# Public Board of Directors

**Schedule** Thursday 2 May 2024, 9:00 — 12:00 BST
**Venue** Boardroom, Learning Centre, Huddersfield Royal Infirmary
**Organiser** Amber Fox

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Pam Robinson
Peter Bamber
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To Note - Presented by Helen Hirst

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- Quality Committee – 11.03.24
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- Kirklees Health and Care Partnership
https://www.kirkleeshcp.co.uk/about-us/kirklees-icb-committee/kirklees-icb-committee-meetings/
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Date: Thursday 4 July 2024
Time: 9.00 – 12.00 pm
Venue: Boardroom, Learning Centre, Huddersfield Royal Infirmary

To Note - Presented by Helen Hirst

## 1. Welcome and Introductions:

Invited Public Governors:

Brian Moore

Pam Robinson

Peter Bamber

To Note

Presented by Helen Hirst

## 2. Apologies for absence:

## Tim Busby, Non-Executive Director

To Note

Presented by Helen Hirst

# 3. Declaration of Interests

To Note

# 4. Minutes of the previous meeting held on 7 March 2024

To Approve

Presented by Helen Hirst

**Chair Approved Minutes of the Public Board Meeting held on Thursday 7 March 2024 at 10.00 am, Rooms 3 & 4, Acre Mills Outpatients**

**PRESENT**

| | |
|---|---|
| Helen Hirst | Chair |
| Brendan Brown | Chief Executive |
| Rob Aitchison | Deputy Chief Executive |
| David Birkenhead | Medical Director |
| Gary Boothby | Director of Finance |
| Suzanne Dunkley | Director of Workforce and Organisational Development (OD) |
| Lindsay Rudge | Chief Nurse |
| Nigel Broadbent (NB) | Non-Executive Director |
| Tim Busby (TB) | Non-Executive Director |
| Andy Nelson (AN) | Non-Executive Director |
| Denise Sterling (DS) | Non-Executive Director |
| Jo-Anne Wass (JW) | Non-Executive Director |
| Peter Wilkinson (PW) | Non-Executive Director |

**IN ATTENDANCE**

| | |
|---|---|
| Robert Birkett | Chief Digital and Information Officer |
| Anna Basford | Deputy Chief Executive/Director of Transformation and Partnerships |
| Victoria Pickles | Director of Corporate Affairs |
| Jonathan Hammond | Chief Operating Officer |
| Stuart Sugarman | Managing Director, Calderdale and Huddersfield Solutions Ltd. |
| Andrea McCourt | Company Secretary |
| Sarah Rothery | General Manager, Resilience, Acute Flow and Transformation *(for item 47/24)* |
| Amber Fox | Corporate Governance Manager *(minutes)* |
| Krish Pilicudale | Insight Development Programme |
| Jenny Clarke | Associate Director of Therapies *(for item 32/24)* |
| Arley Byrne | Senior Clinical Educator for Allied Healthcare Professionals *(for item 32/24)* |
| Jessica Loxam | Occupational Therapy Clinical Educator *(for item 32/24)* |
| Dave Nuttall | Community Therapy Team Leader *(for item 32/24)* |

**OBSERVERS**

| | |
|---|---|
| Kate Wileman | Public Elected Governor |
| Christine Mills | Public Elected Governor |
| Karnesh Patel | Shadow Board |
| Mohammed Maqsood | Shadow Board |
| Sarah Mather | Head of Legal Services |
| Sophie Box | General Manager, Transformation and Reconfiguration Programme |

Three members of the public were in attendance to observe.

**27/24 Welcome and Introductions**

The Chair welcomed everyone to the Board meeting held in public, in particular Jo-Anne Wass in her first Board meeting as Non-Executive Director. The Chair welcomed the presenters Jenny Clarke, Arley Byrne, Jessica Loxam, Dave Nuttall and invited governors, Kate Wileman and Christine Mills as observers to the meeting.

Mohammed Maqsood and Karnesh Patel were in attendance from the Shadow Board to observe.

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

**28/24 Apologies for absence**

No apologies were received.

Chair Approved

**29/24 Declarations of Interest**

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

**30/24 Minutes of the previous meeting held on 11 January 2024**

The minutes of the previous meeting held on 11 January 2024 were approved as a correct record.

**OUTCOME**: The Board **APPROVED** the minutes from the previous meeting held on 11 January 2024 as a correct record.

**31/24 Matters Arising and Action Log**

The action log was reviewed and all actions were completed.

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

**32/24 Staff Story - Allied Health Professional Workforce Transformation**

Jenny Clarke, Arley Byrne, Jessica Loxam and Dave Nuttall were in attendance and shared a staff story detailing the workforce transformation for the Allied Healthcare Professional (AHP) workforce. Sophie Box was in attendance who was the AHP Workforce Manager at the time of the transformation. The presentation detailed how the team transformed the AHP workforce from 2021, with a focus on culture, training and changes to roles and were developing a pipeline to improve the supply and retention of AHPs. There was a strong focus on apprentices, overseas recruitment, students and creation of an AHP Preceptorship which has been in place for one year, with an evaluation planned in June 2024. Over 50 AHPs have been enrolled in the AHP preceptorship and the programme has been shared across West Yorkshire and other Trusts. The Trust is now well embedded with the universities and attended the last recruitment fair where there was a high number of applicants for Physiotherapist posts.

Karnesh Patel commended the team's work and asked how learning could be applied to support other teams across the Trust. The Chief Nurse highlighted the fantastic presentation confirmed the need to invest in the infrastructure and support the learning phase for staff coming into the organisation, which has clear benefits.

Christine Mills congratulated the team and applauded their enthusiasm.

The Chief Operating Officer commented the service has seen a dramatic positive change in two years and the approach could be extended to other professions.

The Deputy Chief Executive commented this gives hope and optimism and asked if there were any groups that had not responded as well. Arley Byrne responded it had been difficult to release time in stretched services, such as speech language and therapy, and the team were now going out to meet with some specialties. Jessica Loxam added that the AHP study days allow colleagues across the workforce to meet.

DS stated the turnaround in the last few years has been transformational and the focus going forward was on sustaining and building on the change.

JW highlighted the importance of links with higher education institutions and sought advice on working with clinical teams with high vacancy levels which affected their ability to have student placements. Arley Byrne responded there is a need to change culture and think differently, for example, students working an extended day, spend time on the ward, focus on a project or service improvement or work virtually.

Chair Approved

The Chair noted the approach embodied the Trust strategy and culture and congratulated the team on their leadership and for sharing their workforce transformation story.

**OUTCOME:** The Board **NOTED** the Staff Story on the Allied Health Professional (AHP) workforce transformation.

**33/24 Chair's Report**

The Chair's report was received which details the actions and activity of the Chair since February 2024 and the Charitable Funds Committee Highlight Report was received.

**OUTCOME:** The Board **NOTED** the Chair's Report and Charitable Funds Committee Highlight Report to the Board.

**34/24 Chief Executive's Report**

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

The key points to note were:

- Announcement of investment in the NHS nationally for digital, revenue funding for day to day business and maternity services.
- National Staff Survey 2023 results will be published today, 7 March 2024. The Trust's results show a consistent and positive improvement in our scores.
- The Chief Executive reminded the Board that industrial action remains an ongoing issue.
- If the Trust delivers more activity than in the plan the expectation was this will be funded – further understanding is required as to whether the Trust is on an aligned incentive contract, West Yorkshire contract or payment by results.
- Challenges to maintain capacity and deliver on all standards.
- CHFT are one of the top three Trusts in the country for its cancer delivery, top six for elective care recovery and in the top quartile for A&E performance and must maintain 76% with a step change improvement to 77%.
- The Trust must reduce length of stay, with a wider conversation and impact on finances in other sectors required that limit the availability to do this; however, there will be increased funding for discharge.
- Patients waiting over 65 weeks will be a focus nationally – CHFT were doing well in this metric.
- Overall, the NHS must deliver a financially balanced plan – this will be challenging.

**<u>Staff Survey Results – Headlines</u>**

The Director of Workforce and OD shared good news on the staff survey results due to hard work from colleagues. It was the first year the Trust's scores were above average for engagement and morale. All seven People Promise measures improved scores except for one area. A few teams have done well, in particular Huddersfield Pharmacy Specials whose scores have increased.

High impact action plans are being adopted for some lower scoring teams. Hot spot areas from last year's results which had had support had seen improvements this year, apart from one team, with 90% of hot spot areas having increased their engagement score.

The most improved NHS People Promise measure was 'work flexibly'. Teamwork and wellbeing have done well in comparison to other Trusts.

The results are being shared with colleagues by the Trust Communications team.

The Chair noted further details would be brought to the Board in May and noted the improvements should be celebrated.

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

Chair Approved

**STRATEGY: TRANSFORMING AND IMPROVING PATIENT CARE**

**35/24 Annual Strategic Plan Progress Report – 2023/2024**

The Deputy Chief Executive/Director of Transformation and Partnerships presented the progress against the 2023/24 annual strategic plan. The report highlighted that of the 15 objectives, two are rated amber, 12 are rated green and one has been completed.

In terms of the reconfiguration programme being close to approval for funding TB queried how long it would be before the Trust incurs any delays. In response, the Deputy Chief Executive/Director of Transformation and Partnerships confirmed that as we were moving forward with the enabling works at Calderdale Royal Hospital, which we had been supported to do, we were not anticipating delays.

**OUTCOME:** The Board **NOTED** the assessment of progress against the 2023-24 strategic plan.

**36/24 2024-2025 One Year Strategic Plan**

The Deputy Chief Executive/Director of Transformation and Partnerships presented the 2024-2025 one year strategic objectives that will support the delivery of the Trust's five year strategic plan as a refresh of the annual objectives for 2024-25 is now required. Quarterly updates of progress against these objectives will be provided at future Board meetings. Each Director has identified objectives against each of the four goals.

NB sought clarity on the monitoring of achievement of the delivery of the objectives, specifically whether the focus in the rating was on actions, monitoring key performance indicators or measuring success against achieving the targets in the KPIs. The Deputy Chief Executive/Director of Transformation and Partnerships responded the inclusion of measures of success has been implemented this year to strengthen how the Trust quantify and justify the RAG (red, amber, green) ratings on progress as narrative can be subjective. She confirmed the RAG rating and measures of success was work in progress and the Trust needs to be clearer about the link between the measure of success and the RAG rating as we move forward.

AN commented we need to be clear what performance we are aiming for and by when.

The Chief Operating Officer explained the plan has been written without national planning guidelines which were not yet available for 2024/25.

Mohammed Maqsood shared observations from the Shadow Board and commented positively on the inclusion of research as an objective and quantification of social value in the report and benefits to the local economy Mohammed asked if the workforce objective was linked to the outcomes of the staff survey, which the Director of Workforce and OD confirmed it was and whether there was sufficient stretch in the objectives against the national targets.

The Deputy Chief Executive/Director of Transformation and Partnerships responded that to set objectives the Trust can deliver on, the strategic objectives are based on capacity, resources and target and are mindful about challenging yet realistic ambitions.

The Chair highlighted strategic partnerships and innovation and transformation was a focus of the Board Development sessions.

**OUTCOME:** The Board **APPROVED** the proposed 2024/25 strategic objectives.

**INTEGRATED PERFORMANCE**

**37/24 Workforce Committee Chair's Highlight Report**

Chair Approved

DS presented the Chair's highlight report from the Workforce Committee meeting of 19 February 2024. The key points to note were:

- Received presentations on the process of Work Together Get Results, noted commitment to train more staff across organisation.
- A presentation was given on the soon to be piloted Critical Event Support Debriefing Service in ED and maternity services to give colleagues peer support – there is some challenge in terms of what is a critical event and any learning will be shared from the pilot.
- Progress on CHFT's recruitment strategy was presented.
- Positive progress in filling vacancies with over 50% of applicants stating that One Culture of Care is a unique attraction.
- Utilisation of the apprenticeship levy is high at 82% - 53% of current apprentices are under 30 and 50% of apprentices are in the bottom 5 IMD (index of multiple deprivation) areas – making a real impact.
- Deep dives presented on the medical staffing Board Assurance Framework (BAF) risk 10/19 – overall score remains unchanged at 16.
- Deep dive on recruitment and retention BAF risk, score remains unchanged at score 12.
- The Quality and Performance Report was presented, which the Committee agreed was much improved.
- Concern was raised about appraisal completion levels – targeted work was being undertaken for these areas.

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

**38/24 Quality Committee Chair Highlight Report**

DS presented the Chair's highlight report from the Quality Committee meetings of 15 January and 12 February 2024. The key points to note were:

- The Patient Safety Incident Response Plan (PSIRP) and Patient Safety Incident Response Framework (PSIRF) Policies were reviewed and approved by Committee. Transition work was underway and go live is planned for 1st April 2024.
- Naso-gastric tube action plan, post never event - good progress has been made, 11 actions closed, plans in place for all outstanding actions and an NG policy has been written.
- Dementia screening update – introduction of well organised ward has seen progress.
- Research activity strong performance continues.
- Maternity and neonatal oversight reports highlighted progress in recruitment for Obstetrics and Gynaecology posts.
- Positive update from Local Maternity and Neonatal System assurance visit.
- Medical Examiner (ME) service was entering the statutory phase in April this year which meant Consultants and GPs will be responsible for informing the ME service of patients who have died and cause of death.

**<u>Update on Maternity Reporting</u>**

The Chief Nurses explained they have reviewed maternity reporting into Board at Quality Committee and the Director of Midwifery will attend future Board meetings to present a maternity Board report. This report will be presented to Quality Committee prior to Board of Directors. The Integrated Performance Report maternity dashboard will include data on national requirements, the Maternity Incentive Scheme, Ockenden and the maternity plan.

The following reports were received for assurance:

Chair Approved

Director of Infection, Prevention and Control – Q3 Report

The Medical Director highlighted it was a positive report, the key points to note were c difficile continues to be an issue across the NHS, ANTT (Aseptic non-touch technique) compliance has seen an increase and there has been a number of norovirus and covid outbreaks; however, there have been no flu outbreaks. The Medical Director congratulated the wards in managing this well and confirmed the Trust was up to date with audits and policies and procedures.

Learning from Deaths – Q2 Report

The Medical Director highlighted the work on initial screening reviews to make them more specific and noted learning from the structured judgement reviews was provided on page 3 of the report. The areas that could be improved go through the quality improvement programmes that the Trust have in place through the year.

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

**39/24 Finance and Performance Committee Chair's Highlight Report**

AN presented the Finance and Performance Committee Chair's highlight report for the meetings held on 30 January and 27 February 2024. The key updates were:

- Continued strong performance in cancer with all key targets met.
- Recovery performance also remains strong and continues to be the best in the West Yorkshire Integrated Care System, ICS.
- The number of 52 week waits has increased with a particular challenge in ENT. Each target missed incurs a fine as a Trust.
- 42 week waiters – ENT remains a challenge, this was the internal target against the national 65 week wait target.
- Expecting to deliver the financial plan for this year, subject to national monies distributed via the Integrated Care Board, ICB.
- Cash position is favourable, aged debt position is stable and better payment practice is above target.
- Two deep dives focused on theatre staffing, utilisation and productivity, a good news story and performance in the Emergency Department (ED). Challenges meeting the 76% 4 hour ED target were noted. A presentation had been received which noted a significant improvement in Consultant staffing and focused on how to meet the target, which included triage processes and using different pathways to stream patients from the ED who do not need to be admitted and an ED "Perfect Week" being held this week.
- £4M gap in the cost improvement programme (CIP) with focus on developing a challenging £25m cost improvement (CIP) programme for 2024/25 with a focus on recurrent savings
- Diagnostics – two challenging areas in neurophysiology and echocardiograms, improving position in neurophysiology.

TB asked what the obstacles were to improve in ENT and the period of time expected to address this. The Chief Operating Officer explained ENT was the biggest challenge across West Yorkshire and there was a focused Elective Recovery West Yorkshire Group considering this. He explained the issue was recruitment and retention of medical staff and noted some success recruiting registrar grades and a middle grade doctor. There was a large appointment slot issue challenge in ENT, with continued use of insourcing, with an ambition to reduce this if the Trust can recruit. A conversation has taken place with the Director of Finance on how to drive ENT waits down with focused work meaning most of the 425 52 week wait patients on 11 January who would potentially have breached having been seen, with only one patient awaiting a first appointment, therefore there was optimism the Trust will have low 52 weeks numbers by the end of March 2024.

Karnesh Patel highlighted confusion communicating the outcome of the Dragon's Den capital bid process, with colleagues unclear about whether bids have been approved. He suggested a RAG

rating system be used. The Director of Finance provided context and acknowledged there was a challenge in how this was communicated which will be reviewed.

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

**40/24 Month 10 Financial Summary**

The Director of Finance presented the financial position as reported at Month 10, the key points to note were:

- Year to date deficit of £21.05m, a £3.62m adverse variance from plan.
- Forecasting to deliver £20.8m deficit plan. Forecast improved by £1m at month 10.
- Looking for £800k support from West Yorkshire on the basis there are funds at WY ICB level.
- Cost Improvement Programme (CIP) was forecasting a £4m shortfall, this related to bed capacity and delays in ED recruitment which longer term will deliver.
- Challenges around capital, end of month 10 spent £28.5m against a £49m plan. Reviewing these schemes to ensure capital spend is incurred.

TB asked about the level of confidence with the plan and the Director of Finance shared that the month 11 position was slightly better than plan, which provides confidence.

PW highlighted that non-pay inflationary pressures remained significant and asked if this was likely to continue. The Director of Finance flagged that the pressure faced by CHFT was significantly above the inflationary uplift funding being received. Notably challenges relating to PFI but also energy and utility costs where previous fixed term arrangements have now ended. Whilst the rate of inflation is currently improving, this will not provide any benefit for 2024/25 as contracts are now in place for items facing the highest growth in inflation. There may be future benefit but not for 2024/25.

The Chair asked how the CIP shortfall compared to previous years. The Director of Finance responded the Trust were pressured this year to take on additional CIP challenge; however, this will help in agreeing a realistic CIP for 2024/25.

**OUTCOME**: The Board **NOTED** the Month 10 Financial position for the Trust as at 31 January 2024.

**41/24 Annual Plan 2024/24**

The Director of Finance shared a planning update presentation for 2024/25, the key points highlighted were:

- National planning guidance still not formally confirmed and expected later in March; however, internal planning process has still progressed. Updated assumptions and ICS allocations received 9 February 2024.
- National deadlines to be confirmed; however, ICS have issued interim deadlines which have been met and the full planning submission is expected Thursday 14 March 2024.
- Revised Planning Assumptions:
  - Cost uplift factor of 1.9% (inflationary funding) – excludes any further Medical Staffing pay settlement.
  - NHS Payment Scheme (NHSPS) efficiency factor of -1.1%
  - ICB Convergence adjustment of -0.97% (reduced from 1.2%)
  - 23/24 Elective Recovery Funding (ERF) assumed to be recurrent, payment model under discussion.
  - The Trust delivered more elective activity this year than it was funded for.
  - Assuming the Trust will go back to the national model to receive pay for the activity delivered.

Chair Approved

- Virtual Ward funding continues for another year.

The Director of Finance described the bridge between forecast outturn and the current plan. The main driver of the opening challenge relates to non-recurrent benefits within 2023-24 and non-recurrent delivery of the 23-24 CIP plan.

Next steps:

- Ongoing external scrutiny/challenge particularly re: headcount
- Internal challenge on developments/pressures.
- System / transformational opportunities needed to reduce the gap, including potentially reducing services.
- £39.1m deficit plan was unlikely to be accepted by the ICS.
- Non-recurrent CIP this year is a key driver of the worsening position - £25m CIP needs to be recurrent.
- Further discussions on income with commissioners and at system level.

In response to the Chief Executive who queried how much money had been taken out over the last few years, the Director of Finance confirmed that the Trust had delivered a 5% CIP each year and noted the 2024/25 CIP should be achievable, with opportunities through working with partners to reduce extra bed capacity and support the CIP.

Karnesh Patel from Shadow Board commented if the Trust moves towards a national model of payment by results the Trust could capitalise on this by facilitating more elective work which could offset some challenges. The Director of Finance responded there has been an agreement if the system delivers more work than it plans to then additional funding is provided to the system.

An extra-ordinary Board of Directors meeting may be required to sign-off the annual plan submission. The Director of Finance will keep the Board updated.

**Approval of cash support requirements Q1**

The Director of Finance presented a paper detailing the quarter 1 2024/25 cash position and Public Dividend Capital (PDC) Revenue Support requirements.

Based on the latest cash forecast and potential £39.1m deficit, the Trust will be required to request cash support in the form of revenue Public Dividend Capital at a value of £20m, due to the planned deficit and prior year creditors. This incurs a PDC Dividend charge at 3.5%.

The cash position will continue to be managed closely to defer and minimise the external support requirement as far as possible.

The Finance Team will continue to work proactively to maximise cash balances and the timing of that drawdown will be reviewed on a monthly basis in order to minimise PDC charges.

NB asked, given uncertainty around the planning for 2024/25, if the Trust was limited to one request in Q1 for next year. The Director of Finance confirmed that the Trust can make a further request in Q2, stated £20m was cautious and assumed the £39.1m deficit plan.

**OUTCOME:** The Board **APPROVED** a request of £20m Revenue Support to be drawn down in Quarter 1 of 2024/24 in order to maintain minimum required cash balances and **APPROVED** the annual plan for 2024/25.

Chair Approved

**42/24** **Capital Plan 2024/25**

The Director of Finance presented the capital plan for 2024/25, the key points to note were:

- £15m internal capital resource
- £42m external capital resource
- Plan has been through Dragon's Den.
- Includes small contingency for other items in year.
- Smaller items of kit and replacement have been included twice for the year.

TB asked, given that there was no planned investment into the £90m backlog for maintenance issues at HRI, whether any areas were incurring excessive maintenance costs and whether this could be mitigated, e.g., by installing condition monitoring equipment or early reading on equipment to minimise disruption to services. The Director of Finance clarified that in 2023-24, investment had been made on backlog maintenance but also an additional further 2nd round of investment too as items from the 2024-25 plan had been brought forward into 2023-24 to allow a number of higher value schemes to be funded in 2024-25.

The Director of Finance advised that the investment is prioritised with Head of Estates but agreed to discuss further and clarify if investment into monitoring equipment would be beneficial in terms of revenue savings.

**Action: Director of Finance to have a discussion with Tom Donaghey to explore opportunities regarding an early reading on equipment.**

**OUTCOME:** The Board **APPROVED** the Trust capital plan for 2024/25.

**43/24** **Integrated Performance Report**

The Chief Operating Officer presented the Integrated Performance Report for January 2024. The key points to note were:

- From January 2024 revisions had been made to the report. Quality is now at the front of the report. Further changes reflected feedback.
- ED performance for January was back to October/November levels at 66.53% with continuing pressures around numbers of attendances and acuity, the Trust are challenged to hit 76% and are just under 74% currently, with lots of ongoing work taking place including operational service moves at CRH to create a medical SDEC, with the Orthopaedic clinic moved from ED to the Rainbow Centre
- Transfer of care numbers were significant at around 120-130
- Two new KPIs are now included in the report, day case rates and capped theatre utilisation – outpatient procedures are excluded from the day case rates and this has been raised with national team to look at accounting for this in a different way.

*The Managing Director for CHS left the meeting.*

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

**44/24** **High Level Risk Register**

The Director of Corporate Affairs presented the report which gave an overview of risks scoring 15 or above. Key points highlighted were:

- Positive meeting with Divisions took place.
- InPhase system - an internal audit report is being presented at the next Audit and Risk Committee with a limited assurance rating as the system is unsuitable and will take a period of 9-12 months to resolve.
- A hybrid of risk management training will be provided in the intervening period.

Karnesh Patel from Shadow Board feedback that he found it challenging to track what was happening for each risk and suggested it would be useful to see a visual position to show the direction of travel. Karnesh highlighted the thematic analysis of the 30 risks that almost 46% were staffing related and 30% were Outpatient related, which were two key areas to focus on.

TB highlighted the good progress identifying the mitigating actions and controls and suggested it would be helpful to see these in the report for assurance.

In response to both of these points, the Director of Corporate Affairs explained the limitations of reporting from the current system which was a manual process; the new system InPhase would provide an automatic risk management reporting system which would facilitate more detailed reporting.

The Chief Nurse invited Karnesh Patel to the next Risk Group to see the pathway and process of risk management.

**Action: Karnesh Patel to be invited to the next Risk Group – Chief Nurse.**

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

**KEEPING THE BASE SAFE**

**45/24 Audit and Risk Committee's Chair's Highlight Report**

NB presented the Audit and Risk Committee Chair's highlight report for the meeting of 31 January 2024, the key points to note were:

- Two deep dives – Naso-Gastric (NG) tubes following a limited assurance audit report and the partnership governance Board Assurance Framework (BAF) risk – NB noted NG tubes report was also monitored at Quality Committee (as DS had feedback); however, it is best practice for Audit and Risk Committee to follow assurance processes on any limited assurance reports received.
- Internal Audit – six reports issued and all were significant or high assurance.
- Benchmarking information provided by Audit Yorkshire reflected positively on CHFT in terms of the proportion of recommendations completed.
- Reviewed the BAF in detail and compared the BAF with other organisations against a benchmarking report. It was agreed that the risks around business continuity would be considered in light of the EPRR report to the Committee planned for April and the Audit Yorkshire thematic review.
- Reviewed draft external audit plan for 2023-24 accounts and noted a change in accounting regulations.

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

**46/24 Board Assurance Framework – Update 3**

The Company Secretary presented the third and final update of the Board Assurance Framework for 2023/24. The internal audit review of the BAF will inform the Head of Internal Audit Opinion for 2023/24. The key points to note were:

- Top three risks remain the same (1/19, 1/23 and 18/19)
- Finance and Performance Committee reviewed risk 18/19 relating to the long term financial sustainability of the Trust and agreed the score should remain at 16 for further review at Q1, 2024/25.

Chair Approved

- One new risk proposed which relates to midwifery staffing, risk 6/23 which had previously been incorporated into the nurse staffing risk, 10b/19. The midwifery staffing risk is scored at 16 and the nursing staffing risk has reduced to a 12.
- 3/23 risk of partnership arrangements has reduced from a 16 to 8 as this risk has not materialised and the Trust has been actively involved in the new partnership working architecture required from the Health and Care Act 2022. Whilst the target score of 8 had been met it felt prudent to retain this risk on the BAF due to the fluidity of the operating environment.

**OUTCOME**: The Board **APPROVED** the updates to the Board Assurance Framework and **NOTED** the top three risks to the achievement of the Trust's strategic objectives and **DISCUSSED** and confirmed that the BAF is appropriately focused on the key risks that impact on the Trust's ability to meet its strategic objectives.

**47/24 NHS Core Standards for Emergency Planning Resilience (EPRR) – Progress Update on the EPRR Action Plan**

The Chief Operating Officer introduced the update on the core standards action plan item relating to Trust responsibilities as a category 1 responder under the Civil Contingencies Act.

The General Manager for Resilience, Acute Flow and Transformation presented the updates, the key points to note were:

- CHFT is a category 1 responder under the Civil Contingencies Act 2004.
- Overall assessment of non-compliant following the confirm and challenge process which found the Trust at 31% compliance.
- All partially compliant core standards have been put into an action plan and split into three categories:
    - Category 1 – 16 actions are locally controlled and should be completed by the of April 2024
    - Category 2 – 21 actions are locally controlled and expect to take at least 8 months to achieve and should be completed by the end of August 2024.
    - Category 3 – 6 actions have an interdependency with other organisations and should be completed by the end of August 2024.
- Submission date expected to be September 2024.
- All green compliant core standards are maintained separately.
- Core standards action tracker is maintained and shows 12 actions already completed and 25 already commenced.
- all actions are currently on track.
- An ICB-led working group attended by CHFT meets fortnightly with a Core Standard review.

AN highlighted the great work which was aligned with major incident plans. The General Manager for Resilience, Acute Flow and Transformation confirmed they have developed some new frameworks. AN comment on the focus now being on testing the business continuity evacuation plans and the Chief Operating Officer confirmed a training and planning session for strategic commanders was planned for Executive Board to test a real life scenario.

The Chief Operating Officer congratulated the fantastic work by the General Manager for Resilience, Acute Flow and Transformation, noted the excellent progress and confirmed the Trust was aiming to be partially compliant.

**OUTCOME:** The Board **RECEIVED** and **NOTED** the Core Standards position presented and was **ASSURED** that an action plan is in place and being actively monitored.

Chair Approved

## A WORKFORCE FOR THE FUTURE

**48/24 Guardian of Safe Working Hours Report – October 2023 – November 2023**

The Medical Director presented the independent report on behalf of the Guardian of Safe Working Hours. The key points to note were:

- Increased number of exception reports this quarter, primarily by FY1 and FY2 doctors due to winter pressures and increased workload.
- All rotas are compliant with the Junior Doctors terms and conditions set out in 2016.
- All exception reports have been actioned. Five exception reports related to immediate safety concerns – two related to junior doctors not having opportunity for a lunch break, three related to minimal staffing levels.
- Gaps in rotas are filled successfully at a 95% fill rate.
- Gaps in rotas are not evenly distributed, there are specialities with more gaps than others.

**OUTCOME:** The Board **NOTED** the Guardian of Safe Working Hours report covering the period October – November 2023.

**49/24 Amendments to Constitution and Standing Orders of the Council of Governors**

The Company Secretary presented the amendments to the Trust Constitution for approval and an updated Standing Orders of the Council of Governors, following a routine review for approval as required by the Trust Constitution.

It was proposed that the Standing Orders of the Council of Governors and the Standing Orders of the Board of Directors become separate documents to the Trust Constitution, rather than annexes as currently as these are updated at different periods to the Constitution.

The amendments have been approved by the Council of Governors with the main material change in the standing orders being reducing the quoracy of the Council of Governors to help with decision making and including the addition of a written resolution.

**OUTCOME:** The Board **APPROVED** the amendments to the Trust Constitution and Standing Orders of the Council of Governors and **APPROVED** the Standing Orders being stand-alone documents rather than forming part of the Trust Constitution.

**50/24 Fit and Proper Persons Annual Assurance 2023/24**

NHS England (NHSE) published a new Fit and Proper Persons Test (FPPT) Framework for Board members (non-statutory) on 2 August 2023 alongside guidance for Chairs and for staff, with full implementation required by 31 March 2024. This follows on from 2019, when Tom Kark KC made recommendations to revise the existing Fit and Proper Persons Test process in his review into its scope, operation and purpose.

The legislation has not changed and the core elements of the previous FPPT guidance remain. The new framework introduced some changes to the checks to ensure Directors satisfy the regulatory requirements. It also aims to situate the FPPT checks as part of the annual appraisal process.

The Board of Directors Fit and Proper Person Self-Declaration Register as at 22 February 2024 was shared. The following groups of staff were required to complete an annual Fit and Proper Persons self-attestation:

- Executive Directors (including the Chief Executive)

Draft Approved

- Non-Executive Directors (including the Chair)
- Directors
- Deputy Directors to Executive Directors (Finance, Medical, Nursing, Operations and Workforce and Organisational Development)

The Chair of the Board is accountable for taking all reasonable steps to ensure the FPPT is effectively implemented and reporting to NHS England.

**OUTCOME:** The Board **NOTED** the arrangements for fit and proper persons checks, specifically the annual self-attestation process and that the Fit and Proper Persons Test has been conducted and that all Board members and those in scope within the Fit and Proper Persons Policy have completed an annual self-attestation and satisfy the requirements.

**51/24** **Governance Report**

The Company Secretary presented the Governance report which contained:

**a. Board of Directors Terms of Reference**

The annual review of the terms of reference were reviewed and approved.

**b. Non-Executive Director Appointments**

An update on recruitment to two Non-Executive Director roles was given, noting that this was complete for one of the two vacancies, noting Jo Wass had commenced. The completion of fit and proper persons tests, in line with NHS England's enhanced framework, and other pre-employment checks remained underway for the second role, with final ratification stage to take place by the Council of Governors at a general meeting.

The Company Secretary advised that the Non-Executive Director maternity champion role will be undertaken by the second Non-Executive Director appointee once commenced in role. In the interim period Andy Nelson will take on the maternity champion role.

**c. Board of Directors Declaration of Interest Register**

The Board of Directors Declarations of Interests Register as at 22 February 2024 was shared.

**d. Request for delegation for Annual Report and Accounts 2023/24**

The Company Secretary requested that the Trust Board delegate the approval of the audited annual accounts and annual report at the Audit and Risk Committee on 25 June 2024, as national submission deadlines do not align with Board meeting dates.

**e. Request for delegation for Quality Accounts 2023/24**

The Company Secretary requested Trust Board approval to delegate authority to the Quality Committee for the approval of the 2023/24 Quality Accounts, with consideration of the Quality Account to take place at the Quality Committee meeting closest to this date, currently 3 June 2024.

**f. Use of Trust Seal**

The Trust seal has been used on one occasion since January 2024 which related to a variation to the contract for The Clock House, Elland.

**g. Board Workplan for 2024 – 2025**

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

Chair Approved

**OUTCOME:** The Board **APPROVED** the Board of Directors Terms of Reference, delegation to the Audit and Risk Committee for the approval of the 2023/24 Accounts and Annual Report, delegation to the Quality Committee for the approval of the 2023/24 Quality Accounts and the Board of Directors workplan for 2024/25.

**OUTCOME:** The Board **NOTED** the use of the Trust seal and the Board of Directors Declarations of Interest Register.

**52/24 Review of Board Sub-Committee Terms of Reference**

The following revised terms of reference were received for Board approval:

a) **Finance and Performance Committee**
b) **Nominations and Remuneration Committee (Board of Directors)**
TB commented he expected a broader brief in terms of reference regarding CHS terms and conditions. The Director of Corporate Affairs agreed to check the partnership agreement.

**Action: Director of Corporate Affairs to check the CHS Partnership Agreement regarding CHS terms and conditions.**

**OUTCOME:** The Board **APPROVED** the Finance and Performance Committee Terms of Reference and **APPROVED** the Nominations and Remuneration Committee (Board of Directors) Terms of Reference, subject to checking the CHS terms and conditions.

**53/24 Items to receive and note**

The following minutes were provided for assurance:

- Finance and Performance Committee – 02.01.24 & 31.01.24
- Quality Committee – 20.12.23 & 15.01.24
- Workforce Committee – 18.12.24
- Charitable Funds Committee – 06.02.24

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

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

**54/24 Any Other Business**

The Chair highlighted that this might by Andy Nelson's last Board meeting as he is due to leave at the end of April/beginning of May. The Chair formally thanked Andy on behalf of the Board for his incredible diligence and tenacity. The Chair stated the organisation will be forever grateful and will miss Andy and wished him well for the future.

**55/24 Date and time of next meeting**

The Chair formally thanked the Board of Directors, colleagues and governors for their attendance and closed the meeting at approximately 13.15 pm.

**Date:** Thursday 2 May 2024
**Time:** 9.00 am – 12:00 pm
**Venue:** Rooms 3 & 4, Acre Mills Outpatients

Chair Approved

# 5. Matters Arising and Action Log

To Note

Presented by Helen Hirst

# ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC) 2024

Position as at: 04.04.24

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

| DATE DISCUSSED | AGENDA ITEM | LEAD | CURRENT STATUS / ACTION | DUE DATE | RAG RATING | DATE ACTIONED & CLOSED |
|---|---|---|---|---|---|---|
| **52/24** 07.03.24 | **Review of Nominations and Remuneration Committee (Board of Directors) Terms of Reference** Director of Corporate Affairs to check the CHS Partnership Agreement regarding CHS terms and conditions. | VP | | 02.05.24 | | |
| **42/24** 07.03.24 | **Capital Plan 2024/25** Director of Finance to have a discussion with Tom Donaghey to explore opportunities regarding an early reading on equipment. | GB | Discussion held and response given to Tim Busby on 4 April 2024. | 02.05.24 | | 04.04.24 |
| **44/24** 07.03.24 | **High Level Risk Register** Karnesh Patel to be invited to the next Risk Group – Chief Nurse. | LR | Karnesh has been invited to the next Risk Group meeting. | 02.05.24 | | 04.04.24 |

# 6. Chair’s Report

To Note

Presented by Helen Hirst

| | |
|---|---|
| **Date of Meeting:** | Thursday 2 May 2024 |
| **Meeting:** | Board of Directors |
| **Title:** | Chair's Update |
| **Author:** | Helen Hirst, Chair |
| **Sponsoring Director:** | N/A |
| **Previous Forums:** | None |
| **Purpose of the Report** | To update the Board on the actions and activity of the Chair. |
| **Key Points to Note** | The enclosed report details information on key issues and activities the Trust Chair has been involved in over the past two months within the Trust, with local system partners and regional and national work. |
| **EQIA – Equality Impact Assessment** | The attached paper is for information only and does not disadvantage individuals or groups negatively. |
| **Recommendation** | The Board is asked to **NOTE** the report of the Chair. |

**Chair's Report to the Board**

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

1. **Trust activities**

**Council of Governors**

Governor activities this last month revolved around recruitment for new Governors to replace those who have reached the end of their term or chosen to stand down. The recruitment campaign starts on 24 April.

For those governors able to attend, Anna Basford gave a really useful and informative briefing on the hospital reconfiguration and transformation programme. As well as the current status of developments she provided an update on the former public consultation and the changes to plans that followed and what we look forward to in the future.

The third 'Health Matters' event for Trust members was entitled Pathology: Under the microscope. Colleagues, Noleen Bailey, Zoe Potter, Samantha Richardson and Jemma Morris provided a fascinating insight into blood sciences, microbiology and histology.

**Board business**

Since my last report a number of Board colleagues were involved in the recruitment of the new Medical Director who will replace David when he retires later in the year. Neeraj Bhasin, Deputy Medical Director was appointed and I look forward to working alongside him on the Board.

The Board held a follow up development session focused on partnerships and discussed the plans for Calderdale Royal Hospital and the new leadership competency framework.

Andy Nelson and I had a great visit to Maternity with Gemma Puckett, Director of Midwifery and Women's Services. It was a relatively quiet day (unusually) which meant we were able to talk more with colleagues and hear about their challenges and plans.

Along with many other Board members, we were treated to a preview of the new Pharmacy Robot at Calderdale. Lis Street, Clinical Director of Pharmacy, hosted our visit which was at the start of a busy day for the team showing colleagues around the new department. The team were rightly very proud of all they had achieved and were on count down for the move from their pretty cramped temporary facility.

The new non-executives, Jo and Vanessa, have now started their induction into the Board and the Trust more generally. It is expected that all Board members will have some time with them over the coming weeks to help them settle in.

I attended the Order of St John service of recognition for families of those who have donated their organs. It was a truly humbling and highly emotional service and a powerful reminder that without donation there are no organ or tissue transplants.

The Charitable Funds Committee held an extra-ordinary meeting to receive the findings and recommendations from Gifted Philanthropy, an organisation we had commissioned to provide us with advice for the future of the Charity. At our next meeting of the Committee in May we will be considering our immediate and longer term actions.

Krish Pilicudale, our Insight Non-Executive Director and Director of Digital Information with the University of Huddersfield invited me to spend the afternoon with him visiting departments and seeing the extensive facilities available for students. The campus was buzzing on the day I attended and I left with a much greater understanding of what a huge asset Huddersfield has and the impact it makes across the region and nationally.

**2. Health and Care System**

Since my last report I have attended both a Calderdale Cares Partnership Board and development session. The Board had a deep dive into Health Inequalities which Rob Aitcheson presented alongside Deb Harkins, DPH. Much of the agenda and both sessions was focused on planning and finance.

The West Yorkshire Partnership Board (the ICP) meeting in public took place at the beginning of March in Leeds Civic Hall. Key issues discussed included: Fair Work Charter, a Creative Health System, Keep it Local (in procurement), Climate Change and Antimicrobial Resistant Infections.

Prior to the Board Cathy Elliot, Chair of West Yorkshire ICB, hosted a peer networking event for chairs, non-executives, associate non-executives and independent members of the ICB. I was one of a few speakers invited to share our experiences of developing our Board within the context of 'well-led'. The Chair and NED development system working group also met this month. We met with NHSE as part of their review of Chair and NED development modules and discussed a further virtual recruitment event for prospective NEDs in May.

I was a speaker at West Yorkshire Partnership's International Women's Day event online to hear from a range of women about their journeys, careers and how they overcame their challenges.

**National/other**

I attended the NHS Providers Chairs and Chief Executives network in mid March where we had a national policy and strategy update and discussions about the productivity challenge and the development of shared leadership models across provider trusts.

I was a speaker at PWC NHS NED programme discussing provider collaboration and the role of boards in this context.

Along with Jo Wass (wearing her University of Leeds hat) I attended the Health Innovation Yorkshire and Humber strategic advisory board meeting where our main theme was Health and Economic Inequalities. This document produced by Health Innovation, NHS Confederation and Yorkshire Universities is an interesting read. YHealth for Growth white paper 'Empowering local places for health and prosperity: new perspectives from Yorkshire and the Humber

**Helen Hirst**
**Chair**
**25 April 2024**

## 7. Chief Executive’s Report - To follow

To Note

Presented by Brendan Brown

# STRATEGY: TRANSFORMING AND IMPROVING PATIENT CARE

## 8. Patient Story – Learning Disabilities Presented by Amanda McKie, Consultant Nurse Learning Disabilities

To Note

## 9. Health Inequalities Update

Presented by Rob Aitchison, Deputy Chief Executive and Rachel Westbourne, Public Health Lead

To Approve

Presented by Rob Aitchison

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|---|---|
| **Date of Meeting:** | Thursday 2 May 2024 |
| **Meeting:** | Public Board of Directors |
| **Title:** | Health Inequalities Update, including review of the NHS Providers Guidance for NHS Board Members on Reducing Health Inequalities and prosed Integrated Performance Report for Health Inequalities |
| **Author:** | Rachel Westbourne, Public Health Specialist Lead |
| **Sponsoring Director:** | Rob Aitchison, Deputy Chief Executive |
| **Previous Forums:** | Trust Health Inequalities Group |
| **Purpose of the Report** | The purpose of this report is to:<br>• update the Board on progress against the actions set out in the Trust's Population Health & Inequalities Strategy (2022-24),<br>• provide a review of the NHS Providers Guidance for NHS Board Members on Reducing Health Inequalities and implications for CHFT,<br>• present a proposed Integrated Performance Reporting snapshot report on health inequalities. |
| **Key Points to Note** | **1. Health inequalities strategy update**<br>• The Health Inequalities Group continues to meet on a monthly basis with representation across service areas and the corporate division, and work continues to progress the delivery of the strategy.<br>• There are activity updates and positive progress against all four of the key workstreams: connecting with our communities and partners, equitable access and prioritisation, lived experience and outcomes, diverse and inclusive workforce.<br>• The Population Health and Inequalities Strategy was adopted to cover an initial time period of 2022-24. An updated strategy will be developed later in the year to cover a longer period of time and reflect our progress to date. Board will be kept up to date with the process before receiving the final updated strategy for approval. |

| | 2. **NHS Providers Guidance for Board Members on Reducing Health Inequalities**<br><br>• In March 2024, NHS Providers published a guide to support NHS trust board members to address health inequalities as part of their core business: Reducing Health Inequalities: A Guide For NHS Trust Board Members<br>• The guidance was developed in part with insight and input from trusts recognised to be leading in this area, including CHFT.<br>• The guidance outlines four specific areas that are necessary for successfully progressing action on health inequalities at a Trust level and outlines what good looks like in each of these areas: leadership, strategic focus, analysis and interpretation of data, building capacity through public health expertise.<br>• The guidance includes a self-assessment tool that can be used alongside the guide to provide a score and maturity rating of the trust's position in the four domains. The guidance also recommends a wide-range of objectives across different areas of board-level responsibility which boards should consider implementing.<br>• An initial review of the guidance (including the self-assessment tool and objectives) has identified that our overall progress and maturity on health inequalities is very strong, particularly with regards to leadership and strategy, quality improvement work in patient pathways, and use of data and intelligence.<br>• There are also potential opportunities for development, and room to go further even in areas where we are already performing well, including:<br>i. Training and development – consider training and development on health inequalities for Board members and across the workforce, consider including health inequalities learning in induction programmes.<br>ii. Developing public heath capacity – consider further developing public health capacity, consider training for frontline staff on public health and a Making Every Contact Count Approach to further embed action on inequalities and health improvement, continue to identify further opportunities for prevention and health improvement interventions.<br>iii. Data and evidence – routinely including ethnicity as part of Performance Reporting on health inequalities, consider opportunities for taking part in health inequalities research.<br>iv. Decision-making and resource allocation – review how consideration of health inequalities is embedded in |
|---|---|

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| | decision-making and resource allocation across the organisation to ensure all opportunities are identified.<br>• Overall, we consider our position and progress on addressing health inequalities to be very strong with many examples of positive work and impact, but we are not complacent and are continuously seeking to go further. The NHS Providers Guidance and the results of the self-assessment will be considered in the development of the updated Health Inequalities Strategy due next year.<br><br>**3. Integrated Performance Reporting on Health Inequalities**<br><br>• A new "snapshot" version of the Integrated Performance Reporting on Health Inequalities has been produced to provide a clear and concise format for monitoring and reporting on key inequalities metrics.<br>• The report provides at-a-glance reporting on key performance metrics (A&E 4-hour targets, missed appointments, diagnostic waiting lists, cancer diagnostics, and 40-week waits) through an inequalities lens (considering specifically patients living in the most deprived areas and patients with a learning disability).<br>• The version presented is an initial draft and will be further developed to include a summary page identifying key areas for review and SPC charts.<br>• We are proposing that this new format would replace the current Health Inequalities section of the IPR report. |
| **EQIA – Equality Impact Assessment** | The Trust's approach to Health Inequalities plays an important role in reducing the impact that inequalities have on access to, experience of, and outcomes from care. Specific initiatives within this work will continue to be reviewed to ensure they do not disadvantage individuals or groups negatively and that wherever possible actions maximise positive impact on protected characteristic groups. |
| **Recommendation** | The Board is asked to **NOTE** the update on progress on action against the Health Inequalities Strategy.<br><br>The Board is asked to **APPROVE** the review of the Trust's position in relation to the NHS Providers Guidance on Reducing Health Inequalities.<br><br>The Board is asked to **APPROVE** the proposed IPR snapshot for health inequalities. |

# Health Inequalities Update Report

including review of the NHS Providers Guidance for NHS Board Members on Reducing Health Inequalities and proposed Integrated Performance Report for Health Inequalities

## 1. Health Inequalities Strategy update

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

### 1.1. Connecting with our communities and partners:

- Colleagues have engaged with community networks and in collaborative partnerships across Kirklees and Calderdale, including attending the Kirklees Tackling Poverty Partnership and the North Halifax Locality Network (specifically targeting some of the most vulnerable communities we serve)
- The BLOSM team continue to work to reduce health inequalities by engaging with vulnerable patients across both EDs and have recently recruited a new Operations Manager with experience of supporting vulnerable adults across both Calderdale and Huddersfield through their work with drug and alcohol services. The team are in the final stages of signing Service Level Agreements with both Change, Grow, Live in Huddersfield and Humankind in Calderdale to enhance partnership working and introduce hospital-based recovery navigators into the BLOSM team.
- BLOSM also recently hosted a visit from NHS England's Children and Young People's Mental Health team to hear about the work the team has done to support young people both in ED and in supporting onwards referrals into community services.
- Colleagues working on addressing health inequalities recently met with partners in the Improving Population Health team at the West Yorkshire Integrated Care Board to identify opportunities for collaboration and to go further in actions to reduce inequalities, and to share our work as good practice examples.
- We have been engaging with partners at Calderdale Council and Healthwatch Calderdale on making sure the new Community Diagnostic Centre best serves the needs of the local communities.

### 1.2. Equitable access and prioritisation:

- A pilot has been undertaken to test an intervention in the Appointment Centre to reduce DNAs, and particularly to reduce the gap in DNAs seen between the most and least deprived communities (IMD quintile 1 compared the IMD quintile 5). A second stage pilot is now being planned.
- The Health Inequalities Vulnerability Matrix (a tool using data to identify patients at the greatest risk of experiencing inequalities) is in use within cancer prehabilitation services. The tool is now also being tested within Clinical Psychology and Maternity.

- A large-scale project to review all outpatient communication and letters in order to improve accessibility is ongoing.
- Work has started to create a bespoke patient communication pathway for our most socially vulnerable patients who attend the community pop-up clinics and face significant barriers to access and receiving appointment letters.
- Work has been undertaken to understand how the new Community Diagnostic Centre in Calderdale could improve access for groups that may currently be underserved or face barriers to access. This has included analysing current diagnostics access data through an inequalities lens to identify target groups.

**1.3. Lived experience and outcomes:**

- There is new lead midwife for health inequalities who is reviewing maternity inequalities data and working closely with the Health Inequalities Group to establish a new action plan for reducing health inequalities in maternity.
- Neurodiversity Week took place 18th – 24th March, with a range of events to raise awareness of neurodiversity and implications for patient outcomes and care, including 3 lunch and learn sessions for staff, information stalls at both hospital sites, the autism awareness bus was at HRI for a day, and fundraising activities to raise money for more Learning Disability care bags in ED.
- Mental Health First Aid Training a Making Every Contact Count Approach to Mental Health further rolled out to colleagues.
- The Trust's new Matron for Patient Experience has joined and is engaging with the Health Inequalities to bring a patient engagement and lived experience focus to the work.

**1.4. Diverse and inclusive workforce**

- A wide range of work continues within the Workforce and Organisational Development team to progress objectives on equality, diversity, and inclusion, and maximising on our role as an employer to reduce inequalities for our staff and local communities.
- Through the Widening Participation programmes, 88 residents have now been supported into CHFT employment and apprenticeships, with a significant proportion coming from the most deprived local areas.
- We continue to support Project SEARCH for people with a learning disability (this initiative offers a year-long supported internship combining classroom-based learning delivered by Calderdale College and work experience in the Trust). This academic year Project Search is made up of ten young people, all which have Education and Healthcare Plan (EHCP) plans and 20% are from Black, Asian or minority ethnic communities.
- Recent EDI events have included events to celebrate Eid and World Hijab Day.
- We continue to offer a wider financial wellbeing package for staff, including the pop-up shops (discreet food banks / recycled clothing for colleagues), financial education, access to low-cost loans through salary finance, Wagestream enables colleagues to access an advance prior to payday, and the credit union supports colleagues to save with higher than the high street interest rates and also offer low cost loans.

The Population Health and Inequalities Strategy was adopted to cover an initial time period of 2022-24. An updated strategy will be developed to cover a longer period of time and reflect our progress to date. Board will be kept up to date with the process before receiving the final updated strategy for approval.

## 2. NHS Providers Guidance for Board Members on Reducing Health Inequalities

In March 2024, NHS Providers published a guide to support NHS trust board members to address health inequalities as part of their core business: Reducing Health Inequalities: A Guide For NHS Trust Board Members

The Guidance was developed in part with engagement with and input form trusts who have notable experience in population health management and reducing health inequalities, including CHFT.

### 2.1. The Guidance

The guidance outlines why Trusts should act on health inequalities, what good looks like in this domain, and specific objectives for Boards on taking action on health inequalities, ranging from operational and clinical delivery of services to the Trust's role as an anchor institution and as an employer of NHS staff. The guidance identifies four specific areas that are necessary for successfully progressing action on health inequalities at a Trust level and outlines what good looks like in each of these areas:

1. **Leadership**, including having a Board-level executive lead for inequalities who champions the agenda across the organisation and board-level discussions; Board having collective responsibility for the Trust's work in reducing health inequalities; and an understanding and consideration of inequalities across all aspects of the organisation, with best practice shared and replicated across the Trust.

2. **Strategic focus**, including commitments to reducing health inequalities set out within organisational strategies and a recognition of this work as core business; development of a specific strategy on health inequalities; regular reviews by board of performance against the strategy, and progress should be publicly documented in the trust's annual report.

3. **Analysis and interpretation of data,** including necessary systems and digital infrastructure in place to support enhanced data capture and reporting on health inequalities; data should be routinely available by deprivation, age, ethnicity and other relevant protected characteristics, and clinical staff should have the knowledge and confidence to use data to better understand their services and address health inequalities; health inequalities data should be routinely incorporated into trust board papers and reporting processes; trust-level data could be enhanced by data-sharing amongst relevant wider systems partners.

4. **Building capacity through public health expertise,** including employing public health specialists and a health care public health team to ensure there is dedicated resource to for action on health inequalities, prevention, and health promotion; public

health representation within the board; the public health team could work with clinical and operational teams to develop interventions, actions and quality improvement processes within the organisation; identification of training needs amongst the workforce in public health and health inequalities and delivery of relevant training and learning development opportunities.

### 2.2. Self-assessment tool:

The guidance includes a self-assessment tool that can be used alongside the guide to provide a score and maturity rating of the trust's position in four domains: building public health capacity and capability; data, insight, and evidence; strategic leadership and accountability; system partnerships. Maturing ratings are (from lowest to highest): not started, emerging, developing, maturing, thriving.

Based on the results, a set of health inequalities objectives will be suggested by the tool to progress further in each domain. It is recommended that the self-assessment tool be used as a starting point for a board level discussion on overall position on progress on health inequalities and specific objectives to be pursued to progress further and develop maturity.

The Trust Lead for Health Inequalities has led an initial review using the self-assessment tool which has given the following results:

| **Domain** | **Score** |
|---|---|
| Building public health capacity & capability | Developing |
| Data, insight, and evidence | Maturing |
| Strategic leadership and accountability | Thriving |
| System partnerships | Thriving |

The full self-assessment responses and results are in Appendix 1.

### 2.3. Objectives for Trust Board Members:

Drawing on relevant NHSE policy and guidance and recommendations from trusts who were consulted in the guidance development, the guidance recommends 88 specific objectives for boards to consider across ten areas of board level responsibility (chair; non-executive directors; chief executive; executive lead for health inequalities; people; strategy; finance; operations / delivery; data, digital and information; clinical, quality, and research).

Six objectives are highlighted by the guidance as priority objectives of particular importance:

- Identify an executive lead for health inequalities on the board.
- Ensure the board receives annual training on health inequalities, with priority for the board member appointed as executive lead for health inequalities. Training should be refreshed, as relevant, and provided in induction processes.

- Set an expectation on executive board members to routinely report to the board on performance and outcomes data broken down by relevant characteristics (where available), such as ethnicity and deprivation.

- Develop in-house public health capacity and capability to support the delivery health inequalities work.

- Work with the chief executive and executive lead for health inequalities to include a commitment to reducing health inequalities in the trust's organisational strategy, which reflects national and system requirements alongside local need.

- Assess the baseline and set targets to improve data reporting by ethnicity, deprivation, and protected characteristics.

We at least partially meet five of these key objectives, and in some cases far exceed them. The notable gap would be the objective for board to receive annual training on health inequalities.

### 2.4. Initial review of our position:

Having considered the self-assessment tool and objectives, we have identified key areas where we think the Trust is performing well and areas where we may want to go further.

**Strengths:**

- **Leadership and strategy** – we have strong leadership, accountability, and strategic commitments on taking action on health inequalities.
- **Action in patient pathways** – there has been quality improvement work to address health inequalities across a number of areas including learning disability and maternity, and ongoing work to improve patient access.
- **Data and evidence** – there is regular analysis and reporting of data through a health inequalities lens, health informatics colleagues very engaged in work to support action on health inequalities and our work is led by data and evidence.

**Opportunities for further development:**

- **Training and development** – consider training and development on health inequalities for Board members and across the workforce, consider including health inequalities learning in induction programmes.
- **Developing public heath capacity** – consider further developing public health capacity, consider training for frontline staff on public health and a Making Every Contact Count Approach to further embed action on inequalities and health improvement, continue to identify further opportunities for prevention and health improvement interventions.
- **Data and evidence** – routinely including ethnicity as part of Performance Reporting on health inequalities, consider opportunities for taking part in health inequalities research.
- **Decision-making and resource allocation** – review how consideration of health inequalities is embedded in decision-making and resource allocation across the organisation to ensure all opportunities are identified.

Overall, we consider our position and progress on addressing health inequalities to be very strong with many examples of positive work and impact, but we are not complacent and are continuously seeking to go further. The NHS Providers Guidance and the results of the self-assessment will be considered in the development of the updated Health Inequalities Strategy due next year.

## 3. Integrated Performance Reporting on Health Inequalities

A new "snapshot" version of the Integrated Performance Reporting on Health Inequalities has been produced to provide a clear and concise format for monitoring and reporting on key inequalities metrics (presented in Appendix 2). Reporting has been simplified and visually designed to make the identification and assessment of inequalities accessible for all. This approach aims to enhance comprehension of data, empowering us to rapidly identify and act on significant disparities and implement improvements effectively.

The report provides at-a-glance reporting on key performance metrics (A&E 4-hour targets, missed appointments, diagnostic waiting lists, cancer diagnostics, and 40-week waits) through an inequalities lens (considering specifically patients living in the most deprived areas and patients with a learning disability). The report also includes brief narrative for each metric to provide any necessary context and details of any action being taken as a result.

The version presented is an initial draft which will be further developed:

- A summary page will be added to highlight key areas for review or where further consideration is needed.
- The scope of the report will be expanded to include data on ethnicity.
- For each population group considered, a second page will be added to display SPC charts, to ensure trends in performance can be analysed.
- Reporting is proposed to move to quarterly reporting rather than one-month period to provide more accurate and meaningful data points.

We are proposing that this new format would replace the current Health Inequalities section of the IPR report.

## Appendix 1: NHS Providers Health Inequalities Self-Assessment Tool – Results breakdown

The self-assessment tool is designed to be used alongside the Reducing Health Inequalities Guide for NHS Trust Board Members. It can be accessed here: https://health-inequality-tool.net/instructions

Completion of the tool involves answering 25 questions across 4 domains. Each question is answered with either "yes", "no", or "partial". The tool gives a maturity level for each of the domains based on your responses.

### CHFT initial assessment (April 24)

Our initial assessment for CHFT produced the following results:

| Theme | Score | Percentage Complete | Maturity Level |
|---|---|---|---|
| 1 - Building public health capacity & capability | 3 | 38% | Developing |
| 2 - Data, insight, evidence and evaluation | 9 | 64% | Maturing |
| 3 - Strategic leadership & accountability | 16 | 89% | Thriving |
| 4 - System partnerships | 8 | 80% | Thriving |

### Key

| Percentage | Maturity Rating |
|---|---|
| 0 | Not started |
| 1-24 | Emerging |
| 25-49 | Developing |
| 50-74 | Maturing |
| 75-100 | Thriving |

The questions and our responses, along with considerations as to why a particular answer was given, are presented below.

**Domain 1 - Building public health capacity & capability**

| Question | Response | Reasoning |
|---|---|---|
| Has your board received training and/or development on health inequalities? | No | No formal training undertaken. |
| Does your trust deliver regular training to all staff groups on health inequalities? | No | There have been one-off sessions with some staff groups, but no regular training currently in place. The health inequalities group provides a place for sharing learning and supporting colleagues to develop understanding in this area. |
| Has your trust delivered any quality improvement work or change programmes related to health inequalities? | Yes | A range of work as outlined in the Population Health and Inequalities Strategy, particularly in relation to learning disabilities, maternity, and access and prioritisation. |
| Does your trust employ public health specialist staff and is the wider workforce encouraged to develop public health expertise? | Partial | Trust has previously hosted Public Health Registrar. Public health specialist currently employed 0.2 FTE. Learning and development opportunities for the wider workforce could be pursued to further develop capacity. |

**Domain 2 - Data, insight, and evidence**

| Question | Response | Reasoning |
|---|---|---|
| Is your trust's data on patient ethnicity accurate and comprehensive? | Yes | Overall, the Trust performs well in this area. |
| Does your trust board routinely receive performance data broken down by ethnicity and deprivation? | Partial | Trust IPR contains LD and IMD reporting and has been recognised nationally as an exemplar. Proposal to also introduce ethnicity reporting. |
| Does your trust use existing population health data (e.g., population demographics and index of multiple deprivation) in your analysis of trust-level data? | Yes | Population health data has been used widely, including within the development of the Population Health and Inequalities Strategy, maternity and learning disability work, analysis of DNAs, development of the Health Inequalities Vulnerability Matrix, and to inform |

| | | |
|---|---|---|
| | | planning for the new Community Diagnostics Centres. |
| Has your trust taken part in any research related to health inequalities? | No | A number of case studies have been featured in national publications and we have taken part in local research on smoking in pregnancy which has inequalities implications, but no formal research on inequalities undertaken. |
| Has your trust carried out engagement with communities to inform work on health inequalities? | Partial | There has been engagement with LD patients and carers / families. There is a patient engagement forum which is to be used for engagement on health inequalities. Opportunities to take this work further in future. |
| Has your trust reviewed any care pathways to consider the extent to which they enable equitable access, experience, and outcomes? | Yes | Includes learning disability work, work in maternity, and analysis of DNAs and waiting times. |
| Has your trust reviewed the accessibility of your services in relation to the digital and health literacy rates of your local population? | Partial | Very strong in a number of areas (e.g., learning disability, endoscopy), but further work possible across the organisation. Work has begun to review all patient communications to make communication more accessible and consider health literacy. |

**Domain 3 - Strategic leadership & accountability**

| **Question** | **Response** | **Reasoning** |
|---|---|---|
| Does your trust have a named board-level Executive Lead for health inequalities? | Yes | The Deputy Chief Executive is the named executive lead for health inequalities. |
| Does your board have health inequalities objectives set in your annual review process? | Yes | Objective featured within the Trust 1-year and 5-year strategic plan. Health inequalities reporting is also included in the Annual Report. |
| Is your Executive lead for health inequalities providing strategic leadership and embedding an | Yes | Provides strategic leadership and chairs the cross-organisational health inequalities group. |

| | | |
|---|---|---|
| equity lens into cross-organisational work? | | |
| Is there a clear governance structure for the trust's health inequalities work within your trust, including a group or committee that provides oversight? | Yes | Health inequalities work is monitored through the Health Inequalities Action Plan and the Health Inequalities Group. Overseen by the Deputy Chief Executive / Executive Lead for Health Inequalities. Regular reporting to Board on health inequalities work throughout the year. |
| Does your trust/board use a health inequalities impact assessment tool in your business case process? | Partial | There is an Equality Impact Assessment tool to be used for reports and business cases. We are in the process of updating this to give more consideration to health inequalities. |
| In allocating trust resources, are opportunities identified to invest in services that will prevent and mitigate healthcare inequalities and realise longer term benefits? | Partial | Health inequalities targeted resources support health inequalities capacity and work within the Trust. Major investments are subject to maximising Social Value. |
| Does your trust have a programme of work aimed at reducing health inequalities experienced by staff members? | Yes | Diverse and Inclusive Workforce stream of the Population Health and Inequalities Strategy and Action Plan. Workforce and OD lead a variety of activity in this area including supporting inclusion groups across the Trust. |
| Does your trust use and implement NHS England's 'Core20PLUS5' framework to guide the organisation's approach to reducing health inequalities? | Yes | CORE20PLUS5 was considered in the development of the Health Inequalities Strategy and is being used to inform the development of a new Children and Young People Strategy. The next iteration of the Health Inequalities Strategy will include an assessment of the CORE20PLUS5 framework and our response to it. |

**Domain 4 - System Partnerships**

| Question | Response | Reasoning |
|---|---|---|
| Is your trust contributing to anchor institution working? | Yes | Work on Social Value portal / assessments, inclusive recruitment programmes, etc. |
| Does your trust have programmes in place to improve access to employment to underrepresented groups in your organisation? | Yes | A range of initiatives including our apprenticeships programme, the Widening Participation Programme, and Project SEARCH (providing employment opportunities for people with learning disabilities). |
| Has your trust engaged in any pathway redesign work with system partners and communities to reduce health inequalities? | Partial | Our learning disability access policy was shared and adopted across WYAAT. We led a project working with a PCN to improve pathways for high-risk respiratory patients. There are examples of good work in this area, but there is opportunity for work at a larger and wider scale. |
| Has your trust worked in collaboration with health inequality leads in Integrated Care System(s) and other provider organisations or collaboratives? | Partial | We have engaged with Health Inequalities leads at the ICS and other partner organisations. We can go further by proactively identifying opportunities to work in collaboration with inequalities leads at the ICS and in other provider organisations. |

## Appendix 2 – Draft Proposed Health Inequalities Integrated Performance Report

# Learning Disabilities

| Measure | Current | Target | Trust Average |
|---|---|---|---|
| Emergency Care Standard | 69% | 76% | 76.8% |
| Outpatient DNAs | 8.1% | 3% | 6.3% |
| Cancer faster diagnosis standard | 33.33% | 75% | 83.8% |
| Patients waiting less than 6 weeks for a diagnostic test | 90.2% | 95% | 90.1% |
| Patients waiting more than 40 weeks to start treatment | 8 | 0 | 740 |

**Emergency Care Standard**

VARIATION

**Action**
Bed occupancy levels, more likely to need admission, presenting late, requiring reasonable adjustments and workforce issues. Audit results to go to HI Meeting.

