COUNCIL OF GOVERNORS MEETING - 20.7.23

Schedule Thursday 20 July 2023, 14:00 — 16:00 BST
Venue Medium Training Room, Learning Centre, CRH
Organiser Kathy Bray

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20. DATE AND TIME OF NEXT MEETING: 189
Date: Thursday 19 October 2023
Time: 2:00 – 4:00 pm (Private meeting 1:00 – 1:45 pm)
Venue: Meeting Rooms 3 and 4, 3rd Floor Acre Mill, HRI

1. Welcome and Introductions

To Note

Presented by Karen Heaton

2. Apologies for Absence:

Helen Hirst (Karen Heaton to Chair)

Brian Moore

Emma Kovaleski

Peter Bamber

To Note

Presented by Karen Heaton

3. Declaration of Interests

To Approve

4. Minutes of the last meeting held on 20 April 2023

To Approve

Presented by Karen Heaton

DRAFT MINUTES OF THE FOUNDATION TRUST COUNCIL OF GOVERNORS MEETING HELD AT 2:00 PM ON THURSDAY 20 APRIL 2023 HELD IN MEETING ROOMS 3 and 4, ACRE MILL OUTPATIENTS AND VIA MICROSOFT TEAMS

PRESENT:

Helen Hirst	Chair

PUBLIC ELECTED GOVERNORS

Stephen Baines **(SB)**	Public Elected - Skircoat and Lower Calder Valley (Lead Governor)
Gina Choy **(GC)**	Public Elected - Calder and Ryburn Valleys
Isaac Dziya **(ID)**	Public Elected – South Huddersfield
John Gledhill **(JG)**	Public Elected – Lindley and the Valleys
Robert Markless **(RM)**	Public Elected - Huddersfield Central
Christine Mills **(CM)**	Public Elected - Huddersfield Central
Veronica Woollin **(VW)**	Public Elected – North Kirklees

STAFF ELECTED GOVERNORS

Sally Robertshaw **(SR)**	Staff Elected – AHPs/HCS/Pharmacist
Jo Kitchen **(JK)**	Staff Elected – Ancillary
Liam Stout **(LS)**	Staff Elected – Medical and Dental

APPOINTED GOVERNORS

Abdirahman Duaale **(AB)**	Calderdale and Huddersfield Solutions Ltd.
Lesley Warner **(LW)**	Kirklees Metropolitan Council

IN ATTENDANCE:

Rob Aitchison **(RA)**	Deputy Chief Executive
Danielle Booth **(DB)**	Membership Assistant
Gary Boothby **(GB)**	Director of Finance
Nigel Broadbent **(NB)**	Non-Executive Director
Brendan Brown **(BB)**	Chief Executive
Karen Heaton **(KH)**	Non-Executive Director
Vanessa Henderson **(VH)**	Membership and Engagement Manager
Eleanor Hicks **(EH)**	Nursing Associate
Andy Nelson **(AN)**	Non-Executive Director
Victoria Pickles **(VP)**	Director of Corporate Affairs (Minute taker)
Lindsay Rudge **(LR)**	Chief Nurse

20/23 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting and particularly Eleanor Hicks, Nursing Associate who was shadowing Jo Kitchen.

The Chair also reminded all members of the Council that the meeting was taking place during the pre-election period and therefore there was a need to be mindful of the guidance surrounding this period for public bodies and their decision making.

21/23 APOLOGIES FOR ABSENCE

Peter Bamber	Public Elected - Calder and Ryburn Valleys

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Peter Bell	Public Elected – East Halifax and Bradford
Sara Eastburn	University of Huddersfield
Sandeep Goyal	Staff elected – Doctors/ Dentists
Karen Huntley	Healthwatch
Emma Kovaleski	Staff Elected - Management/Admin/Clerical
Brian Moore	Public Elected – Lindley and the Valleys
Chris Reeve	Locala
Megan Swift	Calderdale Council
Salma Yasmeen	South West Yorkshire Partnership Foundation Trust

22/23 DECLARATIONS OF INTEREST

The Chair declared an interest in item 9 (Chair's Appraisal Process) and the Non-Executives declared an interest in item 10 (Non-executive Directors' Appraisal Process). There were no other declarations of interest. The Chair reminded the Council of Governors and staff colleagues to declare their interests at any point in the agenda.

23/23 MINUTES OF THE LAST MEETINGS HELD ON 26 JANUARY 2023

OUTCOME: The minutes of the previous meeting held on 26 January 2023 were **APPROVED** as a correct record.

24/23 ACTION LOG AND MATTERS ARISING

It was noted that all actions on the action log had been completed or were included on the agenda for this meeting.

OUTCOME: The Council of Governors **NOTED** the updates to the action log.

25/23 UPDATE FROM THE CHAIR

The Chair provided an update on her recent activity including meeting with several Trust CHuFT award winners and taking part in the Easter walk rounds of service areas. She explained that she had recently attended several partnership meetings at a West Yorkshire and Place level and informed Governors that John Mallalieu had stepped down as Chair of Calderdale Cares Partnership Board and that this role was currently out to advertisement.

HH also confirmed that she had recently completed the final of the NHS Providers Chair Training programme which included the module on working with governors. This had demonstrated the open relationship that Calderdale and Huddersfield NHS Foundation Trust (CHFT) has with its Governors and that this trust and behaviours should be built on with the new governors when they start.

OUTCOME: The Council of Governors **NOTED** the update from the Chair.

GOVERNANCE

26/23 Update from Governors

GC welcomed the meeting being held as a hybrid meeting, with the opportunity to meet face to face. She thanked Vanessa Henderson and Danielle Booth for their support during the pandemic period and their work to enable Governors to fulfill their roles. These comments were echoed by other Governors at the meeting.

OUTCOME: The Council of Governors **NOTED** the update.

27/23 Review of Constitution and Standing Orders of the Council of Governors

VP presented the report setting out the proposed changes to the Constitution and confirmed that the changes need to be approved by both the Council of Governors and the Board of Directors. If accepted, the paper would be presented to the Board of Directors meeting in May. She explained that the proposed changes reflected the Health and Care Act 2022 (July 2022) and the NHS England Code of Governance for NHS Provider Trusts which came into effect on 1 April 2023. Updates also included applications to be a member, nominations for governors and tenure of governor roles.

GC asked about the how Governors would fulfill the new requirement of the Code to engage the public at large. VP responded that there was no set methodology and that work would be done with existing and new Governors on ways to undertake this new duty. She added that good practice and learning would be sought from other Trusts and NHS Providers. Discussion took place on the links between Governors and the work at a West Yorkshire level. HH highlighted the range of engagement and involvement structures in place at both a regional and a place level and that ways to connect into these should be explored rather than duplicating what already exists. It was agreed that this would be discussed further at the new Governor Induction and at the Membership and Engagement Working Group (MEWG).

Action: Governors / VH

OUTCOME: The Council of Governors **APPROVED** the Constitution and Standing Orders of the Council of Governors.

28/23 Chair Appraisal Process 2022/23

KH, as Senior Independent Non-Executive, set out the proposed process for the appraisal of the Chair and confirmed that this follows national guidance issued by NHS England. The appraisal would involve seeking feedback from governors and would be completed by 30 June 2023, with the outcome reported to the Nominations and Remuneration Committee of the Council of Governors, ahead of the Council meeting on 20 July 2023.

OUTCOME: The Council of Governors **APPROVED** the appraisal process for the Chair.

29/23 Non-Executive Appraisal Process 2022/23

HH set out the proposed process for the appraisal of the Non-Executive Directors and confirmed that this follows national guidance issued by NHS England. The appraisal would follow that of the Chair. with the outcome reported to the Nominations and Remuneration Committee of the Council of Governors, ahead of the Council meeting on 20 July 2023.

OUTCOME: The Council of Governors **APPROVED** the appraisal process for the Non-Executive directors.

PERFORMANCE AND STRATEGY

30/23 Feedback Finance and Performance Committee and the Annual Financial Plan

AN provided an update Finance and Performance Committee. It was agreed to provide the summary page in future.

Action: AN / Kathy Bray

AN provided the key highlights from the Integrated Performance Report as:

- Although ED is challenged, and performance fluctuates, performance has improved recently despite the strike. The Trust continues to be one of the best performing in relation to ED waiting times, time spent in department and ambulance handovers.

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- Both targets for elective activity of having no patients waiting more than 104 or 78 weeks were achieved by 31 March 2023. The Trust's 52-week waits are significantly lower than the previous year and the Trust is the best performing on this in West Yorkshire.
- Performance against the cancer targets is also very strong and CHFT is one of only three trusts nationally consistently achieving the key cancer targets.
- The Finance and Performance Committee has undertaken deep dives on stroke and fractured neck of femur (NOF). Stroke performance is improving but still below where we would want it to be, whereas there were not the expected levels of improvement in NOF.
- The Trust has an improving Hospital Standardised Mortality Rate
- Bed occupancy remains very high at over 98% (target is 92%)
- The Transfer of Care list (of those patients medically fit for discharge) remains high with over one hundred patients
- Covid infections in the Trust fluctuate

LW asked how long it had been since the Trust had been running at a manageable capacity. RA responded that there had been pressure on services throughout the year for quite a long period of time and that the Trust no longer saw seasonal variations in activity. He added that it was recognized that all providers were facing pressures and that there was a lag of the impact of Covid. BB added that the shortages in the workforce were affecting not only the Trust, but also other partners and that there was a need to support each other.

LR commented that because there had been changes in the way that services are delivered, often those who are admitted are more acutely unwell. Services such as same day emergency care had been introduced which meant that patients who could be seen and treated easily were seen the same day and discharged.

RM highlighted that both stroke and NOF have been ongoing challenges for a period and that it was important that there remained a continued focus on these areas.

GB shared a presentation on the 2023/24 Annual Plan and explained that the Plan is still under discussion with commissioners. He highlighted the following key points:

- Bed occupancy target is 92% but the Trust plan is for 96%
- Activity target is 108% but have modelled below 108%
- Forecast outturn of £17m deficit for 2022/23 has been met
- 2023/24 deficit plan is £40M after a £25m cost efficiency saving
- The Plan includes elective recovery funding of £14.33m which is at risk pending agreement
- Agency expenditure plan is below the target of 3.7% which will be a challenge
- There will be a need to borrow cash in year
- There is a capital plan of £37m which is significant

SB asked what impact industrial action would have. GB responded that there had been an impact from the junior doctor strike in April and that this was currently being quantified. He explained that if industrial action continues during the year it will have an impact on activity and there is no additional support for this. In addition, nationally Trusts had been given funding for a 2% pay award, however the current offer was more than this and it was not clear where the funding for any additional award would come from.

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RM asked about retention of staff. GB responded that the Trust had received the results of the most recent staff survey and each division had been asked to develop a response plan for their area to address any issues identified, including retention. He added that this is discussed at performance review meetings and it was well recognised that it is better and more cost effective to retain colleagues wherever possible.

LW asked what would happen if the deficit became more significant. GB responded that there are six organisations in the North East and Yorkshire region having a deep dive of their Plan by NHS England and that the Trust was the sixth in this list, meaning this was a national issue and not unique to CHFT. AN responded that the Trust could decide not to deliver some services, but that the priority was to demonstrate that the Trust has a well thought through and balanced plan that supports our communities. RA commented that despite the deficit position, CHFT is considered a well-run organization due to our good performance.

OUTCOME: The Council of Governors **NOTED** the Annual Plan and feedback from the finance and performance committee

QUALITY

31/23 Feedback Quality Committee

It was agreed not to take this item as the Chair of Quality Committee was unable to attend the meeting. It was agreed to circulate the summary paper that went to the Board of Directors.

Action: Kathy Bray

32/23 Quality Account Priorities 2022/23 update / year end position

LR presented the year end position in relation to the 2022/23 quality priorities as follows:

- Recognition and timely treatment of sepsis: the Trust met the 50% target for the percentage of patients coded with sepsis that received all elements of the BUFALO bundle (blood cultures, urine output, fluids, antibiotic, lactate, oxygen); the target of 80% for the administration of antibiotics within an hour of clinical assessment in the Emergency Department was also achieved.
- Reduce the number of hospital-acquired infections including covid-19: This has been a real challenge this year both with covid and c-difficile. In response to the increase in C-difficile the Trust invited NHS England to review actions undertaken and to advise on any further actions. NHS England reported that the Trust was in line with other NHS organisations and made a small number of recommendations including a different approach to training.
- Reduce waiting times in the emergency department: this had not been met due to the notable increase in patients attending ED. This will remain a significant area of focus moving forward, and the Trust aims to meet the new ED targets.

OUTCOME: The Council of Governors **NOTED** the year end position against the 2022/23 Quality Priorities.

33/23 Quality Account Priorities 2023/24

LR confirmed the Quality Account priorities for 2023/24:

- Care of the Acutely Ill Patient: Timely recognition and response to deteriorating patient LR explained that this would have a percentage of patients identified as the measurable target.

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- Nutrition and hydration: To ensure that 80% of patients receive a Malnutrition Universal Screening Tool (MUST) assessment within 24 hours of admission
- Alternatives to hospital admission: the numbers of patients referred to a virtual ward or the Rapid Response Team. LR explained that there were two targets; ensuring that the pathways for the respiratory and frailty virtual ward are right, and that people are accessing them; and that 70% of patients requiring a Rapid Response in Calderdale receive it in two hours (noting that the rapid response service in Huddersfield is provided by Locala).

LR confirmed that the slides would be recirculated with the measurable targets included.

ACTION: LR

HH asked about how the final indicator related to the provision of these services by Locala. RA responded that the two organisations work closely together in delivery of these services and share learning.

LR also presented the Care Quality Indicators selected by the Trust. She explained that there is a national framework from which the Trust must select the five they wish to focus on and the ones chosen were aligned to other work within the Trust. For CHFT these were:

- CQUIN02: Supporting patients to drink, eat and mobilise after surgery
- CQUIN04: Prompt switching of intravenous to oral antibiotic
- CQUIN05: Identification and response to frailty in emergency departments
- CQUIN06: Timely communication of changes to medicines to community pharmacists via the Discharge Medicines Service
- CQUIN07: Recording of and response to NEWS2 score for unplanned critical care admissions

GC asked how Governors would see the impact of these indicators. LR explained that many of these would be using digital technology to record compliance and measure impact and that this would be reported through the Quality Committee.

OUTCOME: The Council of Governors **NOTED** the 2023/24 Quality Priorities.

MEMBERSHIP AND ENGAGEMENT

34/23 Update on Membership and Engagement Strategy Action Plan 2020-23

VH presented the update on the Membership and Engagement Action Plan for 2020-23 and explained that over the three-year period there has been significant progress against the goals of the strategy. She referenced the establishment of the MEWG which has met five times since it was set up in March 2022 and, in conjunction with the Membership Office, has co-created several activities and initiatives to increase membership recruitment and engagement. She referenced that this was both public and staff members. Membership numbers have remained static in key groups, (males, younger age groups, white and Black and Asian).

OUTCOME: The Council of Governors **RECEIVED** the update on progress against the 2020-23 Membership and Engagement Strategy.

35/23 Membership and Engagement Strategy 2023-26

VH presented the refreshed strategy for the next three years. Will have a continued focus on the under represented groups, in particular in trying to recruit younger members. There

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will also be more emphasis on engagement. She referred to the action plan for year 1 and highlighted the need to have an extended role as referred to earlier in the meeting.
GC commented that the way in which the strategy has been put together, with input from both members and governors, was very collaborative. She added that having measurable actions is helpful and will enable a dynamic plan to be delivered.

OUTCOME: The Council of Governors **APPROVED** the Strategy.

COMPANY SECRETARY REPORT

36/23 Governor Elections 2023

The Director of Corporate Affairs reported the outcome of the Governor election process 2023 as follows:
South Huddersfield: John Richardson
North Kirklees: Hollie Hampshaw
Skircoat and Lower Calder Valley: Diane Cothey and Lorraine Wolfenden
Lindley and the Valleys: Pam Robinson
North and Central Halifax: Kathleen Wileman and Anthony Wilkinson
Nurses and Midwives: Emma Karim
AHPs / Health Care Scientists / Pharmacists: Jonathan Drury

It was noted that this left vacancies in North Kirklees and East Halifax and Bradford. VH highlighted that there was a full complement of staff governors now in seats.

HH thanked VH and DB for their hard work in delivering a successful election process**.**

OUTCOME: The Council of Governors **NOTED** the outcome of the elections for 2023.

37/23 Procedure for the appointment of a lead governor

The Director of Corporate Affairs presented a paper setting out the role and duties of the lead governor and a process for the selection and appointment of the role. It was noted that expressions of interest should be submitted by 19 May with the full process to be complete by 13 July 2023. She highlighted an inconsistency in the paper and clarified that supporting statements should include letters of support from three governors.

Governors were also asked to give their views on the appointment of a deputy lead governor. All present agreed that this would be a positive step forward.

OUTCOME: The Council of Governors **APPROVED** the process for the appointment of a lead governor and **AGREED** the appointment of a lead governor.

38/23 Review of Council of Governors attendance register

Members of the Council of Governors were asked to check the record of their attendance at Council of Governor meetings and advise of any discrepancies before 30 April 2023, following which they will be published in the Annual Report and Accounts in June 2023.

OUTCOME: All **AGREED** to inform the Company Secretary of any discrepancies before 30 April 2023.

39/23 Review of the Council of Governors Declarations of Interest Register

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The Director of Corporate Affairs asked all Governors to review the register and make any additional declarations by 30 April 2023 as there is a requirement to include this in the Annual Report and Accounts.

OUTCOME: All **AGREED** to check their declarations and make any additions or changes by 30 April 2023.

40/23 Register of Council of Governors

The register of the Council of Governors setting out constituency, tenure and terms was presented, and all were asked to review it for accuracy.

OUTCOME: The Council of Governors **RECEIVED** and **NOTED** the register.

41/23 Date of the 2023 Annual Members Meeting / Annual General Meeting

The Director of Corporate Affairs confirmed that the Annual Members Meeting / Annual General Meeting would take place at Calderdale Royal Hospital on 25 July 2023 from 5-7pm.

OUTCOME: The Council of Governors **NOTED** the date of the Annual Members Meeting.

42/23 RECEIPT OF MINUTES FROM BOARD COMMITTEES

The minutes of the following meetings were received:

- Quality Committee held on 14 November 2022, 16 January, 20 February
- Workforce Committee held on 14 February 2023
- Audit and Risk Committee held on 31 January 2023
- Finance and Performance held on 6 December 2022, 10 January, 7 February, 28 February
- Charitable Funds Committee held on 15 February 2023

OUTCOME: The Council of Governors **RECEIVED** the minutes from the above -committee meetings.

43/23 INFORMATION TO RECEIVE

The following reports were made available prior to the meeting for information:

- Highlight report from the Workforce Committee
- Council of Governors workplan for 2023

OUTCOME: The Council of Governors **NOTED** the two items

44/23 ANY OTHER BUSINESS

RM raised the reintroduction of Pets as Therapy (PAT) dogs and that services can register their interest to have a PAT dog visit their area.

HH informed the Council of Governors that, as Councillor Warner had chosen not to stand a at the upcoming elections in Kirklees, she would no longer be the appointed Governor for Kirklees Council and that this would be her last meeting of the Council of Governors. HH thanked Councillor Warner for her contributions to the Council of Governors over the last four years.

The Chair thanked all for attending the meeting and for their contribution and formally closed the meeting at approximately 15:55.

DRAFT

DATE AND TIME OF NEXT MEETING
Council of Governors: Thursday 20 July 2023, 14:00 – 16:00 (private meeting 13:00-13:45), Medium Training Room, Learning Centre, Calderdale Royal Hospital

Annual Members Meeting: Tuesday 25 July 2023, 17:00 – 19:00, Learning Centre, Calderdale Royal Hospital.

Date: Thursday 20 July 2023
Time: 2:00 – 4:00 pm (Private meeting 1:00 – 1:45 pm)
Venue: Medium Training Room, Learning Centre, CRH

5. Action Log and Matters Arising

To Note

Presented by Karen Heaton

ACTION LOG FOR COUNCIL OF GOVERNORS

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

Date discussed at CoG Meeting	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
20.04.23 27/23	Review of Constitution To consider at Membership and Engagement Working Group how to fulfil new duty to engage the public at large	VH		October 2023		
20.04.23 30/23	Feedback from Finance and Performance Committee To provide summaries from Committee at future COG meetings	KB		July 2023		
20.04.23 31/23	Feedback from Quality Committee To circulate the committee summary that went to Board of Directors	KB		May 2023		
20.04.23 33/34	Quality Priorities 2023/24 To recirculate Quality Priorities with targets updated	LR		May 2023		

6. Update from Chair

For Information

Presented by Karen Heaton

7. Brief Update from Governors

For Information

8. Appointment of Lead Governor

For Information

Presented by Karen Heaton

9. Notes of the Nomination and Remuneration Committee 22 June 2023

For Information

Presented by Karen Heaton

Draft Minutes of the meeting of the Nomination and Remuneration Committee (Council of Governors) held on Wednesday 22 June 2022, 10:00 – 11:00 am, via Microsoft Teams

MEMBERS

Philip Lewer	Chair
Stephen Baines	Public Elected Governor (Skircoat & Lower Calder Valley) – Lead Governor
Brian Moore	Public Elected Governor (Lindley and the Valleys)
Isaac Dziya	Public Elected Governor (South Huddersfield)

IN ATTENDANCE

Brendan Brown	Chief Executive
Stuart Sugarman	Managing Director, Calderdale and Huddersfield Solutions Ltd (CHS)
Victoria Pickles	Director of Corporate Affairs
Karen Heaton (KH)	Non-Executive Director
Helen Hirst	Chair Designate
Andrea McCourt	Company Secretary
Suzanne Dunkley	Director of Workforce and OD
Amber Fox	Corporate Governance Manager **(minutes)**

13/22 APOLOGIES FOR ABSENCE

Apologies were received from Peter Bamber, Nicola Whitworth, Veronica Woollin and Richard Hopkin.

14/22 DECLARATIONS OF INTEREST

The governors were reminded to declare if they were interested in applying for a Non-Executive Director or Associate Non-Executive Director role in the next 12 months.

KH declared an interest in item 4 (Non-Executive Director Succession Plan) and offered to leave the meeting at this point.

The Chair noted he will leave the meeting at item 10 (Outcome of the Chair's appraisal).

15/22 MINUTES OF THE PREVIOUS MEETING HELD ON 7 APRIL 2022

The minutes of the previous meeting held on 7 April 2022 were approved as a correct record.

OUTCOME: The Committee **APPROVED** the minutes of the previous meeting held on 7 April 2022 as a correct record.

16/22 NON-EXECUTIVE DIRECTOR SUCCESSION PLAN

The Company Secretary presented the Non-Executive Director (NED) Succession Plan for approval which covers the next 18 months and takes into account the future challenges, risks and opportunities facing the Trust as well as the skills and expertise required within the Board of Directors to meet these challenges.

The combined skills and competencies of the current NEDs was made available at Appendix B2. The development areas that were identified include Integrated Care System working, understanding of local economic and health priorities to serve our local PLACEs (Calderdale and Kirklees) and delivery and development of services in our communities with population health focus.

The NEDs time commitments are reviewed on an ongoing basis and were reviewed in light of national guidance received earlier in the year which confirmed the five NED champion roles. It is evident the time commitment provided to the Trust by the NEDs exceeds the time commitment required of the NEDs.

Senior Independent Non-Executive Director (SINED)
The Company Secretary explained the Board appoints the SINED and the Council of Governors ratifies this appointment. Following a review with the Chair and Chair Designate, it was proposed that KH takes on this role from 1 September 2022 subject to approval. An overview of the SINED role was detailed in the paper and it was noted this includes responsibility for undertaking the Chair's appraisal.

NED Tenures and Proposed Extension of Tenures
The Company Secretary presented the proposals of NED tenures and extension of tenures, which is summarised below, the skills and competencies of the NEDs were included within the paper to support the discussion:

- Karen Heaton has completed two tenures of six years and a further 12 months; however, there is provision of extending on a 12 month basis each time subject to a satisfactory appraisal. It was noted the Integrated Care System allow for three terms of nine years. The Committee were asked to approve a further extension of tenure for KH from February 2023 to February 2024 to enable KH to continue on the Workforce Committee and Maternity Services review as Maternity Services Champion and Freedom to Speak Up Champion. Papers confirmed the time commitments of KH and that her appraisal has been satisfactory.

Stephen Baines strongly recommended KH's extension, stating she is an excellent Non-Executive Director. Isaac Dziya seconded this and supported a third term for KH, noting she has already successfully completed two terms.

- Andy Nelson has served two tenures of six years. The Committee were asked to approve a further one year extension to enable him to support the digital agenda, with full details of time commitments included with the papers and confirmation that to date appraisal has been satisfactory.

Stephen Baines and Brian Moore expressed their support for Andy Nelson's extension and stated he is an excellent NED.

- Denise Sterling is now eligible for re-appointment for a second tenure as her first tenure ends on 31 December 2022. Denise supports the quality agenda and Chairs the Quality Committee, and details of her time commitments were shared in the papers and confirmation that appraisal has been satisfactory

The governors were supportive of Denise Sterling's re-appointment for a second tenure from 1 January 2023 to 31 December 2025.

- Peter Wilkinson is now eligible for re-appointment for a second tenure as his first tenure ends on 31 December 2022. Peter supports the estate reconfiguration and full details of his time commitments were included in the papers and confirmation that appraisal has been satisfactory.

The governors were supportive of Peter Wilkinson's re-appointment for a second tenure from 1 January 2023 to 31 December 2025. Stephen Baines attends the Transformation Programme Board which Peter Wilkinson chairs and expressed his full support for Peter's re-appointment.

- Nicola Seanor, Associate NED supports the patient experience agenda and end of life care and Chairs the Patient Experience Group and attends the Board and other NED meetings as part of her development. The Trust are piloting the use of an Associate NED role to help with capacity issues with the NEDs and further support the quality governance agenda. Nicola Seanor was appointed last December 2021 for a 12 month

period. Subject to satisfactory appraisal an extension of tenure by 12 months is recommended for Nicola Seanor, from mid-December 2022 to mid-December 2023).

Stephen Baines, Brian Moore and Isaac Dziya expressed their full support for Nicola's extension.

The Chair has discussed the above with Nicola Whitworth outside of the meeting who was in full support of these recommendations.

OUTCOME: The Nominations and Remuneration Committee (CoG):

- **NOTED** the skills and competencies of the Non-Executive Directors.
- **NOTED** the time commitments of the Non-Executive Directors.
- **RECOMMENDED** to the Council of Governors the appointment of Karen Heaton as Senior Independent Non-Executive Director and Deputy Chair from September 2022.
- **APPROVED** the extension of tenure by 12 months for Karen Heaton from 28 February 2023 for 12 months to 27 February 2024, subject to a satisfactory appraisal.
- **APPROVED** the extension of tenure up to 12 months for Andy Nelson from 1 October 2023 to 30 September 2024, subject to a satisfactory appraisal.
- **APPROVED** a second tenure for Denise Sterling from 1 January 2023 to 31 December 2025.
- **APPROVED** a second tenure for Peter Wilkinson from 1 January 2023 to 31 December 2025.
- **APPROVED** the extension of the pilot of the CHFT Associate Non-Executive Director Nicola Seanor to 14 December 2023 subject to a satisfactory appraisal.

17/22 CHS NON-EXECUTIVE DIRECTOR SUCCESSION PLAN

The Managing Director for CHS presented a paper to recommend the re-appointment of an Associate Non-Executive Director to Calderdale and Huddersfield Solutions Limited (CHS).

With support of the governors, CHS recruited to a development role of an Associate Non-Executive Director to support their agenda for a 12 month pilot on 1 December 2021.

This recommendation is following a succession planning review for CHS Board. It is noted that the said Associate Non-Executive Director is currently part way through her first year which expires on 30 November 2022 and subject to satisfactory appraisal it is recommended that the 12 month period as an Associate Non-Executive Director for a further 12 months (1 December 2022 to 30 November 2023) is approved.

This extension of tenure was approved by the CHS Board on Tuesday 21 June 2022. The Managing Director for CHS stated the Associate NED for CHS is very successful in their role and has added great value.

The Chair explained he contacted Alastair Graham, the previous CHS Chair to confirm his full agreement. The Chair confirmed he supported this recommendation.

The governors in attendance were in unanimous agreement of the extension of tenure for the Associate NED for CHS.

OUTCOME: The Committee **APPROVED** the extension of the pilot of the CHS Associate Non-Executive Director, Shahida Iqbal, to 30 November 2023 subject to a satisfactory appraisal.

18/22 CHANGE TO THE TRUST CONSTITUTION

The Company Secretary explained the Nominations and Remuneration Committee of the Board of Directors consider appointments for Executive Directors and they met on 1 June 2022 to consider a six month review by the Chief Executive. The Committee supported a proposal for a new Executive Director post as a voting member of the Board who will fulfil the Deputy Chief

Executive role. This will no longer sit within the Deputy Chief Nurse's portfolio following a recent retirement.

In order to make this change of Executive Directors from six to seven, the number of Non-Executive Directors needs to increase from seven to eight, including the Chair. This requires a change to the Trust Constitution to increase the number of Executive Directors and Non-Executive Directors each by one.

The Committee are asked to recommend to the Council of Governors a proposal to amend the Constitution to increase the number of Executive Directors and Non-Executive Directors by one and note the creation and recruitment of a further Non-Executive Director role which will be undertaken by this Committee.

The Chief Executive provided context that this is part of a broader review of leadership capacity and how to deliver across two Place's, Kirklees and Calderdale and the Integrated Care Board. This will help support the partnership arrangements in both Place's and support one of the biggest reconfigurations in West Yorkshire. The Trust are also a thought leader on Health inequalities work and need to invest in this to take it forward.

The Chair assured the governors there is a cost envelope to cover these posts.

The governors in attendance were in unanimous agreement of this change and expressed their full support.

OUTCOME: The Committee **RECOMMENDED** to the Council of Governors the **APPROVAL** of the Constitution amendment to Board composition, increasing the number of Executive Directors by one and the number of Non-Executive Directors by one and **NOTED** that a consequence of this approval is the creation and recruitment of a Non-Executive Director role which will be undertaken on behalf of the governors by the Nominations and Remuneration Committee of the Council of Governors.

19/22 APPROVAL OF AN ADDITIONAL NON-EXECUTIVE DIRECTOR (NED) ROLE AND JOB DESCRIPTION AND PERSON SPECIFICATION

Following approval of the Constitutional amendment, the Company Secretary presented the generic Non-Executive Director job description and person specification for approval.

The additional Non-Executive Director will help with NED capacity and will enable greater NED leadership in areas that the Trust does not have capacity to support currently that are key to achievement of the Trust's longer term strategic objectives outlined in the 10 year plan.

The Company Secretary explained the recruitment process when advertising will highlight the areas the postholder will focus on such as:

- Integrated Care System working
- Partner collaboratives
- Equality, diversity and inclusion agenda, further supporting the Trust's role as a leader in eradicating health inequalities within our service provision
- Community service development and transformation

The additional NED role will be a governor led appointment with approval of any recommended candidate.

The governors were in support of the creation of an additional Non-Executive Director role and agreed the job description and person specification for this role.

OUTCOME: The Committee **APPROVED** the creation of an additional Non-Executive Director role and the job description and person specification for this role.

20/22 RECRUITMENT TIMELINE FOR NON-EXECUTIVE DIRECTOR

The Director of Workforce and OD shared the timeline that will be used for the Deputy Chief Executive post and suggested the same timetable could be held for the additional Non-Executive Director post.

- 11th July 2022 – advert launches
- 22nd July 2022 - advert closes
- 28th 29th July 2022 - Shortlist report
- Week commencing 8th August 2022 - Assessment process
- November 2022 – Start date with 3 month notice
- January 2023 – Start date with 6 month notice

The Director of Workforce and OD explained the Trust are not using an advertising agency to recruit to the Deputy Chief Executive post and will be using in-house skills.

The Chair highlighted the importance of recruiting a NED that can support the communities we serve.

OUTCOME: The Committee **APPROVED** the indicative recruitment timeline for the additional Non-Executive Director.

21/22 GOVERNOR CONDUCT MATTERS

The Chair presented a governor conduct issue to the Committee with the detail described in the paper.

The Company Secretary explained this Committee is required to receive and consider reports from the Trust Chair on issues of Governor conduct, eligibility and removal and provide recommendations to the Council of Governors. This includes the process of dealing with any reports or breaches of the Code of Conduct or Trust Constitution.

Brian Moore supported the proposed termination and re-iterated that governors should attend the minimum meetings.

Stephen Baines was fully supportive of this proposal and, if supported by the Council of Governors, he suggested approaching the next governor in line following last year's elections to confirm whether they still wish to be a governor. The Corporate Governance Manager explained this will be explored with the Election Provider as the Trust will be running with a number of governor vacancies.

OUTCOME: The Committee **RECOMMENDED** to the Council of Governors the termination of office for this governor as the governor requirements have not been met as detailed in the paper.

22/22 OUTCOME OF THE CHAIR'S APPRAISAL

The Chair left the meeting at this point.

Karen Heaton, on behalf of the Senior Independent Non-Executive Director, provided a verbal update on the outcome of the Chair's appraisal which started in January and February 2022 and has now been finalised. The Trust followed the guidance provided by NHS England/Improvement (NHSE/I).

Brian Moore, a long serving governor formally expressed his thanks to the Chair for the work he has done over the last four years and wished him well in the future.

The Chief Executive stated the Trust are in a better place for having Philip as the Chair. The Chief Executive stated the reference to this being a “light touch” appraisal has now been removed.

The Chair is meeting with Richard Hopkin as Senior Independent Non-Executive Director to sign-off the final appraisal documentation and the appraisal form will be submitted to NHSE/I before the Chair retires on 30 June 2022.

Stephen Baines stated Philip has been an excellent Chair and has done a fantastic job. He added that the Trust have made a good appointment for a new Chair in Helen Hirst.

KH added Philip has been an excellent Chair and he has built some very important bridges through different categories and communities of people. She added the Chair has placed the Trust in a good position with the ICS. KH stated the Chair optimises one culture of care and is so genuine and caring. She stated the Chair has put us all in a much better place and deserves an excellent appraisal and recognition.

OUTCOME: The Committee **APPROVED** the outcome of the Chair’s appraisal for 2021/22 which was undertaken in line with national guidance and **NOTED** the outcome will be presented to the next Council of Governors meeting on 14 July 2022.

23/22 ANY OTHER BUSINESS

There was no other business.

24/22 FEEDBACK FROM MEETING / ITEMS TO BE ESCALATED

Feedback from the meeting was the papers produced were very clear and thorough.

The meeting closed at approximately 11:00 am.

10. Chair Appraisal 2022/23

To Approve

Presented by Karen Heaton

OUTCOMES OF CHAIR APPRAISAL 2022/2023

The appraisal of the Chair has now been completed and this paper provides an overview of the process and the outcomes to the Nomination and Remuneration Committee of the Council of Governors

Process

Calderdale and Huddersfield NHS Foundation Trust(CHFT) recognises that Board appraisal is an important process for improving board performance and effectiveness. A highly effective board of directors makes a significant contribution to the success of the CHFT and is a source of added value for its patients, workforce, partners and many stakeholders. CHFT is therefore committed to ensuring a formal and transparent procedure is in place to monitor the performance and undertake the appraisal of the Chair and other Non- Executive Directors and report the outcomes in an appropriate and timely manner.

The CHFT process is based on the NHS England 2021 Chair Appraisal Framework for conducting an annual appraisal together with a Provider Chair Competency Framework based around the following competencies:-

- Strategic
- Partnerships
- People
- Professional acumen
- Outcomes focus
- CHFT Values

In order to undertake the appraisal of the Chair a questionnaire based on the NHSE template and incorporating The Nolan Principles was circulated to key stakeholders, including Governors, Non- Executive Directors, Executive Directors and members of the Integrated Care Board. The questionnaire was structured to enable feedback on how the Chair has performed against the competencies set out above and CHFT's organisational values. The feedback highlighting areas of both strength and development is provided to the Chair through an appraisal conversation with the Senior Independent Non- Executive Director (SINED) who has also met with the Lead Governor and Chief Executive to discuss the feedback.

Following the appraisal meeting between the Chair and the SINED a letter will be completed to formally record the discussion and the agreed objectives. This will be submitted to NHSE by the end of June 2023.

Response Rate

Twenty responses were received with consistent very positive feedback whilst recognising that this is the Chair's first year in her role.

Areas of Strength

Helen settled into her role very quickly demonstrating her positive and inclusive approach and her ability to communicate with people at all levels and from diverse backgrounds. She is professional , intelligent and a clear thinker who is keen to seek opportunities to improve CHFT and her personal contribution. Her inclusive leadership encourages individuals to participate in meetings and she readily seeks the views of others putting them at ease in situations which are new to them. She is focussed on the business in hand at Board meetings managing them efficiently and effectively. She demonstrates her growing knowledge of CHFT , its partners, stakeholders and the political environment. She is a strong advocate for "One Culture of Care" which aligns to her own personal values. She is developing productive and valued working relationships with local partners, WYATT and the ICB and networks nationally where she believes she can add value. Helen is also seen as supportive, personable and approachable with strong leadership skills in terms of assurance, governance and accountability and has a strong focus on " the patient" and improving service wherever possible whilst also recognising CHFT's delivery strengths. Helen a strong and open working relationship with the Chief Executive. She also has a good reputation amongst the colleagues she has met, and her down to earth approach is recognised and welcomed.

Helen is viewed as clear strategic thinker, a team player who treats the views of other with respect, valuing everyone's contribution. She encourages others to think "out and above " the operational challenges and inspires through her "can do" attitude. It is acknowledged that Helen saw the need to reduce duplication across Board sub committees and this is an example of where she challenges "the norm". Being open to new ideas and listening to others is a key skill she regularly demonstrates.

Areas for Development

Helen will continue to develop and grow in her role as she is committed to self-development and therefore her effectiveness will also grow. She will continue to strengthen her relationships with partners and stakeholders. Helen has a busy schedule and needs to continually prioritise her time which demonstrates her strong organisational skills , however

clinical colleagues may welcome the opportunity to directly showcase their clinical improvements. Continuing to increase her level of visibility across CHFT will also help to continue to develop her knowledge. Helen recognises the important and valuable role Governors have in CHFT and continuing to develop their opportunity for input and effectiveness whilst finding ways to encourage a more diverse Board and Council of Governors would be welcomed.

Summary

In summary this has been an excellent first year for Helen in her role as Chair and there is no doubt that she will continue to develop her knowledge and skills over the forthcoming year. Helen is seen as a great ambassador for CHFT and has the respect of her non -executive directors and executive directors alike.

Karen Heaton

Senior Independent Non- Executive Director

June 2023

11. Feedback from Audit and Risk Committee

To Note

Presented by Nigel Broadbent

CHAIR'S HIGHLIGHT REPORT
to the Council of Governors

Committee Name:	Audit and Risk Committee (ARC)
Committee Chair:	Nigel Broadbent, Non-Executive Director
Date(s) of meeting:	27 June 2023
Date of Board meeting this report is to be presented:	20 July 2023
ACKNOWLEDGE	
• The Committee thanked the Finance team for preparation of the Trust's accounts and financial statements in advance of the national deadline and the Trust's internal and external audit colleagues for their assistance in finalising these before the deadline. • The Committee also thanked the Company Secretary and other colleagues in preparing the Annual Report for approval by the Committee.	
ASSURE	
• Audit & Risk Committee (ARC) approved the audited accounts, financial statements and annual report of the Trust for the financial year 2022/23. This also included the Annual Governance Statement. • ARC noted the final Head of Internal Audit Opinion which highlighted that Internal Audit had issued 31 audit reports to CHFT during the year of which 4 were high assurance, 19 had significant assurance, 6 had limited assurance and 2 with no opinion. Most of the recommendations from the limited assurance reports had been implemented by year end and there were clear timescales for those still outstanding. On the basis of these reports during the year and their reviews as part of the closedown process the Head of Internal Audit issued an opinion for CHFT that significant assurance can be given that there is a good system on governance, risk management, and internal controls designed to meet the organisation's objectives and that controls are generally being applied consistently. • KPMG, the Trust's external auditors also presented their ISA260 report to the Committee and issued their annual report subject to the completion of the remaining outstanding issues. The ISA 260 made a small number of recommendations to improve internal controls but KPMG concluded that they intend to issue an unqualified opinion on the accounts, that there were no apparent inconsistencies in the Trust's annual report and Annual Governance Statement and have nothing to report in terms of significant weaknesses in the arrangements for value for money.	
AWARE	

- The Trust board should be aware that there were a small number of recommendations in KPMG's ISA260 report which colleagues will act upon prior to next year's audit. These relate to improvements in the processes on related party transactions, and the management review of journal entries. The Trust will also need to undertake an exercise to review floor space data for the purposes of the valuation of land and buildings and implement the new theatre stock systems.
- KPMG completed the outstanding work on their audit on 30 June. There were a small number of relatively minor changes to the accounts as a result of this which were agreed with the Chair of Audit Committee and did not change external audit's assurance on the accounts.
- The annual report and accounts were submitted to NHSE on 30 June 2023.

ONE CULTURE OF CARE

- The Committee put on record their appreciation and thanks for all colleagues involved in preparation of the accounts and the annual report which were given a clear level of assurance from internal and external audit.

12. Final Annual Plan 2023/24

To Note

Presented by Kirsty Archer

Final 2023/24 Plan

May 2023 submission

2023/24 Operational Plan

No change from submission at March 2023

- Improve A&E waiting times: no less than 76% of patients seen within 4 hrs by March 2024 – Plan to achieve
- Reduce adult general and acute (G&A) bed occupancy to 92% or below – Plan for 96%
- Eliminate elective waits of over 65 weeks by March 24 – Plans modelled on no RTT waits > 40 weeks, no ASIs > 18 weeks
- Deliver the system-specific activity target (agreed through the operational planning process) – West Yorkshire ICB target 108%, modelled activity at c.103%
- Cancer: Meet the faster diagnosis standard by March 24 (75% of referrals for suspected cancer diagnosed within 28 days) – Plan to achieve
- Increase percentage of patients that receive a diagnostic test within 6 weeks in line with March 25 ambition of 95% - Plan to achieve

Financial Plan – May 2023

Movement	£m
2023/24 Plan - March submission	**(40.4)**
Capacity funding release	1.0
Additional CIP: Technical flexibility	2.0
Additional CIP: Stretch target	4.5
Sub total	**(32.9)**
NHSE inflation funding / support	6.8
Intra ICB funding distribution	5.3
2023/24 Plan - May submission	**(20.8)**

Deficit plan of £20.8m, improvement of £19.6m from March submission

- £7.5m of local improvement committed
- £12.1m additional funding to be received

Financial plan headlines

- Final plan submission £20.8m deficit, after CIP
- CIP delivery of £32.3m planned, c. 6.2%, in line with increased WYAAT targets
- Elective Recovery Funding of £15.02m included - West Yorkshire proposal likely to be accepted with more challenging wait time targets and penalties

Capital and Cash

- CHFT ICS Capital Allocation - £17.0m
- Leases (IFRS 16) - £5.1m
- Total capital plan incl. external funding £34.0m

- 2023/24 opening cash balance £24.6m
- Capital plan exceeds internally generated depreciation creating a cash pressure
- Deficit position and capital cash requirement will need cash support (non repayable PDC and associated charges) of c.£9.5m

West Yorkshire ICS - Plan

Organisation	22/23 FOT £m	23/24 Final Plan £m	23/24 Final Plan % of income
Airedale NHS Foundation Trust	0.0	(4.3)	(1.8%)
Bradford District Care NHS Foundation Trust	0.0	0.0	0.0%
Bradford Teaching Hospitals NHS Foundation Trust	0.0	0.0	0.0%
Calderdale And Huddersfield NHS Foundation Trust	(17.4)	(20.8)	(4.1%)
Leeds And York Partnership NHS Foundation Trust	1.1	0.1	0.0%
Leeds Community Healthcare NHS Trust	1.0	0.0	0.0%
Leeds Teaching Hospitals NHS Trust	7.6	0.0	0.0%
Mid Yorkshire Hospitals NHS Trust	0.0	0.0	0.0%
South West Yorkshire Partnership NHS Foundation Trust	3.2	0.0	0.0%
Yorkshire Ambulance Service NHS Trust	0.0	0.0	0.0%
Provider Total	**(4.5)**	**(25.0)**	**(0.5%)**

ICB Place	22/23 FOT £m	23/24 Final Plan £m	23/24 Final Plan % of allocation
Bradford	2.9	6.2	0.5%
Calderdale	(0.2)	5.6	1.3%
Kirklees	(1.7)	5.7	0.7%
Leeds	6.4	1.5	0.1%
Wakefield	0.5	6.0	0.8%
WY	(3.4)	0.0	
ICB Total	**4.5**	**25.0**	**0.5%**

- Overall system balanced plan agreed
- £25m further stretch efficiency target to achieve
- Target distributed to Places to be identified

13. Feedback from Workforce Committee and Highlight Report

To Note

Presented by Karen Heaton

CHAIR'S HIGHLIGHT REPORT
to the Council of Governors

Committee Name:	Workforce and OD Committee
Committee Chair:	Karen Heaton.
Date(s) of meeting:	20 June 2023
Date of meeting this report is to be presented:	20 July 2023

ACKNOWLEDGE

The following points are to be noted by the Council of Governors following the meeting of the Committee on 20 June 2023 where the theme was Engagement.

