PUBLIC BOARD OF DIRECTORS MEETING

Schedule Thursday 6 July 2023, 9:00 — 12:00 BST
Venue Forum 1A/B, Learning Centre, Huddersfield Royal Infirmary
Organiser Kathy Bray

Agenda

9:00 1. Welcome and Introductions:
Invited Public Governors:
Robert Markless
John Gledhill
Isaac Dziya
Peter Bamber
To Note - Presented by Helen Hirst

9:01 2. Apologies for absence:
Brendan Brown, Anna Basford
To Note - Presented by Helen Hirst

9:02 3. Declaration of Interests
To Note

9:03 4. Minutes of the previous meeting
held on 4 May 2023
To Approve - Presented by Helen Hirst

APP A - Chair Approved Minutes of the Public Board of Directors 4.5.23.docx 1

9:05 5. Matters Arising and Action Log
To Approve - Presented by Helen Hirst

APP B - Draft Action Log 31.05.23 (Public Board of Directors) -.docx 13

9:07 6. Staff Story: Volunteering - Liam Whitehead and Chloe Hudson attending
To Note - Presented by Suzanne Dunkley

Time	Item	Page
9:22	7. Chair's Report To Note - Presented by Helen Hirst APP C - Chairs Report JulyBoard.docx	15
9:27	8. Chief Executive's Report To Note - Presented by Rob Aitchison APP D - CEO Report July.docx	19
9:32	9. Sustainability - Green Plan - Annual Update To Approve - Presented by Stuart Sugarman APP F - Sustainability Green Plan Update for 6 July BoD 2023 (003).docx	26
9:47	10. Finance and Performance Chair Highlight Report For Assurance - Presented by Andy Nelson APP H - F and P Chair's Highlights 28 June 2023.docx	32
9:57	11. Month 2 Financial Summary For Assurance - Presented by Gary Boothby and Kirsty Archer APP I1 - Month 2 Finance Report_cover sheet_6 Jul 23.docx	34
	APP I2 - Month 2 Finance Report for Board.pdf	36
10:02	12. Workforce Committee Chair Highlight Report For Assurance - Presented by Karen Heaton APP J - chairs highlight report WOD June 2023.docx	40
10:12	13. Audit and Risk Committee Chair Highlight Report To Note - Presented by Nigel Broadbent APP K -ARC Chairs highlight report July 2023 - Copy.docx	42
10:22	14. Quality Committee Chair's Highlight Report - Director of Infection Prevention Control (DIPC) Q4 Report - Learning from Deaths Q4 Report To Approve - Presented by Denise Sterling	

APP L - Chair Quality Committeer highlight report 22.5.23 v1.doc 44

App L1 - DIPC report Q4 April 2023.docx 46

APP L2 - LfD Q4 Report Cover Sheet.docx 52

APP L2 - LfD Q4 Report 2022.23.docx 54

10:32 15. Integrated Performance Report

To Note

APP G1 - QWF_Performance narrative BoD_6th July 2023.docx 58

APP G - IPR June 2023 (May Data).pdf 60

10:37 16. Safeguarding Adults and Children Annual Report

For Assurance - Presented by Lindsay Rudge

APP M - Safeguarding Annual Report Apr 22 Mar 23 - Board of Directors v2.docx 124

APP M2 - Safeguarding Annual Report Apr 22 Mar 23 slide deck.pptx 145

10:47 17. Complaints Annual Report

For Assurance - Presented by Victoria Pickles

APP N - Annual Complaints report 2022-2023 (Final approved version).docx 157

10:57 18. Maternity Report - Presented by Diane Tinker, Director of Midwifery

To Note

APP O - version 2 - Maternity and Neonatal report (June 2023)422900.docx 162

11:07 19. Nursing and Midwifery Staffing Hard Truths Requirement

To Note - Presented by Lindsay Rudge

APP P - NM AHP Safer Staffing report V3 BOD FINAL AS AT 15.06.23.docx 173

11:12 20. Health and Safety Annual Report - Presented by Jonathan

Hammond
For Assurance

APP Q1 - Board Cover Sheet Health and Safety.docx 215

APP Q - Annual health and safety report April 2022 to March 2023.docx 217

11:17 21. Board Assurance Framework
To Approve - Presented by Andrea McCourt

APP R1 - Board Assurance Framework Cover Sheet 6 7 2023.docx 235

APP R - Amended Final 6 July 23 Board update 1 23 24 BOARD ASSURANCE FRAMEWORK Board (version 3) 29 June (003).pdf 241

11:27 22. High Level Risk Register
To Approve - Presented by Victoria Pickles

APP S - High Level Risk Report for Board June 2023 (002).docx 268

APP S2 - ExtremeRisks2019.pdf 270

11:37 23. 2923/24 Financial Plan Overview: Budget Book
To Approve - Presented by Gary Boothby and Kirsty Archer

APP T1 - Budget Book_cover sheet_6 Jul 23.docx 330

APP T2 - Budget Book 2324 Trust.pdf 331

11:42 24. Governance Report
a) Board Workplan
b) Proposed Board Meeting Dates - 2024-2025
c) Use of Trust Seal
d) Committee Board Annual Reports – Annual Report : Workforce, ARC, TPB
e) Chairs Action – Urgent and Emergency Care Bid
To Approve - Presented by Andrea McCourt

APP U - Governance Report Cover Sheet.docx 342

APP U1 - Draft Public BOD Annual Workplan 2023-2024 version 17 - 27.06.23.docx 344

APP U2 - Proposed Board of Directors Future Meeting 348

Dates 2024-2025 v1.docx
APP U3 - 2023 Trust Seal register from 1 January - 1 June 2023.docx 351
APP U42 - Board of Directors - WC Annual Report 2022-2023.docx 353
APP U43 - Audit and Risk Committee Annual Report 2022 2023 (2).docx 362
APP U44 - Cover Sheet for Trust Board 6 July 2023 TPB Annual Report.docx 370
APP U44 - Transformation Progamme Board Annual Report 2022-2023 final version.docx 372
APP U5 - Governance report Chair's Action 1 23 Capital monies for Discharge hub UEC.docx 383
2023 Rolling Seal register from January 2023.docx 386

11:52 25. Review of Board Sub-Committee Terms of Reference

Workforce
To Approve - Presented by Andrea McCourt

APP V - Workforce Committee Terms of Reference - April 2023.docx 388

11:57 26. Items for Receive & Note
1. Minutes of Board Committees
- Finance and Performance Committee 26.4.23, 30.5.23
- Quality Committee 17.4.23, 22.5.23
- Workforce Committee 24.4.23
- Audit and Risk Committee - 25.4.23
- Charitable Funds 10.5.23

Partnership papers: Kirklees Health and Care Partnership
Kirklees ICB Committee meetings - NHS Kirklees Clinical Commissioning Group (kirkleeshcp.co.uk)
and Calderdale Cares Partnership Meeting papers - Calderdale Cares Partnership
To Note

APP W1 - 26 APRIL 2023 Finance and Performance Minutes.docx 394
APP W2 - A Draft FP Minutes 30 MAY 2023.docx 402

APP W3 - FINAL Quality Committee minutes & action log - 17.04.23 (Approved Mon 22 May 2023).docx 410
App W4 - DRAFT Quality Committee minutes & action log - 22.05.23.docx 420
APP W5 - 24 April 2023 Approved Minutes Workforce Committee.pdf 429
APP W6 - 3 May 2023 Approved Minutes Workforce Committee.pdf 436
APP W7 - Draft Chair approved Audit and Risk Committee Meeting Minutes held on 25 April 2023 v2.docx 444
APP W8 - Charitable Trust Funds - Minutes 10 May 2023.docx 455

11:59 27. Date and time of next meeting
Date: Thursday 7 September 2023
Time: 10.00 – 1.00 pm
Venue: Forum Room 1A & 1B, Learning Centre, Sub-Basement, Huddersfield Royal Infirmary

Draft Minutes of the Public Board Meeting held on Thursday 4 May 2023 at 10:00 am, Forum Room 1A / 1B, Sub-Basement, Huddersfield Royal Infirmary

PRESENT

Helen Hirst	Chair
Brendan Brown	Chief Executive
Robert Aitchison	Deputy Chief Executive
David Birkenhead	Medical Director
Lindsay Rudge	Chief Nurse
Suzanne Dunkley	Director of Workforce and Organisational Development (OD)
Gary Boothby	Director of Finance
Tim Busby **(TB)**	Non-Executive Director (until item 71/23)
Nigel Broadbent **(NB)**	Non-Executive Director
Andy Nelson **(AN)**	Non-Executive Director
Karen Heaton **(KH)**	Non-Executive Director

IN ATTENDANCE

Anna Basford	Deputy Chief Executive / Director of Transformation and Partnerships
Jonathan Hammond	Chief Operating Officer
Victoria Pickles	Director of Corporate Affairs
Stuart Sugarman	Managing Director, Calderdale and Huddersfield Solutions Ltd (CHS)
Andrea McCourt	Company Secretary *(minutes)*
Dr Shiva Deep Sukumar	Guardian of Safe Working Hours (item 67/23)
Richard Hill	Head of Health and Safety (item 72/23)

OBSERVERS

Christine Mills	Public Elected Governor
Gina Choy	Public Elected Governor
Brian Moore	Public Elected Governor

49/23 Welcome and Introductions

The Chair welcomed everyone to the Board of Directors meeting held in public, in particular those presenting the Staff Story ‘Developing New Roles at the Trust’, see 54/23.

The Chair congratulated Johnny Hammond and welcomed him to his first official Board meeting following his recent appointment as Chief Operating Officer.

The Chair also welcomed invited governors, Christine Mills, Gina Choy and Brian Moore as observers to the meeting.

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

50/23 Apologies for absence

Apologies were received from Denise Sterling (DS) and Peter Wilkinson, Non-Executive Directors and Rob Birkett, Chief Digital and Information Officer.

51/23 Declaration of Interests

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

CHAIR APPROVED DRAFT

52/23 Minutes of the previous meeting held on 2 March 2023

The minutes of the previous meeting held on 2 March 2023 were approved as a correct record.

OUTCOME: The Board **APPROVED** the minutes from the previous meeting held on 2 March 2023.

53/23 Matters Arising and Action Log

The Chair noted that all actions on the action log were complete.

There were no matters arising to note.

OUTCOME: The Board **NOTED** progress on the action log.

54/23 Staff Story – Developing New Roles in the Trust

The Chair welcomed to the meeting:

- Naomi Hegney, Maternity Health Advisor
- Emma Bowman, Quality and Safety Midwife
- Stevie O'Connell, Maternity Support Worker Educator
- Jill Priestly, Transitional Clinical Nurse Specialist
- Abi King, Associate District Nurse
- Michelle Sykes, Anticipatory Care Practitioner - General Medicine
- John Scaife, Anticipatory Care Practitioner - General Medicine
- Eilidh Gunson, End of Life Care Clinical Advisor
- Arley Byrne, Clinical Educator – Community Health Services

The Chief Nurse advised that the colleagues present were in development roles delivering services for patients of all ages, in multi-professional and multi-disciplinary team roles and support colleagues in terms of education and training. These included:

- Maternity Services: the Maternity Health Advisor outlined her role providing in house stop smoking advice to pregnant women, targeting vulnerable areas, with an 85% quit rates success, the Quality and Safety Midwife described her role creating an environment of safety so people choose to birth at the Trust, supporting the midwifery team and divisional team, reviewing and investigating incidents and sharing learning and the Maternity Support Worker Clinical Educator detailed the development of this role which supports 65 colleagues within a national framework and identifies educational needs;

- Neuro Disability / Complex Needs: the Transitional Clinical Nurse Specialist outlined this role which supports young people from 14 years to transition from paediatric to adult services;

- Community Services: the role of the Associate District Nurse role was outlined, a 12 month secondment undertaken prior to undertaking the District Nurse qualification at University, three people per annum are recruited who work on a rotation basis, learning skills, shadowing, and helping to manage a caseload in and out of hours;

- Ageing Well Practitioners in Calderdale: this role is a joint secondment with Primary Care Networks open to both nurses and Allied Healthcare Professionals,

CHAIR APPROVED DRAFT

who undertake a holistic assessment of patients, including their mental health and promote ageing well and confidence;

- Clinical Advisor to End of Life Care Team: this role, currently funded by the hospice, builds on the End of Life Care team role to promote and improve end of life care for patients, including the bereavement process and support for bereaved families and education and training for colleagues, with engagement with doctors a key aspect of the work;

- Senior Clinical Educator for Allied Healthcare Professionals (AHP): it was noted this role focuses on recruitment and retention of AHP staff, including the development and delivery of in-house preceptorship programme for AHPs, supported access to Continuing Professional Development and work with the University of Huddersfield to support transition for students, with new types of student placements developed (eg digital placements).

The Chief Nurse and Chair, on behalf of the Board, thanked colleagues for sharing their stories and for their passion and commitment.

The Director of Workforce and OD commented that colleagues demonstrated the Trust's "grow our own" approach which supports retention of talent, and the Chair of the Workforce Committee (KH) noted the presentation evidenced One Culture of Care, the reshaping of roles and educational support. The Chief Operating Officer confirmed his support for clinical educator roles and requested support from the Transitional Clinical Nurse Specialist to train staff in key areas such as the Emergency Department and Acute Floor to support patients with a learning disability.

Questions were asked about identification of caseloads for the Ageing Well Practitioners (via GP referral, acute setting, Age UK, pro-active search on System1) and networking with primary care and how the Maternity Health Advisor links with communities, which is via Children's Centres.

The Chief Executive welcomed the work shared by colleagues leading and transforming services.

OUTCOME: The Board **NOTED** the new roles that had been developed across the Trust and gave thanks to colleagues for their presentation.

CHAIR APPROVED DRAFT

55/23 Chair's Report

The Chair presented her report detailing activities since the last meeting within the Trust, and local systems, regionally and nationally.

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

56/23 Chief Executive's Report

The Chief Executive presented this report which detailed progress in relation to local and national agendas, an update against his leadership responsibilities and information on the Trust's top three risks.

In addition to the content of the written report, the following was highlighted:

- The junior doctor strike and period of political and industrial unrest which has involved planning for mutual aid
- national challenges relating to money, performance, productivity, and quality of care
- celebration of good work, such as four entries for The Health Informatics Service (THIS) Health Service Journal Digital Awards 2023, a national request to support other Trusts with elective work and links with the national team on outpatient transformation
- the recent official opening of the Rainbow Hub, a one stop shop for children with complex needs, the first part of our reconfiguration programme
- contribution to discussions on strategy across West Yorkshire
- NHS England publications including the new approach to quality improvement, NHS Impact and the three-year delivery plan for maternity and neonatal services; the Trust maternity development plan will be reviewed by the Quality Committee

In response to a question from TB regarding focus on key items, it was noted that the Trust will continue with our maternity plans and transformational approach, with the Chief Nurse chairing the Maternity Transformation Board and the Non-Executive Director Champion for Maternity, KH, attending.

In response to a question on the impact on the Trust of the planned cost reductions in Integrated Care Boards (KH) the Chief Executive advised this is not yet clear and further details were awaited.

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

57/23 Annual Strategic Plan Final Year Progress

The Deputy Chief Executive and Director of Transformation and Partnerships presented progress against the Strategy for quarter ending 31 March 2023. Of the 19 objectives, 18 were rated green (on-track) and one was complete and has been closed It was noted that progress across all objectives and some areas will continue into 2023/24, with further updates on the 2023/24 objectives to be presented to the Board during the year in line with the workplan.

AN suggested the quarter 4 / final year end report could usefully include final measures for objectives and the Deputy Chief Executive and Director of Transformation, and Partnerships agreed to identify those which are quantifiable.

OUTCOME: The Board **APPROVED** the 2022/23 Annual Strategic Plan Progress Report for the period ending 31 March 2023.

58/23 Annual Plan 2023/2024

The Director of Finance presented an update on changes to the annual plan for 2023/24. He noted that the plan previously submitted had not been approved nationally; this was a Trust financial position of £40.4m deficit which contributed to a £110M deficit position across the West Yorkshire Integrated Care Service (ICS).

It was noted that a revised plan was to be re-submitted on 4 May 2023. There were no changes to the operational plan and activity levels. The revised plan included a planned reduction in the scale of the ICS deficit to £25.2M, of which £20.8M related to the Trust. This represented an improvement of £19.6M, after a cost improvement programme, from the March plan submitted. The Trust had commitment to delivery of a cost improvement programme of £32.3m, an additional £7.5M, circa 6.2%, in line with increased targets across other acute Trusts in West Yorkshire. This £7.5M was to be achieved by a

CHAIR APPROVED DRAFT

capacity funding release of £1M, a cost improvement technical flexibility of £2M and a stretch target of £4.5M, with potential for redistribution of ICS monies currently being explored. It was noted the plan includes £15.02M of elective recovery funding, £6.8M to support inflationary pressures of £12M and Integrated Care Board funding of £5.3M.

It was noted that there was no change to the total capital plan which remained at £34M for 2023/24 including external funding. The need for cash support due to the deficit in quarter 4 2023/24 was noted.

The Director of Finance advised that, due to the scale of the deficit, there will be a review of Trust finances by NHS England which will consider if there are any further opportunities for efficiency.

The Chair noted that the Finance and Performance Committee had reviewed the plan in detail and the Trust welcomed the NHS England review of finances.

The Chief Operating Officer highlighted the Trust's reliance on local authority support in achieving the plan to reduce patients whose care needed to be transferred out of hospital and queried how this would be managed. The Director of Finance responded the involvement of operational clinical colleagues on managing resources and impact on patient flow was key as well as commitment by local authorities to the baseline. The Chief Executive commented that all West Yorkshire organisations are in a difficult financial position.

Brian Moore queried how the pay award will affect the deficit and the Director of Finance noted that to date 2% has been allocated nationally for the pay award, however as the pay deal is higher work is underway nationally to identify funding.

OUTCOME: The Board **APPROVED** the final 2023/24 operational and financial planning submissions on 4 May 2023 in line with revised national deadlines

APPROVED DRAFT

59/23 **Finance and Performance Chair Highlight Report**

AN presented this highlight report with an update from the Finance and Performance Committee meetings held on 4 and 26 April 2023.The contents of the report were reviewed and noted by the Board.

Discussion took place on whether the financial impact of industrial action could be identified, and it was noted that the impact on elective activity, which was minimised, could be quantified, with the Chief Operating Officer reinforcing the continued need to drive productivity. The Director of Workforce and OD noted that there had been an impact on bank and agency spend. The Chief Executive noted that continued industrial action would have a longer-term impact and remained a risk.

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

60/23 **Month 12 Financial Summary**

The Director of Finance presented the financial position as reported at the end of month 12 (March 2023) and noted that, subject to audit, the Trust had delivered the 2022/23 financial plan, a £17.34M deficit with a £0.01M favourable variance from plan, achieved efficiency savings of £20M as planned, with internal capital spent as planned.

An overspend in relation to agency expenditure was noted, which had no negative impact and a more realistic target has been planned for 2023/24.

It was noted, and shown in the papers, that the year-end accounts will show a £10M deficit and not the £17M deficit agreed with NHS England. The difference relates to impairments and revaluation and the benefit is not included within the agreed planned deficit with NHS England.

OUTCOME: The Board **NOTED** the Month 12 Financial Summary as at March 2023.

61/23 Quality Committee Chair Highlight Report

KH presented the Chair's highlight report from the Quality Committee on behalf of DS. The contents of the report were reviewed and noted by the Board.

OUTCOME: The Board **APPROVED** the Quality Committee Chair Highlight Report

62/23 Quality Report

The Quality Report was presented which provided oversight of the quality agenda, assurance on key quality and patient experience outcomes and emerging issues for consideration.

The Medical Director highlighted the following: good performance, changes to the hospital acquired infection quality priority as a result of Covid testing; continued challenges with C difficile infections; links between waits in the Emergency Department (ED) and mortality;, mortality metrics being largely within the expected rates; continued good complaints performance; work to support nutrition and hydration. He noted that two of the five never events reported were being reviewed as to whether these constitute a never event.

The Chief Nurse highlighted the plan to focus on learning from complaints, and progression of sepsis quality improvement work in ED despite significant operational pressures

In response to a query from the Chair about robust recording of compliments the Chief Nurse advised she would consider the recording of compliments as part of her review of quality metrics in the Integrated Performance Report (IPR). Christine Mills queried if we could ask patients to let us know if something is not working without making a complaint and the Chief Nurse advised that she also would have a conversation about how to do this.

Discussion also took place about patient safety incident levels (TB). The new IPR report will help understand whether this was normal variation and the Chief Nurse agreed to review the increase in patient safety incidents in March. NB queried if, for patient safety incidents, there was any relation between slips, trips and falls incidents and pressure ulcers. The Chief Nurse noted that a falls collaborative is in place reporting to the Quality Committee, but that it is not currently assured and work on risk assessment is underway. The Chief Nurse added that pressure ulcers and falls incidents are reducing but will remain the predominant type of hospital patient safety incident.

Discussion also took place on the increasing demand on legal services and implications of this. The Chief Nurse advised that work is underway using the Getting It Right First Time Litigation Data Pack to triangulate claims, inquests and incidents to improve patient safety from learning. In terms of legal resource, the Chief Nurse noted that the team was working through a backlog of cases due to the pandemic and working arrangements with the Coroner's Office and a business case had been submitted to the Business Case Approvals Group for resource given the need.

CHAIR APPROVED DRAFT

AN commented on the rich patient experience data from surveys and carers in the report.

OUTCOME: The Board **NOTED** the Quality Report

63/32 **Workforce Committee Chair Highlight Report**

KH presented the Chair's highlight report from the Workforce Committee. The contents of the report were reviewed and noted by the Board.

AN commented on positive progress recruiting new staff and noted that the Trust has not met the target for staffing. He queried whether there was any learning in setting targets for recruitment. KH commented on success with international recruitment. LR explained that the vacancy position was determined by the workforce model and could not be set at a lower level, despite there being known challenges recruiting to such vacancies. KH noted the importance of reconfiguring roles given recruitment challenges.

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

64/23 **Audit and Risk Committee Chair Highlight Report**

NB presented the Audit and Risk Committee Chair Highlight Report from the meeting held on 26 April 2023. He noted the Committee had received positive assurance about completion of internal audit recommendations by 31 March 2023.

OUTCOME: The Board **NOTED** the Audit and Risk Committee Chair Highlight Report.

65/23 **Integrated Performance Report**

The Chief Operating Officer presented the 2022/23 year-end Integrated Performance Report. The Chair congratulated colleagues for their hard work in delivering care for patients. The Chief Operating Officer commented that colleagues had worked well together during recent industrial action.

OUTCOME: The Board **NOTED** the Integrated Performance Report for March 2023.

66/23 **Staff Survey Results and Action Plan**

The Chair welcomed the following to the meeting:

- Nikki Hosty, Assistant Director of Human Resources
- Diane Tinker, Director of Midwifery
- Sarah Wallwork, Matron, General Surgery

Nikki Hosty presented the 2022 national and local Staff Survey results and actions developed in response. The Trust had a 44% response rate (4% lower than in 2021), with a 46% national response rate and a 6.8/10 engagement score in line with the national average (+0.1 from 2021). Detail was shared on the top and bottom five scores and the most improved and most declined scores. The increase in the "we are always learning" element was welcomed. Benchmarking information against West Yorkshire Trusts was shared. It was noted the Trust has seen improvements across all People Promise Themes, compared to improvement in only two of the seven themes when benchmarked against data for the North East and Yorkshire region.

It was noted the Trust had a strong focus on the People agenda in 2022, including refreshing the People Strategy, with areas summarised in the presentation.

CHAIR APPROVED DRAFT

Hotspot areas for development were shared and it was noted an Executive Director buddy arrangement was in place to coach and support the development of an action plan for each area. The Trust's "grow our own" approach and leadership development work was highlighted, and it was noted that a Leadership Conference had been held recently. The main areas showing improvement were appraisal and development.

In terms of next steps five high impact actions were shared. Oversight of progress with actions was noted to be via the Workforce Committee. Plans to introduce a shadow Board at the end of June were also noted. The Board response, with One Culture of Care a guiding principle and support for hotspot areas, was recognised.

Diane Tinker shared information on how the midwifery team had improved their engagement score through staff engagement, a "Civility Saves Lives" campaign, listening to colleagues about areas for quality improvements (e.g. transition of care)) and supporting this work, new roles to strengthen services and regular communication and updates so that staff felt involved in their service. A Safety champion had supported and encouraged staff to complete the staff survey.

Sarah Wallwork described a range of engagement work that had taken place including:

- engagement with the endoscopy team, improving communication and aligning expectations across the wider team
- improvement projects identified from a staff survey as part of accreditation
- multi-disciplinary time out sessions in General Surgery (e.g. Bariatric team)
- junior doctor inductions which ensured all IT needs were met and doctors felt part of the team immediately
- joint appraisals (e.g. for physicians associates and specialist nurses), with positive feedback on career development and service delivery
- inclusive Directorate management team meetings
- General Manager weekly catch up, monthly ward managers meeting
- Head and Neck – increased communication, a weekly newsletter and meet the team information and pictures for new starters.

The Chair thanked the presenters for sharing their information on what had been done to make improvements and commented on the need to consider how this could be shared more widely.

Discussion took place on:
- the value of encouraging all colleagues to complete the staff survey and the importance of One Culture of Care (KH)
- how to improve the staff survey score which indicated immediate managers did not understand problems (TB) - in response the need to support line managers and have a shared approach to problems was noted
- how the people centred leadership programme was key to addressing the challenges (AN) - the Director of Workforce and OD confirmed this and described a range of information to help colleagues understand what it means to be a manager.

OUTCOME: The Board **NOTED** the Staff Survey Results and **ENDORSED** the high impact actions.

CHAIR APPROVED DRAFT

67/23 Guardian of Safe Working Hours Quarterly Report and Annual Report 2022/2023

Dr Shiva Deep Sukumar presented the quarterly report from December 2022 to February 2023 and annual report, which gave assurance that doctors in training are safely rostered, and their working hours are compliant with the Junior Doctor's contract 2016 and terms and conditions of service.

It was noted that exception reports were mostly from the Surgical and Anaesthetics Division (21) and all were resolved, mostly by payment or time off in lieu. Trainee vacancies were mainly filled with any gaps in rotas filled with bank doctors. It was noted that planning on how to meet demand during recent junior doctor industrial action had taken place and more information on the impact and management of industrial would be provided in the next report to the Board.

The Deputy Chief Executive commented on the comprehensiveness of both reports and that it showed a willingness to learn and drive improvements.

The Chair gave thanks to Dr Shiva Deep Sukumar and for the assurance given in the reports.

OUTCOME: The Board **NOTED** the Quarterly and Annual Guardian of Safe Working Hours Report.

68/23 High Level Risk Register

The Director of Corporate Affairs presented this report which gave an overview of risks scoring 15 or above and themes. She. noted that there had been a recent deep dive on risk by the Audit and Risk Committee. She commented that work was ongoing to confirm and challenge risks scoring 15 or above and that consequently the high number of risks detailed in the paper, 57, may not be accurate.

NB confirmed that a detailed review had taken place in the Audit and Risk Committee and that a number of risks can be brought into an overarching risk (e.g. staffing), reducing the number of individual risks.

OUTCOME: The Board **APPROVED** the High Level Risk Register.

69/23 Fire Strategy 2021-2026 (Update)

The Chief Operating Officer noted the key points in relation to progress with the delivery of the Trust's Fire Strategy, with 75% of the 101 actions completed and 25 still in progress. It was noted that ten of these actions linked to detailed reports on the external façade of buildings following fire safety regulations introduced in 2022. It was noted that smoke clearance in the sub-basement at Huddersfield Royal Infirmary (HRI) was an issue and the report of a feasibility study will be available in one month, with implications considered at that point.

The Deputy Chief Executive and Director of Transformation and Partnerships clarified that the cladding at HRI, which is reliant on reconfiguration investment, needs replacing for structural rather than fire safety reasons and that reconfiguration was needed to decant wards to enable the required fire compartmentation work to be undertaken.

The Chief Operating Officer noted there were mitigations via ongoing assessment in place. The Managing Director of CHS commented that six monthly inspections had been reduced to an annual inspection and work is ongoing with abseilers looking at the windows, cladding and whether any additional mastic is needed.

CHAIR APPROVED DRAFT

OUTCOME: The Board **NOTED** the updated Fire Strategy 2021-2026.

70/23 Risk Management Policy

The Director of Corporate Affairs advised that the Risk Management Policy had been reviewed by the Audit and Risk Committee. Details of key performance indicators will be added and reviewed at the July meeting of the Audit and Risk Committee.

It was noted that a Risk Management Strategy will also be presented for approval at a future date.

AN queried whether there was a need for the Finance and Performance Committee to review the very high scoring high level risks. The Director of Corporate Affairs responded that Committees review the Board Assurance Framework risks which detail the related high level risks and Chairs can request more information on these risks.

The Director of Corporate Affairs noted that the impact in the risk description needs to clearly identify those risks which have a clinical impact rather than a financial or performance impact, where this is appropriate (e.g. theatres) and this will form part of the confirm and challenge work.

NB suggested that once the work on the high level risk register is complete Board Committee Chairs could have a further conversation regarding this.

The Chair commented that once the high level risk register review is complete and the internal audit report on risk management is available this be brought to a future Board meeting to allow for a full discussion.

OUTCOME: The Board **RATIFIED** the Risk Management Policy.

71/23 Health and Safety Annual Workplan and CHFT Health and Safety Policy.

The Director of Workforce and OD introduced this item and thanked Richard Hill for the solid foundations put in place for Health and Safety over the last two years. She noted that the Director lead for Health and Safety had recently changed and was now the Chief Operating Officer.

Richard Hill, Head of Health and Safety, presented the revised Health and Safety Policy, approved by the Audit and Risk Committee for recommendation to the Board. The revised policy has a clearer description of roles and responsibilities for health and safety and a statement of intent signed by the Chief Executive has been added. Reference to a new health and safety dashboard has been added that provides compliance data for the Health and Safety Committee. The Policy uses NHS Workplace Health and Safety standards as a benchmark, standards which have been set by the Health and Safety Executive (HSE) and NHS. The Trust has been benchmarking and rating itself against these standards over the last 18 months to achieve amber /green ratings.

An action plan is in place for 2023/24. Attention was drawn to the need for work on violence and aggression in 2023/24. A new Security Policy is being developed which will give assurance about the Trust approach. De-escalation training for staff was highlighted as key to help manage violence and aggression. It was also noted that sharps injuries were increasing and there is focused work on this.

CHAIR APPROVED DRAFT

The Managing Director for CHS commented that violence and aggression was a constant theme highlighted by Directors of Estates. The Chief Operating Officer noted that a multi-disciplinary team approach at ward and departmental level was required and that this was not a matter solely for the security team.

The Chief Executive commented that conversations were in train regarding de-escalation and Richard Hill explained that security audits and risk assessments on wards were taking place over the next six weeks.

KH suggested it would be helpful if the dashboard benchmarked the Trust against other Trusts as well as the standards to better understand the Trust position. RH advised it was difficult to get such compliance data from other Trusts but that he would explore this.

AN noted the policy references the former Trust ten year strategy and that this should be amended to reflect the current five year strategy. Any other comments on the policy were to be sent to the Chief Operating Officer.

It was confirmed that the Board Health and Safety Champion was the Chief Operating Officer.

OUTCOME: The Board **APPROVED** the Health and Safety Annual Workplan and CHFT Health and Safety Policy.

72/23 Governance Report

The Company Secretary presented the Governance report, which supported the 2022/23 year-end annual reporting process.

The Board was asked to support proposed changes to the Trust Constitution and Standing Orders of the Council of Governors that the Council of Governors, at its meeting on 20 April 2023, had approved. The changes were detailed in the paper, several which were related to 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. A minor change to wording at section 19.1 was also noted and was to be amended.

As noted in relation to Health and Safety the Director lead change in the Scheme of Delegation was amended to reflect this moving to the Chief Operating Officer.

OUTCOME: The Board **APPROVED** the:

- Content of the self-certification documents for the signature of the following declarations for 2022/23: compliance with governance requirements (condition FT 4(8)), compliance with provider licence, (condition G 6(3)) and having the required resources for the next 12 months, (condition S7 (CoS7 (3))
- Board of Directors Attendance Register for 2022/23
- Updates to the Trust Constitution and Standing Orders of the Council of Governors
- Update to Section 31 of the Scheme of Delegation
- Board of Directors Workplan for 2023-2024

CHAIR APPROVED DRAFT

73/23 Review of Board Sub-Committee Terms of Reference

The Company Secretary confirmed that the terms of reference had been reviewed by the Nomination and Remuneration Committee of the Board of Directors.

OUTCOME: The Board **APPROVED** the Nomination and Remuneration (Board) Sub Committee Terms of Reference.

74/23 Items for Review Room

- High Level Risk Report
- Partnership papers: Kirklees Health and Care Partnership and Calderdale Cares Partnership

The following minutes of sub-committee meetings were provided for assurance:
- Finance and Performance Committee 6 December 2022, 10 January, 7 February, 28 February, 4 April 2023
- Quality Committee 14 November 2022, 16 January, 20 February, 20 March 2023.
- Workforce Committee 14 February 2023
- Audit and Risk Committee 31 January 2023

OUTCOME: The Board **RECEIVED** the items listed above which were available in the Review room.

75/23 Date and time of next meeting
The Chair formally thanked the Board of Directors, colleagues and governors for their attendance and closed the meeting at 1.15 pm.

Date: Thursday 6 July 2023
Time: 10 am (post meeting time amended to 9 am)
Venue: Forum Room 1A & 1B, Learning Centre, Sub-Basement, Huddersfield Royal Infirmary

76/23 Any Other Business

The Chair shared details of the Trust Charity event on 9 July 2023, Big Hospital Walk and invited colleagues to join her.

The Chair advised that a Chair's action in relation to capital investment for the discharge hub had been taken and the related papers will be presented to the July meeting of the Board of Directors.

CHAIR APPROVED DRAFT

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC) 2023

Position as at: 31.05.23

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

DATE DISCUSSED	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
4.05.23. 71/23	**Health and Safety Policy**	Chief Operating Officer	Amendment to reference re Trust 5 year Strategy and any other comments received	19 May 2023		
4.05.23. 70/23	**Risk Management Policy**	Director of Corporate Affairs	Review of high level risk register and internal audit plan on risk management	7 March 2024		
4.05.23. 62/23	**Quality Report** i. Recording of Compliments **ii.** Patient feedback if something is not working **iii.** Review patient safety incident levels for March 2023	Chief Nurse	i. Review compliment recording within Integrate Performance Report Quality metrics ii. Have a conversation to explore how to capture patient views if something is not working iii. Review if there were any concerns due to increased number of Patient Safety Incidents in March 2023	6 July 2023		
4.05.23. 57/23	**Annual Strategic Plan Final Year Progress Report**	Deputy Chief Executive and Director of Transformation and Partnerships	Identify quantifiable measures for objectives in the year end report	7 September 2023		

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC) 2023

Position as at: 31.05.23

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

DATE DISCUSSED	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED

Date of Meeting:	6 July 2023
Meeting:	Board of Directors
Title:	Chair's Update
Author:	Helen Hirst, Chair
Sponsoring Director:	N/A
Previous Forums:	None

Purpose of the Report

To update the Board on the actions and activity of the Chair.

Key Points to Note

The enclosed report details information on key issues and activities the Trust Chair has been involved in over recent months within the Trust, with local system partners and regional and national work.

EQIA – Equality Impact Assessment

The attached paper is for information only and does not disadvantage individuals or groups negatively.

Recommendation

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

Chair's Report to the Board

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

1. **Trust activities**

It was lovely to meet some of the new governors at their first induction session and a few more at the Governor Appreciation Lunch. This lunch was a great opportunity for those who have left over the past couple of years together with those whose term ends this summer to meet with colleagues, non-executive directors and other governors to celebrate being a governor in the Trust and for us to say thank you for service to the Trust.

And on the subject of 'appreciation' I enjoyed a couple of hospital walk arounds with representatives from Workforce and OD during the Trust Appreciation Week, where I met with colleagues and heard first hand some of the challenges they were facing. It was a particularly hot week and there were certainly challenges in keeping patients and colleagues cool.

The Trust, in partnership with the University of Huddersfield held a Nursing and Midwifery Conference: Nursing and Midwifery Practice in the 21st Century in May. It was a great day with a brilliant turnout from colleagues across many disciplines in the Trust who heard academic and clinical speakers, including some of our own leaders and the Chief Nurse for North East and Yorkshire, Margaret Kitching. Lindsay Rudge, Chief Nurse and Dr Sara Eastburn, Acting Head of Department (and a stakeholder governor with the Trust) led the conference which everyone felt had been a great success.

On the development front we have had two strategic development events – one with the Board where we focused on the Trust's quality improvement methodology and Board effectiveness and the second with the Board and Council of Governors where we discussed the latest on reconfiguration and strategic partnerships. Along with Executive colleagues I participated in media training which was excellent. I also chaired the first, in a long while, of our member engagement events 'Health Matters' where we invite the Trust's members to hear about the latest developments. This particular one was focused on Cancer and colleagues Caroline Summers, lead cancer nurse, Lucy Beckingham, faster diagnosis programme manager and Nicky Hill who leads on prehabilitation gave informative presentations on the latest innovations, holistic needs assessments and personalised care and support. I met with the latest group of healthcare apprentices to talk to them about opportunities and finally I had the opportunity to attend a fabulous talk, arranged by Neeraj Bhasin, Deputy Medical Director, for the senior medical workforce by Jane Powell who is the President of Yorkshire County Cricket Club as well as a high accomplished sportswoman competing and coaching to Olympic level.

I also met with the people who run the hospital radio in Calderdale who are keen to explore more opportunities post pandemic.

2. **Health and Care System**

I was unable to attend the May Calderdale Cares Partnership Board but did attend a development session of the Partnership in June which was focused on community health and wellbeing and health and the economy.

West Yorkshire Partnership Board meeting (available to watch online) majored on dentistry and oral health with some great insight from Healthwatch. There were also three related items for discussion – inequalities for Black, Asian and Minority Ethic communities and colleagues, data insights on race equality and social determinants of health and inclusion.

I attended the WYAAT senior leadership development programme for aspiring executive leaders across acute providers in West Yorkshire and Harrogate. I was invited to talk about my own career journey. Brendan along with a number of other Chief Executives and Sal Uka, Medical lead for WYAAT and a consultant here at CHFT were also speaking at the session.

Brendan and I along with a number of other CHFT colleagues attended the first in person West Yorkshire community health services collaborative meeting at Brighouse. (It was at the end of April after the deadline for my May Board report). The session demonstrated the breadth of providers involved in community health services including a number of trusts who provide acute and community services. Being clear about scope is one challenge for the collaborative.

At the latest Yorkshire and Humber Chairs' Meeting we heard from Joe Harrison about the latest developments on the NHS App; Em Wilkinson-Brice, National Director of People about the Messenger Review and the soon to be published Workforce Strategy; Richard Barker, Regional Director and Sir Julian Hartley, NHS Providers on the current challenges.

Other system/ partner meetings and events include one to ones with Cathy Elliot, WY ICB Chair, Cllr Pandor, Leader of Kirklees Council and attendance at the Kirklees Civic Dinner, with Brendan, Emma Kovaleski and Vicky Pickles, where the new Mayor of Kirklees was welcomed.

National/other

I was one of the speakers at the ten-year anniversary of the Kings Fund collaborative leadership programme alumni event.

Along with Paul Knight, Consultant and Clinical Lead for Organ Donation and Jayne Greenhalgh, Specialist Nurse Organ Donation, I attended the national organ donation meeting for Trusts with similar donation activity to ourselves. It was the first time I have been to one of these and it really opened my eyes as to the complexity of organ donation and transplant work.

The national NHS conference was held in Manchester in June and this provided an opportunity to hear national NHS speakers and political leaders. Without doubt the highlight of the conference was the George Webster session. George is the first presenter with Down Syndrome on CBeebies and has written a book called This is Me. His talk was about us all being unique people and focusing on what we can do rather than what we can't.

Helen Hirst
Chair
29 June 2023

CHAIR'S HIGHLIGHT REPORT
to the Board of Directors

Committee Name:	Charitable Funds Committee
Committee Chair:	Helen Hirst
Date(s) of meeting:	10 May 2023
Date of Board meeting this report is to be presented:	6 July 2023

ACKNOWLEDGE

The Committee received an insightful presentation about the pre-bereavement project which had been funded by the Charity's palliative care fund.

The Charity has been chosen as one of two charities for the Kirklees Mayoral year. This provides a great opportunity for fundraising and the profile of the Charity.

ASSURE

The Committee received assurance from the Charity Manager about the lessons learned during the last year. Future reporting will concentrate on activity undertaken.

The finance report and the annual accounts were reviewed.

AWARE

The Committee agreed to fund the Bereavement Support Service for a further six months but with the proviso that there is a review about the long term sustainability of this service.

Vicky Pickles is completing the review of governance and the terms of reference and membership in particular. This will come to the next meeting for sign off.

Date of Meeting:	6 July 2023
Meeting:	Public Meeting of the Trust Board
Title of report:	Chief Executive's Report
Author:	Victoria Pickles, Director of Corporate Affairs
Sponsor:	Brendan Brown, Chief Executive
Previous Forums:	None

Actions Requested:
- Consider this report as assurance and progress against both the local and national agenda, and the Trust's strategic priorities.

Purpose of the Report

This report provides a focused update on the Trust's response to specific elements of its service delivery and the evolving health and care landscape.

Key Points to Note

- The meeting takes place during the week of the 75th anniversary of the NHS. It is a time to reflect how far the NHS has come over that time and the progress and innovation demonstrated by our Trust
- We continue to perform well, despite external challenges, including the impact of further industrial action, planned for later in July
- Our financial position remains challenging and is impacted by the financial performance of the wider West Yorkshire system
- The number of positive achievements, areas of high-quality patient care, and successes of our colleagues demonstrate compassionate care in action.

EQIA – Equality Impact Assessment

There are no differential equality impacts resulting from the areas of work highlighted in this report at this point.

Recommendation

The Board of Directors are requested to receive this paper as assurance and progress against both the local and national agenda, and as an update against leadership responsibilities within the CEO portfolio.

Calderdale and Huddersfield NHS Foundation Trust
Chief Executive's Report
28 June 2023

1. Introduction

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

1.2. This week we celebrate 75 years of the NHS. Since 1948, the NHS has always evolved and adapted to meet the needs of each successive generation. From Britain's first kidney transplant in 1960, to Europe's first liver transplant in 1968, the world's first CT scan on a patient in 1971, revolutionising the way doctors examine the body, to the world's first test-tube baby born in 1978. The NHS has delivered huge medical advances, pioneering new treatments, and genomic revolutions.

1.3. As the Board of Calderdale and Huddersfield Foundation NHS Trust we have much to celebrate and be proud of. In this report I set out a range of achievements, high performance and innovation that reflect the NHS at 75 and our ambitions for the future. Of course, this is set against a backdrop of a challenging social and economic climate, and an international recovery from the global pandemic. How we pull together to deliver outstanding compassionate care for our patients and each other is what makes me proud to be the Chief Executive of this Trust and we should take this time of national celebration of the NHS to reflect on just how much our colleagues achieve every day.

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

2.1. Colleagues will see from the new Integrated Performance Report (IPR) on today's agenda that we continue to perform well against key national targets. We are ahead of our trajectory for the numbers of patients having an elective procedure who have been waiting 40, 52 or 65 weeks. It is important that we continue to focus on this as it is a key patient experience and outcome measure. We are seeing patients quickly for most diagnostics, although we have challenges in Echo and Neurophysiology and there is an increased focus on these modalities to reduce waiting times. Cancer performance continues to be strong, and we remain one of the top trusts nationally in this area.

2.2. In the IPR our performance for emergency department waiting times was 71.22% against a national target of 76% to be achieved by the end of March. I am pleased to confirm that at the time of writing this report we have seen performance improve to over 76% despite continued high numbers of attendances (on average 545 patients per day). Bed occupancy is still high and therefore there are longs wait for beds coupled with an increased acuity for those patients admitted. We are also continuing to work with partners in social care to reduce the number of patients on the transfer of care list as this remains significantly higher than our trajectory and contributes to our high bed occupancy.

2.3. Our community services remain extremely busy and the waiting list for community services is high, but we are close to meeting the two-hour target for community response.

2.4. The agenda for this meeting looks at both our areas of performance and our areas of risk. These are: medical and nurse staffing across the Trust; the challenging financial position; and progress with the transformation and reconfiguration of our services. It is important that we continue to focus on the work to manage and mitigate these risks.

2.5. On 7th and 8th June, the Care Quality Commission undertook its inspection of our maternity services as part of its national programme of focused inspections. Initial feedback highlighted areas of good practice including:
- Current work around health inequalities related to postcode, levels of deprivation and ethnicity
- Specialist support offered around surrogacy within the service
- Rainbow Clinic and how this links with the Bereavement Midwife service
- Safeguarding processes and linking with fathers with Mental Health issues
- Breastmilk Donation Bank

Staffing remains an issue within the service, although we have robust recruitment plans in place and innovation in progress in transforming traditional roles, and it is recognised that this is a national workforce problem. We await the final CQC report and will respond to any recommendations or required actions identified.

2.6. Last week we launched our Well Organised Ward (WOW) programme in each of the divisions. The focus of these sessions is on four key fundamentals that support the effective running of a ward, these being:
- Board Rounds
- Plan for every Patient
- Estimated date for discharge
- A multi-disciplinary team approach to all the above

The programme is focused on working through how we can achieve these fundamental measures consistently, using ideas from those working on the wards and being clear on the support that may be required. We know that, through the pandemic, the way we work was challenged and these sessions are focused on working together to get back to those key fundamentals, which, when we get right, make a huge difference to the experience and outcomes for patients, and the experience of colleagues.

2.7. On 6 June, a small team from CHFT, including Jo Scadden-Smith, Speech and Language Therapy Assistant and David Britton Assistant Director of Nursing for Medicine, presented to MPs in Parliament about the importance of carers' visitation rights in hospitals. They spoke about their work to launch the Trust's Keep Carers Caring campaign, and the impact it has had on the wellbeing of patients and carers in the Trust. They were invited by John's Campaign to speak before MPs ahead of the first hearing of a Private Members' Bill in support of policy change that, if passed, would legally entitle patients to always have a carer with them.The five-minute verbal presentation was met with applause from cross-party MPs, with Care Minister, Helen Whately, praising CHFT's "phenomenal best practice". She said: "the whole health and care system should learn from the work happening at CHFT". MP, Tracy Crouch, thanked CHFT for its work and said: "The value to those who care is immeasurable. Keep Carers Caring should be rolled out across the NHS." This is a real example of learning from complaints and incidents and using this learning to make a real and marked difference for our patients.

2.8. The BLOSM service has been nominated for a Nursing Times Award. BLOSM aims to give all patients who attend the emergency department who have experienced adverse life events; such as abuse or violence, access to appropriate community support. This is fantastic recognition of an innovative and effective service which uses the principles of trauma informed practice to help deliver care and educate colleagues.

2.9. Our Pharmacy Led Safari Discharge has been in the national spotlight again recently. Our Deputy Clinical Director of Pharmacy, Katherine Cullen gave a presentation on the service at the biggest annual pharmacy conference in the UK - the Clinical Pharmacy Congress at the London Excel. The service has also featured as a case study in the latest NHS England guidance on "Optimising discharge medication to improve patient flow".

2.10. Our endoscopy teams have gained the prestigious JAG (Joint Advisory Group) accreditation again from the Royal College of Physicians. It's a credit to all colleagues involved, as this accreditation demonstrates that high standards in the units and excellent patient care continue to be met.

2.11. A new Tobacco Dependency Service is now available at both hospitals to support inpatients coping with nicotine withdrawal. Two tobacco dependence advisors support patients with nicotine replacement therapy during their stay in hospital. This is part of the NHS long term plan for tobacco services which states that by 2023/24, NHS-funded tobacco treatment services will be offered to:

- anyone admitted overnight to hospital who smokes
- pregnant women and members of their household
- long-term users of specialist mental health services

3. Transforming services and population outcomes

3.1. Ahead of the NHS's 75th birthday, the NHS Assembly has developed an independent report: The NHS In England at 75: priorities for the future. The aim of this report is to help the NHS, nationally and locally plan how to respond to long term opportunities and challenges. It is informed by feedback from thousands of people who contributed to a rapid process of engagement (with patients, carers, staff, and partners). The Trust took part in this engagement and provided feedback as part of the process. The findings are also intended to help inform the work of NHS England to develop strategies for the years ahead in partnership with Integrated Care Systems.

3.2. NHS England has approved a business case to build an £8m Community Diagnostic Centre at Broad Street Plaza, Halifax. It is hoped that the new centre will be open by Spring 2024. Community Diagnostic Centres are part of a national programme to increase access to diagnostic tests, such as CT scanning, phlebotomy, and cardio-respiratory services in the community. In NHSE's response to our business case, they included feedback about how confident they were in our ability to deliver and how impressed they were with our vision for and commitment to services for the local population.

3.3. Our wider reconfiguration plans continue, with the new Accident and Emergency Department at Huddersfield Royal Infirmary due to be handed over to the Trust ahead of the next Board meeting. Detailed plans for transition into the new premises, open days and formal opening events are being finalised and will be shared with Board colleagues in the next few weeks.

3.4. Our first robot surgery "could not have gone better" - with our first patient up and on his way home less than 48 hours later. Surgeons from the Trust, Tamsyn Grey and Muhammed Hussain, undertook training in Belgium using a new Versius robot (which is also the first in Yorkshire). The system is operated by a surgeon using a 3D console monitor seated in theatre, with robotic arms at the patient's side along with a scrub nurse and assistant. Robotic surgery presents an enhanced and much improved method of manipulating instruments for surgeons and will improve recovery time for patients. The team will also have access to collect data to monitor their personal performance and share learning with others.

3.5. CHFT has recently been recognised in national and local press coverage for being one of only two trusts nationally to use Artificial Intelligence (AI) to dramatically speed up lung cancer diagnoses. Previously it would take up to seven days to report on a chest x-ray for suspected lung cancer, but now, in some cases, we can return a diagnosis in seven seconds.

3.6. In June, colleagues from our Pathology Teams were at Eureka! The National Children's Museum in Halifax as part of National Pathology Week. Children were encouraged to get hands-on to learn about the importance of pathology through playful activities, including:

- Playing with (fake) blood in blood bags
- Learning where different kinds of bugs hide on the body
- Learning about worms and the importance of handwashing
- Using a microscope to look at different tissue types

Pathology week seeks to highlight the important contribution pathologists make to healthcare. The work with Eureka! also reinforces our role as an anchor partner in our local places.

4. **Inclusive workforce and local employment**

4.1. Board members will be aware that industrial action across the public sector continues. Junior doctors have announced their longest period of industrial action to date, running from 13th to 18th July. This will be followed by two days of strikes from consultants on 20th and 21st July. The Royal College of Nursing did not achieve a mandate for further strike action in England, after turnout in the most recent ballot did not reach the required threshold. At the time of writing the report we are awaiting the result of the ballot of the Royal Society of Radiographers. Our teams are planning to mitigate the impact of industrial action as far as possible, and whilst the scale of the impact is not known at this time, there is no doubt that it will impact on our patients, particularly those awaiting an elective procedure.

4.2. At the time of writing this report, we are also awaiting the national workforce plan from the Department of Health and Social Care, due to be published on 30 June 2023. The plan is expected to lay out the government's strategy regarding recruitment, retention, and training of NHS staff.

4.3. June saw a raft of celebration weeks, months and days. As well as 75 years of the NHS, this month also saw 75 years since the HMT Empire Windrush docked in Tilbury, Essex, on 22 June 1948, carrying passengers from the Caribbean to fill labour shortages in the UK. The Trust celebrated colleagues and patients who are descendants of the Windrush generation by hoisting a flag and holding special prayer and music events at both sites. There was also a special Windrush menu available on the day. The diversity and experience of our colleagues is part of our one culture of care, and it is important to recognise the contribution, experience and impact these colleagues have on our services.

4.4. We also celebrated Armed Forces Day. The Trust employs several colleagues who are ex-military or who serve in cadet or volunteer forces. The values held by members of the armed forces community closely align to the NHS values, especially around service, commitment, leadership and respect. At the Trust we are proud to hold the Armed Forces silver award status, which means we are committed to support the Armed Forces community, including existing or prospective employees who are members of the community.

4.5. We also took part in the national estates and facilities day where we recognise and celebrate the importance of these services on the smooth running of our services and their contribution to the compassionate care we give to our patients.

4.6. It has also been Volunteer Week and colleagues will hear about the important work of our volunteers at the board meeting. Volunteers have a huge part to play in the experience of our patients, acting as guides, support on wards and a friendly ear to those in hospital. The celebrations for Volunteer Week culminated in our very first 'Volunteer of the Month' Award, implemented to recognise how integral our volunteers are to both our patients and colleagues. Volunteer Ward Helper, Liz Kelleghan, was the first recipient of the award, after being nominated by the entire team in the Chemotherapy Department.

4.7. As part of the NHS 75 celebrations nationally, a film crew from BBC Look North has been spending time with colleagues in our estates and facilities services, our reception colleagues and volunteers, to focus on the significant contribution people in these roles have on the NHS. I want to give a special mention to HRI Switchboard operator, Richard Oldroyd who marked 50 years working in the NHS in June, most of it at CHFT.

4.8. This year's Project SEARCH interns graduated on Thursday 29th June. The programme which supports young people with a learning difficulty into paid employment continues to be a real success for the Trust.

4.9. Finally for this section, congratulations to Nursing Associate, Vicky Atkinson, has scooped the award for Level 5 Apprentice of the Year at the University of Huddersfield Apprenticeship Awards.

5. Financial, economic, and environmental sustainability

5.1. The NHS system plan to break-even contains high levels of efficiency requirements to deliver a total of around £350m across West Yorkshire. Inflationary pressures, costs of industrial action and risks around elective recovery all have potential impacts on system resources. Within this the Trust has placed itself into 'financial turnaround' with an ambitious efficiency programme to meet our stretch financial target. Colleagues will see from the finance report on this agenda that we are reporting a £4.58m deficit, a £0.39m adverse variance from plan. The in-month position is a deficit of £1.74m, a £0.21m adverse variance. These figures are impacted by the pressures described above as well as higher than expected Utilities costs. These pressures were offset by early delivery of other efficiencies and a higher than planned vacancy rate. The efficiency plan has significant levels of risk associated with it, particularly in relation to ongoing bed pressures, as set out in the Board Assurance Framework. It is important that we continue to have significant focus on our financial position, and its relationship with elective and non-elective activity impact.

5.2. During July there will be a focus on sustainability as part of sustainability week. The latest Green Plan update is included in the papers for this meeting and outlines the Trust's ambition for sustainability to 2026. There is some really pleasing progress set out in this report, confirming that since the baseline year (2013/14) the Trust's CO_2e emissions have reduced by almost 60%. Sustainability will form a key part of our reconfiguration plans and have the potential to make the Trust a real leader in this area.

5.3. Calderdale Cares Partnership, a committee of the NHS West Yorkshire Integrated Care Board, has appointed Jo Bibby to the role of Independent Chair. Jo is the Director of Health at the Health Foundation, responsible for leading the Foundation's Healthy Lives strategy. She has led on areas of health inequalities, patient safety and person-centred care. She is also a trustee at the Centre for Homelessness Impact and has over a decade of experience as a non-executive director at Salford NHS Foundation Trust and Rotherham NHS Foundation Trust. Jo previously worked with the Trust as the Director for the Calderdale and Kirklees Integrated Service Strategy.

6. Recommendations

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

Date of Meeting:	6 July 2023
Meeting:	Board of Directors
Title:	Sustainability: CHFT Green Plan & Travel Plan Progress Update
Author:	Stuart Sugarman
Sponsoring Director:	Stuart Sugarman

Purpose of the Report

- For information to note progress with sustainability

Key Points to Note

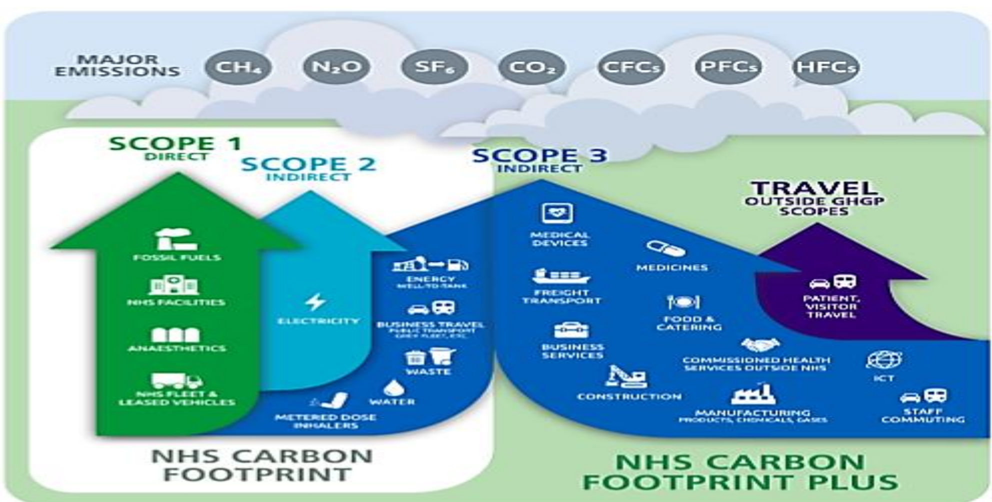
This report provides an update in relation to the CHFT Green Plan and the Travel Plan.

The CHFT Green Plan outlines the Trust's ambition for sustainability to 2026. The Green Plan was first approved by Transformation Programme Board (TPB) in March 2021, and delivery is managed by CHS. Progress is monitored through the Green Planning sub-group and the TPB.

The Green Plan is a Board approved, live strategy document outlining the organisation 's aims, objectives, and delivery plans for sustainable development. This includes impl ementation of the NHS Long Term plan deliverables. It outlines the following targets fo r carbon reduction:

1. **Net Zero for the NHS carbon footprint (Scope 1&2 emissions)**
   - 100% reduction in direct carbon emissions by 2040
   - An 80% reduction to be achieved by 2032 latest (interim target)

2. **Net Zero for the NHS carbon footprint plus (scope 3 including patient and visitor travel)**
   - 100% reduction in indirect/ supply chain emissions by 2045
   - 80% reduction achieved by 2039 latest (interim target)



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

Summary
This paper provides a progress update to the Board of CHFT relating to the Calderdale and Huddersfield Foundation Trust (CHFT) Green Plan and Sustainability Action Plan (SAP) and work with partners on the wider sustainability agenda. The SAP outlines individual actions across 11 key themes. In total there are 206 interventions proposed. 159 of these actions are designated as complete. This is an improvement of 11 in the last quarter.

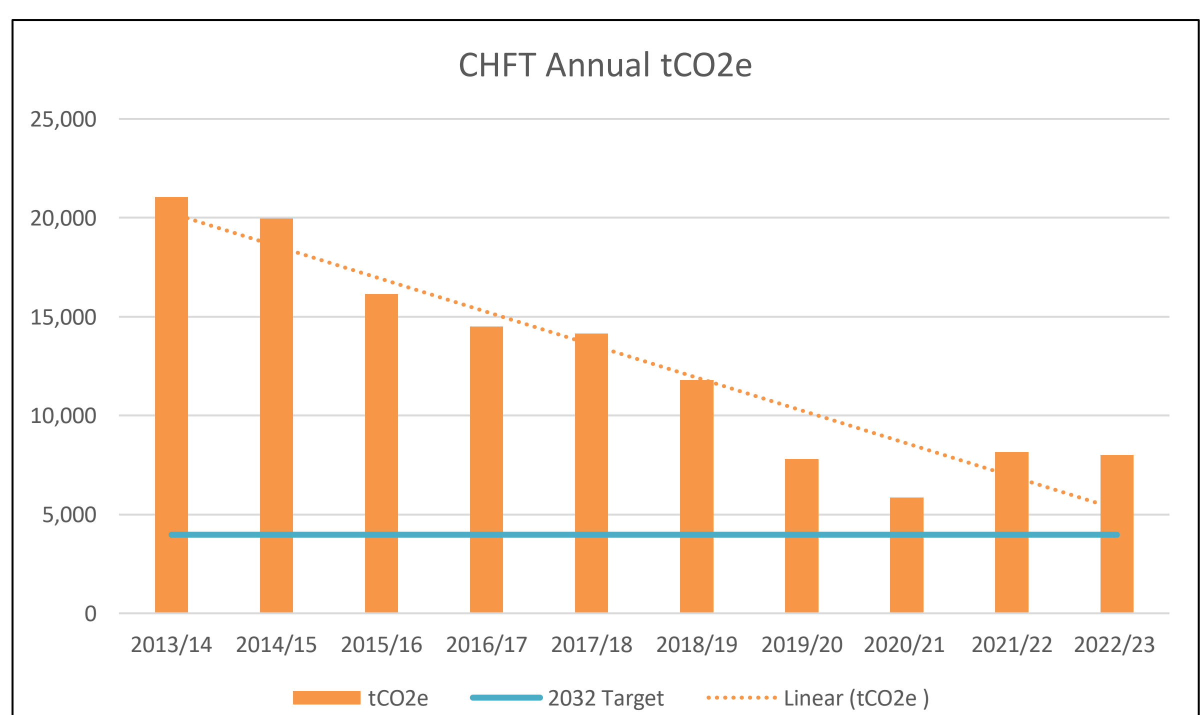
Key progress in Q2 2023/24

- Annual SECR report confirms that CHS emissions for 2022-23 have reduced by 23% since the previous financial year (2021-22)
- Programme of energy audits commenced at CRH to identify areas to focus switch off efforts, as part of ongoing energy efficiency action plan.
- Finance approved procurement of additional energy management software to aid utilities monitoring and measurement.
- Staff energy efficiency survey closed with 84 total responses. Results and staff ideas collected via survey shared with Green Planning Committee. Actions to be picked up via Energy Efficiency Task and Finish Group.
- Application to the Salix Low Carbon Skills Fund (LCSF) to fund Digital Twin building software has been submitted. Awaiting application outcome.
- Clinical feedback following Styker Neptune 3 demo in Theatres positive. 3 units to be installed for a trial period. Currently awaiting clinical approval for enabling works to take place in Theatres at HRI.

Priorities Q3 2023/24

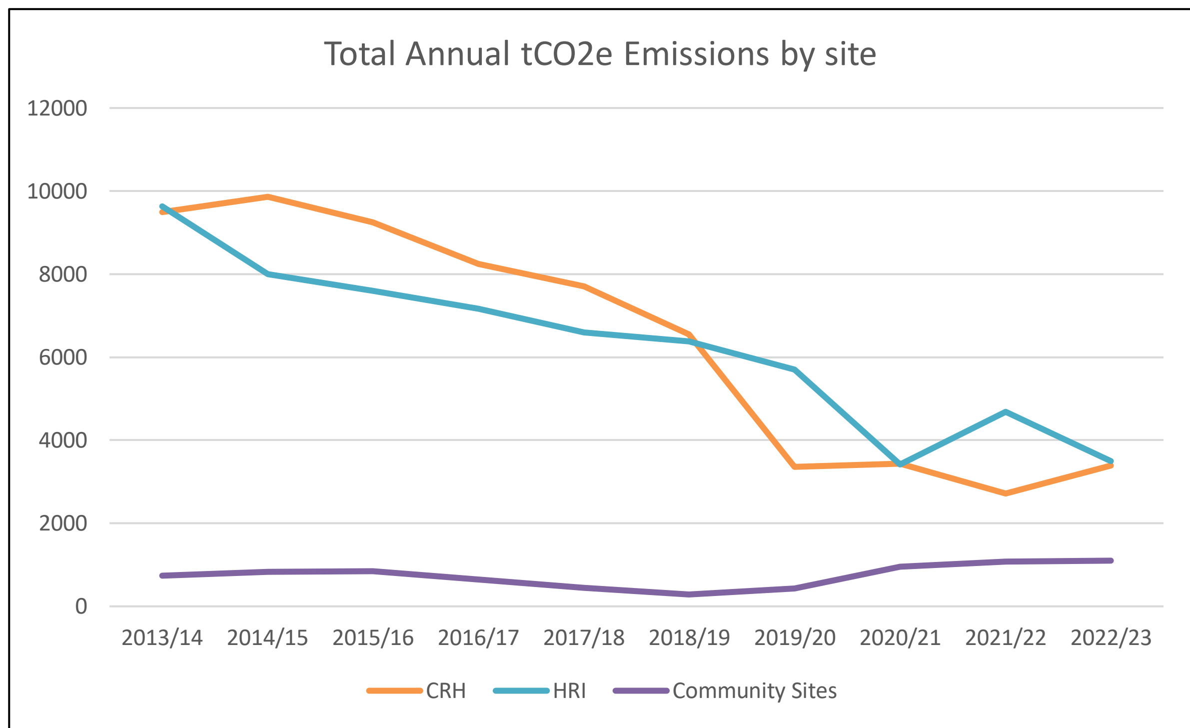
- Application to the North-East and Yorkshire Net Zero Hub Energy Projects Enabling Fund.
- Conversations ongoing regarding a climate sustainability engagement platform, considering cost, feasibility, and potential impact.
- Decision needed regarding a travel platform proposal.
- Groundwork and preparation for EV charger installation at HRI.

Since the baseline year (2013/14) the Trust's CO2e emissions have reduced by almost 60%. This reduction has partly been achieved by interventions adopted by the Trust and through efforts to rationalise the estate. The main contributing factor has been the reduction in the carbon intensity associated with grid electricity supply to our assets, which has been achieved via the procurement of 100% renewable electricity since April 2021. Figure 1 illustrates the Trust's annual emissions since the baseline year, in relation to the 2032 interim target.



Emissions by site

At HRI and other (sites managed by CHS), combined CO2e emissions reduced in total by 20% between 2021-22 and 2022-23. For the same period at CRH, total emissions increased by 25%, this will be an area to focus decarbonisation efforts and building and energy efficiency going forwards.



There is a noticeable dip in emissions for the year 2020/21, this is explained by a reduction in activity due to the Covid-19 pandemic. Emissions have increased slightly across the community sites; however this is due to new sites being brought in to the portfolio (eg The Clockhouse).

Heat Decarbonisation Plan

CHS recently commissioned a heat decarbonisation strategy for the main hospital sites, which supports the reduction in emissions from natural gas to 100% by 2040. The studies concluded that on-site combustion of fuels such as hydrogen, biomass and bio-methane are unlikely to be feasible due to lack of availability, storage risks and air quality concerns. Heat networks are also unlikely to be feasible, therefore the strategy proposes electric heat pumps as the best option to replace the existing natural gas fired heating system, at both acute sites.

Replacement of the existing heating system is an extremely challenging project, which will require major building works and disruption to the working hospital. Any new heating system will require installation parallel to the existing heating system to ensure continuous provision of heat and require extensive design and planning prior to installation.

If the Trust is to achieve Net Zero by 2040, heating projects should be implemented no later than 2036.

To prepare for this, actions from the Heat Decarbonisation Plan have been incorporated into the Sustainability Action Plan, which supports the Green Plan and is monitored via the Green Planning Committee.

Additionally, to ensure the CHFT estate is ‘future-proof’, it is crucial that zero carbon heating design continues to be incorporated and prioritised throughout the ongoing programme of reconfiguration.

The Trust has already begun to make progress towards decarbonisation ambitions via the incorporation of BREEAM into the planning and construction process for the new HRI Emergency Department (ED). This includes installation of an Air Source Heat Pump (ASHP) to generate renewable energy on site. As of May 2023, the HRI ED project surpassed 70% BREEAM credits, achieving the 'Excellent' standard and demonstrating a high level of sustainable value, building efficiency and environmental performance.

Figure 2 HRI ED Air Source Heat Pump prior to install and commissioning

CHFT Travel Emissions and the Travel plan

The travel plan actions are split into 4 themes. 41 of the 47 total actions are complete.

Emissions resulting from Trust owned fleet vehicles are included under scope 1 of the NHS carbon footprint. The CHFT Green Plan has set a target to convert 90% of our fleet to low, ultra-low or zero emission vehicles by 2028, in line with wider national targets for electric vehicles.

As of 2022/23, CHS has achieved this target, as 90.3% of fleet vehicles are low, ultra-low or zero emission vehicles. Emissions attributed to fuel combustion have reduced by 75% since 2021/22, and fuel consumption from the remaining internal combustion engine (ICE) vehicles account for 7% of total emissions in 2022/23. This will reduce to zero once the entire fleet is converted to EV.

To reduce emissions resulting from staff commute, the principal aim of the CHFT Travel Plan is to reduce single occupancy journeys by 5% by 2026 by incentivising other modes of transport including active travel, public transport and lift sharing. Since adoption of the Travel Plan in 2021, single occupancy journeys have reduced by 2% across the Trust. If this trend continues, we expect to meet our 2026 target and we will continue to monitor this progress via biannual staff surveys. To date, CHS have invested in upgrading cycle storage and shower/ changing facilities to incentivise cycling, provide a shuttle between the main hospital sites and are investigating the potential to develop a car share/ journey planning app, bespoke to CHFT.

As part of the travel plan we undertook a survey of colleagues earlier this year which is summarised below:

- Travel survey showed a 4% increase in staff EV users since 2021, and a further 234 colleagues said they may be encouraged to use an EV if there were better charging provision at work. Therefore, we are increasing EV charging provision at HRI and upgrading the charging points at Acre Mill. Overall, there will be 10 affordable charging points available for staff and visitor use, we aim for these to be installed and operational by autumn 2023. We will monitor use of these facilities to develop a strategy to increase provision further, in line with demand.
- 231 survey respondents said that they do not currently car share, but they would like to, or do not drive and would be interested in finding a lift to work with a colleague. We have received a proposal from Car Share/ journey planning app developer regarding creating a bespoke car share platform for CHFT colleagues and tying this in with our shuttle service.
- 26% of survey respondents said that they would be encouraged to use public transport to get to/ from work if there were better public transport links between their home and work. Collaboration between the Trust and WYCA regarding their Bus Service Improvement Plan is ongoing and improving connectivity between HRI and CRH has been identified by the combined authority as a priority.
- A number of survey respondents were unaware of what/where facilities are available for cyclists (storage/ showers/ lockers etc) so we are in process of creating a cycle handbook for the CHFT intranet, so all information for cyclists is clear and in one place.
- 94 respondents said they would use a park and ride service to get to work, with the most popular location being Ainley Top (87%)- this gives an indication of the sort of demand to expect when the park and ride offer becomes available

The wider sustainability agenda

We continue to work very closely with our system partners on the wider sustainability agenda. As part of this work we have set up our own green planning committee involving colleagues throughout the Trust; and as part of our ongoing commitment to this agenda the MD of CHS is a member of a wide number of external climate & environment groups including:

- the West Yorkshire Health and Care Partnership Net Zero Board Leads' Network which seeks to bring key partners together to maximise system change
- chairs the climate workstream for the Calderdale Cares collaborative which aims to share good practise and explore opportunities to work more closely together with our partners in Calderdale
- being a commissioner on the Kirklees Climate commission which works with partners in the commercial sector, the university, schools, colleges, faith and voluntary sectors to raise the climate agenda profile in Kirklees and provide and an independent expert voice to the debate
- a member of Calderdale Climate Action partnership which aims to develop the Council's climate action plan
- working closely with the two hospices we have secure significant quantities of free equipment for them from NHSE supplies that were no longer required

Recommendation
The Board is asked to note progress with the Green Plan, and Travel Plan and contribution to the wider sustainability agenda.

CHAIR'S HIGHLIGHT REPORT
to the Board of Directors

Committee Name:	Finance and Performance Committee
Committee Chair:	Andy Nelson, Non-Executive Director
Date(s) of meeting:	30th May and 28th June 2023
Date of Board meeting this report is to be presented:	6th July 2023

ACKNOWLEDGE

- Continued strong performance in Cancer where we regularly achieve the 2-week wait and 62-day referral to treatment targets
- Recovery performance also remains strong and the best in the West Yorkshire ICS. We now have just one patient waiting over 65 weeks and just over 50 52-week waiters. We have delivered 107% of our elective recovery plan in the year to date
- Complaints performance has remained strong with 94% of complaints closed on time
- The new IPR has been well received and is giving a much clearer view of performance and any actions needed to address missed targets

ASSURE

- At our May meeting we had a presentation/'deep dive' on ED. Encouraging progress on recruitment and on implementing the new workforce models. These are key to reducing ED costs. ED 4-hour performance is showing an improving trend despite high attendances and high patient acuity, but is still some way short of the national target of 76%
- At our June meeting the committee had a presentation/'deep dive' on the work being done to reduce the backlog of follow-up appointments. Some excellent work on validation has seen this backlog reduce by over 4000 and the Elective Transformation programme is driving a number of initiatives, such as PIFU, from which we expect to see further reductions
- The capital spend is behind plan whereas the cash position is ahead of plan – the committee were assured that both are expected to meet the plan set for 2023/4
- The committee has completed its self-assessment and a small number of actions were identified including giving some greater focus to future planning
- The CIP programme is now measuring progress against the full £31.5m target. It was good to see 87% of schemes are at Gateway 2 which shows the strength of the processes and governance around the programme. There is still a £1.4m gap and the ED and LOS schemes are recognised as high risk

AWARE

- Diagnostics performance still good overall but issues in Neurophysiology and Echocardiography for which there are action plans. F&P will be doing a 'deep dive' into Diagnostics at its August meeting
- Transfer of Care (TOC) numbers remain a concern being still typically close to or over 100 – the Urgent and Emergency Care Recovery Plan is key to cracking this problem. There is currently more confidence in making improvements within CHFT than across the place/system. This position along with continuing high levels of bed occupancy is feeding through into our adverse financial position
- At month 2 our we have a £0.39m adverse variance to plan. Other factors playing into this are the impact of the recent strikes and higher non-pay costs in areas such as utilities, maintenance costs and elective recovery
- The adverse variance at CHFT and across the ICS (£14.1m YTD) is attracting some national scrutiny not only in West Yorkshire but in 14 other ICSs
- Our forecast remains to meet the plan but there are clearly risks to this from continuing strike action, activity levels and slippage on high-risk efficiency programmes

ONE CULTURE OF CARE

One Culture of Care considered as part of the performance and finance reports. Senior member of WOD now attends F&P on a regular basis plus WOD representation in deep dives. This allowed the committee to check in on workforce performance (such as sickness levels) and well-being and whether any further actions can be taken given the significant operational pressures staff are facing.

How do We Benchmark with West Yorkshire - RTT

Provider	40 Week Waits	52 Week Waits	65 Week Waits	78 Week Waits	104 Week Waits
Airedale	1,681	662	122	4	0
Bradford	1,839	580	102	1	0
Calderdale and Huddersfield	987	55	1	0	0
Leeds	10,251	3,995	955	129	1
Mid Yorks	5,264	1,904	401	28	0

`

COVER SHEET

Date of Meeting:	Thursday 6th July 2023
Meeting:	Board of Directors
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

Actions Requested:

To receive – to discuss in depth, noting the implications for the Board or Trust without formal approval

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

Year To Date Summary

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 Board is asked to receive the Finance Report and note the financial position for the Trust as at 31st May 2023.

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

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.

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

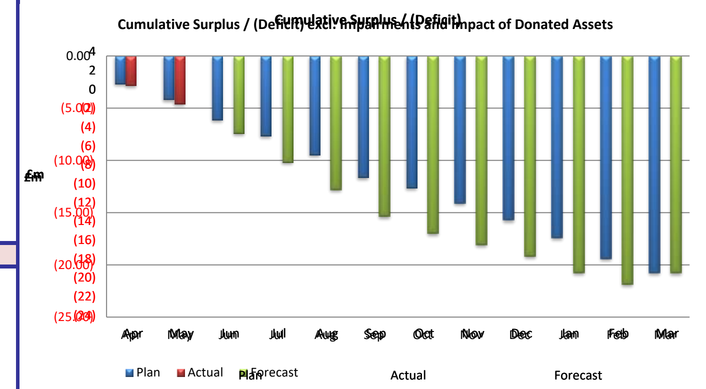
	M2 Plan	M2 Actual	Var
	£m	£m	£m
Elective	£2.77	£3.15	£0.38
Non Elective	£20.85	£20.51	(£0.34)
Daycase	£5.69	£5.79	£0.10
Outpatients	£7.02	£7.51	£0.49
A & E	£5.25	£5.28	£0.03
Other-NHS Clinical	£36.93	£36.24	(£0.69)
CQUIN	£0.00	£0.00	£0.00
Other Income	£9.16	£9.49	£0.34
Total Income	**£87.66**	**£87.97**	**£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	M2 Actual	Var
	£m	£m	£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)**

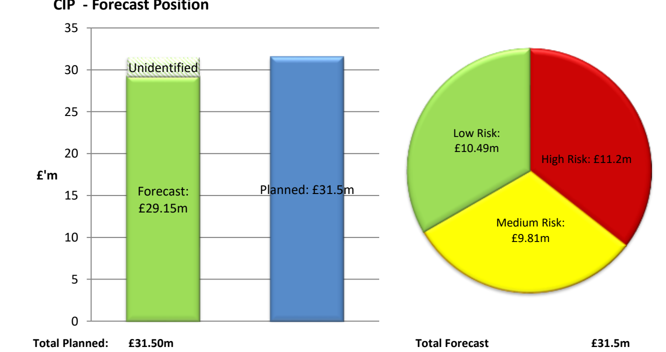
TOTAL GROUP SURPLUS / (DEFICIT)



KEY METRICS

	Year To Date			Year End: Forecast		
	M2 Plan	M2 Actual	Var	Plan	Forecast	Var
	£m	£m	£m	£m	£m	£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

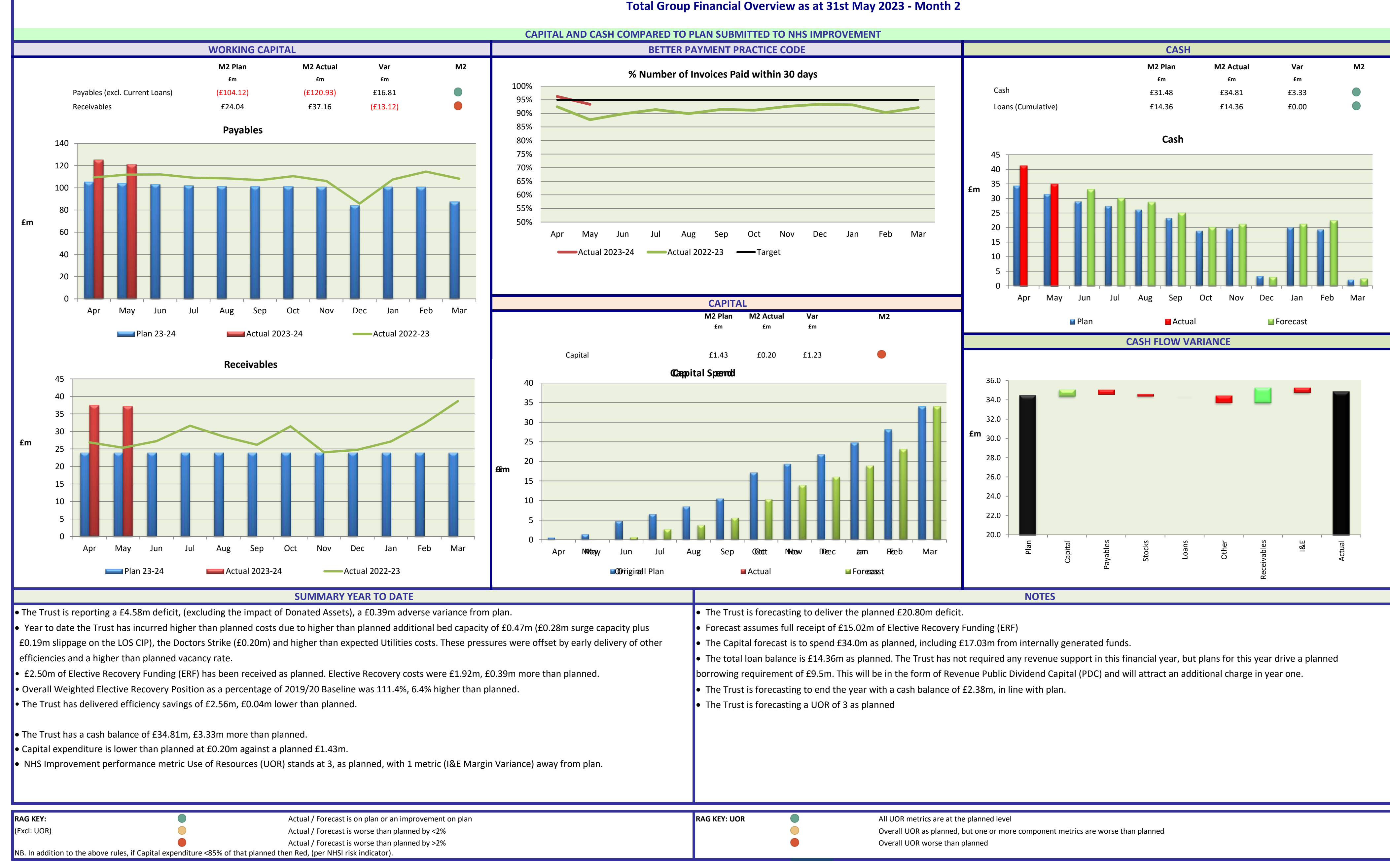
	Plan	Actual	Var
	£m	£m	£m
Elective	£17.69	£17.69	£0.00
Non Elective	£125.90	£125.90	£0.00
Daycase	£36.01	£36.01	£0.00
Outpatients	£44.01	£44.01	£0.00
A & E	£31.42	£31.42	£0.00
Other-NHS Clinical	£215.62	£216.40	£0.78
CQUIN	£0.00	£0.00	£0.00
Other Income	£55.28	£57.01	£1.72
Total Income	**£525.93**	**£528.44**	**£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	Forecast	Var
	£m	£m	£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	Green
Receivables	£24.04	£37.16	(£13.12)	Red

BETTER PAYMENT PRACTICE CODE

CASH

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

CAPITAL

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

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)
- Green: Actual / Forecast is on plan or an improvement on plan
- Amber: Actual / Forecast is worse than planned by <2%
- Red: 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
- Green: All UOR metrics are at the planned level
- Amber: Overall UOR as planned, but one or more component metrics are worse than planned
- Red: Overall UOR worse than planned

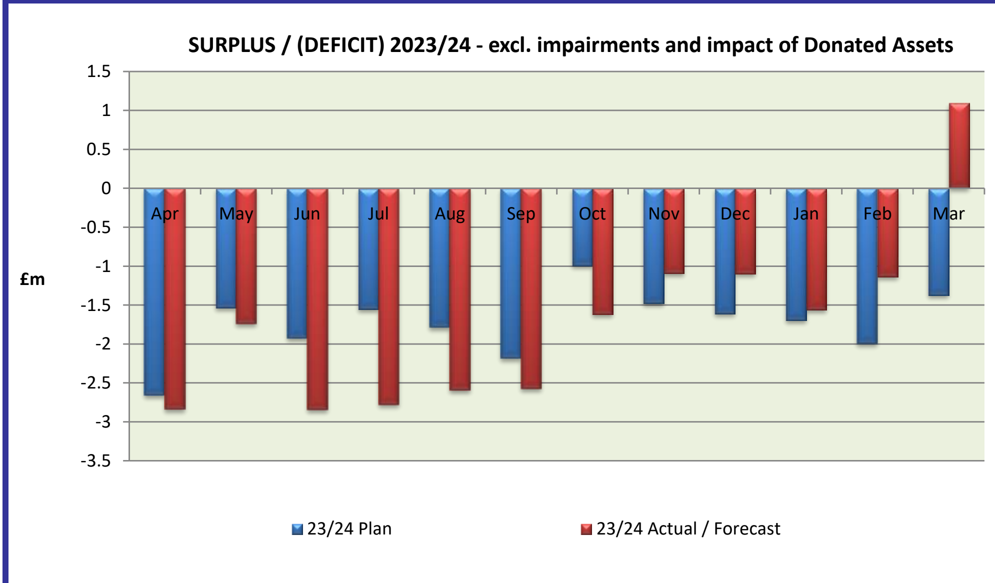
FORECAST 2023/24

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.

CHAIR'S HIGHLIGHT REPORT
to the Board of Directors

Committee Name:	Workforce and OD Committee
Committee Chair:	Karen Heaton.
Date(s) of meeting:	20 June 2023
Date of Board meeting this report is to be presented:	6 July 2023

ACKNOWLEDGE

The following points are to be noted by the Board 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.

.

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.

CHAIR'S HIGHLIGHT REPORT
to the Board of Directors

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:	6 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.

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.

CHAIR'S HIGHLIGHT REPORT
to the Board of Directors

Committee Name:	Quality Committee
Committee Chair:	Denise Sterling, Non-Executive Director
Date(s) of meeting:	22nd May 2023
Date of Board meeting this report is to be presented:	6th July 2023

ACKNOWLEDGE

- The Trust has committed to the Parkinson's pledge to improve the timeliness of administration of Parkinson's medication for in patients. A comprehensive action plan is in place to address the findings from an audit and this has led to significant improvements. Ongoing monitoring of the action plan is through the Trust Medication Safety and Compliance Group. Committee

ASSURE

- Health and Safety Committee Overview –it was reported that compliance with the 30 NHS workplace health and safety standards will be achieved within the next year. Progress is being made on the projects developed to improve the management of the most common risk of injuries, handling and control of exposure to hazardous chemicals, personal safety and security and working arrangements between Head of Health and Safety. Committee noted the work over the past year on Display Screen Equipment assessments (DSE) and queried whether staff working from home have access to DSE assessments and requested this be explored.
- Committee received the Internal Audit report on ward to board reporting which had a focus on the recognition and treatment of sepsis as one of the quality priorities. The review found that the ward to board reporting arrangements for the quality priorities are generally effective and there is significant assurance for the areas audited. The four minor recommendations will be implemented by the end of May 2023
- The Maternity and Neonatal Oversight report provided assurance that the key quality issues within maternity services are being effectively addressed .Highlighted was the neonatal death audit that was undertaken due to the increase in deaths in 2022. The audit findings were that 61% (11/18) of mothers who had a neonatal death lived in the most deprived areas. The audit has been presented at the Maternity Health Equalities Workstream and further analysis to be undertaken.
- Committee noted the Q3 Learning from deaths report.
- Report received on the close down of the 2022-2023 quality priorities and the seven focussed priorities. There is ongoing quality improvement work for the priorities with limited assurance .
- IPR March 2023– It was reported that the Trust continues to be one of the top Trust for cancer performance and this is an achievement. Challenges remain with stroke services as there are vacant stroke consultant posts, locums are in place to support the service. The Trust performance for the Sentinel Stroke National Audit Programme (SSNAP) continues to deteriorate due to therapists vacancies. Committee to request an update on the impact of this on patient care and rehabilitation. Accident and emergency department remained busy with high attendance throughout March. Both the Summary Hospital-level Mortality Indicator (SHMI), and Hospital Standardised Mortality Ratio,(HSMR) are now both in the normal range.

AWARE
• The draft Quality Accounts 2022/2023 were discussed and accepted, final Quality Accounts to be signed off by the committee on the 21st June 2023.
ONE CULTURE OF CARE
• One Culture of Care was taken into account in the discussions.

Date of Meeting:	Wednesday, 21 June 2023
Meeting:	Quality Committee
Title of Report:	DIPC report Q4
Author:	Gillian Manojlovic, Lead Nurse IPC
Presenter of report: (if different from author)	Dr David Birkenhead
Sponsoring Director:	Dr David Birkenhead, DIPC
Previous Forums:	Infection Control Committee 13/4/23
Actions Requested: To note	

Purpose of the Report

The report provides an update on Infection, Prevention and Control (IPC) performance and activity for the final quarter of 22/23.

Key Points to Note

The report includes the year end HCAI data where 4 of the 5 nationally set objectives were breached.

Summaries of the annual PVC and urinary catheter management audits are included with recommendations.

The IPC Board Assurance Framework was presented at ICC in April 23. A new IPC BAF was published on the 18/4/23. The Trust BAF will be reviewed and updated in line with the changes.

https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.england.nhs.uk%2Fwp-content%2Fuploads%2F2022%2F04%2Fnipc-board-assurance-framework.xlsx&wdOrigin=BROWSELINK

EQIA – Equality Impact Assessment

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

Recommendation

The Committee is asked to note the content of the report.

DIPC report Q4 – 1st January 2023 to 31st March 2023

Calderdale and Huddersfield Foundation Trust recognises that effective infection prevention practice, underpinned by the implementation and audit of evidence-based policies, guidelines and education are fundamental to the reduction of risk and patient harm from Healthcare Associated Infections (HCAI). The report will provide assurance against key infection prevention and control performance and quality indicators.

1. Performance targets

Indicator	Objective 2022/23	Year-end performance	Actions/Comments
MRSA bacteraemia	0	2	Increase of 2 on previous year.
C.difficile (HOHA and COHA)	Objective = 38	59	Objective is 1 case above the 21/22 outturn. 38 HOHA and 21 COHA.
MSSA bacteraemia (post admission)	None set	20	Increase of 4 on previous year.
E. coli bacteraemia	Objective = 71	79	Objective is down 20 on 21/22. 48 HOHA and 31 COHA.
Pseudomonas aeruginosa	11	4	New objective for 22/23. 2 HOHA and 2 COHA.
Klebsiella spp.	19	28	New objective for 22/23. 15 HOHA and 13 COHA.
MRSA screening (electives)	95%	77.3%	Deterioration since last month. Main issue in 1D admissions.
ANTT Competency assessments (medical staff)	90%	70%	4% increase
ANTT Competency assessments (nursing and AHP)	90%	88%	6% increase
Hand hygiene	95%	100%	
Level 2 IPC training (Medical staff)	90%	84%	3% decrease
Level 2 IPC training (nursing and AHP)	90%	91%	

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

2. Quality Indicators

Indicator	Year-end agreed target	YTD performance	Comments
MRSA screening (emergency)	95%	87%	Down 3%
Isolation breaches	Non set	NA	To recommence reporting 2023/24

3. MRSA bacteraemia:

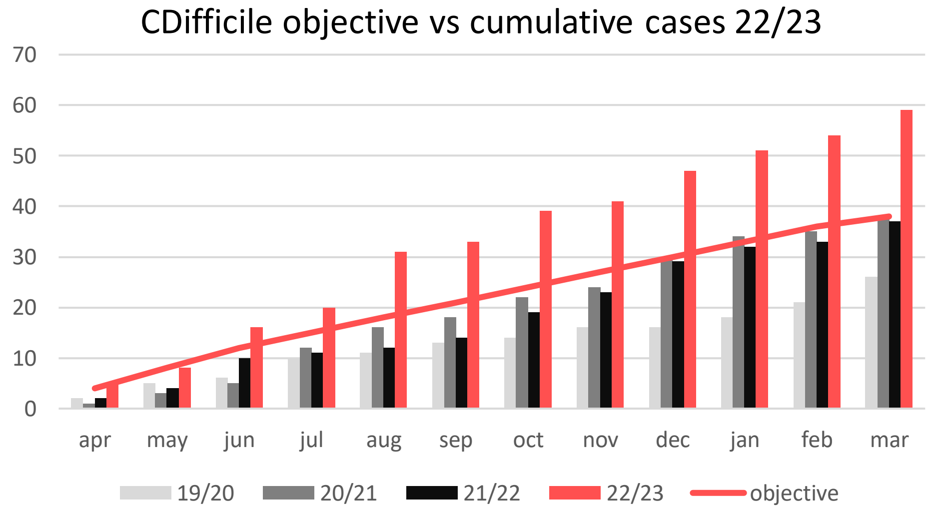
The objective for MRSA cases in year remains at zero. Two cases were reported in Q3. Both have been investigated. Central line management has been noted as an area of learning from both investigations, though not considered the source of infection in either case. These were the first cases of MRSA bacteraemia seen in over 18 months.

4. MSSA bacteraemia:

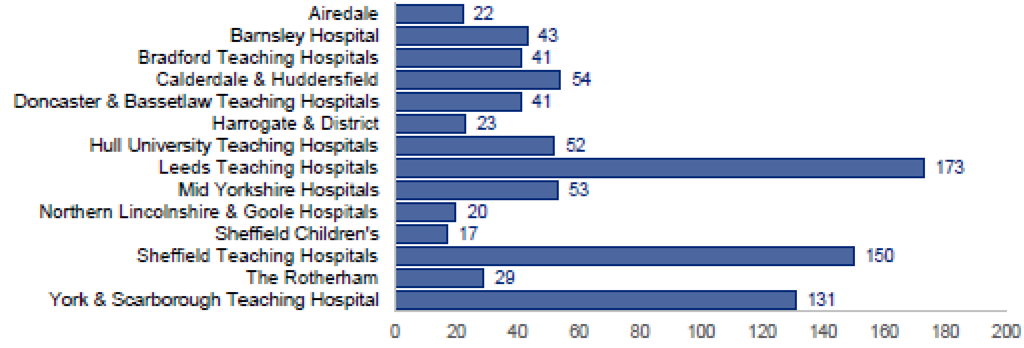
There have been 4 post-admission MSSA bacteraemia cases during the current reporting period making a total of 20 cases at year end. The IPC team continue to review these cases. There is no objective set for MSSA.

5. Clostridium difficile:

The objective for 2022-23 was 38 cases, an increase of 1 case on outturn from 21/22. The objective includes both HOHA cases (hospital onset, healthcare associated) plus COHA (community onset, healthcare associated) infections where there has been an inpatient episode within the previous 28days. There have been 12 cases reported this quarter with a total of 59 cases year to date, breaching the annual objective.



Regional data published by UKHSA shows CHFTs position in comparison to other Trusts *(note: data to February 23, case numbers not rates).*



Each case is investigated. From October, the IPC team took the lead on the CDifficile investigations, and this will be reviewed in April 23.

The CDifficile Improvement Plan launched in August 22 has been reviewed and progress is being made. It has been monitored through IPC Tactical meeting and IPC Performance Board.

A support visit from NHSEI was carried out in February. Feedback included:

- PIR process led by the IPC team – acknowledged risk of limited ownership by divisions.
- The role of the link practitioner (LP) as a broader piece of work across the trust to help increase the profile and ownership of the whole IPC agenda.
- Increase clinical ownership of AMS beyond the responsibility of the time-limited microbiology and antimicrobial pharmacist team. Encourage and empower juniors doctors and engage in AMS audit, utilising EPR to alert the need for review & consider a nurse-led AMS programme (ARK-Hospital)
- Implementation of blood culture national standards.
- Importance of prompt symptom recognition, reporting and robust management, including specimen collection quality.
- Isolation policy praised with helpful isolation room signage to aid compliance.
- Audit the 'time to isolation' from recognition of symptoms.
- 'Keeping you safe in hospital' leaflet might be helpful to make this in other languages, other formats including video links, and more prominent on the trust website.
- The wards visited were clean, even in the older estate, and a compliment to the estates and facilities teams.
- Suggested to colour print the National Standards of Healthcare Cleanliness star ratings to reflect the amount of work gone into achieving these standards.
- Improve the senior clinician support for IPC initiatives;
- Identified lead directors for each section of the BAF. Some organisations have identified a non-executive director with a Board focus on IPC to provide a robust 'check and challenge' to the DIPC report and IPC BAF.

They summarised: although cases of CDI have risen recently, this is broadly in line with regional and national trends. It has given the trust an opportunity to review current practices and identify gaps and opportunities for development. Our visit suggests that there is a strong IPC-focussed culture but there are some opportunities to strengthen this further by developing greater senior and local clinical ownership.

6. E. coli bacteraemia:

There have been 17 cases of Ecoli bacteraemia reported this quarter with a total of 79 post-admission *E. coli* bacteraemia cases at year end. This is over the objective of 72. The Trust is participating in regional improvement work in relation to gram negative bacteraemia.

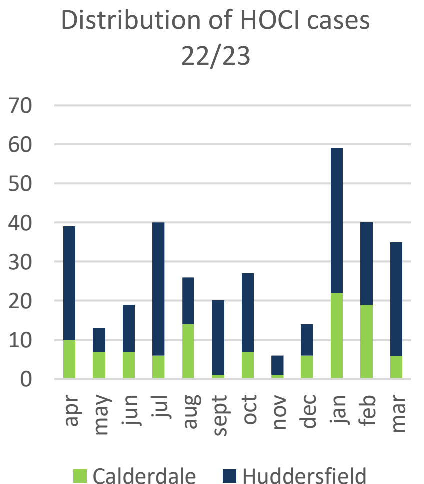
7. Outbreaks & Incidents:

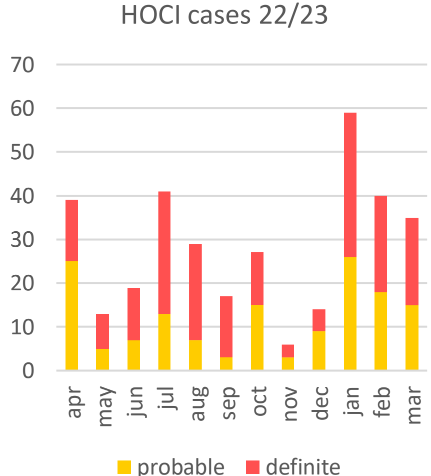
Norovirus: There have been two norovirus outbreaks reported during Q4 affecting ward 5 at HRI and ward 5 at CRH. Both outbreaks were well controlled by the ward teams.