**Update**
- Special cause variation consistently failing target
- Significant Inequality

**Outpatient DNAs**

VARIATION

DNA audit in process, results to go to HI Meeting. Patient communication project introduction of easy read letters may impact DNA.

- Consistently failing target
- Inequality compared to trust av
- 7.2% last month

**Cancer faster diagnosis standard**

VARIATION

Issues with capacity of CN Matron, diagnostics, communication and need for F2F not addressed. Audit in progress, results to HI Meeting & Outpatient board. Escalation to clinical outcomes group.

- Significant inequality
- Random variation unable to consistently meet target
- Decline from 66.7% last month

**Patients waiting less than 6 weeks for a diagnostic test**

VARIATION

Capacity in Echocardiography & Neurophysiology (Reflects CHFT performance). LD Flag added to KP+ Model. Audit in progress results to go to HI Meeting.

- No present Inequality gap
- Random variation unable to consistently meet target
- Increase from 68.3% last month

**Patients waiting more than 40 weeks to start treatment**

VARIATION

Reflects CHFT performance – impacted by issues in Echocardiography and Neurophysiology.

- Increase from 6 patients
- LD Flag added to KP+ model
- Focus given at start of Access meetings

| IMPROVING | ON TARGET | ACTION NEEDED | INEQUALITY PRESENT |
|---|---|---|---|
| 0/5 | 0/5 | 5/5 | 3/5 |

APRIL

Calderdale and Huddersfield
NHS Foundation Trust

# Deprivation IMD1&2

| | Current | Target | Trust Average |
|---|---|---|---|
| **Emergency Care Standard** | 76.3% | 76% | 76.8% |

VARIATION

**Action**
Failing target due to bed occp levels and workforce issues. Continue to monitor and meet with A&E team to discuss improving overall target.

**Update**
- Performance meeting target by exception
- Variation in line with trust average
- No inequality gap

| | Current | Target | Trust Average |
|---|---|---|---|
| **Outpatient DNAs** | 8.9% | 3% | 6.3% |

VARIATION

Pilot calling IMD1&2 patients to reduce DNA's in stage 2. Patient comms project to review letters. Targeted work with DNA outlier specialties.

- Common variation which consistently fails target
- Significant inequality
- Targeted work required

| | Current | Target | Trust Average |
|---|---|---|---|
| **Cancer faster diagnosis standard** | 80.3% | 75% | 83.7% |

VARIATION

Meets national challenge to meet target in Lower GI, Upper GI, Urology, head and Neck and non site specific. Requested Mutual aid from other trusts.

- Performance above target
- No current inequality
- Random variation- does not consistently meeting target

| | Current | Target | Trust Average |
|---|---|---|---|
| **Patients waiting less than 6 weeks for a diagnostic test** | 93.7% | 95% | 90.1% |

VARIATION

Capacity issues in Echocardiography & Neurophysiology. Other Modalities achieving the target. Continue to monitor.

- No inequality – exception
- Random variation - may meet or miss target

| | Current | Target | Trust Average |
|---|---|---|---|
| **Patients waiting more than 40 weeks to start treatment** | 253 | 0 | 740 |

VARIATION

Growing ASI list
Cancelled lists / appointments due to strikes

- Position progressing towards target
- Slight increase of 6 patients
- Month exception

| IMPROVING | ON TARGET | ACTION NEEDED | INEQUALITY PRESENT |
|---|---|---|---|
| 1/5 | 1/5 | 5/5 | 1/5 |

APRIL

# Ethnic Minority

| | Current | Target | Trust Average |
|---|---|---|---|
| Emergency Care Standard | 0% | 76% | 76.8% |
| Outpatient DNAs | 0% | 3% | 6.3% |
| Cancer faster diagnosis standard | 0% | 75% | 83.7% |
| Patients waiting less than 6 weeks for a diagnostic test | 0% | 95% | 90.1% |
| Patients waiting more than 40 weeks to start treatment | | 0 | 740 |

Emergency Care Standard — VARIATION; Action; Update

Outpatient DNAs — VARIATION

Cancer faster diagnosis standard — VARIATION

Patients waiting less than 6 weeks for a diagnostic test — VARIATION

Patients waiting more than 40 weeks to start treatment — VARIATION

| IMPROVING | ON TARGET | ACTION NEEDED | UNDER PERFORMS WIDER POPULATION |
|---|---|---|---|
| 0/5 | 0/5 | 5/5 | 5/5 |

# INTEGRATED PERFORMANCE

# 10. Quality Committee Chair Highlight Report

# - Learning from Deaths Q3 Report

To Note

Presented by Denise Sterling

# CHAIR'S HIGHLIGHT REPORT
# to the Board of Directors

| **Committee Name:** | Quality Committee |
|---|---|
| **Committee Chair:** | Denise Sterling, Non-Executive Director |
| **Date(s) of meeting:** | 11th March 2024, 8th April 2024 |
| **Date of Board meeting this report is to be presented:** | 2nd May 2024 |
| **ACKNOWLEDGE** | • The Quality and safety strategy is still in draft form and is being aligned with the Clinical Strategy which is currently under review. Committee approved that the Strategy progresses in the current format and is fully signed off at a later meeting.<br>• The committee noted the strategic programmes of work outlined in the Patient Experience and Involvement Group Report and the draft ambitions to support unpaid carers at the Trust 2024/2025, a pilot of the Person-Centred Care definition and standard was approved.<br>• A presentation was given on a Patient Story, learning from multi agency reflective practice. The partnership report was based on the case of a young person with complex mental health and additional needs, who remained an in-patient at CHFT for a lengthy period. An independent external review commissioned through the Safeguarding Childrens Partnership in Calderdale has identified learning and recommendations for all agencies.<br>• The Getting it Right First Time (GIRFT) approach has changed, and in response CHFT has reviewed the internal processes to remain effectively engaged with all the GIRFT initiatives. The GIRFT programme will move from being centrally organised to being divisionally led with divisional GIRFT leads. Trust level activity will be coordinated by the Deputy Medical Director and Chief Operating Officer. |
| **ASSURE** | • There is one outstanding action in the Naso Gastric tube action plan in relation to X-rays and all other actions have been completed. Further checks are to be undertaken to ensure the actions are robust and embedded.<br>• A report on theme one of the 3-year Maternity and Neonatal delivery plan was presented. The focus for theme one: the listening to and working with women and families with compassion, the three objectives of the theme was outlined. The progress measures that have been developed in the three-year plan were also highlighted.<br>• Informative PSQB reports were received from the Community and Surgery and Anaesthetics Divisions. This new approach will enable Quality Committee to gain valuable insight into division specific performance on quality, patient safety and patient experience and to provide support. |

| | |
|---|---|
| | • An overview of the action plan was presented to minimise exposure to Nitrous Oxide. The internal audit findings will be reviewed when published and quality checks will be completed of the Control of substances hazardous to health (COSHH) alerts.<br>• It was reported that the Clinical Outcomes Group (COG) is in an improving position with increased attendance and engagement. A comprehensive update was provided of the workstreams and the level of assurance provided from the reports received.<br>• It was noted from the Learning from Deaths quarter 3 report that 240 of the 441 adult in patient deaths (55%) were reviewed using the initial screening tool and this was the best performance since the reviews began. A tool has been developed which should improve the review process and provide more useful data to learn from deaths.<br>• The Quality Report for March 2024 provided an overview on a number of key focus areas. Highlighted was the serious incidents progress update and work underway to clear the orange incidents backlog. There has been a five-fold increase in the number of CNSTs (Clinical Negligence Scheme for Trusts) since January 2024.Sepsis - significant work has taken place with the Emergency Department on reducing the four hour wait targets. The new sepsis guidelines are being developed.<br>• The IPR was presented and committee noted the challenges the Trust faces at the moment in relation to activity. The 76% target around Accident and Emergency 4-hour waits was met, however, this is still an ongoing challenge moving forward. There is good progress on elective recovery which shows a continued improvement, and good performance in relation to cancer targets. Infection prevention and control metrics show a breach in the Clostridium difficile ceiling, and looking at ways to understand the reasons for this and what can be done to mitigate this moving forward. |
| **AWARE** | • A significant number of colleagues have now been trained in different areas of the *Patient Safety Incident Response Framework (PSIRF)* The SWARM process and After-Action Reviews have now been rolled out, with the aim to transition from the current serious incident process to the PSIRF framework between April and the end of May 2024.<br>• Update provided on governance arrangements for Quality committee the former Trust Patient Safety and Quality Board will change into a patient safety and learning group and Divisional teams will report into the Quality Committee on their Patient Safety and Quality Board meetings on a quarterly basis. |
| **ONE CULTURE OF CARE** | One Culture of Care is considered as part of the Quality Committee reports and this was taken into account in the discussions. |

**Learning from Deaths Report Quarter 3 (Oct – December 2023)**

There were **441** adult inpatient deaths at CHFT recorded on Knowledge Portal.

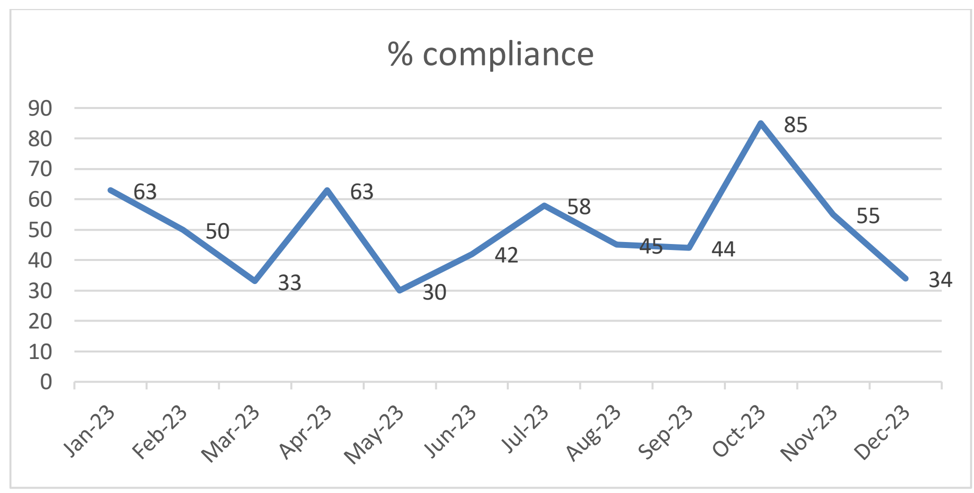
**<u>Initial Screening Reviews (ISR)</u>**

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 **441** adult inpatient deaths recorded in Quarter 3 of 2023/2024, **240** (**55%**) have been reviewed using the initial screening tool.

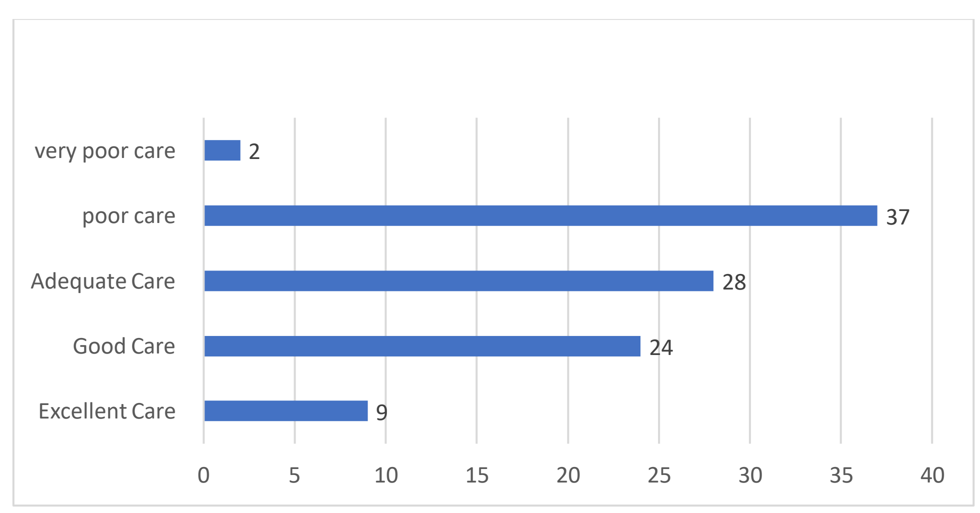
*Of the **381** adult inpatient deaths recorded in Quarter 2 **88** (**21%**) had been reviewed at the time of the last report. Compliance has increased since and is now at **44%***

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




**<u>Quality of care reviewed</u>**

**% Quality Care Scores for ISRs completed in Q3 (Oct to December 2023/24) n=240**



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

39% poor care
61% adequate/good care

Of the 39% that were found to have elements of poor care identified **9** were reported on datix and taken through appropriate Divisional Orange Panel

**Structured Judgement Review (SJR) Overview**

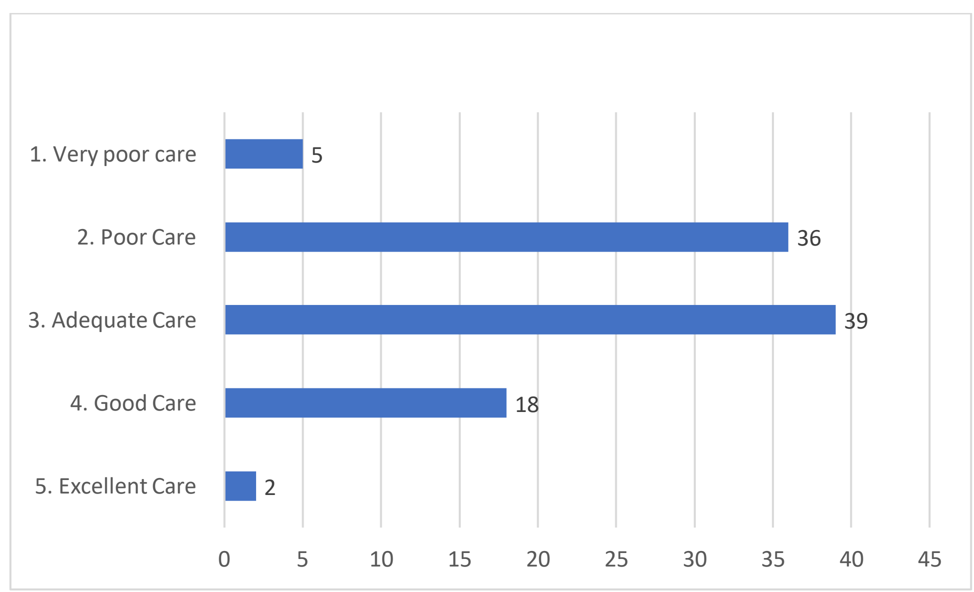
A SJR is undertaken by an individual reviewing a patient's death and mainly comprises of two specific aspects; namely explicit judgement comments being made about the care quality and care quality scores being applied. These aspects are applied to both specific phases of care and to the overall care received. The phases of care are as follows:

- Admission and initial care – first 24 hours.
- Ongoing care.
- Care during a procedure.
- Perioperative/procedure care.
- End-of-life care (or discharge care).
- Assessment of care overall

A total of 65 SJRs were requested in Quarter 3 of which **61** had been completed at the time this report was done.

| | Escalated by ISR | Escalated by ME | 2nd opinion | SI | Elective | Learning Disability | HED alerts | Total |
|---|---|---|---|---|---|---|---|---|
| **total** | **13** | **15** | **13** | **1** | **0** | **1** | **18** | **61** |

**Quality of Care score distribution for 61 completed SJRs %**




59% of cases = Adequate/Good Care
41% of cases = Poor Care

12 SJRs were reported on Datix and escalated to the divisions for validation in Q3.

The findings from SJRs are shared with the speciality mortality leads and appropriate Clinical Directors.

Of the SJRs completed in Quarter 3 2023/2024 the following learning themes and concerns were identified:

**The following good practice was identified:**

- Good thorough documentation.
- end of life care in particular was good
- Good summaries and decision making by Frailty consultant.
- Brilliant documentation and wider MDT involvement
- Documentation of junior doctors was thorough.

**The following poor practice was identified:**

- Delay in senior medical review – 17 hours post admission
- Delay in treating severe hyponatremia.
- RESPECT form for this patient not considered.
- Palliative care team involvement not considered.
- Delayed palliative care involvement.
- Better clinical leadership and decision making may have made difference in quality of care this patient had received
- No consideration of goals of care and DNACPR despite clinical deterioration ,
- Failure to recognise deteriorating patient-
- no further senior reviews in ED despite high NEWS score ,
- no involvement of critical care team – patient goes into cardiac arrest and resuscitation attempted
- No escalation plan in a frail patient on palliative chemo with Stage 4 Lung cancer
- Unnecessary resuscitation
- 11 hours in ED/delay in specialty consultant review
- Failure to recognise terminal decline in patient approaching end of life
- Poor communication with the family resulting in delayed palliation and advanced planning decision
- Missed opportunity in considering RESPECT conversation with the family and getting it right first time
- Urinary tract infection suspected – urinary culture sample not sent.
- Delayed treatment of low potassium and not re checking bloods or VBG in view of deranged results – low potassium 2.7 and high lactate

**Recommendation to Quality Committee**

Board is asked to note the Learning from Deaths Quarter 3 report.

# 11. Maternity and Neonatal Oversight Report

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

To Approve

Presented by Lindsay Rudge

| Date of Meeting: | Thursday 2 May 2024 |
|---|---|
| Meeting: | Board of Directors |
| Title of report: | Maternity and Neonatal Oversight Report |
| Author: | Gemma Puckett, Director of Midwifery and Women's Services |
| Sponsoring Director: | Lindsay Rudge, Chief Nurse, Executive Director Maternity Safety Champion |
| Previous Forums: | Quality Committee |
| Purpose of the Report | Drawing on a range of metrics and information sources, this report summarises the Trust progress against NHS England and Improvement maternity quality surveillance model outcomes. The report aims to provide assurance to the Quality Committee and Board of Directors that there are effective systems of control in place to monitor and continuously improve maternity services at Calderdale and Huddersfield NHS Foundation Trust. |
| Key Points to Note | The position and data contained in this report is for the Trust position at the end of January 2024 unless otherwise specified and as reviewed by the Maternity and Neonatal Transformation Board which took place in February 2024 and the Quality Committee which took place in March 2024. A deep dive of Theme one of the Three-Year Delivery Plan for Maternity and Neonatal Services was reviewed at the Quality Committee in April 2024 and can be found in Appendix 1.<br><br>This report meets the minimum data quality reporting requirements and provides assurance that there are effective systems of control in place to monitor and continuously improve the maternity and neonatal services.<br><br>Sections of the report to draw to the attention of the Quality Committee and Board of Directors are:<br><br>Section 1: Maternity and Neonatal Strategy<br>Section 2: Learning from Experience<br>Section 5: Workforce |
| EQIA – Equality Impact Assessment | There is noteworthy evidence which demonstrates that the experiences and outcomes of mothers and babies from BAME groups and those from the areas of highest levels of deprivation are more likely to be poor.<br><br>Maternity services have reviewed the Health Inequalities Workstream and are consulting with the Public Health Registrar to ensure actions are meaningful and measurable and not taking place in silo of each other. |
| Recommendation | The Board of Directors is asked to **APPROVE** the report. |

**Maternity and Neonatal Report**

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## Maternity and Neonatal Report for Quality Committee

### 1.0 Maternity and Neonatal Strategy

### 1.1 Maternity & Neonatal Three-Year Delivery Plan

The Maternity and Neonatal Transformation Board chaired by the Chief Nurse will have oversight of progress against the Three-Year Delivery Plan for Maternity and Neonatal Services. The board membership includes safety champions, the Maternity Voice Partnership (MVP) Chair and colleagues from the Local Maternity and Neonatal System (LMNS) and Integrated Care Board (ICB).

An annual review of progress against the three-year delivery plan took place in February 2024 with maternity, neonatal and MVP representation.

The review has concluded that the areas of celebration include excellent engagement with the MVP and strong desire to co-design, achievement of the Maternity Incentive Scheme (MIS) and whilst there are workforce challenges, this risk is recognised with appropriate mitigation in place.

It was acknowledged however that there has not been a collaborative approach in developing the original action plan with this sitting in maternity services solely and without the input of the neonatal teams and service users. The group identified that it has been challenging in the context of the number of external assessments and inspections that have taken place after the plan had been published meaning there has not been the focus that would have been intended. It was also discussed that the women, birthing people, and families using the service know little about the plan and therefore there is little understanding of what the plan means to the population and what they would consider important to meet the objectives.

Agreed actions include co-designing the action plan response where possible, ensuring there has been public engagement to understand what the plan means to the women, birthing people and families using the service. This will enable a tailored and comprehensive plan that reflects the needs of the local communities. It was suggested to use a workshop format which engages staff and services users and is structured around a board game *Whose Shoes?*® (Whose Shoes - overview (padlet.com)). The company who facilitates this have been approached and some scoping information received. It is hoped that this can be funded, and a workshop arranged for Q1 2024-25.

A review of each theme has been scheduled for alternate months of the Quality Committee to ensure there is floor to board oversight of the implementation of the delivery plan. The presentation to Quality Committee focussed on theme one can be found in Appendix one.

### 1.2 NHS Resolution Maternity Incentive Scheme
### 1.3

| MIS Declaration | |
|---|---|
| **Date Submission** | **30th January 2024** |
| **Compliance Declared** | **Full compliance** |

| Any areas of mitigation | Yes – Safety Action 1a:<br>X2 cases reported beyond seven working days. |
|---|---|
| MIS compliance validated | Yes – Compliance achieved. Quality committee updated in April 2024. |

## 1.4 Care Quality Commission

| CQC Maternity ratings | |
|---|---|
| Date Inspection | June 2023 |
| Overall Rating | Good |

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

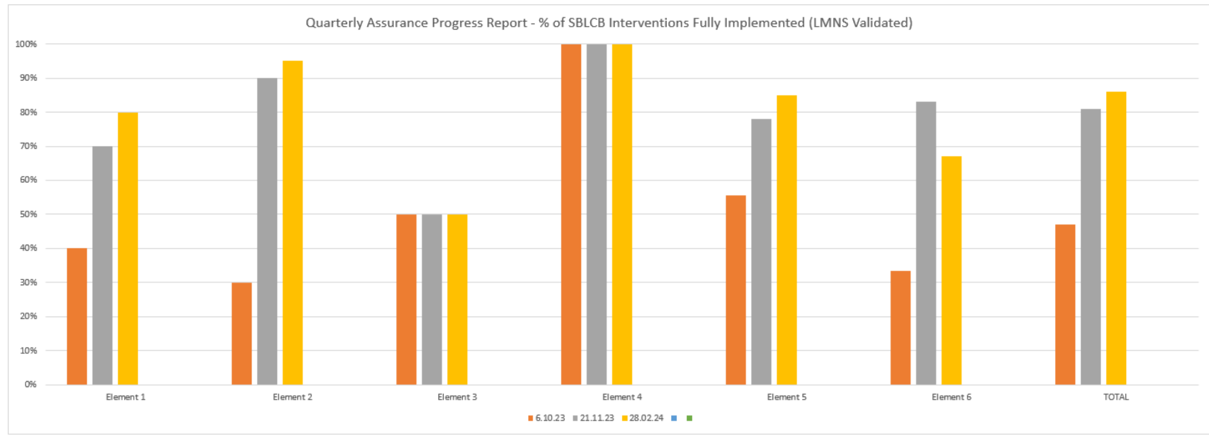
## 1.5 Saving Babies Lives Bundle version 3

### LMNS Quarterly Assurance Meeting Record on Implementation of the Saving Babies Lives Care Bundle (Version 3)

**Trust:** Calderdale and Huddersfield NHS Foundation Trust

**ICB:** North East and Yorkshire

| | Baseline Assessment | Assessment 1 | Assessment 2 | Assessment 3 | Assessment 4 | Assessment 5 | Assessment 6 | Assessment 7 | Assessment 8 | Assessment 9 | Assessment 10 | Assessment 11 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Review Quarter | N/A | Q2 23/24 | Q3 23/24 | | | | | | | | | |
| Assurance Review Date | 6.10.23 | 21.11.23 | 28.02.24 | | | | | | | | | |
| % of Interventions Fully Implemented (LMNS Validated) | | | | | | | | | | | | |
| Element 1 | 40% | 70% | 80% | | | | | | | | | |
| Element 2 | 30% | 90% | 95% | | | | | | | | | |
| Element 3 | 50% | 50% | 50% | | | | | | | | | |
| Element 4 | 100% | 100% | 100% | | | | | | | | | |
| Element 5 | 56% | 78% | 85% | | | | | | | | | |
| Element 6 | 33% | 83% | 67% | | | | | | | | | |
| TOTAL | 47% | 81% | 86% | | | | | | | | | |




A further quarterly review of progress with implementation has taken place by the LMNS and there has been a slight increase in overall implementation with 86% of the bundle implemented. This will be an ongoing assessment and oversight is being supported by the patient safety compliance officer who is now in post in the Directorate Governance Team.

## 2.0 Learning from Experience

### 2.1 Regulatory Escalations

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

### 2.2 Maternity and Newborn Safety Investigations (MNSI – previously HSIB)

As of the 31st of January 2024, the maternity services position is:

| **Cases to date** | |
|---|---|
| Total referrals | 47 |
| Referrals / cases rejected | 16 |
| Total investigations to date | 31 |
| Total investigations completed | 29 |
| Current active cases | 2 |
| Exception reporting | 1 (MI-030975) |

Current Active cases:

| Criteria | Referral date | Status |
|---|---|---|
| Neonatal Death | 08/2023 | • Initial findings previously shared with trust.<br>• Further neonatal clinical advisor review 09/02/2024.<br>• Exception reporting due to additional lines of enquiry identified. |
| HIE/Cooling | 11/2023 | • Awaiting response from two staff re interviews – last date for interviews is 13 Feb.<br>• Initial findings: timing of entries on K2 |

| | | |
|---|---|---|
| | | • Feedback: thanks to maternity governance team and staff who have been involved so far - extremely helpful. |

There have been two rejected cases to date in 2023-24:

| Reference | Criteria | Case open date | Reason for rejection |
|---|---|---|---|
| [redacted] | HIE/Cooling | [redacted]08/2023 | Family did not want investigation as MRI was normal |
| [redacted] | HIE/Cooling | [redacted]11/2023 | COVID-19 criteria not met – MRI normal, no trust or family concerns. |

There has been one referral made to MNSI in January 2024 which may not fit criteria. MNSI contacted to discuss the case, advice given to submit for triage.

MNSI referrals are audited quarterly for compliance with referral with quarter three demonstrating 100% compliance with referrals.

Please note reference number and exact referral dates anonymised to support patient confidentiality.

**2.3 Maternity Incidents**

Maternity incidents are reviewed at a weekly maternity governance MDT meeting. All incidents are reported via Datix and coded as maternity incidents.

| Incidents | |
|---|---|
| **Red / Orange Incidents in January 2024** | 0 |
| **Open SI's January 2024** | 4 (includes 2 MNSI cases) |

There are ongoing pieces of work to address the PMRT and MNSI themes including work with the wider Trust teams to progress access to a MEOW'S chart outside of the maternity setting. There was a successful bid submitted to purchase ultrasound software that will automate the plotting of growth from scans which is currently a manual transcription and subject to error. The fetal movement guideline has been reviewed to strengthen the management of repeated episodes of reduced fetal movements.

A regional workshop took place in December 2023 to review induction of labour and to discuss the challenges being seen across the region with delays, volume of inductions, impact of workforce challenges and the patient experience. This is also reflective of the national picture and the same concerns and challenges have been noted across multiple regions.

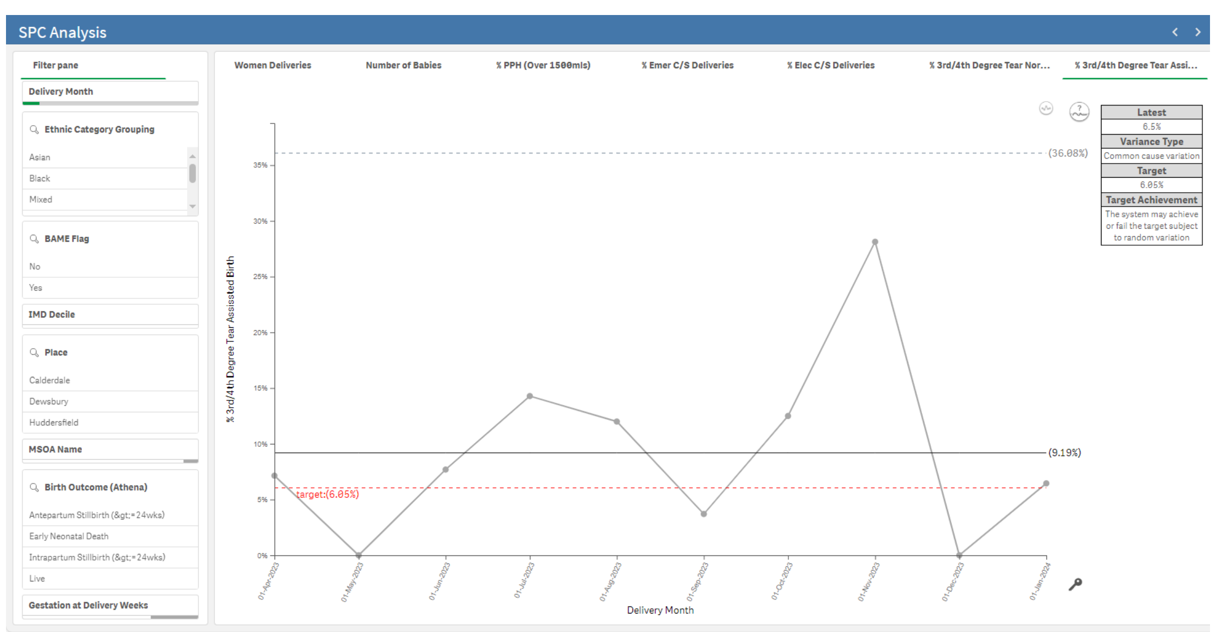
## 3.0 Dashboards

### 3.1 Maternity:

| Key Indicators | Thresholds | | | | | |
|---|---|---|---|---|---|---|
| | Green | Amber | Red | Dec 23 | Jan 24 | YTD |
| Total Bookings <13 Weeks | >90% | - | <90% | 90.00% | 88.63% | 89.3% |
| Total Births within Service | Monitoring Only | | | 360 | 350 | 3596 |
| Bookings <10 weeks | >90% | - | <90% | 67.5% | 57.1% | 62.2% |
| Normal births | >57% | - | <57% | 48.3% | 55.4% | 55.43% |
| Assisted vaginal births | <12.4% | - | >12.4% | 9.17% | 8.86% | 8.34% |
| Elective C/S deliveries | Monitoring Only | | | 15.69% | 415.20% | 14.31% |
| Emergency C/S deliveries | Monitoring Only | | | 26.05% | 20.41% | 21.97% |
| 3rd/4th degree tear - normal birth | <2.8% | - | >2.8% | 0.8% | 0.3% | 0.7% |
| 3rd/4th degree tear - assisted birth | <6.05% | - | >6.05% | 0.0% | 0.0% | 6.0% |
| PPH ≥ 1500ml | <3% | <3.0% | >=3.5% | 3.4% | 3.5% | 2.7% |
| Total stillbirths | 0 | <3 | >=3 | 0 | 1 | 7 |
| Perinatal and Neonatal Deaths | 0 | <3 | >=3 | 2 | 0 | 4 |
| Total stillbirths and Perinatal /Neonatal Deaths | 0 | <3 | >=3 | 2 | 1 | 6 |
| Low birth weight at term - live births - % of live babies at term < 2200g | 0% | - | >=1% | 0.00% | 0.93% | 0.63% |
| 1:1 Care in Labour | >=98% | >=97% | <97% | 99.2% | 100.0% | 98.4% |
| Induction Rate | Monitoring Only | | | 40.5% | 0.0% | 40.1% |
| Planned Home Birth | Monitoring Only | | | 2.52% | 1.46% | 1.58% |
| Smoking at Delivery | < 11% | - | > 11% | 7.00% | 8.16% | 7.35% |
| Smoking at Delivery (Not recorded) | 3% | | >3% | 5.6% | 2.9% | 5.2% |
| CO tested at booking | Monitoring Only | | | 98.9% | 98.9% | 96.3% |
| No. Mothers breastfeeding as First Feed | ≥ 74.4% | - | < 74.4% | 66.7% | 66.1% | 66.0% |
| No. Mothers breastfeeding as First Feed Not Recorded | Monitoring Only | | | 22 | 23 | 228 |
| CO testing at 36 weeks (35-36.6 days ) | ≥ 80% | - | < 70% | 86.14% | 83.83% | 84.15% |

The 3rd and 4th degree tear rates following an assisted birth have been noted as being a concern and a deep dive audit was initiated and due to report back to the Maternity Forum in July 2023 however there was delay in this being completed. The audit has now been reallocated to a new consultant to undertake and is expected to come to Maternity Forum in April 2024. It is pleasing to note that an improvement has been seen through December and January 2024. This has been sustained into February and March 2024 and will be included in the next Quality Committee report for May 2024.

The business intelligence team are supporting the development of the dashboard to be visible through KP+ and to use SPC charting:



The team are working through the current clinical indicators and ensuring the data can be filtered to consider health inequalities. A data deep dive annual review is being organised to review the multiple sources of data that are being collated and submitted to inform prioritisation of service improvement work in the new financial year.

### 3.2 Neonatal

A neonatal dashboard continues to be developed and remains in draft currently.

Further work is needed to refine the dashboard and to consider if the dashboard reported by the neonatal ODN could be used instead of or alongside.

A piece of work is underway to understand and reduce the number of in utero transfer declines. The data has been challenging to collect and differs between the maternity and neonatal services and has not been able to be obtained from the EMBRACE cot bureau as this is also only captured manually. There is no central IT system between the maternity and neonatal services to capture this. Datix is being explored but is reliant on individual reporting. All cases of babies born 'off pathway' are reviewed in each maternity unit in the LMNS. For CHFT this means there is an MDT review of all babies born below 27 weeks gestation to assess if there was opportunity to transfer to a level 3 unit for birth or not and to act on any learning identified.

### 3.3 Avoiding term admission into Neonatal Unit (ATAIN) audit

This audit is completed quarterly and the recommendations from the audit include:

- Continue to discuss all term admissions to NICU at the weekly governance meeting and complete the audit forms.
- Learning need identified for management of hypoglycaemia and babies who are not feeding and thermoregulation.
- Monitor the number and reason following cat 4 LSCS in ATAIN babies.
- MIS workstream continues for a transitional care that aligns with BAPM guidance.
- To present the ATAIN audit at Maternity Forum.
- The action plan for ATAIN is available on the FSS drive. This is updated at the ATAIN meetings and Maternity Forum.

### 3.4 Transitional care audit

This audit is completed quarterly and the areas of development from the latest report include:

- Discussions held about transitional care being permanently located on 4B as a recognised location by staff on the ward.

- New equipment ordered which includes phototherapy lights and neonatal incubators to support those babies requiring this care.

- Member of the neonatal nursing team identified to support and train staff to develop the transitional care service, in line with Maternity Incentive Scheme, Safety Action 3.

- Transitional care guideline sent to guideline group for ratification to reflect working towards these developments.

- Transitional care action plan and audit sent to neonatal forum for discussion (December 2023).

A task and finish group for Transitional Care (TC) has been convened to ensure progress at pace. This group will review the intended delivery model which was proposed to be a midwifery led TC however this has so far not been able to be developed due to workforce challenges. Neonatal services have the skills and knowledge in place already to provide TC level care and a more stable workforce and therefore it is proposed this is taken forward with joint working with the midwifery team to ensure a seamless experience of care.

### 3.5 Perinatal Mortality Review Tool (PMRT) quarterly update

| Date of Incident | Gestation | Type | Data inputted into PMRT | Basic information date by 2 months | Draft report within 4 months | Date report 6 months |
|---|---|---|---|---|---|---|
| 04/2023 | 38+6 | Neonatal death | Leeds | | | |
| 04/2023 | 35+4 | Antenatal stillbirth | 04/2023 | 26/04/2023 | 10/08/2023 | 10/08/2023 |
| 05/2023 | 41+2 | Antenatal stillbirth | 05/2023 | 24/05/2023 | 16/08/2023 | 19/10/2023 |
| | | MIS Starts 30th May - 7th Dec 2023 | | | | |
| 06/2023 | 26+0 | Neonatal death | BRI | | | |
| 08/2023 | 39+6 | Neonatal death | 08/2023 | 10/08/2023 | 27/11/2023 | 06/12/2023 |
| 082023 | 34+2 | Neonatal death | 08/2023 | 16/08/2023 | 08/11/2023 | 08/11/2023 |
| 08/2023 | 30+2 | Antenatal stillbirth | 08/2023 | 23/10/2023 | 06/12/2023 | 06/12/2023 |
| 08/2023 | 40+1 | Antenatal stillbirth | 08/2023 | 04/10/2023 | 06/12/2023 | 06/12/2023 |
| 08/2023 | 36+6 | Antenatal stillbirth | 08/2023 | 04/10/2023 | 27/12/2023 | 27/12/2023 |
| 09/2023 | 32+4 | Antenatal stillbirth | 09/2023 | 18/10/2023 | 17/01/2024 | 14/02/2024 |
| 0202023 | 23+" | Antenatal stillbirth | | | | |
| 10/2023 | 22+6 | Late miscarriage | 11/2023 | 27/12/2023 | 14/02/2023 | 30/04/2024 |
| 11/2023 | 25+^ | Antenatal stillbirth | 11/2023 | 18/0122023 | 24/03/2024 | 24/05/2024 |
| 10/2023 | 29+2 | Neonatal death | eeds | | | |
| | | | | | | |
| 11/2023 | 24 | Antenatal stillbirh | 12/2023 | 18/01/2023 | 21/02/2024 | |
| 12/2023 | 24+3 | Neonatal death | 12/2023 | 18/12/2023 | 11/04/2024 | `11/06/2024 |
| 11/2023 | 38 | Late neonatal death | 12/2023 | 18/12/2023 | 19/03/2024 | 29/05/2024 |
| 12/2023 | 22+1 | Late miscarriage | 12/2023 | 20/12/2024 | 03/04/2024 | 03/06/2024 |
| 11/2023 | 23+4 | neonatal death | | | | |
| 12/2023 | 25+2 | Neonatal Death | 12/2023 | 20/12/2023 | 18/02/2024 | 18/06/2024 |
| 12/2023 | 22+4 | Late miscarriage | 12/2023 | 10/01/2024 | 24/04/2024 | 24/06/2024 |
| 01/2024 | 35+5 | Late neonatal death | eeds | 06/03/2024 | | |
| 01/2024 | 32+2 | Antenatal stillbirth | 01/2024 | 31/01/2024 | 21/05/2024 | 21/07/2024 |

Please note exact referral dates and entry to PMRT tool anonymised to support patient confidentiality.

The PMRT process is currently under review and a meeting to work collaboratively within the Calderdale, Kirklees, and Wakefield (CKW) partnership for peer review has been arranged. This will support having external expert presence on PMRT panels robustly and will enable peer review and development of shared learning.

## 4.0 Listening to Families & Staff

### 4.1 Complaints

The themes of complaints received include communication, feeling heard and concerns around consent for intervention or examination. This reflects feedback received via the MVP and will be a key feature in the new MVP workplan.

The division are continuing to work with the Trust complaint's team to improve compliance with timely complaint responses and have a weekly complaints performance meeting.

The complaints in maternity are often related to care received over 6-12 months previously and sometimes from several years ago which increases the complexity of the investigation due to reduction in reliable recall of care provided.

There is an increasing demand for debriefing following birth however there is only 0.4 WTE allocated to delivering a birth debrief service and the weekly clinic is fully booked for several

months. An enquiry has been raised with the finance team to ascertain if this sits outside of the maternity contract and therefore requires formal commissioning and funding to ensure a robust service.

On 9th January 2024, the All-Party Parliamentary Group (APPG) set up an inquiry to investigate and understand the reasons for traumatic birth and to develop policy recommendations to reduce the rate of birth trauma. The inquiry is inviting written submissions from parents and professionals who work in maternity and is due to report in April 2024.

The MVP has formally acknowledged that whilst there is a desire to move to becoming a Maternity and Neonatal Voices Partnership (MNVP) they currently do not have the capacity to deliver on this, it will however remain the ambition for the future.

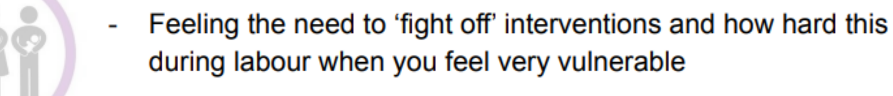
**4.2 MVP feedback**

The MVP chair is core member of the Maternity Forum, guidelines and Maternity and Neonatal Transformation Board and has been engaging with clinical leaders across the maternity service to share feedback and co-design improvements.

Feedback from service users was shared and discussed at the February Maternity and Neonatal Transformation Board and has been shared with all staff in maternity services. This feedback included:

Feedback

- Impact of negative language “you must” “you can’t” “too old”
- Some excellent feedback around decision making and IOL
- Continuing to hear feedback about birth plans not being followed
- Huddersfield birth centre
- Challenges around communication when birthing at Calderdale but receiving antenatal care from a different trust
- Feeling supported to access a home birth “out of guidance” by community midwives
- Lack of ‘low risk’ birth setting: feeling let down by birth centre being ‘relocated’
- Feeling the need to ‘fight off’ interventions and how hard this is during labour when you feel very vulnerable



The Maternity and Neonatal Transformation Board will now have a standing agenda item for a service user to attend or share via a video their lived experience with a plan to consider different areas of care including birth planning, bereavement, and neonatal experiences.

**4.3 Maternity and Neonatal Board Safety Champion Feedback**

Monthly safety champion meetings are held between the board level champions and the maternity and neonatal champions.

The Chief Nurse continues to offer monthly open-door sessions for staff. The dates and times for these and any ‘you said we did’ updates are shared via the ‘Weekly View.’

An annual review of the safety champion roles and responsibilities has taken place to ensure effective delivery of the toolkit and ensuring a robust floor to board oversight and communication. Feedback will be provided in the next report with agreed actions and progress.

**5.0 Workforce**

**5.1 Midwifery Staffing**

The midwifery workforce continues to be challenged and remains on the corporate risk register. Mitigations are in place to manage safe staffing.

The Director of Midwifery has undertaken a review of April 2023-end of January 2024 to collate the totality of leavers and reduced hours versus the amount of recruitment and to aid understanding of the service of where additional efforts need to be focussed. This has been taken from locally held workforce summaries that are produced to support reporting externally to the LMNS and region on midwifery workforce.

| Leavers / Reduced hours | Recruited staff |
| --- | --- |
| 24.33 | 28.96 |

When reviewed over this period, it has demonstrated that despite the successes in recruitment the impact for growth in the midwifery workforce has been minimal with an overall increase in workforce of 4.63 WTE.

The reasons for leaving are mixed with a proportion due to retirement, leaving the profession and promotion. There have been multiple requests to reduce hours with staff citing work life balance and health and wellbeing as the driver for the request.

There has been a good focus on recruitment and steps have been taken to support retention. A practice development support midwife has been employed with a clinical focus working alongside staff on the 'shop floor.' Stay conversations are offered and exit interviews offered with the Director or Deputy Director of Midwifery.

NHSE are providing ongoing funding for recruitment and retention for 2024-2025. Many units have used this funding for a dedicated role to lead on recruitment, retention and pastoral support and the Director of Midwifery recommends that this is considered at CHFT as there is good evidence from other organisations of the difference this has made.

Career pathways to 'grow our own' workforce is in place with two midwifery apprentices recruited and a plan to support another two per year to undertake the course. The shortened programme for registered nurse to registered midwife is now being run through the University of Bradford and CHFT advertised to support two registered nurses onto this course. One application was received for this year's cohort and although shortlisted they did not meet the required level for study at a master's level. The service plan to support this individual who works as a nurse in maternity to undertake a module at master's level to ensure they will be eligible for next year's cohort.

A repeat Birthrate Plus assessment has been commissioned and will also include workforce needed to delivery continuity of carer. The data collection is underway and being shared with the Birthrate Plus team for analysis.

The Trust will be taking part in a centralised recruitment programme for students due to qualify in September 2024 with the LMNS and an open day is planned for February 2024.

We continue to receive flexible working applications to reduce hours to support work life balance or health and wellbeing. Further work is taking place to ensure that conversations about this are held in advance of a flexible working application to review rosters and discuss ways to ensure a healthy balance prior to reducing hours. A review of the amount of bank work completed after reduction is undertaken to ensure colleagues are not then replacing substantive hours with enhanced rate bank shifts and potentially not gaining benefit as per their flexible working request.

The enhanced rate for bank for midwives will be reviewed in March / April 2024 when the second output of students have commenced in post.

**5.2 Midwifery Staffing levels – planned vs actual**

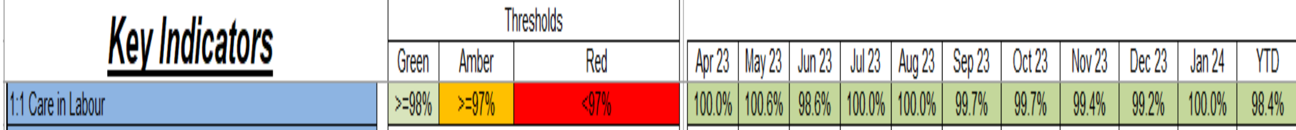
With the continued staffing challenges through the maternity service a review of acuity and staff available occurs each shift, with LDRP completing the Birthrate Plus acuity tool four hourly and staff are redeployed within the hospital setting to appropriate areas to maintain safer staffing levels. Options 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 using 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.

**5.3 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 has been challenging due to vacancies, maternity leave, and short-term sickness, 1:1 care in labour and supernumerary status of the labour ward co-ordinator are prioritised.

In December 2023 – March 2024, the LDRP co-ordinator was supernumerary on 100% of the shifts.

The table below describes the 1:1 care in labour position through 23-24, with this achieved 100% in January 2024 and 98.4% overall year to date.



| Key Indicators | Thresholds | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Green | Amber | Red | Apr 23 | May 23 | Jun 23 | Jul 23 | Aug 23 | Sep 23 | Oct 23 | Nov 23 | Dec 23 | Jan 24 | YTD |
| 1:1 Care in Labour | >=98% | >=97% | <97% | 100.0% | 100.6% | 98.6% | 100.0% | 100.0% | 99.7% | 99.7% | 99.4% | 99.2% | 100.0% | 98.4% |

**5.4 Obstetric Staffing**

Funding has been secured for an additional three obstetric / gynaecology consultant posts and this has been advertised. Interviews took place on 15th March 2024 and successfully substantively appointed one new candidate and a second who was working as a locum.

The Divisional Director and Director of Midwifery have met with the obstetric / gynaecology specialty Doctors to undertake a listening session on how it is feeling to work in the service at CHFT.
A bid for additional funding was submitted to Dragons Den to support achievement of compensatory rest, a split obstetric / gynaecology rota and to improve antenatal clinic capacity.

### 5.5 Neonatal Workforce

The neonatal nursing workforce meets the minimum requirements for qualified in specialty (QIS).

A dedicated clinical practice educator for neonates and a governance lead nurse has both been funded by the ODN. The educator post has been recruited to and the governance lead post will be advertised alongside a maternity post and the current maternity team will become perinatal and women's to ensure robust contingency within the team across all the directorate specialties.

The Advanced Neonatal Nurse Practitioner role requires review to ensure the most effective and efficient usage of the skill set of this role.

As the neonatal service has just transferred into the women's directorate a budget review meeting has been arranged to understand the compliance against BAPM against the current activity in the service.

The first neonatal specific performance review meeting was scheduled for February 2024 and will take place bi-monthly. This will include an oversight of well led metrics including nursing workforce and compliance against the national staffing standards for neonates.

A bid for additional funding was submitted to Dragons Den to support having a second registrar on duty to ensure adequate cover for both neonatal services and paediatrics. This is currently in place with some temporary external funding from the neonatal ODN.

## 6.0 Training

**PROMPT and Fetal Monitoring, NLS – January 2024**

**Midwives:**

| Competence Name | Assignment Count | Required | Achieved | Outstanding | Compliance % |
|---|---|---|---|---|---|
| 372\|LOCAL\|Fetal Monitoring Programme (K2) - 1 year\| | 156 | 156 | 132 | 24 | 84.62% |
| 372\|LOCAL\|Maternity Obstetric Emergency Training (PROMPT) - 1 Year\| | 155 | 155 | 128 | 27 | 82.58% |
| NHS\|CSTF\|Resuscitation - Level 2 - Newborn Basic Life Support - 1 Year\| | 153 | 153 | 116 | 37 | 75.82% |

*New FM study day launched so some variation in compliance expected over next few months

**Maternity Support Workers**

| Competence Name | Assignment Count | Required | Achieved | Outstanding | Compliance % |
|---|---|---|---|---|---|
| 372\|LOCAL\|Maternity Obstetric Emergency Training (PROMPT) - 1 Year\| | 58 | 58 | 54 | 4 | **93.10%** |

**Obstetric Consultants**

| Competence Name | Assignment Count | Required | Achieved | Outstanding | Compliance % |
|---|---|---|---|---|---|
| 372\|LOCAL\|Fetal Monitoring Programme (K2) - 1 year\| | 16 | 16 | 14 | 2 | **87.5%** |
| 372\|LOCAL\|Maternity Obstetric Emergency Training (PROMPT) - 1 Year\| | 16 | 16 | 15 | 1 | **93%** |

**Obstetric Trainees**

| Competence Name | Assignment Count | Required | Achieved | Outstanding | Compliance % |
|---|---|---|---|---|---|
| 372\|LOCAL\|Maternity Obstetric Emergency Training (PROMPT) - 1 Year\| | 26 | 26 | 23 | 3 | **90%** |
| 372\|LOCAL\|Fetal Monitoring Programme (K2) - 1 year\| | 16 | 16 | 14 | 2 | **88%** |

***PROMPT and FM requirement numbers differ due to GP trainees/foundation doctors needing PROMPT but not FM***

**Anaesthetics**

| Competence Name | Assignment Count | Required | Achieved | Outstanding | Compliance % |
|---|---|---|---|---|---|
| 372\|LOCAL\|Maternity Obstetric Emergency Training (PROMPT) - 1 Year\| | 34 | 34 | 32 | 2 | **94%** |

All staff who are non-compliant with PROMPT have been booked on sessions with a rolling programme of allocation to ensure annual completion.
Completion of essential and role specific training is actively managed through directorate and divisional performance meetings. Current areas of concern are compliance against safeguarding training and the directorate is working with the Trust safeguarding team to deliver training.

## 7.0 Developments and Celebrating Success

The women's directorate created a seasonal calendar of some of the achievements of the teams which was shared across the specialty in January 2024. This will be developed to incorporate the neonatal service as well for a review of 2025.

A 'CHuFT to bits' jar for staff to put in items for celebration has been set up to share successes monthly through the unit meetings. These meetings have been commenced for maternity initially to pilot them and will now be expanded to neonates following initial positive feedback.

The perinatal quad leadership programme has been running over the last 4 months with representation from the Women's general manager / deputy director of Operations, deputy director of midwifery, neonatal clinical lead, and a consultant obstetrician. A component of the programme has been for the maternity and neonatal services to undertake a culture survey, and this has been shared widely with maternity, neonatal, anaesthetic and theatre teams who work in maternity services. This survey has closed, and the findings shared with the divisional management team. Culture conversations have taken place with staff, facilitated by a member of the perinatal course leadership to explore the findings. The output if the survey and the conversations will be brought to the next maternity and neonatal transformation board in May 2024.

The staff survey results have been released and initial review has demonstrated improvements across some metrics. The response to the survey will also consider the results of the culture survey to ensure a holistic action plan. This will also be taken to the next maternity and neonatal transformation board.

**Appendix 1: Quality Committee April 2024 Three-year delivery plan for maternity and neonates - Theme 1 review**

Quality Committee
Date: 8th April 2024
Maternity & Neonates: Three Year Delivery Plan for Maternity & Neonates: Theme 1 Update

## Theme 1: Listening to and working with women and families with compassion

**Determining success for Theme 1:**

***It is the responsibility of the Trust to involve service users in quality, governance, and co-production when designing and planning delivery of maternity and neonatal services***

- Overall success will be determined overall by Listening to Women and Families
    - *Outcome measure for this theme will be indicators of women's experience of care from the Care Quality Commission (CQC) maternity survey. They will be aggregated at trust, ICB, and national levels and at national level analysed by ethnicity and deprivation.*

- **<u>Progress measures:</u>**

| | CHFT Position March 2024 |
|---|---|
| Perinatal pelvic health services and perinatal mental health services are in place. | ✓ Work Together get Results planned for Thurs 11th April 2024 with Women's Physio<br>✓ Pelvic health funding received from LMNS to support service planning and implementation |
| The number of women accessing specialist perinatal mental health services as indicated by the NHS Mental Health Dashboard. | ✓ Perinatal mental health Specialist Midwife in post with specialist clinic, obstetric lead and close liaison with adult mental health services<br>✓ New maternal mental health service in ICB due to launch in Quarter 1 24-25 with a link midwife post. Initial roll out will be for birth trauma debrief / support<br>✓ Review of CHFT debrief service needs to take place in view of ICB service |
| The proportion of maternity and neonatal services with UNICEF BFI accreditation. | ✓ Maternity service re-accredited as a Gold BFI service - October 2023.<br>✓ Neonates have certificate of commitment and have started to collate and submit evidence<br>✓ Workforce model to support BFI in neonates requires review- BAPM requirement is protected time. This is not currently funded wihtin the workforce model. |
| Feedback on personalised care gathered via MNVPs from a wide range of service users | ✓ Active MVP and well attended meetings held face to face and virtually in March 24.<br>✓ 15 steps to be planned for 2024<br>✓ 'Whose Shoes' workshop to take place in Q1 2024-25<br>✓ Area for development is to ensure can gather feedback from seldom heard voices – linking with St Augustine's in Halifax, community champions and undertaken a virtual go see for a maternity befrienders model |
| Local evidence of working with women and families to improve services, including co-production | ✓ Visibility of Birth plans in labour rooms<br>✓ Birth infographic<br>✓ Maternity reconfiguration<br>✓ MVP workplan |
| The CQC will continue to consider compassionate and personalised care as key lines of enquiry during inspections | ✓ CHFT Inspected in June 2024 and retained Good status |
| The NHS Resolution CNST Maternity incentive scheme which encourages the use of MNVPs | ✓ Achieved validated position of complaince against all ten safety actions for year 5 |

## Theme 1: Listening to and working with women and families with compassion

### Objective 1: Care that is personalised

- Birth choices clinic – Multidisciplinary planning forum for women who want to make informed choices about their birth that may sit outside of clinical guidance to support a personalised birth plan.
- Review of service user involvement in care when incidents occur and if there is evidence of joint decision making and informed choice
- Active and very engaged MVP chair who liaises regularly, attends Maternity Governance meeting and is a core member of Mat Neo transformation Board
- Seen an improvement in score for feeling informed and involved in decision making for induction of labour.
- Smoke free pathway for women to ensure babies have the best start in life
- Developing audit to assess involvement in care/ joint decision making for all women, close the loop to assure all women experience this.
- Embedding sharing lived experience into multidisciplinary forums and ensuring our response is that we truly hear this, accept it and work together to make improvements where we haven't got things right.
- Need to review what personalized care means in neonates and how we can measure this
- Care that is responsive to health inequalities - feasibility of social vulnerability score and application in maternity services
- Estate for bereavement care and support across maternity and neonates
- Accessibility of care – deep dive into clinic locations, DNA rates across acute and community settings, impact of poverty in getting to the hospital for emergency maternity care.

## Theme 1: Listening to and working with women and families with compassion

Calderdale and Huddersfield NHS Foundation Trust

### Objective 2: Improve equity for mothers and babies

- Reviewed the action plan that is monitored via the Trust health Inequalities group to ensure the plan is relevant to identified inequalities.
- Engagement session with St Augustine's in Halifax to learn more about the lived experience of women and families seeking asylum and refuge and what targeted support could be offered to break down barriers to accessing care
- Virtual 'Go See' with MYTT has taken place to understand more about the maternity befrienders project – to review Core20plus5 funding availability to support developing similar project in CHFT
- Session with Public health registrar to understand more about the impact of poverty and to review how we could develop the social vulnerability tool for use in maternity services
- Interpreting Service: Pilot face to face video interpreting service in ANC and MAC – due to start April
- Reducing the Digital divide - registered with good things foundation charity who are gifting data to support women who fit the criteria for help to reduce the digital divide. The data is gifted at 6 monthly intervals in either a voucher or a sim card to enable them to access online notes, internet, calls etc and improve digital inclusion.
- Antenatal early booking information in videos - Short videos have been produced with lots of early booking information on health ed, parent ed and screening to support the book by 10 weeks campaign
- Planning workforce required to re-launch continuity of carer teams for the most vulnerable women: Intent to re-launch at least one team in next 12 months (subject to safe staffing).
- Data deep dive to understand areas of focus for 2024-2025 to ensure targeted actions that can contribute to making the most difference – planned to take place in next 4 weeks, date to be confirmed
- Development of the maternity dashboard to use SPC charting and to enable breakdown and review of data against known health inequalities

## Objective 3: Work with service users to improve care

### LISTENING TO FAMILIES: PATIENT STORY

First time mum Leah is attending the MatNeo Transformation Board to talk to us about the care she received during labour and birth, and the impact that aspects of her care had on her experience. Leah planned a home birth and was transferred to birth on the labour ward. Leah lives in Halifax and is from a mixed white and black Caribbean background.

### WORKING WITH WOMEN & FAMILIES – MVP WORKPLAN

- The MVP has recently moved from being hosted by the charity Auntie Pam's to its new home with Healthwatch.
- Building strong relationship with St Augustine's in Halifax to engage with women at risk of poorer outcomes.
- Delivering workshop to trainee O&G trainees in May
- 'Born at Home' film showing in Huddersfield followed by engagement event

## MATERNITY INCENTIVE SCHEME

*Leads: GP*

- **Year 5:**
- The Trust submitted a position of compliance with all ten safety actions with a mitigation against safety action 1a.
- NHS R have reviewed all submissions made and completed the external verification of safety actions 1,2 and 10
- CHFT have been notified they have been successful and compliance with all ten safety actions approved.

