Calderdale and Huddersfield NHS Foundation Trust

Public Board of Directors

Schedule	Thursday 4 July 2024, 9:00 — 12:00 BST
Venue	Boardroom, Learning Centre, Huddersfield Royal Infirmary
Organiser	Amber Fox

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1. Minutes of Board Committees
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- Quality Committee – 08.04.24, 08.05.24
- Workforce Committee – 15.04.24
- Audit and Risk Committee – 25.06.24
- Charitable Funds Committee – 07.05.24

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

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27. DATE AND TIME OF NEXT MEETING 457
Date: Thursday 12 September 2024
Time: 9.00 – 12.00 pm
Venue: Rooms 3 & 4, Acre Mills Outpatients
To Note - Presented by Helen Hirst

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1. Welcome and Introductions:

To Note

Presented by Helen Hirst

2. Apologies for absence:

To Note

Presented by Helen Hirst

3. Declaration of Interests

To Note

STRATEGY: TRANSFORMING AND IMPROVING PATIENT CARE

4. Patient Story – Modern Day Slavery (Safeguarding) - Introduced by Lindsay Rudge and Presented by Alison Edwards Including the Safeguarding Adults and Children Annual Report Presented by Lindsay Rudge

To Approve

Presented by Lindsay Rudge

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Patient Story – Modern Day Slavery

Slavery

may long have been officially outlawed, but hard though it might be to believe, numerically there are more slaves today than at any time in history.

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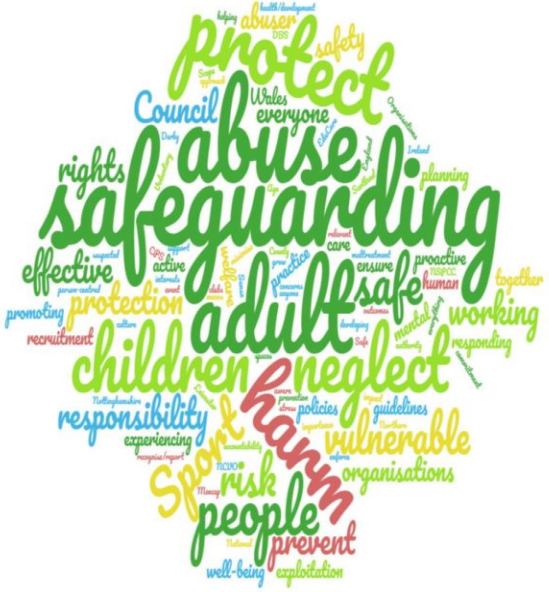

What is Safeguarding?

How do we respond?

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Prevalence in the UK

2023 – 17,004 potential victims referred to the National Referral Mechanism - UK

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Case Study

Situation: A police officer responding to a female victim of domestic abuse in a public place noticed that she was visibly pregnant so referred to the Domestic Abuse Hub for discussion.

Background: There were factors indicating that she was vulnerable: she was a teenager, already having two young children and she did not speak English. The DA hub reviewed the local maternity unit's records and showed that she was not accessing maternity care or had any health links to Calderdale and after further research found she had not received antenatal care at all.

Action: The DA Hub health representative liaised with the Calderdale midwives and requested that they try to locate the woman to ensure that she was getting appropriate care.

The midwives were able to establish she had not yet had any antenatal care for this pregnancy and developed rapport where she disclosed that she had been trafficked into the country along with a male friend. She disclosed also that she had been trafficked to undertake sex work and that he had been used to wash cars. She did not know her location of her children and someone else was accessing her child benefits. She reported that if she was pregnant she was 'safe' during that period of time from sex work and further assaults.

Result: As a result of this information the police investigated the allegations and arrests were made in both Calderdale and Manchester. The woman was reunited with her children and were offered a place of safety within the National Referral Mechanism (NRM), (a process set up by the Government to support victims of trafficking in the UK) with housing, health and legal advice offered.

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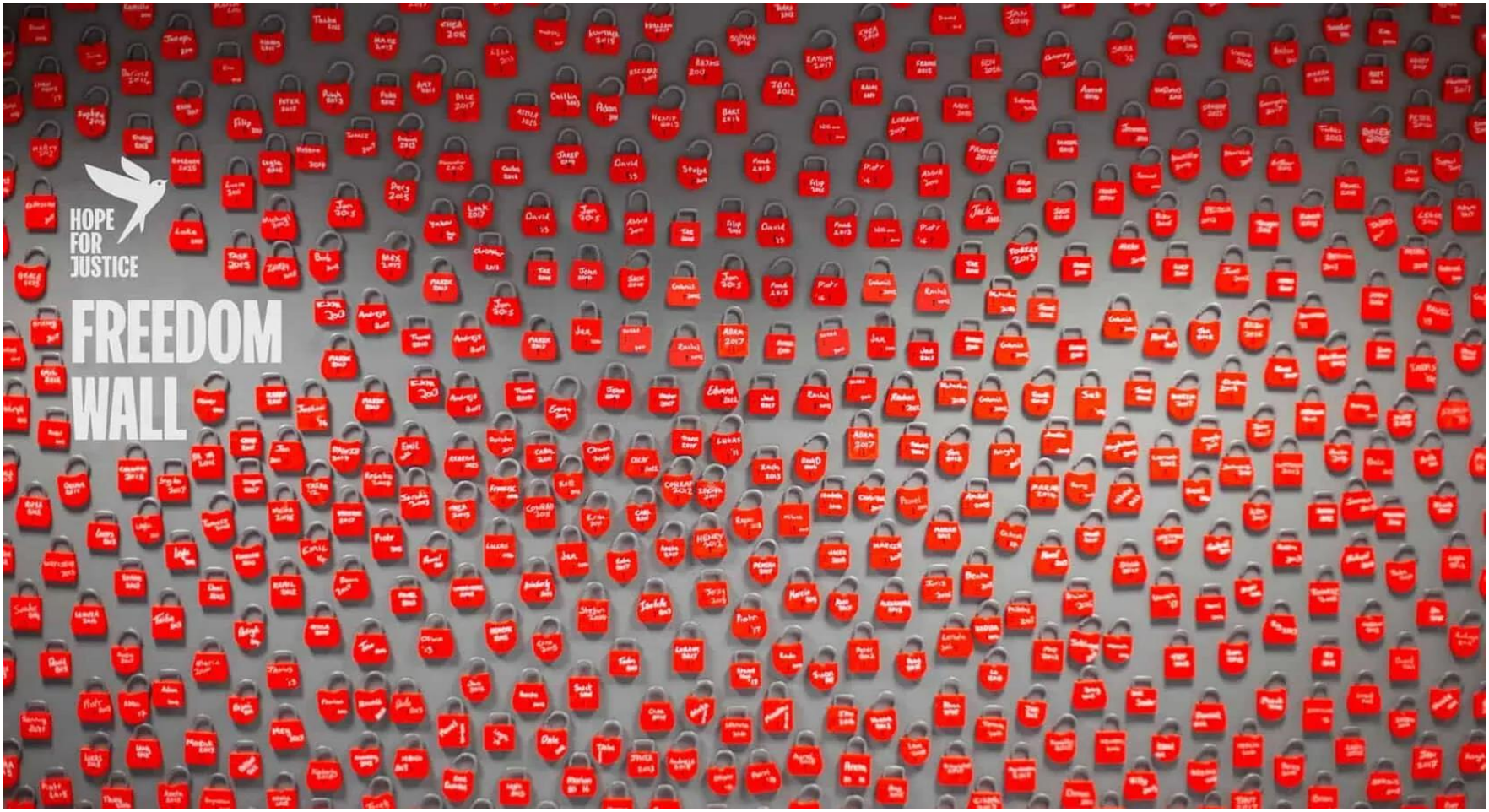


Date of Meeting:	Thursday 4 July 2024
Meeting:	Public Board of Directors
Title:	Safeguarding Adults and Children - Annual Report
Author:	Andrea Dauris, Associate Director of Nursing Alison Edwards, Head of Safeguarding
Sponsoring Director:	Lindsay Rudge, Chief Nurse
Previous Forums:	Safeguarding Committee Meeting 29th April 2024 Quality Committee 3rd June 2024
Purpose of the Report	The purpose of this report is to provide the Board of Directors with an overview of Safeguarding activity within Calderdale and Huddersfield NHS Foundation Trust and how this meets our statutory safeguarding responsibilities under the Children Act 1989/2004; the Care Act 2014 and the Mental Capacity Act 2005. The report is aligned to the Safeguarding Strategy 2022-2024 and focuses on the six safeguarding principles. Safeguarding sits corporately within the Trust and the Named Executive Director is the Chief Nurse. As part of our multi-agency commitment to Safeguarding Adults and Children; Calderdale and Huddersfield NHS Foundation Trust is represented on both Kirklees and Calderdale Safeguarding Adults Boards/ Children's Partnership arrangements by the Associate Director of Nursing Corporate Services / Head of Safeguarding. The Trust Safeguarding Committee reports to and links directly into the Quality Committee on behalf of the Trust Board with a requirement to provide an annual and biannual report.
Key Points to Note	• The Care Act 2014 (Section 42) requires that each local authority must make enquiries, or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect. A new process has now been initiated to support a timely response to Section 42 enquiries and regular review meetings are happening between both Local Authorities and CHFT to monitor progress and highlight any areas of concern. • An automated system has been developed to prompt staff to follow the Burns, Bruises and Scalds Policy when a child presents in ED or all services. This is being recommended for a Nursing Times award and has influenced practice across West Yorkshire. • There continues to be high demand in relation to safeguarding practice reviews; safeguarding adult reviews and domestic homicide reviews which impacts on Team capacity, however, our response has been within timescales. • Compliance with receipt and scrutiny training and FGM training is now above 90%. • Compliance for level 2 safeguarding and level 3 safeguarding training is

	significantly below the 90% compliance target, however there are plans in place to address this gap, this has been as a result of changes made to the training and the target audience of people required to undertake the training. The Quality Committee has oversight of this. • At CHFT we continue to work towards embedding trauma informed pra ctice across the organisation as this is key learning from Safeguarding reviews. • A new Missing Persons procedure has been developed that supports staff to take appropriate action for patients that are at risk of going missing and a robust action and escalation plan for when patients do go missing from the Trust. • The safeguarding team are working towards increasing our resource to support increasing safeguarding supervision compliance, and there is a plan in place to address this gap. • A robust action plan has been developed in response to the Yorkshire Audit report MCA/DOLS completed in February 2024. • As part of our strategic aims, we have a plan in place to ensure the child's voice and making safeguarding personal is embedded. • There is continued work from the safeguarding adults team to support discharge improvement. • There is a multi-agency response to improving the outcomes for Children Looked After and we have progressed this with partners in our local place-based arrangements. • The new Female Genital Mutilation (FGM) policy has been approved which supports our Trust wide response to undertake risk assessments and referrals when there are concerns relating to FGM.
Regulation	Regulation 13: Safeguarding service users from abuse and improper treatment
EQIA – Equality Impact Assessment	Equality impact assessment forms the basis of much of the work of the Safeguarding Team. The role of the team is to ensure that our most vulnerable people in society are protected from harm.
Recommendation	The Board is asked to **APPROVE** the Safeguarding Annual Report and **NOTE** the activity of the Safeguarding Team for the reporting period April 2023 – March 2024 and the contents of report for assurance.

1. INTRODUCTION

This report is the Safeguarding Annual Report for the Quality Committee, for the reporting period April 2023 – March 2024.

The report provides an overview of activity and outlines key achievements and developments on our safeguarding priorities. It has been structured around the key principles of safeguarding, which are central within our safeguarding strategy for 2022-2024 and underpin our safeguarding work. Our Safeguarding Strategy aligns with the Safeguarding Adults Boards and Safeguarding Children's Partnerships priorities.

2. PARTNERSHIP – *collaboration with partner agencies and communities.*

As part of our multi-agency responsibilities to safeguarding adults/children and children looked after, Calderdale and Huddersfield NHS Foundation Trust (CHFT) is represented at both Kirklees and Calderdale Adults Boards and Children's Partnerships arrangements by the Associate Director of Nursing Corporate Services/ Head of Safeguarding. The Named Nurses/ Professional represent the Trust on the sub-groups of these Boards/Partnerships.

We have previously reported delays with meeting the statutory timescales for Section 42 investigations led by the Local Authority and requiring CHFT to investigate or provide information that ensures we are meeting our responsibilities under the Care Act 2014 and our safeguarding adult's policy. The impact of this has been a delay in timely feedback to our patients; their families and carers. Since April 2023, work has progressed at pace resulting in reducing the backlog of information required by the Local Authority to close these investigations. A new process has been developed to support this going forward and improve outcomes for patients, families, and carers. Due to the progress made in the multiagency response to S42 investigations, this has now been removed from the safeguarding risk register.

CHFT's response relating to the Healthcare Safety Investigation Branch (HSIB)- Non-Accidental Injury in Infants attending the Emergency Department - April 2023, has identified the following area for improvement:

- compliance in relation to the West Yorkshire Burns, Bruises, and Scalds Policy (BBS).

<u>This was shared in the biannual report and further work has continued to improve our response to this.</u>

<u>Response:</u>

- The Named Nurse for Safeguarding in partnership with an EPR analyst worked collaboratively to find an automated system to alert staff to complete the actions required to safeguard the child/young person. The solution was based on an auto-prompt that would flag any child under the age of one, asking bespoke questions in line with the policy requirements. This process was embedded in February 2024 and feedback to date is positive and the work is being submitted for a Nursing Times award.
- a Standard Operating Procedure (SOP) has been developed and shared with both emergency departments.
- targeted work continues when process is not followed with wards, and departments to improve CHFT compliance.
- BBS continues to form part of the Safeguarding Level 3 Safeguarding Children Training, as well as the ED Bespoke package.
- Work continues with Kirklees to ensure GP's refer directly into CHFT under this policy.

This will replicate the service for Calderdale. (**Appendix 1** demonstrates a positive example of this).

During this timeframe we have received 1 new request in relation to a safeguarding adult review and 3 new requests relating to domestic homicide reviews. All multi-agency requests for information have been fulfilled and Calderdale and Huddersfield NHS Foundation Trust are contributing towards several safeguarding and domestic homicide reviews; 5 safeguarding practice reviews; 5 safeguarding adult reviews and 7 domestic homicide reviews.

Key themes from these reviews are

- trauma informed practice;
- self-neglect; MCA;
- hidden males/significant others in non-accidental injury in the under 1's.
- transition and elder domestic abuse.

In response to these themes the following areas continue to remain a priority:

- training to include trauma informed practice to support trauma informed care across the organisation.
- development of social and self-neglect pathways.
- development of the online DOLS application process.
- promotion of ICON (infant crying and how to cope).
- review of documentation and recording significant others.
- increasing awareness of elder domestic abuse.
- transition from childhood to adulthood.
- electronic notification on patient record in relation to under 1's presenting with an injury.
- review of the under 18 proforma to support risk assessment.

CHFT continues to work in partnership with SWYPFT formally through the service level agreement and clinical working protocol. There are monthly meetings between SWYPFT's Mental Health Act office, CHFT and the wider partnership to discuss issues and good practice relating to the detention of patients under the Mental Health Act to support learning and the development of practice in relation to this to ensure we meet the needs of our patients. We have seen a 23% increase in our compliance with Receipt and Scrutiny training up to the end of March 2024.

	31.03.23					31.03.24					
Competence Name	Assignment Count	Required	Achieved	Outstanding	Compliance %	Assignment Count	Required	Achieved	Outstanding	Compliance %	% Deviation
372|LOCAL|Mental Health Act Receipt and Scrutiny Training|	92	92	61	31	66.30%	112	112	101	11	90.18%	23.87%
Key											
Aspirational Target >95%											
On target 90% - 94.0											
ear Target 85% - 89.9%											
Below Target<85%											

CHFT have been involved in a recent Kirklees challenge event to review our action plan and commitment to children, and young people at risk of Honour Based Violence (HBV) and Forced Marriage (FM). The feedback from the partnership was positive and provided the Partnership with assurance our staff could respond appropriately to concerns relating to HBV and FM. The panel were particularly keen to hear about the interactive training packages (SLIDO) that have been developed and the plan to develop our programme of lunch and learn

sessions in 2024. The action plan has since been provided and the Named Nurse for Safeguarding Children is reviewing our progress against this.

In July 2023 CHFT attended a focussed event in Calderdale to review the learning from Safeguarding Practice Reviews. A thorough overview of CHFT's current position was provided. Feedback was positive with a few points made for consideration by the Trust. The partnership was keen to ensure that:

- ICON (Infant crying is normal; Comforting methods can help; It is OK to walk away; Never ever shake a baby) was refreshed across the organisation. Work to address this has recommenced.
- that the voice of fathers who are not present at consultations are considered. Our approach to this is currently being reviewed.
- staff are trained to undertake domestic abuse, stalking and harassment (DASH) risk assessment. Work to address this has commenced.

Response:

1. ICON refresher training was delivered to Community Midwives
2. ICON training has been rolled out to all staff in the Neonatal Unit
3. ICON continues to be included in Midwifery Day 2 training, ED Bespoke training and level 3 safeguarding children training which includes the importance of including fathers.
4. Domestic abuse training including DASH risk assessments continues to be provided to colleagues during ED Bespoke Training, Midwifery Day 2 training and to be delivered to Integrated Sexual Health Services

CHFT continue to participate in case audits where children and young people are at risk from exploitation and further audits are planned to take place across both Kirklees and Calderdale to improve the multi-agency responses to safeguarding children and young people.

The Safeguarding Team are continually striving to increase awareness of the safeguarding service within CHFT and to achieve this the team now:

- support with induction; apprentice and the internationally educated nurses training sessions. A bespoke paediatric safeguarding new starters package is currently being developed.
- are starting to encourage students to have short placements with team members to support their learning in relation to safeguarding.
- support the delivery of training for Junior Doctor's on MCA and Safeguarding.
- improve visibility across the Trust, which also includes visibility of the Safeguarding Champions across wards and departments.

The Paediatric Liaison Sister now works from both ED areas on a bi-weekly basis to support with visibility and to provide support across the departments. The Liaison Sister is also working in partnership with the BLOSM Team to improve referrals and engagement as part of routine ED screening.

The Safeguarding Team are working closely with Maternity and Gynaecology to increase visibility and safeguarding supervision compliance and have:

- facilitated safeguarding surgeries for Community Midwifery.
- undertake regular safeguarding walkabouts in both Maternity and Gynaecology.
- continue to provide support with multi-disciplinary meetings, strategy meetings, and discharge planning meetings.

- provided a bespoke safeguarding supervision training course to the mental health lead and community midwifery managers to increase the supervision offer within maternity services.

CHFT have been involved in a multi-agency reflective practice session, which was arranged in response to a challenging case, involving a young person who had a prolonged stay in hospital which was more than 40 weeks and there was no medical need for acute hospitalisation. This was to identify any learning with regards to single and multi-agency working. The aim of the reflective practice event was to enhance practice and improve outcomes for children and young people with complex mental health and additional needs. The report has now been received by CHFT and the plan is to consider how these recommendations might impact on practice, our actions for change and key messages for our staff. Challenge events are to be held in Summer 2024 to share our progress, in relation to practice, joint working and the impact on children, young people, families and services. The final report will be shared with the Calderdale Safeguarding Children Partnership Executive following the challenge events.

The multi-agency pathway for managing discharges of children and young people with complex additional needs has previously been developed and is in use. The effectiveness of this pathway will need to be evaluated over coming months.

3. PROTECTION – *keeping people safe by help, support and stopping abuse.*

Following the Joint Targeted Area Inspection relating to Child Sexual Exploitation/Criminal Exploitation in 2022 there has been good progress on the learning identified for CHFT.

There remain two outstanding actions and the anticipated completion date is June 2024 due to a delay in the changes required being approved within EPR. These are:

- Embed the electronic under 18's and adults at risk proforma.

Response:
The template has now been redeveloped and shared across the organisation for comment. The feedback received has supported a decision not to progress this as a joint children/young people and adult template, and to focus on this being for children and young people only as it was felt that this would not improve current safeguarding adult processes and that the focus needs to be on improving professional curiosity and risk assessment of children and young people. We are now in the final stages of embedding this proforma across our Emergency Departments, Paediatrics and Maternity services. The changes have been approved and the development of a communications strategy is underway. The plan is for this to be embedded by June 2024.

- Develop a process to record referrals to Children's Social Care across the organisation. To support with auditing, reviewing themes and quality assurance.

Response
Work has now progressed, and the function is available to be adopted across the Trust. Work is ongoing with the EPR analyst, and the outstanding work largely relates to the development of a SOP as well as a communications plan to update and support the workforce in adopting this process moving forward.

3.1.1 – Domestic Abuse

CHFT continue to receive funding for our Independent Domestic Violence Advisor (IDVA) from the Ministry of Justice (MOJ) and provide midyear reports and end of year reports for the Ministry of Justice. The midyear report for 2023-2024 shows the role has supported/contacted 212 victims or suspected victims of domestic abuse.

Please see **Appendix 2 and 3** which highlights positive patient outcomes.

The Safeguarding Team provide support not only for our patients but also staff in their personal lives when they are experiencing domestic abuse, which supports one culture of care.

The following comments have been received from our staff:

"In the training session it was interesting to learn about different types of abuse but especially about coercive control. I never knew controlling behaviour is a type of abuse. I wanted to learn more about DA, and it was great that you are around in ED at HRI and therefore I was able to come and speak with you."

"As a victim of DV and being a staff member, it is very assuring that I can come and speak to you without the need of making an appointment and you always made time to catch up with me."

We are continuing to develop a non-fatal strangulation pathway for the Trust, which will give a clear guidance on the medical and safeguarding interventions required when these cases present. This will then be developed into a multi-agency pathway, which will allow external agencies such as Women's Aid and Primary Care to make direct referrals for high-risk non-fatal strangulation victims across the Calderdale and Huddersfield footprint.

A gap analysis of domestic abuse practice across the Trust, identified that staff would benefit from increased bespoke training on the requirements for assessment following a disclosure of abuse. Training in key areas is planned for next year, this work is in line with the Calderdale Domestic Abuse strategy action plan.

In response to the recent reports of sexual assault, harassment and abuse in the NHS, our Executive Lead for domestic abuse and sexual violence is leading on this work, which is overseen by the Resilience and Safety Group. CHFT have signed the Sexual Safety Charter and the following Trust Safeguarding policies support both staff and patient safety - Domestic Abuse Policy, Safeguarding Adults Policy and the Allegations of Abuse Against Staff Policy. Our safeguarding training has also been reviewed to include slides on sexual safety.

3.1.2 – Female Genital Mutilation (FGM)

Our FGM training data demonstrates our compliance is now above 93%

	31.03.23					31.03.24					
Competence Name	Assignment Count	Required	Achieved	Outstanding	Compliance %	Assignment Count	Required	Achieved	Outstanding	Compliance %	% Deviation
372|LOCAL|Female Genital Mutilation|	578	578	519	59	89.79%	623	623	582	41	93.42%	3.63%
Key											
Aspirational Target >95%											
On target 90% - 94.0											
ear Target 85% - 89.9%											
Below Target<85%											

The table below represents the data CHFT share with NHS digital in relation to identified cases of FGM. Our data helps provide a national picture about the nature and prevalence of FGM, and how services can respond to the needs of women who have experienced violence, which

includes how we address this harmful practice and its potentially negative consequences for health. The World Health Organisation (WHO) has indicated that overall FGM has declined over the last three decades. Our data shows a slight increase year on year since 2019-2020 in the numbers of women who present with FGM, demonstrating awareness of the issue of FGM. Due to multiple pregnancies women can present on more than one occasion, due to having had multiple pregnancies and therefore the data is repeated in some cases.

Date	Number of women known FGM that has presented at CHFT
2018 - 2019	44 women 65 notifications
2019 - 2020	40 women 59 notifications
2020 - 2021	41 women 62 notifications
2021 - 2022	50 women 84 notifications
2022 – 2023	56 women 79 notifications
2023 - 2024	58 women 78 notifications

During this reporting period CHFT have been made aware of 2 children who have undergone FGM

Since Dec 2018 we have embedded the Female Genital Mutilation Information Sharing (FGM-IS) system, which is a national recording system and creates a flag on the national spine for all babies that are born to a mum known to have had FGM. This ensures there is a robust national process in place to identify children at risk of FGM across the United Kingdom.

CHFT also flag children at risk who live locally on the electronic patient record (EPR), to ensure that a full risk assessment can be completed if they present within CHFT. This supports a timely safeguarding response to any identified concerns.

FGM-IS – number of records CHFT have created.

	Total
2018 - 2019	2
2019 - 2020	11
2020 - 2021	5
2021 - 2022	12
2022 - 2023	11
2023 – 2024	10

A trust wide FGM policy has now been developed which has been ratified and now available on the intranet this replaces the previous maternity FGM guideline.

3.1.3 Prevent

The Counterterrorism and Security Act (2015) places a duty on CHFT to have; 'due regard to the need to prevent people from being drawn into terrorism.'

CHFT's Safeguarding Team continue to respond to information requests and share these with partner agencies. Over the reporting period there has been 85 requests for information.

Prevent training has now moved to a three yearly requirement from October 2023. This has impacted on our compliance; however, this has continued to increase over subsequent months and sits slightly below the Trust's 90% target at 84%.

The Manchester Arena bombing has triggered consideration by the Government in relation to Martin's Law. The overall scope of this is around lockdown arrangements in public spaces. This is currently in the public consultation phase.

The Prevent Policy was reviewed and ratified in August 23.

	31.03.23					31.03.24					
Competence Name	Assignment Count	Required	Achieved	Outstanding	Compliance %	Assignment Count	Required	Achieved	Outstanding	Compliance %	% Deviation
NHS|MAND|Prevent WRAP - No Renewal|	6344	6344	5958	386	93.92%	6534	6534	5549	985	84.93%	-8.99%
Key											
Aspirational Target >95%											
On target 90% - 94.0											
ear Target 85% - 89.9%											
Below Target<85%											

3.1.4 Trauma Informed Care

We are working together with BLOSM towards becoming a fully Trauma Informed Emergency Department (ED) and have made real progress over the reporting period.

We continue to deliver the ED Bespoke Safeguarding session to staff across our departments and embedded within these sessions the principles of Trauma Informed Practice. These sessions include previous case examples. The ongoing inclusion of external agencies into the sessions brings a different perspective and encourages debate and discussion between ED staff and external partners.

The Named Professional Adults/Deputy Head of Safeguarding sits on the panel for the West Yorkshire 'Right Care, Right Person meeting alongside West Yorkshire Police, which is a Trauma Informed Initiative to share experience and learning between agencies around vulnerable adults and the appropriateness of the care provided in these cases.

We are proud to be part of the West Yorkshire Adversity, Trauma and Resilience network and as part of this our BLOSM Service Lead has recently completed a fellowship on adversity, trauma, and resilience which has supported the opportunity to work alongside colleagues across West Yorkshire from a range of different sectors with a shared focus to embed trauma informed care within the organisations.

We have been chosen as a pilot site to check our readiness to become a Trauma Informed Trust and as part of that have linked in with senior colleagues to start planning what needs to be put in place to make that possible.

The implementation of a trauma informed approach across our departments will have a positive impact on improving outcomes for service users.

The BLOSM Team in conjunction with the Safeguarding Adults Team are currently developing an in-house trauma informed practice training for ED staff with a 'train the trainer' approach.

The social pathways developed by the BLOSM service continue to support how we embed our learning from local safeguarding reviews, with the implementation of drug and alcohol workers within the ED now working in the departments full time.

The following case study highlights good practice from the Safeguarding Team with regards to the Protection of Vulnerable Adults and Children within the Trust:

Following an advice call from an inpatient ward within the Trust, it was highlighted that a young person had been admitted and that they were seeking asylum. Our Named

Professional/Deputy Head of Safeguarding attended the ward to support the staff, following a disclosure from the patient that he was 17 but currently residing in adult emergency accommodation in the community and was at significant risk of abuse and exploitation if he were to be discharged back there. The patient was suffering from PTSD following his arrival in the UK, and so a trauma informed approach was embedded from both the staff on the ward and from the Safeguarding Team.

Because of the complexity of an age assessment not yet being completed by the home office and the patient not being able to disclose his date of birth, the Deputy Head of Safeguarding organised an urgent age assessment through social services, so an appropriate residential placement could be sought.

Outcome:
The young person was assigned a Looked After Child Social Worker and was discharged to an appropriate supportive placement with people his own age, communicated in his first language and with follow up referrals for mental health support and support from Asylum Seeking charities within the community.

3.1.5 Children and Young People with Mental Health Needs

Targeted work has commenced which links with the CHFT transformation plan, and this includes looking at the vision of children and young people's mental health within CHFT. The Paediatric Mental Health Liaison Nurse continues to work closely with the Safeguarding Team, the Ward and CAMHS where children and young people have complex mental health and social needs. This has improved lines of communication between parents and carers and provided an advocacy service for children and young people as part of their admission.

The Mental Health Champion role for CYP has also commenced within CHFT. The Mental Health Champion will assist in the advocacy in creating parity of esteem for children and young people across CHFT, when manging mental health concerns with or without medical concerns. The Champion will work collaboratively with the Mental Health Liaison Nurse, Directorate Matrons/Head Nurses, Safeguarding Team and the wider network to provide necessary training and improve staff confidence and competence. The Paediatric Mental Health Liaison Nurse has organised and facilitated a children's mental health conference to improve knowledge and awareness of managing and supporting patients with mental health crisis/conditions.

Work between CAMHS services and CHFT have continued to be collaborative and have now delivered honorary contracts of employment to support a therapeutic offer to children and young people whilst admitted on the inpatient wards. There is a plan to increase this further. CAMHS are also working within the emergency department to improve timely referral and assessment of patients. This has improved the patient journey and allowed for earlier intervention, ultimately reducing admissions and length of stays.

Measures have been put in place to offer staff a direct de-brief when there has been an escalation in behaviours relating to an inpatient, supporting staff daily, offering advice, and encouraging staff to attend bespoke training sessions. The role also supports with multi-disciplinary team meetings, communicating outcomes across the division, and the Trust.

4. ACCOUNTABILITY – *safeguarding is everyone's responsibility. Everyone in contact with a vulnerable patient should be responsible for identifying and acting on any risks.*

4.1 Mental Capacity Act (MCA)/ Deprivation of Liberty Safeguards (DoLS)

There continues to be a focus on MCA and DoLS, including considering the importance of the executive functioning of our patients from the Safeguarding Team, with the review of the MCA E-learning packages and the introduction of MCA 'Lunch and Learn' sessions at ward level, to increase staff knowledge and confidence around MCA and DoLS. These lunch and learn sessions are evaluating positively by attendees. During this reporting period the team have processed:

- 414 urgent referrals
- 262 extension requests
- 201 applications have been cancelled due to no longer being required.
- of these, 5 applications have resulted in a Best Interest Assessor attending the ward to approve a standard DoLS authorisation.

Over the last year, no DoLS applications have been rejected by either Kirklees or Calderdale, giving the Trust good assurance that all applications made have been appropriate for our patients.

An external audit has been completed and has shown some improvements in the use of best interest decision making and the use of DoLS across the Trust. However, the completion of MCA assessments prior to a DoLS application being made was highlighted as an immediate action.

The Best Interest Decision Making Template has now been added to EPR and follows the Mental Capacity Assessment. There has been evidence of increased good practice with this throughout the Trust.

Over the reporting period there has been a slight drop in compliance with staff requiring level 2 and level 3 training. This will continue to be monitored via the Safeguarding Committee and is in response to review of training requirements earlier in the year.

	31.03.23					31.03.24					
Competence Name	Assignment Count	Required	Achieved	Outstanding	Compliance %	Assignment Count	Required	Achieved	Outstanding	Compliance %	% Deviation
NHS|MAND|Mental Capacity Act - 3 Years|	263	263	249	14	94.68%	300	300	276	24	92.00%	-2.68%
NHS|MAND|Mental Capacity Act Level 2 - 3 Years|	3357	3357	3054	303	90.97%	3296	3296	2949	347	89.47%	-1.50%
372|LOCAL|Mental Capacity Act Level 3 - 3 Years|	875	875	843	32	96.34%	1050	1050	857	193	81.62%	-14.72%
Key											
Aspirational Target >95%											
On target 90% - 94.0											
ear Target 85% - 89.9%											
Below Target<85%											

Our Future Plan:

1. DoLS applications will now not be sent to the Local Authority unless assurance is provided that a full MCA assessment has been completed prior to the application being made.
2. Plans are in place to include the MCA assessment within the online DoLS form which is due to be embedded in the next quarter.
3. DoLS applications continue to be monitored and quality assured by the Safeguarding Team before they are sent to the Local Authority for review.
4. The introduction of an online form for DoLS application is to be introduced soon. DoLS notifications to CQC are now only required when there has been a standard DoLS authorisation. This will alleviate some administration pressure on both staff on the ward and within the Safeguarding Team. Having a more streamlined process and automated dashboard will reduce the risk of human error and increase the time we can spend on patient care.

5. The Safeguarding Team will continue to increase knowledge and confidence throughout the Trust through training, support, and guidance with MCA and DoLS.
6. The Safeguarding Team will use data collection to monitor themes and trends from a Trust perspective with regards to DoLS applications and use this information to recognise gaps in knowledge that will steer training focus for the future.

4.2 Safeguarding Training.

The Safeguarding Children's/Adults/MCA/DoLS training packages for level 2 and level 3 continue with good feedback from staff and include a hybrid approach of e-learning and face to face sessions. This ensures compliance with the Safeguarding Children and Young Peoples: Roles and Competencies for Healthcare Staff (2019), the Looked After Children: Roles and Competencies for Healthcare Staff (2020) and the Safeguarding Adults: Roles and Competencies for Healthcare Staff (2018).

Our year end position in relation to safeguarding level 2 and 3 adults and children's training highlights a significant drop in compliance. The Trust wide review of role specific training, which also coincides with the reintroduction of the face-to-face training has impacted on this.

To support an improvement in compliance the Safeguarding Team have increased the availability of face-to-face sessions over recent months and are working with the Associate Directors of Nursing to ensure staff have been assigned the correct level of training. This position continues to be monitored by the Safeguarding Committee and shared via Divisional PSQB's.

The Level 3 children's training package has been enhanced and re-developed with the content having been updated to reflect local learning and feedback from staff regarding the previous offer. A streamlined offer has been provided, coming into effect in December 2023 and the initial response to the revised package has been positive.

The safeguarding packages are responsive to the needs of the service and the training packages include complex case examples to ensure all client groups are included.

Acknowledging the positive response from staff relating to the use of SLIDO, the Level 3 now includes an extended 3-hour face to face package incorporating SLIDO to improve participant engagement.

The Safeguarding Team are working together to review how mandatory evaluations of the safeguarding packages on offer can be embedded.

	31.03.23					31.03.24					
Competence Name	Assignment Count	Required	Achieved	Outstanding	Compliance %	Assignment Count	Required	Achieved	Outstanding	Compliance %	% Deviation
NHS|CSTF|Safeguarding Adults - Level 1 - 3 Years|	1754	1754	1693	61	96.52%	1766	1766	1723	43	97.57%	1.04%
NHS|MAND|Safeguarding Adults Level 2 - 3 Years|	3901	3901	3623	278	92.87%	3884	3884	3416	468	87.95%	-4.92%
NHS|MAND|Safeguarding Adults Level 3 - 3 Years|	576	576	561	15	97.40%	737	737	493	244	66.89%	-30.50%
NHS|CSTF|Safeguarding Children - Level 1 - 3 Years|	1751	1751	1695	56	96.80%	1762	1762	1719	43	97.56%	0.76%
NHS|MAND|Safeguarding Children Level 2 - 3 Years|	3928	3928	3624	304	92.26%	3873	3873	3417	456	88.23%	-4.03%
NHS|MAND|Safeguarding Children Level 3 - 3 Years|	553	553	500	53	90.42%	741	741	481	260	64.91%	-25.50%
372|LOCAL|Safeguarding Supervision|	731	731	561	170	76.74%	899	899	586	313	65.18%	-11.56%
Key											
Aspirational Target >95%											
On target 90% - 94.0											
ear Target 85% - 89.9%											
Below Target<85%											

Safeguarding supervision compliance remains below our target of 90%. The requirement to attend safeguarding supervision is linked to the level of training staff require, therefore the position described above will have had some impact on supervision compliance. However, acknowledging that compliance with this has been consistently low over a prolonged period, further steps described below have been taken to support an improvement in this area.

The Safeguarding Team have reviewed and updated the safeguarding supervision policy including a review of the allocation and requirements of safeguarding supervision. Review of the allocation found that allocation of safeguarding supervision did not always align to role requirement.

The Paediatric Team continue to work with the Paediatric Clinical Educator, Ward Manager, and the Practice Development Groups to support with supervision compliance, with targeted work continuing.

The Adults Team provide Bi-weekly drop-in supervision sessions on Microsoft Teams for Acute and Community staff to help increase compliance and provide further support for complex cases, with bespoke ad-hoc supervision sessions delivered with specific teams as required.

In Maternity we have completed safeguarding surgeries and safeguarding walkabouts to increase visibility and safeguarding supervision compliance. The Safeguarding Team are actively capturing bespoke and ad-hoc supervision.

Safeguarding supervision is delivered to all attendees of the midwifery day 2 sessions, ED bespoke training and level 3 safeguarding children and adult training sessions.

Bespoke safeguarding supervision training session has been delivered for the Community Midwifery Managers and Perinatal Mental Health Lead to increase the midwifery supervisors. There are plans to hold further training sessions for Maternity to increase the overall number of safeguarding supervisors within the division, this is following expressions of intertest from Midwives to become safeguarding supervisors.

The Safeguarding Team have reviewed and created a safeguarding supervision training package in line with the package that is available through the Safeguarding Children Partnership. This will now be delivered internally to increase access to safeguarding supervision training for prospective supervisors. Once facilitators are trained this will increase the availability of safeguarding supervision across the CHFT footprint.

We continue to develop our safeguarding champions network as this is instrumental in supporting our staff. Community champions have been identified and there are plans to undertake a meet and greet in June 2024 in line with Safeguarding Week. The Named Nurse for Safeguarding Children has worked closely with the Safeguarding Administrators and in consultation with the Champions to review and improve the Safeguarding Champions role. The network now meets on a quarterly basis offering bespoke safeguarding training, steered by the needs of the Champions.

Some of the Safeguarding Champions have taken on an additional role as a Safeguarding Supervision Facilitator to support with ward and departmental compliance, and a recent request has been sent to establish champions with a keen interest in PREVENT to establish a cohort of PREVENT Champions within the network.

4.3 Audit

All audits identified in the safeguarding audit plan have been completed or are underway, with dedicated timescales for completion confirmed. The was not brought for medical appointments, and the paediatric liaison notification audits have been delayed due to team capacity and role vacancy. There has been no detrimental impact of these audits being completed as processes are in place for both these areas and these will be completed in 2024.

Below is a summary of two audits undertaken within the reporting period and a summary of the findings are detailed below:

2024 CHFT are contributing towards a multi-agency health audit for ICON to ensure ICON is embedded across the health spectrum.

4.3.1 – External MCA/DOLS Audit
Following an internal audit in January 2022, this was a planned audit to review the effectiveness and the utilisation of the MCA and DoLS throughout the Trust.

Key Points:

- It was found that an assessment of capacity had not been documented in some of the patient records reviewed in relation to the restrictive care arrangements necessitating a DoLS application. Older patients were less likely to have a capacity assessment documented.
- It was found that capacity assessments were documented as a narrative in EPR rather than using the CHFT Record of Mental Capacity Assessment form and missed key details of the two-stage test of capacity stipulated in the MCA Code of Practice.
- There was no clear documented evidence that ward staff had informed the patient's family about the DoLS application in half of the 20 patient records reviewed.
- Action taken: Development of a robust action plan to address points above and move to a more structured approach to MCA/DoLS processing moving forward.
- Utilise the new online DoLS application to include a compulsory MCA assessment prior to completing a DoLS application.
- Further training and the increased use of incident reporting to encourage learning when process is not followed.

4.3.2 – Allegations of Abuse Against Staff Audit

Aim:
To review Trust compliance with its statutory obligations relating to safeguarding adults and children when allegations of abuse are made against staff.

Objectives:

- Are robust systems to respond to allegations of abuse, resulting in a thorough and proportionate response in place?
- Are the principles of confidentiality maintained to ensure staff, adults and children are protected?
- Is information gathered in a timely way to support the investigative process?
- Is information shared in a justifiable, proportionate, and secure way?
- Is a Senior Manager, designated member of the Safeguarding Team; Director of Workforce and Organisational Development allocated to initiate and manage the process?
- Are referrals made in line with the with the West Yorkshire Consortium Inter Agency Safeguarding and Child Protection Procedures and Safeguarding Adults – West and North Yorkshire and York Multi-Agency Policy and Procedures
- Is this process followed where a concern arises from a complaint?
- To inform any amendments required to the existing policy.

Conclusion:
There has been an increase in referrals to the Safeguarding Team in 2023, which indicates that staff are more aware of their responsibilities under this policy. Following a review of the policy in August 2023, feedback received indicates that the introduction of the flow chart in the appendices has clarified staff responsibilities under this policy.

There are sometimes delays in completing this process due to internal and external factors. However, review of these indicate these are system issues and do not impact on the safety of patients and staff.

No amendments need to be made to the Allegations of Abuse Against Staff Policy.

5. EMPOWERMENT – *people being supported and encouraged to make their own decisions which are supported by informed consent.*

The voice of the child and the lived experience is a golden thread that runs through the work undertaken across the Trust. BLOSM has since launched across both the Emergency Departments in January 2023. The reaction to the pilot has been positive and the exemplary work can be demonstrated following nomination for a Nursing Times Award. The pilot was well received, and recognition from other Trusts was noticeable with further ongoing partnership working be undertaken with other Trusts keen to steer a similar initiative. The presentation included a patient story representing the voice of a young person who has positively highlighted the great work BLOSM is undertaking and the impact that this has had on their life and well-being, this has since been incorporated into the Safeguarding Children Level 3 Training package.

As part of the BLOSM data collection process, BLOSM continues to collate feedback from young people based on their experiences of working with the BLOSM youth workers, this includes asking the young person how their interaction with the Youth Work Team has improved their experience within the department. The key element of the BLOSM evaluation is to ensure that the views and thoughts of the young person is captured and utilised as a method to shape services moving forward. As part of this work, one of the patients involved with BLOSM has supported with redesigning the BLOSM logo this is demonstrated in the patient story below:

Young person attended ED in early 2023 with seizures, clinician referred into BLOSM out of hours as the YP divulged bullying at school and previous disingenuous disclosures of forced marriage, prior safeguarding flags were noted on the patient record.

Contact was made by the BLOSM youth worker and face to face appointments arranged at the young person's home, where they stated they feel most safe and a whole family approach could be used. Group sessions were productive with strengthening trust within the family unit and creating practical coping mechanisms, the youth worker advocating the young person’s voice.

It was established quickly that the young person enjoyed creating art, the youth worker facilitated art therapy which encouraged conversation and understanding, during which difficult conversations were broached, such as disclosures previously made being fictitious, the reasons why and how to utilise less harmful coping strategies in future.
As the sessions continued the YP and BLOSM youth worker developed four colouring books based on different emotions and behaviours, these books are still used by the YP at school. The young person independently re-designed the BLOSM Logo.

Further developments include expanding the BLOSM Team. This includes the introduction of a drug and alcohol worker based in Calderdale, the aim being to identify young people attending ED with substance misuse, supporting with onward referrals and support in the community. Increased funding has also been awarded to recruit a drug and alcohol nurse within the team. These initiatives will support how we address the learning from both our safeguarding practice reviews and safeguarding adult reviews.

The Youth Forum continues to be progressed and an additional event is planned for 5th April 2024. The focus of this session will be on health and well-being, and transitional care. Plans include a joint session between BLOSM and the Halifax Panthers. The action from the previous Youth Forum held in April 2023, has seen two newly appointed Associate Youth Governors join the Trust. An informal session was undertaken for the young people to meet with two of the Trust's governors, prior to meeting with the collective group. The plan is to establish a mechanism to obtain feedback through the Youth Forum and surveys. The two governors are planning to attend the Forum on the 5th April 2024 and there are plans for the young governors to share their experiences and stories at one of the governor events.

Making Safeguarding Personal (MSP) is now a core theme that runs through our safeguarding training. There has been a focus on the effects of poor discharge on making safeguarding personal and how we can better improve outcomes for our patients and families in relation to this. The safeguarding response template for safeguarding adult enquiries has been redeveloped and includes making safeguarding personal in our responses to both the Local Authority and families. This workstream also aligns to the principle of empowerment, given the focus on making safeguarding personal and the impact this has on supporting safe discharge.

The Working Together to Safeguard Children Guidance was published in December 2023. The implementation period is extended to December 2024 to ensure any changes are reflected in operational policy. The Named Nurse for Safeguarding Children is currently reviewing the Safeguarding Children Policy to update following the publication of the revised guidance.

6. PREVENTION – *it is better to take action before harm occurs.*

There has been some targeted work regarding discharge within the Trust, focusing on poor discharge and safeguarding implications with regards to this. This is an opportunity to look at poor discharge from a safeguarding perspective and the themes and trends that surround these cases. There is a safer discharge working group which the Safeguarding Team attend, and safe discharge now forms part of the Level 3 Safeguarding Adult training. Discharge remains a high priority within the safeguarding adults agenda, and further multi agency work to improve discharge is planned in collaboration with both Local Authorities within the next year.

The Safeguarding Adults Team have been working with CHFT Charity to source funding to provide 'homeless packs' for patients being discharged from hospital who are of no fixed abode. Following a consultation with homeless charities in the local area, the safeguarding adults team were successful in sourcing funding from CHFT charity to provide bags to take away which contain some essentials such as hot drink items, non-perishable food, warm socks and a blanket and contacts for signposting support within the Community.

CHFT have actively contributed towards the development of the Calderdale adult thresholds' guidance for practitioners and the self-neglect toolkit.

The principle of early help remains embedded in the Level 3 safeguarding package and promoted as part of the Safeguarding Team's commitment in strategy meetings and MDT's. This continues to be promoted within Paediatric, and Midwifery services and within the risk assessments in the Specialist Midwifery Panel Meeting, MAPLAG and SWANS risk assessment meetings.

Following Serious Adult Reviews where hoarding and/or self-neglect was a key theme, the learning from these reviews' forms part of the tailored training packages, supervision sessions and learning briefings that are disseminated to staff, to support understanding of this complex and multi-faceted issue.

Looked After Children (LAC) - Kirklees

During this reporting period our Designated Doctor Looked After Children (LAC) Kirklees has highlighted a very difficult period in terms of meeting timescales for initial health assessments (IHA's). The reasons for this have been due to high numbers of children coming into care and leaving quickly increasing the number of initial health assessments; an increased number of IHA's being requested for out of area children being placed in Kirklees as this is a significant net importer of LAC; increasing numbers of unaccompanied asylum-seeking children (UASC) and some issues with timeliness and responsiveness of referrals and communications with Social Workers. As LAC health assessments affect other areas in West Yorkshire this has been placed on the West Yorkshire ICB risk register and the CHFT Paediatric risk register. Meetings are being held between CHFT; Locala; Head of Children's Commissioning and the ICB to support and improvement in this position.

<u>Response</u>

- From the 22 April 2024 any referral that comes into Kirklees for an IHA should be managed with the usual clinic time and seen within the 20-day target.
- The General Manager has requested an overview of the 34 patients waiting for IHAs and how many of these are out of area children placed in Kirklees.
- The plan is to reduce by mid-June 2024 and there has been an agreement from the ICB in principle to fund some extra clinics.
- The General Manager is putting a case together for medical and administration resource to support this.
- There is a named link from Children's Social Care for the Looked After Children Team to highlight issues where children are not attending their appointments.

Calderdale Profile of Children Looked After (CLA)

As of 31 March 2024, there were 366 children cared for by Calderdale Local Authority. This is a 2.5% increase on the number of CLA from the previous year. Between April 2023 and March 2024, 132 children became CLA (60 children aged under 5 years, and 71 children aged 5-17 years. There were 123 children that ceased to be looked after during this period (34 children under 5 years old, and 89 over 5 years old). Of the young people over 5 years old leaving care, 51 children had reached 18 years old and were therefore no longer looked after because of their age.

There are 129 CLA currently accommodated outside of Calderdale. Calderdale CLA health team retain responsibility for all these children, and they all have an allocated CLA nurse. When a child or young person is placed outside of Calderdale, an information sharing form is completed to share health information and risk factors with the health service locally, so that timely information sharing and referrals into services can take place in the area they are placed. Calderdale CLA health team complete health assessments on all children or young people placed up to a 50-mile radius, however, in line with the service level agreement, the

Calderdale CLA Team do not complete health assessments more than a 50-mile radius. Any child or young person placed further than 50 miles will have their health assessment completed by the service in their local area. As a result, 33 review health assessments and 9 initial health assessments have been completed by other local health teams during 2023-2024. Once received by the Calderdale CLA Team the health assessments are quality assured to ensure they meet quality standards.

There are 214 CLA placed in Calderdale by external Local Authorities, that we are aware of. This consists of 28 children under 5 years old, and 186 are over 5 years. 120 of these young people are in adolescence. It is the placing Local Authorities legal duty to notify when a child is placed in an area, however this does not always happen, and we are sometimes alerted of children and young people due to them presenting at A&E or the GP, going missing, or when we are requested to complete their statutory health assessment. The Named Nurse has been involved in work both nationally with NHS England, and locally across the partnership to explore the impact this has on services, and the children and young people, to mitigate risk to these children and young people. From May 2023, Calderdale CLA health team began to request that an information sharing form is completed for all children or young people that we became aware had been placed in Calderdale. This helps how we can better understand their health needs and risk factors, to enable timelier referrals and care planning for each child or young person. During the period 2023-2024, Calderdale CLA health team have completed 63 review health assessments, a 17.5% increase on the previous year. There have been 24 initial health assessments in the current reporting period, this is a 17% decrease on the previous year.

In 2023-2024, 21 Unaccompanied Asylum-Seeking Children (UASC) became CLA, only one more than the period 2022-2023, when there were 20. It was anticipated that the rate would be much higher as 2022-2023 saw an 100% increase in UASC from 10 to 20. In addition, changes in the Home Office quotas for UASC indicated that all areas across West Yorkshire would see a significant increase in UASC, however this has not happened in 2023-2024, although there has already been 6 UASC placed in Calderdale up to date in the first quarter of 2024. UASC arrive into care often with little or no health history, significant trauma, and require addition screening and immunisations. It was identified during this reporting period that a large proportion of UASC were 17 at the time of their initial health assessment and would cease to be looked after prior to needing a review. 13 of the 21 UASC received into the care of the Local Authority in 2023-2024 were 17 years old at the time of their initial health assessment. At 18 they would then be deducted from service. The CLA health team now ensure that all UASC are allocated a nurse to ensure all screening, immunisations and referrals are complete prior to the young person being deducted from service. In addition, the CLA nurse ensures that a handover of care is provided to the Pathways Service to aid the transition to leaving care and ensure that health needs are met.

The majority of CLA are white, 80%, with 12% mixed and other ethnic group, and 7% Asian or British Asian. 48% of Asian/British Asian children are UASC, 43% from mixed or another ethnic group, and 10% from the Black ethnic group are UASC.

Special Educational Needs and Disabilities (SEND)

It is accepted nationally that children with a learning disability diagnosis are overrepresented in the CLA population, and that health and educational outcomes are interlinked. Children with disabilities and complex needs have access to a Specialist Children's Looked After Nurse, who completes most of the review health assessments and works closely with the Paediatricians to complete the initial health assessments. Where children are placed out of area in specialist provisions to meet their complex needs, individualised arrangements may be required to ensure their health assessments take place. The data we hold shows that there are 69 children (19% of CLA children) with an Education Health and Care Plan (EHCP).

However, we know from the national data that more than half of CLA have a special educational need +/- an EHCP. Previously the CLA Team would just collect data on children with EHCP's but we know that there are a large proportion of children and young people that have a SEND but do not have an EHCP. We have now started to collate data for children with SEND, as well as those with an EHCP. In addition, the Named Nurse for CLA is working with the SEND Team at the Local Authority to gain a clearer understanding of our CLA population with a SEND.

During the period 2023-2024, there have been 132 Initial Health Assessments (IHA) completed by the Calderdale CLA Team, a 17% increase since 2022-2023. 57 of the assessments took place on CLA under 5 years old and 75 on CLA aged 5 years or older. In the previous year, there were 35 CLA assessments for those under 5 years old and 65 CLA assessments for those aged 5 years or older.

80% of the IHA's completed in this reporting period were completed within timescales, this is a 7% increase from the previous year when only 73% were completed in timescales.

Factors impacting on completion of IHA's are:

- Assessments require completion by other local CLA teams.
- Late notifications – a monthly report is now sent to the Local Authority to highlight themes with late notifications.
- Cancellation of appointments by the Local Authority and carers
- Not being brought to appointments (no cancellation)
- Missing episodes, children at risk of exploitation
- Annual leave
- Children moving area.
- Consent

Review Health Assessments (RHA)

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

There have been 337 RHA's during period 2023-2024, a 17% decrease from the previous year, when 395 health assessments had been completed.
76% of RHA's were completed within timescales, this is a decrease of 15% from the previous year when 91% were completed in timescales.

Factors impacting on completion of RHA's:

- Cancellation of appointments by carers, young people, family bereavement
- Refusal by young person
- Assessments require completion by other CLA teams
- Consent
- Children moving area

Consent has had a large impact in the last two quarters of the year. This became an issue in quarter 3 when CLA health were without administration support for the quarter, and it was identified that the CLA health administration use a considerable amount of time chasing consent from the Local Authority. During quarter 4, a process was developed and agreed with the Local Authority to streamline the consent process, yet the issue remains, meaning health assessments are being completed outside of statutory timeframes. This has been escalated within the Safeguarding Committee at CHFT and to the Designated Nurse for CLA. There is a planned meeting to further explore this between senior leaders within the Local Authority and CHFT. At the end of quarter 4 there were 17 health assessments incomplete. These are as

follows: 5 children are placed out of area and are awaiting a health assessment to be completed by the local team, 4 young people have refused their health assessment, it has been agreed that 1 young person's health assessment should be delayed at this time, and 7 children/young people where the consent was received after 31st March 2024.

The total number of RHA's completed by Calderdale CLA Team is 400, including those completed for other areas. There has been a 13.8% decrease in RHA's completed in this reporting period in comparison to period 2022-2023, when 464 RHA's had been completed, including those completed for other areas. The decrease can be explained by a larger number of children ceasing to be looked after. However, the rate of the overall CLA population in Calderdale has increased from 357 in 2022-2023 to 366 in 2023-2024.

In Calderdale we continue to see an increase in placements above a 50-mile radius which means we have an increased reliance on other areas to complete health assessments within timescales. The CLA Team are receiving increasing requests to complete health assessments for children placed in Calderdale from other Local Authorities which impacts on team capacity.

Health assessments require those completing them to have detailed information of the child or young person's health needs to ensure that they have access to the right local services. The time required to complete these increases when children are placed in Calderdale from other Local Authorities. To support a timelier response from the CLA health team in Calderdale an information sharing form has been introduced requesting this information from the external health team. This provides a health summary which enables the Calderdale CLA Team to screen for outstanding health needs, identify health issues and prioritise those who are most vulnerable. The CLA Team complete the same information for Calderdale children being placed out of area.

Care Leavers

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

During this reporting period 51 young people reached their 18th birthday and became a care leaver. As part of their final health assessment, they are offered their health passport. Health passports are a national initiative which provide a health record for the young person. An information leaflet is provided to the young person at 16 years old at the review health assessment. This details the reason for the health passport. At the last health assessment at 17 years of age the health passport is offered to the young person. In this reporting period 37 care leavers were due to be seen. Passports have been offered to 33 young people; 4 young people have not yet been seen due to refusal. 3 young people refused their passport, and there are 30 passports have been completed or are in the process of completion and to be sent out.

The Calderdale CLA Team continue to offer drop-in sessions at the Orange Box once a month which provide support to Care Leavers with health advice and signposting. This has also improved communication and collaborative working with the Pathways Service.

The following case study illustrates the positive impact of the CLA nurses supporting Care Leavers at the Orange Box:

Care leaver presented at the Orange Box with a diagnosis of epilepsy managed with medication. CLA nurse reviewed the health records and there was no information regarding the diagnosis or medication. GP contacted to arrange for a review of epilepsy. CLA nurse

advised the appointment would need to be made via the online portal. This was actioned by the nurse and a face-to-face appointment requested. The young person was provided with information for mental health support.

The young person was again seen by the CLA nurse 2 months later reporting an increase in seizures. The GP had made a referral to neurology. Poor sleep, increasing use of energy drinks, anxiety, depression, and reduced cannabis use reported. Referral was made to the epilepsy nurse and pathways worker contacted in relation to mental health support. A discussion took place between the CLA nurse and young person in relation to lifestyle choices and options.

The following month the CLA nurse received communication from the epilepsy nurse detailing an appointment date and communicated this with the Care Leave and pathways worker. Later that month a date for a CT scan was received however there was some confusion regarding the date of the scan, and when the CLA nurse contacted the Consultants secretary it was established this had been missed. The CLA nurse contacted Radiology and the scan was rearranged for the next day. This was communicated with the Pathways worker who is supporting the care leaver.

The following month the CLA nurse received communication from the Pathways worker detailing that the young person had sustained an eye injury. CLA nurse contacted the relevant department and appointment made. The young person missed the appointment however the CLA nurse contacted the GP requesting a re referral to the appropriate service. Further contact from the Pathways worker later that month requesting for a change to the EEG appointment. The CLA nurse has contacted the relevant department who are sending details of a new appointment.

Outcome:
CLA has now been seen and the relevant investigations carried out. Recorded diagnosis of epilepsy and prescribed the appropriate medication. Adult Social Worker has now been allocated and assessment completed to confirm a learning difficulty. Consideration is now being given as to whether supported living would be more appropriate.

It is important that the voice of the child and young people is heard and shapes how the CLA service is delivered, to improve our reach to CLA and Care Leavers and reduce the health inequalities they face. In response to this the CLA Team have now:

- Introduced the friends and family test to support gathering regular feedback from children and young people which will support the voice of CLA and Care Leavers.
- Devised a child friendly information leaflet that explains the role of the CLA Team, the health assessment process and support services available in Calderdale.
- Secured the use of the new Rainbow Child Development unit from January 2024 to complete initial health assessments. This provides a child friendly environment with colour, play and distractions to support a positive experience in what is an unsettling time for the child.
- Following identifying that the main group of children refusing dental care are aged 15-17 years, the CLA Team have worked with the Oral Health Team to supply supplies and education with the Pathways workers to increase awareness about oral health. In addition, for young people who are not registered with a Dentist they are signposted to dental practices which are signed up to dental flexible commissioning services scheme which is a scheme designed to improve access to dental care for vulnerable groups.
- Attending the Pathways Service Walk and Talk events, which provides an opportunity to meet with young people in a more formal way, to support positive relationships and trust and the opportunity to discuss any health-related issues if they want to.

7. PROPORTIONALITY – *the least intrusive response appropriate to the risk presented.*

Following the audit of compliance with the Allegations of Abuse Against Staff Policy earlier this year, there has been several briefings to support staff with their understanding of their responsibilities under this policy. The policy has been reviewed and was ratified in August 2023 and now includes a flow chart to clarify individual responsibilities. Between January 2023 and December 2023, 34 staff members were subject to the Allegations of Abuse Against staff policy (4 x LADO and 30 x PiPOT). There has been an increase in referrals under this policy from 25 in 2022, to 34 in 2023.

The Assistant Director of Human Resources; Associate Director of Nursing Corporate and Head of Safeguarding meet monthly to discuss and provide safeguarding oversight with staff members who are being managed under this policy.

The Child Protection – Information Sharing System is well embedded and continues to notify the Safeguarding Team of any children who attend subject to a Child Protection/Child Looked After flag/Unborn at risk. Information continues to be shared as part of the Paediatric Liaison Service for children and young people with a Child Protection flag/Looked After Children flag as part of gold standard information sharing practices.

Our Named Professional/Deputy Head of Safeguarding is conducting a piece of work with our security/health and safety teams to increase knowledge and expertise in least restrictive practice with regards to patients that are subject to a DoLS and has formed a working group with key partners to regularly review security incidents when a patient is on a DoLS and any learning that can be taken.

Our Named Professional/Deputy Head of Safeguarding attends the newly formed Complex MDT, to support with effective discharge and to support in the reduction of safeguarding risks when discharge planning and care planning for complex patients.

West Yorkshire Police have raised that CHFT are making an increased number of referrals to the Police in relation to patients who are classed as missing. Further exploration around this issue has shown that inadequate risk assessments are making it difficult to establish if these patients are high risk and would require Police assessment.

A process is embedded within the organisation to highlight national cases of missing children, young people, and families. Work has begun to review missing children and young people in the Kirklees and Calderdale locality to establish a process to improve lines of communications in these cases.

<u>Response</u>
Our Named Professional Adult Safeguarding/Deputy Head of Safeguarding has led on the task and finish group to develop a new missing persons policy and procedure, to encourage appropriate risk assessment when patients are admitted preventing high risk patients going missing, but also an action plan for staff to follow when a patient does go missing. This also includes a robust escalation procedure which has been agreed with the Yorkshire Ambulance Service and West Yorkshire Police. The task and finish group with continue to be utilised to monitor the use and effectiveness of this pathway, and to source patient outcomes and improvement moving forward.

Appendix 4 shows some of our achievements across CHFT.
Appendix 5 shows some of the feedback we received.

Appendix 1

Burns, Bruises and Scalds Audit

Presented to GP:	Yes		Date & Time: 26.01.2024

Name:		
DOB & Age:	[redacted] – 2 months (at time of incident) [redacted]	
Locality:	☐ Calderdale	X Kirklees
MRN:		
NHS number:		
Concerns:	Family taken baby to the GP with an illness. Whilst being reviewed by the GP, GP noted bruising to the face. Noted to have a skull fracture at point of birth with significant haematoma to frontal parietal region, and smaller bleeds distributes across the remainder of the brain. This was reported on whilst an inpatient on SCBU.	
GP contacted On-call Consultant Paediatrician:	X Yes ☐ No	
Advice given by On-call Consultant Paediatrician:	Emergency Department: ☐ CRH ☐ HRI X Admission to Paediatric Assessment Unit – Ward 3 CRH ☐ Admission to Paediatric Ward 4 - HRI	
Consent given by parent / aware? If not why?	Mum supportive of investigations and why these needed to be conducted.	
Referral to Children's Social Care completed by GP:	X Yes ☐ No, if no what action has been taken?	

Appropriate transport to CHFT?	☐ Yes ☐ No

	X Unknown	
	Mode of Transport: Not recorded in the records. Mode of transport not noted.	
Records update on Systmone records by GP?	X Yes ☐ No	
BBS policy followed? Action taken by CHFT	Yes. • Appropriate multiagency follow up completed. • Paediatrician and Social Care involved. • Strategy Meeting recorded in the records. Safeguarding Team notified.	
Strategy Meeting undertaken?	X Yes No	CHFT in attendance? If no, why? CHFT representation noted. Minutes recorded directly into the records.
Social Worker update from strategy meeting received and embedded into records.	NO. Plan embedded in the records following end of the strategy meeting.	
Outcome:	Plan to process to S47 investigation. Parents not allowed further visitation on the ward unless supervised. 01.02.24 – Interim Care Order obtained. Discharged from Ward 3 CRH dated 02.02.24 into Foster Care.	
Audit completed by:	Signed: Named Nurse for Safeguarding Children.	
	Date: 22.04.24	
	Time: 08.49	

Good practice

There is evidence of good practice throughout the admission. A referral to the On-call Consultant Paediatrician following concern highlighted within the GP practice is noted, resulting in a planned referral onto the children's ward. A thorough clerking record can be noted, which includes the pertinent birth trauma that baby suffered. The strategy meeting was embedded into the records following CHFT representation at the meeting, undertaken by the Consultant Paediatrician who attended at the time. Representation from Children's Social Care, Police, and Health can be noted at the Strategy meeting. The documentation throughout the admission is clear and there are regular updates recorded, including conversations with Social Care, parental engagement with staff, and their attachment with baby and the cares provided. Children's Social Care supported with parental supervision for visitation and were succinct in their efforts to locate an appropriate foster placement. This was further supported with an appropriate and planned discharge date. Clear multi-agency working can be demonstrated between the Acute Trust and Children's Social Care. The CHFT Safeguarding Team were also aware through the daily Sit Rep report and through visibility on the ward. The presentation was logged on SystmOne and shared with the 0-19 service as per process, the team also maintained oversight whilst baby remained an inpatient.

Learning points – Recording mode of transport to hospital would have been beneficial. This would help to ensure the safety of the patient whilst in transit to the acute Trust, and will mitigate and further risk to the child, and prevent the family becoming a flight risk.

There is an agreement that the allocated Social Worker provide a written update to the Safeguarding Team to ensure that these are recorded directly into the records, these are missing on this occasion. However, this agreement was made with Calderdale Children's Social Care and clarification from Kirklees needs to be established.

Appendix 2

Patient Story 1

A Patient was referred to Kirklees DRAMM following disclosure of domestic abuse to the Occupational Therapist.

CHFT IDVA carried out a joint visit with a social worker to review and support a safe discharge from hospital.

She is a victim of domestic abuse. She disclosed controlling and sexual abuse from her husband.

She reported she was 17 when she met him and was only 18 when they got married. She reported that she had endured abuse since then.

She disclosed sexual abuse and financial abuse. She confirmed there had been no strangulation or physical abuse.

She said she had been living in Kirklees for over 4 years but if she was to go out on her own, she would be lost as her husband has never allowed her to go out alone.

She said she did not wish to go back to home to her husband. She stated she was fearful and scared that abuse could become worse, and she no longer wanted to live with her husband.

The Social Worker who carried out a joint visit with the IDVA reported the woman did not have care needs and was independent so therefore there was no further role for her.

A referral was made to Housing solution for emergency accommodation, and into Staying Put in Bradford for emergency accommodation.

The IDVA informed Staff that the woman was waiting for safe accommodation and not to be discharged until somewhere safe is found.

Initially there was an offer for refuge through Staying Put but this was declined due to this being shared accommodation.

Further offer of accommodation was found through Kirklees Housing Solutions which was accepted and held until discharge was arranged.

The IDVA received a call from the ward before discharge as the woman was reporting to be anxious about going into emergency accommodation. The IDVA went to see the woman and provided reassurance around going into emergency accommodation. The woman felt better after this, and transport was arranged for discharge.

Following discharge, the IDVA contacted the woman and her daughter answered. After gaining consent from the woman, the IDVA spoke to her daughter for an update, they were requesting further financial assistance to this was referred to adult social care.

The daughter reported her mum was safe and that her husband made not attempted to contact them.

The daughter informed our IDVA that both her and mum were very thankful to her for regular updates and just checking up see how she was getting on.

Appendix 3

Patient Story 2

CHFT IDVA met a woman on Labour Ward who disclosed ongoing verbal, physical, financial, and coercive abuse from her husband and mother-in-law.

She stated she is frightened of her husband and his family because they have threatened to take her newborn away and send her back to Pakistan.

She has fled domestic abuse and was staying with another relative in Huddersfield, she reported she was unable to go back there as her husband and family have threatened her and her relative that they will kill them wand was fearful that her husband would find her.

The woman had entered UK on a spousal visa and therefore had no recourse to public funds.

The IDVA enquired with several housing/refuges for vacancies which was impacted by her immigration status made.

The ward was happy for mum and baby to remain in hospital until appropriate accommodation was found.

A DASH risk assessment was completed and assessed as high risk and with consent the abuse was reported to the police.

The IDVA liaised with the allocated social worker who was also searching for appropriate accommodation for both mum and the baby.

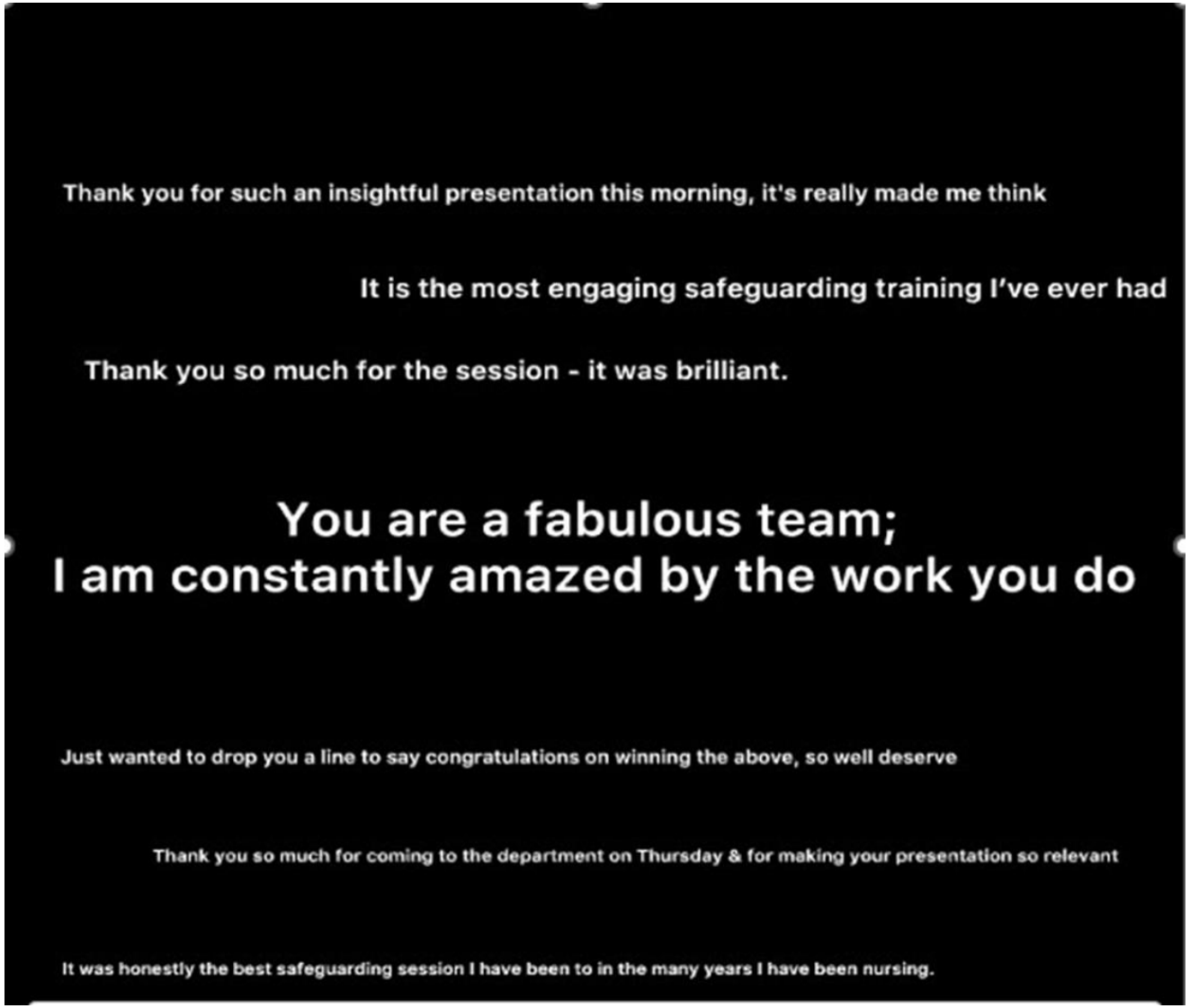
A refuge centre contacted the IDVA with a vacancy and the IDVA liaised with the woman and social worker and mum and baby were safely discharged from hospital.

Feedback from the woman to the IDVA was that she appreciated that she had been kept at every stage and that it was a quick outcome. She reported she felt safe and comfortable, staff at CHFT were wonderful, she recognised the good teamwork and most importantly she was able to communicate with me directly instead of using an interpreter.

Appendix 4


Supported over 6500 staff with safeguarding practice
Administrators supported the team for over 1000 hours
Researched 238 Claires Law applications
Applied for 262 DOLS extensions
NHS
Calderdale and Huddersfield
NHS Foundation Trust
Completed 2510 health searches for the DA panel
Recorded 108 cases of FGM
Sent over 300 feedback reports to the Local Authority
Completed 5 Safeguarding Children Reviews
1300 review health assessments
Attend over 150 hours of complex MDT/Strategy meetings
Delivered Adult level 3 training to 342 staff
Completed 1420 paediatric liaison referrals
Our year in facts and figures
Supported young people at the orange box for over 46 hours
Recruited 230 Safeguarding Champions Trust-wide
Completed 4 DHR Reviews
Completed 414 DOLS Applications
Attended over 220 hours in DRAM meetings
Completed 502 Safeguarding Adult referrals
Spent over 152 hours in meetings to support the prevention of Child Exploitation
2700 follow ups from Was Not Brought & background checks
684 hours spent on Initial Health assessments for looked after children
Our IDVA supported over 197 Domestic Abuse Victims
Delivered Children level 3 training to 310 staff
Completed 5 Serious Adult Reviews

Appendix 5


Thank you for such an insightful presentation this morning, it's really made me think
It is the most engaging safeguarding training I've ever had
Thank you so much for the session - it was brilliant.
You are a fabulous team;
I am constantly amazed by the work you do
Just wanted to drop you a line to say congratulations on winning the above, so well deserve
Thank you so much for coming to the department on Thursday & for making your presentation so relevant
It was honestly the best safeguarding session I have been to in the many years I have been nursing.

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Calderdale and Huddersfield
NHS Foundation Trust

Safeguarding Adults and Children Annual Report April 2023- March 2024

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NHS Foundation Trust

Partnership

- Significant progress with S42 feedbacks to the Local Authorities
- Work ongoing to address the gap in knowledge with the multi-agency Burns; Bruises and Scalds protocol in non-mobile infants
- Providing information and supporting the learning from multi-agency safeguarding reviews
- 23% increase in compliance with receipt and scrutiny training
- Multi-Agency Reflective Practice Session

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NHS Foundation Trust

Protection

- Progress is being made with our long-term actions following the JTAI relating to exploitation 2022
- Working towards the development of a non-fatal strangulation policy
- Data in relation to FGM supporting our response to improving outcomes for women and girls
- Prevent training
- BLOSM leading on developing our approach to trauma informed practice
- Children and Young People with mental health needs

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Accountability

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NHS Foundation Trust

- Audit of DoLS applications
- Slight decrease in MCA/ DoLS training compliance
- Decrease in Safeguarding Adults/ Safeguarding Children/ Safeguarding Supervision compliance
- Allegations of Abuse Against Staff Audit

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Empowerment

- Drug/ alcohol worker Calderdale
- Making safeguarding personal/ Child's voice
- Working Together to Safeguard Children

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NHS Foundation Trust

Prevention

- Introduction of homeless packs
- Difficulties in meeting the statutory timescales for IHA's in Kirklees/ Increasing complexity in children becoming looked after
- Challenges for CLA placed from external Local Authorities in Calderdale
- Consent health assessments (Calderdale)

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Proportionality

- Working group looking at our missing process with West Yorkshire Police
- Local missing children
- Least restrictive practice

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NHS Foundation Trust

Safeguarding is Everyone's Responsibility

STANDING ITEMS

5. Minutes of the previous meeting held on 2 May 2024

To Approve

Presented by Helen Hirst

Draft Minutes of the Public Board Meeting held on Thursday 2 May 2024 at 9.00 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
Andy Nelson (AN)	Non-Executive Director
Denise Sterling (DS)	Non-Executive Director
Vanessa Perrott (VP)	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
Andrea McCourt	Company Secretary
Amber Fox	Corporate Governance Manager *(minutes)*
Amanda McKie	Nurse Consultant Learning Disabilities **(for item 63/24)**
Dr Liaquat Ali	Guardian of Safe Working Hours **(for item 74/24)**
Rachel Westbourne	Public Health Lead **(for item 64/24)**
Claudia De'Vries	Project Manager, Health Inequalities **(for item 64/24)**
Gemma Puckett	Director of Midwifery and Women's Service **(for item 66/24)**

OBSERVERS

Christine Mills	Public Elected Governor
Katheryn Cullen	Shadow Board Member
Arley Byrne	Shadow Board Member
Laura Douglas	Shadow Board Member

56/24 Welcome and Introductions

The Chair welcomed everyone to the Board meeting held in public, in particular Vanessa Perrott was welcomed to her first Board meeting as Non-Executive Director. The Chair welcomed the presenters to the meeting.

Christine Mills, public elected governor was welcomed as an observer to the meeting and Katherine Cullen, Arley Byrne and Laura Douglas were in attendance from the Shadow Board.

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

57/24 Apologies for absence

Apologies were received from Tim Busby, Jo-Anne Wass and Krish Pilicudale.

Governor observers invited, Brian Moore, Peter Bamber and Pam Robinson sent their apologies.

58/24 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.

59/24 Minutes of the previous meeting held on 7 March 2024

The minutes of the previous meeting held on 7 March 2024 were approved as a correct record.

OUTCOME: The Board **APPROVED** the minutes from the previous meeting held on 7 March 2024 as a correct record.

60/24 Matters Arising and Action Log

The action log was reviewed and all actions were completed.

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

61/24 Chair's Report

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

OUTCOME: The Board **NOTED** the Chair's Report.

62/24 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 Chief Executive gave feedback from a national meeting with Chief Executives on 1 May where Amanda Pritchard, NHS Chief Executive, spoke about creating information for the public about the operating context and the future. He highlighted that his report noted the level of performance in the Trust against each of the constitutional standards which was consistently good. The key points noted were:

- Staff survey results are a measure of the work of our people.
- Clinical care delivered across the organisation every day speaks to our One Culture of Care and putting our patients first.
- Financial challenge of a forecast £38.6m deficit for 2024/25, reconfiguration will help mitigate the structural deficit, with confidence in our fiscal management given the Trust's achievements with significant financial deficits in previous years
- The importance of continuing to progress our strategic intent and role as an anchor partner – for example a Memorandum of Understanding with Kirklees College will be signed on behalf of the Trust.

The Chief Nurse shared positive news that the Trust has been accepted to roll out phase one of Martha's law.

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

STRATEGY: TRANSFORMING AND IMPROVING PATIENT CARE

63/24 Patient Story – Learning Disabilities

This item was taken before the Chair's Report and Chief Executive's Report.

The Director of Corporate Affairs introduced Amanda McKie, Consultant Nurse for Learning Disabilities, who was invited to present an update on Learning Disabilities alongside the Health Inequalities report. It was noted that the Trust had received a press enquiry regarding some of the Health Inequalities data in the Trust's Integrated Performance Report, which had been questioned as poor performance. Amanda McKie shared a presentation which highlighted and reminded the Board of what the data is telling us, the people behind the data and the importance of doing the right thing for the patient, which is not always conveyed in the data.

Amanda noted that the November 2023 national report of deaths of people with a Learning Disability (LeDer) highlighted 42% of deaths of people with a learning disability were avoidable,

people wait too long for tests and investigations and organisations systems and processes were the most common reported area of problems with care.

Amanda reminded the Board of the work undertaken during the Covid pandemic to prioritise care for patients with learning disabilities, supported by the Board and that the 18 week target for treatment had been met since October 2021.

Amanda described undertaking an audit of the cancer performance statistics in the health inequalities section of the Integrated Performance Report, as this identified a potential issue for learning disability patients at 28 days on the cancer pathway which dipped to 60% which may, at first, cause concern. She assured the Board that, following analysis, this was not a concern, rather the data reflected reasonable adjustments made for each learning disability patient, with a bespoke pathway to meet the patient's individual needs to ensure the same care outcome, such as the need for a side room and a general anaesthetic, putting the patient first.

Amanda informed the Board about how A&E care bags were supporting patients with learning disabilities whilst waiting in A&E. She reminded Board members of the Learning Disability week in 17-23 June 2024 with a theme 'Do you see me?' focusing on being seen, heard and valued, a positive message created by people with a learning disability to build a movement of change. Board members were invited to join Project Search on the hospital walk rounds.

The Chair and Board members thanked Amanda for her excellent, impactful presentation and confident understanding of the data. The Deputy Chief Executive highlighted Amanda's key contribution to the Health Inequalities Group and the Chief Nurse acknowledged how Amanda's work was influencing across West Yorkshire, echoed by the Chief Operating Officer, who also commented on Amanda's work raising the profile which has seen increased visibility in how learning disability patients have been managed through the Emergency Department and input to daily site meetings to discuss individual patient needs.

The Director of Corporate Affairs noted the presentation highlighted the need to avoid focussing on a target as there may be appropriate differentials for patients.

Discussion took place about reflecting the story in the IPR as it progresses and a plan to work with research to undertake a study on the data and undertake further improvement work). In terms of the next area of focus Amanda confirmed that bridging the gap and build the relationship between primary and secondary care to support patients together with improvements between moving secondary acute care and mental health care.

The Director of Workforce and OD commended the powerful, amazing work on this and asked how this great work is protected considering the financial and operational challenges. Amanda responded this is a challenge and a concern as providing this care comes at a financial cost; however, it is about the right thing to do.

The Chief Nurse explained the Trust has commissioned Audit Yorkshire to undertake an internal audit on the unplanned care pathway which will include primary care and re-admissions as there is a high rate of re-admissions with people with a learning disability. Findings will be presented to the Health Inequalities Group where the focus will be on qualitative improvement work.

VP expressed her interest in the interface with primary care and offered any help to support this. Amanda advised primary care has referral templates to flag learning disability as a reasonable adjustment and GPs are provided with top tips and advice.

In response to a question from the Chair about what progress Amanda would like to see in 12 months Amanda highlighted the key areas as the interface with primary care, identifying patients

from their outpatient journey, reviewing the recommendations from the internal audit report and uptake of the mandated learning disability training.

Amanda stated she would like the Board to hear more from the voices of people with a learning disability which the Chief Executive supported, noting this should be in an appropriate way for the patient group.

Action: Amanda McKie to share details of the learning disabilities week with the Board for support in the walk rounds.

OUTCOME: The Board **NOTED** the patient story on Learning Disabilities.

64/24 Health Inequalities Update

The Deputy Chief Executive introduced Rachel Westbourne and Claudia De'Vries who presented an update on the Trust's self-assessment against a guide from NHS Providers for Boards on reducing health inequalities. The key points noted were:

- Self-assessment tool has 25 questions and an assessment of the Trust's maturity rating and progress in four domains (not started, emerging, developing, maturing or thriving was):
    1. Building public health capacity and capability – developing
    2. Data, insight and evidence – maturing
    3. Strategic leadership and accountability – thriving
    4. System partnerships – thriving
- The Trust achieve a high level of maturity and are making good progress across all domains assessed in the tool / guidance.
- The Trust is particularly strong on leadership and strategy, quality improvement work in patient pathways, and use of data and intelligence.
- Opportunities for further development include further training and development on health inequalities for Board members and across the workforce, further developing public health capacity, routinely including ethnicity as part of performance reporting on health inequalities and review how consideration of health inequalities is embedded in decision making and resource allocation across the Trust.
- A simplified and concise reporting to enable monitoring of health inequalities and provide a snapshot on key metrics (such as A&E 4 hour targets, missed appointments, cancer diagnostics) was presented and will be included in quarterly reporting to Board. The IPR will include reporting on ethnicity in specific areas.

Discussion took place on:

- the Trust has been performing strongly and was reviewing where it could go further.
- retaining focus (PW) given the large number of metrics - the Deputy Chief Executive confirmed the Trust will continue to focus on and refresh the Health Inequalities Strategy.
- supporting new colleagues with Maths and English GCSEs to support career progression.
- developing public health capacity and mainstreaming this into clinical practice (DS) – through clinical and professional strategies and consideration of a shared outward facing leadership post across Calderdale, Kirklees and Wakefield.
- data - a request for more qualitative information on the dashboard to help flag inequity (AN), alongside SPC charts having an option to include narrative to support where missing a target is appropriate (NB) and opportunities for data sharing between public health and local authorities (Chief Digital and Information Officer).

Laura Douglas from Shadow Board stated they would like to see inequalities data in the Integrated Performance Report as business as usual, rather than a standalone report.

OUTCOME: The Board **NOTED** the update on progress on action against the Health Inequalities Strategy, **APPROVED** the review of the Trust's position in relation to the NHS Providers Guide on Reducing Health Inequalities and **APPROVED** the proposed IPR snapshot for health inequalities.

INTEGRATED PERFORMANCE

65/24 Quality Committee Chair Highlight Report

DS presented the Chair's highlight report from the Quality Committee meetings of 11 March and 8 April 2024.

The Learning from Deaths quarter 3 report was received and evidences the best performance since the reviews began.

OUTCOME: The Board **NOTED** the contents of the Quality Committee highlight report.

66/24 Maternity and Neonatal Oversight Report

Gemma Puckett, Director of Midwifery and Women's Services joined the meeting to present the Maternity and Neonatal Oversight report. The key points to note were:

- One year into the three year plan which launched last year which provides a vision and strategy for maternity services
- The Trust is compliant with year five of the maternity incentive scheme which is positive news, focus is now on year 6 which was published in April and will report next March 2025
- Regulatory inspections – CQC reviewed governance which were rated as 'good' overall.
- LSMS (in full) have a dashboard that can break down to ward level
- Campaign currently taking place across WYAAT to access a midwife early.
- Systems development to peer support and assess each other and review governance and opportunities for learning and working together.
- Patient experience – embedding lived experience in forums with members of the public attending Maternity and Neonatal Board from different ethnic backgrounds.
- Workforce remains challenging for midwifery, with good mitigations in place, lots of great effort in recruitment with just over 30 whole time equivalents join midwifery.
- Two outputs from university which help with intakes twice a year and are aiming to recruit a minimum of 35 midwives over the next 12 months.
- Focus on refreshing the recruitment and retention plan in midwifery.
- Neonatal unit have very limited vacancies and do well in terms of retention and learning will be applied.
- Changes in neonatal cot capacity across the region and the changes in activity will be reviewed to assess the impact. CHFT are one of the three bigger level 2 units in the region.
- Obstetrics recruited a new consultant and locum consultant and gone back to advert with applications received from outside of the region.

The Chair asked what the key areas of focus are. The Director of Midwifery responded the three areas were governance, ensuring learning is taking place and meaningful action to strengthen this, fixing the workforce with the national shortage of midwives and encouraging people to work in maternity.

DS asked if the Trust have accessed any of the ongoing funding from NHS England for recruitment and retention. The Director of Midwifery confirmed the Trust have accessed the funding and used it on a recruitment and retention lead midwife and want to focus on strengthening the pastoral element for existing staff and better offer on wellbeing and career development.

AN, as the interim Maternity Champion, asked for an update on the impact of staff requesting reduced hours on the staffing model. The Director of Workforce and OD and Chief Nurse commented on the challenges of equity of flexible working for all professions.

VP, Maternity Champion stated it would be helpful to have a health inequalities process map to focus on where we can make a difference and asked if any Trust has a model that works. The Director of Midwifery responded there is not a model, and a wider conversation is required nationally. She explained different models are not directly transferable to maternity. The Chief Nurse responded they review this locally and make it bespoke to the service.

The Chief Executive asked the Quality Committee to review maternity incidents as well as training compliance.

Action: DS to review maternity incidents at Quality Committee as well as training compliance.

The Chief Executive asked the Director of Midwifery what three things she was focused on and what she is most proud of. The Director of Midwifery responded:

1. Reducing the stillbirth rate with the gap in health inequalities.
2. Workforce retention and supporting staff.
3. Patient experience to listen and accept feedback.

The Director of Midwifery shared she is most proud of her team, their resilience under pressure and how they support each other.

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

67/24 Workforce Committee Chair's Highlight Report

NB presented the Chair's highlight report from the Workforce Committee meeting of 19 February 2024 and noted discussion of the staff survey and approaches from divisions, progress with workforce metrics and a deep dive into the health and well-being Board Assurance Framework risk.

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

68/24 Finance and Performance Committee Chair's Highlight Report

AN presented the Finance and Performance Committee Chair's highlight report for the meetings held on 26 March and 30 April 2024. He drew attention to the strong performance across the Trust, shared feedback from a deep dive on ENT performance and shared the 2024/25 focus on cost efficiency, specifically band and agency expenditure and headcount.

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

69/24 Month 12 Financial Summary

The Director of Finance presented the financial position as reported at Month 12, the key points to note were:

- Reporting a 2023/24 year end deficit position of £13.24m following negotiation of additional monies, with the year-end position improved by £7.5m.
- Agency expenditure for the year was lower than the agency ceiling.
- Capital monies (approx. £50m) were spent in year.
- Majority of invoices paid within required period.
- Challenging year ahead; however, the Trust have a track record of delivering the plan.

The Director of Corporate Affairs stated communications to colleagues have thanked them for their performance and shared the key messages on the Trust's financial position which will be challenging moving forward.

The Chair noted the importance of understanding the impact of decisions, for example on quality and the Chief Nurse advised that quality and equality impact assessments was a key part of efficiency work.

OUTCOME: The Board **NOTED** the Month 12 Financial position for the Trust as at 31 March 2024.

70/24 Audit and Risk Committee Chair Highlight Report

NB presented the Audit and Risk Committee Chair's highlight report for the meeting of 23 April 2024 and noted that all recommendations from internal audit reports had been completed by the year end and positive assurance had been received for business continuity systems.

AN commented on the improved governance structure in the Emergency Preparedness Resilience and Response (EPRR) Annual Report. AN highlighted exercises have been a challenge for years and the multi-agency exercise was encouraging to see.

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

71/24 Integrated Performance Report

The Chief Operating Officer presented the Integrated Performance Report for March 2024. The key points noted were:

- Considerable effort from teams had led to the Trust meeting the 76% 4-hour Emergency Care Standard (ECS) performance target for March (76.79% performance placed the Trust 6 /119 Trusts for type 1 Emergency Department (ED) attendances), with continuation of actions that had made a difference, such as regular weekly meetings with the core team.
- High demand seen in April and start of May 2024 remains challenging.
- Emergency Department senior medical input has made a difference with consultant support into the evenings.
- Elective performance has been great – there is a stretch target to undertake additional transformational work to push on what can be achieved and support mutual aid.
- Learning from improvement work in theatres being applied to outpatients and how to manage follow up backlogs.
- Cancer performance has been excellent throughout the year and has been recognised nationally in the media, with the ambition to maintain this performance.

The Chair raised concerns from governors previously that the stretch target for elective performance to support mutual aid across West Yorkshire could adversely impact on our waiting times for patients in Calderdale and Kirklees. The Chief Operating Officer responded the additional stretch will reduce waiting times even further for our local population, maximising activity undertaken during the week to free up capacity for mutual aid on the weekend.

The Chief Nurse highlighted the position on the infection prevention control (IPC) metrics and focus work next year given some breaches. The Medical Director confirmed the IPC metrics have been discussed at Quality Committee and these are sporadic cases; however, the Trust was not unique in this and was undertaking some focused work to reduce these numbers.

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

72/24 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:

- Top risk related to the ED and risk of reduction in patient experience and quality outcomes due to the operational performance.
- Limited assurance report was issued from internal audit on risk management with a follow up on completed actions and deep dive to Audit and Risk Committee in October 2024, 90% of this relates to the new risk management system which should be embedded by then with risk being one of the first modules to go live.
- Appointed a new Head of Risk and Compliance which has already started to make a difference with risk management in divisions and is also responsible for CQC compliance.

AN referred to the triangulation of risks and how these are covered, such as appointment slot issues and transfer of care (TOC). The Director of Corporate Affairs responded as some of the risks were strategic they fall under the Board Assurance Framework, for example transfer of care (TOC). The Chief Operating Officer responded they are looking into how to triangulate information more effectively to provide a combined narrative and are in discussions with the Chief Digital and Information Officer's team about how to do this on a weekly basis from the data in Knowledge Portal+.

AN asked if the Trust had a mechanism of identifying the risks that have materialised and are being dealt with as key issues. The Director of Corporate Affairs confirmed there is a process of monitoring risks that have become an issue; however, it is delayed and there is ongoing work with the operational teams to close risks once it has occurred.

Arley Byrne from Shadow Board provided feedback on the process and how they felt the performance and quality perspective does not seem linked, for example, how the quality work has impacted on performance. The Chair acknowledged the work to try streamline Committees to avoid duplication of work and asked the Shadow Board to think about how this could be improved. AN added it is about how to balance and not duplicate Committees who are reviewing the metrics from a different lens.

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

A WORKFORCE FOR THE FUTURE

73/24 **Staff Survey Results and Action Plan**

The Director of Workforce and OD presented the results from the 2023 staff survey, noting the People heat map within the Trust also provides intelligence about our workforce. Key findings noted were:

- The Trust has seen an increase in its score in six out of seven People Promise themes when compared to scores in 2022, the score in one theme has stayed the same.
- The Trust's colleague engagement and colleague morale scores have increased.
- The Trust's engagement score is at its highest since 2016.
- A number of the targets are used to assess whether the Trust are achieving the People Strategy – which includes turnover, absence, and staff survey.
- Work underway on context and understanding data through stories and what might be impacting colleagues outside of work impacting on performance, absence.

- Analysis underway to assess if high performing staff survey results map across to high performing Trusts.
- Health and wellbeing and staff feeling confident to raise concerns has decreased since last year; however, is still above the average – one of the high impact actions is to reflect what colleagues see as good health and wellbeing.
- Equality, diversity and inclusion perspective – still work to do with younger colleagues, disability colleagues, LGBQT colleagues; however, a great improvement and engagement from BAME colleagues.
- Hot spot areas have been assigned an Executive Sponsor, an approach which saw an improvements last year.
- Started work on the sexual safety charter which will commence in June 2024 with a podcast from the Chief Executive and one of the Clinical Directors, questions about sexual safety appeared for the first time in the staff survey.
- Five high impact areas are: people centred leadership and development programme, continue to embed the health and wellbeing offer, create a learning organisation ensuring we have development opportunities for all, create a sense of team togetherness at CHFT and robust people 'hot spot' support.
- For 2024/25 divisions will take on more ownership of the staff survey.

The Chair highlighted it was positive to see the improvement and from a West Yorkshire perspective there are no significant outliers.

AN asked what the Trust have done to understand the younger age group. The Director of Workforce and OD responded a Youth Forum is being set up with networks with Kirklees Council.

AN asked what workforce involvement has there been in the actions developed. The Director of Workforce and OD responded the actions are derived from the data from the staff survey and the commentary. These are reviewed in engagement events such as hot houses with Divisions.

Katheryn Cullen from Shadow Board shared they were pleased to see positive results and highlighted one of the areas that did not do so well was on appraisals and setting personal objectives. She asked how the Trust will maintain or see an improvement next year in the current financial challenges and vacancy controls. The Director of Workforce and OD responded the key is to involve staff in this and Divisions will review and prioritise their vacancies. The appraisal focus had been on compliance and the Trust was doing well in comparison to others. The key is to have a good conversation and give time for staff to be heard. The Chair asked the Shadow Board if they have any ideas or suggestions in terms of how the Trust make sure the challenging environment does not have an adverse impact on the staff survey.

VP queried whether presenteeism was looked at and the Director of Workforce and OD responded that currently this was not tracked, however, it could be reviewed.

DS asked if there were any links seen from the higher engagement levels to benefits in productivity or improvement in patient outcomes. The Director of Workforce and OD responded turnover, staff absence, strong operational performance, and strong response to the staff survey were key but narrative was needed to help demonstrate this link.

The Chief Nurse responded there have been three positive national inpatient surveys and, based on the previous staff survey and time period, it is well researched, that this improvement impacts on patient care, with happy staff meaning happy patients.

OUTCOME: The Board **NOTED** the contents of the paper including the response to the results of the 2023 staff survey.

KEEPING THE BASE SAFE

74/24 Guardian of Safe Working Hours Annual Report

Dr Liaquat Ali presented the Guardian of Safe Working Hours Annual Report. The key points to note were:

- 120 exception reports over a period of a year from 1st of April 2023 to 31st March 2024
- Significant numbers of reports were submitted from August to November than rest of year; this is probably due to combination of winter pressure, increased workload and change over during August.
- Almost 80% related to extra hours of working.
- Fourteen exception reports were relating to immediate patient safety issues.
- Substantial numbers of reports were initiated by FY1 doctors which 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.
- Industrial action – almost 90% of junior doctors went on strike during this time.
- Junior Doctors Forum takes place each quarter, chaired by the Deputy Medical Director, the most recent meeting discussed availability of accommodation for colleagues finishing on a late shift.

VP highlighted the encouraging reporting and high numbers could reflect a good culture and are not necessarily a problem, she noted there were higher numbers of reports in general medicine.

DS highlighted it has been a challenging year in industrial action and asked if there were any issues in the wellbeing of the doctors raised in the Junior Doctors Forum. Dr Liaquat Ali responded no concerns were raised at the forum or through exception reports. The Medical Director confirmed they have not heard any concerns from the LMC in terms of mental health and the concerns are related to workload pressures due to extra capacity. The early exception reports relate to new junior doctors who are still gaining experience to manage their workload and seek support from colleagues.

OUTCOME: The Board **NOTED** the Guardian of Safe Working Hours Annual Report covering the period 1 April 2023 – 31 March 2024.

75/24 Fire Strategy Progress Report

The Chief Operating Officer presented an update on the progress of the Fire Strategy in place which captures the recommendations made by Mott MacDonald which informed the Strategy.

Only ten actions (out of 101 actions) were still being progressed raised from the recommendations across all premises, with 90.1% of actions completed. The risks and mitigations of the outstanding actions were highlighted in the report.

OUTCOME: The Board **NOTED** and endorsed the content of the report and continued its support for the Fire Strategy implementation.

76/24 Governance Report

The Company Secretary presented the Governance report which contained:

a. Compliance with the Trust's Provider Licence conditions

The self-certification documents which confirm the Trust's compliance with governance (FT4) and the provider license condition G6(3) was presented for approval.

b. Amendment to the Trust Constitution

A minor change to section 18.3 of the Constitution which allows for any governor to become a lead governor was presented. This was approved at the Council of Governors and aligns with the Code of Governance for NHS Provider Trusts which came into effect on 1 April 2023.

c. Committee Arrangements

The Board Committee membership, frequency and Chair arrangements was presented for information. The Board champion roles were confirmed.

d. Board of Director Attendance Register 2023/24

The Board attendance register for 2023/24 was presented for approval.

e. Board Workplan for 2024 – 2025

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

OUTCOME: The Board **APPROVED** the content of the self-certification documents for the signature of declarations for 2023/24, amendments to the Trust Constitution, Board Attendance Register for 2023/24 and Board Workplan for 2024/25 and **NOTED** the Committee arrangements.

77/24 Items to receive and note

The following minutes were provided for assurance:

- Finance and Performance Committee – 27.02.24
- Quality Committee – 11.03.24
- Workforce Committee – 19.02.24

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.

78/24 Any Other Business

Christine Mills, public elected governor thanked everyone for her six years as a governor, explaining this past 18 months has been challenging; however, staff have encouraged her to remain a governor. She thanked everyone for their patience and explained she has learnt a lot from the role. The Chair thanked Christine for her impactful change as a public elected governor.

The Chair formally thanked Andy Nelson as he comes to the end of his tenure at the end of May. Andy has been a well serving and extremely effective Non-Executive Director for the past 6.5 years.

79/24 Date and time of next meeting

The Chair formally thanked the Board of Directors, colleagues and governors for their attendance and closed the meeting at approximately 12 pm.

Date: Thursday 4 July 2024
Time: 9.00 am – 12:00 pm
Venue: Boardroom, Huddersfield Royal Infirmary

6. Matters Arising and Action Log

To Note

Presented by Helen Hirst

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC) 2024

Position as at: 26.06.24

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
63/24 02.05.24	Amanda McKie to share details of the learning disabilities week with the Board for support in the walk rounds.	Amanda McKie	The walkrounds at both hospitals during Learning Disabilities week are taking place on Tuesday 18th June at Calderdale Royal, and Thursday 20th June at HRI. A spreadsheet of Board availability is being co-ordinated for the visits.	04.07.24		14.05.24
66/24 02.05.24	**Maternity and Neonatal Oversight Report** DS to review maternity incidents at Quality Committee as well as training compliance.	Denise Sterling	A review of the maternity and neonatal incidents and training compliance took place at the 3 June Quality Committee.	04.07.24		25.06.24

7. Chair’s Report including Charitable Funds Committee Annual Report 2023/24

To Note

Presented by Helen Hirst

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 4 July 2024
Meeting:	Board of Directors
Title:	Chair's Update
Author:	Helen Hirst, Chair
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.
Regulation	Regulation 17: Good governance
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. The Board is asked to **RECEIVE** the Annual Report from the Charitable Funds Committee.

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

We held a Council of Governors meeting at the end of April (which was too late for inclusion in the last Chair's report) and as well as the routine items of business had a great presentation from Lis Street, Clinical Director about the Pharmacy Robot.

Appointment and election of new governors has continued. We held two open sessions for prospective governors. Around 15 people attended from across Kirklees and Calderdale. By the beginning of July we should be in a position to know who all our governors are for the next three years. There will be a thank you lunch on 17 July for those governors who are leaving and all Board members are welcome to call in and say goodbye.

I would like to thank the following governors who have either come to the end of their terms or chosen to step back at this time.

<u>Public Elected Governors:</u>

- Brian Moore – Lindley and the Valleys
- Peter Bamber – Calder and Ryburn Valleys
- Gina Choy – Calder and Ryburn Valleys
- Christine Mills – Huddersfield Central
- Diane Cothey – Skircoat and Lower Calder Valley

<u>Staff Elected Governors:</u>

- Sandeep Goyal – Drs/Dentists
- Jo Kitchen – Ancillary
- Liam Stout – Nurses/Midwives

Public governors undertake these roles on an entirely voluntary basis and I am very grateful for the enthusiasm and effort they have all put in to ensure our Council of Governors works effectively for the benefit of the patients we serve.

Board business

The highlight of this last month has to be the opening of the new A&E Department in Huddersfield. The actual opening and transfer from old to new went smoothly. Along with a number of volunteers, including other Board members, it was great to be part of the team and see first-hand how well the transition was planned and executed down to the smallest detail. The sun shone for about five minutes to allow for the official opening of the new department alongside the opening of the new Wellbeing Garden at HRI which has been

made possible through the CHFT Charity. It was lovely to see former Board members attend as well as past and present colleagues.

The Board has had a number of briefings and extra-ordinary meetings to sign off the financial plans for 2024/25. This will be covered further in the financial reports to the Board.

The annual appraisal process for me and the non-executives has to be completed by the end of June each year. All appraisals have been completed and will be reported through the Council of Governors. We have considered the new NHS Leadership Competency Framework in those discussions as well as reviewing each of the non-executive's annual objectives.

Along with Denise Sterling, Jo Wass and executive directors on the Board, I attended the Trust's Expanding Research conference at the end of May. It was a great opportunity to meet people from across the Trust I hadn't met before and gain some insight into their roles and challenges. The research activity being undertaken within the Trust was impressive.

Following the excellent Learning Disabilities presentation at the last Board, I was keen to get more involved in Learning Disabilities Week in the Trust. I joined Project Search interns together with Amanda McKie, Nurse Consultant and Jill Priestley, Transition Clinical Nurse Specialist for Neuro Disability to visit a lot of departments in the Trust to raise awareness of learning disabilities over two days. I met colleagues in roles who I hadn't come across before like play co-ordinators on the Paediatric ward and was overwhelmed by just how busy the stroke ward was and the scale of the multi-disciplinary team in action. It was great to hear the success stories of Project Search interns – some were in the recruitment process for jobs in the Trust, others had secured a job or an apprenticeship.

We said a final goodbye to Andy Nelson this last month. Andy agreed to stay on an additional few weeks to facilitate a smooth handover to Vanessa Perrott and he and I enjoyed a goodbye chat and coffee. Krish Pilicudale has also come to the end of his placement with us on the Non-Executive Director Insight Programme and he moves onto his next Board placement from October. Thank you again to both of them for their contributions.

Charitable Funds Committee

Following the review undertaken by Gifted Philanthropy and the refresh of the branding the Committee took a look at the future plans at its last meeting. Hopefully colleagues will have spotted significant activity at the beginning of June as Amazing in Action week relaunched the charity and its plans for the future. This included a significant social media campaign and a flag raising at CRH and HRI. The Committee signed off a high-level plan to supporting the Trust Children and Young People's Strategy and future engagement with reconfiguration at CRH. The team has seen some small changes including the transfer of the volunteer co-ordinator into the team.

The Committee signed off its Annual Report for 2023/24 which is appended to this report for presentation to the Board.

2. Health and Care System

WYAAT Committee in Common held at the end of April. Keith Ramsey, Chair at Mid Yorkshire has now taken over the Chair from me. As well as our usual programme updates and reports we had a specific focus on productivity and efficiency. We were joined for part of the meeting by Rob Webster and Cathy Elliot, CEO and Chair from West Yorkshire ICB.

West Yorkshire Chairs and Leaders forum met in May discussing the financial and operational planning arrangements. Unfortunately, I missed the June meeting about climate change. I also attended the West Yorkshire NHS Chairs forum, led by Cathy Elliot, this month which is a general catch up type of meeting.

At Yorkshire and Humber Chairs, organised by Dame Linda Pollard, who puts together an excellent agenda for us, we were joined by the CQC discussing the new assessment framework, NHSE sharing an update on Talent Management in our region and NHS Providers updating on the national picture. It was Richard Barker's last meeting with us as Regional Director as he retires at the end June. In my view, Richard has been an outstanding Regional Director and we will all miss him but wish him well.

Calderdale Cares Partnership Board meeting at the end of May concentrated on General Practice in Calderdale. A group of GP Leaders took us through the challenges and opportunities facing general practice and shared some excellent examples of collaborative work and preventative healthcare. The papers for this meeting are in the public domain.

Helen Hirst
Chair
21 June 2024

Charitable Funds Committee

Annual Report 2023/24

1 April 2023 – 31 March 2024

Charitable Funds Committee Annual Report 2023-24

This annual report of the Charitable Funds Committee for 1 April 2023 to 31 March 2024 details:

- The role of the Charitable Funds Committee, including membership and attendance
- The activities of the Charitable Funds Committee set out in the Charity Strategy and the duties within the Terms of Reference.

1. Role of the Charitable Funds Committee

The Charitable Funds Committee has been formally established to manage the Charitable Funds on behalf of the Trust Board, who is the Corporate Trustee, and provide assurance to the Trust Board regarding any activities undertaken by the Charity.

1.1 Introduction

This Annual Report sets out how the Charitable Funds Committee has met its Terms of Reference during the financial year and the Committee's activities from April 2023 to March 2024. In line with best practice, the Charitable Funds Committee annual reports will be presented to the Audit and Risk Committee rather than the Board.

After each meeting the Chair escalates those matters that the Charitable Funds Committee considers should be drawn to the attention of the Board via a Chair's Highlight Report. The minutes of the Committee's proceedings are shared at the next meeting of the Trust Board.

1.2 Terms of Reference

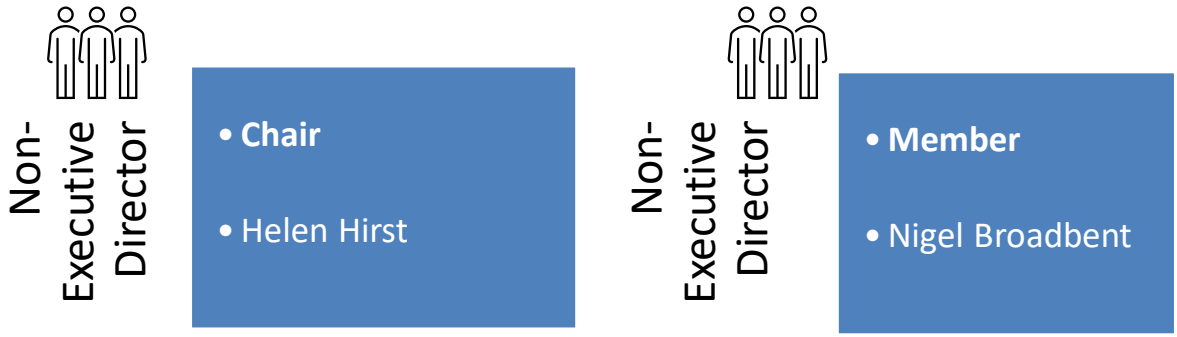
The Committee approved its updated terms of reference on 9 August 2023 with ratification by the Board on 7 September 2023. The Committee meets on a quarterly basis, February, May, August and November.

The Charitable Funds Committee has a well-established workplan which sets out its annual cycle of work and reporting which is regularly reviewed.

1.3 Charitable Funds Committee Membership and Attendance in 2023/24

The Charitable Funds Committee met four times during 2023/24: 10 May, 9 August, 14 November and 6 February 2024.

Membership of the Committee is made up of the Chair of the Board (Chair of the Committee), up to two Non-Executive Directors, Director of Nursing, Medical Director, Director of Finance, Chief Operating Officer, Council of Governors representative and a member of the steering sub-group, or their named deputies.



The quoracy of the Charitable Funds Committee is three members of the Committee, including at least one Non-Executive Director and one officer member and at least one clinician. All meetings were quorate. A Council of Governors representative is a member of the Charitable Funds Committee. A register of attendance by members and those invited to attend during 23/24 is shown at Appendix 1.

The following were in regular attendance at the Charitable Funds Committee meetings during the year:

- Gary Boothby, Director of Finance / Kirsty Archer, Director of Finance (joint role)
- Victoria Pickles, Director of Corporate Affairs
- Emma Kovaleski, Charity Manager
- Lindsay Rudge, Chief Nurse
- David Birkenhead, Medical Director
- Carol Harrison, Charitable Funds Manager
- Zoe Quarmby, Assistant Director of Finance – Financial Control
- Lyn Walsh, Finance Manager
- Jonathan Hammond, Chief Operating Officer or Helen Rees, Deputy

The following also attended for specific items:

- Zoe Quarmby, Assistant Director of Finance – Financial Control for the annual accounts 2022/23
- Richard Lee, KPMG – for the annual accounts 2022/23
- Sanna Samateh, Charitable Finance Officer
- The Committee may request other staff to attend the meetings to present on matters included on the agenda, such as requests for support in funding/fundraising.

Due to a governor resignation, the Charitable Funds Committee did not have a Council of Governors representative on the Committee from 18 October 2023.

2. Charitable Funds Committee Activities 2023/24

The duties of the Charitable Funds Committee as set out in its Terms of Reference are that the Committee will:

- ensure that Charitable Funds expenditure is approved in line with the Trust's Scheme of Delegation and Standing Financial Instructions.
- update and maintain charitable fund policies and procedures in accordance with Charity Commissioning guidance.
- receive and review regular reports on charitable fund income and expenditure and on the investment of the charity's funds.
- ensure that the Trust's charitable funds are established and operated in accordance with relevant law.
- approve the establishment of new designated funds and the closure of any funds on behalf of the Trustee.
- ensure that audited accounts are completed, submitted to the Charity Commission and made available to the public.
- approve the Charity's Strategy and Annual Plan.
- approve spend of funds above £10,000 and up to £50,000 in line with delegated limits.

The principal activities of the Charitable Funds Committee during 2023/24 are detailed below.

Charitable Funds Committee - 10 May 2023

- The Committee received an insightful presentation about the Pre-Bereavement Project by the palliative care team which was funded by the Charity's Palliative Care fund.
- The Charity had been chosen as one of two charities for the Kirklees Mayoral year. This provided a great opportunity for fundraising and the profile of the Charity.
- The Committee received assurance from the Charity Manager about the lessons learned during the last year.
- The finance report and the annual accounts were reviewed.

- The Committee agreed to fund the Bereavement Support Service for a further six months with the provision that there is a review about the long term sustainability of this service.
- Committee terms of reference were reviewed, in particular the membership which came back to a future meeting for approval.

Charitable Funds Committee – 9 August 2023

- The Committee received a thorough report from the Charity Manager about the development of a new brand identify, refresh of the strategy for the charity and activity undertaken during the first quarter in respect of both grants and fundraising.
- The finance report was reviewed with particular attention on unspent allocated resources and the approach the Charity should take. The Committee confirmed that it continued to support the investment approach to invest in an ethical portfolio.
- The revised terms of reference were agreed by the Committee and approved by the Board on 9 August 2023.
- The Charity went through a reset of its strategy and approach. This follows three years of Covid and beyond where the approach was reactive and operational. To complement the revised strategy there was a review of the branding of the Charity. The colour scheme of the branding will remain orange and yellow but the key message of the brand will be about positivity and making an amazing different to those we are here for – colleagues and patients.

Charitable Funds Committee – 14 November 2023

- The Committee signed off the Annual Accounts which had been subject to audit and included the management letter from KPMG. No risks were identified, no audit adjustments made, and no recommendations were brought to the attention of the Committee.
- The accounts, letter of representation and management letter were uploaded to the Charity Commission site by year end.
- There was approval to update the Scheme of Delegation to include a Charitable Assurance Committee that would scrutinise and recommend funding requests above £5k following learning from other NHS Charities.
- Charity team roles were reviewed.

Charitable Funds Committee – 6 February 2024

- The Committee received a thorough report from the Charity Manager about the progress of the strategy and the different fundraising initiatives including £35k for orthopaedic outpatients, £15k to enhance in patient experience for patients within child and adolescent mental health services and £2k for dementia support in A&E at Calderdale.
- The Charity Manager confirmed that operationally they were stronger than ever before at the end of the year.
- The majority of KPIs were on track and several fall in line with the development grant and plans to re-launch the charity in May 2024.
- The Committee heard about the Childrens' Diabetic Nursing Fund, fundraising methods and areas of spend.
- The Committee considered funding request processes and the expectations of the Committee to ensure evidence of impact was included in the decision making. The Committee discussed and invited further consideration of the bidding process ensuring this went beyond 'first come first served'.
- The Committee continues to review former approvals that have not been fully utilised.
- The Committee agreed to ensure that where posts are funded that an exit plan is in place.
- The Charity is going to develop a different finance and activity report going forward working to an agreed budget.
- The Committee was expecting to receive the outputs from the review of the charity from the company called Gifted Philanthropy.
- The League of Friends at CRH are working with the Charity to transfer their charitable funds subject to appropriate governance and approvals with regard to draw down.
- The Trust is considering future arrangements for the annual audit of the charity's annual report and accounts.
- In line with the brand refresh and operational changes being made, CHFT Strategy will be rolling out a new Scheme of Delegation from 1st April 2024.

Charity Manager's Report
The Committee received assurance during the year via the written Charity Manager Reports which showcase the outputs of the charity activity (fundraising, marketing and operations) against agreed KPI's and deliverables. The Charity Manager's Report includes:

- Progress on KPIs
- Progress on the Charity Strategy
- CHFT Charity's Impact
- Planning for the future
- Governance and development.

Staff Lottery Committee
Minutes and any items escalated by the Staff Lottery Committee are received at each meeting for assurance.

Fundraising/Funding Requests
At each meeting, the Committee reviewed any fundraising requests and a new system to manage fundraising applications have been implemented. These included:

- Funding the Bereavement Service for a further 6 months to support bereaved families and improve end of life care on our wards.
- £35k to enhance the experience of children and young people who visit the Orthopaedic Outpatients department at HRI.
- £15k to enhance the inpatient experience for patients who require Child and Adolescent Mental Health Services (CAMHS patients)
- £2k for dementia support to enhance the waiting area and one dedicated cubicle in the A&E at CRH.
- A&E care bags that had been an impactful project the Charity committed to previously for children, young people and adults with Learning Disabilities/Autism who find waiting in A&E difficult.

Gifted Philanthropy
As part of the NHS Charities development grant, Gifted Philanthropy were procured during 2023/24 to conduct a feasibility study for CHFT Charity to look at what the potential is and what the future plans look like. Regular updates on the feasibility study were provided to the Charitable Funds Committee. A longer term fundraising strategy is being developed for 2024/25.

3. Review of Committee Effectiveness

The Committee conducted a self-assessment exercise during February - March 2024 to gauge the Committee's effectiveness by taking the views of Committee members and attendees across themes. The outcome of this is then reviewed by the Committee and an action plan developed using the results of the self-assessment surveys and monitored by the Committee. The self-assessment exercise outcome was shared at the meeting on 7 May 2024 and an action plan agreed for the Committee.

4. Conclusion

As described above, the Charitable Funds Committee has received assurance through the course of 2023/24 and has reported to the Board after each of its meetings by presenting a Highlight Report of the key discussion items. The report is presented by the Chair of the Charitable Funds Committee and the minutes of each meeting are shared with the Board.

The Charitable Funds Committee is therefore of the opinion that the Committee has fulfilled its role of providing assurance to the Board during 2023/24 with its role as set out within the Terms of Reference.

Helen Hirst, Chair
Charitable Funds Committee Chair

May 2024

Attendance	✓	Apologies	×	Not invited /in post

APPENDIX 1

CHARITABLE FUNDS COMMITTEE ATTENDANCE REGISTER - 1 APRIL 2023 – 31 MARCH 2024

Member	10.05.23	09.08.23	14.11.23	06.02.24	TOTAL
Helen Hirst, Chair	✓	✓	✓	✓	4 / 4
Nigel Broadbent Non-Executive Director	✓	✓	✓	✓	4 / 4
In Attendance					
Gary Boothby, Director of Finance		×	✓	✓	3/4
Kirsty Archer, Assistant Director of Finance	✓	×			
Zoe Quarmby, Assistant Director of Finance	✓	✓	✓	✓	4/4
Lyn Walsh, Finance Manager	✓				1/1
David Birkenhead, Medical Director	×	✓	×	✓	2/4
Lindsay Rudge, Chief Nurse	×	✓	✓	✓	3/4
Victoria Pickles, Director of Corporate Affairs	✓	✓	✓	✓	4/4
Emma Kovaleski, Charity Manager	✓	✓	✓	✓	4/4
Jonathan Hammond, Chief Operating Officer			×	✓ (Deputy)	1/2
Carol Harrison, Charitable Funds Manager	✓	✓			2/2

8. Chief Executive’s Report

To Note

Presented by Brendan Brown

Date of Meeting:	Thursday 4 July 2024
Meeting:	Public Meeting of the Trust Board
Title of report:	Chief Executive's Report
Author:	Victoria Pickles, Director of Corporate Affairs
Sponsor:	Brendan Brown, Chief Executive
Previous Forums:	None
Purpose of the Report	This report provides a focused update on the Trust's response to specific elements of its service delivery and the evolving health and care landscape.
Key Points to Note	• The current political and economic climate means there is uncertainty in the NHS. • Increasing demand for NHS services has meant that performance, particularly in emergency care has been challenging. • The Trust continues to be recognised for our strong performance and innovation in elective care. • There is a theme around safety in some of the items on the agenda for this meeting. Sexual safety at work continues to be an area of focus and the Board is being asked to sign up to the Charter. The Safeguarding Annual Report and the patient story within this meeting describe the changing nature of safeguarding and the need to consider this in a wider context including the issues of domestic violence and modern slavery. • The Trust continues to deliver against the agreed financial plan, but this will become increasingly challenging throughout the year.
Regulation	Regulation 17: Good governance
EQIA – Equality Impact Assessment	There are no differential equality impacts resulting from the areas of work highlighted in this report at the point of writing.
Recommendation	The Board of Directors are requested to **RECEIVE** this paper as assurance and progress against both the local and national health and social care agenda, and as an update against leadership responsibilities within the CEO portfolio.

Calderdale and Huddersfield NHS Foundation Trust
Chief Executive's Report
19 June 2024

1. Introduction

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

1.2. Our Board meets on the day of the General Election. As a public sector organisation, we are required to follow pre-election guidance to maintain our political impartiality. The guidance states that Board meetings should be confined to discussing matters that need a board decision or require board oversight. Matters of future strategy should be deferred. This is therefore a shorter than usual report.

1.3. A detailed update of progress against all of the objectives agreed as part of the one-year plan for 2024/25 is included on the agenda for today's meeting.

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

2.1. A General Election does mean additional uncertainty for NHS organisations at a time when recently published data has shown that the NHS faced record demand for services in May. Nationally more than 2.4 million people attended Accident and Emergency (A&E) departments in May – the highest number on record and there were almost 5% more attendances per day compared with those in April.

2.2. Our local figures reflect the national picture. During May we saw an average of 30-50 more attendances at our A&Es compared with the same period last year. Achievement of the four-hour A&E standard has therefore been variable at the start of this new financial year. This has been impacted by the opening of our new department at HRI, in addition to ward closures due to Norovirus and completing planned deep cleaning at Calderdale which further restrict our bed capacity.

2.3. You will see from the Integrated Performance Report at this meeting that cancer performance remains strong as we continue to meet the faster diagnosis standard, and we have also seen an improvement in diagnostic waiting times.

2.4. We have been recognised for our elective recovery work twice in the last month. On 17 June, Jonny Hammond, Chief Operating Officer and Tom Strickland, Director of Operations for Surgery and Anaesthetics presented at the North East and Yorkshire Operational Delivery event on our elective recovery. Attended by representatives from trusts and integrated care boards from across the region, our team's presentation focused on our theatre improvement work; changes to our staffing models to focus on training and improvement and the benefits this has brought; the in depth data models we use and how this enables us to track patients, book in order and address health inequalities within the communities we serve.

2.5. Subsequent to this, on 19 June, NHS Providers published a report highlighting how hospitals, mental health, community and ambulance services are finding new ways to improve services for patients and deliver value for money. The report, Providers Deliver:

Achieving value for money, showcases positive examples of how trusts are making productivity gains in a challenging environment, while continuing to deliver high-quality care, one of which featured how we have worked with colleagues to tackle waiting lists successfully.

2.6. At the time of writing this report, further industrial action by the junior doctor workforce is planned beginning at 7am 27th June 2024 and ending 7am 2nd July. We have planned for these as we have done for the previous periods of industrial action, to minimise cancellations and disruption for patients, while respecting the rights of colleagues to take action.

2.7. Colleagues will also be aware that the Infected Blood Inquiry published its final report on 20 May 2024. You can read the detail of the report here. There is one patient from Huddersfield referenced in the report in Volume 2. Although this case was from the 1980s, we shared a statement on our website and details of where people with questions or requiring support can go to for more information. The Report includes a number of important recommendations for the NHS. NHS England are considering these in detail and determining any immediate actions which should be taken. Once we receive these we will share them through our quality governance routes and bring assurance of our response to the Board.

