Calderdale and Huddersfield NHS Foundation Trust

Public Board of Directors

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

Agenda

9:00	1. Welcome and Introductions: - Julie Mellor, Lead Nurse for Children and Young People (for Item 4: Patient Story) - Gemma Puckett, Director of Midwifery and Women's Services (for item 9) Invited Public Governors: - Lorraine Wolfenden, Lead Governor To Note - Presented by Helen Hirst	1
9:02	2. Apologies for absence: Suzanne Dunkley, Director of Workforce and Organisational Development Jo-Anne Wass, Non-Executive Director Victoria Pickles, Director of Corporate Affairs Rob Birkett, Chief Digital and Information Officer To Note - Presented by Helen Hirst	2
9:03	3. Declaration of Interests	3
	STRATEGY: TRANSFORMING AND IMPROVING PATIENT CARE	4
9:04	4. Patient Story – Children and Young People Strategy Presented by the Chief Nurse and Julie Mellor, Lead Nurse for Children and Young People For Assurance	5

		- Director of Infection Prevention Control Q1 Report - Learning from Deaths Annual Report For Assurance - Presented by Denise Sterling	
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		APP G2 - Q1 Infection Control Report.docx	105
		APP G3 - Learning from Deaths 2023.24 v4 08.08.24 final.docx	110
10:03	11.	Workforce Committee Chair Highlight Report – 15 August 2024 For Assurance - Presented by Denise Sterling	133
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10:13	12.	Finance and Performance Chair Highlight Report – 3 September 2024 For Assurance - Presented by Vanessa Perrott	136
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10:23	13.	Month 4 Financial Summary To Note - Presented by Gary Boothby	140
		APP J1 - Board of Directors Cover Sheet Month 4 Finance Report_12 Sept 2024.docx	141
		APP J2 - Month 4 Finance report for Board.pdf	143
10:28	14.	Audit and Risk Committee Chair Highlight Report – 23 July 2024 - Committee Annual Reports 2023/24 For Assurance - Presented by Nigel Broadbent	147
		APP K1 - Audit and Risk Committee Chair's Highlight Report meeting July 2024.docx	148
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		APP K3 - Quality Committee Annual Report 2023-2024.docx	155

		Approved by ARC 23 July 2024.docx	361
		APP S3 - TPB Terms of Reference June 2024 final version - APPROVED BY TPB 19.6.24.docx	370
11:38	23.	Items to receive and note 1. Minutes of Board Committees - Finance and Performance Committee - 2 July 2024 - Audit and Risk Committee - 23 July 2024 - Charitable Funds Committee - 6 August 2024 - Quality Committee - 3 June, 2 July 2024 - Workforce Committee - 12 June 2024 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	375
		APP T1 - Finance and Performance Minutes 2nd July 2024.docx	376
		APP T2 - Chair Approved Minutes Audit and Risk Committee Meeting held on 23 July 2024 v3.docx	388
		APP T3 - Chair Approved Minutes of the Charitable Funds Committee meeting held on 6 August 2024 v3.docx	399
		APP T4 - FINAL Quality Committee minutes - Mon 3 June 2024 (Approved 2 July 2024).docx	405
		APP T5 - FINAL Quality Committee minutes - Tue 2 July 2024 (Approved 3 Sept 2024).docx	417
		APP T6 - 12 June 2024 approved Minutes Workforce Committee.pdf	426
	24.	DATE AND TIME OF NEXT MEETING Date: Thursday 7 November 2024 Time: 9.00 – 12.00 pm Venue: Rooms 3 & 4, Acre Mills Outpatients To Note - Presented by Helen Hirst	436

1. Welcome and Introductions:

- Julie Mellor, Lead Nurse for Children and Young People (for Item 4: Patient Story)

- Gemma Puckett, Director of Midwifery and Women's Services (for item 9)

Invited Public Governors:

- Lorraine Wolfenden, Lead Governor

To Note

Presented by Helen Hirst

2. Apologies for absence:

Suzanne Dunkley, Director of Workforce and Organisational Development
Jo-Anne Wass, Non-Executive Director
Victoria Pickles, Director of Corporate Affairs
Rob Birkett, Chief Digital and Information Officer

To Note

Presented by Helen Hirst

3. Declaration of Interests

STRATEGY: TRANSFORMING AND IMPROVING PATIENT CARE

4. Patient Story – Children and Young People Strategy

Presented by the Chief Nurse and Julie Mellor, Lead Nurse for Children and Young People

For Assurance

one culture of care

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Children & Young People

Trust-wide Strategy

2024 - 2029

CHFT
CHILDREN & YOUNG PEOPLE

Introduction

The children and young people strategy provides a plan of our 'journey to outstanding' for the care for children and young people in Calderdale and Huddersfield Foundation Trust.

The how

- Developing our Vision
- What are our strategic aims / themes
- Listening to Children and Young People (CYP)
- Carer and Family Contact and Engagement
- Children`s Health Requirements Evidence / Policy / Best Practice / Regulation
- CYP Service Planning and Delivery

NHS 10-year Long Term Plan (2019): Key headlines for CYP

"Children and young people represent a third of our country. Their health and wellbeing will determine our future. Improving their health and wellbeing is a key priority for NHS England and NHS Improvement.

1.7 million children have longstanding illnesses, including asthma, epilepsy and diabetes. England lags international comparators in some important aspects of child health. Our young people are increasingly exposed to two new childhood epidemics – obesity and mental distress.

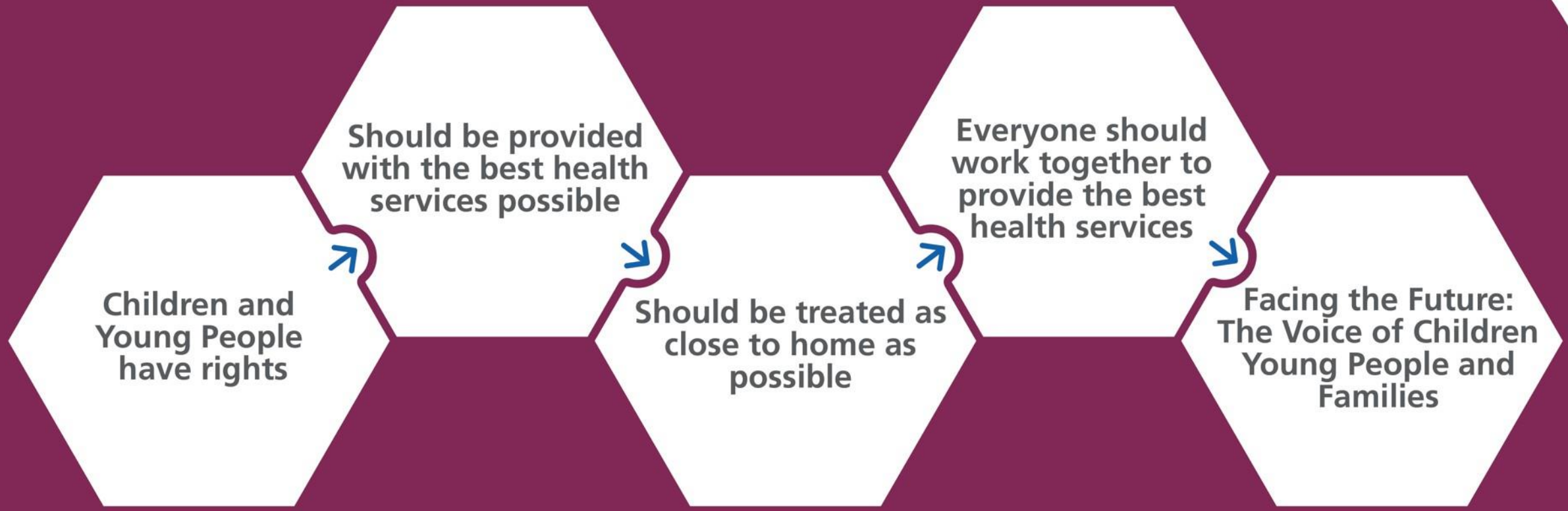
The NHS plays a crucial role in improving the health of children and young people from pregnancy, birth and the early weeks of life through supporting essential physical and cognitive development before starting school to help in navigating the demanding transition to adulthood. Working closely with local government and other public services, the NHS can also play an important role in tackling obesity and improving mental health.

The health of children and young people is determined by far more than healthcare. Household income, education, housing, stable and loving family life and a healthy environment all significantly influence young people's health and life chances. By itself, better healthcare can never fully compensate for the health impact of wider social and economic influences".

Strategic need

Services for children and young people need to be flexible, adaptable, and responsive. Our strategic plan needs to be focused and realistic. We need to be creative and engage with our local families to make the child and young person's journey through our services the best it can be.

Why do we need a strategy for CYP?



7 golden rules for CYP

Understand my rights	A chance to be involved	Remember it is my choices	Value Me	Support Me	Work Together	Keep In Touch
1	2	3	4	5	6	7
"My voice listen to me"	"We are all unique" – age, ethnicity, ability, culture, religion"	"I want to take part…I don't want to this time"	" My voice is important – things you care about might be different from things I care about or want to change"	"Think about how best to communicate with me and don't give up"	"Honesty, Respect, Learn from each other"	"Decisions, changes, why's why not's – So what happens next, let's keep in touch"

CYP commissioners

Where we are today

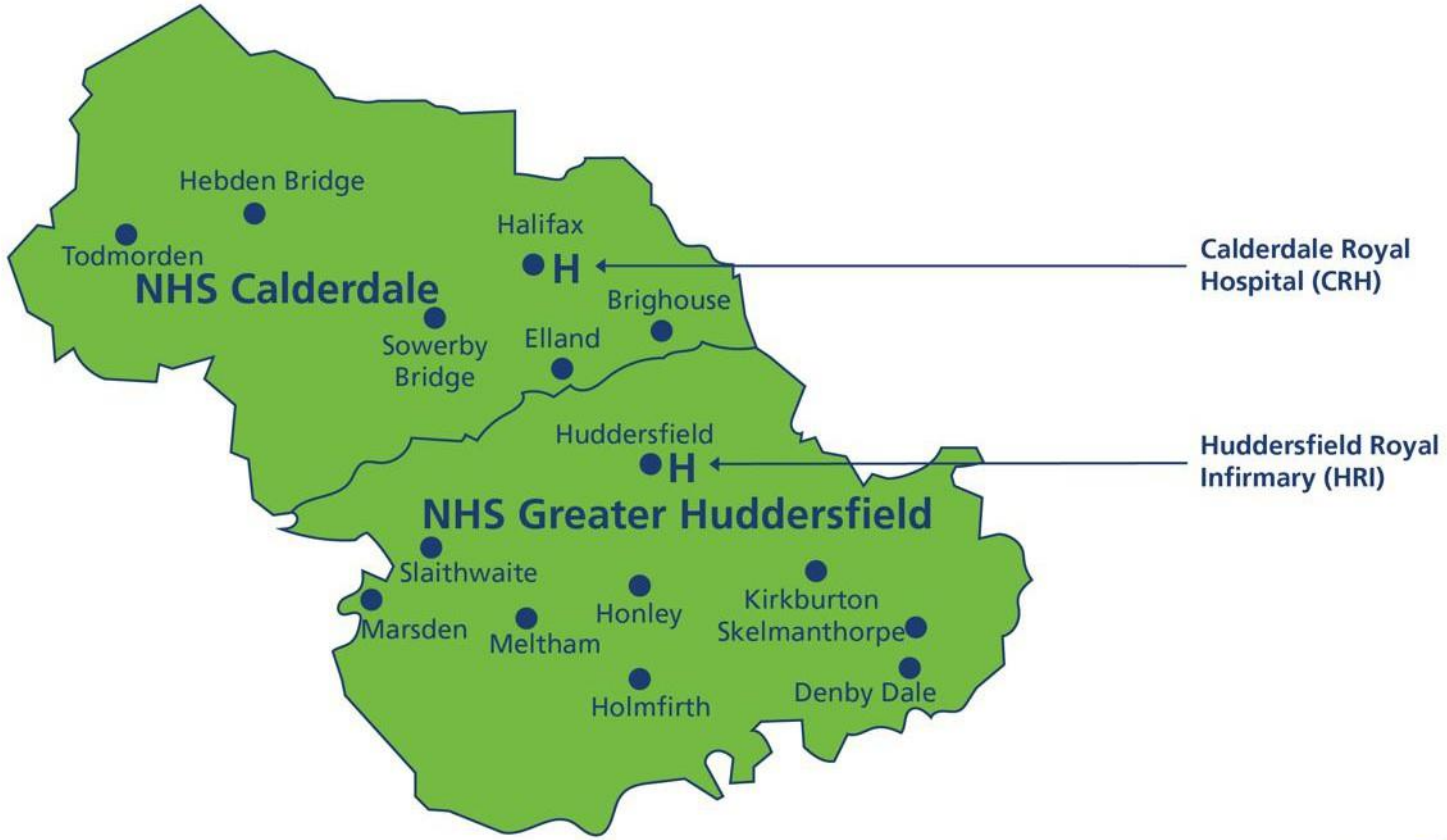
Children and young people's services at CHFT are committed to continually improve and enhance practice in line with best practice standards. As a service we have reflected on our reality, and we are keen to further develop our responses to get results.

Where are we today?

Children and Young People in CHFT - Key Outcomes from 2022 to date:

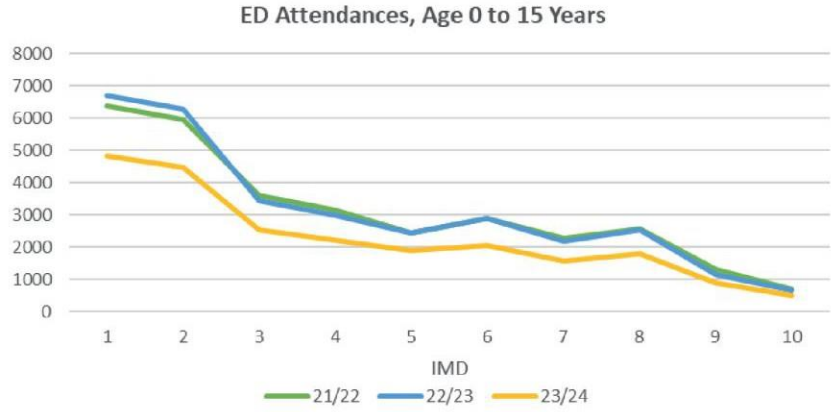
- Key Lines of Enquiry (KLOE) review of services 2023 - NHSE CYP transformation lead.
- Executive and non-executive leads for CYP.
- Children's Board - oversee and monitor the planning, provision and governance of children's and young people's healthcare across the trust to ensure opportunities for maximising outcomes.
- CYP Transformation Plan – Digital tracker of progress with a committed team on our 'Journey to Outstanding'.
- Review of CYP leadership structure completed to support strategic oversight of CYP.
- Enhanced workforce to support local priorities - transition, keyworker sudden unexplained death in children, mental health liaison, respiratory, cardiology, operational manager, governance coordinator, Paediatric Assessment Unit lead.
- Improved environments for CYP eg. Rainbow Community Hub, child friendly areas in Huddersfield and Halifax emergency departments.
- Improved paediatric nursing cover and training for paediatric ED and core play provision.
- Clinical lead NHSE, worked with the children's and emergency department leads for CHFT children's urgent care to support compliance against the RCPCH urgent care standards (June 2018).
- Transition Steering Group - oversee implementation of guidance and clinical care for all young people, including those with a learning or physical disability, transferring their care to adult services in CHFT.
- CYP mental health summit and training events for CHFT staff.
- Youth forum and young people ambassador's. Scoping development of a parents/carers forum.
- Knowing our business - key areas for service improvement for CYP within CHFT identified.

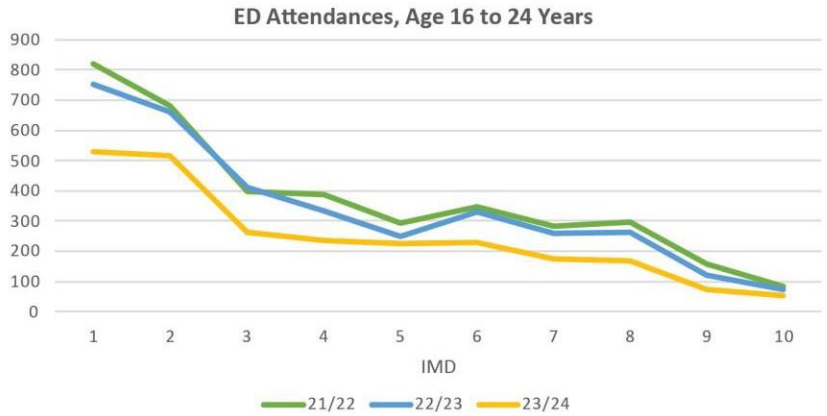
Strategy map – where are our CYP?



How many CYP access our services

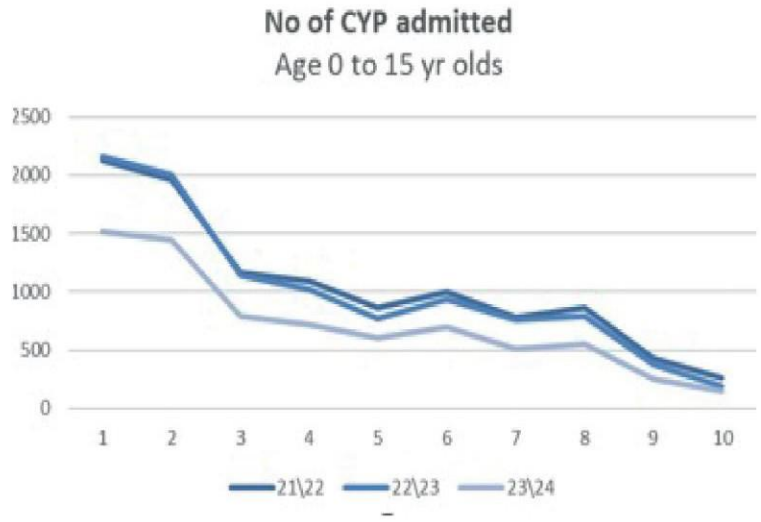
- Average annual Emergency Department attendances 35,700 CYP 0-15 years and 19,962 YP 16 -24 years
- The data shows a higher number of patients live in the most deprived areas (i.e. Index of Multiple Deprivation IMD 1 and 2).
- This trend of social deprivation is the same for CYP ED attendances, OPD attendance and admissions to hospital in each area
- (NB data for 23/24 not full year)

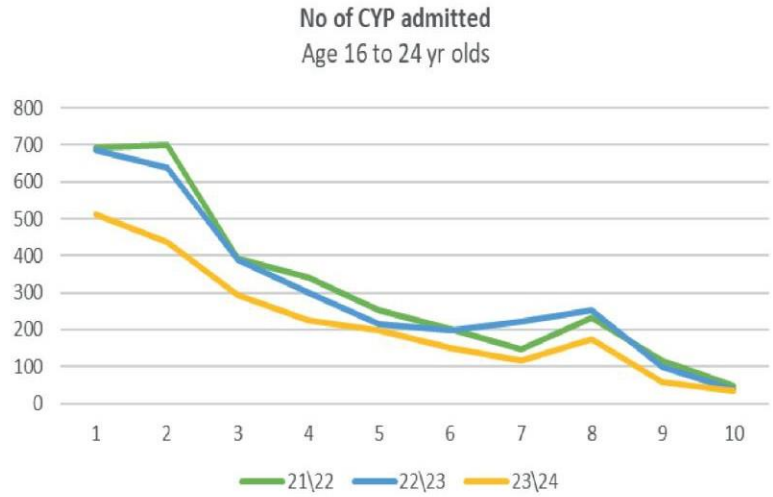




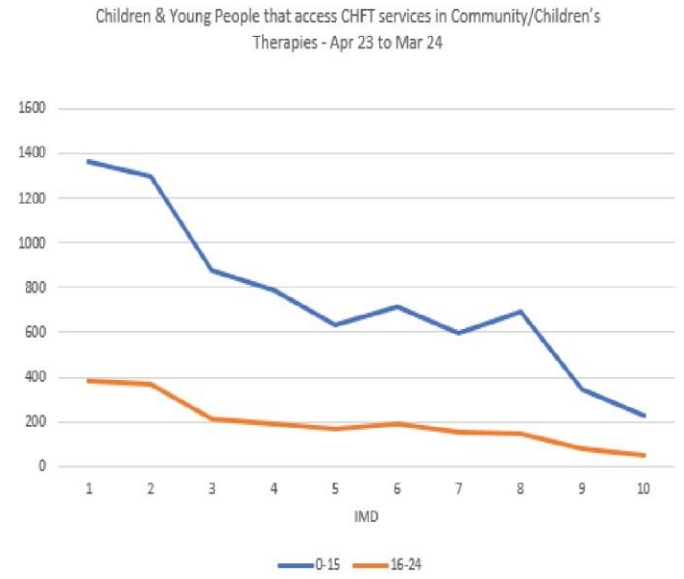
Numbers of children admitted to hospital 2021-2024

Average annual admissions to hospital 34,810 CYP 0-15 years and 18,868 YP 16 -24 years. (NB 2024 not full year data).





Children and young people that access CHFT services in Community and Children's Therapies April 23-Mar 24



7,567
0-15 years

1,969
16-24 years

Similar trend of higher numbers of IMD 1 & 2 reflective of our local community.

The challenges ahead

In the face of many challenges, including a global pandemic, climate change and ongoing inequality, this generation of children and young people are ambitious, socially conscious, and passionate. Children simply hope for a fair chance and value a society where all can have success. As adults we need to make sure that this is the case (CYP Voice Summit - Children's Commissioner 2024).

So, what is important for CYP at CHFT...

REDUCING HEALTHCARE INEQUALITIES FOR CHILDREN AND YOUNG PEOPLE

NHS

CORE20
The most deprived **20%** of the national population as identified by the Index of Multiple Deprivation

The **Core20PLUS5** approach is designed to support Integrated Care Systems to drive targeted action in healthcare inequalities improvement

Target population

PLUS
ICS-chosen population groups experiencing poorer-than-average health access, experience and/or outcomes, who may not be captured within the Core20 alone and would benefit from a tailored healthcare approach e.g. inclusion health groups

CORE20 PLUS 5

Key clinical areas of health inequalities

1. **ASTHMA**
Address over reliance on reliever medications and decrease the number of asthma attacks

2. **DIABETES**
Increase access to Real-time Continuous Glucose Monitors and insulin pumps in the most deprived quintiles and from ethnic minority backgrounds & increase proportion of children and young people with Type 2 diabetes receiving annual health checks

3. **EPILEPSY**
Increase access to epilepsy specialist nurses and ensure access in the first year of care for those with a learning disability or autism

4. **ORAL HEALTH**
Address the backlog for tooth extractions in hospital for under 10s

5. **MENTAL HEALTH**
Improve access rates to children and young people's mental health services for 0-17 year olds, for certain ethnic groups, age, gender and deprivation

Health care inequalities:

Living with a long-term condition (LTC)

> Evidence suggests young people's health declines during transition for example young people with epilepsy are at higher risk of sudden unexpected death in epilepsy (SUDEP) and there are cases where young people are disengaging with medication in diabetes. A significant amount of CYP with asthma are also from the most deprived backgrounds, at least half are from low socio-economic backgrounds
>
> We have a responsibility to adopt an all - age approach earlier.
>
> CYP with LTC's become adults with LTCs.
>
> Start young to create good health earlier as a preventative measure.

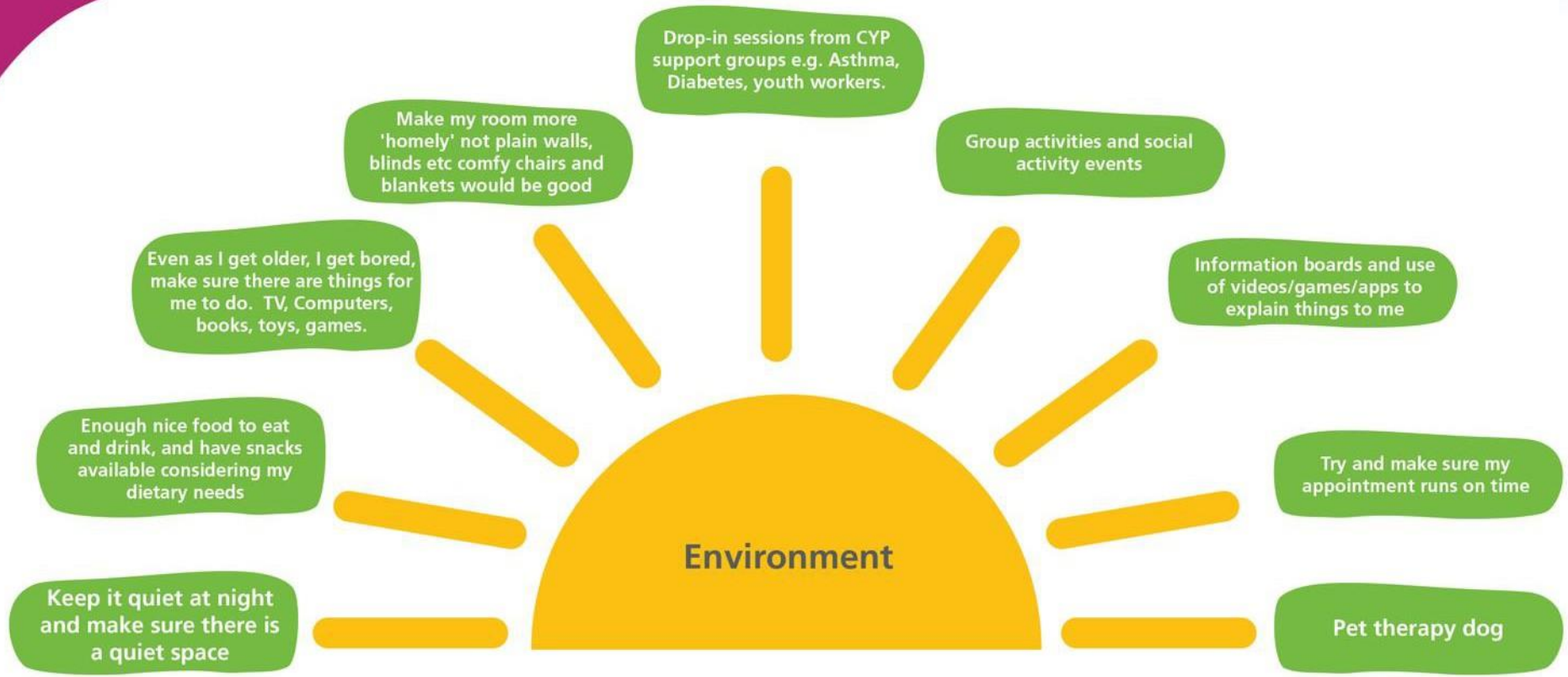
(NHS WY ICB CYP Long Term Conditions)

People's voices in CHFT

We have engaged with local children, young people and families and would like to share the feedback of what is important to them.