**Year 6:**

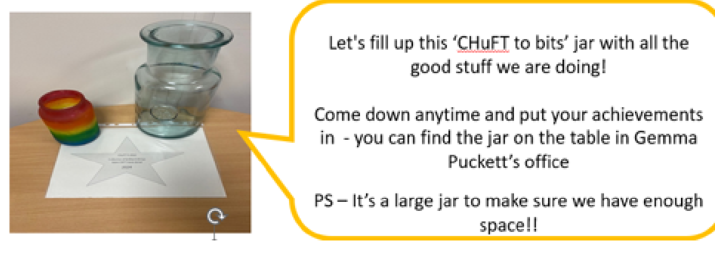
- Year 6 has been published on 2nd April 2024
- An initial review meeting to assess changes, identify safety action owners and review the accompanying tracking tool for use has been arranged
- A monthly complaince oversight group has been put in place to meet with safety action owners, review and collate evidence and escalate any concerns with compliance.
- Trusts must submit their completed Board declaration form to NHS Resolution via nhsr.mis@nhs.net by **12 noon on 3 March 2025**

## Celebrating Success

Lead: GP



- Neonates joined the Women's directorate
- Matron Fozia Arshad has completed Fellowship in healthcare and partnership
- Successful MVP meeting held in person and virtually with over 30 attendee's
- Excellent engagement session with St Augustine's in Halifax with a focus on women and families seeking asylum
- Achievement of Year 5 MIS
- Public health Midwife Kate Heighway attended House of Commons to speak in support of Tobacco and vapes Bill
- Midwife Claire Adams has graduated with a PgCert in Kindness and wellbeing at work and is a well being champion for the birth centre
- SDEC module for the maternity assessment centre has launched - MAC saw over 14000 women and received circa 40000 calls during 2023-24!
- Improvement across almost all questions in the staff survey for the women's directorate
- 'Ask it baskets' launched April 2024
- CHFT Nursing & Midwifery Ambitions 2024-2029 - engagement sessions held with staff
- Appointment of two consultants
- 8.8 WTE midwives commencing in post April 24
- Recruitment films completed
- https://youtu.be/7fSDKt0jj7w
- https://youtu.be/gVlC2wGpSbw



# 12. Workforce Committee Chair Highlight Report

To Note

Presented by Jo-Anne Wass

# CHAIR'S HIGHLIGHT REPORT to the Board of Directors

| **Committee Name:** | Workforce Committee |
|---|---|
| **Committee Chair:** | Jo-Anne Wass, Non-Executive Director |
| **Date of meeting:** | Monday 15 April 2024 |
| **Date of Board meeting this report is to be presented:** | Wednesday 2 May 2024 |
| **ACKNOWLEDGE** | We were pleased to note the following positive achievements:<br><br>**Staff survey:** the results of the latest survey were formally received by the Committee, and it was great to see good progress has been made, with improved scores across the full range of the People Promise at Trust level.<br><br>We were joined by colleagues from across our divisions, who sparked discussion (through a series of mini presentations) about their own local results. This highlighted some great work. It was particularly pleasing to see former "hot spot" areas making real improvements – a well-deserved reward for what has clearly been considerable and concerted effort. We would like to thank everyone involved in achieving this.<br><br>Divisional colleagues themselves commented on how useful it had been to hear what others are doing, and we discussed ways in which we could share good practice more effectively across the Trust.<br><br>Several key **workforce metrics** are on or exceeding target (more detail below). We acknowledged the challenging work and focus that goes in, day in, day out, to achieve these kinds of improvements. |
| **ASSURE** | The Committee received the following assurances in line with its terms of reference:<br><br>• **Vacancies are down slightly**, with both headcount and FTE increasing.<br>• **Turnover continues to improve** and stood at 7.21% in February 2024 (compared with 8.8% in February 2023). There is now an improvement trend of ten months. The Trust's target is 10%.<br>• In month sickness in February 2024 was down to 4.89%. The rolling 12-month average is now 4.73%, meaning **sickness absence is below the Trust's target of 4.75%.**<br>• **Core EST compliance is 93.85%.** The Trust's target is 90%.<br>• An additional 19 health care support worker apprentices are due to start in June 2024. The Trust continues to perform extremely |

| | |
|---|---|
| | well on supporting apprenticeships and is **in the top 10% of employer providers** in the UK.<br>• We reviewed BAF risk 1/22, which is concerned with the impact of health and well-being on the ability to recruit and retain. **The committee accepted the recommendation that this risk score remain at 12**, as there are still areas of the Trust where improvements can be made. But challenged whether (given the improvements evidenced in recruitment and turnover metrics) this was an over-cautious assessment, and encouraged triangulation of data in risk assessments. |
| **AWARE** | The following key risks were discussed by the Committee:<br><br>• **Health care scientists' turnover** is above the Trust's target of 10%.<br>• **Long-term sickness absence** has increased and is 3.19% (above the target of 3%).<br>• **Bank and agency costs** are still showing common cause variation, despite vacancies being filled and sickness absence going down. We should expect to see these costs going down.<br>• **Appraisal compliance was predicted to miss the Trust's target of 95%** and was likely to end the year at c85%.<br>• **Although overall we are hitting the Essential Safety Training target, there are some specific concerns** – e.g. safeguarding adults and children and data security awareness are not hitting target completion rates.<br>• Within the staff survey discussion, we took a particular look at the data from an equality, diversity and inclusion perspective. There are **unacceptable variations of experience for colleagues from BAME backgrounds and for those with disabilities**. The committee will be paying this closer attention in future. |
| **ONE CULTURE OF CARE** | One Culture of Care is considered as part of the workforce reports and in discussions. |

# 13. Finance and Performance Committee Chair Highlight Report

To Note

Presented by Andy Nelson

# 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:** | 26th March 2024 |
| **Date of Board meeting this report is to be presented:** | 2nd May 2024 |
| **ACKNOWLEDGE** | • Continued strong performance in Cancer with all key targets being met.<br>• Recovery performance also remains strong and continues to be the best in the West Yorkshire ICS (see table below). We have 45 52-week waiters and 39 of these are in ENT. However, we expect this number to be lower by the end of March. In terms of our target for 40-week waiters we currently expect all specialties to meet this bar ENT<br>• Quality indicators showing quality of care holding up well despite significant operational pressures.<br>• Thanks to some focussed work our ED performance has improved in March and we are now exceeding the national target of 76% for 4-hour waits<br>• We are still forecasting to deliver the financial plan for this year. Our cash position is favourable, aged debt stable and capital spend on track to meet the plan |
| **ASSURE** | • At our March meeting we had a follow-up deep dive into the work on Unplanned Care Transformation with a particular focus on Length Of Stay (LOS) and Transfer Of Care (TOC). Although we have seen a reduction in LOS in the last 3 months our TOC numbers remain consistently above 100. There are clear plans to reduce unnecessary admissions, re-energise the Well Organised Ward programme and work with councils on the Home First initiative. 2024/5 should hopefully see a positive impact from these initiatives on our LOS and TOC performance.<br>• Given the challenges in ENT we also reviewed progress against the ENT action plan. The key challenge is the number of Appointment Slot Issues which currently stands at over 5000 with some patients wating 45 weeks for an initial appointment. However, the ENT team have done an excellent job of mitigating the risk of patients exceeding 52 weeks. There were almost 700 patients at risk of exceeding 52 weeks at the beginning of January and as of 25th March that number was just 29 – the best performance in West Yorkshire. Better triage, improved referral quality and extra staffing all helping but much more still to do |
| **AWARE** | • Operational pressures are significant, and these continue to play through into our financial position particularly, length of stay, high levels of bed occupancy, high |

| | |
|---|---|
| | attendance rates at ED, non-pay inflationary pressures and the costs of strike action (although we expect these will be fully funded)<br>• At month 11 we are reporting a £23m deficit which is a £3.6m adverse variance to plan. However, due to additional monies provided by the ICB we are now forecasting an end-of-year position of a £13.5m deficit which is £7.3m ahead of our £20.8m deficit plan<br>• Current expectation is that a gap of circa £4m will remain in the 2023/24 CIP programme. Attention is now being given to developing the £25m 2024/25 programme which as of 25th March showed 25% of schemes were at Gateway 2, 50% at Gateway 1 and 25% were unidentified.<br>• The adverse variance to plan across the ICS was £23.5m YTD but forecasting to deliver a balanced budget at year end<br>• The initial draft of the 2024/25 financial plan shows a worsening deficit position compared to this year even assuming a £25m CIP programme. These plans have currently been developed absent formal national planning guidance and are subject to continuing scrutiny and review both internally and with the ICB |
| **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. |

Elective Recovery Position as of 21/3/24

| Provider | 40 Week Waits | 52 Week Waits | 65 Week Waits | 78 Week Waits | 104 Week Waits |
|---|---|---|---|---|---|
| Airedale | 1,511 | 528 | 90 | 10 | 0 |
| Bradford | 1,895 | 472 | 60 | 4 | 0 |
| Calderdale and Huddersfield | 874 | 45 | 0 | 0 | 0 |
| Leeds | 10,805 | 3,719 | 949 | 176 | 3 |
| Mid Yorks | 5,636 | 1,930 | 477 | 42 | 0 |

# 14. Month 12 Financial Summary

To Note

Presented by Gary Boothby

# 15. Audit and Risk Committee Chair Highlight Report - Emergency Preparedness, Resilience and Response and Business Continuity (EPRR) Annual Report

To Note

Presented by Nigel Broadbent

# CHAIR'S HIGHLIGHT REPORT
# to the Board of Directors

| **Committee Name:** | Audit and Risk Committee (ARC) |
|---|---|
| **Committee Chair:** | Nigel Broadbent, Non-Executive Director |
| **Date of meeting:** | 23 April 2024 |
| **Date of Board meeting this report is to be presented:** | 2 May 2024 |
| **ACKNOWLEDGE** | • As at 31 March 2024 there were no overdue recommendations outstanding from Internal Audit reports and only 2 recommendations have missed their original target dates but not their revised target dates. This was described by Internal Audit representatives as 'exceptionally strong' performance. Although there were 3 limited assurance reports issued by Internal Audit in the final quarter of the year, there were only 4 limited assurance audits during the whole year, a reduction from the previous year and not of particular concern. The Head of Internal Audit is therefore minded to issue an opinion of significant assurance.<br>• All decision makers must submit an annual declaration of interests each year. For 2023/24 the level of compliance was 97%, an increase from 93% the previous year. |
| **ASSURE** | • The Committee asked for a deep dive into business continuity which featured as a risk in some trust Board Assurance Frameworks identified as part of a benchmarking exercise. The Committee received a presentation on the Business Continuity Management System (BCMS) in place within the Trust. The presentation confirmed that the BCMS Policy had recently been reviewed and updated and a set of local KPIs developed to monitor business continuity plans. The Committee was provided with assurance about the arrangements in place but noted the risks around business continuity training and exercises due to the limited capacity available to plan and undertake these. The Committee asked the Resilience and Safety Group and the Risk Group to consider, document and score this risk for inclusion on the appropriate risk register. The Business Impact Analysis which identifies the 5 most critical activities of the Trust for business continuity purposes was approved by the Committee. The Emergency Preparedness Resilience & Response Business Continuity annual report for 2023 was |

| | |
|---|---|
| | approved by the Committee and will be shared with the Board.<br>• The Committee approved the draft Annual Governance Statement for 2023/24, compliance with the Code of Governance for NHS provider trusts, and the annual report and accounts timetable for 2023/24.<br>• ARC self-assessment results on its effectiveness were reviewed and an action plan approved based on the results and a series of objectives for the current year. The action plan had been reviewed against best practice advice included with the new Audit Committee handbook. A change that the annual reports of each assurance committee would be considered by ARC who will provide assurance to the Board. The ARC annual report for 2023/24 was approved by the Committee.<br>• Internal Audit Plan for 2024/25 was approved which includes quality audits on quality of discharge, management of sepsis, dementia and delirium and management of adult patients with a Learning Disability.<br>• KPMG, the Trust's external auditors, presented their audit plan for the 2023/24 financial statements highlighting an update to their VFM risk assessment identifying a potential risk of significant weakness with regards to financial sustainability. KPMG intend to carry out additional work on ensuring that the actions required from the NHSE deep dive into financial sustainability and the arrangements for the 2024/25 financial plan have been implemented. |
| **AWARE** | • Reviewed a checklist of financial controls and governance required by the ICB in support of financial plan submissions for 2024/25 and approved the response to the ICB. The main additional controls required relate to non-pay expenditure.<br>• Three new limited assurance reports were issued by Internal Audit in the final quarter of the year – management of contractors, the Mental Health Act and risk management. The Leads for these areas will be invited to attend the Committee to provide assurances about the implementations of actions agreed in response to the audits.<br>• Approved the terms of reference for the Resilience & Safety Group and the Risk Group.<br>• Approved the annual counter fraud plan for 2024/25 and received a progress report in the current year. |
| **ONE CULTURE OF CARE** | • Positive feedback from the meeting on the discussions around business continuity, thanks to all those people involved in ensuring that there were no audit recommendations overdue at year end. |

**Emergency Preparedness, Resilience and Response and Business Continuity Annual Report: January to December 2023**

## 1. Introduction

NHS providers must plan for, and respond to, a wide range of incidents and emergencies that could affect patient health and delivery of care. Incidents can range from a sustained increase in demand for services (operational pressures), severe weather conditions to an infectious disease outbreak or a mass casualty event. Under the Civil Contingencies Act 2004, NHS organisations and providers of NHS funded care, must show that they can deal with these incidents while maintaining services to patients. Emergency Preparedness, Resilience and Response (EPRR) is the programme of work that supports operational preparedness, incident response and recovery.

The CCA 2004 specifies that responders will be either Category 1 (primary responders) or Category 2 (supporting responders). Calderdale and Huddersfield NHS Foundation Trust (CHFT) is a Category 1 responder. So that it can perform its critical activities in the event of an emergency or business interruption, the CCA 2004 states Category 1 responders are required to:

- Assess the risk of emergencies occurring and use this to inform contingency planning.
- Put in place emergency plans.
- Put in place a business continuity management led process to identify and mitigate risks.
- Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency. Share information with other local responders to enhance co-ordination.
- Co-operate with other local responders to enhance co-ordination and efficiency.

This Annual Report summarises the structures and governance in place to ensure we are ready and able to respond to an emergency, the key activities that have taken place within the reporting period and our compliance with the core standards. It also documents the work that has taken place during the January to December 2023 reporting period to strengthen the EPRR and Business Continuity functions at CHFT.

## 2. Governance

The Resilience, Acute Flow and Transformation (RAFT) directorate was established on 1st April 2023, replacing the former Central Operations directorate. RAFT sits

within the Corporate Division and holds the EPRR and Business Continuity functions.

The Trust's EPRR responsibilities are managed and overseen by:

- Chief Operating Officer – also the Accountable Emergency Officer (AEO)
- Director of Operations for Resilience, Acute Flow and Transformation
- General Manager for Resilience Acute Flow and Transformation
- Trust Emergency Planning Officer

RAFT holds a monthly Governance Group, chaired by the Director of Operations, in which an update on Business Continuity and EPRR is provided. The RAFT Governance Group is also the forum for new EPRR risks to be considered and accepted on to the risk register.

### 2.1 Resilience and Safety Group (Formerly Security and Resilience Governance Group)

The Resilience and Safety Group (RSG) was established in April 2023 and replaced the former Resilience and Security Governance Group (SRGG). The new RSG is Chaired by the Chief Operating Officer and merged together the former SRGG, Fire Safety Response Committee and Health and Safety Committee. RSG meets six times annually (bi-monthly) and is in place to ensure that the Trust complies with the legal requirements of the Civil Contingencies Act 2004 as well as fulfilling its non-statutory obligations under NHS England's Core Standards for EPRR. The RSG invites Trust colleagues including Divisional representatives for the clinical Divisions and partners including CHS Ltd, EQUANS and ISS. It routinely escalates or refers information through the sub-Board Audit and Risk Committee and to the Trust Board.

The EPRR and Business Continuity functions are required to submit and present an assurance report at each RSG. The assurance report gives the opportunity to present the most important updates to the group, highlight actions needed to overcome current issues, request support from the RSG and document upcoming priorities. Details of training and exercises taken place have recently been added to the assurance report template.

RSG is the forum to review EPRR risks scoring 8+, request changes to existing risk scores or propose risks for closure. It is also the forum to present the EPRR Workplan ensuring the group have oversight of the work completed, outstanding actions and compliance against Core Standards.

### 2.2 Audit and Risk Committee and Executive Board

The governance structure from the Resilience and Safety Group is to the sub-Board committee, the Audit and Risk Committee. Escalations or points of note from the RSG are forwarded to the Audit and Risk Committee. All Incident Response Plans

requiring approval go to the Audit and Risk Committee and forward to the Executive Board. The Board of Directors receives the Core Standards position and is kept updated on EPRR matters through updates provided at the Weekly Executive Board meeting.

## 3. Emergency Planning, Resilience and Response (EPRR)

The NHS EPRR Framework (2022) describes emergency preparedness as ‘the extent to which emergency planning enables the effective and efficient prevention, reduction, control, mitigation of and response to incidents and emergencies’. Resilience is described as the ‘ability of the community, services, area or infrastructure to detect, prevent and, if necessary, withstand, handle and recover from incident and emergencies’. Response is described as ‘decisions and actions taken in accordance with the strategic, tactical and operational objectives defined by emergency responders, including those associated with recovery’.

Overall objectives of the EPRR function at the Trust include:

- Embed a positive culture towards EPRR.
- Ensure the statutory requirements of the Civil Contingencies Act (2004) are met.
- Identify and implement preventative actions that reduce the risk of disruption to key services.
- Ensure continuity of essential services when faced with a range of disruptive challenges.
- Ensure the recovery of critical functions and return to normal working as quickly as possible following an incident or service disruption.
- Ensure that plans are aligned with those of partner organisations, including the identification of triggers and protocols for activation of EPRR procedures and arrangements.

### 3.1 Plan and Policy Reviews

The following Incident Response Plans and policies were reviewed during the 2023 reporting period as part of the annual review cycle:

- Major Incident Plan (Incident Response Plan)
- Adverse Weather Plan (Incident Response Plan)
- Evacuation and Shelter Plan (Incident Response Plan)
- Pandemic Flu and Other Novel Viruses Plan (Incident Response Plan)
- Fuel Disruption Plan (Incident Response Plan)
- HAZMAT / CBRN Plan (Incident Response Plan)
- Lockdown Plan (Incident Response Plan)

- EPRR Policy
- Trust Resilience Plan (New document)
- Surge and Escalation Plan including Full Capacity Protocol (New document)

### 3.2 NHS Core Standards for EPRR

In line with the NHS England Emergency Preparedness, Resilience and Response (EPRR) Framework (2022), providers and commissioners of NHS funded services must show they can effectively respond to major, critical and business continuity incidents whilst maintaining services to patients. Providers and commissioners of NHS funded care must provide an annual assurance return for their compliance against the NHS Core Standards for EPRR. The NHS Core Standards for EPRR set out the minimum requirements expected of providers of NHS funded services in respect of EPRR.

The purpose of the NHS Core Standards for EPRR are to enable healthcare provider organisations across the country to share a common approach to EPRR. The standards allow co-ordination of EPRR activities according to the organisation's size and scope, providing a consistent and cohesive framework for EPRR activities. There are mandatory standards in the main section, with a deep-dive topic that changes annually.

In the 2023 EPRR Core Standards a total of 62 core standards are applicable to Acute Trusts. Where a standard is met, the provider can state 'full compliance' (green). Where a standard is not fully met but can be achieved within 12 months, the provider can state 'partial compliance' (amber). Where a standard is not met and cannot be achieved within 12 months, the provider must state 'non-compliance' (red). The 62 Core Standards are set out across 10 different domains, these are:

- Governance
- Duty to risk assess
- Duty to maintain plans
- Command and control
- Training and exercising
- Response
- Warning and informing
- Co-operation
- Business continuity
- Chemical biological radiological nuclear and hazardous material.

### 3.3 Changes to the Core Standards Assurance Process

In 2023 there were changes to the Core Standards for EPRR assurance process in the North East and Yorkshire (NEY) region. The changes have been introduced in recognition of the impact on the EPRR function following a number of serious

incidents and emergencies over the past few years including the UK's exit from the European Union, the Covid-19 pandemic, the lessons identified from the Public Inquiries into the Manchester Arena terror attack and the Grenfell Tower disaster, and a year of widespread industrial action in the NHS.

Piloted in the Midlands region in 2022, the new assurance process is designed to introduce a more rigorous assessment process by an independent panel considering organisational evidence alongside the self-assessment. A 'confirm and challenge' undertaken by an independent panel aims to ensure organisational preparedness is assessed against a dedicated assurance framework which can work to ensure collective system resilience. The revised process is to establish a new baseline assessment on the level of readiness to respond to and recover from incidents and emergencies whilst continuing to deliver critical services. The pilot in the Midlands in 2022 demonstrated that there were substantial differences between the initial self-assessment results and the final level of compliance following evidential review of the organisation's documentation. In 2023, three out of the seven regions in England have adopted this revised process; the Midlands, North East and Yorkshire and the North West. The remaining 4 regions of England will continue with the assessment process as prior and so it is highly likely that there will be a differential in the compliance levels between those regions undertaking the new process and those under the old.

Alongside the national NHS England EPRR Core Standards documentation, an additional NEY Assessment Guidelines document was issued setting out an extensive set of compliance requirements against each Core Standard that had to be met to achieve full compliance.

### 3.4 Initial Self-Assessment

The initial self-assessment completed for 2023 returned a score of 85% equating to 'partial compliance'. Within the first self-assessment, 53 indicators were 'fully compliant', 9 indicators 'partially compliant' and 0 'non-compliant'. In the deep-dive, 9 indicators self-assessed as 'fully compliant' with 1 indicator 'partially compliant'. Table 1 shows the 2023 initial self-assessment position.

**Table 1 – 2023 Self-Assessment Position**

| Domain | Total Applicable Standards | Fully Compliant | Partially Compliant | Non Compliant | Not Applicable |
|---|---|---|---|---|---|
| **Governance** | 6 | 3 | 3 | 0 | 0 |
| **Duty to risk assess** | 2 | 1 | 1 | 0 | 0 |
| **Duty to maintain plans** | 11 | 2 | 9 | 0 | 0 |
| **Command and control** | 2 | 0 | 2 | 0 | 0 |
| **Training and exercising** | 4 | 0 | 4 | 0 | 0 |
| **Response** | 7 | 4 | 3 | 0 | 0 |
| **Warning and informing** | 4 | 0 | 4 | 0 | 0 |

| Cooperation | 4 | 1 | 3 | 0 | 3 |
|---|---|---|---|---|---|
| Business continuity | 10 | 4 | 6 | 0 | 1 |
| Hazmat/CBRN | 12 | 4 | 8 | 0 | 7 |
| **Total** | **62** | **19** | **43** | **0** | **11** |

| Deep Dive | Total Applicable Standards | Fully Compliant | Partially Compliant | Non Compliant | Not Applicable |
|---|---|---|---|---|---|
| EPRR Training | 10 | 9 | 1 | 0 | 0 |
| **Total** | **10** | **9** | **1** | **0** | **0** |

| Percentage Compliance | 85% |
|---|---|
| Overall Assessment | Partially Compliant |

### 3.5 Check and Challenge – Primary Evidence Review

Following submission of the initial self-assessment and upload of the primary evidence, NEY Regional EPRR team undertook a review and returned the first check and challenge findings. The first review returned a position in which 43 (of the overall 62 applicable standards) had been ‘challenged’ and 19 standards were ‘accepted’ against the self-assessment. Of the 43 standards challenged, 41 were challenged from fully complaint (green) down to partially compliant (amber); and 2 standards were challenged from a status of fully compliant (green) down to non-compliant (red). No standards were upgraded.

### 3.6 Check and Challenge - Supplementary Evidence Review

Supplementary evidence was uploaded for 24 of the 43 challenged standards within the required timeframe of 5 working days. This included supplementary evidence for the two standards challenged down to non-compliant (red). 19 of the 43 ‘challenged’ standards were accepted. This was agreed with the Accountable Emergency Officer (AEO) in advance of the secondary submission back to the Regional EPRR team.

### 3.7 Confirm and Challenge – Outcome Findings

Following review of the supplementary evidence uploaded, the NEY Regional EPRR panel returned the final confirm and challenge findings in which 8 standards with supplementary evidence provided were now ‘accepted’. This included the two standards downgraded on primary evidence review to non-compliant (red). One was upgraded on secondary evidence review to partial compliance (amber) and the second was upgraded to fully compliant (green).

The final findings of the confirm and challenge process returned an overall compliance rating as ‘non-compliant’ with a compliance percentage score of 31%. The overall assessment concluded 19 standards at fully compliant (green), 43 standards at partial compliant (amber) and 0 non-compliant (red) standards.

The findings of the confirm and challenge assessment (31%) differs significantly to the initial self-assessment (85%), however this is consistent with other organisations across West Yorkshire. All West Yorkshire organisations have seen a significant reduction in their compliance assessment scores following this process, including the West Yorkshire Integrated Care Board (ICB).

The confirm and challenge final assessment position is shown below in Table 2. A Statement of Compliance documenting the 'non-compliant' rating was submitted to NHS England by the Chief Operating Officer on 29 September 2023.

**Table 2 – 2023 Confirm and Challenge Final Assessment**

| Domain | Total Applicable Standards | Fully Compliant | Partially Compliant | Non Compliant | Not Applicable |
|---|---|---|---|---|---|
| **Governance** | 6 | 3 | 3 | 0 | 0 |
| **Duty to risk assess** | 2 | 1 | 1 | 0 | 0 |
| **Duty to maintain plans** | 11 | 2 | 9 | 0 | 0 |
| **Command and control** | 2 | 0 | 2 | 0 | 0 |
| **Training and exercising** | 4 | 0 | 4 | 0 | 0 |
| **Response** | 7 | 4 | 3 | 0 | 0 |
| **Warning and informing** | 4 | 0 | 4 | 0 | 0 |
| **Cooperation** | 4 | 1 | 3 | 0 | 3 |
| **Business continuity** | 10 | 4 | 6 | 0 | 1 |
| **Hazmat/CBRN** | 12 | 4 | 8 | 0 | 7 |
| **Total** | **62** | **19** | **43** | **0** | **11** |

| | |
|---|---|
| **Percentage Compliance** | **31%** |
| **Overall Assessment** | **Non-Compliant** |

## 3.8 Core Standards Action Plan

The confirm and challenge process has highlighted gaps within the Trust's level of preparedness. All standards rated partially complaint have been compiled into an Action Plan (with timescales and owners) which will be used to manage a programme of continuous improvement over the next 12 months. The action plan has been prioritised into 1, 2 and 3 actions:

- **Priority 1** actions are locally controlled actions and should be completed by end April 2024
- **Priority 2** actions are locally controlled actions which are expected to take at least 8 months to achieve and therefore should be completed by end August 2024

- **Priority 3** actions have an interdependency with other agencies and therefore are to some degree reliant upon other organisation's action plans (i.e. the ICB). These should be completed by end August 2024

The EPRR function and delivery of actions will be strategically led by the General Manager for Resilience, Acute Flow and Transformation managing the overall cycle of improvement works. Progress and accountability against action plan will be monitored locally by the Accountable Emergency Officer, reported to Executive Board on a quarterly basis (or more frequently if requested to do so) and reviewed at the quarterly LHRP meetings.

It is recognised that whilst striving to improve the overall level of compliance for the 2024 assessment, maintenance of the standards assessed as fully compliant increases the challenges on the EPRR function.

## 4. BUSINESS CONTINUITY MANAGEMENT SYSTEM

BCMS is a management-led process that identifies risks and disruptions that could affect the capability of the organisation to continue to deliver its critical activities and services during a disruptive incident. Risks and threats are identified within the Business Continuity Plan (BCP) with supporting tactical options to mitigate the impact are documented. A supporting Business Impact Analysis (BIA) that sits alongside the BCP determines target recovery timescales for part-service and full service recovery.

The Business Continuity Management System (BCMS) developed significantly during 2023 following some focussed work and the Trust now holds over 80 Business Continuity Plans for Divisional services and departments, with over 90% having a supporting Business Impact Analysis document. Tracking of Business Continuity Plan expiry dates and progress to review documents is contained within the EPRR Annual Workplan. A set of new Key Performance Indicators (KPIs), developed in late Autumn of 2023, is in place and performance was first reported at the Resilience and Safety Group in December 2023. The KPIs are as follows:

The BCMS KPIs are:

1) Between 95-100% of services that require a BCP have a Plan in place
2) Between 95-100% of BCPs have a supporting BIA
3) At least 90-95% of BCPs are in date at any one time (accounts for the natural cycle of expiring on an annual basis and requiring review)
4) At least 50% of BCPs have a business continuity exercise conducted per year.

5) At least 90-95% of BCPs are within the three-month timescale for conducting annual review and re-approval of a BCP and BIA, post annual expiry date.
6) The Trust promotes Business Continuity Week each year.
7) BCMS KPIs are discussed and recorded at Resilience and Safety Group and documented in the EPRR Annual Report.

The KPI performance in December 2023 is shown in Table 3. Performance will continue to be reported in 2024.

**Table 3 – Business Continuity KPIs in December 2023**

| | Dec-23 |
|---|---|
| **KPI 1** | 95% |
| **KPI 2** | 92% |
| **KPI 3** | 77% |
| **KPI 4** | Not compliant |
| **KPI 5** | 77% |
| **KPI 6** | 100% |
| **KPI 7** | Dec -23 1st report |

Green – On or above target
Amber – Up to 10% below target
Red – More than 10% below target

It is recognised that the undertaking of facilitated Business Continuity exercises falls significantly short of the KPI target (KPI 4). A new Testing and Exercising Framework will be developed for 2024/25 and will consider the best way to conduct exercises throughout the year, including Business Continuity exercises.

Business Continuity training is not currently offered at CHFT as a standard. There is an e-learning programme on the Trust intranet however the content is now out of date and therefore not considered to be suitable.

## 5. CONTINUOUS IMPROVEMENT THROUGH LEARNING, TRAINING AND EXERCISE

As a Category 1 Responder under the CCA 2004, CHFT is required to undertake, at a minimum, the following exercise programme:

- 6 monthly communications tests.
- Annual Table-top exercise

- A three-yearly live exercise (activation of the Trust policy during this time will act as a live exercise if appropriate debriefing and lesson learning can be demonstrated)

### 5.1 Communication Tests

Communication tests were carried out at CHFT in April, July and October 2023. All tests were carried out without the participants knowing in advance that there was to be a communications test. The aim of the exercises was to evaluate the time taken by those on-call to answer and the relay of messages over the telephone. The tests also help to confirm correct telephone numbers are held.

On 23rd April and 17th July 2023, Switchboard tested the call answer to the on-call teams. This included first on-call (Clinical Site Matron), second on-call (Director), Community On-call and the duty manager for ISS (the soft facilities provider at CRH). Logs of the call answer test were submitted as evidence for the NHS Core Standards for EPRR in 2023.

On 18th October 2023, a full 'Major Incident Call Cascade' test was conducted for the first time. The call cascade diagrams had been agreed as part of the revision of the Major Incident Plan in August 2023. Follow ups were made to a random selection of people on the call cascade to check if a call had been received, the detail provided in the call and to check for onward cascade.

Following the communication test, call cascades were amended slightly following feedback. This included scaling down the cascade and also removed the 'stand-by' cascade. A further test will be carried out in April 2024.

### 5.2 Table-top Exercises

A range of table-top exercises have been conducted during 2023, mainly testing the principles within Business Continuity Plans (BCPs). Each table-top exercise prepared and facilitated by the RAFT team includes a PowerPoint presentation with a scenario, injects and probing questions. A post-exercise report with actions is produced with actions, timescales and owners tracked on the EPRR Workplan.

The following table-top exercises have been undertaken in 2023:

- Major Incident table-top with Clinical Site Matrons and Clinical Commanders
- Emergency Department BCP Exercise
- Nerve Centre BCP Exercise
- ISS / EQUANS BCP / JERP Exercise
- Estates / Medical Engineering BCP Exercise
- Procurement (CHS) BCP Exercise

- Catering (CHS) BCP Exercise
- Transport (CHS) BCP Exercise

An energy resilience table-top exercise was also prepared for services to undertake themselves without the need for facilitation by the RAFT team. This exercise was prepared to include a scenario withy injects, an action plan and a supporting workbook. Some clinical services including Radiology conducted this table-top exercise in 2023 and it remains available for ongoing use.

### 5.3 HAZMAT Tent Drill Tests

HAZMAT tent tests were conducted at both sites in 2023. On 6th July 2023 the CRH tent was tested and on 1st November 2023 the HRI tent was tented. This included putting the tent up and checking the equipment. Based on the tent tents, action plans were created and new equipment was ordered as necessary.

Table 4 shows the replacement HAZMAT equipment purchased in 2023 following tent tests.

**Table 4 – Replacement HAZMAT Equipment Purchased in 2023**

| Purchase Order date | Item | Price (£) |
|---|---|---|
| 27/03/2023 | Filters for PRPS Suits | 235.43 |
| 19/04/2023 | Filters for PRPS Suits | 488.64 |
| 04/07/2023 | HRI Tent Service | 625.00 |
| 27/07/2023 | Following Tent Test at CRH | 1007.44 |
| 19/08/2023 | Filters for PRPS Suits | 625.00 |

### 5.4 RAFT Development Days

RAFT Development days were delivered on 21st and 27th June 2023. These full day sessions were for the learning and development of Clinical Site Matrons and Clinical Commanders, many who were relatively new in post, to learn and develop skills in major incident management and response. The development days included a learning on Command and Control, Counter Terrorism (delivered by Counter Terrorism Policing), Fire Safety including a plantroom walkaround at CRH and a scenario based Major Incident table-top exercise.

The days were well evaluated and will be repeated with different learning topics in 2024.

### 5.5 Strategic and Tactical Incident Commander Training

All Strategic and Tactical Commanders are required to undertake training in incident management and response. The ICB have produced a (draft) Training Needs Analysis (TNA) and at CHFT we have commenced training logs against competencies set out in the Minimum Occupational Standards 2022 and the TNA for all Strategic and Tactical Commanders. These are retained within the EPRR Workplan and monitored by the EPRR team within RAFT.

In 2023, all Strategic (except one Executive Director due to a cancelled course in December 2023) and Tactical Commanders undertook the NHS Principles of Health Command online training provided by NHS England. Other courses attended by incident commanders have included media awareness training attended by some Executive Directors, Legal awareness training attended by the Chief Operating Officer and JESIP training attended by the Director of Operations. The General Manager for RAFT completed the Level 4 Award in Health Emergency Preparedness, Resilience and Response awarded by RSPH and was awarded 100% on final assignment.

### 5.6 Loggist Training

The Trust Emergency Planning Officer has run 3 Loggist training sessions during 2023. Full day sessions took place in June, October and November. The Trust now has 13 trained loggists.

### 5.7 Multi-agency Exercises

Engagement in multi-agency exercises off-site is important to ensure the RAFT team are kept up to date with multi-agency response plans to incidents and emergencies. In 2023 attendance the following multi-agency exercises were attended:

- **Synergy 8 - EPRR Resilience Direct Exercise (22 February 2023)**
  A half-day exercise was hosted by Kirklees Council and conducted in an online table-top style. Each participating organisation was part of a scenario response exercise using Resilience Direct. 3 scenarios were sent to players to respond to using the Resilience Direct system between 09:30 and 15:00

- **Major Incident Test – Mid Yorkshire Hospitals NHS Trust (29th June 2023)**

This exercise was run by The Mid Yorkshire Hospitals NHS Trust and included multi-agency partners including Yorkshire Ambulance Service. It was a live exercise which tested their Major Incident Plan. It was attended by the General Manager of RAFT and the Trust Emergency Planning Officer in capacity of observers.

- **West Yorkshire ICB Winter Exercise (11 October 2023)**
  The General Manager for RAFT had been involved in the build of this exercise which was hosted by WY ICB and attended by the General Manager. The exercise was delivered on MS Teams and included partners from across West Yorkshire. The exercise focussed on testing out winter plans including adverse weather.

- **Exercise CDale and Exercise Synergy 9 (17 October 2023)**
  These two exercises took place on the same day. Exercise CDale was a full day exercise hosted by Calderdale Council and attended by the General Manager of RAFT. It was a multi-agency adverse weather exercise with partners from across the West Yorkshire Local Resilience Forum (LRF). Exercise Synergy 9 was a half day exercise hosted by Kirklees Council and attended by the Trust Emergency Planning Officer. It was an exercise to test severe weather and infectious disease outbreak plans and included partners from across health and social care in Kirklees.

- **COMAH Tactical Exercise High Noon (6th December 2023)**
  This COMAH exercise was hosted by West Yorkshire Fire and Rescue Service and Verdant Speciality Solutions Ltd. It tested COMAH response and included WY ICB and other system partners. The General manager for RAFT attended as an observer to the exercise.

### 5.8 Learning from Exercises

Exercises are an important tool to test and validate plans and highlight gaps in procedures or need for mitigations. Upon every exercise planned and facilitated in-house by the EPRR team, a post-exercise report is developed and circulated. The report contains a summary of the exercise and documents recommendations and actions with timescales and owners. A schedule of these recommendations and actions is held on the EPRR Workplan on the ‘Action Learning from Exercises’ tab. Actions are followed up by the Trust Emergency Planning Officer and marked as outstanding or complete.

## 6. PARTNERSHIP WORKING

Engagement in partnership working extends beyond the attendance at exercises. Some of the forums that the Trust engages in to ensure partnership working in relation to EPRR matters are summarised:

- **Calderdale Gold Meeting**
  Attended by the General Manager for RAFT and/or the Director of Operations for RAFT, this meeting brings together multi-agency partners across Calderdale to discuss matters at a Gold level. The meetings was bi-weekly at the start of 2023 however has now dropped to quarterly intervals. An updated is provided at each meeting by the Trust representative emergency planning or operational matters.

- **Local Health Resilience Partnership**
  The Trust has a requirement to attend the LHRP to ensure compliance with the Core Standards. The LHRPs take place quarterly and each has been attended by the General Manager of RAFT. The Chief Operating Officer also attended the LHRP in September 2023.

- **System Silver Calls**
  The WY ICB system puts in system Silver calls to deal with operational matters affecting both Acute providers and community providers. The Director of Operations for RAFT attends the system Silver calls.

- **West Yorkshire Industrial Action Touchpoints**
  During periods of industrial action, the WY ICB put into place daily Touchpoint meetings for all WY health providers. These calls are scheduled for 3 or 4 times per day for every day of the industrial action. There are also pre-planning meetings prior to the start of the industrial action. The meetings have been attended by at least one of the following, the Chief Operating Officer, the Director of Operations for RAFT, the General Manager for RAFT.

## 7. INCIDENT RESPONSE

There were no Major Incidents or Critical Incidents declared by the Trust in 2023. Events that the Trust did deal with included industrial action and escalation to Operational Pressure Escalation Level (OPEL) 4.

### 7.1 Industrial Action

CHFT was not affected by the Royal College of Nursing (RCN) industrial action but was directly affected by industrial action taken by the British Medical Association (BMA) industrial action taken by Junior Doctors and Consultants in 2023.

Table 5 shows the dates of the industrial action by Junior Doctors, Consultants and joint strikes.

**Table 5 – Dates of Strike Action 2023**

| Junior Doctor Strike | Consultants Strike | Joint Junior Doctor and Consultant Strike |
|---|---|---|
| 13 – 15 March 2023 | 20 – 21 July 2023 | 19 – 22 September 2023 |
| 11 – 14 April 2023 | 24 – 25 August 2023 | 2 – 5 October 2023 |
| 14 – 17 June 2023 | | |
| 13 – 17 July 2023 | | |
| 11 – 14 August 2023 | | |
| 20 – 23 December 2023 | | |

Planning for industrial action involved colleagues from across all Divisions and was led by the Chief Operating Officer. Planning meetings were typically scheduled for 1 hour usually taking place 3 times a week. The Chief Operating Officer chaired the meetings that were joined by Executive Directors, Directors of Operations, Divisional and Clinical Directors and a Clinical Site Matron. The Trust Emergency Planning Officer recorded notes and action logs at each planning meeting.
For every period of industrial action, an Industrial Action Response Plan was developed. This contained information including Command and Control arrangements for during the action, rotas and escalation contacts. A Frequently Asked Questions document was also developed and updated as information from Unions was released.

During industrial action, Trust Touchpoint meetings were scheduled to take place. Initially, during the earlier strikes, these touchpoint meetings took place 3 times a day. In the latter strikes, these were reduced to twice a day at 08:30 and 16:00. Attendance was also made to the West Yorkshire industrial action touchpoint meetings.

Industrial action presented pressures to operational teams during the planning rounds and to those colleagues covering additional or longer shifts. The Trust thanked colleagues through forums including CHFT Live and on screensavers for their hard work to keep patient safe and services running during the strike action. Despite the workforce challenges, the strikes were well managed and did not lead to a critical incident being declared for operational pressures or the need to submit derogation requests for a return to work.
Debriefs have taken place post the industrial action periods to capture what went well, what could have been improved and learning that can be implemented.

### 7.2 Operational Pressures

Operational Pressure Escalation Level (OPEL) is the framework used across the NHS to record operational pressure levels in an organisation. NHS England describes OPEL as a unified, systematic and structured approach and assessment of acute hospital urgent and emergency care operating pressures.

The new national NHSE OPEL Framework replacing all previous versions was released in August 2023, revised in October 2023 and to be implemented within Trusts in November 2023. CHFT had a local OPEL framework which was replaced with the publication of this new national OPEL Framework to be consistent with other acute hospital providers.

CHFT first declared OPEL 4 (the highest OPEL level) in December 2022. During 2023, the Trust declared OPEL 4 on a few occasions, though de-escalated to OPEL 3 usually within 24 – 48 hours of the declaration. OPEL 4 brings challenges to operational colleagues as it requires a change in working practices and extra capacity areas open will put pressure on staffing models. Trust OPEL action cards request that at OPEL 4, non-urgent meetings are stood down and operational colleagues work more closely with site management teams. Site Management meetings should be well attended to ensure actions can be allocated to a range of staff both clinical and non-clinical. Safety for patients and maintaining Trust critical activities remains paramount at all times.

During high OPEL 3 / OPEL 4 the Trust has stood up operational Command and Control which has included a Strategic/Gold Command for operational pressures. Whilst high operational pressures bring challenges and adds to workforce pressures, the Trust did not need to declare a critical incident due to operational pressures during 2023.

## 8. RISKS

The management of EPRR risks improved in 2023 with existing risks being updated or closed as appropriate, and new risks being added. Table 6 summarises the EPRR risks logged on the risk register in 2023:

**Table 6 – Active EPRR Risks (2023)**

| Risk Number | Owner | Summary | Rating |
|---|---|---|---|
| 8626 | General Manager RAFT | Risk of structural collapse due to RAAC at Airedale Hospital resulting in loss of estate, casualties or inpatient transfers | 3 |

| 8628 | General Manager RAFT | Risk of severe weather causing damage to estate and disruption to utilities | 6 |
|---|---|---|---|
| 8629 | General Manager RAFT | Risk of failure of utilities at the Trust | 6 |
| 8630 | General Manager RAFT | Risk of Major Incident being declared at the Trust or a mass casualty event | 4 |
| 8676 | General Manager RAFT | Risk that incident management training is not mandatory for all staff | 9 |

**Proposed for Acceptance EPRR Risks (2023)**

| Risk Number | Owner | Summary | Rating |
|---|---|---|---|
| 8709 | General Manager RAFT | Non-compliant core standards assessment 2023 | 6 |

## 8 PRIORITY AREAS FOR 2024

### 8.1 Core Standards Compliance

Working to achieve greater compliance against the Core Standards is of the highest priority for 2024. A comprehensive action plan has been put into place with actions, timescales and owners. The overall aim is to work to achieve as close to partial compliance (>=77%) as possible. Updates against action plan will be provided to the Executive team on a quarterly basis throughout 2024.

### 8.2 Exercise and Training

The Trust is committed to training and developing colleagues in incident response and incident management. A Training and Exercise Programme for 2024/25 will be developed.

Training and learning will continue in 2024 with sessions planned for the Executive team and senior leaders in March 2023 and an exercise for the same group in April 2024. Development sessions will be planned again for the Clinical Site Matrons and Clinical Commanders, with roll out of training to other operational leaders too.

Facilitated exercises will continue to take place along with attendance at multi-agency exercises hosted by other organisations.
Training to comply with the Minimum occupational Standards will continue for Strategic and Tactical Commanders will be planned in accordance with the Training Needs Analysis issued by the ICB, once finalised.

### 8.3 Maintaining Plans and Policies

Incident Response Plans and Policies will be maintained in line with the annual review cycle. A new Command and Control Framework will be developed and issued in 2024.

### 8.4 Business Continuity Management System (BCMS)

The BCMS will continue to be developed, with a focus on achieving or improving the performance against KPIs. Testing and exercising will be a priority for business continuity. Global Business Continuity Week will be promoted in 2024 (13th to 17th May 2024). A Business Continuity Working Group will also be established to support the delegation and management of actions and recommendations within Divisional services.

# 16. Integrated Performance Report

To Note

Presented by Jonathan Hammond

| Date of Meeting: | Thursday 2nd May 2024 |
|---|---|
| Meeting: | Public Board of Directors |
| Title: | Quality & Performance Report |
| Author: | Peter Keogh, Assistant Director of Performance |
| Sponsoring Director: | Jonny Hammond, Chief Operating Officer |
| Previous Forums: | Finance & Performance Committee, Executive Board |
| Purpose of the Report | To provide the Board of Directors with a single combined narrative that seeks to triangulate current performance for the month of March 2024. |
| Key Points to Note | **Performance Summary**<br>**Quality** indicators: SHMI performance has seen an increase for the latest 12 month rolling release and shows performance of 105.20. The site breakdown shows HRI at 103.52 and CRH 107.81. Month on Month performance has declined in December with performance standing at 114.43. Performance remains within the expected range in the latest release and CHFT now sits above this national position however remains comfortably within the expected range nationally. A new 'mortality prediction' tool has been developed to closely replicate the HSMR calculation for live Trust data. This can be used to help forecast where CHFT's HSMR performance is likely to go in the coming data releases and would give a heads-up 3 months in advance of national releases.<br><br>There was 1 MRSA Bacteraemia case infection during March which was the first since December 2022.<br>There were 54 (36 HOHA - Hospital-Onset Healthcare-Associated, 18 COHA – Community-Onset HA) C.difficile infections in 2023/24 against a ceiling of 37. The data now reflects the inclusion of COHA data.<br>There were 72 (30 HOHA, 42 COHA) E.coli infections in 2023/24 against a ceiling of 67 again reflecting the inclusion of COHA data.<br><br>% of complaints closed on time (target 95%) was 76% in March (15 percentage point drop) although this has remained within statistical control limits. On review it has been identified that the quality of responses and end-to-end sign-off processes have impacted on performance; both have been escalated.<br><br>% of adult patients that receive a MUST assessment within 24 hours of admission/transfer to the ward continues its improvement in year. Care of the acutely ill patient (% of patients with a NEWS2 |

| | of 5+ will not have a higher score during their episode of care) – has again improved performance in-month.<br><br>We have performed well in terms of **elective recovery** throughout 2023/24 with just 17 (ENT 10) 52-week waits at the end of March. We had 740 (90 non-ENT) 40-week waits at the end of March. This needs to be considered in context when compared to regional and national peers who are struggling to meet 65 weeks for ENT.<br><br>The plan is to maintain RTT at 40 weeks (ENT 52 weeks) and ASIs at 18 weeks (ENT 40 weeks) for 2024/25.<br><br>For **diagnostics** we have had challenges around staffing in Echo and Neurophysiology although we have seen improvements as we moved into 2024/25 in both areas over recent weeks pushing our overall Trust position above 90% (for those seen within 6 weeks).<br><br>The plans to reduce the **follow-up** backlog is still a priority following the deep dives into each specialty where we have already seen improvements in the booking process which has led to reductions in individual specialty numbers with further improvements expected. There are plans to revisit specialties where improvements have not been as expected.<br><br>**Day Case Rates** - Utilising the new Model Hospital measure (which includes those procedures completed in Outpatients) CHFT has consistently achieved above 91% against an 85% target for 2023/24.<br><br>**Capped Theatre Utilisation** at over 81% has also been recognised as the best performance in WYAAT just below the 85% target.<br><br>**Cancer** performance has been excellent throughout the year and has been recognised nationally in the media. From April 2023 to February 2024 month on month CHFT was the best performing acute Trust (out of 119) in England for Cancer 62-day referral to treatment for 8 out of 11 months (2nd best in other 3 months). We continued to achieve the 3 key cancer metrics in March.<br><br>**ED** performance - a collaborative effort between teams across CHFT saw ED performance significantly improve during the month of March 2024. 76.79% of patients were admitted, transferred or discharged within four hours which equated to the Trust being placed 6th out of 119 acute Trusts for type 1 attendances with only 2 other Trusts with a higher number of ED attendances finishing above. This is despite high TOC numbers and bed occupancy although we have seen a drop in the number of patients waiting over 12 hours in ED.<br><br>ED attendances for both hospital sites during 2023/24 continued to increase with a 14% rise in numbers attending compared to 2019/20. Along with increased attendances, acuity/dependency was significantly high and led to some very challenging operational issues which had an impact on the 4-hour ECS performance and increased numbers of patients waiting above 12 hours in both |
|---|---|

| | |
|---|---|
| | emergency departments and our bed occupancy which in turn resulted in high OPEL scoring. Although we saw an increase in ED attendances these have not necessarily translated into emergency admissions which were actually 11% below the same period in 2019/20. Overall acuity at Trust level for all non-elective admissions has increased by 19% compared to 2019/20 which has impacted on bed pressures, length of stay etc.<br><br>Proportion of **ambulance arrivals** delayed over 30 minutes has increased in March to 8% despite the ED achievement. The key change from October is the use of arrival destination as the trigger for when the clock starts which removes any notify times previously used. We have committed to an average of 23.5 minutes for 2024/25.<br><br>***Performance Matrix Metrics Changes*** *(green improvement, purple deterioration).*<br>• *Day Case Rates – achievement noted above.*<br>• *Total Patients waiting > 40 weeks – noted above.*<br>• *Proportion of Urgent Community Response Referrals reached < 2 hours – improvement in month.*<br>• *Virtual Ward – continuously not achieving.*<br>• *% of patients that receive a diagnostic test within 6 weeks (Learning Disability) – improvement in month.*<br>• *% of patients that receive a diagnostic test within 6 weeks (IMD 1 and 2) – improvement in month.*<br>• *ED Proportion of patients seen within 4 hours – achievement noted above.*<br>• *ED Proportion of patients seen within 4 hours (IMD 1 and 2) – noted above.*<br>• *ED Proportion of patients seen within 4 hours (Learning Disability) – noted above.*<br>• *Proportion of patients spending more than 12 hours in ED – number of points above the mean.*<br>• *E.Coli infection Rate – as noted above.*<br>• *Non-site-specific cancer referrals – SPC movement.* |
| **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 March 2024. |

# Integrated Performance Report
# March 2024

Report produced by

# Contents: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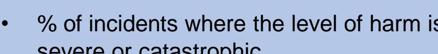
# Performance Matrix Summary:

**Note:**
Improvement in matrix position
Deterioration in matrix position

**Matrix Key**
High Improvement
Improvement
Neutral
Concern
High Concern

## ASSURANCE

| VARIANCE | PASS | HIT or MISS | FAIL |
|---|---|---|---|
| **SPECIAL CAUSE IMPROVEMENT** | • Staff Movement (Turnover)<br>• Core EST Compliance<br> | • Total Patients waiting > 62 days for cancer treatment compared with February 2020<br>• Proportion of patients meeting the faster diagnosis standard<br>• ED Proportion of patients seen within 4 hours | |
| **COMMON CAUSE/NATURAL VARIATION** | • % of incidents where the level of harm is severe or catastrophic<br>• Total Patients waiting >52 weeks<br>• Total Patients waiting >65 weeks<br>• Day Case Rates<br>• Patients dying within their preferred place of death | • Summary Hospital-level Mortality Indicator<br>• Falls per 1,000 Bed Days<br>• CHFT Acquired Pressure Ulcers per 1,000 Bed Days<br>• MRSA Bacteraemia Infection Rate<br>• C. Difficile Infection Rate<br>• E. Coli Infection Rate<br>• Number of Serious Incidents<br>• % of complaints within agreed timescale<br>• Total Patients waiting >40 weeks<br>• Total Patients waiting >40 weeks (Learning Disability)<br>• Total Patients waiting >40 weeks (IMD 1 and 2)<br>• Diagnostic activity undertaken against activity plan<br>• Capped Theatre utilisation<br>• Non-site-specific cancer referrals<br>• Stillbirths per 1,000 total births<br>• Proportion of Urgent Community Response referrals reached < 2 hours<br>• Proportion of patients meeting the faster diagnosis standard (Learning Disability)<br>• % of patients that receive a diagnostic test within 6 weeks (Learning Disability)<br>• ED Proportion of patients seen within 4 hours (IMD 1 and 2)<br>• Proportion of patients meeting the faster diagnosis standard (IMD 1 and 2)<br>• % of patients that receive a diagnostic test within 6 weeks (IMD 1 and 2)<br>• Sickness Absence (Non-Covid) | • % of patients with a NEWS2 of 5+ that do not go on to have a higher score<br>• % of adult patients that receive a MUST assessment within 24 hours of admission/transfer to the ward.<br>• % of patients that receive a diagnostic test within 6 weeks<br>• Early Cancer Diagnosis<br>• Bed Occupancy<br>• % of beds occupied by patients who no longer meet the criteria to reside<br>• ED Proportion of patients seen within 4 hours (Learning Disability)<br>• % Outpatient DNAs (Learning Disability)<br>• % Outpatient DNAs (IMD 1 and 2) |
| **SPECIAL CAUSE CONCERN** | • No KPIs | • Total RTT Waiting List<br>• Proportion of patients spending more than 12 hours in ED<br>• Hospital Discharge Pathway Activity<br>• Virtual Ward | • Proportion of ambulance arrivals delayed over 30 minutes<br>• Transfers of Care |

*Not included in table – Finance, elective activity, follow-up activity, Community WL, Admission avoidance, neonatal deaths. Maternity workforce, Number of Never Events, Care Hours per Patient Day (CHPPD), Appraisal Compliance, Bank and Agency Spend*

# Safe, High Quality Care

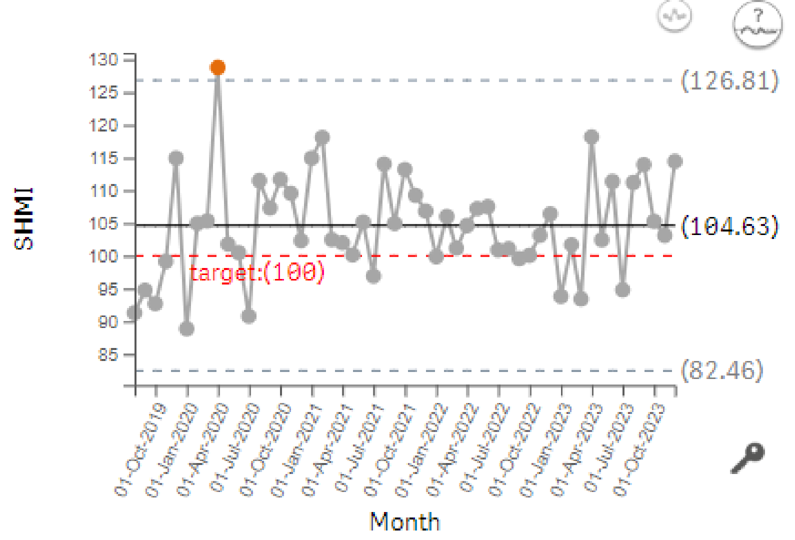
| Metric | Latest Month | Measure | Target | Variation | Assurance | Mean | Lower process limit | Upper process limit |
|---|---|---|---|---|---|---|---|---|
| Summary Hospital-level Mortality Indicator | December 2023 | 105.20 | 100 | | ? | 104.63 | 82.46 | 126.81 |
| Care Hours Per Patient Day (CHPPD) | March 2024 | 8.9/7.8 | - | - | - | - | - | - |
| Falls per 1000 Bed Days | March 2024 | 7.8 | 7.02 | | ? | 7.77 | 5.73 | 9.81 |
| CHFT Acquired Pressure Ulcers per 1000 Bed Days | February 2024 | 1.85 | 1.76 | | ? | 1.70 | 0.92 | 2.48 |
| MRSA Bacteraemia Infection | March 2024 | 1 | 0 | - | - | - | - | - |
| C.Difficile Infection | March 2024 | 4 | 3.1 | | ? | 4.11 | 0 | 11.71 |
| E.Coli Infection | March 2024 | 4 | 5.6 | | ? | 5.94 | 0 | 12.68 |
| Number of Never Events | March 2024 | 0 | 0 | - | - | - | - | - |
| Number of Serious Incidents | March 2024 | 4 | 0 | | ? | 3.31 | 0 | 8.93 |
| % of incidents where the level of harm is severe or catastrophic | March 2024 | 0.82% | 2% | | P | 0.81% | 0% | 1.83% |
| % of complaints within agreed timescale | March 2024 | 76% | 95% | | ? | 89.61% | 71.72% | 100% |

# Summary Hospital-level Mortality Indicator

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

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

**Target:**
100




**What does the chart show/context:**

- CHFT SHMI performance has seen an increase for the latest 12 month rolling release and shows performance of 105.20 and has risen back over the 100 mark.
- The site breakdown shows HRI at 103.52 and CRH 107.81.
- Month on Month performance has declined in December with performance standing at 114.43.
- Performance remains within the expected range in the latest release.
- The latest national SHMI position stands at 98.05 and CHFT now sits above this national position however remains comfortably within the expected range nationally.

**Underlying Issues:**

- This declining position in CHFT's performance seen in August and September 2023 is largely been driven by performance within the 122 – Pneumonia CCS group. A review was undertaken to establish any quality-of-care concerns. There were 2 cases that were assigned as 'poor' care, these were datixed.
- There has been a slight reduction in observed deaths on a national basis this does not seem to have been replicated within the CHFT datasets. Therefore, this is affecting CHFT's expected deaths figures.

**Actions:**

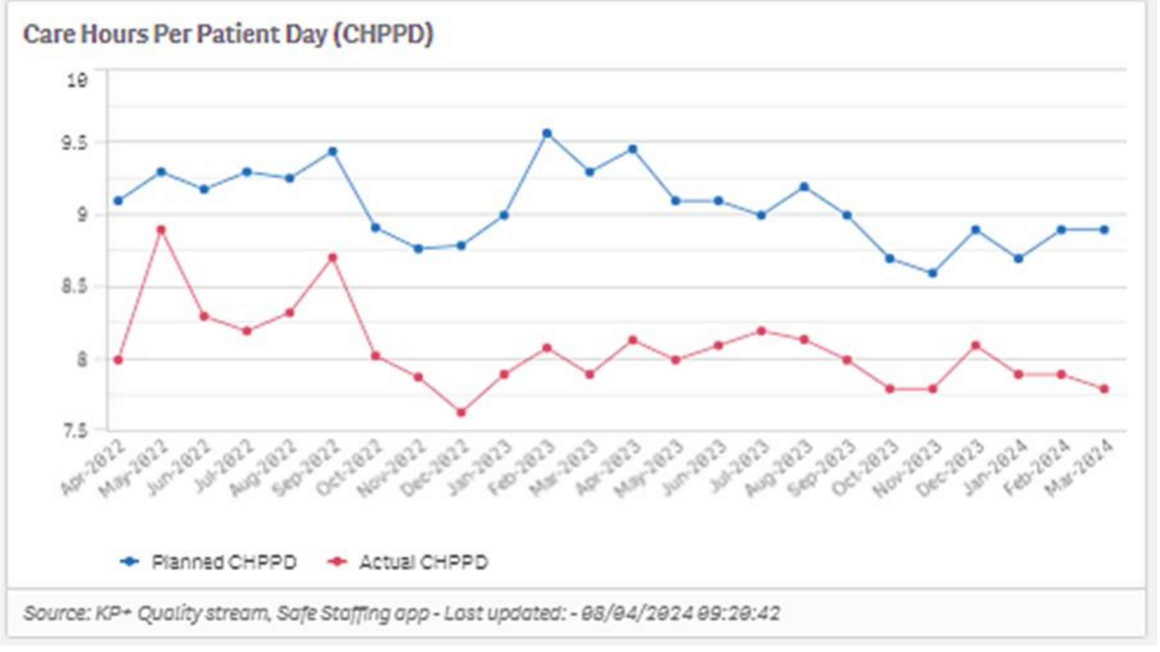
- Clinical Lead has contacted all mortality leads in all specialties to communicate the need to increase the level of mortality reviews being carried out monthly and the timeliness of these reviews being improved.
- Clinical review of patients within the Pneumonia CCS group being undertaken to establish any potential quality of care issues from the August and September 2023 datasets.
- A new 'mortality prediction' tool has been developed to closely replicate the HSMR calculation for live Trust data. This can be used to help forecast where CHFT's HSMR performance is likely to go in the coming data releases and would give a heads-up 3 months in advance of national releases.
- Proposed changes in the way CHFT conduct mortality reviews. A proposal is in place to change the way that CHFT assign and review mortalities internally. Moving away from the fixed 50% target for all deaths to a more targeted review process based on the information within the new mortality prediction tool in KP+, targeting those patients that have died with a low predicted mortality %.

# Care Hours Per Patient Day

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

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

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




**What does the chart show/context:**
- The actual CHPPD is less than the planned by a deficit of 1.1 care hour per patient day.
- The latest data in Model Hospital reports CHFT providing 8.1 CHPPD against a peer median 8.5 and national median 8.4.

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

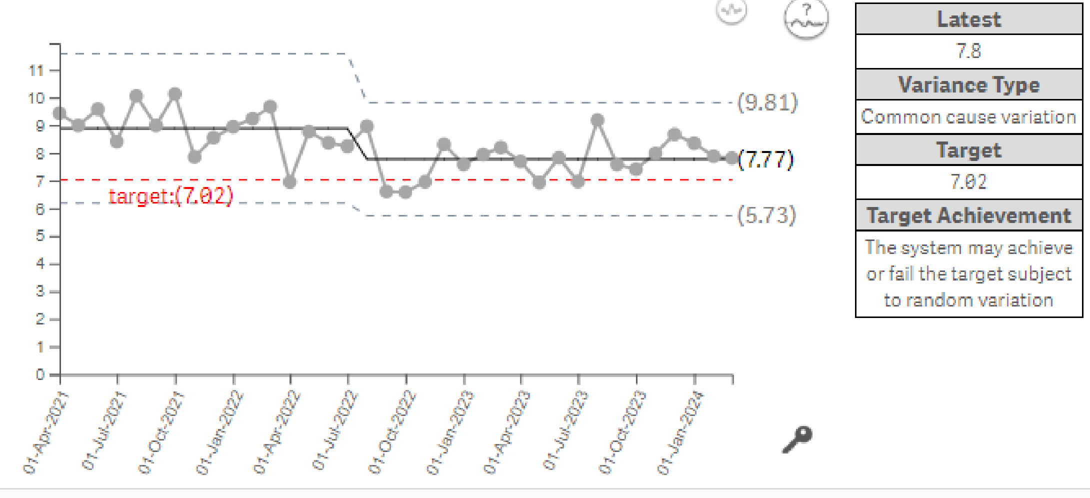
**Actions:**
- Undertake bi-annual Safer Staffing review. This process provides assurance of the correct workforce models based on an evidence-based methodology. The current bi-annual review is in process in March/April 2024.
- Ongoing monthly reviews of recruitment strategies, including employment of new graduates, internationally educated nurses, midwives, Allied Healthcare Professionals (AHPs) and apprenticeships by the Nursing, Midwifery and AHP Workforce Steering Group (NMAHPWSG).
- Review and refresh of the retention strategy by the NMAHPWSG.
- Strong roster management maximises efficiency of the available workforce. Continue monthly roster scrutiny.
- Ongoing work to reduce the need for extra capacity beds.
- Ongoing twice-daily staffing meetings chaired by Divisional Matrons to review any red flags and required care hours determined by Safecare, to ensure real-time safe-staffing across the hospital sites.

# Falls per 1,000 Bed Days

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

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

**Target:**
10% reduction from 2022/23




**What does the chart show/context:**

- The rate of inpatient falls for March was 7.8.
- Currently performance can be expected to vary from 5.73 to 9.81.
- The chart shows that the rate of falls has continued to perform within common cause variation.

**Underlying issues:**

- Enhanced care team issues with 1-1 cover for areas inconsistent.
- Use of high visibility/bay tagging practice inconsistent across areas.

**Actions:**

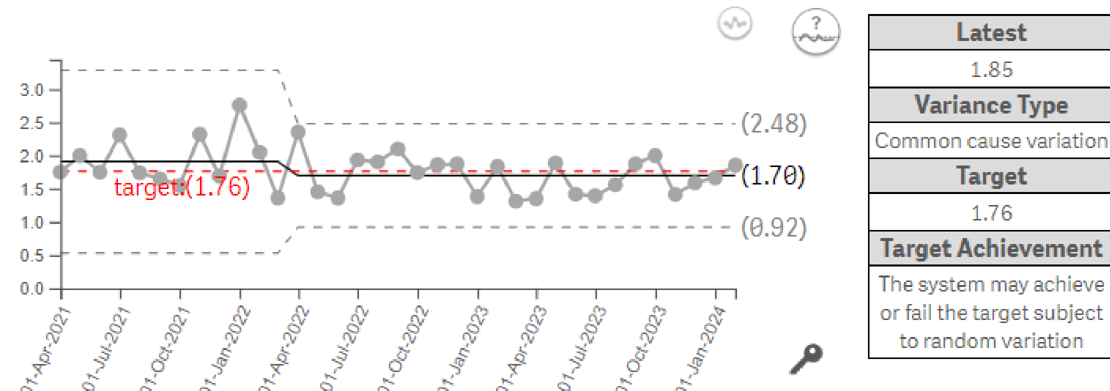
- Continuing with reconfiguration plan around the Enhanced Care Team, update expected and a Work Together Get Results session. Outputs will be shared in due course.
- Education as part of the revamped Enhanced Care team processes and assessments including area matron to review all referrals.
- Bed rails assessment is being reviewed due to concerns it is not reflective of what we need for safe practice, work is continuing with Bradford and Airedale Hospitals - completion date April 2024.
- The Falls policy is in the process of being reviewed to update and make easier to access/read. A temporary extension has been agreed with the Head of Quality and this will be completed by July 2024.
- Commencement of LSBP improvement project on Acute Floor, this is ongoing and there has been an in-month increase in compliance - Ongoing (mark as complete after 3 months of sustained improvement).
- Agree performance targets and KPI measures for 2024/25 with the Falls collaborative - March 2024.
- New KP+ dashboard now in use at the Falls Collaborative.

# Hospital Acquired Pressure Ulcers per 1,000 Bed Days

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

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

**Target:**
10% reduction from 2022/23.




| Latest |
|---|
| 1.85 |
| **Variance Type** |
| Common cause variation |
| **Target** |
| 1.76 |
| **Target Achievement** |
| The system may achieve or fail the target subject to random variation |

*Source: KP+ Quality stream, Pressure Ulcer app - Last updated: - 16/04/2024 22:27:40*

**What does the chart show/context:**

- The data continues to exclude deteriorating pressure ulcers to ensure data accurately reflects current position.
- The incidence of Hospital Acquired PU excluding deteriorating PU for February was 1.85. Currently performance can be expected to vary from 0.92 to 2.48.

**Underlying issues:**

- PU risk assessment within 6 hours of admission/ward transfer requires improvement (43.7% in February 2024 as per Ward Assurance data).
- Performance with PU weekly reassessment shows an improvement at 81.4%.