2.8. Following the review of paediatric audiology services by NHS Lothian in Scotland a Paediatric Hearing Services Improvement Programme has been established by NHS England to support providers and integrated care boards (ICBs) to improve the quality of these services. The programme is undertaking work to understand the scale of the problem and the number of children who have been affected, and to develop strategic tools and interventions to support sustainable improvements. The Care Quality Commission has asked that boards consider the assurance that they have about the safety, quality, and accessibility of children's hearing services. We have had an external review of our services and a copy of that review, the associated action plan and our gap analysis to achieve the UKAS IQIPS (Improving quality in physiological services) accreditation was submitted to Quality Committee for consideration ahead of this Board meeting. While there are actions we need to take, the Quality Committee will receive assurance that the Trust has had no incidents of a child suffering detriment due to delayed or missed diagnosis or treatment or who has not received timely follow up care and support.

2.9. In May, the All Parliamentary Group published a report on Birth Trauma. The Board receives regular progress reporting against our maternity and neonatal services both directly to the meeting and via the Quality Committee. This will remain a key area of focus in our Board programme of work and assurance.

2.10. I am pleased to report that our endoscopy services successfully achieved Joint Advisory Group (JAG) accreditation, which is the formal recognition that an endoscopy service has demonstrated that it has the competence to deliver against the criteria set out in the national JAG standards. The JAG accreditation scheme is a patient-centred and workforce-focused scheme based on the principle of independent assessment against recognised standards.

2.11. Our Radiology department have also recently maintained their accreditation status against the Quality Standards for Imaging, meaning that they have been formally recognised for the outstanding care they provide for our patients.

2.12. Two new scanners (CT and plain film) have also recently been installed. The new equipment can scan a lot faster, require a lower dose of radiation each time, whilst also improving the diagnostic quality of scans.

3. Inclusive workforce and local employment

3.1. From October 2024 current protections against sexual harassment will be strengthened by the Workers Protection Act – an amendment to the Equality Act 2020. The new law will place a duty on employers to take reasonable steps to prevent sexual harassment. Having already confirmed our commitment to the Sexual Safety in Health Care Charter we have developed a strategy to ensure all colleagues feel sexually safe at CHFT. To embed the Charter, our strategy will focus on how we can prevent sexual misconduct, support colleagues involved, report incidents correctly and in a timely manner and learn from our experiences.

3.2. The Board will know that the National Staff Survey included questions related to sexual safety in the workplace for the first time last year. Even though our results were better than the average across England, our ambition is to be known for our clear expectations around values and behaviours and how we will respond to colleague misconduct – including sexual harassment. High impact actions have been developed to raise awareness of sexual misconduct and we will adopt our usual improvement methodology: 'Work Together Get Results' including our Hot House approach to collaboratively embed our strategy. Board members are invited to be photographed signing the Sexual Safety in Health Care Charter at the end of Board today. This will be used to launch our approach in CHFT News later this month.

3.3. May saw both International Day of the Midwife and Nurses' Day and colleagues shared their careers in both professions as part of our celebration event. This also saw the launch of our new Nursing and Midwifery Ambitions co-created by colleagues across the Trust.

3.4. Last month was the national recognition of Volunteers' Week. It is important that we recognise this key group of people who give their time for free to support our patients and colleagues across many of our functions and departments. We know our volunteers are a crucial part of all that we do here at CHFT.

3.5. In May we also highlighted mental health awareness week. We know that Calderdale has some of the highest suicide rates in the country, and these are particularly in working age men. Our Men's Health Group held an event discussing 'Let's Tackle Men's Mental Health'. We also launched Wellbeing Connect to signpost colleagues to the extra support we can offer be it physical, mental, or financial.

3.6. Our latest Leadership Conference in May looked at how we respond as an employer to the changing nature of the workforce and the differences between the existing and emerging generations seeking employment. The event started with a question and answer session with three young people from Calderdale College on their aspirations and expectations for their career and working life.

4. Financial, economic, and environmental sustainability

4.1. The finance report at this meeting shows a month 2 deficit position of £7.6m, a £0.2m favourable variance from plan (based on the May submission). We have also delivered £3.14m of cost improvement, £0.08m higher than planned.

4.2. Key drivers of the favourable variance included a higher than planned cost improvement delivery, and a reduction in the Public Dividend Capital Dividend in line with the revised forecast and capital plan.

4.3. We know that the cost improvement challenge will increase significantly from month 3 due to the way in which the planned savings were profiled, including: unplanned care (length of stay and bed reduction schemes); headcount reduction in line with the asks from NHS England; and schemes to reduce the use of bank and agency staffing.

4.4. As Board colleagues are aware, there was a requirement to make a revised submission in June. The revised plan sets out a £26.26m deficit, reflecting an improvement of £12.3m. This includes a further £5m cost improvement stretch target; £5.6m additional Integrated Care System funding allocation; and £1.7m additional funding to support a technical adjustment. This means that the new cost improvement target is now £32.18m.

4.5. As referenced in my report to the Board in May, this will be a significant challenge for us as an organisation. We have a good track record of delivering on our commitments and plan from a financial perspective, but each year becomes more challenging. We need to ensure that we maintain the quality and safety of services while remaining focused on these efficiency goals.

4.6. All Trusts across the West Yorkshire Association of Acute Trusts (WYAAT) jointly commissioned an external review of our financial positions. This will take place during July, and we will report the findings to the Finance and Performance Committee. Further detail will be discussed and shared as the review concludes and formulates its findings.

4.7. On 25 June, the Audit and Risk Committee reviewed and signed off the year-end documents including the Annual Report and Accounts for 2023/24 and there is a report from the Committee on the findings from our external and internal auditors included on the agenda for this meeting. As a foundation trust, our Annual Report and Accounts must be laid before Parliament prior to publication. The General Election means that Parliament has been dissolved and therefore the Annual Members Meeting / Annual General Meeting where we present these documents will be delayed until the Autumn.

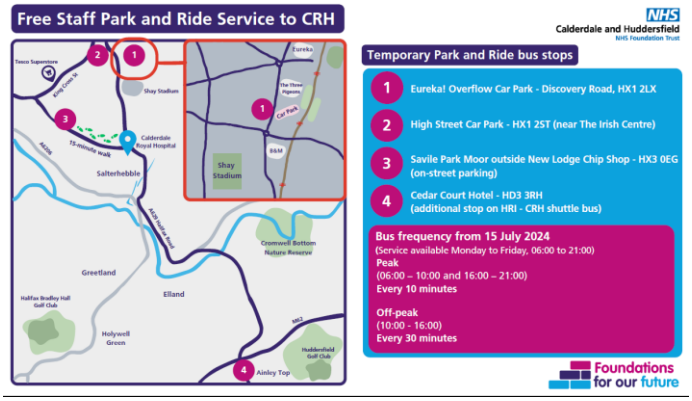
5. Transforming services and population outcomes

5.1. Last month we held the official opening for our new A&E at Huddersfield. Colleagues are becoming accustomed to how patient flows work in the new space and we have put in place learning events at regular intervals to look at what is working well and what may need to change.

5.2. We also formally opened the new non-surgical oncology ward at Huddersfield Royal Infirmary. The new beds and assessment units will be used for both CHFT and Mid Yorkshire NHS Teaching Hospitals patients who need to be admitted under their consultant for care for their cancer treatment.

5.3. On the same day we opened our new Wellbeing Garden at HRI. Funded by the Trust's Charity through a grant from NHS Charities Together, the garden provides a space for quiet and reflection for both patients and colleagues away from the main hospital building. The opening formed part of the Charity's new brand launch as part of Amazing in Action week, with a series of fundraising and awareness events about the Charity and its contribution to enhancing the health and wellbeing of patients, their families and our colleagues.

5.4. This month, the new Park and Ride service will come into effect for Calderdale Royal Hospital (CRH) parking permit holders ahead of the preparatory work for our new, multi-storey car park. To make sure we have enough spaces for our patients and visitors to park, most staff parking spaces across CRH will be designated as patient and visitor only. This means that the overall number of spaces for patients and visitors will remain the same during the preparation and construction of the multi-storey car park. The number of staff parking spaces at CRH will be significantly reduced for a period of up to 18 months whilst construction works are undertaken, impacting most colleagues who currently park on-site.



5.5. In May the Trust was awarded Healthcare Information and Management Systems Society (HIMSS) Stage 6 for its use of data against the Adoption Model for Analytics Maturity (AMAM) following a validation visit and assessment. No other trust or hospital has achieved level 6 (on a scale of 0-7) AMAM within the UK or Europe, so this truly is recognition of the hard work and team approach across CHFT. HIMSS assessments aren't just interested in how a system has been implemented, but want to understand how well embedded it is in the organisation, and how the data is used.

6. Recommendations

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

STRATEGY: TRANSFORMING AND IMPROVING PATIENT CARE

9. 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 4 July 2024
Meeting:	Board of Directors
Title of report:	Maternity and Neonatal Oversight report
Author:	Gemma Puckett, Director of Midwifery and Women's Services
Sponsoring Director:	Lindsay Rudge, Chief Nurse, Executive Director Maternity Safety Champion
Previous Forums:	Maternity and Neonatal Transformation Board Quality Committee
Purpose of the Report	This report summarises the Trust progress against NHS England (NHSE) perinatal quality surveillance model outcomes and delivery of the Three-year plan for maternity and neonatal services. The report aims to provide assurance to the Board of Directors that there are effective systems of control in place to monitor and continuously improve maternity services at Calderdale and Huddersfield NHS Foundation Trust.
Key Points to Note	The position and data contained in this report is for the Trust position at the end of April 2024 unless otherwise specified and as reviewed by the Maternity and Neonatal Transformation Board and the Quality Committee, both of which took place in June 2024. Assure: • The maternity Incentive Scheme is currently on track for compliance against all ten safety actions. • Saving Babies Lives Care Bundle V3 has seen an improvement in overall compliance with 87% of the bundle now implemented. • Listening to women and families lived experience is embedded in key meetings and forums to inform service improvement. Advise: • There has been a successful recruitment programme of newly qualified midwives with circa 31 WTE newly qualified midwives offered posts at CHFT. This will reduce vacancy to less than 10% if all those offered posts commence in post in October 2024. • The wraparound support package for a large intake of newly qualified midwives is being put in place to ensure a successful preceptorship programme. • The perinatal culture programme is progressing with 4 themes identified for focussed quality improvement work. Metrics to support evidence of effectiveness are to be agreed and reported against. Alert: • The rate of stillbirths at CHFT is more than the national average. An externally supported thematic review of cases from January 2024 to date has been undertaken.

	• There were multiple complexities (clinical and / or social) present in 93% of the women who sadly experienced a loss. • There are clear health inequalities evident, and a system wide response has been requested to support the work to reduce the stillbirth rate. • A deep dive of postpartum haemorrhage rates will take place due to flagging as amber twice and red twice over the last 4 months.
Regulations	CQC Regulation 9: Person-centred care CQC Regulation 10: Dignity and respect CQC Regulation 17: Good governance
EQIA – Equality Impact Assessment	There is noteworthy evidence which demonstrates that the experiences and outcomes of mothers and babies from BAME groups and those from the areas of highest levels of deprivation are more likely to be poor. Maternity and neonatal services are working with Integrated Care Board colleagues, local maternity and neonatal system (LMNS) and maternity voices partnership (MVP) to identify and close the gap in health inequalities.
Recommendation	The Board of Directors is asked to **APPROVE** the report.

Maternity and Neonatal Report INDEX	
Section	***Page***

Listening to and working with women and families with compassion
1.1 Lived Experience

The Maternity and Neonatal Transformation Board now has a standing agenda item for a service user to attend or share via the MVP their lived experience. A variety of experiences, both positive and negative, will be shared covering topics including birth choices, bereavement, and neonatal care.

The MVP have attended a regional obstetric trainee workshop to deliver a session on listening to women and families. This received very positive feedback on how beneficial it was to help medical colleagues support personalised care and birth choices and be aware of the language used.

To further develop medical colleagues listening to lived experience and using this to inform practice, the MVP chair will be attending the next CHFT perinatal mortality and morbidity multidisciplinary meeting to share a video of a lived experience of a recent CHFT service user with a discussion following this.

1.2 Improving Experience.

A co-designed workplan is in place with identified actions to respond to the following goals:

- Goal 1: Gather feedback from service users across Calderdale and Huddersfield
- Goal 2: Review services within CHFT
- Goal 3: Co-production with the maternity services
- Goal 4: representation of service user voice at key meetings
- Goal 5: Administration of the CHFT MVP

The Director of Midwifery has attended the Trust Patient Experience Group to present the findings of the 2023 maternity CQC survey and the co-designed response to this which is incorporated into the MVP workplan. This had also been discussed at the Maternity and Neonatal Transformation Board.

1.3 National Reports

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. This report was published in May 2024. There are 12 recommendations that have been made to the Prime Minister.

CHFT is currently undertaking a benchmarking exercise against these recommendations.

1.2 Complaints

The themes of complaints received in the service include communication, feeling heard and concerns around consent for intervention or examination. This reflects feedback received via the MVP through listening events and stores shared directly with them.

The complaints in maternity are often related to care received over 6-12 months previously and sometimes from several years ago. This can increase the complexity of the investigation due to reduction in reliable recall of care provided or unavailability of staff involved in the care.

The actions to address these themes are also included in the 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 and weekly quality and safety huddle.

Training to improve the quality of complaints responses has been arranged through the PHSO and all matrons and ward managers in the service will participate in this.

2.0 Growing retaining and supporting our workforce.

2.1 Midwifery Staffing

What does the chart show/context:

- The FTE rate has increased slightly from March to April from 149.69 to 156.42.

Underlying issues:

- National Shortage of midwives
- Attrition rate of student midwives
- Intense scrutiny of maternity services

Actions:

- Birthrate plus report commissioned and report received at end of April 2024, currently being reviewed through governance processes.
- Recruitment and retention strategy being refreshed.
- Rolling recruitment programme
- Grow your own workforce pathways: Midwifery apprenticeship, shortened programme.
- Recruitment and retention midwife employed to work alongside and support new midwives in clinical practice.
- Stay conversations implemented.
- DoM/DDoM undertaking all exit interviews, retention has improved over last 6 months.
- Recruitment films commissioned and released on social media and being used in adverts and recruitment open days.

- Use of alternative roles such as registered nurses in maternity service
- Participated in centralised recruitment programme for newly qualified midwives with the LMNS - Interviews took place during May 2025
- Robust preceptorship programme

The centralised recruitment of newly qualified midwives (NQM) has taken place during May 2024 with circa 31 WTE post offered and currently accepted. Pre-employment checks will now be progressed. If all those offered commence in post this will reduce the midwifery vacancy to less than 10% against current funded establishment.

Focus will now be placed on the wraparound support required to embed and nurture this large cohort of NQM and will incorporate temporarily increasing the capacity of the midwifery clinical practice education team, roster controls to ensure skill mix is maintained and pastoral support.

2.2 Birth rate plus

The Birthrate plus (BR+) assessment has concluded and the recommendation for the service is 216.75 WTE. This is a reduction of circa 7 WTE from the previous BR+ assessment of 2020. A breakdown of the recommendation and how this compares to the current budget can be seen in table 1.

Table 1

Current Funded	WTE	BR+ Recommendation (applying 90:10 skill mix split)	WTE
Bands 3/4	18.46	Bands 3-4 (10%)	19.35
Bands 5-8	195.66	Direct clinical care Midwifery (90%)	174.18
		Specialist Midwifery / Leadership	23.22
Total	214.12	Total	216.75 *

Totals 197.4 WTE B5-8

Whilst the birth rate has reduced since 2020, the acuity and complexity of women accessing the services has increased. This means there is not a direct correlation in the size a workforce against a reduced birth rate. This picture is reflective of the outcome of other BR+ reviews in other organisations locally and nationally.

The report does not provide a detailed deployment structure for the service as this will require professional judgement based on local need and estate layout.

A workforce structure review has now taken place, and the directorate is working with the finance team to cost the recommended structure. The plan to reach full establishment against the BR+ recommendation is being proposed to take place over 3 years.

This plan also considers the workforce recommendation in BR+ of an additonal 5.83 WTE on top of that specified above to deliver an enhanced continuity of carer model to 15% of women booked with CHFT. This model would be implemented for the most vulnerable women in year 3 of the plan.

The workforce plan would be reviewed every 6 months to ensure the trajectory remained appropriate and in line with any changes in national guidance.

This plan will be approved through divisional board and be brought to the executive team at the next divisional performance meeting before coming to Board for approval.

2.3 Neonatal Nursing

There remains a very small vacancy within the neonatal nursing service following successful recruitment of newly qualified nurses. The number of qualified in specialty (QIS) nurses remains above 70% and therefore compliant with BAPM standards.

2.4 Medical Staffing Obstetrics and neonates

Currently the Directorate has a mixed obstetrics and gynae consultant rota, The directorate have recently recruited one consultant who will commence in post at the beginning of September and recently interviewed and offered a further post. The pressures on the rota will however continue due to the notice of two existing consultants. A further round of recruitment is taking place and interim mitigation is in planning.

A new neonatal consultant commenced in post at the end of April. Funding has been secured to substantively provide a second registrar on the rota at nights.

2.5 Workforce Training and Development

Training data is reviewed monthly through directorate and divisional quality and performance meetings. Staff are allocated to annual maternity safety critical training on a rolling basis, and this is overseen by the clinical practice education lead midwife.

There has been a decline in performance, but this was expected due to the changeover from e-learning for fetal monitoring to a whole day face to face delivery (in line with national guidance) and the increase in staffing seen in April 2024. The trajectory that has been planned for recovering this is currently on track.

Midwives:

Competence Name	Assignment Count	Required	Achieved	Outstanding	Compliance %
372|LOCAL|Fetal Monitoring Programme (K2) - 1 year|	168	168	143	25	85%
372|LOCAL|Maternity Obstetric Emergency Training (PROMPT) - 1 Year|	167	167	127	40	80%
NHS|CSTF|Resuscitation - Level 2 - Newborn Basic Life Support - 1 Year|	153	153	118	35	77%

Maternity Support Workers PROMPT

Competence Name	Assignment Count	Required	Achieved	Outstanding	Compliance %
372|LOCAL|Maternity Obstetric Emergency Training (PROMPT) - 1 Year|	55	55	50	5	90%

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	14	2	87.5%

Obstetric Trainees:

Competence Name	Assignment Count	Required	Achieved	Outstanding	Compliance %
372|LOCAL|Maternity Obstetric Emergency Training (PROMPT) - 1 Year|	27	27	23	4	85%
372|LOCAL|Fetal Monitoring Programme (K2) - 1 year|	17	17	13	4	76%

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

***Doctors returned from Mat leave- study day booked**

Anaesthetists:

Competence Name	Assignment Count	Required	Achieved	Outstanding	Compliance %
372|LOCAL|Maternity Obstetric Emergency Training (PROMPT) - 1 Year|	40	40	35	5	87.5%

2.6 Workforce culture and experience

The perinatal leadership programme has been attended by four members of the team (Deputy Director of Midwifery, Deputy Director of Operations, Consultant Obstetrician, Neonatal Consultant lead).

The perinatal culture survey has been completed and cultural conversations with staff have been held. Although engagement has been good overall there has been limited uptake from some of the multidisciplinary teams, most notably the medical teams and theatre teams. Sessions with these individual groups have been arranged to better understand any barriers to engagement with the programme and to ensure their voices are included.

There have been four main themes identified through the survey and cultural conversations for action:

- Work towards a more accountable culture for staff and managers
- Work towards a culture that improves communication within and between departments.
- Work towards a culture of more civility towards each other
- Work towards a culture of changing the narrative and impact of workforce challenges.

The team are now developing the metrics for measuring improvement and effectiveness. Once agreed these will be reported in a future board paper to demonstrate an improving perinatal culture.

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

3.1 Maternity Incidents

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

The themes of incidents are as follows:

- Mislabelled samples for blood transfusions
    - 7-minute brief piloted in ANC and community - significant reduction in errors seen of circa 50%. Now being rolled out to ward 4 and Labour Ward
    - No SHOT incidents since November 2023 - April 2024.

- Workforce Red flags
    - All red flags are reviewed and managed within the escalation process.
    - Development of additional Safe care red flag reporting for maternity.

- Massive Obstetric haemorrhage (MOH)
    - Embedded reporting process for all MOH of 1500mls or more
    - Weekly review of all Datix submitted has not identified any themes.
    - Deep dive to take place due to flagging amber and red on the dashboard since January 2024.
    - Participating in OBS UK research study on managing MOH.
    - Nominated for an ACE award for management of an MOH of 7 litres.

- Delays in C Section
    - Embedded reporting process of any delays in c sections
    - All delays are reviewed at weekly governance meeting to identify any learning.
    - Audit presented at Joint Obstetric / Anaesthetic Audit session in May.

- Avoiding Term Admissions in Neonates (ATAIN)
    - Increase in admissions following elective c sections – Formal QI project to be undertaken and linked to MIS safety action 3.

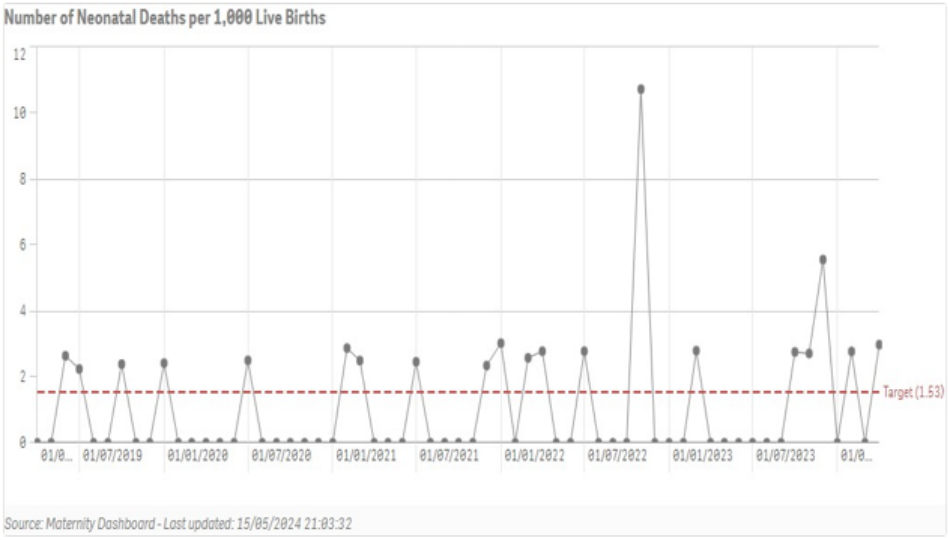
3.2 Perinatal Mortality

Metric	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Neonatal deaths per 1,000 total live births	April 2024	0.00	1.53	-	-	-	-	-
Stillbirths per 1,000 total births	April 2024	8.85	3.33			3.93	0	14.04
Maternity Workforce	April 2024	149.69	tbc			153.64	147.88	159.39

3.3 Neonatal Deaths

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)



Reporting Month: April 2024

What does the chart show/context:

- There was 1 neonatal death in April.

Underlying issues:

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

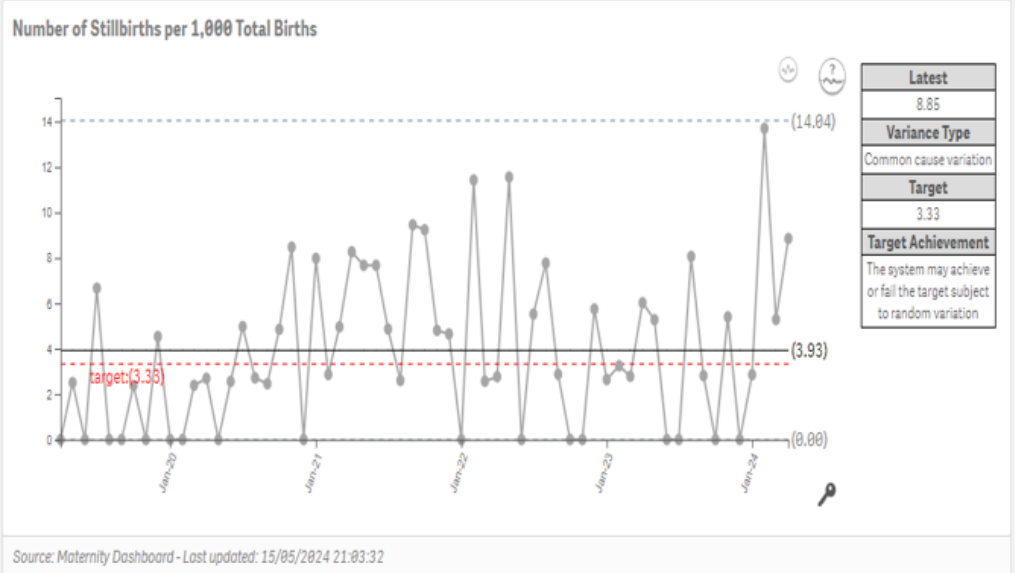
Actions:

- 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.

3.4 Stillbirths

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



Reporting Month: April 2024

What does the chart show/context:

- There were three stillbirths in April.
-

Underlying issues:

- All stillbirths have occurred during the antenatal period.
- Most 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 is no continuity of carer teams currently in place, implementing an interim model of enhanced antenatal and postnatal care for women from this cohort will be a priority. Once the workforce has reached an appropriate level this should be further developed to a full continuity of carer model.
- Deaths will continue to be monitored and investigated.
- Actions below will ensure performance is maintained.

Actions:

- DOM is a member of the Trust Health Inequalities Group.
- 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.
- A CKW review of 2023-24 stillbirths and neonatal deaths is being undertaken.

- An LMNS supported thematic review of the 2024 stillbirth cases took place on 3rd June 2024

3.5 LMNS Supported Stillbirth Review

There have been 15 stillbirths' year to date at CHFT, all of which have undergone an initial review and discussion in orange panel and are being investigated through the PMRT process.

Two cases have been declared as serious incidents and are being additionally managed through this process. None of the cases occurred in the intrapartum period and none met the criteria for referral to Maternity and Newborn Safety Investigation (MNSI) programme.

There are multiple complexities, both social and clinical, present in 93% of the women who sadly have experienced a loss.

The LMNS have supported a review of cases following a request made by CHFT to ensure all opportunities for learning have been identified. This took place on 3 June 2024.

The review confirmed that key areas for improvement had been identified in the Trust reviews. Early pregnancy risk assessments and allocation to monitoring pathways were in line with guidance and there was no recommendation to escalate any other incidents to an SI. There were some additional opportunities identified for development of the small for gestational age pathways and the diabetes service.

The findings are summarised below:

- Feedback from external partners is that it was a well-organised and detailed data presentation to support the review.
- Many of the women had multiple complexities – clinical and social.
- Clear themes of ethnicity and IMD code and in particular Asian Pakistani ethnicity and HX1 ward
- Some cases had no or very limited opportunity for care – either not booked with CHFT or presented late in pregnancy.
- Additional learning identified around management of small for gestational age pathways in the context of multiple risk factors and required scan capacity to then meet this need.
- Viewpoint implementation needs consideration of which growth charts are to be used as CHFT currently use customised charts, however viewpoint uses population based.
- May benefit from a peer review of diabetes service and current pathways.
- Interpreting services and barriers to usage from patient and from staff perspective.
- Engagement work with women who are most represented in poor outcomes to understand any barriers to accessing care.
- Requires a wider system response to the public health and health inequalities seen in the cases.

The next steps agreed are summarised below:

- Ensure the viewpoint implementation project group includes review and decision on chart usage.
- Agree joint ICB and CHFT engagement event with women.
- Task and finish group to review small for gestational age pathways and scan image audit process.
- Task and finish group to review capacity and ANC provision.
- Maternity diabetes service peer review and liaise with LMNS to undertake.

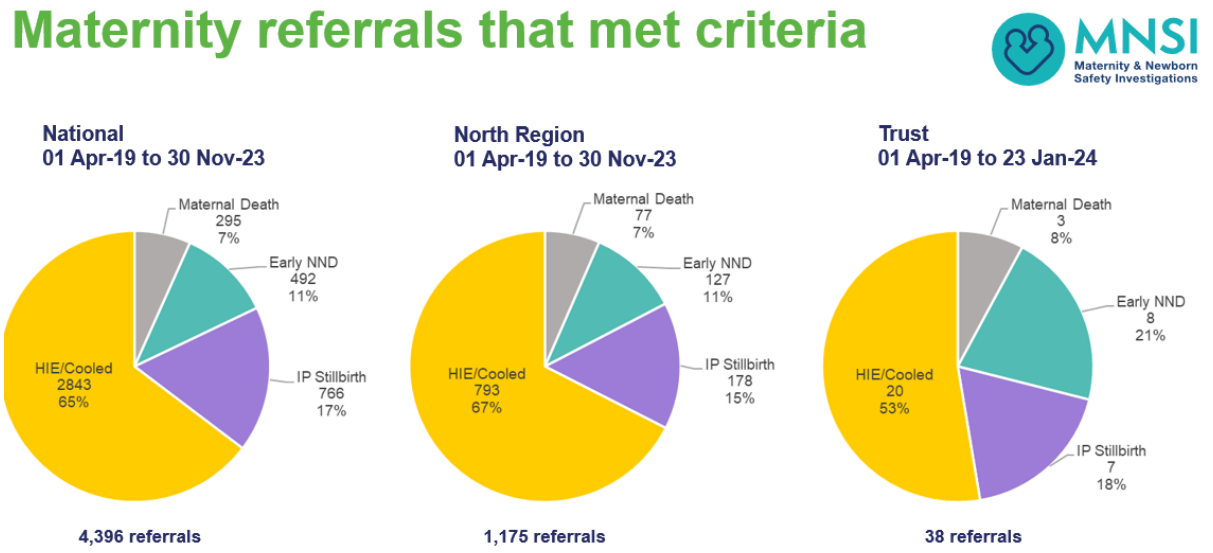
- Multi-Stakeholder meeting for identification of wider system response with Directors of Public health, ICB, LMNS, CHFT to include.
    - pre conceptual care
    - Interpretation and accessibility need.
    - Social vulnerability support
    - PH intervention and support

3.6 Maternity & Newborn Safety Investigations (MNSI)

The data included within this update is from the beginning of April 2019 onwards, when the HSIB maternity programme was live across the whole of England.

Cases to date:

Total referrals	50
Referrals / cases rejected	17
Total investigations to date	33
Total investigations completed	29
Current active cases	4
Exception reporting	2



3.7 Perinatal Mortality Review Tool (PMRT)

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

It has been identified that the Board report is not pulling through into the summary the full information that has been entered in each individual review. This has been escalated to the MBRACE team to identify if this is user error and to ensure appropriate training to rectify this is provided or if there is a fault in the system. A CKW approach to support an external review for PMRT's has been developed and is embedding.

There have been no cases where care has been graded as directly contributing to the outcome.

Due to the data accuracy concerns of the PMRT board summary report for both Quarter 4 report and quarter 1 will be provided in the next board paper once these concerns have been addressed with MBRACE and the team.

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

4.1 Maternity Incentive Scheme

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

4.2 CQC

CQC Maternity ratings	
Date Inspection	June 2023
Overall Rating	Good

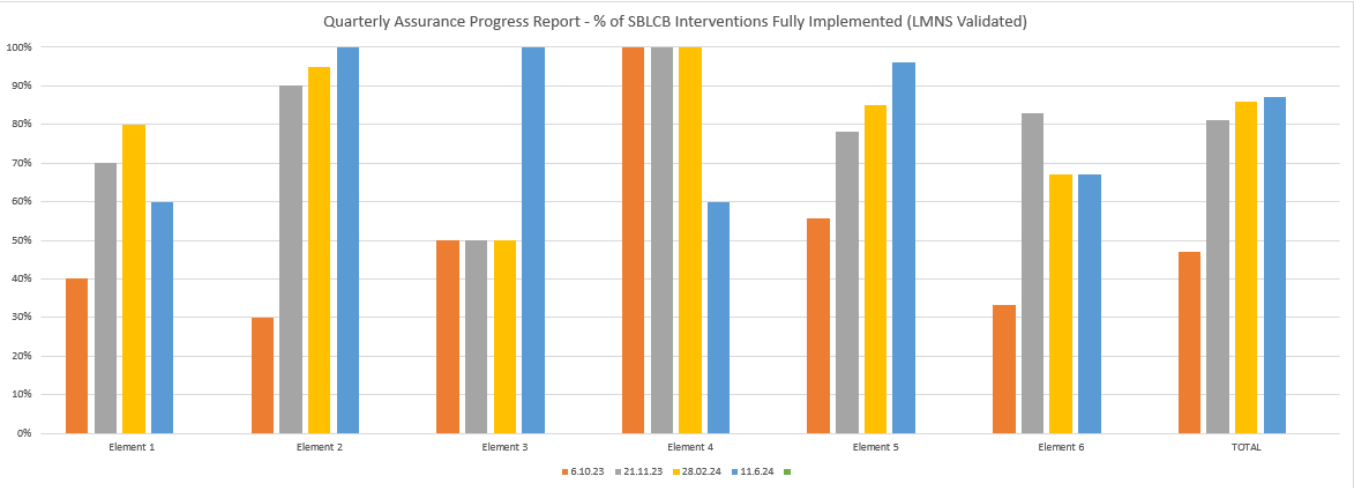
4.3 Regulatory Actions

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

4.4 Saving Babies Lives Care Bundle version 3.

Saving babies Lives evidence review in June 2024 confirmed Trust compliance at 87% overall with more than 50% in every element. This is an increase in overall compliance of 1%. A

decrease in compliance in elements 1 and 4 and this is due to performance against target in some metrics.



4.5 Dashboard

Key Indicators	Thresholds			Jan 24	Feb 24	Mar 24	Apr 24	YTD
	Green	Amber	Red					
Total Bookings <13 Weeks	>90%	-	<90%	88.63%	90.31%	92.31%	86.45%	86.5%
Total Births within Service	Monitoring Only			350	365	378	339	339
Bookings <10 weeks	>90%	-	<90%	57.1%	66.4%	77.2%	63.2%	63.2%
Normal births	>57%	-	<57%	55.4%	47.4%	50.5%	51.0%	51.03%
Assisted vaginal births	<12.4%	-	>12.4%	8.86%	10.96%	10.05%	12.09%	12.09%
Elective C/S deliveries	Monitoring Only			15.16%	16.90%	15.55%	14.67%	14.67%
Emergency C/S deliveries	Monitoring Only			20.41%	24.65%	22.79%	21.56%	21.56%
3rd/4th degree tear - normal birth	<2.8%	-	>2.8%	0.3%	0.6%	0.0%	0.3%	0.3%
3rd/4th degree tear - assisted birth	<6.05%	-	>6.05%	0.0%	0.0%	7.9%	7.3%	7.3%
PPH ≥ 1500ml	<3%	3%-3.5%	>=3.5%	3.8%	3.0%	3.8%	3.3%	3.3%
Total stillbirths	0	<3	>=3	1	5	2	3	3
Perinatal and Neonatal Deaths	0	<3	>=3	0	1	0	1	1
Total stillbirths and Perinatal /Neonatal Deaths	0	<3	>=3	1	6	2	4	4
Low birth weight at term - live births - % of live babies at term < 2200g	0%	-	>=1%	0.93%	0.30%	0.28%	0.96%	0.96%
1:1 Care in Labour	>=98%	>=97%	<97%	100.0%	98.6%	99.5%	98.8%	98.5%
Induction Rate	Monitoring Only			44.0%	33.7%	40.3%	50.5%	50.5%
Planned Home Birth	Monitoring Only			1.46%	0.83%	0.00%	1.20%	1.22%
Smoking at Delivery	< 11%	-	> 11%	8.16%	8.31%	5.09%	6.59%	6.59%
Smoking at Delivery (Not recorded)	3%		>3%	2.92%	5.8%	2.1%	5.1%	5.1%
CO tested at booking	Monitoring Only			98.9%	99.3%	98.9%	99.8%	99.8%
No. Mothers breastfeeding as First Feed	≥ 74.4%	-	< 74.4%	66.1%	62.6%	70.4%	68.0%	68.0%
No. Mothers breastfeeding as First Feed Not Recorded	Monitoring Only			23	37	23	19	19
CO testing at 36 weeks (35-36.6 days)	≥ 80%	-	< 70%	83.83%	90.39%	76.81%	95.41%	95.41%

Areas to note include:

- 3rd and 4th degree tear rates: Improvement has not been sustained – A deep dive has been completed and presented at a clinical audit session. This identified a training need and x2 workshops have been held in May, further dates to be arranged.
- PPH – Since January the rate of PPH has flagged as amber x2 and red x2. Datix submissions for PPH are reviewed at the weekly governance however there no common themes have been identified therefore a deep dive is to take place. CHFT will be participating in OBS UK on management of MOH.
- Stillbirth rate - externally supported review has taken place as described in this report.
- Ongoing work to validate each data point and to move to SPC reporting and presentation of the dashboard using KP+.

4.6 Maternity and Neonatal Board Safety Champion Feedback

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.’

The open-door sessions have seen limited engagement and have been moved to take place in the maternity unit area however this does not appear to have increased staff accessing the board level champion. Further development of these sessions will take place and walkabouts as an alternative mechanism to engage staff will take place.

10. Annual Strategic Plan - 2024-25 Progress Report

To Note

Presented by Anna Basford

Date of Meeting:	Thursday 4 July 2024
Meeting:	Public Meeting of the Trust Board
Title of report:	2024-25 Annual Strategic Plan – Progress Report
Author:	Anna Basford, Deputy Chief Executive / Director of Transformation and Partnerships (with input from all Executive Directors)
Sponsor:	Brendan Brown, Chief Executive
Previous Forums:	None
Purpose of the Report	To provide the Board with an update on progress against the 2024-25 annual strategic plan.
Key Points to Note	In March 2024 the Trust Board approved the 2024-25 annual strategic objectives to be delivered in year 2 of CHFT's five year strategic plan (2023-28). The strategic plans describe the Trust's ambitions across the four goals: • To transform patient care and population health outcomes • To provide the best quality and safety of care • To be the best place to work, supporting a workforce for the future • To be sustainable in our use of financial and environmental resources This report provides an update on progress to implement the 2024-25 annual strategic objectives.
Regulation	Regulation 17: Good governance
EQIA – Equality Impact Assessment	For each objective described in the annual strategic plan the Lead Director is responsible for ensuring that Quality and Equality Impact Assessment is undertaken and where possible that this follows best practice to involve patients, public and colleagues in the process of assessment and the agreement of any required actions to mitigate risks or negative impacts.
Recommendation	The Board is requested to **NOTE** the assessment of progress against the 2024-25 strategic plan.

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

Purpose of Report

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

Structure of Report

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

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

For each objective the following information is provided:

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

Summary

This report highlights that of the 15 objectives:

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

Recommendation

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

Goal: Transforming and improving patient care

Deliverable	Progress rating	Progress summary	Outcome Measure & Assurance route	Board Assurance Framework – Risk Score	Indicative Measure of Delivery
We will have opened the new A&E at HRI and reported on benefits realised, completed build and opened the new Learning and Development Centre (LDC) at CRH, commenced construction of the Multi-storey Car Park (MSCP) at CRH.	**GREEN** on track	The new A&E at HRI opened on 22 May. Benefits realisation / post project evaluation is being undertaken over a 6 month period and a report will be prepared in November. Construction of the new learning and development centre at CRH is in progress and remains on track for opening in October 2024. Enabling ground works for the MSCP are on track to commence in July 2024.	**We will have built new 'state of the art' hospital buildings that will enable delivery of the best safety, outcomes and experience of care for people.** **Lead: AB** Transformation Programme Board , Trust Board ICS, NHSE, DHSC	20 BAF Risk 1/19 Reconfiguration	• Open the new A&E and confirm benefits in post project evaluation report. • Open the new LDC and confirm benefits in post project evaluation report. • Construction underway on MSCP and on track for planned completion by Nov 2025
We will deliver our 12-month digital programme in line with our Trust Digital Strategy. Maintaining a robust and secure infrastructure, developing our digital systems (inc our EPR) in line with our clinical and operational needs (e.g. Patient Portal, Paediatric SDEC); alongside ensuring access to accurate and timely data in order to improve outcomes, operational effectiveness and help shape service redesign.	**GREEN** on track	HIMSS Adoption Model for Analytics Maturity (AMAM) Level six was achieved 24th May, this see use on track to achieve three HIMSS models at level six in 24/25. Progress against the digital strategy continues in line with clinical and operational priorities, some key milestones are the delivery of five SDEC's in Oracle Health EPR and go live of the DrDoctor patient portal. Digital Maturity Assessment (DMA) has been completed and is going through a review and ratification process with the output and scores to follow in the late summer. THIS have been successful in recertification for ISO standards 9001 and 20000:1, the final standard will be accessed in August 24.	**Patients and colleagues will be digitally enabled to provide and receive care wherever this is needed.** **Lead: RB** Divisional digital boards Divisional Operational Boards Data Quality Board Digital Executive Board. Report to Board and Finance and Performance Committee by exception.	12 BAF risk 02/20 Digital Strategy	• HIMSS level (Achieve level 6 in 24/25) · • Progress against CHFT Digital Strategy (e.g. continual delivery of our digital roadmap/plan) · • NHSE Digital Maturity Assessment (DMA) · • Maintain 3 ISO Standards (27000/9001/20000)

We will deliver Year 2 of the Trust's Health Inequalities Strategy using the four key areas of Communities, Lived Experience, Data and Diversity & Inclusion as our delivery framework. We will provide updates to the Board on a regular basis.	**GREEN** on track	The Health Inequalities strategy is now in year 2 with milestones progressing and on-track. This includes: • Continued work to develop a "Health inequalities vulnerability index" to identify patients at increased risk of experiencing inequalities. The tool has been trialled within outpatients and cancer services to date with plans to roll out across the organisation. • Continue to prioritise care for people with a learning disabilities. Qualitative audit undertaken. • Implementation of improved communications for patients who require additional support. • Continued delivery of the BLOSM service within our emergency departments to tackle health inequalities and engage with vulnerable service users attending ED. • Revised Board snapshot report developed (reported quarterly)	**Working with partners we will use population health data to prevent ill health and reduce health inequalities.** **Lead: RA** Health Inequalities Group Executive Board Board of Directors Health Inequalities Oversight Group (England)	12 BAF risk 07/20 Health Inequalities	• Continued delivery of actions within the Trust's approved Health Inequalities strategy 2022-2025 • Act on the health inequalities indicators within the Trust Integrated Performance Report. • Maintain equality of elective care access for different protected groups including an initiative supporting those groups most likely to not attend (DNA) for contacts with the organisation.
We will collaborate with external partners, to offer research to our patients & deliver this safely. We will establish a Calderdale & Kirklees research Group. Survey the CHFT workforce in regard to clinical research to provide us with evidence to enable improvements. Continue to promote the work of Ethnic Minority Research Inclusion (EMRI) group and reverse mentoring to improve	**GREEN** on track	The R&D restructure has been approved and will now move to implementation. We have strengthened collaborative working across place and networks, illustrated in our recent CHFT Research Event CHFT will submit a bid with Bradford Teaching Hospital to be a spoke, with MYHT, in a Commercial Research Delivery Centre. If supported this will provide income and support to further develop a commercial research work portfolio	**We will participate in research and innovation to improve patient care, prevent ill-health, and achieve better outcomes and faster recovery for patients.** **Lead: DB** Research Group Executive Board Quality Committee	12 BAF risk 01/20 Clinical Strategy	• C&K Research Group Shared goals and terms of reference • Monitor studies we enable as part of this collaboration. • Review and act on survey results to make improvements to enable research • Complete the pilot for NIHR reverse mentoring scheme

uptake of research in ethnic groups Support and guide our CHFT workforce to design and lead research as Chief Investigators To enable this growth, we will review the R&D structure to ensure we are fit for purpose, resilient and safe.		in addition to the NIHR funded portfolio. We have increased the number of different roles being involved in leading research, e.g. pharmacy, dietetic, physiotherapy and physician associate colleagues. 13 members of the research team have completed reverse mentoring.			within CHFT research team. • Increase of CHFT chief investigators • R&D structure review complete

Goal: Keeping the base safe

Deliverable	Progress rating	Progress summary	Outcome Measure & Assurance route	Board Assurance Framework – Risk Score	
We will continue implementing the National Patient Safety Incident Reporting Framework (PSIRF) and develop the roles of Patient Safety Partners and Experts by Experience. We will implement the Inphase digital system. We will set the Trust Quality priorities to support delivery of the Trust Quality Strategy. Prepare and support for CQC within the new single assessment framework we will align our internal inspection framework (J2O) with the new CQC quality impact statements. Publish a revised Clinical Strategy and Quality & Safety strategy Revision of the Nursing & Midwifery Strategy to reflect the newly published national strategy.	**GREEN** on track	Progress continues with the PSIRF framework the Trust SI panel terms of reference have been updated to reflect this. The first meeting of the Patient Safety Partners and Experts by Experience panel was held in June. The implementation of Inphase remains on plan. The Trust Quality and Safety Strategy has been approved by the Quality Committee and the quality priorities have been selected and approved. The Nursing and Midwifery Ambition 2025-2029 has been launched. Ongoing progression of the Clinical strategy is underway.	**We will be delivering and enabling outstanding quality, safety and experience of care for people needing hospital and community services.** **Lead: LR** Quality Committee Executive Board	12 BAF risk 04/20 CQC rating	• Continued delivery of actions within the Trust's Patient Experience Strategy 2024/25 and the Trust Quality Strategy 2024/25. • Monitor key performance indicators within the Trust Integrated Performance Report. • Continued monitoring of regulatory standards via the Trust J2O and internal and external inspections/reviews

Working within the resources available we will meet national standards in relation to elective recovery. We will meet priority KPIs for cancer services. We will maintain our position within the top quartile of diagnostic performance. We will maintain our position within the top quartile nationally of ED performance, with a focus on ambulance waits over 30 minutes and over 12 hour ED waits.	**GREEN** on track	We continue to meet key Cancer KPIs. Elective recovery waiting times continue to reduce. There are challenges in a few specialties linked to staffing gaps, however specific action plans are in place and the expectation is still to meet the waiting list reductions planned by year end. Diagnostic performance is on track. Type 1 ED 4 hour performance remains in the top quartile. The move to a new ED at HRI was successful and performance in relation to ambulance handover remains consistent and compares well to peers and nationally. Proportion of over 12 hour waits is at a reduced position for February, March and April 24 compared to Oct 23-Jan 24.	**We will be consistently achieving key performance targets that matter most to patients.** **Lead: JH** Integrated Board Report Executive Board Audit and Risk Committee Finance and Performance Committee Access Delivery Group	16 BAF risk 4/23 Recovery	• Elective backlog • 28,31 and 62 day cancer targets. • Diagnostic DMO1 performance target. • ED four hour target. • Volume of patients with 12 hour length of stay in ED. • Average ambulance wait times.
We will review the governance arrangements against the GGI / HFMA framework in line with good financial controls and complete a well led review. We will also undertake the full self-assessment of compliance with the new CQC Inspection Framework at both Board and Divisional levels.	**GREEN** on track	Working with divisions in the first instance, we have started a self-assessment process against the new Single Assessment Framework from the CQC and there are workshops happening over the summer. The Trust is also taking part in the West Yorkshire external financial review and have submitted our information ahead of the interviews taking place in late June / early July. The outcome of this will be built into the workshops we are planning for Q3/4 on well led. A full external well led review is not due until 25/26.	**We will be 'well-led' and governed and compliant with our statutory duties.** **Lead: VP** Executive Board Trust Board	8 BAF risk 3/23 Partnerships 6 BAF risk 16/19 Health & Safety 12 BAF risk 4/20 CQC rating	• Review undertaken and recommended actions implemented. • Self-assessment complete across all domains including Board well led assessment

Review the Patient experience and involvement strategy to ensure service planning and developments consider the diverse needs of the local population. Initiate two new workstreams for the Patient Experience Involvement Group**:** person centred care and strengthening working in partnership with people and communities. Continue work within the patient experience and Involvement strategy to inform priorities and Keep Carers Caring. Introduce Experts by Experience and Patient Safety Partners. Develop actions across the local system to support identification of unpaid carers, improve their involvement and support their health and wellbeing.	**GREEN** on track	Revision of the strategy is underway. The first meeting of the Patient Safety Partners and Experts by Experience panel was held in June. They were involved in • Patient Correspondence • Patient Portal • Cardiology Services Keep carers caring remains embedded in the Trust. The Patient Experience Team have supported the Transformation team to ensure that patient correspondence includes a clear statement, supporting people to know that they are welcome to be accompanied by a person of their choice when they attend appointments. We have commenced work with partners including Calderdale Local Authority and Kirklees Local Authority to develop a carers charter which will support unpaid carers across the geographical patch. CHFT has been successful in bidding to be one of the first provider sites to implement Martha's Rule. Work has taken place to develop a promotional film to support person centred care across CHFT.	**Patients will be able to shape decisions about service developments and their personal care based on 'what matters' to them and their individual strengths and needs.** **Lead: LR** Quality Committee Executive Board	12 BAF risk 04/19 Patient and Public Engagement	• Continued delivery of actions within the Trust's Patient Experience Strategy 2024/25 and the Trust Quality Strategy 2024/25. • Patient Survey Reports • Friends and Family test results • CHFT compliance with statutory guidance "Working in Partnership with People and Communities" • Healthwatch reports • We will continue to monitor assurance via the Trust CQC Compliance Group. In addition, we will ensure regular engagement meetings continue with our CQC Relationship Owner. • Maternity Incentive Scheme and Ockenden Assurance compliance

Goal: A workforce fit for the future

Deliverable	Progress rating	Progress summary	Outcome Measure & Assurance route	Board Assurance Framework – Risk Score	
We will increase emphasis on appreciation and recognition culminating in a successful CHuFT awards event.	**GREEN** on track	Decision to reschedule the CHuFT awards to Summer 2025 following feedback on the operational pressures in the winter months. 'Summer of Sport' activities launched to engage colleagues and promote the benefits of activity on physical and mental health. There will be a special focus on the Paris Olympics/Paralympics where we will highlight all the great work on inclusion – celebrating the diversity of our workforce and the importance of diversity to compassionate care for our patients. The theatre team have been supported to host an appreciation event. Radiology development programme design/launched inclusive of local appreciation.	**We will be widely known as one of the best places to work through an embedded one culture of care - supporting the health and wellbeing of all colleagues.** **Lead: SD** Workforce Committee	12 BAF risk 11/19 Recruitment and Retention	• Increase CHuFT nominations • appreciation weeks in engagement calendar
We will continue to improve and promote our internal development offer, with a strong focus on leadership.	**GREEN** on track	Leadership conference held in May 2024 with a leading through change by balancing quality, finance and workforce priorities theme. Leadership/management development offer discussed at Executive Board in June 2024. Leadership development publicity material designed including updating internal web pages. Engagement with stakeholders in respect of leadership development activity design/content. Launch of Proud2bOps internal activity programme. Bespoke Radiology leaders/managers development programme launch in May 2024. Place wide HR practitioner conference scheduled for September 2024.	**We will foster an open learning culture that demonstrates lessons learnt, and actively seeks and celebrates best practice.** **Lead: SD** Workforce Committee	12 BAF risk 11/19 Recruitment and Retention	• Succession plans in place for all Divisions to tier 3 • 2 leadership conferences per annum • 10% of managers having completed WTGR training • 10% increase in cohort of empower graduates • management fundamentals rolled out across the Trust

We will implement an inclusive recruitment approach aligned to our values and behaviours and increase internal mobility for under-represented groups.	**GREEN** on track	Recruitment Strategy embedded as part of People Strategy Inclusive Recruitment Hot House in November 2024 KP+ and workforce data analysis to drive approach and areas of focus Careers events held both within the Trust and across the local community to promote Widening Participation approach Outreach work planned throughout 2024 (once per month) will target underrepresented groups including Looked after children, refugees and those long term unemployed and based out in the local communities in line with Purpose Coalition developments.	**We will have a diverse and inclusive workforce of the right shape, size and flexibility to deliver care that meets the needs of patients.** **Lead: SD** Workforce Committee	12 BAF risk 11/19 Recruitment and Retention	• Increased internal mobility for BAME colleagues to band 6 and above roles.
We will develop bespoke learning pathways and curriculums to develop a pipeline of local talent into health and social care vacancies	**GREEN** on track	Review and reset of Widening Participation strategy underway. Widening Participation programmes to support pipelines into the Trust and to support the local community in preparing people for work including Princes Trust, T Levels, Project Search and St Johns Cadets. Apprenticeship Levy spend has reached 86% spend for 23/24, an increase of 14% on 22/23	**We will work with partners to create local employment, career and development opportunities for people.** **Lead: SD** Workforce Committee	12 BAF risk 11/19 Recruitment and Retention	• Increase of number of colleagues recruited from IMD 1-4 • Increase our apprenticeship levy spend by 5% • We will co-launch a health and social care Academy for Calderdale

Goal: Sustainability

Deliverable	Progress rating	Progress summary	Outcome Measure & Assurance route	Board Assurance Framework – Risk Score	
Deliver the ICB and NHSE approved financial plan. Benchmark favourably across both West Yorkshire and Nationally against the National Productivity Metrix	**GREEN** on track	At month 2 the Trust has a favourable variance against the financial plan and remains on course to deliver the 2024/25 plan. Latest productivity benchmarking data shows CHFT to be more productive than national average and WYAAT peers. Productivity data based on the closing 2024/25 position has also been submitted and is understood internally. This has not yet been benchmarked and a new national suite of benchmarking data has been proposed.	**We will be consistently delivering our annual financial plans and demonstrating value for money.** **Lead: GB / KA** Reported to Finance & Performance Committee Monthly regulator discussions	16 BAF risk 18/19 Financial Sustainability	• Deliver approved plan. • Productivity Benchmarks
Deliver a calendar of sustainability engagement events for 2024/25; achieve a minimum recycling target of 40% for non-clinical waste streams; work to reduce single occupancy vehicle journeys by 5% by 2026; make progress towards our targets of a 100% reduction in emissions by 2040 and to convert 90% of our fleet to low, ultra-low and zero emissions vehicles by 2028	**GREEN** on track	Of the 207 actions proposed in our green plan 165 of these are complete. We continue to deliver a calendar of sustainability engagement events. The CHS SECR report (Streamlined Energy and Carbon Reporting) confirmed that the total annual CO2e emissions (2023/24) reduced by 6% compared to the year previous. Total electricity consumption decreased by 3% and natural gas usage decreased by 9%. We have converted 90% of our fleet to low, ultra-low and zero emissions vehicles	**We will have taken action to reduce our impact on the environment and will be on track to achieve targets for carbon net zero.** **Lead: SS** Transformation Programme Board Trust Board	8 BAF risk 06/20 Climate Action	• a 100% reduction in direct (scope 1) carbon dioxide equivalent emissions by 2040. An 80% reduction will be achieved by 2032 • convert 90% of our fleet to low, ultra-low and zero emissions vehicles by 2028 • a minimum recycling target of 40% for non-clinical waste streams • a 5% reduction in single occupancy journeys by 2026

During 2024-25 we will work with our Construction Partner for the new Clinical Build at CRH and with local partners and communities to agree a Social Value action plan that will enable and measure delivery of economic and social benefits for people in Calderdale and Kirklees.	**GREEN** on track	Laing O'Rourke has been appointed as the design and construction partner for the new clinical build at CRH. The Trust has commenced working with them to progress next stage designs and plans that includes the development of a social value action plan.	**Our investments and use of resources will be generating Social Value to support economic recovery in Calderdale and Kirklees Places.** **Lead: AB** Transformation Programme Board Trust Board	9 BAF risk 2/23 Social Value	• Agreed Social Value Action Plan with quantified measures.

INTEGRATED PERFORMANCE

11. Quality Committee Chair Highlight Report

- Director of Infection Prevention Control Q4 Report

To Note

Presented by Denise Sterling

Calderdale and Huddersfield NHS Foundation Trust

CHAIR'S HIGHLIGHT REPORT

Committee Name:	Quality Committee
Committee Chair:	Denise Sterling, Non-Executive Director
Dates of meeting:	28th May 2024 and 3rd June 2024
Date of Board meeting this report is to be presented:	4th July 2024
ACKNOWLEDGE	• Committee Terms of Reference have been reviewed and approved with minor changes. • Terms of Reference for the Medication and Safety Compliance Group were approved. • All actions closed on the committee action plan. • Safe sustainable and productive staffing (SSPSM) report highlighted improved escalation processes and reduced high-cost agency spending. The Trust achieved 13 out of 14 NHS nurse redeployment recommendations and emphasized the importance of having access to detailed data for strategic discussions at Place level. It is hoped that this will provide assurance as the Trust goes through a challenging financial year. • Approved the 2023/24 Quality Account, with delegated responsibility from the Board of Directors.
ASSURE	• Nasogastric tube update – Assurance was provided that all immediate actions have been undertaken and the majority of actions are nearing completion. The action plan will continue to be monitored through the Nutrition and Hydration Group. Updates will now be provided to Quality Committee on a quarterly basis. • Divisional Q4 Quality reports were received from Medicine and Family and Specialist Services, providing a comprehensive overview of how the Divisions are addressing quality, safety and patient experience. This facilitated a thorough discussion. Progress was noted for falls prevention and response rates for complaints. Areas for continued focus included compliance with NICE guidelines, quality priorities, processes and timescales to review policies. • Efforts are ongoing to recruit more midwives and address vacancies. Surrounding organisations are showing a lower vacancy rates and it is hoped CHFT can benefit an increase. Third- and fourth-degree tear rates have shown an increase over the past few months. A deep dive has been completed, and proactive measures are taking place following an audit, with workshops being run during May. • The Medication and Safety Compliance Group (MSCG) report indicated an increase in medication-related incidents over the past six months, with most being no/low harm. A high-level monthly summary of harm-related incidents and a three-monthly review of low harm incidents are proposed. A summary will be included in the quarterly report to the QC. The action plan for Valproate prescribing is on track, and the medication safety team is now fully staffed.

	• The Committee received annual reports for Safeguarding, Patient Experience and Complaints. • Assurance was provided that the Trust is compliant with its statutory responsibilities for safeguarding and in a strong position in terms of safeguarding activity supporting the safeguarding strategy and new initiatives. Work is underway to address the gaps in safeguarding training. • The Patient Experience Group, now the Patient Experience and Involvement Group, has established four key strategic priorities: person-centred care, partnerships with people and communities, insight for improvement, and supporting carers. Aligning with the Health and Social Care Act 2022, new CQC assessment framework changes, and the Chief Nursing Officer for England's priorities, ensuring patient and carer voices are heard. • The complaints report noted the improved response times and ongoing efforts to consistently reach the Trust target of 95%. Focus areas for 2024-25 include learning from complaints, equality monitoring, reporting, and the reopened complaints. • The Quality Committee's annual report for 2023/2024 concluded that the Committee met its terms of reference, providing assurance that systems and processes are in place for delivering safe, high-quality services and making progress on the delivery of the quality improvement priorities. • Serious incident investigations have transitioned to the Patient Safety Incident Response Framework (PSIRF)Divisions are preparing for CQC self-assessments and well-led workshops in June. Quality priorities show steady improvement. Changes to the data reporting for Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio will make CHFT appear a negative outlier in national benchmarks; as CHFT is one of the first two trusts in the country to report in this way, all Trusts will be following this new process. • The report on the Maternity and Neonates 3-year delivery plan focussed on theme 2 of growing, retaining and supporting the midwifery workforce. Recruitment for band 6 neonatal nursing posts has been challenging, but there has been a strong intake of newly qualified nurses. The recruitment and retention strategy is being updated to include diverse career paths. The service is midway through a three-year plan to meet staffing targets, with ongoing financial planning. Maternity and neonatal training compliance is on track. • The emergency department (ED) remains very busy, and the new ED is now open with colleagues getting used to working in the environment. Elective care is going well, and still maintaining good performance around cancer diagnostics and elective recovery is ahead of most peer trusts. Improvements have been noted in dementia and stroke, but challenges persist in speech and language therapy. The Acute Response Team is enhancing responses to deteriorating patients, and a refreshed sepsis policy aims to improve patient escalation. • Noted the internal audit report on Local Standards for Invasive Procedures (LOCSSIPS) this reaudit confirmed that of seven of the nine recommendations are fully implemented and plans are in place for the two partially implemented recommendations.

AWARE	• The stillbirth rate has increased significantly in 2024, with 12 cases so far compared to fewer in the entire previous year. This has prompted a review by the Calderdale Kirklees and Wakefield partnership and the Local Maternity and Neonatal System (LMNS) have also been approached for an external view on the 12 cases, to ensure that learning opportunities are not missed. • The Cancer Delivery Group Report highlighted that the radiotherapy treatment times at LTHT have significantly deteriorated over the last 6 months (breast 10-12 weeks, colorectal 8-10 weeks from MDT to treatment). Discussions are ongoing with Cancer Alliance Directors and WYAAT Chief Operating Officers to explore mutual aid, though no confirmed timeframe for improvements exists, and patients are being informed of the delays. This is extremely challenging as other regions are in a similar or worse position.
ONE CULTURE OF CARE	• One Culture of Care is taken into account in Committee discussions
REGULATIONS	Regulation 12: Safe care and treatment Regulation 17: Good governance

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 4 July 2024
Meeting:	Board of Directors
Title of Report:	Q4 Infection Control
Author:	Belinda Russell, Matron Lead IPC
Sponsoring Director:	Dr David Birkenhead
Previous Forums:	ICC Quality Committee 8 May 2024
Purpose of the Report	The report provides an update on Infection, Prevention and Control (IPC) performance and activity for the fourth quarter of 23/24.
Key Points to Note	Summary of the Peripheral Venous Cannula Device Audit. The planned move to Patient Safety Incidence Response Frame work **PSIRF** for review of HCAI's in line with national guidance.
Regulation	Regulation 12: Safe care and treatment
EQIA – Equality Impact Assessment	This report relates performance information relating to Infection Prevention and Control. It is not expected that the performance metrics reported will be significantly affected by ethnicity, however disability may predispose individuals to certain infections.
Recommendation	The Board is asked to **NOTE** the content of the report.

IPC Report Q4 1st January – 31st March 2024

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

1. Performance targets

2. Indicator	Objective 2023/24	CHFT Year to date performance Last yr to date figures for comparison in brackets	Actions/Comments
MRSA bacteraemia	No target set	1 (2)	Not mentioned on this year's targets continue to be monitored by IPC team. 1 HOHA Decrease of 1 on previous year (2 COCA)
C.Difficile (HOHA & COHA)	37	54 (59)	36 HOHA 18 COHA (25 COCA) (Q4 HOHA 2 Jan, 4Feb, 1March = 7) Decrease of 9 on previous year.
E. coli bacteraemia	67	72 (79)	30 HOHA 42 COHA (235 COCA)
Pseudomonas aeruginosa	2	4(4)	2 HOHA 2 COHA (12 COCA)
Klebsiella spp.	28	38 (28)	16 HOHA 22 COHA (58 COCA)
MSSA	No target set	41 (83)	Not mentioned on this year's targets continue to be monitored by IPC team. 23 HOHA 14 COHA (77 COCA)
ANTT Trust overall competency assessments	90%	90.00%	
ANTT Competency assessments (medical staff)	90%	81.50% (70%)	Increased compliance on last year.
ANTT Competency assessments (nursing and AHP)	90%	92.14 (88%)	Increased compliance on last year.
Hand hygiene	95%	100%	Audit process to be reviewed in 24/25
Level 2 IPC Training Trust overall		91.40%	
Level 2 IPC training (Medical staff)	90%	80.86% (84%)	Decreased compliance on last year
Level 2 IPC training (nursing and AHP)	90%	93.48% (91%)	Increased compliance on last year.

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

3. Quality Indicators

Indicator	Year-end agreed target	YTD performance	Comments
MRSA screening (emergency)	95%	92.07%	Increased 5.8% on last year
Isolation breaches	Non set	Not recorded this quarter	COVID-19 patients remain priority for side room isolation

4. MRSA bacteraemia:

No objective for MRSA cases set in year. **1 HOHA** (currently under investigation, March 2024) and **2 COCA** case to report during the current year.

5. MSSA bacteraemia:

There is no objective set for MSSA. The IPC team continue to review these cases. **23 HOHA and 14 COHA cases in the year**, these have been reviewed with no correlations between the cases.

6. Clostridium difficile:

The objective for 2023-24 is 37 cases, a decrease of 1 case on targets from 22/23. The objective includes both HOHA cases (hospital onset, healthcare associated) plus COHA (community onset, healthcare associated) infections where there has been an inpatient episode within the previous 28 days.

There have been a total of 54 cases: 36 HOHA cases and 18 COHA cases year to date Although cases of CDI have risen within the last 2 years this is broadly in line with regional and national trends.

Each case up to the end of September has been investigated following the PIR guidance within the IPC team. All Cases going forwards will have a Patient Safety Incidence Response Framework (PSIRF) review using a Multi-Disciplinary Team (MDT) approach and steps away from blame being apportioned, instead the emphasis is on what learning can be found across the system using contributory factors which are then appraised into themes; these will help to formulate the IPC team annual plan.

7. E. coli bacteraemia:

There have been 21 cases of E.coli bacteraemia within this quarter: **30 HOHA plus 42 COHA *E. coli* bacteraemia cases in the year**. (Total 72 cases at year end, which is 4 cases over the objective of 68 cases) The Trust is participating in regional improvement work in relation to gram negative bacteraemia.

8. Outbreaks & Incidents:

Areas closed due to outbreaks in Q4: The IPC team have monitored and advised on outbreaks throughout the quarter. All outbreak areas were monitored by the IPC team for staff compliance, patient symptoms, positive results and reopened at the earliest safe opportunity. ALL areas remained open to visitors with advisory signage in place at entrances.

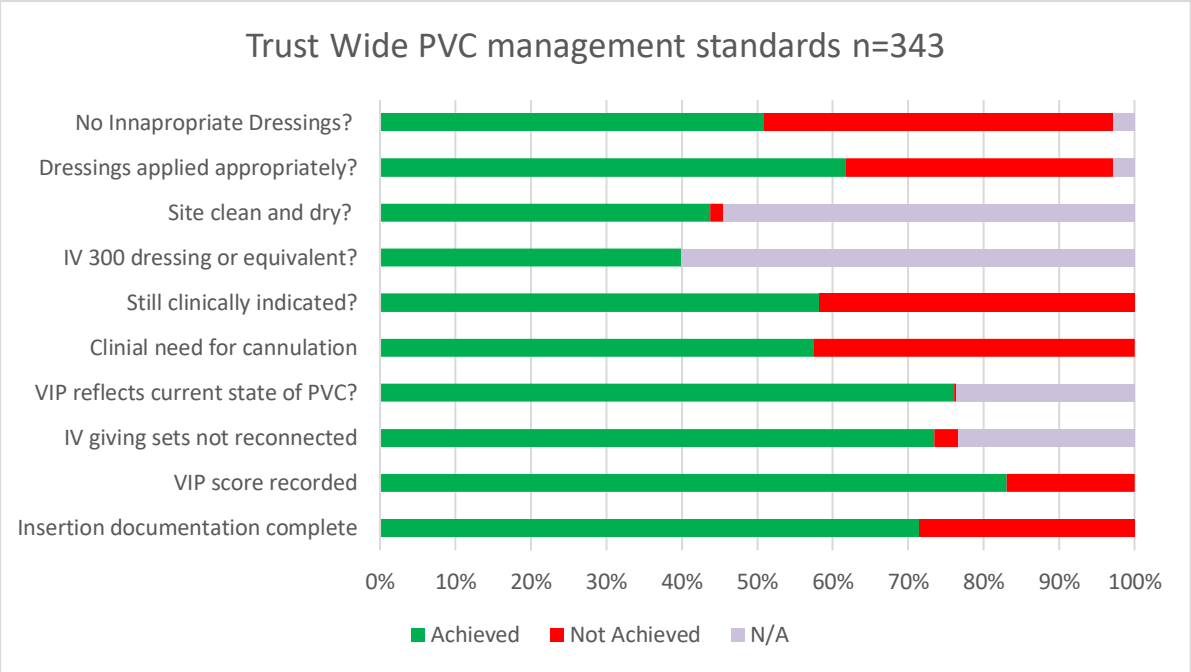
HRI wards	CRH wards
	10.01.24 5D Norovirus
05.02.24 17 C19	14.01.24 5C Norovirus
09.02.24 5 Norovirus	13.02.24 8C COVID-19
25.02.24 5 Norovirus & C19	13.02.24 7C Norovirus + VGE
29.02.24 14 Norovirus	13.02.24 7A Norovirus
03.03.24 20 Norovirus	18.02.24 7D Norovirus.
08.03.24 5 increased C19	11.03.24 6C Covid19
24.03.24 17 beds 1-4 Norovirus	20.03.24 5D Norovirus
26.03.24 6 Norovirus	20.03.24 5C Norovirus
	11.03.24 6C C19 mitigations
	24.03.24 6A C19 Mitigations

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

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

9. Audits

PVC: Peripheral Venous Cannula: Audit has taken place during Q4 within the acute trust: results and recommendations are shared with this meeting and have also been shared to all PSQBs and with the ward managers on the leadership meeting. The recommendations will formulate part of the annual programme and link in with support visits from the IPC team to all wards/areas to contribute to divisional IPC Improvement plans.



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

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

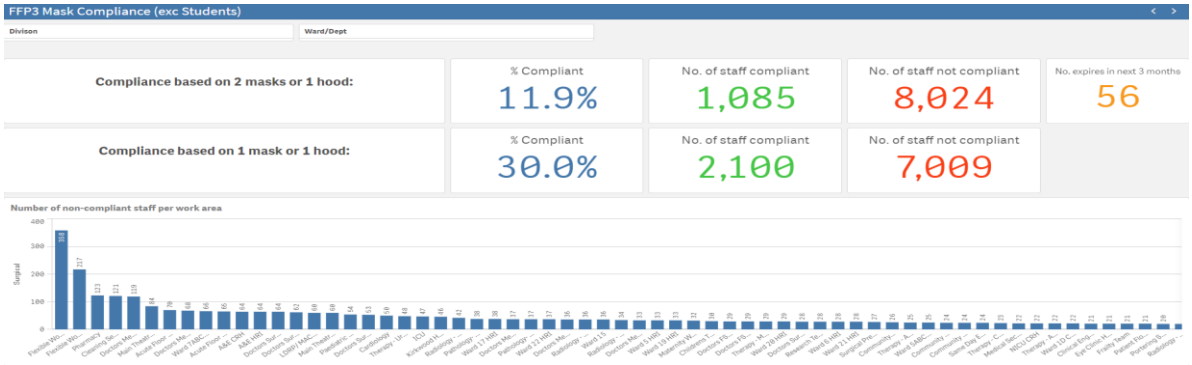
FLO (Front Line Ownership) audits: These are carried out by clinical areas to confirm compliance with set elements of staff and patient safety indicators, teams identify where good practice and areas where standards need improving. These audits are ongoing across all clinical areas The acute ward environment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

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

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

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

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



11. Recommendations

The Board is asked to note the performance against key IPC targets.

12. Workforce Committee Chair Highlight Report

To Note

Presented by Jo-Anne Wass

Calderdale and Huddersfield NHS Foundation Trust

CHAIR'S HIGHLIGHT REPORT
to the Board of Directors

Committee Name:	Workforce Committee
Committee Chair:	Jo-Anne Wass, Non-Executive Director
Date(s) of meeting:	Wednesday 12 June 2024
Date of Board meeting this report is to be presented:	Thursday 4 July 2024
ACKNOWLEDGE	At each committee meeting, we concentrate on one of the themes from the People Strategy. This meeting was looking in detail at colleague **engagement** -- both at the Trust-wide strategies designed to improve colleague engagement, and at how these are being applied within divisions. We were pleased to note the following positive achievements: **Theatre Improvement:** The committee were joined by Emma Mooney and Amy Sheddon (clinical operations managers for transformation and modernisation), who delivered an inspiring presentation on changes made within theatres to improve utilisation, drive down waiting times and improve patient outcomes. Their methodology of introducing speciality theatre user groups (STUGs) has received positive regional and national attention. Most **workforce metrics** continue to hit or exceed target. We are making a significant contribution to the local economy, social mobility and to reducing health inequalities through our apprenticeship programme. We achieved an apprenticeship levy spend of 86% in 22/23, an increase of 14% on the previous year. 64% of our apprentices came from the bottom five most deprived areas (as measured by the Index of Multiple Deprivation).

ASSURE	The committee received the following assurances in line with its terms of reference:
	
	• **Engagement strategies:** comprehensive **strategies are in place** to improve employee engagement at Trust level, and **there is evidence that these are being translated** at divisional level.
	  ○ We were provided with assurance that equality, diversity and inclusion was central to this.
	  ○ The committee were joined by Rachel Rae from the surgery and anaesthetics division and Gemma Plunkett from the family and specialist services

	division, who provided the committee with an overview of local actions to improve colleague engagement. This provided us with assurance that Trust wide strategies and divisional action plans are aligned and mutually reinforcing. o It also sparked a discussion about ways in which we could share good practice more effectively (in a systematic way) across divisions and we have agreed an action on this. • **Nurse, midwifery and allied health professional (AHP) staffing:** we received a detailed report (which had already been to the quality committee and is on the agenda for this board of directors meeting) and **received assurance from the chief nurse that staffing levels were safe, effective and sustainable** over the reporting period. • **Medical workforce programme update:** we received an update and assurance from the chief medical officer, covering a range of issues including plans to reduce bank and agency costs, and noted that the medical workforce has increased from 651 fte in 20/21 to 780 fte in March 2024, with the highest growth being in the consultant group. • **Freedom to Speak Up**: we received the independent report of the FTSU Guardian, providing a summary of issues and themes from the last period. There has been **an increase of 9.6% of concerns raised** over the period, most are raised anonymously, and the first ever reported incidents of staff suffering a detriment from speaking out. The committee were assured that **the Trust is investing in this service**, with another FTSU Guardian starting in post shortly, and there has been an increase in the number of workplace Ambassadors. The Guardian also reported that managers at all levels are responsive, and she feels well supported. The report raised a query about whether training in FTSU should be (role) essential. The committee asked its education sub-committee to consider this. • **Turnover continues to reduce** and stood at 6.99% in April 2024. The Trust's target is 10%. • In month sickness in April 2024 was down to 4.41%. The **target has been reset to a lower value of 4.5%.** • **Overall Essential Safety Training compliance is 93.58%.** The Trust's target is 90%.
AWARE	The Committee: • **Signed off the workforce race equality standard (WRES) and workforce disability equality standard (WDES) data** for publication later in the year.

	• **Noted that vacancies are up slightly**, at 6.1%. The committee received a **useful and detailed report on the vacancy position** and agreed this was a helpful format to review hotspot areas. • **Reviewed Board Assurance Framework risk 10b/19**, which is concerned with nursing staffing levels. **The committee accepted the recommendation that this risk score remain at 12.** • Plans to have a considered and detailed look at **equality, diversity and inclusio**n at a future meeting, bringing together data sources and current strategies and plans. • Was briefed on the **process for workforce planning** which takes place annually as part of the broader operational planning.
ONE CULTURE OF CARE	One Culture of Care is considered as part of the workforce reports and in discussions.
REGULATION	Regulation 18: Staffing

13. Finance and Performance Committee Chair Highlight Report

To Note

Presented by Vanessa Perrott

Calderdale and Huddersfield NHS Foundation Trust

CHAIR'S HIGHLIGHT REPORT
to the Board of Directors

Committee Name:	Finance and Performance Committee
Committee Chair:	Vanessa Perrott, Non-Executive Director
Date of meeting:	2nd July 2024
Date of Board meeting this report is to be presented:	4th July 2024
ACKNOWLEDGE	**PERFORMANCE** • Strong and sustained performance against target in many areas: reduced number of falls, and low numbers of pressure ulcers; and ongoing good cancer performance against 28 day target achieved. • Capped theatre utilisation is acknowledged as best performer in WYAAT at 82.3% (target 85%) • Diagnostic performance is improving with overall performance to 94% and continued progress in ECHO and Neurophysiology. **FINANCE** • In Month 2 the Trust is reporting a £0.20m favourable variance from plan, with a deficit of £7.6m • There is potential financial benefit within the revised plan and an agreement across WY to 'trade' which would ensure CHFT will be paid for delivering planned care activity above plan.
ASSURE	**PERFORMANCE** • A Deep dive into Outpatients follow ups, Bookings and DNAs was presented highlighting work done to validate and cleanse data; and to train staff on booking follow ups. Although there is no external metric, OPD F\ups are considered important to the Trust for patient care and quality. A review of the work on OPD bookings will come back to F and P in a few months. • CHFT currently has a relatively stable RTT Waiting list position which is below the revised target for 2024/25 of 36,538. For ENT and Gynaecology, there has been an increase in ASIs (ENT is a capacity issue whilst Gynaecology has seen an increase in demand) **FINANCE** • Revised financial plan has resulted in a reduced deficit plan from CHFT from £38.6m to £26.26m. • The CIP requirement has been stretched to £32.18m. Of this, £30m is to come from new schemes and £2.18m FYE from 23/24 schemes with a recurrency level of 68%. • The Committee approved the updates to the BAF risks which it has responsibility for relating to demand and capacity, local and national performance targets, capital funding and longer-term financial sustainability. On financial sustainability it was agreed that reference would be made within the risk to the preparation of medium term financial plans. • The Committee also approved the National Cost Collection pre-submission report which provides benchmarking financial

	information nationally and which is used locally in planned care reviews, feeds into GIRFT and is used to assess potential CIP areas
AWARE	**PERFORMANCE** • Percentage of complaints closed on time has fallen into special cause variation (70% against target of 90%). Underlying reasons include sickness absence of key members of staff; complexity of complaints and poor quality of responses. Training in progress for staff to address this. • Bed occupancy rates (20% occupied by those who no longer meet the criteria to reside); and high numbers of TOC patients are impacting on ED waiting times and beds available for Stroke patients. (Failing targets in both these areas.) Stroke performance will be looked at in a deep dive at a future F and P meeting. **FINANCE** • There is some ongoing uncertainty around aspects of the financial plan which will be monitored through this Committee. The financial risk for achieving the year-end target is currently rated high (20) on the risk register.
ONE CULTURE OF CARE	One Culture of Care considered as part of the performance and finance reports.
REGULATIONS	Regulation 13: Financial position Regulation 17: Good governance

Elective recovery against West Yorkshire (as of 25/6/24)

Provider	40 Week Waits	52 Week Waits	65 Week Waits	78 Week Waits	104 Week Waits
Airedale	1,512	384	14	0	0
Bradford	1,949	477	70	0	0
Calderdale and Huddersfield	756	76	18*	0	0
Leeds	9,615	3,717	705	35	3
Mid Yorks	7,259	2,567	394	2	0

*A growing ASI (Appointment Slot Issue) list (especially in ENT) represents a risk to the continuing reduction in list size

14. Budget Book 2024/25

To Approve

Presented by Gary Boothby

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Date of Meeting:	Thursday 4 July 2024
Meeting:	Public Board of Directors
Title:	Budget Book 2024/25
Author:	Philippa Russell - Assistant Director of Finance
Sponsoring Director:	Gary Boothby - Director of Finance
Purpose of the Report	To update the Board on the final financial plan and to gain approval of the budget for 2024/25.
Key Points to Note	The attached Budget Book provides a summary of the 2024/25 final financial plan as submitted to NHS England (NHSE) including: - Income & Expenditure Summary - Establishment - Balance Sheet Plan - Cashflow Plan - Divisional Budgets - Activity and Income - Agency Plan - Reserves summary - Capital Plan Budget and commentary as at 12th of June 2024 and reconciled to the NHSE Financial Planning Return submitted on that date. Attached: 2024/25 Budget Book
Regulation	Regulation 13: Financial position
EQIA – Equality Impact Assessment	Any decisions taken in support of the overall financial plan will be subject to Equality Impact Assessment and Quality Impact Assessment on a case by case basis, for examples changes linked to the efficiency programme.
Recommendation	The Board is asked to **APPROVE** the 2024/25 Budget Book.

compassionate care

NHS
Calderdale and Huddersfield
NHS Foundation Trust

BUDGET BOOK
2024-25

2024/25 Financial Plan - Overview

The Trust's financial plan for 2024/25 is for a £26.3m deficit.

Planning Assumptions:

Income Changes:

- Block Contract allocations uplifted:
  + 0.6% Tariff uplift (1.7% inflation less 1.1% efficiency requirement)
- Allocations adjusted to reflect 'Convergence Adjustment' of -0.97%
- Share of local Convergence Adjustment (Calderdale ICB) -£0.49m
- In 2024/25 the Trust is operating under the National Payment by Results (PBR) funding mechanism for activity within the scope of Elective Recovery.
- Assumes additional Elective Recovery Funding earned above baseline value of £8.14m.
- Additional non-recurrent ICB funding allocation of £5.60m
- Additional non-recurrent funding allocation of £1.70m to support PFI remeasurement pressure

Cost Changes:

- 23/24 Elective Recovery budgets (net of any efficiency) made recurrent.
- Includes inflationary costs of £15.7m, of which only £7.6m are funded through the NHS Payment Scheme uplift.
- Pay inflation included at 2% as per national guidance.
- Non Pay inflation includes impact of current RPI on PFI / B Braun contracts.
- The efficiency plan submitted as part of the May plan submission assumed delivery of £27.18m of savings, (£25m of new schemes plus the Full Year Effect (FYE) of 23/24 schemes. The Trust has now submitted a revised plan than includes an additional £5m of savings increasing the efficiency requirement for this year to £32.18m (£30m new schemes plus £2.18m FYEs).

Risks

- Payment by Results (PbR) methodology for Elective Recovery. The income plan assumes full delivery of the 24/25 Elective Recovery plan and that any associated costs are managed within the agreed funding envelope.
- Risk of further strike action resulting in increased costs and impacting on elective recovery.
- Risk that additional funded bed capacity is insufficient to meet demand due to DTOC, growth or winter pressures.
- Risk of further inflationary pressures above planned level.
- Risk that any Pay Award above the 2% planning assumption is not fully funded.
- A challenging efficiency requirement of £32.18m which equates to 5.9% of operating expenditure, including an additional £5.0m stretch target.

24/25 Plan (CHFT Group): Income & Expenditure

Income & Expenditure	23/24 Budget	23/24 Actual	24/25 Plan (Excl. Efficiency)	24/25 Efficiency	24/25 Total Plan
	£'m	£'m	£'m	£'m	£'m
NHS Clinical Income[1]	474.70	492.62	498.51	0.06	498.56
Other Income	55.37	62.12	55.25	1.42	56.67
TOTAL INCOME	530.07	554.74	553.76	1.47	555.23
Medical	(98.97)	(106.39)	(110.12)	7.05	(103.08)
Nursing	(101.45)	(101.61)	(108.83)	7.49	(101.34)
Sci Tech & Ther	(44.92)	(43.02)	(48.43)	1.13	(47.30)
Support to clinical staff	(55.85)	(53.04)	(58.32)	0.75	(57.57)
Any Other Spend[1]	(0.68)	(1.66)	(2.95)	0.94	(2.01)
Managers and infrastructure support	(48.50)	(51.94)	(55.24)	1.90	(53.35)
Ambulance Service	0.00	(0.08)	(0.06)	0.00	(0.06)
PAY EXPENDITURE	(350.38)	(357.73)	(383.97)	19.26	(364.70)
Drugs	(47.98)	(45.82)	(51.02)	0.94	(50.08)
Clinical Supplies & Services	(33.68)	(35.62)	(40.17)	2.44	(37.73)
Other Costs	(80.02)	(94.55)	(95.68)	8.07	(87.61)
NON PAY EXPENDITURE	(161.68)	(176.00)	(186.87)	11.44	(175.43)
TOTAL EXPENSES	(512.06)	(533.73)	(570.83)	30.70	(540.13)
EBITDA	**18.01**	**21.01**	**(17.08)**	**32.18**	**15.10**
Non Operating Expenditure	(39.15)	(52.85)	(38.48)	0.00	(38.48)
TOTAL SURPLUS/(DEFICIT)	**(21.15)**	**(31.84)**	**(55.56)**	**32.18**	**(23.38)**
Less: Items excluded from Control Total[2]	0.34	18.60	(2.88)	0.00	(2.88)
TOTAL SURPLUS/(DEFICIT) on a Control Total Basis	**(20.80)**	**(13.24)**	**(58.43)**	**32.18**	**(26.25)**

Overview:

- Total deficit plan of £26.25 as per revised plan submission (June 2024).
- The efficiency plan submitted as part of the May plan submission assumed delivery of £27.18m of savings, (£25m of new schemes plus the Full Year Effect (FYE) of 23/24 schemes. The Trust has now submitted a revised plan than includes an additional £5m of savings increasing the efficiency requirement for this year to £32.18m (£30m new schemes plus £2.18m FYEs).
- Position includes inflation, growth, and approved pressures and developments.
- Minimal contingency available to cover any in year pressures or developments approved through the Business Case Approval Group.

[1] Excludes notional income and expenditure relating to 6.3% pension contributions paid by NHS England in 23/24

[2] Donated Asset Income, Donated Asset Depreciation, Donated Consumables, Impairments plus PFI remeasurement adjustment

24/25 Plan (CHFT Group): Establishment

Whole Time Equivalent (WTE)	23/24 Budget	23/24 Actual	24/25 Plan (Excl. Efficiency)	24/25 Efficiency	24/25 Total Plan
	WTE	WTE	WTE	WTE	WTE
Medical	786.52	713.59	807.52	(20.00)	787.52
Nursing	1,946.89	1,792.10	1,990.51	(50.00)	1,940.51
Sci Tech & Ther	857.76	846.29	878.21	(21.00)	857.21
Support to clinical staff	1,801.77	1,670.70	1,870.10	(44.00)	1,826.10
Any Other Spend	1.19	0.19	1.19	0.00	1.19
Non Medical - Non-Clinical	1,110.66	1,091.58	1,149.36	(33.00)	1,116.36
TOTAL	6,504.79	6,114.45	6,696.89	(168.00)	6,528.89

Notes

- WTE as at 31st March of each year
- WTE actual for 23/24 is substantive staff only (excluding bank and agency workers)

24/25 Plan (CHFT Group): Statement of Financial Position

Statement of Financial Position	23/24 Budget As at 31 Mar 24 £'m	23/24 Actual As at 31 Mar 24 £'m	24/25 Plan As at 31 Mar 25 £'m
Non Current Assets			
Property, Plant & Equipment	151.38	184.38	211.89
On B/S PFI Assets	58.77	65.18	60.69
Right to Use Leases[1]	22.00	9.31	23.16
Investment in Joint Venture	6.68	5.89	5.32
Other	2.87	2.75	2.80
	241.69	267.51	303.87
Current Assets			
Inventories	8.49	8.36	8.66
Receivables	17.69	17.26	14.96
Other	6.63	3.97	3.97
Cash	2.19	27.05	4.83
	34.99	56.65	32.42
Current Liabilities			
Loans	(2.21)	(2.21)	(2.21)
Deferred Income	(9.69)	(12.79)	(9.43)
Payables	(66.98)	(84.77)	(69.06)
Provisions	(4.60)	(6.87)	(4.81)
Leases (Incl PFI)	(6.20)	(11.16)	(12.12)
	(89.67)	(117.80)	(97.63)
Non Current Liabilities			
Loans	(11.05)	(11.05)	(8.84)
Leases (Incl PFI)	(75.89)	(135.67)	(133.44)
Provisions	(1.12)	(0.84)	(0.84)
Other	(0.82)	(0.62)	(0.63)
	(88.88)	(148.17)	(143.75)
TOTAL ASSETS EMPLOYED	**98.13**	**58.18**	**94.90**
Taxpayers Equity			
Public Dividend Capital	324.93	334.78	398.21
Income & Exp Reserve	(230.50)	(287.95)	(310.10)
Revaluation Reserve	3.71	11.35	6.79
TOTAL TAXPAYERS EQUITY	**98.13**	**58.18**	**94.90**

1. New accounting standard IFRS 16 relating to leases implemented from 22/23

Key Assumptions:

- No asset valuation adjustments are assumed.

24/25 Plan (CHFT Group): Statement of Cash Flow

Statement of Cash Flow	23/24 Budget £'m	23/24 Actual £'m	24/25 Plan £'m
Surplus/(deficit) from Operations	**(17.69)**	**(31.84)**	**(23.38)**
non-cash flows in operating surplus/(deficit)			
Non-cash donations/grants credited to income	(0.08)	(0.49)	(0.08)
Depreciation and amortisation	21.26	17.94	21.25
Other operating non-cash (income)/ expenses	17.82	26.16	17.16
Impairments	0.00	8.74	0.00
Gain on disposal of assets	0.00	0.00	0.00
	39.00	**52.36**	**38.33**
Operating Cash flows before movements in working capital	**21.31**	**20.52**	**14.96**
Movement in working capital	**(3.40)**	**10.94**	**(0.09)**
Net cash inflow/(outflow) from operating activities	17.91	31.46	14.86
Net cash inflow/(outflow() from investing activities			
Capital Expenditure	(28.92)	(46.10)	(49.50)
Proceeds on disposal of property, plant and equipment	0.00	0.00	0.00
Increase/(decrease) in Capital Creditors	(1.00)	10.34	(17.46)
Other cash flows from investing activities	0.66	2.37	1.29
	(29.26)	**(33.39)**	**(65.67)**
Net cash inflow/(outflow) before financing	**(11.35)**	**(1.93)**	**(50.80)**
Net cash inflow/(outflow) from financing activities			
Public Dividend Capital Received	11.81	22.71	32.53
Revenue Support Public Dividend Capital	9.50	8.30	30.91
PDC Dividends paid	(1.54)	(2.04)	(0.07)
Repayment of Loans	(2.21)	(2.21)	(2.21)
Financing	(22.27)	(22.56)	(23.57)
Non-Current Movements	0.00	0.15	0.10
	(4.71)	**4.35**	**37.69**
Net increase/(decrease) in cash	**(16.05)**	**2.43**	**(13.11)**
Opening cash [1]	21.69	24.63	17.94
Closing cash	**5.64**	**27.05**	**4.83**

Note 1: Planned opening cash balance based on 23/24 Month 11 Forecast as per planning submission.

Key Assumptions:

- Capital Plan totals £54.58m, £49.50m plus £5.00m new leases and £0.08m Donated Assets:
  * £16.97m internally funded
  * £32.53m funded by Public Dividend Capital (PDC)

- Revenue cash support will be required to support the revised deficit plan of £26.25m, the internally funded capital plan which exceeds internal funding sources by £4.49m and an element of working capital movement that relates to the previous year's deficit.
- Cash support is in the form of Revenue PDC - planned value is £30.91m for 24/25. This does incur an additional PDC Dividend charge in the first year of draw down.

24/25 Plan by Division: Income & Expenditure

Division	23/24 Contribution Actual £'m	24/25 Income Plan £'m	24/25 Pay Plan £'m	24/25 Non Pay Plan £'m	24/25 Contribution Plan £'m
Medical Division	(144.03)	9.41	(111.83)	(42.15)	(144.57)
Surgical Division	(104.93)	2.35	(82.82)	(25.13)	(105.60)
Families & Specialist Services	(93.68)	14.03	(78.37)	(33.32)	(97.66)
Community Division	(32.45)	3.78	(35.72)	(3.64)	(35.58)
Corporate Division	(56.11)	(2.15)	(24.84)	(34.26)	(61.26)
Estates & Facilities	0.00	0.00	0.00	0.00	0.00
Health Informatics	1.38	21.54	(12.43)	(7.44)	1.67
PMU	2.20	9.30	(2.84)	(4.71)	1.75
CHS LTD*	0.69	70.67	(13.29)	(56.68)	0.70
Central Inc/ Technical Accounts*	415.34	494.39	(5.86)	(78.76)	409.77
Trust Reserves	(1.65)	2.97	3.30	(1.75)	4.52
Surplus / (Deficit)*	**(13.24)**	**626.28**	**(364.70)**	**(287.83)**	**(26.25)**
LESS Inter-company payments	**(0.00)**	**(71.05)**	**0.00**	**71.05**	**0.00**
GROUP Surplus / (Deficit)	**(13.24)**	**555.23**	**(364.70)**	**(216.78)**	**(26.25)**

* Includes inter-company transactions

Notes:

• The planned income and expenditure totals shown above include inter-company payments of £71.15m between the Trust and its subsidiary company (CHS Ltd). These payments are excluded when reporting the Income & Expenditure position for the Group (as required by NHS England).

24/25 Plan: Activity & Income

Activity	23/24 Budget [1]	23/24 Actual [1]	24/25 Plan (Excl. CIP)	24/25 CIP	24/25 Total Plan
	Spells	Spells	Spells	Spells	Spells
NHS Clinical Income					
Elective	4,636	4,658	4,170	0	4,170
Non Elective	53,866	54,070	38,535	0	38,535
Daycase	49,935	53,089	49,622	0	49,622
Outpatients	434,259	454,105	452,467	0	452,467
A & E	174,293	177,798	176,460	0	176,460
$SDEC_1$			31,292	0	31,292
Other-NHS Clinical	1,975,197	2,186,437	2,377,230	0	2,377,230
TOTAL SPELLS	2,692,185	2,930,157	3,129,776	0	3,129,776

Income	23/24 Budget	23/24 Actual	24/25 Plan (Excl. CIP)	24/25 CIP	24/25 Total Plan
	£'m	£'m	£'m	£'m	£'m
NHS Clinical Income					
Elective	17.65	18.91	17.53	0.00	17.53
Non Elective	125.90	131.61	119.60	0.00	119.60
Daycase	32.73	35.92	36.94	0.00	36.94
Outpatients	35.82	39.88	48.78	0.00	48.78
A & E	31.42	33.18	33.27	0.00	33.27
$SDEC_1$			15.59	0.00	15.59
Other-NHS Clinical	231.18	233.12	226.81	0.06	226.87
CQUIN	0.00	0.00	0.00	0.00	0.00
Other Income	55.37	62.12	55.25	1.42	56.67
TOTAL INCOME	530.07	554.74	553.76	1.47	555.23

Key Assumptions:

• Contract Income based on Aligned Payment Incentive (API) approach with a fixed and variable element.

• In 2024/25 the Trust is operating under the National Payment by Results (PBR) funding mechanism for activity within the scope of Elective Recovery.

• The financial value of elective recovery activity is being monitored against a financial baseline set by NHS England (NSHE). Our Financial and activity plans assume that the Trust will exceed this Elective Recovery Funding (ERF) baseline and secure additional funding of £8m.

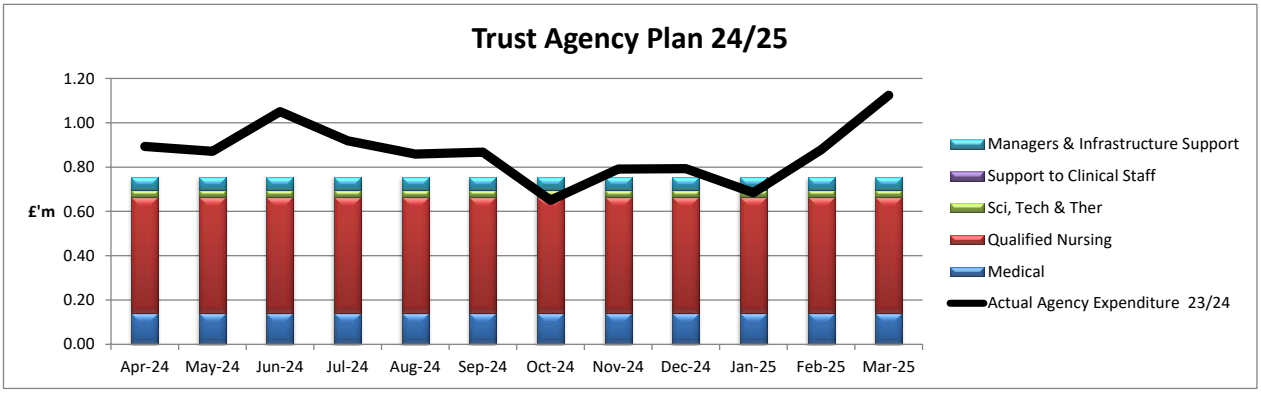
• Final plan includes £7.3m non-recurrent funding allocation (£5.6m additional Integrated Care System (ICS) allocation & £1.7m additional funding to support the pressure arising from the PFI remeasurement (technical adjustment)).

1. Same Day Emergency Care (SDEC) activity was previously captured across the different Points of Delivery (Elective, Daycase, Outpatient and Non-Elective) and is now accounted for seperately as shown above. An ERF baseline adjustment has been submitted to NHSE to remove the SDEC activity from the scope of ERF.

24/25 Plan: Agency Trajectory

Agency Plan 24/25	Apr-24 £'m	May-24 £'m	Jun-24 £'m	Jul-24 £'m	Aug-24 £'m	Sep-24 £'m	Oct-24 £'m	Nov-24 £'m	Dec-24 £'m	Jan-25 £'m	Feb-25 £'m	Mar-25 £'m	Total £'m
Medical	0.14	0.14	0.14	0.14	0.14	0.14	0.14	0.14	0.14	0.14	0.14	0.14	1.69
Qualified Nursing	0.52	0.52	0.52	0.52	0.52	0.52	0.52	0.52	0.52	0.52	0.52	0.52	6.27
Sci, Tech & Ther	0.03	0.03	0.03	0.03	0.03	0.03	0.03	0.03	0.03	0.03	0.03	0.03	0.38
Support to Clinical Staff	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Managers & Infrastructure Support	0.06	0.06	0.06	0.06	0.06	0.06	0.06	0.06	0.06	0.06	0.06	0.06	0.73
Total	0.76	0.76	0.76	0.76	0.76	0.76	0.76	0.76	0.76	0.76	0.76	0.76	9.07

Actual Agency Expenditure 23/24	0.89	0.87	1.05	0.92	0.86	0.87	0.65	0.79	0.79	0.68	0.88	1.12	10.38



Key Assumptions:

- In 24/25 the Agency Ceiling is set at System level and equates to 3.2% of total pay expenditure.
- For CHFT this would equate to £11.63m for the year.
- The Agency plan is lower than that value at £9.07m and reflects some ambitious efficiency plans to retract from high cost agency, recruit to vacancies and reduce additional capacity requirements.

24/25 Plan: Reserves

Reserves Summary	24/25 Plan £'m	Notes
Uncommitted Reserves		
Contingency Reserve	0.17	Assumed as Pay in Plan
Winter Contingency Reserve		No Contingency held - budgets allocated to Divisions
Education & Training Reserve	0.45	
CDC Contingency	0.04	
Reconfiguration Reserve	0.04	
	0.71	
Planning Gap		
Unidentified CIP - Planning Gap	0.00	
CIP in scoping not yet allocated	(6.30)	To be allocated once plans are fully developed
	(6.30)	
Committed Reserves		
Approved Business Cases / carried forward	0.70	To be transferred to Divisions once costs are incurred
Pressures & Developments on hold	1.67	To be transferred to Divisions once approval confirmed
	2.37	
TOTAL RESERVES	**(3.22)**	

Notes:

• CIP in scoping includes new Headcount reduction and Bank & Agency portfolios - GW2 savings to be allocated to Divisions at M3

24/25 Plan: Capital

Scheme Category	Capital Schemes	24/25 Plan £'m
Estates	CRH Main Entrance	0.30
	Acre Mill	0.12
	Plate Heat exchanges	0.02
		0.44
New Build	Catheterisation Laboratory	1.66
	Car Park - CRH	7.96
	Sub-station Enabling works	2.97
		12.59
Equipment	Fluoroscopy	0.75
	Isolator HPS	0.45
		1.20
Other	Urgency and Emergency Care	1.00
	Contingency	1.75
		2.75
Total Internally Funded		**16.97**
Funded by Public Dividend Capital (DHSC)	Community Diagnostics Centres	18.28
	Diagnostics Digital Capability	0.81
	Reconfiguration - CRH	3.36
	YIC Shared Reporting Solutions	0.09
	HPS	10.00
Donated Assets		0.08
Total Externally Funded		**32.61**
IFRS16	Leases	5.00
TOTAL CAPITAL EXPENDITURE		**54.58**

Key Assumptions:

• Internally generated funds from Depreciation (£21.25m), are also required to cover the cost of repayments on the PFI (£3.79m), other leases (£2.77m) and Capital Loans (£2.21m), leaving £12.48m available for Capital Expenditure. £16.97m has been planned as shown above. Cash support of £4.49m will be required to cover the shortfall.

• Capital plans as reported to NHSI also include Right of Use Leases, following changes to accounting standards (IFRS 16).

15. Month 2 Financial Summary including Annual Plan 24/25

To Note

Presented by Gary Boothby

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Date of Meeting:	Thursday 4 July 2024
Meeting:	Public Board of Directors
Title:	Month 2 Finance Report
Author:	Philippa Russell - Assistant Director of Finance
Sponsoring Director:	Gary Boothby - Director of Finance
Previous Forums:	Finance & Performance Committee
Purpose of the Report	The purpose of this report is to provide a summary of the financial position as reported at the end of Month 2 (May 2024)
Key Points to Note	**<u>Year To Date Summary</u>** In Month 2 the Trust is reporting the income and expenditure position against the plan submitted in May, as per NHS England's external reporting requirements. The plan has been re-submitted in June and the changes have been reflected in the forecast position. Budgets will be realigned from M3 to reflect this revised plan. The Trust is reporting a year-to-date deficit position £7.60m, (excluding the impact of Donated Assets, Impairments and the PFI remeasurement due to IFRS16), a £0.20m favourable variance from plan (May submission). The in-month position is a deficit of £3.71m, a £0.16m favourable variance. • Key drivers of the favourable variance were higher than planned CIP delivery and a reduction in PDC Dividend in line with the revised forecast and capital plan. • The CIP challenge will increase significantly from Month 3 due to the profiling of planned savings including: Unplanned Care (LOS and Bed reduction schemes), Headcount Reduction and Bank and Agency schemes. Achievement of the 24/25 plan, will require a significant improvement in the run-rate through full delivery of targeted savings. • In 2024/25 the Trust is operating under the National Payment by Results (PBR) funding mechanism for activity within the scope of Elective Recovery. Delivery of planned care activity in Month 2 was slightly above the planned level. Overall Weighted Elective Recovery Position as a percentage of plan was 101.5%. • Year to Date the Trust has delivered efficiency savings (CIP) of £3.14m, £0.08m higher than planned.

	• Year to Date Agency expenditure is £1.43m, £0.08m lower than planned. Expenditure is below the Integrated Care Board (ICB) Agency Ceiling of 3.2% of total pay expenditure. **Key Variances** • Income is £0.74m lower than planned due to: slippage on the implementation of Community Diagnostic Centres (CDCs) and the profiling of PBR Elective Recovery Income and Depreciation funding. • Pay costs are £0.88m lower than the planned level year to date with the key drivers being slippage on the implementation of CDCs (offset by lower than planned income) and higher than planned vacancies (vacancy freeze (CIP)and midwifery vacancies). • Non-pay operating expenditure is £0.69m higher than planned year to date including non-recurrent legal costs and higher than planned Independent Sector spend for Elective Recovery. **Forecast** The Trust has submitted a revised plan for a £26.26m deficit, reflecting an improvement of £12.3m: £5m stretch CIP target; £5.6m additional ICS funding allocation; and £1.7m additional funding to support the pressure arising from the PFI remeasurement (technical adjustment). Revised CIP Target is now £32.18m (£30m new schemes plus £2.18m Full Year Effect of 23/24 schemes). Attached: Month 2 Finance Report
Regulation	Regulation 13: Financial position
EQIA – Equality Impact Assessment	The attached paper is for information only. Where this information is used to inform changes to services, policies or procedures, an Equality Impact Assessment will first be completed to assess the effects that it is likely to have on people from different protected groups, as defined in the Equality Act 2010.
Recommendation	The Board is asked to **RECEIVE** the Finance Report and note the financial position for the Trust as at the end of May 2024.

EXECUTIVE SUMMARY: Total Group Financial Overview as at 31st May 2024 - Month 2

KEY METRICS

	M2 Plan £m	M2 Actual £m	M2 Var £m	YTD (MAY 2024) Plan £m	YTD Actual £m	YTD Var £m	Forecast 24/25 Plan £m	Forecast £m	Forecast Var £m
I&E: Surplus / (Deficit)	(£3.87)	(£3.71)	£0.16	(£7.79)	(£7.60)	£0.20	(£38.55)	(£26.26)	£12.30
Agency Expenditure (vs Plan)	(£0.76)	(£0.75)	£0.00	(£1.51)	(£1.43)	£0.08	(£9.07)	(£6.64)	£2.43
Capital	£0.09	£0.15	(£0.06)	£0.10	£0.15	(£0.05)	£53.34	£54.58	(£1.25)
Cash	£23.54	£16.53	(£7.01)	£23.54	£16.53	(£7.01)	£14.32	£4.82	(£9.50)
Invoices paid within 30 days (%) (Better Payment Practice Code)	95.0%	91.7%	-3%	95.0%	93.0%	-2%			
Cost Improvement Plans (CIP)	£1.55	£1.60	£0.06	£3.06	£3.14	£0.08	£32.18	£32.18	£0.00
Use of Resource Metric	3	3		3	3		3	3	

Year To Date Summary

In Month 2 the Trust is reporting the income and expenditure position against the plan submitted in May, as per NHS England's external reporting requirements. The plan has been re-submitted in June and the changes have been reflected in the forecast position. Budgets will be realigned from M3 to reflect this revised plan.

The Trust is reporting a year to date deficit position £7.60m, (excluding the impact of Donated Assets, Impairments and the PFI remeasurement due to IFRS16), a £0.20m favourable variance from plan (May submission). The in-month position is a deficit of £3.71m, a £0.16m favourable variance.

- Key drivers of the favourable variance were higher than planned CIP delivery and a reduction in PDC Dividend in line with the revised forecast and capital plan.
- The CIP challenge will increase significantly from Month 3 due to the profiling of planned savings including: Unplanned Care (LOS and Bed reduction schemes), Headcount Reduction and Bank and Agency schemes. Achievement of the 24/25 plan, will require a significant improvement in the run-rate through full delivery of targeted savings.
- In 2024/25 the Trust is operating under the National Payment by Results (PBR) funding mechanism for activity within the scope of Elective Recovery.

Delivery of planned care activity in Month 2 was slightly above the planned level. Overall Weighted Elective Recovery Position as a percentage of plan was 101.5%.

- Year to Date the Trust has delivered efficiency savings (CIP) of £3.14m, £0.08m higher than planned.
- Year to Date Agency expenditure is £1.43m, £0.08m lower than planned. Expenditure is below the Integrated Care Board (ICB) Agency Ceiling of 3.2% of total pay expenditure.

Key Variances

- Income is £0.74m lower than planned due to: slippage on the implementation of Community Diagnostic Centres (CDCs) and the profiling of PBR Elective Recovery Income and Depreciation funding.
- Pay costs are £0.88m lower than the planned level year to date with the key drivers being slippage on the implementation of CDCs (offset by lower than planned income) and higher than planned vacancies (vacancy freeze (CIP)and midwifery vacancies).
- Non-pay operating expenditure is £0.69m higher than planned year to date including non-recurrent legal costs and higher than planned Independent Sector spend for Elective Recovery.

Forecast

The Trust has submitted a revised plan for a £26.26m deficit, reflecting an improvement of £12.3m: £5m stretch CIP target; £5.6m additional ICS funding allocation; and £1.7m additional funding to support the pressure arising from the PFI remeasurement (technical adjustment).

Revised CIP Target is now £32.18m (£30m new schemes plus £2.18m Full Year Effect of 23/24 schemes).

Total Group Financial Overview as at 31st May 2024 - Month 2

INCOME AND EXPENDITURE COMPARED TO PLAN SUBMITTED TO NHS IMPROVEMENT

YEAR TO DATE POSITION: M2

CLINICAL ACTIVITY

	M2 Plan	M2 Actual	Var
Elective	707	670	(37)
Non-Elective	6,371	7,123	752
Daycase	8,247	8,659	412
Outpatient	77,020	77,624	604
A&E	29,491	31,563	2,072
Other NHS Non-Tariff	408,080	377,396	(30,684)
Total	**529,916**	**503,034**	**(26,882)**

TOTAL GROUP: INCOME AND EXPENDITURE

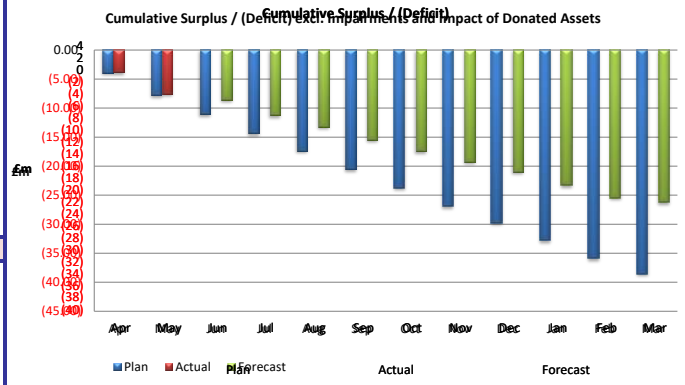
	M2 Plan	M2 Actual	Var
	£m	£m	£m
Elective	£2.99	£2.73	(£0.26)
Non Elective	£19.87	£20.93	£1.07
Daycase	£6.09	£6.57	£0.48
Outpatients	£8.30	£8.35	£0.05
A & E	£5.56	£5.90	£0.34
Other-NHS Clinical	£39.01	£35.87	(£3.14)
CQUIN	£0.00	£0.00	£0.00
Other Income	£9.42	£10.15	£0.73
Total Income	**£91.23**	**£90.49**	**(£0.74)**
Pay	(£62.25)	(£61.38)	£0.88
Drug Costs	(£8.27)	(£7.94)	£0.32
Clinical Support	(£6.66)	(£6.65)	£0.02
Other Costs	(£11.99)	(£13.03)	(£1.04)
PFI Costs	(£2.89)	(£2.88)	£0.02
Total Expenditure	**(£92.06)**	**(£91.87)**	**£0.19**
EBITDA	**(£0.83)**	**(£1.38)**	**(£0.55)**
Non Operating Expenditure	(£6.97)	(£6.22)	£0.75
Surplus / (Deficit) Adjusted*	**(£7.79)**	**(£7.60)**	**£0.20**

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

DIVISIONS: INCOME AND EXPENDITURE

	M2 Plan	M2 Actual	Var
	£m	£m	£m
Surgery & Anaesthetics	(£17.87)	(£17.82)	£0.04
Medical	(£24.41)	(£24.77)	(£0.36)
Families & Specialist Services	(£16.68)	(£16.29)	£0.39
Community	(£5.87)	(£5.75)	£0.12
Estates & Facilities	£0.00	(£0.00)	(£0.00)
Corporate	(£10.12)	(£10.16)	(£0.04)
THIS	£0.28	£0.31	£0.04
PMU	£0.29	£0.49	£0.20
CHS LTD	£0.14	£0.14	(£0.00)
Central Inc/Technical Accounts	£66.70	£66.01	(£0.69)
Reserves	(£0.24)	£0.24	£0.49
Surplus / (Deficit)	**(£7.79)**	**(£7.60)**	**£0.20**

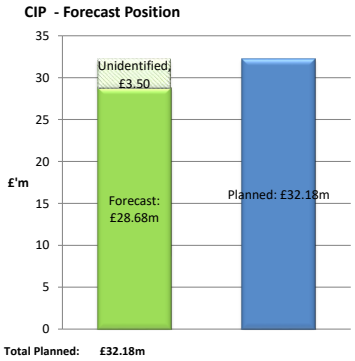
TOTAL GROUP SURPLUS / (DEFICIT)

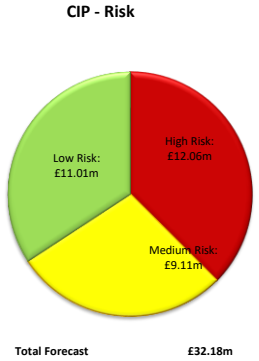


KEY METRICS

	Year To Date			Year End: Forecast			
	M2 Plan	M2 Actual	Var	Plan	Forecast	Var	
	£m	£m	£m	£m	£m	£m	
I&E: Surplus / (Deficit)	(£7.79)	(£7.60)	£0.20	(£38.55)	(£26.26)	£12.30	
Capital	£0.10	£0.15	(£0.05)	£53.34	£54.58	(£1.25)	
Cash	£23.54	£16.53	(£7.01)	£14.32	£4.82	(£9.50)	
Invoices Paid within 30 days (BPPC)	95%	93%	-2%				
CIP	£3.06	£3.14	£0.08	£32.18	£32.18	£0.00	
	Plan	Actual		Plan	Forecast		
Use of Resource Metric	3	3		3	3		

COST IMPROVEMENT PROGRAMME (CIP)





YEAR END 24/25

CLINICAL ACTIVITY

	Plan	Actual	Var
Elective	4,170	3,973	(197)
Non-Elective	38,535	43,076	4,541
Daycase	49,622	52,373	2,751
Outpatient	452,467	456,002	3,535
A&E	176,460	188,883	12,423
Other NHS Non- Tariff	2,408,522	2,227,154	(181,368)
Total	**3,129,776**	**2,971,462**	**(158,315)**

TOTAL GROUP: INCOME AND EXPENDITURE

	Plan	Actual	Var
	£m	£m	£m
Elective	£17.53	£16.05	(£1.48)
Non Elective	£119.60	£126.09	£6.50
Daycase	£36.94	£40.07	£3.13
Outpatients	£48.78	£49.03	£0.25
A & E	£33.27	£35.31	£2.04
Other-NHS Clinical	£235.96	£231.19	(£4.76)
CQUIN	£0.00	£0.00	£0.00
Other Income	£56.58	£63.41	£6.82
Total Income	**£548.65**	**£561.15**	**£12.50**
Pay	(£364.70)	(£365.11)	(£0.41)
Drug Costs	(£50.08)	(£48.87)	£1.20
Clinical Support	(£39.00)	(£38.63)	£0.37
Other Costs	(£73.75)	(£78.30)	(£4.55)
PFI Costs	(£17.36)	(£17.27)	£0.09
Total Expenditure	**(£544.90)**	**(£548.19)**	**(£3.28)**
EBITDA	**£3.75**	**£12.96**	**£9.21**
Non Operating Expenditure	(£42.30)	(£39.21)	£3.09
Surplus / (Deficit) Adjusted*	**(£38.55)**	**(£26.26)**	**£12.30**

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

DIVISIONS: INCOME AND EXPENDITURE

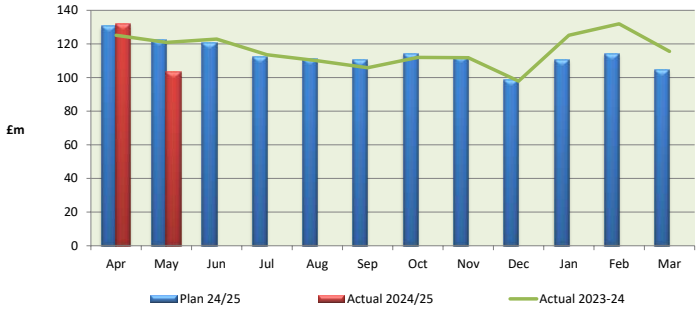
	Plan	Forecast	Var
	£m	£m	£m
Surgery & Anaesthetics	(£105.60)	(£106.02)	(£0.42)
Medical	(£144.57)	(£145.19)	(£0.61)
Families & Specialist Services	(£97.66)	(£97.03)	£0.63
Community	(£35.58)	(£35.45)	£0.13
Estates & Facilities	£0.00	(£0.00)	(£0.00)
Corporate	(£61.26)	(£60.57)	£0.69
THIS	£1.67	£1.67	(£0.00)
PMU	£1.75	£1.75	(£0.00)
CHS LTD	£0.70	£0.67	(£0.03)
Central Inc/Technical Accounts	£397.48	£407.92	£10.44
Reserves	£4.51	£5.98	£1.47
Surplus / (Deficit)	**(£38.55)**	**(£26.26)**	**£12.30**

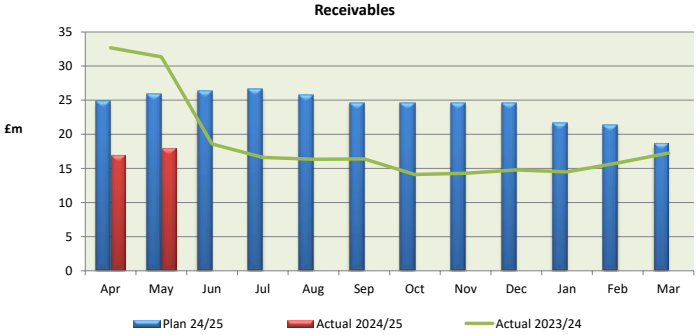
Total Group Financial Overview as at 31st May 2024 - Month 2

CAPITAL AND CASH COMPARED TO PLAN SUBMITTED TO NHS IMPROVEMENT

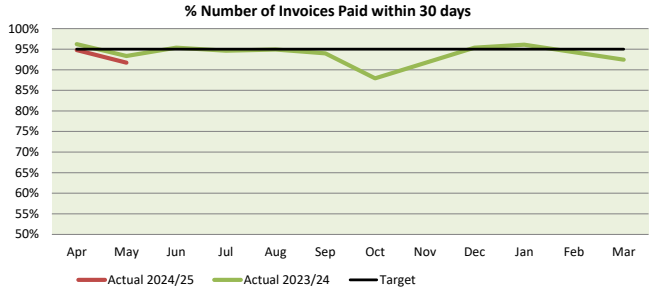
WORKING CAPITAL

	M2 Plan £m	M2 Actual £m	Var £m	M2
Payables (excl. Current Loans)	(£122.68)	(£103.43)	(£19.25)	
Receivables	£22.73	£20.10	£2.63	



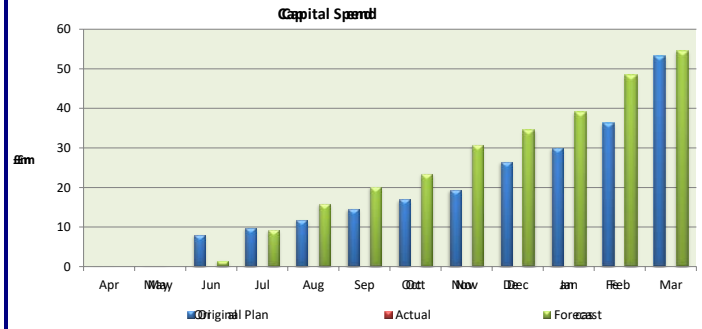


BETTER PAYMENT PRACTICE CODE



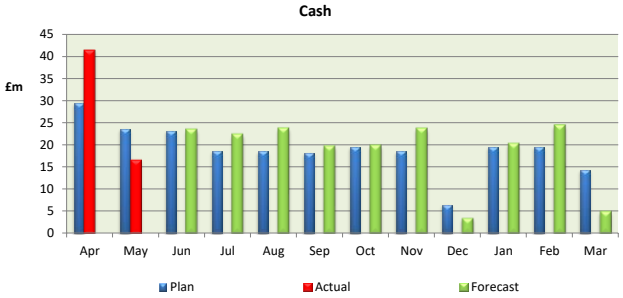
CAPITAL

	M2 Plan £m	M2 Actual £m	Var £m	M2
Capital	£0.10	£0.15	(£0.05)	

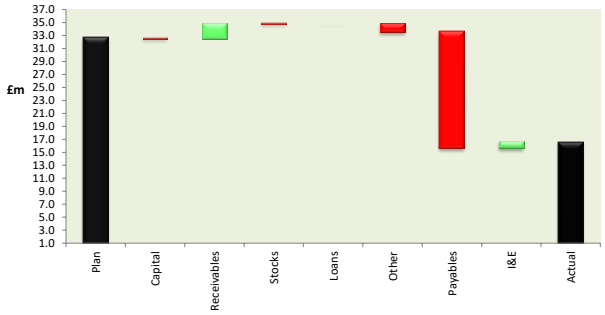


CASH

	M2 Plan £m	M2 Actual £m	Var £m	M2
Cash	£23.54	£16.53	(£7.01)	
Loans (Cumulative)	£12.15	£12.15	£0.00	



CASH FLOW VARIANCE



SUMMARY YEAR TO DATE

- The Trust is reporting a £7.60m deficit, (excluding the impact of Donated Assets and PFI remeasurement IFRS16), a £0.20m favourable variance from plan.
- Key drivers of the favourable variance were higher than planned CIP delivery and a reduction in PDC Dividend in line with the revised forecast and capital plan.

- In 2024/25 the Trust is operating under the National Payment by Results (PBR) funding mechanism for activity within the scope of Elective Recovery.
- Delivery of planned care activity in Month 2 was slightly above the planned level. Overall Weighted Elective Recovery Position as a percentage of plan was 101.5%.

- Year to Date the Trust has delivered efficiency savings (CIP) of £3.14m, £0.08m higher than planned. .
- The Trust has a cash balance of £16.53m, £7.01m lower than planned due to the timing of the payroll payment.
- Capital expenditure is higher than planned at £0.15m against a planned £0.01m.
- NHS Improvement performance metric Use of Resources (UOR) stands at 3, as planned, with all metrics at the planned level.
- The Trust is forecasting a UOR of 3 as planned.

NOTES

- The Trust is forecasting to deliver a £26.26m deficit, as per the revised plan submission (12th Jun 2024). Planned figures shown in this report reflect the M2 budget which is in line with the May plan submission. The Trust's revised plan reflects an improvement of £12.3m: £5m stretch CIP target; £5.6m additional ICS funding allocation; and £1.7m additional funding to support the pressure arising from the PFI remeasurement (technical adjustment).
- Revised CIP Target is now £32.18m (£30m new schemes plus £2.18m Full Year Effect of 23/24 schemes.

- The Capital forecast is to spend £54.58m, as per the revised plan.

- The Trust is forecasting to end the year with a cash balance of £4.82m, in line with the revised plan and reflects changes in the profiling of the Public Dividend Capital Funding plan. This includes £2.92m of Capital PDC awarded for 24/25 where the cash payment is expected next year.
- The total loan balance is £12.15m as planned.
- The revised plan reduces the Trust's reliance on Revenue Support Public Dividend Capital (PDC) from £42.02m to £30.91m.