- Failure to meet target for EST on Fire Safety remains a concern although it was noted there was an improvement in take up. Delivery of face -to face training continues to be a challenge and the Team are targeting areas with lower take up .An update report on the numbers taking up the training will be provided at each meeting of the Committee.
- The Committee received presentations on the Engagement Dashboard, the Staff Survey High Impact Action Plan, Progress with Hot Spot Management The Psychology of Engagement, CHFT's evolving Wellbeing Offer, and the Directorate Heatmap. In addition, there were case studies covering Staff Survey Action Plan and Recognising Colleague Contribution.
- IPR- concern remains over the level of short-term sickness absence. Work is ongoing to improve the level of sickness absence with areas identified for support and action. Recruitment is much stronger and in particular in midwifery and nursing. Agency and bank costs remain high because of sickness absence, recruitment shortage areas and industrial action. The Committee noted that the overall domain score had improved from 62.5% to 71.2%.
- The Quarterly Vacancy data was presented, and it was noted that the establishment had increased by 106 which had impacted on the number of vacancies overall.

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ASSURE

- The Committee received a detailed report covering Developing Workforce Safeguards and the Nursing and Midwifery Safer Staffing Report which was approved. Whilst challenges remain the Committee was assured that mitigations were in place to manage the risks.
- The Board Assurance Framework covering Colleague Engagement was discussed and it was noted that whilst there are more supporting actions the overall score remains unchanged.
- The report on Trade Unions Facility Time was presented and will be posted on the Government website before the end of June.
- The Freedom to Speak Up annual report was presented and again showed colleagues are speaking up with fewer than last year remaining anonymous.

AWARE

- Staffing levels continue to remain a challenge alongside turnover. Although recruitment has been going well and in particular international recruitment.
- The Committee will continue to keep a close watch on the number of colleagues taking up Fire Safety Training

ONE CULTURE OF CARE

- One Culture of Care considered as part of the workforce reports and in discussions.

14. 2023/24 Quality Account Priorities quarter 1 update

To Note

Presented by Lindsay Rudge

15. Receive details of 2022/2023 Annual Members Meeting – 25.7.23

To Note

Presented by Andrea McCourt

COMPANY SECRETARY REPORT

Presented by Andrea McCourt

16. Future Council of Governor Meeting Dates 2023 and Proposed Council of Governor Meetings 2024

To Note

Presented by Andrea McCourt

Council of Governors Meetings Dates - 2023

Date	Time	Location
Thursday 19 October 2023	1:00 – 1:45 pm (Private) 2:00 – 4:0 pm (Public)	Microsoft Teams

Joint Council of Governors and Non-Executive Directors Informal Workshops

Date	Time	Location
Thursday 21 September 2023	2:00 – 4:00 pm	Microsoft Teams or Acre Mill Meeting Rooms 3 & 4

Joint Council of Governors and Board of Directors Workshops

Date	Time	Location
Tuesday 14 November 2023	1:00 – 4:00 pm	Microsoft Teams Or alternate sites TBC

Bank Holidays 2023
Monday 1 May 2023 (Early May Bank Holiday)
Monday 29 May 2023 (Spring Bank Holiday)
Monday 28 August 2023 (Summer Bank Holiday)
Monday 25 December 2023
Tuesday 26 December 2023

Proposed Council of Governors Meetings Dates - 2024

Date	Time	Location
Thursday 25 January 2024	1:00 – 1:45 pm (Private) 2:00 – 4:0 pm (Public)	Large Training Room, Learning Centre,CRH
Thursday 25 April 2024	1:00 – 1:45 pm (Private) 2:00 – 4:0 pm (Public)	Forum Rooms 1A + 1B, Learning Centre, HRI
Thursday 25 July 2024	1:00 – 1:45 pm (Private) 2:00 – 4:0 pm (Public)	Large Training Room, Learning Centre,CRH
Thursday 24 October 2024	1:00 – 1:45 pm (Private) 2:00 – 4:0 pm (Public)	Forum Rooms 1A + 1B, Learning Centre, HRI

*Date of the Annual Members Meeting for 2024 to be confirmed in 2024

Joint Council of Governors and Non-Executive Directors Informal Workshops

Date	Time	Location
Thursday 15 February 2024	2:00 – 4:00 pm	Large Training Room, Learning Centre, CRH
Thursday 19 September 2024	2:00 – 4:00 pm	Forum Rooms 1A + 1B, Learning Centre, HRI
Thursday 12 December 2024	12:30 – 4:00 pm	

Joint Council of Governors and Board of Directors Workshops

Date	Time	Location
Tuesday 14 May 2024	1:00 – 4:00 pm	Large Training Room, Learning Centre, CRH
Tuesday 12 November 2024	1:00 – 4:00 pm	Forum Rooms 1A + 1B, Learning Centre, HRI

Bank Holidays 2024
Monday 1 January 2024 (New Year's Day)
Friday 29 March 2024 (Good Friday)
Monday 1 April 2024 (Easter Monday)
Monday 6 May 2024 (Early May Bank Holiday) – to be confirmed
Monday 27 May 2024 (Spring Bank Holiday)
Monday 26 August 2024 (Summer Bank Holiday)
Wednesday 25 December 2024 (Christmas Day
Thursday 26 December 2024 (Boxing Day)

17. RECEIPT OF MINUTES FROM BOARD SUB COMMITTEES

a. Quality Committee held on 17 April 2023, 22 May 2023

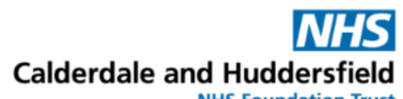
b. Workforce Committee held on 24 April 2023, 3 May 2023

c. Audit and Risk Committee held on 25 April 2023

d. Finance and Performance held on 26 April 2023, 30 May 2023

e. Charitable Funds Committee held on 10 May 2023

For Information



QUALITY COMMITTEE

Monday, 17 April 2023

STANDING ITEMS

55/23 WELCOME AND INTRODUCTIONS

Present

Denise Sterling **(DS)**	Non-Executive Director **(Chair)**
Dr David Birkenhead **(DB)**	Medical Director
Gina Choy **(GC)**	Public Elected Governor
Sharon Cundy **(SC)**	Head of Quality and Safety
Lucy Dryden **(LD)**	Quality Manager for Calderdale Integrated Care Board
Jason Eddleston **(JE)**	Deputy Director of Workforce & Organisational Development
Jonathan Hammond **(JH)**	Deputy Chief Operational Officer
Karen Heaton **(KH)**	Non-Executive Director
Joanne Middleton **(JMidd)**	Deputy Chief Nurse
Andy Nelson **(AN)**	Non-Executive Director
Victoria Pickles **(VP)**	Director of Corporate Affairs
Lindsay Rudge **(LR)**	Chief Nurse
Elisabeth Street **(ES)**	Clinical Director of Pharmacy
Michelle Augustine **(MA)**	Governance Administrator **(Minutes)**

In attendance

Charlotte Anderson **(CA)**	Interim Quality Performance Manager **(item 58/23)**
Laura Douglas **(LD)**	Deputy Head of Midwifery **(item 64/23)**
Kimberley Scholes **(KS)**	General Manager – Planned Access & Data Quality **(item 62/23)**

Apologies

Mr Neeraj Bhasin **(NB)**	Deputy Medical Director
Kim Smith **(KS)**	Assistant Director for Quality and Safety

56/23 DECLARATIONS OF INTEREST

There were no declarations of interest.

57/23 MINUTES OF THE LAST MEETING AND ACTION LOG

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

58/23 MATTERS ARISING – PATIENT INCIDENTS AND HARM

Charlotte Anderson was in attendance to provide an update on the above, and noted that a Knowledge Portal application is now available to view the falls, harm falls, medication incidents and pressure ulcer indicators. Access can be provided by **CA** for anyone if required.

The data taken from the application was shared on screen depicting the percentage of patients discharged with harm, days into stay when incident happened, CHFT acquired pressure ulcers per 100 bed days and inpatient falls per 100 bed days.

In regard to patients discharged with harm, the average was 2.9%, and this was also broken down by their length of stay. As length of stay increases, patients are more likely to be discharged with harm, however, it is not reflective of when the patient has the harm. This was further broken down into a graph, depicting the days into the stay when the incident took place. 44% of all harm occurred in one to six days of the stay, and gradually reduces the longer the patient stays in hospital.

In relation to pressure ulcers, pre-COVID, the average rate of pressure ulcers per 1000 bed days was 1.5, and during COVID this went up to 2.2, and in the period post-COVID (July 2021 onwards) this had reduced to 2.05. The last four months have all been below the average, which indicates a positive trend in the reduction of pressure ulcers per 1000 bed days.

In relation to falls, the average rate of inpatient falls per 1000 bed days was 7.5. During COVID this went up to 10, and in the period post-COVID (July 2021 onwards) this has reduced to 8.3. The last six months have all been below the average, and if this continues, will see a positive trend in the reduction of inpatient falls per 1000 bed days, and will be close to pre-pandemic levels.

AN asked if there was an indication of when numbers would return to pre-COVID levels, and it was also asked if CHFT benchmarks against other Trusts. **CA** stated that there is no benchmark data for pressure ulcers, however, there is data for falls within the model hospital which is currently being clarified. **LR** also stated that it is difficult to benchmark pressure ulcers, and following discussions with directors in other organisations, how pressure ulcers are categorised (category 3, category 4, unstageable, etc), can vary between organisations. In regard to returning to pre-COVID levels, **LR** stated that this is difficult to predict, in terms of patient acuity.

JH asked if further analysis could be taken into length of stay and when harm occurs, to get a clear narrative of what is taking place, as this could be good information for discussions with clinical colleagues on the importance of reducing length of stay and reducing the risk of harm to patients. **CA** agreed to look into this. **LR** stated that a task and finish group has been set up to put a hard stop on assessment areas, ensuring that patients are not transferred until all assessments are undertaken.

DS asked about the current length of stay. **CA** stated that further work with another colleague will be required in order to provide this data.

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

SPECIFIC REPORTS

59/23 2023-2024 QUALITY PRIORITIES

Sharon Cundy presented the above report, circulated at appendix C, highlighting the three chosen quality priorities for 2023-2024, which have been shared with the Council of Governors and also at the Weekly Executive Board:

- Care of the Acutely Ill Patient
- Nutrition and Hydration
- Alternatives to Hospital Admission

LR stated that the outcomes for the priorities need to be specific in order to track against the measures. **LR** also noted that the outcome for the nutrition and hydration quality priority will need to be amended to '*To ensure that 95% of patients receive a Malnutrition Universal Screening Tool (MUST) assessment within 24 hours of admission/transfer to ward area*'. **SC** agreed to amend the outcome of the nutrition and hydration priority.

AN asked about the outcome for the alternatives to hospital admission. **LR** stated that there is an outcome around utilisation against the capacity available, and an outcome for the pathway will be described in further detail. **LR** asked that the update is provided outside of the meeting, in order for the information to be submitted to the Council of Governors this week. This was agreed by the Committee.

OUTCOME: The Quality Committee approved the 2023-2024 quality priorities.

60/23 2023-2024 COMMISSIONING FOR QUALITY AND INNOVATION (CQUIN)

Sharon Cundy presented the above report, circulated at appendix D, highlighting the five CQUINs which have been shared with divisions, discussed at the Weekly Quality Meetings, and supported by the Weekly Executive Board.

The highlighted focused CQUINs align with the Quality Priorities:

- CQUIN02: Supporting patients to drink, eat and mobilise (DrEaMing) after surgery
- CQUIN04: Prompt switching of intravenous to oral antibiotic
- CQUIN05: Identification and response to frailty in emergency departments
- CQUIN06: Timely communication of changes to medicines to community pharmacists via the Discharge Medicines Service
- CQUIN07: Recording of and response to NEWS2 score for unplanned critical care admissions

The remaining CQUINs will continue to be monitored as part of the Trust governance processes for scrutiny and oversight.

AN asked about the payment column of the report, and queried whether this was the target to achieve. **LD** stated that CQUINs align to payments, therefore, if the maximum percentage is achieved, the likelihood is that the allocated amount will be paid. **VP** also stated that all CQUINs contribute to our contract and are measured, however, certain CQUINs with a payment are prioritised, therefore, it is important that they align to work already underway, in order to achieve the upper target and not place additional pressure on the organisation.

OUTCOME: The Committee noted the report and expecting updates via the Quality Report.

61/23 REVIEW OF QUALITY GOVERNANCE STRUCTURE

Victoria Pickles presented the reviewed structure, circulated at appendix E, which highlights a streamlined reporting structure for the Quality Committee.

Some groups which were set up during COVID, have now been removed as they are no longer required, and some groups have also been added. Groups with a quality metric will still report into Quality Committee, as well as their new reporting Committee. The Chairs of groups have also been reviewed, as well as the frequency of meetings. **LR** stated that it is important that overarching groups with several sub-groups are optimised and working as they should.

KH noted that the Chair of the Nominations and Remuneration Committee needs to be amended. **AN** also noted some amendments to the Finance and Performance Committee and will liaise with **VP** outside of the meeting to align.

DS asked whether the outstanding recommendations from the internal audit on the Quality Structure have now been actioned. **VP** stated that all recommendations have now been actioned and will be submitted to the Audit and Risk Committee next week.

Reviews of the governance structure will continue throughout the year, and cross-referencing against the Quality Committee workplan will need to take place to ensure that relevant reports are timetabled at the appropriate time.

OUTCOME: The Committee noted the report.

62/23 FOLLOW-UP APPOINTMENT CONCERNS REPORT

Kimberley Scholes and Jonathan Hammond provided an update on the above report, circulated at appendix F.

JH provided a brief recap on the concerns about patients lost to follow-up, and the task and finish group set up to investigate. The key findings were that there was no evidence to patients being lost to follow-up, however, there was an acknowledged risk of the backlog of follow-up patients due to the cessation of planned activity through COVID, recognition of issues in relation to validation and recognition of challenges in consistency in the use of the Electronic Patient Record. A series of recommendations were made as an output of the task and finish group, which have now been reviewed, and discussions on how to take forward, address any underlying issues and how they fit into current programmes of work relating to elective recovery.

Each recommendation in the report was summarised, along with the steps undertaken.

In relation to training, **KH** questioned whether the four whole time equivalent staff would be for a temporary period. **LR** stated that the posts were developed for clinical teams to work with the training teams and to return to their clinical settings as a point of contact in clinical areas, and optimise the use of the Electronic Patient Record.

In relation to the governance and business as usual, **AN** noted that it will feed into the Finance and Performance Committee to ensure that the actions are taking place.

The Chair noted the progress made and is encouraging to see that the backlog has reduced from 17,000 to 13,000, and a robust system is in place to work through the recommendations.

OUTCOME: The Quality Committee noted the report and thanked **JH** and **KS** for the update

SAFE

63/23 Q4 TRUST PATIENT SAFETY AND QUALITY BOARD REPORT

Sharon Cundy presented the above report, circulated at appendix G, highlighting the key points.

The items for escalation from the Trust Patient Safety and Quality Board into Quality Committee included:

- General attendance and quoracy of sub-group meetings – this is being actioned by the Associate Directors of Nursing
- Attendance of deputies attending Trust PSQB meetings – This is due to operational pressures
- Challenges with staffing with divisions, and the management time capacity of responsiveness
- Medicine Division – Quality Governance Lead was long term sick, now returned on phased return, with the Families and Specialist Services Division Quality Governance Lead now supporting.

Next steps for the Trust Patient Safety and Quality Board is the trialling of condensed divisional reports, which will be used from quarter 1 and audited in quarter 2.

KH queried the re-opened patient safety alert on the safer administration of insulin, and asked if this has now been closed. **SC** stated that the evidence for this alert has now been attached.

KH also noted the ongoing concern of attendance at the meeting, and asked if there was confidence that this will be dealt with effectively, as it is important that colleagues attend meetings and that they are quorate. **SC** stated that this has been raised with the Associate

Directors of Nursing who will be monitoring, and a follow-up meeting is due to take place in a few weeks' time. **LR** also confirmed that the chairing of the Trust Patient Safety and Quality Board will be taken over by herself going forward, with the membership due to be revised, and ensuring that reports into Quality Committee details the safe indicators from the revised Integrated Performance Report.

AN noted the increase in GP prescribing incidents within the Community division. **LR** stated that this has been followed up with the Associate Director of Nursing for the division, as this is a primary care prescribing issue, and work is ongoing with Community Pharmacists. **ES** also noted that this is linked to anticipatory medicines and the pink care forms not going out when patients are discharged, and asked to be followed up by GPs which causes delays for patients. Work has taken place with the end of life care teams to strengthen the process.

DS noted the positive initiative of the trauma and orthopaedic wards' introduction of a 'ten days to discharge pathway' to inform staff to start preparing for discharge upon admission, and asked if this was not routine and taking place across the Trust as a whole. **LR** stated that one of the workstreams as part of the length of stay work is around ensuring that people have an estimated date of discharge as a clear plan for every patient.

DS also noted the Parkinson's Pledge and asked how this is being monitored. **ES** stated that elements sit within the Pharmacy Board and the Medication Safety and Compliance Group, with a pledge to ensuring that Parkinson's medication are administered timely. It was agreed that further detail on this would be welcomed at this meeting to see the evidence of commitment to the pledge.
Action: An update on the Parkinson's Pledge to be brought to the Quality Committee

DS further noted that CHFT are the first Trust in the UK with the electronic controlled drug registers and asked what plans there were to share this good story. **ES** has attended local intelligence networks for all controlled drugs accountable officers, across all of Yorkshire.

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

64/23 MATERNITY SAFETY AND NEONATAL REPORT

Laura Douglas presented the above report, circulated at appendix H, highlighting the key points.

At the time of writing, the maternity dashboard was not available as it had not yet been verified, however, this will be included in next month's report.

KH commented on the good progress with the detailed transformation plan and asked if a CQC inspection is expected this year. **LD** stated that the service is prepared for the anticipated CQC inspection, as part of the national maternity CQC reviews.

AN commented on the workforce model. **LR** stated that there is a potential difference of around 20 whole time equivalent midwives with the fallen birth rate and also recognise the complexity of women in the caseload. Further work is being done, with another run of the model using the official BirthRate Plus calculation. It is anticipated that this will be clarified at the end of the month, alongside the skill mix and the registered nurse put in to support midwives. There are also challenges to utilise the Huddersfield Birth Centre to support women of Kirklees, and dialogue is taking place with the Overview and Scrutiny Committee members. In the meantime, the vacancy position of Mid Yorkshire NHS Trust has also deteriorated, which further puts challenges on the women of Kirklees. A responsive model for the Calderdale Birth Centre is also being looked into to support women.

In relation to the neonatal audit, **LR** asked whether this has been reviewed from the women's index of multiple deprivation (IMD). **LD** stated that this is carried out anyway on an individual basis, and will have been featured in the audit. **LR** stated that the IMD codes were not included and mentioned that it would be helpful to include these to establish if there were any common

themes. **LD** assured the Committee that given the significant increase of the 18 neonatal deaths, there were no concerns as a result of the audit. The extreme prematurity stood out; however, work is already underway on prematurity as part of the Maternity Incentive Scheme work. There were no further themes or trends of concern, and it is not known why there has been an increase in preterm births. **LR** stated that it would be helpful to look at this at a regional level to see if it is linked to our places, and other organisations. **LD** agreed to mention this to the audit lead to add to the actions for the audit.

OUTCOME: The Committee noted the assurance provided, and thanked **LD** for the update.

65/23 EAST KENT 'TRUE FOR US' REPORT

LD stated that there is a section in the maternity services report at item 64/23 which explains the position. A further review of learning from serious incidents, claims, complaints, and coroners' cases is taking place, with plans to amalgamate these to test the embedding of actions. A multidisciplinary embedded learning meeting took place in April 2023 with representation from the Local Maternity and Neonatal System (LMNS) and the Non-Executive Maternity Safety Champion. A further event is planned in May 2023 to conclude the review.

RESPONSIVE

66/23 QUALITY REPORT

Sharon Cundy presented the above report, circulated at appendix J.

In regard to the level of incidents, **AN** asked whether they were comparable to the previous year, and if there is any difference in the number or nature of serious incidents.

In relation to complaints, **AN** stated that there has been good progress with closing complaints within timeframe, however, some have been re-opened, and asked if this was due to a quality issue. **LR** stated that additional questions are being asked, and the reopened complaints relate to those questions being answered, however, data for this will be provided.

In relation to the legal services, **AN** asked what was driving the volume of claims. **LR** stated that there is a backlog of claims that are being worked through, however, the true increase will be quantified.

SC was unable to answer **AN's** queries, and agreed to return with responses.

DB updated that Hospital Standardised Mortality Ratio is now at 96 and Summary Hospital-level Mortality Indicator is at 103 as described in the report.

LR also noted that during the reporting period, the external NHS England Infection Control Assurance visit took place in regard to the clostridium difficile position described in the report. Overall, they were pleased with practice and made a few recommendations.

OUTCOME: The Quality Committee noted the report.

67/23 INTEGRATED PERFORMANCE REPORT

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

DB noted that the accident and emergency position has been challenged through winter with very high tendencies and challenges relating to flow out of the accident and emergency department. This is starting to improve slowly, however, there are ongoing challenges in relation to strike actions. Stroke is still difficult and challenged around workforce, with work ongoing with divisions to improve the service moving forward. **LR** added that there is progression to switch to a more multi-professional dementia screening process, with improvement due over the coming months.

KH noted achieving the 104 and 78 week challenges, and that cancer performance was back on track. Sickness absence is increasing and is a concern, and will be followed up at the Workforce Committee meeting next week.

OUTCOME: The Quality Committee noted the report.

RESPONSIVE

68/23 BOARD ASSURANCE FRAMEWORK RISK 6/19 – COMPLIANCE WITH QUALITY AND SAFETY STANDARDS

Lindsay Rudge presented the report, circulated at appendix L1.

The risk score was increased from 12 to 15 in November 2022 due to limited assurance as a result of the internal audit which took place in the summer of 2022, however, all actions have now been completed, therefore, it is recommended that the risk is reduced again to a score of 12, and to update the Board Assurance Framework accordingly.

OUTCOME: The Quality Committee supported and approved the reduction in the risk score.

69/23 BOARD ASSURANCE FRAMEWORK RISK 4/20 – CQC RATING

Victoria Pickles presented the report, circulated at appendix L2, and reported that the Trust continues to monitor the risk, with no plans to reduce the score, which remains at 12.

70/23 SELF ASSESSMENT OF COMMITTEE'S EFFECTIVENESS

The Chair asked for Committee's response to the self-assessment form, which will be forwarded after the meeting, with a return date of 28 April 2023. Responses will form part of the Committee's Annual Report.

ITEMS TO RECEIVE AND NOTE

71/23 INFECTION PREVENTION AND CONTROL (IPC) BOARD TERMS OF REFERENCE

A copy of the above terms of reference were circulated at appendix N for approval.

OUTCOME: The Quality Committee ratified the terms of reference.

72/23 MEDICINE MANAGEMENT COMMITTEE MINUTES

A copy of the above minutes were circulated at appendix O.

There were no queries.

OUTCOME: The Quality Committee noted the minutes.

73/23 QUALITY COMMITTEE ANNUAL WORK PLAN

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

Further work is to be undertaken in light of the recent governance reporting review.

74/23 ANY OTHER BUSINESS

There was no other business.

75/23 MATTERS FOR ESCALATION TO THE TRUST BOARD

- Updated governance reporting and work undertaken to streamline the governance structure, and work taken place to complete actions from the internal audit
- Update on two Board Assurance Framework risks – 6/19 – Compliance with quality and safety standards and 4/20 – CQC rating
- Updated neonatal report and assurance provided
- Progression made on the follow-up appointments concerns report
- Updated Quality Report received

POST MEETING REVIEW

76/23 REVIEW OF MEETING

No comments were made.

NEXT MEETING

Monday, 22 May 2023
2:30 – 5:00 pm
Microsoft Teams

QUALITY COMMITTEE ACTION LOG

Following meeting on Monday, 17 April 2023

Overdue	New / Ongoing	Closed	Going Forward

MEETING DATE AND REF	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	RAG RATING / DUE DATE
NEW / ONGOING ACTIONS				
17.04.23 (63/23)	**Trust PSQB Report - Parkinson's Pledge**	**Elisabeth Street**	**DS** also noted the Parkinson's Pledge and asked how this is being monitored. **ES** stated that elements sit within the Pharmacy Board and the Medication Safety and Compliance Group, with a pledge to ensuring that Parkinson's medication are administered timely. It was agreed that further detail on this would be welcomed at this meeting to see the evidence of commitment to the pledge. **Action 17.04.23**: An update on the Parkinson's Pledge to be brought to the Quality Committee	**See agenda item 80/23**
20.03.23 (47/23)	**Public sector equality duty (PSED) annual report**	**Chair / L.Rudge / V.Pickles**	Agreement is needed on whether this will come through the Patient Experience report, and also the frequency of the discussions. Action: Frequency of reporting to be agreed at agenda-setting meeting **Update at meeting on 17.4.23**: Update on frequency to be provided next month.	**Monday, 22 May 2023**
24.10.22 (168/22)	**Split Paediatric Service**	**Elena Gelsthorpe-Hill / Venkat Thiyagesh**	**LR** commented on the risk relating to the APNP model at Huddersfield, which is at a score of 16 on the risk register, stating that Simon Riley-Fuller (ADN in FSS) has been asked to review this. It was also noted that the Emergency Department (ED) are also looking at the impact of any incidents or near misses that have occurred as a result of the described risk, the results of which can be returned to a future Quality Committee for oversight and assurance to ensure that the risk is not tolerated. **Action 24.10.22**: For any results of the review of the risk and impact of incidents and near misses to be returned to the Quality Committee **March Update**: Followed-up with **SRF** as to whether the risk reviews have taken place, and also with the Risk Management Team as to whether there have been any reports from ED in relation to the impact of incidents or near misses as a result of the above risk. Awaiting responses on both. Update: Risk 7776 was originally scoring 20, and reduced to a 16 as there are not gaps every day for the PNP cover. Of note, a trainee has handed in their final dissertation and if successful, will be able to add as part of the PNP rota later this year. It is anticipated at this point, that the risk score will reduce further. The Children's Directorate and ED team have collated a paper that has been presented to WEB in terms of plans for urgent care delivery for CYP on both hospital sites. If approved this will cumulate in the APNP's being based on the CRH site. Dr Morris, Tom Ladlow, Fiona Stuttard, Chloe Gough and Julie Mellor are aiming to meet to try to progress this work. **April Update:** Awaiting an executive sponsor. Division escalated to Performance Review Meeting and awaiting response. **Update 17.4.23: LR** stated that Venkat Thiyagesh and Helen Barker presented a paper to the Weekly Executive Board around the staffing model, which was approved. **Action 17.4.23:** Update to be provided at the next meeting.	**Update due Weds, 21 June 2023**
24.10.22 (171/22)	Integrated Performance Report **Length of stay update**	**Charlotte Anderson**	**LR** also stated that it would be helpful to bring a presentation on the data to see the broader impact of all the increased activity and that expanded bed base to see what that means in terms of harm and incidence. Action: Presentation to be requested for Quality Committee **Update:** Charlotte Anderson (Performance and Intelligence Lead) will attend the April meeting to present. **Update 17.4.23: See item 58/23** **DS** asked about the current length of stay. **CA** stated that further work with another colleague will be required in order to provide this data. **Update**: Availability of report to be confirmed	**To be confirmed**
CLOSED ACTIONS				
16.01.23 (1/23)	**Quality Report**	**Kim Smith/ Jonathan Hammond / THIS**	**DS** commented on the ED quality priority and the increasing numbers of patients in ED who are breaching the eight, 10 and 12 hour targets, however, was pleased to see that no patients were coming into any harm, however, the pressure ulcer data states that there is an increase in hospital acquired Pressure Ulcers due to long waits and time spent on trollies. **DS** asked how reviews in ED are linking to ward level. **LR** stated that it cannot be said that patients are not coming to any harm on the	

			long waits, as there are some serious incidents regarding delay in treatment. It was suggested that a review of the incidents related to ED over the Christmas period is carried out. **Action 16.01.23**: A report of a review of incidents relating to the ED over the Christmas period to return to a future meeting, and triangulating data of increased acuity and admissions into the bed base as discussed at item 06/23. **Update**: Information to be triangulated with the more detailed analysis carried out in relation to demand. This will help frame the improvement work in ED. **March Update:** To be presented at the April meeting. **Update: A deep dive of the incidents over the Christmas period was carried out, and triangulated with the information at item 58/23. It should be noted that only 4 incidents were reported, 1 x severe and 3 x catastrophic. On review of the four incidents, any harm caused was not directly related to increased acuity or admissions.** **Just to note we are currently looking at any incidents that are reported during the industrial action and reviewing to ascertain if any learning is required from these.** **Update 17.4.23**: **LR** stated that the incidents are being reviewed on a daily basis, and not identified any harm caused	**CLOSED** **Mon 17 April 2023**

QUALITY COMMITTEE
Monday, 22 May 2023

STANDING ITEMS

77/23 WELCOME AND INTRODUCTIONS

Present

Denise Sterling **(DS)**	Non-Executive Director **(Chair)**
Mr Neeraj Bhasin **(NB)**	Deputy Medical Director
Dr David Birkenhead **(DB)**	Medical Director
Gina Choy **(GC)**	Public Elected Governor
Sharon Cundy **(SC)**	Head of Quality and Safety
Lucy Dryden **(LD)**	Quality Manager for Calderdale Integrated Care Board
Jason Eddleston **(JE)**	Deputy Director of Workforce & Organisational Development
Karen Heaton **(KH)**	Non-Executive Director
Andy Nelson **(AN)**	Non-Executive Director
Lindsay Rudge **(LR)**	Chief Nurse
Elisabeth Street **(ES)**	Clinical Director of Pharmacy
Michelle Augustine **(MA)**	Governance Administrator **(Minutes)**

In attendance

Gemma Berriman **(GB)**	Director of Operations **(for Jonathan Hammond)**
Richard Hill **(RHill)**	Head of Health and Safety **(item 81/23)**
Rebecca Hogan **(RH)**	Student Nurse on Placement **(observing)**
Diane Tinker **(DT)**	Head of Midwifery **(item 83/23)**
Lucy Walsh **(LW)**	Student Nurse on Placement **(observing)**

Apologies

Jennifer Clark **(JC)**	Head of Therapies
Jonathan Hammond **(JH)**	Deputy Chief Operational Officer
Joanne Middleton **(JMidd)**	Deputy Chief Nurse
Victoria Pickles **(VP)**	Director of Corporate Affairs
Kim Smith **(KS)**	Assistant Director for Quality and Safety

78/23 DECLARATIONS OF INTEREST

There were no declarations of interest.

79/23 MINUTES OF THE LAST MEETING AND ACTION LOG

The minutes of the last meeting held on Monday, 17 April 2023, circulated at appendix A, were approved as a correct record. The action log can be found at the end of these minutes.

80/23 MATTERS ARISING – PARKINSON'S UPDATE

Elisabeth Street presented the Parkinson's Update, as circulated at appendix B, highlighting the work done on the timeliness of medicines used for Parkinson's patients.

The Chief Executive Officer (CEO) was approached by an ex-GP who suffers from Parkinson's, as part of a national ask to Trust CEOs to make a pledge to support improving the timeliness of Parkinson's drugs. A joint piece of work was carried out with Dr Fred Bell (Consultant), Sarah Higgins (Parkinson's Specialist Nurse) and Pharmacy to focus on and improve this.

The drug which is commonly used for Parkinson's – Levodopa – should be given to the patient within 30 minutes of when the medication is due, which is time critical. Data from NHS England in 2018-2019 showed that one missed dose can create an extra 28,500 days in hospital in

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England and Wales for Parkinson's patients. The factors which can be put in place to improve this was done through an audit of a small cohort of nine patients, which resulted in only one patient having their medication within 30 minutes, and an average of 7.8 hours' delay for the remaining patients. An ongoing, comprehensive action plan, which will be monitored at the Medicines Safety and Compliance Group has been produced, with recommendations of:

- Supporting patients to self-administer their medication as and when they can
- using Cerner and alerts available and functionality within Cerner to alert Pharmacy, prescribers, and nurses when a patient requires the drugs and the timings
- General training and awareness, and a key message on the detriment and destabilisation which can be caused within a short time
- Ensuring that Pharmacy have the correct medication in place
- A visual alert being used with nursing colleagues to highlight when medication is due

The Medication Safety Officer will also be working closely with Dr Bell and Sarah Higgins to refocus on the actions, and there is also a plan to re-audit later in the year.

KH commented on the detailed action plan and the request for support of additional colleagues to attend the task and finish group. **ES** stated that support has now been provided by key Emergency Department nurses.

In terms of highlighting into community and patients bringing in their own medication, **LR** asked whether anything is being done with primary care colleagues. **ES** stated that this can be reviewed by the Medication Safety and Compliance Group, as nothing has taken place for some time. **LR** also asked how Integrated Care Board colleagues may want to support this through their quality structures, and requested that this is commented on in the quality report for Calderdale Cares and the Integrated Care Board for Kirklees.

DS commented on how responsive and proactive the Trust has been in committing to the Parkinson's pledge.

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

SPECIFIC REPORTS

81/23 HEALTH AND SAFETY COMMITTEE OVERVIEW

Richard Hill was in attendance to provide an update on the circulated report at appendix C, highlighting the NHS workplace health and safety standards to be met.

There are around 30 standards, with the majority in green, demonstrating compliance. There are still some areas where compliance is not yet demonstrated, namely, lone working and violence and aggression, however, work is taking place, and it is expected that all standards will demonstrate compliance in the next 12 months. The key subjects highlighted were:

- Falls injuries (non-clinical) - these are decreasing, with collaboration with Equans and Calderdale and Huddersfield Solutions (CHS), especially during the winter months, to increase awareness.
- Clinical Sharps Injuries – a list of activities ongoing to reduce the number of sharps injuries was highlighted, and it had been identified, over the last six months, that there has been a contribution from diabetic needles being left in trays or incorrectly disposed of, therefore, work is ongoing with the Diabetic Team leads to put together some awareness. It is anticipated that the clinical sharps injuries will decline over the next six months.
- Moving and handling injuries – there has been a slight increase in moving and handling injuries due to colleagues not attending courses, and new ways to delivering training sessions are being explored.
- Control of Substances Hazardous to Health (COSHH) assessments – There are about 8000 substances on the data management system, which is now in the process of being reviewed to provide new training to refresh all COSHH assessments. The COSHH sub-

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group has been re-instated and the next meeting takes place in four weeks, to ensure that the data management system is being addressed.

- Working arrangements between Head of Health and Safety and Occupational Health – **RH** will be working with Occupational Health over the next four months to ensure that all checks with work-related loss-time injuries, stress management, Display Screen Equipment (DSE) referrals and needle stick injuries are in place.
- Care of the spine and upper limbs – The paper-based DSE assessment for all colleagues who work at a desk that can or do suffer from spinal conditions, has now been converted to a e-form, for colleagues to access and complete the DSE questions. Responses are returned to **RH** who follows up on any actions. Over the last 12 months, 220 assessments were carried out, with 10% of those highlighting spinal or medical conditions that require extra assistance through referrals.
- Personal safety and security – Work has been ongoing over the last three to four months, with a new strategy and document drafted, and a new security annual work plan, due to be shared at next month's Resilience and Safety Group meeting for approval.

DS commented on the positive report and asked about the DSE assessments and access for home workers. It was asked what support is available for colleagues in reducing potential risk, as there has been recent data that suggests that the increase in long-term sickness is in relation to homeworking. **RH** stated this will need to be raised with Human Resources (HR) as the assessments for homeworkers are not carried out, due to the financial implications of the outcomes of the DSE assessments. This will need to be followed-up with HR in the future, and RH agreed to follow this up with the Director of Workforce and Organisational Development.

KH commented on the standards and expected all to demonstrate compliance in the next 12 months. **KH** also expressed concern over the DSE assessments and the organisation's duty of care. It was stated that this needs to be explored more closely.

AN commented on the violence and aggression and asked what is being done to ensure that there is an accurate picture on the number of incidents. **RH** stated that they are reported on Datix and colleagues are encouraged to report these incidents. **RH** is in the process of carrying out ward security audits over the next eight weeks, and expects to have an accurate picture of the number of incidents. This will all link into the drafted security policy and any communication pieces that follow will be on the intranet, to raise the importance of reporting incidents.

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

82/23 INTERNAL AUDIT REPORT – WARD TO BOARD REPORTING

Sharon Cundy presented the above report, circulated at appendix D.

The objective of the audit was to provide assurance around the Trust's Ward to Board reporting arrangements, and the focus on the recognition and treatment of sepsis, as one of the Trust's key quality priorities. In order to meet this objective, the audit focused on whether robust governance arrangements were in place from Ward to Board, to deliver effective oversight, as well as strategic and operational direction.

The review found that the Trust's Ward to Board reporting arrangements for it's quality priorities were generally effective, with significant assurance for all audited items, however, there were four recommendations for improvement. The Quality and Safety Team have set a target of the end of May 2023 to achieve these. All recommendations are in relation to the quality report and the executive summary, which are currently being reviewed.

KH commented on the audit and conveyed thanks to all involved.

OUTCOME: The Quality Committee noted the report.

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SAFE

83/23 MATERNITY SAFETY AND NEONATAL REPORT

Diane Tinker presented the above report, circulated at appendix E, highlighting the key points.

DT reported that the neonatal update will now be combined into this monthly maternity report.

In relation to workforce, **AN** asked whether the service is now in a position to model what the numbers should be, and whether the service is now at the 90/10 mix. **DT** stated that the 90/10 mix is a comfortable skill mix, with some recommendations suggesting an 80/20 split. In regard to the figures, this was agreed in principle at hard truths, however, this is yet to be confirmed by **LR**, to be the nationally reported figures.

LR reported that there will be a reset of the maternity transformation plan, to reflect Ockenden 2 amalgamating into the three year delivery plan.

DS commented on the ATAIN (Avoiding Term Admissions Into Neonatal units) audit and the increased number of babies presenting with jaundice, and asked if this was a similar picture across the Local Maternity System. **DT** stated that this was picked up as part of the service's ATAIN work, however, it has been found that although there is a management of jaundice guideline in place, further work needs to be done on phototherapy, due to differing equipment on neonatal units and the wards. Once this work has been done, this will be monitored to see if there is an improvement and a reduction in the number of babies with jaundice.

DS also asked about the smoking cessation programmes, as there are still a high number of mothers that smoke or were previous smokers. **DT** stated that the two maternity support workers now in post are doing a lot of work around smoking, and can include an update in the next report.

LR commented on the Index of Multiple Deprivation (IMD) codes from the neonatal audit, and the postcodes which were highlighted – two in Huddersfield and two in Halifax. There has been further analysis, which was shared with the health inequalities group, however, it was asked that the actions taken in those localities is shared, and whether any targeted work is needed with the maternity voices partnership. From an Integrated Care Board perspective, it is expected that the data is reviewed and raised at both quality committees.

NB reported on health and inequalities work being done with Greenwood PCN (primary care network) around acute asthma in paediatrics and adults, and part of that work involves attending the Deighton Carnival, which covers the Huddersfield postcodes and areas of the IMD. Paediatric asthma specialist nurses will be linking with the PCN team and the Kirklees Wellbeing Team, who have a specific stand on smoking cessation, and it was asked whether someone would be interested to join the team to extend discussion into maternity. **NB** agreed to forward the details to **DT**. GB asked that the details are also forwarded to Kate Frost and Sarah Rothery, who are leading on the smoking cessation for adults.

<u>OUTCOME</u>: The Committee noted the report and thanked **DT** for the update.

EFFECTIVE

84/23 Q3 LEARNING FROM DEATHS REPORT

David Birkenhead presented the above report, circulated at appendix F, highlighting that the report is a quality of care review, rather than a review of deaths.

Of the 480 adult inpatient deaths recorded in quarter 3, 151 (32%) were reviewed using the initial screening tool. The learning from those deaths were outlined in the report, as well as some of the very positive aspects of care.

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AN asked whether the 50% target is a national target. **DB** stated that this is a local target put in place, and the learning has been consistent for a number of years.

AN also asked how it is assured that learning comes from the reviews and how it is embedded. **DB** stated that there are no complex issues, however, communication with patients is a frequent issue, with several workstreams and discussions at governance meetings throughout the organisation, however, patient communication will always be a challenge, and forms a focus for complaints. It was stated that other Trusts would see similar themes if they were to be benchmarked.

OUTCOME: The Quality Committee noted the report.

RESPONSIVE

85/23 DRAFT QUALITY ACCOUNT

Sharon Cundy reported on the above, which was circulated at appendix G and available for the Committee to read.

The Quality Accounts were shared with stakeholders and the Executive team, with a response for comments due back by Friday, 16 June 2023.

KH commented on the document and asked if this was a standard or a chosen format, as it was very detailed. **SC** reported that this was not a standard format, however, welcomed any comments. **KH** asked that the final version includes page numbers and for the report to be proof-read, as there were variations in fonts. **LR** assured **KH** that this was a draft version of the accounts, and will proof-read and formatted by the publisher.

DS also commented on the very detailed report, which includes fantastic information, however, some sections will require editing. **AN** commented on the narrative of the sections, however, the omission of the data to justify the statements made.

The Committee have until Friday, 16 June 2023 to provide any further comments on the Quality Account, and to be forwarded to **SC** and **MA**. The final version of the Quality Account will be signed off at the next Quality Committee meeting on Wednesday, 21 June 2023.

OUTCOME: The Quality Committee noted the report.

86/23 2022-2023 QUALITY PRIORITY CLOSE DOWN

Sharon Cundy reported on the above, circulated at appendix H, which outlines the close-down of the three quality priorities and seven focused priorities.

AN commented on the very thorough report, which includes measurable outcomes.

DS stated that it was encouraging to see ongoing actions and improvement work for the areas that did not achieve their targets, and a commitment to move them forward.

OUTCOME: The Quality Committee noted the report.

87/23 INTEGRATED PERFORMANCE REPORT

Dr David Birkenhead and Lindsay Rudge presented the above report, circulated at appendix I, highlighting key points.

The NHS in general, and CHFT in particular remain challenged in relation to the number of patients accessing services from an acute point of view, however, CHFT has maintained one of the best cancer performances in the country, despite supporting Bradford and Mid Yorkshire Trusts during that period. Accident and emergency departments remain very busy, alongside pressures of the organisation being in Opel 3 and Opel 4, however, compared to peer Trusts,

DRAFT

CHFT maintained good progress, although not meeting the national targets, but acuity remains high.

In relation to the recovery position, CHFT are performing well in reducing long waits for patients.

There are still some challenges in relation to stroke care, due to a limited number of stroke physicians, however, plans are in place to mitigate the risk with a number of locums in place to support the service. **LR** noted to the Committee that despite the stroke bed base being expanded due to a number of consistent outliers on the acute floor, there still remains a high number of outlying patients on the acute floor. In terms of the Sentinel Stroke National Audit Programme (SSNAP) data, this will continue to deteriorate from a therapy perspective, due to a decreased number of therapists for patients on the acute floor. An update may be required on the therapeutic intervention being reduced and the impact this is having on patients. **AN** reported that a deep dive is scheduled at the Finance and Performance Committee in August 2023.

DB reported on the Summary Hospital-level Mortality Indicator at 104, and the Hospital Standardised Mortality Ratio, which has further improved. There is now some stability, with both indicators now in the normal range.

In some of the key messages, **DS** commented on the challenge of poor discharges, and asked if this was across the system or the responsibilities of CHFT. **DB** stated that there are system challenges in relation to discharge, both in terms of capacity and residential care, however, there are increased delays in transfers of care. Work is ongoing with partners in social care and the community to reduce and avoid admissions, however, this is largely a capacity issue. **GB** stated that a huge amount of work has been done in improvement and working groups on length of stay, and is well planned in monitoring going forward.

DS commented on the influenza campaign, and this year's uptake, which was not as good as in previous years, and asked whether this translated into an increased numbers of colleagues with influenza. **DB** reported on not knowing this information, however, this may be difficult to quantify, due to the number of respiratory illnesses over winter. **DS** asked if there would be a different approach or strategy for this year's uptake. **DB** stated that planning will start in September/October for the influenza campaign, but was not sure of the offer, as it was joint with COVID last year, and may depend on any guidance published for this year.