**Actions**:

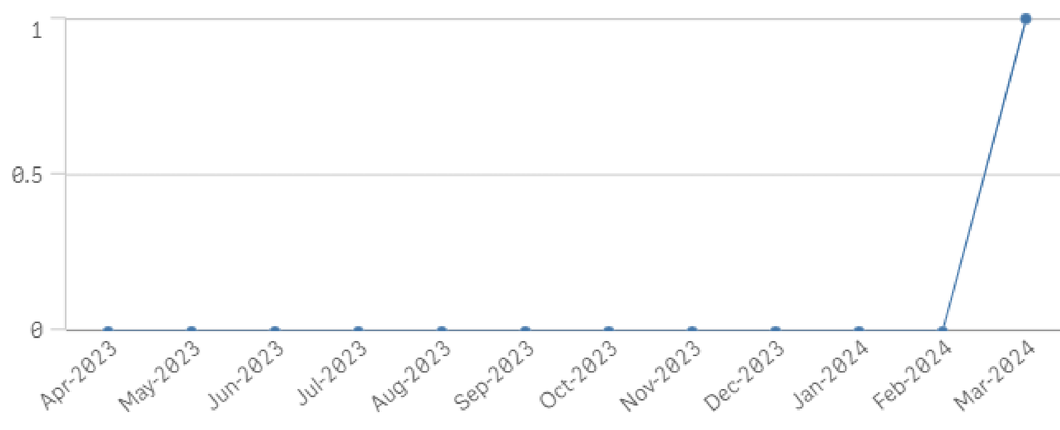
- Pressure Ulcer risk assessment within 6 hours of admission/ward transfer is captured on Live Assessment data within KP+.
- Targeted improvement continues for the low performing wards via the Pressure Ulcer Collaborative.
- SSKIN bundle review completed, and changes submitted to the EPR clinical analyst in collaboration with BTHFT and Airedale.
- Processes for Pressure Ulcer investigations and learning continue to be reviewed as part of Patient Safety Incident Response Framework.
- A Pressure Ulcer AAR/Checklist for Community Division is in the initial stages of development.
- Introduction of PU surveillance system within the Model Health System on the 1st April 2024. A new process for PU validation currently being trialled between clinical coding and Tissue Viability.

# MRSA Bacteraemia Infections

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

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

**Target:**
To have no cases of MRSA Bacteraemia infections that are Trust-Assigned in 2023/24.




**What does the chart show/context:**
- There was 1 MRSA Bacteraemia infection in March.
- YTD 2023/24 – 1 HOHA

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

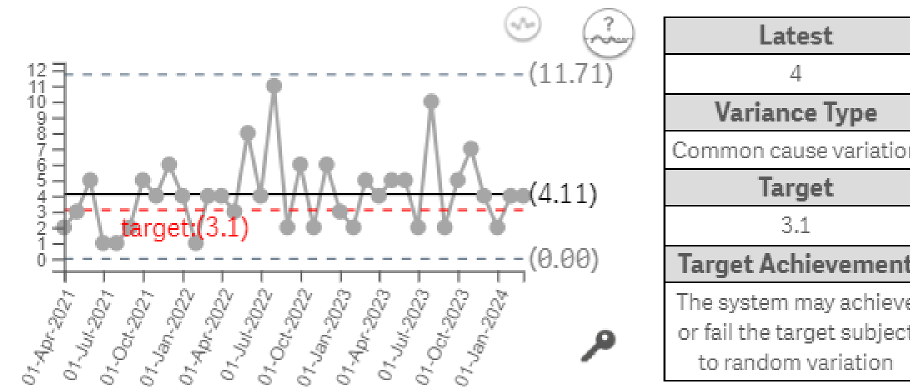
**Actions:**
- MRSA screening data cleanse has been completed and improvements seen.
- Colonisation suppression visual user guides have been provided to patients to ensure correct application.
- Mandatory training to be monitored through IPC Performance Board on a monthly basis.
- Any infections are investigated and discussed at panel, this infection was discussed at SI panel and downgraded to Orange panel and we are awaiting the full outcome from the Medical division, initial learning around missing admission swabs has already been escalated across appropriate areas. Further learning will be presented at IPC Performance Board and patient safety meetings.

# C.difficile Infections

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

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

**Target:**
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 4 C.difficile infections in March.
- Currently performance can be expected to vary from 0 to 11.71.
- YTD 2023/24 – 54 (36 HOHA, 18 COHA) against a ceiling of 37.
- This month's data reflects the standard contract changes to reporting from April 2023 to include COHA. This has not been previously captured within the IPR.

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

**Actions:**
- The Trust has implemented an improvement plan including a programme of HPV deep cleaning.
- C.diff ward rounds, antimicrobial ward rounds and a review of the investigation process for cases.
- NHSEI 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.
- The PSIRF for investigating C.difficile cases has now gone live and this moves it back to divisions to take ownership of cases within their areas. Themes will be pulled on a 6-monthly basis and will form part of the planning for future IPC workstreams.

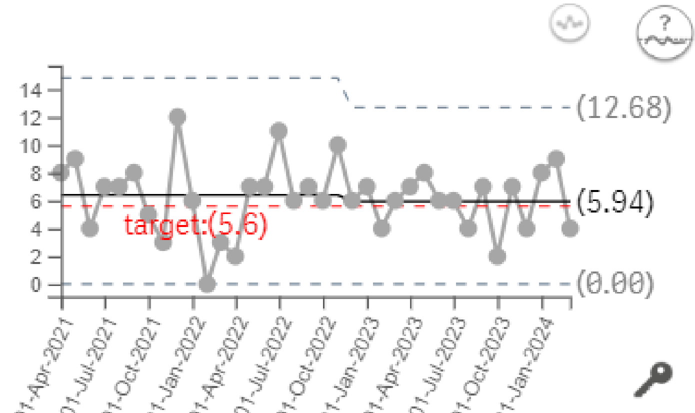
# E.coli Bacteraemia Infections

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

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

**Target:**
To not exceed 67 cases in 2023/24. Hospital onset healthcare associated (HOHA) and community onset hospital associated (COHA)

**Number of E.Coli Infections**
Post 48 Hours




| Latest |
| --- |
| 4 |
| **Variance Type** |
| Common cause variation |
| **Target** |
| 5.6 |
| **Target Achievement** |
| The system may achieve or fail the target subject to random variation |

*Source: KP+ Quality stream, Infection Control Dashboard app - Last updated:22/04/2024 16:22:33*

**What does the chart show/context:**
- There were 4 E.coli infections in March.
- Currently performance can be expected to vary from 0 to 12.68.
- YTD 2023/24 – 72 infections against a ceiling of 67 (30 HOHA, 42 COHA
- This month's data reflects the standard contract changes to reporting from April 2023 to include COHA. This has not been previously captured within the IPR.

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

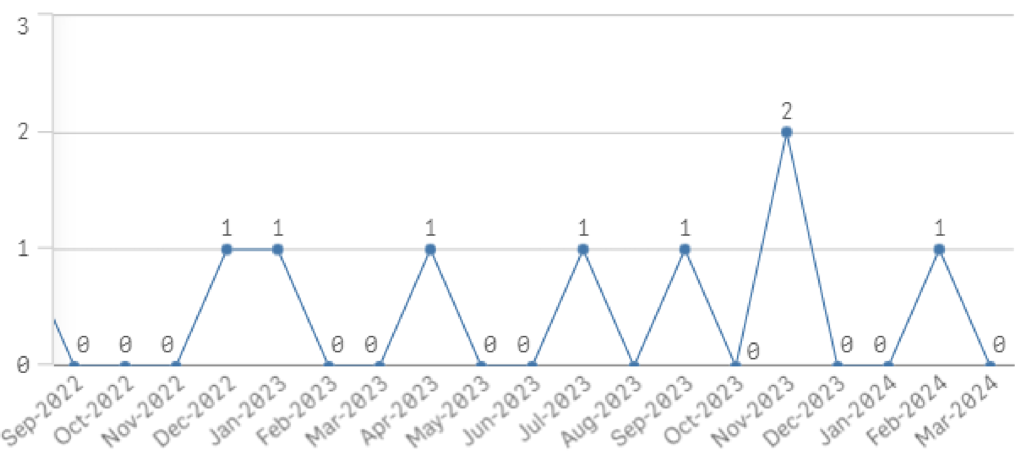
**Actions:**
- Extended surveillance of all the cases is conducted and uploaded to the UKHSA DCS system for national analysis.
- As part of the workplan of the IPCT, an annual audit of catheter management has been completed and recommendations shared with the divisions for implementation.
- A regional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

# Number of Never Events

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

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

**Target:**
To have no never events




**What does the chart show/context:**
- There were no never event incidents subsequently declared as an SI and reported to StEIS in March 2024.
- The Trust is unable to consistently meet the target and may achieve or fail subject to random variation month to month.

**Underlying issues:**
- There were no never events reported in this period.

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

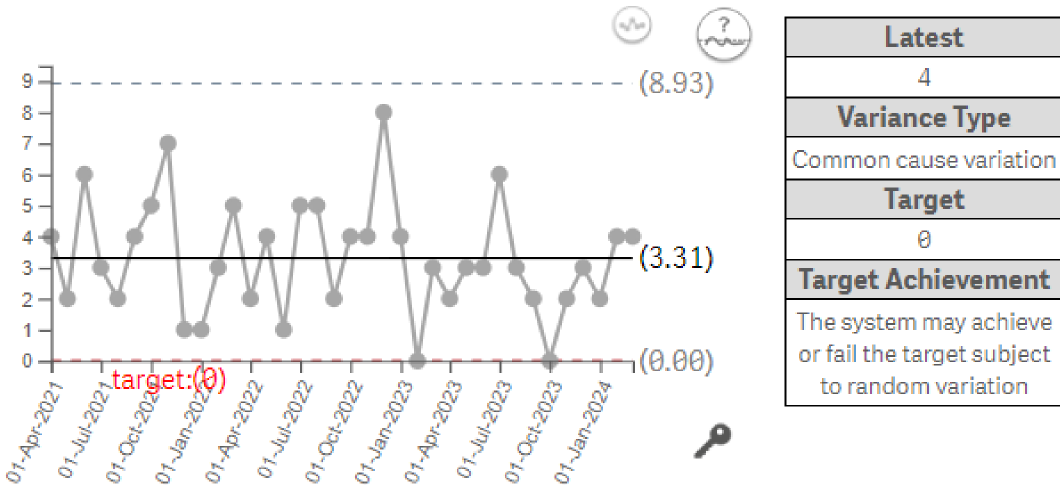
# Number of Serious Incidents

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

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

**Target:**
To have no serious incidents

**Number of Serious Incidents**




*Source: KP+ Quality stream, Incidents app - Last updated:15/04/2024 09:20:16*

**What does the chart show/context:**

- There were 4 serious incidents reported in March 2024 that have been validated and reported to StEIS.
- Currently performance is subject to common cause variation and can be expected to vary from 0 to 8.93.

**Underlying issues:**

- All 4 incidents reported in this period are currently under investigation, 3 of the incidents occurred in the FSS division, 1 was classed as moderate harm with the other 2 being classed as severe. 1 incident occurred in the Medical division and was classed as severe.
- The 4 incidents reported were reported under different categories:
  1. Delay in treatment
  2. Prescribing error
  3. Treatment /procedure – maternal complication
  4. Poor outcome for baby

**Actions:**

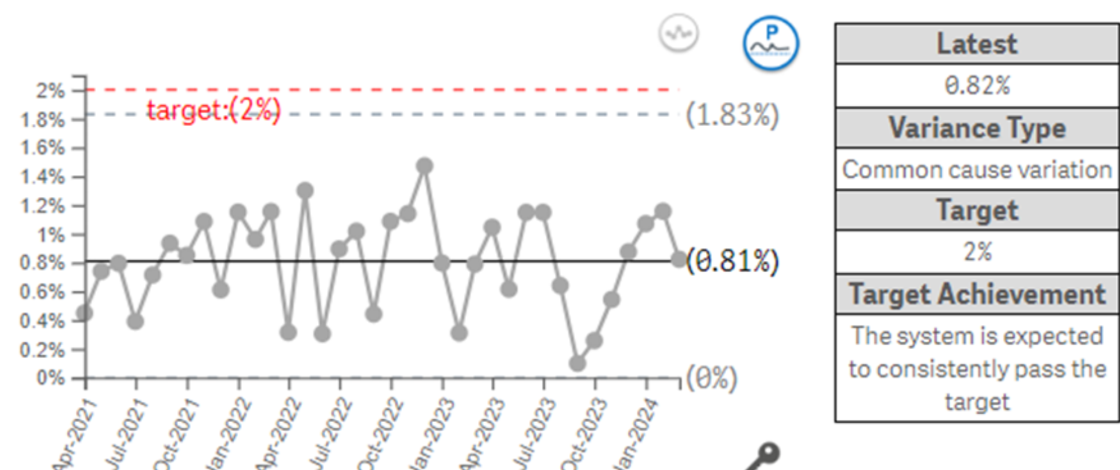
- SWARMs held to identify learning and immediate actions.
- Themes initially identified were in relation to assessment, treatment and diagnosis.
- The Risk management Team and the Quality Governance Leads continue to support the Divisions to triangulate and review data for learning.

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

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

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

**Target:**
2% or less




**What does the chart show/context:**
- The percentage of incidents where the level of harm was severe or catastrophic was 0.82% in March 2024.
- Currently performance is subject to common cause variation and can be expected to vary from 0% to 1.83%.

**Underlying issues:**
- The 4 incidents reported in this period are currently under investigation and have been reported to StEIS.

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

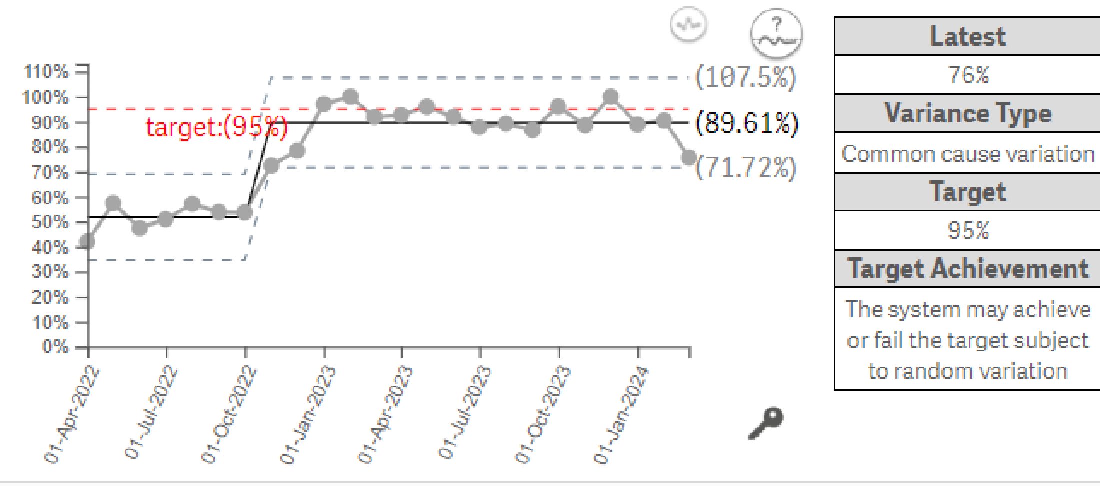
# % of complaints within agreed timescale

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

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

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

% of Complaints Closed within agreed timescale




Source: KP+ Quality stream, Complaints app - Last updated:15/04/2024 10:40:23

**What does the chart show/context:**
- In March 2024 76% of complaints were closed within the agreed timescale (15 percentage point drop) although this has remained within statistical control limits.
- Currently performance can be expected to vary from 71.72% to 100%.

**Underlying issues:**
- Issues with the quality of responses has continued which unfortunately has caused delays in response being sent.
- A further impact on performance is timeliness of final sign-off.

**Actions:**
- A meeting has been held with Divisional Lead and actions have been put in place to improve quality of responses
- Escalation process for final sign-off agreed
- An audit has commenced to understand more where the delays are and why the quality of responses has declined. An audit of the standard of communication with complainants and the number of extensions requested has also been done – currently analysing data
- Escalated to Divisional Leads for complaints to ensure everything is being done to respond to complainants within agreed timeframes and if not extensions agreed before the due date.
- Continue to monitor Trust performance daily and meet with Divisions on a weekly basis to maintain oversight of performance.

# Quality Priorities:

| Metric | Latest Month | Measure | Target | Variation | Assurance | Mean | Lower process limit | Upper process limit |
|---|---|---|---|---|---|---|---|---|
| Alternatives to Hospital Admission – Number of referrals into the Frailty service | March 2024 | 277 | TBC | | - | 320.8 | 216.9 | 424.7 |
| % of episodes scoring NEWS of 5 or more not going on to score higher | March 2024 | 62.6% | 70% | | F | 58.9% | 53.7% | 64.0% |
| % of adult patients that receive a MUST assessment within 24 hours of admission/transfer to the ward. | March 2024 | 87.1% | 95% | | F | 83.6% | 78.11% | 89.1% |

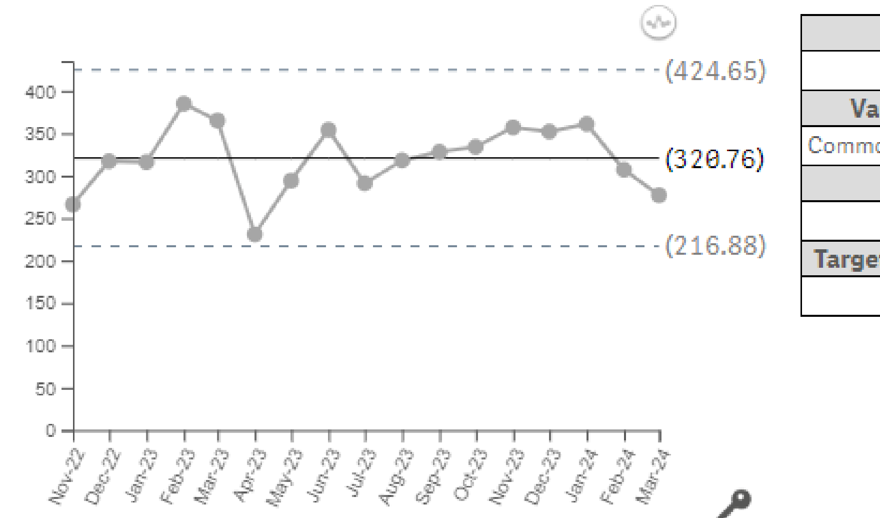
# Alternatives to Hospital Admission – Frailty Service

Executive Owner: Lindsay Rudge    Clinical Lead: Charlotte Bowdell/ 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:**
Target to be confirmed on the number of referrals per month

UCR/Frailty Virtual Ward New Referrals into Service




| Latest |
| --- |
| 277 |
| **Variance Type** |
| Common cause variation |
| **Target** |
| N/A |
| **Target Achievement** |
| N/A |

Source: SR Data. Last updated 17/04/2024 16:54:25

**What does the chart show/context:**
- New referrals into service for the whole Urgent Community Response / Frailty Virtual Ward service.
- Average of 321 per month for all - 277 for March 2024.

**Underlying issues:**
- CHFT Pharmacists are referring in Locala patients as an interim measure until access to Locala SystmOne units is configured.
- Currently there is only a 5-day consultant offer for frailty virtual ward as 7-day cover is not funded. This limits referrals towards the end of the week due to concern they may need consultant input over a weekend.

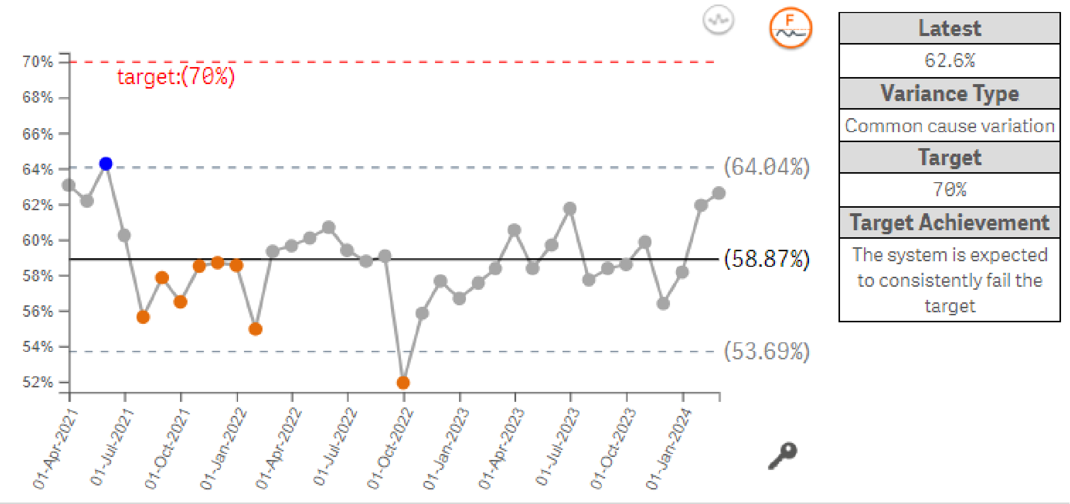
**Actions:**
- Medical division reviewing medical cover to support a 7-day Multi Discipline Team meeting for Frailty virtual ward. Other organisations have not all been able to recruit consultants but backfilled with a registrar.
- Advanced Clinical Practitioner working on Frailty Same Day Emergency Care on a weekend is supporting Kirklees virtual Frailty service with advice and guidance.
- Workforce model review to support activity and demand occurring in Calderdale frailty VW.
- Kirklees are reviewing the urgent community response service to establish if they can be aligned with the virtual ward.
- Frailty criteria have been amended to ensure we can take more frail and older people from across areas.
- Next phased step-up pathway being designed to take GP and day patients as currently just from Urgent Community Response Service.
- Respiratory - criteria now changed to include patients requiring oxygen weaning.
- Team attend safety huddles each day.

# Care of the Acutely Ill Patient

Executive Owner: David Birkenhead 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:**
70% of patients with a NEWS2 of 5+ will not have a higher score during their episode of care




**What does the chart show/context:**
- Performance was 62.6% in March 2024.
- The Trust is unable to meet the target of 70% and will consistently fail the target.
- Currently performance is subject to common cause variation
- Performance can be expected to vary from 53.69% to 64.04%.

**Underlying Issues:**
- Doctors do not carry NerveCenter devices "in hours" which may result in delays in escalating for review, as well as delays in requesting a senior review by a registrar or consultant in line with NEWS2 policy.
- Some of the patients with NEWS 5 or more who go on to score higher will include end of life care patients who are appropriately managed.

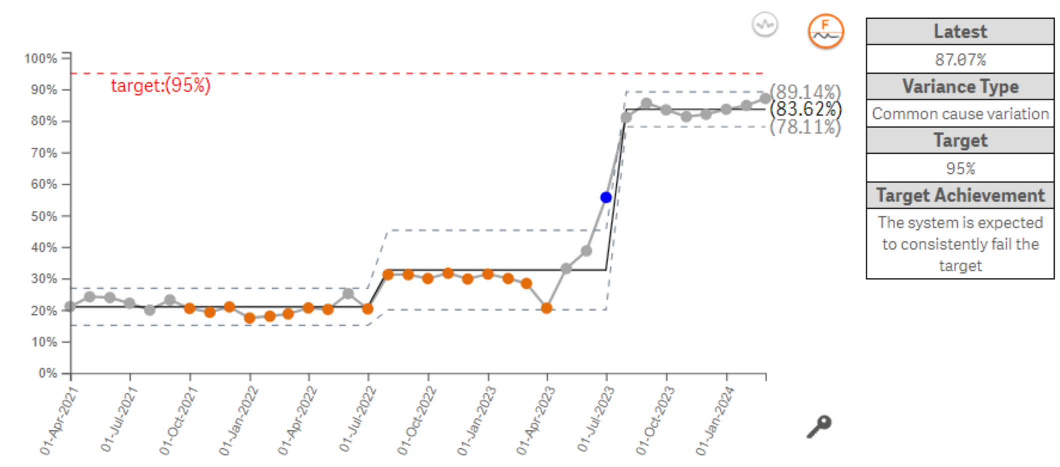
**Actions**:
- A new KP+ dashboard has been developed which includes an overview of ward areas with the highest NEWS scores. This highlights the higher acuity areas to be the acute medical wards and the respiratory ward.
- A retrospective audit of patients with NEWS 5 or 6 who score higher is underway to identify learning opportunities for quality improvement. Data from January to March 2024 (37 cases) suggests that 78.4% of patients were reviewed within an hour of NEWS 5 or more, but only 51.4% were reviewed by a registrar or consultant within an hour of NEWS 7 or more.
- The Acute Response Team (ART) was introduced from April 2024, who will respond to patients scoring NEWS2 5 and above. This target and the retrospective monthly audit data will continue to be reviewed to understand whether response times for NEWS 7 or more has improved with the introduction of the ART team and identify any quality improvement opportunities.

# 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 March 2024 performance was 87.07%.
- Performance is in common cause variation and improvements are being sustained.
- Currently performance can be expected to be between 78.11% and 89.14% and therefore is expected to consistently fail the target.

**Underlying Issues**
- MUST assessment training compliance has improved and has now moved from 80.6% to 85%.

**Actions**:
- MUST assessment, completion and training continues to be monitored through the Nutrition & Hydration Group.
- The Nurse in Charge within each ward continues to monitor and ensure their staff complete the MUST training.
- MUST posters will be displayed on every ward area with instructions on how to complete as a visual aid.
- The operational group are looking at charitable funds to buy small pocket tape measure for all staff to aid compliance.

# Elective Care:

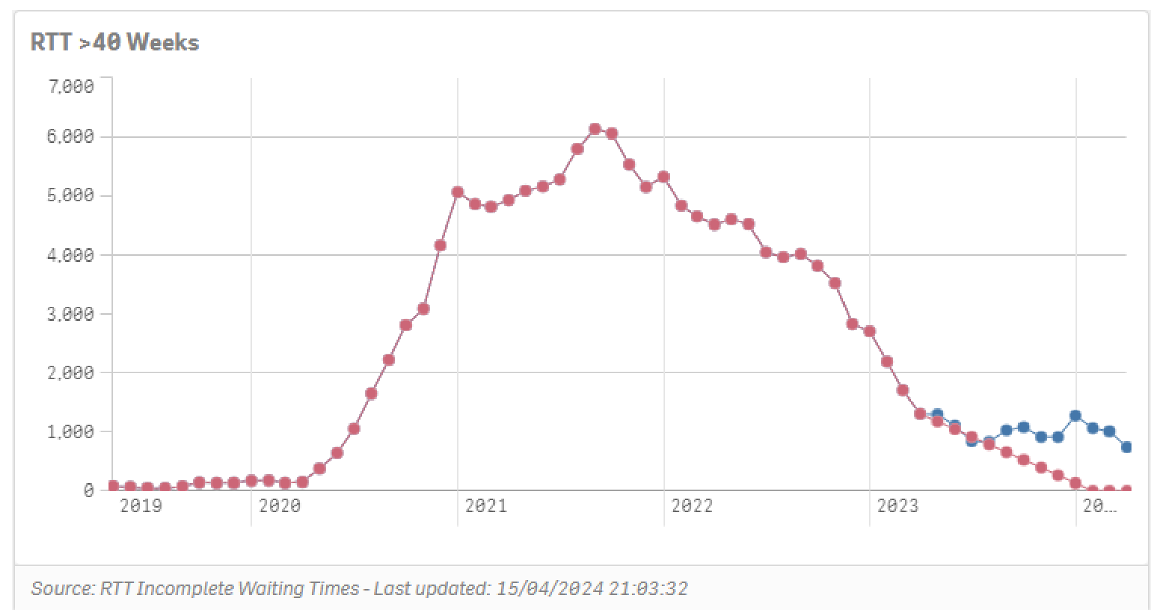
| Metric | Latest Month | Measure | Target | Variation | Assurance | Mean | Lower process limit | Upper process limit |
|---|---|---|---|---|---|---|---|---|
| Total Patients waiting >40 weeks to start treatment | March 2024 | 740 | 0 | | | - | - | - |
| Total Patients waiting >52 weeks to start treatment | March 2024 | 17 | 0 | | | - | - | - |
| Total Patients waiting >65 weeks to start treatment | March 2024 | 0 | 0 | | | - | - | - |
| Total RTT Waiting List | March 2024 | 35,677 | 31,586 | | | 32,610 | 30,290 | 34,930 |
| Total elective activity undertaken compared with 2023/24 activity plan | March 2024 | 110.3% | 100% | - | - | - | - | - |
| Percentage of patients waiting less than 6 weeks for a diagnostic test | March 2024 | 90.1% | 95% | | | 86.4% | 79.4% | 93.3% |
| Diagnostic Activity undertaken against activity plan | March 2024 | 14,410 | 14,547 | | | 13,413 | 11,316 | 15,509 |
| Total Follow-Up activity undertaken compared with 2023/24 activity plan | March 2024 | 91.9% | 100% | - | - | - | - | - |
| Day Case Rates | November 2023 | 91.2% | 85% | | | 91.6% | 93.5% | 89.6% |
| Capped Theatre Utilisation | March 2024 | 81.8% | 85% | | | 81.6% | 73.0% | 90.3% |

# 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:**

- Our 40-week position stands at 740 at the end of March against the target trajectory of 0.
- Most of our remaining patients who are waiting over 40 weeks are in ENT (650), General Surgery (38), and T&O (16). All other specialties have <6. Of the specialties listed, all have improved in March, except for ENT.

**Underlying issues:**

- A growing ASI list (especially in ENT) represents a risk to the continuing reduction in list size.
- Cancelled lists/appointments due to strike action have resulted in a delay in reducing the 40-week position.
- Whilst ENT has 40-week waits at the end of March the focus was on ensuring 52-week compliance by the end of March within the specialty – there were 13.

**Actions:**

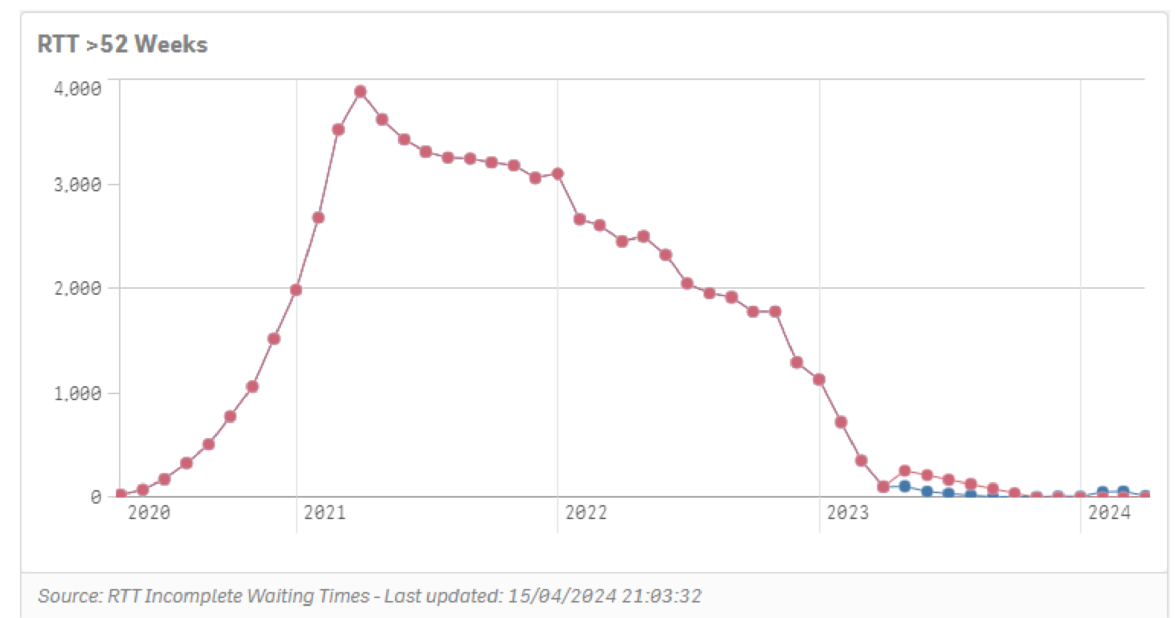
- Operational teams to be tracking patients to at least 40 weeks.
- KP+ writeback model being used by all operational teams to ensure that tracking actions are transparent and cannot be overwritten by Validation teams.
- ENT Task and Finish Group concluded with actions in place.
- Actions have been identified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

# 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:**

- Our 52-week position now stands at 17 (13 in ENT and 1 each in T&O, Gastroenterology, Cardiology and Paediatric Services).
- There are 261 patients waiting between 46 and 52 weeks, mainly ENT (247 – up from 129).
- All other specialties have 4 or fewer patients waiting between 46 and 52 weeks.

**Underlying issues:**

- The longer-term risk to the 52-week position is specifically from ENT ASIs.
- The non-ENT patients have treatment plans in place for the end of April 2024.

**Actions:**

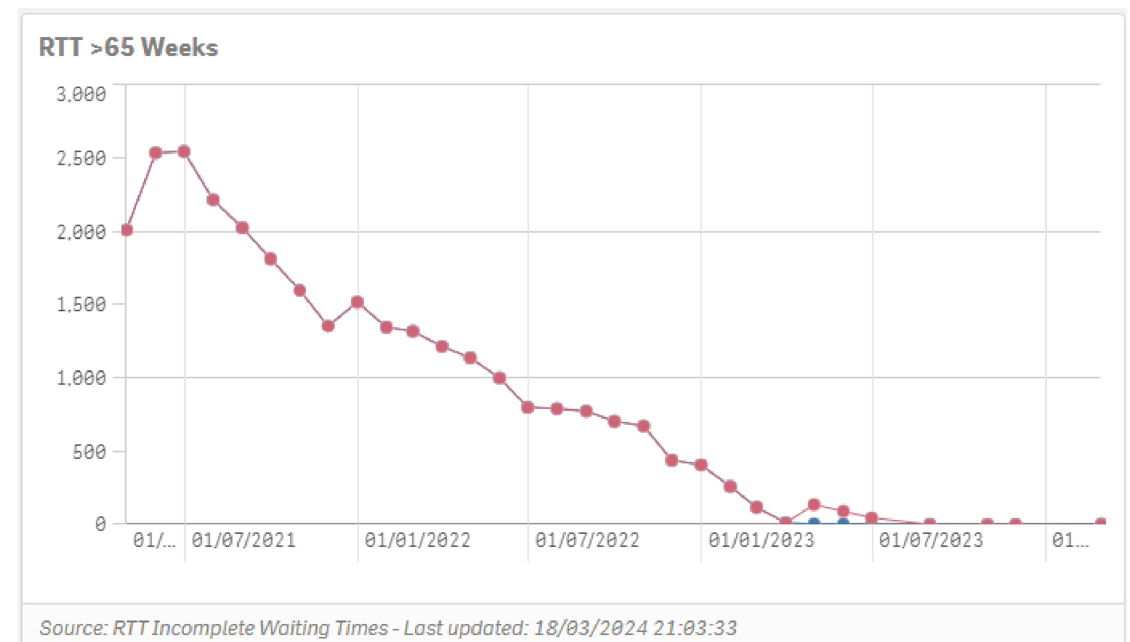
- Operational teams to be tracking patients to at least 40 weeks and are attempting to track down to 30 weeks.
- To support 52-week delivery by the end of April - and maintain delivery from May onwards - S&A have restructured A&C resource to enable greater tracking of ENT's RTT position.
- KP+ writeback model being used by all Operational teams to ensure that tracking actions are transparent and cannot be overwritten by Validation teams.
- ENT Task and Finish Group concluded with actions in place and are working to 52-week compliance by the end of April.
- Actions have been identified in 3 cohort areas:
    - Demand management
    - Increasing internal capacity
    - Increasing external capacity

# 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:**
- At the end of March there were 0 patients waiting over 65 weeks.

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**Underlying issues:**
- No underlying issues – regularly achieving monthly 0 position

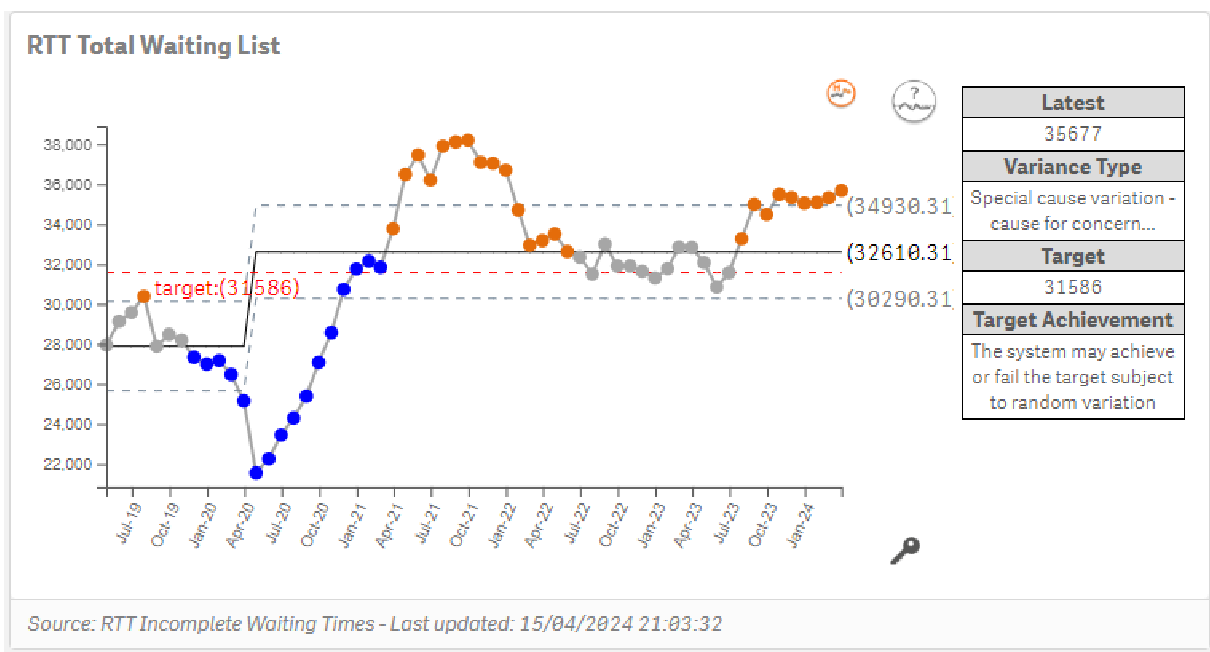
**Actions:**
- No actions required

# 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:**
- The list remains high and stands at 35,677 at the end of March.

**Underlying issues:**
- We currently have a relatively stable RTT Waiting list position, although it is creeping up and has remained at a higher level than the target of 31,586.
- For ENT and Gynaecology we have seen an increase in ASIs (ENT is a capacity issue whilst Gynaecology has seen an increase in demand).
- Cardiology has seen an increase in wait time for diagnostics (Echo).
- Ophthalmology has increased due to an improvement in data quality which means the inclusion of pathways for those on the portal (EyeV) awaiting triage.
- There has also been a slowdown in elective activity due to industrial action.
- The national position continues to grow monthly. The ICS position suggests we are the only Trust in the region currently not seeing a 20% increase in pathways over the last 12 months.

**Actions:**
- Validation team to monitor LUNA (National DQ RTT Benchmarking tool – currently in top 30 Trusts in the country for RTT DQ Assurance).
- Meet the trajectory for no ASIs over 18 weeks by the end of April 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 2023/24 activity plan

Executive Owner: Jonathan Hammond Operational Lead: Kim Scholes Business Intelligence Lead: Oliver Hutchinson
Finance Lead: Helen Gaukroger

**Rationale:**
Recover elective activity levels to above those seen in the pre-Covid period, to address the growing elective care waiting list.

**Target:**
Recover elective (day cases/elective inpatients) services so that activity levels are at least 100% of 2023/24 activity plan

**What does the chart show/context:**

- CHFT has exceeded the elective activity 2023/24 target in 10 of the 12 months of the 2023/24 financial year.
- Performance in March 2024 was above plan at 110.3% in month.
- Both day case activity and electives were above the planned position for March 2024.
- The end of year performance for the elective activity overall has achieved activity levels that are above the planned position standing at 107.0%, which is a total of 3,158 spells more than the plan for the 2023/24 financial year.
- Both day case and electives achieved greater activity levels than the plan for the 2023/24 financial year with performance standing at 107.7% and 100.5% respectively.
- SDEC activity included in March (will be excluded from April 2024).

**Underlying issues:**

- Impact of industrial action.

**Actions:**

- There has been a KP+ Contract Monitoring Report model set up for 2023/24 to break this data down to specialty level. Finance leads to work with divisional GMs and Ops managers to ensure awareness of this position at specialty and divisional level.

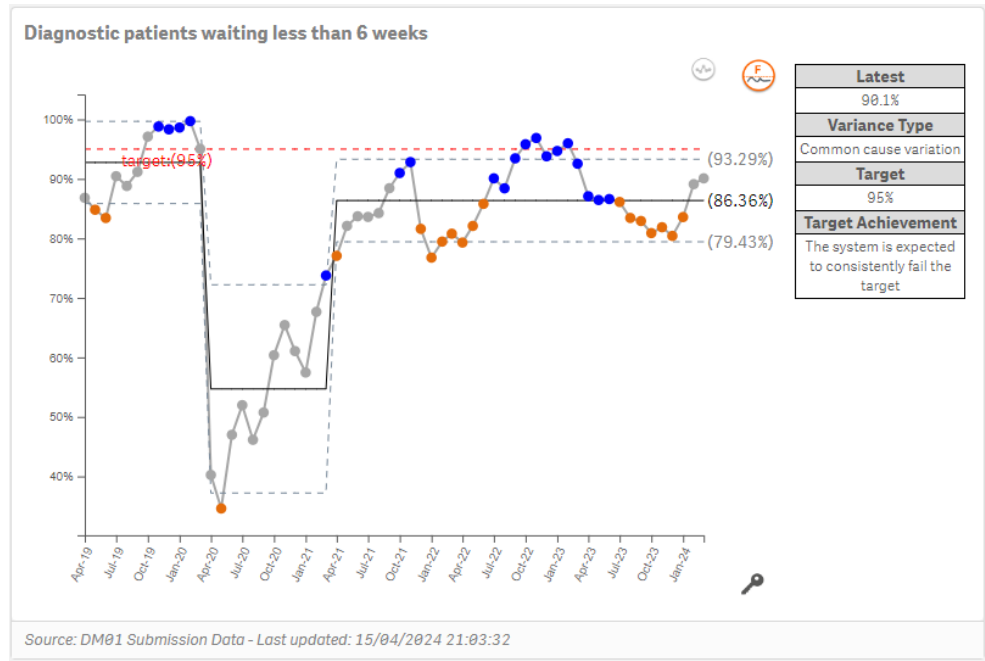
# Percentage of patients waiting less than 6 weeks for a diagnostic test

Executive Owner: Jonathan Hammond
Business Intelligence Lead: Fiona Phelan

Operational Leads: Thomas Strickland/Stephen Shepley/Helen Rees
Finance Lead: Helen Gaukroger

**Rationale:**
Maximise diagnostic activity focused on patients of highest clinical priority.

**Target:**
Increase the percentage of patients that receive a diagnostic test within 6 weeks in line with the March 2025 ambition of 95%.




**What does the chart show/context:**
- The Trust is expected to consistently fail the target of 95%.
- Performance can be expected to vary between 80% and 94%, but it is moving in the right direction.

**Underlying issues:**
- 2 modalities (Echocardiography/Neurophysiology) still have significant numbers of pathways >6 weeks.
- Whilst the Trust performance is meeting the 95% target in most modalities, we are still consistently below this for Echocardiography (61.0% up from 58.7%) and Neurophysiology (77.8% up from 76.0%). Both modalities have maintained their improvements in March.

**Actions:**
**Echocardiography**
- Further recovery has ensued since, and we continue to work towards total recovery of the backlog.
- Weekend clinics running regularly with positive uptake from our staff
- Reporting backlog now at manageable levels.
- Plan for more trainees to become accredited to run clinics independently towards autumn
- Due to sickness and lack of uptake around easter, the performance has gone off trajectory however, we expect this to be back on track with additional lists planned in until July.

**Neurophysiology**
- Seen a continued reduction in 6-week breaches and remain on plan to have no breaches by mid-June 2024.
- Funding available for weekend clinics to clear backlog.
- Increase of EMG slots for consultants and doctors, 1/day each.
- Neurophysiology Support Assistant contacting EMG/CTS patients to confirm attendance - mitigating DNAs/last minute cancellations – routine/ongoing.
- Short-notice cancellation list utilised routinely.
- Fully staffed by 1st April 2024, with succession planning already in place.

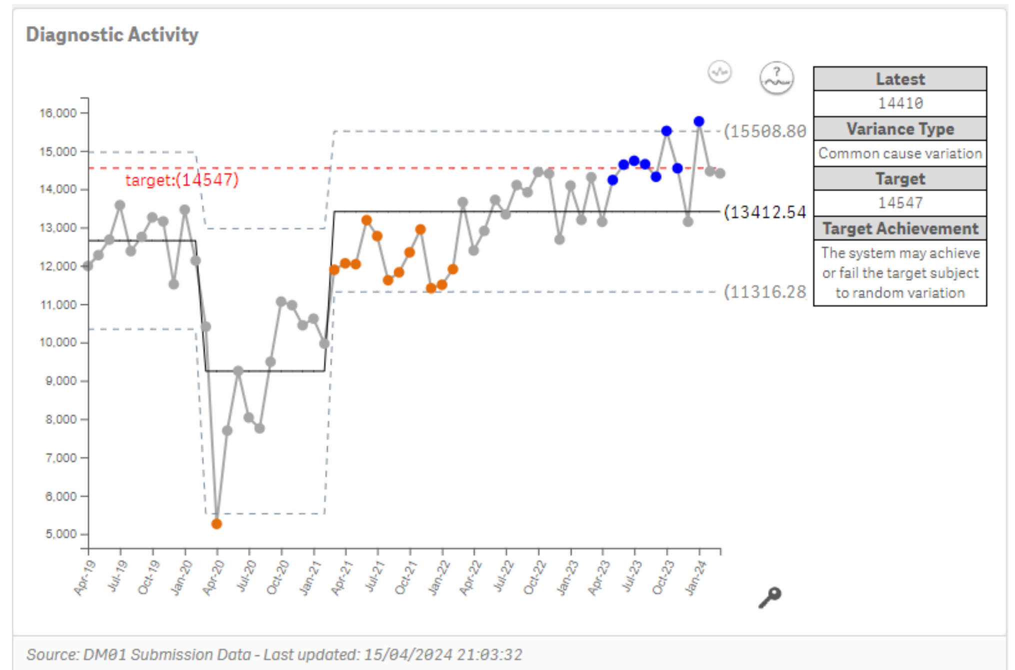
# Total Diagnostic Activity undertaken against the activity plan

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 has been achieving levels around the target of 14,547 since May, but it may achieve or fail the target subject to random variation. The activity is close to the target at 14,410.
- Performance can be expected to vary between 11,316 and 15,509. Activity is similar to pre-Covid levels.

**Underlying issues:**

- Overall, we have been performing around the target level, but since some modalities are already operating at 6 weeks or less from a diagnostic waiting time perspective, additional activity is not currently needed as per the planning submission made at the start of the year.
- Both Echocardiography and Neurophysiology are the two areas where activity is below the plan, and we are materially off target against 95% of patients being seen within 6 weeks. March has again seen significant improvements in the <6 weeks position.

**Actions:**

**Echocardiography**

- Further recovery has ensued since, and we continue to work towards total recovery of the backlog.
- Weekend clinics running regularly with positive uptake from our staff
- Reporting backlog now at manageable levels.
- Plan for more trainees to become accredited to run clinics independently towards autumn
- Due to sickness and lack of uptake around easter, the performance has gone off trajectory however, we expect this to be back on track with additional lists planned in until July.

**Neurophysiology**

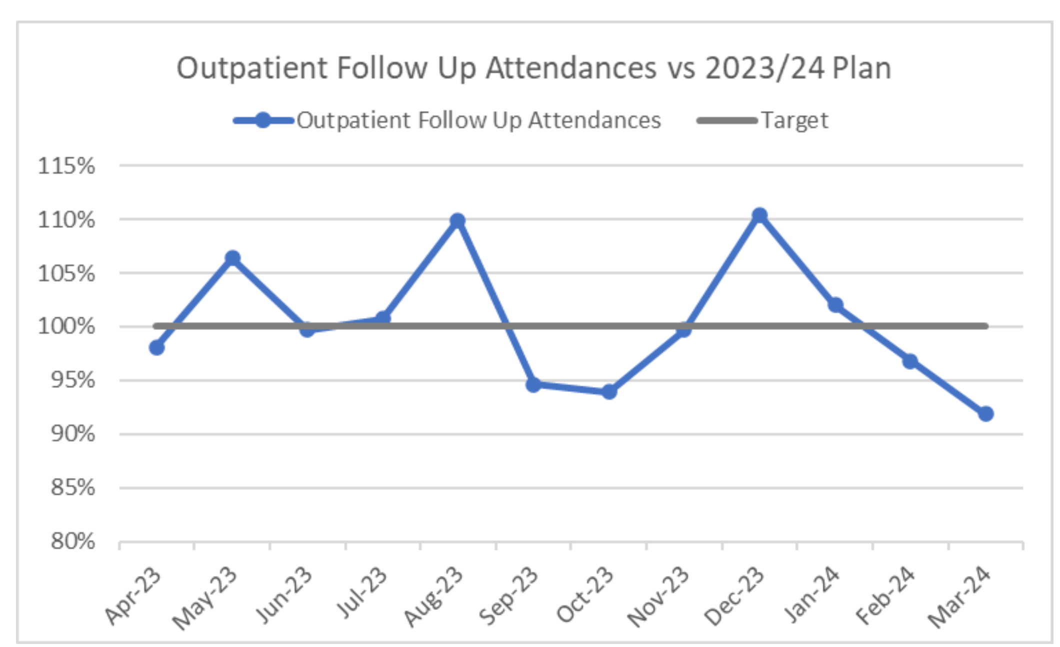
- Seen a continued reduction in 6-week breaches and remain on plan to have no breaches by mid-June 2024.
- Funding available for weekend clinics to clear backlog.
- Increase of EMG slots for consultants and doctors, 1/day each.
- Neurophysiology Support Assistant contacting EMG/CTS patients to confirm attendance - mitigating DNAs/last minute cancellations – routine/ongoing.
- Short-notice cancellation list utilised routinely.
- Fully staffed by 1st April 2024, with succession planning already in place.

# Total Follow-Up attendances undertaken compared with 2023/24 activity plan

Executive Owner: Jonathan Hammond Operational Lead: Kim Scholes Business Intelligence Lead: Oliver Hutchinson
Finance Lead: Helen Gaukroger

**Rationale:**
To measure the relative reduction in follow-up outpatient attendances (consultant and non-consultant led) in 2023/24 compared to 2023/24 activity plan

**Target:**
% of 2023/24 activity plan (source: 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 reduced for month 12 and CHFT achieved 91.9% of the planned position in-month for follow-up attendances.
- CHFT however did achieved greater activity levels than were in the plan for 2023/24 with activity standing at 100.4% of that plan.

**Underlying issues:**
- Although the national target for follow-up activity is 75% of 2019/20 activity, due to a significant follow-up backlog (28,816), CHFT have not taken this up.
- 40% of the backlog has been waiting less than 12 weeks.

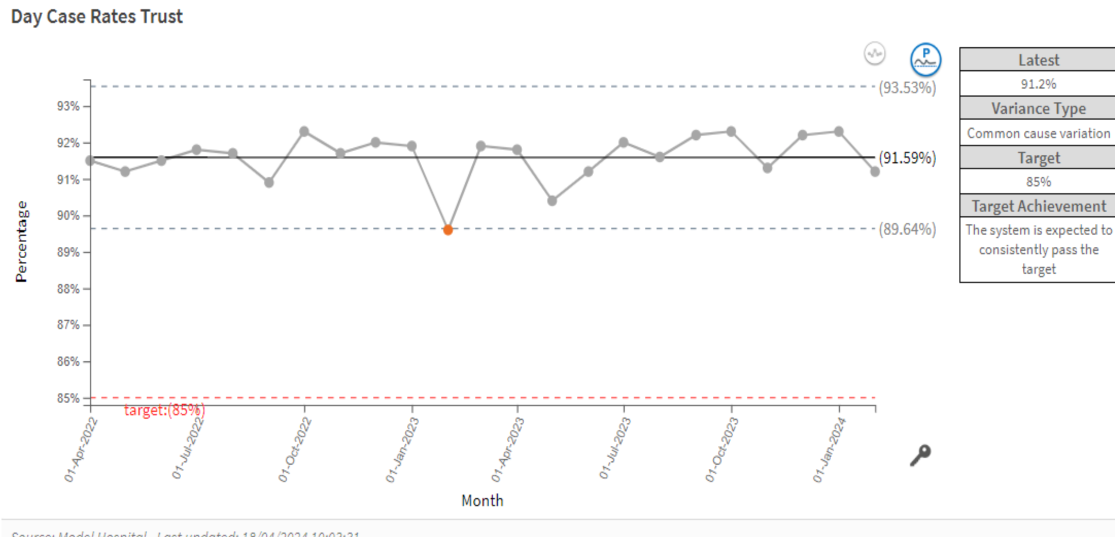
**Actions:**
- There are currently 9,310 (of the 28,816 backlog) records that are awaiting a clinical prioritisation within CHFT's MPage system, this is a reduction of 500 from last month. Cohorts for incomplete outcomes have been brought into the low hanging fruit validation process. Specialties will then have a clean MPage validation list for clinical prioritisation.
- Following the introduction of Targeted Admin Validation of the Holding List (3,500), we now have 28,816 follow-up patients past see by date and this is gradually increasing weekly.
- The first round of the follow-up training programme has now been completed in all specialty areas. The impact was reviewed to identify any further training needs, with a second round of training being proposed to start in the coming months.
- Plans to introduce a regular 'Outpatient Access' meeting focussing on the follow-up backlog and introduce a waiting time target for each specialty area.

# Day Case Rates

Executive Owner: Jonathan Hammond Operational Lead: Tom Strickland Business Intelligence Lead: Inderjit Singh

**Rationale:**
To measure the relative increase

**Target:** Over 85%




**What does the chart show/context:**

- Utilising the new Model Hospital measure (uses SUS data - which includes those procedures completed in outpatients) reported day case rate for the 3 months to the end of February 2024.
- CHFT performance reported as 91.2% against an 85% target.

**Underlying issues:**

- Several General Surgery cases that are CEPOD patients are being admitted via SDEC as 'Elective planned'. As of Friday 8th March SDEC are no longer required to 'admit' patients therefore CEPOD patients can be treated as 'emergencies' without this affecting Failed discharge rates.
- Data quality challenges around "intended management". Cases are being listed on Bluespier and completed as day case however these are not counted due to PM office amendments not being made.
- Reverse conversion are not counted – If a patient is listed for an inpatient stay but is completed as day case this is not reflected in our day case rate.

**Actions:**

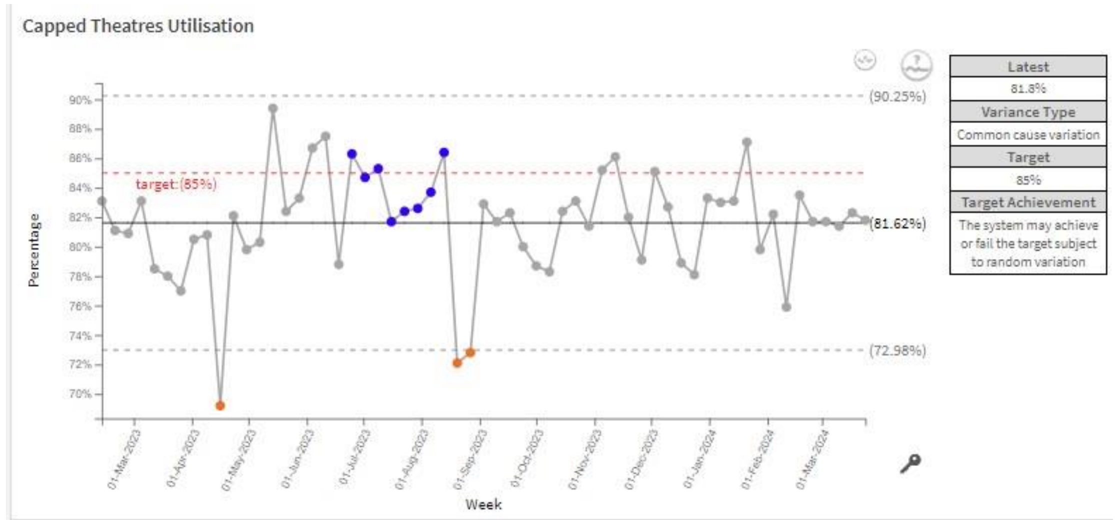
- Impact of SDEC changes are being monitored through Division and the HIS team.
- Day case rates are monitored at a specialty level through the monthly STUG meetings.
- Procedure specific data reviewed each month to identify improvement opportunities or data quality challenges.
- Specific actions in development for procedures where CHFT are identified as true outliers e.g. TURBTs.

# Capped Theatre Utilisation

Executive Owner: Jonathan Hammond Operational Lead: Gemma Pickup Business Intelligence Lead: Inderjit Singh

**Rationale:**
To measure the relative increase

**Target:** Over 85%




**What does the chart show/context:**

- Model Hospital Capped Theatre Utilisation is reported on a weekly basis and only reports 1 week at a time.
- The report shown being w/e 24th March 2024 – performance at 81.8%.

**Underlying issues:**

- Regional Go Sees have identified inconsistencies as to how organisations record 'Start' times.
- Lots of work done to improve intercase downtime however there are often large gaps between am and pm patients due to breaks and staff changes. Identified that one regional Trust has an extra member of staff in theatre to support collecting next patient to ensure quick turnaround.
- Model Hospital unable to explain how they account for 60 minute lunchtime despite this being reported as an 'allowed' gap.

**Actions:**

- Utilisation is monitored at a specialty list level through the monthly STUG meetings to identify improvement opportunities or data quality challenges. Work with the STUG to identify themes and concerns.
- Issue with scheduling in some specialties. Working to review amount of time being allocated to specific procedures
- Monthly 6-4-2 Meetings with specialties have now commenced. Theatre transformation leads have met with Consultant body to discuss. Working towards better communication around utilisation and scheduling.

# Cancer:

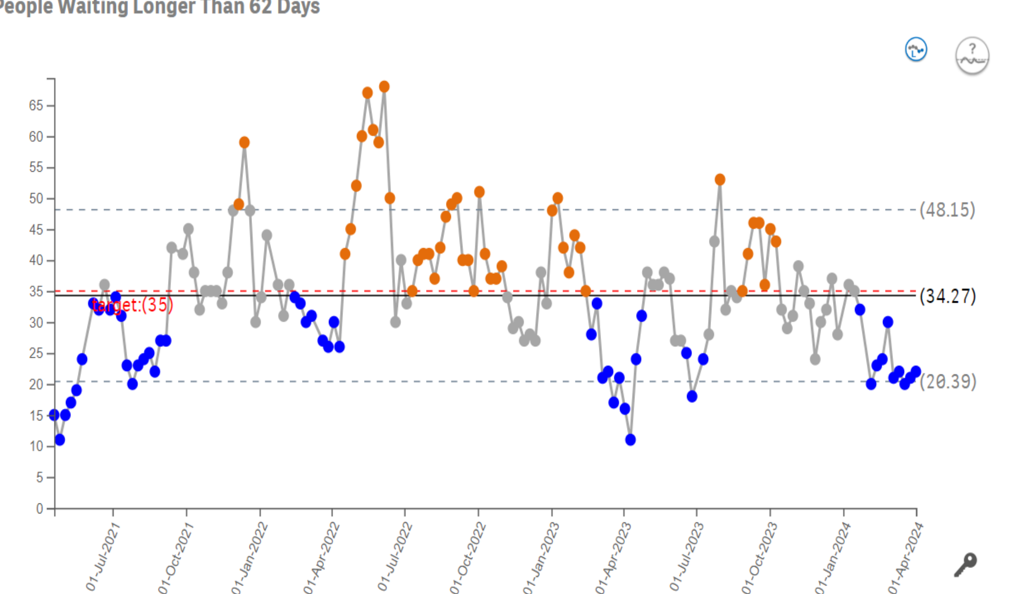
| Metric | Latest Month | Measure | Target | Variation | Assurance | Mean | Lower process limit | Upper process limit |
|---|---|---|---|---|---|---|---|---|
| Total Patients waiting >62 days to begin cancer treatment compared with February 2020 baseline | 1st April 2024 | 22 | 35 | | | 34.3 | 20.4 | 48.2 |
| Proportion of patients meeting the faster diagnosis standard | March 2024 | 83.7% | 75% | | | 77.2% | 67.3% | 87.1% |
| Non-Site-Specific Cancer Referrals | March 2024 | 33 | 25 | | | 22.6 | 7.5 | 37.7 |
| Early cancer diagnosis: 75% of cases diagnosed at stage 1 or 2 by 2028 | March 2024 | 57.1% | 75% | | | 48.8% | 33.7% | 63.9% |

# 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: Courtney Burkinshaw

**Rationale:**
The NHS Constitution outlines what patients can expect and their rights when they are referred on a cancer diagnosis and treatment pathway.

**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.




**What does the chart show/context:**

- As of Monday 1st April there were 22 patients on the long waiters' report.
- 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.

**Underlying issues:**

- Lower GI, Head & Neck, and Upper GI contributing to over 62-day waiters.

**Actions:**

- Over 62-day waiters continuing to be escalated to divisional teams where appropriate. Need to identify changes that can be made to improve performance
- Need for Head and Neck review as to how we move this forward as constant pressure in the service.
- Implementation of FIT pathway starts on the 22nd April may help LGI eventually when more GP come on board.
- Need for increased capacity in OPA and theatre when new Consultants in LGI commence.
- Dermatology capacity needed as struggling to diagnose and then late onward referrals to Plastics/Max-fax.

# Proportion of patients meeting the faster diagnosis standard

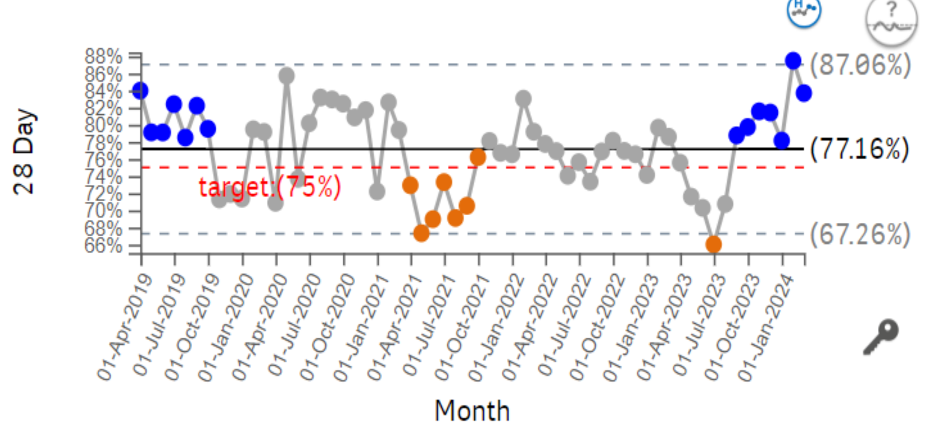
Executive Owner: Jonathan Hammond Operational Lead: Maureen Overton Business Intelligence Lead: Courtney Burkinshaw

**Rationale:**
Faster Diagnosis will facilitate an improvement in the Cancer early detection rate and thereby increase the chances of patients surviving.

**Target:**
Maximum four weeks (28 days) from receipt of referral, to point at which patient is told they have cancer, or cancer is definitely excluded. Target 75%.

