approved Incident Reporting Policy commenced and being embedded. • Board approved Infection Prevention Control (IPC) Board Assurance Framework (BAF) aligned with NHS England evidence-based framework •Compliance register refresh and scrutiny by Compliance Group • Focused Journey to Outstanding (J2O) programme currently being reviewed to align with CQC single assessment framework. • Ward assurance visits programme - clinical area quality dashboard reviewed at at Nursing and Midwifery Workforce meeting. Process in place for reviewing quality metrics at ward and department level, reviewed and aligned to CQC key lines of enquiry. • Care of the Acutely Ill Patient programme in place to improve mortality outcomes. • Nursing and Midwifery Strategy "Nursing Ambitions"- enhanced quality dashboard monitored through nursing workforce meeting. • Children and Young Peoples Improvement Plan and Childrens Board has been established. • Learning from deaths programme and medical examiners office - processes in place to flag concerns and issues for further investigation. • Freedom to Speak Up process to support a culture for raising any safety concerns. • Participation in the national GIRFT Programme and national elective recovery programme.	First line Assessment of compliance with NICE guidance with increased oversight at CEAG. Performance against safety must dos reviewed at ward / matron level. HSMR & SHMI. Consistent mandatory and essential training compliance. Improved real time assurance on impact of safety staffing and quality - Nursing Midwifery Workforce Group Second line Clinical audit plan reviewed with increased oversight at CEAG. Sub-groups report into Quality Committee as per governance arrangements and workplan. KPIs in Integrated Performance Report, PSQB reports to Quality Committee. 6 July 2023, Board report on Infection Control and progress with IPC BAF recommendations. June 2023 signifcant assurance opinion on IPC BAF following internal audit review, Board approved Risk Management Strategy September 2023 Monthly Quality report to Quality Committee which includes update on Serious Investigations (SI) progress soon to be Patient Safety Incident Investigation (PSII) and a lessons learnt section. Reporting arrangements for Divisional PSQB's into Quality Committee agreed. Safer Staffing Hard Truths report to Board 10.11.22., 6.7.23, 11.1.24, 4.7.24. Maternity Services report to Quality Commitee monthly and Board (May, July, September 2024) Complaints performance improved allowing time to focus on learning from complaints, with themes and trends identified and linked to Quality Priorities 2024/25 Ward to Board internal audit significant assurance opinion reviewed by Quality Committee (May 2023). 7.9.23. Board development session quality and safety and PSIRF Freedom to Speak process reporting into Workforce / Quality Committees and Board. Risk management deep dive to Audit & Risk Committee 22.10.24. Third line CQC maternity inspection report August 2023 - retained overall good rating. CQC rating of Good, regional Ockenden Assurance Visit (28.6.22.) CQC engagement visit to HRI ED and Maternity Services positive feedback Aug 2024 Maternity Incentive Scheme - Inpatient, Children's and Young Peoples survey and urgent care survey 2023. Quality Internal audit report on quality governance CH 07/24 Account reviewed by stakeholder bodies for 2023/24 with positive feedback . Independent assurance on clinical audit strategy. Feedback through ongoing relationship with arms length regulatory bodies. CQC - Undertaken discharge review and Surgical Services visits. Independent Service Reviews (ISR) and accreditations. Health Services Investigation Branch reports and on site visits	• Recruiting to vacancies in revised quality and safety team structure Action: Complete recruitment March 2025 Lead: Deputy Chief Nurse/ Director of Corporate Affairs Variability in quality of divsional risk registers and understanding of their roles in risk management **Action:** Risk register training for divisional staff to support improved use of risk register to accurately identify risks to quality and safety of care Lead: Deputy Chief Nurse Timescale: ~~March~~ November 2024 Ability to triangulate data to identify themes, trends and early warning signs of quality and safety issues **Action:** Developing phased project implementation plan for new risk management software with transition to new system by February 2025 Deputy Chief Nurse Quality Improvement (QI) methodology not embedded or consistent Action: Recruiting for QI lead and develop QI training package March 2025 Lead: Deputy Chief Nurse	Establishment of Same Day Emergency Care (SDECs) will deteriorate the statistical calculations associated with HSMR and SHMI for up to 2 years. **Action:** Clinical Outcomes Group monitoring impact,seek assurance that quality and safety are maintained - ongoing to March 2026. Implementation of recommendations from internal audit review of risk management processes Lead: Chief Nurse, Director of Corporate Affairs Timescale: November 2024 Integrated Provision in the community: relative immaturity of Place-based quality and safety governance and assurance and regulatory/ statutory provider framework for integrated care. Continue to develop Place based governance infrastructure Lead: Director of Operations Community.	3x5 = 15	3x5= 15 =	2x5 = 10

Action	**Timescales**	**Lead**
Recruitment to revised quality and safety team structure	~~March 2024~~ March 2025	Deputy Chief Nurse
Risk register training for divisional staff	~~March~~ November 2024	Chief Nurse
Risk management software phased project plan developed and delivered	February 2025	Deputy Chief Nurse
Clinical Outcomes Group monitoring of mortality data	Ongoing to June 2026	Medical Director
QI recruitment and development of training package	March 2025	Deputy Chief Nurse

Links to risk register:
Also see BAF risk re clinical strategy 1/20, 10a/19 and 10b/19 relating to staffing
8528 ED operational performance
6079 follow up out patient appointments

TRUST GOAL: 2 KEEPING THE BASE SAFE BEST QUALITY AND SAFETY OF CARE

Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING OCTOBER 2024 category: Regulation Risk appetite: Moderate**
04/20 July 2020	Quality Committee	Chief Nurse	Risk of not maintaining the Trust CQC overall rating of good and increasing the number of services achieving an outstanding rating as assessed by the new CQC single assessment framework and potential for ratings to be changed by CQC based on other intelligence or data from CQC portal outside of on site inspection of services, due to failure to comply with quality statements resulting in a reduction of quality of services to patients and an impact on reputation See BAF risk 6/19 - quality of care and poor compliance with standards	CQC Group meets bi-monthly, oversight of organisational compliance against CQC single assessment framework (SAF) quality standards and reports to Quality Committee. Group raises awareness of single assessment framework, sharing updates re inspection programmes and intelligence, themes and trends from CQCinspection reports elsewhere. CQC workshops in alternate months to support operational divisional leads with understanding and readinessof evidence for CQC inspection. Childrens and Young Peoples 2018 actions monitored in FSS division via transformation plan Regular engagement meetings with CQC and on site focus visits taking place, October 2024 call with Chief Executive. Self assessment / ward accrediation process for internal assessment against CQC standards (Journey to Outstanding) reviewed and updated, plan for this to be piloted and being rolled out. Option for Journey to Outstanding focused visit as required. Dedicated CQC lead who attends the CQC Regulatory Advisory Group (national) CQC action plan following CQC maternity inspection largely delivered, monitored by CQC Group for Trust oversight, with local oversight by team Independent Well-led Governance development review completed. CQC intranet resource for staff with information on CQC reports, standards, self assessment documentation. CQC Housekeeping Evidence List rolled out to Divsions June 2024, ongoing support and monitoring with divisional staff to complete evidence. Generic presentation about CQC to support divisions with CQC readiness. Board paper cover sheet confirms relevant CQC regulation for subject of paper to raise awareness of how Board discussions align with regulations.	**First Line:** Reports to CQC Group from divisions with increased scrutiny Journey to Outstanding results and action plan and findings shared with wards and presented to CQC Group. **Second Line:** Quality Summit / Board Development Session (Well-led) CQC maternity inspection action plan progress reports to Quality Committee Quality Committee reports from CQC Group and as part of Bi monthly quality report Divisional review of must do and should do actions from 2018 CQC report complete with closure statements presented to WEB and July 2024 Quality Committee Quality Committee highlight report to each Board WEB report on MD/SD actions closed May 2024 **Third Line:** ED and maternity visits August 2024 - maternity updates on actions presented to CQC amd assured re: completion of must do maternity actions. Formal engagement meetings with CQC and rolling programme of on site visits. Current CQC rating of "good" including well-led governance - maternity services rated as good overall in CQC maternity inspection report August 2023 External Speaker attended May WEB to give an overview of the new CQC Single Assessment Framework May 2024	New inspection frameworks for acute and community services published October 2023. Report to Board planned 2025 Board Level Well-Led preparation workshops to commence once intelligence from published inspection reports shared . Working up pilot for ward accreditations process Maternity staffing position remains national issue - see BAF risk **6/23** Maternity bereavement suite in planning stage, lead: Director of Midwifery and Women's Servicesin line with reconfiguration plans. Update intranet CQC resource on single assessment framework. Lead: Senior Compliance Manager TImeframe: December 2024	Ongoing work to seek assurance from Medical Divsion re: CQC readiness. Lead: Head of Risk and Compliance Timescale: March 2025 Awaiting confirmation of CQC's approach to insepection and implementation of the Single Assessment Framework in line with the CQC 2021 strategy. Lead: Head of Risk and Compliance to monitor situation together with West Yorkshire network to share intelligence and learning. Extent of awareness of CQC regulations across the wider organisation not known - build awareness within ongoing CQC readiness work and self-assessments / generic presentation Lead: Senior Compliance Manager	**Initial** **4x3=12** **Current** **4x3=12** **Target** **3x2=6**

Action	**Timescales**	**Lead**
Ongoing support with Divisional senior leadership team colleagues to ensure CQC housekeeping evidence is in place - full completion across whole organisation by June 2025	June 2025	Chief Nurse
Development of input to PLACE level framework for system reviews with partners, (e.g SEND inspection)	~~March 2024~~ March 2025	Chief Nurse
Assessment of compliance against newly published inspection framwork for Acute Hospitals and for Community Services to be undertaken and report to Board -	~~January 2024~~ ~~January~~ March 2025	Chief Nurse Director of Corporate Affairs

Links to risk register:
None

BOARD ASSURANCE FRAMEWORK
OCTOBER 2024
KEEPING THE BASE SAFE - BEST QUALITY AND SAFETY OF CARE

TRUST GOAL: 2 KEEPING THE BASE SAFE BEST QUALITY AND SAFETY OF CARE											
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING OCTOBER 2024 Risk appetite: Low (Ham and Safety)**		
								Initial	**Current**	**Target**
1/23 June 2023	Finance and Performance Committee	Chief Operating Officer	Risk that continued high acute demand, high patient acuity and shortfall in community provision leads to the requirement for additional beds over and above planned levels. This impacts on Urgent and Emergency quality of care, performance targets, staffing and financial pressures.	Well Organised Ward (WOW) programme and toolkit with four "must dos" to ensure consistency of fundamental actions at ward level by clincial teams. The Urgent and Emergency Care Delivery group (UECDG) is the overall assurance meeting for the delivery of Urgent and Emergency Care and reports to the Finance and Performance Committee and the Trust's Transformation Programme Board. It meets monthly to strategically review the performance of UEC delivery through the data dashboard and the improvement groups. The UECDG has two focused Improvement Groups: Same Day Emergency Care (SDEC) and Length of Stay (LOS). The Improvement Groups are supported by project individual Task and Finish groups, which provide monthly data-led updates into the appropriate Improvement Group for appropriate discussion, challenge and steer. The Improvement Groups report assurance of the delivery of UEC into the UECDG. 'Go see's' to Barsnley regarding learning from a system with lowest proportion of over 7 day patients. Learning wrapped in to the UEC imporvement programme and additional actions such as 'Long stay weekly reviews' with senior clinical teams implemented. Working with partners in Calderdale and Kirklees to agree target operating models for integrated community urgent and intermediate health and care models of care (with interfaces to single points of access and neighbourhood teams). Target operating models to frame effective use of business as usual and transformation based monies aligned with Place and wider system objectives. Agreement in principle with Calderdale partners on target operating model, gap analysis against and use of recurrent and non-recurrent funding to support delivery against that gap. Sept 23 - Agreement in place to use allocated funding for discharge to enhance reablement which will support improved discharge of cohorts of patients on the transfer of care (TOC) list. Recruitment and roll out underway. Joint community dashboard developed along with system partners and enables focus through system silver escalation meetings and to support focused action to enable sufficient capacity. Dashboard now in use through system silver meetings and so embedding in to BAU processes is underway. Implementation of Integrated flow hub from start of October at HRI. Encompassing extended space for Medical Same Day Emergenyc Care (SDEC), Frailty SDEC, Discharge Lounge, Digital command centre and central area for discharge planning.	**First Line** Length of stay improvement group in place meeting monthly. Separate working groups in place with clear leads that report in to the improvement group. Same Day Emergency Care (SDEC) improvement group in place , which through september and october are being supported by the external CLEAR project team. Seperate working groups with clear leads that report in to the improvement group. ED improvement workstream led by ED directorate Senior Management Team which also reports to UECDG. **Second Line** Urgent and Emergency Care delivery group chaired by COO, meeting monthly, improvement workstreams report in to U and E CDG, against identified KPI's. U and E CDG reports in to Finance and Performance committee which reports in to Trust Board. Focus through Turnaround Executive on the financial savings linked to reduction in LOS and reduced bed base. **Third Line** NHS England (NHS E) monitoring and production of reports linked to Emergency Department and bed occupancy. Monthly meetings with COO and NHSE. Calderdale and Huddersfield U and E Care Board meets monthly with community teams, ICB and Local authority representation. CHFT UECDG reports updates on workstreams in to this.	Community provision and commissioning models for that provision . **Action:** Ongoing discsussion with Calderdale and Kirklees partners Lead: Director of Operations Community Michael Folan, Deputy Chief Executive, Chief Operating Officer Transfer of care list for Kirklees and Calderdale running at high levels, 100-130. HIgher volume of patients requiring support on discarge and community provision not able to meet demand. Partner discussions continue which will form part of the planning discussions 2024/25 Lead: Director of Operations Community Michael Folan, Deputy Chief Executive, Chief Operating Officer Continued embedding of WOW, SDEC improvement, Integrated flow hub, learning from Barnsley 'Go See'. Lead: Director of Operations Resilience and Flow Team (RAFT), Chief Operating Officer	Absence of agreement in principle with Kirklees partners on target operating model to support increased discharge of patients on Transfer of Care (TOC) list, gap analysis against and use of recurrent and non-recurrent funding to support delivery against that gap analysis. Lack of assurance re capacity and provision of social care. Discharge run rate from the TOC list remains insufficient to reduce and maintain at a lower level, the overall number. This continues to form part of system discussions 2024/25 regarding the operational, performance and finance impact. Lead: Chief Operating Officer, Deputy Chief Executive, Director of Finance Ongoing system-wide discussions regarding programme of work focused on Home First and move away from discharge to assess beds. CHFT continues to implement on Calderdale footprint and in active dicsussions with Kirklees partners to move to an agreed model that would impact on reducing TOC list. Lead: Chief Operating Officer, Deputy Chief Executive, Director of Finance	4 x 5 = 20	4 x 5= 20	4x3=12

Action:	**Timescales**	**Lead**
Use of allocated 'pot 2' funding to enhance reablement for Calderdale. Roll out of programme in alignment with recruitment	~~Ongoing to March 24~~ Ongoing through 2024/25	Chief Operating Officer, Deputy Chief Executive
System wide discussions re Home First for Kirklees.	~~31 March 2024~~ Ongoing	
Planning discussions with a focus on agreement with Calderdale and Kirklees regarding capacity to support reduction in TOC list	~~30 April 2024~~ Ongoing	
Continued shift to single point of access and flexibility accross community provision in Calderdale, to enable reduction in post discharge ready date length of stay (LOS). Collection of data on benefits to support ongoing discussions re: kirklees provision	~~August 2024~~ Ongoing	
Continued roll out of SDEC and LOS reduction programmes	Ongoing through 2024/25	

High level risks:
8606 unable to reduce acute in patient bed base in line with reduction plan, 8528 ED operational performance

BOARD ASSURANCE FRAMEWORK
OCTOBER 2024
KEEPING THE BASE SAFE - BEST QUALITY AND SAFETY OF CARE

TRUST GOAL: 2 KEEPING THE BASE SAFE BEST QUALITY AND SAFETY OF CARE										
Ref	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING OCTOBER 2024 Risk category: Strategic Risk appetite: Significant**		
								Initial	**Current**	**Target**
9/19	Transformation Programme Board (TPB)	Executive Director of Finance	Risk of failure to maintain current estate and equipment and develop future estates model to provide high quality patient care Impact - Poor quality of care and treatment - Poor patient experience - Poor staff experience and negative impact on their health and wellbeing - Regulatory action - Inability to implement service change - Reputational damage with stakeholders	• Governance arrangements and SLAs with CHS monitored at CHS Board, monhtly contract and performance meeting with quarterly CHS / Trust Joint Liaison Committee,overseeing estate, facilities and medical engineering risks • Governance arrangement and performance contracts with PFI monitoring at monthly Contract & Performance meetings in place. • 6 Facet estate condition survey 2023 informs estates investment plan. • Systematic review of Divisional and Corporate compliance, • Capital funding secured for Multi Storey Car Park (MSCP) CRH in 2024/25 capital plan • Medical device and maintenance policies procedures, Planned Preventive Maintenance (PPM) Programme - improvements made to PPM and end of life service contracts •Premises Assurance Model (PAMs) illustrates to patients, commissioners & regulators that robust systems are in place in regarding the premises and associated services are safe • CHS Medical Engineer in post • Categorisation / risk analysis of medical devices (high, medium, low) to prioritise maintenance • Independent audit of medical devices • Health Technical Memorandum (HTM) compliance structure in place including external Authorsing Engineers (AE's) who independantly audit both CRH and HRI Estates against statutory guidance. • Authorising engineer for fire •Concordat with West Yorkshire fire authority * Quarterly PFI Liaison Committee established Oct 2020 with PFI & CHFT to receive assurance against compliance, Head of Estates and H&S lead from CHS now attend the Risk Group to align Trust and CHS risk registers • 6 monthly insepctions of cladding at HRI with report to CHS Board and Transformation Programme Board - programme of cladding works towards the end of the reconfiguration timetable supported by the Transformation Programme Board 12 December 2023 Minor refurbishment of old A&E HRI to form Integrated Hub including environmental upgrades (flooring, decoration) and strip out of uncompliant resus area.	First line • Close management of service contracts to ensure planned maintenance activity has been performed. Audit plan in place for both PFI and CHS and regular audits completed by Service Performance. Risk register reports. Joint HTM Meetings in place with Trust,PFI & CHS. Audits of routine checks, estates * Trust Health & Safety Manager with oversight of H&S across Trust & between partners. Audit of HTM Compliance to confirm appropriate control measures in place to manage the HRI and community estate completed Q1 2023. *RAAC surveys completed and assurances provided from Leased In Properties. New A&E at HRI operational, meets the latest HTM/HBN guidance and statutory/legislative compliance. Second line Estates strategy (revised) approved at Board 2.9.21. H&S Update to Board: January 2022. Priorities shared with Service Performance to implement with CHS/PFI Board review of feasibility study for development of HRI which mitigates known estates issues (5 March 2020 private Board) Health and Safety Committee monitors medical devices training and escalates concerns to Audit & Risk Committee (Audit & Risk to approve newly developed H&S Committee TORs) Medical Engineering Committee monitors medical devices action plan, new equipment and addresses risk analysis of devices Review of PFI arrangements, via Service Performance Audits / Reports. Assurance provided by HTM Compliance reports via external Authorised Engineers inspections against HTM standards. WEB reports on medical devices July 2019 Third line CQC Compliance report.PAMS. HSE review of water management. Familiarisation visits by local operational Fire and Rescue teams. External assurance from authorising engineers for high voltage/ low voltage s+F51ystems.PLACE assessment (Patient-Led Assessments of the Care Environment) undertaken October 2022 by Quality Performance and Service Manager. Developed 6 facet survey action plan which includes a 5 year capital plan. - MSCP enabling works commenced Aug 24	• Multi Storey Car Park (MSCP) works to commence April 2025 subject to legal approvals * Approval of 5 year estates capital plan prepared on the back of the 6 facet survey action plan: Head of Estates Unable to demolish DATs building to reduce backlog maintenance as planned as required for staff offices. **Action:** Estates monitoring of situation and maintenance of statutory compliance.		4x4 = 16	5x3= 15	2x4 = 8

Action	**Timescales**	**Lead**
MSCP works to commence at CRH Approval of a 5 year estates capital plan	April 2025	Head of Estates for all

Links to risk register:
Risk 7413 - Fire compartmentation risk, HRI, 8161 CT scanning, 8562 Pathology, 7955 x ray

BOARD ASSURANCE FRAMEWORK
OCTOBER 2024
KEEPING THE BASE SAFE - BEST QUALITY AND SAFETY OF CARE

TRUST GOAL: 2 KEEPING THE BASE SAFE BEST QUALITY AND SAFETY OF CARE										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING OCTOBER 2024 Risk category: Regulation Risk appetite: Moderate**		
16/19 9/1/20	Audit and Risk Committee	Director Champion - Chief Operating Officer	Risk of not being compliant with the Health and Safety at Work Act (1974) and supporting regulations resulting in harm to staff, patients, the public, visitors, potential regulatory failure, finanical risk and reputational damage	• Board approved 5 year H&S strategy NHS Workplace Safety Standards provides framework for H&S activity, relevant policies reviewed and shared with stakeholders specific to roles and responsibilities (policy tracker written). The Strategy has been revised in early 2023 • Resilience and Safety Group approval of H&S policies • General Health and Safety Policy (updated early 2023) clearly highlights the overarching roles and responsibilities and arrangements to achieve compliance. New lone working policy, and a new security policy approved April 2024, revised Violence & Aggression Policy with behaviour support cards, revised COSHH policy • Individual health and safety policies under continuous review across 2022/23 and shared with CHFT Resilience and Safety Group Meeting - each policy with individual subject matter expert ownerships • SLA in place for CHS to provide Health and Safety Induction Training of on-site contractors and visitors • Executive Director Health and Safety Champion identified • Proactive Resilience and Safety Group Meeting firmly established. • Head of Health and Safety involved in all new sub committees to H&S committee. 8 H&S subgroups formed - maintains traction upon stakeholder responsibilities • Annual report on Health and Safety to Board which is to be a combined fire, security and health and safety risk paper and presented for 2023 submission • Health and Safety with updates to Board, Audit and Risk Committee oversight and attendance to present at Quality Committee every 6 months . • Health and Safety mandatory ESR training for staff (3 years). • Auditing and monitoring of compliance via new health and safety dashboard which is presented at each Resilience and Safety Group Meeting. Desktop meetings take place between the subject matter lead and the Head of Health and Safety across the year to ensure/seek assurance of continuous compliance. New prevention and management of violence and aggression collaborative group created, meets monthly to review trends/patterns and hot spots New prevention and management of violence and aggression people orientated risk assessments completed New prevention and management of violence and aggression building orientated risk assessments completed, and working in partnership with West Yorkshire Police designing-out crime officers New PCSO started in the Trust - May 2024	<u>First line</u> Minutes of the Resilience and Safety Group Meeting evidence good level of engagement by all partners. Review of Resilience and Safety Group Meeting by members confirmed good sharing of current information, monitoring of trends, review of policies, sharing of health and safety incidents and learning, medical devices training & monitoring, fire and security information .Policy approval bia <u>Policy approval via Resilience and Safety Group</u> <u>Second line</u> Updated COSHH policy approved by Executive Board 20.6.24. Board joint responsibility for risk understood with Weightmans Solicitor Legal update given in 2023 WEB reports on mandatory training, health and safety training compliance -Resilience and Safety Group Meeting to Audit and Risk Committee, with annual deep dive. Quality Committee engagement planned for 2022, 18 October 2022 and then every 6 months with last most recent update April 2024 Audit Yorkshire January 2021 9 January 2020 external Health and Safety review presented to Board • 2021/22 Annual Health and Safety report and action plan to Board - 12 January 2023, May 2023 • Health and Safety Strategy revised September 2022, review of 2023 - 2028 Strategy by Audit and Risk Committee 31.1.23. • Audiit & Risk Committee review of H&S annual report 2023/24 on 22 October 2024 Updates to Board on H&S 3 September 2020, 14 January 2021, 1 July 2021, 13 January 2022, 7 November 2024, <u>Third line</u> External health and safety review (Quadriga) 2019.	Development and implementation of NHS Workplace Health and Safety Standards - 90% achieved (10% left = Security compliance), Lead: Head of H&S Timescale: ~~May September~~ January 2025 Strengthening of assurance required for COSHH compliance. Cross-divisional engagement project to improve compliance started in early part of 2024. Transfer of COSHH assessments to new SYPOL page in system, meaning true number of substances now held on file. Stage 2 focus is review of COSHH assessments with department/ward leads. Implementation of the lone worker policy/risk assessment requirements.	Work continues upon the security compliance requirements, with a plan of action now written and working towards completion by January 2025. The action plan is cross referenced against NHS Violence Reduction Standards and the NHS Workplace Health and Safety Standards. 2023/24 Health and Safety annual report to Resileince and Security Group 22.10.24. then Audit & Risk Committee and Board.	**Initial**	**Current**	**Target**
								3x3 = 9	**3x2 =6 =**	**3x1 = 3**

Action	**Timeframe**	**Lead**
Development and implementation of NHS Workplace Health and Safety Standards (10% remaining to do) Formation of a cross divisional improvement plan to seek better compliance Delivery of security improvement plan Implemetation of lone worker policy/ risk assesment requirements	~~May 2024~~ ~~September 2024~~ January 2025 ~~Mid 2024~~ ~~September 2024~~ January 2025 Autumn 2023 improvement plan completed and now stage 2 (implementation process - ~~May 2024~~ Sept 2024) September 2024	Head of Health and Safety for all actions

Links to risk register:
7413 fire compartmentation

TRUST GOAL: 2 KEEPING THE BASE SAFE BEST QUALITY AND SAFETY OF CARE										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING OCTOBER 2024 Risk category: Innovation/Technology Risk appetite: Moderate**		
5/23 November 2023	Audit and Risk Committee	Chief Digital and Information Officer	Risk of an impact to the delivery of clinical or corporate services due to reduced or no digital provision resutling from a cyber attack impacting on patients via exposure of patient records, inability of workforce to access / record patient care affecting quality and safety, financial and reputational risk . (Including but not limited to Cyber vulnerability, Social engineering, malware, ransomeware, phishing emails, loss of data and DOS attacks)	Significant internal and external security technical controls including: Vulnerability Management, Threat Management, Real time threat monitoring. Dedicated Cyber team monitoring and addressing threat notifications. Incident response and recovery - Business continuity plans (BCP) for clinical and non-clinical areas in the event of no digital provision. Monitoring via national ATP (Advanced Threat Protection) service. Programme of maintenance / replacement of digital systems ensuring up to date operating systems and configurations as per NCSC guidelines. Dedicated resource through cyber security team for management of cyber security issues, inlcuding an NSCS accredited lead. Policies on the handling and storage of data, and Data Protection officer: Information Security Policy, Network Security Policy (identity and access management) & Incident reporting system Essential training for staff on information security and cyber risks via ESR & Controls on supplier systems /supplier chain security Process for testing resilience and recovery plans through Emergency Preparedness and Resilience includes loss of digital connectivity.	<u>First Line</u> Formal certification re cyber securtiy via ISO 27001 - Information Security Standard, ITSEC manager - Cyber advisor certified by NCSC, Data Protection Security Toolkit (DSPT) compliant, Cyber Essentials compliance. <u>Second Line</u> Deep dive on cyber security to Audit and Risk Committee July 2023 3 monthly updates to Executive Board on EPRR Deep dive on assurance from key suppliers in relation to cyber at Audit & Risk Committee 22 October 2024 Internal Audit report THIS 03 2024 confirmed moderate risk rating and high assurance level for Data Security Protection Toolkit. <u>Third Line</u> Compliance with NHS Digital / NHS England Data Security Protection Toolkit 2023/24. External 3rd party security testing at least annually.	The ever changing landscape/threat around cyber security Lead: Keith Redmond Ongoing	Further assurance required from partner organisation with connectivity with CHFT (techincal mitigation in place) and shared regional systems, e.g. LIMS. **Action:** Seek assurance from WYAAT / ICS / Chief Digital Information Officers partners Lead: Rob Birkett Timeframe: ~~March~~ December 2024	**Initial**	**Current**	**Target**
								5 x 3 = 15	5 x 3= 15	5 x 2 = 10

Action	**Timescale**	**Lead**
Monitoirng of cyber threat	Ongoing	Keith Redmond
Seek assurance re: cyber security from system partners	~~March~~ December 2024	Rob Birkett