Group A Strep: In February 23, 4 patients on the stroke ward were identified as positive for Group A strep from clinical sites. Control measures were put in place and the cases were investigated with WGS completed on the isolates. 3 of the cases were reported as connected demonstrating that there had been cross infection on the ward. No further cases have since been reported.

Covid-19: There have been 9 Covid19 outbreaks recorded during the reporting period affecting wards H5, H6, H11 (plus influenza), H15 and H17 plus C6C, C6AB and Calderdale stroke floor. All Covid-19 outbreaks are managed in line with Covid19 outbreak management guidelines and are monitored for 28 days following the last new case.

Healthcare associated Covid19 Infections (HOCI's): For this reporting period there have been 134 HOCI cases (75 definite, 59 probable). This is a steep increase on the previous quarter following significant outbreaks in January. HOCI cases with significant symptoms (respiratory support/ICU etc) are reported and investigated via Datix.





Water safety at HRI: Ongoing management of increased bacterial contamination is demonstrating improvements in all areas. UKHSA continue to support the Trust in addressing the water concerns. Remedial actions continue to be under advisement from the Trust water specialist and several outlets have been removed.

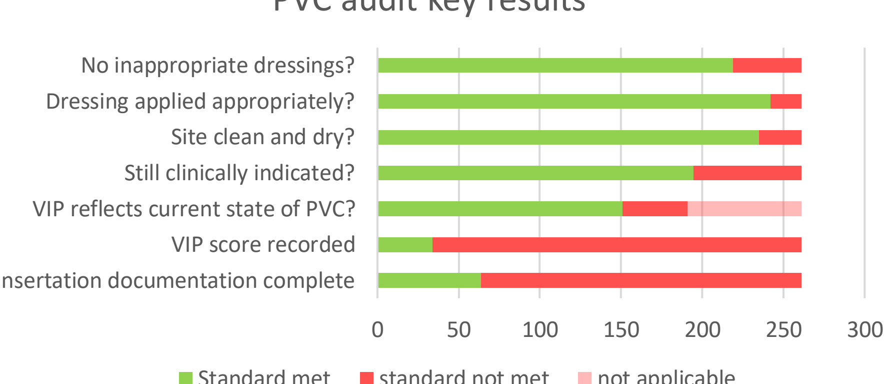
8. Audits

Urinary catheter annual audit: the audit was completed in December 22 and the full report provided to ICC.. The data suggests a downward turn in compliance since the beginning of the pandemic and the following recommendations are to be addressed by the divisions and reported via performance board.

- Improve EPR documentation
- Improve awareness of HOUDINI assessment and daily review
- Increase awareness and use of fixation devices
- Improve use of fluid intake and output monitoring
- Reiterate the need for ANTT for cares and specimen taking.

For community settings, the IPC team in collaboration with community colleagues are completing a community audit commencing April 23.

PVC annual audit: The audit has been completed in January 23 and the full report provided to ICC. The main concern was the documentation of insertion and ongoing care including VIP scores. A selection of results is below. The recommendations in the report are to be addressed by the divisions and reported via performance board.



IPC Board Assurance framework: The IPC BAF self-assessment framework has been reissued and reviewed. Several areas require improvement and an update will be provided to ICC in July. Internal audit has reviewed the BAF and a report is pending.

Quality Improvement Audits: The programme continues, though has been disrupted due to system pressures.

FLO (Front Line Ownership) audits: These are carried out by clinical areas to confirm compliance with set elements of staff and patient safety indicators, teams identify where good practice and areas where standards need improving. These audits are ongoing across all clinical areas and include elements of Covid-19 mitigations. Current scores are showing in-patient areas at 93%, theatres 96% and community bases at 97%.

9. Recommendations

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

Date of Meeting:	Thursday 6th July 2023
Meeting:	Public Board of Directors
Title:	Learning from Deaths Q4 Report
Authors:	Mandy Hurley, Quality Governance Lead
Sponsoring Director:	David Birkenhead, Executive Medical Director
Previous Forums:	Mortality & Surveillance Group

Purpose of the Report

To provide the Board with assurance of the Learning from Deaths (LfD) mortality review process

Key Points to Note

In Quarter 4 (Jan – March 2023), there were 422 adult inpatient deaths.

25% of all adult inpatient deaths have been reviewed using the initial screening tool (ISR). This is a declining figure on previous months:

	Q1	Q2	Q3	Q4
Number of deaths	411	383	480	422
Reviews	152	119	151	104
%	**37**	**31**	**32**	**25**

The Board is reminded of the slight lag between issuing cases for review and completion of this report (MSG have allocated mortalities up to March 2023). However, we are falling short of the 50% target. Extra capacity for completion of ISRs has been offered by our Trust CT trainees. Trainees will be provided with confirmation of completion for their portfolios once they have undertaken 10 completed ISRs. Mortality Leads have been contacted to remind all reviewers that the timeframe from allocation to completion of a review is 4 weeks.

In Q4, 5 cases were escalated to divisions via the Datix reporting process and taken through Divisional Orange Panels for further investigation & validation

EQIA – Equality Impact Assessment

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

Additional aspects of EQIA include:

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

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

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

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

Recommendation

The Board is asked to **NOTE** the Learning from Deaths Q4 Report.

Learning from Deaths Report

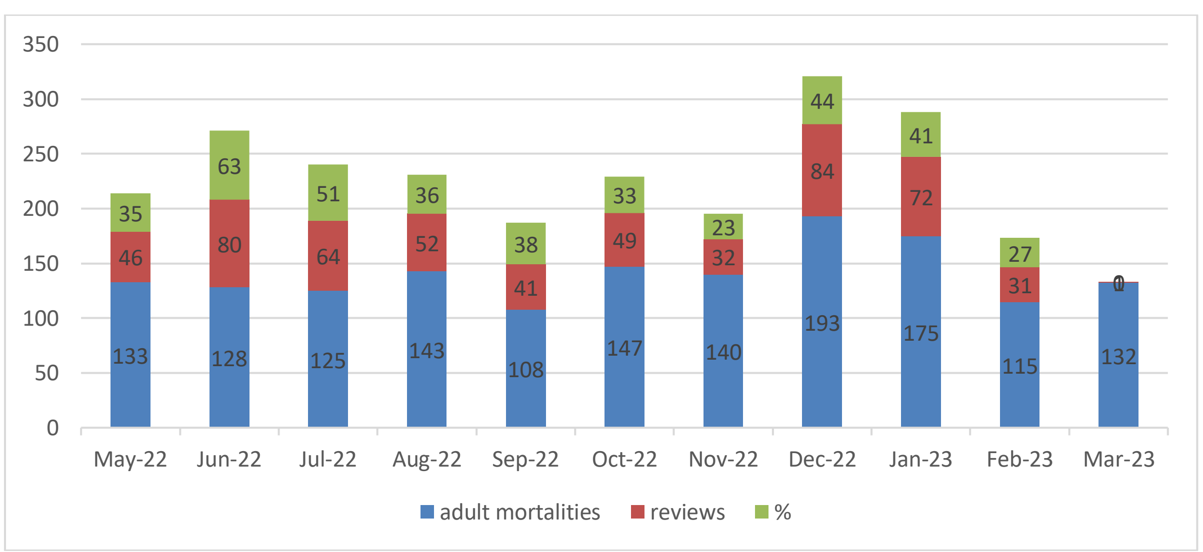
In Quarter 4 (Jan – March 2023), there were **422** adult inpatient deaths at CHFT recorded on Knowledge Portal.

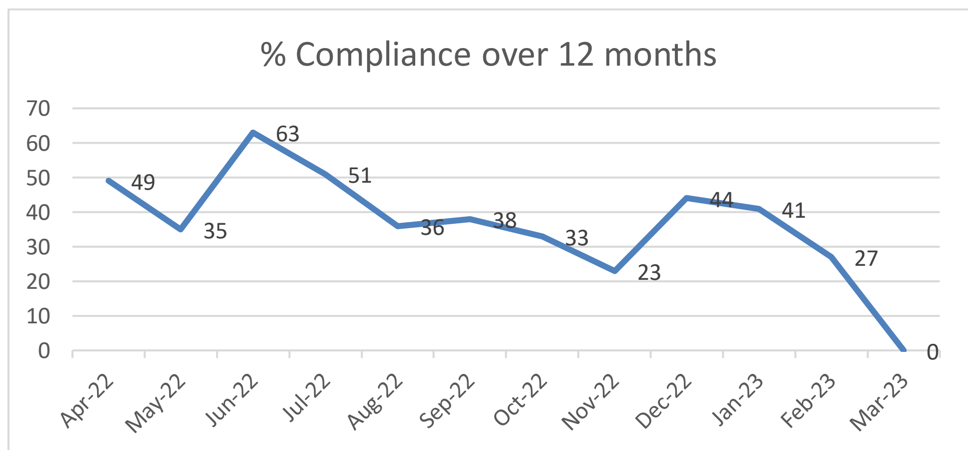
Initial Screening Reviews (ISR)

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

Of the **422** adult inpatient deaths recorded in Quarter 4 of 2022/2023, **104** (**25%**) have been reviewed using the initial screening tool. The committee is reminded of the slight lag between issuing cases for review and completion of this report (MSG have allocated mortalities up to March 2023). However, we are still falling short of the 50% target. Extra capacity for completion of ISRs has been offered by our Trust CT trainees. Trainees will be provided with confirmation of completion for their portfolios once they have undertaken 10 completed ISRs. And Mortality Leads have been contacted to remind all staff that the timeframe from allocation to review is 4 weeks.

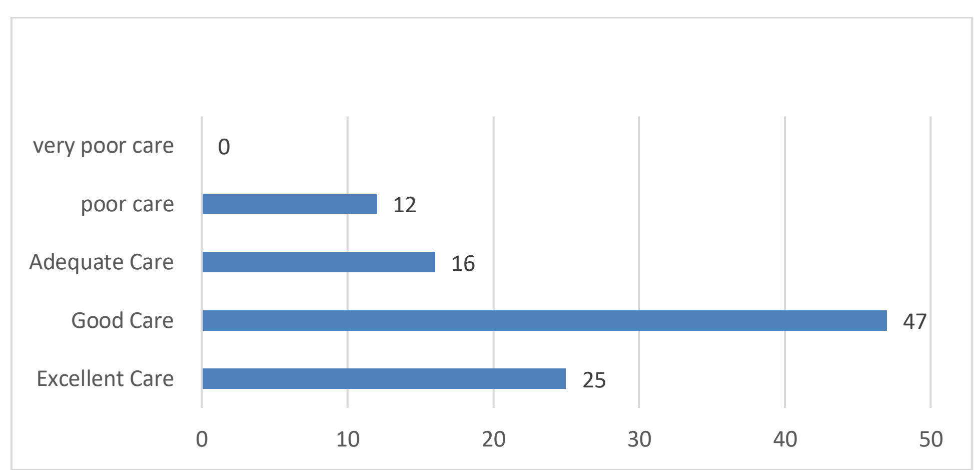
The table below shows the number of adult inpatient deaths reviewed by ISR by month over the last 12 months





Quality of care reviewed

% Quality Care Scores for ISRs completed in Q4 (Jan to March 2022/23) n=104



12% (12 cases) = poor care. 7 of these reviews were deemed poor care, sent for 2nd opinion and resulted in both reviewers agreeing on poor care. All have been reported on datix and are going through the respective divisional orange panels for validation

All ISRs that are escalated to SJR must have a valid rationale recorded for escalation purposes.

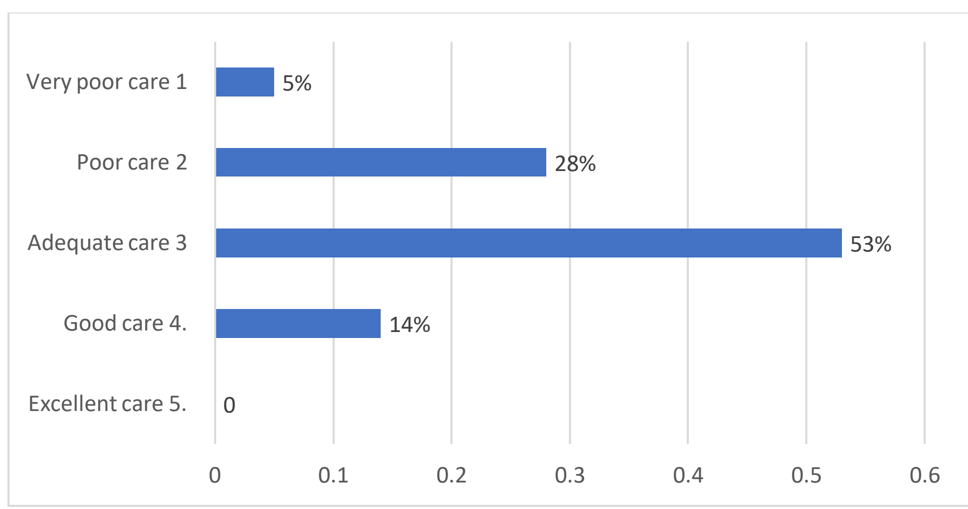
Structured Judgement Reviews Overview

211 SJRs were requested in the last 12 months.

	Escalated from ISR	Escalated by ME	2nd opinion	SI Panel	Elective	LD	Complaint	Coroner	HED Alerts & Spike in deaths	Total
April 22	3	6	2	1	0	1	0	0	0	**13**
May 22	8	10	6	0	1	0	0	0	1	**26**
June 22	5	3	4	1	0	0	0	0	24	**37**
July 22	6	0	1	0	1	0	0	0	0	**8**
Aug 22	8	3	2	0	0	1	0	0	1	**15**
Sept 22	7	0	6	1	0	1	0	0	0	**15**
Oct 22	1	1	3	0	0	1	0	0	9	**15**
Nov 22	2	3	2	0	0	0	0	0	16	**23**
Dec 22	1	10	4	1	0	0	0	0	5	**21**
Jan 23	7	5	1	1	0	1	0	0	0	**15**
Feb 23	3	3	3	0	0	1	1	0	0	**11**
March 23	4	4	2	1	0	1	0	0	0	**12**
Total	**55**	**48**	**36**	**6**	**2**	**7**	**1**	**0**	**56**	**211**

A total of 38 SJRs were requested in Quarter 4 (Jan to March) of 2022/23 of which **36** have been completed. The findings from SJRs are shared with the speciality mortality leads and appropriate Clinical Directors.

Quality of Care score distribution for 36 completed SJRs



Of the 12 reviews deemed very poor care & poor care, 5 cases have been reported on Datix and will be discussed & validated at Divisional Orange Panel

Datix ref: 224722 – Acute Floor HRI – awaiting review at orange panel
Datix ref: 223726 – Acute Floor CRH – awaiting review at orange panel
Datix ref: 222715 – Oncology Ward HRI – awaiting review at orange panel
Datix ref: 221604 – ward 20 HRI – Reviewed at medicine orange panel and downgraded to yellow
Datix ref: 221606 – Ward 7B CRH - Reviewed at medicine orange panel and downgraded to yellow

Of the SJRs completed in Quarter 4 2022/2023 the following learning themes and concerns were identified:

The following good practice was identified:

- Good virtual input from learning disability team and involvement of carers and NOK.
- The input from the palliative care team was excellent – frequent and holistic.
- Excellent aspects of care, particularly regarding identification of ceiling of care, communication with the patient's family, and the involvement of the safeguarding team
- Excellent communication with NoK

The following poor practice was identified:

- Despite a valid DNACPR order in place CPR was started
- Palliative Care Team not involved in patient at End of Life
- 91 year old patient with at least moderate to severe heart failure, did not have a ceiling of care review when they deteriorated
- Poor decision making around DNACPR and escalation.
- Poor communication and delayed decision making led to patient having unnecessary CPR

- Lack of holistic care
- Delay in urgent test such as Ascitic tap on a gastro ward

Recommendation to Quality Committee

Quality Committee is asked to note the Learning from Deaths Quarter 4 report.

Date of Meeting:	Thursday 6th July 2023
Meeting:	Board of Directors
Title:	QUALITY & PERFORMANCE REPORT
Author:	Peter Keogh, Assistant Director of Performance
Sponsoring Director:	Jonny Hammond, Chief Operating Officer
Previous Forums:	Executive Board, Finance & Performance Committee

Actions Requested: To note

Purpose of the Report

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

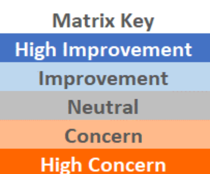
The Board of Directors is asked to note the narrative and contents of the report for May 2023.

Integrated Performance Report May 2023

Contents:

Section	Page
Performance Matrix Summary	3
Elective Care	4
Cancer	13
Urgent and Emergency Care and Flow	18
Maternity and Children’s Health	26
Community Services	29
Safe, High Quality Care	33
Quality Priorities	45
Workforce	49
Finance	56
Appendix	59

Performance Matrix Summary:



VARIANCE \ ASSURANCE	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:

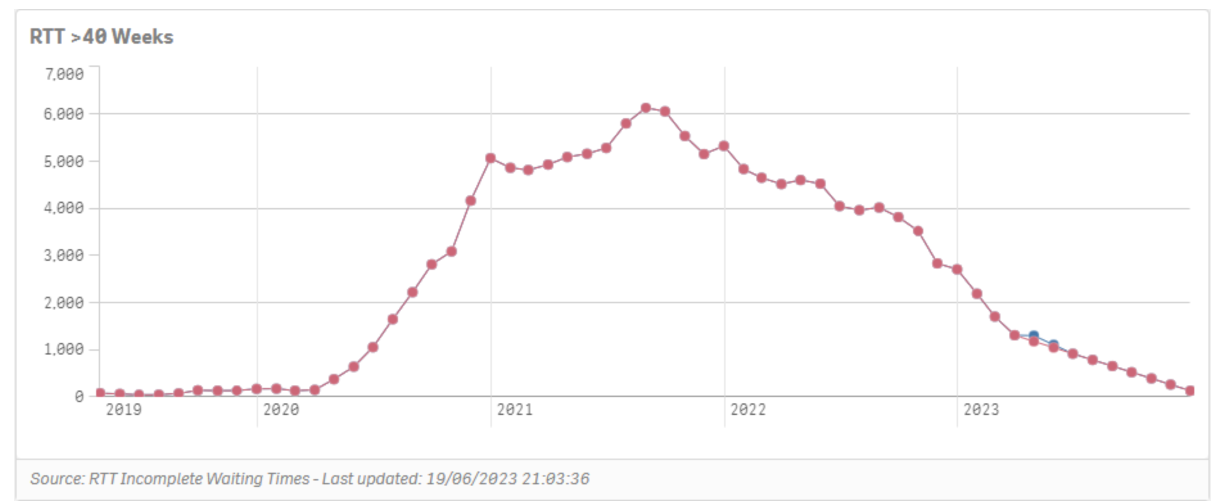
Metric	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Total Patients waiting >40 weeks to start treatment	May 2023	1,107	0					
Total Patients waiting >52 weeks to start treatment	May 2023	59	0					
Total Patients waiting >65 weeks to start treatment	May 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.

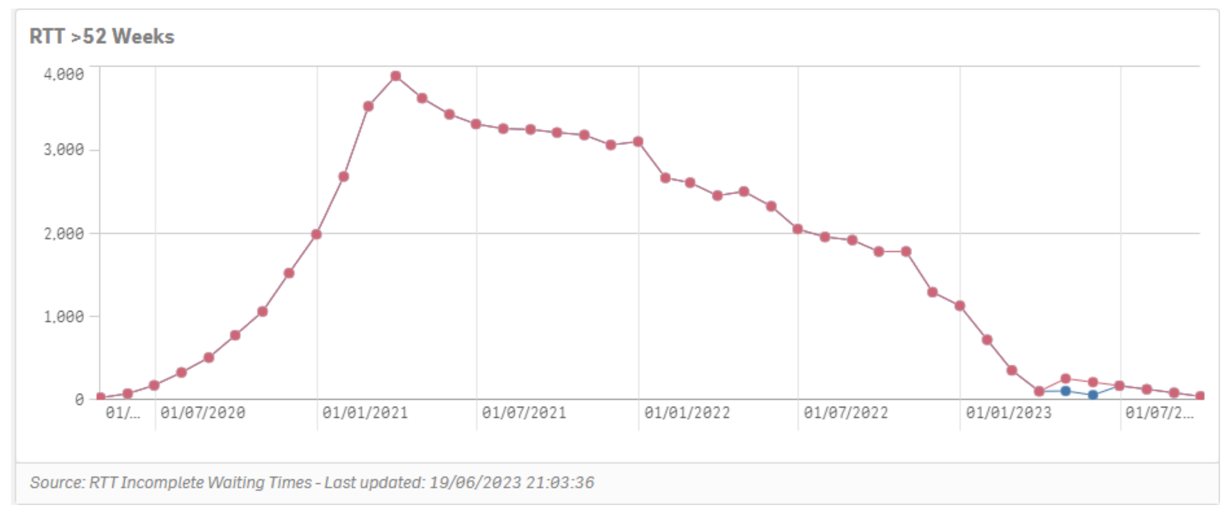
Actions:
Operational teams to be tracking patients to at least 40 weeks.
KP+ writeback Model to being used by all operational teams to ensure that tracking actions are transparent and cannot be overwritten by Validation teams.
For ENT, a new Head and Neck Locum Surgeon has started in May and the directorate 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.

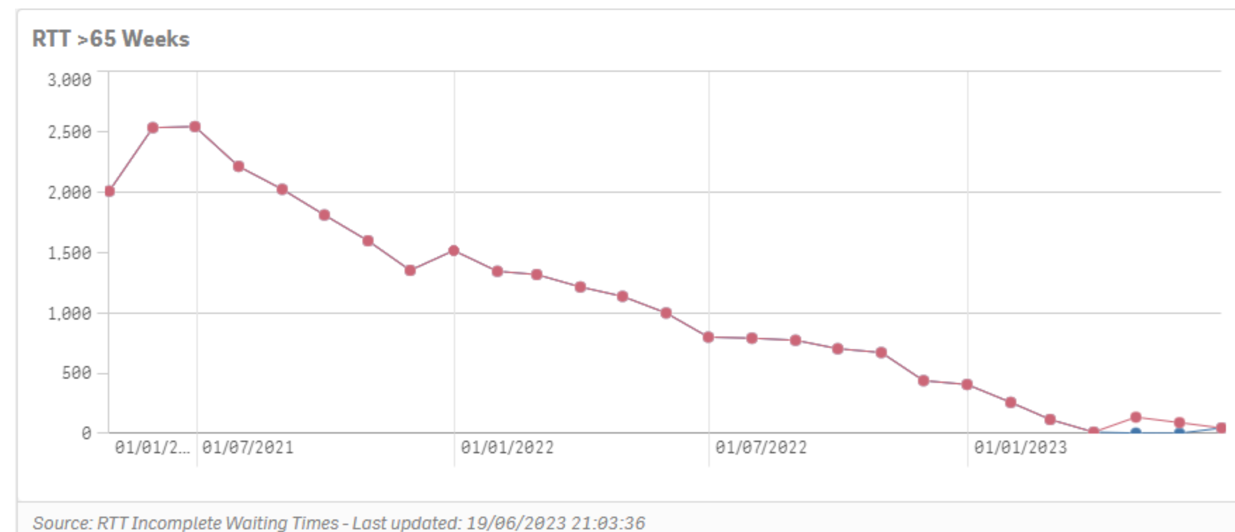
Actions:
Operational teams to be tracking patients to at least 40 weeks.
KP+ writeback Model to being used by all Operational teams to ensure that tracking actions are transparent and cannot be overwritten by Validation teams.
For ENT, a new Head and Neck Locum Surgeon has started in May and the directorate 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.

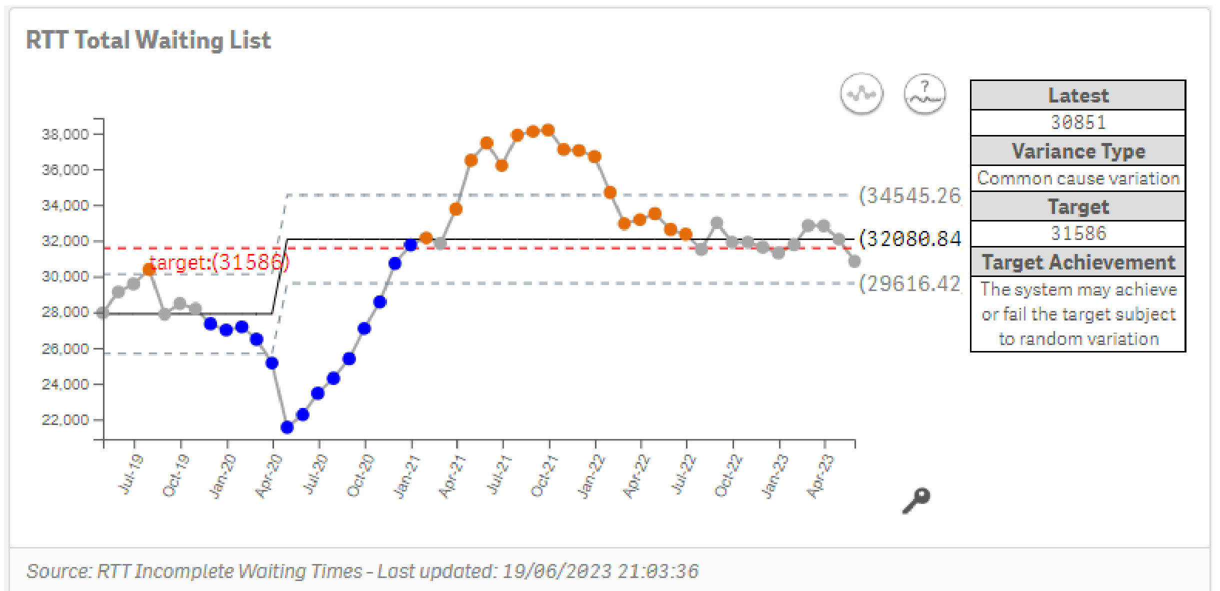
Actions:
Ensure that ENT Ops/General Manager Continue to ensure that these theatre sessions are not cancelled and that patients are pre-assessed in a timely fashion.
Operational teams to be tracking patients to at least 40 weeks to stop patients getting close to 65 weeks in future months.

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

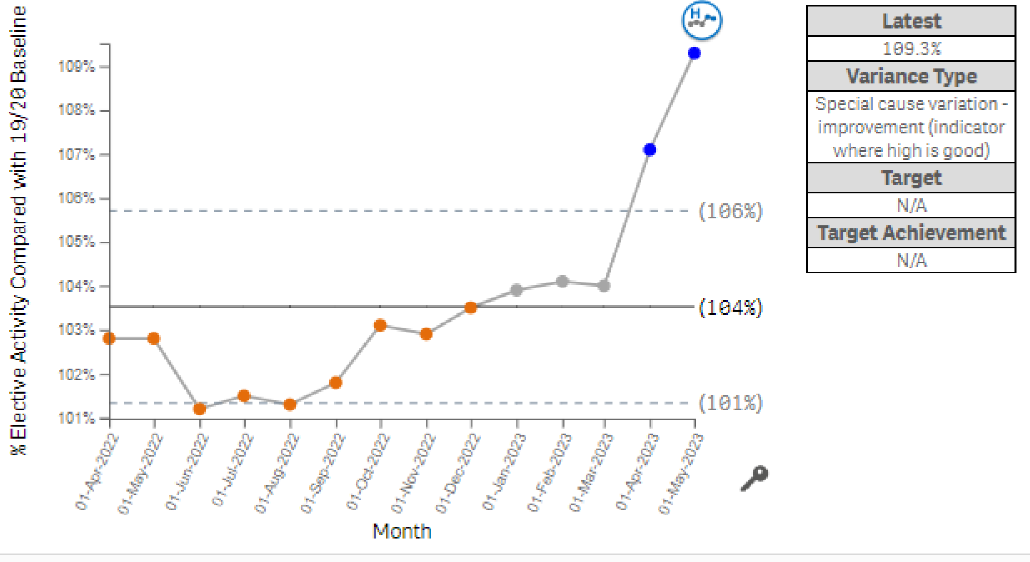
Actions:
Validation team to monitor LUNA (National DQ RTT Benchmarking tool – currently in top 30 Trusts in the country for RTT DQ Assurance).
Meet the trajectory for No ASIs over 18 weeks by the end of March 2024.
Meet the trajectory for 40/52/65 weeks.
Operational teams to be tracking patients to at 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.



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.

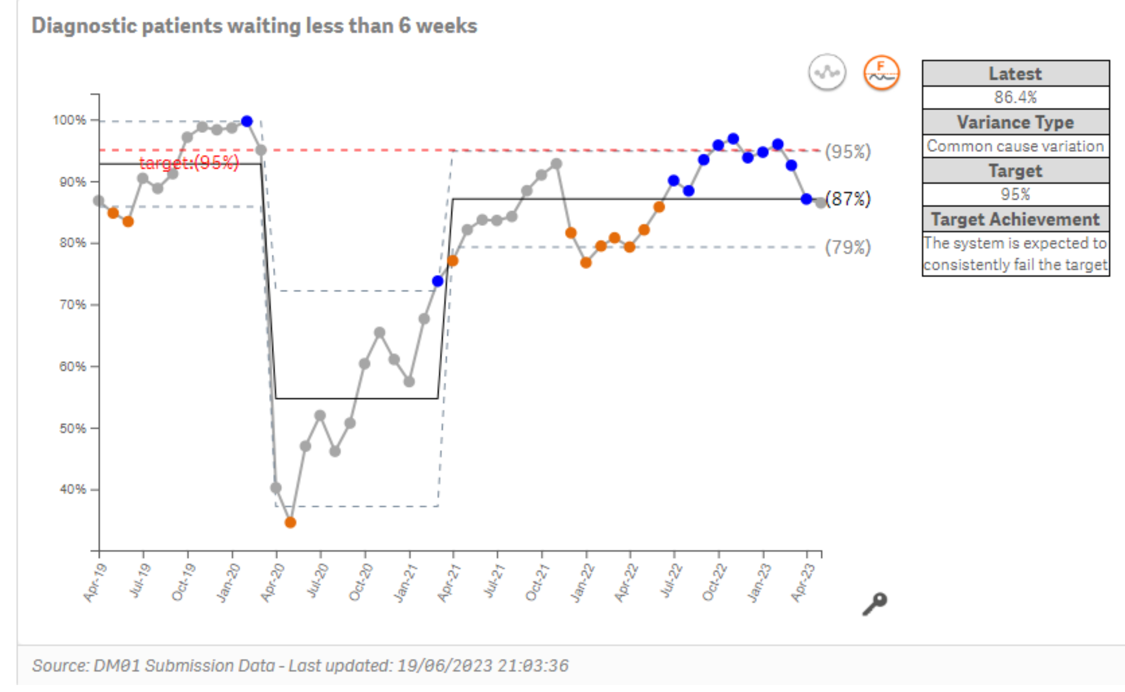
Percentage of patients waiting less than 6 weeks for a diagnostic test

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.

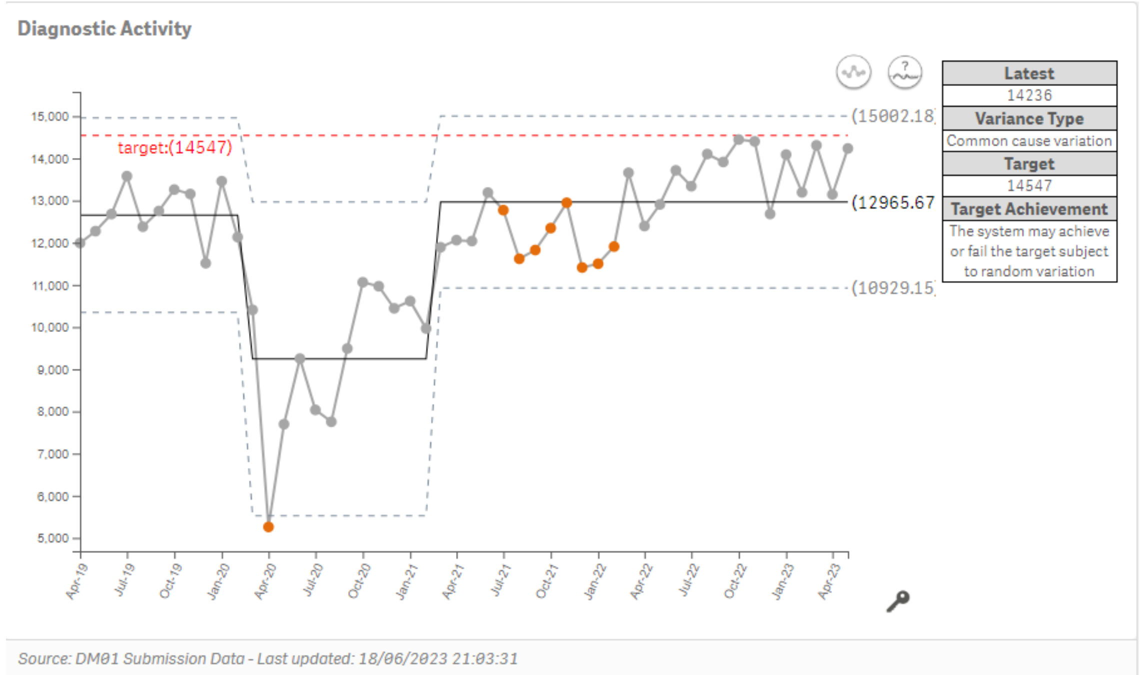
Total Diagnostic Activity undertaken against the activity plan

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.

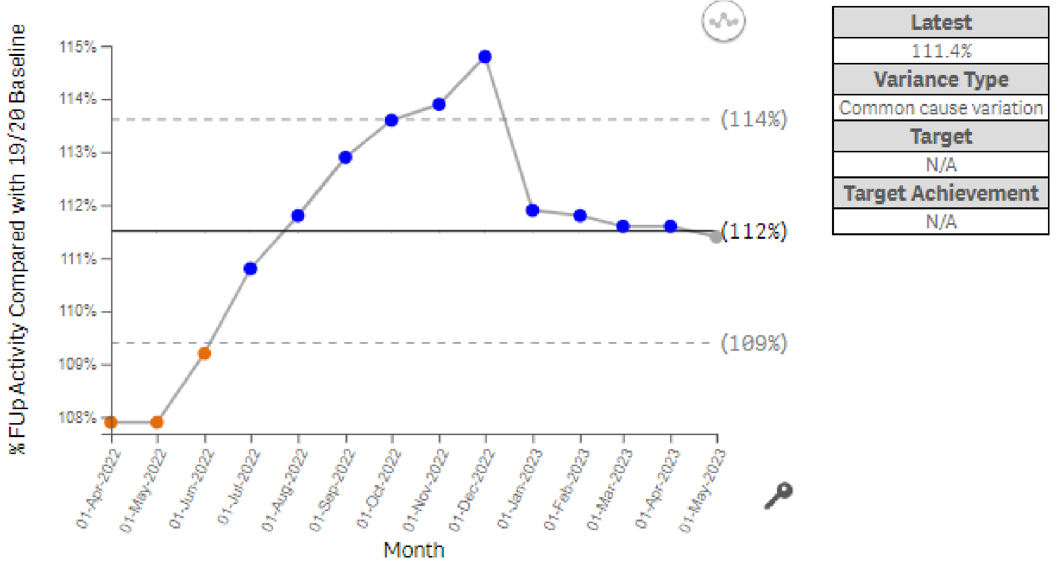
Neurophysiology
- Physiologists have now joined the team.
- The service has now been granted funding to book more locum EMG clinics until the end of June.
- Specialty doctor will be in position around July this year to perform independent EMG clinics.
- Trajectory to recover being reviewed.
- Interview 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:

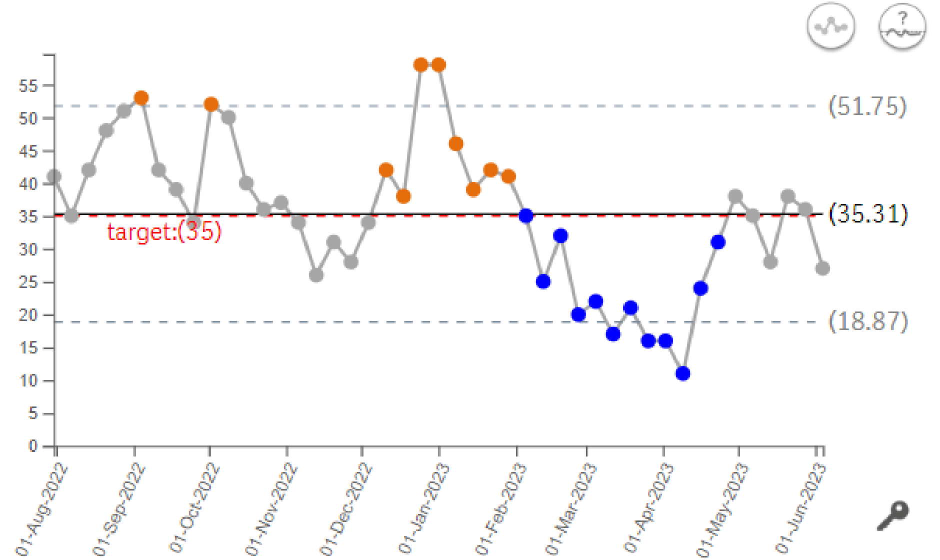
Metric	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Total Patients waiting >62 days to begin cancer treatment compared with February 2020 baseline	4th June 2023	27	35		?	35.31	18.87	51.75
Proportion of patients meeting the faster diagnosis standard	May 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



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:

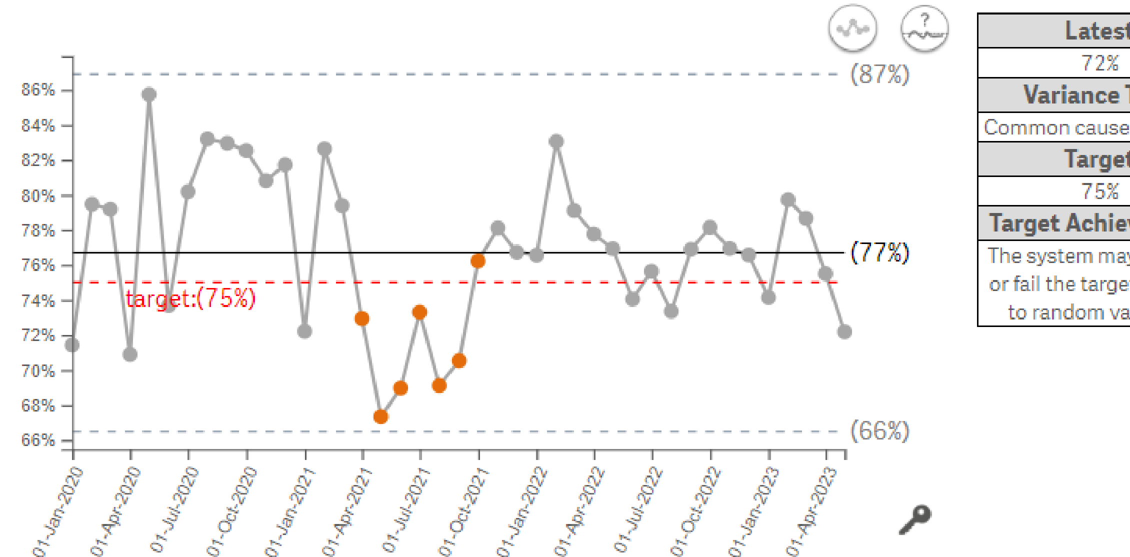
- Over 62-day waiters continuing to be monitored on a case by case basis by PPC team.

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%.



Latest
72%
Variance Type
Common cause variation
Target
75%
Target Achievement
The system may achieve or fail the target subject to random variation

What does the chart show/context:

- Latest monthly performance stands at 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.

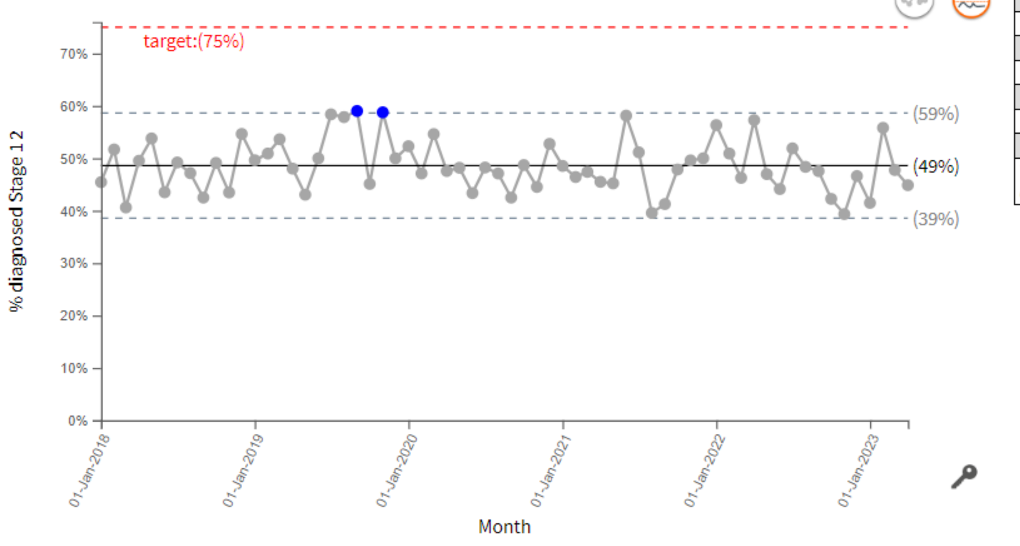
Early cancer diagnosis: 75% of cases diagnosed at stage 1 or 2 by 2028

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.

Cancers Diagnosed by Stage 1 and 2



Latest
44.9%
Variance Type
Common cause variation
Target
75%
Target Achievement
The system is expected to consistently fail the target

What does the chart show/context:
- The Trust is expected to consistently fail the target of 75%.
- Performance can be expected to vary between 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:

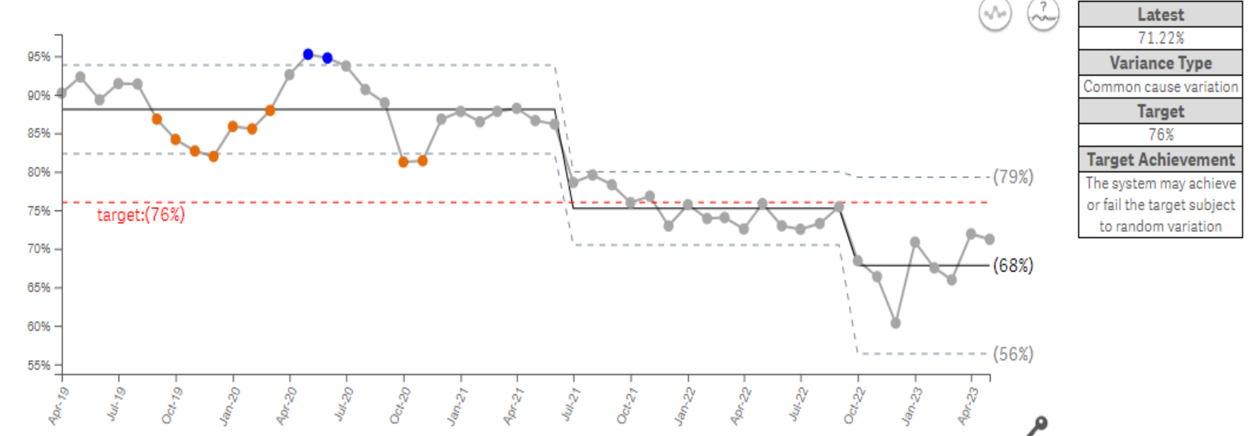
Metric	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Proportion of patients seen within 4 hours	May 2023	71.22%	76%		?	68%	56%	79%
Proportion of ambulance arrivals delayed over 30 minutes	May 2023	1.8%	0%		F	4%	1%	7%
Proportion of patients spending more 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%		F	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	H	?	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.

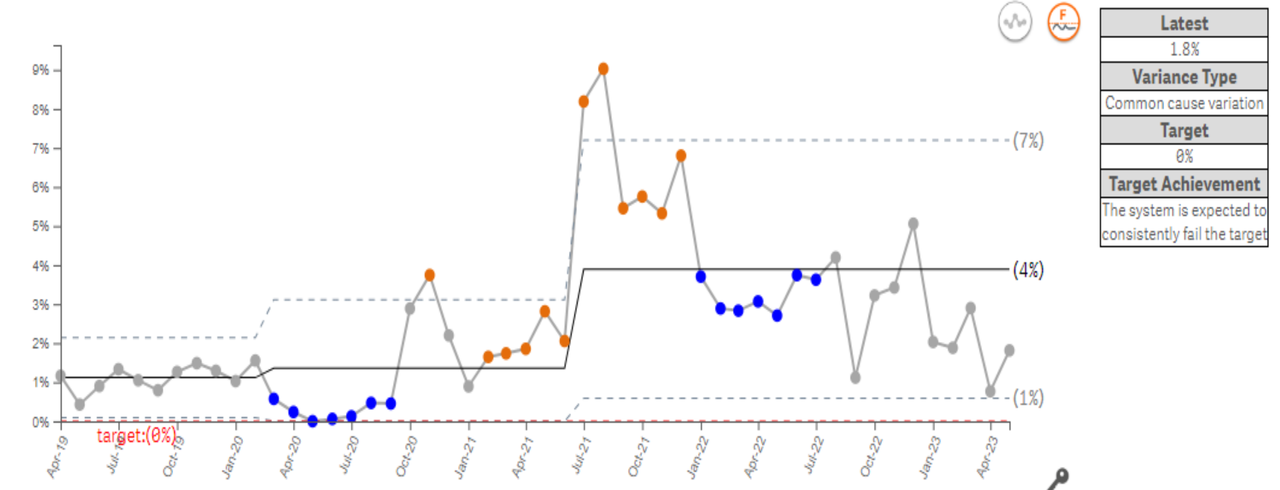
Proportion of ambulance arrivals delayed over 30 minutes

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)

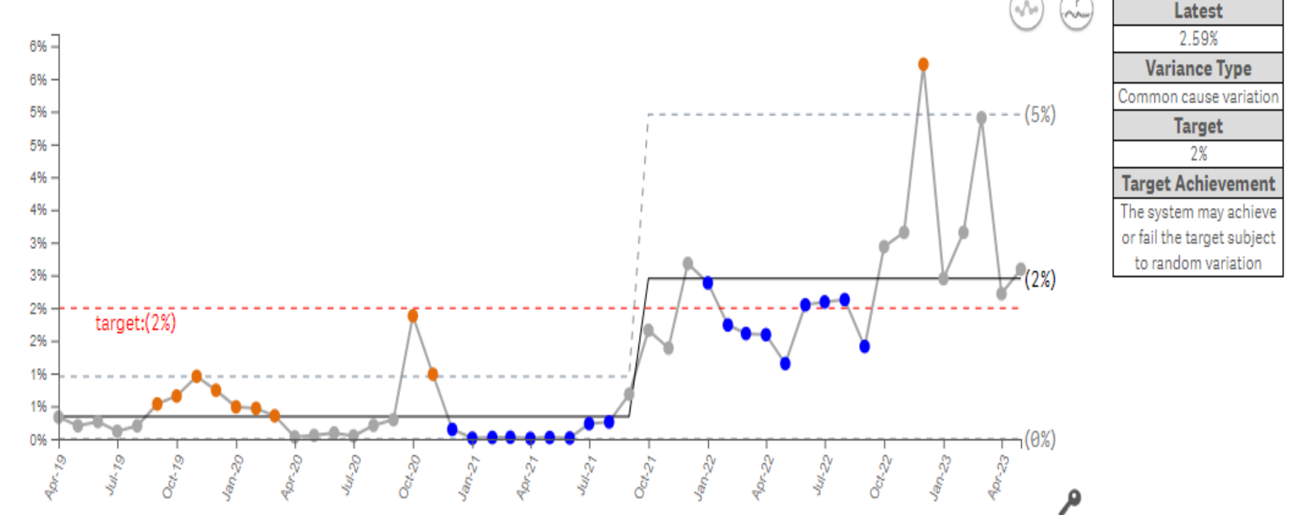
Actions:
Improvement for all metrics for ambulance handovers - SOP in action that ensures consistent approach to validation.

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

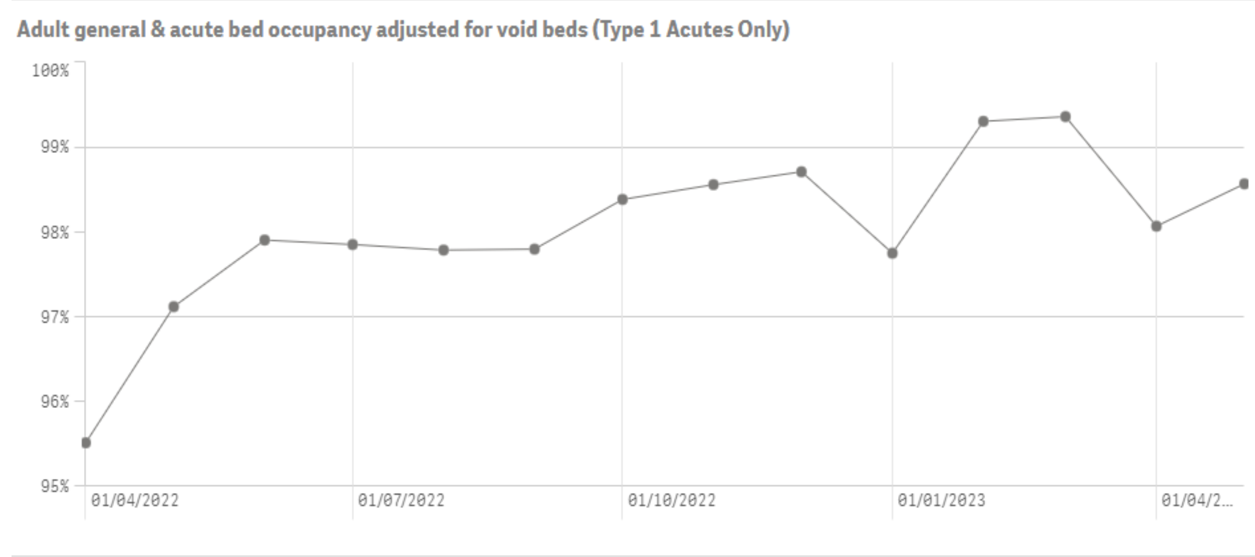
Actions:
Continue to monitor all long waiting patients and expedite DTA's to allow for beds to be acquired earlier in the patient pathway. We continue to work with Clinical Site Matron teams in early identification of patients who will require admission.

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.

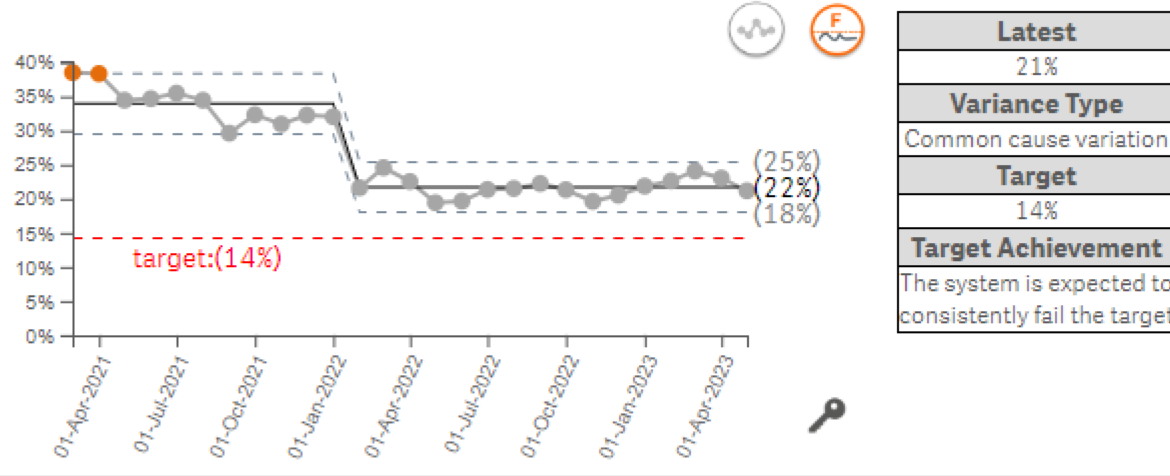
Actions:
- LOS reference group - targets in place to reduce LOS across Wards for TOC and Non-TOC patients to help reduce bed occupancy levels.
- Undertaking work to have a clear core beds base.
- Working with operational site teams to maintain capacity and drop occupancy levels.
- Long length of stay 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.

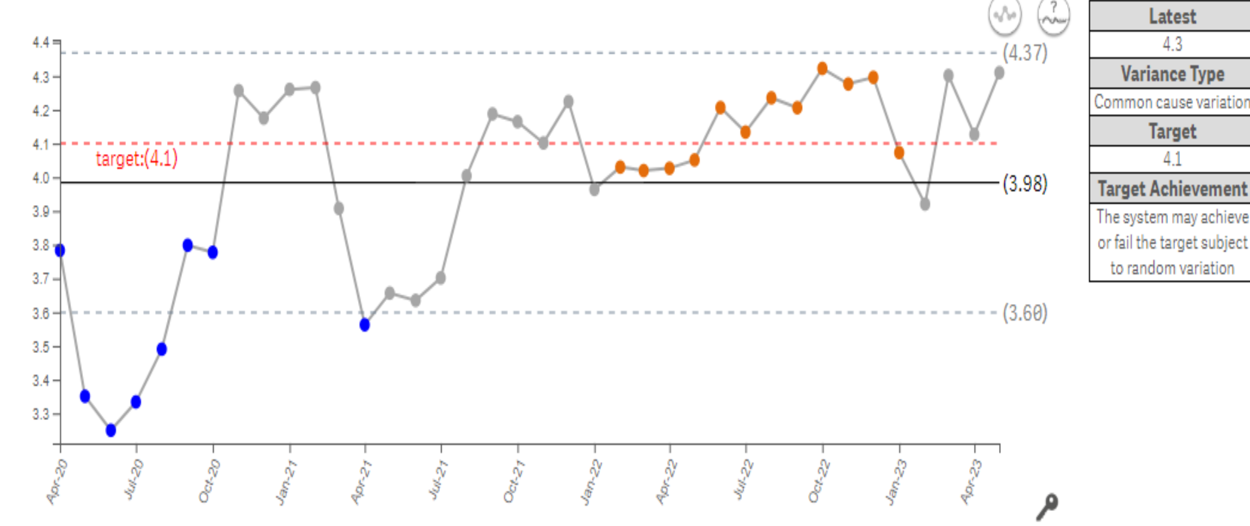
Actions:
- Set up digital boards with 5 wards
- Amalgamate the R2R project into the digital boards project
- Length of stay reduction programme will monitor R2R position alongside Plan For Every Patient (PFEP)

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

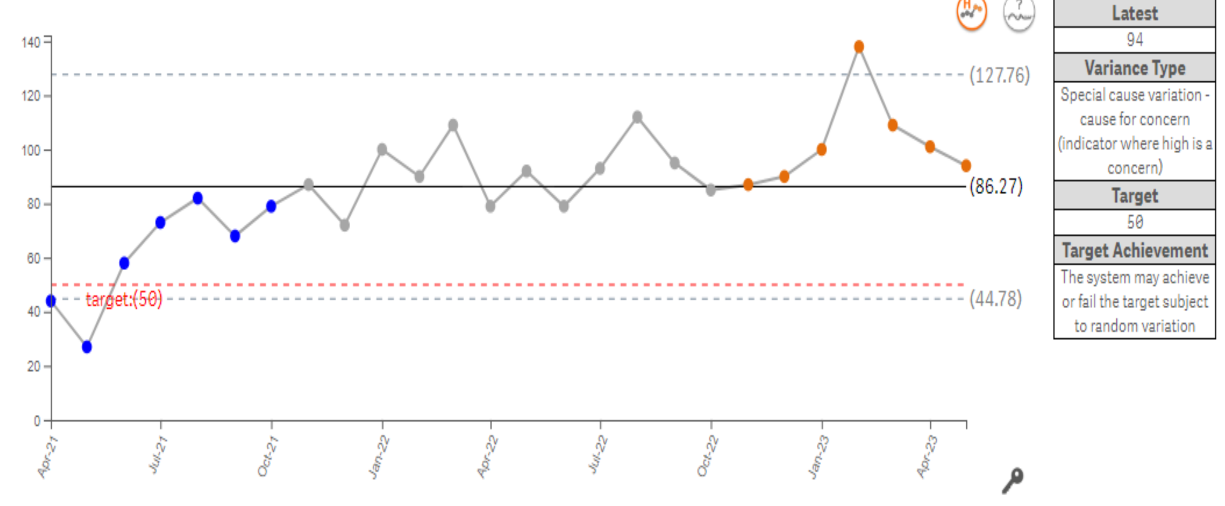
Actions:
- Two Improvement groups commenced, SDEC and LOS working groups to look at
  - Plan for Every Patient/Reason 2 Reside
  - Home First/D2A
  - Criteria Led Discharge
  - UCR/Virtual Ward
- KPIs for each working group
- Feedback to take place monthly at UECDG against the KPIs and available data
- 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:

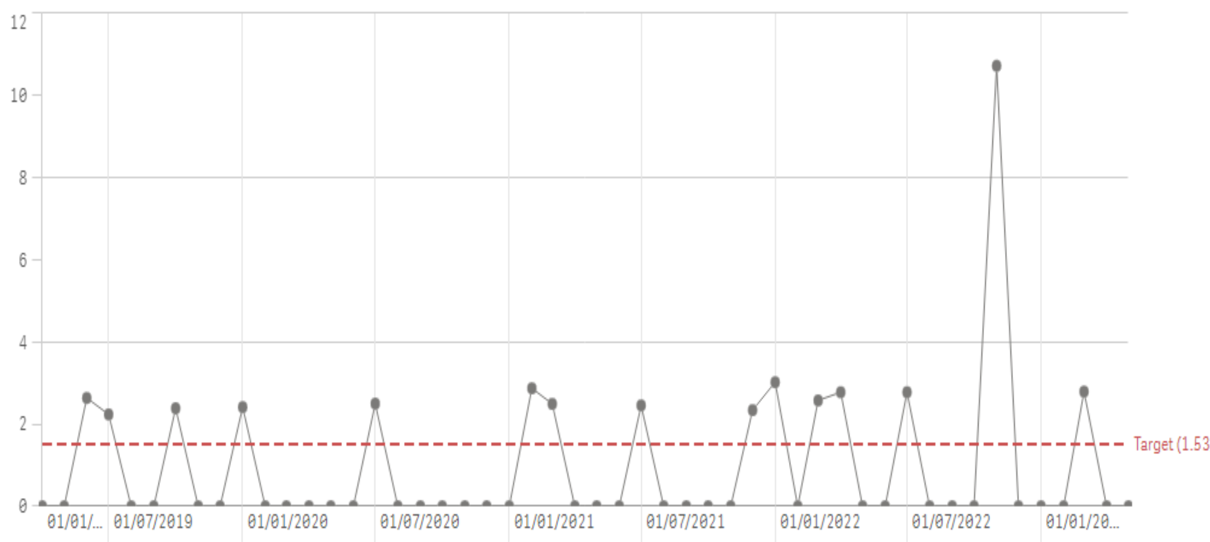
Metric	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Neonatal deaths per 1,000 total live births	May 2023	0	1.53					
Stillbirths per 1,000 total births	May 2023	5.28	3.33		?	3.85	0	13.09

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.

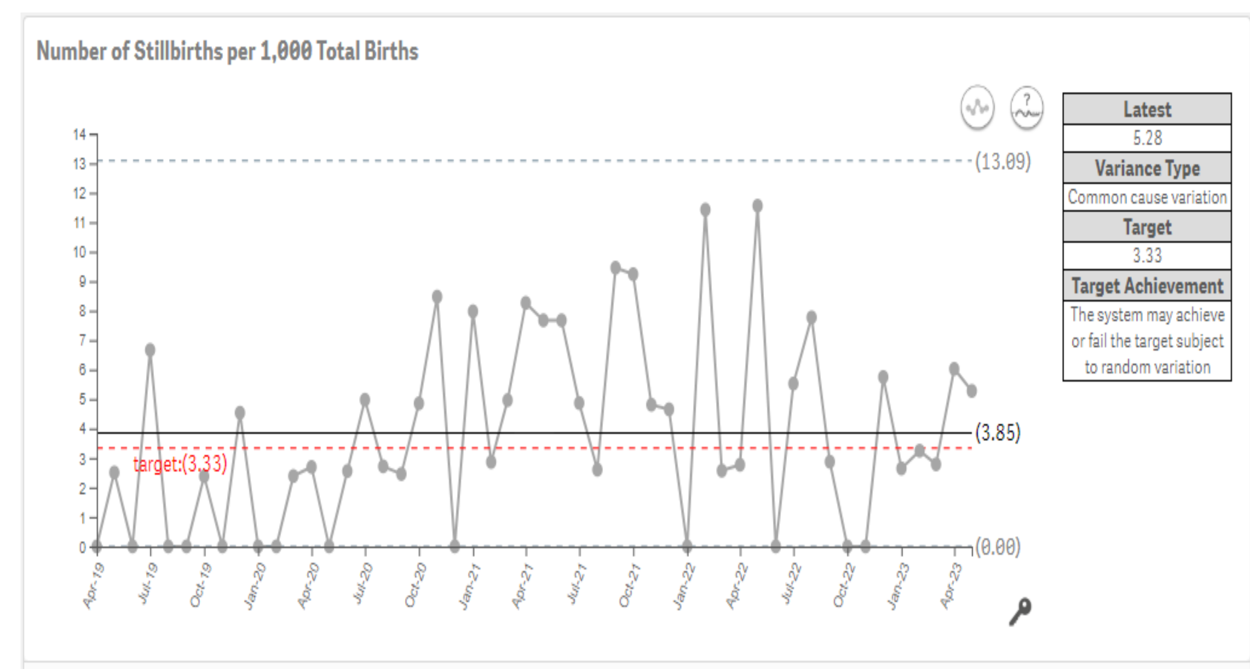
Actions:
- All early neonatal deaths reviewed at Orange Panel and weekly governance meeting
- All neonatal deaths MDT PMRT completed
- All early neonatal deaths referred to HSIB
- Regular quarterly stillbirth/neonatal audit undertaken
- Responsive review of neonatal deaths undertaken due to increase 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:

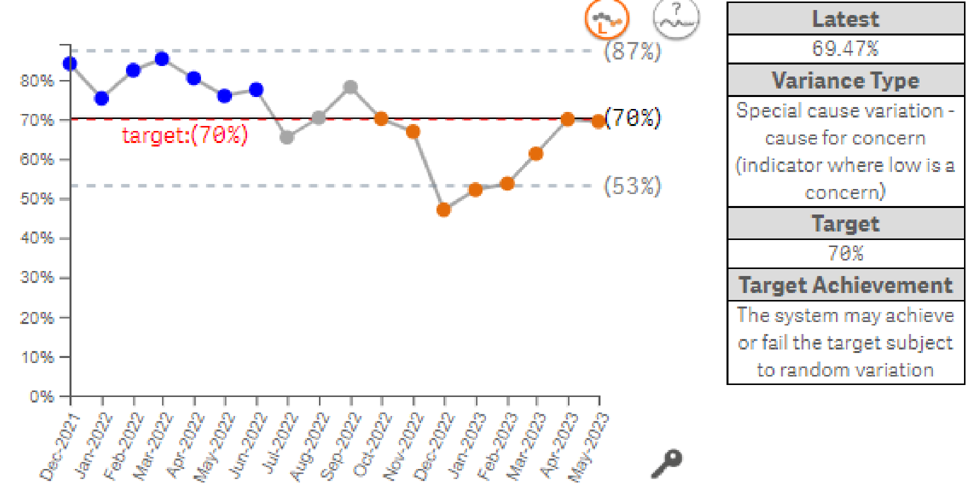
Metric	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Proportion of Urgent Community Response referrals reached within 2 hours	May 2023	69.5%	70%			70%	53%	87%
Community Waiting List	May 2023	5,934	4,387 (end 23/24)					
Virtual Ward	May 2023	33%	80%					

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%.



Latest
69.47%
Variance Type
Special cause variation - cause for concern (indicator where low is a concern)
Target
70%
Target Achievement
The system may achieve or fail the target subject to random variation

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.

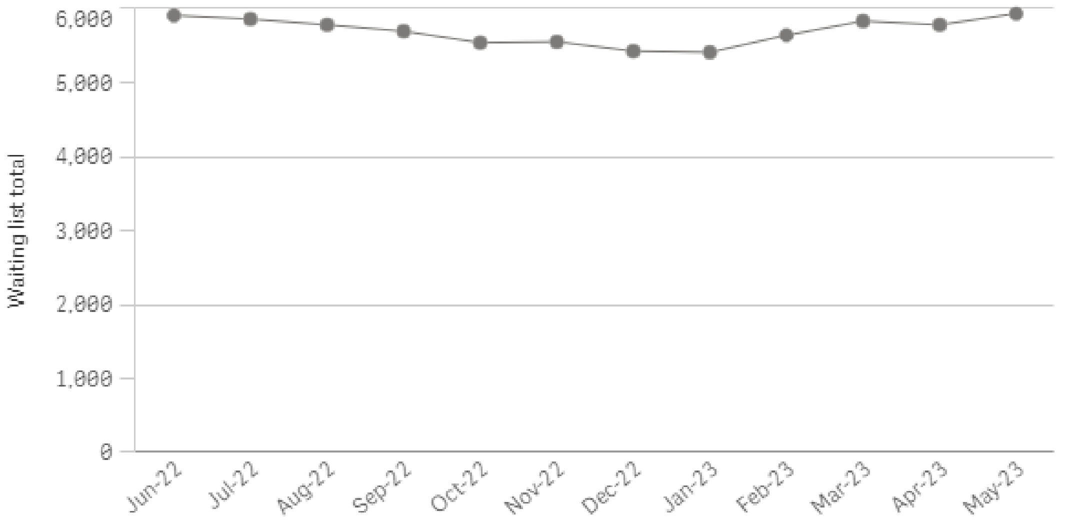
Actions:
Communications to service leads around accurate data recording.
Audit as described above to identify joint improvement work needed with LCD.

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.

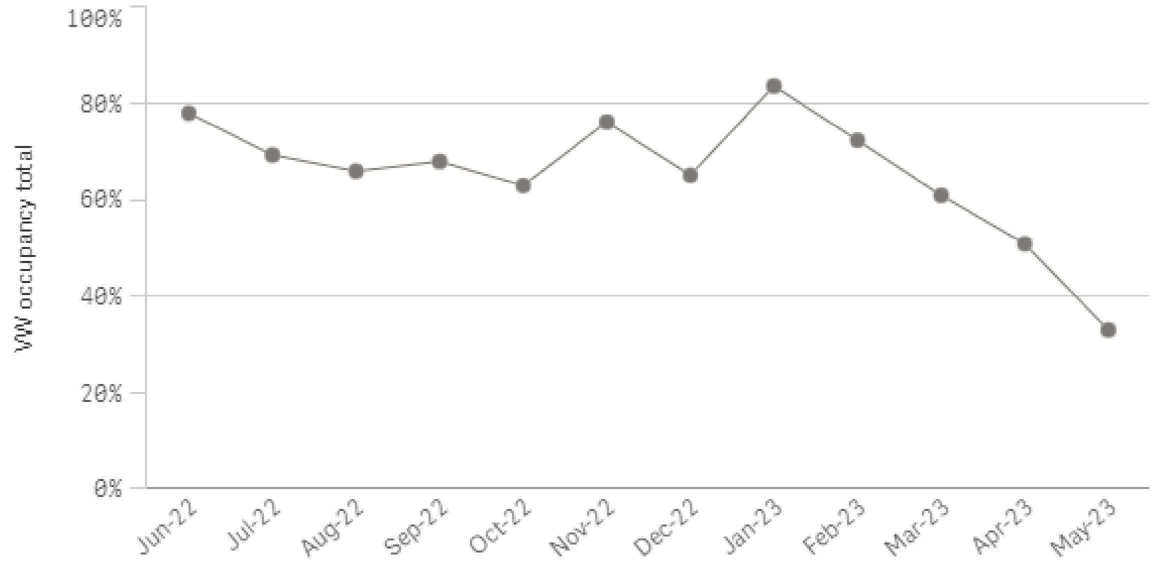
Actions:
Recruitment opportunities being considered (incl. developmental and rotational posts and lower banding).
Short-term waiting list initiatives being planned for Children's SALT alongside agreed dates for implementation for new service structure which will improve efficiency.

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:

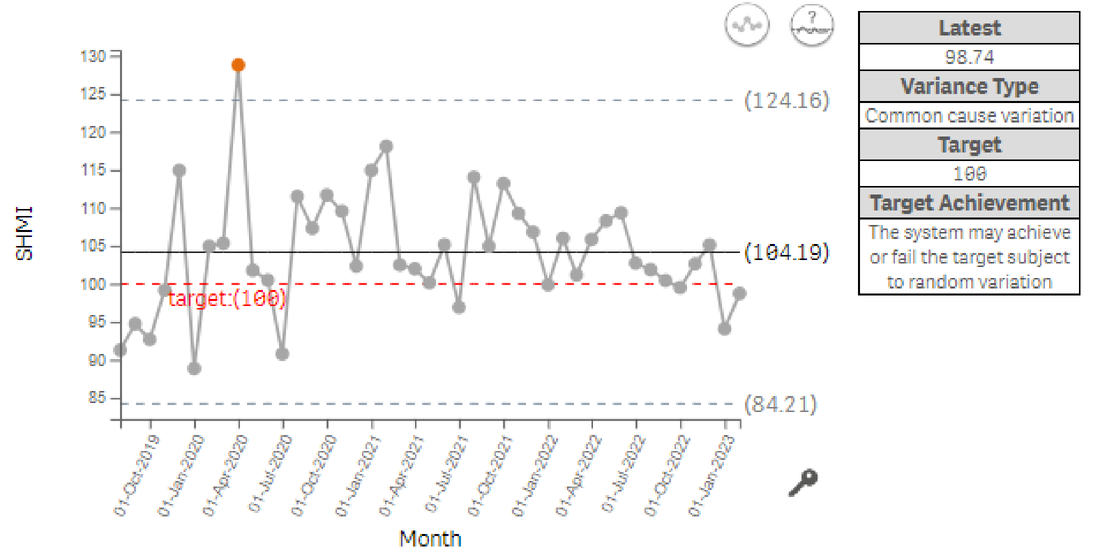
Metric	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Summary Hospital-level Mortality Indicator	February 2023	98.74	100		?	104.19	84.21	124.16
Care Hours Per Patient Day (CHPPD)	May 2023	9.1/8.0	-	-	-	-	-	-
Falls per 1000 Bed Days	May 2023	7.2	7.02	L	?	8.56	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%		P	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.

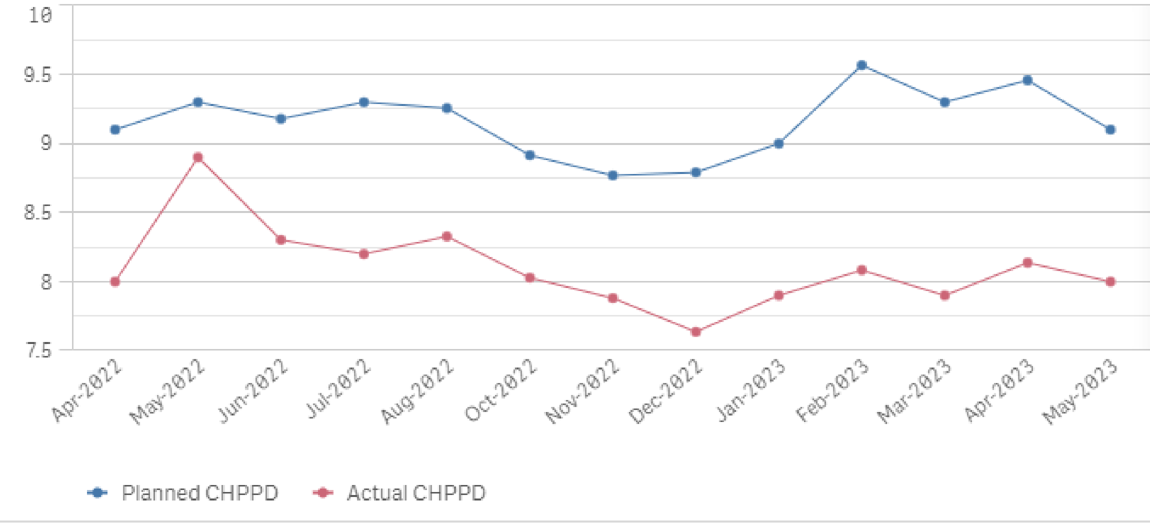
Actions:
As noted above there was an increase in overall deaths in December 2022 and notable increase from the average number of monthly deaths in the Emergency Department. A review of these deaths is being undertaken to clarify that this is due to a spike in acute, co-morbid patients and not due to 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.

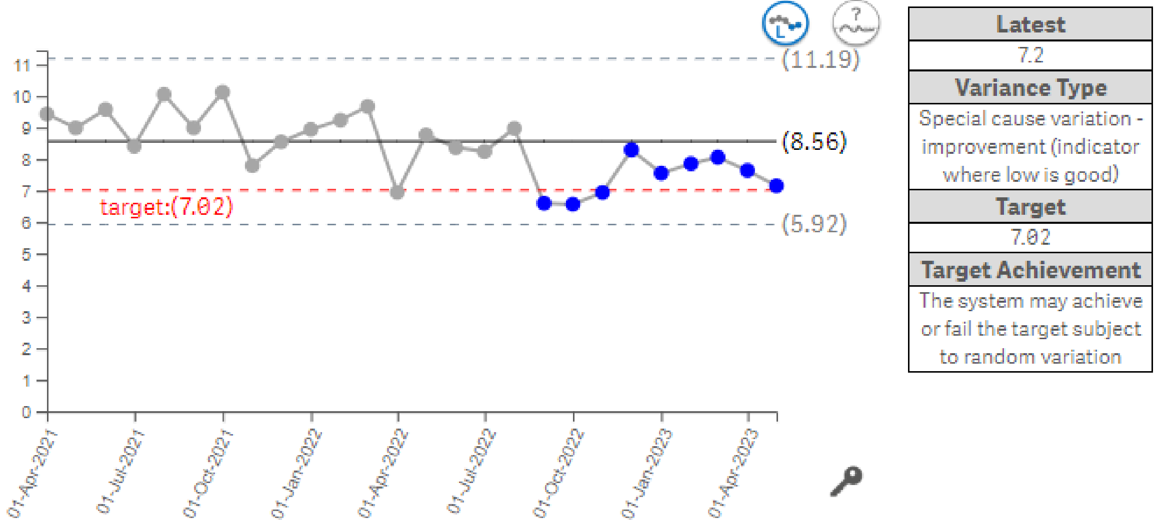
- The Hard Truths process gives assurance of the correct workforce models based on evidence-based acuity and dependency data, agreed nurse sensitive quality indicators and professional judgement.
- Recruitment strategies including employment of new graduates; internationally educated nurses, midwives, 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

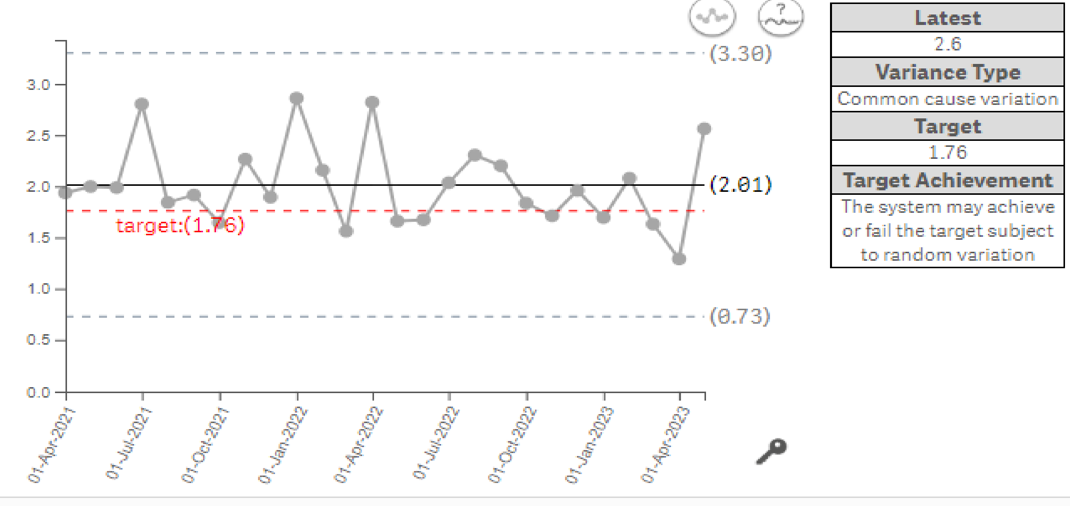
Actions:
- Relook at the TOR of the falls collaborative
- Falls link nurses to be allocated and invited
- Appoint a medical lead to lead falls
- Renee to continue with reconfiguration plan around the enhanced care team
- Education as part of the revamped Enhanced Care team processes and assessments

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.

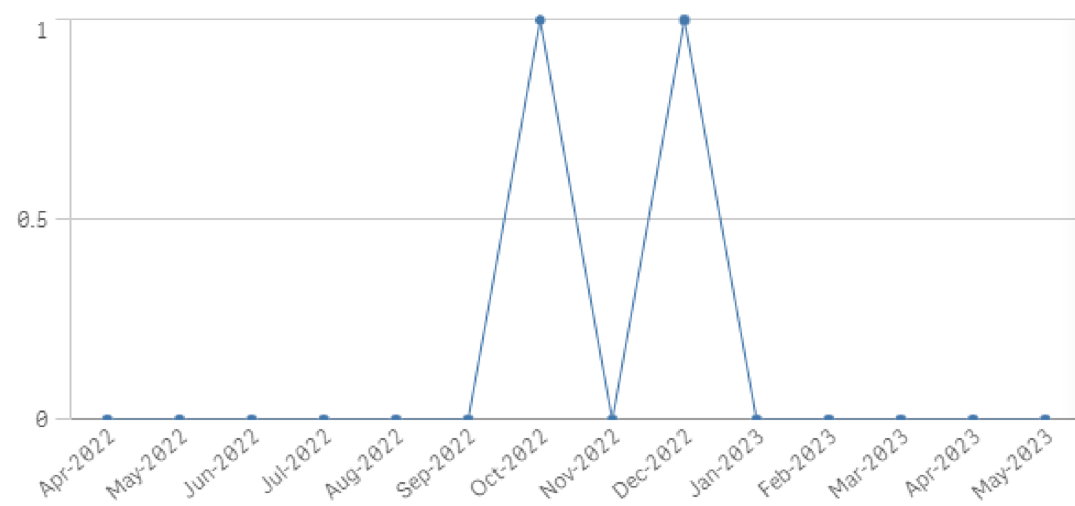
Actions:
- PURPOSE T PU risk assessment tool replacing Waterlow on 17th July 2023
- New revised care plans implemented for hospital and community to align with PURPOSE T
- PU CQUIN data collection has commenced
- Processes for PU investigations and learning being reviewed in line with PSIRF
- Heel PU 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:

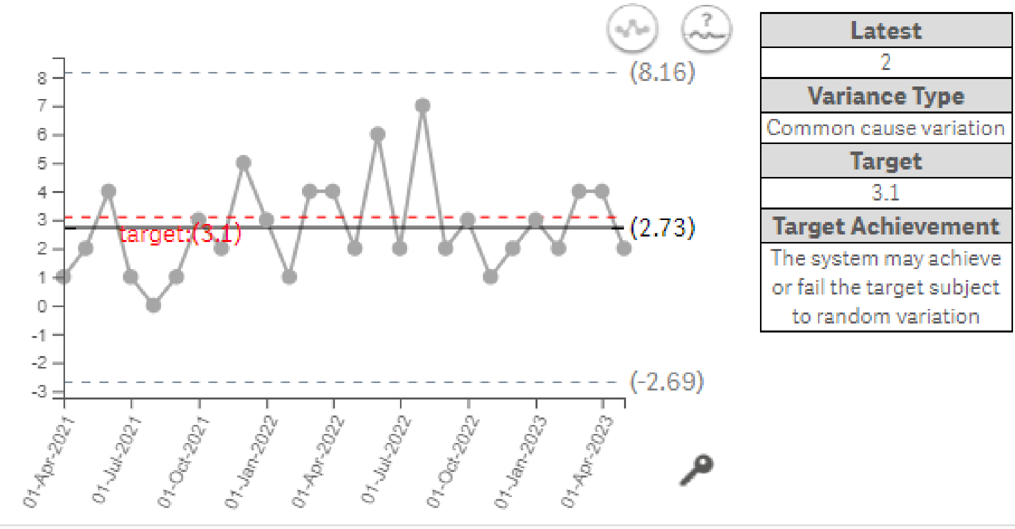
- Admission/pre-admission MRSA screening is monitored. Data accuracy has been an issue. An initial data cleanse has been completed and improvements seen. A further piece of work is underway with FSS.
- Colonisation suppression prescribing is via a POWERPLAN in EPR. Visual user guides are provided to 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.

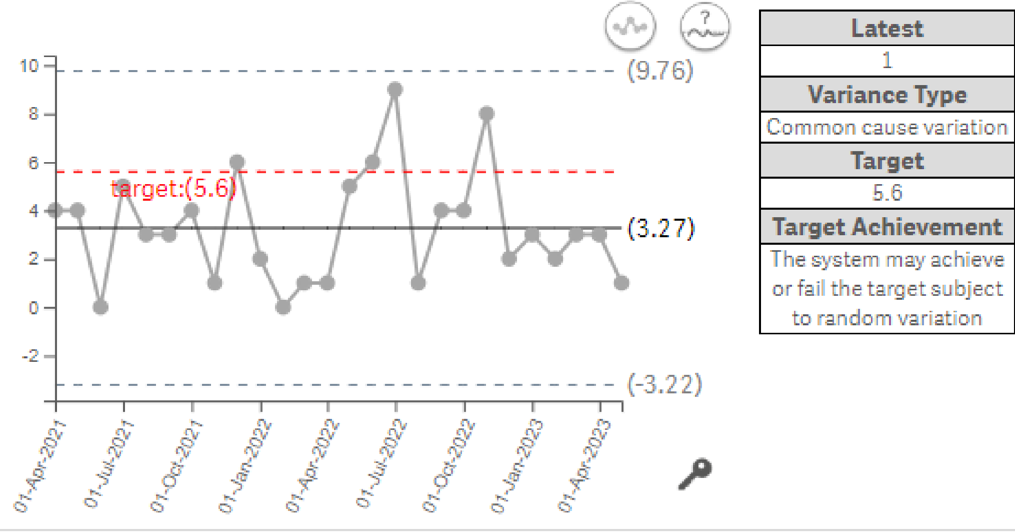
Actions:
The Trust has implemented an improvement plan including a programme of HPV deep cleaning (to be agreed), C.Diff ward rounds, antimicrobial ward rounds and a review of the investigation process for cases. NHSEI has carried out a support visit in March, with positive feedback. Their recommendations 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:

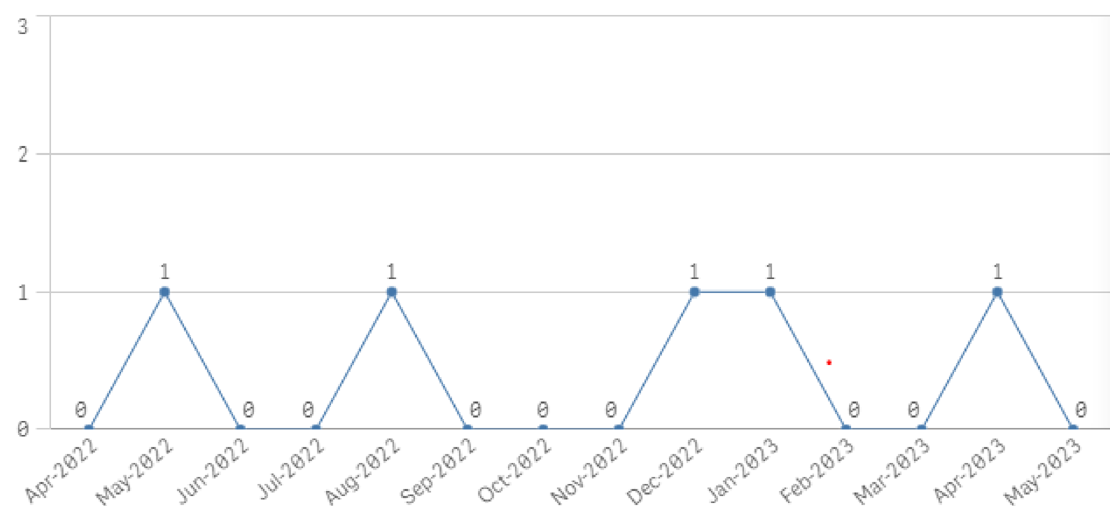
- Extended surveillance of all the cases is conducted and uploaded to the UKHSA DCS system for national analysis.
- As part of the workplan of the IPCT, an annual audit of catheter management has been completed and recommendations shared with the divisions for implementation.
- A regional working group (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

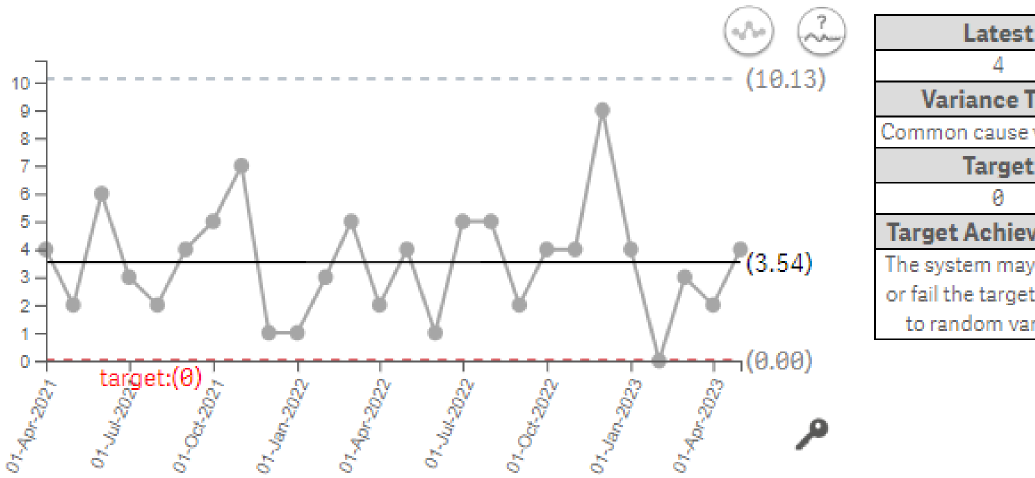
Actions:
- Immediate learning identified following all incidents
- Investigations ongoing
- A deep dive of Never Events has been commissioned due to themes and trends identified
- SWARM model introduced to support staff, patients and families

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).

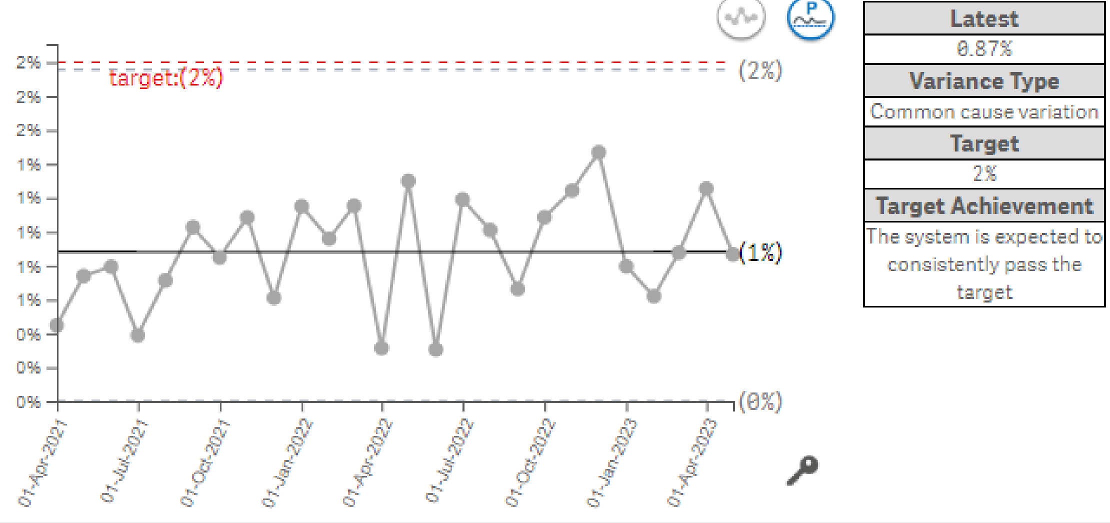
Actions:
Risk management team supporting the Divisions to review data for learning. In addition, Quality & Safety Team working with Care of the Acutely Ill Patient Lead to ensure quality improvements are commenced where required. This will align to the Quality Priority for Care of the Acutely Ill Patient 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



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.

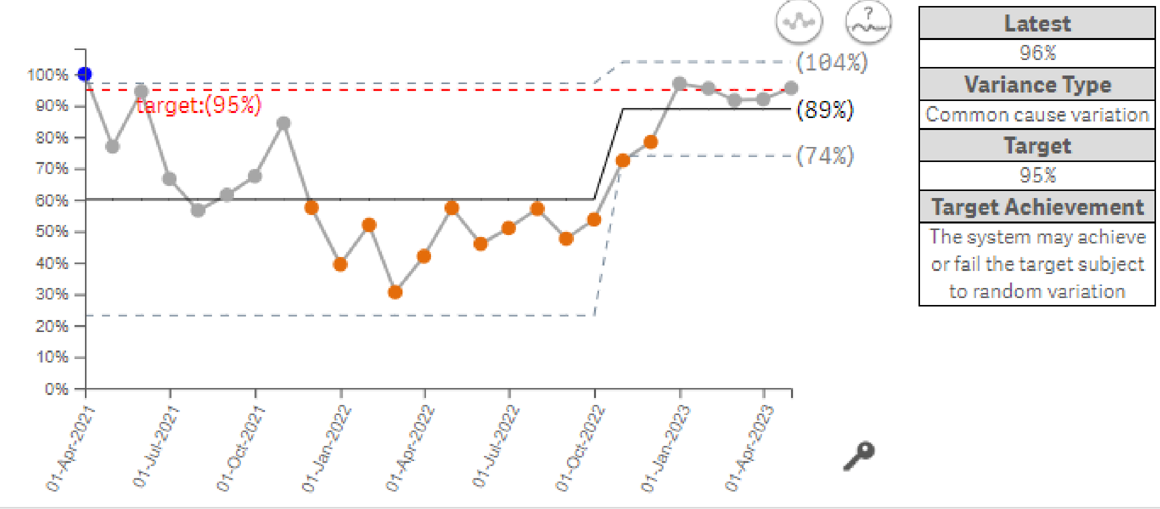
% of complaints within agreed timescale

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.

% of Complaints Closed within agreed timescale



Latest
96%
Variance Type
Common cause variation
Target
95%
Target Achievement
The system may achieve or fail the target subject to random variation

Source: KP+ Quality stream, Complaints app - Last updated:29/06/2023 05:37:53

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:

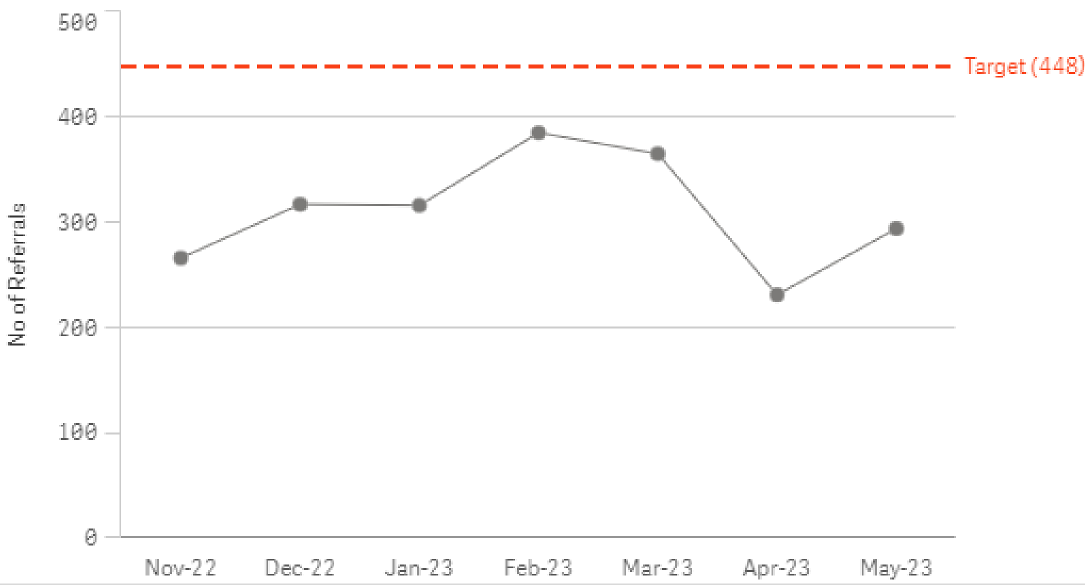
Metric	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Alternatives to Hospital Admission – Number of referrals into the Frailty service	May 2023	294	448	-	-	-	-	-
% of episodes scoring NEWS of 5 or more going on to score higher	May 2023	33.8%	30%		?	32%	28%	36%
% of adult patients that receive a MUST assessment within 24 hours of admission/transfer to the ward.	May 2023	21.05%	95%		F	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.

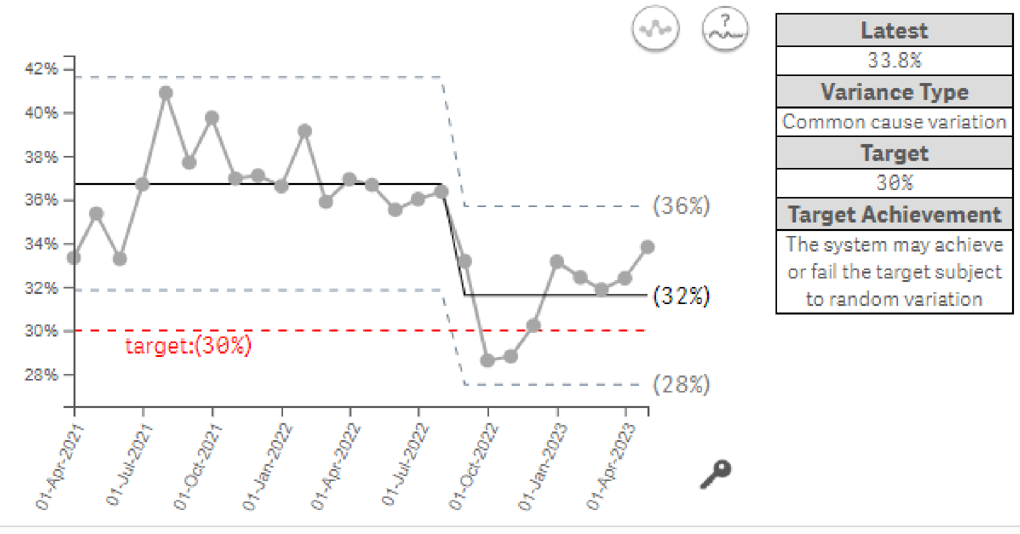
Actions:
Medical division reviewing medical cover to support a 7-day MDT for frailty virtual ward. Other organisations have not all been able to recruit consultants but backfilled with a registrar.
The Advanced Clinical Practitioner working on frailty SDEC on a weekend is supporting Kirklees virtual 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

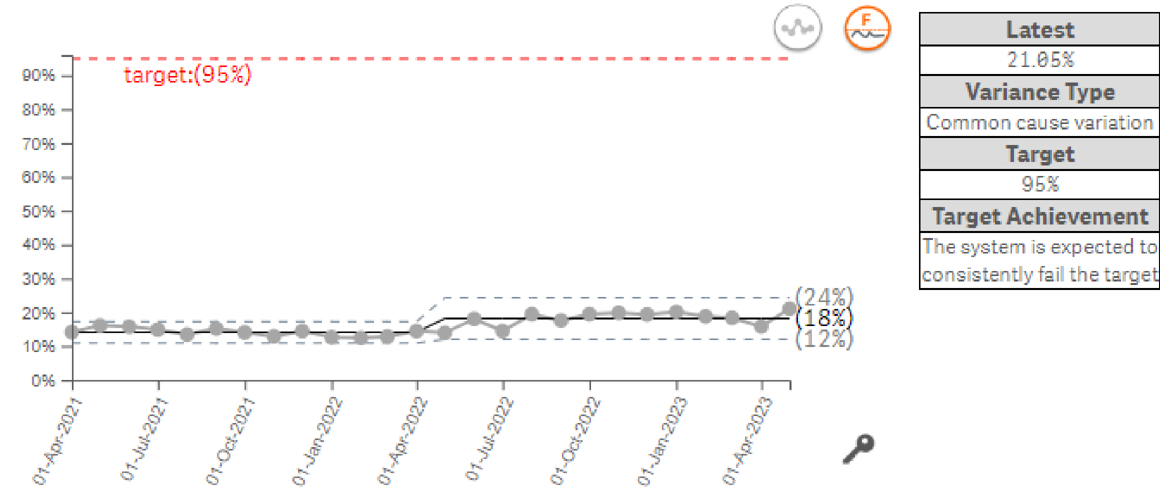
Actions:
- All divisions have a consistent representative at the Deteriorating Patient & Sepsis collaborative.
- Ward Managers and Matrons to regularly check KP+ for their Observations on Time performance.
- Deteriorating Patient CQUIN audit will highlight any further actions to be fed through Deteriorating 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.