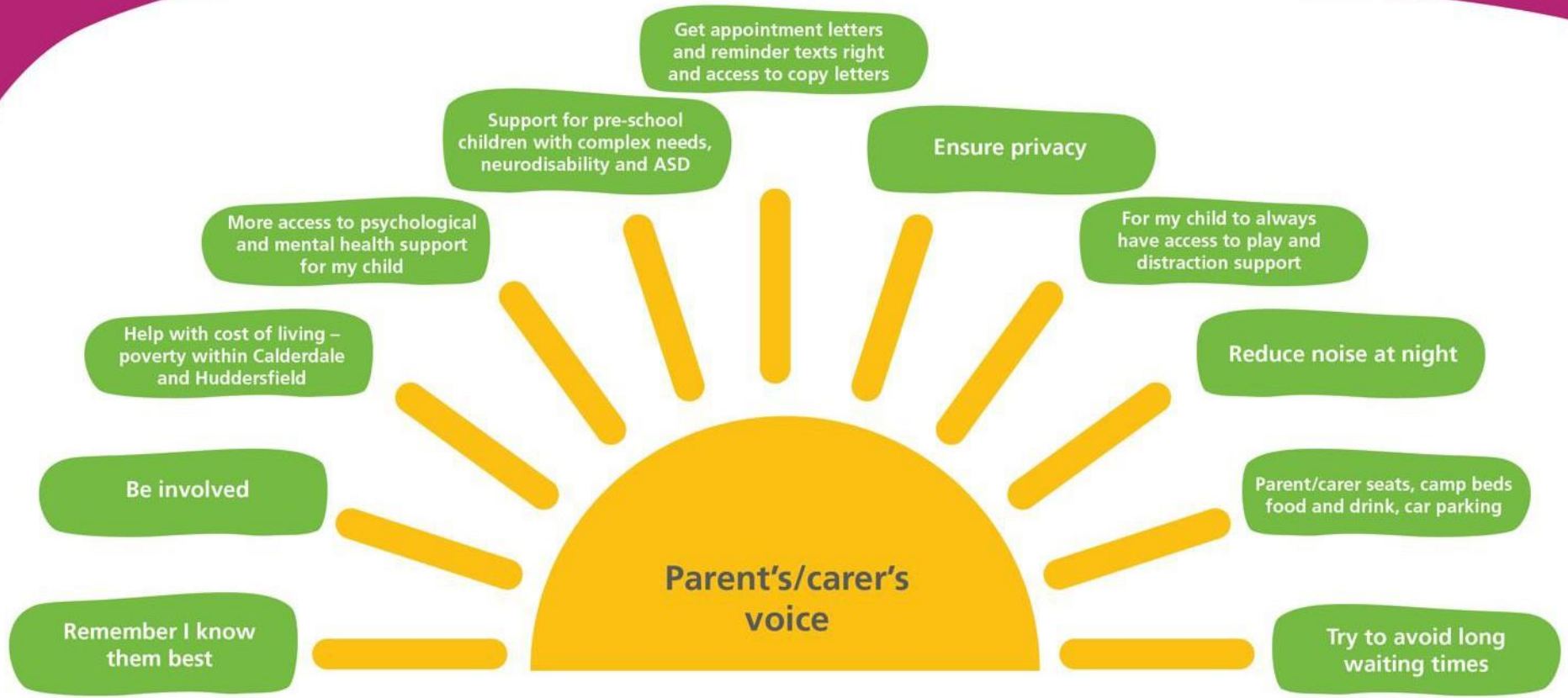
What our local CYP think

What our local CYP say



What our local CYP want

What our local families want



Visions & ambitions for tomorrow

Our locally developed strategy is supported by CHFT charity to help brighten the care and experience of children, young people and families who access services across CHFT.

Calderdale and Huddersfield NHS Charity

CHFT response

Vision - We will look after you and your family, making sure you are treated well, kept informed and reassured, so you can trust and rely on us.

To do this - We will provide compassionate high-quality care for children and young people and their families. We work in partnership with service users to meet their individual needs. Our staff provide safe care in a suitable child friendly environment

Ambition - By July 2024, in line with the wider Trust strategy and ambitions we will develop a trust wide strategy for children and young people with agreed core values for outstanding compassionate care delivery.

To have oversight of all children and young people services within CHFT. An all-age approach across the Trust is supported by the Children's Board and a two-way floor to board culture. We will work with CYP wider partners and networks.

CHFT CHILDREN & YOUNG PEOPLE

Calderdale and Huddersfield NHS Charity

Making an amazing difference for Children and Young People at CHFT

- Opportunity to bring forward elements of the CYP strategy, short and longer term
- Opportunity to establish an unrestricted fund dedicated to CYP
- Supports in raising the profile of CHFT Charity and increased fundraising

Calderdale and Huddersfield NHS Charity

Past projects:

Tickle Flex for needle phobic children – Childrens Diabetic Clinic

A&E care Bags

Hope Packs

Enhancement to Orthopaedic Outpatients

Rainbow Community Hub

Childrens Diabetes Team Building Days

Shhh Campaign to tackle noise at night

My Forever Box

Philips Ambient Experience for MRI

Parent/Carer hygiene packs

Ray of Sunshine fundraising campaign

Aims to brighten the care and experience of babies, children, young people and their families, in hospital and within the community.

Vision – is for all babies, children and young people who are cared for by CHFT, whether in hospital or in the community to have their individual needs met, reducing avoidable distress and trauma.

Our messages

To babies, children and young people – we know that hospitals can be scary places, especially if you are in pain or worry about being sick. We know how important sleep, play distraction and entertainment are to you, so we will work hard to make sure we can provide you with a healthcare experience that meets your individual need.

To parents and carers – we know how worrying it is seeing your baby, child or young person in pain or distress, and while we will do everything possible to enhance their healthcare experience we want to look after you too. We will work hard to make sure your experience in hospital or the community as a parent or carer meets your individual needs too.

To CHFT colleagues – we will work with you to identify ways in which we can enhance the experience of babies, children, young people, their parents and carers that are over and above the everyday. This could be through funding equipment and projects, sourcing gifts in kind or increasing the number of volunteers dedicated to supporting babies, children and young people.

Calderdale and Huddersfield NHS Charity

Ray of Sunshine fundraising campaign

How we will achieve this

We are prioritising 7 key areas to raise funds and support projects:

- Help me to sleep well
- Keep me entertained and distracted
- Provide me with a homely and visually appealing environment
- Offer me peer support and social activities
- Help me to stay calm and comfortable
- Provide me with play therapy support
- Help my parents/carers feel welcome and cared for

Year 1 – 24/25

We will launch the Ray of Sunshine Fundraising Campaign and raise funds to support ongoing projects that enhance the experience of babies, children and young people through play, entertainment, distraction and peer support activities.

We will mobilise projects to make a hospital stay for parents/carers more comfortable.

We will do this by engaging with communities across Calderdale and Huddersfield fundraise in aid of the Ray of Sunshine Campaign.

We will review volunteer support and mobilise additional volunteer opportunities, such as PAT, play and reading volunteers.

Years 2-5 – 25/29

We will continue to fund the annual costs to provide play, entertainment, distraction and peer support activities.

We will work with colleagues to identify opportunities to provide a child friendly environment through service redesign/reconfiguration.

Calderdale and Huddersfield NHS Charity

Children and Young People Directorate 1 Year Strategy 24/25

Our Trust Vision:	Together with Partners we will deliver outstanding compassionate care to the communities we serve			
Our Values & Behaviours:	We put Patients and People First / We Go See / We Work Together to Get Results / We Do the 'Must Dos' / We care for ourselves and each other in the same way we care for our patients through 'One Culture of Care'			
Our Goals:	Transforming Services & Population Outcomes	Keeping the base safe – best quality and safety of care	Inclusive workforce and local employment	Financial , Economic and Environmental Sustainability
Our Results:	Work collaboratively with all other Trust Divisions to progress efficient and clear pathways of care for children and young people.	Safeguarding and promoting the welfare of children and young people must be integral to the care provided.	Ensure clear workforce models in place for all services that reflect National guidance.	Deliver an outpatient service where capacity is maximised and meets demand.
	Review and embed Same Day Emergency Care (SDEC) working across Paediatric assessment unit and outpatients. Review 'virtual ward' Children's Outreach model to enable more children and young people to be cared for in the community.	Ensure workforce models are used effectively to reflect national standards and support the safety and efficiency of Children's services. We will ensure safe staffing in both Nursing, Medical and support staff- risk assessing and putting mitigation in place and using creative thinking to look at alternative's roles Engagement in reconfiguration process for Children and Young People in line with Targeted Operating Model.	Ensure plan in place for recruitment and retention of the workforce and utilising new roles and training opportunities.	Work as a directorate with all budget holders so they have ownership of their budgets to ensure value for money.
			Review staff feedback measures and consider appropriate action planning and engagement for sustaining a positive workplace culture.	Collect and analyse clinical and patient-focused outcomes to ensure we provide the highest quality care.
	Ensure equity of service for all children and young people who travel through our outpatient service in hospital or in the community and help to address health inequalities.	Progress our journey to outstanding to ensure CQC preparedness for all services through the CYP Transformation plan, Children's Board and a two-way floor to board culture.	Put plans in place to ensure that staff wellbeing is a Directorate priority, resulting in a healthy workforce and an improved wellbeing score in the annual staff survey. Support and encourage agile/flexible working as appropriate.	Continue to implement digital solutions that enhances patient care.

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Our Goals:	**Transforming Services & Population Outcomes**	**Keeping the base safe – best quality and safety of care**	**Inclusive workforce and local employment**	**Financial , Economic and Environmental Sustainability**
Our Results:	Continue to work in partnership with children, young people, their families and carers to understand their individual needs and to advocate on their behalf to improve the care that we provide. Developing family friendly methods to capture feedback.	Learn and improve services based on feedback from incidents and near misses and patient feedback e.g. Ensure compliance with the medicines code to keep out children and young people safe.	Train and develop our staff to ensure that have the skills to deliver holistic care of children and young people.	
	Deliver the transition quality improvement plan working in partnership across all Divisions	Enhance joined-up working services across the ICB/region on improving care for children and young people with mental health and social care needs	Refresh the Governance structure of the Children Directorate to ensure everyone has clarity of individuals roles and responsibilities	
	Ensure improved advanced care planning/end of life care for children's young people and their families			

Trust wide CYP strategic planning and delivery

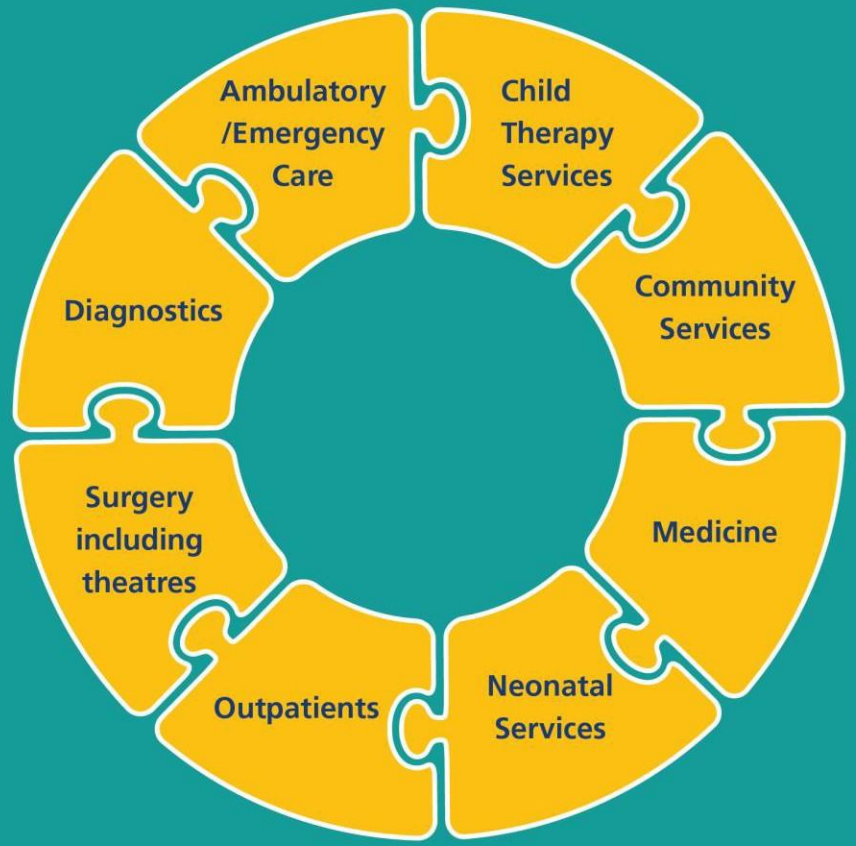
This involves not only the Children's Directorate, but all services that touch the lives of children requiring healthcare in our Trust.

It is expected that services will be delivered smoothly, which are appropriate to the age and needs of the child or young person, with staff in the workforce who have the right skills that offer evidenced based interventions.

We are keen to work with teams who have services for children and young people across the Trust

"Invest today for our adults tomorrow"

Consider "If not me who" ....
Can you help champion services for Children and Young People in your area?



Overarching Trust Strategy for Children Young People 2024 - 2029

Our Trust Vision:	We will look after you and your family, making sure you are treated well, kept informed and reassured, so you can trust and rely on us			
Our Values & Behaviours:	We put Patients and People First / We Go See / We Work Together to Get Results / We Do the 'Must Dos' / We care for ourselves and each other in the same way we care for our patients through 'One Culture of Care'			
Our Goals:	**Transforming Services & Population Outcomes**	**Keeping the base safe – best quality and safety of care**	**Inclusive workforce and local employment**	**Financial , Economic and Environmental Sustainability**
Our Results:	Partnership working across divisional teams and wider external networks (e.g. Childrens social care WYATT, CAMHS, ICB, ODN, NHSE, Healthwatch,)	Governance Children's Board that oversees and monitors the planning provision and governance of CYP healthcare across the Trust to ensure opportunities for maximising outcomes. To do this the Board will oversee the delivery of an overarching CHFT CYP Transformation Plan.	Safe staffing – National core standards for CYP - RCPCH –medical staffing, RCN in line with local benchmarks, service reviews and Safer Nursing Care Tools.	Cohesive working between clinical, finance, leadership, medical device and procurement teams to ensure cost efficiency and purchase/maintenance of assets
	Core values for Trust wide care delivery for CYP Safeguarding vulnerable CYP and families – 6 principles of safeguarding, Protection, Partnership, Accountability, Empowerment, Prevention and Proportionality. Consent and Mental capacity– ensuring CYP are involved CYP and family friendly communication Child friendly environment	Risk and compliance –CYP Transformation Plan - Best practice guidance for CYP, ongoing assurance linked to speciality standards , evidence-based practice (e.g. NICE, RCPCH, ODN), Research based practice to improve children's outcomes.	Safe levels of staffing to support CYP and their families: Leadership, Medical, nursing, allied health professionals, therapy, play, operational, administrative, support staff.	Supporting families living in poverty with access to treatment, e.g., NHS travel costs scheme, navigating and negotiating appointments, signposting to support and education
	Sophie's Legacy –e.g., enhanced provision of Play & Distraction, Improvements to food for children in hospital and parents to be fed when staying with their child.	Learning and Improvement - responses and approach to investigation under PSIRF which will be an MDT and Multi system approach with focus on learning and involving families. Subject Matter Experts (SME) for CYP. Patient Safety partners and link to the patient experience and involvement strategy.	Essential paediatric key training skills for staff caring for CYP –Paediatric positive approach. Scope essential skills required for the workforce model of staff & learners.	Identify recommendations for changes to workforce and service delivery to support the care of Children and young people Trust wide.

Overarching Trust Strategy for Children Young People 2024 - 2029

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Our Goals:	**Transforming Services & Population Outcomes**	**Keeping the base safe – best quality and safety of care**	**Inclusive workforce and local employment**	**Financial , Economic and Environmental Sustainability**
Our Results:	Advocacy for CYP through Service redesign/reconfiguration Voice of the child, Continue to work in partnership with children, young people, their families and carers to understand their individual needs and to advocate on their behalf to improve the care that we provide e.g. Youth Forum/ Young Ambassadors. You're Welcome, Young People's Health Challenge, Harvey's Gang. Parent/Carers Forum	Safety and culture – civility work aligned to one culture of care, Embedding culture of family centered care – "who is important to me" Martha's rule , management of deteriorating patient.	Recruitment & retention of staff skilled in caring for CYP, Paediatric SNCT, succession planning, staff engagement CYP international recruitment. – Link with Trust wide training needs analysis strategy CYP apprenticeships.	
	Provision of an integrated urgent care service providing one point of access for urgent care.	Developing leaders at all levels to think about safety impact for CYP.	Supporting learners in placements and scope CYP QI placement for learners.	
	Development of Virtual ward/ Children's Outreach	Preparation for external reviews. Actively invite feedback about our services, new assessment framework, development of accreditation framework J2O refresh and how this is used.	Responsive training and clinical education in line with changing needs of service provision e.g., care of young person in mental health crisis, Same day emergency care, CYP friendly areas with appropriately trained staff where children are seen in an adult hospital setting.	
	Embedding Transition to adult services			
	Ensure equity of service for all children and young people who travel through our outpatient service in hospital or in the community and help to address health inequalities Ensure improved advanced care planning/palliative /end of life care for children's young people and their families.	Triangulation of claims, incidents and complaints involving CYP to identify areas of improvement	Review of Psychological support for CYP living with chronic illness Scope enhanced links with social services e.g. Hospital social worker , access to youth workers, voluntary services.	

Our journey forward

Trust wide approach to continue our journey forward to make an amazing difference for children and young people in CHFT.

Implementation, tracking and managing progress

Take home message

Listen and engage me in decisions about my care

Be welcoming; attitude and communication play a big part in how I respond

Respect my rights and remember it can be a scary situation that I am in

Create an environment that builds trust and keeps me safe

If you have any questions...

Visit: CHT.NHS.uk
Email: CHFT@CHT.nhs.uk

Support the Ray of Sunshine campaign

Make an amazing difference for Children and Young People by donating to the Ray of Sunshine Campaign.

Visit: www.chftcharity.co.uk
Email: chft@cht.nhs.uk

Calderdale and Huddersfield NHS Charity are the official charity of Calderdale and Huddersfield NHS Foundation Trust. Registered charity number: 1103694.

5. Minutes of the previous meeting held on 4 July 2024

To Approve

Presented by Helen Hirst

Chair Approved Minutes of the Public Board of Directors Meeting held on Thursday 4 July 2024 at 9.00 am, Boardroom, Learning Centre, Huddersfield Royal Infirmary

PRESENT

Helen Hirst	Chair
Brendan Brown	Chief Executive
Rob Aitchison	Deputy Chief Executive
David Birkenhead	Medical Director
Gary Boothby	Director of Finance
Suzanne Dunkley	Director of Workforce and Organisational Development (OD)
Lindsay Rudge	Chief Nurse
Nigel Broadbent (NB)	Non-Executive Director
Tim Busby (TB)	Non-Executive Director
Denise Sterling (DS)	Non-Executive Director
Peter Wilkinson (PW)	Non-Executive Director
Vanessa Perrott (VP)	Non-Executive Director
Jo-Anne Wass (JW)	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)*
Alison Edwards	Head of Safeguarding **(for item 85/24)**
Gemma Puckett	Director of Midwifery and Women's Service **(for item 88/24)**
Carol Gregson	Freedom to Speak Up Guardian **(for item 101/24)**
Caroline Lane	Freedom to Speak Up Guardian **(for item 101/24)**

OBSERVERS

Brian Moore	Public Elected Governor **(Lead Governor)**
Sarah Wilson	Head Nurse, Community

There were three members of the public in attendance to observe.

80/24 Welcome and Introductions

The Chair welcomed everyone to the Board meeting held in public, in particular the presenters, members of the public observing and Alison Edwards, Head of Safeguarding who was in attendance to present the patient story.

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

81/24 Apologies for absence

No apologies were received.

82/24 Declarations of Interest

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

83/24 Minutes of the previous meeting held on 2 May 2024

The minutes of the previous meeting held on 2 May 2024 were approved as a correct record.

OUTCOME: The Board **APPROVED** the minutes from the previous meeting held on 2 May 2024 as a correct record.

84/24 Matters Arising and Action Log

The action log was reviewed and all actions were completed.

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

85/24 Patient Story – Modern Day Slavery, including the Safeguarding Adults and Children Annual Report

The Chief Nurse introduced Alison Edwards, Head of Safeguarding, who was invited to present a patient story on modern day slavery. Alison described how we may encounter modern day slavery in everyday lives as well as our professional lives, explained how safeguarding has evolved (now broader and more complex), the prevalence of modern day slavery in the UK and the importance of staff having the skills to recognise and respond to the everchanging context.

Alison shared a case study of human trafficking which was referred to the Domestic Abuse Hub at Calderdale and had a positive outcome.

Alison asked Board members for their commitment and action to prevent modern day slavery across the broader community in both their professional and personal lives, reporting any concerns to the Police.

The Chief Nurse thanked Alison for demonstrating the complexity and breadth of safeguarding.

The Chair asked if the domestic abuse hub serve both Kirklees and Calderdale. Alison responded the domestic abuse hub is only at Calderdale. The work in Kirklees is managed by Locala.

JW asked if there were any concerns with mandatory training compliance. The Chief Nurse responded the deteriorating position in safeguarding training compliance was expected whilst updating the training to align with intercollegiate documents, noting an assurance regarding improvement in training compliance towards the end of the year had been given to the Quality Committee. Alison explained there is a requirement nationally for certain levels of safeguarding training to take place face to face and it has taken some time to re-introduce this post Covid. The Chief Nurse and Head of Safeguarding confirmed there is good feedback on the training which focuses on good discussions and case studies.

The Chair asked how the Trust support staff in a busy Emergency department (ED) spot the signs of modern slavery. Alison responded they were delivering ED adult bespoke training and were about to launch the children ED bespoke training as the department felt staff in ED have a requirement to undertake a higher level of training. The Chief Operating Officer re-iterated there are different requirements for different staffing groups and asked if the site team working 24/7 can receive the training as they will be a point of contact for any concerns.

VP asked what their mechanism was for sharing learning following a safeguarding case. Alison confirmed they share any learning via briefings, Safeguarding Champion Networks, operational group, Safeguarding Committee and through Divisions which can be cascaded. If there is a case from a particular area, debriefs and targeted learning takes place.

<u>Safeguarding Adults and Children Annual Report</u>

The Safeguarding Adults and Childrens Annual Report was received by the Board which provided an overview of Safeguarding activity within the Trust for the reporting period April 2023 – March 2024.

TB asked how the Trust monitor success with a multi-agency approach and developing new multi-agency pathways. Alison responded the multi-agency pathway approach was introduced as

a result of learning following a complex case and prolonged stay in hospital. This has now been agreed and a report on this was received at Quality Committee. A Task and Finish Group is looking at any learning from this and how to improve the process which will report into the Health Assurance Improvement Group that sits across all agencies. In addition, the children's partnership is arranging a progress event and undertaking an audit.

There was a discussion on mental health support and the successful mental health liaison nurse role, further information on this will be included in the next report.

PW asked if prevention and the pressure to discharge is an area that continues to be a pressure point. Alison responded there is pressure to get the right provision for adults and children to ensure they are safe for discharge, and they are working closely with partners and the local authority to improve the flow.

OUTCOME: The Board **NOTED** the modern day slavery patient story and **APPROVED** the Safeguarding Adults and Children Annual Report which detailed activity of the Safeguarding Team for the reporting period April 2023 – March 2024.