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

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

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

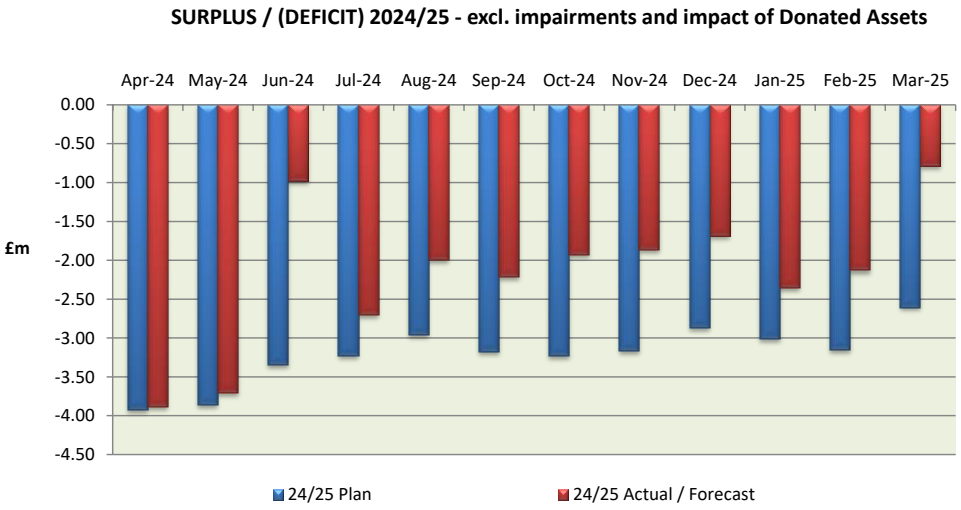
FORECAST 2024/25

24/25 Forecast (31 Mar 25)

Statement of Comprehensive Income	Plan £m	Forecast £m	Var £m	
Income	£548.73	£561.15	£12.41	
Pay expenditure	(£364.70)	(£365.11)	(£0.41)	
Non Pay Expenditure	(£180.20)	(£183.08)	(£2.88)	
Non Operating Costs	(£40.20)	(£36.42)	£3.78	
Total Trust Surplus / (Deficit)	**(£36.37)**	**(£23.46)**	**£12.91**	
Deduct impact of:				
Impairments & Revaluations (AME)[1]	£0.00	£0.00	£0.00	
Remeasurement of PFI (IFRS16)[2]	(£2.77)	(£3.47)	(£0.70)	
Donated Asset depreciation	£0.68	£0.68	£0.00	
Donated Asset income (including Covid equipment)	(£0.08)	£0.00	£0.08	
Net impact of donated consumables (PPE etc)	£0.00	£0.00	£0.00	
Gain on Disposal	£0.00	£0.00	£0.00	
Adjusted Financial Performance	**(£38.55)**	**(£26.26)**	**£12.30**	

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

MONTHLY SURPLUS / (DEFICIT)



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

Technical Adjustments due to PFI Remeasurement

Remeasurement of the PFI, (where costs are recognised on an IFRS 16 basis), results in a technical benefit this year. At a national level, NHS accounts are prepared on a UK GAAP basis and for the purposes of assessing Financial Performance NHS England require us to make an adjustment to reflect the difference between the two accounting methods as shown in the table to the left. This removes the PFI / PDC Dividend benefit seen in year, but also a level of underlying benefit that has been imbedded within the financial position for a number of years, (£1.7m). The latest planning guidance has seen an additional allocation made to our ICS to compensate for this adjustment and this income has been passed onto the Trust and forms part of the £12.30m plan improvement.

16. Audit and Risk Committee Chair's Highlight Report and Committee Annual Report 2023/24

To Note

Presented by Nigel Broadbent

Calderdale and Huddersfield NHS Foundation Trust

CHAIR'S HIGHLIGHT REPORT
to the Board of Directors

Committee Name:	Audit and Risk Committee (ARC)
Committee Chair:	Nigel Broadbent, Non-Executive Director
Date of meeting:	25 June 2024
Date of Board meeting this report is to be presented:	4 July 2024
ACKNOWLEDGE	• The financial performance of CHFT was within plan, showing a £13.2m deficit at year end compared with the £20.8m deficit plan, an improvement of £7.6m due to additional non-recurrent savings and the receipt of additional income from the ICS. • The 2023/24 accounts, financial statements and the annual report were all approved within the national timescales • The 2023/24 accounts were unqualified by the Trust's external auditors, KPMG. • Significant assurance was given by the Head of Internal Audit for Audit Yorkshire, that CHFT has a good system of governance, risk management and internal controls. • At 31 March 2024 there were no recommendations overdue from internal audit reports and only 2 recommendations overdue with revised target dates.
ASSURE	• The Trust's annual report for 2023/24 including the assessment of the Trust's going concern status, the Annual Governance Statement, and the accounts for 2023/24 were all approved by the Audit and Risk Committee. • The Audit & Risk Committee also approved the management letter of representation. • Only 4 reports were issued by Internal Audit for 2023/24 with limited assurance out of a total of 23 issued for the year. In accordance with good practice, the Executive lead for the area covered by each limited assurance report was invited to the Audit & Risk Committee to discuss progress with the management response to the audit report recommendations and to ensure that they are being implemented in a timely manner. Audit & Risk Committee also reviews each Internal Audit report issued with significant or high assurance.
AWARE	• Audit & Risk Committee reviewed and agreed the estate valuation received and used in the accounts in relation to one of the key risks identified within the external audit. • The external audit annual report concluded that:

	– There were no significant weaknesses identified on financial sustainability, governance and improving efficiency, economy and effectiveness. – There was one significant risk on financial sustainability in relation to the medium-term plans of the Trust to return to a balanced recurrent position but KPMG were satisfied that this did not give rise to a significant weakness due to the detailed action plan which had been agreed with NHSE and by setting a delivery timescale for this plan. Management has agreed in response to the external audit recommendation that the Trust will develop an updated medium term financial plan and share this with system partners by 31 March 2025. – There were no significant inconsistencies in the Trust's annual report. – KPMG did not need to issue any reports in the public interest.
ONE CULTURE OF CARE	• The Committee thanked those in the Trust involved in preparing the accounts, financial statements, annual report and associated documents including the Trust Finance team, the Internal Audit service from Audit Yorkshire and the external auditors, KPMG.
REGULATIONS	Regulation 17: Good governance Regulation 13: Financial position

Audit and Risk Committee Annual Report 2023/24

This annual report of the Audit and Risk Committee for 1 April 2023 to 31 March 2024 details:

- The role of the Audit and Risk Committee, including membership and attendance
- The activities of the Audit and Risk Committee reflecting the five key areas of oversight

1. Role of the Audit and Risk Committee

The role of the Audit and Risk Committee is to provide assurance to the Trust Board regarding the monitoring and review of financial and other risks and associated controls, corporate governance and the assurance frameworks of the Trust and its subsidiaries.

1.1 Background

It is a formal requirement for all NHS Trusts to have an Audit and Risk Committee. Information about the appropriate operation of the Audit Committee is set out in the official *NHS Audit Committee Handbook* published in March 2024. During 2023/24 the Audit and Risk Committee adhered to the 2018 Audit Committee Handbook and in 2024/25 will review the operation of the Committee against the updated handbook alongside the action plan from the self-assessment of the effectiveness of the Committee.

This report describes the Audit and Risk Committee's activities from April 2023 to March 2024 and in particular various matters for which the Audit and Risk Committee has oversight for the Board including:

- Financial reporting
- Risk management
- External audit
- Internal audit
- Governance arrangements.

After each meeting the Chair escalates those matters that the Audit and Risk Committee considers should be drawn to the attention of the Board via a Chair's Highlight Report. The minutes of the Committee's proceedings are shared at the next meeting of the Trust Board.

1.2 Terms of Reference

The Committee approved its updated terms of reference on 25 July 2023, with ratification by the Board on 7 September 2023. The updates reflected changes in partnership arrangements and closer working with other Committees, and updates to the Chair of Audit and Risk Committee's job description and person specification. The Committee meets on a quarterly basis, with an additional meeting for the review of the annual report and accounts.

The Audit and Risk Committee has a well-established workplan which sets out its annual cycle of work and reporting which is regularly reviewed.

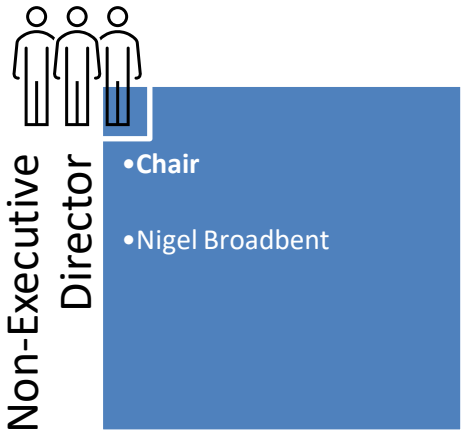
1.3 Audit and Risk Committee Membership and Attendance in 2023/24

The Audit and Risk Committee met five times during 2023/24: 25 April, 27 June, 25 July, 24 October 2023 and 31 January 2024.

The membership of the Audit and Risk Committee is three Non-Executive Directors (NED), and all meetings were quorate. Up to two governors are invited to attend and observe each meeting. A

register of attendance by members and those invited to attend during 2023/24 is shown at Appendix 1.

There were no changes to the Non-Executive Director membership of the Committee during 2023/24.



The following were in regular attendance at the Audit and Risk Committee meetings during the year:

- Gary Boothby, Director of Finance / Kirsty Archer, Director of Finance (joint role)
- Andrea McCourt, Company Secretary
- Victoria Pickles, Director of Corporate Affairs
- Rob Birkett, Chief Digital and Information Officer
- Ric Lee, Engagement Director and Matthew Moore, KPMG
- Salma Younis, Senior Manager, KPMG
- James Boyne, External Audit Director, KPMG (from 31 January 2024)
- Leanne Sobratee, Internal Audit Manager, Audit Yorkshire
- Helen Higgs, Head of Internal Audit
- Shaun Fleming, Local Counter Fraud Specialist, Audit Yorkshire

The following also attended for specific items:

- Zoe Quarmby, Assistant Director of Finance – Financial Control for the annual accounts 2022/23
- Executive leads for the areas subject to deep dives by the Committee during the course of the year

2. Audit and Risk Committee Activities 2023/24

The principal activities of the Audit and Risk Committee during 2023/24 are detailed below.

2.1 Financial Governance

Financial Reporting - Annual Report and Accounts for 2022/23

The Committee considered the draft Annual Report and Accounts for 2022/23 and, with delegated authority given to the Committee from the Board of Directors at the Board meeting on 2 March 2023, the Committee approved the 2022/23 Annual Report and Accounts on behalf of the Board at a meeting on 27 June 2023. This included accounts for the wholly owned subsidiary, Calderdale Huddersfield Solutions.

Standing Orders, Standing Financial Instructions and Scheme of Delegation

The Committee regularly reviewed waivers of Standing Orders and approved losses and special payments and bad debt write offs. Following discussion at Audit and Risk Committee, a new process for reducing the losses of patients' personal effects was implemented and received positive feedback.

The Committee, in July 2023, approved revised Standing Financial Instructions and a Scheme of Delegation.

Standards of Business Conduct and Conflicts of Interest

The Committee reviewed the Trust position on declarations of interest in terms of compliance with the Standards of Business Conduct and Conflict of Interest Policy. The Committee at its meeting on 25 April 2023 noted an improved compliance position by decision makers from 86% in 2021/22 to 93% in 2022/23.

2.2 External Audit

KPMG is the Trust's external auditor, with November 2023 being the final year of a three year period for which they were appointed covering the financial accounting period 2023/24.

The Committee reviewed the annual accounts provided by the auditors as part of its audit for 2022/23, including final audit reports, value for money arrangements, management letters and their Auditor Annual Report for 2022/23. KPMG presented their ISA260 report to the Committee on 27 June 2023 which made a small number of recommendations to improve internal controls; however, KPMG concluded an unqualified opinion on the accounts, meaning that the accounts give a true and fair view of the financial performance and position of the Trust. KPMG also gave assurances about the preparation and content of the Trust's annual report, that the Annual Governance Statement (AGS) had been prepared in line with DHSC requirements, and that there were sufficient arrangements in place for the Trust to secure value for money in its use of resources.

The Committee reviewed and approved the draft External Audit Plan for 2023/24, highlighting the main change which related to the audit requirements around the introduction of IFRS16 on accounting for PFI contracts. The Committee noted audit fees for 2023/24 were increased in line with inflation and fees for the subsequent year (subject to contract extension) will need to be discussed at the Audit and Risk Committee in April 2024.

The Committee annually reviews the performance of the external auditors.

The external audit provider KPMG was not commissioned by the Trust during the year to undertake any significant non-audit work.

External auditors also briefed the Committee at each meeting on sector related matters of interest.

2.3 Internal Audit (IA)

The Trust purchases internal audit services from Audit Yorkshire to review the adequacy of controls and assurances in place via a comprehensive audit programme. The internal audit service provided by Audit Yorkshire meets mandatory NHS Internal Audit standards and provides appropriate independent assurance to the Audit and Risk Committee. The Committee considered the major findings of internal audit work and the management response to them.

In relation to the 2022/23 annual report and annual governance statement, the annual Head of Internal Audit Opinion for 2022/23 confirmed an overall significant assurance regarding the system of internal control in the Trust which was a positive outcome. This was based on three criteria: assessment of the effectiveness of Board Assurance Framework and risk management systems, results of individual reviews within the audit risk-based plan and Internal Audit's assessment of the Trust's response to recommendations.

The Committee reviewed and approved the Internal Audit Plan for 2023/24 and detailed programme of work for 2023/24, which ensures there is enough coverage in the audit planning of the Trust's key strategic risks that could impact on the achievement of its objectives.

With regard to delivery of the 2022/23 internal audit plan the Committee received 4 high assurance opinion reports, 19 significant assurance opinion reports, 6 limited assurance opinions, 0 low opinion reports and 2 no opinion reports. The limited assurance opinion reports related to complaints, quality governance structure, ambulance handovers, absence management, MUST assessments and Safer procedures for NATSSIPS and LOCSSIPS. Further details on implementation of recommendations relating to these limited assurance opinion reports was given in the 2022/23 Annual Governance Statement. All reports where an opinion is provided have recommendations, with an action plan in place to address these recommendations and a target date set until all actions are completed, with an electronic system to support the tracking of progress against recommendations.

Internal Audit provides a progress report at each Committee meeting which enables the Committee to monitor progress against the actions. Completion of recommendations from previous years continued to be closely reviewed by the Committee and a number of overdue recommendations were followed up with the Executive team by the Audit and Risk Committee Chair and progress continued to be monitored by the Committee. At the end of 2022/23 there were no overdue recommendations and 20 recommendations overdue but with a revised implementation date, 11% of the total recommendations from audit reports during the year.

The content of all limited and low assurance reports is discussed in detail at the Audit and Risk Committee. In addition, limited or low assurance reports are followed-up once the latest agreed recommendation due date has passed and the Trust audit lead is invited to the next Committee meeting to provide assurance actions in the audit are being embedded. During the course of 2023/24 the Audit and Risk Committee undertook deep dives following the limited assurance reports on NATSSIPs and LOCSSIPs (from 2022/23) and the Nasogastric tube processes. In each case, the relevant audit lead was invited to the Audit and Risk Committee to provide assurance that the actions agreed in the recommendations to the report were being implemented.

The Committee annually reviews the performance of the internal auditors in year through agreed performance indicators and to date this has been satisfactory.

Benchmarking information provided by Audit Yorkshire on 31 January 2024 across their clients reflected positively on CHFT in terms of the proportion of internal audit recommendations completed.

2.4 Counter Fraud

The Trust takes the prevention and detection of fraud very seriously and the Counter Fraud Specialist continues to work to raise the profile of fraud in the Trust, explores the potential for fraud and investigates cases of fraud.

The Committee received and approved the 2023/24 Counter Fraud Plan, regular progress reports and updates against this plan and the annual Counter Fraud report for 2022/23. The Committee monitored compliance with the Counter Fraud Authority Functional Standard which requires NHS Providers to put in place and maintain appropriate counter fraud arrangements. The NHS Counter Fraud Functional Standard is divided into 13 NHS requirements and all organisations are required to assess themselves against these requirements annually and to produce a Counter Fraud Functional Standard Return. The Director of Finance has overall responsibility for counter fraud work at the Trust. The Trust recorded one amber rating and compliance was assessed against the remaining 12 components, and green ratings were selected for each standard. The Committee noted impressive progress to all the components since the revised standard was introduced in February 2021. The one amber rating relates to the process of embedding the prescribed fraud risk assessment methodology required by the NHS Counter Fraud Authority and the current assessment is due to the processes still being embedded.

Details of fraud prevention work undertaken were shared. The Local Counter Fraud Specialist attended each meeting during 2023/24.

2.5 Risk Management

During the year, the Committee continued to review the risk management approach across the Trust. A Risk Management Review deep dive and review of the Risk Management Policy took place in April 2023. The Committee noted ongoing work to strengthen risk management processes, particularly regarding the risk register and noted work planned to procure risk management software compatible with the introduction of the Patient Safety Incident Response Framework.

The Board Assurance Framework (BAF) was reviewed by the Committee three times, on 25 July 2023, 24 October 2023 and 31 January 2024. The Committee has specific oversight for a BAF risk relating to health and safety and this risk was reviewed during the year. A new cyber security risk was introduced to the BAF in October 2023 at a risk score of 15 was approved by the Committee. The Audit and Risk Committee will continue to have oversight of this risk. The BAF was also reviewed against benchmarking information from other NHS organisations and provided further assurances about the types of risks included within the Trust's BAF.

A deep dive into the partnership working BAF risk 3/23 was presented by the Deputy Chief Executive/Director of Transformation and Partnerships on 31 January 2024 and following assurances about the risk not having materialised, the Committee approved the proposal to reduce the partnership working BAF risk score.

The Head of Internal Audit Opinion gave a significant assurance opinion for 2023/24, confirmed the BAF provided adequate assurance to the Board in relation to the key risks to achieving its strategic objectives. It confirmed that the BAF contained all the essential elements required and the Board and Board Committees participated effectively in the BAF monitoring and review arrangements.

2.6 Assurances Received by the Committee

In addition to its usual business, the Committee received the following assurances during the year:

- **Clinical Audit Programme** – recognising that oversight of the clinical audit programme is exercised through the Quality Committee but the Audit and Risk Committee needs to be assured about the systems in place to support high quality care as a key component of good governance, a paper was received from the Associate Medical Director who had taken over the portfolio of clinical audit which provided an update on clinical audit activity to the 24 October 2023 Committee meeting. The paper described a significant amount of work that had taken place through the Clinical Effectiveness and Audit Group to make improvements to the process. It was noted a database for clinical audit went live on Knowledge Portal and a new process was introduced which included project proposals and strict timeframes when audits would be completed.
- **Health and Safety** – the Health and Safety Committee changed to the Resilience and Safety Committee during 2023/24 streamlining the work of three former Committees/Groups relating to health and safety, security and fire matters. Amendments to the Health and Safety Policy were noted at the Committee in April, which described a change in relation to responsibility for Health and Safety, with Director responsibility moving from the Director of Workforce and Organisational Development to the Chief Operating Officer (COO). An amendment to this effect to the scheme of delegation was presented to the Trust Board on 4 May 2023 and approved.

  The Committee also reviewed the 2022/23 Fire Safety Annual Report and noted the good progress over the last 12 months on the actions set out in the Fire Strategy. The significant capital funding allocated for fire safety across the Trust was noted which allowed for improvement work across the Trust, including a feasibility study for smoke extraction, replacement fire doors and compartmentation works at HRI. The mandatory fire safety training target was achieved with compliance reported at 90.39%.

- **Information Governance** – the Assistant Information Governance Manager gave a deep dive presentation on Information Governance (IG) within CHFT at the meeting on 31 January 2024. Details were given of current four priorities and progress including the Data Security and Protection Toolkit (DSPT), data security awareness across the Trust, Corestream software implementation and reducing IG incidents due to inappropriate access.

- **Risk Management** – A deep dive of risk management processes took place on 25 April 2023 presented by the Head of Risk and Compliance. Details of the actions to strengthen risk management processes were noted. The plan to move the risk register to a new risk IT system which would be compliant with the Patient Safety Incident Response Framework was noted.

  The revised Risk Management Policy was approved at the meeting on 25 April 2023 and a Risk Management Strategy was presented on 25 July 2023. The separation of the Risk Management Strategy and Risk Management Policy took place to allow staff to have one central point for guidance on risk registers.

- **Data Quality Board** – On 25 July 2023 the Information Assistant Director and Performance Assistant Director presented an annual deep dive into Data Quality, gave details of the areas routinely reviewed by the group and areas of success, i.e., clinical quality audits, clinical coding and implementation of the new Integrated Performance Report (IPR). There was also reference to the positive impact that data quality has had on the Trust's recovery position and the significant progress the Trust has made in addressing health inequalities in access to elective care.

- **Cyber Security** - A deep dive on the Trust's cyber security arrangements was also presented at the meeting on 25 July 2023 by the Chief Technology Officer. The deep dive into the Trust's cyber security focused on the Trust's response and management of cyber attacks in order to protect the Trust against these threats. Assurance was also gained from the ISO27001 accreditation and the Data Security Protection toolkit. As a result of the deep dive and on the recommendation of the Audit and Risk Committee, the risk of cyber attacks was added to the Board Assurance Framework and subsequently approved by the Board.

2.7 Governance and Reporting Groups

The Committee reviewed the Foundation Trust Code of Governance and noted the Trust was compliant with all provisions of the code. The Committee noted this was the last year reporting compliance against the Code of Governance for NHS Trust 2014 and future compliance reports would be against the updated NHS England Code of Governance for NHS Provider Trusts.

The Committee considered the terms of reference of the newly established Resilience and Safety Group and requested additions to the functions and scope of the group which it will approve in April 2024.

In year reporting to the Committee from the following sub-groups took place with summary highlight reports and minutes shared with the Committee:

- Information Governance and Records Management Steering Group
- Risk Group
- Compliance Group
- Resilience and Safety Group (replacing Health and Safety Committee, Fire Committee and SRGG)
- Data Quality Board

3. Review of Committee Effectiveness

On an annual basis the Committee undertakes a self-assessment exercise to gauge the Committee's effectiveness by taking the views of Committee members and attendees across themes. The outcome of this is then reviewed by the Committee and an action plan developed using the results of the self-assessment surveys and monitored by the Committee. The self-assessment

exercise took place in Spring 2024 and the outcome of this was shared at the meeting of 25 April 2024 and an action plan agreed for the Committee.

In line with best practice, it was agreed that Board Committee annual reports, from 2023/24 onwards, would be presented to the Audit and Risk Committee rather than the Board, with the Audit Committee Annual Report still being presented to the Board for assurance purposes. The Board will be advised of the scrutiny of the annual reports through the Audit and Risk Committee highlight report.

4. Conclusion

As described above, the Audit and Risk Committee has received assurance through the course of 2023/24 from management, other assurance committees, the risk management processes and progress reports from counter fraud, external and internal audit.

The Audit and Risk Committee therefore confirms that it has fulfilled its role of providing assurance to the Board during 1 April 2023 to 31 March 2024 regarding the monitoring and review of financial and other risks and associated controls, corporate governance and the assurance frameworks of the Trust and its subsidiaries.

Audit and Risk Committee Chair

April 2024
Nigel Broadbent, Non-Executive Director, Audit and Risk Committee Chair
Amber Fox, Corporate Governance Manager
Andrea McCourt, Company Secretary

Attendance	✓	Apologies	×	Not invited /in post

AUDIT & RISK COMMITTEE ATTENDANCE REGISTER - 1 APRIL 2023 – 31 MARCH 2024

Member	25.04.23	27.06.23 ARA Sign-Off	25.07.23	24.10.23	31.01.24	TOTAL
Nigel Broadbent, Non-Executive Director (Chair) from 25.10.2022	✓	✓	✓	✓	✓	5 / 5
Denise Sterling Non-Executive Director	✓	✓	✓	✓	✓	5 / 5
Peter Wilkinson, Non-Executive Director	✓	✓	✓	×	✓	4 / 5
In Attendance						
Gary Boothby, Director of Finance				✓	×	5/5
Kirsty Archer, Assistant Director of Finance	✓	✓	✓	✓	✓	
Zoe Quarmby, Assistant Director of Finance		✓				1/1
Robert Birkett, Chief Digital Information Officer	✓		✓	✓	✓	4/4
Andrea McCourt, Company Secretary	✓	✓	×	✓	✓	4/5
Victoria Pickles, Director of Corporate Affairs	✓	✓	✓	✓	×	4/5
Helen Higgs, Head of Internal Audit	×	✓	×	✓	✓	3/5
Chris Boyne, Deputy Head, Audit Yorkshire				✓		1/1
Leanne Sobratee, Audit Yorkshire	✓	✓	✓	✓	✓	5/5
Shaun Fleming, Local Counter Fraud Specialist	✓		×	✓	✓	3/4
Steven Moss, Local Counter Fraud Specialist			✓			1/1
Ric Lee, Engagement Director, KPMG	✓	✓	✓	×		3/4

Matthew Moore, Audit Manager, KPMG	✓	✓		✓	✓	**4/4**
James Boyle, External Audit Director, KPMG					✓	**1/1**
Governor Observer(s)						
Liam Stout (Staff Governor)	×	✓	✓	×	✓	**3/5**
Isaac Dziya (Public Governor)				✓		**1/5**

17. Integrated Performance Report

To Note

Presented by Jonathan Hammond

Date of Meeting:	Thursday 4 July 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 May 2024.
Key Points to Note	**Performance Summary** **Quality** indicators: SHMI performance has seen an increase for the latest 12 month rolling release and shows performance of 109.54. The site breakdown shows HRI at 107.52 and CRH at 112.72. Month on Month performance has declined in February with performance standing at 107.58. CHFT now sits above this national position however remains comfortably within the expected range nationally. Falls per 1,000 bed days improved again in month and achieved target for the 2nd month. Hospital acquired Pressure Ulcers per 1,000 bed days improved further at is at its lowest rate for over 2 years. % of complaints closed on time (target 95%) was 70% in May which was our lowest performance for over 18 months and has pushed the indicator into special cause variation – cause for concern. Performance has been impacted by unplanned sickness of key individuals along with clinical staff, and the complexity of the complaints received. Issues with the quality of responses Trust-wide has continued which has caused delays in responses being sent. Actions have been put in place to address the issues. There were two serious incidents (one of which was a Never Event) reported in May, both in FSS, both will undergo a Patient Safety Incident Investigation (PSII) under the new Patient Safety Incident Response Framework (PSIRF). **Quality Priorities** - % of patients that have been screened for dementia has improved over the last 3 months. However, Stroke - % of stroke patients admitted directly to an acute stroke unit within 4 hours of hospital admission has dipped below 30% against its 90% 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) – has remained

	around 60% in-month against a target of 70%. A quality improvement project will be undertaken to improve timely review by the Registrar or Consultant for patients with a NEWS of 7 or more. We continue to perform well in terms of **elective recovery** with 37 (ENT 30) 52-week waits at the end of May. We had 713 (163 non-ENT) 40-week waits at the end of May. For **diagnostics** we have seen performance improve to 94% overall (for those seen within 6 weeks) with further progress in Echo and Neurophysiology. **Day Case Rates** - Utilising the new Model Hospital measure (which includes those procedures completed in Outpatients) CHFT has improved again for the 3 months to the end of April to 92.2% against an 85% target. **Capped Theatre Utilisation** at 82.3% for May has also been recognised as the best performance in WYAAT just below the 85% target. **Cancer** performance continues to be excellent in May with the 28-day faster diagnosis performance now achieving the new target of 77%. **ED** performance decreased to 69% in May. Bed Occupancy and discharges the previous day are possibly the biggest factors in ED performance. Although CHFT has excellent performance for DTA to Admission > 12 hours, this is NOT the case for > 4 hours where in May over 38% waited > 4 hours for their admission following Decision to Admit. TOC numbers were high at 138. Bed occupancy reduced slightly to 97% but we have seen a decrease in the number of patients waiting over 12 hours in ED. Proportion of **ambulance arrivals** delayed over 30 minutes has increased to 6.9% from 4.4% in April. **Maternity and Children's Health** – for stillbirths the majority of women who have experienced a loss have multiple complexities, both social and clinical. There is a disproportionate representation of women who are BAME, English is not their first language and live in IMD codes 1-4. This is reflective of the national picture and there is a national task group taking place to better understand why these women experience poorer outcomes. In **Community** Virtual Ward occupancy is improving as is just below the 80% target. **Workforce** – Turnover and Sickness Absence lowest rates for over 3 years. ***Performance Matrix Metrics Changes – Improvement*** • *Sickness Absence (Non-Covid) – lowest levels for 3 years.* ***Performance Matrix Metrics Changes – Deterioration*** • *Total RTT Waiting List – numbers above upper control limit.*

	• *% of complaints within agreed timescale – dropped below lower control limit.* • *Core EST Compliance – SPC subtlety around the mean.* • *Patients dying within their preferred place of death – dropped below mean.*
Regulation	Regulation 17: Good governance
EQIA – Equality Impact Assessment	The IPR does not report performance with a breakdown of Protected Characteristics either for workforce or patient data. Workforce equality monitoring is conducted at Workforce Committee via WRES, WDES and Staff Survey. The Public Sector Equality Duty annual report is presented to Board annually, as well as our gender pay gap report.
Recommendation	The Board of Directors is asked to **NOTE** the narrative and contents of the report for May 2024.

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Integrated Performance Report
May 2024

Report produced by this

Contents:

Performance Matrix Summary:

Note:
Improvement in matrix position
Deterioration in matrix position

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

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

Not included in table – Finance, elective activity, First attendance, Follow Up activity, Community WL, neonatal deaths., Maternal Mortality, Brain Injuries (maternity), Number of Never Events, Care Hours per Patient Day (CHPPD), MRSA, Appraisal Compliance, Bank and Agency Spend

Safe, High Quality Care

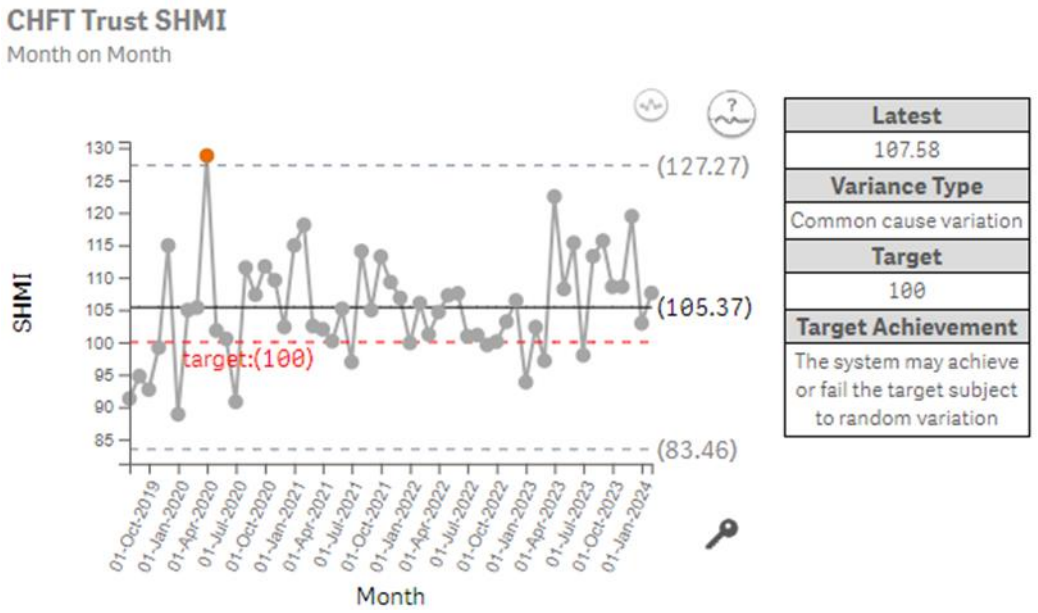
Metric	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Summary Hospital-level Mortality Indicator	February 2024	109.54	100			105.37	83.46	127.27
Care Hours Per Patient Day (CHPPD)	May 2024	9.4/8.7	-	-	-	-	-	-
Falls per 1000 Bed Days	May 2024	6.7	7.08			7.68	5.7	9.67
CHFT Acquired Pressure Ulcers per 1000 Bed Days	April 2024	1.12	1.76			1.68	0.81	2.56
MRSA Bacteraemia Infection	May 2024	0	0	-	-	-	-	-
C.Difficile Infection	May 2024	3	3.1			4.46	0	12.87
E.Coli Infection	May 2024	2	5.6			5.56	0	11.81
Number of Never Events	May 2024	1	0	-	-	-	-	-
Number of Patient Safety Incident Investigations (PSII)	May 2024	2	0			3.00	0	8.53
% of incidents where the level of harm is severe or catastrophic	May 2024	0.58%	2%			0.79%	0%	1.9%
% of complaints within agreed timescale	May 2024	70%	95%			88.16%	70.04%	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 109.54.
- The site breakdown shows HRI at 107.52 and CRH at 112.72.
- Month on Month performance has declined in February with performance standing at 107.58.
- Performance remains within the expected range in the latest release.
- The latest national SHMI position stands at 98.38 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 reported via the incident reporting system.
- 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.

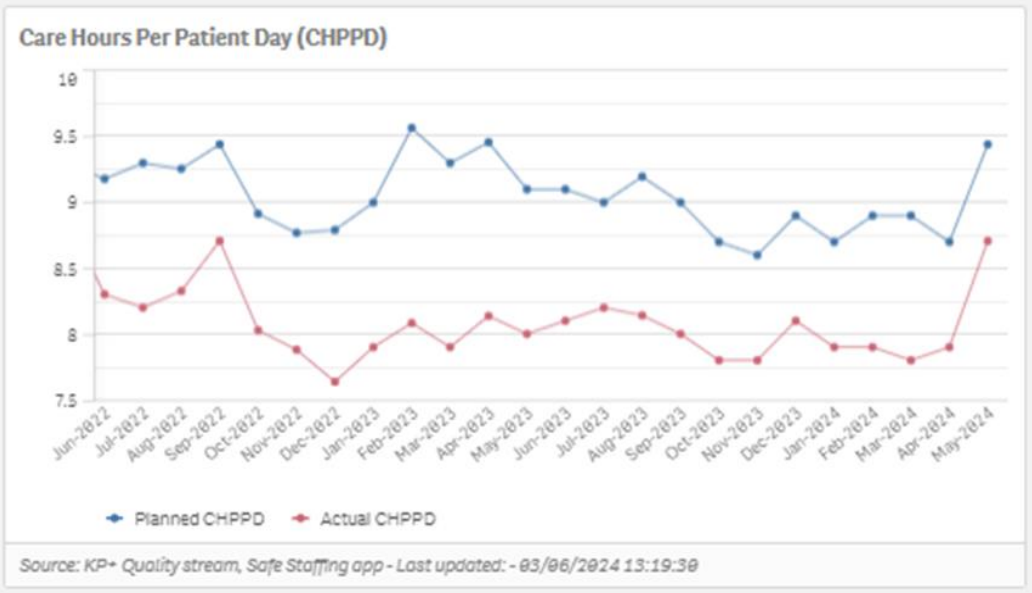
Actions:
- Clinical Lead has contacted all mortality leads in all specialties to communicate the need to increase the level of mortality reviews being carried out monthly and the timeliness of these reviews being improved.
- Clinical review of patients within the Pneumonia CCS group being undertaken 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 0.7 care hour per patient day.
- The latest data in Model Hospital reports CHFT providing 7.7 CHPPD against a peer median 8.5 and national median 8.3. This data is from April 2024. There was no update to the platform in May.

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.

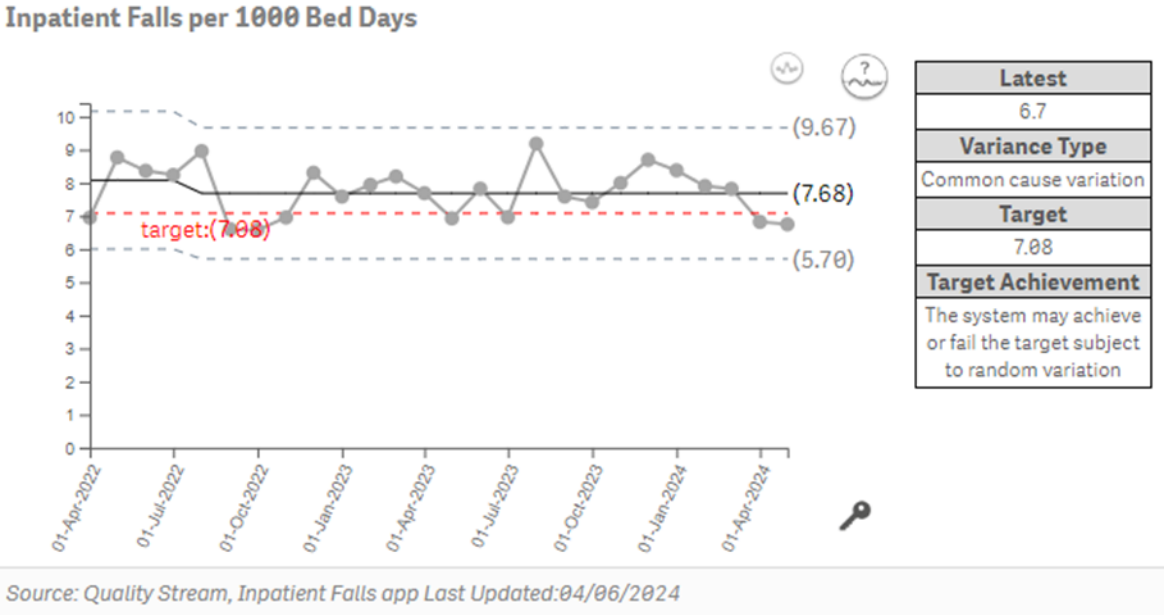
Actions:
- Undertake bi-annual Safer Staffing review. This process provides assurance of the correct workforce models based on an evidence-based methodology. The next bi-annual review will commence with data collection in June 2024, with Chief Nurse panels in September 2024.
- Ongoing monthly reviews 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).
- Recruitment to substantively staff 2 extra capacity ward areas (11a and 8b) to reduce use of staff bank.
- Review and refresh of the retention strategy by the NMAHPWSG.
- Strong roster management maximises efficiency of the available workforce. Continue monthly roster scrutiny.
- Ongoing twice-daily staffing meetings chaired by Divisional Matrons to review any red flags and required care hours determined by Safecare, to ensure real-time safe-staffing across the hospital sites.

Falls per 1,000 Bed Days

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

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

Target:
10% reduction from 2023/24



What does the chart show/context:
- The rate of inpatient falls for May was 6.7 which is below the target of 7.68
- Currently performance can be expected to vary from 5.7 to 9.67.
- The chart shows that the rate of falls has continued to decrease since December 2023.

Underlying issues:
- Use of high visibility/bay tagging practice inconsistent across areas
- Falls alarm availability on ward areas
- Awaiting EPR bed rail risk assessment build of signed-off version with Bradford and Airedale - expected completion September. *Please note CHFT remain uncompliant with national alert.*
- Falls policy review date is July 2024.

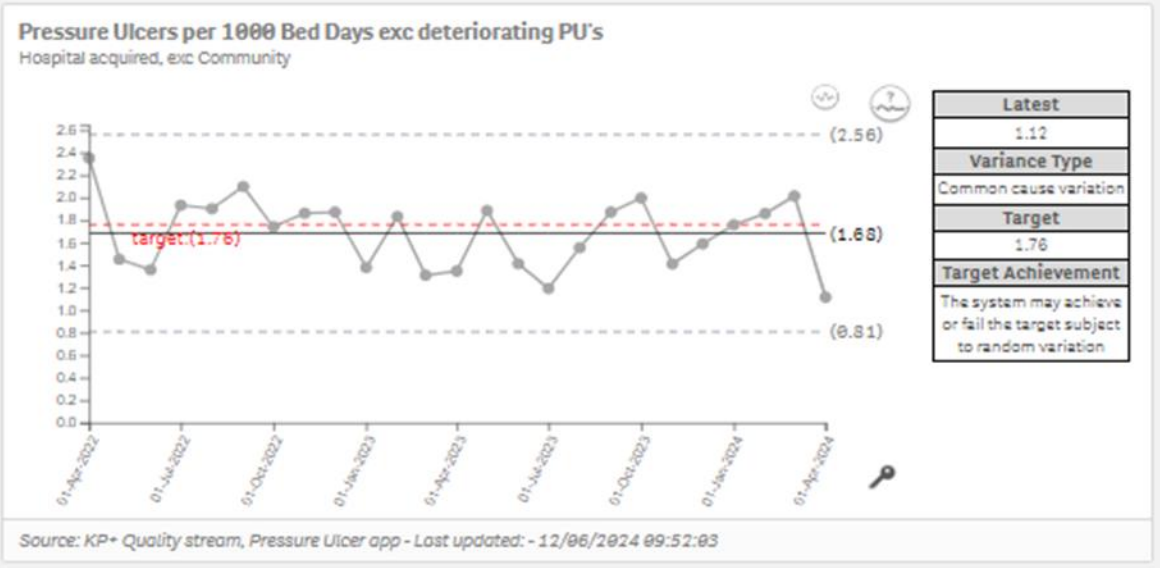
Actions:
- The Falls policy is in the process of being reviewed to update and make easier to access/read - it has been circulated for comment to the falls collaborative.
- Falls collaborative sending a message by falls link nurses that it is the area's responsibility to order falls alarms not the collaborative as there is no central budget to access.
- Support as required with bed rails risk assessment build.

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.



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 April was 1.12. Currently performance can be expected to vary from 0.81 to 2.56.

Underlying issues:
- PU risk assessment within 6 hours of admission/ward transfer remains static and requires improvement, 45.7% for April 2024 (Ward Assurance data).
- Performance with PU weekly reassessment saw a decrease at 74.3%.

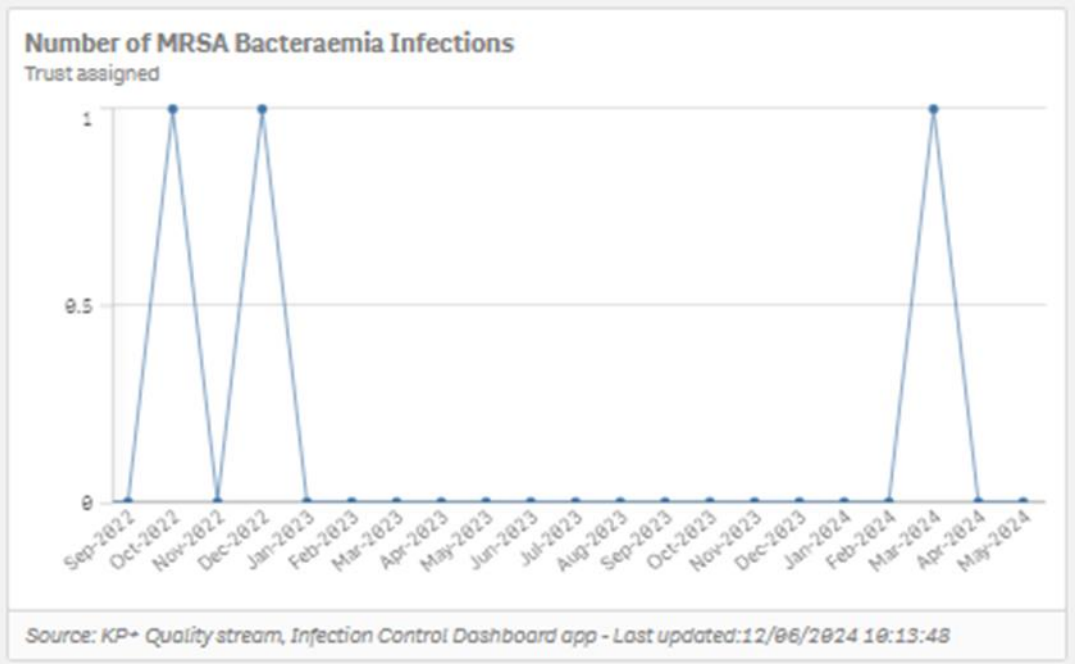
Actions:
- Pressure Ulcer risk assessment within 6 hours of admission/ward transfer is captured on Live Assessment data within KP+.
- Targeted improvement continues for the low performing wards via the Pressure Ulcer Collaborative.
- SSKIN bundle review completed in collaboration with BTHFT and Airedale, awaiting go live date.
- A Pressure Ulcer AAR/Checklist for Community Division is in use, with AAR meetings now taking place.
- Introduction of PU surveillance system within the Model Health System on the 1st April 2024.
- PU validation increased to fortnightly to meet coding requirements for data collection.
- April 2024 Mattress Audit data results has prompted a trust-wide review of practises relating to mattress management.

MRSA Bacteraemia Infections

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

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

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



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

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

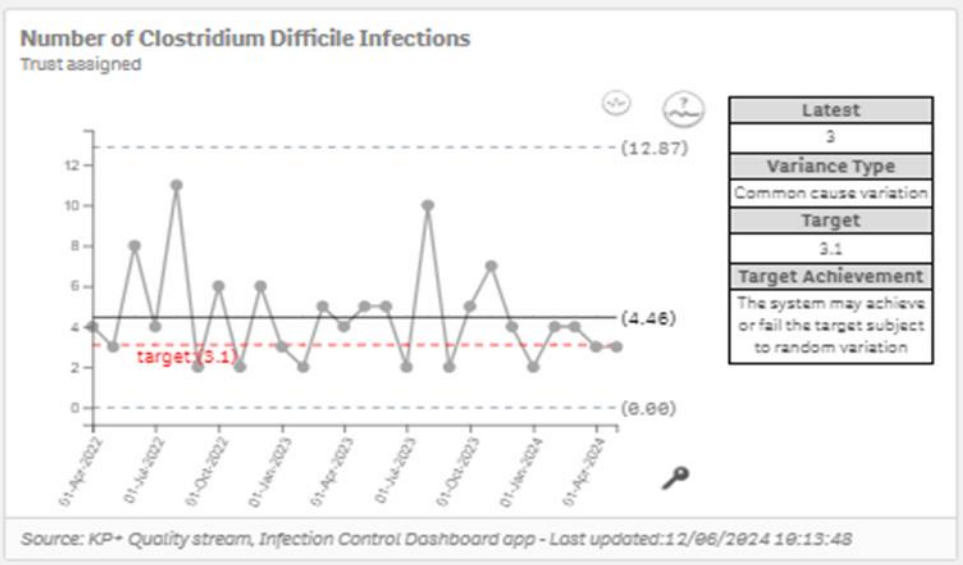
Actions:
- MRSA screening data cleanse has been completed and improvements seen.
- Colonisation suppression visual user guides have been provided to patients to ensure correct application.
- Mandatory training to be monitored through IPC Performance Board on a monthly basis.
- Any infections are investigated 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: 2024/25 Targets have not been released yet - our previous target was - 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) and Community onset hospital associated (COHA).



What does the chart show/context:
- There were 3 C.difficile infections in May.
- Currently performance can be expected to vary from 0 to12.87.
- YTD 2024/25 – 6 (4 HOHA & 2 COHA) against a ceiling of 37.
- This month's data reflects the standard contract changes to reporting from April 2023 to include COHA. We began to capture this from March 2024 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.

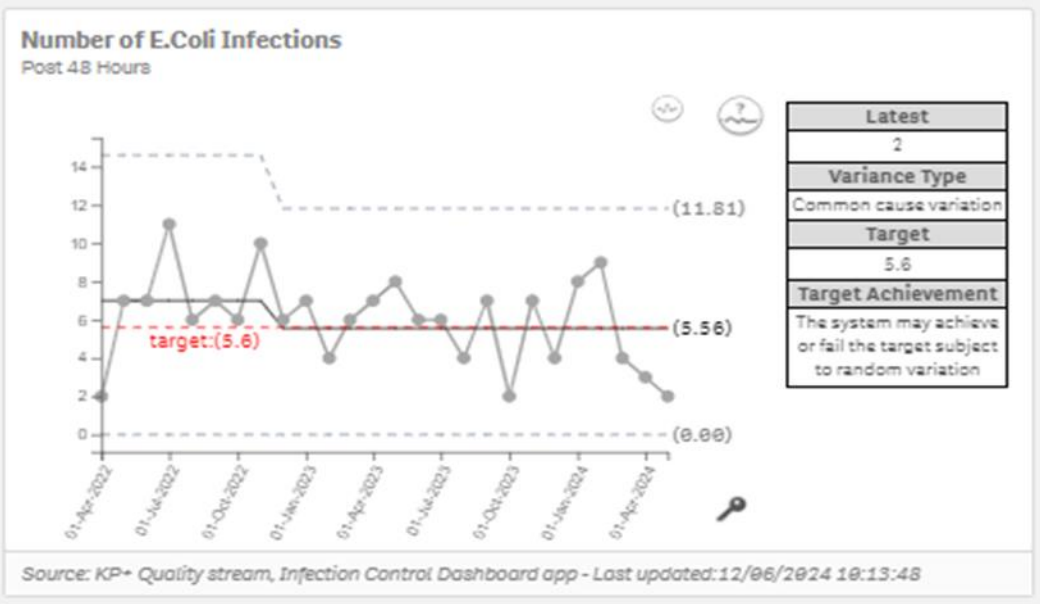
Actions:
- The Trust has implemented an improvement plan including a deep cleaning programme of HPV cleaning, this requires extra funding.
- C.diff ward rounds, antimicrobial ward rounds and a review of the investigation process for cases.
- NHSEI recommendations inform the improvement plan. The improvement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

E.coli Bacteraemia Infections

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

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

Target: 2024/25 Targets have not been released yet - our previous target was -
To not exceed 67 cases in 2023/24. Hospital onset healthcare associated (HOHA) and Community onset hospital associated (COHA)



What does the chart show/context:
- There were 2 E.coli infections in May.
- Currently performance can be expected to vary from 0 to 11.81.
- YTD 2024/25 – 5 (2 HOHA, 3 COHA) infections against a ceiling of 67
- This month's data reflects the standard contract changes to reporting from April 2023 to include COHA. We began to capture this from March 2024 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.

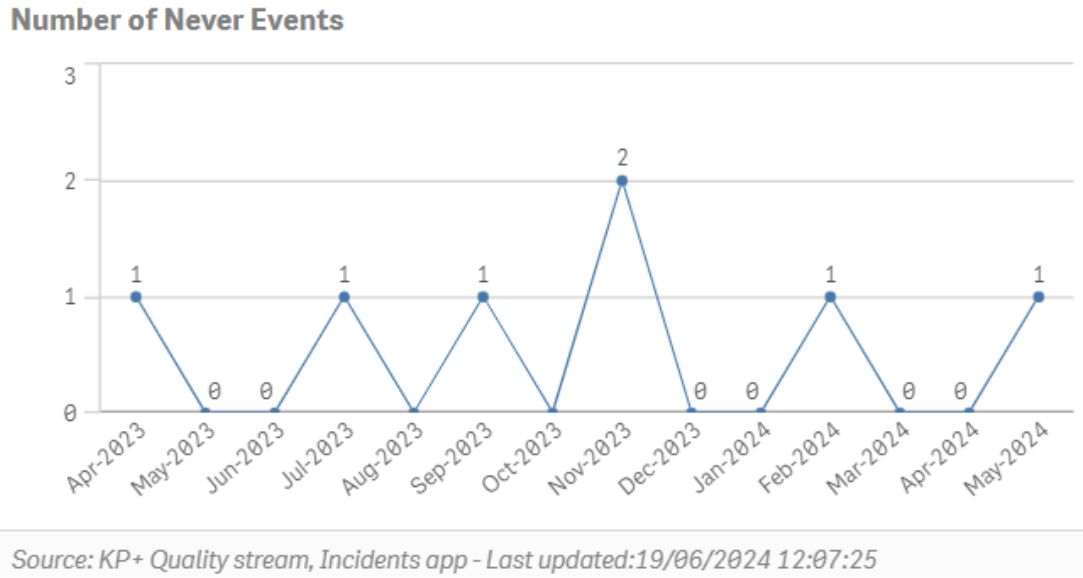
Actions:
- Extended surveillance of all the cases is conducted and uploaded to the UKHSA DCS system for national analysis.
- As part of the workplan of the IPCT, an annual audit of catheter management has been completed and recommendations shared with the divisions for implementation.
- A regional working 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 was one never event declared and validated by the Trust Patient Safety Event Review Panel and this patient safety event will undergo a Patient Safety Incident Investigation (PSII) under the new Patient Safety Incident Response Framework (PSIRF).
- The Never Event occurred in the Families and Specialist Services Division.
- The Trust is unable to consistently meet the target and may achieve or fail subject to random variation month to month.

Underlying issues:
- No LocSSIP in place for this type of procedure.
- Assistant during procedure not attending as second checker.

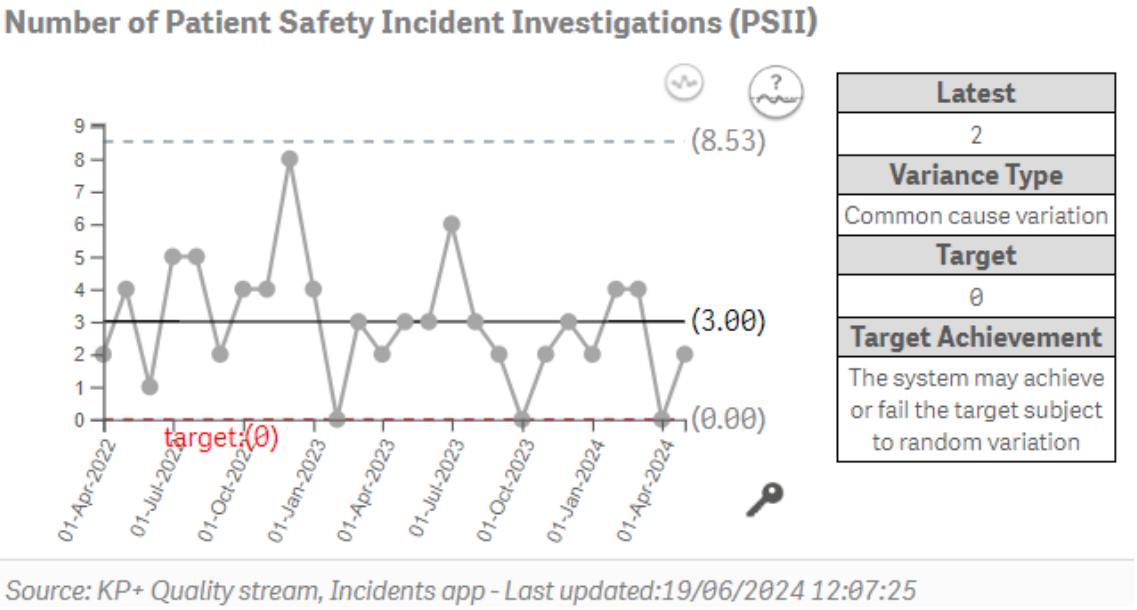
Actions:
- Immediate actions completed and PSII ongoing.
- The Trust will continue to hold SWARM huddles as required to ensure learning is identified to keep our patients and staff safe.

Number of Patient Safety Incident Investigations (PSII)

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

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

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



Source: KP+ Quality stream, Incidents app - Last updated:19/06/2024 12:07:25

What does the chart show/context:
- There were two serious incidents (one of which is the Never Event) reported in May 2024 that have been declared and validated at the Trust Patient Safety Event Review Panel.
- Currently performance is subject to common cause variation and can be expected to vary from 0 to 8.24.

Underlying issues:
- Both incidents were reported in the Families and Specialist Services Division. The Never Event was categorised under treatment/care delivery and the other serious incident was categorised as a complication of treatment, both of which are currently under investigation/review.
- No immediate issues identified for the serious incident following the SWARM however, investigation/review not yet completed.

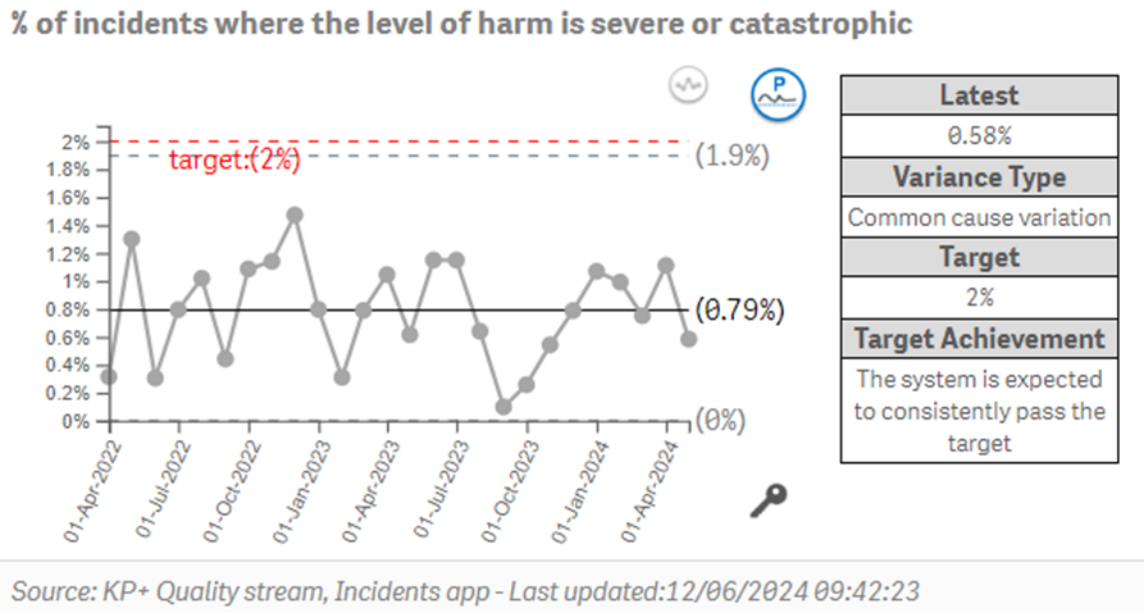
Actions:
- SWARMs held for both incidents to identify learning and immediate actions.
- No themes identified, both categorised in different areas.
- The Risk management Team and the Quality Governance Leads continue to support the Divisions to triangulate and review data for learning.

% 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 0.58% in May 2024.
- Currently performance is subject to common cause variation and can be expected to vary from 0% to 1.9%.

Underlying issues:
- There was one catastrophic harm incident reported within this period and this is currently undergoing a Patient Safety Incident Investigation under the new Patient Safety Incident Response Framework. No immediate issues identified during the SWARM.

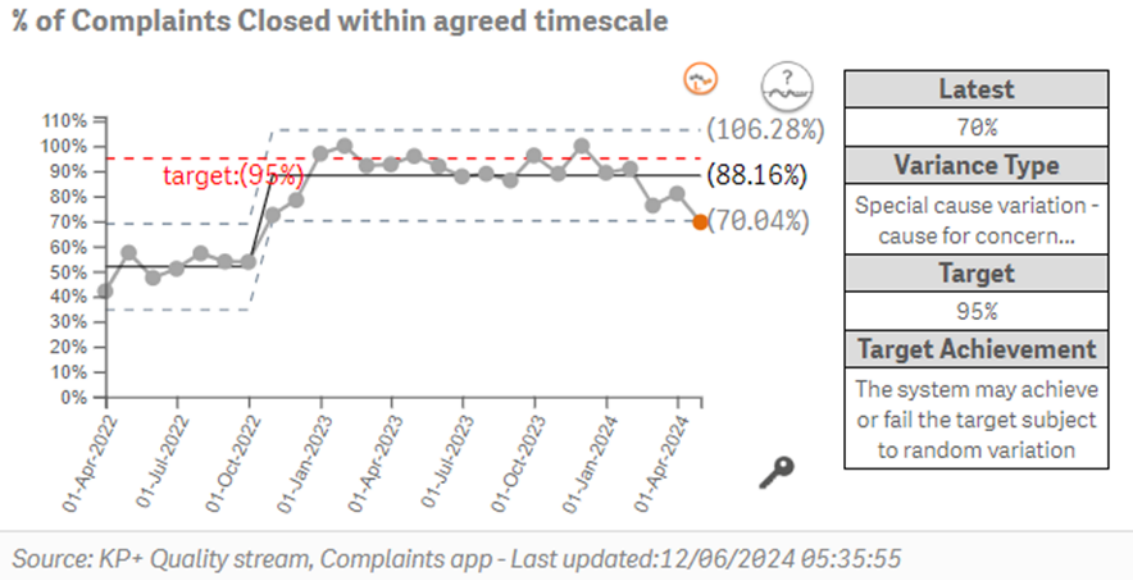
Actions:
- The Risk Management Team and the Quality Governance Leads continue to work with clinical teams/departments to identify and triangulate themes and trends for implementation of quality improvement initiatives and shared learning Trust-wide.
- To continue to monitor the trend within the upper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

% of complaints within agreed timescale

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

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

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



What does the chart show/context:
- In May 2024 70% of complaints were closed within the agreed timescale.
- We may fail or achieve the target subject to random variation.
- Currently performance can be expected to vary from 71.55% to 100% and is in special cause indicating concern.

Underlying issues:
- Performance this month has been impacted by unplanned sickness of key individuals along with clinical staff, and the complexity of the complaints received.
- Issues with the quality of responses Trustwide has continued which has caused delays in responses being sent.

Actions:
- A training package is being explored to support all investigating officers with drafting complaint responses.
- FSS now holding weekly quality huddle with complaints being on the agenda with Head Nurse oversight.
- FSS to refresh process for screening and allocating complaints for investigation.
- FSS have reviewed all open complaints to understand where the delays are and to progress as quickly as possible – which is already having a positive impact.
- Continue to monitor Trust performance daily and meet with Divisions on a weekly basis to maintain oversight of performance.

Quality Priorities:

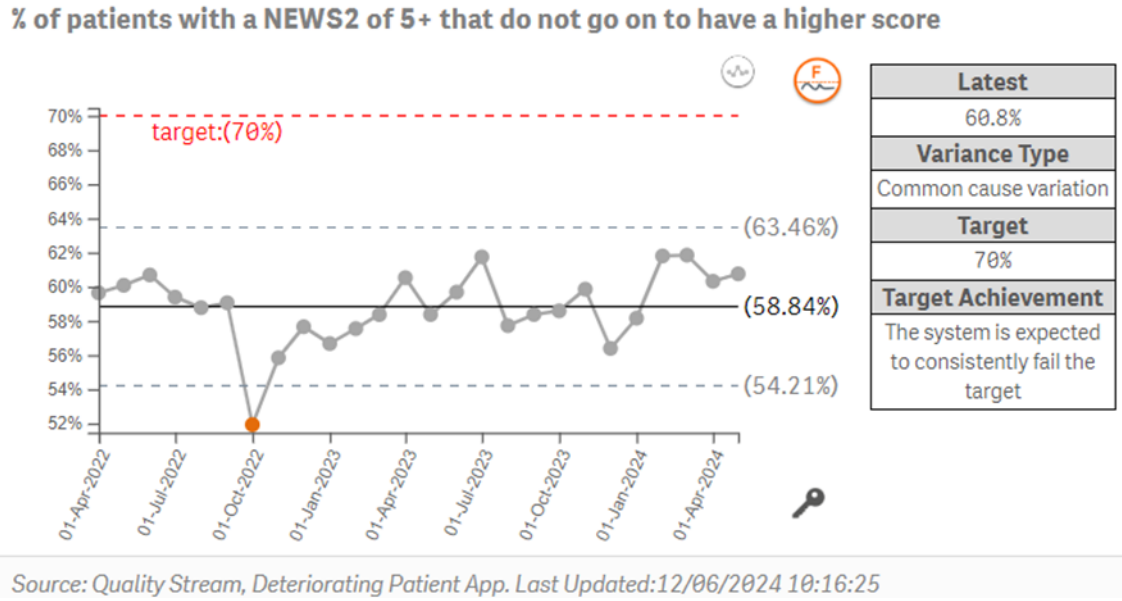
Metric	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Care of the acutely ill patient - % of episodes scoring NEWS of 5 or more not going on to score higher	May 2024	60.8%	70%			58.84%	54.21%	63.46%
Personalisation of care - % of patients that have been screened for dementia	May 2024	61.76%	90%			41.84%	28.69%	54.98%
Stroke - % of stroke patients admitted directly to an acute stroke unit within 4 hours of hospital admission	May 2024	26.2%	90%			32.81%	12.17%	53.45%

Care of the Acutely Ill Patient

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

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

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



What does the chart show/context:
- Performance was 60.8% in May 2024.
- The Trust is unable to meet the target of 70% and will consistently fail the target.
- Currently performance is subject to common cause variation
- Performance can be expected to vary from 54.21% to 63.46%.

Underlying Issues:
- A retrospective audit of patients with NEWS 5 or more who go on to score higher has highlighted that fewer than 50% of patients with NEWS 7 or more are reviewed by a registrar or consultant, in accordance with the NEWS2 policy.
- Extra capacity wards are open and are usually staffed by different doctors each day. Nursing staff may not always know who the responsible registrar or consultant is for their ward.
- Some of the patients with NEWS 5 or more who go on to score higher will include patients nearing the end of life who are appropriately palliated.

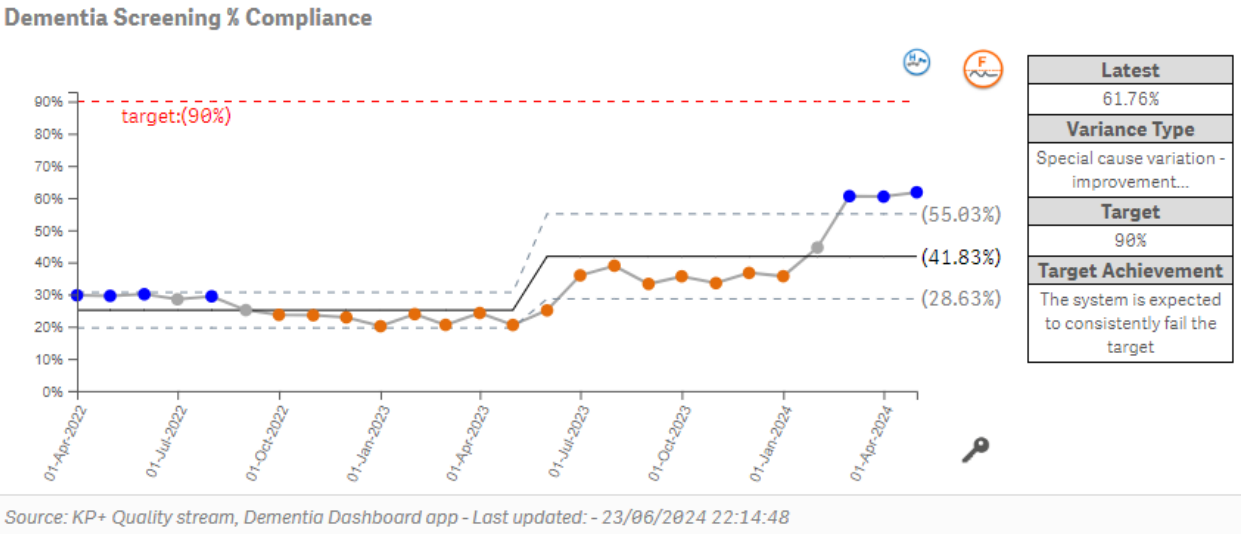
Actions:
- A quality improvement project will be undertaken to improve timely review by the Registrar or Consultant for patients with a NEWS of 7 or more.
- This project will have two main elements
  - Ensuring that the ward nursing team know to contact the medical registrar or consultant for patients who score a NEWS 7 or more
  - Engaging and raising awareness amongst registrars and consultants regarding the need to review patients with NEWS 7 or more within the hour
- Following an initial pilot on the acute floors a PDSA cycle will be used to roll out this project to other medical wards, followed by other specialty wards.

Personalisation of Care

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

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

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



Source: KP+ Quality stream, Dementia Dashboard app - Last updated: - 23/06/2024 22:14:48

What does the chart show/context:
- Performance was 61.76% in May.
- The Trust is unable to meet the target of 90% and will consistently fail the target.
- Currently performance is subject to special cause indicating improvement.
- Performance can be expected to vary from 28.69% to 54.98%.

Underlying issues:
- Dementia screening assessments remains an area of priority with areas identified for further training as compliance is not yet meeting the national standard of 90%
- There has been a reduction in training for staff due to continued staffing issues within the enhanced care team.

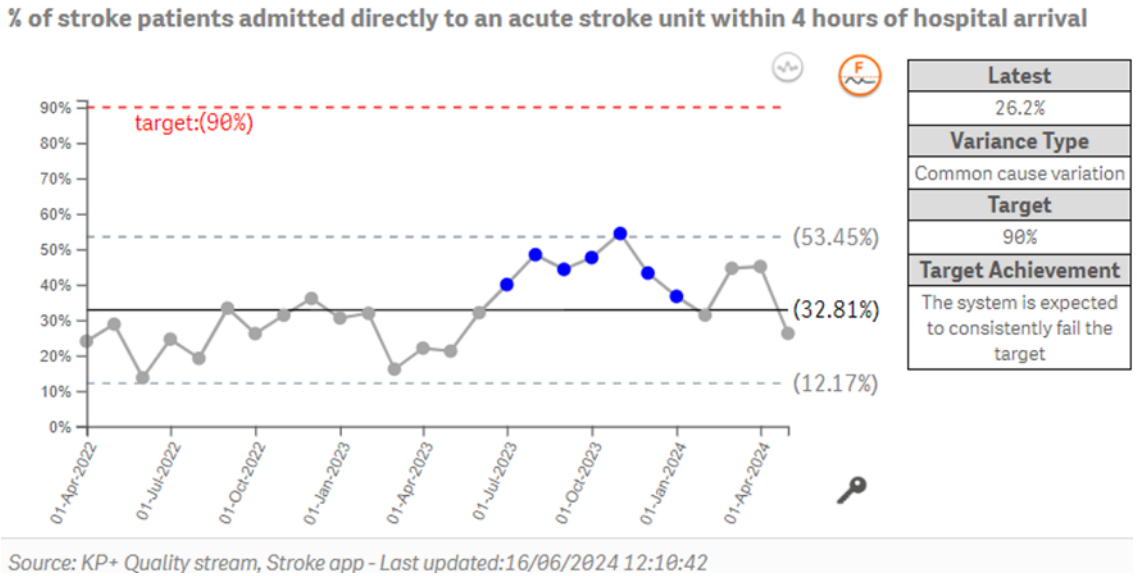
Actions:
- The dementia operational group met for the first time 4th June 2024 and highlighted the need for dementia and delirium screening to remain an area of focus.
- The enhanced care team will work with ward areas to identify dementia link nurses to lead on improving compliance with the dementia screening tools. The dementia matron will support the link nurses and provide training.

Stroke

Executive Owner: Lindsay Rudge Clinical Lead: Karthik Viswanathan Business Intelligence Lead: Charlotte Anderson

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

Target:
90%.



What does the chart show/context:
- Performance was 26.2% in May 2024 which is in expected range.
- The Trust is unable to consistently meet the target of 90% and is showing a performance level that is shown to statistically fail this target with the current process.
- Currently performance can be expected to vary from 12.17% to 53.45%.

Underlying Issues:
- Availability of beds across Stroke Floor.
- Level of therapy input has decreased impacting negatively on the length of stay (LoS) and delays discharge.
- Outlier numbers remain high to create bed capacity across the Acute Stroke Unit (ASU).
- Performance against CT scan within one hour of attendance to Emergency Department impacts the timeframe for admission to ASU however, this has improved recently
- Patients admitted to ASU via Acute Floor due to capacity constraints as a result of increased length of stay

Actions:
- Various workstreams set up to continue with improvement against this metric and SSNAP generally:
  - Outliers
  - CT/Radiology
  - DTOC
- Agreement for change of process whereby the portering team will be contacted with an ETA for arrival of stroke patients to A&E. Porter will meet patient and stroke team to escort patient to CT and back.

Elective Care:

Metric	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Total Patients waiting >40 weeks to start treatment	May 2024	713	0			-	-	-
Total Patients waiting >52 weeks to start treatment	May 2024	37	0			-	-	-
Total RTT Waiting List	May 2024	35,676	36,538			33,365	31,672	35,058
Total elective activity undertaken compared with 2023/24 activity plan	May 2024	101.4%	100%	-	-	-	-	-
Percentage of patients waiting less than 6 weeks for a diagnostic test	May 2024	94.0%	95%			82.0%	88.2%	94.3%
Diagnostic Activity undertaken against activity plan	May 2024	15,096	14,547			14,111	12,007	16,215
Total First attendances and procedures undertaken compared with 2024/25 activity plan	May 2024	110.8%	100%	-	-	-	-	-
Total Follow-Up activity undertaken compared with 2023/24 activity plan	May 2024	99.6%%	100%	-	-	-	-	-
Day Case Rates	April 2024	92.2%	85%			91.6%	93.5%	89.7%
Capped Theatre Utilisation	May 2024	82.3%	85%			81.8%	73.6%	90.0%

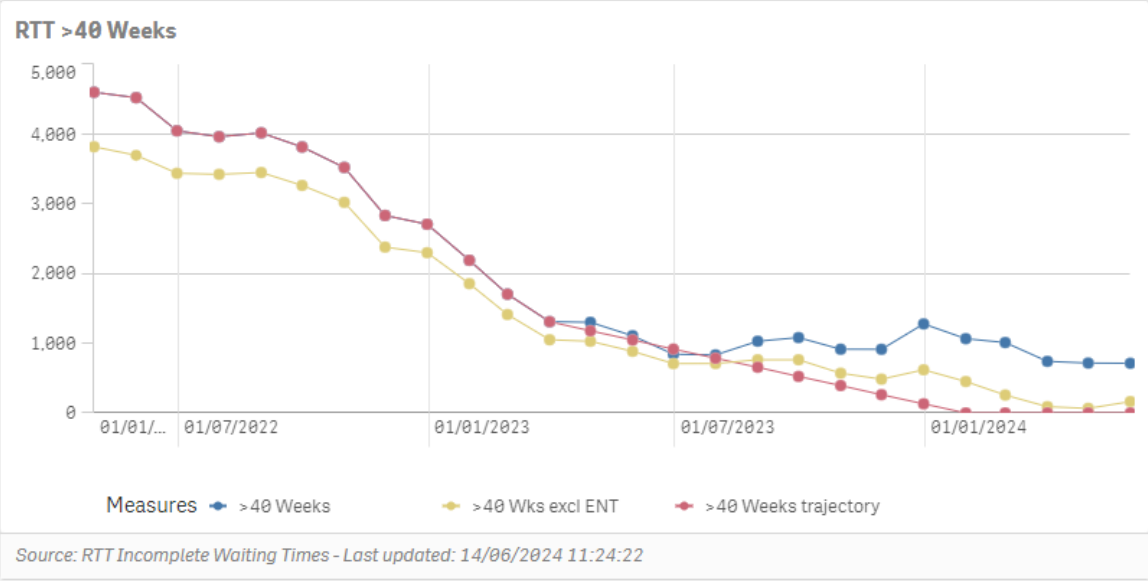
Total Patients waiting more than 40 weeks to start consultant-led treatment

Calderdale and Huddersfield NHS Foundation Trust

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

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

Target:
Aim to have 0 patients waiting more than 40 weeks by January 2024.



What does the chart show/context:
- Our 40-week position stands at 713 at the end of May against the target trajectory of 0 (163 excluding ENT).
- Most of our remaining patients who are waiting over 40 weeks are in ENT (550), General Surgery (42), Plastic Surgery (28) Gynae (19), MaxFax (18) and Cardiology (11). All other specialties have <8. Of the specialties listed, all have got worse in May apart from 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.

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 meetings have been put in for Cardiology, Gynaecology, Dermatology and Gastroenterology and Max Fax specialties.

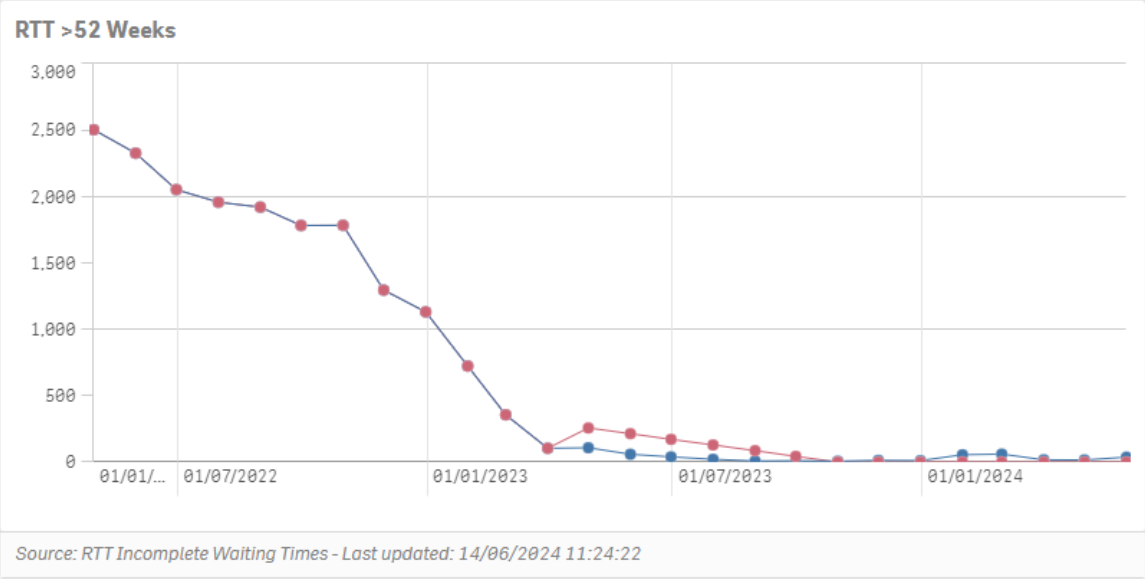
Total Patients waiting more than 52 weeks to start consultant-led treatment

Calderdale and Huddersfield NHS Foundation Trust

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

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

Target:
Aim to have 0 patients waiting more than 52 weeks by September 2023.



What does the chart show/context:
- Our 52-week position now stands at 37 (30 in ENT, 4 in Elderly Medicine and 1 each in Urology, Neurology, and MaxFax).
- There are 288 patients waiting between 46 and 52 weeks, mainly ENT (269 – Up from 232) and General Surgery (7).
- All other specialties have 3 or fewer patients waiting between 46 and 52 weeks.
- There are 3 patients who have been waiting between 60 and 65 weeks (1 each for Urology, ENT and Elderly Medicine).

Underlying issues:
- The longer-term risk to the 52-week position is specifically from ENT ASIs.
- The non-ENT patients have treatment plans in place.

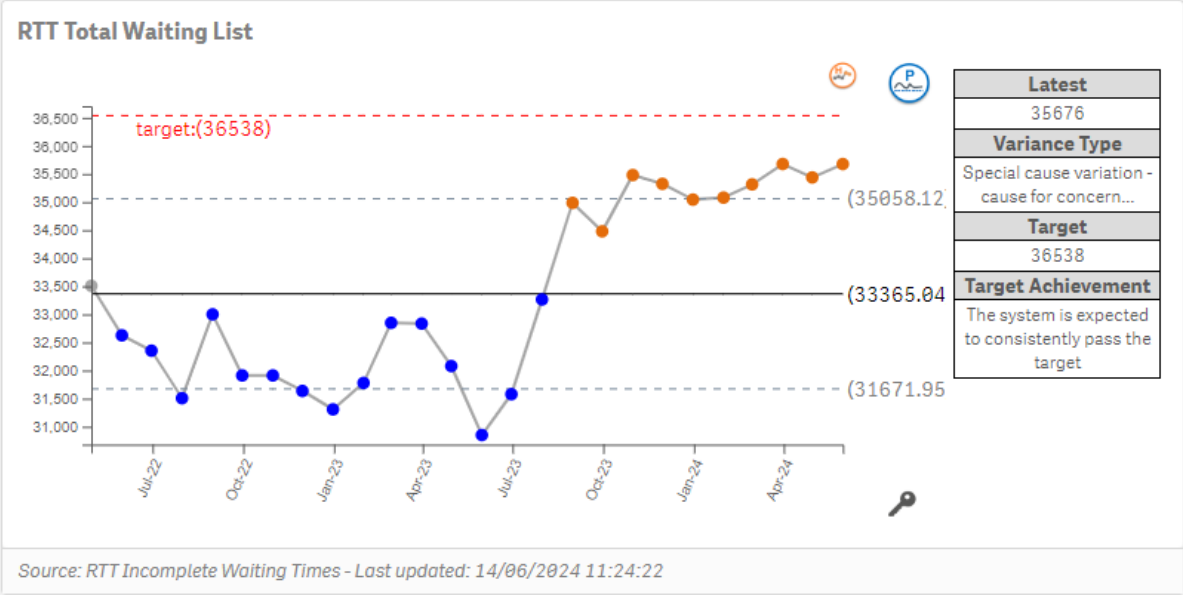
Actions:
- Operational teams to be tracking patients to at least 40 weeks and are attempting to track down to 30 weeks.
- To support 52-week delivery and maintain delivery from May onwards - S&A have restructured A&C resource to enable greater tracking of ENT's RTT position.
- KP+ writeback model being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

Total RTT Waiting List

Executive Owner: Jonathan Hammond Operational Lead: Kim Scholes Business Intelligence Lead: Fiona Phelan

Rationale:
To measure the size of the Referral to Treatment (RTT) incomplete pathways waiting list.

Target:
36,538 (activity plan 2024/25)



What does the chart show/context:
- The list remains high and stands at 35,676 at the end of May.

Underlying issues:
- We currently have a relatively stable RTT Waiting list position which is below the revised target for 2024/25 of 36,538.
- For ENT and Gynaecology, we have seen an increase in ASIs (ENT is a capacity issue whilst Gynaecology has seen an increase in demand).
- 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.

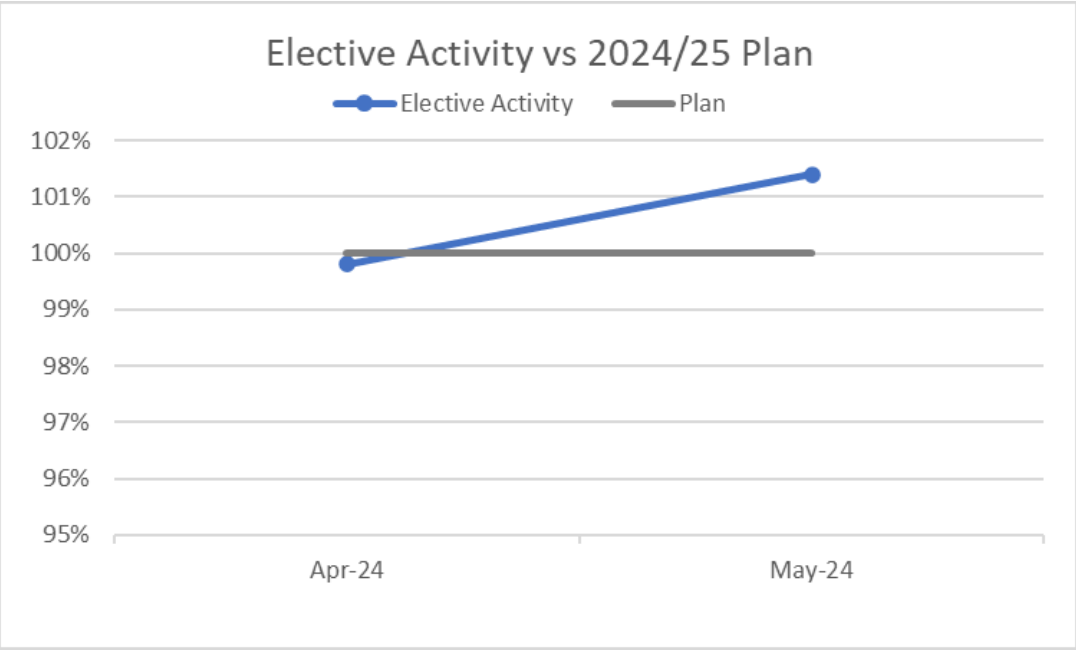
Actions:
- Validation team to monitor LUNA (National DQ RTT Benchmarking tool – currently in top 30 Trusts in the country for RTT DQ Assurance).
- Meet the trajectory for no ASIs over 18 weeks by the end of April 2024.
- Meet the trajectory for 40/52 weeks.
- Operational teams to be tracking patients 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 2024/25 activity plan

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

Rationale:
Recover elective activity levels to meet the National Elective Recovery target.

Target:
Recover elective (day cases/elective inpatients) services so that activity levels are at least 100% of 2024/25 activity plan



What does the chart show/context:
- CHFT has exceeded the elective activity 2024/25 plan in May 2024 which is an increase from the activity levels seen in April 2024.
- Performance in May 2024 was above plan at 101.4% in month.
- Day case activity was above plan at 102.9% however electives were below the planned position for May 2024 standing at 87.1%.
- The year-to-date performance for the elective activity overall has achieved activity levels that are above the planned position standing at 101.1%, which is a total of 85 spells more than the plan for the 2024/25 financial year so far.

Underlying issues:
- Potential impact of industrial action in June 2024.

Actions:
- There has been a KP+ Contract Monitoring Report model set up for 2024/25 to break this data down to specialty level. Finance leads to work with divisional GMs and Ops managers to ensure awareness of this position at specialty and divisional level.

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

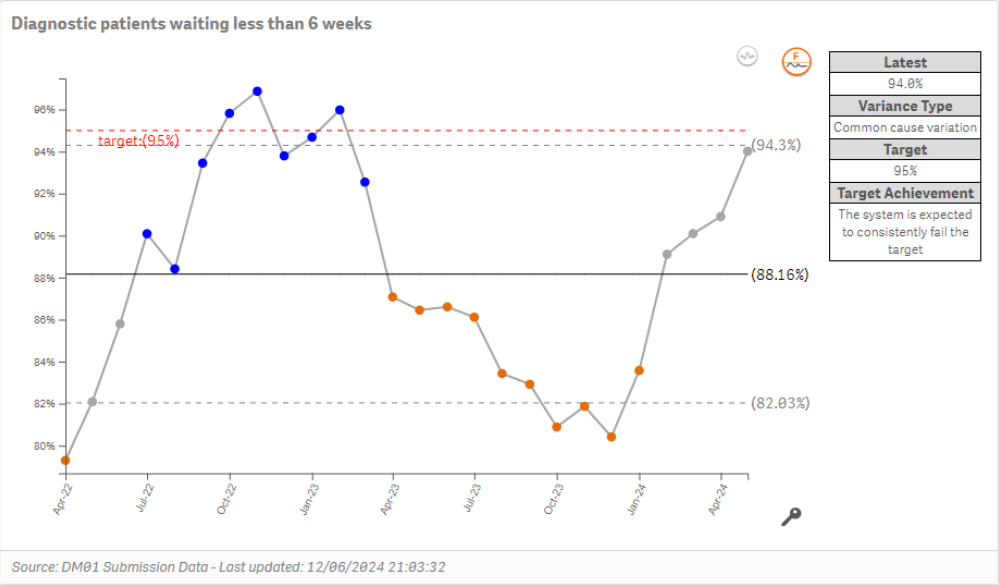
Calderdale and Huddersfield NHS Foundation Trust

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 still expected to consistently fail the target of 95%.
- Performance can be expected to vary between 82% 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 (77.2% up from 62.0%) and Neurophysiology (79.1% up from 67.6%). Neurophys resumed the upward trend in May (following a downturn in April).

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
- The performance has resumed the upward trajectory and is expected to remain on track with additional lists planned in until July.

Neurophysiology
- Total numbers have reduced significantly due to increase in capacity/staffing, and minimal numbers of >6 week waits – these waits are due to complex patients needing consultant led clinic/double/triple appointment slots.
- Rota is being reviewed weekly to ensure maximum capacity.
- Neurophysiology Support Assistant contacting EMG/CTS patients to confirm attendance - mitigating DNAs/last minute cancellations – routine/ongoing.
- Short-notice cancellation list utilised routinely.
- Succession planning/training of junior staff in place.
- We remain on plan to have no breaches by the end of June 2024

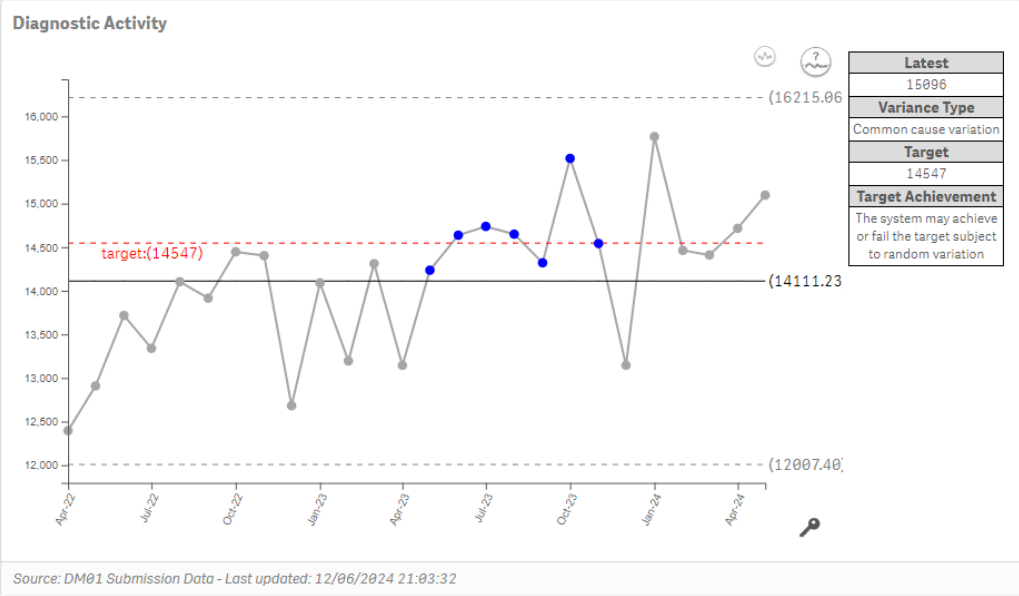
Total Diagnostic Activity undertaken against the activity plan

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 2023, but it may achieve or fail the target subject to random variation. The activity for May 2024 is above the target at 15,096.
- Performance can be expected to vary between 12,007 and 16,215. 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. May 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
- The performance has resumed the upward trajectory and is expected to remain on track with additional lists planned in until July.

Neurophysiology

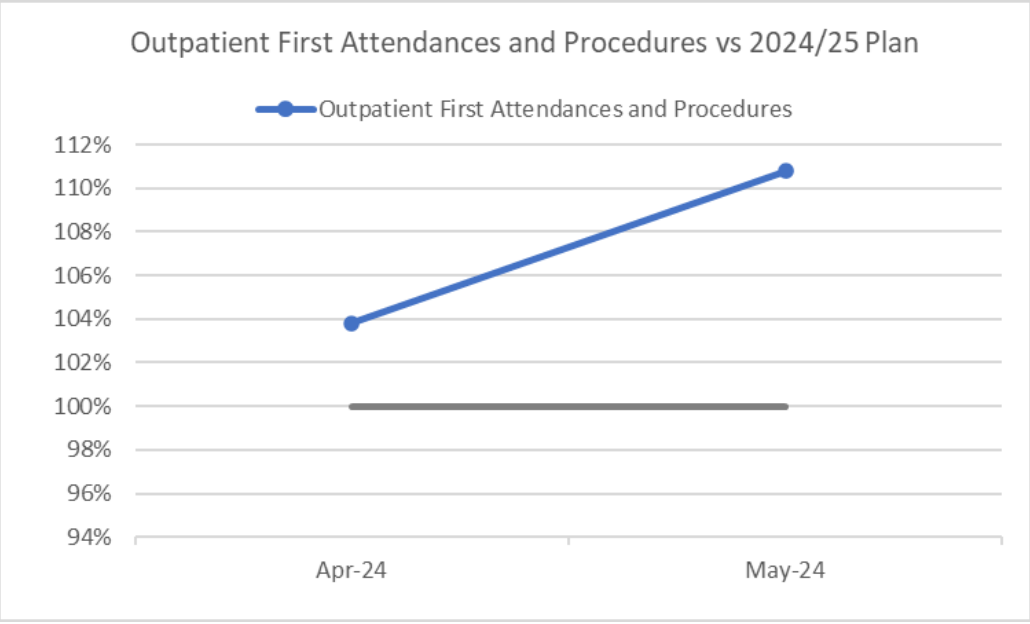
- Total numbers have reduced significantly due to increase in capacity/staffing, and minimal numbers of >6 week waits – these waits are due to complex patients needing consultant led clinic/double/triple appointment slots.
- Rota is being reviewed weekly to ensure maximum capacity.
- Neurophysiology Support Assistant contacting EMG/CTS patients to confirm attendance - mitigating DNAs/last minute cancellations – routine/ongoing.
- Short-notice cancellation list utilised routinely.
- Succession planning/training of junior staff in place.

Total First attendances and procedures undertaken compared with 2024/25 activity plan

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

Rationale:
Recover first attendance and procedure levels to meet the National Elective Recovery target.

Target:
100% of 2024/25 activity plan (source: activity plan 2024/25)



What does the chart show/context:
- Outpatient first attendance and procedure activity has increased in month 2 compared to the 2024/25 activity plan having delivered 110.8% of planned activity in the month of May 2024. Both first attendances and procedures are above planned levels at 105.1% and 138.3% respectively.
- CHFT have so far delivered 107.7% of the activity plan for the year to date which represents 1,939 more outpatient first attendances and procedures than the planned position for the first 2 months of the year.

Underlying issues:
- Although CHFT have delivered above the planned activity levels from an outpatient first attendances perspective for the first 2 months of the year the ASI list does still continue to track on an upward trajectory currently standing at 17,099 records.
- There has been an increase in incomplete outcomes in the first 2 months of 2024/25, this is causing some activity to not make it through to this position.

Actions:
- Cardiology have plans in place to run some extract clinics for first waiters to address the growing ASI list.
- Gynaecology have been running some ‘Super Saturday Clinics’ for extra first capacity, there are plans in place for further clinics in the coming months.
- ENT continue to work with Pioneer to support with the management of the waiting list.

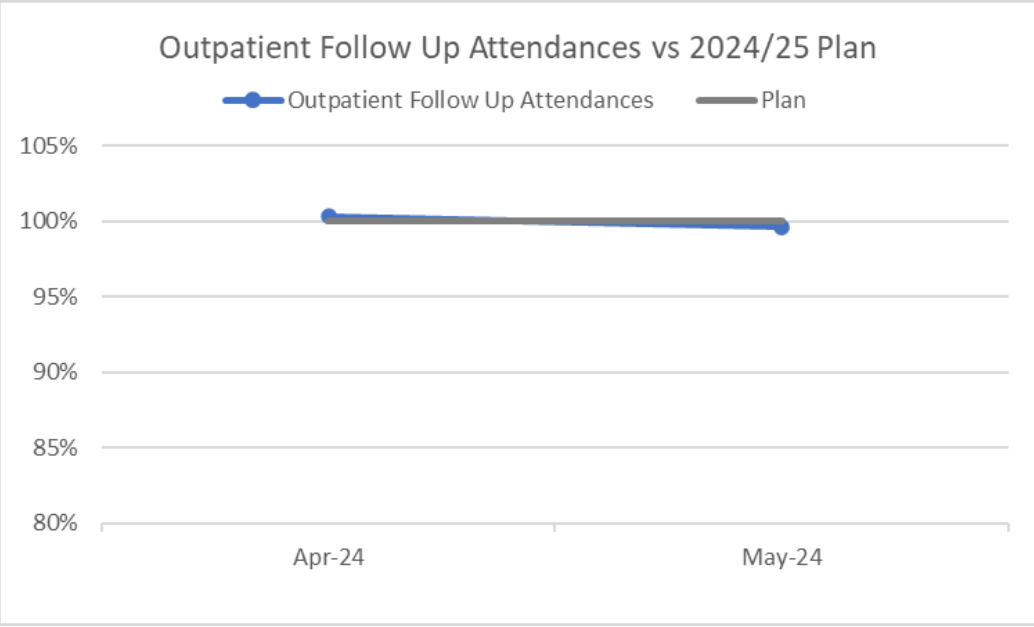
Total Follow-Up attendances undertaken compared with 2024/25 activity plan

Calderdale and Huddersfield NHS Foundation Trust

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

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

Target:
100% of 2024/25 activity plan (source: activity plan 2024/25)



What does the chart show/context:
- CHFT made the decision at the start of 2022/23 to not adopt the 25% reduction in Outpatient follow-up activity, this has continued for 2024/25.
- Activity was slightly below the planned position in May 2024 standing at 99.6% of the planned position in-month for follow-up attendances.
- For the year-to-date position CHFT activity is currently showing a performance of 98.1% of the 2024/25 plan being delivered over the first 2 months of the year. This represents a total of 771 attendances below the planned position to date.

Underlying issues:
- 40% of the backlog has been waiting less than 12 weeks.

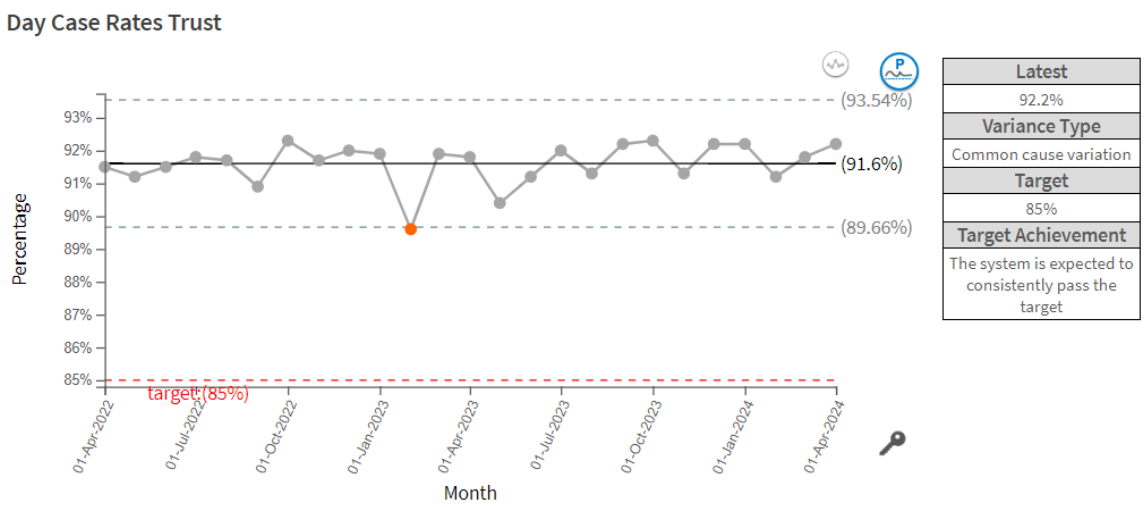
Actions:
- There are currently 7,967 (of the 30,072 backlog) records that are awaiting a clinical prioritisation within CHFT's MPage system, this is a reduction of 1,000 from last month. Cohorts for incomplete outcomes have been brought into the low hanging fruit validation process. Specialties will 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 30,072 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.
- A regular 'Outpatient Access' meeting focussing on the follow-up backlog and capacity management has been established and each directorate has attended 2 meetings thus far. There has also been a waiting time target for each specialty area introduced to track improvement work.

Day Case Rates

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

Rationale:
To measure the relative increase

Target: Over 85%



What does the chart show/context:

- 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 April 2024. CHFT performance reported as 92.2% against an 85% target.

Underlying issues:

- Data quality challenges around “intended management”. Cases are being listed on Bluespier and completed as day case however these are not counted due to PM office amendments not being made.
- Reverse conversion are not counted – If a patient is listed for an inpatient stay but is completed as day case this is not reflected in our day case rate.

Actions:

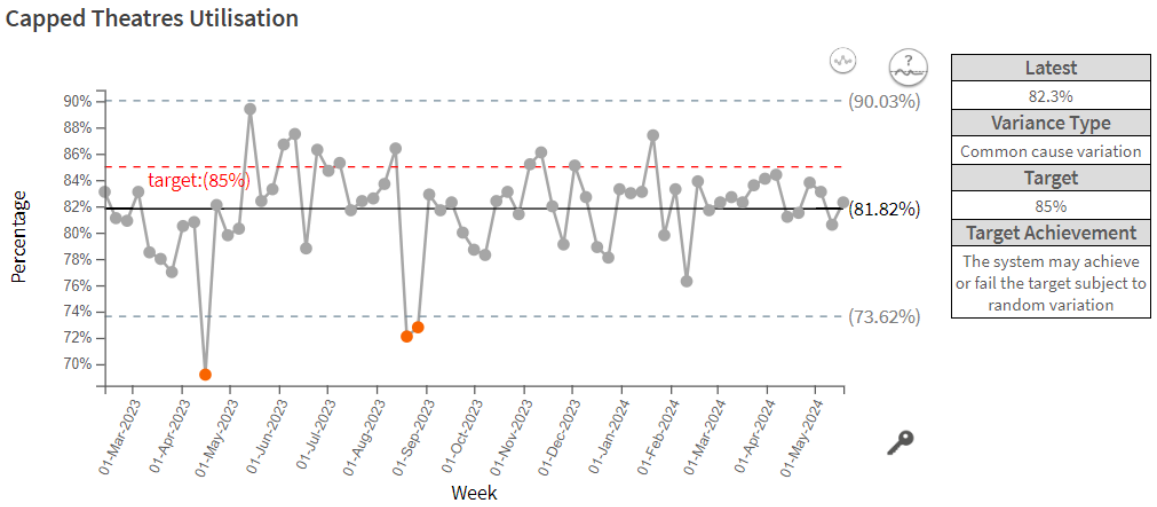
- Impact of SDEC changes are being monitored through Division and the HIS team.
- Day case rates are monitored at a specialty level through the monthly STUG meetings.
- Procedure specific data reviewed each month to identify improvement opportunities or data quality challenges.
- Specific actions in 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%



Source: Model Hospital - Last updated: 12/06/2024 01:17:12

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 19th May 2024 – performance at 82.3% against an 85% target

Underlying issues:

- Regional Go Sees have identified inconsistencies as to how organisations record 'Start' times.
- Lots of work done to improve intercase downtime however there are often large gaps between AM & PM patients due to breaks and staff changes. Identified that one regional trust has an extra member of staff in theatre to support collecting next patient to ensure quick turnaround.
- Model Hospital unable to explain how they account for 60 minute lunchtime despite this being reported as an 'allowed' gap. Negatively impacts CHFT as other Trusts in the region still operate on an AM/PM model

Actions:

- Utilisation is monitored at a specialty list level through the monthly STUG meetings to identify improvement opportunities or data quality challenges. Work with the STUG to identify themes and concerns.
- Issue with scheduling in some specialties. Working to review amount of time being allocated to specific procedures
- Weekly 6-4-2 Scheduling meetings with specialties now working well. Working towards better communication around utilisation and scheduling

Cancer:

Metric	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Proportion of patients meeting the 62-Day standard	May 2024	88.2%	85%			89.1%	82.6%	95.6%
Proportion of patients meeting the faster diagnosis standard	May 2024	77.98%	77%			76.8%	68.7%	85.0%
Non-Site-Specific Cancer Referrals	May 2024	28	27			23.0	9.4	36.6
Early cancer diagnosis: 75% of cases diagnosed at stage 1 or 2 by 2028	May 2024	43.3%	75%			47.9%	33.2%	62.6%

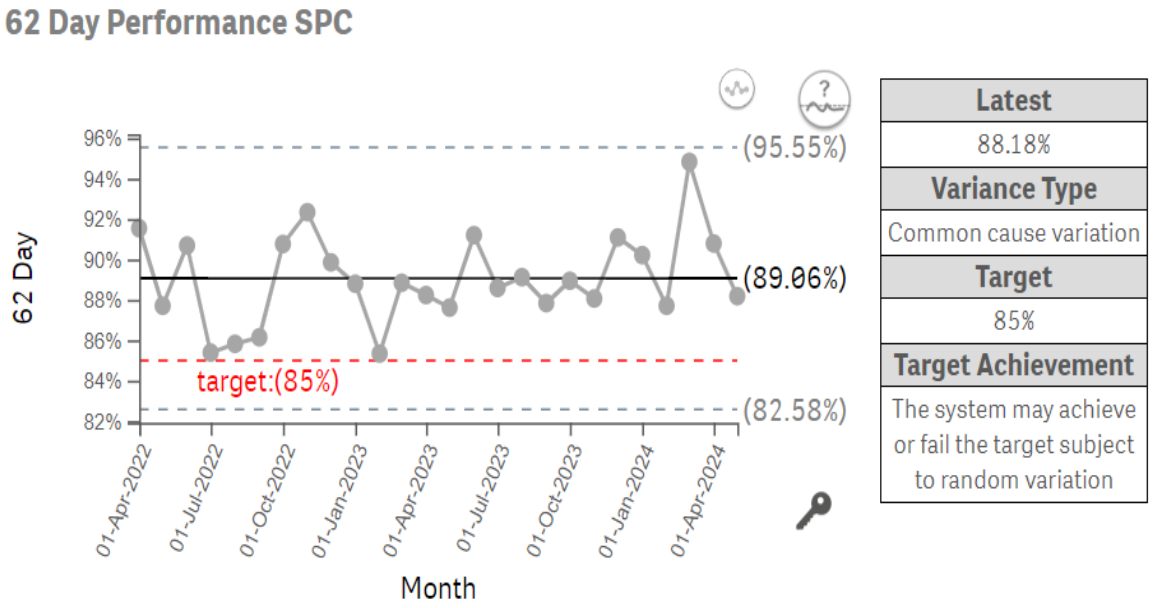
Proportion of patients meeting the 62-day cancer referral to treatment standard

Calderdale and Huddersfield NHS Foundation Trust

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

Rationale:
The NHS Constitution outlines what patients can expect and their rights when they are referred on a cancer diagnosis and treatment pathway. Patients who receive a cancer diagnosis after an urgent suspected cancer referral, referral for breast cancer symptoms, or via cancer screening should start treatment within 62 days of that initial referral.

Target: 85%



What does the chart show/context:
- This chart shows number of patients who have been given their first treatment within 62 days.
- The Trust consistently hits this target and current performance stands at 88.18%

Underlying issues:
- Lack of capacity at first seen.
- 28 day target performance due to diagnostic capacity, Radiology. Repeat tests.
- H&N at 25% in May. Issues with thyroid surgery.
- SKIN still delays in pathway with diagnostic biopsies, late referral to Max/Fax and plastics
- Lower GI and Bowel Screening, capacity for clinic and theatre.

Actions:
- Teams need to review their pathways from beginning to end.
- Escalation of risk at weekly meeting with PPC's, Opps/GM's
- Continue to monitor patients on PTL between day 48 – 62 and prevent patients reaching over 104. Daily checks and weekly meeting to review these patients.
- Capacity to be reviewed alongside other completing pressures
- Competing capacity for theatres with other Trust targets

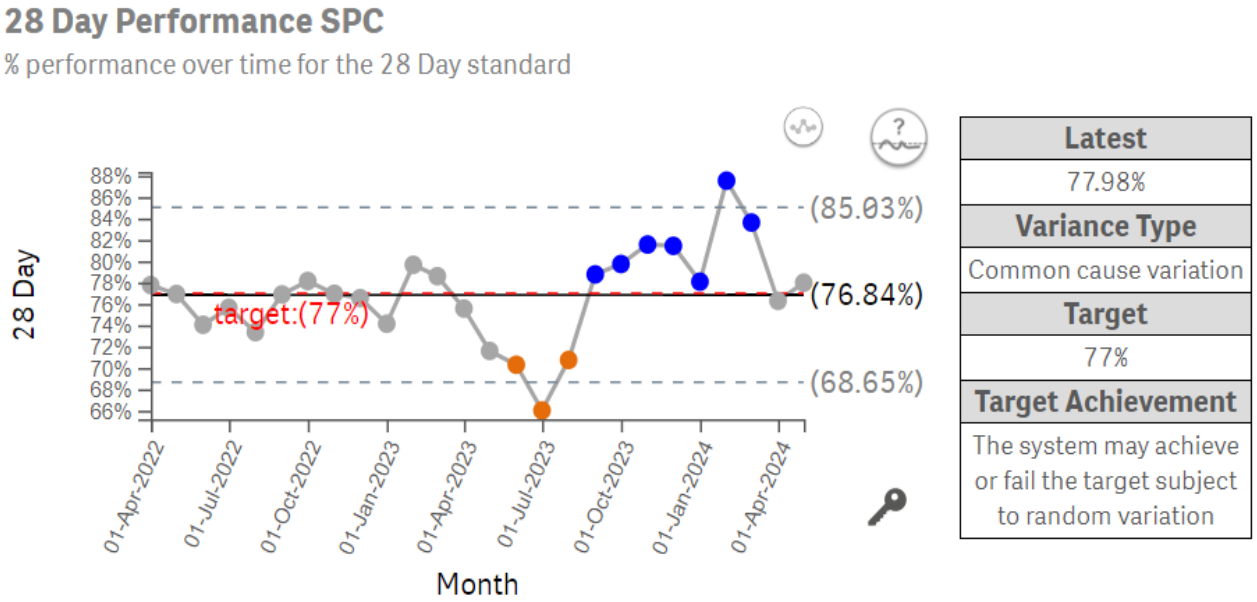
Proportion of patients meeting the faster diagnosis standard

Calderdale and Huddersfield NHS Foundation Trust

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

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

Target:
Maximum four weeks (28 days) from receipt of referral, to point at which patient is told they have cancer, or cancer is definitely excluded. Target 77%.



Latest
77.98%
Variance Type
Common cause variation
Target
77%
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 77.98% which is above the National target
- National performance tends to be under the 77% target.
- The Trust is expected to meet or fail the target of 77% subject to random variation. Performance can be expected to vary between 69% and 85%

Underlying issues:
- Skin patients now being seen within 28 Days (96.9% in May).
- Lower GI - 53.1% in May. 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.
- H&N (63.3% in May) we are frequently chasing results letters/appointments for results.

Actions:
- Discussions with UGI regarding the use of PAs on the pathway, improved performance in the last 2 months.
- Head and Neck attending the next CDG to highlight their challenges and how they will try to address these
- Lower GI and H&N work ongoing with team and closely monitoring of patients at weekly risk meeting.
- A recovery plan for Breast was presented at the June Cancer Delivery Group, which is now showing more optimised capacity and a reduced polling range.

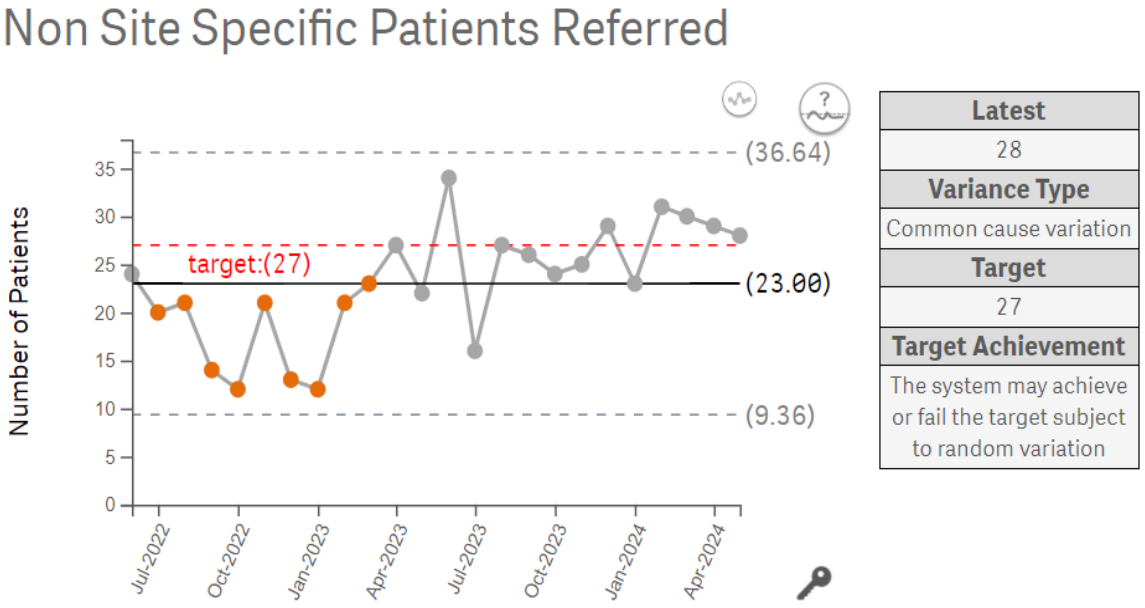
Non-Site-specific Cancer Referrals

Calderdale and Huddersfield NHS Foundation Trust

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

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

Target: 27 as per activity plan for 2024/25



Latest
28
Variance Type
Common cause variation
Target
27
Target Achievement
The system may achieve or fail the target subject to random variation

What does the chart show/context:
- The Trust is unable to consistently meet the target of 27 and may achieve or fail the target subject to random variation. Performance can be expected to vary between 8 and 38.

Underlying issues:
- Referrals continue to be variable.

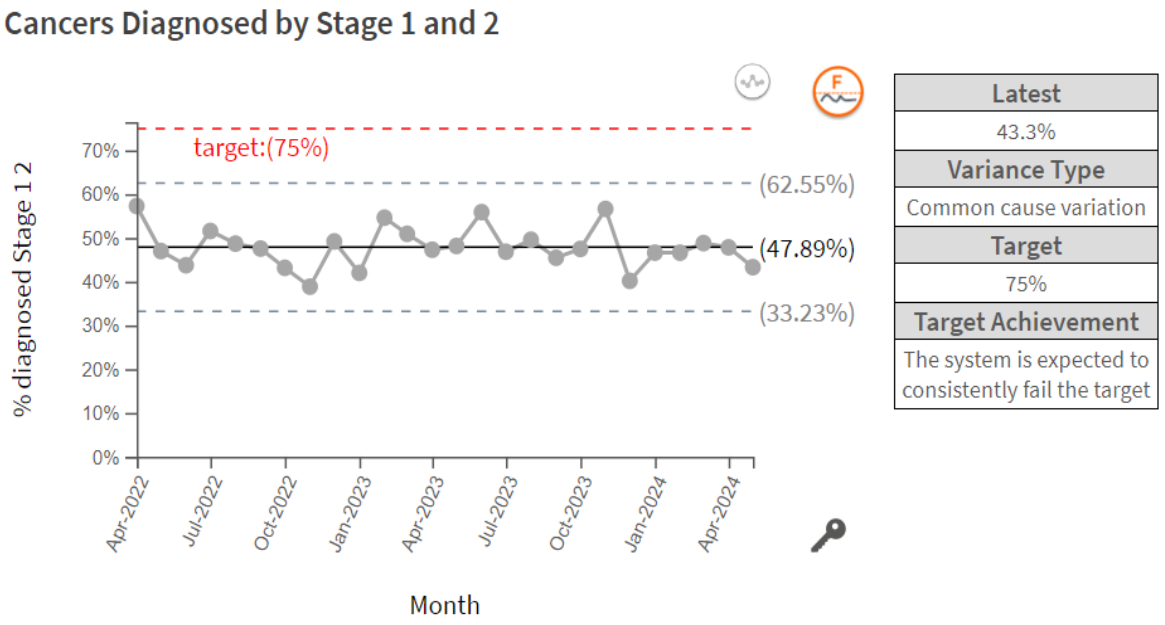
Actions:
- FIT pathway, with an option to refer patients with a negative FIT (FIT less than 10) to NSS may lead to an increase in referrals, this pathway started on the 20th May 2024.
- Sharing quarterly NSS referrals data with PCNs, continuing to raise the NSS service profile.
- Rolled out NSS in the community to a second PCN in Calderdale, Calder and Ryburn PCN, Opening up to a second PCN in Kirklees (Viaduct PCN).
- Opening discussions regarding clinical sessions based in the CDC.

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
43.3%
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 33% and 63%.
- 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 (20th May).
- The Faster Diagnostic Framework will also support this unit of work..

Urgent and Emergency Care and Flow:

Metric	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Proportion of patients admitted, transferred or discharged within 4 hours	May 2024	69.0%	78%			68.6%	60.3%	76.9%
Proportion of ambulance arrivals delayed over 30 minutes	May 2024	6.9%	0%			3.85%	0.37%	7.34%
Proportion of patients spending more than 12 hours in an emergency department	May 2024	3.8%	2%			3.4%	0.7%	6.2%
Adult G & A acute bed occupancy adjusted for void beds (Type 1 Acutes Only)	May 2024	97.3%	96%			98.3%	96.5%	100%
% of beds occupied by patients who no longer meet the criteria to reside	May 2024	20%	14.2%			21.0%	17.6%	24.5%
Hospital Discharge Pathway Activity – AvLOS pathway 0	May 2024	4.5	4.1			4.3	3.9	4.7
Transfers of Care	May 2024	138	n/a			107	68	145

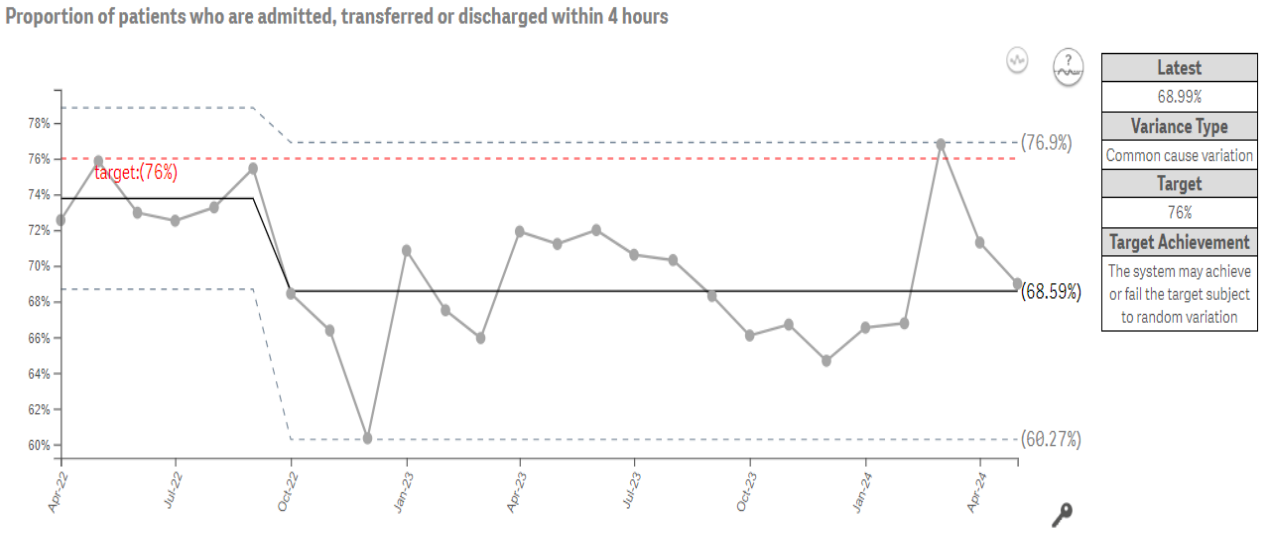
Proportion of patients admitted, transferred or discharged within 4 hours

Calderdale and Huddersfield NHS Foundation Trust

Executive Owner: Jonathan Hammond Operational Lead: Jason Bushby Business Intelligence Lead: Alastair Finn

Rationale:
To monitor waiting times in A&E.

Target:
NHS Objective to improve A&E waiting times so that no less than 78% of patients are admitted, transferred or discharged within 4 hours by March 2025.



Source: UEC Sitrep/YAS data - Last updated: 17/06/2024 21:03:32

What does the chart show/context:
- We saw a decrease in performance to 68.99% in May 2024
- The performance for CRH was 72.0% and HRI was 65.7%

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

Actions:.
- Evenings into nights is problematic and breach review identifies poor skill/seniority mix in employed medical workforce. Now addressed with 2 ST4+ on nights and evening consultant staying on until department is clear.
- We are monitoring our admitted and non-admitted performance daily to try improve the overall 4-hour standard performance. We have changed the rag rating on these KPIs to factor in the changing of SDEC recording.
- Testing of full capacity protocol is underway, aimed at supporting reducing long waits in ED.
- Increased ED Consultant presence from May 2024, will be on site until midnight 7 days per week
- Manager of the Day for ED role initiated through March is to continue:
- Breach validation SOP completed – will ensure consistent validation process

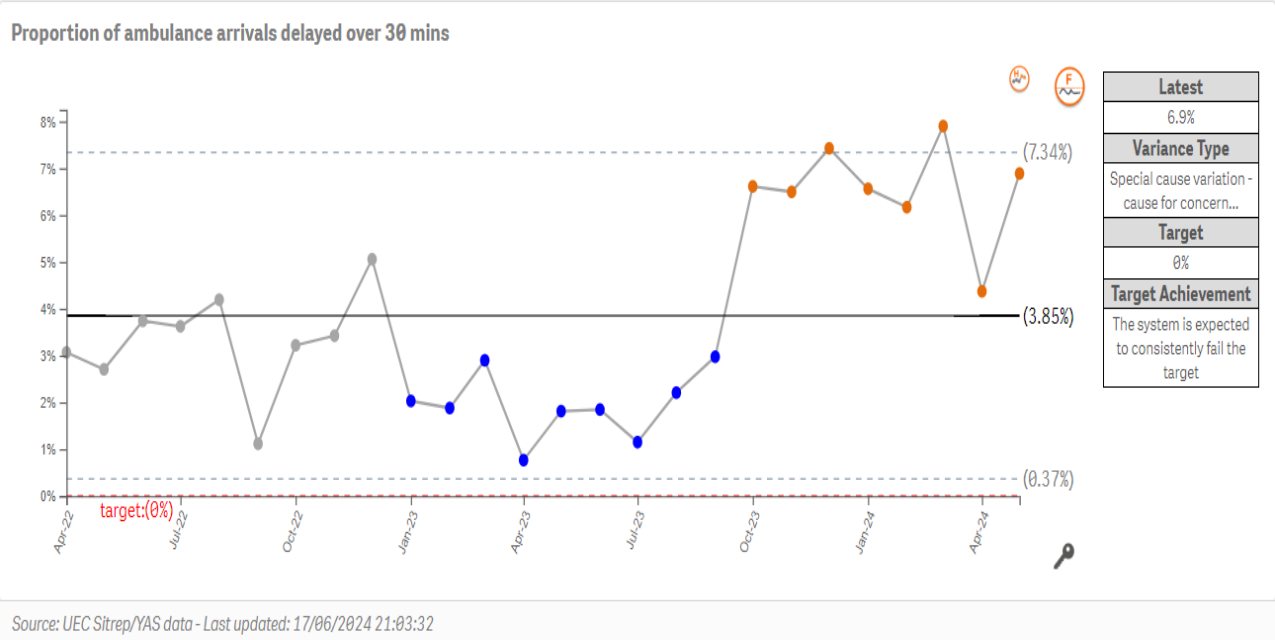
Proportion of ambulance arrivals delayed over 30 minutes

Calderdale and Huddersfield NHS Foundation Trust

Executive Owner: Jonathan Hammond Operational Lead: Jason Bushby Business Intelligence Lead: Alastair Finn

Rationale:
Proportion of ambulances which experience a delay (by more than 30 minutes) in transferring the patient over to the care of ED staff.