Links to risk register:
None

BOARD ASSURANCE FRAMEWORK
OCTOBER 2024
INCLUSIVE WORKFORCE AND LOCAL EMPLOYMENT

TRUST GOAL: 3. INCLUSIVE WORKFORCE AND LOCAL EMPLOYMENT

Ref & Date added	OWNER Board committee	Exec Lead	RISK DESCRIPTION *(What is the risk?)*	KEY CONTROLS *(How are we managing the risk?)*	POSITIVE ASSURANCE & SOURCES *(How do we know it is working?)*	GAPS IN CONTROL *(Where are we failing to put controls / systems in place?)*	GAPS IN ASSURANCE *(Where are we failing to gain evidence about our system/ controls?)*	RATING OCTOBER 2024 Risk Category: Workforce Risk appetite: Low		
								Initial	Current	Target
10a/19	Workforce Committee	Executive Medical Director	**Risk** Risk of not being able to deliver safe and effective high quality care and experience for patients due to gaps in the clinical workforce (local and national challenges) **Impact on** - Quality and safety of patient care and Trust's ability to deliver some services. - Ability to deliver range of key performance indicators as defined by multiple organisations - Increased risk of litigation and negative publicity. - Poor staff morale - Increased sickness absence - Continued financial pressure due to use of locums / agency staff - ambition to demonstrate the Trust is an "outstanding" organisation by CQC standards	• Consultant succession planning • "Grow our own" approach - through different methodologies, alternative workforce models, allied health care professional roles, advanced practitioner. Recruit to FY3 posts,Radiology Global Fellowship posts. • Medical associate professions (such as Physician Associate) employed at CHFT to work alongside the medical workforce - approved PA governance framework defines scope of practice and governance arrangements. • CESR programme to increase Consultant workforce in appropriate specialties, Emergency Medicines scheme for oversease doctors with Royal College (Hybrid International Emergency Medicines) supports recruitment and retention. • Guardian of Safe Working ensures safe working hours for resident doctors. • E -job planning for Consultants ensures efficient use of medical staff workforce and visibility of Consultant workforce activity, E-rostering provides understanding of rota gaps and workforce, with medical e job planning and e rostering delivery team now in place. •Study leave policy approved, gives greater visibility of study leave taken and cost of study leave enabling better capacity planning and financial planning of medical staff. Electronic application process being developed to enable reporting and enhanced audit of study leave. • Recruitment and retention success, Trust reconfiguration programme positively impacts on recruitment, continued use agency and well-established bank medical staff for shortage specialties, agency spend within control totals with medical workforce bank and agency spend under review, use current staff effectively - all new employees opted in to a bank contract (unless opt out). Elective and clinical attachment placements (attracts international colleagues). • NHS Emeritus intitiative to provide additional resource of experienced recently retired senior medical staff, avoids agency charges, from December 2024 • Ongoing medical staffing recruitment. Refreshed induction for trainees including EST completion • Medical Workforce Programme monthly meeting with wider group of stakeholders - provides an overview of the programme to ensure full visibility, shared view and tracking of all medical workforce based projects, with highlight reports from workstream leads. • Recruitment through external agencies for posts difficult to recruit to • 2021 national contract for specialty doctors and specialist doctors enables appointments at specialist level with more independence. Adopted SAS (Staff and Associate Specialists) doctor charter. •Refreshed engagement approach - eg Medical Director's Office created well-being talks, SAS Forum, Junior Doctor Forum, Consultant and SAS body informal catch up events. •SAS advocate and SAS tutor roles support more effective engagement with SAS cohort. • WYAAT networking approach to pressured specialties, eg Non-Vascular Interventional Radiology, supporting MYHT with Non Surgical Oncology, LTHT (Leeds) support CHFT with Neurology • Enhanced reporting data (eg sickness absence, staff in post by grade/specialty, turnover, vacancy, retention) enabling a more robust view of medical workforce status. • Mend the Gap related work (report which identifed gender pay gap for medical and dental staff) - Deputy Medical Director lead work through Inclusion Group to understand CHFT position and agree actions as required. • Specialty rota reviews to ensure compliance with European Working Time Directive and 2016 terms and conditions and to enhance training opportunities for all grades of doctors. • GP industrial action with a range of actions may impact on workforce in terms of increased demand. • Doctors in training agreement of pay awards removes risk of industrial action.	First line Staffing levels, training & education compliance reported and review through departmental and divsional governance structures, weekly meeting with Divisional Directors and Medical Director's office (COO attending). Escalation of any short term gaps to Bronze tactical meeting/ internal command arrangements. Roll out of new approach to sharing training data across Trusts for junior doctors IPR with key KPIs including sickness levels, and agency spend, with monitoring of spend. Weekly divisional medical staffing meetings to optimise fill rates. Medical workforce steering group meetings re-launched Significant Consultant recruitment across a number of specialities, especially within ED. Second line Monthly performance meetings review workforce reports Workforce Committtee - continued reduction in medical vacancies – net recruitment gain of 43 wte medical and dental posts from June 2023 to June 2024. Turnover remains under 10% to May 2024 (6.27%) Medical Appraisal and revalidation report to Board, September 2024 Guardian of Safe Working Hours annual and quartely report to Board. Refresh of Recruitment Strategy Medical Workforce Programme Update to Workforce Committee Deep dive review of this risk at Workforce Committee 19.2.24. Third Line Internal Audit report on Consultant and SAS job planning with significant assurance. GIRFT benchmarking tool RAG rates workforce establishment position. Plans discussed with NHS England. Assurance process with CQC colleagues - feeback from relationship with arms-length bodies GMC Survey on Junior Doctor Experience. GMC Employer Liaison Meeting with Responsible Officer / Medical Director. Local Negotiating Committee (with BMA in attendance) regular engagement to raise any concerns regarding medical workforce.	Dependence on HEE allocation of trainees and expansion of opportunity for trainees to work less than full time contributes to rota gaps. Action: Challenge to HEE where appropriate on allocations, lead Medical Director - ongoing Review of job planning framework and implementation of a job planning Consistency Committee to ensure a reduction in unwarranted variation between job plans, departments and divisions. Deputy Medical Director by ~~September 2024~~ Policy to be agreed by January 2025 to impact 2026/27 job planning Action plan being created and implemented in response to GMC Training survey to support positive training experience for trainees. Lead: Director of Medical Education, November 2024 Scoping of options related to the medical workforce cip portfolio due to financial position by Deputy Medical Director by November 2024. Collaborative tender for a direct engagement service for agency medical staff, with award by December 2024 - should ensure supply of agency staff where required and optimise rates of pay. Lead: Deputy Medical Director. Developing comprehenisve clincial leadership map to support succession planning, financial oversight and equity. Deputy Medical Director by December 2024.	Short term sickness absence may be under-reported by medical staff. Divisional directors monitor and manage. E rostering to increase oversight of absences - 2025. Investigation of agency & bank spend, identification of potential for retraction by grade and service area Lead Deputy Medical Director ~~April~~ August 2024 Optimisation and embedding of PA governance framework **Action:** Refine and embed PA governance framework Deputy Medical Director January 2025 Devolved HR model for medical staff to divisions implemented with additional training sessions to support divisions with management of medical staff issues. Lead: Medical HR Manager	4 x 4= 16	4 x4=16 =	3 x 3 = 9

Action		Lead
Review of job planning framework and implementation of a job planning Consistency Committee	~~September 2024~~ Policy to be agreed by January 2025	Deputy Medical Director for all actions unless stated
Scoping of medical workforce cip	November 2024	
Optimisation and embedding of Physician Associate (PA) governance framework	~~Autumn 2024~~ January 2025	
Develop action plan in response to GMC Training Survey	~~October~~ November 2024	Deputy Director of Medical Education
Clinical leadership map to be developed	December 2024	

Links to high level risk register:
7078 medical staffing
Also see BAF risk 1/20 clinical strategy

BOARD ASSURANCE FRAMEWORK
OCTOBER 2024
INCLUSIVE WORKFORCE AND LOCAL EMPLOYMENT

TRUST GOAL: 3. INCLUSIVE WORKFORCE AND LOCAL EMPLOYMENT

Ref & Date added	OWNER Board committee	Exec Lead	RISK DESCRIPTION *(What is the risk?)*	KEY CONTROLS *(How are we managing the risk?)*	POSITIVE ASSURANCE & SOURCES *(How do we know it is working?)*	GAPS IN CONTROL *(Where are we failing to put controls / systems in place?)*	GAPS IN ASSURANCE *(Where are we failing to gain evidence about our system/ controls?)*	RATING OCTOBER 2024 Risk Category: Workforce Risk appetite: Low		
								Initial	Current	Target
10b/19 2021/22	Workforce Committee	Chief Nurse	**Risk** Risk of not being able to deliver safe and effective high quality care and experience for patients due to insufficient nursing staff caused by an inability to attract, recruit, retain, reward and develop colleagues. **Impact on** - Quality and safety of patient care and Trust's ability to deliver some services. - Ability to deliver national targets and CQUINS. - Increased risk of litigation and negative publicity. - poor staff morale - Increased sickness absence - Continued financial pressure due to use of locums / agency staff - ambition to demonstrate the Trust is an "outstanding" organisation by CQC standards	• Senior nurse staffing meetings twice a day, 7 days a week provide an on the day repsonse to staffing position, responding to areas of escalation (red flags) and agreeing actions to mitigate the curent position. This meetings also determines the agree OPEL safer staffing postion. Clear esclations to the Associate Directors of Nursing rota and approval sought for agency to mitigate unresolved staffing position. Community nursing 7 day on call arrangements to manage staffing with escalation process. Executive oversight of twice yearly nrusing establishment review in line with NQB guidance • Adherence to best practice rostering processes. Preceptorship framework ensures standardised approach for new registrants who can fill shifts as registered nurse to support acheivement of workforce models and retention. OPEL safer staffing actions cards. •Internal pay enhancements profroma developed to support response to workforce pressures • Strengthened escalation and reporting arrangements for quality and safety (short term and medium/long term), including enhanced dashboard which provides clear visibility on workforce and impacts on patient experience, quality and safety, •Local Nursing and Midwifery retention strategy developed in line with national recommendations and high impact actions initiated, approved November 2022. • Apprenticeship Strategy in place to support career pathways into nursing, AHPS • Utilisation of bank and agency staff in place, managed and escalated through a Standard Operating Procedure. • E-roster system in place and linked Safer Care IT system being used to match staffing levels to patient acuity. • Role of the Clinical Site Matron and responsiblity for tactical command • Journey to Outstanding (J2O) processs, reviewers provided with information on staffing levels, eg ward information on vacancies and fill rates re; falls, pressure ulcers and friends and family test which will include an assessment of staffing levels. People Strategy in place to support colleague health and well-being in line with national People Plan priorities • Quality and Safety oversight meetings in place for clinical areas where concerns exist on nurse sensitive indicators. • Safe staffing information presented to the Workforce and Quality Committee, • Nursing and Midwifery, AHP Workforce Steering Group, meet monthly with an overview of recruitment and retention strategies supported by Business Intelligence dashboard identifying progress and hotspots for consideration. EQIA change process considers staffing position to avoid negative impact for staff and patients • Safe, Sustainable and Productive Staffing meeting meets monthly which focus on the quality metrics associated with the staffing postion (Enhanced Dashboard Metric) Launch of the nursing and midwifery 5 year ambitions May 2024	First line Twice daily staffing meetings . Monthly review of the Enhanced Dashboard Metric that tracks CHPPD/FIll Rate and a number of staff metrics to track any potential harm as a result of staffing position Business Intelligence dashbaord provides monthly review of vacancy position, identifying potential hotspots and identification of any futher actions required to respond to the staffing position. Review of workforce and quality metrics by Nursing, Midwifery and AHP Steering Group, with actions taken as needed Clinical Site Matron summary site reports which provide assurance of site staffing postion and action to respond to any concerns,. Second line Monthly performance meetings (PRM) review workforce reports as well as introduction of corporate PRM (remit for educational activities) Workforce Commitee receives updates on recruitment and retention issues for both oversight and scrutiny Twice yearly report to Workforce Committee, Quality Committee and Board of Directors on safer staffing for both oversight and scrutiny and assurance (January and July). Annual and bi-annual safer staffing reviews of Nursing and Midwifery staffing levels provides assurances of the current workforce models or provides a rationale/evidence base for change. This approch is reflective of best practice in adopting triangulation of safer staffing metrics. 12 June 2024 Workforce Committee, 2 July 2024 Board of Directors Nursing and quality KPIs embedded in Integrated Performance Report. J20 reports presented to divsional PSQB provide opportunity for staff to feedback concerns re: staffing position to the division Workforce Committee undertakes deep dive of this identified risk to confirm key controls are clearly identifeid and assurances are robust and comprehensive - 12 June 2024 Third Line Vacancy information reported into NHSE. Assurance process with CQC colleagues - feedback from relationship wth arms-length bodies. Preceptorship framework approved by NHS England for newly registered nursing (December 2023) - achievement of quality mark Achievement of NHS Pastoral Quality Care Award for nursing staff.	1. At periods of operational pressure, insufficent workforce availability to meet demand above core bed base and in community services. **Action:** Approval to recruit to 2 clinical areas above bed base which has a positive impact on bank and agency spend. Tier 1 agency retraction plan (June 2024 led by divisional ADNs) Controlled use of bank and agency staff (as per retraction plan) and derogated staffing models in place as per OPEL action staffing cards. 2. Unable to control use of extra capacity wards Approval to recruit to 2 clinical areas above bed base which has a positive impact on bank and agency spend. **Action:** Engagement in length of stay improvement work and nursing representative at tactical meetings to manage staffing position Lead: Associate Director of Nursing Resilience, Acute Flow and Transformation Directorate Ongoing Lower number of pre reg nursing students signing up for Degree courses **Action:** Developing 5 year workforce plan with WOD and HEI to describe pathways and entry routes. Timescale: March 2025 Lead: ADN Corporate Nursing	Need for discussion on skill mix issues created by a combined effect of high proportion of new graduate nursing workforce and internationally educated nurses Action: Learning needs analysis and training and education delivery plan by March 2025 Lead: ADN Corporate Nursing Quality Assurance process revised and relaunched need to ensure ongoing suppirt and monitoring to ensure that this is embedded Lead: Deputy Chief Nurse Timescale: Jan 25	4x4 = 16	4x3 = 12	3x3 = 9

Action	Timescales	Lead
Length of stay improvement work and invovlement in tactical meetings re staffing	Ongoing	Associate Director of Nursing, Resilience, Acute Flow and Transformation
Learning needs analysis and training and education delivery plan (rolling programme)	March 2025	ADN Corporate Nursing

Links to risk register:
None.

BOARD ASSURANCE FRAMEWORK
OCTOBER 2024
INCLUSIVE WORKFORCE AND LOCAL EMPLOYMENT

TRUST GOAL: 3. INCLUSIVE WORKFORCE AND LOCAL EMPLOYMENT

Ref & Date added	OWNER Board committee	Exec Lead	RISK DESCRIPTION *(What is the risk?)*	KEY CONTROLS *(How are we managing the risk?)*	POSITIVE ASSURANCE & SOURCES *(How do we know it is working?)*	GAPS IN CONTROL *(Where are we failing to put controls / systems in place?)*	GAPS IN ASSURANCE *(Where are we failing to gain evidence about our system/ controls?)*	RATING OCTOBER 2024 Risk Category: Workforce Risk appetite: Low		
								Initial	Current	Target
6/23 January 2024	Workforce Committee	Chief Nurse	**Risk** Risk of not being able to deliver safe and effective high quality care and experience for patients due to insufficient midwifery staff caused by national shortage of midwives and retention of existing workforce. **Impact on** - Quality and safety of patient care and Trust's ability to deliver some services. - Ability to deliver national targets - Increased risk of litigation and negative publicity. - poor staff morale - Increased sickness absence - staff fill rates due to limited availability of agency staff - ambition to demonstrate the Trust is an "outstanding" organisation by CQC standards	• Midwifery daily oversight and staffing meetings with,maternity escalation plan to mitigate risk • Local maternity system staffing and oversight meeting daily which ensures shared approach to managing activity • BirthratePlus tool report identified required mdiwfery workforce model • BI workforce dashboard (vacancy, turnover, projections) provides a monthly review of vacancy position •Senior midwifery leadership rota provides ongoing visibility and dialogue across clinical areas, supporting staffing escalation • Adherence to best practice rostering processes. • OPEL safer staffing actions cards. • Role of the Clinical Site Matron and responsiblity for tactical command • Internal pay enhancements profroma developed to support response to workforce pressures Utilisation of bank and agency staff in place, managed and escalated through a Standard Operating Procedure. 20% bank enhancements continues for maternity workforce to encourage uptake of shifts. •LMS co-ordinated centraliesd recruitment for newly qualified midwives across the local maternity system to secure recruitment and support levellling up across Trusts • Local Midwifery retention strategy • Flexible approach to maternity staffing includes registered nurses working in maternity services • Maternity Transformation Programme Board has oversight of 3 year maternity delivery plan and associated actions to manage risk, including staffing • Apprenticeship Strategy in place to support career pathways into midwifery • E-roster system in place • Journey to Outstanding (J2O) processs, provides opportunity for staff to feedback on staffing levels. • Quality and Safety governance meetings for monitoring metrics and standard KPIs, eg 1:1 care in labour • Safe staffing information on midwifery presented to the Workforce and Quality Committee, with direct report from Director of Midwifery to Quality Committee and Trust Board • Nursing and Midwifery, AHP Workforce Steering Group, meet monthly with an overview of recruitment and retention strategies supported by Business Intelligence dashboard identifying progress and hotspots for consideration. • Safe, Sustainable and Productive Staffing meeting meets monthly which focuses upon the quality metrics associated with the staffing postion (Enhanced Dashboard Metric) • Board Non-Executive Director maternity champion Nursing, Midwifery and AHP Steering Group and Safe Sustainable Productive staffing meetings provide assurance of good roster management and achievement of associated KPIs for midwifery.	First line circa 30+ wte midwives (both newly qualififed and experienced) recruited and starting in post during Q3 2024/25 Daily staffing meetings provide an on the day repsonse to staffing position. Business Intelligence dashboard provides monthly review of vacancy position, identifying potential hotspots and identification of any futher actions required to respond to the staffing position. Clinical Site Matron summary site reports provide assurance of site staffing postion and action to respond to any concerns. Maternity and Neo-Natal Transformation Board receives workforce update bi-monthly Second line Monthly performance meetings (PRM) review workforce reports as well as introduction of corporate PRM Workforce Commitee receives updates on recruitment and retention issues for both oversight and scrutiny Quality Committee and Trust Board receives full midwifery workforce report six times a year via Maternity and Neonatal Oversight Report. Twice yearly report to Workforce Committee, Quality Committee and Board of Directors on safer staffing (11.1.24, 4.7.24),for both oversight and scrutiny and assurance (January and July). Annual and bi-annual safer staffing reviews of Nursing and Midwifery staffing levels provides assurances of the current workforce models or provides a rationale/evidence base for change. This approch is reflective of best practice in adopting triangulation of safer staffing metrics. KPIs embedded in Integrated Performance Report. Workforce Committee undertakes deep dive of this identified risk to confirm key controls are clearly identifeid and assurances are robust and comprehensive 15 steps visit by maternity Board Champion August 2024 Third Line Positive CQC engagement visit to maternity services 2024 Workforce position reported into LMS, Performance reported into NHSE. Assurance process with CQC colleagues - feedback from relationship wth arms-length bodies. Maternity CQC report from visit June 2023 confirms leaders had responsive approach for managing midwifery staffing shortages to mitigate risk. Maternity Voices partnership ensures regular patient feedabck on experience of care	National shortage of registered midwives impacting on staffing recuritment pipeline. Maternity workforce model reviweed - approval of revised model underway through divisional Trust governance processes . Lead: Director of Midwifery Timescale: 31.12.24. Refresh of Midwifery Recruitment and Retention Strategy Lead: Director of Midwifery Timescale: ~~31.7.24~~. 31.12.24.	CQC maternity report (August 2023)- requires improvement for safe domain. CQC action plan in response to safe "must do" re qualified staff for monitoring by Maternity Transformation Programme Board. Director of Midwifery Need to strengthen reporting and escalation arrangements for mdiwfery quality and safety metrics **Action:** Develop enhanced dashboard to include midwifery quality and safety metrics which provides clear visibility on workforce and impacts on patient experience, quality and safety Lead: Director of Midwifery Timescale: 31.12.24.	4x4 = 16!	4x4 = 16	3x3 = 9

Action	Timescales	Lead
Implementation of CQC must do action for maternity re staffing	See action plan	Director of Midwifery for all actions
Approval of revised maternity workforce model through divisional govenance processes.	31.12.24	
Refresh of Midwifery Recruitment and Retention Strategy	~~31.7.24~~ 31.12.24.	
Develop enhanced dashboard to include midwifery quality and safety metrics	31.12.24	

Links to risk register:
6911 midwifery workforce

BOARD ASSURANCE FRAMEWORK
OCTOBER 2024
INCLUSIVE WORKFORCE AND LOCAL EMPLOYMENT

TRUST GOAL: 3. INCLUSIVE WORKFORCE AND LOCAL EMPLOYMENT											
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING OCTOBER 2024 Risk Category: Quality, Innovation & Improvemnent Risk appetite: Low**		
								Initial	**Current**	**Target**
1/24	Workforce Committee	Executive Director of Workforce and Organisation Dewvelopment	Risk of an inability to attract and retain colleagues and increasing colleague absence due to increasing demands if the Trust does not provide its current and aspiring leaders with the right tools, skills and development opportunities to ensure they are confident and competent in providing one culture of care to their workforce. **Impact** • Ability to deliver Trust priorities and objectives, transformational change and sustainable services • Inability to attract, retain and develop colleagues. • The Trust not being seen as an employer of choice or developing the inclusivity of our workforce. • one culture of care and compassionate care is not embedded. • Low colleague engagement. • Impact on wellbeing of our colleagues and absence levels.	• People Strategy details six key areas to attract and retain workforce: Equality, Diversity and Inclusion, Health and Wellbeing, Engagement, Improvement, Talent Management and Workforce Design • CHFT Widening Participation strategy - being reviewed and will include identification of new pathways to widen access into employment with CHFT and the wider community. • Process redesign workshops undertaken in 3 areas to identify improvement opportunities to the colleague journey. • Workforce planning for 2024/25 including development of workforce planning approach with Huddersfield University. • Three active wellbeing groups, mens mental health, change society (menopause) and carers network. • A range of financial wellbeing partners with partners providing effective cost of living support including financial education resources (salary finance, credit union and wagestream). 10% of the CHFT workforce is utilising Wagestream. • Promoting the offers that are available nationally and across the place based system • Recruitment strategy embedded and forms part of People Strategy - recrutiment strategy details key themes and activities for attracting and recruiting colleagues, developing our workforce, widening participation and CHuFT to be CHFT • Programme of recruitment events • Succession planning approach • Management Fundamentals package provides practical tools, support and advice for new and existing managers to undertake their role effectively • Workforce design tool developed which guides colleagues when considering how their services is delivered and the workforce model needed, incldues a number of workforce design "must dos" .	**First Line Assurance** • Induction and Onboarding Hot House in May 2024. • KP+ workforce metrics module 'live' from February 2024 and expended in terms of metrics available to divisions. • Wellbeing Connect. • Introduction of a new people centred Employee Assistance Programme • KP+ workforce metrics module **Second Line Assurance** • Workforce Committee seeks assurance on recruitment, retention and reviews key workforce indicators • Integrated Performance report with key workforce metrics to Workforce Committee and Board each meeting **Third Line Assurance** • National staff survey • Sickness absence benchmarks favourably against WYAAT	• Comparative workforce data for the medical staff group. **Action**: a refreshed Medical e-rostering roll-out plan by 31 March 2025. • Comparative workforce data for the AHP staff group. **Action**: expanded utilisation of e-roster across all AHP teams and development of reporting capability by 31 March 2025. • Systematic/embedded inclusive recruitment processes. **Action**: Inclusive Recruitment Hot House in November 2024. • Management capability to manage wellbeing conversations. **Action**: Ensure managers access Management Fundamental tools and are putting them into practice. Communications and engagement plan will be developed and fundamentals useage will be regularly reviewed. 31 December 2024. • Areas of practice from Wellbeing Advisors outside of framework. **Action**: Education session for the Wellbeing Advisors by 31 October 2024.	• Comparative workforce data for the medical staff group. **Action**: a refreshed Medical e-rostering roll-out plan by 31 March 2025. • Comparative workforce data for the AHP staff group. **Action**: expanded utilisation of e-roster across all AHP teams and development of reporting capability by 31 March 2025. • Systematic/embedded inclusive recruitment processes. **Action**: Inclusive Recruitment Hot House in November 2024. • Management capability to manage wellbeing conversations. **Action**: Ensure managers access Management Fundamental tools and are putting them into practice. Communications and engagement plan will be developed and fundamentals useage will be regularly reviewed. 31 December 2024. • Areas of practice from Wellbeing Advisors outside of framework. **Action**: Education session for the Wellbeing Advisors by 31 October 2024.	**3x4 =12 !**	**3x4 =12**	**3x3 = 9**

Actions	**Action, Lead, Timescales**	**Lead**
• A refreshed Medical e-rostering roll-out plan.. • Expanded utilisation of e-roster across all AHP teams and development of reporting capability • Lead an Inclusive Recruitment Hot House • Ensure managers access Management Fundamental tools and are putting them into practice. Communications and engagement plan will be developed and fundamentals useage will be regularly reviewed. • Education session for the Wellbeing Advisors	31 March 2025 31 March 2025 20 November 2024 31 December 2024 31 October 2024	Medical Director Chief Nurse Assistant Director of HR (JR) Assistant Director of HR (NH) Assistant Director of HR (NH)

BOARD ASSURANCE FRAMEWORK
OCTOBER 2024
FINANCIAL, ECONOMIC AND ENVIRONMENTAL SUSTAINABILITY

TRUST GOAL: 4. FINANCIAL, ECONOMIC AND ENVIRONMENTAL SUSTAINABILITY										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING OCTOBER 2024 Risk Category: Financial / Assets Risk appetite: Moderate**		
								Initial	**Current**	**Target**
14/19	Finance and Performance Committee	Executive Director of Finance	**Risk** Risk that the Trust will not secure sufficient capital funding to maintain facilities over the longer term and meet safety and regulatory standards resulting in patient harm and regulatory intervention. **Impact** - financial sustainability not secured - inability to provide safe high quality services - inability to invest in patient care or estate	Capital programme managed by Capital Management Group and overseen by Business Case Approval Group, including forecasting and cash payment profiling. Prioritised capital programme agreed as part of 2024/25 financial plan. Historic delivery of the capital plan. Contingency set within annual plan Transformation Programme Board has oversight of significant strategic investment, chaired by Non-Executive Director with relevant commercial experience. Senior Finance participation in West Yorkshire Integrated Care System Capital Group which meets regularly to review capital forecasts from all partners to manage regional capital envelope and reports to ICS Finance Forum. Horizon scanning for external funding opportunities and bids for funding regularly submitted where these align with strategic objectives and managing risk.	<u>First line</u> Oversight at Finance and Performance Committee and Board Capital Management Group reports Transformation Programme Board minutes <u>Second line</u> Strategic outline case for reconfiguration approved by NHS E . <u>Third Line</u> Monthly reporting to Transformation Programme Board, Finance and Performance Committee and Board Monthly report to ICS	The long term capital spend required for HRI is in excess of internally generated capital funds. The long term plan for HRI requires additional funds from a combination of regulator approved business case, emergency capital and ICS capital. This is widely recognised and accepted by the regulators. Lead: Director of Finance **Action:** Representation to key bodies re: securing appropriate funding.	5 year capital plans submitted to ICS but longer term funding allocation process is still to be agreed by ICS partners. Lead: Director of Finance Backlog maintenance costs will remain in excess of planned capital spend. Action: Internal capital spend is prioritised on a risk basis. Price not yet agreed for CRH reconfiguration works and remains subject to change. Progressing elements where possible. Construction partner appointed. Approval of Full Business Case Lead: Chief Executive, Director of Partnerships and Transformation and Director of Finance Treasury approval of reconfiguration business case . Action: Close monitoring of Treasury plans via NHS E on behalf of Trust	4x5 20	4x3 = 12	3x4=12

Action	**Timescales**	**Lead**
Ongoing monitoring of financial position through Finance & Performance Committee and Board	Ongoing	Director of Finance

Links to risk register:
None

BOARD ASSURANCE FRAMEWORK
OCTOBER 2024
FINANCIAL, ECONOMIC AND ENVIRONMENTAL SUSTAINABILITY

TRUST GOAL: 4. FINANCIAL, ECONOMIC AND ENVIRONMENTAL SUSTAINABILITY											
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING OCTOBER 2024 Risk Category: Financial / Assets Risk appetite: Moderate**		
								Initial	**Current**	**Target**
18/19 March 2020	Finance and Performance Committee	Executive Director of Finance	Risk of failure to secure the longer term financial sustainability of the Trust (achieving financial breakeven and providing value for money) due to the size of the underlying and current financial deficit and reliance on cash suppport. Whilst the Trust is developing a business case to support financial sustainability in the medium term, this plan is subject to approval and the release of capital funds **Impact** - financial sustainability not secured - increased regulatory scrutiny - Reduced ability to meet cash requirements - inability to invest in patient care or estate	Working with partner organisations across WYAAT and ICS to identify and implement system savings and opportunities Place based recovery monitored at WY Finance and Performance Committee Budgetary control process with increased profile and ownership Turanround Executive (meets weekly, with Deputy Chief Executive Chair) monitoring cost improvement plan delivery in year and development of 5 year cost improvement plans. Accurate activity, income and expenditure forecasting Development of 25 year financial plans in support of Business Case Standing Financial Instructions set authorisation limits, Audit and Risk Committee in place to monitor key areas of compliance. Finance and Performance Committee in place to monitor performance and steer necessary actions. Transformation Programme Board to monitor delivery of key capital schemes.	<u>First line</u> Reporting on financial position, cash and capital through divisional Boards, Performance Review meetings and Exec Board monthly. Capital Management Group meeting receives capital plan update reports <u>Second line</u> Scrutiny at Finance & Performance Committee & Board. Reports on progress with strategic capital to Transformation Programme Board. Board Finance reporting.ICS submitted financial plan for 2024/25 with risks clearly articulated to NHSE. Internal audit report on efficiencies - significant assurance April 2022. WYAAT Board to Board event September 2022 re: efficiency identified themes for new WYAAT strategy. <u>Third line</u> NHSE deep dive of financial position 7.6.23. ICS Director of Finance assured re Trust financial management systems. Action plan monitored through Finance & Performance Committee.Monthly return to NHS E and ICB. CRH Outline Business Case submitted November 2021. WYAAT commissioned review for Q1 2024/25. Quarterly segmentation review with ICS Director of Finance. Action plan being presented and monitored to F&P following PWC review	Progression of transformation plans are reliant on external approval and funding Impact of national workforce shortages eg. qualified nurses and A&E doctors. Key enablers to reconfiguration, e.g. PFI commercial negotiaition and approval required to progress. **Action:** Continued liaison with regulator and HM Treasury Lead: Chief Executive Limited additional revenue costs have been included for the development of the Reconfiguration Business Case. Inability to remove beds in line with annual plan resulting in additional financial pressures (from 4/23 targets). Impact of national strikes will affect delivery of elective activity with potential loss of income. Direct costs are to be covered. Need for a medium term financial plan to return to recurrent financial balance: **Action:** Development of high level medium term financial plan to return to recurrent balance and share plan with system partners. Lead: Director of Finance Timescale: 31.3.25.	PLACE based recovery plans still to be developed. PWC review now commissioned to review other PLACE partners. **Action:** Development of plans to drive system efficiences. Lead: Partnership reps, CHFT Director of Finance, Director of Transformation and Partnerships, Chief Operating Officer Timescale: January 2025 Inability to remove beds in line with annual plan resulting in additional financial pressures. **Action:** Agree key set of metrics with system partners and monitor delivery / performance Lead: Chief Operating Officer and Director of Finance	5x5 = 25	4x4 = 16	3x4=12

Action	**Timescales**	**Lead**
System financial recovery plans to be developed	~~May 2024 01/10/2024~~ January 2025	Director of Finance
Agree key metrics with system partners and monitor performance against these	March 2025	Chief Operating Officer and Director of Finance
Development of high level medium term financial plan to return to recurrent balance and share plan with system partners	March 2025	Director of Finance

Links to high level risk register risks:
None
See BAF risks 10a/19, 10b/19 and 6/23 re workforce shortages