86/24 Chair's Report including the Charitable Funds Committee Annual Report 2023/24

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

As Corporate Trustee, the Charitable Funds Committee Annual Report for 2023-24 was presented for approval. This report will be presented at the Audit and Risk Committee in July 2024.

OUTCOME: The Board **NOTED** the Chair's Report and **APPROVED** the Charitable Funds Committee Annual Report for 2023/24 as Corporate Trustee.

87/24 Chief Executive's Report

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

The Director of Workforce and OD provided an update on sexual safety at work. 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 Healthcare 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. 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.

The Chief Digital and Information Officer provided an update in relation to the cyber attack incident on 4 June 2024 at a London Trust's pathology system supplier called Synnovis. This was a ransomware attack and the Chief Digital and Information Officer confirmed CHFT do not use this supplier and were not impacted by this. A number of national calls have been taking place to talk through the incident and provide advice and guidance. The Trust are taking all appropriate action to keep the base safe and a cyber security risk is on the Board Assurance Framework. NB advised the Audit and Risk Committee plans to review assurances on third party systems at its October 2024 meeting.

JW asked if staff are blocked from using systems if they are not up to date with their mandatory training. The Chief Digital and Information Officer responded access is not blocked due to new

starters and leavers; however, there are some restrictions made on the Electronic Patient Record (EPR).

The Director of Corporate Affairs and Chief Operating Officer shared a slide presentation in response to a recent letter from NHS England on emergency care following undercover filming in ED at Shrewsbury and Telford Hospital which has six recommendations to consider as a Board. The presentation provided context on high attendance levels in the Trust EDs, the increased acuity of patients attending ED, the governance arrangements for urgent care across the system and three key schemes these oversee, as well as the in hospital and out of hospital improvement actions in the Urgent and Emergency Care Recovery Plan year 2. Assurance sources for Board members on standards of care were highlighted. The Medical Director gave an update on the position against the seven day services Board Assurance Framework which had been reported to Quality Committee. Executive leadership and escalation protocols were outlined. A further update will be provided at the next Board meeting.
Action: Update on emergency care response to be provided in September 2024 and slides to be circulated to the Board.

The Chair highlighted the opening of the new Emergency Department in May 2024 and the level of organisational planning that went into this. She explained this was a fantastic demonstration of a full multi-disciplinary team effort.

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

STRATEGY: TRANSFORMING AND IMPROVING PATIENT CARE

88/24 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 noted were:

- Maternity incentive scheme was on track to achieve compliance against all 10 safety actions.
- Saving Babies Lives Care Bundle has seen an improvement in overall compliance.
- Listening to women and families lived experience is embedded in key forums including clinical audit sessions with the medical team.
- Successful recruitment programme of newly qualified midwives with circa 31 WTE offered posts at CHFT Successful recruitment programme, this is great news and will reduce vacancies to fewer than 10% if all those offered posts commence in post in October 2024
- Wraparound support package for a large intake of newly qualified midwives is being put in place to ensure a successful preceptorship programme.
- Perinatal culture programme is progressing with 4 themes identified for focussed quality improvement work.
- Rate of stillbirths at CHFT is more than the national average and 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. A system wide response to the findings is the next step.
- A deep dive of postpartum haemorrhage rates will take place due to flagging as amber twice and red twice over the last 4 months.
- The maternity workforce is not representative of the local community and bespoke engagement is needed to understand how to develop a more representative workforce.

The Director of Midwifery stated she was proud of how the team have responded to some complex cases recently and there will be focus on positivity week next week following a thank you day.

TB asked if the Trust has identified all they can do to understand the root cause of the stillbirth rates. The Director of Midwifery responded the Trust have followed the clinical pathways

prescribed nationally and they are focusing on how to make this more individualised with the increase in complexities. The Obstetric clinical lead is undertaking a piece of work to make the guidelines as clear as possible and pilot the social vulnerability tool, however there was no single root cause.

TB queried whether it was possible to get to a full establishment recruitment position sooner than three years. The Director of Midwifery responded they have worked hard on recruitment and they need to work equally hard on retention. The focus on full establishment over three years is due to the national shortage of midwives and they are reliant on a training programme to get to a full workforce position. She explained there were lots of enquiries made at the Nursing and Midwifery Strategy launch day and they are looking at putting on a midwifery day to gain more interest.

TB asked for an update on the training trajectory and recovery of this position. The Director of Midwifery responded they have changed the way staff are trained and will report on this by December 2024.

VP commented the root cause analysis is complex and highlighted BMI is in proportion to the social status and asked who the Trust were working with to address this. The Director of Midwifery explained they were working with the ICB Maternity Programme Manager on BMI in pregnancy and they are looking for a system response to support women to reduce their BMI prior to pregnancy, this will need primary care support. She explained the Trust also run a BMI care clinic.

VP stated it is powerful to hear voices and she asked how the Trust make sure actions are fact based. The Director of Midwifery responded they are looking at making birth plans more visible to staff so birth partners or women can update this proactively. The Chief Nurse explained they have agreed to have qualitative and quantitative measures through the Labour Board which will report to Quality Committee.

The Chief Executive asked for an update on when actions are going to start and the impact of this in the next report. He challenged the Trust to lead on some of this work, for example, calling a quality summit to look at the breadth of this. The Chief Nurse confirmed a conversation is underway with the Chief Nurse in the Integrated Care Board (ICB).

DS asked what the university are doing to recruit a more diverse workforce and understand themes or trends. The Director of Midwifery responded the current workforce is not representative of our communities and the local maternity and neonatal system (LMNS) were looking at this with bespoke engagement at the University. She explained people enter the programme without realistic expectations and stated it is a wonderful, rewarding career but emotionally challenging. The Trust are looking at being part of the recruitment process in a more meaningful way and the Director of Midwifery is keen to be involved in discussions about career choices.

The Chief Operating Officer explained how data can be used to help staff recognise the most vulnerable patients with poorer outcomes, explaining they recently used data to identify the most likely to be admitted. This work will be taken through the Health Inequalities Group. The Director of Midwifery added they use the social vulnerability tool to identify social metrics and the most vulnerable patients are flagged on the system with regular MDT reviews. They are exploring funding from the LMNS to understand how to contact vulnerable patients and offer support, such as offering transport to patients who are unable to attend.

The Chair commented there are a number of positive concrete actions being implemented and asked to see the progress on these in the next report. She also asked that the report described the positive stories about what had gone well, particularly in the complex births, as learning from

good practice is just as relevant. She asked for an update to be provided on what the Trust have been pro-actively doing to retain the newly qualified midwives recruited and for the outcome of this to be reported after the October intake.

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

89/24 **Annual Strategic Plan – 2024/25 Progress Report**

The Director of Transformation and Partnerships presented an update on progress against the 2024-25 annual strategic plan. This provides an update on year two against the 5 year strategic plan agreed in 2023. All 15 strategic objectives are rated green and on track.

NB said it was good to see the link to the BAF and asked about the correlation between the increased risk proposed for clinical strategy on the BAF and the strategic objective rated as green and on track. The Director of Transformation and Partnerships explained these were two different types of risks, with the one year objective looking at what actions are taking place in year and the BAF looks at broader strategic risks which can impact the overall Trust ambitions. The Director of Corporate Affairs confirmed this report provides an update on the current year, not the five year plan.

OUTCOME: The Board **NOTED** the assessment of progress against the 2024-25 strategic plan.

INTEGRATED PERFORMANCE

90/24 **Quality Committee Chair Highlight Report**

DS presented the Chair's highlight report from the Quality Committee meetings of 28 May, 3 June and 2 July 2024. The key points noted were:

- Approved the 2023/24 Quality Account on 2 July 2024 with delegated responsibility from the Board of Directors.
- New approach inviting Divisions to present their quality reports which is going well and identifies areas for continued focus.
- Patient experience and involvement group has established four key strategic priorities – excellent work moving agenda forward aligning with the Health and Social Care Act 2022.
- Internal re-audit on Local Standards for Invasive Procedures (LOCSSIPS) – seven of the nine recommendations are fully implemented and two are partially implemented. Compliance is being monitored by senior management.
- Making progress on the delivery of the quality improvement priorities.
- Cancer Delivery Group report highlighted that radiotherapy treatment times at Leeds Teaching Hospitals Trust (LTHT) have significantly deteriorated over the last six months. Discussions to explore mutual aid is underway, though at present there is no timeframe for improvement and this remains a challenge.
- Research and development bi-annual report highlighted the Trust are submitting jointly with two neighbouring Trusts to become a commercial research centre.
- Reviewed the CQC "must do" and "should do" actions which were now closed.
- Quality Committee had received a report on the Trust's assessment of its paediatric audiology services, the results of an external review by NHS England North East and Yorkshire and progress towards compliance with the UKAS IQIP. It was noted that no incidences of a child suffering detriment due to delayed or missed diagnosis or treatment or not received timely follow up care and support. A report on progress had been shared with the CQC.

The **Infection, Prevention and Control Report for Q4** was received. Performance did not hit all targets set and aligns with regional and national trends, for example clostridium difficile. The planned move to Patient Safety Incidence Response Framework PSIRF for review of HCAI's in

line with national guidance. The number of closed bed and areas during Q4 were mainly due to norovirus or covid outbreaks, this was impacted by the high occupancy rate of 98% which affected isolation. A thematic review will inform the IPC team annual plan.

The Chief Operating Officer advised he had spoken to the Chief Operating Officer at LTHT about their actions in relation to the cancer radiotherapy waiting times and a discussion is taking place at the West Yorkshire Association of Acute Trusts (WYAAT) Chief Operating Officers meeting and the Cancer Alliance, with no resolution yet.

OUTCOME: The Board **NOTED** the contents of the Quality Committee Chair Highlight Report and **NOTED** the Q4 Infection, Prevention and Control Report.

91/24 Workforce Committee Highlight Report

JW presented the Workforce Committee Chair's highlight report for the meeting held on 12 June 2024 which focused on colleague engagement from the People Strategy. The key points noted were:

- Looking at colleague engagement through an equality, diversity and inclusion lense.
- Fantastic presentation from Emma Mooney and Amy Sheddon, Clinical Operations Managers for transformation and modernisation about changes made within theatres to improve utilisation, reduce waiting times and improve patient outcomes.
- Majority of workforce metrics continue to hit or exceed target.
- In month sickness in April 2024 was down to 4.41%. The target has been reset to a lower value of 4.5%.
- Reviewed BAF risk 10b/19 regarding nursing staffing levels and agreed the score to remain at 12.

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

92/24 Finance and Performance Committee Chair's Highlight Report

VP provided an update from the Finance and Performance Committee meeting held on 2 July 2024. The key points noted were:

- 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%.
- Diagnostic performance is improving with overall performance to 94% and continued progress in echo and Neurophysiology which have been dealt with incredibly by the team.
- 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, outpatient follow ups are considered important for patient care and quality.
- Revised financial plan has resulted in a reduced deficit plan from £38.6m to £26.26m which was on track at month 2, reporting a favourable variance of £0.2m.
- Efficiency savings have been stretched to £32.2m which brings the Trust in line with other Trusts. The schemes have a recurrency level of 68% which brings a challenge for next year.
- Due to the financial changes and uncertainty, a review of the financial sustainability BAF risk took place which is currently rated at 20, this remains the same.
- Approved the National Cost Collection pre-submission report which provides benchmarking financial information nationally and is used locally in planned care reviews, feeds into GIRFT and is used to assess potential CIP areas.
- Complaints performance and stroke performance was discussed at both Quality Committee and Finance and Performance Committee and a stroke deep dive will take place later in the year.

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

93/24 Budget Book 2024/25

The Director of Finance presented the final financial plan and budget for 2024/25 for approval. The Budget Book provides a summary of the 2024/25 final financial plan as submitted to NHS England (NHSE) including the cash flow position and balance sheet.

TB asked if there were any restrictions or risks associated with securing the additional Public Dividend Capital (PDC) funding and queried whether this included £10m for HPS. The Director of Finance clarified the HPS capital monies were received last financial year and there was some internal brokerage between capital schemes.

The Director of Finance confirmed the revenue cash support requested at month 2 was rejected, with only 25% of the request received, due to there being sufficient cash availability in the West Yorskhire system, He noted there were no immediate implications for suppliers, however this was a future potential risk and a cash risk had been added to the risk register.

NB asked if the budget book can be shared earlier in the process with the Finance and Performance Committee. The Director of Finance agreed, explaining the movement in headcount would need reviewing at the Committee.

OUTCOME: The Board **APPROVED** the 2024/25 Budget Book.

94/24 Month 2 Financial Summary

The Director of Finance presented the financial position as reported at the end of Month 2, the key points noted were:

- The plan has been re-submitted in June and the changes have been reflected in the forecast position.
- 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 strong and slightly above the planned level.
- Year to Date the Trust has delivered efficiency savings (CIP) of £3.14m, £0.08m higher than planned.

OUTCOME: The Board **NOTED** the Month 2 Financial position for the Trust as at the end of May 2024.

95/24 Audit and Risk Committee Chair Highlight Report and Committee Annual Report 2023/24

NB presented the Audit and Risk Committee Chair's highlight report for the meeting of 25 June, the key points noted were:

- 2023/24 accounts, financial statements and the annual report were all approved.
- Significant assurance was given by the Head of Internal Audit Opinion 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 two recommendations overdue with revised target dates.
- Limited Assurance - Only four 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 Committee to ensure that they are being implemented in a timely manner. The limited

assurance which related to risk management arrangements was not a concern for the Head of Internal Audit Opinion as the Trust were implementing a new risk management system.
- The 2023/24 accounts were unqualified by the Trust's external auditors, KPMG. No significant weaknesses identified on financial sustainability, governance and improving efficiency, economy and effectiveness.
- The Annual Members Meeting has been postponed until October 2024 due to the elections.

NB presented the Audit and Risk Committee Annual Report for 2023/24 which demonstrated the Committee met its terms of reference.

NB and the Chair thanked all the teams involved and noted the 2023/24 annual accounts would be presented at the Annual Members Meeting in the autumn.

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

96/24 **Integrated Performance Report**

The Chief Operating Officer presented the Integrated Performance Report for May 2024.

TB challenged whether the Trust are making the most of virtual ward as utilisation seems to fluctuate with only five day cover as seven day cover is not funded. The Chief Operating Officer responded utilisation has improved, demand fluctuates and noted he would look at how we assure ourselves that the community offer is fully utilised; flexibility is key and the urgent community response (UCR), virtual ward and home first principle should help with this. TB queried whether funding was an issue and the Chief Operating Officer advised conversations about funding will take place at the Urgent and Emergency Care Board. Two additional posts at CRH are being recruited to support the additional work taking place on pathway 1 at CRH.

The Chief Operating Officer confirmed the NHSE emergency care letter discussed earlier is also on the place Board for discussion and a place based response.

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

A WORKFORCE FOR THE FUTURE

97/24 **Safer Staffing Annual Report**

The Chief Nurse presented the paper which gave an overview of Nursing, Midwifery and Allied Health Professional (AHP) staffing capacity and compliance in the 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. The key points noted were:

- Successful recruitment into midwifery was positive.
- Positive trajectory for Band 5 registered nurses to have no vacancies by September 2024. 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.
- Strong narrative around growing our own workforce.
- AHP position has much improved – significant work has been taking place.
- BAF risk score remains at a rating of 12 for nursing staffing and 16 for midwifery staffing until vacancies are filled.
- Care Hours Per Patient Day (CHPPD) is a national metric and review of this data reveals CHFT to be in quartile 2 providing 8.1 CHPPD at Trust level.

The Chair highlighted it was encouraging to see improved representation across staff groups.

OUTCOME: The Board **APPROVED** the ongoing plan to provide safe staffing provisions within nursing, midwifery and AHP disciplines across the Trust.

98/24 Public Sector Equality Duty (PSED) Annual Report

The Director of Corporate Affairs presented the Public Sector Equality Duty annual report. This was the last report of this type to the Board on how the Trust was complying with the equality duty as, going forwards, there is no requirement to produce a report and the Board will receive information on Equality, Diversity and Inclusion metrics via other reports.

It was noted that discussion would take place amongst Board members to review any further Board assurance reporting on equality, diversity and inclusion and health inequalities and their impact.

OUTCOME: The Board **APPROVED** the Public Sector Equality Duty (PSED) Report.

KEEPING THE BASE SAFE

99/24 Board Assurance Framework – Update 1

The Company Secretary presented update 1 of the Board Assurance Framework. The key points noted were:

- There is a total of 22 risks on the BAF and the top three risks remain the same.
- Finance and Performance Committee agreed to add another action onto the longer term financial risk to develop a high level medium term financial plan to return to recurrent balance by the end of March 2025.

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. The Chair asked if the clinical strategy is limited only to development of new services. The Medical Director responded the clinical strategy is broader than new services; however, there are constraints in terms of capacity to focus on other activity. The Chief Executive confirmed the strategy is broader than reconfiguration and speaks to the longer term.

The Director of Transformation and Partnerships explained the clinical strategy describes the ambition to scope and expand, including how we work together with other partners, use research and development and harness digital technology, all of which have resource constraints.
Action: 1/20 clinical strategy updated on the BAF to reflect the discussion.

NB asked if the health inequalities risk should be a higher score, which will be reviewed at the Audit and Risk Committee on 23 July 2024 and feed into the next update to the Board on the Board Assurance Framework.

OUTCOME: The Board **APPROVED** the increased risk score for clinical strategy risk 1/20, **APPROVED** the Board Assurance Framework and **CONSIDERED** any future risks.

100/24 High Level Risk Register

The Director of Corporate Affairs presented the report which gave an overview of risks scoring 15 or above.

The new system, provided by InPhase, will replace the current Datix system/Bespoke Risk Register, and will provide a more comprehensive reporting structure to Board and its committees in line with the new Patient Safety Incident Reporting Framework. A project plan is currently underway to support the transition.

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

101/24 Freedom to Speak Up Annual Report

Carol Gregson, Freedom to Speak Up (FTSU) Guardian who has been in post since January 2024 presented the Freedom to Speak Up Annual Report and Caroline Lane was introduced who was in her first week in post as Freedom to Speak Up Guardian.

- From 1 July there are two Freedom to Speak Up Guardians, each working 0.5 WTE to support speaking up in the Trust.
- FTSU now sits under the Corporate Division under the Director of Corporate Affairs, with Jo Wass as Non-Executive Director champion.
- 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.
- Focus is on anonymous concerns, hard to reach areas and protected characteristics.
- Care Quality Commission (CQC) new single assessment framework includes a full section on FTSU and we are undertaking a review of our compliance with the CQC quality statements.
- Ethnicity - The total number of FTSU request made during 23-24, 9% were from a BAME background, 58% had not declared and 32% from a white background.

TB highlighted the 10% increase in number of concerns raised and asked if this was due to the process being embedded or less trust in managers. Carol Gregson responded there has been a steady increase in the number of concerns raised since she started and whilst the Trust embed the process in the organisation. JW stated the Trust should be looking to reduce the number of anonymous concerns raised as this was key to a culture of being confident to raise issues. JW flagged three people reported a detriment for speaking up which could suppress others from raising concerns.

The Chief Operating Officer suggested looking at where there were themes and high volumes in departments which could demonstrate where leaders are not being proactive enough and identify why these concerns haven't been explored in their own department. JW responded the Workforce Committee have agreed to triangulate the freedom to speak up data with the staff survey data to identify any hot spot areas.

The Deputy Chief Executive explained the need to balance confidentiality and asked if there was anything the Trust can do to reduce the number of anonymous concerns raised. Carol Gregson responded they have chosen to allow people to speak up confidentially. The Deputy Chief Executive suggested this should be about respecting anonymity, explaining the Trust will respond in the right way. JW highlighted the importance of feedback to the individual who raised their concern and check in on the wellbeing of the staff member.

The Chief Executive reminded the Board that we need to allow anonymous reporting and these arrangements were to ensure colleagues felt heard.

OUTCOME: The Board **NOTED** the Freedom to Speak Up Annual Report.

102/24 Complaints Annual Report

The Director of Corporate Affairs presented the report which provided a summary of complaints received in the Trust between 1 April 2023 and 31 March 2024. The key points noted were:

- Overall number of complaints received in year has decreased.
- Performance on response times has remained consistently above 80% since the improvements made in 2023 and is regularly above 90%.
- 19% of closed complaints have been re-opened. This remains relatively high and is an area of focus for the 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 strengthen both the capturing and reporting of equality data.

TB stated it is great to see number of complaints received reducing, he highlighted fewer complaints were closed than we received which was the opposite last year and asked if there was anything the Board needed to be aware of. The Director of Corporate Affairs responded this is due to operational pressures of those who are handling the complaints and some of the complexity of complaints being received. Similar to FTSU, the complaints procedure needs to be made accessible.

The Chief Nurse highlighted the importance to keep trying to resolve any additional questions to get to a position to close the complaint in partnership and to meet the expectations, accepting this can take longer. She explained the importance of getting it right the first time and seeing the right response as soon as possible.

OUTCOME: The Board **NOTED** the Complaints Annual Report.

GOVERNANCE

103/24 Governance Report

The Company Secretary presented the Governance report which contained:

a. Modern Slavery Statement

The modern slavery statement was refreshed and presented for approval. This statement confirmed the Trust's commitment to ensuring no modern slavery or human trafficking takes place in our business or supply chain and demonstrates that the Trust follows best practice, with all reasonable steps taken to prevent slavery and human trafficking.

b. Trust Seal Report

There have been no uses of the seal since the last report to Board on 7 March 2024.

c. Amendment to the Trust Constitution: Staff Membership

A minor change to section 7.6 of the Constitution to add the staff membership class of ancillary was presented. An election for the ancillary staff governor vacancy is currently underway. The Council of Governors will be asked to approve the amendment at the meeting on 17 July 2024.

d. Governance Structure

The Board was 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 Peoples Board, chaired by the Chief Nurse.

e. Board of Directors Workplan for 2024 – 2025

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

OUTCOME: The Board **APPROVED** the Modern Slavery Statement, amendment to the Trust Constitution and Board Workplan for 2024/25 and **NOTED** the use of the Trust seal in the last quarter and the addition of the Children and Young Peoples Board reporting to Quality Committee.

104/24 Items to receive and note

The following minutes were provided for assurance:

- Finance and Performance Committee – 26.03.24 and 30.04.24
- Quality Committee – 08.04.24 and 08.05.24
- Workforce Committee – 15.04.24
- Audit and Risk Committee – 25.06.24
- Charitable Funds Committee – 07.05.24

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

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

105/24 Any Other Business

The Chair announced this was Brian Moore's last meeting as lead governor as he comes to the end of his governor term of office. The Chair formally thanked Brian for all his support at the Trust and stated he had been incredibly helpful over the years.

The Board were reminded of the Council of Governors thank you lunch taking place on Wednesday 17 July, 12:45 pm in the Boardroom, Huddersfield Royal Infirmary.

106/24 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 12.15 pm.

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

6. Matters Arising and Action Log

To Note

Presented by Helen Hirst

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC) 2024

Position as at: 02.09.24

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
04.07.24 87.24	Chief Executive's Report Update on emergency care response to be provided in September 2024 and slides to be circulated to the Board.	BB/JH/VP	Slides circulated to the Board on 4/7/24. Update on emergency care within Chief Executive report 12.9.24.	12.09.24		12.09.24
04/07/24	Board Assurance Framework – Update 1 1/20 clinical strategy risk to be updated on the BAF to reflect the Board discussion.	AM	Update to 1/20 clinical strategy risk description by Medical Director.	07.11.24		16.08.24

7. Chair’s Report including Charitable Funds Committee Terms of Reference and the Trust Organ and Tissue Donation Guidance

To Approve

Presented by Helen Hirst

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	12 September 2024
Meeting:	Board of Directors
Title:	Chair's Update
Author:	Helen Hirst, Chair
Sponsoring Director:	N/A
Previous Forums:	None
Purpose of the Report	To update the Board on the actions and activity of the Chair.
Key Points to Note	The enclosed report details information on key issues and activities the Trust Chair has been involved in over the past two months within the Trust, with local system partners and regional and national work.
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. • **APPROVE** the revised Terms of Reference for the Charitable Funds Committee. • **ENDORSE** the principles of the Trust Organ and Tissue Donation Guidance developed by the Organ and Tissue Donation Engagement Group.

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.

Much has been publicised and trailed of the health policies and plans of the new Labour Government and these have been discussed in many of my local, regional and national discussions. Brendan will cover some of what we are expecting in his report to the Board. The Board will also look at this further at our development session in October.

1. **Trust activities**

Council of Governors

The newly elected or appointed governors have now taken up their roles and, at a thank you lunch on 17 July, we said farewell to those who were leaving.

We held a Council of Governors meeting on 17 July where the agenda was primarily of a routine nature. As well as feedback from Board Committees and the CHS Board, the Governors noted the outcome of this year's annual appraisal process for the Chair and Non-Executive Directors.

A Governors' Induction Day was held at the end of July.

The Governors have appointed Lorraine Wolfenden as Lead Governor and Pam Robinson as Deputy Lead Governor.

Brian Moore, former lead governor, will reprise his role at the Annual Members' Meeting to be held on 19 September 2024.

Board business

Outside of the usual Board schedule, the Board held a short private meeting to discuss the outcome of a job plan appeal. I have also attended this month's Audit and Risk Committee and Workforce Committee as an observer as well as the Transformation Programme Board of which I am a member.