DS commented on the heat map for annual leave take up, and a number of directorates in the red, and asked if this was linked to the pressures of work where colleagues were not in a position to take annual leave at certain times. **JE** stated that it was a combination of things; an extended carry-over which built up as a consequence of COVID pressures into annual leave year's up to 2025-2026, however, last year, there were a number of things preventing colleagues from taking annual leave. JE also reported that an annual leave buy-back scheme was recently launched for this year's carry-over, as well as messages about the importance to take time away from the workplace.

OUTCOME: The Quality Committee noted the report.

ITEMS TO RECEIVE AND NOTE

88/23 CLINICAL OUTCOMES GROUP MINUTES

Dr David Birkenhead reported on the above, circulated at appendix J.

LR commented on the business case which was submitted to the Business Case Approval Group for the 24-hour response team and noted that this was approved in principle and hopefully towards the end of the year, this will be completed.

DRAFT

This is in relation to deteriorating patients and extending the provision of the HOOP (hospital out of hours programme) service and merging it with critical care outreach, to provide a more comprehensive review of those patients in a more rapid response. It was requested that an update is provided at a future meeting for the Committee's understanding of the purpose and intended outcomes.
Action: Update to be provided on the business case.

The matters agreed for escalation to the Quality Committee were Hospital Standardised Mortality Ratio and Summary Hospital-level Mortality Indicator update (also see item 87/23); NACEL audit (results received and action plan to be developed), and the End of Life Care Strategy in draft. **DB** was not certain on how close the strategy was to completion; however, it may link into the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) process, which is being implemented and also ongoing work with hospices.

OUTCOME: The Quality Committee noted the minutes.

89/23 QUALITY COMMITTEE ANNUAL WORK PLAN

A copy of the above was available at appendix K for information, with work still to be finalised on the working document.

90/23 ANY OTHER BUSINESS

The Committee conveyed thanks to Kim Smith, who will be retiring from the Trust, for her input and support.

91/23 MATTERS FOR ESCALATION TO THE TRUST BOARD

- Good news story on the Parkinson's pledge (see item 80/23)
- In terms of assurance, the Ward to Board internal audit (see item 82/23)
- Health and Safety Standards and the DSE organisational duty of care for colleagues working from home (see item 81/23)
- 2022/2023 Quality Priorities sign-off and ongoing work (see item 86/23)
- Items from the Integrated Performance Report (see item 87/23)
- Maternity Report (see item 83/23)

POST MEETING REVIEW

92/23 REVIEW OF MEETING

The reports provided the highlights requested, which allowed time for discussion and questioning.

NEXT MEETING

Wednesday, 21 June 2023
2:30 – 5:00 pm
Microsoft Teams

DRAFT

QUALITY COMMITTEE ACTION LOG

Following meeting on Monday, 22 May 2023

Overdue	New / Ongoing	Closed	Going Forward

MEETING DATE AND REF	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	RAG RATING / DUE DATE
			UPCOMING ACTIONS	
22.05.23 (88/23)	**Clinical Outcomes Group Report**	**Catherine Briggs**	**LR** commented on the business case which was submitted to the Business Case Approval Group for the 24-hour response team and noted that this was approved in principle and hopefully towards the end of the year, this will be completed. This is in relation to deteriorating patients and extending the provision of the HOOP (hospital out of hours programme) service and merging it with critical care outreach, to provide a more comprehensive review of those patients in a more rapid response. It was requested that an update is provided at a future meeting for the Committee's understanding of the purpose and intended outcomes. **Action 22 May 2023**: Update to be provided on business case. **Update June:** Update to be provided at the 24 July meeting	**Update due Monday, 24 July 2023**
24.10.22 (168/22)	**Split Paediatric Service**	**Elena Gelsthorpe-Hill / Venkat Thiyagesh**	LR commented on the risk relating to the APNP model at Huddersfield, which is at a score of 16 on the risk register, stating that Simon Riley-Fuller (ADN in FSS) has been asked to review this. It was also noted that the Emergency Department (ED) are also looking at the impact of any incidents or near misses that have occurred as a result of the described risk, the results of which can be returned to a future Quality Committee for oversight and assurance to ensure that the risk is not tolerated. Action 24.10.22: For any results of the review of the risk and impact of incidents and near misses to be returned to the Quality Committee March Update: Followed-up with **SRF** as to whether the risk reviews have taken place, and also with the Risk Management Team as to whether there have been any reports from ED in relation to the impact of incidents or near misses as a result of the above risk. Awaiting responses on both. Update: Risk 7776 was originally scoring 20, and reduced to a 16 as there are not gaps every day for the PNP cover. Of note, a trainee has handed in their final dissertation and if successful, will be able to add as part of the PNP rota later this year. It is anticipated at this point, that the risk score will reduce further. The Children's Directorate and ED team have collated a paper that has been presented to WEB in terms of plans for urgent care delivery for CYP on both hospital sites. If approved this will cumulate in the APNP's being based on the CRH site. Dr Morris, Tom Ladlow, Fiona Stuttard, Chloe Gough and Julie Mellor are aiming to meet to try to progress this work. **April Update:** Awaiting an executive sponsor. Division escalated to Performance Review Meeting and awaiting response. **Update 17.4.23: LR** stated that Venkat Thiyagesh and Helen Barker presented a paper to the Weekly Executive Board around the staffing model, which was approved. **Action 17.4.23:** Update to be provided at future meeting.	**Update due Monday, 24 July 2023**
24.10.22 (171/22)	Integrated Performance Report **Length of stay update**	**Charlotte Anderson**	LR also stated that it would be helpful to bring a presentation on the data to see the broader impact of all the increased activity and that expanded bed base to see what that means in terms of harm and incidence. Action: Presentation to be requested for Quality Committee **Update:** Charlotte Anderson (Performance and Intelligence Lead) will attend the April meeting to present. **Update 17.4.23:** See item 58/23 **DS** asked about the current length of stay. **CA** stated that further work with another colleague will be required in order to provide this data. Update: Availability of report to be confirmed	**To be confirmed**
			CLOSED ACTIONS	
20.03.23 (47/23)	**Public sector equality duty (PSED) annual report**	**Chair / L.Rudge / V.Pickles**	Agreement is needed on whether this will come through the Patient Experience report, and also the frequency of the discussions. Action: Frequency of reporting to be agreed at agenda-setting meeting **Update on 17.4.23**: Update on frequency to be provided next month. **Update May 2023**: It was agreed that a quarterly update will be provided to the Patient Experience and Caring Group around patient engagement and equality, which will be reported into the Quality Committee.	**CLOSED Monday, 22 May 2023**

17.04.23 (63/23)	**Trust PSQB Report - Parkinson's Pledge**	**Elisabeth Street**	**DS** also noted the Parkinson's Pledge and asked how this is being monitored. **ES** stated that elements sit within the Pharmacy Board and the Medication Safety and Compliance Group, with a pledge to ensuring that Parkinson's medication are administered timely. It was agreed that further detail on this would be welcomed at this meeting to see the evidence of commitment to the pledge. **Action 17.04.23**: An update on the Parkinson's Pledge to be brought to the Quality Committee **Update 22.05.23:** See item 80/23.	**CLOSED Monday, 22 May 2023**

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

Minutes of the WORKFORCE COMMITTEE

Held on Tuesday 24 April 2023, 2.00pm – 4.00pm
VIA TEAMS

PRESENT:

David Birkenhead	(DB)	Medical Director
Nigel Broadbent	(NB)	Non-Executive Director
Suzanne Dunkley	(SD)	Director of Workforce and OD
Karen Heaton	(KH)	Non-Executive Director (Chair)
Jonny Hammond	(JH)	Chief Operating Officer
Lindsay Rudge	(LR)	Chief Nurse
Denise Sterling	(DS)	Non-Executive Director

IN ATTENDANCE:

Mark Bushby	(MB)	Workforce Business Intelligence Manager
Jason Eddleston	(JE)	Deputy Director of Workforce and Organisational Development
Terry Gamble	(TG)	Staff Side Chair
Nikki Hosty	(NH)	Assistant Director of HR (for item 30/23)
Keith Rawnsley	(KR)	Fire Safety Officer (for item 27/23)

22/23 **WELCOME AND INTRODUCTIONS**

The Chair welcomed members to the meeting.

23/23 **APOLOGIES FOR ABSENCE**

Vicky Pickles, Director of Corporate Affairs

24/23 **DECLARATION OF INTERESTS**

There were no declarations of interest.

25/23 **MINUTES OF MEETING HELD ON 14 FEBRUARY 2023**

The minutes of the Workforce Committee held on 14 February 2023 were approved as a correct record.

26/23 **ACTION LOG – APRIL 2023**

The action log was received.

27/23 Matters Arising

EST – Fire Safety Training

KR explained that he had just returned from annual leave and therefore provided a verbal update to the actions identified at the February 2023 Committee meeting.

- Current compliance rates

KR had not received the updated figures. KR has a view compliance rates will improve as EST compliance is now linked to pay progression.

- Activity taken place since February Committee meeting

The updated e-learning programme is now up and running. The evaluation feature of the programme isn't yet functional.

- Alternative training considered and implemented

The Fire Safety Committee agreed to a blended approach of face to face and e-learning. KH advised other trusts locally have returned to face to face training.

- Increase in face to face training trial

KR confirmed colleagues are booking onto the face to face training sessions. Numbers and attendance will be monitored over the next month.

- Number of team training sessions delivered

KR confirmed team training is feasible and may be more advantageous as it can be tailored to specific teams and their environment.

- Consideration of fire wardens training their teams

KR holds a view there wouldn't be confidence the required training standard across the Trust is being delivered adding the depth of knowledge also plays into the training.

SD was concerned how we would reach the 90% compliance target within year given the operational pressures affecting colleagues who intend to undertake face to face training. She asked what the overall monthly uptake would need to be to reach target. KR responded that the numbers indicate 5 training sessions per week targeted at patient facing colleagues plus the e-learning programme ought to meet the required number. Additional sessions can be added if required.

Following further discussion the Committee requested a detailed report is brought to the June meeting that describes a structured framework to improve compliance, plans to mitigate risk and take up numbers.

MB stated the e-learning guidance will need to be updated if this training is not solely for non patient facing colleagues. MB also explained focus was given to launching the programme and the testing portion would now be implemented.

ACTION: Detailed report to be presented at the June meeting (KR).

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

28/23 **QUALITY AND PERFORMANCE REPORT (WORKFORCE) – MARCH 2023**

MB presented the report.

<u>Summary</u>

Performance on workforce metrics is now back to amber and the Workforce domain has decreased to 64.3% in February 2023. This is due to the inclusion of the non-medical colleague appraisal compliance. 6 of the 14 current metrics that make up the Workforce domain score are not achieving target - non Covid long term sickness, data security awareness EST compliance, fire safety EST compliance, infection control EST compliance, and medical and non-medical appraisals.

<u>Workforce – February 2023</u>

The Staff in Post has increased slightly at 6264, which, is due, in part to 27.01 FTE leavers in February 2023. FTE in the Establishment was 5988.05 and along with student nurses. Turnover decreased to 8.70% for the rolling 12-month period March 2022 to February 2023. This is a decrease on the figure of 8.86% for January 2023.

Sickness absence – February 2023
The in-month Non Covid sickness absence decreased to 5.06% in February 2023. However, the rolling 12-month rate for non Covid sickness increased to 4.83% from 4.73% in January. stress, anxiety, and depression problems were the highest reason for sickness absence, accounting for 26.19% of sickness absence in February 2023, with cold, cough, and flu the second highest at 15.10% in February 2023. The RTW completion rate has been removed as a target metric from November 2022 although will continue to be monitored.

Essential Safety Training – February 2023
Performance has increased in 7 out of 10 of the core suite of essential safety training. With 8 out of 10 above the 90% target with 3 achieving the 95% 'stretch' target. Data security awareness target has been amended to fall in line with national guidelines and is now 95%, and is the first month in the previous year to achieve over 90%. Learning disabilities awareness EST commenced from 10 May 2022, however is not included in overall EST compliance score or domain score totals. Overall compliance increased to 93.20% from 92.76% and is the fifth increase month on month. It is however no longer above the stretch target of 95.00%.

Workforce Spend – February 2023
Agency spend decreased for the month to £1.27M, whilst bank spend decreased in month by £0.46M to £2.91M.

Recruitment – February 2023
3 of the 5 recruitment metrics reported reached target in January 2023. The time for unconditional offer to acceptance in February 2023 decreased to 0.0 days.

SD explained there is a lot work being carried out in response to the data for example the re-launch of the absence programme, Workforce CIP portfolio to reduce agency and bank spend and recruitment initiatives. NB asked how many posts would need to be filled to achieve agency target. SD responded in the region of 100 vacancies across all staffing groups adding that trends are looked at in Turnaround Executive meetings. MB confirmed he would undertake some analysis work by Division and report back to the next meeting. LR gave further explanation in terms of nursing trajectories in relation to stabilising bank and agency spend.

DS noted stress, anxiety and depression is the highest reason for absence and sought assurance return to work (RTW) conversations are still taking place. SD confirmed RTW does have focus in the Divisions and is monitored by the absence management programme and other forums impacted by absence and agreed this is an important step in managing absence.

In terms of colleague health and wellbeing, TG asked if analysis at Divisional level is undertaken. SD responded the People Heat Map document provides identification of hot spots enabling targeted focus.

KH commented her points had been raised, particularly the link between sickness absence and bank and agency spend.

ACTION: Analysis of vacancies by Division to be provided at next meeting (MR).

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

29/23 **ESR ANNUAL ASSESSMENT 2022/23 - AT A GLANCE**

MB presented a graphic produced by the NHS ESR team following the Trust's annual ESR Assessment. The assessment looked across a broad range of functional areas within EST.

This identified usage and highlights where ESR is utilised well and where the Trust can gain further efficiencies. The key points to note are:-

- use of ESR functionality
- Implemented and embedded Applicant, Employee, and Manager Self Service
- ESR Learning Management used as the primary platform for eLearning and competency recording which allows for training to be completed and reported via ESR self-service
- Utilising ESR functionality that benefits the Enabling Staff Movement programme, removing barriers for newly hired employees, or colleagues transferring to new organisations.

JE stated it is clear from the summary that we've worked very hard to gain the benefits. JE asked if this is a National ESR team mandated programme? MB responded the use is heavily encouraged adding the National Staff Movements Programme (transfer of data portion) has been established for some years and will fit in well with the new passport system. The more trusts that are using functionalities increases the benefits to other trusts.

JH stated it is good to see training transferred across Trusts and asked MB if part of the roll out plan in ESR is to include Robotic Process Automation programme. MB responded that a number of trusts use RPA. Our focus has been to maximise interfaces that automatically pulls in information and avoids lots of inputting. We will continue to increase usage as the system develops.

KH stated this was a very clear, well formatted report. DS was pleased to see effective use of ESR. The annual assessment report will be added to the Committee's workplan for future reporting.

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

30/23 **2022 STAFF SURVEY UPDATE ON IMMEDIATE ACTIONS**

NH provided a verbal update on hotspot management. Executive sponsors (buddies) and engagement leads agreed for each hot spot area. Action plans will be finalised by 2 May 2023. From this date buddies will connect with the engagement leads to discuss offers of support, guidance and coaching and also match hotspot areas with areas of best practice. Progress will be reported through a 'you said we did' mechanism. The list of Executive sponsors and engagement leads will be shared with the notes. The Committee noted the Director of Workforce and OD will lead on high impact action progress across the Trust.

KH felt this a positive approach and looked forward to seeing the progress. NH confirmed a comprehensive progress report will be presented at the Engagement themed Committee meeting on 20 June 2023.

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

31/23 **BOARD ASSURANCE FRAMEWORK**
RISK 11/19 RECRUITMENT/RETENTION INCLUSIVE LEADERSHIP

SD presented the report. The key points to note were:-

- Recruitment strategy for 2022-25 implemented across the Trust – Grow our Own and embed One Culture of Care throughout
- Board agreed succession planning approach which links to coordinated talent management pipeline programmed including Empower programme and Enhance talent approach.
- Shadow Board introduced as part of talent management approach and increase leadership diversity

- Refreshed our values and behaviours
- Health & Wellbeing strategy
- Clinical Director review complete with induction programme developed and now in place
- Widening access programme rolled out July 2021

Positive assurances

- Clinician led transformation programmes
- Staff recognition and CHuFT awards
- Inclusive recruitment programme
- Turnover good – above 8%
- Reduction in vacancies
- Talent management framework
- GMC good survey results
- Staff survey results show increase across all People Promise domains

Gaps in control

The Committee noted gaps in neurology and ophthalmology specialisms. Gaps in the AHP workforce continue to be a challenge. LR proposed that Jenny Clarke, Head of Therapies attends Workforce Committee meetings. The Committee noted Jenny is taking a lead on AHP workforce and supported her attendance at future Committee meetings. The impact of the 2023 pay award and other pay related developments is as yet unknown.

The risk rating has been reviewed and recommend the score remains at 12.

KH noted the assurances in place. She asked in terms of retention if we are being flexible and creative enough. SD agreed we need to be more creative particularly in our 'stay' conversations. Retire and return now is now easier due to pensions flexibility. We need to be generally more assertive and push harder in creating our unique selling points. An 'all things retention' report is being collated to better inform our next steps.

TG appreciates the values and behaviours instilled in the workforce. TG asked if leavers surveys are reviewed to identify themes or patterns. SD responded the surveys are often generic. She strongly promotes managers having rich conversations to really understand the reasons for leaving. LR reported she is to attend Board of Directors meeting in May to present on staff experience and stated we should not underestimate the Trust's range of offers. JH echoed the value of individual conversations. JH commented on challenges ahead in terms of work life balance and coverage of services particularly evenings and weekends. SD agreed on the delicacy of this and highlighted the importance of one culture of care.

NB reiterated the comprehensive list of assurance. In terms of performance, NB asked if the new workforce report format will include benchmarking data. SD confirmed benchmarking is key adding the Workforce Monthly Monitoring meetings undertake deeper dives into the data.

ACTION: Retention to be reported at a future meeting (SD)
Jenny Clarke, Head of Therapies to be invited to Committee meetings (TR).

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

32/23 **NHS PAY OFFER AND INDUSTRIAL ACTION**

SD provided a verbal update on the current position.

No news currently from the BMA about a third strike.
54% of RCN members chose to reject the pay offer. CHFT RCN members are not striking.
Unison accepted the pay offer
Other unions to declare the outcome of their ballot

Orthoptic Society declared and voted to accept the pay offer
RCM and Society of Radiographer due to declare their ballot outcome 25 April 2023
GMB and Unite due to declare their ballot outcome 27 April 2023

The outcomes of the GMB and Unite ballots will be significant in terms of next steps for the unions and the government. SD commented on the unusual position of major trade unions differing on a pay offer.

We will continue to make our environment supportive for all colleagues as we respond to industrial action. One culture of care will thread through our leadership and communications. SD commended operational and clinical teams in an amazing job ensuring we maintain safe care.

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

33/23 **WORKFORCE COMMITTEE TERMS OF REFERENCE**

Amendments to membership had been made in the Committee's terms of reference.

OUTCOME: The Committee **AGREED** the amended terms of reference.

34/23 **WORKFORCE COMMITTEE WORKPLAN**

Going forward each Committee will have a theme based on one of the six chapters of the People Strategy, for example the next meeting will have a focus on Equality, Diversity and Inclusion. Other business items will be discussed as per the workplan.

The 2023 Committee Self Assessment Questionnaire will be issued to Committee core members w/c 24 April 2023.

OUTCOME: The Committee **REVIEWED** the Workplan.

35/23 **MEDICAL WORKFORCE PROGRAMME UPDATE**

Neeraj Bhasin unable to attend. Requested item deferred to June meeting.

36/23 **NURSING WORKFORCE PROGRAMME UPDATE**

Andrea Dauris unable to attend. Requested item deferred to June meeting.

37/23 **DEVELOPING WORKFORCE SAFEGUARDS**

Andrea Dauris and Neeraj Bhasin unable to attend. Requested item deferred to June meeting.

38/23 **ONE CULTURE OF CARE – MEETING REVIEW**

SD commented the meeting covered examples that one culture of care underpins everything we do.

39/23 **ANY OTHER BUSINESS**

No other business was discussed.

40/23 **MATTERS FOR ESCALATION TO THE BOARD OF DIRECTORS**

KH will present the highlight report to the Board capturing the topics discussed highlighting:-

Fire Safety training
Workforce Performance report
Good stories re new Recruits
Good ESR usage
Staff Survey sponsors, buddies and engagement leads
Board Assurance Framework
NHS Pay Offer
Terms of Reference

41/23 **DATE AND TIME OF NEXT MEETING:**

3 May 2023, 2pm – 4.30pm: Equality, Diversity and Inclusion

20 June 2023, 2pm – 4.30pm: Engagement Chapter

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

Minutes of the WORKFORCE COMMITTEE: EQUALITY, DIVERSITY AND INCLUSION

Held on Tuesday 3 May 2023, 2.00pm – 4.00pm
VIA TEAMS

PRESENT:

David Birkenhead	(DB)	Medical Director
Nigel Broadbent	(NB)	Non-Executive Director
Suzanne Dunkley	(SD)	Director of Workforce and OD
Karen Heaton	(KH)	Non-Executive Director (Chair)
Jonny Hammond	(JH)	Chief Operating Officer
Lindsay Rudge	(LR)	Chief Nurse
Denise Sterling	(DS)	Non-Executive Director

IN ATTENDANCE:

Rob Aitchison	(RA)	Deputy Chief Executive	
Mark Bushby	(MB)	Workforce Business Intelligence Manager (for item 49/23)	
Sarah Eastburn	(SE)	Governor	
Jason Eddleston	(JE)	Deputy Director of Workforce and Organisational Development	
Leigh-Anne Hardwick	(LAH)	HR Business Partner (for item 49/23)	
Nikki Hosty	(NH)	Assistant Director of HR (for items 48/23 and 49/23)	
Adam Matthews	(AM)	WOD Business Manager (for item 48/23)	
Helen Senior	(HS)	Staff Side Chair	
Polly Shunje	(PS)	Claims Administrator	For item 53/23
Louise Riby	(LR)	Lead Nurse	For item 53/23
Toseef Ahmed	(TA)	Job Coach, Project Search	For item 53/23
Tracey Thompson	(TT)	Intern Project Search	For item 53/23
Liam Whitehead	(LW)	(for item 54/23)	

42/23 **WELCOME AND INTRODUCTIONS**

The Chair welcomed members to the meeting.

43/23 **APOLOGIES FOR ABSENCE**

Terry Gamble, Staff Side Chair

44/23 **DECLARATION OF INTERESTS**

There were no declarations of interest.

45/23 **MINUTES OF MEETING HELD ON 24 APRIL 2023**

The minutes of the Workforce Committee held on 24 April 2023 were approved as a correct record.

46/23 **ACTION LOG – APRIL 2023**

The action log was received.

47/23 EQUALITY, DIVERSITY AND INCLUSION (ED&I) INTRODUCTION

SD introduced this ED&I focused meeting stating there are interesting and great opportunities for us, acknowledging the pressures and challenges making it more important than ever that we continue together to uphold our values and behaviours that are epitomised by one culture of care. Employers are looking for leaders and care givers of the future who are diverse and fair and have a strong ethical and environmental commitment and a true goal or purpose. SD read out some very positive colleague responses when asked what CHFT is known for.

48/23 LEADERSHIP FRAMEWORK & INCLUSIVE RECRUITMENT

AM presented the Leadership Framework that was launched at the 26 April 2023 Leadership Conference. The framework outlines 7 leadership elements that constitute effective leadership within the Trust. Our aim is to embed these elements into our recruitment, appraisal, performance management and talent processes in order to drive optimum performance. Colleagues can assess their strengths and areas of development by way of self assessment and 360 degree feedback tools. Implementation of inclusive a recruitment toolkit, a deep dive into internal promotions and career guidance and support were highlighted as examples to deliver inclusive recruitment. Our values and behaviours will be embedded into all recruitment activities and align our approach to grow our own. We will address poor practice and educate to ensure equity of opportunity and create a workplace where all colleagues have the best experience.

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

49/23 ED&I DATA DASHBOARD

MB presented the dashboard.

Protected Characteristics as at 31 March 2023

- CHFT gender split is 81.49% female and 18.51% male.
- Higher proportion of female colleagues in all staff groups except Medical and Dental.
- CHFT Executive Board comprises of 6 males (60%) and 4 females (40%).

Ethnic Origin as at 31 March 2023

- CHFT ethnicity split is 23.84% BAME and 73.71% white.
- Over the last 12 months the proportion of BAME colleagues within the Trust has increased by 2.5%, an additional 196 people.
- CHFT Executive Board comprises of 10 colleagues, all are white. This is disproportionate compared to the Trust composition and the local population.

Disability as at 31 March 2023

- CHFT disability split is 5.02% with a declared disability and 90.22% without a disability. Remaining colleagues not declared. Over the last 12 months the proportion of colleagues declaring a disability within the Trust has increased by 0.41%, an additional 31 people.
- Two members of the CHFT Executive board have declared a disability (20%).

Pay Grade comparison BAME colleagues as at March 2023

- 1009 BAME colleagues employed who were in post 12 months ago; 77 of these have progressed into higher band positions over the last 12 months, this equates to 7.63% of BAME colleagues progressing to a higher band.
- Over the 12 month period there has been a decrease in Apprentice/Band 2 grades as Band 3-4 increase, and decreases to Band 5 as Band 6-8a increase.

Pay Grade comparison White colleagues

- 4011 white colleagues employed who were in post 12 months ago; of these, 404 have progressed into higher band positions. This equates to 10.07% of white colleagues progressing to a higher band.

- The data shows decreases in Apprentice/Band 2 grades as Band 3-4 increase, and decreases to Band 5 as Band 6-8d increase.

- Overall BAME colleagues have a lower chance of progression. No colleagues in bands 8ABC or D or band 9 progressed into a higher band compared to white colleagues.

Apprentice progression
- Widening the reporting window to 2 years allows for a more accurate picture of apprentice progression.
- Comparing Apprentices 2 years ago in March 2021 and their progression in March 2023, 61.29% of Apprentices were promoted to a higher banding. 5.38% are continuing their apprenticeship and 39.78% are no longer employed at CHFT.
- Of those still working for CHFT, 66.67% of BAME apprentices progressed to a higher band, and 60.26% white.
- We can see there are a higher number of White colleagues who have left their trust during/after their apprenticeships (34.62%) whereas there are 26.67% of BAME staff.

JE asked if BAME colleagues take longer to complete or don't complete their apprenticeship compared to white colleagues. MB explained the apprenticeship data would need to be examined to confirm the position.

JH asked if BAME colleagues are applying and being interviewed for roles but not being successful. MD responded a deep dive is to be undertaken to better understand the position.

Apprentice Leavers
- Apprentices that were in employment on March 2022 and have since left the Trust, 55.56% of leavers were due to Voluntary Resignation. 42.86% BAME and 60% white.
- 37.04% of Apprentice leavers have an unknown reason. This is due to the termination form not having the leaving reason as a Mandatory field. This field has since been made mandatory for Managers to complete.
- The main voluntary registration reasons for BAME apprentices were Health, Relocation & Further Education.
- The main voluntary resignation reason for white apprentices was Work Life Balance, followed by Health, Relocation and Other/Not Known

LR was interested in apprentice leaver reasons as there is a high turnover in healthcare support workers. MB responded there is no pattern adding that future reporting will be more informative now the 'unknown' category has been removed from the termination form.

Apprentice Levels
- The majority of BAME colleagues are undertaking a Level 2 apprenticeship, with 75% of apprenticeships Level 2-4.
- White colleagues are more evenly split between Level 2-4, and higher level 5-7 apprenticeships.

Gender pay gap as at 31 March 2022
- 81.5% of the Trust's workforce was female and 18.5% of the Trust's workforce was male.
- The gender pay gap (difference in hourly rate of) as a mean is 28.9% and a median of 19.2%.
- Women earn 81p for every £1 that men earn when comparing median hourly pay
- Women in CHFT occupy 67.2% of the highest paid jobs, and 85.7% of the lowest paid jobs.
- When comparing bonus pay, women's median pay is the same as men's. When comparing mean bonus pay, women are paid 41% lower.
- 13.1% of men receive a bonus payment compared to 2.8% of women.
- Long service awards are included in the bonus payment calculation. During the 2021-22 81.9% of long service awards went to female colleagues.
- Clinical Excellence Awards are included in the bonus payment calculation, CEA's have a much higher value than long service awards. 32% of CEA payments went to women.

WRES
White colleagues have seen a reduction in harassment, bullying or abuse from patients / service users / public in the last 12 months, however BAME colleagues have seen the opposite with an increase reported. While this follows the general trend seen by the benchmark group,

CHFT has seen a larger increase for BAME colleagues with over a third of those completing the survey stating they had been subjected to this kind of bullying/harassment.

Colleagues have seen a reduction in bullying/harassment from staff during 2022, however BAME colleagues have seen the reverse with an increase reported. CHFT is better than the benchmark median for both white and BAME colleagues.

CHFT is better than the benchmark median for both white and BAME colleagues who said their organisation acts fairly with regard to career progression/promotion. However, the reported gap between white and BAME colleagues in this metric has widened to 11.8%.

White colleagues reporting a reduction, and BAME an increase from the previous year of experiencing discrimination from a manager/team leader. CHFT is better than the benchmark median for both white and BAME colleagues. However, BAME staff are reporting that they are almost three times as likely to experience discrimination from their manager/colleagues than white staff.

<u>MWRES</u>

- Medical & Dental is the only staff group in the Trust that has a higher proportion of BAME colleagues than white.
- As at March 2023 there are 22.24% (159) more BAME colleagues than white.
- Over three quarters of Career grade doctors within the Trust are BAME.
- In the past 12 months all grades of M&D staff have seen increases in the proportion of BAME colleagues, this follows national trends.
- Nationally 41.9% of all doctors are BAME (as shown in the MWRES 2021 report)
- BAME M&D colleagues earn on average 10.5% (£7,888) less per year compared to white colleagues.

JH advised that new training is in the pipeline to support colleagues in the management of violence and aggression.

KH thanked MB for the extensive information and suggested this data set is retained for next year's report for comparison.

LAH joined the meeting to inform the Committee of an audit undertaken of all disciplinary cases during the period 2021-2022. The findings show BAME colleagues are 3 times more likely to enter a disciplinary process than white colleagues. The data showed only 50% of BAME colleagues received a formal sanction whilst 91% white colleagues received a formal sanction. The majority of cases sat within the Medical Division over a range of directorates and roles. Most cases related to inappropriate behaviours. Assessment against the Improving People Practices confirmed internal processes are being followed. Further scrutiny of the training materials will ensure robust records are maintained to inform a refresh programme. A review of the triage and case review processes will also be undertaken along with an external comparison across regional trusts.

DS was pleased this audit had been undertaken. In terms of only 50% of BAME colleagues receiving a formal sanction, DS asked if early and different conversations could have resolved issues. LAH confirmed before any case goes forward for investigation it is reviewed with independent HR support to determine if a full investigation is necessary. HS echoed the concerns. JE advised that our triage questions were adopted locally from a national piece of work and confirmed the questions will be reviewed as part of the further analysis work being undertaken.

NS presented the 2022 Staff Survey data. Nationally, there has been very little movement in scores in the People Promise elements from 2021 to 2022.

CHFT overview:-

<u>Positive themes</u>

- Learning opportunities, more colleagues accessing development

- Support for career development
- We are compassionate and inclusive

Themes for improvement
- Management Development
- Flexible working and better work life balance

We are compassionate and inclusive
- 74.2% of colleagues feel CHFT respects individual differences, 4.9% higher than the benchmark average
- Our highest People Promise sub score for morale is diversity and equality scoring 8.3
- BBAME colleagues score higher for both engagement (+0.2) and motivation (+0.5) compared to white colleagues
- 59.2% of colleagues feel CHFT acts fairly with regards to career progression/promotion, regardless of protected characteristics, this is 3.6% above the benchmark average

High Impaction Action Plan
1. People centred leadership and management programme
2. Continue to evolve the health and wellbeing offer
3. Create a learning organisation offering development opportunities for all
4. Create a sense of togetherness across CHFT
5. Hot spot management focus (an Executive Director buddy and an engagement lead to support hot spot management)

KH felt there was some real positives adding that we should be proud about what's going on in our Trust.

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

50/23 **INCLUSION GROUP**

The Inclusion Group has been established as a formal sub-group of the Workforce Committee. The group will create and oversee a framework in which all our ED&I activity is commissioned, designed, delivered and managed in order to deliver our strategic objectives. JE presented the group's purpose, duties and guiding principles. The Committee noted JE is Chair of the group. It will meet 6 times per year and feedback progress into the Workforce Committee.

KH stated the group has the hallmarks of pulling all things ED&I together stating it is important that our policies and structures are enablers. KH is interested to see progress over the next 12 months.

OUTCOME: The Committee **NOTED** the establishment of the Inclusion Group.

51/23 **EQUALITY NETWORKS**

Pride Network
RN, Chair of the Pride Network presented an overview of activities that have taken place and what is coming next. Information stalls during Pride month provided a visible presence to both colleagues and patients and demonstrated our inclusivity. A Pride Pledge has been introduced for colleagues. Going forward, focus for the Network is education, policy review and increased patient inclusion.

RA is pleased to support the Pride Network as its Executive Sponsor and is looking forward to the next 12 months adding that RN is a fantastic ambassador, she has real drive. KH asked if membership is growing. RN responded that recently work pressures have impacted on attendance. An on-line teams chat has been established should colleagues wish to check in.

Race Equality Network (REN)
Neeraj Bhasin, Chair of the REN was unable to attend the meeting. NH read out a statement provided by Neeraj. DS stated it is a pleasure to be the Executive Sponsor for the REN. The group has been rebranded to promote inclusivity. The Network has supported colleagues very well over the last year and continues to support the Trust in achieving its strategic objectives. There is some challenge in connecting with colleagues to maintain that ongoing commitment. The Network provides appropriate challenge to the organisation and DS is confident the team leading and driving the work of the Network will make positive progress.

Disability Network
TN provided an overview of the group. The group has been re-named as part of its relaunch and all colleague members have been contacted with the new meeting dates. TN has been working with HR recruitment and Occupational Health colleagues looking at access to work. Information and guidance on reasonable adjustments has been shared via the Line Manager bulletin. A colleague disability passport is being explored. Prior to attending the meeting TN had received information to support Dyslexic friendly organisations.

KH thanked everyone for their contribution and wished all the Network groups success and looked forward to receiving future updates.

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

52/23 **INCLUSION CALENDAR**

CB presented the 2023 Inclusion Calendar. A range of activities had taken place and future events planned for each month. During Ramadan fasting packs had been distributed to colleagues followed by a celebratory Eid day connecting colleagues by sharing lived experiences and learning. Three wellbeing festivals have taken place to date, most recently a stress awareness theme to boost wellbeing, morale and share support mechanisms available to colleagues. Last year's Appreciation Week received excellent reviews and a further event is planned for later this month. CB commented on the positive colleague feedback from the Executive Director walkarounds. Colleagues appreciate the connections and conversations. The calendar is a live document accessible via the Intranet.

DS wanted to share a reflection on her attendance at the Eid celebration day. DS recognised real opportunities in combining celebration and education. Adopting this approach is an excellent way forward.

OUTCOME: The Committee **NOTED** the Inclusion Calendar.

53/23 **COLLEAGUE STORIES**

PS attended the meeting to share her experience of the Empower Programme. PS joined the programme after hearing great things from other colleagues. PS described her journey on the programme and the positive effects the programme had on her. PS now has the confidence to stretch herself beyond her comfort zone. She now co-chairs the REN and has participated in interview panels. PS was delighted to have been nominated for a CHuFT award making her feel proud and valued, giving her a real morale boost.
KH thanked PS for her being honest and open adding how great it is to have a new comfort zone. A very inspiring story.

LR shared her CHFT journey. She joined the Trust in 2018 on a band 6 in the FSS Division. Upon joining the Trust LR soon submitted an 'Ask Owen' asking how we could involve Executives on the floor so they could better understand the day to day pressures. This resulted in the introduction of 'back to the floor'. In 2019 LR applied for a band 7 post. She was unsuccessful however a secondment opportunity was offered as an Operations Manager. Two weeks into the role the pandemic hit. During this time LR's skills and knowledge

developed. In 2021 LR was appointed to a Matron post in FSS albeit struggling hugely with confidence as the Trust was in a stage of recovery from the pandemic. LR joined the Empower Programme, and with the support of a mentor, who challenged and guided LR to believe in herself. LR became a mentor herself for the Empower Programme. LR is now head nurse in FSS.

KH congratulated LR on her achievements and was pleased to see she is in a positive place. KH also thanked LR for joining the meeting whilst on maternity leave.

TT attended the meeting to provide an overview of the work of the Project Search programme, a supported internship for young adults with learning disabilities or autism. It is a one academic year programme supporting young people in placements in the Trust. The Trust provides a mentor for each individual. 5 interns are now employed by the Trust. TT talked about a young, deaf man working in Pharmacy stores who each day teaches the team a new sign so colleagues can talk to him.

TA was an intern at the Trust gaining experience in several placements at CHFT. He now works for the Trust as an engagement support worker. TA described how his placements boosted his self esteem and generally improved his life. TA was delighted to have won a Star Award presented by the Chief Executive. He has completed his Care Certificate, is a Butterfly Champion and a Learning Disability Champion.

KH stated how great it is to hear TA's positive story and the successes of Project Search. Well done to everyone involved.

OUTCOME: The Committee **THANKED** colleagues for telling their stories.

54/23 **EMPLOYABILITY ROUTES**

LW presented an overview of various pathways developed since 2021. The guiding principles include:-

- Harness local talent representative of the communities we serve
- Progression and equality of opportunity
- Grow our own
- Career development & progression
- Engage & mobilise partnerships

LW highlighted the power of partnerships and impact. The presentation detailed a deep dive into the data on progression into apprenticeships. The data is really positive and reflects the hard work of the team. LW introduced Sarah, a former apprentice now permanently employed by the Trust.

Sarah told the Committee that in 2008 she moved to India with her mother and school was difficult for her. When she returned to the UK she struggled with both education and social interaction. Sarah dropped out of college when she fell pregnant and for four years was a stay at home mum. Sarah then embarked on a pathway towards an apprenticeship at the Trust. Six months prior to her apprenticeship she volunteered at the Trust on the Maternity wards. Sarah is now a therapy assistant in trauma and orthopaedics and finds the role very rewarding. In future years she is looking to commence an apprenticeship in physiotherapy.

LW thanked Sarah for telling her story. KH commented on Sarah's determination wishing her every success in the future.

OUTCOME: The Committee **NOTED** the presentation and **THANKED** Sarah for talking to the Committee.

55/23 **WORKFORCE COMMITTEE WORKPLAN**

OUTCOME: The Committee **REVIEWED** the Workplan noting ED&I will be added as an annual update.

56/23 **ONE CULTURE OF CARE – MEETING REVIEW**

One culture of care has been woven in through every aspect of every agenda item.

57/23 **ANY OTHER BUSINESS**

No other business was discussed.

58/23 **MATTERS FOR ESCALATION TO THE BOARD OF DIRECTORS**

KH will present the highlight report to the Board capturing the topics discussed highlighting trajectories and key points and the fantastic colleague stories.

59/23 **DATE AND TIME OF NEXT MEETING:**

20 June 2023, 2pm – 4.30pm: Engagement Chapter

Draft Minutes of the Audit and Risk Committee Meeting held on Tuesday 25 April 2023 commencing at 10:00 am via Microsoft Teams

PRESENT

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

IN ATTENDANCE

Kirsty Archer	Director of Finance
Rob Birkett	Chief Digital and Information Officer
Victoria Pickles	Director of Corporate Affairs (items 24/23 and 25/23)
Andrea McCourt	Company Secretary
Richard Dalton	Head of Risk and Compliance
Shaun Fleming	Local Counter Fraud Specialist, Audit Yorkshire
Leanne Sobratee	Internal Audit Manager, Audit Yorkshire
Chris Boyne	Deputy Head, Audit Yorkshire
Richard Lee	Partner, KPMG
Matthew Moore	Senior Manager, KPMG

19/23 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the Audit and Risk Committee.

20/23 APOLOGIES FOR ABSENCE

Apologies were received from Kim Smith, Assistant Director of Patient Safety.

21/23 DECLARATIONS OF INTEREST

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

22/23 MINUTES OF THE MEETING HELD ON 31 JANUARY 2023

The minutes of the meeting held on 31 January 2023 were approved as a correct record.

OUTCOME: The Committee **APPROVED** the minutes of the previous meeting held on 31 January 2023.

23/23 MATTERS ARISING AND ACTION LOG

The action log was reviewed and updated accordingly.

8/23 – Internal Audit Sickness Absence Report (limited assurance) - DS gave assurance this action was complete as the report had been discussed at the Workforce Committee on 14 February 2023 and the Workforce Committee will continue to monitor completion of all recommendations.

12/23 – Treasury Management Policy - the Director of Finance confirmed the Treasury Management Policy was now complete and approved and reminded the Committee that this policy is approved by the Audit and Risk Committee, with the annual Treasury Management update presented to the Finance and Performance Committee.

DRAFT

Amendments to Health and Safety Policy

The Company Secretary advised the Committee of a change in relation to responsibility for Health and Safety, with Director responsibility moving from the Director of Workforce and Organisational Development to the Chief Operating Officer (COO). An amendment to this effect to the scheme of delegation will be presented to 4 May 2023 Board meeting for approval. A change in relation to the departure of the Trust Resilience and Security Management Specialist was also noted.

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

24/23 DEEP DIVE – RISK MANAGEMENT REVIEW

Richard Dalton, Head of Risk and Compliance, gave a presentation which set out the risk profile of the Trust and actions to strengthen risk management processes. Differences in the management of risk registers within directorates were noted, including scoring, and limited evidence of action plans to measure the progress of risk on the risk register was noted. Details of governance processes for reviewing risks within clinical divisions were given. A table summarising risks by grading and date of entry was shared, with 539 risks currently on the risk register. The risk flow chart by risk score was presented, with risks scoring 15 or above being presented to the Risk Group after review within risk challenge meetings and discussion by Patient Safety Quality Boards.

The Head of Risk and Compliance advised that all risks with scores of 15 were to be reviewed by 15 May 2023 with a plan for directorates to then review every organisational risk with support and training from the risk team. The plan to move the risk register to a new risk IT system which would be compliant with the Patient Safety Incident Response Framework was noted, subject to approval of a business case.

Discussion took place on:

- Staff buy in to the proposed changes (PW) - noted to be positive, welcomed by staff, supporting staff access to data to improve risk identification and management.
- DS queried plans for managing outdated risks - it was noted that these risks would be reviewed over the next few months as part of risk confirm and challenge meetings with divisions, closing risks as appropriate and adding new risks for reworded risks, an approach that had been piloted within the Family and Specialist Services division
- Potential to map data from the new risk system to other Trust data
- Capacity to review all 72 risks with a score of 15 (NB) - it was noted there is a clear action plan to exit from risks by focusing on what should happen in month and this discipline should enable the Risk Group to focus on new risks, deep dives, risks that may look out of kilter or have not been updated
- Aggregation of risks (NB) where it makes sense to do so, eg theatre capacity
- Risk management training (NB) – noted this includes training for senior leaders, development of a training video for staff accessible via the intranet, and education as part of regular risk and challenge meetings

The Director of Corporate Affairs added that the internal audit plan for Q3 of 2023/24 includes risk management and is timed to allow the work described to be completed and then tested via the audit.

The Head of Risk and Compliance was thanked for his presentation.

25/23 APPROVAL OF STRATEGY AND POLICIES

Risk Management Policy

The Head of Risk and Compliance presented the revised Risk Management Policy for approval, noting that a Risk Management Strategy would be presented in July 2023 to the Committee for approval. The separation from a Risk Management Strategy and Policy back to two separate documents will allow staff to have one central point for guidance on risk registers. Changes to the policy highlighted were noted in the cover sheet and highlighted in red. A revised structure and flowchart for the management of assurance and risk at Appendix 9 was noted as well as the addition of a terms of reference for a risk challenge meeting held within divisions and directorates at Appendix 10, with Patient Safety Quality Boards informed of new risks. Reference to the high level risk register has been removed with a focus on the risk score.

Discussion took place on:

- Benefit of separating the strategy and policy and the need to use the most current Trust behaviours diagram and update Appendix 3
- Including a reference to the Trust recently approved 1 year and 5 year strategy to ensure alignment (PW)
- Key Performance Indicators (KPIs) – assurance these are measurable and the need to consider whether to add KPIs re training and how this can be measured (eg from Knowledge Portal +).

OUTCOME: The Committee **APPROVED** the Risk Management Policy.

The Committee noted the Occupational Health Policy which had been approved by the Health and Safety Committee.

26/23 INTERNAL AUDIT

1. Internal Audit Progress Report Follow Up Report

Leanne Sobratee, Internal Audit Manager presented the Internal Audit Progress Report as at April 2023 and the Internal Audit Follow-Up Report which covers the Trust-wide position on the implementation of Internal Audit recommendations that were due during Q4 2022/23 up to 31 March 2023.