BOARD ASSURANCE FRAMEWORK
OCTOBER 2024
FINANCIAL, ECONOMIC AND ENVIRONMENTAL SUSTAINABILITY

TRUST GOAL: 4. FINANCIAL, ECONOMIC AND ENVIRONMENTAL SUSTAINABILITY												
Ref & Date added	**OWNER** Board committee	Exec Lead	**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING OCTOBER 2024 Risk Category: Environmental Sustainability Risk appetite: Moderate**		
								Initial	**Current**	**Target**
06/20 July 2020	Transformation Programme Board (TPB)	Executive Director of Finance	Risk of climate action failure and not improving our environmental sustainability, including not reducing carbon emissions across the organisation and not reducing the impact of climate change across Huddersfield and Calderdale due to a lack of behaviour change (eg travel, waste, procurement) and not embedding climate and environmental considerations in decision-making. Resulting in adverse effects on natural environment, public health, vulnerable patients, energy costs, waste disposal fees, non-compliance costs and also creating a negative impact on reputation.	Leadership on climate change managed by CHS's Environment Manager and sponsored by the MD of CHS who is the Trust's lead for climate and sustainability. Connected into a range of West Yorkshire sustainability groups involving the WY Combined Authority, WYAAT and local Councils. System working - MD CHS Climate Commissioner for Kirklees Climate Commission to respond to the climate emergency across Kirklees and member of Calderdale Council Climate Action Group, developing a climate action plan for Calderdale. Green Plan approved and in place, aligned with ICS Green Plan, aims to reduce the impact of travel on the environment and reduce carbon emissions Green Planning Committee (meets monthly,attended by internal and external partners) chaired by MD CHS oversees delivery of sustainbility action plan, dashboard monitors the impact of the Green Plan, reports to Transformation Programme Board on quarterly basis. Travel Plan in place to support more active travel, less car use and more car sharing, Travel Co-ordinator monitors progress. Reconfiguration design and build principles led by a sustainability design brief and overseen by Transformation Programme Board. Green solutions - eg remote temperature monitoring at parts of HRI to reduce energy cost and carbon emission. Green solutions integral to HRI A& new build, eg air source heat pump for renewable energy, permeable paving, due to achieve excellent BREEAM sustainability rating Carbon Literacy Training of CHS senior management team. 100% energy bought from green sources and installation of LED lighting to reduce energy consumption. Light swtich off campaign. Signed up to NHS pledge to reduce plastic usage in hospital . Recycling awareness raising with staff to encourage correct waste disposal Asset tracking ensures live track of equipment and reduces wastage. Procurement Strategy ensures minimum 10% wighting for socal value wighting in all prucrement Funding bids to support sustainable activities by CHS, eg Salix Low Carbon Skills Fund for the development of the Trust's Heat Decarbonisation Plan. CHS awarded £46K to implement Coolnomix energy saving project at HRI, 5 22kw EV chargers installed as part of the ED development at HRI. 4 charging points at Acre Mill upgraded to integrate with the MER user app Digital Strategy supports sustainability - eg out patient transformation such as remote out patient appointments reduces travel, patient initiated follow up.	First line Monthly monitoring of the Trusts energy consumption Quarterly Update on progress with Green Plan and Sustainability Plan, via newly developed Green dashboard of key indicators to Transformation Programme Board. 44 of 47 travel plan actions complete. Green Plan - 163 of 206 actions complete. 12 month Trust-wide environmental calendar with focus on sustainable activities. Second line 1. Monitor against our Green Plan and Sustainability Action Plan (SAP) approved at 6 May 2021 Board meeting, following reviewed by Transformation Programme Board 8 March 2021. Green Plan shared with ICS. 2. Annual Board paper on sustainability/climate change, July 2023, May 2022, Green Plan progress update to Board September 2024. 2023/24 Trust Annual Report details progress with sustanability. 3. Reports through to Green Planning Committee and JLC. Third line:Share energy data records with NHS E on new NHS energy data platform.	QIA sustainability impact assessment procedure to be reviewed along with business case applications for capital projects over £50,000 to ensure that sustainability is considered in business cases. Lead: Stuart Sugarman via Environmental Co-ordinator Timescale: ~~June~~ December 2024 Increase number Electrical Vehicle (EV) chargers at CRH: Lead: Stuart Sugarman Timescale to December 2024 Multi Storey Car Park at CRH once built		4x4 = 16	4x2 = 8	4x2=8

Action	**Date**	**Lead**
12 month environmental calendar focsuing on sustianable activities	Jan - December 2024	Stuart Sugarman
Increased number of EV chargers	Once muli-storey car park at CRH built	Stuart Sugarman
Review QIA procedure and business case applications re sustainability	December 2024	Stuart Sugarman via Environmental Co-ordinator

Links to high level risk register risks:
None

BAF Risks - Review By Committee

REF	RISK DESCRIPTION	BOARD / COMMITTEE WITH OVERSIGHT
Transforming Services & Population Outcomes		
01/19	Risk that the Trust does not secure approval of the Hospital Services Reconfiguration, Outline Business Case and Full Business Case resulting in being unable to progress changes to improve quality of care, workforce resilience and mitigate estates risks.	**Transformation Programme Board**
01/20	Risk of not delivering the ambitions in the Trust clinical strategy due to lack of collaboration due to lack of time, commitment, relationships and absence of shared vision, resulting in missed opportunities in terms of quality, efficiency, capacity, patient experience and workforce.	**Transformation Programme Board**
02/20	Risk of not securing appropriate investment to fund the Digital Strategy ambitions, ensuring infrastructure and technology is up to date and future proof due to funding not being available locally and nationally impacting on workforce efficiency and patient experience.	**Transformation Programme Board**
07/20	Risk of slow progress addressing health inequalities in the 20% of the most deprived patients in our communities, due to incomplete population health and patient ethnicity data, healthcare service delivery not matching patient needs in the most deprived areas, lack of quality priorites to advance health equity, lack of resource allocation and programmes for health prevention, ineffective partnership working and lack of sustained focus on actions to address ill health and prevention, resulting in the Trust not reducing health inequalities for our most vulnerable patients with protected characteristics.	**Trust Board of Directors**

Keeping the base safe best quality and safety of care		
06/19	Risk that patients do not receive high quality, safe care due to poor compliance with internally and externally set standards on quality and safety resulting in patient harm or poor patient experience.	**Quality Committee**
04/19	Risk that patients are not able to shape decisions about their care based on what matters to them due to lack of clear strategy and capacity for patient and service user engagement resulting in not designing services using patient recommendations	**Quality Committee**
09/19	Risk of failure to maintain current estate and equipment and to develop future estates model resulting in patient harm, poor quality patient care or regulatory enforcement.	**Transformation Programme Board**
16/19	Risk of not being compliant with the Health and Safety at Work Act and regulations due to lack of clarity on roles resulting in harm to staff, patients, the public, visitors, potential regulatory failure and reputational damage.	**Audit and Risk Committee**
04/20	Risk of not maintaining the Trust CQC overall rating of good and increasing the number of services achieving an outstanding rating as assessed by the new CQC single assessment framework and potential for ratings to be changed by CQC based on other intelligence or data from CQC portal outside of on site inspection of service due to failure to comply with quality statements resulting in a reduction of qualiy of services to patients and an impact on reputation.	**Quality Committee**
1/23	Risk re demand and capacity requiring additional beds above planned levels resulting in staffing and financial pressures.	**Finance and Performance Committee**
5/23	Risk of an impact to the delivery of clinical or corporate services due to reduced or no digital provision resutling from a cyber attack	**Audit and Risk Committee**
Inclusive workforce and local employment		
10a/19	Risk of not being able to deliver safe and effective high quality care and experience for patients due to insufficient medical staff caused by an inability to attract, recruit, retain, reward and develop colleagues.	**Workforce Committee**
10b/19	Risk of not being able to deliver safe and effective high quality care and experience for patients due to insufficient nursing staff caused by an inability to attract, recruit, retain, reward and develop colleagues.	**Workforce Committee**
6/23	Risk of not being able to deliver safe and effective high quality care and experience for patients due to insufficient midwifery staff caused by an inability to attract, recruit, retain, reward and develop colleagues.	**Workforce Committee**
1/24	Risk of an inability to attract and retain colleagues and increasing colleague absence due to increasing demands if the Trust does not provide its current and aspiring leaders with the right tools, skills and development opportunities to ensure they are confident and competent in providing one culture of care to their workforce.	**Workforce Committee**

Financial, Economic and Environmental Sustainability		
14/19	Risk that the Trust will not secure sufficient capital funding to maintain facilities over the longer term and meet safety and regulatory standards resulting in patient harm and regulatory intervention.	**Finance and Performance Committee**
18/19	Risk of failure to secure the longer term financial sustainability of the Trust (achieving financial breakeven and providing value for money) due to the size of the underlying and current financial deficit and reliance on cash support.	**Finance and Performance Committee**
06/20	Risk of climate action failure and not improving our environmental sustainability	**Transformation Programme Board**

ACRONYM LIST

BAF	Board Assurance Framework
BTHFT	Bradford Teaching Hospitals NHS Foundation Trust
CCIO	Chief Clinical Information Officer
CNIO	Chief Nursing Information Officer
CIP	Cost Improvement Plan
CQC	Care Quality Commission
CQUIN	Commissioning for Quality indictor
ASSURAN	Calderdale Huddersfield Solutions LTD
ED	Emergency Department
EPAU	Early Pregnancy Assessment Unit
EPR	Electronic Patient Record
F&P	Finance and Performance Committee
FBC	Full Business Case
FFT	Friends and Family Test
HPS	Huddersfield Pharamcy Specials
HSMR	Hospital Standardised Mortality Ratio
IBR	Integrated Board Report
ICB	Integrated Care Board
ICS	Integrated Care System
IIP	Investor In People
ITFF	Independent Trust Financing Facility
KPI	Key performance indicators
NHS E	NHS England
OBC	Outline Business Care
OSC	Overview and Scrutiny Committee
PFI	Private Finance Initiative
PMO	Programme Management Office
PPI	Patient and public involvement
ITFF	Independent Trust Financing Facility
KPI	Key performance indicators

Outline Business Care
Overview and Scrutiny Committee
Private Finance Initiative

TMA	Transitional Monitoring Approach
WEB	Weekly Executive Board
WYAAT	West Yorkshire Association of Acute Trusts
DHSC	Department of Health and Social Care
IPC	Infection Prevention Control

	New risk
	Breach of risk appetite/ risk exposure
1-6	Low risk
8-12	Medium risk
15-25	High risk

INITIALS LIST

AB	Anna Basford, Director of Transformation and Partnerships
SD	Suzanne Dunkley, Executive Director of Workforce and OD
NB	Neeraj Bhasin, Executive Medical Director
GB	Gary Boothby, Executive Director of Finance
JH	Jonny Hammond, Chief Operating Officer
RB	Rob Birkett, Chief Digital and Information Officer
AM	Andrea McCourt, Company Secretary
VP	Victoria Pickles, Director of Corporate Affairs
SS	Stuart Sugarman, Managing Director CHS
BB	Brendan Brown, Chief Executive
RA	Rob Aitchison, Deputy Chief Executive
LR	Lindsay Rudge, Chief Nurse
KA	Kirsty Archer, Deputy Director of Finance
ALL	All Board members

23. High Level Risk Register

To Note

Presented by Victoria Pickles

Date of Meeting:	Thursday 7 November 2024
Meeting:	Board of Directors
Title:	High Level Risk Report
Author:	Saj Rahman, Risk Manager
Sponsoring Director:	Victoria Pickles, Director of Corporate Affairs
Previous Forums:	Risk Group; Audit and Risk Committee
Purpose of the Report	The purpose of this report is to provide an overview of the risks scoring fifteen or more.
Key Points to Note	**Introduction** High level risks have the potential to impact on the entire organisation. Risks are identified and added to the risk register by colleagues across the organisation. Each division has a governance group in place that looks at all risks scoring 12 or above plus any new risks. Those scoring more than 15 are reviewed at the Trust-wide Risk Group and if accepted are included on the High-Level Risk Register (HLRR). Where a risk presents a risk to the delivery of the Trust Strategy, either individually or as a collective, this is included on the Board Assurance Framework. **Current risk process** The Trust continues to manage and document risks using a bespoke risk register. When a risk is identified, the risk and impact on patient care is documented and then reviewed by the relevant department and division. All the appropriate information, including all mitigating actions to ensure the safety of patients and staff is maintained, is included. The Trust uses the information to not only track potential risks, but it also helps to inform local planning, management decisions and priorities and most importantly, share learning Trust wide. The current risk register system continues to be problematic in terms of being able to triangulate data, identify themes, and track risks and ensure risk owners are aware when updates are required. The Trust will be transitioning to a new risk, incident, and performance system this year. The new system, provided by InPhase, will replace the current Datix system/Be Spoke Risk Register, and will provide a more comprehensive reporting structure to Board and its committees in line with the new Patient Safety Incident Reporting Framework. A project plan is currently underway to support the transition. The risk team continue to work with divisions to comprehensively review their risks and ensure that there is a clear programme of review, management, and mitigation in place.

Current risk profile

Currently there are 23 high scoring risks on the Trust risk register (see details at the end of the report):

- 3 are scored as very high.
- 20 are scored as high.
- All risks have been recently reviewed and the mitigations (progress) updated.
- Of the 23 risks, three have had their risk scores increased.
- Seven risks have had their risk score reduced since the last report. All the 7 risks that have had a reduction in risk score are current scoring below 15 and are no longer included in the higher-level risk report. Of the 7 risk that have had a reduction, one has been closed.

Each risk is aligned to one of the Trust's strategic objectives. The current risks scoring very high (20-25) demonstrate the following themes:

- Keeping the base safe:
  - There is a risk due the capacity available to validate outpatient appointments.
  - There is a risk of delayed diagnosis, treatment for cancer patients' due consultant who specialise in cancer on long term sickness absence and the fixed term contract of 1 another consultant having expired.

- Transforming and improving patient care
  - There is a risk of a reduction in patient experience and quality outcomes due to the operational performance within the Emergency Department (ED) and the maintenance across all Emergency Care Standards due to prolonged patient length of stay within the ED and the impact this has on patient flow out of the ED.

There are some clear themes across the risks on the HLRR:

- 9 risks related to staffing, either in relation to fragile services or recruitment challenges in certain staff groups.
- 12 risks are in relation to deliver of service, demand, and capacity, particularly in outpatient specialties and some diagnostic services.
- 1 risk in relation to potential equipment failure, due to its age.
- 1 risk in relation to Fire Hazard at Huddersfield Royal Infirmary.

Future actions

A Risk Management Audit Yorkshire Internal Audit was commissioned by the Audit and Risk Committee in early 2024 with the results published in March 2024. The outcome was limited assurance which was predominately down to the functionality of the bespoke risk register system and risk management training needs for staff. As of October 2024, 4 of the 11 recommendations have been completed with the remaining 7 due for completion once the risk registers have been migrated across to the new InPhase System.

	In July 2024 work began to transition from the Datix System to the new InPhase management system for Incidents, complaints, risk register as well as various other quality modules. The proposed date for the risk register migration and go live was November 2024 but unfortunately due to incidents and complaints taking priority due to the reliance on Datix which will be decommissioned in March 2025, the revised 'Go Live' date for the risk register module will be end of mid-March 2025. The implementation of the new risk management system InPhase will provide a significant upgrade over the current bespoke in-house system. Offering enhanced functionality, greater flexibility, and improved user experience. InPhase will deliver more intuitive dashboards, advanced reporting features, and real-time data insights, allowing for more effective monitoring and management of risks across the organisation. The new system will automatically send out notifications to risk user, as a reminder when the next review date is due. Divisional processes and governance have been strengthened relating to the management of high-level risks and we are seeing the risk register used in a much more active way. Divisional risk and challenge meetings have been developed and are proving to have strengthened oversight and management of all divisional risks, with more risks being reviewed and updated in timeframe.
EQIA – Equality Impact Assessment	Risks are assessed considering any impact on equality.
Attachments:	**Appendix 1**- All risks scoring 15 or more. **Appendix 2** - Risks that have increased in scores (High Level). **Appendix 3** - High Level Risk that have reduced in score since last report. **Appendix 4** - Risks that scored 15+ during last report but have now closed/merged.
Recommendation	The Board is asked to **CONSIDER** and discuss risks scoring 15 or more report and **NOTE** the ongoing work to strengthen the management of risks.

Appendix 1 – All Risk scoring 15 or more.

Risk Level	Risk No	Division	Directorate	Department	Objective	Risk Summary	Current Risk Score
Very High	8528	Medical	Emergency Care	Accident and emergency HRI/CRH	Transformation and improving patient care	There is a risk of a reduction in patient experience and quality outcomes due to the operational performance within the Emergency Department (ED) and the maintenance across all Emergency Care Standards due to prolonged patient length of stay within the ED and the impact this has on ED flow. Resulting in poor patient experience, reduction in quality measures and increased length of stays in the ED departments.	20 4 x 5.
Very High	8669	Surgery & Anaesthetics	Head and Neck	Ear, Nose and Throat	Keeping the base safe	There is a risk of delayed diagnosis, treatment for cancer patients' due consultant who specialise in cancer on long term sickness absence and the fixed term contract of 1 another consultant having expired.	20 4 x 5
Very High	8324	Corporate	Planned Access and Data Quality	RTT Validation	Keeping the base safe	There is a risk of high volume of outstanding clinical outpatient validation and prioritisation on Mpage system.	20 4 x 5
High	8562	Family & Specialist Services	Pathology	Blood sciences	Keeping the base safe	There is a risk of Enforced removal of Siemens Track within the Biochemistry Department.	16 4 x 4
High	8161	Family & Specialist Services	Radiology	CT	Keeping the base safe	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 Calderdale Royal Hospital due to the age of the equipment.	16 4 x 4
High	8098	Surgery & Anaesthetics	Head and Neck	Ophthalmology	Keeping the base safe	There is a risk of clinic cancelation, delays and reduced capacity in all areas of ophthalmology due to macular injection staff shortages.	16 4 x 4
High	8609	Surgery & Anaesthetics	Head and Neck	Ear, Nose and Throat	Keeping the base safe	There is a risk of prolonged waiting times for patients within ENT due to multifactorial elements including an increase in referrals over the last 6 months, and inability to return to pre-covid levels of activity.	16 4 x 4

High	8219	Family & Specialist Services	Pathology	Blood sciences	Keeping the base safe	There is a risk of loss of Cross-Site Biochemistry Service (24/7) due to the reduction in qualified BMS, inability to recruit and reduced ability to retain qualified staff. (Single qualified BMS staff covers both CRH and HRI out of core hours)	16 4 x 4
High	8009	Medical	Integrated Medical Specialties	All Departments	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 integrated medical specialities.	16 4 x 4
High	7955	Family & Specialist Services	Radiology	Main X-Ray	Keeping the base safe	There is a risk of being unable to deliver plain film services from three plain film rooms at Calderdale Royal Hospital (CRH) due to the rooms becoming obsolete.	16 4 x 4
High	6079	Family & Specialist Services	Appointment and Records	Appointments Service	Transforming and improving patient care	There is a risk of being unable to provide sufficient appointments for patients requiring Outpatients follow-up due to capacity and demand	16 4 x 4
High	8121	Family & Specialist Services	Womens service	Gynae OPD HRI/CRH	Keeping the base safe	There is a risk of being unable to provide sufficient new and follow outpatient appointments for those patients requiring review by Gynaecology team, this is due to back log and some reduced available capacity.	16 4 x 4
High	6911	Family & Specialist Services	Women's Services	All Departments	Keeping the base safe	There is a risk of not meeting current midwifery workforce models due to current vacancies and periods of increased absence (maternity / long term sickness),	16 4 x 4
High	6949	Family & Specialist Services	Pathology	Blood sciences	Keeping the base safe	There is a risk of not being able to deliver a two site Blood Transfusion / Haematology service due to being unable to recruit and retain enough Health care professionals in Biomedical Scientists.	16 4 x 4
High	8606	Medical	All Departments Medical	All Departments	Financial sustainability	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 additional cost	16 4 x 4

High	8529	Corporate	Workforce & Organisational Development	Resourcing / Recruitment	Keeping the base safe	There is a risk of care being compromised in the children services due to insufficient Nurses, Midwives, and Healthcare support workers available to deliver safe and compassionate care.	16 4 x 4
High	8736	Surgery & Anaesthetics	Head & Nick	Ophthalmology	Keeping the base safe	There is a risk of clinic cancelation, delays, and reduced capacity in all areas of ophthalmology due to macular injection staff shortages.	16 4 x 4
High	7413	Corporate	Finance and Procurement	Corporate Finance	Keeping the base safe	There is a risk of fire spread at Huddersfield Royal Infirmary due to insufficient fire compartmentation in areas which could result in fire spread / damage to buildings / equipment and harm to staff, patients, and visitors.	15 5 x 3
High	8398	Surgery & Anaesthetics	General and Specialist Surgical Services	Colorectal	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.	15 3 x 5
High	8700	Family & Specialist Services	Childrens services	PAOU	Keeping the base safe	There is a risk of significant staffing shortfalls on the Paediatric Assessment Unit (PAU) due to no agreed workforce model for PAU and the current workforce model encompassing both ward 3 and ward 4 where staff are required to work across both areas.	15 3 x 5
High	8633	Family & Specialist Services	Women's service	Maternity	Keeping the base safe	There is a risk that there is currently insufficient Consultant Clinic capacity to deliver timely Antenatal care for the local population (this was identified as a "Must Do" in a recent CQC inspections report for Maternity services). This may result in delays to care, late detection of anomalies, budgetary pressures, and a poor patient experience.	15 3 x 5.
High	8657	Family & Specialist Services	Women's service	Maternity	Keeping the base safe	There is risk of poor outcomes for Obstetrics and Gynae patients due to the current Consultant Medical Workforce being on call or COTW for both large specialities at the same time.	15 3 x 5.

High	8712	Family & Specialist Services	Pharmacy	Pharmacy	Keeping the base safe	There is a risk that patients will receive incorrect medication or miss doses of critical medication due to a lack of pharmacy support to the emergency department (ED).	15 3 x 5.

Appendix 2 – Risks that have increased in score (High Level – also included in Appendix 1)

Risk Level	Risk No	Division	Directorate	Department	Objective	Risk Summary	Risk Score
High	8736	Family & Specialist Services	Pathology	Microbiology	Keeping the base safe	There is a risk of Reduction in number of staff to deliver service with inability to recruit to vacant posts. This is due to Natural staff loss (due to planned move of service to Leeds), resulting in inability to deliver late/weekend and on-call service plus likely impact on accreditation.	15 3 x 5. (Risk increased from risk score of 12).
High	8529	Medical	Emergency Care	Accident & Emergency CRH/HRI	Transforming and improving patient care	There is a risk of insufficient paediatric nurses to care for paediatric patients in the Emergency Department at HRI in line with current RCPCH guidance (2 per 24 hours 7/7) due paediatric workforce model gaps that could result in poor paediatric patient experience and inability to provide timely assessment and interventions.	15 3 x 5. (Risk increased from risk score of 12).
High	8098	Surgery & Anaesthetics	Head and Neck	Ear, Nose and Throat	Keeping the base safe	There is a risk of clinic cancelation, delays and reduced capacity in all areas of ophthalmology due to macular injection staff shortages resulting in permanent sight loss for patients, cancellations of non-emergency capacity and increased holding lists.	16 4 x 4. (Risk increased from risk score of 12).

Appendix 3 – High Level Risks that have reduced in score since last report.

Risk Level	Risk No	Division	Directorate	Department	Objective	Risk Summary	Current Risk Score
Moderate	8729	Medical	Medical Specialities	Respiratory	Keeping the base safe	There is a risk of serious harm to patients requiring chest drains due to an identified training gap among middle grade medical staff in the trust and them being unable to safely and effectively complete chest drain insertions.	Risk reduced from a risk score 15 to 9
Moderate	8509	Surgery & Anaesthetics	Head and Neck	Ophthalmology	Keeping the base safe	"There is a risk of significant harm due to insufficient glaucoma appointments available to cope with demand due to increasing patient numbers and inability to recruit substantive consultant.	Risk reduced from risk score of 15 to 12.
Moderate	8315	Surgery & Anaesthetics	Head and Neck	Ophthalmology	Keeping the base safe	There is a risk of significant of increasing waiting lists and delays to new and follow up appointments due to not having enough substantive Paediatric Consultants. This could result in catastrophic or significant harm to the patient.	Risk reduced from risk score 15 to 12.

Moderate	8641	Surgery & Anaesthetics	Critical Care	Critical Care Outreach	Keeping the base safe	"There is a risk of non-compliance with national standards (GPICS) due to inadequate pharmacy staffing in CHFT's critical care units resulting in staff burnout, increase in medication errors, risk to patient safety and exposure to legal consequences or regulatory penalties.	Risk reduced from risk score 15 to 12.
Moderate	6345	Corporate	Workforce & Organisational Development	Resourcing / Recruitment	Keeping the base safe	"There is a risk of: insufficient Trust employed Nurses, and HCSW to deliver safe and compassionate care on a shift-by-shift basis, as defined by the agreed Workforce Models or Care Hours Per Patient Day (CHPPD)	Risk reduced from risk score 20 to 12.
Moderate	8508	Surgery & Anaesthetics	Head and Neck	Ophthalmology	Keeping the base safe	"There is a live current risk to CHFT being unable to provide a Consultant Glaucoma Service due to no Consultant in post at CHFT. Resulting in not providing the required supervision and training to specialty doctors required for the royal college of ophthalmology standards impacting standards of care, staff development, delays and clinical outcomes for patients.	Risk reduced from risk score 15 to 12.

Appendix 4 – Risks that scored 15+ during last report but have now closed/merged.

Risk Level	Risk No	Division	Directorate	Department	Objective	Risk Summary	Risk Score	Reason for Risk Closure
Low	8361	Surgery & Anaesthetics	Critical Care	Pain Clinic	Keeping the base safe	There is a risk of disruption to services in the pain clinic due to impending retirement of Band 6 CNS in January 2024, and potential retirement of Band 7 (CNS) at some point (turned 55 in October 2021) resulting in only one experienced Band 6 Clinical Nurse Specialist leaving a gap in knowledge and a risk to patient care, as there will be limited resources to review patients on the wards and nurse clinics would have to stop.	Risk reduced from risk score of 15 to 2.	Staffing level back to full establishment

24. Governance Report

a) Use of Trust Seal

b) West Yorkshire Association of Acute Trusts (WYAAT) Memo of Understanding

c) Board of Directors Workplan for 2024/2025

To Approve

Presented by Andrea McCourt

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 7 November 2024
Meeting:	Public Board of Directors
Title:	Governance Report
Author:	Andrea McCourt, Company Secretary
Sponsoring Director:	Victoria Pickles, Director of Corporate Affairs
Previous Forums:	None
Purpose of the Report	This paper presents the following governance items to the Board: a) Use of Trust Seal b) West Yorkshire Association of Acute Trusts (WYAAT) Memorandum of Understanding c) Board of Directors Workplan to 31 March 2025
Key Points to Note	**a) Use of Trust Seal** Since the last update to the Board on 7 March 2024, the Trust seal has been used on three occasions relating to: • Alterations at the Elland Loan Store • Enabling works for the Multi-Storey Car Park at Calderdale Royal Hospital • Community Diagnostic Centres lease of land and buildings Further details are provided in Appendix S2. **RECOMMENDATION:** The Board is asked to **NOTE** the use of the Trust seal from April to October 2024. **b) West Yorkshire Association of Acute Trusts (WYAAT) Memorandum of Understanding (MoU)** At the WYAAT Committee in Common meeting on 30 July 2024 the WYAAT Memorandum of Understanding was reviewed. The WYAAT MoU was originally co-produced and signed by all WYAAT Trusts in 2017. This defined the objectives, scope, and ways of working (through a Committee in Common, CIC model) for WYAAT. Further reviews and updates were approved by CIC on 30 July 2019 and 27/07/2021. Following the development of the WYAAT Strategy (supported by CIC on 30 January 2024) and a lessons learned exercise reported to WYAAT CIC on 30 April 2024, a review of the MoU was agreed by WYAAT Programme

	Executive as required. This review was undertaken by WYAAT Company Secretaries and the WYAAT Director. The revised document proposes changes to reflect current legislation and operation of WYAAT in light of the approval and publication of the WYAAT Five Year Strategy and to reflect the learning from the WYAAT aseptics programme. The document proposes the following revisions: • Made contemporaneous in language reflecting the July 2022 legislation e.g. removal of references to Sustainability and Transformation Partnerships (STPs) in favour of Integrated Care Boards (ICBs) and Integrated Care Partnerships (ICPs). • Reference to the 'WYAAT Strategy' encompassing the development of the strategy, and delivery of the associated priorities and programmes in the annual plan rather than the 'Collaborative Programme' terminology in the originally drafted document. • Updates to Code of Governance referenced in Section 4.1.4 to ensure the most contemporaneous guidance is referenced. • Clarified reporting through public boards via the Annual Report (Section 6.1.5) • Removed reference to competition and procurement compliance (section 12). Review of the updated provider licence would deem this section no longer relevant or required. • Schedule 2 – it is recommended that the assurance framework is updated to include HR Directors and Estates and Facilities Directors' Groups in the formal governance framework. • Schedule 2 (Section 6.8) provision to instigate a programme review when it progresses through a stage e.g. from business case approval to implementation, based on aseptics lessons learned review. • Schedule 5 – CIC Terms of Reference (ToRs) refined in respect of our risk management approach. • Schedule 5 – inclusion of a provision to which prevents the chairing of two collaboratives simultaneously (Section 5.4) • Schedule 5 – broaden measures to assess effectiveness in line with committee reviews in trusts / good practice (Section 5.10) • Schedule 5 – New section (Section 6) on extraordinary meetings based on the learning from the aseptics lessons learned exercise. • Schedule 6 – updated with ability to communicate notices via email (Section 9). **RECOMMENDATION:** The Board is asked to **APPROVE** the revised WYAAT MoU at Appendix S3.

	c) Board of Directors Workplan to 31 March 2025 The Board workplan provides the basis for the preparation of Board agendas for the coming year. Ad-hoc items and reports will be included on meeting agendas as necessary. The workplan to 31 March 2025 is presented for approval at Appendix S4. **RECOMMENDATION:** The Board is asked to **APPROVE** the Board workplan.
Regulation	CQC Regulation 17: Good governance
EQIA – Equality Impact Assessment	The content of this report does not adversely affect people with protected characteristics.
Recommendations	The Board is asked to **APPROVE** the: • WYAAT Memorandum of Understanding • Board Workplan to 31 March 2025 The Board is asked to **NOTE** the use of the Trust seal on three occasions as detailed.

CALDERDALE & HUDDERSFIELD NHS TRUST: REGISTER OF SEALING OR EXECUTIONS – REPORT APRIL – OCTOBER 2024

CONSECUTIVE NUMBER	DATE OF SEALING OR EXECUTION	DATE OF AUTHORITY	DESCRIPTION OF DOCUMENTS SEALED OR EXECUTED PERSON	PERSONS ATTESTING SEALING OR EXECUTION
02-24	4 July 2024	4 July 2024	License to Alter re: installation of a mezzanine area with addition of equipment racking and goods lift to the warehouse space used by the Elland Loan store. (The lease at Elland Loan store/THIS building is with CHS Ltd, with the Trust as a Guarantor).	Gary Boothby Director of Finance Lindsay Rudge Chief Nurse
03-24	17 July 2024	17 July 2024	Legal documents associated with the early enabling works for the Multi Storey Car Park (MSCP). • Letter of Indemnity • Trust Certificate • Notice of Assignment	Brendan Brown Chief Executive Gary Boothby Director of Finance
04-24	9 September 2024	9 September 2024	Community Diagnostic Centres - deed of variation of contract between CHFT and CHS Limited to 31.8.18. Operated Healthcare Facility Agreement for the construction of and provision of works and services at Trust/ Facilities Sites. Addition of leases of land and buildings for units 5 and 6b Broad Street Halifax, HX1 1UX (Broad Street lease) and Community Diagnostic Facility, National Health Innovation Campus, University of Huddersfield, Southgate (Innovation Centre lease).	Gary Boothby Director of Finance Brendan Brown Chief Executive On behalf of CHS: Stuart Baron Finance Director

YORKSHIRE ASSOCIATION OF ACUTE TRUSTS

DATE 30TH JULY 2024

1. AIREDALE NHS FOUNDATION TRUST
2. BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST
3. CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST
4. HARROGATE AND DISTRICT NHS FOUNDATION TRUST
5. LEEDS TEACHING HOSPITALS NHS TRUST
6. MID YORKSHIRE TEACHING NHS TRUST

MEMORANDUM OF UNDERSTANDING FOR WEST YORKSHIRE ASSOCIATION OF ACUTE TRUSTS

WEST YORKSHIRE ASSOCIATION OF ACUTE TRUSTS

No	Date	Version Number	Author
1	11/10/16	1-1.4	CB/RM
2	10/11/2016	V2	Co Secs
3	14/11/2016	V3.4	CB/RM/ CG
4	17/11/2016	V3.5	Co Secs
5	5/12/2016	V4	Co Secs
6	5/12/2016	V5	Co Secs
7	6/1/2017	V6	Co Secs
8	02/2017	FINAL	Boards
9	30/07/2019	CiC review	Co Sec
10	30/07/2019	CiC Approved	CiC Members
11	27/07/2021 – schedule 2 only	CiC Approved v2	CiC Members
12	30/07/24	CiC Approved (July 24)	CiC Members

Insert approval date

CONTENTS

WEST YORKSHIRE ASSOCIATION OF ACUTE TRUSTS

Date: July 2024

This Memorandum of Understanding (**MoU**) is made between:

(1) **AIREDALE NHS FOUNDATION TRUST** of Skipton Road, Keighley, West Yorkshire, BD20 6TD;

(2) **BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST** of Duckworth Lane, Bradford, BD9 6RJ;

(3) **CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST** of Acre Street, Huddersfield, HD3 3EA;

(4) **HARROGATE AND DISTRICT NHS FOUNDATION TRUST** of Lancaster Park Rd, Harrogate, North Yorkshire HG2 7SX;

(5) **LEEDS TEACHING HOSPITALS NHS TRUST** of Great George Street, Leeds, West Yorkshire, LS1 3EX;

(6) **MID YORKSHIRE TEACHING NHS TRUST** of Aberford Road, Wakefield, WF1 4DG; and

(each a "**Party**" and together the "**Parties**").