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:

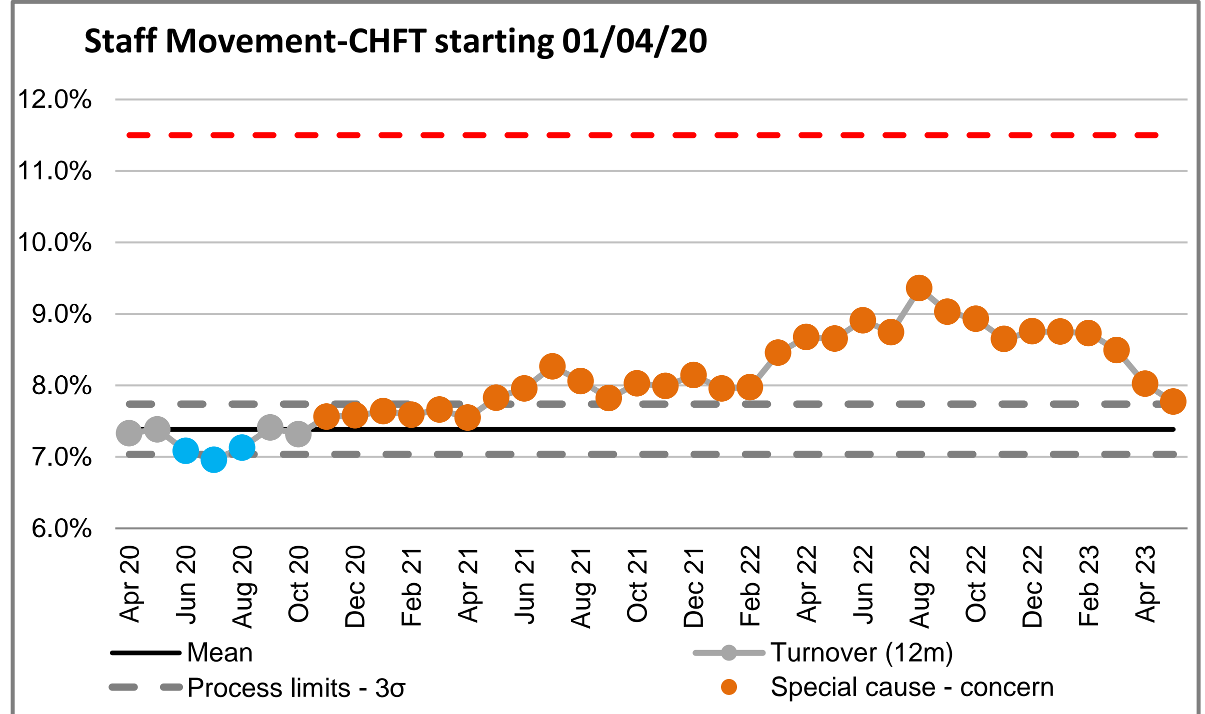
Metric	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Staff Movement (Turnover)	May 23	7.77%	11.5%	H	P	7.38%	7.30%	7.45%
Sickness Absence (Non-Covid)	May 23	4.47%	4.75%	H	P	3.97%	3.94%	4.02%
Appraisal Compliance (12m rolling)	May 23	79.3%	95.0%	H	F	53.8%	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.

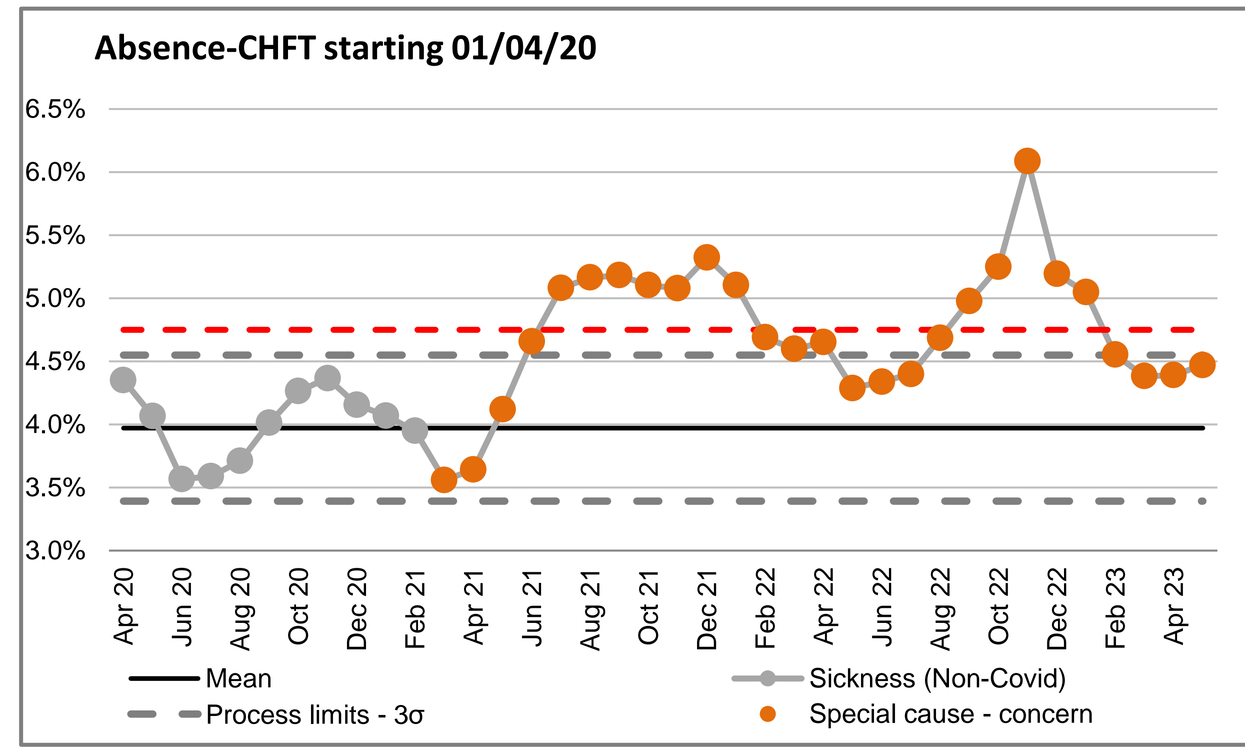
HCSW retention review is underway with an exit interview review. Actions to address an increasing number of leavers will then be developed.

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.

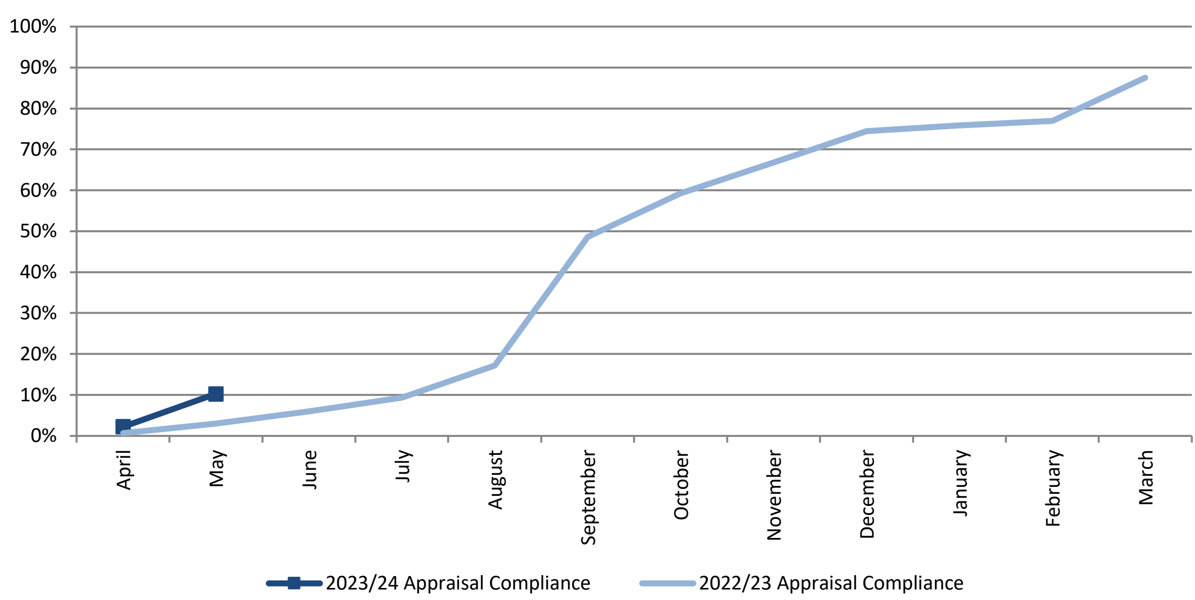
HRBP's link with the Trust Workforce Psychologist to assess how best to access and support colleagues suffering with stress and anxiety symptoms, and how to proactively provide support to minimise/reduce absence length where possible.

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

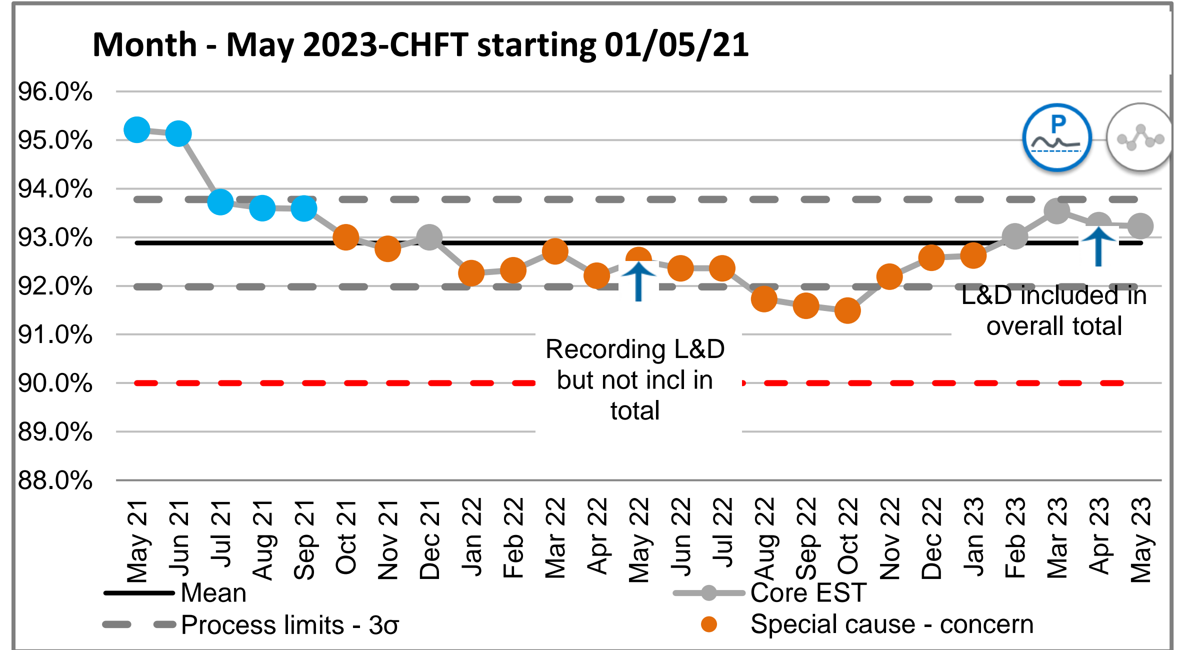
Actions:
- A “how to guide to appraisals” video has been developed for the 2023/24 appraisal season and is part of our “management fundamentals” offer to make it a more “people centred conversation”.
- ESR recording guidance produced to support managers so we capture all activity.
- Targeted approach 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.

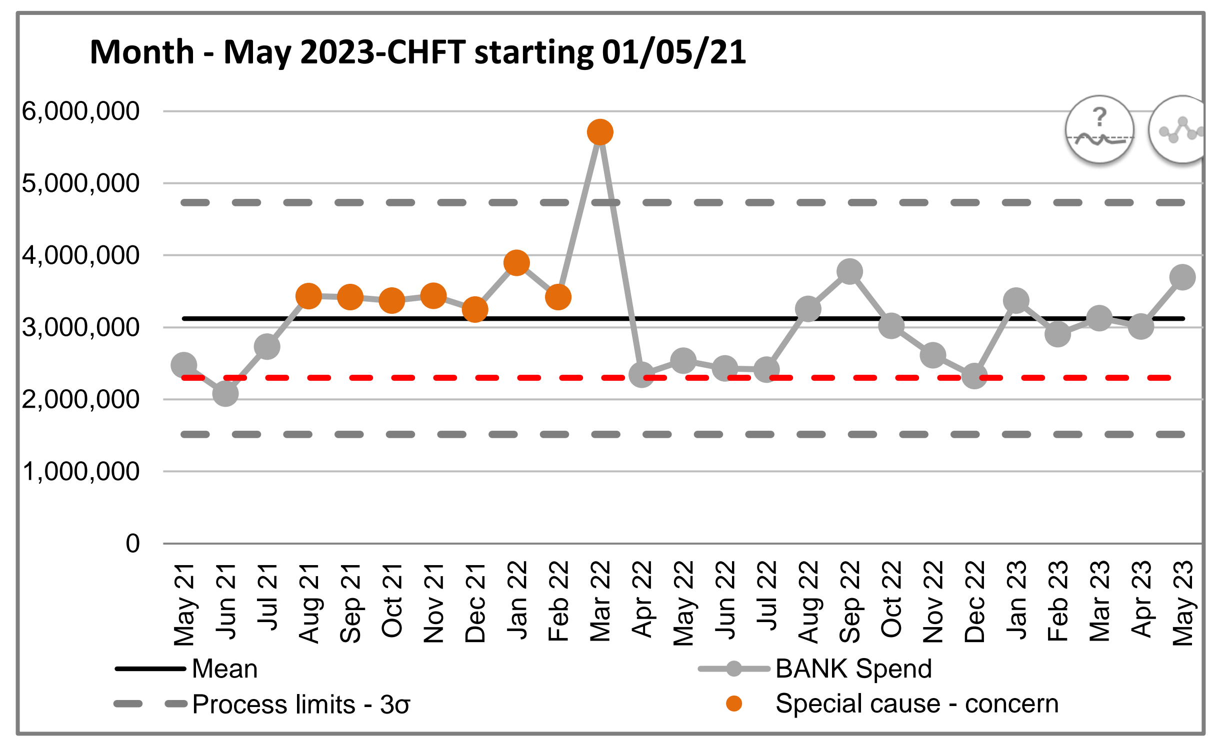
All colleagues that are non-compliant with Data Security Awareness are being contacted to encourage completion of the training before 30th June 2023.

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.

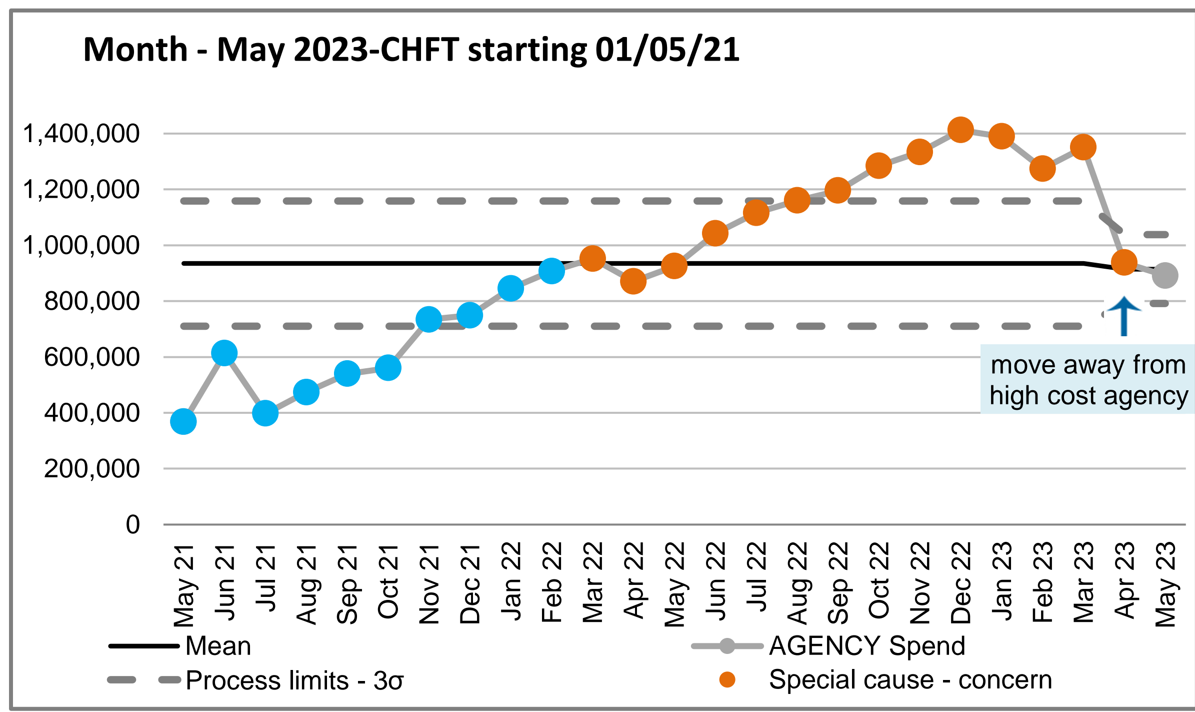
Actions:
Director approval is required for any variation from agreed bank rates.

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.

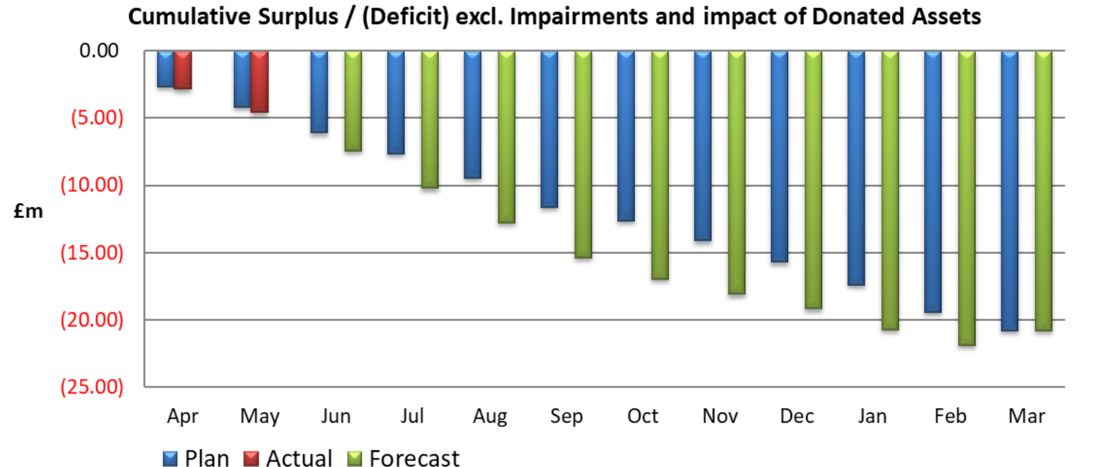
Work to reduce Tier 3 agency usage commenced in January 2023 and the Trust ceased routinely sending shifts to Tier 3 agencies in May 2023. Tier 3 agencies are now only used in exceptional circumstances and require approval from the Deputy Chief Nurse.

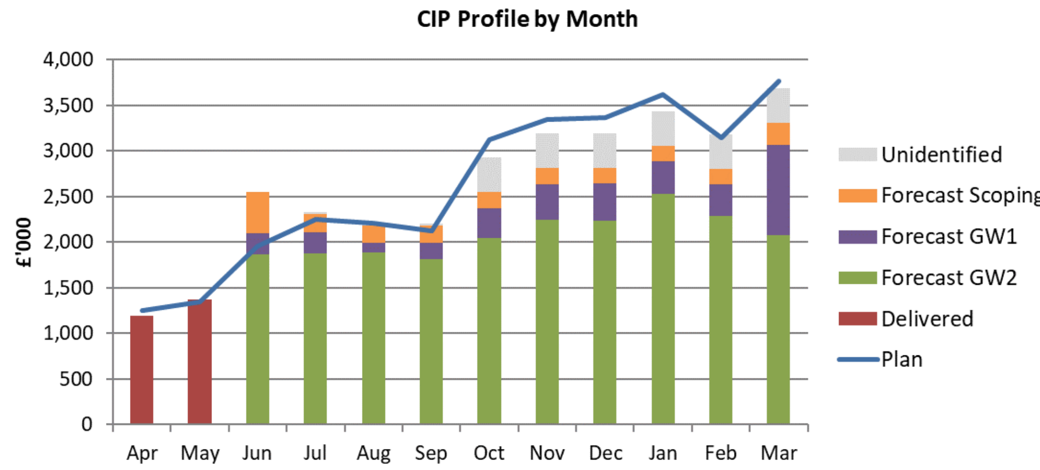
Finance:

- 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.

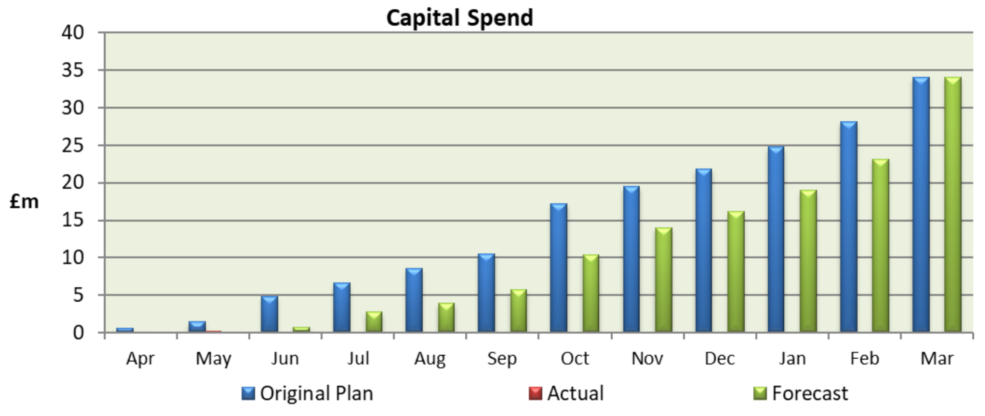
Underlying issues:

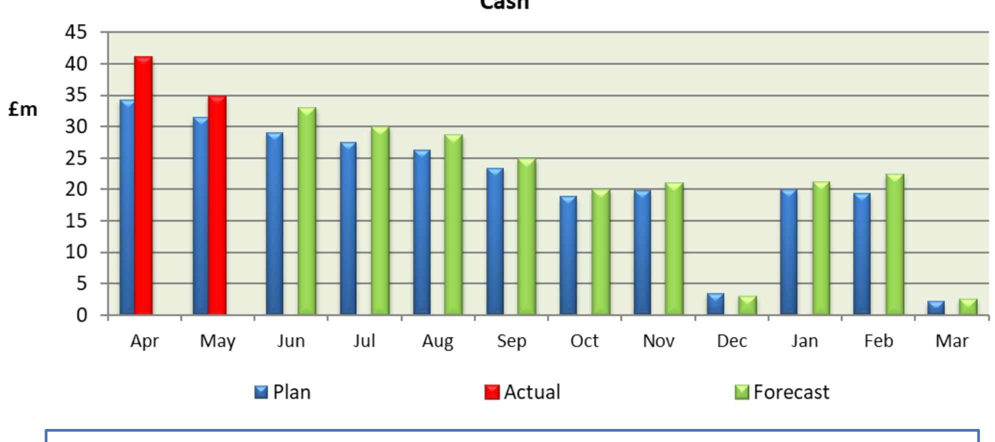
- Year to date the Trust has incurred higher than planned costs due to higher than planned additional bed capacity of £0.47m (£0.28m surge capacity plus £0.19m slippage on the LOS CIP), the Doctors Strike (£0.20m) and higher than expected Utilities costs. These pressures were offset by early delivery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

Date of Meeting:	6 July 2023
Meeting:	Board of Directors
Title:	Safeguarding Adults and Children - Annual Report
Author:	Andrea Dauris (Associate Director of Nursing – Corporate Services) Alison Edwards (Head of Safeguarding – CHFT)
Sponsoring Director:	Lindsay Rudge (Chief Nurse)
Previous Forums:	Safeguarding Committee Meeting 7 June 2023 Quality Committee 21 June 2023

Actions Requested:

TO NOTE: The key activity of the Safeguarding Team for the reporting period April 2022 - March 2023

Purpose of the Report

This report provides an overview of the national and local context of safeguarding and areas of practice included in safeguarding across the Trust for the reporting period April 2022 - March 2023.

The report provides assurance to the Board of Directors highlighting key performance activity and information of how its statutory responsibilities are being met, and of any significant issues or risks, and how these are mitigated.

The report provides a focus on the work and commitment to safeguarding children and adults provided by the Safeguarding Team referring to: -

- Prevent
- Safeguarding Boards/Partnerships
- Hidden Harms
- Mental Capacity Act and Deprivation of Liberty Safeguards/Liberty Protection Safeguards
- Training
- Safeguarding Supervision
- Adult Safeguarding
- Children's Safeguarding
- Mental Health
- Children Looked After Calderdale
- Maternity Safeguarding

Key Points to Note

- We have achieved above 90% compliance in levels of safeguarding Adults/Children/ Prevent/ MCA/DoLS training
- Training compliance is below 90% for Female Genital Mutilation (FGM- 89% - 2% increase since March 2022) and Receipt and Scrutiny Training (66% - 2% decrease since March 2022)
- Our internal safeguarding training and MCA programme has been reviewed and is now compliant with the Intercollegiate Documents for Children, Adults and Looked After Children
- Safeguarding supervision is reported at 76% which demonstrates a 20% increase in compliance since March 2022.
- We continue to maintain a business-as-usual functionality continuing with day-to-day operations and attendance at multi-agency virtual Safeguarding Adults Board meetings and Children's Partnership meetings for Calderdale and Kirklees and their sub-groups.
- We continue to report on our progress in relation to the Safeguarding Strategy (2022 - 2024) through the Safeguarding Committee to monitor our progress in relation to our key priorities, ensuring these are aligned with the safeguarding Adult's Boards and Children Partnerships.
- We have completed the Safeguarding Standards and Mental Capacity assurance documents requested by the ICB (formerly CCG) and have developed an action plan to address any gaps in service.
- CHFT staff have continued to make Deprivation of Liberty applications throughout this period ensuring the rights of our patients are safeguarded. Our most recent data demonstrates a 20% increase in applications since March 2022.
- We have collated and submitted our response to the consultation on the Mental Capacity Act Code of Practice.
- Our Deputy Head of Safeguarding/Named Professional Adult Safeguarding commenced in post in November 2022. However, we have are continuing to support a vacancy relating to our Named Nurse Children Looked After/ Care Leavers. Recruitment processes are underway.
- Initial and Review Health Assessments carried out by the Children Looked After Team in Calderdale have continued.
- We have started work to address our response to section 42 investigations and are working closely with the Local Authority to move forward with this.
- In response to National Reviews and Local Safeguarding Reviews we have worked to improve our processes in relation to hidden males and significant others.

EQIA – Equality Impact Assessment
https://intranet.cht.nhs.uk/non-clinical-information/equality-and-diversity/equality-impact-assessment-process/
(consider the accessibility / readability of this report from a standpoint of our protected characteristic groups. Confirm that an EQIA has been completed in relation to potential impact arising from the report finding and recommendations – summarise if any significant issues have arisen from this assessment)

Equality impact assessment forms the basis of much of the work of the Safeguarding Team. The role of the team is to ensure that those in the most vulnerable groups are protected from harm.

Recommendation

The Board of Directors is asked to note the key highlights of the report.

Signed off by: ……………………….

Date signed off: ……………………..

1. INTRODUCTION

This report is the Safeguarding Adults and Children Annual Report for the Trust Board, for the reporting period April 2022 – March 2023.
The report provides an overview of activity and outlines key achievements and developments on priorities and our safeguarding strategy for 2022-2024.

2. PREVENT

The Counterterrorism and Security Act (2015) places a duty on CHFT to have; *'due regard to the need to prevent people from being drawn into terrorism.'*
CHFT Safeguarding Team undertakes regular patient information requests regarding potentially high-risk individuals and shares these with PREVENT partner agencies. We also attend Channel panel meetings (Calderdale) to discuss individual cases to understand their vulnerability to being drawn into terrorism activities, as well as engaging with the person and partner agencies (e.g., Child and Adolescent Mental Health Service - CAMHS, Housing, Social Care to support these vulnerable individuals to consider how they can make positive changes to their lives.
PREVENT training is now available by Government PREVENT wrap training. We have worked closely with the PREVENT lead in the local authority and the BAME network to address some issues that have been highlighted in relation to this training. In response to the concerns raised; there has been contact with the Department of Health (DOH) and NHSE who have been keen to receive feedback in relation to the concerns raised about the content of this training. A developing training programme has been shared with the BAME network to support inclusion of their thoughts for future training. The PREVENT Co-ordinator is arranging a meeting with the Home Office Lead; the NHS Prevent Lead and CHFT to discuss this further and how to proceed.
CHFT has met its statutory responsibilities with the key achievements set out below: -

Key Achievements
- All staff receive the Government approved Prevent e-learning training.
- Our training compliance has remained consistently above 90% throughout the year.
- Prevent activity and information is shared quarterly with NHSE and our Designated Safeguarding Nurses in the ICB.
- Named Nurse Safeguarding Children and Named Professional for Adults now attend Channel panel meetings (Calderdale) where partner agencies discuss individuals in the pre-radicalisation phase to prevent them being drawn into terrorism.

Priorities 2023-2024 (including actions from 2022-2024 Safeguarding Strategy workplan)
- Proposal to increase PREVENT training to 3 yearly to ensure compliance with the Core Skills Training Framework.

3. SAFEGUARDING BOARDS/ PARTNERSHIPS

The Safeguarding Team have maintained the safeguarding service. The Named Professional Adult Safeguarding/ Deputy Head of Safeguarding commenced in post in November. However, since January 2023 the Named Nurse Children Looked After/ Care Leavers has been vacant resulting in not all statutory posts being in place. Recruitment to this post has now been successful and the postholder will commence in post in April 2023. There has been further recruitment of a 0.8 wte Specialist Nurse in the Children Looked After /Care Leavers Team.
Given the gap in cover arrangements the team have prioritised essential work and informed key partners of the staffing position.

The Safeguarding Boards and Partnerships have been kept fully briefed and updated throughout this period. The number of requests for information in relation to safeguarding and domestic homicide reviews has increased during this reporting period. An increase in requests can create a service pressure however, the Safeguarding Team have fulfilled all partnership requests for information within timescales and have contributed towards multiple safeguarding and domestic homicide reviews during this period. We have developed a process with the Risk Management Team to ensure the Serious Incident Panel have oversight of the safeguarding review process. Significantly, many of the reviews have identified that trauma informed practice approaches, should improve the health outcomes of patients with complex needs and may address some local health inequalities. Kirklees and Calderdale Safeguarding Adults Board/ Children's Partnership have recognised the work of the BLOSM project (Bridging the gap; Leading a culture in change; Overcoming adversity; Supporting vulnerable people; Motivating independence and confidence) and the pilot relating to the Trauma Navigators in our Emergency Departments. The BLOSM project supports a trauma informed approach to emergency care and through the development of social pathways, the trauma navigators and ED staff can support vulnerable service users who attend our ED departments and are able to respond to their specific needs on a 24-hour basis.

Self-neglect continues to be a significant theme in Serious Adult Reviews (SARS) and the self-neglect pathways and risk escalation conferences continue to be promoted and are in regular use. Other SAR reports have identified the use of the Mental Capacity Act (MCA) with patients who may have difficulties with their executive functioning (such as those with substance misuse problems, head injuries and phobias etc). We have updated the MCA policy to reflect this area and have input into various groups (such as the High Intensity User Group) to ensure that recent case law is drawn to the attention of staff working with people with complex needs. MCA/DoLS will be a key theme during our safeguarding week 2023.

We continue to work closely with SWYFT to support staff with the management of complex mental health patients (adults and children) within the Divisions over the past twelve months. The new Mental Health Receipt and Scrutiny E-learning package is now up and running and this should support and increase in compliance across the Trust. Work has also begun to engage staff with more bespoke training from SWYFT around the scrutiny of mental health paperwork. This will include the development of a flow chart for clinical staff outlining their responsibilities to help increase confidence when managing mental health act papers.

The learning from both local safeguarding practice reviews and the National Panel Thematic Review on Non-Accidental Injury to Under One Year Olds identifies hidden males/significant others as a key area of learning and in response to these we have worked to improve our processes in relation to hidden males and significant others. Safeguarding children training has been strengthened to reflect this. Hidden males/significant others will be a focus topic during Safeguarding Week in June 2023 to ensure this continues.

Key Achievements

- Carried out business as usual within the team and continued to maintain our operational service throughout.
- We have sent our Kirklees and Calderdale partners assurances regarding our business continuity arrangements.
- Continued to attend virtual Safeguarding Adults Board meetings and Children's Partnership meetings for Kirklees, and their safeguarding subgroups.
- Collaboratively our partner SWYFT has worked with CHFT to support the management of complex mental health patients.
- Contributed to Safeguarding Week 2022, promoting MCA/DoLS/Self-Neglect/Hidden males and significant others.
- Supported the BLOSM project.

Priorities 2023-2024 (including actions from 2022-2024 Safeguarding Strategy workplan

- Continue to support the learning from safeguarding and domestic homicide reviews which influences our safeguarding practice.
- Monitor our progress in relation to our safeguarding Strategy.
- Continue to support the work of the BLOSM project.
- Support Safeguarding Week 2023

3.1 Hidden Harms

Crimes such as child abuse, child exploitation, domestic abuse (including "honour" based abuse), sexual violence and modern-day slavery, typically take place behind closed doors, hidden away from view. The pandemic provided an opportunity for hidden harms to children and adults to escalate, and this has increased the complexity of the needs of families requiring effective early intervention and help. Our response to this is described below:

3.2 Health based Independent Domestic Violence Advisor (IDVA)

CHFT recruited to the role and our IDVA who commenced in post 24.01.2022. Funding for the IDVA post has been extended until 2025.

The role of the health IDVA is first line contact for patients who are victims, offering refuge, emergency accommodation, support, liaison with police and establishing links for individuals and their families to longer term community-based support. This now occurs often whilst the victim is in hospital or in the Emergency Department (ED).

The role includes accessing and screening the referrals made by the ED and then referring into either the DRAMM (Calderdale) or DRAMM (Kirklees) daily risk assessment multi-agency meetings. Proactively the health IDVA service aims to improve the training and education of front-line staff to develop understanding and confidence in responding to domestic abuse.

The IDVA has a visible presence in ED supporting staff and seeing patients presenting with domestic abuse or when a patient discloses domestic abuse.

As part of the funding CHFT provide midyear reports and end of year reports for the Ministry of Justice (MOJ). The year end report for 2022-2023 shows the role has supported/ contacted 177 victims or suspected victims of domestic abuse. The IDVA supports victims from 16 years of age.

IDVA success story

A victim of high-risk domestic abuse attended hospital for an appointment and disclosed to staff ongoing domestic abuse, over a period of years from family members. Staff contacted the IDVA who attended the department. The victim was very afraid and reluctant to share further information. With time, privacy and compassion the lady made disclosures about domestic abuse, control, and threats. After explanation from the IDVA about how legal and safeguarding processes could support the disclosure, action was taken and the victim was supported, with long term accommodation for her and her children, education and legal support and now feels safe and well. A police investigation is underway.

On leaving the victim thanked everyone and said – "I will not get beaten up again, not tonight, not tomorrow, never again".

The IDVA continues to provide bespoke training for domestic abuse monthly. Routine and targeted enquiry is now included in the ED bespoke and midwifery two-day training.

3.3 Calderdale Domestic Abuse Services

Safe Lives were commissioned to undertake a whole system review by operationalising a Public Health approach. Using systems thinking methodology and through the lens of the whole family this identified opportunities for improving the risk led response, early intervention, and prevention of domestic abuse. This included a systems-wide assessment of the current local landscape, identifying data and ongoing monitoring opportunities, consulting with service users and providers to understand risk and protective factors.

The new Domestic Abuse DRAMM (Daily Risk Assessment Management Meeting) was successfully implemented in Calderdale. Following this report, the domestic abuse hub moved to a DRAMM meeting. The Domestic Abuse Specialist Practitioner attends the daily meeting and shares health information from CHFT, LOCALA and SWYPFT.
The first MARAC (Multi-Agency Risk Assessment Conference) meeting was held in July 2022. CHFT is represented at MARAC by the Named Midwife Safeguarding & Domestic Abuse Lead providing CHFT's health updates into the risk assessment and discussion of high-risk domestic abuse cases. Questionnaires to evaluate the impact of MARAC have been distributed and a report will be produced later in 2023.

An audit was completed in October 2022 to conduct a review of all health providers responses to domestic abuse, which included children of all ages including unborns to identify if any areas of process and procedures from the Domestic Abuse hub required improvement. The audit concluded that:

- There is evidence that health provides appropriate and relevant information from all health providers in the DRAMM meeting and that information sharing is robust.
- There was evidence of exemplary record keeping relating to domestic abuse and risk.
- All health records are appropriately flagged to indicate high risk domestic abuse.

3.4 Kirklees Joint Targeted Area Inspection (JTAI) Child Sexual Exploitation/ Criminal Exploitation

Notification of the inspection was received from the CCG now the ICB 13/06/2022 and this was completed 01/07/2022. The agencies involved were the Police; Children's Social Care; Education and relevant Health Services.

These Inspections are carried out by inspectors from:

OfSTED
Care Quality Commission (CQC)
Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS)

The focus of the inspection was to better understand and evaluate the multi-agency response in relation to criminal exploitation, and to look at whether agencies have a distinct and effective focus on identifying children at risk of or experiencing sexual exploitation. The scope of the inspection was to evaluate practice over the previous 6 months.

Overall summary from Inspectors.
The feedback from the JTAI Inspection team was summarised with an overarching positive narrative. They particularly thanked colleagues for their enthusiasm and engagement, patience and co-ordination and how readily learning opportunities have been taken on board.

It was noted that Team Kirklees have: Strong professional relationships; Meetings are well attended by partners; 'Health' voices are heard and valued; Strong evidence of working together; Young people are cared for by well supported and knowledgeable practitioners; Practitioners are well supported by skilled, knowledgeable and approachable safeguarding teams; Our partnership is well led; Together we are tenacious, creative and persistent at engaging with our young people; Together we support risks being reduced to young people

Our young people said to the inspectors:

"They listened a lot"

"I'm feeling positive about the future"

Feedback specific to CHFT

- training data good (in expected target area).
- supervision mandatory and the rostered small groups supports good discussion and reflection which will enhance knowledge and skills.
- vulnerable children are identified early using CP-IS and internal flagging systems, with work underway with local authority to enhance flagging systems.
- navigator posts in autumn to support trauma presentations demonstrate the Trust's commitment to supporting 11-25 years old cohorts with trauma presentations.
- inconsistencies in professional curiosity, records didn't consistently demonstrate curiosity and were sometimes 'medical model' focused.
- work to be done around recognising the 'golden' opportunities when a young person presents and exploring the route cause rather than just the medical presentation.
- some barriers to consistently using the screening questions and would benefit from some specific 'exploitation' focused questions to support clinical colleagues to be further curious about the root causes behind a presentation but they noted the plans to review the tools used.
- noted the delay in the trauma pathways in ED being embedded, with recent further delay noted in referral to CSC.
- liaison out, remembering to link in with GP colleagues.

This inspection has resulted in improved partnership working with the Youth Engagement Service. Where children and young are identified as being at risk of criminal exploitation there is now a robust flagging and timely information sharing system in place. There has been a drive to increase awareness in relation to professional curiosity with the development of a 7-minute briefing and inclusion of this in safeguarding and ED bespoke training.

The action plan has progressed with several actions now completed. The three outstanding actions require further scoping, multiagency support, and further discussion before these can be implemented successfully. These continue to be monitored via the Safeguarding Committee and Kirklees Health Assurance Improvement Group.

Key Achievements

- We continue to support local partnership meetings for children and young people at risk of exploitation.
- We have agreed a system with the local authority to flag hospital records of children/young people at risk of exploitation.
- Worked alongside ED and Paediatric colleagues to support the Kirklees JTAI.
- The under 18 and adults at risk CHFT bespoke proforma has now been built into EPR.
- We have monitored our safeguarding data closely throughout the year and provide assurance to the Safeguarding Boards/Partnership relating to our activity.
- Continue to review the impact of the Health Based IDVA.
- Increased access to Domestic Abuse training.
- Attendance at Calderdale MARAC.

Priorities 2023-2024 (including actions from 2022-2024 Safeguarding Strategy workplan)

- Continue to raise awareness of the complex issues relating to contextual safeguarding and the use of multiagency meetings to share intelligence around this.
- Develop awareness and training regarding the under 18's and adults at risk safeguarding proforma.
- Raising awareness of the Trauma Informed approach to working with patients and their families.
- To continue to support the Trauma Navigators role/ BLOSM pilot and pathways.
- Support staff to identify and provide support for those who have multi-complex needs; are homeless or display signs of self-neglect.
- Revise the under 18 and vulnerable adults proforma and embed across the organisation
- Support the JTAI action plan.

4 MENTAL CAPACITY ACT (MCA) AND DEPRIVATION OF LIBERTY SAFEGUARDS (DoLS)

Work continues to promote the principles of the MCA and in particular supporting staff in considering the importance of the executive functioning of a patient. We have launched the new MCA Level 1, 2 and 3 E-Learning packages across the Trust, and the Safeguarding Adults team are offering 'lunch and learn' sessions on MCA and DoLS processes at ward level and team meetings. The response from staff has been good and compliance remains above 90%.

All CHFT DoLS applications continue to be quality assured by the Adult Safeguarding Team providing evidence that the restrictions on the patient, that amount to a deprivation of liberty, are the least restrictive and in the patient's best interests, in addition to meeting the statutory requirement for an urgent DoLS authorisation and an application for a Standard Authorisation. Once the Standard Authorisation has been granted, the team ensure that any conditions on CHFT are complied with and that the Relevant Persons Representative (RPR) or paid RPR is identified in the patient's records. We continue to work closely with the Independent Mental Capacity Advocate (IMCA) Service.

4.1 DoLS Data

	Number of Urgent DoLS Authorisations	Number of Standard Authorisations	Average p/month
2018/19	219	27	18
2019-20	186	20	15
2020-21	191	0	16
2021-22	350	3	29
April 22- March 23	435	6	36

The number of Urgent Applications has risen by 20% in the reporting period and reflects CHFT staffs ongoing commitment to protecting the Human Rights of their patients. We continue to make applications for Deprivation of Liberty Safeguards, in line with the Mental Capacity Act 2005 and work to ensure that the rights of those who may lack the relevant capacity are protected.

4.2 The Mental Capacity (Amendment) Bill

The Mental Capacity (Amendment) Act received Royal Assent in May 2019 and introduces the Liberty Protection Safeguards to replace DoLS. The purpose of the Bill is to provide a simplified legal framework and authorisation process which is accessible, clear, delivers improved outcomes for people deprived of their liberty and places the person at the heart of decision making.

Implications for CHFT
This is a significant piece of statutory work which will include several departments to ensure the implementation is effective. There will be a transition period during which existing Authorisations will remain valid.

Hospitals will become the responsible body and will be responsible for authorising the deprivation of liberty (it will no longer be the Local Authorities responsibility, but the Hospital Manager). To ensure CHFT meets it statutory and legal responsibilities and to guarantee the deprivation is lawful, referral pathways and the authorisation process will need to be considered and agreed within the organisation.

For the responsible body to authorise any deprivation of liberty, it needs to be clear that:

- The person lacks capacity to consent to the care arrangements
- The person is of unsound mind
- The arrangements are necessary and proportionate

Under Liberty Protection Safeguards (LPS), the Authorisation can be used in a variety of settings (i.e.) those who live at home and have respite care and a day centre. Staff will need to be trained and aware of what the new LPS encompasses, as well as what an objection is including how to refer to an Approved Mental Capacity Practitioner (AMCP) when the patient is objecting to the arrangements. The role of the AMCP is to carry out a pre-authorisation review and to determine whether to approve the arrangements.

LPS will apply to children aged 16 and 17.

The MCA code of practice/regulations was released for consultation in March 2022. The Safeguarding Team has collated the consultation response from CHFT, and this has been submitted. The consultation period closed on the 14/07/2022 and the Government will need to consider its response and it was anticipated that this would take place over the winter of

2022-2023. Following this period of consideration, the code of practice resulted in lack of clarity around what constitutes a deprivation of liberty, and this makes it difficult to plan for the resource required to support LPS. A more recent update states that the implementation of LPS will be delayed beyond the life of this Parliament and so external planning meetings for this have been stepped down. However, our staff must continue to ensure they are competent in their knowledge of and their understanding of the application of the Mental Capacity Act and Deprivation of Liberty Safeguards.

An audit of MCA/DoLS has been completed and the results show there is variable knowledge and skills amongst our workforce relating to MCA and DoLS. An action plan has been developed to support staff in their understanding of this to help support the correct application of the MCA and DoLS. The training offer relating to MCA/DoLS has been reviewed and the e-learning packages have now been identified on the electronic staff record. The e-learning will be supplemented by bespoke face to face sessions as described above.

Key Achievements

- DoLS referrals during this period have continued which demonstrates an awareness amongst our staff to ensure the Human Rights of our patients are maintained.
- We continue to quality assure all referrals made by CHFT staff.
- Training offer has been reviewed and identified on the electronic staff record.
- Developed and delivered bespoke training sessions in response to identified gaps in knowledge and skills.
- Audit completed relating to the use MCA/ DoLS/ development of action plan.
- The MCA/ DOLS policy has been updated.

Priorities 2023-2024 (including actions from 2022-2024 Safeguarding Strategy workplan)

- Continue to ensure that all staff are trained in the MCA/ DoLS according to their role.
- Task and finish group to support progress of the action plan to support staff with the application of MCA/DoLS.
- Deliver bespoke MCA training to those who work with children to ensure a foundation for LPS implementation.
- Develop a streamlined process in relation to DoLS applications

5 TRAINING

The Safeguarding Children's training packages for level 2 and level 3 have now been reviewed and include a hybrid approach of e-learning and face to face sessions. This ensures compliance with the Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff (2019) and the Looked After Children: Roles and Competencies for Healthcare Staff (2020).

The Named Professional Safeguarding Adults is now in post to ensure compliance with the Safeguarding Adults: Roles and Competencies for Healthcare Staff (2018). Levels 1 and 2 have been updated with a new E-learning package, and the Level 3 safeguarding adults training is now face to face. Bespoke packages have been designed to provide staff in key areas with more specific safeguarding knowledge. These have been developed in response to multiple complex cases and these are initially being directed towards the community division, the acute sector and the Emergency Department.

ED bespoke training has been reviewed and a new format established and implemented. Joint working between BLOSM, an external provider and the Named Professional Adult Safeguarding is ongoing to implement bespoke trauma informed practice training with our

Emergency Departments. It is anticipated these sessions will start in May 2023 and will increase CHFT's response in meeting identified learning from recent safeguarding reviews.

	31.03.22					31.03.23					
	Assignment Count	Required	Achieved	Outstanding	Compliance %	Assignment Count	Required	Achieved	Outstanding	Compliance %	% Deviation
	6176	24091	22378	1713	92.89%	6344	24703	22941	1762	92.87%	0.02%
Competence Name						**Assignment Count**	**Required**	**Achieved**	**Outstanding**	**Compliance %**	
NHS|MAND|Mental Capacity Act - 3 Years|	202	202	184	18	91.09%	263	263	249	14	94.68%	3.59%
NHS|MAND|Mental Capacity Act Level 2 - 3 Years|	3329	3329	3144	185	94.44%	3357	3357	3054	303	90.97%	-3.47%
372|LOCAL|Mental Capacity Act Level 3 - 3 Years|	776	776	727	49	93.69%	875	875	843	32	96.34%	2.66%
NHS|CSTF|Safeguarding Adults - Level 1 - 3 Years|	1750	1750	1654	96	94.51%	1754	1754	1693	61	96.52%	2.01%
NHS|MAND|Safeguarding Adults Level 2 - 3 Years|	3807	3807	3608	199	94.77%	3901	3901	3623	278	92.87%	-1.90%
NHS|MAND|Safeguarding Adults Level 3 - 3 Years|	537	537	519	18	96.65%	576	576	561	15	97.40%	0.75%
372|LOCAL|Female Genital Mutilation|	606	606	529	77	87.29%	578	578	519	59	89.79%	2.50%
NHS|MAND|Prevent WRAP - No Renewal|	6176	6176	5784	392	93.65%	6344	6344	5958	386	93.92%	0.26%
NHS|CSTF|Safeguarding Children - Level 1 - 3 Years|	1747	1747	1647	100	94.28%	1751	1751	1695	56	96.80%	2.53%
NHS|MAND|Safeguarding Children Level 2 - 3 Years|	3755	3755	3561	194	94.83%	3928	3928	3624	304	92.26%	-2.57%
NHS|MAND|Safeguarding Children Level 3 - 3 Years|	590	590	562	28	95.25%	553	553	500	53	90.42%	-4.84%
372|LOCAL|Mental Health Act Receipt and Scrutiny Training|	82	82	56	26	68.29%	92	92	61	31	66.30%	-1.99%
372|LOCAL|Safeguarding Supervision|	727	727	397	330	54.61%	731	731	561	170	76.74%	22.14%
Grand Total	**6176**	**24091**	**22378**	**1713**	**92.89%**	**6344**	**24703**	**22941**	**1762**	**92.87%**	-0.02%

Key

- Aspirational Target >95%
- On target 90% 94.0
- ear Target 85% 89.9%
- Below Target<85%

(Figure 1)

Figure 1 indicates the year end Trust position for Safeguarding training compliance. Compliance data is monitored in the Safeguarding Committee. As of March 2023, overall compliance is at 92.87%.

5.1 Exception reporting: Receipt and Scrutiny Training and Safeguarding Children Supervision.

We continue to work with SWYFT and our Nurse Consultant in Mental Health to ensure our staff are supported in receipt and scrutiny of Mental Health Act papers. Receipt and Scrutiny training is now implemented as an E learning package for those requiring this competency, with bespoke sessions provided by SWYFT and our Nurse Consultant in Mental Health to supplement and increase in knowledge.

The levels of Receipt and Scrutiny (of statutory Mental Health Act documentation) training is 66% for this period. Although this is a 2% decrease since March 2022, there is a 9% increase since September 2022 and it is anticipated that this will continue to increase now this training is available.

Safeguarding Supervision is delivered virtually though Microsoft Teams and compliance is 76%. This demonstrates a 20% increase since March 2022. Compliance continues to be monitored via the Safeguarding Operational Group and Safeguarding Committee and the plan to increase compliance is ongoing. Safeguarding Adult Supervision has adopted a drop in approach, with first focussing on staff who are non-compliant but then rolling this out to all staff who have the supervision requirement. This has been received well by the community division

and has now been embedded into the acute sector. Sessions run twice monthly, and attendance has been positive.

Work is underway to refresh and embed the safeguarding champions role across the CHFT footprint, including improving measures for safeguarding supervision facilitation. Recent feedback from clinical staff identified that they were not always aware of who their champion was. In response to this, a review of the safeguarding champions network was completed in December 2022. Safeguarding champions will now be identifiable by a badge and there is a communication launch due in 2023 to promote this role. Going forward we are looking at increasing the champions network to include MCA and Prevent champions.

Key Achievements

- We continue to engage and share training compliance with Divisions bi-monthly.
- Review of Safeguarding Children Training to ensure compliance with the Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff (2019) and the Looked After Children: Roles and Competencies for Healthcare Staff (2020).
- Review and implementation of Receipt and Scrutiny training.
- Review of the Safeguarding Supervision Policy.
- Review of the Adult Safeguarding training to ensure compliance with the safeguarding Adults: Roles and Competencies for Healthcare Staff (2018)

Priorities 2023-2024 (including actions from 2022-2024 Safeguarding Strategy workplan)

- Continue to develop a more targeted approach to increase safeguarding supervision compliance.
- Continue to work with SWYFT to support attendance at the Receipt & Scrutiny training.
- Review and support the development of the Safeguarding champions role.
- Introduction of MCA/ Prevent champions.

6. ADULT SAFEGUARDING

Safeguarding adults is a statutory requirement under the Care Act (2014). Safeguarding adult's means protecting a person's right to live in safety and free from harm, abuse and neglect.

Ineffective or unsafe discharges has seen a slight improvement over the last quarter with a reduction seen in unsafe discharges resulting in Safeguarding referrals. This position continues to be shared at Safeguarding Committee meetings which has representation from the four divisions. The Safeguarding Team continue to work with local authority partners to ensure oversight and investigation of all these cases. Kirklees Local Authority have previously agreed that poorly managed discharges can be managed by a different approach to Calderdale and that some of these can be managed as quality-of-care concerns. In Calderdale all ineffective discharges are managed as S42 investigations under the Care Act 2014. To date this process remains unchanged.

The strategic transformation programme has been addressing continual improvement and the Trust now has in place the Safari programme at HRI whereby pharmacists are working directly with discharges to ensure that the patient fully understands their medication use, potential side effects and that they have the correct medication for their discharge. The initial safeguarding data appears to confirm that the medication issues on discharge have decreased, and we anticipate this improvement will be sustained. Additionally, the Standard Operating Procedure (SOP) introduced in ED has made some improvements with the quality of discharges from ED.

The Director of Operations has confirmed that information relating to discharges is now monitored through the Urgent & Emergency Care Delivery Group (U&ECDG).

The clinical site matrons do look at discharge as part of their everyday role, however the ward matrons and ward teams have more of a key role in this and it should fall under their remit to monitor through their directorate and divisional PSQBs. This information is then reported through the U&ECDG as exceptions to ensure we capture any learning at ward level.

The Deputy Head of Safeguarding/Named Professional Adult Safeguarding will attend U&ECDG once in post and will continue to work with the Local Authorities to provide assurance relating to discharges with a safeguarding element.

Where CHFT are required to provide feedback regarding adult safeguarding initial investigations to the Local Authority, we are not meeting the multi-agency agreed timeframes which are defined in the multi-agency safeguarding adult's policy. We have started work to address this and the Named Professional Adult Safeguarding now holds a monthly meeting with both Local Authorities to discuss historical cases with an open and honest discussion on how to move forward. Although operational pressures remain an issue for all partners this appears to be effective in starting to close the longest historic cases.

The Risk Management Team also attend this meeting to align Trust and safeguarding processes and increase understanding between the two teams of how this can be addressed. The Risk Management Team are meeting regularly to review incidents and the Safeguarding Team feed into these huddles.

Key Achievements

- Worked alongside the Local Authority to close some of the chronic cases.
- Slight improved position re. ineffective discharges
- Clear process for monitoring discharges and supporting learning from these.

- **Priorities 2023-24 (including actions from 2022-24 Safeguarding Strategy workplan)**
- Streamline safeguarding processes and investigations.
- Working with the new Lead Nurse Children to progress the embedding of the Transition Policy.
- To contribute to support Divisions in relation to hospital discharges with safeguarding factors
- Continue to work alongside both Local Authorities and support Divisions to providing timely feedback.

7. CHILDREN SAFEGUARDING

CHFT is fully committed to the principles set out in the government guidance 'Working Together to Safeguard Children – 2018, the Children Act 1989/2004" and to joint working with both the Calderdale and Kirklees Safeguarding Children Partnerships. The Trust works within

the West Yorkshire Safeguarding Children Policies and Procedures for the protection of all children who attend CHFT.

The Trust remains committed to safeguarding children which includes the introduction of the BLOSM pilot which commenced in January 2023. The Trauma navigators work closely with the Emergency Department staff cross site, supporting vulnerable patients between the ages of 11 and 25. The Safeguarding Team have supported the development of several pathways to ensure these vulnerable young people are supported at point of attendance. For example, these pathways include presentations relating to violent assaults, injury by a bladed weapon, firearm, or mental health presentations. There is ongoing work to improve our referral response where children and young people attend with substance misuse issues. There is ongoing review of the data we collect to and share with the partnership to ensure this is reflective of both the local and national issues.

The safeguarding team are committed to improving visibility across the organisation, with a steer to ensure that the role of the Safeguarding Advisor and the Paediatric Liaison Sister offer direct support to clinical staff. The aim moving forward is to encourage professional curiosity, professional challenge and to support children and young people are heard across the organisation.

In addition, multi-agency work supporting and addressing barriers to discharge in relation to prolonged admissions to wards and stays in the Emergency Departments is ongoing.

Key Achievements

- Effective partnership working demonstrated as part of the Kirklees JTAI (Joint Targeted Area Inspection) undertaken June – July 2022. Positive feedback received. Action plan developed and recommendations successfully being progressed.
- Safeguarding Children Policy reviewed.
- Process established for identifying where 16- to 17-year-olds are admitted, joint working relationships with departments developed and safeguarding team continuing to support.
- Developed a pathway with the Calderdale Integrated Care Board (ICB) formerly CCG and Calderdale Children's Social Care for non-mobile babies referred under the BBS protocol via GP services in response to a serious incident.
- Contributed to the development of a multi-agency Barriers to Discharge Flowchart / Escalation flowchart to support with complex prolonged admissions relating to children and young people.
- A new ad-hoc electronic ED Paediatric Liaison Notification form went live in January 2023.
- Paediatric Sit Rep embedded into core safeguarding work, children and young people reviewed and supported by the team. Sit reps are now produced over the weekend where previously they were produced Monday to Friday.
- Robust oversight of paediatric patients who have mental health concerns and closer working with the paediatric department with the support of the newly appointed Mental Health Liaison Nurse. Safeguarding representation at MDT meetings established.

Priorities 2023-24 (including actions from 2022-24 Safeguarding Strategy workplan)

- Paediatric Liaison Sister and Safeguarding Children / Maternity Advisor to maintain links with the Trauma Navigators - BLOSM.
- Improvements being made relating to safeguarding team visibility in both Emergency Departments and wards in relation to 16-17 year olds
- Continued work ongoing to support inclusion of the child's voice/lived experience of the child in safeguarding practice.
- Audit introduction of the ad-hoc electronic paediatric liaison notification form.

- Progress the ongoing work relating to the improvement of the quality of the paediatric discharge summaries.
- Audit BBs pathway for GP's.
- Support increasing referral to substance misuse services
- Development of a flowchart to support with barriers to discharge from the Emergency Departments

8. MENTAL HEALTH

CHFT works in partnership with SWYPFT formally through the service level agreement and the clinical working protocol. We are using the values described in our 4 pillars in developing a mental health strategy with our partners though the Mental Health Operational Group. There are reciprocal representatives and papers shared at SWYPFT's Mental Health Act Committee and CHFT's Safeguarding Committee meeting, and we continue to work in close partnership to meet the needs of our patients.

The Mental Health Liaison Team (MHLT) support and work with CHFT trust staff to ensure that all patients who are referred are reviewed and supported in a timely way.

Around one in four women experience mental health problems in pregnancy and during 12 months after giving birth. If left untreated, mental health issues can have a significant negative and long-lasting effects on the woman, the child and the wider family. CHFT Maternity Services continue to work with SWYFT, Locala and the voluntary sector to provide services for pregnant and post-natal women who have mental health concerns, including those who may have experienced baby loss/removal at birth/birth trauma.

A safeguarding team representative attends the Mental Health Operational Group and the Multi-agency Suicide Prevention Action Group.

Key Achievements

- The Safeguarding Team have continued to support the MHA Office with their scrutiny and reporting mechanism.
- There are honorary contracts in place for Consultants who work for SWYPFT and based in the Mental Health Liaison Team.

Priorities 2023-24 (including actions from 2022-24 Safeguarding Strategy workplan)

- Reforming the Mental Health Act' White Paper Consultation took place, and the Government has now published its response to the Consultation. When more information becomes available, CHFT will consider the proposals and ensure that policies and procedures are updated accordingly. There may be changes to the Mental Capacity Act Policy and Procedures that will need to be implemented.
- Ongoing promotion of MHA receipt and scrutiny training to improve compliance.

9. CHILDREN LOOKED AFTER AND CARE LEAVERS (CALDERDALE)

The aim of the Children Looked After (CLA) health service is to ensure that children looked after by the Metropolitan Borough of Calderdale have their health needs addressed. This includes the provision of a detailed, high-quality assessment of children's health needs. The

team works in partnership with the Calderdale Metropolitan borough Council and local health providers to ensure that appropriate services are developed to meet the needs of Calderdale CLA.

This section of the report outlines the delivery of health services to CLA between April 2022 – March 2023, in line with national statutory guidance.

Looked after children may live in foster homes, residential placements or with family members (connected carer's).

Calderdale Profile of Children Looked After

- As of 31st March 2023, there were 357 children cared for by Calderdale Local Authority. This is a 5.6% increase on the number of CLA from the previous year. Between April 2022-March 2023, 110 children became CLA. This is broken down into 39 children aged under 5 years and 71 children aged 5-17 years.
- There are 123 CLA currently accommodated outside of Calderdale. 31 review health assessments and 14 initial health assessments have been completed by other local health teams with the remaining 77 being completed by the Calderdale CLA health team.
- There are 214 CLA placed in Calderdale by external Local authorities. 35 are under 5 years and 179 are over 5 years. The Calderdale CLA health team have completed 52 review health assessments and 29 initial health assessments
- In 2022-2023, 20 Unaccompanied Asylum-Seeking Children (UASC) became CLA in comparison to 10 in the previous year which is a 100% increase. Changes in Home Office quotas for UASC means that all areas across West Yorkshire will see a significant increase in arrivals over the coming months.
- The majority of CLA are white, 83%, with 6% mixed and other ethnic group, and 5% Asian or British Asian. 40% of Asian/ British Asian children are UASC, 55% of UASC are from other ethnic group and 5% from the black/black British ethnic group.

Special Educational Needs and Disabilities (SEND)

It is accepted nationally that children with a learning disability diagnosis are overrepresented in the CLA population, and that health and educational outcomes are interlinked. Children with disabilities and complex needs have access to a specialist Children's Looked After Nurse, who completes most of the review health assessments and works closely with the Paediatricians to complete the initial health assessments. Where children are placed out of area in specialist provisions to meet their complex needs, individualised arrangements may be required to ensure their health assessments take place. In Calderdale we have 54 children (15% of CLA children) with an EHCP.

Initial Health Assessments

An initial health assessment (IHA) should be undertaken within four weeks of a child entering care. Statutory guidance states this should be completed by a doctor.

- 109 Initial Health Assessments have been completed in this period for Calderdale CLA children, a 18.5% increase from the previous year when 92 Initial Health assessments had been completed. 14 of these have been completed by other areas .

- 39 of the assessments took place on CLA under 5 years old and 65 on CLA aged 5 years or older. In the previous year, this was 35 CLA under 5 years old and 57 CLA aged 5 years or older.
- There has been a 187.5% increase from 16 to 46 Initial Health Assessments completed for other Local Authorities since the previous year.
- All Initial Health Assessments have been completed face to face.
- The total number of Initial Health Assessments completed by Calderdale CLA team is 141, including those completed for other areas. There has been a 30.5% increase of Initial Health Assessments completed in this reporting period in comparison to period 2021-2022, when 108 Initial Health Assessments had been completed.
- 79 out of the 109 Calderdale Initial Health Assessments (73%) have been completed within timescales. This demonstrates a 13% decrease from the previous year. Placement moves and late notification from the Local Authority being the main reason for Initial Health Assessments not being completed within the statutory 4-week timescale.

Review Health Assessments

A review health assessment (RHA) should be completed annually for over 5-year-olds and every 6 months for children under 5 years.

- There have been 395 Review Health Assessments completed in the reporting period in total for Calderdale CLA children, an 11.6% increase from the previous year when 354 Review Health Assessments had been completed.

- 58% of Review Health Assessments have been completed within Calderdale, which is a decrease of 10% of assessments having been completed in Calderdale in comparison to the 68% in the previous reporting year.

- 34% of assessments have been completed outside of Calderdale but within a 50-mile radius and by the Calderdale CLA team, a 5% increase to the previous year, when 29% were completed within a 50-mile radius and by the Calderdale CLA team.

- In line with the service level agreement, the Calderdale CLA team do not complete health assessments in excess of a 50-mile radius. There has been an increase of 5% of Review Health Assessments being completed by other health teams where children are placed more than 50 miles away from Calderdale, from 3% in period 2021/2022 to 8% in the period 2022/2023.

- There has been a 9% decrease from 76 in 2021/2022 to 69 in 2022/2023, where Calderdale CLA team have completed Review Health Assessments for other Local Authorities.

- The total number of Review Health Assessments completed by Calderdale CLA team is 464, including those completed for other areas. There has been a 7.9% increase of Review Health Assessments completed in this reporting period in comparison to period 2021-2022, when 430 Review Health Assessments had been completed, including those completed for other areas.

- 361 (91%) of Review Health Assessments have been completed within timescales in the period 2022/2023, in comparison to reporting period of 2021/2022, when 92% were completed in timescales. There are varied reasons for this, the most frequent reason was other areas completing the RHA, followed by the young person refusing the RHA.

Care Leavers

Local Authorities are expected to stay in touch with care leavers and provide statutory support to help their transition to independent living. A Care Leaver is a young person who has been looked after for at least 13 weeks since the age of 14 years and who was in care on their 16th birthday

There are 149 care leavers currently actively working with Pathways at present – 83 males and 65 females. Health passports are a national initiative which provide a health record for the young person. An information leaflet is provided to the young person at 16 years old at the review health assessment. This details the reason for the health passport. At the last health assessments at 17 years of age the health passport is offered to the young person. In this reporting period 16 health passports were issued to young people. 37 care leavers were seen in the reporting period. Passports have been offered to all 37 young people. 20 passports were sent, 1 young person refused their passport, and there are 16 passports still to be sent out. The delay in sending the passports out has been due to ongoing lack of capacity in the team in recent months. The team are aware which young people are waiting for their passport, and this will be prioritised once the team is at full capacity.

To ensure the needs of Children Looked After and Care Leavers are met, the team work flexibly, ensuring appointments are available to suit the young person's wishes.

During the second half of this reporting period the CLA team have experienced significant staffing pressures. Recruitment processes have been successful, and the team should be at full complement in the first quarter of 2023.

Key Achievements

- Further development of the use of electronic records to support with data collection and analysis.
- Audit to review children placed in Calderdale from out of area and the impact this has on their unmet health needs, Calderdale Health Service provision and to highlight any gaps.
- CLA health team group supervision to look at team development/new ways of working.
- CLA implementation of processes to support externally placed children/young people.
- Reintroduction of the CLA team to the Orange Box

Priorities 2023-24 (including actions from 2022-24 Safeguarding Strategy workplan)

- Continue collaborative work with partner agencies to support Care Leavers.
- Working with Calderdale Children's Services to improve completion of SDQ's (Strengthening Difficulties Questionnaire).
- Develop data collection tools to support data collection relating to health analysis and KPI's.
- Support improved communication links (GP pathways/ LA placement moves in and out of Calderdale).

10. Maternity Safeguarding

Within maternity services, safeguarding from early intervention to child protection is a key factor. Babies can be particularly vulnerable to abuse, and early assessment, intervention and support provided during the antenatal period can help minimise any potential risk of harm. Issues that can impact on parenting ability are parental substance misuse, perinatal mental illness, domestic abuse, where a member of a household poses risk or potential risk to children, parents known to services because of historical concerns i.e. neglect, child protection

planning or removal of children and parents who are or was looked after children and parents under the age of 18 though this list is not exhaustive (West Yorkshire Consortium Inter Agency Safeguarding and Child Protection Procedures).

Where it has been identified that the woman or her family have safeguarding concerns and more detail is required, practitioners document this information within the confidential element of the electronic maternity patient record (Athena). This ensures that all maternity staff have a clear overview of the concerns within the pregnancy as well as the plan for the unborn if the case is open to children's social care.

CHFT maternity service have a specialist midwifery panel that meets once a week. The purpose of this panel is to ensure that there is a robust review process in place for referrals to the Specialist Midwives with a clear rationale for outcome of the referral based on criteria and a follow up process if cases need review.

The panel reviews all referrals to ascertain whether the pregnant woman would benefit from additional support or case loading by the Substance Misuse Specialist Midwife or additional support and caseload supervision by the Perinatal Mental Health Lead (Midwifery Services). The panel provides a safeguarding management plan for Midwives to follow.

In response to the review commissioned by the Child Safeguarding Practice Review Panel- The Myth of Hidden Men and the findings from national and local safeguarding practice reviews, CHFT has:

- Reviewed the standard operating procedure and terms of reference for the specialist midwifery panel
- Fathers/ partners and significant others are reviewed in all cases discussed at panel
- Secured a bid to obtain Dad's pads
- ICON training delivered
- Newsletter/ 7-minute briefings developed and shared across the organisation.
- Screensaver developed
- Safeguarding training strengthened in relation to hidden males/ significant others/ professional curiosity/ think family approach

10. 1 Swans (supporting women in antenatal services)

Within Kirklees key agencies such as children's social care, MARAC (Multi-agency risk assessment conference – domestic abuse), West Yorkshire Police, CHFT Midwifery services, Mid Yorkshire Midwifery services, SWYPFT Perinatal Mental Health, Pennine Domestic Abuse Service (PDAP), Integrated Sexual Health Service and Drug and Alcohol Service work together to provide holistic health care and safety planning to ensure the safety of adults, children and the unborn.

This meeting is organised and managed by LOCALA, but the meeting is chaired by the Named Midwife Safeguarding from CHFT and MYHT and is held monthly to have a coordinated approach to safeguarding and assessing the health and social needs of 'vulnerable' pregnant women and the unborn who are affected by substance misuse, domestic abuse, poor physical, sexual and mental health, homelessness, poverty, involvement in sex work, criminal justice system, multiple removal of previous children and possible concealed pregnancy.

From April 2022 to March 2023 there were 57 new referrals made for woman being cared for by CHFT maternity services, and 132 review cases discussed.

10.2 MAPLAG (Multi agency pregnancy liaison advisory group)

The MAPLAG was established within Calderdale following a Serious Case Review in 2007. This meeting is organised and led by CHFT Named Midwife Safeguarding where assessment of risk to the unborn is discussed. The meetings are attended by Children's Social Care and Family Intervention Team, CHFT Maternity services, CHFT perinatal mental health lead, SWYFPT perinatal mental health, LOCALA perinatal health visitor, domestic abuse health practitioner, Calderdale Drug and Alcohol Service.

From April 2022 to March 2023 there were 39 new referrals made for women being cared for by CHFT maternity services, and 111 review cases discussed.

An audit has been completed for all cases heard at MAPLAG (2021-2022) to assess the outcome for women and babies. The audit has been presented at the Health Assurance & Improvement Group (HAIG) and the Domestic Abuse Operational Group in 2022. The audit concluded that:

- There is good evidence of effective multi-agency working within the MAPLAG process and effective discussion of risk
- There is evidence of effective escalation and de-escalation of concerns
- There is support for women where substance misuse is a factor
- Mental health information for families is effectively fed into risk assessment, including fathers of unborn babies which supports the work around the myth of hidden men
- Police attendance has stopped therefore this information is not routinely fed into risk assessments. The Police are addressing this.
- Not all the referral form is utilised in the MAPLAG meeting and relevant therefore further review of the MAPLAG protocol is required
- Multi-agency contributions are vital to support collaborative working and risk reduction for vulnerable women and their babies

Key Achievements

- Ensured that mandatory FGM reporting responsibilities are maintained with the submissions to NHSE.
- Ensured processes in place for the Trust to ensure all female children born to FGM survivors, records are flagged with the female genital mutilation information sharing (FGM-IS) flag.
- CHFT is continuing to participate with the Children Partnership Board within Calderdale and Kirklees in relation to FGM. This is to represent health and help to reduce the risk to children in our local area.
- Provided external FGM training with Karma Nirvana.
- FGM Audit
- Process agreed with both Local Authorities to refer unborn babies of FGM survivors into Children's Social Care. This will include risk assessment.
- Reviewed MAPLAG and SWANS process to ensure enhanced risk assessment processes are in place within the multi-agency arena.
- Developed a process to review partners/ significant others for all referrals into the specialist midwifery panel.
- Delivered ICON training.
- Audit transfer of antenatal/ postnatal information.

- Database developed to capture referral information to social care

Priorities 2023-24 (including actions from 2022-24 Safeguarding Strategy workplan)

- To update CHFT FGM policy.
- To ensure a think family approach is embedded in Maternity
- Audit of ICON and embed within the neonatal unit
- Audit transfer of safeguarding information from maternity records into EPR
- MAPLAG audit
- To update the supervision and domestic abuse training within division

Safeguarding Adults and Children Annual Report April 2022- March 2023

THINK MCA

SAFEGUARDING IS EVERYONES RESPONSIBILITY

SAFEGUARDING Is Everyone's Responsibility

Prevent

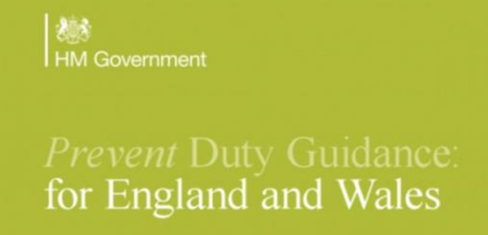
Prevent is about safeguarding people and communities from the threat of terrorism

Key Achievements

- Our training compliance has remained consistently above 90% throughout this period.
- Prevent activity and information is shared quarterly with NHSE and our Designated Safeguarding Nurses in the ICB formerly CCG.
- CHFT Safeguarding Team leads for adults and children attend Channel panel meetings where partner agencies discuss individuals in the pre-radicalisation phase to prevent them being drawn into terrorism.

Priorities 2023-24 (including actions from 2022-24 Safeguarding Strategy workplan)

- Proposal to increase PREVENT training to 3 yearly to ensure compliance with the Core Skills Training Framework
- To meet with REN network to ensure concerns raised about training are represented across regional networks



Safeguarding Boards/ Partnerships

Key Achievements

- Continued to attend and support Adult Boards/ Children's Partnership meetings and information requests, despite a considerable increase in these requests relating to SARs/ DHRs and SPRs
- Contributed to Safeguarding week promoting MCA/ DoLS/ Self Neglect/ Hidden males and significant others
- Supported the BLOSM project which has supported our response to the findings from SARS

Priorities 2023-2024 (including actions from 2022-24 Safeguarding Strategy workplan)

- Continue to support the learning from safeguarding and domestic homicide reviews
- Continue to support the work of the BLOSM project
- Support Safeguarding Week 2023

Hidden Harms

Hidden Harms take place behind closed doors or away from view eg domestic abuse, sexual abuse, child sexual abuse and modern slavery. Our response to these harms is:

Key Achievements

- Domestic Abuse audit
- Increased access to domestic abuse training
- Progress of the JTAI action plan to improve services for children and young people at risk of exploitation

Priorities 2023-24 (including actions from 2022-24 Safeguarding Strategy work plan)

- Continue to raise awareness of the complex issues relating to contextual safeguarding and progress the outstanding multi-agency actions from the JTAI inspection.
- Continue to review the impact of the Health Based IDVA
- Raise awareness of the trauma informed approach to working with patients and their families who have complex needs

MCA and DoLS/ Liberty Protection Safeguards

The MCA protects and restores power to vulnerable people who may lack capacity to make decisions

Key Achievements

- E-learning MCA/ DoLS training offer reviewed and identified on ESR
- MCA/ DoLS audit completed/ Action plan developed
- MCA/ DoLS policy reviewed

Priorities 2023-24 (including actions from 2022-24 Safeguarding Strategy workplan)

- Task and Finish group to support staff with understanding and application MCA/ DoLS/ Re-audit MCA/ DoLS
- Develop bespoke MCA/ DoLS training
- Development of a streamlined process in relation to DoLS applications

Training Compliance

	31.03.22					31.03.23					
	Assignment Count	Required	Achieved	Outstanding	Compliance %	Assignment Count	Required	Achieved	Outstanding	Compliance %	% Deviation
	6176	24091	22378	1713	92.89%	6344	24703	22941	1762	92.87%	-0.02%
Competence Name						**Assignment Count**	**Required**	**Achieved**	**Outstanding**	**Compliance %**	
NHS|MAND|Mental Capacity Act - 3 Years|	202	202	184	18	91.09%	263	263	249	14	94.68%	3.59%
NHS|MAND|Mental Capacity Act Level 2 - 3 Years|	3329	3329	3144	185	94.44%	3357	3357	3054	303	90.97%	-3.47%
372|LOCAL|Mental Capacity Act Level 3 - 3 Years|	776	776	727	49	93.69%	875	875	843	32	96.34%	2.66%
NHS|CSTF|Safeguarding Adults - Level 1 - 3 Years|	1750	1750	1654	96	94.51%	1754	1754	1693	61	96.52%	2.01%
NHS|MAND|Safeguarding Adults Level 2 - 3 Years|	3807	3807	3608	199	94.77%	3901	3901	3623	278	92.87%	-1.90%
NHS|MAND|Safeguarding Adults Level 3 - 3 Years|	537	537	519	18	96.65%	576	576	561	15	97.40%	0.75%
372|LOCAL|Female Genital Mutilation|	606	606	529	77	87.29%	578	578	519	59	89.79%	2.50%
NHS|MAND|Prevent WRAP - No Renewal|	6176	6176	5784	392	93.65%	6344	6344	5958	386	93.92%	0.26%
NHS|CSTF|Safeguarding Children - Level 1 - 3 Years|	1747	1747	1647	100	94.28%	1751	1751	1695	56	96.80%	2.53%
NHS|MAND|Safeguarding Children Level 2 - 3 Years|	3755	3755	3561	194	94.83%	3928	3928	3624	304	92.26%	-2.57%
NHS|MAND|Safeguarding Children Level 3 - 3 Years|	590	590	562	28	95.25%	553	553	500	53	90.42%	-4.84%
372|LOCAL|Mental Health Act Receipt and Scrutiny Training|	82	82	56	26	68.29%	92	92	61	31	66.30%	-1.99%
372|LOCAL|Safeguarding Supervision|	727	727	397	330	54.61%	731	731	561	170	76.74%	22.14%
Grand Total	**6176**	**24091**	**22378**	**1713**	**92.89%**	**6344**	**24703**	**22941**	**1762**	**92.87%**	-0.02%

Key

- Aspirational Target >95%
- On target 90% - 94.0
- ear Target 85% - 89.9%
- Below Target<85%

The chart above indicates the year end Trust position for Safeguarding training compliance. Compliance data is monitored in the Safeguarding Committee.

Adult Safeguarding

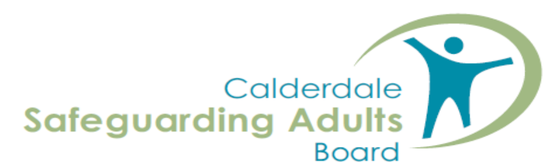
Is protecting a person's rights to live in safety, free from abuse and neglect

Key Achievements

- Worked closely with the local authority to close some of the historic safeguarding cases
- Slight improved position re. ineffective discharges
- Clear process for monitoring discharges and supporting the learning from these

Priorities 2023-24 (including actions from 2022-24 Safeguarding Strategy workplan)

- To contribute to support Divisions and the work to drive quality improvements in relation to hospital discharges
- To work alongside the Local Authority and support Divisions with regard to providing timely feedback to S42 investigations
- Work with the lead nurse children to embed the transition policy



Safeguarding Children

Working together to protect the welfare of children and protect them from harm

Key Achievements

- Safeguarding Children policy reviewed
- Contributed to the development of multi-agency pathway in response to NAI in babies
- Electronic Paediatric Liaison notification form went live Jan 23

Priorities 2023-24 (including actions from 2022-24 Safeguarding Strategy workplan)

- Improving team visibility in ED and clinical areas
- Audit the electronic PLF/ NAI pathway
- Specialist representation at the Children and Young People's Board

Mental Health Act

The Mental Health Act covers the assessment, treatment and rights of people with a mental health disorder.

Key Achievements

- The safeguarding team have continued to support the MHA Office with their scrutiny and reporting mechanisms
- Receipt and Scrutiny training is now available for staff via ESR
- Honorary contracts in place for Consultants who work for SWYFT, based in the MHLT

Priorities 2023-24 (including actions from 2022-224 Safeguarding Strategy) work plan

- Consultation response published by the Government in relation to “Reforming the Mental health Act”
- Ongoing promotion of MHA receipt and scrutiny training to improve compliance.

Children Looked After (CLA)

Children and Young people in the care of the Local Authority. The CLA team works with Calderdale Council to ensure the health needs of looked after children in Calderdale are met

Key Achievements

- Implementation of processes to support externally placed children/ young people
- Further development of electronic patient records to support with data collection and analysis
- CLA attending the Orange Box

Priorities 2022-23 (including actions from 2022-24 Safeguarding Strategy workplan)

- Continue collaborative work with partner agencies to support Care Leavers.
- Working with Calderdale Children's Services to improve completion of SDQ’s (Strengthening Difficulties Questionnaire).
- Develop data collection tools to support data collection relating to health analysis and KPI’s

Maternity Safeguarding

Within maternity services, safeguarding from early intervention to child protection is a key factor in keeping the unborn and pregnant women safe

Key Achievements

- Audit effectiveness MAPLAG
- Data collection transfer Antenatal/ Postnatal information
- Response to the Myth of Hidden Men

Priorities 2023-24 (including actions from 2022-24 Safeguarding Strategy workplan)

- Review the FGM policy
- Audit ICON and embed within the Neonatal Unit
- Strengthen supervision and domestic abuse training

Safeguarding is Everyone's Responsibility

Calderdale & Huddersfield NHS Foundation Trust's Annual Complaints Report 2022/23

INTRODUCTION

The Trust is accountable to its patients, public and communities we serve for providing high quality care that is safe, effective, and focused on patient experience. When things do not go as planned, we want to make sure that our patients and their families receive an appropriate explanation and apology that is delivered with compassion and recognition of the distress that they have experienced. The Trust seeks to ensure that the organisation learns lessons to avoid similar episodes occurring again and to improve the experiences of our patients, their families, and their carers.

This report provides information on the complaints received in the Trust between 1 April 2022 and 31 March 2023; providing a summary of complaints received, areas concerned, main issues raised, and themes/trends identified. It also looks at our key performance indicators:

1. The number of agreed response targets met
2. The number of complainants who came back dissatisfied following receipt of their initial response

The information in this report has been based on analysis of data from the Trust Risk Management Information System (Datix) Complaints module and from the Trust's Knowledge Portal (KP+) system.

PATIENT ADVICE AND LIAISON SERVICE

1. PALS Process

The Patient Advice and Liaison Service (PALS) supports patients, their families, and their carers by listening to queries and concerns in confidence and helping people find solutions as quickly as possible. The aim of the PALS service is to respond quickly and effectively to service users' concerns, so that their problems are resolved and do not develop into a formal complaint. Agreement with Divisional Leads is to escalate any concerns relating to an on-going, in-patient admission immediately to the Matron, so that they can make contact with the service user and determine a resolution. Data for this service is shared within the Trust's Annual Report

2. Formal complaints

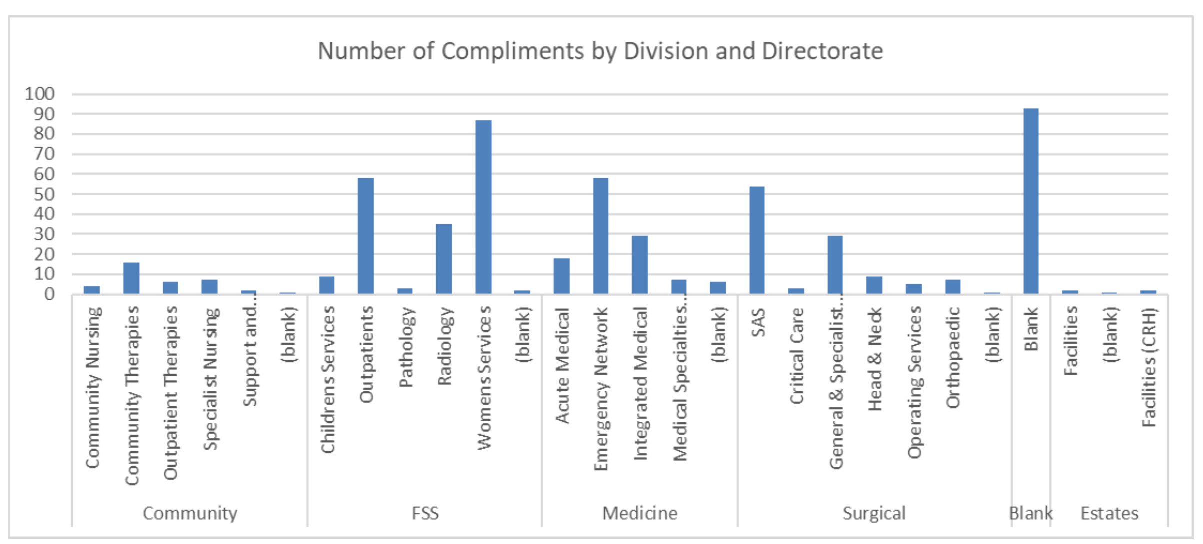
All formal complaints are dealt with in accordance with the Local Authority Social Services and NHS Complaints (England) Regulations 2009. Formal complaints are typically detailed, identifying problems and issues relating to episodes of care that have already happened (for example, questions as to why a diagnosis was not made at an earlier time). Complaints received anywhere within the Trust are sent to the PALS and Complaints Team, formally acknowledged, and sent to the appropriate divisional senior management team. The divisional senior management team identifies a suitable investigating officer who will investigate the complaint and a written response is then provided within the agreed timeframe. The response details the investigation outcome, along with any learning points and actions that have been identified.

Once the investigating officer has concluded their investigation, their investigation response will be sent to the Divisional Assistant Director of Nursing for approval, the response will then be sent to the Head of PALS and Complaints for quality checking. Following this process there is a final review and sign-off by a member of the Executive Team on behalf of the Chief Executive.

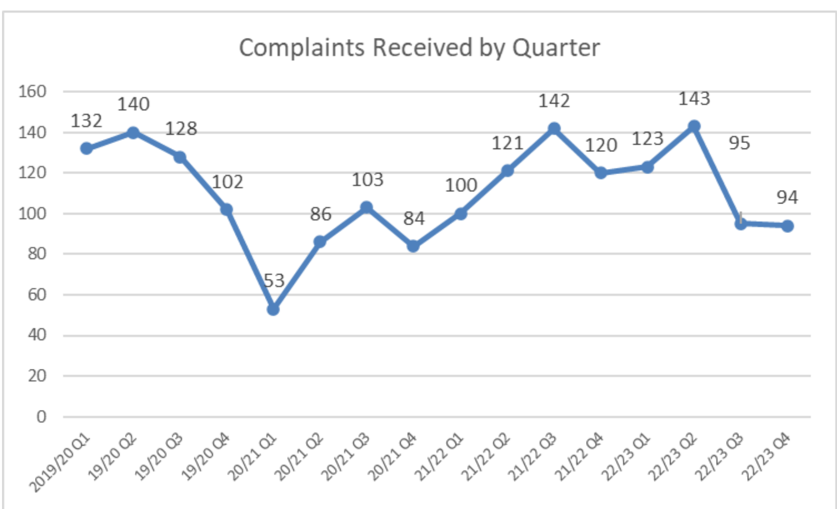
Complaints and Compliments 2022/23 at a glance

455 **Formal complaints RECEIVED**	This is a slight decrease from 2021/22 (480). Emphasis continues to be placed on resolving concerns in real time via the PALS service as quickly and effectively as possible, however the operational demands have seen a rise in concerns escalating to complaints.
529 **Formal complaints CLOSED**	529 formal responses have been sent throughout this reporting period which equates to 10 per week, on average. 379 formal complaints were closed the previous year, demonstrating that 150 more complaints were closed – which is a 39% increase.
67 **Formal complaints RE-OPENED**	67 out of the 529 formal complaints were re-opened, which equates to 13%. This is a relatively high number however this is expected to be higher due to the number closed in the same time period. (This was not reported in previous reports but will be compared in next year's annual report; this is further detailed in the "forward plan 23/24")
500 **Compliments RECEIVED**	This is lower than the previous year of 609 compliments. Further work is being done to capture positive/complimentary feedback and report this Trust wide. There are lots of examples of compliments made across all areas of the Trust and it is a challenge to collate these in an effective and efficient way, so this will not be a comprehensive figure of all positive feedback received in the Trust. All compliments are valued by staff and are a useful source of intelligence on what the Trust is doing well.

Compliments: Compliments received are highlighted below broken down by divisions and directorates

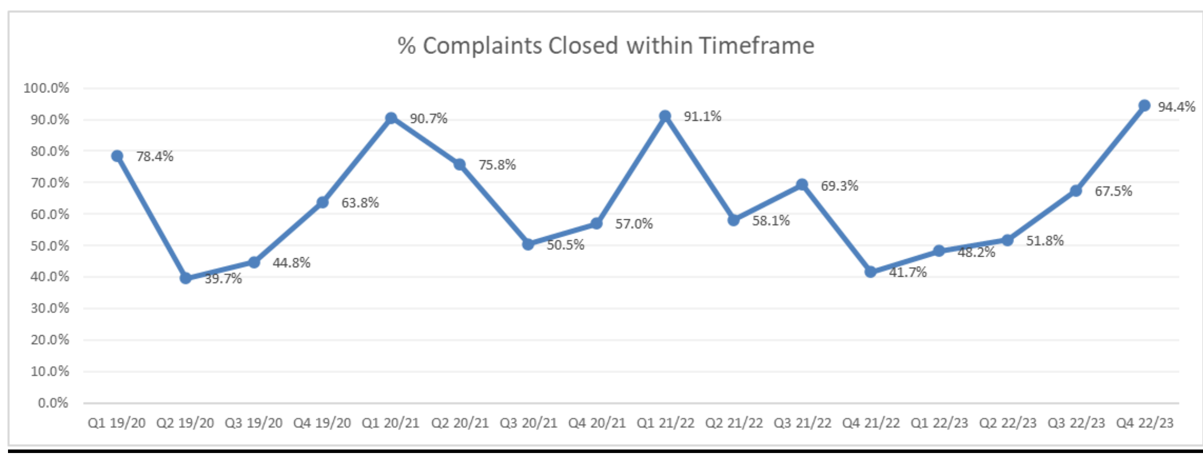


Complaints: The number of complaints received per quarter



It is evident from the data shown above that since 2019, the highest numbers of complaints were received in quarter 3 of last year.

Complaints: The Trust's performance on response times compared to previous years



During this year we have focused on improving the way in which we process, investigate, and respond to complaints, consistently improving our performance. We have made a significant improvement over the year from 41.7% of complaints being responded to within timeframe to 94.4%.

The Trust's default position is to respond to complaints within 40-60 working days depending on complexities. If there are delays to the investigation and we believe a longer period will be required, contact should be made with the complainant offering apologies and negotiate a new, agreed timeframe.

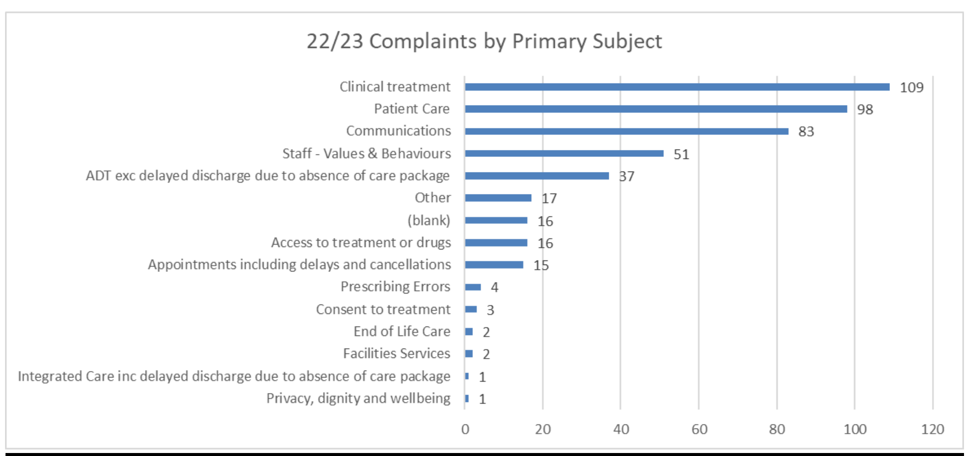
A missed deadline potentially exacerbates a complainant's feelings, and we are working hard to improve our communication and response rate in this regard. As mentioned previously, weekly high-level scrutiny meetings with Divisional Leads are now embedded to continually monitor performance. Any issues or concerns are then escalated during those meetings, and these are then fed through to the Executive Team.

This was a quality priority throughout 2022/23 and will continue to be throughout 2023/24 alongside other priorities identified in the Trust Quality Account.

Divisional themes and analysis

The primary issue identified in each complaint is demonstrated below. The overriding theme within formal complaints is patient care, including nutrition and hydration, followed by clinical treatment and communication.

- Of the 455 complaints received, 109 were related to clinical treatment being recorded as the primary subject; this equates to 24%.
- 98 of the 455 complaints related to patient care, including nutrition and hydration (22%) and 83 complaints were concerning communication (18%).



The Parliamentary and Health Service Ombudsman

The Parliamentary and Health Service Ombudsman (PHSO) have worked with the NHS, other public service organisations, members of the public and advocacy groups to develop a shared vision for NHS complaint handling. Training packages have now been released for relevant members of Trust staff to complete to ensure we are compliant with these standards going forward.

The new PHSO Complaint Standards Framework sets out a single set of standards for staff to follow and provides standards for leaders to help them capture and act on the learning from complaints. These were recently launched with further modules expected this year. The PHSO has introduced some internal changes in relation to how they manage and handle their referrals as the time taken to assess complaints is longer than they had planned for. The introduction of mediation meetings with the Trust's and complainants to avoid full investigations, has seen a varied success rate.

Forward Plan for 2023/2024

The Trust aims to continue its high performance and consistently reach our target of 95% of complaints being responded to within the agreed timeframes. Whilst this work is on-going, we are now committed to analysing and understanding re-opened complaints. Complaints are re-opened for several reasons.

1. The information provided within the initial response has prompted further questions which cannot be avoided.
2. The information provided has not fully addressed the concerns which can be improved with effective communication at the outset, to determine the expectations of the complainant and what outcome they hope to achieve, as well as what specific questions they would like to be answered.

3. Despite the information provided, the complainant does not agree with the Trust's position and either further work is required to resolve this or signpost to the PHSO for an independent assessment.

This year we hope to lessen the number of complaints re-opened by "getting it right first time". Analysis of this specific area of complaints has begun and continues to be monitored. To support this on-going work, a further objective is to improve our learning, both divisionally and Trust wide, to ensure similar complaints are not repeated and we can demonstrate to complainants that improvements and changes have been made as a result of their complaints. Assurance from Divisions will be provided to demonstrate that teams are implementing learning, evidencing changes made and communicating these changes to all appropriate staff.