**28 Day Performance SPC**

% performance over time for the 28 Day standard




| Latest |
|---|
| 83.70% |
| **Variance Type** |
| Special cause variation - improvement... |
| **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 83.70%.
- National performance tends to be under the 75% target.
- The Trust is expected to consistently meet the target of 75%. Performance can be expected to vary between 67% and 87%

**Underlying issues:**
- Skin patients now being seen within 28 Days. **Letters not typed up soon enough**. General backlog of 900-1,000 letters.
- Some improvement with Lower GI although we are working hard in this area as we still do not achieve day 28, factors preventing this are diagnostic tests turnaround for actual test and results. Delay with CTCs.
- In H&N we are frequently chasing results letters/appointments for results.

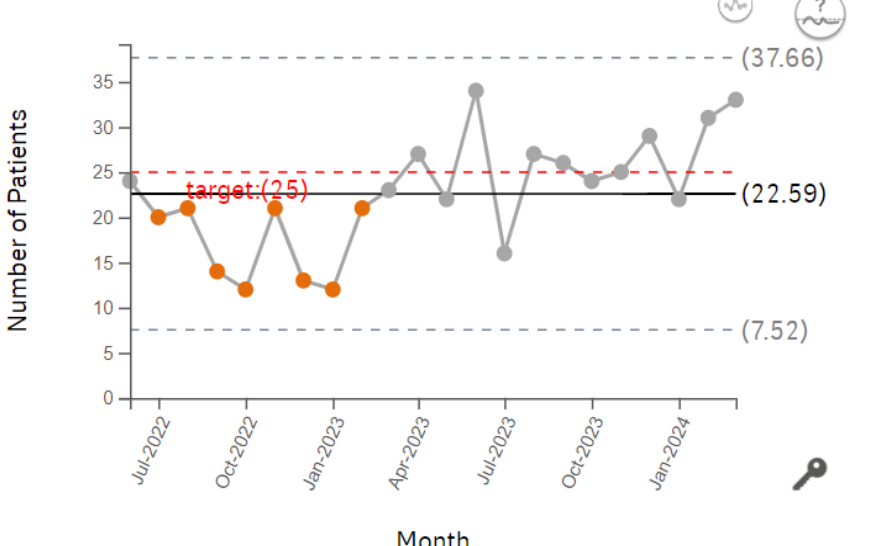
**Actions:**
- Skin have reverted back to their face-to-face clinics - Skin and the overall 28-day target have improved as a result. However implementation of Telederm is a national expectation.
- Dedicated on the day MRI reporting for patients on a fast-track prostate pathway, with biopsy slots available across the week will sustain the performance of the FDS for prostate patients.
- Discussions with UGI regarding the use of PAs on the pathway, improved performance in the last 2 months.
- Head and Neck, request for mutual aid from other Trusts and frequently chasing results letters/appointments for results, other Trusts struggling with ENT so mutual aid is unlikely.
- Lower GI and H&N work ongoing with team and closely monitoring of patients at weekly risk meeting.

# Non-Site-specific Cancer Referrals

Executive Owner: Jonathan Hammond    Operational Lead: Maureen Overton    Business Intelligence Lead: Courtney Burkinshaw

**Rationale:**
The non-specific symptoms (NSS) pathway provides a route for patients presenting with vague symptoms who may have a serious illness.

**Target:** 25 as per activity plan – March 2024




| Latest |
|---|
| 33 |
| **Variance Type** |
| Common cause variation |
| **Target** |
| 25 |
| **Target Achievement** |
| The system may achieve or fail the target subject to random variation |

**What does the chart show/context:**
- The Trust is unable to consistently meet the target of 25 and may achieve or fail the target subject to random variation. Performance can be expected to vary between 7 and 38.

**Underlying issues:**
- Referrals continue to be variable.

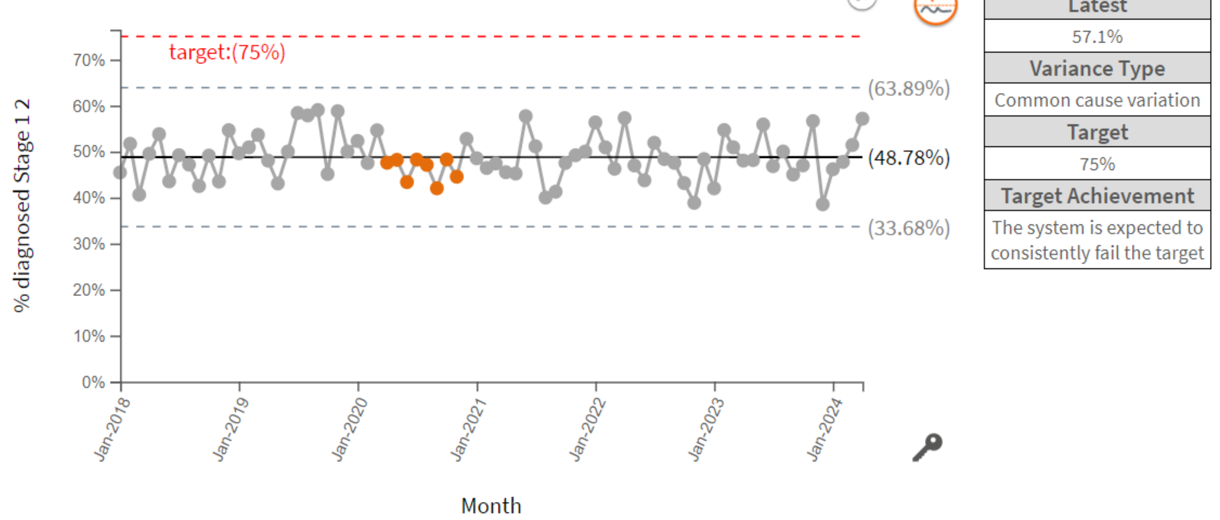
**Actions:**
- FIT pathway, with an option to refer patients with a negative FIT (FIT less than 10) to NSS.
- Sharing quarterly NSS referrals data with PCNs, continuing to raise the NSS service profile.
- Rolled out NSS in the community to a second PCN in Calderdale, Calder and Ryburn PCN, Opening up to a second PCN in Kirklees (Viaduct PCN).
- A&E referrals are continuing to grow.

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

Executive Owner: Rob Aitchison    Operational Lead: Maureen Overton    Business Intelligence Lead: Courtney Burkinshaw

**Rationale:**
Cancer is one of the biggest contributors to inequalities in life. Early presentation, referral, screening and diagnosis are key to addressing the health inequalities around diagnosis of cancer.

**Target:**
75% of all diagnosed cancer to be stage 1 or 2 by 2028.




| Latest |
|---|
| 57.1% |
| **Variance Type** |
| Common cause variation |
| **Target** |
| 75% |
| **Target Achievement** |
| The system is expected to consistently fail the target |

**What does the chart show/context:**
- The Trust is expected to consistently fail the target of 75%.
- Performance can be expected to vary between 34% and 64%.
- Nationally this metric stands at 49%

**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.
- Roll out of self-referral chest x-ray in 2024 and Targeted Lung Health checks will contribute to finding lung cancers at an earlier stage.

# Urgent and Emergency Care and Flow:

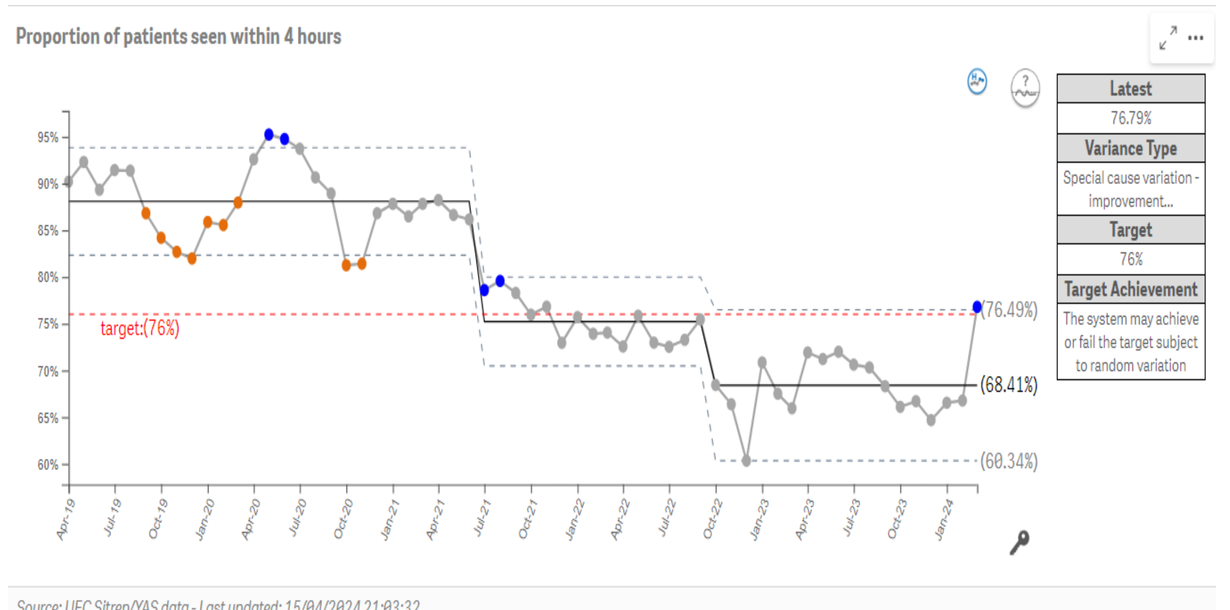
| Metric | Latest Month | Measure | Target | Variation | Assurance | Mean | Lower process limit | Upper process limit |
|---|---|---|---|---|---|---|---|---|
| Proportion of patients admitted, transferred or discharged within 4 hours | March 2024 | 76.8% | 76% | | | 68.4% | 60.3% | 76.5% |
| Proportion of ambulance arrivals delayed over 30 minutes | March 2024 | 7.9% | 0% | | | 4.2% | 1.1% | 7.3% |
| Proportion of patients spending more than 12 hours in an emergency department | March 2024 | 3.08% | 2% | | | 3.08% | 0.71% | 5.45% |
| Adult G & A acute bed occupancy adjusted for void beds (Type 1 Acutes Only) | March 2024 | 99.2% | 96% | | | 98% | 97% | 100% |
| % of beds occupied by patients who no longer meet the criteria to reside | March 2024 | 18% | 14.2% | | | 21.4% | 17.8% | 25.0% |
| Hospital Discharge Pathway Activity – AvLOS pathway 0 | March 2024 | 4.3 | 4.1 | | | 4.0 | 3.7 | 4.5 |
| Transfers of Care | March 2024 | 108 | 50 | | | 94 | 53 | 135 |

# Proportion of patients admitted, transferred or discharged 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% of patients are admitted, transferred or discharged within 4 hours by March 2024 with further improvement in 2024/25.




**What does the chart show/context:**
- The Trust met the 76% target in March for the first time in 2023/24. Special cause variation improvement.
- The performance for March was 76.79%, this is a big increase from previous months. This was linked to a big push from NHSI/CHFT to achieve the target in March.

**Underlying issues:**
- Increase in occupied beds - long wait for beds.
- Increase in acuity.
- TOC numbers still high.

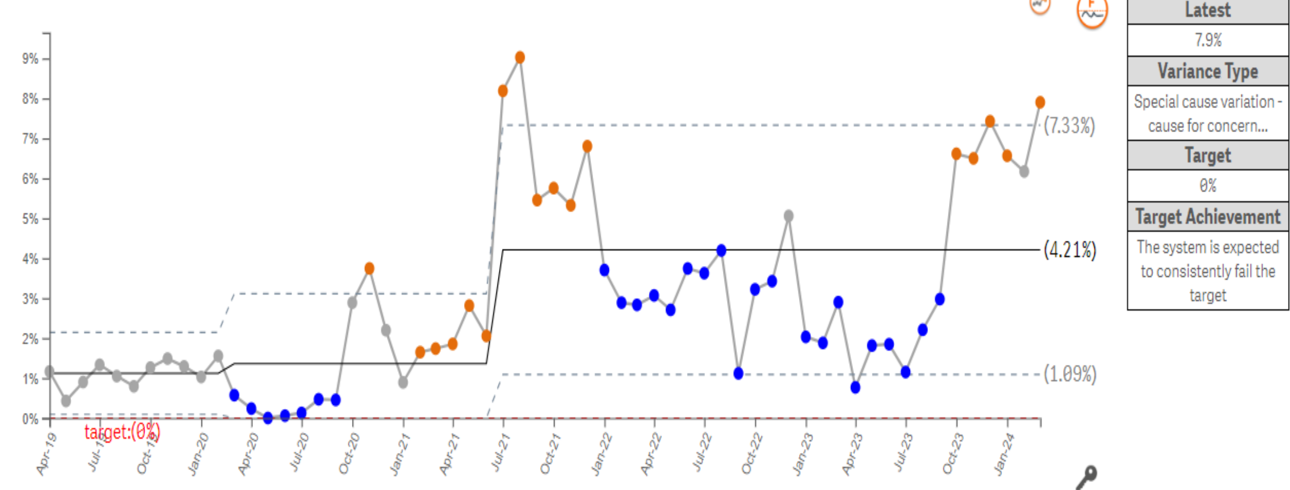
**Actions:**
- Recruitment into Medical WFM at interview stage, 22 Consultants as of 01/03/24. We will have Consultant cover 16 hours per day over 7 days by April 2024.
- Evenings into nights is problematic and breach review identifies poor skill/seniority mix in employed medical workforce. Now addressed with 2 ST4+ on nights and evening consultant staying on until department is clear.
- We are monitoring our admitted and non-admitted performance daily to try improve the overall 4-hour standard performance.
- Testing of full capacity protocol is underway, aimed at supporting reducing long waits in ED.

# 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).




**What does the chart show/context:**
- The performance for March 7.9%.
- The Trust is expected to consistently fail the target of 0%. Performance can be expected to vary between 1% and 7%.

**Underlying issues:**
- We have seen a deterioration in performance from October and this will continue as the reporting for YAS handovers has changed. The key change is the use of arrival destination as the trigger for when the clock starts. This removes any notify times previously used and as a result we have seen an increase in handover times.
- 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.
- 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.
- Testing of full capacity protocol is underway, aimed at supporting reducing long waits in ED.

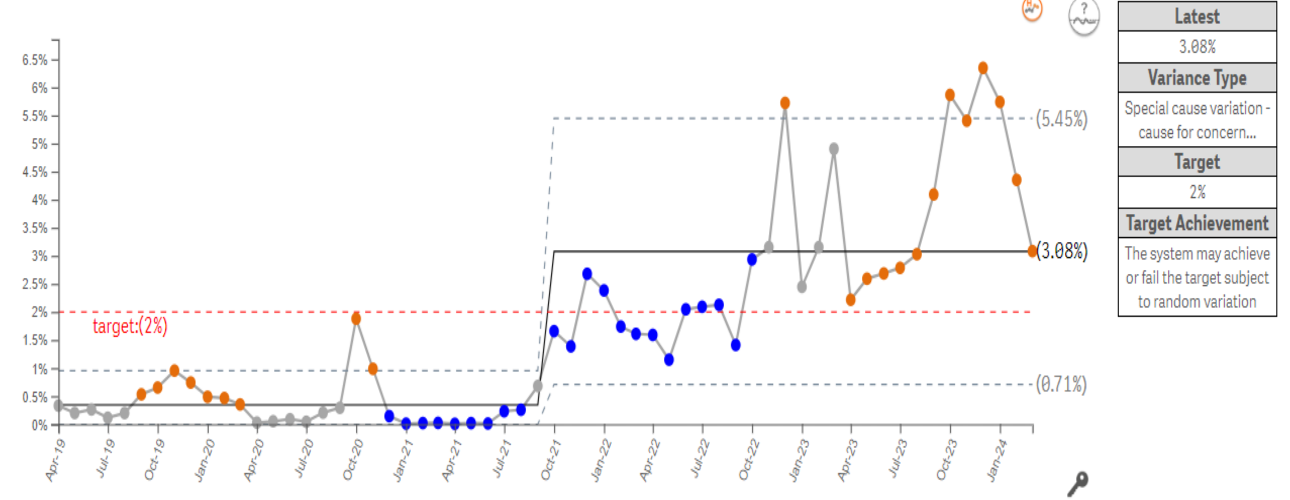
# Proportion of patients spending more than 12 hours in an emergency department

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).

Proportion of patients spending more than 12 hours in an emergency department




Source: UEC Sitrep/YAS data - Last updated: 15/04/2024 21:03:32

**What does the chart show/context:**
- Improvement in performance in March to 3.08% with 477 patients waiting over 12 hours in ED.
- Improvement in validation process in March to reduce breaches

**Underlying issues:**
- Increase in demand
- Wait for beds
- Increase in acuity

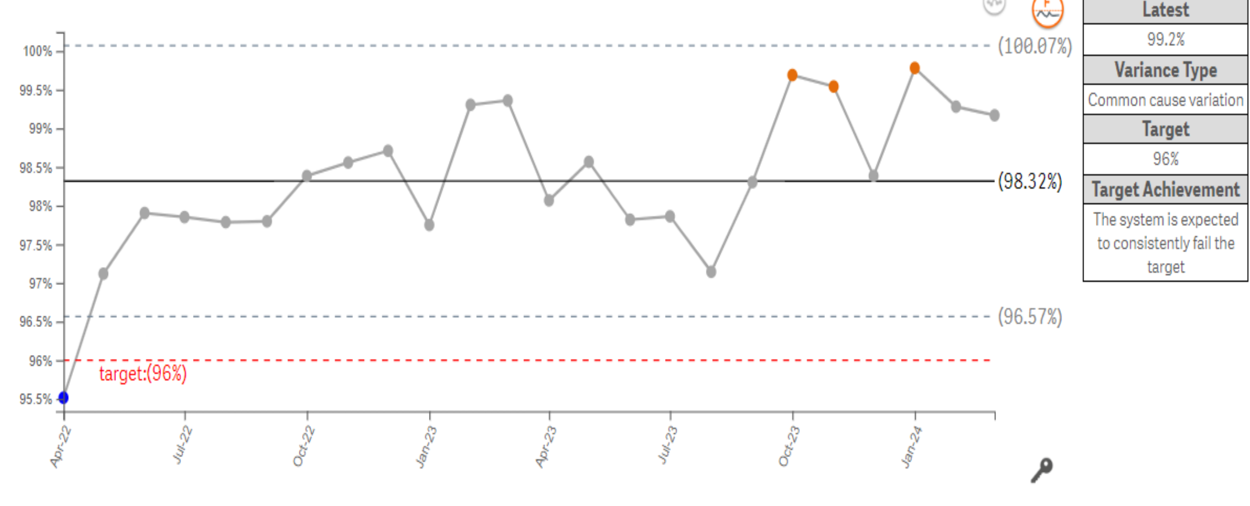
**Actions:**
- Continue to monitor all long waiting patients and expedite DTAs to allow for beds to be acquired earlier in the patient pathway.
- We continue to work with Clinical Site Matron teams in early identification of patients who will require admission.
- Testing of full capacity protocol is underway, aimed at supporting reducing long waits in ED.

# 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 in March was extremely high at 99.2%. The Trust is expected to consistently fail the target of 96%.
- It is important to factor in the bed base when analysing this graph.

**Underlying issues:**
- Large numbers of surge and super surge beds remain open as well as flexed capacity across the Acute Floor, Respiratory floor and other wards.
- Extra capacity opened to improve ECS and prevent long waits within the Emergency Department.
- Increased acuity increasing LOS.
- High TOC numbers and delays into care homes and EMI beds.

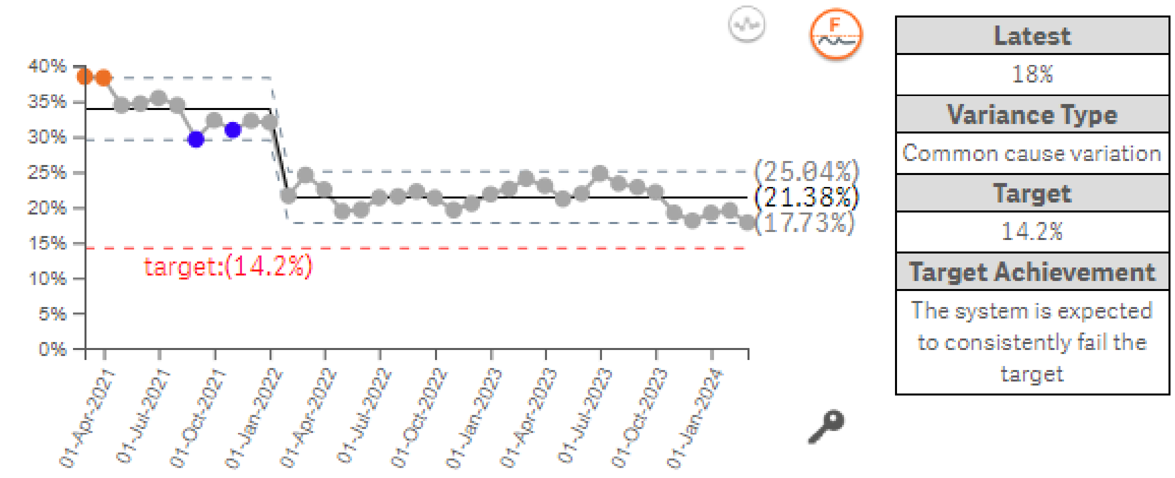
**Actions:**
- LOS reference group - targets in place to reduce LOS across wards for TOC and non-TOC patients to help reduce bed occupancy levels.
- Funded and unfunded bed base now established.
- Working with operational site teams to maintain capacity and drop occupancy levels.
- Long length of stay work.
- Trajectory for reducing TOC numbers.
- LOS Improvement Group to change with different data and ward-based discussions to link with WOW work.

# Percentage of beds occupied by patients who no longer meet the criteria to reside

Executive Owner: Jonathan Hammond Operational Lead: Michael Folan Business Intelligence Lead: Alex King

**Rationale:**
Understand the numbers of beds which are not available for patients who do meet the criteria to reside and therefore points to resources which are unavailable due to discharge issues.

**Target:** Less than 14.2% as per activity plan (March 2024).




**What does the chart show/context:**

- In March 18% of patients had no reason to reside.
- Slightly more beds were occupied in March, but this was still in line with the number of patients with no reason to reside, hence the percentage remaining similar to previous months.
- March's data is below the mean line, but within normal variation.
- The Trust will consistently fail the target of 14.2% and performance can be expected to vary between 18% and 26%.

**Underlying issues:**

- Increases in acuity across our ward areas.
- Patients not transferred onto the TOC list in a timely manner despite wards waiting for a pathway 1-3 outcome.
- The criteria to reside not being managed at ward and department level in the board and ward rounds.
- Confusion around utility and operational use of criteria to reside and relationship to discharge ready date and entry onto TOC.

**Actions:**

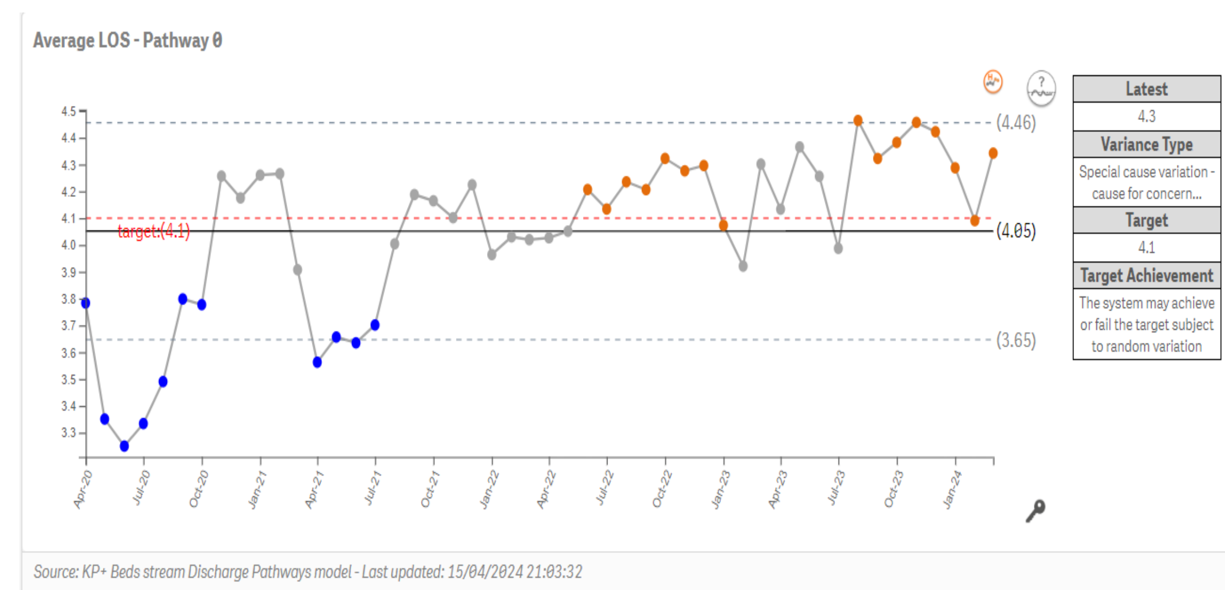
- Incorporating in well organised ward work a clear strategic steer around the operational use of discharge ready date for;
    1. Identifying patients ceasing to have a reason to reside.
    2. 'Starting' the clock to drive out unwarranted LOS across pathways 0-3.
    3. To support accurate reporting of discharge ready date (at the moment using referral date on TOC as a proxy for DRD but not accurate and only covers a subset of patients).
- Joint CHFT, Community and Local Authority dashboard under development which will give greater visibility and focus on the delays to discharge for patients on TOC.

# Hospital Discharge Pathway Activity

Executive Owner: Jonathan Hammond  Operational Lead: Renee Comerford  Business Intelligence Lead: Alastair Finn

**Rationale:**
A reduction in average length of stay for pathway 0 (less complex patients who do not require input from Health and Social care) releases capacity, gives a better patient experience and reduces possible exposure to hospital infections. Pathway 0 patients make up the majority of hospital discharges.

**Target:**
8% reduction on 2022/23 Average Length of Stay to 4.1 days.




**What does the chart show/context:**
- In March average length of stay was 4.3 days.
- Performance can be expected to vary between 3.65 and 4.46 days.

**Underlying issues:**
- Increasing attendances to ED
- Increasing acuity
- Delays in discharging

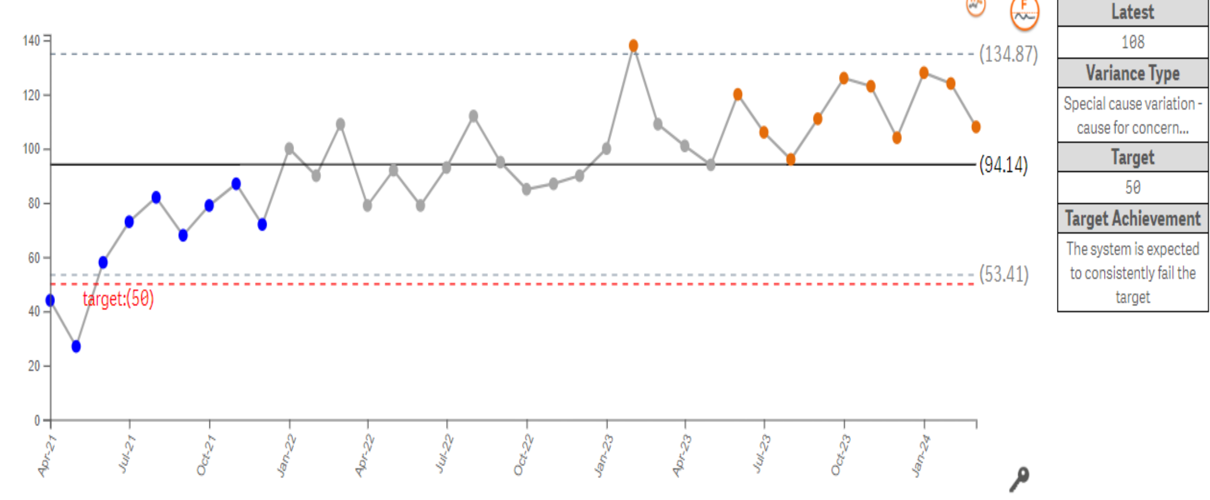
**Actions:**
- Improvement groups continue with PMO support to develop and improve groups.
- Launch of the Well Organised Ward Programme.
- Approval of funding to reablement and trusted assessors.
- New LOS pack launched in October 2023.
- Governance structures defined within the divisions and through PRMs.

# Transfers of Care

Executive Owner: Jonathan Hammond Operational Lead: Michael Folan Business Intelligence Lead: Alastair Finn

**Rationale:**
Delayed transfer of care occurs when a patient is ready to leave a hospital but is still occupying a bed. Delays can occur when patients are being discharged home or to a supported care facility, such as a residential or nursing home, or are awaiting transfer to a community hospital or hospice. Delayed transfers can cause considerable distress and unnecessarily long stays in hospital for patients. They also affect waiting times for NHS care as delayed transfers reduce the number of beds available for other patients.

**Target:** 50 patients or less




**What does the chart show/context:**
- The snapshot for the end of March was 108 patients on the TOC list which is higher than the target set at the start of the financial year.
- TOC numbers have been climbing since 2021 peaking in February 2023.
- Referrals to TOC have also followed the same trajectory.

**Underlying issues:**
- Increasing numbers on TOC
- Increasing referrals to TOC
- Resources to manage TOC have remained the same.
- Increasing need for discharge support due to aging population and increasing dependency.

**Actions:**
- Ward LOS trajectories in place and a reporting mechanism designed.
- Weekly Long LOS reviews undertaken for those patient over 60 days.
- Weekly LOS Meetings with system flow coordinator.
- Training package for complex discharges with legal team.
- System meeting to discuss TOC.
- Joint CHFT, Community and Local Authority dashboard under development which will give greater visibility and focus on the delays to discharge for patients on TOC.

# Maternity and Children's Health:

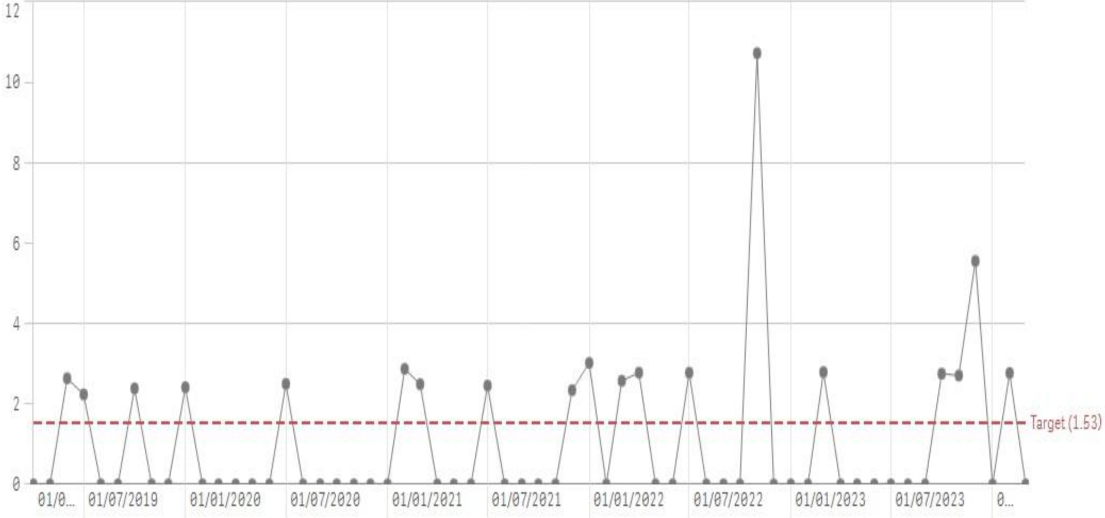
| Metric | Latest Month | Measure | Target | Variation | Assurance | Mean | Lower process limit | Upper process limit |
|---|---|---|---|---|---|---|---|---|
| Neonatal deaths per 1,000 total live births | March 2024 | 0.00 | 1.53 | - | - | - | - | - |
| Stillbirths per 1,000 total births | March 2024 | 5.29 | 3.33 | | ? | 3.84 | 0 | 13.97 |
| Maternity Workforce | March 2024 | 149.69 | tbc | | | 153.64 | 147.88 | 159.39 |

# Neonatal deaths per 1,000 total live births

Executive Owner: David Birkenhead Clinical Lead: Gemma Puckett Business Intelligence Lead: Saima Hussain

**Rationale:**
The Long-Term Plan committed the NHS to accelerate action to achieve the national maternity safety ambition of 50% reductions in stillbirth, maternal mortality, neonatal mortality and serious brain injury by 2025.

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




**What does the chart show/context:**
- There were no neonatal deaths in March

**Underlying issues:**
- Currently no underlying issues identified.
- Deaths will continue to be monitored and investigated as required. Actions below will ensure performance is maintained.

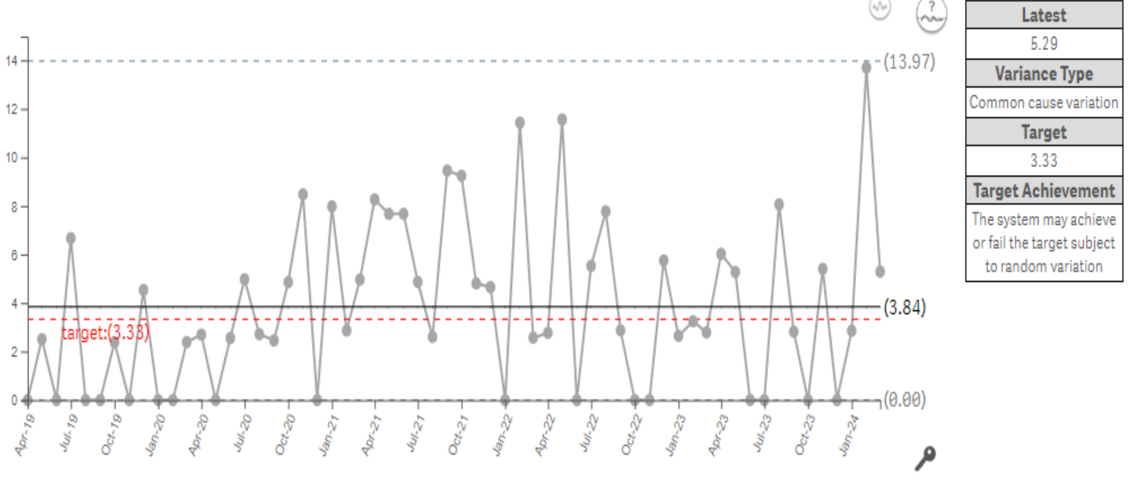
**Actions:**
- All early neonatal deaths reviewed at Orange Panel and weekly governance meeting.
- All neonatal deaths MDT PMRT (perinatal mortality review tool) completed.
- All early neonatal deaths referred to MNSI (The Maternity and Newborn Safety Investigations Programme).
- Regular quarterly stillbirth/neonatal audit undertaken.
- MDT with tertiary fetal medicine centre for known fetal anomalies.
- Work to develop the maternity and neonatal dashboard is underway including availability on KP+, use of SPC charting and benchmarking against the national maternity ambition.

# Stillbirths per 1,000 total births

Executive Owner: David Birkenhead Clinical Lead: Gemma Puckett Business Intelligence Lead: Saima Hussain

**Rationale:**
The Long-Term Plan committed the NHS to accelerate action to achieve the national maternity safety ambition of 50% reductions in stillbirth, maternal mortality, neonatal mortality and serious brain injury by 2025.

**Target:**
3.33 deaths per 1,000 live births. MBRRACE-UK




**What does the chart show/context:**
- There were two stillbirths in March.

**Underlying issues:**
- The majority of women who have experienced a loss are from a BME background, English is not their first language and live in areas of deprivation. This is reflective of the national picture and there is a national task group taking place to better understand why these women experience poorer outcomes.
- There are no continuity of carer teams currently in place and reinstating these for women from this cohort will be a priority once the workforce position has improved.
- Deaths will continue to be monitored and investigated as required.
- Actions below will ensure performance is maintained.

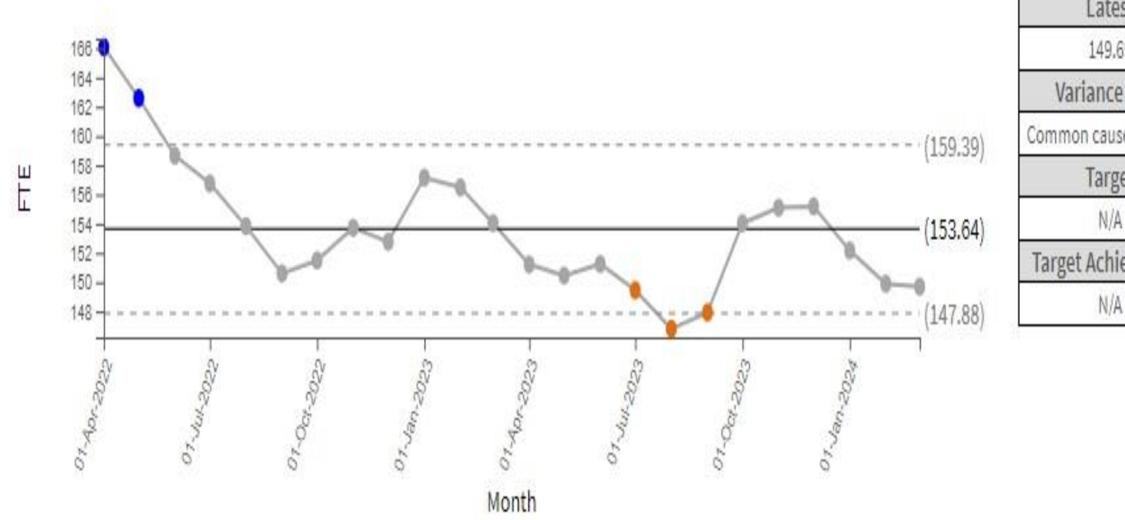
**Actions:**
- DOM now a member of the Trust Health Inequalities Group and a matron has been identified to oversee the operationalisation of any actions related to reducing health inequalities.
- All stillbirths are reviewed at Orange Panel and weekly governance meeting, health inequalities are considered.
- All stillbirths have an MDT PMRT completed (Perinatal Mortality Review Tool - a structured national tool that is used to review all deaths).
- All intrapartum stillbirths are referred to MNSI (The Maternity and Newborn Safety Investigations Programme, previously known as HSIB).
- Regular quarterly stillbirth/neonatal audit is undertaken.
- The structures for learning and sharing within the directorate are currently under review.
- Birthrate plus assessment of workforce commissioned to ensure appropriate workforce model in place and in consideration of continuity of carer.

# Maternity Workforce

Executive Owner: Lindsay Rudge    Clinical Lead: Gemma Puckett    Business Intelligence Lead: Saima Hussain

**Rationale:**
To ensure the right numbers of the right staff are available to provide safer, more personalised, and more equitable care

**Target:**




**What does the chart show/context:**
- The FTE rate has decreased slightly from February to March from 149.89 to 149.69.

**Underlying issues:**
- National Shortage of midwives
- Attrition rate of student midwives
- Retention & work life balance of existing staff
- Intense scrutiny of maternity services

**Actions:**
- Rolling recruitment programme which has also included international recruitment
- Grow your own workforce pathways: Midwifery apprenticeship, shortened programme
- Recruitment and retention midwife employed to work alongside and support new midwives in clinical practice
- Stay conversations implemented
- DoM/DDoM undertaking all exit interviews
- Recruitment films commissioned and released on social media and being used in adverts and recruitment open days
- Use of alternative roles such as registered nurses in maternity service
- Participate in centralised recruitment programme for newly qualified midwives with the LMNS
- Robust preceptorship programme
- Development of the PMA model
- Implement a programme of attending schools to encourage school leavers to consider midwifery as a career

# Community Services:

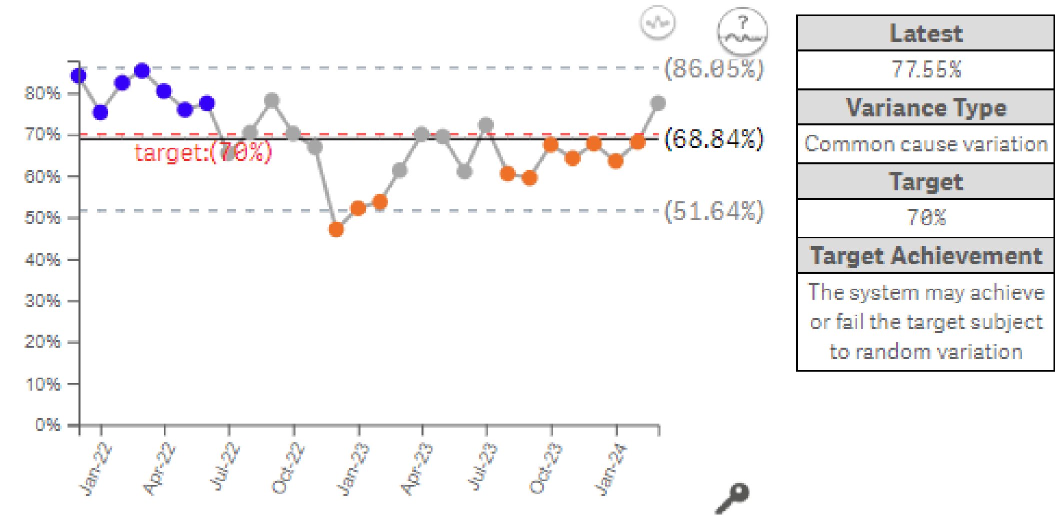
| Metric | Latest Month | Measure | Target | Variation | Assurance | Mean | Lower process limit | Upper process limit |
|---|---|---|---|---|---|---|---|---|
| Proportion of Urgent Community Response referrals reached within 2 hours | March 2024 | 77.6% | 70% | | | 68.8% | 51.6% | 86.1% |
| Community Waiting List | March 2024 | 6,214 | 4,387 (end 2023/24) | H | - | 6000.8 | 5710.9 | 6290.7 |
| Virtual Ward | March 2024 | 55% | 80% | L | ? | 92.2% | 50.9% | 133.5% |
| Patients dying within their preferred place of death | March 2024 | 95.9% | 80% | | P | 93.2% | 82.6% | 100.0% |

# Proportion of Urgent Community Response referrals reached within two hours

Executive Owner: Rob Aitchison Operational/Clinical Lead: Michael Folan/Hannah Wood Business Intelligence Lead: Gary Senior

**Rationale:**
Urgent Community Response services are a commitment in the NHS Long-Term Plan to provide urgent care to people in their homes if their health or wellbeing suddenly deteriorates.

**Target:**
% of 2-hour UCR referrals that achieved the 2-hour response standard. Clinical contact within 2 hours of referral into service. Target: 70%.




**What does the chart show/context:**
- Current position for March 2024 is at 77.6%.
- 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 51% and 86%.

**Underlying issues:**
- Change of Service-led SystmOne functionality use in December 2022 resulted in data recording issues with the contact time (Clock stop).

**Actions:**
- Communications to service leads around accurate data recording.
- Ongoing cases where 2 hours' time is taken by LCD to triage due to their processes therefore is out of the 2-hour window prior to reaching UCR.
- Manual audit being completed to examine the different elements of the 2-hour response.

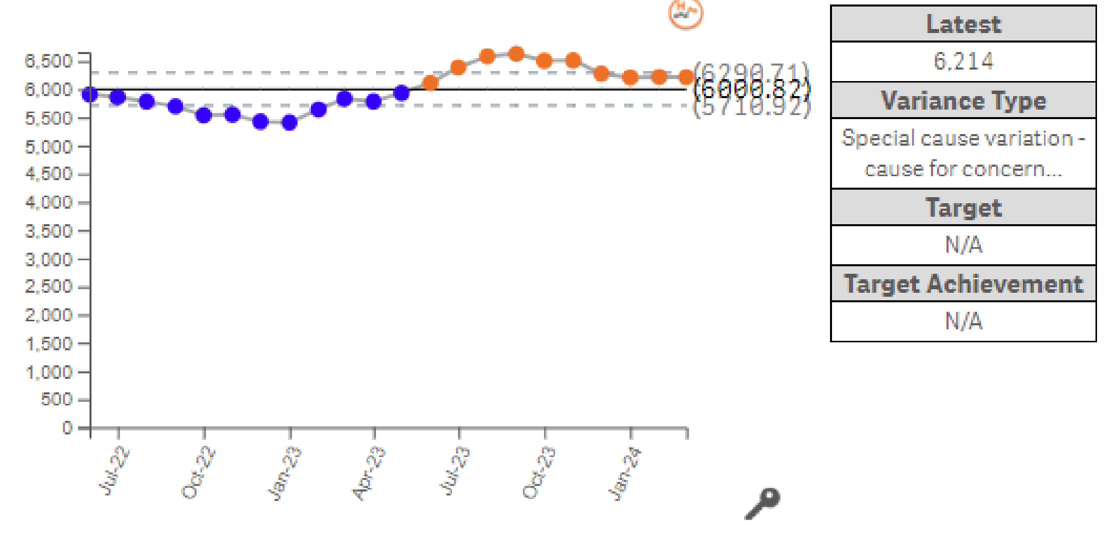
# Community Waiting List

Executive Owner: Rob Aitchison    Operational Lead: Michael Folan/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.

**Waiting list total**




Source: SR Data. Last updated 17/04/2024 16:54:25

**What does the chart show/context:**
- 6,214 total in March 2024.
- Nationally MSK and Podiatry have the highest numbers waiting.
- The MSK waiting list at CHFT accounts for 630 patients on the community waiting list.

**Underlying issues:**
- Podiatry and Children's SALT are our main concerns.
- Children's SALT workforce issues remain difficult, we currently have 1.2 band 6 vacancies in that team having recruited to other outstanding vacancies as well as 2x WTEs on maternity leave. Recent recruitment should support this position but will take a number of months until in post. 1x WTE B7 post to advert and staff member has finished with the Trust. Team Lead has also reduced hours at financial year end. Locum has also finished with the Trust.
- Podiatry is appropriately prioritising high-risk patients, therefore the routine waiting list has been reducing. Additional clinics are now happening following some recruitment and the service specification is also under review which will have an impact.

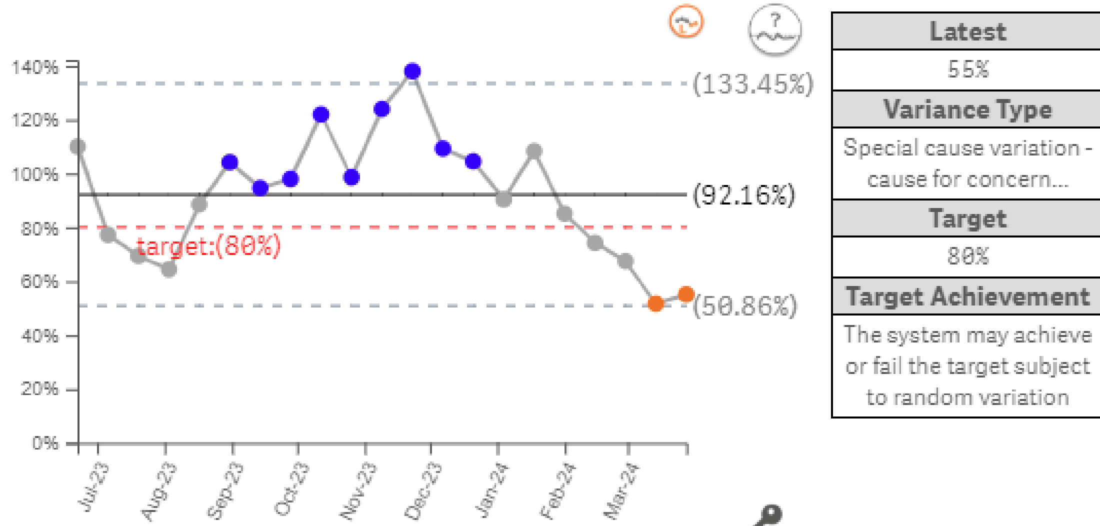
**Actions:**
- SALT recruitment pressures – 2x recruits with start dates, ongoing B7 recruitment, looking for locum support
- Transition to new SALT service structure has begun with percentage increase in wait list reducing since this point. Service now in a sustainable position with number of referrals added each month also being removed – backlog still being addressed.
- The Podiatry service is undergoing a review, including workforce modelling and a review of the service specification. The plan is to implement to new service spec in the new financial year. The engagement work will begin in May 2024.

# Virtual Ward

Executive Owner: Rob Aitchison   Operational Lead: Michael Folan/Hannah Wood   Business Intelligence Lead: Gary Senior

**Rationale:**
Monitor occupancy rate of Virtual Wards - Respiratory and Frailty services. The CHFT plan currently has a bed base of 42

**Target:**
Number of patients on the Virtual Ward caseload compared to the number of beds available/allocated. Target 80%.




**What does the chart show/context:**
- Current combined position for March 2024 is 55%.
- March 2024 not achieving target of 80% - special cause variation
- Admissions and activity remain consistent and above trajectory.

**Underlying issues:**
- Currently there is only a 5-day consultant offer for frailty virtual ward as 7-day cover is not funded. This limits referrals towards the end of the week due to concern they may need consultant input over a weekend.

**Actions:**
- Medical division reviewing medical cover to support a 7-day Multi Discipline Team meeting for Frailty virtual ward. Other organisations have not all been able to recruit consultants but backfilled with a registrar.
- Advanced Clinical Practitioner working on Frailty Same Day Emergency Care on a weekend is supporting Kirklees virtual Frailty service with advice and guidance.
- Kirklees are reviewing the urgent community response service to establish if they can be aligned with the virtual ward.
- Frailty criteria have been amended to ensure we can take more frail and older people from across areas.
- Next phased step-up pathway being designed to take GP and day patients as currently just from Urgent Community Response Service.
- Respiratory - criteria now changed to include patients requiring oxygen weaning.
- Team attend safety huddles each day.

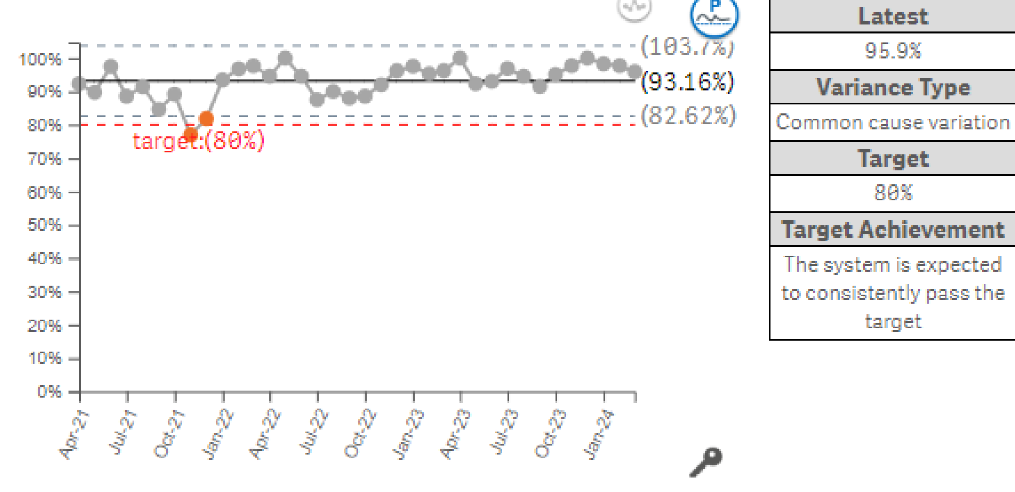
# Patients dying within their preferred place of death

Executive Owner: Lindsay Rudge     Operational Lead: Michael Folan/Abbie Thompson     Business Intelligence Lead: Gary Senior

**Rationale:**
% of patients dying within their preferred place of death – Community Palliative Care.

**Target:** Over 80%

% All patients




Source: SR Data. Last updated 17/04/2024 16:45:58

- CSPCT – Calderdale Specialist Palliative Care Team
- PPD – Preferred place of death
- CNS – Clinical Nurse Specialist
- WFM – Work Force Model

**What does the chart show/context:**

- Consistently above 80% target (exception November 2021).
- March 2024 total 95.9% (Out of Hours End of Life care100% and Palliative 92.9%) 87.5% died at 'home'.

**Underlying issues:**

- Workload pressures – continual increase in patient referrals per annum.
- Acuity and complexity of need – evidenced by number of low performance scores – patients are increasingly in urgent need of specialist intervention due to late presentation / diagnosis or multiple comorbidity.
- CSPCT continue to work additional hours to keep patients safe – limiting GP call-outs by utilising Independent Prescribing / assessment skills and coordinating care with Acute hospital teams to streamline patient interventions and reduce length of hospital stay (avoiding ED wherever possible).
- OOH EoLC – currently working extended hours for a further 12 months (March 2025) as result of successful Innovation bid. Need to secure funding to facilitate the new Workforce Model to include (in conjunction with existing joint service agreement with Marie Curie) from April 2025.
- Hospital SPCT In-Reach project funded by Calderdale ICB Innovation Bid commenced December 2023 – awaiting dashboard data – significant impact on facilitating patients back to home / care home or hospice – reduced in-patient admission and reduced length of stay improves achieving PPD.
- Care Home Palliative CNS project funded by Cald ICB Innov Bid commenced July 2023 –working alongside QUEST - has improved patient safety and outcomes in ensuring patients not inappropriately admitted to hospital and supported to remain in care home setting.

**Actions:**

- To ensure continued funding for all teams (with review of WFM for HSPCT) to maintain this strong position of achieving preferred place of death, facilitating the vast majority to die at home, appropriate admission to hospice and reducing deaths in the acute hospital setting.

# Health Inequalities: Learning Disabilities

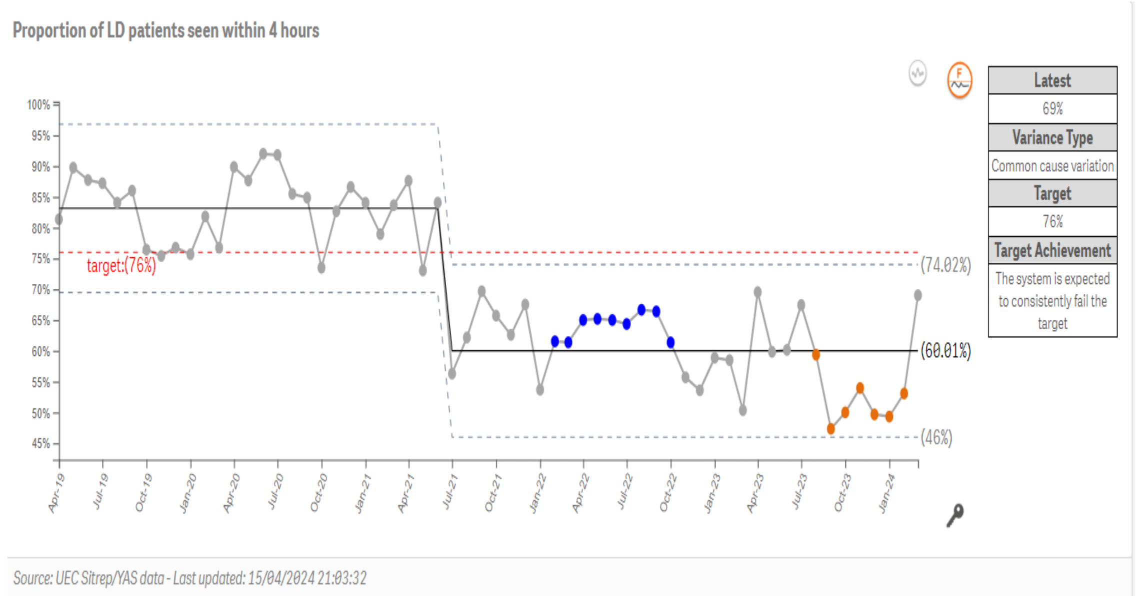
| Metric | Latest Month | Learning Disability Measure | Overall Measure | Target | Variation | Assurance | Mean | Lower process limit | Upper process limit |
|---|---|---|---|---|---|---|---|---|---|
| Emergency Care Standard | March 2024 | 69% | 76.8% | 76% | | F | 60% | 46% | 74% |
| Outpatients DNAs | March 2024 | 8.1% | 6.4% | 3% | | F | 9.05% | 3.09% | 15.01% |
| Cancer Faster Diagnosis Standard | March 2024 | 33.3% | 83.7% | 75% | | ? | 63% | 0% | 100% |
| % of patients waiting less than 6 weeks for a diagnostic test | March 2024 | 90.2% | 90.1% | 95% | | ? | 86.3% | 69.9% | 100% |
| Patients waiting more than 40 weeks to start treatment | March 2024 | 8 | 740 | 0 | H | F | - | - | - |

# Emergency Care Standard: Learning Disability

Executive Owner: Rob Aitchison Operational Lead: Jason Bushby/Amanda McKie Business Intelligence Lead: Alastair Finn

**Rationale:**
To monitor waiting times in A&E for patients with a Learning Disability

**Target:**
NHS Objective to improve A&E waiting times so that no less than 76% of patients are admitted, transferred or discharged within 4 hours by March 2024 with further improvement in 2024/25.




**What does the chart show/context:**

- The Trust is consistently failing the 4-hour target of 76% for patients with a Learning Disability attending ED. Performance can be expected to vary between 46% and 74%.
- The performance in March increased to 69% which is lower than the overall Trust 4-hour standard which was 76.79%. Higher conversion rate to inpatients impacts on performance.

**Underlying issues:**

- Bed occupancy levels within the organisation, resulting in bed waits within the ED which in turn causes congestion, lack of clinical space for patients to be reviewed and diverts ED medical and nursing resource to care for patients who would be better cared for in an inpatient bed space.
- Audit showed Learning Disability patients more likely to need admission often due to late presentation and a longer wait as requirement for a side room on admission (reasonable adjustment).
- Workforce related issues, short term sickness, vacancy levels, which cause on the day workforce model gaps within the ED medical and nursing workforce resulting in potential delays to ED investigation, treatments and time to see clinician.

**Actions:**

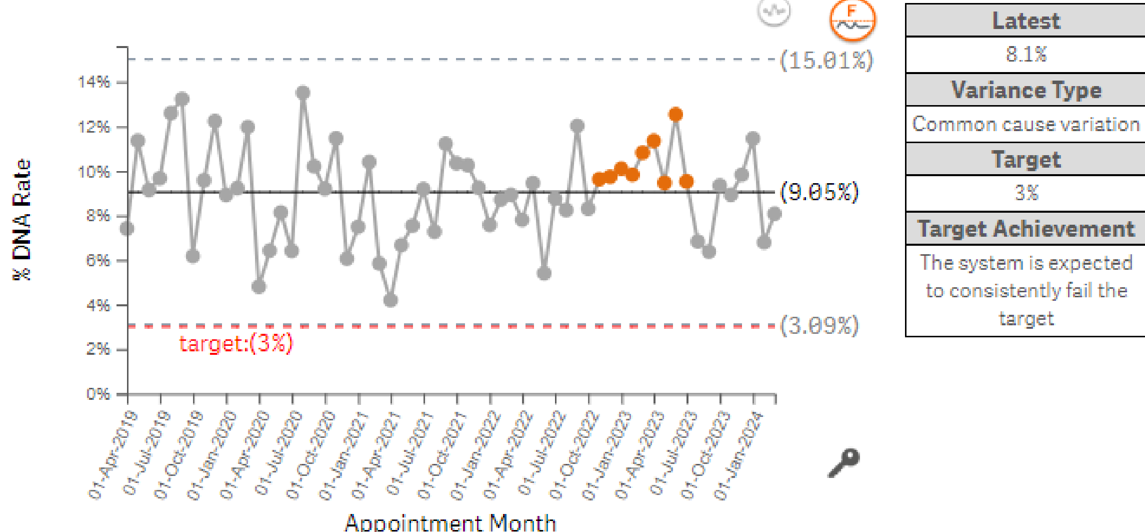
- Health Inequalities Meeting to support learning and actions from Learning Disability audit.

# % Did Not Attend (DNA): Learning Disability

Executive Owner: Rob Aitchison Operational Lead: Kim Scholes/Amanda McKie Business Intelligence Lead: Oliver Hutchinson

**Rationale:**
To monitor DNA rates at first and follow-up appointments for patients with a Learning Disability

**Target:**
3% - Elective Transformation Workstream target to reduce to 3% by the end of 2023/24.




| Latest |
| --- |
| 8.1% |
| **Variance Type** |
| Common cause variation |
| **Target** |
| 3% |
| **Target Achievement** |
| The system is expected to consistently fail the target |

**What does the chart show/context:**

- The current DNA rate for appointments for patients with a Learning Disability declined in March 2024 and stands at 8.1%.
- This performance has remained within the expected range from April 2019 to date and shows consistent common cause variation throughout that time.
- This sits above the DNA % for the wider population at CHFT for outpatient appointments which currently stands at 6.4% for March 2024.

**Underlying issues:**

- Need to audit DNAs to understand reasons for high DNA rate for patients with a Learning Disability.

**Actions:**

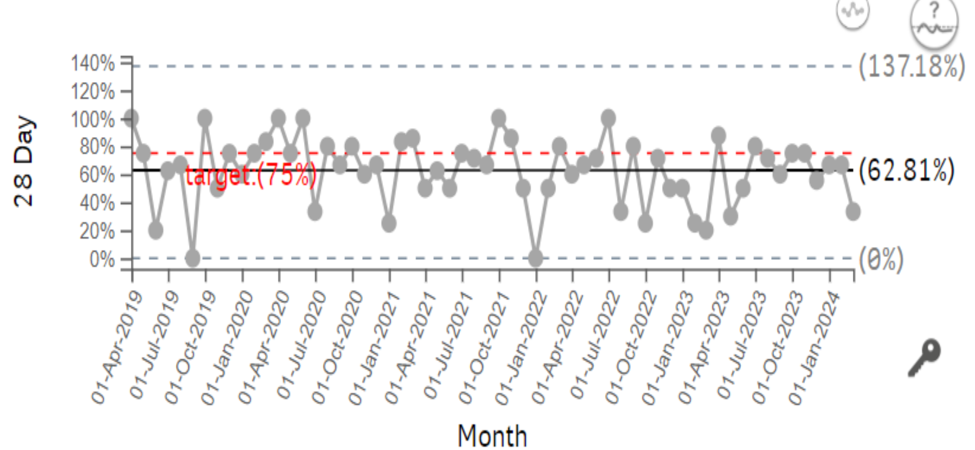
- Audit of patients to understand reasons for DNA completed. To be reported to Health Inequalities meeting.
- Project to improve patient communication and letters – including new templates and considerations of accessible information standards and health literacy.

# Proportion of patients meeting the faster diagnosis standard: Learning Disability

Executive Owner: Rob Aitchison Operational Lead: Maureen Overton/Amanda McKie Business Intelligence Lead: Courtney Burkinshaw

**Rationale:**
Faster Diagnosis will facilitate an improvement in the Cancer early detection rate and thereby increase the chances of patients surviving.

**Target:**
Maximum four weeks (28 days) from receipt of referral, to point at which patient is told they have cancer, or cancer is excluded. Target 75%.




**What does the chart show/context:**
- Latest monthly performance stands at 33.33% which is below the NHSE target and Trust performance of 83.7% for non-Learning Disability patients.
- 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 0% and 100%.

**Underlying issues:**
- Capacity of Complex Needs Matron.
- 2-week referral to first seen date is consistently achieved for patients with a Learning Disability so focus needs to be on diagnostic and communication of diagnosis part of the pathway.

**Actions:**
- Audit of patients to understand reasons for high level of breaches to be done March 2024 and is expected to be reported at the April Cancer Delivery Group meeting. Findings will be added to the April 2024 IPR.