RECITALS

I. In entering into and performing their obligations under this MoU, the parties are working towards a collaborative programme incorporating corporate services, clinical support services, and clinical services including ownership and commitment to collaboration as set out in the WYAAT Five Year Strategy (2024 – 2029). In particular, this MoU is intended to support the Parties' on-going work towards the delivery of more efficient acute services for patients in the WYAAT service area.

II. The Parties together form the West Yorkshire Association of Acute Trusts ("**WYAAT**") and have agreed to collaborate to bring together NHS trusts delivering acute hospital services across the WYAAT service area in delivering region-wide efficient and sustainable healthcare for patients. WYAAT will develop and deliver a collaborative approach across acute care providers. The Parties have formed a WYAAT Committee in Common ("**WYAAT CIC**") which has the specific remit of leading the strategic development of WYAAT, setting overall ambition and direction to deliver the WYAAT Strategy and programmes and initiatives for an acute provider transformation to a more collaborative model of care for the WYAAT service area, the intention being to deliver a system model, operating as a network, that is coherent, integrated, consistent (reducing unwanted variation) and focused on quality and value for the population and patients (the "**WYAAT Strategy**").

III. This MoU is focused on the Parties' agreement to develop the detail in relation to the function and scope of the WYAAT CIC; developing the principles that will underpin collaborative working and the timetable for implementation in order to tackle a number of significant operational, clinical and financial challenges for acute services in the WYAAT service area.

OPERATIVE PROVISIONS

1. **DEFINITIONS AND INTERPRETATION**

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

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

1.2.1 a reference to a "**Party**" is a reference to the organisations party to this MoU and includes its personal representatives, successors or permitted assigns and a reference to "**Parties**" is a reference to all parties to this MoU;

1.2.2 a reference to writing or written includes faxes and e-mails.

2. PURPOSE AND EFFECT OF MOU

2.1 The Parties have agreed to work together on behalf of patients and the population to deliver the best possible experience and outcomes within the available resources for corporate and acute services across the WYAAT service area. The aim is for the Parties to organise themselves around the needs of the West Yorkshire and Harrogate population rather than planning at an individual organisational level so as to deliver more integrated, high quality cost effective care for patients as detailed in Schedule 1. The Parties wish to record the basis on which they will collaborate with each other through the WYAAT in this MoU.

2.2 This MoU sets out:

2.2.1 the key objectives for the development of WYAAT;

2.2.2 the principles of collaboration;

2.2.3 the governance structures the Parties will put in place; and

2.2.4 the respective roles and responsibilities the Parties will have during the development and delivery of the collaboration model.

2.3 The Parties agree that, notwithstanding the good faith consideration that each Party has afforded the terms set out in this MoU, save as provided in paragraph 2.4 below, this MoU shall not be legally binding.

2.4 Paragraphs 17, 19 and 20 shall come into force from the date hereof and shall give rise to legally binding commitments between the Parties.

2.5 Included as Schedules 6-8 to the MoU are agreements on the management of relationships for confidentiality (legally binding), conflicts of interest and sharing of information in line with competition law between the Parties.

3. KEY PRINCIPLES

3.1 The Parties shall undertake the development and delivery of the WYAAT Strategy in line with the Key Principles as set out in Schedule 1 (the "**Key Principles**").

3.2 The Parties acknowledge the current position with regard to the WYAAT and the contributions, financial and otherwise, already made by the Parties.

4. PRINCIPLES OF COLLABORATION

4.1 The Parties agree to adopt the following principles when carrying out the development and delivery of the WYAAT Strategy (the "**Principles of Collaboration**"):

4.1.1 address the vision. In developing WYAAT the Parties seek to establish a model of collaborative care and corporate services across a network of acute hospital trusts that are focused on the delivery of high quality, sustainable acute care for the population, enabled by integrated solutions and delivering best value for the taxpayer and operating a financially sustainable system;

4.1.2 collaborate and co-operate. Establish and adhere to the governance structure set out in this MoU to ensure that activities are delivered and actions taken as required to deliver change collectively and in partnership with each other and the wider NHS ;

4.1.3 be accountable. Take on, manage and account to each other, the wider NHS and the WYAAT service area population for performance of the respective roles and responsibilities set out in this MoU;

4.1.4 be open and transparent and act with integrity. Communicate openly with each other about major concerns, issues or opportunities relating to WYAAT and comply with the seven Principles of Public Life established by the Nolan Committee (the Nolan Principles) and the Code of Governance of NHS England (April 2024) including implementing a transparent and explicit approach to the declaration and handling of relevant and material conflicts of interests arising.

4.1.5 adhere to statutory requirements and best practice. Comply with applicable laws and standards including procurement rules, competition law, data protection and freedom of information legislation;

4.1.6 act in a timely manner. Recognise the time-critical nature of the WYAAT Collaborative Programme development and delivery and respond accordingly to requests for support;

4.1.7 manage stakeholders effectively. Ensure communication and engagement both internally and externally is clear, coherent, consistent and credible and in line with

the Parties' statutory duties, values and objectives.

4.1.8 deploy appropriate resources. Ensure sufficient and appropriately qualified resources are available and authorised to fulfil the responsibilities set out in this MoU; and

4.1.9 act in good faith to support achievement of the Key Principles and in compliance with these Principles of Collaboration.

5. GOVERNANCE

5.1 The governance structure summarised below of this MoU provides a structure for the development and delivery of the WYAAT Strategy.

5.2 The governance arrangements will be:

5.2.1 based on the principle that decisions will be taken by the relevant organisations at the most appropriate level in accordance with each organisation's internal governance arrangements (as defined by each trust's Constitution, Standing Orders, Standing Financial Instructions and Scheme of Delegation), particularly in respect of delegated authority;

5.2.2 shaped by the Parties in accordance with existing accountability arrangements, whilst recognising that different ways of working will be required to deliver the transformational ambitions of the WYAAT Collaborative Programme. The Parties intend that there should be as far as permissible a single governance structure to help oversee and deliver the WYAAT Collaborative Programme in accordance with the Key Principles; and

5.2.3 underpinned by the following principles:

i. the Parties will remain subject to the NHS Constitution, compliance with regulatory bodies and their provider licence (Code of Governance) and retain their statutory functions and their existing accountabilities for current services resources and funding flows; and

ii. clear agreements will be in place between the providers to underpin the governance arrangements.

6. ACCOUNTABILITY AND REPORTING LINES

Accountability and reporting should be undertaken at the following levels within WYAAT:

6.1 WYAAT Committee in Common ("WYAAT CIC")

The WYAAT CIC will receive reports at each meeting from the Programme Executive highlighting but not limited to:

6.1.1 progress throughout the period;

6.1.2 decisions required by the WYAAT CIC and their recommendation to respective Trust Boards for approval;

6.1.3 issues being managed;

6.1.4 issues requiring escalation to the WYAAT CIC; and

6.1.5 progress planned for the next period.

Under a standing agenda item, WYAAT CIC will agree the key communications arising from its meetings that should be relayed to the Parties' respective organisations. The minutes, and a summary report from the WYAAT Director will be circulated promptly to all WYAAT CIC Members as soon as reasonably practical for inclusion on the private agenda of each Parties' Board meeting. The WYAAT Director will provide an Annual Report summarising achievements of WYAAT for the preceding financial year which, following approval from WYAAT CIC, will be published in the public domain.

6.2 WYAAT Programme Executive

The WYAAT CIC will hold each of the Parties' Chief Executive to account for the delivery of their sponsored workstreams within the WYAAT Strategy via the WYAAT Programme Executive.

7. ROLES AND RESPONSIBILITIES

The Parties shall undertake the roles and responsibilities set out in this MoU to help develop the WYAAT Strategy in line with the Key Principles

7.1 WYAAT Committee in Common

7.1.1 The WYAAT CIC comprises senior members of the Parties and defines the strategy and holds accountability for its delivery, alongside providing overall oversight and direction to the development of WYAAT . It is chaired by existing Chairs of the Parties, on a rotational basis, as underpinned by principles of continuity and equity collectively agreed by members, for a minimum duration of six months or three meetings, whichever is the lesser.

7.1.2 The WYAAT CIC shall be managed in accordance with the governance arrangements in section 5 and the Terms of Reference in Schedule 5.

7.2 WYAAT Programme Executive

7.2.1 The WYAAT Programme Executive will provide assurance to the WYAAT CIC that the key deliverables are being met and that the development of the WYAAT Strategy is within the boundaries set by the WYAAT CIC. It will provide management at programme and workstream level.

8. DECISION MAKING

8.1 The Parties intend that WYAAT CIC Members will each operate under a common model scheme of delegation whereby each WYAAT CIC Member shall have delegated authority to make decisions on behalf of their organisation relating to:

8.1.1 matters falling under the scope of the WYAAT CIC and agreed collaborative

programme underpinned by 'case for change';

8.1.2 the devolving of the Key Principles set out in Schedule 1; and,

8.1.3 in accordance with the WYAAT Gateway Decision Making Framework set out in Schedule 4 on behalf of their respective organisations.

8.2 Each party will reflect in its Standing Orders, Standing Financial Instructions and scheme of Delegation the authority delegated to its representatives on the WYAAT CIC.

8.3 The Parties intend that WYAAT CIC Members shall report to and consult with their own respective organisations at Board level, (noting that decisions on recommendations made by the CIC will always be made by the Boards of Member Trusts) providing the governance assurance that ensures compliance with their regulatory and audit requirements, for organisational decisions relating to, and in support of, the WYAAT Key Principles and facilitating these functions in a timely manner.

9. ESCALATION

9.1 If any Party has any issues, concerns, or complaints regarding the WYAAT Strategy, or any matter in this MoU, such Party shall notify the other Parties and the Parties acknowledge and confirm that they shall then seek to resolve the issue by a process of discussion.

9.2 Subject as otherwise specifically provided for in this MoU, any dispute arising between the Parties out of or in connection with this MoU will be resolved in accordance with Schedule 3 (Dispute Resolution Procedure).

9.3 If any Party receives any formal or media enquiry, complaint, claim or threat of action from a third party (including, but not limited to, claims made by a supplier or requests for information made under the Freedom of Information Act 2000) in relation to the development of the WYAAT, the matter shall be promptly referred to the WYAAT Director in the interests of consistency, however recognising the request remains the responsibility of the receiving organisation.

10. CONFLICTS OF INTEREST

10.1 The Parties agree that they will:

10.1.1 disclose to each other the full particulars of any relevant or material conflict of interest which arises or may arise in connection with this MoU, the development of the collaboration model or the performance of activities under the WYAAT Strategy, immediately upon becoming aware of the conflict of interest whether that conflict concerns the Parties or any person employed or retained by the Parties for or in connection with the development and delivery of the WYAAT Strategy; and

10.1.2 not allow themselves to be placed in a position of conflict of interest or duty in regard to any of their rights or obligations under this MoU (without the prior consent of the other Parties) before participating in any action in respect of that matter.

10.1.3 comply with the terms of any agreed conflict of interest protocol as set out in paragraph 2.5 above.

11. FUTURE INVOLVEMENT AND ADDITION OF PARTIES

The Parties are the initial participating organisations in the development of the WYAAT Strategy but it is intended that other providers to the WYAAT service area population may also come to be partners (including for example independent sector and third sector providers). Partner organisations may where appropriate be invited to meetings of the WYAAT CIC as observers or through an additional stakeholders forum. If appropriate to achieve the key deliverables, the Parties may also agree to include additional party or parties to this MoU. If they agree on such a course the Parties will cooperate to enter into the necessary documentation.

12. REVIEW

12.1 The WYAAT CIC shall discuss and agree as a minimum:

12.1.1 the principles of collaboration;

12.1.2 the governance arrangements as set out in Section 5;

12.1.3 the scope of the WYAAT Strategy and individual workstreams;

12.1.4 the progress against the key deliverables; and

12.1.5 key decisions required in support of Schedule 4.

13. TERM AND TERMINATION

13.1 This MoU shall commence on 2 February 2017 (having been executed by all the Parties) and shall expire on termination as outlined in section 14.2 of this MoU.

13.2 This MoU may be terminated in whole by:

13.2.1 mutual agreement in writing by all of the parties

13.2.2 in accordance with Clause 15.2; or

13.2.3 in accordance with paragraph 1.5) of schedule 3.

13.3 Any Party may withdraw from this MoU giving at least six calendar months' notice in writing to the other Parties. The MoU will remain in force between the remaining parties (unless otherwise agreed in writing between all the remaining parties) and the remaining Parties will agree such amendments required to the MoU in accordance with Clause 16.

13.4 In the event a Party is put into administration, special measures and/or is otherwise not able to perform its role under the WYAAT Strategy and this MoU, the remaining Parties shall be entitled to consider and enforce, on a case by case basis, a resolution of the WYAAT CIC for the removal of the relevant Party from the MoU on a majority basis provided that:

13.4.1 reasonable notice shall have been given of the proposed resolution; and

13.4.2 the affected Party is first given the opportunity to address the WYAAT CIC meeting at which the resolution is proposed if it wishes to do so.

13.5 This MoU shall be terminated in accordance with the provision at 14.2.

14. CHANGE OF LAW

14.1 The Parties shall take all steps necessary to ensure that their obligations under this MoU are delivered in accordance with applicable law. If, as a result of change in applicable law, the Parties are prevented from performing their obligations under this MoU but would be able to proceed if a variation were made to the MoU, then the Parties shall consider this in accordance with the variation provision at paragraph 16.

14.2 In the event that that the Parties are prevented from performing their obligations under this MoU as a result of a change in applicable law and this cannot be remedied by a variation or a variation is not agreed by all Parties, then the Parties shall agree to terminate this MoU on immediate effect of the change in applicable law.

15. VARIATION

This MoU may only be varied by written agreement of the Parties signed by, or on behalf of, each of the Parties.

16. CHARGES AND LIABILITIES

16.1 Except as otherwise provided, the Parties shall each bear their own costs and expenses incurred in complying with their obligations under this MoU, including in respect of any losses or liabilities incurred due to their own or their employee's actions.

16.2 No Party intends that any other Party shall be liable for any loss it suffers as a result of this MoU.

17. NO PARTNERSHIP

Nothing in this MoU is intended to, or shall be deemed to, establish any partnership or joint venture between the Parties, constitute any Party as the agent of another Party, nor authorise any of the Parties to make or enter into any commitments for or on behalf of the other Parties.

18. COUNTERPARTS

18.1 This MoU may be executed in any number of counterparts, each of which when executed and delivered shall constitute an original of this MoU, but all the counterparts shall together constitute the same agreement.

18.2 The expression “counterpart” shall include any executed copy of this MoU transmitted by fax or scanned into printable PDF, JPEG, or other agreed digital format and transmitted as an e-mail attachment.

18.3 No counterpart shall be effective until each Party has executed at least one counterpart.

19. GOVERNING LAW AND JURISDICTION

This MoU shall be governed by and construed in accordance with English law and, without affecting the escalation procedure set out in paragraph 9 above, each Party agrees to submit to the exclusive jurisdiction of the courts of England.

WEST YORKSHIRE ASSOCIATION OF ACUTE TRUSTS

We have signed this Memorandum of Understanding on the date written at the head of this memorandum.

SIGNED by) .....

Duly authorised to sign for and on) Authorised Signatory

behalf of) Title:

AIREDALE NHS FOUNDATION TRUST) DATE:

SIGNED by) .....

Duly authorised to sign for and on) Authorised Signatory

behalf of) Title:

BRADFORD TEACHING HOSPITALS)

NHS FOUNDATION TRUST) DATE:

SIGNED by) .....

Duly authorised to sign for and on) Authorised Signatory

behalf of) Title:

CALDERDALE AND HUDDERSFIELD)

NHS FOUNDATION TRUST) DATE:

SIGNED by) .....

Duly authorised to sign for and on) Authorised Signatory

behalf of) Title:

HARROGATE AND DISTRICT)
NHS FOUNDATION TRUST) DATE:

SIGNED by) .....

Duly authorised to sign for and on) Authorised Signatory

behalf of) Title:

LEEDS TEACHING HOSPITALS)

NHS TRUST) DATE:

SIGNED by) .....

Duly authorised to sign for and on) Authorised Signatory

behalf of) Title:

MID YORKSHIRE TEACHING)

NHS TRUST) DATE:

Approved by those present at the meeting on 30 July 2024. Linda Pollard, Chair LTHT
Phil Wood, CEO LTHT
Sarah Armstrong, Chair, HDFT
Jonathan Coulter, CEO, HDFT
Andrew Gold, Chair, ANHSFT
'Foluke Ajayi, CEO, ANHSFT
Brendan Brown, CEO, CHFT
Helen Hirst, Chair, CHFT
Sarah Jones, Chair, BTHFT
Mel Pickup, CEO, BTHFT
Keith Ramsay, Chair, MYTT

Insert approval date

Len Richards, CEO, MYTT

SCHEDULE 1 THE KEY PRINCIPLES

1. Significant financial pressures within the WYAAT service area health system, linked to increasing service demand, longer life and medical advances, require a different approach to the delivery of good health and well-being for the population of West Yorkshire and Harrogate (WYH).
2. There are significant variations in the current corporate and acute care system ranging from, for example average unit cost for trauma and orthopaedic day case activity and use of differing national providers for pathology services to differing workforce staffing solutions.
3. Through the WYAAT Strategy, the Parties' Key Principles are to achieve a sustainable, safe, high quality and cost effective acute care system across WYH, based on clear integrated and standardised models, networks and alternative service delivery models where risk and benefits will be collectively managed. This will be achieved through addressing the following:
   - 3.1 Achieving clinical and financial stability across the WYAAT service area health system
   - 3.2 Enhancing partnership working between providers, leading to interdependency, care delivered by stream or pathway rather than by individual organisations and by collective provider responsibility
   - 3.3 A five step approach to collaboration which will deliver the following objectives:
     - 3.3.1 Developing a 'centres of excellence' approach to higher acuity specialties e.g. hyper-acute stroke, neurology, cancer, vascular, Ear Nose and Throat (ENT), maxillofacial surgery, eliminating avoidable cost of duplication and driving standardisation
     - 3.3.2 Developing WYH standardised operating procedures and pathways across services, building on current best practice and using Getting it Right First Time (GIRFT) and Model Health System data to drive out variations in quality as well as operational efficiency and facilitating safer free movement of bank staff across providers.
     - 3.3.3 Collaborating to develop clinical networks and creating alliances as a vehicle (e.g. hyper acute stroke, cancer etc.) which will protect local access for patients whilst consolidating skills (and therefore resilience) and reducing operational cost of duplicated facilities. Using GIRFT, Model Hospital, outcome variation data and WYAAT work on sustainable services to identify the case for change for specific services, the model being based on the 'chain' concept.
     - 3.3.4 Developing workforce planning at scale to secure the pipeline of fit for

purpose staff and improved productivity, managing workforce risk at system level and supporting free movement of bank and agency staff with the aim of reducing spend on agency and reduce the administration costs of the flexible workforce.

3.3.5 Delivering economies of scale in support functions such as procurement, pathology services, estates and facilities management and other infrastructure e.g. IT.

SCHEDULE 2 GOVERNANCE FRAMEWORK

1. INTRODUCTION

The purpose of the West Yorkshire Association of Acute Trusts (WYAAT), as set out in the Memorandum of Understanding (MoU), is for the trusts to work together on behalf of patients and the population to deliver the best possible experience and outcomes within the available resources for corporate and acute services across the WYAAT service area. The aim is to organise around the needs of the West Yorkshire and Harrogate (WYH) population rather than planning at individual organisational level so as to deliver more integrated, high quality, cost effective care for patients.

2. PURPOSE

The purpose of this Schedule to the MoU is to provide a Governance Framework for the WYAAT Strategy. It provides a systematic approach to the initiation and management of the Strategy.

3. OBJECTIVES OF THE WYAAT COLLABORATIVE PROGRAMME

WYAAT's objectives are set out in Schedule 1 to the MOU.

The purpose of the WYAAT Strategy is to deliver these objectives in order to deliver more integrated, high quality, cost effective care for patients across the WYAAT service area. WYAAT programmes will design services across multiple organisations, consider innovative, collaborative models of care to improve collective outcomes and performance and make collective efficiencies.

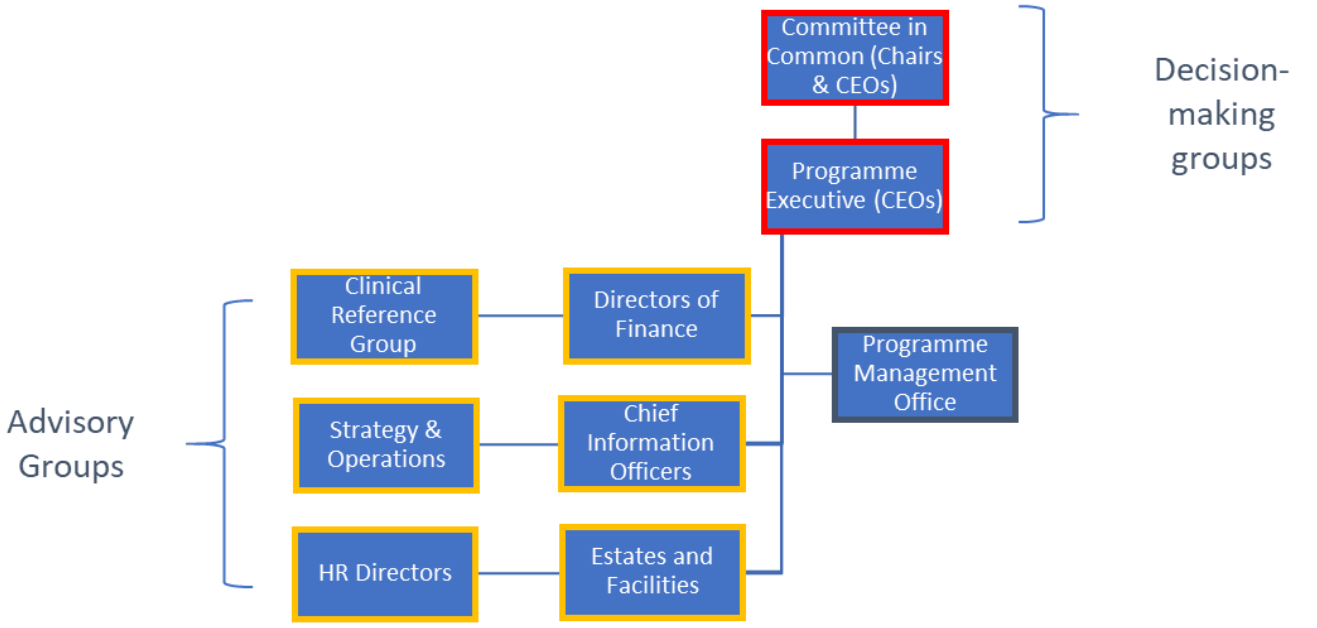
4. WYAAT STRATEGY DRIVERS

The WYAAT Strategy will be a portfolio of individual programmes covering clinical services, clinical support services and corporate services. Its priorities will be generated from a range of external and internal drivers including:

- National NHS strategies, priorities and programmes e.g. NHS Long Term Plan, The Long Term Workforce Plan, NHS Delivery plan for tackling the Covid-19 backlog of care, The NHS Patient Safety Strategy
- WY Integrated Care Board and Partnership strategies, priorities and workstreams
- NHS E Operational Planning guidance and process
- WYAAT clinical, operational, and financial sustainability priorities
- WYAAT baseline analysis of variation

5. GOVERNANCE STRUCTURE

The WYAAT MoU establishes the Committee in Common (CIC) and the Programme Executive. This Schedule establishes the governance structure below to support the CIC and Programme Executive.



5.1. Committee in Common.

5.1.1 The role and terms of reference of the CIC are set out in the main WYAAT MOU and Schedule 5 (CIC Terms of Reference) as providing strategic oversight and direction to the WYAAT Strategy. The CIC oversees delivery of the programmes, reviewing key deliverables, ensuring adherence to timescales and receiving assurance that risks are being managed.

5.1.2 The CIC consists of the Chairs and Chief Executives of the WYAAT trusts. It meets quarterly, or more frequently if required, and is chaired by one of the trust chairs for the lesser of six months or three meetings. The WYAAT Programme Director and the Company Secretary of the trust holding the Chair also attend the meetings.

5.1.3 As set out in the MoU and CIC Terms of Reference, members of the CIC shall only exercise the functions and powers of a party to the extent that they are actually permitted to ordinarily exercise such functions and powers under that party's internal governance. Members are expected to report to and consult

with their own organisation at Board level, providing governance assurance that is compliant with their regulatory and audit requirements.

5.1.4 The CIC has no delegated powers from the trusts beyond those already held by its members under their organisation's Constitution, Standing Orders, Standing Financial Instructions and Scheme of Delegation. In practice this means that decisions on gateway approvals for WYAAT programmes (see section 7 below) will usually be made by trust boards (or another appropriate board sub-committee in line with each trust's governance) based on a recommendation from the CIC.

5.2. Programme Executive.

5.2.1 The role of the Programme Executive is to oversee the delivery of the WYAAT Collaborative Portfolio, holding to account the Senior Responsible Owners and Executive leads for delivery of their WYAAT programme and receiving assurance that risks associated with delivery of programmes are being identified, mitigated and managed. The members of the group are the Chief Executives of the constituent trusts and the WYAAT Programme Director (non-voting). Meetings are held on a monthly basis.

5.2.2 In a similar way to the CIC, members of the group can only exercise functions and powers to the extent that they ordinarily exercise these under the governance arrangements of their employing trust.

5.3. Advisory Groups (Clinical Reference Group, Directors of Finance Group, Strategy & Operations Group, Chief Information Officers Group).

5.3.1 The Advisory Groups provide advice and assurance to the Programme Executive and CIC at gateway approval stages. They are responsible for reviewing strategic outline cases and business cases from the following perspectives and making a recommendation whether the case should be recommended to the CIC for approval by the trusts:

Group	Assurance Perspective & Considerations
Clinical Reference Group	**Quality** Clinical effectiveness and outcomes Patient safety Patient experience Clinical governance Ensuring a robust Quality Impact Assessment has been completed Ensuring a robust Equality Impact Assessment has been completed Workforce implications

Group	Assurance Perspective & Considerations
Directors of Finance Group	**Financial Sustainability** Financial benefits and costs Capital requirements Commercial, contractual, legal, tax risks and implications Financial governance
Strategy & Operations Group	**Operations & Performance** Alignment with national, ICS, place and organisational strategies Public, commissioner, system engagement and communications Operational benefits and risks Implications for performance against NHS Constitutional Standards and other performance measures Workforce implications
Chief Information Officers Group	**Information Management and Technology** Alignment with national, ICS, place and organisational IM&T strategies Cyber security Capacity and compatibility of trust IM&T infrastructure with new systems IM&T implementation, capacity and costs
Human Resources Directors Group	**Workforce** Alignment with national, ICS, place and organisational workforce strategies Workforce implications Workforce implementation, capacity and costs
Estates and Facilities Directors Group	**Estates and facilities** Alignment with national, ICS, place and organisational infrastructure strategies Infrastructure and capital requirements Estates and facilities implementation, capacity and costs

5.4. Programme Governance.

5.4.1 Each programme is led by one of the Chief Executives as Senior Responsible Owner (SRO). As a minimum each programme will also have a lead Executive Director (often a Strategy Director or Chief Operating Officer), a lead Medical Director and lead Finance Director.

5.4.2 Each programme will establish a steering group/board which meets on a regular basis. It will be chaired by the lead Executive Director and will include other lead directors and senior leaders from all participating trusts. Following approval of the Strategic Outline Case, most programmes will establish a formal programme

board, often at executive level, with representatives from all trusts and from a range of disciplines (e.g. Chief Nurse, HRD, CIO, Estates Director). Members are responsible for contributing to the successful delivery of the programme and for communicating key messages and issues to their respective organisation and feeding back any responses in return.

5.4.3 Programmes will be supported by programme and project management capacity. Initially this may be from existing resources within the WYAAT PMO, prioritised by the Programme Director, but as the programme develops dedicated resources will be provided as agreed by either the Programme Executive or CIC. The programme manager is responsible for the creation and maintenance of the: milestone plan, benefits log, risk register, quality and equality impact assessments. Each month they will produce a Highlight Report covering key activities in the month and those planned for the next; current and planned milestones; risks and issues including those requiring escalation; and benefits tracking. They are also responsible for managing the change control process.

5.4.4 Programme steering groups or programme boards are responsible for delivery of the programme across all trusts. They must ensure good trust engagement and commitment to delivery of agreed activities and integration into 'business as usual' arrangements on completion and have authority to manage the programme within the bounds of time, cost and quality agreed by the Programme Executive or CIC. Changes to the programme which exceed the agreed bounds must be escalated to the Programme Executive and, if necessary, the CIC.

6. ASSURANCE

Assurance on the progress of the Strategy overall and its constituent programmes is provided by the following:

6.1. **SRO/Programme Board/Programme Leads**. The CIC, Programme Executive and the advisory groups are able to hold the leadership of each programme to account for its delivery. They can also hold the Programme Director to account for oversight of the Strategy overall.

6.2. **Strategy Milestone Plan**. Setting out overall timescales and gateway approvals. Maintained by the WYAAT PMO on behalf of the Programme Director. Provided to the Programme Executive monthly and to the CIC quarterly.

6.3. **Strategy Risk Register**. Capturing the most significant risks on individual programmes and also common risks to multiple programmes which create a significant risk to the Strategy overall. Maintained by the WYAAT PMO on behalf of the Programme Director. Provided to the Programme Executive monthly and to the CIC quarterly.