The weekly scrutiny/performance meetings are to continue, as introduced by the Trust's Chief Nurse. These meetings feed into the weekly Executive oversight. It has also been reinforced that lead investigators are expected to keep complainants updated about the progress of their complaint. ensure that processes are in place to monitor this and to escalate any delays. Monthly complaints reports continue to be submitted to the Quality Committee and the Patient Experience Group and we continue to triangulate our findings through the divisional Patient Safety Quality Board's

The Trust continues to build a PALS and Complaints team with effective divisional relationships to meet regulatory standards, Trust priorities and the needs of our communities.

Quality Improvement

As reported last year, to ensure we provide a high-quality service, the Trust has invested in a new telephone system, which was implemented on 31 May 2023. This enables the Trust to monitor the number of calls being received, how long each call is active, how long service users are waiting to be answered and how many calls are abandoned; this allows the team to adjust staffing accordingly. This telephone service has had a direct impact on our service users and it continues to demonstrate a positive change for both staff in the small corporate team and our patients and their relatives.

For 2023/24 we want to focus on identifying areas and sharing in a more robust way, the learning and quality improvement that has happened as a result of complaints feedback. We intend to hold a quality summit later in the year to bring together learning from complaints, incidents, concerns and other sources of intelligence and identify what high impact actions we can take as a result on a trust, division or departmental basis.

Conclusion

In concluding our review of the year's activity, it is important to recognise the improvements made in the Trust's performance and percentage of complaints responded to within agreed timeframes. This remains a challenge for clinical and operational teams, as well as for those liaising directly with families and patients in the PALS and Complaints Team. This work will continue, and we hope to evidence even more improvements and learning in next year's annual complaints report.

Date of Meeting:	June 2023
Meeting:	Board of Directors – 6 July 2023
Title of report:	Maternity and Neonatal Oversight report
Author:	Diane Tinker, Director of Midwifery and Women's Services
Sponsor:	Lindsay Rudge, Chief Nurse, Executive Director Maternity Safety Champion
Previous Forums:	None

Actions Requested

- To note

Purpose of the Report

To provide the Board of Directors with a suite of information that provides an oversight of key quality issues within maternity services.

Key Points to Note

- The Maternity Transformation Plan has been updated to reflect the 3-year Delivery Plan for Maternity and Neonates and the Ockenden expectations.
- The Trust has received confirmation that it has been received the financial rebate for achieving the 10 Safety Actions for Year 4 of the Maternity Incentive Scheme.
- Year 5 of the Maternity Incentive Scheme was launched on the 31 May 2023 with a submission date of the 1 February 2024 at 12 noon.
- The service currently has 3 open and 1 closed HSIB investigations in month and a resume of each case is included within the report.
- The neonatal death audit highlighted that 61% (11/18) of mothers who had a neonatal death lived in the most deprived areas. A thematic review was undertaken for the 11 cases with IMD codes 1 and 2. No themes were identified that required further additional actions.
- Smoking cessation - in the first 3 months of the in-house service, 96 of 119 eligible women were contacted. 81 of these engaged (accepted NRT) and 41 set a quit date of which 34 had a confirmed quit 4 weeks after their quit date.
- Due to the decrease in births the maternity staffing model has been reviewed calculated using the **principles** of the Birthrate Plus tool and is based on a 1:24 ratio and birth rate of 4313 (22/23) against a previous birth rate of 4902 (2020).
- The model reflects a skill mix calculation of 90%/10% split between midwives and non-midwifery support staff as recommended by Birthrate Plus.
- In addition to the clinical midwifery workforce model, the model also reflects an additional uplift of midwife roles by 8% with the function of supporting non-clinical management and governance.
- The new model total midwifery establishment calculated using the principles of the model would be 174.63wte

- The maternity service has been involved in LMNS regional recruitment for student midwives who qualify in September 2023 and has offered 14wte post (16 students).
- Following international recruitment 2 midwives are expected to arrive the end of June and will attend the regional 4-week OSCE course throughout July with the expectation that they will be in placement the last week in July.
- A further 3 international midwives have recently been offered posts following the second round of recruitment, with the midwives expected to arrive in September 2023.
- Two of the most important safe staffing indicators relate to the provision of 1:1 care in labour and the supernumerary status of the labour ward (LDRP) coordinator. In April 2023 the LDRP co-ordinator was supernumerary on 100% of the shifts and 1:1 care in labour was 98.5%.
- The neonatal nursing workforce tool (2020) expectation is that at least 70% of the registered staff hold a post registration qualification in neonatal care (Qualification in Speciality QIS), currently, 69% of registered staff hold QIS.
- The neonatal unit has recently received the Certificate of Commitment from UNICEF UK, recognition that a provider is committed to working to Baby Friendly accreditation.

EQIA – Equality Impact Assessment

There is significant evidence which demonstrates that the experiences and outcomes of mothers and babies from BAME groups and those from the areas of highest levels of deprivation are more likely to be poor.

Maternity services have an active Health Inequalities work stream to drive improvement work for those most at risk. CHFT’s midwifery reader has produced a cultural survey that has been shared with staff to understand knowledge gaps ahead of developing training opportunities for midwives and obstetricians.

Recommendation

The Board of Directors asked to note the assurances provided within the report.

Maternity and Neonatal Report for Board of Directors

1. Maternity Transformation Plan

The 3-year Delivery Plan for Maternity and Neonates was published on the 31 March 2023, the plan was published to combine the findings and recommendations from the Ockenden and East Kent reports. The Ockenden 1 7 Essential and Immediate Actions (EIA's) remain mandated but following the LMNS Board meeting it has been confirmed that Trusts are not expected to progress the Ockenden 2 actions.

The Maternity Transformation Plan has been updated with the sections highlighted in grey to be archived.

Action Plan		New Action	Not Yet Started	area of concern	In Progres	On Track	Completed	Total Actions	Comments and exceptions
Safe Care & Trained Workforce	locally designed plan relating to workforce addressing staff	0	0	0	0	0	24	24	Now archived a new Safe and Caring workforce plan will be devised for the new financial year -
Governance	locally designed plan that addresses governance in Maternity	0	0	0	2	0	17	19	Some progress within Maternity governance structure, work underway with Divisional Governance structure
Ockenden 1	action plan in relation to Ockenden 1	0	0	0	0	0	35	35	All actions now completed -now archived will be a further review in Nov 23 by LMS and peers will review prior to that
Ockenden 2	action plan in relation to Ockenden 2 deliverables for this to be shared early in 2023	0	12	2	27	0	51	92	Plan to review again next month following a review of the 3 year Maternity and Neonatal plan. Discussed at LMNS Board confirmation for Trusts to be working towards 3 Year Plan Continues to be progress with a number of actions. 12 actions that have no yet progressed which is a similar position since Nov 22, currently we are waiting for National guidance. -2 areas of concern Split rota for 0 & G and dedicated reg at night for Neonates. Awaiting decision through business planning processes
Maternity Incentive Scheme	provision for the maternity incentive scheme has been built into our CNST maternity pricing for 2022/23. incentivises ten maternity safety	0	0	0	0	0	54	54	Have now met all aspects of MIS with sign off by chief exec, board and ICB - now archived. New MIS Year 5 to be added
Maternity Self-Assessment	A self assessment that is outlined in Ockenden 2	0	0	30	33	0	107	170	Self assessment undertaken initially in June and reassessed in Sept Self assessment reviewed again March 23 will review again in 6 months - seen some progress with Marchs benchmarking
GIRFT - Gynae	national programme designed to improve the treatment and care of patients through in-depth review of services,	0	18	0	17	0	0	35	Newly benchmarked this month further action to be taken
GIRFT Maternity	As above	0	6	0	12	0	5	23	no further updates
3 year Delivery Plan for Maternity and Neonates	this is following the Ockenden 2 report and the East Kent review	0	0	0	24	7	8	39	initial benchmarking exercise undertaken against the three year plan. Multi professional MVP and organisation Transformation Board set up to provide oversight of the plan and agree timeframe

2. NHS Resolution Maternity Incentive Scheme

The Trust has received confirmation that it has been received the financial rebate for achieving the 10 Safety Actions for Year 4 of the Maternity Incentive Scheme.

Year 5 of the Maternity Incentive Scheme was launched on the 31 May 2023 with a submission date of the 1 February 2024 at 12 noon.

3. Healthcare Safety Investigation Branch (HSIB)

As of the 12 May 2023 the maternity services position is:

Cases to date	
Total referrals	41
Referrals / cases rejected	15
Total investigations to date	26
Total investigations completed	23
Current active cases	3

HSIB are now reporting data the beginning of April 2019 onwards, when the HSIB maternity programme was live across the whole of England.

Current active cases:

HSIB case number: MI-023484
HSIB criteria: Early Neonatal Death
Incident date: 13/04/2023
Referral date: 17/04/2023

Brief History
Normal birth, baby born in good condition, no resuscitation required.
At 40 minutes of age poor colour and tone noted, reviewed, and transferred to NNU. Diagnosed persistent pulmonary hypertension of the newborn, transferred to Leeds. Baby died the following day.

Immediate actions taken
None

HSIB case number: MI-023484
HSIB criteria: Early Neonatal Death
Incident date: 05/03/2023
Referral date: 06/03/2023

Brief History
Off pathway breech homebirth, baby born in poor condition at home. Initially transferred to HRI for resuscitation and then on to BRI for ongoing cares. Subsequently baby died at 25 hours of age.

Immediate actions taken
None

HSIB case number: MI-019964
HSIB criteria: Maternal Death
Incident date: 29/12/2022
Referral date: 30/12/2022

Brief History
33 weeks pregnant, admitted on 23 December unwell signs of chest infection, admitted to ICU on the 24 December as condition deteriorated and required further respiratory support. Subsequently she was diagnosed as flu +ve and Strep A +ve. Her condition deteriorated on

29 December and a decision was made for caesarean section, however she suffered a cardiac arrest prior to transfer. A perimortem caesarean section was performed in ICU, unfortunately despite extensive resuscitation she sadly passed away. Following initial resuscitation baby was transferred to the NNU and is doing well.

Immediate actions taken
Provision of neonatal resuscitation grab bag for use in births outside the maternity service whilst awaiting arrival of full neonatal resuscitation trolley

Perimortem lower segment caesarean section pack accessible via theatre co-ordinator

Closed case in month:

HSIB case number: MI-017349
HSIB criteria: Early neonatal Death
Incident date: 05/11/22
Referral date: 07/11/22

Brief History
Attended early labour, Cat 1 caesarean section for fetal bradycardia and reduced movements. Born with no spontaneous respiratory effort and heart rate. Full resuscitation required including adrenaline, incubated, and ventilated on the Neonatal unit. Decision for reorientation of care due to baby's condition. Baby passed away day after birth.

Immediate actions taken
New emergency resuscitation trolleys obtained for theatre to aid familiarity and access to resuscitation equipment
Remind all staff regarding the importance of using 2222 and rehearsal of calls during simulation training

Recommendation
The Trust to ensure when a CTG is in progress that the recording of the trace is of high quality and when necessary, take steps to improve the quality of the recording.

Rejected cases in last month: None

4. Maternity Incidents

Maternity incidents reviewed at weekly maternity governance MDT meeting. All incidents are reported via Datix and coded as maternity incidents. The comparative data for March 2023 and April 2023 is described below.

	March 23	**April 23**
Shoulder Dystocia	**8**	**2**
Term admission to the Neonatal Unit	**17**	**21**
2nd Theatre opened	**4**	**6**
Delay in Emergency Caesarean Section	**16**	**15**

Month	Maternity SI's	Maternity Never Events	Open HSIB cases	Total Stillbirth (SB) / Neonatal Death (NND)	Stillbirths Antenatal	Stillbirths Intra-partum	HIE Grade 2/3	Early NND	Late NND	Notification to ENS	Maternal Mortality
April 2023	0	0	3	2	2	0	0	0	0	0	0

35+4 weeks antenatal stillbirth, admitted to MAC via ambulance with abdominal pain, no loss pv. No fetal heart on admission. Posterior rupture identified at LSCS.

30+5 weeks feticide due to multiple fetal anomalies.

5. Maternity Dashboard

Key Indicators	Thresholds									
	Green	Amber	Red	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	YTD
Normal births	>57%	-	<57%	55.2%	55.7%	56.3%	59.74%	55.7%	57.23%	57.23%
Assisted vaginal births	<12.4%	-	>12.4%	9.65%	6.32%	9.52%	6.17%	8.36%	8.73%	8.73%
Elective C/S deliveries	Monitoring Only			15.18%	12.98%	13.33%	14.43%	15.38%	12.84%	12.84%
Emergency C/S deliveries	Monitoring Only			19.78%	23.01%	18.93%	18.36%	18.80%	23.55%	23.55%
3rd/4th degree tear - normal birth	<2.8%	-	>2.8%	0.5%	0.0%	1.3%	0.3%	1.1%	0.9%	0.9%
3rd/4th degree tear - assisted birth	<6.05%	-	>6.05%	5.6%	4.5%	2.8%	10.5%	6.7%	6.9%	6.9%
PPH ≥ 1500ml	<3%	<3.0%	>=3.5%	3.25%	3.54%	3.73%	2.6%	3.42%	5.20%	5.2%
Total stillbirths	0	<3	>=3	0	2	1	1	1	2	2
Total stillbirths and Perinatal /Neonatal Deaths	0	<3	>=3	4	2	2	2	3	0	0
Low birth weight at term - live births - % of live babies at term < 2200g	0%	<1%	>=1%	0.28%	0.62%	1.97%	2.08%	0.30%	2.24%	2.24%
1:1 Care in Labour	>=98%	>=97%	<97%	98.3%	98.5%	98.9%	99.7%	99.4%	98.5%	98.5%
Induction Rate	Monitoring Only			35.8%	40.0%	39.4%	49.0%	42.1%	46.0%	46.0%
Planned Home Birth	Monitoring Only			0.54%	2.06%	1.33%	0.98%	1.14%	0.92%	0.92%
Smoking at Delivery	< 11%	-	> 11%	8.13%	9.44%	11.47%	10.16%	12.25%	7.65%	7.65%
Smoking at Delivery (Not recorded)	3%		>3%	7.6%	5.0%	6.9%	5.9%	5.1%	6.7%	6.7%
CO tested at booking	Monitoring Only			85.6%	89.7%	89.6%	97.0%	92.7%	91.8%	91.8%
No. Mothers breastfeeding as First Feed	≥ 74.4%	-	< 74.4%	63.7%	64.4%	69.0%	63.5%	61.4%	64.0%	64.0%
No. Mothers breastfeeding as First Feed Not Recorded	Monitoring Only			21	19	19	17	22	19	19
CO testing at 36 weeks (35-36.6 days)	≥ 80%	-	< 70%	74.5%	88.24%	93.77%	84.09%	87.16%	83.20%	83.20%

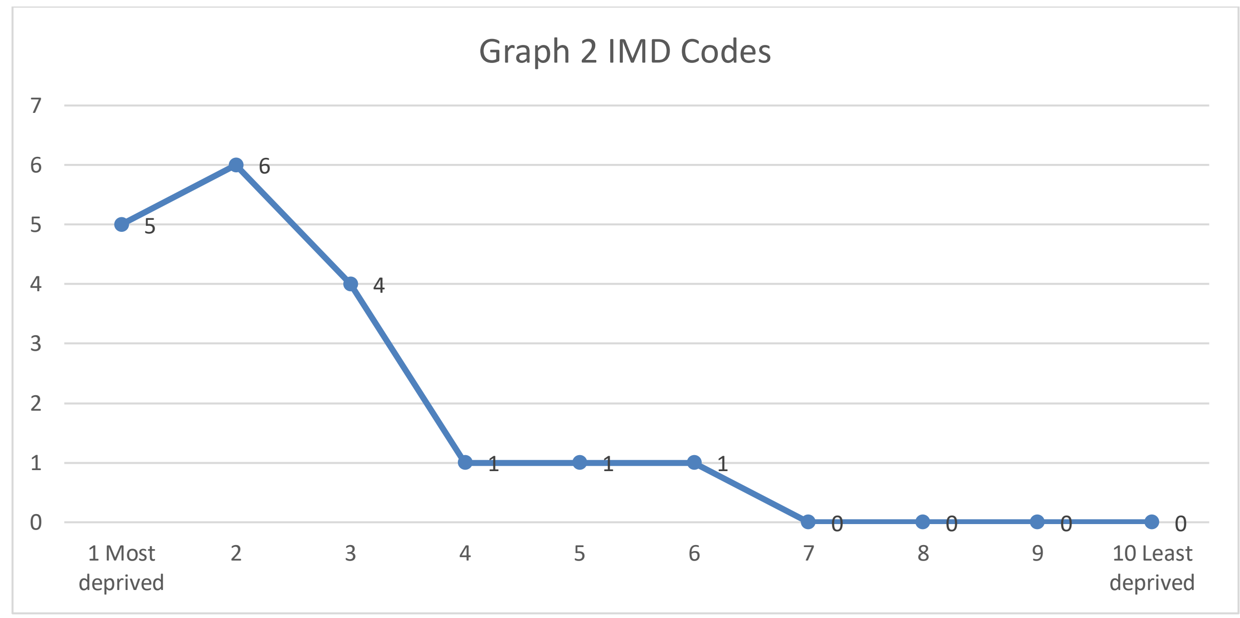
Actions in progress

- A deep dive into 3rd/4th degree tears has been instigated following 3 consecutive months of triggering Red on the dashboard.

- A review of all emergency caesarean sections is being undertaken following an increase in rate to 23.55%.

6. Neonatal Deaths 2022 Audit

Neonatal deaths audit included in report last month with postcodes but not IMD codes.



The audit highlighted that 61% (11/18) of mothers who had a neonatal death lived in the most deprived areas. These were mainly in the town centre areas of Huddersfield (HD1, HD2) and Halifax (HX1, HX2). Thematic review undertaken for the 11 cases with IMD codes 1 and 2.

- 3 congenital anomalies – all close relative marriages
- 4 extreme preterm <24 weeks
- 2 prolonged rupture of membranes
- 2 unbooked, 1 booked at another Trust
- 2 late bookers >13 weeks
- 6 Asian Pakistani, 3 English first language, 3 English not first language - 2 spoke good English, 1 with limited English
- 3 smokers
- 1 history of past or current drug misuse
- 4 mental health issues
- 3 BMI >35
- All MAC calls reviewed, managed, and advised appropriately

Current practice to address specific health inequalities:

- Close relative marriage midwife started 7.5hrs per week 1 June 2023
- LMNS workstream early booking
- Maternity Health Advisers – smoking pathway
- Substance misuse midwife in post
- Perinatal Mental Health midwife started in post end May
- BMI to be recommenced

7. Smoking update

The NHS Long Term Plan for reducing smoking aims that by 2023/24, all people admitted to hospital who smoke will be offered NHS funded tobacco treatment services. The model will be adapted for pregnant women and their partners, with a new smoke-free pregnancy pathway including focused sessions and treatments.

CHFT Maternity Smokefree Pregnancy Pathway was launched in October 2022 delivered by trained Maternity Health Advisers. Pregnant smokers are referred to the service at booking and offered free NRT and support to quit for up to 12 weeks. The service is offered to all women by telephone and NRT is posted out.

To target health inequalities the Maternity Health Advisers, have face to face clinics in Central and North Halifax, the two deprived areas identified as high smoking rates. Negotiation for space in Children's Centres to provide the same in Huddersfield is being progressed.

One Health Adviser is working with the Substance Misuse Midwife and has engaged a small number of women through the PRAMS and SWANS clinics. The other Health Adviser is beginning to work alongside the Perinatal Mental Health team as those with mental health issues frequently continue to smoke.

The Maternity Health Advisers have completed training to Level 2 Tobacco Dependency Advisers, including practical training with Yorkshire smokefree and Very Brief Advice (VBA) training is delivered on Mandatory Day 2 to all Midwives.

Further enhanced training is planned and available to Midwives and MSW's who deliver antenatal care on the 20 and 21 June.

In the first 3 months of the in-house service, 96 of 119 eligible women were contacted. 81 of these engaged (accepted NRT) and 41 set a quit date of which 34 had a confirmed quit 4 weeks after their quit date.

- Of women who set a quit date 83% quit.
- Of all women eligible 28.57% quit.

These early indicators show that the in-house service is performing at least as well as the previous external referrals and appears to be doing slightly better.

Anonymised case studies provided by the in-house service have been featured in The West Yorkshire ICB Improving Population Health newsletter, on their website, and included in the regional #MumsCan campaign targeting young mothers.

CHFT have been asked by the NHSE Regional Tobacco Lead to present at a Conference in September about their work. Feedback from women who have quit smoking through the in-house service is very positive.

The nest steps are to implement a pathway for maternity in patients working alongside implementation of tobacco dependency treatment for all patients admitted to hospital across the Trust.

8. Maternity Complaints

Maternity services currently have 7 open complaints as of 9 June 2023, 1 complaint overdue, extensions have been requested and agreed with 2 complaints. 1 of the extensions is due to a meeting being arranged with the complaint and the clinical investigators. 1 complaint is now being investigated as an SI following presentation at the SI panel on the 6 June 2023. The division are continuing to work with the Trust complaint's team to improve compliance with timely complaint responses.

9. Maternity and Neonatal Board Safety Champion Staff Engagement Feedback

During discussion with staff there was real positive feedback around the response that the Trust had taken with regards to a concern that had been raised by a midwife about inappropriate communication she had received when ringing a family up who were waiting an induction of labour. Staff were also really positive about the additional media response around expectations and what was acceptable behaviour in terms of what staff faced.

Staff expressed how they would like to see more thank you and appreciation cards from management but really loved the focus work around kindness and civility that has been undertaken.

A long discussion was held around the recording of red flags and how to capture these in an easy way, this will be explored further with the matrons and colleagues.

There was a discussion between about the difference between the B2 and B3 MSWs with a view that the team felt they should all be on the same band and there should not be a differential between the two because at times it created a hierarchical position between the two different levels, and they felt it didn't always make people feel valued. A national framework has been introduced around B2 and B3 maternity support workers (MSW), with a MSW clinical educator undertaken a review.

There was also discussion around the different routes in undertake midwifery training and how to increase student intakes into midwifery.

There was good feedback from a MSW who worked on transitional care, she felt that it was like one big family and on LDRP although they were busy the staff were very positive about lots of different aspects and feeling involved. They felt they had more opportunity to do things on social media and recognised the support from the pastoral teams.

10. Midwifery Staffing

Midwifery services submit workforce data to NHSEI each month and in March 2023 recorded 149.64 whole time equivalent (WTE) midwives which includes 3 Matrons and the Deputy Director of Midwifery but does not include 3.80WTE staff nurses against an establishment of 198 WTE midwives. March 2023 is the latest data as month 1(April) is a limited return only with the first full return submitted in month 2 (May).

Due to the decrease in births the maternity staffing model has been revised calculated using the principles of the Birthrate Plus tool and is based on a 1:24 ratio and birth rate of 4313 (22/23) against a previous birth rate of 4902 (2020). The model reflects a skill mix calculation of 90%/10% split between midwives and non-midwifery support staff as recommended by Birthrate Plus. In addition to the clinical midwifery workforce model the model also reflects an additional uplift of midwife roles by 8% with the function of supporting non-clinical management and governance.

The new model total midwifery establishment is therefore 174.63wte which consists of:

161.73wte clinical midwives following skill mix

12.9wte non-clinical midwives

The current total midwifery vacancy rate against this revised staffing model is 14.31% (149.64wte of 174.63wte employed March 2023) and the current clinical midwifery vacancy rate against revised staffing model is 13.70% (142.24wte of 161.73wte employed at March 2023).

A full review by Birthrate plus will be commissioned to ensure acuity and continuity models are reflected in the service WFM.

With the continued staffing challenges through the maternity service a review of acuity and staff available occurs each shift, with LDRP completing the Birth Rate Plus acuity tool 4 hourly and staff are redeployed within the hospital setting to appropriate areas to maintain safer staffing levels. Options in escalation also include the utilising of the on-call community midwives and non-clinical midwives, and temporary relocation of Calderdale Birth Centre to LDRP. The service has a robust escalation policy, with responses that include utilising the on-call community midwives and non-clinical midwives, and temporary relocation of Calderdale Birth Centre to LDRP. All episodes of escalation are reported via the incident reporting system and then reviewed at the weekly maternity governance meeting.

The maternity service has been involved in LMNS regional recruitment for student midwives who qualify in September 2023 and has offered 14wte post (16 students).

Following international recruitment 2 midwives are expected to arrive the end of June and will attend the regional 4-week OSCE course throughout July with the expectation that they will be in placement the last week in July. A further 5 have recently been offered posts following the second round of recruitment, with the midwives expected to arrive in September 2023.

Additionally, following approval at Hard Truths and successful recruitment a governance matron has been appointed and will joining the team in the next few months.

Responsive model introduced on Calderdale Birth Centre

With the current staffing challenges at times of escalation Calderdale Birth Centre (CBC) has been relocated to LDRP. During these times of relocation, women can still follow a low-risk pathway and receive midwifery led care albeit in a high-risk labour ward.

However, following discussion with women and staff it was highlighted that the preferred place of birth would be CBC, therefore a responsive model was developed. In the responsive model the midwives follow the woman and her place of birth choice rather than staffing a building. Guidelines and standard operating procedures were reviewed and developed to support this change.

The responsive model was successfully launched on the 1 May 2023 with 40 births throughout May compared to 3 births in April 2023.

Maternity Safe Staffing Indicators

Two of the most important safe staffing indicators relate to the provision of 1:1 care in labour and the supernumerary status of the labour ward (LDRP) coordinator. Although midwifery staffing remains challenging due to vacancies 1:1 care in labour and supernumerary status of the labour ward co-ordinator are prioritised.

In April 2023 the LDRP co-ordinator was supernumerary on 100% of the shifts.

The table below describes the 1:1 care in labour position over the previous 6 months.

Month	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	April 23
1:1 care in labour	98.3%	98.5%	98.9%*	100%	100%	98.5%

11. Neonatal Services

Nurse Staffing

Currently there are no vacancies within either the qualified or unqualified nursing workforce establishment.

The neonatal nursing workforce tool (2020) expectation is that at least 70% of the registered staff hold a post registration qualification in neonatal care (Qualification in Speciality QIS). Currently, there are 69% of registered staff with the QIS, with 3 staff nurses undertaking the foundation course which is the high dependency and special care modules of the post registration qualification. Following consolidation of practice, they will complete the intensive care module.

Developments

The neonatal unit has recently received the Certificate of Commitment from UNICEF UK. This is the first award given by UNICEF UK in recognition that a provider has an infant feeding policy and an action plan to achieve Baby Friendly accreditation, and the commitment to implement the plan.

Date of Meeting:	Thursday 6th July 2023
Meeting:	Board of Directors
Title of Report:	Nursing, Midwifery and Allied Health Professional Annual Safer Staffing Report
Author:	Andrea Dauris – Associate Director of Nursing (Corporate)
Presenter of report: (if different from author)	Lindsay Rudge – Chief Nurse
Sponsoring Director:	Lindsay Rudge – Chief Nurse
Previous Forums:	Workforce Committee – 20th June 2023 Quality Committee – 21st June 2023

Actions Requested:
- To note

Purpose of the Report

The purpose of this report is to provide the Board of Directors with an overview of Nursing, Midwifery and Allied Health Professional (AHP) staffing capacity and compliance within Calderdale and Huddersfield NHS Foundation Trust in line with the National Institute for Excellence (NICE) Safe Staffing, National Quality Board (NQB) and the NHS Improvement Workforce Safeguards guidance.

This is supported by an overview of staffing availability over the reporting period and progress with assessing acuity and dependency of patients on ward areas. This data collection has been used to inform the Nursing and Midwifery establishment reviews for 2023-2024.

It is a national requirement for the Board of Directors to receive this report bi-annually.

Key Points to Note

The following details what are considered the key points to note:

- Based on the current Nursing and Midwifery recruitment strategies, May's vacancy position sits at 201.28 FTE, a deteriorating position since the last report. This position does not include the planning assumptions associated with the bed retraction plans.
- Whilst noticeable peaks in sickness absence are reported during the 12-month reporting period, there is a positive reduction in sickness absence for Month 12 across both workforce groups

- Staffing fill rates continued to fluctuate between 82% - 90% during the day. A position reflective of ongoing sickness/absence, additional capacity areas and enhanced service delivery in some areas
- The CHPPD at Trust level has remained stable demonstrating where safely possible the workforce is being flexed in line to meet patient activity and patient needs. Benchmarking from the Model Hospital suggests at a Trust level CHFT sits in the upper part of quartile 2, positioned between peers. This is reflective of the ongoing fill rate position.
- During the reporting period 284 Nursing and Midwifery staffing related incidents were reported through the Datix reporting system. Two hundred and eighty-two (282) of these incidents were reported as no harm and 2 as minor harm. There was appropriate escalation when the incidents occurred.
- The Trust's International Registered Nurse recruitment campaign continues at pace with ongoing success, expanding into both midwifery and AHP services
- The Trust remains committed to reviewing the roles and function within teams, demonstrated through approval in providing ongoing investment for a further 19 registered nurse degree apprenticeships.
- The retention initiatives that have been identified
- The continued focused leadership to support this agenda.
- The impact upon patient experience and the quality agenda if the Trust fails to provide safe staffing numbers across all clinical areas.
- Risk 6345 describes the current risk associated with insufficient Nursing, Midwifery and Health Care Support workers and is reported at level 20

EQIA – Equality Impact Assessment

Ethnicity, age, disability, sexuality, socio-economic status, religious beliefs, non-English speakers and being a member of a social minority (e.g. migrants, asylum seekers, and travellers) may all influence rates of access to CHFT patient services. These factors may also influence the level of nursing, midwifery or allied healthcare professional staff required to provide safe care.

Consideration of the impact of equality issues on the provision of safe care to all patients is an integral part of standard nursing practice. As such, considering equality issues that may influence the provision of safe staffing forms an integral part of the scoping document.

Evidence shows us a direct correlation between quality, safety and patient experience and nurse staffing levels. Failure to have staffing in place that meets the care needs of patients means there is a potential risk of poor outcomes for all service users. Should this be the case then people from protected characteristic groups could have been disproportionally impacted given the evidence to suggest a less favourable experience for people from these groups across all NHS services.

Recommendation

The Board of Directors is asked to note the content of the report for assurance.

CONTENTS	
1.0	Introduction
2.0	Safer Staffing
3.0	National compliance
4.0	Sickness and Absence levels
5.0	Hard Truths data
6.0	Escalation and reporting arrangements for Quality and Safety
7.0	Recruitment and Registered Nurse Trajectory
8.0	Nursing and Midwifery Workforce
9.0	Summary
10.0	Recommendations
APP 1	Tiered approach to psychological support
APP 2	Nursing and Midwifery retention plan

1.0. INTRODUCTION

The purpose of this report is to provide an overview for Nursing, Midwifery and Allied Health Professional (AHP) capacity and compliance with the NICE Safe Staffing, National Quality Board (NQB) Standards and the NHS Improvement Workforce Safeguards guidance. Demonstrating safe staffing is one of the essential standards that all health care providers must meet to comply with the Care Quality Commission (CQC) regulation and Nursing and Midwifery Council (NMC) recommendations.

This is supported with an overview of staffing availability over the previous six months and progress with assessing acuity and dependency of patients on ward areas. This data has supported the review of the Nursing and Midwifery establishment reviews for 2022/2023 in addition to providing a cumulative oversight of Care Hours Per Patient Day (CHPPD) and fill rates.

It is well documented that there is an established relationship between higher Registered Nurse (RN) staffing levels and improved patient outcomes and care quality (Griffiths et al 2020).

Developing Workforce Standards (2018) was established from safe staffing work when system leaders identified a gap in support around workforce and built on the National Quality Board (2016) guidance. The standards provide a framework for the approach taken to determine safe staffing processes which includes three components:

- Evidence base tools and data
- Professional judgment
- Outcomes

It is this framework that has been used to determine CHFT's safe staffing processes and the recent safer staffing review.

Within Midwifery Services, a baseline assessment was commissioned using Birthrate Plus, which continues to inform the recent safer staffing review. Appendix 3 outlines the proposed WFM changes in line with a reduced birth rate.

This report describes CHFT's position in response to the national guidance for the reporting period April 2022 to March 2023.

<u>CHFT's Reality</u>

2.0 SAFER STAFFING

2.1 Nursing and Midwifery Establishment review 2022/2023.

Since the last establishment review, the Trust continues to approach the setting of nursing and midwifery establishments as set out in NQB standards. This includes the implementation of the Safer Nursing Care Tool (SNCT), an evidence-based workforce planning tool that provides patient acuity and dependency intelligence, which has informed the Trust establishment setting process. SNCT is an objective tool that utilises levels of care to support workforce planning and has been recognised for

supporting safe staffing across in-patient wards, receiving the endorsement from NICE in 2014.

During the reporting period the Safer staffing review process commenced in January with Safer Care Nursing Tool (SNCT) data collection completing in April. This was followed by five divisional panels presented to the Chief Nurse which completed in May 2023.

This included an appraisal of the proposed workforce models, in addition to identification of the right skills, in the right place at the right time, supporting any divisional training plans. Decision making was premised on the principles as set out in the Developing Workforce Safeguards guidance (2018) which drew together SNCT data analysis, professional judgement, and a suite of metrics such as: sickness/absence data, nurse sensitive indicators and complaints to inform recommendations.

The table below summarises the changes which were approved: -

Division	Area	Current WTE	Agreed WTE	Comments	23/24 Cost (£'000)	Proposed Funding method
Medicine	Emergency Departments	188.84	188.84	Changes to the WFM on both sites to skill mix the B2 and B3 roles to respond to service need. Changes to the shift patterns at CRH ED. The changes are supported by Lead Nurse and ADN.	0	Cost Neutral
Surgery	Ward 14	18.98	20.94	Increase to HCSW role at the weekends to ensure parity of service cover. Changes to shift patterns. Switch to long days funds additional HCA requirement. Professional judgement informed the WFM. This was supported by Matron and ADN	0	Cost Neutral

Division	Area	Current WTE	Agreed WTE	Comments	23/24 Cost (£'000)	Proposed Funding method
Surgery	Ward 22	36.19	35.88	To remove the RN twilight and replace with HCSW twilight. Remaining monies to fund a nutritional assistant. Changes are supported from feedback from complaints and SNCT data and approval of Matron and ADN	0	Cost Neutral
Maternity Services	Maternity Services	198	197.59	Approved changes include: - Governance Matron 8a, Band 7 LDRP coordinator, B5 compliance and complaints officer. Professional judgement and Birth rate data has informed decision making. Approved by DOM and Deputy DOM. Recent review of birthrate and total midwery workforce in Appendix 3	Additional costs contained within existing budget	New posts have been funded by converting vacant Midwifery posts
Central Operations	Discharge Lounge	7.83	7.03	Changes to B6 and B2 roles to strengthen nurse leadership and reflect patient flow	Cost saving £73,484	Savings will offset additional capacity costs
Families and Specialist Services (FSS)	Paediatrics (including paediatric assessment area)	45.1	47.1	Changes to ANP and paediatrics WFM to strengthen B8a and B7 leadership roles. Approved by Matron and ADN.	0	Cost neutral
FSS	Neonate Intensive Care unit	50.36	50.06	Changes to role to support strengthening of the B7 leadership. Approved by Matron and ADN	0	Cost neutral: funded through vacancies at B6,3 & 2
Total					**-73K**	

In addition to the above requested changes, additional funding was allocated through Business Planning for Additional Capacity / Emergency Department as detailed below. This additional expenditure is targeted for cost improvement with a plan in place to reduce additional bed capacity through actions to improve Length of Stay and reduce Delayed Transfers of Care.

Additional Capacity / Growth Funded through 23/24 Business Planning Round

Division	Detail	Budget allocated	CIP assumed	Adjusted Budget
		£'000	£'000	£'000
Medicine	Emergency Department funding to match revised WFMs	1,779		1,779
Medicine	Bed Capacity Ward 15	1,640		1640
Medicine	Bed Capacity Ward 4D	1,100	(1,092)	8
Medicine	Bed Capacity Ward 6AB	577	(577)	0
Medicine	Bed Capacity Acute Floor	766	(766)	0
Medicine	Bed Capacity Respiratory Floor	768	(661)	107
Medicine	Bed capacity Ward 7A	553		553
Surgery	Ward 14 weekend working	146		146
Surgery	Birth centre	300	(300)	0
Surgery	SDEC longer opening in support of escalated bed base	87		87
Corporate	Ward 11a (Discharge Lounge)	600	(600)	0
	Agency and Bank Premium	2,747	(1,103)	1644
Totals		11,063	(5,099)	5,964

2.2 Community Nursing Services

The Community Healthcare Division presented an appraisal of their current establishments, which, following a review of current services did not make any recommendations for changes. However, the overview of services highlighted a diversity of service provision, in addition to investment in service developments including the Ageing Well Programme, Urgent Community Response and Virtual Wards which contributes to a growth in the number of registered nurses and AHP’s.

Community Division - additional staffing for 23/24

Funding Source	Recurrent / Non Recurrent	Detail	WTE	Budget allocated
				£'000
Innovation Fund	Non Rec (Apr 24)	Aging Well Practitioners	5.00	279
Innovation Fund	Non Rec (Jul 25)	Care Home Worker	1.00	44
Innovation Fund	Non Rec (Mar 24)	OOH Palliative Care	0.60	26
WY ICB	Rec	Urgent Community Response	11.59	490

Parkinsons UK	Non Rec (Jul 25)	Parkinsons Nurse	1.00	42
Trust / ICB Matched funding	Non Rec matched funding 23/24	Virtual Ward	10.72	1,600
Trust	Rec	Bladder and Bowel	1.00	44
	Non Rec (Mar 24)	Enhanced Health in Care Homes	3.00	86
Trust	Rec	District Nursing weekend support	0.61	22
Totals			**34.52**	**2,633**

In participating in the beta testing of the development of a community evidence-based data collection tool, initial results indicate up to 40% of Calderdale patients fell into the highest two dependency/acuity category, which implies that dependent/acute patients are being diverted from inpatient care, thereby reducing inpatient pressures. The Community Nursing Safer Staffing Tool (CNSST) has subsequently been launched.

The division shared the district nurse development programme which has now been established in response to service retention challenges and has been well-received in addition to supporting a programme of community nurse leadership.

Over the reporting period a significant improving turnover position for community nursing was shared with a shift from an elevated position of 9.41% to 3.63%.

A key theme across many of the Community Nursing teams was the growth in service provision, which the division continue to explore funding opportunities in addition to new innovative ways of working to respond to these challenges.

2.3 Maternity Services

The two previous reports highlighted the gap in registered midwives between the recommendations from Birthrate Plus to the funded establishment. Birthrate Plus was commissioned to undertake a full baseline assessment for the period 1 April 2019 – 31 March 2020 and the report was produced and provided to the Trust in November 2020. Birthrate Plus methodology is consistent with the recommendations in the NICE safe staffing guideline for midwives in maternity settings and has been endorsed by the Royal College of Midwives and the Royal College of Obstetricians and Gynaecologists. A current maternity workforce gap analysis was also a requirement within the 7 immediate and essential actions in response to the Ockenden Report.

The Birthrate Plus review highlighted a requirement for 226.84 wte total midwives, of which 20.81 wte could be staff nurses or suitable qualified support staff at agenda for change bands 3 or 4. The requirement of 206.03 wte (226.84 wte total - 20.81 wte support staff = 206.03 wte) registered midwives was to provide traditional midwifery care, the review further highlighted the requirement for 213.41 wte registered midwives to provide maternity continuity of carer for 54% of the total women booked at CHFT.

The funded gap of 20 wte registered midwives (226.84 - 20.81= 206.03 vs establishment 186 wte) and 9.44 wte band 3 support staff (20.81 - 11.37) was reduced

when CHFT successfully submitted a bid and received a share of the £95.9 million initial investment into maternity services from NHSE/I. This funding was aimed at filling the staffing gaps evidenced by the workforce gap analysis and was an action following the publication of the Ockenden Report. CHFT maternity services submitted a bid for 20 wte registered midwives based on the November 2020 Birthrate Plus report and were allocated funding for 10.9 wte in April 2021. In April 2022 recurrent funding was received for both midwifery and obstetric staffing, the allocation for midwifery staffing was 12 wte registered midwives, therefore the current funded establishment for registered midwives is 198 wte.

Midwifery services submit workforce data to NHSEI each month and in March 2023 recorded 149.17 whole time equivalent (WTE) midwives which includes 3 Matrons and the Deputy Director of Midwifery but does not include 3.80WTE staff nurses against an establishment of 198 WTE midwives (Table 1).

Since completion of the Birthrate Plus review in 2020, there has been a notable reduction in births from 4902 to 4313 by the end of the financial year 2022/23.

Due to the decrease in birth activity the workforce model has been recalculated using the 1:24 ratio as recommended in the Birthrate Plus report, this will overestimate the staffing required as it covers all ante, intra and postnatal care. This proposed new establishment was agreed at Hard Truths including a proposal to apply a 90/10 skill mix between midwives and non-midwifery support staff which allows for a flexible and sustainable service. The skill mix will include maternity support workers working in community, on the transitional care pathways and staff nurses providing postnatal care on both the labour ward and postnatal ward.

Additionally, through Hard Truths posts were approved to continue to strengthen the maternity governance team, improve the elective caesarean section pathway and to increase the senior clinical presence on labour ward. These posts are summarised earlier in the report.

Table 1: Vacancy levels March 2023

	Births	Planned WTE (MW and RN)	Actual WTE	Planned Leavers (to end June 23)	Midwives and RN in recruitment pipeline
CHFT	4313	198	152.97	2.02	3.61

There continues to be challenges in recruiting to the current vacancies. The service has continued to develop its recruitment and retention strategy and has held recruitment events to attract newly qualified and existing midwives to the service. CHFT has experienced unprecedented midwifery staffing shortfalls against planned workforce levels across all areas due to vacancy, sickness, and maternity leave. In March 2023 overall midwife staffing vacancy including vacancy and maternity leave was 31.59% (Table 2), prior to reviewing the reduction in the birth rate. To ensure the safety of women and babies, and in accordance with guidance from NHSEI, the maternity service has prioritised provision of 1:1 care for women in established labour. This has contributed to decisions for the continued suspension of services at Huddersfield Birth Centre and the continued suspension of the roll out of maternity continuity of carer.

Table 2: Staff unavailability end March 2023

		Annual Leave (Target 15%)	Maternity Leave (1%)	Sickness (4%)	Total* (Uplift 22%)
CHFT	RM/RN	18.7%	3.2%	5.71%	31.59%*
	MSW	16.57%	4.94%	7.47%	32.81%*

*Total includes annual leave, maternity leave, sickness, study leave, working day unavailability and other leave

Local exit interviews undertaken by the Director of Midwifery suggest the main reasons midwives are leaving continue to be due to leaving the midwifery profession, promotion, relocation, and retirement. The maternity recruitment and retention working party has developed a recruitment and retention strategy, which also includes stay interviews hosted by the Deputy Director of Midwifery and Matrons with discussions around options of flexible or alternative working to support colleagues. The maternity services Deputy Director of Midwifery and Band 7 lead on workforce with clinical educators who work clinically with the newly qualified midwives to provide support. Previously the clinical educators were funded from NHSE but having realised the benefits of clinical support a permanent full-time band 6 clinical educator has been recruited.

The challenges in recruitment and the strive to improve the maternity services has also led to developing new ways of working. Following approval at Hard Truths in September 2022 and through external funding midwives have been recruited to the roles of bereavement lead, governance midwife, public health midwife and a clinical educator for support workers, with a clinical educator for midwives starting in post in the next few months.

In addition, maternity support workers have been appointed to both substantive and fixed term contracts with some already in post and others commencing over the next few months. The appointment to fixed term posts has been recognised as a short-medium term strategy to support the currently midwifery vacancies.

The maternity service continues to be involved in LMNS regional recruitment for student midwives who qualify in September 2023. In preparation for this CHFT maternity services held two recruitment events to showcase our service and to meet the team on the 27 February and 20 March 2023. Both events were well attended with student midwives from both CHFT and other local Trusts. Following regional recruitment there will be 14WTE newly qualified Midwives joining the trust.

The Trust received external funding to support recruitment to 5 international midwives, with the target that the international midwives will have passed their English Language and NMC Computer Based Test and have arrived in England between 1 August 2022 and 31 December 2023. The recruitment process continues for the 2 international midwives that were offered posts, the expectation is that they will be in the country by the end of June, to commence their OSCE programme July 2023. Further recruitment will be undertaken to recruit to the other 3 international midwifery posts.

Despite these challenges women continue to be offered three choices of place of birth in line with the aspirations of Better Births: home birth, midwife led alongside birth centre and consultant led unit. Calderdale Birth Centre is introducing a responsive model in May where staff follow the women rather than staffing a building.

With the continued staffing challenges throughout the maternity service a review of acuity and staff available occurs each shift, with LDRP completing the Birth Rate Plus acuity tool 4 hourly, staff are then redeployed within the hospital setting to appropriate areas to maintain safer staffing levels (Table 3). The service has a robust escalation policy, with responses that include utilising the on-call community midwives and non-clinical midwives, and temporary relocation of Calderdale Birth Centre to LDRP. All episodes of escalation are reported via the incident reporting system and then reviewed at the weekly Maternity Governance meeting.

Table 3: Birthrate Plus acuity data

	% RAG rated Green*	% RAG rated Amber*	% RAG rated Red*
06/03/23	40.47%	57.14%	2.38%
13/03/23	42.85%	54.76%	0%
20/03/23	54.76%	45.23%	0%
27/03/23	64.28%	35.71%	0%
Total	50.6%	48.2%	0.6%

*Red more than 3 midwives short in the census period
*Amber up to 3 midwives short in the census period
*Green number of midwives available meets the acuity

**1 episode where data not recorded =0.6%

Two of the most important safe staffing indicators relate to the provision of 1:1 care in labour and the supernumerary status of the labour ward (LDRP) coordinator. NHS Resolution's Maternity Incentive Scheme states that the midwifery coordinator in charge of labour ward must have supernumerary status, which is defined as having no caseload of their own during their shift to ensure there is an oversight of all birth activity within the service. 1:1 care in labour has remained consistently above 98% over the last six months and the coordinator remaining supernumerary has remained consistently at 100% over the last 4 months (Tables 4 and 5).

Table 4: 1:1 care in labour position over the previous 6 months.

Month	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	March 23
1:1 care in labour	99%	98.3%	98.5%	98.9%	100%	100%

Table 5: Co-ordinator supernumerary over previous 6 months

Month	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	March 23
Co-ordinator supernumerary	100%	100%	100%	100%	100%	100%

2.4 Nursing and Midwifery Forward Planning

The Emergency Department (ED) tool for Safer Nursing Care Tool (SNCT) has been published and nationwide training is being delivered by NHSE/I. The Trust has acquired the license for use and has registered the Associate Director of Nursing, Head of Nursing and Midwifery Workforce and Education and Matrons for ED for training in the use of the tool. A trial of data collection was undertaken during the current round of Hard Truths.

The Trust is also now in receipt of the license for the Community Nursing Safer Staffing Tool (CNSST) and have commenced a programme of training in readiness for data collection within the District Nursing service. Both evidence-based tools will be implemented within the next round of establishment reviews.

2.5 Allied Healthcare Professional (AHP) Overview

There is no single guidance or standard approach to inform safe staffing levels required in services provided by Allied Health Profession (AHPs) with the exception being for stroke https://www.rcplondon.ac.uk/guidelines-policy/stroke-guidelines (RCP, 2016) and critical care https://www.ficm.ac.uk/sites/ficm/files/documents/2021-10/gpics-v2.pdf (GPICS, 2019). For other areas, each AHP has profession specific information and guidance only available to support staffing levels of a particular type of service. As West Yorkshire AHP leads, it has been agreed to use the work carried out at Airedale NHS Foundation Trust on Workforce models as a guide.

NHSI have mandated all AHP roles have electronic job plans in place. This project has commenced and remains in progress. The workforce modelling and gap analysis against establishment is also in progress with a report to be submitted to the Community Division's PSQB in the first instance.

The Community Division is currently supporting a workforce manager to embed the recommendations from Health Education England's (HEE) AHP Workforce Strategy including the associated recruitment initiatives. In addition, the Trust has a senior Clinical Educator in post to optimise the early years' experience with a key focus on embedding a strong preceptorship programme. The ongoing development of an AHP preceptorship at CHFT is gaining regional and national attention. It is being designed along national benchmarking and will be applying for accreditation in 2024.

The work of the Nursing, Midwifery and AHP Workforce Steering Group, has commissioned the development of an AHP recruitment and retention tracker. This tracker provides projections based on current turnover rates to determine and provide oversight of potential clinical hotspots. Work is ongoing to improve this tool as it currently provides a basic level of each profession but does not take into account areas which are converting "other" budget into AHP roles. For example, Ageing Well Practitioners have 0 budget for OTs but have 2.0 OTs in post. This impacts overall data and recruitment position for OTs across the trust.

Below provides an overview of current vacancy positions across the areas with a high vacancy position and a descriptor of the strategies that are being employed to address

shortfalls. Figures have been provided by Therapy Service Managers for real time accuracy.

2.5.1 Dietitians

The current vacancy position represents a 6% vacancy rate, which is expected to further increase based on current leavers and new funding streams aimed at strengthening dietitian support into nursing homes. Primary Care Networks (PCN) have also demonstrated a demand for these roles which places further pressure on the workforce supply locally.

Actions taken:
Apprenticeships.

- Dietetic apprenticeships to start in May 2024 (next available cohort)

New roles

- Additional clinical lead for paediatrics advertised. This role will provide additional clinical support to paediatric clinics and the neonatal department.
- Professional lead recruitment complete, post holder to commence 1 May 2023 with the aim to improve the service and consequently the reputation and promotion in an effort to make the department a more desirable place to work and improve the number of applications to vacancies.

2.5.2 Occupational Therapists (OT)

OT as a profession currently has an 8% vacancy rate. Gaps are predominantly in the acute therapy teams with leavers choosing to work in the community or with external providers.

Actions taken:
Apprenticeships.

- 2 CHFT employees currently on the OT degree apprentice course with an additional 2 starting in September 2023.

International Recruitment.

- Process in the final stages, 3 International OTs expected to arrive by June 2023.

Rotations Development.

- New OT rotations in Paediatrics and Mental Health (SWYFT Collaboration) confirmed for October 2023.
- Ongoing work with local partners to expand rotations into Calderdale Council and Overgate Hospice.

University Links

- Strong links with Huddersfield and Bradford University and OT Course Leads. Regular attendance to lectures and career events.

New Roles

- Recruitment to an OT Clinical Educator who will support newly qualified OTs within trust. Their focus will be training of new staff to improve blurred boundary training and profession specific competencies.
- Aim to recruit to the OT professional lead position who will work with service managers to ensure the profession is developed in line with national guidance and to meet the needs of the local population, ensuring staff are given the correct learning opportunities and developed to aid retention.
- Over recruitment of 5 posts during summer 2023 to buffer the known leaver rate.

2.5.3 Radiographers

At the time of last reporting the Trust had 28 wte vacancies representing 19% of the workforce. As of March 2023, this had improved significantly with 14.44 WTE vacancies representing a deficit of 10%.

Actions taken:

- International recruitment
- Increased roles for support workforce
- Apprenticeships

2.5.4 Speech and Language Therapists

Speech and Language Therapists currently have a 38% vacancy rate. This high vacancy rate continues to result in the team running a priority service.

Feedback has indicated staff are moving to neighbouring Trusts with a higher allocation of Continuing Professional Development (CPD) time and specialist development opportunities.

Actions taken

Work with HEIs

- 2 CHFT employees due to start apprentice degree in September 2023.
- Placements from University of Huddersfield to train those who live locally and retain in the area for employment.

International Recruitment.

- HEE are exploring option of SALT International Recruitment in 2023. CHFT have expressed interest in being part of this project.

Rotations Development.

- Reinstating Band 5 SALT rotations across Community, Inpatient and Children’s therapy planned for 2023.

New Roles

- 2 x development band 5 to band 6 posts created for Adult SALT

- Support Band 6 role to the head and neck service to improve sustainability and succession plan.

2.5.6 Physiotherapists

Physiotherapy currently has a 10% vacancy rate across trust. The recruitment of physiotherapists is usually successful; however the turnover rate is high due to neighbouring organisations and other providers offering additional training or financial incentives.

Actions Taken:

Apprenticeships.

- 2 CHFT employees currently on the physiotherapy degree apprentice course with an additional 4 starting in September 2023.

Rotations Development.

- New PT rotations to include paediatrics confirmed for October 2023.
- Ongoing work with local partners to expand rotations into Calderdale Council and Overgate Hospice.

New Roles

- Physiotherapist based within Occupational Health
- Ongoing work to create a rotation within the research and development department
- Over recruitment of 10 physiotherapists during summer 2023 due to known leaver rate.

3.0 NATIONAL COMPLIANCE

The Developing Workforce Safeguards published by NHSE/I in October 2018 were designed to help Trusts manage workforce planning and staff deployment. Trusts are now assessed for compliance with the triangulated approach to deciding staffing requirements described within the NQB guidance. This combines evidence-based tools with professional judgement and outcomes to ensure the right staff, with the right skills are in the right place at the right time.

As part of this cycle of establishment review divisions provided an overview of nurse/midwifery leadership structures and clinical nurse specialist post holders.

The recommendation from the Chief Nurse is there is good compliance with the Developing Workforce Safeguards.

4.0 SICKNESS AND ABSENCE LEVELS

Figures 1 - 5 show the sickness level at the Trust during the reporting period.

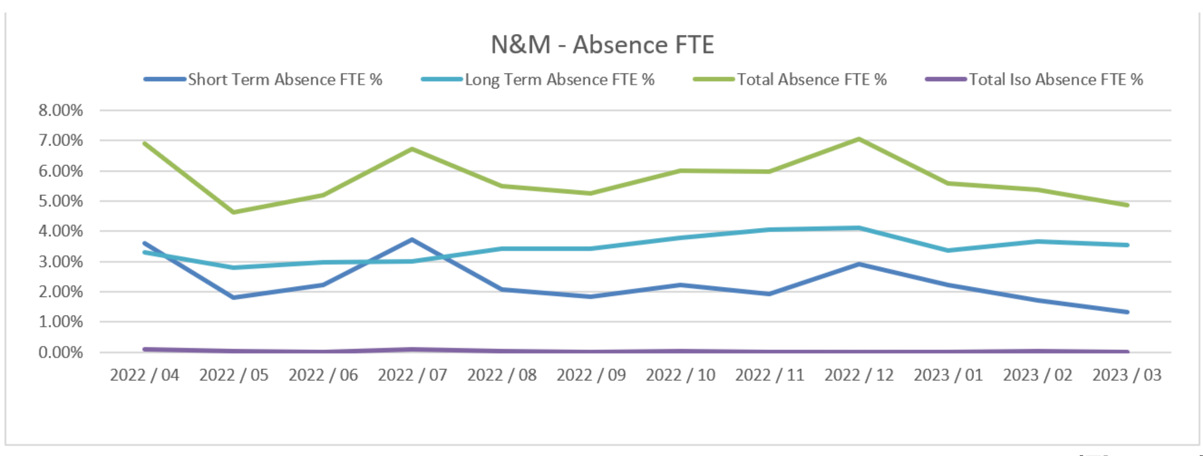
During the reporting period total absence continued to be a challenging position with peaks in April, July and December for both workforce groups. This position is attributable to natural COVID fluctuations as well as other absence such as stress, anxiety, and depression.

Whilst these findings are not peculiar to nursing and midwifery, CHFT recognises that support for colleague wellbeing has been vital during and post the pandemic. The health and wellbeing support available at CHFT continues to be refined and tailored to support the diversity of our people and continues to be a critical response to supporting the health and wellbeing of nursing, midwifery and AHP colleagues. More recently this has been refined to include a tiered approach to supporting healthcare professionals at increased risk of psychological distress (Appendix 1)

Qualified Nursing & Midwifery

Month	ST FTE Lost	LT FTE Lost	Total FTE Lost	Available FTE	Short Term Absence FTE %	Long Term Absence FTE %	Total Absence FTE %	Isolation FTE Lost	Total Iso Absence FTE %	Total Absence
2022 / 04	1,800.46	1,649.04	3,449.50	49,996.44	3.60%	3.30%	6.90%	54.41	0.11%	7.01%
2022 / 05	930.53	1,444.18	2,374.71	51,449.25	1.81%	2.81%	4.62%	11.80	0.02%	4.64%
2022 / 06	1,103.22	1,481.04	2,584.26	49,740.04	2.22%	2.98%	5.20%	8.71	0.02%	5.21%
2022 / 07	1,907.04	1,540.60	3,447.64	51,311.73	3.72%	3.00%	6.72%	46.89	0.09%	6.81%
2022 / 08	1,065.75	1,750.63	2,816.38	51,176.31	2.08%	3.42%	5.50%	15.32	0.03%	5.53%
2022 / 09	902.39	1,700.28	2,602.67	49,551.14	1.82%	3.43%	5.25%	8.07	0.02%	5.27%
2022 / 10	1,160.73	1,988.92	3,149.65	52,477.41	2.21%	3.79%	6.00%	13.00	0.02%	6.03%
2022 / 11	984.69	2,088.75	3,073.43	51,336.89	1.92%	4.07%	5.99%	0.00	0.00%	5.99%
2022 / 12	1,553.59	2,188.72	3,742.32	53,081.21	2.93%	4.12%	7.05%	8.68	0.02%	7.07%
2023 / 01	1,195.31	1,790.63	2,985.94	53,401.99	2.24%	3.35%	5.59%	0.00	0.00%	5.59%
2023 / 02	829.47	1,787.87	2,617.34	48,696.43	1.70%	3.67%	5.37%	12.00	0.02%	5.40%
2023 / 03	713.98	1,917.77	2,631.74	53,962.18	1.32%	3.55%	4.88%	5.00	0.01%	4.89%

(Figure 1)

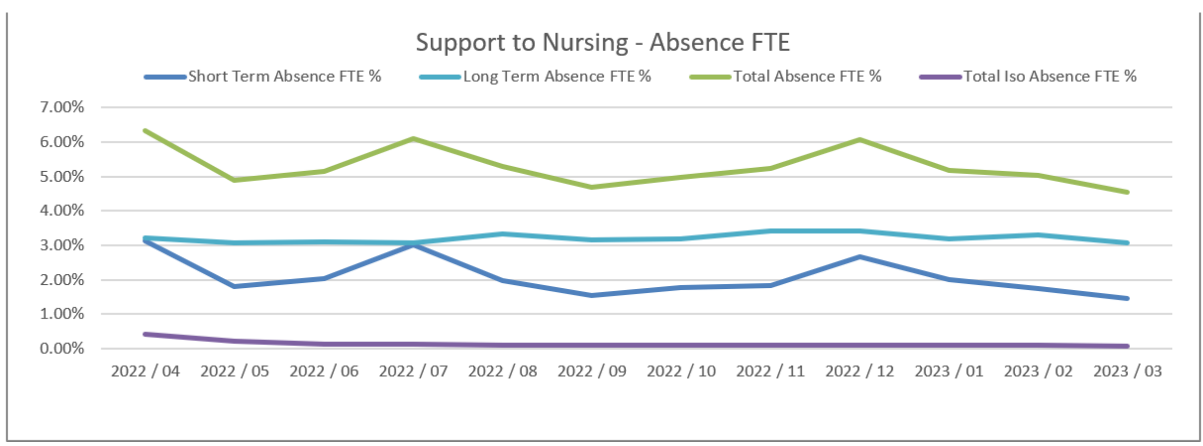


(Figure 2)

Nursing support

	Sickness Absence							Isolation Absence		Sickness + Iso
Month	ST FTE Lost	LT FTE Lost	Total FTE Lost	Available FTE	Short Term Absence FTE %	Long Term Absence FTE %	Total Absence FTE %	Isolation FTE Lost	Total Iso Absence FTE %	Total Absence
2022 / 04	5,081.83	5,215.59	10,297.42	162,676.99	3.12%	3.21%	6.33%	107.17	0.41%	6.74%
2022 / 05	3,037.81	5,155.18	8,192.99	167,746.02	1.81%	3.07%	4.88%	55.80	0.21%	5.09%
2022 / 06	3,312.05	5,031.57	8,343.62	161,949.99	2.05%	3.11%	5.15%	37.00	0.14%	5.30%
2022 / 07	5,061.51	5,163.64	10,225.16	167,399.39	3.02%	3.08%	6.11%	37.20	0.14%	6.25%
2022 / 08	3,304.47	5,559.49	8,863.97	167,194.12	1.98%	3.33%	5.30%	25.80	0.10%	5.40%
2022 / 09	2,495.11	5,100.52	7,595.63	161,945.03	1.54%	3.15%	4.69%	27.00	0.11%	4.80%
2022 / 10	3,016.11	5,415.05	8,431.16	169,374.55	1.78%	3.20%	4.98%	24.80	0.09%	5.07%
2022 / 11	3,021.59	5,634.04	8,655.62	164,935.95	1.83%	3.42%	5.25%	24.00	0.09%	5.34%
2022 / 12	4,556.13	5,825.01	10,381.14	170,549.34	2.67%	3.42%	6.09%	24.80	0.10%	6.18%
2023 / 01	3,451.08	5,437.47	8,888.55	171,211.47	2.02%	3.18%	5.19%	24.80	0.10%	5.29%
2023 / 02	2,700.39	5,144.10	7,844.49	155,431.40	1.74%	3.31%	5.05%	22.40	0.10%	5.14%
2023 / 03	2,526.99	5,315.33	7,842.32	172,403.77	1.47%	3.08%	4.55%	15.20	0.06%	4.61%

(Figure 3)



(Figure 4)

The impact of the combined actual RN wte and average sickness absence position has been further modelled across the four divisions (figure 5) to give context to the workforce challenges.

	Medicine	**Surgery**	**FSS**	**Community – (DN hubs and OOH)**
Budgeted RN WTE	602.98	422.76	269.89	116.78
Actual RN wte	517.49	406.06	254.67	112.68
RN vacancy wte	85.49	16.7	15.22	4.1
RN % vacancy gap	14.18%	3.95%	5.64%	3.51%
Average absence above budgeted headroom (22%)	9.57%	7.45%	6.45%	4.41%
Total combined vacancy and average absence position above headroom**.**	23.75%	11.40%	12.09%	7.92%

(Figure 5)

*Data source: Healthroster budgeted vs actual position 27th March 2023
*Average absence calculated from 1st April 2022 – 31st March 2023

(This position includes the additional capacity areas: Ward 15, 4d and 6ab – which were approved for non-recurrent funding in the bi-annual establishment review.)

5.0 SAFER STAFFING (HARD TRUTHS) DATA

Hard Truths is a process initiated by NHS England and the Care Quality Commission (CQC) (2014). It combines the robust Trust bi-annual staffing reviews with a commitment to greater openness and transparency by publishing data regarding nursing, midwifery, and care staff levels. This data is provided through the monthly Trust report to NHSE, detailing both registered nursing and midwifery staffing numbers and unregistered support staff numbers. The data also includes the Trust provision of care hours per patient day (CHPPD). This data for all acute Trusts is now published on NHS Model Hospital.

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 worker on each ward for the 24-hour period, then dividing by the number of patients on the ward each day at midnight.

Due to the way it is calculated, actual CHPPD is influenced not only by numbers of staff on duty, but also the bed occupancy. Therefore, wards with fewer patients, or with high numbers of day-case patients who are discharged prior to midnight, demonstrate significantly higher CHPPD.It should be noted that **CHPPD reveals the total nursing and support worker hours available per patient on the ward at midnight**. It does not reflect the actual hours required to meet the care needs for these patients, which could be significantly more for those with high acuity or dependency, or fewer for patients with low acuity and who are independent in self-care.

Required care hours are calculated separately, using real-time patient acuity and dependency data which is recorded on the Safecare application. The required hours can then be compared with available hours. This is used to inform the twice daily staffing meetings to ensure deployment of staff according to care demand at the time

The Model Hospital platform https://model.nhs.uk is used to benchmark the CHFT nursing workforce data against the national average, as well as ‘Peer Hospital’ data. This data is generally updated quarterly, the analysis of which is reported to the weekly Safe, Sustainable and Productive Staffing Meeting as part of the group workplan.

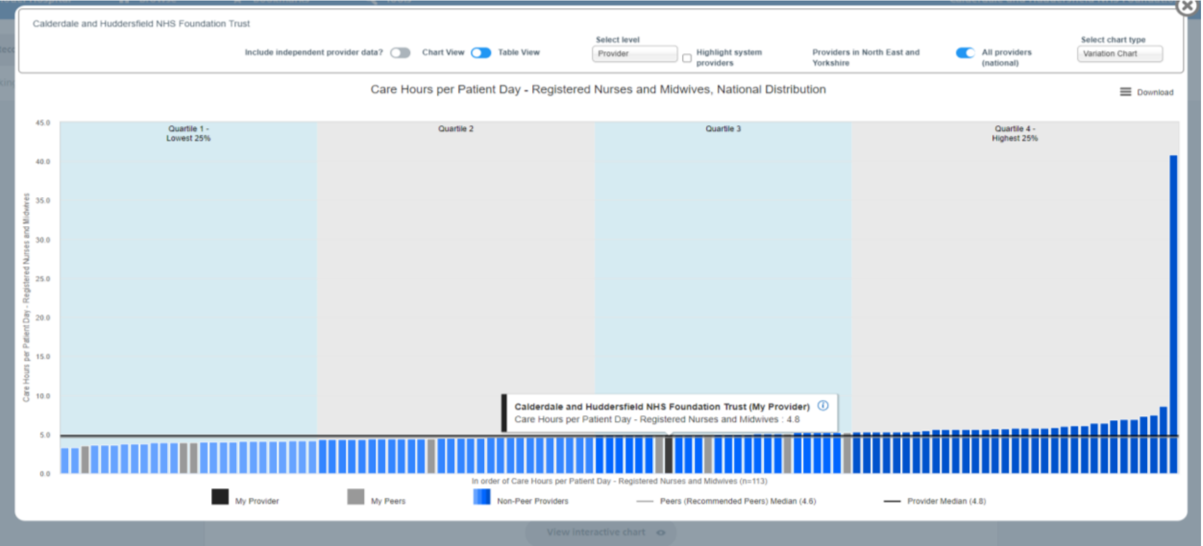
There is no ‘correct’ number of CHPPD to be achieved. However, significant variation from the national average or the ‘peer group’ average, should warrant further investigation. CHPPD significantly higher than average could indicate inefficiencies in staffing. CHPPD significantly lower than average could indicate too few staff and associated patient safety risks.

The latest information from Model Hospital on CHPPD is from January 2023. Review of this data reveals CHFT to be in the lower part of quartile 2 providing 7.9 CHPPD at Trust level (figure 6). The national and peer median CHPPD for January 2023 was 8.1. Four peers (grey bars in chart) provide more CHPPD than CHFT (highest 9.1), with the remaining 4 peers providing fewer CHPPD (lowest 6.4). This latest data shows a reduction from a CHPPD of 8.9 in July 2022, which put CHFT at the top of quartile 3 at that time.

(Figure 6)

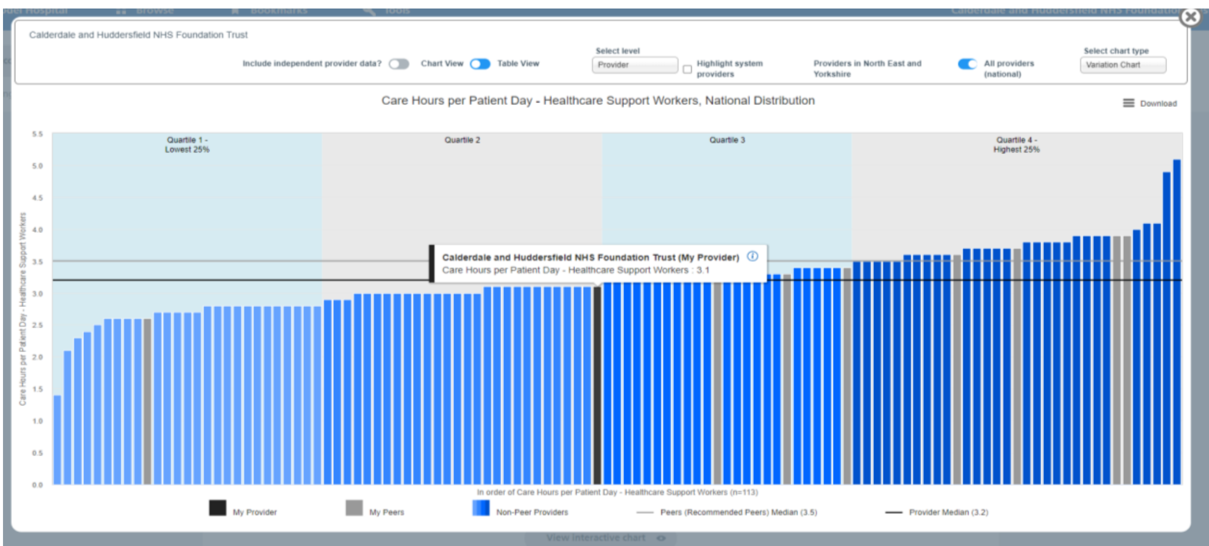
In addition to Trust-wide total CHPPD. The Model hospital can be used to benchmark the care hours provided by Registered Nurses and Midwives compared to the CHPPD provided by Healthcare Support Workers, thereby giving an indication of the CHFT benchmark with respect to skill mix.

Review of the latest Model Hospital data (January 2023) revealed the CHPPD hours provided by registered nurses and midwives was 4.8, this compared to a national median of 4.8 and a peer median of 4.6 (figure 7).



(Figure 7)

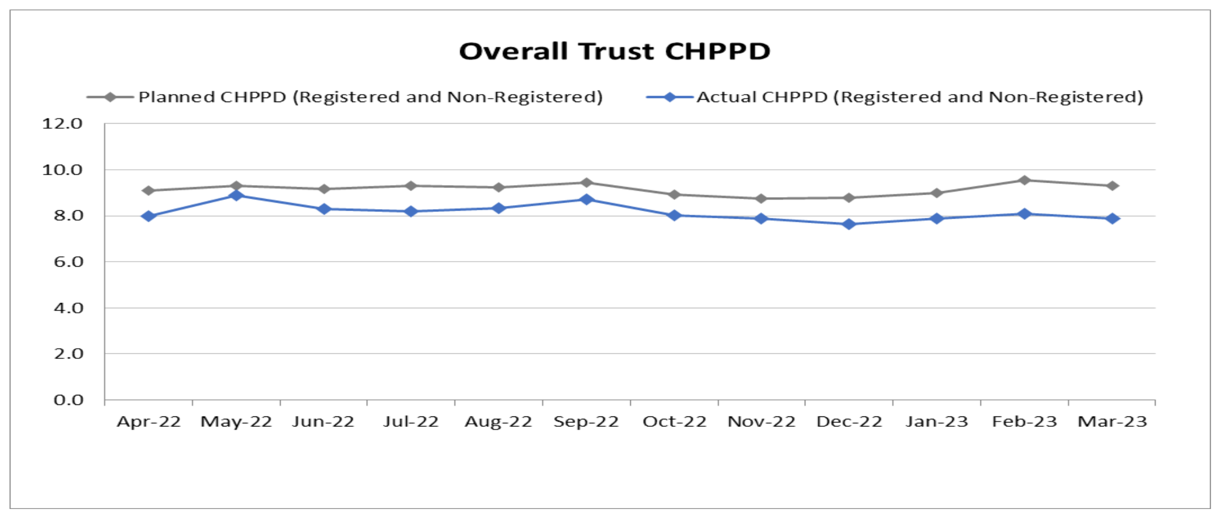
CHPPD provided by healthcare support workers at CHFT was 3.1. This compared to a national median of 3.2 hours and a peer median of 3.5 hours **(**figure 8).



(Figure 8)

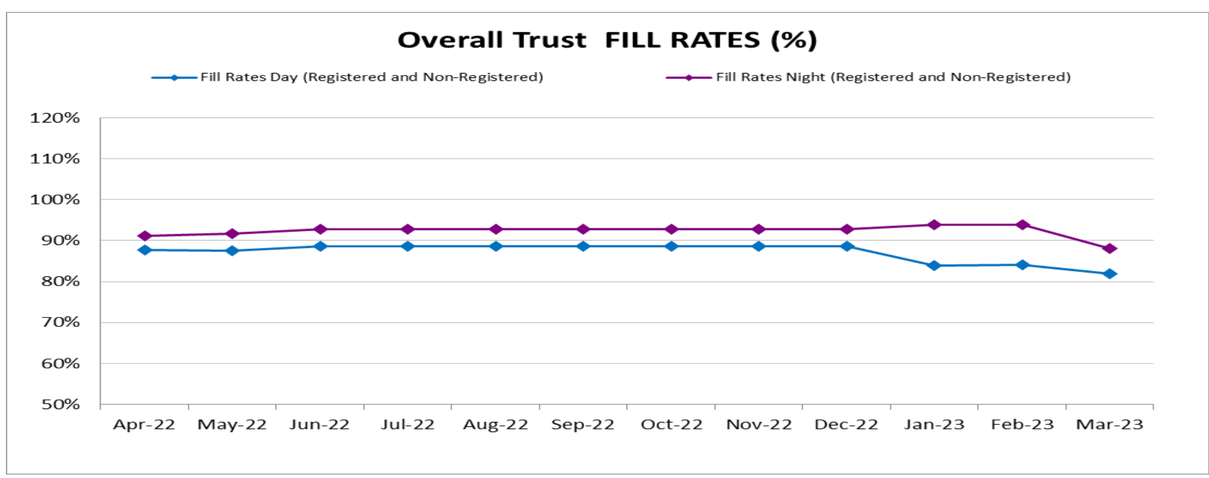
Review of this latest Model Hospital data gives no indication that CHFT is an outlier with respect to total CHPPD, or to the CHPPD skill mix provision.

CHPPD



(Figure 9)

Fill rates



(Figure 10)

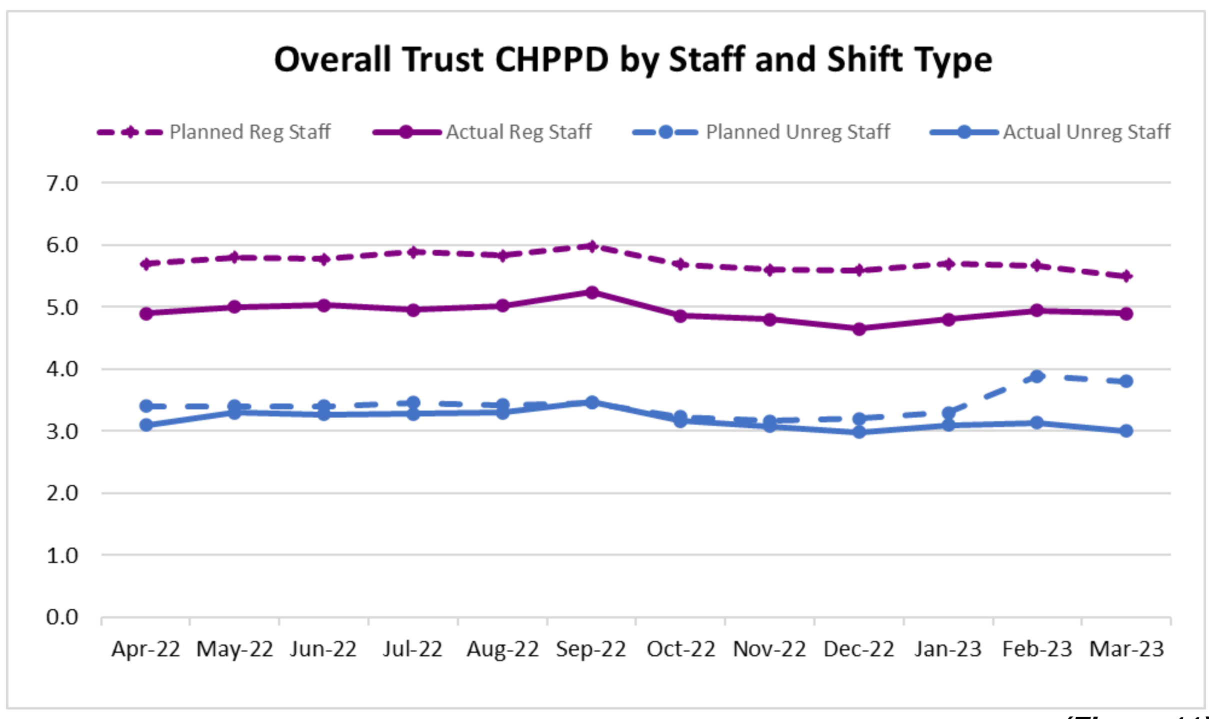
Whilst fill rates are no longer a reporting requirement to NHSE/I they continue to be a useful measure for analysis. Fill rates are calculated by comparing planned hours against actual hours worked for both registered nurses (RNs) and health care support workers (HCSW). Factors affecting fill rates include:

- Sickness (lower if not filled)
- Vacancies (lower if not filled)
- Enhanced Care Support Worker requirements, otherwise known as 1:1 observation (when additional staff above agreed WFM are rostered on to support)

For the reporting period, fill rates continued to fluctuate between 82% - 90% during the day (figure 10). This position continues to impact on the overall Trust CHPPD position with an ongoing shortfall reported between planned and actual care hours during the reporting period (figure 9). This is reflective of the ongoing challenging

sickness/absence position, opening of additional escalation areas, in addition to supporting enhanced service delivery in some areas.

In recognising the established relationship between higher registered nurse staffing and improved patient outcomes and care quality (Griffiths et al 2020), figure 11 breaks down the CHPPD by staff groups, which highlights the most challenging gap can be seen within the RN workforce.



(Figure 11)

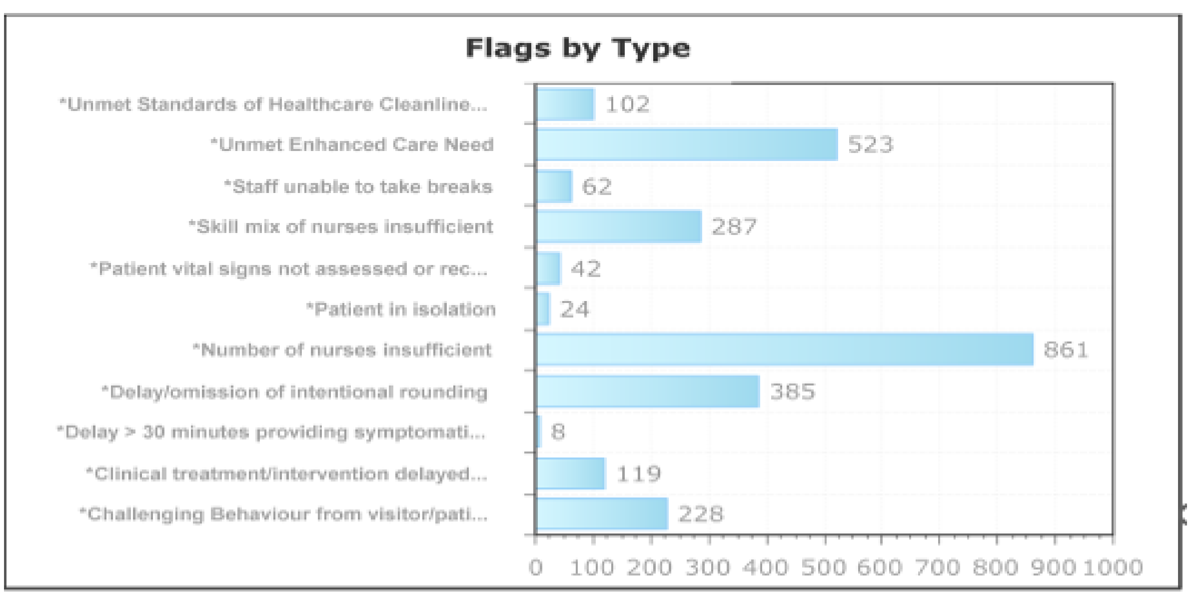
Divisional narrative from Associate Directors of Nursing and Matron teams highlights ensuring safe staffing across all services has been a constant process that has been significantly challenging for all involved. Nonetheless, staffing resource has been safely flexed to meet patient demand, activity, and acuity and the continued effort given by our teams to ensure service provision has been outstanding.

5.1 Red Flag Escalation

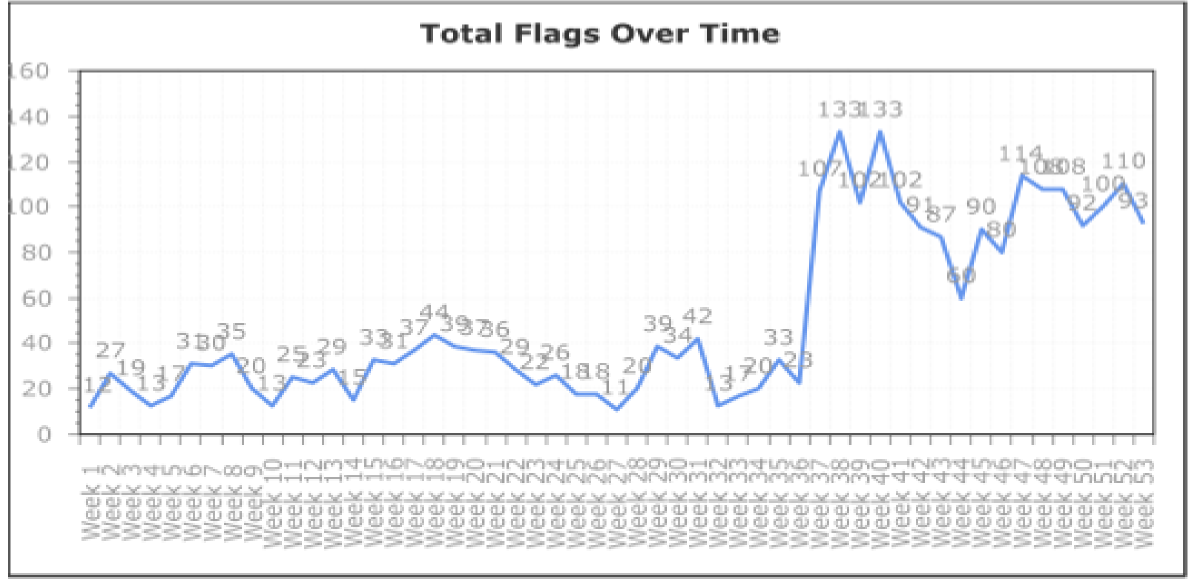
To supplement the process of rating the status of staffing requirements within the roster system, a system of red flag escalation has been developed in line with NICE (2014) guidance. Nursing red flags are events that have an impact on the way care is delivered to patients, therefore requiring a prompt response by the Nurse in Charge or a more senior nurse to mitigate patient safety concerns. Nursing red flags can be raised at any point during a shift.

The red flag process forms a key part of the governance arrangements and ongoing monitoring of the staffing position.

Figure 12 provides a breakdown of red flags for the reporting period 1st April 2022 – 31st March 2023, with insufficient number of nurses, the most reported category.



(Figure 12)



(Figure 13)

There continues to be a stepped changed in the reporting of Red Flags demonstrated in figure 13 which reflects the strengthened governance arrangements in this area. The reporting of red flags is identified and responded to within the twice daily staffing meetings.

In isolation this data does not provide a clear understanding of the actual impact upon patient experience or the workforce in delivering patients' care. It is recognised that despite no adverse clinical outcome, delays in care have the potential to negatively impact the overall experience of patients and colleagues.

5.2 Quality

There is a well-established correlation between staffing levels, safe care and patient experience.

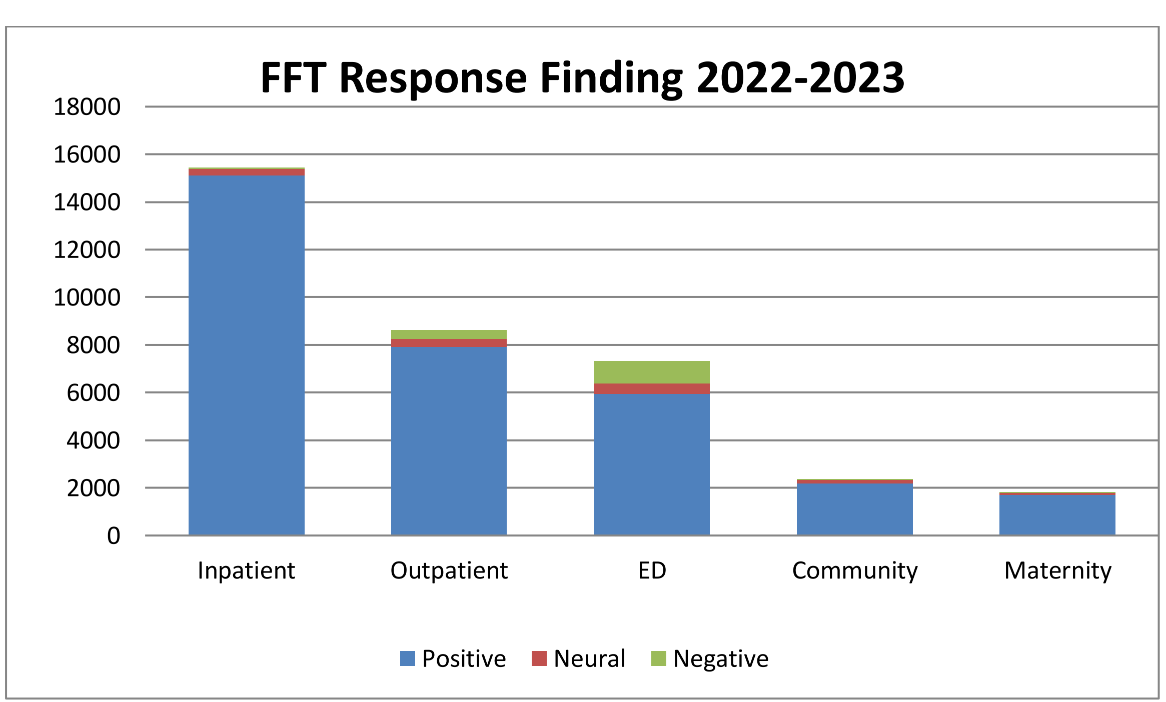
As such it is important for any staffing review to take into consideration the quality of the care provided using nurse sensitive indicators. For this report three recognised nurse sensitive indicators have been used: Friends and Family Test, falls and pressure ulcer data.

The Enhanced Dashboard Metric has been fully integrated into clinical practice and was reported against during the Divisional Hard Truth Panel meetings, supporting the triangulation of several quality metrics against the acuity and dependency data, thereby informing establishment reviews.

Additionally, the Enhanced Dashboard Metric is reported into the Nursing and Midwifery Safer Staffing meeting on a weekly basis. Data within this report is analysed through Divisional Teams to determine the actions required to respond to data triangulation and mitigation against any impacts. Work is underway to develop the dashboard further to support ongoing ward to board reporting as set out in the Developing Workforce Safeguards (2018) guidance. Initial engagement with NHSE has indicated positive feedback in the work that is being led within the Trust.

5.2.1 Friends and Family Test (FFT)

During 2022/2023 the Trust received 35,529 completed Friends and Family Tests (FFT) responses. 92.5% of patients, carers and family member reported a positive experience whilst receiving care and treatment within the Trust. 4% reported it to be negative, and 3.5% described their experience as neither good nor bad.



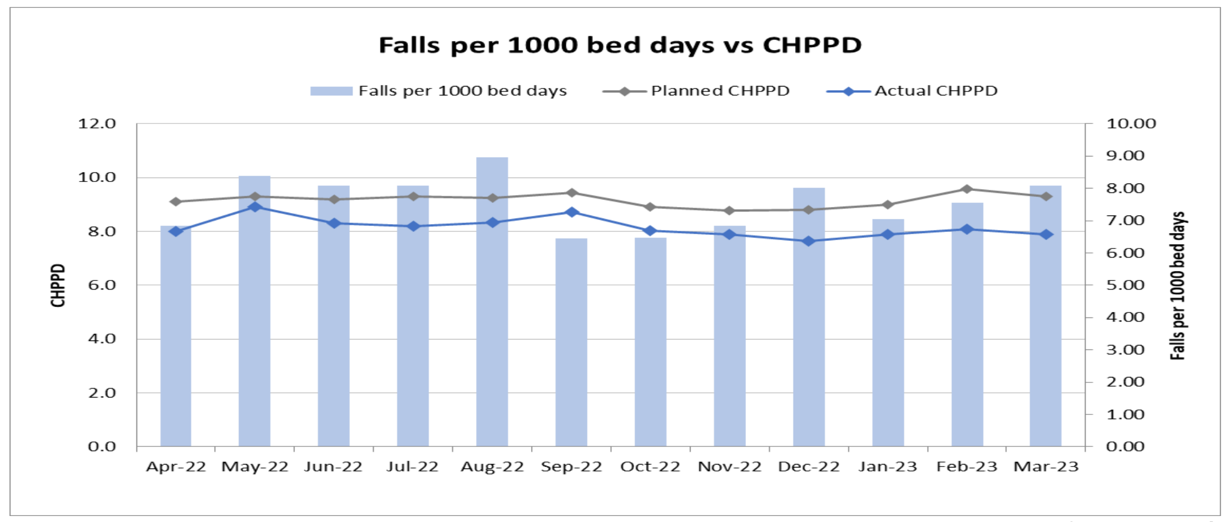
Microsoft Forms have now been developed to ensure data is captured more robustly and this will now filter into KP+. This will hopefully increase the number of online responses, improve the narrative where patients explain their experiences of the service, and staff who are delivering compassionate care are recognised

5.2.2 Falls and Pressure Ulcers

The charts below provide an overview of the reporting of incidents related to falls per 1000 bed days (Figure 14) and ulcers per 1000 bed days (Figure 15).

Falls

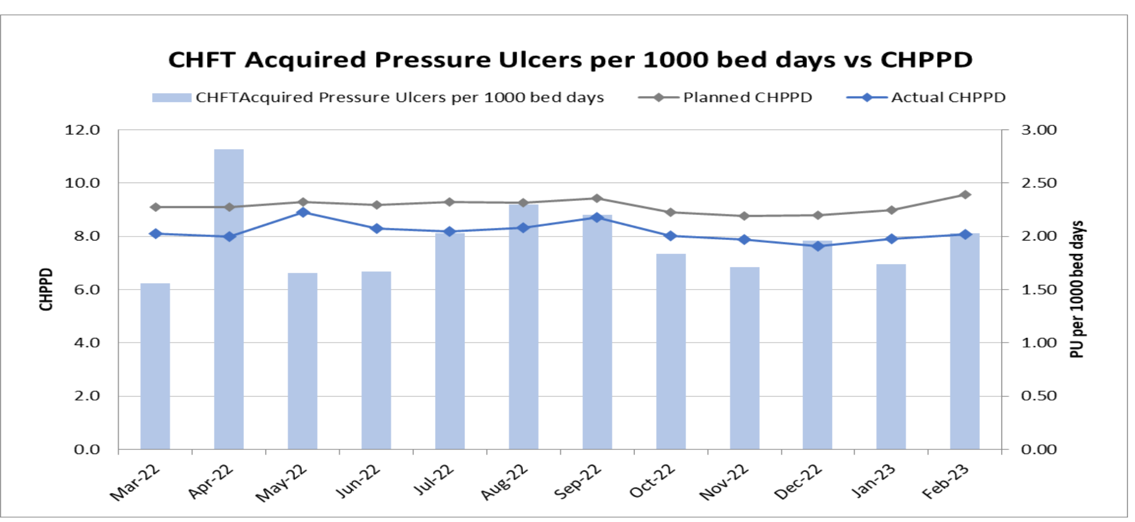
Throughout the reporting period there is a shortfall between the planned and actual CHPPD which fluctuates between 0.4 and 1.5, with the incidence of falls peaking in August where the CHPPD gap is at 0.9 (figure 14). Interestingly, the gap in CHPPD is 0.9 also in October where the lowest incidence of fall is reported.



(***Figure 14)***

Pressure Ulcers

Due to validation processes for the purpose of the reporting period of this report pressure ulcer data is only available up until February 2022. Data for pressure ulcers per 1000 bed days demonstrates a fluctuating position with the highest incidence identified in April where CHPPD demonstrated an overall gap between planned and actual of 1.1. The same CHPDD deficit position was report in July where the incidence of pressure ulcers was lower per 1000 bed days.



(Figure 15)

Analysis of the data indicates variability in the incidence of the two nurse indicators that may be attributable to the gap in planned and actual CHPPD.

Analysis of the gap in CHPPD continues to be identified as the most challenging for the RN workforce (figure 11).

Given the established relationship between higher registered nurse staffing and improved patient outcomes and care quality (Griffiths et al 2020), it is reasonable to suggest the impact of ongoing enhanced delivery of some services, additional capacity, current vacancy position and the impact of staff sickness absence continue to impact upon patient experience.

5.2.3 Incident reporting

There were 284 Nursing and Midwifery staffing related incidents that were reported through the Datix reporting system, all of which were reported as no significant harm to patients. Two hundred and eighty-two (282) of these incidents were reported as no harm and 2 as minor harm. There was appropriate escalation when the incidents occurred, and this is recorded within the incident records.

There continues to be a strong theme around staff being redeployed to support other areas and the impact of this. This is now being monitored within the Safe, Sustainable and Productive Staffing meeting with ongoing engagement via a survey to those staff that are redeployed.

The Risk Management Team along with the Quality Governance Leads for each division review all incidents daily and highlight any themes and trends so that learning can be collated and improvements made. In addition to this, the Quality & Safety team now hold a weekly MICCI (Mortality, Incidents, Complaints, Claims and Inquests) meeting to ensure triangulation of all areas (including risks and audit). This meeting along with daily oversight of all incidents provides oversight and scrutiny within the Quality & Safety team.

CHFT'S RESPONSE

Short-term strategies

6.0 ESCALATION AND REPORTING ARRANGEMENTS FOR QUALITY AND SAFETY

Throughout the pandemic Safe Staffing has been a key focus and remains one of the Trust's Must Do priorities. Addressing this has been a key focus of the Senior Nursing Team and a range of actions remain in place to manage risk.

- The senior nurse leadership rota continues to be supported by the Associate Directors of Nursing and Lead Nurses to provide ongoing visibility and dialogue across clinical areas, and support staffing escalations across the 7 days.

- Twice daily Nursing and Midwifery Staffing meetings chaired by the Associate Director of Nursing are in operation 7 days a week.

The purpose of this meeting is to review the real-time safer staffing assessments and agree actions required to respond to short-term staffing escalations and changing acuity and dependency to assist with staff deployments.

Real-time staffing is provided through Safecare which gives a live view of the nursing staffing position measured against the acuity and dependency of our patients, facilitating comparisons of staffing levels and skill mix to the actual patient demand to maintain safe staffing across the Trust as a whole. Safecare LIVE plays a pivotal role in these meetings providing visibility across wards, transforming rostering into an acuity based daily staffing process that unlocks productivity and safeguards patient safety.

In addition, Safecare allows the nursing team to assist the ward manager with real-time roster management to ensure we have the right person, in the right place, at the right time to inform operational decisions to maintain safer staffing Trust wide.

Decision making within this forum is informed by an appraisal and risk assessment of the divisional information presented and any staffing shortfalls are mitigated against.

Medium-long term strategies

7.0 RECRUITMENT AND REGISTERED NURSE TRAJECTORY

The NHS Long Term Plan has set a target of reducing nursing vacancies by 5% by 2028 and the Trust remains committed to driving down the vacancy position at CHFT. This will be addressed by a comprehensive, multi-pronged Recruitment Strategy with ongoing alignment to the NHS People Plan and government mandate. This includes specific commitments around:

- **Looking after our people** – with quality health and wellbeing support for everyone.

- **Belonging in the NHS** – with a particular focus on tackling the discrimination that some staff face.
- **New ways of working and delivering care** – making effective use of the full range of our people's skills and experience
- **Growing for the future** – how we recruit and keep our people, and welcome back colleagues who want to return.

This is supported by the launch of the Trust's People Strategy and Recruitment Strategy 2022-2025. The Recruitment Strategy is supported by a detailed action plan which is underpinned by several principles including:

- International recruitment across all staff groups
- Values based recruitment
- Learning from the pandemic and developing a flexible, adaptable workforce
- Valuing development for all
- Growing our own and retention of our workforce

Below provides further detail surrounding our recruitment strategy:

7.1 International Nurse Recruitment

During this reporting period 98 internationally educated nurses have arrived in the UK for employment at CHFT. 56 nurses have taken the NMC competency test and registered. 42 are at different stages of their training with exams booked between April-June. The national delay to test availability is improved but continues to be problematic. There is a reduction in first time pass rate which is reflected nationally, this combined with the delays for tests is resulting in extended training times and a longer timeframe for NMC registration.