# Percentage of patients waiting less than 6 weeks for a diagnostic test: Learning Disability

Executive Owner: Rob Aitchison Operational Leads: Thomas Strickland/Stephen Shepley/Helen Rees/Amanda McKie
Business Intelligence Lead: Rebecca Spencer

**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%.

LD Diagnostic patients waiting less than 6 weeks

(102.64%)
target:(95%)
(86.25%)
(69.86%)
100%
95%
90%
85%
80%
75%
70%
Jul-22
Oct-22
Jan-23
Apr-23
Jul-23
Oct-23
Jan-24

Latest
90.2%
Variance Type
Common cause variation
Target
95%
Target Achievement
The system may achieve or fail the target subject to random variation

Source: DM01 Submission Data - Last updated: 08/04/2024 21:03:32

**What does the chart show/context:**

- Latest monthly performance stands at 90.2% which does not meet the NHSE target of 95%. In-month performance is significantly lower than CHFT overall performance which is 90.1%.
- The Trust is unable to consistently meet the target of 95% and may achieve or fail the target subject to random variation. Performance can be expected to vary between 69% and 100%.

**Underlying issues:**

- Learning Disability patient performance reflects CHFT performance and is being impacted by capacity issues in Echocardiography and Neurophysiology.

**Actions:**

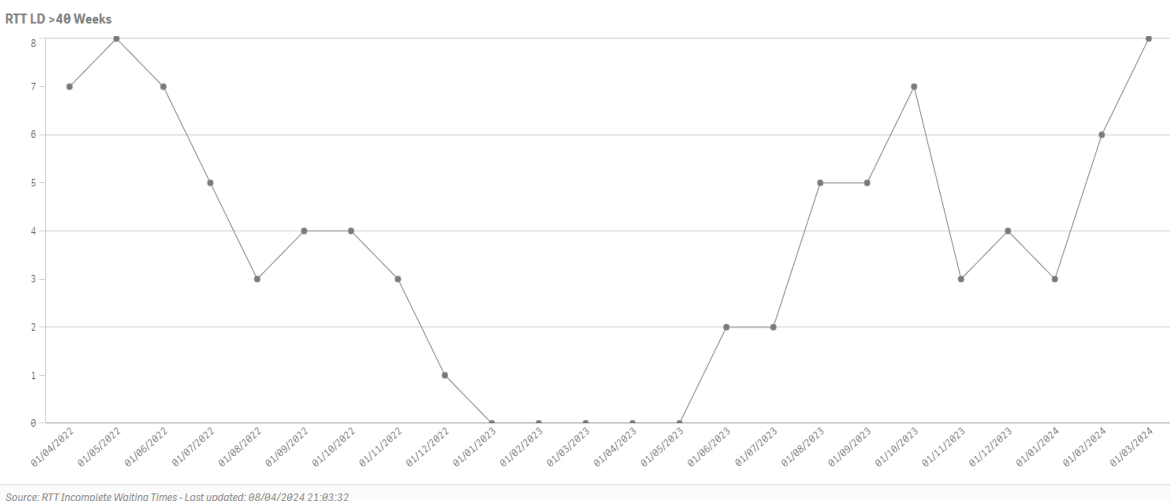
- Audit of Learning Disability breaches to check no other reasons for breaches other than capacity completed. To be reported to Health Inequalities meeting.
- Matron for Complex Needs given access to KP+ model to monitor Learning Disability patients on a diagnostic waiting list.

# Total Patients waiting more than 40 weeks to start consultant-led treatment: Learning Disability

Executive Owner: Rob Aitchison Operational Lead: Thomas Strickland/Amanda McKie
Business Intelligence Lead: Rebecca Spencer

**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 (excluding ENT) from April 2024 onwards.




**What does the chart show/context:**
- There are currently 8 patients with a Learning Disability who have waited more than 40 weeks

**Underlying issues:**
- Learning Disability patient performance reflects CHFT performance.

**Actions:**
- Focus to be given at start of Access meetings for any learning disability patients over 40 weeks.
- Results from audit to be taken to Health Inequalities Meeting for discussion and agreement on any required actions.
- Matron for Complex Needs given access to KP+ model to monitor Learning Disability patients on an RTT waiting list and will be included as part or monthly meetings with Surgical team when reviewing waiting lists for Learning Disability patients.
- Identified issue of patient needing F2F appointments at clinician review but not actioned to be addressed.

# Health Inequalities: Deprivation (IMD 1 and 2)

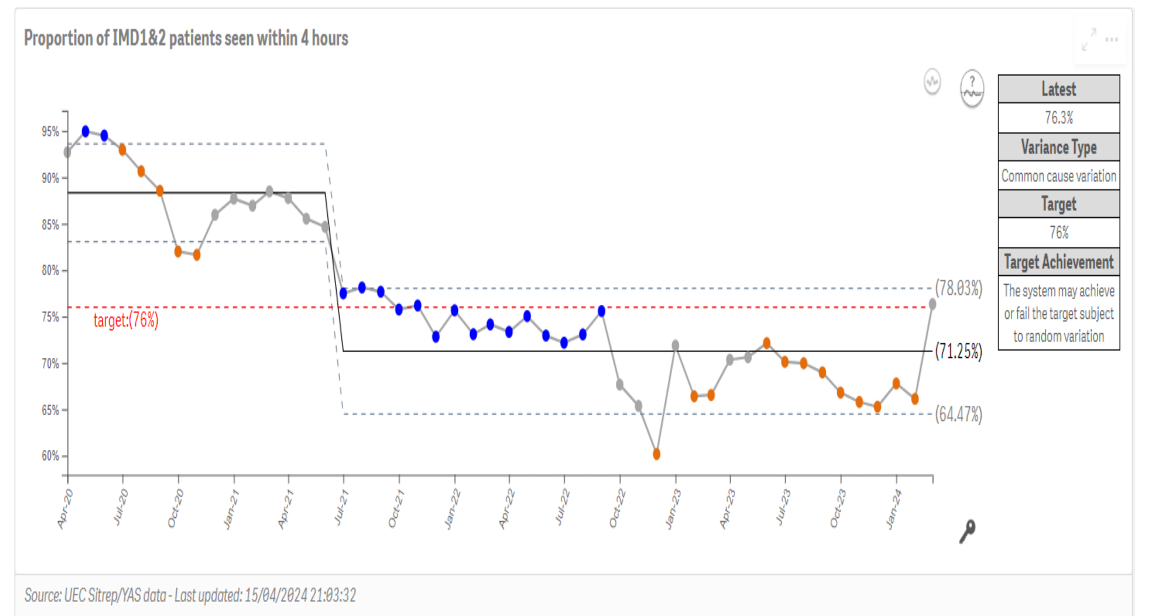
| Metric | Latest Month | IMD 1& 2 Measure | Overall Measure | Target | Variation | Assurance | Mean | Lower process limit | Upper process limit |
|---|---|---|---|---|---|---|---|---|---|
| Emergency Care Standard | March 2024 | 76.3% | 76.8% | 76% | | | 71.3% | 64.5% | 78.0% |
| Outpatients DNAs | March 2024 | 8.9% | 6.3% | 3% | | | 9.6% | 8.1% | 11.1% |
| Cancer Faster Diagnosis Standard | March 2024 | 80.3% | 83.7% | 75% | | | 75.4% | 62.2% | 88.6% |
| % of patients waiting less than 6 weeks for a diagnostic test | March 2024 | 93.7% | 90.1% | 95% | | | 86.2% | 69.6% | 100% |
| Patients waiting more than 40 weeks to start treatment | March 2024 | 253 | 740 | 0 | | | - | - | - |

# Emergency Care Standard: Deprivation (IMD 1 and 2)

Executive Owner: Rob Aitchison Operational Lead: Jason Bushby Business Intelligence Lead: Alastair Finn

**Rationale:**
To monitor waiting times in A&E for patients with deprivation levels IMD 1 and 2

**Target:**
NHS Objective to improve A&E waiting times so that no less than 76% (80% local target) of patients are admitted, transferred or discharged within 4 hours by March 2024 with further improvement in 2024/25.




**What does the chart show/context:**
- The Trust achieved the target of 76% for March.
- Performance can be expected to vary between 64% and 78%.
- The performance for March was 76.3% which is in line with the overall Trust performance for all ED attendances.

**Underlying issues:**
- Bed occupancy levels within the organisation, resulting in bed waits within the ED which in turn causes congestion, lack of clinical space for patients to be reviewed and diverts ED medical and nursing resource to care for patients who would be better cared for in an inpatient bed space.
- Workforce related issues, short term sickness, vacancy levels, which cause on the day workforce model gaps within the ED medical and nursing workforce resulting in potential delays to ED investigation, treatments and time to see clinician.

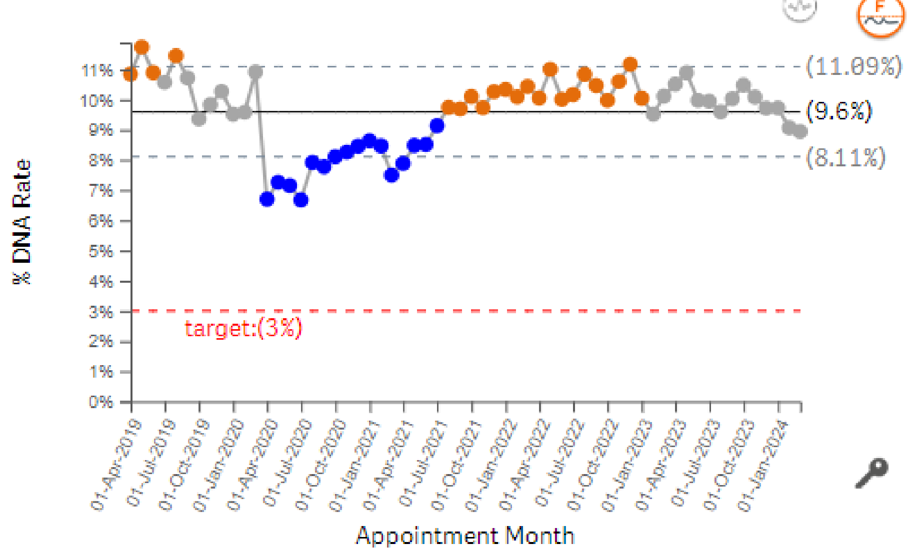
**Actions:**
- Recruitment into Medical WFM at interview stage, 3 locum consultants appointed.
- Evenings into nights is problematic and breach review identifies poor skill/seniority mix in employed medical workforce. Now addressed with 2 ST4+ on nights and evening consultant staying on until department is clear.
- We are monitoring our admitted and non-admitted performance daily to try improve the overall 4-hour standard performance.
- Testing of full capacity protocol is underway, aimed at supporting reducing long waits in ED.

# % Did Not Attend (DNA): Deprivation (IMD 1 and 2)

Executive Owner: Rob Aitchison    Operational Lead: Kim Scholes    Business Intelligence Lead: Oliver Hutchinson

**Rationale:**
To monitor DNA rates at first and follow-up appointments for patients who are in the most deprived areas

**Target:**
3% - Elective Transformation Workstream target to reduce to 3% by the end of 2023/24.




| Latest |
|---|
| 8.9% |
| **Variance Type** |
| Common cause variation |
| **Target** |
| 3% |
| **Target Achievement** |
| The system is expected to consistently fail the target |

**What does the chart show/context:**

- The current DNA rate for appointments for patients from the IMD 1 and 2 groups stands at 8.9% for March 2024.
- This performance has remained within the expected range from April 2021 to date and shows consistent common cause variation throughout that time.
- This performance does however represent performance that is consistently failing the target of 3%.
- This sits above the DNA % for the wider population at CHFT for outpatient appointments which currently stands at 6.4% for March 2024.

**Underlying issues:**

- Need to audit DNAs to understand reasons for high DNA rate for IMD 1 and 2 patients.

**Actions:**

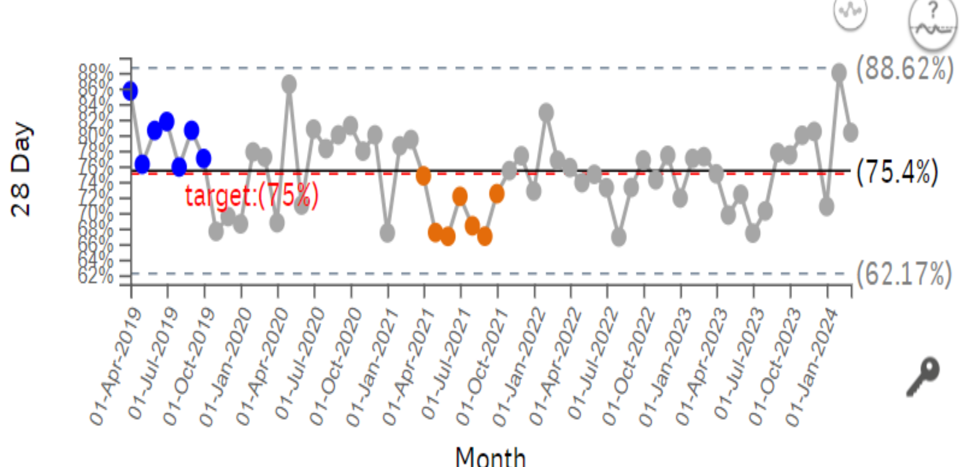
- Project to improve patient communication and letters – including new templates and considerations of accessible information standards and health literacy.
- Stage 2 of trial to commence calling patients from IMD 1&2 who are most likely to DNA and booking appointment to an agreed time/ date with the aim to reduce the DNA rate.
- Implementation of social vulnerability metrics being piloted in different areas.
- New DNA meeting to start and to include HI data.

# Proportion of patients meeting the faster diagnosis standard: Deprivation (IMD 1 and 2)

Executive Owner: Rob Aitchison Operational Lead: Maureen Overton Business Intelligence Lead: Courtney Burkinshaw

**Rationale:**
Faster Diagnosis will facilitate an improvement in the Cancer early detection rate and thereby increase the chances of patients surviving.

**Target:**
Maximum four weeks (28 days) from receipt of referral, to point at which patient is told they have cancer, or cancer is excluded. Target 75%.




**What does the chart show/context:**

- Latest monthly performance stands at 80.31% which is above the NHSE target. Performance for this group of patients is in line with the overall Trust performance at 83.7%.
- 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 63% and 89%.

**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. Head and Neck and Haematology are also not meeting the 28-day target.

**Actions:**

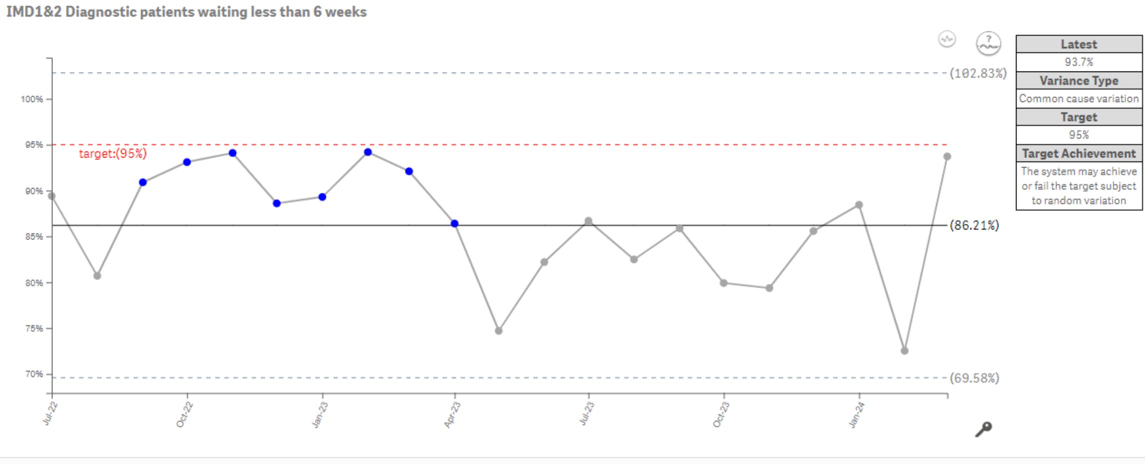
- Dermatology is still struggling with minor ops and biopsies.
- Head and Neck, continue to have problems with OPA and diagnostics request for mutual aid from other Trusts.

# Percentage of patients waiting less than 6 weeks for a diagnostic test: Deprivation (IMD 1 and 2)

Executive Owner: Rob Aitchison
Operational Leads: Thomas Strickland/Stephen Shepley/Helen Rees
Business Intelligence Lead: Rebecca Spencer

**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:**

- Latest monthly performance stands at 93.7% which is below the NHSE target and overall CHFT in-month performance of 90.1%
- The Trust is unable to consistently meet the target of 95% and may achieve or fail the target subject to random variation. Performance can be expected to vary between 69.5% and 100%.

**Underlying issues:**

- 2 modalities (Echocardiography/Neurophysiology) still have significant numbers of pathways >6 weeks.
- Without those modalities, the remaining tests are achieving over 95%.

**Actions:**

- Echocardiography and Neurophysiology - As per overall Trust action plans.

# Total Patients waiting more than 40 weeks to start consultant-led treatment: Deprivation (IMD 1 and 2)

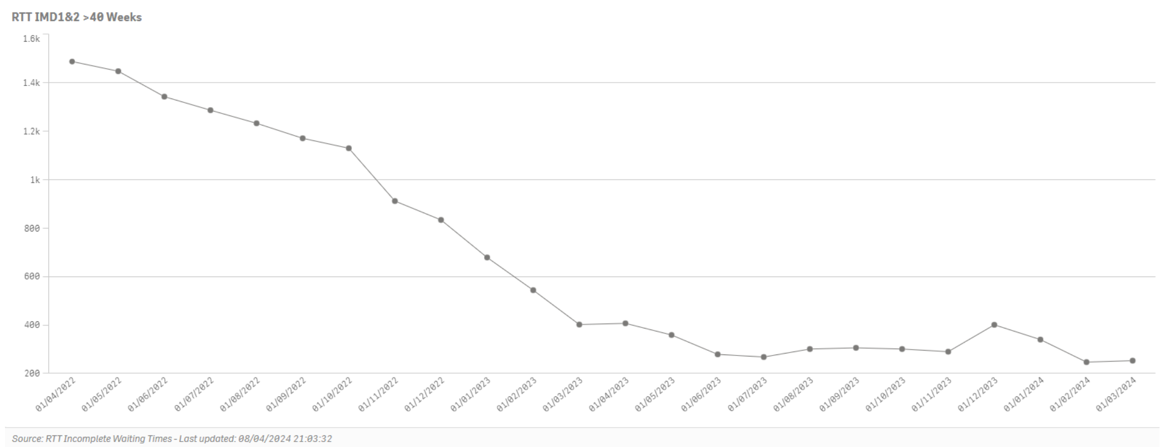
Executive Owner: Rob Aitchison

Operational Lead: Thomas Strickland

Business Intelligence Lead: Rebecca Spencer

**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 (excluding ENT) from April 2024 onwards.




**What does the chart show/context:**

- Our 40-week position reduced rapidly between April 2022 and April 2023 and has since started to level out.

**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.

**Actions:**

- Operational teams to be tracking patients to at least 40 weeks.
- KP+ writeback model being used by all operational teams to ensure that tracking actions are transparent and cannot be overwritten by Validation teams.
- ENT Task and Finish Group concluded with actions in place and are working to 52-week compliance by the end of March.
- Actions have been identified in 3 cohort areas:
    - Demand management
    - Increasing internal capacity
    - Increasing external capacity
- Number of >40 week waits impacted by Industrial action is being tracked.

# Workforce:

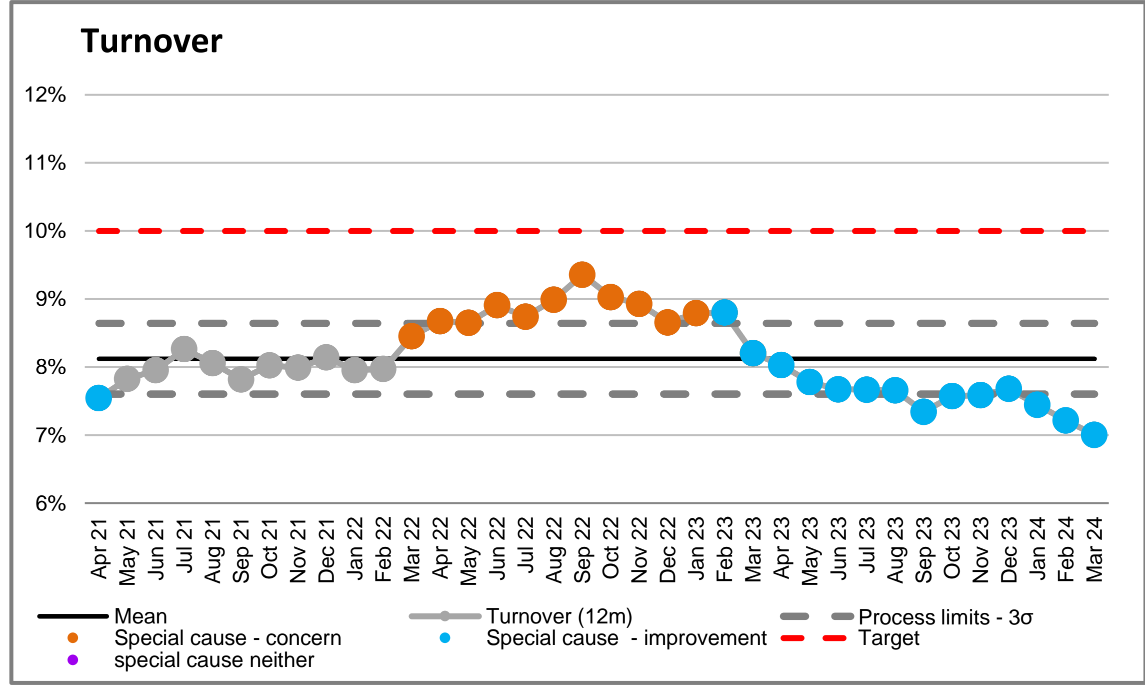
| Metric | Latest Month | Measure | Target | Variation | Assurance | Mean | Lower process limit | Upper process limit |
|---|---|---|---|---|---|---|---|---|
| Staff Movement (Turnover) | March 2024 | 7.01% | 10.0% | | | 8.12% | 7.60% | 8.64% |
| Sickness Absence (Non-Covid) | March 2024 | 4.54% | 4.75% | | | 4.84% | 4.19% | 5.50% |
| Appraisal Compliance (YTD) | March 2024 | 83.60% | 95.0% | - | - | - | - | - |
| Core EST Compliance | March 2024 | 93.29% | 90.0% | | | 93.19% | 92.11% | 94.27% |
| Bank Spend | March 2024 | £3.07M | - | | | £3.20M | £2.00M | £4.18M |
| Agency Spend | March 2024 | £1.13M | £0.53M | | | £0.89M | £0.58M | £1.20M |

# Staff Movement (Turnover)

Executive Owner: Suzanne Dunkley | Lead: Adam Matthews | Business Intelligence Lead: Mark Bushby

**Rationale:**
It is healthy for an organisation to have a reasonable level of staff turnover, there is a balance between losing valuable, knowledgeable staff and bringing in new colleagues with fresh ideas and ways of working.

**Ceiling: 10.00%** **Current: 7.01%**




**What does the chart show/context:**
- Total FTE lost due to colleagues leaving all employment with the Trust against the average headcount of the reporting period.
- Turnover is consistently below the Trust ceiling of 10.00%.
- Current turnover rate is slightly below the mean average at 7.01%.
- The Trust benchmarks well against other WYAAT organisations.

**Underlying issues:**
- Directorates with turnover above the 10% ceiling include FSS Management (23.6%), Workforce and OD (15.2%) and Quality (12.7%).

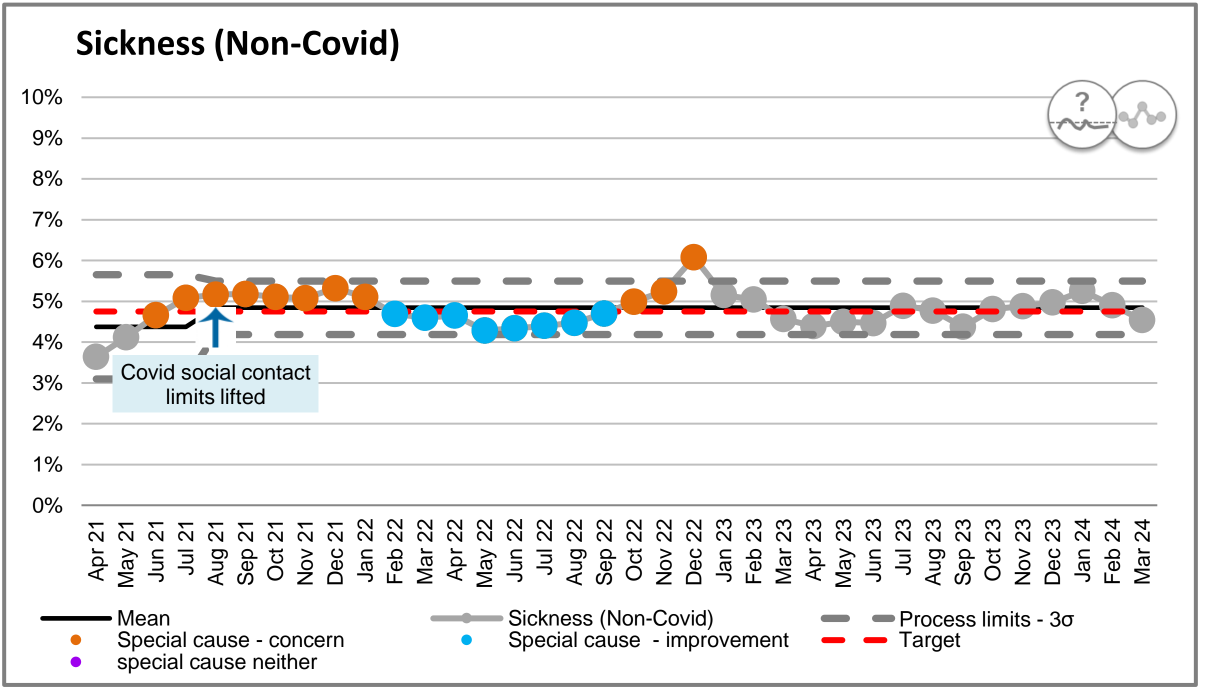
**Actions:**
- Trust level and local level activities underway to continue to improve the Trust retention, turnover and stability rates. These actions include:-
  - Task and finish group to review approach to exit interviews and questionnaires.
  - Review and improve ‘stay conversation.
  - Review of workforce metrics to identify gaps in retention activity for certain groups
  - Review of recruitment process to embed inclusive recruitment.
  - Communication of revised national approach to retirement options.

# Sickness Absence (Non-Covid)

Executive Owner: Suzanne Dunkley | Lead: Azizen Khan | Business Intelligence Lead: Mark Bushby

**Rationale:**
It is important for the Trust to monitor sickness absence levels to ensure any trends are investigated to inform future planning around availability.

| **Target: 4.75%** | **Current:** | **Total** | **4.54% (in month)** | **4.73% (12m)** |
|---|---|---|---|---|
| | | **Long** | **2.77% (in month)** | **3.03% (12m)** |
| | | **Short** | **1.77% (in month)** | **1.71% (12m)** |




**What does the chart show/context:**

- The target for absence is close to the mean and falls between the upper and lower process limits, as such compliance will be unpredictable on a month-by-month basis due to common cause variation.

**Underlying issues:**

- Top 3 reasons for sickness in March 2024 – Anxiety/Stress/Depression, Cold, Cough, Flu – Influenza and Other Musculoskeletal.

**Actions:**

- HR teams review regularly all open ended LTS cases to ensure timely actions are taken and that where for example cases relate to an MSK issue that colleagues are aware of self-referral options for internal physiotherapy.
- Any identified hotspot areas undertake a deep dive to review cases and where any training needs are identified this is managed.
- Absence data remains a key item on directorate and divisional meetings and teams are asked to provide updates via a plan on a page to address areas with absence above target or where absence is increasing.
- Knowledge portal+ has been rolled out across all divisions to allow easier access to absence data and the use of SPC charts is now part of absence reporting within directorate meetings.
- HR teams are reviewing Managing Attendance training with a view to rolling this out as a face-to-face session once HR teams are at full establishment.
- Information regarding the Trust Health Passport, Reasonable Adjustments and Access to work is now accessible on the Workforce and Organisational Development Intranet pages. A communication plan being drafted to support awareness raising.

# Appraisal

Executive Owner: Suzanne Dunkley    Lead: Nicola Hosty    Business Intelligence Lead: Mark Bushby

**Rationale:**
A performance appraisal is a regular assessment of how an individual is performing in their job role. It can have many benefits in practice, being used to identify individual learning needs, identify continuing development needs of employees and demonstrate competency in practice.

**Target: 95.0% (Annual), 95.0% (in month)**    **Current: 83.60% (in month)**

**Appraisal**

100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%

April May June July August September October November December January February March

2023/24 Appraisal Compliance    2022/23 Appraisal Compliance    Target

**What does the chart show/context:**
- Appraisal compliance has continued to be below the in-month planned position with 83.60% and has not achieved the 95% target set for the end of March 2024.
- Appraisal compliance is performing above the rate of the previous year at the same point in time.

**Underlying issues:**
- Time and availability of colleagues to undertake appraisal.
- Accurate and timely recording of appraisal conversations on ESR.
- Challenge to colleagues around appraisal being a “tick box” exercise.
- Seasonal variance especially during the summer and winter holidays.
- Regular strike action impacting priorities.

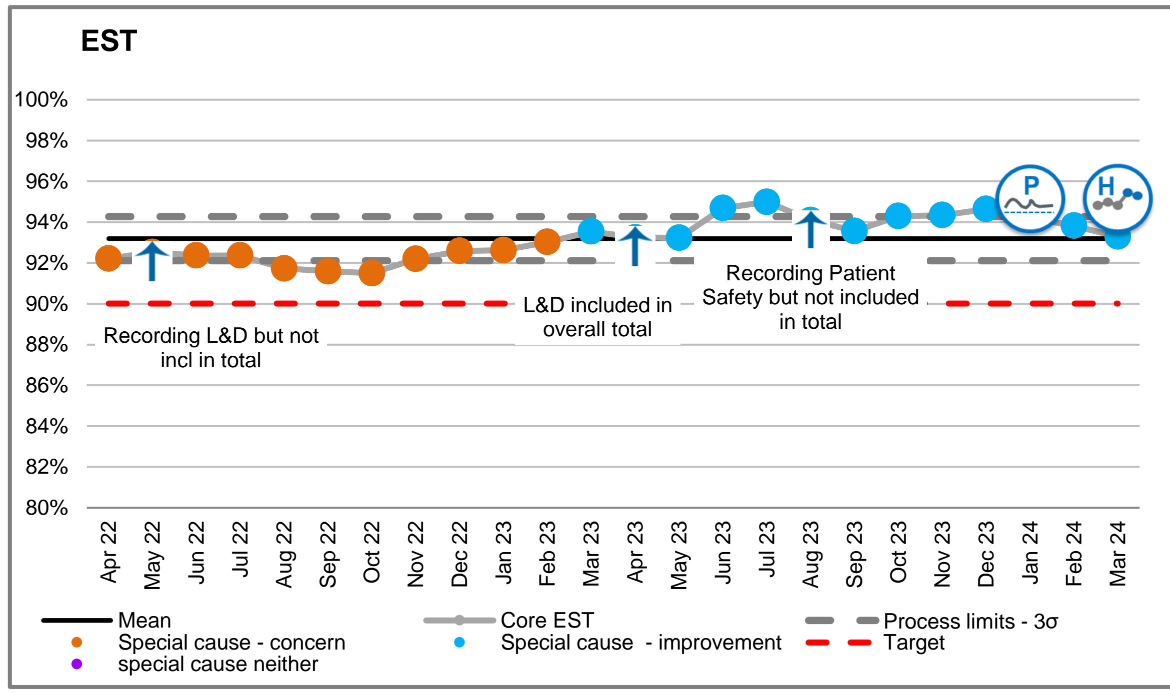
**Actions:**
- ‘How to’ guide to appraisals video now available as part of our management fundamentals offer, to make it a more people centred conversation.
- New to manager programme launch features appraisals in content.
- ESR recording guidance produced to support managers to ensure all activity is captured.
- Targeted approach to support hotspot areas including Connect & Learn sessions (managers’ and appraisees’ guides) to improve the quality of conversations.
- Connect & Learn sessions ongoing with session attended by 25 managers on 31st August, 58 attendees in October and 41 attendees in November 2023. Additional sessions delivered in February 2024.
- Recent audit from NHS England completed showcasing best practice, impact data and general process.
- Hotspot areas targeted via OCOC charter support workshops that includes appraisal management.

# Core EST Compliance

Executive Owner: Suzanne Dunkley | Lead: Nicola Hosty | Business Intelligence Lead: Mark Bushby

**Rationale:**
Training staff is important in health and social care to ensure the safety of people receiving and giving care and to maintain high standards of care quality. It ensures that colleagues in the Trust are following up-to-date procedures and reduces the risk of errors and prevents accidents. This means they and our patients can be safe in the workplace

**Target: 90.0%** **Current: 93.29%**




**What does the chart show/context:**

- The Trust is consistently achieving the 90% target; EST compliance is slightly below the 95% stretch target at 93.29%
- Compliance in March 2024 remains above the mean indicating further ongoing improvement since March 2023.
- From April 2023 Learning Disability Awareness is now included in the overall EST compliance rate.

**Underlying issues:**

- Safeguarding Adults and Childrens compliance has dropped below 90%, this is likely due to a review of RST as safeguarding is tiered learning.

**Actions:**

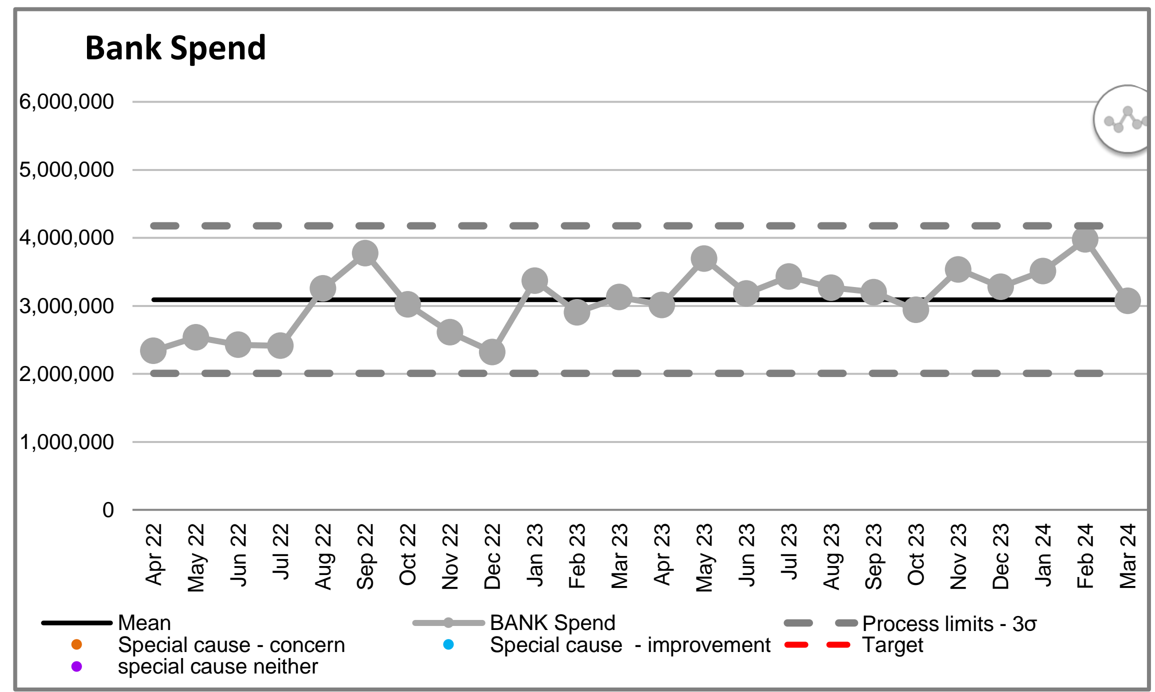
- Compliance rates are shared with Directorates on a weekly basis.
- Enhanced Divisional accountability.
- Local campaigns to focus on mandatory learning in Divisions.
- Task and Finish group is being formed to review RST and progress will be fed back to the Education Committee.

# Bank Spend

Executive Owner: Suzanne Dunkley    Lead: Samuel Hall    Business Intelligence Lead: Mark Bushby

**Rationale:**
It is important for the Trust to monitor Bank staff spend as it can help to minimise temporary staffing costs ensuring value for money and compliance.

**Current: £3.07M**




**What does the chart show/context:**

- An increase in May 2023 is due to the 5% pay award for April 2023 and May 2023.
- Bank spend is currently £3.07m in March 2024, a decrease from £3.97m in February.

**Underlying issues:**

- There is a dependency on bank to support the running of extra capacity areas that flex open and closed.
- Bank and Agency workers support in covering unplanned absences (sickness etc.).
- CHFT have been in extra capacity areas throughout the month of January and February, increasing demand.
- Increased demand for HCSWs to support 1:1 patient requirements.

**Actions:**

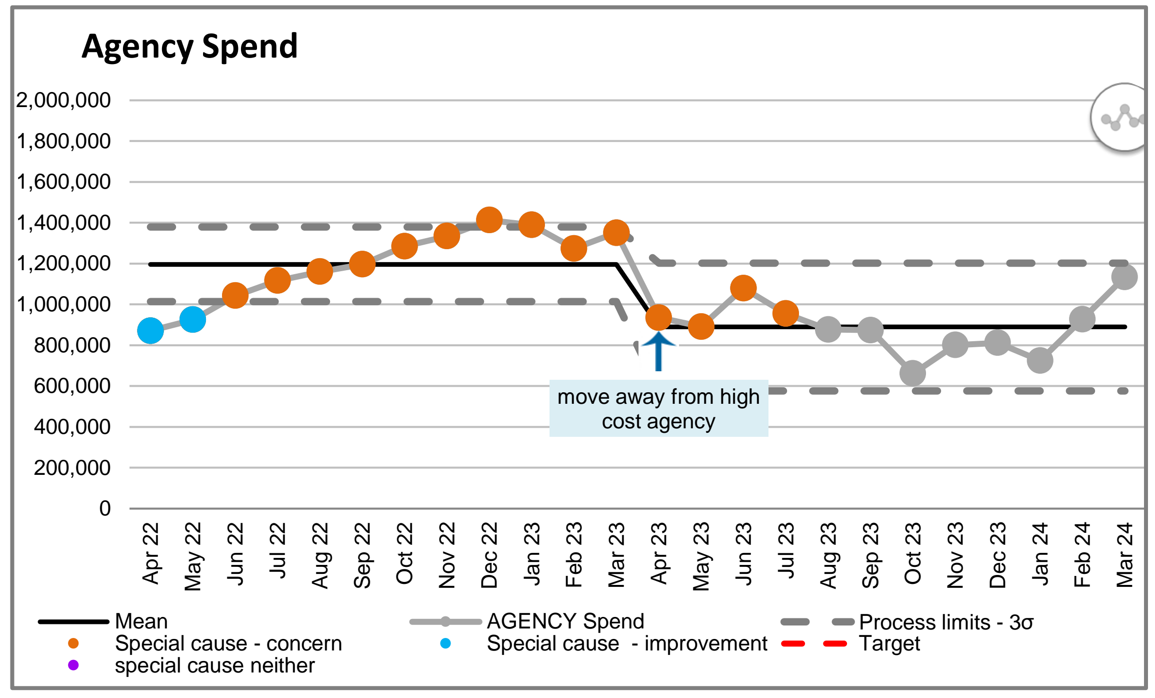
- 20% premium for Nursing and ODP colleagues has been successfully removed
- Medical Bank and Agency spend reviewed and regular Bank users sent to Senior Management Teams to confirm plan to remove/recruit to positions.

# Agency Spend

Executive Owner: Suzanne Dunkley　Lead: Samuel Hall　Business Intelligence Lead: Mark Bushby

**Rationale:**
It is important for the Trust to monitor Agency staff spend as it can help to minimise temporary staffing costs ensuring value for money and compliance and can encourage the recruitment and retention of staff.

**Target: £0.53M**　**Current: £1.13M**




**What does the chart show/context:**
- The Trust moved away from high-cost agency during April 2023.
- Agency spend is now following normal cause variation from October 2023.
- Spend in March 2024 at £1.13m.

**Underlying issues:**
- There is a reliance on agency usage in some areas as a result of vacancies and difficulties in recruiting.
- Agency spend still remains high and a proportion of that spend can be attributed to Agency Consultants working in hard to fill areas, as well as remaining rota gaps in ED.
- Agency usage and volume still remains high in comparison to CHFT's positive Nursing vacancy position.

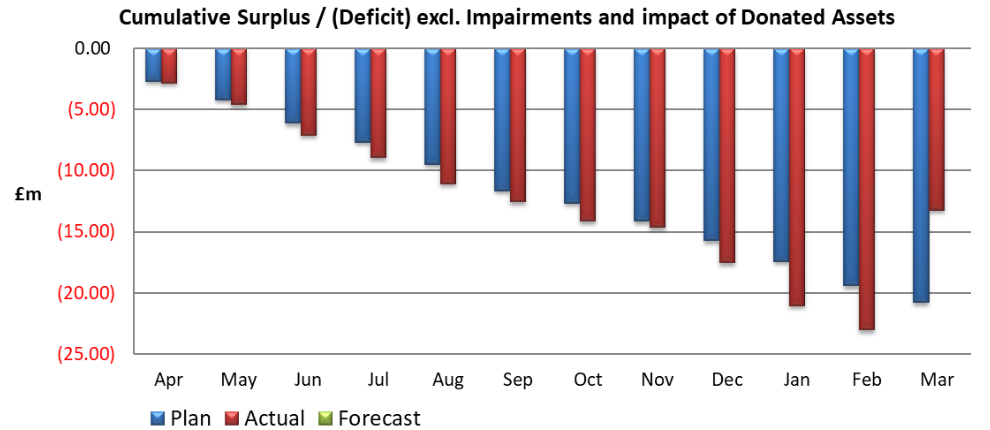
**Actions:**
- Review of agency usage across the board.
- Consideration of Direct Engagement model to generate saving for Agency medical staff.
- Nursing Agency lead time reduced to 21 days in October 2023 to allow Bank colleagues more time to fill.
- Promote that CHFT colleagues are a priority for additional shifts and Flexible Workforce can cancel booked agency workers to give shifts to CHFT colleagues (screensaver, email to colleagues).

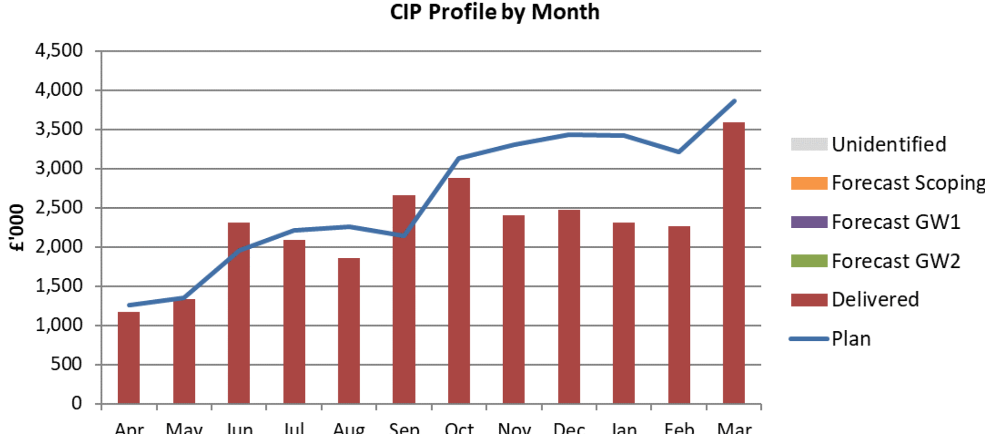
# Finance:

- Cumulative Surplus
- CIP Profile
- Capital Spend
- Cash Balance

# Financial Performance

Executive Owner: Gary Boothby 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 year-end deficit of £13.24m, a £7.56m favourable variance from plan.
- The Trust delivered efficiency savings of £27.32m for the year, £4.18m lower than planned.

**Underlying issues:**

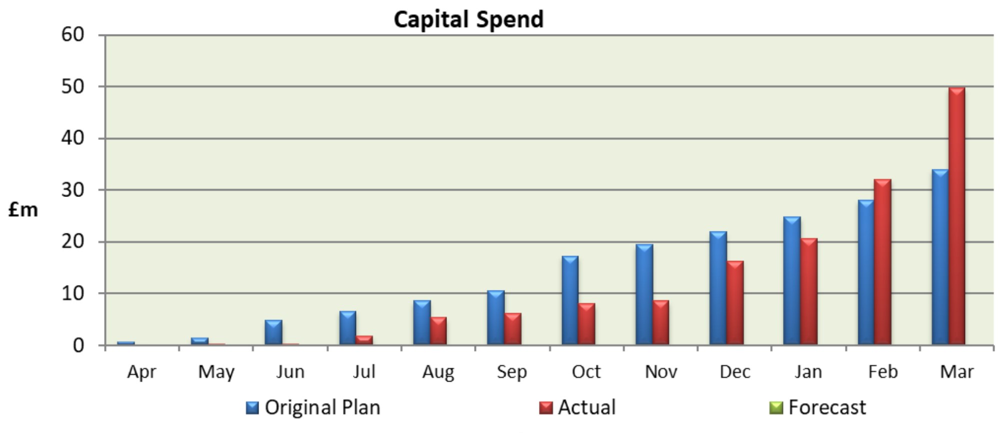
- Key drivers of the favourable variance included: £8.2m additional Integrated Care System (ICS) Income received in Month 12 (Provider Support); additional Elective Recovery Funding (ERF) of £1.65m; and higher than planned commercial income (Huddersfield Pharmacy Specials). These benefits were offset to some extent by ongoing pressures on bed capacity due to an excess of patients awaiting Transfer of Care (TOC) / higher than planned Length of Stay (LOS), £4.9m pressure due to impact on associated efficiency plans and surge capacity; Strike costs of £3.2m (offset by additional ICS allocation); and non-pay inflationary pressures.
- In Month 12 there were additional operational pressures contributing to higher than forecast costs including an increase in Nursing Agency of c.£0.27m with all available surge capacity open; and £0.24m of costs associated with the drive to improve performance in the Emergency Department.

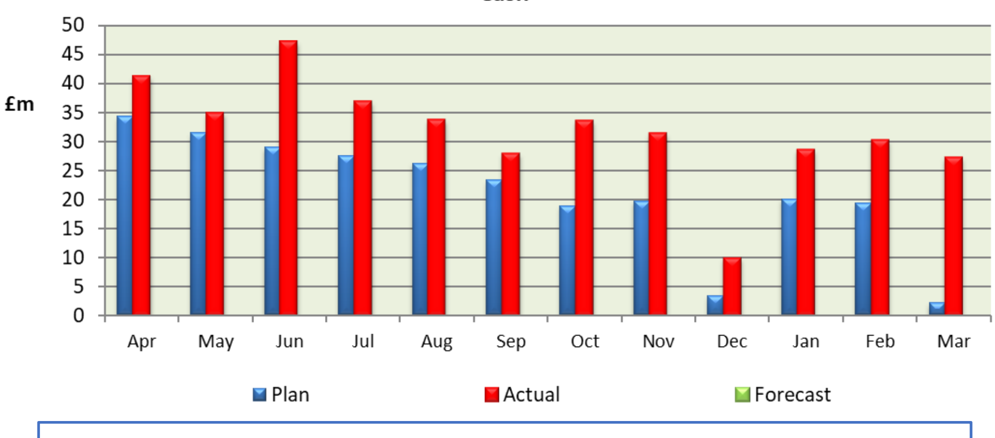
**Actions:**

- The focus is now on finalising 24/25 efficiency plans, delivering the 24/25 financial plan and strengthening grip and control measures including: Non-Pay spend review; Bank and Agency expenditure and the Trust Communications plan.

# Financial Performance: Capital, Cash and Use of Resources

Executive Owner: Gary Boothby




| Use of Resources Metric: | 23/24 Plan: 3 | 23/24 Actual: 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 £49.84m on Capital programmes this year, £15.84m higher than planned, including: additional Public Dividend Capital (PDC) funding awarded to support the Community Diagnostic Centre (CDC) and Pharmacy Manufacturing Unit expansion; and an increased capital allocation for Reconfiguration.
- At the end of March, the Trust had a cash balance of £27.05m, £24.86m higher than planned. Use of Resources (UOR) stands at 3, as planned, with all metrics as planned.

**Underlying issues:**

- The Capital overspend is due to additional allocations agreed in year including CDC (Halifax) and the expansion of the Pharmacy Manufacturing Unit. Leases remained underspent.
- The Trust revised down its request for Revenue Support PDC to £8.3m, £1.2m less than planned.
- The cash position has improved due to the additional £8.2m of ICS funding received in Month 12 and an improved working capital position, driven by an increase in Capital Creditors.

# Appendix A – Variation and Assurance Icons

## Variation Icons:

| *Icon* | *Technical Description* | *What does this mean?* | *What should we do?* |
|---|---|---|---|
| | Common cause variation, NO SIGNIFICANT CHANGE. | This system or process is **currently not changing significantly**. It shows the level of natural variation you can expect from the process or system itself. | **Consider if the level/range of variation is acceptable**. If the process limits are far apart you may want to change something to reduce the variation in performance. |
| H | Special cause variation of a CONCERNING nature where the measure is significantly HIGHER. | **Something's going on!** Your aim is to have low numbers but you have some high numbers – something one-off, or a continued trend or shift of high numbers. | **Investigate** to find out what is happening/ happened.<br>Is it a one-off event that you can explain?<br>Or do you need to change something? |
| L | Special cause variation of a CONCERNING nature where the measure is significantly LOWER. | **Something's going on!** Your aim is to have high numbers but you have some low numbers - something one-off, or a continued trend or shift of low numbers. | **Investigate** to find out what is happening/ happened.<br>Is it a one-off event that you can explain?<br>Or do you need to change something? |
| 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.<br>**Celebrate** the improvement or success.<br>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! | Find out what is happening/ happened.<br>**Celebrate** the improvement or success.<br>Is there **learning** that can be shared to other areas? |

## Assurance Icons:

| *Icon* | *Technical Description* | *What does this mean?* | *What should we do?* |
|---|---|---|---|
| ? | This process will not consistently HIT OR MISS the target as the target lies between the process limits. | The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **within** those limits then we know that the target may or may not be achieved. The closer the target line lies to the mean line the more likely it is that the target will be achieved or missed at random. | Consider whether this is acceptable and if not, you will need to change something in the system or process. |
| 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 B (i) – Metrics Rationale and Background

| Metric | Details |
|---|---|
| Total Patients waiting >40, 52, 65 weeks to start treatment and Total RTT Waiting List | Waiting times matter to patients. Most patients want to be referred, diagnosed and treated as soon as possible. To measure and encourage compliance with recovery milestones for the RTT waiting list. |
| Total elective activity undertaken compared with 2023/24 activity plan | A key planning requirement for 2023/24 is to recover elective activity levels to above those seen in the pre-Covid period, to order to address the growing elective care waiting list. |
| Percentage of patients waiting less than 6 weeks for a diagnostic test | Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%. |
| Diagnostic Activity undertaken compared with 2019/20 baseline | Maximise diagnostic activity focused on patients of highest clinical priority. Recovery of diagnostic testing is a key NHS objective and critical to wider elective recovery, including RTT performance. |
| Total Follow-Up activity undertaken compared with 2023/24 activity plan | To measure the relative reduction in follow-up outpatient attendances (consultant and non-consultant led) in 2023/24 compared to 2023/24 activity plan |
| 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. Measure is number of non-site specific referrals received in a month against target from operational plan for 2024/25 |
| Day Case Rates | Day case surgery, where the patient is admitted, undergoes intervention and is discharged on the same day, is an important aspect of service provision in the NHS. Day case surgery brings recognised benefits for both patients and system-wide efficiencies related to patient quality and experience, reduced waiting times and release of valuable bed stock. |

# Appendix B (ii) – Metrics Rationale and Background

| Metric | Details |
|---|---|
| Capped Theatre Utilisation | Capped theatre utilisation is a metric used to measure how well the allocated planned theatre session time has been utilised in an individual theatre list. It is calculated by taking the total needle to skin time of all patients within the planned session time and dividing it by the session planned time. High capped utilisation signifies that the allocated planned session time has been well utilised. |
| Early cancer diagnosis: 75% of cases diagnosed at stage 1 or 2 by 2028 | Cancer is one of the biggest contributors to inequalities in life expectancy with people from the most deprived communities more likely to get cancer, be diagnosed at a late stage for certain types of cancer and to die from the disease. Early presentation, referral, screening and diagnosis are key to addressing this. |
| Proportion of patients admitted, transferred or discharged within 4 hours | Monitor waiting times in A&E. Longer waits associated with poorer patient outcomes. NHS Objective to improve A&E waiting times so that no less than 76% of patients are admitted, transferred or discharged within 4 hours by March 2024 with further improvement in 2024/25. |
| Proportion of ambulance arrivals delayed over 30 minutes | Proportion of ambulances which experience a delay (by more than 30 minutes) in transferring the patient over to the care of ED staff. Patients arriving via an ambulance should be transferred over to the care of hospital staff within 15 minutes of arrival at an Emergency Department (ED). Handover delays can be detrimental to the health of the patient and can have a knock-on impact on the ambulance service (crews are unable to attend to other potentially life-threatening calls). Such delays at the front door of ED can also be a sign of potential overcrowding within the ED. |
| Proportion of patients spending more than 12 hours in an emergency department | To monitor long waits in A&E which could indicate overcrowding in ED and can cause poor patient experience. The number of patients that spend more than 12 hours between arrival and admissions, transfer or discharge, as a proportion of total attendances. |
| Neonatal deaths per 1,000 total live births | The Long-Term Plan committed the NHS to accelerate action to achieve the national maternity safety ambition of 50% reductions in stillbirth, maternal mortality, neonatal mortality and serious brain injury by 2025. The number of neonatal deaths is influenced by a number of factors, including the quality of care delivered to the mother and baby and appropriate surveillance for all women. The rate of deaths within 28 days of birth per 1,000 live births. A neonatal death is defined as a live born baby born at 24 weeks gestational age or later, or with a birthweight of 400g or more, who died before 28 completed days after birth. |
| Stillbirths per 1,000 total births | The focus of this indicator is to measure progress in reducing the rate of stillbirths against the trajectory towards the 2025 ambition. Measures the rate of stillbirths per 1,000 live births and stillbirths. A stillbirth is defined as a baby delivered at or after 24 weeks gestational age showing no signs of life, irrespective of when the death occurred. |
| % of patients dying within their preferred place of death – Community Palliative Care. | The focus of this indicator is to measure the proportion of patients who die in their preferred place of death. Everyone deserves the best possible experience at the end of their lives. The place where someone’s cared for at the end of their life and whether this matches what they want – is an important part of this experience. |

# Appendix B (iii) – Metrics Rationale and Background

| 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 B (iv) – 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 B (v) – 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 | 95% of adult patients to receive a MUST assessment within 24 hours of admission/transfer to the ward. Compliance with completion of MUST will ensure we have the majority of our patients at risk identified early and referred to the dietitian team. |
| Emergency Care Standard - Learning Disability | To monitor waiting times in A&E for patients with a learning disability to ensure equity across all patient groups |
| Outpatients DNA's - Learning Disability | To monitor DNA rates at first and follow-up appointments for patients with a learning disability to ensure equity across all patient groups |
| Cancer Faster Diagnosis Standard - Learning Disability | 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. |
| Percentage of patients waiting less than 6 weeks for a diagnostic test - Learning Disability | Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%. Maximise diagnostic activity focused on patients of highest clinical priority. |

# Appendix B (vi) – Metrics Rationale and Background

| Metric | Details |
|---|---|
| Patients waiting more than 40 weeks to start treatment - Learning Disability | Waiting times matter to patients. Most patients want to be referred, diagnosed and treated as soon as possible. To measure and encourage compliance with recovery milestones for the RTT waiting list for learning disability patients. |
| Emergency Care Standard - Deprivation | To monitor waiting times in A&E for patients from the most deprived areas (IMD 1 and 2) to ensure equity across all patient groups |
| Outpatients DNA's - Deprivation | To monitor DNA rates at first and follow-up appointments for patients from most the most deprived areas (IMD 1 and 2) to ensure equity across all patient groups |
| Cancer Faster Diagnosis Standard - Deprivation | 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. |
| Percentage of patients waiting less than 6 weeks for a diagnostic test - Deprivation | Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%. Maximise diagnostic activity focused on patients of highest clinical priority. |
| Patients waiting more than 40 weeks to start treatment - Deprivation | Waiting times matter to patients. Most patients want to be referred, diagnosed and treated as soon as possible. To measure and encourage compliance with recovery milestones for the RTT waiting list for patients from the most deprived areas (IMD 1 and 2) |

# 17. High Level Risk Register

To Note

Presented by Victoria Pickles

| | |
|---|---|
| **Date of Meeting:** | Thursday 2 May 2024 |
| **Meeting:** | Board of Directors |
| **Title:** | High Level Risk Report |
| **Author:** | Saj Rahman, Risk Manager |
| **Sponsoring Director:** | Victoria Pickles, Director of Corporate Affairs |
| **Previous Forums:** | Risk Group; Audit and Risk Committee |
| **Purpose of the Report** | The purpose of this report is to provide an overview of the risks scoring fifteen or more. |
| **Key Points to Note** | **Introduction**<br>High level risks have the potential to impact on the entire organisation.<br><br>Risks are identified and added to the risk register by colleagues across the organisation. Each division has a governance group in place that looks at all risks scoring 12 or above plus any new risks. Those scoring more than 15 are reviewed at the Trust-wide Risk Group and if accepted are included on the High-Level Risk Register (HLRR). Where a risk presents a risk to the delivery of the Trust Strategy, either individually or as a collective, this is included on the Board Assurance Framework.<br><br>**Current risk process**<br>The Trust continues to manage and document risks using a bespoke risk register. When a risk is identified, the risk and impact on patient care is documented and then reviewed by the relevant department and division. All the appropriate information, including all mitigating actions to ensure the safety of patients and staff is maintained, is included. The Trust uses the information to not only track potential risks, but it also helps to inform local planning, management decisions and priorities and most importantly, share learning Trust wide.<br><br>The current risk register system continues to be problematic in terms of being able to triangulate data, identify themes, and track risks and ensure risk owners are aware when updates are required. The Trust will be transitioning to a new risk, incident, and performance system this year. The new system, provided by InPhase, will replace the current Datix system/Be Spoke Risk Register, and will provide a more comprehensive reporting structure to Board and its committees in line with the new Patient Safety Incident Reporting Framework. A project plan is currently underway to support the transition.<br><br>The risk team continue to work with divisions to comprehensively review their risks and ensure that there is a clear programme of review, management, and mitigation in place. |

| | **Current risk profile**<br>Currently there are 34 high scoring risks on the Trust risk register (see details at the end of the report):<br>• 7 are scored as very high.<br>• 27 are scored as high.<br>• All risks have been recently reviewed and the mitigations (progress) updated.<br>• Of the 34 risks, four have had their risk scores increased.<br>• Two risks have had their risk score reduced since the last report. Both are scoring below 15 and are no longer included in the higher-level risk report.<br><br>Each risk is aligned to one of the Trust's strategic objectives. The current risks scoring very high (20-25) demonstrate the following themes:<br><br>• Keeping the base safe:<br>- Several risks relating to staffing and vacancies in medical, nursing, and therapy posts across a range of services including the emergency department, ophthalmology, cancer services, and radiology.<br>We continue to monitor the impact of these through the incident reporting system.<br>- There is a risk due the capacity available to validate outpatient appointments.<br>- There is a risk in relation to Clinical information being missed on the Electronic Document Management Systems, (EDMS).<br>• Transforming and improving patient care<br>There is a risk of a reduction in patient experience and quality outcomes due to the operational performance within the Emergency Department (ED) and the maintenance across all Emergency Care Standards due to prolonged patient length of stay within the ED and the impact this has on patient flow out of the ED.<br><br>There are some clear themes across the risks on the HLRR:<br>- 15 risks related to staffing, either in relation to fragile services or recruitment challenges in certain staff groups.<br>- 12 risks are in relation to demand and capacity, particularly in outpatient specialties and some diagnostic services.<br>- A total of 4 risks in relation to potential equipment failure, inability to deliver service due to the rooms becoming obsolete due to their age, non-compliance with national standards for Audiological testing due to the use of unilateral Visual Reinforcement Audiology System and potential failure of equipment due to it coming towards the end of its period under guarantee.<br><br>**Future actions**<br><br>The scope has been agreed for an internal audit of risk management, looking at the process from ward to board of risk identification, management, mitigation, scoring and reporting. The results of this audit was presented to Audit and Risk Committee on 23 April 2024.<br><br>The transition to the new incident reporting system this year will support a risk register that can be triangulated across several key indicators which includes safeguarding, FTSU concerns, incidents, and complaints. This will facilitate early identification of emerging themes and trends as well as a better understanding of the impact of any existing risks. A project plan is being developed supported by the risk management and system |
|---|---|

| | |
|---|---|
| | implementation team. The Datix system will run concurrently alongside this for 12 months to support a safe transition.<br><br>Divisional processes have been strengthened relating to the management of high-level risks and we are seeing the risk register used in a much more active way. Divisional risk and challenge meetings continue to develop and are moving towards management of all risks on the risk register. |
| **EQIA – Equality Impact Assessment** | Risks are assessed considering any impact on equality. |
| **Attachments:** | **Appendix 1**- All risks scoring 15 or more.<br>**Appendix 2** - Risks that have increased in scores (High Level).<br>**Appendix 3** - High Level Risk that have reduced in score since last report.<br>**Appendix 4** - Risks that scored 15+ during last report but have now closed/merged. None. |
| **Recommendation** | The Board is asked to **CONSIDER** and discuss risks scoring 15 or more report and **NOTE** the ongoing work to strengthen the management of risks. |