Although not strictly board business, July presented me with a unique opportunity to see the Trust up close and personal. A member of my family was admitted through the Emergency Department (ED) at Calderdale onto Ward 2A, transferred to 2D and then 6B. They were in hospital three and a half weeks. ED was so, so busy but I saw great camaraderie between colleagues and exceptional care and communication for the patient. Once a decision had been made to admit, the patient was transferred to a proper bed which, although still in ED, made all the difference in terms of comfort. It was the thing they repeated over and over again as being such a positive thing. On transfer to the wards the patient was well cared for

and communicated with. As visitors we were often offered a cup of tea and our questions answered professionally and with compassion. I saw and heard that colleagues cared about the person, not just their clinical needs and they developed a rapport with one charge nurse in particular who was exceptional. There were clear and detailed explanations of the diagnosis and treatment that the patient understood and this extended to a robust conversation about the pros and cons of fitting a naso-gastric tube. Towards the end of life, we sat down with a Physician's Associate who explained everything very clearly and kindly, as did the Medical Examiner in speaking to me following the death. While there were a couple of things that could have been better, overall, I experienced a Trust, through its colleagues, living its values and providing great care.

Charitable Funds Committee

The Charitable Funds Committee had a great presentation on the Trust's Children and Young People's Strategy and the partnership between the Trust and the Charity to support its launch and future fundraising opportunities.

The Charity Manager presented an impressive report of a range of fundraising activities within the first quarter. The Charity is now hosting the volunteering function within the Trust and this brings new opportunities.

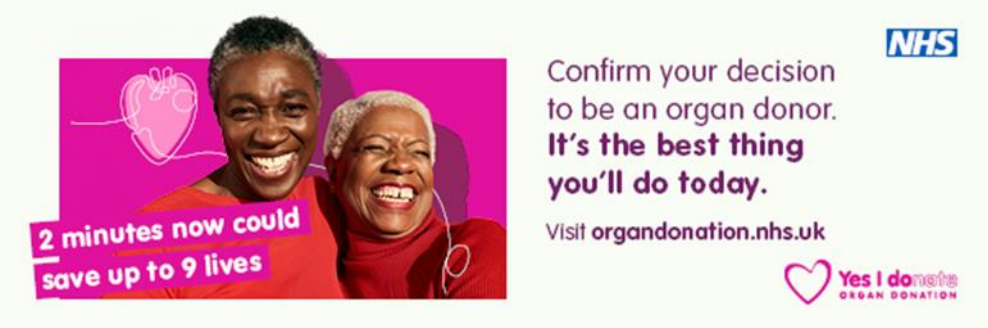
Following a review of our governance we have established a Charity Steering Group to support the Committee and also made some recommendations to the Committee's Terms of Reference. These are presented for approval by the Board. Kate Wileman, Public Governor has joined the Committee as a member – this differs from the Governor role on other committees where they are observers.

Organ and Tissue Donation Engagement Group

The Group met in August and heard reports from the NHS Blood and Transplant Authority (NHSBT) about our gold standard performance in this area. In particular, we are an exceptional performer in ensuring the presence of a specialist nurse in donation discussions with families. This is key to facilitating donation. We discussed our training successes where we have now run out of eligible people to train! The funds we receive from the NHSBT have enabled us to pay for backfill which has been key to our 100% compliance.

Paul Knight, Clinical Lead talked through where we had seen some missed opportunities recently and the learning and improvement required. We also discussed campaigns and preparations for Organ Donation Week which starts on 23 September 2024.

Paul Knight, Jayne Greenhalgh, Specialist Nurse and I have been reviewing the guidelines in use at the Trust to support organ and tissue donation and although the operational detail is not for the Board, we would like the Board to endorse the principles of our guidance. These are appended to this paper.



2. Health and Care System

Calderdale Cares Partnership Development session focused on embedding physical activity into the health care system and a refresh of the partnership's priorities and delivery plan.

West Yorkshire Partnership Board meeting this month discussed early diagnosis of cancer and the real living wage. There was a great presentation and discussion about inequality experiences by people with mental health conditions, learning disabilities and autism and some good examples of where, by looking deeply at multiple factors e.g. ethnicity, gender as well as the condition, improvements could be made with good evidence based outcomes.

West Yorkshire Association of Acute Trusts (WYAAT) Committee in Common, held at the end of July, was the last of this cycle chaired by Keith Ramsey, Chair at Mid Yorkshire before he hands over to Sarah Armstrong, Chair at Harrogate and District NHS Foundation Trust. As well as our usual programme updates and reports we had a specific focus on the feedback from a review undertaken across WYAAT members by Price Waterhouse Coopers. This review proposes a range of actions that Trusts are considering individually and collectively. Our non-executive directors had a briefing on the detail from Gary Boothby and Rob Aitchison. There will be further consideration at Finance and Performance Committee and future Boards.

As external assessor, I supported the recruitment of new non-executive directors with Mid Yorkshire Hospitals Trust and West Yorkshire ICB during the last month.

3. National

An NHS Providers Chair and Chief Executive Forum was held at the end of June where we discussed the future for the NHS with Paul Corrigan CBE, one of the new Government's advisers (although he wasn't at the time). The next meeting in September will focus on the Care Quality Commission review.

Helen Hirst
Chair
21 August 2024

Calderdale and Huddersfield NHS Foundation Trust

Charitable Funds Committee Terms of Reference

1. Constitution

The Board of Directors hereby resolves to establish a committee of the Board to be known as the Charitable Funds Committee. The Committee is a sub-committee of the Board and has no executive powers other than those specifically delegated in these Terms of Reference.

2. Authority

The Board of Directors of Calderdale and Huddersfield NHS Foundation Trust is the Corporate Trustee of the Trust's charitable funds, which are managed under a Charity registered with the Charity Commission - registration number 1103694. The Committee is authorised by the Board of Directors to carry out any activity within its Terms of Reference.

3. Purpose

The purpose of the Committee is to manage the Charitable Funds on behalf of the Corporate Trustee.

4. Duties

The Committee will:

- Ensure that Charitable Funds expenditure is approved in line with the Charity's Scheme of Delegation and the Trust's Standing Financial Instructions.
- Update and maintain charitable fund policies and procedures in accordance with Charity Commission 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 accounts are completed, approved, 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.
- Receive recommendations and Reports from the Charitable Funds Steering Group

5. Membership

The Committee will comprise:

- Chair of the Board of Directors (Chair of Committee)
- Up to two Non-Executive Directors
- Director of Nursing
- Medical Director
- Director of Finance
- Chief Operating Officer
- Council of Governors' representative
- Member of steering sub group

6. In attendance

- Director of Corporate Affairs
- Charity Manager
  Finance Manager

The Committee may request other staff to attend the meetings to present on matters included on the agenda.

7. Quoracy

Three members of the committee must be in attendance, including at least one Non-Executive Director and one officer member, including at least one clinician. If an issue to be discussed at the committee meeting affects an Executive Director, they must declare their interest at the time. In the absence of the Chair, a Non-Executive Director will chair the meeting.

8. Attendance

All members are expected to attend a minimum of 75% of meetings. 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 jeopardize the functioning of the Committee, the Chair will discuss the matter with the member and, if necessary, seek a substitute or replacement.

Members unable to attend should indicate in writing to the Committee secretary, at least 7 days in advance of the meeting and nominate a deputy except in extenuating circumstances of absence. In normal circumstances, any members who are unable to attend must nominate a deputy who is appropriately briefed to participate in the meeting.

9. Reporting

The minutes of the Committee meetings will be submitted to the Trust Board when approved along with a Chair's report of the meeting.

The Chair of the Committee shall, at any time, draw to the attention of the Trust Board any issue which requires their attention.

10. Review

The Terms of Reference shall be reviewed on an annual basis and ratified by the Board.

Organ and Tissue Donation Guidance and Principles

1. Calderdale and Huddersfield NHS Foundation Trust, working in partnership with NHS Blood and Transplant (NHSBT), seeks to maximise the opportunities for solid organ donation and endorses the principle that consideration of organ donation is an integral part of end of life care in critical care units.

2. Calderdale and Huddersfield NHS Foundation Trust commits to working in partnership with NHS Blood and Transplant (NHSBT) to maximise opportunities for tissue donation throughout both hospitals.

3. The organ donation (deemed consent) Act 2019 sets out a framework that recognises that patients can be deemed to consent to organ donation in the absence of clear evidence that they would wish to opt out of organ donation.

4. This document provides clear guidance and procedures for organ and tissues donation and has been developed in line with best practice guidance from professional and regulatory bodies.

5. This document applies to adults only in respect of organ donation and adults and children in respect of tissue donation.

Principles

1. The explicit wishes of an individual in relation to organ and/or tissue donation after their death are identified, acknowledged and respected.

2. Consideration of organ donation will be an integral part of the end of life pathway on our critical care units. Where organ donation is a possibility all bereaved families will have the opportunity to consider organ and/or tissue donation in a timely and sensitive manner by trained colleagues who have access to specialist advice.

3. Colleagues involved in the identification and care of potential organ/tissue donors will have the appropriate knowledge and skills and have underdone appropriate training. When appropriate they will refer to external specialised teams to carry out the wishes of patients and families in a respectful, sensitive and dignified manner.

8. Chief Executive’s Report

To Note

Presented by Brendan Brown

Date of Meeting:	Thursday 12 September 2024
Meeting:	Public Meeting of the Trust Board
Title of report:	Chief Executive's Report
Authors:	Brendan Brown, Chief Executive Officer and Victoria Pickles, Director of Corporate Affairs
Sponsor:	Brendan Brown, Chief Executive Officer
Previous Forums:	None
Purpose of the Report	This report provides a focused update on the Trust's response to specific elements of its service delivery and the evolving health and care landscape.
Key Points to Note	1. This report provides an update to the Board on significant national, regional, and local developments that affect the context within which we operate 2. The report details significant changes and events that have occurred since the Board last met, and that have a bearing on the care and services we deliver as an anchor partner 3. Following the scenes of violence, racism and Islamophobia fuelled by social media across the country, this report also details the leadership and response underway in response to the experience of our colleagues and communities.
Regulation	CQC Regulation 17: Good governance
EQIA – Equality Impact Assessment	There are no differential equality impacts resulting from the areas of work highlighted in this report at the point of writing.
Recommendation	The Board of Directors are requested to receive this paper as assurance and progress against both the local and national health and social care agenda, and as an update against leadership responsibilities within the CEO portfolio.

Calderdale and Huddersfield NHS Foundation Trust
Chief Executive's Report
5 September 2024

1. Introduction

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

1.2. There have been several significant national events since our last Board meeting.

1.3. Following the General Election in July, Labour came into Government and set out their priorities for the coming legislative year. A new Secretary of State (SOS) for Health and Social Care, Rt Hon Wes Streeting MP was appointed who delivered his first statement in the role on 5 July 2024, highlighting that in his view that the NHS is 'broken' and advised that a new NHS Strategy/Ten Year Plan is being prepared for early 2025. The Secretary of State has also commissioned a full and independent investigation into the state of the NHS, to uncover the extent of the issues facing the health sector to be carried out by Rt Hon Professor Lord Darzi. The initial findings from this review are due to be published later this month and will inform the strategy currently being developed.

1.4. I have written to the Secretary of State setting out our position as a Trust, the fact that we are halfway through an ambitious programme of reconfiguration and inviting him to see our plans and the work that takes place in a productive, good district general hospital that serves as an anchor partner across two communities. I have been involved in two conversations with him to date as part of both a regional and national NHS CEO discussion, and the highlights from these meetings are:

- An ambition for a one team culture between the Department of Health and Social Care (DHSC) and NHS England (NHSE)
- An ask of inclusive leadership across the NHS that includes honest feedback from leaders
- Clarification that his comment that the NHS is broken is not a criticism of staff and leaders, but a reflection of what voters were saying pre-election. Whilst potentially broken, he envisages the NHS can be fixed if we work together as a leadership team
- The SOS recognises the challenges of activity and performance in the coming months, but wants to focus on a safe winter, within current resources
- The financial envelope has been set for this year, and a further spending review will take place next year

1.5. We also have five new Members of Parliament representing the communities we provide services to: Kate Dearden MP, Halifax; Josh Fenton-Glynn MP, Calder Valley; Harpreet Uppall MP, Huddersfield; Paul Davies MP, Colne Valley; and Jade Botterill MP, Ossett and Denby Dale. All five MPs are within the Labour Party. I have met with three of our newly elected MP's and have meetings scheduled for the other two new members after the Board meeting.

1.6. The other significant event has obviously been the incidences of violent disorder in UK towns and cities during July. People from all over the world choose to work at CHFT and

live in our local communities, and we could not provide the care that we do, in the way that we do without them. I am proud of both the richness of our diversity and the distinctive diverseness of the communities we serve. The recent events across the country were shocking, inappropriate and have had a lasting impact on many of our colleagues, and our local communities. We have always been clear that we will not tolerate violence, racism or abuse from colleagues, patients, or visitors, but it would be naïve to assume because we have made the statement of intolerance it means it will stop. What we are facing impacts on all of us, both in and out of work, for our families, our friends, and our children. I met with several colleagues form a richness of backgrounds who have shared their personal experiences. We have put in place support mechanisms and resources for people to access and we will continue to encourage people to report both formally and informally through our various channels their experiences and we will address any incidents raised with us. This is an on-going response, and one we will continue to pay leadership attention to.

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

2.1. It is important to recognise and report that we have remained as one of the top performing Trusts for the emergency care standard, despite the challenges we have faced with the number of patients needing our emergency care. The opening of our integrated flow hub in the site of the old accident and emergency department at Huddersfield will support continued focus on this as we approach the winter. The hub will include a Digital Command Centre; the patient flow and clinical site management teams; Medical and Frailty Same Day Emergency Care services; and a discharge lounge.

2.2. We have also been the top performing Trust nationally for achieving the 62-day referral to treatment cancer target for several months, which is a credit to the breadth of both our clinical and non-clinical teams involved in the complex pathways of cancer care delivery.

2.3. Our work to reduce the elective backlog is also attracting national profile. We are one of very few Trusts with no patients waiting over 52 weeks and in most of our specialties have no patients waiting over 40 weeks. We were featured in a case study by NHS Providers on productivity and delivering value for money and our Chief Operating Officer and Director of Operations for Surgery and Anaesthetics have been invited to the NHS Providers Annual Conference in Liverpool to talk about our work. It has also continued to be covered in the media with Ashish Joshi from Sky News filming a piece in HRI and an interview with the Economist being planned later this month. This is a real credit to the hundreds of dedicated colleagues involved, from medical secretaries and schedulers to the multi-disciplinary team of professionals working in theatre.

2.4. At the last Board meeting we discussed the recent position within maternity services, that detailed the number of stillbirths that have occurred, and an update on this is included in the maternity report to this meeting. As there had been 15 stillbirths this year to date, the Trust requested an external review, supported by the West Yorkshire Local Maternity and Neonatal System (LMNS) which identified multiple contributory complexities, both social and clinical. Some of the themes related to ethnicity, Index of Multi Deprivation (IMD) code, management of small for gestational age babies, multiple risk factors, diabetes, obesity,

and women who are on more than one pathway. There were also issues noted regarding barriers to accessing services and translation offers. We are producing an action plan which includes a social vulnerability tool to include in risk assessing women. However, in recognition of the need for involvement and action from wider system partners a series of meetings have taken place to agree a system action plan. Our Chief Nurse is working with the Place Director of Nursing to support this. In addition, engagement sessions are scheduled with communities to understand barriers to accessing maternity services.

2.5. I shared with Board colleagues a copy of the recent letter from the Care Quality Commission following publication of the interim findings of the review of their operational effectiveness led by Dr Penelope Dash. The purpose of the ongoing review is to examine the suitability of CQC's new single assessment framework and methodology for inspections and ratings of providers. The next stage of the review will focus on patient safety, exploring the perspectives of patients and the role of regulation – including CQC, and other regulatory bodies – in improving safety. The review is expected to conclude this autumn. Our priority remains to maintain a good, honest, mutually respectful relationship with the CQC as our regulator. They visited us last month to look at both the new Accident and Emergency Department at Huddersfield Royal Infirmary and our maternity and neonatal services as part of their engagement visits to our services. We have also put ourselves forward to participate in a national pilot for their new engagement arrangements.

2.6. NHS Providers recently published their findings following a survey of all trusts on regulation and oversight. At the time of the survey, trusts were managing continuing operational and financial pressures, alongside ongoing industrial action, while the Care Quality Commission (CQC) and NHS England (NHSE) were introducing changes to their respective approaches to regulation and oversight. The survey also reflects the first full year of statutory integrated care boards (ICBs) and trusts' experiences of working with ICBs while their dual role as system partners and performance managers of trusts was further embedded. You can read their findings here. It is interesting to note the differing experiences of regulation felt by trusts and to note the comments made about single word ratings given the recent announcement by the Government to change this approach within Ofsted.

2.7. CHFT was the best performing Trust in West Yorkshire in the recent CQC Inpatient Survey. The survey covered 63,500 patients nationally who stayed in acute or specialist hospitals for at least one night in November last year. Our patients gave us an overall experience rating of 8.3 out of 10.

2.8. Our neonatal services were the subject of a BBC World Service podcast in August. BBC Journalist, Becky Green, gave birth to premature twin boys in 2018. They were looked after by our colleagues in neonatal care at CRH during this time. Earlier this year Becky came back to the unit to speak with Neonatal Care Sister, Jo Richardson, about her experience.

2.9. The Trust has been selected as a sample Trust to have a review of our mortuary service as part of the Independent Inquiry into the issues raised by the David Fuller Case. Compliance with mortuary standards fall under the Human Tissue Authority (HTA) regulatory framework and the Trust has also recently had an assessment by the HTA. The Director of Corporate Affairs and I recently visited both of our mortuaries. What I saw was discreet, understated, and compassionate care for our patients in a safe, clean, secure environment. One of the gaps that has been identified as part of this assurance work, is

board committee oversight of our compliance with the HTA and a report on this will go to Quality Committee later in the year followed by an Annual Report from the Designated Individual to ensure that this is addressed and considered as part of governance arrangements.

2.10. On a related note, the Trust hosts the Medical Examiners (ME) on behalf of the Calderdale and Huddersfield places. The Medical Examiner service is part of a national initiative that has been developed to scrutinise all deaths that do not require referral to His Majesty's Coroner. Our CHFT ME Team has been in place since 2020. On 9 September, the service will become statutory meaning that, by law, all deaths will need to be scrutinised by a Medical Examiner. In practice, this means that no Medical Certificate of Cause of Death (MCCD, informally referred to in hospital as a "death certificate") will be accepted by the registrars unless it has been signed off on by an ME who has scrutinised the case. This is a big change, and the ME service has been working with our clinicians, GPs, care homes, funeral directors, and community groups to put in place arrangements to be ready for this coming into place.

3. Inclusive workforce and local employment

3.1. I want to start by congratulating our Matron for Workforce Development, Vicki Power and Staff Nurse, Sarah Kenningley, who have been shortlisted in two categories at the Nursing Times Workforce Awards. There were more than 500 submissions this year, so this truly shows the strength of their entries. Vicki will represent us in the Nurse Manager of the Year category and Sarah, in the Preceptee of the Year category. I know that we will all be rooting for them at the Awards in November.

3.2. As referenced earlier in my report, the diversity of our colleagues is something we are proud of at CHFT. In addition to working with our Race Equality Network and colleagues from a Black and Minority Ethnic background on the impact of the riots, Deputy Medical Director and our Race Equality Network Co-Chair, Neeraj Bhasin, recorded a special message 'Free to be me' to celebrate the end of South Asian Heritage Month, which has received over 100 views.

3.3. We have also continued to support and develop other networks for our colleagues. On 30 August we held our annual Pride Parade at Huddersfield Royal Infirmary to mark the end of CHFT's Pride Month, which has celebrated inclusivity and raised further awareness that confronting discrimination is key to understanding that everyone is entitled to be accepted for who they are.

3.4. The Trust also has a new equality network called the Youth Forum chaired by Healthcare Assistant, Emma Kent. The first network meeting is to take place at HRI on Tuesday, 17 September, and is open to anyone under 30 and aimed at ensuring the voices of our younger colleagues are heard, to support making the Trust a more youth friendly workplace.

3.5. Our change network is also in place and is aimed at supporting colleagues affected by any aspect of menopause or wanting to learn about menopause. The Change Society, chaired by Outpatient Manager Wendy Hewitt, provides an informal, safe space where any colleague, can join a conversation, and benefit from speaking to like-minded colleagues.

3.6. The NHS National Staff Survey 2024 will launch on 16 September 2024. Colleagues will have around 8 weeks to complete the survey, which is anonymous, and we will be

encouraging as many as possible to provide their views which give us invaluable feedback on what it is like to work at CHFT.

3.7. As Board colleagues will know, this meeting will be David Birkenhead's last formal Board meeting as Medical Director before he retires at the end of October. David has been Medical Director for over 10 years and has provided leadership through some significant challenges including of course the global pandemic, recent industrial action, and the public consultation on the reconfiguration of our services. There will be many opportunities for us to mark David's time with the Trust and the NHS over the coming months, but I wanted to take this opportunity to thank him for not only his calm, measured, strategic leadership but also his steadfast commitment to patient care.

3.8. Neeraj Bhasin will start the role of Medical Director from November, and I am delighted that we have recently appointed Julie O'Riordan as Deputy Medical Director to join the team alongside Nikhil Bhuskute. Julie is currently Deputy Medical Director at Airedale NHS Foundation Trust, and previously worked at CHFT in a range of clinical leadership roles, most recently as a Divisional Director.

4. Financial, economic, and environmental sustainability

4.1. The finance report at this meeting shows a year-to-date deficit position of £12.14m, a £0.29m adverse variance to plan. The in-month position is a deficit of £2.73m, a £0.27m adverse variance.

4.2. This position has been affected by additional direct costs of £0.45m in June/July due to the Junior Doctors industrial action and Elective Recovery Funding of £1.15m being lower than the stretch target assumed in planning and compounded by additional bed capacity open above planned levels.

4.3. The Board will be aware that we had a challenging cost improvement target this year and to date we have delivered efficiency savings (CIP) of £7.23m, only £0.19m lower than planned.

4.4. The Trust is forecasting to deliver the planned £26.26m deficit, but the 'likely case' scenario suggests a gap of £5.58m due to: likely slippage on the delivery of efficiencies; potential Elective Recovery Funding loss; and the impact of Industrial Action.

4.5. Along with the other West Yorkshire Association of Acute Trust (WYAAT) hospitals, we participated in an external review of our financial arrangements and position. A copy of that report has now been received by WYAAT and we are working through the recommendations individually and jointly. We are also considering joint cost improvement opportunities and a programme of work to support this has been put in place at WYAAT.

4.6. The Board will receive an update against the Green Plan at this meeting which outlines the Trust's ambition for sustainability to 2026. This update sets out the achievements made in 2023/24 and what we plan to do this year including new electric vehicle charging points, more solar panels, tree planting and the installation of LED lighting.

4.7. September is NHS England North East and Yorkshire Greener NHS Month with a focus on Waste Reduction and we will be participating in this through all our communication channels. The video produced by the team at NHS England, featuring colleagues from

across our region, sets out some of the things Trusts are doing, many of which are replicated here at CHFT.

5. Transforming services and population outcomes

5.1. The next few months will be significant for the progress of our reconfiguration. At the start of September, we held the launch event for the latest plans for our clinical build at Calderdale Royal Hospital. Clinical and operational leaders from across the Trust were invited to receive presentations from Laing O'Rourke, our build partners, and the internal reconfiguration team about the proposed configuration and flow of space within the new buildings and the timeline for the build. There was also an opportunity to see what spaces will look like and how colleagues would work within the new environment using a virtual reality suite. We hope to roll out the opportunity to see this to more colleagues over the coming months.

5.2. As Board colleagues will be aware, we closed the main front car park at Calderdale Royal Hospital at the end of July. Patient and public parking is now centred on the Women and Childrens' car park at the Godfrey Road side of the building. The majority of colleagues can now no longer park on site and during the summer we gained feedback on the park and ride arrangements and adjusted bus timetables and routes accordingly. Now that the schools are back from summer leave and most colleagues have returned from their summer break, we will continue to monitor the arrangements and check whether any further changes are required. I want to take this opportunity to thank all affected colleagues for the way in which they have responded and adjusted their arrangements to accommodate these changes.

5.3. Work has therefore now started on ground preparations for the new multi-storey car park with a view to the build beginning early in the new year.

5.4. The Learning and Development Centre redevelopment at CRH is progressing well. Internal fit out is nearing completion and we are on track for the Centre to open at the end of October.

5.5. Off site, the new Community Diagnostic Centre in Halifax opened in July and is working well. The official opening event will be held the day before this Board meeting.

5.6. In relation to diagnostics, it was pleasing to hear Secretary of State for Science, Innovation and Technology, the Rt Hon Peter Kyle MP talk about his visit to Huddersfield Royal Infirmary and our use of Artificial Intelligence (AI) in the diagnosis of lung cancer. He also referenced the very personal impact that he felt the availability of such rapid diagnoses could have had in the care of his mother.