All nurses are supported to transition into life within the UK, in addition to a robust training package and wrap around pastoral support that has seen positive results with 0% attrition during the 2022-23 programme.

Pastoral support has been at the centre of this project since its inception and recognised by NHS/E as imperative to making international recruitment work. CHFT pride themselves on a programme of pastoral support which includes:

- IR Facebook page for social engagement before and after arrival.
- Access to CHFT's international recruitment specialist who guides recruits through the whole process from interview to taking their test. Assisting with transport, accommodation, visas, registering with GPs, shopping and the local area, booking tests including travel to Ireland.
- A welcome session and booklet that includes information about the UK, the local area and also the NHS including its background and the role of a nurse in the UK today.
- An open-door policy where during working hours all candidates past and present can drop in for support.
- Clinical support and orientation.
- Welcome packs and meet and greets (we are the first people recruits meet when they arrive).

- Support with NMC registration.

During 2022 the NHS Pastoral Care Quality Award was introduced, to achieve this award a set of standards for best practice pastoral care need to have been met. This is an opportunity for the CET/Trust to have work recognised and to demonstrate the Trust's commitment to supporting internationally recruited staff at every stage from recruitment and beyond. We are working towards applying for this quality mark in quarter 2.

During 2022 the impact of this approach can be measured against the attrition which currently sits at <1% in first year of employment.

The Clinical Education Team are now working towards a 2023 target of 30 and the remaining 6 internationally educated nurses from the 2022 target. It is expected that this will be achieved by the end of May, a delay of 8 weeks.

Work has commenced with colleagues from the family and specialist services division to consider employing a small number of international nurses to work in paediatric areas. The preparation and support needs of these nurses will be different and scoping work has commenced to explore this further.

Work has continued in partnership with Locala to support their programme of international nurse recruitment aimed at Community Services. This work has been valuable as it has allowed Locala to share the challenges which will be valuable in terms of successful recruitment to our own community services.

Work continues with maternity colleagues and NHSE with an aim to recruit 5 internationally educated midwives by July 2023. This timeline has since been revised to December 2023 to reflect the national challenges relating to supply of midwives and average time to complete the CBT part 1 exam. This project remains in its infancy, but 3 midwives have received offers of employment and are working their way through pre-employment checks and pre-arrival requirements.

Work has also commenced with AHP colleagues and NHSE with an aim to recruit 3 occupational therapists by June 2023. The project is in its infancy, but recruitment activity has commenced, and 3 OT are under offer. The CET and AHP educator are working collaboratively to ensure there is a robust pastoral and training offer on arrival in the UK.

As the numbers of internationally educated nurses increase, attention is turning towards professional development opportunities and revalidation support. This is integral in ensuring the Trust has a valued and supported workforce. Activity includes linking with regional and national groups to benchmark CHFT against other organisations. As part of NHSE stay and thrive initiative CET have been successful in securing a bid to support the delivery of an international educated development day which is expected to be delivered across quarter 2.

7.2 Recruitment of Newly Qualified Nurses

Face to face recruitment sessions were reintroduced throughout 2022 with a hybrid approach offered. The success of the recruitment sessions resulted in 61 graduates accepting posts across various divisions, they commenced in post across September – October 2022. An additional graduation point in January-February saw 17 graduates commence in post. All graduates were supported with a welcome event and enrolled in role specific induction and preceptorship programmes which enhances competence and in turn confidence with the aim of retaining those recruited.

A national preceptorship framework was released during 2022 which has allowed the existing offer to be benchmarked and for the team to analyse any gaps. Work will continue into 2023 with us moving towards a quality framework submission.

CET have been successful in securing a NHSE bid to develop and deliver a reversed supernumerary concept which is expected to increase graduate confidence whilst shortening the supernumerary period required. Recruitment to a CE post and project planning is in its infancy but with the aim for the concept to be trialled in September.

Attracting our final year students remains a priority and recruitment events have taken place in March and April. The events offered interviews on the day with 46 people offered employment. There are 71 nurses in the pipeline to start in September 2023. In the next quarter attention will be given to organising a welcome event and transitional plans.

The CET continue to work collaboratively with recruitment and divisional colleagues to ensure events are a success and are aligned to the Trust values and priorities.

7.3 Nursing Associate Apprenticeships (TNAs)

8 apprentices successfully registered as Nursing Associates (NAs) in 2022/23, these have been allocated to vacant RN positions across the Trust. A further 11 are due to complete in quarter 1 following the completion of cohort 6’s training. Work is currently being undertaken with divisional leads around deployment plans and it expected that they will transition into NA roles in June 2023.

There are 4 active cohorts of Trainee Nursing Associates (TNAs) (50 apprentices in total, of which 11 are due to qualify in June 2023). Business case approval was granted securing the programme until 2024 when a further business case will be required, this translates into a further 40 places across 2023. Recruitment activity for cohort 10 commenced in quarter 4 and there are 17 applicants moving through recruitment checks and University enrolment. They will commence the course in June 2023 and plans are being confirmed to support their induction and base training areas.

As Nursing Associate numbers grow attention has started to turn to professional development opportunities and revalidation support. A listening event and focus group was held in October 2022 fostering the Trust’s values to put people first and hear from the staff. Staff attended a national celebration event in March 23 which allowed for the sharing of good and innovative practice. The information gained from these activities will inform and strengthen the support offer and future development of the

role. Various workforce planning events have also taken place with divisions to consider utilisation, governance and how the role can be embedded further into our clinical teams and services.

7.4 Registered Nurse Degree Apprenticeships

The 2 apprentices on the full 3-year apprenticeship have moved into their final year (qualifying in January 2024). In quarter 3 deployment and transitional plans will be confirmed to support the apprentices into their registered nurse roles.

A significant milestone was achieved in January 23 when the 1st cohort of 7 Nursing Associates on the 2-year shortened RN apprenticeship successfully completed the course and moved into RN roles. They have subsequently been enrolled into the relevant preceptorship groups and support will continue to ensure they successfully continue to transition into their new role.

The 2nd cohort of 6 Nursing Associates started their registered nurse apprenticeship in October 2021 which is progressing well with a view to qualifying in May 2023. Work has commenced with divisional colleagues to ensure they are enrolled into preceptorship and supported to transition into an RN role.

An opportunity for a further cohort of Nursing Associates was supported by finance and nurse leaders and a small cohort of 7 was agreed. These posts have been recruited to and 6 apprentices commenced the course in October 2022.

A small cohort of 3 NAs were recruited and started the programme in February 2023 this has been supported by community divisions finance team.

Projected numbers and associated business cases for 2023 and beyond are being finalised within Trust and with partner Universities.

7.5 Return to Practice Nurses

5 nurses returned to practice in this reporting period. 3 have completed the course and registered with the NMC. 2 nurses are due to complete the course in quarter 1. The next cohort is due to commence in September 2023 and recruitment is ongoing. In response to the low number of applicants across recent years, a review of the current strategy continues which includes new recruitment materials, opportunities for other professional groups and exploring alternative training opportunities in collaboration with Workforce and Organisational Development, NHSE Project Team and local course providers.

7.6 Retention initiatives

In response to a national rise in registered nurse attrition since the start of the pandemic, NHSE launched a national retention strategy in July 2022: NHS England » Looking After Our People – Retention .

The strategy focusses on 5 high-impact interventions to improve the experience of nurses and promote retention of staff.

- Implementation of Legacy Mentoring
- Implementation of the National Preceptorship Framework
- Guidelines and Policies for Menopause Support
- Encourage Staff to Access Simplified Pensions guidance and Explore Flexible Retirement Options
- Complete the Retention Self-Assessment Checklist

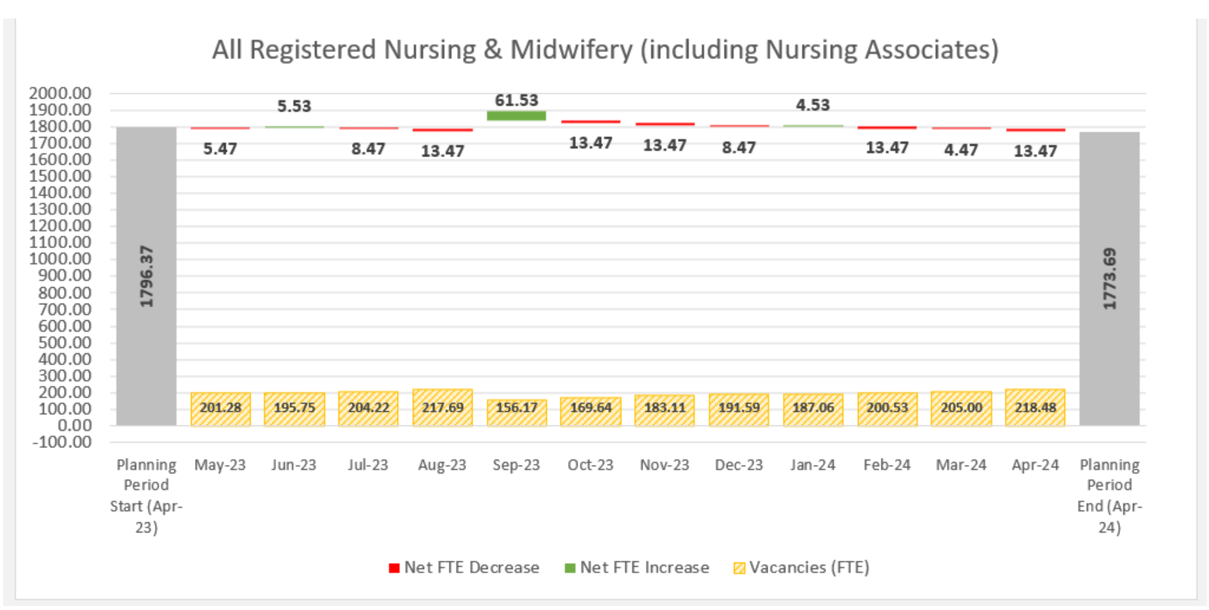
The self-assessment toolkit was populated in October 2022, and action plans developed to ensure CHFT are implementing appropriate retention strategies. The work is overseen by the Nursing, Midwifery and AHP Workforce Steering Group.

CHFT have been successful in the NHSE bid for funding support to initiate legacy mentoring. This funding equates to 0.8WTE of band 6 for 1 year.

The CHFT retention plan on a page is detailed in appendix 2

7.7 Summary position

Based on the current Nursing and Midwifery recruitment and retention strategies, with an assumed turnover rate of 9% applied to all workforce groups May 2023 vacancy position sits at 201.28 FTE, a deteriorating position since the last report. Incorporating the current recruitment strategies, projections indicate this position will have increased to 218.48 FTE in April 2024. These projections do not include the workforce implications associated with the bed retraction plans. A deep dive has been requested across a number of clinical areas to qualify this current position, which was challenged at the recent Nursing, Midwifery and AHP Steering Group.



(Figure 16)

7.8 Health Care Support Workers (HCSW)

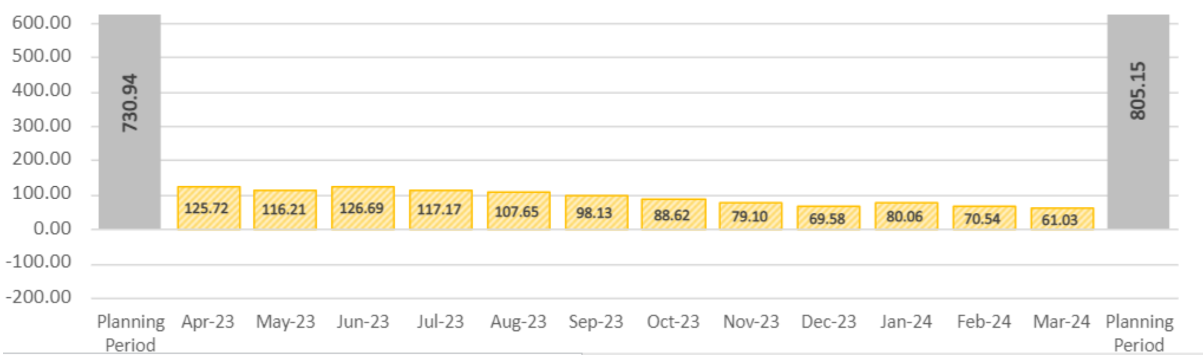
The National 'Zero HCSW Vacancy' campaign continues into 2023, with an overall aim of growing the Healthcare Support Worker (HCSW) workforce in line with demand, ensuring inclusive and sustainable recruitment while reducing the attrition of existing HCSWs.

The key principle of the 2022 programme was adopting a 'new to care' model and this is expected to continue in 2023. The programme has shown that introducing a 'new to care' model of recruitment is reducing the destabilisation of other health and social care providers whilst creating a sustainable workforce and increasing representation of the local community.

In response to this CHFT have formed a task and finish group to review the impact this would have if implemented within the Trust. Members of the group range from Recruitment Leads, Matrons and Senior Nursing & HR Management.

Data quality concerns were raised early into the formation of the task and finish group, with data submitted to NHS England on the 21 April 2023 showing CHFT are reporting a high 139.74 wte vacancy position. However, following detailed investigation through go see activity, the actual vacancy position was found to be significantly lower. In addition, it was identified that Trainee Nursing Associates (TNA) contribute to the unregistered shift fill but due to the structure of the report aren't accounted for in the vacancy position. This has been queried with NHS England and meetings are planned for May to review this along with an expectation that updated workforce models within ESR will show a more reflective position.

The 12-month trajectory (figure 17) for the workforce predicts a vacancy position of 61.03 wte by March 2024. This has been calculated based on an estimated joiner rate of 15 wte per month, this would reduce further to 7.03 wte once the 54 wte TNA workforce is offset.



(Figure 17)

During the first quarter of 2023, there were a total of 82.85 wte offers made and recruitment activity will likely remain significant due to the volume of turnover within the HCSW role. A need to invest into retention planning has been identified and remains a key topic in steering and task and finish groups.

The central HCSW recruitment team continue to support clinical managers to fill vacancies across all divisions, reducing the time to hire timeframes and ensuring consistency by centrally advertising, shortlisting, appointing and removing duplication in terms of single applicants applying and being offered multiple times. The administration time for clinical leads is further reduced by the recruitment team completing uniform and IT registrations and providing ongoing support to recently appointed HCSWs, improving the onboarding experience.
Furthermore, the team also continue to increase the flexible staffing pool by recruiting applicants into bank HCSWs positions and supporting colleagues once they have joined the staff bank.

7.9 Widening Participation at CHFT

Over the last 12 months, the Apprenticeship & Widening Participation Team have continued to evolve and create a new range of entry pathways for local people to access work readiness and employment opportunities here at the Trust. This includes progression into entry clinical and nonclinical apprenticeships, volunteering, work experience and a variety of pre-employment routes including St John's cadets, the Princes Trust and aspirational raising activities and employability support. These pathways and progression routes into the workforce have helped support and recruit into clinical and nonclinical areas.

One of the main objectives of this work is to help "grow our own", with particular focus on supporting underrepresented groups from across our local communities. The development of a range of external partnerships has been pivotal in the success so far as we strive to:

- Harness and leverage the power and commitment of local people whilst retaining the very best local talent in our local communities.
- To be the local apprenticeship "employer of choice" in Huddersfield and Calderdale.
- To ensure the staff base is representative of the people we serve and reaching out even further.
- To ensure promotion of the hugely important role of "pre-employment pathways" and progression into paid bank, substantive entry roles and apprenticeships.
- To encourage and support CHFT colleagues to follow a career path that suits them and their life making full use of resources such as the apprenticeship levy and the continued offer of "in work support" including careers advice and guidance.
- To use our Health & Social care employer status as a key driver for economic and social recovery, particularly impacting those who face additional barriers and from underrepresented groups.

Through CHFT's "grow our own" this work is integral in supporting the Nursing, Midwifery and AHP workforce of the future.

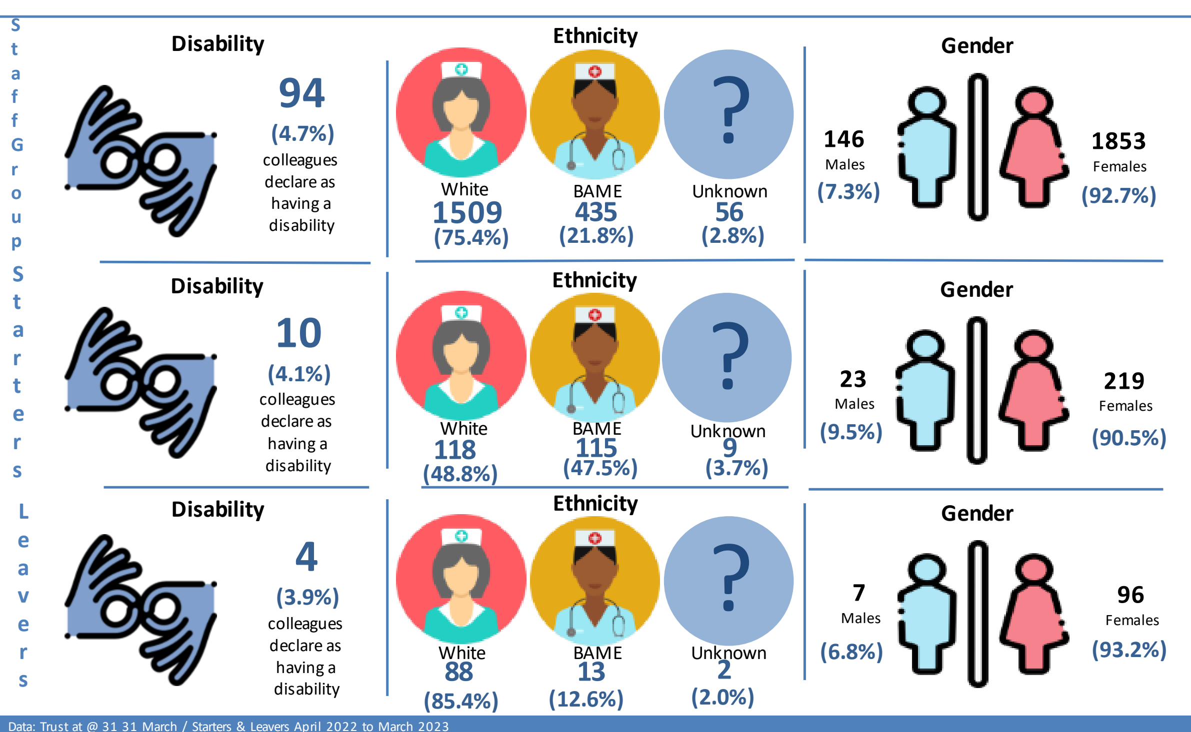
7.9.1 Apprenticeships at CHFT

CHFT is an “employer apprenticeship provider” that delivers the Health Care Support Worker apprenticeship. Non-clinical entry level apprenticeships are delivered in partnership across a range of local providers. Both pathways are promoted and prioritised to existing pre-employment participants from a range of projects CHFT has embedded pre-entry pathways into this offer through the Princes Trust ‘Get Into, Volunteering’, NHS Cadets, Project Search and SWAP (sector-based academies) and other participants referred in via external partnerships.

The Trust offers internal pathways upon completion of an entry apprenticeship into a substantive band 2 position or higher-level apprenticeship. 95% progressed into substantiative posts. Currently there are 325 live apprentices in total (81% clinical & 19% nonclinical), 101 x apprentices are internal “employer provider” HCSW apprentices with over 25% progressing from our Widening Participation pathways. Nearly 40% of our apprentices come from the top 3 IMD areas across Calderdale & Kirklees.

8.0 NURSING AND MIDWIFERY WORKFORCE

8.1 Equality Diversion and Inclusion



(Figure 18)

The current qualified nursing workforce comprises of 1999 staff, 94 (4.7%) of which have declared a disability, comparable to CHFT as a whole at 5.0%.

435 (21.8%) of all registered nurses at CHFT are of BAME ethnicity, this is below the reported overall CHFT figure of 23.8%, while just under 3% have not declared their ethnic origins.

The majority (93%) of RNs are female, this is above the Trust whole workforce gender split of 75.2% female, 24.8% male.

Over the reporting period for Nursing and Midwifery there has been a net…

- …increase of 11 disabled colleagues.
- …decrease of 6 white staff.
- …increase of 102 BAME staff.
- …increase of 5 staff of unknown ethnic origins.
- …increase of 13 males.
- …increase of 27 females.

8.2 Revalidation

Revalidation is the process that all nurses and midwives in the UK and nursing associates in England need to follow to maintain their registration with the Nursing and Midwifery Council (NMC). Revalidation promotes continual development and reflection in practice and is a requirement to undertake every three years.

In 2023 approximately 172 nurses, midwives and nursing associates revalidated, with 206 due to revalidate during 2023.

The NMC provides a comprehensive suite of resources which support registrants through the process of revalidation. This is signposted through CHFT intranet page which also provides additional information to support the process.

8.3 Nursing and Midwifery Council (NMC) referrals

During the reporting period there are 11 active cases that have been referred to the NMC with 3 cases being recently closed.

9.0 SUMMARY

- During the reporting period establishment reviews have been undertaken as set out within national guidance, based upon the principles of the safer staffing triangulation approach. This approach has informed the changes that have been approved.

10.0 RECOMMENDATIONS

The Board of Directors is asked to: -

- Receive this report and note the on-going plans to provide safe staffing levels within nursing, midwifery and AHP disciplines across the Trust.

- Note the maternity staffing position and the local position which is common with the national profile.
- Note the compliance standards used in relation to SNCT, and the ongoing quality of data it provides to underpin the Trust establishment process.
- Note the assurance regarding the daily processes to monitor and manage nurse and midwifery staffing levels at ward level.
- The recommendation from the Chief Nurse that there is good compliance with the Developing Workforce Safeguards

Appendix 1: Tiered approach to psychological support

Where we're headed: Tiered approach

NHS
Calderdale and Huddersfield
NHS Foundation Trust

For staff experiencing prolonged distress where their need has not or cannot be met by partner organisations

Specialist 1:1 assessment and therapy

Specialist psychological interventions to respond to psychological distress triggered or maintained by workplace events

Staff who are feeling the acute impact of workplace incidents psychologically (increased stress, anxiety, low mood)

Critical incident peer-support debriefs

Psycho-ed groups

Virtual mental health kit

Psychologically informed groups to explore the impact of challenging work events

All staff are encouraged to engage with these offers as-and-when required to support wellbeing

Mindfulness groups

Peer-support groups

Care first

Schwartz rounds

Friendly ear service

Supportive listening spaces to facilitate psychological reflection and skills-growth

Appendix 2: Retention Initiatives

Career Stage	Link to NHSE Toolkit	Action	Lead
All Stages	Leadership and Teamwork	Collate themes from exit interviews and monitor attrition through business intelligence	S-RF/ MB
Late Career	Pride and Meaningful Recognition	Explore Legacy Mentoring	JY
Late Career	Health and Wellbeing	Ensure Menopause Policy Refreshed if required	JR
Mid Career	Professional Development and Careers	Establish Career Framework- linked to Talent Management Framework	AD/CL /JC
All Stages	Professional Development and Careers	Expand Professional Nurse Advocacy Programme and Strengthen Implementation	JY
Early Career	Professional Development and Careers	Create guidelines for structured supernumerary period in clinical setting to complement induction/preceptorship framework	VD
Early Career	Pride and Meaningful Recognition	Achieve Pastoral Care Award for international recruits implement Stay and Thrive strategy	VP

Appendix 3: Midwifery Staffing Revised Workforce Models Propo

Date of Meeting:	June 2023
Meeting:	Quality Committee
Title of report:	Midwifery Staffing Revised Workforce Model proposal
Author:	Diane Tinker, Director of Midwifery and Women's Services
Sponsor:	Lindsay Rudge, Chief Nurse, Exec Director Maternity Safety Champion
Previous Forums:	None

Actions Requested
To approve the new workforce model for Midwifery staffing.

Purpose of the Report

To provide an update on the review of the current birth rate and revised midwifery staffing model.

Key Points to Note

- The revised maternity staffing model has been calculated using the principles of the Birthrate Plus tool and is based on a 1:24 ratio and birth rate of 4313 (22/23).
  This is a decrease against the previous birth rate of 4,902 (2020)
- The model reflects a skill mix calculation of 90%/10% split between midwives and non-midwifery support staff as recommended by Birthrate Plus
- In addition to the clinical midwifery workforce model the model also reflects an additional uplift of midwife roles by 8% with the function of supporting non-clinical management and governance.
- The new model **total** midwifery establishment is therefore **174.63wte** which consists of:
    - **161.73wte** clinical midwives following skill mix
    - **12.9wte** non-clinical midwives
- The current **total** midwifery vacancy rate against this revised staffing model is **14.31%** (149.64wte of 174.63wte employed at March 2023) and the current **clinical** midwifery vacancy rate against revised staffing model is **13.70%** (142.24wte of 161.73wte employed at March 2023).

EQIA – Equality Impact Assessment

There is significant evidence which demonstrates that the experiences and outcomes of mothers and babies from BAME groups and those from the areas of highest levels of deprivation are more likely to be poor.

Maternity services have an active Health Inequalities work stream to drive improvement work for those most at risk. CHFT's midwifery reader has produced a cultural survey that has been shared with staff to understand knowledge gaps ahead of developing training opportunities for midwives and obstetricians.

Recommendation

Approve the revised workforce model for clinical midwifery staffing
To commission a full review by birthrate plus to ensure acuity and continuity models are reflected in the service WFM

Midwifery establishment

Birthrate plus was completed at CHFT in 2020, when completed the birth rate was 4902.

The clinical midwifery establishment recommended from Birthrate plus for 4902 births was calculated at 206 whole time equivalent (wte) clinical midwives.

Historically, the workforce model was only funded at 186wte for total midwifery establishment and following the publication of the Ockenden report and the associated funding for clinical midwifery staff the establishment funding increased to 198wte.

Since this time, CHFT has since seen a reduction in births at 4313 (as of March 2023).

Due to the decrease in the Birthrate the workforce model has been recalculated using the 1:24 ratio as recommended in the Birthrate Plus report.

Using the 1:24 ratio the new clinical midwifery establishment is 179.7wte (4313 divided by 24=179.7).

Evidence-based skill mix calculation

- Once the clinical midwifery establishment has been calculated a skill mix percentage can be applied.
- The decision to replace midwifery time with maternity support workers, nursery nurses or staff nurses must be a local decision.
- A professional consensus of expert midwifery opinion is that a 90%/10% split between midwives and non-midwifery support staff allows for flexible and sustainable services.
- This skill mix adjustment is based on the support staff replacing midwifery hours only in postnatal services, including transitional care of babies.
- In recent years the role and scope of support staff has been evolving and, in many services, they now play a part in providing direct care to women antenatally, such as in providing parentcraft advice and in delivering public health interventions and even during labour, for example by accompanying an experienced midwife to a home birth. This would suggest that a split of 85:15 or even 80:20 might be appropriate in some services.

At CHFT at **10% skill mix** will be applied, therefore 17.97wte (10% of 179.7=17.97wte) midwifery posts will be replaced with maternity support workers and staff nurses. These posts include maternity support workers working in community, on the transitional care pathways and staff nurses working on both the labour ward and postnatal ward.

Addition of non-clinical midwifery roles.

All maternity services require additional roles to manage and provide maternity services, over and above that of clinical care. Such roles include senior midwifery management, governance and risk, practice development and any other role which involve considerable liaison with other services and co-ordinating care plans rather than providing direct clinical care.

Following the calculation of the clinical midwifery establishment and the applied skill mix, Birthrate Plus recommends assessing these roles by adding a percentage of the total clinical midwifery establishment.

For tertiary maternity services it recommends 10% and 8% for all other units. Therefore, for CHFT it would recommend an 8% addition, which would equate to 12.9wte (8% of 161.73 = 12.9). However, it remains a local decision as to the percentage to add into the total clinical establishment.

Workforce model summary

Based upon the historic number of **4902** births, the clinical midwifery establishment recommendation from Birthrate plus in 2020 was 206wte.

The current funded establishment is 198wte based on 4902 births (previous 186wte funded and the Ockenden uplift applied).

The below information summarises the proposed midwifery establishment based upon the current birth rate of **4313.**

Workforce model based on 4313 births	Calculation	Proposed wte
Clinical Midwifery establishment based on 1:24 ratio consisting of:	4313 divided by 24 =179.7wte	**179.7**
Maternity support workers / staff nurse (based on skill mix of 90/10 split	10% of 179.7 = 17.97	**17.97**
Clinical Midwifery establishment following skill mix	179.7–17.97 = 161.73wte	**161.73**
Non-clinical midwifery establishment (additional to clinical establishment)	8% of 161.73 = 12.9wte	**12.9**
Total Midwifery established (clinical and non-clinical)	161.73+12.9 =174.63	**174.63**

The new proposed **total** midwifery establishment is therefore **174.63wte** which consists of:

- **161.73wte** clinical midwives following skill mix
- **12.9wte** non-clinical midwives

Revised vacancy position for midwifery establishment

Following review of above this results in an overall reduction on the midwifery vacancy position as detailed below:

Current clinical midwifery establishment 142.24wte (March 2023)

New **clinical midwifery** vacancy 19.49wte = **13.70%**

Current total midwifery establishment including non-clinical 149.64wte (March 2023)

New **total midwifery** including non-clinical midwifery vacancy 24.99wte = **14.31%**

Planned recruitment

Following a successful regional recruitment process 14wte newly qualified midwives offered posts.

Following successful international recruitment 2 midwives have been offered post and are due to arrival in the end of June, with further interviews planned aimed at recruiting to 3 further posts.

Meeting: Board of Directors	Report Author: Richard Hill
Date:	**Sponsoring Director: Jonny Hammond**
Strategic Direction – Area: • Keeping the base safe	**Actions Requested:** • To note

Title and brief summary: Health and Safety Report – a summary of the actions completed to ensure compliance to HSE requirements and a safe base for colleagues and patients

Forums where this paper has previously been considered:
Resilience and Safety Group Meeting

Governance Requirements:

Executive Summary:
CHFT is required to meet the requirements of health and safety legislation which is enforced by the Health and Safety Executive. Furthermore there is a moral obligation to provide a safe and secure environment for colleagues and patients. To achieve these requirements, CHFT use the NHS Health and Safety Standards as guidance towards compliance. These are valuable because they have been written by the HSE and NHS and explain everything that is needed. The work over the last 2.5 years has seen CHFT meet most of those standards, with outstanding requirements to be achieved by September/October 2023.

Work also continues to ensure oversight and management of compliance and this is done through regular meetings with subject matter leads across the year.

Purpose:
The purpose of this report is to provide the Board with an update about the levels of compliance across the Trust.

Background / Overview:
This report gives a background of the last 12-month financial period which shows what action is being taken to meet the requirements of health and safety legislation. The report provides good assurance of compliance but equally it gives information about what is taking place to meet any remaining gaps. There is regular oversight of and meetings taking place across the year with key stakeholders to keep compliance in good shape and this is reported into the Resilience and Safety Group meetings which take place bi-monthly.

The Issue:
A key piece of work over the next 4 months is an improvement in security compliance. A plan has been drawn-up and a great deal of work with other agencies has already taken place between now and the end of this financial reporting period**.**

Next Steps:
Work continues with key stakeholders and there is a programme of meetings across the year between the Head of Health and Safety and these people. The aim of the meetings is to complete a desk-top audit of compliance so that assurance continues to remain in place but also to agree actions for those parts of legislation which are still to be met.

Recommendation:
The Board of Directors is asked to note the progress made against the action plan presented, and to approve this Health and Safety Annual Report.

Appendix Attached:

Annual health and safety report April 20?

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST
BOARD OF DIRECTORS
JANUARY 2023
HEALTH AND SAFETY ANNUAL REPORT FROM 1st APRIL 2022 TO 31st MARCH 2023

1. PURPOSE

The purpose of this report is to provide the Board with information about the levels of compliance across the Trust. The overarching benchmark to compliance is the NHS Workplace Health and Safety Standards which is underpinning the work completed now and the future. As a helpful reminder, the NHS Workplace Health and Safety Standards describe what is required and the evidence needed, covering thirty different pieces of legislation and an equal number of subordinate regulations. The standards have been written between the NHS and the Health and Safety Executive and therefore provide a high level of assurance. The level of compliance now is shown in Appendix C.

2. PROGRESS AND ACTIONS

Planning Reviews

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

- A review of the General Health and Safety Policy has been done to ensure attention continues to be given to key areas of risk and that has been placed on the Intranet for colleagues. New risks and mitigation were added to that policy, including ligature.

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

Collaboration

- Promotion of the importance of reporting incident has taken place with awareness at the Matron meetings and Band 7 Meetings, together with advice on the requirements for reporting shared on the health and safety intranet page. The aim is to ensure CHFT have maximum visibility of accidents and incidents (DATIX) so that the right level of attention and resources can be provided.

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

- Relationship building has taken place with over fifty practice managers and building operations managers, because many of the community-based colleagues occupy their buildings. The aim has been to seek confirmation of their due diligence measures, with special attention given to some of the higher matters, including asbestos exposure risks, electrical conditions, gas safety and legionella risks. All fifty buildings were visited to assess office conditions and assurances of compliance have been received from the practice managers and building operation managers. These assurances provide CHFT confidence that colleagues are working in safe conditions and equally CHFT can demonstrate its own legal commitments on this subject.

- Closer alignment between the Head of Health and Safety, Manual Handling Team, and the Occupational Health Team has taken place because of the synergies between risks and workload. This is helping avoid replication of advice, making for more efficient working.

- Collaborative work has taken place with Overgate Hospice to help them strengthen their due diligence measures, including risk assessments, policies, training etc. This has resulted in the hospice having much better compliance arrangements which will hopefully help their future negotiating options when renewing their insurance payments, but also provide a safe working environment to their colleagues.

Reviews

- All clinical and non-clinical areas across the Trust have now been subject to a workplace health and safety risk assessment. This keeps CHFT in line with regulatory expectations.

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

- A review of the maternity risk assessment has taken place, in partnership with WOD/subject matter leads, with improved content and sign-posting information. The aim of the assessment is to provide good advice to colleagues upon choosing the right level of posture and comfort and options around minimising physical effort in the workplace. The reviewed maternity assessment is now embedded in the maternity pack that is given to colleagues.

- The display screen assessment has been revised and made more accessible to colleagues who want it. The opportunity to complete a display screen equipment assessment has been offered to more than 106 desk-based colleagues who are spending most of their working day in front of a monitor inputting data. Evidence has been shown by the HSE, that prolonged data inputting has inherent risks in relation to aches/pains of the upper shoulders, central neck area, eye fatigue and repetitive strain injuries. The aim of the assessment is for the colleague to make the right choices and adjustments., and equally to avoid absence from work due to related illness. 10% of completed assessments have resulted upon follow-action to help improve colleagues experience which has included extra equipment/adjustments etc.

3. HEALTH AND SAFETY COMMITTEE

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

- **Dates of meetings**

- April 2022
- June 2022
- October 2022
- December 2022
- February 2023

Reporting of Injuries, Diseases and Dangerous Occurrences /Enforcement Actions

This piece of legislation is about those injuries which are the more severe end of the injury spectrum and or include any injury leading to more than 7 days of work. A list of diseases and dangerous occurrences are equally reported to the Health and Safety Executive. During the reporting period of this report, there has been no reportable diseases or dangerous occurrences. It can also be reported, that CHFT has not received any enforcement actions or visits by the HSE.

4. INITIATIVES 2022-2023

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

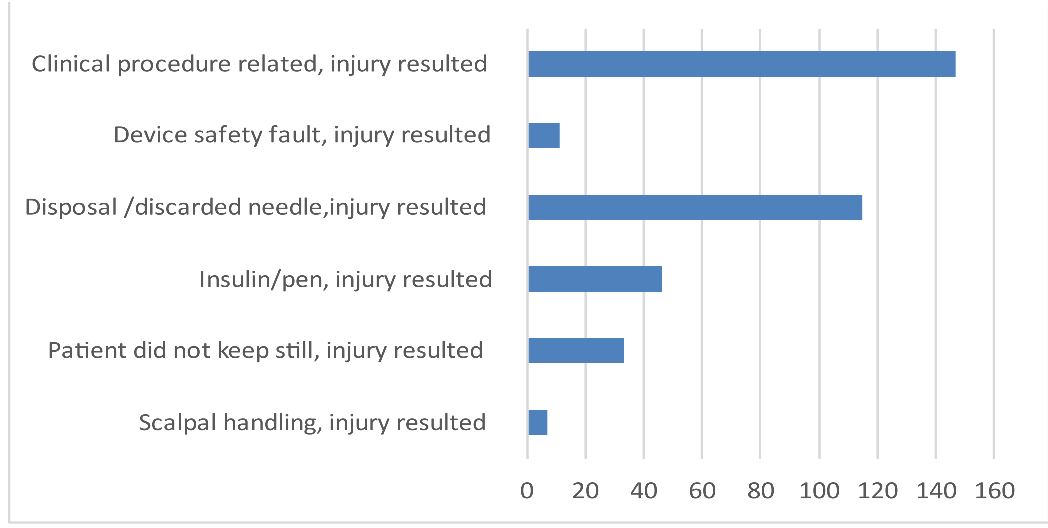
There is an opportunity to work triangularly, between the Head of Health and Safety, Head of Occupational Health and the Moving and Handling Lead. This is because there is shared interest and understanding on some of the risks which appear on DATIX and therefore working smarter together to get results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

Sharps Injury Reduction Work

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

The bar chart represent the route causes associated with needle-stick injuries. These periods run from January to December each year

Graph (1) Needle-stick Injuries 5-year data 2017yr to 2022yr



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

Sharps Injury Reduction Actions

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

	Doctors to read and is a fast way for them to be quickly inducted into the Trust, when only doing a couple of shifts
	5-key messages added to the Intranet weekly screensaver A reminder on sharps safety • Are you trained to use a sharps bin? • Use the temporary closure mechanism • Don't over fill the bin • Dispose of sharps at point of care • Is your bin correctly assembled and labelled?

Ligature Risks

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

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

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

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

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

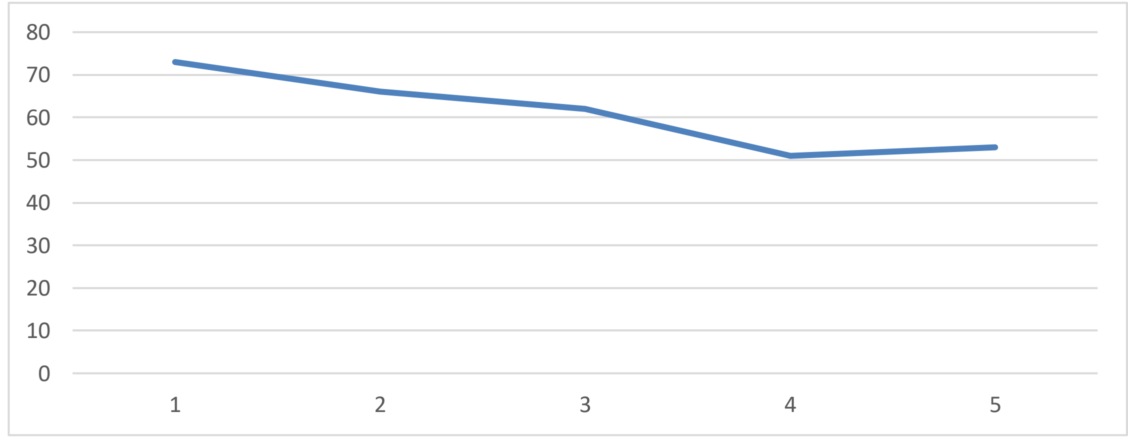
- An audit process is now in place to ensure all the above continues to be in place.

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

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

The completion of training and risk assessment is achieved by the appointment of 'Facilitators'. A total of 183 Facilitators have been appointed, of those, forty-two are based in the community. This is a doubling of the numbers, compared to previous years. Promotion of the sessions continue, and it is hoped that attendance will improve if pressure on services change.

Graph (2) Moving and Handling Injuries 5-year data 2017yr to 2022yr
These periods run from January to December each year



The expectation is that these extra measures (below) will take effect during 2023yr.

Measures in place to help reduce the risk of moving and handling injuries	Extra measures implemented to further help reduce injuries
Moving and handling training courses delivered throughout the year	A new bariatric equipment provider has been appointed because the service delivery needed improving
Moving and handling risk assessments completed	A new sling provider is proposed with the aim of improving the safety design features compared to the original offer.

Random audits are carried out by the moving and handling team across the Wards	The moving and handling team have started working collaboratively with the tissue viability practitioner to help with complex patient assessments
	The number of moving and handing facilitators have now been doubled to help increase the availability of places for colleagues
	Promotion of the course are via Intranet and taken to the Band 7 meetings and news-lines on the Intranet

Optical Laser and Non-Ionising Radiation Compliance

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

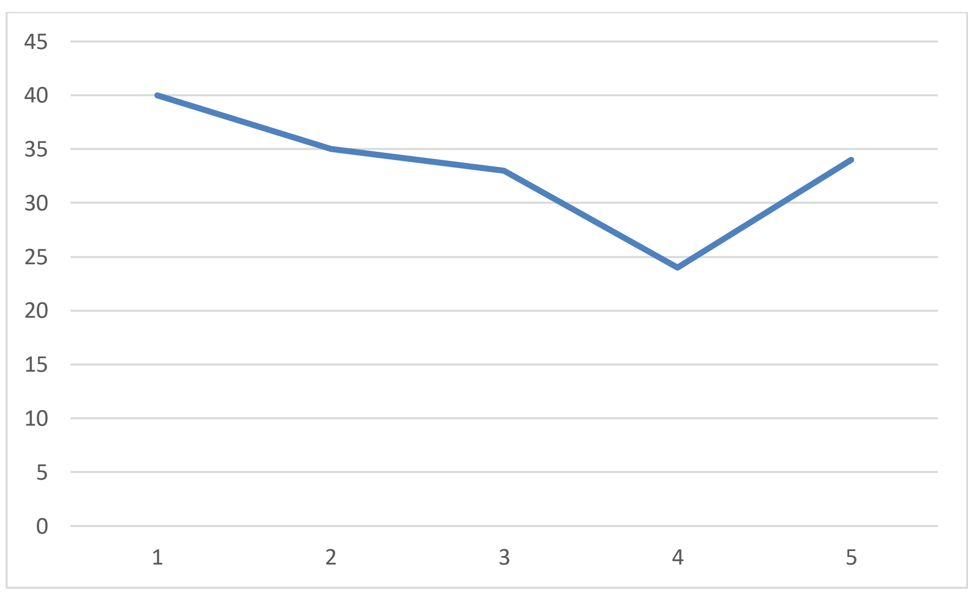
Table – Audits carried out by IRS Ltd during 2022yr

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

Slips, Trips and Falls Injuries

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

Graph (3) Slips, Trips and Falls 5-year data 2017yr to 2022yr
These periods run from January to December each year



The expectation is that these extra measures (see below) will take effect during 2023yr.

Legacy ideas in place to help reduce slips, trip, fall accidents	New ideas to help reduce accidents
The FLO audit for wards includes a section on floor conditions and the results are monitored centrally.	There is a tenuous link between fire evacuation and an opportunity to receive compliance of floor conditions. The fire marshal weekly inspections now have a section on the flooring (so that there are no slips/trips/falls hazards)
The IPC Audits are carried out jointly with the clinical teams, Service Performance and Service Partners (i.e. CHS/ISS/EQUANS). The audits focus on different areas of site in rotation. The checklist considers condition of the flooring and more general infrastructure.	EQUANS have produced new risk assessments which provides assurance of due diligence measures in place to reduce the risk injuries related to slips.

Service performance checks are carried out by Service Performance Team. The checklist considers condition of the flooring and more general infrastructure.	ISS & CHS Ltd have reviewed their floor cleaning risk assessments and method statements
A building safety tour is instigated at CRH by the PFI Provider to provide assurance that their suppliers (ISS and EQUANS) are operating and maintain the building to the required standards.	ISS Ltd completed a health and safety roadshow and a section of that is around slips, trips and falls prevention
	A communication piece has been shared on the Intrant and just before winter started, to increase awareness around taking many of the actions being taken by CHS Ltd/EQUANS to manage ground conditions and gritting
	A newsletter has been produced and there is a section on there around awareness of ground conditions in winter months and gritting of designated paths.
	Attendance by the Head of Health and Safety takes place at the Falls Collaborative, EQUANS/ISS/CHS meetings
	There is a joint risk assessment in place at CRH and HRI. Since the risk assessments were carried out action has taken place to address some of the gaps in control. These include: • The replacement of a 60 sq ft surface mat at CRH at the A&E entrance to help quicker drying of shoes when entering in wet weather from this direction. • The IPC audits have been reinitiated, with detailed checklists that cover flooring. • toolbox talks are held to remind cleaning staff regarding the correct positioning of wet floor signage. • Wards have had communications shared from Service Performance Team to remind them how to raise jobs for flooring concerns or in the event of spillages when cleaning services are required. • A review of themes of Datix incidents has been carried out and cross checked against current controls.

Revised Health and Safety Policy

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

ISO-45001 Occupational Health and Safety

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

Air Monitoring – Entonox Levels

This gas is used as a pain relief for patients experiencing high levels of discomfort and any unintended exposure to colleagues from second hand inhalation. This is the second year CHFT have appointed a consultant to carry out these tests and follows the good results of the previous year.

Board Health and Safety Legislation Update

A presentation was agreed to be delivered to the Board by Weightmans Solicitors in March 2023. The aim of the session was to inform Board members about any emerging risks and to remind the Board about some of the key features of responsibilities.

Health Informatics Service / Huddersfield Pharmacy Specials

Work continues with both business functions and regular health and safety meetings take place with management and staff side health and safety representatives. Each business has been given an action plan to work towards and these action plans are leading to fruition and completion.

5. CONCLUSION

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

6. RECOMMENDATION

The Board of Directors is asked to note the progress made against the action plan presented, and to approve this Health and Safety Annual Report.

Richard Hill
Head of Health & Safety

INTENTIONALLY BLANK PAGE

Appendix (A) 5 Year Health and Safety Strategy

	Health & Safety Strategy 2023 2027	2023 yr.	2024 yr.	2025 yr.	2026 yr.	2027 yr.	Is this consistent with the CHFT Health and Safety Policy	Is this measurable or capable of performance evaluation	Are these reflective of risks / opportunities	Are these monitored	Are these communicated	Are these updated regular	Are there resources in place	Is stakeholder responsibility identified	Can the actions achieve CHFT Board Strategy requirements
1	Monitoring of the NHS Workplace Health and Safety Standards using audit options. Outcome is a to ensure the individual standards continue to remain in place and effective.	x	x	x	x	x	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
2	In conjunction with the NHS Workplace Health and Safety Standards, using the ISO 45001 Occupational Health and Safety System and its ten clauses. Outcome is to achieve over and above just legal compliance, but to forensically examine the effectiveness of policies/roles/responsibly/arrangements/audits	x	x	x	x	x	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
3	Networking across NHS Trusts to benchmark and share best practice by sharing and exchanging new ideas . Outcome is to learn from the experiences of other Trusts and use that knowledge to help benefit each organisation own aim and ambitions.	x	x	x	x	x	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

	Health & Safety Strategy 2023 2027	2023 yr.	2024 yr.	2025 yr.	2026 yr.	2027 yr.	Is this consistent with the CHFT Health and Safety Policy	Is this measurable or capable of performance evaluation	Are these reflective of risks / opportunities	Are these monitored	Are these communicated	Are these updated regular	Are there resources in place	Is stakeholder responsibility identified	Can the actions achieve CHFT Board Strategy requirements
4	Engagement with the reconfiguration meetings for CRH & HRI by attendance at consultation meetings and sharing opinions and ideas. Outcome is to monitor risk and provide relevant input when necessary.	x	x	x	x	x	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
5	Creating a more triangulated direct working arrangement with the Occupational Health /HR/Moving & Handling Team upon issues which triangulate and include subjects such as maternity assessments and referrals, display screen equipment and referrals, sharps prevention projects and finally moving and handling referrals. Outcome is to share data and agree joint plans to help resolve/reduce/eliminate future repeated incidents/requests. Outcome is to work SMART .	x	x	x	x	x	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
6	Supporting the work being carried out to improve personal safety of colleagues and the threat of violence and aggression by attendance at relevant meeting and sharing ideas and opinions. Outcome is to support the efforts taking place to improve personal safety and wellbeing and helping to reduce the number of actual bodily harm experienced by some colleagues	x	x	x	x	x	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

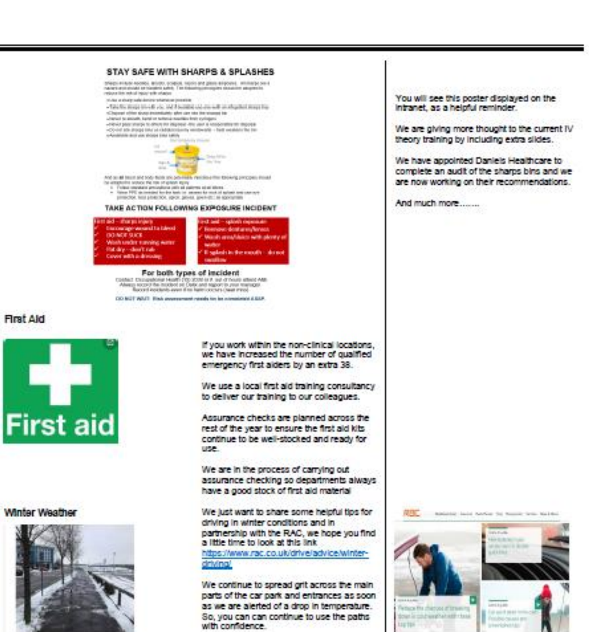
	Health & Safety Strategy 2023 2027	2023 yr.	2024 yr.	2025 yr.	2026 yr.	2027 yr.	Is this consistent with the CHFT Health and Safety Policy	Is this measurable or capable of performance evaluation	Are these reflective of risks / opportunities	Are these monitored	Are these communicated	Are these updated regular	Are there resources in place	Is stakeholder responsibility identified	Can the actions achieve CHFT Board Strategy requirements
7	Working jointly with EQUANS/ISS/CHS Ltd on campaigns/roadshows to promote safe conditions across the estate: Outcome is to to work together common issues that affect both workforces	x		x		x	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
8	Liaising with CHS Ltd to ensure guarantees are in place for colleagues working in 3rd party buildings located across both Kirklees and Calderdale . Outcome is to receive assurance that landlord responsibilities for gas, electrical, asbestos are being met: Outcome is that landlords are taking positive action to provide a w nm wellbeing.	x		x		x	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
9	A continued focus upon accident/reductions and working in partnership with the subject matter leads and seeking continuous improvements with the accident/injury reduction frequencies. Outcome is to ensure a firm control of any emerging risks.	x	x	x	x	x	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Appendix (B) Newsletter available for all colleagues to read on the Intranet
This was published on the intranet for all colleagues to read in October 2022yr and repeated in March 2023yr with different topcis of interest

Health & Safety News

Personal Safety

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



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

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

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

And much more…….

First Aid

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

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

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

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

Winter Weather

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

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

Health & Safety News

Entonox Air Monitoring

We have appointed a local consultant to carry out air monitoring for Entonox levels. Don't worry, we don't have any concerns but just like other Trusts we continue to ensure the working environment continues to be in good shape.

The monitoring is completed with a device and attached to the person's collar over an 8-hr. period. The results continue to give us assurances, however in the rare, unlikely event of a leak, we can take quick action.

Maternity Risk Assessment

We have taken a fresh look at your Maternity Risk Assessment. It is now ready to complete with your line manager during your time in work leading up to your final weeks before the birth of your child.

Moving and Handling

- We have completed joint working with our mortuary colleagues and porters, to promote transferring the deceased from the clinical area to the mortuary.
- We have doubled the number of facilitator courses on offer to you. Please do keep attending all courses so we avoid any disappointments.
- We have appointed a new bariatric equipment provider, which gives us an improved service to you.
- We are now reviewing our supplier of slings and improving all the background processes that support it.

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

Email: questionshealthsafety.committee@cht.nhs.uk

Appendix (C) Timetable – Joint Audit of Compliance Using the NHS Workplace Health and Safety Standards 2023/2024yr
This allows for regular desk top auditing and monitoring of compliance across the year

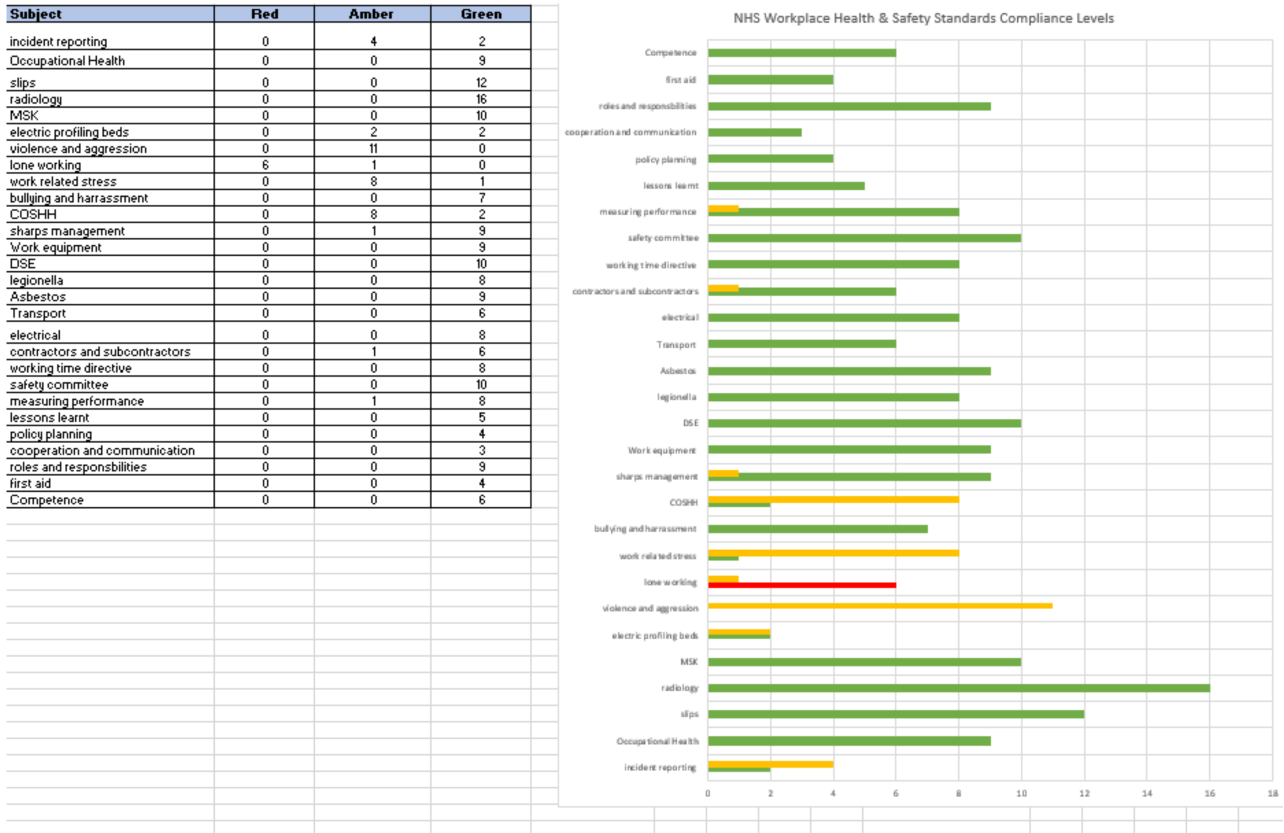
Health & Safety Compliance Reviews

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

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

Appendix (D) – Compliance levels against the NHS Workplace Health and Safety Standards (These standards are written by the HSE and NHS and are descriptions of how to meet compliance)

(Updated: 22nd June 2023yr)



Subject	Red	Amber	Green
incident reporting	0	4	2
Occupational Health	0	0	9
slips	0	0	12
radiology	0	0	16
MSK	0	0	10
electric profiling beds	0	2	2
violence and aggression	0	11	0
lone working	6	1	0
work related stress	0	8	1
bullying and harrassment	0	0	7
COSHH	0	8	2
sharps management	0	1	9
Work equipment	0	0	9
DSE	0	0	10
legionella	0	0	8
Asbestos	0	0	9
Transport	0	0	6
electrical	0	0	8
contractors and subcontractors	0	1	6
working time directive	0	0	8
safety committee	0	0	10
measuring performance	0	1	8
lessons learnt	0	0	5
policy planning	0	0	4
cooperation and communication	0	0	3
roles and responsbilities	0	0	9
first aid	0	0	4
Competence	0	0	6

Coding:

Green = compliant
Amber = progressing
Red = planned

Date of Meeting:	Thursday 6 July 2023
Meeting:	Board of Directors
Title:	Board Assurance Framework – Update 1 2023/24
Author:	Andrea McCourt, Company Secretary
Previous Forums:	None

Purpose of the Report

The Board Assurance Framework is the key source of evidence that links the Trust's strategic objectives to risk and assurance. It is the main tool that the Board uses for discharging its overall responsibility for internal control and is presented to the Board three times a year.

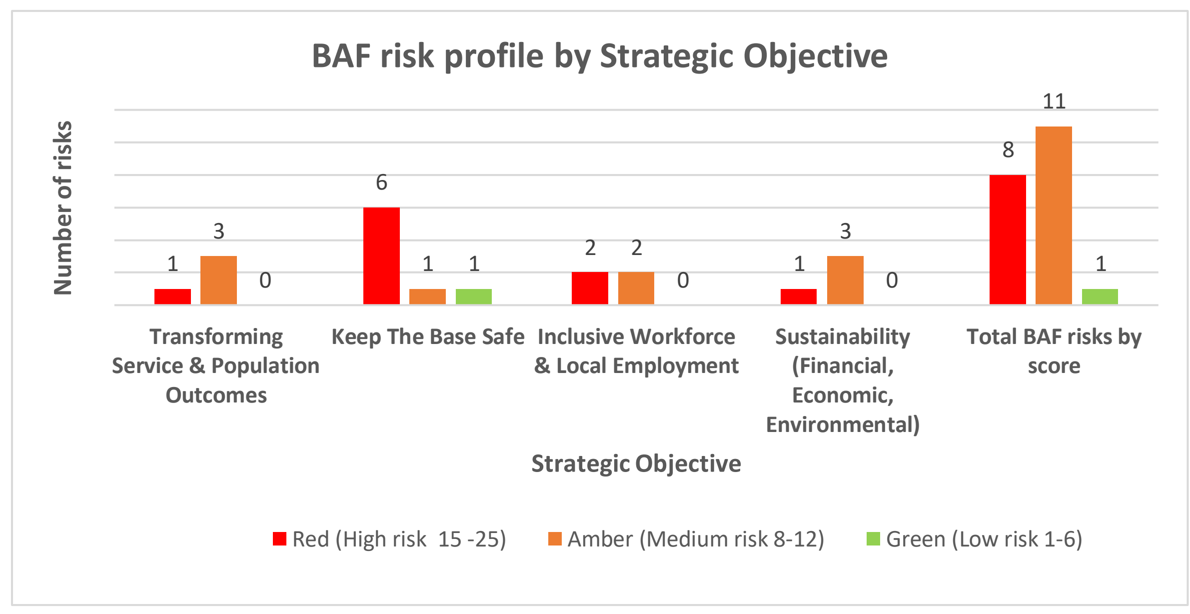
This report presents for approval the first report of the Board Assurance Framework (BAF) for 2023/24 for approval. Due to sequencing of meeting timings the report will be reviewed by the Audit and Risk Committee after the Board meeting at its meeting on 25 July 2023.

Key Points to Note

The Trust approved a revised one year and five year strategy in March 2023. The Board Assurance Framework has been reviewed against these strategies to ensure that it captures risks relevant to the current strategic objectives with changes summarised below.

Risk Profile

The Trust has the following risk profile for risks to its strategic objectives as at 29 June 2023 with a total of 20 risks.



The Keeping the Base Safe goal has the greatest number of risks (8 of 20) and the highest number of red risk scores, at six of the 20 risks on the BAF

The risks presented are aligned with the revised strategic objectives agreed by the Board in March 2023 as follows:

Transforming services and population outcomes	Board Assurance Framework Risks	Board Committee oversight
We will have built new modern 'state of the art' hospital buildings that will enable delivery of the best safety, outcomes and experience of care for people.	Risk 1/19 reconfiguration	Transformation Programme Board
Patients and colleagues will be digitally enabled to provide and receive care – in any location this is needed – to improve patient experience and outcomes.	Risk 02/20 Digital Strategy Investment	Transformation Programme Board
Working with partners we will use population data to prevent ill health and reduce health inequalities.	Risk 07/20 Health Inequalities	Board via Health Inequalities reporting
Working with academic, health and social care partners we will participate in research and innovation to prevent ill health, improve patient care and achieve better outcomes and faster recovery for patients.	Risk 1/20 Clinical Strategy	Quality Committee

Keeping the base safe – best quality and safety of care	Board Assurance Framework Risks	Board Committee oversight
We will be delivering and enabling outstanding quality, safety and experience of care for people needing hospital and community services.	Risk 6/19 high quality safe care for patients Risk 9/19 Estate & equipment	Quality Committee Transformation Programme Board
We will be consistently achieving key performance targets that matter most to patients.	Risk 1/23 Demand and capacity Risk 18/19 local and national performance targets	Finance and Performance Committee
We will be well-led and governed and compliant with our organisational and partnership statutory duties.	Risk 3/23 Partnerships Risk 16/19 Health & Safety Risk 4/20 CQC rating	Board Audit and Risk Committee Quality Committee
Patients will be able to shape decisions about personal developments and their personal care based on 'what matters' to them and their individual strengths and needs.	Risk 4/19 (moved from Transforming services objective)	Quality Committee

Inclusive workforce and local employment	Board Assurance Framework Risks	Board Committee oversight
We will be widely known as one of the best places to work through an embedded one culture of care – supporting the health and wellbeing of all colleagues.	Risk 1/22 health and well-being and leadership	Workforce Committee
We will foster an open learning culture that listens to colleagues, demonstrates lessons learnt and actively seeks and celebrates best practice.	Risk 11/19 recruitment and retention	Workforce Committee
We will have a diverse and inclusive workforce of the right shape, size and flexibility to deliver care that meets the needs of patients	Risk 10a/19 medical staffing Risk 10b/19 nurse staffing	Workforce Committee
We will be ambitious in our work with partners to create local employment, career, voluntary and development opportunities for People.	Risk 2/23 Social Value	Transformation Programme Board Workforce Committee

Financial, economic and environmental sustainability	Board Assurance Framework Risks	Board Committee oversight
We will be consistently delivering our annual financial plans and demonstrating value for money.	Risk 18/19 financial sustainability Risk 14/19 capital funding	Finance and Performance Committee
We will have taken action to reduce our impact on the environment and will be on track to achieve targets for carbon net zero.	Risk 6/20 Environmental sustainability	Transformation Programme Board
Our investments and use of resources will generate social value to support economic recovery in Calderdale and Kirklees places.	Risk 2 /23 Social Value	Transformation Programme Board

All BAF risks have been reviewed and updated by the lead Director and / or teams with updates shown in red font for ease of reference in the enclosed worksheets within the BAF.

Top Risks

The BAF, via the heat map, shows the top risks for the Board are:

- Transforming Services and Population Outcomes - approval relating to hospital services reconfiguration, risk score of 20
- Keeping the Base Safe – demand and capacity (beds), risk score of 20
- Sustainability - risk 18/19 relates to the long term financial sustainability of the Trust and has a risk score of 16.

Risk Movement:

- five risks have been removed, one of which has been merged
- three new risks are proposed for addition

Director lead changes for existing BAF risks to note are as follows:

- lead Director change for Health and Safety, risk 16/19, due to the movement of health and safety to the portfolio of the Chief Operating Officer
- the lead Director for risk 4/19 Patient and Public Involvement has changed from the Chief Nurse to Director of Corporate Affairs and moved to the Keep the Base Safe goal

Discussion took place at the Finance and Performance Committee on 28 June 2023 regarding risk 8/19 on national and local performance targets. It was agreed that this risk would be retained with a refocus on current issues that are impacting performance, such as length of stay, discharge and transfers of care. The updated risk 8/19 will be presented to the Board in update two of the BAF at the Board meeting in September 2023.

Risks Removed

Risk Removed	Rationale	Elements captured in current / new risks	Previous Discussions
7/19 Compliance with NHS England	This risk was on the BAF to support our strategic ambitions and originated from regulatory non- compliance with NHS England in relation to the financial position. Referenced within other BAF risks as needed.	1/19 reconfiguration risk and 18/19 longer term financial risk	Agreed at Finance and Performance Committee 30 May 2023
3/19 Trust unable to deliver appropriate services across seven days due to staffing pressures.	These clinical standards were first issued by NHS England in 2018 to support delivery of high quality care and improve outcomes on a seven day basis for patients admitted to hospital in an emergency. Four of the standards were priority standards (consultant direct assessment, diagnostics, interventions and ongoing review, every day of the week). The standards remain but are not a key risk to the Trust's strategy. National reporting is no longer required. Audits of progress against the standards will continue to be reported to and scrutinised by the Quality Committee.	N/A	Agreed by Medical Director 13 June 2023
15/19 External growth from commercial ventures	Risk realised via reduction in financial contributions from joint ventures. Risk does not align with Trust strategy and changed NHS operating context of collaboration.	Financial aspects within BAF long term financial sustainability risk 18/19	Agreed at Finance and Performance Committee 30 May 2023
5/20 Recovery	Assurance re positive performance on recovery and risk not materialised.	N/A	Agreed at Finance and Performance Committee 30 May 2023
12/19 Engagement	Merged with risk 1/22 health and well-being	N/A	Director of Workforce & OD

Risks Added

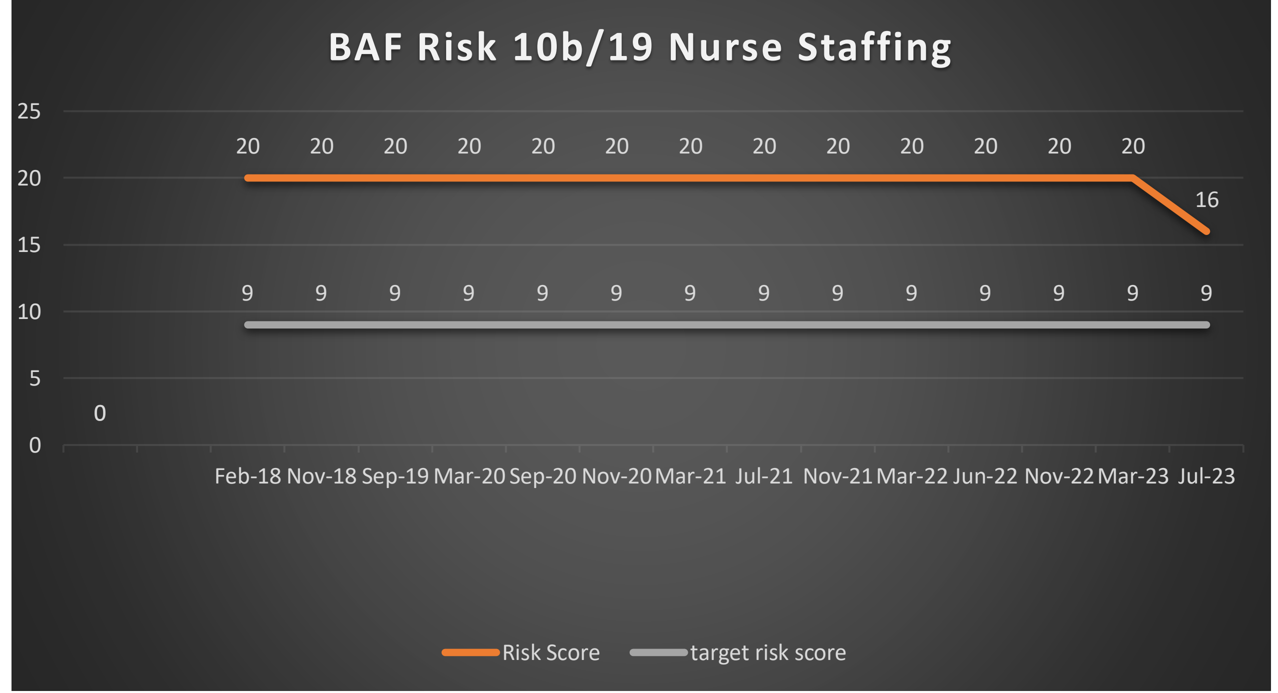
Risk Added	Risk Score	Strategic Goal	Director Lead	Committee Oversight
1/23 Demand and capacity	16	Keeping the base safe	Chief Operating Officer	Finance and Performance Committee
2/23 Social Value	9	Financial, economic and environmental sustainability	Deputy Chief Executive and Director of Transformation and Partnerships	Transformation Programme Board
3/23 Partnership governance	16	Keeping the base safe	Director of Corporate Affairs	Board

Risk Score Movement

There is one risk with downward movement in risk score noted below. The rationale for the movement in risk score given together with the risk score history is below.

Risk score movement	BAF Risk reference and score	Risk score
⇩	10b/19 Nurse staffing	16 (reduced from 20)

- ***10b/19 Nurse Staffing*** - risk reduced from a risk score of 20 to 16 with a reduction in the risk likelihood score from 5 to 4 due to bed retraction plan, with potential for reduction in vacancies of around 60 whole time equivalent, reduction in Tier 3 agency spend, stabilisation of care hours per patient day (Q2 Model hospital) and safer staffing levels which are increasingly at OPEL 2 level.



Risk Exposure
Where a BAF risk score is higher than the risk appetite (e.g. risk score of 15 or above where risk appetite is moderate) this has been identified as a breach of the risk appetite.

In considering risk exposure the Trust needs to assess whether any further mitigating actions are needed and review the adequacy of information and assurance on the management of risks with risk exposure.

As at 23 June 2023 there are six areas of risk exposure summarised below.

Strategic Goal: Transforming and Improving Care	Risk Score	Risk Appetite category	Risk Appetite
7/20 Health Inequalities	12 =	Harm and safety	Low
Strategic Goal: Keeping the Base Safe	**Risk Score**	**Risk Appetite category**	**Risk Appetite**
6/19 Quality and Safety	15 =	Regulation	Moderate
8/19 Performance targets	20 =	Regulation	Moderate
1/23 Demand and capacity (beds)	16 !	Harm and safety	Low
Strategic Goal: Workforce			
1/22 Health and well-being, leadership	12	Workforce	Low
Strategic Goal: Sustainability			
18/19 Financial sustainability	16	Financial/Assets	Moderate

EQIA – Equality Impact Assessment

The BAF has a specific risk, risk 07/20, which relates to the Trust not reducing health inequalities for our most vulnerable patients.

The Trust Board receives a report four times a year on progress with health inequalities actions at Board meetings.

In terms of other risks, should any of the Board Assurance Framework risks materialise and impact people from different protected characteristics the risk owner is accountable for assessing these and determining any proposed actions to mitigate any equality impact arising from the risk.

Recommendation

The Board is asked to:

i. **APPROVE** the removal of five risks scores on the Board Assurance Framework
ii. **APPROVE** the reduction in risk score to 16 of the risk 10b/19 nurse staffing
iii. **APPROVE** the additional risks and updates to the risks on the Board Assurance Framework
iv. **CONSIDER** if there are any further risks to the achievement of strategic objectives

Update 1 -For 6 July 2023 Board
2023/24

BOARD ASSURANCE FRAMEWORK
2023/24 Update 1

Contents:

1 Summary sheet
2 Risk Appetite
3 Full List
4 Heat map
5 Transforming and improving patient care
6 Keeping the base safe
7 A workforce fit for the future
8 Sustainability
9 Key

SUMMARY BOARD ASSURANCE FRAMEWORK RISKS BY TRUST STRATEGIC GOAL

REF	TOP RISKS	Initial Score	Current score	Target Score	Lead	Link to High Level Risk Register	Risk Category	Risk Appetite
TRUST GOAL: 1. TRANSFORMING SERVICES AND POPULATION OUTCOMES								
01/19	Risk that the Trust does not secure approval of the Hospital Services Reconfiguration Outline Business Case and Full Business Case resulting in being unable to progress changes to improve quality of care, workforce resilience and mitigate estates risks.	25	**20=**	10	AB	2827, 7413	Strategic/ Organisational	Significant
TRUST GOAL: 2 KEEPING THE BASE SAFE - BEST QUALITY AND SAFETY OF CARE								
1/23	**Risk re demand and capacity requiring additional beds above planned levels resulting in staffing and financial pressures.**	20	**20**	12	JH	7689, 8283, 8324, 8034	Harm and safety	Low
TRUST GOAL: 3. INCLUSIVE WORKFORCE AND LOCAL EMPLOYMENT								
18/19	Risk re: longer term financial sustainability of the Trust (as a going concern and providing value for money) due to the size of the underlying financial deficit with the growing level of debt and reliance on borrowing.	25 =	**16 =**	12	GB	8057	Financial/Assets	Moderate

Area of risk exposure

SUMMARY BOARD ASSURANCE FRAMEWORK RISKS BY TRUST STRATEGIC GOAL

REF	RISK DESCRIPTION	Initial Score	Current score	Target Score	Lead	Link to High Level Risk Register	Risk Category	Risk Appetite
Transforming services and population outcomes								
01/19	Risk that the Trust does not secure approval of the Hospital Services Reconfiguration, Outline Business Case and Full Business Case resulting in being unable to progress changes to improve quality of care, workforce resilience and mitigate estates risks.	25	**20=**	10	AB	7413	Strategic/ Organisational	Significant
01/20	Risk of not delivering the ambitions in the Trust clinical strategy due to lack of collaboration due to lack of time, commitment, relationships and absence of shared vision, resulting in missed opportunities in terms of quality, efficiency, capacity, patient experience and workforce.	15	**12 =**	10	DB	None	Strategic/ Organisational	Significant
02/20	Risk of not securing appropriate investment to fund the Digital Strategy ambitions, ensuring infrastructure and technology is up to date and future proof due to funding not being available locally and nationally impacting on workforce efficiency and patient experience.	12	**12 =**	9	RB	None	Innovation/ Technology	High
07/20	Risk of slow progress addressing health inequalities in the 20% of the most deprived patients in our communities, due to incomplete population health and patient ethnicity data, healthcare service delivery not matching patient needs in the most deprived areas, lack of quality priorites to advance health equity, lack of resource allocation and programmes for health prevention, ineffective partnership working and lack of sustained focus on actions to address ill health and prevention, resulting in the Trust not reducing health inequalities for our most vulnerable patients with protected characteristics.	16	**12 =**	8	RA	None	Harm and safety	Low
Keeping the base safe best quality and safety of care								
06/19	Risk that patients do not receive high quality, safe care due to poor compliance with internally and externally set standards on quality and safety resulting in patient harm or poor patient experience.	15	**15 =**	10	LR / DB	See sheet	Regulation	Moderate
04/19	**Risk that patients are not able to shape decisions about their care based on what matters to them due to lack of clear strategy and capacity for patient and service user engagement resulting in not designing services using patient recommendations**	12	**12=**	4	VP	None	Regulation	Moderate
09/19	Risk of failure to maintain current estate and equipment and to develop future estates model resulting in patient harm, poor quality patient care or regulatory enforcement.	16	**15 =**	8	GB	7413, 7474, 7955, 8415	Strategic/ Organisational	Significant
16/19	Risk of not being compliant with the Health and Safety at Work Act and regulations due to lack of clarity on roles resulting in harm to staff, patients, the public, visitors, potential regulatory failure and reputational damage.	9	**6 =**	3	JH	. 7413, 7474, 8415	Regulation	Moderate
04/20	Risk of not maintaining the Trust CQC overall rating of good and increasing the number of services achieving an outstanding rating as assessed by the new CQC single assessment framework and potential for ratings to be changed by CQC based on other intelligence or data from CQC portal outside of on site inspection of service due to failure to comply with quality statements resulting in a reduction of qualiy of services to patients and an impact on reputation.	12	**12 =**	6	LR	None	Regulation	Moderate
1/23	**Risk re demand and capacity requiring additional beds above planned levels resulting in staffing and financial pressures.**	16!	20	12	JH	7689, 8283, 8324, 8034	Harm and safety	Low
3/23	**Risk that decision making processes and capacity of Trust colleagues is impacted due to the evolving nature of partnership governance across the system and emergent governance arangements**	16!	**16 =**	8	AB	None	Strategic/ Organisational	Significant
8/19	Risk of failure to achieve local and national performance targets resulting in patient harm, poor patient experience or enforcement action.	16	**16 =**	12	JH	7615, 7454	Regulation	Moderate

SUMMARY BOARD ASSURANCE FRAMEWORK RISKS BY TRUST STRATEGIC GOAL

Inclusive workforce and local employment								
10a/19	Risk of not being able to deliver safe and effective high quality care and experience for patients due to insufficient medical staff caused by an inability to attract, recruit, retain, reward and develop colleagues.	16	**16 =**	9	DB	7637, 8072, 8277, 8508	Quality/Innovation & Improvement	Significant
10b/19	Risk of not being able to deliver safe and effective high quality care and experience for patients due to insufficient nursing staff caused by an inability to attract, recruit, retain, reward and develop colleagues.	16	**16** ↓	9	LR	6345, 8454, , 7776, 7539, 8473, 8483	Quality/Innovation & Improvement	Significant
11/19	Risk of not attracting or retaining colleagues who are confident and competent to provide compassionate care to patients and compassionate and inclusive leadership to colleagues.	16	**12 =**	9	SD	None	Quality/Innovation & Improvement	Significant
1/22	**Risk of colleague absence and retention rising due to: increasing demands and requirements for health and wellbeing offers that are not appropriate, not accessible, not embedded or not affordable; and/or inability or unwillingness to attract develop and retain compassionate and inclusive leaders who are able to succesfully lead their teams through sustained periods of change**	12	**12 =**	4	SD	None	Workforce	Low
Financial, Economic and Environmental Sustainability								
14/19	Risk that the Trust will not secure sufficient capital funding to maintain facilities over the longer term and meet safety and regulatory standards resulting in patient harm and regulatory intervention.	20	**12 =**	12	GB	None	Financial/Assets	Moderate
18/19	Risk of failure to secure the longer term financial sustainability of the Trust (achieving financial breakeven and providing value for money) due to the size of the underlying and current financial deficit and reliance on cash support. developing a business case to support financial sustainability in the medium term, this plan is subject to approval and the release of capital funds. Impact financial sustainability not secured- increased regulatory scrutiny, reduced ability to meet cash requirements, inability to invest in patient care or estate.	25 =	**16 =**	12	GB	8057	Financial/Assets	Moderate
06/20	Risk of climate action failure and not improving our environmental sustainability	16	**8 =**	8	SS	None	Strategic/ Organisational	Significant
2/23	**Risk that the Trust cannot maximise its impact as an anchor institution in local communities to demonstrate social value**	**9 !**	9	6	AB	None	Partnership	Significant

Area of risk exposure

CHFT RISK APPETITE STATEMENT - Revised September 2022

Risk Category	This means	Risk Appetite
Strategic / Organistional	We seek out innovation to deliver higher quality patient care, accepting this brings risk.	**SIGNIFICANT**
Reputation	We will not shy away from making difficult decisions in the best interests of patient safety but appreciate this may attract scrutiny / interest from stakeholders.	**HIGH**
Financial / Assets	We will invest resources to enable us to deliver improvements in care ensuring rigorous impact assessments. We will resource opportunities and always consider price, value and benefits, and local impact, aiming to deliver our services within our financial plans, retaining flexibility to capitalise on opportunities.	**MODERATE**
Regulation	We will make every effort to comply with regulation and will explain our approach.	**MODERATE**
Legal	We will comply with the law.	**LOW**
Innovation / Technology	We change how we deliver care to meet the challenges of the future by actively pursuing digital innovation, while providing safe, effective and efficient care for patients.	**HIGH**
Commercial	We explore new opportunities which will enhance and support our core business and reputation for providing patient care.	**HIGH**
Harm and safety	We take as little risk as possible when it comes to harm and safety to keep our patients safe and achieve the best clinical outcomes.	**LOW**
Workforce	We have one Culture of Care with colleagues looking after each other as well as the people we care for, ensuring patient safety and promoting the well-being of our staff.	**LOW**
Quality innovation and improvement	We seek innovation in the way we deliver services and employ staff as a key enabler for improving quality, patient safety and experience.	**SIGNIFICANT**
Partnership	We accept a level of risk in working with partners to support service transformation and operational delivery.	**SIGNIFICANT**

HEAT MAP

LIKELIHOOD (frequency)	CONSEQUENCE (impact / severity)				
	Insignificant (1)	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Extreme (5)**
High Likely (5)			6/19 Compliance with quality standards =	1/23 Demand and bed capacity !	
Likely (4)			02/20 Digital Strategy =	18/19 Long term financial sustainability = 8/19 National and local performance targets = 10a /19 Medical Staffing levels = 10b/19 Nurse Staffing levels ↓ 3/23 Partnership governance !	1/19 Approval of hospital reconfiguration outline business case and full business case =
Possible (3)			2/23 Anchor institution & social value !	1/22 Health and Well-Being and leadership = 4/19 Patient & Public Engagement = 04/20 CQC rating = 14/19 Capital = 11/19 Recruitment and retention = 01/20 Clinical Strategy = 07/20 Health Inequalities =	9/19 HRI Estate fit for purpose =
Unlikely (2)			16/19 Health & Safety =	6/20 Sustainability =	
Rare (1)					

= no change to risk score ! is a new risk ↓ redued risk score

Assessment is Likelihood x Consequence

BOARD ASSSURANCE FRAMEWORK
JUNE 2023
TRANSFORMING SERVICES AND POPULATION OUTCCOMES

TRUST GOAL: 1. TRANSFORMING SERVICES AND POPULATION OUTCOMES										
Ref & Date added	**OWNER** Board committee	Exec Lead	**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING JUNE 2023** Risk category: Strategic Risk appetite: Significant		
								Initial	Current	Target
1/19	Board of Directors / Transformation Programme Board	Deputy Chief Executive / Director of Transformation & Partnerships	Risk that the Trust does not secure approval of the Hospital Services Reconfiguration, Outline Business Case (OBC) and Full Business Case (FBC) from NHSI, DHSC, Ministers and HM Treasury and as a result the Trust is unable to progress changes that will improve the quality of care, workforce resilience and mitigate estate risks **Impact** Trust unable to improve long term clinical quality and deliver compliance with statutory, regulatory and accepted best practice.	Formal governance structures established: - Transformation Programme Board, formal sub-committee of the Trust Board oversees service transformation and reconfiguration plans. - Quarterly review meetings with NHSE&I, and DHSC colleagues to advise on planning assumptions used in business cases to ensure compliance with HM Treasury and DHSC requirements and facilitate future approval(s). External professional and technical capacity and expertise procured with design partner appointed in March 2020. Turner Townsend have been appointed to provide a Project Director. Close working with: - Joint Health Scrutiny Committee, wider stakeholders and colleagues to ensure full involvement in the development of the plans and business cases. - West Yorkshire Health & Care Partnership and Calderdale Cares Partnership and Kirklees Health and Care Partnership to ensure alignment of the reconfiguration plans with their strategic objectives to facilitate the ICS and Place based formal letters of support for the business cases. A Round Table Board is established that has members from NHSE, WY ICS, DHSC, Calderdale and Kirklees Places and meets quarterly to ensure system alignment and support for business case planning assumptions and development.	First line Transformation Programme Board-oversight of governance and content of business case development including relationship management with Stakeholders and the ICS, NHSE/ DHSC Second line Trust Board approval of business cases (SOC approved, March 2019). Reconfiguration OBC and FBC for new A&E at HRI approved by Trust Board in October 2021. Travel Plan approved by the TPB and the Green Plan by the Trust Board. Planning Permission for the new A&E at HRI was approved in September 2021. Planning Permission for the build of a Multi-storey car park and the new clincal buildings at CRH was approved by Calderdale Council in March 2022 Third line ICS and NHSE review and approval of business cases prior to submission to DHSC. SOC approved by DHSC in November 2019. FBC for new A&E at HRI approved by NHSE Joint Investment Sub-Committee (JISC) in December 2021. Construction of the new A&E is in progress and remains on schedule for completion in Summer 2023. The Reconfiguration OBC was approved by NHSE Joint Investment Committee (JIC) on 25th February 2022. Reconfiguration OBC submitted for approval by Treasury.	• See below for further detail. 1. Her Majesty's Revenue and Customs (HMRC) advice on preferred procurement route 2. Agreement for development on the CRH site.	Work has been undertaken and presented to Transformation Programme Board (TPB) to define the skills and capacity needed for next stage of the programme to develop the Reconfiguration Full Business Case. Approval has been given to secure the necessary additional capacity / expertise. Project structures for the next phase of work have been implemented and progress is reported into the TPB each month.	5x5 = 25	5x4 = 20	2x5 = 10

Gaps in Control	Timescales	Lead
1.Trust and CCGs need to agree clinical protocols with Yorkshire Ambulance Services to ensure patients are transported to the hospital that provides the services that will meet their clinical needs – whether this is in Halifax, Huddersfield or other specialist providers, such as Leeds. 2. The Trust must obtain advice from Her Majesty's Revenue and Customs (HMRC) regarding the preferred procurement route through the Trust's wholly owned subsidiary (Calderdale & Huddersfield Solutions Ltd). 3. The Trust will have concluded discussions with the PFI Special Purpose Vehicle (SPV) to enable the development on the CRH site. 4. Provision of aditional car parking at CRH.	1. Discussions have taken place with YAS and activity modelling and clinical protocols have been agreed. 2. The Trust has written to HMRC regarding the preferred procurement route through Calderdale and Huddersfield Solutions. 3. An agreement with the PFI Special Purpose Vehicle has been developed and is progressing to completion -this will require Treasury approval. 4. Build of a Multi-storey car park at CRH by 2024.	AB for all actions

Links to risk register from current service configuration:
2827 - over reliance on middle grade doctors in A&E - workforce standards, A&E and critical care
7413 - fire compartmentation risk HRI

BOARD ASSSURANCE FRAMEWORK
JUNE 2023
TRANSFORMING SERVICES AND POPULATION OUTCCOMES

TRUST GOAL: 1. TRANSFORMING SERVICES AND POPULATION OUTCOMES										
Ref & Date added	**OWNER** Board committee	Exec Lead	**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING JUNE 2023 Risk category: Strategic Risk appetite: Significant**		
								Initial	Current	Target
Ref: 01/20 Added July 2020	Transformation Programme Board (TPB)	David Birkenhead, Medical Director	Risk of not delivering the ambitions described in the Trust clinical strategy due to lack of collaboration across the West Yorkshire system to enhance the quality and resilience of clinical services due to lack of time, commitment, relationships and absence of shared vision, resulting in missed opportunities in terms of quality, efficiency, capacity, patient experience and workforce NB: See 1/19 reconfiguration risk which has signifcant overlap with this risk	Refreshed Clinical Strategy - describes Trust position on service development across West Yorkshire (WY) Transformation Programme Board - clinical strategy informing decisions made to reconfigure services and ensure that the redesigned hospital model is fit for purpose (see BAF risk 1/19 reconfiguration) ICS - member of the WY& H Partnership Board which agrees service direction, strategy and financial allocations and controls. More effective working relationships with partners and establishment of networked approaches to Pathology and Vascular Surgery. Transformation Programme Board ensures estate is aligned with the clinical strategy. Recently established Planned Care Alliance to co-ordinate and plan phased approach to reset, including redesign to planned care Member of WYAAT which identifies, agrees and manages programmes of work targeted to improve services and patient experience across West Yorkshire. WYAAT governance framework with specific forums for acute Trusts including Chief Exec forum, Committeee in Common and programme office with oversight. Recruiting for additional Oncology staff to strengthen capacity Report into Oncology Services for WY by Mike Richards complete and supports CHFT as a hub. Independent reivew report (Dec 2021) recommends two site service model for NSO. CHFT Medical Director Chairs South sector implementation Board for NSO. Project Manager support. Target Operating Models in process of agreement. CHFT/ MYHT Partnership Board established which discusses fragile services and fosters closer working relationships CHFT partner at Calderdale and Kirklees PLACE level clinical and professional forums,Quality Forum and PLACE Boards (sub group of ICB) to agree local health priorities and strategy. CHFT Medical Director appointed as SRO for South Pathology Network	**First Line** Clinical strategy developed and shared with WEB (23.5.19.) **Second Line (Board / Committee)** Clinical strategy - Board 4 July 2019 (private), refreshed Clinical Strategy July 2021 Board approved Response to COVID-19 has by necessity driven enabling work for the strategy, including remote working, developments in community care, and virtual outpatients. New Pathology Partnership Update to January 2023 Board (CHFT Medical Director is SRO) LIMS implemetation progressing, CHFT planned for 2024. Managed service contract for laboratory equipment currently in procurement phase. Laboratory in Leeds to support the Pathology network is nearing completion. **Third Line** Vascular network established with Bradford WYAAT Pathology Board established. Diagnostics Board and Imaging Collaborative established across West Yorkshire	Non-Surgical Oncology (NSO) - acute system pressures across WY require additional support from CHFT. Working with MYHT to ensure short term service support in place, whilst sustainable WY solution in place. Action: Public engagment led by system partners on NSO service model commenced, runs to end of August 2023. West Yorkshire and Harrogate WYAAT Clinical Strategy under development. Action: WYAAT clinical lead refrehsing clinical strategy ICS to develop clinical strategy - ICS Medical Director to confirm timeframe WYAAT and ICS system-wide approaches to reset. Performance of CHFT in relation to Covid recovery programme may reduce ability to deliver new services Action: Extend Trust clinical strategy to include research and innovation strategic ambitions. Lead: Deputy Medical Director 31 July 2023 Trust financial deficit position may limit development of new services -see BAF risk 18/19 long term financial sustainability	Review alignment of Trust clinical strategy with ICS 5 year plan for Better Health and Well-Being for everyone. Lead: David Birkenhead Timescale: 31.1.24. (dependent on completion by ICS)	3x5=15	3x4=12	3x3=9

Action	Timescales	Lead
Extend Trust clinical strategy to include research and innovation strategic ambitions WYAAT - Refresh of West Yorkshire Clinical Strategy, incorporating work on fragile services ICS Clinical Strategy to be developed - Medical Director to confirm plans Review alignment of Trust clinical strategy with ICS 5 year plan for Better Health and Well-Being for everyone	31 July 2023 WYAAT to confirm ICS Medical Director to confirm 31 January 2024	Deputy Medical Director David Birkenhead, Medical Director WYAAT clinical lead / WYAAT Chief Executives, David Birkenhead

Links to risk register: None
See 1/19 reconfiguration BAF risk and 18/19 financial risk

BOARD ASSSURANCE FRAMEWORK
JUNE 2023
TRANSFORMING SERVICES AND POPULATION OUTCCOMES

TRUST GOAL: 1. TRANSFORMING SERVICES AND POPULATION OUTCOMES										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING JUNE 2023 Risk Category; Innovation/Technology Risk Appetite: High**		
								Initial	**Current**	**Target**
02/20 July 2020	Transformation Programme Board	Managing Director - Digital Health	Risk of not securing appropriate investment to fund and deliver the Digital Strategy ambitions, ensuring infrastructure and technology is up to date and future proof due to funding not being available locally and nationally impacting on workforce efficiency and patient experience	Year 3 of 5 year Digital Strategy and continued review by Weekly Executive Board and annually to Board which will meet the needs and build the foundation for the next 5 year digital strategy Continued central funding available and committed capital funding from the Trust which will enable progression. Joint Director of Digital Operations and Delivery role co-ordinating digital programmes and providing leadership whilst maintaining alignment toTrusts operational needs. Year 3 of the Digital Strategy (23/24 digital/EPR plan) focuses on improving on the digital basics and optimised use of existing systmes where funding may not be available. Governance via Digital Health Forum and Digital Operations Board.Digital Operations Board chaired by Chief Digital and Information Officer (CDIO), with reviewed terms of reference Monthly meetings with Chief Digital and Information Officer (CDIO) and Director of Finance reviewing progress with digital investment strategy. Divisional Digital Boards ensure appropriate spend of investment and report into the Digital Operations Board which has oversight of investment in line with strategy. EPR team restructured to ensure sufficient capacity and capability, with funding to support third Trust via project. CNIO and CCIO play a key role in the Digital Prioritisation Process (part of the Digital Health Team). COO, Chief Nurse,and Medical Director supporting the direction of digital developments in line with CHFT operational requirements. Clinical Change resource in place to help aid digital adoption and deliver benefits.	**First Line:** Digital Operations Board meeting bi-monthly, programme of work and progress presented at each meeting. **Second Line** Board approved Digital Strategy and associated investment plan (2 July 2020) provides direction . Additional funds for digital capital expenditure for 2023/24 secured. 10 November 2022 Digital Strategy Progress and Update to Board with plan to 2025. 2 September 2021 Board approved THIS Commercial Strategy confirms the Trust contribution target and allows for re-investment into THIS. Review 10 November 2022 Board. BCAG provides assurance that digital benefits are realised and digital business cases are aligned to the Trust Digital Strategy. **Third Line:** Digital Aspirant Trust Scan for Safety Programme in progress. WYAAT Chief Information Officer meetings ensures alignment of stategy on regional digital deployment.		Availability of funding - continual monitoing of central funding available for digital investment. Lead: CDIO - ongoing	**4x3 = 12**	**4x3 = 12**	**3x3=9**

Action	**Timescales**	**Lead**
Monitoring via Finance and Performance Committeee Monitoring of availability of central funding for digital investment	Ongoing Ongoing	Gary Boothby Rob Birkett

Links to risk register see linked 1/19 reconfiguration risk

BOARD ASSSURANCE FRAMEWORK
JUNE 2023
TRANSFORMING SERVICES AND POPULATION OUTCCOMES

TRUST GOAL: 1. TRANSFORMING SERVICES AND POPULATION OUTCOMES										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING JUNE 2023 Risk category: Harm and Safety Risk appetite: low**		
								Initial	**Current**	**Target**
07/20 Added July 2020	Trust Board	Deputy Chief Executive	Risk of failing to respond to the health inequalities that exist within our populations due to lack of quality priorites to advance health equity, incomplete population health and patient ethnicity data, helthcare service delivery not matching patient needs in the most deprived areas or lack of resource allocation and programmes for health prevention, resulting in the Trust not reducing health inequalities for our most vulnerable patients with protected characteristics.	Deputy Chief Executive is the named Board Executive providing accountable leadership for tackling health inequalities. 2022-2024 Population Health and Inequalities Strategy approved at November 2022 Board with updates to Board throughout the year. Strategy focussed around four key areas of priority: Connecting with our communities and partners Access and prioritisation Lived experience and outcomes Diverse and inclusive workforce Health Inequalities Group, chaired by Deputy CEO, ensures oversight of all Trust workstreams in relation to health inequalities. Progress against delivery of Health and Inequalities Strategy reported regularly into the Trust Board. Equality impact assessment (EQIA) process for service and policy changes.	**First Line** - Trust-wide health inequalities group meets monthly and oversees the organisations action plan and response to health inequalities. Health inequalities consideration and understanding included as a core element of all services supported by the development of data and performance information to enable greater activity analysis of access and outcomes through routine performance monitoring. **Second Line** - Progress against delivery of Health and Inequalities Strategy reported formally into the Trust Board on a quarterly basis (July 2023). Approved Board succession plan seeks to ensure clear talent pipelines for each Executive and non Executive roles in the Trust, including actions to ensure inclusive recruitment, and actions to ensure that the Board reflects the gender make up of local communities. EQIA referenced in all Board paper front sheets **Third Line** The Trust is working in collaboration as part of the West Yorkshire (WY) Integrated Care Board, WY Association of Acute Trusts and WY Community Collaborative, as well as continuing to showcase work nationally.	Continue to explore approach to diversity with WYAAT and ICB colleagues to ensure a regional approach. The Trust is working to deliver NHS wide high impact actions in respective of equality and diversity. Lead: Director of Workforce and Development Timescale: September 2023 Update in relation to use of patient level demographic information to prioritise clinical care - methodology current being trialled within cancer pre-habilitation service. Further plans to use the tool to identify those at higher risk of non-attendance at outpatient appointments. Lead: Deputy Chief Executive Timescale: 30.9.23. Population Health - continue to develop place-based approach to population health information to inform service planning and decision making. Deputy CEO and Managing Director of HIS leading on this work on behalf of CHFT Lead: Deputy CEO and Managing Director of HIS Timescale: 30.09.23	Population Health and Inequalities Strategy (2022-24) now in place. Progress against action plan underway	4x4=16	4x3=12=	2x4=8