Target:
Patients arriving via an ambulance should be transferred over to the care of hospital staff within 15 minutes of arrival at an Emergency Department (ED). 0% should wait over 30 minutes to handover (NHS Standard Contract 2023/24).



What does the chart show/context:
- The performance for May was 6.9%.
- The Trust is expected to consistently fail the target of 0%. Performance can be expected to vary between 0.37% and 7.34%.

Underlying issues:
- We have seen a deterioration in performance from October 2023 and this will continue as the reporting for YAS handovers has changed. The key change is the use of arrival destination as the trigger for when the clock starts. This removes any notify times previously used and as a result we have seen an increase in handover times.
- 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.

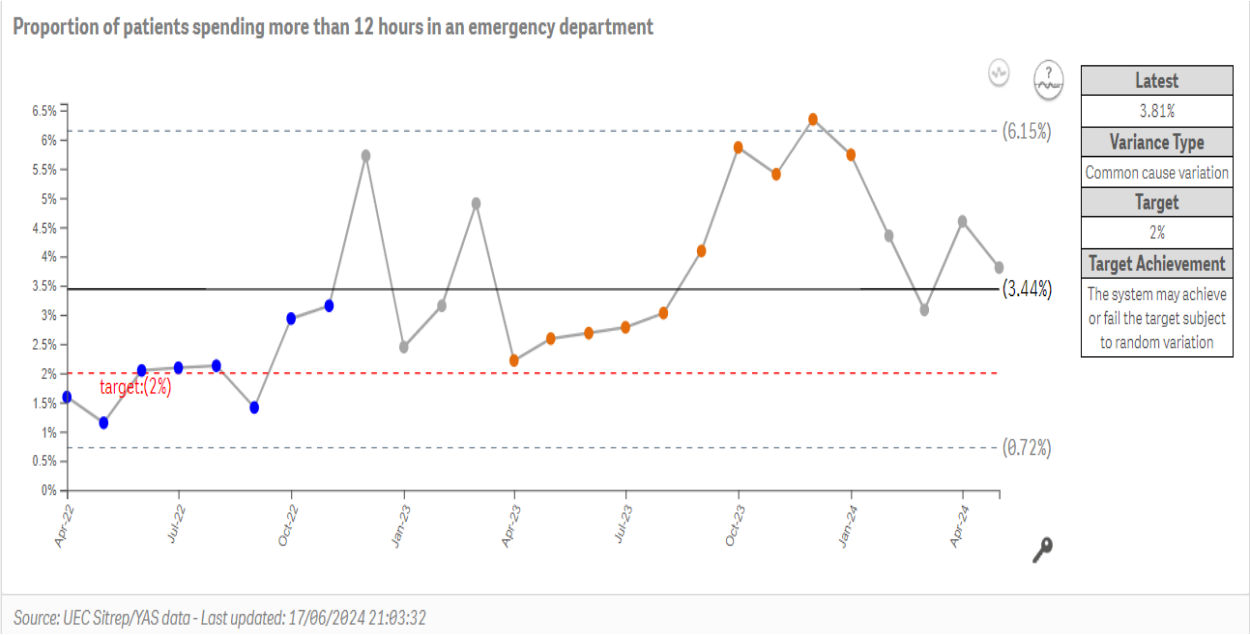
Proportion of patients spending more than 12 hours in an emergency department

Calderdale and Huddersfield NHS Foundation Trust

Executive Owner: Jonathan Hammond Operational Lead: Jason Bushby Business Intelligence Lead: Alastair Finn

Rationale:
To monitor long waits in A&E.

Target:
The number of patients that spend more than 12 hours between arrival and admission, transfer or discharge, as a proportion of total attendances. Less than 2% of patients should wait more than 12 hours (NHS Standard Contract 2023/24).



What does the chart show/context:
- Performance for May was 3.81% with 625 over 12-hour 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.
- Increased ED Consultant presence from May 2024, will be on site until midnight 7 days per week
- Manager of the Day for ED role initiated through March is to continue:
- Breach validation SOP completed – will ensure consistent validation process

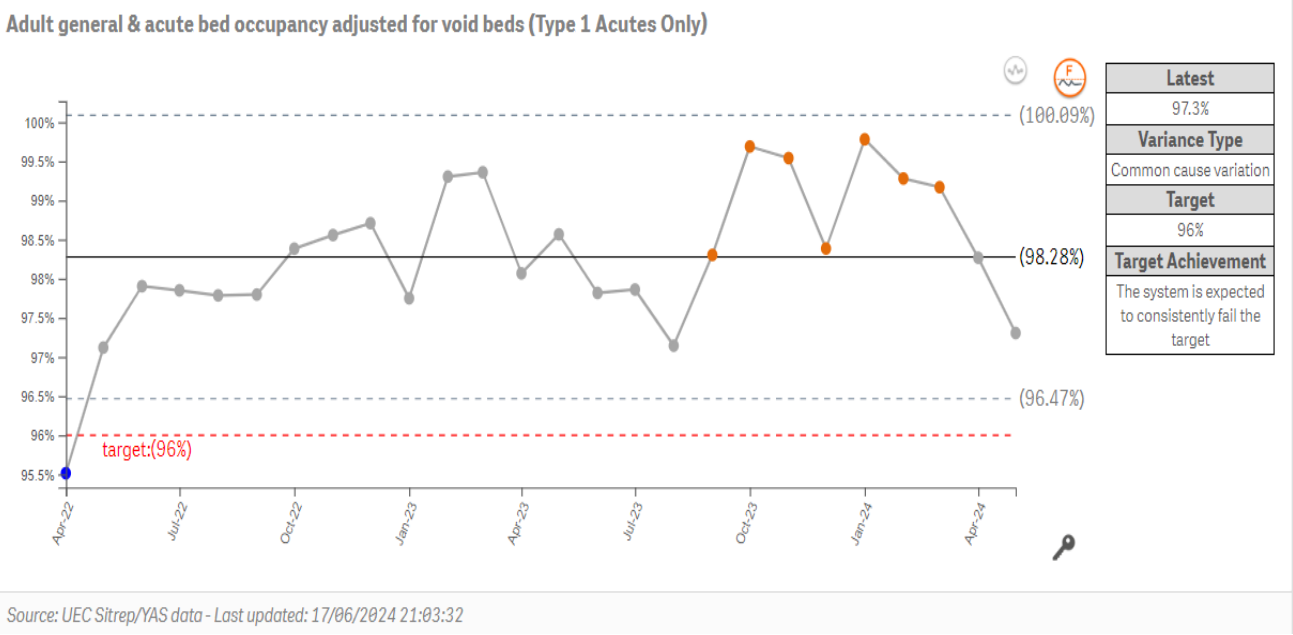
Adult general & acute bed occupancy adjusted for void beds (Type 1 Acutes Only)

Calderdale and Huddersfield NHS Foundation Trust

Executive Owner: Jonathan Hammond Operational Lead: Gemma Berriman Business Intelligence Lead: Alastair Finn

Rationale:
Understand the proportion of adult general and acute beds that are occupied.

Target:
Target 96% or less.



Source: UEC Sitrep/YAS data - Last updated: 17/06/2024 21:03:32

What does the chart show/context:
- Adult bed occupancy in May reduced slightly to 97.3%. The Trust is expected to consistently fail the target of 96%.
- It is important to factor in the bed base when analysing this graph.

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

Actions:
- Funded and unfunded bed base now established.
- Working with operational site teams to maintain capacity and drop occupancy levels.
- Long length of stay work continues.
- Trajectory for reducing TOC numbers.
- WOW improvement project has established KPIs reporting into Urgent and Emergency Care Delivery Group.

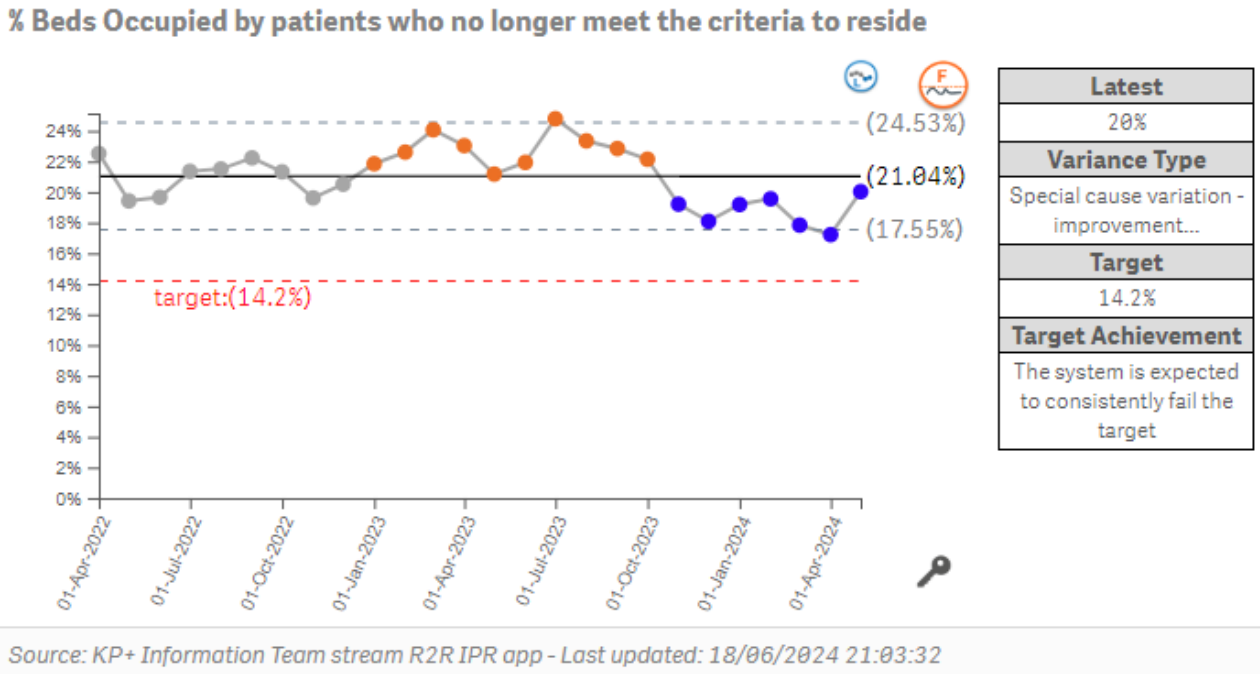
Percentage of beds occupied by patients who no longer meet the criteria to reside

Calderdale and Huddersfield NHS Foundation Trust

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

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

Target: Less than 14.2% as per activity plan (March 2025).



What does the chart show/context:

- In May 20% of patients had no reason to reside.
- Slightly more beds were occupied in May, but this was still in line with the number of patients with no reason to reside, hence the percentage remaining similar to previous months.
- The Trust will consistently fail the target of 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.
- Agreed at UECB to incorporate TOC dashboard and performance targets for P1-3 into its governance structure for 24/25. Those targets link to reducing LOS post discharge ready and will feed into NR2R performance.

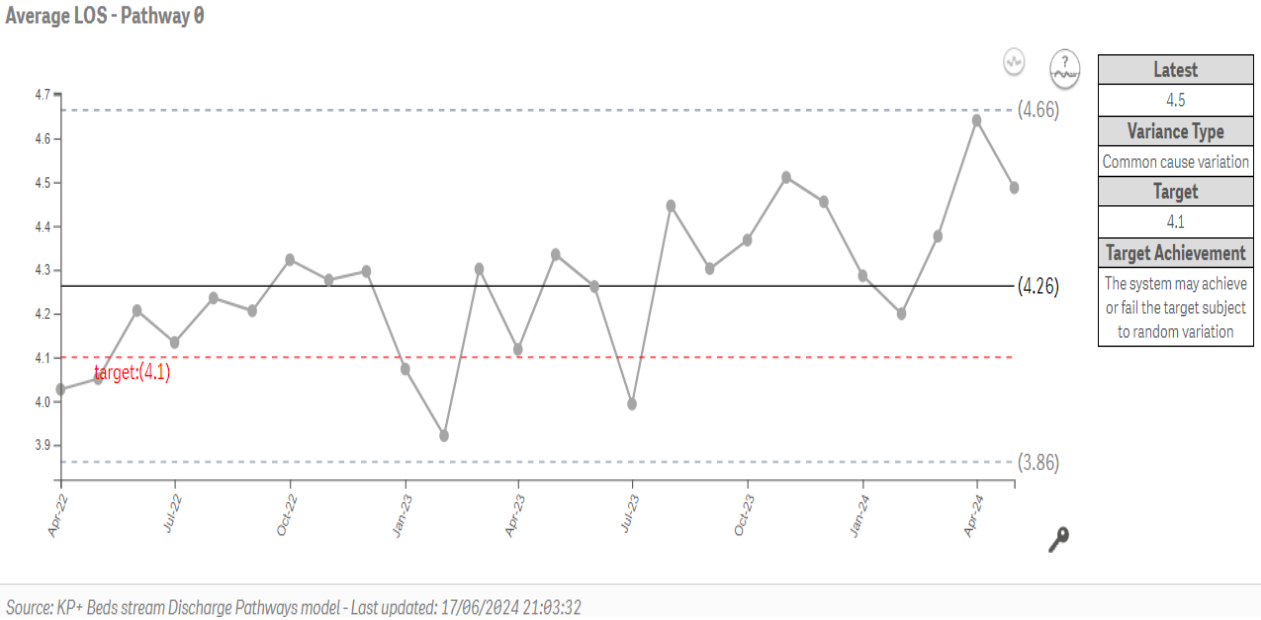
Hospital Discharge Pathway Activity

Calderdale and Huddersfield NHS Foundation Trust

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

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

Target:
Average Length of Stay for pathway 0 patients to 4.56 days.



Source: KP+ Beds stream Discharge Pathways model - Last updated: 17/06/2024 21:03:32

What does the chart show/context:
- In May the average length of stay for pathway 0 patients was 4.1 days.
- Performance can be expected to vary between 3.86 and 4.66 days.

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

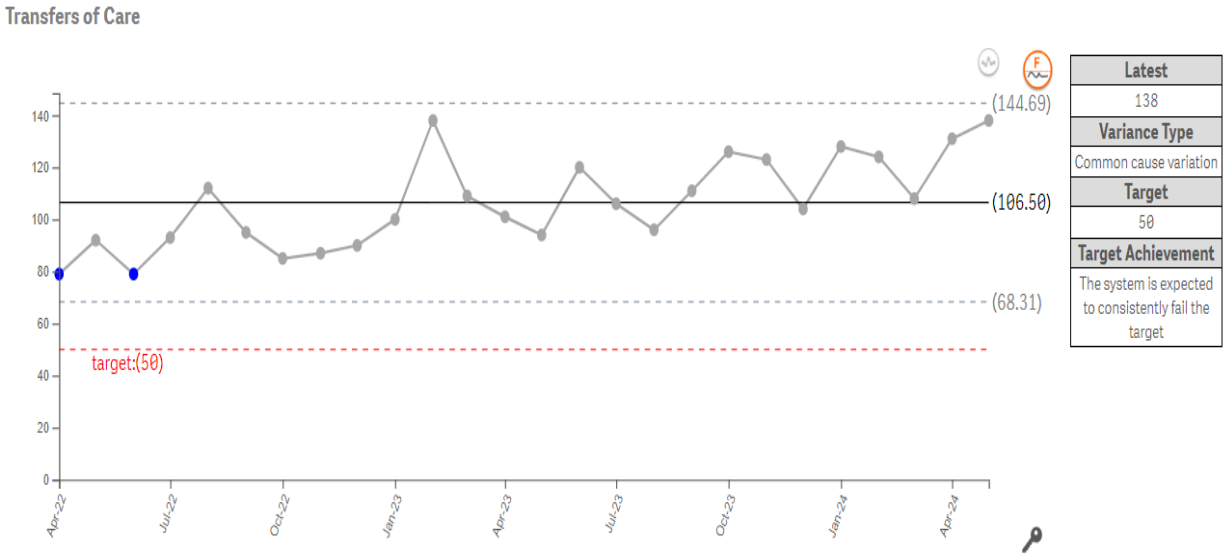
Actions:
- Improvement groups continue with PMO support to develop and improve groups.
- Launch of the Well Organised Ward (WOW) Programme.
- Approval of funding to reablement and trusted assessors.
- New pack for UECDG to help support improvements
- Governance structures defined within the divisions and through PRMs.

Transfers of Care

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

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

Target: TBC



Source: KP+ DToC Stream DToC Summary model - Last updated: 17/06/2024 21:03:32

What does the chart show/context:
- The snapshot for the end of May was 138 patients on the TOC list
- 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:

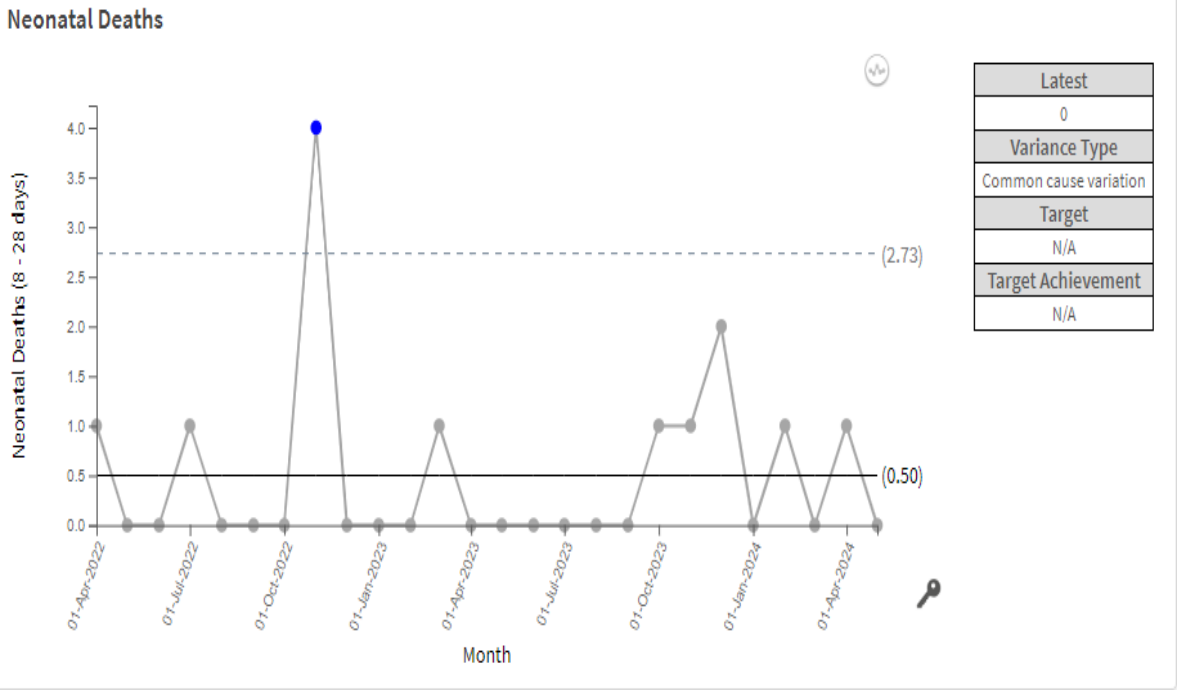
Metric	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Neonatal deaths per 1,000 total live births	May 2024	0	1.53		-	-	-	-
Stillbirths per 1,000 total births	May 2024	3	3.33			1.54	0	5.98
Maternity Workforce	May 2024	152.8	195			153.7	147.3	160.1
Maternal Mortality	May 2024	0	0		-	-	-	-
Pre-Term Births	May 2024	7.6%	8%			6.9%	1.9%	11.7%
Brain Injuries	May 2024	0	2.2		-	0.38	0	1.98

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 May

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

Calderdale and Huddersfield NHS Foundation Trust

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

Rationale:
The government's National Ambition is to halve the rate of stillbirths from a 2010 baseline by 2025, with a 20% reduction by 2020, reducing the rate from 5.1 per 1,000 births in 2010 to 4.1 in 2020 and 2.5 in 2025.
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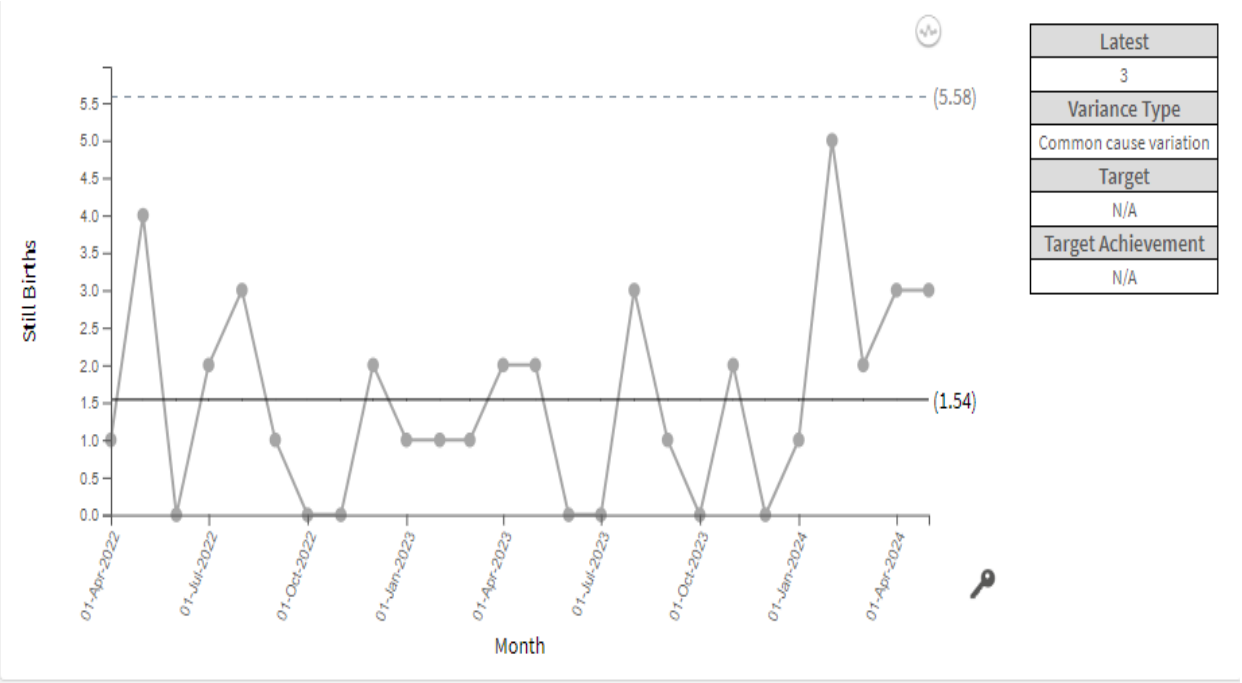
Target:
3.33 deaths per 1,000 live births. MBRRACE-UK



Latest
3
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

What does the chart show/context:
- There were three stillbirths in May.

Underlying issues:
- All stillbirths have been during the antenatal period.
- The majority of women who have experienced a loss have multiple complexities, both social and clinical. There is a disproportionate representation of women who are BAME, English is not their first language and live in IMD codes 1-4. This is reflective of the national picture and there is a national task group taking place to better understand why these women experience poorer outcomes.
- There are no continuity of carer teams currently in place, implementing an interim model of enhanced antenatal and postnatal care for women from this cohort will be a priority. Once the workforce has reached an appropriate level this should be further developed to a full continuity of carer model.
- Deaths will continue to be monitored and investigated.

Actions:
- DOM is a member of the Trust Health Inequalities Group.
- 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 term intrapartum stillbirths are referred to MNSI (The Maternity and Newborn Safety Investigations Programme, previously known as HSIB).
- Regular quarterly stillbirth/neonatal audit is undertaken.
- A CKW review of 2023-24 stillbirths and neonatal deaths is being undertaken
- An LMNS supported thematic review of the 2024 stillbirth cases took place on 3rd June 2024

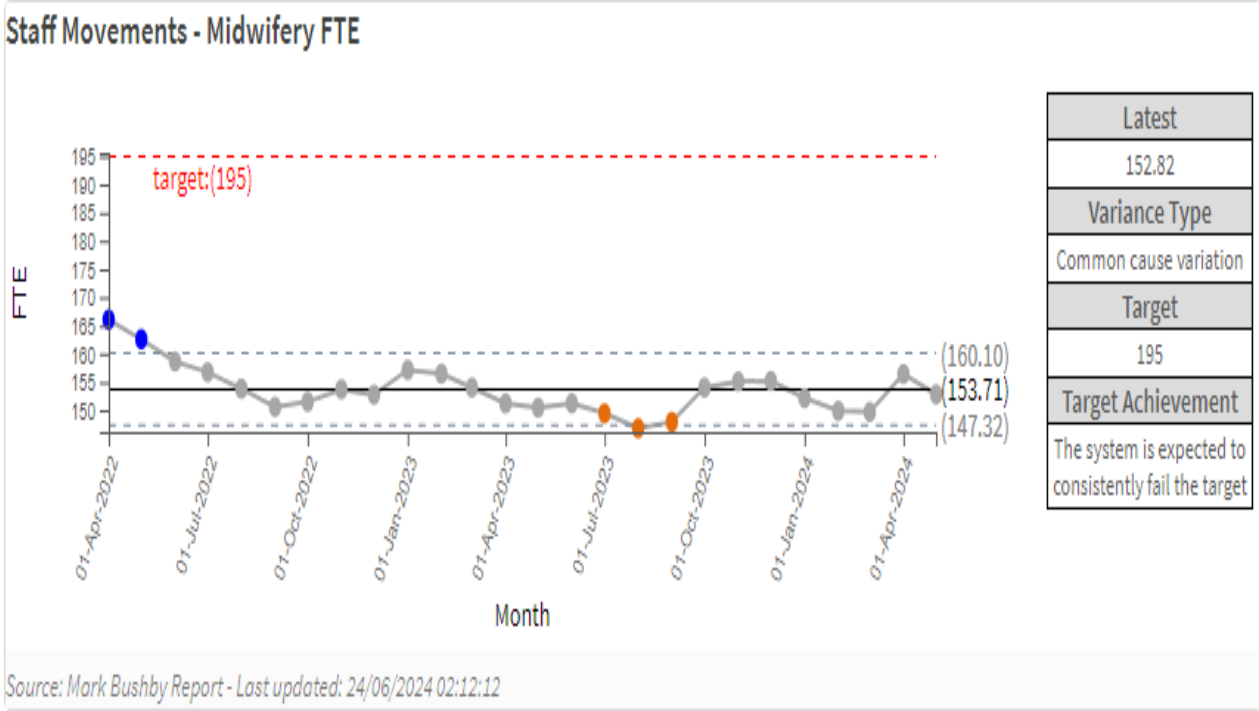
Maternity Workforce

Calderdale and Huddersfield NHS Foundation Trust

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

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

Target:
195 WTE (current funded establishment)



What does the chart show/context:
- The FTE rate has decreased slightly from April 156.42 to 152.82 in May.

Underlying issues:
- National Shortage of midwives
- Attrition rate of student midwives
- Intense scrutiny of maternity services

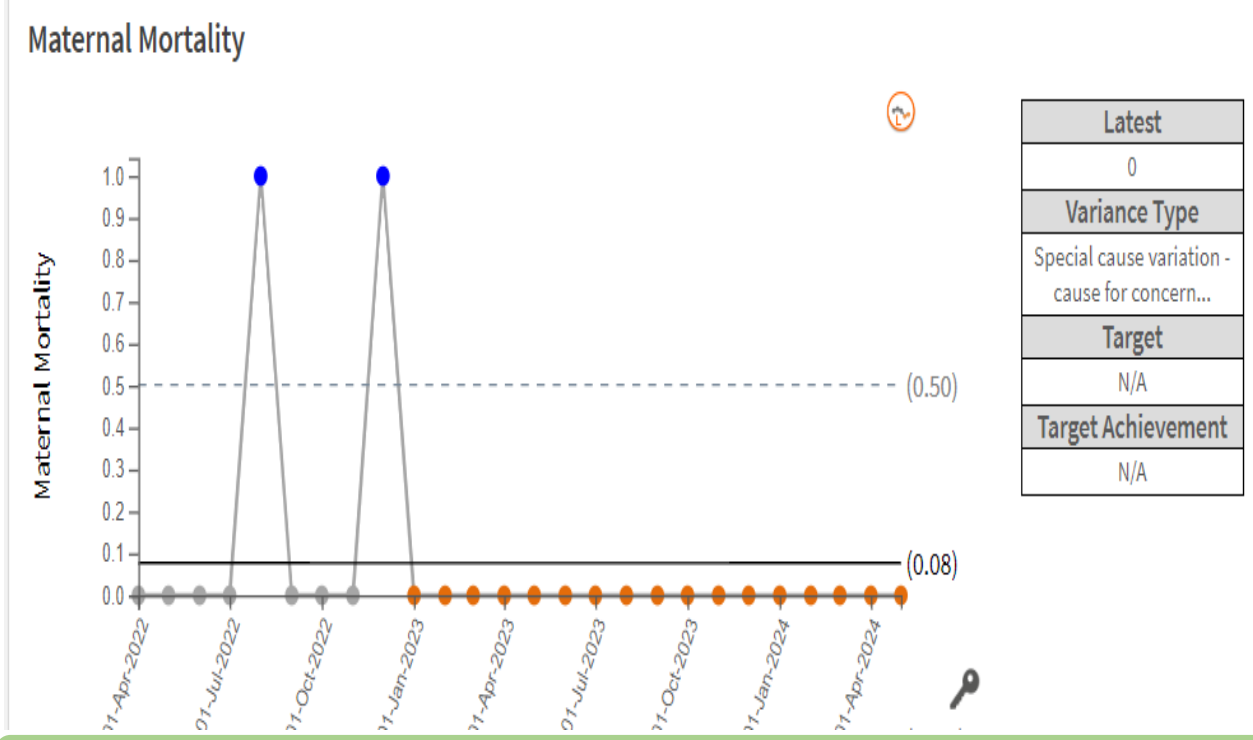
Actions:
- Birthrate plus report commissioned and report received at end of April 2024, currently being reviewed through divisional governance
- Recruitment and retention strategy being refreshed
- Rolling recruitment programme
- Grow your own workforce pathways: Midwifery apprenticeship, shortened programme
- Recruitment and retention midwife employed to work alongside and support new midwives in clinical practice
- Stay conversations implemented
- DoM/DDoM undertaking all exit interviews, retention has improved over last 6 months
- Recruitment films commissioned and released on social media and being used in adverts and recruitment open days
- Use of alternative roles such as registered nurses in maternity service
- Participate in centralised recruitment programme for newly qualified midwives with the LMNS - Interviews took place in May 2025 with circa 31 WTE offered
- Robust preceptorship programme

Maternal Mortality

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

Rationale: The government's National Ambition is to halve the rate of maternal deaths from a 2010 baseline by 2025,. with a 20% reduction by 2020, reducing the rate from 10.6 per 100,000 maternities in 2010 to 8.5 in 2020 and 5.3 in 2025

Target: 0



Latest
0
Variance Type
Special cause variation - cause for concern...
Target
N/A
Target Achievement
N/A

What does the chart show/context:
- There have been no maternal deaths since December 2022.

Underlying issues:
- There have been no maternal deaths since December 2022.

Underlying issues:
- Timely recognition of a deteriorating pregnant or postnatal patient outside of the maternity setting

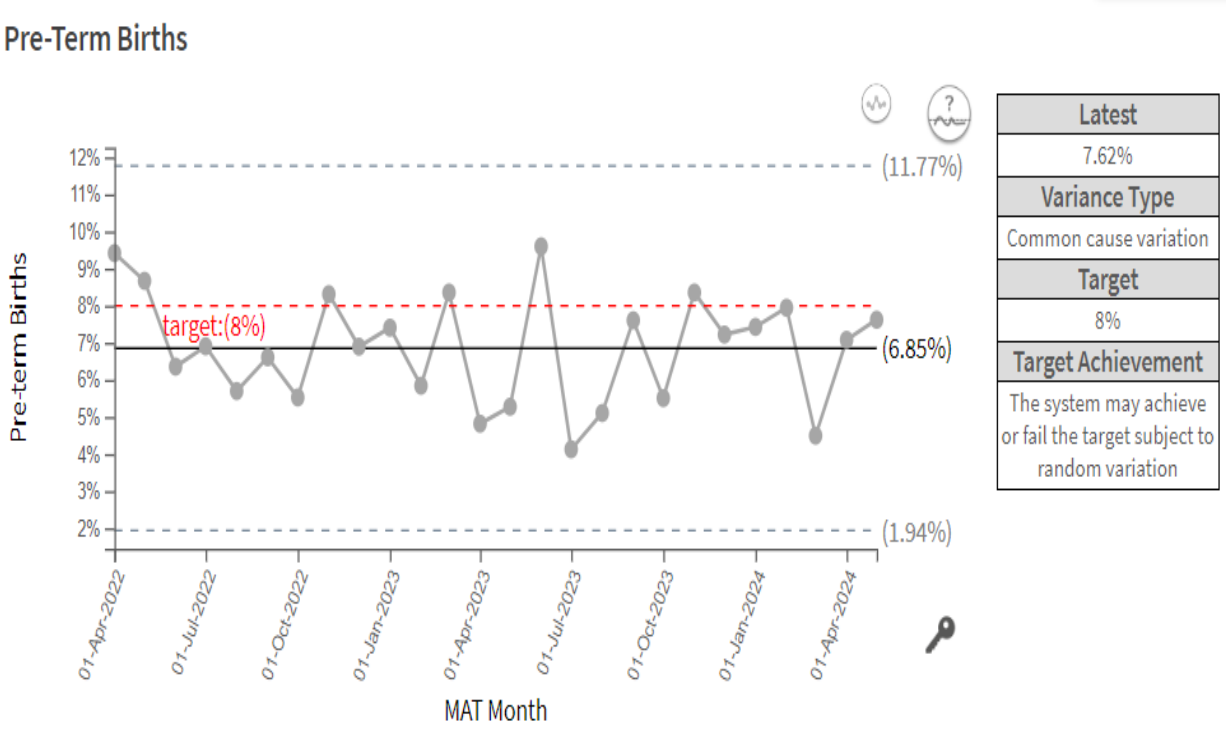
Actions:
- Implementation of MEOWS score for pregnant or postnatal women who are being cared for outside of the maternity setting
- Training sessions for key clinical areas outside of maternity setting
- Strengthening of pathway for management of pregnant or postnatal women who present to ED

Pre-Term Births

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

Rationale: The governments national ambition for pre-term birth rate is to achieve a 25% reduction from an 8% baseline in 2015 to 6% in 2025.

Target:
Reduce all Preterm births (delivery < 37 weeks) from 8% to 6% by 2025



What does the chart show/context:
- Performance has been below the target for the last 6 months.

Underlying issues:
- No underlying issues have been identified

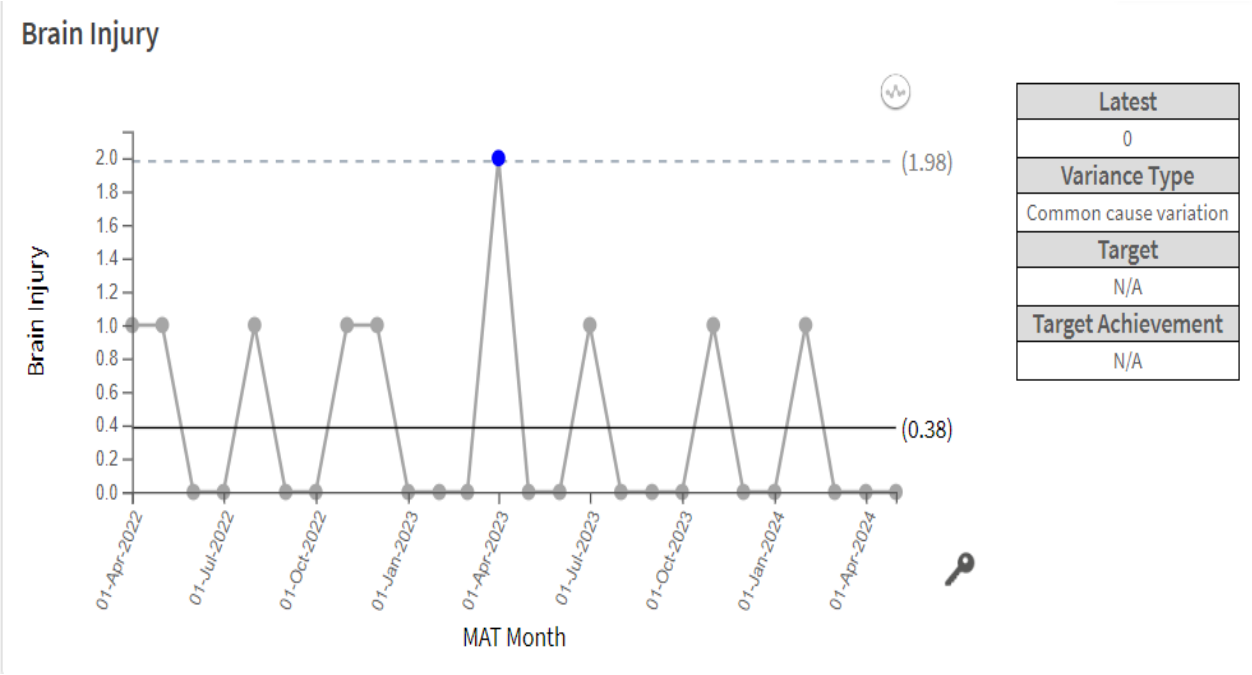
Actions:
- Continue to fully implement element 5 of Saving Babies Lives Bundle version 3
- Continue review of all pre-term births where babies are born in a unit without the correct level of neonatal unit support
- Continue to participate in LMNS pre-term birth workstream
- Develop in-utero transfer guidance to support being able to accept requests for transfer from across the region in line with network recommendations

Brain Injuries

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

Rationale: The government's National Ambition is to halve the rate of intrapartum brain injuries from a 2010 baseline by 2025.

Target:
Reducing the rate from 4.3 per 1,000 live births in 2010 to 3.5 in 2020 and 2.2 in 2025.



Latest
0
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

What does the chart show/context:
- There have been no brain injuries since February 2024.

Underlying issues:
- Timely escalation in an emergency.
- Loss of situational awareness.

Actions:
- Change of ward layout to support.
- Each Baby Counts Teach and Treat re-launch.
- Maternity and Neonatal safety critical training includes escalation and use of SBAR.

Community Services:

Metric	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Proportion of Urgent Community Response referrals reached within 2 hours	May 2024	67.5%	70%			66.9%	49.8%	84.1%
Community Waiting List – over 52 weeks	May 2024	1,330	1,142 (Mar25)	-	-	-	-	-
Virtual Ward	May 2024	77%	80%			88.1%	49.8%	126.3%
Patients dying within their preferred place of death	May 2024	91.3%	80%			94.6%	86.5%	102.6%

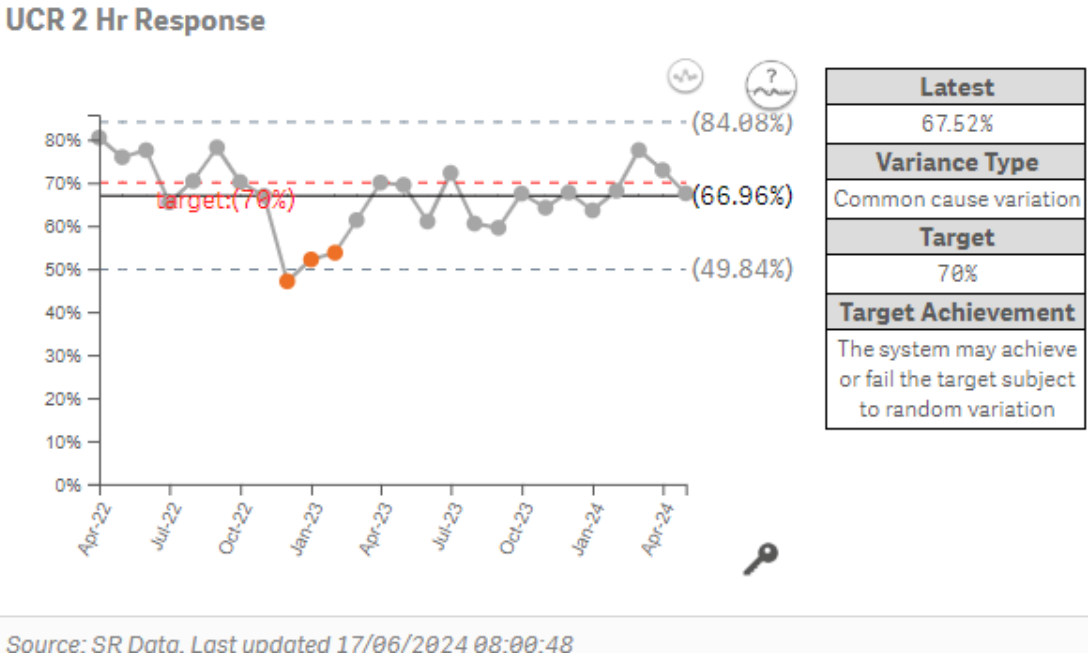
Proportion of Urgent Community Response referrals reached within two hours

Calderdale and Huddersfield NHS Foundation Trust

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

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

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



What does the chart show/context:
- Current position for May 2024 is at 67.5%.

Underlying issues:
- Logging time of arrival during visit which could well be some time after arrival.
- Complexity with LCD where their triage may mean that we have little time to get out to the properties.

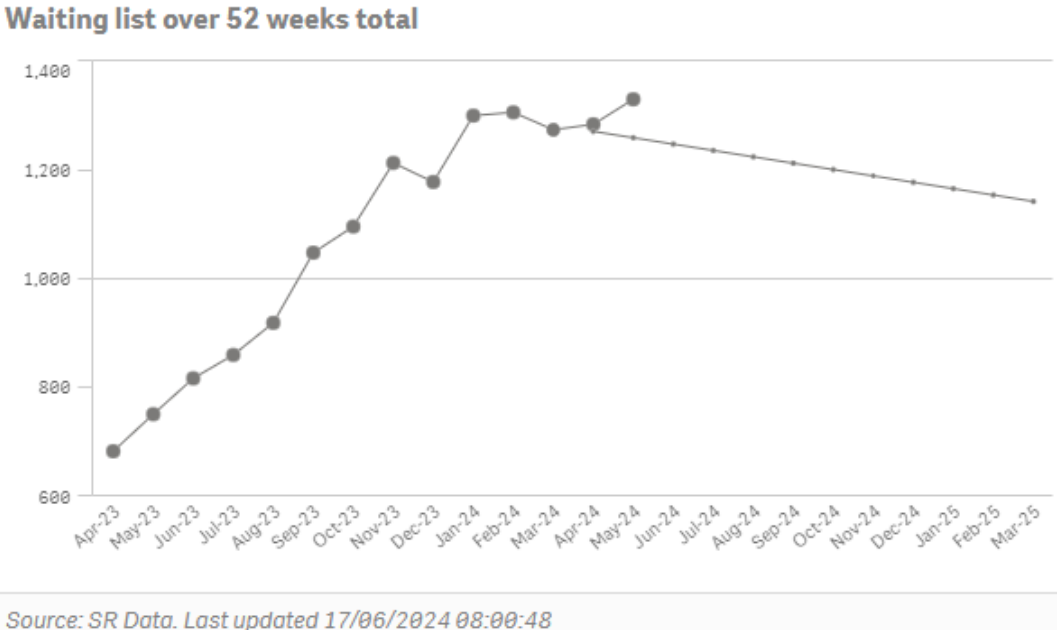
Actions:
- Communications to service leads around accurate data recording.
- Ongoing cases where 2 hours' time is taken by LCD to triage due to their processes therefore is out of the 2-hour window prior to reaching UCR.
- Manual audit being completed to examine the different elements of the 2-hour response.
- Continuing to attempt to increase referrals into the service and working with LCD and primary care to do this – audit completed.
- Looking at "trusted" routes for other professionals into UCR to make the triage quicker when another healthcare professional had already assessed the patient.

Community Waiting List - over 52 weeks

Executive Owner: Rob Aitchison Operational Lead: Michael Folan/Carly Hartshorn Business Intelligence Lead: Gary Senior

Rationale:
Understand resilience amongst providers of community health services and provide valuable data on waiting times and waiting list information.

Target:
The total number of patients (Adults and Children) on community waiting lists waiting over 52 weeks at a given time.
Target 1,142 by March 2025 (as shown in Trajectory below).



What does the chart show/context:
- 1,330 total (all therapies) in May 2024.

Underlying issues:
- Children's SALT is our main concern.
- Children's SALT workforce issues remain difficult, we currently have 1.2 band 6 vacancies in that team having recruited to other outstanding vacancies as well as 2x WTEs on maternity leave. Recent recruitment should support this position but will take a number of months until in post. 1x WTE B7 post to advert and staff member has finished with the Trust. Team Lead has also reduced hours at financial year end. Locum has also finished with the Trust.

Actions:
- SALT recruitment pressures – 2x recruits with start dates, ongoing B7 recruitment, looking for locum support
- Transition to new SALT service structure has begun with percentage increase in wait list reducing since this point.
- Service now in a sustainable position with number of referrals added each month also being removed – backlog still being addressed.
- Share KP+ model to assist in management of patients.

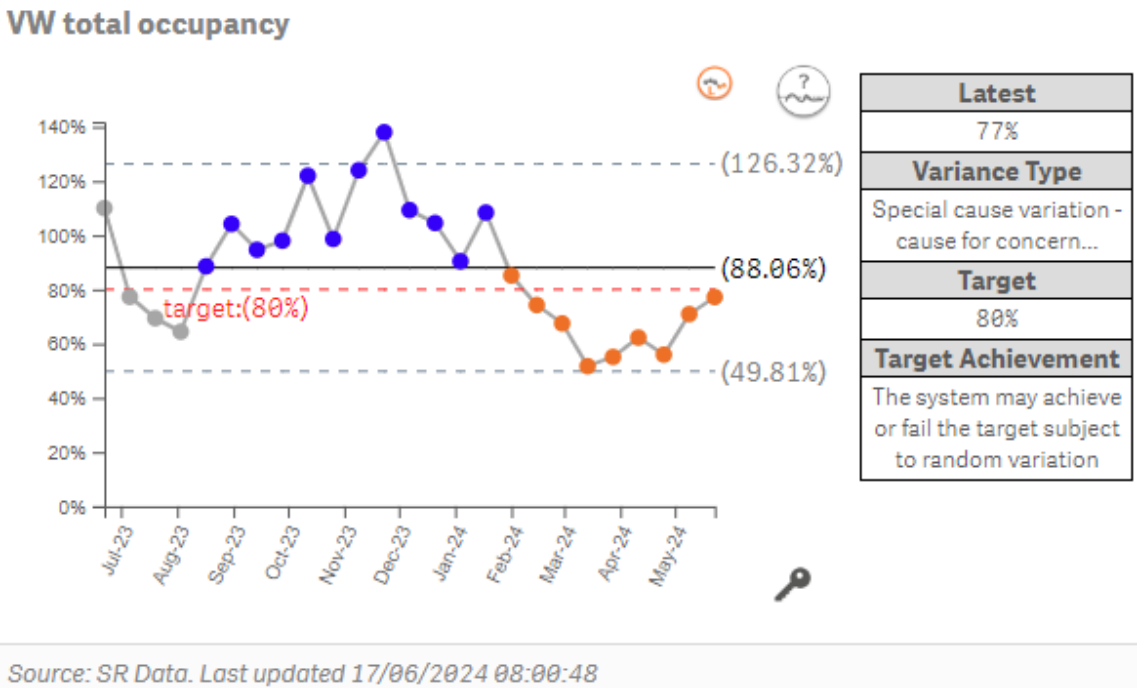
Virtual Ward

Calderale and Huddersfield NHS Foundation Trust

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

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

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



Source: SR Data. Last updated 17/06/2024 08:00:48

What does the chart show/context:
- Current combined position for May 2024 is 77%.
- Not achieving target since February 2024 - Special cause variation.
- Admissions and activity remain consistent with 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.
- Further work with Acute visiting service and GPs for VW and UCR referrals and how we streamline this and ensure the patient gets to the right service.
- Respiratory - criteria now changed to include patients requiring oxygen weaning.
- Attendance at June's medical division meeting to do some training about virtual ward.

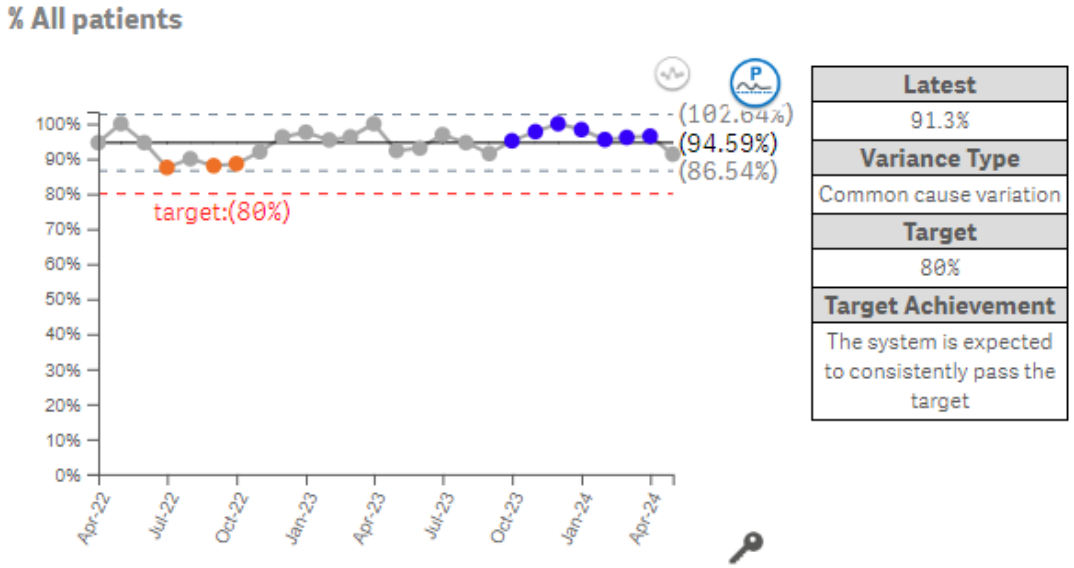
Patients dying within their preferred place of death

Calderdale and Huddersfield NHS Foundation Trust

Executive Owner: Lindsay Rudge Operational Lead: Michael Folan/Abbie Thompson Business Intelligence Lead: Gary Senior

Rationale:
% of patients dying within their preferred place of death – Community Palliative Care.

Target: Over 80%



Source: SR Data. Last updated 17/06/2024 08:00:44

- 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
- May 2024 total 91.3% (Out of Hours End of Life care 100% and Palliative 86.7%)
  93.8% died at 'home'.

Underlying issues:
- Workload pressures – high referral numbers and staff vacancies across all teams
- Acuity and complexity of need – patients are increasingly in urgent need of specialist intervention due to late presentation / diagnosis or multiple comorbidity.
- CSPCT continue to work additional hours to keep patients safe – limiting GP call-outs by utilising Independent Prescribing / assessment skills and coordinating care with Acute hospital teams to streamline patient interventions / reduce length of hospital stay (avoiding ED wherever possible).
- OOH EoLC – currently working extended hours for a further 12 months (March 2025) as result of successful Innovation bid. Need to secure funding to facilitate the new Workforce Model to include (in conjunction with existing joint service agreement with Marie Curie) from April 2025.
- HSPCT – significant staffing depletion requiring review of WFM to enable prompt review of patients to facilitate discharge to home / care home / hospice– Dashboard development ongoing.
- HSPCT In-Reach project funded by Calderdale ICB Innovation Bid commenced December 2023 – awaiting dashboard data – significant impact on facilitating patients back to home / care home or hospice – reduced in-patient admission and reduced length of stay improves achieving PPD.
- Care Home Palliative CNS project funded by Cald ICB Innov Bid commenced July 2023 –working in collaboration with QUEST - has improved patient safety and outcomes in ensuring patients not inappropriately admitted to hospital and supported to remain in care home setting.

Actions:
- To ensure continued funding for all teams (with review of WFM for HSPCT) to maintain this strong position of achieving preferred place of death, facilitating the vast majority to die at home, appropriate admission to hospice and reducing avoidable admissions and deaths in the acute hospital setting.

Workforce:

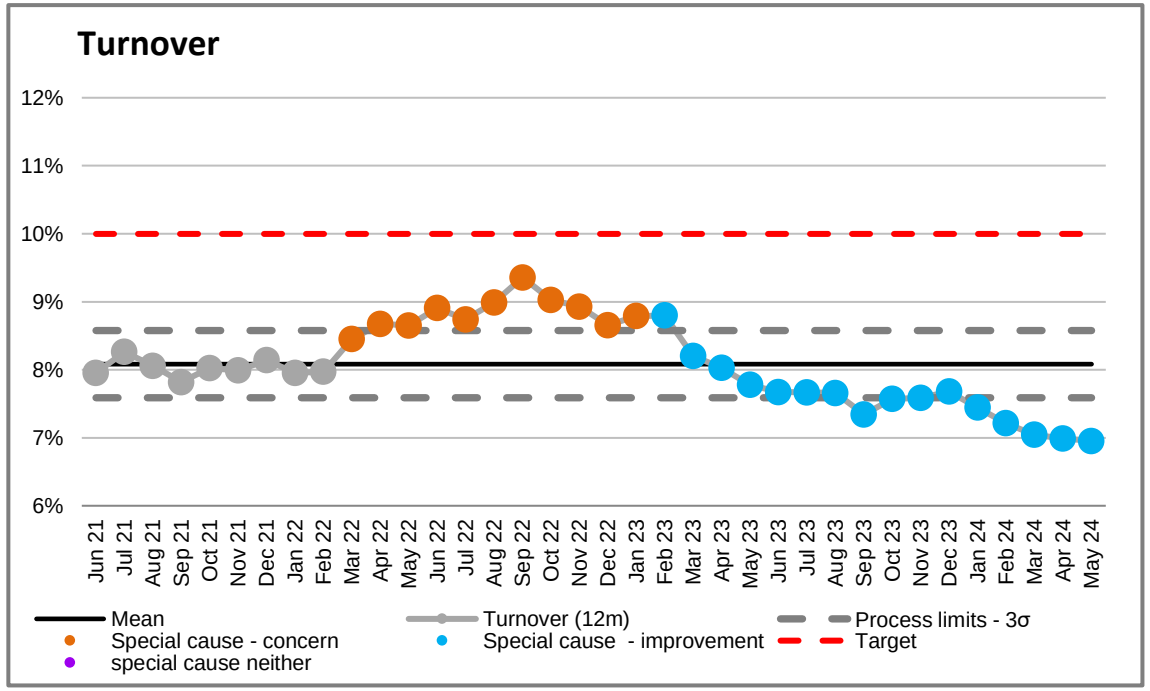
Metric	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Staff Movement (Turnover)	May 2024	6.95%	10.00%			8.08%	7.59%	8.58%
Sickness Absence	May 2024	4.05%	4.50%			4.83%	4.17%	5.50%
Appraisal Compliance (YTD)	May 2024	13.00%	90.00%	-	-	-	-	-
Core EST Compliance	May 2024	93.68%	90.00%			93.30%	92.23%	94.37%
Bank Spend	May 2024	£2.64M	-			£3.11M	£2.02M	£4.21M
Agency Spend	May 2024	£0.75M	£0.76M			£0.86M	£0.49M	£1.24M

Staff Movement (Turnover)

Executive Owner: Suzanne Dunkley Lead: Adam Matthews Business Intelligence Lead: Mark Bushby

Rationale:
It is healthy for an organisation to have a reasonable level of staff turnover, there is a balance between losing valuable, knowledgeable staff and bringing in new colleagues with fresh ideas and ways of working.

Ceiling: 10.00% **Current: 6.95%**



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 6.95%.
- The Trust benchmarks well against other WYAAT organisations.

Underlying issues:
- Directorates with turnover above the 10% ceiling include FSS Management (22.7%), Workforce and OD (18.3%) and Outpatients and Records Services (12.2%)

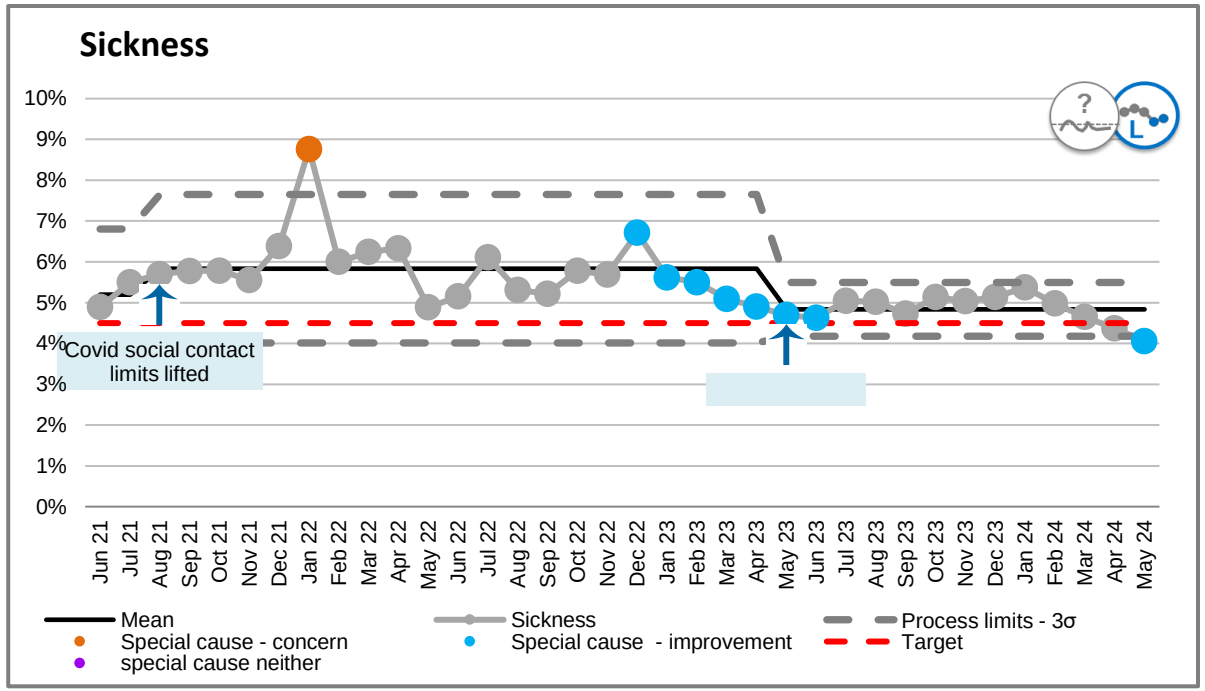
Actions:
- Trust level and local level activities underway to continue to improve the Trust retention, turnover and stability rates. These actions include:-
  - Task and finish group to review approach to exit interviews and questionnaires.
  - Review and improve ‘stay conversation.
  - Review of workforce 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

Executive Owner: Suzanne Dunkley Lead: Azizen Khan Business Intelligence Lead: Mark Bushby

Rationale:
It is important for the Trust to monitor sickness absence levels to ensure any trends are investigated to inform future planning around availability.

Ceiling: 4.50%	**Current:**	**Total**	**4.05% (in month)**	**4.84% (12m)**
		Long	**2.30% (in month)**	**2.99% (12m)**
		Short	**1.76% (in month)**	**1.85% (12m)**



What does the chart show/context:
- The target for absence is close to the mean and falls between the upper and lower process limits, as such compliance will be unpredictable on a month-by-month basis due to common cause variation.
- From April 2024, the Trust ceiling for sickness absence has been reduced from 4.75% to 4.50% which is shown across all months for reference
- From April 2024, Covid Sickness is now included in the absence data

Underlying issues:
- Top 3 reasons for sickness in May 2024 – Anxiety/Stress/Depression, Gastrointestinal Problems and Other musculoskeletal problems

Actions:
- HR teams regularly review all open ended LTS cases to ensure timely actions are taken and that where for example cases relate to an MSK issue that colleagues are aware of self-referral options for 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 sessions once HR teams are at full establishment.
- Updated guidance for H&WB support has been shared across divisions to ensure colleagues are aware of the new employee assistance programme.
- Corporate WOD colleagues are leading workforce redesign workshops with stakeholders to improve processes around attendance management. One workshop was held on 10 May and the second is to be scheduled for next month.
- Men's Mental Health event on 28 June 2024 in the HRI Lecture Theatre including a live performance, panel discussion and an interactive workshop to help support conversations about mental health

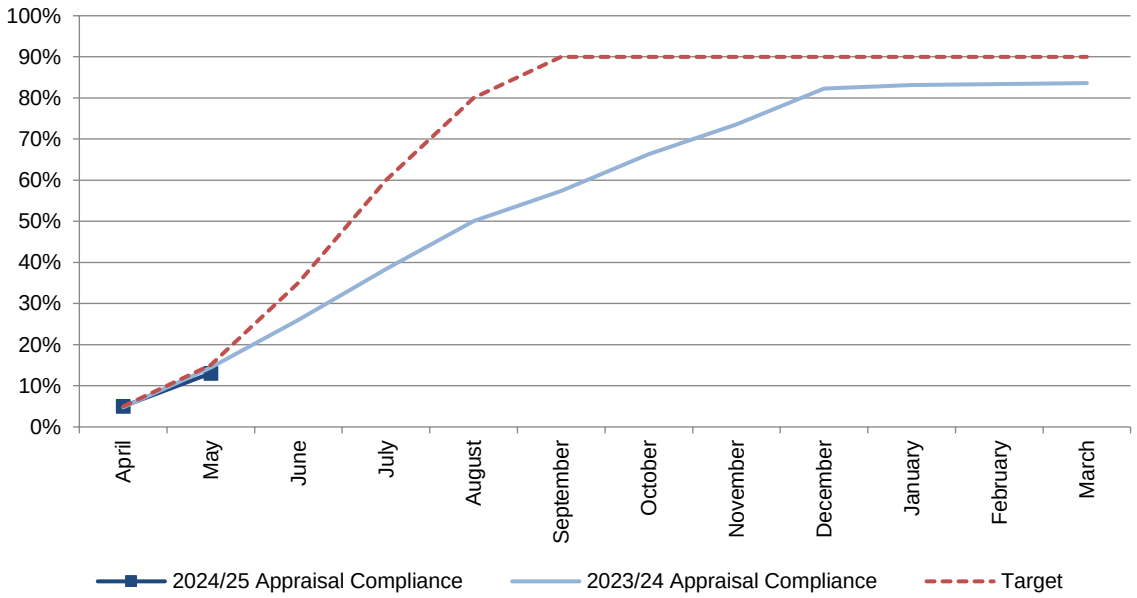
Appraisal

Executive Owner: Suzanne Dunkley Lead: Nicola Hosty Business Intelligence Lead: Mark Bushby

Rationale:
A performance appraisal is a regular assessment of how an individual is performing in their job role. It can have many benefits in practice, being used to identify individual learning needs, identify continuing development needs of employees and demonstrate competency in practice. The appraisal season runs from 1 April 2024 to 30 September 2024.

Target: 90.00% (Annual), 15.00% (in month) **Current: 13.00% (in month)**

Appraisal



What does the chart show/context:
- Appraisal compliance is slightly below the in-month planned position with 13.00%.
- Appraisal compliance is performing slightly below the rate of the previous year at the same point in time.

Underlying issues:
- Time and availability of colleagues to undertake appraisal.
- Accurate and timely recording of appraisal conversations on ESR.
- Challenge to colleagues around appraisal being a “tick box” exercise.
- Seasonal variance especially during the summer and winter holidays.
- Regular strike action impacting priorities.

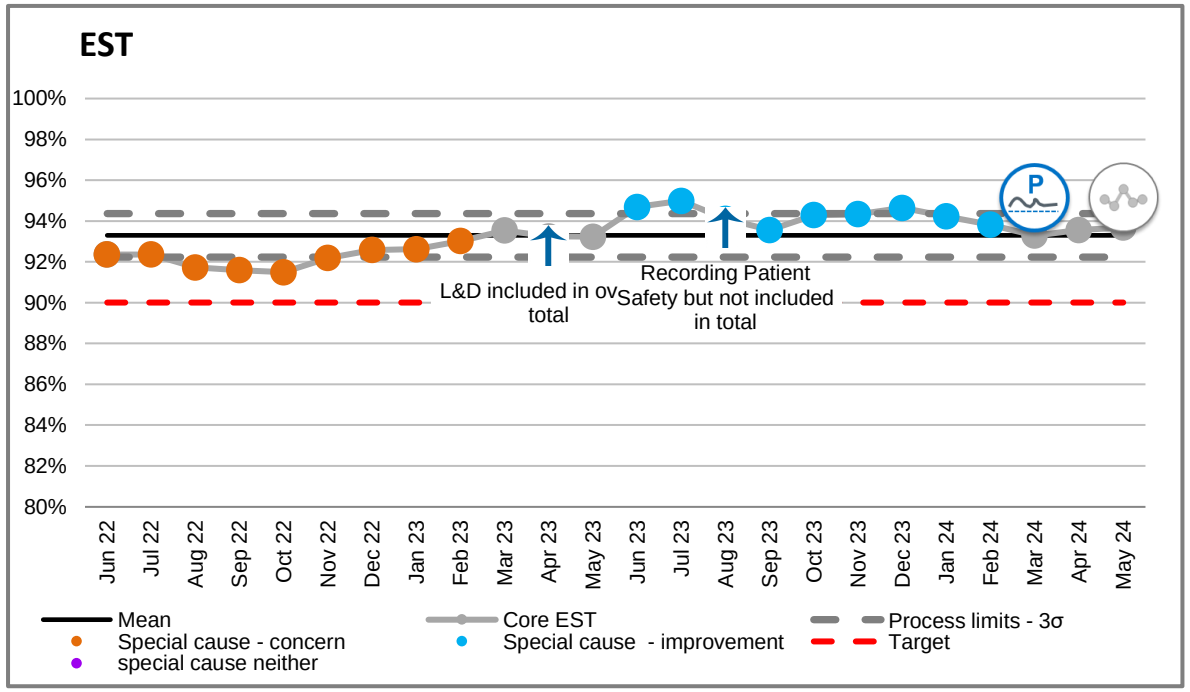
Actions:
- ‘How to’ guide to appraisals video now available as part of our management fundamentals offer, to make it a more people centred conversation.
- New to manager programme launch features appraisals in content.
- ESR recording guidance produced to support managers to ensure all activity is captured.
- Targeted approach to support hotspot areas including Connect & Learn sessions (managers’ and appraisees’ guides) to improve the quality of conversations.
- Recent audit from NHS England completed showcasing best practice, impact data and general process.
- Hotspot areas targeted via OCOC charter support workshops that includes appraisal management.

Core EST Compliance

Executive Owner: Suzanne Dunkley Lead: Nicola Hosty Business Intelligence Lead: Mark Bushby

Rationale:
Training staff is important in health and social care to ensure the safety of people receiving and giving care and to maintain high standards of care quality. It ensures that colleagues in the Trust are following up-to-date procedures and reduces the risk of errors and prevents accidents. This means they and our patients can be safe in the workplace

Target: 90.00% **Current: 93.68%**



What does the chart show/context:
- The Trust is consistently achieving the 90% target; EST compliance is slightly below the 95% stretch target at 93.68%
- Compliance in May 2024 remains above the mean indicating further ongoing improvement since March 2023.

Underlying issues:
- Safeguarding Adults and Childrens compliance has dropped below 90%, this is likely due to a review of RST as safeguarding is tiered learning.

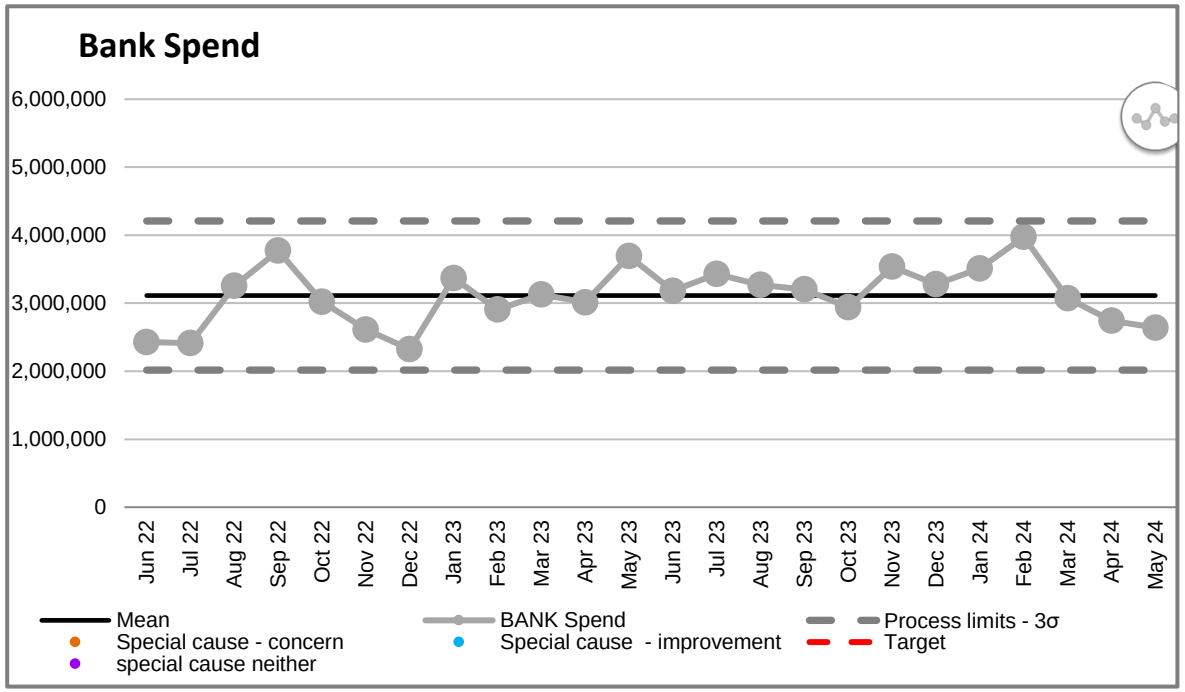
Actions:
- Compliance rates are shared with Directorates on a weekly basis.
- Enhanced Divisional accountability.
- Local campaigns to focus on mandatory learning in Divisions.
- Task and Finish group is being formed to review RST and progress will be fed back to the Education Committee.

Bank Spend

Executive Owner: Suzanne Dunkley Lead: Samuel Hall Business Intelligence Lead: Mark Bushby

Rationale:
It is important for the Trust to monitor Bank staff spend as it can help to minimise temporary staffing costs ensuring value for money and compliance.

Current: £2.64M



What does the chart show/context:
- An increase in May 2023 is due to the 5% pay award for April 2023 and May 2023.
- An increase in February 2024 can be attributed to back-pay of WTD % that was not accurately applied
- Bank spend is currently £2.64M in May 2024, a decrease from £2.74m in April.

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)
- Increased demand for HCSWs to support 1:1 patient requirements.

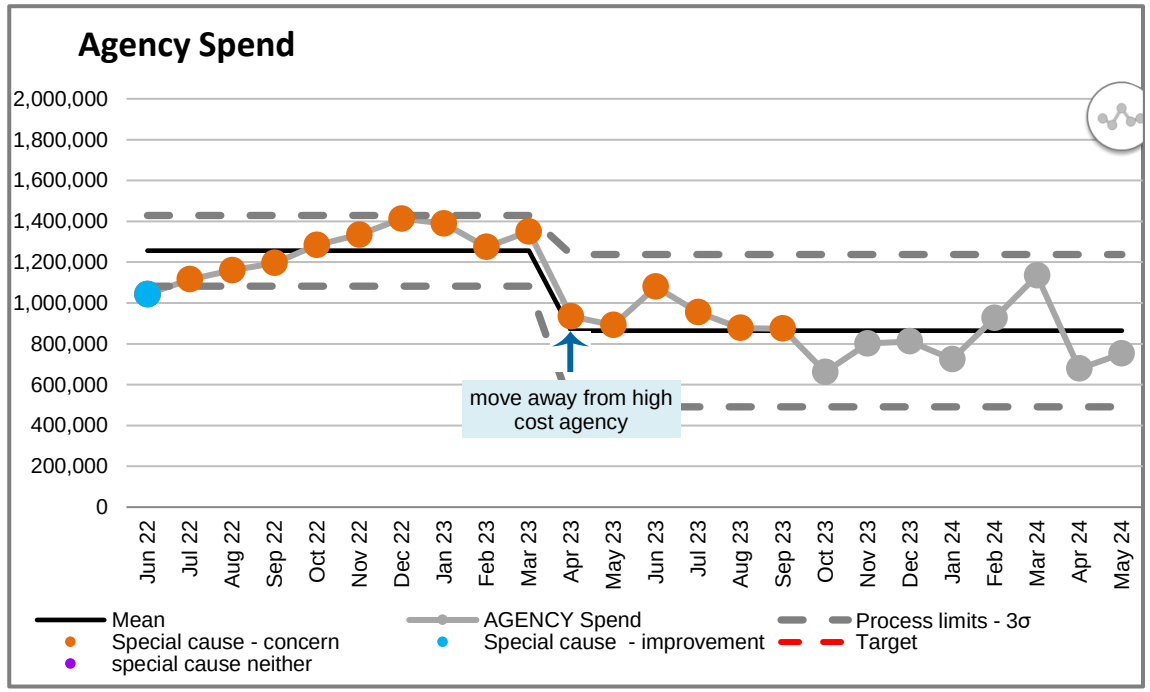
Actions:
- 20% premium for Nursing and ODP colleagues has been successfully removed
- Bank and Agency CIP group established and closely monitoring Temporary Staffing usage throughout the organisation

Agency Spend

Executive Owner: Suzanne Dunkley | Lead: Samuel Hall | Business Intelligence Lead: Mark Bushby

Rationale:
It is important for the Trust to monitor Agency staff spend as it can help to minimise temporary staffing costs ensuring value for money and compliance and can encourage the recruitment and retention of staff.

Target: £0.76M **Current: £0.75M**



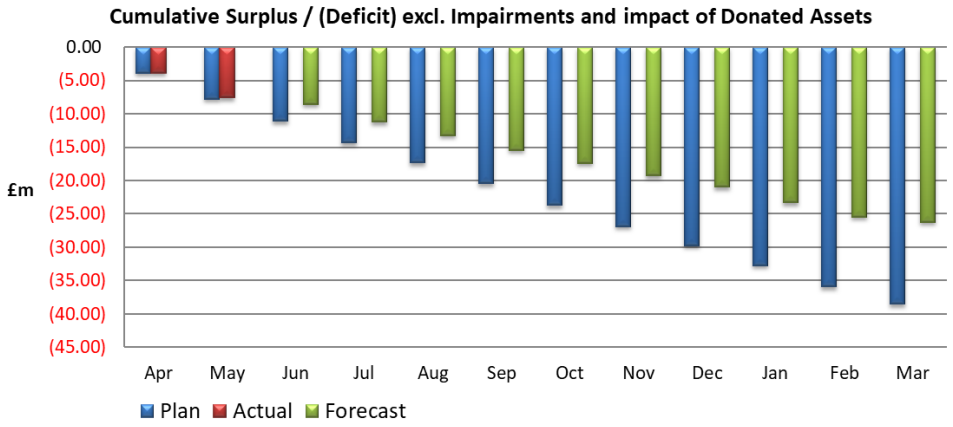
What does the chart show/context:
- The Trust moved away from high-cost agency during April 2023.
- Agency spend is now following normal cause variation from October 2023.
- Spend in May 2024 at £0.75m.

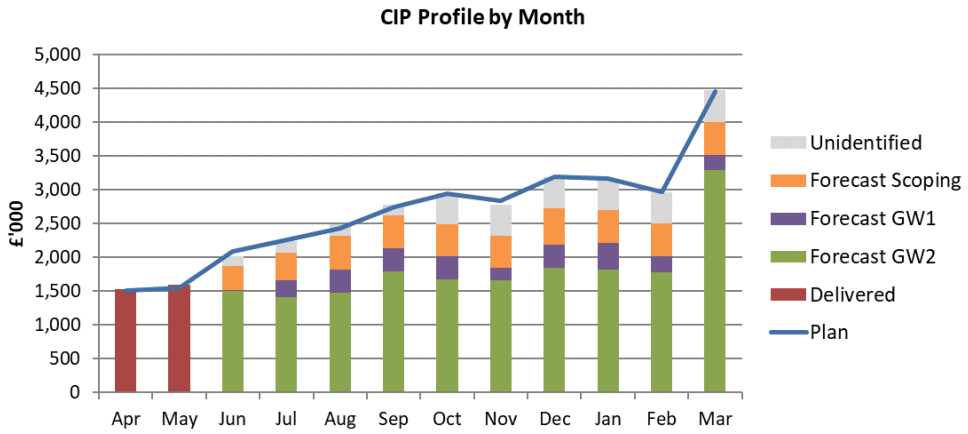
Underlying issues:
- There is a reliance on agency usage in some areas as a result of vacancies and difficulties in recruiting.
- Although decreasing, agency usage remains high and a proportion of that spend can be attributed to Agency Consultants working in hard to fill areas, as well as remaining rota gaps in ED.
- Agency usage and volume still remain high in comparison to CHFT's positive Nursing vacancy position.

Actions:
- Review of agency usage across the organisation
- Consideration of Direct Engagement model to generate saving for Agency medical staff
- Nursing Agency lead time reduced to 7 days to reduce Agency usage and promote alternative sourcing of cover.
- Nursing - Tier 1 agency retraction plan in development, implementation immediately imminent

Financial Performance

Executive Owner: Gary Boothby Finance Lead: Philippa Russell





Rationale:

- To monitor year to date and forecast performance against the 2024/25 financial plan and efficiency target

Target:

- The Trust has submitted a revised plan for a £26.26m deficit, reflecting an improvement of £12.3m: £5m stretch CIP target; £5.6m additional ICS funding allocation; and £1.7m additional funding to support the pressure arising from the PFI remeasurement (technical adjustment).
- Revised CIP Target is now £32.18m (£30m new schemes plus £2.18m Full Year Effect of 2023/24 schemes.

What do the charts show/context:

- The Trust is reporting a year-to-date deficit of £7.60m, a £0.20m favourable variance from plan. The Trust has delivered efficiency savings of £3.14m year-to-date, £0.08m more than planned.

Underlying issues:

- Key drivers of the favourable variance were higher than planned CIP delivery and a reduction in PDC Dividend in line with the revised forecast and capital plan.
- The CIP challenge will increase significantly from Month 3 due to the profiling of planned savings including: Unplanned Care (LOS and Bed reduction schemes), Headcount Reduction and Bank and Agency schemes.
- Achievement of the 2024/25 plan will require a significant improvement in the run-rate through full delivery of targeted savings.

Actions:

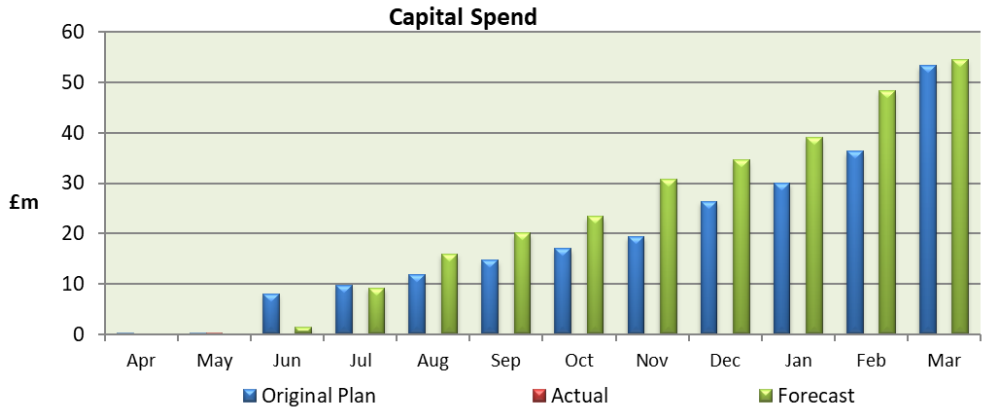
- The focus is on developing all identified efficiency schemes to Gateway 2, delivering the 2024/25 financial plan and implementing strengthened grip and control measures including: Headcount reduction plans; Bank and Agency expenditure reduction; and Non-Pay expenditure controls.

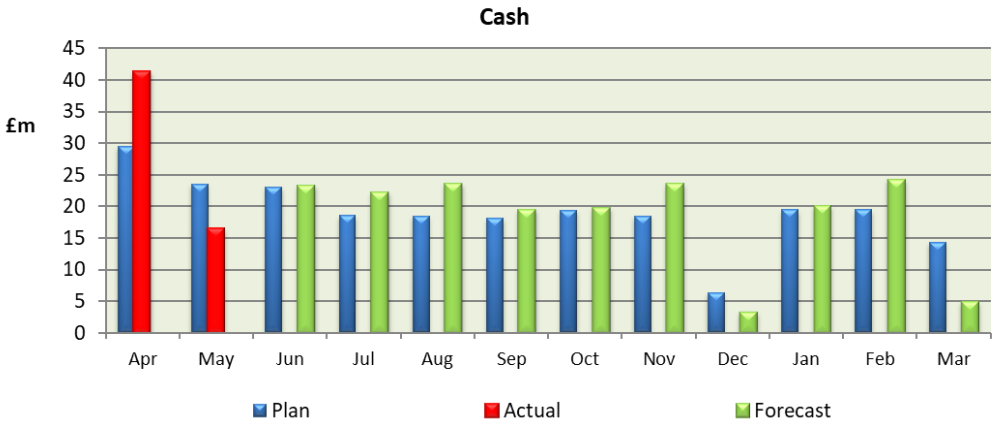
Financial Performance: Capital, Cash and Use of Resources

Calderdale and Huddersfield NHS Foundation Trust

Executive Owner: Gary Boothby

Finance Lead: Philippa Russell





Use of Resources Metric:	24/25 Plan: 3	24/25 Actual: 3

Rationale:

- To monitor year to date and forecast Capital expenditure, Cash balance and Use of Resources metric against the 2024/25 financial plan.

Target:

- The Trust Capital Plan for 2024/25 has been updated for the June revised plan submission to £54.58m. Following the revised plan submission which includes additional Integrated Care System (ICS) funding to support the deficit position, the Trust has revised down its Revenue Support Public Dividend Capital request for the year to £30.91m. This level of cash support will be required to support the revised deficit plan of £26.26m, the internally funded capital plan which exceeds internal funding sources by £4.49m and an element of working capital movement that relates to the previous year's deficit.
- The Use of Resources metric is the financial element of the 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 2024/25 is level 3.

What do the charts show/context:

- The Trust has spent £0.15m on Capital programmes year-to-date, £0.05m more than planned. At the end of May, the Trust had a cash balance of £16.53m, £7.01m lower than planned. Use of Resources (UOR) stands at 3, as planned, with all metrics as planned.

Underlying issues:

- The cash position was below plan due to the combination of an adverse variance in cash flow year to date of £16.12m, offset in part by a higher than forecast year end cash balance (£9.11m). The adverse cash flow variance in month is due to the timing of payroll, which was paid slightly earlier than usual due to the bank holiday and in advance of the monthly close-down.

Appendix A – Variation and Assurance Icons

Calderdale and Huddersfield NHS Foundation Trust

Variation Icons:

Icon	*Technical Description*	*What does this mean?*	*What should we do?*
	Common cause variation, NO SIGNIFICANT CHANGE.	This system or process is **currently not changing significantly**. It shows the level of natural variation you can expect from the process or system itself.	**Consider if the level/range of variation is acceptable**. If the process limits are far apart you may want to change something to reduce the variation in performance.
	Special cause variation of a CONCERNING nature where the measure is significantly HIGHER.	**Something's going on!** Your aim is to have low numbers but you have some high numbers – something one-off, or a continued trend or shift of high numbers.	**Investigate** to find out what is happening/ happened. Is it a one-off event that you can explain? Or do you need to change something?
	Special cause variation of a CONCERNING nature where the measure is significantly LOWER.	**Something's going on!** Your aim is to have high numbers but you have some low numbers - something one-off, or a continued trend or shift of low numbers.	**Investigate** to find out what is happening/ happened. Is it a one-off event that you can explain? Or do you need to change something?
	Special cause variation of an IMPROVING nature where the measure is significantly HIGHER.	**Something good is happening!** Your aim is high numbers and you have some - either something one-off, or a continued trend or shift of low numbers. Well done!	Find out what is happening/ happened. **Celebrate** the improvement or success. Is there **learning** that can be shared to other areas?
	Special cause variation of an IMPROVING nature where the measure is significantly LOWER.	**Something good is happening!** Your aim is low numbers and you have some - either something one-off, or a continued trend or shift of low numbers. Well done!	Find out what is happening/ happened. **Celebrate** the improvement or success. Is there **learning** that can be shared to other areas?

Assurance Icons:

Icon	*Technical Description*	*What does this mean?*	*What should we do?*
	This process will not consistently HIT OR MISS the target as the target lies between the process limits.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **within** those limits then we know that the target may or may not be achieved. The closer the target line lies to the mean line the more likely it is that the target will be achieved or missed at random.	Consider whether this is acceptable and if not, you will need to change something in the system or process.
	This process is not capable and will consistently FAIL to meet the target.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **outside of those limits in the wrong direction** then you know that the target cannot be achieved	**You need to change something in the system or process if you want to meet the target.** The natural variation in the data is telling you that you will not meet the target unless something changes.
	This process is capable and will consistently PASS the target if nothing changes.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **outside of those limits in the right direction** then you know that the target can consistently be achieved.	**Celebrate the achievement**. Understand whether this is by design (!) and consider whether the target is still appropriate; should be stretched, or whether resource can be directed elsewhere without risking the ongoing achievement of this target.

Appendix B (i) – Metrics Rationale and Background

Calderdale and Huddersfield NHS Foundation Trust

Metric	Details
Total Patients waiting >40, 52 weeks to start treatment and Total RTT Waiting List	Waiting times matter to patients. Most patients want to be referred, diagnosed and treated as soon as possible. To measure and encourage compliance with recovery milestones for the RTT waiting list.
Total elective activity undertaken compared with 2023/24 activity plan	A key planning requirement for 2023/24 is to recover elective activity levels to above those seen in the pre-Covid period, to order to address the growing elective care waiting list.
Percentage of patients waiting less than 6 weeks for a diagnostic test	Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%.
Diagnostic Activity undertaken compared with 2019/20 baseline	Maximise diagnostic activity focused on patients of highest clinical priority. Recovery of diagnostic testing is a key NHS objective and critical to wider elective recovery, including RTT performance.
Total Follow-Up activity undertaken compared with 2023/24 activity plan	To measure the relative reduction in follow-up outpatient attendances (consultant and non-consultant led) in 2023/24 compared to 2023/24 activity plan
Proportion of patients meeting the 62-day cancer referral to treatment standard	The NHS Constitution outlines what patients can expect and their rights when they are referred on a cancer diagnosis and treatment pathway. Patients who receive a cancer diagnosis after an urgent suspected cancer referral, referral for breast cancer symptoms, or via cancer screening should start treatment within 62 days of that initial referral.
Proportion of patients meeting the faster diagnosis standard	Faster Diagnosis will facilitate an improvement in the Cancer early detection rate and thereby increase the chances of patients surviving. Expectation is that 75% or more of patients will a maximum four weeks (28 days) from receipt of urgent GP (GMP, GDP or Optometrist) referral for suspected cancer, breast symptomatic referral or urgent screening referral, to point at which patient is told they have cancer, or cancer is definitely excluded.
Non-Site-Specific Cancer Referrals	The non-specific symptoms (NSS) pathway provides a route for patients presenting with vague symptoms who may have a serious illness. Measure is number of non-site-specific referrals received in a month against target from operational plan for 2024/25
Day Case Rates	Day case surgery, where the patient is admitted, undergoes intervention and is discharged on the same day, is an important aspect of service provision in the NHS. Day case surgery brings recognised benefits for both patients and system-wide efficiencies related to patient quality and experience, reduced waiting times and release of valuable bed stock.

Appendix B (ii) – Metrics Rationale and Background

Calderdale and Huddersfield NHS Foundation Trust

Metric	Details
Capped Theatre Utilisation	Capped theatre utilisation is a metric used to measure how well the allocated planned theatre session time has been utilised in an individual theatre list. It is calculated by taking the total needle to skin time of all patients within the planned session time and dividing it by the session planned time. High capped utilisation signifies that the allocated planned session time has been well utilised.
Early cancer diagnosis: 75% of cases diagnosed at stage 1 or 2 by 2028	Cancer is one of the biggest contributors to inequalities in life expectancy with people from the most deprived communities more likely to get cancer, be diagnosed at a late stage for certain types of cancer and to die from the disease. Early presentation, referral, screening and diagnosis are key to addressing this.
Proportion of patients admitted, transferred or discharged within 4 hours	Monitor waiting times in A&E. Longer waits associated with poorer patient outcomes. NHS Objective to improve A&E waiting times so that no less than 76% of patients are admitted, transferred or discharged within 4 hours by March 2024 with further improvement in 2024/25.
Proportion of ambulance arrivals delayed over 30 minutes	Proportion of ambulances which experience a delay (by more than 30 minutes) in transferring the patient over to the care of ED staff. Patients arriving via an ambulance should be transferred over to the care of hospital staff within 15 minutes of arrival at an Emergency Department (ED). Handover delays can be detrimental to the health of the patient and can have a knock-on impact on the ambulance service (crews are unable to attend to other potentially life-threatening calls). Such delays at the front door of ED can also be a sign of potential overcrowding within the ED.
Proportion of patients spending more than 12 hours in an emergency department	To monitor long waits in A&E which could indicate overcrowding in ED and can cause poor patient experience. The number of patients that spend more than 12 hours between arrival and admissions, transfer or discharge, as a proportion of total attendances.
Neonatal deaths per 1,000 total live births	The Long-Term Plan committed the NHS to accelerate action to achieve the national maternity safety ambition of 50% reductions in stillbirth, maternal mortality, neonatal mortality and serious brain injury by 2025. The number of neonatal deaths is influenced by a number of factors, including the quality of care delivered to the mother and baby and appropriate surveillance for all women. The rate of deaths within 28 days of birth per 1,000 live births. A neonatal death is defined as a live born baby born at 24 weeks gestational age or later, or with a birthweight of 400g or more, who died before 28 completed days after birth.
Stillbirths per 1,000 total births	The focus of this indicator is to measure progress in reducing the rate of stillbirths against the trajectory towards the 2025 ambition. Measures the rate of stillbirths per 1,000 live births and stillbirths. A stillbirth is defined as a baby delivered at or after 24 weeks gestational age showing no signs of life, irrespective of when the death occurred.
% of patients dying within their preferred place of death – Community Palliative Care.	The focus of this indicator is to measure the proportion of patients who die in their preferred place of death. Everyone deserves the best possible experience at the end of their lives. The place where someone's cared for at the end of their life and whether this matches what they want – is an important part of this experience.

Appendix B (iii) – Metrics Rationale and Background

Calderdale and Huddersfield NHS Foundation Trust

Metric	Details
Proportion of Urgent Community Response referrals reached within 2 hours	Urgent Community Response services are a commitment in the NHS Long Term Plan to provide urgent care to people in their homes if their health or wellbeing suddenly deteriorates. % of 2-hour UCR referrals subject to the 2-hour response standard (as specified in the UCR technical guidance), with an RTT end date in reporting month, that achieved the 2-hour response standard.
Community Waiting List over 52 weeks	Understand resilience amongst providers of community health services and identify specific issues (e.g. changes to activity, the extent of any backlogs). Provide valuable data on waiting times and waiting list information. Data used by national teams and systems to inform recovery plans and reduce waiting lists across community health services.
Virtual Ward	A virtual ward is a safe and efficient alternative to NHS bedded care that is enabled by technology. Virtual wards support patients who would otherwise be in hospital to receive the acute care, monitoring and treatment they need in their own home. This includes either preventing avoidable admissions into hospital, or supporting early discharge out of hospital.
Hospital Discharge Pathway Activity	Monitors discharges from hospital to ensure that patients are discharged safely to the most appropriate place and that they continue to receive the care and support they need after they leave hospital.
Adult G & A acute bed occupancy adjusted for void beds (Type 1 Acutes Only)	Understand the proportion of adult general and acute beds that are occupied. The proportion of adult general and acute beds occupied (adjusted for Covid void beds). Covid void beds are beds that are closed due to Covid, but which are unoccupied. These beds cannot accept new admissions unless the patient is Covid-positive.
% of beds occupied by patients who no longer meet the criteria to reside	Understand the numbers of beds which are not available for patients who do meet the criteria to reside and therefore points to resources which are unavailable due to discharge issues. There is significant interest in discharges and beds due to ongoing pressures which NHS providers face and even more so over the Winter period. This indicator shows the numbers of beds which are not available for patients who do meet the criteria to reside and therefore points to resources which are unavailable due to discharge issues.
Transfers of Care	Counting DTOCs helps whole systems to understand unmet need and identify bottlenecks and ensures that pathways through the system are patient-oriented rather than organisation or service-centred. Helps systems to improve services for patients by reducing situations where people are in hospital longer than they need to be, which can have a detrimental effect on their recovery, rehabilitation and long-term health and well-being.
Maternity Workforce	To ensure the right numbers of the right staff are available to provide safer, more personalised, and more equitable care
Maternal Mortality	The government's National Ambition is to halve the rate of maternal deaths from a 2010 baseline by 2025,. with a 20% reduction by 2020, reducing the rate from 10.6 per 100,000 maternities in 2010 to 8.5 in 2020 and 5.3 in 2025

Appendix B (iv) – Metrics Rationale and Background

Calderdale and Huddersfield NHS Foundation Trust

Metric	Details
Pre-Term Births	The governments national ambition for pre-term birth rate is to achieve a 25% reduction from an 8% baseline in 2015 to 6% in 2025.
Brain Injuries	The government's National Ambition is to halve the rate of intrapartum brain injuries from a 2010 baseline by 2025.
Care Hours Per Patient Day (CHPPD)	CHPPD is the national benchmark measure for safer staffing and provides a single consistent way of recording and reporting deployment of staff working on inpatient wards/units. It is calculated by totalling the number of hours worked by registered nurses, nursing associates, and in some cases allied health professionals, as well as healthcare support workers on each ward for the 24-hour period, then dividing by the number of patients on the ward each day at midnight. There is no 'correct' number of CHPPD to be achieved. However, variation between the actual and planned CHPPD, should warrant further investigation.
Inpatient Falls per 1000 Bed Days	Inpatient falls are the most frequently reported safety incident in hospital. Not all falls are preventable but 20–30% of falls can be prevented by assessing risks and intervening to reduce these risks.
CHFT Acquired Pressure Ulcer per 1000 Bed Days	Pressure ulcers (PUs) remain a concerning and often avoidable harm for the patients who develop them, and the healthcare professionals involved in their prevention and management. PU are in the 'top ten harms' in the NHS in England. Investigations into the causes of pressure ulcers frequently show that unwarranted variation from evidence-based practice contributes to the development of pressure ulcers.
Summary Hospital-level Mortality Indicator	This is to monitor the ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die based on average England figures, given the characteristics of the patients treated here. It covers all deaths reported of patients who were admitted to Non-Specialist Acute Trusts in England and died either while in hospital or within 30 days of discharge.
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

Calderdale and Huddersfield NHS Foundation Trust

Metric	Details
Number of Patient Safety Incident Investigations (PSII)	To identify areas where CHFT can reduce risks and prevent harm, the reporting of all near misses and serious incidents is imperative to ensure we improve safety and learn from these events to prevent recurrence. Promoting a positive reporting culture is essential to CHFT's learning success for all our patients, families and staff.
Never Events	To identify areas where CHFT can reduce risks and prevent harm, the reporting of all near misses and serious incidents is imperative to ensure we improve safety and learn from these events to prevent recurrence. Promoting a positive reporting culture is essential to CHFT's learning success for all our patients, families and staff.
Complaints	CHFT views any complaint as an extension of our service users' care and the Trust is committed to moving towards a user-centric service. Effective processes and procedures for handling concerns, feedback, stories, compliments, and complaints are pivotal to organisational learning success
Personalisation of Care	Dementia is a significant challenge and a key priority for the NHS, when people with dementia come into acute care, their length of stay is longer than people without dementia. Recognition of dementia also allows for improved care during the hospital admission
Care of the Acutely Ill Patient	The identification and recording of deterioration, enabling swifter response, which will reduce the rate of preventable deaths. Reducing the need for higher levels of care will free up capacity particularly in ICU by avoiding admissions and reducing lengths of stay, both of which are significant factors in the NHS's recovery efforts.
Stroke	This measure is looking at the % of stroke patients admitted directly to an acute stroke unit within 4 hours of hospital admission. This is the national standard, with direct admission to a stroke unit within 4 hours being a large driver for patient outcomes.
Health Inequalities: Cancer Faster Diagnosis Standard - Learning Disability, Deprivation and Ethnicity	Faster Diagnosis will facilitate an improvement in the Cancer early detection rate and thereby increase the chances of patients surviving. Expectation is that 75% or more of patients will a maximum four weeks (28 days) from receipt of urgent GP (GMP, GDP or Optometrist) referral for suspected cancer, breast symptomatic referral or urgent screening referral, to point at which patient is told they have cancer, or cancer is definitely excluded.
Health Inequalities: Percentage of patients waiting less than 6 weeks for a diagnostic test - Learning Disability, Deprivation and Ethnicity	Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%. Maximise diagnostic activity focused on patients of highest clinical priority.

Appendix B (vi) – Metrics Rationale and Background

Calderdale and Huddersfield NHS Foundation Trust

Metric	Details
Heath Inequalities: Patients waiting more than 40 weeks to start treatment - Learning Disability, Deprivation and Ethnicity	Waiting times matter to patients. Most patients want to be referred, diagnosed and treated as soon as possible. To measure and encourage compliance with recovery milestones for the RTT waiting list for learning disability patients.
Health Inequalities: Emergency Care Standard – Learning Disabilities, Deprivation and Ethnicity	To monitor waiting times in A&E for patients from the most deprived areas (IMD 1 and 2) to ensure equity across all patient groups
Health Inequalities: Outpatients DNA's – Learning Disabilities, Deprivation and Ethnicity	To monitor DNA rates at first and follow-up appointments for patients from most the most deprived areas (IMD 1 and 2) to ensure equity across all patient groups

10 MINUTE BREAK

A WORKFORCE FOR THE FUTURE

18. Safer Staffing Annual Report

To Approve

Presented by Lindsay Rudge

Calderdale and Huddersfield
NHS Foundation Trust

Board of Directors

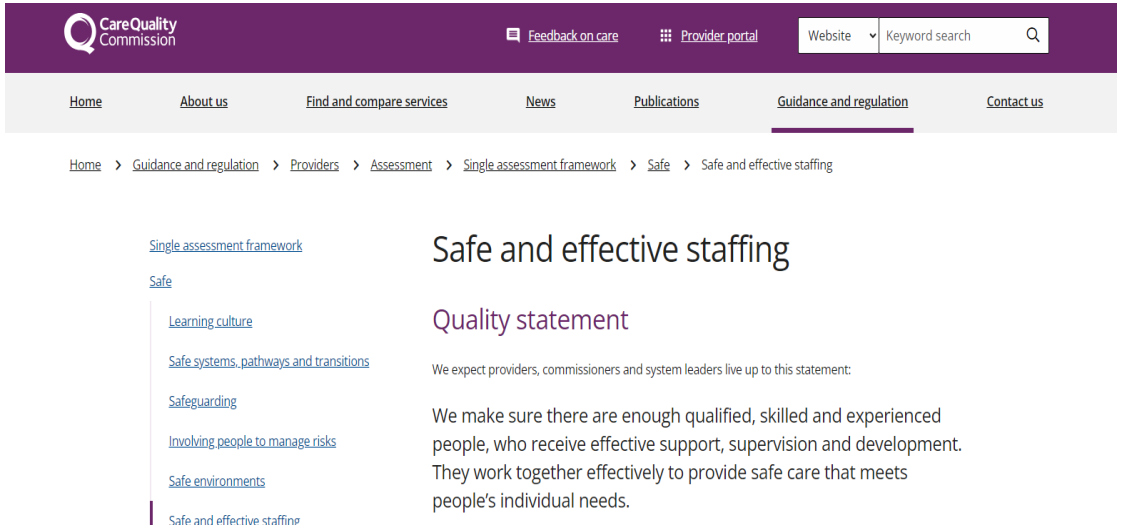
NURSING, MIDWIFERY AND ALLIED HEALTH PROFESIONAL

SAFER STAFFING REPORT

Reporting period: 1st April 2023– 31st March 2024

Context

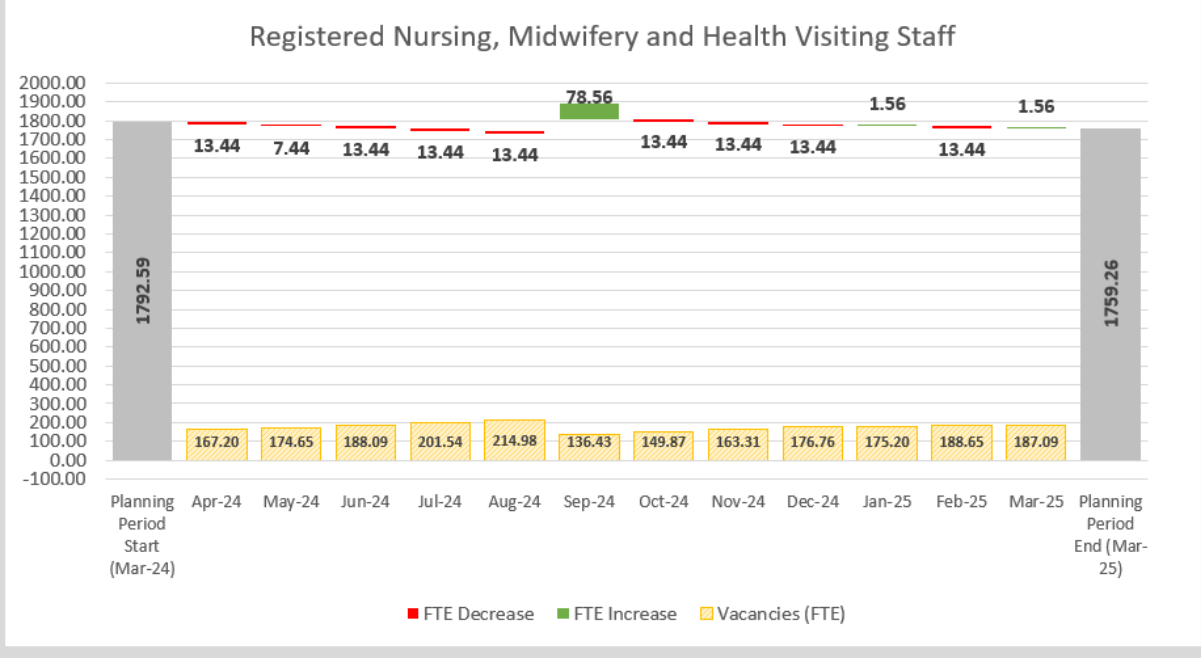
- The purpose of this report is to provide an overview for Nursing and Midwifery and Allied Health Professional (AHP) capacity and compliance with the NICE Safe Staffing, National Quality Board (NQB) Standards and the NHS Improvement Workforce Safeguards guidance.
- Demonstrating safe staffing is one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

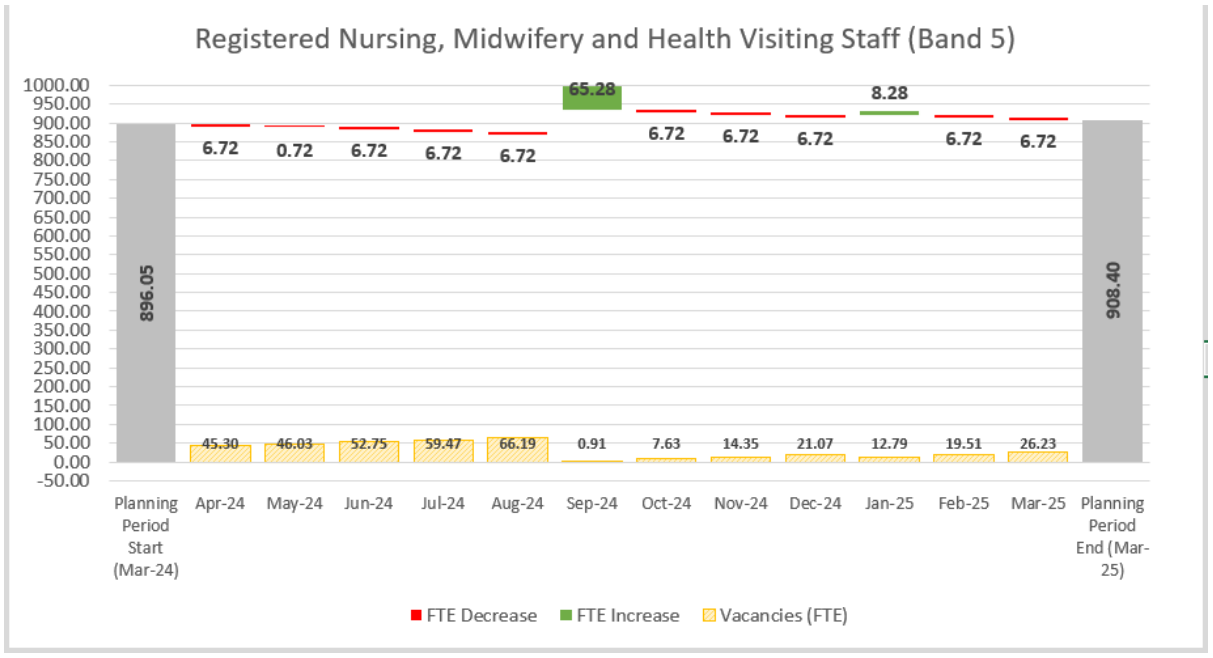


Key points to note: vacancy

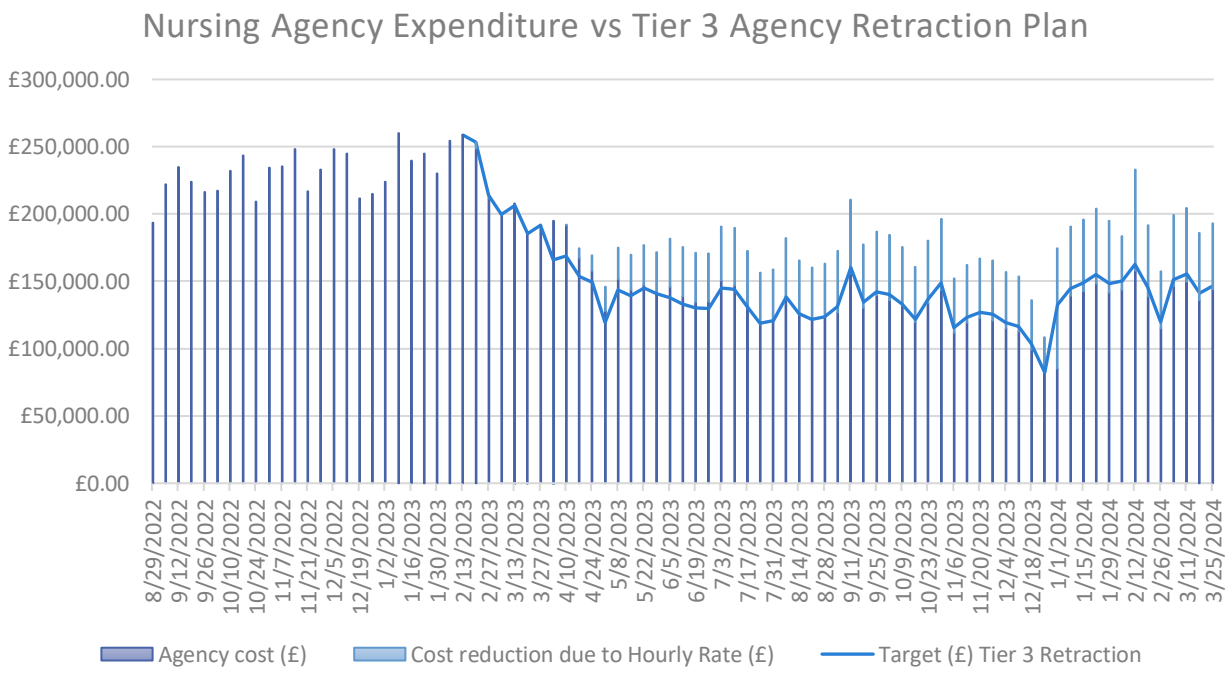
Calderdale and Huddersfield NHS Foundation Trust

- Overall, Nursing and Midwifery vacancies at CHFT remain aligned with the national position. The Trust remains committed to the national policy drivers in ensuring there are safe and sustainable workforce provisions. With that said, CHFT's band 5 nursing workforce remains one of our largest safety-critical resources, therefore maintaining momentum in reducing the vacancy deficit in this cohort of staff remains our absolute priority, notwithstanding the national workforce pressures.





Since the last report operational pressures continue with multiple areas working above their baseline capacity. Despite a positive downward trend in reliance upon agency, further retraction has been compounded by the inability to move out of the additional bed capacity. It is anticipated this position will improve given a recent decision to substantially recruit to two of the escalation areas.



Key points to note: BAF risk score for Nursing

The Board Assurance Framework (BAF) risk score for Nursing (Ref: 10b/19) remains at a score of 12.

TRUST GOAL: 3. INCLUSIVE WORKFORCE AND LOCAL EMPLOYMENT									
Ref & Date added	OWNER Board committee	Exec Lead	RISK DESCRIPTION *(What is the risk?)*	KEY CONTROLS *(How are we managing the risk?)*	POSITIVE ASSURANCE & SOURCES *(How do we know it is working?)*	GAPS IN CONTROL *(Where are we failing to put controls / systems in place?)*	GAPS IN ASSURANCE *(Where are we failing to gain evidence about our system/*	RATING JUNE 2024 Risk Category: Workforce Risk appetite: Low	
								Initial	Current	Target
10b/19 2021/22	Workforce Committee	Chief Nurse	**Risk** Risk of not being able to deliver safe and effective high quality care and experience for patients due to insufficient nursing staff caused by an inability to attract, recruit, retain, reward and develop colleagues. **Impact on** - Quality and safety of patient care and Trust's ability to deliver some services. - Ability to deliver national targets and CQUINS. - Increased risk of litigation and negative publicity. - poor staff morale - Increased sickness absence - Continued financial pressure due to use of locums / agency staff - ambition to demonstrate the Trust is an "outstanding" organisation by CQC standards	• Senior nurse staffing meetings twice a day, 7 days a week provide an on the day repsonse to staffing position, responding to areas of escalation (red flags) and agreeing actions to mitigate the curent position. This meetings also determines the agree OPEL safer staffing postion. Clear esclations to the Associate Directors of Nursing rota and approval sought for agency to mitigate unresolved staffing position. Community nursing 7 day on call arrangements to manage staffing with escalation process. Executive oversight of twice yearly nrusing establishment review in line with NQB guidance • Adherence to best practice rostering processes. Preceptorship framework ensures standardised approach for new registrants who can fill shifts as registered nurse to support acheivement of workforce models and retention. OPEL safer staffing actions cards. •Internal pay enhancements profroma developed to support response to workforce pressures • Strengthened escalation and reporting arrangements for quality and safety (short term and medium/long term), including enhanced dashboard which provides clear visibility on workforce and impacts on patient experience, quality and safety, •Local Nursing and Midwifery retention strategy developed in line with national recommendations and high impact actions initiated, approved November 2022. • Apprenticeship Strategy in place to support career pathways into nursing, AHPS • Utilisation of bank and agency staff in place, managed and escalated through a Standard Operating Procedure. • E-roster system in place and linked Safer Care IT system being used to match staffing levels to patient acuity. • Role of the Clinical Site Matron and responsiblity for tactical command • Journey to Outstanding (J2O) processs, reviewers provided with information on staffing levels, eg ward information on vacancies and fill rates re; falls, pressure ulcers and friends and family test which will include an assessment of staffing levels. People Strategy in place to support colleague health and well-being in line with national People Plan priorities • Quality and Safety oversight meetings in place for clinical areas where concerns exist on nurse sensitive indicators. • Safe staffing information presented to the Workforce and Quality Committee, • Nursing and Midwifery, AHP Workforce Steering Group, meet monthly with an overview of recruitment and retention strategies supported by Business Intelligence dashboard identifying progress and hotspots for consideration. EQIA change process considers staffing position to avoid negative impact for staff and patients • Safe, Sustainable and Productive Staffing meeting meets monthly which focus on the quality metrics associated with the staffing postion (Enhanced Dashboard Metric) Launch of the nursing and midwifery 5 year ambitions May 2025	<u>First line</u> Twice daily staffing meetings . Monthly review of the Enhanced Dashboard Metric that tracks CHPPD/FIII Rate and a number of staff metrics to track any potential harm as a result of staffing position Business Intelligence dashbaord provides monthly review of vacancy position, identifying potential hotspots and identification of any futher actions required to respond to the staffing position. Review of workforce and quality metrics by Nursing, Midwifery and AHP Steering Group, with actions taken as needed Clinical Site Matron summary site reports which provide assurance of site staffing postion and action to respond to any concerns,. <u>Second line</u> Monthly performance meetings (PRM) review workforce reports as well as introduction of corporate PRM (remit for educational activities) Workforce Commitee receives updates on recruitment and retention issues for both oversight and scrutiny Twice yearly report to Workforce Committee, Quality Committee and Board of Directors on safer staffing for both oversight and scrutiny and assurance (January and July). Annual and bi-annual safer staffing reviews of Nursing and Midwifery staffing levels provides assurances of the current workforce models or provides a rationale/evidence base for change. This approch is reflective of best practice in adopting triangulation of safer staffing metrics. 12 June 2024 Workforce Committee, 2 July 2024 Board of Directors Nursing and quality KPIs embedded in Integrated Performance Report. J20 reports presented to divsional PSQB provide opportunity for staff to feedback concerns re: staffing position to the division Workforce Committee undertakes deep dive of this identified risk to confirm key controls are clearly identifeid and assurances are robust and comprehensive - 12 June 2024 <u>Third Line</u> Vacancy information reported into NHSE. Assurance process with CQC colleagues - feedback from relationship wth arms-length bodies. Preceptorship framework approved by NHS England for newly registered nursing (December 2023) - achievement of quality mark Achievement of NHS Pastoral Quality Care Award for nursing staff.	1. At periods of operational pressure, insufficent workforce availability to meet demand above core bed base and in community services. Action: Approval to recruit to 2 clinical areas above bed base which has a positive impact on bank and agency spend. Tier 1 agency retraction plan (June 2024 led by divisional ADNs) Controlled use of bank and agency staff (as per retraction plan) and derogated staffing models in place as per OPEL action staffing cards. 2. Unable to control use of extra capacity wards Approval to recruit to 2 clinical areas above bed base which has a positive impact on bank and agency spend. Action: Engagement in length of stay improvement work and nursing representative at tactical meetings to manage staffing position Lead: Associate Director of Nursing Resilience, Acute Flow and Transformation Directorate Ongoing	Need for discussion on skill mix issues created by a combined effect of high proportion of new graduate nursing workforce and internationally educated nurses Action: Learning needs analysis and training and education delivery plan by March 2025 Lead: ADN Corporate Nursing Developing a new ward assurance process which will provide ongoing monitoring of quality and safety Lead: Deputy Chief Nurse Timescale: June / July 2024	4x4 = 16	4x3 = 12	3x3 = 9

Action	Timescales	Lead
Length of stay improvement work and invovlement in tactical meetings re staffing Learning needs analysis and training and education delivery plan (rolling programme)	Ongoing March 2025	Associate Director of Nrusing, Resilience, Acute Flow and Transformation ADN Corporate Nursing

Links to risk register:
Risk 6345 - nurse staffing risk, 7994 enhanced care nursing staff,

Key points to note: BAF risk score for Midwifery

The BAF risk score for Midwifery (Ref: 6/23) remains at a score of 16

TRUST GOAL: 3. INCLUSIVE WORKFORCE AND LOCAL EMPLOYMENT									
Ref & Date added	OWNER Board committee	Exec Lead	RISK DESCRIPTION *(What is the risk?)*	KEY CONTROLS *(How are we managing the risk?)*	POSITIVE ASSURANCE & SOURCES *(How do we know it is working?)*	GAPS IN CONTROL *(Where are we failing to put controls / systems in place?)*	GAPS IN ASSURANCE *(Where are we failing to gain evidence about our system/ controls?)*	RATING JUNE 2024 Risk Category: Workforce Risk appetite: Low	
								Initial	Current	Target
6/23 January 2024	Workforce Committee	Chief Nurse	**Risk** Risk of not being able to deliver safe and effective high quality care and experience for patients due to insufficient midwifery staff caused by an inability to attract, recruit, retain, reward and develop colleagues. **Impact on** - Quality and safety of patient care and Trust's ability to deliver some services. - Ability to deliver national targets - Increased risk of litigation and negative publicity. - poor staff morale - Increased sickness absence - Continued financial pressure due to use of locums / agency staff - ambition to demonstrate the Trust is an "outstanding" organisation by CQC standards	• Midwifery daily oversight and staffing meetings with ,maternity escalation plan to mitigate risk •Senior midwifery leadership rota provides ongoing visibility and dialogue across clinical areas, supporting staffing escalation • Adherence to best practice rostering processes. • OPEL safer staffing actions cards. • Role of the Clinical Site Matron and responsiblity for tactical command • Strengthened escalation and reporting arrangements for quality and safety (short term and medium/long term), including enhanced dashboard which provides clear visibility on workforce and impacts on patient experience, quality and safety • Internal pay enhancements profroma developed to support response to workforce pressures Utilisation of bank and agency staff in place, managed and escalated through a Standard Operating Procedure. 20% bank enhancements continues for maternity workforce to encourage uptake of shifts. •Local Nursing and Midwifery retention strategy developed in line with national recommendations and high impact actions initiated, approved November 2022. • Flexible approach to maternity staffing includes registered nurses working in maternity services •Maternity Transformation Programme Board has oversight of 3 year maternity delivery plan and associated actions to manage risk, including staffing •Apprenticeship Strategy in place to support career pathways into midwifery • International recrutiment of mdiwives and sysytem wide recruitment across local maternity system (LMS) • E-roster system in place • Journey to Outstanding (J2O) processs, provides opportunity for staff to feedback on staffing levels. • Quality and Safety governance meetings for monitoring metrics and standard KPIs, eg 1:1 care in labour, • Safe staffing information on midwifery presented to the Workforce and Quality Committee, with direct report from Director of Midwifery to Quality Committee • Nursing and Midwifery, AHP Workforce Steering Group, meet monthly with an overview of recruitement and retention strategies supported by Business Intelligence dashboard identifying progress and hotspots for consideration. • Safe, Sustainable and Productive Staffing meeting meets alternative weeks which focuses upon the quality metrics associated with the staffing postion (Enhanced Dashbaord Metric)	First line Daily staffing meetings provide an on the day repsonse to staffing position, Business Intelligence dashbaord provides monthly review of vacancy position, identifying potential hotspots and identification of any futher actions required to respond to the staffing position. The activity undertaken within the Nursing, Midwifery and AHP Steering Group which has a workplan focused upon responding to the insufficient staffing position by determing programmes of work related to recrutitment and retention and compliance with a number of metrics (as above) Clinical Site Matron summary site reports which provide assurance of site staffing postion and action to respond to any concerns,. Second line Monthly performance meetings (PRM) review workforce reports as well as introduction of corporate PRM Workforce Commitee receives updates on recruitment and retention issues for both oversight and scrutiny Twice yearly report to Workforce Committee, Quality Committee and Board of Directors on safer staffing (11.1.24),for both oversight and scrutiny and assurance (January and July)Annual and bi-annual safer staffing reviews of Nursing and Midwifery staffing levels provides assurances of the current workforce models or provides a rationale/evidence base for change. This approch is reflective of best practice in adopting triangulation of safer staffing metrics. KPIs embedded in Integrated Performance Report. J20 reports presented to FSS PSQB providing an assessment of the staffing position Workforce Committee undertakes deep dive of this identified risk to confirm key controls are clearly identifeid and assurances are robust and comprehensive Third Line Performance reported into NHSE. Assurance process with CQC colleagues - feedback from relationship wth arms-length bodies Maternity CQC report from visit June 2023 confirms leaders had responsive approach for managing midwifery staffing shortages to mitigate risk. Maternity Voices partnership ensures regular patient feedabck on experience of care	National shortage of registered midwives impacting on staffing recuritment pipeline: Action: Commissioning use of the birth rate plus tool, revised workforce models in line with current birthrate, international recruitment Bid submitted to Business Case Approvals Group (BCAG) awaiting outcome- expect to reduce budgeted wte actions Nursing, Midwifery & AHP Steering Group to review this risk February 2024, lead Deputy Chief Nurse	CQC maternity report (August 2023)- requires improvement for safe domain. CQC action plan in response to safe "must do" re qualified staff for monitoring by Maternity Transformation Programme Board. Director of Midwifery	4x4 = 16!	4x4 = 16	3x3 = 9

Action	Timescales	Lead
Implementation of CQC must do action for maternity re staffing	See action plan	Director of Midwifery
Use of bank and agency staff to meet demand	Ongoing	ADN Corporate Nursing
Plan to re run birth rate plus tool to support review of WFM	March 24	Deputy Chief Nurse
Supporting newly recruited Midwives and international midwives through preceptorship and supernummerary periods - March 24		ADN Corporate Nursing ADN Corporate Nursing

Links to risk register:
6911 midwifery workforce

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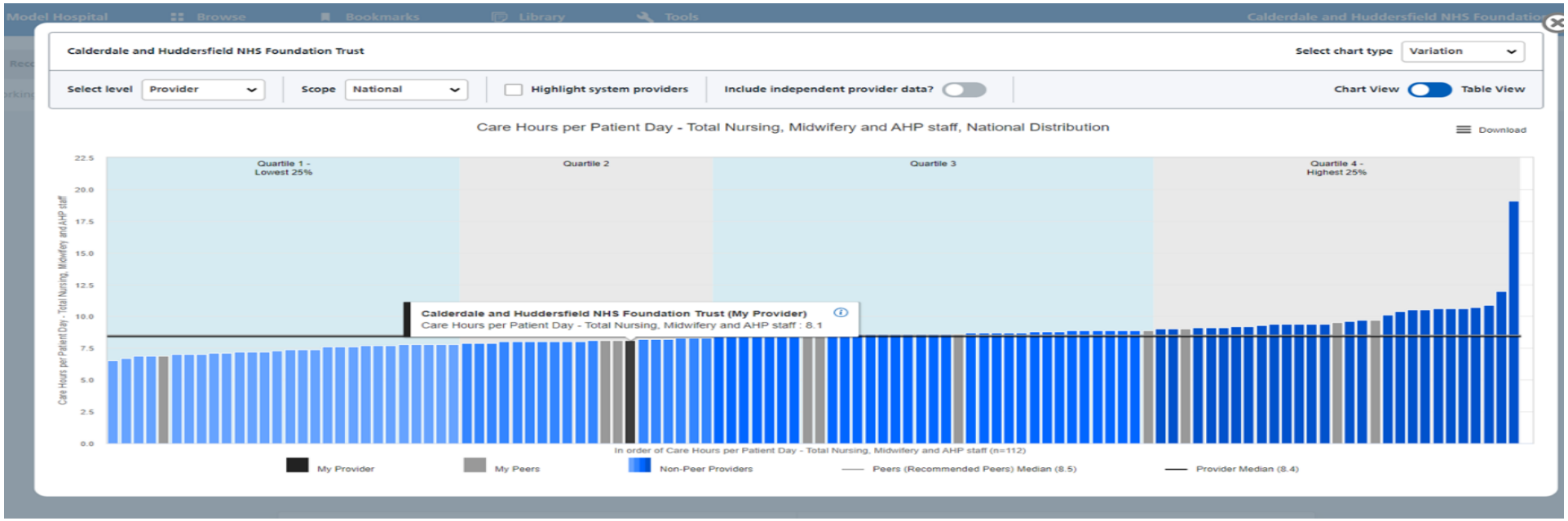
Key points to note: Care Hours Per Patient Day (CHPPD)

Calderdale and Huddersfield NHS Foundation Trust

- **The CHPPD at Trust level has remained stable demonstrating where safely possible the workforce is being flexed in line to meet patient activity and patient needs.** This is undertaken proactively through rostering but also on the day through twice daily staffing meetings. **Benchmarking from the Model Hospital suggests at a Trust level CHFT sits in quartile 2 at 8.1. The national median CHPPD for January 2024 was 8.4 CHPPD with the Peer Median being 8.5 CHPPD.**



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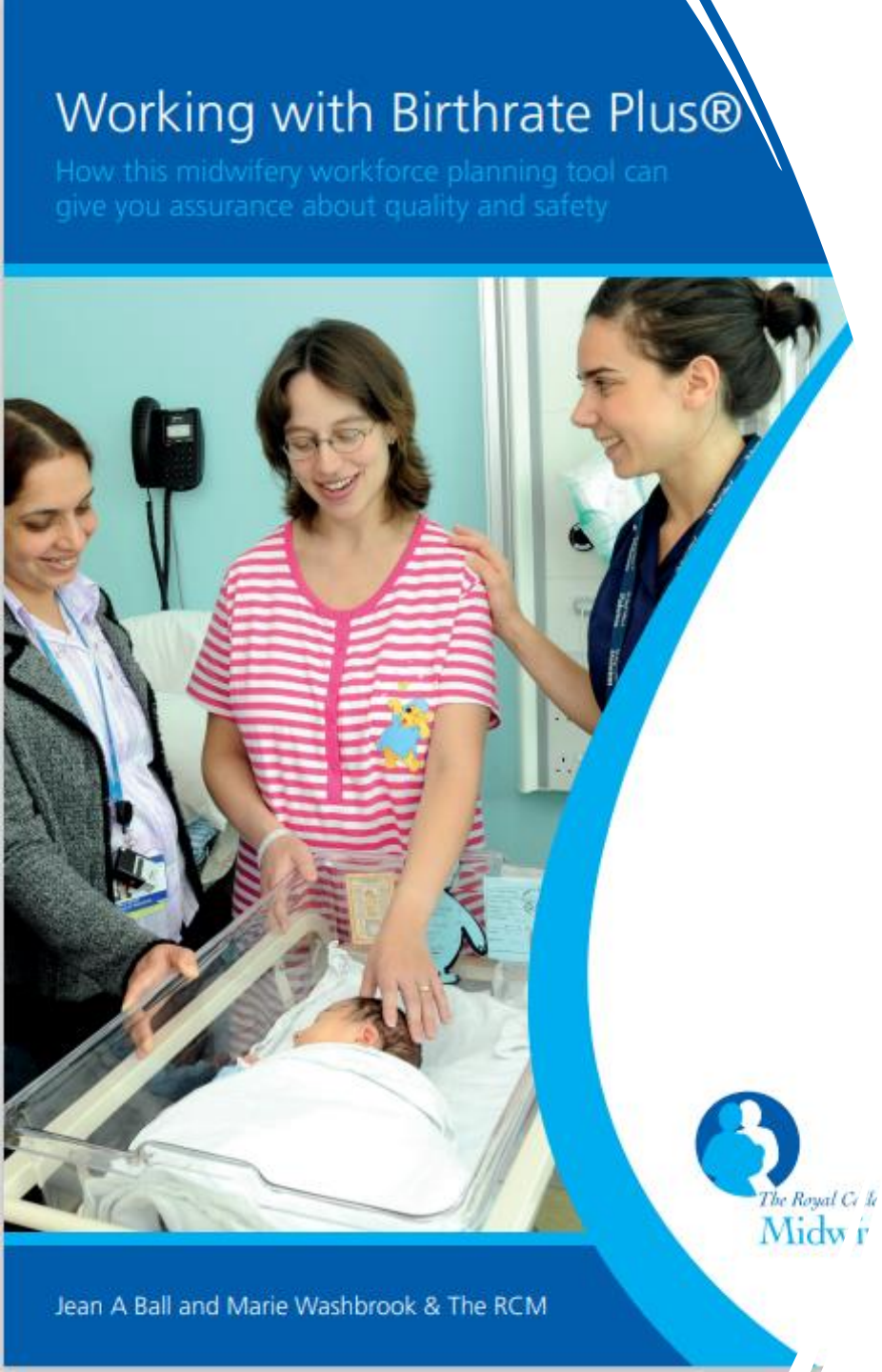

Key points to note: Midwifery Services

- CHFT are in receipt of the recently commissioned Birthrate+ report. Work is underway to review the report, overlay professional judgement and provide a recommendation through Trust governance processes. A key headline from the report indicates there is no requirement to reduce the maternity establishment.