5.7. We have recently rolled out the mymobility Care Management platform for our patients, preparing for and recovering from joint replacement surgery. The mymobility app has been designed with our Trust surgical team and complements the traditional care provided by surgical care teams, allowing them to deliver tailored information and guidance remotely, through a mobile or web application. Pre-surgery and post-surgery, the mymobility app has been designed by and with Trust colleagues to support patients by providing them with information such as how to prepare for surgery and recovery, helpful

reminders, and scheduled exercises. Since its launch, more than 160 patients have been enrolled onto the mymobility app at CHFT.

5.8. New state-of-the-art equipment has also recently been installed in the biochemistry lab in Huddersfield Royal Infirmary as part of the ongoing pathology upgrade work in our collaborative pathology partnership with The Leeds Teaching Hospitals NHS Trust and The Mid Yorkshire Teaching NHS Trust. The equipment introduces urgent care prioritisation and faster testing times for acute tests, such as Troponin (used for supporting diagnosis of myocardial infarction).

5.9. Innovation and our transformation work will form part of the showcase at our Annual Members Meeting on 19 September, and I will be presenting the look back to 2023/24 and look forward to 2025. All are welcome to come along.

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.

9. Maternity and Neonatal Oversight Report

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

To Approve

Presented by Lindsay Rudge and Gemma Puckett

Date of Meeting:	Thursday 12 September 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 July 2024 unless otherwise specified and as reviewed by the Maternity and Neonatal Transformation Board which took place in August 2024. The Quality Committee received an update on progress against theme 3 of the Three year delivery plan for maternity and neonates in September 2024. Assure: • The maternity Incentive Scheme is currently on track for compliance against all ten safety actions. • The service user voice is embedded into key forums including Maternity and Neonatal Transformation Board, maternity governance meeting and the directorate patient experience group. Advise: • There has been a successful recruitment programme of midwives with circa 35 WTE posts offered at CHFT. These are predominantly newly qualified midwives (NQM, 31wte). This will reduce vacancy to less than 10% if all those offered posts commence in post in October 2024. • The perinatal culture leadership programme has now completed with the quadrumvirate completing their final coaching and support programme. The action plan in response to the cultural conversations with staff is now being finalised, will be shared with the workforce, and monitored through the Maternity & Neonatal transformation board. • The next assessment of compliance with the Saving Babies Lives Care Bundle will take place in September 2024. Alert: • The rate of stillbirths at CHFT is more than the national average.

	• There is now a downward trend in the rate per 1000 births being seen. • 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 meeting was held on 29th July 2024. • The level of Qualified in speciality (QIS) nurses reported as meeting the minimum level of >70% previously may have included those who had completed the foundation level course but not yet the full qualification. This is not in line with BPAM reporting requirements. A review of the neonatal nursing workforce is underway. The calculation will be reset and reporting moving forwards will be in line with the definition. Initial review indicates the current level of QIS is circa 60%.
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 ICB 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***

1.0 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 maternity voices partnership (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 feedback will contribute to the ongoing development of the co-designed MVP workplan.

Further to the work to review the themes across the rates of stillbirth and reviewing data on accessing care early in pregnancy there is clear evidence that women and families in HX1 ward are disproportionately represented in this data.

A joint bespoke engagement event with this cohort of women has been planned between CHFT and the Integrated Care Board (ICB) and is due to take place in September 2024.

The focus of the engagement activity will be to talk to women and their birthing partners within the HX1 and surrounding areas of Calderdale who have accessed antenatal maternity care within the last 12 months to understand their experiences of:

- their antenatal maternity journey.
- how it felt / feels to be pregnant living in HX1 and the surrounding areas.
- accessing early pregnancy care and are there any barriers to this and what are these specifically?
- the different levels of knowledge of access to antenatal care, and possible gaps in knowledge.
- cultural needs and preferences of women living in HX1 and the surrounding areas.
- common barriers faced in accessing antenatal care before 10 weeks of pregnancy, and what might help women living in HX1 and surrounding area access care at an earlier stage.
- who do pregnant women and birthing parents in HX1, and surrounding areas feel comfortable contacting or engaging with if they had a concern for themselves or their baby?
- the understanding within the community of HX1 and surrounding areas of reduced foetal movements.
- language barriers – how does it feel to use an interpreting service within an appointment?
- what happens when you don't feel listened to?
- impact of deprivation / cost of living crisis on access to maternity care for e.g., transport, childcare etc.

The engagement with the women and families will be facilitated by ICB community engagement champions.

1.2 Complaints

The themes of complaints received in the service include communication, feeling heard and attitudes and behaviours. This reflects feedback received via the MVP through listening events and stories 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.

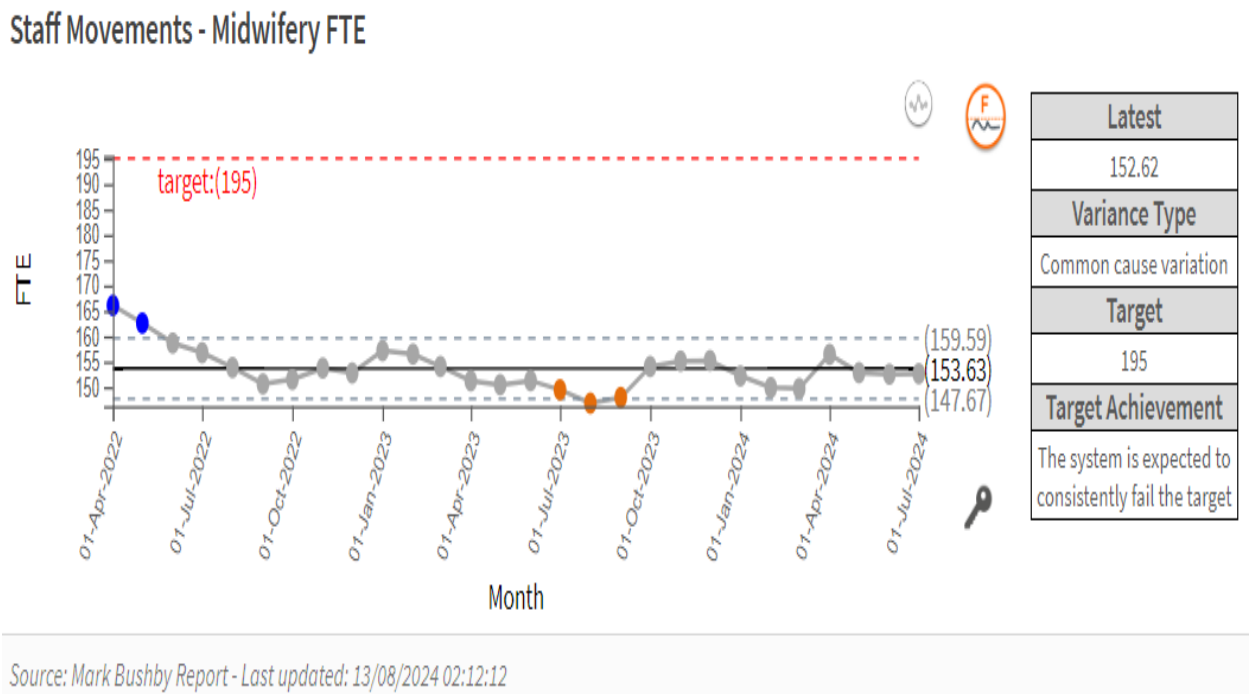
Training to improve the quality of complaints responses has been arranged through the Parliamentary and Health Service Ombudsman (PHSO) and all matrons and ward managers in the service will participate in this with sessions arranged at the beginning of September 2024.

Preventing families feeling the need to complain by addressing any concerns and improving debrief before discharge from the service is a directorate quality priority.

Many subject access requests for maternity records, including across multiple pregnancies, have been received into the Trust over the last 2 months.

2.0 Growing retaining and supporting our workforce.

2.1 Midwifery Staffing



Source: Mark Bushby Report - Last updated: 13/08/2024 02:12:12

What does the chart show/context:

- The FTE rate has increased slightly from 152.52 in June to 152.62 in July.

Underlying issues:

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

Actions:

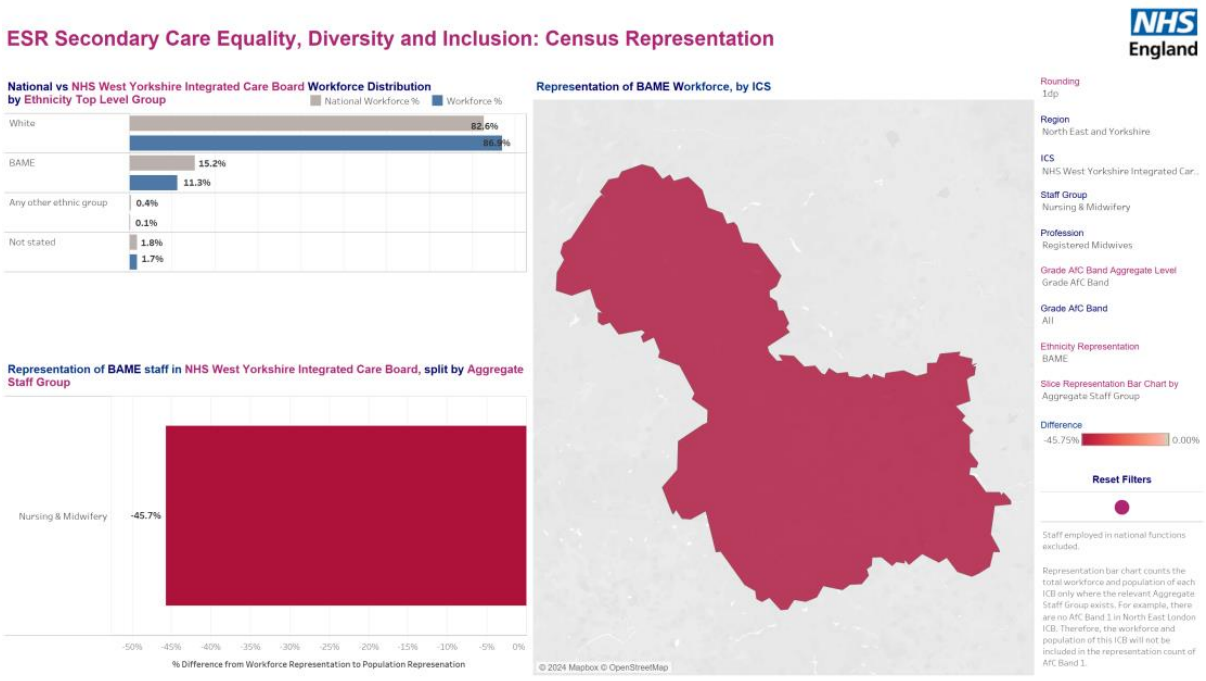
- Birthrate plus report commissioned and report received at end of April 2024, currently being reviewed through divisional governance.
- Recruitment and retention strategy being refreshed.
- Rolling recruitment programme
- Grow your own workforce pathways: Midwifery apprenticeship, shortened programme.
- Recruitment and retention midwife employed to work alongside and support new midwives in clinical practice.
- Stay conversations implemented.
- DoM/DDoM offer to undertake all exit interviews, retention has improved over last 6 months.
- Recruitment films commissioned and released on social media and being used in adverts and recruitment open days.
- Use of alternative roles such as registered nurses in maternity service
- Circa 31 WTE offered to newly qualified midwives to commence in October 2024
- 4 WTE Band 6 midwives offered posts following interviews in July 2024
- Robust preceptorship programme

The centralised recruitment of newly qualified midwives (NQM) took place during May 2024 with circa 31 WTE post offered and currently accepted. A further 4 WTE Band 6 midwifery posts have been offered and accepted. If all those offered commence in post this will reduce the midwifery vacancy to less than 10% against current funded establishment.

2.2 Workforce Diversity in Midwifery

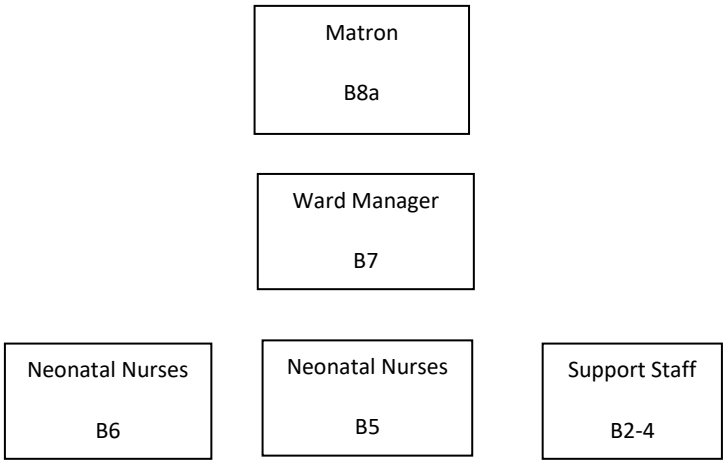
Improving diversity in the workforce is one of the LMNS workforce priorities with some initial plans to start with school engagement, targeting specific schools based on local population.

The following data demonstrates the diversity of the midwifery workforce across West Yorkshire and is reflective of the local picture at CHFT. The Director of Midwifery is meeting with the University of Huddersfield leads during the first week of September and will be discussing how we can work together to improve the diversity of students coming into training. The LMNS also plan to link with the universities as part of the workforce EDI workstream.



2.3 Neonatal Nursing

A review of the nursing leadership structure has been undertaken as there was no matron oversight of the service and two ward manager roles. This had led to a gap in the links to the organisational nursing leadership structures processes for oversight of quality. A consultation process has now completed, and the structure will now be as follows:



As part of the transition to the Women's and Families Health directorate, the nursing workforce tool has been reviewed. Qualified in specialty (QIS) has previously been reported as meeting the minimum requirement of >70% however, following a deeper dive into neonatal workforce it has been brought to light that we have previously incorporated into the calculation those who had completed the foundation element but not yet the full QIS qualification. We are liaising with the neonatal Operational Delivery Network (ODN) workforce lead and there is an ODN led peer visit arranged for September 2024 to help better understand the position and actions required to increase the QIS position. Initial review indicates the current level of QIS nurses is circa 60%.

2.4 Medical Staffing Obstetrics and neonates

Currently the Directorate has a mixed obstetrics and Gynae Consultant rota, following recent recruitment we have recruited three consultants due to start in September, October, and November. One consultant has left the Trust for a career break and a further consultant is joining another organisation for a specialist urogynaecology post. The pressures on the rota will therefore continue at present. A locum post to cover the career break has been interviewed for and the post offered. A more detailed review of the mandated PA's needed to meet the maternity safety agenda, the capacity and demand for the antenatal clinics and essential core activity will be brought to the divisional management team to assess what the gap will be once the new consultants have come into post and to inform development priorities.

There have been no changes to the medical workforce for neonates.

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.

The data below is for the mandatory safety training in obstetric emergencies (PROMPT) and fetal monitoring. This data is the position at the end of July 2024.

Midwives:

Competence Name	Assignment Count	Required	Achieved	Outstanding	Compliance %
372|LOCAL|Fetal Monitoring Programme (K2) - 1 year|	159	159	134	25	83%
372|LOCAL|Maternity Obstetric Emergency Training (PROMPT) - 1 Year|	159	159	125	34	80%
NHS|CSTF|Resuscitation - Level 2 - Newborn Basic Life Support - 1 Year|	158	158	128	40	81%

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

*All NQM booked on PROMPT

Maternity Support Workers PROMPT

Competence Name	Assignment Count	Required	Achieved	Outstanding	Compliance %
372|LOCAL|Maternity Obstetric Emergency Training (PROMPT) - 1 Year|	62	62	52	10	83%

*New MSWs in post- all training booked

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|	26	26	24	2	92%
372|LOCAL|Fetal Monitoring Programme (K2) - 1 year|	17	17	13	3	82%

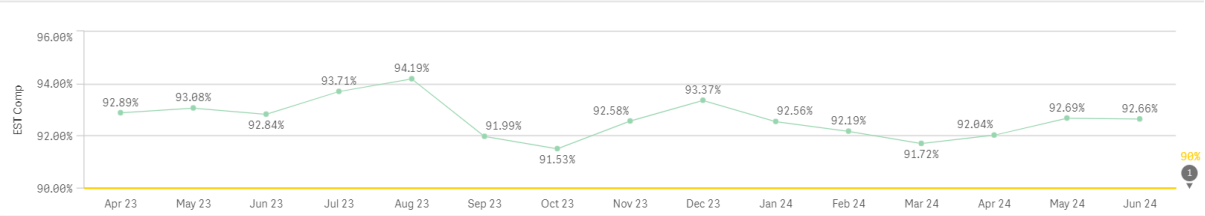
***PROMPT and FM requirement numbers differ due to GP trainees/foundation doctors needing PROMPT but not FM**

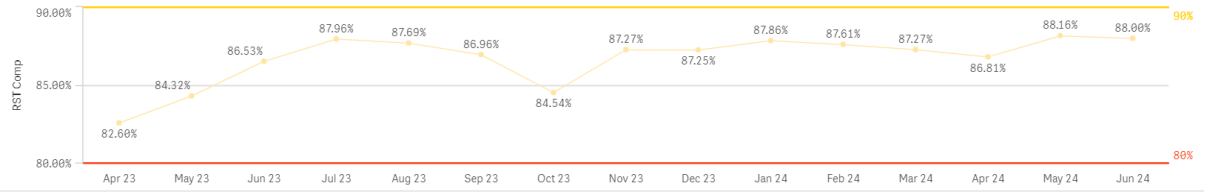
Anaesthetists:

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

Compliance is on track to achieve a minimum of 90% in all staff groups by the end of the reporting period for maternity incentive scheme (MIS) safety action eight.

The following graphs demonstrate compliance against essential safety training (EST) and role specific training (RST) respectively.

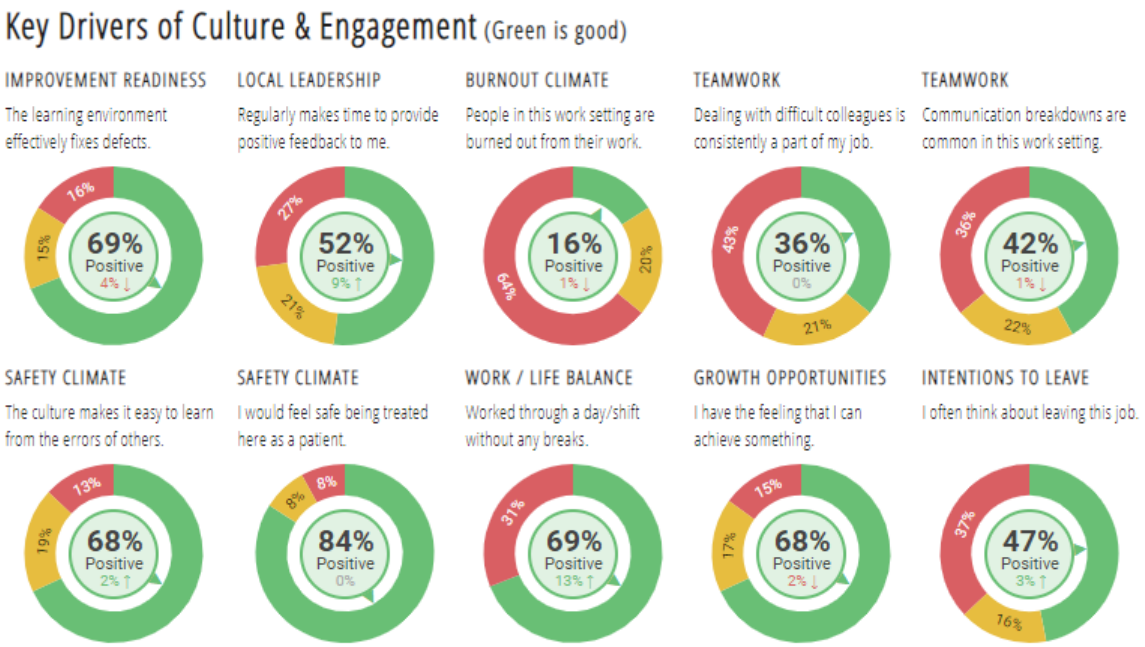




2.6 Workforce culture and experience

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) acting as the quadrumvirate.

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 action plan which will be shared with all staff and 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:

- Workforce Red flags
  - All reviewed and managed within escalation process.
  - Developed Safecare red flag reporting for maternity.
  - Workforce for midwifery and obstetrics on risk register with monthly review.
- Massive Obstetric haemorrhage
  - Reporting process embedded in practice.
  - Deep dive to take place due to flagging amber and red on the dashboard – delayed due to workforce capacity challenges.
- Delays in C Section
  - Reporting process embedded in practice.

- All delays are reviewed at weekly governance meeting to identify any learning.
- Audit presented at Joint Obstetric / Anaesthetic Audit session in May.

Moderate & Serious Incidents:

- X3 Stillbirths in July / August 2024
- X1 neonatal death in August 2024

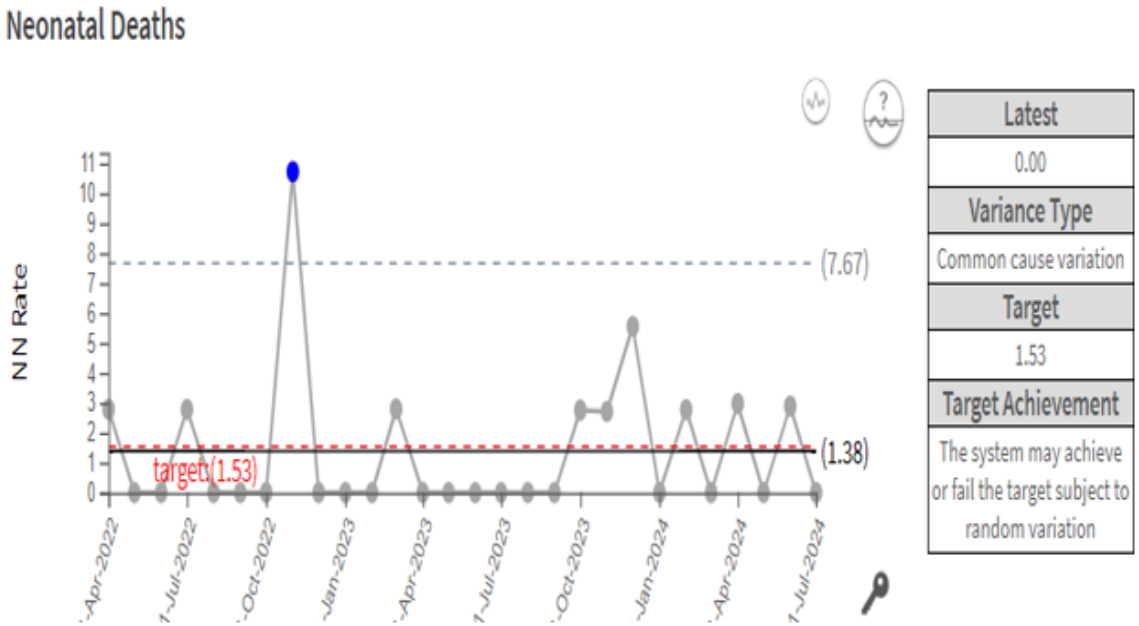
3.2 Perinatal Mortality & Morbidity – National Maternity safety Ambitions

Metric	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Neonatal deaths per 1,000 total live births	July 2024	0.0	1.53			1.38	0	7.67
Stillbirths per 1,000 total births	July 2024	2.73	3.33			4.32	0	15.58
Maternity Workforce	July 2024	152.6	195		F	153.6	147.6	159.6
Maternal Mortality	July 2024	0	0	L		0.1	0	0.5
Pre-Term Births	July 2024	6.28%	8%			6.8%	2.0%	11.6%
Brain Injuries	July 2024	0	2.2		P	0.36	0	1.8

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)



What does the chart show/context:

- There were no neonatal deaths in July 2024.

Underlying issues:

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

Actions:

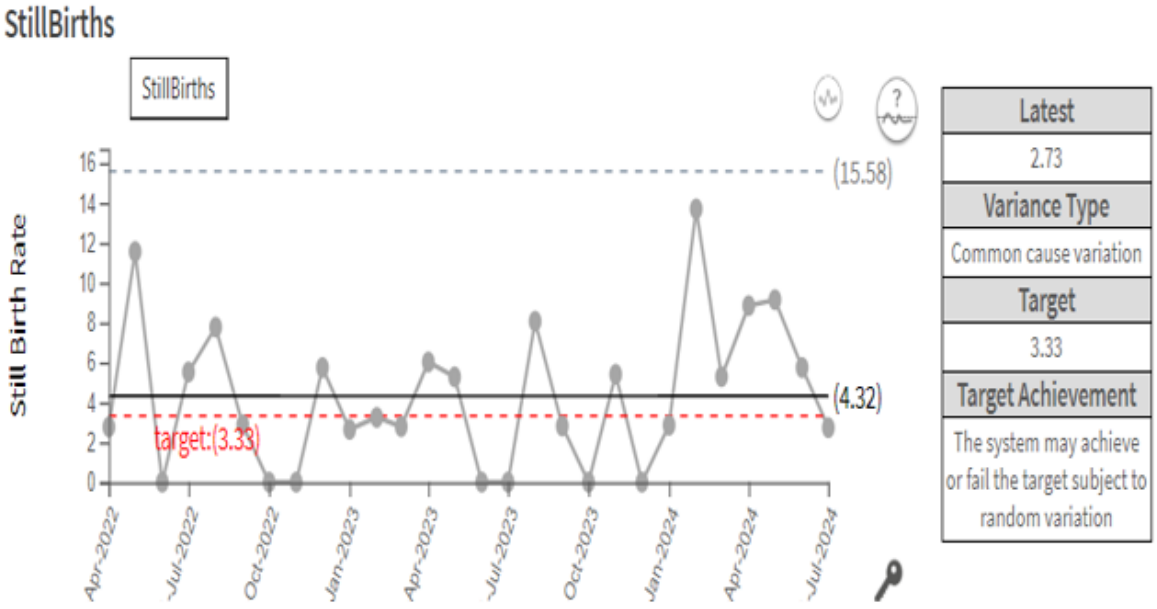
- All early neonatal deaths reviewed at Orange Panel and weekly governance meeting.
- All neonatal deaths MDT PMRT (perinatal mortality review tool) completed.
- All term early neonatal deaths referred to MNSI (The Maternity and Newborn Safety Investigations Programme).
- Regular quarterly stillbirth/neonatal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

3.4 Stillbirths

There have been 19 stillbirths calendar year to date with 1 occurring in July and 2 in August 2024.