Action	**Timescales**	**Lead**
Action Plan for more diverse Board and senior staffing consistent with local community and explore with WYAAT /ICBs	September 2023	Suzanne Dunkley
Development of tool to prioritise clinical care based on pateint demographic information to prioritise clinical care	30.9.23.	Rob Aitchison
Development of Place-based approach to population health information for service planning	30.9.23.	Rob Aitchison / Rob Birkett

Links to risk register: 2827

BOARD ASSURANCE FRAMEWORK
JUNE 2023
KEEPING THE BASE SAFE - Best Quality and Safety of Care

TRUST GOAL: 2 KEEPING THE BASE SAFE BEST QUALITY AND SAFETY OF CARE										
Ref	**OWNER** Board committee	Exec Lead	**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING** **JUNE 2023** **Risk category: Regulation** **Risk appetite: Moderate**		
								Initial	**Current**	**Target**
06/19	Quality Committee	Chief Nurse/ Executive Medical Director	**Risk** Risk that patients do not receive high quality, safe care due to poor compliance with internally and externally set standards on quality and safety resulting in patient harm or poor patient experience. **Impact** - Quality and safety of patient care and Trust's ability to deliver some services. - Enforcement notices with regulators - Ability to deliver national targets and CQUINS. - Increased risk of litigation and negative publicity. - Poor staff morale	• Quality governance arrangements monitor quality and safety bi monthly reports to Quality Committee for assurance , Monthly reports to Trust Patient Safety Quality Board for oversight and scrutiny • Quality and Safety strategy in place, currently under review, clinical division report into performance review meetings on delivery of the ambitions of the strategy and strengthened quality section in performance review meetings (analysis of quality and safety priorities) • Quality Committee scrutinises quality priorities with specific KPIs in place, and the Maternity Transformation Plan • Serious incident (SI) investigation process identifies recommendations to improve care with strong governance in place and process in place to address any immediate learning • Clinical Effectiveness and Audit Group (CEAG) reviews assurance on guidance and national audits • Clinical Outcomes Group monitors workstreams for patient safety and quality, reporting into Quality Committee • Risk management strategy revised and refreshed, trengthened risk management arrangements at divisional level. • Patient Safety Incident Response Framework (PSIRF) and draft investigation model that aligns with PSIRF framework implementation plan now in place, with aligned and approved Incident Reporting Policy • Board approved Infection Prevention Control (IPC) Board Assurance Framework (BAF) •Compliance register refresh and scrutiny by Compliance Group • Focused Journey to Outstanding (J2O) programme • Ward assurance visits programme - clinical area quality dashboard reviewed at at Nursing and Midwifery Workforce meeting. Process in place for reviewing quality metrics at ward and department level, reviewed and aligned to CQC key lines of enquiry • Care of the Acutely Ill Patient programme in place to improve mortality outcomes • Nursing and Midwifery Strategy (October 2021) details minimim staffing requiremets and quality standards for patient care. • Children and Young Peoples Improvement Plan	First line Assessment of compliance with NICE guidance with increased oversight at CEAG. Performance against safety must dos reviewed at ward / matron level. HSMR & SHMI. Consistent mandatory and essential training compliance Improved real time assurance on impact of safety staffing and quality - Nursing Midwifery Workforce Group Second line Clinical audit plan reviewed with increased oversight at CEAG Bi-monthly Quality Report to Quality Committee, QC highlight report to Board. Maternity report to Quality Committee. Regular report to Board on maternity - response to Ockenden review KPIs in Integrated Performance Report, PSQB reports to Quality Committee. 6 July 2023, Board report on Infection Control and progress with IPC BAF recommendations. June 2023 signifcant assurance opinion on IPC BAF following internal audit review, Board approved Risk Management Policy May 2023 Serious incident report to Quality Committee which includes lessons learnt section and "backlog" investigations addressed with positive feedback from CCG . Safer Staffing Hard Truths report to Board 10.11.22., 6.7.23. Refreshed Nursing and Midwifery Strategy (2021) approved by Quality Committee and Board. Maternity Services report to Board (March, May, July 2022) Complaints performance improved allowing time to focus on learning from complaints, with themes and trends identified and linked to Quality Priorities 2023/24. Ward to Board internal audit significant assurance opinion reviewed by Quality Committee (May 2023). Third line CQC rating of Good, regional Ockenden Assurance Visit (28.6.22.)CQC In patient Children's and Young Peoples survey 2021 and visit 2022. Quality Account reviewed by stakeholder bodies for 2021/22 with positive feedback . Independent assurance on clinical audit strategy. Feedback through ongoing relationship with arms length regulatory bodies. CQC TMA visits have taken place in ED, Maternity, Surgical Services and End of Life Care.Independent Service Reviews (ISR) and accreditations. Health Services Investigation Branch reports and on site visits	• Review of quality and safety team structure and strategy underway Lead: Deputy Chief Nurse Timescale: Completion by August 2023 • Plan to transfer Infection Prevention Control (IPC) Board Assurance Framework to new NHS England framework which is evidence-based to ensure compliance with IPC standards and develop IPC action plan to include gaps in the IPC BAF. Lead: Medical Director Timescale: September 2023 Risk register training for divisional staff to support improved use of risk register to accurately identify risks to quality and safety of care Lead: Deputy Chief Nurse Timescale: September 2023 Integrated Provision in the community: relative immaturity of Place-based quality and safety governance and assurance and regulatory/ statutory prvider framework for integrated care.	• CQC report following matenrity inspection awaited CQC assessed the Trust as requires improvement for safe domain - no further inspection since 2018 Internal audit further review of quality governance structure during 2023/24 Q3 Internal audit review of risk management processes Lead: Chief Nurse, Director of Corporate Affairs Timescale: December 2023 IPC BAF to be presented to the Infection Control Committee quarterly from July 2023 Lead: Chief Nurse Integrated provision in the community - potential for system partners to undertake gap analysis	3x5 = 15	3x5= 15 =	2x5 = 10

Action	Timescales	Lead
Review of quality and safety team structure	August 2023	Deputy Chief Nurse
Risk register training for divisional staff	September 2023	Deputy Chief Nurse
Implementation of recommendations re: quality governance structure and internal audit follow up review	December 2023	Medical Director / Chief Nurse
IPC BAF transfer to new framework and share at Infection Control Committee	September 2023	Chief Nurse

Links to risk register:
Also see BAF risk re clinical strategy ref add
7615 emergency care delays not meeting the 4 hour emergency care standard, 6715 inconsistent completion EPR documentation, 6035 C difficile infections, 8429 Cardiology PCI / angiogram wait, 8009 out patient capacity Integrated Medical Specialties, 6078 out patient follow up, 7689 out patient, diagnostic waits, 8283 radiologu demand and capacity, 8509 Opthalmology insufficient glaucoma out patient appointments, 8358 Opthalmology (corneal appointments), 7640 Pharmacy staffing
See also BAF risks 10a/19 and 10b/19 relating to staffing

BOARD ASSURANCE FRAMEWORK
JUNE 2023
KEEPING THE BASE SAFE - Best Quality and Safety of Care

TRUST GOAL: 2 KEEPING THE BASE SAFE BEST QUALITY AND SAFETY OF CARE										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING JUNE 2023 Risk category: Regulation Risk appetite: Moderate**		
								Initial	**Current**	**Target**
04/20 July 2020	Quality Committee	Chief Nurse	Risk of not maintaining the Trust CQC overall rating of good and increasing the number of services achieving an outstanding rating as assessed by the new CQC single assessment framework and potential for ratings to be changed by CQC based on other intelligence or data from CQC portal outside of on site inspection of services, due to failure to comply with quality statements resulting in a reduction of quality of services to patients and an impact on reputation See BAF risk 6/19 - quality of care and poor compliance with standards	CQC Group with refreshed terms of reference meets monthly, oversee compliance with regulatory standards/ -and reports to Quality Committee, monitoring progress against 2018 must do and should do actions. Action plans in place re: must do and should do actions from 2018 CQC report, compliance with medical staffing in ED dependent on reconfigutaion and GPICS standards on critical care. Regular engagement meetings with CQC and on site focus visits taking place Process for internal assessment against CQC standards (Journey to Outstanding) Dedicated CQC lead Independent Well-led Governance development review completed. CQC resource centre portal for staff with information on CQC reports, standards, self assessment documentation. Ward accreditation processes (Journey to Outstanding) reviewed and updated, piloted and being rolled out. Journey to Outstanding (J20) implemented with increased breadth and depth of assurance - working towards business as usual model Focused Journey to Outstanding programme review of maternity services	**First Line:** Reports to CQC & Compliance Group from divisions with increased scrutiny Journey to Outstanding results and action plan and findings shared with wards and presented to CQC & Compliance Group . Also have focused J20 process Divisional review of must do and should do actions from 2018 CQC report, September 2022 **Second Line:** Quality Committee reports from CQC Group and as part of Bi monthly quality report Quality update report to each Board bi monthly CQC well-led governance phase 2 report shared at Board workshop July 2021 Board Development Session 7 October 2021 on CQC effective domain. Maternity Services Update to Board 5.5.22. , review and assessment against East Kent Maternity report (10 November 2022) Caring Domain CQC Board Development Session 9.6.22. Update on CQC with Board at Board Development session, including review of quality statements February 2023 **Third Line:** Formal engagement meetings with CQC and rolling programme of on site visits. Current CQC rating of "good" including well-led governance Board well-led interviews undertaken by external reviewer as part of Board Development Programme CQC maternity review undertaken June 2023	Framework not yet developed at PLACE level for system / PLACE based CQC reviews under new regulatory framework. Action: progress through PLACE based Quality architecture. Lead: Medical Director / Chief Nurse Timescale: December 2023	CQC maternity report due in next few months with potential to impact rating. 2023 move to Single Assessment Framework for future CQC inspections and rating regime. Towards the end of 2023 CQC will gradually start to carry out assessments in the new way. This means a new approach to inspection and new assessment framework. In summer a new online provider portal will be lunched. This will be done in stages and provide support and guidance. In the first stage: Providers will be able to submit statutory notifications CHFT now have access to this portal and will submit notifications via this methodology for greater level of assurance	4x3=12	4x3=12	3x2=6

Action	**Timescales**	**Lead**
Journey to Outstanding implementation underway via rolling programme including focused visits Well -led governance assessment for senior leadership team Development of PLACE level framework for system reviews with partners	12 month rolling programme July 2023 December 2023	Chief Nurse Director of Corporate Affairs Chief Nurse

Links to risk register:
None

BOARD ASSURANCE FRAMEWORK
JUNE 2023
KEEPING THE BASE SAFE - Best Quality and Safety of Care

TRUST GOAL: 2 KEEPING THE BASE SAFE BEST QUALITY AND SAFETY OF CARE										
Ref & Date added	**OWNER** Board committee	Exec Lead	**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING JUNE 2023 Risk appetite: Low (Ham and Safety)**		
								Initial	Current	Target
1/23 June 2023	Finance and Performance Committee	Chief Operating Officer	Risk that continued high acute demand, high patient acuity and shortfall in community provision leads to the requirement for additional beds over and above planned levels. This results in staffing and financial pressures.	The Urgent and Emergency Care Delivery group (UECDG) is the overall assurance meeting for the delivery of Urgent and Emergency Care and reports to the Finance and Performance Committee and the Trust's Transformation Programme Board. The UECDG meets on a monthly basis to strategically review the performance of UEC delivery through the data dashboard and the improvement groups. The UECDG has two focused Improvement Groups: Same Day Emergency Care (SDEC) and Length of Stay (LOS), latter has phased reduction plan The Improvement Groups are supported by project Task and Finish groups. The Task & Finish Groups provide monthly data-led updates into the appropriate Improvement Group for appropriate discussion, challenge and steer. The Improvement Groups report assurance of the delivery of UEC into the UECDG. Working with partners in Calderdale and Kirklees to agree target operating models for integrated community urgent and intermediate health and care models of care (with interfaces to single points of access and neighbourhood teams). Target operating models to frame effective use of business as usual and transformation based monies aligned with Place and wider system objectives. Agreement in principle with Calderdale partners on target operating model, gap analysis against and use of recurrent and non-recurrent funding to support delivery against that gap analy	**First Line** Length of stay improvement group in place meteing monthly. Separate working groups in place with clear leads that report in to the improvement group. Same Day Emergency Care (SDEC) improvement group in place . Seperate working groups with clear leads that report in to the improvement group. ED improvement workstream led by ED directorate Senior Management Team. **Second Line** Urgent and Emergency Care delivery group chaired by COO, meeting monthly, improvement workstreams report in to U and E CDG, against identified KPI's. U and E CDG reports in to Finance and Performance committee which reports in to Trust Board. **Third Line** NHS England (NHS E) monitoring and production of reports linked to Emergency Department and bed occupancy. Monthly meetings with COO and NHSE. Calderdale and Huddersfield U and E care Board meets monthly with community teams, ICB and Local authority representation.	Engagement with clinical teams at ward level in relation to well-organised ward. Action: Sessions planned June / July 2023 Lead: Chief Operating Officer, Director of Workforce and OD and Chief Nurse Kirklees community provision and commissioning models for that provision . Action:ongoing discsussion with Kirklees partners Lead: Director of Operations Community Michael Folan, Deputy Chief Executive, Chief Operating Officer	Absence of agreement in principle with Kirklees partners on target operating model, gap analysis against and use of recurrent and non-recurrent funding to support delivery against that gap analysis. Lack of assurance re capacity and provision of social care System-wide discussions regarding programme of work focused on Home First and move away from discharge to assess beds. CHFT to continue to work with partners. Lead: Chief Operating Officer and Deputy Chief Executive Timescale: 31 October 2023	4 x 5 = 20	4 x 5= 20	4x3=12

Action:	Timescales	Lead
Sessions with ward teams Impact of pay pressures on workforce availability being reviewed System wide discussions re Home First	01/07/2023 October 2023	Chief Operating Officer, Director of WOD and OD, Chief Nurse COO & Deputy Chief

High level risks: 8034 acute in patient bed base, 7689 waits out patients, diagnostics, routine operations, 8283 radiology demand, 8324 volume for clinical out patient validation,

BOARD ASSURANCE FRAMEWORK
JUNE 2023
KEEPING THE BASE SAFE - Best Quality and Safety of Care

TRUST GOAL: 2 KEEPING THE BASE SAFE BEST QUALITY AND SAFETY OF CARE										
Ref	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING JUNE 2023 Risk category: Strategic Risk appetite: Significant**		
								Initial	**Current**	**Target**
9/19	Transformation Programme Board	Executive Director of Finance	Risk of failure to maintain current estate and equipment and develop future estates model to provide high quality patient care Impact - Poor quality of care and treatment - Poor patient experience - Poor staff experience and negative impact on their health and wellbeing - Regulatory action - Inability to implement service change - Reputational damage with stakeholders	• Governance arrangements and SLAs with CHS monitored at CHS Board, monhtly contract and performance meeting with quarterly CHS / Trust Joint Liaison Committee,overseeing estate, facilities and medical engineering risks • Governance arrangement and performance contracts with PFI monitoring at monthly Contract & Performance meetings in place. • Systematic review of Divisional and Corporate compliance, • Funding secured for ED HRI and MSCP CRH and in 2022/23 capital plan • Medical device and maintenance policies procedures, Planned Preventive Maintenance (PPM) Programme - improvements made to PPM and end of life service contracts •Premises Assurance Model (PAMs) illustrates to patients, commissioners & regulators that robust systems are in place in regarding the premises and associated services are safe • CHS Medical Engineer in post • Categorisation / risk analysis of medical devices (high, medium, low) to prioritise maintenance • Independent audit of medical devices • Health Technical Memorandum (HTM) compliance structure in place including external Authorsing Engineers (AE's) who independantly audit both CRH and HRI Estates against statutory guidance. • Authorising engineer for fire •Concordat with West Yorkshire fire authority * Quarterly PFI Liaison Committee established Oct 2020 with PFI & CHFT to receive assurance against compliance, Plans in place to demolish DATs building to reduce backlog maintenance. Head of Estates and H&S lead from CHS now attend the Risk Group to align Trust and CHS risk registers • 6 monthly insepctions of cladding at HRI with report to CHS Board and Transformation Programme Board - programme of cladding works towards the end of the reconfiguration timetable supported by the Transformation Programme Board 19 December 2022 Capital has been secured for 20202/23 to meet the 2022/23 plan and requirements as agreed in the annual internal capital planning round.	First line • Close management of service contracts to ensure planned maintenance activity has been performed. Audit plan in place for both PFI and CHS and regular audits completed by Service Performance. Risk register reports. Joint HTM Meetings in place with Trust,PFI & CHS. Audits of routine checks, estates * Trust Health & Safety Manager with oversight of H&S across Trust & between partners. Audit of HTM Compliance to confirm appropriate control measures in place to manage the HRI and community estate completed Q1 2023. Second line Estates strategy (revised) approved at Board 2.9.21. H&S Update to Board: January 2022. Priorities shared with Service Performance to implement with CHS/PFI Board review of feasibility study for development of HRI which mitigates known estates issues (5 March 2020 private Board) Health and Safety Committee monitors medical devices training and escalates concerns to Audit & Risk Committee (Audit & Risk to approve newly developed H&S Committee TORs) Medical Engineering Committee monitors medical devices action plan, new equipment and addresses risk analysis of devices Review of PFI arrangements, via Service Performance Audits / Reports. Assurance provided by HTM Compliance reports via external Authorised Engineers inspections against HTM standards. WEB reports on medical devices July 2019 6 Facet estate condition survey presented to Board 4 July 2019 is informing estates investment plan for HRI Third line CQC Compliance report.PAMS. HSE review of water management. Familiarisation visits by local operational Fire and Rescue teams. External assurance from authorising engineers for high voltage/ low voltage systems.PLACE assessment (Patient-Led Assessments of the Care Environment) undertaken October 2022 by Quality Performance and Service Manager	• Multi Storey Car Park - the Trust awaits the outcome of the business case review process with HM Treasury before further progress can be made.		4x4 = 16	5x3= 15	2x4 = 8
Action					**Timescales**			**Lead**		
Review of HTM compliance					Complete by 30.6.23.			Head of Estates		
Links to risk register: Risk 7413 - Fire compartmentation risk, HRI ,8415 angiography (flouorscopy equipment)										

BOARD ASSURANCE FRAMEWORK
JUNE 2023
KEEPING THE BASE SAFE - Best Quality and Safety of Care

TRUST GOAL: 2 KEEPING THE BASE SAFE BEST QUALITY AND SAFETY OF CARE										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING JUNE 2023 Risk category: Regulation Risk appetite: Moderate**		
								Initial	**Current**	**Target**
16/19 9/1/20	Audit and Risk Committee	Director Champion - Chief Operating Officer	Risk of not being compliant with the Health and Safety at Work Act (1974) and supporting regulations resulting in harm to staff, patients, the public, visitors, potential regulatory failure, finanical risk and reputational damage	•Board approved 5 year H&S strategy NHS Workplace Safety Standards provides framework for H&S activity, relevant policies reviewed and shared with stakeholders specific to roles and responsibilities (policy tracker written). The Strategy has been revised in early 2023 •General Health and Safety Policy (updated early 2023) clearly highlights the overarching roles and responsibilities and arrangements to achieve compliance • Individual health and safety policies under continuous review across 2022/23 and shared with CHFT Resilience and Safety Group Meeting - each policy with individual subject matter expert ownerships • SLA in place for CHS to provide Health and Safety Induction Training of on-site contractors and visitors • Executive Director Health and Safety Champion identified • Proactive Resilience and Safety Group Meeting firmly established. • Head of Health and Safety involved in all new sub committees to H&S committee. 8 H&S subgroups formed - maintains traction upon stakeholder responsibilities • Annual report on Health and Safety to Board which is to be a combined fire, security and health and safety risk paper and presented for 2023 submission • Health and Safety with updates to Board, Audit and Risk Committee oversight and attendance to present at Quality Committee every 6 months . • Health and Safety mandatory ESR training for staff (3 years). Auditing and monitoring of compliance via new health and safety dashboard - a visual representation of compliance and is presented at each Resilience and Safety Group Meeting. Desktop meetings take place between the subject matter lead and the Head of Health and Safety across the year to ensure/seek assurance of continuous compliance - so sign off October 2023 Resilience and Safety Group Meeting	First line Minutes of the Resilience and Safety Group Meeting evidence good level of engagement by all partners. Review of Resilience and Safety Group Meeting by members confirmed good sharing of current information, monitoring of trends, review of policies, sharing of health and safety incidents and learning, medical devices training & monitoring, fire and security information . Second line Board joint responsibility for risk understood with Weightmans Solicitor Legal update given in 2023 WEB reports on mandatory training, health and safety training compliance -Resilience and Safety Group Meeting to Audit and Risk Committee, with annual deep dive. Quality Committee engagement planned for 2022, 18 October 2022 and then every 6 months with last update in early 2023yr. Audit Yorkshire January 2021 9 January 2020 external Health and Safety review presented to Board • 2021/22 Annual Health and Safety report and action plan to Board - 12 January 2023, May 2023 • Health and Safety Strategy revised September 2022, review of 2023 - 2028 Strategy by Audit and Risk Committee 31.1.23. Updates to Board on H&S 3 September 2020, 14 January 2021, 1 July 2021, 13 January 2022, Third line External health and safety review (Quadriga) 2019.	Development and implementation of NHS Workplace Health and Safety Standards - 90% achieved (10% left = Security compliance and COSHH compliance), Lead: Head of H&S Timescale: November 2023 Action: COSHH = recently formed COSHH sub group meetings with key Users every 3 months to review COSHH incidents / near misses and compliance status of completed COSHH assessments. COSHH sub-group although new requires embedding longer term, and this will take place naturally as the meetings become BAU. Security = a security improvement plan has been written and sets out SMART actions Lead: Richard Hill Timescale: Summer/Autumn 2023.	COSHH = compliance key remaining part of the NHS Standards and a sub-group has been set-up to achieve compliance. Security = compliance key remaining part of the NHS Standards and a clear set of actions has been produced, to ensure security compliance is achieved and this is being implemented across the Summer into Autumn months of 2023	3x3 = 9	3x2 =6 =	3x1 = 3

Action	**Timeframe**	**Lead**
Development and implementation of NHS Workplace Health and Safety Standards (10% remaining to do)	November 2023	Head of H&S all actions
Embed COSHH sub group	December 2023	
Delivery of security improvement plan	Autumn 2023	

Links to risk register:

BOARD ASSURANCE FRAMEWORK
JUNE 2023
KEEPING THE BASE SAFE - Best Quality and Safety of Care

TRUST GOAL: 2 KEEPING THE BASE SAFE BEST QUALITY AND SAFETY OF CARE										
Ref & Date added	**OWNER** Board committee	Exec Lead	**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING JUNE 2023 Risk category: Regulation Risk appetite: Moderate**		
								Initial	Current	Target
4/19	Quality Committee	Director of Corporate Affairs	**Risk** Risk that patients are not able to shape decisions about their care based on what matters to them due to lack of clear strategy and capacity for patient and service user engagement resulting in not designing services using patient recommendations **Impact** - poor patient experience - Non delivery of improvements in services - inequitable service / care for patients - Risk of legal challenge - Reputational impact	• Patient Experience Group (PEG) mandates the workplan and oversees progress and audit activity for public involvement and patient experience • Governor and Healthwatch are members of PEG •Dedicated senior leadership post for patient experience, equality and diversity and matron for complex care needs •Patient and Service User Engagement Strategy approved by Quality Committee. • Observe and Act patient observation tool as part of Journey to Outstanding reviews •Carer's Strategy approved March 2022, developed with service users and local voluntary sector organisations •Patient Story Process Map 2022 in place with a robust process for capturing, sharing, and learning through patient stories • Matron on Reconfiguration Team leads on patient experience • Complaints mapped to IMD (index of multiple deprivation) groupings • DIrector of Corporate Affairs Chairs Calderdale Place Communications, Involvement and Equality Group and have members on the Kirklees equivalent	**First line** Patient Experience Group Quarterly report on patient and public experience and equality to Quality Committee Examples of good practice on patient and public involvement including reconfiguration programme, children's services, carers etc **Second line** Patient Story to PEG, Quality Committee and Board Governor attends PEG Director of Corporate Affairs chairs Place Communications, Involvement and Equality Group reporting in to ICB Member of Place Based story tellers network PEG reporting to Quality Committee quarterly Keep carers caring presentation to Parliament **Third line** Quality Accounts, CQC rating of Good - report referenced positive examples of patient engagement. Healthwatch reports Recent external Government led review of accessibility of Trust website led to some actions which are now all complete	1. Patient and Public Engagement Strategy requires revisions - Chief Nurse to refresh by July 2023, with sign off by Quality Committee 2. Work to do to improve compliance with Accessible Information Standard Director of Corporate Affairs to complete outstanding actions by March 2024. Affairs 3. Review of translation services contract required following patient feedback. Not clear if meeting KPIs.See action 3 below. 4. Need systematic way of capturing and reporting on patient and public engagement and its link to equality.Action:below. 5. Development of library of stories for sharing at Trust and Place level required Action: Work with story tellers network and community journalist to develop stories	Public Sector Equality Duty report was not robust for 2022/23 Action: Process agreed for key Committees to identify and populate report throughout the year to capture all relevant activity: Lead: Workforce Committee / Quality Committee Timescale: December 2023	3x4 = 12	4x3 = 12 =	1x4 = 4

Action	Timescales	Lead
1. Refresh of Patient and Public Engagement Strategy	July 2023	Chief Nurse
2. Complete actions to comply with Accessible Information Standard	March 2024	Director of Corporate Affairs
3. Review contract with translation services provder	September 2023	Director of Corporate Affairs
4. Develop reporting databased and format for quarterly report to Quality Committee and annual report to Board (PSED report	September 2023	Director of Corporate Affairs
	September 2023	Chief Nurse

Links to risk register:
No risks on the high level risk register

BOARD ASSURANCE FRAMEWORK
JUNE 2023
KEEPING THE BASE SAFE - Best Quality and Safety of Care

TRUST GOAL: 2 KEEPING THE BASE SAFE BEST QUALITY AND SAFETY OF CARE										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING JUNE 2023** Risk category: Strategic Risk appetite: Significant		
								Initial	**Current**	**Target**
3/23	Anna Basford, Deputy Chief Executie and Director of Transformation and Partnerships	Board of Directors	Risk that decision making processes and capacity of Trust colleagues is impacted due to the evolving nature of partnership governance across the system and emergent governance arangements	Ensuring we have a voice and influence at all levels within the region and places: -Chief Executive is the Chair of the West Yorkshire Association of Acute Trusts and a member of the West Yorkshire Integrated Care Board - Chair and Chief Executive attend ICS - Chair and Chief Executive members of Calderdale Place ICB - Director of Finance has role as Finance Lead for Kirklees Place - Chief Executive and Deputy Chief Executive members of Kirklees Place ICB - Other Director and senior leadership part of governance structures and workstreams at West Yorkshire and Place levels Directors in Senior Responsible Officer roles across Places Board discussions on system governance arrangements and direction of travel Round table arrangements in place for reconfiguration decision making involving regional and local partners	**First Line** • Chief Executive and Chair reports to Board • WYAAT Reports to Board • Round table discussions reported through Transformation Board **Second Line** • Trust members in Place and Regional decision making arrangements • Shared involvement in Place based reviews including safeguarding, Ofsted etc **Third Line** • Place review	Operating Model arrangments at ICB level not yet clear Action: Invite ICB CEO to provide an update to Board on progress with operating model and impact on Trust Timescale: October 2023 Lead: CEO Place based governance arrangements not fully embedded and reporting arrangements finalised. Quality governance reporting not clear Action: Governance arrangements to be reviewed and in particular quality governance Timescale: September 2023 Lead: CHief Nurse / Medical Director	CQC system assessment framework not yet confirmed	4x4 =16	4x4=16	4x2=8

Actions	Timescales	Lead
Invite ICB CEO to provide an update to Board on progress with operating model and impact on Trust	October 2023	CEO
Review Quality Governance arrangements	September 2023	Chief Nurse / Medical Direct

High level Risk Register risks - none

TRUST GOAL: 2 KEEPING THE BASE SAFE BEST QUALITY AND SAFETY OF CARE										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING** JUNE 2023 Risk category: Regulation Risk appetite: Moderate		
								Initial	**Current**	**Target**
8/19	Finance and Performance Committee	Chief Operating Officer	**Risk** Risk of failure to achieve local and national performance targets **Impact** - deterioration of patients waiting longer for treatment - Poor patient experience -Elective recovery Funding - Reputational damage with stakeholders - clinician dissatisfaction	Clinical prioritisation of all patients on waiting lists to identify current priority status and a process for regular review of clinical need. Increased number of outcome metrics within performance reporting monitored through performance framework . WYAAT system approach to capacity management. Urgent Care System Board and ICS Discharge Forum with social care providers to plan / consider options, supplemented with Reason To Reside Work Performance Management and Accountability Framework to support delivery of national standards and Trust quality,financial and operational objectives. Daily escalation of performance issues from divisional hubs into Bronze, Silver and Gold levels as appropriate. Access Delivery Group, Cancer Group, Urgent Care Delivery Group meet monthly to monitor recovery programmes, standards and waiting lists. Modelling of waiting list projections in place and monitored through Access Delivery Group. Health Inequalities linked to elective recovery monitored at a divisional level. Clinical prioritisation/holistics needs assessment matrix. Continue to utilise external capacity for backlogs, internal enhancement scheme being reviewed and new scheme in place to try and secure further additionality. OPEL escalation arrangements reviewed and updated to provide clearer escalation process	**First line** Daily Bronze meeting and silver when required with process to enact GOLD if needed. New OPEL levels in place Trust feeds into weekly silver meeting with partners. All areas have access to KP+ Risk registers reviewed at Divisional PSQBs & PRMs. Performance bulletin issued regularly to stakeholders Integrated Performance report focus of one WEB each month for detailed scrutiny of recovery performance and activity. Integrated Performance Report overhauled and in place using statistical process charts and NHS Digital good practice for performance reporting Elective care transformation programme relaunched **Second line** Integrated Performance Report discussed at each Board sub committee and Board of Directors **Third line** Routine reporting to NHS England Comparison data nationally shows Trust as one of the best performers on elective recovery and one of four Trusts achieveing all three key cancer standards Prof Tim Briggs visit demonstrated good practice in elective position and shared as an exemplar nationally Awarded elective recovery hub and community diagnostic hubs	Insufficent theatre capacity for elective workacross the system . Action: Considering mutual support opportunities across West Yorkshire. Timescale: September 2023 Lead: COO Overreliant on outsourcing capacity to manage elective demand and backlogs. Action: Elective care transformation programme to include GIRFT recomendations to enable sustainable programme of elective and implementation of elective hub Timescale: December 2023 Lead: COO .	Still not meeting A&E wait time target of 75% by March 2024	4x5 = 20	4x4 = 16	4 x 3 = 12
Actions					**Timescale**			**Lead**		
Improvement Programmes - Theatres and Emergency Department					Dec-23			Chief Operating Officer		
Links to risk register: 7615 - 4 hour Emergency Care standard, 7454 Radiology service provision										

TRUST GOAL: 3. INCLUSIVE WORKFORCE AND LOCAL EMPLOYMENT

Ref & Date added	OWNER Board committee	Exec Lead	RISK DESCRIPTION *(What is the risk?)*	KEY CONTROLS *(How are we managing the risk?)*	POSITIVE ASSURANCE & SOURCES *(How do we know it is working?)*	GAPS IN CONTROL *(Where are we failing to put controls / systems in place?)*	GAPS IN ASSURANCE *(Where are we failing to gain evidence about our system/ controls?)*	RATING JUNE 2023 Risk Category: Quality, Innovation & Improvement Risk appetite: Significant Initial	Current	Target
10a/19	Workforce Committee	Executive Medical Director	**Risk** Risk of not being able to deliver safe and effective high quality care and experience for patients due to gaps in the clinical workforce (local and national challenges) **Impact on** - Quality and safety of patient care and Trust's ability to deliver some services. - Ability to deliver range of key performance indicators as defined by multiple organisations - Increased risk of litigation and negative publicity. - Poor staff morale - Increased sickness absence - Continued financial pressure due to use of locums / agency staff - ambition to demonstrate the Trust is an "outstanding" organisation by CQC standards	•Consultant Succession planning • "Grow our own" approach - through different methodologies • CESR programme to increase Consultant workforce in appropriate specialties, Emergency Medicines scheme for oversease doctors with Royal College (Hybrid International Emergency Medicines) supports recruitment and retention. Global fellows in Radiology, •Guardian of Safe Working ensures safe working hours for junior doctors. • E -job planning in place for Consultants ensures efficient use of medical staff workforce and visibility of Consultant workforce activity (planning for April 2023/24 underway) • Recruitment and retention success, continued use agency and well-established bank medical staff for shortage specialties, agency spend within control totals, use current staff effectvely - all new employees opted in to a bank contract (unless opt out) • Mitigate shortages in specialties nationally,eg Radiology by network working, explore advanced practitioner to support Consultant workforce, use external reporting for Radiology • WYAAT networking approach to pressured specialties, eg Non-Vascular Interventional Radiology, supporting MYHT with Non Surgical Oncology, Neurology • Ongoing medical staffing recruitment. • Focus on alternative workforce models, allied health care professional roles – Physician Associates and Advanced practitioner. Recruit to FY3 posts,Radiology Global Fellowship posts • Medical Workforce Programme monthly meeting with wider group of stakeholders - provides an overview of the programme to ensure full visibility, shared view and tracking of all medical workforce based projects, with highlight reports from workstream leads. • Recruitment through external agencies for posts difficult to recruit to •New national contract launched for specialty doctors and specialist doctors enabling appointments at specialist level with more independence. Adopted SAS (Staff and Associate Specialists)doctor charter. •Refreshed engagement approach - eg Medical Director's Office created well-being talks, SAS Forum, Junior Doctor Forum •SAS asdvocate appointed and new SAS tutor appointed - these support more effective engagement with SAS cohort • Enhanced reporting data (eg sickness absence, staff in post by grade/specialty, trunover, vacacncy, retention) enabling a more robust view of medical workforce status. E-rostering provides understanding of rota gaps and workforce required 2023/24 approach to Clinical Excellence Award discussed and agreedwith Local Negotiating Committee to support retention of long standing Consultants	First line Staffing levels, training & education compliance reported and review through departmental and divsional governance structures. Escalation of any short term gaps to Bronze tactical meeting/ internal command arrangements. Weekly meeting between Divisional Directors and Medical Director's Office (with COO attending) to enable sharing of information. Roll out of new approach to sharing training data across Trusts for junior doctors IPR with key KPIs including sickness levels, and agency spend, with monitoring of spend. Weekly divisional medical staffing meetings to optimise fill rates. Medical workforce steering group meetings re-launched Second line Monthly performance meetings review workforce reports Workforce Committtee - continued reduction in medical vacancies – net recruitment gain of 38 medical and dental posts from 9 June 2022 to 8 June 2023. Medical Appraisal and revalidation report to Board, September 2022 Guardian of Safe Working Hours annual and quartely report to Board. Refresh of Recruitment Strategy Medical Workforce Programme Update to Workforce Committee Third Line GIRFT benchmarking tool RAG rates workforce establishment position Plans discussed with NHS England Assurance process with CQC colleagues - feeback from relationship with arms-length bodies GMC Report on Junior Doctor Experience GMC Employer Liaison Meeting with Responsible Officer / Medical Director Local Negotiating Committee (with BMA in attendance) regular engagement to raise any concerns regarding medical workforce.	Medical e- rostering lead gap and restructuring of e-restering team (Deputy Medical Director by September 2023) Guardian of Safe Working Hours recruitment - Deputy MD Sept 23 (NB) Dependence on HEE allocation of trainees. Potemtial for Strike action and extending to Consultant body from July Action: Monitor ballot results (WOD) and plan as needed by operational teams. Trainee Induction being reviewed to ensure engaging and relevant. Director of Medical Education, August 2023 Plan to restart elective and clinical attachment placements (attracts international colleagues), lead: Becky Colvwill, July 2023	Short term sickness absence may be under-reported by medical staff. Action: Divisional directors to monitor and manage. Working Together to Get Results sessions to build on success of embedded Physician Associate scheme by providing development opportunities and additional support to junior doctor rotas and aid retention. Lead: Deputy Medical Director Timescale: Meetings to be held by December 2022, plan to be developed 2023 Develop business case for lead Physician Associate: Deputy Medical Director 31.3.23.	4 x 4= 16	4 x4=16 =	3 x 3 = 9

Action	Timescales	Lead
Business Case for lead Physician Associate	31 July 2023	Deputy Medical Director
Monitor outcome of junior doctor pay negotiations and Consultant ballot	30 June 2023	
Trainee Induction Refresh	August 2023	Director of Medical Education
Plan for restarting elective and clinical attachment placements	31 July 2023	Becky Colwill, Medical Education

Links to risk register:
8072 Paediatric / Neonatal medical night rota, 7637 paediatric medical staffing, 8277 Neurology, 8508 Opthalmology (Glaucoma)

BOARD ASSURANCE FRAMEWORK
JUNE 2023
INCLUSIVE WORKFORCE AND LOCAL EMPLOYMENT

TRUST GOAL: 3. INCLUSIVE WORKFORCE AND LOCAL EMPLOYMENT

Ref & Date added	OWNER Board committee	Exec Lead	RISK DESCRIPTION *(What is the risk?)*	KEY CONTROLS *(How are we managing the risk?)*	POSITIVE ASSURANCE & SOURCES *(How do we know it is working?)*	GAPS IN CONTROL *(Where are we failing to put controls / systems in place?)*	GAPS IN ASSURANCE *(Where are we failing to gain evidence about our system/ controls?)*	RATING JUNE 2023 Risk Category: Quality, Innovation & Improvemnent Risk appetite: Significant Initial	 Current	 Target
10b/19 2021/22	Workforce Committee	Chief Nurse	**Risk** Risk of not being able to deliver safe and effective high quality care and experience for patients due to insufficient nursing staff caused by an inability to attract, recruit, retain, reward and develop colleagues. **Impact on** - Quality and safety of patient care and Trust's ability to deliver some services. - Ability to deliver national targets and CQUINS. - Increased risk of litigation and negative publicity. - poor staff morale - Increased sickness absence - Continued financial pressure due to use of locums / agency staff - ambition to demonstrate the Trust is an "outstanding" organisation by CQC standards	• Senior nurse staffing meetings twice a day, 7 days a week. •Senior nurse leadership rota provides ongoing visibility and dialogue across clinical areas, supporting staffing escalation • Adherence to best practice rostering processes. OPEL safer staffing actions cards. •Internal pay enhancements profroma developed to support response to workforce pressures • Strengthened escalation and reporting arrangements for quality and safety (short term and medium/long term), including enhanced dashboard which provides clear visibility on workforce and impacts on patient experience, quality and safety, •Local Nursing and Midwifery retention strategy developed in line with national recommendations and high impact actions initiated, approved November 2022. • Flexible approach to maternity staffing includes RN working in maternity services •Apprenticeship Strategy in place to support career pathways into nursing, midwifery,AHPS • Utilisation of bank and agency staff in place, managed and escalated through a Standard Operating Procedure. 20% bank enhancements continues for registered workforce to encourage uptake of shifts. • E-roster system in place and linked Safer Care IT system being used to match staffing levels to patient acuity. • Role of the Clinical Site Matron and responsiblity for tactical command • Journey to Outstanding (J2O) processs, reviewers provided with information on staffing levels, eg ward information on vacancies and fill rates re; falls, pressure ulcers and friends and family test which will include an assessment of staffing levels. • Ward assurance process for identifying 'at risk' wards which are under resourced or under performing in place including Hard Truths processes, People Strategy in place to support colleague health and well-being in line with national People Plan priorities • Quality and Safety oversight meetings in place for clinical areas where concerns exist on nurse sensitive indicators. • Safe staffing information presented to the Workforce and Quality Committee, • Nursing and Midwifery, AHP Workforce Steering Group, meet monthly with an overview of recruitement and retention strategies supported by Business Intelligence dashboard identifying progress and hotspots for consideration. • Safe, Sustainable and Productive Staffing meeting meets alternative weeks which focuses upon the quality metrics associated with the staffing postion (Enhanced Dashbaord Metric)	First line Twice daily staffing meetings provide an on the day repsonse to staffing position, responding to areas of escalation (red flags) and agreeing actions to mitigate the curent position. This meetings also determines the agree OPEL safer staffing postion. Clear esclations to the Associate Directors of Nursing rota and approval sought for Tier 3 agency to mitigate unresolved staffing position. Alternative week review of the Enhanced Dashboard Metric that tracks CHPPD/FIll Rate and a number of staff metrics to track any potential harm as a result of staffing position Annual and bi-annual safer staffing reviews of Nursing and Midwifery staffing levels provides assurances of the current workforce models or provides a rationale/evidence base for change. This approch is reflective of best practice in adopting triangulation of safer staffing metrics. Business Intelligence dashbaord provides monthly review of vacancy position, identifying potential hotspots and identification of any futher actions required to respond to the staffing position. The activity undertaken within the Nursing, Midwifery and AHP Steering Group which has a workplan focused upon responding to the insufficient staffing position by determing programmes of work related to recrutitment and retention and compliance with a number of metrics Clinical Site Matron summary site reports which provide assurance of site staffing postion and action to respond to any concerns,. Second line Monthly performance meetings (PRM) review workforce reports as well as introduction of corporate PRM Workforce Commitee receives updates on recruitment and retention issues for both oversight and scrutiny Twice yearly report to Workforce Committee, Quality Committee and Board of Directors for both oversight and scrutiny and assurance (January and July) KPIs embedded in Integrated Performance Report. J20 reports presented to divsional PSQB providing an assessment of the staffing position Workforce Committee undertakes deep dive of this identified risk to confirm key controls are clearly identifeid and assurances are robust and comprehensive Third Line Performance reported into NHSE. Assurance process with CQC colleagues - feedback from relationship wth arms-length bodies	Insufficent workforce availability to meet demand above core bed base and in community services. Action: Ongoing use of bank and agency staff and derogated staffing models in place as per OPEL action staffing cards.	Ability to be clear about national and local supply of workforce through pre-registration training porgrammes to meet vacancies and demand. Action: Continue to work with national recruitmnt and retention programmes and Health Education Institutes Lead: Lindsay Rudge	4x4 = 16	→ 4x4 = 16	3x3 = 9

Action	Timescales	Lead
Use of bank and agency staff to meet demand	Ongoing	Andrea Dauris Chief Nurse

Links to risk register:
Risk 6345 - nurse staffing risk, 7539 Paediatric Nurse staffing, 8454 midwifery staffing, 7776 Paediatric staffing (APNP), 7539 Paediatric ward vacancies, 8473 senior leadership childrens nursing, 8483 senior leadership neontal.

BOARD ASSURANCE FRAMEWORK
JUNE 2023
INCLUSIVE WORKFORCE AND LOCAL EMPLOYMENT

TRUST GOAL: 3. INCLUSIVE WORKFORCE AND LOCAL EMPLOYMENT										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING JUNE 2023 Risk Category: Quality, Innovation & Improvemnent Risk appetite: Significant**		
								Initial	**Current**	**Target**
11/19	Workforce Committee	Executive Director of Workforce and Organisation Dewvelopment	Being an employer of choice means we can attract, retain and develop colleagues to deliver one culture of care. Risk of not attracting or retaining colleagues who are confident and competent to provide compassionate care to patients and compassionate and inclusive leadership to colleagues due to a lack of clear OD strategy and focus on development for current and aspiring leaders means that we will not be able to deliver the Trust's objectives and sustainable services for the future **Impact** - Ability to deliver transformational change compromised. - Potential to affect the quality of patient care. - Low staff morale.	• Recruitment strategy for 2022-25 launched and launch meetings taken place with nursing and medical workforce leaders • Recruitment event calendar for multi-group events proposed for 2023/2024 • Review of social media approach • Expanded International Recruitment pathways • Initial review of inclusive recruitment processes undertaken • Values based recruitment and selection training now face to face • Internal career planning guidance document to support 'grow our own' being developed • Progressed into implementation phase for values based recruitment • OD Plan developed • Deployed a screening tool for values and behaviours as part of the onboarding process. • Board to agree Succession Planning approach which links to co-ordinated talent management pipeline programme including Empower programme and Enhance talent approach • Inclusive Leadership is one of the modules within our core Leadership Development programme. Each module is a three hour education session with action to implement practical application of the learning. Check in sessions will then be held to collate evidence of the application which will enable the organisation to monitor the growth of inclusive leadership. • Workforce Committee seeks assurance on recruitment, retention and reviews key workforce indicators • Focused recruitment and retention work through medical, nursing and AHP workstreams provides an opportunity to review traditional methods of recruitment which includes looking at alternative roles • Work together get results to Improve programme in place provides a link to the Trust journey to being an outstanding Trust and how we will use our own internal methodology to improve patient and colleague care. • Refreshed our values and behaviours - to be incorporated in values based recruitment • Workforce design methodology developed to support with workforce remodelling and reconfiguration • Strategy for Equality, Diversity and Inclusion which will attract a wider and more diverse workforce that will understand the differing needs of our patients.	First line • Clinicians leading of transformation programmes • Recruitment to key roles across the Trust - see BAF risk 10a • Workforce Committee reviews key workforce indicators at its meetings • CHuFT Awards Recognition programme, 130+ nominations from a range of grades, Divisions and specialisms colleague to colleague nomination • REN happy with progress made on inclusive recruitment • Values Based Recruitment Second line Integrated Performance Report and Workforce Committee reports show Turnover of 8.28% Results of Medical turnover review discussed at Executive Board. Reduction in vacancies to 115.26 Revalidation report to Board. Talent Management framework to Board in July 2022. Monthly Workforce Monitoring data including recruitment KPI reviewed by WOD Third line GMC survey of trainees is positive, with CHFT having no negatively outlying results in comparison with other WYAAT Trusts.	• Lack of comparative workforce data for medical and AHP staff groups compared to nursing, due to the delayed implementation of e-rostering. **ACTION**: Complete Medical roll-out by March 2024. • Review of inclusive recruitment approaches **ACTION**: further work to be undertaken to embed inclusive recruitment by March 2024.		4x4 = 16	3x4 =12 =	3x3 = 9

Actions	**Action, Lead, Timescales**	**Lead**
Further work to be undertaken to embed inclusive recruitment	31/03/2024	Suzanne Dunkley
Complete roll-out of e-rostering for Medical and AHPs	31/03/2024	David Birkenhead/Lindsay Rudge

Links to risk register: None

BOARD ASSURANCE FRAMEWORK
JUNE 2023
INCLUSIVE WORKFORCE AND LOCAL EMPLOYMENT

TRUST GOAL: 3. INCLUSIVE WORKFORCE AND LOCAL EMPLOYMENT										
Ref & Date added	**OWNER** Board committee	Exec Lead	**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING JUNE 2023** **Risk Category: Workforce** **Risk appetite: Low**		
								Initial	**Current**	**Target**
1/22 June 2022 refreshed June 2023	Workforce Committee	Executive Director of Workforce and Organisational Development	**Risk** Risk of colleague absence and retention rising due to: increasing demands and requirements for health and wellbeing offers that are not appropriate, not accessible, not embedded or not affordable; and/or inability or unwillingness to attract develop and retain compassionate and inclusive leaders who are able to succesfully lead their teams through sustained periods of change **Impact** - Ability to deliver transformational change compromised. - Potential to affect the quality of patient care. - Low staff morale. - Non–achievement of key Trust priorities - Poor response to staff survey / Quarterly Pulse Survey	• Workforce and OD Wellbeing and Engagement teams in place • Clear responsibility for wellbeing and engagement in Assistant Director of HR portfolio. • Employee Assistance Programme through CareFirst • Friendly Ear Service • 50 Health and Wellbeing ambassadors to engage with colleagues across all services areas as investing in employee wellbeing • Health and Wellbeing Risk Assessment available to all colleagues. • Workforce Psychologist in post with an Assistant Workforce Psychologist commencing July 2022. • Development of new Workforce Psychology offer • Appreciation week held w/c 22 May 2023 • Financial wellbeing resources currently in development • Refreshed guidelines on wellbeing hour • Weekly Wellbeing advisor walkarounds • Suicide prevention resource pack • Revised appraisal documentation with greater emphasis on health and well-being • Place-based funding for colleagues to access fast track MSK treatment. • Refreshed People Strategy and values and behaviours • 4 Hot Houses per year • Leadership conferences • 9 point plan for moving to a engagement score of 7 which is monitored by Workforce Committee. • External validation of our staff survey action plans and reflecting on results. • Colleague engagement focused on listening events, friendly ear and supportive events to engage colleague offering over difficult few years. • Leadership visibility / walkarounds carried out by senior colleagues • Weekly Communication to staff by Chief Executive with Q&A session: operational update(Mondays), CHFT LIVE meeting (Wednesdays), Chief Exeutive Update (Fridays) • Freedom to Speak Up (FTSU) Guardian and ambassador network • CHuFT awards and monthly Star Award • One Culture of Care checklist to aid visibility visit and provide consistency • Colleague engagement groups, now expanded to include following networks: Women's Voices, Armed Forces, Carers, International Colleagues in addition to REN network, Colleague Disability Action Group, Pride. Network chairs meet regularly to share best practice. • Equality, Diversity and Inclusion events • Executive buddies assigned to staff survey hotspot areas • Appraisal workshops held	First line Monthly workforce monitoring meeting reviews all workforce data sets Increase in completed appraisals in 2022/23 Monthly absence review meeting Second line Sickness absence metrics reported to every Board meeting via the Integrated Performance Report. Quarterly metrics provided by CareFirst. Workforce Committee reviews progress on engagement with health and wellbeing activities / programmes. PRMs monitoring roll out of staff survey actions Staff survey 2022 results and high impact actions presented to Board May 2023. Deep dive of risk to Workforce Committee People Heat Map Third line Quarterly People Pulse survey/ national staff survey Sickness absence benchmarking data through Model Health and Public View systems		Lack of assurance of the progress being made with hotspot areas from Staff Survey results. **ACTION**: Targeted plan for hotspot areas by June 2023.	3x4 = 12	3x4 =12	1x4 = 4
Action to address gap in control					**Action and timescale**			**Lead**		
Targeted plan for hotspot areas					Jun-23			HR Business Partners		

Links to risk register:
No high level risk register related risks scoring over 15.

BOARD ASSURANCE FRAMEWORK
JUNE 2023
FINANCIAL, ECONOMIC AND ENVIRONMENTAL SUSTAINABILITY

TRUST GOAL: 4. FINANCIAL, ECONOMIC AND ENVIRONMENTAL SUSTAINABILITY										
Ref & Date added	**OWNER** Board committee	Exec Lead	**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING JUNE 2023 Risk Category: Financial / Assets Risk appetite: Moderate**		
								Initial	Current	Target
14/19	Finance and Performance Committee	Executive Director of Finance	**Risk** Risk that the Trust will not secure sufficient capital funding to maintain facilities over the longer term and meet safety and regulatory standards resulting in patient harm and regulatory intervention. **Impact** - financial sustainability not secured - inability to provide safe high quality services - inability to invest in patient care or estate	Capital programme managed by Capital Management Group and overseen by Business Case Approval Group, including forecasting and cash payment profiling. Prioritised capital programme agreed as part of 2023/24 financial plan. Historic delivery of the capital plan. Contingency set within annual plan Transformation Programme Board has oversight of significant strategic investment, chaired by Non-Executive Director with relevant commercial experience. Senior Finance participation in West Yorkshire Integrated Care System Capital Group which meets regularly to review capital forecasts from all partners to manage regional capital envelope and reports to ICS Finance Forum. Horizon scanning for external funding opportunities and bids for funding regularly submitted where these align with strategic objectives and managing risk.	<u>First line</u> Oversight at Finance and Performance Committee and Board Capital Management Group reports Transformation Programme Board minutes <u>Second line</u> Strategic outline case for reconfiguration approved by NHS E . <u>Third Line</u> Monthly reporting to Transformation Programme Board, Finance and Performance Committee and Board Monthly report to ICS	The long term capital spend required for HRI is in excess of internally generated capital funds. The long term plan for HRI requires additional funds from a combination of regulator approved business case, emergency capital and ICS capital. This is widely recognised and accepted by the regulators. Lead: Director of Finance Action: Representation to key bodies re: securing appropriate funding.	5 year capital plans submitted to ICS but longer term funding allocation process is still to be agreed by ICS partners. Lead: Director of Finance – Backlog maintenance costs will remain in excess of planned capital spend. Action: Internal capital spend is prioritised on a risk basis. Price not yet agreed for CRH reconfiguration works and remains subject to change. Progressing elements where possible, Approval of Full Business Case Lead: Chief Executive, Director of Partnerships and Transformation and Director of Finance Treasury approval of reconfiguration business case Action: Close monitoring of Treasury plans via NHS E on behalf of Trust	4x5 20	4x3 = 12	3x4=12
Action					**Timescales**			**Lead**		
Ongoing monitoring of financial position through Finance &Performance Committee and Board					Ongoing			Director of Finance		
Links to risk register: None										

BOARD ASSURANCE FRAMEWORK
JUNE 2023
FINANCIAL, ECONOMIC AND ENVIRONMENTAL SUSTAINABILITY

TRUST GOAL: 4. FINANCIAL, ECONOMIC AND ENVIRONMENTAL SUSTAINABILITY										
Ref & Date added	OWNER Board committee Exec Lead		RISK DESCRIPTION (What is the risk?)	KEY CONTROLS (How are we managing the risk?)	POSITIVE ASSURANCE & SOURCES (How do we know it is working?)	GAPS IN CONTROL (Where are we failing to put controls / systems in place?)	GAPS IN ASSURANCE (Where are we failing to gain evidence about our system/ controls?)	RATING JUNE 2023 Risk Category: Financial / Assets Risk appetite: Moderate		
								Initial	Current	Target
18/19 March 2020	Finance and Performance Committee	Executive Director of Finance	Risk of failure to secure the longer term financial sustainability of the Trust (achieving financial breakeven and providing value for money) due to the size of the underlying and current financial deficit –and reliance on cash suppport. Whilst the Trust is developing a business case to support financial sustainability in the medium term, this plan is subject to approval and the release of capital funds **Impact** - financial sustainability not secured - increased regulatory scrutiny - Reduced ability to meet cash requirements - inability to invest in patient care or estate	Working with partner organisations across WYAAT and ICS to identify and implement system savings and opportunities - Joint Financial Recovery Group set up following review of PLACE based arrangements with partners Budgetary control process with increased profile and ownership Turanround Executive (meets weekly, with Deputy Chief Executive Chair) monitoring cost improvement plan delivery in year and development of 5 year cost improvement plans. Accurate activity, income and expenditure forecasting Development of 25 year financial plans in support of Business Case Standing Financial Instructions set authorisation limits, Audit and Risk Committee in place to monitor key areas of compliance. Finance and Performance Committee in place to monitor performance and steer necessary actions. Transformation Programme Board to monitor delivery of key capital schemes.	First line Reporting on financial position, cash and capital through divisional Boards, Performance Review meetings and Exec Board monthly. Capital Management Group meeting receives capital plan update reports Second line Scrutiny at Finance and Performance Committee and Board. Reports on progress with strategic capital to Transformation Programme Board. Board Finance reporting.ICS submitted balanced financial plan for 2023/24 with risks clearly articulated to NHSE. Internal audit report on efficiencies - significant assurance April 2022. WYAAT Board to Board event September 2022 re: efficiency identified themes for new WYAAT strategy. Third line NHSE deep dive of financial position 7 June 2023. ICS Director of Finance assured re Trust financial management systems. Initial findings have not identified further financial opportunities. Monthly return to NHS E and ICB. CRH Outline Business Case submitted November 2021	Progression of transformation plans are reliant on external approval and funding Impact of national workforce shortages eg. qualified nurses and A&E doctors. Key enablers to reconfiguration, e.g. Project Echo reliant upon external approval to progress. Action: Continued liaison with regulator and HM Treasury Lead: Chief Executive Limited additional revenue costs have been included for the development of the Reconfiguration Business Case.	Joint Financial Recovery Group requires further work to fully embed alongside wider PLACE based working. Action: Development of plans to drive efficiences across the Kirlees and Calderdale PLACE Lead: Partnership reps, CHFT Director of Finance, Director of Transformation and Partnerships, Chief Operating Officer Timescale: September 2023	5x5 = 25	4x4 = 16	3x4=12
Action					**Timescales**			**Lead**		
System financial recovery plans to be developed led by external resource					Sep-23			Director of Finance		
Links to high level risk register risks: Risk 8057 relating to financial position. See BAF risks 10a and 10b re workforce shortages										

BOARD ASSURANCE FRAMEWORK
JUNE 2023
FINANCIAL, ECONOMIC AND ENVIRONMENTAL SUSTAINABILITY

TRUST GOAL: 4. FINANCIAL, ECONOMIC AND ENVIRONMENTAL SUSTAINABILITY											
Ref & Date added	**OWNER** Board committee	Exec Lead	**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING JUNE 2023 Risk Category: Strategic Risk appetite: Significant**			
								Initial	**Current**	**Target**	
06/20 July 2020	Transformation Programme Board	Executive Director of Finance	Risk of climate action failure and not improving our environmental sustainability, including not reducing carbon emissions across the organisation and not reducing the impact of climate change across Huddersfield and Calderdale due to a lack of behaviour change (eg travel, waste, procurement) and not embedding climate and environmental considerations in decision-making. Resulting in adverse effects on natural environment, public health, vulnerable patients, energy costs, waste disposal fees, non-compliance costs and also creating a negative impact on reputation.	Leadership on climate change managed by CHS's Environment Manager and sponsored by the MD of CHS who is the Trust's lead for climate and sustainability. Connected into a range of West Yorkshire sustainability groups involving the WY Combined Authority, WYAAT and local Councils. System working - MD CHS Climate Commissioner for Kirklees Climate Commission to respond to the climate emergency across Kirklees and member of Calderdale Council Climate Action Group, developing a climate action plan for Calderdale. Green Plan approved and in place, aligned with ICS Green Plan, aims to reduce the impact of travel on the environment and reduce carbon emissions Green Planning Committee (meets monthly,attended by internal and external partners) chaired by MD CHS oversees delivery of sustainibility action plan, dashboard monitors the impact of the Green Plan, reports to Transformation Programme Board on quarterly basis. Travel Plan in place to support more active travel, less car use and more car sharing, Travel Co-ordinator monitors progress. Reconfiguration design and build principles led by a sustainability design brief and overseen by Transformation Programme Board. Green solutions - eg remote temperature monitoring at parts of HRI to reduce energy cost and carbon emission. Green solutions integral to HRI A& new build, eg air source heat pump for renewable energy, permeable paving, due to achieve excellent BREEAM sustainability rating Carbon Literacy Training of CHS senior management team. 100% energy bought from green sources and installation of LED lighting to reduce energy consumption. Light swtich off campaign. Signed up to NHS pledge to reduce plastic usage in hospital . Recycling awareness raising with staff to encourage correct waste disposal Asset tracking ensures live track of equipment and reduces wastage. Procurement Strategy ensures minimum 10% wighting for socal value wighting in all pucrement . Funding bids to support sustainable activities by CHS, eg Salix Low Carbon Skills Fund for the development of the Trust's Heat Decarbonisation Plan. Digital Strategy supports sustainability - eg out patient transformation such as remote out patient appointments reduces travel, patient initiated follow up.	First line Monthly monitoring of the Trusts energy consumption Quarterly Update on progress with Green Plan and Sustainability Plan, via newly developed Green dashboard of key indicators to Transformation Programme Board. 41 of 47 travel plan actions complete. Green Plan - 159 of 206 actions complete. Second line 1. Monitor against our Green Plan and Sustainability Action Plan (SAP) approved at 6 May 2021 Board meeting, following reviewed by Transformation Programme Board 8 March 2021. Green Plan shared with ICS. 2. Annual Board paper on sustainability/climate change, July 2023, May 2022 2023/24 Trust Annual Report details Third line Share energy data records with NHS E on new NHS energy data platform	QIA procedure to be reviewed along with business case applications to ensure that a standing section for sustainability is featured and addressed in Board paper submissions. Lead: Stuart Sugarman via Environmental Co-ordinator Timescale: June 2024 Developing 12 month Trust-wide environmental calendar with focus on sustainable activities. Lead: Stuart Sugarman Timescale to December 2024 Increase number Electrical Vehicle (EV) chargers: Lead: Stuart Sugarman Timescale: September EV chargers at A&E HRI, Multi Storey Car Park at CRH once built	CHS to present Green Plan and Travel Plan to Joint Overview & Scrutiny Committee on behalf of Trust. Lead: Stuart Sugarman July 2023	4x4 = 16	4x2 = 8	4x2=8	

Action	Date	Lead
12 month environmental calendar and activities	Jan - December 2024	Stuart Sugarman
Increased number of EV chargers	September 2023	Stuart Sugarman
Review QIA procedure and business case applications re sustainability	01/06/2024	Stuart Sugarman via Environmental Co-ordinator

No related risks on high level risk register

BOARD ASSURANCE FRAMEWORK
JUNE 2023
FINANCIAL, ECONOMIC AND ENVIRONMENTAL SUSTAINABILITY

TRUST GOAL: 4. FINANCIAL, ECONOMIC AND ENVIRONMENTAL SUSTAINABILITY

Ref & Date added	**OWNER** Board committee	Exec Lead	**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING JUNE 2023** Risk Category: Partnership Risk appetite: Significant **Initial**	**Current**	**Target**
2/23	Transformation programme Board	Deputy Chief Executive / Director of Transformation & Partnerships	**Risk** Risk that the Trust cannot maxiimise its impact as an anchor institution in local communities to demonstrate social value in employment, career and development opportunities from investments and use of resources due to competing priorities and lack of partnership working **Impact** unable to support broader economic and social development as required under new NHS Provider Licence	Transformation Programme Board has oversight of Trust work to support generation of social value and economic support in our local Places. The Trust has developed a social value action plan in relation to its major capital investments and is monitoring delivery against specific projects within the estate investment programme. Trust 1 and 5 year strategy aligned to ICS and 2 Place strategies, with specific strategic objectives re sustainability with progress reported to the Board quarterly . Trust Chief Executive and Chair are members of Calderdale and Kirklees Place based Integrated Care Boards. Director memebrship of Calderdale and Kirklees Health and Well Being Boards and therefore contribute to Place and WY ICS strategy. Strategic collaboration with Huddersfield University development of Health Academy for the local area - regulatr meetings and partnerhsip projects, e.g. Community Diagnostic Centre. Collaboration with Calderdale and Kirklees Further Education Colleges and voluntary sector to increase routes into employment in our local Places, e.g. T -Level Cadet Pathway. Widening Participation Team promote activities for disadvantaged young people, work experience placements, Project Search. Apprenticeship schemes. Work with the Purpose Coalition to tackle challenges facing patients, customers, colleagues and communiities and map Trust activities against the Purpose Goals.	**First line** Reconfiguration leadership team HRI Project team manages social value for A&E delivery **Second Line** Transformation Programme Board highlight report to Board Progress report on strategic objectives to Board **Third Line** Updates to West Yorkshire ICS on social value generation via capital invetstment and use of local supply chain. Update to Calderdale Place-based Committee on social value quarterly. Levelling Up Impact Report from Purpose Coalition confirms Trust commitment to being a purpose-led organisation and plays a central role in its communities beyond healthcare service.	Communication and engagement of wider colleagues and partners of this work to inform and shape actions. Action: Share Levelling Up Impact Report and seek feedback on further opportunities to work with partners Lead: Deputy Chief Executive & Director of Transformation & Partnerships Timescale: March 2024 Stretch Trust performance as a local employer and anchor partner by implementing the recommendations of the Purpose Coalition. Lead: Oversight by Associate Director of Strategy Timeframe Update December 2023:	December 2023 update on progress with recommendations of the Purpose Coalition to WEB Lead: Associate Director of Strategy	3x3 = 9	3x3 = 9	3x2= 6

Action	**Timescale**	**Lead**
Share Levelling Up Impact Report and seek opportunities to work with partners. Implement recommendations of the Purpose Coalition as local employer (3) and anchor partner (2)	31 March 2024 March 2024	Deputy Chief Executive & Director of Transformation & Partnerships, Associate

Links to high level risk register: None. See related BAF risk 3/23 re partnership duties, 6/20 sustainability, 7/20 health inequalities

KEY

ACRONYM LIST

BAF	Board Assurance Framework
BTHT	Bradford Teaching Hospitals NHS Foundation Trust
CCIO	Chief Clinical Information Officer
CNIO	Chief Nursing Information Officer
CIP	Cost Improvement Plan
CQC	Care Quality Commission
CQUIN	Commissioning for Quality indictor
CHS	Calderdale Huddersfield Solutions LTD
ED	Emergency Department
EPAU	Early Pregnancy Assessment Unit
EPR	Electronic Patient Record
F&P	Finance and Performance Committee
FBC	Full Business Case
FFT	Friends and Family Test
HPS	Huddersfield Pharamcy Specials
HSMR	Hospital Standardised Mortality Ratio
IBR	Integrated Board Report
ICS	Integrated Care System
IIP	Investor In People
ITFF	Independent Trust Financing Facility
KPI	Key performance indicators
NHS E	NHS England
OBC	Outline Business Care
OSC	Overview and Scrutiny Committee
PFI	Private Finance Initiative
PMO	Programme Management Office
PPI	Patient and public involvement
ITFF	Independent Trust Financing Facility
KPI	Key performance indicators
	Outline Business Care
	Overview and Scrutiny Committee
	Private Finance Initiative
PMU	Pharmacy manufacturing unit

TMA	Transitional Monitoring Approach
WEB	Weekly Executive Board
WYAAT	West Yorkshire Association of Acute Trusts
ICS	Integrated Care System
DHSC	Department of Health and Social Care
IPC	Infection Prevention Control

(yellow)	New risk
(grey)	Breach of risk appetite/ risk exposure
1-6	Low risk
8-12	Medium risk
15-25	High risk

INITIALS LIST

AB	Anna Basford, Director of Transformation and Partnerships
SD	Suzanne Dunkley, Executive Director of Workforce and OD
DB	David Birkenhead, Executive Medical Director
GB	Gary Boothby, Executive Director of Finance
JH	Jonny Hammond, Chief Operating Officer
RB	Rob Birkett, Chief Digital and Information Officer
AM	Andrea McCourt, Company Secretary
VP	Victoria Pickles, Director of Corporate Affairs
SS	Stuart Sugarman, Managing Director CHS
BB	Brendan Brown, Chief Executive
RA	Rob Aitchison, Deputy Chief Executive
LR	Lindsay Rudge, Chief Nurse
KA	Kirsty Archer, Director of Finance
ALL	All Board members

Date of Meeting:	5 July 2023
Meeting:	Public Board of Directors
Title:	High Level Risk Report
Author:	Richard Dalton, Head of Risk and Compliance
Sponsoring Director:	Victoria Pickles, Director of Corporate Affairs
Previous Forums:	Risk Group

Purpose of the Report

The purpose of this report is to provide an overview of the risks scoring 15 or above.

Key Points to Note

Introduction
The new risk policy has been approved and is published on the trust intranet site. The Head of Risk and Compliance and Risk manager are meeting with Divisions to review all risks on the risk register. During the review meetings ongoing training and support id being provided to all CHFT staff that attend. Training is being delivered face to face as requested by the Divisions. There is a plan to produce a training video and training slides for staff to access via the risk management intranet site.

Current risk process and position
The Trust manages and documents risk using a bespoke risk register. When a risk is identified, the risk and impact on patient care is documented on the electronic risk register, is considered in detail by the appropriate department and governance structure. All the appropriate information surrounding the risk is documented including all mitigating actions to ensure the safety of patients and staff is maintained. The Trust uses the information to learn and develop as an organisation.

Currently there are 52 risks that rated as high (36) and very high (16). There have been 0 new risks added; 5 have had their risk score reduced; and 0 have had their risk score increased.

Each risk is aligned to one of the Trust's strategic objectives. Against each of these objectives the current risks scoring very high (20-25) are on the following themes:

- Transforming care:
  - The capacity of the pharmacy department in relation to the British Oncology Pharmacy Association (BOPA) standards

- Keeping the base safe
  - There are several risks relating to staffing and vacancies in medical, nursing and therapy posts across a range of services including the emergency department, maternity, paediatrics, and radiology. Risks describe the Trust's ability to meet the care hours per patient day and delays for induction of labour.
  - Risks to meeting targets and waiting times including emergency care standard, Percutaneous Coronary Intervention (PCI) and angiogram waiting times, and national radiology targets.
  - There is a risk to the fluoroscopy service due to age of the equipment.

- There is a risk due the capacity available to validate outpatient appointments

Themes of risks scoring high (15-16) are:

- Sustainability
  - Financial plan: funding related to increasing activity to clear the backlog from covid as per the national target.
- Transforming care
  - Digital systems – both the use of and business continuity
  - The provision of play therapy to support the whole organisation
  - The workforce capacity within the ultrasound department to meet the Royal College of Obstetricians and Gynaecologists (RCOG) guidance.
  - Workforce capacity to meet the needs of individual care for the most vulnerable care
  - Medical cover for maternity assessment centre
  - Scanning capacity for rescanning within maternity
- Keeping the base safe
  - The number of referrals into services; appointment availability; level of unplanned and emergency care activity; demand on inpatient capacity; lack of theatre capacity to meet recovery plans; support for mental health patients; health inequalities because of the elective recovery and follow up back log.
  - The provision of plain film radiology due to age of equipment.
  - Point of care staffing capacity
  - Training requirements for staff in the use of digital services
  - The provision of pharmacy within ICU
  - The maintenance of the asset management log
  - Senior nursing leadership cover with children's/ neonatal services
  - Fire safety
  - Medication storage on ward 9
- Workforce
  - ICU well-being of staff

These risks reflect the key areas of challenge reflected in the board agenda today and align to the strategic risks set out on the Board Assurance Framework.

Future development work

An options appraisal and business case has been developed to move the risk register to a new IT provider. The system is designed to triangulate data gathered within the organisation to provide a clear and detailed evidence of the risk posed to the Trust. A new IT system is being reviewed to ensure new Patient Safety Incident Reporting Framework (PSIRF) requirements are met, whereby risks and serious incidents will be brought together so that learning can more easily be identified and shared.

EQIA – Equality Impact Assessment

Risks are assessed considering any impact on equality.

Recommendation

The Board is asked to **CONSIDER** and discuss risk scoring 15 or more report and note the ongoing work to strengthen the management of risks.

Extreme and Major Risks (15 or over)

	Risk No	Div	Dir	Dep	Opened	Status	Objective	Risk Description plus Impact	Existing Controls	Gaps In Controls	Initail	Current	Target	Action Plans	Progress Update	Review	Target
Very High	6911	Family & Specialist Services	Women's Services	All Departments	Jan-2017	Active	Keeping the base safe	There is a risk of not meeting current midwifery workforce models due to current vacancies and periods of increased absence (maternity / long term sickness), resulting in the inability to provide safe staff and timely care across the maternity footprint. Overarching risk linked to: 8454 - induction of labour 8455 - Maintaining 1:1 care 8457 - Meeting maternity triage time 8458 - birth centre experience 8097 - ability to deliver Continuity of care 8456 - community caseload size	Right staff in the right place - twice daily staffing meetings Twice yearly review of workforce models with Director of Nursing, Deputy Director of Nursing and Head of Midwifery Maternity Escalation Policy Use of NICE approved safer staffing tool - Birth Rate Plus Active recruitment - LMNS wide, localised and international recruitment Sickness/ Absence Management: Monthly staffing forecast to support recruitment and rotation planning Daily monitoring of delays and escalating for mutual aid as required Feed in to tactical meeting All unfilled shifts escalated to bank / agency for shift fill Maternity bleep holder to offer leadership and oversight Use of incentive schemes to aid bank pick up at periods of heightened absence Workforce revised to support skill	Midwifery bank predominantly made up of CHFT midwives, limiting cover Inability to predict activity for on the day planning National shortage of registered midwives, impacting on staffing recruitment pipeline	9 3 x 3	20 4 x 5	2 1 x 2	Daily staffing reviews and review of rosters Quarterly analysis of shift fill in line with Birth Rate Plus Monthly analysis of shift fill in line with UNIFY Safer Staffing Requirements Monthly analysis of 1:1 care in established labour and supernumerary coordinator status Use of NICE Safe Staffing Red Flags Quarterly review of community midwifery caseload size Monitoring of bookings and births to support workforce planning Revise workforce models in line with current birth rate - presented to Hard Truths May 23 awaiting approval Recruitment and retention working party with strategy to follow	June 23 - Update GH, LD, JM - propose reduction in score following review of WFM and existing controls. Reduction in birth rate and quality matrix supporting controls working May 23 - Divisional Risk Register confirm and challenge update 23/5/23 Present: SRF, NB, TO, LM, GH, FA, NV, RR, DT, LR Staffing levels same, no change to risk, shared recruitment across LMS - Currently at the right level, hoping for better recruitment of students this year. Offering posts on 8/6/23, when in post look to reduce risk in September. May 23 reviewed by LD and GH Work ongoing to review workforce model calculations due to fall in birth rate being presented at Hard Truths May 23. ongoing recruitment in place April 23 PSQB - Discussed. DT is working with Lindsay Rudge to see if the workforce model needs changing as a number of births have been lost. It is being looked at whether the birth rate plus assessment should be completed again and there is a lot of work around ongoing recruitment. Two	Jul-2023	Oct-2023

Very High	7078	Corporate	Medical Director's Office	Operational	Oct-2017	Active	Keeping the base safe	Medical Staffing Risk (see also 6345 nurse staffing, 2827 A&E middle grade, 7454 radiology, 5747 interventional radiology) Risk of not being able to deliver safe, effective and high quality care with a positive experience for patients due to difficult to recruit to Consultant posts in Gastroenterology, Radiology, Dermatology and Ophthalmology, and dual site working which impacts on medical staffing rotas resulting in: - increase in clinical risk to patient safety due to reduced level of service / less specialist input - negative impact on staff morale, motivation, health and well-being and ultimately patient experience - negative impact on sickness and absence - negative impact on staff mandatory training and appraisal - cost pressures due to increased costs of interim staffing - delay in implementation of key strategic objectives	Medical Staffing Job planning established which ensures visibility of Consultant activity. E-rostering roll out commenced to ensure efficient use of Consultant time Establishment of staff bank to ensure vacant posts filled WYAAT networked approach to pressured specialties Medical Workforce Group chaired by the Medical Director. Active recruitment activity including international recruitment at Specialty Doctor level - new electronic recruitment system implemented (TRAC) - HR resource to manage medical workforce issues. - Identification of staffing gaps within divisional risk registers, reviewed through divisional governance arrangements	Medical Staffing Risk of pensions issue impacting on discretionary activity National shortage in certain medical specialties Regional re-organisation could potentially de-stabilise the workforce E-rostering partially implemented for doctors (expected by Sept 2020) - centralised medical staffing roster has commenced but not fully integrated into the flexible workforce team - measure to quantify how staffing gaps increase clinical risk for patients	20 4 x 5	20 4 x 5	9 3 x 3	• Monitored by Medical Workforce Programme Steering Group • Active recruitment including international	April 2023 Foundation Trainees rotated as planned in early April without delay into their new training placements and further recruitment activity has continued. There are a number of junior Trust doctors due to commence over the next couple of months within Medicine. There is a lot of consultant recruitment underway at present with a number of posts out to advert. This includes roles in Emergency Medicine, Respiratory Medicine, Gastroenterology, Cardiology, Neurology, Neurophysiology and Palliative Care, Ophthalmology, Orthopaedics, Urology and Radiology. Recent appointments at consultant level have been made, including Paediatrics, and Anaesthetics, in addition to retire and return arrangements for a Paediatric and Gynaecology consultant. There are also ten pending new starters at locum consultant level. March 2023 Interviews were held for a new Divisional Director within the Medicine Division to replace the current postholder who has been in the role for over 12 years. There were two internal applicants and an offer has been made to an existing Clinical Director, with an expectation that the new DD will commence in post without delay once the current DD retires. Expressions of interest have been invited across the medicine division for a new clinical director to replace them. A new clinical director has just	Jun-2023	Jun-2023

Very High	7539	Family & Specialist Services	Children's Services	Children's Ward CRH (3)	Oct-2019	Active	Keeping the base safe	There is a risk to timely patient care on the paediatric wards due to a significant number of nurse vacancies: Ongoing recruitment strategy in place with short and longer term plans in place. Currently 8 new starters (B5) from September. This leaves the vacancy as below from September Band 6 0.29 WTE Band 5 2.58 WTE (with additional 3.53 on maternity leave) The impact of this could result in poor patient experience and delays in care which could have the potential to cause harm.	Holding list for students due to qualify - 8 due to qualify in september and will be offered B5 contract in conjunction with recruitment/HR from June. Vacancy for substantive positions and mat leave cover on TRAC - rolling advert now out and interviews Recruitment video completed Extra hours offered to existing staff Sickness summit and management of staff sickness in line with policy Review of workforce model in line with hard truths process Flexible use of workforce across the directorate Scoping other options for recruitment - rotational post, sedation, bank posts. Approval for use of high cost agency for shift fill. Plan to support RN to work on paeds with a full supportive package in place. 2 x RN interested in this.	Rolling advert out.	12 3 x 4	20 4 x 5	1 1 x 1	Directorate sickness summits. Recruit to agreed vacancy to meet workforce model Update December 2020 - scoping options for alternative recruitment plans in addition to traditional methods. Update September 2021 - Over recruitment by 3.5 WTE B5. Awaiting Divisional sign off - Paediatric Nurse recruitment meetings ongoing - More Trust support for overseas recruitment -Continue rolling band 5 advert Update December 2021 - Recruitment event on 5/2/22 Update April 2022 - Students interviewed and ready to start in September - support staff advertised to increase numbers on ward and increase support - Trainee associates in training to complete December 2022 Update July 2022 - Hard truths process to consider workforce model planned for August. Update October 22 Matron has worked with Clinical managers to agree short, medium and long term goals to try and fill these Short and medium term goals Rolling B5 advert out, to	Divisional Risk Register confirm and challenge update meeting held on 26/04/2023 Present: SRF, SS, NV, LRa, TO, VT, EGH, JM, WK, JE, HF By September Risk could be significantly reduced, robust recruitment plans in place. eight new starters from September (0.29 Band 6, 2.58 Band 5, 3.53 on maternity leave). Meetings in place to scope international overseas nurses. Holding twice weekly huddles to review across directorate. Agreed should stay at score of 20. April PSQB - there is a short, medium and long term recruitment strategy. Eight newly qualified Band 5s are starting in September; this will then be a vacancy factor of 2.8, which previously was above 20 in September 2022. This impacts on the skill mix so preparation is being done with the clinical educator. SR-F commented that some training has been pulled recently so a dip in compliance is expected due to staff having to support clinically. There is work around the workforce model generally also. 17th Feb 23 Recruitment day planned for 25th February to recruit to B4 and B5 qualified positions on the ward. 2 x B6 recruited. 2 x NA have also qualified and started in post. October 22 Matron has worked with Clinical managers to agree short, medium and long term goals to try and fill these Short and medium term goals Rolling B5 advert out, to continue B6 and B2 jobs to go out on TRAC B5 nursing development post emailed out to staff today with expressions of interest requested by Wednesday 12th October (complete). Although this will not bridge any of the B6 vacancies it will help with retaining staff and will also offer support to co-ordinator role/NIC role. Children's ward video (from 2017 pre covid) to be	Jul-2023	Sep-2023

Very High	7557	Medical	Emergency Care	Accident & Emergency CRH/HRI	Oct-2019	Active	Keeping the base safe	There is a risk to patient safety and experience for children and families visiting the Emergency Departments at CHFT. Due to the current workforce model at HRI which does not support the RCEM and National guidelines (RCPCH) which recommend 2 x Qualified Registered Children's Nurses on a shift in an ED at any one time. Resulting in the inability to: Provide care appropriately for sick children Recognise the sick and deteriorating child Have staff trained in appropriate distraction techniques for children Lack of awareness of all safeguarding flags and signs to be aware of in children attending the department. The potential pressures posed by IPC regulations will put further strain on the ability to meet paediatric demand coming through the ED as limited space to segregate.	6 RSCN nurses employed at Calderdale. 6 Nurses currently on the Child In ED course via the university RN's working in the department who have previously completed the child in ED course - Ongoing - Course every two months. APNP's attending the HRI site to care for sick children Work on going to look at an interim model while awaiting reconfiguration	Unable to recruit RSCN's in current workforce model Risk of recruiting RSCN's leading to poor morale and leaving the trust Unable to send a large proportion of staff on the Child in ED course due to study leave	16 4 x 4	20 4 x 5	1 1 x 1	To subscribe to the child in ED course at every intake via the university. Create a business case to increase the work force model to achieve RSCNs on each shift Proposed Paeds staffing model to go to CISG in November	14/3/23- Currently no RCNs employed at HRI ED. Advert is out for band 5 permanent cover. Band 6 Secondment cover. HRI Mitigation utilising Pead's positive Nurses to cover paed's area - Compliance currently 60.30%. Risk score increased due to significant risk and ongoing incidents through lack of paeds provision. CRH - At present 5.84 RCNs employed and currently working. 0.88 on long term sick. 2.58 RCNs due to start June 2023. Cover will increase to 24/7 from April 23. Mitigation Night cover staffed with paeds positive nurses - compliance currently 65%. Ongoing incidents when no RCN cover. FSA post CRH out to advert 2.58 wte. Paeds CRH HCA out to advert 2.58 wte. CRH - At present 5.84 RCNs employed and currently working. 0.88 on long term sick. 2.58 RCNs due to start June 2023. Cover will increase to 24/7 from April 23. Mitigation Night cover staffed with paeds positive nurses - compliance currently 65%. Ongoing incidents when no RCN cover. Nov 2022 - CRH now has 7 RCNS - No night cover. Dedicated Paeds area and stream now at HRI & CRH supported by O/PNP's will continue to	Jun-2023	Jul-2023
Very High	7615	Medical	All Directorates Medical	All Departments/Wards Medical	Dec-2019	Active	Keeping the base safe	There is a risk of not meeting the emergency care standards. Due to increasing demand on Emergency Care, patient flow issues, delays in assessment and discharge due to lack of social care staffing (hospital based social work team), lack of timely domiciliary care in community More recently there have been increasing demand for side rooms due to the need to isolate patients with possible COVID-19, this has caused increasing delays. Resulting in poor patient experience, patient harm, increased scrutiny and reputational damage	Operational procedures to improve patient experience and flow are in place and reviewed at 3 hourly bed meetings Ambulance hand over time Time to triage Seen in 60 minutes by a medic Digital - manages time and RAG rates Clinical site commanders KPI - refer for inpatient bed before 3 hours Coordinators managing ED Matrons in place at both EDs Urgent care action cards direct staff Housekeepers providing fundamental care External support for dept in times of pressure - eg gynae, paeds Surge and Escalation plan - OPEL Training of on call managers and	Partners not being able to deliver YAS - transport - escalation and response times and transfer to bed base Interruption of the Local Care Direct Service, GP closures for training Vacancy Non compliance with action cards and process without escalation Engagement and understanding of the risk at ward level and across teams Continued increase in demand in ED High bed occupancy levels due to increased demand and restricted social care services	15 3 x 5	20 4 x 5	1 1 x 1	Patient Flow action plan in place Governance - reported monthly at WEB Patient Flow one of the 4 core must do's is being monitored at gold. owner – DOP for medicine Accountability- Directors Relaunch of the safer project System wide working action owner is John Parnoby	November 2021 - Risk score increased and accepted at PSQB October 21 - Plan for every patient program relaunched with additional resource to accelerate role out. ED improvement plan is being monitored through Gold as part of the flow "must do" System wide working action owner is John Parnoby. (Updated by L Taylor following a risk meeting with J Hammond) May 2021 - Relaunch of the safer project, apart from this the risk remains the same. (Updated by L Taylor following a risk meeting with J Hammond) January 2021- ED Action plan in place to monitor standards of care especially for those patients who remain in the department over 4 hours. December 2020 Protocol for managing long waits in ED has been reviewed	Oct-2022	Feb-2023

Very High	7689	Trustwide	All Divisions	All Departments/Wards	Mar-2020	Active	Keeping the base safe	There is a risk that patients may have to wait for outpatient appointments, diagnostic tests or routine operations Due to cancellations of routine surgery and rescheduling of clinics Resulting in their condition deteriorating, potential impact on treatment options available and a less positive outcome	EPR booking and validation processes Urgent fast-track processes in place Risk assessment for re-prioritisation of appointments Virtual appointments commenced in some prioritised areas	Unable to meet target KPI's for RTT and diagnostics, and that patients will wait longer than is best practice for outpatient appointments with an increase in the ASI list and holding list.	20 4 x 5	20 4 x 5	4 2 x 2	Clinical review and prioritisation of essential patients Medicine: risk assessment of booked and due, consider remote or delay 3-6 months. Working up CAS model and recovery plan. Incident reporting for identifying patient harm or impact on prognosis or outcome Complaints and PALS Team logging enquiries and concerns re waits for appointments, and patients not wishing to attend for	September 22 - Clinic capacity increasing across all specialties . Increasing weekend clinics in Neuro and Rheum to reduce backlog of New and F/up. Clinics still being cancelled within 6 weeks. 3 week text reminder to start in order to reduce short notice cancellation rate. Deep dive of cancellation data commencing May 22 - Clinic capacity increasing across all specialties in order to reach 104% of 19/20 numbers. Increasing number of patients on a PIFU pathway. Insourcing continuing with increasing numbers of referrals being sent for ENT. Surgery IPT patients to the IS. Patient cancellation rates increasing. Clinics still being cancelled within 6 weeks	Oct-2022	Mar-2023
Very High	7454	Family & Specialist Services	Radiology	Main X-Ray	Apr-2019	Active	Keeping the base safe	Service Delivery Risk There is a risk to Radiology service provision due to a reduction in Consultant capacity resulting in a reduction of cover in some specialist areas and overall general capacity with the potential for breaching national targets.	- Agency Sonographer cover (This Is My...). - NHS Locum cover. - IR: Daytime support from neighbouring organisation (1 day per week); reconfiguration completed in November and now sharing OOH cover with WYVAS. - NHS locum and Bank locum in place providing block cover (x weeks on/ x weeks off). - Head & Neck - part time consultant in post, US scanning supported by locum sonographer - Additional reporting support from external providers. - Neuro: Additional reporting support from external providers and temporary change to job plans. - General on-call: Increase in use of external provider cover and existing Consultants picking up additional stand-by shifts. - Global Fellow in place (Paeds) - Leaving in November 2022. - Support from BHFT and Mid Yorks in exceptional circumstances (e.g. NAI's/reporting).	Vacancies in all areas, including: - Intervention: Gap when contracted NHS Locum is on annual leave/other leave. - Neuro: Reduced capacity and no capacity during annual leave/other leave. - Paediatrics. - Head and Neck (i.e. biopsies).	15 3 x 5	20 4 x 5	1 1 x 1	- Actively seeking recruitment in all areas including use of introduction agencies. - Actively seeking NHS and agency locum for all required areas. - Existing consultants working through competencies to enable coverage of gaps. - Outsourcing increased to free up capacity where possible. - Locum support employed when available e.g. breast radiologists - Appointed a NHS Locum Chest Radiologist. - Chest substantive started April 2022. - New starters join on-call rota. - Recruited an additional Global Fellow due to start in 2022 - date tbc. - Advertised for Paediatric Consultant Radiologist. Interviewed and post offered and accepted. Candidate gave backword.	Earlier updates saved in File Notes. March 2021 Update: Risk reviewed, all areas updated as required. Position remains the same as December 2020 update. July 2021 Update: Position remains the same as March 2021. We are currently in the process of recruiting new Radiologists. November 2021 Update: A number of new Radiologists have come into post in October/November. February 2022 Update: Risk reviewed and changes in workforce reflected. Overall Consultant numbers have increased. April 2022 Update: Risk remains the same at this time. August/September 2022 Update: Locum Paediatric Radiologist will not work with us from November 2022 onwards. Working on an internal contingency for Paediatric support. November 2022 Update: Paediatric Radiologist's last day is 11 November 2022 with last working day being the 4th. Part-time cover has been agreed with 2 x LTHT Paediatric Consultant Radiologists	Jul-2023	Mar-2024

Very High	8072	Family & Specialist Services	Children's Services	Paediatric Medical Staff	Jun-2021	Active	Keeping the base safe	The paediatric and neonatal medical rota only allows for 1 registrar at night. The registrar is responsible for the medical running of both ward 3 (CRH), ward 4 (HRI), NICU (CRH), postnatal emergencies, labour suite emergencies, CRH ED, resus and taking calls from HRI ED. The requirement to attend emergencies or urgent cases at once could result in harm to patients. Often the registrar is called to a number of patients at the same time. This prevents them from being able to effectively cover across all areas and can cause time delays to care, adversely impacting safety, quality and patient experience. Most units of a similar size have 2 night registrars and this is within Neonatal standards. Whilst this is mitigated with consultants supporting the department with any emergencies, this does not support gaps in staffing within the current establishment. Having just 1 registrar at night poses risks to the health of trainees and the reputation of trainee placements at CHFT. The expectation for NICU is a dedicated registrar to improve safety and patient care. Tier 2 NICU staffing is not in line with BAPM national standards as a Tier 2 practitioner should be immediately and solely available to the neonatal service and labour ward. Current	- An on-call consultant supports the registrar with any emergencies (however, the on-call consultant is infrequently a neonatal consultant) - A Twilight Consultant is resident 2-4 evenings per week (however, the twilight consultant is a paediatric consultant) - From September 2021, the tier 2 rota was amended so that most evenings we have a Twilight Registrar. - See action plan section for updates.	The registrar rota requires an increase in 2.6 registrars to enable 2 registrars overnight. - See action plan section for updates.	12 3 x 4	20 4 x 5	4 2 x 2	- Risk repeatedly raised at PRM and PSQB. - Request additional funding to support increased Registrar support. Update September 2021 EGH - Winter bid agreed - agreement to go out for 1.4 WTE registrars for 6 months to support a 14 person rota. Roles currently out to advert. Update November 2021 EGH - First round of recruitment unsuccessful - 2 candidates who were unsuccessful at interview - Posts went back out to advert - awaiting interviews/outcome WC 8/11/21. Successful applicant started in post 13/12/21. Update March 2022 EGH - 2nd place candidate recruited and started 13/12/21. However, due to pregnancy related sickness and increased COVID-19 related sickness throughout January-March we have not been able to measure the impact of this. - Directorate submitted a development to make this post permanent from April 2022, however this was not approved by the Trust. - Ockenden report published with an action to ensure Neonatal staffing is within guidelines. We are not meeting these guidelines	Divisional Risk Register confirm and challenge update meeting held on 26/04/2023 - LR. Present: SRF, SS, NV, LRa, TO, VT, EGH, JM, WK, JE, HF Raised at last PRM, currently auditing and assessing risk - Feed back into PRM process. April 2023 - see action plans. January 2023 - see action plans November 2022 - see action plans. October 2022 - see action plans. September 2022 - see action plans. July 2022 - as above. July 2021 - Agreement to increase score after discussion with Division and expected surge from August 2021. Increase agreed in PSQB in July. Update September 2021 - As above. October 2021 - 6 month of winter funding granted, however recruitment not successful as candidates not suitable due to experience/length of posts. To go back out to advert. Risk mitigated some days due to rota allowing 2 registrars at night. Update November 2021 - First round of recruitment unsuccessful - 2 candidates who were unsuccessful at interview - Posts went back out to advert - awaiting interviews/outcome WC 8/11/21 Update December 2021 - 1 registrar started in post on 13/12 (temporary for 6 months)	Aug-2023	Aug-2023
Very High	8283	Family & Specialist Services	Radiology	All Radiology	Mar-2022	Active	Keeping the base safe	Service Delivery Risk: There is a risk of demand outstripping capacity across all areas of radiology due to (a) an increase in demand/recovery plans; (b) intermittent reduction in staffing capacity; and (c) persistent equipment failures resulting in longer waiting times, breach of 6 week wait standard and delayed diagnosis.	- Weekly monitoring of activity/capacity. - All requests are vetted, however, even with this capacity is at its maximum. - Radiology requesting that they be informed of Trust wide service changes impacting on radiology. - Rolling program of staff development. - Annual over recruitment of newly	- Limited control over referrals. - Short term sickness and high turn over of staff in some areas. - Ageing and obsolete equipment. - Radiology having limited input into recovery plans.	12 3 x 4	20 4 x 5	9 3 x 3	- Workforce plan, equipment plan and Radiology 5 Strategy to be presented/approved at WEB.	August 2022: Full review and update of risk, risk score increased to reflect current position. November 2022 Update: Funding for equipment replacement for oldest equipment approved at Capital planning. This is a program of replacement and construction work. The timescales for some replacements are lengthy but work on the replacement plan has commenced. International recruitment of Radiographers is stalling support for pastoral assistance and is still to be resolved.	Jun-2023	Mar-2024

Very High	8316	Family & Specialist Services	Pharmacy	Pharmacy	Apr-2022	Active	Transforming and improving patient care	There is a risk of systemic anti-cancer therapy prescriptions containing errors which are not identified by the pharmacy team. Due to an historic increase in workload without a proportionate investment in pharmacy staffing resource to process this increased workload. This has resulted in a clinical verification of systemic anti-cancer therapy prescription process which does not meet national standards and results in the pharmacist potentially providing sub-standard clinical check (despite sharing joint responsibility with the prescriber for the accuracy prescription) and more importantly, puts the patient at risk of medication error. A more in depth description of how current practice and national clinical standards vary can be found below. The British Oncology Pharmacists Association (BOPA) and the Royal Pharmaceutical Society (RPS) standards for pharmacists clinical screening of systemic anti-cancer therapy (SACT). The key areas of concern where CHFT are not compliant with the national standards relate to: blood results, critical test results, interactions, out of date protocols and checking the treatment is appropriate for the patient's diagnosis. Due to the current pathway, the pharmacists verify and therefore endorse the prescription as been safe and appropriate for that specific patient but a lot of the information which	Current clinical verification primarily undertaken by ADU pharmacists and is basic and none-compliant with national standards as highlighted above. Cancer nurses currently working on both day case units check blood results and pre-SACT assessment, but this can be ad hoc and not comprehensive due to their daily workload. Pharmacists providing clinical verification do undergo a training package which is historic and does not meet the BOPA training standards published in 2021. Current training package suggests checking of 20 prescriptions on a competency, other regional and the BOPA training standards recommend a minimum of 50 prescriptions of varying difficulty. Oral chemotherapy prescriptions are checked by Rowlands pharmacists who undergo the training package but are not cancer services pharmacists. When looking at recent Datixes on chemotherapy related incidents they are few and far between, we know there is recognised under reporting. Have spoken to senior sister about nurses completing Datixes, it is well known there is under reporting as the nurses are working at capacity and do not have time to complete. Nurses currently take responsibility of checking blood results on the Day Case Units for parenteral chemotherapy given, nurse and day case capacity highlighted as an issue with additional MYHT workload in risk entry ref 8084.	Rowlands locum pharmacists provide cover, despite no formal training. Pre-SACT pathway currently not consistent with current standards and has been highlighted as it's own risk for addition to medicines risk register. Despite workload increase, no additional resource for underlying clinical pharmacy service, number of Datixes have increased. Recent audit w/c 13th February 2023 53 interventions carried out by clinical pharmacist; 26 of which involved prescribing in some capacity, 3 changes to prescriptions due to recent blood work. Interventions over the week took 6 hours 27 mins to resolve.	15 3 x 5	20 4 x 5	1 1 x 1	Business case to be written which will include benchmarking of CHFT WTE oncology pharmacist numbers compared to those both within WYAAT and also compared to national figures. This will highlight that current oncology pharmacist staffing is insufficient to meet the current SACT demands. Priorities are to recruit to clinical pharmacy positions which would allow the clinical verification of SACT prescriptions to be undertaken by specialist clinical cancer services pharmacists as per BOPA /RPS standards . The training package will be rewritten so that it is compliant with nationally (BOPA) recognised training standards, current staff will undergo refresher training to highlight additional steps of the clinical verification of SACT SOP which are currently omitted resulting in non-adherence.	May 2022- review of wording of the entry. Business case still pending (awaiting finance input) June 2022- Business case still pending finance input, have chased. July 2022- Business case still pending finance, case submitted to haematology and oncology divisions for review prior to submission to BCAG in September. August 2022- Business case still pending finance, case submitted to haematology and oncology divisions for review prior to submission to BCAG in September. September 2022- Paper discussed at BCAG and supported in principle, however due to the Trusts financial position, additional meeting due in quarter 4 looking at investments for 2023/24 to ensure wise use of limited monies. This paper would be reviewed in this financial planning meeting. October 2022- Awaiting finance meeting in quarter 4 November 2022- Awaiting finance meeting in quarter 4 Divisional Risk Register confirm and challenge update 8/12/22 Present: SRF, ES, KC, SP, AH, SS, NB, NV, LH, LR Supported by BCAG in September, on P&D request, provide evidence on increases in patients, costs, rotas etc. Updating current BCP. Speak to Saima re performance stats. January 2023; Awaiting outcome of financial planning meeting in quarter 4 February 2023; Awaiting outcome of financial planning meeting in quarter 4 March 2023; Division fed back no funding allocated for 2023/24. Meanwhile patient numbers are increasing, SACT numbers are increasing, acuity of patients is increasing but no increase to pharmacy resource. Risk ratings increase due to the above. March 2023: Underpinning SOPs and policies are been updated to compile with national standards.	Jun-2023	Jul-2023