The report confirmed there are no overdue recommendations, 20 recommendations have missed their original target date some of which were due by the end of April 2023, within revised target date and 32 recommendations were not yet due. Over the 12 month period 124 recommendations have been completed. It was noted active follow up of recommendations, particularly those with revised target dates will continue, with commentary on the latest position added into the Head of Internal Audit Opinion in June.

The Director of Finance advised the improved position reflected the higher profile given to completion of the recommendations in the organisation and through Directors and offered support with further follow up as required.

The Deputy Head of Audit Yorkshire commented that the Trust was in an excellent position with no overdue recommendations at the year end, with a focus on completing those due for completion by the end of April 2023.

Internal Audit Progress Report

The Internal Audit Manager advised that six reports had been completed within the last quarter as follows, all were available in the review room:

- 1 high assurance report
- 4 significant opinion assurance reports
- 1 no opinion report
- 1 limited assurance report (MUST assessments, nutrition and hydration)

One report on Safer Procedures: NatSSIPs and LocSSIP is in draft but due for completion as the lead has now reviewed the report, agreed the findings and an action plan is being completed. This will be a limited assurance report and will be circulated to members outside of the meeting and be presented formally at the meeting on 25 July 2023.

A total of 351 days have been delivered; this represents 94% of planned audit days. The team is currently on track to complete work on the plan by 30 April 2023 with plans to finalise the Infection Control Board Assurance Framework report (significant opinion) and a report on the new theatre stock system (no opinion report).

Discussion took place on the limited assurance MUST report which found issues with timeliness of initial assessments and re-assessments, recording in EPR and reporting / escalation to ward managers to improve compliance. The Deputy Head of Audit Yorkshire advised that audits at five other acute Trusts had identified the same issues over the last 18 months. Audit Yorkshire advised they plan to look at good practice to address the issues highlighted on nutrition and hydration and outlined the approach they would take to identifying and sharing such learning in response to a question from the Chair. DS added that nutrition and hydration is a 2023/24 quality priority and MUST assessment, and compliance will be closely monitored by the Quality Committee.

It was noted that having six reports with limited assurance was a return to the usual level now that more operational audits have been resumed post Covid.

2. Internal Audit Plan 2023/24

The Internal Audit Manager presented the Internal Audit Plan for 2023/24, based on year two of the 2022/23 three year plan. The key points to note were:

- Plan developed using an assessment of risks, risk documentation and meetings with Executive Board members, good engagement noted
- 350 days within the plan, with any unused days from the 2022/23 plan (anticipated to be seven) used to reduce the billable days
- Plan was approved at Executive Board on 23 March 2023
- Internal Audit Charter was enclosed at Appendix C

In relation to the action log item 27/22 and incorporation of the Green Plan into the audit plan it was confirmed that whilst this did not form part of the audit plan, Audit Yorkshire intend to undertake a thematic review on sustainability which will be shared with Committee at a future date. It was noted that the nursing audit plan included PLACE assessments and that any ICS related audits may be include in the 2024/25 plan.

NB queried the process for revising the three year Internal Audit plan and it was confirmed that a new three year plan is developed once the existing three year plan ends, rather than this being a rolling three year plan.

Leanne Sobratee thanked the Trust for great engagement with 2022/23 Internal Audit plan which is at 94% completion. She advised that Audit Yorkshire is revising its report template, which will have a one page summary, following a positive pilot of the template at York District Hospitals with positive feedback

Action: LS to circulate the revised template for future Internal Audit reports to Audit and Risk Committee members.

OUTCOME: The Committee **APPROVED** the Internal Audit Plan for 2023/24.

27/23 COMPANY SECRETARY'S BUSINESS

1. The Company Secretary presented the updated NHS accounts timetable for the annual report and accounts for 2022/23. The key dates to note were:

Financial Accounts

- Deadline for draft accounts (or agreement of balances) is 27 April 2023 (noon)
- Audited accounts submission is 30 June 2023 (noon)

Annual Report

- Annual Governance Statement and Annual report submitted by 30 June 2022

The Committee will approve the annual report and accounts at its extra-ordinary meeting on 27 June 2023 having received delegation for this from the Board on 2 March 2023.

OUTCOME: The Committee **NOTED** the final annual report and accounts timetable for 2022/23 and key dates.

2. Annual Governance Statement

As part of the annual reporting arrangements the Company Secretary presented for review the draft 2022/23 Annual Governance Statement which has been developed in line with the 2022/23 Foundation Trust Annual Reporting Manual guidance from NHS England. It was noted the number of internal audit reports referred to in the statement will be updated once the year end position is confirmed. It was noted the Trust was planning to declare there have been no significant control issues during 2022/23, a similar position to that reported for 2021/22. The draft statement has been reviewed by the Chief Executive and the Audit and Risk Committee Chair and circulated to auditors for comment, with Internal Audit comments incorporated in the draft presented.

NB confirmed he had reviewed the statement. Discussion took place about consideration of referencing the Integrated Care System's risk register / Board Assurance Framework in future years as appropriate, noting partnership working was detailed in the statement and the statement was for the Trust as a statutory organisation.

OUTCOME: The Committee **APPROVED** the draft Annual Governance Statement for 2022/23.

3. Review of Code of Governance Compliance

The Company Secretary confirmed the Trust is compliant with all provisions of the Code of Governance as detailed in the enclosed paper which the Chair had reviewed in detail. It was noted that this was the last year reporting compliance against the Code of Governance for NHS Trusts 2014 and future compliance reports would be a review against the updated NHS England Code of Governance for NHS Provider Trusts.

OUTCOME: The Committee **APPROVED** the Trust's compliance with the Code of Governance

4. Self-Assessment of Effectiveness Committee 2022/23

The Company Secretary presented the 2022/23 self-assessment summary of responses and associated action plan in relation to Committee administration and operation of the Committee. The following were reviewed:

a. Outcome Report 2022/23
b. 2022 Action Plan Progress
c. 2023 Action Plan

It was noted the 2023 action plan included a review of deep dives, building in time for reflection at the end of the meeting, reviewing skills and experience mapping and adding the Committee terms of reference to the Trust website. The Chair commented that in undertaking the self-assessment consideration had been given to the National Audit Office on Good Practice for Audit and Risk Assurance Committees. This included using external advice where necessary and the Committee being sighted on all corporate strategic risks such as cyber security and procurement.

DS highlighted the need to consider progress updates on clinical audit during the year given that currently the Committee receives one report a year on clinical audit.

Action:

NB/Company Secretary to bring to 25 July 2023 meeting suggestions for assurance / deep dives for areas identified in the National Audit Office report.

DS/NB/Company Secretary to discuss reporting on progress with clinical audit and amend workplan as agreed.

OUTCOME: The Committee **APPROVED** the outcome of the Audit and Risk Committee self-effectiveness review for 2022/23 and the areas of continued improvement for 2023 action plan.

5. Audit and Risk Committee Annual Report 2022/23 (5A) and Attendance Register

The Company Secretary presented the Audit and Risk Committee Annual Report for 2022/23 which will be presented for assurance to the Board of Directors at its meeting in July 2023. The report detailed the work of the Committee from April 2022 to March 2023. The Company Secretary confirmed the report provided assurance to the Board that the Committee had met its Terms of Reference.

The attendance register of the Audit and Risk Committee from 1 April 2022 to 31 March 2023 was presented for any comment or corrections. The attendance of the Non-Executive Directors will be published in the annual report and accounts for 2022/23. The Company Secretary highlighted a typing error in the attendance table which will be amended.

It was confirmed that going forwards Chris Boyne, Deputy Head, Audit Yorkshire would attend Committee meetings rather than Helen Higgs.

PW / NB commented they had found the report easy to follow.

OUTCOME: The Committee **APPROVED** the Audit and Risk Committee's Annual Report 2022/23 and recommended this to the Board.

6. Audit and Risk Committee Workplan 2023/24

OUTCOME: The Committee **APPROVED** the Audit and Risk Committee's Workplan for 2023/24.

7. Declarations of Interest 2022/23 Update

In line with the Conflicts of Interest and Standards of Business Conduct Policy, the Company Secretary presented a report confirming declarations made in 2022/23, which included the position on declarations by decision-makers.

Compliance at the end of the 2022/23 financial year for declarations by decision making staff was reported as 93%, an improvement from 86% for the 2021/22 financial year, with a total of 1,239 decision makers for 2022/23. Declarations by type were also noted, with clinical private practice noted to be the highest area.

Weekly reminders to submit an annual declaration had been sent to all decision makers during March 2023 which helped increase compliance. In line with Contract regulations the Trust is obliged to make available to the public the names of those decision-makers who did not make a declaration.

Non-Executive Director members gave thanks for the positive position and the Deputy Head, Audit Yorkshire confirmed this was exceptionally good performance.

OUTCOME: The Committee **APPROVED** the year end position on declarations of interest.

28/23 LOCAL COUNTER FRAUD

1. Local Counter Fraud 2023/24 Annual Plan

Shaun Fleming, Local Counter Fraud Specialist, presented the Local Counter Fraud Annual Plan for 2023/24 for approval, noting this was based on the mandatory requirement of the 13 functional standards. The key points to note were:

- 68 days planned: 63 proactive days across the areas of strategic governance, fraud awareness, fraud prevention, detection and deterrence and fraud investigation and pursuit of sanctions and redress and five reactive days based on

a Trust fraud risk assessment (a reduction of four proactive days based on 2022/23),
- Process for risk assessment of the plan undertaken
- Plan includes completion of the Government Counter Fraud Profession risk assessment methodology
- The full detailed 2023/24 plan was provided in Appendix A of the paper

NB queried if there was flexibility in the number of days for investigation and Shaun Fleming confirmed as this is reactive work, five days are built into the plan, with flexibility should the level of referrals require more days.

2. Local Counter Fraud Progress Report,

Shaun Fleming, Local Counter Fraud Specialist presented the Local Counter Fraud progress report. The key points to note were:

- Two enquiries are now closed, both with no further action
- Counter Fraud newsletter March 2023 shared
- Counter Fraud survey undertaken in March 2023 – outcome will be shared at 25 July Audit and Risk Committee
- Fraud Prevention Master Classes Programme completed for 2022/23
- Fraud alerts and intelligence sharing noted
- National Fraud Initiative is underway and will be reported on during the year
- Mandated fraud risk assessment methodology is being used with the top five fraud risks detailed in the paper noted
- Fraud referral benchmarking / trend information noted
- 2022/23 plan was on target. 82 days used against of a plan of 72 in 2022/23, with increase due to increase in referrals which is positive

The Director of Finance assured the Committee that the relevant teams responded promptly to fraud alerts when received. She also noted that "Managing our Money" budget holder training is key, due to the challenging financial position, and the Local Counter Fraud Specialist will be invited to present as part of this training to further raise awareness of counter fraud.

The Local Counter Fraud Specialist was thanked for his work.

OUTCOME: The Committee **APPROVED** the 2023/24 Annual Plan and **RECEIVED** the Local Counter Fraud Progress Report

29/23 EXECUTIVE DIRECTOR OF FINANCE'S BUSINESS

1. Review of Losses and Special Payments

The Director of Finance presented a report summarising the losses and special payments transacted in quarter 4 2022/23. It was noted this included bad debt write off for overseas visitors approved at the Committee meeting on 31 January 2023.

The increase in value of losses and special payments was noted (£659.88K in 2022/23 compared to £377.53K in 2021/22). Reasons for the increase included a salary sacrifice VAT rebate in relation to cars (approved by NHS England) and a legal case relating to redundancy payments on a contract taken on by the Health Informatics Service in Q1 of £275K. The Director of Finance commented that the larger payments do not have a bearing on the 2022/23 financial position as these were either pass through items or provision had been made for this in a prior financial year. It was confirmed that one item

had been approved by the Committee Chair outside of the meeting: a legal claim on contractual payments.

PW queried the reason for the relatively high figure for HPS and the Director of Finance noted that HPS losses had been included in the report more recently for transparency and completeness. She confirmed the losses related to HPS loss of sales for products which expired before use. The Director of Finance also noted that there was a similar situation in the Pharmacy department as they need to hold certain medications for emergencies which are not frequently used and risk expiring. Work is underway via the Cash Committee on ensuring robust processes are in place to minimise losses with the aim of identifying and sharing learning between these departments.

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

2. Waivers of Standing Orders Report

The Director of Finance presented the quarter 4 report for 2022/23 noting this now aligns with procurement IT systems given the amendments made to Standing Financial Instructions. The report detailed 241 procurement events, of which 13 were single source procurements under threshold at a total cost of £241.5K. Total procurement activity was £29,728,028. There was one single source over threshold (£207K) which related to a piece of equipment with only one UK supplier. Eleven items exempt from single source rules (£525K).

OUTCOME: The Committee **NOTED** the waivers of standing orders.

30/23 EXTERNAL AUDIT

VFM Risk Assessment Sector Update

Ric Lee, KPMG Director, presented the Value for Money risk assessment for the 12 month period 2022/23 and noted that External Audit provide an opinion on both financial statements and value for money arrangements across the Trust to identify if there are any significant weaknesses, with national guidance used to assess these arrangements.

The context of the Trust's significant underlying financial deficit position and the Integrated Care System's (ICS) financial deficit position were highlighted as challenging.

Ric Lee outlined the management self-assessment process that had taken place across the three domains of financial sustainability, governance and improving economy, efficiency and effectiveness. The Director of Finance commented this had been a robust process and aligned with a financial sustainability checklist completed earlier in the year by Internal Audit.

Ric Lee, KPMG confirmed the assessment detailed a narrative for each of the three domains below:

- financial sustainability -the deficit position was well understood, plans to address the deficit were in place, cost improvement savings had been met, internal and external reporting took place, planning arrangements underway for 2023/24.
- Governance - appropriate arrangements had been in place to monitor risks, fraud and whistleblowing

- Improving economy, efficiency and effectiveness - minutes evidence value for money when decisions were made, adequate performance reporting, partnership working and patient experience, benchmarking, procurement.

No significant risks of weakness were identified for any of the three domains, however KPMG will monitor revisions to system plans for 2023/24 and how these impact on the Trust.

The summary of findings for each significant risk was included in the report to support the assessment. This information will be included at a summary level within ISA 260 report and the final commentary on value for money (the Annual Auditor Report) will be issued for publication on the Trust website by September 2023.

The Director of Finance noted that a further submission of the 2023/24 annual plan would take place by 4 May 2023 as the plan submitted had not yet been accepted; this may impact on cost improvement plans.

Matthew Moore noted that demonstrating delivery of in year savings plans is key given the deficit position.

In relation to the benchmarking report Ric Lee advised that this provides a comparison tool which for any outliers can prompt discussion in the appropriate Committee. NB advised that he will make the Finance and Performance Committee Chair aware of this.

The Director of Finance thanked KPMG for their work and the Chair thanked both KPMG and the Finance team for their work.

OUTCOME: The Committee **NOTED** the Value For Money update.

31/23 SUMMARY REPORTS

A summary report of work undertaken since January 2023 was provided for the following sub-committees and minutes of these meetings were made available in the review room:

1. Risk Group
2. Information Governance and Risk Strategy Committee
3. Health and Safety Committee
4. Data Quality Board

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

32/23 ANY OTHER BUSINESS

No other business was raised.

33/23 MATTERS TO CASCADE TO BOARD OF DIRECTORS

- Progress with Internal Audit recommendations with none outstanding as at 31 March 2023.
- Positive engagement with Internal Audit on 2023/24 plan
- Nil declaration year end position of 93%, improved from 86% the previous year
- Work on fraud alerts / awareness
- Approval of the Annual Governance Statement and review of Code of Compliance for governance
- Risk Management deep dive completed and updated Risk Policy approved
- Committee action plan agreed for 2023 following self-assessment

34/23 DATE AND TIME OF THE NEXT MEETING

Tuesday 27 June 2023 **2.00 – 3.00 pm – Extra Ordinary Meeting – MS Teams**
Tuesday 25 July 2023 10.00 – 12.30 pm – MS Teams

35/23 REVIEW OF MEETING

Given positive progress and engagement with Internal Audit the Director of Finance questioned whether there were other aspects of core Committee business we can get some broader engagement from. It was agreed that members should reflect on securing wider organisational input outside the meeting and share suggestions.

The meeting closed at approximately 12.05.

Minutes of the Finance & Performance Committee held on Wednesday 26th April 2023, 09.30am – 12.00noon Via Microsoft Teams

PRESENT

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

IN ATTENDANCE

Kirsty Archer (KA)	Director of Finance
Philippa Russell (PR)	Deputy Director of Finance
Andrea McCourt (AM)	Company Secretary
Rochelle Scargill (RS)	PA to Director of Finance (Minutes)
Brian Moore (BM)	Public Elected Governor
Peter Keogh (PK)	Assistant Director of Performance
Rob Aitchison (RA)	Deputy Chief Executive
Vicky Pickles (VP)	Director of Corporate Affairs
Stuart Baron (SB)	Associate Director of Finance
Anna Basford (AB)	Director of Transformation and Partnerships
Isaac Dziya (ID)	Public Elected Governor
Karen Heaton (KH)	Non-Executive Director
Robert Birkett (RB)	Managing Director of THIS

APOLOGIES

Robert Markless (RM)	Public Elected Governor
Adam Matthews (AM)	HR Business Partner

ITEM

071/23 WELCOME AND INTRODUCTIONS

The Chair welcomed attendees to the meeting.

072/23 DECLARATIONS OF INTEREST

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

073/23 MINUTES OF THE MEETING HELD 4th April 2023

The minutes were approved as an accurate record.

074/23 MATTERS ARISING

075/23 ACTION LOG

The Action Log was reviewed as follows:

0180/21 IPR – New version will present April data at the May meeting.

033/23 Draft Minutes from Sub Committees- All received action closed.

063/23 Turnaround Executive – On agenda close action.

FINANCE & PERFORMANCE

076/23 INTEGRATED PERFORMANCE REVIEW – MARCH 2023

The Assistant Director of Performance (PK) gave a verbal update due to the timing of the meeting.

As well as the usual monthly review a review of the full year has also been done. The Trust has performed well in its key metrics during 2022/23 amid unprecedented levels of attendance at the Emergency Departments.
Cancer performance has been outstanding and has been recognised nationally in the media. From August 2022 to January 2023 month on month CHFT was the best performing acute/combined Trust in England for Cancer 62-day referral to treatment. In total best performing for 8 out of 11 months to February in 2022/23. Similarly for 14-day Referral to Date First Seen CHFT was the best performing acute/combined Trust in England for 6 out of 11 months to February in 2022/23.

Although the Trust missed the Emergency Care 4-hour standard during 2022/23, it has benchmarked extremely well nationally. For 8 out of 12 months in 2022/23 the Trust was placed in the top 10 best performing acute/combined Trusts for type 1 attendances with only one other Trust with greater attendances finishing above. There has been an 11% rise in ED attendances compared to pre-pandemic levels and the acuity of patients has increased.

The OPEL position at the start of year was sustained at OPEL 2. We moved to OPEL 3 over Summer and by December reached OPEL 4 due to the challenges previously described. We did return to OPEL 3 before reaching OPEL 4 again at the end of March.

Performance has been excellent against 104, 78 and 52 week waits for elective recovery. More work is to be done on outpatient wait times. Stroke performance has been difficult throughout the year which has been discussed at previous meetings.

In regard to non-elective work, there have been a couple of work programs set up to look at length of stay (LOS) and the use of same day emergency care (SDEC). The is to reduce our bed occupancy and number of patients on our delayed transfer of care list which reached a peak of over 150 but averages around 100.
Continuing to focus on ambulance handover times which have reduced. Doctor and nurse strikes have had a modest impact on overall performance.

The completed IPR report will be sent to all attendees later in the week.

077/23 RECOVERY UPDATE

The Assistant Director of Performance presented the recovery update.

CHFT has performed better than other Trusts in WYAAT and are rated highly compared to other trusts nationally.
THE new national target for this year is reduce wait times to below 65 weeks. CHFT has been working on 52 weeks for the last few months having cleared most of the longer waits. At the time of this meeting there were only 12 patients who had been waiting for 65 weeks and circa 130 waiting over 52 weeks (versus 2500 at the beginning of the year).

The Trust has delivered 104% of 2019/20 levels activity levels and therefore achieved the 104% national volume target.

Appointment slots for outpatients have seen more of an impact from the various strikes. The plan was to reach pre-pandemic levels but have ended up maintaining the numbers.
Outpatient follow ups have been a challenge throughout the year, however the harm review process is now in place.

JH – Professor Tim Briggs is putting a piece of work together at a national level to try and pair trusts that are performing well on elective recovery with others that are not performing as well.

KH – Questioned what work is underway around outpatients.

AB - Responded that the outpatient transformation board is making a number of changes to the way that patients access outpatient services. Straight to test have had an impact on the efficiency of outpatient services. Patient initiated follow-ups instead of automatic follow up appointments, provide support and information that allows the patient to trigger the follow up if required. Attendance to the board allows full discussion around any potential changes to the pathways. The implementation of a new patient portal will allow patients to manage their own appointments.

A discussion took place around some of the recurring themes.

The Committee **RECEIVED** the Recovery update.

078/23 MONTH 12 FINANCE REPORT (Including High Level Risks and Efficiency Performance)

The Deputy Director of Finance presented the Month 12 Finance Report.

Key points-

- The Trust is reporting a £17.34m deficit which is a £0.01m positive variance from plan for the 2022/23 financial year.
- The doctors strike created costs incurred in month of £300k.
- The Trust was also asked to include the cost of the proposed Agenda for Change pay award. National funding has been provided for the award but does not cover all staff and left a £0.50m adverse impact.
- Some additional capacity costs in month which were higher than forecast in line with the OPEL 4 position, strikes and other challenges.

- The pressures were offset by some additional funding from system partners to support operational and inflationary pressures and vascular risk where services have been transferred.
- Received £12.7m of elective recovery funding which was £400k lower than planned following the return of some of the funding being to Kirklees Place to support their independent sector pressures.
- Agency spend was as per forecast and higher medical agency costs were seen due to the strike action. Lower nursing agency costs following the retraction of tier three agencies which are the most expensive.
- Cash position was £24.63m versus a plan of £19.26m and £31.3m was spent on capital which was £10.7m less than the plan.

The Committee **RECEIVED** the Month 12 financial report.

079/23 TREASURY MANAGEMENT ANNUAL REPORT

Deputy Director of Finance noted the key points from the report included within the meeting papers.

The year started with £54m cash reserves in the bank which were sufficient to support the deficit. We have benefitted from the block payment system which moved the payments to the 1st of the month in year which further improved the cash position. At the end of the year there was £24.6m in the bank which is partially due to the weighting of capital expenditures. The annual leave accrual did not reduce as planned in year but will go out at some point this coming year.

Even with a healthy cash position, the focus on tightly managing cash and debt management has been retained, but this will require even greater focus in 2023/24 as cash reserves will be exhausted. The Trust's deficit plan for 2023/24 will see a return to borrowing in the form of Revenue Support PDC as per the current plan which is subject to change.

We will continue to hold the cash in our government banking services account rather than invest it, as the interest is at a reasonable level and we benefit from lower public dividend charges.

Better payment practice code (BPPC) has a target to pay 95% of all invoices within 30days. Not quite reached the target in year but we have reached 90%. There is no external scrutiny on this target.

Cash availability may be more of an issue next year and there is a need to manage cash between CHFT and CHS to ensure prompt payment of invoices.

A trajectory to reduce aged debt over 30days old to £3m was set at the beginning of the year. Performance against this trajectory has been variable with the Trust ending the year with aged debt of £4.4m. This includes a debt of £0.75m that relates to one Huddersfield Pharmacy Specials (HPS) customer Nitespharma and a further £0.7m relating to the West Yorkshire ICB. Without these two specific debts the target would have been met.

A payment plan has been agreed with Nitespharma and interest will be charged on the debt, but it is expected that it will take a number of months to clear the debt. It is suggested to set the trajectory for aged debt to £3.5m for this year to allow for Nitespharma and some low risk ICB debt.

The Trust's 2023/24 Capital plan is £34m, with £17m internally funded, £11.8m funded from Public Dividend Capital and £5.1m for Leases (IFRS16). Following some changes to the national capital guidance, CHFT can approve business case of £25m or below but in practice it would be difficult to do this without ICB approval.

BM – Expressed concern that Nitespharma will take two years to pay off.

RA – responded as chair of HPS board. HPS decided to cease supply of wholesale items which Nitespharma used to purchase from HPS. At the last HPS board a series of actions were agreed including GB to write to them to formally confirm the payment plan. The high level of debt does only equate to two to three months of wholesale trading with Nitepharma.

AN – Agree the suggested new trajectory for aged debt of £3.5m. In theory cash can be shared across the ICB. Our plans assume that this will not happen as there has been no guidance issued as to how this sharing will work.

The Committee **RECEIVED** the Treasury Management Annual report.

080/23 22/23 CAPITAL PLAN REPORT

Associate Director of Finance provided an overview of the capital expenditure for 2022/23. The capital planning was done slightly different in year with two separate “dragons den” events. One in February 2022 and a second in September to bring items forward from 2023/24. £16.7m was spent on capital schemes, using our own cash resource and £10.7m using external funding. The internal spend was in line with the overall plan but external spending was significantly less than plan due to some slippage in reconfiguration caused by delayed decisions.
The numbers are different to the ones in the earlier reports as an extra £410k was received from the ICS after the earlier reports were submitted.

Within the paper is listed each scheme and how much was spent.

GB – noted that the £410k from the ICS was to help out as other areas had not managed their capital spend as effectively as CHFT.

Discussions took place as to how the capital schemes are managed and the time frames involved with extra funding. The committee were assured that the capital was well managed by the Business Case Approvals and Capital Management Groups,

The Committee **RECEIVED** the 2022/23 capital report.

081/23 2923/2024 FINANCIAL PLANNING – UPDATE ON PROGRESS

The Director of Finance gave a verbal update on the current situation around planning. The plan, which was submitted following approval by this committee, has not been accepted by NHS England. West Yorkshire ICB were offered a deal where if we could reduce the planned deficit of £110m down to £60m, it would release £30m of national money. This would leave West Yorkshire with a £30m gap which may be an acceptable deficit for the new year and would allow us to continue to have access to national capital funding.

As part of the process CHFT plans have been improved by £7.5m. This has been identified from money that will no longer be spent, for example there was some capacity funding that CHFT were holding on behalf of the system. Potential flexibilities and discussions that took place around year end covers another £2mwhich leaves an outstanding £4.5m that must be found.

The CIP challenge has been accepted in part because at 5% (£25m) CHFT was an outlier with a lower CIP target than others in the ICB. It is accepted that this is additional risk and is comparable with other providers.

Discussions are taking place as to how the additional money that has been made available at ICB level for inflation is apportioned across the ICB. All parties are making a case that the funding within the tariff is insufficient. The proposal made yesterday was for CHFT to receive £6.5m which would improve the plan.

Conversations are still ongoing as to whether CHFT will be required to complete another deep dive.

The ICS group is scheduled to meet on Friday and hopefully agree the final plan. This final plan can then be taken to CHFTs May Board meeting for approval.

The Committee **RECEIVED** the financial planning update.

082/23 TURNAROUND EXECUTIVE

The Deputy Chief Executive covered the key items in the latest Turnaround Executive update on the Cost Improvement Programme (CIP). The position is currently very positive. The £25m stretch target was always going to be a challenge, added to which is how we transition out of some of the Covid costs described in previous meetings. In comparison to other organisations CHFT is further on with the CIP work with £8m of schemes already at gateway 2 and £13.8m at gateway 1.

The risk profile of schemes has improved as we move away from high risk schemes and there has been significant improvement in the proportion of

schemes that are recurrent moving from 59% to 74% which is a much better position than the 2022/23 CIP.

Trust colleagues have been positive about this year's CIP process.

The Committee **RECEIVED** the Turnaround Executive update

083/23 CHFT PRODUCTIVITY

The Director of Finance talked around papers provided in the pack.

Nationally there is a view that NHS providers are less productive post pandemic. A triangulation tool is in use to quantify the scale of this reduced productivity and therefore the potential opportunity for improvement. The tool does not suggest how to deliver against the opportunities.

As a result of the calculation used by NHS England, it has been determined that CHFT has seen expenditure grow by 9.5% compared to pre-Covid. The average across West Yorkshire is 8%. This does not include transfer of services etc. and the data used is not entirely accurate from CHFTs perspective. The activity level is showing that CHFT had an activity increase of 7.4%; the highest of any trust in West Yorkshire. The spells are then weighted by the cost of the spell where, for example, non-elective work is cheaper than elective. The end result is showing that CHFT had a net activity growth of 0.5%.

Therefore, CHFT improved activity by 0.5% but it cost 9.5% more to achieve this. The summary being that we are spending more to perform less and that there is an 8.1% productivity opportunity. We can demonstrate through our work on the CIP that we are driving productivity improvement.

It is felt the data being used is flawed in that processes, workflows and NICE guidance has changed during and since the pandemic which has not been accounted for.

There is slightly less productivity opportunity for CHFT than there is for some peers across West Yorkshire, and it does not triangulate as to why we have one of the biggest financial deficits compared to others. However, our income is lower than it should be which is affecting this metric.

We are being penalised in that some work that was previously classed as elective is now being done as day case which is measured differently. A piece of work is being put together to explain why the productivity is scoring so low. Surgery have compared their lists now versus 2019/20 and the are working at the same level. Other divisions are doing the same.

It is expected that the metric will improve going forward, but it has resulted in extra scrutiny this year but it is not something where a regulatory target has been set. All requests to change the baseline have been rejected.

The Committee **RECEIVED** the productivity paper.

084/23 DRAFT MINUTES FROM SUB-COMMITTEES

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

- Access Delivery Group – Paused from February until April
- Business Case Approvals Group
- Capital Management Group
- THIS Executive Group
- Urgent and Emergency Care.

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

085/23 WORKPLAN – 2023/24

The workplan for 2023/24 has been brought to this meeting for approval. The following changes have been made:

- HPS – Commercial strategy review refresh moved to year end.

- HPS – Annual Report to pick up year end in June.

- BAF reviews and reviews of high-level risks lined up with the Board workplan.

- Deep dives have been scheduled following discussion with JH.

Self-Assessments for this meeting are due to be completed. The questionnaires will be sent out with a date set for a response. The actions will be reviewed at the May meeting.

Committee **APPROVED** the work plan for 2023/24.

086/23 ANY OTHER BUSINESS

None.

087/23 MATTERS TO CASCADE TO BOARD inc. ONE CULTURE OF CARE

- CHFTs performance especially on elective recovery.
- Financial plan hopefully now finalised.
- That the committee were assured by the reports on treasury management and the capital plan.
- Productivity.

DATE AND TIME OF NEXT MEETING:

Tuesday 30th May 13:30 – 16:00 MS Teams

Minutes of the Finance & Performance Committee held on Tuesday 30th May 2023, 13.30am – 16.00noon Via Microsoft Teams

PRESENT

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

IN ATTENDANCE

Philippa Russell (PR)	Deputy Director of Finance
Andrea McCourt (AM)	Company Secretary
Rochelle Scargill (RS)	PA to Director of Finance (Minutes)
Peter Keogh (PK)	Assistant Director of Performance
Vicky Pickles (VP)	Director of Corporate Affairs
Anna Basford (AB)	Director of Transformation and Partnerships
Isaac Dziya (ID)	Public Elected Governor
Karen Heaton (KH)	Non-Executive Director
Robert Markless (RM)	Public Elected Governor
Adam Matthews (AM)	HR Business Partner
Helen Hirst	Trust Chair
Helen Rees	Director of Operations - Medicine
Jonathan Hammond	Chief Operating Officer
Huw Masson	ED Consultant
Jason Bushby	Deputy Director of Operations ED.

APOLOGIES

Kirsty Archer (KA)	Director of Finance
Rob Aitchison (RA)	Deputy Chief Executive
Stuart Baron (SB)	Associate Director of Finance
Brian Moore (BM)	Public Elected Governor
Robert Birkett (RB)	Managing Director of THIS

ITEM

088/23 WELCOME AND INTRODUCTIONS

The Chair welcomed attendees to the meeting.

089/23 DECLARATIONS OF INTEREST

090/23 MINUTES OF THE MEETING HELD 26th April 2023

The minutes were approved as an accurate record.

091/23 MATTERS ARISING

092/23 ACTION LOG

The Action Log was reviewed as follows:

0180/21 IPR – New version on agenda. Close action.

093/23 ED DEEP DIVE FOLLOW UP

The Director of Operations Medicine, Deputy Director of Operations ED and ED Consultant gave a joint presentation providing a follow up on the last ED deep dive. Key points included:

- 250 attendances across both sites every day. Seems to be consistent now.
- Covid workforce model still in place.
- YTD performance – 71.64%. The new national standard has been set at 76% with a CHFT internal target of 80%. Urgent care hubs funded by ICB's have provided alternate workstreams for patients.
- A new workforce model has been developed so that the correct staffing is available at the right time to make decisions and move patients through.
- More acute patients requiring admissions.
- Use of virtual wards to reduce admissions.
- Ambulance handovers – West Yorkshire Audit looked at SOP's and processes as CHFT have excellent performance at avoiding handovers over 60 minutes.
- Ten KPI's for ED which are monitored by the Urgent and Emergency Care Group.
- ED remains financially challenging but the new workforce model is key to addressing this.
- The new workforce model and new rotas for staffing are currently being implemented. 5 new consultants have been offered posts of which 2 are substantive and 3 are bank workers. This will improve availability of staff and the two highest cost agency staff have now been released. Having had recruitment success at consultant level now working through other staffing. This will reduce agency spend.
- Development of the urgent care hub - what can this look like in the future. Currently hands over to local care direct out of hours but could the hub be used differently.

JH commented that people who attend ED but do not need to be there can affect the conversion rate. Need to focus on what is correct for CHFT.

Consultant increase will not improve the overnight wait times as this would require a bigger number of consultants. Retention has not been an issue at consultant level.

Consultant rota to be in place in July and fully implemented by September / October. Will allow focus on the 4-hour target. Whole workstreams across the hospitals need to be involved in achieving the target as discharge and length of stay all impact achievement of it.

DRAFT

There was a discussion around costs and efficiency targets and that achieving the full £4m saving in 2023/4 would be a stretch. The team believe a saving of £4m in ED costs is doable but can it be done in one year.

It is likely the committee will want the ED team to report back later in this year to assess progress against the performance and efficiency targets,

FINANCE & PERFORMANCE

094/23 INTEGRATED PERFORMANCE REVIEW (IPR) – APRIL 2023

The Assistant Director of Performance (PK) gave an update using the new format IPR report.

For April 2023 we are now introducing the new Integrated Performance Report (IPR) for Board of Directors specifically concentrating on metrics included in the NHS Oversight Framework alongside those from the NHS Priorities and Operational Planning guidance. A series of Statistical Process Control (SPC) charts are contained within the IPR which will be used to understand current performance.

Key points on the new format:-

- There were previously over 100 different metrics reported against; that is now down to around 40. More workforce metrics will be included and further work is required in relation to the Community metrics.
- At the front of the IPR is a matrix summary.
- At the back is an appendix showing the meaning of the symbols and the reasoning behind the metrics.
- Finance, virtual ward, community waiting list, bed occupancy, non-site specific cancer referrals, admission avoidance and neonatal deaths are not included in the summary table but this may change.
- SPC language and terms are used in the report to maintain a consistent narrative
- The new format is being trialled for three months and if changes are required, they will be made at that point.

Key items –

- Excellent performance on elective recovery. The internal target is to have zero patients waiting over 40 weeks by March 2024.
- Comparing nationally, CHFT is 8th out of 121 for the least number of patients waiting longer than 52 weeks and the other 7 all started with smaller backlogs
- Some specialities, for example ENT, need to be monitored closely.

DRAFT

- The national target for this year is have no patients waiting over 65 weeks. CHFT currently only have a couple of patients in this category and the target is to have zero by the end of June 2023.
- The numbers on the total RTT waiting list have reduced since Covid.
- Elective activity – In April we exceeded the elective activity target reaching 107.1% against a target of 103% and is the highest ever level of performance for this indicator since its inception.
- Waiting less than 6 weeks for a diagnostic test. Performing well above 95% target when Echocardiology and Neurophysiology are excluded. There have been staffing and systems issues in both areas and these are being addressed.
- .
- Cancer – Excellent progress was made last year which has been recognised in national media. Four metrics have been included in the new IPR.
- Non-site-specific cancer referrals. – Not in SPC format yet.
- Transfer of care – Target of 50 for this year by Summer. Latest month measure over 100.
- Two metrics for maternity. Neonatal and Still births.
- Community – three metrics currently. Virtual ward needs further work.
- Summary Hospital Mortality Rate as previously looks at the 12-month running total and is a few months behind. January's performance at 95.99 contributing to an improving position on a 12-month rolling basis
- Complaints performance remains strong with 92% of complaints closed on time in April.
- Currently three quality priorities have been identified, but these will be expanded.
- More metrics are required to monitor workforce performance.

The committee provided positive feedback on the new format. The report is clear and the matrix summary at the beginning is particularly useful. Could be helpful to the reader to bring the first appendix page, which explains the icons, to the front of the report.

Any month-on-month changes will be highlighted during the presentation.

Longer slot to be given for IPR on the agenda for the next meeting.

The committee **RECEIVED** the Integrated Performance Report for April.

095/23 RECOVERY UPDATE

The Assistant Director of Performance presented the recovery update.

- CHFT continues to reduce its elective backlog faster than all Trusts across WYATT.
- 52 week waits – just over 100 to be cleared by end of next month.

DRAFT

- 40 week waits – ENT have the biggest numbers. Plans are in place to address these.
- ASI's – Target to reduce waits over 18 weeks to zero by March 2024.

The committee briefly discussed the need to refresh this report and section of the meeting so that it focusses more time on the backlogs of outpatient follow-ups and appointments.

The Committee **RECEIVED** the Recovery update.

096/23 MONTH 1 FINANCE REPORT (Including High Level Risks and Efficiency Performance)

The Deputy Director of Finance presented the Month 1 Finance Report.

Key points-

- M1 deficit of £2.84m, a £0.18m adverse variance from plan.
- Assumes full receipt of variable Elective income / Elective Recovery Funding.
- Early indications are that the Trust delivered the M1 activity plan (subject to data validation).
- £1.21m CIP delivered, £0.04m lower than planned.
- In Month 1 the Trust incurred higher than planned costs due to the Doctors Strike (estimated to be c. £0.29m), some higher than planned additional bed capacity and higher than expected Utilities costs. These pressures were offset to some extent by some slippage on recruitment particularly in Community Division.
- Revised annual financial plan submitted to the ICB and NHSE with a £20.80m deficit.
- Final submitted plan included a £6.5m stretch efficiency target taking the total efficiency requirement from £25m to £31.50m.
- No capital spent in month 1. Challenging plan for the year to spend £24m.
- Cash slightly above plan. Plan to borrow later in the year £9.5m.
- Use of resources measures planned to be at level 3.
- Key elements of aged debt linked to Huddersfield Pharmacy Specials (HPS) and ICB. ICB is low risk and plan in place for HPS debt

The Committee **RECEIVED** the Month 1 financial report.

Finance risks for approval –

- Risk ratings for Finance to be approved.
- I and E score of 20. Includes key risks of the CIP, uncertainty around Elective Recovery Funding and the need to fund bed capacity
- Strike action has no planned funding.
- Borrowing requirement and cash management between CHFT and CHS is an increased risk.

DRAFT

ACTION: Leave risk description as is for cash flow but add more to the narrative to more clearly explain the risk.

Finance risk scores **APPROVED**

097/23 2923/2024 FINANCIAL PLANNING – UPDATE ON PROGRESS

The Director of Finance gave an update on the final plan that was submitted. Most of the detail has been seen by this committee at previous meetings.

There was a request to improve the plan which was discussed at a meeting with the ICB. The agreement was to submit a balanced plan with an expected £25m deficit. This will allow access to capital and other cash which may become available to the system.

The suggested alternate recovery plan for West Yorkshire has been accepted.

The Trust now need to plan for a £31m CIP (vs current £25m plan) but are talking to the local system about availability of funds so that the additional internal stretch is reduced.

Included in the pack is the letter sent to NHSE confirming the agreement to the new plan.

Deep dive by NHSE scheduled for 7th June.

The Committee **RECEIVED** the financial planning update.

098/23 TURNAROUND EXECUTIVE

The Director of Transformation and Partnerships covered the key messages. As of today, the majority of the £25m CIP target has been confirmed with £18m at Gateway Two and £6.6m at Gateway One. This leaves 0.6m not identified.
There are some final actions to complete to move length of stay and workforce efficiencies to Gateway Two.
Of the 0.6m not identified – corporate savings identified savings needed to close the gap.
74% of the efficiencies identified are recurrent.
The plan is to start to see delivery of the schemes in the next two weeks.

The Committee **RECEIVED** the Turnaround Executive update

099/23 BAF RISKS

The Company Secretary provided the first update following the board approval of the 2023/24 1 year and 5-year strategy.

The following decisions were agreed:

- The removal of risk 7/19 – NHS Improvement Compliance - to be replaced with a new risk relating to a being a well-governed Trust and fulfilling partnership duties.
- The removal of risks 8/19 Performance targets and 5/20 Recovery service capacity. The trust performed well in terms of recovery activity, and it is no longer deemed a strategic risk.
- A new risk has been developed for approval, risk 1/23 relating to demand and beds, scored at 16 which is enclosed and is:
  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 results in staffing and financial pressures.
  Discussion took place around increasing the risk score to 20 from 16 as extra beds opening impacts across the whole service.
- A new risk relating to performance and compliance with targets will be developed for presentation to the July Board.

ACTION: New risk 1/23 update the score to 20 and approve.

Finance risks – no change proposed to the risk scores. Reflect the operational risks described in the Finance update.

Risk 15/19 – Relating to the Trust not delivering external growth for commercial ventures within the Trust.
Reasons to remove – the risk has been realised with a reduction in contribution.
Reasons to remain - Constrains capital investment if removed.

Following discussions, it was deemed that this is not a strategic risk and should be removed from the BAF framework.

The Committee **APPROVED** the removal of BAF Risks 7/19, 8/19, 15/19 and 5/20 and the inclusion of a new risk 1/23 but with a score of 20

100/23 DRAFT MINUTES FROM SUB-COMMITTEES

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

- **Access Delivery Group** – would like a cover sheet as per other meetings.
- **Business Case Approvals Group** – Development funding has already been committed for this year and there is no contingency due to the financial position.
- **Capital Management Group**
- **Cash Committee** – Target of 95% of invoices was not achieved all year. Improvement in month 1 when target was met.
- **CHFT / THIS SLA Meeting**
- **HPS Board** – HPS have been given a lower target for contribution and there is confidence that this will be achieved.

- **Pennine Property Partnership**
- **THIS Executive Group**
- **Urgent and Emergency Care**.

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

101/23 WORKPLAN – 2023/24

The workplan for 2023/24 has been brought to this meeting for review.

No changes to the plan this month.

Committee **APPROVED** the work plan for 2023/24.

102/23 ANY OTHER BUSINESS
None.

103/23 MATTERS TO CASCADE TO BOARD inc. ONE CULTURE OF CARE

- Key points around ED.
- New IPR report.
- Recovery update.

DATE AND TIME OF NEXT MEETING:
Wednesday 28th June 10:30 – 13:00 MS Teams

DRAFT

Minutes of the Charitable Funds Committee meeting held on Wednesday 10 May 2023, 11.00 – 12.30pm via Microsoft Teams

PRESENT

Helen Hirst (HH)	Chair
Kirsty Archer (KA)	Deputy Director of Finance
Nigel Broadbent (NB)	Non-Executive Director
Adele Roach (AR)	REN Staff Representative

IN ATTENDANCE

Vicky Pickles (VP)	Director of Corporate Affairs
Emma Kovaleski (EK)	Charity Manager
Zoe Quarmby (ZQ)	Asst Director of Finance – Financial Control
Carol Harrison (CH)	Charitable Funds Manager (Minutes)
Lyn Walsh (LW)	Finance Manager
Rebecca Fletcher (RF)	Specialist Nurse – Palliative Care (for item 6)
Gemma Gordon (GG)	Specialist Nurse – Palliative Care (for item 6)
Anthony Thomas (AT)	Specialist Nurse – Palliative Care (for item 6)
Gillian Sykes (GS)	End of Life Care Facilitator (for item 7)

1. DECLARATION OF INDEPENDENCE

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

2. APOLOGIES FOR ABSENCE

No further apologies were received.

3. MINUTES OF MEETING HELD ON 15 FEBRUARY 2023

The minutes of the meeting held on 15 February 2023 were approved as an accurate record.

VP gave an update regarding the amended cost for the Quiet Close Waste Bins which was approved outside of the February meeting.

4. ACTION LOG

The action log was reviewed, and it was agreed to close the following actions:

11.05.22 – 1
15.02.23 – 2
15.02.23 – 3
15.02.23 – 4
15.02.23 – 5

Other actions were either ongoing or not fully closed and have remained on the Action Log.