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Key points to note:- Patient experience

- The impact upon patient experience and the quality agenda if the Trust fails to provide safe staffing numbers across all clinical areas.

Date of Meeting:	Thursday 4 July 2024
Meeting:	Public Board of Directors
Title:	Nursing, Midwifery and Allied Health Professional Annual Safer Staffing Report
Author:	Andrea Dauris, Associate Director of Nursing – Corporate
Sponsoring Director:	Lindsay Rudge, Chief Nurse
Previous Forums:	Quality Committee Workforce Committee
Purpose of the Report	The purpose of this report is to provide the Board of Directors with an overview of Nursing, Midwifery and Allied Health Professional (AHP) staffing capacity and compliance within Calderdale and Huddersfield NHS Foundation Trust in line with the National Institute for Excellence (NICE) Safe Staffing, National Quality Board (NQB), NHS Improvement Workforce Safeguards guidance and CQC's Regulation 18: Staffing. This is supported by an overview of staffing availability over the reporting period, progressing with assessing acuity and dependency of patients within inpatient and community settings and the quality impact upon nurse sensitive indicators. The data collection has been used to inform the Nursing and Midwifery establishment reviews for 2024/25. It is a national requirement for the Board of Directors to receive this report bi-annually.
Key Points to Note	The following details that are considered the key points to note: • Overall, Nursing and Midwifery vacancies at CHFT remain aligned with the national position. The Trust remains committed to the national policy drivers in ensuring there are safe and sustainable workforce provisions. With that said, CHFT's band 5 nursing workforce remains one of our largest safety-critical resources, therefore maintaining momentum in reducing the vacancy deficit in this cohort of staff remains our absolute priority, notwithstanding the national workforce pressures. • Since the last report operational pressures continue with multiple areas working above their baseline capacity. Despite

	a positive downward trend in reliance upon agency, further retraction has been compounded by the inability to move out of the additional bed capacity. It is anticipated this position will improve given a recent decision to substantially recruit to two of the escalation areas. • The Board Assurance Framework (BAF) risk score for Nursing (Ref: 10b/19) remains at a score of 12. • The BAF risk score for Midwifery (Ref: 6/23) remains at a score of 16. • Staffing fill rates continued to fluctuate between 84% - 88.3% during the day. A position reflection of vacancies, ongoing sickness/absence and additional capacity areas. • The CHPPD at Trust level has remained stable demonstrating where safely possible the workforce is being flexed in line to meet patient activity and patient needs. Benchmarking from the Model Hospital suggests at a Trust level CHFT sits in quartile 2 at 8.1. The national median CHPPD for January 2024 was 8.4 CHPPD with the Peer Median being 8.5 CHPPD. • CHFT are in receipt of the recently commissioned Birthrate+ report. Work is underway to review the report, overlay professional judgement and provide a recommendation through Trust governance processes. A key headline from the report indicates there is no requirement to reduce the maternity establishment. • There was a total of 360 Nursing & Midwifery staffing related incidents that were reported through the Datix system during the period 01 April 2023 to 31 March 2024. Women's services reported the highest staffing incidents with 223 incidents (215 classed as no harm and 8 classed as minor harm) relating to staffing reported. Of the 360 staffing incidents, 343 incidents were recorded as no significant harm to patients, 12 minor harm and 5 moderate harms. There was appropriate escalation when the incidents occurred. • Achievement of the Quality Mark against the national preceptorship framework • The continued focused leadership to support this agenda. • The impact upon patient experience and the quality agenda if the Trust fails to provide safe staffing numbers across all clinical areas. The Chief Nurse has confirmed they are satisfied that staffing is safe, effective, and sustainable. This position is achieved through mitigations identified in the BAF associated risks (referenced within the report), ongoing operational governance arrangements aimed at maintaining the daily staffing position and monthly safer staffing meeting forums.

Regulation	Regulation 18: Staffing
EQIA – Equality Impact Assessment	Ethnicity, age, disability, sexuality, socio-economic status, religious beliefs, non-English speakers and being a member of a social minority (e.g. migrants, asylum seekers, and travellers) may all influence rates of access to CHFT patient services. These factors may also influence the level of nursing, midwifery or allied healthcare professional staff required to provide safe care. Consideration of the impact of equality issues on the provision of safe care to all patients is an integral part of standard nursing practice. As such, considering equality issues that may influence the provision of safe staffing forms an integral part of the scoping document. Evidence shows us a direct correlation between quality, safety and patient experience and nurse staffing levels. Failure to have staffing in place that meets the care needs of patients means there is a potential risk of poor outcomes for all service users. Should this be the case then people from protected characteristic groups could be disproportionally impacted given the evidence to suggest a less favourable experience for people from these groups across all NHS services.
Recommendation	The Board is asked to receive this report and **APPROVE** the ongoing plan to provide safe staffing provisions within nursing, midwifery and AHP disciplines across the Trust.

CONTENTS	
1.0	Introduction
2.0	Safer Staffing
3.0	National compliance
4.0	Sickness and Absence levels
5.0	Safer Staffing data
6.0	Escalation and reporting arrangements for Quality and Safety
7.0	Recruitment and Registered Nurse Trajectory
8.0	Nursing, Midwifery and Allied Health Professional Workforce
9.0	Summary
10.0	Recommendations
APP 1	SNCT assessment to meet criteria
APP 2	Midwifery Risk BAF 6/23
APP 3	Nursing Risk BAF 10b/19

1.0. INTRODUCTION

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

This is supported with an overview of staffing availability over the previous six months and progress with assessing acuity and dependency of patients on inpatient and district nursing services. This data has supported the review of the Nursing, Midwifery and AHP establishment reviews for 2023/2024 in addition to providing a cumulative oversight of Care Hours Per Patient Day (CHPPD) and fill rates.

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

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

- Evidence base tools and data
- Professional judgment
- Outcomes

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

This report describes CHFT's position in response to the national guidance for the reporting period 1st April – 31st March 2024.

2.0 SAFER STAFFING

2.1 Nursing and Midwifery Establishment reviews.

The Trust continues to approach the setting of nursing and midwifery establishments as set out in NQB standards. This includes the implementation of the Safer Nursing Care Tool (SNCT), an evidence-based workforce planning tool that provides patient acuity and dependency intelligence, which has informed the Trust establishment setting process. SNCT and Community Safer Nursing Care Tool (CSNCT) are objective tools that utilise levels of care to support workforce planning and have been recognised for supporting safe staffing across in-patient wards and district nursing services. Appendix 1 demonstrates 100% compliance against the standards required to maintain high levels of reliability and validity when undertaking SNCT data collection.

During the reporting period the Safer Care Nursing Tool (SNCT) data collection was undertaken in January 2024. This was followed by six divisional panels presented to the Chief Nurse which completed in April 2024. Each review was aligned to the components below: -

- SNCT/CSNCT acuity and dependency data to inform each service review.
- Professional judgement application to workforce planning and representative of speciality and activity requirements
- The appropriate skill-mix reflective of service activity.
- A six-month review of nurse/midwifery sensitive indicators for each area
- Benchmarking CHPPD data aligned with national mean and peer providers.
- Identification of training plans based on the right skills, in the right place at the right time
- Consideration of the financial impact of budgets

Decision making was premised on the principles as set out in the Developing Workforce Safeguards guidance (2018) drawing together the components highlighted above to inform recommendations.

The table below summarises the changes which were approved: -

Division	Area	Current WTE	Agreed WTE	Comments	Cost £0	Proposed Funding method
Medicine	Frailty Service	35.94	35.94	Changes to shift patterns aligned to mapping of service activity. Approved by Matron and ADN.	£0	Cost neutral
Medicine	CRH ED	96.23	97.94	Additional Late shift created in response to SNCT data collection results/professional judgement and quality metrics. Supported by Matron, Lead Nurse and ADN	£37,260	Approved at Chief Nurse panel subject to confirmation of divisional funding and business case approvals group.
Medicine	HRI ED	103.9	103.9	Removing Clinical Educator B7 and reducing the late shift x1 24/7 band 5 to support increasing the long day x1 24/7 band 5. Supported by Matron, Lead Nurse and ADN.	£0	Subject to Chief Nurse panel approval Cost neutral

Division	Area	Current WTE	Agreed WTE	Comments	Cost (£'0)	Proposed Funding Method
Medicine	HRI ED	103.9	109.03	Introduction of an engagement support worker with the department focused upon support the mental distress of patients entering department. Supported by Lead Nurse/Matron and ADN.	£199,826	Integrated Care Board Funding
Surgery	Theatres	200.13	201.53	Review of all the theatre WFM's to align activity. Includes a clinical educator post 0.8WTE.	£0	Cost neutral
Surgery	Surgical Assessment Unit	42.89	41.26	Additional shift pattern created for a twilight RN. A change in HCSW shift patterns that support service activity. Supported by SNCT data, professional judgement. Approved by Matron and ADN.	£0	Cost Neutral
Families and Specialist Services (FSS)	NICU	44.35	TBC	Review of NICU workforce model Direction of travel approved by DOM and DDOM	£0	Cost Neutral
Total					**£237,086**	

2.2 Community Nursing Services

The Community Healthcare Division presented an appraisal of their current establishments, which, following a review of current services made recommendations which have been summarised earlier in the report. The overview of services continued to highlight the diversity of service provision. The division successfully completed their second round of data collection within District Nursing Services using the new evidence-based Community Nursing Safer Staffing Tool (CNSST).

Since completion of the data collection, communication from the national team has requested a three month pause on the use of the tool and advised that any recent

rounds of data collection are not used to inform workforce changes. Further updates are awaited from the national team.

2.3 Maternity Services

As identified in previous safer staffing reports the midwifery vacancy position was determined following commissioning of Birthrate Plus who undertook a full baseline assessment for the period 1 April 2019 – 31 March 2020, providing the Trust with a report in November 2020. Birthrate Plus methodology is consistent with the recommendations in the NICE safe staffing guideline for midwives in maternity settings and has been endorsed by the Royal College of Midwives and the Royal College of Obstetricians and Gynaecologists.

A further commissioning of Birthrate Plus had been agreed to take place in quarter 4 of 2023-2024 reflective of the tools recommendations to repeat 3 yearly. This has been completed and the full draft report was made available at the end of April 2024. An initial discussion has been held with the chief nurse and the report will be discussed through divisional PRM in June 2024 and brought to Board of Directors in July 2024. BR+ has recommended 216.75 WTE, a slight upward step change from a current budgeted position of 214.12WTE. Birthrate plus recommendations are based upon a total whole time equivalent position for both direct clinical care and specialist non-clinical care but does not provide a recommended workforce structure that should be implemented. This is locally decided based on professional judgement and is now being applied ready for review alongside the report through Trust governance processes.

Table 1: Vacancy levels March 2024 (PWR return excluding Band 8's)

	Births	Planned WTE (MW and RN)	Actual WTE (MW & RN)	Planned Leavers (to end March 2024)	Midwives and RN in recruitment pipeline (to end March 2024)
CHFT	4334	195	143.87	1.8	10.13

There continues to be challenges in recruiting to the current vacancies (table 1) which is reflective of the regional and national position. The midwifery position is set out within BAF reference 6/23 with a current risk rating of 16 (appendix 2).

The service has continued to develop its recruitment and retention strategy, holding recruitment events to attract newly qualified and existing midwives to the service. Vacancy has been further compounded by sickness, and maternity leave however a repeat Birthrate Plus will enable a reset vacancy against current birth rate and acuity and support identification of a more accurate position for reporting once approved at Trust board. To ensure the safety of women and babies, and in accordance with guidance from NHSE, the maternity service has prioritised provision of 1:1 care for women in established labour and supernumerary status of the labour ward coordinator. This has contributed to decisions for the continued suspension of services at Huddersfield Birth Centre and the continued suspension of the roll out of maternity continuity of carer.

Local exit interviews undertaken by the Director of Midwifery or Deputy director of midwifery continue, however the flow of leavers has significantly reduced in the last 6 months. The maternity services Deputy Director of Midwifery and Band 7 lead on workforce with clinical educators who work clinically with the newly qualified midwives to provide support. Previously the clinical educators were funded from NHSE but having realised the benefits of clinical support a permanent full-time band 6 clinical educator has been recruited. Further assessment of the support needed to continue to improve retention and staff satisfaction is taking place and will be considered as a part of the workforce structure review based on the birthrate plus findings.

The maternity service continues to be involved in LMNS regional recruitment for student midwives who qualify in September 2024. In preparation for this CHFT maternity services held recruitment events to showcase the service and to meet the teams. Bespoke recruitment films have been created demonstrating CHFT's one culture of care and to showcase the service. These have been well received and used in recruitment events and shared widely through social media. The recruitment events were well attended with student midwives from both CHFT and other local Trusts.

Despite these challenges women continue to be offered three choices of place of birth in line with the aspirations of Better Births: home birth, midwife led alongside birth centre and consultant led unit. Calderdale Birth Centre has introduced a responsive model in May 2023 where staff follow the women rather than staffing a building.

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

Two of the most important safe staffing indicators relate to the provision of 1:1 care in labour and the supernumerary status of the labour ward (LDRP) coordinator. NHS Resolution's Maternity Incentive Scheme states that the midwifery coordinator in charge of labour ward must have supernumerary status, which is defined as having no caseload of their own during their shift to ensure there is an oversight of all birth activity within the service. 1:1 care in labour has remained consistently above 98% and the coordinator remaining supernumerary has remained consistently at 99-100% through 2023-2024.

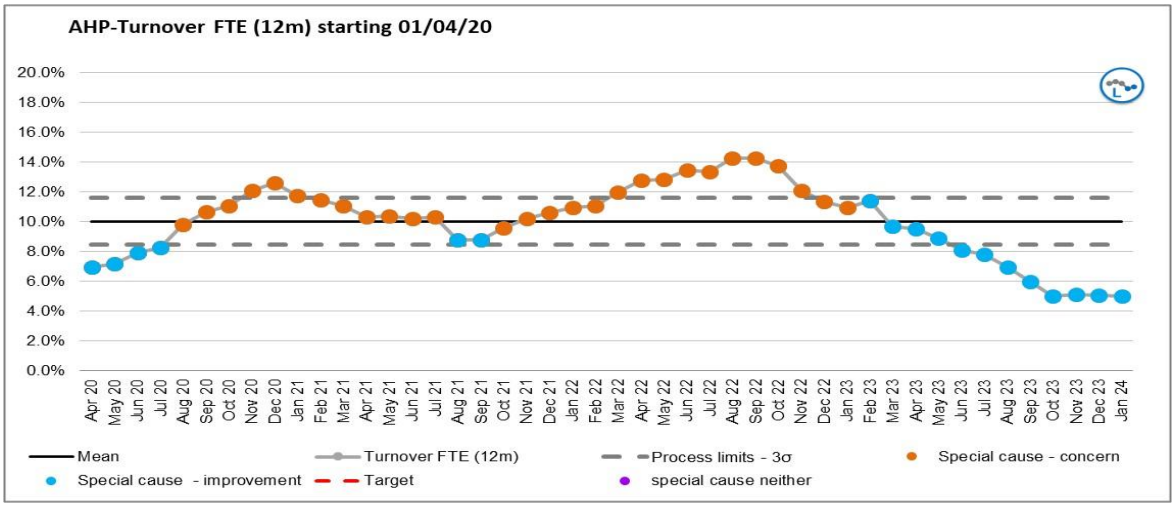
2.4 Allied Healthcare Professional (AHP) Establishment reviews.

For this reporting period, the Chief Nurse held an AHP safer staffing panel meeting. The principles that provide the framework for all safer staffing panel meetings were adhered to and reflected those identified within the Developing Workforce Standards (2018).

The Community Division continues to employ an AHP workforce manager to embed the recommendations from Health Education England's (HEE) AHP Workforce

Strategy including the associated recruitment initiatives. This post provides leadership to the AHP Clinical Educators who are now in post to improve the experience and development of the support workforce, students and registered workforce to optimise patient care. The team are also responsible for recruitment and retention initiatives with qualitative and quantitative data demonstrating a significant benefit. A successful business case accessing tariffs monies has been approved to secure permanents funding for the workforce manager and senior clinical educator post.

The work of the Nursing, Midwifery and AHP Workforce Steering Group, has commissioned the development of an AHP recruitment and retention tracker. This tracker provides projections based on current turnover rates to determine and provide oversight of potential clinical hotspots. This is monitored monthly and informs the AHP workforce team of where focus is required. Since the employment of the AHP workforce team the turnover rate of AHPs has reduced from 12% (November 2022) to 6% (September 2023), a position which continues to be maintained (figure 1).



(Figure 1)

As has been previously reported several factors have been attributed to the reduction in the turnover rate including but not limited to:

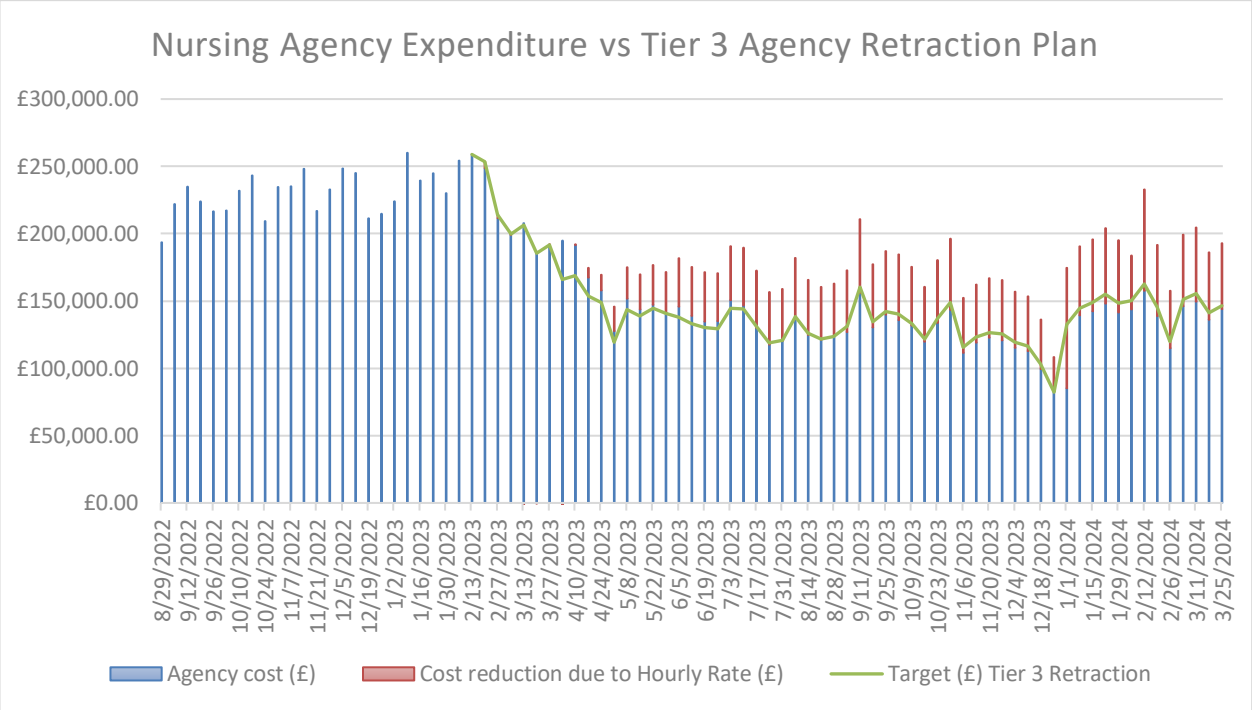
- The development of career pathways from entry at level 2 apprenticeship to advanced clinical practitioner or management roles.
- Preceptorship established across AHP's.
- 25% increase in student capacity across physiotherapy and OT
- The development of several new roles:
  - Professional Lead SALT
  - Professional Lead Dietitian
  - Principal SALT for Critical Care
  - Band 5 OT rotation within SWYFT
  - Band 5 PT rotation within Research
  - Non-AHP team leader roles
  - Assistant practitioners (as rehab assistants and discharge co-ordinators, joint role)

2.5 Agency Usage

CHFT introduced a high-cost Agency Retraction plan in February 2023. As part of the plan, visibility of vacant shifts to Tier 3, which are the most expensive agency option available, was reduced. As a result of this, Tier 3 Nursing Agency bookings reduced steeply from mid-April into May 2023, subsequently ceasing entirely as of July 2023. Due to very limited visibility of available shifts, 4 out of 5 Tier 3 agencies agreed to review their rates and align themselves with Tier 1 rates, which offers supply at a substantially reduced cost to CHFT.

Figure 2 shows the reduction in cost due to the improved average hourly rate position costs for temporary Nurse staffing for 2023/24.

The average hourly rate has significantly decreased from £53 per hour on average (prior to agency retraction plan) to approximately £39 per hour. Although this is positive and means we are receiving much better value for money, the volume of agency usage has not decreased in line with CHFT's improved band 5 nursing vacancy position as expected.



(Figure 2)

3.0 NATIONAL COMPLIANCE

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

The recommendation from the Chief Nurse is there continues to be good compliance with the Developing Workforce Safeguards (next review schedule June/July 2024).

4.0 SICKNESS AND ABSENCE LEVELS

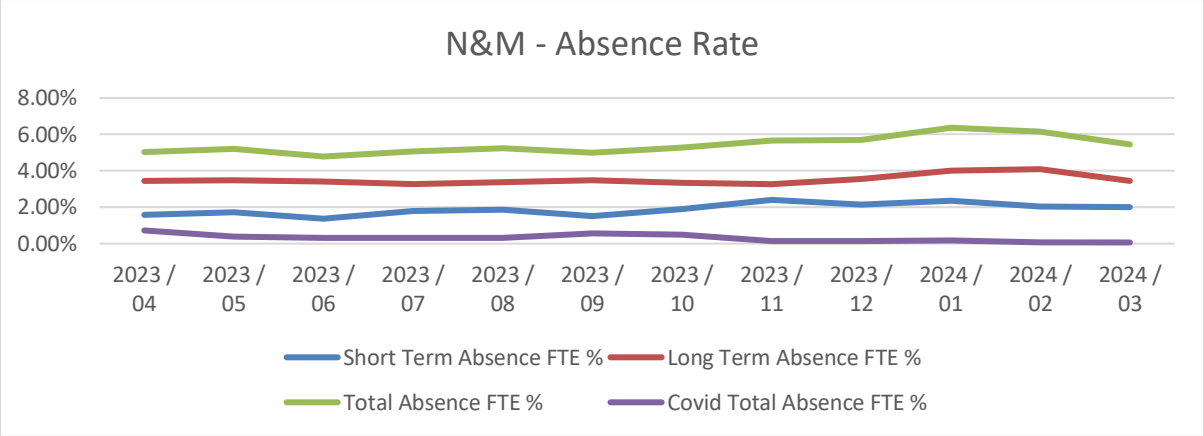
Figures 3 - 8 show the sickness level at the Trust during the reporting period.

During the reporting period total absence continued to be a challenging position with peaks in January across all workforce groups. The top 3 reasons for absence are anxiety, stress and depression, musculoskeletal and gastrointestinal. Whilst Covid absence has generally dropped throughout the year, a slight increase can be seen during the winter months.

<u>Qualified Nursing & Midwifery</u>

Month	ST FTE Lost	LT FTE Lost	Total FTE Lost	Available FTE	Short Term Absence FTE %	Long Term Absence FTE %	Total Absence FTE %	Covid Short Term Absence FTE %	Covid Long Term Absence FTE %	Covid Total Absence FTE %
2023 / 04	823.72	1,802.42	2,626.13	52,283.26	1.58%	3.45%	5.02%	0.43%	0.29%	0.72%
2023 / 05	935.57	1,896.41	2,831.98	54,244.91	1.72%	3.50%	5.22%	0.13%	0.25%	0.38%
2023 / 06	718.94	1,793.96	2,512.90	52,506.90	1.37%	3.42%	4.79%	0.09%	0.22%	0.31%
2023 / 07	969.08	1,779.14	2,748.22	54,145.21	1.79%	3.29%	5.08%	0.10%	0.22%	0.32%
2023 / 08	997.89	1,816.27	2,814.16	53,874.17	1.85%	3.37%	5.22%	0.14%	0.16%	0.30%
2023 / 09	792.23	1,825.31	2,617.54	52,322.78	1.51%	3.49%	5.00%	0.39%	0.18%	0.57%
2023 / 10	1,057.21	1,855.33	2,912.54	55,345.54	1.91%	3.35%	5.26%	0.35%	0.14%	0.49%
2023 / 11	1,290.17	1,755.47	3,045.64	53,726.24	2.40%	3.27%	5.67%	0.12%	0.04%	0.15%
2023 / 12	1,184.02	1,975.23	3,159.25	55,581.31	2.13%	3.55%	5.68%	0.14%	0.00%	0.14%
2024 / 01	1,314.50	2,213.15	3,527.65	55,403.31	2.37%	3.99%	6.37%	0.17%	0.00%	0.17%
2024 / 02	1,064.80	2,124.26	3,189.06	51,938.06	2.05%	4.09%	6.14%	0.09%	0.00%	0.09%
2024 / 03	1,110.89	1,917.07	3,027.96	55,588.68	2.00%	3.45%	5.45%	0.06%	0.00%	0.06%

(Figure 3)

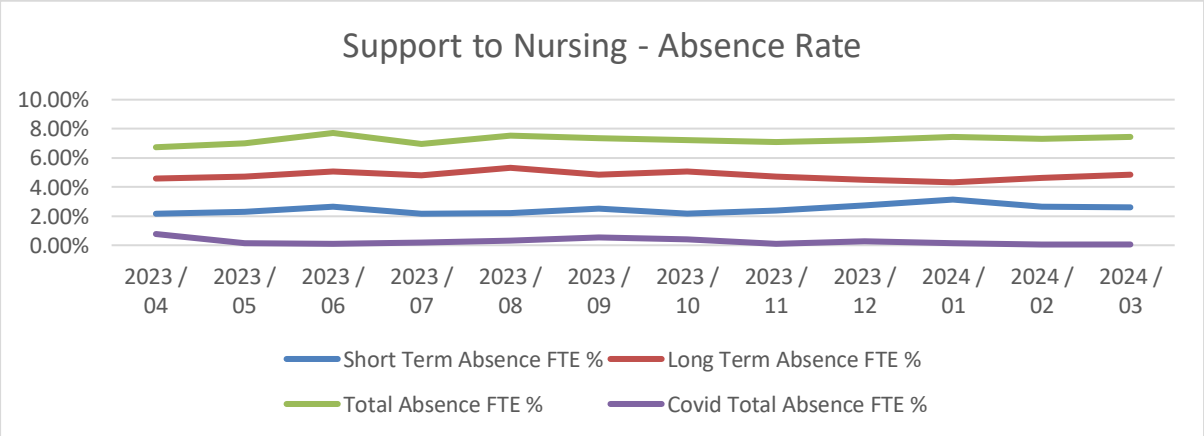


(Figure 4)

Nursing support

Month	ST FTE Lost	LT FTE Lost	Total FTE Lost	Available FTE	Short Term Absence FTE %	Long Term Absence FTE %	Total Absence FTE %	Covid Short Term Absence FTE %	Covid Long Term Absence FTE %	Covid Total Absence FTE %
2023 / 04	536.29	1,126.57	1,662.87	24,695.41	2.17%	4.56%	6.73%	0.57%	0.20%	0.77%
2023 / 05	584.76	1,212.15	1,796.91	25,603.46	2.28%	4.73%	7.02%	0.08%	0.05%	0.13%
2023 / 06	663.28	1,272.29	1,935.57	25,095.16	2.64%	5.07%	7.71%	0.04%	0.05%	0.09%
2023 / 07	544.13	1,195.67	1,739.79	25,006.91	2.18%	4.78%	6.96%	0.15%	0.05%	0.21%
2023 / 08	553.05	1,342.12	1,895.17	25,227.46	2.19%	5.32%	7.51%	0.29%	0.05%	0.34%
2023 / 09	620.72	1,186.20	1,806.92	24,505.57	2.53%	4.84%	7.37%	0.50%	0.05%	0.56%
2023 / 10	551.38	1,287.83	1,839.21	25,392.29	2.17%	5.07%	7.24%	0.37%	0.05%	0.42%
2023 / 11	579.19	1,156.39	1,735.57	24,474.05	2.37%	4.72%	7.09%	0.10%	0.01%	0.11%
2023 / 12	683.25	1,119.26	1,802.51	25,019.45	2.73%	4.47%	7.20%	0.27%	0.00%	0.27%
2024 / 01	784.89	1,081.47	1,866.36	25,014.99	3.14%	4.32%	7.46%	0.14%	0.00%	0.14%
2024 / 02	622.00	1,082.23	1,704.23	23,378.75	2.66%	4.63%	7.29%	0.05%	0.00%	0.05%
2024 / 03	657.07	1,225.44	1,882.51	25,354.91	2.59%	4.83%	7.42%	0.06%	0.00%	0.06%

(Figure 5)

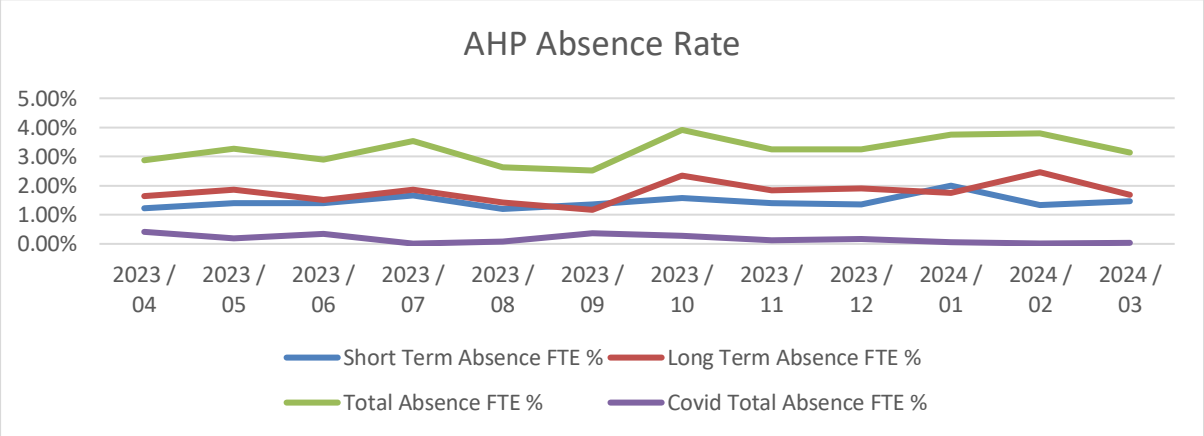


(Figure 6)

Allied Health Professionals

Month	ST FTE Lost	LT FTE Lost	Total FTE Lost	Available FTE	Short Term Absence FTE %	Long Term Absence FTE %	Total Absence FTE %	Covid Short Term Absence FTE %	Covid Long Term Absence FTE %	Covid Total Absence FTE %
2023 / 04	173.05	232.07	405.11	14,142.37	1.22%	1.64%	2.86%	0.15%	0.26%	0.41%
2023 / 05	204.09	271.55	475.64	14,536.18	1.40%	1.87%	3.27%	0.06%	0.14%	0.19%
2023 / 06	194.88	209.20	404.08	13,935.22	1.40%	1.50%	2.90%	0.21%	0.14%	0.35%
2023 / 07	239.24	269.00	508.24	14,396.96	1.66%	1.87%	3.53%	0.00%	0.01%	0.01%
2023 / 08	175.64	208.88	384.52	14,652.95	1.20%	1.43%	2.62%	0.07%	0.00%	0.07%
2023 / 09	199.08	172.32	371.40	14,741.91	1.35%	1.17%	2.52%	0.37%	0.00%	0.37%
2023 / 10	247.63	366.57	614.20	15,692.37	1.58%	2.34%	3.91%	0.28%	0.00%	0.28%
2023 / 11	218.60	285.27	503.87	15,532.74	1.41%	1.84%	3.24%	0.12%	0.00%	0.12%
2023 / 12	219.13	309.51	528.64	16,296.04	1.34%	1.90%	3.24%	0.18%	0.00%	0.18%
2024 / 01	327.31	286.88	614.19	16,376.34	2.00%	1.75%	3.75%	0.07%	0.00%	0.07%
2024 / 02	206.00	378.09	584.09	15,359.66	1.34%	2.46%	3.80%	0.01%	0.00%	0.01%
2024 / 03	241.94	276.55	518.49	16,480.97	1.47%	1.68%	3.15%	0.03%	0.00%	0.03%

(Figure 7)



(Figure 8)

5.0 SAFER STAFFING (HARD TRUTHS) DATA

Safer staffing reviews are a process initiated by NHS England and the Care Quality Commission (CQC) (2014). It combines the robust Trust annual and bi-annual staffing reviews with a commitment to greater openness and transparency by publishing data regarding nursing, midwifery, and care staff levels. This data is provided through the monthly Trust report to NHSE, detailing both registered nursing and midwifery staffing numbers and unregistered support staff numbers. The data also includes the Trust provision of care hours per patient day (CHPPD). This data for all acute Trusts is published on NHS Model Hospital.

CHPPD is the national benchmark measure for safer staffing and provides a single consistent way of recording and reporting deployment of staff working on inpatient wards/units. It is calculated by totalling the number of hours worked by registered nurses, nursing associates, and in some cases allied health professionals, as well as

healthcare support worker on each ward for the 24-hour period, then dividing by the number of patients on the ward each day at midnight.

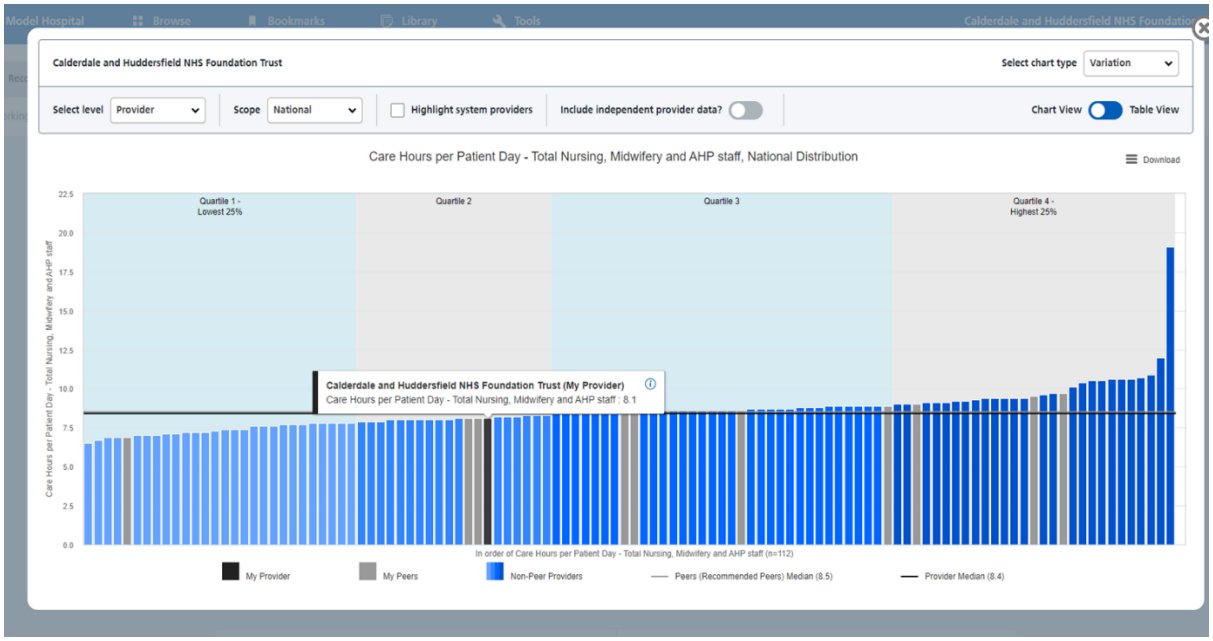
Due to the way it is calculated, actual CHPPD is influenced not only by numbers of staff on duty, but also the bed occupancy. Therefore, wards with fewer patients, or with high numbers of day-case patients who are discharged prior to midnight, demonstrate significantly higher CHPPD. It should be noted that **CHPPD reveals the total nursing and support worker hours available per patient on the ward at midnight**. It does not reflect the actual hours required to meet the care needs for these patients, which could be significantly more for those with high acuity or dependency, or fewer for patients with low acuity and who are independent in self-care.

Required care hours are calculated separately, using real-time patient acuity and dependency data which is recorded on the Safecare application. The required hours can then be compared with available hours. This is used to inform the twice daily staffing meetings to ensure deployment of staff according to care demand at the time. Safecare was updated on 1 April 2024 to ensure the acuity and dependency categories on Safecare were in line with the new Safer Nursing Care Tool (SNCT) categories used to capture the bi-annual acuity and dependency data.

The Model Hospital platform https://model.nhs.uk is used to benchmark the CHFT nursing workforce data against the national average, as well as 'Peer Hospital' data. This data is generally updated quarterly, the analysis of which is reported to the monthly Safe, Sustainable and Productive Staffing Meeting as part of the group workplan.

There is no 'correct' number of CHPPD to be achieved. However, significant variation from the national average or the 'peer group' average, should warrant further investigation. CHPPD significantly higher than average could indicate inefficiencies in staffing. CHPPD significantly lower than average could indicate too few staff and associated patient safety risks.

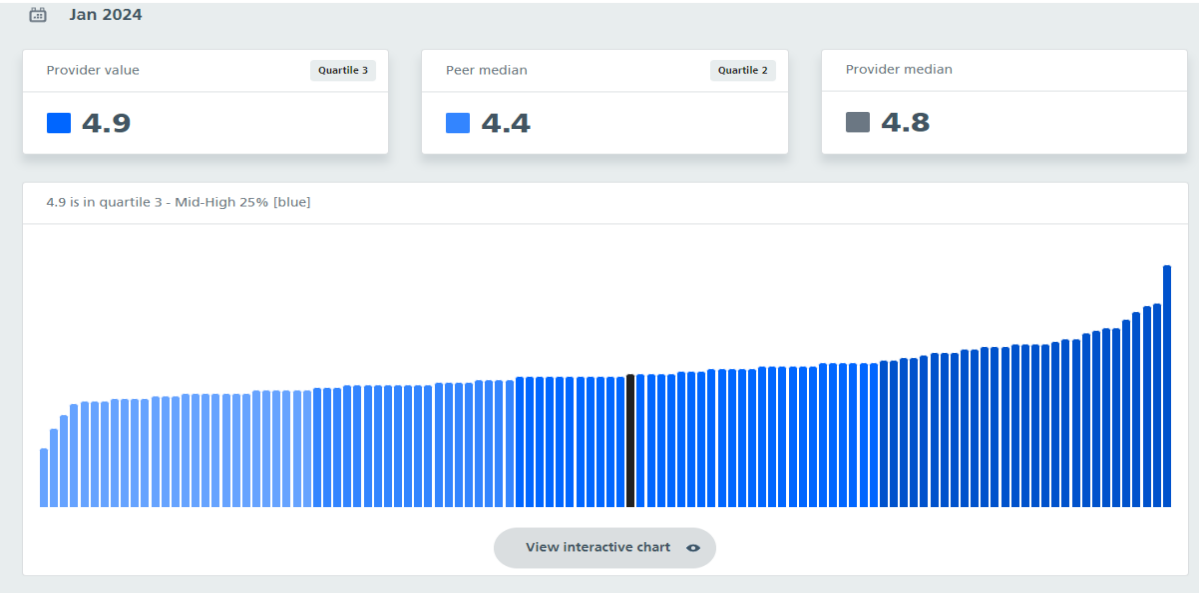
The information from Model Hospital on CHPPD is from January 2024 data. Review of this data reveals CHFT to be in the quartile 2 providing 8.1 CHPPD at Trust level (figure 9). The national median CHPPD for January 2024 was 8.4 CHPPD with the peer median being 8.5 CHPPD. Seven peers provide more CHPPD than CHFT (highest 9.1), with the remaining three peers providing fewer CHPPD (lowest 6.4). This latest data shows a relatively static benchmark position of CHFT for CHPPD since the previous report which outlined the July 2023 position.



(Figure 9)

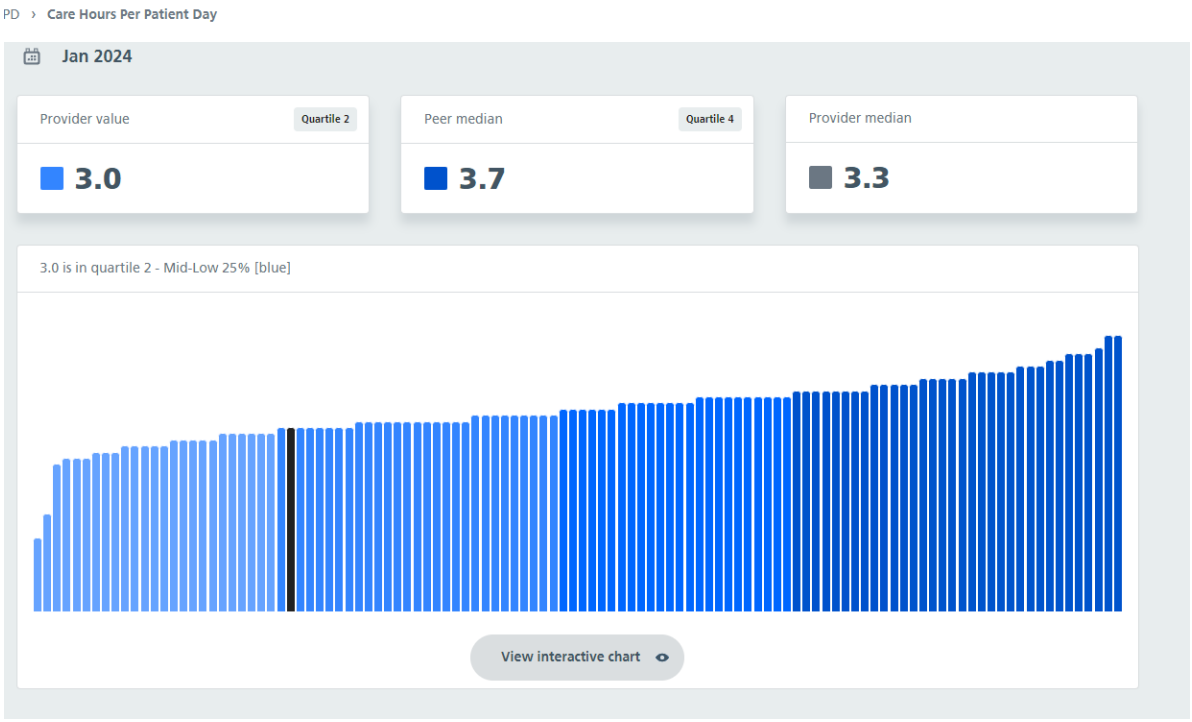
In addition to Trust-wide total CHPPD the Model hospital can be used to benchmark the care hours provided by Registered Nurses and Midwives compared to the CHPPD provided by Healthcare Support Workers, thereby giving an indication of the CHFT benchmark with respect to skill mix.

Review of the latest Model Hospital data (January 2024) revealed the CHPPD hours provided by registered nurses and midwives was in quartile 3 at 4.9, this compared to a national median of 4.8 and a peer median of 4.4 (figure 10).



(Figure 10)

CHPPD provided by healthcare support workers at CHFT was 3.0 This compared to a national median of 3.3 hours and a peer median of 3.7 hours (figure 11).



(Figure 11)

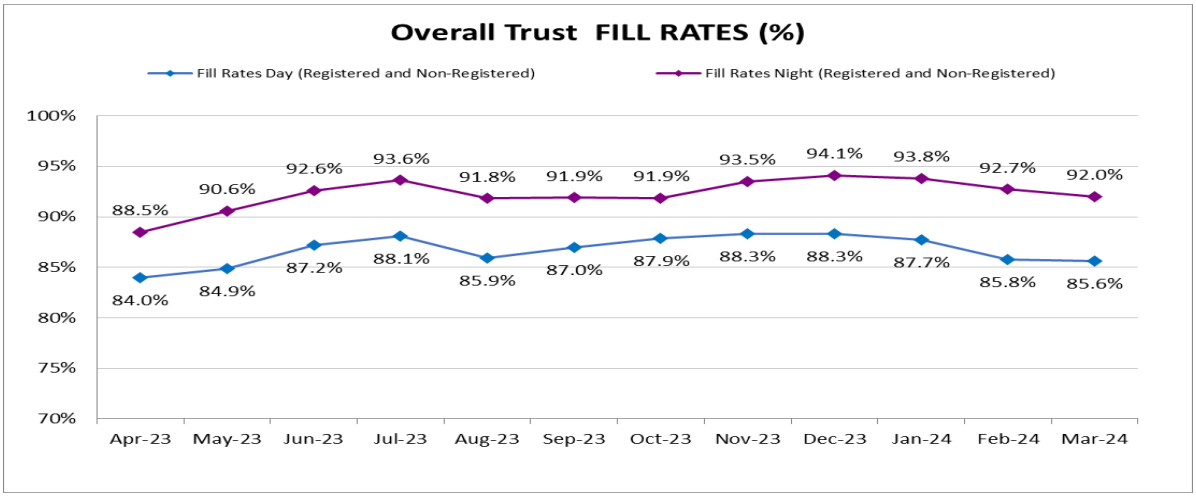
Review of this latest Model Hospital data gives no indication that CHFT is a significant outlier with respect to total CHPPD, or to the CHPPD skill mix provision.

<u>Fill rates.</u>

Whilst fill rates are no longer a reporting requirement to NHSE they continue to be a useful measure for analysis. Fill rates are calculated by comparing planned hours against actual hours worked for both registered nurses (RNs) and health care support workers (HCSW). Factors affecting fill rates include:

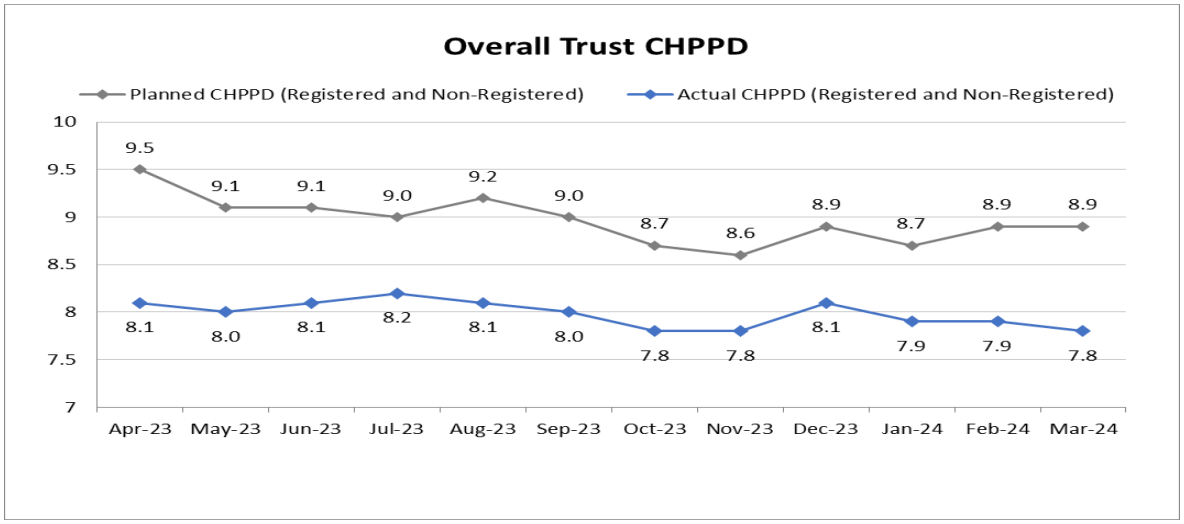
- Sickness (lower if not filled)
- Vacancies (lower if not filled)
- Enhanced Care Support Worker requirements, otherwise known as 1:1 observation (when additional staff above agreed WFM are rostered on to support)

For the reporting period, fill rates continued to fluctuate between 84% - 88.3% during the day (figure 12).



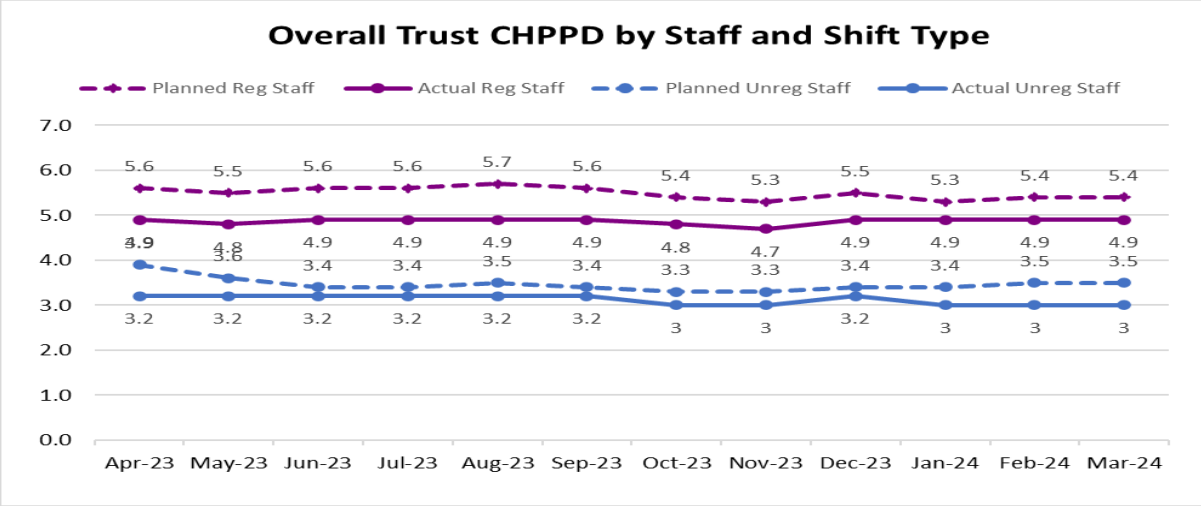
(Figure 12)

This position continues to impact on the overall Trust CHPPD position with an ongoing shortfall reported between planned and actual care hours during the reporting period (figure 13). This is reflective of the ongoing sickness/absence position, opening of additional escalation areas, in addition to supporting enhanced service delivery in some areas.



(Figure 13)

In recognising the established relationship between higher registered nurse staffing and improved patient outcomes and care quality (Griffiths et al 2020), figure 14 breaks down the CHPPD by staff groups. Analysis over the reporting period indicates the gap within the RN workforce is reducing, conversely towards the latter part of the year the HCSW gap is broadening.



(Figure 14)

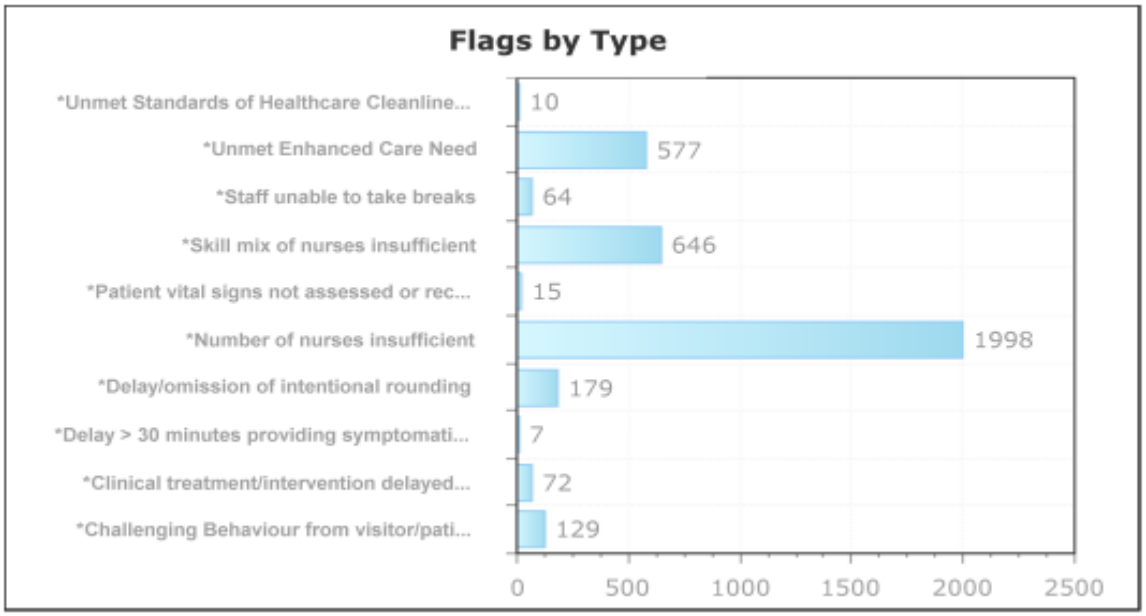
Addressing workforce shortfalls is managed through divisional team rostering processes and twice daily staffing meetings which are chaired by divisional Matrons. These processes support the staffing resource being safely flexed to meet patient demand, activity, and acuity and the continued effort given by our teams to ensure service provision remains outstanding.

5.1 Red Flag Escalation

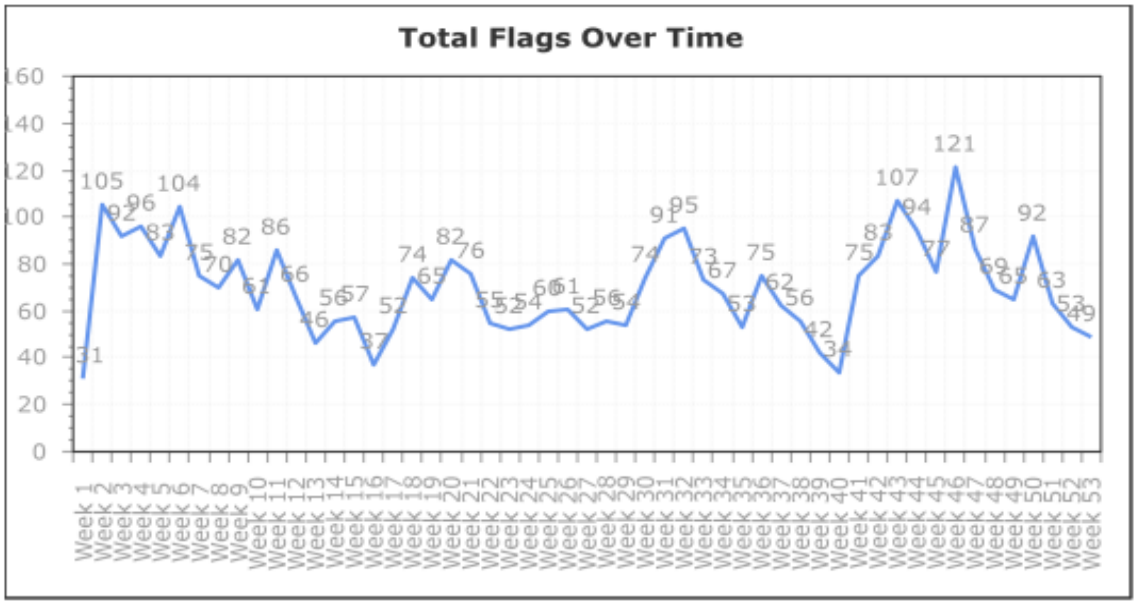
To supplement the process of rating the status of staffing requirements within the roster system, a system of red flag escalation has been developed in line with NICE (2014) guidance. Nursing red flags are events that have an impact on the way care is delivered to patients, therefore requiring a prompt response by the Nurse in Charge or a more senior nurse to mitigate patient safety concerns. Nursing red flags can be raised at any point during a shift.

The red flag process forms a key part of the governance arrangements and ongoing monitoring of the staffing position. The reporting of red flags is identified and responded to within the twice daily staffing meetings.

Figure 15 provides a breakdown of red flags for the reporting period 1st April 2023 – 30th March 2024, with insufficient number of nurses, the most reported category.



(Figure 15)



(Figure 16)

A downward trend in the reporting of Red Flags is demonstrated in figure 16 which may be related to the improving Band 5 vacancy position. This position correlates to the stepping down of the OPEL (Operational Pressures Escalations Levels) safe staffing score from an OPEL 3 to OPEL 2.

In isolation this data does not provide a clear understanding of the actual impact upon patient experience or the workforce in delivering patients' care. It is recognised that despite no adverse clinical outcome, delays in care have the potential to negatively impact the overall experience of patients and colleagues.

5.2 Quality

There is a well-established correlation between staffing levels, safe care and patient experience.

As such it is important for any staffing review to take into consideration the quality of the care provided using nurse sensitive indicators. For this report four recognised nurse sensitive indicators have been used: Friends and Family Test, falls and pressure ulcer data and medication incidents.

The Enhanced Dashboard Metric has been fully integrated into clinical practice and was reported against during divisional safer staffing panel meetings, supporting the triangulation of several quality metrics against the acuity and dependency data, thereby informing establishment reviews.

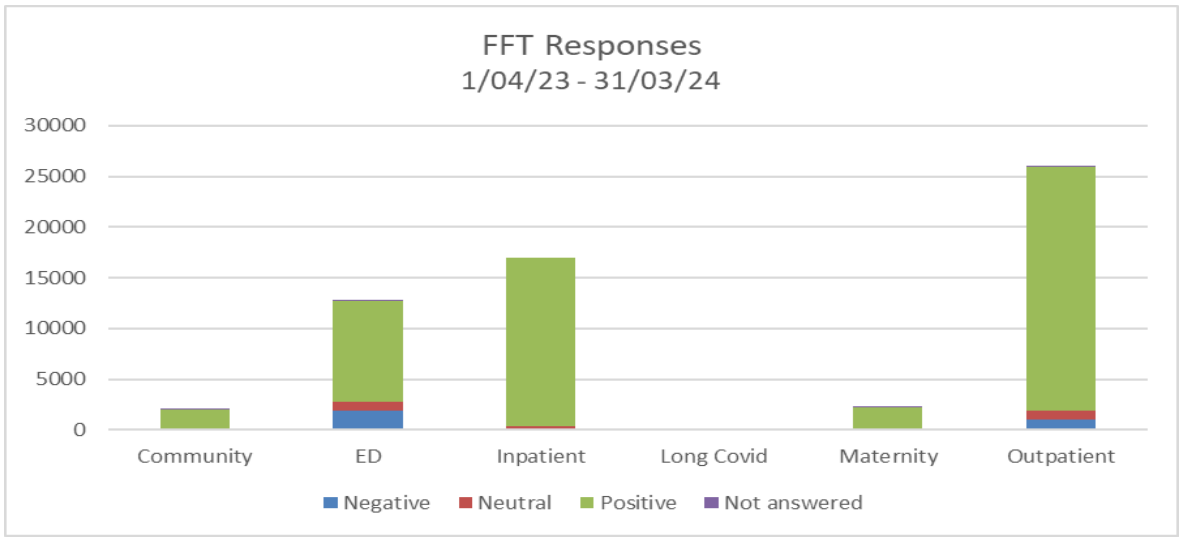
Additionally, the Enhanced Dashboard Metric is reported into the Safe, Sustainable and Productive Staffing meeting monthly. Data within this report is analysed through divisional teams to determine actions required to respond to data triangulation and mitigation against any impacts. Initial engagement with NHSE has indicated positive feedback in the work that is being led within the Trust.

5.2.1 Friends and Family Test (FFT)

Between 1st April 2023 and 31st Mach 2024, the Trust received a total of 59,903 responses to the Friends and Family Tests (FFT).

In September 2023, the Long Covid Clinic was added to the list of services that are externally report the FFT figures to NHS England.

91.4% of patients, carers and family members reported a positive experience whilst receiving care and treatment within the Trust. 5% reported their experience to be negative, and 3.4% described their experience as neither good nor bad.



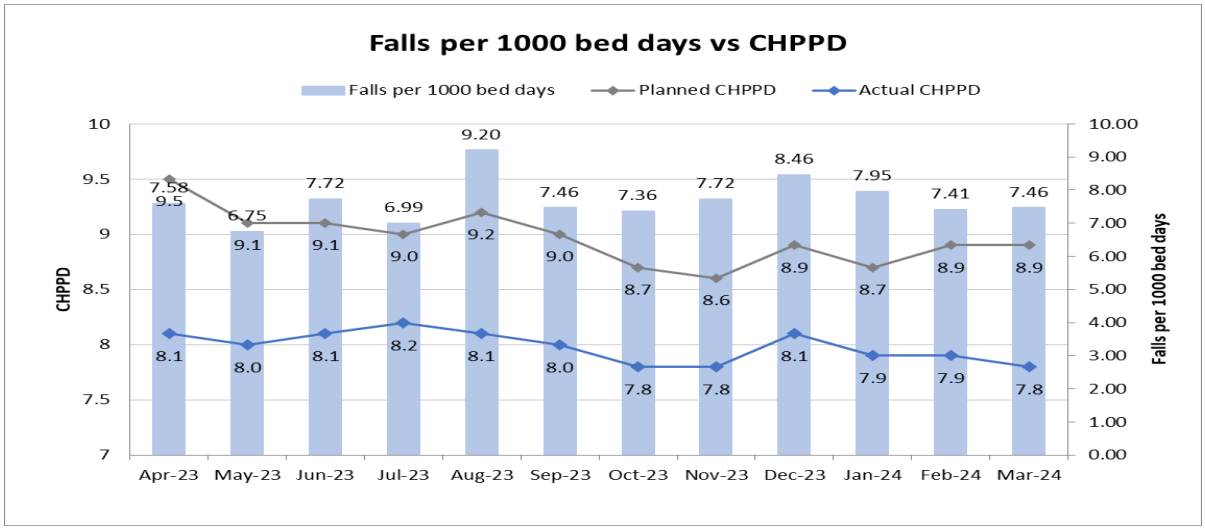
Microsoft Forms continue to be used to ensure data is captured more robustly and the data collated filters into KP+.

5.2.2 Falls and Pressure Ulcers

The charts below provide an overview of the reporting of incidents related to falls, pressure ulcers and medication incidents per 1000 bed days (figure 17 – 19).

Falls

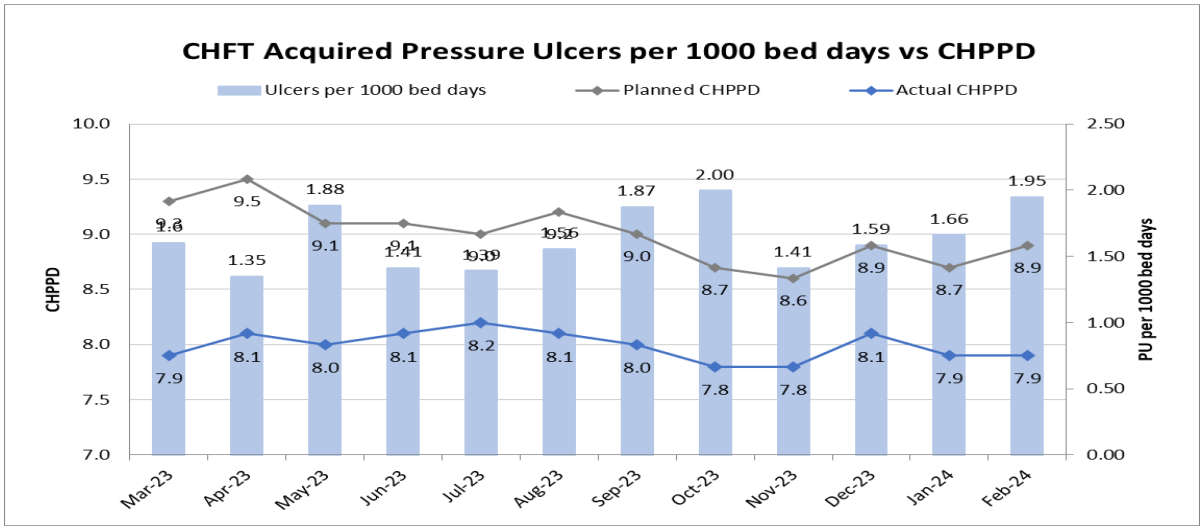
Throughout the reporting period there is a shortfall between the planned and actual CHPPD which fluctuates between 0.8 and 1.4, with the incidence of falls peaking in August where the CHPPD gap is at 1.1 (figure 17). Interestingly, the overall gap in CHPPD is 1.1 also in May where the lowest incidence of fall is reported.



(***Figure 17)***

Pressure Ulcers

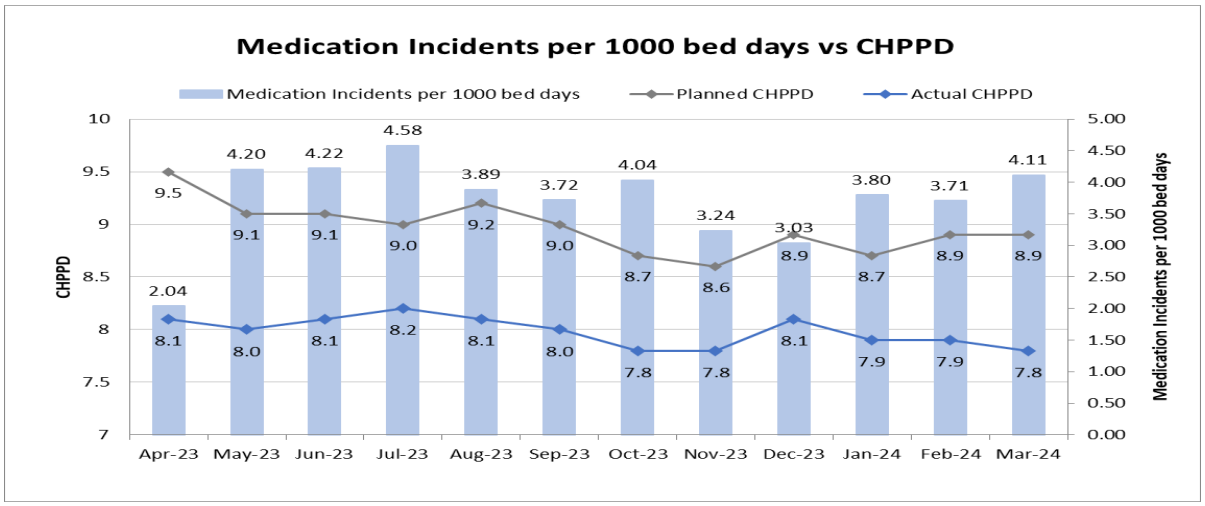
Due to validation processes for the purpose of the reporting period of this report pressure ulcer data is only available up until February 2024. Data for pressure ulcers per 1000 bed days demonstrates a fluctuating position with the highest incidence identified in October where CHPPD demonstrated an overall gap between planned and actual of 0.9. The lowest incidence of pressure ulcers occurred in April when CHPDD reported a 1.4 deficit position between the planned and actual.



(Figure 18)

Medication Incidents

During the reporting period the incidence of medication incidents can be seen to fluctuate with the lowest level of incidents reported in April 2023 where the gap in CHPPD shortfall was reported at its highest with a shortfall of 1.4 (figure 19).



(Figure 19)

Analysis of the data indicates variability in the incidence of the three nurse indicators that may be attributable to the gap in planned and actual CHPPD.

5.2.3 Incident Reporting

There was a total of 360 Nursing & Midwifery staffing related incidents that were reported through the Datix system during the period 01 April 2023 to 31 March 2024. Women's services reported the highest staffing incidents with 223 incidents (215 classed as no harm and 8 classed as minor harm) relating to staffing reported. Of the 360 staffing incidents, 343 incidents were recorded as no significant harm to patients, 12 minor harm and 5 moderate harms. There was appropriate escalation when the incidents occurred, and this is recorded within the incident records.

Throughout the reporting period, there is an evident theme around units in escalation and lack of suitably trained/skilled staff and staff having to be redeployed to other areas for patient safety. This continues to be monitored within the Safe, Sustainable and Productive Staffing meeting with ongoing engagement via a survey to those staff that are redeployed.

The Ward Managers and Matrons for their areas along with the Risk Management Team and the Quality Governance Leads for each division review all incidents daily and highlight any themes and trends so that learning can be collated, and improvements made. In addition to this, the Quality & Safety team continue to hold a weekly MICCI (Mortality, Incidents, Complaints, Claims and Inquests) meeting to ensure triangulation of all areas (including risks and audit). This meeting along with daily oversight of all incidents provides oversight and scrutiny within the Quality & Safety team.

The current Trust Risk Management Reporting Software, commonly known as Datix will be replaced by a new software system called InPhase in Autumn of this year and this will help to triangulate data to ensure learning is captured more robustly.

CHFT'S RESPONSE

6.0 ESCALATION AND REPORTING ARRANGEMENTS FOR QUALITY AND SAFETY

Safe Staffing is a key area of focus and remains one of the Trust's Must Do priorities. Led by the Senior Nursing Team a range of actions remain in place to manage any associated risk. This includes but not limited to:

- A monthly safe, sustainable and productive meeting
- Monthly nursing, midwifery and AHP Steering Group
- Twice daily Nursing and Midwifery Staffing meetings chaired by divisional matrons which are in operation 7 days a week.

The purpose of the staffing meeting is to review the real-time safer staffing assessments and agree actions required to respond to short-term staffing escalations and changing acuity and dependency to assist with staff deployments.

Real-time staffing is provided through Safecare which gives a live view of the nursing staffing position measured against the acuity and dependency of our patients, facilitating comparisons of staffing levels and skill mix to the actual patient demand to maintain safe staffing across the Trust as a whole. Safecare LIVE plays a pivotal role in these meetings providing visibility across wards, transforming rostering into an acuity based daily staffing process that unlocks productivity and safeguards patient safety.

In addition, Safecare allows the nursing team to assist the ward manager with real-time roster management to ensure we have the right person, in the right place, at the right time to inform operational decisions to maintain safer staffing Trust wide.

Decision making within this forum is informed by an appraisal and risk assessment of the divisional information presented and any staffing shortfalls are mitigated against.

7.0 RECRUITMENT AND REGISTERED NURSE TRAJECTORY

The national picture for nursing vacancies remains turbulent, and a concerted emphasis on the NHS Long Term Workforce Plan (NHSE, 2023) has determined growing domestic education and training and increased training provision should be the fundamental building blocks for CHFT's recruitment and retention strategies.

This is supported by the Trust's People Strategy and Recruitment Strategy 2022-2025 and more recently the Colleague Retention Programme.

Below provides further detail surrounding the Trusts related activity:

7.1 International Nurse Recruitment

During this reporting period 49 internationally educated nurses have arrived in the UK for employment at CHFT. 53 nurses have taken the NMC competency test and registered. Following successful changes to the training programme, CHFTs first-time pass rate remained around 45% and stayed above national average across year. Length of programme, test availability and transition when registered adversely effected timeframe for NMC registration and associated supernumerary period. The Clinical Education Team (CET) have promoted confidence and competence via pastoral and clinical support during and following the OSCE programme and have worked with divisions to manage supernumerary time.
The final nurse recruit will arrive in April completing the 2023/24 recruitment target set and agreed with NHSE. This individual is working towards entry to the child part of the register therefore OSCE preparation will be provided by an external company and the OSCE exam will follow in May. The arrival of this final nurse will formally complete the current international nurse recruitment programme, which was paused in December 2023 due to the significant reduction in band 5 vacancies. The recruitment of 248 Internationally Educated Nurses (IEN) across the last 5 years has successfully achieved the original ambition of narrowing the nursing vacancies and supporting of safe staffing.

All nurses have been supported to transition into life within the UK, including a robust training package, wrap around pastoral care and ongoing transitional support on registration; all positively contributing to a low attrition rate.

Pastoral support has been at the centre of this project since its inception and recognised by NHSE as imperative to making international recruitment work. CHFT pride themselves on a programme of pastoral support which includes:

- IR Facebook page for social engagement before and after arrival.
- Access to CHFT's international recruitment specialist who guides recruits through the whole process from interview to taking their test. Assisting with transport, accommodation, visas, registering with GPs, shopping and the local area, booking tests including travel to Ireland.

- A welcome session and booklet that includes information about the UK, the local area and also the NHS including its background and the role of a nurse in the UK today.
- An open-door policy where during working hours all candidates past and present can drop in for support.
- Clinical support and orientation.
- Welcome packs and meet and greets (we are the first people recruits meet when they arrive).
- Support with NMC registration.

During 2022 the NHS Pastoral Care Quality Award was introduced by NHSE. It details a set of standards for best practice and during 2023 CHFT was successfully awarded the quality mark. This formally recognises the CET and Trust's commitment to supporting internationally recruited staff at every stage from recruitment and beyond.

The CET continue to work with others to establish international recruitment in other fields of Nursing, maternity, and AHP groups. Work continued with West Yorkshire Integrated Care Board, members of the Keralan government and colleagues from the family and specialist services division recruiting 1 international nurse into children's services.

Recruitment of internationally educated midwives gained traction during this period with 5 midwives arriving in the UK ahead of the revised December deadline. All have successfully passed their NMC competency tests. Attention is now focused on supporting them to further develop and thrive in their careers at CHFT. Positively attrition is 0%.

The AHP NHSE target has also been met and 3 staff have been recruited and commenced employment. The CET and AHP educator worked collaboratively to ensure there was a robust pastoral and training offer for their arrival in the UK. Further AHP employment is planned with a total of 14 radiographers to support an expansion of services in the development of the community diagnostic centre. This recruitment is progressing with just 2 people still to arrive, it is expected their arrivals will fall within Q1.

As the numbers of internationally educated nurses have increased over the last few years, attention has turned towards professional development opportunities and revalidation support. This is integral in ensuring the Trust has a valued and supported workforce. Activity has included linking with regional and national groups to benchmark CHFT against other organisations. As part of NHSE stay and thrive initiative CET was successful in securing a bid to support the delivery of an international educated development day. This event was attended by around 100 nurses who found it inspiring, motivating, and provided generally positive feedback. A further bid has been submitted and it is hoped a similar event can be offered in summer.

7.2 Recruitment of Newly Qualified Nurses

Together with the recruitment of experienced nurses, new graduate recruitment was targeted throughout the reporting period for the peak course completion points of September and January. CHFT continue to be an attractive employer for the local HEI with most graduates being a University of Huddersfield student. Regular recruitment events, advertising and University engagement continued across year resulting in a favourable pipeline against our vacancy position. Q2 activity focused on transitional support for the applicants including scoping their preferred work areas against divisional vacancies. Q2 through to Q3 resulted in 72 nurses joining the Trust across September-November. Recruitment activity continued across Q3 with a further 16 nurses recruited across winter. All graduates were supported with a welcome event and enrolled in role specific induction and preceptorship programmes which enhances competence and in turn confidence with the aim of retaining those recruited.

Following the introduction of the national preceptorship quality mark in late 2022 benchmarking of CHFTs programme was completed in Q1. Work was undertaken by the CET to ensure CHFT were fully compliant with the framework, resulting in the Trust being awarded the quality mark for the programme. This serves as a national gold standard, with the potential to attract prospective employees to CHFT for their first role. Branding and communications have been undertaken internally and externally to highlight the achievement. The CET will continue to monitor compliance against the framework into the next reporting period to ensure continued compliance with the gold standards and innovation of the preceptorship offer.

CET successfully secured a NHSE bid to develop and deliver a reversed supernumerary concept with the aim of increasing graduate confidence whilst shortening the supernumerary period required. Recruitment to a CE post to support this project and a project plan was initiated early in the reporting period however, there was slippage in the progress of the project due to recruitment and sickness challenges. The timeline was adjusted in agreement with the regional RePair lead and trialled in January 2024. The results are favourable with graduates undertaking the reversed supernumerary method reporting an increase in confidence and ability in managing workload and time effectively and caring independently for patients. The CET plan to repeat the project in 2024 with a larger sample size across more areas. It is anticipated that the project can continue to support graduates with the aim of positively impacting supernumerary time.

At the end of the reporting period 24 graduates are in pipeline for a September start. Plans are in place for an April careers event in which its anticipated there will be a significant number of graduates attend. Attracting final year students remains a priority however the vacancy position is more favourable and collaborative work with the recruitment team continues along with consultation via the NWAHPSG meetings to establish an approach to managing the 2024/25 pipeline, ensuring recruitment remains aligned to workforce requirements and Trust values and priorities.

7.3 Nursing Associate Apprenticeships (TNAs)

27 apprentices successfully registered as Nursing Associates (NAs) during this reporting period, these have been allocated to vacant RN/NA positions across the

Trust. A further 13 are due to complete in the later part of quarter 1 following the completion of cohort 8's training. Work is currently being undertaken with divisional leads around deployment plans and it expected that they will transition into NA roles in June 2024.
There are 4 active cohorts of Trainee Nursing Associates (TNAs) (55 apprentices in total, of which 13 are due to qualify in June 2024). Business case approval was granted securing the programme until 2026 when a further business case will be required, this translates into a further 20 places across 2024. Recruitment activity for cohort 12 commenced in quarter 4 and there are 18 applicants moving through recruitment checks and University enrolment. They will commence the course in June 2024 and plans are being confirmed to support their induction and base training areas. As Nursing Associate numbers grow attention has started to turn to professional development opportunities and revalidation support. A Clinical Educator and Registered Nursing Associate attended the inaugural NA conference in Birmingham in September, which focused on the development of the role. The information gained from these activities will inform and strengthen the support offer and future development of the role. Various workforce planning events have also taken place with divisions to consider utilisation, governance and how the role can be embedded further into our clinical teams and services.

In October Ofsted inspected our TNA HEI provider, University of Huddersfield (UoH) for the first time. Staff including apprentices and members of the CET were asked to support and were interviewed by inspectors as part of the process. A rating of outstanding was awarded, and the UoH shared their appreciation noting the exceptional relationship and collaboration between CHFT and UoH. This rating will positively impact the future recruitment to these programmes.

The NA workforce are making a difference to patient care and services across all divisions, and this was further highlighted during the 2023 University of Huddersfield Apprenticeship Awards when one NA won their category for TNA of the year. The organisation was also shortlisted for large employer. Further submissions are planned for 2024.

7.4 Registered Nurse Degree Apprenticeships

The 2 apprentices on the full 3-year apprenticeship completed their final year, qualifying in January 2024. Deployment into the workforce has been completed for one nurse, unfortunately the other chose to leave the organisation for other opportunities.
A significant milestone was achieved in 2023 when the first Nursing Associates on the 2-year shortened RN apprenticeship successfully completed the course and moved into RN roles, there are now 12 Nurses who have progressed in this way. They have subsequently been enrolled into the relevant preceptorship groups and support will continue to ensure they successfully continue to transition into their new role.

There are 3 active cohorts totalling 16 apprentices at different stages of their training. Recruitment activity will commence later in the year to support a further 5 opportunities to internal Nursing Associates. This supports the Trust's commitment to the 'grow our own' approach to training and development. The course has minimal attrition with only 2 apprentices leaving the programme before completion.

Business case approval was granted for 2024/25 securing a further 10 opportunities across 2 cohorts for NAs wishing to top up to RN. Ambitions for beyond this are being explored within Trust and with partner Universities. Recruitment for the next cohort will commence in Q1 and apprentices will commence their studies in October 2024.

7.5 Return to Practice Nurses

Via our employer model, 3 nurses commenced onto a return to practice course in this reporting period. 1 completed the course and registered with the NMC and following a short period away from CHFT with another employer has now returned and is working as a nurse. 2 students commenced the course in September however 1 needed to leave the course early due to health reasons. The other student has required an extension to complete and is expected to register with the NMC in the next quarter. Following a downward trend in interest and applications across 2023 recruitment to the February 2024 intake was unsuccessful. This is reflective of the national position and intelligence from the regional NHSE lead suggests CHFT's numbers are in line with others in region. A meeting is scheduled with the regional lead to explore further and to allow us to strategize plans to recruit to this programme on balance with the improved vacancy position in Trust.

It should be noted that section 7.1 – 7.5 reflects activity that is led by the Clinical Education Team, for which the workload has grown significantly over recent years to support the recruitment agenda. In response to this, and the ambitions set out in the NHS Long Term Workforce Plan, the increased undergraduate work was recognised through approval of a business case to access student tariff monies to increase the educator workforce. This effectively ensured posts previously funded by non-recurrent monies were made substantive.

7.6 Retention initiatives

In response to a national rise in registered nurse attrition since the start of the pandemic, NHSE launched a national retention strategy in July 2022: NHS England » Looking After Our People – Retention .

Important principles to consider are:

- Targeted interventions for different career stages are required: early career, experience at work and later career. There are different risk points related to job satisfaction and retention of nurses and midwives at these stages, and CHFT's response and support needs to be tailored accordingly.

- Bundles of high-impact actions are more effective than single actions. A bundle approach is needed to deliver sustained gains, applied to the different career stages and informed by evidence of what drives job satisfaction, experience and therefore retention.

The strategy focussed on the 5 high-impact interventions to improve the experience of nurses and promote retention of staff.

- Implementation of Legacy Mentoring: Early Career Retention

  Money from NHSE was used to pilot a legacy mentor in Community Division The impact of this role, in conjunction with Professional Nurse Advocacy skills will be evaluated as part of this pilot.

- Implementation of the National Preceptorship Framework: Early Career Retention

  The CHFT preceptorship programme has been revised and received the national quality award in October 2023.

- Guidelines and Policies for Menopause Support: Mid/Late Career Retention

  Menopause policy implemented. CHFT achieved Menopause Friendly Workplace Accreditation

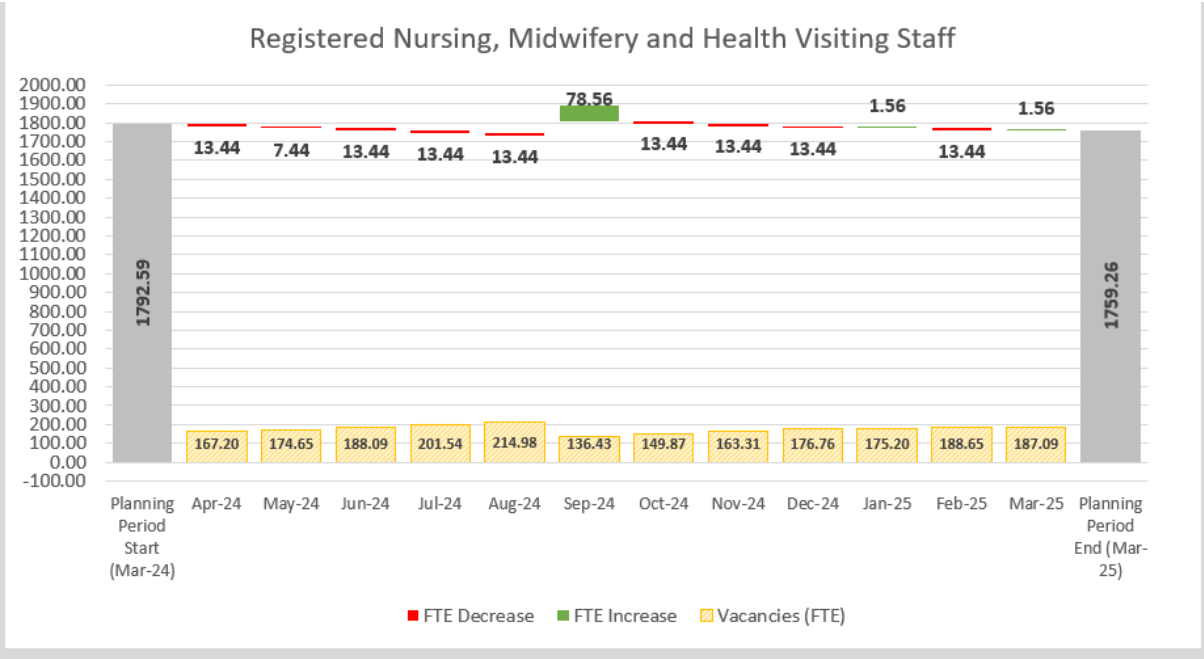
- Encourage Staff to Access Simplified Pensions guidance and Explore Flexible Retirement Options: Late Career Retention

  Links to pensions advice available on the intranet. Policies being updated in light of new NHS pensions scheme regulations.

- Complete the Retention Self-Assessment Checklist
  The self-assessment toolkit was populated in October 2022, and influenced the prioritisation of the retention strategies at CHFT.
  This work is overseen and under review by the Nursing, Midwifery and AHP Workforce Steering Group. The impact of retention strategies will be monitored by business intelligence data on workforce attrition. A further re-appraisal of the retention self-assessment checklist is planned in Q1.

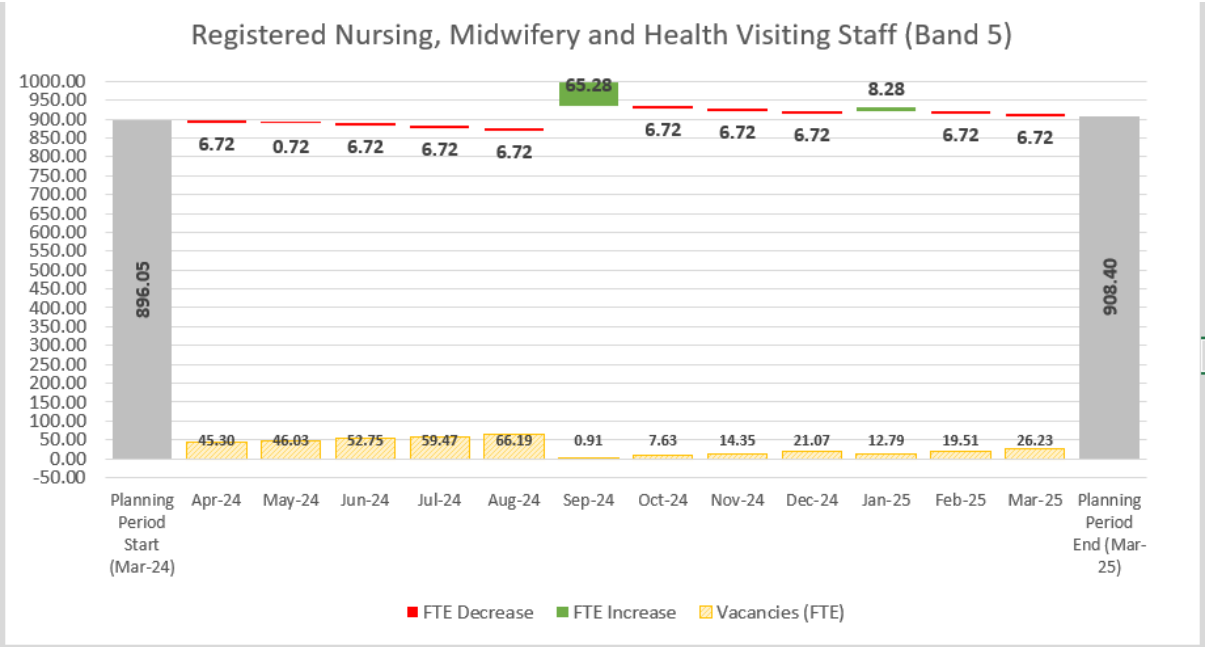
7.7 Summary position

Business Intelligence data reveals a total nursing and midwifery vacancy position of 153.76wte vacancies (figure 20). Of these, there are only 38.58wte band 5 vacancies (figure 21). This is an improved position since the previous report. Recruitment from the June Nursing Associate graduates and September 2024 BSc Nursing graduates is anticipated to completely close these vacancies.



(Figure 20)

In developing a clear position associated with the B5 vacancy position (figure 21), attention is now focused upon understanding vacancies associated across the B6 and above roles. Early findings suggested the actual vacancy position across these areas may be less than that which is reported.



(Figure 21)

In noting the current and ongoing strategies in place to response to the overall nursing vacancy position the related BAF risk 10b/19 has recently been reviewed and maintains an overall risk rating of 12 (appendix 3).

7.8 Health Care Support Workers (HCSW)

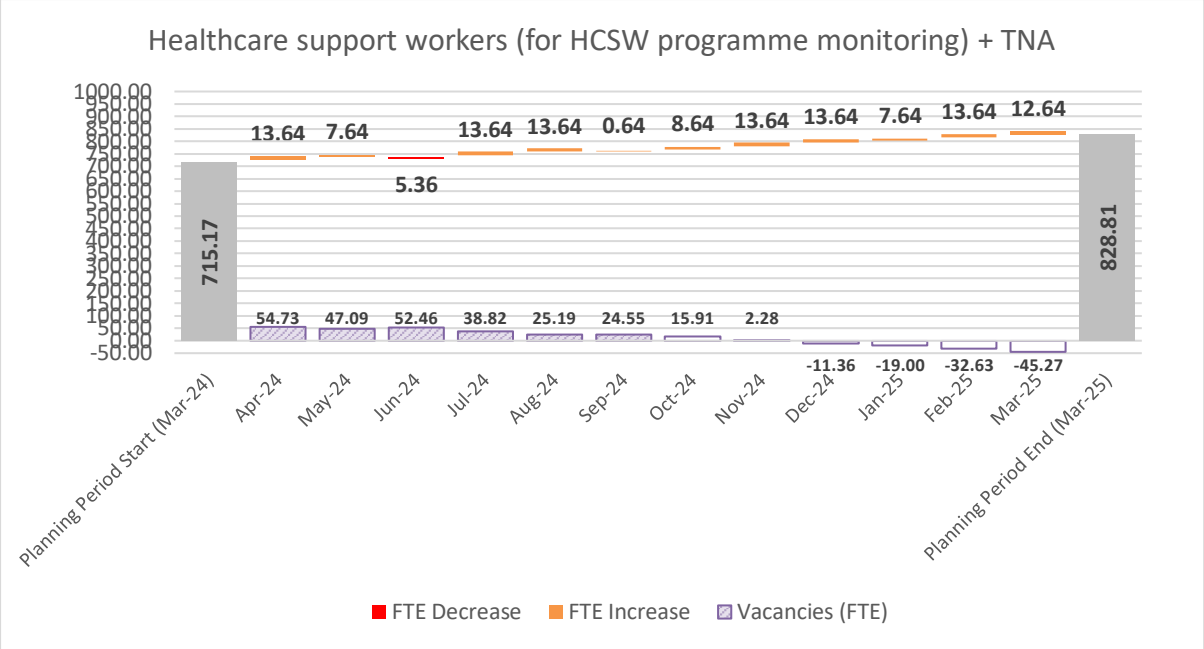
The National ‘Zero HCSW Vacancy’ campaign continues into 2023/24, with an overall aim of growing the Healthcare Support Worker (HCSW) workforce in line with demand, ensuring inclusive and sustainable recruitment while reducing the attrition of existing HCSWs.

At the start of the 2023 financial year NHS/E made the decision to terminate funding associated with the HCSW Programme and stated an expectation that Trusts should now absorb the financial responsibility, because of this the HCSW Recruitment Team were disbanded and the recruitment of HCSWs was placed back into divisions. Decentralisation of recruitment continues with recruitment activity coordinated by divisional teams, allocating to departments on appointment.

The labour market for HCSW’s nationally remains a challenging market and CHFT have not only suffered a reduction in applications over the year but also a reduction in applicants meeting the set CHFT criteria.

It was hoped that the introduction of a “new to care” model, in line with the national programme, would address these challenges by reducing the destabilisation of other health and social care providers whilst creating a sustainable workforce and increasing representation of the local community. Despite a successful expression of interest to the NHS/E HCSW programme to access non-recurrent monies to pilot “new to care” CHFT have determined we are unable to progress this proposal at this time.

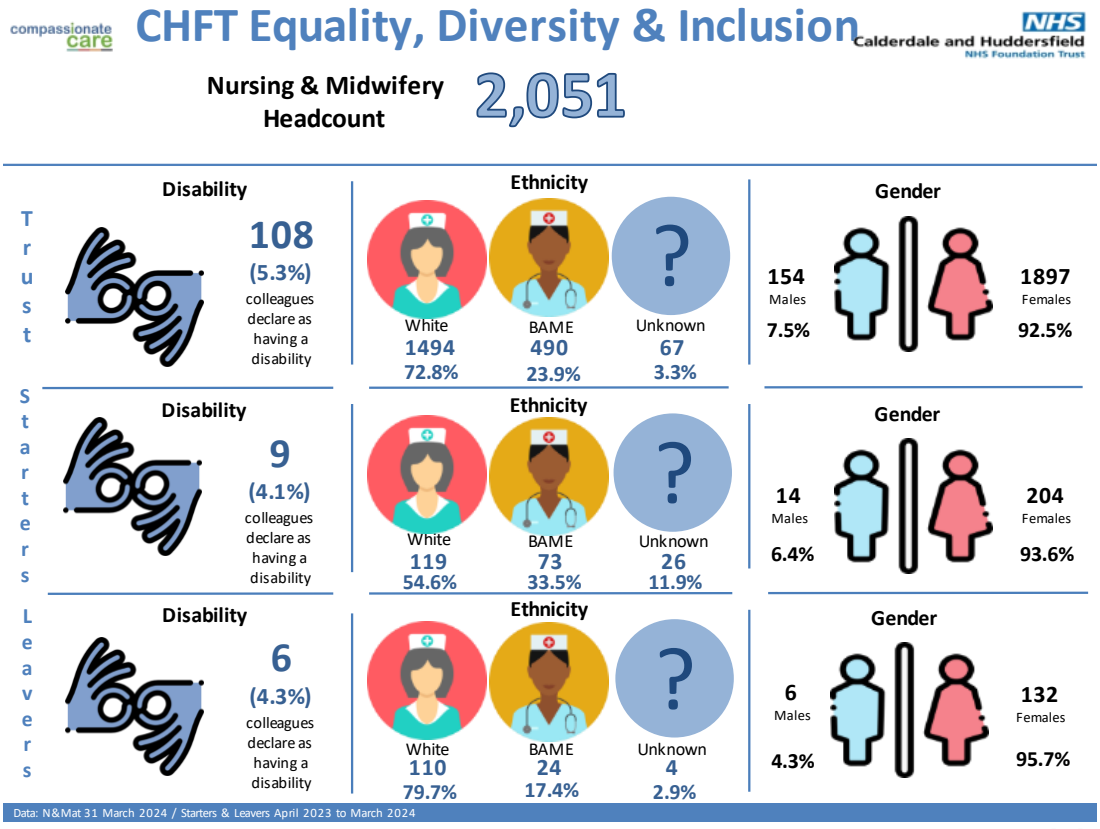
As of March 2024, HCSW including TNA identified a combined vacancy position of **68.37 FTE** (figure 22**)** which represents a deterioration in the vacancy position since the previous report. Based on the assumed turnover rate (9%) and forecast hires HCSW roles will be over established by March 2025. To note, forecasted hires also include the onboarding of HCSW through apprenticeship programme. These projections should be caveated noting the recent rounds of recruitment which have been less successful in terms of appointable candidates.



(Figure 22)

8.0 NURSING, MIDWIFERY AND ALLIED HEALTH PROFESSIONALS' WORKFORCE

8.1 Equality Diversion and Inclusion



(Figure 23)

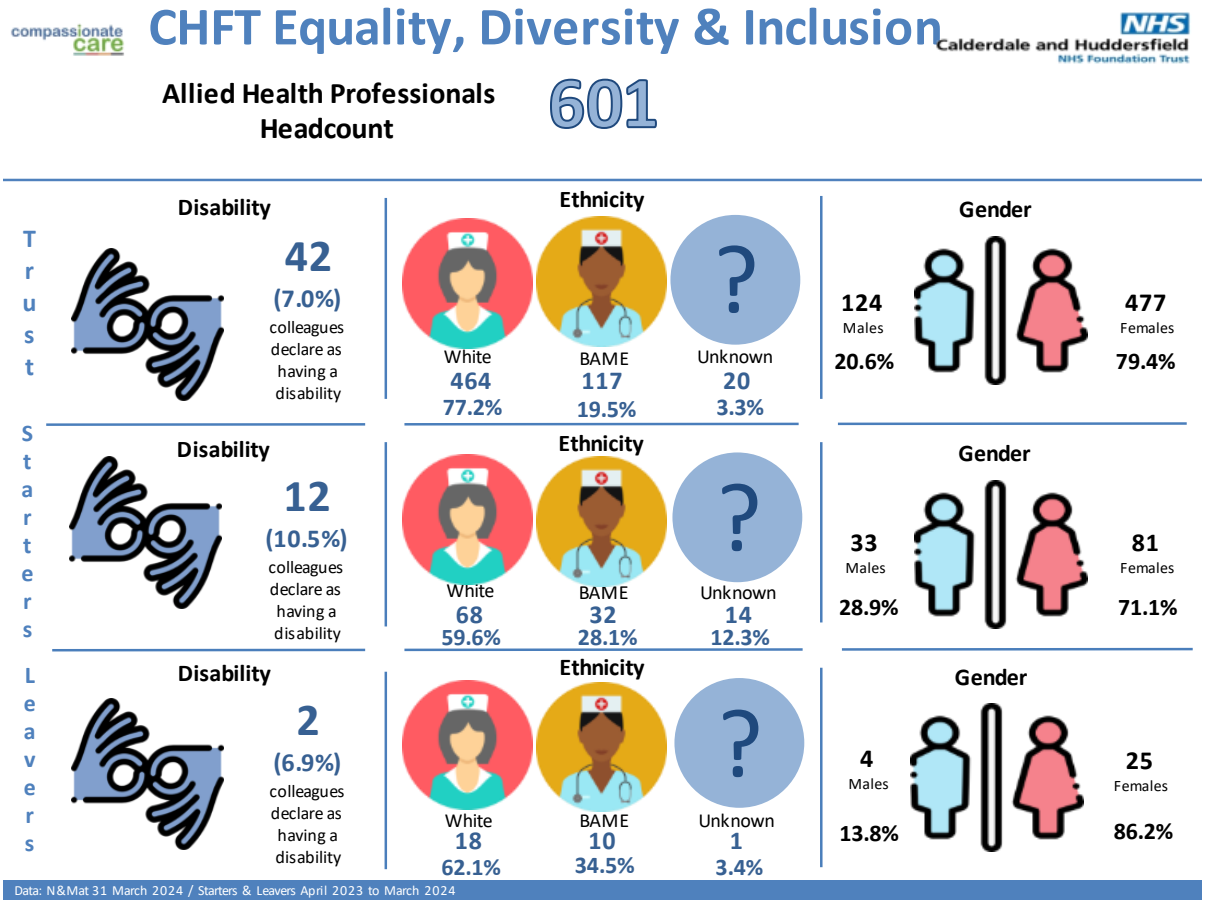
The current qualified nursing and midwifery workforce comprises of 2051 staff, 108 (5.3%) of which have declared a disability, comparable to CHFT as a whole at 5.7%.

490 (23.9%) of all registered nurses at CHFT are of BAME ethnicity, this is below the reported overall CHFT figure of 25.5%, while 3.3% have not declared their ethnic origins.

The majority (92.5%) of RNs are female, this is above the Trust whole workforce gender split of 80.5% female, 19.9% male.

Over the reporting period for Nursing and Midwifery there has been a net: -

- …increase of 14 disabled colleagues.
- …decrease of 15 white staff.
- …increase of 55 BAME staff.
- …increase of 11 staff of unknown ethnic origins.
- …increase of 8 males.
- …increase of 43 females.



(Figure 24)

The current qualified allied health professional's workforce comprises of 601 staff, 42 (7.0%) of which have declared a disability, comparable to CHFT as a whole at 5.7%.

117 (19.5%) of all allied health professionals at CHFT are of BAME ethnicity, this is below the reported overall CHFT figure of 25.5%, while 3.3% have not declared their ethnic origins.

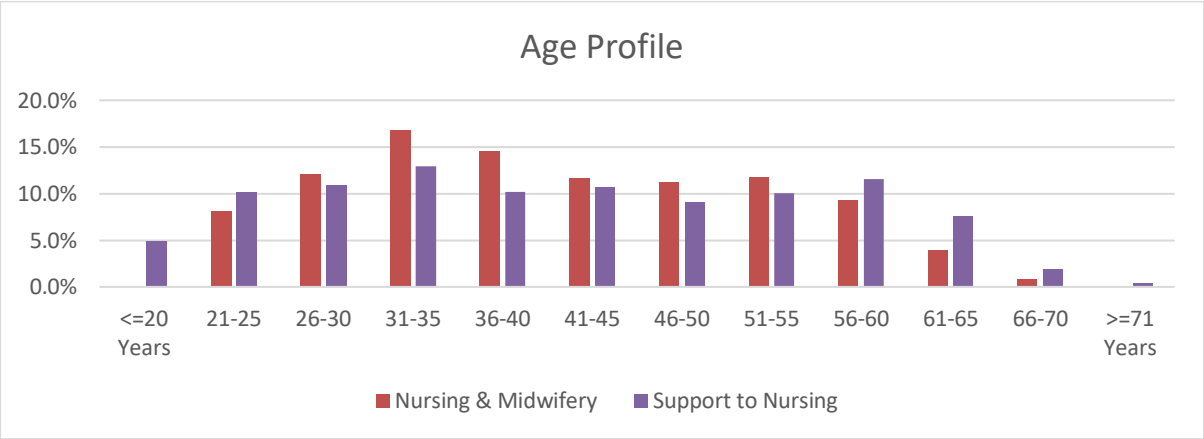
The majority (79.4%) of AHPs are female, this is below the Trust whole workforce gender split of 80.5% female, 19.9% male.

Over the reporting period for Allied Health Professionals there has been a net: -

- …increase of 11 disabled colleagues.
- …increase of 37 white staff.
- …increase of 15 BAME staff.
- …increase of 12 staff of unknown ethnic origins.
- …increase of 2 males.
- …increase of 38 females.

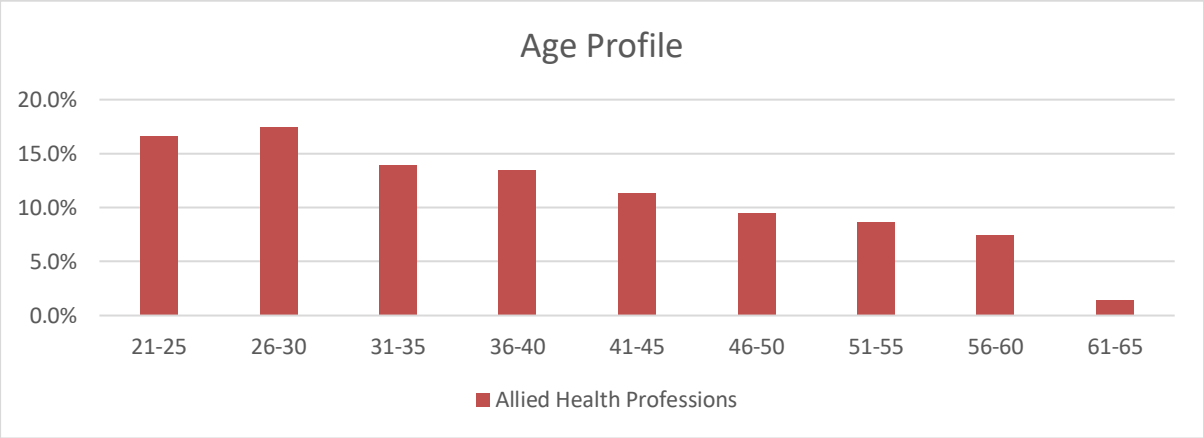
Figure 25 provides a breakdown of the age profiles of both nurses, midwives and support to nursing roles.

Age Profile



(Figure 25)

Figure 26 provides a breakdown of the age profiles of allied health professionals.



(Figure 26)

Work is underway between colleagues in Corporate Nursing and Workforce and OD to further analyse workforce metrics to target high impact actions relating to EDI, recruitment, retention, and wellbeing.

8.2 Revalidation

Revalidation is the process that all nurses and midwives in the UK and nursing associates in England need to follow to maintain their registration with the Nursing and Midwifery Council (NMC). Revalidation promotes continual development and reflection in practice and is a requirement to undertake every three years.

Currently the Trust has 2,051 nursing and midwifery staff and 81 nursing associates. Of these, approximately 645 who are due to revalidate within the next 12 months (495 of these are due in 2024)

The NMC provides a comprehensive suite of resources which support registrants through the process of revalidation. This is signposted through CHFT intranet page which also provides additional information to support the process.

8.3 Nursing and Midwifery Council (NMC) and Health and Care Professions Council (HCPC) referrals

There are currently 21 open NMC cases (one of these cases is an agency nurse) and there are 2 open HCPC cases.

Since 1st January 2024 there has been 8 new NMC cases and 2 new HCPC cases.

9.0 SUMMARY

During the reporting period, except for four clinical areas, establishment reviews have been undertaken as set out within national guidance, based upon the principles of the safer staffing triangulation approach. This approach has informed the changes that have been approved.

The four areas that have not adhered to the principles of safer staffing have been requested to undertake further data collection prior to any consideration for workforce changes can be considered.

10.0 RECOMMENDATIONS

The Board of Directors is asked to: -

- Receive this report and note the on-going plans to provide safe staffing levels within nursing, midwifery and AHP disciplines across the Trust.
- Note the ongoing recruitment and retention plans to support each service.
- Note the maternity staffing position and the local position which is common with the national profile.
- Note the compliance against the triangulated approach that underpins the Trust's establishment processes and the ongoing quality of data it provides.

Appendix 1: SNCT assessment to meet criteria.

Criteria	Y/N	Evidence required
Have you got a licence to use the SNCT from Imperial Innovations?	Y	License agreements signed by Executive Director of Nursing 2023.
Do you collect a minimum of 20 days' data twice a year for this?	Y	Data for the Adult In-Patient Wards and Acute Assessment Areas is now collected for 30 consecutive days in line with the updated SNCT (Nov 2023). This occurs each January and June.
Are a maximum of three senior staffing trained and the levels of care recorded?	Y	Database of training demonstrates all areas have at least one senior person trained, some areas have more than 3 people trained (all at band 6 or above) to enable adequate shift coverage for data collection.
Is an established external validation of assessments in place?	Y	Process has been established to ensure senior staff with no direct management duties will be allocated to ward for each data collection. Evidence is provided with the data collection tool
Has inter-rater reliability assessment been completed with these staff	Y	Training the Trainer was provided by The Shelford Group in July 2021 and updated in November 2023. An on-going in-house training programme is delivered by the Head of Workforce and Education. The train, the trainer and in-house programmes include the assessment of inter-rater reliability.
Is A&D data collected daily, reflecting the total care provided for the previous 24 hrs as part of a bed-to-bed ward round review	Y	Retrospective scoring is collected during each dataset at 3pm daily for inpatient wards and acute assessment areas in line with SNCT guidance. Data is collected for CSNCT in line with guidelines
Are enhanced observation patients reported separately?	Y	Enhanced observation requirements are now captured as part of the new 1c and 1d SNCT categories. The workforce requirements for this are reported separately and used to inform the Enhanced Care Support Worker Team
Has the executive Board agreed the process for reviewing and responding to safe staffing recommendations based on the output of SNCT and professional judgement.	Y	Agreed through previous board reports and approval of the Framework for Agreeing Nursing and Midwifery Staffing Establishments Guidance 2021

Appendix 2: Midwifery BAF Risk 6/23 – ***see agenda item 20: Board Assurance Framework Update 1 for latest risk detail.***

Appendix 3: Nursing BAF Risk 10b/19 – ***see agenda item 20: Board Assurance Framework Update 1 for latest risk detail.***

19. Public Sector Equality Duty (PSED) Annual Report

To Approve

Presented by Suzanne Dunkley, Victoria Pickles and Lindsay Rudge

Date of Meeting:	Thursday 4 July 2024
Meeting:	Public Meeting of the Trust Board
Title of report:	Public Sector Equality Duty (PSED)
Author:	Victoria Pickles, Director of Corporate Affairs
Sponsor:	Suzanne Dunkley, Executive Director of Workforce and Organisation
Previous Forums:	None
Purpose of the Report	The Public Sector Equality Duty (PSED, or "the duty"), which applies in Great Britain (England, Scotland, and Wales), requires public authorities to have due regard to certain equality considerations when exercising their functions, like making decisions. Public authorities are required to publish information annually on how they are complying with the equality duty.
Key Points to Note	The Trust has significantly increased its activities for colleagues, patients, and the public across all protected characteristics during 2023/24. During 2024/25 working with our partners across both places and the West Yorkshire system we will continue to focus on supporting colleagues from these groups directly and through our networks. We will also continue to strengthen our public and patient involvement work and consider how this impacts on health inequalities.
Regulations	CQC Regulation 9: Person-centred care CQC Regulation 17: Good governance CQC Regulation 18: Staffing
EQIA – Equality Impact Assessment	All equality groups have been consulted on the Equality, Diversity, and Inclusion approach we are taking in the Trust.
Recommendation	The Board of Directors is asked to **APPROVE** the Public Sector Equality Duty Report.

Public Sector Equality Duty

Introduction

The Public Sector Equality Duty (PSED, or “the duty”), which applies in Great Britain (England, Scotland, and Wales), requires public authorities to have due regard to certain equality considerations when exercising their functions, like making decisions.

The Public Sector Equality Duty (PSED) sets out the main statutory duty that all public authorities must, in the exercise of their functions, have due regard to the need to:
- eliminate unlawful discrimination, harassment, and victimisation
- advance equality of opportunity
- foster good relations.

Public authorities are required to publish information annually on how they are complying with the equality duty. NHS authorities will also monitor and publish information on the patients who accessed their services in the previous financial year by each protected characteristic.

Our Workforce

Equality, Diversity, and Inclusion is managed across three departments: Workforce equality is led through our Workforce and Organisational Development team; patient experience through our Quality team and Membership by our Company Secretary. Each team is equally responsible for the progress required as part of the PSED.

Teams work closely together to progress our work on equality, diversity, and inclusion as well as health inequalities and the Trust has made good progress on its Health Inequalities strategy.

The people strategy has six chapters:

Chapter	Commitment
Equality, Diversity & Inclusion	We celebrate difference and are inclusive.
Health & Wellbeing	We prioritise colleague health and wellbeing.
Engagement	We seek views and act upon them.
Improvement	We continuously improve services for people.
Talent Management	We grow our own.
Workforce Design	We design services informed by patient and colleague experience.

These chapters and the activity within them are regularly checked via our biannual hot house events where we ask for feedback from colleagues to help inform the organisation what is

working well, what can be improved and any new, creative ideas we could bring to life to progress 'One Culture of Care.'

Equality, Diversity, and Inclusion (EDI)

Equality, diversity, and inclusion is important to CHFT. We have developed a 5-year plan to embed equality, diversity, and inclusion into everything we do in our Trust. We aim to build environments where there are happy, productive, motivated people in our organisation that respects and embraces difference in each other and in our patients. Having a diverse group of people working at CHFT means we have channels to share a whole range of ideas and solutions that, delivers inclusive and compassionate care. A place where everyone is treated equitably, respecting the diversity of all who work here and enable all colleagues to achieve their full potential, to contribute fully, and to gain maximum benefit from the opportunities available.

We are all, at any point in our lives, several protected characteristics at once. 80% of colleagues are patients and members of our community. Our approach is to celebrate difference, engage colleagues to learn about difference and tackle inequalities.

In 2023, we established an Inclusion Group reporting directly into the Workforce Committee, a main Board sub-Committee. The group's purpose is to oversee all workforce EDI activity in support of the achievement of Trust strategic and operational objectives. It is still in its infancy, but its early work has focused on responding to the national EDI improvement plan and identifying its immediate priorities. The Group will champion organisation responses to WDES and WDES staff survey feedback and it has initiated data reporting/analysis of ethnicity and disability pay gaps in readiness for new statutory reporting responsibilities. In addition, it is sponsoring the development of Trust wide EDI education/learning resources, helping to strengthen the leadership of equality network groups and implementation of an inclusion activity calendar that enables colleagues to fully participate in making the Trust an inclusive place to work.

All EDI activity is informed by: -

- Staff Survey
- Workforce data i.e., workforce profile, recruitment, disciplinaries, leavers
- Engagement with colleagues i.e., walkarounds, events
- Equality group discussions

We have Trust sponsored, colleague-led, equality network groups:

- Pride Network
- Race Equality Network
- Disability Network
- Women's Voices Network
- Armed Forces Network

- Carers Network
- International Colleague Network

We have hosted several EDI events in 2023 including Windrush Celebration Event, Black History Month, Ramadan packs, Veterans Awareness Day, International Women's Day, Diwali, National Inclusion Week, South Asian Heritage month and our very first CHFT Pride Parade. Over 350 colleagues in total have attended events throughout 2023. Plus, we have developed an EDI education suite which is available for all via our intranet page.

Wellbeing

Colleague wellbeing is a people priority here at CHFT. We have supported 1000s of colleagues through a range of interventions. Colleagues perform better when they are well, energised, fit, and valued. It is more important than ever that NHS workplaces become environments that encourage and enable staff to lead healthy lives and make choices that support positive wellbeing. Our One Culture of Care approach is our enabler to ensure colleagues take care of one another the same way we care for our patients.

Our core wellbeing interventions are our Friendly Ear service hosted by our internal wellbeing advisors and the Employee Assistance Programme hosted by Care First, who provide free wellbeing support 24/7, 365 days a week.

We have hosted two wellbeing festivals throughout 2023 focussing on themes such as stress and TALK (tiny acts of loving kindness). These events help the wellbeing team to connect with colleagues to highlight where colleagues can come to if they need some wellbeing support and discuss issues such as mental health, financial wellbeing and general dietary advice and fitness. Over 360 colleagues attended.

We have 87 wellbeing ambassadors in the organisation who are colleague volunteers who support teams locally and connect people to support quickly.

CHFT worked with West Yorkshire Health and Care Partnership to become a Menopause Accredited Friendly Employer in 2023. We have a Change Society (menopause) peer support network with 94 members, and they have been influential to support the organisation to ensure we have a menopause policy and gained the accreditation.

We have a dedicated colleague psychology team who are trained in EMDR and help inform our people approach through a psychological lens. The team have led a programme where 14 colleague volunteers are trained to host critical event peer support debriefs in the organisation.

There were four Schwartz Rounds held in 2023 with topics including, 'a day in the life of', 'why I do the job I do', 'tales of the unexpected' and 'scary moments'. 64 colleagues accessed the rounds in 2023.

Colleague wellbeing is one of the most talked about subjects on walk rounds. This feedback helps us to focus on reviewing and developing our approach.