**Appendix 1 – All Risk scoring 15 or more.**

| Risk Level | Risk No | Division | Directorate | Department | Objective | Risk Summary | Current Risk Score |
|---|---|---|---|---|---|---|---|
| Very High | 8528 | Medical | Emergency Care | Accident and emergency HRI/CRH | Transformation and improving patient care | There is a risk of a reduction in patient experience and quality outcomes due to the operational performance within the Emergency Department (ED) and the maintenance across all Emergency Care Standards due to prolonged patient length of stay within the ED and the impact this has on ED flow. Resulting in poor patient experience, reduction in quality measures and increased length of stays in the ED departments. | 20 4 x 5. |
| Very High | 8669 | Surgery & Anaesthetics | Head and Neck | Ear, Nose and Throat | Keeping the base safe | There is a risk of delayed diagnosis, treatment for cancer patients' due consultant who specialise in cancer on long term sickness absence and the fixed term contract of 1 another consultant having expired. | 20 4 x 5 |
| Very High | 7078 | Corporate | Medical Director's Office | Operational | Keeping the base safe | There is a risk of reduced level of service in the Radiology team due to staff vacancies. | 20 4 x 5 |
| Very High | 8324 | Corporate | Planned Access and Data Quality | RTT Validation | Keeping the base safe | There is a risk of high volume of outstanding clinical outpatient validation and prioritisation on Mpage system. | 20 4 x 5 |
| Very High | 8508 | Surgery & Anaesthetics | Head and Neck | Ophthalmology | Keeping the base safe | There is a risk of not being able to provide a Consultant Glaucoma Service due to no Consultant in post at CHFT. | 20 4 x 5 |
| Very High | 8509 | Surgery & Anaesthetics | Head and Neck | Ophthalmology | Keeping the base safe | There is a risk of insufficient glaucoma appointments available to cope with demand due to vacancy levels. | 20 4 x 5 |
| Very High | 8278 | Family & Specialist Services | Appointment Records | Health Records | Keeping the base safe | There is a risk of patient legacy Clinical information being missed on the Electronic Document Management Systems, EDMS. This is Due to a new EDMS, OnBase Patient Window, being introduced into the Trust October 2023, to replace the ImageNow EDMS system | 20 4 x 5 |

| High | 8734 | Community | Community Therapies | Speech and language therapies | Keeping the base safe | There is a risk of patients not being assessed for their swallowing and communication needs following a stroke in a timely manner.<br>due to vacancies within the speech and language therapy service. | 16 4 x 4 |
|---|---|---|---|---|---|---|---|
| High | 8562 | Family & Specialist Services | Pathology | Blood sciences | Keeping the base safe | There is a risk of Enforced removal of Siemens Track within the Biochemistry Department. | 16 4 x 4 |
| High | 8161 | Family & Specialist Services | Radiology | CT | Keeping the base safe | There is a risk of being unable to provide a CT scanning service in the event of a fatal breakdown of the CT scanner at Calderdale Royal Hospital due to the age of the equipment. | 16 4 x 4 |
| High | 8098 | Surgery & Anaesthetics | Head and Neck | Ophthalmology | Keeping the base safe | There is a risk of clinic cancelation, delays, and reduced capacity in all areas of ophthalmology due to macular injection staff shortages. | 16 4 x 4 |
| High | 8609 | Surgery & Anaesthetics | Head and Neck | Ear, Nose and Throat | Keeping the base safe | There is a risk of prolonged waiting times for patients within ENT due to multifactorial elements including an increase in referrals over the last 6 months, and inability to return to pre-covid levels of activity. | 16 4 x 4 |
| High | 8219 | Family & Specialist Services | Pathology | Blood sciences | Keeping the base safe | There is a risk of loss of Cross-Site Biochemistry Service (24/7) due to the reduction in qualified BMS, inability to recruit and reduced ability to retain qualified staff. (Single qualified BMS staff covers both CRH and HRI out of core hours) | 16 4 x 4 |
| High | 8009 | Medical | Integrated Medical Specialties | All Departments | Keeping the base safe | There is a risk of outpatient capacity not being sufficient to ensure timely appointments for both new and follow up patients across integrated medical specialities. | 16 4 x 4 |
| High | 7955 | Family & Specialist Services | Radiology | Main X-Ray | Keeping the base safe | There is a risk of being unable to deliver plain film services from three plain film rooms at Calderdale Royal Hospital (CRH) due to the rooms becoming obsolete. | 16 4 x 4 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| High | 6079 | Family & Specialist Services | Appointment and Records | Appointments Service | Transforming and improving patient care | There is a risk of being unable to provide sufficient appointments for patients requiring Outpatients follow-up due to capacity and demand | 16 4 x 4 |
| High | 6345 | Corporate | Workforce & Organisational Development | Resourcing / Recruitment | Keeping the base safe | There is a risk of care being compromised in the children services due to insufficient Nurses, Midwives, and Healthcare support workers available to deliver safe and compassionate care. | 16 4 x 4 |
| High | 8121 | Family & Specialist Services | Women’s service | Gynae OPD HRI/CRH | Keeping the base safe | There is a risk of being unable to provide sufficient new and follow outpatient appointments for those patients requiring review by Gynaecology team, this is due to back log and some reduced available capacity. | 16 4 x 4 |
| High | 6911 | Family & Specialist Services | Women's Services | All Departments | Keeping the base safe | There is a risk of not meeting current midwifery workforce models due to current vacancies and periods of increased absence (maternity / long term sickness), | 16 4 x 4 |
| High | 6949 | Family & Specialist Services | Pathology | Blood sciences | Keeping the base safe | There is a risk of not being able to deliver a two site Blood Transfusion / Haematology service due to being unable to recruit and retain enough Health care professionals in Biomedical Scientists. | 16 4 x 4 |
| High | 8606 | Medical | All Departments Medical | All Departments | Financial sustainability | There is a risk of not being able to reduce the acute inpatient bed base due to rising patient acuity, non-elective demand and challenges in community bed and social care provision resulting in additional cost | 16 4 x 4 |
| High | 7413 | Corporate | Finance and Procurement | Corporate Finance | Keeping the base safe | There is a risk of fire spread at Huddersfield Royal Infirmary due to insufficient fire compartmentation in areas which could result in fire spread / damage to buildings / equipment and harm to staff, patients, and visitors. | 15 5 x 3 |
| High | 8147 | Family & Specialist Services | Keeping the Base safe | Radiology Interventional | Radiology | There is a risk of being unable to use the pressure injectors within both intervention labs (@ CRH/HRI) due to the age of the equipment. | 15 3 x 5 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| High | 7994 | Corporate | Corporate Nursing | Enhanced Care Team | Transforming and improving patient care | There is a risk of not being able to deliver individualised patient centred care for our most vulnerable patients due to the current number of vacancies within the team and inability to fill staff bank requests to provide this service. | 15 3 x 5 |
| High | 8361 | Surgery & Anaesthetics | Critical Care | Pain Clinic | Keeping the base safe | There is a risk of disruption to services in the pain clinic due to impending retirement of Band 6 CNS in January 2024, and potential retirement of Band 7 (CNS) in the new future resulting in only one experienced Band 6 Clinical Nurse to review patients on the wards and nurse clinics would have to stop. | 15 3 x 5 |
| High | 8398 | Surgery & Anaesthetics | General and Specialist Surgical Services | Colorectal | Keeping the base safe | There is currently a risk of high volumes of patients awaiting a follow up appointment within Colorectal surgery due to increased referrals post covid and historical patients waiting for their appointments. | 15 3 x 5 |
| High | 8315 | Surgery & Anaesthetics | Head and Neck | Ophthalmology | Keeping the base safe | There is a risk of increasing waiting lists and delays to new and follow up appointments in the ophthalmology paediatric service due to not having enough substantive Paediatric Consultants. | 15 5 x 3 |
| High | 8637 | Surgery & Anaesthetics | Head and Neck | Audiology | Keeping the base safe | There is a risk of non-compliance with national standards for Audiological testing due to the use of unilateral Visual Reinforcement Audiology System (VRS) instead of the recommended bilateral system resulting in potentially compromising the quality of testing for paediatric (children aged 2.5 and below) patients and breach of any external audits. | 15 5 x 3 |
| High | 8700 | Family & Specialist Services | Childrens services | PAOU | Keeping the base safe | There is a risk of significant staffing shortfalls on the Paediatric Assessment Unit (PAU) due to no agreed workforce model for PAU and the current workforce model encompassing both ward 3 and ward 4 where staff are required to work across both areas. | 15 3 x 5 |
| High | 8641 | Surgery & Anaesthetics | Critical Care | Critical Care Outreach | Keeping the base safe | There is a risk of non-compliance with national standards (GPICS) due to inadequate pharmacy staffing in CHFT's critical care units resulting in staff burnout, increase in | 15 3 x 5 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | | | medication errors, risk to patient safety and exposure to legal consequences or regulatory penalties. | |
| High | 7479 | Family & Specialist Services | Children services | Children services CRH | Keeping the base safe | There is risk that young people with acute mental health needs and /or behavioural/social care needs, such as self-harm, suicidal ideation and eating disorders, will be managed on the paediatric ward for an extended period by staff that do not have the appropriate skillset. | 15 3 x 4. |
| High | 8633 | Family & Specialist Services | Women's service | Maternity | Keeping the base safe | There is a risk that there is currently insufficient Consultant Clinic capacity to deliver timely Antenatal care for the local population (this was identified as a "Must Do" in a recent CQC inspections report for Maternity services). This may result in delays to care, late detection of anomalies, budgetary pressures, and a poor patient experience. | 15 3 x 5. |
| High | 8657 | Family & Specialist Services | Women's service | Maternity | Keeping the base safe | There is risk of poor outcomes for Obstetrics and Gynae patients due to the current Consultant Medical Workforce being on call or COTW for both large specialities at the same time. | 15 3 x 5. |
| High | 8712 | Family & Specialist Services | Pharmacy | Pharmacy | Keeping the base safe | There is a risk that patients will receive incorrect medication or miss doses of critical medication due to a lack of pharmacy support to the emergency department (ED). | 15 3 x 5. |

**Appendix 2 – Risks that have increased in score (High Level – also included in Appendix 1)**

| Risk Level | Risk No | Division | Directorate | Department | Objective | Risk Summary | Risk Score |
|---|---|---|---|---|---|---|---|
| High | 7479 | Family & Specialist Services | Children services | Children services CRH | Keeping the base safe | There is risk that young people with acute mental health needs and /or behavioural/social care needs, such as self-harm, suicidal ideation and eating disorders, will be managed on the paediatric ward for an extended period by staff that do not have the appropriate skillset. | 15 3 x 4. (Risk increased from risk score of 12). |
| High | 8633 | Family & Specialist Services | Women's service | Maternity | Keeping the base safe | There is a risk that there is currently insufficient Consultant Clinic capacity to deliver timely Antenatal care for the local population (this was identified as a "Must Do" in a recent CQC inspections report for Maternity services). This may result in delays to care, late detection of anomalies, budgetary pressures, and a poor patient experience. | 15 3 x 5. (Risk increased from risk score of 12). |
| High | 8657 | Family & Specialist Services | Women's service | Maternity | Keeping the base safe | There is risk of poor outcomes for Obstetrics and Gynae patients due to the current Consultant Medical Workforce being on call or COTW for both large specialities at the same time. This may result in poor outcomes for patients, delays in care, Inhibited activity recovery and poor patient experience. | 15 3 x 5. (Risk increased from risk score of 12). |
| High | 8712 | Family & Specialist Services | Pharmacy | Pharmacy | Keeping the base safe | There is a risk that patients will receive incorrect medication or miss doses of critical medication due to a lack of pharmacy support to the emergency department (ED). | 15 3 x 5. (Risk increased from risk score of 12). |

**Appendix 3 – High Level Risks that have reduced in score since last report**

| Risk Level | Risk No | Division | Directorate | Department | Objective | Risk Summary | Current Risk Score | Reason for Risk Reduced score. |
|---|---|---|---|---|---|---|---|---|
| Low | 8650 | Family & Specialist Services | Outpatients | Outpatients | Keeping the base safe | There is a risk of no surgical OPD clinic capacity within the OPD estate due to loss of clinic rooms to meet demand due to the closure of area one (surgical OPD) at Calderdale Royal Outpatients for building Cath Lab as part of cardiology transformation plans. | Risk currently scored at 9. Reduced from risk score 16. | CRH Outpatient footprint reviewed, and T&F group have repurposed areas and rooms to meet clinic room provision. |
| Moderate | 8627 | Family & Specialist Services | Appointment and Records | Health Records | Keeping the base safe | There is a risk not being able to deliver effective patient care/experience and having to shut Outpatient Reception desks. Due to high volumes of vacancies, in Outpatient Reception areas. | Risk currently scored at 12. Reduced from risk score 16 | Now recruited the 2 Apprentices. |

**Appendix 4 – Risks that scored 15+ during last report but have now closed/merged.**

**None.**

# 18. 10 MINUTE BREAK

# A WORKFORCE FOR THE FUTURE

# 19. Staff Survey Results and Action Plan

To Note

Presented by Suzanne Dunkley

# 2023 Staff Survey Briefing

Board of Directors 2 May 2024

# People Promise

| | 2023 | 2022 | 2021 |
|---|---|---|---|
| *We are compassionate and inclusive* | 7.4 (+0.1) | 7.3 (=) | 7.2 |
| *We are recognised and rewarded* | 6.0 (+0.2) | 5.8 (+0.1) | 5.7 |
| *We each have a voice that counts* | 6.8 (=) | 6.8 (=) | 6.7 |
| *We are safe and healthy* | 6.1 (+0.2) | 5.9 (+0.1) | 5.8 |
| *We are always learning* | 5.6 (+0.2) | 5.4 (+0.3) | 5.1 |
| *We work flexibly* | 6.2 (+0.3) | 5.9 (+0.1) | 5.8 |
| *We are a team* | 6.7 (+0.1) | 6.6 (+0.1) | 6.5 |

| | Engagement | | | Comparator Group | | |
|---|---|---|---|---|---|---|
| | 2023 | 2022 | 2021 | 2023 | 2022 | 2021 |
| Staff engagement | 7.0 (+0.2) | 6.8 | 6.7 | 6.9 (Picker) | 6.8 (NSS) | 6.8 (NSS) |
| Morale | 6.0 (+0.3) | 5.7 | 5.6 | 5.9 (Picker) | 5.7 (NSS) | 5.8 (NSS) |

# Highs and Lows

| Top 5 scores vs Picker Average | Trust | Picker Avg |
|---|---|---|
| Q19d. Feedback given on changes made following errors/near misses/incidents | 65% | 60% |
| Q10b. Don't work any additional paid hours per week for this organisation, over and above contracted hours | 68% | 63% |
| Q25d. If friend/relative needed treatment would be happy with standard of care provided by organisation | 66% | 62% |
| Q8a. Teams within the organisation work well together to achieve objectives | 70% | 67% |
| Q15. Organisation acts fairly: career progression | 60% | 57% |

| Bottom 5 scores vs Picker Average | Trust | Picker Avg |
|---|---|---|
| Q13d. Last experience of physical violence reported | 62% | 70% |
| Q4d. Satisfied with opportunities for flexible working patterns | 50% | 53% |
| Q14d. Last experience of harassment/bullying/abuse reported | 47% | 50% |
| Q23d Appraisal helped me agree clear objectives for my work | 32% | 35% |
| Q24b There are opportunities for me to develop my career in this organisation | 52% | 55% |

| Most improved scores | Trust 2023 | Org 2022 |
|---|---|---|
| Q25c. Would recommend organisation as place to work | 62% | 56% |
| Q11c. In last 12 months, have not felt unwell due to work related stress | 59% | 53% |
| Q3i. Enough staff at organisation to do my job properly | 26% | 32% |
| Q3h. Have adequate materials, supplies and equipment to do my work | 59% | 54% |
| Q7b. Team members often meet to discuss the team's effectiveness | 60% | 55% |

| Most declined scores | Trust 2023 | Org 2022 |
|---|---|---|
| Q11a. Organisation takes positive action on health and well-being | 57% | 59% |
| Q20b. Would feel confident that organisation would address concerns about unsafe clinical practice | 57% | 59% |
| Q24a. Organisation offers me challenging work | 69% | 70% |
| Q2c. Time often/always passes quickly when I am working | 72% | 73% |

*Tables are based on absolute % differences, not statistical significance*

# Engagement/morale/response WYAAT comparison

| | Engagement 2023 | Engagement 2022 | Morale 2023 | Morale 2022 | Completed Questionnaires | 2023 Response Rate |
|---|---|---|---|---|---|---|
| **CHFT** | **7.0 (+0.2)** | **6.8** | **6.0 (+0.3)** | **5.7** | **2721 (+53)** | **44% (=)** |
| Airedale NHS Foundation Trust | 6.9 **(=)** | 6.9 | 5.8 **(=)** | 5.8 | 1334 | 40.5% |
| Bradford Teaching Hospitals NHS Foundation Trust | 7 **(+0.1)** | 6.9 | 6.1 **(+0.3)** | 5.8 | 2905 | 42.85% |
| Harrogate and District NHS Foundation Trust | 7.1 **(+0.3)** | 6.8 | 6.1 **(+0.4)** | 5.7 | 2196 | 45.66% |
| Leeds Teaching Hospitals NHS Trust | 7 **(+0.2)** | 6.8 | 5.9 **(+0.2)** | 5.7 | 11,138 | 54.56% |
| The Mid Yorkshire Hospitals NHS Trust | 6.6 **(+0.2)** | 6.5 | 5.8 **(+0.1)** | 5.7 | 2868 | 28.87% |

# People Promise
# WYAAT comparison

| | We are compassionate and inclusive | We are compassionate and inclusive | We are recognised and rewarded | We are recognised and rewarded | We each have a voice that counts | We each have a voice that counts | We are safe and healthy | We are safe and healthy | We are always learning | We are always learning | We work flexibly | We work flexibly | We are a team | We are a team |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2023 | 2022 | 2023 | 2022 | 2023 | 2022 | 2023 | 2022 | 2023 | 2022 | 2023 | 2022 | 2023 | 2022 |
| **CHFT** | **7.4 (+2)** | **7.2** | **6.0 (+2)** | **5.8** | **6.8 (+1)** | **6.7** | **6.1 (+2)** | **5.9** | **5.6 (+2)** | **5.4** | **6.2 (+3)** | **5.9** | **6.7 (+1)** | **6.6** |
| Airedale NHS Foundation Trust | 7.2 | 7.3 | 5.9 | 5.9 | 6.8 | 6.8 | * | 6.0 | 5.5 | 5.3 | 6.1 | 6.1 | 6.6 | 6.8 |
| Bradford Teaching Hospitals NHS Foundation Trust | 7.4 | 7.3 | 6.1 | 5.9 | 6.9 | 6.8 | * | 5.9 | 5.9 | 5.6 | 6.3 | 6.1 | 6.9 | 6.4 |
| Harrogate and District NHS Foundation Trust | 7.6 | 7.4 | 6.3 | 6.0 | 6.9 | 6.8 | * | 6.0 | 5.8 | 5.4 | 6.5 | 6.2 | 7.1 | 6.6 |
| Leeds Teaching Hospitals NHS Trust | 7.4 | 7.3 | 6.0 | 5.8 | 6.9 | 6.8 | * | 5.9 | 5.9 | 5.6 | 6.4 | 6.1 | 6.9 | 6.7 |
| The Mid Yorkshire Hospitals NHS Trust | 7.0 | 7.0 | 5.7 | 5.7 | 6.4 | 6.6 | * | 5.9 | 5.5 | 5.3 | 5.9 | 5.8 | 6.5 | 6.5 |

* *Unavailable from Picker due to data quality issue for Q13a-d. Currently being investigated by Survey Coordination Centre and NHS England Nationally*

# 2023 Hot Spot Service Areas

| Division | Hot Spots/Ones to Watch | 2022 Engagement score | 2023 Engagement score | Executive Sponsor/ Buddy |
|---|---|---|---|---|
| Surgery and Anaesthetics | Operating Services<br>Orthopaedics<br>Surgical Divisional Support | 5.9<br>6<br>7.3 | 6.5 (increase by 0.6)<br>6.6 (increase by 0.6)<br>7.8 (increase by 0.5) | Gary Boothby/Kirsty Archer |
| Medicine | Emergency Care<br>Medical Divisional Management<br>Medical Specialities | 6.2<br>7<br>6.4 | 7 (increase by 0.8)<br>7.4 (increase by 0.4)<br>6.5 (increase by 0.1) | Lindsay Rudge/Vicky Pickles |
| FSS | Radiology<br>Pathology | 6.4<br>6.4 | 6.4 (= no movement)<br>6.2 (decrease by 0.2) | Jonny Hammond/ David Birkenhead |
| Community | Community Therapies | 6.8 | 6.9 (increase by 0.1) | Rob Birkett /Andrea McCourt |
| Corporate | Central Operations (now RAFT)<br><br>Corporate Services | 6.1<br><br>7.8 | 6.8 (increase by 0.7)<br><br>8.1 (increase by 0.3) | Anna Basford |
| HPS/PMU | PMU | 5.9 | 6.9 (increase by 1.0) | Rob Aitchison |

# 2024 Hot Spot Service Area
# Executive Sponsor / Buddy arrangements

| Directorate | 2023 Score | Executive Sponsor |
|---|---|---|
| Pathology | 6.2 | Gary Boothby |
| Radiology | 6.4 | Rob Aitchison |
| Medical Specialities | 6.5 | Jonny Hammond |
| Operating Services | 6.5 | David Birkenhead |
| Outpatient and Record Services | 6.5 | Vicky Pickles |
| Head and Neck | 6.6 | Rob Aitchison |
| Orthopaedics | 6.6 | Lindsay Rudge |
| Surgical Medical Secretaries | 6.6 | Anna Basford |

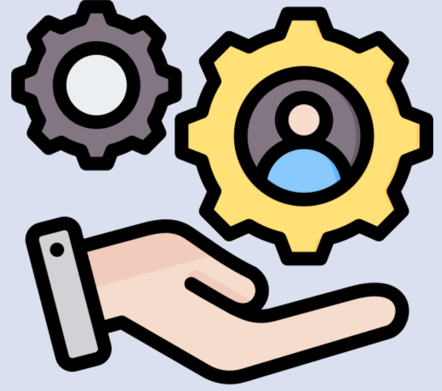
# Equality, Diversity and Inclusion Overview

- Age – most engaged 66+ and least engaged 21-30
- Disability – overall engagement score 0.5 points lower than colleagues who do not consider themselves to have a disability
- Ethnicity – The engagement score for BAME colleagues is 7.2 which is higher than white colleagues at 6.9
- Gender – The engagement score improved by 0.2 points for female colleagues and 0.1 for male colleagues.
- Sexuality – LQBTQ+ colleagues engagement score is 0.6 points lower than the organisation overall
- Religion – Colleagues that have stated they prefer not to say what their identified religion is are the least engaged group with Sikh colleagues the most engaged

# 2024 High Impact Actions

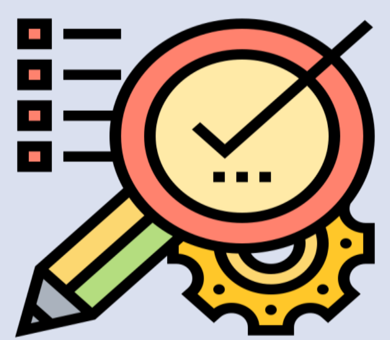
1. Providing managers with the skills and tools to lead via One Culture of Care.

2. Develop clear career development pathways across CHFT.



3. Refresh our wellbeing offer that meets the needs of all our colleagues, is accessible and highly valued.

4. Intensify our work on inclusion, making CHFT a great place to work for everyone



5. Develop bespoke support programmes for staff survey hot spot areas

# KEEPING THE BASE SAFE

# 20. Guardian of Safe Working Hours Annual Report

Presented by Dr Liaquat Ali, Guardian of Safe Working Hours

To Note

| | |
|---|---|
| **Date of Meeting:** | Thursday 2 May 2024 |
| **Meeting:** | Public Board of Directors |
| **Title:** | Annual report (**1st of April 2023 to 31st March 2024**) from the Guardian of Safe Working Hours, CHFT |
| **Author:** | Dr Liaquat Ali, Guardian of Safe Working Hours |
| **Sponsoring Director:** | Dr David Birkenhead, Medical Director |
| **Previous Forums:** | None |
| **Purpose of the Report** | The purpose of this report is to provide an overview and assurance of the Trusts compliance with safe working hours for doctors/dentists in training across the Trust, and to highlight any areas of concern. |
| **Key Points to Note** | 1. Exception reports<br>2. Information about cover arrangements for out of hours rota gaps<br>3. Junior doctors strike<br>4.Junior Doctors Forum |
| **EQIA – Equality Impact Assessment** | The opportunity to exception report is available for all doctors in training and Trust doctors on the 2016 contract irrespective of any protected characteristics. |
| **Recommendation** | The Board is asked to **NOTE** the contents of the report. |

**GOSWH Quarterly Report 1st of April 2023 to 31st March 2024**

**Introduction:**

The purpose of this report is to give assurance to the Board that the doctors in the training are safely rostered and that their working hours are compliant with the Junior doctor's contract 2016 and in accordance with the Junior Doctors terms and conditions of service (TCS). The report includes the data from 1st of April 2023 to 31st March 2024.

**Executive summary:**

The Trust has used Allocate software since August 2017 to enable trainees to submit exception reports. All doctors in training and locally employed Trust doctors employed on the 2016 Terms and Conditions have an Allocate account. Educational supervisors and clinical supervisors also have access to this software.

There are 120 exception reports over a period of a year from 1st of April 2023 to 31st March 2024 and significant numbers of reports were submitted from August to November than rest of year (68 versus 52); this is probably due to combination of winter pressure, increased workload and change over during August. Substantial numbers of reports were initiated by FY1 doctors twice in numbers by the rest of trainee grade doctors. This is expected as the junior doctors are in the first year of working within the NHS and are getting familiar with how the system works. Almost eighty percent were related to extra hours of working. Fourteen exception reports were relating to immediate patient safety issues. Among these twelve reports were relevant to minimum staffing level in the ward, two were about not having opportunity for lunch break and missed educational opportunities. Understaffing was due to sickness. Allocate software indicates twelve percent ERs as unresolved, include reports initiated during this quarter are carried forward next month.

All our junior doctor rotas are fully compliant with the 2016 TCs. Rota gaps remain a challenge, when/where Health Education England don't provide a trainee, however several Trust doctors are recruited to cover wherever possible. Where there are out of hours gaps, the flexible workforce team work to cover these shifts with bank/agency locums, with the junior doctor's cross-covering during the day.

**Background Data:**

**Number of doctors / dentists in training (total): 231.53, Non -Training Junior Doctors: 152.88 (as per data by the end of Feb 2024)**

Admin support is provided to the Guardian: The Medical HR team manage the payment for exception reports wherever this is agreed and create Allocate accounts for all those that need access. They also do initial prompts to clinical supervisors and educational supervisors regarding exception reports. There is a regular meeting scheduled with the GOSWH and the Medical HR manager for additional support if required.

The Medical Education team manage the invites, agenda, and minutes for the quarterly Junior Doctors Forum meeting.

**Safety concern raised through Exception Report:**

Fourteen exception reports were recorded about immediate safety issues; Twelve reports were relevant to minimum staffing level in the ward, two were about not having opportunity for lunch break and missed educational opportunities. Understaffing was due to sickness. These were resolved by additional payment to junior doctors and rota coordinator was informed to ensure adequate staffing level in the ward.

**Work Schedule reviews**:

There were three work schedule reviews during this period. But one of the educational supervisors agreed with trainee to consider work schedule review and provide additional support on call team at night.

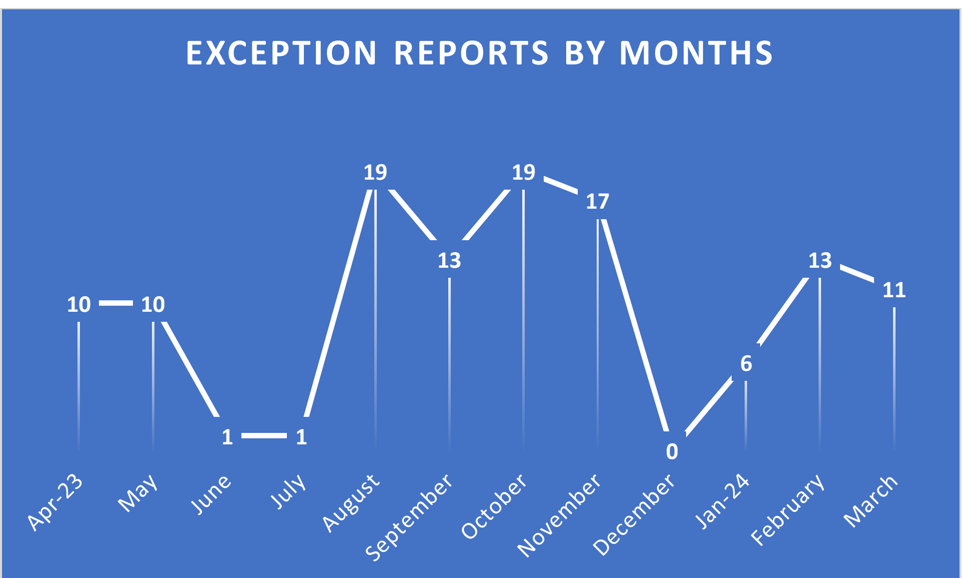
**Exception Reports - details:**

Total ER – 120

**Distribution of exception reporting in relation to various reasons**

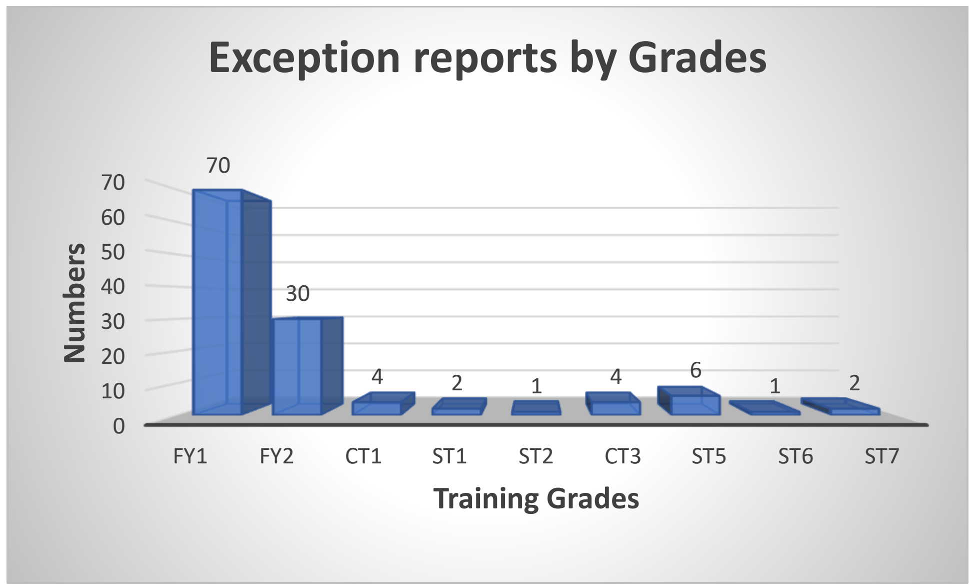
Out of these 120 reports, 82 were related to extra hours of working ,14 relating to immediate patient safety issues,15 related to service support available to the doctor and 6 were related to pattern of work. Seventeen ERs related to missed educational opportunities (missed training day)

**Exception Reports (ER) from1st of April 2023 to 31st March 2024:**



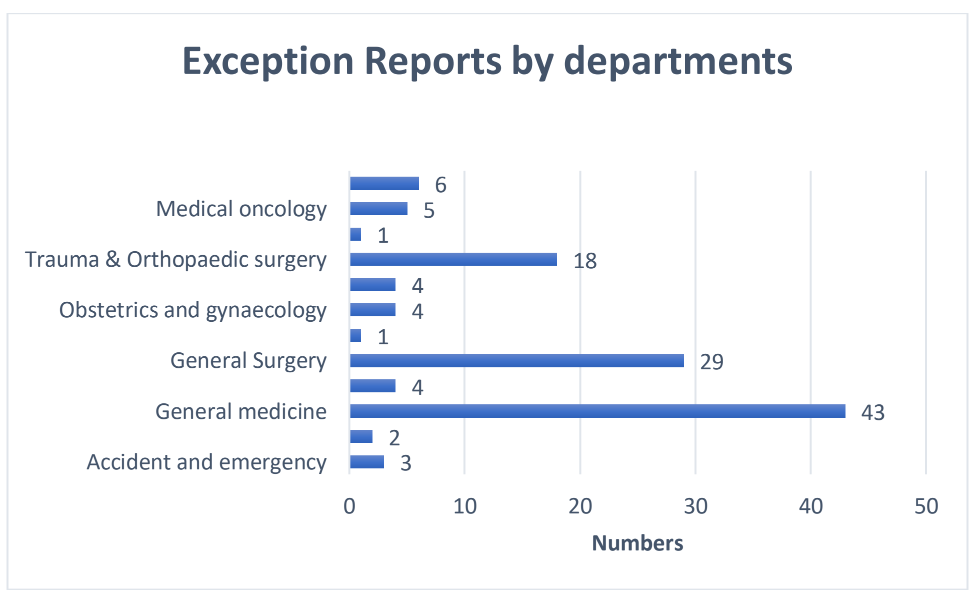

In total 120 reports were submitted over a year. As we can see, the numbers of exception reports were almost twice in figure from August to November than rest of year. This was likely due to change over during this period and subsequently dropped during rest of quarters.

**Exception report by Grades**



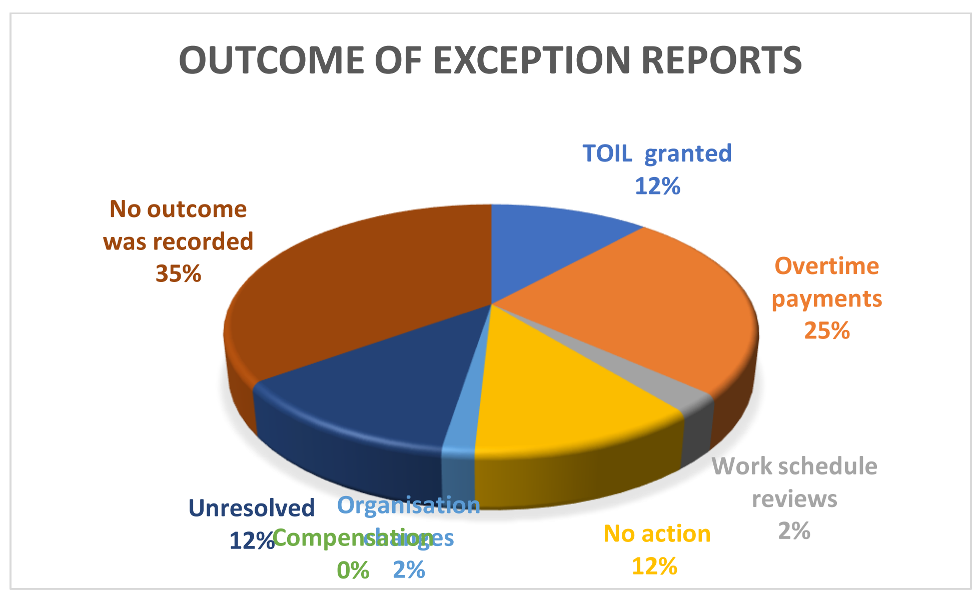

Most of the ER were from FY1 doctors. This is expected as the junior doctors are in the first year of working within the NHS and are still getting familiar with how the system works. I have noted ERs from senior trainees as well.

**Exception reports by Departments**:




We see that more ER have been submitted in General medicine as compared to General Surgery.

**Outcome of exception reports**:




Not all ERs were resolved fully. Those shown as no outcome recorded include where the outcome was given by the supervisor after meeting with the trainee, but the doctor has not closed the report. Those shown as unresolved include reports initiated during this quarter were carried forward next month.

**Steps from last Board meeting:**

**Fines:**

There haven't been any fines issued in last one year.

**Trainee Vacancies:**

Data on Rota gaps is challenging to obtain, as most rosters up to the Consultant level are covered by a combination of doctors in training, Trust doctors and specialty doctors. Where there are trainee vacancies, a Trust doctor may be recruited for a fixed term to cover that gap. Or alternative cover may be arranged for out of hours commitments. As can be seen from the data held within ESR most of our training posts are filled currently.

| | Dec-23 | | | Jan-24 | | | Feb-24 | | |
|---|---|---|---|---|---|---|---|---|---|
| Role | Budgeted FTE | Actual FTE | Vacancies by FTE | Budgeted FTE | Actual FTE | Vacancies by FTE | Budgeted FTE | Actual FTE | Vacancies by FTE |
| Consultant | 312.06 | 282.93 | 29.13 | 312.06 | 286.14 | 25.92 | 311.26 | 293.83 | 17.43 |
| Foundation Year 1 | 48.00 | 53.76 | -5.76 | 48.00 | 53.76 | -5.76 | 48.00 | 52.43 | -4.43 |
| Foundation Year 2 | 37.00 | 35.99 | 1.01 | 37.00 | 36.10 | 0.90 | 37.00 | 35.00 | 2.00 |
| General Medical Practitioner | 0.00 | 0.20 | -0.20 | 0.00 | 0.20 | -0.20 | 0.00 | 0.20 | -0.20 |
| Medical Director | 1.00 | 1.20 | -0.20 | 1.00 | 1.20 | -0.20 | 1.00 | 1.20 | -0.20 |
| Specialty Doctor | 128.56 | 82.52 | 46.04 | 128.56 | 83.52 | 45.04 | 128.56 | 83.52 | 45.04 |
| Specialty Registrar | 139.76 | 144.23 | -4.47 | 139.76 | 142.34 | -2.58 | 139.76 | 140.53 | -0.77 |
| Staff Grade (Closed to new entrants) | 1.00 | 1.00 | 0.00 | 1.00 | 1.00 | 0.00 | 1.00 | 1.00 | 0.00 |
| Trust Grade Doctor - Foundation Level | 32.00 | 16.00 | 16.00 | 32.00 | 15.00 | 17.00 | 32.00 | 12.00 | 20.00 |
| Trust Grade Doctor - Specialist Registrar Level | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| Trust Grade Doctor - Specialty Registrar | 43.94 | 51.63 | -7.69 | 43.94 | 52.63 | -8.69 | 43.94 | 56.36 | -12.42 |
| GP Trainees - Trust Based (Specialty Registrar) | 39.00 | 44.59 | -5.59 | 39.00 | 45.59 | -6.59 | 39.00 | 40.22 | -1.22 |
| **Total** | **782.32** | **714.05** | **68.27** | **782.32** | **717.47** | **64.85** | **781.52** | **716.29** | **65.23** |

**Shifts covered by Bank and Agency**:

Out of hours shifts on trainee rotas can arise for several reasons. As you can see from the table below, most shifts are filled with alternative cover. It varies in each quarter but snapshot of quarters from March 2023 to May 2023 and September-November 2023 given as an example.

| **Bank and Agency fill rates by division- March 2023 – May 2023** | | | |
|---|---|---|---|
| | % Unfilled hours | % Filled Bank hours | % Filled Agency hours |
| Division of Family and Specialist Services | 19.92% | 75.79% | 4.28% |
| Division of Medicine | 11.62% | 75.02% | 13.34% |
| Division of Surgery and Anaesthetics | 9.83% | 82.86% | 7.30% |

| Bank and Agency fill rates by Division, September- November 2023 | | | |
|---|---|---|---|
| | % unfilled hours | % filled Bank hours | % filled Agency hours |
| **FSS** | 5.44% | 89.19% | 5.37% |
| **Medicine** | 5.77% | 79.91% | 14.31% |
| **Surgery and Anaes-thetics** | 8.47% | 88.83% | 2.69% |

This data provide reassurance that more bank staff (Trust staff) is used to cover unfilled shifts.

**Industrial Action:**

Significant planning was done within all divisions to pull together a comprehensive plan with a focus on patient and staff safety protecting critical services to deliver lifesaving care and maintaining elective care for cancer patients during junior doctor's strike. The strike actions have taken place : 11th April to 15th April 2023; 14th June to 17th June, 13th to 18th of July and 11th to 15th of August 2023; between 7am Wednesday 20 September to Saturday 23 September at 7am and co-ordinated joint strike action took place by both consultants and junior doctors on 2, 3 and 4 October and furthermore three days strikes from 20th of Dec to 22nd of December and five days between 24th to 28th of February 2024 this year.

Significant numbers of doctors participated in strikes as obvious by following data:

## Strike in April 2023:

| | Tuesday 11 April | | Wednesday 12 April | | Thursday 13 April | | Friday 14 April | |
|---|---|---|---|---|---|---|---|---|
| | Presented for Work | Industrial Action | Presented for Work | Industrial Action | Presented for Work | Industrial Action | Presented for Work | Industrial Action |
| Division of Family and Specialist Services | 5 | 16 | 8 | 16 | 5 | 17 | 4 | 12 |
| Division of Medicine | 12 | 89 | 11 | 88 | 9 | 81 | 9 | 77 |
| Division of Surgery & Anaesthetics | 5 | 54 | 11 | 49 | 7 | 46 | 11 | 37 |
| **Total Number** | **22** | **159** | **30** | **153** | **21** | **144** | **24** | **126** |
| **CHFT as Lead Employer** | | | | | | | | |
| Psychiatry | 0 | 7 | 0 | 8 | 0 | 11 | 1 | 8 |
| GP Practice Trainees | 31 | 25 | 29 | 23 | 26 | 21 | 22 | 17 |

**Strike in September, October and November 2023:**

| September IA Dates | Total presented for work | Total on IA |
|---|---|---|
| 20 | 37% | 63% |
| 21 | 22% | 78% |
| 22 | 19% | 81% |
| October IA Dates | Total presented for work | Total on IA |
| 2 | 36% | 64% |
| 3 | 37% | 63% |
| 4 | 37% | 63% |
| December IA Dates | Total presented for work | Total on IA |
| 20 | 25% | 75% |
| 21 | 30% | 70% |
| 22 | 27% | 73% |

The Medical Director wrote to all medical and dental staff to confirm the details of the action, to remind colleagues to be respectful of others' views and to share a document with frequently asked questions. Well-being support was available to all and regularly referenced in Trust updates.

The industrial action is confirmed as 'Christmas Day' levels of care. This means that emergency care will continue to be provided, although elective work may need to be cancelled. The medical team was supported by physician associates, pharmacists, trust grade doctors and training doctors who did not participate in the strike action. Fortunately, no unpredictable events took place. ER were recorded during strike action. Adequate support services were available in terms of: The Safari team was available to prescribe for TTOs (take home prescriptions), and a "Floater" prescriber was available as well as Microsoft TEAM setup (CHFT – Digital Support) to act as a central resource to facilitate any issues colleagues may have with Cerner, Blood TRACK, ABG machine access and prescribing. There was a significant level of support for industrial action with approximately 90% of those eligible going on strike.

**Junior Doctors Forum:**

Junior doctors forum takes place quarterly, chaired by Deputy Medical Director/Guardian of safe working hours and members include DME/deputy, LNC chair, Junior doctor representatives and medical HR. This provides Opportunity for JDs to get involved in service improvement (rota masters can be informed prior to ensure attendance). We discuss specialty specific issues, Involvement in disbursement of fines, report from GSW regarding exception reports and Performance manage GSW.

Recent forum took place on 19th of December 2023 and 16th of April 2024 and audience was informed about post rest facilities, availability of accommodation/taxi services for colleagues finishing on a late shift or too tired to travel home. HR department updated about consultation held for change of FY2 rota working in Trauma &orthopaedic department which has been made live with effect from Feb 2024. Doctors were informed about programme "Welcome to UK practice". Medical education department briefed regarding study leave guidebook.

**Regional GOSWH conferences and webinars**:
Dr Shiva Deep Sukumar, consultant Radiologist has stepped down as Guardian of Safe Working Hours and Dr Liaquat Ali, Consultant Respiratory Physician has been appointed as the new Guardian. He commenced in role mid- October 2023.
Dr Ali attended Yorkshire and Humber GOSWH Regional Meeting on 25th October and the Guardian of Safe working virtual national conference on 6th of Nov 2023 in his new role to liaise with other GOSWH.

**Summary:**
The trainees at CHFT have access to an allocate account to initiate exception reports and they have the provision if they want to raise any issue regarding safety concern, missed educational opportunities and extra work-outside their agreed rota. The rotas that are in the place are fully compliant with the rules of the 2016 contract and there is scope to review these where feedback highlights when changes may be needed.

# 21. Fire Strategy Progress Report

To Note

Presented by Jonathan Hammond

| | |
|---|---|
| **Date of Meeting:** | Thursday 2 May 2024 |
| **Meeting:** | Board of Directors |
| **Title:** | Fire Strategy |
| **Author:** | Keith Rawnsley, Trust Fire Officer |
| **Sponsoring Director:** | Jonathan Hammond, Chief Operating Officer |
| **Previous Forums:** | Supporting Information has been shared with the RAFT and Resilience and Safety group |
| **Purpose of the Report** | The paper provides the Board with a progress report on the delivery of the Trust's Fire Strategy.  Agreed by Board March 2021 running until 2026.<br><br>Supporting appendices includes information on:<br><br>• Spreadsheet of actions extracted from the report. |
| **Key Points to Note** | • The Trust Board has approved Fire Strategy in place that captures the recommendations made by Mott MacDonald who produced the Strategy.<br>• A 5-year Fire strategy was approved in 2021.<br>• To date is the third year of implementation.<br>• Priority scores have been agreed, so realistic outcomes are achievable.<br>• One hundred and one actions raised across all premises, 10 actions in progress, 90.1% completed<br>• The remaining detailed reports of the external façades are being costed via AFL architects.<br>• Compartmentation, an audit of HRI and other Trust owned building has taken place to assess the work required. Next steps include a procurement exercise to cost remedials works and operational impact of conducting works. CHS are looking at external training of operatives to undertake some internal remedial works. Both financial impact and operational impact on services of completing these works will need assessment.<br>• Whilst ICU (Ward 1) & Ward 11 was being refurbished an opportunity arose to improve the fire compartmentation.<br>• Design work and a feasibility study has been completed for smoke control in sub-basement. Completion of works would require funding and also alignment with the long-term strategy of the HRI estate post reconfiguration.<br>• Lifts works complete. Awaiting final Authorised Engineer sign off May 2024.<br>• The Fire Strategy has been taken to the Resilience and Safety group where each outstanding action is reviewed and will conti nue to be monitored. |

| | |
|---|---|
| | **Summary**<br><br>**Acre Mills OPD** 10 Actions – All actions complete<br>**Acre Mills Personnel Building** 12 actions – All actions complete<br>**Beechwood Medical Centre** 13 Actions – All actions complete<br>**Broad Street Plaza** 13 Actions - 1 action in progress<br>**Unit 18 Records Store** 4 Actions – All actions complete<br>**CRH** 8 Actions – 4 actions in progress<br>**Loan Store & THIS** 2 Actions – All actions complete<br>**HRI** 11 Actions – 4 actions in progress<br>**Park Valley Mills** 11 Actions- 1 action in progress<br>**HPS** 6 Actions- All actions complete<br>**Spring Cottage Nursery** 6 Actions – All actions complete<br><br>**Risks**<br><br>**Fire Strategy:**<br>**Compartmentation**- the findings from the survey continues to show issues with the compartmentation in buildings across CHFT and fire door issues. Significant funding would be required to address this, along with decanting areas which would significantly impact on services. Despite improvements such as partial resolution on ICU & full resolution on Ward 11 at HRI the risk of fire spread in other areas remains high.<br>**Smoke extraction-** survey and detailed design work for the sub-base ment is complete but reconfiguration plans, and funding availability will affect whether to proceed or not.<br><br>**Mitigations**<br><br>• Raising awareness of the compartmentation issues and taking opportunities to improve the standard when possible, such as ICU, Ward 11, noted on risk register 7413.<br>• Regular checks completed on the existing cladding, more for structural purposes than fire.<br>• Awareness of lack of smoke venting, it was not required when the building was built.<br>• Staff training, promotion of face to face where possible.<br>• Fire detection.<br>• Regular review through Resilience and safety group with divisional reps. |
| **EQIA – Equality Impact Assessment** | An Equality Impact Assessment has been completed to assess the effects that it is likely to have on people from different protected groups, as defined in the Equality Act 2010.The equality impact for specific actions arising will be assessed, considered, and mitigated as appropriate. |
| **Recommendation** | The Board is asked to **NOTE** and endorse the content of the report and continue its support for the Fire Strategy implementation. |

# GOVERNANCE

## 22. Governance Report

a) Compliance with the Trust’s Provider Licence conditions

b) Amendment to the Trust Constitution

c) Committee arrangements

d) Board of Director Attendance Register 2023/24

e) Board of Directors Workplan for 2024/2025

To Approve

Presented by Andrea McCourt

<table>
<tr><td>Date of Meeting:</td><td>Thursday 2 May 2024</td></tr>
<tr><td>Meeting:</td><td>Public Board of Directors</td></tr>
<tr><td>Title:</td><td>Governance Report</td></tr>
<tr><td>Author:</td><td>Andrea McCourt, Company Secretary</td></tr>
<tr><td>Sponsoring Director:</td><td>Victoria Pickles, Director of Corporate Affairs</td></tr>
<tr><td>Previous Forums:</td><td>None</td></tr>
<tr><td>Purpose of the Report</td><td>This paper presents the following governance items to the Board:<br><br>a) Compliance with the Trust’s Provider Licence conditions<br>b) Amendment to the Trust Constitution<br>c) Committee arrangements<br>d) Board of Director Attendance Register 2023/24<br>e) Board of Directors Workplan for 2024/2025</td></tr>
<tr><td>Key Points to Note</td><td>a) Self-certification of Compliance with Provider Licence Conditions<br><br>Foundation Trusts complete annually a number of self-certifications to provide assurance that the Trust:<br><br>- is compliant with the conditions of their NHS provider licence (or provide explanatory text where this is not the case)<br>- has the required resources available if providing commissioner requested services<br>- is compliant with governance arrangements.<br><br>The purpose of this paper is to seek Board approval of the enclosed self–certification schedules for 2023/24 at Appendix Q2. Self -certification relates to the following conditions:<br><br>
<table>
<tr><th>Condition</th><th>Description</th><th>Internal Assurance Process</th></tr>
<tr><td>FT4 (8)</td><td>Compliance with systems and processes for good governance and forward compliance with the governance condition for the 2024/25 financial year and any risks.</td><td>Confirmed - compliance is confirmed in the attached Appendix T1.<br><br>Evidence of compliance with Code of Governance for NHS Provider Trusts reviewed at Audit and Risk Committee 25 April 2024.</td></tr>
</table>
</td></tr>
</table>

| | | |
|---|---|---|
| | | Governor training confirmed by lead governor on behalf of the Council of Governors |
| G6 (3) | Trust compliance with its NHS provider licence, NHS acts and NHS Constitution in 2023/24. | Confirmed - see Appendix Q |
| G6 (4) Publication | Publication of condition G6(3) self certification | To be added to Trust website by 30 June 2024 |
| Condition CoS7(3) | Continuity of Service and having the required resources available for the next 12 months for providing commissioner requested services | Narrative based on 2024/25 position and ongoing oversight of financial position by Finance and Performance Committee (see Appendix Q) |

*Available resources if providing commissioner requested services* - condition S7 (CoS7 (3)) relates to continuity of service and having the required resources available for the next 12 months. The Trust is confirming that it has a reasonable expectation that resources will be available for 2024/25 subject to the factors detailed in the return which is enclosed at Appendix T2. This is because the Trust remains in breach of its licence, for the availability of resources certification (CoS7) the Trust is declaring that it has a reasonable expectation to have the required resources available (declaration 3b) and the factors relating to this are stated in the return. This is consistent with the response that the Trust has given over the previous financial years whilst in breach of the licence.

The self-certification documents confirm Trust compliance with governance (FT4) and the provider licence condition G6(3).

**RECOMMENDATION:** The Board is asked to **APPROVE** the content of the self-certification documents for the signature of declarations.

**b) Amendment to the Trust Constitution**

The Council of Governors agreed a minor amendment to its Constitution on 25 April 2024 relating to section 18.3 which allows for any governor to become lead governor. Previously this option was only available to publicly elected governors. This change aligns with the Code of Governance for NHS Provider Trusts which came into effect on 1 April 2023.

The Trust Board is required to also approve amendments to the Constitution.

**RECOMMENDATION:** The Board is asked to **APPROVE** the amendment to section 18.3 of the Trust Constitution.

**c) Committee Arrangements**

The Chair has reviewed Board Committee membership, chair arrangements and meeting frequency, due to two Non-Executive Directors finishing (Karen Heaton and Andy Nelson) and two recent Non-Executive Director appointments, Jo Wass and Vanessa Perrott.

Changes to Board Committee chair arrangements are:

- Workforce Committee Chair – Jo Wass
- Finance and Performance Committee Chair – Vanessa Perrott

There has been some movement of members between Committees as shown in Appendix Q3, which confirms Non-Executive Director Board Committee membership from July 2024, with a phased approach to the new arrangements. This paper also provides further detail on each of the Board champion roles which are confirmed as.

**Maternity Board Safety Champion** – Vanessa Perrott

**Well-Being Guardian** – Denise Sterling

**Freedom to Speak Up Champion** – Jo Wass

**Security Management** – Nigel Broadbent

**Doctors Disciplinary** – all Non-Executive Directors

**RECOMMENDATION:** The Board is asked to **NOTE** the arrangements for Non-Executive Directors and Board Committees and Board champion roles.

**d) Board of Directors Attendance Register for the Annual Report 2023/24**

The attendance of Directors at Board of Directors meetings during 2023/24 is required to be detailed within the Trust annual report. The Board of Directors attendance register is attached at Appendix Q4. Any changes to this should be notified to the Company Secretary.

**RECOMMENDATION:** The Board is asked to **APPROVE** the Board of Directors Attendance Register for 2023/24.

**e) Board of Directors Workplan 2024/25**

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 2024/25 workplan is presented for approval at Appendix Q5.

**RECOMMENDATION:** The Board is asked to **APPROVE** the Board workplan for 2024/25.

| EQIA – Equality Impact Assessment | The content of this report does not adversely affect people with protected characteristics. |
| --- | --- |
| **Recommendations** | The Board is asked to **APPROVE** the:<br><br>• content of the self-certification documents for the signature of declarations for 2023/24<br>• amendments to section 18.3 of the Trust Constitution<br>• Board of Directors Attendance Register for 2023/24<br>• Board of Directors Workplan for 2024/25 |

## Corporate Governance Statement FT 4 -Self Certification Calderdale and Huddersfield NHS Foundation Trust 2023/24

| Corporate Governance Statement | Response | Risks and Mitigating Actions |
|---|---|---|
| 1. *The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.* | **Confirmed** | The Trust monitors and reviews its systems and processes to ensure they comply with good governance as detailed in the Annual Governance Statement.<br><br>The Trust received a CQC good rating at a well-led inspection in April 2018, with a "requires improvement" rating for use of resources.<br><br>The Trust has completed an externally commissioned a well-led development governance review and the Board of Directors continues to review its effectiveness as part of its development programme. |
| 2. *The Board has regard to such guidance on good corporate governance as may be issued by NHS England from time to time* | **Confirmed** | The Trust pays due regard to guidance issued by NHS England and liaises through national and regional networks.<br><br>NHS England guidance is also noted through the Trust's external audit technical updated reported each quarter to the Audit and Risk Committee, with a similar report shared via internal auditors.<br><br>Compliance with NHS England's Code of Governance for NHS Provider Trusts for 2023/24 was reviewed by the Audit and Risk Committee in April 2024.<br><br>The Trust has amended its Constitution and governance documentation in line with the Health and Care Act 2022 in line with NHS England's Code of Governance for NHS Provider Trusts effective from 1 April 2023. |
| 3. *The Board is satisfied that the Licensee has established and implements:*<br>*(a) Effective Board and Committee structures;*<br>*(b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and* | **Confirmed** | a) The Trust has a robust Board and Board Committee governance structure which is reviewed annually and approved by the Board of Directors when changes are made. The governance structure is also depicted within the Trust Risk Management Strategy.<br><br>b) Each Board Committee has a term of reference reviewed annually, assesses effectiveness on an annual basis and develops an action plan. |

| | | |
|---|---|---|
| 4. *(c) Clear reporting lines and accountabilities throughout its organisation.* | | c) There is clear organisational structure for operational management which sets out reporting lines and accountabilities. |
| 5. *The Board is satisfied that the Licensee has established and effectively implements systems and/or processes:*<br><br>*(a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;*<br><br>*(b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations;*<br><br>*(c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;* | **Confirmed** | a) Board Committees give assurance to the Board that the Trust is operating effectively. These include Board Committees scrutinising the following matters:<br>- finance and performance<br>- quality<br>- workforce<br>- audit and risk<br><br>The sub group reporting structure to Board Committees also provide comprehensive coverage of Trust business. In terms of management of resources a Turnaround Executive has been in place given the Trust's financial position<br><br>b) The Trust Board receives an Integrated Performance Report<br><br>c) The Trust has a governance structure linking the Board, key Board Committees with responsibility for the oversight of operations and an Executive team structures.<br><br>The Trust's wholly owned subsidiary, Calderdale Huddersfield Solutions Ltd. has its own governance structure and relationships and reporting to the Trust.<br><br>The Trust declared no significant control issues in its 2023/24 annual governance statement and detailed the Trust's risk management framework and current strategic risks. The Board Assurance Framework and risk register are reviewed regularly by the Board and Board Committees. |

| | | |
|---|---|---|
| *(d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);* | | d) The Trust has a clear Standing Financial Instructions and Scheme of Delegation in place that determines the framework for financial decision-making, management and control. These were revised in year. Planning was in line with national guidance with collaboration with system partners. A paper to confirm going concern is provides to the Audit and Risk Committee as part of the year end accounts information. |
| *(e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;* | | e) A monthly Integrated Board Performance Report has is produced and reviewed by the Executive team, at Board Committee meetings as per their terms of reference and by the Board. This has been revised and now focusses 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 included as best practice to understand current performance and drive meaningful conversations at Board. |
| *(f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;* | | f) The Trust identifies key risks through the Board Assurance Framework and the high level risk register. |
| *(g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and* | | g) The Board monitors delivery against financial plans through its Finance & Performance Committee and through the Board with particular focus on those areas identified of greatest risk. |
| *(h) To ensure compliance with all applicable legal requirements.* | | h) Trust legal obligations are brought to the attention of Directors. |

| | | |
|---|---|---|
| 6. *The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure:*<br><br>*(a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;*<br><br>*(b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;*<br><br>*(c) The collection of accurate, comprehensive, timely and up to date information on quality of care;*<br><br>*(d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;*<br><br>*(e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and* | **Confirmed** | a) There is an effective objective setting and performance review process in place for Board members. Board succession planning is considered within the Nomination and Remuneration Committees. A fit and proper person declarations register is maintained and reported to the Board annually.<br><br>b) Quality account priorities (agreed with governors) and other quality priorities have been agreed and reported, along with other quality metrics, to the Quality Committee and Board.<br><br>c) A quality highlight report from the Quality Committee is presented to each Board meeting. The Trust has a Quality Strategy in place and engages in a wide range of quality improvement collaboratives to improve patient care. There is a robust quality impact assessment process in place for service changes<br><br>d) The Integrated Performance Report details quality metrics ensuring up to date information on the quality of care for the Board and the Quality Committee.<br><br>e) The Trust has a Patient Experience Group and engages with key stakeholders, including governors, through its Observe and Act patient experience tool, local and national surveys, Friends & Family Test, PALS, patient stories reported to Board. Governors are involved in selection of three of the Trust's quality priorities. |

| | | |
|---|---|---|
| *A(f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.* | | f) At Board level, the Medical Director and Chief Nurse have joint responsibility for quality issues to the Board, including assurance on quality governance. The monthly Integrated Performance Report identifies and escalates key quality performance issues to the Board. Within the organisation, an incident reporting system is in place, with a structure for the escalation of incidents to relevant meetings within the Quality governance structure and to the Executive Board, Quality Committee and Board.<br><br>. |
| 7. *The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.* | **Confirmed** | The Trust is compliance with the NHS England Code of Governance in respect of appropriate numbers of Non-Executive and Executive Directors.<br><br>The Trust has in place a formal appointment process to the Board overseen by a Nomination and Remuneration Committees which ensures that appropriately qualified Board members are recruited and appointed, with appraisal processes in place to review existing Board members.<br><br>A fit and proper person declarations register is maintained and reported to the Board with self attestation forms completed in line with NHS England's enhanced framework for Fit and Proper Persons and the Trust Fit and Proper Persons Policy. |

**Training of Governors FT 4 -Self Certification Calderdale and Huddersfield NHS Foundation Trust 2023/24**

| Training of Governors Statement | Response | Risks and Mitigating Actions |
|---|---|---|
| *The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.* | **Confirmed** | A comprehensive two day induction session is provided for all new governors. An annual training programme for governors includes training on finance, quality and performance. A development session is also held with governors. NHS Provider governor event details are shared with governors.<br><br>The lead governor confirmed on 5 April 2024 that a comprehensive programme of training was in place for governors. |

## General Condition 6 Systems for Compliance with Licence Conditions and Continuity of services condition 7 - Availability of Resources

| 1 & 2 General Condition 6 – Systems for compliance with Licence Conditions | Response |
|---|---|
| 1 Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution. | **Confirmed** |

| Continuity of services condition 7 - Availability of Resources 2024/25 | Response |
|---|---|
| 3b After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services. | **Confirmed** |

**Statement of main factors taken into account in making the above declaration**

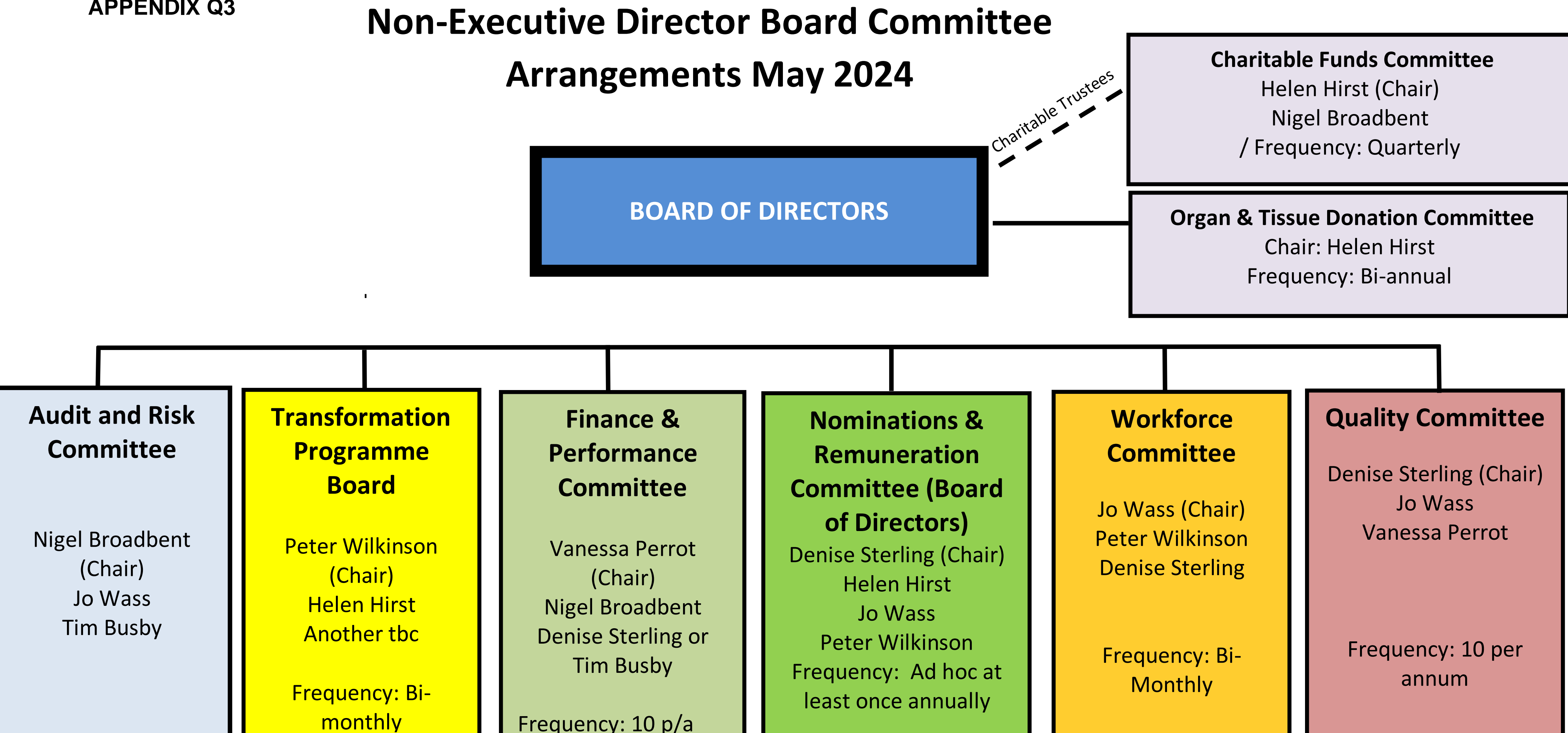
In making the above declaration regarding continuity of service, the main factors which have been taken into account by the Board of Directors are as follows

Given the underlying deficit position and the planned deficit for 2024/25, the Trust has given this due consideration and notes the following: Funding for the Trust's services will be received from commissioners in this period, embedding historic levels of Financial Recovery Funding (FRF). The Trust will work with partners across the Integrated Care System to manage elective recovery plans and access associated funding. The 2024/25 financial plan submitted in line with national timescales described a deficit position which exceeds the cash holdings at the outset of the financial year. As such, the Trust will require cash support. This will be accessed through the national mechanism allowing for Public Dividend Capital to be received to support and maintain cash flow.