It was noted that future agendas should include a reminder for declarations of interest.

ACTION: CH to amend Action Log re closed items – **10.05.23 – 1** and
VP to add declarations to work plan – **10.05.23 - 2**

5. CHARITY MANAGER'S REPORT
EK presented this report. Discussions were held around lessons learned, the branding refresh, the voluntary income section needing to include all income for consistency with the SOFA income figures, and for future Charity Manager's reports to focus on activity rather than numbers.

6. PRE-BEREAVEMENT PROJECT PRESENTATION
RF, GG and AT gave an informative presentation about the Pre-Bereavement Project to the Committee. This project has been funded by the Charity's Palliative Care fund.

7. BEREAVEMENT SUPPORT SERVICE
GS presented her request for a further six months' funding for the Bereavement Support Service. The Committee agreed to fund this but asked that sustainability be considered once this funding stops, especially as this is supporting salaries. It may be that the Charity has a role to play in the Sustainability Plan.

ACTION: CH to set up an approval for this extra funding - **10.05.23 - 3**

8. FINANCE REPORT – ACCOUNTS 2022/23 OVERVIEW
CH presented this paper and its contents were noted. NB agreed to go over some points with CH outside of the meeting. Future Finance Reports will include sections on outstanding approvals and a five year view.

9. GOVERNANCE UPDATE
VP presented the Terms of Reference and asked that they be reviewed and asked for feedback, in particular regarding membership, in the next two weeks. The final version will be brought back to the next meeting for sign off.

ACTION: VP to present final Terms of Reference for approval - **10.05.23 - 4**

10. MINUTES OF STAFF LOTTERY COMMITTEE MEETING 3 APRIL 2023
These papers are for information only and their contents were NOTED.

11. STAFF LOTTERY COMMITTEE MEMBERSHIP CHANGES
This paper was reviewed and all changes were ratified.

12. ANY OTHER BUSINESS
AR asked EK for an update on her Windrush event bid. EK confirmed she would give a decision next week.

DATE AND TIME OF NEXT MEETING:
9 August 2023, 11am.

18. INFORMATION TO RECEIVE

1. Highlight Report from Finance and Performance Committee

For Information

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COVER SHEET

Date of Meeting:	Thursday 20 July 2023
Meeting:	Council of Governors
Title:	Month 2 Finance Report
Author:	Philippa Russell – Acting Deputy Director of Finance
Sponsoring Director:	Gary Boothby – Director of Finance / Kirsty Archer – Acting Director of Finance
Previous Forums:	Finance & Performance Committee, Board of Directors

Actions Requested:

To receive – For information

Purpose of the Report

To provide a summary of the financial position as reported at the end of Month 2 (May 2023)

Key Points to Note

<u>Year To Date Summary</u>

The Trust is reporting a £4.58m deficit, (excluding the impact of Donated Assets), a £0.39m adverse variance from plan. The in-month position is a deficit of £1.74m, a £0.21m adverse variance.

Year to date the Trust has incurred higher than planned costs due to higher than planned additional bed capacity of £0.47m (£0.28m surge capacity plus £0.19m slippage on the LOS CIP), the Doctors Strike (£0.20m) and higher than expected Utilities costs. These pressures were offset by early delivery of other efficiencies and a higher than planned vacancy rate.

- £2.50m of Elective Recovery Funding (ERF) has been received as planned.
- West Yorkshire proposed mechanism for allocating Elective Recovery Funding (ERF) has now received national approval. This proposal focuses on targeting achievement of waiting list performance rather than activity volumes. Financial penalties would be imposed for any patients not treated within the 52 week target, although there is likely to be a cap on the maximum funding deduction and the mechanism for managing this process and any overachievement has yet to be agreed.
- The Trust has delivered efficiency savings of £2.56m, £0.04m lower than planned.
- Agency expenditure year to date was £1.83m, £0.28m lower than the Agency Ceiling, (3.7% of total pay expenditure) and £0.18m lower than planned.
- Overall Weighted Elective Recovery Position as a percentage of 2019/20 Baseline was 111.4%, 6.4% higher than planned.

Key Variances

- Income is £0.31m above the plan due to higher than planned commercial income (Health Informatics).
- Pay costs were £0.17m lower than the planned level. The Trusts incurred pay pressures due to additional bed capacity, with the additional impact of the April strike action (£0.20m impact), both of which led to higher than planned Bank costs. Year to date costs associated with additional bed capacity are £0.47m - £0.28m surge capacity plus £0.19m slippage on an efficiency scheme targeting a reduction in bed capacity through targeted work on Length of Stay and Transfers of Care. These additional costs have been offset by higher than planned vacancies especially in Community Division, where there has been delays in recruiting to new posts for new projects including Virtual Ward and an underspend associated with Elective Recovery, offset in turn by additional costs incurred on Insourcing to support the Recovery plan.
- Non-pay operating expenditure is £1.71m higher than planned year to date with pressure on utilities, maintenance and rates costs, higher than planned insourcing / outsourcing costs associated with Elective Recovery and commercial contracts in Health Informatics. Costs associated with Elective Recovery have also been impacted by the Junior Doctors Strike with an element of catch up required to manage priority patients.

Forecast

The Trust is forecasting to deliver the planned £20.80m deficit, but the 'likely case' scenario includes £6.3m of unidentified mitigation required to offset forecast pressures and emerging risks including: unidentified CIP, (£2.1m of the £6.5m final plan stretch target); likely slippage on some high-risk efficiency programmes; further strike action; and challenges delivering the bed plan.

Attachment: Month 2 Finance Report

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 Council of Governors is asked to receive the Finance Report for information.

EXECUTIVE SUMMARY: Total Group Financial Overview as at 31st May 2023 - Month 2

KEY METRICS

	M2				YTD (MAY 2023)				Forecast 23/24			
	Plan £m	Actual £m	Var £m		Plan £m	Actual £m	Var £m		Plan £m	Forecast £m	Var £m	
I&E: Surplus / (Deficit)	(£1.54)	(£1.74)	(£0.21)	Red	(£4.20)	(£4.58)	(£0.39)	Red	(£20.80)	(£20.80)	(£0.00)	Green
Agency Expenditure (vs Ceiling)	(£1.06)	(£0.89)	£0.16	Green	(£2.11)	(£1.83)	£0.28	Green	(£12.67)	(£6.88)	£5.79	Green
Capital	£0.82	£0.20	£0.62	Red	£1.43	£0.20	£1.23	Red	£34.00	£34.00	(£0.00)	Green
Cash	£31.48	£34.81	£3.33	Green	£31.48	£34.81	£3.33	Green	£2.19	£2.38	£0.19	Green
Invoices paid within 30 days (%) (Better Payment Practice Code)	95.0%	93.3%	-2%	Amber	95.0%	94.7%	0%	Amber				
CIP	£1.34	£1.37	£0.03	Green	£2.60	£2.56	(£0.04)	Amber	£31.50	£31.50	(£0.00)	Green
Use of Resource Metric	3	3		Amber	3	3		Amber	3	3		Green

Year To Date Summary

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Total Group Financial Overview as at 31st May 2023 - Month 2

INCOME AND EXPENDITURE COMPARED TO PLAN SUBMITTED TO NHS IMPROVEMENT

YEAR TO DATE POSITION: M2

CLINICAL ACTIVITY

	M2 Plan	M2 Actual	Var
Elective	722	782	60
Non-Elective	8,856	8,574	(282)
Daycase	7,853	8,131	278
Outpatient	68,939	72,207	3,269
A&E	29,128	29,061	(67)
Other NHS Non-Tariff	307,348	331,031	23,682
Total	**422,847**	**449,787**	**26,940**

TOTAL GROUP: INCOME AND EXPENDITURE

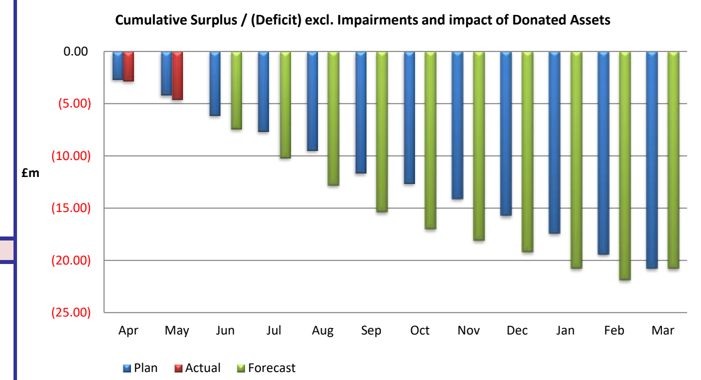
	M2 Plan £m	M2 Actual £m	Var £m
Elective	£2.77	£3.15	£0.38
Non Elective	£20.85	£20.51	(£0.34)
Daycase	£5.69	£5.79	£0.10
Outpatients	£7.02	£7.51	£0.49
A & E	£5.25	£5.28	£0.03
Other-NHS Clinical	£36.93	£36.24	(£0.69)
CQUIN	£0.00	£0.00	£0.00
Other Income	£9.16	£9.49	£0.34
Total Income	**£87.66**	**£87.97**	**£0.31**
Pay	(£58.45)	(£58.28)	£0.17
Drug Costs	(£7.73)	(£7.38)	£0.35
Clinical Support	(£5.47)	(£5.44)	£0.03
Other Costs	(£11.11)	(£13.14)	(£2.03)
PFI Costs	(£2.70)	(£2.76)	(£0.07)
Total Expenditure	**(£85.46)**	**(£87.01)**	**(£1.54)**
EBITDA	**£2.20**	**£0.97**	**(£1.24)**
Non Operating Expenditure	(£6.40)	(£5.55)	£0.85
Surplus / (Deficit) Adjusted*	**(£4.20)**	**(£4.58)**	**(£0.39)**

* 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

DIVISIONS: INCOME AND EXPENDITURE

	M2 Plan £m	M2 Actual £m	Var £m
Surgery & Anaesthetics	(£16.80)	(£16.57)	£0.23
Medical	(£22.13)	(£23.14)	(£1.01)
Families & Specialist Services	(£15.35)	(£15.18)	£0.17
Community	(£5.28)	(£4.96)	£0.32
Estates & Facilities	£0.00	(£0.00)	(£0.00)
Corporate	(£9.51)	(£9.51)	£0.00
THIS	£0.25	£0.17	(£0.08)
PMU	£0.15	£0.27	£0.11
CHS LTD	£0.02	(£0.03)	(£0.05)
Central Inc/Technical Accounts	£64.78	£64.52	(£0.26)
Reserves	(£0.33)	(£0.15)	£0.18
Surplus / (Deficit)	**(£4.20)**	**(£4.58)**	**(£0.39)**

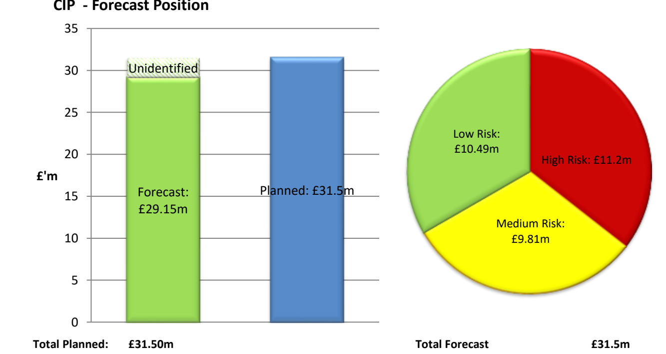
TOTAL GROUP SURPLUS / (DEFICIT)



KEY METRICS

	Year To Date			Year End: Forecast		
	M2 Plan £m	M2 Actual £m	Var £m	Plan £m	Forecast £m	Var £m
I&E: Surplus / (Deficit)	(£4.20)	(£4.58)	(£0.39)	(£20.80)	(£20.80)	(£0.00)
Capital	£1.43	£0.20	£1.23	£34.00	£34.00	(£0.00)
Cash	£31.48	£34.81	£3.33	£2.19	£2.38	£0.19
Invoices Paid within 30 days (BPPC)	95%	95%	0%			
CIP	£2.60	£2.56	(£0.04)	£31.50	£31.50	(£0.00)
	Plan	Actual		Plan	Forecast	
Use of Resource Metric	3	3		3	3	

COST IMPROVEMENT PROGRAMME (CIP)



Total Planned: £31.50m

Total Forecast £31.5m

YEAR END 23/24

CLINICAL ACTIVITY

	Plan	Actual	Var
Elective	4,636	4,636	0
Non-Elective	53,866	53,866	0
Daycase	49,935	49,935	0
Outpatient	434,259	434,259	0
A&E	174,293	174,293	0
Other NHS Non- Tariff	1,975,197	2,121,427	146,230
Total	**2,692,185**	**2,838,416**	**146,230**

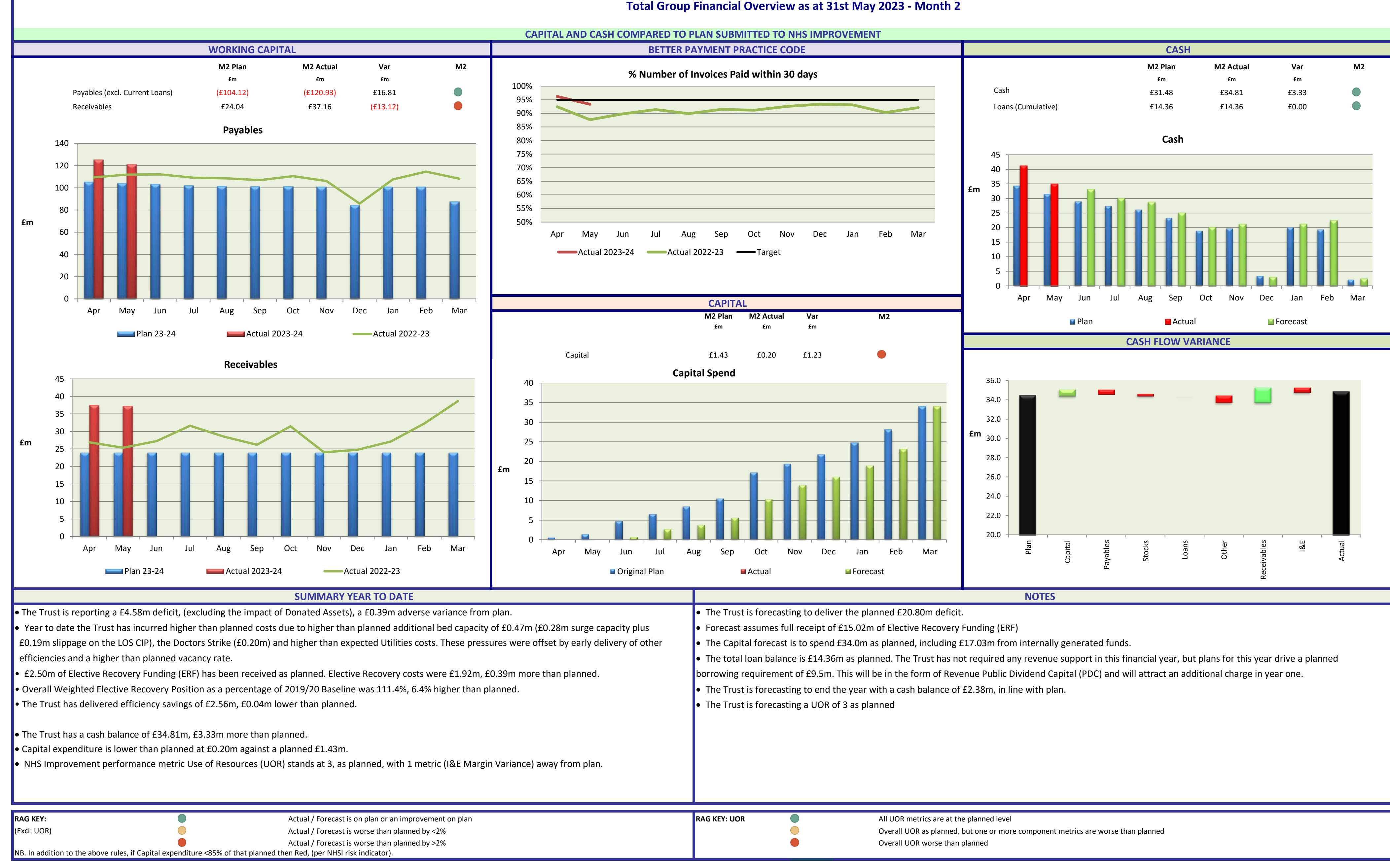
TOTAL GROUP: INCOME AND EXPENDITURE

	Plan £m	Actual £m	Var £m
Elective	£17.69	£17.69	£0.00
Non Elective	£125.90	£125.90	£0.00
Daycase	£36.01	£36.01	£0.00
Outpatients	£44.01	£44.01	£0.00
A & E	£31.42	£31.42	£0.00
Other-NHS Clinical	£215.62	£216.40	£0.78
CQUIN	£0.00	£0.00	£0.00
Other Income	£55.28	£57.01	£1.72
Total Income	**£525.93**	**£528.44**	**£2.50**
Pay	(£346.53)	(£349.56)	(£3.03)
Drug Costs	(£47.98)	(£46.86)	£1.11
Clinical Support	(£33.64)	(£29.70)	£3.94
Other Costs	(£63.67)	(£69.35)	(£5.68)
PFI Costs	(£16.19)	(£16.58)	(£0.39)
Total Expenditure	**(£508.01)**	**(£512.05)**	**(£4.05)**
EBITDA	**£17.93**	**£16.38**	**(£1.54)**
Non Operating Expenditure	(£38.72)	(£37.18)	£1.54
Surplus / (Deficit) Adjusted*	**(£20.80)**	**(£20.80)**	**(£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

DIVISIONS: INCOME AND EXPENDITURE

	Plan £m	Forecast £m	Var £m
Surgery & Anaesthetics	(£101.33)	(£101.78)	(£0.45)
Medical	(£132.24)	(£135.56)	(£3.31)
Families & Specialist Services	(£93.27)	(£93.69)	(£0.42)
Community	(£32.69)	(£32.19)	£0.50
Estates & Facilities	£0.00	(£0.00)	(£0.00)
Corporate	(£56.00)	(£55.99)	£0.00
THIS	£1.42	£1.42	£0.00
PMU	£0.93	£0.93	(£0.00)
CHS LTD	£0.71	£0.47	(£0.25)
Central Inc/Technical Accounts	£389.64	£390.48	£0.84
Reserves	£2.02	£5.10	£3.08
Surplus / (Deficit)	**(£20.80)**	**(£20.80)**	**(£0.00)**



Total Group Financial Overview as at 31st May 2023 - Month 2

CAPITAL AND CASH COMPARED TO PLAN SUBMITTED TO NHS IMPROVEMENT

WORKING CAPITAL

	M2 Plan £m	M2 Actual £m	Var £m	M2
Payables (excl. Current Loans)	(£104.12)	(£120.93)	£16.81	●
Receivables	£24.04	£37.16	(£13.12)	●

BETTER PAYMENT PRACTICE CODE

CASH

	M2 Plan £m	M2 Actual £m	Var £m	M2
Cash	£31.48	£34.81	£3.33	●
Loans (Cumulative)	£14.36	£14.36	£0.00	●

CAPITAL

	M2 Plan £m	M2 Actual £m	Var £m	M2
Capital	£1.43	£0.20	£1.23	●

CASH FLOW VARIANCE

SUMMARY YEAR TO DATE

- The Trust is reporting a £4.58m deficit, (excluding the impact of Donated Assets), a £0.39m adverse variance from plan.
- Year to date the Trust has incurred higher than planned costs due to higher than planned additional bed capacity of £0.47m (£0.28m surge capacity plus £0.19m slippage on the LOS CIP), the Doctors Strike (£0.20m) and higher than expected Utilities costs. These pressures were offset by early delivery of other efficiencies and a higher than planned vacancy rate.
- £2.50m of Elective Recovery Funding (ERF) has been received as planned. Elective Recovery costs were £1.92m, £0.39m more than planned.
- Overall Weighted Elective Recovery Position as a percentage of 2019/20 Baseline was 111.4%, 6.4% higher than planned.
- The Trust has delivered efficiency savings of £2.56m, £0.04m lower than planned.

- The Trust has a cash balance of £34.81m, £3.33m more than planned.
- Capital expenditure is lower than planned at £0.20m against a planned £1.43m.
- NHS Improvement performance metric Use of Resources (UOR) stands at 3, as planned, with 1 metric (I&E Margin Variance) away from plan.

NOTES

- The Trust is forecasting to deliver the planned £20.80m deficit.
- Forecast assumes full receipt of £15.02m of Elective Recovery Funding (ERF)
- The Capital forecast is to spend £34.0m as planned, including £17.03m from internally generated funds.
- The total loan balance is £14.36m as planned. The Trust has not required any revenue support in this financial year, but plans for this year drive a planned borrowing requirement of £9.5m. This will be in the form of Revenue Public Dividend Capital (PDC) and will attract an additional charge in year one.
- The Trust is forecasting to end the year with a cash balance of £2.38m, in line with plan.
- The Trust is forecasting a UOR of 3 as planned

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

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

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

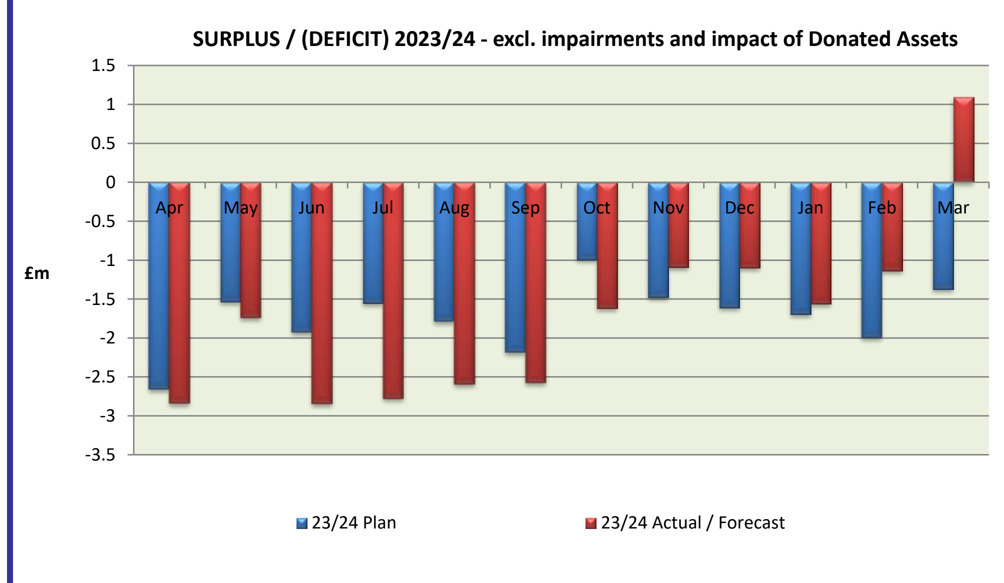
FORECAST 2023/24

23/24 Forecast Position (31 Mar 24)

Statement of Comprehensive Income	Plan £m	Forecast £m	Var £m
Income	£519.154	£528.517	£9.363
Pay expenditure	(£339.667)	(£349.562)	(£9.896)
Non Pay Expenditure	(£161.476)	(£162.491)	(£1.015)
Non Operating Costs	(£39.153)	(£37.761)	£1.392
Total Trust Surplus / (Deficit)	**(£21.141)**	**(£21.298)**	**(£0.156)**
Deduct impact of:			
Impairments & Revaluations (AME)[1]	£0.000	£0.000	£0.000
Donated Asset depreciation	£0.429	£0.579	£0.150
Donated Asset income (including Covid equipment)	(£0.084)	(£0.080)	£0.004
Net impact of donated consumables (PPE etc)	£0.000	£0.000	£0.000
Gain on Disposal	£0.000	£0.000	£0.000
Adjusted Financial Performance	**(£20.797)**	**(£20.799)**	**(£0.002)**

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

MONTHLY SURPLUS / (DEFICIT)



Forecast Position:

Whilst the Trust is reporting a 'likely' case forecast in line with plan, Divisional forecasts suggest that the Trust is likely to need to find at least £6.3m of currently unidentified mitigation to offset significant risks. £4.4m is linked to extremly high risk efficiency programmes including: a reduction in LOS and DTOC and associated bed closures; staffing efficiencies in A&E; and benefits associated with WYAAT system wide business cases. Plus forecast pressures due to: Strike costs for April and June of £0.6m (any further future strikes will increase these costs) and higher than planned non pay inflationary pressures.

The worst case scerario is a £14.6m adverse variance from plan and in addition to the above includes: a level of unidentified efficiency linked to the £6.5m efficiency stretch; other high risk efficiency schemes; a further risk on additional 'Surge' bed capacity during the winter months; ongoing pressures due to supernumerary overseas nurses, mobile CT requirements and Radiology outsourcing. These risks are offset by some identified mitigations.

All scenarios assume full delivery of the Elective Recovery plan and therefore no claw back.

Indications are that there will be no significant pressure due to the AfC pay award, but allocations are subject to final confirmation.

Other Assumptions and Potential Risks / Opportunities

- West Yorkshire proposed mechanism for allocating Elective Recovery Funding (ERF) has now received national approval. This proposal focuses on targeting achievement of waiting list performance rather than activity volumes. Financial penalties would be imposed for any patients not treated within the 52 week target, although there is likely to be a cap on the maximum funding deduction and the mechanism for managing this process and any overachievement has yet to be agreed.
- Plans assume Agency and Bank premium payments are only required to deliver additional recovery.
- Risk that any further Pay Award decisions are not fully funded.

2. Quality and Performance Report

For Information

Date of Meeting:	Thursday 20 July 2023
Meeting:	Council of Governors
Title:	QUALITY & PERFORMANCE REPORT
Author:	Peter Keogh, Assistant Director of Performance
Previous Forums:	Executive Board, Finance & Performance Committee, Board of Directors
Actions Requested:	For information

Purpose of the Report

To provide the Council of Governors with a single combined narrative that seeks to triangulate current performance for the month of May 2023.

Key Points to Note

For May 2023 we continue to perform well in terms of **elective recovery** 65/52/40 weeks. For ENT specifically where numbers are growing there is a Task and Finish group in place to address actions moving forward. For diagnostics we still have challenges in Echo and Neurophysiology with new trajectories being developed to get performance back on track.

Cancer performance continues to be strong although we did miss the faster diagnosis target in May. Amongst the patients were 7 patients who have a learning disability who were diagnosed over 28 days, the cancer team continue to monitor learning disability patients and work with carers and the complex needs matron to ensure patients are diagnosed faster.

ED performance for May was 71.22% and we have seen a decrease in our performance in the last 7 months as the demand through ED has increased. Bed occupancy is still high and therefore there are longs wait for beds coupled with an increased acuity for those patients admitted. We are looking at admitted/non-admitted patients separately in terms of their length of stay in ED and with large numbers of surge and super surge beds still open we are keeping beds flexed but empty to drop bed occupancy and maintain flow. There are still high TOC numbers and delays into care homes. We have the SDEC and LOS working groups looking at Plan for Every Patient/Reason 2 Reside, Home First/D2A, Criteria Led Discharge and UCR/Virtual Ward.

For **Community** there are further metrics being considered for inclusion. Currently there is further work being carried out around the data for Proportion of Urgent Community Response referrals reached within two hours. A manual audit is being completed to examine the different elements of the 2-hour response and this has identified joint improvement work needed with LCD.

We have increased the number of **Quality** metrics in the IPR to include CHPPD, Falls and Pressure Ulcers alongside and never events that may occur. In terms of SHMI CHFT remain slightly above the national position but remain within the expected range and have moved significantly towards the national average over the recent data releases. The sepsis team reviewed a cohort of notes to understand if there could be a more accurate initial diagnosis

rather than a more generic first admission documentation of ‘sepsis,’ as the generic description would drive up sepsis mortality indicators. From February 2023 sepsis deaths will have some additional validation by members of the sepsis team to determine if a more definitive diagnosis could be coded and therefore improve accuracy of recording. As a result Sepsis performance has improved significantly and has dropped below the 100 mark, this is the best performance since 2021.

Complaints closed within timescale has achieved the target in May which needs to be noted.

The target of 95% of adult patients to receive a MUST assessment within 24 hours of admission/transfer to the ward is a particularly difficult challenge for the Trust. Policies and a task and finish group are in place but a key piece of work is the request for stop moments before any patient is transferred off the assessment units to ensure that all assessments have been completed and that work is ongoing to reconfigure the admission workflow on EPR to support documentation and the nursing process during admission. This is expected to Go Live in September and engagement work with teams has started in preparation.

Further **Workforce** metrics have been included around EST, Appraisals plus bank and agency spend. Bank spend is above target due to a reliance on bank usage to cover unplanned unavailability and to support the recovery programme.

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 Council of Governors is asked to note the narrative and contents of the report for May 2023.

Integrated Performance Report May 2023

Report produced by

Contents:

Section	Page
Performance Matrix Summary	3
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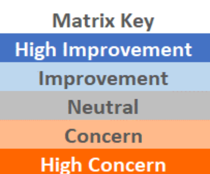
Performance Matrix Summary:



ASSURANCE / **VARIANCE**

	PASS	HIT & MISS	FAIL
SPECIAL CAUSE IMPROVEMENT	• Total Patients waiting >40 weeks • Total Patients waiting >52 weeks • Total Patients waiting >65 weeks	• Total elective activity compared with 2019/20 baseline • Falls per 1,000 Bed Days • % of complaints within agreed timescale	
COMMON CAUSE	• % of incidents where the level of harm is severe or catastrophic	• Total RTT Waiting List • Diagnostic activity undertaken against activity plan • Total Follow-Up activity compared with 2019/20 baseline • Total Patients waiting over 62 days to begin cancer treatment compared with February 2020 baseline • Proportion of patients meeting the faster diagnosis standard • ED Proportion of patients seen within 4hrs • Proportion of patients spending more than 12 hours in ED • Hospital Discharge Pathway Activity • Stillbirths per 1,000 total births • Summary Hospital-level Mortality Indicator • CHFT Acquired Pressure Ulcers per 1,000 Bed Days • MRSA Bacteraemia Infection Rate • C Difficile Infection Rate • E Coli Infection Rate • Number of Never Events • Number of Serious Incidents • % of complaints within agreed timescale • % of episodes scoring NEWS of 5 + going on to score higher	• % of patients that receive a diagnostic test within 6 weeks • Early Cancer Diagnosis • Proportion of ambulance arrivals delayed over 30 minutes • % of beds occupied by patients who no longer meet the criteria to reside • % of adult patients that receive a MUST assessment within 24 hours of admission/transfer to ward
SPECIAL CAUSE CONCERN	• Staff Movement (Turnover) • Sickness Absence (Non-Covid)	• Transfers of Care • Proportion of Urgent Community Response referrals reached < 2 hours	

Not included in table – Finance, Virtual Ward, Community Waiting List, Bed occupancy, Non-Site-Specific Cancer Referrals, Admission avoidance (frailty), neonatal deaths and CHPPD.

Elective Care:

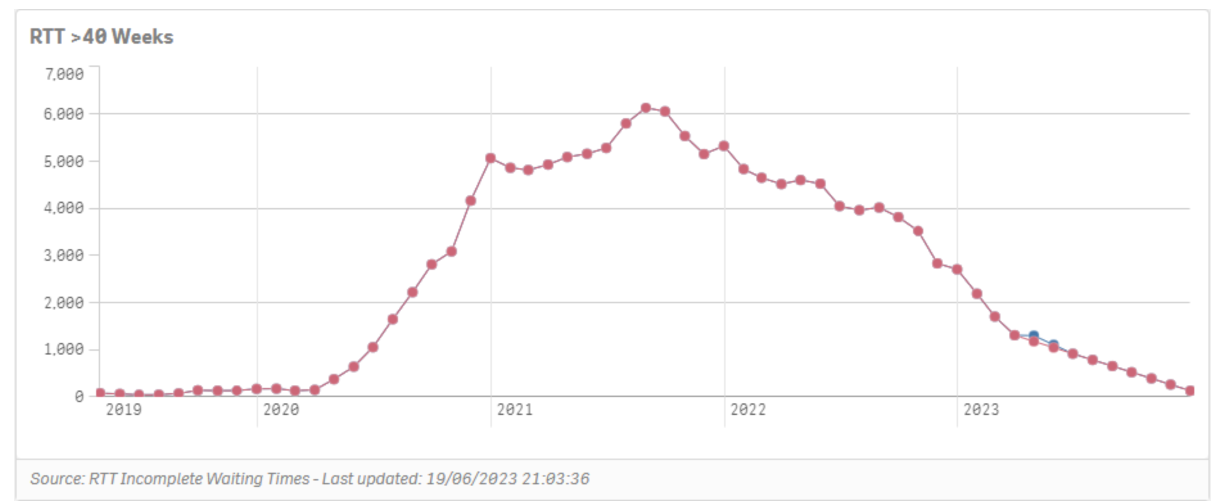
Metric	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Total Patients waiting >40 weeks to start treatment	May 2023	1,107	0					
Total Patients waiting >52 weeks to start treatment	May 2023	59	0					
Total Patients waiting >65 weeks to start treatment	May 2023	3	0					
Total RTT Waiting List	May 2023	30,851	31,586			32,081	29,616	34,545
Total elective activity undertaken compared with 2019/20	May 2023	109.3%				104%	101%	106%
Percentage of patients waiting less than 6 weeks for a diagnostic test	May 2023	86.45%	95%			87%	79%	95%
Diagnostic Activity undertaken against activity plan	May 2023	14,236	14,547			12,966	10,929	15,002
Total Follow-Up activity undertaken compared with 2019/20 baseline	May 2023	111.4%				112%	109%	114%

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

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 2024.



What does the chart show/context:
This chart shows the number of patients on the RTT Incomplete Pathways list who have been waiting more than 40 weeks to start treatment. The aim is to show progress towards 0 patients waiting more than 40 weeks by January 2024 (internal target).
Our 40-week position has been reducing monthly from a peak of 6,000 to a current position of 1,107 at the end of May 2023. Our current trajectory to get to 0 by the end of January 2024 was 1,047 so we are currently slightly behind trajectory.
The majority of our remaining patients who are waiting over 40 weeks are in ENT (223), Max Fax (151), Gastroenterology (86), General Surgery (213), Urology (71) and Gynaecology (84).

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 may have resulted in a delay in reducing the 40-week position. Of our specialties with patients over 40 weeks, ENT is currently the most challenging and has ASIs that are now 33 weeks since referral.

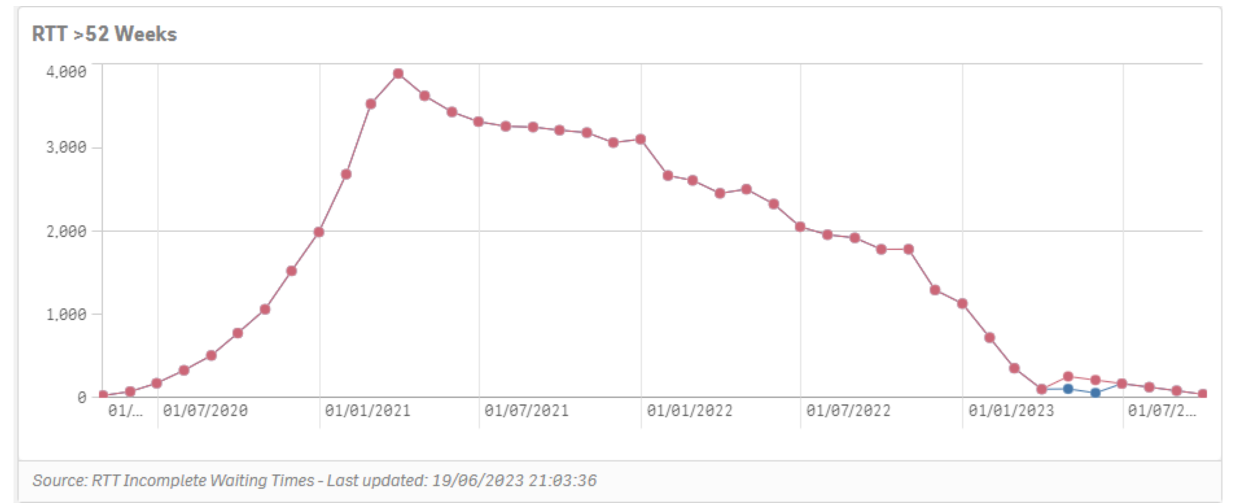
Actions:
Operational teams to be tracking patients to at least 40 weeks.
KP+ writeback Model to being used by all operational teams to ensure that tracking actions are transparent and cannot be overwritten by Validation teams.
For ENT, a new Head and Neck Locum Surgeon has started in May and the directorate is planning for him to support with some of these long waiting ENT patients.
For ENT, the Division is in discussions with Leeds around the potential for a Leeds Associate Specialist to operate at CRH on both CHFT and Leeds Patients.

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

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 September 2023.



What does the chart show/context:
This chart shows the number of patients on the RTT Incomplete Pathways list who have been waiting more than 52 weeks to start treatment. The aim is to show the progress towards 0 patients waiting more than 52 weeks by September 2023 (internal target).
Our 52-week position has been reducing monthly from a peak of 4,000 to a current position of 59. The majority of our remaining patients who are waiting over 52 weeks are in ENT (18 with a further 112 between 46 and 52 weeks), Max Fax (11) and Gastroenterology (10). No other specialty has more than 5 patients waiting over 52 weeks.

Underlying issues:
Of the patients in ENT that are over 46 weeks who do not have a treatment date in place, most are waiting for a theatre date. The majority of patients in Max Fax have a Minor Ops Appointment booked. We would expect the Max Fax and Gastroenterology position to improve again over the next month.

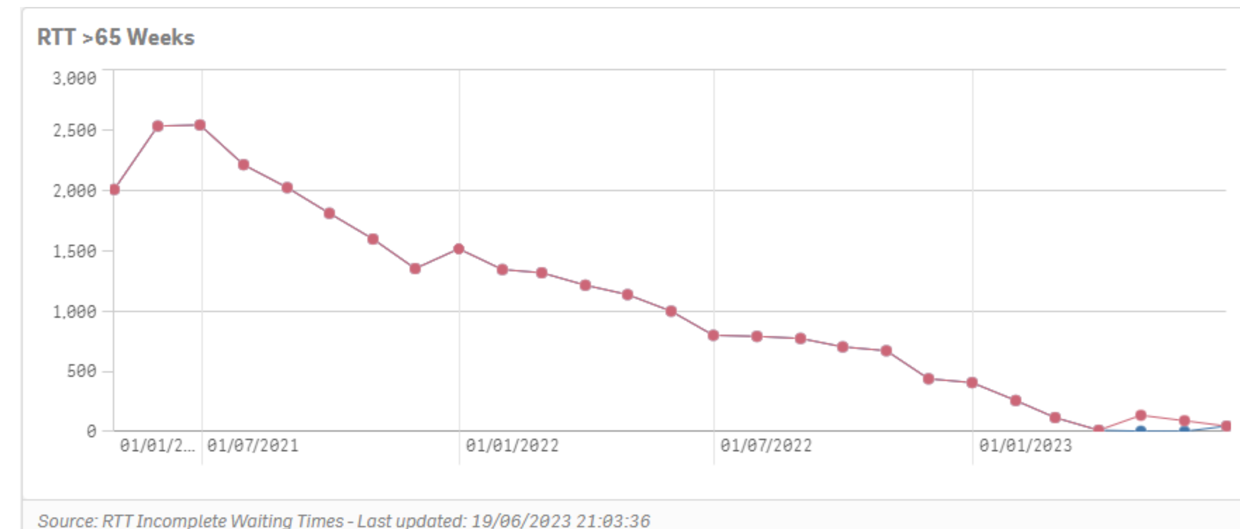
Actions:
Operational teams to be tracking patients to at least 40 weeks.
KP+ writeback Model to being used by all Operational teams to ensure that tracking actions are transparent and cannot be overwritten by Validation teams.
For ENT, a new Head and Neck Locum Surgeon has started in May and the directorate is planning for him to support with some of these long waiting ENT patients.
For ENT, the Division is in discussions with Leeds around the potential for a Leeds Associate Specialist to operate at CRH on both CHFT and Leeds Patients.

Total Patients waiting more than 65 weeks to start consultant-led treatment

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. Waiting times matter to patients.

Target:
Aim to have 0 patients waiting more than 65 weeks by March 2024 (internal target June 2023).



What does the chart show/context:
This chart shows the number of patients on the RTT Incomplete Pathways list who have been waiting more than 65 weeks to start treatment. The aim is to show the progress towards 0 patients waiting more than 65 weeks by March 2024 (internal target June 2023). Our 65-week position has been reducing monthly from a peak of 2,500 to a current position at the end of May of 3.

Underlying issues:
Remaining 65-week pathways that are in General Surgery, ENT and Ophthalmology are expected to be treated in early June 2023.

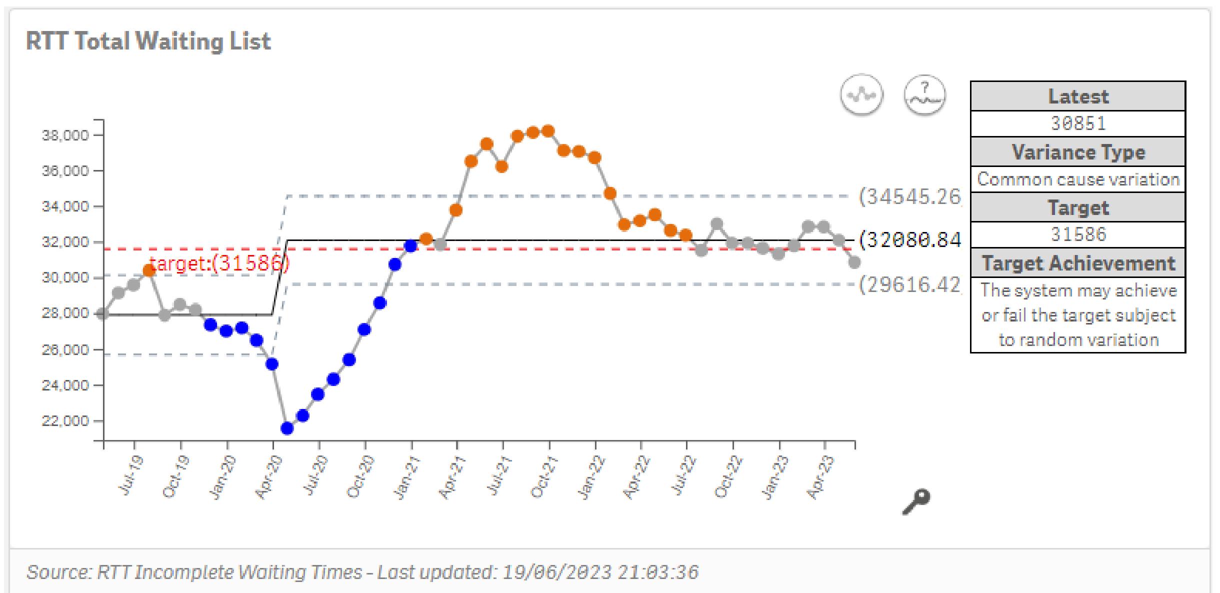
Actions:
Ensure that ENT Ops/General Manager Continue to ensure that these theatre sessions are not cancelled and that patients are pre-assessed in a timely fashion.
Operational teams to be tracking patients to at least 40 weeks to stop patients getting close to 65 weeks in future months.

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:
31,586 (activity plan 2023/24)



What does the chart show/context:
This chart shows the size of the RTT Incomplete Pathways list as submitted each month on the 18 Weeks RTT PTL.
Our waiting list size has been consistently between 31,000 and 33,000 since February 2022 after increased variation at the start of 2020 (a reduction caused by a number of patients being returned to GPs at the start of Covid/not accepting new referrals and then an increase due to referrals being accepted but capacity being reduced in both admitted/non-admitted areas between July 2020 and July 2021).

Underlying issues:
We currently have a stable RTT Waiting list position.