We have designed a comprehensive wellbeing offer (including the benefit of a weekly wellbeing hour) that provides our colleagues the opportunity to sustain their workplace health and wellbeing. The offer focuses on four themes social, physical, financial, and mental. Activities include:

- Engaging, clear communications –supporting “it’s okay not to be okay” and reducing the stigma of mental health.
- Induction
- Refreshed appraisal approach including wellbeing check-in, including improved conversations regarding colleague development.
- Compassionate leadership programme – role modelling, harness curiosity, create time and space to talk.
- Connect and Learn Session – Health & Wellbeing Conversations
- Men’s health week roadshow
- 5 a side football tournament
- Top up shops – discreet food banks / recycled clothing for colleagues
- Cost of Living – focus on financial education, access to low-cost loans through salary finance, 24/7 support through Employee Assistance Programme, promotional material regarding what help is available on the local patch.
- SS Dance and Fitness - weekly sessions held on site.
- Wellbeing and relaxation sessions with medicine directorates in conjunction with local businesses
- Wellbeing and Engagement calendar of events One Culture of Care Calendar - One Culture of Care Event Calendar (pagetiger.com)

Engagement

At the heart of everything we deliver within the engagement team we ensure that One Culture of Care is at the heart, where we care for each other the same way we care for our patients.

Engagement activity is a collaborative effort where teams work together to get results.

Our annual staff survey results and quarterly People Pulse survey results will inform the direction and advise whether the activities we deliver are relevant and are effective.

Recognition and Appreciation

We all know our colleagues do brilliant things every day, whether that is something transformational or a tiny act of kindness that has a big impact. That is why we focus on appreciation. We have developed local appreciation toolkits including thank you cards, nomination forms for monthly star awards and information regarding our annual CHuFT awards.

Our monthly star award scheme has generated 196 nominations and 12 successful stars. Exceptional efforts from colleagues range from clinical to nonclinical and all demonstrated how they go above and beyond to ensure they deliver compassionate care for patients and one culture of care for colleagues. All winners are chosen by a panel of 5 colleague volunteers. Where winners are voted by the people and chosen by our people.

The annual CHUFT awards offered colleagues to nominate someone who had delivered excellence in 7 categories. 285 colleagues were invited to the event including golden ticket winners and colleagues who nominated others. The event was a huge positive impact with the lead up to the event where we had a record breaking 339 nominations, representing almost 750 colleagues and 8 winners. Beyond the event we held a CHuFT on the Road campaign where we visited 35 areas to celebrate nominations, the short list and the winners continuing our celebratory feeling across the Trust.

We hosted two appreciation events across the CHFT footprint. Giving colleagues an opportunity to shout about their colleagues and discuss the current appreciation programme asking for their views to shape the approach in the future. 60+ colleagues engaged in the appreciation events.

Long service awards have also been relaunched in 2023 and now includes the return of face-to-face events and presentation. 34 colleagues have so far attended two events with a further four events planned in 2024.

Learning and Development

Between 1st April 2023 until 31st December 2023, The Organisational Development Team delivered a range of interventions across CHFT with headlines including:

- More than 1000 colleagues have accessed OD interventions and tools so far in 23/24.
- At least 50 teams have benefited from an OD intervention so far in 23/24.
- Average Divisional Participation: (Corporate 15%, Community 15%, FSS 21%, THIS 5%, Medical 23%, Surgery 7%, PMU 5%, CHS 4%, Unknown 5%)
- Average Gender Participation: Female 80%, Male 20%
- Average Ethnicity Participation: White 82%, BAME 18%
- Average Disability Participation: Disabled stated 7%, non-Disabled 81%, Not Disclosed 12%
- Hot House sessions attended by over 100 colleagues across CHFT.
- 12 x bespoke OD management and leadership interventions delivered to Pathology, Quality team, FSS Leadership, APNP's, Endoscopy, Paediatrics and Finance. Themes have included leadership development, effective team communication, courageous conversations, 3R's, team building, WTGR, listening events and Insights profiling.
- Delivered 2 x Operational Leaders conferences attended by over 75 operational managers.
- Delivered 2 x Executive Leadership Conferences attended by over 75 senior leaders.

- Over 100 colleagues have accessed the 2-day collaborative WTGR workshops.
- 21 colleagues have graduated from our ‘Empower’ inclusive personal development programme with season 5 underway.
- 343 colleagues have participated in ‘connect & learn’ workshops.
- 22 team and managers have completed TED training.
- 36 Teams and managers have undertaken OCOC charter training.
- More colleagues are accessing apprenticeships than ever before, especially those at Level 5 and above in Management and Strategic Leadership
- We have surpassed last year’s appraisal uptake where we currently stand at 83.16%.
- We will develop career pathways for colleagues at all levels and within all professions and put in place a plan to address any gaps or risks.

Widening Participation at CHFT

Over the last 12 months, the Apprenticeship & Widening Participation Team have continued to evolve and create a new range of entry pathways for local people to access work readiness and employment opportunities here at the Trust. This includes progression into entry clinical and nonclinical apprenticeships, volunteering, work experience and a variety of pre-employment routes including, T levels, NHS cadets, the Prince’s Trust and aspirational raising activities and employability development.

One of the main objectives of this work is to help "grow our own", with particular focus on supporting underrepresented groups from across our local communities. The development of a range of external partnerships has been pivotal in the success so far as we strive to:

- Harness and leverage the power and commitment of local people whilst retaining the absolute best local talent in our local communities.
- To be the local apprenticeship “employer of choice” in Huddersfield and Calderdale.
- To ensure the staff base is representative of the people we serve and reaching out even further.
- To ensure promotion of the hugely important role of “pre-employment pathways” and progression into paid bank, substantive entry roles and apprenticeships.
- To encourage and support CHFT colleagues to follow a career path that suits them and their life making full use of resources such as the apprenticeship levy and the continued offer of “in work support” including careers advice and guidance.
- To use our Health & Social care employer status as a key driver for economic and social recovery, particularly impacting those who face additional barriers and from underrepresented groups.

What have we achieved?

We have supported 88 residents into CHFT employment and apprenticeships from our widening participation pathways:

- 33 have progressed from the Prince’s Trust

- 5 from volunteering
- 20 from Kickstart
- 20 from SWAP
- 10 from Project Search

60% of those who progress into employment reside in the top 5 IMD areas locally so further demonstrates how the team are ensuring we reach the most deprived areas within our communities.

Widening Participation activity has so far reached over 4500 young adults across Kirklees and Calderdale delivering a range of in person and Microsoft Teams careers and aspirational based activities. Targeting high schools, further education institutions and local community, statutory and charitable organisations with a range of workshops via outreach helps to promote applications into the Trust, apprenticeship masterclasses, 'Sector spotlight' Q&As, aspirational visits to the Trust and bespoke trust careers events in local institutions.

The Widening Participation Team has also developed a range of external partnerships that promote extracurricular activities for local disadvantaged young people including NHS Cadets - a youth volunteering programme delivered by St John Ambulance. This is a personal development and volunteering led program for over 250 young people so far targeting aged 14-18 - across 3 cohorts each academic year - which prioritises underrepresented groups across Kirklees and Calderdale who have been disproportionately affected by the pandemic. Outside of London, West Yorkshire has the second highest take up of NHS Cadets in the UK, with 103 cadets currently registered on our most recent start (January 2024). Crucially, 20% are Young Carers, 45% receive free school meals, 30% cadets have at least one or more NEET (not in education, employment, or training) indicators, 10% were previously excluded from school and 45% of the 103 cadets are from Black, Asian and minority ethnic communities.

The Trust is also supporting 'Project Search' for people with a Learning Disability – this offers a year-long supported internship combining classroom-based learning delivered by Calderdale College and work experience in the Trust. The aim is to boost opportunities to learn new skills to help secure fulltime, paid employment. 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. Last academic year 6 out of 8 interns progressed into full-time employment.

The team have also developed an offer to support colleagues with job applications and interview practice so to help reduce anxieties when applying for progression opportunities. We have delivered targeted sessions to support our BAME and disabled colleagues. A partnership with 'REALISE Training' has been successful who deliver functional skills in math's, English and digital skills to colleagues seeking upskilling. 35 colleagues have so far registered over the last 6 months.

The Prince's Trust pathway run's quarterly for cohorts of up to 10 young, disadvantaged adults aged 18-30. Participants gain 4-6 weeks work experience as ward helpers with the potential to progress into apprenticeship pathways where appropriate. Prince's Trust cohorts has welcomed over 95 young people into CHFT in total with 33 candidates progressing into entry level apprenticeships.

CHFT's targeted volunteering project has so far recruited over 120 young adults into CHFT in 2023/ 24 (funding expires in March 2024). Of those, 75% are aged 19-24, 70% White British, 30% Black, Asian or minority ethnic. This is targeting young adults - 16-30 - from underrepresented groups, interested in working for the NHS with referrals received from a range of educational, statutory, and charitable partners. 5 volunteers have also progressed into apprenticeships.

A" New to Care" pathway is currently in development and will seek to provide access to Health Care Assistant vacancies regardless of previous experience or qualifications. The "bootcamp" approach seeks to provide a blueprint for future HCA recruitment and provide opportunities for those in our communities who may not have previously considered a career in health care.

Apprenticeships at CHFT

We are also a "employer apprenticeship provider" that delivers our own Health Care Support Worker apprenticeship. Non-clinical entry level apprenticeships are delivered in partnership across a range of local providers. Both pathways are promoted and prioritised to existing pre-employment participants from a range of projects CHFT has recently embedded into the Trust including Kickstart, Princes Trust 'Get Into,' Inclusive Volunteering project, NHS Cadets, Project Search and SWAP (sector-based academies) and other participants referred in via external partnerships.

These are projects that specifically target school and college leavers and NEET young adults with additional barriers to entry or those from underrepresented groups from across Calderdale and Huddersfield's local communities. Over 88 local young unemployed adults have accessed apprenticeships and employment at CHFT as a direct result of new entry pathways.

The Trust offers clear internal pathways upon completion of an entry apprenticeship into a substantive band 2 positions or higher-level apprenticeships. Graduates from CHFT's entry level apprenticeships are also prioritised to apply for one of forty Clinical TNA Foundation degree pathways to encourage continued training participation - 15 candidates (38%) were successful last year. Throughout 2023/24, CHFT added 145 new apprenticeship starts, 49 new entrants and 96 from existing Trust colleagues which has seen metrics return to pre-pandemic levels. CHFT have also increased apprenticeship levy spend by over 10% on 22/23 resulting in 53% of CHFT colleagues accessing L5+ apprenticeships (the highest take up in the region and 10% above the national average).

EDS (Equality Delivery System)

EDS is a framework that helps the Trust, in discussion with local partners including local people, review and improve performance for people with protected characteristics. CHFT collaborated with partners across Kirklees, Calderdale, and Wakefield to deliver patient focus groups for Domain 1 themes (Maternity, Children and Young People's Mental Health and Learning Disabilities) for which we were scored as 'Achieving' overall.

We are now working to ensure Domains 2 and 3 are delivered to that same standard.

Our patients

This section provides an overview of the patient experience and involvement programmes of work in relation to the Public Sector Equalities Duties.
Throughout 2023 the Trust has continued to respond to the learning from Covid-19 whilst focussing upon strengthening the feedback and involvement of patients, carers, members of the public and colleagues to improve the quality of care and experience across CHFT.

The Trust is committed to developing and co-ordinating services around what matters to people and has several strategic programmes of work which are led through the Patient Experience and Involvement Group. The strategic programmes support the Trust to identify diverse needs, with a particular focus on people and communities who suffer the greatest inequalities in healthcare and variation in services.

Strategic programmes of work led by the Patient Experience and Involvement Group support the Trust to meet their equality, diversity and inclusion objectives, and support additional work programmes across the Trust. In 2023 the strategic work programmes included: Person Centred Care; Strengthening working in partnership with people and communities; Insight to identify improvement priorities and Keep Carers Caring.

In 2023 the Trust strengthened their approach to working in partnership with people, recognising that to meet the Triple Aim (a new duty introduced within the Health and Care Act, 2022) greater involvement of people and communities, including those seldom reached or with characteristics protected by the Equality Act 2010, was essential.

To ensure that services are planned and developed whilst considering the needs of different people, including those in vulnerable circumstances the Trust has broadened their approach to involvement, and developed two voluntary roles.

The first new role to support wider inclusion at the Trust is called an "Expert by Experience" in recognition of the level of knowledge and experience people have developed whilst using or caring for someone receiving services at the Trust.

The second role is called a "Patient Safety Partner," which also amplifies the voice of patients, but primarily supports the improvement of patient safety across the Trust.

Both roles support people to share their knowledge and experience of using the Trust's services and increase the Trust's understanding of the diverse needs and barriers to accessing health services that people can experience.

The roles will provide a forum for involving patients and carers, and support colleagues in involving patients, carers, and members of the public at the outset of programmes of work as the Trust moves to a level of co-production required to deliver the best possible experience of care possible.

The new roles support the Trust objectives in relation to equality, diversity, and inclusion by providing an additional mechanism for the Trust to hear and understand what is important to individuals. By amplifying the patient voice, the Trust has been able to listen more, and act upon the experience people share. This has been particularly effective in enabling the Trust to understand challenges some people experience when accessing health services which can be more difficult to hear through less nuanced mechanisms such as national patient surveys.

Examples of where this approach has been effective at the Trust include:

- The Patient Transport Booking process now has a mandatory question for all bookings to understand and plan for any accessibility needs. Examples may include sight impairment; mobility support or communication difficulties.

- Changes to signs at the Trust. This has included removing handwritten signs; changing the colour of signage; identifying where signs need illuminating and where signs have been obstructed from view for people who may be in a wheelchair or mobility scooter.

- Introducing tablets to enable patients to share feedback whilst they are in the department, resulting in timely feedback from patients using Colorectal services.

- Increasing the size of cups in response to feedback has improved experience for people accessing radiology services.

- Listening to the experience of a carer has highlighted a training need to support colleagues in relation to parking arrangements for people with a disabled permit (blue badge)

Widening involvement, in a safe and supported manner which allows for nuance, is critical to the Trust's understanding and identification of improvement activities to ensure equal access to fair and inclusive services.

As with any new programme of work, policy review or change in service the consideration of equalities, inclusion and diversity was assessed using the Trust process for Equality Impact Assessments, as the proposal to recruit to Experts by Experience and Patient Safety Partners was developed.

The Trust has worked in partnership with "Experts by Experience" and partners to review promotional materials, including Healthwatch, Disability Calderdale and the Royal National Institute for the Blind to seek feedback on the inclusivity of the materials. Information has been developed to meet the Accessible Information Standards, including read-aloud software and are available in the top five languages, other than English, prevalent in the communities we serve.

The Trust has collaborated with partners, including Voluntary, Community and Social Enterprise Organisations to promote inclusivity and reach members of the community who are seldom reached. This has included utilising existing networks through partners such as the Integrated Care Board and Healthwatch and sharing information in an alternative setting (to a health setting), where insight has suggested some people feel more comfortable.

The Trust is committed to improving experience through working in partnership with patients, carers, members of the public and partner organisations. Feedback (or insight) is encouraged through several methods which include:

- Friends and Family Test
- Care Opinion
- Working with volunteers, members, and governors
- National and Local surveys
- Listening events and focus groups
- Learning from feedback and sharing learning
- Working with partners
- Maternity Neonatal Voice Partnerships
- Community and Advocacy Groups
- PLACE audits
- Observe and Act reviews.

Feedback whether through patient surveys, complaints, compliments or the Patient Advice and Liaison Service is shared at the strategic patient experience and involvement group meeting, chaired by the Chief Nurse. This enables themes, trends, and priorities to be identified and actions agreed.

In 2023 the complaints team transformed their processes to improve the experience people receive and so that consistently 80% are responded with the agreed timescale.

The Trust has welcomed the return of forums such as the Children and Young People forum following Covid-19, and mindful of the inequalities in health experienced by particular communities throughout the pandemic, has focussed on increasing opportunities which support people to share their feedback, especially where these can improve the Trust's knowledge of experience from people with protected characteristics. This has led the Trust to focus on working in partnership with people to make improvements in several areas, including the following.

Improving the Experience of People with Visual Impairment
This collaborative group has led to improvements across the Trust, particularly by providing insight as to challenges people with visual impairment found when accessing services at the Trust. Several visits to areas across the Trust have been invaluable in identifying improvements which can be made and have led to requests for further site visits.

Working collaboratively within the group, has also enabled the Trust to identify effective and accessible solutions to challenges such as using "bump ons" to help people with visual impairment find the nurse call bell button.

Accessible Information Standards
The Accessible Information Standard provides all NHS Providers with a specific, consistent approach to identifying, recording flagging, sharing, and meeting the information and communication support needs of patients, service users, carers and parents with a disability, impairment, or sensory Loss.

To meet the Accessible Information Standard the Trust must:

- Ask people if they have any information or communication needs and find out how to meet their needs.
- Record those needs clearly and in a set way.
- Highlight or flag the person's file or notes so they have information or communication needs and how to meet those needs.
- Share information about people's information and communication needs with other providers of NHS and adult social care when they have consent or permission to do so.
- Take steps to ensure that people receive information which they can access and understand and receive communication support it they need it.

In 2023 the Director for Corporate Affairs was appointed as the Accessible Information Standards Lead for the Trust. Work has taken place across the Trust to improve the accessibility of information for patients which has included:

- Access to services such as Interpretation, British Sign Language, Hearing Loop, Audio technology
- Providing information in formats such as easy read and other languages
- Communication alerts recorded on the Electronic Patient Record on admission to services.

The Trust has continued to promote the Accessible Information Standards and a review of the Electronic Patient Record has evidenced the identification of communication needs being recorded and flagged.

The digital transformation programme at the Trust will shortly see the introduction of a patient portal, which will offer patients and their carers (where appropriate) greater accessibility to their health information. To ensure that the developments are accessible for all patients the digital transformation team are seeking “Experts by Experience” to develop the functionality of the portal.

The Health Informatics team complete an accessibility audit of the Trust internet pages to identify areas which do not meet the standard.

The next steps to improve experience through the Accessible Information Standards work programme will include an audit of Accessible Information Standards compliance within the Trust audit programme to identify areas for improvement. Areas for improvement will be monitored and reported through the Patient Experience and Involvement Group.

The Trust’s Accessible Information Policy will be published.

Colleagues will be encouraged to access training resources in relation to Accessible Information Standards available through NHS England (Health Education England).

Improving the Health Inequalities of People with Learning Disabilities
The Trust aims to transform the way in which people receive care, by ensuring they are supported by care navigation throughout the referral to treatment process. This is championed by the Chief Executive Officer.
As part of the Trust’s commitment to reducing health inequalities across all programmes of work, the Trust has developed a business intelligence system (KP+), which enables the trust to identify and analyse data through a health inequalities lens.

The Trust has undertaken focussed work to improve the health inequalities of people with a learning disability; those living in IMD 1+2 communities, and ethnicity. Within KP+, the Trust has implemented a robust flagging system for people with learning disabilities, enabling the Trust to interrogate and compare data against the general population, undertake deep dive audits and review disparity.

The Nurse Consultant for Learning Disabilities at the Trust developed a task and finish group which included Experts by Experience and / or self-advocates alongside colleagues across the Trust.

Working collaboratively with the data, identified that through robust identification of people with learning disabilities the group were able to develop case studies. The case studies indicated inequalities in accessing secondary care services for people with learning disabilities across the Trust.

The Trust has made several changes following the findings which have included:

- Internal audits and improvement plans which are integrated into the Trust Performance Report.
- Changes to the referral pathway from primary care
- Changes to the local referral template to accommodate the Learning Disability Flag
- Producing data in an accessible format

The Trust has sought to influence the National referral template to include a free text box for details of reasonable adjustments required.

The Trust has also led the development of a West Yorkshire wide dashboard to contain a waiting list for people with learning disabilities as part of the focussed work to prioritise patients with learning disabilities on specific waiting lists.

Improving Experience through the Health Inequalities Group
The Health Inequalities Group have led several improvement initiatives in 2023.

A multiagency working group worked collectively to reduce inequalities in health for people who experience asthma. The collaborative effort focussed on:

- improving patient identification
- patient referral processes
- enhancing information sharing between primary and secondary care
- addressing behavioural and social determinants of health linked to respiratory conditions.

Community education sessions were provided in a collaborative approach which included partners from the Primary Care Network and the Local Authority Public Health Team, with a specific focus on supporting vulnerable respiratory patients with cold or damp housing.

The Health Inequalities group have developed a “health inequalities vulnerability matrix” to identify patients most susceptible to experiencing inequalities in health. The tool is being piloted and will be evaluated to identify if it can be used to support a holistic approach to prioritisation of care.

Using insight gained from past activity, including previous appointment data, alongside health and social factors have supported the Health Inequalities group to explore strategies for reducing “Did Not Attend” rates among the Trust’s vulnerable groups.

Detailed analysis of data focusing on IMD 1 & 2 alongside ethnicity has informed improvement plans to target patient communication, appointment letters and accessibility, which will be a focus area within 2024.

Mental Health Promotion and Equality of Access for People with Mental Health Problems

In 2023 the Consultant Nurse for Mental Health and Paediatric Mental Health Liaison Sister have led on several projects to support their roles within promoting mental health promotion and improving access and parity of esteem for people with mental health problems.

The Mental Health Operational Group has extended its membership to include representation from junior medical staff and the emergency department. The group has worked with Kirklees Mental Health Alliance and Calderdale Acute mental Health Forum to engage with service users and carers. This has supported the group to contribute to the patient journey work stream for urgent and emergency mental health care.

The Group have worked closely with the Electronic Patient Record and Informatic teams at the Trust to introduce Mental Health specific tools that lead to an action onto the Electronic Patient Record that could be meaningfully measured.

The Group have used the Whooley questions (recommended by National Institute of Clinical Excellence) for screening for depression in people with long-term conditions and for self-harm in children and young people, into the respective Adult and Child admission assessments.

The Mental Health Operational Group is committed to using the data from the specific Mental Health tools to provide meaningful data of screening and actions taken. The next steps will include agreeing key performance indicators which will be inked to action that impacts the health outcomes and experience patients receive.

Supporting Unpaid Carers

In 2023 the Trust provided a focussed effort to improve the identification of, and support for unpaid carers. This included developing a Carer’s Strategy and supporting local Healthwatch partners to pilot a Carer’s Lanyard to offer unpaid carers a method of being identified during their time within the Trust.

A “Keep Carers Caring” campaign promoted the recognition of unpaid carers across both staff and patient / carer groups, with an emphasis on the inequalities in health unpaid carers experience because of their caring roles.

Initiatives to seek feedback from unpaid carers identified at the Trust have been prioritised, to inform further improvements the Trust can make. The feedback provided rich insight including:

- Most unpaid carers felt a means of identification helped them to feel empowered and to be involved in care planning for their loved one.
- Unpaid carers did not always recognise themselves as a carer.
- Unpaid carers did not always know where to find support or advice in relation to being a carer.
- Being listened to and involved in care planning was important to carers.
- Navigating across a patient journey and different organisations, co-ordinating providers is challenging.

The Trust was invited to share the achievements made in relation to support for unpaid carers with Members of Parliament by John's Campaign in 2023.

In response to the feedback gathered throughout 2023, the Trust is working with partner organisations and the latest insight findings (Carers UK Survey, 2023 and State of Care Report, 2023) to develop improvement actions across the local system which will support identification of unpaid carers, improve the involvement of unpaid carers and initiatives to support unpaid carers to improve their health and wellbeing.

Person Centred Care
Feedback across the Trust has emphasised the importance of providing person centred care and supporting individuals to achieve "what matters most" to them.

The Trust identified that Person centred care can mean different things to different people and developed a shared definition for the Trust to pilot in November 2023.

Engagement with colleagues, patients and carers was completed in December 2023 to understand how asking patients, colleagues, and carers at the Trust "what matters most to them", may improve their experience. Some of the feedback received included:

Patients:
"Feels great that someone has asked me what matters to me."
"I feel like I have more control."
"It feels personal and centred."
"Good to be included."
"I want to be discharged safely and to know what is happening to my health."

Carers:
"We feel happy that someone has asked what matters to us."
"If everyone is more engaged with our expectations and knew what we wanted, then hospital experience will be better."

“Hopefully if our expectations are met and someone can talk to me every day so that I know what the progress with my husband is, our experience will be better.”

Colleagues:
“Having this information allowed me to think about strategies to support and achieve the patient goals.”
“Great initiative – something everyone in the trust can contribute to.”
“It allows patients to see a side of health professionals where we are the listeners, and they are the leads in the conversation.”

The person-centred care work programme is due to pilot the shared definition, with a standard for documenting and reviewing what is important to individuals, as the trust ensures the patient and or their carer remains at the heart of decision making and planning of their care.

Looking ahead to 2024/25 the Next Steps Include:

- Strengthening support for colleagues to improve their knowledge and skills in relation to involving people in programmes of work.

- Increasing the use of patient stories at the Trust to capture the patient’s experiences and support colleagues to make improvements informed by what matters most to the patient.

- Expand the reach of Experts by Experience across the Trust to ensure the diverse voices of patients, carers and members of the public are welcomed, heard, and involved.

- Increased representation of Experts by Experience and Patient Safety Partners to ensure service developments and changes are informed by the experience and knowledge of people who use the services.

- Implement the Hospital Discharge Toolkit in partnership with the Local Authority to support Unpaid Carers

- Map CHFT compliance with statutory guidance “Working in Partnership with People and Communities” to inform the review of the Patient Experience and Involvement Strategy

- Refresh the patient experience and involvement strategy embedding inclusion, co-design, and co-production.

- Pilot the Person-Centred Care Definition and Standard and develop further work strands to support person centred care.

- Review the visiting policy at CHFT following the consultation on visiting arrangements and ahead of expected changes to CQC fundamental standards to cover visiting.

- Implement CHFT's response to Martha's Law

Membership and the Council of Governors

Our membership profile
We strive to ensure that we have a diverse membership that is representative of the people we serve and our community. In line with our Membership and Engagement Strategy, we regularly monitor how representative our membership is compared with the most recent census data, using age, gender, and ethnicity demographics.

Due to successful member recruitment events at our local university and a local college during 2023, representation of people from Asian/Asian British backgrounds rose by 2%. These recruitment events also allowed us to increase the number of younger members of the Trust.

Despite this, as at 31 December 2023 the groups most under-represented within our membership community continued to be younger people and people from Asian/Asian British backgrounds, as shown in the tables below. Our recruitment activities during 2024 will continue to focus on under-represented groups, particularly Asian / Asian British.

Under/over representation by ethnicity:

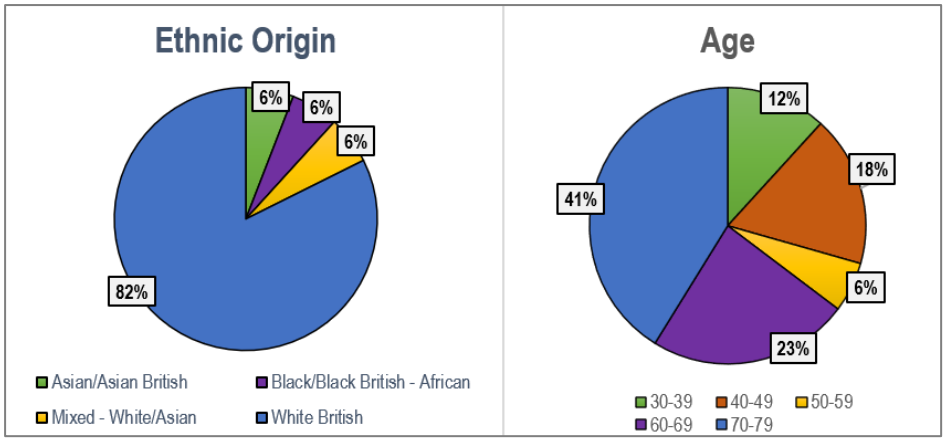
Ethnic group	Under/over represented
White	Over by 4.1%
Mixed	Over by 0.2%
Asian/Asian British	Under by 5.0%
Black/Black British	Over by 1.5%

Under/over representation by age band:

Age band	Under/over represented
16 - 29	Under by 14.0%
30 - 49	Under by 9.5%
50 - 69	Over by 2.8%
70 and over	Over by 20.7%

Our Council of Governors profile
Analysis of data relating to our elected governors shows that the majority (82%) of them are White British and that almost two thirds are over the age of 60.

This can be seen in the charts below:



We will use our governor elections in 2024 as an opportunity to broaden the diversity of our Council of Governors by encouraging nominations from all groups where there are vacancies during our engagement activities, with a particular focus on Asian/Asian British groups.

A significant achievement in 2023 came with the appointment of two Associate Youth Governors, both of whom are members of the Trust's Youth Forum. The Associate Youth Governors will help to ensure that younger members of our communities have a voice on the Council of Governors and will offer a perspective to guide the Trust to make decisions and provide services which include everyone and support innovative development of services suitable for future generations.

This development means we have achieved the objective from our Membership and Engagement Strategy for 2023-26 to "recruit members from younger sectors of our communities and introduce a 'Junior Champion' figurehead to promote youth membership".

Engagement Activities

The Membership and Engagement Working Group (MEWG) met three times in 2023. Working in conjunction with the Membership and Engagement team, the group made good progress in 2023 towards the goals in our Membership and Engagement strategy relating to engagement activities between governors and our members/members of the public.

We reintroduced our member events, "Health Matters," during 2023 and widened the invitation to colleges and sixth forms, which was a successful venture, allowing us the opportunity to engage with younger people.

Our governors are keen to engage with a wide variety of communities, and in September 2023, they each made a pledge describing what they personally would do to facilitate more engagement activities. These will be revisited in 2024 to establish what progress has been made.

During 2023 public governors continued to attend their local Ward Based Partnership meetings hosted by Kirklees Council to forge links with community groups and identify engagement opportunities with those groups in Kirklees.

Similarly, some of our public governors in Calderdale have, during 2023, met with clerks from town and parish councils to create opportunities to engage with community groups across their constituencies.

Summary

In summary, the Trust has significantly increased its activities for colleagues, patients, and the public across all protected characteristics during 2023/24. During 2024/25 working with our partners across both places and the West Yorkshire system we will continue to focus on supporting colleagues from these groups directly and through our networks. We will also continue to strengthen our public and patient involvement work and consider how this impacts on health inequalities.

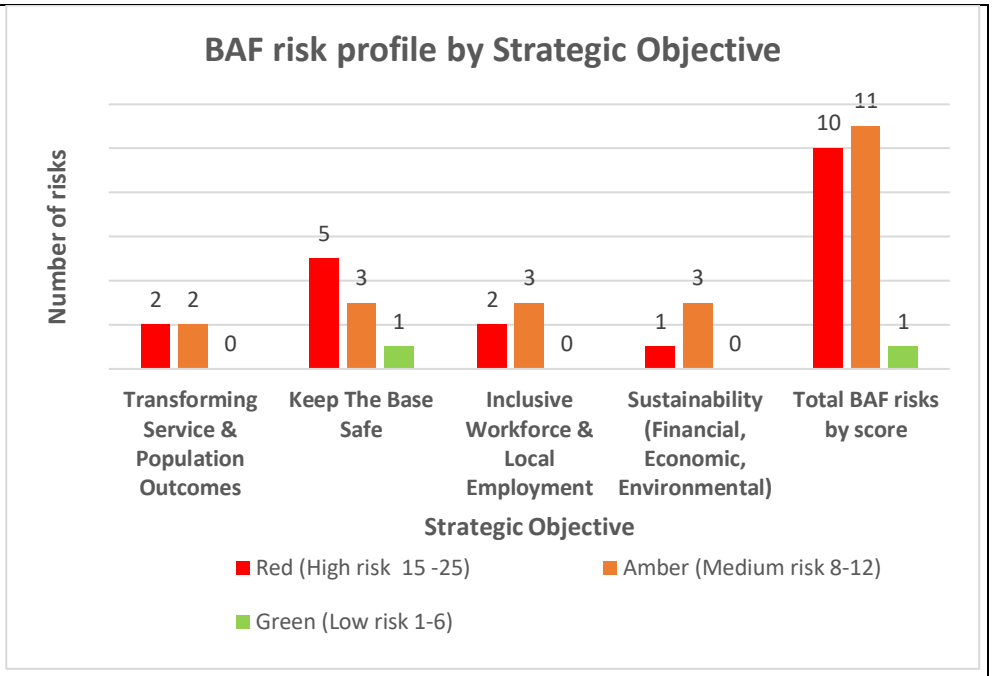
KEEPING THE BASE SAFE

20. Board Assurance Framework – Update 1

To Approve

Presented by Andrea McCourt

Date of Meeting:	Thursday 4 July 2024
Meeting:	Board of Directors
Title:	Board Assurance Framework Update 1 2024/25
Author:	Andrea McCourt, Company Secretary
Sponsoring Director:	Victoria Pickles, Director of Corporate Affairs
Previous Forums:	None
Purpose of the Report	The Board Assurance Framework is the key source of evidence that links the Trust's strategic objectives to risk and assurance. It is the main tool that the Board uses for discharging its overall responsibility for internal control and is presented to the Board three times a year. This report presents for approval the first report of the Board Assurance Framework (BAF) for 2024/25 for approval. Due to sequencing of meeting timings the report will be reviewed by the Audit and Risk Committee after the Board meeting at its meeting on 23 July 2024.
Key Points to Note	The Trust approved revised strategic objectives for 2024/25 in March 2024 and has a five year strategy which was approved by the Board in March 2023. The Board Assurance Framework has been reviewed against these strategic objectives to ensure that it captures risks relevant to the current strategic objectives, with changes summarised below. **Risk Profile** The Trust has the following risk profile for risks to its strategic objectives as at 24 June 2024 with a total of 22 risks. The Keeping the Base Safe goal has the greatest number of risks (9 of 22) and the highest number of red risk scores, at five of the 22 risks on the BAF.



The risks presented are aligned with the strategic objectives of the Trust's five year strategy, of which 2024/25 is year two. This alignment of the risks and objectives is shown below, together with confirmation of which Board Committee has oversight for the risk.

Transforming services and population outcomes	Board Assurance Framework Risks	Board Committee oversight
We will have built new modern 'state of the art' hospital buildings that will enable delivery of the best safety, outcomes and experience of care for people.	Risk 1/19 reconfiguration	Transformation Programme Board
Patients and colleagues will be digitally enabled to provide and receive care – in any location this is needed – to improve patient experience and outcomes.	Risk 02/20 Digital Strategy Investment	Transformation Programme Board
Working with partners we will use population data to prevent ill health and reduce health inequalities.	Risk 07/20 Health Inequalities	Board via Health Inequalities reporting
Working with academic, health and social care partners we will participate in research and innovation to prevent ill health, improve patient care and achieve better outcomes and faster recovery for patients.	Risk 1/20 Clinical Strategy	Transformation Programme Board

Keeping the base safe – best quality and safety of care	Board Assurance Framework Risks	Board Committee oversight
We will be delivering and enabling outstanding quality, safety and experience of care for people needing hospital and community services.	Risk 6/19 high quality safe care for patients Risk 9/19 Estate & equipment	Quality Committee Transformation Programme Board
We will be consistently achieving key performance targets that matter most to patients.	Risk 1/23 Demand and capacity Risk 4/23 local and national performance targets	Finance and Performance Committee
We will be well-led and governed and compliant with our organisational and partnership statutory duties.	Risk 16/19 Health & Safety Risk 4/20 CQC rating Risk 5/23 Cyber security Risk 3/23 Partnerships	Audit and Risk Committee Quality Committee Board Board
Patient and service user engagement in service design	Risk 4/19 Patient engagement	Quality Committee

Inclusive workforce and local employment	Board Assurance Framework Risks	Board Committee oversight
We will be widely known as one of the best places to work through an embedded one culture of care – supporting the health and wellbeing of all colleagues.	Risk 1/22 absence, retention, and leadership	Workforce Committee
We will foster an open learning culture that listens to colleagues, demonstrates lessons learnt and actively seeks and celebrates best practice.	Risk 11/19 recruitment and retention	Workforce Committee
We will have a diverse and inclusive workforce of the right shape, size and flexibility to deliver care that meets the needs of patients.	Staffing Risks: 10a/19 medical staffing 10b/19 nurse staffing 6/23 midwifery staffing	Workforce Committee
We will be ambitious in our work with partners to create local employment, career, voluntary and development opportunities for People.	Risk 2/23 Social value (also sustainability)	Transformation Programme Board Workforce Committee

Financial, economic and environmental sustainability	Board Assurance Framework Risks	Board Committee oversight
We will be consistently delivering our annual financial plans and demonstrating value for money.	Risk 18/19 financial sustainability Risk 14/19 capital funding	Finance and Performance Committee
We will have taken action to reduce our impact on the environment and will be on track to achieve targets for carbon net zero.	Risk 6/20 Environmental sustainability	Transformation Programme Board
Our investments and use of resources will generate social value to support economic recovery in Calderdale and Kirklees places.	Risk 2 /23 Social Value	Transformation Programme Board

Top Risks

The BAF, via the heat map, shows the top risks for the Board, consistent with those in March 2024 are:

- Transforming Services and Population Outcomes - approval relating to hospital services reconfiguration, risk score of 20
- Keeping the Base Safe – demand and capacity (beds), risk score of 20
- Sustainability - risk 18/19 relates to the long term financial sustainability of the Trust and has a risk score of 16.

Risk Movement:

All BAF risks have been reviewed and updated by the lead Director and / or teams with updates shown in red font for ease of reference in the enclosed worksheets within the BAF.

No risks have been removed and there are no new risks are proposed for addition.

There is one risk with upward movement in risk score noted below. The rationale for the movement in risk score given together with the risk score history is below.

Risk score movement	BAF Risk reference and score	Risk score
	1/20 Clinical Strategy	15 (increased from 12)

- ***1/20 Clinical Strategy*** - risk increased from a risk score of 12 to 15 with an increase in the likelihood score from 4 to 5 due to the financial deficit position within the Trust which may limit the development of new services.

Risk Exposure

Where a BAF risk score is higher than the risk appetite (e.g. risk score of 15 or above where risk appetite is moderate) this has been identified as a breach of the risk appetite.

In considering risk exposure the Trust needs to assess whether any further mitigating actions are needed and review the adequacy of information and assurance on the management of risks with risk exposure.

As at 24 June 2024 there are six areas of risk exposure against strategic goals summarised below.

	<table><tr><th>Transforming and Improving Care</th><th>Risk Score</th><th>Risk Appetite category</th><th>Risk Appetite</th></tr><tr><td>7/20 Health Inequalities</td><td>12 =</td><td>Harm and safety</td><td>Low</td></tr><tr><td colspan="4">Keeping the Base Safe</td></tr><tr><td>6/19 Quality and Safety</td><td>15 =</td><td>Regulation</td><td>Moderate</td></tr><tr><td>1/23 Demand and capacity (beds)</td><td>20 =</td><td>Harm and safety</td><td>Low</td></tr><tr><td>4/23 Performance</td><td>16 =</td><td>Regulation</td><td>Moderate</td></tr><tr><td colspan="4">Workforce</td></tr><tr><td>1/22 Health and well-being, leadership</td><td>12</td><td>Workforce</td><td>Low</td></tr><tr><td colspan="4">Sustainability</td></tr><tr><td>18/19 Financial sustainability</td><td>16</td><td>Financial/Assets</td><td>Moderate</td></tr></table>
Regulation	CQC Regulation 17: Good Governance
EQIA – Equality Impact Assessment	The BAF has a specific risk, risk 07/20, which relates to the Trust not reducing health inequalities for our most vulnerable patients. The Trust Board receives a report four times a year on progress with health inequalities actions at Board meetings. In terms of other risks, should any of the Board Assurance Framework risks materialise and impact people from different protected characteristics the risk owner is accountable for assessing these and determining any proposed actions to mitigate any equality impact arising from the risk.
Recommendations	The Board is asked to: i. **APPROVE** the increased risk score for the clinical strategy risk (1/20) ii. **APPROVE** the Board Assurance Framework iii. **CONSIDER** if there are any further risks to the achievement of strategic objectives

Update 1 - For July 2024 Board
2024/25

Calderdale and Huddersfield NHS Foundation Trust

BOARD ASSURANCE FRAMEWORK
2024/25 Update 1

Contents:

compassionate care

REF	RISK DESCRIPTION	Initial Score	Current score	Target Score	Lead	Link to High Level Risk Register	Risk Category	Risk Appetite
Transforming Services & Population Outcomes								
01/19	Risk that the Trust does not secure approval of the Hospital Services Reconfiguration, Outline Business Case and Full Business Case resulting in being unable to progress changes to improve quality of care, workforce resilience and mitigate estates risks.	25	**20=**	10	AB	7413, 8528	Strategic/ Organisational	Significant
01/20	Risk of not delivering the ambitions in the Trust clinical strategy due to lack of collaboration due to lack of time, commitment, relationships and absence of shared vision, resulting in missed opportunities in terms of quality, efficiency, capacity, patient experience and workforce.	15	**15** ↑	10	DB	None	Strategic/ Organisational	Significant
02/20	Risk of not securing appropriate investment to fund the Digital Strategy ambitions, ensuring infrastructure and technology is up to date and future proof due to funding not being available locally and nationally impacting on workforce efficiency and patient experience.	12	**12 =**	9	RB	None	Innovation/ Technology	High
07/20	Risk of slow progress addressing health inequalities in the 20% of the most deprived patients in our communities, due to incomplete population health and patient ethnicity data, healthcare service delivery not matching patient needs in the most deprived areas, lack of quality priorites to advance health equity, lack of resource allocation and programmes for health prevention, ineffective partnership working and lack of sustained focus on actions to address ill health and prevention, resulting in the Trust not reducing health inequalities for our most vulnerable patients with protected characteristics.	16	**12 =**	8	RA	None	Harm and safety	Low
Keeping the base safe best quality and safety of care								
06/19	Risk that patients do not receive high quality, safe care due to poor compliance with internally and externally set standards on quality and safety resulting in patient harm or poor patient experience.	15	**15 =**	10	LR / DB	8528, 6079	Regulation	Moderate
04/19	Risk that patients are not able to shape decisions about their care based on what matters to them due to lack of clear strategy and capacity for patient and service user engagement resulting in not designing services using patient recommendations	12	**12=**	4	VP	None	Regulation	Moderate
09/19	Risk of failure to maintain current estate and equipment and to develop future estates model resulting in patient harm, poor quality patient care or regulatory enforcement.	16	**15 =**	8	GB	7413, 8161,8562, 7955,	Strategic/ Organisational	Significant
16/19	Risk of not being compliant with the Health and Safety at Work Act and regulations due to lack of clarity on roles resulting in harm to staff, patients, the public, visitors, potential regulatory failure and reputational damage.	9	**6 =**	3	JH	. 7413	Regulation	Moderate
04/20	Risk of not maintaining the Trust CQC overall rating of good and increasing the number of services achieving an outstanding rating as assessed by the new CQC single assessment framework and potential for ratings to be changed by CQC based on other intelligence or data from CQC portal outside of on site inspection of service due to failure to comply with quality statements resulting in a reduction of qualiy of services to patients and an impact on reputation.	12	**12 =**	6	LR	None	Regulation	Moderate
1/23	Risk re demand and capacity requiring additional beds above planned levels resulting in staffing and financial pressures.	16	**20 =**	12	JH	8606, 8528	Harm and safety	Low
3/23	Risk that decision making processes and capacity of Trust colleagues is impacted due to the evolving nature of partnership governance across the system and emergent governance arangements	16!	8 =	8	AB	None	Strategic/ Organisational	Significant
4/23	Risk of failure to achieve local and national performance targets resulting in patient harm, poor patient experience or enforcement action.	16	**16**	12	JH	8528, 8324, 8398,	Regulation	Moderate
5/23	Risk of an impact to the delivery of clinical or corporate services due to reduced or no digital provision resutling from a cyber attack	15	**15**	10	RB	None	Regulation	Moderate

Inclusive workforce and local employment								
10a/19	Risk of not being able to deliver safe and effective high quality care and experience for patients due to insufficient medical staff caused by an inability to attract, recruit, retain, reward and develop colleagues.	16	**16 =**	9	DB	7078,8508,8315 8509	Quality/Innovation & Improvement	Significant
10b/19	Risk of not being able to deliver safe and effective high quality care and experience for patients due to insufficient nursing staff caused by an inability to attract, recruit, retain, reward and develop colleagues.	16	12 =	9	LR	6345	Workforce	Low
6/23	Risk of not being able to deliver safe and effective high quality care and experience for patients due to insufficient midwifery staff caused by an inability to attract, recruit, retain, reward and develop colleagues.	16	**16 =**	9	LR	6911	Workforce	Low
11/19	Risk of not attracting or retaining colleagues who are confident and competent to provide compassionate care to patients and compassionate and inclusive leadership to colleagues.	16	**12 =**	9	SD	None	Quality/Innovation & Improvement	Significant
1/22	Risk of colleague absence and retention rising due to: increasing demands and requirements for health and wellbeing offers that are not appropriate, not accessible, not embedded or not affordable; and/or inability or unwillingness to attract develop and retain compassionate and inclusive leaders who are able to succesfully lead their teams through sustained periods of change	12	**12 =**	4	SD	None	Workforce	Low
Financial, Economic and Environmental Sustainability								
14/19	Risk that the Trust will not secure sufficient capital funding to maintain facilities over the longer term and meet safety and regulatory standards resulting in patient harm and regulatory intervention.	20	**12 =**	12	GB	None	Financial/Assets	Moderate
18/19	Risk of failure to secure the longer term financial sustainability of the Trust (achieving financial breakeven and providing value for money) due to the size of the underlying and current financial deficit and reliance on cash support.	25 =	**16 =**	12	GB	None	Financial/Assets	Moderate
06/20	Risk of climate action failure and not improving our environmental sustainability	16	**8 =**	8	SS	None	Strategic/ Organisational	Significant
2/23	Risk that the Trust cannot maximise its impact as an anchor institution in local communities to demonstrate social value	**9 !**	**9**	6	AB	None	Partnership	Significant

New risk
Area of risk exposure

REF	TOP RISKS	Initial Score	Current score	Target Score	Lead	Link to High Level Risk Register	Risk Category	Risk Appetite
TRUST GOAL: TRANSFORMING SERVICES AND POPULATION OUTCOMES								
01/19	Risk that the Trust does not secure approval of the Hospital Services Reconfiguration Outline Business Case and Full Business Case resulting in being unable to progress changes to improve quality of care, workforce resilience and mitigate estates risks.	25	**20=**	10	AB	8528, 7413	Strategic/ Organisational	Significant
TRUST GOAL: 2 KEEPING THE BASE SAFE BEST QUALITY AND SAFETY OF CARE								
1/23	Risk re demand and capacity requiring additional beds above planned levels resulting in staffing and financial pressures.	20	**20**	12	JH	7689, 8283, 8324, 8034	Harm and safety	Low
TRUST GOAL: 4. FINANCIAL, ECONOMIC AND ENVIRONMENTAL SUSTAINABILITY								
18/19	Risk re: longer term financial sustainability of the Trust (as a going concern and providing value for money) due to the size of the underlying financial deficit with the growing level of debt and reliance on borrowing.	25 =	**16 =**	12	GB	8057	Financial/Assets	Moderate

Area of risk exposure

CHFT RISK APPETITE STATEMENT - Revised September 2023

Risk Category	This means	Risk Appetite
Strategic / Organistional	We seek out innovation to deliver higher quality patient care, accepting this brings risk.	**SIGNIFICANT**
Reputation	Where required we will make difficult decisions in the best interests of patient safety but appreciate this may attract scrutiny / interest from stakeholders.	**HIGH**
Financial / Assets	We will invest resources to enable us to deliver improvements in care ensuring rigorous impact assessments. We will resource opportunities and always consider price, value and benefits, local and system impact, aiming to deliver our services within our ICS approved financial plans, retaining flexibility to capitalise on opportunities.	**MODERATE**
Regulation	We will make every effort to comply with regulation and will explain our approach.	**MODERATE**
Legal	We will comply with the law.	**LOW**
Innovation / Technology	We change how we deliver care to meet the challenges of the future by actively pursuing digital innovation, while providing safe, effective and efficient care for patients.	**HIGH**
Commercial	We explore new opportunities which will enhance and support our core business and reputation for providing patient care.	**HIGH**
Harm and safety	We take as little risk as possible when it comes to harm and safety to keep our patients and colleaguessafe and achieve the best clinical outcomes.	**LOW**
Workforce	We have one Culture of Care with colleagues looking after each other as well as the people we care for, ensuring patient safety, appropraite staffing levels and promoting the well-being of our staff.	**LOW**
Quality innovation and improvement	We seek innovation in the way we deliver services and employ staff as a key enabler for improving quality, patient safety and experience.	**SIGNIFICANT**
Partnership	We accept a level of risk in working with partners to support service transformation and operational delivery.	**SIGNIFICANT**

LIKELIHOOD (frequency)	CONSEQUENCE (impact / severity)				
	Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Extreme (5)
High Likely (5)			01/20 Clinical Strategy ↑		
Likely (4)			02/20 Digital Strategy =	**18/19 Long term financial sustainability =** 4/23 National and local performance targets = 10a /19 Medical Staffing levels = 6/23 Midwifery Staffing levels =	**1/19 Approval of hospital reconfiguration outline business case and full business case =** **1/23 Demand and bed capacity =**
Possible (3)			2/23 Anchor institution & social value =	1/22 Absence and retention = 4/19 Patient & Public Engagement = 04/20 CQC rating = 14/19 Capital = 11/19 Recruitment and retention = 07/20 Health Inequalities = 10b/19 Nurse Staffing levels	5/23 Cyber security = 9/19 HRI Estate fit for purpose = 6/19 Compliance with quality standards =
Unlikely (2)			16/19 Health & Safety =	6/20 Sustainability = 3/23 Partnership governance	
Rare (1)					

= no change to risk score ! is a new risk ↓ reduced risk score ↑ increased risk score Top 3 risks shown in bold

BOARD ASSSURANCE FRAMEWORK
JUNE 2024
TRANSFORMING SERVICES AND POPULATION OUTCOMES

TRUST GOAL: 1. TRANSFORMING SERVICES AND POPULATION OUTCOMES										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING JUNE 2024 Risk category: Strategic Risk appetite: Significant**		
1/19	Board of Directors / Transformation Programme Board	Deputy Chief Executive / Director of Transformation & Partnerships	Risk that the Trust does not secure approval of the Hospital Services Reconfiguration, Outline Business Case (OBC) and Full Business Case (FBC) from NHSI, DHSC, Ministers and HM Treasury and as a result the Trust is unable to progress changes that will improve the quality of care, workforce resilience and mitigate estate risks **Impact** Trust unable to improve long term clinical quality and deliver compliance with statutory, regulatory and accepted best practice.	Formal governance structures established: - Transformation Programme Board, formal sub-committee of the Trust Board oversees service transformation and reconfiguration plans. - Quarterly review meetings with NHSE, WY ICS, and DHSC colleagues to advise on planning assumptions used in business cases to ensure compliance with HM Treasury and DHSC requirements and facilitate future approval(s). External professional and technical capacity and expertise procured with design partner appointed in March 2020. Turner Townsend have been appointed to provide a Project Director. Close working with: - Joint Health Scrutiny Committee, wider stakeholders and colleagues to ensure full involvement in the development of the plans and business cases. - West Yorkshire Health & Care Partnership and Calderdale Cares Partnership and Kirklees Health and Care Partnership to ensure alignment of the reconfiguration plans with their strategic objectives to facilitate the ICS and Place based formal letters of support for the business cases. A Round Table Board is established that has members from NHSE, WY ICS, DHSC, Calderdale and Kirklees Places and meets quarterly to ensure system alignment and support for business case planning assumptions and development.	First line Transformation Programme Board-oversight of governance and content of business case development including relationship management with Stakeholders and the ICS, NHSE/ DHSC Second line Trust Board approval of business cases (SOC approved, March 2019). Reconfiguration OBC and FBC for new A&E at HRI approved by Trust Board in October 2021. Travel Plan approved by the TPB and the Green Plan by the Trust Board. Planning Permission for the build of a Multi-storey car park and the new clincal buildings at CRH was approved by Calderdale Council in March 2022 Third line ICS and NHSE review and approval of business cases prior to submission to DHSC. SOC approved by DHSC in November 2019. FBC for new A&E at HRI approved by NHSE in December 2021. Construction of the new A&E complete, opened on 22 May 2024. The Reconfiguration OBC was approved by NHSE Joint Investment Committee (JIC) on 25th February 2022. Reconfiguration OBC submitted for approval by Treasury. In March 2024 Laing O'Rourke were appointed as the preferred construction partner to progress the design stage of the new clinical building at Calderdale Royal Hospital.	• See below for further detail. 1. His Majesty's Revenue and Customs (HMRC) advice on preferred procurement route 2. Agreement for development on the CRH site.	Work has been undertaken and presented to Transformation Programme Board (TPB) to define the skills and capacity needed for next stage of the programme to develop the Reconfiguration Full Business Case. Approval has been given to secure the necessary additional capacity / expertise. Project structures for the next phase of work at CRH are under review and will be reported into the TPB.	**Initial**	**Current**	**Target**
								5x5 = 25	**5x4 = 20**	**5x2 = 10**

Gaps in Control	**Timescales**	**Lead**
1.Trust and ICBs need to agree clinical protocols with Yorkshire Ambulance Services to ensure patients are transported to the hospital that provides the services that will meet their clinical needs – whether this is in Halifax, Huddersfield or other specialist providers, such as Leeds. 2. The Trust must obtain advice from Her Majesty's Revenue and Customs (HMRC) regarding the preferred procurement route through the Trust's wholly owned subsidiary (Calderdale & Huddersfield Solutions Ltd). 3. The Trust will have concluded discussions with the PFI Special Purpose Vehicle (SPV) to enable the development on the CRH site. 4. Provision of aditional car parking at CRH.	1. Discussions have taken place with YAS and activity modelling and clinical protocols have been agreed. 2. The Trust has written to HMRC regarding the preferred procurement route through Calderdale and Huddersfield Solutions. 3. An agreement with the PFI Special Purpose Vehicle has been negotiated and is progressing to completion -this will require Treasury approval. 4. Build of a Multi-storey car park at CRH to commence in 2024.	Deputy Chief Executive / Director of Transformation & Partnerships for all actions

Links to risk register from current service configuration:
8528 - ED operational performance
7413 - fire compartmentation risk HRI
Quarterly risk management report on the Reconfiguration Programme Risk Register to Transformation Programme Board

BOARD ASSSURANCE FRAMEWORK
JUNE 2024
TRANSFORMING SERVICES AND POPULATION OUTCOMES

TRUST GOAL: 1. TRANSFORMING SERVICES AND POPULATION OUTCOMES										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING JUNE 2024 Risk category: Strategic Risk appetite: Significant**		
								Initial	**Current**	**Target**
Ref: 01/20 Added July 2020	Transformation Programme Board (TPB)	David Birkenhead, Medical Director	Risk of not delivering the ambitions described in the Trust clinical strategy due to financial and workforce constraints, delivery of reconfiguration and agreed joint vision for clinical services resulting in missed opportunities in terms of quality, efficiency, capacity, patient experience and workforce NB: See 1/19 reconfiguration risk which has signifcant overlap with this risk,18/19 financial risk, 10a/19 medical staffing risk	2024 refresh of current Clinical Strategy (2021-25) underway - describes Trust position on service development across West Yorkshire (WY) Transformation Programme Board - ensures estate is aligned with the clinical strategy, which informs decisions made to reconfigure services and ensure redesigned hospital model is fit for purpose (see BAF risk 1/19 reconfiguration) ICS - member of the WY& H Partnership Board which agrees service direction, strategy and financial allocations and controls. More effective working relationships with partners and establishment of networked approaches to Pathology and Vascular Surgery. Member of WYAAT which identifies, agrees and manages programms of work targeted to improve services and patient experience across West Yorkshire. WYAAT governance framework with specific forums for acute Trusts including Chief Exec forum, Committeee in Common and programme office with oversight. Recruiting for additional Oncology staff to strengthen capacity CHFT Deputy Chief Executive chairs South sector implementation Board for Non Surgical Oncology (NSO) services across MYHT & CHFT. Project Manager support. Target Operating Models agreed. West Yorkshire & Humber Diagnostics Board (chaired by MYHT Chief Executive) reviews reports from workstreams on diagnostics (radiology, pathology). Managed Service Contract for Pathology implementation underway- completion by December 2024 Deputy Chief Executive chairing New Pathology Pattnership (NPP) to progress the new network West Yorkshire Imaging Collaborative reports to Diagnostics Board CHFT/ MYHT Partnership Board meets monthly to discuss fragile services and foster closer working relationships CHFT partner at Calderdale and Kirklees PLACE level clinical and professional forums,Quality Forum and PLACE Boards (sub group of ICB) to agree local health priorities and strategy.	**First Line** Update on review and refresh of clinical strategy shared with WEB (16.5.24.s). Updates on NSO South Sector model to WEB - most recently 30.05.24. **Second Line (Board / Committee)** Refreshed Clinical Strategy July 2021 Board approved WYAAT Strategy approved by Board March 2024 Pathology Partnership Update to January 2023 Board Transformation Programme Board highlight report and minutes to Board **Third Line** Vascular network established with Bradford WYAAT Pathology Board established. Diagnostics Board and Imaging Collaborative established across West Yorkshire WYAAT / PLACE meetings	Public engagment led by system partners on NSO service model ongoing. check RA Industrial action impacting capacity to deliver clinical strategy LIMS (Laboratory Information System) implemetation delayed until 2025 or beyond, which will delay transfer of Pathology work between network partners. WYAAT and ICS system-wide approaches to reset. Performance of CHFT in relation to Covid backlog position remains focus of work. Awaiting ambitions of government for healthcare post election. CHFT reconfiguration delays impacts timescale for service transformation - action: progressing supporting elements where possible. Trust financial deficit position may limit development of new services -see BAF risk 18/19 long term financial sustainability Action: Increase likelihood of this risk score from 4 to 5, 12 to 15 (June 2024)	Review alignment of Trust clinical strategy with WYICB Joint Forward Plan (Delivering Our Integrated Care Strategy) Lead: David Birkenhead Timescale: ~~September~~ November 2024 Review and refresh of clinical strategy to ensure it reflects CHFT and system ambitions. Review this risk once refreshed clinical strategy approved. Lead: Medical Director / Associate Director of Strategy. Timescale: Board approval planned for ~~September~~ 7 November 2024	3x5=15	3x5=15 ↑	3x3=9

Action	**Timescales**	**Lead**
Monitor impact of industrial action on clinical strategy progress	Ongoing	Medical Director
Progress supporting elements of reconfiguration where possible as part of clinical strategy	Ongoing	Medical Director / Deputy Chief Executive and Director of Transformation and Partnerships
Review and refresh of clinical strategy	~~September~~ November 2024	Medical Director
Review alignment of Trust clinical strategy with ICS 5 year plan for Better Health and Well-Being for everyone	~~September~~ November 2024	

Links to risk register: None

BOARD ASSSURANCE FRAMEWORK
JUNE 2024
TRANSFORMING SERVICES AND POPULATION OUTCOMES

TRUST GOAL: 1. TRANSFORMING SERVICES AND POPULATION OUTCOMES										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING JUNE 2024 Risk Category; Innovation/Technology Risk Appetite: High**		
								Initial	**Current**	**Target**
02/20 July 2020	Transformation Programme Board	Chief Digital and Information Officer (CDIO)	Risk of not securing appropriate investment to fund and deliver the Digital Strategy ambitions, ensuring infrastructure and technology is up to date and future proof due to funding not being available locally and nationally impacting on workforce efficiency and patient experience	Year 4 of 5 year Digital Strategy and continued review by Weekly Executive Board and annually to Board which will meet the needs and build the foundation for the next 5 year digital strategy Continued central funding available and committed capital funding from the Trust which will enable progression. Director of Digital Operations and Delivery role co-ordinating digital programmes and providing leadership whilst maintaining alignment toTrusts operational needs. Year 4 of the Digital Strategy (24/25 digital/EPR plan) focuses on improving on the digital basics and optimised use of existing systmes where funding may not be available. Governance via Digital WEB and Digital Operations Board.Digital Operations Board chaired by Chief Digital and Information Officer (CDIO), with reviewed terms of reference Monthly meetings with Chief Digital and Information Officer (CDIO) and Director of Finance reviewing progress with digital investment strategy. Divisional Digital Boards ensure appropriate spend of investment and report into the Digital Operations Board which has oversight of investment in line with strategy. EPR team restructured to ensure sufficient capacity and capability, with funding to support third Trust via project. CNIO and CCIO play a key role in the Digital Prioritisation Process (part of the Digital Health Team). COO, Chief Nurse,and Medical Director supporting the direction of digital developments in line with CHFT operational requirements. Clinical Change resource in place to help aid digital adoption and deliver benefits.	**First Line:** Digital Operations Board meeting bi-monthly, programme of work and progress presented at each meeting. **Second Line** Board approved Digital Strategy and associated investment plan (2 July 2020) provides direction . Additional funds for digital capital expenditure for 2023/24 secured. 11 January 2024 Digital Strategy Progress and Update to Board with plan to 2025. 2 September 2021 Board approved THIS Commercial Strategy confirms the Trust contribution target and allows for re-investment into THIS. Review 10 November 2022 Board. BCAG provides assurance that digital benefits are realised and digital business cases are aligned to the Trust Digital Strategy. **Third Line:** WYAAT & WYICS Chief Information Officer meetings ensures alignment of stategy on regional digital deployment as well as availability and eligibility for central digital funding. Good relationship with NHSE digital funding lead, Trust has received limited central funding in 2024/25.	Limited likelihood of securing centralised capital funding (NHS E) as it will be nationally limited in 2024/25. Action: Bids prepared to take advantage of any national capital underspend that becomes available in year. Lead: CDIO Timeframe: In Process	Availability of funding - continual monitoing of central funding available for digital investment. Lead: CDIO - ongoing	**4x3 = 12**	**4x3 = 12**	**3x3=9**

Action	**Timescales**	**Lead**
Digital bids prepared and monitoring of availability of central funding for digital investment	Ongoing	Rob Birkett

Links to risk register see linked 1/19 reconfiguration risk

BOARD ASSSURANCE FRAMEWORK
JUNE 2024
TRANSFORMING SERVICES AND POPULATION OUTCOMES

TRUST GOAL: 1. TRANSFORMING SERVICES AND POPULATION OUTCOMES											
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING FEBRUARY 2024 Risk category: Harm and Safety Risk appetite: low**		
								Initial	**Current**	**Target**
07/20 Added July 2020	Trust Board	Deputy Chief Executive	Risk of failing to respond to the health inequalities that exist within our populations due to lack of quality priorites to advance health equity, incomplete population health and patient ethnicity data, helthcare service delivery not matching patient needs in the most deprived areas or lack of resource allocation and programmes for health prevention, resulting in the Trust not reducing health inequalities for our most vulnerable patients with protected characteristics.	Deputy Chief Executive is the named Board Executive providing accountable leadership for tackling health inequalities. 2022-2024 Population Health and Inequalities Strategy approved at November 2022 Board with updates to Board throughout the year. Strategy focussed around four key areas of priority: Connecting with our communities and partners Access and prioritisation Lived experience and outcomes Diverse and inclusive workforce Health Inequalities Group, chaired by Deputy CEO, ensures oversight of all Trust workstreams in relation to health inequalities. Progress against delivery of Health and Inequalities Strategy reported regularly into the Trust Board. Equality impact assessment (EQIA) process for service and policy changes. Exploring actions to better recognise and address the impacts of poverty on health. Implementation of the Shadow Board - September 2023 Board Diversity Action Plan approved NHS EDI Improvement Plan - 6 high impact actions, one relating to members of Boards having an appraisal objective linked to EDI	**First Line** - Trust-wide health inequalities group meets monthly and oversees the organisations action plan and response to health inequalities. Health inequalities consideration and understanding included as a core element of all services supported by the development of data and performance information to enable greater activity analysis of access and outcomes through routine performance monitoring. **Second Line** - Progress against delivery of Health and Inequalities Strategy reported formally into the Trust Board on a 6 monthly basis. 2023 / 24 Annual Report reported on the required inequalities indicators and include additional narrative on the Population Health and Inequalities Strategy, our approach to addressing inequalities, and actions undertaken to reduce inequalities in line with NHS England requirements. Approved Board succession plan seeks to ensure clear talent pipelines for each Executive and non Executive roles in the Trust, including actions to ensure inclusive recruitment, and actions to ensure that the Board reflects the gender make up of local communities. EQIA referenced in all Board paper front sheets **Third Line** The Trust is working in collaboration as part of the West Yorkshire (WY) Integrated Care Board, WY Association of Acute Trusts and WY Community Collaborative, as well as continuing to showcase work nationally.	Continue to explore approach to diversity with WYAAT and ICB colleagues to ensure a regional approach. The Trust has delivered a number of successful interventions in respective of equality and diversity including the apprenticeship programme and Project SEARCH. Work continues overseen by the Trust's Inclusion group. Lead: Director of Workforce and Development Timescale: ~~March 2024~~ August 2024 Update in relation to use of patient level demographic information to prioritise clinical care - methodology trialled and used within cancer pre-habilitation services and outpatient services. Plans to add social vulnerability information to Trust systems. Lead: Deputy Chief Executive Timescale: ~~March 2024~~ August 2024 Population Health - continue to develop place-based approach to population health information to inform service planning and decision making. Deputy CEO and Managing Director of HIS leading on this work on behalf of CHFT Lead: Deputy CEO and Managing Director of HIS Timescale: ~~March 2024~~ August 2024	Population Health and Inequalities Strategy (2022-24) now in place. Progress against action plan continues. Policy to be refreshed and relaunched for 2025-27 period. Lead: Deputy Chief Executive ~~June 2024~~ March 2025	4x4=16	4x3=12=	2x4=8

Action	**Timescales**	**Lead**
Action Plan for more diverse Board and senior staffing consistent with local community and explore with WYAAT /ICBs	~~31/03/2024~~ 31/08/2024	Suzanne Dunkley
Development of tool to identify and highlight social vulnerability	~~31/03/2024~~ 31/08/2024	Rob Aitchison
Development of Place-based approach to population health information for service planning	~~31/03/2024~~ 31/08/2024	Rob Aitchison / Rob Birkett

Links to risk register: None

BOARD ASSURANCE FRAMEWORK
JUNE 2024
KEEPING THE BASE SAFE - BEST QUALITY AND SAFETY OF CARE

TRUST GOAL: 2 KEEPING THE BASE SAFE BEST QUALITY AND SAFETY OF CARE										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING JUNE 2024 Risk category: Regulation Risk appetite: Moderate**		
04/19	Quality Committee	Director of Corporate Affairs	**Risk** Risk that patients are not able to shape decisions about their care based on what matters to them due to lack of clear strategy and capacity for patient and service user engagement resulting in not designing services using patient recommendations and not meeting statutory requirements **Impact** - poor patient experience - Non delivery of improvements in services - inequitable service / care for patients - Risk of legal challenge - Reputational impact	• Patient Experience and Involvment Group (PEIG) provides strategic leadership and key programmes of work to improve experience of care and support the Trust to involve patients, carers and colleagues. • Governor and Healthwatch are members of PEIG • Dedicated senior leadership post for patient experience, equality and diversity and matron for complex care needs • PEIG work programmes informed by Insight including Person Centred Care; Strengthening working in Partnership with people and communities; Insight to inform Improvement Priorities and Supporting Carers; Divisional PSQB's updated on PEIG programmes of work and requests for support sought. Refresher training to support colleagues on Involvement / working in partnership developed and promoted. PEIG seeks to identify inequalities and barriers to accessing care through insight received and ensures this insight is shared with the Equalities Group. The Matron for Patient Experience is a member of the Equalities Group to ensure cross pol+A1lination. • Observe and Act patient observation tool as part of Journey to Outstanding reviews • Ambitions to support Carers at CHFT for 2024 / 2025 informed by carers, partner agencies, insight and colleagues developed. Accessible Information action plan progress reported to PEIG quarterly •Patient Stories widely used across the Trust to share good practice and also areas where experience of care can be improved. 6 CHFT colleagues trained in 2024 to record digital stories (patient, carer or staff experiences) to further amplify the voice of patients and service users and contribute to improvements in experience and service delivery and design • Matron on Reconfiguration Team leads on patient experience • Complaints mapped to IMD (index of multiple deprivation) groupings • Director of Corporate Affairs Chairs Calderdale Place Communications, Involvement and Equality Group and have members on the Kirklees equivalent	**First line** Patient Experience Involvement Group Quarterly report on patient experience and involvment to Quality Committee Examples of good practice on patient and public involvement including reconfiguration programme, children's services, carers etc. These are captured in bi monthly divisional highlight reports ; Expert by Experience and Patient Safety Partners recruited and Expert Panel meeting bi-monthly **Second line** Patient Story to PEIG, Quality Committee and Board Governor attends PEIG Director of Corporate Affairs chairs Place Communications, Involvement and Equality Group reporting in to ICB Member of Place Based story tellers network PEIG reporting to Quality Committee quarterly, and Annual Bi monthly Carer meetings with key partners including Local Authority, Healthwatch, ICB **Third line** Quality Accounts, CQC rating of Good - report referenced positive examples of patient engagement. Healthwatch reports, and joint initiatives and positive working relationship Recent external Government led review of accessibility of Trust website led to some actions which are now all complete	1. New Equality Delivery System 22 in place- clarity on the ask of providers versus that of Places. Clarity being sought with NHS England and Place lead 2. Work to do to improve compliance with Accessible Information Standard (AIS) Director of Corporate Affairs to complete outstanding actions by March 2024 AIS policy drafted - to be approved 3. Review of translation services contract required following patient feedback. Not clear if meeting KPIs.Review with procurement and bridging contract in place to continue service provision whilst review completed 4. Vacancy in Patient Experience post and identified administrative support to implement proposed section 242 process	Need systematic way of capturing robust assessment of the duty to involve, support for colleagues, including signposting to existing networks through ICB engagement leads and reportiong on patient and public engagement and its link to equality.	**Initial** **3x4 = 12**	**Current** **4x3 = 12 =**	**Target** **1x4 = 4**

Actions	**Timescales**	**Lead**
1. Complete actions to comply with Accessible Information Standard.	~~March~~ September 2024	Chief Nurse
2. Procure new contract for translation services	~~March~~ September 2024	Head of Procurement
3. Recruit to Head of Patient Experience	July 2024	Chief Nurse
4. Develop record of patient and public involvement activity across the Trust	July 2024	Head of Patient Exprience
5. Implement new section 242 assessment into EQIA / QIA process	~~March 2024~~ July 2024	Director of Corporate Affairs

Links to risk register:
No risks on the high level risk register

BOARD ASSURANCE FRAMEWORK
JUNE 2024
KEEPING THE BASE SAFE - BEST QUALITY AND SAFETY OF CARE

TRUST GOAL: 2 KEEPING THE BASE SAFE BEST QUALITY AND SAFETY OF CARE										
Ref	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING JUNE 2024 Risk category: Regulation Risk appetite: Moderate**		
								Initial	**Current**	**Target**
06/19	Quality Committee	Chief Nurse/ Executive Medical Director	**Risk** Risk that patients do not receive high quality, safe care due to poor compliance with internally and externally set standards on quality and safety resulting in patient harm or poor patient experience. **Impact** - Quality and safety of patient care and Trust's ability to deliver some services. - Enforcement notices with regulators - Ability to deliver national targets and CQUINS. - Increased risk of litigation and negative publicity. - Poor staff morale	• Quality governance arrangements monitor quality and safety in line with our governance structure approved by the Board of Directors. • Quality and Safety strategy in place and approved by Quality Committee. Divisional reports quarterly to Quality Committee provides oversight of divisional management of quality and safety. • Quality Committee scrutinises quality priorities with specific KPIs in place, and the Maternity Transformation Plan • Serious incident (SI) investigation process currently transferring to the new Patient Safety Incident Investigation (PSII) under the new Patient Safety Incident Response Framework (PSIRF) identifies recommendations to improve care with strong governance in place and process in place to address any immediate learning. • Clinical Effectiveness and Audit Group (CEAG) reviews assurance on guidance and national audits. • Clinical Outcomes Group monitors workstreams for patient safety and quality, reporting into Quality Committee. • Risk management strategy revised and refreshed, strengthened risk management arrangements at divisional level. • Patient Safety Incident Response Framework (PSIRF) and new investigation model that aligns with PSIRF framework being tested, with aligned and approved Incident Reporting Policy commenced and being embedded. • Board approved Infection Prevention Control (IPC) Board Assurance Framework (BAF) aligned with NHS England evidence-based framework •Compliance register refresh and scrutiny by Compliance Group • Focused Journey to Outstanding (J2O) programme currently being reviewed to align with CQC single assessment framework. • Ward assurance visits programme - clinical area quality dashboard reviewed at at Nursing and Midwifery Workforce meeting. Process in place for reviewing quality metrics at ward and department level, reviewed and aligned to CQC key lines of enquiry. • Care of the Acutely Ill Patient programme in place to improve mortality outcomes. • Nursing and Midwifery Strategy - enhanced quality dashboard monitored through nursing workforce meeting. • Children and Young Peoples Improvement Plan and Childrens Board has been established. • Learning from deaths programme and medical examiners office - processes in place to flag concerns and issues for further investigation. • Freedom to Speak Up process to support a culture for raising any safety concerns. • Participation in the national GIRFT Programme and national elective recovery programme.	First line Assessment of compliance with NICE guidance with increased oversight at CEAG. Performance against safety must dos reviewed at ward / matron level. HSMR & SHMI. Consistent mandatory and essential training compliance. Improved real time assurance on impact of safety staffing and quality - Nursing Midwifery Workforce Group Second line Clinical audit plan reviewed with increased oversight at CEAG. Sub-groups report into Quality Committee as per governance arrangements and workplan. Maternity report to Quality Committee and Board - response to Ockenden review KPIs in Integrated Performance Report, PSQB reports to Quality Committee. 6 July 2023, Board report on Infection Control and progress with IPC BAF recommendations. June 2023 signifcant assurance opinion on IPC BAF following internal audit review, Board approved Risk Management Strategy September 2023 Monthly Quality report to Quality Committee which includes update on Serious Investigations (SI) progress soon to be Patient Safety Incident Investigation (PSII) and a lessons learnt section. Reporting arrangements for Divisional PSQB's into Quality Committee agreed. Safer Staffing Hard Truths report to Board 10.11.22., 6.7.23. Maternity Services report to Quality Commitee and Board (March, May, July 2022) Complaints performance improved allowing time to focus on learning from complaints, with themes and trends identified and linked to Quality Priorities 2023/24. Ward to Board internal audit significant assurance opinion reviewed by Quality Committee (May 2023). 7.9.23. Board "True for Us" report in response to Lucy Letby case, Board development session quality and safety and PSIRF Freedom to Speak process reporting into Workforce / Quality and Board. Third line CQC maternity inspection report August 2023 - retained overall good rating. CQC rating of Good, regional Ockenden Assurance Visit (28.6.22.) CQC. Maternity Incentive Scheme - Inpatient, Children's and Young Peoples survey and urgent care survey 2023. Quality Internal audit report on quality governance CH 07/24 Account reviewed by stakeholder bodies for 2023/24 with positive feedback . Independent assurance on clinical audit strategy. Feedback through ongoing relationship with arms length regulatory bodies. CQC - Undertaken discharge review and Surgical Services visits. Independent Service Reviews (ISR) and accreditations. Health Services Investigation Branch reports and on site visits	• Recruiting to vacancies in revised quality and safety team structure Action: Complete recruitment March 2024 Lead: Deputy Chief Nurse/ Director of Corporate Affairs Quality priorities but gap re: Quality and Safety Strategy Action: Development of Quality and Safety Strategy Chief Nurse Timescale: April 2024 Variability in quality of divsional risk registers and understanding of their roles in risk management Action: Risk register training for divisional staff to support improved use of risk register to accurately identify risks to quality and safety of care Lead: Deputy Chief Nurse Timescale: ~~March~~ November 2024 Ability to triangulate data to identify themes, trends and early warning signs of quality and safety issues Action: Developing phased project implementation plan for new risk management software with transition to new system by February 2025 Deputy Chief Nurse	Establishment of Same Day Emergency Care (SDECs) will deteriorate the statistical calculations associated with HSMR and SHMI for up to 2 years. Action: Clinical Outcomes Group monitoring impact,seek assurance that quality and safety are maintained - ongoing to March 2026. Implementation of recommendations from internal audit review of risk management processes Lead: Chief Nurse, Director of Corporate Affairs Timescale: November 2024 Inconsistent application of quality improvement (QI) methodology Action: Scope target audience and delivery method for QI methodology training Lead: Deputy Chief Nurse Timescale: ~~January~~ July 2024 Integrated Provision in the community: relative immaturity of Place-based quality and safety governance and assurance and regulatory/ statutory provider framework for integrated care. Continue to develop Place based governance infrastructure Lead: Director of Operations C+A3ommunity.	3x5 = 15	3x5= 15 =	2x5 = 10

Action	**Timescales**	**Lead**
Recruitment to revised quality and safety team structure	~~March 2024~~ March 2025	Deputy Chief Nurse
Risk register training for divisional staff	~~March~~ November 2024	Chief Nurse
Risk management software phased project plan developed and delivered	February 2025	Deputy Chief Nurse
Clinical Outcomes Group monitoring of mortality data	Ongoing to June 2026	Medical Director

Links to risk register:
Also see BAF risk re clinical strategy 1/20, 10a/19 and 10b/19 relating to staffing
8528 ED operational performance
6079 follow up out patient appointments

TRUST GOAL: 2 KEEPING THE BASE SAFE BEST QUALITY AND SAFETY OF CARE

Ref & Date added	OWNER Board committee	Exec Lead	RISK DESCRIPTION *(What is the risk?)*	KEY CONTROLS *(How are we managing the risk?)*	POSITIVE ASSURANCE & SOURCES *(How do we know it is working?)*	GAPS IN CONTROL *(Where are we failing to put controls / systems in place?)*	GAPS IN ASSURANCE *(Where are we failing to gain evidence about our system/ controls?)*	RATING JUNE 2024 category: Regulation Risk appetite: Moderate		
								Initial	Current	Target
04/20 July 2020	Quality Committee	Chief Nurse	Risk of not maintaining the Trust CQC overall rating of good and increasing the number of services achieving an outstanding rating as assessed by the new CQC single assessment framework and potential for ratings to be changed by CQC based on other intelligence or data from CQC portal outside of on site inspection of services, due to failure to comply with quality statements resulting in a reduction of quality of services to patients and an impact on reputation See BAF risk 6/19 - quality of care and poor compliance with standards	CQC Group with refreshed terms of reference meets monthly, oversee compliance with regulatory standards/ –and reports to Quality Committee, monitoring progress against 2018 must do and should do actions. Action plans in place re: must do and should do actions from 2018 CQC report, compliance with medical staffing in ED dependent on reconfiguration and GPICS standards on critical care. Regular engagement meetings with CQC and on site focus visits taking place Process for internal assessment against CQC standards (Journey to Outstanding) Dedicated CQC lead CQC action plan developed following CQC maternity inspection, monitored by CQC Group for Trust oversight, with local oversight by team Independent Well-led Governance development review completed. CQC resource centre portal for staff with information on CQC reports, standards, self assessment documentation. Ward accreditation processes (Journey to Outstanding) reviewed and updated, piloted and being rolled out. Journey to Outstanding (J20) implemented with increased breadth and depth of assurance - working towards business as usual model Focused Journey to Outstanding programme review of maternity services and community paediatric services. Reviewing J2O process against revised CQC framework. CQC Housekeeping Evidence List rolled out to Divsions June 2024	**First Line:** Reports to CQC Group from divisions with increased scrutiny Journey to Outstanding results and action plan and findings shared with wards and presented to CQC Group . **Second Line:** Quality Summit / Board Development Session (Well-led) CQC maternity inspection action plan progress reports to Quality Committee Quality Committee reports from CQC Group and as part of Bi monthly quality report Divisional review of must do and should do actions from 2018 CQC report complete with closure statements presented to July 2024 Quality Committee Quality Committee highlight report to each Board **Third Line:** Formal engagement meetings with CQC and rolling programme of on site visits. Current CQC rating of "good" including well-led governance - maternity services rated as good overall in CQC maternity inspection report August 2023 Providers will be able to submit statutory notifications CHFT now have access to this portal and will submit notifications via this methodology for greater level of assurance External Speaker attended May WEB to give an overview of the new CQC Single Assessment Framework May 24	New inspection frameworks for acute and community services published October 2023. Board Level Well-Led preparation workshops to commence. CQC Workshops to commence for Senior Divisional colleagues to support with CQC Readiness Action: need to undertake assessment against new CQC Single Aassessment Framework Lead: Director of Corporate Affairs	Focus Task Force to Support Medical Divsion with CQC readiness June 24 CQC maternity report August 2023 rating of requires improvement for safe Delivery of CQC action plan for 2 must do actions (training and qualified staffing levels) and 5 should do actions 2023 move to Single Assessment Framework for future CQC inspections and rating regime. CQC will gradually start to carry out assessments in the new way. This means a new approach to inspection and new assessment framework.In summer a new online provider portal will be lunched. This will be done in stages and provide support and guidance.	4x3=12	4x3=12	3x2=6

Action	Timescales	Lead
Ongoing support with Divisional senior leadership team colleagues to ensure CQC housekeeping evidence is in place	June 2025	Chief Nurse
Journey to Outstanding implementation underway via rolling programme including focused visits	12 month rolling programme	Chief Nurse
Development of PLACE level framework for system reviews with partners	~~March 2024~~ March 2025	Chief Nurse
Assessment of compliance against newly published inspection framwork for Acute Hospitals and for Community Services to be undertaken and report to Board	~~January 2024~~ January 2025	Director of Corporate Affairs

Links to risk register:
None

BOARD ASSURANCE FRAMEWORK
JUNE 2024
KEEPING THE BASE SAFE - BEST QUALITY AND SAFETY OF CARE

TRUST GOAL: 2 KEEPING THE BASE SAFE BEST QUALITY AND SAFETY OF CARE											
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** (*Where are we failing to gain evidence about our system/ controls?)*	**RATING JUNE 2024 Risk appetite: Low (Ham and Safety)**		
								Initial	**Current**	**Target**
1/23 June 2023	Finance and Performance Committee	Chief Operating Officer	Risk that continued high acute demand, high patient acuity and shortfall in community provision leads to the requirement for additional beds over and above planned levels. This results in staffing and financial pressures.	Well Organised Ward programme and toolkit with four "must dos" to ensure consistency of fundamental actions at ward level by clincial teams. The Urgent and Emergency Care Delivery group (UECDG) is the overall assurance meeting for the delivery of Urgent and Emergency Care and reports to the Finance and Performance Committee and the Trust's Transformation Programme Board. It meets monthly to strategically review the performance of UEC delivery through the data dashboard and the improvement groups. The UECDG has two focused Improvement Groups: Same Day Emergency Care (SDEC) and Length of Stay (LOS). The Improvement Groups are supported by project individual Task and Finish groups, which provide monthly data-led updates into the appropriate Improvement Group for appropriate discussion, challenge and steer. The Improvement Groups report assurance of the delivery of UEC into the UECDG. Working with partners in Calderdale and Kirklees to agree target operating models for integrated community urgent and intermediate health and care models of care (with interfaces to single points of access and neighbourhood teams). Target operating models to frame effective use of business as usual and transformation based monies aligned with Place and wider system objectives. Agreement in principle with Calderdale partners on target operating model, gap analysis against and use of recurrent and non-recurrent funding to support delivery against that gap. Sept 23 - Agreement in place to use allocated funding for discharge to enhance reablement which will support improved discharge of cohorts of patients on the transfer of care (TOC) list. Recruitment and roll out underway.	**First Line** Length of stay improvement group in place meeting monthly. Separate working groups in place with clear leads that report in to the improvement group. Same Day Emergency Care (SDEC) improvement group in place , which through september and october are being supported by the external CLEAR project team. Seperate working groups with clear leads that report in to the improvement group. ED improvement workstream led by ED directorate Senior Management Team which also reports to UECDG. **Second Line** Urgent and Emergency Care delivery group chaired by COO, meeting monthly, improvement workstreams report in to U and E CDG, against identified KPI's. U and E CDG reports in to Finance and Performance committee which reports in to Trust Board. Focus through Turnaround Executive on the financial savings linked to reduction in LOS and reduced bed base. **Third Line** NHS England (NHS E) monitoring and production of reports linked to Emergency Department and bed occupancy. Monthly meetings with COO and NHSE. Calderdale and Huddersfield U and E Care Board meets monthly with community teams, ICB and Local authority representation. CHFT UECDG reports updates on workstreams in to this.	Kirklees community provision and commissioning models for that provision . Action:ongoing discsussion with Kirklees partners Lead: Director of Operations Community Michael Folan, Deputy Chief Executive, Chief Operating Officer Transfer of care list for Kirklees and Calderdale running at high levels, 100-130. HIgher volume of patients requiring support on discarge and community provision not able to meet demand. Partner discussions continue which will form part of the planning discussions 2024/25 Lead: Director of Operations Community Michael Folan, Deputy Chief Executive, Chief Operating Officer	Absence of agreement in principle with Kirklees partners on target operating model to support increased discharge of patients on TOC list, gap analysis against and use of recurrent and non-recurrent funding to support delivery against that gap analysis. Lack of assurance re capacity and provision of social care. Discharge run rate from the TOC list remains insufficient to reduce and maintain at a lower level, the overall number. This continues to form part of planning discussions 2024/25. Lead: Chief Operating Officer, Deputy Chief Executive, Director of Finance Ongoing system-wide discussions regarding programme of work focused on Home First and move away from discharge to assess beds. CHFT to continue to work with partners. Lead: Chief Operating Officer, Deputy Chief Executive Joint community dashboard developed along with system partners and enables focus through system silver escalation meetings and to support focused action to enable sufficient capacity. Next steps - embedding in to BAU processes and work with partners on reducing post discharge ready length of stay Lead: Chief Operating Officer and Deputy Chief Executive Timescale: ~~31/03/24~~ Ongoing through 2024/25	4 x 5 = 20	4 x 5= 20	4x3=12

Action:	**Timescales**	**Lead**
Use of allocated 'pot 2' funding to enhance reablement for Calderdale. Roll out of programme in alignment with recruitment	~~Ongoing to March 24~~ Ongoing through 2024/25	Chief Operating Officer, Deputy Chief Executive
System wide discussions re Home First for Kirklees.	~~31 March 2024~~ Ongoing	
Planning discussions with a focus on agreement with Calderdale and Kirklees regarding capacity to support reduction in TOC list	30 April 2024	
Continued shift to single point of access and flexibility accross community provision in Calderdale, to enable reduction in post discharge ready date length of stay (LOS).	August 2024	
Collection of data on benefits to support ongoing discussions re: kirklees provision		
Continued roll out of SDEC and LOS reduction programmes	Ongoing through 2024/25	
High level risks		
8606 unable to reduce acute in patient bed base in line with reduction plan, 8528 ED operational performance		

TRUST GOAL: 2 KEEPING THE BASE SAFE BEST QUALITY AND SAFETY OF CARE

Ref	OWNER Board committee Exec Lead		RISK DESCRIPTION *(What is the risk?)*	KEY CONTROLS *(How are we managing the risk?)*	POSITIVE ASSURANCE & SOURCES *(How do we know it is working?)*	GAPS IN CONTROL *(Where are we failing to put controls / systems in place?)*	GAPS IN ASSURANCE *(Where are we failing to gain evidence about our system/ controls?)*	RATING JUNE 2024 Risk category: Strategic Risk appetite: Significant		
								Initial	Current	Target
9/19	Transformation Programme Board	Executive Director of Finance	Risk of failure to maintain current estate and equipment and develop future estates model to provide high quality patient care Impact - Poor quality of care and treatment - Poor patient experience - Poor staff experience and negative impact on their health and wellbeing - Regulatory action - Inability to implement service change - Reputational damage with stakeholders	• Governance arrangements and SLAs with CHS monitored at CHS Board, monhtly contract and performance meeting with quarterly CHS / Trust Joint Liaison Committee,overseeing estate, facilities and medical engineering risks • Governance arrangement and performance contracts with PFI monitoring at monthly Contract & Performance meetings in place. • 6 Facet estate condition survey 2023 informs estates investment plan. • Systematic review of Divisional and Corporate compliance, • Capital funding secured for Multi Storey Car Park (MSCP) CRH in 2024/25 capital plan • Medical device and maintenance policies procedures, Planned Preventive Maintenance (PPM) Programme - improvements made to PPM and end of life service contracts •Premises Assurance Model (PAMs) illustrates to patients, commissioners & regulators that robust systems are in place in regarding the premises and associated services are safe • CHS Medical Engineer in post • Categorisation / risk analysis of medical devices (high, medium, low) to prioritise maintenance • Independent audit of medical devices • Health Technical Memorandum (HTM) compliance structure in place including external Authorsing Engineers (AE's) who independantly audit both CRH and HRI Estates against statutory guidance. • Authorising engineer for fire •Concordat with West Yorkshire fire authority * Quarterly PFI Liaison Committee established Oct 2020 with PFI & CHFT to receive assurance against compliance, Head of Estates and H&S lead from CHS now attend the Risk Group to align Trust and CHS risk registers • 6 monthly insepctions of cladding at HRI with report to CHS Board and Transformation Programme Board - programme of cladding works towards the end of the reconfiguration timetable supported by the Transformation Programme Board 12 December 2023	First line • Close management of service contracts to ensure planned maintenance activity has been performed. Audit plan in place for both PFI and CHS and regular audits completed by Service Performance. Risk register reports. Joint HTM Meetings in place with Trust,PFI & CHS. Audits of routine checks, estates * Trust Health & Safety Manager with oversight of H&S across Trust & between partners. Audit of HTM Compliance to confirm appropriate control measures in place to manage the HRI and community estate completed Q1 2023. *RAAC surveys completed and assurances provided from Leased In Properties. New A&E at HRI operational, meets the latest HTM/HBN guidance and statutory/legislative compliance. Second line Estates strategy (revised) approved at Board 2.9.21. H&S Update to Board: January 2022. Priorities shared with Service Performance to implement with CHS/PFI Board review of feasibility study for development of HRI which mitigates known estates issues (5 March 2020 private Board) Health and Safety Committee monitors medical devices training and escalates concerns to Audit & Risk Committee (Audit & Risk to approve newly developed H&S Committee TORs) Medical Engineering Committee monitors medical devices action plan, new equipment and addresses risk analysis of devices Review of PFI arrangements, via Service Performance Audits / Reports. Assurance provided by HTM Compliance reports via external Authorised Engineers inspections against HTM standards. WEB reports on medical devices July 2019 Third line CQC Compliance report.PAMS. HSE review of water management. Familiarisation visits by local operational Fire and Rescue teams. External assurance from authorising engineers for high voltage/ low voltage s+F51ystems.PLACE assessment (Patient-Led Assessments of the Care Environment) undertaken October 2022 by Quality Performance and Service Manager	• Multi Storey Car Park - enabling works commence July 2024, legal approval awaited before further progress can then be made. * Development of 6 Facet survey action plan (survey covered HRI, CRH, Acre Mills & Broad Street) by July 2024, lead: Head of Estates Unable to demolish DATs building to reduce backlog maintenance as planned as required for staff offices. Action: Estates monitoring of situation and maintenance of statutory compliance.		4x4 = 16	5x3= 15	2x4 = 8

Action	Timescales	Lead
Parking - Full enforcement of ANPR at HRI & Acre Mill	July 2024.	Head of Estates for all
Development of 6 Facet Survey action plan	July 2024	

Links to risk register:
Risk 7413 - Fire compartmentation risk, HRI, 8161 CT scanning, 8562 Pathology, 7955 x ray

BOARD ASSURANCE FRAMEWORK
JUNE 2024
KEEPING THE BASE SAFE - BEST QUALITY AND SAFETY OF CARE

TRUST GOAL: 2 KEEPING THE BASE SAFE BEST QUALITY AND SAFETY OF CARE

Ref & Date added	OWNER Board committee Exec Lead		RISK DESCRIPTION *(What is the risk?)*	KEY CONTROLS *(How are we managing the risk?)*	POSITIVE ASSURANCE & SOURCES *(How do we know it is working?)*	GAPS IN CONTROL *(Where are we failing to put controls / systems in place?)*	GAPS IN ASSURANCE *(Where are we failing to gain evidence about our system/ controls?)*	RATING JUNE 2024 Risk category: Regulation Risk appetite: Moderate
16/19 9/1/20	Audit and Risk Committee	Director Champion - Chief Operating Officer	Risk of not being compliant with the Health and Safety at Work Act (1974) and supporting regulations resulting in harm to staff, patients, the public, visitors, potential regulatory failure, finanical risk and reputational damage	•Board approved 5 year H&S strategy NHS Workplace Safety Standards provides framework for H&S activity, relevant policies reviewed and shared with stakeholders specific to roles and responsibilities (policy tracker written). The Strategy has been revised in early 2023 •Resilience and Safety Group approval of H&S policies •General Health and Safety Policy (updated early 2023) clearly highlights the overarching roles and responsibilities and arrangements to achieve compliance. New lone working policy, and a new security policy approved April 2024, revised Violence & Aggression Policy with behaviour support cards, revised COSHH policy • Individual health and safety policies under continuous review across 2022/23 and shared with CHFT Resilience and Safety Group Meeting - each policy with individual subject matter expert ownerships • SLA in place for CHS to provide Health and Safety Induction Training of on-site contractors and visitors • Executive Director Health and Safety Champion identified • Proactive Resilience and Safety Group Meeting firmly established. • Head of Health and Safety involved in all new sub committees to H&S committee. 8 H&S subgroups formed - maintains traction upon stakeholder responsibilities • Annual report on Health and Safety to Board which is to be a combined fire, security and health and safety risk paper and presented for 2023 submission • Health and Safety with updates to Board, Audit and Risk Committee oversight and attendance to present at Quality Committee every 6 months . • Health and Safety mandatory ESR training for staff (3 years). • Auditing and monitoring of compliance via new health and safety dashboard which is presented at each Resilience and Safety Group Meeting. Desktop meetings take place between the subject matter lead and the Head of Health and Safety across the year to ensure/seek assurance of continuous compliance. New prevention and management of violence and aggression collaborative group created, meets monthly to review trends/patterns and hot spots New prevention and management of violence and aggression people orientated risk assessments completed New prevention and management of violence and aggression building orientated risk assessments completed, and working in partnership with West Yorkshire Police designing-out crime officers New PCSO started in the Trust - May 2024	First line Minutes of the Resilience and Safety Group Meeting evidence good level of engagement by all partners. Review of Resilience and Safety Group Meeting by members confirmed good sharing of current information, monitoring of trends, review of policies, sharing of health and safety incidents and learning, medical devices training & monitoring, fire and security information .Policy approval bia Policy approval via Resilience and Safety Group Second line Updated COSHH policy approved by Executive Board 20.6.24. Board joint responsibility for risk understood with Weightmans Solicitor Legal update given in 2023 WEB reports on mandatory training, health and safety training compliance -Resilience and Safety Group Meeting to Audit and Risk Committee, with annual deep dive. Quality Committee engagement planned for 2022, 18 October 2022 and then every 6 months with last most recent update April 2024 Audit Yorkshire January 2021 9 January 2020 external Health and Safety review presented to Board • 2021/22 Annual Health and Safety report and action plan to Board - 12 January 2023, May 2023 • Health and Safety Strategy revised September 2022, review of 2023 - 2028 Strategy by Audit and Risk Committee 31.1.23. Updates to Board on H&S 3 September 2020, 14 January 2021, 1 July 2021, 13 January 2022, Third line External health and safety review (Quadriga) 2019.	Development and implementation of NHS Workplace Health and Safety Standards - 90% achieved (10% left = Security compliance), Lead: Head of H&S Timescale: ~~May~~ September 2024 Strengthening of assurance required for COSHH compliance. Cross-divisional engagement project to improve compliance started in early part of 2024. Transfer of COSHH assessments to new SYPOL page in system, meaning true number of substances now held on file. Stage 2 focus is review of COSHH assessments with department/ward leads. Implementation of the lone worker policy/risk assessment requirements	Work continues upon the security compliance requirements, with a plan of action now written and working towards completion by mid-2024yr. The action plan is cross referenced against NHS Violence Reduction Standards and the NHS Workplace Health and Safety Standards.	Initial: 3x3 = 9 Current: 3x2 =6 = Target: 3x1 = 3

Action	Timeframe	Lead
Development and implementation of NHS Workplace Health and Safety Standards (10% remaining to do)	~~May 2024~~ September 2024	Head of H&S all actions
Formation of a cross divisional improvement plan to seek better compliance	~~Mid 2024~~ September 2024	
Delivery of security improvement plan	Autumn 2023 improvement plan completed and now stage 2 (implementation process - ~~May 2024~~ Sept 2024)	
Implemetation of lone worker policy/ risk assesment requirements	September 2024	

Links to risk register:
7413 fire compartmentation

TRUST GOAL: 2 KEEPING THE BASE SAFE BEST QUALITY AND SAFETY OF CARE										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING JUNE 2024 Risk category: Strategic Risk appetite: Significant**		
								Initial	**Current**	**Target**
3/23	Anna Basford, Deputy Chief Executive and Director of Transformation and Partnerships	Board of Directors	Risk that decision making processes and capacity of Trust colleagues is impacted due to the evolving nature of partnership governance across the system and emergent governance arangements	Ensuring we have a voice and influence at all levels within the region and places: -Chief Executive is the Chair of the West Yorkshire Association of Acute Trusts and a member of the West Yorkshire Integrated Care Board - Chair and Chief Executive attend ICS - Chair and Chief Executive members of Calderdale Place ICB - Director of Finance has role as Finance Lead for Kirklees Place - Chief Executive and Deputy Chief Executive members of Kirklees Place ICB - Other Director and senior leadership part of governance structures and workstreams at West Yorkshire and Place levels Directors in Senior Responsible Officer roles across Places Board discussions on system governance arrangements and direction of travel Round table arrangements in place for reconfiguration decision making involving regional and local partners	**First Line** • Chief Executive and Chair reports to Board • WYAAT Reports to Board • Round table discussions reported through Transformation Board **Second Line** • Trust members in Place and Regional decision making arrangements • Shared involvement in Place based reviews including safeguarding, Ofsted etc **Third Line** • Place review	ICB Operating Model published with 30% reduction in running costs by April 2025 may lead to disruption with ICB partners and individuals - outcome of impact of operating model for West Yorkshire awaited.	CQC system assessment framework not yet confirmed	4x4 =16	4x2=8	4x2=8

Actions	**Timescales**	**Lead**
Seek assurance on impact of the changes described in published operating model	Ongoing review	CEO
High Level Risk Register risks - none		

BOARD ASSURANCE FRAMEWORK
JUNE 2024
KEEPING THE BASE SAFE - BEST QUALITY AND SAFETY OF CARE

TRUST GOAL: 2 KEEPING THE BASE SAFE BEST QUALITY AND SAFETY OF CARE											
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** (*Where are we failing to gain evidence about our system/ controls?)*	**RATING JUNE 2024 Risk category: Regulation Risk appetite: Moderate**		
								Initial	**Current**	**Target**
4/23 Added September 2023	Finance and Performance Committee	Chief Operating Officer	**Risk** Risk of failure to achieve local and national performance targets **Due to** Strike action; workforce gaps; partner responsiveness; activity pressures **Impact** - deterioration of patients waiting longer for treatment - Poor patient experience -Elective recovery Funding - Reputational damage with stakeholders - clinician dissatisfaction	Clinical prioritisation of all patients on waiting lists to identify current priority status and a process for regular review of clinical need. Increased number of outcome metrics within performance reporting monitored through performance framework . WYAAT system approach to capacity management. Urgent Care System Board and ICS Discharge Forum with social care providers to plan / consider options Daily escalation of performance issues from divisional hubs into Bronze, Silver and Gold levels as appropriate. Access Delivery Group, Cancer Group, Urgent Care Delivery Group meet monthly to monitor recovery programmes, standards and waiting lists. Silver meeting has trajectory for reducing Transfer of Care list and is working through agreed actions Health Inequalities linked to elective recovery monitored at a divisional level. OPEL escalation arrangements reviewed and updated to provide clearer escalation process. Approved surge and escalation plan and implementation of full capacity protocol. Performance is discussed at the Finance and Performance Committee and any areas of under performance are considered in detail or as part of deep dives New ED opened 22 May 2024	**First line** Daily Bronze meeting and silver when required with process to enact GOLD if needed. New OPEL levels in place Trust feeds into weekly silver meeting with partners. All areas have access to KP+ Risk registers reviewed at Divisional PSQBs & PRMs. Performance bulletin issued regularly to stakeholders Integrated Performance report focus of one WEB each month for detailed scrutiny of recovery performance and activity. Integrated Performance Report overhauled and in place using statistical process charts and NHS Digital good practice for performance reporting Elective care transformation programme relaunched **Second line** Integrated Performance Report discussed at each Board sub committee and Board of Directors Assurance on overall performance discussed in detail at Finance and Performance Committee **Third line** Routine reporting to NHS England - met A and E wait time target of 76% in March 2024. Comparison data nationally shows Trust as one of the best performers on elective recovery and one of four Trusts achieveing all three key cancer standards Prof Tim Briggs visit demonstrated good practice in elective position and shared as an exemplar nationally Awarded elective recovery hub and community diagnostic hubs	Not meeting diagnostic wait times in some modalities - action plan in place to address re neurophysiology and ECG COO - ~~January 2024~~ March 2025 Strike action impacting on delivery of elective, diagnostics, outpatients and non-elective activity - Strike planning meetings in place internally and with partners COO. There is a need to model impact to date and project potential impact going forward - Ongoing Impact of the opening of the new A&E and the actions of individuals on the use of A&E unknown but could impact performance at the HRI site and overall in the short term. Action: Impact on performance from new A&E opening being monitored COO - August 2024	A and E wait time target dropped in April and May to 70%. Continued improvement required. Lead: Director of Operations Medicine, COO. 31.03.25 Annual Plan doesn't achieve 92% bed occupancy. CHFT agreed bed occupancy target 96%. Lead: Director of Ops Medicine, COO. 31st March 2025 Transfer of Care list remains high at approx 130 in May. Lead: Director of Ops Community, COO, Deputy Chief Exec. 31st ~~March~~ August 2024 Reduction in outpatient follow-ups not yet being met. Actions continue. Validation WTGR session planned August 2024. Lead: Director Ops FSS, COO. ~~01.06..24~~. 30.09.24. Plan to have no over 52 week waits for elective RTT not being met due to specific pressures within ENT. Plan remains to clear all over 52 weeks during 24/25. Lead: Directors of Ops Surgery, COO. ~~01.06.24.~~ 31.03.25. Improved position against DMO1 (6 week diagnostic) target for Cardiology and Neurophysiology. Actions continue. Lead: Director of Operations Medicine, COO. 30.06.24.	**4x5 = 20**	**4x4 = 16**	**4 x 3 = 12**

Actions	**Timescale**	**Lead**
Deliver action plan to address waiting times in neurophysiology and cardiology Strike action planning/ undertake modelling of the impact of Industrial action on elective activity and model this going forward to enable projections Monitor impact of opening new A&E and model resulting performance Actions re: A&E target, bed occupancy, transfer of care list, out patient follow ups, 52 week waits	~~January 2024~~ March 2025 Ongoing ~~April 2024~~ August 2024 ~~31.3.24.~~ 31.03.25.	Chief Operating Officer for all Respective divisional Director of Operations

Links to risk register: 8528 Emergency Department operational performance , 8324 non-compliance with elective access policy (RTT validation), 8398 colorectal surgery

BOARD ASSURANCE FRAMEWORK
JUNE 2024
KEEPING THE BASE SAFE - BEST QUALITY AND SAFETY OF CARE

TRUST GOAL: 2 KEEPING THE BASE SAFE BEST QUALITY AND SAFETY OF CARE											
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING JUNE 2024 Risk category: Innovation/Technology Risk appetite: Moderate**		
								Initial	**Current**	**Target**
5/23 November 2023	Audit and Risk Committee	Chief Digital and Information Officer	Risk of an impact to the delivery of clinical or corporate services due to reduced or no digital provision resutling from a cyber attack impacting on patients via exposure of patient records, inability of workforce to access / record patient care affecting quality and safety, financial and reputational risk . (Including but not limited to Cyber vulnerability, Social engineering, malware, ransomeware, phishing emails, loss of data and DOS attacks)	Significant internal and external security technical controls including: Vulnerability Management, Threat Management, Real time threat monitoring. Dedicated Cyber team monitoring and addressing threat notifications. Incident response and recovery - Business continuity plans (BCP) for clinical and non-clinical areas in the event of no digital provision. Monitoring via national ATP (Advanced Threat Protection) service. Programme of maintenance / replacement of digital systems ensuring up to date operating systems and configurations as per NCSC guidelines. Dedicated resource through cyber security team for management of cyber security issues, inlcuding an NSCS accredited lead. Policies on the handling and storage of data, and Data Protection officer: Information Security Policy, Network Security Policy (identity and access management) & Incident reporting system Essential training for staff on information security and cyber risks via ESR & Controls on supplier systems /supplier chain security Process for testing resilience and recovery plans through Emergency Preparedness and Resilience includes loss of digital connectivity.	<u>First Line</u> Formal certification re cyber securtiy via ISO 27001 - Information Security Standard, ITSEC manager - Cyber advisor certified by NCSC, Data Protection Security Toolkit (DSPT) compliant, Cyber Essentials compliance. <u>Second Line</u> Deep dive on cyber security to Audit and Risk Committee July 2023 3 monthly updates to Executive Board on EPRR <u>Third Line</u> Compliance with NHS Digital / NHS England Data Security Protection Toolkit **2022/23** (resubmission for 2023/24 30.6.24.) External 3rd party security testing at least annually	The ever changing landscape/threat around cyber security Lead: Keith Redmond Ongoing	Further assurance required from partner organisation with connectivity with CHFT (techincal mitigation in place) and shared regional systems, e.g. LIMS. Action: Seek assurance from WYAAT / ICS / Chief Digital Information Officers partners Lead: Rob Birkett Timeframe: ~~March~~ December 2024	**5 x 3 = 15**	**5 x 3= 15**	**5 x 2 = 10**
Action					**Timescale**			**Lead**		
Monitoirng of cyber threat Seek assurance re: cyber security from system partners					Ongoing ~~March~~ December 2024			Keith Redmond Rob Birkett		
Links to risk register: None										

BOARD ASSURANCE FRAMEWORK
JUNE 2024
INCLUSIVE WORKFORCE AND LOCAL EMPLOYMENT

TRUST GOAL: 3. INCLUSIVE WORKFORCE AND LOCAL EMPLOYMENT											
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** (Where are we failing to gain evidence about our system/ controls?)	**RATING JUNE 2024 Risk Category: Workforce Risk appetite: Low**		
								Initial	**Current**	**Target**
10a/19	Workforce Committee	Executive Medical Director	**Risk** Risk of not being able to deliver safe and effective high quality care and experience for patients due to gaps in the clinical workforce (local and national challenges) **Impact on** - Quality and safety of patient care and Trust's ability to deliver some services. - Ability to deliver range of key performance indicators as defined by multiple organisations - Increased risk of litigation and negative publicity. - Poor staff morale - Increased sickness absence - Continued financial pressure due to use of locums / agency staff - ambition to demonstrate the Trust is an "outstanding" organisation by CQC standards	•Consultant succession planning • "Grow our own" approach - through different methodologies, alternative workforce models, allied health care professional roles – Physician Associates (PA Governance Framework approved 20.6.24.) and Advanced practitioner. Recruit to FY3 posts,Radiology Global Fellowship posts. • CESR programme to increase Consultant workforce in appropriate specialties, Emergency Medicines scheme for oversease doctors with Royal College (Hybrid International Emergency Medicines) supports recruitment and retention. •Guardian of Safe Working ensures safe working hours for junior doctors. • E -job planning for Consultants ensures efficient use of medical staff workforce and visibility of Consultant workforce activity, E-rostering provides understanding of rota gaps and workforce required Study leave policy approved, gives greater visibility of study leave taken and cost of study leave enabling better capacity planning and financial planning of medical staff. • Recruitment and retention success, Trust reconfiguration programme positively impacts on recruitment, continued use agency and well-established bank medical staff for shortage specialties, agency spend within control totals with medical workforce bank and agency spend under review, use current staff effectively - all new employees opted in to a bank contract (unless opt out). Elective and clinical attachment placements (attracts international colleagues) • WYAAT networking approach to pressured specialties, eg Non-Vascular Interventional Radiology, supporting MYHT with Non Surgical Oncology, LTHT (Leeds) support CHFT with Neurology • Ongoing medical staffing recruitment. Refreshed induction for trainees including EST completion • Medical Workforce Programme monthly meeting with wider group of stakeholders - provides an overview of the programme to ensure full visibility, shared view and tracking of all medical workforce based projects, with highlight reports from workstream leads. • Recruitment through external agencies for posts difficult to recruit to •New national contract launched for specialty doctors and specialist doctors enabling appointments at specialist level with more independence. Adopted SAS (Staff and Associate Specialists)doctor charter. •Refreshed engagement approach - eg Medical Director's Office created well-being talks, SAS Forum, Junior Doctor Forum, Consultant and SAS body informal catch up events. •SAS advocate and SAS tutor roles support more effective engagement with SAS cohort. • Enhanced reporting data (eg sickness absence, staff in post by grade/specialty, turnover, vacancy, retention) enabling a more robust view of medical workforce status. • Industrial action planning has given us an understanding of baseline staffing levels •Consultant agreement and SAS agreement of pay awards removes risk of industrial action by Consultants •Mend the Gap related work (report which identifed gender pay gap for medical and dental staff) - Deputy Medical Director lead work through Inclusion Group to understand CHFT position and agree actions as required.	First line Staffing levels, training & education compliance reported and review through departmental and divisional governance structures, weekly meeting with Divisional Directors and Medical Director's office (COO attending). Escalation of any short term gaps to Bronze tactical meeting/ internal command arrangements. Roll out of new approach to sharing training data across Trusts for junior doctors IPR with key KPIs including sickness levels, and agency spend, with monitoring of spend. Weekly divisional medical staffing meetings to optimise fill rates. Medical workforce steering group meetings re-launched Significant Consultant recruitment across a number of specialities, especially within ED. Second line Monthly performance meetings review workforce reports Workforce Committtee - continued reduction in medical vacancies – net recruitment gain of 42 wte medical and dental posts from March 2023 to March 2024. Turnover remains under 10% to March 2024 (6.43%) Medical Appraisal and revalidation report to Board, September 2023 Guardian of Safe Working Hours annual and quartely report to Board. Refresh of Recruitment Strategy Medical Workforce Programme Update to Workforce Committee Deep dive review of this risk at Workforce Committee 19.2.24. Third Line Internal Audit report on Consultant and SAS job planning with significant assurance. GIRFT benchmarking tool RAG rates workforce establishment position. Plans discussed with NHS England. Assurance process with CQC colleagues - feeback from relationship with arms-length bodies GMC Survey on Junior Doctor Experience. GMC Employer Liaison Meeting with Responsible Officer / Medical Director. Local Negotiating Committee (with BMA in attendance) regular engagement to raise any concerns regarding medical workforce.	Progress recruitment for approved medical e job planning and e rostering delivery team. Deputy Medical Director by ~~June~~ August 2024 Dependence on HEE allocation of trainees. Continued junior doctor industrial action. Action: Pre-strike planning including clinical activity risk assessment, responding to changing legal position (eg re use of agency staff), registers and contract notifications of deductions. Lead: Medical Director. Director of Workforce and OD/ Chief Operating Officer Review of job planning framework and implementation of a job planning Consistency Committee to ensure a reduction in unwarranted variation between job plans, departments and divisions. Deputy Medical Director by September 2024 Action plan in response to GMC Training survey to support positive training experience for trainees. Lead: Deputy Director of Medical Education, October 2024	Short term sickness absence may be under-reported by medical staff. Divisional directors monitor and manage. Investigation of agency & bank spend, identification of potential for retraction by grade and service area Lead Deputy Medical Director ~~April~~ August 2024 Implementation of PA governance framework Action: Deputy Medical Director to share framework with LNC and colleagues, review of implementation to Executive Board Autumn 2024.	**4 x 4= 16**	**4 x4=16 =**	**3 x 3 = 9**

Action		**Lead**
Industrial action planning, including clinical risk assessment and responding to changes in legal position	Ongoing	Deputy Medical Director for all actions unless stated
Review of job planning framework and implementation of a job planning Consistency Committee	September 2024	
Investigation of medical staffing agency and bank spend	~~April~~ ~~2024~~ August 2024	
Review implementation of Physician Associate (PA) governance framework	Autumn 2024	Deputy Director of Medical Education
Develop action plan in response to GMC Training Survey	October 2024	

Links to risk register:
7078 medical staffing, 8508 + 8509 Opthalmology, 8315 Paediatric Opthalmology
Also see BAF risk 1/20 clinical strategy

TRUST GOAL: 3. INCLUSIVE WORKFORCE AND LOCAL EMPLOYMENT

Ref & Date added	OWNER Board committee	Exec Lead	RISK DESCRIPTION *(What is the risk?)*	KEY CONTROLS *(How are we managing the risk?)*	POSITIVE ASSURANCE & SOURCES *(How do we know it is working?)*	GAPS IN CONTROL *(Where are we failing to put controls / systems in place?)*	GAPS IN ASSURANCE *(Where are we failing to gain*	RATING JUNE 2024 Risk Category: Workforce Risk appetite: Low		
								Initial	Current	Target
10b/19 2021/22	Workforce Committee	Chief Nurse	**Risk** Risk of not being able to deliver safe and effective high quality care and experience for patients due to insufficient nursing staff caused by an inability to attract, recruit, retain, reward and develop colleagues. **Impact on** - Quality and safety of patient care and Trust's ability to deliver some services. - Ability to deliver national targets and CQUINS. - Increased risk of litigation and negative publicity. - poor staff morale - Increased sickness absence - Continued financial pressure due to use of locums / agency staff - ambition to demonstrate the Trust is an "outstanding" organisation by CQC standards	• Senior nurse staffing meetings twice a day, 7 days a week provide an on the day repsonse to staffing position, responding to areas of escalation (red flags) and agreeing actions to mitigate the curent position. This meetings also determines the agree OPEL safer staffing postion. Clear esclations to the Associate Directors of Nursing rota and approval sought for agency to mitigate unresolved staffing position. Community nursing 7 day on call arrangements to manage staffing with escalation process. Executive oversight of twice yearly nrusing establishment review in line with NQB guidance • Adherence to best practice rostering processes. Preceptorship framework ensures standardised approach for new registrants who can fill shifts as registered nurse to support acheivement of workforce models and retention. OPEL safer staffing actions cards. •Internal pay enhancements profroma developed to support response to workforce pressures • Strengthened escalation and reporting arrangements for quality and safety (short term and medium/long term), including enhanced dashboard which provides clear visibility on workforce and impacts on patient experience, quality and safety, •Local Nursing and Midwifery retention strategy developed in line with national recommendations and high impact actions initiated, approved November 2022. • Apprenticeship Strategy in place to support career pathways into nursing, AHPS • Utilisation of bank and agency staff in place, managed and escalated through a Standard Operating Procedure. • E-roster system in place and linked Safer Care IT system being used to match staffing levels to patient acuity. • Role of the Clinical Site Matron and responsiblity for tactical command • Journey to Outstanding (J2O) processs, reviewers provided with information on staffing levels, eg ward information on vacancies and fill rates re; falls, pressure ulcers and friends and family test which will include an assessment of staffing levels. People Strategy in place to support colleague health and well-being in line with national People Plan priorities • Quality and Safety oversight meetings in place for clinical areas where concerns exist on nurse sensitive indicators. • Safe staffing information presented to the Workforce and Quality Committee, • Nursing and Midwifery, AHP Workforce Steering Group, meet monthly with an overview of recruitment and retention strategies supported by Business Intelligence dashboard identifying progress and hotspots for consideration. EQIA change process considers staffing position to avoid negative impact for staff and patients • Safe, Sustainable and Productive Staffing meeting meets monthly which focus on the quality metrics associated with the staffing postion (Enhanced Dashboard Metric) Launch of the nursing and midwifery 5 year ambitions May 2024	<u>First line</u> Twice daily staffing meetings . Monthly review of the Enhanced Dashboard Metric that tracks CHPPD/FIll Rate and a number of staff metrics to track any potential harm as a result of staffing position Business Intelligence dashbaord provides monthly review of vacancy position, identifying potential hotspots and identification of any futher actions required to respond to the staffing position. Review of workforce and quality metrics by Nursing, Midwifery and AHP Steering Group, with actions taken as needed Clinical Site Matron summary site reports which provide assurance of site staffing postion and action to respond to any concerns,. <u>Second line</u> Monthly performance meetings (PRM) review workforce reports as well as introduction of corporate PRM (remit for educational activities) Workforce Commitee receives updates on recruitment and retention issues for both oversight and scrutiny Twice yearly report to Workforce Committee, Quality Committee and Board of Directors on safer staffing for both oversight and scrutiny and assurance (January and July). Annual and bi-annual safer staffing reviews of Nursing and Midwifery staffing levels provides assurances of the current workforce models or provides a rationale/evidence base for change. This approch is reflective of best practice in adopting triangulation of safer staffing metrics. 12 June 2024 Workforce Committee, 2 July 2024 Board of Directors Nursing and quality KPIs embedded in Integrated Performance Report. J20 reports presented to divsional PSQB provide opportunity for staff to feedback concerns re: staffing position to the division Workforce Committee undertakes deep dive of this identified risk to confirm key controls are clearly identifeid and assurances are robust and comprehensive - 12 June 2024 <u>Third Line</u> Vacancy information reported into NHSE. Assurance process with CQC colleagues - feedback from relationship wth arms-length bodies. Preceptorship framework approved by NHS England for newly registered nursing (December 2023) - achievement of quality mark Achievement of NHS Pastoral Quality Care Award for nursing staff.	1. At periods of operational pressure, insufficent workforce availability to meet demand above core bed base and in community services. Action: Approval to recruit to 2 clinical areas above bed base which has a positive impact on bank and agency spend. Tier 1 agency retraction plan (June 2024 led by divisional ADNs) Controlled use of bank and agency staff (as per retraction plan) and derogated staffing models in place as per OPEL action staffing cards. 2. Unable to control use of extra capacity wards Approval to recruit to 2 clinical areas above bed base which has a positive impact on bank and agency spend. Action: Engagement in length of stay improvement work and nursing representative at tactical meetings to manage staffing position Lead: Associate Director of Nursing Resilience, Acute Flow and Transformation Directorate Ongoing	Need for discussion on skill mix issues created by a combined effect of high proportion of new graduate nursing workforce and internationally educated nurses Action: Learning needs analysis and training and education delivery plan by March 2025 Lead: ADN Corporate Nursing Developing a new ward assurance process which will provide ongoing monitoring of quality and safety Lead: Deputy Chief Nurse Timescale: June / July 2024	4x4 = 16	4x3 = 12	3x3 = 9

Action	Timescales	Lead
Length of stay improvement work and invovlement in tactical meetings re staffing	Ongoing	Associate Director of Nursing, Resilience, Acute Flow and Transformation
Learning needs analysis and training and education delivery plan (rolling programme)	March 2025	ADN Corporate Nursing

Links to risk register:
Risk 6345 - nurse staffing risk

TRUST GOAL: 3. INCLUSIVE WORKFORCE AND LOCAL EMPLOYMENT

Ref & Date added	OWNER Board committee	Exec Lead	RISK DESCRIPTION *(What is the risk?)*	KEY CONTROLS *(How are we managing the risk?)*	POSITIVE ASSURANCE & SOURCES *(How do we know it is working?)*	GAPS IN CONTROL *(Where are we failing to put controls / systems in place?)*	GAPS IN ASSURANCE *(Where are we failing to gain evidence about our*	RATING JUNE 2024 Risk Category: Workforce Risk appetite: Low		
								Initial	Current	Target
6/23 January 2024	Workforce Committee	Chief Nurse	**Risk** Risk of not being able to deliver safe and effective high quality care and experience for patients due to insufficient midwifery staff caused by national shortage of midwives and retention of existing workforce. **Impact on** - Quality and safety of patient care and Trust's ability to deliver some services. - Ability to deliver national targets - Increased risk of litigation and negative publicity. - poor staff morale - Increased sickness absence - staff fill rates due to limited availability of agency staff - ambition to demonstrate the Trust is an "outstanding" organisation by CQC standards	• Midwifery daily oversight and staffing meetings with,maternity escalation plan to mitigate risk • Local maternity system staffing and oversight meeting daily which ensures shared approach to managing activity • BirthratePlus tool report identified required mdiwfery workforce model • BI workforce dashboard (vacancy, turnover, projections) provides a monthyl review of vacancy position •Senior midwifery leadership rota provides ongoing visibility and dialogue across clinical areas, supporting staffing escalation • Adherence to best practice rostering processes. • OPEL safer staffing actions cards. • Role of the Clinical Site Matron and responsiblity for tactical command • Internal pay enhancements profroma developed to support response to workforce pressures Utilisation of bank and agency staff in place, managed and escalated through a Standard Operating Procedure. 20% bank enhancements continues for maternity workforce to encourage uptake of shifts. •LMS co-ordinated centraliesd recruitment for newly qualified midwives across the local maternity system to secure recruitment and support levellling up across Trusts • Local Midwifery retention strategy • Flexible approach to maternity staffing includes registered nurses working in maternity services • Maternity Transformation Programme Board has oversight of 3 year maternity delivery plan and associated actions to manage risk, including staffing • Apprenticeship Strategy in place to support career pathways into midwifery • E-roster system in place • Journey to Outstanding (J2O) processs, provides opportunity for staff to feedback on staffing levels. • Quality and Safety governance meetings for monitoring metrics and standard KPIs, eg 1:1 care in labour • Safe staffing information on midwifery presented to the Workforce and Quality Committee, with direct report from Director of Midwifery to Quality Committee and Trust Board • Nursing and Midwifery, AHP Workforce Steering Group, meet monthly with an overview of recruitment and retention strategies supported by Business Intelligence dashboard identifying progress and hotspots for consideration. • Safe, Sustainable and Productive Staffing meeting meets monthly which focuses upon the quality metrics associated with the staffing postion (Enhanced Dashboard Metric) Nursing, Midwifery and AHP Steering Group and Safe Sustainable Productive staffing meetings provide assurance of good roster management and achievement of associated KPIs for midwifery.	First line Daily staffing meetings provide an on the day repsonse to staffing position. Business Intelligence dashboard provides monthly review of vacancy position, identifying potential hotspots and identification of any futher actions required to respond to the staffing position. Clinical Site Matron summary site reports provide assurance of site staffing postion and action to respond to any concerns. Maternity and Neo-Natal Transformation Board receives workforce update bi-monthly Second line Monthly performance meetings (PRM) review workforce reports as well as introduction of corporate PRM Workforce Commitee receives updates on recruitment and retention issues for both oversight and scrutiny Quality Committee and Trust Board receives full midwifery workforce report six times a year via Matenrity and Neonatal Oversight Report. Twice yearly report to Workforce Committee, Quality Committee and Board of Directors on safer staffing (11.1.24, 4.7.24),for both oversight and scrutiny and assurance (January and July). Annual and bi-annual safer staffing reviews of Nursing and Midwifery staffing levels provides assurances of the current workforce models or provides a rationale/evidence base for change. This approch is reflective of best practice in adopting triangulation of safer staffing metrics. KPIs embedded in Integrated Performance Report. Workforce Committee undertakes deep dive of this identified risk to confirm key controls are clearly identifeid and assurances are robust and comprehensive Third Line Workforce position reported into LMS, Performance reported into NHSE. Assurance process with CQC colleagues - feedback from relationship wth arms-length bodies. Maternity CQC report from visit June 2023 confirms leaders had responsive approach for managing midwifery staffing shortages to mitigate risk. Maternity Voices partnership ensures regular patient feedabck on experience of care	National shortage of registered midwives impacting on staffing recuritment pipeline. Review maternity workforce model to meet BirthratePlus tool requirement recommendations. Lead: Director of Midwifery Timescale: 31.8.24. Refresh of Midwifery Recruitment and Retention Strategy Lead: Director of Midwifery Timescale: 31.7.24.	CQC maternity report (August 2023)-requires improvement for safe domain. CQC action plan in response to safe "must do" re qualified staff for monitoring by Maternity Transformation Programme Board. Director of Midwifery Need to strengthen reporting and escalation arrangements for mdiwfery quality and safety metrics Action: Develop enhanced dashboard to include midwifery quality and safety metrics which provides clear visibility on workforce and impacts on patient experience, quality and safety Lead: Director of Midwifery Timescale: 31.12.24.	4x4 = 16!	4x4 = 16	3x3 = 9

Action	Timescales	Lead
Implementation of CQC must do action for maternity re staffing	See action plan	Director of Midwifery all actions
Review maternity workforce model to meet BirthratePlus tool requirement recommendations.	31.8.24	
Refresh of Midwifery Recruitment and Retention Strategy	31.7.24	
Develop enhanced dashboard to include midwifery quality and safety metrics	31.12.24	

Links to risk register:
6911 midwifery workforce

BOARD ASSURANCE FRAMEWORK
JUNE 2024
INCLUSIVE WORKFORCE AND LOCAL EMPLOYMENT

TRUST GOAL: 3. INCLUSIVE WORKFORCE AND LOCAL EMPLOYMENT										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING JUNE 2024 Risk Category: Quality, Innovation & Improvemnent Risk appetite: Significant**		
11/19	Workforce Committee	Executive Director of Workforce and Organisation Dewelopment	Being an employer of choice means we can attract, retain and develop colleagues to deliver one culture of care. Risk of not attracting or retaining colleagues who are confident and competent to provide compassionate care to patients and compassionate and inclusive leadership to colleagues due to a lack of clear OD strategy and focus on development for current and aspiring leaders means that we will not be able to deliver the Trust's objectives and sustainable services for the future **Impact** - Ability to deliver transformational change compromised. - Potential to affect the quality of patient care. - Low staff morale.	• Refresh of Widening Partcipation strategy planned for Q2 and Q3. • Process redesign workshops (new starter and onboard, and termination) • Workforce Planning finalised for 2024/25 • Actions developed as part of the Colleague Retention Programme • Proposed approach for Board recruitment alongside Board Diversity Action Plan • Workforce Design and Transformation in AHPs leading to improved recruitment and retention • Recruitment strategy embedded and forms part of People Strategy • Recruitment events in place for 2023/4 – 4 large scale events to take place • Review of social media approach • Initial review of inclusive recruitment processes undertaken • Internal career planning guidance document to support 'grow our own' being developed • Progressed into implementation phase for values based recruitment • OD Plan developed • Deployed a screening tool for values and behaviours as part of the onboarding process. • Board to agree Succession Planning approach which links to co-ordinated talent management pipeline programme including Empower programme and Enhance talent approach • Inclusive Leadership is one of the modules within our core Leadership Development programme. Each module is a three hour education session with action to implement practical application of the learning. Check in sessions will then be held to collate evidence of the application which will enable the organisation to monitor the growth of inclusive leadership. • Workforce Committee seeks assurance on recruitment, retention and reviews key workforce indicators • Work together get results to Improve programme in place provides a link to the Trust journey to being an outstanding Trust and how we will use our own internal methodology to improve patient and colleague care. • Refreshed our values and behaviours - to be incorporated in values based recruitment • Workforce design methodology developed to support with workforce remodelling and reconfiguration • Strategy for Equality, Diversity and Inclusion which will attract a wider and more diverse workforce that will understand the differing needs of our patients. • Further work undertaken to widen Trust welcome, induction and onboarding. This will be followed by further work to embed colleague journey after day one	First line • Clinicians leading of transformation programmes • Recruitment to key roles across the Trust - see BAF risk 10a • Values Based Recruitment • Colleague Retention Programme Paper taken to Workforce Committee on 18 December 2023 • Revised Workforce Report to Workforce Committee to monitor key workforce indicators • Induction and Onboarding Hot House held in May 2024 Second line Integrated Performance Report and Workforce Committee reports show turnover of 6.95% Revalidation report to Board. Roll-out of KP+ for workforce metrics from February 2024 Third line GMC survey of trainees is positive, with CHFT having no negatively outlying results in comparison with other WYAAT Trusts.	• Lack of comparative workforce data for medical and AHP staff groups compared to nursing, due to the delayed implementation of e-rostering. **ACTION**: Complete Medical roll-out by March 2025. • Review of inclusive recruitment approaches **ACTION**: Inclusive recruitment hot house to take place in November 2024.		**Initial** 4x4 = 16	**Current** 3x4 =12 =	**Target** 3x3 = 9
Actions					**Action, Lead, Timescales**			**Lead**		
Inclusive recruitment hot house to take place in November 2024. Complete roll-out of e-rostering for Medical and AHPs					~~31/03/2024~~ 30/11/2024 ~~31/03/2024~~ 31/03/2025			Suzanne Dunkley David Birkenhead/Lindsay Rudge		
Links to risk register: None										

BOARD ASSURANCE FRAMEWORK
JUNE 2024
INCLUSIVE WORKFORCE AND LOCAL EMPLOYMENT

TRUST GOAL: 3. INCLUSIVE WORKFORCE AND LOCAL EMPLOYMENT											
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING JUNE 2024 Risk Category: Workforce Risk appetite: Low**		
								Initial	**Current**	**Target**
1/22 June 2022 refreshed June 2023	Workforce Committee	Executive Director of Workforce and Organisational Development	**Risk** Risk of colleague absence and retention rising due to: increasing demands and requirements for health and wellbeing offers that are not appropriate, not accessible, not embedded or not affordable; and/or inability or unwillingness to attract develop and retain compassionate and inclusive leaders who are able to succesfully lead their teams through sustained periods of change **Impact** - Ability to deliver transformational change compromised. - Potential to affect the quality of patient care. - Low staff morale. - Non–achievement of key Trust priorities - Poor response to staff survey / Quarterly Pulse Survey	• Wellbeing Connect phone line launched in May 2024 • Summer of Sport brochure and activities to be launched in June 2024 to coincide with Euro 2024, Olympics, Paralympics and Wimbledon. • 2024/25 Engagement Calendar created • Wellbeing Advisors will be more closely aligned to and embedded in divisional activity via a transfer into Division (Divisions will directly manage wellbeing activity/wellbeing advisors) • Launched CreditUnion • Launch of salary advance through WageStream in February 2024. • Enhancing our top up shop approach by engaging in a partneship with Neighborly • Workforce Psychologist training volunteers on peer support critical incident debriefing • Management fundamentals wellbeing section • New to manager programme wellbeing section • Appreciation week held twice a year • High impact action plan relating to staff survey • Employee Assistance Programme through CareFirst • Friendly Ear Service • 50 Health and Wellbeing ambassadors to engage with colleagues across all services areas as investing in employee wellbeing • Health and Wellbeing Risk Assessment available to all colleagues. • Weekly Wellbeing advisor walkarounds • Suicide prevention resource pack • Appraisal documentation with greater emphasis on health and well-being • Place-based funding for colleagues to access fast track MSK treatment. • 4 Hot Houses per year • Leadership conferences • External validation of our staff survey action plans and reflecting on results. • Colleague engagement focused on listening events, friendly ear and supportive events to engage colleague offering over difficult few years. • Leadership visibility / walkarounds carried out by senior colleagues • Weekly Communication to staff by Chief Executive with Q&A session: operational update(Mondays), CHFT LIVE meeting (Wednesdays), Chief Exeutive Update (Fridays) • Freedom to Speak Up (FTSU) Guardian and ambassador network • CHuFT awards and monthly Star Award • One Culture of Care checklist to aid visibility visit and provide consistency • Colleague engagement groups, now expanded to include following networks: Women's Voices, Armed Forces, Carers, International Colleagues in addition to REN network, Colleague Disability Action Group, Pride. Network chairs meet regularly to share best practice. • Equality, Diversity and Inclusion events • Executive buddies assigned to staff survey hotspot areas • Appraisal workshops held • Activity being aligned to the NHS EDI Long Term Plan • EDI objectives now in appraisals	First line Monthly workforce monitoring meeting reviews all workforce data sets Monthly absence review meeting Second line Revised Workforce Report to Workforce Committee monitors key workforce indicators Sickness absence metrics reported to every Board meeting via the Integrated Performance Report. Quarterly metrics provided by CareFirst. PRMs monitoring roll out of staff survey actions Staff survey 2022 results and high impact actions presented to Board May 2023. Deep dive of risk to Workforce Committee People Heat Map Third line Quarterly People Pulse survey/ national staff survey Sickness absence benchmarking data through Model Health and Public View systems	Moving engagement and wellbeing activity to Divisions. Management have not received training yet. **ACTION** - Development tools and resources to upskill managers regarding engagement and wellbeing - 30 September 2024		3x4 = 12	3x4 =12 =	1x4 = 4

Action to address gap in control	**Action and timescale**	**Lead**
Development tools and resources to upskill managers regarding engagement and wellbeing	Sep-24	Head of Apprenticeships & Widening Participation

Links to risk register:
No high level risk register related risks scoring over 15.