6.4. **Benefits Map**. Shows how the outputs of the projects and programmes will lead to benefits for patients and the population of WYH. At the initial stages of programmes, the

outputs and benefits will be broadly described, but they will be more tightly defined and quantified as the programme develops through to full business case and into implementation. Maintained by the WYAAT PMO on behalf of the Programme Director. Provided to the Programme Executive monthly and to the CIC quarterly.

6.5. **Individual Programme Highlight Reports**. A monthly report describing progress, actions completed and planned milestones, risks and benefits for each programme. Maintained by each programme manager on behalf of the programme board and SRO. Provided to the Programme Executive monthly and to the CIC quarterly.

6.6. **Programme Brief and Programme Initiation Document**. These documents, approved by the Programme Director and Programme Executive respectively, ensure that new programmes are only initiated where they are in line with WYAAT's objectives and strategy, and there is a clear description of the scope of any further work to define the programme and the resources required.

6.7. **Gateway Approvals of Strategic Outline Cases & Business Cases**. Formal approval is required at each gateway to enable the project or programme to continue and to be provided with the necessary resources for the next stage. The case should be signed off by the programme board and SRO for review by the advisory groups. The advisory groups provide advice to the Programme Executive on any issues with the case and make a recommendation whether it should be recommended to the CIC. Where appropriate, for instance programmes which require DHSC or HM Treasury approval, external assurance and review of cases will also be undertaken. The Programme Executive makes a recommendation to the CIC and the CIC decides whether to recommend to trust boards that the case should be approved. If the case is not approved the programme would be closed down.

6.8. **Programme Reviews**. The CIC, Programme Executive or advisory groups may require programme SROs and programme boards to complete and provide a formal programme review at any time. A programme review will be instigated when a programme enters a new stage e.g. from business case to implementation to ensure the governance, leadership and resources are aligned to the required objectives of the subsequent phase.

6.9. **Annual Report**. While the primary purpose of the WYAAT Annual Report is to provide trust boards and other stakeholders with an annual update on the Strategy delivery, it also provides assurance to the CIC and Programme Executive about the overall progress of WYAAT and the delivery of the strategy. It is formally approved by the CIC each year and published in the public domain.

6.10. **WYAAT PMO**. The PMO is responsible for ensuring the adoption of a systematic programme approach aimed at maximising delivery. This includes identifying any interdependencies and integrating activities across different programmes and projects to avoid duplication. It maintains a milestone plan, risk register and benefits map for the overall Strategy and manages a programme assurance process to ensure all programmes are robustly established and managed. It is led by the WYAAT Programme Director who, along with the Finance Lead and Clinical Lead, is responsible for the

governance, coordination and alignment of programmes with the overall WYAAT objectives. The WYAAT Director is accountable to the Chair of the Programme Executive.

7. PROGRAMME LIFECYCLE

Each programme will follow a four stage programme lifecycle set out below. At each stage of the lifecycle there should be appropriate:

- Clinical and staff engagement and involvement (e.g. facilitated workshops)
- Patient, public, political (e.g. MPs, Overview and Scrutiny Committees, Health and Wellbeing Boards) and commissioner engagement and involvement
- Governor engagement
- External scrutiny (e.g. Clinical Senate, NHS England)
- Use of systematic, evidence based, quality improvement and change models
- Quality and equality impact assessment
- Use of a transparent options appraisal process

Stage	Description	Decision making
Initiation	**Programme Brief.** Short description of the opportunity, the rationale for it being a collaborative project, the approach that could be taken and a programme preparation plan.	WYAAT Director
	Programme Initiation Document. Description of the project: rationale, purpose and objectives, scope, desired outcomes and benefits, approach, estimated timescales and required resources. Includes initial quality and equality impact assessments.	Programme Executive
Planning	**Strategic Outline Case** Description of services, the challenges facing them, sets out the opportunity and potential benefits from changing the existing operating model. Includes quality and equality impact assessments, costs and resource estimates for developing the new operating model and the business case, likely return on investment, contribution from each trust and outline risk/gain share arrangements. Sets out the proposed governance arrangements and evaluation framework. A single Strategic Outline Case will always be completed for the whole programme.	Committee in Common **Gateway 1** CIC makes recommendation to trusts to approve the SOC and confirm their commitment to developing the OBC.

	Outline Business Case(s) Sets out the future operating model and the ways in which it could be delivered. Refines the quality and equality impact assessments, benefits, costs and timescales. Evaluates a range of options and recommends selection of the preferred option. Depending on the programme, there may be a single OBC for the whole programme, or there may be a number of project OBCs. Recommendations to trusts on approval of smaller, less complex project OBCs may be delegated by the CIC to the Programme Executive.	Committee in Common: **Gateway 2** CIC makes recommendation to trusts to approve the OBC and to confirm their support for the preferred option and their continuing participation to develop the FBC.

Stage	Description	Decision making
	Full Business case(s). A detailed description of the proposed model and associated benefits, costs and risks. Full quality and equality impact assessments. Financial and non- financial appraisal for each trust and for WYAAT in total. Sets out the investment profile, implementation plan and benefits realisation plan, including its constituent projects, activities, timescales and accountability for implementing the new model. As for the OBC there may be a single FBC for the whole programme, or a number of project FBCs.	Committee in Common: **Gateway 3** CIC makes recommendation to trusts to approve the FBC and to confirm their support for implementation and any formal agreements/ contracts required.
Implementation	**Implementation Plan** All projects and activities required to implement the programme and realise the benefits are initiated. Regular monitoring and management of progress by the Programme Board; reporting of costs and benefits; maintenance of risk register; and review and updating of quality and equality impact assessment. Includes the management of the formal change control process. Regular reports on progress to the Programme Executive and CIC.	Programme Board within delegated limits. Programme Executive or CIC where changes to the programme exceed the delegated limits.
Post implementation Evaluation	**Programme Closure Report** Once the programme has completed implementation of its constituent projects a recommendation will be made to close the programme. The report will evaluate whether the programme has delivered the outputs expected and whether these have led to the outcomes and benefits required (NB some benefits may remain to be realised by operational teams after programme closure). The report will also include a review of how effectively the programme was managed and what lessons can be learned for future programmes.	Committee in Common **Gateway 4** CIC make recommendation to trusts to approve closure of the programme.

8. RISK AND GAIN SHARING PRINCIPLES

8.1. Some WYAAT programmes (or their constituent projects) will have the potential to disproportionately benefit some participating WYAAT organisations at the expense of others. The Strategic Outline Case will set out the potential impact of the implementation of a programme or project and will describe the 'risk and gain share' model between the WYAAT members affected by the programme or project, in preparation for selection of the preferred option in the OBC. The model will be tailored

to each programme or project and will be designed on the following principles reflecting that organisations are working for the delivery of better care and a more sustainable system for patients in the WYAAT service area:

8.1.1 Any losses made by a WYAAT member as a direct result of the implementation of a programme or project will be reimbursed by the other affected members.

8.1.2 The costs of implementing the programme or project will be met by the participating WYAAT members in the proportions set out in the FBC and agreed at Gateway 3.

8.1.3 The net financial benefits of the programme or project will be allocated to member trusts on a “fair shares” basis with the precise method being tailored to the programme or project. The method will be set out in the FBC and agreed at Gateway

SCHEDULE 4 - DISPUTE RESOLUTION PROCEDURE

4. **AVOIDING AND SOLVING DISPUTES**

1.1 The Parties commit to working co-operatively to identify and resolve issues to their mutual satisfaction so as to avoid all forms of dispute or conflict in performing their obligations under this MoU.

1.2 The Parties believe that:

1.2.1 by focusing on the agreed Key Principles underpinned by the five step approach as set out in the MoU and in Schedule 1;

1.2.2 being collectively responsible for all risks; and

1.2.3 fairly sharing risk and rewards.

they reinforce their commitment to avoiding disputes and conflicts arising out of or in connection with this MoU.

1.3 A Party shall promptly notify the other Parties of any dispute or claim or any potential dispute or claim in relation to this MoU or its operation (each a '**Dispute**') when it arises.

1.4 In the first instance the WYAAT Programme Executive shall seek to resolve any Dispute to the mutual satisfaction of each of the Parties. If the Dispute cannot be resolved by the WYAAT Programme Executive within ten Business Days (a **Business Day** being a day other than a Saturday, Sunday or public holiday in England when banks in London are open for business) of the Dispute being referred to it, the Dispute shall be referred to the WYAAT CIC for resolution.

1.5 The WYAAT CIC shall deal proactively with any Dispute on a “Best for Meeting the Key Principles” basis in accordance with this MoU so as to seek to reach a majority decision. If the WYAAT CIC reaches a decision that resolves, or otherwise concludes a Dispute, it will advise the Parties of its decision by written notice. The Parties recognise that any dispute or operation of this procedure will be without prejudice to and will not affect the statutory duties of each Party. This MoU is not intended to be legally binding save as provided in clause 2.4 and, given the status of this MoU (as set out in Section 2), if a Party disagrees with a decision of the WYAAT CIC or the independent facilitator, they may withdraw from the MoU at any point in accordance with paragraph 14.

1.6 If a Party does not agree with the decision of the WYAAT CIC reached in accordance with Section 4 above, it shall inform the WYAAT CIC within ten Business Days and request that the WYAAT CIC refer the Dispute to an independent facilitator in accordance with paragraph 2 below.

1.7 The Parties agree that the WYAAT CIC, on a ‘Best for Meeting the Key Principles’ basis, may determine whatever action it believes is necessary including the following:

1.7.1 If the WYAAT CIC cannot resolve a Dispute, it may request that an independent facilitator) assist with resolving the Dispute; and

1.7.2 If an independent facilitator is selected then they shall:

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

ii. assist the WYAAT CIC to work towards a consensus decision in respect

of the Dispute;

iii. regulate his or her own procedure and, subject to the terms of this MoU, the procedure of the WYAAT CIC at such discussions;

iv. determine the number of facilitated discussions which must take place within 20 Business Days of the independent facilitator being appointed; and

v. have its costs and disbursements met by the Parties.

1.7.3 If the independent facilitator cannot facilitate the resolution of the Dispute, the Dispute must be considered afresh in accordance with this Schedule and in the event that after such further consideration again fails to resolve the Dispute, the WYAAT CIC may decide to:

i. terminate the MoU; or

ii. agree that the Dispute need not be resolved.

SCHEDULE 4 WYAAT DECISION MAKING

1. The Memorandum of Understanding (**MoU**) and Terms of Reference (**TOR**) for the WYAAT Committee in Common (**WYAAT CIC**) take into consideration existing accountability arrangements of participating trusts and decisions being made under a scheme of delegation.

2. Whilst it is recognised that some decisions taken at the WYAAT CIC may not be of obvious benefit to all individual participating trusts, it is anticipated that the WYAAT CIC will look to act in the basis of the best interests of the wider population by investing in a sustainable system of healthcare across the WYAAT service area in accordance with the Key Principles when making decisions at WYAAT CIC meetings.

3. There are expected to be two categories of decision making:
   - 3.1 **Mandatory Participation Decisions**. All affected WYAAT members need to participate in the initiative for reasons of interdependency, safety or financial viability. These decisions will be made on the basis of all WYAAT members reaching an agreed decision in common.
   - 3.2 **Voluntary Participation Decisions**. Participation in the initiative is consensual and voluntary, so WYAAT members will need to confirm their own commitment and involvement at key stages (Gateways) in order to ensure the Business Case assumptions (e.g. benefits, costs and risks) are robust. Only trusts participating in the initiative (the eligible constituency) will be able to vote at the decision Gateways.

4. GATEWAY DECISION MAKING

- 4.1 The WYAAT 'Gateway' decision making mechanism should be used (where appropriate) to achieve agreements that will be binding across relevant members. The mechanism will follow a staged approach and unless new material comes to light, once progression has been made through the respective stages, progress will remain at the relevant stage that has been reached and will not 'fall back'. On agreement of progression through stages, members will commit to the next steps in developing the proposal. Once a trust has committed to participate at a specific Gateway it cannot withdraw until the next Gateway.
- 4.2 All programmes proposed as part of the WYAAT Strategy will require a Strategic Outline Case which will include a detailed case for change (Gateway 1). At this stage the WYAAT CIC will determine if the proposal warrants further development and consideration and is appropriate to pass to the next stage of development. This stage will also consider whether this a mandatory or voluntary participation programme and which WYAAT members would be directly or indirectly affected and eligible/required to vote (to be known as the eligible constituency).

4.3 The Gateways and decision-making requirements are shown in the table below:

Gateway	Mandatory Participation Decisions	Voluntary Participation Decisions
Gateway 1 **Strategic Outline Case** (Case for Change, initial options appraisal)	Unanimous support of all WYAAT members	Support of all participating WYAAT members
Gateway 2 **Outline Business Case** (Recommendation of preferred option)	Unanimous support of all WYAAT members	Support of all participating WYAAT members
Gateway 3 **Full Business Case** (Detailed description of preferred model and implementation plan)	Unanimous support of all WYAAT members	Support of all participating WYAAT members
Gateway 4 **Programme Closure** (Confirmation that the programme has delivered the expected outputs, outcomes and benefits)	Unanimous support of all WYAAT members	Support of all participating WYAAT members

4.4 Where a unanimous decision cannot be reached initially, the dispute resolution process set out in Schedule 3 to the MoU will be used.

4.5 If a Trust does not support or vote for a proposal then it will not be bound to act in accordance with that proposal as the trusts remain independent statutory bodies under the WYAAT Strategy.

5. BILATERAL AND TRIPARTITE AGREEMENTS BETWEEN INDIVIDUAL TRUSTS

5.1. The WYAAT MoU and its schedules, including this Gateway Decision-Making Framework, do not preclude any Party from developing bilateral or tripartite agreements with other trusts in WYAAT outside the WYAAT Strategy. It is expected that there will be transparency in developing such agreements. The associated benefits and risks of such agreements should be appropriately considered in terms of their impact on other providers and the WYAAT Strategy. The option for other WYAAT trusts to join an initiative should also be considered.

5.2. The WYAAT MoU and its schedules, and being part of the WYAAT CIC, does not preclude existing Parties alliances or existing relationships with other organisations.

5.3. Parties may wish to invite other organisations to be party to initiatives agreed by the WYAAT CIC.

SCHEDULE 5
TERMS OF REFERENCE FOR
THE WYAAT COMMITTEE IN COMMON

THESE TERMS OF REFERENCE FORM PART OF THE WYAAT MEMORANDUM OF UNDERSTANDING. DEFINITIONS AND TERMINOLOGY ALIGN TO THE MEMORANDUM OF UNDERSTANDING

1 SCOPE

1.1 The WYAAT Committee in Common (WYAAT CIC) will be responsible for leading the strategic development of WYAAT in accordance with the Key Principles*, setting overall ambition and direction in order to deliver the WYAAT Strategy.

2 STANDING

2.1 Members shall only exercise functions and powers of a Party to the extent that they are actually permitted to ordinarily exercise such functions and powers under that Party's internal governance.

3 GENERAL RESPONSIBILITIES OF THE WYAAT CIC

3.1 The general responsibilities of the WYAAT CIC are:

i. Defining the strategy and providing strategic oversight and direction to the development of WYAAT as a provider collaborative;
ii. ensuring alignment of all Parties to the vision and strategy;
iii. formally recommending the final form of the Strategy; including determining roles and responsibilities within the workstreams;
iv. reviewing the key deliverables and ensuring adherence with the required timescales and budget;
v. Defining risk appetite and tolerances;
vi. receiving assurance that workstreams have been subject to robust quality impact assessments
vii. reviewing of the risks associated with the performance of any of the Parties in terms of the impact to the WYAAT Strategy – recommending remedial and mitigating actions across the system;
viii. receiving assurance that risks associated with the delivery of the WYAAT Strategy, and wider system risks impacting the Parties are being identified, managed and mitigated;
ix. promoting and encouraging commitment to the Key Principles;

x. formulating, agreeing and implementing approaches for delivery of the WYAAT Strategy;

xi. seeking to determine or resolve any matter referred to it by the WYAAT Programme Executive or any individual Party and any dispute in accordance with the MoU;

xii. reviewing and approving the Terms of Reference of the WYAAT Programme Executive;

xiii. agreeing the Programme Budget and financial contribution and use of resources in accordance with the Risk and Gain Sharing Principles;

4 MEMBERS OF THE WYAAT CIC

4.1 Each Party will appoint their Chair and Chief Executive as WYAAT CIC Members and the Parties will at all times maintain a WYAAT CIC Member on the WYAAT CIC.

4.2 Each WYAAT CIC member will nominate a deputy to attend on their behalf. The Nominated Deputy will be a voting board member of the respective Party. The Nominated Deputy will be entitled to attend and be counted in the quorum at which the WYAAT CIC Member is not personally present and do all the things which the appointing WYAAT CIC Member is entitled to do.

4.3 Each Party will have one vote.

4.4 The Parties will all ensure that, except for urgent or unavoidable reasons, their respective WYAAT CIC Member (or their Nominated Deputy) attend and fully participate in the meetings of the WYAAT CIC.

5 PROCEEDINGS OF WYAAT CIC

5.1 The WYAAT CIC will meet quarterly, or more frequently as required by the Committee.

5.2 The WYAAT CIC shall meet in private where appropriate in order to facilitate discussion and decision making on matters deemed commercially sensitive and by virtue of the confidential nature of the business to be transacted across the WYAAT members. It is agreed by the Parties that the necessary checks and balances on openness, transparency and candour continue to exist and apply by virtue of the Parties each acting within existing accountability arrangements of the Parties' respective organisations and the reporting arrangements of the WYAAT CIC into the Parties' Trust Boards.

5.3 The Parties will select one of the Parties' Chairs to act as the Chair of the WYAAT CIC meetings on a rotational basis for a period of six months or three meetings, whichever is the lesser.

5.4 The Chair of WYAAT will not simultaneously act as Chair of another Collaborative in West Yorkshire and Harrogate.

5.5 The WYAAT CIC may regulate its proceedings as they see fit save as set out in these Terms of Reference.

5.6 No decision will be taken at any meeting unless a quorum is present. A quorum will not be present unless every Party has at least one WYAAT CIC Member present.

5.7 Members of all Parties will be required to declare any interests which will be recorded and set out in a register and reviewed at the beginning of each meeting.

5.8 A meeting of the WYAAT CIC may consist of a conference between the WYAAT CIC Members who are not all in one place, but each of whom is able directly or by telephonic or video communication to speak to each of the others, and to be heard by each of the others simultaneously.

5.9 Each WYAAT CIC Member will have an equal say in discussions and will look to agree recommendations in line with the Principles of the WYAAT Strategy.

5.10 The WYAAT CIC will review the meeting effectiveness at the end of each meeting. Additionally, a survey of CIC members to assess effective will be undertaken on an annual basis. The findings of this will be reviewed by CIC in order to ensure continuous improvement.

6 EXTRAORDINARY MEETINGS

6.1 In exceptional circumstances, where a decision is required, an extraordinary meeting of the CIC can be called between the scheduled meetings.

6.2 A request for an extraordinary meeting can be instigated by any Party and must be supported by at least two further Parties.

6.3 All attempts will be made to provide five working days' notice for an extraordinary meeting, with a minimum notice period of 48 hours where there is an urgent requirement for CIC to meet.

6.4 All extraordinary meetings will comply with the provisions within these terms of reference, in line with ordinary meetings of the CIC.

7 DECISION MAKING WITHIN THE WYAAT CIC

7.1 Each WYAAT CIC Member will comply with the existing accountability arrangements of their respective appointing organisation and will make decisions which are permitted under their organisation's Standing Orders, Standing Finance Instructions and Scheme of Delegation. The Parties intend that WYAAT CIC Members shall report to and consult with their own respective organisations at Board level, (noting that decisions on recommendations made by the CIC will always be made by the Boards of Member Trusts) providing the governance assurance that ensures compliance with their regulatory and audit requirements, for organisational decisions relating to, and in

support of, the WYAAT Key Principles and facilitating these functions in a timely manner.

7.2 Recognising that some decisions may not be of obvious benefit to or impact directly upon all Parties, WYAAT CIC Members shall seek to pay due regard to the best interests of the wider population in investing in a sustainable system of healthcare across the WYAAT service area in accordance with the Key Principles when making decisions at WYAAT CIC meetings.

7.3 In respect of matters which require decisions where all Parties are affected the Parties will seek to make such decisions on the basis of all WYAAT CIC Members reaching an agreed consensus decision in common in accordance with the Key Principles.

7.4 In respect of the matters which require decisions where only some of the Parties are affected, then the Parties shall reference the WYAAT Gateway Decision Mechanism at Schedule 4 of the Memorandum of Understanding.

8 ATTENDANCE OF THIRD PARTIES AT WYAAT CIC MEETINGS

8.1 The WYAAT CIC shall be entitled to invite any person to attend but not take part in making decisions at meetings of the WYAAT CIC.

9 ADMINISTRATION FOR THE WYAAT CIC

9.1 Meeting administration for the WYAAT CIC will be provided by the WYAAT Programme Office including responsibility for governance advice, maintaining the register of interests and the minutes of the meetings of the WYAAT CIC.

9.2 The Agenda for the meeting will be agreed by the WYAAT CIC Chair. Papers for each meeting will be sent from the Programme Office to WYAAT CIC Members no later than five working days prior to each meeting. By exception, and only with the agreement of the Chair, amendments to papers may be tabled before the meeting.

9.3 The draft minutes, and a summary report from the WYAAT Director will be circulated promptly to all WYAAT CIC Members as soon as reasonably practical for inclusion on the private agenda of each Parties' Board meeting. The Chair of the meeting will be responsible for approval of the first draft set of minutes for circulation to members. The WYAAT Director will provide a summary for sharing in the public domain.

9.4 The WYAAT CIC will produce an annual report to the Boards of all Parties.

10 REVIEW

10.1 The WYAAT CIC will review these Terms of Reference at least annually for approval by the Parties.

SCHEDULE 6 CONFIDENTIALITY AGREEMENT

RECITALS

1. The Parties together have formed the West Yorkshire Association of Acute Trusts ("WYAAT") and have agreed to collaborate to bring together NHS trusts delivering acute hospital services across the WYAAT Service Area in delivering region-wide efficient and sustainable healthcare for patients. WYAAT, as partner in the West Yorkshire Integrated Care System ("WYICS"), will develop and deliver a WYAAT Strategy to facilitate integrated methods of working across acute care providers.
2. The Parties have formed a WYAAT Committee in Common (WYAAT CIC) which has the specific remit of overseeing a comprehensive system wide integration programme to deliver the objective of an acute provider transformation to a more collaborative model of care for the WYAAT Service Area, the intention being to deliver a system model, operating as a network, that is coherent, integrated, consistent (reducing unwanted variation) and focused on quality and value for the population and patients. This "WYAAT Strategy" is to be initially developed and delivered by the WYAAT CIC.
3. The Parties are engaged in a phased approach towards developing the governance of the WYAAT collaborative working, the initial step being the formation of the WYAAT CIC for the delivery of more efficient acute services for patients in West Yorkshire and Harrogate District.
4. The Parties have entered into a protocol for managing the sharing of information to agree the ways of protecting the use of data (including confidential information) within each Party's organisation throughout the WYAAT Strategy development and delivery. The Parties have entered into a Conflict of Interest Protocol (Conflict of Interest Protocol) to govern the treatment of conflicts of interest that may arise in the WYAAT Strategy.
5. The purpose of this Agreement is to ensure that Confidential Information (as defined below) revealed to each other in the course of the WYAAT Strategy development process remains confidential and is not used by the Parties for any purpose other than the further development of the WYAAT Strategy.
6. The Parties intend this Confidentiality Agreement to be legally binding.

OPERATIVE PROVISIONS

1. Definitions

The definitions in this clause shall apply to this Agreement:

1.1 **Operational Day**: a day other than a Saturday, Sunday or a bank holiday in England.

1.2 **Confidential Information**: means

1.2.1 information (however recorded, preserved or disclosed) that is directly or indirectly disclosed, whether before or after the date of this Agreement, as part of or ancillary to:

i. the Parties responses to the WYAAT Strategy;

ii. any due diligence process for the WYAAT Strategy;

iii. any business case(s) for the WYAAT Strategy;

iv. any submission to the Competition and Markets Authority;

v. the preparation of other documents to progress and conclude the development of the WYAAT Strategy; and

vi. any post WYAAT Strategy implementation plans; or

1.2.2 the nature, content or substance of any discussions and/or negotiations taking place concerning the WYAAT Strategy and the status of those discussions and/or negotiations; or

1.2.3 information contained in any version of the Memorandum of Understanding which set out the terms upon which the development and delivery of the WYAAT Strategy will take place; or

1.2.4 information contained in any version of a WYAAT Strategy business case of any Party; or

1.2.5 any other information that the Parties agree in writing is confidential; or

1.2.6 any information that would be regarded as confidential by a reasonable business person relating to:

i. the business, affairs, patients, customers, clients, suppliers, plans, intentions, or market opportunities of the Disclosing Party; or

ii. the operations, processes, product information, know-how, designs, trade secrets or software of the Disclosing Party; or

1.2.7 any information developed by the Parties in the course of carrying out this Agreement; but does not include any information if:

1.2.8 the information is, or subsequently becomes, public knowledge other than as a direct or indirect result of the information being disclosed in breach of this Agreement or of any other undertaking of confidentiality addressed to the Party to whom the information relates (except that any compilation of otherwise public information in a form not publicly known shall nevertheless be treated as Confidential Information); or

1.2.9 a Party can establish, to the reasonable satisfaction of the other Parties, that it found out the information or the information was, is or becomes available to a Party from a source not connected with the other Parties and that such source is not under any obligation of confidence in respect of that information; or

1.2.10 a Party can establish, to the reasonable satisfaction of the other Parties, that the information was known to the Party or lawfully in the possession of the Party before the date of this Agreement and that it was not under any obligation of confidence in respect of that information (but, for the avoidance of doubt, information that was provided prior to the date of this Agreement but which is caught by Clause 1.1.2 (b) above shall be treated as information that was provided under an obligation of confidence); or

1.2.11 the Parties agree in writing that it is not confidential or may be disclosed; or

1.2.12 a Party can establish, to the reasonable satisfaction of the other Parties, that it developed the information independently of the Confidential Information; or

1.2.13 a Party can establish, to the reasonable satisfaction of the other Parties, that the information legitimately and lawfully came in to its possession otherwise than for the Purpose (as defined below).

i. **Disclosing Party:** a Party which discloses or makes available directly or indirectly Confidential Information.

ii. **Purpose:** considering, evaluating and negotiating the development and delivery of the WYAAT Strategy.

iii. **Recipient:** a Party which receives or obtains directly or indirectly Confidential Information.

iv. **Representative:** employees, agents and professional advisers (including

but not limited to accountants, lawyers and management consultants) of the Recipient appointed to assist on the evaluation, development and delivery of the WYAAT Strategy.

1.3 Clause, schedule and paragraph headings shall not affect the interpretation of this Agreement.

1.4 A person includes a natural person, corporate or unincorporated body (whether or not having separate legal personality) and that person's legal and personal representatives, successors and permitted assigns.

1.5 Words in the singular shall include the plural and vice versa: words denoting the masculine gender include the feminine gender; words denoting persons include bodies corporate and unincorporated associations and partnerships.

1.6 A reference to a statute or statutory provision is a reference to it as it is in force for the time being, taking account of any amendment, extension, or re-enactment, and includes any subordinate legislation for the time being in force made under it.

1.7 Any obligation in this Agreement on a person not to do something includes an obligation not to agree or allow that thing to be done.

2. CONSIDERATION

2.1 In consideration of the benefits to all Parties in sharing Confidential Information for the purpose of pursuing the WYAAT Strategy development and delivery and in further consideration of each Party agreeing to pay the other Parties on demand GBP £1, the Parties agree to be bound by the terms of this Agreement.

3. OBLIGATIONS OF THE PARTIES AND REPRESENTATIVES

3.1 Each Recipient will (and will direct and procure each of its Representatives that he or she will):

i. keep the Confidential Information secret;
ii. use or exploit the Confidential Information only for the Purpose;
iii. not directly or indirectly disclose (or knowingly allow it to be disclosed) or make available, in whole or in part, any Confidential Information to any person who is not a Representative who needs to know this Confidential Information for the Purpose;
iv. take all reasonable steps to ensure that no Confidential Information is visible to, or capable of being overlooked by any person who is not a Representative who needs to know this Confidential Information for the Purpose;
v. ensure that reasonable endeavours are taken to ensure that the Confidential Information is protected against theft or unauthorised access;
vi. not alter, modify or vary any of the Confidential Information in any way;

vii. apply the same security measures and degree of care to the Confidential Information as the Recipient applies to its own confidential information, which the Recipient warrants as providing adequate protection from unauthorised disclosure, copying or use;

viii. inform the other Parties immediately on becoming aware, or suspecting, any person who is not a Representative has become aware of Confidential Information;

ix. comply with Clause 5 of the Information Sharing Agreement; and not use any previously shared information in an anti-competitive manner; and in respect of any such previously shared information, the Parties agree that this Agreement applies and the Parties agree that the Conflict of Interest Protocol and the Information Sharing Agreement shall also apply.

3.2 The Recipient may only disclose the Disclosing Party's Confidential Information to those of its Representatives who need to know this Confidential Information for the Purpose, provided that:

i. it informs these Representatives of the confidential nature of the Confidential Information before disclosure or upon signing this Agreement (whichever is the later) and obtains from its Representatives enforceable undertakings to keep the Confidential Information confidential in terms at least as extensive and binding upon the Representatives as the terms of this Agreement are upon the Parties; and

ii. at all times, it is responsible for these Representatives' compliance with the obligations set out in this Agreement.

3.3 Each Party is responsible for its Representatives' compliance with the obligations set out in this Agreement.

3.4 Representatives may only make such copies of, reduce to writing or otherwise record the Confidential Information as are strictly necessary for the Purpose and shall:

i. clearly mark all such documents as 'Confidential';

ii. ensure that all such documents supplied to him or her made by him or her can be separately identified from his own information; and

iii. use all reasonable endeavours to ensure that all copies within their control are protected against theft or unauthorised access.

3.5 If discussions in relation to the development and delivery of the WYAAT Strategy cease, or the Disclosing Party so requests in writing at any time, the Parties shall immediately:

i. return to the Disclosing Party all Confidential Information received; and

ii. destroy or permanently erase all documents and materials and any copies supplied to it or made by it or by its Representatives containing, reflecting incorporating or based on Confidential Information; and

iii. erase all of the Confidential Information from its computer systems or

which is stored in electronic form (to the extent possible).

3.6 Nothing in Clause 3.5 shall require a Party to return or destroy Confidential Information or copies that the Party is required to retain by applicable law or to be able to evidence due compliance with good governance and the proper discharge of its functions or to satisfy the rules or regulations of any applicable governmental or regulatory body to which such person is subject and to the extent reasonable to permit the Recipient to keep evidence that it has performed its obligation under this Agreement.

3.7 Each Party will establish and maintain adequate security measures (including any reasonable security measures proposed by the other Parties from time to time) to safeguard Confidential Information from unauthorised access or use.

3.8 Each Party is aware of its obligations under Clause 4.2 of the Information Sharing Agreement.

3.9 No Party shall make, or permit any person to make, any public announcement concerning this Agreement, the Purpose or its prospective interest in the Purpose without the prior written consent of the other Parties (such consent not being unreasonably withheld or delayed) except as is required by law or any governmental or regulatory body or by any court or other authority or competent jurisdiction. No Party shall make use of the other Parties' names or any information acquired through its dealing with the other Parties for publicity or marketing purposes without the prior written consent of the other Parties.