Very High	8324	Corporate	Planned Access and Data Quality	RTT Validation	Jul-2022	Active	Keeping the base safe	High volume of outstanding clinical outpatient validation and prioritisation on Mpage is resulting in the inability to identify next steps in patients pathways which causes delays and non compliance with the Trust Elective Access Policy. Prior to clinical review these patients have already been admin reviewed which on average removes 50%. There are currently a total of 15,841 patients awaiting clinical review and prioritisation on Mpage. This comprises several patient cohorts: Cancelled appointments with requests (CAWRs) - 585 Holding List (12 weeks overdue) - 8,715 Incomplete Orders (IOs) - 6,541 9,054 patients have been waiting more than 90 days with the longest wait being 546 days. There are several risks of not clinically reviewing these patients 1. A proportion of patients won't need a clinic appointment therefore by not reviewing them we are missing the opportunity to remove them from the backlog and could have an appointment booked in the meantime which would would waste valuable capacity. 2. A proportion of patients could be urgent but will be delayed in receiving an appointment, therefore the Trust carries a level of unknown risk. 3. The incomplete order patients do not have an order within EPR therefore will never receive an	Full reporting in KP+ at patient, clinician and specialty level. Reviewed at customer contact meetings. Auto generated email to clinicians when they have 20+ validations to complete	Insufficient clinic time available to review patients in a timely manner	20 4 x 5	20 4 x 5	6 3 x 2	New Access Committee launched in May 2022 and meets on a monthly basis. The target is for no patient to wait more than 30 days for clinical assessment.	08/03/22 There are currently a total of 14,238 patients awaiting clinical review of this 8,984 patients have been waiting more than 90 days. In addition to this we currently have 3,595 P rated patients on the holding list that are now overdue due to insufficient capacity. There is now a focus on clinical validation of the >90 day IO patients which is currently stands at 3,203. This is reported weekly through performance targets with a trajectory to get to zero by end of May 23. Repeat admin validation of >90 day IO's has now been completed and over 2k patients were able to be removed from clinical validation. We are working closely with the RPA team to automate select pieces of admin validation in order to increase capacity. We continue to highlight outstanding validation and capacity issues and customer contact meeting with emphasis on IO patients. Data and training packs sent to all Directorates and TEAMS training sessions have been completed on request. 22/09/22 There are currently a total of 15,649 patients awaiting clinical review of this 9,781 patients have been waiting more than 90 days. In addition to this we currently have 3,308 P rated patients on the holding list that are now overdue due to insufficient capacity. We are now reporting this through quality priorities and EB/ADG. Pulling a proposal together around further admin validation opportunities what resource this would require. Continue to highlight outstanding validation and capacity issues and customer contact meeting with emphasis on IO patients. Training sessions being scheduled with managers and clinicians around using the system and reporting available to increase engagement and viability.	Sep-2023	Oct-2023
Very High	8415	Family & Specialist	Radiology	Angiography & Fluoroscopy	Sep-2022	Active	Keeping the base safe	Financial Risk: There is a risk relating to the cost of repair or replacement of the Fluoroscopy equipment at HRI in the event of an unexpected breakdown (temporary or fatal) due to the age and lack of maintenance support. This links to risk 8146.	- Any faults or downtime to be reported via Datix. - Ability to use equipment at CRH.	- Maintenance contract no longer in place for equipment. - No funding to replace equipment in the event of fatal breakdown. - No funding in place for any necessary repairs/replacement parts.	20 4 x 5	20 4 x 5	3 3 x 1	- To redirect referrals to CRH.	November 2022 - OP and Inpatients continue to be referred to CRH. Use of mobile c-arm to support Endoscopy patients at HRI. Plan being put together to keep discussions open and consider longer term plan. Divisional Risk Register confirm and challenge update 8/12/22 Present: SC, GE, SS, SRF, NV, NB, LH, LR Linked to Risk 8416. Challenge around risk score	Jun-2023	Mar-2024

Very High	8429	Medical	Medical Specialities	Cardiology	Oct-2022	Active	Keeping the base safe	PCI waiting time (19 weeks) and angiogram (15 weeks) waiting time >6 weeks. There is a significant risk that chest pain patients (NOAC and Elective) may have a heart attack (STEMI or NSTEMI) whilst awaiting their procedure. This is because once diagnosed from clinic (2 week wait for NOAC) and a further test such as CT angio (7 week wait) to diagnose, the total time from referral to treatment will be 30 weeks. This could have a significant impact on acute admissions and the bed base over time and may be worse through the Winter period. This could also have a significant impact on patients as they may have a heart attack that results in significant damage, and/or could lead to death if left untreated. At present, the waiting list continues to expand due to the current acute pressures, demand, and the increase in the complexity of cases. As a result, the risk has now become significant and urgent action is required.	Referrals to be validated on urgency, however there are too many patients at present with similar clinical histories. Patients rang if any spare capacity on a list, e.g cancellation	No more capacity, therefore unable to bring waiting list down. 1 x lab Lack of cross-cover in job plans.	20 5 x 4	20 5 x 4	4 2 x 2	- Requested extra lists, but no agreement on payment. - Continue to maximise capacity where possible.	Accepted at PSQB Dec 2022 (Risk score 15) 23.12.22 risk increased - Trust has been in OPEL 4-8 inpatients on 6D this has reduced ability to complete elective procedures. Cases reviewed re: urgent and list of cancelled patients escalated. 6D closed to inpatients 22.12.22- to review risk rating depending on events over Christmas/New Year period. Risk still very high as 6D has 8 inpatients w/c 02/01/23. Waiting time for PCI now 25 weeks and increasing week on week.	May-2023	
Very High	8454	Family & Specialist	Women's Services	Maternity	Nov-2022	Active	Keeping the base safe	There is a risk of delay in admission for induction of labour, due to reduced midwifery staffing, resulting in poor neonatal outcome and poor patient experience Linked to overarching staffing risk No 6911	Daily review of IOL position and risk assessment at morning safety brief by Hot Week / On call Consultant Obstetrician Escalation pathway - neighbouring maternity units contacted for request to facilitate IOL where delays occur Women offered daily fetal wellbeing monitoring during period of delay	NICE guidance recommendation for IOL Inability to predict capacity and demand at neighbouring trust	20 4 x 5	20 4 x 5	6 3 x 2	Quality Improvement piece of work regarding IOL Delays reviewed at weekly governance	June update - LD, GH, DT, JM - following successful implementation of QI project delays in IOL have reduced. Propose to reduce score 12 (likelihood to 3) May 23 - Divisional Risk Register confirm and challenge update 23/5/23 Present: SRF, NB, TO, LM, GH, FA, NV, RR, DT, LR	Jun-2023	Jun-2024

Very High	8508	Surgery & Anaesthetics	Head and Neck	Ophthalmology	Feb-2023	Active	Keeping the base safe	There is a live current risk to CHFT being unable to provide a Consultant Glaucoma Service due to no Consultant in post at CHFT. Resulting in not providing the required supervision and training to specialty doctors required for the royal college of ophthalmology standards impacting standards of care, staff development, delays and clinical outcomes for patients.	Advert out for x2 locum consultant - 1 success and due to start 8/5/23. 1 post still out to advert AHP's providing new patient clinics. Technicians providing diagnostic clinics Agreed Agency Consultant to take on glaucoma standard capacity. Trust Drs protected glaucoma slots. Regular meetings with failsafe team re pending lists, ASI's and HLs WLIs for virtual appointments. IPT trabeculectomies to neighbouring trust WYAAT / regional involvement Escalation to Aletta Carbone (CD H&N) and Thomas Strickland (DOp S&A)	No substantive consultant leading service - Not having a Consultant is preventing the glaucoma service to run as clinics require a lead resource. Current workforce have been asked to take on this, however due to not specialising within the area there has been no success to create these resources at a complex level. Not having substantive resources is causing instability within the service and is in turn affecting recruitment and retention due to lack of support for current workforce. Repeated attempts to recruit have been unsuccessful National shortage of glaucoma specialists No locum consultant able to perform surgical intervention Risk to agency / bank giving last minute notice.	20 4 x 5	20 4 x 5	6 2 x 3	Advertise Glaucoma Consultant vacancy Business case for Speciality doctor Collaborative working amongst AHP's regarding service improvement in screening and stable clinics Review of the pathway / AHP and nursing training Quality assurance systems to ensure patients are seen by the right clinician at the right time Opportunities to work differently to optimise capacity 90 clinics required to review all 719 patients past their end date. 5 super red clinics required for the 30 patients currently validated as requiring interventions. However not all patients requiring F2F review have been validated therefore the total number of high risk patients has not been identified. (datix will need to follow to capture the harm) To look at competencies and JPs with each ACP. However this will be a future provision not an intermin help.	08/06/2023 resignation of optometrist specialising in glaucoma currently supporting new patient service. Adds to fragility of service. ? new risk to report as now single point of failure to all new patients or increase current risk to service. Escalated to TS. 24.05.23 - Discussed at Risk Group agreed risk score of 20. Recommendation from COO's is that there is a WYAAT service wide review for glaucoma. 22/05/2023- discussed at PSQB to increase to 25 due to no consultant (locum candidate does not look appropriate to interview) and locum agency still no definitive date. It was decided that 25 was for risks with evidential harm currently happening, where as here we are raising a likely risk. It was explained what the services does not know the risk that it is sat on due to 4000 patients not having been reviewed and the number that could come through with harm and sight loss once reviewed. Risk team agreed to review other risks at 25 to compare. It was raised that glaucoma had been a risk of 25 previously but had reduced to 20 as there was impending consultants due to start however these have not come to fruition. Waiting for risk team to advice. COO has raised at region WYAAT and COO meetings. Sal Uka has agreed to support discussions for mutual aid and IPT patients (currently IPT poses a risk as there is a delay in acceptance of these patients regionally). Regional GM meeting with Louise Corp to agree rota for mutual aid 23/5/23. 11/05/23- Locum agency consultant delayed start date, service still without lead.	Jun-2023		

Very High	8509	Surgery & Anaesthetics	Head and Neck	Ophthalmology	Feb-2023	Active	Keeping the base safe	There is a risk of significant harm due to insufficient glaucoma appointments available to cope with demand due to increasing patient numbers and inability to recruit substantive consultant. This will result in long delays, multiple rescheduling of existing routine patients having to be moved to accommodate more urgent appointments on a weekly basis. Many appointments falling outside the recommended guidelines due to capacity issues. Delays in treatment could result in loss of sight and could lead to irreversible blindness, in turn leading to a potential influx in litigation with financial implications due to patients who have not been seen in the right place at the right time.	Risk stratification of waiting lists Micromanagement of clinics and utilisation of slots by existing consultant and failsafe Pathways to ensure efficient and correct requests Agency consultants and WLI Discussions with WYAAT and ICBs to look at community pathways and primary care solutions IPT agreements with neighbouring trusts 4462 pts on holding list, 719 past end date, 200 Red Longest waiter 17 weeks past end date, 495 Amber. Longest waiter 27 weeks past end date (one outlier 116 wks past end date) 30 patients have been validated as Super red requiring intervention to limit sight loss.	Lack of medical staff, AHP support, clinical capacity and clinical space to see the required demand resulting in an increase in holding lists. Clinics being stood down to enable staffing of gaps in emergency/ acute and MR services Single point of failure to service if agency consultant were to leave. Further cancellation of clinics to enable theatre sessions. Lack of consultant able to offer complex surgical intervention for high risk patients Increase in virtual review not desirable to medical workforce. Accepted risk already for increased incomplete outcomes (monitored via access meetings) due to increased virtual pathways	20 4 x 5	20 4 x 5	6 2 x 3	Job advert for additional substantive or locum consultant with a special interest in glaucoma Business case for additional specialty doctor position Identify and develop areas that may be suitable for diagnostic or virtual pathways (already in place, impact on virtual pathways as limited virtual review resource available)	31.05.2023 - 290 incomplete outcomes which are all virtual glaucoma clinic appointments awaiting review. Do to lack of reviewers due to no substantive consultant, offered out WLIs to clinical staff to support undertaking these virtual reviews of those low risk routine glaucoma patients to try and get on top of the backlog while we continue to actively scope recruitment options. 24.05.23 - Discussed at Risk Group agreed risk score of 20. Recommendation from COO's is that there is a WYAAT service wide review for glaucoma. 22/05/2023- discussed at PSQB to increase to 25 due to no consultant (locum candidate does not look appropriate to interview) and locum agency still no definitive date. It was decided that 25 was for risks with evidential harm currently happening, where as here we are raising a likely risk. It was explained what the services does not know the risk that it is sat on due to 4000 patients not having been reviewed and the number that could come	Jun-2023	
High	8473	Family & Specialist Services	Children's Services	All Departments	Dec-2022	Active	Keeping the base safe	There is a risk of insufficient WTE of matron leadership to support the children's directorate due to the size of the portfolio for the role (Children's inpatients, Outpatients, Child development Centre, Diabetes, Epilepsy, Specialist Nurses, Transition, Special Schools and Children's Community Nursing Team). This results in sporadic leadership to provide quality and safety assurance for patient care and support for the clinical managers and wider MDT teams. This also results in concerns for the inability to deliver key strategic agenda items for CYP from the Long-Term Plan (NHSE), RCPCH Standards and Journey to Outstanding reviews are likely to remain limited with the current structure. There is also no defined Clinical Governance support for the Directorate. There has also been two Serious Incidents (Nov, Dec 2022) which in part can be attributed to the need for more visible senior leadership.	NHSE Regional Lead for CYP peer review visit. 0.8wte recruited to cover substantive 1.0wte Matron Maternity Leave CQC CYP Transformation meetings ADN/Lead Nurse for CYP supporting with Operational workload.		16 4 x 4	16 4 x 4	0 0 x 0	ADN /Chief Nurse - consideration of additional Matron for community & Band 7 leadership as part of hard truths process Review of WFM with separate safe staffing for each clinical area - PAU, HDU, POD's and Ward 4. Shelford acuity data collection in progress January 2023 with a plan to repeat in June 2023 Recruitment to Governance lead for CY ADN/Lead Nurse/Finance developed paper for realignment of existing nursing budget to support strengthened leadership for the directorate - approved by Division in April 2024. Pending approval from Chief nurse as part of Hard Truths Process in May 2023. Meeting in pace. If approved this would support mitigation of this risk	June 2023 - Matron post on Trac - approved through hard truths process and via Division. Pending Trust panel approval to go to advert Divisional Risk Register confirm and challenge update meeting held on 26/04/2023 Present: SRF, SS, NV, LRa, TO, VT, EGH, JM, WK, JE, HF We have 0.8 whole time equivalent to cover to support the whole directive from a Matron prospective. SRF, JM and Finance have developed a paper for realignment of existing nursing budget to support a strengthened leadership. If approved, we'll go out for recruitment, which will mitigate the risk. Approval of structure in Division, meeting with Chief Nurse ahead of approval at Hard Truths.	Aug-2023	

High	8483	Family & Specialist Services	Children's Services	Neonates	Jan-2023	Active	Keeping the base safe	There is a risk of having insufficient substantive funding of senior nursing leadership for Neonates due to this not being part of the workforce model for Neonates. This results in sporadic senior oversight of neonatal care and concerns for the inability to deliver key strategic agenda items for the Neonatal agenda, for example GIRFT, Ockenden and the Long Term Plan. Progress to meet these is likely to remain limited with the current structure.	Temporary uplift of existing Band 7 Clinical Manager into Matron role due to end March 2023 - extended by ADN to June 2023. Review of existing WFM as part of hard truths process. Clinical Manager linking with regional ODN Neonatal network.		16 4 x 4	16 4 x 4	0 0 x 0	ADN to review as part of staffing workforce models. To be considered as part of Directorate business planning process 2023 - on hold.	Divisional Risk Register confirm and challenge update meeting held on 26/04/2023 Present: SRF, SS, NV, LRa, TO, VT, EGH, JM, WK, JE, HF Working with Finance, taking paper on Friday to support senior post	May-2023	Jun-2023
High	8438	Family & Specialist Services	Women's Services	All Departments	Oct-2022	Active	Keeping the base safe	Risk of non compliance with Ockenden 2 recommendations in relation to provision of separate consultant rota for obstetrics and Gynaecology medical staff due to lack of consultants to create a separate rota resulting in suboptimal care for local women and their families and loss of reputation	Datix trigger list for Obstetric and Gynaecology Duties of the hot week consultant guidance in place and has been agreed by all pts on the rota extended resident consultant hour on labour ward to ensure 2nd ward round with MDT	Availability of medical staff to provide fully functioning split rota Additional funding A fully functioning split rota Additional funding post Ockenden 2 lack of risk assessment and escalation protocol for periods of competing workload, with a mandate for this to be agreed at board level. Meeting of the RCOG guidance re role of the hot week consultant for O and G Capacity impacted in ANC due to lack of cover for hot week consultant, resulting in additional cost at bank rate as clinic requires cover and can not be covered by existing job plans	16 4 x 4	16 4 x 4	4 4 x 1	Paper completed outlining proposal for split rota - Oct 22 Submission for business planning 23/24 financial year - outcome required further information to support submission, continue current mitigation Incidents reviewed at weekly governance meeting Audit for consultant attendance at cases - reviewed weekly and presented quarterly Plan to review risk and update in light of publication of 3 year delivery plan and consider current risk and score.	May 23 - Divisional Risk Register confirm and challenge update 23/5/23 Present: SRF, NB, TO, LM, GH, FA, NV, RR, DT, LR Divisional meeting to take place asap re funding.- will require an update in June re the development of escalation protocol in June 23 May 23 reviewed GH LD no funding identified as yet - discussion to be had with Divisional team when discussed at Directorate PRM March 23 reviewed by GH and LD we are currently waiting for a final decision from execs regarding funding Feb 23 LD DT review - continue to await case outcome for split rota and additional recruitment of consultants to be completed.	Jun-2023	Oct-2023

High	7678	Trustwide	All Divisions	All Departments/Wards	Mar-2020	Active	Keeping the base safe	There is a risk of reduction in safe Medical staffing levels below the minimum required to maintain safety Due to the impact of Covid-19 on capacity particularly in Critical Care, Respiratory Medicine, Acute Medicine, Elderly Medicine and Emergency Department Resulting in unsafe levels of patient care In addition, because Covid-19 directly impacts sickness absence and self-isolation of the medical workforce, a reduction in the medical workforce is to be expected. Outside of surges of COVID-19 impact is reduced but non-COVID activity remains high.	Options implemented during COVID surges and episodes of high activity and stood down when activity and staffing pressures lessen Identified lead for Medical redeployment (CP) Covid Incident Control meetings and governance arrangements Staffing Incident Command once or twice-daily meetings Cancellation of annual leave Cancellation of study leave Suspension of appraisal Tools used Guidance on shaping the Medical Workforce Staffing framework for ICU used Developed acuity tool to inform doctor deployment	SPA time for revalidation and appraisal Do not have all staff on e-rostering Reporting of sickness absence and self-isolation is not consistent for medical staffing Overseas recruited medical staff cannot travel to UK to commence work - anaesthetics, gastro, ED, Radiology	20 4 x 5	16 4 x 4	6 3 x 2	Work with regional partners to mitigate impacts on smaller services Staff testing to identify those safe to return to work Redeployment of staff to critical areas Return to Practice Doctors being approached by Health Education England Bank adverts across grades and specialties Continue recruitment as usual Consolidated junior doctor rotas New rotas for middle grade (start 6.4.20) and consultant on-site 24/7 cover (start 13.4.20) - second phase start 9 November 2020 Mapping capacity against minimum and strech levels in non-high and intensity areas Skilllsets - Physician CPAP trained, non-physician trianing package for high intensity areas	October 2020: Notifications to junior doctors and registrars regards new rota changes to be miplemented from 9.11.2020, Fully compliant with rules set out in 2016 junior doctor contract. Medical Workforce briefings in place, doctor representatives publicised. Message to consultants regards rota changes effective 9.11.2020. 01.05.2020 IMT risk review 20.04.2020 As of 13.4.20 nearly 200 training grade doctors, physician associates and 14 ACP's on same compliant rota pattern. Majority still working in their base area until step change in demand. Consultant Acute Physicians working a 24/7 onsite rota joined by resp physicians working till midnight and contactable thereafter and elderly medicine now doing twilight rotas until midnight. General Surgeons already work this shift pattern which continues. Three senior medical registrars on site overnight Anaesthetists are providing direct support to the Critical care expansion plans Twice daily medical deployment meetings, 7 days a week chaired by Deputy Medical Director with DD's, and other colleagues incl. junior doctor input. Activity, sickness and acuity reviewed. T&O supporting ED with management of the Minors workflow Training grade doctors WhatsApp for communication. Core group of senior colleagues and 11 junior doctor/physician associate leaders representatives to ensure working together	Aug-2021	Nov-2021
High	8537	Family & Specialist Services	Children's Services	Children's Community Nursing Team	Mar-2023	Active	Keeping the base safe	There is a risk to patient safety in the special schools from the start of September 2023 due to the increased number of pupils requiring health interventions. The frequency and intensity of interventions required for children with complex needs is increasing. This is further exacerbated with 2 of the schools opening additional school sites which require nursing support. The impact of this will result in three of the school sites not having a nurse on site with a complex caseload e.g. a ventilated patient, a tracheostomy patient and an unstable epileptic. Children with complex needs have the potential for deterioration at short notice and this can result in the school nursing team has the potential to respond to more than one medical emergency occurring simultaneously, together with qualified nursing duties for safe patient care.	There is a nurse on site in all of the special schools, with one sixth form site staffed by a HCA only. The site currently staffed by a HCA has a level of dependency of pupil need which the HCA is able to support. Additional nursing support is provided on a daily basis from within the current special school nursing team prior to school starting to draw up and check medication. The CCNT cover sickness or leave within the special school nursing team which impacts on CCNT cover arrangements.	There is no contingency to manage an increased number of pupils with increased intensity and frequency of interventions. The current workforce model has been in place for several years and has not evolved with the increased workload. On one site the school nurse works alone for 1 hour per day with a caseload of 160 pupils to manage. It is not uncommon for there to be 2 calls for assistance simultaneously during these times (Seizures, pulling gastrostomy buttons out, unstable diabetic, etc. In addition this nurse supports 70 on a satellite site. (total pupils currently supported by 1 nurse each day is 244)	16 4 x 4	16 4 x 4	3 1 x 3	CCNT Community Nurse Manager is working with Vicky Brown (finance) to review pupil numbers and interventions in the special schools to consider a revision of the special school workforce model and a contract variation. Directorate Team to meet with finance and formulate a plan for further discussion with the Contracting Team and ICB	1st meeting with the CCNT Manager and finance 15/3/23 Clinical manager has collated the data of pupil numbers/acuity and dependency. Divisional Risk Register confirm and challenge update meeting held on 26/04/2023 Present: SRF, SS, NV, LRa, TO, VT, EGH, JM, WK, JE, HF Discussions as a directorate, VB looked at workforce model, Alison will meet with LRo to progress work. Next steps to look at further funding. Include Helen Gaukrodger re funding. April PSQB - Risk accepted it was agreed the workforce model is no longer fit for purpose. SR-F suggested a task and finish group, which EG-H will arrange. 11/05/23 meeting with SLT and school nurse at Ravenscliffe to discuss potential pupil numbers, potential configuration of school sites and dependency from September 2023 17/05/23 ongoing work with finance to document current workforce model. Summary of individual special school staff working hours, contracts and SLA shared with finance for inclusion.	May-2023	Aug-2023

High	8416	Family & Specialist Services	Radiology	All Radiology	Sep-2022	Active	Keeping the base safe	Financial Risk: There is risk of an increase in expenditure relating to reporting of images due to a significant increase in the imaging requiring reporting (linked to increase in demand) and the increased cost in reporting costs which will result in an overspend of the Radiology Directorate budget.	- Regular monitoring of reporting backlogs - Daily allocation of images for reporting - Regular liaison with external reporting company re: capacity, allocation, turnaround times etc.	- Inability to control demand for imaging which in turn creates reporting - Inability to control reporting capacity for external reporting companies	16 4 x 4	16 4 x 4	9 3 x 3	- To continue to monitor reporting needs on a daily basis - To continue to liaise with external reporting companies to maximise reporting - Offer of additional reporting to in-house Radiologists at a premium rate for a short period of time to help reduce backlogs - Consider other options for increasing in-house reporting capacity	November 2022 Update: Recent tendering exercise has ensured all providers are from an appropriate framework and two new providers have been identified/contracts entered into. Backlogs experienced in the Summer due to reduced capacity are much improved. This is due to premium payments for in-house Radiologist insourcing which meant better uptake by CHFT Consultants. Utilisation of premium rate outsourcing 24hr turnaround also helped to reduce backlogs. There continues to be a direct correlation between high Emergency Department attendances and high levels of out of hours reporting and associated costs. Increased spend on reporting has been forecast to the end of the	Jun-2023	Mar-2024
High	8358	Surgery & Anaesthetics	Head and Neck	Ophthalmology	Jul-2022	Active	Keeping the base safe	There is a risk of significant harm due to insufficient corneal appointments available to cope with demand due to increasing patient numbers and inability to recruit substantive consultant. This will result in existing routine patients having to be moved to accommodate more urgent appointments on a weekly basis. Many appointments falling outside the recommended guidelines due to capacity issues. Delays in treatment could lead to clinical incidents including increase of complaints and permanent sight loss if patients are not seen in a timely manner.	Risk stratification of waiting lists Micromanagement of clinics and utilisation of slots by existing consultant and failsafe Pathways to ensure efficient and correct requests Weekly WLI by consultant No of overdue f/up patients: 396 with the longest waiter being from Feb 2022 this excludes clinically validated patients that have been moved on. This include high risk urgent patients. No of overdue new patients: 18, Next available slots are in sept 2022 (9-10 weeks away)	Lack of medical staff, optometry support, clinical capacity and clinical space to see the required demand resulting in an increase in holding lists. Single point of failure to service if one of existing consultants should be off. Further cancellation of clinics to enable theatre sessions.	16 4 x 4	16 4 x 4	0 5 x 0	Job advert for additional substantive or locum consultant with a special interest in cornea Business case for additional optometry hours to enable low risk caseload to be moved away from consultant clinics Identify and develop areas that may be suitable for diagnostic or virtual pathways	12/05/2023 - 7 applicant for locum consultant post. To be shortlisted and interviews on 13th June. 13/04/23 - Consultant post back out to recruitment on Trac. Close Date May with aim to interview in June. 09/02/2023 Optometry business case rejected. Virtualizing low risk patients identified and transformation project discussed. Needs escalating Recruited consultant withdrawn due to 'a better job offer' 08/08/22 Holding list validation 530 overdue pts, 48 of which are high risk, booked until end of sept with	Jul-2023	
High	8161	Family & Specialist Services	Radiology	CT	Sep-2021	Active	Keeping the base safe	Service Delivery Risk: There is a risk of being unable to provide a CT scanning service in the event of a fatal breakdown of the CT scanner at CRH due to the age of the equipment (9 years old, lease expires 2022) which may result in the inability to scan patients and a failure to meet national standards (i.e. Stroke).	- Scanner regularly serviced - Maintenance and Service contract in place - Current use of mobile CT scanner in the event of a breakdown (at an additional cost) - Ability to scan patients at HRI if needed	- No cover when the mobile scanner leaves site (planned to leave March 2022) - Our staff are not trained to use the mobile scanner (the scanner is provided by a private company and is manned by their staff).	9 3 x 3	16 4 x 4	4 2 x 2	- CT scanner to be included within the new MES - To utilise the mobile unit where ever possible - To transfer to HRI, if appropriate. - CHFT staff now training to use the mobile scanner. - Replacement scanner included in equipment replacement scheme planning.	Discussed at Radiology October Board - risk to remain as proposed for the time being, to update when all CHFT staff have been trained on the mobile unit scanner. November 2021: Radiology Board agreed to approve this risk, additional risk linking to financial impact to also be added. February 2022: Cancellation of use of mobile scanner presented at EQUIA Panel who did not approve the scheme. Funding to keep the mobile	Jun-2023	Mar-2024

High	8277	Medical	Integrated Medical Specialties	Neurology	Mar-2022	Active	Keeping the base safe	"There is a potential risk to patient care and treatment as not sustaining the day to day delivery of the Neurology service due to the depletion of the medical workforce, and not being to recruit replacement Consultants, will result in an unsustainable service. Broad overview of service requirements: - 70 new outpatient referrals per week - 25 inpatient referrals per week - Current backlog ASI's 979 - Holding list over 12 weeks 847 - Validation - 2300 to complete "	Reducing inpatient cover to 3 days a week Clinics have been stepped down to provide time for validation to ensure we fully understand the service risk and patient impact. Additional bank shifts offered.	Explored joint working with Leeds not possible until August 2022 at the earliest due to their current gaps. Approached Mid Yorks/Bradford to understand ability to offer mutual aid however, they are also under resourced and cannot support. Outsourcing in place but limited capacity. Looking to maintain rotational reg placement however, with reduced medical workforce and supervisory capacity this is a risk of being removed, reducing capacity further. Locum Agency's approached but no	20 4 x 5	16 4 x 4	6 3 x 2	Ongoing recruitment - interview of one candidate on 8th April. Discussions with deanery to maintain rotational registrar. Implemented different ways of working to mitigate risk (see existing controls).	22/07/2022 - Risk accepted at PSQB 21/06/2022 - Risk accepted at Directorate Board. Now needs presenting at PSQB in July 12/9/2022 - Clinics stepped down effective from beginning of September releasing consultant capacity to facilitate inpatient reviews as a result of a reduced medical workforce due to retirements, people leaving and an inability to recruit 21/10/2022 - Reduction in risk score accepted at PSQB 27/3/2023 - Leeds support is now in place for A&G and a third party from April will be involved in triaging all new referrals to reduce outpatient demand which is currently being managed via insourcing, However we still have reduced capacity	Apr-2023	Sep-2023
High	8280	Corporate	THIS	THIS -Operational	Mar-2022	Active	Transforming and improving patient	Risk of: EPR/Imprivata/SSO not releasing the previous credentials when accessed via tap and go. Due to: intermittent issue between Cerner EPR and the Imprivata product Resulting in: Patient care being logged in EPR under the wrong user/clinician.	TBC - Digital Health Team investigating Imprivata aware Logged with Cerner - 10/03/22	Further investigation and fix from Cerner Raising awareness for clinicians to check	12 4 x 3	16 4 x 4	4 4 x 1	Bi-weekly meetings set up to monitor progress Issue logged with Cerner and followed up daily Clinicians asked to monitor and ensure they are the ones logged in	This has been logged and escalated with Cerner as high priority (via IRC) Cerner recommend Imprivata upgrade which is currently being planned for June 2022. CNIO/CCIO aware and monitoring the impact Aug 2022: Awaiting further update from cerner with issues. Nov 22: Essential work taking place with the core network. 24th November. PMO assigned to this project. Awaiting core network work to be completed then this will take place hopefully early january 22. Nov EB 22: No further update Feb 2023: Kick off meeting on 25th January 2023.	Jul-2023	Aug-2023

High	7479	Family & Specialist Services	Children's Services	Children's Ward CRH (3)	Jun-2019	Active	Keeping the base safe	There is risk that young people with acute mental health needs and /or behavioral/social care needs will be managed on the paediatric ward for an extended period by staff that do not have the appropriate skillset. There is a significant concern around children and young people with self-harm, suicidal ideation, eating disorders, and the increased complexities associated. Due to a national shortage of inpatient provision for young people with acute mental health issues they are waiting for a specialist bed or Children's Social care management. Resulting in potential harm to the patient, other patients, carers and staff. COVID-19 has had a significant detrimental impact on the number of acutely unwell children and young people with mental health conditions. This increase has been seen both locally and nationally, in numbers and acuity. As an example, from January 2022 to June 2022, there were 80 admissions of CYP in crisis to the children's ward.	1. Agreed joint admissions guidance with CAMHS provider 2. Restrictive holding policy in place 3. Mental health awareness training undertaken for key staff 4. All incidents investigated 5. Paediatric representation at the mental health operational group 6. All requested for one to one shifts immediately escalated 7. Paediatric/CAMHS partnership meetings commenced 8. Clear escalation plans formulated 9. CAMHS hot and cold debriefs instigated 10. Clinically related challenging behaviour guidelines 11. Restraint and use of force guidance (clinical holding) 12. Clinical PEARLS 13. Barriers to discharge protocol in place between CAMHS, Social Care and CHFT	Skill set of staff to care for children with complex psychological needs Inability to provide a one to one support from staff with the correct skill set and experience Consistency of escalation during out of hours periods Clarity of escalation pathway to ensure awareness and timely transfer of patients to inpatient mental health settings external to the trust	20 4 x 5	16 4 x 4	4 2 x 2	February 2023 Mental Health Liaison Nurse in post Review of mental health guidelines in progress MH liaison nurse shared Training opportunities shared with children's ward team April 2023 Task and finish group set up with ward staff to address learning from incidents, debrief and address learning needs. November 2022 Induction plan for Band 6 liaison nurse jointly developed between Paediatrics and Camhs. Aiming for CAMHS team to allocated band 3 to the children's ward following their recruitment. Linking with CHFT Nurse Consultant for Mental health re training plan and oversight. Paediatric attendance at Mental Health Operational group October 2022 Band 6 Mental Health liaison nurse appointed. Debrief sessions for team following complex cases. Task and finish group in place to develop Multi agency protocol for escalation and removing barriers to discharge. July 2022	Divisional Risk Register confirm and challenge update meeting held on 26/04/2023 Present: SRF, SS, NV, LRa, TO, VT, EGH, JM, WK, JE, HF Task and finish group created for ward staff to address learning needs from incidents, debrief and address learning needs. Also been contacted by the lead of the ICB to provide some feedback about the effectiveness of Angie Salmons coming into Mental Health post. Mitigations: Ongoing work with ICB, from local prospective to push with CAMHS. Support of Band 3, not in post yet due to recruitment difficulties. April 2023 -as above February 2023 as above October 2022 -as above July 2022 - as above March 2022 - as above December 2021 - Anti-ligature risk assessment completed for the children's ward (3, CRH) November 2021 - Initial joint meeting with Camhs, CCG to sope new ways of working and channels for escalation. Sept 21 - Escalation at PSQB, PRM, Tactical, and externally to the Division as required. Escalation to CCG, CAMHS, Social Care, and ODN. Escalated concern regarding lack of 1:1s to CCG - CCG coordinating CAMHS supporting this. July 2021 - The situation continues to be challenging. Daily MDTs to support patients continue, however there have been issues with attendance from Social Care. Good support from CAMHS. Plan to get an escalation process in place across teams. April 2021 The situation has worsened due to the pandemic and not having access to school etc. Also Calderdale has a high number of children in care that have been relocated and the private providers are unable to deal with the behaviours and therefore they present at ED Dec 20 Aiming to roll out We can Talk Mental Health training in CHFT in new financial year.	Jul-2023	Dec-2023

High	8009	Medical	Integrated Medical Specialties	All Departments	Feb-2021	Active	Keeping the base safe	There is a risk of outpatient capacity not being sufficient to ensure timely appointments for both new and follow up patients across IMS. This is exacerbated by the restriction of face to face appointments that are required although this is partially mitigated through video and phone clinics. For specialties such as Neurology physical examination is more likely and face to face appointments required following an initial telephone appointment or video call and therefore adding additional pressure to already stretched capacity. This risk is due to the size of the backlog that has built up during the covid pandemic. This is resulting in delayed appointments and ultimately the risk of not diagnosing a patient and seeing and treating then within the 18 week RTT pathway.	CAS clinic and advice and guidance to manage referrals into the trust	Capacity to deliver against the demand due to the backlog built up over covid As at 21st May 2023 Neurology ASI's - 837 Follow up past due to - 3064 Haematology ASI - 119 Follow up past due to - 7 Dermatology ASI - 232 Follow up past due to - 1383 Nephrology ASI - 72 Follow up past due to - 117 Rheumatology ASI - 216 Follow up past due to - 2701	16 4 x 4	16 4 x 4	2 1 x 2	Looking to increase the medical workforce where budget allows and as short term mitigation increasing the number of clinics run through waiting list initiatives. To continue to aid recovery the directorate are continue to maximize the use of recovery funding to deliver WLI clinics both internally and externally with a focus on reducing patients on an open RTT pathway to under 40 weeks initially with a further push to get below this based on capacity and available funding.	30/6/2021 - A change in the set up of outpatient clinics for both face to face and telephone has allowed increased face tro face capacity to start to address the ASI backlog. Additionally work is underway with CCG to look at possibilities of outsourcing to increase capacity 21/05/2021 - Risk accepted at PSQB 05/10/21 Neurology: Outsourcing of new referrals starting with Pioneer. Interview for joint consultant post- not appointed. interview for vacant middle grade post- appointed, currently going through HR process. Specialty Doctor returned from long term sickness. To review position in 2 months. Rheumatology: Middle grade returned from Egypt and now working full time. Appointed band 8 nurse- nurse led clinics to start when in post. Advertising for 1.8 Band 6 posts. Business case for oncology pharmacist which would free up additional 4 nursing and 2 consultant sessions per week- currently with SMT. Dermatology: Middle grade vacancy filled and applicant started 27th September. Received	Jun-2023	Mar-2024
High	8034	Medical	All Directorates Medical	All Departments/Wards Medical	Apr-2021	Active	Keeping the base safe	There is a risk of not being able to reduce the acute inpatient bed base due to rising patient acuity, non-elective demand and challenges in community bed and social care provision resulting in a potential delay to Covid recovery plans and reduction in the bed base.	• Admission avoidance through the Emergency Department and Ambulatory areas • Trust wide work on discharge planning - plan for every patient and R2R • Linking with Community colleagues to support earlier discharge and TOC list • Developing clinical pathways to support outreach clinical service (Covid Community clinics) • SAFER programme - P4EP	• Capacity in Community services • Workforce gaps • Delay in presentation of certain patient groups due to not proactively seeking out medical services during the pandemic • Continued increase in acute demand • Increased acuity of patients impacting on LOS	12 4 x 3	16 4 x 4	2 2 x 1	• Trust wide discussions regarding IPC restrictions of bed base • Continued review of recovery plans in the event that acute pressure increases • Balance of workforce distribution to elective and acute work • SAFER program and system wide program of improvement work (perfect storm) • Continued review of bed base to best manage demand • Clear bed plan worked up which includes the order of retraction out of extra capacity beds	24 March 2023 - Risk updated by David Britton. We remain in extra capacity areas and have been in OPEL 4 recently. Unable to retract out of AF CRH beds currently to put SDEC back in. 4D and 8b also open at CRH along with extra beds on the RF and 6ab. November 21 - Risk updated by L Taylor on behalf of DOP - Balance of workforce distribution to elective and acute work. SAFER program and system wide program of improvement work (perfect storm) Continued review of bed base to best manage demand Score increased and accepted at PSQB 23/04/2021 - Risk accepted at PSQB 19/05/2021 - Risk reviewed at the Acute Directorate risk review meeting. No change to the risk currently 30/03/2021 - Risk reviewed by ADN, extra capacity beds remain open on 4d, 6ab and flex beds on the	Apr-2023	Apr-2023

High	8057	Corporate	Finance and Procurement	Trustwide Finance	May-2021	Active	Financial sustainability	Risk of not achieving the Full Year 2022/23 Financial Plan: The Trust is planning a deficit position of £17.35m for 22/23, (revised June 22). There is a risk that the Trust fails to achieve this plan due to: - a challenging efficiency requirement of £20m, which equates to 4.8% of operating expenditure. - ongoing cost of Covid-19 and the potential for a Winter surge. - Recovery costs in excess of planned levels, or the Trust does not deliver sufficient activity to secure planned Elective Recovery Funding. - Inflationary pressures exceed planned levels.	Business As Usual Controls: Standing Financial Instructions set spending limits Project Management Office in place to support the identification of efficiencies. Efficient and Effective Use of Resources Group (ERG) meets weekly to drive forward identification of efficiencies, monitoring of progress and potential mitigation for any slippage. Accurate activity, income and expenditure forecasting Finance and Performance Committee in place to monitor performance and steer necessary actions Executive review of divisional business meetings Budget reviews hold budget holders to account Accountability guidance and escalation process for budget holders. Controls around use of agency	Uncertainly regarding mechanism for releasing Elective Recovery Funding. Access to the Elective Recovery Fund will depend on activity performance and achieving target of 104% of 19/20 elective activity. Lack of direct consequence to budget holders for poor budgetary management. Capacity planning challenges - including impact of external pressures. Much reduced funding available to support costs incurred as a result of Covid-19.	20 5 x 4	16 4 x 4	12 4 x 3	• The Trust is engaging with both Place Partners and the ICS to review financial plans and understand the drivers of the deficit position. • Mitigation workshop held in Sep 22 and additional schemes identified are being worked up. • Efficiency planning for future years has started with a number of Workshops in September with a focus on delivering recurrent savings both through Reconfiguration and over the intervening period. Ouputs to be reviewed and the detail worked up over the next few weeks. • Engaging with system partners to develop system recovery forum and commission external support.	Year To Date the Trust is reporting a deficit of £20.40m, a £3.48m adverse variance to plan. The Trust is forecasting to deliver the planned deficit of £17.35m by the year end. Whilst there remains a risk to delivery of this forecast due to the ongoing impact of inflationary pressures, the Pay Award funding shortfall, additional capacity requirements and Bank and Agency staffing pressures, non recurrent mitigations have been identified to offset the majority of these overspends. A mitigation gap of c. £1.0m remains. The I&E risk is assessed to have reduced compared to previous months and the score has been reduced from 20 to 16 as agreed at Finance and Performance Committee on the 7th of February. As at the end of December, £19.94m of efficiencies (£0.06m below the target level) have been identified and it now expected that the full £20m targeted will be deliverable. Additional NHS funding to support inflation allowed an improvement to the planned deficit position of £2.75m, a revised full year deficit of £17.35m. Regardless of this funding, inflationary costs continue to drive an underlying pressure that is higher than the value funded through contract income, in particular in our PFI contract value which	Mar-2023	Mar-2023

High	7776	Family & Specialist Services	Children's Services	All Paediatric inpatients	Apr-2020	Active	Keeping the base safe	Due to difficult to fill Advanced Nurse Practitioner posts, there is an inability to cover the 24 hour rota on the HRI site. There are also often gaps within the tier 1 medical rota at CRH, meaning sometimes a decision has to be taken to pull the PNP to CRH to support this gap. This results in non-resident paediatric cover/paediatric APLS on the HRI site at times. This results in poor staff experience and may result in further staff leaving. This may impact on patient safety in the emergency department and onsite paediatric cover for children on ward 4.	Current rota does allow for the APNP to work some shifts on the CRH site protective CPD time Supervision Regular team meetings 5.24 required to cover 24/7 - 7.29 WTE in post, of which 3.0 are in training (not part of rota) use of technology to access training and attendance at meeting APNP escalation process in place Training 2wte APNPs -start date September 2020 and a further 1wte from September 2021 Lead Consultant for APNPs identified. Ensuring APLS cover in ED when there are gaps Roll out of paediatric positive Internal training for ED staff (Compliance March 23, CRH 65% HRI 57%).and Care of acutely ill child via University Use of bank and locum cover to support gaps - considerable financial pressure Joint working with Ed to ensure APLS cover in place.	Opportunity to work regular hours on the CRH site Portfolio development -April 2023 pending Trust agreement on funding arrangements via RCPCH or edgecombe portfolio tools. Lack of fill rate for gaps despite use of bank/locum cover	9 3 x 3	16 4 x 4	6 3 x 2	February 2023 Children's Directorate and ED team have collated a paper that has been presented to WEB in terms of plans for urgent care delivery for CYP on both hospital sites. If approved this will cumulate in the APNP's been based on the CRH site. Awaiting approval and Executive sponsorship November 2022 ED & Children's directorate discussion at SI panel 4.11.22 - agreed for directorate teams to meet to agree next steps with executive team oversight. ED to potential scope recruiting Paediatric trained staff/APNP's for ED specifically. October 2022 -Divisional team/Directorate management team discussion re role and meeting in place. Also impact of shortfall in junior medical cover for CRH site - PNP's integral to keeping the paediatric base safe. Plan to meet with ED Colleagues end October September 2022 - Divisional team chased for meeting regarding PNPs - following this meeting there will be wider discussion with	June 2023 - Draft rota in progress to scope redeployment of PNP workforce to CRH site. Initial engagement event held with PNP team. Joint working T&F group between ED and Children's team to develop future staffing model. Divisional Risk Register confirm and challenge update meeting held on 26/04/2023 Present: SRF, SS, NV, LRa, TO, VT, EGH, JM, WK, JE, HF Additional whole time trainee will be part of rota from Aug 2023 (as above), ongoing program to raise numbers, role signed off yesterday which will help. Vulnerabilities to consider on HRI site. Support from Division, still waiting for Executive sponsor in terms of progressing the phased approach following the presentation that Venkat and Helen Barker presented to Web. April 2023 Additional 1.0wte trainee due to complete training and will be on the rota from August 2023. It is anticipated this will reduce the bank and agency spend for the directorate February 2023 As above November 2022 As above September 2022 - As above. July 2022 - As above. March 2022 - Progress on Paeds ED business case, being led by the Medicine Division. Awaiting Board sign off and potential timescales.	Aug-2023	Nov-2023

High	7955	Family & Specialist Services	Radiology	Main X-Ray	Dec-2020	Active	Keeping the base safe	Service Delivery Risk: There is a risk that we will be unable to deliver plain film services from three plain film rooms at Calderdale Royal Hospital (CRH) due to the rooms becoming obsolete due to their age (these rooms are 20 years old and are beyond their normal life span and no longer have maintenance cover due to the lack of parts and qualified engineers). This would result in the rooms no longer being in use and disruption to all acute (including the Emergency Department) and main x-ray services. The equipment includes, for example, the rooms, the retrofit units and peripheral kit such as printers, CR readers and consoles. Also refer to risk 7581 in relation to the financial impact of a breakdown.	- Maintenance cover*. - Datix reporting of breakdowns. *Whilst we have maintenance cover we are experiencing difficulties in sourcing replacement parts. On a previous occasion a replacement part has had to be made as the part was no longer available. This is resulting in longer periods of downtime and eventually parts will not not be able to be replaced.	- Continued maintenance cover due to age and lack of available parts.	12 4 x 3	16 4 x 4	4 2 x 2	- Plan for MES. - Equipment on the 5 year capital plan.	August 2022 - Position remains the same, gaps updated Earlier entries moved to "File notes" section. September 2022 - 3 x plain films at HRI and 3 x plain film rooms at CRH have been approved by capital for replacement in 23/24. October 2022 - OPT (Dental) machine at CRH is now out of use due to age and is no longer supported. Funding was approved in September for replacement 22/23. Meetings with procurement have started regarding all room replacements and plans. November 2022 - Equipment replacement process with procurement. Sign off for manufacturer choice should be 11th Nov 2022. Awaiting start dates for estates work and new build to be complete at HRI. Divisional Risk Register confirm and challenge update 8/12/22 Present: SC, GE, NB, NV, SS, SRF, LH, LR Risk score may reduce once the ED Xray kit goes in January 2023 Update: The risk remains the same. February 2023 Update: The risk remains the same.	Jun-2023	Mar-2024
High	7637	Family & Specialist Services	Children's Services	Paediatric Medical Staff	Jan-2020	Active	Keeping the base safe	There is a risk that, due to regular sickness and isolation across the Tier 1 and Tier 2 medical staffing rota, the delivery of safe care for the Paediatric and Neonatal unit may be compromised. There is currently reliance on existing staff and bank and agency staff to fill shifts at both tier levels. If gaps are not filled there is a risk to patient safety. There's also an impact on the Consultant workforce, who may need to cover Tier 2 gaps, which can impact on other workload. This risk is ongoing and will be reviewed as part of rotations.	1. Fixed-term tier 2 post filled (historic) 2. Tier 2 6 month fixed-term (winter funding) post filled (historic) 3. Calculating additional funding required as part of business planning (some pressure accepted, however development not accepted) - looking at 23/24 4. Regular weekly meetings with medical staffing commenced in May 2021 to ensure gaps are picked up with as much notice as possible, with all possible options for cover explored.	Adequate workforce to enable an adequate rota.	16 4 x 4	16 4 x 4	6 2 x 3	1. Rotas monitored on a weekly basis, with daily escalation plans in place. 2. Continue work with HR to ensure rotational doctor information/updates in received in good timeframes. 3. Continue to seek recruitment for 2 x qualified APNPs. 2 trainee APNPs in post since Autumn 2020 and a 3rd trainee to start in Autumn 2021. Out to advert x4 times. No applicants. 4. Utilise existing APNPs/ANNPs to support medical rotas when able to. Engage with ED regarding gaps to ensure appropriate mitigation.	Update June 2023 EGH - 1 x Trust Doctor started in May (12 months). 2 other Trust Doctors due to start - June (12 months) and August (12 months) - these were rota gaps on the current rotation, however due to TRAC authorisation delays, these doctors will overlap with the future rotation - depending on gaps, this may impact 24/25 finances. - Sickness rates relatively ok and being well managed - however, risk remains due to gaps and significant impact when there are gaps. Divisional Risk Register confirm and challenge update meeting held on 26/04/2023 - LR Present: SRF, SS, NV, LRa, TO, VT, EGH, JM, WK, JE, HF Pressure approved, reduced rota slots, twilight registrar due to gaps in rotation, awaiting a few doctors starting. Risk continues despite getting approval of funding as its more around having gaps covered - Mainly due to sickness across tiers 1 and 2. Other issues:	Aug-2023	Sep-2023

High	7092	Trustwide	All Divisions	All Departments/Wards	Oct-2017	Active	Keeping the base safe	Medication Safety - risk of incorrect prescription details This may be due to selection errors, untrained users in EPR users not responding to decision support alerts , or users not following SOPS. This may result in incorrect drug details -eg selection of drug , incorrect drug doses , frequencies and durations. Incorrect information could be sent to the GP regarding drugs stopped , amended or new drugs started during hospital admission.	Training and SOPs are available Medications Safety Group reviews incidents of incorrect prescribing. Order sentences are built - which filters drugs and dosage by age/weight and gives a suggested dose Pharmacy / senior doctor review and feedback to junior prescribers Guided prescribing through care plans Critical incident / complaints reviews Training and education before access is granted Role based access control within EPR Audit of drug errors leading to design	Training could be improved and refresher sessions offered. EPR SOPS are available but staff often unaware and dont follow- leading to errors Reducing the number of paper drug charts and paper outpatient prescribing. Not all prescriptions are verified by a pharmacist before administration Supervision of junior medical staff and adoption of good practice needs reviewing	9 3 x 3	16 4 x 4	6 3 x 2	Escalate to Division - training and supervision of prescribing staff is required	March 2019 - This risk is a prescribing issue and needs to be held by the Prescribers - - so the risk needs to be held by the divisions rather than pharmacy October 2020 - risk to be held by divisions and not pharmacy	Dec-2020	Feb-2021
High	6035	Medical	All Directorates Medical	All Departments/Wards Medical	Jun-2014	Active	Keeping the base safe	There is a risk that Medicine division has a higher prevalence of C.Diff infections, which is greater than the agreed acceptable tolerance levels for 2021/2022 due to gaps in assurance measures around cleaning Resulting in the increased number of patient contracting C.Diff.	Established infection control measures to minimise the occurrence of C. Diff infections: Monthly hand hygiene compliance monitoring Early patient risk assessment as deemed appropriate Antibiotic prescribing and ongoing monitoring in line with current policy Standard isolation precautions and infection control guidelines with	Gaps in assurance measures around cleaning and FLO audits, highlighted to Ward managers/ sisters that all High Impact Interventions should include robust documentation of any failures in compliance. Risk of inappropriate prescritption of antibiotics particularly out of hours	16 4 x 4	16 4 x 4	4 2 x 2	Share learning Monitor incidents Deliver RCAs and identify contributory factors to address	May 2020 update: Have had 2 CDiff cases in the months of Jan, Feb, Mar, & April. RCA's undertaken and discussed. Rates and learning continued to be monitored via Divisional IPC meetings which are currently being re-instated and the corporate IPC performance board. Learning from RCA and areas of substandard or good practice shared and disseminated via PSQB Improved screening with prompt isolation	Aug-2022	Feb-2023
High	6078	Family & Specialist Services	Appointment and Records	Appointments Service	Aug-2014	Active	Keeping the base safe	There is a risk of being unable to provide sufficient appointment slots to manage demand. Due to an increase in referrals to services/reduced available capacity to manage demand. Resulting in: - poor patient experience - increased administration (reliance on spreadsheets to track capacity requirements) - risk to failure of RTT targets - impact on contract income targets	Process: Fortnightly communication to Clinical Divisions highlighting capacity requirements. Regular communications with Ops managers / GMs. KP+ system allows for real time monitoring of slots, waiting lists and canx/DNA rates. All GP referrals are now referred via ERS. Worklists include ASIs, enabling review of the referral prior to offering appointment including the	Variations in capacity and demand plans. Consultant vacancy factor. Not all services review referrals prior to offering an appointment. Lack of monitoring of no AC relevant slot utilisation	16 4 x 4	16 4 x 4	3 3 x 1	Monitor ASI position at customer contact meetings. CAS/RAS service operating in some services. Insourcing work on-going to help reduce ASI numbers.	July No change in risk- Discussed at PSQB ASI action plan developed which includes trajectories at specialty level Further actions planned to improve the position including weekly cross-divisional access meetings to monitor performance, development of a capacity management team within appointment centre, development of the Knowledge portal as a capacity planning tool to assist directorates. Further action to confirm full divisional recovery plans to reduce ASI list further. Review at weekly	Jul-2023	Dec-2023
High	6079	Family & Specialist Services	Appointment and Records	Appointments Service	Aug-2014	Active	Transforming and improving patient	Follow-Up Appointments – A risk of being unable to provide sufficient appointments for patients requiring OP follow-up. Resulting in delay in patient care, poor patient experience, caused by capacity & demand issues post covid.	Validation of Holding List both admin and clinical to provide p values for patients and to remove duplicate requests. Clinical Assessment of all patients waiting >12 weeks from appointment due date. Monitor holding list & clinical validation position at customer contact meetings.	Insufficient slots to manage demand Variable clinical engagement in clinical assessment process Clinical vacancies. Complex and convoluted booking rules. Lack of monitoring of no AC relevant slot utilisation	16 4 x 4	16 4 x 4	4 4 x 1	May 2021 - CHFT Clinical prioritisation and recovery plan (post COVID) being held monthly with COO support. Fortnightly customer contact meetings on-going. On-going admin validation.	Partial booking roll out completed on all specialties to reduce impact on patients when clinics are cancelled/reduced. Report of capacity/demand requirements available on Knowledge Portal Process in place to validate and clinically assess patients waiting 3m beyond appointment due date. Clinical Divisions working up capacity/demand plans. Shortfalls addressed via additional WL clinics. Validation and Clinical Assessment process designed and agreed with Executive Board. WEF	Jul-2023	Dec-2023

High	6100	Family & Specialist Services	Children's Services	Paediatric Medical Staff	Sep-2014	Active	Keeping the base safe	There is a risk of patient safety/delays (inc. ECS) as... - The paediatric department is not fully complying with the Royal College of Paediatrics and Health (RCPCH) paediatric acute medical standards. One example is paediatric consultant (or equivalent) presence at peak times of activity (17:00 - 22:00), leading to delays in senior review (all examples can be shown on the Directorate RCPCH action plan). This could result in delays in care and diagnosis and poor patient outcomes. 2 additional consultants are needed to support this rota. - The neonatal department is not fully complying with BAPM standards. The neonatal unit should have 7 consultants. 1 additional consultant is needed to support this. - There is a lack of resource to ensure children and young people are seen in appropriate time-frames in outpatient clinics. The above results in a greater number of incidents and an impact on flow, both impacting the medical care of children and young people. It is also impacting staff wellbeing. The paediatric consultant workforce is flexible and proactive in putting the needs of patients first. There is acknowledgement that the safety of the service is enhanced by their flexibility and this can impact on service delivery the next day. This is not sustainable.	- 24/7 on call consultant cover - Twilight consultant cover around 2-4 evenings per week - 24/7 Tier 2 rota (resident) - however, there are often gaps - 24/7 Paediatric Nurse Practitioner support at HRI. 4 hourly acuity and capacity risk assessment using RCN standards with escalation policy if demand compromises safe nursing care. However, there are often gaps due to sickness and vacancies. - Minimum roster standard - 1 APLS trained nurse on each inpatient area 24/7. - High levels of workforce compliance with HDU training and sepsis awareness training. - Matron daily sit rep provides daily focus on staffing, workload and risks	Gap in budget.	12 3 x 4	16 4 x 4	3 3 x 1	1. Rapid access clinics established once per week. 2. Winter resilience plan established in summer 2021 (also considering COVID-19 related factors). OPEL plan in place. OPEL plan being reviewed December 2022. See progress update for further action plan updates.	Update June EGH - Developments remain on pause across the Trust. Raised as 1 of 3 safety concerns to the Division - not escalated at Divisional PRM. Divisional Risk Register confirm and challenge update meeting held on 26/04/2023 LR Present: SRF, SS, NV, LRa, TO, VT, EGH, JM, WK, JE, HF Should have twilight cover Monday to Friday, currently it's 2 to 4 shifts a week at maximum with the current funding. Been through business planning, currently on hold awaiting approval. Update April 2023 EGH - Development submitted and on pause (plus all developments trust wide) - escalated concerns regarding this to the division on 3/3/23 - asked to escalate this at the next PRM (5/4/23) for escalation at divisional PRM. Awaiting update. Update March 2023 EGH - PCC funding has enabled the service to have a twilight consultant every week night until 31/3/23 (this means we are meeting standards but it's also helped with winter pressures). This is not a sustainable model with continuing elective activity with the same number of consultants - Development raised to increase the consultant workforce to enable the service to meet standards, however all developments across the Trust have been paused. Escalation raised with the division on 3/3/23 - asked to take this to PRM on 31/3/23 so the divisional team can raise this at the divisional PRM Update January 2023 EGH - Challenging paediatric winter has been evident. Additional (internal) consultant twilight shifts in place every week day evening from the start of December 2022 until the end of January 2023. Already realised in the budget by the Senior Finance Manager and General Manager	Aug-2023	Oct-2023

High	6345	Corporate	Workforce & Organisational Development	Resourcing / Recruitment	Jul-2015	Active	Keeping the base safe	There is a risk of: insufficient Trust employed Nurses, Midwives, and HCSW to deliver safe and compassionate care on a shift-by-shift basis, as defined by the agreed Workforce Models or Care Hours Per Patient Day (CHPPD) Due to: an inability to fill vacancies, the requirement to staff additional capacity areas and/or excessive unplanned staff absence Resulting in: • patient harm (inc. but not limited to: serious incidents, failure to detect deterioration, falls, pressure ulcers, medication incidents, infections) • poor patient experience • reduced staff morale • increased sickness and attrition of staff • reduced staff competence (due to inability to attend training) • increased financial pressure (due to use of bank and agency) • poor learner experience (due to inadequate supervision)	Nurse Staffing To ensure safety across 24 hour period: - use of electronic duty roster to set nurse staffing within agreed workforce models, approved by Hard Truths Process and monitored by Matron and general managers - risk assessment of nurse staffing levels for each shift reviewed at least twice times each 24 hour period using the Safer Care tool with actions instigated by Matrons to mitigate any shortfall. Formal escalation to Deputy Chief Nurse or thier delegate to agree mitigating actions requiring agency bookings. - staff redeployment where necessary - nursing retention strategy - flexible workforce used for shortfalls (bank/nursing, internal, agency) and weekly report as part of HR workstream - active recruitment activity, including international recruitment - Introduction of new roles eg Nurse associate - Identification and training of	Low numbers of applications to nursing posts across grades and specialities National shortage of Registered Nurses	16 4 x 4	16 4 x 4	9 3 x 3	• Local/domestic recruitment • International recruitment project • Nursing associate role development and deployment of graduating cohorts • Workforce transformation (NA's, TNA's and ACP's) • Developing nursing retention strategy • Use of flexible workforce • Utilisation of nursing workforce using safe care live • Response to the NHS interim people plan - significantly grown the number of undergraduate Health students to improve the pipeline of nurses to recruit	June 23 Following formal review at the Nursing and Midwifery Workforce Steering Group it was deceided to reduce the 'likelihood' of this risk to 4. This is based on a consistent level of OPEL 2 at the twice daily staffing meetings, an ability to reduce agency bookings due to increased shift-fill by substantive staff, and a stable and sustained CHPPD report, benchmarked at high quartile 2 on Model Hospital. The existing controls continue to be in operation and effective. September 2022 International Recruitment remains on target to deliver 100 International Nurse Recruits by the end of December 2022. 69 Newly graduated nurses have been employed and started on their induction and preceptorship programme. Following this recruitment work is ongoing to retract from use of Agency staff, starting with high cost agencies. Business Inteligence Information continues to inform recruitment plans over the next 12 months. Active face to face rcruitment fayres have been planned throughout Autumn 2022 to recruit the current 3rd year student nurses for September 2023. A focussed piece of work driven by NHSE has	Nov-2022	Sep-2023

High	6715	Corporate	Corporate Nursing	Workforce and Clinical Development	Apr-2016	Active	Keeping the base safe	There is a risk to patient safety, outcome and experience due to inconsistently completed documentation on EPR. This has the potential to result in a negative impact for the patient in increasing their length of stay, lack of escalation should deterioration occur, poor communication both internally and externally and difficulties with efficient multidisciplinary working. In addition to this, inaccurate coding and submissions, appropriate remuneration for care delivered and the inability to be able to be able to establish the correct patient pathway in response to review, complaints, serious incidents and legal requirements.	Structured documentation within EPR as per induction training. Training and education around documentation within EPR - development of E Learning Modules for training. KP+ Model regarding monthly and weekly ward assurance. Doctors and nurses EPR guides and SOPs. Datix reporting Relevant Boards and specialist groups that support clinical documentation which include -Clinical Records Group -Clinical Outcomes Group -Information Governance and Record Strategy Group -Deteriorating Patient -Pressure Ulcer Collaborative -Nutrition and Hydration Quality Priority for 2021/22 in relation to strengthening record keeping within the Trust.	Remaining paper documentation not built in a structured format in EPR which has been a challenge to the organisation since go live of the electronic patient record due to KP+ reporting tool does not provide assurance around documentation - requires review of components being extracted. There are gaps in recruitment currently within the nursing, training and EPR Change Team which would support an improved electronic record. Not all SOP's are in date.	20 4 x 5	15 3 x 5	6 3 x 2	September 2020 - Action plan to review current status and progress improvement - Clinical Records Group - review attendance and TOR - Review data extraction for clinical records relating to Ward Assurance in KP+ model to ensure accuracy. - Roll out White Board Functionality in EPR - identify areas to formulate improvement before roll out across the organistion - Support improvement at ward level in improvement of key metrics - promote ward ownership - Implementation of Optimisation Strategy in stages - Stage 1 In-depth Analysis of current working practices amongst staff working in the trust - OPD and In-patient services. Stage 1 results will determine Stage 2 relating to recommendations and development of Digital Champions - Explore Training and Support - alternative methods of delivery and at the elbow support - Work Together Get Results - Workshops to collectively discuss and promote digital record keeping within the work environment - understand barriers for failure to comply and put measures in to support change as a result	April 2023: Work is still ongoing to review wokrflows and over the next 12 months there will be a programme to re train the wokrforce in the correct wokrflows. Change facilitators commenced in post 17th April 2023. Feb 2023: Work commenced on improving the nursing clinical record and pharmacy drug catalogue. The training team continues to teach new doctors workflow and evaluations underway with CCIO. Nov 22: CV's obtained for developers to be employed by the trust to improve some of the work within workflows. Training team continue to work on wards and support staff. Junior doctor training complete training team now moving on to senior doctor grades. Sept 22: Work still ongoing to priorities work and fund the additional resource needed. Training team evaluating impact of new doctor training to feedback to CNIO and CCIO. August 2022: Work on going with Bradford and CHFT head of EPR has been asked by CNIO's for both trust to provide a quote for the resource needed to complete this work and improve workflows for both nursing and clinical. Task and finish groups completed and all the information gathered. June 2022: CNIO still attending weekly quality reviews looking at why documentation is limited in some areas and why assessments are missed. Doctors training being relooked at and workshops taking place. Admission task and finish group still going ahead making good progress with what is needed to complete a full and comprehensive admission document. April 2022: Task and finish group set up to look at clinician training and review the whole process. These are being led by the training team and are underway. Nursing admission task and finish group set up first meeting on 29th April to review admission process and what works for the areas. CNIO attending weekly quality reviews looking at why documentation is limited in some areas and	May-2023	Apr-2024

High	7413	Corporate	Finance and Procurement	Corporate Finance	Feb-2019	Active	Keeping the base safe	There is a risk of fire spread at HRI due to insufficient fire compartmentation in areas which could result in fire spread / damage to buildings / equipment and harm to staff, patients and visitors.	Following a fire compartmentation undertaken in 2014 capital funding has been made available to improve compartmentation and fire safety across HRI Site. Fire committee has been established in November 2019 where fire safety is discussed and any risks escalated. Chief Operating Officer, is the nominated executive lead for fire safety Works undertaken by CHS includes:- • Replacement of fire doors in high risk areas • Replacement fire detection / alarm system compliant to BS system installed • Fire Risk Assessments complete • Decluttering of wards to support ensure safe evacuation • Improved planned preventative maintenance regime on fire doors • Regular planned maintenance on fire dampers Fire Safety Training continues throughout CHFT via CHS Fire Safety Office • Face to face • Fire marshal • Fire evacuation • Fire extinguisher	Number of areas awaiting fire compartmentation works Consequence of decanting ward area to carry out risk prioritised compartmentation works	15 5 x 3	15 5 x 3	1 1 x 1	May 2021 The fire strategy has been produced by outside consultants and a work plan is being developed. The fire policy is ready to be approved by the fire committee. Dec 2019 - CHFT Fire Committee established with involvement from CHS and PFI. Fire Strategy to be developed to provide a short, medium and long term plan aligning with Trusts reconfiguration plans. Fire Committee to review fire risks. July 2019: NHSI capital bid for 19/20 June 2019: Fire risk assessments, installation of sockets May 2019: Delivery of fire training Feb 2019: Walk around on wards between CHS, CHS Fire Officer and Matrons with the aim of de-cluttering wards to ensure a safe and effective evacuation. Feb 2018 The Trust has bid to NHSI for early release of capital monies to support further fire compartmentation work. However, in order for CHS to manage this in a prioritised risk based approached it is essential the	June 23 Awaiting survey from surveyors March 23 Survey by CHS to understand the scale of the works required on the compartmentation is being carried out, Sept 2022 Drawings continue to be reviewed May 2022 AFL architects have been updating the drawings, once received we will cross reference what we should have and what we actually have to identify gaps. June 2021 Position still the same, we need the awareness of what building stock is to stay and what is removed, so we can target work to fit the reconfiguration. May 2021 60 minute fire compartmentation completed along with ward 18. Some areas have not been addressed, but guidance on what building stock is being kept or demolished will help with planning further work. 30 minute sub-compartmentation is still outstanding, but this will require a lot of work and cause major disruption as wards will need to be vacated for a considerable amount of time. December 2020 60 minute Fire Door replacement scheme nearing completion and Ward 18 now fully compartmentalised. 30 minute sub compartmentation still outstanding April 2020 additional fire risks due to impact of Covid-19, fire loading, increased use of oxygen, increased storage of supplies and equipment, movement of staffing, utilisation of theatres as critical care wards, fire evacuation routes altered. Full risk impact scoped and added to Covid risk register. MARCH 2020 Fire Committee reviewing Fire Risk to ensure appropriate risks identified and sufficient controls are in place. Fire Committee meeting 8th April 2020 and will review / approve all Fire related risks.	Jul-2023	Sep-2023

High	7640	Family & Specialist Services	Pharmacy	Pharmacy	Feb-2020	Active	Keeping the base safe	There is a risk that patients do not receive appropriate medication because of the the current staffing which results in a lack of assurance that patients are receiving an appropriate level of pharmacy input. Pharmacy service to ITU is not compliant with national standards for provision of intensive care services. We have 1.0 WTE B8a pharmacist in post (approx 0.7 WTE of time is dedicated to ICU delivery). There is reduced cover from existing band 7 pharmacists due to current vacancies. In the NHS England Critical Care specification document it states that pharmacy cover should be provided: "Clinical pharmacists supporting delivery of medicines optimisation in critical care areas must provide patient-centred care, including: medicines reconciliation (on admission and discharge), independent patient medication review with attendance of multi-professional ward rounds and professional support activities, including: clinical guidelines, medication-related clinical incident reviews and clinical audit and evaluation." In The Intensive Care Society and the Faculty of Intensive Care Medicine Version 2.1 of the Guidelines for the Provision of Intensive Care Services (GPICS); it states the following - CHFT data include below each standard: 1. There must be a designated	A number of experienced pharmacists are available to provide cover to ITU on both sites - and there is some ward round attendance.	We do not meet the national standard outlined above. Additional resource required with reconfiguration and the planned bed new bed base. Lack of resilience to meet any COVID surge Limited cover available for sickness/leave without impacting on other service areas	6 2 x 3	15 3 x 5	1 1 x 1	See details in risk above. Business case for expanded service to be submitted in Spring 2024 as part of pressures for 2024/25	Update March 2020: No fully compliant in the past but situation is currently worse because the two substantive ITU pharmacists are currently in a new position and on secondment till end June 2020 Update April 2020 - due to current Covid situation and significant increase in ITU beds there is increased input to ITU and additional pharmacists are being trained up to a minimum standard May 20 - vacancy control now put on TRAC - awaiting approval and then can close risk Sept 20 - risk to remain open whilst we are unable to provide 7 day service to ITU. Jan 22 - Still unable to provide a 7 day service to ITU. Senior ITU pharmacist currently undergoing training and development to be at the advance level required. ********************** STANDARDS 1. There must be a designated intensive care pharmacist for every critical care unit. 2. The critical care pharmacist must have sufficient job time within which to do the job. There should be 0.1 whole time equivalent (WTE) pharmacist for every Level 3 bed and for every two Level 2 beds for a 5/7 a week service. 3. Clinical pharmacy services should be available seven days per week. However, as a minimum, the service must be provided five days per week (Monday-Friday) with plans to extend the ward service to seven days a week before 2020. 4. The most senior pharmacist within a healthcare organisation who works on a daily basis with critically ill patients must be competent to at least Advanced Stage II (excellence level) in adult critical care pharmacy. 5. Other clinical pharmacists who provide a service to intensive care areas and have the minimum	Dec-2023	Dec-2023

High	7994	Corporate	Corporate Nursing	Enhanced Care Team	Jan-2021	Active	Transforming and improving patient care	There is a risk of not being able to deliver individualised patient centred care for our most vulnerable patients who require a higher level of enhanced care due to the current number of vacancies within the team and inabiliy to fill staff bank requests to provide this service. This may have a resulting impact on: The safety of these patients due to their presentation of dementia,delirium or risk of falls. Positive experience for our patients. Cost pressures due to increased costs of interim staffing. Patients who are cognitively impaired,mobilising unsupervised in the clinical environment and inadvertantly being a contributing factor to COVID outbreaks (as investigated through recent RCA.)	Existing referal process to the ECSW lead provides a stepped approach to patient care interventions prior to referral to the team for 1;1 care requirements. Each patient following referral has a assesment by the lead or delegated RN to determine existing interventions ,care planning and support that can be initiated at ward level to support patient safety and exprience. Utilisation of existing ward workforce to maintain patient safety by cohorting patients to maximise visibility and care delivery.utilisation of engagement support workers. Utilisation of the restricted visiting protocol (due to COVID 19 guidance)to facilitate carer presence with strict risk assesment and criteria for PPE if patient is experiencing distress. Escalation to ward matron to review staffing requirenents and available staffing against acuity and dependancy through daily safecare and workforce meetings.	Recent recruitment into HCA posts on the wards has had significant impact on service WTE 6.04. Although retention within the team historically is relatively short term, as it often provides a platform to new opportunities and career progression involves moving job roles therefore depleting the service, this however has a positive impact on the Workforce Strategy. Recruitment process has been time delayed with approval status and low numbers of internal applicants(first week of advert in line with recruitment process). CEV staff in team are self isolating as patient facing job role.	10 2 x 5	15 3 x 5	6 2 x 3	JAN 2021 Recruitment to vacancies currently wte 8.36 (@ 24.1.21) ongoing. Scope use of therapy assistants on staff bank to support service during day Scope use of potential medical students to work on bank Scope high user areas (care of elderly) to rotate into ECSW team for 6 months alongside recruitment process of HCA's Capture data from wards with ESW in place in relation to providing 1 to 1 care versus number of referrals. Review JD for ECSW post in line with HCSW Recruitment Strategy.	24.1.21 Interviews planned for early Feb 2021 for workforce vacancies. Block booking of bank staff for 1;1 care to provide continuity of care. 09/07/2021 Review of staffing - currently we have 23.4 WTE however due to high levels of staff sickness we are unable to meet workforce model. Bank shift requests have increased due to low acuity and high numbers of referrals. 27/07/21 Awaiting authorisation for recruitment of 1.0 ECA. Two other staff members have handed in their notice, very high levels of staff sickness. 24/08/2021 x4 FTE have left, awaiting authorisation for post to be advertised. Working with recruitment re this. x5 FTE long term sick. Bank shifts have increased and staff are working flexibly to support the service. 23/09/2021 Successfully appointed 0.8 FTE B6. Currently interviewing for 6 FTE B2s. Interviews lasting until 28/09/2021. X8 applicants to be interviewed. 12/01/2023 Currently have 16/07 WTE B2s in post. 4.64 B2s sick. 1 WTE B2 maternity. 0.8 WTE B6 post vacant from 03/02/2023. This post is currently awaiting review from panel.	Jul-2021	Sep-2021
High	8259	Family & Specialist Services	Women's Services	MAC	Feb-2022	Active	Transforming and improving patient	There is a risk of not meeting the required triage times of women attending our Maternity Assessment Centre for emergency assessment and treatment in line with the new standardised triage tool, due to the lack of dedicated obstetric medical cover. This may result in potential harm and deterioration of the patient if not seen and treated in a timely manner due to a breach in triage review time.	Current process is that MAC is covered by the on-call acute obstetric team covering labour ward. They attend MAC to review women when they are available. Implementation of new standardised triage tool (BSOTs) to ensure women are being approporiately risk assessed and prioritised for review approaraitely. Escalation process for delays in MAC is to the obstetric on call	When labour ward is busy often the obstetric team, including consultant are not available to review women.	15 3 x 5	15 3 x 5	2 1 x 2	Require a focus on identifying a dedicated obstetric registrar to cover MAC . - Doctor allocation from 15 May 23 Task and Finish group Review SOP's Link with ED, radiology, ANC, gynae Monthly MAC triage time audit Monitor datix through weekly governance	May 23 - Divisional Risk Register confirm and challenge update 23/5/23 Present: SRF, NB, TO, LM, GH, FA, NV, RR, DT, LR Potential to reduce score or close, now have a Registrar (Mon to Fri) and a Band 7 Service Lead, will consider score/re-audit at Womens Directorate PRM. May 23 reviewed by GH and LD Reg not yet moved to MAC due to some residual issues regarding the pathway March 23 reviewed by GH and LD -plan to move acute HRI Reg to CRH to cover MAC from the 1st	Jun-2023	Jul-2023
High	8398	Surgery & Anaesthetics	General and Specialist Surgical Services	Colorectal	Aug-2022	Active	Keeping the base safe	There is currently a risk of high volumes of patients awaiting a follow up appointment within Colorectal surgery due to increased referrals post covid and historical patients waiting for their appointments, resulting in patients waiting longer for their appointments which will delay treatment and care for these patients.	Clinicians have prioritised work to ensure long waiters have been treated for surgery, along with the cancer patients. Currently as of 16/08/2022 922 patients are over due appointments, of which 118 patients are overdue 52 + weeks and 141 overdue 39+ weeks	There has been a 30% increase in demand with no increase in resources to see more patients. There is no failsafe officer.	15 3 x 5	15 3 x 5	6 2 x 3	Clinicians have sight of the patients that are overdue , to implement plans to mitigate and clinically validate these patients as not all patients require follow up appointments. To write a business case for an additional Colorectal Consultant.	31/05/2023 - Still high volume of patients, unable to identify quick wins and learning to help with backlog. We will need to review once the new consultant starts to free up some time for the clinicians 20/03 Current position statement, still with high volumes of patients awaiting validations. Appointed additional consultant due to start July 2023. Work ongoing with admin teams to see if can validate using trends to present at the consultant meeting	Aug-2023	Aug-2023

Rating	ID	Division	Directorate	Specialty	Opened	Status	Strategic objective	Risk description	Controls in place	Gaps in controls	Initial	Current	Target	Actions	Progress	Review date	Next review
High	8421	Family & Specialist Services	Women's Services	ANC CRH/HRI	Sep-2022	Active	Transforming and improving patient care	There is a risk that currently the service does not have enough capacity to meet scanning requirements in line with clinical pathways eg rescanning low lying placentas at 32 weeks and inadequate surveillance of pregnancies at increased risk of SGA this may result in undiagnosed placenta praevia /incorrect place of birth/major antepartum haemorrhage/maternal death and possible cases of undetected SGA	Ultrasound department will rescan on non-obstetric lists Midwifery sonographers to support with capacity (in place) Early scheduling of repeat USS Clinical guideline's agreed and in place in relation national scanning guidance for SGA clinical pathway in place in relation to management of placenta previa which includes scanning guidance	The capacity in main ultrasound on non-obstetric lists may impact on availability Inability to control patient attendance (DNAs)	15 5 x 3	15 5 x 3	5 5 x 1	Commission a full review of capacity and demand of ultrasound scans for all elements of the Maternity Pathways (August 23) Review DNA's and action plan to improve attendance Monthly audit of outcomes for SGA babies Audit report to Maternity Forum Any late low lying placenta resulting in poor clinical outcomes datix completed and discussed at weekly Governance	June 23 Merged risk 6757 with 8421 and updated actions GH JM . May 23 - Divisional Risk Register confirm and challenge update 23/5/23 Present: SRF, NB, TO, LM, GH, FA, NV, RR, DT, LR Look at Ultrasound risks in total, LD to set up meeting with team - FA, MJ (as below). Look at demand and capacity and review with NB. May 23 -reviewed by LD and GH DDOM to meet with service matrons to review all risks regarding ultrasound capacity to move to an overarching risk and risk score March 23 - reviewed by LD and GH no further update this month Feb 23 review DT LD MJ - scan capacity continues to be an issue, meetings set up to progress work and review number of USS risks Jan 23 DT, LD, GH review - scan capacity remains an issue. Capacity remains linked to associated	Jun-2023	Jul-2023
High	8344	Family & Specialist	Women's Services	Maternity	Jun-2022	Active	Keeping the base safe	There is a risk of human error in transcribing information, due to the lack of maternity reporting software resulting in misinterpretation of doppler waveforms.This may lead to an error in identifying women at risk of severe growth restriction or incorrect management of growth restricted fetuses - both of which may result in stillbirths	Doppler waveform results are produced on the scan report and staff have to manually plot using a ruler and then make a decision of care based on this result Increased clinician awareness Qualified staff member to review /plot the result	Lack of capacity for independent second check of result plotting Reliance on process to identify abnormal doppler results	15 5 x 3	15 5 x 3	4 4 x 1	1.review of current software provision 2. develop a case for maternity scanning reporting software.- due to increased costings, further business case completed for BCAG June/July 23 3. SGA quarterly audit 4. Raise at digital board	May 23 - Divisional Risk Register confirm and challenge update 23/5/23 Present: SRF, NB, TO, LM, GH, FA, NV, RR, DT, LR Maternity reporting electronic software to improve patient safety and metrics, once approved by Division, may need to go through Dragons Den. May 23 reviewed by GH and LD case to be signed off by Directorate and Division and then Trust	Jun-2023	Jul-2023
High	8315	Surgery & Anaesthetics	Head and Neck	Ophthalmology	Apr-2022	Active	Keeping the base safe	There is a risk of significant of increasing waiting lists and delays to new and follow up appointments in the ophthalmology paediatric service as well as delays in improvement, quality assurance, staff development and pressure on the service due to not having enough substantive Paediatric Consultants. This could result in catastrophic or significant harm to the patient.	One FT substantive consultant with 3x Paeds sessions a week Job to be advertised for substantive paediatric consultant Collaboration with locum consultants Utilisation of existing orthoptic and optometry skills Links with admin staff regarding pending lists, ASI's Regular validation	Lack of capacity Lack of additional substantive consultant Lack of speciality middle grade	15 5 x 3	15 5 x 3	0 0 x 0	Validation of waiting lists Advertise attractive substantive Paeds Consultant vacancy Collaborative working amongst AHP's regarding service improvement and working differently Service improvement Review of the pathway / AHP and nursing training Paediatric leads orthoptic/ optom and also Paediatric ACP Quality assurance systems to ensure patients are seen by the right clinician at the right time Opportunities to work differently to optimise capacity	01/09/22 Locum Paeds consultant to start 2 days a week in October, Job advert out for substantive position. 03/11/22 Only candidate for interview was not successful. Job is back out to advert. 08/12/22 Locum Dr given 4 weekend clinic dates, lack of uptake from support staff 358 pts past end date. 33 high risk 13/04/2023 - Locum post back out to advert on Trac 12/05/2023 - Locum advert unfortunately had no applicants. Interviewed agency which was unsuccessful. To re-advertise. Continue to utilise Ms Gogi on weekends and virtually.	Jul-2023	Jul-2023

High	8453	Family & Specialist Services	Pharmacy	Pharmacy	Nov-2022	Active	Keeping the base safe	There is a risk that patients may receive incorrect or delayed medicines due to a shortage of Pharmacist and Pharmacy Technicians and Pharmacy ATOs. There is a 20% vacancy in the Clinical Pharmacist workforce and in the Pharmacy Dispensary Team. This shortage means that there can be delays or omissions in medication drug history checks, reconciliation, screening of inpatient medicine orders and follow up of pharmacy interventions, coupled with an impact on the dispensing and release of medication for inpatient and at discharge.	Prioritization of core medicines areas (1) discharge turnaround (2) medicine supplies. Prioritization of DWP and Safari cover to support patient flow. Staff with substantive posts undertaking additional hours as bank staff. Use of bank Pharmacist and Pharmacy technician where available to support gaps in the rota Staff recruitment to vacant posts. Training for new starters which priorities roles. Flexible working with the Pharmacy Team to priorities patient facing roles.	Cannot resource all available vacancies even with bank staff	15 3 x 5	15 3 x 5	1 1 x 1	Recruitment Plan to address vacancies Discussion of stepping down functions and activities Discussion re restriction of leave /study time Review of co-coordinator Roles to support junior work force and patient flow Testing of a different weekend model of working across CRH and HRI sites	19 Jan 23: Accepted risk by Pharmacy Board KC March 23: Recruitment ongoing. Risk remains May 23: Risk Confirm & Challenge Meeting 19/5/23 Present: SRF, ES, KC, SP, LR Successful recruitment, by August in a better position. Pharmacy Technicians now in place, 3 vacancies to recruit out of 7, currently working on advert. June 23: Risk remains, recruitment ongoing. To review in 3 months time.	Sep-2023	Sep-2023
High	8468	Family & Specialist Services	Pharmacy	Pharmacy	Nov-2022	Active	Keeping the base safe	There is a risk of being unable to supply timely medication to the organisation due to pharmacy staffing not being sufficient to cover the additional beds opened during heightened operational pressures (Opel 4).Additional inpatient beds (> 90) have been opened to cope with system pressures. These extra capacity beds require additional pharmacy input, both for new patient admissions and discharges. The combination of increased bed base,increased acuity of patients and increased number of discharges without additional pharmacy staffing results in delays in TTOs, reduced % of meds rec completion and increase in medication errors.Over patient experience on discharge poor. Critical medication could be delayed or omitted either as an IP or due to discharge without medication.	We cancel all non essential work so that patient flow / TTOs are the priority however for prolonged periods of times this results in some must does not being done. This includes increase in risk of medication safety issues, reduced % of patients with completed Meds rec, poor compliance with meds safety audits and poor meds stock management with increased risk of medication waste. Since 2020 there has been temporary funding provided for pharmacy dispensaries to be open from 5-6pm at both HRI and CRH (average time staff leave = 6.30pm). This has allowed staff to cover by working additional bank hours to provide the service. However this lead to staff working additional hours above their contracted hours on mandated basis. Some staff have adjusted their hours on a contractual basis to finish later. The option to start later and finish later has been adopted by some staff but this means there are	Less staff available in the morning to cover work demands Finishing times are becoming progressively longer after 6pm/ impact on health and well being of staff Pharmacy not always informed if additional consultants employed at weekends to increase number of discharges Reduced job satisfaction and risk of retention issues due to staff feeling that they don't have the time do to their job properly (as seen in staff survey results) Lack of access to quality locum pharmacy staff to boost WTE available	15 3 x 5	15 3 x 5	1 1 x 1	Within departmental pressures for 2023-24 funding requested to staff the service long term. Request funding for Rowland's to open additional hours at weekends during winter period to support dispensing of ED and outpatient prescriptions allowing the inpatient pharmacy to focus on inpatient medication requirements.	Jan 19th 2023. Accepted by Pharmacy Board for Risk Register KC March 2023: Unclear if pressures and developments for 2023/24 will fund this risk to cover late night opening. Currently no funding to expand the service to cover OPEL 4 additional bed base May 2023: Risk Confirm & Challenge Meeting 19/5/23 Present: SRF, ES, KC, SP, LR The funding of £121k transferred to Oncology risk, so this risk remains May PSQB - Risk accepted at 15, the score will be reduced when the staff recruited are in post in the summer. June 2023: Pharmacy now closing at 5pm as opposed to 6pm. Some staff still required to work till 6pm to finish the work from the day. Plan to review the staffing regualrly dependent on the pressure on the service. Escalation beds open still putting pressure on the service.	Sep-2023	Mar-2024
High	8504	Family & Specialist Services	Women's Services	Yorkshire Fertility (was ACON)	Jan-2023	Active	Financial sustainability	There is a risk of delayed fertility treatment due to a current 10.5 week wait for Yorkshire Fertility patients to have a semen analysis. This is resulting in a direct impact on the business as clinics are under utilised due to the wait for the test, as next stages of investigations cannot happen with out the result and also direct impact on patient outcome due to time limited activities for fertility patients and poor patient experience.	Escalated to General Manager for pathology and Lead Andrologist to see what can be done to improve wait times Lead Andrologist to look at the andrology diary and audit DNA rates for their service	Both Fee pay and NHS patients are unable to have their IVF treatment as waiting for the test to plan appropriate treatment it will have an impact on patient satisfaction and experience as many couples will be unhappy with the wait.	15 3 x 5	15 3 x 5	1 1 x 1	Offered MY services to help with data analysis	May 23 - Divisional Risk Register confirm and challenge update 23/5/23 Present: SRF, NB, TO, LM, GH, FA, NV, RR, DT, LR Met with Pathology with regards extra shifts at weekends (post VAS clinics), 8 samples a day via Pathology was 25, looking at figures and reviewing. GH speak to SR, should this risk be on the Pathology Risk Register. May 23 Review LD / GH continues to be challenges with wait times escalated to GM for pathology re next steps Feb 23 - Review LD / GH - score reviewed and unable to reduce from 15 due to frequency /	Jun-2023	Jun-2023

High	8528	Medical	Emergency Care	Accident & Emergency CRH/HRI	Mar-2023	Active	Transforming and improving patient care	There is a risk of a reduction in the operational performance within the Emergency Department (ED) and the maintenance across all Emergency Care Standards due to prolonged patient length of stay within the ED and the impact this has on ED flow. National target is 76% of all patients to be seen, treated, admitted or discharged within 4 hours.	Workforce models for both Medical and Nursing including vacancy levels constantly monitored and reviewed to ensure the ED has the best opportunity in dealing with this extra activity. Use of the Urgent Care Hubs co-located within the ED as a service to see and treat low acuity patient. Use of Local Care Direct as a service to see and treat low acuity patient out of hours. ED long waiter SOP and the use of ED nursing rounding to ensure long waiting patients are cared for whilst waiting bed placement.	A clear escalation plan within the organisation to decant patient from the Emergency Department (ED) who have a prolonged waits for an inpatient bed. Lack of Medical Same Day Emergency Care provision at the Calderdale Royal Hospital resulting in the ED been unable to stream patients away from the department. Lack of robust SDEC referral process to streamline suitable patient into SDEC service from the front door of the ED.	16 4 x 4	15 3 x 5	6 2 x 3	Continue to promote the use of the Urgent Care Hub and Local Care Direct as services to see and treat low acuity patients. Promote ED consultant at the front door at times of increased congestions. Continue to collaborate with divisional colleagues in relation to SDEC pathways and the streaming of patients. Continue to collaborate with divisional colleagues in relation to re-opening a medical SDEC at the CRH site.	Approved at PSQB April 23	Jul-2023	Jun-2024

Extreme + Major Risks = 52

Lead	Laura Douglas
Exec Dir	Diane Tinker
RC	NWG
Tolerate	

Pauline North
David Birkenhead
WF

Jenni Etchells/Lola Duncan/Tammy Willis
Simon Riley-Fuller
PSQB

Liane King/Chloe Gough	Helen Rees
David Britton	Lyndsay Rudge
NWG	WEB

T Strickland, S Shepley, A Ameen, L Willia	Sarah Clenton
Helen Barker	Stephen Shepley
NA	DB

Venkat Thiyagesh/Elena Gelsthorpe-Hill	Sarah Clenton
Nikhil Bhuskute/Stephen Shepley	Prf. Bhuskute
PSQB	DB

Milly Finch
Elisabeth Street
NA

Kimberley Scholes	Emma Hurst
Jo Fawcus	Prof. Bhuskute
PCB	PSQB

James Battye	Ann Frost
	Diane Tinker
DB	PSQB

Emma Griffiths
Natalka Drapan
PSQB

Emma Griffiths	Julie Mellor
Aletta Carbone	Simon Riley Fuller
PSQB	PSQB

Simon Riley-Fuller/Wendy Kilner	Gill Harries
Simon Riley Fuller	Stephen Shepley
PSQB	PSQB

Cornelle Parker, Pauline North	Jenni Etchells/Alison Gormley
David Birkenhead	
WF	NA

Sarah Clenton	Natalka Drapan	Lucy Thomson
Prof. Bhuskute	Aletta Carbone	Stephen Shepley
DB	PSQB	PSQB

Chris Roberts /Andy Hardy	Louise Croxall
Purav Desai	Rob Birkett
PSQB	DB

Jenni Etchells/Julie Mellor
Simon Riley-Fuller
HSC

Chris Roberts	Helen Rees
Johnathan Hammond	Jonathan Hammond
PSQB	PSQB

Philippa Russell
Gary Boothby
FPC

Julie Mellor
Simon Riley-Fuller
PSQB

Emma Hurst	Venkat Thiyagesh/Elena Gelsthorpe-Hill
Stephen Shepley	Nikhil Bhuskute/Stephen Shepley
PSQB	PSQB

TBC (Medical education)	Chris Lord-Tyrer	Nicholas Buckley	Nicholas Buckley
David Birkenhead	David Birkenhead	Helen Barker	Helen Barker
QC	ICPB	PCB	PCB

Venkat Thiyagesh/Elena Gelsthorpe-Hill
Nikhil Bhuskute/Stephen Shepley
PSQB

Janet Youd
Ellen Armistead, Suzanne Dunkley
WF

Louise Croxall/Graham Walsh
Ellen Armistead
WEB

Keith Rawnsley
Jonathan Hammond
FIREC

Katherine Cullen
Nikhil Bhuskute
DB

Emily Snowdon	Laura Douglas	Laura Cooper
Ellen Armstead	Diane Tinker	Thomas Strickland
WF	PSQB	PCB

Ann Frost	Emma Burbidge	Natalka Drapan
Gill Harries	Gill Harries	Aletta Carbone
PSQB	HSC	PSQB

Katherine Cullen	Katherine Cullen	Helen Gibbons
Elisabeth street	Elisabeth Street	Gill Harries
PSQB	NA	PSQB

Tom Ladlow		DB	

COVER SHEET

Date of Meeting:	Thursday 6th July 2023
Meeting:	Board of Directors
Title:	Budget Book 2023/24
Author:	Philippa Russell – Acting Deputy Director of Finance
Sponsoring Director:	Gary Boothby – Director of Finance / Kirsty Archer – Acting Director of Finance
Previous Forums:	N/A

Actions Requested:
To approve

Purpose of the Report

To update the Board on the final financial plan and to gain approval of the budget for 2023/24.

Key Points to Note

The attached Budget Book provides a summary of the 2023/24 final financial plan as submitted to NHS England (NHSE) including:

Income & Expenditure Summary
Establishment
Balance Sheet Plan
Cashflow Plan
Divisional Budgets
Activity and Income
Agency Plan
Reserves summary
Capital Plan

Budget and commentary as at 4th of May 2023 and reconciled to the NHSE Financial Planning Return submitted on that date.

EQIA – Equality Impact Assessment

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

Recommendation

The Board is asked to approve the 2023/24 Budget Book.

BUDGET BOOK
2023-24

2023/24 Financial Plan - Overview

The Trust's financial plan for 2023/24 is for a £20.8m deficit.

Planning Assumptions:

Income Changes:

- Block Contract allocations uplifted:
  - + 1.8% Tariff uplift (2.9% inflation less 1.1% efficiency requirement)
  - + 0.9% Growth (Integrated Care Board (ICB)) / + 0.21% (NHS England)
- Allocations adjusted to reflect 'Convergence Adjustment' of -0.71%
- Share of local Convergence Adjustment (Calderdale ICB) -£0.49m
- Covid-19 funding reduced by c.90%
- Includes Elective Recovery Funding of £15.02m.
- Additional non-recurrent ICB funding allocation of £12.10m

Cost Changes:

- Includes elective recovery costs of £10.05m required to achieve activity plan and reduce elective waits to less than 40 weeks by the end of the financial year.
- Includes inflationary costs of £25.03m, of which only £11.67m are funded through the NHS Payment Scheme uplift.
- Pay inflation included at 2% as per national guidance.
- Non Pay inflation includes impact of current RPI on PFI / B Braun contracts.
- Assumes delivery of £25m efficiency plus a further £6.5m stretch efficiency target: Total efficiency requirement of £31.5m or 6.3% of Operating Expenditure, (£32.3m including Full Year Effect of 22/23 schemes).

Risks

- West Yorkshire proposed mechanism for allocating Elective Recovery Funding (ERF) remains subject to final approval. This proposal would focus 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.
- Risk of further strike action resulting in increased costs and impacting on elective recovery.
- Risk that additional funded bed capacity is insufficient to meet demand due to DTOC, Covid-19 or winter pressures.
- Risk of further inflationary pressures above planned level, particularly utilities costs.
- Plans assume Agency and Bank premium payments are only required to deliver additional recovery.
- Scale of CIP challenge with an additional £6.5m stretch target to identify, some schemes still being developed and a number of high risk schemes including those linked to Emergency Department rosters and Length of Stay reduction.
- Risk that any Pay Award above the 2% planning assumption is not fully funded.