The National position continues to grow on a monthly basis and ICS position suggests we are the only Trust in the region currently not seeing a 20% increase in pathways over the last 12 months

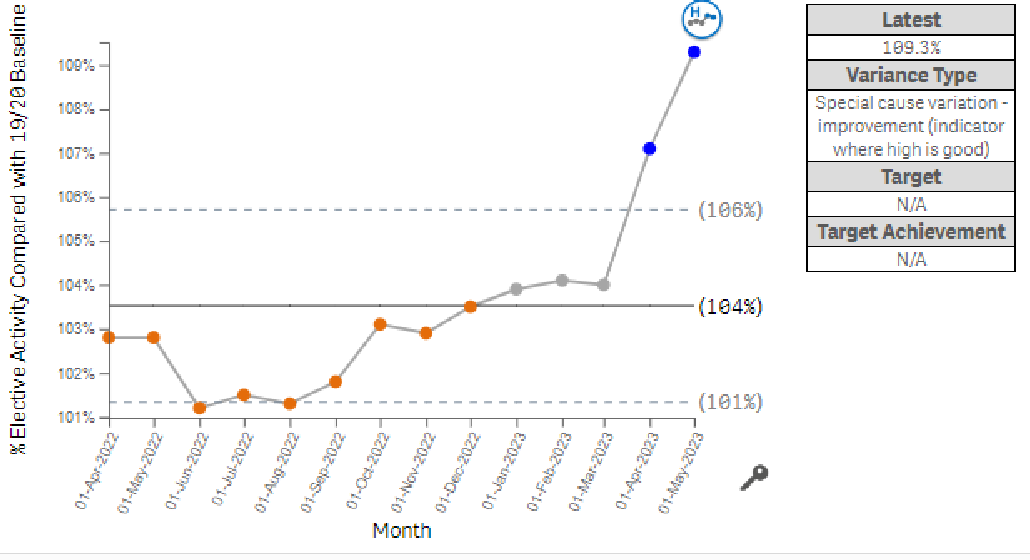
Actions:
Validation team to monitor LUNA (National DQ RTT Benchmarking tool – currently in top 30 Trusts in the country for RTT DQ Assurance).
Meet the trajectory for No ASIs over 18 weeks by the end of March 2024.
Meet the trajectory for 40/52/65 weeks.
Operational teams to be tracking patients to at least 40 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 2019/20 baseline

Executive Owner: Jonathan Hammond   Operational Lead: Kim Scholes   Business Intelligence Lead: Oliver Hutchinson
Finance Lead: Helen Gaukroger

Rationale:
Recover elective activity levels to above those seen in the pre-Covid period, to address the growing elective care waiting list.

Target:
Recover elective (day cases/elective inpatients/Outpatient firsts) services so that activity is above planned levels for 2023/24 activity.



Latest
109.3%
Variance Type
Special cause variation - improvement (indicator where high is good)
Target
N/A
Target Achievement
N/A

What does the chart show/context:
CHFT continues to be over the planned position for 2023/24 year to date. Performance showed in April 2023 a special cause variation for improvement. This trend continues in May and has showed the highest level of performance for this indicator since its inception at the start of the 2022/23 financial year with a performance of 109.3%.

Underlying issues:
We exceeded our planned position for month 2. This was mainly driven by Day Case activity. However it is important to remember that this is baselined against the same month in 2019/20, we would expect this position to move closer to the planned position over the next few months.

Actions:
KP+ CMR model set up for 2023/24 to break this data down to specialty level. Finance leads to work with divisional GM's and Ops managers to ensure awareness of this position at specialty and divisional level.

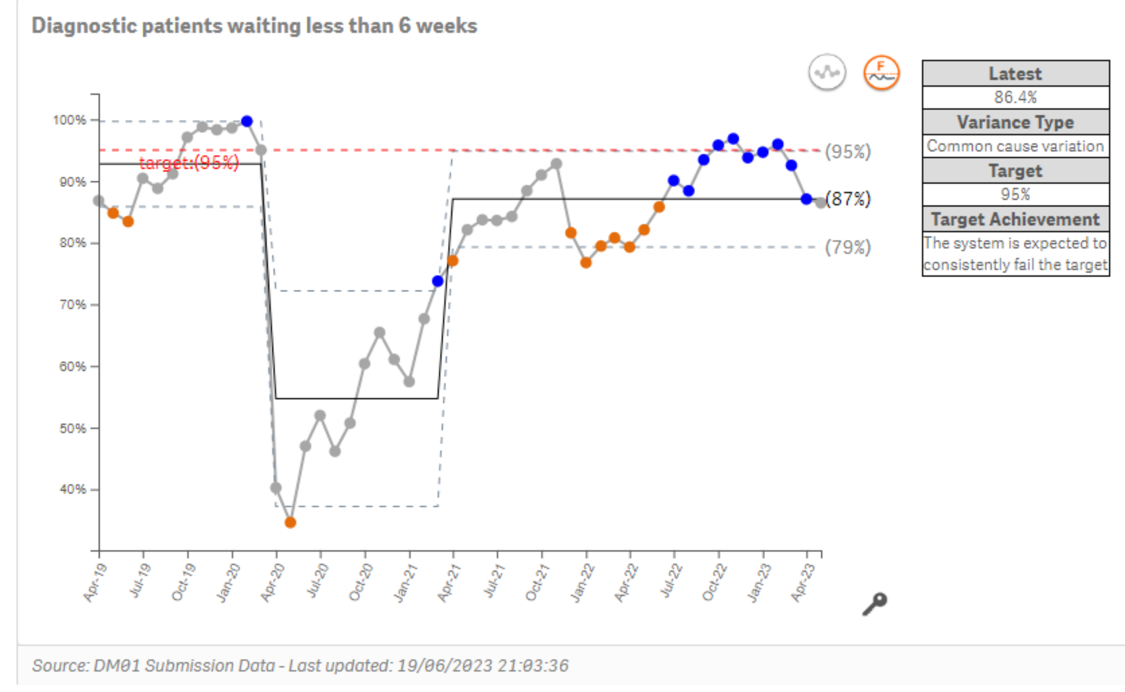
Percentage of patients waiting less than 6 weeks for a diagnostic test

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 is expected to consistently fail the target of 95%. Performance can be expected to vary between 79% and 95% However performance is in special cause variation – improvement (where high is good). Whilst the Trust performance is close to meeting the 95% target in most modalities, we are consistently below this for Echocardiography (58.64%) and Neurophysiology (45.87%) (May 2023 %s).

Underlying issues:
2 modalities (Echocardiography/Neurophysiology) still have significant numbers of pathways >6 weeks. Without those modalities, the remaining tests are achieving over 99%.

Actions:
COO asked for new trajectory for Echo and need to discuss options with other WY Trusts.
Echocardiography
- Additional physiologists will be in place over the coming months.
- As part of the Cardiology digitalisation project booking was stopped and capacity reduced over a two-week period whilst we migrated onto TomTec, this has now happened and we have reopened booking.

Neurophysiology
- Physiologists have now joined the team.
- The service has now been granted funding to book more locum EMG clinics until the end of June.
- Specialty doctor will be in position around July this year to perform independent EMG clinics.
- Trajectory being reviewed.
- Interview for 2nd consultant 4th July – Outcome of this looks positive.
- Mutual aid also being explored with MYHT.

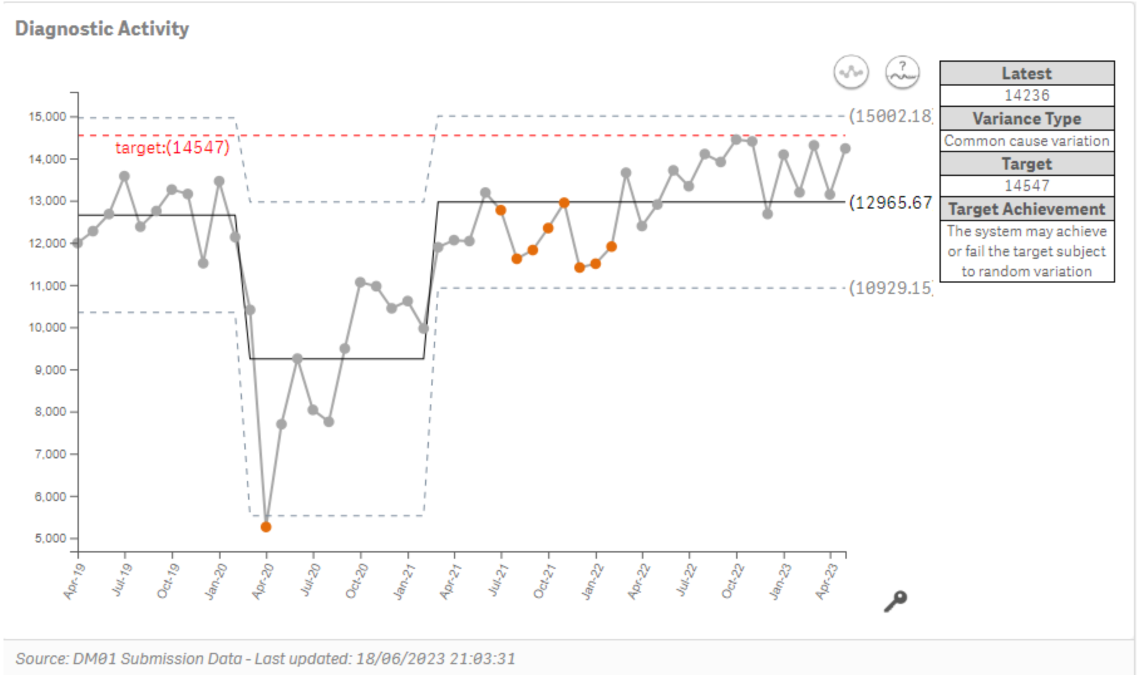
Total Diagnostic Activity undertaken against the activity plan

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 is unable to consistently meet the target of 14,547 and may achieve or fail the target subject to random variation. Performance can be expected to vary between 10,952 and 14,864. Activity is similar to pre-Covid levels.

Underlying issues:
Most modalities are performing below the target level, but due to being at 6 weeks or less from a diagnostic waiting time perspective this is not an appropriate target to meet at the moment.
Both Echocardiography and Neurophysiology are the two areas where activity is under plan and we are materially off target against 95% of patients being seen within 6 weeks.

Actions:
Echocardiography
- Additional physiologists will be in place over the coming months.
- As part of the Cardiology digitalisation project booking was stopped and capacity reduced over a two-week period whilst we migrated onto TomTec, this has now happened and we have reopened booking.
- Trajectory to recover being reviewed.

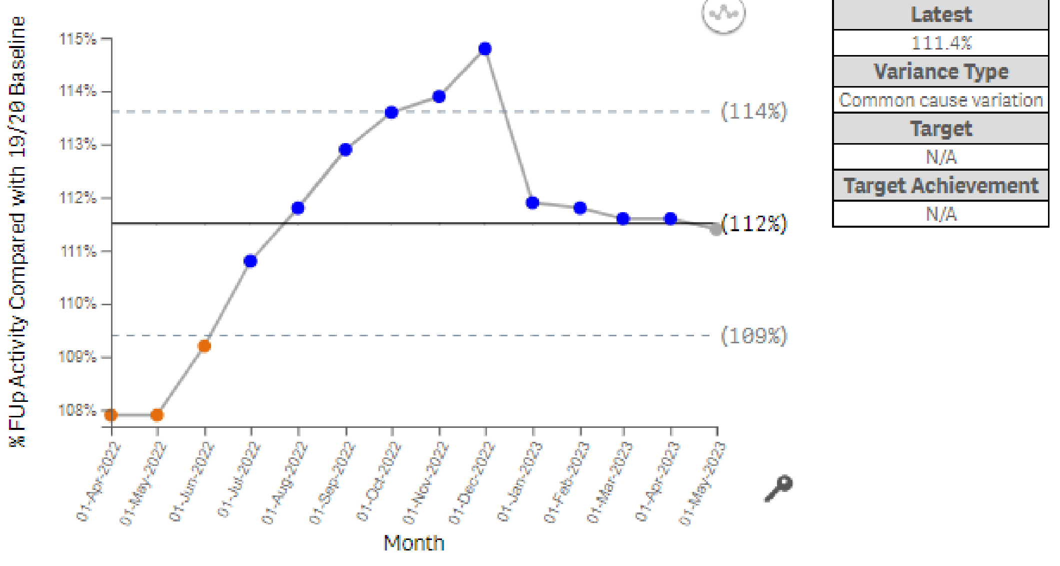
Neurophysiology
- Physiologists have now joined the team.
- The service has now been granted funding to book more locum EMG clinics until the end of June.
- Specialty doctor will be in position around July this year to perform independent EMG clinics.
- Trajectory to recover being reviewed.
- Interview for 2nd consultant on 4th July – Outcome of this looks positive.
- Mutual aid also being explored with MYHT.

Total Follow-Up activity undertaken compared with 2019/20 baseline

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 pre-Covid levels (2019/20).

Target:
Activity plan 2023/24



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 2023/24. Performance has consistently been over 100% of the 2019/20 baseline and in line with the internal plan for follow-up activity throughout 2022/23, again this has continued for April and May 2023. The trend is showing a positive special cause variation above the average performance levels as indicated by the blue data points on the SPC chart. However, May 2023 has reduced slightly and CHFT are now showing as 'hit or miss' for this indicator, however this is largely due to the first 3 months shown in the graph and performance continues to be above target.

Underlying issues:
Although the national target for follow-up activity is 75% of 2019/20 activity, due to the significant follow-up backlog (Over 24,900) CHFT have not taken this up, although the majority of this backlog has been waiting for less than 12 weeks.

Actions:
There are currently 7,612 (of the 24,900 backlog) records that are awaiting a clinical prioritisation within CHFT's MPage system, this is a reduction of 2,500 from last month. Specialties need to have a plan to address this backlog to ensure patients are booked by clinical priority.

Following the narrative from last month the admin validation work has started and cohort 1, which is in relation to patients that have a future appointment booked in the same specialty has been completed, resulting in 1,817 requests being closed and the overall Trust backlog reducing from 27,000 to 24,900.

Further admin validation has started, on the second cohort of requests, which relate to patients with duplicate requests on the backlog. This work will continue over the coming months. To date this cohort has led to 367 requests being closed down.

Deep dives are being undertaken at specialty level, to create a bespoke plan for each specialty to continue to reduce the follow-up backlog and long waiters.

Cancer:

Metric	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Total Patients waiting >62 days to begin cancer treatment compared with February 2020 baseline	4th June 2023	27	35			35.31	18.87	51.75
Proportion of patients meeting the faster diagnosis standard	May 2023	72%	75%			77%	66%	87%
Non-Site-Specific Cancer Referrals	May 2023	30	25					
Early cancer diagnosis: 75% of cases diagnosed at stage 1 or 2 by 2028	May 2023	44.9%	75%		F	49%	39%	59%

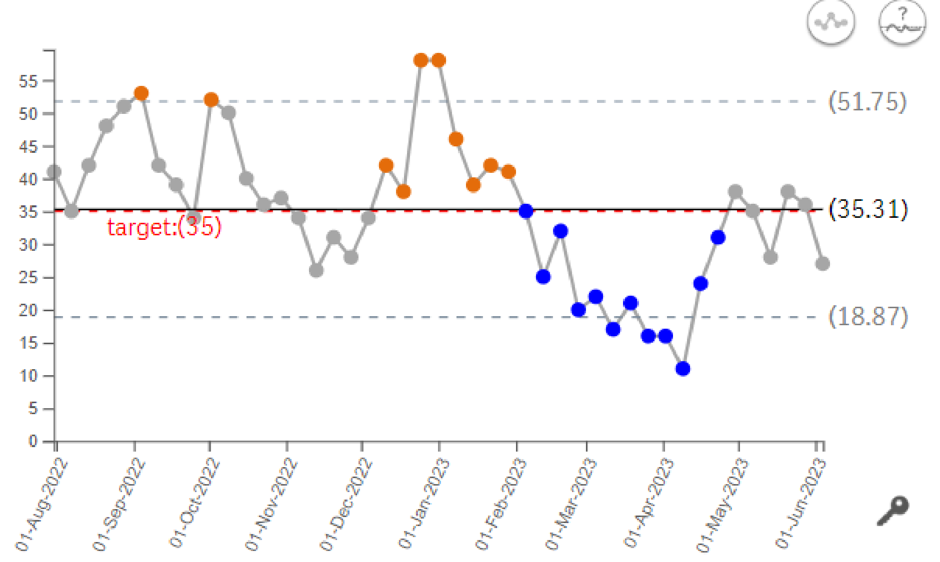
Total Patients waiting over 62 days to begin cancer treatment compared with February 2020 baseline

Executive Owner: Jonathan Hammond Operational Lead: Maureen Overton Business Intelligence Lead: Bethany Mayfield

Rationale:
The NHS Constitution outlines what patients can expect and their rights when they are referred on a cancer diagnosis and treatment pathway.

Target:
Return the number of people waiting for longer than 62 days to the level in February 2020. Target 35 as per activity plan 2023/24

People waiting longer than 62 days



Latest
27
Variance Type
Common cause variation
Target
35
Target Achievement
The system may achieve or fail the target subject to random variation

What does the chart show/context:

- The snapshot reflects the Sunday position of that week.
- The Trust is unable to consistently meet the target of 35 or less and may achieve or fail the target subject to random variation. Performance can be expected to vary between 19 and 52. However performance is in special cause improvement.
- CHFT has one of the lowest over 62-day PTLs nationally and this is tied into our 62-day performance which stands as one of the best in the country. Effort has gone in to reduce our PTL to pre-pandemic levels by March 2023 and we are currently surpassing the reduction target.

Underlying issues:

- At least 50% of the long waiters are Colorectal. These are due to the already mentioned underlying issues.
- We also do not work at weekends, therefore this report does not take into account Friday's activity, which is captured on Monday's tracking.
- As of Monday 12th June there were only 19 patients on the long waiters report.

.

Actions:

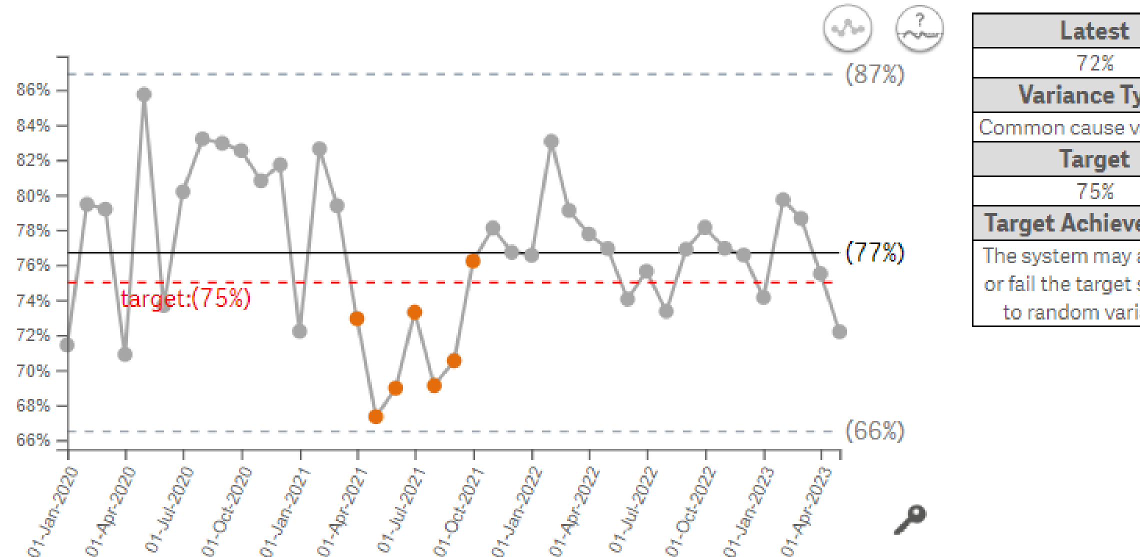
- Over 62-day waiters continuing to be monitored on a case by case basis by PPC team.

Proportion of patients meeting the faster diagnosis standard

Executive Owner: Jonathan Hammond Operational Lead: Maureen Overton Business Intelligence Lead: Bethany Mayfield

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%.



What does the chart show/context:

- Latest monthly performance stands at 72%, below the NHSE target.
- Performance is variable however as of the latest financial year the Trust meets the target more often than it fails. National performance tends to be under the 75% target.
- The Trust is unable to consistently meet the target of 75% and may achieve or fail the target subject to random variation. Performance can be expected to vary between 67% and 87%

Underlying issues:

- Nationally, pathways where performance against the 28-day FDS is challenged are; Lower GI, Upper GI and Urology and this is reflected locally.
- The introduction of telederm has impacted on 28-day performance this month.
- Non-Site-Specific, Sarcoma and ENT have performed below the 75% FDS target during May, as lower volume tumour sites, limited impact on overall performance.

Actions:

- Working with primary care to collaborate and resolve issues with telederm.
- Pathway Navigator has started in post 12th June with a focus on day 0-28 in Lower GI and Upper GI.
- Non-Site-Specific looking at; recording of diagnosis, patient availability for diagnostics.
- In May, there were 7 patients who have a learning disability who were diagnosed over 28 days, the cancer team continue to monitor learning disability patients and work with carers and the complex needs matron to ensure patients are diagnosed faster.

Non-Site-specific Cancer Referrals

Executive Owner: Jonathan Hammond Operational Lead: Maureen Overton Business Intelligence Lead: Bethany Mayfield

Rationale:
The non-specific symptoms (NSS) pathway provides a route for patients presenting with vague symptoms who may have a serious illness.

Target: 25 as per activity plan – March 2024

What does the chart show/context:

- Referrals are variable, between 10 to 30 referrals a month.

Underlying issues:

- Referrals have increased this month and are above the projected number (30).
- The Physician's Associate started in post during May and is running video/telephone clinics alongside the Specialist CNS.

Actions:

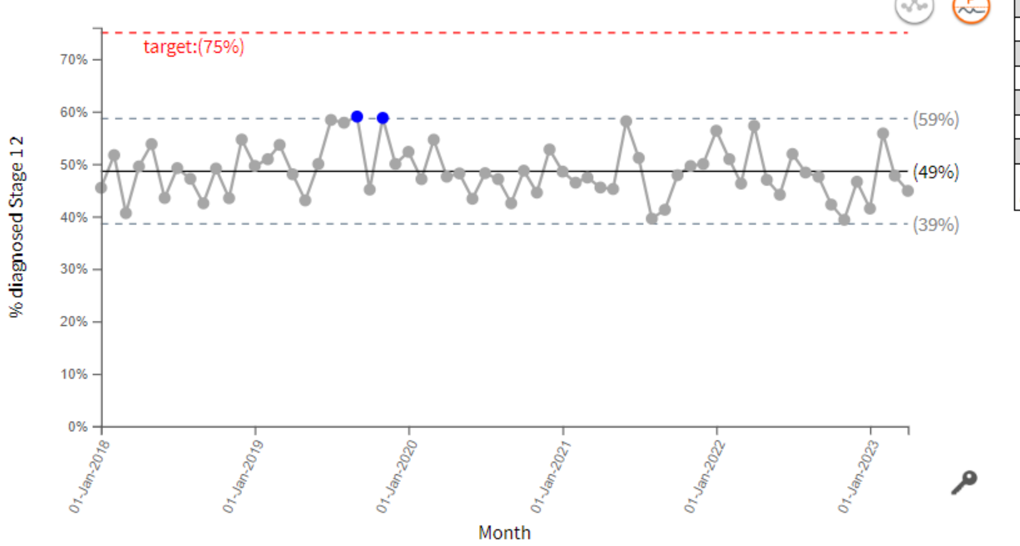
- The Specialist CNS will start assessing patients in primary care week commencing 12th June.
- Share quarterly NSS referrals data with PCNs, continuing to raise the NSS service profile.

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: Bethany Mayfield

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.



What does the chart show/context:
- The Trust is expected to consistently fail the target of 75%.
- Performance can be expected to vary between 45% and 58%.
- Nationally this metric stands at 52%, and CHFT are around this mark.

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:
- This metric will be rolled out alongside a series of NHSE pilots, including FIT testing, and Dermatoscopes, with the aim that these pilots will improve access and earlier diagnosis.
- The Faster Diagnostic Framework will also support this unit of work.

Urgent and Emergency Care and Flow:

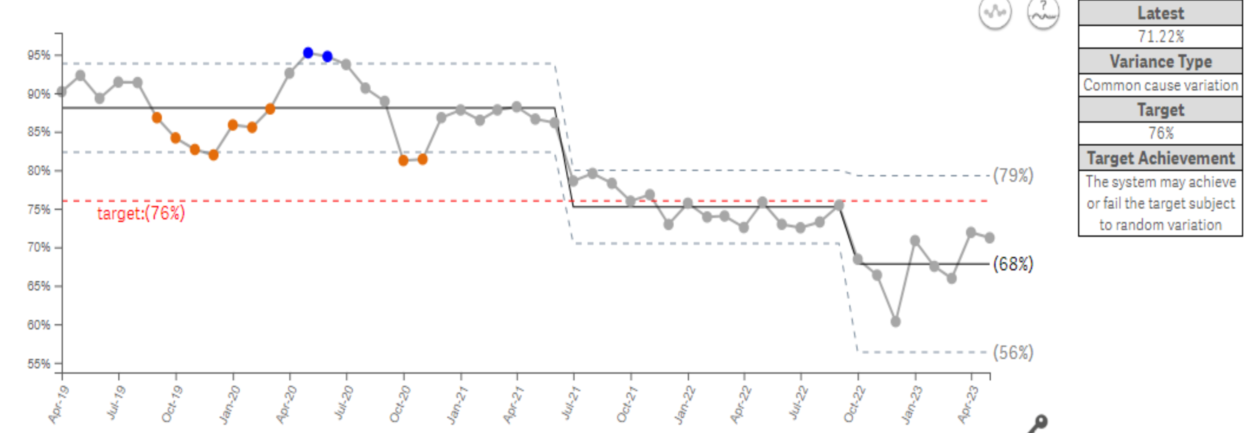
Metric	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Proportion of patients seen within 4 hours	May 2023	71.22%	76%			68%	56%	79%
Proportion of ambulance arrivals delayed over 30 minutes	May 2023	1.8%	0%			4%	1%	7%
Proportion of patients spending more than 12 hours in an emergency department	May 2023	2.59%	2%			2%	0%	5%
Adult G & A acute bed occupancy adjusted for void beds (Type 1 Acutes Only)	May 2023	98.6%	96%					
% of beds occupied by patients who no longer meet the criteria to reside	May 2023	21%	14.21%			22%	18%	25%
Hospital Discharge Pathway Activity – AvLOS pathway 0	May 2023	4.3	4.1			3.98	3.60	4.37
Transfers of Care	May 2023	94	50			86.27	44.78	127.76

Proportion of patients seen within 4 hours

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 76% (80% local target) of patients are seen within 4 hours by March 2024 with further improvement in 2024/25.



What does the chart show/context:
The Trust is unable to consistently meet the target of 76% and may achieve or fail the target subject to random variation. Performance can be expected to vary between 65% and 73%

The performance for May was 71.22%. We have seen a decrease in our performance in the last 7 months as the demand through ED has increased. The average daily attendances for May were 489 which is on average 30 more attendances than April. The performance is significantly lower than the 76% target brought in from April 2023 onwards. Nevertheless we were in the top 10 Acute Trusts for type 1 performance.

Underlying issues:
- Increase in attendances
- Increase in occupied beds - long wait for beds
- Increase in acuity

Actions:
Recruitment into Medical WFM at interview stage, 3 Locum Consultants appointed. 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. Non-admitted performance has improved with a mean time of 176minutes, internal target set at 160minutes.

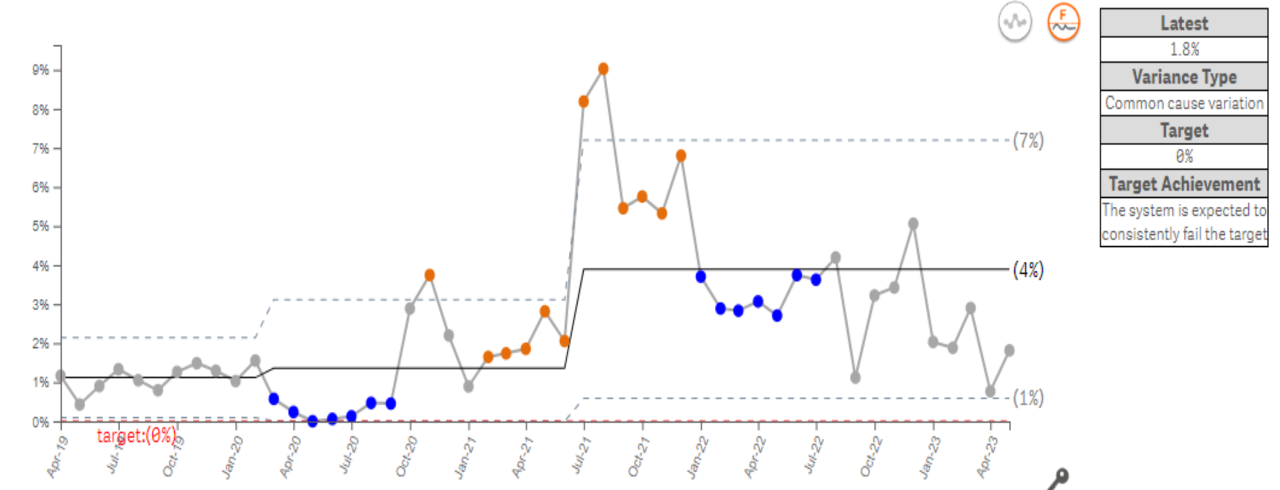
Proportion of ambulance arrivals delayed over 30 minutes

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).

Proportion of ambulance arrivals delayed over 30 mins



Source: UEC Sitrep/YAS data - Last updated: 14/06/2023 21:03:39

What does the chart show/context:
The Trust is expected to be consistently failing the target of 0% Performance can be expected to vary between 1% and 7%

We have seen a reduction in the proportion of ambulances which delay by more than 30 minutes in transferring the patient over to care of ED at the start of 2023. We continue to validate all patients over 30 minutes every day. We have found due to this there is a material difference in what is being reported as part of the Daily Ambulance Collection which is taken straight from the figures reported by YAS. SOP brought in to improve performance on these at the start of April and this has had a positive impact with a big reduction in the number of over 30-minute delays as can see from the last 2 points on the graph.

Underlying issues:
- 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)

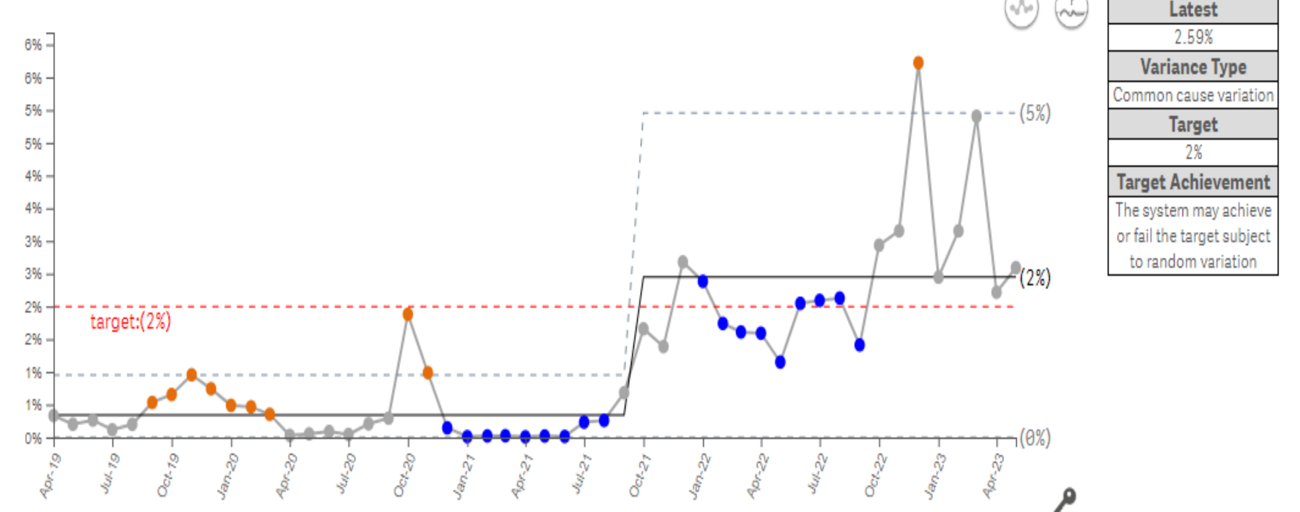
Actions:
Improvement for all metrics for ambulance handovers - SOP in action that ensures consistent approach to validation.

Proportion of patients spending more than 12 hours in an emergency department

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:
The Trust is unable to consistently meet the target of 2% and may achieve or fail the target subject to random variation. Performance can be expected to vary between 0% and 5% however performance is in special cause variation – cause for concern (where high is concerning).

In May the performance was 2.59% with 393 patients waiting over 12 hours in ED. This is an improvement on the previous 6 months and is just above the 2% target.

Underlying issues:
- Increase in demand
- Wait for beds
- Increase in acuity

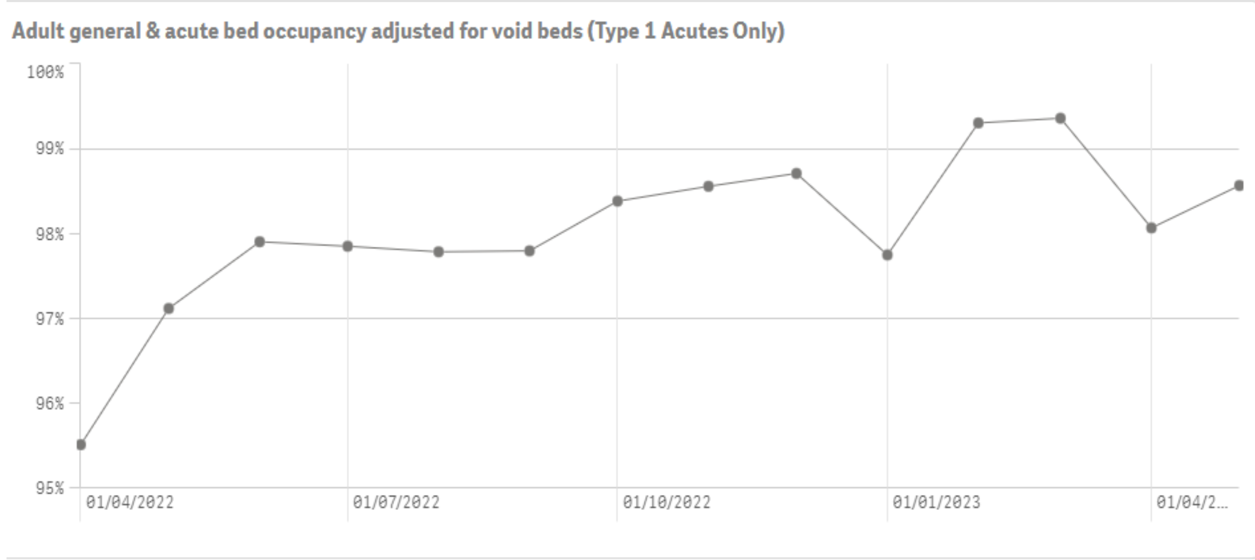
Actions:
Continue to monitor all long waiting patients and expedite DTA's to allow for beds to be acquired earlier in the patient pathway. We continue to work with Clinical Site Matron teams in early identification of patients who will require admission.

Adult general & acute bed occupancy adjusted for void beds (Type 1 Acutes Only)

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 remains high with May at 98.6%. We have seen the acuity of patients increase in recent months with patients staying in hospital for longer periods. It is important to factor in the bed base when analysing this graph. The current internal target for bed occupancy is 96% (internal target).

Underlying issues:
- Large numbers of surge and super surge beds remain open as well as flexed capacity across the Acute Floor and Respiratory floors.
- More clarity required regarding core bed base, surge and super surge beds.
- Keeping beds flexed but empty to drop bed occupancy and maintain flow.
- Increased acuity increasing LOS.
- High TOC numbers and delays into care homes and EMI beds.

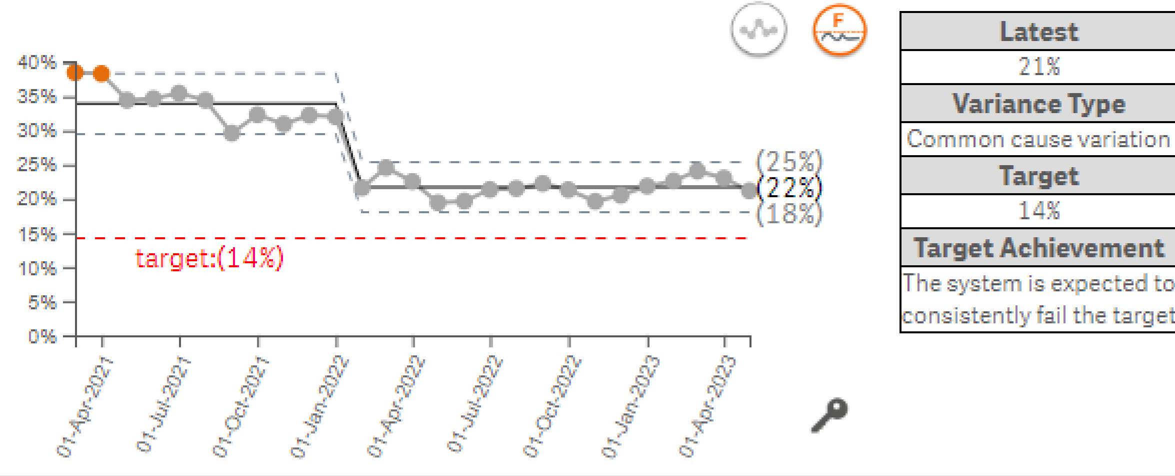
Actions:
- LOS reference group - targets in place to reduce LOS across Wards for TOC and Non-TOC patients to help reduce bed occupancy levels.
- Undertaking work to have a clear core beds base.
- Working with operational site teams to maintain capacity and drop occupancy levels.
- Long length of stay work.
- Trajectory for reducing TOC numbers.

Percentage of beds occupied by patients who no longer meet the criteria to reside

Executive Owner: Jonathan Hammond Operational Lead: Sarah Rothery 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 14.2% as per activity plan (March 2024).



What does the chart show/context:
In May 21% of patients had no reason to reside. More beds were occupied in May but this was still in line with the amount of patients with no reason to reside, hence the percentage remaining similar to previous months. May's data is above the mean line, but within normal variation. The Trust will consistently fail the target of 14.2% and is in common cause variation. Performance can be expected to vary between 18% 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.

Actions:

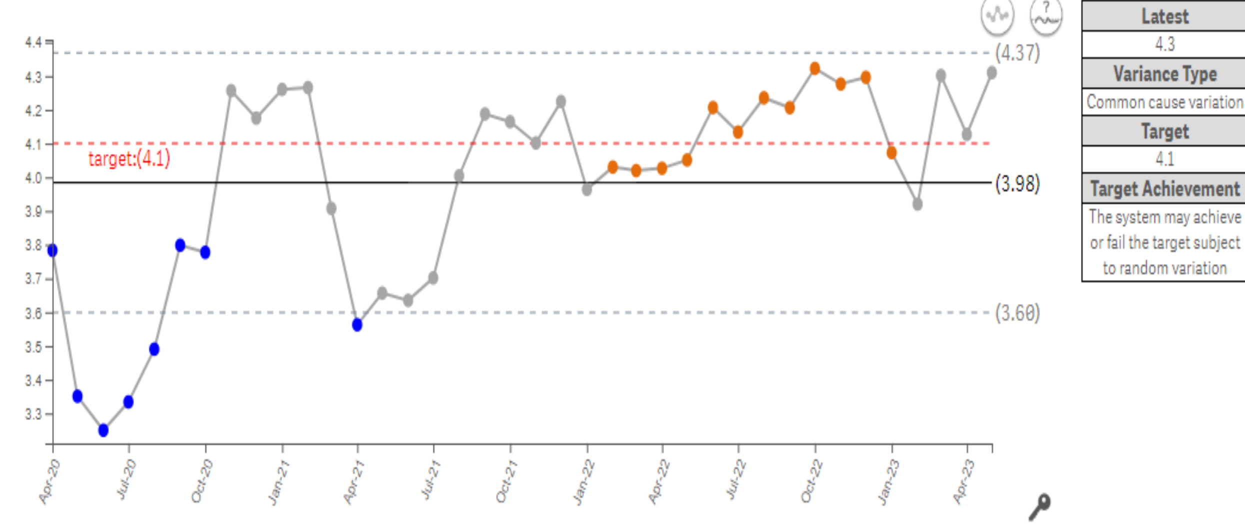
- Set up digital boards with 5 wards
- Amalgamate the R2R project into the digital boards project
- Length of stay reduction programme will monitor R2R position alongside Plan For Every Patient (PFEP)

Hospital Discharge Pathway Activity

Executive Owner: Jonathan Hammond   Operational Lead: Gemma Berriman   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:
8% reduction on 2022/23 Average Length of Stay to 4.1 days.



What does the chart show/context:
Performance can be expected to vary between 3.6 and 4.3 days. We saw an increase in the LOS in May however we discharged a number of long LOS patients in month which increased the LOS however this is a positive.

Underlying issues:

- Increasing attendances to ED
- Increasing acuity
- Delays in discharging

Actions:

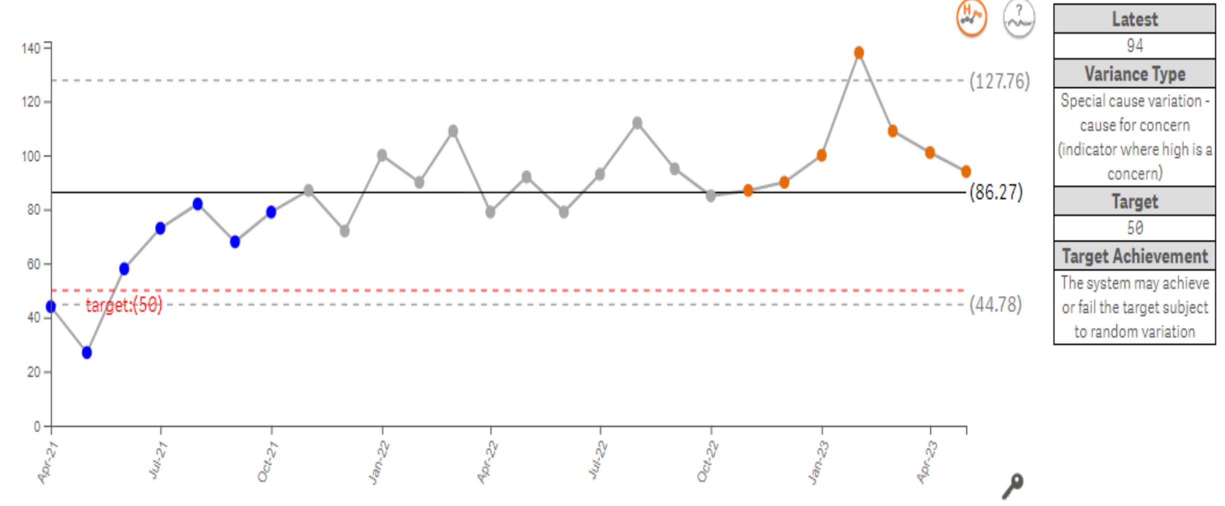
- Two Improvement groups commenced, SDEC and LOS working groups to look at
  - Plan for Every Patient/Reason 2 Reside
  - Home First/D2A
  - Criteria Led Discharge
  - UCR/Virtual Ward
- KPIs for each working group
- Feedback to take place monthly at UECDG against the KPIs and available data
- Data to also encompass qualitative data
- Clear project leads and group members
- Monthly working group meetings to be held across the workstreams
- Links with CIP and planning to be in place
- Scrutinising and understanding the data
- Feedback from wards on LOS trajectory
- Data to also encompass qualitative data
- Project roll out on wards 19 and 20 for Home first
- Elderly Care Criteria-Led Discharge roll-out
- New LOS meetings looking at all wards all patients not on TOC (MDT approach)
- Engagement session regarding board rounds

Transfers of Care

Executive Owner: Jonathan Hammond Clinical Lead: Gemma Berriman 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 patients or less



What does the chart show/context:
TOC numbers have been climbing since 2021 peaking in February 2023. Referrals to TOC have also followed the same trajectory. Resources to manage TOC have remained the same.