3.10 If a Party develops or uses a product or a process (other than for the Purpose) which, in the reasonable opinion of the other Parties, might have involved the use of any of the Disclosing Party's Confidential Information, the Party shall, at the request of the Disclosing Party, supply to the other Parties information reasonably necessary to establish that the Confidential Information has not been used in the development of the product or process.

3.11 The provisions of Clauses 3.5, 3.6 and 3.10 of this Agreement shall continue to apply to any such documents and materials retained by a Party, subject to Clause 8.3.

4. FORCED DISCLOSURE

4.1 Subject to Clause 4.2, a Party may disclose Confidential Information to the extent:

i. required by law (including in response to a request pursuant to the Freedom of Information Act 2000) or any order of any court or other authority of competent jurisdiction or any competent judicial, governmental or regulatory body (including the Health Select Committee and the Information Commissioner); or

ii. necessary to enable a Party to comply with any statutory function or duty of that Party or to satisfy the requirement for public accountability and good governance in the discharge of its functions, which requires disclosure of Confidential Information.

4.2 Before a Party discloses any information under this Clause 4, it shall (to the extent permitted by law) use all reasonable endeavours to:

i. give the other Parties as much notice as possible;

ii. inform the other Parties of the full circumstances of the disclosure and the information that will be disclosed;

iii. consult with the other Parties as to possible steps to avoid or limit disclosure and take those steps where they would not result in significant adverse consequences to other Parties, including considering whether any exemptions under the Freedom of Information Act 2000 apply; and

iv. where the disclosure is by way of public announcement, agree the wording with the other Parties in advance.

4.3 Each Party shall co-operate with the other Parties if it decides to bring in any legal or other proceedings to challenge the validity of the requirement to disclose Confidential Information.

4.4 If a Party is unable to inform the other Parties before Confidential Information is disclosed, it shall (to the extent permitted by law) inform the other Parties immediately after the disclosure of the full circumstances of the disclosure and the information that has been disclosed.

5. RESERVATION OF RIGHTS AND ACKNOWLEDGEMENT

5.1 All Confidential Information shall remain the property of the Disclosing Party. Each Party reserves all rights in its Confidential Information. No rights, including, but not limited to, intellectual property rights, in respect of a Party's Confidential Information are granted to the other Parties and no obligations are imposed on the Parties other than those expressly stated in this Agreement.

5.2 Except as expressly stated in this Agreement, no Party makes any express or implied warranty or representation concerning its Confidential Information, or the accuracy or completeness of the Confidential Information.

5.3 The disclosure of Confidential Information by a Party shall not form any offer by, or

representation or warranty on the part of, the Disclosing Party to enter into any further agreement in relation to the Purpose, or the development or supply of any product or service to which the Confidential Information relates.

5.4 Each Party shall be liable to the other Parties for the actions or omissions of its Representatives under this Agreement, as if they were the actions or omissions of the Recipient.

6. INDEMNITY

6.1 Each Party warrants that it has the right to disclose its Confidential Information to the other Parties and to authorise the other Parties to use such Confidential Information for the Purpose.

6.2 Each Party shall indemnify and keep fully indemnified the other Parties at all times against all liabilities, costs (including legal costs on an indemnity basis), expenses, damages and losses (including any direct, indirect or consequential losses, loss of profit, loss of reputation and all interest, penalties and other reasonable costs and expenses suffered or incurred by the other Parties) arising from any breach of this Agreement as a result of its breach.

7. TERM AND TERMINATION

7.1 The obligations contained in this Agreement shall take effect on the date of the Agreement and shall continue for the Term.

7.2 Subject to clause 7.2 this Agreement will be terminated:

i. If any of the Parties decide not to become, or continue to be involved in the Purpose; or

ii. on discontinuance of the development and delivery of the WYAAT Strategy**.**

7.3 If any Party decides not to become or continue to be involved in the Purpose it shall notify the other Parties in writing immediately. The obligations of each Party shall, notwithstanding any earlier termination of negotiations or discussions between the Parties in relation to the Purpose, continue for a period of six years from the termination of this Agreement.

7.4 Termination of this Agreement shall not affect any accrued rights or remedies to which any Party is entitled.

8. GENERAL LEGAL PROVISIONS

8.1 This Agreement, the Memorandum of Understanding, the Information Sharing Protocol and the Conflict of Interests Protocol constitute the whole agreement between the Parties and supersedes all previous agreements between the relevant Parties relating to their subject matter. Each Party acknowledges that, in entering into

this Agreement, it has not relied on, and shall have no right or remedy in respect of, any statement, representation, assurance or warranty (whether made negligently or innocently) other than as expressly set out in this Agreement, the Memorandum of Understanding, the Information Sharing Agreement and the Conflict of Interests Protocol. Nothing in this Clause 8.1 shall limit or exclude any liability for fraud or for fraudulent misrepresentation.

8.2 This Agreement shall be governed by the laws of England.

8.3 No variation or waiver of this Agreement or any part of it will be effective unless made in writing, signed by or on behalf of all the Parties (or their authorised representatives) and expressed to be such a variation or waiver.

8.4 Failure to exercise, or any delay in exercising, any right or remedy provided under this Agreement or by law shall not constitute a waiver of that or any other right or remedy, nor shall it preclude or restrict any further exercise of that or any other right or remedy.

8.5 No single or partial exercise of any right or remedy provided under this Agreement or by law shall preclude or restrict the further exercise of that or any other right or remedy.

8.6 A Party that waives a right or remedy provided under this Agreement or by law in relation to another Party, or takes or fails to take any action against that Party, does not affect its rights in relation to any other Party.

8.7 The Parties shall attempt to resolve any dispute between them in respect of this Agreement by negotiation in good faith.

8.8 Except as otherwise provided in this Agreement, no Party may assign, sub-contract or deal in any way with, any of its rights or obligations under this Agreement or any document referred to in it.

9. NOTICES

9.1 Any notice required to be given under this Agreement, shall be in writing and shall be delivered personally, or sent by pre-paid first class post or recorded delivery or by commercial courier or by secure NHS email with an assigned read receipt, to each Party required to receive the notice at its address as specified by the relevant Party by notice in writing to each other Party.

9.2 Any notice or other communication shall be deemed to have been duly received:

i. if delivered personally, when left at the address and for the contact referred

to in this clause on the date and at the time that the delivery receipt is signed; or

ii. if sent by pre-paid first class post or recorded delivery, at 9.00 am on the second Operational Day after posting; or

iii. if delivered by commercial courier, on the date and at the time that the courier's delivery receipt is signed

iv. if sent by secure email, on the date and time that a read receipt is received by the sender.

10. NO PARTNERSHIP

Nothing in this Agreement is intended to, or shall be deemed to, establish any partnership or joint venture between any of the Parties, constitute any Party the agent of another Party, nor authorise any Party to make or enter into any commitments for or on behalf of any other Party.

11. THIRD PARTY RIGHTS

No person other than a Party to this Agreement shall have any rights to enforce any term of this Agreement whether under the Contracts (Rights of Third Parties) Act 1999 or otherwise.

YORKSHIRE ASSOCIATION OF ACUTE TRUSTS

SCHEDULE 7

PROTOCOL FOR MANAGING CONFLICTS OF INTEREST

IN RELATION TO THE STRATEGY FOR THE WEST YORKSHIRE

ASSOCIATION OF ACUTE TRUSTS

1. INTRODUCTION

1.1 This document forms part of the governance arrangements for the West Yorkshire Association of Acute Trusts (WYAAT) Committee in Common (CIC) and should be considered in conjunction with the overall Memorandum of Understanding and Terms of Reference of that Committee.

1.2 The members of WYAAT will adhere to the NHS England Guidance on Managing Conflicts of interest.

1.3 The objectives of this Protocol are to:

1.3.1 manage any Conflict so that the Parties are able to discuss the development of the WYAAT Strategyand make decisions on its delivery in accordance with principles of probity, fairness, non-discrimination, equality and transparency;

1.3.2 minimise the risk of a successful challenge being brought by a third party as a result of the unmanaged and undisclosed exploitation of a Conflict; and

1.3.3 ensure that the management of the Conflict during the negotiations does not prejudice the ability of any Party or Individual to continue to fulfil their role, does not undermine their ability to make decisions, and does not damage public trust and confidence in the Parties.

2. DEFINITIONS

2.1 For the purposes of this document a ‘conflict of interest’ is defined as:

‘A set of circumstances by which a reasonable person would consider that an individual’s ability to apply judgement or act, in the context of delivering, commissioning or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold’.

2.2 A conflict of interest may be:

i. Actual – There is a material conflict between one or more interests.

ii. Potential – There is the possibility of a material conflict between one or more interests in the future.

2.3 A material interest is one which a reasonable person would take into account when making a decision regarding the use of tax-payers money because the interest has relevance to that decision.

2.4 Interests fall into the following categories:

i. Financial interests – where an individual may get direct benefit* from the consequences of a decision they are involved in making

ii. Non-financial professional interest – where an individual may obtain a non-financial professional benefit* from the consequences of a decision they are involved in making such as increasing their professional reputation or promoting their professional career

iii. Non-financial personal interests – where an individual may benefit* personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit because of decisions they are involved in making

iv. Indirect interests – where an individual has a close association ** with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest who would stand to benefit from a decision they are involved in making.

v. Loyalty interests - Conflicts of interest can arise when decision making is influenced subjectively through association with colleagues or organisations out of loyalty to the relationship they have, rather than through an objective process. The scope of loyalty interests is potentially huge, so judgement is required for making declarations.

A benefit may arise from the making of a gain or avoiding a loss

** These associations may be close family members and relatives, close friends and associates and business partners.

3. CONFLICTS OF INTEREST

3.1 The Parties agree that other than being a party to WYAAT:

3.1.1 a conflict of interest (Conflict) arises when in developing and delivering the WYAAT Strategy an individual or organisation:

i. owes duties to two or more organisations and those duties are in conflict with one another; or

ii. has any financial interest, direct or indirect, in any contract, proposed contract or other matter around the WYAAT Strategydevelopment and delivery and is present at a meeting at which the contract or other matter is the subject of consideration; and/or

iii. the individuals' or organisations' ability to exercise judgement, or act in a role is, could be, or is seen to be impaired or otherwise influenced by their involvement in another role or relationship.

iv. if in doubt, any Individual or Party concerned should assume that a potential Conflict exists.

3.1.2 applying the meaning of a Conflict to an Individual, a Conflict does potentially exist if an Individual simultaneously has a role at more than one Party or has previously had or will have a role at a Party while being employed at another as the case may be;

3.1.3 the existence of a Conflict does not in itself indicate that a person or organisation in question has done anything wrong. Where Conflicts are unavoidable they need to be managed appropriately;

3.1.4 if any Party materially breaches this Protocol then the Parties may agree to discontinue the respective Party involvement in the further discussions around the WYAAT Strategy development and delivery; and

3.1.5 this document accordingly sets out a Protocol that the Parties have agreed to adopt for the purpose of managing a Conflict.

4. PROCESS FOR MANAGING CONFLICTS OF INTEREST

4.1.1 Individuals and the Parties will adhere to the NHS England Guidance on Managing Conflicts of Interest.

4.1.2 The Parties acknowledge that they are independent statutory providers and that the intent of the WYAAT Strategy is to deliver region wide efficient and sustainable healthcare for patients, so whilst it is contemplated that there will be Conflicts, the Parties expect these to be managed in a reasonable manner to ensure the objective is met and that the appropriate Parties are part of WYAAT discussions and, where reasonable, any decisions.

4.1.3 Each individual must ensure that their declarations are up to date on the register of their own organisation in the first instance. An up to date register of interests of all Committee members will be provided to the Chair (noting adherence to Schedule 5 section 5.4) of the WYAAT Committee in Common prior to each meeting.

4.1.4 Where a Party is aware of a Conflict which:

i. has not been declared, either in the register or orally, they will declare this at the start of the meeting;

ii. has previously been declared, in relation to the scheduled or likely business of the meeting, the Party concerned will bring this to the attention of the Chair of the meeting, together with details of arrangements which have been confirmed for the management of the Conflict.

4.1.5 The Chair of the meeting will then determine how this should be managed and inform the Party of their decision. Where no arrangements have been confirmed, the Chair of the meeting may require the individual to withdraw from the meeting or part of it if appropriate. The Party or Individual as applicable will then comply with these arrangements, which must be recorded in the minutes of the meeting.

4.1.6 Where the Chair of any meeting has a Conflict, previously declared or otherwise, in relation to the scheduled or likely business of the meeting, they must make a declaration and a deputy chair will be appointed to act as chair for the relevant part of the meeting. Where arrangements have been confirmed for the management of the Conflict in relation to the chair, the meeting must ensure these are followed. Where no arrangements have been confirmed, the deputy chair may require the chair to withdraw from the meeting or part of it. Where there is no deputy chair, the Parties present at the meeting will select one.

4.1.7 Any declarations of Conflicts and arrangements agreed in any meeting will be recorded in the minutes and the register of Conflicts for the Parties in respect of the WYAAT Strategy development and delivery. The Chair will make a decision as to whether the relevant section of the minutes should be redacted for those individuals who declared a conflict and this decision will be recorded in the minutes.

4.1.8 Where more than 50% of the Parties representatives at a meeting are required to withdraw from a meeting or part of it, owing to the arrangements agreed for the management of Conflicts, the Chair (or deputy) will determine whether or not the discussion can proceed.

4.1.9 In making this decision the Chair will consider whether the meeting is quorate, in accordance with the number and balance set out in the WYAAT CIC Terms of Reference. Where the meeting is not quorate, owing to the absence of certain Parties, the discussion will be deferred until such time as a quorum can be convened. Where a quorum cannot be convened from the Parties owing to the arrangements for managing Conflicts, the chair shall consult with the Conflict Leads on the action to be taken. This may include inviting on a temporary basis alternate individuals from the affected Parties to make up the quorum (where these are permitted members who are not subject to a Conflict) so that they can progress the item of business.

SCHEDULE 8

INFORMATION SHARING PRINCIPLES

IN RELATION TO THE DEVELOPMENT OF A STRATEGY FOR WEST YORKSHIRE ASSOCIATION OF ACUTE TRUSTS

1. INTRODUCTION

This document forms part of the governance arrangements for the West Yorkshire Association of Acute Trusts (WYAAT) Committee in Common (CIC) and should be considered in conjunction with the overall Memorandum of Understanding and Terms of Reference of that Committee.

2. DEFINITIONS

2.1 In this Agreement the following words and expressions shall have the following meanings:

2.1.1 Business as Usual: all activities undertaken by any Party in the ordinary course of business save for any activity in connection with the WYAAT Strategy development and delivery;

2.1.2 Confidential Information: shall have the meaning given to it in the Confidentiality Agreement;

2.1.3 Competitively Sensitive Information: any Confidential Information which would or might enable the recipient to alter its commercial strategy and may include, by way of illustration, trade secrets, confidential financial information and confidential commercial information, including without limitation, information relating to the terms of actual or proposed contract or sub-contract arrangements (including bids received under competitive tendering), future pricing, business strategy and costs data, as may be utilised, produced or recorded by any Party, the publication of which an organisation in the same business would reasonably be able to expect to protect by virtue of business confidentiality provisions; and

2.1.4 Data: information, data and material recorded in any form and shared between any or all of the Parties including Confidential Information and Commercially Sensitive Information.

3. PRINCIPLES

The following key principles guide the sharing of data between the Parties

3.1 The Parties endorse, support and promote the accurate, timely, secure and

confidential sharing of both person identifiable and anonymised data where such data sharing is essential for the provision of effective and efficient services to the local population.

3.2 The Parties are fully committed to ensuring that if they share data it is in accordance with their legal, statutory and common law duties, and, that it meets the requirements of any additional guidance.

3.3 Where it is agreed that the sharing of data is necessary, only that which is needed, relevant and appropriate will be shared and that would only be on a "need to know" basis.

3.4 The data being shared will only be used for the purpose for which it was originally intended.

3.5 All Parties must have in place policies and procedures to meet the national requirements for Data Protection, Data Security and Confidentiality [https://ico.org.uk/for-organisations/guide-to-data-protection]. The existence of, and adherence to, such policies provide all Parties with confidence that data shared will be transferred, received, used, held and disposed of appropriately.

3.6 In line with these policies, the Parties have developed and approved a single Information Sharing Agreement to allow the sharing of non-person identifiable information to support WYAAT programmes and projects. If the Parties need to share person or patient identifiable information to support a WYAAT programme or project, an individual information sharing agreement will be put in place for each programme or project, where required, in order to ensure secure and appropriate sharing of information.

3.7 The Parties acknowledge their 'Duty of Confidentiality' to the people they serve. In requesting release and disclosure of data from other Parties' employees and contracted volunteers will respect this responsibility and not seek to override the procedures which each organisation has in place to ensure that data is not disclosed illegally or inappropriately. This responsibility also extends to third party disclosures; any proposed subsequent re-use of data which is sourced from another organisation should be approved by the source organisation.

3.8 When disclosing data about individuals, Parties will clearly state whether the data being supplied is fact, opinion, or a combination of the two.

3.9 The Parties will have in place effective procedures to address complaints relating to the disclosure of data, and information about these procedures should be made available to service users.

4. CONFIDENTIAL INFORMATION

4.1 The Parties can share information with each other and NHS England for the purpose of the WYAAT Strategy development and delivery subject to the provisions of the Confidentiality Agreement.

4.2 The WYAAT Programme Office and each Party shall maintain clear records of all the Confidential Information exchanges they are part of.

5. COMPETITIVELY SENSITIVE INFORMATION

5.1 The Parties shall not disclose to each other any Competitively Sensitive Information. The Parties acknowledge that:

5.1.1 information is not Competitively Sensitive Information if it relates to activities or markets in which the relevant Parties do not currently compete and where there is no realistic prospect that they will in future compete;

5.1.2 subject to section 6, information is not Competitively Sensitive Information if it relates to any arrangements involving information exchange and collaboration (including for the purpose of joint projects contemplated or being implemented by the Parties under WYAAT) for the purpose of Business as Usual activities; and

5.1.3 information is not Competitively Sensitive Information if it relates to activities or markets in which the respective Parties are actual or potential competitors and disclosure of the relevant information would not affect the recipient Party's commercial strategy or decisions; this may apply if, for example:

i. the information is historical, aggregated (as defined below) and/or anonymised; or

ii. the information is freely available in the public domain.

5.2 In this clause 5 "aggregated" means that the price, cost and volume of individual services or contracts for the provision of services, the subject matter of which forms or could form the basis of competition between the Parties, cannot be determined from the Data.

6. DOCUMENT CREATION

6.1 The Parties acknowledge that documents created by any Party for the WYAAT Strategy development may be required to be disclosed to the UK merger authorities.

6.2 The Parties agree to take due care and attention when creating documents (including but not limited to emails and handwritten notes) to avoid the use of language that could be misinterpreted.

6.3 If any Party is asked by external legal advisors to provide Data, any documents must be clearly marked "Privileged and confidential: prepared at the request of external legal advisers".

DATE OF MEETING	CQC Regulation	7 March 2024	2 May 2024	4 July 2024	12 September 2024	7 November 2024	16 January 2025	13 March 2025
Date of agenda setting/Feedback to Execs		31 Jan 2024	20 March 2024	21 May 2024	12 August 2024	2 October 2024	TBC	TBC
Date final reports required		23 February 2024	19 April 2024	21 June 2024	29 August 2024	25 October 2024	6 January 2025	28 February 2025
STANDING AGENDA ITEMS								
Introduction and apologies	N/A	✓	✓	✓	✓	✓	✓	✓
Declarations of interest	N/A	✓	✓	✓	✓	✓	✓	✓
Minutes of previous meeting, matters arising and action log	N/A	✓	✓	✓	✓	✓	✓	✓
Patient/Staff Story	N/A	✓	✓	✓	✓	✓	✓	✓
Chair's report	17	✓	✓	✓	✓	✓	✓	✓
Chief Executive's report	17	✓	✓	✓	✓	✓	✓	✓
Integrated Performance report (Inc: Quality, Finance, Workforce)	17	✓	✓	✓	✓	✓	✓	✓
Financial Update	13	✓	✓	✓ & Budget book	✓	✓	✓	✓
Health Inequalities			✓			✓		✓
Quality Committee Chair's Highlight Report & Minutes	17 & 12	✓	✓	✓	✓	✓	✓	✓
Audit and Risk Committee Chair's Highlight Report & Minutes	17	✓	✓	✓	✓	✓	✓	✓
Finance and Performance Committee Chair's Highlight Report & Minutes	17 & 13	✓	✓	✓	✓	✓	✓	✓
Workforce Committee Chair's Highlight Report & Minutes	17 & 18	✓	✓	✓	✓	✓	✓	✓
Charitable Funds Committee Chairs Highlight Report & Minutes	17	✓		✓	✓		✓	

COLOUR KEY TABLE FOR AGENDA ITEMS LISTED IN LEFT HAND COLUMN	
Items for approval	To formally receive a report or strategy for discussion and particularly approve recommendations or a particular course of action
Items to receive	To discuss in depth, noting the implications for the Board or Trust without formal approval
Items to note	For the intelligence of the Board without in-depth discussion
Items for assurance	To assure the Board that effective systems of internal control are in place

DATE OF MEETING	CQC Regulation	7 March 2024	2 May 2024	4 July 2024	12 September 2024	7 November 2024	16 January 2025	13 March 2025
STRATEGY & PLANNING AGENDA ITEMS								
Strategic Objectives – 1 year plan / 5 year strategy	17	✓		✓*1 year Strategic Objectives report 1 of 3*		✓*2024-2025 Strategic Objectives Progress Report 2 of 3*		✓*2024-2025 Strategic Objectives Progress Report 3 of 3*
Digital Health Strategy	17						✓	
Digital Update (Digital story and an update on the broader THIS work, not just the CHFT aspects)	17						✓	
Risk Management Strategy	17	✓						✓
Charity Strategy	17						✓	
Annual Plan	*13 **	✓	✓ for 2024/25					✓
Capital Plan	*13 **	✓					✓	
Resilience / Surge & Escalation Plan	12					✓		
Green Plan (Climate Change)	17				✓			
Reconfiguration (commercial)	17							
QUALITY AGENDA ITEMS								
Director of Infection Prevention Control (DIPC) quarterly report	12	✓Q3		✓Q4	✓Q1	✓Q2		✓Q3
DIPC Annual Report	12			✓				
Learning from Deaths Quarterly Report	20	✓ Q2	✓ Q3		✓Q4 Annual Report		✓Q1	✓ Q2
Maternity and Neonatal Oversight Report (invite Director of Midwifery)	17, 9 & 10		✓	✓	✓	✓	✓	✓
Maternity Incentive Scheme	12						✓	

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Safeguarding Adults and Children Report	13			✓ Annual Report			✓ Bi-annual	
Complaints Annual Report	16			✓				
WORKFORCE AGENDA ITEMS								
Staff Survey Results and Action Plan	17		✓					✓
Nursing and Midwifery Staffing Hard Truths Requirement	18			✓ Annual Report			✓ Bi-Annual	✓
Guardian of Safe Working Hours Update	18	✓		✓	✓	✓		✓
Guardian of Safe Working Hours Annual Report	18		✓					
Diversity	17					✓ Board Diversity Action Plan		✓
Medical Revalidation and Appraisal Annual Report	18				✓ Annual Report			
GOVERNANCE & ASSURANCE AGENDA ITEMS								
Emergency Planning Annual Report / EPRR Core Standards Submission	12		✓ Annual Report				✓ Compliance statement	✓ Annual Report
Freedom to Speak Up Annual Report	10, 12, 17			✓ Annual Report			✓ 6 month report FTSU themes and qualitative presentation	
Health and Safety Policy **(next due for review August 2025)**	17							
Health and Safety Annual Report	17				Moved to Nov	✓		

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Board Assurance Framework	17	✓ 3		✓ 1		✓ 2		✓ 3
Risk Appetite Statement	17				✓			
High Level Risk Register	12, 17	✓	✓	✓	✓	✓	✓	✓
Standing Orders/SFIs/SOD review (next review due March 2025 unless changes required beforehand)	17							✓
Non-Executive appointments	17	✓					✓	✓
Annual review of NED roles	17						✓	
Board workplan	17	✓	✓	✓	✓	✓	✓	✓
Board meeting dates	17			✓				
Use of Trust Seal	17	✓		✓		✓		✓
Declaration of Interests & Fit and Proper Persons Declarations Board of Directors (annually)	5	✓						✓
Attendance Register (annually)	17		✓					
Fit and Proper Person Self Declaration Register	5	✓						✓
Seek delegation from Board to ARC for the annual report and accounts 2023/24	17	✓						✓
BOD Terms of Reference	17	✓						✓
Sub Committees Terms of Reference	17	✓F&P ✓ NRC BOD	✓ NRC CoG	✓QC	✓ARC ✓ Workforce ✓ TPB ✓ CFC			✓F&P ✓ NRC BOC
Trust Constitution changes (+as required)	17	✓	✓	✓	✓	✓	✓	✓
Compliance with Licence Conditions (final year 2022/23)	17		✓					
THIS Update	17						✓	

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Fire Strategy 2021-2026	17		✓					✓
Annual Fire Safety Report	17						✓	
Audit and Risk Committee Annual Report 2023/2024	17			✓				
Workforce Committee Annual Report 2023/24	17				✓ (ARC Highlight Report)			
Finance and Performance Committee Annual Report 2023/2024	17				✓(ARC Highlight Report)			
Quality Committee Annual Report 2023/24	17				✓(ARC Highlight Report)			
Transformation Programme Board Annual Report	17				✓(ARC Highlight Report)			
WYAAT Annual Report and Summary Annual Report	17						✓	
Kirklees ICB Committee Papers (Link)	17	✓	✓	✓	✓	✓	✓	✓
Calderdale Cares Partnership Committee Papers (Link)	17	✓	✓	✓	✓	✓	✓	✓

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25. Items to receive and note

1. Minutes of Board Committees

- Finance and Performance Committee, 3 September 2024 & 1 October 2024
- Quality Committee, 3 September 2024
- Audit and Risk Committee, 22 October 2024

2. Partnership papers:

- Kirklees Health and Care Partnership https://www.kirkleeshcp.co.uk/about-us/kirklees-icb-committee/kirklees-icb-committee-meetings/
- Calderdale Cares Partnership https://www.calderdalecares.co.uk/about-us/meeting-papers/

To Receive

Calderdale and Huddersfield NHS Foundation Trust

Minutes of the Finance & Performance Committee held on
Tuesday 3rd September 2024, 14.00 – 16.30
Via Microsoft Teams

Minutes to be read in conjunction with Agenda papers and Chair's highlight report

PRESENT

Vanessa Perrott (VP)	Non-Executive Director (Chair)
Nigel Broadbent (NB)	Non-Executive Director
Gary Boothby (GB)	Director of Finance (item 112 onwards)
Jonathan Hammond (JH)	Chief Operating Officer
Denise Sterling (DS)	Non-Executive Director

IN ATTENDANCE

Rochelle Scargill (RLS)	PA to Director of Finance (Minutes)
Kirsty Archer (KA)	Deputy Director of Finance
Andrea McCourt (AM)	Company Secretary
Peter Keogh (PK)	Assistant Director of Performance
Helen Rees (HR)	Director of Operations – Medicine (For deep dive item only)

OBSERVERS

Robert Markless (RM)	Public Elected Governor
Sarah Rothery (SR)	Staff Governor

APOLOGIES

Stuart Baron (SB)	Deputy Director of Finance
Adam Matthews (AdM)	HR Business Partner
Anna Basford (AB)	Deputy Chief Executive and Director of Transformation and Partnerships.
Rob Aitchison (RA)	Deputy Chief Executive

ITEM

106/24 WELCOME AND INTRODUCTIONS

The Chair welcomed attendees to the meeting. It was noted that RM has been re-elected as Governor and would continue to attend F and P meetings. A second governor (??) will normally join but was unable to attend. SR attended in his/her stead.

107/24 DECLARATIONS OF INTEREST

None

108/24 MINUTES OF THE MEETING HELD 2nd July 2024

The previous minutes were approved as an accurate record.

Going forward it was noted that meeting minutes should now be read in conjunction with meeting papers and Chair's report.

109/24 MATTERS ARISING

110/24 ACTION LOG

The Action Log was reviewed as follows:

All actions were closed.

111/24 DEEP DIVE – EMERGENCY DEPARTMENT and SAMEDAY EMERGENCY CARE(SDEC)

Helen Rees joined the meeting to present an update from the deep dive last presented to this committee in February.

The committee were asked to note that there has been a slight drop in the unplanned attendances to SDEC at HRI. The reason for this is that the Medical SDEC has now opened at Calderdale. Previously patients were being transported from Calderdale to the SDEC at Huddersfield. Overall SDEC numbers have increased. Differences in performance between HRI and CRH are largely down to difficulty with bed pressures at HRI.

Extra consultants have now been recruited, to extend cover from 10pm until 12 pm in the ED departments on both sites. The longer term plan is to have consultant cover 24/7 at Huddersfield which is the more pressured of the two sites.

A 12 week review was presented following the opening of the new ED at HRI. Many positives reported by staff. There was no mention on the Paediatric experience within the presentation. This was not included within the highlight report but there has been positive in relation to the environment.

There are considerations to open more SDECs in the specialties of Paediatrics and of Obstetrics and Gynaecology.

More details on the organisation and flow between A and E and SDECs emerged during the discussion and questions. Models are currently a combination of “push” from A and E and “pull” into SDECs. Different modelling options are being explored.

(14.29 – GB joined the meeting.)

RM asked if there had been any patient surveys carried out since the opening of the new ED. Also do the SDECS close overnight?

HR – A full patient survey has not yet been carried out but is planned for the future. There are periodic national surveys specifically around ED’s but there has not been one since the new ED opened.
The SDECS do close overnight and there are different workflows for patients dependent on their requirements. The viability of carrying out some diagnostics overnight is also a consideration. Looking at the possibility of using some of our digital solutions in order to book patients for the following morning.

NB – How do we measure impact on key metrics with the creation of SDECs etc?
HG – There has been an upward trend in overall performance since the Calderdale SDEC opened.

JH – There are a lot of variables so it is not easy to see how individual changes have impacted. Weekly trends are being monitored to see what has the most impact on ED performance. Bed occupancy stand out as having the biggest impact e.g. more discharges on a Monday leads to better performance on the Tuesday.
The Integrated Flow Hub is scheduled to open at Huddersfield early October which will help with discharges and decrease length of stay.

The reconfiguration team have led on the review of the new ED with the aim of taking any learning forward into the upcoming reconfiguration projects.

Bed occupancy also affects the ambulance handovers. If there are patients in beds who are well enough to be discharged it prevents the flow of patients into ED.

DS – The benefits to patients and the service have been covered, but are there any financial benefits from the new ED?
Not yet but as reconfiguration progresses and the flow of patients improves, we expect to see some financial benefit. There have been significant financial improvements this year as a result of successful consultant recruitment which has reduced bank and agency spend. Recruitment has been more successful since the opening of the new ED as more candidates have been attracted.
It was noted that a better functioning SDEC will also reduce costs of A and E.