BOARD ASSURANCE FRAMEWORK
JUNE 2024
FINANCIAL, ECONOMIC AND ENVIRONMENTAL SUSTAINABILITY

TRUST GOAL: 4. FINANCIAL, ECONOMIC AND ENVIRONMENTAL SUSTAINABILITY										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING JUNE 2024** **Risk Category: Financial / Assets** **Risk appetite: Moderate**		
								Initial	**Current**	**Target**
14/19	Finance and Performance Committee	Executive Director of Finance	**Risk** Risk that the Trust will not secure sufficient capital funding to maintain facilities over the longer term and meet safety and regulatory standards resulting in patient harm and regulatory intervention. **Impact** - financial sustainability not secured - inability to provide safe high quality services - inability to invest in patient care or estate	Capital programme managed by Capital Management Group and overseen by Business Case Approval Group, including forecasting and cash payment profiling. Prioritised capital programme agreed as part of 2024/25 financial plan. Historic delivery of the capital plan. Contingency set within annual plan Transformation Programme Board has oversight of significant strategic investment, chaired by Non-Executive Director with relevant commercial experience. Senior Finance participation in West Yorkshire Integrated Care System Capital Group which meets regularly to review capital forecasts from all partners to manage regional capital envelope and reports to ICS Finance Forum. Horizon scanning for external funding opportunities and bids for funding regularly submitted where these align with strategic objectives and managing risk.	<u>First line</u> Oversight at Finance and Performance Committee and Board Capital Management Group reports Transformation Programme Board minutes <u>Second line</u> Strategic outline case for reconfiguration approved by NHS E . <u>Third Line</u> Monthly reporting to Transformation Programme Board, Finance and Performance Committee and Board Monthly report to ICS	The long term capital spend required for HRI is in excess of internally generated capital funds. The long term plan for HRI requires additional funds from a combination of regulator approved business case, emergency capital and ICS capital. This is widely recognised and accepted by the regulators. Lead: Director of Finance Action: Representation to key bodies re: securing appropriate funding.	5 year capital plans submitted to ICS but longer term funding allocation process is still to be agreed by ICS partners. Lead: Director of Finance – Backlog maintenance costs will remain in excess of planned capital spend. Action: Internal capital spend is prioritised on a risk basis. Price not yet agreed for CRH reconfiguration works and remains subject to change. Progressing elements where possible. Construction partner appointed. Approval of Full Business Case Lead: Chief Executive, Director of Partnerships and Transformation and Director of Finance Treasury approval of reconfiguration business case . Action: Close monitoring of Treasury plans via NHS E on behalf of Trust	4x5 20	4x3 = 12	3x4=12

Action	**Timescales**	**Lead**
Ongoing monitoring of financial position through Finance & Performance Committee and Board	Ongoing	Director of Finance

Links to risk register: None

BOARD ASSURANCE FRAMEWORK
JUNE 2024
FINANCIAL, ECONOMIC AND ENVIRONMENTAL SUSTAINABILITY

TRUST GOAL: 4. FINANCIAL, ECONOMIC AND ENVIRONMENTAL SUSTAINABILITY

Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING JUNE 2024** **Risk Category: Financial / Assets** **Risk appetite: Moderate**		
								Initial	**Current**	**Target**
18/19 March 2020	Finance and Performance Committee	Executive Director of Finance	Risk of failure to secure the longer term financial sustainability of the Trust (achieving financial breakeven and providing value for money) due to the size of the underlying and current financial deficit and reliance on cash suppport. Whilst the Trust is developing a business case to support financial sustainability in the medium term, this plan is subject to approval and the release of capital funds **Impact** - financial sustainability not secured - increased regulatory scrutiny - Reduced ability to meet cash requirements - inability to invest in patient care or estate	Working with partner organisations across WYAAT and ICS to identify and implement system savings and opportunities Place based recovery monitored at WY Finance and Performance Committee Budgetary control process with increased profile and ownership Turanround Executive (meets weekly, with Deputy Chief Executive Chair) monitoring cost improvement plan delivery in year and development of 5 year cost improvement plans. Accurate activity, income and expenditure forecasting Development of 25 year financial plans in support of Business Case Standing Financial Instructions set authorisation limits, Audit and Risk Committee in place to monitor key areas of compliance. Finance and Performance Committee in place to monitor performance and steer necessary actions. Transformation Programme Board to monitor delivery of key capital schemes.	First line Reporting on financial position, cash and capital through divisional Boards, Performance Review meetings and Exec Board monthly. Capital Management Group meeting receives capital plan update reports Second line Scrutiny at Finance & Performance Committee & Board. Reports on progress with strategic capital to Transformation Programme Board. Board Finance reporting.ICS submitted financial plan for 2024/25 with risks clearly articulated to NHSE. Internal audit report on efficiencies - significant assurance April 2022. WYAAT Board to Board event September 2022 re: efficiency identified themes for new WYAAT strategy. Third line NHSE deep dive of financial position 7.6.23. ICS Director of Finance assured re Trust financial management systems.–Action plan monitored through Finance & Performance Committee.Monthly return to NHS E and ICB. CRH Outline Business Case submitted November 2021. WYAAT commissioned review for Q1 2024/25. Quarterly segmentation review with ICS Director of Finance.	Progression of transformation plans are reliant on external approval and funding Impact of national workforce shortages eg. qualified nurses and A&E doctors. Key enablers to reconfiguration, e.g. PFI commercial negotiaition and approval required to progress. Action: Continued liaison with regulator and HM Treasury Lead: Chief Executive Limited additional revenue costs have been included for the development of the Reconfiguration Business Case. Inability to remove beds in line with annual plan resulting in additional financial pressures (from 4/23 targets). Impact of national strikes will affect costs and delivery of elective activity with potential loss of income.	PLACE based recovery plans still to be developed. Action: Development of plans to drive system efficiences. Lead: Partnership reps, CHFT Director of Finance, Director of Transformation and Partnerships, Chief Operating Officer Timescale: October 2024 Inability to remove beds in line with annual plan resulting in additional financial pressures. Action: Agree key set of metrics with system partners and monitor delivery / performance Lead: Chief Operating Officer and Director of Finance	**5x5 = 25**	**4x4 = 16**	**3x4=12**

Action	**Timescales**	**Lead**
System financial recovery plans to be developed Agree key metrics with system partners and monitor performance against these	~~May 2024~~ 01/10/2024 March 2025	Director of Finance Chief Operating Officer and Director of Finance

Links to high level risk register risks: None
See BAF risks 10a/19, 10b/19 and 6/23 re workforce shortages

BOARD ASSURANCE FRAMEWORK
JUNE 2024
FINANCIAL, ECONOMIC AND ENVIRONMENTAL SUSTAINABILITY

TRUST GOAL: 4. FINANCIAL, ECONOMIC AND ENVIRONMENTAL SUSTAINABILITY										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING JUNE 2024 Risk Category: Strategic Risk appetite: Significant**		
								Initial	**Current**	**Target**
06/20 July 2020	Transformation Programme Board	Executive Director of Finance	Risk of climate action failure and not improving our environmental sustainability, including not reducing carbon emissions across the organisation and not reducing the impact of climate change across Huddersfield and Calderdale due to a lack of behaviour change (eg travel, waste, procurement) and not embedding climate and environmental considerations in decision-making. Resulting in adverse effects on natural environment, public health, vulnerable patients, energy costs, waste disposal fees, non-compliance costs and also creating a negative impact on reputation.	Leadership on climate change managed by CHS's Environment Manager and sponsored by the MD of CHS who is the Trust's lead for climate and sustainability. Connected into a range of West Yorkshire sustainability groups involving the WY Combined Authority, WYAAT and local Councils. System working - MD CHS Climate Commissioner for Kirklees Climate Commission to respond to the climate emergency across Kirklees and member of Calderdale Council Climate Action Group, developing a climate action plan for Calderdale. Green Plan approved and in place, aligned with ICS Green Plan, aims to reduce the impact of travel on the environment and reduce carbon emissions Green Planning Committee (meets monthly,attended by internal and external partners) chaired by MD CHS oversees delivery of sustainbility action plan, dashboard monitors the impact of the Green Plan, reports to Transformation Programme Board on quarterly basis. Travel Plan in place to support more active travel, less car use and more car sharing, Travel Co-ordinator monitors progress. Reconfiguration design and build principles led by a sustainability design brief and overseen by Transformation Programme Board. Green solutions - eg remote temperature monitoring at parts of HRI to reduce energy cost and carbon emission. Green solutions integral to HRI A& new build, eg air source heat pump for renewable energy, permeable paving, due to achieve excellent BREEAM sustainability rating Carbon Literacy Training of CHS senior management team. 100% energy bought from green sources and installation of LED lighting to reduce energy consumption. Light swtich off campaign. Signed up to NHS pledge to reduce plastic usage in hospital . Recycling awareness raising with staff to encourage correct waste disposal Asset tracking ensures live track of equipment and reduces wastage. Procurement Strategy ensures minimum 10% wighting for socal value wighting in all prucrement Funding bids to support sustainable activities by CHS, eg Salix Low Carbon Skills Fund for the development of the Trust's Heat Decarbonisation Plan. CHS awarded £46K to implement Coolnomix energy saving project at HRI, 5 22kw EV chargers installed as part of the ED development at HRI. 4 charging points at Acre Mill upgraded to integrate with the MER user app Digital Strategy supports sustainability - eg out patient transformation such as remote out patient appointments reduces travel, patient initiated follow up.	First line Monthly monitoring of the Trusts energy consumption Quarterly Update on progress with Green Plan and Sustainability Plan, via newly developed Green dashboard of key indicators to Transformation Programme Board. 44 of 47 travel plan actions complete. Green Plan - 163 of 206 actions complete. 12 month Trust-wide environmental calendar with focus on sustainable activities. Second line 1. Monitor against our Green Plan and Sustainability Action Plan (SAP) approved at 6 May 2021 Board meeting, following reviewed by Transformation Programme Board 8 March 2021. Green Plan shared with ICS. 2. Annual Board paper on sustainability/climate change, July 2023, May 2022 2022/23 Trust Annual Report details progress with sustanability. 3. Reports through to Green Planning Committee and JLC. Third line:Share energy data records with NHS E on new NHS energy data platform	QIA sustainability impact assessment procedure to be reviewed along with business case applications for capital projects over £50,000 to ensure that sustainability is considered in business cases. Lead: Stuart Sugarman via Environmental Co-ordinator Timescale: ~~June~~ December 2024 Increase number Electrical Vehicle (EV) chargers at CRH: Lead: Stuart Sugarman Timescale to December 2024 Multi Storey Car Park at CRH once built		4x4 = 16	4x2 = 8	4x2=8

Action	**Date**	**Lead**
12 month environmental calendar focsuing on sustianable activities	Jan - December 2024	Stuart Sugarman
Increased number of EV chargers	Once muli-storey car park at CRH built	Stuart Sugarman
Review QIA procedure and business case applications re sustainability	December 2024	Stuart Sugarman via Environmental Co-ordinator

No related risks on high level risk register

BOARD ASSURANCE FRAMEWORK
JUNE 2024
FINANCIAL, ECONOMIC AND ENVIRONMENTAL SUSTAINABILITY

TRUST GOAL: 4. FINANCIAL, ECONOMIC AND ENVIRONMENTAL SUSTAINABILITY

Ref & Date added	OWNER Board committee	Exec Lead	RISK DESCRIPTION *(What is the risk?)*	KEY CONTROLS *(How are we managing the risk?)*	POSITIVE ASSURANCE & SOURCES *(How do we know it is working?)*	GAPS IN CONTROL *(Where are we failing to put controls / systems in place?)*	GAPS IN ASSURANCE *(Where are we failing to gain evidence about our system/ controls?)*	RATING JUNE 2024 Risk Category: Partnership Risk appetite: Significant		
								Initial	Current	Target
2/23	Transformation programme Board	Deputy Chief Executive / Director of Transformation & Partnerships	**Risk** Risk that the Trust cannot maxiimise its impact as an anchor institution in local communities to demonstrate social value in employment, career and development opportunities from investments and use of resources due to competing priorities and lack of partnership working I**mpact** unable to support broader economic and social development as required under new NHS Provider Licence	Transformation Programme Board (TPB) has oversight of Trust work to support generation of social value and economic support in our local Places. Trust social value action plan for major capital investments and is monitoring delivery against specific projects within the estate investment programme. Construction partner for new clinical build at CRH appointed and plan being developed. Trust 1 and 5 year strategy aligned to ICS and 2 Place strategies, with specific strategic objectives re sustainability with progress reported to the Board quarterly . Trust Chief Executive and Chair are members of Calderdale and Kirklees Place based Integrated Care Boards. Director memebrship of Calderdale and Kirklees Health and Well Being Boards and therefore contribute to Place and WY ICS strategy. Strategic collaboration with Huddersfield University development of Health Academy for the local area - regular meetings and partnerhsip projects, e.g. Community Diagnostic Centre. Collaboration with Calderdale and Kirklees Further Education Colleges and voluntary sector to increase routes into employment in our local Places, e.g. T -Level Cadet Pathway and to discuss and develop opportunities for shared learning and collaboration to generate social value. Widening Participation Team promote activities for disadvantaged young people, work experience placements, Project Search. Apprenticeship schemes. Work with the Purpose Coalition to tackle challenges facing patients, customers, colleagues and communiities and map Trust activities against the Purpose Goals. Levelling Up Impact Report from Purpose Coalition confirms Trust commitment to being a purpose-led organisation and plays a central role in its communities beyond healthcare service. Recommendations being progressed (re: local employer and anchor partner)	**First line** Reconfiguration leadership team. HRI Project team manages social value for A&E delivery. Quarterly Updates on Trust Social Value actions and delivery reported to Transformation Programme Board. **Second Line** Transformation Programme Board highlight report to Board Progress report on strategic objectives to Board Levelling Up Impact Report presented at the Executive Board and the TPB. **Third Line** Updates to West Yorkshire ICS on social value generation via capital invetstment and use of local supply chain. Update to Calderdale Place-based Committee on social value quarterly. Social value generated through investment in the new A&E at HRI reported to Kirklees VCSE forum, Calderdale and Kirklees JHSC, WYAAT learning networks, the Health Foundation learning network and stakeholders.		Development of the Social Value action plan related to planned capital investment at CRH and reporting to TPB. The plan will be developed with the construction partner. Lead: Deputy Chief Executive & Director of Transformation & Partnerships Timeframe: 31.3.25.	3x3 = 9	3x3 = 9	3x2= 6

Action	Timescale	Lead
Development of social value action plan with new CRH build construction partner	31.3.25	Deputy Chief Executive & Director of Transformation & Partnerships

Links to high level risk register: None. See related BAF risk 3/23 re partnership duties, 6/20 sustainability, 7/20 health inequalities

BAF Risks Review By Committee

REF	RISK DESCRIPTION	BOARD / COMMITTEE WITH OVERSIGHT
	Transforming Services & Population Outcomes	
01/19	Risk that the Trust does not secure approval of the Hospital Services Reconfiguration, Outline Business Case and Full Business Case resulting in being unable to progress changes to improve quality of care, workforce resilience and mitigate estates risks.	**Transformation Programme Board**
01/20	Risk of not delivering the ambitions in the Trust clinical strategy due to lack of collaboration due to lack of time, commitment, relationships and absence of shared vision, resulting in missed opportunities in terms of quality, efficiency, capacity, patient experience and workforce.	**Transformation Programme Board**
02/20	Risk of not securing appropriate investment to fund the Digital Strategy ambitions, ensuring infrastructure and technology is up to date and future proof due to funding not being available locally and nationally impacting on workforce efficiency and patient experience.	**Transformation Programme Board**
07/20	Risk of slow progress addressing health inequalities in the 20% of the most deprived patients in our communities, due to incomplete population health and patient ethnicity data, healthcare service delivery not matching patient needs in the most deprived areas, lack of quality priorites to advance health equity, lack of resource allocation and programmes for health prevention, ineffective partnership working and lack of sustained focus on actions to address ill health and prevention, resulting in the Trust not reducing health inequalities for our most vulnerable patients with protected characteristics.	**Trust Board of Directors**
	Keeping the base safe best quality and safety of care	
06/19	Risk that patients do not receive high quality, safe care due to poor compliance with internally and externally set standards on quality and safety resulting in patient harm or poor patient experience.	**Quality Committee**
04/19	Risk that patients are not able to shape decisions about their care based on what matters to them due to lack of clear strategy and capacity for patient and service user engagement resulting in not designing services using patient recommendations	**Quality Committee**
09/19	Risk of failure to maintain current estate and equipment and to develop future estates model resulting in patient harm, poor quality patient care or regulatory enforcement.	**Transformation Programme Board**
16/19	Risk of not being compliant with the Health and Safety at Work Act and regulations due to lack of clarity on roles resulting in harm to staff, patients, the public, visitors, potential regulatory failure and reputational damage.	**Audit and Risk Committee**
04/20	Risk of not maintaining the Trust CQC overall rating of good and increasing the number of services achieving an outstanding rating as assessed by the new CQC single assessment framework and potential for ratings to be changed by CQC based on other intelligence or data from CQC portal outside of on site inspection of service due to failure to comply with quality statements resulting in a reduction of qualiy of services to patients and an impact on reputation.	**Quality Committee**
1/23	Risk re demand and capacity requiring additional beds above planned levels resulting in staffing and financial pressures.	**Finance and Performance Committee**
3/23	Risk that decision making processes and capacity of Trust colleagues is impacted due to the evolving nature of partnership governance across the system and emergent governance arangements	**Trust Board of Directors**
4/23	Risk of failure to achieve local and national performance targets resulting in patient harm, poor patient experience or enforcement action.	**Finance and Performance Committee**
5/23	Risk of an impact to the delivery of clinical or corporate services due to reduced or no digital provision resutling from a cyber attack	**Audit and Risk Committee**
	Inclusive workforce and local employment	
10a/19	Risk of not being able to deliver safe and effective high quality care and experience for patients due to insufficient medical staff caused by an inability to attract, recruit, retain, reward and develop colleagues.	**Workforce Committee**
10b/19	Risk of not being able to deliver safe and effective high quality care and experience for patients due to insufficient nursing staff caused by an inability to attract, recruit, retain, reward and develop colleagues.	**Workforce Committee**
6/23	Risk of not being able to deliver safe and effective high quality care and experience for patients due to insufficient midwifery staff caused by an inability to attract, recruit, retain, reward and develop colleagues.	**Workforce Committee**
11/19	Risk of not attracting or retaining colleagues who are confident and competent to provide compassionate care to patients and compassionate and inclusive leadership to colleagues.	**Workforce Committee**
1/22	Risk of colleague absence and retention rising due to: increasing demands and requirements for health and wellbeing offers that are not appropriate, not accessible, not embedded or not affordable; and/or inability or unwillingness to attract develop and retain compassionate and inclusive leaders who are able to succesfully lead their teams through sustained periods of change	**Workforce Committee**
	Financial, Economic and Environmental Sustainability	
14/19	Risk that the Trust will not secure sufficient capital funding to maintain facilities over the longer term and meet safety and regulatory standards resulting in patient harm and regulatory intervention.	**Finance and Performance Committee**
18/19	Risk of failure to secure the longer term financial sustainability of the Trust (achieving financial breakeven and providing value for money) due to the size of the underlying and current financial deficit and reliance on cash support.	**Finance and Performance Committee**
06/20	Risk of climate action failure and not improving our environmental sustainability	**Transformation Programme Board**
2/23	Risk that the Trust cannot maximise its impact as an anchor institution in local communities to demonstrate social value	**Transformation Programme Board**

ACRONYM LIST

BAF	Board Assurance Framework
BTHFT	Bradford Teaching Hospitals NHS Foundation Trust
CCIO	Chief Clinical Information Officer
CNIO	Chief Nursing Information Officer
CIP	Cost Improvement Plan
CQC	Care Quality Commission
CQUIN	Commissioning for Quality indictor
ASSURAN	Calderdale Huddersfield Solutions LTD
ED	Emergency Department
EPAU	Early Pregnancy Assessment Unit
EPR	Electronic Patient Record
F&P	Finance and Performance Committee
FBC	Full Business Case
FFT	Friends and Family Test
HPS	Huddersfield Pharamcy Specials
HSMR	Hospital Standardised Mortality Ratio
IBR	Integrated Board Report
ICB	Integrated Care Board
ICS	Integrated Care System
IIP	Investor In People
ITFF	Independent Trust Financing Facility
KPI	Key performance indicators
NHS E	NHS England
OBC	Outline Business Care
OSC	Overview and Scrutiny Committee
PFI	Private Finance Initiative
PMO	Programme Management Office
PPI	Patient and public involvement
ITFF	Independent Trust Financing Facility
KPI	Key performance indicators

Outline Business Care
Overview and Scrutiny Committee
Private Finance Initiative

TMA	Transitional Monitoring Approach
WEB	Weekly Executive Board
WYAAT	West Yorkshire Association of Acute Trusts
DHSC	Department of Health and Social Care
IPC	Infection Prevention Control

	New risk
	Breach of risk appetite/ risk exposure
1-6	Low risk
8-12	Medium risk
15-25	High risk

INITIALS LIST

AB	Anna Basford, Director of Transformation and Partnerships
SD	Suzanne Dunkley, Executive Director of Workforce and OD
DB	David Birkenhead, Executive Medical Director
GB	Gary Boothby, Executive Director of Finance
JH	Jonny Hammond, Chief Operating Officer
RB	Rob Birkett, Chief Digital and Information Officer
AM	Andrea McCourt, Company Secretary
VP	Victoria Pickles, Director of Corporate Affairs
SS	Stuart Sugarman, Managing Director CHS
BB	Brendan Brown, Chief Executive
RA	Rob Aitchison, Deputy Chief Executive
LR	Lindsay Rudge, Chief Nurse
KA	Kirsty Archer, Deputy Director of Finance
ALL	All Board members

21. High Level Risk Register

To Note

Presented by Victoria Pickles

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Date of Meeting:	Thursday 4 July 2024
Meeting:	Board of Directors
Title:	High Level Risk Report
Author:	Saj Rahman, Risk Manager
Sponsoring Director:	Victoria Pickles, Director of Corporate Affairs
Previous Forums:	Risk Group; Audit and Risk Committee
Purpose of the Report	The purpose of this report is to provide an overview of the risks scoring fifteen or more.
Key Points to Note	**Introduction** High level risks have the potential to impact on the entire organisation. Risks are identified and added to the risk register by colleagues across the organisation. Each division has a governance group in place that looks at all risks scoring 12 or above plus any new risks. Those scoring more than 15 are reviewed at the Trust-wide Risk Group and if accepted are included on the High-Level Risk Register (HLRR). Where a risk presents a risk to the delivery of the Trust Strategy, either individually or as a collective, this is included on the Board Assurance Framework. **Current risk process** The Trust continues to manage and document risks using a bespoke risk register. When a risk is identified, the risk and impact on patient care is documented and then reviewed by the relevant department and division. All the appropriate information, including all mitigating actions to ensure the safety of patients and staff is maintained, is included. The Trust uses the information to not only track potential risks, but it also helps to inform local planning, management decisions and priorities and most importantly, share learning Trust wide. The current risk register system continues to be problematic in terms of being able to triangulate data, identify themes, and track risks and ensure risk owners are aware when updates are required. The Trust will be transitioning to a new risk, incident, and performance system this year. The new system, provided by InPhase, will replace the current Datix system/Be Spoke Risk Register, and will provide a more comprehensive reporting structure to Board and its committees in line with the new Patient Safety Incident Reporting Framework. A project plan is currently underway to support the transition. The risk team continue to work with divisions to comprehensively review their risks and ensure that there is a clear programme of review, management, and mitigation in place.

Current risk profile
Currently there are 30 high scoring risks on the Trust risk register (see details at the end of the report):

- 5 are scored as very high.
- 25 are scored as high.
- All risks have been recently reviewed and the mitigations (progress) updated.
- Of the 30 risks, two have had their risk scores increased.
- Since the last report(in March 2024), there has been a total of 2 risk that have had their risk score reduced – which one of the risk was reduced from a risk score 20 to risk score 16, (and is included in the high-level risk report) whilst the other risk has had their risk score reduced from 15 to currently scoring at 12 (and no longer included in the HLRR)
- Since the last report there has been a total of 1 risk that has been closed.

Each risk is aligned to one of the Trust's strategic objectives. The current risks scoring very high (20-25) demonstrate the following themes:

- Keeping the base safe:
  - Several risks relating to staffing and vacancies nursing, and therapy posts across a range of services including the emergency department, maternity, Cancer services, Glaucoma services and ophthalmology. We continue to monitor the impact of these through the incident reporting system.
  - There is a risk due the capacity available to validate outpatient appointments.

  .
- Transforming and improving patient care
  - There is a risk of a reduction in patient experience and quality outcomes due to the operational performance within the Emergency Department (ED) and the maintenance across all Emergency Care Standards due to prolonged patient length of stay within the ED and the impact this has on patient flow out of the ED.

There are some clear themes across the risks on the HLRR:

- 16 risks related to staffing, either in relation to fragile services or recruitment challenges in certain staff groups.
- 9 risks are in relation to demand and capacity, particularly in outpatient specialties and some diagnostic services.
- 2 risks reference potential failure of equipment due to it coming towards the end of its period under guarantee – some of these will be addressed by the recent decisions relating to capital expenditure and therefore should be reduced by the time of the next report.

Future actions

The transition to the new incident reporting system later 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. 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.
Regulation	CQC Regulation 17: Good governance
EQIA – Equality Impact Assessment	Risks are assessed considering any impact on equality.
Attachments:	**Appendix 1**- All risks scoring 15 or more. **Appendix 2** - High Level Risk that have reduced in score since last report. **Appendix 3** - Risks that scored 15+ during last report but have now closed/merged. **Appendix 4** - Risks that have increased in scores (High Level).
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 specialises 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
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	8734	Community Healthcare	Community theatre	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 due to vacancies within the speech and language therapy service. .	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	8633	Family & Specialist Services	Women's Services	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 5 x 3
High	8657	Family & Specialist Services	Women's Services	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	15 5 x 3

						time. This may result in poor outcomes for patients, delays in care, Inhibited activity recovery and poor patient experience	
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	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	15 5 x 3
High	8729	Medical	Medical Specialities	Respiratory	Keeping the base safe	There is a risk of serious harm to patients requiring chest drains due to a lack of appropriately trained middle grade medical staff in the trust currently.	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 medication errors, risk to patient safety and exposure to legal consequences or regulatory penalties.	15 3 x 5

Appendix 2 – 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 reduction
High	8509	Surgery & Anaesthetics	Head and Neck	Ophthalmology	Keeping the base safe	There is a risk of significant harm due to insufficient glaucoma appointments available to cope with demand due to increasing patient numbers and inability to recruit substantive consultant.	16 4 x 4	Risk reduced from score of 20. As holding list position much improved propose reduction in risk reflecting current position
Moderate	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.	12 3 x 4	Risk reduced from 15. While work still needs undertaking to make the rooms fully compliant with BSA standards the presence of bilateral speakers is sufficient to reduce the risk rating to 12.

Appendix 3 – Risks that scored 15+ during last report but have now closed/merged.

Risk Level	Risk No	Division	Directorate	Department	Objective	Risk Summary	Reason for closure
High 16 4 x 4	8147	FSS	Radiology	Intervention Radiology	Keeping the base safe	There is a risk of being unable to use the pressure injectors within both intervention labs (@ CRH/HRI) Cause: Fatal breakdown of the injectors (due to age) • Age of equipment • Inability to source replacement parts Effect: Patients requiring alternative non-invasive imaging for diagnosis. Impact: Inability to diagnose the source of a bleed in a time critical situation. In the event of a failure on both sites the patients would be required to be emergency transferred to Bradford/Leeds Hospital.	The new injector has now been delivered. Awaiting installation and training. To close.

Appendix 4 – Risks that have increased in score (High Level):

Risk Level	Risk No	Division	Directorate	Department	Objective	Risk Summary	Risk Score
High	8633	Family & Specialist Services	Women's Services	Maternity	Keeping the base safe	To be reviewed with 8657 Consultant staffing Split rota 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 12 to 15)
High	8657	Family & Specialist Services	Women's Services	Maternity	Keeping the base safe	To be reviewed with 8633 Consultant staffing Antenatal clinic 8121 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 12 to 15)

22. Freedom to Speak Up Report - Presented by Carol Gregson, Freedom to Speak Up Guardian

To Note

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Date of Meeting:	Thursday 4 July 2024
Meeting:	Public Board of Directors
Title:	Freedom to Speak Up Annual Board Report
Author:	Carol Gregson, Freedom to Speak Up Guardian
Sponsoring Director:	Victoria Pickles, Director of Corporate Affairs
Previous Forums:	Workforce Committee – 12 June 2024
Purpose of the Report	This paper provides information to the Board in respect of the Freedom to Speak Up (FTSU) arrangements at CHFT and FTSU activity in the Trust from the 1st April 2023 to the 31st March 2024.
Key Points to Note	• From 1 July there will be two Freedom to Speak Up Guardians, each working 0.5 WTE to support speaking up in the Trust • 1 April 2023 to 31 March 2024 saw the highest ever number of concerns raised – 94, a 9.6% increase over time. • Quarter 2 saw our first reported incidents of staff suffering detriment because of speaking out. • The highest number of concerns are from an unknown source and we need to make tackling this and promoting psychological safety a priority • There also needs to be a focus on encouraging a speaking up culture among ethnically diverse colleagues • Changes from the National Guardian's Office to the role of Ambassadors is being implemented alongside a support network for the Ambassadors • The Care Quality Commission new single assessment framework includes a full section on FTSU and we are undertaking a review of our compliance with the quality statements • The work being undertaken to create a culture where staff feel safe to speak up and make FTSU business as usual at CHFT through understanding colleague understanding of FTSU arrangements, whether they have ever spoken up, their experience of speaking up and whether they would do it again.
Regulations	Regulation 9: Person-centred care Regulation 10: Dignity and respect Regulation 12: Safe care and treatment Regulation 17: Good governance

EQIA – Equality Impact Assessment	The equality impact for specific actions arising following consideration of the report will be assessed, considered, and mitigated as appropriate.
Recommendation	The Board is asked to **RECEIVE** and **COMMENT** on the report.

WORKFORCE COMMITTEE

12 JUNE 2024

FREEDOM TO SPEAK UP ANNUAL REPORT

1. PURPOSE

This paper provides information to the Board in respect of the Freedom to Speak Up (FTSU) arrangements at Calderdale and Huddersfield Foundation Trust (CHFT) and FTSU activity in the Trust from the 1st April 2023 to the 31st March 2024.

2. BACKGROUND

FTSU is vital in healthcare if we are to continually improve patient safety, patient experience, and the working conditions for colleagues. The National Guardian's Office (NGO) believes a positive speaking up culture makes for a safer workplace, for workers, patients, and service users. At CHFT we continue to work towards speaking up becoming business as usual.

Effective speaking up arrangements help to protect patients and improve the experience of NHS workers. Having a healthy speaking up culture is an indicator of a well-led Trust. The recently published Single Assessment Framework from the Care Quality Commission has a separate quality statement under the well-led section relating to speaking up. This asks that trusts have a culture of speaking up and that this is evidenced by:

- Staff at all levels within the trust are equally encouraged and empowered to speak up.
- That they feel safe to speak up without fear of detriment, that is without experiencing disadvantageous and/or demeaning treatment as a result.
- Included in this is that staff are confident that their voices will be heard.
- That managers across the trust feel confident to listen and act when someone speaks up and improvements happen as a result. These are communicated back to those who raise matters.
- Leaders are seen to promote FTSU through actively demonstrating positive behaviours.
- That appropriate training and support is available to equip FTSU leads to actively support the FTSU Guardian.

The NGO report that 25,382 cases were raised with FTSU Guardians from 1st April 2022 to 31 March 2023 – an increase of 25% on the previous year.

3. PROGRESS UPDATE

3.1 The FTSU Network at CHFT

The Trust currently has one FTSU Guardian, Carol Gregson who works 18.75 hours per week. A second Guardian has been recruited and is due to start on the 1st July who will also work 18.75 hours per week. Andrea Gillespie, the previous Guardian for 2.5 years retired in March 2024. The FTSU Guardian attends the FTSU regional meetings for the Northeast and Yorkshire network monthly meetings where there is regular attendance from the NGO. The Guardian also buddies

with the FTSU Guardian at Bradford Teaching and Airedale Hospitals. The Guardians meet monthly via MS Teams for peer support.

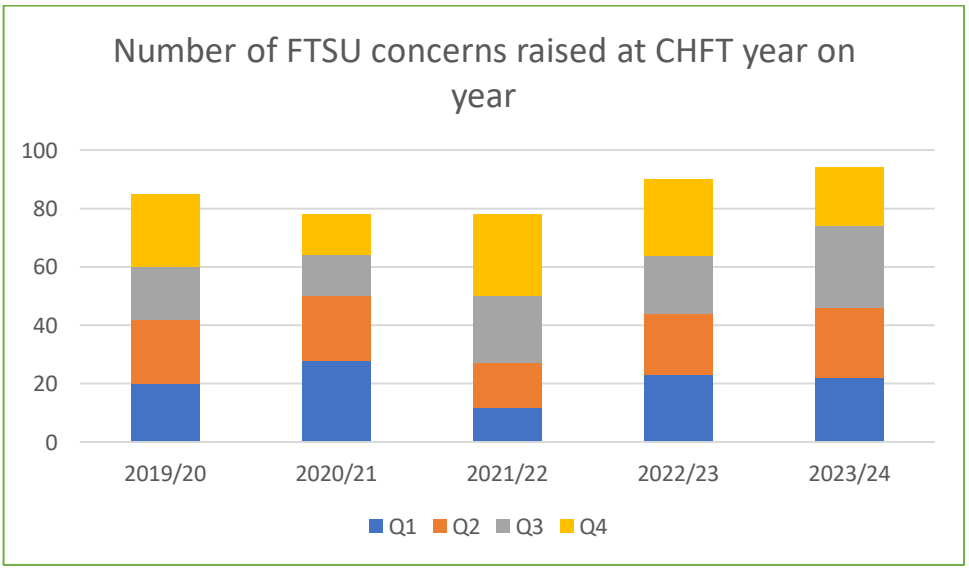
Victoria Pickles, Director of Corporate Affairs is the Executive Sponsor for FTSU since December 2023 and Jo-Anne Wass is the newly appointed Non-Executive Sponsor for FTSU.

There are 26 Ambassadors in the organisation that promote the FTSU agenda in their areas of work and are a point of contact and source of support for any colleague who wants to discuss, raise, and escalate a concern. The Ambassadors currently have no protected time to dedicate to FTSU within their substantive roles which significantly limits the support they provide to the FTSU Guardian and colleagues, and the opportunities they have to raise the FTSU profile within the organisation. As a result, a review of the FTSU Ambassador network is currently being undertaken. The review is looking at the expectations and effectiveness of the role, the network size and how we can capture feedback from our current Ambassadors. This is being fed into the new way of working.

Following the review, it has been decided that the FTSU Guardians and the FTSU Ambassadors will continue to meet bi-monthly. The meetings will be chaired by the FTSU Guardians and regular agenda items will include updates and minutes from the Regional Meetings, data submissions and national reviews, i.e. case reviews completed by the NGO in other organisations. In addition to this, an activity log for the Ambassadors is going to be included as per NGO guidance released in November 2023, so that we can capture wider reaching themes and trends within the organisation. Attendance at the meetings has recently been poor as it has become more difficult for the Ambassadors to attend – to combat this, meetings will be held bi-monthly and alternately via MS Teams and face to face. Microsoft Teams meetings will be recorded so that Ambassadors can update at a time convenient to them.

3.2 FTSU concerns raised from the 1st April 2023 to the 31st March 2024

Number of FTSU concerns raised at CHFT since 2019 to the end of March 2024 can be seen below, with our highest ever number of concerns this year totalling 94 – a rise of 9.6% since the service was introduced in the Trust.

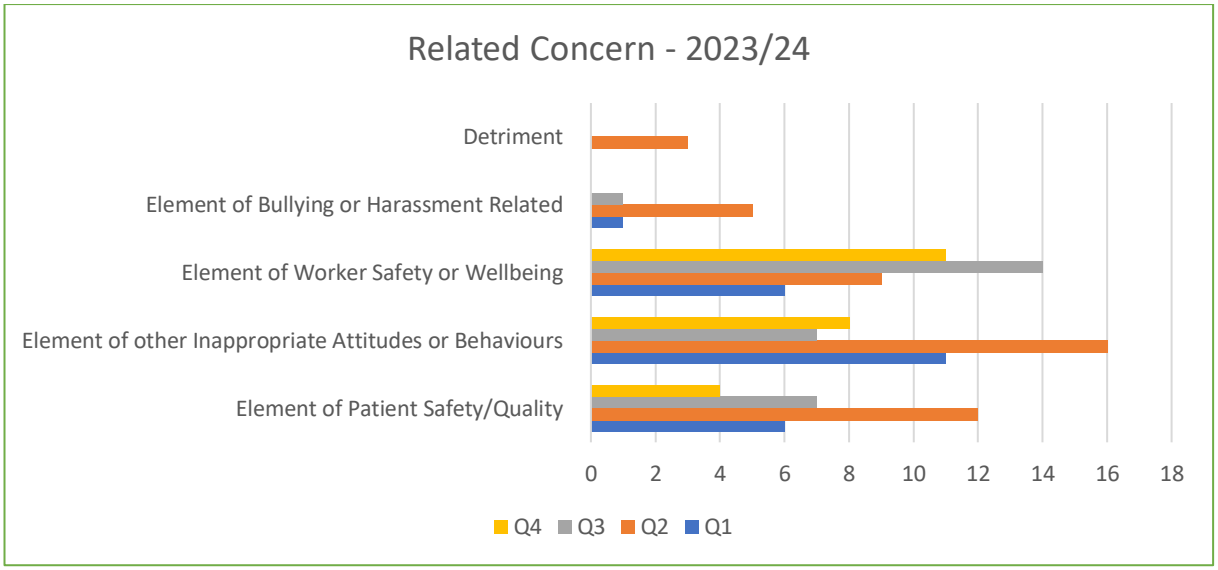


In February 2022 the NGO revised the guidance for recording cases and reporting data which took effect from the 1st of April 2022. The guidance added a new category of 'inappropriate attitudes or behaviours' which prompted the adoption of the Advisory, Conciliation and Arbitration Service (ACAS) definitions of bullying and harassment. This category is to be selected when there is risk of other attitudes or behaviours that do not constitute bullying and harassment. In addition, the 'colleague safety' category was extended to include colleague wellbeing.

The graph below shows the total number of concerns raised in 2023/2024 and the number of concerns raised as per the NGO's submission categories. Please note that multiple categories can be selected for each individual concern.

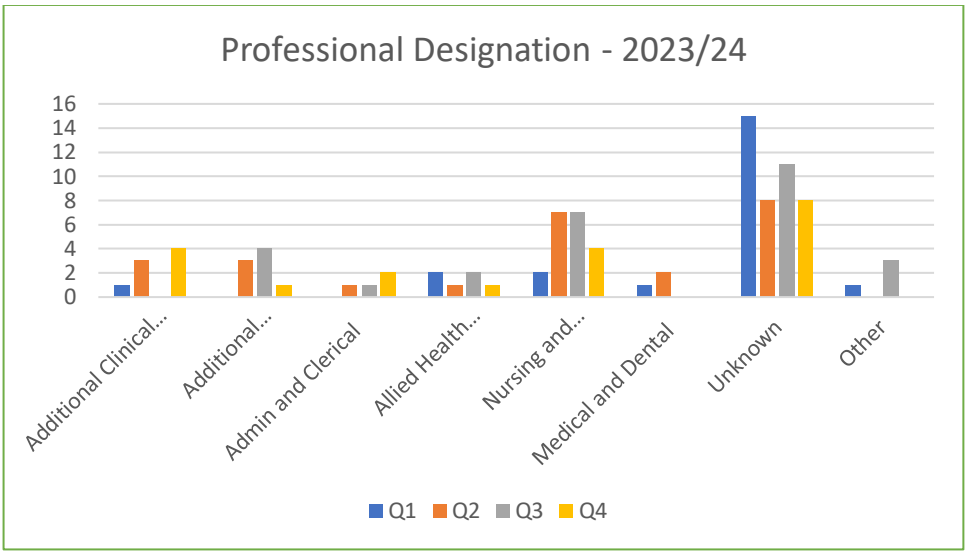
Further changes to the submission of data were released in February 2024 with an implementation date of 1st April 2024 (Quarter 1) – I am pleased to say that CHFT already collect this data within its portal. Just to note CHFT continues to submit quarterly data to the NGO which feeds into the national figures around FTSU.

Quarter 2 saw our first reported incidents of staff suffering detriment because of speaking out.



Colleagues raising FTSU concerns are requested to indicate which professional/ worker group (as defined by the NGO) that they belong to. The NGO revised the groups to take effect from 1st April 2022. The 'corporate services' and 'healthcare assistants' groups have been discontinued and a new group 'additional clinical services' has been added. The definitions for all groups have been revised and we are seeing our second year of those changes.

The graph below indicates the number of concerns raised per quarter by staff group at CHFT. Registered nurses and midwives have submitted the highest number of concerns. The data is utilised to identify staff groups where more FTSU promotion and education is required. The 45 'not known' are colleagues who have raised their concerns anonymously. This is a concern and our work will include a focus on psychological safety and to speak up within the Trust.

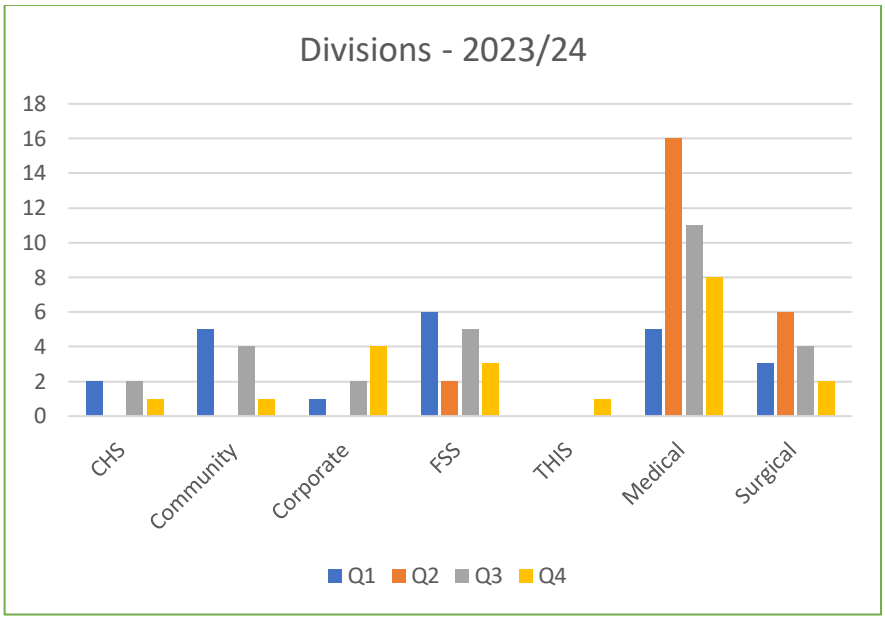


Colleagues raising their concerns require different levels of support due to the complexity and level of sensitivity of their concern and their emotional state at the time of contacting FTSU. As a result, the FTSU Guardian continues to spend a large proportion of time listening and supporting colleagues, referring them for counselling where appropriate and following up on concerns raised within Division.

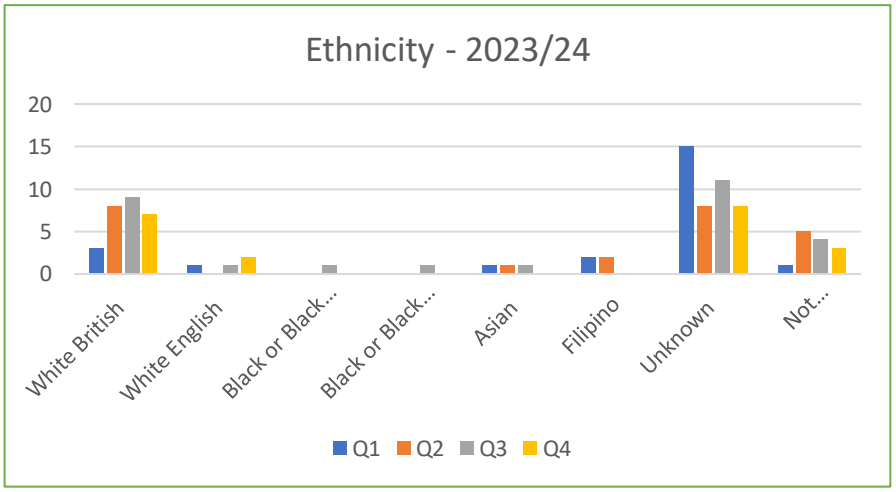
The subjects of the concerns raised are extremely varied. However, there are some common themes which remain the same from last year. The element of inappropriate attitudes and behaviours continues to remain high, closely followed by an element of worker safety or wellbeing. Colleagues raising their concerns describe colleagues being unkind, unsupportive and a sense of inequality.

The FTSU Guardian is connecting with Divisions for assurance that they are aware of the types of issues being raised, they are listening to their teams, they are taking steps to address the multiple issues and monitoring the effectiveness of their actions. Alongside this, formulating a governance structure with FTSU feeding into existing structures reinforcing awareness and promotion of the service.

Multiple concerns raised this year are predominantly in 2 areas – medicine and surgery, as can be seen below – with specific themes. We are seeing improvements in these areas now with more focused work with the senior management teams.



The table below illustrates the ethnicity of the colleagues that have raised their concerns via FTSU at CHFT. The numbers recorded in the unknown category include the concerns raised anonymously and concerns received via other routes, such as email, that are added to the portal by the FTSU Guardian. Review of the portal is underway to look at how we can better capture data and amend on receipt of concerns by the Guardian. As you can see, there is further work to do to encourage a culture of speaking up from our disadvantaged groups which will be targeted in this coming year.



In addition, a review of the current Ambassador network across the organisation has commenced regarding suitability, willingness to support, divisional or departmental representation, along with those staff from disadvantaged groups – all of which will help reduce barriers for speaking up, allow targeted promotion and support the culture of freedom to speak up without fear of detriment.

Feedback from colleagues raising their concerns continues to be positive. In the last year we have had 17 feedback responses – 14 advising that they would use the service again and 3 not. Here are some examples:

- **Yes** - often when speaking out about management at the Trust, it very much feels like them against you and there is a mistrust build re; staff/management at the hospital. However, Freedom to Speak up very much shows there are people within the trust that supports its employees, especially when speaking up and going against the grain. Freedom to speak up were very supportive, both informatively and emotionally and helped guide me in my grievance process and cared for my welfare. I am very thankful for your support during a stressful period at work.

- **No** - Complaint took far too long to be investigated - over 18 months. FTSU facilitator offered excellent support; however senior management appeared unable to take control of the situation. Too many people involved and had to go over information already provided time and again to different people. Outcome of FTSU complaint addressed some of the issues raised but not all.

- **Yes** - I was hesitant to approach FTSU initially, as within the department where I work, it had caused some animosity, more-so regarding anonymous persons bringing an issue to light. I am, however, very pleased that I did. I was listened to - perhaps for the first time regarding an incident and subsequent 'bullying'. I was treated with respect and taken seriously. I did find that I hadn't experienced these things from my manager or from colleagues within my own department, so to have a 'safe' place to discuss the issues, concerns and have action was not only a relief, but it really did help to turn my mental health around. FTSU works - the person I spoke with was professional, collated information - not only from my side, raised concerns when appropriate and really is the reason I am still here at work at all.

- **Yes** - I would use the FTSU Guardian again should other avenues to share concerns not be available. I found the FTSU Guardian supportive and authentically listened to my concerns and took supportive action to enable me to have my voice heard. As a result of my concerns raised, I understand that the team did reflect and make some changes to the seek to understand process in the organisation. Thank you for authentic listening.

- **Yes** - My concern was listened to in a non-judgemental way. I felt that my concern was taken seriously and the advice that I was given was much appreciated and I felt empowered to act upon this advice. I felt that this was dealt with in a compassionate and caring manner.

Yes - Very kind, friendly and helpful. Gave very good advice.

3.3 FTSU Training at CHFT

All CHFT colleagues have access to the NGO FTSU e-learning package via ESR. The package includes 3 modules, Speak Up, Listen Up and Follow up which were developed by the NGO in collaboration with Health Education England. The Speak Up module is designed to be completed by all colleagues, the Listen Up module is to be completed by managers of all levels and the Follow Up module is for senior leaders to complete. Ambassadors are asked to complete all 3 packages. In May 2023 communications were produced to inform colleagues of its existence on ESR. The training is not included as part of an essential safety training core package and as such is reflected in the current training figures.

Details of the training has been added to the FTSU pages and training pages on the intranet and the FTSU Guardian promotes the training at any opportunity. Some trusts have made the decision to make this training mandatory with a 3 yearly update requirement. This is being explored as part of the organisations Freedom to Speak Up arrangement’s reflection and planning exercise.

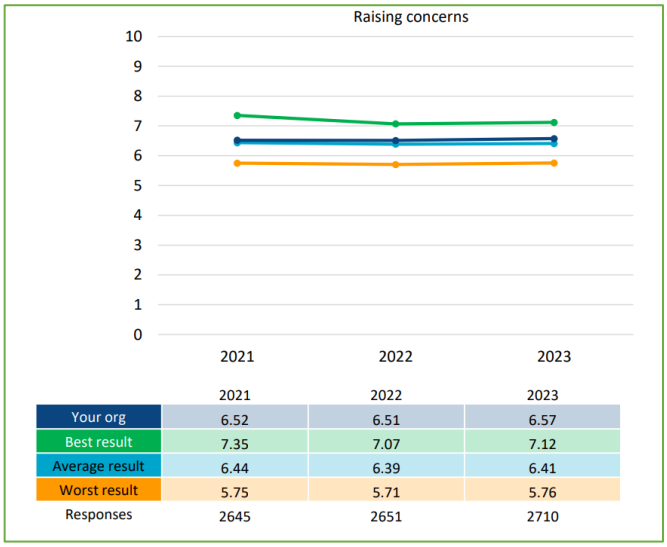
The table below shows current figures for training for each of the levels at CHFT.

Training Levels	CHFT Training Figures – ESR
Level 1 **Speak Up** – core training for all staff	157
Level 2 **Listen Up** – all managers and Ambassadors	28
Level 3 **Follow Up** – senior leaders and Ambassadors	13

As part of the self-assessment work, we will be looking at what level of training we expect to be undertaken across the organisation. We will also consider what is included in the Trust Induction and how this can be reflected in the training figures.

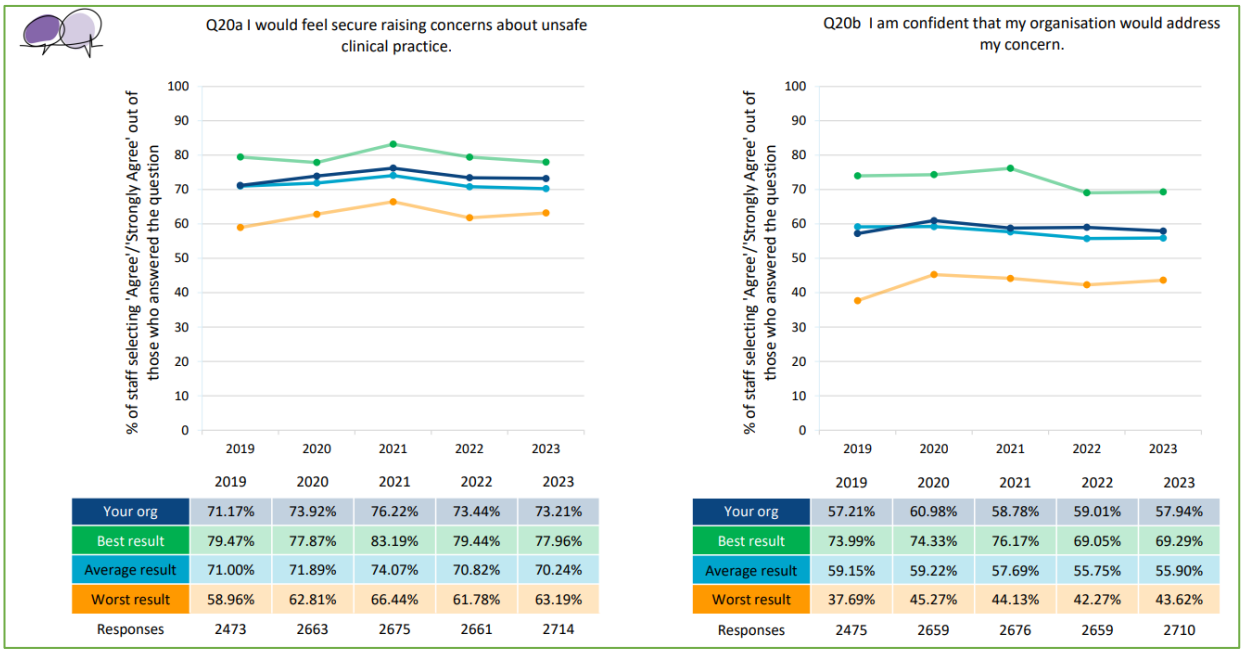
3.4 Staff Survey 2023

Last year's staff survey showed a 44% response rate. CHFT has remained consistent in its response to raising concerns with a slight increase in the last year.



	2021	2022	2023
Your org	6.52	6.51	6.57
Best result	7.35	7.07	7.12
Average result	6.44	6.39	6.41
Worst result	5.75	5.71	5.76
Responses	2645	2651	2710

The majority of staff feel secure when raising concerns. But there is less confidence that the Trust will address those concerns.



	2019	2020	2021	2022	2023
Your org	71.17%	73.92%	76.22%	73.44%	73.21%
Best result	79.47%	77.87%	83.19%	79.44%	77.96%
Average result	71.00%	71.89%	74.07%	70.82%	70.24%
Worst result	58.96%	62.81%	66.44%	61.78%	63.19%
Responses	2473	2663	2675	2661	2714

	2019	2020	2021	2022	2023
Your org	57.21%	60.98%	58.78%	59.01%	57.94%
Best result	73.99%	74.33%	76.17%	69.05%	69.29%
Average result	59.15%	59.22%	57.69%	55.75%	55.90%
Worst result	37.69%	45.27%	44.13%	42.27%	43.62%
Responses	2475	2659	2676	2659	2710

4. Update regarding change to Care Quality Commission – Well Led

In April, the CQC launched its new single assessment framework. This includes FTSU as part of the 5 key questions within the Well-Led element. The Quality statement around this includes fostering a positive culture where people feel that they can speak up and their voice will be heard. It goes on to explain what the quality statement means:

- Staff and leaders act with openness, honesty and transparency.
- Staff and leaders actively promote staff empowerment to drive improvement. They encourage staff to raise concerns and promote the value of doing so. All staff are confident that their voices will be heard.
- There is a culture of speaking up where staff actively raise concerns and those who do are supported, without fear of detriment. When concerns are raised, leaders investigate sensitively and confidentially, and lessons are shared and acted on.
- When something goes wrong, people receive a sincere and timely apology and are told about any actions being taken to prevent the same happening again.

5. NGO UPDATE

The FTSU Guardian receives support through monthly bulletins, regional network meetings and the national conference. The FTSU Guardian is required to complete the NGO training along with an annual update – in addition to this in May 2024 a new core module for the FTSU Guardian was added titled 'Equity, Diversity, Inclusion and Belonging'.

The NGO has requested that organisations complete the actions below:

- Update their local Freedom to Speak Up policy to reflect the new national policy template. This has been completed, ratified and is currently available on the Trust Intranet - CALDERDALE & HUDDERSFIELD NHS TRUST (cht.nhs.uk)

- Complete an assessment of the organisations FTSU arrangements using the revised guidance and template produced by the NGO. Currently the Executive Director and FTSU

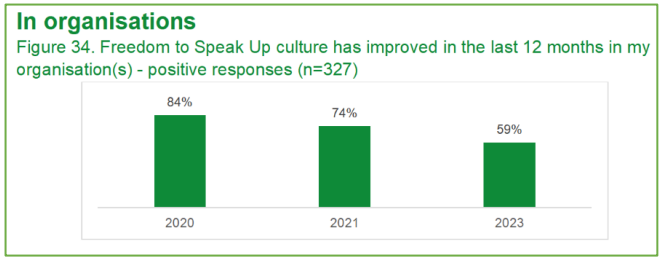
Guardian are reviewing the guidance and have created a provisional assessment which will be completed as part of a Board exercise over the next 3 months.

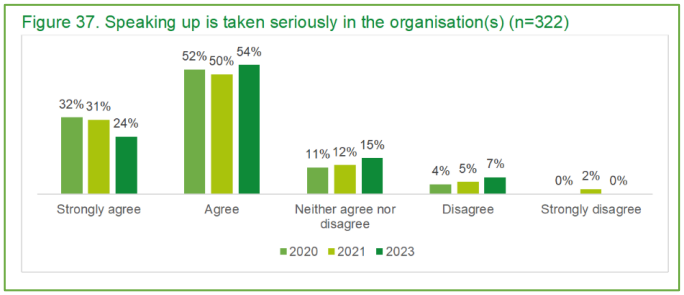
- Create a development plan to respond to the findings from the self-assessment and any other intelligence about FTSU gathered through the National Staff Survey and other feedback

Publications from the NGO this year have included their FTSU Guardian Survey 'Listening to Guardians' in July 2023 and Guidance for FTSUG's in relation to Ambassadors in November 2023.

The survey focuses on FTSU Guardians' answers to the 2023 FTSU survey. Some key findings included:

- minimal change in the ring-fenced time available over the last 12 months;
- that the majority of time is spent on being reactive to concerns raised with an increase from 2021 to 2023;
- a positive response in access to the Chief Executive at 92%;
- almost three-quarters of respondents (74%) thought that senior leaders supported workers to speak up, up three percentage points compared to the last survey (71%, 2021) but down nine percentage points from 2020 (83%).
- there was a thirteen percentage point drop in those who 'strongly agreed' that senior leaders supported workers to speak up.
- more worryingly there is a reported decline since 2020 in perceived culture but a small increase in organisations taking speaking up seriously as can be seen below:





- 78% of guardians advised that they would recommend the role to a friend but that 44% of respondents stated that the role had reduced their health and wellbeing – a decrease of five percentage points on the last survey.
- 96% of respondents felt valued by individuals raising concerns although guardians did not always feel they were meeting the needs of workers in their organisation.

Dr Jayne Chidgey-Clark advises that to reap the benefits which speaking up can bring, it is vital that FTSU is welcomed as a tool for improvement and nurtured within organisations with the responsibility falling to everyone, not just on FTSU Guardians.

The November 2023 Guidance for FTSU Guardians in relation to Ambassadors, confirms that their role is around awareness raising, signposting, and learning (issues/themes captured). It advises that Ambassadors should be appointed in a 'fair and open way', completed the recommended training and understanding not only from them but also their managers, regarding role expectations and potential time commitment of the role.

The size and composition of the network should be reviewed as well as diversity considering colleagues who may face additional barriers to speaking up. Regular support should be received and an opportunity to share their learning managed – an activity log is recommended which is being reviewed at CHFT.

All of this has fed into CHFT's recent review into its ambassador network.

6. RISK ASSESSMENT

Regular evaluation of the number and complexity of concerns received is essential for assurance. This should assess appropriate resource available to lead, manage and co-ordinate FTSU at CHFT. It should also include evaluation that concerns are supported in a timely, appropriate, and supportive response for colleagues raising a concern and enables a full and proper enquiry and resolution of the concern. A sudden increase in the number and/or complexity of concerns or an increasing trend that is not appropriately considered and attended to, could create risk to the integrity and credibility of FTSU at the Trust. FTSU activity is reviewed regularly by the FTSU Guardian in conversation with others and any additional resource requirements and/or different ways of working that can be applied are considered. Continuing development of FTSU is vital if the service is to grow and reach out to all our colleagues. The Trust is likely to see a significant positive change in the service in the coming year due to the increase in guardian people and hours.

7. CONCLUSION

The Board is asked to note the content of this report.

Carol Gregson
Freedom to Speak Up Guardian

June 2024

23. Complaints Annual Report

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Date of Meeting:	Thursday 4 July 2024
Meeting:	Public Board of Directors
Title:	Annual Complaints Report
Author:	Emma Catterall, Head of Complaints
Sponsoring Director:	Victoria Pickles, Director of Corporate Affairs
Previous Forums:	Quality Committee - 3 June 2024
Purpose of the Report	The purpose of this report is to provide the Board with a summary of the complaints received in the Trust between 1 April 2023 and 31 March 2024 and themes/trends identified.
Key Points to Note	• The overall number of complaints received in year has decreased. • Performance on response times has remained consistently above 80% since we made the improvements in 2023, and is regularly above 90%. • 19% of closed complaints have been re-opened. This remains a relatively high number and is an area of focus for this year. • Compliance with equality monitoring is variable. As we move to InPhase as our database for logging and reporting on complaints data, we will work to strength both the capturing and reporting of equality data.
Regulation	Regulation 16: Receiving and acting on complaints
EQIA – Equality Impact Assessment	Not required. As referenced above, one of the key areas of focus for 2024/25 will be an improvement in capturing and reporting equality monitoring data on complaints, Patient Advice and Liaison queries and compliments.
Recommendation	The Board is asked to **RECEIVE** and **COMMENT** on the report.

Calderdale & Huddersfield NHS Foundation Trust's Annual Complaints Report 2023/24

INTRODUCTION

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

This report provides information on the complaints received in the Trust between 1 April 2023 and 31 March 2024; providing a summary of complaints received, areas concerned, and themes/trends identified. It also looks at our key performance indicators:

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

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

PATIENT ADVICE AND LIAISON SERVICE

1. PALS Process

The Patient Advice and Liaison Service (PALS) supports patients, their families, and their carers by listening to queries and concerns in confidence and helping people find solutions as quickly as possible. The aim of the PALS service is to resolve problems at this stage and avoid the need for people to have to submit a formal complaint. Agreement with Divisional Leads is to escalate any concerns relating to an on-going, in-patient admission immediately to the Matron, so that they can contact the service user and agree a resolution. Data for this service is shared within the Trust's Annual Report

2. Formal complaints

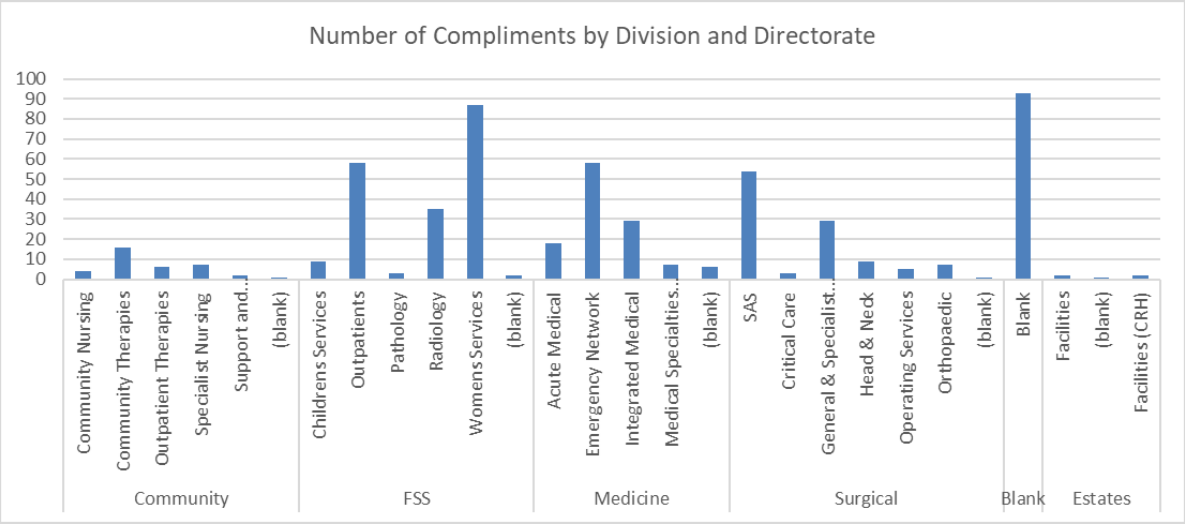
All formal complaints are dealt with in accordance with the Local Authority Social Services and NHS Complaints (England) Regulations 2009. Formal complaints are typically detailed, identifying problems and issues relating to episodes of care that have already happened (for example, questions as to why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

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

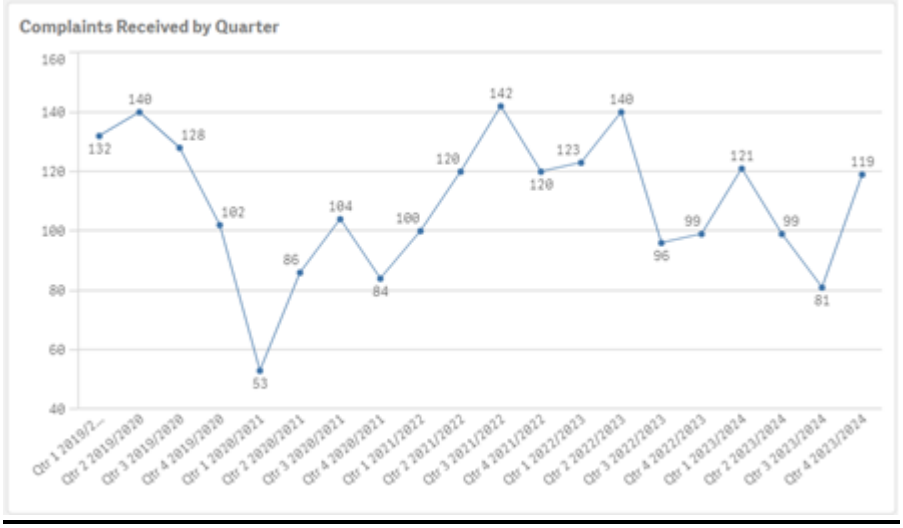
Complaints, Concerns and Compliments 2023/24 at a glance

420 **Formal complaints RECEIVED**	This is a decrease from 2022/23 (455). Emphasis continues to be placed on resolving concerns in real time via the PALS service as quickly and effectively as possible, which may be reflective in the decline in formal complaints received.
388 **Formal complaints CLOSED**	388 formal responses have been sent throughout this reporting period which equates to 7 per week, on average. 529 formal complaints were closed the previous year, demonstrating that 141 fewer complaints were closed, attributable to the fewer complaints received.
74 **Formal complaints RE-OPENED**	74 out of the 388 formal complaints that were closed, were re-opened, which equates to 19%. This remains a relatively high number and is disappointing compared to 13% in the previous year.
1849 **Concerns were received by the PALS team**	This is slightly lower than the previous year (1877), however highlights what a valuable service the PALS team provide to our patients and service users.
502 **Compliments RECEIVED**	This is slightly higher than the previous year of 500 compliments. Further work continues to capture positive/complimentary feedback and report this Trust wide. There are lots of examples of compliments made across all areas of the Trust and it is a challenge to collate these in an effective and efficient way, so this will not be a comprehensive figure of all positive feedback received in the Trust. All compliments are valued by staff and are a useful source of intelligence on what the Trust is doing well.

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

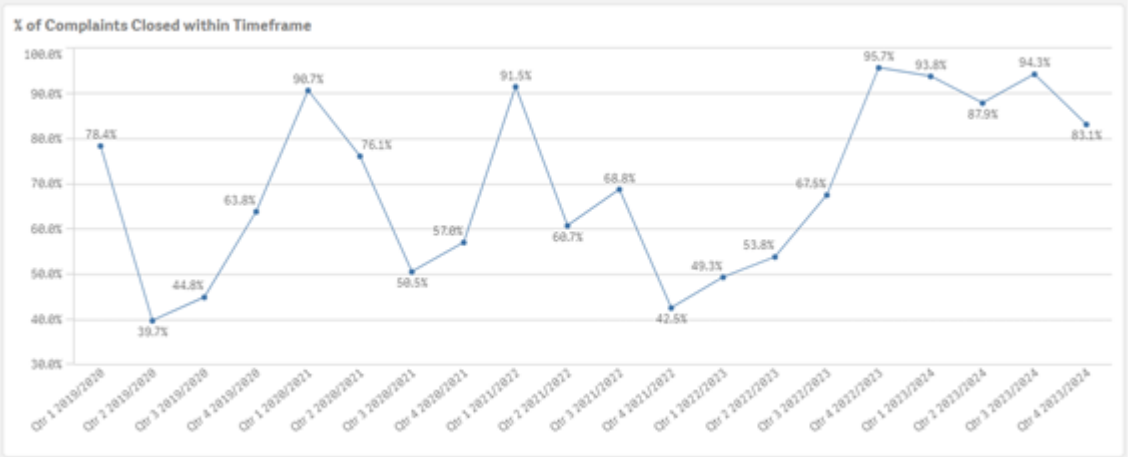


Complaints: The number of complaints received per quarter



It is evident from the data shown above that since 2019, the highest numbers of complaints were received in quarter 2 of last year.

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



During this year we have continued to focus on improving the way in which we process, investigate, and respond to complaints, maintaining our performance. Our performance is over 83%. We saw a dip in Q4, the increases in activity within the Trust at that time. While we have seen a significant improvement in performance, we need to do further work to achieve the Trust's target of 95% consistently.

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

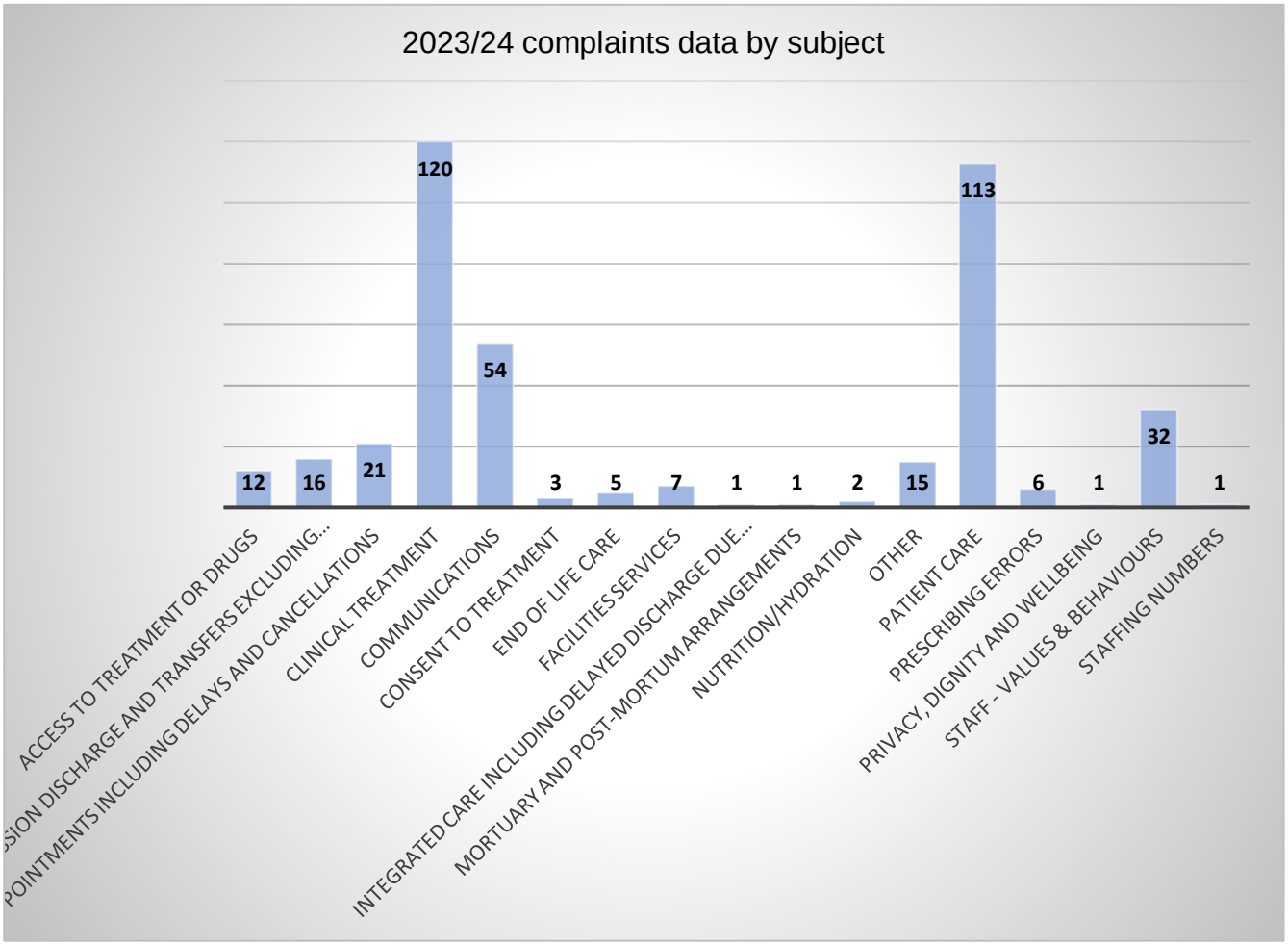
A missed deadline potentially exacerbates a complainant's feelings, and we are working hard to improve our communication and response rate in this regard. As mentioned in last year's report, weekly high-level scrutiny meetings with Divisional Leads are now embedded to continually monitor performance.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

This was a quality priority throughout 2023/24 and will continue to be throughout 2024/25 alongside other priorities identified in the Trust Quality Account, including the quality of Trust responses to ensure complaints are resolved without being re-opened.

Divisional themes and analysis

The primary issue identified in each complaint is described below. The overriding theme within formal complaints is clinical treatment, followed by patient care and communication. Of the 420 complaints received:

- 120 (29%) were related to clinical treatment being recorded as the primary subject;
- 113 related to patient care (27%);
- 54 complaints were concerning communication (13%).



The Parliamentary & Health Service Ombudsman

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

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

Forward Plan for 2024/25

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

1. The information provided within the initial response has prompted further questions which cannot be avoided.
2. The information provided has not fully addressed the concerns which can be improved with effective communication at the outset, to determine the expectations of the complainant and what outcome they hope to achieve, as well as what specific questions they would like to be answered.
3. Despite the information provided, the complainant does not agree with the Trust's position and either further work is required to resolve this or signpost to the PHSO for an independent assessment.

Our improvement work is focused on the second of these reasons and an aim of "getting it right first time". To support this we will focus on:

- Compliance processes around learning, with evidence sought from divisions on implementing learning, evidencing changes made and communicating these changes to all appropriate staff. Continuing the weekly scrutiny/performance meetings
- Reinforcing that lead investigators are expected to keep complainants updated about the progress of their complaint, and ensuring that processes are in place to monitor this and to escalate any delays.
- Compliance with equality monitoring is also variable, and whilst relevant information is captured when initially logging a complaint, during 2024/25 we will be looking at how we can improve both the capture, analysis and reporting of equality monitoring information for both PALS and complaints.
- The Trust continues to build a PALS and Complaints team with effective divisional relationships to meet regulatory standards, Trust priorities and the needs of our communities.

Conclusion

During 2023/24 we have maintained the improvement in response times, recognising that this remains a challenge for clinical and operational teams, as well as for those liaising directly with families and patients in the PALS and Complaints Team. This work will continue, and we will evidence even more improvements and learning in next year's annual complaints report.

GOVERNANCE

24. Governance Report

a) Modern Slavery Statement

b) Trust Seal Report

c) Amendment to the Trust Constitution: Staff Membership

d) Governance Structure

e) Board of Directors Workplan for 2024/2025

To Approve

Presented by Andrea McCourt

Date of Meeting:	Thursday 4 July 2024
Meeting:	Public Board of Directors
Title:	Governance Report
Author:	Andrea McCourt, Company Secretary
Sponsoring Director:	Victoria Pickles, Director of Corporate Affairs
Previous Forums:	None
Purpose of the Report	This paper presents the following governance items to the Board: a) Modern Slavery Statement b) Trust Seal Report c) Amendment to the Trust Constitution: Staff Membership d) Governance Structure e) Board of Directors Workplan for 2024/2025
Key Points to Note	**a) Modern Slavery Statement** Modern Slavery is a global issue and a concern for public services. All staff at the Trust, in clinical and non-clinical roles, have a responsibility to consider issues regarding modern slavery and human trafficking and incorporate their understanding of these issues into their day-to-day practice. The three main areas relate to: • Our people through recruitment • Our patients presenting for treatment (safeguarding) • Our supply chain. The aim of the Trust's Modern Slavery statement is to confirm our commitment to ensuring no modern slavery or human trafficking takes place in our business or supply chain and demonstrate that the Trust follows best practice, with all reasonable steps taken to prevent slavery and human trafficking. Section 54 (1) of the Modern Slavery Act (2015) requires commercial organisations operating in the UK with an annual turnover of £36m to produce a slavery and human trafficking statement for each financial year of the organisation. The Act specifies two legal requirements for the statement: 1. Statements must be published on the organisation website with a link in prominent place on the UK homepage.

2. Statements should be approved by the Board of Directors and signed by a Director.

A House of Lords Select Committee on the Modern Slavery Act will report by 30 November 2024 on the implementation of the Act and it's effectiveness. Any changes resulting from this for the Trust's statement will be considered in 2025.

The enclosed Statement has been updated and confirms our commitment to the Modern Slavery Act 2015.

Since the last statement from the Trust there have been updates to NHS terms and conditions which strengthen the NHS and Trust's position on Modern Slavery.

RECOMMENDATION: The Board is asked to **APPROVE** the Modern Slavery Statement.

b) Seal Report

There have been no uses of the seal since the last report to the Board on 7 March 2024.

c) Amendment to Trust Constitution – Staff Membership

The Trust Board and the Council of Governors are required to approve amendments to the Constitution.

It has been identified that section 7.6 relating to staff membership, which confirms the classes of staff membership, should show six seats and currently shows only five. The amendment is to add the staff member class of ancillary staff (e.g. healthcare assistants, housekeeper, Operating Department Practitioners) which has one staff governor seat. An election for the ancillary staff governor vacancy is currently underway. This amendment addresses an anomaly in the Constitution.

The Council of Governors will be asked to approve the amendment to its Constitution at their meeting on 17 July 2024.

RECOMMENDATION: The Board is asked to **APPROVE** the addition of the ancillary seat for staff membership to section 7.6 of the Constitution, subject to approval by the Council of Governors on 17 July 2024.

d) Governance Structure - Quality Committee

The Board is asked to note there is an additional group reporting to the Quality Committee which has been added to the Governance structure. This is the Children and Young People Board, chaired by the Chief Nurse, which has operational and transformational oversight for the quality and safety of care provided to children across the Trust.

RECOMMENDATION: The Board is asked to **NOTE** the addition of the Children and Young People Board reporting to the Quality Committee.

	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 U3. **RECOMMENDATION:** The Board is asked to **APPROVE** the Board workplan for 2024/25.
Regulation	CQC Regulation 17: Good governance
EQIA – Equality Impact Assessment	The content of this report does not adversely affect people with protected characteristics.
RECOMMENDATIONS	The Board is asked to **APPROVE** the: • Modern Slavery Statement to 31 March 2025 • Amendment to section 7.6 of the Trust Constitution • Board of Directors Workplan for 2024/25 The Board is asked to **NOTE** the: • Addition of the Children and Young People Board reporting to the Quality Committee.

Calderdale and Huddersfield
NHS Foundation Trust

Modern Slavery and Human Trafficking Statement

Introduction

Modern Day Slavery is a violation of a person's human rights and is a global issue and concern for public services It can take the form of human trafficking, forced labour, bonded labour, forced or servile marriage, descent-based slavery, and domestic slavery.

The Modern Slavery Act 2015 ('the Act') introduced changes in UK law focused on increasing transparency in supply chains, to ensure commercial supply chains are free from modern slavery. The Health and Care Act 2022 introduced new provisions on modern slavery within the NHS to ensure that the NHS is not buying or using goods or services produced by or involving any kind of slave labour.

This statement is made in line with section 54(1) of the Act and sets out the steps that Calderdale and Huddersfield NHS Foundation Trust (CHFT) and its subsidiary Calderdale and Huddersfield Solutions Limited take to prevent modern slavery and human trafficking in our business or supply chain for the year ending 31 March 2025.

Trust Commitment to Prevent Slavery and Trafficking

The Trust, as an authorised statutory body and a provider of health care services, recognises the significant role the NHS must play in both combatting Modern Slavery and supporting victims. Our acute care team, the Executive team, contractors, and all employees fully support the Government's objectives to eradicate modern slavery and human trafficking.

Our Trust and Supply Chains

In accordance with the Act, CHFT takes steps to ensure modern slavery is not taking place in any part of its own business or any of its supply chains. We are committed to social and environmental responsibility and have zero tolerance for modern slavery and human trafficking.

All staff at the Trust, in clinical and non-clinical roles, have a personal responsibility to consider issues regarding modern slavery and human trafficking and incorporate their understanding of these issues into their day-to-day practice. The three main areas relate to:

- Our workforce through recruitment
- Our patients presenting for treatment (safeguarding)
- Our supply chain through procurement.

Arrangements for Preventing Modern Slavery and Human Trafficking, including Policies, training and due diligence

Our Patients

Modern slavery is incorporated in the Trust's safeguarding policies which are linked to West Yorkshire multi-agency policies.

There is a clear line of accountability for safeguarding, with any identified concerns regarding modern slavery and human trafficking escalated as part of the Trust's safeguarding process, working in conjunction with our partner agencies.

The Trust Accounting Officer has ultimate accountability for ensuring that safeguarding and promoting the welfare of children and adults is discharged effectively across the Trust.

The Chief Nurse is the Executive lead for safeguarding and has responsibility for providing leadership and gaining assurance in relation to safeguarding issues within the Trust. We provide safeguarding training for our workforce, with all Trust staff being required to complete children and adult safeguarding training, with higher levels of safeguarding training provided appropriate to roles.

The Trust uses a national framework to assist in formal identification of victims of modern slavery and help to coordinate the referral of victims to appropriate services. This is known as the national referral mechanism and staff are directed to the Home Office website for further information.

The Trust works with multiagency partners locally to identify emerging risks and prepare our workforce to act if they have concerns.

The Trust reviews all safeguarding referrals via its incident reporting system and shares the data at its Safeguarding Committee which reports to the Quality Committee, a Board level Committee, chaired by a Non-Executive Director.

The Trust has systems to encourage the reporting of concerns and the protection of whistleblowers, and has a dedicated Freedom to Speak up Guardian, Non-Executive Director lead, and policy.

Our Workforce

The Trust's recruitment and employment checks process ensures all employment checks are in line with national NHS employment checks standards. These include identification, right to work, qualification, registration, Disclosure and Barring Service, and reference checks.

In addition, the Trust requires external agency engagements to be made via framework approval suppliers, who are audited centrally and required to confirm that all staff have been checked for their right to work, identification, qualification, and registration in line with NHS employment check standards commensurate with trust processes.

As part of ongoing professional development and delivery, it is encouraged that procurement staff are encouraged required to undertake the CIPS Ethical Procurement and Supply training and Social Value Mandatory eLearning via Government Commercial Function. This helps our teams to do the following when carrying our commercial activity:

- identify modern slavery risks;
- manage risks effectively in supply chains and existing contracts; and
- act when victims of modern slavery are identified.

Our Supply Chain

The Trust's procurement is managed by Calderdale and Huddersfield Solutions Ltd (CHS), a wholly owned subsidiary of the Trust. Working with suppliers, CHS Ltd provides procurement, contracting and supply chain services to the Trust.

As a key principle of all procurement activity, steps are taken to identify, prevent and mitigate modern slavery in its contractual service provision and supply chains. Consideration is made for compliance with Procurement Policy Note 05/19: 'Tackling Modern Slavery in Government Supply Chains' (and as updated in 02/23).

As part of ongoing professional development and delivery, procurement staff are required to undertake the CIPS Ethical Procurement and Supply training and Social Value Mandatory eLearning via Government Commercial Function.

Policies and procedures are in place that assess supplier risk in relation to the potential for modern slavery or human trafficking when making procurement decisions.

Included within our procurement process is a mandatory exclusion question regarding compliance with Section 54 of the Modern Slavery Act 2015. We also apply appropriate and proportionate quality criteria to ensure true value is obtained, reducing the risk of price-focused competition. This may include detail of prospective suppliers' working practices, policies, and procedures. Where procurements are deemed to be high risk, enhanced activities will be undertaken at Selection Questionnaire stage, with suppliers being asked to provide specific self-declarations for each member of their supply chain.

The Trust(s) major supplier of clinical consumables, equipment and maintenance services is NHS Supply Chain (NHSSC) who operates with a Supplier Code of Conduct which outlines main principles for suppliers' labour standards and worker welfare. All suppliers to NHSSC are expected to adhere to these principles, which address issues such as child labour, forced labour, wages, working hours and health and safety. The supplier code of conduct is a contractual requirement and has been part of all NHS Supply Chain framework agreements since 2009. Through the adoption of the NHS Standard terms and conditions of supply of goods and/or services the Partnership ensure standard contracts comply with all relevant legislation, including terms regarding Modern Slavery Act compliance principles. We also utilise various public sector framework agreements and these frameworks contain such provision. The contracts set out the behaviours expected throughout

procurement and supply chain relationships. We include performance indicators in supplier contracts so we can monitor progress against contractual commitments. These can include Social Value and training commitments, and obligations for suppliers to conduct supply chain analysis. Calderdale and Huddersfield Foundation Trust and Calderdale and Huddersfield Solutions Ltd remains committed to ensuring that modern slavery is not taking place in any part of its own business or any of its supply chains.

The Board of Directors has considered and approved this statement and will continue to support the requirements of the legislation.

Signed on behalf of the Board of Directors by

Brendan Brown
Chief Executive

DATE OF MEETING	7 March 2024	2 May 2024	4 July 2024	12 September 2024	7 November 2024	16 January 2025	13 March 2025
Date of agenda setting/Feedback to Execs	31 Jan 2024	20 March 2024	21 May 2024	31 July 2024	2 October 2024	TBC	TBC
Date final reports required	23 February 2024	19 April 2024	21 June 2024	29 August 2024	25 October 2024	3 January 2025	28 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							

COLOUR KEY TABLE FOR AGENDA ITEMS LISTED IN LEFT HAND COLUMN	
Items for approval	To formally receive a report or strategy for discussion and particularly approve recommendations or a particular course of action
Items to receive	To discuss in depth, noting the implications for the Board or Trust without formal approval
Items to note	For the intelligence of the Board without in-depth discussion
Items for assurance	To assure the Board that effective systems of internal control are in place

DATE OF MEETING	7 March 2024	2 May 2024	4 July 2024	12 September 2024	7 November 2024	16 January 2025	13 March 2025
Strategic Objectives – 1 year plan / 5 year strategy	✓		✓*1 year Strategic Objectives report 1 of 3*		✓*2024-2025 Strategic Objectives Progress Report 2 of 3*		✓*2024-2025 Strategic Objectives Progress Report 3 of 3*
Digital Health Strategy						✓	
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
Maternity and Neonatal Oversight Report (invite Director of Midwifery)		✓	✓	✓	✓	✓	✓
Maternity Incentive Scheme						✓	
Safeguarding Adults and Children Report			✓ Annual Report			✓ Bi-annual	
Complaints Annual Report			✓				

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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		✓
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 **(next due for review August 2025)**							
Health and Safety Annual Report				✓			
Board Assurance Framework	✓ 3		✓ 1		✓ 2		✓ 3
Risk Appetite Statement				✓			

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DATE OF MEETING	7 March 2024	2 May 2024	4 July 2024	12 September 2024	7 November 2024	16 January 2025	13 March 2025
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 2023/24	✓						✓
BOD Terms of Reference	✓						✓
Sub Committees Terms of Reference	✓F&P ✓ NRC BOD	✓ NRC CoG	✓QC	✓ARC ✓ Workforce	✓ TPB		✓F&P ✓ 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						✓	

COLOUR KEY TABLE FOR AGENDA ITEMS LISTED IN LEFT HAND COLUMN	
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DATE OF MEETING	7 March 2024	2 May 2024	4 July 2024	12 September 2024	7 November 2024	16 January 2025	13 March 2025
Audit and Risk Committee Annual Report 2023/2024			✓				
Workforce Committee Annual Report 2023/24				✓ (ARC Highlight Report)			
Finance and Performance Committee Annual Report 2023/2024				✓(ARC Highlight Report)			
Quality Committee Annual Report 2023/24				✓(ARC Highlight Report)			
Transformation Programme Board Annual Report				✓(ARC Highlight Report)			
WYAAT Annual Report and Summary Annual Report						✓	
Kirklees ICB Committee Papers (Link)	✓	✓	✓	✓	✓	✓	✓
Calderdale Cares Partnership Committee Papers (Link)	✓	✓	✓	✓	✓	✓	✓

COLOUR KEY TABLE FOR AGENDA ITEMS LISTED IN LEFT HAND COLUMN	
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25. Review of Board Committee Terms of Reference

a) Quality Committee

QUALITY COMMITTEE
TERMS OF REFERENCE – v8.1

1. Constitution

1.1. The Board of Directors hereby resolves to establish a Committee to be known as the Quality Committee. The Quality Committee has no executive powers, other than those specifically delegated in these Terms of Reference.

2. Authority

2.1. The Quality Committee is constituted as a Standing Committee of the Board of Directors. Its constitution and terms of reference are subject to amendment by the Board of Directors.

2.2. The Committee derives its power from the Board of Directors and has no executive powers, other than those specifically delegated in these terms of reference.

2.3. The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference – it is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

2.4. The Committee is authorised by the Board of Directors to request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary.

3. Purpose

3.1. The purpose of the Quality Committee is:

- To provide assurance to the Board of Directors that there is continuous and measurable improvement in the quality of the services provided through review of governance, performance and internal control systems supporting the delivery of safe, high quality patient care

- To ensure that the risks associated with the quality of the delivery of patient care are managed appropriately.

3.2. The Quality Committee is responsible for:

- Reviewing proposed quality improvement priorities and monitoring performance and improvement against the Trust's quality priorities and the implementation of the Quality Account.

- Seeking assurance in the implementation of action plans to address shortcomings in the quality of services should they be identified.

- The ongoing monitoring of compliance with national quality standards and local requirements.

4. Duties

The duties of the Committee, given below, cover quality improvement, governance and risk, quality and safety reporting and audit and assurance.

Quality improvement

4.1. To review proposed quality improvement priorities and monitor progress and compliance against defined quality priorities.

4.2. To maintain a focus on patient experience through a number of data sources including stories; friends and family test; national surveys and seek assurance that the Trust is learning from experience.

4.3. To oversee the development of the Quality Accounts to ensure accuracy of data and compliance with timescales for publication and review progress against these.

4.4. To review the Trust's compliance with the Care Quality Commission essential standards of quality and safety and seek assurance regarding progress with action plans in response to quality concerns identified from inspection findings, warning notices and compliance actions.

4.5. To receive, through the reporting schedule, assurance of high quality care provision and compliance with national and local guidelines, standards and requirements.

4.6. To establish, develop and maintain systems and processes for the regular evaluation and monitoring of compliance against any relevant internal and external assessments, standards or criteria.

Governance and risk

4.7. Ensure all quality risks are appropriately managed across the Trust and that appropriate review and assurance mechanisms are in place, receiving and reviewing quality risks on the Board Assurance Framework.

4.8. In response to the publication to redefine the Non-Executive Director (NED) Champion roles (NHS England's Enhancing board oversight: a new approach to non-executive director champion roles), the Committee will consider and review on behalf of the Board the following:

- Hip fracture, falls and dementia
- Learning from Deaths (assuring published information on the Trust's approach, achievements and challenges via a report to the public Board)
- Palliative Care and End of Life Care
- Safeguarding (annual report to Board)
- Resuscitation (requiring Resuscitation Policy sign off on behalf of the Board)
- Children and Young People (Core Service Inspection Framework for Children and Young People refers to an interview with the NED in the Board with responsibility for Children and Young People, noting oversight – NED on Quality Committee
- Health and Safety (aspects include patient safety, employee safety and system leadership)
- Safety and Risk

4.9. Promote a just and open culture in which incident and risk reporting is encouraged and supported as part of the delivery of safe and effective healthcare.

4.10. Seek assurance on the process for reviewing and reporting all patient safety events; obtaining quarterly performance reports from the Trust Quality and Patient Safety Forum on the lessons learnt and any quality improvement work undertaken.

4.11. Seek assurance against compliance with NICE guidelines / guidance and any rationale for non or partial compliance

4.12. Seek assurance that there are effective systems of governance, performance and internal control in relation to clinical services, research and development through an annual governance review.

4.13. Review performance against the quality and safety aspects of the Integrated Performance Report

4.14. Undertake an annual review of the quality impact assessment process to gain assurance that the risks to any impact on quality arising from proposed cost improvements have been managed and mitigated.

4.15. Ensure any procedural, policy or strategy documents which fall within the remit of the Committee are appropriately written, ratified and monitored for compliance in accordance with the Policy for Development and Management of Procedural Documents (Policy for Policies) and any key national standards and best practice

4.16. Receive reports from each of the sub-groups to the Committee, and that benchmarking information is included, as necessary

4.17. Establish an annual work plan which the Committee will review quarterly

4.18. Produce an annual report against delivery of the terms of reference of the Quality Committee.

Quality and safety reporting

4.19. In accordance with the Committee reporting schedule, receive assurance from the Committee's sub-groups, review reports and any associated recommendations, including actions to gain assurance of compliance and quality improvement.

Audit and assurance

4.20. To approve and oversee delivery of the clinical audit plan and a review of its findings.

4.21. To receive all reports regarding the Trust produced by the Care Quality Commission and other external bodies, e.g. Royal Colleges, and seek assurance on the delivery of actions to address recommendations

4.22. Receive reports from invited service reviews and external visits (as appropriate) and seek assurance regarding delivery of actions

4.23. To receive reports on significant concerns or adverse findings highlighted by external bodies in relation to quality and safety and the actions being taken to address these.

4.24. Gain assurance from divisions that they implement the activity required to achieve compliance with service quality and governance standards.

4.25. To receive internal audit reports (with a quality element) and seek assurance on recommendations

5. Membership and attendance

5.1. The Committee shall consist of the following members:

- Three Non-Executive Directors, one of which will Chair the meeting
- Medical Director
- Chief Nurse
- Director of Corporate Affairs

5.2. The following will be expected to attend each meeting:

- Deputy Chief Nurse
- Deputy Medical Director
- Chief Operating Officer
- Deputy Director of Workforce and Organisational Development
- Assistant Director of Quality & Safety
- Clinical Director of Pharmacy / Trust Controlled Drug Accountable Officer
- Associate Director of Allied Health Professionals (AHPs)
- Head of Quality and Safety
- Governance administrator (minutes)

5.3. The Chair of the Board of Directors will appoint a representative of the Council of Governors to attend each meeting as an observer. The appointment will be reviewed each year

5.4 The following shall be required to attend the meetings to present their sub-group report, as required:

- Representative from each division **(Quarterly)**
- Representative from Medicines Management Committee **(6-monthly)**
- Representative from Safeguarding Committee **(6-monthly)**
- Representative from Resuscitation Committee **(6 monthly)**
- Representative from Thrombosis Committee **(Quarterly)**
- Representative from Hospital Transfusion Committee **(6 monthly)**
- Representative from Medical Gases and NIV Group **(6 monthly)**
- Representative from Cancer Board **(Quarterly)**
- Representative from Medical Devices and Procurement Group **(TBC)**
- Representative from Radiation Protection Board **(TBC)**

5.5 Other members/attendees may be co-opted or requested to attend as considered appropriate.

5.6 A quorum will be four members of the Committee and must include at least two Non-Executive Directors and one Director.

5.7 Attendance is required at 75% of meetings. Members unable to attend should indicate in writing to the Committee Administrator of the meeting and nominate a deputy except in extenuating circumstances of absence. In normal circumstances any members who are unable to attend must nominate a deputy who is appropriately briefed to participate in the meeting.

5.8 A register of attendance will be maintained and the Chair of the Committee will follow up any issues related to the unexplained non-attendance of members. Should continuing non-attendance of a member jeopardise the functioning of the Committee, the Chair will discuss the matter with the member and, if necessary, select a substitute or replacement.

6. Administration

6.1. The Committee shall be supported by the Administrator, whose duties in this respect will include:

- In consultation with the Chair develop and maintain the reporting schedule to the Committee
- Collation of papers and drafting of the agenda for agreement by the Chair of the Committee
- Taking the minutes and keeping a record of matters arising and issues to be carried forward
- Advising the group of scheduled agenda items
- Agreeing the action schedule with the Chair and ensuring circulation
- Maintaining a record of attendance.

7. Frequency of meetings

7.1. The Committee will meet 10 times per year.

8. Reporting

8.1. The Committee Administrator will produce and maintain a standard agenda; any additional agenda items must be sent to the Secretary no later than 7 days prior to the meeting, urgent items may be raised under any other business.

8.2. An action schedule will be articulated to members following each meeting and must be duly completed and returned to the Administrator for circulation with the agenda and associated papers.

8.3. The agenda will endeavour to be sent out to the Committee members five working days prior to the meeting date, together with the updated action scheduled and other associated papers.

8.4. Formal minutes shall be taken of all committee meetings. Once approved by the committee, the minutes will go to the next Board of Directors' meeting.

8.5. A summary report will be presented to the next Board of Directors' meeting.

9. Review

9.1. As part of the Trust's annual committee effectiveness review process, the Committee shall review its collective performance.

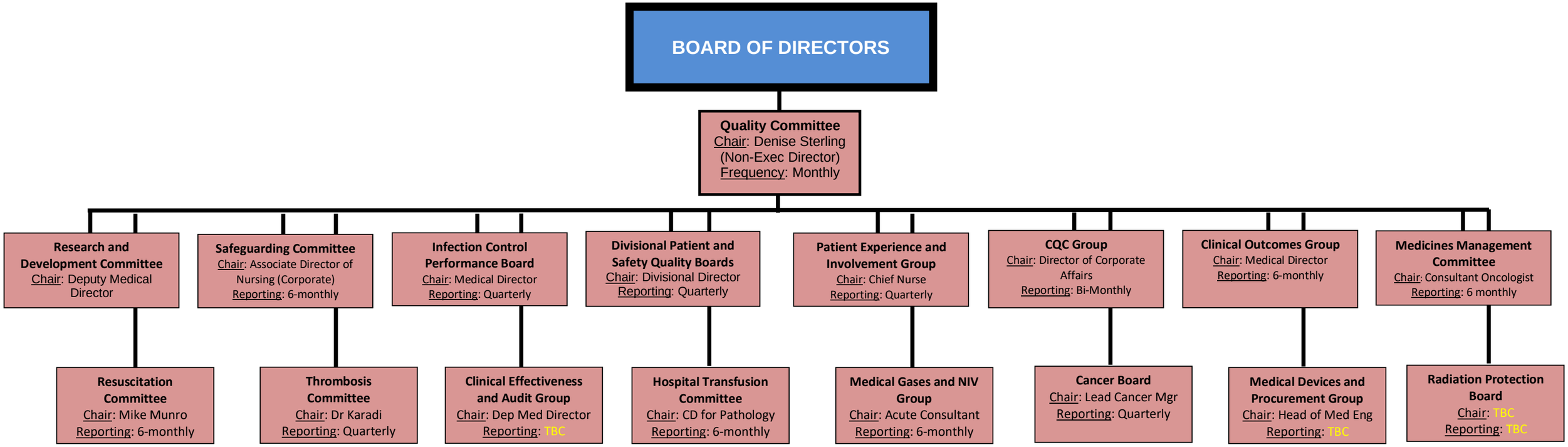
9.2. The terms of reference of the Committee shall be reviewed by the Board of Directors at least annually.

10. Monitoring effectiveness

10.1. In order that the Committee can be assured that it is operating at maximum effectiveness in discharging its responsibilities as set out in these terms of reference and, if necessary, to recommend any changes to the Senior Management Team, the Chair will ensure that once a year a review of the following is undertaken and reported to the next meeting of the Committee:

- The objectives set out in section 3 were fulfilled;
- Members attendance was achieved 75% of the time;
- Agenda and associated papers distributed five working days prior to the meetings;
- The action points from each meeting are circulated within two working days, on 80% of occasions

Sub-Groups


BOARD OF DIRECTORS
Quality Committee
Chair: Denise Sterling (Non-Exec Director)
Frequency: Monthly
Research and Development Committee
Chair: Deputy Medical Director
Safeguarding Committee
Chair: Associate Director of Nursing (Corporate)
Reporting: 6-monthly
Infection Control Performance Board
Chair: Medical Director
Reporting: Quarterly
Divisional Patient and Safety Quality Boards
Chair: Divisional Director
Reporting: Quarterly
Patient Experience and Involvement Group
Chair: Chief Nurse
Reporting: Quarterly
CQC Group
Chair: Director of Corporate Affairs
Reporting: Bi-Monthly
Clinical Outcomes Group
Chair: Medical Director
Reporting: 6-monthly
Medicines Management Committee
Chair: Consultant Oncologist
Reporting: 6 monthly
Resuscitation Committee
Chair: Mike Munro
Reporting: 6-monthly
Thrombosis Committee
Chair: Dr Karadi
Reporting: Quarterly
Clinical Effectiveness and Audit Group
Chair: Dep Med Director
Reporting: TBC
Hospital Transfusion Committee
Chair: CD for Pathology
Reporting: 6-monthly
Medical Gases and NIV Group
Chair: Acute Consultant
Reporting: 6-monthly
Cancer Board
Chair: Lead Cancer Mgr
Reporting: Quarterly
Medical Devices and Procurement Group
Chair: Head of Med Eng
Reporting: TBC
Radiation Protection Board
Chair: TBC
Reporting: TBC

Version Control	
1.1	first draft circulated for review to Chair / Director of Nursing
1.2	Amendments prior to Board of Directors
1.3	Amendments after submission to Quality Committee
1.4	Further amendments
1.5	Further amendments
2	Amendments made: ▪ Director of Workforce and Organisational Development added to section 5.1; ▪ Section 5.2 added ▪ Divisional attendance amended in section 5.4 ▪ Quorum amended at section 5.6 ▪ Medication and Safety Compliance Group and Cancer Board added to sub-groups at appendix 2 ▪ Medication and Safety Compliance Group and Cancer Board added to reports at appendix 3
3	Amendments made: ▪ Chief Operating Officer removed from membership ▪ Executive Director of Planning, Estates and Facilities removed from membership ▪ Two non-executive directors instead of three ▪ Purpose added in relation to internal audits
3.1	Amendments made (with Chair) (June 2019) ▪ Organ Donation Committee and Cancer Board added to sub-groups at appendix 2 ▪ Frequency of sub-group meetings amended at appendix 2 ▪ Frequency of meetings amended at appendix 3
4	Amendments made (Jan 2020) ▪ Organ Donation Committee removed from sub-groups at appendix 2 ▪ Addition of named NED at appendix 2 ▪ Frequency of Medication Safety & Compliance Group changed from quarterly to monthly - appx 2 & 3
4.1	Amendments made (June 2020) ▪ Clinical Director of Pharmacy added to membership ▪ Executive Director of Workforce and Organisational Development amended to Deputy Director of Workforce and Organisational Development
5	Amendment made (January 2021) ▪ Assistant Director of Patient Experience added to membership
5.1	Amendment made (April 2021) ▪ Medicines Management Committee added as a sub-group ▪ CQC and Compliance Group; Clinical Effectiveness and Audit Group; Clinical Ethics Group and Medical Gases Group added as sub-groups ▪ Serious Incident Review Group; Medication Safety and Compliance Group and Cancer Board removed as sub-groups
5.2	Amendment made (July 2021) ▪ Cancer Board reinstated as a sub-group, to receive minutes only ▪ Amendment Oct 2021 – CM no longer public elected governor
5.3	Amendment made (November 2021) ▪ Chief Operating Officer added to core membership
5.4	Amendment made (February 2022) ▪ Removal of Assistant Director for Patient Experience from core membership ▪ Addition of Legal Services reporting into Quality Committee ▪ Addition of Associate NED onto core membership
6	Amendment made 3 March 2022 ▪ Additional areas of responsibility in light of B0994_Enhancing-board-oversight-a-new-approach-to-non-executive-director-champion-roles_December-2021.pdf (england.nhs.uk)
6.1	Amendment made in June 2022 ▪ Addition of Director of Corporate Affairs into core membership
6.2	Amendment made in October 2022 ▪ Addition of Head of Quality and Safety into core membership
6.3	Amendment made in December 2022 ▪ Addition of Deputy Chief Executive into core membership
7	Amendment made in February 2023 ▪ Addition of Deputy Medical Director onto membership ▪ Removal of Legal Services Report and Cancer Board Minutes ▪ Quoracy amended
7.1	Amendment made in March 2023 ▪ Following governance reporting structure review: – Clinical Ethics Panel, Cancer Delivery Group, Clinical Effectiveness and Audit Group, and Medical Gases and NIV Group removed as sub-groups. – Chair of Trust Patient Safety and Quality Board amended to Chief Nurse;

	– Chair of CQC Group amended to Director of Corporate Affairs. – Compliance Group added as sub-group. ▪ Addition of Associate Director of AHPs to membership
7.2	Amendment made in October 2023 ▪ Compliance Group removed as sub-group. ▪ Head of Risk removed from membership
8	Amendment made in February 2024 ▪ Trust Patient Safety and Quality Board removed as sub-group. ▪ Divisional Patient Safety and Quality Board added as a sub-group ▪ Patient Experience and Caring Group renamed to Patient Experience and Involvement Group ▪ Medication Safety and Compliance Group added as a sub-group ▪ Medical Gases Group added as sub-group ▪ Clinical Effectiveness and Audit Group added as a sub-group ▪ Transfusion Committee added as a sub-group ▪ Resuscitation Committee added as a sub-group ▪ Thrombosis Committee added as a sub-group ▪ Cancer Board added as a sub-group ▪ Radiation Protection Board added as a sub-group
8.1	Amendments made in May 2025 ▪ Clarity made to points 8.3 and 10.1 for papers to be distributed five working days prior to the meetings. ▪ Item 4.10 amended to incorporate Patient Safety Incident Response Framework (PSIRF) ▪ Item 7.1 amended to state that a meeting will take place 10 times per year ▪ The review of the high-level risk register removed from item 4.7 ▪ Benchmarking information added to item 4.16
Issued by Quality Committee and Date of Review	May 2024
Approved by Board of Directors	TBC

26. Items to receive and note

1. Minutes of Board Committees

- Finance and Performance Committee – 26.03.24
- Quality Committee – 08.04.24, 08.05.24
- Workforce Committee – 15.04.24
- Audit and Risk Committee – 25.06.24
- Charitable Funds Committee – 07.05.24

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

Calderdale and Huddersfield NHS Foundation Trust

Minutes of the Finance & Performance Committee held on Tuesday 26th March 2024, 09.30am – 12noon Via Microsoft Teams

PRESENT

Andy Nelson (AN)	Non-Executive Director (Chair)
Nigel Broadbent (NB)	Non-Executive Director
Gary Boothby (GB)	Director of Finance
Rob Aitchison (RA)	Deputy Chief Executive
Anna Basford (AB)	Director of Transformation and Partnerships

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
Andrea McCourt (AM)	Company Secretary
Thomas Strickland (TS)	Director of Operations – Surgery ENT item only
Gemma Berriman (GBE)	Director of Operations – RAFT - Deep Dive only
Michael Folan (MF)	Director of Operations – Community – Deep Dive only
Sarah Bevan (SBE)	General Manager – Medicine- Deep Dive only
Krish Pilicudale (KP)	Insight Development Programme
Colin Duffield (CD)	Assistant Service improvement Manager – Deep Dive only

OBSERVERS

Pam Robinson (PR)	Public Elected Governor

APOLOGIES

Brian Moore (BM)	Public Elected Governor
Jonathan Hammond (JH)	Chief Operating Officer
Stuart Baron (SB)	Deputy Director of Finance
Adam Matthews (AM)	HR Business Partner
Robert Markless (RM)	Public Elected Governor

ITEM

056/24 WELCOME AND INTRODUCTIONS

The Chair welcomed attendees to the meeting including members of the shadow board.

057/24 DECLARATIONS OF INTEREST

058/24 MINUTES OF THE MEETING HELD 27th February 2024

The previous minutes were approved as an accurate record.

059/24 MATTERS ARISING

060/24 ACTION LOG

The Action Log was reviewed as follows:

046/24 ENT action Plan Update – On agenda. Close Action.

061/24 ENT RECOVERY SLIDES

TS shared the ENT update slides from the pack. The presentation is looking at ENT ASI's which are patients who have been referred but have not yet had an appointment. The number of ASI's reached a peak of 6000 in September 2021. Since then, the number did reduce before the service encountered problems. Two insourcing companies were being used - Pioneer and Omnes. Omnes did not deliver the expected results, so CHT had to move away from them. ENT also lost an experienced consultant and the backlog began to increase again reaching 6000 patients 9 months ago.

A Task and Finish group was set up and action plan put in place. Internal capacity is still not at the desired level and Pioneer is still being used. ENT is also impacted by a colleague who has been on long term sick for 6 months. There has been successful recruitment of two overseas head and neck consultant locums and, as part of business planning, approval has been given to have a rolling advert out for ENT posts with the intention of moving away from Pioneer and back in house.

A consultant led triage of all outstanding ASI's was carried out which reduced the number of patients waiting as they had improved, did not want to be seen or had been treated. A directory of services has been put in place so that GP's can directly refer to the correct specialism e.g. Audiology instead of to ENT for the patient to be seen. The improved referral quality has reduced the number of referrals. The impact of the work can already be seen in the ENT ASI trajectory. Since January 2024, the 52-week waits have been reduced from almost 700 to 29. The plan is to be at zero in the next two weeks.

KP – Noted the improvement in ASI to 5000, but asked within this number are any waiting for urgent treatment, and have any estimated waiting times being shared with patients?
The GP's have the option to mark the referrals as urgent. All of the patients have bene triaged and will continue to be monitored.

The committee all agreed that this was a very positive update on ENT and asked for congratulations to be shared with the team.

The benefits of withdrawing from Pioneer and employing substantive posts would be significant. Pioneer charge premium rates for their service.

AB – Suggested that wider sharing of this information could assist with recruitment. ENT is known to be a problem area for recruitment as it is not just a CHFT problem.

Bradford is seen to be at the forefront of ENT treatment and have in post several GPs with Special Interest (GPwSI) in ENT who triage any referrals to ENT. When CHFT has fully recruited this could be something to explore to reduce the ASI numbers further.

The Committee **RECEIVED** the ENT update.

062/24 DEEP DIVE TRANSFER OF CARE FOLLOW UP

GBE shared the presentation included in the pack. A group has been put together and a list of deliverables created. The actions are monitored through the Urgent and Emergency Care Board (UECB).
CHFT always have a high bed occupancy and there is an improvement opportunity to reduce length of stay. The key is looking at the detail behind the numbers and working with system partners. This will impact all services if length of stay can be reduced.

AN asked if the improvements on length of stay seen so far are in relation to the actions that have been put in place.
There has been a sustained reduction, but we are not in the position we want to be. It is not easy to link the benefits seen to specific actions. There are differences across Calderdale and Huddersfield.

SBE updated on the outcomes of the Clinically Led Workforce and Activity Redesign (CLEAR) programme. Shared the aims that have been put in place with the intention of reducing unnecessary admissions. Listed the quick wins, recommendations and the projected impact for each service.