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.

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



What does the chart show/context:

- There was one stillbirth in July.

Underlying issues:

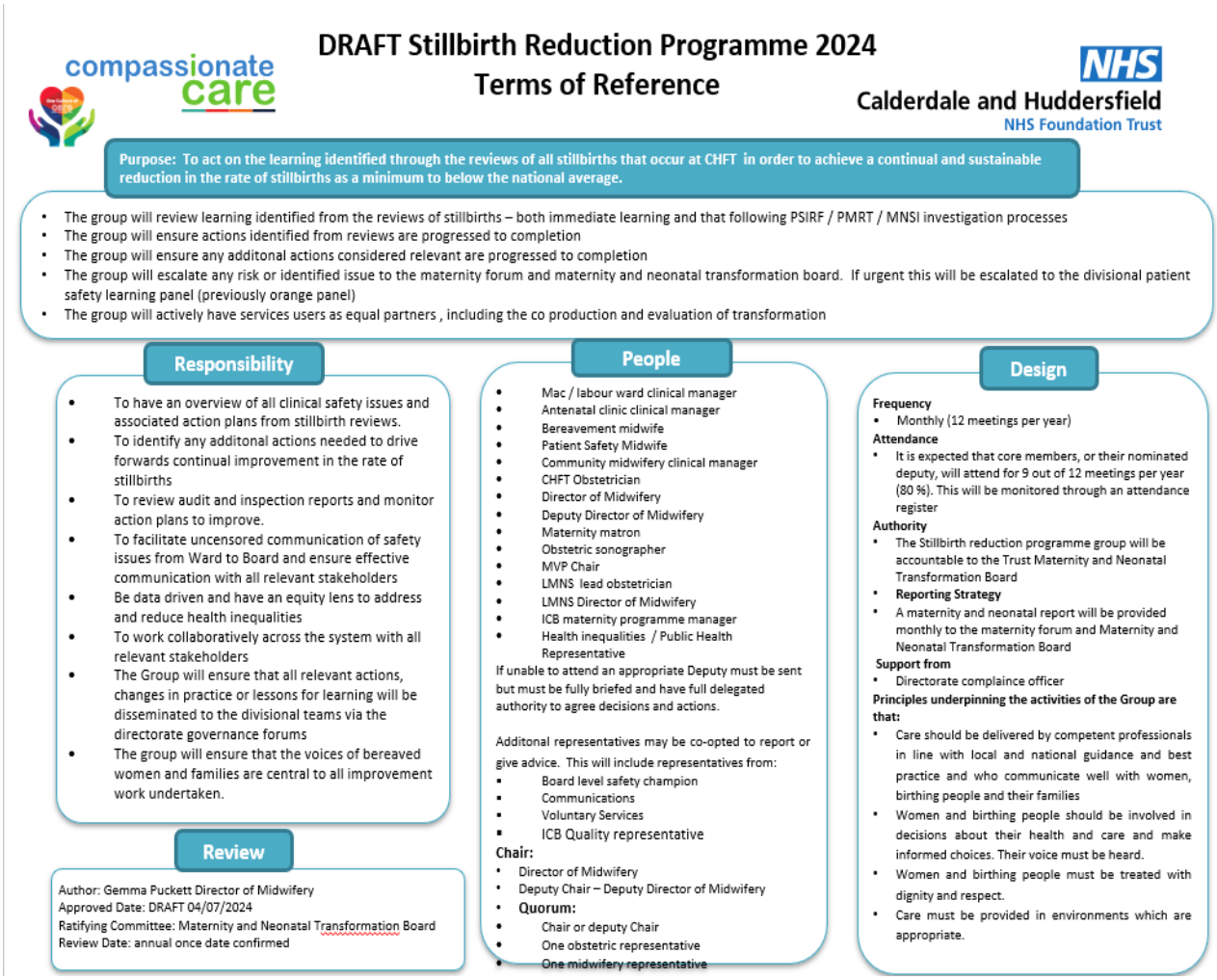
- The majority of women who have experienced a loss have multiple complexities, both social and clinical. There is a disproportionate representation of women who are BAME, English is not their first language and live in IMD codes 1-4. This is reflective of the national picture and there is a national 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

- All stillbirths are reviewed at the divisional patient safety panel and weekly governance meeting, health inequalities are considered.
- All stillbirths have an MDT PMRT completed (Perinatal Mortality Review Tool - a structured national tool that is used to review all deaths).
- All term intrapartum stillbirths are referred to MNSI.
- Regular quarterly stillbirth/neonatal audit is undertaken.
- An LMNS supported thematic review of the 2024 stillbirth cases took place on 3rd June 2024.
- A system stillbirth summit took place on 29th July 2024 and a stillbirth reduction programme will take place following this.

3.5 Stillbirth task and finish response.

Further to the LMNS supported thematic review, a Trust stillbirth reduction programme has been stepped up and the draft terms of reference for this are as follows:



A system response meeting was called with system partners including ICB, LMNS, directors of public health and safeguarding.

Multiple complexities, both social and clinical were present in 93% of the cases with some thematic issues identified. These related to ethnicity, Index of Multi Deprivation (IMD) code, management of small for gestational age babies, multiple risk factors, diabetes, obesity, and women who are on more than one pathway. There were also issues noted regarding barriers to accessing services and translation offers. CHFT are producing an action plan which includes a social vulnerability tool to include in risk assessing women, however in recognition of the need for involvement and action from wider system partners a series of meetings have taken place to agree a system action plan. The Place Director of Nursing and CHFT Chief Nurse are working together to support this.

In addition, engagement sessions are scheduled with communities to do some focused work to understand barriers to accessing maternity services, and cultural comprehension was discussed.

System review summary and next steps:

- Consider findings in context of Child Death Overview Panel (CDOP) outcome intelligence and connections to Safeguarding partnerships.
- Partnership approach-including strengthening primary care interface and expectations regarding women's health.
- Improve maternity connectivity, including pre conceptual care into the Starting Well Programme

- Public Health to review Prevention programme, particularly diabetes and obesity.
- West Yorkshire Obesity Strategy to include pre conceptual focus.

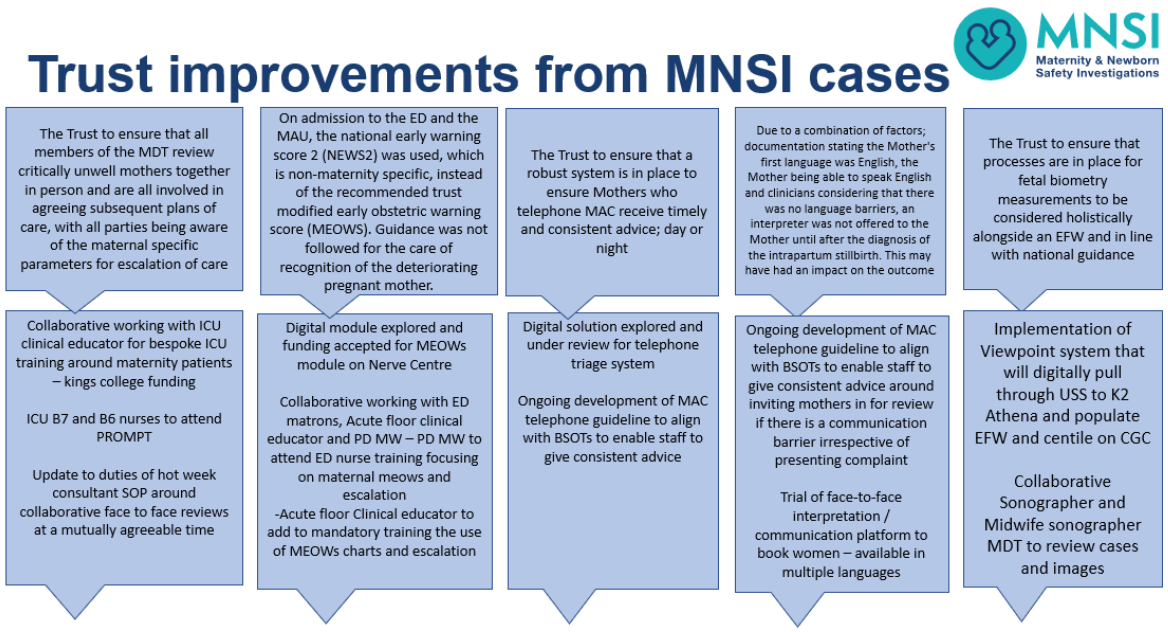
Internal actions include:

- A vulnerability tool has been developed at CHFT and adapted for maternity services. This has been created in KP+ as draft and work is ongoing to validate the efficacy. It has been retrospectively applied to the cases of stillbirth as part of a testing process. The next steps are for presentation of the tool to the consultant obstetric body and agree how best this can be applied in practice. Areas being considered for application inlcude enhanced clinical pathways, MDT review of the most vulnerable 20% on a regular basis, continuity of carer or early intervention midwifery support, social prescribing support.
- Viewpoint ultrasound software implementation to support identification and monitoring of growth restricted pathways – project group in place.
- Move to population-based growth charts for monitoring fundal height and ultrasound growth to standardise this with viewpoint software.
- Diabetes caseload management solution to support tracking of caseload.
- Bid for CoC funding to support early intervention midwife/maternity befriender social prescribing roles.
- Workforce model implementation plan for roll out of continuity of carer to most vulnerable.
- Submit a business case for a consultant midwife (in line with Ockenden requirement to meet RCM leadership manifesto) with a portfolio of closing the gap in health inequalities and personalised care.

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	51
Referrals / cases rejected	18
Total investigations to date	33
Total investigations completed	32
Current active cases	1
Exception reporting	1 (MI-036918)



3.7 Perinatal Mortality Review Tool (PMRT)

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

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

A trust board summary report from the PMRT tool has been included in Appendix 1 in line with the maternity incentive scheme safety action one.

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

4.1 Maternity Incentive Scheme (MIS)

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

4.2 CQC

CQC Maternity ratings	
Date Inspection	June 2023
Overall Rating	Good

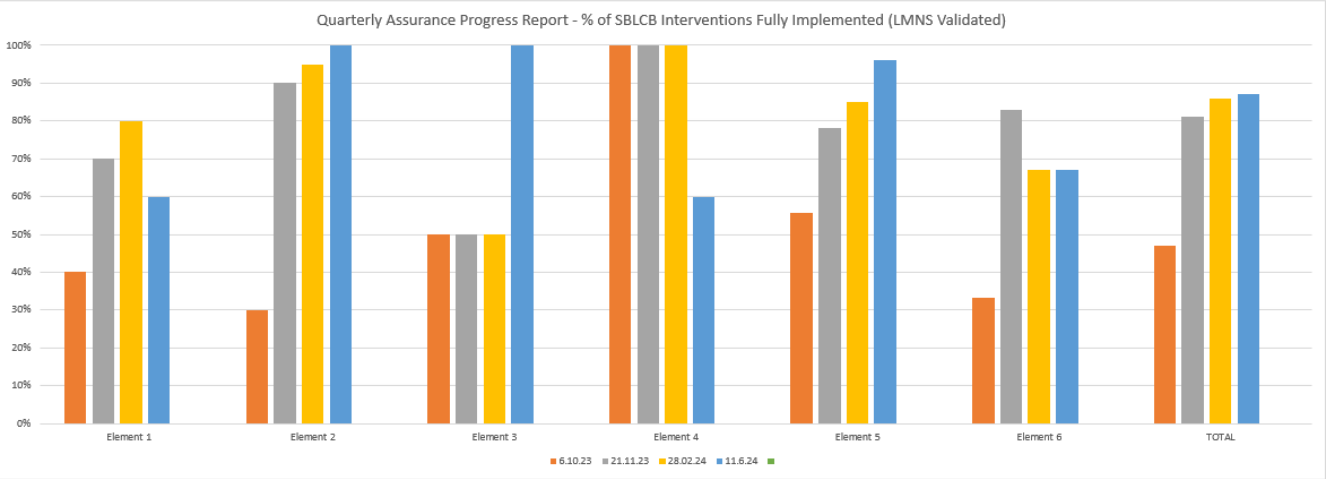
CQC Neonatal ratings	
Date Inspection	Not yet inspected as core service
Overall Rating	N/A

4.3 Regulatory Actions

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

4.4 Saving Babies Lives Care Bundle version 3.

Saving babies Lives evidence review in 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			Apr 24	May 24	Jun 24	Jul 24	YTD
	Green	Amber	Red					
Total Bookings <13 Weeks	>90%	-	<90%	86.45%	89.10%	89.20%	89.32%	88.4%
Total Births within Service	Monitoring Only			339	328	348	364	1379
Bookings <10 weeks	>90%	-	<90%	63.2%	67.6%	67.9%	68.0%	66.5%
Normal births	>57%	-	<57%	51.0%	47.6%	51.4%	55.5%	67.96%
Assisted vaginal births	<12.4%	-	>12.4%	12.09%	11.59%	9.20%	9.34%	10.51%
Elective C/S deliveries	Monitoring Only			14.67%	17.39%	13.41%	13.19%	14.60%
Emergency C/S deliveries	Monitoring Only			21.56%	24.22%	25.07%	21.15%	22.96%
3rd/4th degree tear - normal birth	<2.8%	-	>2.8%	0.3%	0.6%	1.5%	0.8%	3.2%
3rd/4th degree tear - assisted birth	<6.05%	-	>6.05%	7.3%	2.6%	0.0%	0.0%	2.8%
PPH ≥ 1500ml	<3%	3%-3.5%	>=3.5%	3.3%	2.5%	2.9%	4.4%	3.3%
Total stillbirths	0	<3	>=3	3	3	2	1	9
Perinatal and Neonatal Deaths	0	<3	>=3	1	0	1	0	2
Total stillbirths and Perinatal /Neonatal Deaths	0	<3	>=3	4	3	3	1	11
Low birth weight at term - live births - % of live babies at term < 2200g	0%	-	>=1%	0.96%	0.31%	0.00%	0.88%	0.54%
1:1 Care in Labour	>=98%	>=97%	<97%	98.8%	99.7%	99.4%	99.4%	98.5%
Induction Rate	Monitoring Only			50.5%	47.7%	42.4%	36.7%	44.1%
Planned Home Birth	Monitoring Only			1.20%	0.93%	2.33%	1.10%	0.44%
Smoking at Delivery	< 11%	-	> 11%	6.59%	7.76%	6.41%	6.04%	6.68%
Smoking at Delivery (Not recorded)	3%		>3%	5.1%	4.0%	4.4%	8.5%	5.6%
CO tested at booking	Monitoring Only			99.8%	98.3%	98.6%	97.1%	98.5%
No. Mothers breastfeeding as First Feed	≥ 74.4%	-	< 74.4%	68.0%	71.8%	69.5%	64.5%	68.3%
No. Mothers breastfeeding as First Feed Not Recorded	Monitoring Only			19	15	26	26	86
CO testing at 36 weeks (35-36.6 days)	≥ 80%	-	< 70%	95.41%	94.01%	94.74%	94.58%	94.68%

Areas to note include:

- 3/4th degree tear rates: Improvement has been seen and will continue to be observed - x2 workshops have been held in May, further dates have been arranged. A work together get results (WTGR) has been held with physiotherapy colleagues to create a plan for roll out of the pelvic health specification in line with the Three-year delivery plan.
- Postpartum Haemorrhage (PPH) – Since January, the rate of PPH has flagged as amber x2 and red x2. A deep dive of PPH was due to be undertaken however this has been delayed due to workforce capacity challenges. There has been an improvement in this rate subsequently however a deep dive will still be conducted.
- Ongoing work to validate each data point and to move to KP+ and SPC reporting.

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. Walkabouts as an alternative mechanism to engage staff have taken place which have been more successful. There is no specific feedback through the safety champion mechanism to highlight to the Board.

Appendix 1 – PMRT Trust Board Summary Report Q4 23-24 and Q1 24-25 combined.

PMRT - Perinatal Mortality Reviews Summary Report

This report has been generated following mortality reviews which were carried out using the national Perinatal Mortality Review Tool

Calderdale & Huddersfield NHS Foundation Trust

Report of perinatal mortality reviews completed for deaths which occurred in the period:

1/1/2024 to 30/6/2024

Summary of perinatal deaths*

Total perinatal* deaths reported to the MBRRACE-UK perinatal mortality surveillance in this period: *21*

Summary of reviews**

Stillbirths and late fetal losses				
Number of stillbirths and late fetal losses reported	Not supported for Review	Reviews in progress	Reviews completed and published ***	Grading of care: number of stillbirths and late fetal losses with issues with care likely to have made a difference to the outcome for the baby
20	2	6	12	0

Neonatal and post-neonatal deaths				
Number of neonatal and post-neonatal deaths reported	Not supported for Review	Reviews in progress	Reviews completed and published ***	Grading of care: number of neonatal and post-neonatal deaths with issues with care likely to have made a difference to the outcome for the baby
3	0	3	0	0

*Late fetal losses, stillbirths and neonatal deaths (does not include post-neonatal deaths which are not eligible for MBRRACE-UK surveillance) – these are the total deaths reported and may not be all deaths which occurred in the reporting period if notification to MBRRACE-UK is delayed. Termination of pregnancy are excluded. All other perinatal deaths reported to MBRRACE-UK are included here regardless of whether a review has been started or is published.

** Post-neonatal deaths can also be reviewed using the PMRT

*** If a review has been started, but has not been completed and published then the information from that review does not appear in the rest of this summary report

Report Generated by: Emma Bowman
Date report generated: 30/08/2024 15:14

Table 1: Summary information for the babies who died in this period and for whom a review of care has been completed – number of babies (N = 12)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
Late Fetal Losses (<24 weeks)	0	0	--	--	--	--	0
Stillbirths total (24+ weeks)	0	0	2	1	8	1	12
Antepartum stillbirths	*0*	*0*	*2*	*1*	*8*	*1*	*12*
Intrapartum stillbirths	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Timing of stillbirth unknown	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Early neonatal deaths (1-7 days)*	0	0	0	0	0	0	0
Late neonatal deaths (8-28 days)*	0	0	0	0	0	0	0
Post-neonatal deaths (29 days +)*	0	0	0	0	0	0	0
Total deaths reviewed	0	0	2	1	8	1	12
Small for gestational age at birth:							
IUGR identified prenatally and management was appropriate	0	0	0	0	0	0	0
IUGR identified prenatally but not managed appropriately	0	0	0	0	0	0	0
IUGR not identified prenatally	0	0	0	0	2	0	2
Not Applicable	0	0	2	1	6	1	10
Mother gave birth in a setting appropriate to her and/or her baby's clinical needs:							
Yes	0	0	2	1	8	1	12
No	0	0	0	0	0	0	0
Missing	0	0	0	0	0	0	0
Parental perspective of care sought and considered in the review process:							
Yes	0	0	2	1	8	1	12
No	0	0	0	0	0	0	0
Missing	0	0	0	0	0	0	0
Booked for care in-house	0	0	0	0	0	0	0
Mother transferred before birth	0	0	0	0	0	0	0
Baby transferred after birth	0	0	0	0	0	0	0
Neonatal palliative care planned prenatally	0	0	0	0	0	0	0
Neonatal care re-orientated	0	0	0	0	0	0	0

*Neonatal deaths are defined as the death within the first 28 days of birth of a baby born alive at any gestational age; early neonatal deaths are those where death occurs when the baby is 1-7 days old and late neonatal death are those where the baby dies on days 8-28 after birth. Post-neonatal deaths are those deaths occurring from 28 days up to one year after birth

Table 2: Placental histology and post-mortems conducted for the babies who died in this period and for whom a review of care has been completed – number of babies (N = 12)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
Late fetal losses and stillbirths							
Placental histology carried out							
Yes	0	0	2	1	8	1	12
No	0	0	0	0	0	0	0
Hospital post-mortem offered	0	0	2	1	8	1	12
Hospital post-mortem declined	0	0	2	1	7	1	11
Hospital post-mortem carried out:							
Full post-mortem	0	0	0	0	1	0	1
Limited and targeted post-mortem	0	0	0	0	0	0	0
Minimally invasive post-mortem	0	0	0	0	0	0	0
External review	0	0	0	0	0	0	0
Virtual post-mortem using CT/MR	0	0	0	0	0	0	0
Neonatal and post-neonatal deaths:							
Placental histology carried out							
Yes	0	0	0	0	0	0	0
No	0	0	0	0	0	0	0
Death discussed with the coroner/procurator fiscal	0	0	0	0	0	0	0
Coroner/procurator fiscal PM performed	0	0	0	0	0	0	0
Hospital post-mortem offered	0	0	0	0	0	0	0
Hospital post-mortem declined	0	0	0	0	0	0	0
Hospital post-mortem carried out:							
Full post-mortem	0	0	0	0	0	0	0
Limited and targeted post-mortem	0	0	0	0	0	0	0
Minimally invasive PMpost-mortem	0	0	0	0	0	0	0
External review	0	0	0	0	0	0	0
Virtual post-mortem using CT/MR	0	0	0	0	0	0	0
All deaths:							
Post-mortem performed by paediatric/perinatal pathologist*							
Yes	0	0	0	0	1	0	1
No	0	0	0	0	0	0	0
Placental histology carried out by paediatric/perinatal pathologist*:							
Yes	0	0	2	1	8	1	12
No	0	0	0	0	0	0	0

*Includes coronial/procurator fiscal post-mortems

Table 3: Number of participants involved in the reviews of late fetal losses and stillbirths without resuscitation (N = 12)

Role	Total Review sessions	Reviews with at least one
Chair	0	0%
Vice Chair	0	0%
Admin/Clerical	1	8% (1)
Bereavement Team	4	25% (3)
Community Midwife	0	0%
External	3	25% (3)
Management Team	0	0%
Midwife	63	100% (12)
Neonatal Nurse	0	0%
Neonatologist	0	0%
Obstetrician	12	75% (9)
Other	0	0%
Risk Manager or Governance Team	51	100% (12)
Safety Champion	0	0%

Table 4: Number of participants involved in the reviews of stillbirths with resuscitation and neonatal deaths (N = 0)

Role	Total Review sessions	Reviews with at least one
Chair	0	0%
Vice Chair	0	0%
Admin/Clerical	0	0%
Bereavement Team	0	0%
Community Midwife	0	0%
External	0	0%
Management Team	0	0%
Midwife	0	0%
Neonatal Nurse	0	0%
Neonatologist	0	0%
Obstetrician	0	0%
Other	0	0%
Risk Manager or Governance Team	0	0%
Safety Champion	0	0%

Table 5: Grading of care relating to the babies who died in this period and for whom a review of care has been completed – number of babies (N = 12)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
STILLBIRTHS & LATE FETAL LOSSES							
Grading of care of the mother and baby up to the point that the baby was confirmed as having died:							
A - The review group concluded that there were no issues with care identified up the point that the baby was confirmed as having died	0	0	1	1	6	1	9
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	0	0	0	0	0	0
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	1	0	2	0	3
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
Grading of care of the mother following confirmation of the death of her baby:							
A - The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby	0	0	2	1	6	1	10
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother	0	0	0	0	1	0	1
C - The review group identified care issues which they considered may have made a difference to the outcome for the mother	0	0	0	0	1	0	1
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
NEONATAL AND POST-NEONATAL DEATHS							
Grading of care of the mother and baby up to the point of birth of the baby:							
A - The review group concluded that there were no issues with care identified up the point that the baby was born	0	0	0	0	0	0	0
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	0	0	0	0	0	0
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
Grading of care of the baby from birth up to the death of the baby:							
A - The review group concluded that there were no issues with care identified from birth up the point that the baby died	0	0	0	0	0	0	0
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	0	0	0	0	0	0
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
Grading of care of the mother following the death of her baby:							
A - The review group concluded that there were no issues with care identified for the mother following the death of her baby	0	0	0	0	0	0	0
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother	0	0	0	0	0	0	0
C - The review group identified care issues which they considered may have made a difference to the outcome for the mother	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0

Table 6: Cause of death of the babies who died in this period and for whom a review of care has been completed – number of babies (N = 12)

Timing of death	Cause of death
Late fetal losses	**0 causes of death out of 0 reviews**
Stillbirths	**12 causes of death out of 12 reviews**
	Cause of death not obstetric but due to the splenetic aneurysm bleed
	1 DKA 2 Placental insufficiency 3 True knot in the cord leading to maternal and fetal vascular malperfusion.
	Fetal groth restriction secondary to maternal severe hypertension
	Placental insufficiency and Trisomy 21
	The cause of death was undetermined
	Placental abruption
	Placental abruption
	Uncontrolled diabetes Placental insufficiency
	Placaental insufficiency
	Placental malprefussion
	The cause of death was undetermined
	Maternal and fetal malprefussion.
Neonatal deaths	**0 causes of death out of 0 reviews**
Post-neonatal deaths	**0 causes of death out of 0 reviews**

Table 7: Issues raised by the reviews identified as relevant to the deaths reviewed, by the number of deaths affected by each issue* and the actions planned

Issues raised which were identified as relevant to the deaths	Number of deaths	Actions planned
There is no evidence in the notes that this mother was asked about domestic abuse at booking	1	No action entered
This mother had a previous baby which was growth restricted/small for gestational age and her antenatal care was not appropriate given this history	1	Women to be supported to take aspirin. To add to the weekly view re UAD scans
This mother had gestational diabetes during her pregnancy which was not managed according to national or local guidelines	1	The monitoring of women (follow up, number of visits) at the joint diabetic clinic is one of the terms of at the serious investigation

*Note - depending upon the circumstances in individual cases the same issue can be raised as relevant to the deaths reviewed and also not relevant to the deaths reviewed.