JH – Also to note that costs in ED have been driven by demand for ED post covid compared to pre covid. In the las financial year there has been an increase between 4-9% dependant on the month. This causes congestion in ED at times which then causes staffing pressures which then incur costs.

FINANCE & PERFORMANCE

112/24 IPR

The Associated Director of Performance presented to the committee. The new addition of the quarterly health inequalities data was noted in the paper. **Successes in performance and challenge areas were presented and discussed.**

The SHMI data was highlighted as a special cause for concern. It was briefly discussed as there had been extensive discussion on the SHMI in the Quality meeting.
Complaints handling was similarly discussed in brief.

Sickness and turnover rates best in the last three years. Elective recovery remains good and Diagnostics have hit target (95%) for first time in 18 months.

Virtual ward performance is well below target and was discussed further.

JH - Virtual ward - changes have been made to create more flexible capacity alongside the Urgent Care teams. Early data suggests this is having a positive affect on length of stay. The virtual ward data is being reviewed to make sure that it accurately reflects the current pathways. Capacity issues mean it cannot be staffed 24/7 every day which is affecting the performance metric.

NB – DNA's are due a deep dive in February. Some focus on health inequalities to be included. – ACTION

Questions of clarification were raised against the Care hours per day. These are reported against a median rather than a mean. The national standard is to report against the median.
Capped Theatre utlilisation performance was reported to have decreased in the IPR. Clarification was asked for the report stating "MH unable to explain how they account for 60 minute lunch time."
MH in the report refers to Model Hospital. The data for the theatre utilisation does not account for any overruns. There have been a couple of instances where the data has not been accurately measured in the past and after it has been raised by CHFT and other organisations the data has been corrected.

Targets for the TOC list were discussed as they are not yet agreed. JH reported that it is challenging to get the whole system agreed to a singular target, but all acknowledge that is significantly higher than pre covid. For this year we are trying to focus on length of stay targets for the different pathways. There is a need to be really clear about each of the pathways and where the blockages are. It is anticipated that the integrated care hub, and new position of the discharge lounge will impact on the TOC list.

Stroke performance remains well below target. It was decided that this should be prioritised and discussed through a Deep Dive at the next F and P meeting and to move the deep dive on Cancer to later in the year. ACTION: to amend the work plan

The Committee **RECEIVED** the IPR.

113/24 RECOVERY UPDATE

The Associated Director of Performance presented the Recovery update.

CHFT is still performing well. The stretch target in the report is what features in the overall financial plan. Achievement of the stretch target will deliver the planned elective recovery funding. We are broadly on track with the overall levels of activity but the value of the activity is lower than planned.

ACTION: Extra slide included on outpatient follow ups to be shared outside this meeting.

Any comparisons with other Trusts either in or outside of WYAAT will be against the national target of 52 week waits. The 40 week is a CHFT internal target.

NB – Is there any risk to the system if other Trusts in West Yorkshire do not achieve the targets.
JH – Last year extra funding was distributed in relation to achievements against plan. Some trusts were fined last year if targets were not achieved. CHFT have received mutual aid requests from other trusts to see if we can accommodate some of their patients, this could be of financial benefit now that we are on payment by results contracts.

VP – Is there any benchmark outside of WYAAT that could be useful for our purposes?
PK - Nationally only Northumbria and Royal Berkshire have less 52 week waiters than CHFT.

The committee **RECEIVED** the Recovery Update

114/24 MONTH 4 FINANCE REPORT

The Deputy Director of Finance covered the month 4 finance position.

The overall ICS position was not released until after the papers were produced. Year to date there is a £12 million adverse variance to plan giving a variance of £64m to a £52m planned variance. The in-month position is a deficit of £3.51m, a £1.82m adverse variance. Reasons include the impact of strike action and high bed utilisation over the summer months.

Staff pay costs remain high due to high levels of vacancy, high bed occupancy rates and the impacts of strike action. However, CHFT is below the Agency Ceiling.

Further work on identifying CIP projects has been successful. Most of the CIP has now been identified, although it remains largely from non-recurrent sources.

Modelling has taken place which gives 3 scenarios of 'Best, Mid and Worst'. Best scenario is to deliver the plan to target. Mid scenario is more likely. This would result in being 1.7 m adverse to plan. Worst case scenario is less likely and would result in being significantly adverse to plan.

Questions were raised about support coming in and about degree of clarity over how the WYAAT £50m is to be dispersed.

Industrial action funding will come in at some point, the timescale has yet to be announced. Only direct costs will be covered. There will be no funding for any lost activity.
It was agreed earlier in the year that West Yorkshire would receive £50m to cover the deficit. CHFT will receive a proportion of this, but the equivalent value must be seen as an improvement on plan. The system is not performing to plan. Some partners have high percentages of their CIPs which remain unidentified. This presents a risk.
The oversight framework has been published with a plan to employ third parties to come in and do some of the grip and control. CHFT are in a good position as PWC have already been and completed their report. Of the five acute providers in West Yorkshire, four are under higher scrutiny including CHFT. Meetings have been set up and last Friday it was agreed which measures would be looked at in the meetings.

NB –What is the contingency plan to deliver the “likely” scenario even if CIP is delivered?
GB – The biggest challenge is the bed pressure. The bed plan assumed that we would be coming out of beds in July and August but in July and August there has been an extra £600k spent on having beds open. Greater engagement is required from system partners.

Committee **RECEIVED** the Month 4 Finance report.

115/24 NATIONAL COST COLLECTION SUBMISSION REPORT

The pre-submission report came to the last meeting. The work was initially set up to influence the tariff costs but that does not happen. Every year it does create the average reference cost with 100 being the mean. Anything less than 100 is classed as above average and anything over 100 as below average. This is broken down between elective and non-elective. Overall CHFT is below 100 and across West Yorkshire is one of two providers below 100 which is positive.

The data is used internally and shows that CHFT is expensive for non-elective but cost efficient for elective work.

The actions within the report are internal for finance to complete. The final submission was brought to the Committee for approval.

The Committee **APPROVED** the National Cost Collection.

116/24 PWC REPORT

The Director of Finance spoke around the recently received PWC report. PWC have produced several reports broken down by system and trust. They have rated each trust where they think there are opportunities for efficiencies. There are less opportunities identified for CHFT than other Trusts. Short to medium term they have identified £15m across WYAAT partners. This does not include opportunities that may have already been counted elsewhere. The report also suggests a £1m opportunity around medical bank. We know that we pay a slightly higher rate than other Trusts in the region, but this has been a conscious decision which has reduced our agency bill. In terms of medicine optimisation, a couple of drugs have been identified where savings could be made, but one of them is already in the CIP programme for this year.

ACTION: To come up with a detailed plan to address the report with milestones, plans and trajectories to come back to the next meeting.

WYAAT have set up 6 workstreams and there is an overlap between the workstreams. Any feedback will be added to the report to come back to this committee.

Periodic reports to come back to this committee 1st October, December and February meetings.

DS – The report introduction comments make a statement that CHFT has an ambitious 5 year strategy but it is not evidenced with detailed and tangible targets.
GB – A budget holder survey was sent out for four days and had a limited response. The response that was received suggested that the budget holders do not have a buy in to our long term financial plans and cannot see how important their role is.
We will be looking for better engagement from budget holders.

The Committee **RECEIVED** the PWC Report

117/24 TURNAROUND EXECUTIVE CIP PROGRESS

The Director of Finance gave a verbal update. Papers were included in the pack.

Over the last week another £2.5m CIP has been identified including an increase to the HPS income target. Now left with a £1.2m gap.
CHFT is within the NHS metric for the headcount portfolio, with currently 160-180 less staff in post than planned, and will not breach that target.

Further conversations to take place with divisions on how to bridge the gap the risk being that when identified it will be non-recurrent. This needs to be identified within the next two weeks then work can commence on next year. There are opportunities within workforce which are transformational and will not have a fast turnaround.

Confident that the CIP target will be delivered but there will be a bit more of a challenge in the overall position.

DS – Are they contingency plans place for winter?
GB – The bed plan is phased to have more beds open in Winter than in Summer and currently in the process of bidding for capacity money. There is risk as we have not been able to close beds during August as planned. There are no contingency funds.
JH – Some of the ideas trialled during the March project have been taken into the plan. For example, the Calderdale SDEC worked well and has remained open but meant that Orthopaedics had to be relocated using capital funds. Additional work was done on validation which it was noted in March could be improved.

The Committee **RECEIVED** the Turnaround Executive update.

118/24 DRAFT MINUTES FROM SUB-COMMITTEES
The following minutes and summaries thereof were received by the Committee:

- Access Delivery Group – Work has been done around the children and young people's waiting list following national direction and guidance including waiting list data. More work is required but it will come back to this committee – ACTION.
- Business Case Approval Group
- Capital Management Group
- Cash Committee
- CHFT / SPC Quarterly

- THIS Executive Board
- CHFT/ CHS Joint Liaison
- HPS Board
- Urgent and Emergency Care
- Pennine Property Partnership

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

119/24 WORKPLAN – 2024/25

Stroke was highlighted within the IPR. The stroke and cancer deep dives to be switched on the workplan.

Add PWC report to work plan 1st October – December and February.

The Committee **APPROVED** the draft work plan.

120/24 ANY OTHER BUSINESS

None.

121/24 MATTERS TO CASCADE TO BOARD inc. ONE CULTURE OF CARE

- To be picked up through the Chair's highlight report.

DATE AND TIME OF NEXT MEETING:
Tuesday 1st October 2024 14:00 – 16:30 MS Teams

Calderdale and Huddersfield NHS Foundation Trust

Minutes of the Finance & Performance Committee held on
Tuesday 1st October 2024, 14.00 – 16.30
Via Microsoft Teams

Minutes to be read in conjunction with Agenda papers and Chair's highlight report

PRESENT

Vanessa Perrott (VP)	Non-Executive Director (Chair)
Nigel Broadbent (NB)	Non-Executive Director
Gary Boothby (GB)	Director of Finance
Jonathan Hammond (JH)	Chief Operating Officer
Denise Sterling (DS)	Non-Executive Director

IN ATTENDANCE

Rochelle Scargill (RLS)	PA to Director of Finance (Minutes)
Kirsty Archer (KA)	Deputy Director of Finance
Andrea McCourt (AM)	Company Secretary
Peter Keogh (PK)	Assistant Director of Performance
Helen Rees (HR)	HR Business Partner
Adam Matthews (AdM)	Director of Operations – Medicine (For deep dive item only)

OBSERVERS

Robert Markless (RM)	Public Elected Governor
Julie Pryce (JP)	Staff Governor

APOLOGIES

Stuart Baron (SB)	Deputy Director of Finance
Anna Basford (AB)	Deputy Chief Executive and Director of Transformation and Partnerships.
Rob Aitchison (RA)	Deputy Chief Executive

ITEM

122/24 WELCOME AND INTRODUCTIONS
The Chair welcomed attendees to the meeting.

123/24 DECLARATIONS OF INTEREST
None

124/24 MINUTES OF THE MEETING HELD 3rd September 2024
The previous minutes were approved as an accurate record subject to minor corrections regarding designations and names.

125/24 MATTERS ARISING

126/24 ACTION LOG
The Action Log was reviewed as follows:

Recovery Plan – Extra slide presented at last meeting to be shared with the Committee.

PWC Report – On Agenda. Close action.

127/24 DEEP DIVE – STROKE

VP introduced the background to the deep dive. Stroke is a quality priority, currently failing the target of 90% (40%).
HR attended to present an updated deep dive on stroke following previous attendances at this committee in February and August 2023.
HR compared current performance with previous performance and identified areas of ongoing challenge (workforce vacancies in medical and Speech and Language, access to specialist stroke units) as well as areas of improvement (access to CT scan and discharge process). "Go sees" to from other hospitals (such as Barnsley and Pinderfields) have generated some ideas.

The slides contain details on these and will be shared after the meeting .

ACTION: Papers to be shared after the meeting – HR.

JH noted that CHFT performance mirrors that seen across most of West Yorkshire and nationally. Conversations have taken place across the West Yorkshire and the West Yorkshire Stroke Network has just recruited two additional clinical leads.
NB – Are the key issues the same across West Yorkshire? The bed base and recruitment?
HR – Yes. Stroke consultants are difficult to recruit as there is a shortage. Speech and Language therapists are also experiencing the same problems.
RM – What are the implications for patients in terms of the challenges faced? Is there a difference in the Community support between Calderdale and Kirklees?
JH – There is a challenge with access to specific stroke beds. The team have put a lot of work in to make sure that wherever a patient is admitted they still receive an assessment from the stroke team and a thrombolysis.
"Long stay Wednesdays" have been introduced which uses a multidisciplinary team approach to look at how we can accelerate discharge for those patients that don't need to be in hospital.
There is a difference between how services are commissioned between Calderdale and Kirklees. Early supported discharge is available in both but is provided by *Locala* in Kirklees and CHFT in Calderdale. There are some differences between the two which need to be reduced as much as possible.
DS – Can a different approach by used to reduce some of the vacancies? What is the likelihood of the business case progressing?
HR – The workforce has been looked at in the past and is still under review. Different skill mixes are being explored some of the ideas are not immediate fixes as training etc. needs to be completed. In addition, the team have been exploring the possibility of using technology and different ways of delivering therapy.
Finance is potentially a barrier to the business case for the stroke hub along with being able to recruit the required resource. So we are exploring doing this in a different way.

DS - Have areas been identified where we can expect to see further improvement before the end of the year?
HR – Hopeful that access to the stroke unit will increase so that 90% of a patients stay in on the stroke unit. Speech and language will continue to be difficult.

ACTION: A further update to come back to this committee next year.

FINANCE & PERFORMANCE

128/24 MONTH 5 FINANCE REPORT

- The Deputy Director of Finance covered the month 5 finance position. The in-month position is a deficit of £1.87m, £0.05m adverse to plan. The Trust is forecasting to deliver the planned £26.26m deficit, but the 'likely case' scenario suggests a gap of £5.58m.

GB – As of last Friday the West Yorkshire ICS are still reporting that they will deliver the plan.
NB – In relation to the forecast scenarios are there any mitigations that could address any variances?
KA – The scale of mitigation in the mid case forecast is £4.2m and there is no more mitigation available beyond this. Should more be required then the focus would be on trying to reduce the individual risks if we were in this situation.

The biggest risks to delivering the plan are the number of open beds and winter pressures. CHFT has less control over this and is dependent on system partners.

DS – The report shows that legal costs are higher than planned. What was the driver behind this? Could this increase further?
GB – The red line deal for reconfiguration as mentioned previously at Board. Weekly meetings have been taking place for almost two years to complete this work. We are now the nearest we have ever been to a conclusion.

The Committee **RECEIVED** the Month 5 Finance Position

129/24 REVIEW TREASURY MANAGEMENT ACTIVITIES

The Deputy Director of Finance spoke around the treasury management update paper. CHFT is to receive £25m of the total £50m given to WYAAT following the submission of the cash support plan. This is non recurrent funding and does not materially alter the financial plan. Based on this CHFT does not intend to submit any further cash support requests in the remainder of this financial year.

VP – In view of the cash coming and the numbers presented in the paper, are we overspending by £6m?
KA - The cash received will not be spent but it may affect our cash balance to a favourable position.
NB – The timing of receipt of the extra £25m deficit funding is uncertain, but is there a point when we need it in cash terms?

KA – The uncertainty is around whether we receive the full £25m or half in October. Either way, cash support had not been planned for October as the education and training funding is received in October.

The Committee **RECEIVED** the Treasury Management update.

130/24 TURNAROUND EXECUTIVE

Two weeks ago there was a remainder of £1m of CIP unidentified. This has now been identified. Some of the schemes may slip slightly but fully developed plans will be in place.
The aim is to close CIP for this year and start on next year's in line with planning.

VP – In any assumptions for next year would the higher bed base seen this year be included?
GB - There are opportunities to do something different and maximise the existing community services and alternative models.

GB also explained that CHFT is trying to agree a different approach to CIP target for next year in terms of budget setting principles and to look at things a bit differently. Budget holders to take more responsibility and accountability for their budgets. Requests below £50k to be managed by the divisions. In addition, we are In the process of agreeing what portfolios will be looked at.

131/24 PWC REPORT

The Director of Finance highlighted points from the paper included in the pack.
ACTION: Medium term financial plan to be added to the workplan for January. – Complete.

NB – Some of the financial benefits identified by PWC are limited. Will it be possible for CHFT to be able to put numbers to each of the actions as targets? Could we score which is going to produce the biggest financial benefits?
GB – Opportunities do not necessarily translate to benefits. Unable to add value to all e.g. budget holder training.
NB – In view of the current financial position should the managing our money training be essential to all to reflect the risk?
KA – The training is role specific essential training. Budget holders must complete the training but if anyone has an interest it is open to everyone.

ACTION: Workplan to be updated to reflect the PWC update to come back in January not December or February as currently. – Complete.

132/24 IPR

The Associated Director of Performance presented to the committee. Successes in performance and challenge areas were presented and discussed.

Proportion of urgent community responses (UCR) has improved and achieved the target for a 2-hour response. PK explained what UCR is as follows. Community UCR referral relates

to patients who are not within the hospital and how soon they are responded to. Community have to respond within two hours.

VP – Virtual ward is disappointing.
PK – It has been up and down over the last few months. The way it is calculated needs to be looked at and there has been a resource issue.
NB – Number of falls is at its lowest level. What is this attributed to?
DS – The number of falls champions has increased at ward level. The falls collaborative has also started to work more closely with the champions.
RM – Transfer of care is still high. Are we expecting any improvement? Is there a difference between Calderdale and Kirklees?
GB – We are engaging with partners in Kirklees which currently has the worse provision. A proposal is being developed to try and do something a bit different. It is not expected to have an immediate short-term affect but will have a longer-term impact. Work done in Calderdale is having a different impact and data has also been compared with Wakefield. It has demonstrated that it is not about the resource but about the pathways. As a result work is underway reviewing the pathways and how we can get patents on the right one sooner. The proposal is scheduled for the Kirklees committee in the near future. Data is now available to demonstrate the differences.

The Committee **RECEIVED** the IPR.

133/24 RECOVERY UPDATE

The Associated Director of Performance presented the Recovery update. CHFT has continued good performance in elective recovery.

VP – The variation month by month on elective recovery outpatients by speciality seems sizeable. Is the data accurate or is this a true representation?
KA - The profiling of the plan does consider forecast variability including holiday periods etc. e.g In August we planned for a reduction.
DS – For specialties with a worsening position has there been a change to the referral rate, has it increased?
PK – Some have seen an increase. The figures can also be affected by the number of clinics or available staffing in month.
ACTION: PK to speak to Helen around the variances in percentages.

The committee **RECEIVED** the Recovery Update

134/24 BAF RISKS

The company secretary spoke to the second BAF review risk for this year.

AM has met with JH prior to the meeting, and it has been suggested that performance risk 423 can be closed. Threat of industrial action has now been removed and the diagnostic performance is improving. Transfer of care has been moved into the acute pressures risk. This would just leave one performance risk.
This also corresponds with a suggestion from Audit Yorkshire that it is better to focus on a fewer number of risks.

The next BAF update is due in January.

NB – The Audit Yorkshire report will be looked at in detail at the Audit and Risk committee but the number of risks is not unexpected considering the reconfiguration work.
DS – The committee is reassured that the risk can be re-added if required.

The Committee **APPROVED** the changes as suggested above.

135/24 DRAFT MINUTES FROM SUB-COMMITTEES

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

- Business Case Approval Group
- Capital Management Group
- Urgent and Emergency Care

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

136/24 WORKPLAN – 2024/25

- Stroke deep dive update to be added for 6 months.
- Medium term financial plan to be added to January.
- PWC actions update in January.

January is also when planning will start to come to this committee which will make for a very full agenda. Look at the possibility of removing the finance month report and/or the recovery report from the meeting agenda. Leave the papers in to be read by the committee but do not have a discussion in the meeting.
ACTION: VP Plan for January meeting.

The Committee **APPROVED** the draft work plan.

137/24 ANY OTHER BUSINESS

DS will not be attending the future meetings. Tim Busby will be attending this committee for the remainder of the financial year. DS was thanked for her contribution.

ACTION: Today's deep dive to be added to Convene once received. – Complete.

138/24 MATTERS TO CASCADE TO BOARD inc. ONE CULTURE OF CARE

- To be picked up through the Chair's highlight report.
- Good news stories to be added.
- CIP stretch still to be delivered.
- Bed base and operational pressures

DATE AND TIME OF NEXT MEETING:

QUALITY COMMITTEE
Tuesday, 3 September 2024

STANDING ITEMS

146/24 – INTRODUCTIONS, APOLOGIES AND ATTENDANCE REGISTER

Present

Denise Sterling **(DS)**	Non-Executive Director **(Chair)**
Nikhil Bhuskute **(NBhu)**	Deputy Medical Director
David Birkenhead **(DBi)**	Medical Director
Jennifer Clark **(JC)**	Associate Director of Therapies
Sharon Cundy **(SC)**	Head of Quality and Safety
Jason Eddleston **(JE)**	Deputy Director of Workforce & Organisational Development
Jonathan Hammond **(JH)**	Chief Operating Officer
Marta Kovacs **(MK)**	Public Elected Governor
Joanne Middleton **(JMidd)**	Deputy Chief Nurse
Vanessa Perrott **(VPe)**	Non-Executive Director
Gemma Puckett **(GP)**	Director of Midwifery and Women's Services
Pam Robinson **(PR)**	Public Elected Governor
Elisabeth Street **(ES)**	Clinical Director of Pharmacy
Michelle Augustine **(MA)**	Governance Administrator **(Minutes)**

In Attendance

Liz Pepper **(LP)**	Medical Examiner Service Manager **(item 157/24)**

Apologies

Neeraj Bhasin **(NBha)**	Deputy Medical Director
Lucy Dryden **(LD)**	Quality Manager for Calderdale Cares Partnership Board
Elizabeth Morley **(EM)**	Associate Director of Quality and Safety
Victoria Pickles **(VPi)**	Director of Corporate Affairs
Lindsay Rudge **(LR)**	Chief Nurse
Jo-Anne Wass **(JW)**	Non-Executive Director

Marta and Pam were welcomed to the meeting as the new public elected governors.

A copy of the attendance register was circulated at appendix A.

147/24 - DECLARATIONS OF INTEREST

There were no declarations of interest.

148/24 – MINUTES OF THE LAST MEETING AND ACTION LOG

The minutes of the last meeting held on Tuesday, 2 July 2024, circulated at appendix B, were approved as a correct record. The action log can be found at the end of these minutes.

149/24 – TERMS OF REFERENCE

The terms of reference, circulated at appendix C, were amended to include a paragraph relating to the quoracy of the meeting. These will be submitted to the Board of Directors next week.

OUTCOME: The Committee approved the amended terms of reference.

RESPONSIVE

150/24 - INTEGRATED PERFORMANCE REPORT (IPR)

Jonathan Hammond and David Birkenhead presented the report, as circulated at appendix D.

DB noted that the quality aspects of the report are covered in reports later in the meeting, and will be picked up at that point.

JH provided an update that a deep dive on stroke will be brought to Quality Committee in October. **JH**, **LR** and **DB** met with the medical team in relation to timeliness of access to an acute stroke bed within 4 hours. Performance is low and the metric is not where it needs to be, however, actions are in place, and an additional Work Together, Get Results (WTGR) session is planned for mid-September, which will be reported as part of the deep dive.

DB added that palliative care inreach into the stroke unit will also be reviewed, due to the complex patients, and a more holistic view is needed on how to manage them moving forward.

VPe asked if anything had been learned from what has not succeeded, which may give some insight as to what is taking place. **JH** stated that the model has been followed, albeit trying to run it more effectively and efficiently, however, there has been a shift in terms of the complexity of patients, and a shift in demand, which is still higher than it was pre-COVID that has not been overcome. The biggest challenge is bed occupancy. If a stroke bed occupancy of 80-85% could be retained, there would be no issues with access to the front end. It is recognised that improvements need to be made along the entire pathway, including back out into community, as community services are not being accessed as effectively as could be, which needs focus, whilst having discussions with those services about the changes that they may need to make to be more responsive or to adjust to the complexity of the patients.

DB added that there are system issues, and CHFT, along with a number of other organisations have their challenges in relation to stroke metrics. There are some underlying issues in relation to medical and therapy staffing. There has been a change in the number of patients presenting and their complexities, therefore, a system response is required in terms of the prevention work to try and reduce the overall incidence of stroke.

JM also commented that one of the pieces of work being done is looking at collaboratives and the quality improvement methodology to be clear on what point interventions have been put in place, in order to map whether it has worked from an improvement perspective.

As part of one of the actions for the quality priority for stroke, **DS** asked how effective it has been so far with providing focused quality care for the cohorted patients who were outliers. **JH** responded that this has started, with Ward 8B at Calderdale being used to outlie patients, however, the actions mentioned by **JM** and **DB** will play into this, therefore, it is too early to say how effective this has been.

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

151/24 - QUALITY REPORT

Joanne Middleton and Nikhil Bhuskute presented the report, as circulated at appendix E.

In terms of the Clinical Outcomes Group dashboard, there has been a gradual and increasing position in the Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR) due to two episodes of excess death in respiratory areas. Deep dives were carried out into both episodes and found that the underlying cause was predominantly the suboptimal capture of comorbidities in these groups, which raised the SHMI and HSMR position. It was also found that there were no cases of significant quality of care issue in these groups.

Recent concerns were raised regarding the CHFT position compared to hospitals in areas around London. The underlying cause is that SHMI does not consider health inequalities, and the majority of hospitals in the report were in the North of England, where it is known that the Index of Multiple Deprivation (IMD) and overall health inequalities are significantly different between London and hospitals in the North.

With Same Day Emergency Care (SDEC) activity now removed from SHMI calculations, which is currently being done by only two trusts across the country, CHFT will be in a negatively outlined position until all trusts fall in line with benchmarking in March 2025.

A focused piece of improvement work is being done to improve the sepsis identification and management in the Emergency Departments, which will make a significant impact in patients not deteriorating and improving their overall outcomes.

In relation to SHMI, **VPe** asked if there were any peer hospitals in the North of England which CHFT could be compared to. **DB** responded that there was an article in the Daily Mail which looked at trusts' SHMI, and CHFT were 14th. Peer trusts in Bradford and Leeds were higher. The only organisation in a positive position was Harrogate.

The issues in relation to the SDEC and how that will alter our data moving forward is going to be challenging. CHFT predictions will be a 5 to 10 point rise in SHMI and HSMR, which is a result of the reduced denominations, not a quality of care issue.

DS commented on the positive report, including the implementation of Patient Safety Incident Response Framework (PSIRF) and the Quality Strategy action plan.

OUTCOME: **JM** and **NBhu** were thanked for the update, and the Committee noted the report.

SUB-GROUP REPORTS

152/24 – PATIENT EXPERIENCE AND INVOLVEMENT GROUP REPORT

Joanne Middleton presented the report as circulated at appendix F, noting that Vicki Drummond (Senior Nurse in the Patient Experience Team) who authored the report, has transformed the Patient Experience and Involvement Group (PEIG) group in terms of her insight, connections with system partners and understanding of legislation.

The key points to note were highlighted.

DS commented on the positive impact that the group is making, and stated that nutrition and hydration features as a key theme in a number of reports, and asked whether the Group is able to gather and triangulate the information into informing the development work that has taken place. **JM** stated that this has started and once InPhase is fully embedded this will become easier. **JM** also noted that **LR** has commissioned a review of all collaboratives to understand how they are measuring improvement and whether they are all consistently doing so, particularly with key collaboratives like nutrition and hydration, as a number of complaints are still being seen for this fundamental care.

OUTCOME: The Committee noted the update.

153/24 – CLINICAL OUTCOMES GROUP REPORT

David Birkenhead presented the above report as circulated at appendix G, highlighting that this report provides the detail behind the metrics in the quality report.

- Sepsis - a patient group directive has been produced for nursing colleagues to give antibiotics in the Emergency Department (ED), which will significantly improve the metric. There are some challenges in relation to of the data quality metrics, whereby patients being in the denominator that should not be included, therefore the position stated may be worse than reality, however, this is being refined moving forward.

- Deteriorating patient – further work is required around the use of Nervecentre to ensure that all colleagues are using it appropriately and not switching alerts off. In terms of the metrics, **JM** added that the use of live systems are being looked into being more responsive to assessments.

- Acute Kidney Injury – this relates to the nutrition and hydration discussions earlier, with specialist nursing colleagues who are supporting the work and ward champions to hopefully drive through improvement.

- Dementia – it is important that dementia screening is improved, and also that the necessary actions are followed up, with some focused work once the metric starts to improve. **JM** also added that delirium screening will become a nursing task.

- End of life care – improvement is being driven through three priorities in terms of advanced care planning, recognition of the end of life, and education and training. New colleagues are due to start within palliative care and Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) is being rolled out throughout the organisation and picking up pace, which will see some improvement over the coming months. **JM** stated that there have been some pressures within the hospital palliative care team from a nursing perspective, whereby the seven-day service has been suspended. The palliative care consultants are currently picking up calls, and in the process of recruiting.

DB thanked **SC** for her input into this detailed report.

OUTCOME: The Committee noted the update.

154/24 – MEDICATION SAFETY AND COMPLIANCE GROUP REPORT

Elisabeth Street presented the report, circulated at appendix H, and highlighted the key points to note.

VPe asked about the serious incident involving the theft of pregabalin and whether there was any learning on issues which helped to pick up the incident and good actions taken. **ES** stated that nursing colleagues on the ward identified concerns and escalating to senior pharmacy and nursing colleagues. The drug is allowed to be kept on the ward, under very close 6-hourly monitoring. If it is made to be a schedule 2 drug, it would then be locked and secured in a controlled drugs (CD) cupboard, however, there would be no way of knowing where the drug has gone if any were to go missing. The monitoring will help identify who is on duty at the time, if there were any patients so the pharmacy team can check the prescribing system to see if any doses were administered and there is justifiable use. There is agreement of who the problem is shared with. The positive was that there was a very comprehensive plan from the West Yorkshire CD liaison officer in West Yorkshire.

OUTCOME: The Committee noted the update.

155/24 – Q1 INFECTION CONTROL REPORT

David Birkenhead presented the above report as circulated at appendix I, highlighting an improving position over the last year.

Clostridium difficile numbers are slightly lower than last year, as well as Escherichia coli (E. coli) bacteraemia, Pseudomonas aeruginosa, Klebsiella, and Methicillin-resistant Staphylococcus aureus (MSSA), which is positive for the first quarter, particularly given the acuity and pressures in the organisation and the extra beds opened.

Thresholds have now been set for 2024/2025, with all showing increases over last year's thresholds:

- Clostridium difficile - 57
- E. coli - 70
- Pseudomonas aeruginosa - 5
- Klebsiella - 33

There have been a number of cases of Norovirus in Q1, resulting in a number of wards being closed as a result. COVID-19 has had a less of an impact, and currently have a relatively small numbers of patients in the organisation with COVID, with two or three patients toward the end of last week.

There are significant staffing challenges in the infection control nursing cohort, with both Band 7 colleagues leaving, and are recruiting to those positions and expecting colleagues to start at the end of October, beginning of November. The team are being supported, particularly in their on-call rotas, by site matrons.

In preparation for winter, fit testing will be improved across the organisation, and the team are supporting and identifying colleagues who must be fit tested to manage COVID and influenza. The COVID and influenza vaccine campaign will commence in October.