23/24 Plan (CHFT Group): Income & Expenditure

Income & Expenditure	22/23 Budget £'m	22/23 Actual £'m	23/24 Plan (Excl. Efficiency) £'m	23/24 Efficiency £'m	23/24 Total Plan £'m
NHS Clinical Income[1]	431.60	466.52	463.71	0.07	463.79
Other Income	53.74	57.17	54.10	1.27	55.37
TOTAL INCOME	485.35	523.69	517.81	1.34	519.15
Medical	(89.51)	(95.65)	(103.06)	8.14	(94.92)
Nursing	(92.20)	(102.18)	(108.05)	9.46	(98.59)
Sci Tech & Ther	(41.24)	(41.27)	(44.79)	0.78	(44.00)
Support to clinical staff	(49.34)	(52.80)	(54.88)	0.91	(53.97)
Any Other Spend[1]	(1.00)	(0.38)	(1.27)	0.62	(0.64)
Managers and infrastructure support	(45.50)	(50.38)	(50.09)	2.55	(47.54)
PAY EXPENDITURE	(318.79)	(342.66)	(362.13)	22.46	(339.67)
Drugs	(45.79)	(45.40)	(47.76)	(0.22)	(47.98)
Clinical Supplies & Services	(34.28)	(33.71)	(35.84)	2.20	(33.64)
Other Costs	(71.50)	(89.45)	(85.58)	5.71	(79.87)
NON PAY EXPENDITURE	(151.58)	(168.56)	(169.17)	7.69	(161.48)
TOTAL EXPENSES	(470.36)	(511.21)	(531.30)	30.16	(501.15)
EBITDA	**14.98**	**12.48**	**(13.49)**	**31.50**	**18.01**
Non Operating Expenditure	(32.68)	(22.54)	(39.15)	0.00	(39.15)
TOTAL SURPLUS/(DEFICIT)	**(17.69)**	**(10.06)**	**(52.65)**	**31.50**	**(21.15)**
Less: Items excluded from Control Total[2]	0.34	(7.28)	0.34	0.00	0.34
TOTAL SURPLUS/(DEFICIT) on a Control Total Basis	**(17.35)**	**(17.33)**	**(52.30)**	**31.50**	**(20.80)**

Overview:

- Total deficit plan of £20.80m.
- 23/24 Budget includes planned income and expenditure linked to Elective Recovery activity and waiting list targets.
- Efficiency requirement for 23/24 is £25m plus a further £6.5m stretch target. Total efficiency requirement as reported to NHSE is £32.30m, including £0.83m full year effect of 22/23 schemes.
- Position includes inflation, growth, and approved pressures and developments.
- No remaining contingency held to cover any in year developments approved through the Business Case Approval Group.

[1] Excludes notional income and expenditure relating to 6.3% pension contributions paid by NHS England in 22/23

[2] Donated Asset Income, Donated Asset Depreciation, Donated Consumables and Impairments

23/24 Plan (CHFT Group): Establishment

Whole Time Equivalent (WTE)	22/23 Budget	22/23 Actual	23/24 Plan (Excl. Efficiency)	23/24 Efficiency	23/24 Total Plan
	WTE	WTE	WTE	WTE	WTE
Medical	725.49	749.97	765.13	(1.34)	763.79
Nursing	1,924.14	1,749.23	1,947.30	(64.30)	1,883.00
Sci Tech & Ther	828.64	757.89	848.62	(0.77)	847.85
Support to clinical staff	1,753.43	1,552.75	1,758.84	(3.60)	1,755.24
Any Other Spend	2.19	1.71	2.19	0.00	2.19
Managers and infrastructure support	1,168.93	1,201.90	1,164.28	(17.00)	1,147.28
TOTAL	6,402.82	6,013.45	6,486.36	(87.01)	6,399.35

Notes
- WTE as at 31st March of each year

23/24 Plan (CHFT Group): Statement of Financial Position

Statement of Financial Position	22/23 Budget As at 31 Mar 23 £'m	22/23 Actual As at 31 Mar 23 £'m	23/24 Plan As at 31 Mar 24 £'m
Non Current Assets			
Property, Plant & Equipment	148.37	145.59	151.38
On B/S PFI Assets	60.20	65.02	58.77
Right to Use Leases[1]	22.30	20.48	22.00
Investment in Joint Venture	4.38	6.02	6.68
Other	2.49	2.95	2.87
	237.73	240.07	241.69
Current Assets			
Inventories	7.61	8.02	8.49
Receivables	22.17	34.35	17.69
Other	4.80	4.58	6.63
Cash	19.26	24.63	2.19
	53.85	71.58	34.99
Current Liabilities			
Loans	(2.21)	(2.21)	(2.21)
Deferred Income	(7.45)	(13.16)	(9.69)
Payables	(68.96)	(80.88)	(66.98)
Provisions	(5.45)	(8.24)	(4.60)
Leases (Incl PFI)	(6.60)	(5.95)	(6.20)
	(90.67)	(110.44)	(89.67)
Non Current Liabilities			
Loans	(13.25)	(13.25)	(11.05)
Leases (Incl PFI)	(78.81)	(77.51)	(75.89)
Provisions	(1.12)	(0.80)	(1.12)
Other	(0.80)	(0.71)	(0.82)
	(93.99)	(92.28)	(88.88)
TOTAL ASSETS EMPLOYED	**106.92**	**108.92**	**98.13**
Taxpayers Equity			
Public Dividend Capital	312.63	303.77	324.93
Income & Exp Reserve	(209.47)	(201.82)	(230.50)
Revaluation Reserve	3.76	6.98	3.71
TOTAL TAXPAYERS EQUITY	**106.92**	**108.92**	**98.13**

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

Key Assumptions:

- No asset valuation adjustments are assumed.

23/24 Plan (CHFT Group): Statement of Cash Flow

Statement of Cash Flow	22/23 Budget £'m	22/23 Actual £'m	23/24 Plan £'m
Surplus/(deficit) from Operations	**(17.69)**	**(10.06)**	**(21.15)**
non-cash flows in operating surplus/(deficit)			
Non-cash donations/grants credited to income	(0.08)	(0.55)	(0.08)
Depreciation and amortisation	16.75	16.94	21.26
Other operating non-cash (income)/ expenses	15.86	12.98	17.82
Impairments	0.00	(7.41)	0.00
Gain on disposal of assets	0.00	(0.00)	0.00
	32.53	**21.96**	**39.00**
Operating Cash flows before movements in working capital	**14.83**	**11.90**	**17.86**
Movement in working capital	**(5.98)**	**1.71**	**(3.40)**
Net cash inflow/(outflow) from operating activities	8.86	13.61	14.45
Net cash inflow/(outflow() from investing activities			
Capital Expenditure	(37.10)	(30.55)	(28.92)
Proceeds on disposal of property, plant and equipment	0.00	(0.00)	0.00
Increase/(decrease) in Capital Creditors	(5.98)	(3.75)	(1.00)
Other cash flows from investing activities	0.32	1.07	0.66
	(42.75)	**(33.22)**	**(29.26)**
Net cash inflow/(outflow) before financing	**(33.90)**	**(19.61)**	**(14.80)**
Net cash inflow/(outflow) from financing activities			
Public Dividend Capital Received	22.77	13.89	11.81
Revenue Support Public Dividend Capital	0.00	0.00	9.50
PDC Dividends paid	(1.63)	(1.07)	(1.54)
Repayment of Loans	(2.21)	(2.21)	(2.21)
Financing	(20.52)	(20.31)	(22.27)
Non-Current Movements	0.00	(0.80)	0.00
	(1.59)	**(10.51)**	**(4.71)**
Net increase/(decrease) in cash	**(35.48)**	**(30.12)**	**(19.51)**
Opening cash [1]	54.65	54.74	21.69
Closing cash	**19.16**	**24.63**	**2.19**

Note 1: Planned opening cash balance based on 22/23 Month 10 Forecast as per planning submission.

Key Assumptions:

• Capital Plan totals £34.01m, £28.92m plus £5.09m new leases and £0.08m Donated Assets:
  * £17.03m internally funded
  * £11.81m funded by Public Dividend Capital (PDC)

• Cash balance is adversely impacted by the £20.8m planned deficit and a planned reduction in creditors and accruals.
• The Trust will require to borrow cash in the form of Revenue PDC - planned value is £9.5m for 23/24. This does incur an additional PDC Dividend charge in the first year of borrowing.

23/24 Plan by Division: Income & Expenditure

Division	22/23 Contribution Actual £'m	23/24 Income Plan £'m	23/24 Pay Plan £'m	23/24 Non Pay Plan £'m	23/24 Contribution Plan £'m
Medical Division	(132.86)	6.47	(98.99)	(39.72)	(132.24)
Surgical Division	(101.48)	2.61	(79.09)	(24.96)	(101.43)
Families & Specialist Services	(87.15)	5.52	(70.96)	(27.85)	(93.29)
Community Division	(27.06)	4.17	(33.68)	(3.26)	(32.77)
Corporate Division	(54.54)	1.48	(24.73)	(32.96)	(56.20)
Estates & Facilities	0.00	0.00	0.00	0.00	0.00
Health Informatics	1.25	19.83	(11.02)	(7.78)	1.03
PMU	1.57	8.10	(2.72)	(4.45)	0.93
CHS LTD*	0.22	63.68	(12.42)	(50.55)	0.71
Central Inc/ Technical Accounts*	379.63	465.04	(6.07)	(73.56)	385.41
Trust Reserves	3.08	6.38	(0.01)	0.69	7.06
Surplus / (Deficit)*	**(17.33)**	**583.28**	**(339.67)**	**(264.41)**	**(20.80)**
LESS Inter-company payments	**(0.00)**	**(64.12)**	**0.00**	**64.12**	**(0.00)**
GROUP Surplus / (Deficit)	**(17.33)**	**519.15**	**(339.67)**	**(200.29)**	**(20.80)**

* Includes inter-company transactions

Notes:

• The planned income and expenditure totals shown above include inter-company payments of £64.12m between the Trust and its subsidiary company (CHS Ltd). These payments are excluded when reporting the Income & Expenditure position for the Group (as required by NHS Improvement).

23/24 Plan: Activity & Income

Activity	22/23 Budget [1]	22/23 Actual [1]	23/24 Plan (Excl. CIP)	23/24 CIP	23/24 Total Plan
	Spells	Spells	Spells	Spells	Spells
NHS Clinical Income					
Elective	5,776	4,648	4,636	0	4,636
Non Elective	58,360	53,763	53,866	0	53,866
Daycase	50,173	51,153	49,935	0	49,935
Outpatients	436,084	454,560	434,259	0	434,259
A & E	170,928	173,828	174,293	0	174,293
Other-NHS Clinical	1,873,315	1,997,456	1,975,196	0	1,975,196
TOTAL SPELLS	2,594,636	2,735,408	2,692,185	0	2,692,185

Income	22/23 Budget	22/23 Actual	23/24 Plan (Excl. CIP)	23/24 CIP	23/24 Total Plan
	£'m	£'m	£'m	£'m	£'m
NHS Clinical Income					
Elective	23.05	18.08	17.69	0.00	17.69
Non Elective	123.29	122.73	125.90	0.00	125.90
Daycase	31.95	33.37	36.01	0.00	36.01
Outpatients	32.67	36.06	44.01	0.00	44.01
A & E	28.76	30.59	31.42	0.00	31.42
Other-NHS Clinical	191.88	225.70	208.68	0.07	208.76
CQUIN	0.00	0.00	0.00	0.00	0.00
Other Income	53.74	57.17	54.10	1.27	55.37
TOTAL INCOME	485.35	523.69	517.81	1.34	519.15

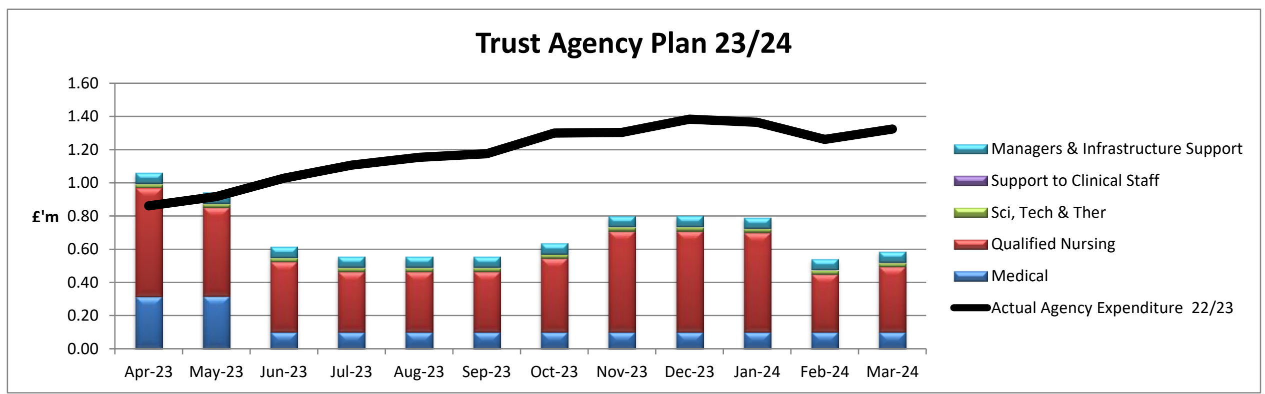
Key Assumptions:

- Contract Income based on Aligned Payment Incentive (API) approach with a fixed and variable element.
- Overall Income envelope has now been agreed, but contract negotations with the ICB are ongoing regarding the pricing of activity and the agreement of the fixed / variable split. This may result in some changes to the income allocation across Points of Delivery (POD).
- CQUIN is operating but is now embedded within POD rather than shown as a seperate income stream.
- System block Covid-19 funding significantly reduced compared to last year at £2.3m.
- Includes £15.02m of Elective Recovery Funding (ERF). West Yorkshire proposed mechanism for allocating ERF remains subject to final approval. This proposal would focus 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.
- Final plan includes £12.1m non-recurrent funding allocation (£6.8m NHSE inflation funding / support & £5.3m intra ICB redistribution of funding).

23/24 Plan: Agency Trajectory

Agency Plan 23/24	Apr-23 £'m	May-23 £'m	Jun-23 £'m	Jul-23 £'m	Aug-23 £'m	Sep-23 £'m	Oct-23 £'m	Nov-23 £'m	Dec-23 £'m	Jan-24 £'m	Feb-24 £'m	Mar-24 £'m	Total £'m
Medical	0.32	0.32	0.10	0.10	0.10	0.10	0.10	0.10	0.10	0.10	0.10	0.10	1.65
Qualified Nursing	0.66	0.54	0.42	0.36	0.36	0.36	0.44	0.61	0.61	0.60	0.35	0.39	5.71
Sci, Tech & Ther	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.25
Support to Clinical Staff	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.05
Managers & Infrastructure Support	0.07	0.07	0.07	0.07	0.07	0.07	0.07	0.07	0.07	0.07	0.07	0.07	0.79
Total	1.06	0.94	0.62	0.56	0.56	0.56	0.64	0.80	0.80	0.79	0.54	0.59	8.46

Actual Agency Expenditure 22/23	0.86	0.92	1.03	1.11	1.15	1.18	1.30	1.30	1.38	1.36	1.26	1.32	14.18



Key Assumptions:

- In 23/24 the Agency Ceiling is set at System level and equates to 3.7% of total pay expenditure.
- For CHFT this would equate to £12.57m for the year.
- The Agency plan is significantly lower than that value at £8.46m and reflects some ambitious efficiency plans to retract from high cost agency, recruit to vacancies and reduce additional capacity requirements.

23/24 Plan: Reserves

Reserves Summary	23/24 Plan £'m	Notes
Uncommitted Reserves		
Contingency Reserve	0.10	Assumed as Pay in Plan
Winter Contingency Reserve	0.00	No Contingency held - budgets allocated to Divisions
Education & Training Reserve	0.82	
Reconfiguration Reserve	0.06	
	0.92	
Planning Gap		
Unidentified CIP - Planning Gap	(4.17)	Efficiency gap to be identified (Final Plan requirement)
Identified CIP not yet allocated	(3.12)	To be allocated once plans are fully developed
	(7.29)	
Committed Reserves		
Covid-19 Reserve	0.07	FFP3 Filters
Income Reserve	(4.75)	Capacity funding pending allocation (costs already committed)
22/23 Pay Award Reserve	0.50	To cover vacant posts. Budget for 22/23 additional pay award allocated to occupied posts only.
PPE Reserve	0.70	Central procurement to cease during 23/24
Clinical Excellence Awards	0.90	Pending agreement of 23/24 award
Approved Pressures & Developments	0.79	To be transferred to Divisions once costs are incurred
Pressures & Developments on hold	0.93	To be transferred to Divisions once approval confirmed
	(0.86)	
TOTAL RESERVES	**(7.23)**	

Key Assumptions:

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

23/24 Plan: Capital

Scheme Category	Capital Schemes	23/24 Plan £'m
Backlog Maintenance	Ventilation Systems	0.05
	CQC Environmental	0.05
	Emergency Lighting	0.20
	Contingency - Build Works	6.00
		6.30
New Build	Catheterization Laboratory	1.20
	CT Scanner Build	1.27
		2.47
Equipment	Clinical Diagnostics	1.07
	Catheterization Laboratory - Equip	2.00
	Pharmacy Robot	0.93
	Car Park CRH	2.00
	HRI Emergency Department	0.50
	Other	1.60
		8.09
Plant & Machinery	Loan Store Decontamination Machine	0.17
		0.17
Total Internally Funded		**17.03**
Funded by Public Dividend Capital (DHSC)	Reconfiguration of Services	6.50
	Community Diagnostic Centre (CDC)	1.30
	Digital Diagnostics Capability Programme	1.75
	CT Scanner	2.27
Donated Assets		0.08
Total Externally Funded		**11.89**
IFRS16	Lease Equipment	4.89
	Lease remeasurement	0.20
TOTAL CAPITAL EXPENDITURE		**34.01**

Key Assumptions:

• Internally generated funds from Depreciation (£21.26m), are also required to cover the cost of repayments on the PFI (£3.78m), other leases (£2.29m) and Capital Loans (£2.21m), leaving £12.98m available for Capital Expenditure. £17.03m has been planned as shown above. Cash Reserves of £4.05m will be required to cover the shortfall.

• Capital plans as reported to NHSI also include Right of Use Leases expensed as operating expenditure prior to April 2022, following changes to accounting standards (IFRS 16).

Date of Meeting:	Thursday 6 July 2023
Meeting:	Public Board of Directors
Title of report:	Governance Report
Author:	Andrea McCourt, Company Secretary
Sponsor:	Victoria Pickles, Director of Corporate Affairs
Previous Forums:	None

Purpose of the Report

This paper presents the following governance items to the Board:

1. Board Workplan Update
2. Proposed Board Meeting Dates 2024-2025
3. Use of Trust Seal
4, Board Committee Annual Reports:
   4.1 Finance and Performance
   4.2 Workforce
   4.3 Audit and Risk
   4.5 Transformation Programme Board
5. Chair's Action – Urgent and Emergency Care Bid

Key Points to Note

1. BOARD WORKPLAN UPDATE

The Board workplan provides the basis for the preparation of Board agendas for the coming year. Ad-hoc items and reports will be included on meeting agendas as necessary. The updated 2023/24 workplan at Appendix U1 is presented for approval.

RECOMMENDATION: The Board is asked to **APPROVE** the updated Board of Directors workplan for 2023-2024.

2. PROPOSED BOARD MEETING DATES 2024-2025

The Board is asked to approve the proposed Board of Directors and Board Development meeting dates for the period April 2024 – March 2025 as scheduled on the attached Appendix U2.

RECOMMENDATION: The Board is asked to **APPROVE** the proposed Board meeting dates for the period April 2024 – March 2025.

3. USE OF TRUST SEAL

The Trust Seal has been used on two occasions since September 2022, once in relation to lease agreement for Westgate House, Halifax and in relation to the renewal lease and licence for Lindley GP, 62 Acre Street, Lindley HD3 3DY as detailed on Appendix U3.

RECOMMENDATION:

iv The Board is asked to **NOTE** the use of the Trust Seal since September 2022.

4. BOARD COMMITTEE ANNUAL REPORTS

The Board is asked to receive and note the Board Committee Annual Reports at Appendix U4:

4.1 Finance and Performance
4.2 Workforce
4.3 Audit and Risk
4.4 Transformation Programme Board

RECOMMENDATION: The Board is asked to **RECEIVE AND NOTE** the Board Committee Annual Reports.

5. CHAIR'S ACTION – URGENT AND EMERGENCY CARE BID

The Trust governance framework allows for urgent decisions to be made in line with the powers which the Board of Directors has retained to itself within the Standing Orders.

This decision-making process involves consideration of the decision by the Chair and Chief Executive, having consulted with at least two Non-Executive Directors not involved in recommending the decision. It is a requirement that the exercise of such powers by the Chief Executive and the Chair is reported to the next formal meeting of the Board of Directors for ratification.

This report presents for ratification one urgent decision taken in line with the provision of the Board of Directors Standing Orders for Urgent decisions in line with the Constitution of Calderdale and Huddersfield NHS Foundation Trust.

This related to a capital bid to NHS England against a national pot of £250M capital monies for a consolidated operations centre and discharge hub aligned to the Urgent and Emergency Care Strategy. The Chair's action was signed on 28 April 2023. The bid was not successful.

The content of this report does not adversely affect people with protected characteristics.

Recommendation

The Board is asked to **APPROVE** the:

1. Board Workplan Update
2. Proposed Board Meeting Dates 2024-2025
3. Use of Trust Seal
4, Board Committee Annual Reports:
   4.1 Finance and Performance
   4.2 Workforce
   4.3 Audit and Risk
   4.5 Transformation Programme Board
5. Chair's Action – Urgent and Emergency Care Bid

Draft BOARD PLAN 2023/2024 – as at 29.06.23 V18

PUBLIC BOARD WORKPLAN 2023-2024

DATE OF MEETING	4 May 2023	6 July 2023	7 Sep 2023	2 Nov 2023	11 Jan 2024	7 Mar 2024
Date of agenda setting/Feedback to Execs	5 April 2023	31 May 2023	19 July 2023	11 Oct 2023	15 Nov 2023	10 Jan 2024
Date final reports required	21 April 2023	23 June 2023	25 August 2023	20 October 2023	29 December 2023	23 February 2024
STANDING AGENDA ITEMS						
Introduction and apologies	✓	✓	✓	✓	✓	✓
Declarations of interest	✓	✓	✓	✓	✓	✓
Minutes of previous meeting, matters arising and action log	✓	✓	✓	✓	✓	✓
Patient/Staff Story	✓	✓	✓	✓	✓	✓
Chair's report	✓	✓	✓	✓	✓	✓
Chief Executive's report	✓	✓	✓	✓	✓	✓
Integrated Performance report (Inc: Quality, Finance, Workforce)	✓	✓	✓	✓	✓	✓
Financial Update	✓	✓ & Budget book	✓	✓	✓	✓
Health Inequalities		✓		✓		✓
Quality Committee Chair's Highlight Report & Minutes	✓	✓	✓	✓	✓	✓
Audit and Risk Committee Chair's Highlight Report & Minutes	✓	✓	✓	✓	✓	✓
Finance and Performance Committee Chair's Highlight Report & Minutes	✓	✓	✓	✓	✓	✓
Workforce Committee Chair's Highlight Report & Minutes	✓	✓	✓	✓	✓	✓
Charitable Funds Committee Chairs Highlight Report & Minutes		✓	✓		✓	
STRATEGY AND PLANNING						
Strategic Objectives – 1 year plan / 5 year strategy	✓ Year-end Quarterly Report	-	✓ - *2023-2024 Strategic Objectives Progress Report*	✓		✓
Digital Health Strategy				✓		
Risk Management Strategy	✓RM Policy		RM Strategy			✓

DATE OF MEETING	4 May 2023	6 July 2023	7 Sep 2023	2 Nov 2023	11 Jan 2024	7 Mar 2024
Annual Plan	✓ for 2023/24					✓
Capital Plan					✓	
Winter Plan				✓		
Green Plan (Climate Change)		✓				
Reconfiguration (commercial)			TBC AB			
QUALITY						
Quality Board update	✓	✓	✓	✓	✓	✓
Director of Infection Prevention Control (DIPC) quarterly report	✓Q3	✓Q4	✓Q1	✓Q2		✓Q3
DIPC Annual Report		✓				
Learning from Deaths Quarterly Report		✓ Q3	✓Q4 Annual Report	✓Q1	✓Q2	✓ Q3
Maternity Incentive Scheme					✓	
Safeguarding Adults and Children Annual / Bi-Annual Report		✓ Annual Report ✓ Annual Report			✓ Bi-annual	
Complaints Annual Report		✓				
WORKFORCE						
Staff Survey Results and Action Plan	✓		✓			✓
Health and Well-Being			✓			
Nursing and Midwifery Staffing Hard Truths Requirement		✓ Annual Report			✓ Bi-Annual	✓
Guardian of Safe Working Hours (quarterly)	✓Q4		✓Q1	✓ Q2	✓Q3	
Guardian of Safe Working Hours Annual Report	✓					
Diversity			Board Diversity Action Plan			✓
Medical Revalidation and Appraisal Annual Report			✓ Annual Report			
Freedom to Speak Up Annual Report			✓ Annual Report		✓ 6 month report FTSU themes	

DATE OF MEETING	4 May 2023	6 July 2023	7 Sep 2023	2 Nov 2023	11 Jan 2024	7 Mar 2024
Public Sector Equality Duty (PSED) Annual Report						✓
GOVERNANCE & ASSURANCE						
Health and Safety Update (if required – routinely reports to ARC)	✓				✓	
Health and Safety Policy **(May 2023)**	✓					
Health and Safety Annual Report		✓				
Board Assurance Framework		✓ 1		✓ 2		✓ 3
Risk Management Strategy		✓				
Risk Appetite Statement			✓			
High Level Risk Register	✓	✓	✓	✓	✓	✓
Standing Orders/SFIs/SOD review (next review due March 2025 unless changes required beforehand)						
Non-Executive appointments				✓		✓
Annual review of NED roles				✓		
Board workplan	✓	✓	✓	✓	✓	✓
Board meeting dates		✓				
Use of Trust Seal		✓		✓		✓
Declaration of Interests – Board of Directors (annually)						✓
Attendance Register – (annually)	✓					
Fit and Proper Person Self-Declaration Register						✓
Seek delegation from Board to ARC for the annual report and accounts 2021/22						✓
BOD Terms of Reference						✓
Sub Committees Terms of Reference	✓ NRC	✓ Workforce	✓ARC	✓ TPB		✓QC ✓ NRC BOC
Constitutional changes (+as required)	✓	✓	✓	✓	✓	✓
Compliance with Licence Conditions (final year 2022/23)	✓					

DATE OF MEETING	4 May 2023	6 July 2023	7 Sep 2023	2 Nov 2023	11 Jan 2024	7 Mar 2024
Huddersfield Pharmaceuticals Specials (HPS) Annual Report				✓		
Fire Strategy 2021-2026	✓ (B/f from March 2023 BOD)					✓
Committee review and annual reports		✓				
Audit and Risk Committee Annual Report 2022/2023		✓				
Workforce Committee Annual Report 2022/23		✓				
Finance and Performance Committee Annual Report 2022/2023		Deferred to Sept '23	✓			
Quality Committee Annual Report 2022/23		Deferred to Sept '23	✓			
Transformation Programme Board Annual Report				✓(TPB review Sept)		
WYAAT Annual Report and Summary Annual Report					✓	
Kirklees ICB Committee Papers (Link)	✓	✓	✓	✓	✓	✓
Calderdale Cares Partnership Committee Papers (Link)	✓	✓	✓	✓	✓	✓

Colour Key to agenda items listed in left hand column:	
Items for approval	To formally receive a report or strategy for discussion and particularly approve recommendations or a particular course of action
Items to receive	To discuss in depth, noting the implications for the Board or Trust without formal approval
Items to note	For the intelligence of the Board without in-depth discussion
Items for assurance	To assure the Board that effective systems of internal control are in place (see Review Room papers)

Proposed Public Board of Directors Meetings and Development Sessions*
2024-2025

Date	Time Meeting Room held	Location
Thursday 7 March 2024	08.00 – 3.00 pm	Boardroom, HRI
***Thursday 4 April 2024**	08:00 – 3:00 pm	Forum 1A and Forum 1B (HRI)
Thursday 2 May 2024	08:00 – 3:00 pm	Large Training Room (CRH)
***Thursday 6 June 2024**	08:00 – 3:00 pm	Forum 1A and Forum 1B (HRI)
Thursday 4 July 2024	08:00 – 3:00 pm	Large Training Room (CRH)
***Thursday 1 August 2024**	08:00 – 3:00 pm	Large Training Room (CRH)
Thursday 5 September 2024	08:00 – 3:00 pm	Forum 1A and Forum 1B (HRI)
***Thursday 3 October 2024**	08:00 – 3:00 pm	Forum 1A and Forum 1B (HRI)
Thursday 7 November 2024	08:00 – 3:00 pm	Large Training Room (CRH)
***Thursday 5 December 2024**	08:00 – 3:00 pm	Forum 1A and Forum 1B (HRI)
Thursday 9 January 2025	08:00 – 3:00 pm	Large Training Room (CRH)
***Thursday 6 February 2025**	08:00 – 3:00 pm	Forum 1A and Forum 1B (HRI)
Thursday 6 March 2025	08:00 – 3:00 pm	Forum 1A and Forum 1B (HRI)

Date	Time	Location
Thursday 1 December 2022	08:30 – 12:00 pm	Moved into the Boardroom
Thursday 2 February 2023	08:30 – 12:00 pm	Forum Room 1A and B
Thursday 6 April 2023	8:30 – 12:00 pm	Forum Room 1A and B
Thursday 1 June 2023	8:30 – 12:00 pm	Forum Room 1A and B Booked all day?
Thursday 3 August 2023	8:30 – 12:00 pm	Forum Room 1A and B Booked all day as Exec Meeting?
Thursday 5 October 2023	8:30 – 12:00 pm	Forum Room 1A and B Booked all day?
Thursday 7 December 2023	8:30 – 12:00 pm	Forum Room 1A and B Booked all day?
Thursday 1 February 2024	8:30 – 12:00 pm	Forum Room 1A and B

Board Strategy Development Sessions 2023-2024

NHS
Calderdale and Huddersfield
NHS Foundation Trust

CALDERDALE & HUDDERSFIELD NHS TRUST: REGISTER OF SEALING OR EXECUTIONS – REPORT FOR THE PERIOD 1 JANUARY – 31 MAY 2023

CONSECUTIVE NUMBER	DATE OF SEALING OR EXECUTION	DATE OF AUTHORITY	DESCRIPTION OF DOCUMENTS SEALED OR EXECUTED PERSON	PERSONS ATTESTING SEALING OR EXECUTION
01-23	18 May 2023	18 May 2023	The Trust signature and seal for the Lease agreement for Westgate House, Halifax. The property is the new central Halifax location for Community Division offices following the vacation of Lister Lane as approved by business case with Michael Folan, Director of Operations.	NAME: Gary Boothby TITLE: Executive Finance Director NAME: Lindsay Rudge TITLE: Chief Nurse Date: 18 May 2023
02-23	18 May 2023 2023	18 May 2023	The documents required Trust signature and seal for the renewal lease and license for Lindley GP, 62 Acre Street, Lindley HD3 3DY. CHFT currently lease the property to Lindley GP and the lease is up for renewal. The partners have now formed Lindley Group Practice Limited and the license to assign is the document used to assign the lease from the partners names to the company. The lease term runs until 31 March 2028.	NAME: Gary Boothby TITLE: Executive Finance Director NAME: Lindsay Rudge TITLE: Chief Nurse Date: 18 May 2023

Register of Seal

Date of Meeting:	**6 July 2023**
Meeting:	**Board of Directors**
Title of report:	**Workforce Committee Annual Report 2022/2023**
Author:	**Tracy Rushworth, Workforce Committee Secretary** **Jason Eddleston, Deputy Director of Workforce and Organisational Development**
Sponsor:	**Karen Heaton, Non-Executive Director/Workforce Committee Chair**
Previous Forums:	**Workforce Committee 20 June 2023**

Actions Requested

- To note

Purpose of the Report

The Workforce Committee annual report for 2022/2023 details:-

- The role of the Committee, membership and attendance between 1 April 2022 and 31 March 2023 and the terms of reference
- The activities of the Committee between 1 April 2022 and 31 March 2023
- A self-assessment completed by core Committee members relating to the effectiveness of the Committee.

Key Points to Note

This Annual Report is presented for information and assurance.

Recommendation

The Board of Directors is asked to note the content of the report.

WORKFORCE COMMITTEE ANNUAL REPORT 2022/2023

This Workforce Committee annual report for 2022/2023 details:-

- The role of the Committee, membership and attendance between 1 April 2022 and 31 March 2023 and the terms of reference
- The activities of the Committee between 1 April 2022 and 31 March 2023
- A self-assessment completed by core Committee members of the effectiveness of the Committee.

1. INTRODUCTION

1.1 Purpose of the Workforce Committee

The purpose of the Committee is to provide assurance to the Board on the quality and impact of workforce and organisational development strategies and the effectiveness of workforce management in the Trust. This includes but is not limited to recruitment and retention, colleague health and wellbeing, learning and development, colleague engagement, organisational development, leadership, workforce spend and workforce planning.

The Committee oversees that there is continuous and measurable improvement in workforce activities through review of key workforce metrics in order to support the delivery of workforce performance targets.

The Committee receives assurance in relation to internal workforce activity from a number of annual reports prior to national publication. These reports include Freedom to Speak Up, Workforce Race Equality Standard, Workforce Disability Equality Standard and Gender Pay Gap. The Committee is responsible for reviewing and monitoring performance and improvement against the associated action plans.

1.2 Terms of Reference

The Committee has approved Terms of Reference in place.

The Terms of Reference were reviewed by the Committee in June 2022. The Director of Corporate Affairs was added to the membership of the Committee. There were no further amendments.

1.3 Workforce Committee Membership and Attendance in 2022/2023

Between 1 April 2022 and 31 March 2023 the Committee met 6 times.

The core membership and attendance at the 6 Committee meetings is set out below:-

Name	Role	Number of meetings attended
CORE MEMBERS		
Karen Heaton	Non-Executive Director **(Chair)**	6/6
Ellen Armistead[1]	Chief Nurse	1/1
David Birkenhead	Medical Director	6/6
Suzanne Dunkley	Director of Workforce Organisational Development	5/6
Jason Eddleston	Deputy Director of Workforce & Organisational Development	6/6
Jo Fawcus[2]	Chief Operating Officer	1/3
Jonny Hammond[3]	Chief Operating Officer	0/2
Andrea McCourt	Company Secretary	5/6
Vicky Pickles[4]	Director of Corporate Affairs	0/4

Lindsay Rudge[5]	Chief Nurse	4/5
Denise Sterling	Non-Executive Director	6/6

[1]Member until May 2022
[2]Member until October
[3]Member from December 2022
[4]Member from August 2022
[5]Member from June 2022

2. WORKFORCE COMMITTEE ACTIVITIES 2022/2023

The activities in 2022/2023 of the Committee are set out below.

2.2 CHFT Workforce Strategy

A link to the refreshed People Strategy was shared with the Committee in June 2022. The strategy retains an interactive digital approach. Its content incorporates comments/views from colleagues including those about One Culture of Care and our values and behaviours and it captures familiar themes including health and wellbeing, inclusion, engagement, improvement, talent management and work design. A People Strategy Hot House took place in July 2022.

2.2.1 Recruitment Strategy

The 2022/2025 Recruitment Strategy was presented to the Committee in April 2022. The strategy described the goal 'To recruit, develop and retain an outstanding workforce which delivers one culture of care to each of our patients and makes CHFT an employer of choice for our local communities'. The strategy has an overarching four key themes; Attraction and Recruitment, Developing our Workforce, Widening Participation, and Why we are CHuFT to be CHFT. The strategy outlined specific themes and activities underpinning the four key themes. The strategy will be shared more widely and be embedded as part of the strategic recruitment work and through the recruitment microsite. An action plan was shared with the Committee in October 2022.

2.2.2 Apprenticeship Strategy

The progress against targets set for 2021/2022 were presented to the Committee in June 2022. Currently 220 staff at CHFT are on an apprenticeship programme. From April 2022, the rate of apprentice pay for all entry level apprentices was standardised. New employability programmes supported over 160 people to feed into apprenticeship opportunities. A new 3 year Apprenticeship Strategy is being designed that will align to the new Recruitment Strategy and the NHS People Plan. In December 2022 the Committee noted the Widening Participation team had fully integrated into the Apprenticeship Team as a result of change of leadership. A strategy update for 2022/2023 was presented. Project delivery focuses on access to entry clinical and non-clinical apprenticeships/ bank whilst continuing to build capacity, scope new opportunities and challenge new ways of working.

2.2.3 Equality, Diversity and Inclusion Strategy

In June 2022 the Committee received a progress report against the 5 year plan. The first two years of the strategy had focused on equality groups, empowering colleagues, unconscious bias education and inclusion roadshows and pledged commitment to inclusive recruitment, review of workforce policies and enhanced development for middle managers. Now in its third year the strategy's focus is on inclusive leadership development. An inclusive leadership module is included in the development programme and the compassionate leadership offer. Cross divisional working, an enhanced focus on visibility, toolkits and refreshed values and behaviours is delivering good progress. In December 2022 the Committee received an overview on the Engagement Team and Equality Network activity during 2022 and the plans for 2023.

2.2.4 Development for All

In April 2022 the Committee received the new interactive OD development for all brochure, an e-magazine which all colleagues can access via their Trust email account. The approach fosters one culture of care, focusing on change and improvement, wellbeing, inclusion and engagement. CHFT aims to implement an inclusive workforce development approach centred on leadership, personalised learning, networks, experiential learning and unlocking the talent of our people. Everything we deliver will align to the overall NHS People Promise. An update was presented to the Committee in February 2023 that provided examples of partnership working, apprenticeship successes, tools to engage colleagues and the CHFT Leadership Offer.

2.2.3 Health and Wellbeing

In June 2022 the Committee received an update on the range of activities during the period 1 June 2021 to 31 May 2022 and the progress made. Colleagues consider the wellbeing support offer comprehensive and like the format - a core offer that also signposts to other options. Specific themes identified from the 2021 staff survey results along with colleague feedback have been built into the Health and Wellbeing Strategy. The next 12 months will include a focus on leadership visibility, a refreshed appraisal and appreciation toolkits. In December 2022 the Committee were informed a Workforce Psychologist had been appointed concentrating on trauma.

2.2.4 Equality Network Groups

During the reporting period the Committee received an update from each of the equality groups – Women's Voices, Race, LGBT and the Disability Group. Success stories were showcased along with challenges and opportunities to further develop the groups. The network groups contribute to underpinning one culture of care.

2.3 Team Engagement and Development (TED)

In April 2022 the Committee received an overview of TED, a team engagement approach to a diagnostic survey exploring 8 dimensions. It allows structured engagement discussions, offering a toolkit of resources with measurable outcomes. It emphasises the impact of teams on care, and highlights benefits throughout different levels, benefitting the team, the team leader and the organisation. The framework reinforces one culture of care and gives colleagues a voice to be part of a team.

2.4 Enhanced Support to Colleagues

In April 2022 the Committee received for information and discussion details of two incentives to be revisited; buy back of annual leave and Pensions recycling. Both items would be further discussed at Executive Board and Board of Directors.

2.5 Colleague Engagement Plan

The 2022 engagement, inclusion and Health & Wellbeing calendar was presented to the Committee in April 2022. Successful activities already taken place included LGBT+ history month, International women's day and elimination of racial discrimination – root out racism pledge. Other events to come included a Wellbeing event, A day to be CHuFT and the CHuFT Awards. The calendar brings together engagement, inclusion, wellbeing and development. Events will focus on outcomes of the staff survey to continue to encourage colleagues to use their voice.

2.6 Developing Workforce Safeguards Report

On 12 April 2022 the Committee received a report to provide an update on the progress against the 14 key recommendations as set out in the Developing Workforce Safeguards (2018). The Trust is compliant with 9 recommendations and partially compliant with 5 recommendations. A revised action plan was provided with a further update presented on 11 October 2022.

2.7 Nursing Workforce Programme Update

A report was presented to the Committee on 12 April 2022 to provide an overview of the schemes to establish safe and effective nurse and midwifery staffing. The strategies are coordinated through the Nursing and Midwifery Steering Group. An update was provided to the Committee on 11 October 2022.

2.8 West Yorkshire and Harrogate (WY&H) People Plan

In April 2022 the Committee received an overview of the main focus of the WY&H People Plan and how the publication of the plan will impact CHFT. The Plan has a clear focus which is more staff working differently in a compassionate culture. The Plan brings together work in all health and social care sectors – local authorities (LAs), universities and colleges, NHS trusts including mental health and community.

2.9 Progress on Staff Survey Action Plans

In June 2022 an overview reminder of the 2021 staff survey results was presented to the Committee. Results against the People Promise Theme questions highlighted improvement needs to be made in colleague engagement. A summary of the workforce priorities was provided. Progress against both Trust and divisional actions and key events taking place ahead of the 2022 staff survey were outlined.

2.10 Freedom to Speak Up Annual Report

The Committee received the 1 April 2021 – 31 March 2022 annual report in June 2022. The key points noted were:-

- The number of concerns raised in 2021/2022 and the number of concerns raised as per the NGO's submission categories and by staff groups.
- The themes of concerns and the hot spots for concerns.
- The work being undertaken to create a culture where staff feel safe to speak up and make FTSU business as usual at CHFT.

A mid-year report in December 2022 showed a significant increase in the number of concerns raised by colleagues in Q1 and Q2 and a decrease in the number raised anonymously when compared with 2021 data. FTSU concerns are taking longer to process as they become more complex, and colleagues are requiring additional emotional support.

2.11 Board Assurance Framework (BAF)

The Committee regularly reviews the BAF to ensure that all risks relating to workforce are identified and managed to mitigate the risks. Four workforce risks are noted:

- Medical Staffing
- Nurse Staffing
- Recruitment/Retention inclusive leadership
- Colleague Engagement

2.12 Trade Union Facility Time

In June 2022 the Committee received a paper that set out reporting requirements for public sector organisations in relation to paid trade union facility time and the Trust's data for the period 1 April 2021 to 31 March 2022. This data represents approved time off for trade union duties for medical and non-medical local trade union representatives. The Trust honours its obligation with 13 staff side partner organisations. Time is managed appropriately such that 0.015% of the overall pay bill is spent on TU duties, notably below the unofficial 0.06% benchmark set by the Government.

2.13 Annual Plan

In June 2022 the Committee received the information submitted as part of the 2022/23 CHFT workforce narrative and the final workforce numbers submission with supporting narrative setting out future assumptions, actions, and risks. The narrative element of the submission is split into 10 themes. The first theme is specifically workforce related and comprises 4 objectives which require action by all organisations in the West Yorkshire Health and Care Partnership over the next 12 months. The final submission of the workforce numerical plan sets out the planned fte position for all staff groups for the period 1 April 2022 to 31 March 2023.

2.14 Gender Pay Gap (GPG)

In August 2022 the Committee received the Trust data on the gender pay gap for March 2022 that will be submitted in March 2023. The key points being 5040 female colleagues employed by the Trust compared to 1185 male. CHFT's median pay gap decreased from 20.1% in 2020 to 19.2% in 2021 and has since remained at 19.2% in 2022. There has been a continued reduction in the mean GPG from 30.9% in 2020 to 30.2% in 2021 to 28.9% in 2022. In order to drive improvement an action plan has been developed focusing on access to leadership roles, management of clinical excellence awards, colleague development and experience. The action plan will be monitored through the Women's Voices network. An update on the action plan was shared with the Committee in February 2023.

2.15 Workforce Race Equality Standard (WRES)

In August 2022 the Committee received the annual report and associated action plan. Progress updates would be provided to the Committee. An overview of positive improvements included increase in overall BME workforce, increase in manager pay bands, likelihood of appointment is almost equal between white and BME, increases in perceived equal opportunities for BME staff progression and decreases in BME staff experiencing harassment/bully/abuse in both categories

2.16 Workforce Disability Equality Standard (WDES)

In August 2022 the annual report and associated action plan was received by the Committee. Improvements were highlighted in self-declaration rates and disabled staff are more likely to be appointed. The report highlighted a number of areas for improvement. Progress updates will be provided to the Committee.

2.17 Colleague Availability, An Overview of Divisional Process Planning Response

The pandemic had stimulated a need to look at everything within our control to improve availability. In August 2022 the Committee received a number of assurances by way of a presentation by divisional colleagues that complexities of workforce availability is being well managed.

2.18 Nursing and Midwifery Safer Staffing

On 11 October 2022 a report was presented to the Committee that provided an overview for nursing, midwifery and Allied Health Professionals staffing capacity and compliance in line with the National Institute for Excellence Safe Staffing, National Quality Board and the NHS Improvement Workforce

Safeguards guidance. This is supported by an overview of staffing availability over the reporting period and progress with assessing acuity and dependency of patients on ward areas. The data collection informed the Nursing and Midwifery establishment reviews for 2022/2023.

2.19 Medical Workforce Programme

In October 2022 a report presented to the Committee described the current medical workforce establishment and measures being taken to address medical staffing risk. A refresh of the medical workforce steering group is also being undertaken and a look at cultural changes to explore how we can do things differently.

2.20 Diversity Partners Programmes

The Committee received a paper in October 2022 that showed the Trust's continued commitment to supporting equality, diversity and inclusion (ED&I) by joining the NHS Diversity in Health and Care Partners programme. The Trust is entering into year 3 of its ED&I strategy and the next step is to review the strategy and plans with support from this programme which is underpinned by the NHS values.

2.21 Allied Health Professionals (AHP) Workforce Manager

In December 2022 Sophie Box introduced herself as the new workforce project lead working alongside AHPs to improve recruitment and retention and colleague experience at CHFT. The response fits in with the Trust's recruitment strategy of 'grow our own'. It looks at how we interact with future early careers, use of technology, virtual elements of supervision and individual App style preceptorship collectively creating a branding aspect across AHPs.

2.22 Return to Work (RTW) Interviews

The Committee received a report in December 2022 asking it to consider options in response to the 80% target not being achieved since June 2021. Reduction in intense operation HR support saw compliance reduce to c65%. The Committee noted that CHFT is the only Trust that reported RTW against a KPI target. The Committee agreed to the removal of the workforce target for RTWs as a KPI and improvements to the online portal. The requirement for line managers to record in ESR or Health Roster will remain and compliance will be discussed at monthly divisional boards and taken to PRM and/or Workforce Committee on a quarterly basis.

2.23 2022 NHS Staff Survey Results

In February 2023 the high level survey results were presented on screen only to the Committee. The comprehensive results were embargoed until 9 March 2023. Benchmark results were available on 21 February 2023.

2.24 Internal Audit Report for CHFT: Medical Revalidation CH/15/2023

The findings of an audit of medical revalidation in November/December 2022 were presented to the Committee in February 2023. The report carried a high assurance opinion for each of the domains. Audit Yorkshire stated this reflects the effective systems and processes in place for medical revalidation. Consequently no recommendations have been made. The Committee noted the outstanding report.

2.25 Shadow Board

In February 2023 the Committee learned that a recent audit recommended that by 2025 our senior leadership team should match the Trust's diverse community. As a result, an action highlighted in the Board's representation action plan is to develop and implement a Shadow Board in 2023/2024. The Shadow Board will be a fundamental part of our wider talent management offer presenting

development opportunities for aspirant directors and senior leaders. A communications launch piece is being developed.

2.26 Absence Management (Sickness Absence) Audit Recommendations

The findings of an audit conducted by Audit Yorkshire in November 2022 in relation to the Trust's arrangements for the effective management of sickness absence were presented to the Committee in February 2023. The overall audit opinion was 'Limited Assurance'. 5 recommendations for action were highlighted, 3 major, 1 moderate and 1 minor. 11 actions were agreed in response to the audit findings. 8 actions are complete with 1 to be completed in March 2023 and 2 in April 2023. An action plan was shared with the Committee.

2.27 Education Committee (EC)

Notes of the EC are shared with the Committee.

2.28 Inclusion Group (IG)

In December 2022 the Committee learned of the arrangements for the new IG, a sub-group of the Workforce Committee. The IG would meet every 2 months commencing December 2022 and provide updates to the Committee.

2.28 Review and Monitor Key Workforce Metrics

At each of its meetings the Committee reviews the Quality and Performance (Workforce) report. The report comprises of key workforce metrics:-

- Sickness absence
- Retention and Turnover
- Essential Safety Training
- Appraisal
- Recruitment
- Bank/Agency Spend

The Committee receives a quarterly vacancy report for all staff groups. The report provides information about current vacancies, recruitment activities, updates on hotspot areas and actions taken.

During the period 1 April 2022 to 31 March 2023 the Committee undertook deep dives into the following:-

- Admin and Clerical Turnover
- Allied Health Professionals Turnover
- Age Profile
- EST Fire Safety Training

2.29 Hot House events

The CHFT colleague journey Hot House took place on 29 April 2022. The Hot House focused on our 2021 staff survey results and provided an opportunity to reflect and identify what we can all do to improve colleague experience at CHFT. Divisional representatives, wellbeing ambassadors and equality group representatives attended the event.

A People Strategy themed Hot House took place on 7July 2022. Feedback from the event would be collated and incorporated into the Strategy. Some of the amazing ideas will be translated onto posters and QR codes. The Strategy will connect to celebration and appreciation events planned for

later in the year. The benefits of a hot house approach and 3Rs methodology was strongly recommended.

On 24 November 2022 a Hot House took place that would help shape the leadership model at CHFT. Attendees were asked what they think good leadership looks like in CHFT to drive employee satisfaction, patient satisfaction and overall good performance.

3. EFFECTIVENESS OF WORKFORCE COMMITTEE

On an annual basis, the Committee undertakes a self-assessment exercise to gauge its effectiveness by taking the views of Committee members and attendees across a number of themes. The outcome of this is then reviewed by the Committee and an action plan developed and monitored by the Committee. The self-assessment exercise took place, in May 2023. The results are set out in Appendix 1. The action plan will be developed, presented and agreed at a future meeting.

4. CONCLUSION

As described above, the Committee has received assurance through the course of 2022/2023 from a number of sources. The Committee confirms it has fulfilled its role to the Board during 1 April 2022 to 31 March 2023 undertaking its key functions of providing assurance that that there is continuous and measurable improvement in the development of workforce strategies, the effectiveness of workforce management in the Trust which align to One Culture of Care and which ensure workforce risks are managed appropriately.

Tracy Rushworth
Workforce Committee Secretary

Jason Eddleston
Deputy Director of Workforce and Organisational Development

June 2023

Audit and Risk Committee Annual Report 2022/23

This annual report of the Audit and Risk Committee for 1 April 2022 to 31 March 2023 details:

- The role of the Audit and Risk Committee, including membership and attendance
- The activities of the Audit and Risk Committee reflecting the five key areas of oversight

1. Role of the Audit and Risk Committee

The role of the Audit and Risk Committee is to provide assurance to the Trust Board regarding the monitoring and review of financial and other risks and associated controls, corporate governance and the assurance frameworks of the Trust and its subsidiaries.

1.1 Background

It is a formal requirement for all NHS Trusts to have an Audit and Risk Committee. Information about the appropriate operation of the Audit Committee is set out in the official *NHS Audit Committee Handbook* (Fourth Edition) published in 2018. The Audit and Risk Committee adheres to this guidance.

This report describes the Audit and Risk Committee's activities from April 2022 to March 2023 and in particular various matters for which the Audit and Risk Committee has oversight for the Board including:

- Financial reporting
- Risk management
- External audit
- Internal audit
- Governance arrangements.

After each meeting the Chair escalates those matters that the Audit and Risk Committee considers should be drawn to the attention of the Board via a highlight report. The minutes of the Committee's proceedings are shared at the next meeting of the Trust Board.

1.2 Terms of Reference

The Committee has an approved terms of reference in place. The Committee approved its terms of reference on 26 July 2022, with ratification by the Board on 1 September 2022. The Committee meets on a quarterly basis, with an additional meeting for the review of the annual report and accounts.

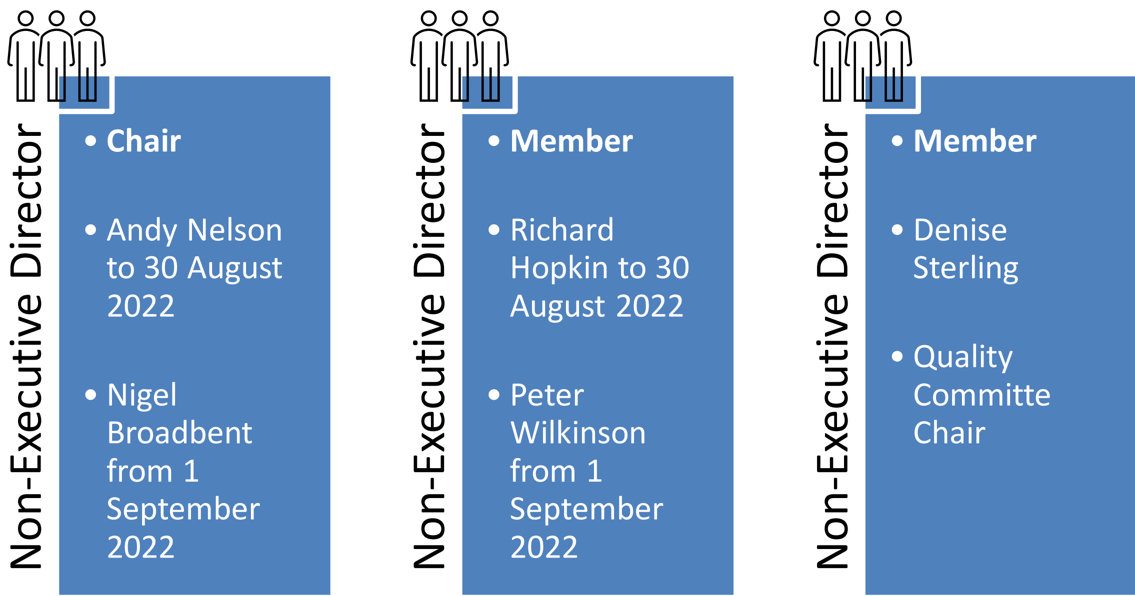
The Audit and Risk Committee has a well-established workplan which sets out its annual cycle of work and reporting which is regularly reviewed.

1.3 Audit and Risk Committee Membership and Attendance in 2022/23

The Audit and Risk Committee met five times during 2022/23: 26 April, 5 July, 26 July, 25 October 2022 and 31 January 2023.

The membership of the Audit and Risk Committee is three Non-Executive Directors (NED) and all meetings were quorate. Up to two governors are invited to attend and observe each meeting. A register of attendance by members and those invited to attend during 2022/23 is shown at Appendix 1.

There were changes to the Non-Executive Director membership of the Committee during 2022/23 following a review of Board Committee Chair roles arising from changes in Non-Executive Director appointments during the year:



The following were in regular attendance at the Audit and Risk Committee meetings during the year:

- Gary Boothby/ Kirsty Archer, Director of Finance (joint role)
- Andrea McCourt, Company Secretary
- Kim Smith, Assistant Director Quality and Safety
- Ric Lee, Engagement Director, KPMG
- Salma Younis, Senior Manager, KPMG
- Leanne Sobratee, Internal Audit Manager, Audit Yorkshire
- Shaun Fleming, Local Counter Fraud Specialist, Audit Yorkshire

The following also attended for specific items:

- Zoe Quarmby, Assistant Director of Finance – Financial Control for the annual accounts 2021/22

2. Audit and Risk Committee Activities 2022/23

The principal activities of the Audit and Risk Committee during 2022/23 are detailed below.

2.1 Financial Governance

Financial Reporting - Annual Report and Accounts for 2021/22

The Committee considered the draft Annual Report and Accounts for 2021/22 and, with delegated authority given to the Committee from the Board of Directors at the Board meeting on 3 March 2022, the Committee approved the 2021/22 Annual Report and Accounts on behalf of the Board at a meeting on 5 July 2022. This included accounts for the wholly owned subsidiary, Calderdale Huddersfield Solutions.

Standing Orders, Standing Financial Instructions and Scheme of Delegation

The Committee regularly reviewed waivers of Standing Orders and approved losses and special payments and bad debt write offs.

On 31 January 2023 the Committee approved and recommended to the Board revised Standing Orders of the Board of Directors, Standing Financial Instructions and revisions to the Scheme of Delegation which were approved by the Board on 2 April 2023.

The Committee also approved the Treasury Management Policy.

Standards of Business Conduct and Conflicts of Interest
The Committee reviewed the Trust position on declarations of interest in terms of compliance with the Standards of Business Conduct and Conflict of Interest Policy and noted a compliance position on nil declarations by decision makers of 86%. A revised policy was also reviewed and approved by the Committee.

2.2 External Audit

KPMG is the Trust's external auditor, with November 2022 being the start of the second of a three year period for which they were appointed.

The Committee reviewed the annual accounts provided by the auditors as part of its audit for 2021/22, including final audit reports, value for money arrangements, management letters and their Auditor Annual Report for 2021/22. An unqualified audit opinion was given.

The Committee reviewed and approved the External Audit Plan and annually reviews the performance of the external auditors.

The external audit provider KPMG was not commissioned by the Trust during the year to undertake any significant non-audit work.

External auditors also briefed the Committee at each meeting on sector related matters of interest.

2.3 Internal Audit (IA)

The Trust purchases internal audit services from Audit Yorkshire to review the adequacy of controls and assurances in place via a comprehensive audit programme. The internal audit service provided by Audit Yorkshire meets mandatory NHS Internal Audit standards and provides appropriate independent assurance to the Audit and Risk Committee. The Committee considered the major findings of internal audit work and the management response to them.

In relation to the 2021/22 annual report and annual governance statement, the annual Head of Internal Audit Opinion for 2021/22 confirmed significant assurance regarding the system of internal control in the Trust.

The Committee reviewed and approved the Internal Audit strategy, annual plan and detailed programme of work for 2022/23, which embraced operational as well as financial and business areas.

With regard to delivery of the 2022/23 internal audit plan the Committee received 2 high assurance opinion reports, 25 significant assurance opinion reports 5 limited assurance opinions and 1 no opinion reports. The limited assurance opinion reports related to complaints, the quality governance structure, absence management, ambulance handover and MUST (hydration and nutrition) assessments. Further details on implementation of recommendations relating to these limited assurance opinion reports is given in the 2022/23 Annual Governance Statement. All reports where an opinion is provided have recommendations, with an action plan in place to address these recommendations and a target date set until all actions are completed, with an electronic system to support the tracking of progress against recommendations.

Internal Audit provides a progress report at each Committee meeting which enables the Committee to monitor progress against the actions. Completion of recommendations from previous years continued to be closely reviewed by the Committee and a number of overdue recommendations

were followed up with the Executive team by the Audit and Risk Committee Chair and progress continued to be monitored by the Committee.

The Committee annually reviews the performance of the internal auditors in year and to date this has been satisfactory.

2.4 Counter Fraud

The Trust takes the prevention and detection of fraud very seriously and the Counter Fraud Specialist continues to work to raise the profile of fraud in the Trust, explores the potential for fraud and investigates cases of fraud.

The Committee received and approved the 2022/23 Counter Fraud plan, regular progress reports and updates against this plan and the annual Counter Fraud report for 2021/22. The Committee monitored compliance with the new Counter Fraud Authority Functional Standard and was pleased to note the improvement to a green rating in 2022.

Details of fraud prevention work undertaken were shared. The Counter Fraud Specialist attended all meetings to which he was invited.

2.5 Risk Management

During the year, the Committee continued to review the risk management approach across the Trust. A review of the Risk Management Strategy and Policy scheduled for 31 January 2023 was deferred to April 2023 as was a deep dive. The Committee noted ongoing work to strengthen risk management processes, particularly regarding the risk register and noted work planned to procure risk management software compatible with the introduction of the Patient Safety Incident Response Framework currently planned for autumn 2023.

The Board Assurance Framework (BAF) was reviewed by the Committee three times, on 26 July 2021, 25 October 2022 and 31 January 2023. The Committee has specific oversight for a BAF risk relating to health and safety and this risk was reviewed during the year.

The Head of Internal Audit Opinion gave a significant assurance opinion for 2022/23, confirmed the BAF provides adequate assurance to the Board in relation to the key risks to achieving its strategic objectives. (TBC) It confirmed that the BAF contained all the essential elements required and the Board and Board Committees participated effectively in the BAF monitoring and review arrangements.

2.6 Assurances Received by the Committee

In addition to its usual business, the Committee received the following assurances during the year:

- **Clinical Audit Programme** – recognising the need for the Committee to be assured about the systems in place to support high quality care as a key component of good governance, a paper was received from the clinical audit lead which provided an update on clinical audit activity to the 25 October 2022 Committee meeting. The paper described arrangements for national and local audits as well as plans for improvement work on clinical audit.

- **Health and Safety** – the Head of Health and Safety presented a deep dive highlighting work that had been undertaken, including work on implementation of the NHS Workplace Health and Safety Standards and workplace assessments. It was noted the Trust had a well embedded Health and Safety Committee with strong engagement from clinical and non-clinical colleagues. The sharing of information on building compliance by third party providers was an area that needed strengthening and actions in relation to this were underway.

The Health and Safety Strategy for 2023-28 was reviewed and approved, which has been aligned towards the NHS workplace safety, health, and safety standards. This was noted as a focus of the implementation of the strategy. The Health and Safety Policy was reviewed and approved.

The Committee reviewed the Emergency Preparedness Resilience and Response Annual Report for 2021/22 and progress against the 2021 core standards, with training and testing of business continuity plans noted as priorities for 2022/23.

The Committee also reviewed the 2021/22 Fire Safety Annual Report and noted fire safety improvement work underway and a planned review of the fire safety training package to support improved compliance.

- **Information Governance** – the Security and Confidentiality Officer gave a deep dive presentation on Information Governance (IG) within CHFT. Details were given of current priorities and progress including the Data Security and Protection Toolkit (DSPT), data security essential training and the development of a new Trust information asset management system to improve control of information assets.

- **Risk Management** –. A deep dive of risk management processes took place on 26 April 2022 presented by the Assistant Director of Quality and Safety and the Head of Risk and Compliance. Details of improvements in risk management processes underway were shared including supporting divisions to gain greater consistency on the management and recording of risks. The need for further training and development to support colleagues in managing risk was highlighted, and the critical friend approach being taken by the risk management team was noted.

  The Committee also noted planned changes to risk management software for the bespoke risk register and changes to the process for adding risk to the high level risk register, with all risks scoring 15 being added to the high level risk register. A review of the Risk Management Strategy and Policy was deferred to 2023/24.

- **Data Quality Board** – On 26 July 2022 the Information Director presented an annual deep dive into Data Quality, gave details of the areas routinely reviewed by the group and areas of success, i.e. clinical audits, IT resource for Emergency Care Data Sets. Details were also shared of deep dives to address issues, such as 28-day theatre cancellations. Future areas the group would address were noted and a "Plan on a Page" for 2022/23 was shared.

2.7 Governance and Reporting Groups

The Committee reviewed the Code of Governance and noted the Trust was compliant with all provisions of the code.

Terms of reference were approved for the Data Quality Board, Information Governance and Records Strategy Group and the Health and Safety Committee.

In year reporting to the Committee from the following sub-groups took place with summary highlight reports and minutes shared with the Committee:

- Information Governance and Records Strategy Committee
- Risk Group
- Compliance Group *
- Health and Safety Committee
- Data Quality Board

Assurance regarding compliance was via a CQC and Compliance Group. In year it was agreed to have two groups with a dedicated remit to allow greater scrutiny on each aspect. A term of reference for the Compliance Group was approved by the Committee on 31 January 2023.

3. Review of Committee Effectiveness

On an annual basis the Committee undertakes a self-assessment exercise to gauge the Committee's effectiveness by taking the views of Committee members and attendees across themes. The outcome of this is then reviewed by the Committee and an action plan developed using the results of the self assessment surveys and good practice guidance from the National Audit Office on the Audit and Risk Assurance Committee effectiveness tool and monitored by the Committee. The self-assessment exercise took place in Spring 2023 and the outcome of this was shared at the meeting of 25 April 2023 and an action plan agreed for the Committee.

4. Conclusion

As described above, the Audit and Risk Committee has received assurance through the course of 2022/23 from management, other assurance committees, the risk management processes and progress reports from counter fraud, external and internal audit.

The Audit and Risk Committee therefore confirms that it has fulfilled its role of providing assurance to the Board during 1 April 2022 to 31 March 2023 regarding the monitoring and review of financial and other risks and associated controls, corporate governance and the assurance frameworks of the Trust and its subsidiaries.

Audit and Risk Committee Chair

Date tbc April 2023

Nigel Broadbent, Non-Executive Director, Audit and Risk Committee Chair
Andrea McCourt, Company Secretary

Attendance	✓	Apologies	×	Not invited /in post

AUDIT & RISK COMMITTEE ATTENDANCE REGISTER - 1 APRIL 2022 – 31 MARCH 2023

Member	26.04.22	05.07.22 ARA Sign-Off	26.07.22	25.10.22	31.01.23	TOTAL
Andy Nelson, Non-Executive Director (Chair) up to and inc. 26.07.2022	✓	✓	✓			3 / 3
Nigel Broadbent, Non-Executive Director (Chair) from 25.10.2022		✓ Induction Period	✓ Induction Period	✓	✓	2 / 2
Richard Hopkin Non-Executive Director	✓	✓	✓			3 / 3
Denise Sterling Non-Executive Director	×	✓	✓	✓	✓	4 / 5
Peter Wilkinson, Non-Executive Director				×	✓	1 / 2
In Attendance						
Gary Boothby, Director of Finance	✓	✓	×	×	X	5/5
Kirsty Archer, Director of Finance	×	✓	✓	✓	✓	
Jim Rea, Managing Director, Digital Health	✓					1/5
Robert Birkett, Director, Digital Health			×	×	X	
Andrea McCourt, Company Secretary	✓	✓	✓	✓	✓	5/5
Philippa Russell, Deputy Director of Finance					✓	1./1
Kim Smith, Assistant Director of Quality and Safety	✓	✓	✓	×	✓	4/5
Helen Higgs, Head of Internal Audit	✓	✓	×	×	×	2/5
Leanne Sobratee, Audit Yorkshire	✓	✓	✓	✓	✓	5/5
Shaun Fleming, Local Counter Fraud Specialist	✓		✓	✓	✓	4/4

Ric Lee, Engagement Director, KPMG	✓	✓	×	×	✓	**3/5**
Salma Younis, Audit Manager, KPMG	✓	✓	✓	×		**3/5**
Matthew Moore, Audit Manager, KPMG					×	
Governor Observer(s)						
Liam Stout (Staff Governor)	✓		×	✓	✓	**3/5**
Isaac Dziya (Public Governor)	×		×	×	x	**0/5**

Date of Meeting:	6 July 2023
Meeting:	Board of Directors - Public
Title:	Transformation Programme Board Annual Report 2022-2023
Author:	Jackie Ryden (Governance Lead Reconfiguration Programme)
Sponsoring Director:	Anna Basford (Deputy CEO/Director of Transformation and Partnerships)
Previous Forums:	N/A

Purpose of the Report

This paper presents the annual report of the Transformation Programme Board for 2022-2023 which details the role of the Transformation Programme Board including membership and attendance and describes the activities of the Transformation Programme Board during the year in line with the duties within the terms of reference.

Key Points to Note

In line with the other Trust Board sub-committees, good practice states that the Trust Board sub-committees should be reviewed annually to determine if they have been effective, and whether further development work is required. This Annual Report summarises the activities of the Trust's Transformation programme Board for the financial year 2022-2023 setting out how it has met its terms of reference and key priorities. These were reviewed and updated in March 2022.

The principal activities of the Transformation Programme Board during 2022-2023 were as follows:

- Monitoring delivery of the Reconfiguration Programme milestones
- Monitoring Communication and Engagement activity for the Reconfiguration Programme
- Receiving regular updates on Reconfiguration Programme Risks and associated mitigation and management plans
- Receiving updates on Strategic Capital Projects
- Receiving regular updates on the Trust Green Plan
- Receiving regular updates on the Trust Travel Plan
- Receiving updates on Board Assurance Framework and risks associated with Transformation Programme Board

The Committee has carried out its business in the last 12 months in accordance with the terms of reference and has received assurance through the course of 2022-2023 from a number of sources. The meetings have been well attended with valuable input from Executive colleagues, Non-Executive Directors and managers outside the Committee. A self-assessment was completed and no additional actions were identified.

EQIA – Equality Impact Assessment

The Reconfiguration Programme aims to address the needs of the whole population, including those who currently experience disadvantage and the plans are intended to help

improve access, experience, and outcomes for all. The proposed changes do not generate differential discriminatory equality impacts.

Recommendation
The Board is asked to **NOTE** the assurances in the Annual Report that the Transformation Programme Board met its duties for 2022-2023 and **APPROVE** the Report.

Transformation Programme Board Annual Report 2022/2023

This annual report of the Transformation Programme Board for 2022/2023 details:

- The role of the Transformation Programme Board including membership and attendance
- The activities of the Transformation Programme Board
- The effectiveness of the Transformation Programme Board

1. Role of the Transformation Programme Board

The role of the Transformation Programme Board is to oversee the development and delivery of complex transformation programmes in the Trust and to provide assurance on these matters to the Trust.

1.1 Background

The Transformation Programme Board is constituted as a Standing Committee of the Trust Board. Its constitution and terms of reference are subject to amendment by the Trust Board.

The Committee derives its power from the Trust Board and has no executive powers, other than those specifically delegated in these terms of reference. The Committee will comply with the Trust's Standing Orders and Standing Financial Instructions and schemes of delegation.

The Committee is authorised by the Trust Board to investigate any activity within its terms of reference – it is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Trust Board to request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary.

This report describes the Committee's activities from April 2022 to March 2023 and various matters for which the Transformation programme Board has oversight for the Board to manage the programme plan and sign off the key outputs and decisions at each stage of the programme including:

- monitoring and ensuring delivery of the plan of key activity, milestones and critical path
- patient and staff communications and engagement
- procurement and commercial processes and decisions
- review of all the key deliverables and the activities required to deliver them
- the activities required to validate the quality of the deliverables
- the resources and time needed for all activities and any need for people with specific capabilities and competencies
- the dependencies between activities and any associated constraints when activities will occur
- the points at which progress will be monitored, controlled and reviewed
- the provision of regular reports, updates and assurance to CHFT Board, NHSE&I and Treasury
- maintenance of a detailed risk registers and mitigation of risk factors affecting the successful delivery of the project
- maintenance of a benefits realisation registers and monitoring of delivery

- considering and recommending to the Trust Board any changes to the project scope, budget or timescale if required
- review of serious issues, which have reached threshold level
- brokering relationships with stakeholders within and outside the project to maintain positive support for the programme
- maintaining awareness of the broader strategic perspective advising the SRO on how it may affect the project
- approving the design brief, appointment of external consultant team and approving the programme of work and the critical path.

1.2 Terms of Reference

The Committee has an approved terms of reference in place. The Committee reviewed and approved its terms of reference on 22 March 2022, with ratification by the Trust Board on 5 May 2022. The Committee meets monthly.

1.3 Transformation Programme Board Membership and Attendance in 2022/2023

The Committee met eight times during 2022/23.

The membership of the Transformation Programme Board includes three Non-Executive Directors. Peter Wilkinson has been the Committee Chair since the Committee was set up in September 2019.

In addition, the Committee consists of the following members:

- Chief Executive
- Chief Operating Officer
- Medical Director
- Director of Nursing
- Director of Workforce & Organisational Development
- Director of Finance
- Deputy CEO/Director of Transformation and Partnerships (Programme Director)
- Deputy CEO/Operations Director for Reconfiguration
- Director of Corporate Affairs
- Managing Director Digital Health
- Managing Director Calderdale and Huddersfield Solutions Limited.

The following are also required to attend all meetings:

- Assistant Director of Transformation and Partnerships/Reconfiguration Programme Lead
- Associate Director of Finance
- Governance Lead Reconfiguration Programme

The Lead Governor is invited to attend and observe each meeting.

A quorum will be four members of the Committee and must include at least three board members of which one must be a Non-Executive Director and one an Executive Director. The meetings in 2022/2023 were always quorate and an attendance register is included in Appendix A.

After each meeting, the Chair reported back to the next Trust Board meeting, drawing attention to those matters of significance for the Board. The draft minutes of the meetings are received by the Private Session of the Trust Board.

2. Transformation Programme Board 2022/2023

The principal activities of the Transformation Programme Board during 2022/2023 are detailed below.

Monitoring delivery of the Reconfiguration Programme milestones –key milestones delivered during 2022/2023 include:

- Monitoring of the Gateway 2 Review action plan to deliver against the recommendations made following the Gateway 2 review in September 2021.
- Regular updates on the planning application developments and confirmation of the planning permission approval for the Learning and Development Centre in April 2023.
- An update was provided in July 2022 on the development of the programme governance for the next stage of the programme.
- Approval of a revised programme timeline as recommended by the Gateway Review team.
- Regular programme risk management reports presented linking with the Trust Board Assurance Framework (BAF) where appropriate.
- Regular design updates and presentations received along with regular updates on the communication and engagement activities with key stakeholders throughout the programme
- An annual review was undertaken of the cladding at HRI following the recommendations from the task and finish group in January 2022 as requested by the Programme Board to explore, consider and make recommendations on feasible Cladding options for HRI.
- A recurring item for discussion in all TPB meetings was introduced in June 2022 to review what elements of One Culture of Care could be identified, making the link between colleague and patient culture of care.

Communication and Engagement activity for the Reconfiguration Programme – throughout 2022/2023, the Trust has continued to engage and involve colleagues, local people and key stakeholders including Joint Health Scrutiny Committee; DHSC; NHSE/I; Provider partners across WYAAT; Commissioners; Political Leaders and Officers and Community Groups and Networks in the work of the programme.

A refresh of the Communication and Involvement Strategy for the programme covering the period 2022 to 2024 was completed and approved by the TPB in May 2022. Delivery of this strategy will ensure the continuation of a robust approach to communication and engagement is delivered. In addition, project specific communication and engagement plans have been developed to ensure the strategy aligns with each project deliverable and milestones plan. A detailed report was developed and shared in March 2023 to update the TPB on the programme of communication and engagement activities completed in 2022. Quarterly updates on communication and engagement activity are shared into TPB.

Receiving updates on Design Work – the Programme Board received presentations and updates on the journey from the development of the target operating models and the principles to underpin site configurations for the use of accommodation at HRI and CRH in relation to clinical and non-clinical services post-reconfiguration. The principles informed the plan for location of services within the estate at each site.

In March 2023 the current version of the overarching Target Operating Model Transition and Implementation Summary Chapter of the FBC was approved as recommended by the Gateway Review. This will be kept under review and refreshed as necessary.

A presentation was shared to update the Programme Board in March 2023 on the progression of design plans with the CRH A&E/Same Day Emergency Care and the CRH Ward Block.

Receiving updates on Strategic Capital Projects – In May 2022 the strategic capital investments within the 2022/2023 capital plan were approved for reporting and monitoring by the TPB. The projects identified were: Cardiology Ultrasound Equipment, Catherisation Laboratory, Additional CT Scanner at CRH, HPS Cleanroom and Isolator, A&E Xray at CRH and HRI and the Pharmacy Robot. The format for reporting on these projects was revised in December 2022 to provide more clarity and make them easier to understand.

Overseeing the Green Committee

The Green Committee has developed terms of reference which are reviewed annually and shared with the Transformation Programme Board. The main areas of responsibility for this group are shown below with update reports into the Programme Board on a quarterly basis:

- Monitoring necessary actions that ensure compliance with relevant regulations / legislation
- Engaging with key stakeholders (staff, leadership, visitors)
- Responding to emerging priorities surrounding sustainability
- Fulfilling agreed objectives set out in the Green Plan
- Meeting agreed targets and milestones set out in the SAP and sustainability roadmap.

Receiving updates on the Trust Green Plan

The most recent update provided in April 2023 into the Programme Board on the Trust Green Plan and Sustainability Action Plan (SAP). The SAP outlined individual actions across 10 key themes identifying a total of 203 interventions, of which 148 were reported as complete. In addition, key progress made up to March 2023 included:

Since November 2022, over 600 trees have been planted at HRI.

- A costed EV strategy has been developed by CHS, which recommends capital purchase. This has been signed off by finance and installation of 10 EVCPs planned for summer 2023 at HRI.
- Green Plan engagement calendar 2023 approved by Green Planning Committee.

Receiving updates on the Trust Travel Plan – to support the hospital site developments within the Reconfiguration Programme, a Travel Plan and associated action plan were developed and approved in February 2021. Updates on this travel action plan are presented into the Programme Board on a quarterly basis. Travel plan actions are split into 4 themes with 41 of the 47 total actions complete as of March 2023.

Key progress made against the travel plan actions up to March 2023 included:

- Staff travel survey approved by travel and transport workstream closed at the end of February with a total of 891 responses.
- The Environment and Energy Officer presented the survey findings and analysis to the Travel and Transport workstream and Green Planning Committee in March 2023. Survey data has been shared with relevant stakeholders.
- As the Trust opens the new ED at HRI, the parking facility will offer several cost-effective EV changing points for use by staff and patients/ visitors. EV charging points at Acre Mill will be upgraded to allow for compatibility with new 'back of house' monitoring software.
- Development of an EV charging point strategy paper by CHS. This recommends a capital purchase approach, which has been signed off by finance.
- A plan has been approved to make HRI North Drive more pedestrian friendly, this is awaiting funding approval.

Receiving regular updates on Project Echo – given the interdependencies between Project Echo and the Reconfiguration Programme it is essential for Programme Board members to be updated and informed of progress in relation to Project Echo to determine any impact on the Reconfiguration. This has been a standing agenda item on the Programme Board agenda to ensure adequate visibility and when necessary, escalation of associated matters. A regular 'Round Table' meeting to discuss the Calderdale and Huddersfield service reconfiguration plans is held with Stakeholder representatives from NHS England/Improvement (NHSE/I), Department of Health and Social Care (DHSC), the West Yorkshire Integrated Care Board (ICB) and Place based ICB in Kirklees and Calderdale. The meetings were held quarterly in 2022 and the frequency increased to monthly in 2023.

Receiving updates and assurances on items of governance within the reconfiguration programme including the results of the two internal audits on the Major Capital Expenditure HRI A&E and the Reconfiguration Programme as a whole. Both reports received an overall opinion of significant assurance with only one minor recommendation and no recommendations respectively.

In addition to the above, the Transformation Programme Board also received reports and updates on the following:

- Annual review of the Five-Year Digital Strategy.
- Proposal to progress an improved retail catering offering within the main entrance at CRH.
- Updates on the Community Diagnostics Programme.
- Social Plan developed by the Construction Partner, IHP, for the development of the new A&E at HRI.

3. Review of Committee Effectiveness

The Committee has recently completed an annual self-assessment exercise to gauge the Committee's effectiveness by taking the views of Committee members and regular attendees across a number of themes. The outcome of this is shown at Appendix B and has been reviewed by the Committee. The self-assessment exercise took place in April 2022 and the outcome of this was presented to the Programme Board on 16 May 2022.

The outcomes were similar to last year, with a slight strengthening in some areas. No new actions were identified. However, it was noted that the membership of the Transformation Programme Board will be changing with new members joining the Board over the next few months. It is therefore planned to repeat the exercise in six months.

4. Conclusion

The Committee has carried out its business in the last 12 months in accordance with the terms of reference and has received assurance through the course of 2022/2023 from a number of sources. The meetings have been well attended with valuable input from Executive colleagues, Non-Executive Directors and managers outside the Committee. A self-assessment has been recently completed with no new actions identified.

Peter Wilkinson
Transformation Programme Board Chair
27 June 2023

Attendance	✓	Apologies	×

ATTENDANCE REGISTER – TRANSFORMATION PROGRAMME BOARD
1 APRIL 2022 – 31 MARCH 2023

DIRECTOR	14.4.22 Can-celled	16.5.22	13.6.22	18.7.22	15.8.22 Can-celled	19.9.22 Can-celled	19.10.22	14.11.22	19.12.22	18.1.23	Feb 23 Can-celled	22.3.23	Total
Peter Wilkinson (Chair)		√	√	√			√	√	√	√		√	8/8
Alastair Graham		√											1/1
Tim Busby			x	√			x	x	x	x		x	1/7
Nigel Broadbent				x			√	√	√	√		√	5/6
Andy Nelson		x	x	√			√	√	√	√		√	6/8
David Birkenhead		√	√	x			√	x	√	√		x	5/8
Ellen Armistead		√											1/1
Lindsay Rudge			x	x			√	√	x	√		√	4/7
Gary Boothby		√	√	x			X KA	X KA	X KA	√		√	4/5
Jo Fawcus		√	√	x									2/3
Jonny Hammond							x	√	x	√		x	2/5
Brendan Brown		x	√	x			√	√	√	√		√	6/8
Suzanne Dunkley		√	√	x			x	x	x	√		√	4/8
Anna Basford		√	x	√			√	√	√	√		√	7/8
Jim Rea		x	√										1/2
Rob Birkett				√			x	√	x	x		x	2/6
Stuart Sugarman		√	√	√			x	√	√	x		√	6/8

Vicky Pickles				√			√	√	√	x		√	**5/6**
Rob Aitchison								√	x	√		√	**3/4**
Nicola Bailey		√	√	√			√	√	√	√		√	**8/8**
Stuart Baron		√	√	√			x	√	√	√		√	**7/8**
Stephen Baines		√	√	√			√	√	√	√		√	**8/8**
Stephen Jenkins		√	√	√			√	√	x	√		√	**7/8**

KA – Kirsty Archer

Appendix B

Self – assessment of effectiveness of the Transformation Programme Board

Ten responses were received, and the findings are below:

- ***Committee focus***
  - The Committee has set itself a series of objectives it wants to achieve this year
    - Strongly agreed = **30%**
    - Agreed = **70%**
  - The Committee has made a conscious decision about how it wants to operate in terms of the level of information it would like to receive for each of the items on its cycle of business.
    - Strongly agreed = **40%**
    - Agreed = **40%**
    - Unable to answer = **20%**
  - Committee members contribute regularly across the range of issues discussed.
    - Strongly agreed = **30%**
    - Agreed = **50%**
    - Disagreed = **10%**
    - Unable to answer = **10%**
- ***Team Working***
  - The Committee has the right balance of experience, knowledge and skills.
    - Strongly agreed = **40%**
    - Agreed = **50%**
    - Unable to answer = **10%**
  - The Committee has structured its agenda to cover topics to ensure delivery of the key milestones for the capital investment and estate development at Huddersfield Royal Infirmary and Calderdale Royal Hospital to enable service reconfiguration. This includes major capital schemes that are high risk, high value and of significant strategic importance.
    - Strongly agreed = **50%**
    - Agreed = **50%**
  - The Committee ensures that the relevant executive director/manager attends meetings to enable it to secure the required level of understanding of the reports and information it receives.
    - Strongly agreed = **60%**
    - Agreed = **30%**
    - Unable to answer = **10%**
  - Management fully briefs the committee via the assurance framework in relation to the key risks and assurances received and any gaps in control/assurance in a timely fashion thereby eradicating the potential for 'surprises'
    - Strongly agreed = **30%**
    - Agreed = **60%**
    - Unable to answer = **10%**
  - The sub-groups report timely and clear information in support of the committee thereby eradicating the potential for 'surprises.
    - Strongly agreed = **20%**
    - Agreed = **50%**
    - Unable to answer = **30%**

- I feel sufficiently comfortable within the committee environment to be able to express my views, doubts and opinions.
  - Strongly agreed = **90%**
  - Unable to answer = **10%**

- Members hold their assurance providers to account for late or missing assurances.
  - Agreed = **20%**
  - Disagree = **70%**
  - Unable to answer = **10%**

- When a decision has been made or action agreed, I feel confident that it will be implemented as agreed and in line with the timescale set down.
  - Strongly agreed = **50%**
  - Agreed = **50%**

- ***Effectiveness***

  - The quality of committee papers received allows me to perform my role effectively.
    - Strongly agreed = **40%**
    - Agreed = **50%**
    - Unable to answer = **10%**

  - Members provide real and genuine challenge – they do not just seek clarification and/or reassurance.
    - Strongly agreed = **30%**
    - Agreed = **70%**

  - Debate is allowed to flow, and conclusions reached without being cut short or stifled due to time constraints etc.
    - Strongly agreed = **60%**
    - Disagreed = **40%**

  - Each agenda item is 'closed off' appropriately so that I am clear what the conclusion is, who is doing what, when and how etc. and how it is being monitored.
    - Strongly agreed = **60%**
    - Agreed = **40%**

  - At the end of each meeting, we discuss the outcomes and reflect back on decisions made and what worked well, not so well etc
    - Strongly agreed = **20%**
    - Agreed = **40%**
    - Disagreed = **30%**
    - Unable to answer = **10%**

  - The Trust Board challenges and understands reporting from the Committee
    - Strongly agreed = **20%**
    - Agreed = **40%**
    - Disagreed = **20%**
    - Unable to answer = **20%**

  - There is a formal appraisal of the committee's effectiveness each year which is evidence based and takes into account my views and external views.
    - Strongly agreed = **50%**
    - Agreed = **50%**

- ***Committee engagement***

  - The Committee actively challenges both management and other assurance providers during the year to gain a clear understanding.
    - Strongly agreed = **40%**
    - Agreed = **50%**
    - Disagreed = **10%**

  - The committee is clear about the complementary relationship it has with other committees that play a role in relation to clinical governance, quality and risk management.
    - Strongly agreed = **30%**
    - Agreed = **50%**
    - Disagreed = **10%**
    - Unable to answer = **10%**

- ***Committee leadership***

  - The committee Chair as a positive impact on the performance of the committee.
    - Strongly agreed = **100%**

  - Committee meetings are chaired effectively and with clarity of purpose and outcome.
    - Strongly agreed = **100%**

  - The committee Chair is visible within the organisation and is considered approachable.
    - Strongly agreed = **20%**
    - Agreed = **60%**
    - Unable to answer = **20%**

  - The committee Chair allows debate to flow freely and does not assert his/her own views too strongly.
    - Strongly agreed = **100%**

  - The committee Chair provides clear and concise information to the Board on the activities of the committee and the implications of all identified gaps in assurance/control.
    - Strongly agreed = **70%**
    - Agreed = **20%**
    - Unable to answer = **10%**

URGENT DECISION

This urgent decision is being taken in line with the provision of the Board of Directors Standing Orders for Urgent decisions in line with the Constitution of Calderdale and Huddersfield NHS Foundation Trust.

This decision must be approved by the following, having consulted with at least two Non-Executive Directors not involved in recommending the decision:

- Chair
- Chief Executive

REFERENCE	**01/23**
MATTER FOR URGENT DECISION:	Board approval of bid to NHS England against a national pot of £250M capital monies for a consolidated operations centre and discharge hub aligned to the Urgent and Emergency Care Strategy.
REASON FOR URGENT DECISION	Board approval required to support a bid to NHS England for capital monies from the targeted investment fund for an urgent and emergency care scheme - consolidated operations centre and discharge hub to support admission avoidance and discharge. The bid is for £4M The Trust does not have a Board meeting to approve this by 28 April 2023 hence use of Chair's action as the next available Board meeting to approve this submission is 4 May 2023, after the 28 April 2023 deadline. Integrated Care System and region are also required to sign this off once Board approval has been received.
PREVIOUS FORUMS (incl outcome of discussion)	The Trust was informed of the opportunity to bid on Friday 21 April 2023 and the response time was one week. This did not align with routine meetings to enable discussion in usual forums. Discussion has taken place amongst the Executive team and the bid will be retrospectively notified to the Finance and Performance Committee. The Chief Operating Officer is the lead for the bid.
KEY RELATED DOCUMENTS	The Trust bid to NHS England details the scheme, Senior Responsible Officer, project delivery overview, financial overview and case and estate metrics.
DURATION OF DECISION:	One time only
DECISION:	**APPROVED**
DATE OF DECISION:	28 April 2023

CHIEF EXECUTIVE	Name: Brendan Brown Signature: Date: 28 April 2023
CHAIR	Name: Helen Hirst Signature: Date: 28 April 2023
CONSULTATION WITH 2 NON-EXECUTIVE DIRECTORS	Name: Nigel Broadbent Date: 28 April 2023 Name: Andy Nelson Date: 28 April 2023 Consultation by: Chair
DATE REPORTED TO TRUST BOARD	6 July 2023

compassionate
care

CALDERDALE & HUDDERSFIELD NHS TRUST: REGISTER OF SEALING OR EXECUTIONS – REPORT FOR THE PERIOD JANUARY – OCTOBER 2023

CONSECUTIVE NUMBER	DATE OF SEALING OR EXECUTION	DATE OF AUTHORITY	DESCRIPTION OF DOCUMENTS SEALED OR EXECUTED PERSON	PERSONS ATTESTING SEALING OR EXECUTION
01-23	18 May 2023	18 May 2023	The Trust signature and seal for the Lease agreement for Westgate House, Halifax. The property is the new central Halifax location for Community Division offices following the vacation of Lister Lane as approved by business case with Michael Folan, Director of Operations.	NAME: Gary Boothby TITLE: Executive Finance Director NAME: Lindsay Rudge TITLE: Chief Nurse Date: 18 May 2023
02-23	18 May 2023 2023	18 May 2023	The documents required Trust signature and seal for the renewal lease and license for Lindley GP, 62 Acre Street, Lindley HD3 3DY. CHFT currently lease the property to Lindley GP and the lease is up for renewal. The partners have now formed Lindley Group Practice Limited and the license to assign is the document used to assign the lease from the partners names to the company. The lease term runs until 31 March 2028.	NAME: Gary Boothby TITLE: Executive Finance Director NAME: Lindsay Rudge TITLE: Chief Nurse Date: 18 May 2023

c				

WORKFORCE COMMITTEE

TERMS OF REFERENCE

Version:	2.4 Amendments following review by Committee Chair and Director of Workforce and Organisational Development 2.5 Amendments following November 2020 review by Committee. 2.6 Director of Corporate Affairs added to core membership of the group. 2.7 Amendments following review of membership
Approved by:	Board of Directors
Date approved:	5 July 2018,
Date issued:	5 July 2018, January 2021, May 2021, May 2022
Review date:	May 2023

WORKFORCE COMMITTEE TERMS OF REFERENCE

1. Constitution

1.1 The Trust hereby resolves to establish a Committee to be known as the Workforce Committee (“the Committee”).

2. Authority

2.1 The Committee is constituted as a Standing Committee of the Board of Directors (“the Board”). Its constitution and terms of reference are subject to amendment by the Board.

2.2 The Committee derives its power from the Board and has no executive powers, other than those specifically delegated in these terms of reference.

2.3 The Committee is authorised by the Board to investigate any activity within its terms of reference – it is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

2.4 The Committee is authorised by the Board to request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary.

3. Purpose

3.1 The purpose of the Committee is to provide assurance to the Board on the quality and impact of workforce and organisational development strategies and the effectiveness of workforce management in the Trust. This includes but is not limited to recruitment and retention, colleague health and wellbeing, learning and development, colleague engagement, organisational development, leadership, workforce spend and workforce planning.

3.2 The Committee will assure the Board of the achievement of the objectives set out in the ‘A workforce fit for the future’ section of the Trust’s 10-year strategy.

3.3 The Committee may set up subgroups aligned to key areas of its activity as it deems appropriate.

4. Duties

4.1 The Committee is required to:-

4.1.1 Consider and recommend to the Board, the Trust’s overarching Workforce Strategy and associated activity/implementation plan.

4.1.2 To obtain assurance of the delivery of the strategy through the associated activity/implementation plan.

4.1.3 To obtain assurance of the delivery of strategies and associated activity/implementation plans in relation to Equality, Diversity and Inclusion, Freedom to Speak Up, Staff Survey, education and training, leadership development, one culture of care

4.1.4 Provide advice and support on the development of significant workforce related policies .

4.1.5 Consider and approve strategies associated to the delivery of the Workforce Strategy

4.1.6 Consider and recommend to the Board the key workforce performance

targets for the Trust and

4.1.7 To receive regular reports to assure itself that key workforce performance targets are achieved and to request and receive exception reports where this is not the case.

4.1.8 Review the workforce risks of the high level risk register and the Board Assurance Framework.

4.1.9 Hold the Executive Director of Workforce and Organisational Development to account in relation to risk, risk mitigation and future activity/plans.

4.1.10 Receive reports in relation to internal and external quality and performance targets relating to workforce.

4.1.11 To conduct reviews and analysis of strategic workforce issues and to agree an operational response.

5. Membership and attendance

5.1 The Chair of the Committee is a Non-Executive Director and at least two other Committee members will be a Non-Executive Director. In the absence of the Chair, one of the other Non-Executive Directors shall be nominated and appointed as Chair for the meeting.

5.2 The Chair of the Board of Directors shall not be a member of the Committee but may be in attendance.

5.3 Formal Committee meetings will be supported by at least four strategic sessions known as Hot Houses. Arrangements for the strategic sessions are set out in Appendix 1.

5.4 The core membership of the Committee is as follows:-

Three Non-Executive Directors, Director of Workforce and Organisational Development, Chief Operating Officer, Director of Nursing, Medical Director, Director of Corporate Affairs, , ,

<u>The following may be requested to attend as required for specific agenda items:-</u>

Deputy Director of Workforce and Organisational Development
Workforce Business Intelligence Lead
Workforce and Organisational Development Assistant Directors and Human Resources Business Partners.
Staff side representatives.
Divisional Directors and Directors of Operations from each Division.
5 ‘free’ places to any member of staff, with a minimum of 3 apprentices.

Up to two Governors will observe the meeting.

5.5 A quorum will be four members and must include at least two Non-Executive Directors and one Executive Director.

5.6 Attendance is required at 75% of meetings, Members unable to attend should indicate in writing to the Committee Secretary at least 7 days in advance of the meeting and nominate a deputy except in extenuating circumstances of absence. In normal circumstances any members who are unable to attend must nominate a deputy who is appropriately briefed to participate in the meeting. To ensure Director attendance the Committee’s buddies are the Deputy Chief Executive (Internal) and Chief Digital Information Officer

5.7 A register of attendance will be maintained and the Chair of the Committee will follow up any issues related to the unexplained non-attendance of members. Should continuing non-attendance of a member jeopardise the functioning of the Committee, the Chair will discuss the matter with the member and, if necessary, select a substitute or replacement.

6. Administration

6.1 The Committee shall be supported by the Secretary, whose duties in this respect will include:-

- In consultation with the Chair develop and maintain the reporting schedule to the Committee
- Collation of papers and drafting of the agenda for agreement by the Chair of the Committee
- Taking the minutes and keeping a record of matters arising and issues to be carried forward
- Advising the group of scheduled agenda items
- Agreeing the action schedule with the Chair and ensuring circulation within 48 hours of each meeting
- Maintaining a record of attendance

7. Frequency of meetings

7.1 The Committee will meet quarterly as a minimum to carry out a deep dive review of workforce performance and metrics and quarterly to discuss strategic issues (Appendix 1).

8. Reporting

8.1 The Committee Secretary will produce and maintain a standard agenda; any additional agenda items must be sent to the Secretary no later than 10 working days prior to the meeting, urgent items may be raised under any other business.

8.2 An action schedule will be articulated to members 48 hours following each meeting and must be duly completed and returned to the Secretary for circulation with the agenda and associated papers.

8.3 The agenda will be sent out to the Committee members 5 working days prior to the meeting date, together with the updated action scheduled and other associated papers.

8.4 Formal minutes shall be taken of all Committee meetings. Once approved by the Committee, the minutes will go to the next Board meeting.

8.5 In accordance with the Committee reporting schedule, receive assurance from the Committee's sub-groups, currently the Education Committee. It should review reports and any associated recommendations, including actions to gain assurance of compliance and quality improvement.

8.6 A summary report will be presented to the next Board meeting.

9. Review

1.1 As part of the Trust's annual committee effectiveness review process, the Committee shall review its collective performance.

1.2 The terms of reference of the Committee shall be reviewed by the Board at least annually.

Appendix 1

The following is the proposed list of invitees to the quarterly strategic, Hot House sessions:-

Group one: Chief Operating Officer, Director of Nursing, Medical Director, Director of Finance, Director of Corporate Affairs and their Deputies plus any member of the Executive group with a special interest in the subject.

Group two: A maximum of 3 x Non-Executive Directors, 2 x Governors as invited by the Chair of the Workforce Committee.

Group three: Workforce and Organisational Development team members who lead on the 'hot house' topic plus Deputy Director of Workforce and Organisational Development, Workforce and Organisational Development Assistant Directors and Human Resource Business Partners.

Group four: Staff side representatives.

Group five: Network colleagues from colleague engagement network and BAME network.

Group six: a minimum of 3 apprentices.

Group seven: 5 'free' places to any member of staff who has a particular interest in the subject.

Group eight: national leaders in the subject field and/or representatives from best practice organisations.

Hot House topics will be determined at the end of the calendar year and can be subject to change as service need dictates.

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.

- 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.

DRAFT

- **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

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.

<u>OUTCOME</u>: 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.

<u>OUTCOME</u>: 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

DRAFT

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

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-

DRAFT

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.

DRAFT

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.

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**

DRAFT

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.

Summary

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.

Workforce – February 2023

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.

MWRES

- 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:-

Positive themes

- 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

DRAFT

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.

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 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.