Table 8: Top 10 issues** raised by the reviews which are of concern but not directly relevant to the deaths reviewed, by the number of deaths in which this issue was identified* and the actions planned

Issues raised which were identified as not relevant to the deaths	Number of deaths	Actions planned
This mother booked late. Are there any organisations to consider in relation to her booking late?	3	No action entered
		No action entered
		No action entered
This mother booked late. Did this affect her care?	3	No action entered
		No action entered
		No action entered
The baby was small for gestational age at birth, scans were indicated but had not been performed	2	Review the timing of CTG when waiting for a scan at the guidelines group
		No action entered
The baby had to be transferred elsewhere for the post-mortem	1	No action entered
There is no evidence in the notes that this mother was asked about domestic abuse at booking	1	No action entered
This mother booked early enough but her mid-trimester anomaly scan was carried out after 20+6 weeks	1	No action entered
This mother booked early enough but was not offered trisomy screening	1	No action entered
This mother had poor/no English and family members were used as interpreters during her labour and birth	1	No action entered
This mother had poor/no English and family members were used as interpreters on occasions during her antenatal care	1	No action entered
This mother had poor/no English and language line was used to interpret during her labour and birth	1	No action entered

*Note - depending upon the circumstances in individual cases the same issue can be raised as relevant to the deaths reviewed and also not relevant to the deaths reviewed.

** There are further issues which can be downloaded directly as a spreadsheet using the Extract Issues/Factors button

Table 9: Top 5 contributory factors related to issues identified as relevant to the deaths reviewed, by the frequency of the contributory factor and the issues to which the contributory factors related

Issue Factor	Number of deaths	Issues raised for which these were the contributory factors
Patient Factors - Clinical Conditions	1	This mother had gestational diabetes during her pregnancy which was not managed according to national or local guidelines
Staff Factors - Cognitive Factors	1	This mother had a previous baby which was growth restricted/small for gestational age and her antenatal care was not appropriate given this history
Communication - Communication Management	1	There is no evidence in the notes that this mother was asked about domestic abuse at booking

INTEGRATED PERFORMANCE

10. Quality Committee Chair Highlight Report - 2 July 2024

- Director of Infection Prevention Control Q1 Report

- Learning from Deaths Annual Report

For Assurance

Presented by Denise Sterling

Calderdale and Huddersfield NHS Foundation Trust

CHAIR'S HIGHLIGHT REPORT
to the Board of Directors

Committee Name:	Quality Committee
Committee Chair:	Denise Sterling
Date of meeting:	2nd July 2024
Date of Board meeting this report is to be presented:	12th September 2024
ACKNOWLEDGE	• Strong progress is being made against the objectives in the Trust's research strategy, with increased research engagement, growing numbers of clinical research champions, enhanced staff training. Work is ongoing to expand the commercial and non-commercial research portfolio.
ASSURE	• The Medical Gas and NIV group reported key achievements, including updated policies, completed inspections with no major concerns, and improved Entonox training compliance. • The Hospital Transfusion Service is making strides in addressing key challenges, including the proactive management of three Serious Hazards of Transfusion (SHOT) incidents and targeted training that has effectively reduced the number of rejected blood samples in midwifery. Substantial improvements have been made in compliance with mandatory BloodTrack training and updates to transfusion policies are pending approval. • The May 2024 IPR, highlights strong performance in elective recovery, cancer diagnosis targets and improvements in falls per 1,000 bed days, hospital-acquired pressure ulcers, and day case rates. Stroke admissions to an acute unit within four hours fell below 30%, steps are being taken to improve stroke care and manage Clostridium difficile risks through deep cleaning initiatives at CRH. There are concerns with rising SHMI and HSMR rates due to changes in patient admission data, and targeted reviews are underway to address quality issues. • A deep dive into acute kidney injury (AKI) highlighted that over the past year, the Trust exceeded benchmarks for the length of stay and the 30 day mortality rate. Compliance with assessments and investigations was low, prompting targeted actions which will be monitored through the divisional Patient Safety and Quality Board (PSQB) meetings and the AKI collaborative to significantly improve compliance by the end of Quarter 4. • The Ward Assurance Deep Dive provided an update on key pieces of work undertaken to produce a refreshed

	ward assurance framework re named quality assurance to include departments and community settings. Outlining clear roles, responsibilities, and governance with daily "must-dos" for the nurse in charge. A quick reference guide and a comprehensive dashboard on the knowledge portal have been created, with oversight occurring through matron one-to-ones, divisional PSQBs, and committees. • The Maternity and Neonatal Oversight Report - the Trust is on track with the Maternity Incentive Scheme and has achieved 87% compliance with the Saving Babies Lives Care Bundle V3. Recruitment of newly qualified midwives is set to reduce vacancies below 10%. Ongoing concerns include stillbirth rates above the national average, prompting an external review and a system-wide response is being sought to address the health inequalities. There is also a planned deep dive into postpartum haemorrhage rates due to flagging as amber twice and red twice over the last 4 months. • The Committee's annual assessment of effectiveness was presented and the action plan and Committee objectives for 2024/25 were approved.
AWARE	• A comprehensive review of the Trust's progress on the 2018 CQC Inspection's 'Must Do' and 'Should Do' recommendations has been completed. The review aimed to ensure ongoing compliance, identify any gaps, and update the Trust's position on these actions. The Quality Committee considered and agreed the closure of 11 recommendations from the 2018 CQC Inspection (4 Must Do actions & 7 Should Do actions) Updates for the 2 remaining 'Should Do' actions will be presented at the July 2024 CQC Group. • National concerns about the quality and safety of paediatric audiology services, led to a review of the services provided by the Trust. Although initial assessments identified significant risks, recent evaluations show improvements, and the Trust is actively working through an action plan and the risk rating has been reduced. The Trust is working towards 'Improving Quality in Physiological Services' (IQIPs) accreditation as soon as possible. as recommended by the Paediatric Hearing Services Improvement Programme.
ONE CULTURE OF CARE	• One Culture of Care is integrated into Committee discussion.
REGULATIONS	• CQC Regulation 12: Safe care and treatment • CQC Regulation 17: Good governance

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Date of Meeting:	12 September 2024
Meeting:	Board of Directors
Title of Report:	Q1 Infection Prevention and Control
Author:	Belinda Russell, Matron Lead IPC
Sponsoring Director:	Dr David Birkenhead, Medical Director
Previous Forums:	ICC Quality Committee – 3 September 2024
Purpose of the Report	The report provides an update on Infection, Prevention and Control (IPC) performance and activity for the first quarter of 24/ 25.
Key Points to Note	A large number of outbreaks of Norovirus across the Trust has affected patient flow and length of stay within the first quarter which has occupied a large proportion of the IPC team's workload as reactive work.
Regulation	CQC 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.

DIPC Report Q1 1st April – 30th June 2024

Calderdale and Huddersfield Foundation Trust recognises that effective infection prevention practice, underpinned by the implementation and audit of evidence-based policies, guidelines and education are fundamental to the reduction of risk and patient harm from Healthcare Associated Infections (HCAI). The report will provide assurance against key infection prevention and control performance and quality indicators. The objective targets for 24/25 have not yet been given, we continue to monitor against 23/24 target figures.

1. Performance targets

Indicator	Objective 2023/24 No new target set 24/25	CHFT Year to date performance Last yr to date figures for comparison in brackets	Actions/Comments
MRSA bacteraemia	No target set	0 (0)	Not mentioned on this year's targets continue to be monitored by IPC team. 0 HOHA (1 COCA)
C.Difficile (HOHA & COHA)	37	12 (15)	8 HOHA 4 COHA (5 COCA) (Q1 HOHA 2 April 2May 4June =8)
E. coli bacteraemia	67	10 (21)	3 HOHA 7 COHA (50 COCA)
Pseudomonas aeruginosa	2	1 (2)	1 HOHA 0 COHA (1 COCA)
Klebsiella spp.	28	9 (15)	6 HOHA 3 COHA (11 COCA)
MSSA	No target set	8 (12)	Not mentioned on this year's targets continue to be monitored by IPC team. 3 HOHA 5 COHA (10 COCA)
ANTT Trust overall competency assessments	90%	91.42%	
ANTT Competency assessments (medical staff)	90%	83.11%	Increased compliance on last year
ANTT Competency assessments (nursing and AHP)	90%	93.52%	Increased compliance on last year
Hand hygiene	95%	100%	Audit process renewed in 24/25
Level 2 IPC Training Trust overall		92%	
Level 2 IPC training (Medical staff)	90%	82.91%	Decreased compliance on last year
Level 2 IPC training (nursing and AHP)	90%	93.91%	Increased compliance on last year.

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

2. Quality Indicators

Indicator	Year-end agreed target	YTD performance	Comments
MRSA screening (emergency)	95%	92.07%	Increased 5.8% on last year
Isolation breaches	None set	Not recorded this quarter	COVID-19 patients remain priority for side room isolation

3. MRSA bacteraemia

No objective for MRSA cases set in year. **0 HOHA** and **1 COCA** case to report during the current year.

4. MSSA bacteraemia

There is no objective set for MSSA. The IPC team continue to review these cases. **3 HOHA and 5 COHA cases in the year**, these cases will continue to be reviewed with any correlations between the cases then being escalated appropriately.

5. 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 cases: 8 HOHA cases and 4 COHA cases year to date

6. E. coli bacteraemia

E.coli bacteraemia within this quarter: 3 **HOHA cases and 7 COHA *E. coli* bacteraemia cases in the year** The Trust is participating in regional improvement work in relation to gram negative bacteraemia.

7. 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
	21.04.24 5D Norovirus
01.04.24 Acute floor 9B VGE	22.04.24 5B Norovirus
02.05.24 5 C19 mitigations	25.04.24 2B VGE
25.04.24 11A VGE/norovirus	26.04.24 8D norovirus
08.05.24 15B C19 mitigations	02.05.24 2B Norovirus
09.05.24 5 Norovirus	09.05.24 6AB C19 mitigations
20.05.24 VGE	12.05.24 8BD Norovirus
31.05.24 5 C19 mitigations	19.0.24 6C Norovirus
16.06.24 20B C19 mitigations	21.05.24 5 ABCD Norovirus
	07.06.24 2A bay closed rotavirus

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.

Increased incidence of norovirus: large numbers of cases of confirmed norovirus were seen and monitored, involving both the restriction and closure of several ward areas during the first quarter of 24/25 which may have affected both patient flow and length of stay**.**

8. Audits

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

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

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

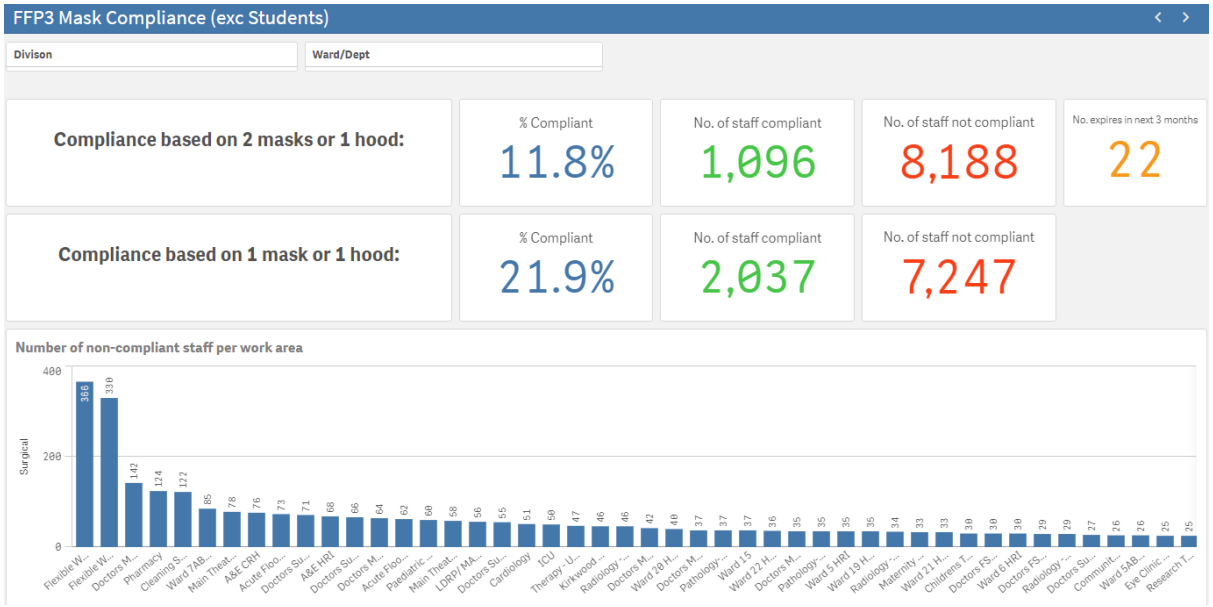
National Standards of Cleanliness: Implementation of the new National Standards of Cleanliness (2021) which will replace the National Specifications for Cleanliness in the NHS (2007) has begun. This is applicable to all Healthcare settings and has several mandatory elements:

- Functional risk categories
- Elements, frequencies, and performance parameters
- Cleaning responsibilities
- Audit frequency

- Star ratings
- Efficacy checks
- Commitment to cleanliness charter

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

Fit testing: Data can now be seen on Knowledge Portal + 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.



9. Recommendations

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

Date of Meeting:	12 September 2024
Meeting:	Board of Directors
Title:	Learning from Deaths Annual Report 2023/24
Author:	Mandy Hurley - Quality Governance Lead Nikhil Bhuskute, Deputy Medical Director Sharon Cundy, Head of Quality & Patient Safety
Sponsoring Director:	David Birkenhead Executive Medical Director
Previous Forums:	Mortality & Surveillance Group – 29th August 2024 Quality Committee – 3 September 2024
Purpose of the Report	• To provide Quality Committee with assurance of the Learning from Deaths mortality review process • To provide a review of mortality during 2023/24 • To provide a focus on Learning Disabilities mortality reviews • To provide a focus on Maternity & Newborn Safety Investigations
Key Points to Note	**Learning from Deaths Annual Report 2023/24** • Following an extended period of a low HSMR throughout 2020 and 2 022, this measure has risen throughout 2023. • The Medical Examiner's office continues to perform scrutiny on deaths within the Trust and those from the wider community. On the 9th September 2024, the Medical Examiner service will become statute. This means that all deaths occurring in any health setting, which are not investigated by HMC, will be reviewed by an NHS medical examiner. • 811 Level 1 Initial Screening Reviews took place covering 48% of dea ths against a target of 50%. • 210 Level 2 Structured Judgement Reviews (SJR's) took place comp ared with 164 in 2022/23.
Regulation	CQC Regulation 20: Duty of candour
EQIA – Equality Impact Assessment	Demographic characteristics relating to age, gender, ethnicity and index of multiple deprivation are included in the report. Deaths of those with learning disabilities aged 4 and upwards: managed through the national LeDeR programme (learning disabilities mortality review). All deaths in patient with learning disabilities are reported externally and reviewed, regardless of the cause of death or place of death. This process runs alongside our internal mortality reviews and does not replace out internal process. All deaths are reviewed internally using a SJR. These reviews are collated and an annual report is provided by the Matron for Complex Care and presented to the Mortality Surveillance Group. A review of Learning disability deaths for 2021/22 is presented within this paper.

	Child deaths: Whilst all deaths are notified to the Child Death Overview Panel and a core data set collected, not all deaths will be reviewed in detail and are therefore considered for SJR review. Particular consideration is given to the review of sudden unexpected deaths in infancy and childhood; accidental deaths; deaths related to maltreatment; suicides; and any deaths from natural causes where there are potential lessons to be learnt about prevention. Maternal deaths are reported to the National MBRRACE-UK, to allow confidential review and wider learning dissemination. Maternal deaths are normally notified to the woman's area of residence. These cases are also reported on Datix to ensure local governance and risk management structures are followed. All cases of maternal death are discussed at the weekly maternity governance meeting and reported to the Patient Safety Quality Board. Quarterly reports are presented to the Mortality Surveillance Group. Stillborn and perinatal deaths are reported to the National MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) to allow confidential review by HSIB and wider learning dissemination. These cases are also reported on Datix to ensure local governance and risk management structures are followed. Stillbirths and neonatal deaths are reviewed by a multidisciplinary team and reported nationally via the Perinatal Mortality Review Tool.
Recommendation	The Board is asked to **NOTE** the report.

Learning from Deaths Annual Report 2023/2024

Executive Summary:
During 2023/24 there were 1691 adult in-patient deaths reported at Calderdale and Huddersfield NHS Foundation Trust (CHFT). 811 Initial Screening Reviews (ISRs) took place covering 48% of deaths against a Trust target of 50%. This demonstrates an improvement on 2022/23 where 42% of deaths were reviewed. In addition to these reviews, 210 Structured Judgement Reviews (SJRs) took place compared with 164 in 2022/23.

Purpose:
This report summarises the key learning identified in the mortality reviews completed for 2023/24 and it will provide an overview of Trust-level mortality data and performance for the latest available Healthcare Evaluation Data (HED) providing assurance that any highlighted concerns are investigated thoroughly, and appropriate action taken.

Background:
In December 2015, the secretaries of State for Health commissioned the Care Quality Commission (CQC) to carry out a review of how acute, community and mental health Trusts across the country investigate incidents and learn from deaths. This was to find out whether opportunities for preventing deaths have been missed, and identify any improvements needed.

The NHS Quality Board national guidance was followed in July 2018 with specific guidance for NHS Trusts on working with families and carers. This was co-produced with families and carers to provide Trusts with advice on how they should support, communicate, and engage with families following the death of someone in their care.

Whilst the guidance from the National Quality Board makes it clear that Trusts should report on inpatient deaths and those inpatients that have died within 30 days of leaving hospital. Locally Trusts can determine their own individual approaches to undertaking mortality reviews including definitions of deaths in scope for review.

Consequently, mortality data is therefore not comparable between Trusts. As such CHFT will continue to evolve its processes and refine reporting over time in accordance with local and national learning. This is in addition to the detailed reporting and investigation of deaths meeting the national criteria for serious incident review.

CHFT is committed to accurately monitoring and understanding its mortality outcomes. Reviewing patient outcomes, such as mortality, is important to help provide assurance and evidence that the quality of care is of a high standard and to ensure any identified issues are effectively addressed to improve patient care. Learning from deaths is supported by two key policies within CHFT: the Incident Reporting, Management and Investigation Policy and the Learning from Deaths policy. These policies guide and inform the organisation about reporting, investigating and learning from deaths. Reviewing mortality ensures that CHFT aligns to the NHS Outcomes Framework.

Mortality Reviews:
All adult inpatient deaths require a mortality review and learning from the deaths of people in our care can help us to not only improve the quality of the care we provide to patients and their families but to also identify where we could do more.

Trends and themes are reported to the Mortality Surveillance Group (MSG) and each division within the Trust. Any SJR that reveals any concerns around care provision, service provision, or identifies issues which may have contributed to the death of a service user or patient are

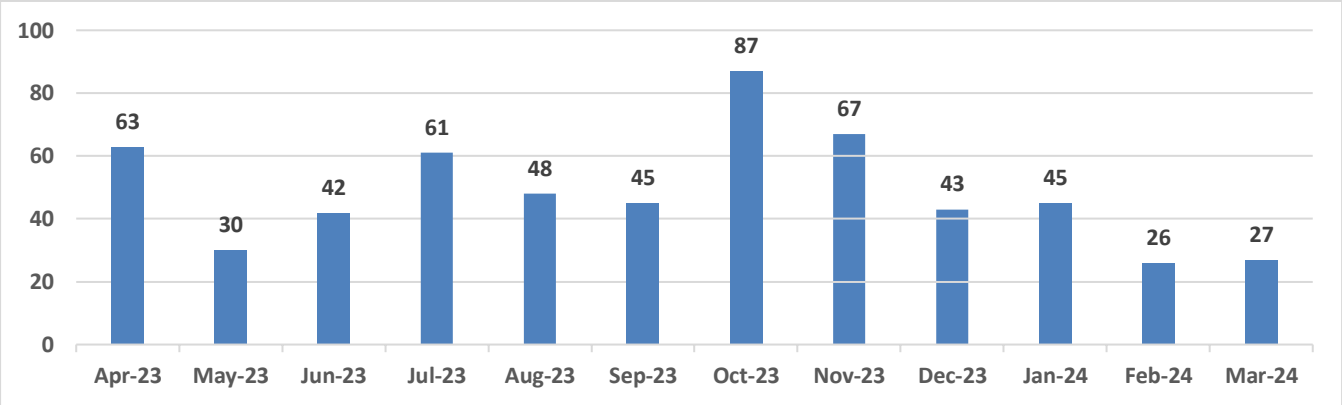
presented to the MSG and, where appropriate, are reviewed via a serious incident investigation.

Unexpected patient safety related deaths are directed to the Serious Incident Review (SI) panel and are subject to a serious incident investigation as appropriate.

Initial Screening Review (ISR):
The online initial screening review tool focuses on initial assessment, ongoing care and end of life management. Reviewers are asked to provide their judgement on the overall quality of care. On a monthly basis the specialities are informed of their mortalities and are asked to complete ISRs.

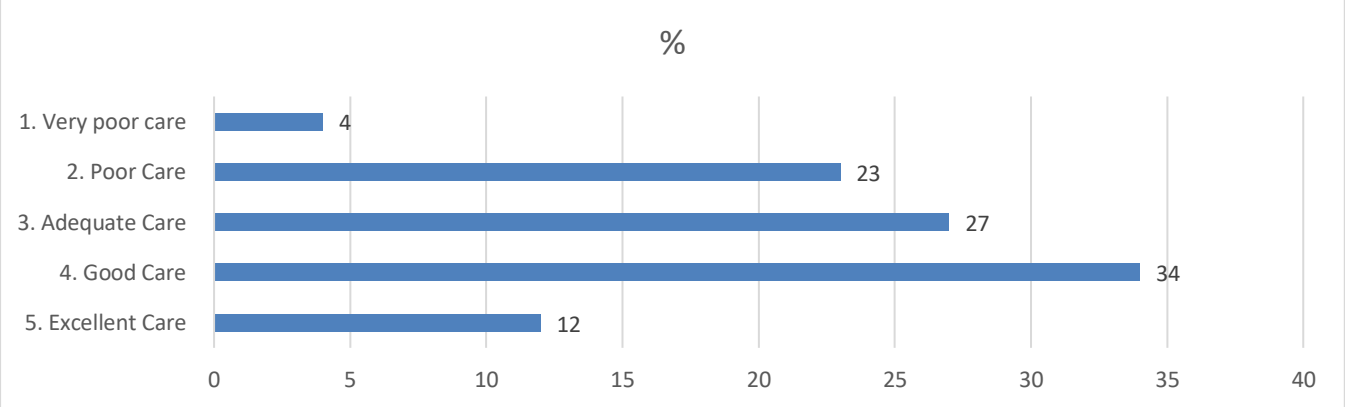
During 2023/2024, 1691 adult in-patients died. Of these 811 **(48%)** have been reviewed using the initial screening tool (ISR). This process aimed to achieve an ISR review of 50% of all CHFT adult inpatient deaths. This target has not been met; however, compliance has steadily increased over the previous 2 years , in comparison to March 2021 when compliance was 30%.

Number of adult inpatient deaths reviewed by ISR (%) by month:



In the 811 cases reviewed the quality of care was assessed as follows:

Quality of Care Score distribution for completed ISR's:



Poor care or very poor care scores trigger further investigation using structured judgement review (SJR). Elements of poor care were identified in 27% of cases and escalated for SJR.

Structured Judgement Reviews (SJR's):

SJR is a standardised case note review methodology. SJR blends traditional, clinical judgement-based review methods with a standard format. This approach requires reviewers to make safety and quality judgements over phases of care, to make explicit written comments about care for each phase, including feeding back to members of the multi-professional team examples of excellent care and providing a score for each phase and an overall score.