**Signed on behalf of the Board of Directors of Calderdale and Huddersfield NHS Foundation Trust**

| | |
|---|---|
| **Signature** | **Signature** |
| **Name: Brendan Brown** | **Name: Helen Hirst** |
| **Role: Chief Executive** | **Chair** |
| **Date:** | **Date:** |

APPENDIX Q3




**Trust Chair:** Helen Hirst

**Senior Independent Non-Executive Director:** Denise Sterling

**Deputy Chair:** Peter Wilkinson

**Calderdale Huddersfield Solutions Board Chair:** Tim Busby

**APPENDIX Q3**

## Board Champion Roles

In line with NHS England guidance from December 2021 the Trust has the following Non-Executive Director champion roles, with further details on each of the roles given at Appendix 1.

**Maternity Board Safety Champion** – Vanessa Perrot

**Well-Being Guardian** – Denise Sterling

**Freedom to Speak Up Champion** – Jo Wass

**Security Management** – Nigel Broadbent

**Doctors Disciplinary** – all Non-Executive Directors

**APPENDIX Q3**

**Appendix 1**

**NON-EXECUTIVE DIRECTOR CHAMPION ROLES**

(extract from Enhancing Board Oversight, NHS England)

**Maternity Board Safety Champion**

In response to the Morecambe Bay Investigation (2015), this role was established through Safer Maternity Care 2016, which stated that "Senior trust managers will want to ensure unfettered communication from 'floor-to-board' by appointing a board level maternity champion". The role is in line with recommendations from the Ockenden Review (2020) and while not a statutory requirement, for trusts providing maternity services having a named NED maternity board safety champion is recommended.

The champion should act as a conduit between staff, frontline safety champions (obstetric, midwifery and neonatal), service users, local maternity system (LMS) leads, the regional chief midwife and lead obstetrician and the trust board to understand, communicate and champion learning, challenges and successes.

The named champion could be the chair of the quality and safety committee and the requirements of the role could be discharged through the appropriate committee provided Trusts ensure that the clinical director and director of midwifery are integral to these Committee meetings. NEDs should use appreciative inquiry approaches and the Maternity Self-Assessment Tool to provide assurance to the board that the best quality maternity care is being provided by their trust. Trusts may also wish to note that the NSR maternity incentive scheme safety actions refer to the maternity board safety champion role under Safety Action 9. Along with other recommendations contained in the Ockenden Review, this role will be reviewed nationally in 2-3 years' time to gauge its effectiveness.

A Trust role description is in place for this NED for Oversight of Maternity Services and is scheduled for review in June 2022.

**Wellbeing Guardian**

This role originated as an overarching recommendation from the Health Education England 'Pearson Report' (NHS Staff and Learners' Mental Wellbeing Commission 2019) and was adopted in policy through the 'We are the NHS People Plan for 2020-21 – action for us all'. The NED should challenge their trust to adopt a compassionate approach that prioritises the health and wellbeing of its staff and considers this in every decision.

The role should help embed a more preventative approach, which tackles inequalities. As this becomes routine practice for the Board, the requirement for the wellbeing guardian to fulfil this role is expected to reduce over time. The Guardian community website provides an overview of the role and a range of supporting materials.

## APPENDIX Q3

### Freedom to Speak Up Champion (FTSU)

The Robert Francis Freedom to Speak Up Report (2015) sought to develop a more supportive and transparent environment where staff are encouraged to speak up about patient care and safety issues. In line with the review, it is recommended that all NHS trusts should have this functional FTSU guardian role so that staff have a clear pathway and an independent and impartial point of contact to raise their concerns in the organisation. The role of the NED champion is separate from that of the guardian. The NED champion should support the guardian by acting as an independent voice and board level champion for those who raise concerns. The NED should work closely with the FTSU guardian and, like them, could act as a conduit through which information is shared between staff and the board (p.146, Francis FTSU report). All NEDs should be expected to provide challenge alongside the FTSU guardian to the executive team on areas specific to raising concerns and the culture in the organisation. When an issue is raised that is not being addressed, they should ask why. A full description of NED responsibilities can be found in the NHS E/I FTSU supplementary information July 2019 which can be accessed via this link.

https://www.england.nhs.uk/wp-content/uploads/2021/05/ftsu-supplementary-information.pdf

### Doctors disciplinary NED champion/independent member

Under the 2003 Maintaining High Professional Standards in the modern NHS: A Framework for the Initial Handling of Concerns about Doctors and Dentists in the NHS and the associated Directions on Disciplinary Procedures 2005 there is a requirement for chairs to designate a NED member as “the designated member” to oversee each case to ensure momentum is maintained. There is no specific requirement that this is the same NED for each case. The framework was issued to NHS Foundation Trusts as advice only.

### Security Management NED Champion

Under the Directions to NHS Bodies on Security Management Measures 2004 there is a statutory requirement for NHS bodies to designate a NED or non-officer member to promote security management work at board level. Security management covers a wide remit including counter fraud, violence and aggression and also security management of assets and estates. Strategic oversight of counter fraud now rests with the Counter Fraud Authority and violence/aggression is overseen by NHS England and NHS Improvement.

While promotion of security management in its broadest sense should be discharged through the designated NED, relevant Committees may wish to oversee specific functions related to counter fraud and violence/aggression. Boards should make their own local arrangements for the strategic oversight of security of assets and estates.

**Reference:**

B0994_Enhancing-board-oversight-a-new-approach-to-non-executive-director-champion-roles_December-2021.pdf (england.nhs.uk)

| Attendance | ✓ | Apologies | × |
|---|---|---|---|
| Not in post | | Not invited | - |

## ATTENDANCE REGISTER – PUBLIC BOARD
## 1 APRIL 2023 – 31 MARCH 2024

| DIRECTOR | 04.05.2023 | 06.07.2023 | 07.09.2023 | 02.11.2023 | 11.01.2024 | 07.03.2024 | TOTAL |
|---|---|---|---|---|---|---|---|
| Helen Hirst | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 6 / 6 |
| Brendan Brown | ✓ | × | ✓ | ✓ | ✓ | ✓ | 5 / 6 |
| Robert Aitchison | ✓ | ✓ | ✓ | × | ✓ | ✓ | 5 / 6 |
| David Birkenhead | ✓ | ✓ | × | ✓ | ✓ | ✓ | 5 / 6 |
| Lindsay Rudge | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 6 / 6 |
| Gary Boothby | ✓ | × | × | ✓ | ✓ | ✓ | 4 / 6 |
| Kirsty Archer | - | ✓ | ✓ | - | - | - | 2 / 2 |
| Suzanne Dunkley | ✓ | ✓ | × | ✓ | ✓ | ✓ | 5 / 6 |
| Peter Wilkinson | × | ✓ | × | ✓ | ✓ | ✓ | 4 / 6 |
| Nigel Broadbent | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 6 / 6 |
| Tim Busby | ✓ | × | ✓ | ✓ | ✓ | ✓ | 5 / 6 |
| Andy Nelson | ✓ | ✓ | × | ✓ | ✓ | ✓ | 5 / 6 |
| Denise Sterling | × | × | ✓ | ✓ | ✓ | ✓ | 4 / 6 |
| Karen Heaton | ✓ | ✓ | ✓ | ✓ | ✓ | | 5 / 5 |
| Jo-Anne Wass | | | | | | ✓ | 1 / 1 |
| **ATTENDEES** | | | | | | | |
| Anna Basford | ✓ | × | ✓ | ✓ | ✓ | ✓ | 5 / 6 |
| Rob Birkett | × | ✓ | × | ✓ | ✓ | ✓ | 4 / 6 |
| Stuart Sugarman | ✓ | ✓ | ✓ | × | ✓ | ✓ | 5 / 6 |
| Jonathan Hammond | ✓ | ✓ | × | ✓ | ✓ | ✓ | 5 / 6 |
| Victoria Pickles | ✓ | ✓ | × | ✓ | ✓ | ✓ | 5 / 6 |
| Andrea McCourt | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 6 / 6 |

DRAFT

| DATE OF MEETING | 7 March 2024 | 2 May 2024 | 4 July 2024 | 12 September 2024 | 7 November 2024 | 9 January 2025 | 6 March 2025 |
|---|---|---|---|---|---|---|---|
| Date of agenda setting/Feedback to Execs | 31 Jan 2024 | 20 March 2024 | 21 May 2024 | 31 July 2024 | TBC | TBC | TBC |
| Date final reports required | 23 February 2024 | 19 April 2024 | 21 June 2024 | 29 August 2024 | 25 October 2024 | 27 December 2024 | 22 February 2025 |
| **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 & PLANNING AGENDA ITEMS** | | | | | | | |
| Strategic Objectives – 1 year plan / 5 year strategy | ✓ | | ✓ *1 year Strategic Objectives report 1 of 3* | | ✓ *- 2023-2024 Strategic Objectives Progress Report 2 of 3* | | ✓ *- 2023-2024 Strategic Objectives Progress Report 3 of 3* |
| Digital Health Strategy | | | | | | ✓ | |

| DATE OF MEETING | 7 March 2024 | 2 May 2024 | 4 July 2024 | 12 September 2024 | 7 November 2024 | 9 January 2025 | 6 March 2025 |
|---|---|---|---|---|---|---|---|
| Digital Update (Digital story and an update on the broader THIS work, not just the CHFT aspects) | | | | | | ✓ | |
| Risk Management Strategy | ✓ | | ✓ | | | | |
| Charity Strategy | | | | | ✓ | | |
| Annual Plan | ✓ | ✓ for 2024/25 | | | | | ✓ |
| Capital Plan | ✓ | | | | | ✓ | |
| Resilience / Surge & Escalation Plan | | | | | ✓ | | |
| Green Plan (Climate Change) | | | ✓ | | | | |
| Reconfiguration (commercial) | | | | TBC | | | |
| **QUALITY AGENDA ITEMS** | | | | | | | |
| Director of Infection Prevention Control (DIPC) quarterly report | ✓Q3 | | ✓Q4 | ✓Q1 | ✓Q2 | | ✓Q3 |
| DIPC Annual Report | | | ✓ | | | | |
| Learning from Deaths Quarterly Report | ✓ Q2 | ✓ Q3 | ✓Q4 Annual Report | | ✓Q1 | | ✓ Q2 |
| Update on Maternity Reporting (invite Director of Midwifery) | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Maternity Incentive Scheme | | | | | | ✓ | |
| Safeguarding Adults and Children Report | | | ✓ Annual Report | | | ✓ Bi-annual | |
| Complaints Annual Report | | | ✓ | | | | |
| **WORKFORCE AGENDA ITEMS** | | | | | | | |
| **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 Update** | ✓ | | ✓ | ✓ | ✓ | | ✓ |
| Guardian of Safe Working Hours Annual Report | | ✓ | | | | | |
| Diversity | | | | | ✓ Board Diversity Action Plan | | ✓ |

| DATE OF MEETING | 7 March 2024 | 2 May 2024 | 4 July 2024 | 12 September 2024 | 7 November 2024 | 9 January 2025 | 6 March 2025 |
|---|---|---|---|---|---|---|---|
| Medical Revalidation and Appraisal Annual Report | | | | ✓ Annual Report | | | |
| Public Sector Equality Duty (PSED) Annual Report | | ✓ | ✓ | | | | ✓ |
| **GOVERNANCE & ASSURANCE AGENDA ITEMS** | | | | | | | |
| Emergency Planning Annual Report / EPRR Core Standards Submission | | ✓ Annual Report | | | | ✓ Compliance statement | ✓ Annual Report |
| Freedom to Speak Up Annual Report | | | | ✓ Annual Report | | ✓ 6 month report FTSU themes and qualitative presentation | |
| **Health and Safety Update** **(if required – routinely reports to ARC)** | | | | ✓ | | ✓ | |
| **Health and Safety Policy** | | | | ✓ | | | |
| Health and Safety Annual Report | | | | ✓ | | | |
| Board Assurance Framework | ✓ 3 | | ✓ 1 | | ✓ 2 | | ✓ 3 |
| Risk Appetite Statement | | | | ✓ | | | |
| High Level Risk Register | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Standing Orders/SFIs/SOD review (next review due March 2025 unless changes required beforehand) | | | | | | | ✓ |
| Trust Constitution - as required | | | | | | | |
| Non-Executive appointments | ✓ | | | | ✓ | | ✓ |
| Annual review of NED roles | | | | | ✓ | | |
| Board workplan | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Board meeting dates | | | ✓ | | | | |
| Use of Trust Seal | ✓ | | ✓ | | ✓ | | ✓ |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Declaration of Interests & Fit and Proper Persons Declarations– 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 | ✓F&P<br>✓ NRC BOD | ✓ NRC CoG | ✓QC<br>✓ Workforce | ✓ARC | ✓ TPB review Sept | | ✓F&P<br>✓ NRC BOC |
| Constitutional changes (+as required) | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Compliance with Licence Conditions (final year 2022/23) | | ✓ | | | | | |
| THIS Update | | | | | | ✓ | |
| Huddersfield Pharmacy Specials (HPS) Annual Report | | | | ✓ | | | |
| Fire Strategy 2021-2026 | | ✓ | | | | | ✓ |
| Annual Fire Safety Report | | | | | | ✓ | |
| Audit and Risk Committee Annual Report 2023/2024 | | | ✓ | | | | |
| Workforce Committee Annual Report 2023/24 | | | ✓ | | | | |
| Finance & Performance Committee Annual Report 2023/2024 | | | ✓ | | | | |
| Quality Committee Annual Report 2023/24 | | | ✓ | | | | |
| Transformation Programme Board Annual Report | | | ✓ | | | | |
| WYAAT Annual Report and Summary Annual Report | | | | | | ✓ | |
| Kirklees ICB Committee Papers (Link) | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Calderdale Cares Partnership Committee Papers (Link) | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |

| | **<u>COLOUR KEY TABLE FOR AGENDA ITEMS LISTED IN LEFT HAND COLUMN</u>** |
|---|---|
| **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) |

23. Items to receive and note

1. Minutes of Board Committees
- Finance and Performance Committee – 27.02.24
- Quality Committee – 11.03.24
- Workforce Committee – 19.02.24

2. Partnership papers:
- Kirklees Health and Care Partnership https://www.kirkleeshcp.co.uk/about-us/kirklees-icb-committee/kirklees-icb-committee-meetings/
- Calderdale Cares Partnership https://www.calderdalecares.co.uk/about-us/meeting-papers/

To Receive

**Minutes of the Finance & Performance Committee held on Tuesday 27th February 2024, 09.30am – 12noon Via Microsoft Teams**

PRESENT

| | |
|---|---|
| Andy Nelson (AN) | Non-Executive Director (Chair) |
| Nigel Broadbent (NB) | Non-Executive Director |
| Karen Heaton (KH) | Non-Executive Director |
| Gary Boothby (GB) | Director of Finance |
| Rob Aitchison (RA) | Deputy Chief Executive |
| Anna Basford (AB) | Head of Transformation and Partnerships |
| Jonathan Hammond (JH) | Chief Operating Officer |

**IN ATTENDANCE**

| | |
|---|---|
| Rochelle Scargill (RLS) | PA to Director of Finance (Minutes) |
| Kirsty Archer (KA) | Deputy Director of Finance |
| Peter Keogh (PK) | Assistant Director of Performance |
| Philippa Russell (PR) | Assistant Director of Finance |
| Stuart Baron (SB) | Deputy Director of Finance |
| Adam Matthews (AM) | HR Business Partner |
| Andrea McCourt (AM) | Company Secretary |
| Helen Rees (HR) | Director of Operations – Medicine |
| Jason Bushby (JB) | Deputy Director of Operations – Medicine |
| Thomas Ladlow (TL) | Head Nurse – Medicine |
| Alastair Finn (AF) | Performance Information Lead |
| Katherine Cullen (KC) | Shadow Board |
| Arley Byrne (ABY) | Shadow Board |

**OBSERVERS**

| | |
|---|---|
| Helen Hirst (HH) | Chair |
| Pam Robinson (PR) | Public Elected Governor |
| Robert Markless (RM) | Public Elected Governor |

**APOLOGIES**

| | |
|---|---|
| Robert Birkett (RB**)** | Managing Director of THIS |
| Brian Moore (BM) | Public Elected Governor |

**ITEM**

**038/24 WELCOME AND INTRODUCTIONS**

The Chair welcomed attendees to the meeting including members of the shadow board.

**039/24 DECLARATIONS OF INTEREST**

**040/24 MINUTES OF THE MEETING HELD 31st January 2024**

The previous minutes were approved as an accurate record.

**041/24 MATTERS ARISING**

**042/24 ACTION LOG**

The Action Log was reviewed as follows:

033/24 - Terms of reference section 4.5 to be re-written. On Agenda.

**043/24 TERMS OF REFERENCE REVIEW**

The terms of reference have been updated as per discussion at the last meeting. Following conversations outside of this meeting the decision has been made to remove the section that refers to Procurement as this is covered by the CHFT / CHS Joint Liaison Committee which reports into this committee.

The membership of the committee needs to be clarified and some minor layout issues are to be corrected. Once these are done the committee were happy for the terms of reference to go to the Trust Board for approval.

The Committee **APPROVED** the terms of reference. To submit to Board.

**044/24 DEEP DIVE ED FOLLOW UP**

HR, JB, TL and AF gave a follow up on the deep dive that was presented to this committee in May 2023.

Wait times have increased over the last year as have the number of attendances. In May last year our 4-hour performance was 71.3% and in February 2024 was 64.9%. The number of 12-hour waits has also increased. Ambulance wait times have not increased when we exclude the change in how the wait time is measured.

Comparing the 4-hour performance across WYATT Bradford have seen an improvement in their performance figures which is a result of changes to the way that they work. They are streaming all P4 and P5 patients through their SDEC.

Re-assurance was given to the committee that CHFT are prioritising treatment of higher acuity patients. The acuity of patients has increased over the same time period.

Work has been done to stabilise the ED budget. Agency costs have been reduced by converting them to substantive posts and three of the budgets are now back in balance with significant improvements in the nursing and medic budget.

A CQC urgent and emergency care survey was recently carried out which focused on the patient experience. This showed we performed well and scored above the national average.  ED have taken action on each of the 5 key areas for improvement and are creating a “You said, We did” response to them.

Workforce – The number of consultants has now increased to 22 from 10 in May 2023. This has enabled 16-hour consultant cover 7 days a week. Nursing recruitment has improved down from a vacancy of 18% (16WTE) August 2023 to 3.4% (2.97WTE) in January 2024. A tiered progression model has been implemented and 3 advanced clinician practitioners are expected to be at ST3 by August 2024. Band 2 HCA's will be re-banded to Band 3 once they have completed a 12-18month training program. Work is now under way on retention of staff.

A perfect week is planned in ED week commencing 4th March. This will include the implementation of an SDEC service on the Calderdale site. Patients will then be processed through the correct workstream while being cautious not to move the problems from the ED to another area.

Advanced Trauma Life Support course is the design stage and has potential to become income generating.

The committee commented on the positive outcomes and planned developments and congratulated the team.

KH asked if the budget shown in the presentation included strike costs. Some of the costs are included.

ABY enquired about the ACP's mentioned in the presentation. Were they recruited ready trained, or have they been developed in house? They all arrived as trainees with the last two qualifying last year.

JH – The positive learning that has resulted from the strikes and being at OPEL 4 is the importance of joint workforce models and ED working closely with the Acute ward team. Bradford have seen by doing this it has removed some of the barriers to transferring patients. The Clear project review over the last four to five months has given an external perspective of the opportunities around SDEC's.

**FINANCE & PERFORMANCE**

**045/24 IPR**

The Assistant Director of Performance highlighted the key points of the January IPR.

For January 2024 we have followed national guidance and pushed **Quality** to the forefront of our reporting. Two new indicators have been added to the elective section, day case rates and cap utilisation rates for theatres.

All quality indicators fall into common cause variation with mainly hit or miss but also pass for some indicators. E. Coli infection rates are now consistently hitting target.

Care of the acutely ill patient (% of patients with a NEWS2 of 5+ will not have a higher score during their episode of care) - currently performance is subject to common cause variation, however another data point below the mean will trigger the data to be in special cause variation for concern. A QIP is underway to establish the impact of the mandatory use of Nervecenter devices within the medical team to

improve the response time for patients with NEWS 7 or above, and in turn the impact this has on improvement in NEWS score.

% of complaints closed on time (target 95%) was 90% in January following periods of sickness and delays in signing off.

We continue to perform well in terms of **elective recovery** with the exception of ENT which is working towards achieving zero 52-week waits at the end of March. All other specialties should be in a position to achieve the 40-week target of zero waiters. The plan is to maintain RTT at 40 weeks (ENT 52 weeks) and ASIs at 18 weeks (ENT 40 weeks) for 2024/25.

For **diagnostics** we still have challenges in Echo and Neurophysiology although we have seen improvements in both areas over recent weeks.

The plans to reduce the **follow-up** backlog is still a priority following the deep dives into each specialty where we have already seen improvements in the booking process which has led to reductions in individual specialty numbers.

**Cancer** performance continues to be strong with all targets met including faster diagnosis target being achieved for the fifth month running.

**ED** performance for January was back to October/November levels at 66.53% with continuing pressures around numbers of attendances and acuity. TOC numbers and bed occupancy have increased although there was a small drop in the number of patients waiting over 12 hours in ED.

Proportion of **ambulance arrivals** delayed over 30 minutes saw a small reduction in January. The key change from October is the use of arrival destination as the trigger for when the clock starts which removes any notify times previously used. We have committed to an average of 23.5 minutes for 2024/25.

RM – transfer of care and reason to reside are reported as two separate lines but are they the same thing? There have been stories in the press around patients seeing consultants which meets the 52-week target, but this has been followed by significant delays. Are CHFT monitoring what happens to patients once they have seen the consultant?

JH – There are some small differences between transfer of care and reason to reside. Reason to reside has to be reported nationally and the transfer of care is the framework used by CHFT with Place partners to have conversations around what patients need in order to be discharged.CHFT has good processes in place to monitor patients wherever they are in their treatment pathway.

NB – Bed occupancy in January increased again to high levels. In previous meetings action plans to try and reduce these have been discussed. Is there an

expected timeline when the bed occupancy could be expected to reduce and what are the assumptions for next year.

JH - Planning for next year has taken into account the increased acuity of patients which is expected to continue to increase next year. A baseline has been created and further work will take place with community partners and local authorities to look at the programmes of work and apply it to the bed base number. The plan is for 96% capacity to allow some flexibility and improve flow from ED.

AN asked if elective recovery was starting to revert to pre-pandemic levels? JH - prior to the pandemic CHFT were working towards 18 week waits.

The Committee **RECEIVED** the IPR for January

**046/24 RECOVERY UPDATE**

The Assistant Director of Performance highlighted the following:

- The trust-by-trust comparison is showing CHFT is still in a better position for patient waiting times than other trusts in the region
- Activity remains above plan.
- ENT remains challenging with the majority of 52 weeks and 40-week waiters being in ENT. Plans are in place to reduce these. ENT is also the biggest challenge with Outpatient ASI's over 18 weeks with 2507 of 3654 being in ENT.
- Follow ups – there has been some improvement across individual specialities following the deep dives and training. A lot of work has been completed but there is more to do.
- Diagnostics – Since the report was written, there has been further improvement in Echocardiology and Neurophysiology. Neurophysiology is now below the trajectory and Echocardiology is only slightly above.

AN – A task and finish group was set up to look at ENT. Are there any updates from that group?
JH – Some of the actions are linked to recruitment which has been a challenge at different grades. We were successful in recruiting an additional bank consultant but the one who was already in post is now leaving. There has been interest at a registrar level which will make a significant difference the number of clinics. There will be a requirement to continue to use Pioneer into the new year which has been planned for, but as recruitment is successful it is expected that the use of Pioneer can be reduced. As CHFT will be fined for each patient waiting over 52 weeks we have expended extra budget to reduce the 52-week waiters in ENT to as close to zero as possible by the end of March.

**ACTION**: For next month 2-3 slides in the IPR specifically on ENT.

The Committee **RECEIVED** the Recovery Update

**047/24 MONTH 10 FINANCE REPORT**

The Assistant Director of Finance gave the highlights from the financial position as reported at Month 10, January 2024.

The Trust is reporting a year-to-date deficit of £21.05m which is an adverse variance of £3.62m from plan. The in-month position is a deficit of £3.51m which is a £1.82m adverse variance. Contributors to this include CIP delivery not going to reach plan mainly with the length of stay scheme. Further strike costs of £400k per month and while funding has been received for earlier strikes nothing has yet been received for the December or January strikes.

Additional capacity was open in January and the extra 28 beds created an additional cost. Despite this performance in elective recovery still remained strong achieving 109% of our plan year to date. Agency costs have stabilised and while still above plan, they remain below the ceiling.

Capital – year to date £20.6m has been spent which is around £4m lower than planned. Some of the significant schemes have incurred delays but we are still forecasting to deliver the full capital programme of £49.12m by year end. This has favourably impacted the cash position and led to a reduced support requirement from PDC.

Aged debt remains stable at £3m which is just above target, however over £700k is still the Nitespharma debt. Further escalation and actions have been taken to recover this debt. The better payment practice also remained above target.

We continue to forecast an on-plan position of a £20.8m deficit at year end although the likely case remains with £1.7m worse than plan. We are still assuming additional elective recovery funding of £1.6m and funding for the most recent strike action.

Several mitigations are offsetting the pressures. Commercial income is above plan and there is some slippage in planned developments and investments. Also forecast is a contribution from the CDC's with planned income expected regardless of activity.

PFI re-evaluation has created a technical hit of £11.3m but the NHSE are not including this in their measurement of system performance. It may impact on the PDC dividend since the net assets have reduced so CHFT should pay back less.

As of last Friday, the ICB still have a £10m gap to plan for 2023/24. Inconsistencies in the balance sheet reporting are being reviewed. It was agreed across West Yorkshire that a balanced plan would be delivered. CHFT have been over delivering on performance and achieved more than they have been paid for but that is due to the basis of the funding.

KH – Non pay operating expenditure is higher than planned this year. Are the increases factored into next year's plan. Yes. Some of the overspend will be offset by income.

Aged debt for Nitespharma is £730k and they are paying £4k per month. There is concern that it was allowed to reach that level of debt and are steps in place for the debt to be reduced at a faster rate?

Nitespharma were originally paying invoices with no issues but then the decision was made to cease wholesaling in HPS which has impacted this business. Discussions are underway involving specialist debt solicitors who have been engaged through the CHFT debt collection advisors. The company balance sheet still has assets, so the option has been given to either agree to a repayment plan or secure the debt against the company assets until it has been paid off.

NB Asked what has been put in place to stop this happening again? There are control accounts in place, however this case was unique in that it was a decision to stop wholesaling that created this problem. There is a lot of awareness on the HPS board that this should not be allowed to happen again.

KA noted that HPS do provide an account manager report into cash committee. Other than the Nitespharma debt HPS are closely managing their aged debt and are in a much better position overall.

The committee **RECEIVED** the Month 10 Finance Report.

**048/24 TURNAROUND EXECUTIVE 2023/24 CIP PROGRESS**

The Deputy Chief Executive gave a brief update.

The big focus is on schemes for 2024/25 which also feeds into the planning conversations. The deadline is 12th March for savings scheme to be scoped to gateway 1. The CIP target is £25m and the aim is to identify as much of this as possible being recurrent savings. All divisions have been asked to achieve a 2% saving through general housekeeping which is challenging but should be achievable. Alongside this are the bigger transformation portfolios. There will be an update at the next F&P meeting.

The Committee **RECEIVED** the Turnaround Executive update

**049/24 2024/25 FINANCIAL PLAN**

The Deputy Director of Finance shared a presentation with the committee. We have still not received any national planning guidance. There were some updated planning assumptions received on 9th February but no guidance. The national deadlines have also to be confirmed but in the meantime CHFT is working to some ICS deadlines. In the last week there has been a workforce submission, draft financial planning submission, operational planning activity and performance submissions.
Information has been received on the inflation refunding but this will be offset by the efficiency factor and the convergence adjustment.

- Cost uplift factor of 1.9% (inflationary funding)
- NHS Payment Scheme (NHSPS) efficiency factor of 1.1%
- ICB Convergence adjustment of -0.97% (reduced from 1.2%)

This then drives the need for efficiency in the overall plans. There has been some good news in that the virtual ward funding is to continue.

Elective Recovery Funding assumed to be recurrent alongside additional ICS inflationary funding. We have now been advised to remove the costs and income for the doctors pay award.

Following all this work there is an underlying deficit of £58.4m before any new movements. Inflation has raised some of the costs this year and the PFI contract incurs inflation costs which are contractually committed at the RPI rate. These plus the pressures and developments that have been put forward by divisions, increases the potential deficit to £76m for next year.

As mentioned earlier the CIP target has been agreed at £25m which then leaves CHFT with a deficit of £51m.

Discussions are ongoing around elective recovery funding. The current year the decision was made to work on a different model for elective recovery which fixed our elective recovery funding at an agreed level based on waiting times. The national approach is nearer a payment by results model, so you are paid more on volume than waiting times. WYAAT discussions have said that the preference for this year is to move to the national approach in order to have the opportunity to earn more income. This would give CHFT an opportunity of £6m - £12m. It does rely on system performance rather than an organisation's performance so does carry some risk.

Assuming a benefit of £12m of elective recovery funding reduces the deficit to £39.1m.

A different approach was taken to planning this year where all divisions had sight of all the pressures. After the first round of approvals some of the investments would increase the number of whole-time equivalents (WTE). We are being challenged externally to not increase the number of WTE so we will need to revisit these investments. Some of the posts are funded externally but further scrutiny is expected.GB and KA are meeting with the ICB on Thursday.

Conversations are ongoing with commissioners around income. CHFT are incurring additional costs which are not funded due to the current fixed block funding that is in place.

NB asked if CHFT is an outlier with the amount of CIP that was non-recurrent this year. CHFT is an outlier with inflation not just because of the PFI but also because of the utilities. There has been protection for CHFT over the last few years as we had fixed price utilities contracts which have now ended. Nationally it has been suggested that 70% of CIP across providers was recurrent this year. CHFT was lower than that figure

This draft plan will go to Private Board next week plus or minus any changes that come through.

The Committee **RECEIVED** the Planning update.

**050/24 2024/25 CAPITAL PLAN**

The Deputy Director of Finance shared a brief overview of the capital plan for 2024/25. There have been changes to the paper since it was submitted for distribution to this

committee. There is an increase of £700k which is in relation to our allowance increasing for our financial performance. If a system delivers its financial performance, it results in an increase of capital allocation.

CHFT have continued to balance operational capital priorities alongside investment in significant schemes such as the new MSCP that supports the Trust's overall Reconfiguration Programme. 2023/24 has seen the Trust utilise Trust and system funding to pull forward operational priorities from 2024/25 so funding is available to support key strategic investments aligned to the Reconfiguration programme. This resource management is compounded by the £15m PDC (£5m in 23/24, £10m in 24/25) for the Medicines Manufacturing national investment which will incur spend across 2024-2026/27.

The spend profile for the major schemes means we have been able to set aside £2.2m of contingency for unplanned requirements such as broken kit or estates issues. Requests will be assessed on a case-by-case basis.

NB asked if there is a longer-term capital plan for maintenance and IT upgrades etc. It has been tried in the past and the last time the annual request totalled around £60m of which £15m was approved.

The Committee **APPROVED** capital plan to go to board.

**051/24 REVIEW TREASURY MANAGEMENT ACTIVITIES**

The Deputy Director of Finance explained the detail around the cash support required by CHFT.
There is a high level of capital creditors expected at year end and an application for cash support must be submitted on 13th March for the new financial year. The request will go to Board for approval on 7th March.
Planning is not complete as previously described so the cash support is based on the current draft plan which describes a deficit of £39m. A combination of the pressures for next year, capital creditors expected at year end and timing differences on the receipt of income means the decision has been made to request £20m of PDC for quarter one.
The committee is asked to remember that we can make the application then request to draw down less if it is not required however, it is not a simple process to ask for an increase in cash if required.

The Committee **APPROVED** the cash support request to go to Board.

**052/24 DRAFT MINUTES FROM SUB-COMMITTEES**

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

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

- THIS Executive Board
- Pennine Property Partnership
- CHFT/THIS SLA Review

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

**053/24 WORKPLAN – 2023/24**

The deep dive for next month is a follow up to the Transfer of Care/Length of Stay deep dive the committee received in October 2023.

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

**054/24 ANY OTHER BUSINESS**

This is the last meeting for Karen Heaton. The committee thanked her for her contributions.

**055/24 MATTERS TO CASCADE TO BOARD inc. ONE CULTURE OF CARE**

- ED deep dive
- Performance and finance have consistent themes.
- Planning for 2024/25
- Agreed Terms of Reference for the committee.

**DATE AND TIME OF NEXT MEETING:**

Tuesday 26th March 2024 09:30 – 12:00 MS Teams

# QUALITY COMMITTEE
## Monday, 11 March 2024

**PRESENT**

| | |
|---|---|
| Denise Sterling **(DS)** | Non-Executive Director **(Chair)** |
| David Birkenhead **(DB)** | Medical Director |
| Gina Choy **(GC)** | Public Elected Governor |
| Lucy Dryden **(LD)** | Quality Manager for Calderdale Cares Partnership Board |
| Jason Eddleston **(JE)** | Deputy Director of Workforce & Organisational Development |
| Jonathan Hammond **(JH)** | Chief Operating Officer |
| Elizabeth Morley **(EM)** | Associate Director of Quality and Safety |
| Joanne Middleton **(JMidd)** | Deputy Chief Nurse |
| Andy Nelson **(AN)** | Non-Executive Director |
| Victoria Pickles **(VP)** | Director of Corporate Affairs |
| Lindsay Rudge **(LR)** | Chief Nurse |
| Elisabeth Street **(ES)** | Clinical Director of Pharmacy |
| Jo-Anne Wass (JW) | Non-Executive Director |
| Lorraine Wolfenden **(LW)** | Governor |
| Michelle Augustine **(MA)** | Governance Administrator **(Minutes)** |

**IN ATTENDANCE**

| | |
|---|---|
| Siobhan Dorotiak **(SD)** | Quality Manager, Calderdale Cares Partnership Board **(observing)** |
| Laura Douglas **(LD)** | Deputy Head of Midwifery **(item 50/24)** |
| Alexandra Keaskin **(AK)** | Matron for Patient Experience |
| Ian Noonan **(IN)** | Consultant Nurse, Mental Health **(item 49/24)** |

**STANDING ITEMS**

**41/24 - APOLOGIES**

| | |
|---|---|
| Neeraj Bhasin **(NBha)** | Deputy Medical Director |
| Nikhil Bhuskute **(NBhu)** | Deputy Medical Director |
| Sharon Cundy **(SC)** | Head of Quality and Safety |
| Gemma Puckett **(GP)** | Director of Midwifery and Women's Services |

**42/24 - DECLARATIONS OF INTEREST**

There were no declarations of interest.

**43/24 – MINUTES OF THE LAST MEETING AND ACTION LOG**

The minutes of the last meeting held on Monday, 12 February 2024, circulated at appendix B, were approved as a correct record. The action log can be found at the end of these minutes.

**44/24 – MATTERS ARISING**

- *West Yorkshire's Patient Safety Incident Response Framework (PSIRF) Position Statement* - Elizabeth Morley presented the report as circulated at appendix C.

  The CHFT position against other providers on 26 January 2024 showed a draft Patient Safety Incident Response Plan (PSIRP) awaiting sign-off. The updated position is that a

final Patient Safety Incident Response Plan (PSIRP) has now been reviewed and signed-off. This will now go to the next West Yorkshire Association of Acute Trusts (WYAAT) meeting for approval. By the end of this month, CHFT will have most of the training sessions up and running, with a go-live date of mid-April 2024.

In relation to the governance arrangements slide, **DS** queried the CHFT route and where it feeds into. **LR** stated that this would be at Place level. **SC** is part of the Patient Safety Networks and **LR** and **DB** attend the Quality Committee.

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

- *Governance Arrangements* - Lindsay Rudge presented the structure as circulated at appendix D, which was part of a paper submitted to the Board of Directors and approved. Further work is to take place around the sub-groups of the Quality Committee, with progression of Patient Safety Incident Response Framework (PSIRF) and the learning groups. Divisional teams will report into the Quality Committee on their Patient Safety and Quality Board meetings on a quarterly basis, and the former Trust Patient Safety and Quality Board will change into a patient safety and learning group.

  **OUTCOME**: The Committee noted the structure.

## SPECIFIC REPORTS

### 45/24 - UPDATE ON NASOGASTRIC (NG) TUBE ACTION PLAN

Joanne Middleton provided a verbal update, which will be circulated at the end of the minutes.

**DS** asked about the number of unclosed actions and asked for an indication of when the actions can be completed. **JMidd** stated that all actions have been carried out, however, further checks are to be done to ensure the actions are robust and have been embedded. The only outstanding action is in relation to the stickers to identify that an Xray needs checking. The process has been agreed, and now awaiting a response from Procurement. **LR** stated that a report will return with the planned re-audit, for assurance that all actions have been closed.

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

### 46/24 – 2024 / 2025 QUALITY PRIORITIES

Lindsay Rudge provided a verbal update on the 2024-2025 Quality Priorities, stating feedback is now being awaited, and the confirmed Quality Priorities will be brought to the next Quality Committee.

### 47/24 – QUALITY AND SAFETY STRATEGY

Lindsay Rudge presented the report as circulated at appendix F as a draft, working document, due to the Clinical Strategy also being currently revised which needs to be reflected in the Quality and Safety Strategy, and the restated quality improvement position in terms of Work Together, Get Results.

**AN** commented on the comprehensive strategy, and asked how much of it is a continuation of work that has been done, and what the key differences for the next strategy phase would be. **LR** reported that the difference for the next phase is getting the quality improvement focus through the programmes and ensuring that people have the right skills for quality improvement and that they are supported. Another part of the next phase is being clear about the number

of collaboratives versus business as usual. **AN** suggested a paper with the signed-off strategy which includes a few key messages, which **LR** agreed to.

**JMidd** also commented that Patient Safety Incident Response Framework (PSIRF) is another differences, in terms of how incidents are investigated and how learning is gathered and informs the quality improvement practice.

**OUTCOME**: The Committee approved that the Strategy progresses in the current format and is fully signed-off at a later meeting.

## CARING

### 48/24 – PATIENT EXPERIENCE AND INVOLVEMENT GROUP REPORT

Lindsay Rudge presented the report as circulated at appendix G.

**OUTCOME**: The Committee noted the overview of strategic programmes of work being undertaken; approved the pilot of the Person Centred Care definition and standard; and noted (not approved as included in the report) the draft ambitions to support unpaid carers at the Trust for 2024 / 2025.

### 49/24 - PATIENT STORY: LEARNING FROM MULTI-AGENCY REFLECTIVE PRACTICE SESSION (MARPS)

Lindsay Rudge presented the paper as circulated at appendix H, which is a partnership report based on a case of a young person who resided at CHFT for some time, and an independent external review was carried out for learning, commissioned through the Safeguarding Children's Partnership in Calderdale.

Following the first discharge, the young person is again at CHFT, and **LR** was unsure that any lessons were learnt or in a position to demonstrate a timely discharge. Ian Noonan, who was in attendance, stated that there are now quite a few things now in place which were not at the start of this young person's admission.

Following discussion, the significant learning and developments were noted, and **LR** acknowledged and thanked **IN** for his support and invaluable expertise on this particular case.

## SAFE

### 50/24 – MATERNITY AND NEONATAL OVERSIGHT REPORT

Laura Douglas was in attendance to present the report as circulated at appendix I.

In terms of the Maternity Voice Partnership (MVP), **AN** asked what mechanism is in place to ensure MVPs have responded and taken action. **LD** responded that there is a new MVP Chair, who has exposure to activities and engagement which were not previously available.

**AN** also asked about the birth rate plus assessment, and whether this was an external, to which **LD** confirmed. **AN** also asked about the recruitment challenge of AHPs and whether there were any lessons to be learned which could be used in maternity. **LR** stated that recruitment increased by 4.68 during the whole recruitment period, due to the difference in colleagues reducing their hours of a whole time equivalent which has accelerated. Work is ongoing with the University, with hopes of being in a better position next year. In terms of retention, **LD** stated that this is looked at regularly and have support for newly qualified

colleagues. From an organisational development perspective, **LR** stated that maternity has been recognised as a hotspot area in terms of wrap-around support and focus at an executive level for the year 2024-2025.

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

### 51/24 – UPDATE ON MINIMISING EXPOSURE TO NITROUS OXIDE ACTION PLAN

Elisabeth Street presented the action plan as circulated at appendix J.

Next steps are to review the internal audit findings when published, and to quality check the Control of substances hazardous to health (COSHH) alerts.

**OUTCOME**: The Committee noted the update and look forward to the audit results.

## EFFECTIVE

### 52/24 – CLINICAL OUTCOMES GROUP REPORT

David Birkenhead presented the report as circulated at appendix K.

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

## RESPONSIVE

### 53/24 - INTEGRATED PERFORMANCE REPORT

Lindsay Rudge provided a verbal update, stating that the quality section has now moved to the beginning of the report.

A strong performance is maintained across a number of metrics, and there were some concerns around the health inequality data where people with a learning disability are still not being seen as quickly within the Emergency Department as other patients. Internal audit have been commissioned to look at the patient pathway for people with a learning disability, as their readmission rate is high. There are some challenges in some of the diagnostic services around echocardiology and neurophysiology, however, some improvement is starting to be seen. There are still high rates of bed occupancy, and the discharge pathway has improved in terms of performance in length of stay after five months.

**DB** reported on infection control and stated that Clostridium difficile rates are high across the UK at this point in time. Length of stay has increased morbidity amongst the population, with an increasingly elderly and frail population in hospital. Admission to side rooms is difficult due to those being taken up by flu and COVID, which contributes to an increased challenge around Clostridium difficile. There have been high rates of influenza this year, with four times as many patients in hospital as in previous years.

**LR** also reported on a number of metrics where outpatients in an IMD code one and two, had a higher did not attend.

### 54/24 – COMMITTEE'S SELF-ASSESSMENT / EFFECTIVENESS

The Chair noted that questions relating to the Committee's effectiveness will be circulated in the first week in April, for a return of responses by Friday, 12 April 2024.

## ITEMS TO RECEIVE AND NOTE

### 55/24 - ANY OTHER BUSINESS

- *Update on Electronic Patient Record issue* – Following a Health Service Journal (HSJ) article on 23 February 2024 around Durham and Darlington's installation of Electronic Patient Record, it contributed to some preventable deaths within the ED, and the issue was associated with time to be seen either not being recorded or not being visible within Electronic Patient Record at the launch point. Time to be seen is different from the registered time and linked to prioritisation and acuity. The digital health team at CHFT reviewed this within the CHFT Electronic Patient Record. During our build in 2017, this was recognised as a potential issue, and were ensured that the box was added in the nursing triage form for time to be seen. The triage nurse then manually adds the time to be seen from the initial registration time, indicating that time. This is displayed in the tracking board in the ED as well as in EPR and clinicians in ED can filter in order of time to be seen. This approach and learning will be shared across other Cerner trusts where appropriate. The Committee were assured that a review was undertaken to ensure the same issue and risks were not present at CHFT.

- *Quality Committee meetings from July onwards* – The Chair noted discussions of a review of the days that Board sub-committees are scheduled, with a proposal that sub-committees will take place on Tuesdays and Thursdays, therefore, from July 2024, Quality Committee meetings will take place on a Tuesday, with upcoming diary changes being made shortly.

### 56/24 - BOARD TO WARD FEEDBACK

There were no items for feedback.

### 57/24 - MATTERS FOR ESCALATION TO THE TRUST BOARD

- Quality and Safety Strategy
- Nasogastric tube action plan update
- Patient Experience and Involvement Group Report
- Learning from the Multi-Agency Reflective Practice Session
- Maternity and Neonatal Oversight Report
- Safety aspect from Nitrous Oxide Action Plan
- Highlights from the Clinical Outcomes Group Report

### 58/24 - QUALITY COMMITTEE ANNUAL WORK PLAN

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

## POST MEETING REVIEW

### 59/24 - REVIEW OF MEETING

The meeting over-ran, however, there were important discussions on a number of agenda items.

## NEXT MEETING

Monday, 8 April 2024
2:30 – 5:00 pm
Microsoft Team

# CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

**Minutes of the WORKFORCE COMMITTEE: IMPROVEMENT CHAPTER**

**Held on Monday 19 February 2024, 2.00pm – 4.30pm**
**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) |
| Denise Sterling | (DS) | Non-Executive Director |

**IN ATTENDANCE:**

| | | |
|---|---|---|
| Mark Bushby | (MB) | Workforce Business Intelligence Manager (for items 14/24, 15/24 and 16/24) |
| Jason Eddleston | (JE) | Deputy Director of Workforce and Organisational Development |
| Helen Hirst | (HH) | Chair |
| Nikki Hosty | (NH) | Assistant Director of HR (for items 07/24 and 08/24)) |
| Andrea McCourt | (AMc) | Company Secretary |
| Jo Middleton | (JM) | Deputy Chief Nurse |
| Rachel Pierce | (RP) | Head of Recruitment (for item 09/24) |
| Chris Roberts | (CR) | Deputy Director of Operations, Medicine/Shadow Board |
| Jackie Robinson | (JR) | Assistant Director of HR |
| James Teal | (JT) | OD Practitioner (for item 06/24) |
| Donna Ferrier | (DF) | Non-Surgical Onology Project Manager |
| Liam Whitehead | (LW) | Head of Apprenticeships (for item 10/24) |
| Lorraine Wolfenden | (LF) | Governor |

## 01/24 WELCOME AND INTRODUCTIONS

The Chair welcomed members to the meeting. The Committee noted Lorraine Wolfenden is a new Governor member.

## 02/24 APOLOGIES FOR ABSENCE

Lindsay Rudge, Chief Nurse

## 03/24 DECLARATION OF INTERESTS

There were no declarations of interest.

## 04/24 MINUTES OF MEETING HELD ON 18 DECEMBER 2023

The minutes of the Workforce Committee held on 18 December 2023 were approved as a correct record.

05/24 **ACTION LOG – FEBRUARY 2024**

The action log was received.

06/24 **WORK TOGETHER GET RESULTS (WTGR)**

JT presented an update on 2023 WTGR activity. He explained the Programme connects to the People Strategy 'Improvement' Chapter. The 2 day programme comprises a number of learning tools designed to enable colleagues to make transformational change. 7 programmes took place in 2023 with 71 colleagues going through the programme. JR introduced DF who attended one of the programmes.

DF shared her two experiences of using the WTGR methodology to guide change. She described the significant challenges at the first session and how it was far from a good experience. In response DF stated that pre-engagement and communication were vital steps in achieving the positive outcome at the second WTGR session. KH thanked DF for her honesty and emphasised the high value on acting from learning.

JT concluded that a WTGR community has been established so that colleagues who have undertaken the programme can connect and share good practice. 10 programme dates are scheduled for 2024 and due to demand more dates are being planned.

DS also commented on the positives from learning. DS queried what colleagues are asked to take away from the training programme. JT responded the programme is designed that over the 2 days colleagues will work on a live example and then continue to take this forward. NH added the programme is explicit that the tools should be applied immediately after the programme. To enhance the learning, resources will be shared with the WTGR community to continue the dialogue. NB agreed there is real merit for other colleagues in sharing good outcomes.

**OUTCOME:** JT and DF were **THANKED** for the WTGR update and sharing the WTGR experiences.

07/24 **CRITICAL EVENT SUPPORT DEBRIEFING SERVICE**

NH presented the 'Psychology Pyramid' that describes the 3 tiers of support available for colleagues. The lowest tier outlines a number of support mechanisms maximising quick access for colleagues. The critical incident support briefing sits in the middle tier to provide a semi-structured approach to facilitate reflection on what happened, the effect on colleagues involved and how staff can approach coping individually and in their teams. 14 colleagues are now trained and qualified to facilitate the debriefs. The service will be piloted in ED and maternity services over the next 6 months prior to roll out to all areas later in the year.

JE asked if there is a feel for what kind of critical incidents the team will be responding to. NH responded the feedback from colleagues particularly in Maternity and ED identified a lack of immediate support following a patient related critical event.

**OUTCOME:** NH was **THANKED** for the update and the Committee **SUPPORTED** the establishment of the debrief service.

08/24 **INITIAL INTELLIGENCE ON NATIONAL STAFF SURVEY 2023**

NH gave a verbal update on the results. The Committee noted the results are embargoed until 10 March.

SD thanked NH and the team for facilitating the survey.

JE commented the Inclusion Group and Education Committee will at their next meeting review their respected themes in order to get an early start on responding to the results.

**OUTCOME:** The Committee **NOTED** the results will be presented in detail at a future meeting.

09/24 **REVIEW PROGRESS ON RECRUITMENT STRATEGY**

RP provided an update against the Recruitment Strategy highlighting the key points:-

Attraction and recruitment

- CHFT website dedicated international applicants' pages
- NHS Pastoral Care Quality Award achieved by Clinical Education Team
- October 2023 careers event – 54 applicants offered an apprenticeship/HCSW/staff nurse role
- Positive feedback on CHFT Welcome Events. 489 colleagues attended between April and December 2023.
- 75% of colleagues aware of one culture of care prior to starting in post. 54% said OCOC influenced their decision to join CHFT.

Developing our workforce

- Revision of internal transfer process for HCSW and Staff Nurses to support retention.
- Promotion of talent pool in recruitment documentation
- Employability support for unsuccessful internal applicants
- Diversity and Inclusion initiatives

Widening participation

- Revised talent pool guidance in R&S training for managers
- Employability support workshops
- T Level cadets to bank appointments
- Outreach engagement in local community settings and signposting to Trust wide recruitment events
- Supporting divisional areas to recruit their own volunteers

Why we are CHuFT

- Updated benefits of being on the bank to applicants and managers
- Revised interview guidance to promote benefits of offering bank roles to appointable applicants outsides of substantive appointments

KH asked if there was a sense of improvement across the Trust. RP stated the enhanced support offered to both applicant and managers has led to significant positive outcomes.

SD congratulated RP on the success of the Welcome Events. HH added she has also received great feedback on the Events. JR remarked that our workforce data speaks for itself noting that a session will be held in March to look at workforce metrics, particularly recruitment activity. Learning and good practice will be shared across neighbouring trusts.

**OUTCOME:** The Committee **THANKED** RP for the update.

10/24 **REVIEW PROGRESS ON APPRENTICESHIP STRATEGY**

LW provided a progress update on the Strategy. Since July 2022, the Widening Participation team have fully integrated into the Apprenticeship Team. Progress against the strategy includes:-

- Maintained employer provider performance (achievement, low attrition, progression)
- Employer Provider curriculum development, LDD support, OFSTED and audit readiness.
- Embedded new multi skilled apprenticeship team structure.
- Progress against key priority areas; learner experience and pastoral support, linking increased levy spend to workforce development and OD strategy, curriculum development, new to care, “apprenticeship first”, grow our own.
- Increased Apprenticeship Levy spend activity by 10% on 22/23
- Implemented Apprenticeship Levy data dashboard and application tool.
- Utilising apprenticeship levy to support succession planning and OD focus resulting in uptake of L5+ apprenticeships with external providers and linked to OD portfolio (53% of all CHFT Apprenticeships compared to 35% In 22/23).
- External partnership engagement has resulted in increased WP take up into entry apprenticeships (30% enter HCSW pathways from WP)
- Created additional WP pathways (T levels, New to Care) and removing barriers to entry.
- Continuation of free Maths and English offer for colleagues

DS thanked LW for a great report that showed the volume of work undertaken. In terms of volunteer to career initiative, she asked if this is likely to continue if funding is provided. LW confirmed reconfiguration in the team will enable the continuation and gave examples of activities to support this.

In relation to the mentoring programmes, DS asked where the mentors will be identified from. LW advised there are 85 potential mentors. He acknowledged the need to increase this number and believes the New to Care pathway will support this. DS added that in her experience being a mentor is a personal development opportunity.

SD commended the impressive work and commented on the challenging times ahead. JE noted the NHSE reported announcement by the government on apprenticeship funding including the ability to cover backfill costs from the levy.

KH asked how the learner experience is evaluated. LW advised for apprenticeships the employer provider contract provides a robust system. Development of feedback collection/evaluation for other learners has been identified as an action in 2024/2025.

JE stated the Education Committee has agreed to gather intelligence and respond to the learner experience.

**OUTCOME:** The Committee **NOTED** the progress made.

11/24 **BAF DEEP DIVE 10A/19**

DB presented the report to provide assurance in terms of risk and mitigation. The Committee noted progress in the following areas:-

- Recruitment, engagement activity, Flexible Workforce, policy development, regional network working, CESR, engagement with GMC

Challenges remain in:-

- eRostering/eJob Planning Team, ongoing industrial action

The risk remains at 16.

NB noted the positive news and asked about the target risk of 9 and what needs to happen to get to this position. DB responded generally there is improvement in most specialties making a good argument to decrease the risk score, however the aggregated risk is the reason the score remains at 16.

**OUTCOME:** The Committee **NOTED** the BAF deep dive.

12/24 **MEDICAL WORKFORCE STAFFING REPORT**

DB presented the report, summarising the key highlights:-

- Recurrent periods of industrial action impacting on workforce, clinical/non-clinical capacity. Pay offer to consultants has been rejected. Mandate for further strike dates.
- Proactive and innovative recruitment solutions and has seen a significant net increase in consultant recruitment, with a downward trend in turnover.
- Engagement with the PA workforce around concerns they have with respect to the statements issued by the BMA and some social media output.
- Within the eRoster/eJob Planning team there remains limited resilience and a paper has been successfully presented to BCAG to create the future resource within the team.
- Ongoing regional work through WYAAT to address Fragile Services eg Neurology but there is mitigation in terms of WYAAT arrangements and recruitment to Neurology.
- Work has commenced to focus on Medical Workforce Agency and Bank costs.
- Pay progression and study leave policies agreed with the LNC.
- Continue to arrange wellbeing talks and engagement events.
- Appointment of new GOSWH.
- Teams are undertaking rota reviews and a new Junior Doctor Induction has been implemented.

DS was pleased to see turnover is under 10% and asked if there is any learning from exit surveys. DB didn't feel there are any key issues relating to colleague reasons for leaving.

DS enquired about expected progress in the usage of e-job planning and e-rostering. The Committee was asked to note that all medical colleagues have a job plan however E-rostering is more complex making it difficult to determine usage though DB is hopeful this year 60-70% of medical colleagues will be on the system.

JE asked about the position on embedding the role of PAs at the Trust. DB confirmed there are good working relationships at CHFT and doesn't feel there are any fundamental issues. Work will continue to enhance the PA roles.

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

13/24 **BAF DEEP DIVE 11/19**

**RECRUITMENT/RETENTION/INCLUSIVE LEADERSHIP**

SD presented the deep dive.

**Key controls** identified in the BAF have been reviewed and updated. Additional controls include:-

- A Colleague Retention Programme action plan.
- A Board Diversity Action Plan.
- The Allied Health Professionals (AHPs) workforce design/transformation Programme.
- An expanded international recruitment pathway for AHPs.
- 2024/2025 workforce planning activity.

In respect of **Positive Assurance,** the BAF has been updated to include:-

- Colleague Retention Programme paper considered at the Workforce Committee meeting on 18 December 2023.
- Workforce Design Hot House event Programme developed for roll out.
- Revised workforce metrics report available at Workforce Committee.
- KP+ workforce metrics module 'live' from February 2024.

In terms of **Gaps in Control,** three aspects have been added to the BAF. Each has an associated action:-

- Comparative workforce data for the medical staff group.
  **Action:** a refreshed Medical e-rostering roll-out plan.
- Comparative workforce data for the AHP staff group.
  **Action:** expanded utilisation of e-roster across all AHP teams and development of reporting capability.
- Systematic/embedded inclusive recruitment processes.
  **Action:** a review of recruitment systems and processes by March 2024.

The **Risk Rating** has been reviewed and the risk rating score remains unchanged at 12.

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

## 14/24 QUALITY AND PERFORMANCE REPORT (WORKFORCE) JANUARY 2024

MB presented the highlights (data as at 31 December 2023):-

- Both headcount and FTE have seen a continued trend upwards through November 2023, levelling off in December 2023; with a slight decrease of 17 employees (~17 FTE) from the previous month.
- During 2023-24 CHFT vacancy rate has fallen month on month down to a low of 5.88% in November 2023; a small reduction in actuals in December has increased the overall number of vacancies causing rates to increase to 6.21%
- Operational Planning commenced in January 2024. Divisional colleagues continue to assess financial and operational plans to develop workforce models and workforce planning for the next 12 months.
- Turnover has seen a period of continued improvement between February 2023 (8.8%) and December 2023 (7.65%) with string of 9 months below the average turnover rate of 8.15%.
- Healthcare Science staff group continues to have a turnover rate above the Trusts new target of 10%. FSS anticipates that there will be further turnover of BMS and Support roles within pathology as the New Pathology Partnership moves closer to be transacted.
- In month sickness increased marginally by 0.03% in December 2023 to 4.85%. This is expected movement over the winter period, long term sickness increased to 2.93%, just below the Trust target, while short term sickness saw a decrease from November to 1.77% and is now just above the target of 1.75%.
- Top 3 reasons for absence during December 2023: Anxiety/Stress/Depression (33.12%), Gastro (10.53%), MSK (10.40%).
- 16.91 Average FTE Lost per FTE, a continued decrease from August 2023.
- 82% of appraisals have been completed as at the 31 December 2023, 13% behind the 95% target position, however this is 4.2% higher than the same point last year.
- Continued overall strong Core EST compliance, improved position at 94.66%.
- Safeguarding Children has remained below the Trust target of 90% with Safeguarding Adults also now dipping below this threshold. This is likely due to the work on RST and adjusting the level of training required in these subjects.
- Patient Safety compliance increased to 81%.
- Role Specific EST is undergoing work to cleanse target audiences, this will impact compliance rates as colleagues are added/removed; at the time of reporting compliance rates had seen an increasing position moving overall RST to 85.26% with 3 Divisions now showing a compliance rate above the 85% amber threshold.
- Prevent training moved from a once-only requirement to a 3 yearly refresher period, this has impacted the previously high compliance in this subject; compliance has increased from ~50% following this change to ~75% at present.
- Additional 24 x new HCSW apprentices due to start in February 2024
- Bank spend continues to follow common cause variation around the mean. Overall bank spend during 2023-24 has remained largely consistent month on month showing much less variation compared to 2022-23. Bank spend is currently £3.27M in December 2023.
- Agency spend is now following normal cause variation from August 2023. Spend in December at £0.81M.

DS noted that 500 more appraisals had been undertaken in the last round and asked how non-compliance is picked up. JR responded Divisional management teams have access to the compliance reports which are broken down by team, staff group and at individual level. The Committee noted appraisal compliance is linked to pay progression and the roll out of KP+ will provide increased intelligence.

KH stated the report's new format is clear and easy to read.

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

15/24 **ESR ASSESSMENT**

MB presented the report on the Trust's ESR assessment. The key highlights are:-

- From 2023/24 the annual assessment moved to a set of ESR self-service standards intended to evaluate organisations against 10 metrics that will underpin the future workforce system that will eventually replace ESR, and supports the People Digital plan.
- CHFT is fully meeting 6 out of 10 metrics (Level 2).
- Standards 2 (Manager Self Service Pay Affecting Changes) and 7 (Manager Self Service Pay Progression) were only partially met (Level 1).
- Standards 5 and 10 were categorised as Level 0.
  - Standard 5 describes Trusts using ESR to record Health and Wellbeing information. CHFT goes above and beyond the capability of ESR using tools outside of the system and as such does not currently utilise this functionality. This is common across many NHS organisations.
  - Standard 10 describes Trusts using ESR for the analysis of vacancy/turnover/retention data. CHFT undertakes all of these and meets all the higher criteria of Level 2. However, the Trust has not previously used the ESR Exit Questionnaire, which is a requirement of Level 1. As such the Trust is unable to be scored higher than Level 0 in this metric.

- Based on the results of the assessment the Trust will:
  - Look to enable the ESR Exit Questionnaire (moving Standard 10 to Level 2 compliance) and revise processes to embed this.
  - Reach out to other Trusts in the region that have scored Level 2 in Standard 2 and 7 to gain feedback on moving to a full Manager Self Service position and the risks/benefits associated with implementing this.

AMc asked if there are any consequences for being at red or amber. MB advised the report is a benchmark for trusts to assess their own position particularly against readiness for the new system launch in 2025. KH queried if there are timescales to implement any changes. MB stated there aren't any specific timescales however the assessments highlight deficits that trusts may choose to target.

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

16/24 **GENDER PAY GAP**

MB presented the report outlining the Trust data on the gender pay gap for the year ending 31 March 2023. The refreshed data shows no change to the data previously reported in August 2023. JE confirmed from 1 April 2024 the Inclusion Group will be reviewing 'live' gender pay reporting data.

**OUTCOME:** The Committee **NOTED** the content of the report and **APPROVED** the submission of the gender pay gap data by the 30 March 2024 deadline.

17/24 **ITEMS TO RECEIVE AND NOTE**

Education Committee

The notes of 7 December 2023 and 11 January 2024 meetings were received. The terms of reference had been revised to reflect changes to the core membership and change in frequency of the meeting. The Education Committee will now meet on a monthly basis.

**OUTCOME:** The Committee **APPROVED** the Education Committee Terms of Reference.

Inclusion Group

The notes of 11 December 2023 meeting were received.

18/24 **REVIEW WORKFORCE COMMITTEE ANNUAL REPORT ACTION PLAN**

The Committee reviewed the actions. The next self-assessment is scheduled for April 2024.

NB asked if there are other examples to measure effectiveness of a workforce committee. SD and HH offered to explore this with WYAAT colleagues. JE advised the arrangements were tested out some time ago and the current process was the best available approach at that time. JE endorsed KH's view on the need for a strong response from Committee members about their experience.

19/24 **WORKFORCE COMMITTEE WORKPLAN**

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

20/24 **MEETING REVIEW**

LW stated how good it's been to hear all the positive things at CHFT.

SD on behalf of Workforce and OD and the wider Trust thanked KH for being a phenomenal Non-Executive Director for the Committee and the Trust and wished KH a wonderful retirement.

21/24 **ANY OTHER BUSINESS**

CR provided a message in Chat on the success of the Shadow Board and how it is benefiting the first cohort. There will certainly be support for a second cohort and volunteers from the first cohort to support this. He thanked the Committee for the opportunity to observe.

22/24 **MATTERS FOR ESCALATION TO THE BOARD OF DIRECTORS**

- WTGR presentation
- Piloting of critical evens support debriefing service
- Good progress on Recruitment and Apprenticeships Strategies
- BAD Deep Dives
- Medical Workforce Staffing

- Quality and Performance Report
- ESR Annual Assessment
- Approval of Gender Pay Gap
- Approval of Education Committee terms of reference

23/24 **DATE AND TIME OF NEXT MEETING:**

Hot House
13 March 2024, 2.00pm-4.00pm

Workforce Committee:
15 April 2024, 2.00pm – 4.30pm
Chapter: ED&I

## 24. DATE AND TIME OF NEXT MEETING

Date: Thursday 4 July 2024

Time: 9.00 – 12.00 pm

Venue: Boardroom, Learning Centre, Huddersfield Royal Infirmary

To Note

Presented by Helen Hirst