NB – What is the status of the proposals? Have they been through planning for next year? What is the process?
Medicine have achieved the quick wins. Used the existing resources but to expand into the old ED to use the full estate there would need to be an investment in staff. The integrated care hub will be used to pilot the service before reconfiguration. Any financial savings will be reinvested as there is no new funding available.
RA – There was no SDEC in Calderdale until the beginning of March. As mentioned, there is no further funding available this year, but it is expected that this will be an enabling project for other schemes.
GBE – Setting up the SDEC was a collaborative piece of work and there is now rotation of ED staff through the SDEC's which is encouraging less silo working. The standard is all type 1 emergency departments should have an SDEC linked to it.

Well Organised Ward's (WOW) have 4 must dos attached to them. The idea is to know exactly which stage the patients are at and that there is a plan in place for each one. Patients are more complex, so we need to know what is happening at ward level each day to deal with that. There has been mixed success to date primarily because colleagues did not have the headspace when this was initially introduced. A 3-month programme has now been introduced in ward areas where they can set up their own projects linked to a minimum of the two key areas identified. Initially targeting the wards with the biggest issues. The work will be monitored through the UECB. Prior to Covid colleagues were used to analysing their own data but that has been lost over the last few years so data analysts are assisting at all levels. The first group will feedback in June but positive changes have already been seen.

MF spoke of the Home First Improvement Group. Five sub-groups have been created and getting the right people is vital to making these work. These groups report into the Home First Improvement Group.
Some changes to culture and the introduction of new models. Pathway 1 is the highest volume of activity and where the CIP opportunity is greatest. Part of the home first model will be creating single points of access for both Calderdale and Huddersfield to simplify the transfer process.
Key driver is quality and doing the right thing for the patients. There is a clear link between quality and cost. Delivering right care at the right time and in the right place for patients, without unnecessary hospital stays also delivers a leaner more focussed bed base.
In 2024/2025 the scope of each improvement scheme has been investigated and weighed against delivery to allow planning of a £2.1M cost reduction in organisational spend.

NB – what is the confidence level in terms of improvement that relies upon other people?
MF - there is more leverage in pathway 1 so once the single point of access has been agreed very confident of improvement here.

MF also noted that length of stay has increased but there has been no increase in demand.

GB commented that Unplanned care is a CIP portfolio and it is expected that the cases would be developed within these portfolios and a net saving presented.

A lot has been learnt over the last year and no target numbers have been set for TOC as it changes so quickly. TOC demand is increasing year on year even before Covid. Length of stay is the key.

The Committee **RECEIVED** the Deep Dive Transfer of Care Follow-Up.

FINANCE & PERFORMANCE

063/24 MONTH 11 FINANCE REPORT

The Assistant Director of Finance told the committee that as of Month 11 the Trust is reporting a year-to-date deficit position of £23m which is a £3.6m variance to plan. The key drivers for this are the same as reported in previous months.
It has been confirmed that strike funding for months 9-11 will be paid in month 12.
The pressures have been offset by some benefits including just under £400k of additional elective recovery funding, higher than planned commercial income from HPS and some non-recurrent CIP.
We continue to achieve activity above plan at 109.2%. The agency spend is above plan at £1.7m but below the agency ceiling so both CHFT and the ICB have managed to remain below the ceiling.

Forecast still showing a likely variance of £700k at year end. Within the last week there has been confirmation of additional funding from the ICB which is now in the

bank. An extra £8.2m in total. As a result, the expectation is to be a better position with a deficit of £13.3m instead of the £20.8m planned.

KA clarified that the additional funding of £8.2m is all non-recurrent so it improves the year end position but does not impact next year.

Capital – Year to Date £32.1m has been spent which is £4m more than planned which includes some new projects for which we have received funding in year, such as the CDC's and HPS expansion. Planning to spend as per the forecast. The cash for some of the schemes is still in the bank so the cash position is £10.8m above plan.

Aged debt stands at £3.1m improvement which is a small improvement since month 10. Over £700k of the debt is with Nitespharma. CHFT applied for £4.4m of PDC which was received in February but was not required due to the capital position. Need to make sure there is separation between the capital and revenue. Cash support will still be required for quarter 1 as there will be capital creditors to pay and a deficit position to fund.

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

064/24 2024/25 PLANNING

The Deputy Director of Finance gave an update on planning for 2024/25. National guidance has not yet been received.
The financial plan was submitted to the ICS and NHSE on the 21st March with a deficit of £40.8m. This is different to the £39.1m presented in the previous F&P meeting due to a technical adjustment applied through the NHSE planning template and relates to the change in accounting practice (IFRS16) for the PFI remeasurement.

The National Planning Timetable currently has a final plan submission date of 2nd May 2024. This does not fit with the current CHFT Board timetable for approval however, the planning dates are subject to change.

The plan with the £40m deficit contains some risks. The model for elective recovery funding has not been agreed. It has been decided that inflation is not as high as predicted so the inflation cost factor is set to be reduced. There is a risk on the depreciation funding due to the ICS cap on funding. There is a potential increase in the contract baseline for ICS high-cost drugs and devices to reflect growth and inflationary pressures. The junior doctors have just voted to continue to continue industrial action for another 6 months. Pressure is coming from the system to increase efficiency to 5.5% from the current 4.6% which would increase the CIP target from £25m to £30m. Currently there are no fully developed plans for the £25m.

GB highlighted that extra scrutiny on the plan is expected as a system. Other systems have already had deep dives.

The Committee **RECEIVED** the 2024/25 Planning Update

065/24 TURNAROUND EXECUTIVE CIP PROGRESS

The Deputy Chief Executive gave a brief update on the CIP progress for 2024/25. The target currently is £25m.

The full value has been allocated to portfolios which have leads and programme support wrapped around them. The same process will be used as in previous years with accountability in place. Any changes to targets would need a change form in place but the group are not currently accepting changes but asking colleagues to find another way to reach the target.

Deep dives into the portfolios have taken place over the last two weeks. A number of these have all the elements at gateway 2 and others are making good progress. There are a small number of higher risk schemes around non-elective savings.

There are currently:
- 25% at Gateway 2
- 50% at Gateway 1
- 25% unidentified.

Not all Trusts have the same rigorous processes in place that CHFT has. The next steps are to complete the deep dives in the next two weeks alongside developing a menu of things that we may implement if the £25m CIP target is not reached.

The Committee **RECEIVED** the Turnaround Executive update

066/24 IPR

The Assistant Director of Performance gave the monthly update. As per last month the quality indicators have been moved to the front of the report. Some of the indicators have fallen into the fail category including the percentage of adults who receive a MUST assessment within 24 hours of admission.

There was 1 never event in February bring the total for the financial year to 6. These have all been fully investigated.

Complaints – 91% were closed on time in February. There have been some issues with the quality of responses received and they have had to be returned. An audit has been scheduled to understand the detail behind this.

The narrative around elective recovery has been updated to reflect the work being undertaken in ENT. There is an expectation that all specialities bar ENT will have no patients waiting longer than 40 weeks by the end of the year. CHFT has been singled out by the BBC as being in the top 6% of Trusts in England with the lowest waiting times for elective surgery.

Diagnostics -ECHO and Neurophysiology have both improved recently. The Trust position is now showing over 90% of tests being completed within 6 weeks for the first time in over 18 months. The plan for 2024/25 is to return to the target 95% position.

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.

Cancer performance continues to be strong with the 28-day faster diagnosis target peaking at just below 90%. We are just one of a handful of Trusts to meet all national targets.

ED performance - there is a huge amount of work happening in our A&E departments alongside learning from the recent Perfect Week, with significant improvements against our Emergency Care Standard since January with CRH on track to hit the 76% target in 3 of the last 4 weeks. 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 and we have managed to achieve the length of stay target of 4.1 days for pathway 0 patients.

Proportion of **ambulance arrivals** delayed over 30 minutes has reduced again in February. 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.

NB noted the decline around six-week diagnostic testing for those patients with a learning disability which does not reflect the overall picture. It depends on the service, but small numbers of patients fall into this category, so it disproportionately impacts the performance. We continue to actively monitor these patients.

RA highlighted that work is being done around DNA rates where only a small number of patients with learning disabilities are accessing care at the first attempt. External funding has been received to allow a colleague to track patients through the system. When the work has been done a presentation on DNA performance can be put together and brought to this committee.

The Committee **RECEIVED** the IPR

067/24 RECOVERY UPDATE

The Assistant Director of Performance gave a brief update noting that the majority of the information had been addressed in earlier agenda items.
CHFT remains in a better position than other local trusts.

52 weeks - Only small numbers remain.
40 weeks - seen overall reduction particularly for non-ENT patients.
Outpatients ASI's - Still a big number and the focus is on 18 weeks.
Follow up patients – The ask is for a 10% reduction.
ECHO is now almost back on trajectory following successful recruitment.
Neurophysiology has reached better position than the planned trajectory.

Discussions are underway as to how activity will be paid for in the new year. A payment by results funding scheme would generate more income for elective work. However, debates are around at what point additional income would be generated. The suggestion is anything above 107% but there is a proposal to have differential targets across Yorkshire so CHFT would be anything over 109%.

The Committee **RECEIVED** the Recovery Update.

068/24 SELF ASSESSMENT RESPONSES

The annual self -assessments have been completed. Some of the themes form the feedback include:

- More time for forward planning
- In the 24/25 work plan suggested deep dives have been added but some months have been left without a deep dive to create agenda space
- Spend more time completing the meeting review.

How do we forward focus?
Today's meeting as an example. More time on what performance and financial risks and assumptions for next year. More important at certain times of the year. Switch the emphasis for next year.

ACTION: AN – consider forward planning and weave in the workplan.

069/24 DRAFT MINUTES FROM SUB-COMMITTEES

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

- Access Delivery Group
- THIS Executive Board
- Urgent and Emergency Care

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

070/24 WORKPLAN – 2023/24 and 2024/25

The first attempt at the workplan for 2024/25 was presented to the committee. It is initially based on the plan for this year. The following changes were requested:

- BAF risks being forward the 2nd July to the May meeting. Remove the 1st April one.
- Capital plan has been moved to February 2025.
- Annual report is due to board in July but the intention to complete it before AN leaves.

GB asked if all other committee meetings have 12 meetings annually?
The committee membership and frequency is currently being reviewed. There is a suggestion to remove the August and December 31st meetings to allow for leave.
PR highlighted that month 9 can be a key point for forecasting and a crucial month for accounting.

Every Trust has to report monthly various returns however not every Trust has a monthly Finance and Performance committee. The reports would still need to be done even if the meeting did not happen.

The Committee **APPROVED** the removal of the August meeting, but further discussion required on the December meeting – **ACTION** AN/GB. Any changes will need to align with Trust-wide changes for Board Committees once they have been confirmed. A final work plan will be presented for approval at the next F&P meeting

071/24 ANY OTHER BUSINESS

072/24 MATTERS TO CASCADE TO BOARD inc. ONE CULTURE OF CARE

- Deep dives on Transfer of Care and ENT
- 2024/25 Planning – position and risks
- Positive news on year-end financial position
- Improving performance in ED and diagnostic testing

DATE AND TIME OF NEXT MEETING:
Tuesday 30th April 2024 09:30 – 12:00 MS Teams

Calderdale and Huddersfield NHS Foundation Trust

Minutes of the Finance & Performance Committee held on
Tuesday 30th April 2024, 09.30am – 12noon
Via Microsoft Teams

PRESENT

Andy Nelson (AN)	Non-Executive Director (Chair)
Nigel Broadbent (NB)	Non-Executive Director
Gary Boothby (GB)	Director of Finance
Rob Aitchison (RA)	Deputy Chief Executive
Anna Basford (AB)	Deputy Chief Executive and Director 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
Andrea McCourt (AM)	Company Secretary
Adam Matthews (AdM)	HR Business Partner
Vanessa Perrott (VP)	Non-Executive Director – Shadowing AN.

OBSERVERS

Pam Robinson (PR)	Public Elected Governor
Brian Moore (BM)	Public Elected Governor
Robert Markless (RM)	Public Elected Governor

APOLOGIES

Krish Pilicudale (KP)	Insight Development Programme
Philippa Russell (PR)	Assistant Director of Finance
Stuart Baron (SB)	Deputy Director of Finance

ITEM

073/24 WELCOME AND INTRODUCTIONS

The Chair welcomed attendees to the meeting. Vanessa Perrott attended who will be the new chair when Andy retires.

074/24 DECLARATIONS OF INTEREST

075/24 MINUTES OF THE MEETING HELD 26th March 2024

The job title for Anna Basford had been recorded incorrectly. Once corrected the previous minutes were approved as an accurate record.

076/24 MATTERS ARISING

077/24 ACTION LOG

The Action Log was reviewed as follows:

068/24 Self-Assessment Responses / Forward Planning in the workplan – On agenda. Close Action.

FINANCE & PERFORMANCE

078/24 MONTH 12 FINANCE REPORT

The Deputy Director of Finance informed the committee of the year-end position. At the end of the year a deficit of £13.24m was reported which was a £7.56m favourable variance from plan. The end of year position is subject to external audit who are due on site at the beginning of May but have already started requesting information.
The favourable variance was because of the division of the ICB surplus to provider organisations who were requiring cash support.

The same themes as seen in earlier months explained the variances. Strike costs, high bed occupancy and inflationary pressures which were offset by additional ERF funding, strike funding and additional commercial income from HPS and THIS. 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.

NB – What assumptions have been assumed for next year around for example,bed base and commercial income?
A lot of work has taken place around bed base modelling as the CIP scheme planned for last year did not deliver. The increased acuity of patients has been taken into consideration as has the growth in demand. HPS overperformed in year but they were one-offs so it has not been assumed they will continue into this year. The starting point for the new year is just less than last year's outturn. The budgets around utilities have been right sized based on the more accurate data now available.

JH highlighted that one of the deep dives scheduled for this committee later the year is around length of stay which will examine bed occupancy, length of stay and transfer of care – all elements which have driven adverse variances in spend this year.

AN asked about agency and bank spend, as the latter is high, and how we compare with other Trusts?
Bank spend is not compared but agency spend is. The agency ceiling was for the whole of the ICB not for individual trusts. We know that we compare reasonably well with neighbouring trusts.

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

079/24 TREASURY MANAGEMENT ANNUAL REPORT

The Deputy Director of Finance gave a verbal update on Treasury Management using the detail on the cash page in the month 12 finance report.

The year ended with £24.86m more cash in the bank than forecast. The full detail is in the paper but was also favourably impacted by the previously mentioned ICB surplus distribution.

Aged debt reduced in line with the set trajectory ending with £2.94m of aged debt against a target of £3m or less, noting that £700k of the debt is owed by Nitespharma to HPS. Legal advice has been taken and a formal payment agreement is currently with them to sign.

Performance against the Better Payment Practice Code achieved 92.4% against a target of 95% for paying invoices within 30 days. There are capacity challenges with the Accounts Payable team currently. The whole process from order to payment is being reviewed to make sure we are not creating work.

For the first quarter of 2024/25 the Board had approved an application for revenue support of £20m. in view of the end of year cash position this request has now been reduced to £11.8m due to the £8.2m extra cash from the ICB. The deficit position is still forecast at £40m for the year. There is now complexity on how cash is managed across the ICB with there no longer being a link between the cash resources in the organisation funded by depreciation for internally funded capital. The capital limit is set by the ICB but does not take into consideration the amount of cash in the bank. New guidance has been issued in the last couple of weeks which allows applications for a different type of cash support particularly in support of capital which is being worked through. It maybe that future requests for approval of borrowing will go to Board, though it is worth noting that there is a lot of challenge from the national capital and cash team for every application.

The £11.8m PDC is to cover the first quarter of this year to cover capital creditors and the financial plan. This would be the maximum for this quarter. Daily cash flows are forming part of the planning.

It is clear that the distinction between revenue cash and capital cash is becoming more pronounced.

ACTION: Written update on Treasury Management to be presented to the next meeting. This will tie in with the current position taking into account the latest guidance.

The Committee **RECEIVED** the Treasury update.

080/24 2024/25 PLANNING

The Director of Finance updated the committee with the latest version of the financial plan as submitted last Friday. The plan shows a deficit of £38.57m after achieving

£25m CIP and moving to payment by results for activity instead of the current block payments.

There have been some challenges in reaching this plan, including the ICS shortfall of £10m which was then divided across the system of which then gave CHFT an additional £1.3m challenge but significant work has gone into improving the position.

Each organisation has been set a stretch target which must be reached before being eligible for elective recovery funding. It was assumed that since we were moving from block contracts everyone in west Yorkshire would be given the same target of 107%. However, the target for CHFT is 110% which will affect the amount in income received.

CHFT has adopted a turnaround approach to the CIP and tightening up what can be spent and stopping discretionary spending. The intention is to implement the measures ourselves before a third party comes in to implement measures. There is an extra risk around the depreciation funding which was allocated on the morning of submission but could be reclaimed around month 9 or 10. GB has agreed that this will be an ICB challenge not just an CHFT challenge.

KA asked the committee to note that the guidance stated to assume a 2% pay award for this year but the awards have not yet been agreed. It is assumed that any pay award would be fully funded. Likewise, it is assumed any strike action will be fully funded as told not to plan for any strike action in the plan.

The level of recurrent CIP achieved last year was lower than that achieved by our peers. The ICB have introduced significant controls and checklists, most of which are already being done by CHFT.

Capital and Cash. There is a £15.7m internally funded capital programme which will fund the multi-storey car park at Calderdale, the Cath Lab and substation works plus other minor schemes.
In addition, there is a £32m externally funded programme for the CDC for Huddersfield, the Huddersfield Pharmacy Specials expansion, reconfiguration and some digital investment.

The deadline of 31st March has passed but the contracts have not yet been signed with commissioners for income. However, the guidance did not come out until after the deadline. Communications around the financial position are being shared across the organisation.

The Committee **RECEIVED** the 2024/25 Planning Update

081/24 TURNAROUND EXECUTIVE CIP PROGRESS

The Deputy Chief Executive shared a presentation with the committee.

When going through the process of identifying the £25m CIP the last £10m was proving challenging despite following the same process as previous years. The turnaround executive regrouped around 2-3 weeks ago and started to look at things differently and changed the process slightly.

Of the £25m, £24m has been identified of which £17.2m is either at gateway 1 or 2. 81% of this is recurrent CIP.

Currently developing a revised Workforce CIP Strategy which will include a reduction in headcount and agency caps in each division. This will be through the following enabling processes and controls:

- A vacancy freeze with some exemptions
- Freezing new revenue investments
- A non-pay panel
- A freeze on new posts.

A review of previous investment decisions was also undertaken releasing £1m.

Monthly updates will continue to this committee.

NB highlighted that 81% of schemes being recurrent still leaves £5m that is non-recurrent. This would create a challenge for the next financial year. At what stage would the process start trying to turn this into recurrent?

RA - The 81% does not include the newer schemes though the intention is to start looking at 2025/26 around September. 75% of CHFT spend is on people.

NB Has risk been taken into consideration when allocating headcount reductions to divisions? Maternity for example struggles to recruit and has several vacancies.

RA- Everything will be risk assessed as part of the process. Targets have been broadly allocated and it is down to the divisions to determine how these are achieved.

VP noted that there was not much around sustainability in the CIP. Earlier in the meeting it was mentioned that there is more accurate data around utility usage but nothing else. Also how to does the headcount reduction tie into the NHS long-term workforce plan around retaining staff and changing/reforming roles of staff.

RA – The overall workforce plan has a lot around grow your own and developing staff though training opportunities. Retaining staff is a good way of reducing some of the premium spend.

AB – highlighted some of the sustainable cost improvement plans that have been implemented over the last few years e.g. LED lighting and waste disposal. The bigger schemes need capital investment. Also, looking to the future where some of the capital investments will drive a lower life cycle cost around the running of the estate.

Workforce – The long-term plan for CHFT is enabled by the service reconfiguration plans which will allow for the right services on the right site and improved workforce models. Target date of 2031.

GB – Sustainability is a factor in non-pay procurement and is one of the scoring points in tenders.

There are opportunities to be had from looking at workforce models with the work done in the ED work last year is a good example leading to a reduction in cost of £2m. We must use the resources we have effectively.

In summary it will feel different this year. Initially starting with a vacancy freeze for 3 months and sending out clear messages to all staff around what is needed for the CIP this year. The challenge across the whole NHS has been highlighted.

The Committee **RECEIVED** the Turnaround Executive update.

082/24 IPR

The Assistant Director of Performance gave a summary of the March (Month 12) position.

- Summary Hospital- level Mortality Indicator (SHMI) has seen an increase in the latest 12 month rolling figures.
- There was one MRSA infection in March which is the first since December 2022.
- C.difficile and Ecoli infections are just above the targets set and they now include Community Onset Healthcare Associated (COHA) numbers.
- 76% of complaints were closed on time in March against a target of 95%. The quality of responses and the end-to-end sign off processes have impacted performance – both have been escalated
- The number of patients receiving a MUST assessment within 24 hours of admission continues to improve.
- Elective recovery performance continues to be positive with only 17 cases over 52 weeks and 740 waiting over 40 weeks at the end of March.
- Diagnostics – challenges throughout the year in both Echo and Neurophysiology. However, improvements have been seen towards the end of the year with both specialities achieving over 90%.
- Cancer performance remains excellent and has been recognised in the national media.
- ED 4-hour performance significantly improved in March 2024 to 76.79% following a collaborative effort between teams and the Trust reached 6th out of 119 trusts for type 1 attendances. ED attendances continue to increase at both sites along with the acuity of patients.
- Ambulance handover delays over 30minutes increased in month to 8%. Committed to an average handover time of 23.5minutes for 2024/25.

JH – Asked the committee to note that the ED target of 76% does not include Type 2 patients. Type 1 and 3 only. Bradford completed a review of ambulance handover times as monitored by the Yorkshire Ambulance Service against their own figures and found a disparity, so a West Yorkshire wide piece of work is due to start to look into this.

AB – Looking back the Trust achieved exceptional performance for which we have been recognised throughout the year. Alongside this we have also delivered the financial plan and received exceptional patient experience and staff survey results.
There is a plan in place to use the old ED at HRI as an integrated care hub which will help with discharges.

AdM – The absence rate achieved target in March 2024 The new target for 2024/25 is going to be reduced to less than 4.5% which will have a positive impact on bank and agency spend.

The Committee **RECEIVED** the IPR

083/24 RECOVERY UPDATE

The Assistant Director of Performance gave a brief update noting that the majority of the information had been addressed in earlier agenda items.
CHFT remains in a better position than other local trusts.
Full year performance reached 109% of the plan.

As of 15th April 2024, the recovery performance showed:

- 52 weeks – 20 patients.
- 40 weeks – 798 patients.
- 32 weeks – New internal target – To reach 0 excluding ENT by January 2025. Target for ENT is zero patients waiting 52 weeks. Already below trajectory.
- Outpatients ASI's – No external target.
- Follow up patients – No external target. Work continuing with the booking process to improve the numbers.
- Echocardiology numbers have increased slightly but performance improving overall.
- Neurophysiology – on target and plan to have no breaches by mid-June 2024.

AN – suggested that going forward the Recovery Update would no longer need the removing the 52-week graph and proposed including a couple of slides to provide the committee with the ENT position and progress against actions to improve that position. This would mitigate the need for any future ENT deep dive

AB – Outpatient follow ups is the information available for other trusts? Could we take any learning?
PK – There is no benchmarking available as most other trusts are not looking at this.

The Committee **RECEIVED** the Recovery Update.

084/24 ASI Issue

The Chief Operating Officer gave a verbal update. Last Summer a problem was identified with ASI drop offs on the national e-Referral System (ERS) When patients need a new patient appointment, they are added to the appointment slot issues list for 18 weeks. The national system does not keep patients on the system for longer than 6 months and a manual input is required to put the patients back on the list.

Last year it was discovered that the manual process was not picked up if the colleague was absent. A full audit of patients was carried out identifying all the patients that had potential to drop off and a significant number were discovered. Actions were put in place to prevent the same thing happening again. It was also raised regionally and nationally and with NHSEngland and we were advised that the system, used by all trusts, could not be updated to prevent this happening.

With the actions in place an audit was requested to look at the last six months to ensure no other patients had dropped off the system. It was discovered that for one week within that period some more patients had dropped off the list. This was due to human error where only half of the report had been inputted. The affected patients have been contacted and given new appointments. The problem has been raised with NHSEngland again who are happy with the approach taken.

A monthly audit will now be taking place so that if any patients drop of the list, they will not have been affected by longer than one month. The extra back log is expected to be cleared by June.

NB – This is a time-consuming exercise for what is a problem with the national system. Are other trusts in the same position? Do they have a less time-consuming work around?
JH- Has happened in another couple of other trusts. No other solutions identified.

085/24 ANNUAL REPORT

The annual report was shared with the committee for approval.

Some corrections were identified as being required on the attendance log:
- Philippa Russell attended 11 out of 12 meetings.
- Remove Helen Hirst from observer and add a note at the bottom of the register.
- Karen to be marked as end of tenure not retiring.
- Isaac is a Deputy Observer as is Brian.

AM and RLS to work together on correcting the log.

The report is to go to the Audit and Risk committee before submission to Board.

The Committee **APPROVED** the report with the changes above.

086/24 DRAFT MINUTES FROM SUB-COMMITTEES

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

- Access Delivery Group
- Business Case Approval Group
- Capital Management Group
- THIS Executive Board
- CHFT/ CHS Joint Liaison

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

087/24 WORKPLAN – 2023/24 and 2024/25

A draft workplan for the new year was presented. Meeting dates for the sub-committees are still to be confirmed following planning work on the committee meetings.
It was discussed at the last meeting that the number of these committees would be reduced from 10 per year to 12. It has been decided that the May and August meetings

will be stood down. May as this is month 1 in the financial year so reporting is minimal. The following updates were suggested for the plan.

- HPS Commercial Strategy. RA to advise the date this will be ready to present.
- BAF – Remove the requirement from April 2025. BAF are reviewed three times per year.

Feedback from the annual review requested more focus on future planning. This has been scheduled for the December meeting which does not have a deep dive planned.

Deep dives have been identified and planned in following discussion with JH.

The Committee **APPROVED** the draft work plan.

088/24 ANY OTHER BUSINESS

This is the last meeting which will be chaired by Andy Nelson. The committee gave their thanks and wished him the best for the future. Andy thanked the committee for their support.

089/24 MATTERS TO CASCADE TO BOARD inc. ONE CULTURE OF CARE

- Positive performance in ED, Cancer and Elective Recovery
- Assurance over Treasury Management
- 24/25 plan and CIP challenges

DATE AND TIME OF NEXT MEETING:

Tuesday 2nd July 2024 09:30 – 12:00 MS Teams

QUALITY COMMITTEE
Monday, 8 April 2024

STANDING ITEMS

60/24 – INTRODUCTIONS, APOLOGIES AND ATTENDANCE REGISTER

Present

Denise Sterling **(DS)**	Non-Executive Director **(Chair)**
Neeraj Bhasin **(NBha)**	Deputy Medical Director
Nikhil Bhuskute **(NBhu)**	Deputy Medical Director
David Birkenhead **(DB)**	Medical Director
Gina Choy **(GC)**	Public Elected Governor
Sharon Cundy **(SC)**	Head of Quality and Safety
Jason Eddleston **(JE)**	Deputy Director of Workforce & Organisational Development
Elizabeth Morley **(EM)**	Associate Director of Quality and Safety
Andy Nelson **(AN)**	Non-Executive Director
Victoria Pickles **(VP)**	Director of Corporate Affairs
Gemma Puckett **(GP)**	Director of Midwifery and Women's Services
Lindsay Rudge **(LR)**	Chief Nurse
Elisabeth Street **(ES)**	Clinical Director of Pharmacy
Lorraine Wolfenden **(LW)**	Governor
Michelle Augustine **(MA)**	Governance Administrator **(Minutes)**

In Attendance

Simon Riley-Fuller **(SRF)**	Associate Director of Nursing, Families & Specialist Service **(observing)**
Rachel Rae **(RR)**	Associate Director of Nursing, Surgery & Anaesthetics **(item 64/24)**
Caroline Lane **(CL)**	Interim Associate Director of Nursing, Community **(item 63/24)**
Debbie Wolfe **(DW)**	Head of Therapies, Community Division **(item 63/24)**
Mandy Hurley **(MH)**	Quality Governance Lead, Community Division **(observing)**

Apologies

Jennifer Clark **(JC)**	Associate Director of Therapies
Lucy Dryden **(LD)**	Quality Manager for Calderdale Cares Partnership Board
Jonathan Hammond **(JH)**	Chief Operating Officer
Joanne Middleton **(JMidd)**	Deputy Chief Nurse
Jo-Anne Wass **(JW)**	Non-Executive Director

61/24 - DECLARATIONS OF INTEREST

There were no declarations of interest.

62/24 – MINUTES OF THE LAST MEETING AND ACTION LOG

The minutes of the last meeting held on Monday, 11 March 2024, circulated at appendix B, were approved as a correct record. The action log can be found at the end of these minutes.

SAFE

63/24 – DIVISIONAL REPORTING – COMMUNITY Q4 REPORT

Caroline Lane and Debbie Wolfe were in attendance to present the report as circulated at appendix C.

- *Incidents* – consistently around 200-240 per month. Incidents under investigation were shown 1 in October 2023, 1 in December 2023, 8 in January 2024 and 27 in February 2024. In relation to medication incidents, the top 5 themes over the last 12 months were noted as missed doses (43); administered wrong dose (19); delay in supply (19); missed, lost, stolen or wasted medication (18) and delay in administering (15). Actions are in place to mitigate these. The missed dose and delay in administering medication incidents tend to relate to insulin. There are currently four orange investigations with actions outstanding.
- *Top 10 Community incidents in Q4* – these were noted as Moisture-Associated Skin Damage (MASD) – incontinence-related 104; Category 2 pressure ulcers 72; Deep Tissue Injury (DTI) 46; Moisture-Associated Skin Damage (MASD) – non-continence related 44; unstageable 42; admitted with pressure ulcer – (category 2) 25; admitted with pressure ulcer (unstageable) 18; wrong diagnosis 16; category 3 pressure ulcer 15 and category 1 pressure 13.
- *Risk Register Summary* – the division have 39 risks (one scoring 15+, 21 scoring between nine and 12, and 17 scoring between two and 10). Six new risks were accepted and two closed risks were approved in the division in Q4.
- *Compliments / complaints* - the division have one ongoing complaint. The total number of complaints between 2023 and 2024 were 11. Compliments are now being collated by the Patient Advice and Liaison Service (PALS) team and are included in the report.
- *NICE guidelines* – the division have five partially compliant and three awaiting assessment guidelines.
- *Compliance* – Dysphagia management policy is currently under review, which requires cross-divisional input. The division's compliance tracker is updated and reviewed regularly.
- *Clinical Audit Status* – the division have 10 projects underway, and updates on the national audits which the division take part in were provided.
- *Clinical Outcomes Group dashboard* – The division currently do not have much representation at the Clinical Outcomes Group; however, this is being addressed, and an update will be provided for the next report.
- *Collaboratives* – the division currently do not lead on any collaboratives, however, from 1 April 2024, the Tissue Viability service will be under the division, and going forward, will report on the Pressure Ulcer Collaborative in future reports.
- *CQC Preparedness* – preparation for the external visit from Calderdale Health SEND is in progress; and the senior management team have alternate weekly Journey to Outstanding (J2O) visits within the division, where teams are visited, and findings and learning are disseminated. This will be added to the Patient Safety and Quality Board agendas to be reported monthly.
- *Quality Priorities* – these include 'Proportion of Urgent Community Response referrals reached within two hours' and Virtual Ward.
- *Patient Experience* – this includes engagement sessions held with a range of service users to test remote monitoring devices for virtual ward; digital patient story telling training; developing plan for increasing patient engagement, including the implementation of personalised care in community services; a number of Friends and Family Test (FFT) comments for standout colleagues across the division, and a 97% positive response rate for FFT. The themes from the FFTs comments on what could be done better were listed.
- *Learning / Feedback* – following a cluster of orange incidents relating to pressure ulcers, a decision making tool for pressure redistribution equipment has been devised; and the division have been involved in 'Perfect March' and will be continuing to improve the discharge workstream and the services available in Community, for when patients are discharged.

AN asked about the top ten incidents in Q4 and whether these incidents would have been seen in previous quarters. **CL** stated that pressure ulcers have always been the top incident and have been for a number of years, due to the service not being 24-hours, however, work is closely done with care agencies, either in patient homes or in residential homes, ensuring that correct advice on patient education and recommendations are provided. The division also have patients who are at end of life who do get end of life skin changes, which also contributes to the incidents.

AN also asked about the Urgent Community Response quality priority, and the action around accurate data recording. **CL** stated that data is locked into SystmOne, however, are working with the division's Digital Board on how to move to one platform, This is a substantial piece of work. **LR** also asked about the priority, and whether there have been any incidents in relation to the impact to patients, if the two hour response is not met. **CL** stated that if the two hours cannot be met, the referral is diverted to another service, and the service will triage and risk assess.

In relation to Virtual Ward and the bed base, **AN** asked whether the 80% target was set at a sensible level. **CL** stated that a low number of beds were started with, which increased to the current level, however, targeted work has taken place during 'Perfect March' to ensure that all the virtual ward beds will be utilised.

DS noted the work underway with the Medical division to review medical cover to support a 7-day Multi Discipline Team meeting for Frailty virtual ward, and asked whether the model used by other organisations to backfill with a registrar was considered. **CL** stated that work with the Divisional Director of the Medical division is taking place to ascertain what the medical cover would be, and also whether other professionals with that advanced skill set can be used, as an alternative to consultants.

With regard to medication incidents and the 43 missed doses, and 19 administered wrong doses administered over a year, **DB** asked about the rate and how many doses were actually administered over the time period. **CL** was unable to recall the figure, however, over 100 insulins are administered in one day across the nursing workforce, and it tends to be the cohort where the missed doses take place. **DB** asked if there was any harm in relation to those incidents, and whether the breakdown in severity was known. **CL** stated there has not been any significant harm, but can clarify, however, all medication incidents are escalated to GPs for their awareness.

Across all divisional reports, **VP** commented on upcoming public engagement work around some services in Community, and asked that reference to those are included in all divisional reports going forward.

For the next report, **DS** commented that an update on actions taken for risks which score 15 and above would be useful.

OUTCOME: The Committee thanked the division and noted the informative report.

64/24 – DIVISIONAL REPORTING – SURGERY Q4 REPORT

Rachel Rae was in attendance to present the report as circulated at appendix D.

- *Incidents* – the division have around 200 per month, and themes are consistent. The top five themes are appointments, admissions and discharge; medication incidents; assessment, treatment and diagnosis; falls and pressure ulcers. There is a correlation with appointments, admissions and discharges to complaints. The division encourage reporting, hold weekly orange panel meetings, had a big focus on closing overdue actions and have no outstanding serious incidents. The division will be rolling out the Patient Safety Incident Response Framework (PSIRF) and Human Factors programme and currently undertaking training; and also implementing the SWARM and After Action Reviews. Learning is cascaded through the divisional Patient Safety and Quality Board (PSQB) meeting and learning posters.
- *Complaints* – During Q4, the division had 144 concerns, 30 compliments and 26 formal complaints. The themes include post-operative concerns, Delays in treatment and diagnosis, and Communication. The approach of the division is to try to resolve the complaints at the time; ensure actions are focused; have weekly meetings to review and discuss, and focus on effective feedback and promote positive responsive leadership. With regard to learning, the Patient Safety Incident Response Framework (PSIRF) and Human Factors have allowed the division to examine their processes, and give direct feedback to those involved.

- *Risk Register Summary* – the head and neck directorate have the three of the biggest risks for the division at the moment, with two in the glaucoma service scoring 20, and one in ear, nose and throat (ENT) for head and neck cancer regarding consultant cover. The division focus on plans to reduce or close risks and focus on mitigating risks.
- *NICE guidance* - the division have four partially compliant and two awaiting assessment guidelines. One guideline is not working toward full compliance – NG 38: Fractures (non-complex). The NICE recommendation states: 'When needed for distal radius fractures, perform surgery, (i) within 72 hours of injury for intra-articular fractures and (ii) within 7 days of injury for extra-articular fractures; however, CHFT does not differentiate between the intra and extra fractures and will treat all within 7 days.
- *Clinical Audits* – the division have 33 overdue audits, which are monitored through Directorate meetings and the Patient Safety and Quality Board (PSQB) meeting.
- *CQC Preparedness* – the division had a CQC engagement visit last year for surgical pathways and ICU; an Operational Delivery Network Paediatric Surgery visit in February 2024; and an Endoscopy Joint Advisory Group (JAG) full inspection in February 2024, passed all elements, and awaiting the final report. The division do not currently have a Journey to Outstanding (J2O) dashboard; however, most ward areas have been visited with a minimal number of actions, and mainly green and amber compliance. Non-wards (operating theatres, endoscopy, ICU, some outpatients) have not yet been assessed, but this is upcoming. The J20 assessment document is being revised and ward assurance is being aligned to the new J20 reviews.
- *Quality Priorities* – these include nutrition and hydration and deteriorating patient. In regard to nutrition and hydration, the division made a step change of having live assessments open on the wards, with the nurse in charge responsible for monitoring that all patients are within time frame. There are no concerns in response to the deteriorating patient.
- *Patient Experience* – the division focused on the innovation shown in Endoscopy, which can be shared with the wider division and the Trust as a whole.

AN commented on the glaucoma risks in ENT and asked if the issue with consultant cover was local to CHFT or if this was a general ENT issue seen in other Trusts. **RR** stated that at West Yorkshire Association of Acute Trust (WYAAT) level, this has become a special case around regional working, particularly in glaucoma. Some progress is being made; however, the consultant element is not available, nevertheless, mitigation is good.

OUTCOME: The Committee thanked the division and noted the informative report.

The Committee provided feedback on the first reports from the divisions, stating that reports were positive; gave the divisions an opportunity to share good stories; provided opportunities for future deep dives if there is a commonality of issues across clinical services; and good to see positive outcomes of patient experience being reported.

65/24 – MATERNITY REPORT: 3-YEAR PLAN – THEME 1 FOCUS

Gemma Puckett provided a verbal update, stating that at the last meeting, the alternative schedule of reporting was discussed, whereby a detailed report will be provided one month, and a review of each of the themes of the three-year plan for assurance will be provided the next month. This month's report is from theme 1: listening to and working with women and families from compassion.

The action for the organisation in relation to theme one is to involve service users and quality, governance, and co-production when designing and planning delivery of maternity and neonatal services. The success is determined entirely through the CQC annual maternity survey, which takes a cohort of women, asks them questions around the service, and reports at the end of the year. This means that the report is received almost a year later, which means working in retrospect, however, the service is keen to develop better mechanisms for live feedback.

A presentation was shared which highlights the progress measures in the three-year plan and the service's current status; the three objectives of the themes; the maternity incentive scheme and celebrating success.
ACTION: Presentation to be shared at the end of the minutes.

GP also noted that the alignment of the maternity / neonatal meetings are now out of sync, as the Board meeting will be taking place tomorrow, therefore, the rest of the year's reporting will be realigned.

DS commented on the feedback on personalised care gathered via maternity and neonatal voices partnerships, and asked what approach will be used to obtain feedback from more diverse voices. **GP** stated that leaders who are already working within diverse communities need to be utilised. **NBha** extended any assistance which may be required from the Race Equality Network.

GP was thanked for the volume of activity and the fantastic amount of work carried out to deliver the plan.

OUTCOME: The Committee noted the report.

66/24 – Q4 INFECTION PREVENTION AND CONTROL REPORT

ACTION: Report deferred to the next meeting.

EFFECTIVE

67/24 – Q3 LEARNING FROM DEATHS REPORT

Nikhil Bhuskute presented the report as circulated at appendix G.

During quarter 3 (October to December 2023), there were 441 adult inpatient deaths. 240 (55%) were reviewed using the initial screening tool, and it was noted that this has been the best performance so far, since the reviews began. Out of the 240 reviewed, 39% were recorded as' poor care' and escalated for a further structured judgement review. Out of the 39%, nine cases were reported on datix and were sent for divisional orange panel review.

A total of 65 structured judgement reviews were requested in quarter 3, with 41% recorded as 'poor care', and 12 of those reported on Datix and escalated to orange panel for review.

There have been wide ranges of themes, generally around delays in the Emergency Department, time taken for review, end of life care and the use of the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) form.

Following the last update provided in January 2024, a point was raised on whether there was any scope to improve the review process. The Business Intelligence team have now developed a tool, which works similarly to the way Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) data is calculated, and provides a live table of deaths taking place in the hospital, which can rank according to the likelihood of death. The new tool will select a criteria of patients who were less than 20% likely to die, carry out the initial reviews from this category, and then take random samples from the remaining patients. This is likely to provide more useful data to learn from those deaths, and this will be trialled in the next quarter. The initial calculations mean no less reviews will take place; however, the quality of the reviews will change. A 'go see' visit is planned for the end of April 2024 to Wigan and Wythenshawe Hospital to explore their robust process of learning from deaths.

AN asked whether the use of the tool to improve the review process is the first step in the journey to the thematic approach, and whether the difference in themes from quarter 2 are due to operational pressures. **NBhu** stated that in the last quarter, a common theme was delay in

diagnosis, compared to previously, which was around end of life care. It was stated that the way in which patients are selected may provide a different answer, but this will be noted in the next quarter.

With regard to end of life care, **LR** asked whether this report has been shared with the End of Life Care Group for a response. **NBhu** stated that the End of Life Care team are aware of the outcomes, however, agreed to send the report to the team for a response.

MH commented on a 'go see' to Tameside General Hospital and their process. They do not undertake initial screening reviews; however, they use their medical examiner's office as their triage process for structured judgement reviews, and queried whether this was something which could be discussed as a process for CHFT. It was agreed that a separate discussion outside of the meeting will take place.

OUTCOME: The Committee noted the report.

WELL LED

68/24 – GETTING IT RIGHT FIRST TIME (GIRFT) REPORT

Neeraj Bhasin presented the report as circulated at appendix H, which describes the change in process of how CHFT will approach GIRFT moving forward and current activity.

The national GIRFT approach has changed, and the suggested need to evolve internal processes to adapt, has now taken place. The centrally led process has now moved to a more divisionally led response, in agreement with divisional teams. **JH** and **NBha** will remain as Trust leads for GIRFT, however, there are now divisional nominated GIRFT leads across all four divisions. Where there are discrete projects, such as further faster, these will be held by individual leads. Communication, which comes in via the central inbox, will now be managed by the Transformation team, with support from **NBha**. The oversight and upward reporting have been refined, according to divisions, and the final process change has been to the update of the internal and external webpages, which will be done by the divisional teams.

Whilst the processes now have an operational and transformation angle, it is clear that the success of GIRFT in the organisation has been down to it being clinically led, and is a Multi-disciplinary Team approach, which will remain, moving forward. Current activities were outlined in the report.

AN commented on the benefits capture and asked whether the improvements will still continue to be monitored and tracked around the quality improvement, rather than GIRFT. **NBha** stated that key performance indicators (KPIs) will continue to be measured, however, will not measure a 'GIRFT effect'.

AN also asked about the current GIRFT activities, and whether the Patient Engagement Portal and Targeted Did not attend (DNA) reduction work are nationally driven activities. **NBha** stated that these activities were already underway in the organisation.

DS commented on GIRFT now being a divisionally owned process, and asked whether GIRFT would feed into divisional reports, now that divisions report directly into the Quality Committee. **NBha** stated that divisions could describe their GIRFT activity within their reports, however, some Trust level overarching report will still be required.

OUTCOME: The Committee noted the report.

RESPONSIVE

69/24 - QUALITY REPORT

Nikhil Bhuskute presented the report as circulated at appendix I, summarising the main points:

- *Incidents* – within the 12 month reporting period between 1 April 2023 and 31 March 2024, there were a total of 34 serious incidents, including six never events, out of which three were still open and going to the serious incident panel. There were 24 serious incidents, four of which were Healthcare Safety Investigation Branch investigations. Six serious incidents were closed within the 60 working day timeframe (five for the medical division and one for the surgery and anaesthetics division). The backlog of orange incident are within the medical division, with 64 ongoing. Between 1 April 2023 and 31 March 2024, 75 were closed. **LR** assured the Committee of an upcoming meeting with David Britton (Associate Director of Nursing – medical division) to discuss their position with incidents and complaints.
- *Complaints* – between February and March 2024, the Trust closed 54 out of 62 formal complaints, within agreed timeframes, equating to 87% performance. Currently, the Trust have 141 open formal complaints, with 130 of these on track to be responded to within agreed timeframes, which equates to a Trust performance of 92%, if achieved.
- *Patient Safety Incident Response Framework (PSIRF)* – a significant number of colleagues have now been trained in different areas of the framework. 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. There has been some interest in the Patient Safety Partners role.
- *Legal Services* – There has been a five-fold increase in the number of CNSTs (Clinical Negligence Scheme for Trusts) since January 2024, and a total of £434,538 damages settled. There were 70 active inquests, four of which were high risk.
- *Clinical Outcomes Group Dashboard:*
    - *Hospital Standardised Mortality Ratio (HSMR) / Summary Hospital-level Mortality Indicator (SHMI)* - due to the increased death rate during August and September 2023 within the pneumonia coding group, it is likely that there will be an increase in the SHMI and HSMR data going forward. As explained earlier at item 67/24, the new tool will provide SHMI and HSMR data three months in advance, meaning corrective measures can be put in place. The overall position is still satisfactory.
    - *Sepsis* - significant work has taken place with the Emergency Department on reducing the four hour wait targets. The new sepsis guidelines are being developed, and an upcoming meeting is to take place with Sepsis Collaborative team for an update on next steps.

AN asked on progress with the CQC self-assessment process. **NBhu** stated that the tools have been welcomed by teams who are currently working through them. An upcoming quality-focussed Weekly Executive Board (WEB) meeting will give teams an opportunity to discuss further action plans.

AN commented on the five-fold increase in clinical negligence claims. **NBhu** commented on the response from the Legal team that there is a demand for requests, and likely to be further payouts, however, the nature of the claims cannot be provided until a deep dive over a period of one year takes place.

AN also commented on the continued challenge of staffing and asked how this is being addressed. **VP** stated that a request via Dragon's Den, as part of this year's business plan was rejected, therefore, there is to be a restructure of the work done by the legal team, as there is a mismatch in the volume of work and the team available, and some of the work being done by the legal team is not appropriate. There has also been a backlog of inquests from the Courts, which are currently being worked through. This is a trend seen with other trusts.

In relation to the transition from the current serious incident process to the PSIRF framework, **DS** asked for assurance that the organisation are aware of the transition. **NBhu** stated that this will be determined in the next six weeks during the launch, while divisions understand the process, and teams are being prepared to deliver the process. **VP** stated that this is not only for the readiness of colleagues internally, but also for patients and some external partners who also need to understand the changes being made.

In regard to internal training, **EM** stated that this will still be taking place over the next few weeks, and assured the Committee that a colleague from the Quality and Safety Team will 'buddy' a division, and sit within the orange panels to help guide incidents through the new process. **LR** stated that the Trust will not 'go live' if processes are not complete, however, the end of May is the target.

OUTCOME: The Committee noted the report.

70/24 - INTEGRATED PERFORMANCE REPORT

David Birkenhead provided an update on the report circulated at appendix J, highlighting the challenges the organisation 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 and what can be done to mitigate this moving forward, including new technologies like UV light sterilisation, which is quicker than the hydrogen peroxide fogging currently done, however, this may become a blended approach. Deep cleaning is also being looked at regarding releasing space to decant wards, and also focusing on antimicrobial usage. Escherichia coli (E.coli) bacteraemia have shown an improvement, unfortunately, there was a post-48 hour Methicillin-resistant staphylococcus aureus (MRSA) bacteraemia recently, however, this was the first case in around 16 months.

LR commented on further work to be done around patients with a learning disability, as the indicators are deteriorating, which Amanda McKie (Consultant Nurse for Learning Disabilities) is working on. There has also been a spike in still births, and an investigation has been commissioned, which the FSS division will return via the formal maternity report. It was also noted that Malnutrition Universal Screening Tool (MUST) has increased to 85. In relation to sepsis, **DB** reported on a national request for data, which highlighted the Trust's standard being set higher than the national dataset, therefore, not in an outlying position. **LR** stated that it would be useful going forward, to agree the national dataset within the Integrated Performance Report (IPR) and other measures within the Care of the Acutely Ill Patient (CAIP) Programme and Clinical Outcomes Group dashboards.

AN raised a challenge to the Committee as to whether the full IPR is needed at this Committee, as other sections are covered at other Board sub-committees, and current quality measures are covered within other Quality Committee reports. It was suggested that the IPR is removed from this Committee as a regular agenda item; the Quality Report slightly enhanced, and the three quality priority measures more detailed. **LR** reported attending the Workforce Committee which has a discrete part of the IPR, however, would need assurance that Finance and Performance Committee were looking at emergency care and cancer through the lens of the Medical Director / Nurse Director / other clinical members of the Quality Committee, and if they were, then the Quality Committee would also be looking at their data. There is a difficulty with quality and safety, as the performance data is all about quality and safety, due to everything being around the quality of patient care.

It was agreed that a follow-up conversation will take place outside the meeting between **VP**, **LR**, **DB**, **AN** and **DS** to discuss how to better manage the volume of the Quality Committee agenda.

OUTCOME: The Committee noted the report.

ITEMS TO RECEIVE AND NOTE

71/24 – MINUTES FROM:

- **CLINICAL OUTCOMES GROUP**
  A copy of the minutes from Wednesday, 7 February 2024 were circulated at appendix K.

  Items for escalation from the Clinical Outcomes Group to the Quality Committee were noted as learning disabilities, as noted at item 70/24 and dementia screening, which in January 2024 was at 35%.

  DB highlighted to the Committee that both learning disabilities and dementia are on the Clinical Outcomes Group agenda and have been flagged. The substantial amount of work ongoing around learning disabilities was reported, as well as a positive presentation provided, and assurance of an expected improved position across the organisation. In terms of dementia, there was an acknowledgment that the organisation is not where it should be in terms of compliance with screening, however, there are plans, moving forward on how to increase compliance, and also ensuring that necessary actions are in place for patients with dementia, and ongoing care for those patients is appropriate. Dementia champions have been put in place and a Lead Nurse has now been appointed for dementia screening.

- **INFECTION CONTROL PERFORMANCE BOARD**
  A copy of the 17 January 2024 minutes were circulated at appendix L.

OUTCOME: The Committee noted the minutes.

72/24 – CONSENT POLICY

A copy of the Consent Policy was circulated at appendix M.

OUTCOME: The Committee approved the Policy.

73/24 - ANY OTHER BUSINESS

The Committee were reminded to complete the self-assessment checklist, which was circulated today.

74/24 - BOARD TO WARD FEEDBACK

- New divisional reports received.
- Update on maternity report: three year plan – theme 1
- Patient Safety Incident Response Framework (PSIRF) divisional ‘buddies’ and the need to continue monitoring of complaints and incidents

75/24 - MATTERS FOR ESCALATION TO THE TRUST BOARD

- Divisional Reporting
- Revised process for Getting It Right First Time
- Maternity Three Year Theme 1 Report
- Elements from Quality Report
- Elements from the Integrated Performance Report

76/24 - QUALITY COMMITTEE ANNUAL WORK PLAN

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

MINUTES APPROVED – 08.05.24

POST MEETING REVIEW

77/24 - REVIEW OF MEETING

- Very good meeting
- Good presentations from divisions

NEXT MEETING

Wednesday, 8 May 2024
2:30 – 5:00 pm
Microsoft Teams

QUALITY COMMITTEE
Wednesday, 8 May 2024

STANDING ITEMS

78/24 – INTRODUCTIONS, APOLOGIES AND ATTENDANCE REGISTER

Present

Andy Nelson **(AN)**	Non-Executive Director **(Chair)**
Nikhil Bhuskute **(NBhu)**	Deputy Medical Director
David Birkenhead **(DBi)**	Medical Director
Gina Choy **(GC)**	Public Elected Governor
Jason Eddleston **(JE)**	Deputy Director of Workforce & Organisational Development
Jonathan Hammond **(JH)**	Chief Operating Officer
Joanne Middleton **(JMidd)**	Deputy Chief Nurse
Elizabeth Morley **(EM)**	Associate Director of Quality and Safety
Gemma Puckett **(GP)**	Director of Midwifery and Women's Services
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

Charlotte Anderson **(CA)**	Performance and Intelligence Lead – THIS **(item 87/24)**
David Britton **(DBr)**	Associate Director of Nursing - Medical Division **(item 85/24)**
Andrea Dauris **(AD)**	Associate Director of Nursing - Corporate Nursing **(item 87/24)**
James Evans **(JEv)**	Head Nurse - Families and Specialist Services (FSS) **(item 86/24)**
Richard Hill **(RH)**	Head of Health and Safety **(item 83/24)**
Helen Hirst **(HH)**	CHFT Chair **(observing)**

Apologies

Neeraj Bhasin **(NBha)**	Deputy Medical Director
Jennifer Clark **(JC)**	Associate Director of Therapies
Sharon Cundy **(SC)**	Head of Quality and Safety
Lucy Dryden **(LD)**	Quality Manager for Calderdale Cares Partnership Board
Victoria Pickles **(VP)**	Director of Corporate Affairs
Denise Sterling **(DS)**	Non-Executive Director

A copy of the attendance register was circulated at appendix A.

79/24 - DECLARATIONS OF INTEREST

There were no declarations of interest.

80/24 – MINUTES OF THE LAST MEETING AND ACTION LOG

The minutes of the last meeting held on Monday, 8 April 2024, circulated at appendix B, were approved as a correct record. The action log can be found at the end of these minutes.

81/24 – MATTERS ARISING

Update on Pathway zero, length of stay and role of acuity

Jonathan Hammond provided an update, following discussion at the Quality Committee meeting on 12 February 2024, on the challenges of discharge pathways, pathway zero, and increasing length of stay.

The presentation, which had already been through the Finance and Performance (F&P) Committee, described the strategy around unplanned care transformation.

Unplanned episodes of inpatient care account for around 60,000 admissions annually, and take up a vast majority of the bed base. Over the last few years, there has been an increase in demand, with a pattern of reduced admissions as a proportion of attendances through the Emergency Department (ED), and an increase in the acuity of patients. This was noted post COVID, and subsequently, through a yearly change. In terms of acuity, from last year compared to the year before, there was an increase of around 3% in acuity, and admissions, as a proportion, went down by 2%. Good work has taken place around admission avoidance; however, it is recognised that more complex patients are being admitted to hospital, which brings additional challenges to the organisation particularly in length of stay.

The aims of the programme of work were described, as well as its structure, governance and workstreams. The use of data and key measures were also highlighted, which included:

- *Emergency Department (ED) performance* – There was a significant improvement in March, and data has been developed to understand admitted performance against non-admitted performance, ED attendances, breaches, bed occupancy and 12 hour waits. Work is ongoing to triangulate this data on a weekly basis to create a clear narrative on what is happening in the organisation, which will help improvement work moving forward.
- *Bed Occupancy and Transfer of Care (ToC)* – Bed occupancy is a particular challenge for the organisation, which tends to run at around 97-98%, which then goes into surge and super-surge beds, some of which are funded and some not, which is where the financial challenge arises. The aim, as bed occupancy is reduced, is to close some of the additional beds, as this reduces pressure in terms of staffing. Going into this financial year, it has been agreed to focus on achieving a 96% bed occupancy. This is the balance between the number of beds that can be held open from a financial perspective, and also what is required to maintain safe services for patients. In relation to ToC patients - those who are awaiting support before going home, and also referred to as pathway 1, 2 and 3 – they are monitored on a day-by-day and a week-by-week basis. There is a shared dataset with community partners, and mechanisms in place to escalate when required. Over time, there has been a significant increase in the number of patients on the ToC list, with pre-COVID numbers being around 40-50 patients, to now being around 120,which is a significant pressure.
- *Length of Stay (LoS)* – pathway zero patients are those who do not need any additional support when they return home. This is the group of patients where improvements can be made without partner involvement, and where the well organised ward work (WOW) comes into force.

In terms of the data, there is an emphasis on tracking improvements against pathway zero patients, and improvements against pathway 1, 2 and 3 patients, both before and after they are added to the ToC list, which is focused on through the Urgent and Emergency Care Board.

In summary, there are three key streams of work; the well organised ward (WOW) - which is what can be done internally around pathway zero patients in order to help support the work for pathway one to three patients; Home First Improvement Group – working with community partners on pathway 1, 2, and 3 patients, and Improvement work around admission avoidance.

JW commented on the key measures, and asked how CHFT benchmark against peer organisations, regionally and nationally. **JH** reported that there will be new benchmarking data available for pathway zero patients, which will enable organisations to compare themselves easily with length of stay information. Benchmarking information on Emergency Department (ED) performance is available for pathway 1, 2 and 3 patients, which looks at the volume of patients seen within 60 minutes, bed occupancy, and a few other metrics. Regionally, Bradford has a very different set-up in terms of community services, particularly in relation to intermediate care and rehabilitation beds, than CHFT. In terms of pathway zero, it would be useful to be able to compare with other trusts more effectively and identifying best practice.

In relation to the bed occupancy benchmarking data, **JW** asked how CHFT is progressing. **JH** stated that CHFT bed occupancy is higher than most, and adjustments have been made recently due to CHFT measuring it slightly different than others. CHFT does benchmark low compared to others against decision to admit breaches.

JW also asked about work done with partners, how that is going and if there are any issues. **JH** reported that a key piece of current work with Calderdale Council was simplifying the process for the reliance on a single point of access. This was highlighted during 'Marvellous March' where wards provided feedback on the difficulty of referring people into services. There is still work to be done with Kirklees, with discussions taking place with Locala and local authorities to replicate what is being done in Calderdale. Other key elements are needing more capacity for services to reduce length of stay and for trusted assessment. Currently, from a Calderdale perspective, if an internal therapist or discharge co-ordinator does an assessment of need, that is trusted, however, from a Kirklees perspective, there is a wait for a social worker to carry out the assessment, which can take a number of days, which extends the length of stay.

OUTCOME: The Committee thanked **JH** for the update.

Nasogastric tube update

Joanne Middleton provided an update on the nasogastric tube action plan. A copy of the report will be added to the end of the minutes.

Assurance was provided that all immediate actions have been undertaken and the majority of actions are on the cusp of completion. The action plan will continue to be monitored through the Nutrition and Hydration Group.

JM asked the Committee whether updates could return on a quarterly basis, rather than monthly, in order for progress to be made on the work with Bradford, the Policy, and the audit findings.

OUTCOME: The Committee agreed on quarterly updates for this report.

82/24 – QUALITY COMMITTEE TERMS OF REFERENCE

A copy of the revised terms of reference were circulated at appendix E, which now included the new sub-groups at item 5.4, and the frequency of the meeting amended to 10 times per year at item 7.1.

Following discussion, further amendments were agreed:

- Items 8.3 and 10.1 to clarify that papers will be distributed five days before the meeting.
- Item 4.10 to incorporate Patient Safety Incident Response Framework (PSIRF)
- *'High-level risk register'* is removed from item 4.7, as the Committee does not review the high-level risk register.

The Quality Committee agreed to approve the terms of reference once amendments made.
ACTION: Changes to be made to the terms of reference.

SPECIFIC REPORTS

83/24 – HEALTH, SAFETY AND SECURITY UPDATE

Richard Hill was in attendance to provide an update on health, safety and security. A copy of the presentation will be added to the end of the minutes.

The report was split into two sections of compliance - Health and Safety and Personal Safety. The health and safety compliance included non-patient slips, trips and falls; needlestick injuries from dirty / clean sharps; moving and handling injuries, and substances hazardous to health.

In relation to personal safety, discussions for funding for training on high risk wards and departments for conflict management training are underway; a new Police Community Support Officer (PCSO) starts on 24 May 2024, and new monthly violence and aggression reduction collaborative meetings take place with stakeholders which include the security team and divisional leads. Two new Policies have been approved, with plans to operationalise the content in the coming months.

JW asked to what extent this data correlates with data from the staff survey, as the survey shows that colleagues with certain protected characteristics are experiencing violence and aggression in some cases, more than others, and queried whether support and development was targeted appropriately. **JE** reported that there is a lot of data which requires review in relation to the disproportionate responses from service users with pre-existing characteristics, and moving to action is key.

AN asked if there was an increase in violence and aggression incidents. **RH** stated that this is a national issue and all NHS trusts are facing increasing incidents.

OUTCOME: The Committee noted the update.

SAFE

84/24 – MEDICATION SAFETY AND COMPLIANCE GROUP REPORT

Elizabeth Street presented the report as circulated at appendix G, highlighting the key points since the last report, including:

- *Terms of Reference* – reviewed and included in the report, with discussion taking place to getting medical representation on the Group as a gap has been identified.
- *Medication safety team* – this is now fully staffed.
- *Incidents* – there has been an increase in the last six months with medication-related incidents, and a high-level monthly summary of harm related incidents is proposed, followed by a three-monthly review of low harm incidents. The majority of incidents reported during quarter 4 of 2023-24, were no/low harm, with the themes and trends and reasons for the incidents detailed in the report.
- *Benchmarking* – For the reporting period from January to March 2024, 423 medication errors were reported, and out of the 338,424 medicines prescribed, the CHFT error rate was 0.12%, compared to one UK hospital study which showed that of 36,200 prescription orders, there was an error rate of 1.5%.
- *Methocarbamol prescribing* – there has been a reduction in Methocarbamol use, as CHFT was a high prescriber.
- *Positive patient identification* – work ongoing on barcode scanning of patient wristbands, due to a number of incidents where patients have been given the wrong drug and barcode scanning was not used.
- *National Patient Safety Alert for Valproate prescribing* – action plan is on track

- *Controlled Drugs (CD)*:
  - *CD Sub-group* - **ES** mentioned that at the March 2024 Quality Committee when the reporting structure of the Committee's sub-groups were presented, the Controlled Drugs (CD) sub-group was still included, however, discussions and decisions were made to amalgamate it into the main Medication Safety and Compliance Group.
  - *CQC CD self-assessment tool* – this has now been completed, and an action plan will be devised
  - *Quarterly submission to CD Local Intelligence Network* – the mandatory required submissions met and the key issues were detailed in the report.

ES reported awaiting the results of the HSJ judging panel, which took place yesterday, for the award for the controlled drug electronic system developed.

ES reported meeting with **EM** and **SC** today to discuss how the Patient Safety Incident Response Framework (PSIRF) and thematic reviews will fit into the Medication Safety and Compliance Group.

JW commented on the useful benchmarking information and suggested that the terms of reference references benchmarking information for all Committee reports.

DBi asked if there were any further improvements to be made to lower the number of incidents. **ES** stated that the majority of the incidents reported in the quarter were low harm and proposed that a review is carried out every three months to establish if there are any themes with those low harm incidents, as there are definite improvements which can be made.

In relation to data on medicines reconciliation, **DBi** asked whether there was a high prescribing error rate. **ES** confirmed this, stating that for all wards, around 50% of patients get medicine reconciliation in 24 hours. If this was increased, there would be a reduction in prescribing error rates.

The terms of reference of the Medication Safety and Compliance Group were approved.

OUTCOME: The Committee noted the report.

85/24 – DIVISIONAL REPORTING – MEDICINE - Q4 REPORT

David Britton was in attendance to present the report as circulated at appendix H.

- *Inquests* – There were 56 live inquests out of 70 in total, with the division holding 75% of the inquest portfolio for the Trust.
- *Incidents* - The top three incidents reported in quarter 4 were slips, trips and falls, followed by appointment / admission / transfer / discharge, then medication issues. Falls is a recurring theme every month, however, there has been a change over the last few months with the areas which historically saw the most falls – Acute Floors at HRI and CRH – due to the amount of work carried out on those areas by the Falls Collaborative lead, including ensuring there are falls cohorted bays, early identification of falls risks and better compliance with falls assessments on admissions. The Acute Floor at HRI advocate the lying and standing blood pressure element of falls prevention, which historically had low compliance of around 10-11%, and now seeing around 36-37%.
- *Compliments / Complaints* – the division saw a decrease to 67% in March 2024 relating to response rates, and recognised the challenges which caused the dip. Processes were changed and an increase was noted in April 2024 up to 80%. The division are focusing on complaints extensions, and being stricter on the numbers approved, with a robust process in place. The division are also focusing on reopened complaints and working with the Head of Complaints to involve the recruited experts by experience with some of the reopened complaints. 52 compliments were logged during quarter 4.

- *Risk register summary* – the division have completed a significant amount of work on their register and process, and now in a better place in terms of accuracy. The division hold quarterly risk review meetings with all directorates, to review all risks to ensure they are still appropriate and accurate. The division's highest risk - risk 8528 - is in relation to the Emergency Care Standard, (ECS) and quality, safety and patient experience. Through some of the dedicated work carried out in March in relation to the ECS, there was a drop in the number of long-wait patients in the Emergency Department (ED). In order for the risk to be reduced any further, this needs to be sustained through to the next financial year.
- *Compliance* – The division has one non-compliant NICE guideline; 27 overdue clinical audits, all of which have appropriate action, and five overdue Polices.
- *CQC Preparedness* – The division are in the process of gathering the themes from two recent CQC reports to carry out a gap analysis for the Trust, in relation to urgent and emergency care.
- *Quality Priorities* - Compliance is at 84% for nutrition and hydration, and at 36% for the deteriorating patient, with work still to be done to improve compliance.
- *Patient Experience* – The division still have work to do in relation to engagement, and have a few ongoing initiatives, particularly in stroke and the well organised ward.
- *Learning / Feedback* – An example of work relating to patient communication carried out by Ward 20 following a complaint, was highlighted.

DBi commented on the NICE compliance and ask if recorded justification was available as to the reasons for the amount of partially compliant and non-compliant guidance, and whether they were regularly reviewed. **DBr** responded that there is a process, and clear actions against each guideline. **DBi** suggested that the assurance for these is followed up at the Clinical Effectiveness and Audit Group (CEAG). **AN** asked if there were any NICE guidance which were fully compliant. **DBi** stated that the report is by exception, therefore the fully compliant guidelines are not captured on the report. **AN** suggested that the full status is presented in future.

LR commented on the division's processes to review policies, stating that some policies are significant to the quality risks seen in the Integrated Performance Report. It was asked if there were any definitive timescales as to when those outstanding policies would be updated. **DBr** was not aware of the timescales for each of the policies, however, this will be followed up outside of the meeting and updated at the next meeting.
ACTION: An update on timescales for policies to be brought to the next meeting.

AN mentioned the increase in the pressure ulcer incidents during March 2024 and asked if there was anything in particular to comment on. **DBr** reported that the division are still in the process of reviewing the pressure ulcer investigation checklist, however, similar themes are being noted in terms of ensuring that accurate assessments are carried out, and pressure ulcer equipment is in place.

OUTCOME: The Committee thanked the division and noted the informative report.

86/24 – DIVISIONAL REPORTING – FAMILIES AND SPECIALIST SERVICES (FSS) - Q4 REPORT

James Evans was in attendance to present the report as circulated at appendix I.

- *Duty of candour* – the data retrieved from the Knowledge Portal showed some concerns, and the data was unable to be drilled down any further, therefore, the division will be bringing duty of candour into a weekly meeting in the division to review it in more detail.
- *Incidents* – there was a decline in the green and orange incidents, and the trend seems to be increasing for yellow and red incidents. The children's service has a process which started in August 2023, where every category of incident from the previous two weeks are reviewed and discussed and the learning shared. Good learning is fed back from these reviews, and colleagues are now noticing and becoming more aware of themes and trends. An overview of the five red incidents during the quarter showed no themes. Every incident reported since

April 2023 was highlighted, to demonstrate a downward trend in incidents being reported. The top themes were transfusion reporting error, appointments, and adverse events that affect staffing levels.

- *Learning from incidents and complaints and patient experience* – an example of the newsletter which the children's service shares learning from was highlighted.
- *Serious incident learning* – an example of changes put in place following learning from a serious incident was shared.
- *Complaints* – from April 2023 to March 2024, the division's overall performance was 86%. The division are working on the number of extensions requested, as there were 77 complaints last year, with 76 extension requests. It was assured that not all complaints were extended, however, some were complex complaints requiring multiple extensions. Part of the work includes training for colleagues who respond to complaints. The top five themes from 2022-2023 and 2023-2024 were highlighted, with similar themes noted, and some forming quality priorities for 2024-2025.
- *Risk register summary* – the division have 11 risks which score 15 and above, and it is felt, that via the risk register confirm and challenge meetings, that some of the high-level risks can be reduced in the near future.
- *Compliance* – The division's NICE compliance for guidelines awaiting assessment was at 3.4%, with those guidelines not yet due for review. Fully compliant guidance was at 80%, and partially compliant guidelines at 16%. The division are aware that further focus is required on NICE guidance and propose to review at the Patient Safety and Quality Board (PSQB) meetings in order for each directorate to report on. Clinical audit compliance was at 94%, and the audits overdue are now in the process of data being collected or awaiting reports to be published.
- *Clinical Outcomes Group dashboard* – the division are awaiting the development of a divisional dashboard; therefore, this will be reported in the next report.
- *CQC Preparedness* – the division are expecting Special Educational Needs and Disability (SEND) inspections for Kirklees and Calderdale; had good United Kingdom Accreditation Service (UKAS) inspections within radiology and pathology, and expecting children and young people inspections by the Delivery Network. Work is ongoing to prepare for Journey to Outstanding (J2O) inspections which has helped form the actions plans which feed into the Children's Board.
- *Quality Priorities* – the division's own priorities from the last year were highlighted, which included incidents, complaints, workforce and risk register. Each directorate will also have their own quality priorities. The division will then base their divisional priorities on the themes from the directorates.
- *Learning and Feedback* – feedback given to a volunteer from a patient following the relocation of an outpatient service to the Rainbow building at Calderdale was shared. The patient found it very confusing finding their way to the Rainbow building and was also unable to get through some of the doors. The matron for outpatients and the volunteer walked the journey and found that it was quite difficult for people that might have mobility issues, therefore, now provide information on the reception desk where a lot of the patients first attend, informing them on how to access the service.

EM provided clarity on duty of candour, stating that the Policy is undergoing a review and the concerns from the division's data may be confusion around what is a statutory requirement and what can be done professionally. The Trust's solicitors have been instructed to provide some training, and a guide is being developed for colleagues which goes through the five stages of duty of candour.

In relation to complaints, **JW** commented noticing that the length of time taken to close a complaint is measured, and queried whether this is balanced alongside whether people are satisfied with how their complaint has been handled, and whether this is impacting on the number of complaints which are reopened. **LR** responded that work took place to get response performance to its current position and the focus for the next year will be the quality of complaint responses, by getting it right first time and extending deadlines only in extenuating

circumstances. **JEv** stated that the reasons why the division have a number of extensions is due to further information required.

As part of the Patient Safety Incident Response Framework (PSIRF), **LR** noted that a patient safety and learning group is being set up to replace the Trust Patient Safety and Quality Board (PSQB) meeting, which will not only include learning from incidents, but learning overall.

OUTCOME: The Committee thanked the division and noted the informative report.

87/24 – SAFE SUSTAINABLE AND PRODUCTIVE STAFFING MEETING (SSPSM) REPORT

Andrea Dauris was in attendance to present the report as circulated at appendix J, highlighting the key changes since the last report:

- The ongoing divisional work to provide assurance of the escalation process related to red flags has shown an improving position, with divisions describing their mitigations to the escalations.
- The agency retraction cost improvement programme, to reduce higher cost agency spend, and bring in line with the plan of £500,000 per month spend, was successfully achieved.
- The Trust benchmarked positively against the *Recommendations for the management of NHS nurse redeployment and crisis workforce recovery,* which was a research study understanding the impacts of redeployment for nurses during the pandemic. There were 14 recommendations, of which 13 were achieved.
- Two deep dives were undertaken and commissioned following the introduction of the Enhanced Dashboard Metric (EDM) for the surgical division's surgical assessment unit, details of which were included in the report.
- Charlotte Anderson was in attendance to provide a demonstration of the Enhanced Dashboard Metric.

AD stated that the suite of indicators for each division is triangulated to a workforce position, which can be rapidly responded to, rather than carrying out a retrospective review. This allows divisions to see what is happening in a timely way; ascertain whether a deep dive is required, and whether the workforce metrics are negatively impacting on patient experience.

LR stated that the detailed data is important to show how the base is kept safe against the workforce, which becomes important during strategic conversations at Place level. It is hoped that this provides assurance that as the Trust goes through a challenging financial year, that the quality impact assessments in place based on the EDM data will be able to track the impacts in real time.

JW commented on the impressive data and asked if there were any plans in place to help colleagues understand the process. **AD** stated that this has been developed through an iterative process through the pandemic, triggered from a discussion when additional capacity areas were opened. A monthly meeting takes place with representation from all of divisions, who work with teams to ascertain what is required from the quality metrics and the patient experience. The Health Informatics team are crucial in carrying out the analysis and overview, which divisions review regularly and are now familiar with. Divisions use the annual and bi-annual safer data to inform their determination of whether workforce models need to change going forward or if the model is correct.

OUTCOME: **AD** and **CA** were thanked for the report and demonstration.

88/24 – MATERNITY REPORT: 3-YEAR PLAN – THEME 1 FOCUS

Gemma Puckett presented the report as circulated at appendix K, highlighting:

- *Workforce* – whilst the service has recruited well, there has only been a slight increase in workforce of 4.63 whole time equivalent (WTE). Interviews are taking place next week for newly qualified midwives, with an intent to recruit 20 midwives, and up to 30 if available. Surrounding organisations have a significantly reduced vacancy position in comparison to CHFT, therefore, hopeful to see a benefit. It has also been noted that there is an increase in the number of student midwives who have selected Calderdale as their first choice for work. Interviews have also taken place for Consultant Obstetricians, with the appointment of one, and a substantive appointment to a Locum post.
- *Third- and fourth-degree tear rates* – there was an improvement over a few months, however, unfortunately in the last few months, there has been an increase. A deep dive has been completed, and proactive measures are taking place following the audit, with workshops being run during May for midwifery and medical staff and refreshing the midwifery champion role. Funding has also been sourced for pelvic health as part of the three-year plan response through the Local Maternity and Neonatal System (LMNS), with a work together, get results session with the Physiotherapy team on how to best utilise that funding, to hopefully see a sustained improvement moving forward.
- *Stillbirth rate* – the service previously reported a cluster in February 2024, and subsequently, another has occurred in April 2024, with a year-to-date total of 12. This is more than what was seen for the entire year last year. This has been raised as a concern, as the service were already undertaking a Calderdale, Kirklees, and Wakefield (CKW) partnership review of all stillbirth and neonatal deaths over the last financial year, as a learning exercise for peer review and for shared learning opportunities. The Local Maternity and Neonatal System (LMNS) have also been approached for an external view on the 12 cases, to ensure that nothing is being missed as an opportunity for learning. The Public Health Registrar has also been invited to be a part of that review, to focus on social vulnerability and health inequality.
- *Complaints* – a lot sit within the women's directorate, in particular maternity, and are often complex to answer. Some are historical and difficult to respond to due to colleagues no longer being at the Trust, or clinical records indicating a difference to the recollection of the patient, therefore, work is taking place on the quality of responses. What is often seen with complaints is women seeking debrief from their births and perinatal mental health support. The workforce requires a review of how to best use the very limited resource around debrief support and equip colleagues to have conversations in a meaningful way. Work will also be done with the new maternal mental health service – Paths - who are also launching as part of that service, a debrief which is incredibly limited and will only be provided to around 240 (1%) of the women across West Yorkshire. The publication of the All-Party Parliamentary Group (APPG) report on birth trauma is also being awaited, which may have a range of recommendations or potentially funding, to improve.

LR reported attending the Calderdale Cares Partnership Quality Group, where further support was discussed, which can be brought to the next meeting.

JW commented that benchmarking information may be useful for inclusion in the report, to ascertain whether CHFT is an outlier against peer organisations. **GP** agreed and stated that work is ongoing with the Business Intelligence Team on the maternity dashboard for statistical process control (SPC) charting to benchmark and reflect health inequalities.

AN asked when the report from the Birthrate plus external assessment would be available. **GP** reported that the birth rate plus has now been reported back, and the output has landed where the budgeted establishment was expected, and higher than the reworked workforce model indicated. The structure will now be worked through to ensure the correct people are doing the right things in the right place. The service is fortunate to have a separate funding stream through the Local Maternity and Neonatal System (LMNS), and want to plan how that can be used to support the core service to deliver the three-year plan, particularly around continuity of carer,

which will be critical to address some of the stillbirth rates and poor outcomes and experiences of women, as they are most vulnerable and disproportionately represented in the data.

AN asked about the workforce establishment based on the Birthrate plus report, to which **LR** commented was calculated at around 202.6 against the CHFT establishment of around 178. The key message is that birth rates have fallen, hence the three-year review, however, the acuity and complexity of women have increased.

OUTCOME: The Committee noted the report.

89/24 – Q4 INFECTION PREVENTION AND CONTROL REPORT

David Birkenhead presented the report as circulated at appendix L, highlighting the last quarter and year end data.

There were a number of challenges in relation to Clostridium difficile, which were smaller cases than the last year, however, they are isolated cases rather than outbreaks, which is positive. Training and compliance is in a slightly better position than last year, but still some work to do with medical staff. There has also been a number of outbreaks and closed beds and wards over the last quarter mainly due to Norovirus and COVID-19, and an occupancy rate of 98% does not allow for easy isolation of patients. The level compliance with fit testing against two masks is particularly important around COVID and influenza, with work to be done in improving the number of colleagues who are fit tested to both of those.

OUTCOME: The Committee noted the report.

WELL LED

90-92/24 – BOARD ASSURANCE FRAMEWORK (BAF) RISKS 4/19: PUBLIC AND PATIENT INVOLVEMENT; RISK 6/19: QUALITY AND SAFETY STANDARDS AND RISK 4/20 – CQC RATING

Lindsay Rudge presented the risks as circulated at appendices M, N and O, highlighting that all risks were submitted to the Board of Directors in March 2024. In relation to the patient and public involvement risk, this has been strengthened through the patient experience and improvement group and confident that actions are progressing. The quality and safety standards risk has been updated and may need to return to the Quality Committee more frequently as some of the schemes within the cost improvement plan programme are delivered. In relation to CQC, an externally facilitated session around the new singe assessment framework will take place this week; there will be a roll-out of a well-led review, and **LR** and **VP** will be meeting with the Chief Nurse from York and Scarborough, to gain some intelligence from their well-led review, as they were one of the first Acute trusts to undergo the new framework inspection. The CQC risk will be reformatted and recirculated.
ACTION: Correct version of the CQC BAF risk to be re-circulated.

AN provided clarity to **JW** following a query on the purpose of the Board Assurance Framework (BAF) risks, and the summary report provided directly to the Board of Directors which details the active management of the risks.

OUTCOME: The Committee noted the BAF Risks.

93/24 – COMMITTEE ACTION PLAN AND PROGRESS

Andy Nelson presented the report as circulated at appendix P, commenting on two of the Committee's actions - the Quality and Safety Strategy and Patient Safety Incident Response Framework (PSIRF) implementation.

LR confirmed that the Strategy is now ready to be launched and will be going to the Leadership Conference next week.
ACTION: Quality and Safety Strategy to be brought to the next Quality Committee meeting.

In relation to Patient Safety Incident Response Framework (PSIRF), regular updates are now being provided via the Quality Report, and it was agreed that this action can now be closed.

RESPONSIVE

94/24 - INTEGRATED PERFORMANCE REPORT (IPR)

David Birkenhead provided an update on the report circulated at appendix Q, highlighting the Summary Hospital-level Mortality Indicator (SHMI) which has been increasing over the last few months. It is currently at 105 which is above the target of 100, and focused work is being undertaken to understand why. Performance is still within the expected range, and the current action plan is still the correct one in relation to managing the metric and ensuring that care is provided to patients in a consistent and safe way, which the Care of the Acutely Ill Patient (CAIP) Programme is focused on.

NBhu reported that the mortality rate is likely to increase due to the same day emergency care (SDEC) patients being removed from the calculation. It was also noted that CHFT is one of the few trusts who will be using the new process of calculation.

LR noted comments from the last meeting regarding concerns around the data for patients with a learning disability within the IPR stating that a presentation was received into the Board of Directors which explained the metrics and the work which is being undertaken by Amanda McKie (Consultant Nurse for Learning Disabilities) through the Health Inequalities Group.

OUTCOME: The Committee noted the report.

ITEMS TO RECEIVE AND NOTE

95/24 – SUB-GROUP TERMS OF REFERENCE

Community Patient Safety and Quality Board (PSQB)
Surgery and Anaesthetics Patient Safety and Quality Board (PSQB)

A copy of the above, circulated at appendices R and S, were approved by the Committee.

AN suggested that a generic template is used for Patient Safety and Quality Board (PSQB) terms of reference, which will be taken to divisions, to amend.

96/24 – MINUTES FROM:

Clinical Outcomes Group

A copy of the minutes from Wednesday, 6 March 2024 were circulated at appendix T for information.

Kirklees Quality Board

A copy of the minutes from the NHS West Yorkshire Integrated Care Board - Kirklees Quality Sub-Committee from 29 February 2024 were circulated at appendix U.

Calderdale Quality Group

A copy of the minutes from the Calderdale Cares Partnership Quality Group on 10 January 2024 were circulated at appendix V.

LR noted the focus on the strategic piece of work on stroke at both Place levels.

OUTCOME: The Committee noted the minutes.

97/24 - ANY OTHER BUSINESS

Lindsay Rudge updated that CHFT has been selected in the first 100 trusts to implement Martha's Law / Rule and will keep the Committee updated.

There were several discussions on how authors should correctly use the Committee's cover sheet to draw attention to the Committee on pertinent issues from reports.

98/24 - BOARD TO WARD FEEDBACK

There were no items.

99/24 - MATTERS FOR ESCALATION TO THE TRUST BOARD

- Nasogastric tube update – good progress and updates will now be quarterly
- Divisional reports received – informative addition to the Quality Committee agenda
- Medication and Safety Compliance Group report
- Safe sustainable and productive staffing meeting (SSPSM) report
- Maternity and Neonatal report – workforce and stillbirths
- All actions closed on the Committee Action Plan
- Committee Terms of Reference reviewed and approved with minor changes

100/24 - QUALITY COMMITTEE ANNUAL WORK PLAN

A copy of the above was available at appendix W for information, with the addition of the new sub-groups' reporting to be added. From the discussion of the Terms of Reference, it was noted greater emphasis needs to be given to End of Life Care in the workplan.

POST MEETING REVIEW

101/24 - REVIEW OF MEETING

This item was not taken.

NEXT MEETING

Monday, 3 June 2024
2:30 – 5:00 pm
Microsoft Teams

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

Minutes of the WORKFORCE COMMITTEE: IMPROVEMENT CHAPTER

Held on Monday 15 April 2024, 2.00pm – 4.30pm
VIA TEAMS

PRESENT:

David Birkenhead	(DB)	Medical Director
Nigel Broadbent	(NB)	Non-Executive Director
Lindsay Rudge	(LR)	Chief Nurse
Jo-Anne Wass	(JW)	Non-Executive Director (Chair)

IN ATTENDANCE:

Mark Bushby	(MB)	Workforce Business Intelligence Manager (for items 27/24)
Sara Eastburn	(SB)	Governor
Jason Eddleston	(JE)	Deputy Director of Workforce and Organisational Development
Terry Gamble	(TG)	Staff Side Chair
Nikki Hosty	(NH)	Assistant Director of HR (for items 28/24, 29/24 and 31/24)
Lis Street	(LS)	Clinical Director - Pharmacy
Kate Wileman	(KW)	Governor

For item 30/24:-

Jason Morris	(JM)	Head of Quality, HPS
Lisa Whiteley	(LW)	HR Business Partner (Community)
Simon Riley-Fuller	(SRF)	Associate Director of Nursing (FSS)
Leigh-Anne Hardwick	(LAH)	HR Business Partner (FSS)
Helen Rees	(HS)	Director of Operations (Medicine)
Rachel Rae	(RR)	Associate Director of Nursing (Surgery & Anaesthetics)

24/24 **INTRODUCTIONS AND APOLOGIES**

JW introduced herself as a new Non-Executive Director and Chair of the Workforce Committee. JW is also employed at the University of Leeds, working previously in the NHS occupying various roles.

KW was welcomed to her first meeting.

Apologies received from Suzanne Dunkley, Director of Workforce and Organisational Change and Denise Sterling, Non-Executive Director.

25/24 **DECLARATION OF INTERESTS**

There were no declarations of interest.

26/24 **MINUTES AND ACTION LOG FROM LAST MEETING**

The minutes of the Workforce Committee held on 19 February 2024 were approved as a correct record subject to a correction that DB was present at the meeting.

27/24 **WORKFORCE REPORT**

MB presented the report which represented data to the end of 29 February 2024. The headlines included:-

- Both headcount and FTE have seen a continued trend upwards.
- Current vacancy rate of 5.92%, down from December 23/January 24.
- Operational planning for 2024/25 has been undertaken, with plans submitted to Place/ICB during March 2024, final adjustments to be submitted by mid-April 2024.
- Turnover has seen a period of continued improvement between February 2023 (8.8%) and February 2024 (7.21%) with string of 10 months below the average turnover rate of 8.12%.
- Healthcare Science staff group continues to have a turnover rate above the Trust's new target of 10%.
- In month sickness decreased by 0.35% in February 2024 to 4.89%. Long term absence has increased and remains above the Trust target of 3.00% at 3.19%, while short term has dropped significantly (-0.47%) and is back below the Trust target of 1.75% at 1.70%.
- Top 3 reasons for absence during February 2024: Anxiety/Stress/Depression (26.2%), MSK (12.5%), Cold/Cough/Flu (12.1%)
- Rolling 12-month absence rate of 4.73% (below the Trust target of 4.75%).
- Average of 16.98 days lost to sickness per FTE holding steady from December 2023.
- February 2024 non-medical appraisal compliance has increased marginally to 84.4%, with an expected year end rate of ~85%.
- Continued overall strong Core EST compliance of 93.85%.
- Safeguarding Adults and Children have remained below the Trust target of 90%. Expected return to above 90% has not occurred.
- Data security awareness remains below the national 95% target.
- Patient Safety compliance increased to 86.6%.
- Role Specific Training is undergoing work to cleanse target audiences.
- Prevent training moved from a once-only requirement to a 3 yearly refresher period in October 2023, impacting compliance rates.
- Additional 19 new HCSW apprentices due to start in June 2024, this is in addition to the 16 new recruits who started in January 2024.
- As an Employer Provider we continue to demonstrate strong performance against our KPIs, putting the Trust in the top 10% for employer provider performance in the UK.
- The Trust has 343 Apprentices (90 of which are HCSW apprentices) in total with a strong growth in those accessing Level 5+ apprenticeships (53%) above the national average of 42% and highest number of L5+ starts in the region.
- 100 Work Experience students profiled between April 2024 and July 2024, 175 current active volunteers, 96 St John' Cadets recruited in January 2024, and 53 T-level Cadets in total (35 in Year 12 and 18 in Year 13).
- National Staff Survey results updated for 2023. Overall response rate of 43.5%, an increase of 53 responses from 2022.
- 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 £3.97M in February 2024.

- Agency spend is now following normal cause variation from August 2023. Spend in February at £0.93M.

JE explained the appraisal target is 90% for 2024/25. For 2025/26 the target figure will revert back to the pre-pandemic target of 95%. JW was pleased to note the focus on balancing the completion rate with the quality of appraisals. The recent West Yorkshire Audit provided significant assurance around the Trust's appraisal activity.

In general terms across the data, JW asked if consideration could be given to adopting a wider approach to benchmarking in order to show CHFT's position against best practice in England rather than just West Yorkshire.

JW commented on the great progress across the workforce metrics. However, she drew attention to the consistent bank and agency spend against the reduction in vacancies. The Committee noted growth in both headcount and FTE. LR reiterated this point and highlighted that from a nursing perspective the majority of the spend was to support the additional capacity wards. The Committee was reassured by the continued strong focus to deliver the financial target and noted LR is taking the executive lead on the 2024/2025 bank and agency reduction programme across clinical and non-clinical services.

Action: Provide a high level summary of bank and agency spend to include benchmarking information (LR).

OUTCOME: The Committee **NOTED** the Workforce Report.

28/24 **BAF DEEP DIVE (RISK 1/22) COLLEAGUE WELLBEING**

NH presented the deep dive and highlighted the following key points:-

<u>New activity</u>
Peer support debrief
Moving to wellbeing connect
Cost of living support resources
Mindfulness sessions
Menopause accreditation

<u>Gaps in control</u>
Management capability to manage wellbeing conversations
Wellbeing advisors transferred to divisional HR operations teams

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

NB referred to the improvements in the key metrics that the Committee had been discussing in the previous item - for example absence and retention had both improved - and asked at what stage consideration will be given to lowering the risk score, given that the metrics are moving in the right direction. NH responded feedback from managers and colleagues indicates the risk is at the appropriate level. LR agreed adding that the need to support colleague health and wellbeing is greater than ever.

JW proposed future BAF deep dives should explicitly include triangulation to the workforce data reports and should also briefly explain the rationale for retaining/changing the score.

OUTCOME: the Committee **NOTED** the BAF deep dive and the unchanged score.

29/24 **NSS STRATEGY**

NH presented the People Promise scores from the 2023 staff survey results. Improvement has been seen across the majority of areas. The Committee noted:-

- Trust Engagement score increased by 0.2 points
- Trust Morale score increased by 0.3 points

NH described the 5 high impact actions to drive further improvement :-

- Provide managers with the skills and tools to lead via One Culture of Care
- Develop clear career development pathways
- Refresh our wellbeing offer
- Intensify work on inclusion
- Develop bespoke support programmes for staff survey hot spot areas

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

30/24 **NSS IN OPERATION**

Huddersfield Pharmacy Specials (HPS)
In June 2023 the Committee learned HPS overall engagement scores were constantly below the Trust average. A comprehensive action plan was developed following workshops involving all the team.

JM presented the 2023 survey results which showed HPS had most improved scores across the People Promise themes and their best results since 2018. The Committee expressed huge congratulations to JM and the team on the phenomenal turnaround.

Community Division
The Division's engagement score has increased and was above the Trust average. Marked increase in scores against 2022 declining scores was noted. LW explained deep dives will be undertaken into 4 areas where scores have declined. Triangulation of the survey results, local questionnaires and people heatmap metrics will support development of the response plan. The Committee noted a Community Division Health and Wellbeing Board is to be established.

Families and Specialist Services (FSS)
Overall engagement score has improved and is the highest since 2020. SRF reported Women's Services Directorate had an improved engagement score having been a hot spot area in 2021 and 2022. Colleagues in Pathology are significantly impacted by the New Pathology Partnership resulting in a negative impact on staff survey results. SRF outlined the programme of work to support this team. Targeted actions to respond to low scores against 'Your Personal Development' give focus to quality of appraisals.

JW recognised the concerns in the Pathology Department and encouraged managers and colleagues to seek additional support if needed.

Medicine Division

HR reported the Division has increased in both engagement score and all People Promise themes. Emergency Care, once a hot spot area, had a much improved engagement score. One specialty saw a marginal increase and will be a main area of focus. Future Business and Performance meeting agendas will include an item on the Division's People Heatmap metrics with the ambition of significant improvement.

Surgery and Anaesthetics Division

The Division's engagement score has increased year on year. RR explained the Division's key principle is strong, effective and compassionate leadership. One specialty identifies as a hot spot area, however positively its scores have also increased year on year. General Surgery scores consistently higher than the Trust's average and is an example of best practice. A 6-month plan has been designed to tackle the 5 high impact actions.

NB congratulated the teams on really positive progress. He asked how the examples of best practice will be shared across divisions. Divisions this year have taken more lead than in previous years and some commonalities are seen in the response plans. A good example is the adoption of a Health and Wellbeing Board which is already well established in the FSS Division. SRF echoed the point of sharing good practice and explained some cross divisional changes have already been implemented. A new action for Performance Review Meetings (PRM) is a commitment to sharing good practice. JW was pleased to see the ownership by divisions and suggested an approach where managers and leaders who have had success in improving staff engagement might be formally connected with hot spot areas.

The impact of quality appraisal discussions was again recognised.

JW asked if there was any other support the divisional colleagues needed in terms of the high impact actions. Both RR and SRF acknowledged the wrap around support in place adding that listening to each of the presentations today had been very useful.

OUTCOME: The Committee **NOTED** the improvements in the survey results and **THANKED** the divisions for their presentations.

31/24 **NSS THROUGH THE LENS OF ED&I**

NH updated the Committee on activity and progress of the ED&I strategy. She described the 5-year journey and what the 2023 staff survey results say about our progress.

NH explained the Inclusion Group provides an overall view of connectivity between the equality network Chairs and the Executive Sponsors. It provides senior oversight of all data, progress, areas of concern and activity. Executive Sponsors work closely with equality network Chairs to understand the issues and ensure EDI has a voice at Board level.

In terms of diversity, the staff survey results scores in the People Promise section are tracking better than the national average and increasing year on year.

200 colleagues reported they have experienced discrimination:-

- Ethnicity discrimination is tracking better than average, however a high percentage is being reported.
- Gender and Religion discrimination are tracking higher than average.
- Sexual orientation discrimination is tracking lower than average.
- Disability discrimination is tracking against average.
- Age discrimination is tracking better than average.

The presentation outlined the response plan designed to tackle specific areas.

JE advised the Inclusion Group is to undertake a workshop that will concentrate on the staff survey information, live WRES and WDES data and activity/progress against our local plans and the National ED&I plan. The outputs from the session will be shared at a future Committee meeting.

NB was pleased to hear about the campaign to make positive impact against discrimination. He highlighted the variances in reported numbers in the staff survey against freedom to speak up for example and asked if colleagues feel they can report instances of bullying and harassment. NH commented there is disparity between colleagues choosing to declare personal information such as disability on ESR and the information they provide when completing an anonymous survey. The intention of the re-set of the Disability Network and the LGBTQ Network is to promote the Trust as a safe space for everyone. JE agreed the results indicate work to do to demonstrate to colleagues that raising concerns does effect response to behaviours and values which do not align with One Culture of Care. TG welcomed the approach to addressing the concerns.

LS raised a point about under represented groups at Band 7 and felt there may be benefit of deeper analysis to determine colleague intentions.

JW suggested hearing 'staff stories' would help the Committee better understand the issues.

OUTCOME: The Committee **NOTED** the progress made against the ED&I Strategy and the Staff Survey results. It also **NOTED** WRES and WDES data will be shared at the June Committee meeting for publication sign off and action plans to be discussed at a future meeting.

32/24 **ITEMS TO RECEIVE AND NOTE**

Notes from the 8 February 2024 and 7 March 2024 Education Committee were circulated.

Notes from the 29 February 2024 Inclusion Group were circulated.

33/24 **ANY OTHER BUSINESS**

No other business was raised.

34/21 **MATTERS FOR ESCALATION TO THE BOARD OF DIRECTORS**

- Bank and agency spend
- Progress in turnover/sickness/vacancies
- Appraisal
- BAF Deep Dive
- Staff survey session with Divisions
- ED&I

35/24 **WORKFORCE COMMITTEE WORKPLAN**

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

36/24 **MEETING REVIEW**

The meeting was well facilitated. It allowed sufficient time to hear from Divisions and good conversations progressed.

37/24 **DATE AND TIME OF NEXT MEETING:**

Hot House
23 May 2024, 2.00pm-4.00pm

Workforce Committee:
12 June 2024, 2.00pm – 4.30pm
Chapter: Engagement

Draft Minutes of the Extra-Ordinary Audit and Risk Committee Meeting held on Tuesday 25 June 2024 commencing at 10:00 am via Microsoft Teams

PRESENT

Nigel Broadbent **(NB)**	Non-Executive Director **(Chair)**
Tim Busby **(TB)**	Non-Executive Director

IN ATTENDANCE

Andrea McCourt	Company Secretary
Gary Boothby	Executive Director of Finance
Kirsty Archer	Deputy Director of Finance
Helen Higgs	Head of Internal Audit, Audit Yorkshire
Leanne Sobratee	Internal Audit Manager, Audit Yorkshire
James Boyle	External Audit Director, KPMG
Matthew Moore	Senior Manager, KPMG
Zoe Quarmby	Assistant Director of Finance
Amina Phiri	KPMG
Amber Fox	Corporate Governance Manager *(minutes)*

The Chair welcomed everyone to the extra-ordinary Audit and Risk Committee meeting to sign off the Annual Report and Accounts for 2023/24 which has been delegated to this Committee by the Board of Directors.

35/24 APOLOGIES FOR ABSENCE

Apologies were noted from Denise Sterling, Peter Wilkinson, Victoria Pickles and Brendan Brown.

36/24 DECLARATIONS OF INTEREST

The Chair reminded the Committee to declare any items of interest at any point in the agenda.

37/24 MINUTES OF THE MEETING HELD ON 23 APRIL 2024

The minutes of the meeting held on 23 April 2024 were approved as a correct record.

OUTCOME: The Committee **APPROVED** the minutes of the previous meeting held on 23 April 2024.

38/24 ACTION LOG AND MATTERS ARISING

The action log was reviewed, several actions were complete with the remaining due in July 2024.

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

39/24 ANNUAL REPORT AND ACCOUNTS

a) Estate Valuation Assessment

The Director of Finance presented the Estate Valuation Assessment which advised the Trust estate has been valued by Cushman and Wakefield. There has been no fundamental change to the use or condition of the estate and therefore management concludes that the use of the Expert and approach to determine the valuation of the Trust estate was appropriate.

The review concluded that there is no overall evidence of required impairment to the Trust estate.

NB referred to an issue in previous years related to floor spaces and measurements and asked if

the Trust can take assurance this has now been addressed. The Director of Finance and Senior Manager from KPMG confirmed this has been addressed.

OUTCOME: The Committee **NOTED** the Estate Valuation Assessment.

b) Audited Annual Accounts and Financial Statements 2023/24

The Deputy Director of Finance presented the Audited Annual Accounts and Financial Statements for the year ended 31 March 2024. KPMG colleagues have had the opportunity to review and comment on the accounts and statements.

The Deputy Director of Finance described the difference between the deficit position in the year end accounts of £31.84m and the month 12 regulatory deficit position of 13.24m. The various movements were outlined in the report. The material movements to note were the impairments and revaluations of £8.74m and the remeasurement of PFI at £9.57m; both create a pressure for 2024/25. The remeasurement of PFI is due to a change in accounting standard for this financial year in the NHS which brings the PFI asset fully on the balance sheet. The new guidance determines how the value of the lease liability is calculated under IFRS16. The Trust has used the NHS England (NHSE) issued models for the calculations which have been reviewed by KPMG as they are complex models.

The Trust were able to deliver a month 12 position as committed to the ICB which contributed to the overall balanced West Yorkshire position. As a result, the Trust benefited from some additional income distribution in month 12. The Trust reported a year end position £7.56m better than original plan. This late income allocation impacted on the Trust's cash position to £27.2m for the new financial year.

The Trust made some significant capital investments in year; however, the cash payments for significant invoices falls into the new financial year.

NB thanked KB for the reconciliation explanation and asked, in terms of the standard IFRS16, if there would be further changes next year. The Deputy Director of Finance responded no further changes are expected and NB recognised the comparison next year should be consistent. The Deputy Director of Finance explained there was recognition by NHSE that this is an exceptional difference in setting the control total and was now reflected in the regulatory plans.

NB referred to note 3, the comparison of income between years in terms of elective recovery funding (ERF) and national funding for pay awards and asked if this income is shown in a different way. The Assistant Director of Finance and Director of Finance clarified the way we receive ERF has come through a different route this year, as part of the baseline contract payment. The Director of Finance confirmed the monies were received in 2023/24.

NB thanked all those involved in the annual accounts and financial statements for 2023/24.

OUTCOME: The Committee **APPROVED** the Audited Annual Accounts and Financial Statements for the year ended 31 March 2024.

c) Letter of Representation

The Director of Finance presented the letter of representation that the Trust is required to submit and includes standard wording on how the accounts have been prepared and on a going concern basis.

AM advised of a change required to the final Letter of Representation, the letter will be signed off by the Chief Executive.

Matthew Moore, KPMG highlighted to the Committee appendix 1 regarding one unadjusted mis-statement referred to in the letter.

OUTCOME: The Committee **APPROVED** the Letter of Representation which will be signed off by the Chief Executive.

d) Head of Internal Audit Opinion and Annual Report

The Internal Audit Manager presented the Internal Audit Annual Report and highlighted the following key points:

- 350 planned days delivered against the agreed Internal Audit 2023/24 plan
- 23 audit reports issued in the year (22 finalised and one which is still in draft which is a significant assurance report) as follows:
  - 5 - High Assurance
  - 13 - Significant Assurance
  - 4 - Limited Assurance
  - 1 – No Opinion

- Compliant with the public sector internal audit standards throughout the year and maintained independence throughout the year.
- 9 KPIs in the annual report – seven scored 100%, one scored 99% and management responses scored 77%.

TB commented it was a positive report with significant assurance and asked, in the interest of continuous improvement, what is the main area of focus moving forwards. The Head of Internal Audit responded every year they look at current risks on the BAF and risk registers and the plan would be adapted to address any risks in year.

The Head of Internal Audit gave a ***significant assurance*** opinion, explaining there is a good system of governance, robust risk management and there were no overdue recommendations and only two with a revised target.

NB asked in terms of continuous improvement, is there anything the Trust can do to get a high level of assurance that we could learn from. The Head of Internal Audit responded no high assurance overall opinion has been given as there are always risks and issues. She explained they are more comfortable seeing a significant opinion as there is always rooms for improvement.

TB highlighted one of the audits that was cancelled relating to infection control and asked whether this was being rescheduled. The Internal Audit Manager responded this was not prioritised in the new plan as there were more risks elsewhere to prioritise. The Director of Finance gave assurance that when changes to plan are developed, these are discussed with the Director and Deputy Director of Finance and an assessment of risk is made at that point. The Committee can also review and override these decisions.

NB asked if there is anything the Committee can do to improve the speed of response to internal audit reports. The Internal Audit Managed responded the speed depends on findings of the audit and how many departments are involved. She explained overall there is good engagement.

NB thanked Internal Audit for all their hard work on the internal audit plan for 2023/24.

OUTCOME: The Committee **NOTED** the Head of Internal Audit Opinion with a significant assurance overall opinion and **NOTED** the Internal Audit Annual Report.

e) Annual Governance Statement (AGS)

The Director of Finance reported that the 2023/24 Annual Governance Statement (AGS) was reviewed and approved by the Audit and Risk Committee on 25 April 2024. The Annual Governance Statement has been developed in line with NHS England guidance.

The statement described the Trust's system of internal control that has been in place during 2023/24. It has been reviewed at various stages by the Chief Executive, Executive Directors, Internal and External Audit as well as the Audit and Risk Committee.

The Annual Governance Statement confirmed the Trust had no significant control issues in the financial year 2023/24, a position consistent with the Head of Internal Audit Opinion and KPMG Year End Report detailed in the papers.

The Company Secretary explained since the meeting on 25 April the Head of Internal Audit Opinion is now included which strengthens the statement.

OUTCOME: The Committee **APPROVED** the Annual Governance Statement.

f) Annual Report 2023/24 including Going Concern

The Company Secretary presented the Annual Report for 2023/24 which has been developed in line with the NHSE Foundation Trust Annual Reporting Manual.

The annual report includes the Performance Report, Accountability Report and Auditors Report and changes to the guidance are highlighted below.

Performance Report:

- Task Force on climate-related financial disclosure. i.e. Trust governance of climate - related issues, including Board oversight and management's role in assessing and managing climate-related issues.
- Information on the Trust's work to tackle health inequalities, including the extent to which the Trust has exercised its functions consistent with NHS England's statement under section 13SA(1) of the NHS Act 2006 on how NHS bodies should exercise their powers to collect, analyse and publish information related to health inequalities.

Accountability Report:

- The work that the Trust has undertaken for the revised process for the core standards for Emergency Preparedness, Resilience and Response (EPRR), requires the inclusion of a Resilience Statement in the Annual Report.

A detailed review has taken place by NB, DS and PW and their feedback is incorporated.

External Audit has completed their audit review of the annual report. Queries and changes arising from this review have been incorporated. There have been two amendments made to the Annual Report text following feedback from external audits, one relating to the remuneration report text and one the staff report. Amendments to the remuneration report relate to benefits in kind and salary sacrifice.

External audit has confirmed the content of the annual report meets all requirements and, subject to approval, the plan was to submit this to NHSE by Friday 28 June 2024 by noon.

The Company Secretary confirmed the Annual Members Meeting (AMM) where the accounts are formally shared would normally be held in July; however, due to the general election it will likely be held early Autumn 2024.

The Company Secretary confirmed an annual report summary is being developed and will be published on the Trust website at the same time as the annual report.

NB thanked everyone for their contributions to the 2023/24 Annual Report.

NB asked if the remuneration changes are due to complexity or if changes need to be made to processes. The Company Secretary responded that going forwards benefits in kind will be included in the remuneration report.

The Company Secretary confirmed the accounts were completed on a Going Concern basis which is included within the annual report.

OUTCOME: The Committee **APPROVED** the Director of Finance's recommendation that the Trust is a going concern and **APPROVED** the Annual Report 2023/24.

g) Year End Audit Report 2023/24 – ISA 260

James Boyle, Audit Director KPMG and Matthew Moore, Senior Manager, presented the key findings within the ISA 260 Year End Audit Report for 2023/24.

James Boyle, Audit Director KPMG advised:

- They expect to issue an unqualified, unmodified audit opinion on the financial statements.
- Audit work is substantially complete, the only outstanding work is on CHS expenditure – not anticipating this to impact on year end deadlines.
- Clean report; however, it was a detailed audit with a lot of rigour and challenge.

The Finance team, particularly Zoe Quarmby and Kirsty Archer were thanked for their co-operation during the audit process.

Matt Moore, highlighted the significant risks identified in plan based on the auditing standards required for all audits:

- **Fraud risks from expenditure recognition** – tested year end cut off – no issues to report.
- **Management overrides of controls** – journals process with appropriate evidence to support the journals in the year – highlighted high risk journals which are correctly evidenced.
- **Valuation of land and buildings** – been through a rigorous testing approach – assumptions and assertions – no issues to report.
- **IFRS16** – reviewed based on a new model this year – the consistency of calculations has been tested – no issues to report.
- No significant control issues.
- **VFM risk assessment** – identified one significant risk around ongoing financial sustainability of the organisation. This was followed up in terms of how the Trust responded to the NHSE deep dive report, how the Trust monitor and the action plan through the Finance and Performance Committee, specific actions that have been delivered to date and the future longer term actions. The financial plan and various changes have been reported regularly to Finance and Performance Committee, allowing appropriate governance of the submission to take place. Based on the findings, no significant weaknesses have been identified in the Trust's arrangement during 2023/24.

OUTCOME: The Committee **NOTED** the External Auditor's Year-End Report ISA 260.

h) Auditor's Annual Report 2022/23

James Boyle, Audit Director KPMG presented the draft Auditor's Annual Report which summarised the conclusion of the value for money work undertaken, noting this is a public document to be added to the Trust website by September 2024. He confirmed the report does not highlight any issues of concern to be reported to the public and was a positive report.

James Boyle assured the Committee that no significant risks or weaknesses against these domains had been found.

OUTCOME: The Committee **NOTED** the External Auditor's Annual Audit Report.

i) CHFT Consistency Statement
James Boyle, Audit Director KPMG confirmed two draft opinions have been provided which they intend to sign and were provided separately.

j) CHFT Independent Auditors Report
The Independent Auditor's report to the Council of Governors was presented which certified the completion of the audit of the accounts in line with legislation. It was noted this would be added into the annual report.

40/24 ANY OTHER BUSINESS
The Chair formally thanked those in the Trust involved in preparing the financial statements, accounts and annual report. He also thanked the Internal Audit team from Audit Yorkshire and KPMG and colleagues for their work in getting us to this position.

41/24 MATTERS TO CASCADE TO BOARD OF DIRECTORS
The Board of Directors will be updated on 4 July 2024 via the Chair's highlight report of the approval of the financial statements, clean audit opinion from Audit Yorkshire and KPMG.

NB reported it was a good set of accounts which were well prepared. There were good levels of assurance from internal and external audit, with an unqualified opinion provided on the accounts.

The meeting closed at approximately 10:50 am.

42/24 DATE AND TIME OF THE NEXT MEETING

Date: Tuesday 23 July 2024
Time: 10.00 am
Via: Microsoft Teams

Chair Approved Minutes of the Charitable Funds Committee meeting held on Tuesday 7 May 2024, 10:30 am in Room 3, Acre Mills Outpatients

Present

Helen Hirst (HH)	Chair
Nigel Broadbent (NB)	Non-Executive Director
Gary Boothby (GB)	Director of Finance
David Birkenhead (DB)	Medical Director

In attendance

Victoria Pickles (VP)	Director of Corporate Affairs
Emma Kovaleski (EK)	Charity Manager
Sanna Samateh (SS)	Charitable Finance Officer
Jonathan Hammond (JH)	Chief Operating Officer
Lyn Walsh (LW)	Financial Accountant
Amber Fox	Corporate Governance Manager *(minutes)*

17/24 WELCOME AND APOLOGIES FOR ABSENCE

The Chair welcomed everyone to the meeting held in person.

Apologies were received from Lindsay Rudge and Zoe Quarmby.

18/24 DECLARATIONS OF INTEREST AND INDEPENDENCE

All present declared their independence and the Director of Corporate Affairs declared an interest as Trustee of Overgate Hospice.

19/24 MINUTES OF THE PREVIOUS MEETINGS HELD ON 6 FEBRUARY 2024 & 11 APRIL 2024

The minutes of the previous meetings held on 6 February 2024 and 11 April 2024 were approved as a correct record.

OUTCOME: The Committee **APPROVED** the minutes of the previous meetings held on 6 February and 11 April 2024.

20/24 ACTION LOG

The action log was reviewed and updated accordingly.

GB asked if the Committee agreed to continue funding the A&E care bags. EK responded the Committee didn't agree to fund the care bags until further information was received and they are looking into a fundraising or grant finding process to continue with these. However, in light of the new ED opening, they are reviewing the need for these bags as they will be in a better quality environment. An update will be provided in the next Charity Manager's report.

VP referred to the charitable funds audit which was reviewed at Audit and Risk Committee and asked when the charity accounts will be completed and new arrangements in place for the audit. GB responded a conversation took place with Airedale to review using an independent local firm and Airedale are currently going through a process reviewing their specification before contacting local firms. GB confirmed a timetable should be able to be produced shortly after this work has taken place. The timetable for the audit to be complete is 31 December 2024 when it needs to be submitted to the Charity Commission.

GB asked for an update on the Steering Group that was being arranged to review bids from April 2024. VP and EK explained they are reviewing the Steering Group this week

in line with additional changes and learning being taken from other NHS charities. VP explained this came to light on the back of NHS Charities Together explaining how committees are structured dependent on the size of the charity, and the Committee effectiveness review feedback which brought in some views around how to take into account the voices of different groups. Following discussion about prioritisation of bids versus first come first served, VP and EK said they will share a proposal at the next meeting which will look at a bidding process aligned to the Dragon's Den for some funds and a fundraising or grant funding process for others.

NB asked how the Committee will determine the agreed level of delegation to the Steering Group and the range of funds that can be allocated. VP agreed this is important and explained it aligns with the forecast plan and what percentage of funds can be allocated at each fundraising round.

Action: VP and EK to share a proposal on the Steering Group at the next meeting, including the range of funds that can be allocated at each fundraising round.

HH suggested the Committee need to take some action to agree how to manage bids in the interim period whilst a fair and equitable process is being introduced. The Committee acknowledged they would like to have a process in place before September; however, it may not be realistic. EK offered to share an overview of fundraising requests that have been received over the last few weeks to give the Committee an understanding of what is being spent. DB suggested new bids are put on hold until September 2024. VP agreed a note will be drafted to explain how the process will work in the future with a new bidding round in September and only exceptions will be accepted between this time. GB clarified if there is a fund being raised for a specific purpose, these activities should continue. VP confirmed if the funds are within their delegated limit and sit within their fundraising this is acceptable.

HH asked when the Committee will decide on the split of the designated compared to non-designated donations as per the Strategy discussions. VP explained a piece of work will take place with finance to review the spend of these funds and a proposal will be brought back to the November meeting.

NB clarified if this only applies to future funds and not retrospectively. GB responded the Committee considered over the years the number of small funds with no bids allocated to them and an option was to amalgamate the funds.

Action: VP/EK to feedback in November on designated/non-designated funds decision making as part of the Strategy.

OUTCOME: The Committee **NOTED** the updates to the action log and **AGREED** a bidding process will be introduced in September and between May and September only by exception will the Committee consider any bids against the general purpose fund. The process for designated funds will be reviewed by the Committee in November 2024.

21/24 CHARITY STORY: ICU

EK shared a touching patient story from ICU to highlight the impact of the patient ICU diaries and person-centred giving. This individual decided to take on a charity walk, an hour for each day their relative was in ICU and to understand what it's like for an NHS worker to be constantly on their feet all day. This is in remembrance of their loved one and to support the nurses and doctors, particularly on MAU and every other NHS worker that provide support as a way of giving back.

EK explained they are shining a light on end of life and palliative care and making the most out of this fundraising.

VP highlighted this coincides with Dying Well week this month and this story will be used as part of a thank you and to acknowledge the acute services and the community who look after patients at end of life.

OUTCOME: The Committee **NOTED** the Charity Story from ICU.

22/24 CHARITY MANAGER'S REPORT INCLUDING PROGRESS AGAINST STRATEGY

EK presented the year end Charity Manager's report. The key points to highlight were:

- Majority of KPIs are on track to be delivered by year end.
- Fundraising was successful throughout the year.
- Planned budget gross income from planned events was £32k; however, delivered a total income of £50k for the year.
- Voluntary income donated to the charity, excluding large scale grants and legacies has seen a marked increase of 53% overall this year against figures for 22/23.
- Legacies continue to be an unpredictable income source. In the year the charity has received an increase in the legacy value, with a total income of £183,116 being gifted from 13 donors.
- Mayors Charity Dinner took place on Friday 3 May 2024 at Huddersfield Town Hall. The dinner was an evening of celebration and recognition for our wonderful communities across Kirklees, whilst raising funds for the Mayor's chosen Charities, Calderdale and Huddersfield NHS Charity and the Royal Air Force Association.
- My Forever Boxes have continued to be funded during the year.
- Finished developing the garden at HRI with a joint A&E, garden celebration opening party being planned for 5 June 2024.

GB highlighted it was a positive report and asked if a table can be included to describe the planned budget income compared to the reality. EK agreed to provide a table with an overview of the fundraising events. GB added there may be learning from some events.
Action: EK to share a table with an overview of the fundraising events in 2023/24 year, to compare the planned budget with the reality.

OUTCOME: The Committee **NOTED** the year end Charity Manager's Report.

23/24 FEASIBILITY STUDY RESPONSE

EK shared the recommendations from the feasibility report discussed in April 2024. The key points to note were:

- Brand new website for the charity is now live.
- Amazing in Action Week 1st to 8th June – CHFT Charity will be relaunching and rebranding fully from 1st June. A Business Networking Event during the week at HRI - hoping to secure potential partners.
- Official opening of A&E and wellbeing garden on 5 June 2024.
- Fundraising campaigns for the future – In conversations with Departments to review their Trust wide strategies and understand how the charity can support these. EK in conversation with Julie Mellor to review the Children's and Women's Strategy and which recommendations in the strategy could be charitable. This is the first time a Trust-wide strategy would adopt the Charity for delivery. The costs have not been worked up yet and would involve a generic paediatric fundraising appeal which would support children in hospitals and to provide an environment

to suit their needs. EK explained this is incredibly supportive of the future for CRH and support for a Paediatric A&E Department with a larger scale fundraising campaign.

- Action for the Committee to agree a budget for the year of £32k to deliver against planned activity, this doesn't include any staffing costs or audit fees. A recommendation is to move Volunteering into the charity within six months and formally make the role of Fundraising Co-ordinator permanent which is currently substantive to June 2024.

GB highlighted the KPIs for 24/25 show three to be completed by March 2024 and asked if this should be March 2025. EK clarified these should state March 2025 (year end).
Action: EK to update the deadlines for the 24-25 KPIs.

NB asked if the aim to support the Children and Young People Strategy was to fundraise or for a general purpose bid. EK explained promotional items would be required to kickstart this work which will be a fundraising appeal to bring monies into the charity.

JH expressed his support in linking the charitable funds to key priorities in the strategies and asked if this is an approach that can work with other strategies in the organisation i.e., the cancer strategy. EK has been working closely on the future of cancer services with significant opportunities to engage with local companies. HH questioned why this action didn't come out of the feasibility review. VP explained Paediatrics will shine a light on this and hope to engage others way of thinking. HH acknowledged other actions from the feasibility study may need to be postponed in light of this being a key focus.

GB challenged how the Committee quantify the investment in the charity team structure on a recurrent basis compared to the income received. NB agreed there will need to be performance measures and action plans associated with the posts to monitor delivery. VP confirmed the job description of the Fundraising Co-ordinator was tested and assessed and there is a lot of work to do and potential e.g. grant opportunities, legacy focus work and campaigns.

NB confirmed they are reviewing an overall budget for the charity for the year on 21 May 2024 which will report back to the next meeting in August.

GB asked if there is an admin challenge with moving the general purpose funds to amazing difference funds. EK confirmed this is only a name change and VP clarified this is setting the expectation of what can be delivered in this fund and changing the comms lense.

GB asked if a brand new fund is created, how the Committee decides what goes into the amazing difference and wellbeing fund. VP shared some learning from Airedale, where the existing staff lottery members agreed to split the pot 50/50 into prizes and a wellbeing fund to support staff and teams in the organisation. Those who were part of the staff lottery were consulted in to ensure they were happy with this. The Trust then promoted the staff lottery to bring in more funds overall which was successful. VP explained Airedale matched what was in the lottery pot to show their commitment and support with a bidding round at the lottery committee. HH asked if CHFT can connect this to the staff lottery rebrand and promotion, which was supported.

OUTCOME: The Committee **APPROVED** for the CHFT Charity to dedicate time and resource to integrating within the Children and Young People Strategy and involvement in is delivery.

OUTCOME: The Committee **APPROVED** the plan for 24/25 and accompanying budget of £32k to deliver against planned activity.

OUTCOME: The Committee **NOTED** the feasibility study response.

24/24 FINANCE REPORT – Q4

LW presented the year end Finance Report as at 31 March 2024. The key points to note were:

- £2.5m fund balances
- Gain of £270.7k from investments
- £380k income against £346k expenditure
- £180k legacy
- General funds and governance costs were broken down for information.

OUTCOME: The Committee **NOTED** the year end finance report as of 31 March 2024.

25/24 INVESTMENT REPORT

The full financial statements at year end have not been received which details investments. LW to share year of investments once received with the Committee.
Action: LW to share the investment report once received with the Committee.

OUTCOME: The Committee **NOTED** the investment report will be received in due course.

26/24 COMMITTEE EFFECTIVENESS REVIEW AND ACTION PLAN

The Director of Corporate Affairs explained each Committee undertakes a self-effectiveness review to see if any improvements can be made and if the Committee are meeting their terms of reference.

The summary of responses from members were shared which were generally positive. There were a few suggestions from members on how to improve the effectiveness of the Committee.

GB asked if the Committee should revisit improving the diversity as it was previously improved by approaching the BAME network. VP responded this could be re-visited; however, it only looks at one element of diversity. She explained this could be an opportunity for the Steering Group to encourage participation from different diversities.

OUTCOME: The Committee **NOTED** the summary of the Committee effectiveness review responses and action plan.

27/24 COMMITTEE ANNUAL REPORT 2023/24

VP presented the CFC Annual Report for 2023/24 drafted by the Corporate Governance Manager which will be presented to the Board as Corporate Trustee at the next meeting as part of the Chair's report in July 2024 which will raise awareness of the work of the Committee.

OUTCOME: The Committee **APPROVED** the Charitable Funds Committee Annual Report 2023/24.

28/24 REVIEW OF ATTENDANCE

The attendance register for 2023/24 was received. Attendance was good throughout the year with regular meetings taking place.

OUTCOME: The Committee **NOTED** the attendance register for 2023/24.

29/24 LEAGUE OF FRIENDS ANNUAL REPORT 2022/23

The Charity are working closely with the League of Friends and the League of Friends Annual Report for 2022/23 was shared.

VP confirmed there is a plan for the League of Friends in a few years as part of the new build at CRH. EK shared the League of Friends recently transferred £15k to the charity and EK has shared two funding requests with the League of Friends for them to consider. NB suggested the charity could approach the League of Friends at the next bidding round. EK explained she is looking at proposing the League of Friends support maternity.

OUTCOME: The Committee **NOTED** the League of Friends Annual Report 2022/23.

30/24 MINUTES OF STAFF LOTTERY COMMITTEE MEETING HELD ON 6th FEBRUARY & 9th APRIL 2024

The minutes of the Staff Lottery Committee held on 6th February and 9th April 2024 were received for information.

GB highlighted the importance in broadening this and staff being aware that bidding is available.

OUTCOME: The Committee **RECEIVED** the minutes of the Staff Lottery Committee.

31/24 ANY OTHER BUSINESS

There was no other business.

DATE AND TIME OF THE NEXT MEETING

Tuesday 6 August 2024, 10:30 - 12:00 pm, Rooms 3 & 4, 3rd floor, Acre Mills Outpatients or via Microsoft Teams.

Attendance Log 2024/25

	7 May 2024	6 Aug 2024	5 Nov 2024	Feb 2025	Total
Member					
Helen Hirst (Chair)	✔				1/1
Nigel Broadbent	✔				1/1
Gary Boothby	✔				1/1
David Birkenhead	✔				1/1
Lindsay Rudge	✖				0/1
Jonathan Hammond	✔				1/1
Attendance					
Emma Kovaleski	✔				1/1
Victoria Pickles	✔				1/1
Zoe Quarmby	✖				0/1
Lyn Walsh	✔				1/1
Sanna Samateh	✔				1/1

27. DATE AND TIME OF NEXT MEETING

Date: Thursday 12 September 2024

Time: 9.00 – 12.00 pm

Venue: Rooms 3 & 4, Acre Mills Outpatients

To Note

Presented by Helen Hirst