Underlying issues:
- Increasing numbers on TOC
- Increasing referrals to TOC
- Increasing need to 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

Maternity and Children’s Health:

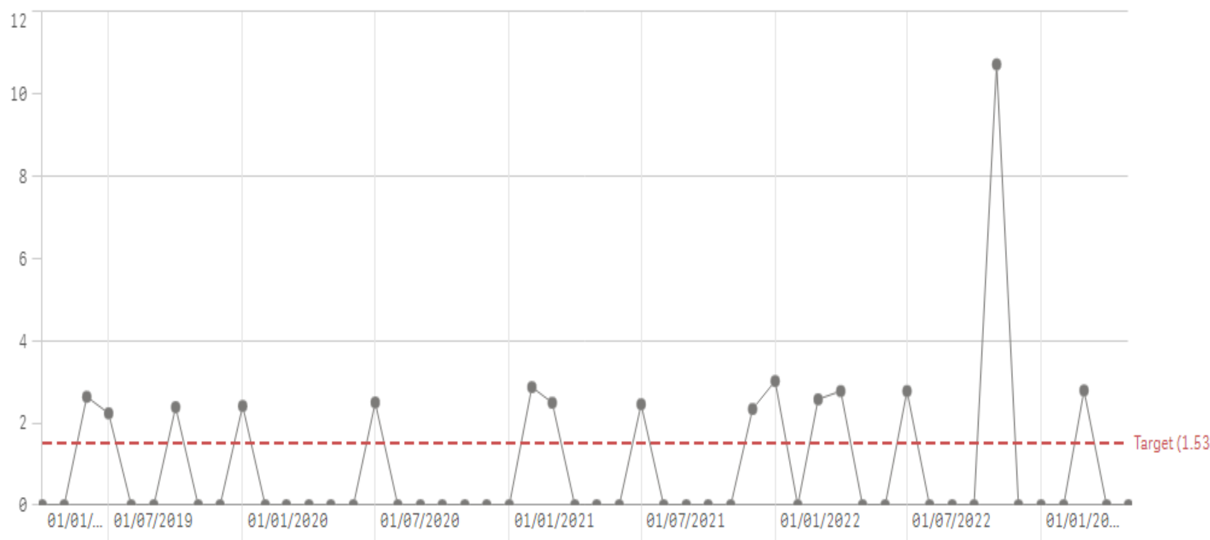
Metric	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Neonatal deaths per 1,000 total live births	May 2023	0	1.53					
Stillbirths per 1,000 total births	May 2023	5.28	3.33			3.85	0	13.09

Neonatal deaths per 1,000 total live births

Executive Owner: David Birkenhead   Clinical Lead: Diane Tinker   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:
The Trust is unable to consistently maintain the minimum number of deaths per 1,000 live births and may achieve or fail the target subject to random variation.

Underlying issues:
Currently there are no underlying issues. Deaths will continue to be monitored and investigated as required. Actions below will ensure performance is maintained.

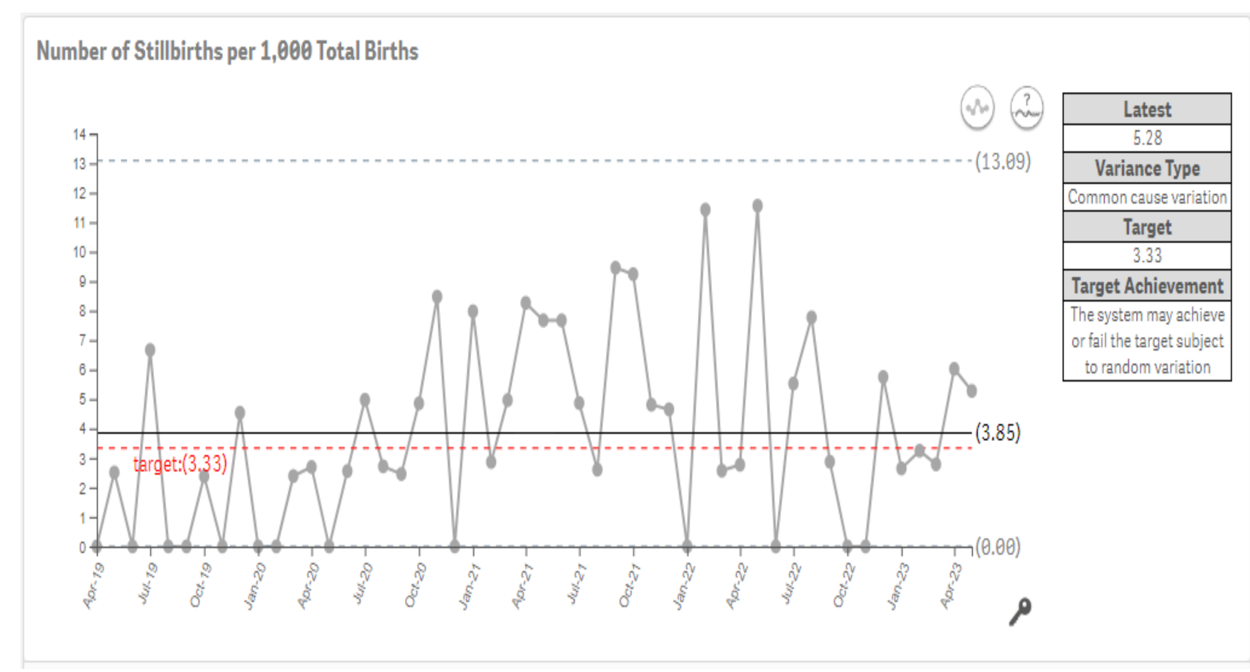
Actions:
- All early neonatal deaths reviewed at Orange Panel and weekly governance meeting
- All neonatal deaths MDT PMRT completed
- All early neonatal deaths referred to HSIB
- Regular quarterly stillbirth/neonatal audit undertaken
- Responsive review of neonatal deaths undertaken due to increase in 2022
- Audit discussed at Maternity Health Equalities Workstream
- Monthly Saving Babies Lives Group
- MDT with tertiary fetal medicine centre for known fetal anomalies

Stillbirths per 1,000 total births

Executive Owner: David Birkenhead Clinical Lead: Diane Tinker 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:
3.33 deaths per 1,000 live births. MBRRACE-UK



What does the chart show/context:
The Trust is unable to consistently maintain the minimum number of deaths per 1,000 total births and may achieve or fail the target subject to random variation.

Underlying issues:
Currently there are no underlying issues. Deaths will continue to be monitored and investigated as required. Actions below will ensure performance is maintained.

Actions:
- All stillbirths reviewed at Orange Panel and weekly governance meeting
- All stillbirths MDT PMRT completed
- All intrapartum stillbirths referred to HSIB
- Regular quarterly stillbirth/neonatal audit undertaken
- Audit discussed at Maternity Health Equalities Workstream
- Monthly Saving Babies Lives Group
- MDT with tertiary fetal medicine centre for known fetal anomalies

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	May 2023	69.5%	70%			70%	53%	87%
Community Waiting List	May 2023	5,934	4,387 (end 23/24)					
Virtual Ward	May 2023	33%	80%					

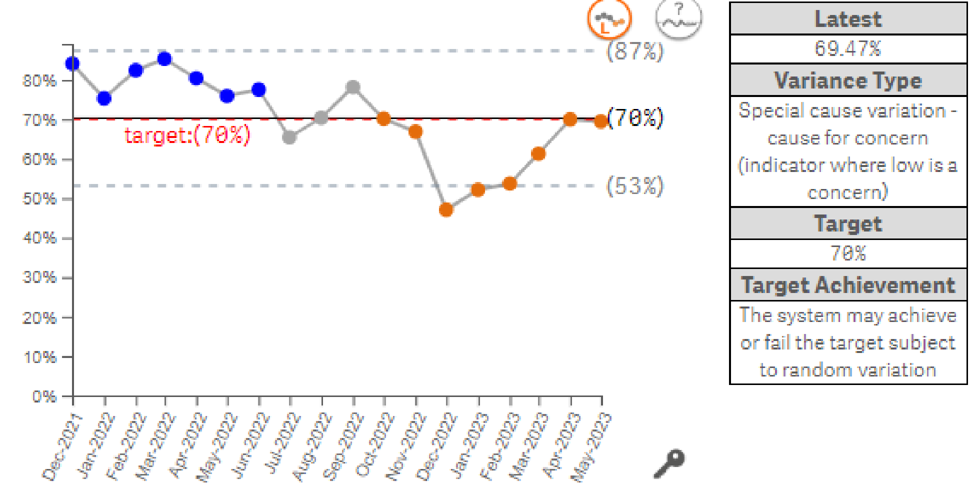
Proportion of Urgent Community Response referrals reached within two hours

Executive Owner: Rob Aitchison   Clinical Lead: 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 subject to the 2-hour response standard that achieved the 2-hour response standard. Clinical contact within 2 hours of referral into service. Target: 70%.

UCR 2 Hr Response



Source: SR Data. Last updated 20/06/2023 08:00:48

What does the chart show/context:
December 2021 – June 2022 showing as over 70% target. Followed by 5-month period (July – November 2022) of random variation. From December 2022 onwards significant drop in performance due to service adopting new functionality – however improving position month on month with May 2023 at 69.5% - just below 70% target.
The Trust is unable to consistently meet the target of 70% and may achieve or fail the target subject to random variation. Performance can be expected to vary between 53% and 87%.
Regionally (NE and Yorks) are showing a response rate achievement of 85% and Nationally the figure shows 84% (April 2023).

Underlying issues:
Change of Service-led SystmOne functionality use in December 2022 resulted in data recording issues with the contact time (Clock stop). Therefore the figures are not a true reflection of the performance – manual audit suggests 84.4% for December 2022, 83.4% for January 2023, 76.1% for February 2023, 87% for March 2023.
Manual audit being completed to examine the different elements of the 2-hour response e.g. how much time there is for Local Care Direct (LCD) to manage triage and call, and then the response time left for UCR to respond – initial findings have seen that in some cases it has taken over an hour for LCD to triage and add to UCR waiting list which significantly reduces the time to get to patient – particularly considering that the journey can take up to an hour if living on the borders of the borough. This is not reflected in LCDs data as they report 100% compliance with meeting the 2hour target but it is having a knock-on effect on the time left out of that 2hours for us to respond. Work ongoing around this.

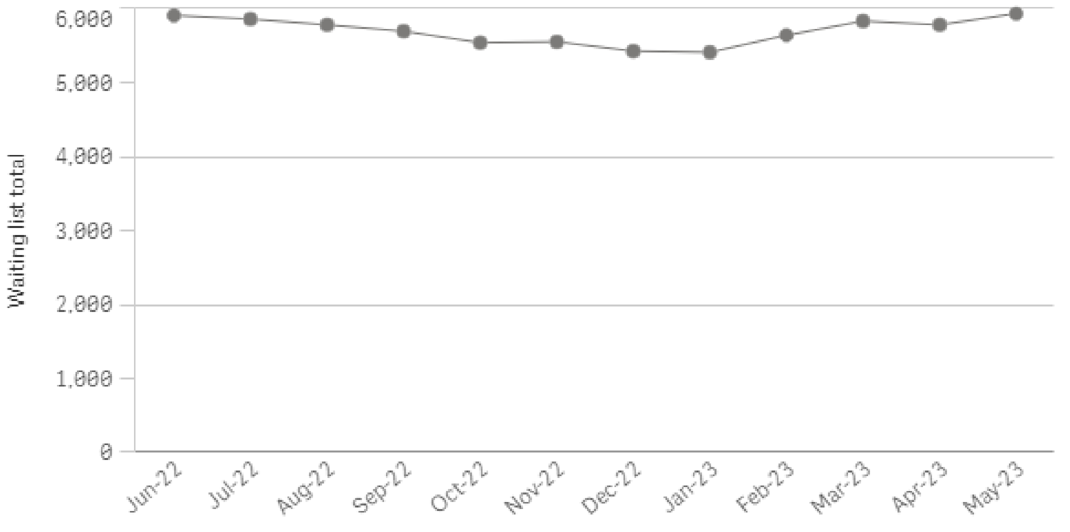
Actions:
Communications to service leads around accurate data recording.
Audit as described above to identify joint improvement work needed with LCD.

Community Waiting List

Executive Owner: Rob Aitchison   Operational Lead: Nicola Glasby   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 on community waiting lists at a given time.
Target 4,387 by the end of 2023/24.



What does the chart show/context:
The overall waiting list numbers trend has seen a slight reduction from when data collection began in June 2022 to January 2023. Since then the trend shows an overall increase in numbers. 5,934 total in May 2023.
Regionally (NE and Yorks) the waiting list numbers have increased by 0.6% and Nationally show a decrease of 1.4% (March 2023 to April 2023) (month in arrears).
Regionally MSK, Podiatry and Children's SALT having the highest numbers waiting.
At CHFT Podiatry and Children's SALT are our main concerns however MSK recovered well post-pandemic and now has a reasonably stable waiting list position.
Nationally the main reported reason for preventing reductions in waiting lists are workforce availability (26%) and an increase in demand/referrals (22%).

Underlying issues:
The main reasons for current waiting list position in Children's SALT are workforce availability issues, we currently have 7 band 6 vacancies in that team. There are ongoing recruitment issues into these posts and consideration is being given to feasibility of recruitment of band 5 staff in the absence of suitable band 6 candidates.
Podiatry has seen an increase in referral numbers and complexity of patients and is prioritising high risk patients, therefore the routine waiting list has remained fairly static, and longer than we would like for the last year.

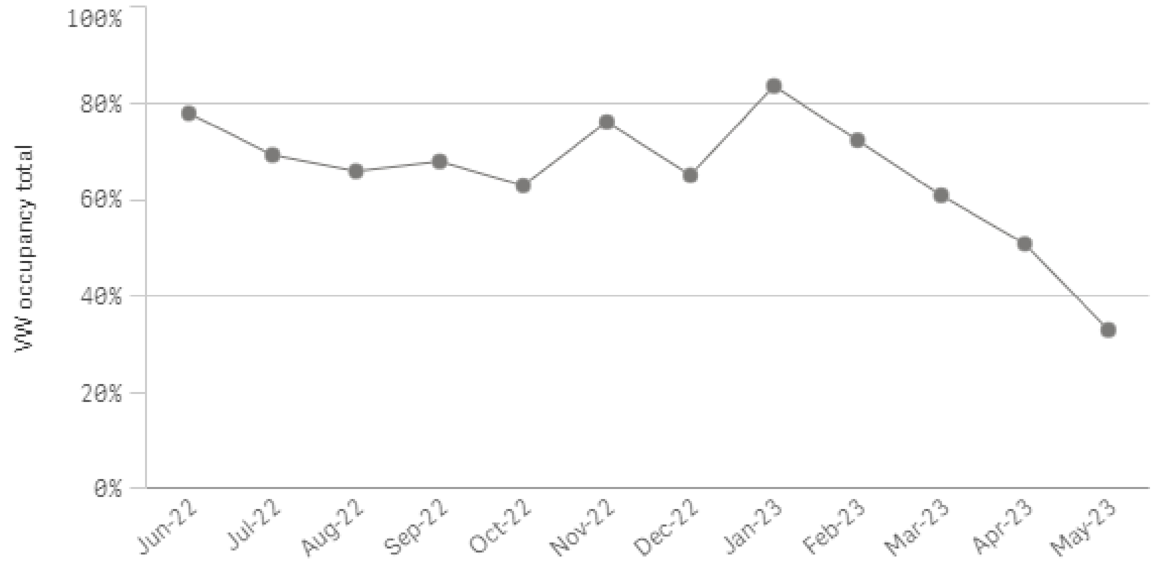
Actions:
Recruitment opportunities being considered (incl. developmental and rotational posts and lower banding).
Short-term waiting list initiatives being planned for Children's SALT alongside agreed dates for implementation for new service structure which will improve efficiency.

Virtual Ward

Executive Owner: Rob Aitchison Operational Lead: Renee Comerford Business Intelligence Lead: Gary Senior

Rationale:
Monitor occupancy rate of Virtual Wards - Respiratory and Frailty services.

Target:
Number of patients on the Virtual Ward caseload at a given time compared to the number of beds available/allocated. Target 80%.



What does the chart show/context:
Achieved target once (January 2023) across the 10-month period since Virtual Ward service began. 4-month decline in occupancy rate. Currently at 33% occupancy May 2023.

Underlying issues:
Occupancy caseload cohorts are snapshots at given points in the month and therefore depending on allocation at those moments the % rate can vary significantly.
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.
Current Respiratory Foundry submission categorised as ‘Hospital at Home’ with 50 beds, evolved from Early Supported Discharge (ESD) service.
Frailty Virtual Ward currently has 12 beds allocated with occupancy currently running at 68%
Very few referrals to the team unless from frailty team.

Actions:
Audit by team to review outcomes and patient experience.
Medical division reviewing medical cover to support a 7-day MDT for frailty virtual ward. Other organisations have not all been able to recruit consultants but backfilled with a registrar.
ACP working on frailty SDEC 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 has been amended to ensure we can take more frail and older people from across areas.
Next phased step-up pathway being designed to take GP and day patients as currently just from UCR. 12 beds available now for frailty which is above trajectory.
Respiratory - criteria now changed to include patients requiring oxygen weaning.
Team attend the safety huddles each day. Communication with pathways - criteria to go on intranet.

Safe, High Quality Care:

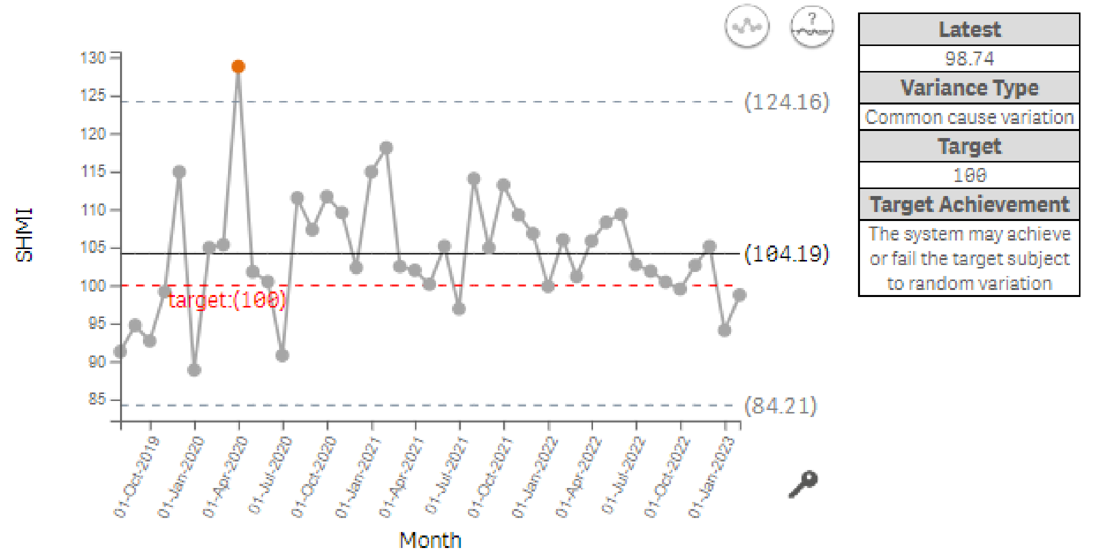
Metric	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Summary Hospital-level Mortality Indicator	February 2023	98.74	100			104.19	84.21	124.16
Care Hours Per Patient Day (CHPPD)	May 2023	9.1/8.0	-	-	-	-	-	-
Falls per 1000 Bed Days	May 2023	7.2	7.02			8.56	5.92	11.19
CHFT Acquired Pressure Ulcers per 1000 Bed Days	May 2023	2.6	1.76			2.01	0.73	3.30
MRSA Bacteraemia Infection	May 2023	0	0			-	-	-
C.Difficile Infection	May 2023	2	3.1			2.73	0	8.16
E.Coli Infection	May 2023	1	5.6			3.27	0	9.76
Number of Never Events	May 2023	0	0			-	-	-
Number of Serious Incidents	May 2023	4	0			3.54	0	10.13
% of incidents where the level of harm is severe or catastrophic	May 2023	0.87%	2%			1%	0%	2%
% of complaints within agreed timescale	May 2023	96%	95%			89%	74%	100%

Summary Hospital-level Mortality Indicator

Executive Owner: David Birkenhead   Clinical Lead: Neeraj Bhasin   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 a 12-month rolling figure standing at 102.07 and the latest reporting month of February 2023 standing at 98.74. Performance did deteriorate in December 2022, which was expected with the high number of deaths we observed in that month. This performance has then improved for the first 2 months of 2023 which we did expect looking at the performance for HSMR. The National SHMI performance on the latest data release is sitting at 101.71, CHFT remain slightly above this national position but remain within the expected range nationally and have moved significantly towards the national average over the recent data releases.

Underlying issues:
Sepsis remains the main alerting condition. The sepsis team reviewed a cohort of notes to understand if there could be a more accurate initial diagnosis e.g. urinary tract infection/infective exacerbation of COPD, rather than a more generic first admission documentation of ‘sepsis’, as the generic description would drive up sepsis mortality indicators. The notes review showed there could be significantly more specific diagnoses which would reduce the alerting. Therefore, from February 2023 sepsis deaths will have some additional validation by members of the sepsis team to determine if a more definitive diagnosis could be coded and therefore improve accuracy of recording. The first month of this new process has come into the latest data release and the Sepsis performance has improved significantly and has dropped below the 100 mark, this is the best performance since 2021.

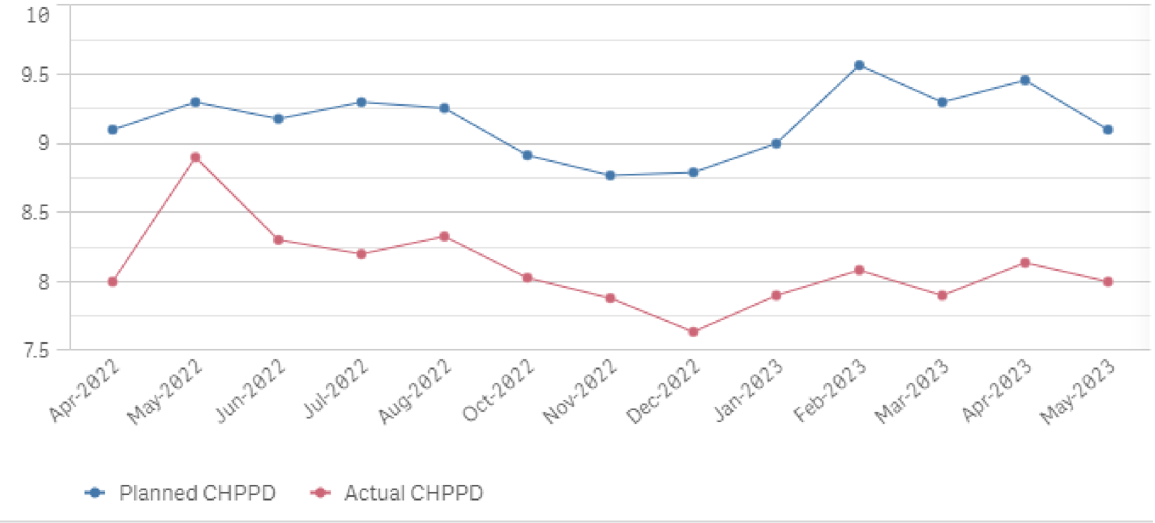
Actions:
As noted above there was an increase in overall deaths in December 2022 and notable increase from the average number of monthly deaths in the Emergency Department. A review of these deaths is being undertaken to clarify that this is due to a spike in acute, co-morbid patients and not due to any issues with care delivery.

Care Hours Per Patient Day

Executive Owner: Lindsay Rudge   Clinical Lead: Andrea Dauris   Business Intelligence Lead: Charlotte Anderson

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. For May 2023 the planned CHPPD was 9.1 and the actual was 8.0. The step change in the planned CHPPD in February reflects the inclusion of additional shifts required for 1:1 care which were previously excluded from the planned data.

Benchmarking data in Model Hospital shows that in Q2, CHFT are currently delivering 7.9 CHPPD against a peer median of 8.6 and a national median of 8.1.

Underlying issues:
The CHPPD deficit reflects unfilled shifts of both the registered and unregistered workforce.

Actions:
Reducing the CHPPD deficit is dependent on having the right workforce aligned to appropriate workforce models.

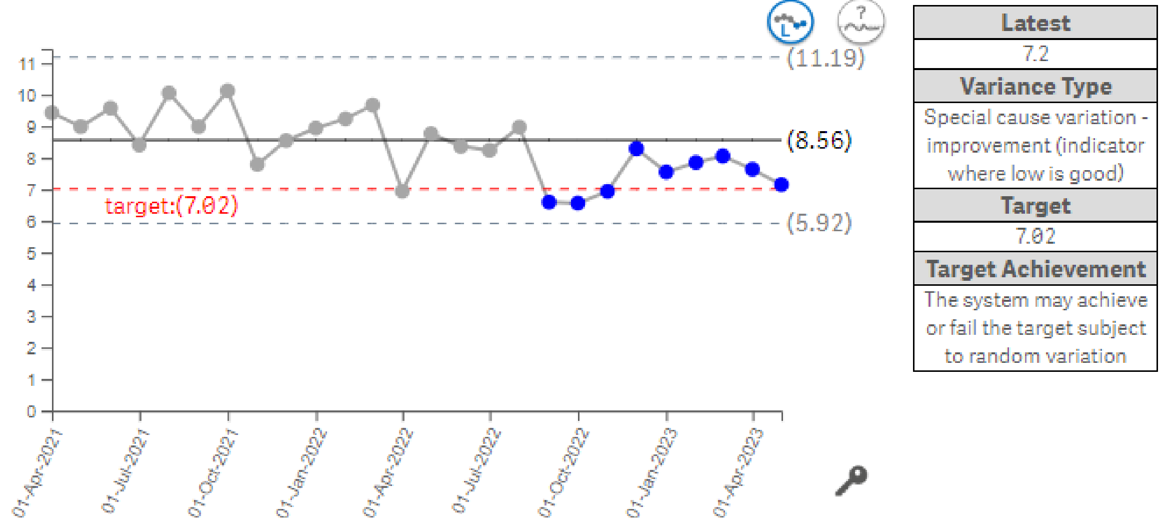
- The Hard Truths process gives assurance of the correct workforce models based on evidence-based acuity and dependency data, agreed nurse sensitive quality indicators and professional judgement.
- Recruitment strategies including employment of new graduates; internationally educated nurses, midwives, and AHPs and supporting apprenticeships are focussed on closing the vacancy gap and subsequent agency spend.
- There is a comprehensive retention strategy aimed at preventing attrition of staff overseen by the workforce steering group.
- Strong roster management maximises efficiency of the available workforce.
- Twice-daily staffing meetings 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: Rhiann Armitage

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 2022/23



What does the chart show/context:
The rate of inpatient falls for May was 7.2. Currently performance can be expected to vary from 5.9 to11.2. The last 9 months have been under the average and therefore indicate an improvement in performance.

Underlying issues:
- Falls collaborative needs reformatting and attendance from falls link nurses from each directorate mandated due to historic poor attendance
- Dr Chakrabarty wishes to step down from his falls lead role
- Enhanced care team issues with 1-1 cover for areas inconsistent
- Inconsistencies in wards using falls prevention measures e.g. bay tagging, co-horting

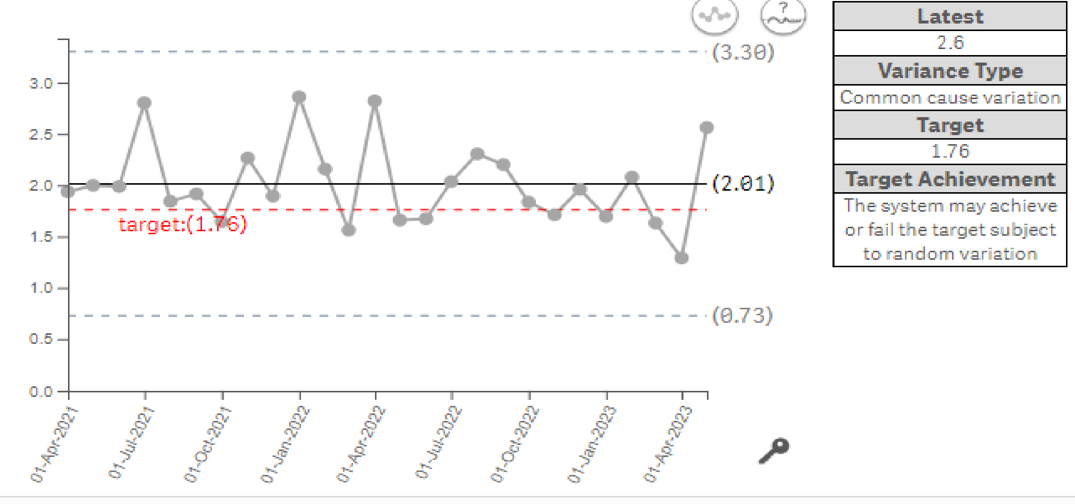
Actions:
- Relook at the TOR of the falls collaborative
- Falls link nurses to be allocated and invited
- Appoint a medical lead to lead falls
- Renee to continue with reconfiguration plan around the enhanced care team
- Education as part of the revamped Enhanced Care team processes and assessments

Hospital Acquired Pressure Ulcers per 1,000 Bed Days

Executive Owner: Lindsay Rudge | Clinical Lead: Judy Harker | Business Intelligence Lead: Charlotte Anderson

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.



What does the chart show/context:
The rate of Hospital Acquired Pressure Ulcers for May was 2.6. The Trust is unable to consistently meet the target and may achieve or fail subject to random variation month to month. Currently performance can be expected to vary from 0.73 to 3.30.

Underlying issues:
A total of 978 CHFT newly acquired pressure ulcers occurred in 2022/2023. This compares with 844 in 2021/2022. The Trust is not consistently risk assessing patients in a timely manner resulting in a potential delay in initiating preventative care. Medical device related PU continue to occur. 15% of PU were caused by devices in 2022/23, some of which were deemed avoidable.

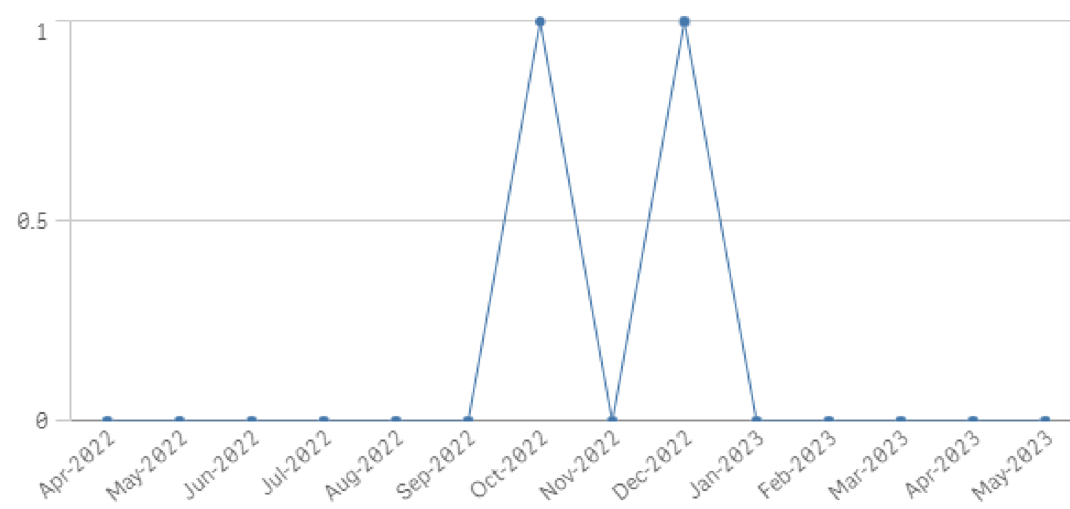
Actions:
- PURPOSE T PU risk assessment tool replacing Waterlow on 17th July 2023
- New revised care plans implemented for hospital and community to align with PURPOSE T
- PU CQUIN data collection has commenced
- Processes for PU investigations and learning being reviewed in line with PSIRF
- Heel PU audit being undertaken in Orthopaedics as part of national PRESSURE 3 RCT
- Ongoing QI work as part of PU Collaborative
- New elfH PU training being rolled out in July 2023

MRSA Bacteraemia Infections

Executive Owner: David Birkenhead   Clinical Lead: Belinda Russell   Business Intelligence Lead: Charlotte Anderson

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:
To have no cases of MRSA Bacteraemia infections that are Trust-Assigned in 2023/24.



What does the chart show/context:
There were no MRSA Bacteraemia case infections in May. The Trust is unable to consistently meet the target of 0 infections and may achieve or fail subject to random variation.

Underlying issues:
Staphylococcus aureus (SA) is a common bacteria which many people carry on their skin or in their noses without any symptoms or infections developing. MRSA is an antibiotic resistant SA. MRSA infections associated with deep abscess, pneumonia, invasive devices, prosthetic joints and implants can result in a bacteraemia.
The key control measures are:

- Admission screening and isolation
- Colonisation suppression
- Use of ANTT
- Environmental and equipment disinfection

Actions:

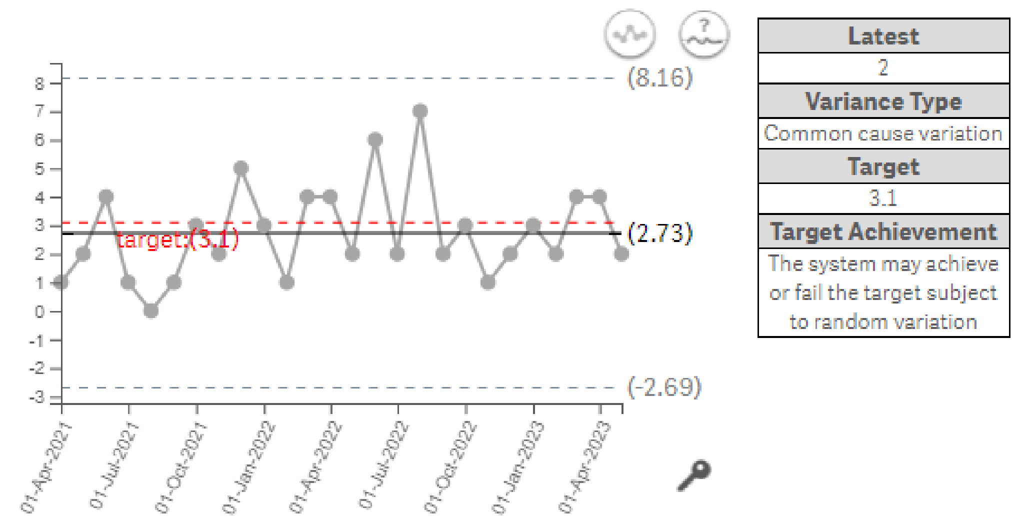
- Admission/pre-admission MRSA screening is monitored. Data accuracy has been an issue. An initial data cleanse has been completed and improvements seen. A further piece of work is underway with FSS.
- Colonisation suppression prescribing is via a POWERPLAN in EPR. Visual user guides are provided to patients to ensure correct application.
- Isolation guidance and signage is in place.
- ANTT and IPC level2 training is mandated for clinical staff and monitored through the divisional PSQBs and IPC Performance Board. Both require improvement.
- Implementation of the National Standards of Cleaning is complete in the hospital sites and rolling out in the community sites. Disinfectant wipes remain in use.
- Any infections are investigated and discussed at panel. All learning is shared.

C.Difficile Infections

Executive Owner: David Birkenhead   Clinical Lead: Belinda Russell   Business Intelligence Lead: Charlotte Anderson

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:
To not exceed 37 cases of C.Diff infections in 2023/24. The risk of healthcare acquired infections to patients should be reduced. Hospital onset healthcare associated (HOHA) & community onset hospital associated (COHA).



What does the chart show/context:
There were 2 C.Difficile infections in May. The Trust is unable to consistently meet the 3.1 objective and may achieve or fail subject to random variation month to month. Currently performance can be expected to vary from 0 to 8.16.

Underlying issues:
Clostridium Difficile is a bacterial infection acquired through the ingestion of spores which readily survive in the environment and are unaffected by standard disinfectants.
Key control measures are:
- Early identification of symptoms, isolation and testing
- Prevention through antimicrobial stewardship.

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.

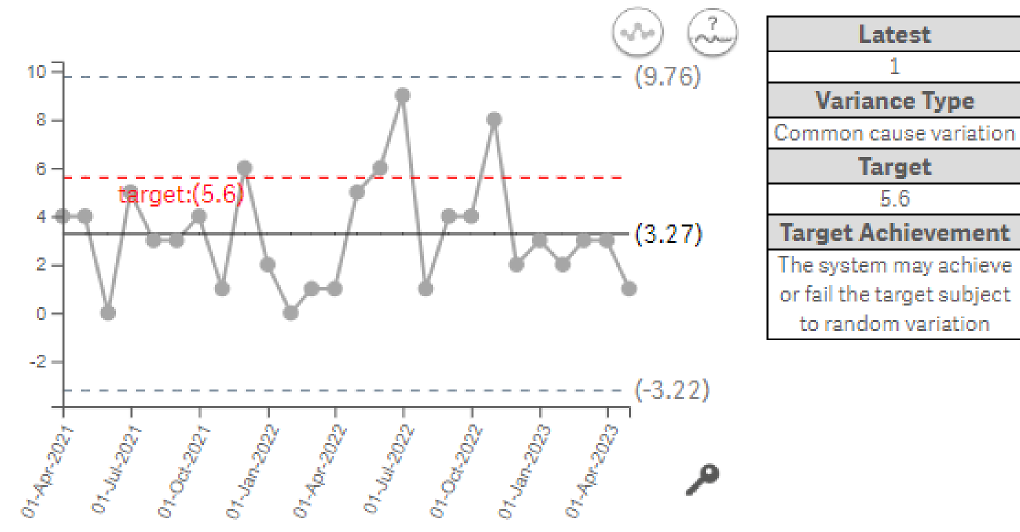
Actions:
The Trust has implemented an improvement plan including a programme of HPV deep cleaning (to be agreed), C.Diff ward rounds, antimicrobial ward rounds and a review of the investigation process for cases. NHSEI has carried out a support visit in March, with positive feedback. Their recommendations will further inform the improvement plan. The improvement plan is monitored at IPC Performance Board.

E.Coli Bacteraemia Infections

Executive Owner: David Birkenhead Clinical Lead: Belinda Russell Business Intelligence Lead: Charlotte Anderson

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:
To not exceed 67 cases in 2023/24. Hospital onset healthcare associated (HOHA) and community onset hospital associated (COHA).



What does the chart show/context:
There was 1 E.Coli infection in April. The Trust is unable to consistently meet the 5.6 objective and may achieve or fail subject to random variation month to month. Currently performance can be expected to vary from 0 to 9.76.

Underlying issues:
Being part of the normal gut flora, E.Coli bacteraemia are often associated with urinary tract infections, hepatobiliary procedures etc. 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.

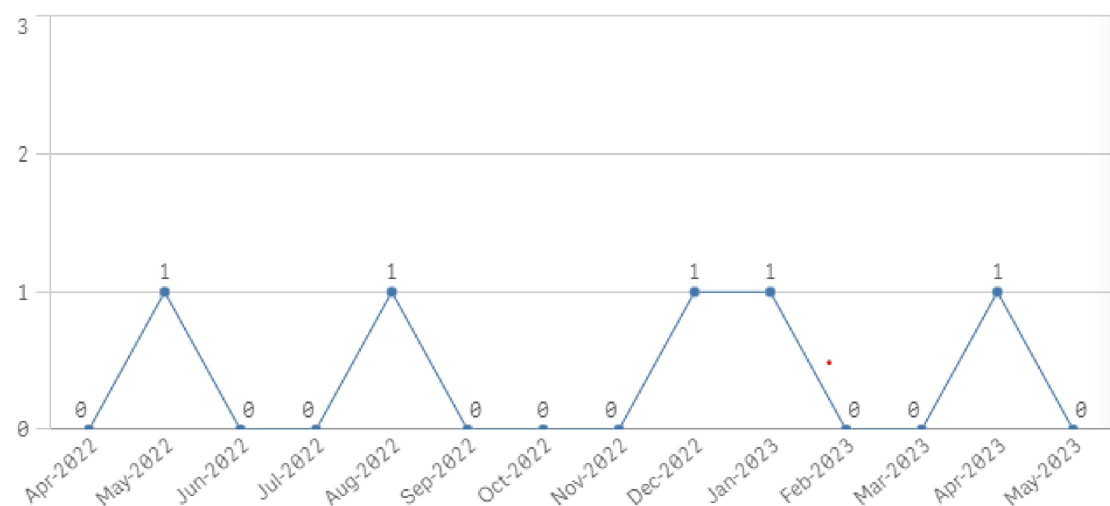
Actions:
- Extended surveillance of all the cases is conducted and uploaded to the UKHSA DCS system for national analysis.
- As part of the workplan of the IPCT, an annual audit of catheter management has been completed and recommendations shared with the divisions for implementation.
- A regional working 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 of these groups.

Number of Never Events

Executive Owner: Lindsay Rudge   Operational Lead: Richard Dalton   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 were 0 never events reported in May 2023. The Trust was unable to consistently meet the target and may achieve or fail subject to random variation month to month. Currently performance can be expected to vary from 0 to 1.

Underlying issues:
- Human Factors
- Staff training in all areas
- Communication

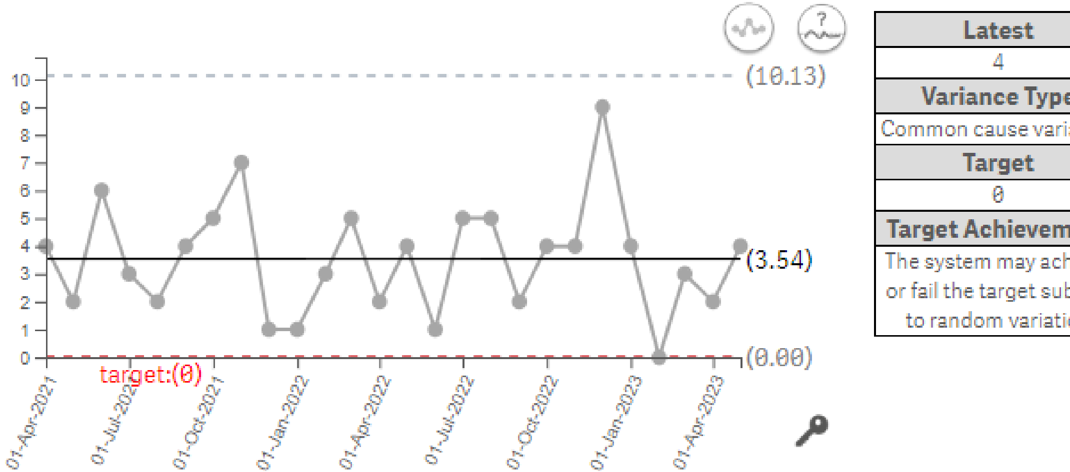
Actions:
- Immediate learning identified following all incidents
- Investigations ongoing
- A deep dive of Never Events has been commissioned due to themes and trends identified
- SWARM model introduced to support staff, patients and families

Number of Serious Incidents

Executive Owner: Lindsay Rudge Operational Lead: Richard Dalton 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 serious incidents



What does the chart show/context:
There were 4 serious incidents reported in May 2023. The Trust is unable to consistently meet the target and may achieve or fail subject to random variation month to month. Currently performance can be expected to vary from 0 to 10.13.

Underlying issues:
In total there were 4 incidents validated at SI panel as a serious incident in May that resulted in severe or catastrophic harm to patients meeting the SI framework. These were reported across 3 divisions: 1 for Families and Specialist Services, 2 for Medical and 1 for Surgical & Anaesthetics Services.

The most common reported type of incidents resulting in severe/ catastrophic harm/death to patients is medication errors (3) and delay or failure to monitor (1).

Actions:
Risk management team supporting the Divisions to review data for learning. In addition, Quality & Safety Team working with Care of the Acutely Ill Patient Lead to ensure quality improvements are commenced where required. This will align to the Quality Priority for Care of the Acutely Ill Patient and the CQUIN for 2023/24.

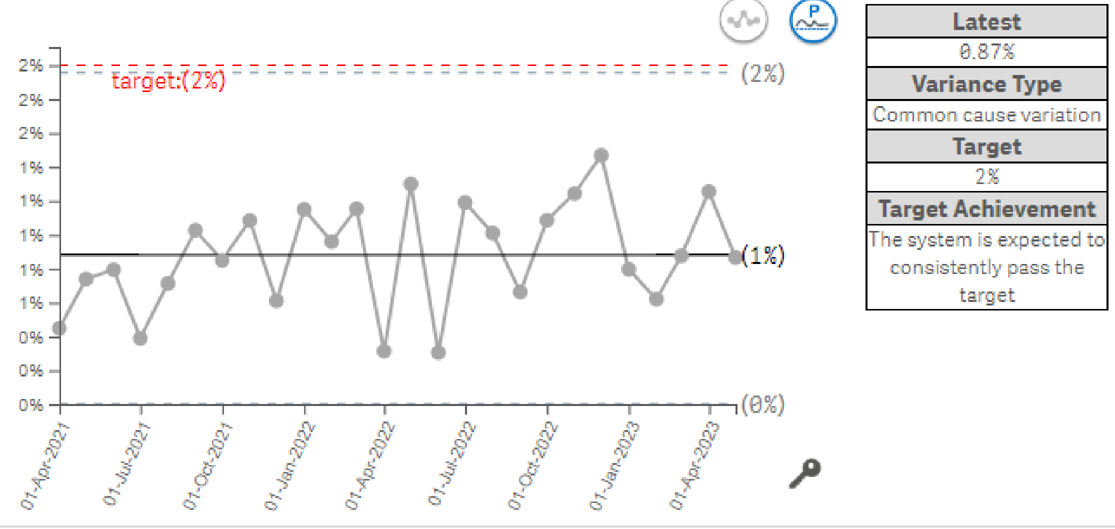
% of incidents where the level of harm is severe or catastrophic

Executive Owner: Lindsay Rudge Operational Lead: Richard Dalton 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

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



Source: KP+ Quality stream, Incidents app - Last updated:04/06/2023 22:15:27

What does the chart show/context:
0.87% of all harm reported in May 2023 was severe or catastrophic. The Trust is expected to consistently pass the target. Currently performance can be expected to vary from 0 to 2%.