VPe asked whether any respiratory syncytial virus (RSV) and measles are being noted locally. **DB** stated that one or two patients are being seen with measles in the organisation, presenting through the Emergency Department (ED), however, not RSV as yet. Vaccination campaigns are being looked into for whooping cough, RSV and measles for healthcare workers and maternity services.

DS asked whether there were any new strategies coming into the organisation in relation to enhancing infection prevention. **DB** stated that there is nothing particularly new, however, there is a move in the UK to the National Infection Control Manual - instead of having local policies and procedures, there is a move to this national manual which will standardise the approach to infection prevention and control (IPC) across the UK. CHFT have been looking into ultraviolet (UV) light disinfection as an alternative and quicker process to hydrogen peroxide vapour (HPV), however, given the financial position of the organisation and the fact that it is probably no more effective than HPV, this is currently not considered as urgent. New products which might help with IPC are being looked into, however, getting the basics right is what drives good infection control rather than new approaches. When looking at reconfiguration, IPC are heavily involved in discussions and will help moving forward with the new hospital.

OUTCOME: The Committee noted the report.

EFFECTIVE

156/24 – Q4 LEARNING FROM DEATH AND ANNUAL REPORT

Nikhil Bhuskute presented the report, circulated at appendix J, which includes all aspects of deaths within the hospital and how we learn from them. The report also includes updates from the Medical Examiner (ME) office and maternal and neonatal deaths.

The key points highlighted were the improved position in initial screening reviews (ISR), at 48% against a target of 30, and for the last two years, the position has been gradually improving from 30% to the current position of 48%. A new process has been put in place to improve the quality of case selections. Previously, patients were randomly selected to have an ISR, however, a mortality predictive tool has now been developed by the Business Intelligence Team. Patients who have less than a 20% chance of dying are selected and used for an ISR, as there is more of a likelihood of finding improvement themes in this group of patients, rather than randomly selecting patients who had an expected death.

From the ISRs, poor care was found in 27% of patients, which were then escalated to the structured judgement review (SJR) which also takes inputs from the ME office, and any disputed ISRs.

The three key learnings derived from the process were communication, documentation and the deteriorating patient, and the actions and areas of good practice were included in the report.

In relation to the copy and paste function as part of the key learning, **VPe** asked whether this has been relayed to the platform creators. **NBhu** stated that this has been fed back, however, the way the current platform is built, the copy and paste function cannot be removed, therefore, a change cannot be made to the system.

OUTCOME: The Committee noted the report.

157/24 – MEDICAL EXAMINER REPORT

Liz Pepper presented the report, circulated at appendix K, highlighting that since the last report in February 2024, Parliamentary sign-off has taken place for the commencement of the legislation for the Death Certification Reforms, which will take effect from Monday, 9 September 2024.

JMidd asked whether relatives may be waiting much longer to get a death certificate and how this affects different faiths who require an early release of a relative. **LP** stated that faith deaths will be dealt with as a priority, meaning no delays.

DS asked whether there were sufficient team members with the increased workload. **LP** stated that there is a vacancy for a Medical Examiner (ME) out to advert, taking it up to 12 members for the team.

DS thanked **LP** for the update and good to see that a service is being offered to meet the needs of the Community.

OUTCOME: The Committee noted the report.

SAFE

158/24 – MATERNITY AND NEONATAL REPORT – THEME 3 FOCUS OF 3 YEAR PLAN

Gemma Puckett presented the report as circulated at appendix K, highlighting theme 3 which is developing and sustaining a culture of safety, learning and support.

GP summarised objectives 1: developing a positive safety culture; 2: learning and improving; and 3: support and oversight.

In relation to the stillbirths, there have been 19 stillbirths to date, this calendar year, with a cluster in February 2024. There is a downward trend in the number of stillbirths, however, there is work to be done.

Alongside the stillbirth rate, there has been an increase in the number of concealed pregnancies and wider action is needed, including the development of the West Yorkshire Obesity Strategy to include a pre-conceptual focus. A stillbirth task and finished group has been developed (terms of reference included).

Successes included positive feedback about care received from a family who had experienced an earlier pregnancy loss; the directorate patient experience report received positive feedback at the Trust Patient Experience and Involvement Group (PEIG); Matron Jo Machon is one of 10 matrons nationally who have been selected to participate in the review of the Matron's Handbook, positive feedback from the CQC engagement visit in maternity services, and positive pants week began on National Thank You day.

VPe commented on colleagues support with the open-door policy and asked about a Schwartz round. **GP** commented on further discussions needed for potential bespoke Schwartz rounds for maternity and neonatal colleagues as it has been a challenging year.

VPE also asked about the workforce, which **GP** confirmed that around 35 whole time equivalent midwives will be due to start around mid-October, and four Band 6 midwives coming from other organisations. This will be reflected in the data from November onwards.

OUTCOME: The Committee noted the report.

WELL LED

159/24 – BOARD ASSURANCE FRAMEWORK (BAF) RISKS

Joanne Middleton and David Birkenhead presented the risks as circulated at appendix M, for:

- 4/19 – Public and patient involvement
- 6/19 – Compliance with quality and safety standards, and
- 4/20 – CQC Rating

There were no changes to the risk ratings since last presented to the Quality Committee.

OUTCOME: The Committee noted the report.

ITEMS TO RECEIVE AND NOTE

160/24 – MINUTES FROM:

Infection Control Performance Board
A copy of the minutes from Tuesday, 25 June 2024 were circulated at appendix N for information.

Kirklees Quality Board
A copy of the minutes from Wednesday, 31 July 2024 were circulated at appendix O for information.

Calderdale Quality Board
A copy of the minutes from Wednesday, 15 May 2024 were circulated at appendix P for information.

OUTCOME: The Committee noted the minutes.

161/24 - ANY OTHER BUSINESS

There were no other items of business.

162/24 - BOARD TO WARD FEEDBACK

There were no items.

163/24 - MATTERS FOR ESCALATION TO THE TRUST BOARD

- Approved revised Committee terms of reference
- Update on Quality Report
- Update on sub-group reports received – Patient Experience and Involvement Group (PEIG), Clinical Outcomes Group, Medication Safety and Compliance Group; Q1 IPC.
- Noted the Board Assurance Framework (BAF) risks reviewed
- Update on all reports received at the Committee.

164/24 - QUALITY COMMITTEE ANNUAL WORK PLAN

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

POST MEETING REVIEW

165/24 - REVIEW OF MEETING

- Detail in reports has been very helpful
- Good discussion of reports

NEXT MEETING

Tuesday, 15 October 2024
9:30 – 12:00 noon
Microsoft Teams

ACTION LOG FOR QUALITY COMMITTEE

Position as at: Tuesday, 3 September 2024

Red	Amber	Green	Blue
Overdue	Due	Closed	Going Forward

DATE DISCUSSED	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
08.05.24	**85/24 – DIVISIONAL REPORTING – MEDICINE - Q4 REPORT**	David Britton	**LR** asked if there were any definitive timescales as to when those outstanding Policies would be updated. **DBr** was not aware of the timescales for each of the Policies, however, this will be followed up outside of the meeting and updated at the next meeting. **ACTION:** An update on timescales for Policies to be brought to the next meeting. – **Sepsis** - with Lindsay and David B for review – **Update**: Sepsis Policy now approved. – **Nutrition and Hydration** - plan for the draft to go to the June N&H group – **Implantable Cardioverter Defibrillator** - await update – **Oral hygiene Care** - SALT reviewing, await further update. **ACTION**: **MA** to follow-up on progress with other policies. **Update June:** Resuscitation – Under review. Due for ratification in August. No further update received for Nutrition, ICD or Oral Hygiene Care Policies. **Update July:** – The Review of the Oral Hygiene policy has now been completed and will be shared for comments. – The Nutrition and Hydration policy is currently being reviewed and updated. **Update:** – **Implantable Cardioverter Defibrillator** - now live and on **intranet** – **Nutrition and Hydration Policy** - will be updated November 2024 – **Oral hygiene Care** – speech and language therapy (SALT) reviewing, and awaiting further update	Tuesday, 3 September 2024		
08.04.24	**NASOGASTRIC TUBE UPDATE**	Joanne Middleton	**ACTION – 8 Apr 2024:** Following last month's verbal update, a report will return next month with results of the planned re-audit and assurance that all actions have been closed. **UPDATE - See item 81/24 of May's agenda** **ACTION: Further updates to be brought to the Committee on a quarterly basis**	Tuesday, 12 November 2024		
08.05.24	**92/24 – BOARD ASSURANCE FRAMEWORK RISK 4/20: CQC**	Lindsay Rudge	**ACTION**: Correct version of BAF risk to be re-circulated. **Update:** This will be circulated after the Audit and Risk Committee meeting on 23 July 2024 **Update: See item 159/24**			CLOSED Sept 2024

Calderdale and Huddersfield NHS Foundation Trust

Chair Approved Minutes of the Audit and Risk Committee Meeting held on Tuesday 22 October 2024 commencing at 10:00 am via Microsoft Teams

PRESENT

Nigel Broadbent (NB)	Non-Executive Director **(Chair)**
Jo Wass (JW)	Non-Executive Director
Tim Busby (TB)	Non-Executive Director

IN ATTENDANCE

Andrea McCourt	Company Secretary
Victoria Pickles	Director of Corporate Affairs
Gary Boothby	Director of Finance
Kirsty Archer	Deputy Director of Finance
Shaun Fleming	Local Counter Fraud Specialist
Matthew Moore	Senior Manager, KPMG
Amber Fox	Corporate Governance Manager *(minutes)*
Chris Boyne	Deputy Director, Audit Yorkshire
Robert Birkett	Chief Digital and Information Officer
Lindsay Rudge	Chief Nurse *(for item CH/01/2025 NG Tubes Limited Assurance Report)*
Jo Middleton	Deputy Chief Nurse *(for item CH/01/2025 NG Tubes Limited Assurance Report)*
Shelley Rochford	Head of Risk and Compliance
Sarah Rothery	General Manager for Resilience, Acute Flow and Transformation *(for item* 70/24)
Rabiya Ali	Public Elected Governor
Howard Blagbrough	Public Elected Governor

The Chair welcomed everyone to the Audit and Risk Committee meeting and introductions were made.

59/24 APOLOGIES FOR ABSENCE

Apologies were noted from Leanne Sobratee, Internal Audit Manager.

60/24 DECLARATIONS OF INTEREST

The Chair reminded the Committee to declare any items of interest at any point in the agenda.

61/24 MINUTES OF THE MEETING HELD ON 23 JULY 2024

The minutes of the extra-ordinary meeting held on 23 July 2024 were approved as a correct record.

OUTCOME: The Committee **APPROVED** the minutes of the previous meeting held on 23 July 2024.

62/24 MATTERS ARISING AND ACTION LOG

The action log was reviewed, and all actions due for completion were closed, with one ongoing action 54/24 regarding Committee annual reports and self-assessment, due by 28 January 2025.

AY Briefing Note Audit Committee review of Board committee annual reports (Appendix B2)
A report from Audit Yorkshire shared their review of Board Sub-Committee annual reports and self-assessments. NB highlighted an idea from another Trust which undertook self-assessment via a discussion rather than completing a checklist. NB proposed a piece of work takes place before the next meeting.

Action: NB/AM/VP to undertake a piece of work looking at Board Committee Annual Reports and self-assessments and share options and a proposal at the next Committee meeting on 28 January 2025

Limited Assurance Reports: The following limited assurance report was received at the meeting in July 2024. The audit lead was invited to this meeting to provide assurance that action is being taken regarding the recommendations.

CH/01/2025 Naso-Gastric (NG) Tubes Audit – Lindsay Rudge / Jo Middleton
Lindsay Rudge, Chief Nurse explained there were three NG tube never events which have actions, a limited assurance report from Internal Audit and a further limited assurance report following a re-audit which highlighted issues regarding incomplete documentation of NG activities and policy confusion, as well as some positive developments.

Jo Middleton, Deputy Chief Nurse provided an overview of the comprehensive action plan in place relating to NG tubes.

It was proposed that the NG action plan be monitored by the Trust Quality Safety Lessons Learned Forum to ensure that all aspects of the action plan are appropriately governed, and safety improvement plans are developed in line with recommendations. The Forum will also provide assurance that learning is shared and embedded across the organisation on behalf of Trust Board.

TB asked if some of the actions decided on were not in place when the re-audit took place. The Chief Nurse explained there had been partial implementation of actions when the re-audit took place and this continues to evolve, with oversight of the actions going forward by the Quality Safety Lessons Learned forum, rather than the Clinical Outcomes Group. The Deputy Chief Nurse explained the re-audit focused mainly on record keeping and a separate place to document the NG tube activities within patient progress notes has been a change of practice.

JW asked for an update in relation to the medical staff compliance training and competence. The Chief Nurse stated there has been recognition some of the EST (essential safety training) and role specific training has increased over time and the medical staff induction programme has been changed to allow greater time for colleagues coming into the organisation to undertake this suite of training.

NB asked if there was a plan to undertake a further follow up on nasogastric (NG) tubes. Chris Boyne confirmed there will be a follow up of each recommendation and Internal Audit will validate the evidence provided for actions. Quality Committee will provide assurance on action closure and confirm this to the Audit and Risk Committee. The Chief Nurse suggested NG Tubes would form part of the Internal Audit Programme for next year.

OUTCOME: The Committee **NOTED** the updates to the action log and **NOTED** the updates provided on the previous limited assurance report related to NG Tubes.

63/24 RISK MANAGEMENT DEEP DIVE

Vicky Pickles, Director of Corporate Affairs and Shelley Rochford, Head of Risk and Compliance presented a deep dive presentation on risk management. The key points noted were:

- Risk management has been evolving over the last two years and the next steps are dependent on the new risk management system.
- Focus over the last 18 months has been on strengthening the risk management process within each Division. Additional governance has been put in place for the clinical divisions to ensure risks are regularly reviewed and a formal approval is in place for any risks going onto the high level risk register. Data was shared which showed an ongoing improvement in more timely reviews of risks.

- Corporate risks currently do not have a point of central co-ordination and there will be a re-establishment of the Corporate Risk Group from January 2025.
- There has been a decline in the number of overall risks on the risk register compared to last year as a result of the review process. A total of 262 risks are on the risk register compared to 539 last year. There has been a reduction in the number of very high and high scoring risks.
- Head of Risk and Compliance was now in post.
- The Risk and Compliance Group has been re-established.
- A step by step guide has been produced to support colleagues when updating risks on the bespoke Risk Register system.
- Deep Dive of all risks is undertaken and presented at the Risk Group.
- Audit Yorkshire's review of risk management identified strong governance structures within Divisions to manage and monitor risks.
- Risk Management is included in the Quality and Safety Preceptorship training.
- The implementation of the new risk management system InPhase will provide a significant upgrade over the current bespoke in-house risk register system, with a proposed go live date of March 2025. The new system will offer enhanced functionality, greater flexibility and improved user experience. InPhase will deliver more intuitive dashboards, advanced reporting features and real-time data insights. The new system will automatically send out notifications to risk owners as a reminder when the next review date is due.
- Internal Audit recommendations will be completed once InPhase has been fully implemented.
- Risk Management Policy and Strategy will be reviewed and aligned to the changes with InPhase and a Standard Operating Procedure will be produced.

The Director of Corporate Affairs informed the Committee there has been a delay with the implementation of InPhase due to the company being bought by Ideagen. The priority for the Trust has been to move incidents onto the new InPhase system, followed by risk management, as the Datix system will be coming to an end in the new year. The Head of Risk and Compliance explained there are three modules on Datix that had to be prioritised which are Incidents, Central Alerts System (CAS) alerts and complaints.

The Director of Finance asked when the Board Assurance Framework (BAF) will move onto the new InPhase system. The Director of Corporate Affairs explained as the BAF isn't currently on a system, this will be one of the last modules to transition onto the system. She added that not many organisations were using the BAF model on InPhase; however, it does have advantages including the triangulation of risks that align to the BAF.

JW asked what the link was between the corporate high level risks and the divisional risks. The Director of Corporate Affairs explained the difference between the BAF which covers the strategic risks of the organisation such as the capital programme and individual service risks.

NB clarified the outstanding internal audit recommendations will be updated for completion by March 2025 when the new InPhase system is implemented.

CYBER SECURITY – THIRD PARTY ASSURANCES DEEP DIVE - PRESENTED BY ROB BIRKETT

Rob Birkett, Chief Digital and Information Officer presented a deep dive presentation on cyber security, third party assurances. The presentation took the Committee through:

- Real time threat monitoring
- Incident response and recovery
- Threat intelligence and management
- Vulnerability management
- Compliance management

- Cyber threat types
- Cyber Supply Chain Risk (CSCR) Management

TB asked how frequently backups for systems are undertaken and how easily it would be to restore. The Chief Digital and Information Officer confirmed some systems continually back up or several times a day and he confirmed there are 24 hour backups for each supplier and the supplier should be able to pull the backup at the same time as the Trust. The Chief Digital and Information Officer stated the Trust perform well in terms of data security awareness and achieved 97% compliance last year for data security and awareness training.

Chris Boyne highlighted the recent limited assurance report on cyber security patching practices within the Trust as there were known vulnerabilities where assets were not fully patched and an action plan was already in place to address these issues. The Chief Digital and Information Officer added they generally receive significant or high assurance so this is an area to focus on and there are mitigations in place around patching and a clear action plan to address this.
Action: Rob Birkett to provide an update on the THIS 02 2025 Cyber Security - Patching Audit Limited assurance report at the next meeting in January 2025.

OUTCOME: The Committee **NOTED** the Deep Dives into Risk Management and Cyber Security provided for assurance.

64/24 Executive Director of Finance's Business

1. Review of Losses and Special Payments

The Deputy Director of Finance presented the losses and special payments for quarter 2 2024/25 in adherence to the Standing Financial Instructions (SFI) of the Trust. The key points highlighted were:

- Pharmacy losses in quarter 2 compared to quarter 1 has been raised with the Director of Pharmacy and there are a couple of specific issues, including some flu vaccines that had expired, this has been reviewed to minimise risk for this year's flu campaign.
- Ongoing focus at the Cash Committee to minimise losses.

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

2. Waivers of Standing Orders Report

The Director of Finance presented the waivers of standing orders report for quarter 2 2024/25. He highlighted one single source tender over the threshold that related to contact lenses and informed members that a tendering process will take place over the next 12 months to look for a better contract.

NB asked if there were any risks or challenges to expect from organisations with setting this up for procurement and how the Trust will know which service to use out of the bundle of suppliers. The Director of Finance explained going through a market exercise will reduce the procurement risk due to the value. He explained end users will be heavily involved in the procurement process which will be based on strict criteria to obtain best value for money. He explained the Trust may choose to go with a couple of suppliers dependent on the lenses available as there may be risk associated with only choosing one supplier.

Howard Blagbrough asked why the Trust are supplying contact lenses through the hospital and not through opticians. The Director of Finance responded this is dependent on what type of lenses they are, there will be some specific requirements for the Trust to provide these particular lenses. The Deputy Director of Finance clarified the Trust also take payment from patients for contact lenses.

POST MEETING NOTE

The Director of Finance clarified with Ophthalmology that the lenses the Trust buy are specialist lenses and not the type that can be bought on the high street. Additionally, the Trust receives income for these where eligibility for payment allows. Additionally, the team advised that the Trust still need to use a few suppliers following the tender as no single supplier provides the full specialist range required.

OUTCOME: The Committee **NOTED** the waivers of standing orders.

65/24 Internal Audit

1. Review Internal Audit Follow Up Report

The Deputy Director Audit Yorkshire presented the follow up report which sets out the Trust-wide position on the implementation of Internal Audit recommendations which have fallen due during Q2 2024/25. The key points were noted:

- 79 recommendations (69%) were completed.
- 20 recommendations (16%) missed their original target dated and revised target dates have been agreed for all of these.14 of these related to Risk Management and Oversight and Consultant Job Planning.
- One recommendation is overdue.

2. Follow up of Internal Audit Progress Report

The Deputy Director Audit Yorkshire presented the progress report, the key points noted were:

- On track to fully deliver the internal audit plan by the end of March 2025.
- Seven audit reports have been agreed with management since the last Committee.
- Benchmarking report has been included in the Review Room for information.
- An event on Governance and Risk Management is taking place on 10 December 2024 and members were encouraged to book on.
- A limited assurance report was provided on Cyber Security Patching – see deep dive discussion minute 63/24.

TB asked what the next steps would be on the limited assurance reports, which were salary overpayments and cyber security patching. The Deputy Director Audit Yorkshire explained the salary overpayments limited assurance report is in draft and they are in the process of agreeing an action plan with management. The Director of Finance stated they have identified issues within salary overpayments and there have been some delays in finalising this report due to the number of stakeholders involved. Limited assurance reports are presented to Audit and Risk Committee once finalised. A full action plan is included in the review room and management commit to dates when these will be completed.

Action: Suzanne Dunkley/Gary Boothby/ Kirsty Archer to provide an update on actions relating to the limited assurance report on Salary Overpayments at the Committee meeting on 28 January 2025.

The Deputy Director Audit Yorkshire highlighted the level of detail in terms of significant assurance reports which highlights areas of good practice, for example, the planned care pathway transformation programme.

NB highlighted the benchmarking report of the Board Assurance Framework has been shared in the review room. He also highlighted an Internal Audit benchmarking report which compared audit outcomes over the last two years showed the Trust has a lower proportion of limited assurance reports compared to other organisations.

JW asked if the reasoning for the consultant job planning recommendations being overdue were reasonable and flagged that a number of these recommendations seemed quite significant. NB reminded the Committee normal practice would be to invite the audit lead to the next meeting to provide an update. The Deputy Director Audit Yorkshire advised they could request more information. The Director of Finance explained some of these recommendations have been around for a long time and are tricky issues. The job planning actions are challenging and needs agreement and for some directorates/divisions the job planning process is quite time consuming. The Allocate software used for job planning has potentially presented some opportunities with deep dives into some specialties.

NB agreed to raise the number of outstanding recommendations relating to the consultant job planning audit report in his highlight report to the board.

The Director of Corporate Affairs suggested it should be a prompt for inviting colleagues to share their update if the recommendation has been moved more than once from the original target date.

Action: Neeraj Bhasin to be invited to the Audit and Risk Committee on 28 January to update on Consultant Job Plan Recommendations.

OUTCOME: The Committee **NOTED** the progress made with the 2024/25 Internal Audit Plan and progress against completing Internal Audit recommendations.

3. Significant and High Assurance Audit Report

The following final internal audit reports were available in the review room:

- CH02 2025 Government arrangements re unplanned care
- CH03 2025 Handovers
- CH04 2025 Medical records management
- CH05 2025 Governance processes reporting Well Organised Ward
- CH06 2025 Learning disabilities
- THIS 01 2025 THIS compliance with ISO Standards
- THIS 02 2025 Cyber security patching

Benchmarking

- BAF and Risk Management review
- Internal Audit output comparison 2022/23 and 2023/24
- Risk management and BAF working

4. Internal Audit Monthly Insight Report

The monthly Insight Reports were provided for information.

66/24 External Audit

Sector Update

Matt Moore, Senior Manager, KPMG presented the sector update which was circulated during the meeting.

OUTCOME: The Committee **NOTED** the External Auditor's Sector update.

Vicky Pickles, Director of Corporate Affairs left the meeting.
Matt Moore left the meeting.

67/24 Board Assurance Framework – Update 2

The Company Secretary presented update 2 of the Board Assurance Framework which will be presented to the Board on 7 November 2024, including two specific risks that the Committee has oversight for relating to cyber security and health and safety, both of which had been discussed at the meeting.

When undertaking the second update of the BAF, the Trust has been mindful of the Audit Yorkshire benchmarking report on BAFs issued in the summer 2024. The Department of Health recommends a mean average of 12 principal risks should be on the BAF. This identified the Trust as an outlier with 22 BAF risks at the time of the report.

Four risks are proposed for removal from the BAF as the target risk scores have been achieved, reducing the number of total risks to 18. Risk updates state where it is expected that a risk will have reduced to its target score at update 3, of which there are currently two.

TB suggested the Trust should be mindful about the response to the benchmarking report and said he would not want the Trust to lose the specific risks and it is unhelpful to reduce the number of risks too much as the risks become more general and more challenging to address. The Company Secretary agreed that more specific risks allow for better management of risks and controls and explained the rationale for the risk reductions. She noted a balanced response had been taken, acknowledging the Trust position as an outlier with a reduction of risks from 22 to 18.

NB flagged the risk of also having too many risks where you do not have time to address or focus on them all at Board level and stated it is about getting the right balance. NB suggested the Trust does not need to reduce to 12 risks on the BAF but need to have the right number to focus on.

JW agreed the answer is balance and to not make the risks too generic and the importance of questioning why you are an outlier.

OUTCOME: The Committee **APPROVED** the Board Assurance Framework and the removal of risks 2/23, 3/23, 4/23 and new Workforce risk (1/24) replacing two previous workforce risks 11/19 and 1/22 and reduction in risk score for 4/19 and **CONSIDERED** if there are any further risks to the achievement of strategic objectives.

68/24 Company Secretary's Business

1. Managing Conflicts of Interest Policy

The Company Secretary presented the revised managing conflicts of interest policy. The national guidance for decision makers is Band 8d and above; however, the Trust previously lowered this to Band 7 and above and are proposing to continue with the Band 7 threshold. The Company Secretary highlighted the Trust's good compliance position with declarations achieving over 90%.

JW pointed out a reference related to sub-committee terms of reference in the policy. The Company Secretary responded each Committee are asked to declare any interests at the start of each meeting; however, she will review this in the policy.
Action: Company Secretary to review the reference to sub-committee terms of reference in the policy.

JW explained a HR Director in the NHS shared experience where staff did not realise they had a conflict of interest and asked how the Trust tackle this. The Company Secretary explained the Trust take a multi-faceted approach on declarations of interest which includes communicating with colleagues at key times of the year, reviewing information on clinical private practice being picked

up through other routes, a page on the intranet with guidance on situations and advice to staff by the Company Secretary.

The Director of Finance flagged an inconsistency in what is declared by Directors and Non-Executive Directors in terms of WYAAT Forums and key decision-making groups.
Action: Company Secretary to provide guidance on what to include and examples of this in the next reminder for declarations.

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

2. Audit and Risk Committee Workplan

The Audit and Risk Committee workplan for 2025 was shared. The two limited assurance reports and an update on the Consultant Job Planning recommendations will be added to the next meeting in January 2025.

OUTCOME: The Committee **APPROVED** the Committee Workplan for 2025.

69/24 Local Counter Fraud

1. Local Counter Fraud Progress Report

Shaun Fleming, Local Counter Fraud Specialist, presented the summary of work for 2024-25.

2. Local Counter Fraud Risk Assessment

The Local Counter Fraud Specialist presented the Fraud Risk assessment component three which included reviews by Trust staff of the scoring of fraud risk areas. The new functional standards return came into force a few years ago, currently scored amber with the aim to move to green.

Appendix B – Criminal prosecutions and other means of disposal was shared.

3. Counter Fraud Policy Review

The policy has been updated and the changes are reflected in red, the policy now incorporates a new type of fraud offence relating to failure of an organisation to prevent fraud.

NB asked if there were any examples of the new offence being applied elsewhere. The Local Counter Fraud Specialist explained there were no examples at the moment; however, they will include any examples in future reports.

The policy will be reviewed on a more regular basis and every two years, opposed to every five years.

4. Counter Fraud Newsletter

The latest Counter Fraud Newsletter was made available in the review room.

OUTCOME: The Committee **NOTED** the Local Counter Fraud Progress Report, Local Counter Fraud Risk Assessment and **APPROVED** the Counter Fraud Policy.

70/24 Health and Safety Annual Report

Sarah Rothery, General Manager for Resilience, Acute Flow and Transformation presented the Health, Security and Safety Annual Report for 2023/24.

TB asked if violence and aggression was getting worse for staff based on the number of incidents and what the Trust can do about prevention. TB highlighted a drop in training compliance for manual handling and noted medical devices has seen an increase in incidents.

Sarah Rothery responded they will look at producing the statistics and she confirmed they are receiving more Datix incident reports for adverse behaviour. She explained there has been a push on encouraging staff to report these incidents and targeted training is taking place for high-risk areas.

JW raised MSK injury was one of the highest reasons for sickness absence at the moment and asked where this was tracked. Sarah Rothery responded the team does not track role specific training and JW stated she will follow up with Workforce to understand if this is monitored at the Education Committee (a sub-Committee of the Workforce Committee).

JW asked if mental health is reported in terms of sickness/anxiety. Sarah Rothery confirmed there is a Mental Health Group and the Resilience and Safety Group is chaired by the Chief Operating Officer which meets every other month and the meetings will be refined moving forward. The Director of Finance confirmed the Trust record absence in relation to stress, anxiety and mental health.

The Director of Finance explained the security service has historically been provided by Leeds for Huddersfield Royal Infirmary and this is moving back in house shortly. A further £10k has been invested in security to increase the number of hours and colleagues into this service to respond to the number of incidents. The Director of Finance explained there is an increase in the number of incidents at HRI and they are working with the local authority to try to understand this. The training now includes a requirement for incidents to be escalated to the site matron.

OUTCOME: The Committee **NOTED** the progress made against the action plan presented, and the Health, Safety and Security Annual Report for 2023/2024.

71/24 Review of Sub-Committee Terms of Reference

Risk and Compliance Group
The Risk and Compliance Group terms of reference were presented for approval.

OUTCOME: The Committee **APPROVED** the Risk and Compliance Terms of Reference.

72/24 Summary Reports (Minutes for assurance)

The following summary reports and minutes were shared.

1. **Information Governance and Records Management Steering Group – 03.09.24**
   JW flagged medical staff compliance training at 33%. The Director of Finance flagged the report stated just short of 600k emails were received over last 30 days and almost 3m messages where no threats detected and was going to clarify this with the author.

2. **Data Quality Board – 18.07.24 & 29.08.24**
3. **Risk Group – 14.08.24**

OUTCOME: The Committee **NOTED** the summary reports and minutes from the groups above.

73/24 ANY OTHER BUSINESS
There was no other business.

74/24 MATTERS TO CASCADE TO BOARD OF DIRECTORS

- Concerns about number of recommendations outstanding related to Consultant Job Plans.
- Limited Assurance Reports on Patching and Salary Overpayments.
- Other key items on the agenda

75/24 EXTERNAL AUDIT TENDER PROCESS

The Company Secretary explained the contract with external auditor, KPMG comes to an end in 2025 and the procurement process for a new external audit provider has started with the timetable detailed in the paper shared. A recommendation will come to the meeting in January 2025 and four governors with experience in procurement are involved in the procurement process, together with the Audit and Risk Committee Chair.

OUTCOME: The Committee **NOTED** the update on the external audit tender process.

76/24 REVIEW OF MEETING

Howard Blagbrough said he felt the meeting was easy to follow for his first meeting.

The meeting closed at approximately 12:32 pm.

DATE AND TIME OF THE NEXT MEETING

Date: Tuesday 28 January 2025
Time: 10.00 am – 12:30 pm
Via: Microsoft Teams

26. DATE AND TIME OF NEXT MEETING

Date: Thursday 16 January 2025

Time: 9.00 – 12.00 pm

Venue: Rooms 3 & 4, Acre Mills Outpatients

To Note

Presented by Helen Hirst