Underlying issues:
In total there were 10 incidents submitted in the month of May that were categorised as severe or catastrophic harm (these were reported across 3 divisions: 3 for Families and Specialist Services, 6 for Medical and 1 for Community). Not all of these incidents will be validated in May as awaiting presentation at Serious Incident (SI) Panel.

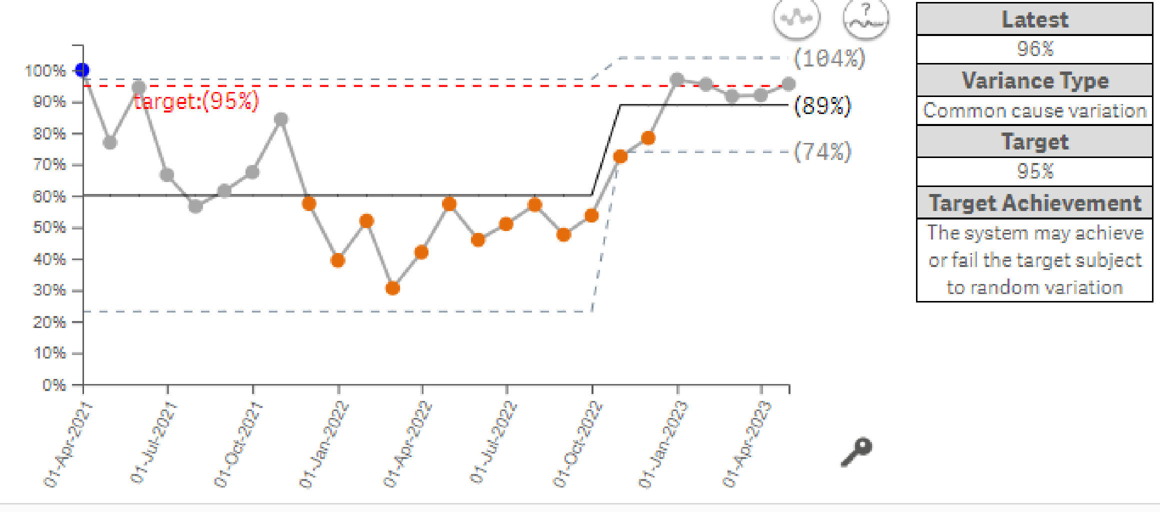
Actions:
Risk Management Team working with clinical teams/departments to ascertain what can be done to identify deteriorating patients sooner. In addition, Quality & Safety Team working with Care of the Acutely Ill Patient Lead to ensure quality improvements are commenced where required. This will align to the Quality Priority for Care of the Acutely Ill Patient and the CQUIN for 2023/24. In addition to this, learning is currently being triangulated with all areas within the Q&S team so that this can be shared Trust-wide in a learning forum.

% 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 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

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



What does the chart show/context:
Performance in May was 96%. The Trust is unable to consistently meet the 95% target however performance has improved significantly over the past 7 months. Currently performance can be expected to vary from 74% to 100%.

Underlying issues:
The Trust has met the 95% target this month with 96% which is the highest performance since January 2023. We continue to work collaboratively with Divisions to ensure this performance is maintained and if possible increases further.

Actions:
Continue to monitor Trust performance daily and meet with Divisions on a weekly basis to maintain oversight of performance and to identify any potential issues which may have an impact on Trust-wide performance.

Quality Priorities:

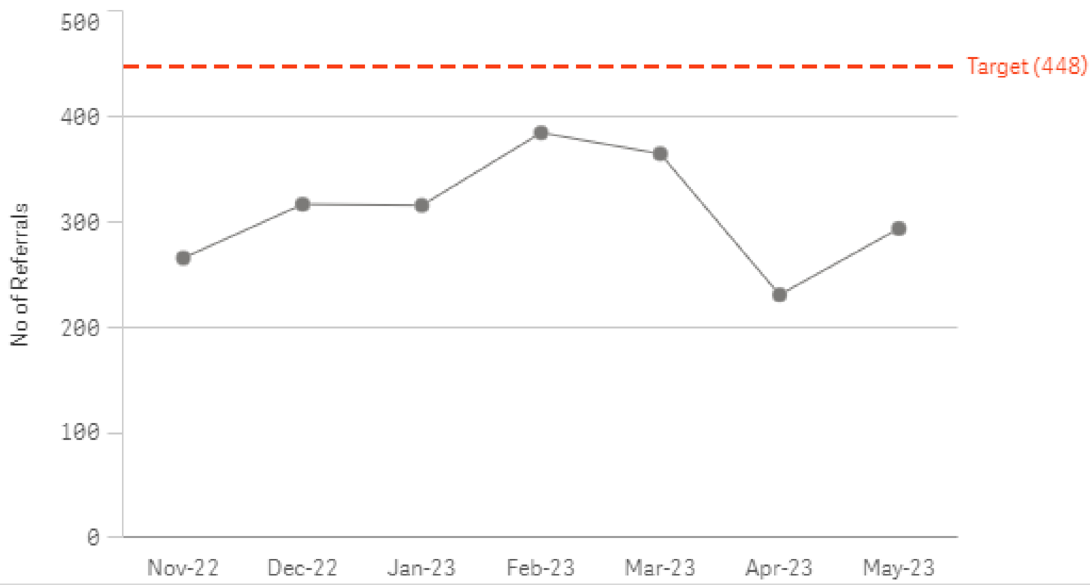
Metric	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Alternatives to Hospital Admission – Number of referrals into the Frailty service	May 2023	294	448	-	-	-	-	-
% of episodes scoring NEWS of 5 or more going on to score higher	May 2023	33.8%	30%			32%	28%	36%
% of adult patients that receive a MUST assessment within 24 hours of admission/transfer to the ward.	May 2023	21.05%	95%			18%	12%	24%

Alternatives to Hospital Admission – Frailty Service

Executive Owner: Lindsay Rudge Clinical Lead: Renee Comerford/ Hannah Wood Business Intelligence Lead: Gary Senior

Rationale:
To enable patients to receive the care and treatment they need in their own home, safely and conveniently rather than being in hospital.

Target:
To have 448 referrals per month by the end of March 2024.



What does the chart show/context:
New referrals into service for the whole Urgent Community Response / Frailty Virtual Ward service. Average of 311 per month for all. Data shows downward trend after peak in February 2023

Underlying issues:
Data includes Locala patients referred into CHFT SystmOne unit by CHFT Pharmacists as an interim measure to manage these patients' medication needs until access to Locala SystmOne units was configured for them.
Due to no 7-day consultant cover, the team have to be selective with who they accept onto a virtual ward service towards the end of the week to ensure they do not require an MDT over the weekend.
Staffing across Locala has impacted the number they can safely care for at home so this has been reviewed weekly.

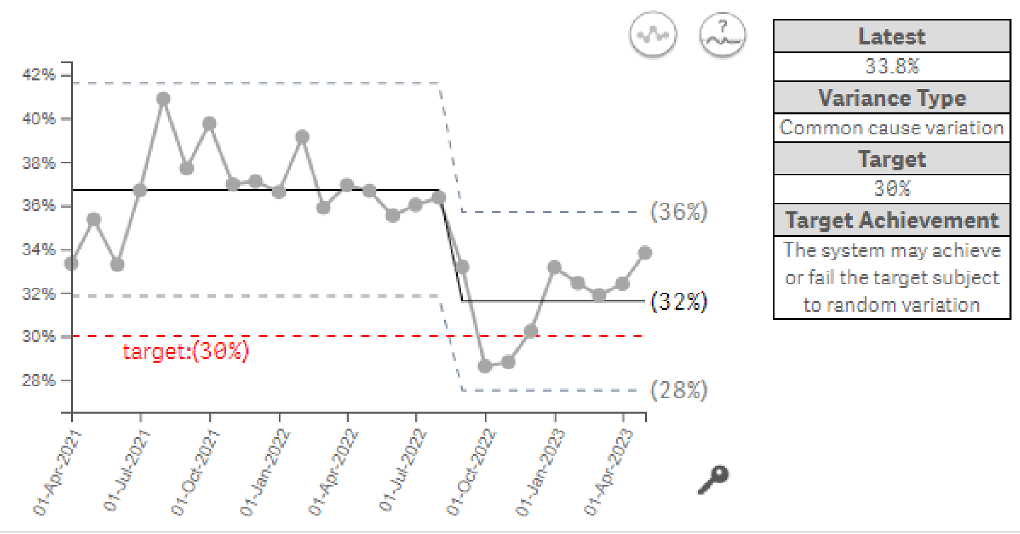
Actions:
Medical division reviewing medical cover to support a 7-day MDT for frailty virtual ward. Other organisations have not all been able to recruit consultants but backfilled with a registrar.
The Advanced Clinical Practitioner working on frailty SDEC on a weekend is supporting Kirklees virtual 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 has been amended to ensure we can take more frail and older people from across all areas. More comms going out and more engagement planned.
Next phased step-up pathway being designed to take GP and day patients as currently just from UCR. 12 beds available now for frailty which is above trajectory.
Team attend the safety huddles each day at CRH to support comms and pull patients out.
Recruitment ongoing for Kirklees - this has been successful.

Care of the Acutely Ill Patient

Executive Owner: Lindsay Rudge   Clinical Lead: Cath Briggs/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:
No more than 30% of patients scoring NEWS of 5 or more go on to score higher.



What does the chart show/context:
Performance was 33.8% in May. The Trust is unable to consistently meet the target of 30% and may achieve or fail subject to random variation. Currently performance can be expected to vary from 28% to 36%.

Underlying issues:
- Staff training and understanding of escalation parameters
- Doctors do not carry NerveCenter devices "in hours"
- Raised NEWS2 often closed down by the system as not actioned
- Observations not carried out on time in line with policy
- Appropriateness of plan when escalation is raised

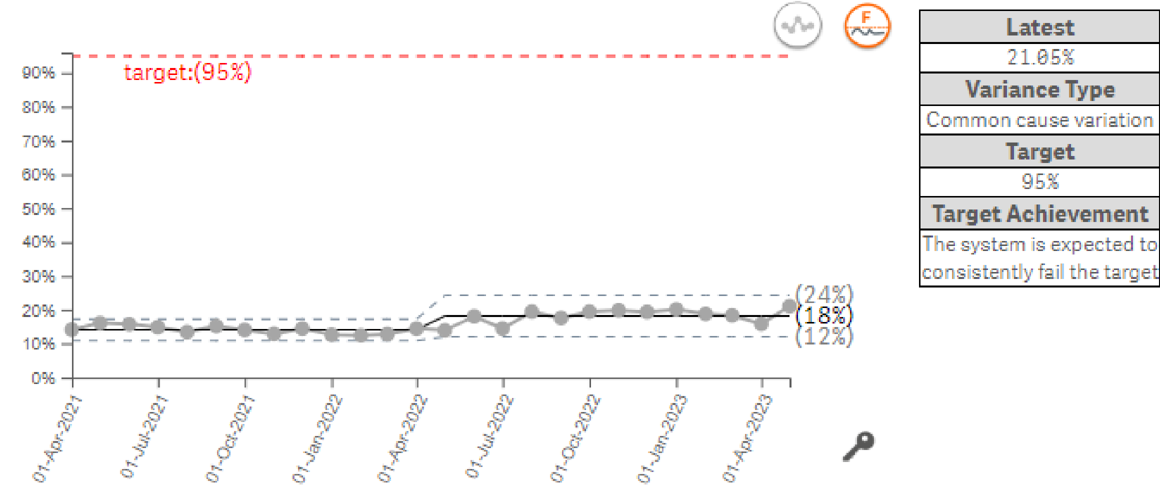
Actions:
- All divisions have a consistent representative at the Deteriorating Patient & Sepsis collaborative.
- Ward Managers and Matrons to regularly check KP+ for their Observations on Time performance.
- Deteriorating Patient CQUIN audit will highlight any further actions to be fed through Deteriorating Patient & Sepsis collaborative.

Nutrition and Hydration

Executive Owner: Lindsay Rudge   Operational Lead: Vanessa Dickinson   Business Intelligence Lead: Charlotte Anderson

Rationale:
Compliance with completion of MUST to be above 95% across the organisation – this will ensure we have the majority of our patients at risk identified early and referred to the dietitian team.

Target: 95% of adult patients to receive a MUST assessment within 24 hours of admission/transfer to the ward.



Source: KP+ Quality stream, Ward Assurance app - Last updated: - 05/06/2023 12:43:27

What does the chart show/context:
In May performance was 21.05%. Currently performance can be expected to be between 12% and 24% and therefore will consistently fail the 95% target.

Underlying issues:
- Staff training for compliance for the MUST is at 83.9%.
- An audit has been completed by Audit Yorkshire regarding MUST assessments which resulted in limited assurance.

Actions:
- Work ongoing regarding identifying training compliance for all staff.
- Work ongoing with the protected mealtime initiative, a full audit regarding ward compliance will be carried out in June.
- Task and finish group set up to work on the new National Standards for Healthcare Food and Drink.
- Policies relating to N&H have been updated and in use.
- A key piece of work is the request for stop moments before any patient is transferred off the assessment units to ensure that all assessments have been completed and that work is ongoing to reconfigure the admission workflow on EPR to support documentation and the nursing process during admission. This is expected to Go Live in September and engagement work with teams has started in preparation.

Workforce:

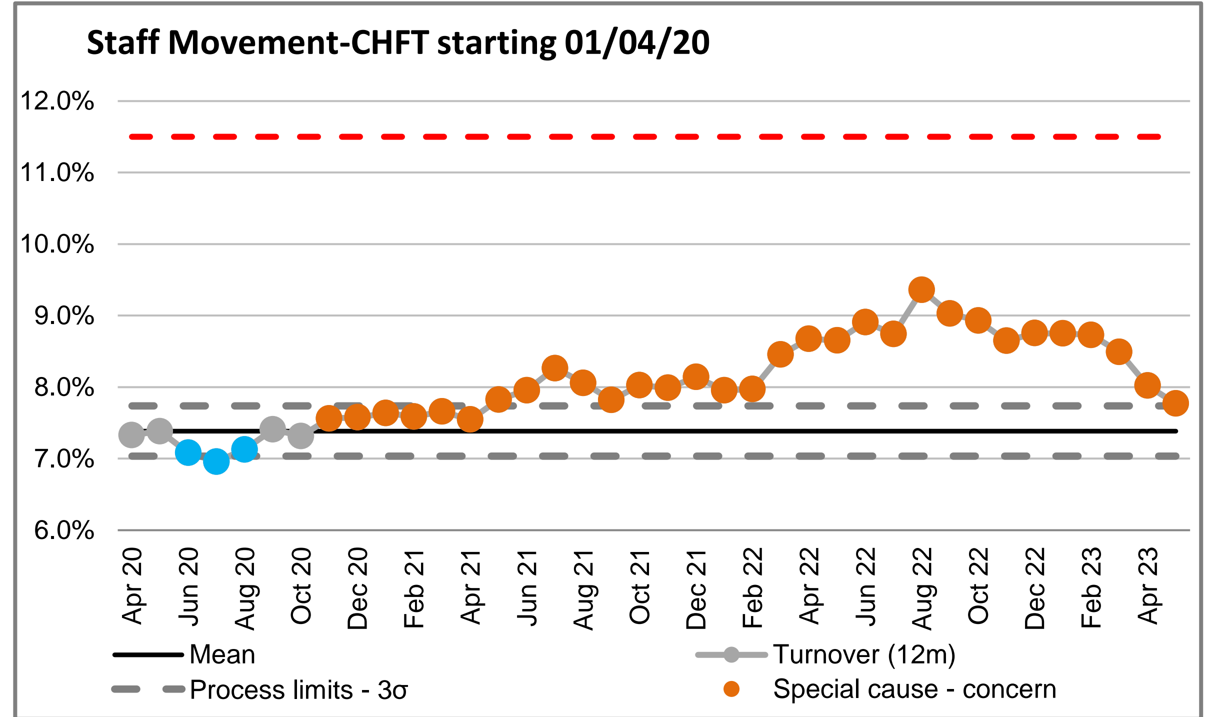
Metric	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Staff Movement (Turnover)	May 23	7.77%	11.5%	H	P	7.38%	7.30%	7.45%
Sickness Absence (Non-Covid)	May 23	4.47%	4.75%	H	P	3.97%	3.94%	4.02%
Appraisal Compliance (12m rolling)	May 23	79.3%	95.0%	H	F	53.8%	53.35%	54.43%
Core EST Compliance	May 23	93.23%	90.0%	P		92.88%	91.96%	93.82%
Bank Spend	May 23	£3.7M	£2.3M			£3.12M	£1.51M	£4.73M
Agency Spend	May 23	£0.9M	£0.9M			£0.91M	£0.79M	£1.95M

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.

Target: 11.5%



What does the chart show/context:

- Total FTE lost due to colleagues leaving all employment with the Trust against the average headcount of the reportingg period.
- Turnover is consistently below the Trust target of 11.5%.
- Turnover rates have continued to be above the mean average.
- May 2023 rolling turnover rate has decreased to 7.77% from 8.49% in April.

Underlying issues:

- High Allied Health Professional (AHP) turnover through the first half of 2022/23.
- Estates & Ancillary turnover high in the second half of 2022/23, currently at 12.32%.
- Additional Professional, Scientific and Technical at 11.25%.
- Consistently outside of process limits from March 2022 to current date.

Actions:
The Trust launched a new People Strategy in 2022 and it will be formally reviewed in July 2023.

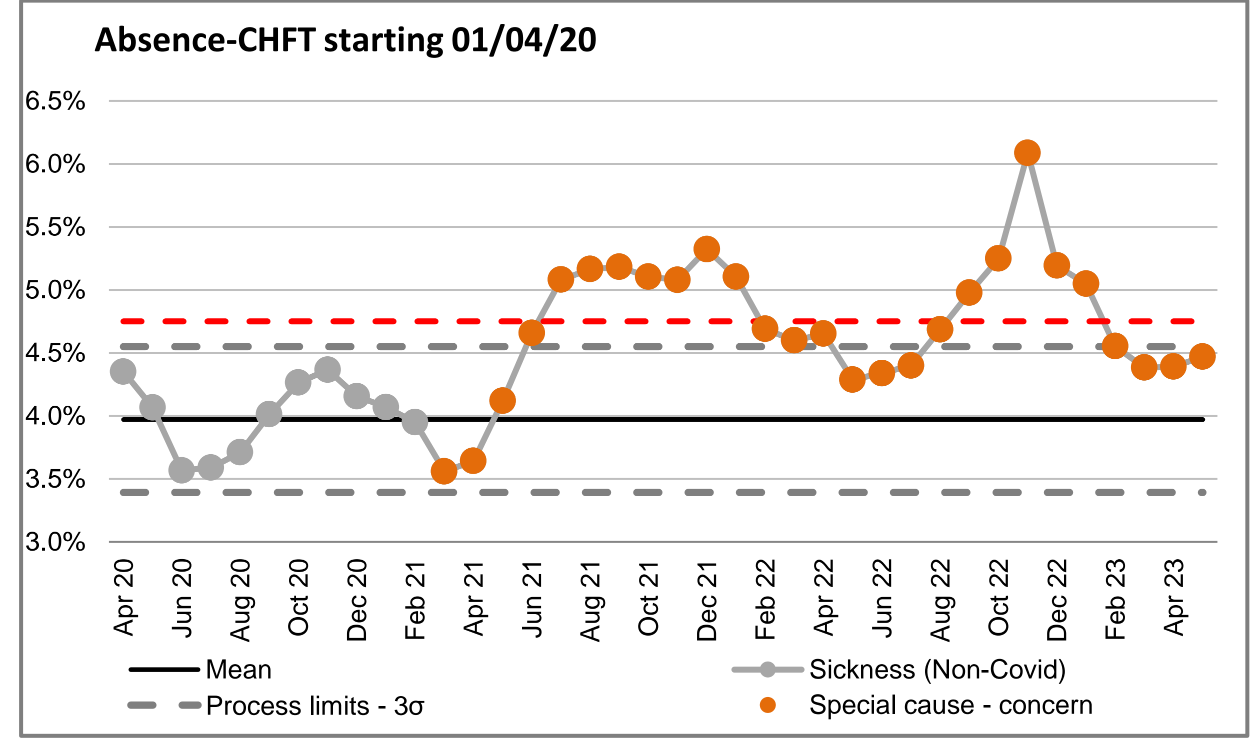
HCSW retention review is underway with an exit interview review. Actions to address an increasing number of leavers will then be developed.

Sickness Absence (Non-Covid)

Executive Owner: Suzanne Dunkley Lead: Leigh-Ann Hardwick 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.

Target: 4.75%



What does the chart show/context:

- Absence rate of CHFT colleagues due to non-covid sickness reasons, as recorded in ESR/Allocate. Calculated as a percentage of FTE Days Lost within the reporting month.
- From March 2021 sickness saw an upward trend before remaining above the average mean sickness rate.
- December 2022 saw an unusually high level of sickness absence due to Cough/Cold/Flu absence has since continued to fall following normal seasonal variation as we move into spring.
- The data shows consistently being above the average, however the Trust is consistently hitting the target with 8 out 12 months hitting target in the past year.

Underlying issues:
Top 3 reasons for sickness in May 2023 – Anxiety/Stress/Depression, Other musculoskeletal problems, and Gastrointestinal problems (a change from Chest & Respiratory problems the previous month)

Actions:
The trust now has access to direct physio appointments through the Occupational Health team. All colleagues with MSK/Back issues are being sent the self-referral form for access to this service.

Absence review meetings are held monthly to explore trends in data and assess required actions. This is in addition to a line-by-line review of all open long-term absence cases.

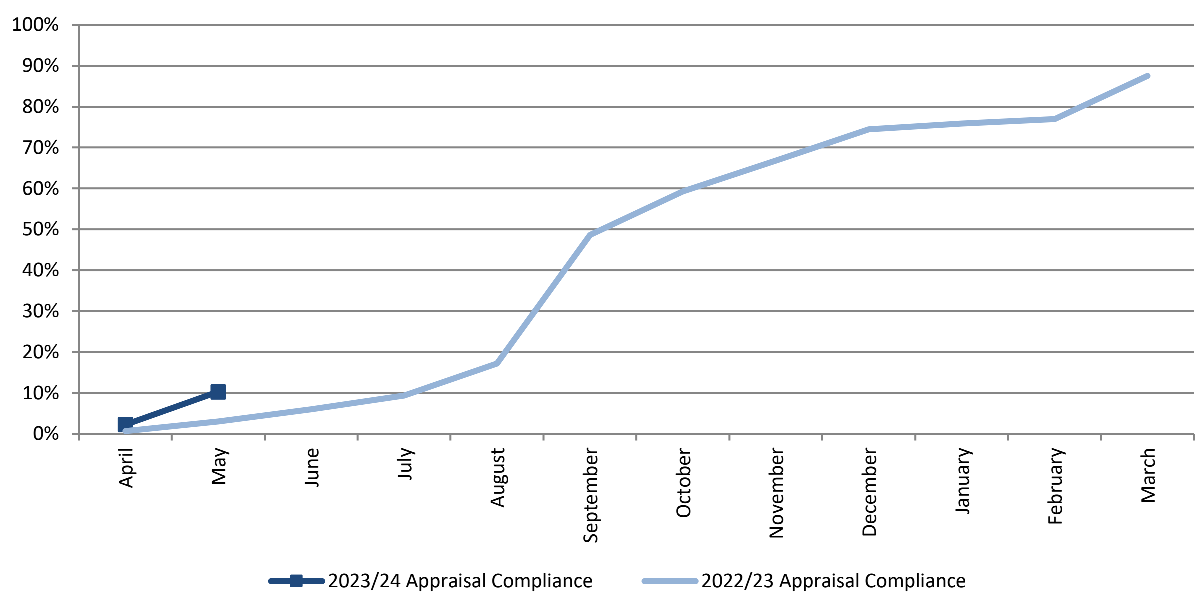
HRBP’s link with the Trust Workforce Psychologist to assess how best to access and support colleagues suffering with stress and anxiety symptoms, and how to proactively provide support to minimise/reduce absence length where possible.

Appraisal

Executive Owner: Suzanne Dunkley   Lead: Liam Whitehead   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 Trust operates an appraisal season and the 2023/24 appraisal season will run from 1st April to 31st December 2023.

Target: 95.0%



What does the chart show/context:
- Total compliance where Appraisals have been completed in the current appraisal season
- Appraisal Compliance rates are continually failing to hit the target of 95%
- 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

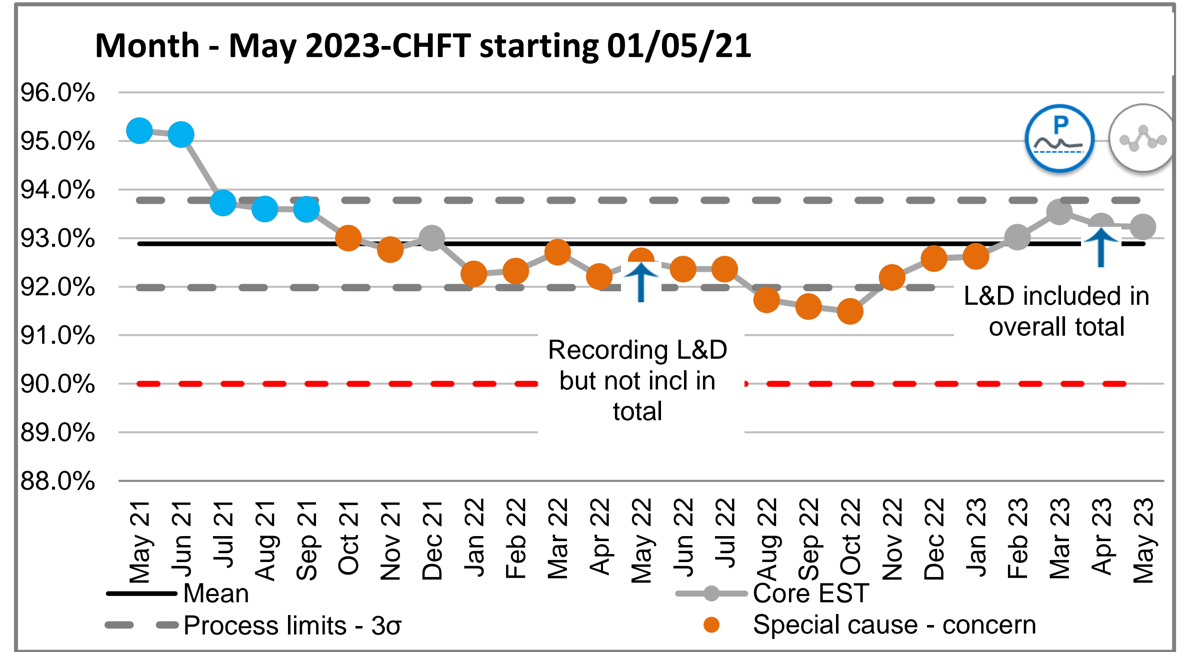
Actions:
- A “how to guide to appraisals” video has been developed for the 2023/24 appraisal season and is part of our “management fundamentals” offer to make it a more “people centred conversation”.
- ESR recording guidance produced to support managers so we capture all activity.
- Targeted approach to support hot spot areas including Connect & Learn sessions (managers’ and appraisees’ guides) so to focus and improve upon the quality of conversations that managers are having with colleagues and appraisee preparedness.
- We go see – areas of good practise for appraisal.

Core EST Compliance

Executive Owner: Suzanne Dunkley Lead: Adam Matthews 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: 90.0%



What does the chart show/context:

- Total EST Compliance over a 24-month period.
- The Trust is currently achieving its target and is subject to common cause variation in the monthly data.
- 2 points of note are May 2022 when the Trust started to record Learning Disabilities core module although it was not yet included in the overall score, and April 2023 when it was included in the overall compliance score.

Underlying issues:
The Trust must achieve 95% compliance with Data Security Awareness by 30th June 2023 to ensure it is compliant with all 10 elements of the Data Security and Protection toolkit.

Actions:
Compliance rates are shared with Directorates on a weekly basis.

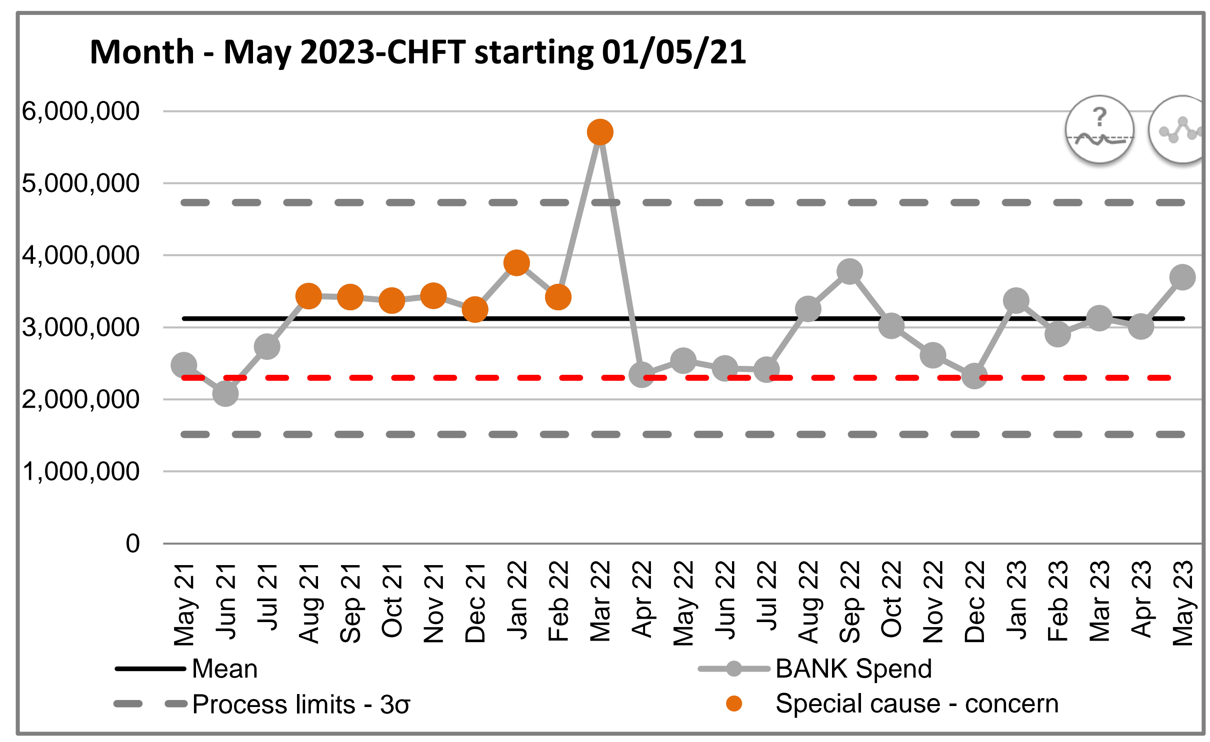
All colleagues that are non-compliant with Data Security Awareness are being contacted to encourage completion of the training before 30th June 2023.

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.

Target: %



What does the chart show/context:

- Bank spend over the last 24 months by month
- The general view is there is a hit and miss result to the target with common cause variation
- Bank spend has reduced over the last 12 months to the 12 months preceding
- The spike in March 2022 was due to a year-end financial accrual
- An increase in May 2023 is due to the 5% pay award for April 2023 and May 2023

Underlying issues:
There is a reliance on bank usage to cover unplanned unavailability and to support the recovery programme.

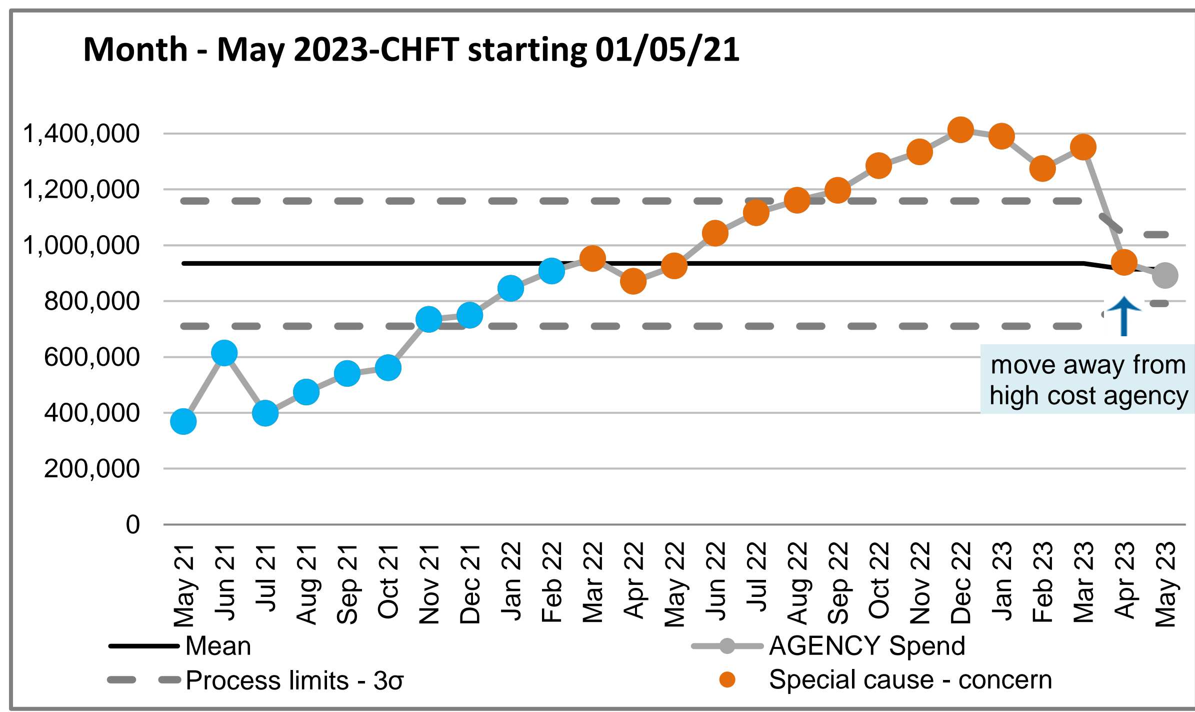
Actions:
Director approval is required for any variation from agreed bank rates.

Agency Spend

Executive Owner: Suzanne Dunkley Lead: Adam Matthews 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.

In month target: £0.94M



What does the chart show/context:

- Agency spend over the last 24 months by month
- There had been an increasing trend in monthly Agency spend from May 2022 with a peak in March 2023.
- This has since fallen due to the Trust moving away from high-cost agency use
- May sees the first month of a common cause in the variation

Underlying issues:
There is a reliance on agency usage in some areas as a result of vacancies and difficulties in recruiting.

Actions:
Use of Thornbury Nursing Services was ceased from January 2023. However, one to one Paediatric mental health shifts were covered by Thornbury, with funding from the ICB.

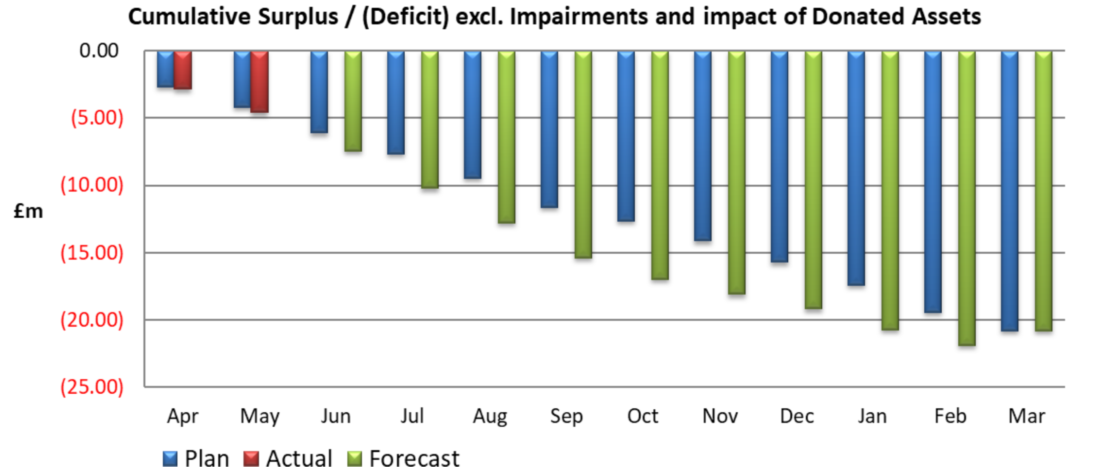
Work to reduce Tier 3 agency usage commenced in January 2023 and the Trust ceased routinely sending shifts to Tier 3 agencies in May 2023. Tier 3 agencies are now only used in exceptional circumstances and require approval from the Deputy Chief Nurse.

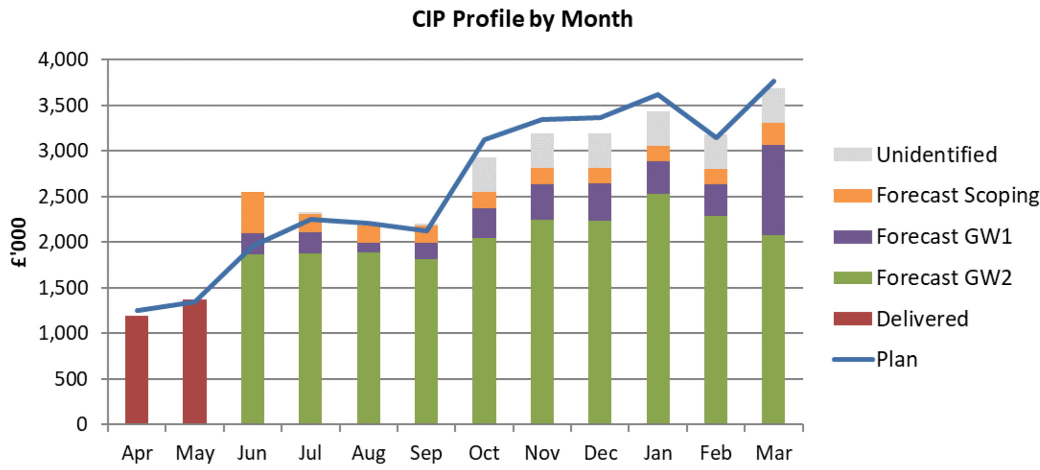
Finance:

- Cumulative Surplus
- CIP Profile
- Capital Spend
- Cash Balance

Financial Performance

Executive Owner: Gary Boothby / Kirsty Archer   Finance Lead: Philippa Russell





Rationale:
To monitor year to date and forecast performance against the 2023/24 financial plan and efficiency target.

Target:
The financial plan for 2023/24 is a £20.80m deficit and delivery of £31.50m of efficiency savings through the Cost Improvement Programme (CIP).

What do the charts show/context:
The Trust is reporting a YTD deficit of £4.58m, a £0.39m adverse variance from plan. The forecast is to deliver the £20.80m deficit as planned. The Trust has delivered efficiency savings of £2.56m year to date, £0.04m lower than planned.

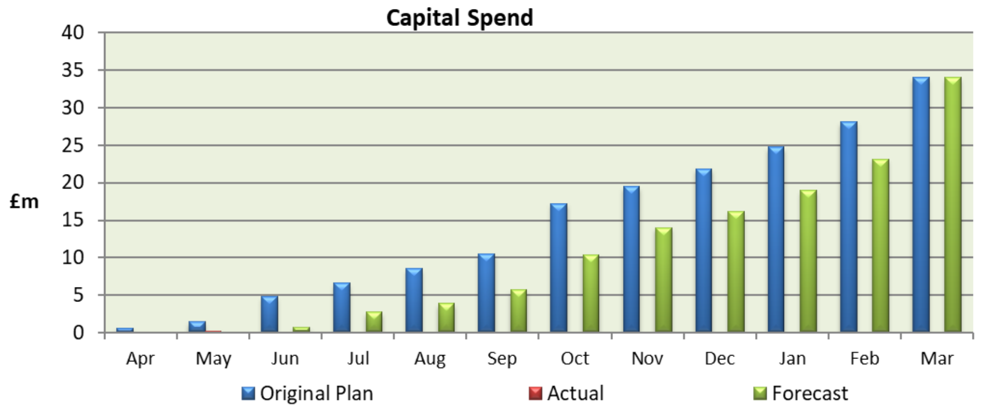
Underlying issues:

- Year to date the Trust has incurred higher than planned costs due to higher than planned additional bed capacity of £0.47m (£0.28m surge capacity plus £0.19m slippage on the LOS CIP), the Doctors Strike (£0.20m) and higher than expected Utilities costs. These pressures were offset by early delivery of other efficiencies and a higher than planned vacancy rate.
- Assumes full receipt of variable Elective income / Elective Recovery Funding.
- Delivery of activity was ahead of the M2 activity plan.
- The Trust is forecasting to deliver the planned £20.80m deficit, but the 'likely case' scenario includes £6.3m of unidentified mitigation required to offset forecast pressures and emerging risks including: unidentified CIP, (£2.1m of the £6.5m final plan stretch target); likely slippage on some high-risk efficiency programmes; further strike action; and challenges delivering the bed plan.

Actions:
To develop remaining scoping and Gateway 1 schemes to Gateway 2 (fully developed and ready to deliver) and identify opportunities to fill the remaining unidentified CIP gap.

Financial Performance: Capital, Cash and Use of Resources

Executive Owner: Gary Boothby / Kirsty Archer   Finance Lead: Philippa Russell



Use of Resources Metric:	Plan (YTD): 3	Actual (YTD): 3
	23/24 Plan: 3	Forecast: 3

Rationale:
To monitor year to date and forecast Capital expenditure, Cash balance and Use of Resources metric against the 2023/24 financial plan.

Target:
The Capital Plan for 2023/24 is to spend £34.01m including £11.89m of externally funded Capital. Cash balance is planned to reduce over the year due to the planned financial deficit and capital expenditure. The Trust will be required to borrow cash in the form of Revenue Public Dividend Capital (PDC). The Use of Resources metric is the financial element of the Single 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 23/24 is level 3.

What do the charts show/context:
The Trust has spent £0.20m on Capital programmes year to date, £1.23m lower than planned. At the end of May, the Trust had a cash balance of £34.81m, £3.33m higher than planned. Use of Resources (UOR) stands at 3, as planned, but with 1 metric (I&E Margin Variance) away from plan.

Underlying issues:
The Capital underspend is due to delays in the Pharmacy Robot project and HRI Reconfiguration.

Appendix – Variation and Assurance Icons

	Variation/Performance 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.
H	Special cause variation of an 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?
L	Special cause variation of an 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.	
H	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?
L	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!	

	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.
F	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.
P	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 – Metrics Rationale and Background

Metric	Details
Total Patients waiting >40, 52, 65 weeks to start treatment. 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 2019/20	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. NHS England priorities and planning guidance sets out the requirement to recover elective services so that activity levels are at least 104% of baseline of 2019/20 activity over the course of 2022/23. This is for day case/elective and Outpatient first activity.
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 2019/20 baseline	An ambition to reduce follow-up activity as per the 2022/23 NHS Operational Planning and Commissioning Guidance and the personalised outpatient plan element of the Elective Recovery Plan (with each provider and system required to reduce reviews by a minimum of 25% by March 2023). Systems are expected to plan how the redeployment of the released capacity will be used to increase elective activity that increases completed pathways.
Total Patients waiting >62 days to begin cancer treatment compared with February 2020 baseline	The NHS Constitution outlines what patients can expect and their rights when they are referred on a cancer diagnosis and treatment pathway. The number of patients seen following an urgent suspected cancer referral has remained at a record high since March 2021. Expectation to return the number of people waiting for longer than 62 days to the level in February 2020.
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.

Appendix – Metrics Rationale and Background

Metric	Details
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 seen 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% (80% local target) of patients are seen 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.
Staffing fill rates against funded establishment for maternity staff	Ensure there are sufficient numbers of staff in maternity services to support delivery of the Long-Term Plan. Appropriate staffing levels are also required to implement continuity of care for patients.

Appendix – Metrics Rationale and Background

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	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.

Appendix – Metrics Rationale and Background

Metric	Details
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 on the basis of 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.
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.
% 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.

Appendix – Metrics Rationale and Background

Metric	Details
Serious Incidents	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
Alternatives to Hospital Admissions - Frailty	To enable patients to receive the care and treatment they need in their own home, safely and conveniently rather than being in hospital.
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.
Nutrition and Hydration	Compliance with completion of MUST to be above 95% across the organisation – this will ensure we have the majority of our patients at risk identified early and referred to the dietitian team.

19. Any Other Business

To Receive

Presented by Karen Heaton

20. DATE AND TIME OF NEXT MEETING:

Date: Thursday 19 October 2023

Time: 2:00 – 4:00 pm (Private meeting 1:00 – 1:45 pm)

Venue: Meeting Rooms 3 and 4, 3rd Floor Acre Mill, HRI