The identified phases of care are:

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

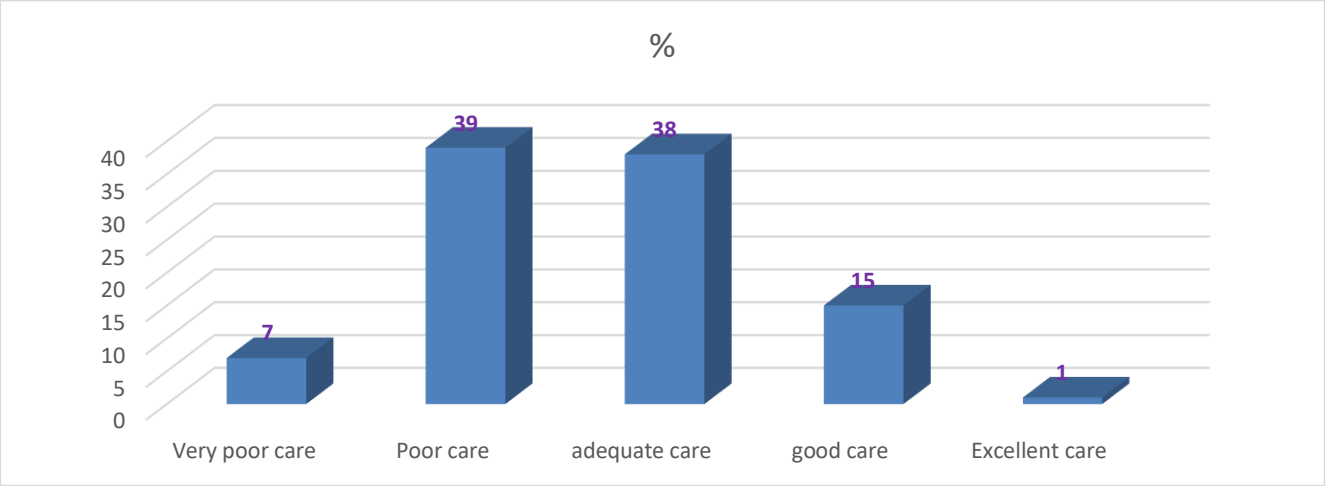
In 2023/24, 210 SJRs were completed, and the chart below identifies where the SJRs were requested. With the introduction of the ME office, CHFT has seen an increase in the requests for an SJR.

Number of SJRs requested in 2023/24.

ME office	ISR	2nd opinion	Mortality Alerts	LD patients	Incidents/complaints
59	55	57	26	7	6

As with the ISR's, the SJRs give an overall care score. The chart below gives the breakdown of quality care scores for completed SJRs in 2023/24.

Quality Care Score distribution for 210 completed SJR:

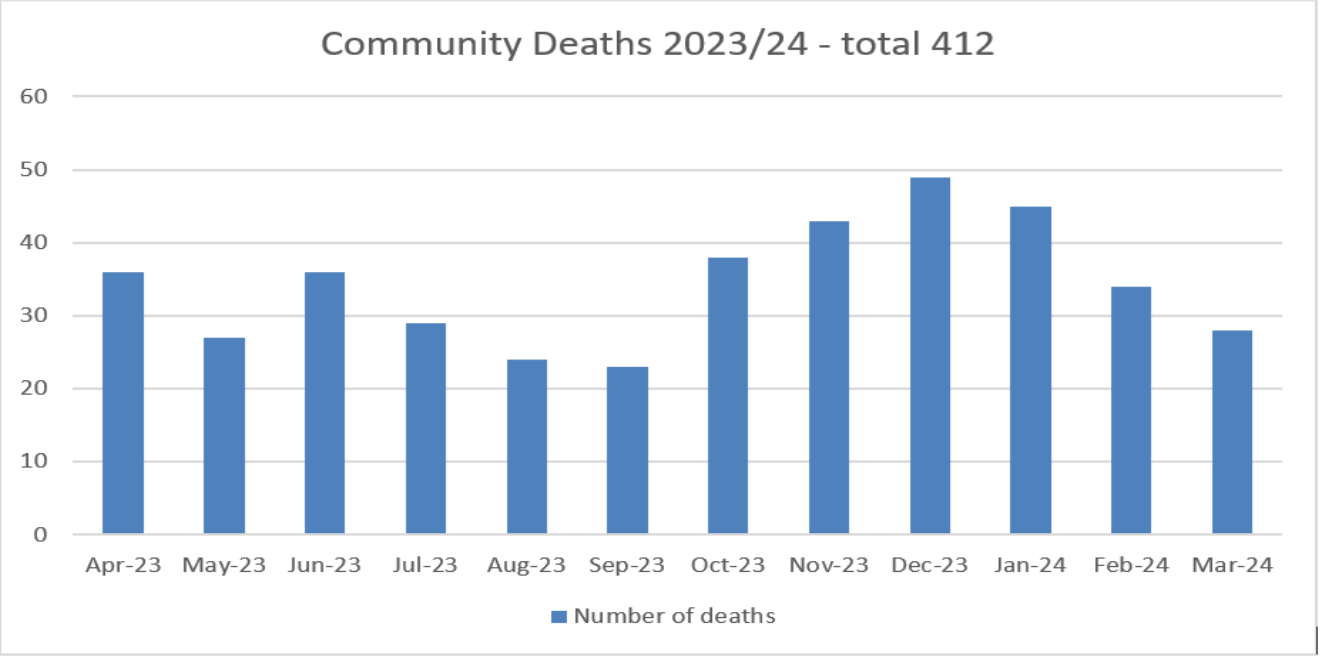


All cases given a care score of poor care or very poor care and are subject to a 2nd opinion SJR. Following 2nd opinion SJRs, any cases agreed as a care score of 1 or 2 are reported as moderate harm incidents onto the Trust Risk Management Software System, known as Datix.

Community Mortality reviews:

Initial Screening Reviews:

Data is provided monthly on all deaths of patients who die within 30 days of discharge from hospital. A randomised selection of 50% of patients listed (only NHS numbers visible – no patient names at point of selection) are chosen.



Examples of key learning and actions from mortality reviews 2023/24

There have been several themes identified during this period, examples include:

1. Communication
2. Documentation
3. The deteriorating patient

As a consequence of what the Trust has learnt during the reporting period, the following actions have been taken:

- Early communication to the families when a patient is at the end of life remains a recurring theme. In addition to this, delays in referral to Palliative Care services were highlighted as were palliative prescribing issues that incorporated prescription charts requiring amendments or more stock of anticipatory medications needed.

- Learning within this area has been collated by the EoLC team and actions are provided in the EoLC Strategy in appendix 1.

- The importance of accurate recording keeping using EPR has been highlighted and not 'copying and pasting' from previous entries which can lead to confusion if the clinical picture changes when new observations or results have been taken from the patient. This has been actioned via safety huddles and a Trust wide Safety Message.

- The importance of a full holistic assessment of patients with a Learning Disability or Autism. The role of passports for patients with a Learning Disability or Autism is pivotal

and they can help staff to support the individual and their families in areas that are important to the individual. The LD Nurse Consultant continues to champion these documents Trust wide.

- Also Lack of senior review and the deteriorating patient continue to be recurring themes. The Trust has developed a new dashboard using a software system called KP+ which provides an overview of ward areas with the highest NEWS2 scores. Work is also being carried out to improve these responses by focusing on whether ward nurses are aware to call a Registrar or Consultant when the NEWS2 is 7 or more. Work will also take place to understand why Registrars are not getting to review patients within one hour when asked, and whether this is due to too many patients being unwell at the same time or whether staffing needs to be reviewed.

- In addition to this work, with the introduction of the Acute Response Team (ART), the team can identify any quality improvement opportunities.

CHFT have also seen areas of excellent care, for example, we are achieving patient's wishes to achieve their preferred place of death and staff are using the Individualised Care of Dying Document care plan. The ReSPECT forms with DNACPR status is discussed with both the patient and their families and appropriate escalation to GP teams for review and facilitation of GP video calls as required.

Other areas of good practice were:

- Sharing of excellence in care by individuals and teams in various Trust settings.
- Reviewers from a range of disciplines have been recruited and trained to build resilience into the system.
- The reviewer training will continue with a key focus on supporting the challenging conversations for staff in different settings.
- Additional multi-disciplinary reviewers will continue to be recruited and trained to enable further resilience and support for the review process.
- Improved communication/relationship between divisional representatives and the Mortality Chair.

Maternity and Newborn Safety Investigations (MNSI)
MNSI look at factors that have harmed or may harm NHS patients. MNSI work closely with patients, families and healthcare staff affected by patient safety incidents, and never attribute blame or liability.

Maternity incidents are assessed against the MNSI criteria by the governance midwife and those which meet the criteria are submitted to MNSI. Each of these incidents will also be presented at the Trust's weekly Serious Incident (SI) panel so any immediate learning can be identified.

The themes of learning from MNSI cases are as follows:

Trust top recommendations*

MNSI Maternity & Newborn Safety Investigations

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

2020/21
- Fetal Monitoring
- Guidance
- Clinical Assessment

• 1 report with no recommendations
• 5 reports with recommendations

2021/22
- Escalation
- Clinical Assessment
- Risk Assessment
- Fetal Monitoring
- Guidance

• 3 reports with no recommendations
• 7 reports with recommendations

2022/23
- Birth Environment
- Risk Assessment
- Escalation
- Guidance
- Fetal Monitoring

• 2 reports with no recommendations
• 4 reports with recommendations

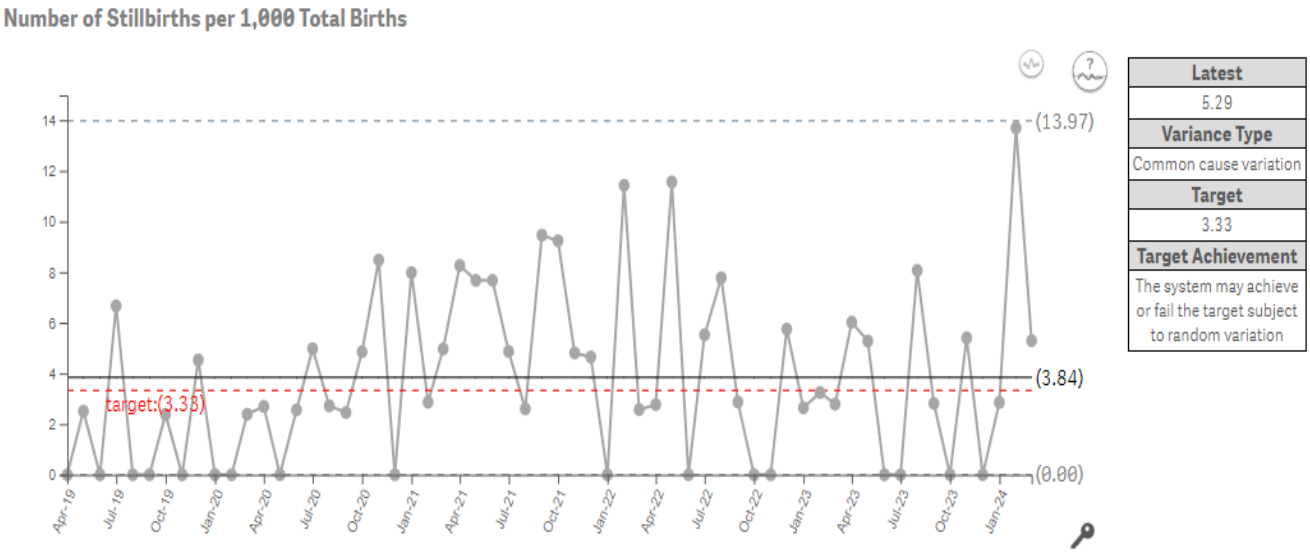
2023/24
- Clinical Assessment
- Fetal Monitoring
- Ultrasound Scans
- Triage

• 2 report with no recommendations
• 4 reports with recommendations

Neonatal/still births

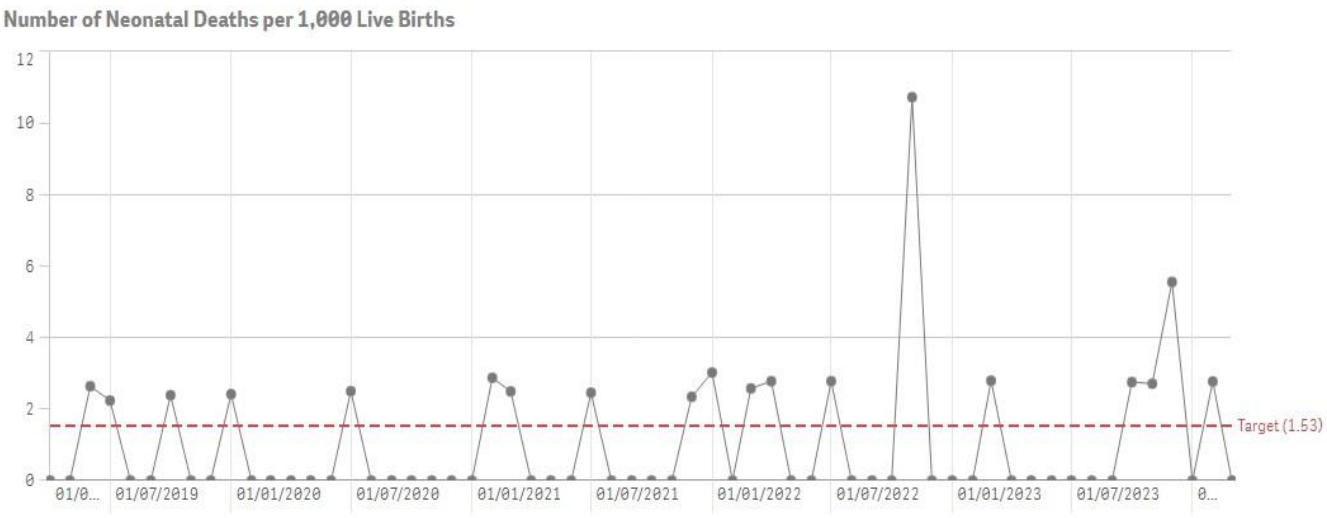
The data, themes, trends and learning for neonatal deaths and stillbirths is reviewed through the maternity and neonatal transformation board, quality committee and reported to Trust Board as a part of the perinatal quality surveillance model. This data is a core metric in the Trust IPR.

Stillbirths:



Source: Maternity Dashboard - Last updated: 14/04/2024 21:03:32

Neonatal Deaths:



All stillbirths and neonatal deaths are reviewed using a structured perinatal mortality review tool (PMRT) by a multidisciplinary team and including an external clinician. A mutual support pathway for external presence has been developed between CHFT and Mid Yorkshire teaching Trust (MYTT).

Learning:

There was a cluster of stillbirths in February 2024. A rapid multidisciplinary review of the cases took place to establish if there were any commonalities and immediate safety actions that were required.

- The findings of this review identified themes of ethnicity, language barriers and IMD code but no other significant commonalties.
- Two cases had already been identified as having care and service delivery issues and had been declared as serious incidents.

Immediate safety actions included:

- ensuring appropriate equipment was available.
- failsafe review of the maternity diabetes caseload to ensure all women with a known diagnosis were receiving care and appointments appropriately.
- ongoing work to roll out a maternity specific early warning score in key clinical services outside of the maternity setting.
- ongoing piece of work for the maternity assessment centre including training, call handling and improving the call system to manage high volume and call oversight.

Actions ongoing to support improvement in clinical outcomes and patient experience:

1. **Closing the gap in Health inequalities:**
   - Reducing digital divide – successful in a bid for the provision of SIM cards with data to support access to digital records, information and contact with services. An additional bid has been submitted to fund some devices to further support this.
   - English Speaking for Other languages (ESOL) – classes for women who do not have English as 1st language, these are attended and supported by a midwife to support accessing care.
   - Early booking campaign - understanding data on which women do not present early for care and targeting actions specifically to this community. DOM attending the race equality network in June 2024 to seek support for alternative ways and places to share messages and identify community champions who can support this work.
   - Development and pilot of the social vulnerability score in maternity - to identify those at risk outside of current clinical risk assessments and identify appropriate alternative care pathways to support which may include social prescribing interventions.
   - Attended St Augustine Centre in HX1 – to hear lived experience and to understand more about barriers to care.
   - Go see with MYTT to learn more about the maternity befrienders model and how this could apply in CHFT – in consideration of social prescribing pathway of care.
   - Plan in place to review DNA data in maternity across hospital and community settings.
   - Review of LMNS funding received and how this could be used to support alternative plans of care such as transport for those where this presents barriers to accessing care.
   - Pilot of virtual face to face interpreting service in antenatal clinic and maternity assessment centre

2. **Public health:**
   - Continue to engage women in smoking cessation- reviewing current remit of MSW health advisors to expand to additional early intervention work.
   - BMI clinic is in place with a current patient and staff engagement survey in progress to inform the current service delivery model.
   - Participated in the Close relative marriage pilot in Kirklees, this has included understanding knowledge gaps in staff and training to have discussions.
   - Working with Calderdale Starting well strategy and core participant in family hubs
   - Co-design of the breastfeeding strategy in Calderdale, CHFT continue to maintain BFI gold status for maternity and are completing stage 1 for the neonatal service.
   - Perinatal Mental Health Service in place with specialist midwife and liaising with PATHs who will be providing a maternal mental health service in the coming months.
   - Work together to get results to develop pelvic health pathways using funding received from the LMNS.
   - Developed pregnancy advice videos and enquiry made about developing more in alterative languages particularly around reduced fetal movements.

3. **Maternity Assessment Centre:**
   - Introduction of Birmingham Symptom-Specific Obstetric Triage System (BSOTS) with an ongoing training programme for staff, development of digital oversight of BSOTS and regular audit of the model
   - Review of the workforce model to ensure appropriate staffing and leadership.
   - Dedicated medical cover identified on the rota and escalation to the hot week consultant if this needs to be redeployed for risk assessment and agreement.
   - Developing SDEC concept and recognition of MAC as a core emergency access clinical service rather than being seen as part of labour ward.

- Go see with Bradford to review alternative access pathways such as open access.
- Further actions needed to understand and remove barriers to attending.

4. **Data and Digital development:**
   - Reducing the digital divide as described above.
   - Development of SPC chart, use of KP+, validation of all metrics and benchmark
   - Development of how we use data to inform quality improvement and actions.

5. **Patient engagement:**
   - Co-designed MVP workplan incorporating all routes of service user feedback.
   - Embedding lived experience into MDT / Trust forums
   - Funding secured for a whose shoes workshop and to use stillbirth review to agree where best to target this engagement session.
   - To adopt the National Bereavement care Pathway, CHFT is currently an outlier by not participating but does deliver most recommendations. This will support evidence of delivery for the Three-Year Plan.
   - ICB and CKW joint working to improve how to hear seldom heard voices.

6. **Enhanced CoC:**
   - LMNS funding will be received shortly for rolling out enhanced continuity of carer - Plan to utilise this initially for early intervention support (MSW / social prescribing) until workforce position has improved.
   - Improve and sustain Antenatal and postnatal continuity for those most at risk as an interim measure.
   - Plan for implementation of full CoC models for those most at risk.

7. **Governance processes:**
   - Continue to implement full SBL bundle - current progress.
   - Continue to work towards achievement of MIS year 6.
   - Perinatal culture programme completion
   - Refresh of existing governance forums to ensure effective floor to board escalation and oversight.
   - Roll out of PSIRF.

8. **Strengthening interdepartmental / specialty working:**
   - Implementation of Meows outside of the maternity setting
   - Review of the pathway for pregnant women who attend ED.
   - Strengthening of perinatal relationships with DoM now overseeing Neonatal services

9. **Workforce R&R:**
   - Refresh of the recruitment and retention strategy and consideration of the diversity of the workforce.
   - Completion of Birthrate plus workforce review
   - Pastoral support for staff including – psychological support, ensuring a just and civil culture, sharing good practice, celebrating success, sharing learning, improving communication, visibility of leadership and hearing staff voices.

Learning Disabilities Mortality:

CHFT has been monitoring the deaths of people with a learning disability over a 12-year period. Since 2016 all deaths of people aged 18+ with a learning disability who die whilst an inpatient at CHFT have been subject to a Structured Judgement Review (SJR) as per Trust policy.

The Purpose of the 2023/24 annual report is to evaluate and summarise the key themes and trends from the SJRs reported between 1st April 2023 and 31st March 2024 and will focus on factors including:

- Age of death
- Month of death
- Gender
- Ethnicity
- Causes of death
- Overall assessment of the quality of care

The National annual LeDeR report was published in November 2023 and an update regarding any key learning and recommendations made.

Purpose around LeDeR:

- improve care for people with a learning disbility and autistic people.
- reduce health inequalities for people with a learning disability and autistic people.
- prevent people with a learning disability and autistic people from early deaths.

From 1st April 2023 – 31st March 2024 11 deaths were reported for people with a learning disability having died at CHFT in inpatient bed, all 11 were subject to an internal SJR.

Some of the report's key findings include:

- CHFT had 11 adult inpatient deaths reported to LeDer during 23/24
- Of these cases 55% were male and 45% female
- All deaths that were reviewed were from a white ethnic background.
- Average age of death was 55 which is lower than the National age of 62.7 (2022)
- 45% had a moderate, 27.5% had a severe learning disability and 27.5% had PMLD.
- 55% were deemed adequate, 36% good with 9% reported poor quality (latter subject to an orange investigation)
- To note one other death was reported to LeDeR but not subject to internal SJR – out of hospital cardiac arrest and died in resus. The death is subject to a coroner's investigations, Trust completed an Action After Review (AAR) due in court in Autumn 2024.

Governance Arrangements

- The Consultant Nurse for Learning Disability is the lead for reporting all deaths to LeDer and requests a SJR internally and works in partnership with the Medical Examiner's Office
- The Consultant Nurse for Learning Disability is the key contact for LeDeR reviewers and the Local Area Contact.
- The Consultant Nurse for Learning Disability provides two reports per year to MSG, Q1+2 report and Q3+4 with the annual report.
- MSG it responsible for escalation to Trust Quality Committee
- Information is also escalated to the Trust Safeguarding Committee

Areas of good practice

- Patient care was satisfactory with the diagnosis, management plan and decision making good
- Team kept dad up to date appropriately and involved in DNACPR decisions
- Challenging interactions between family/carers and medical team – appear to have been dealt with appropriately
- Family updated regularly – good practice
- Dr Hashimi in particular gave the patient good, thoughtful and kind care, and also supported the family in coming to terms with the patients final illness and death.
- IMCA appointed
- Palliative care team involvement

- Good communication and involving the LD matron.
- Completing a DATIX for missed medication
- Some very good medical care, particularly the on call SHO team
- Recognition of dying and palliation involving palliative care team

Areas of concern

- No recheck of phosphate levels after giving replacement therapy
- Delays in giving antibiotics following CT scan
- Lack of effort to provide nutrition given presenting complaint
- Lack if input from nursing/therapy team lead to patient been nursed in bed which contributed to deconditioning and likely deterioration
- Could have sought an opinion from haematology to cause of low platelets
- Delay in organising USS

Patient spent a long time in the emergency department, with a consultant review coming outside of the recommended timeframe.

Future Improvement Work

- Alignment of the GP LD registers in Calderdale completed, planned in Kirklees 2024/25
- KP+ LD model and LD flag added to other models.
- RPA ensuring all clinical codes related to LD are flagged, uploading all flags to CRIS (Radiology EPR) and can upload completed passports, reasonable adjustment flag to be added to all LD patients' records.
- All referrals on ERS have had LD flag added and reasonable adjustment box for GPs to complete on referral into CHFT.
- Audits completed in several pathways presented to health inequalities meeting.
- Reasonable adjustments audits take place.
- Review of access policy planned.
- Oliver McGowan mandatory training part 1 go lives July 2024

National Service evaluation of bereaved relative's satisfaction with patient's end of life care 2023 using the FAMCARE 2 tool.

CHFT participates in the national survey of the quality of end-of-life care, organized by the Association for Palliative Medicine of Great Britain and Ireland. The aim of the survey is to see how well we do in our care of patients referred to palliative care services. This information is needed so we can improve services and make sure that all patients receive the best possible care towards the end of their lives.

The aim of the survey is to measure bereaved relatives' satisfaction with the end-of-life care service provided to their deceased relative using the FAMCARE 2 tool.

2023 has seen a very positive result for CHFT. The findings showed 'Very Satisfied' results were above the national audit and showed an improvement in the results from 2022. This was shown to be in all areas apart from Question 12. However, Question 12 was above the national average when combining 'Very Satisfied' and 'Satisfied' data.

The local response rate of 53% is higher than that achieved in 2022 which was 36% and higher than the national response rate was 30%. The good response rate is likely due to the personal contact between team and the bereaved family to ask permission to send out the questionnaire, to mitigate causing distress / burden. This permission is sought during the usual bereavement contact phone call or visit, which also provides an opportunity to provide additional resources for support or signposting to other services.

Negative comments related to one family who had commented on the lack of support from the doctor (their own GP) and referred to external service provision (not the Palliative Care services). The team do try to explain that the FAMCARE survey is only related to specific services, and despite written information to explain the remit of the survey, almost every year that one or two families use this as an opportunity to express their concerns. Unfortunately, due to anonymity of the responses, there is no way for the team to contact the individual family to offer support.

verall the team's performance has been consistently rated higher than national average over past few years, but this year's results are exceptionally high. The highest scores were related to how the team meet with patient and family, how things were explained, maintaining respect and dignity, how effective the team were in managing uncontrolled symptoms and how responsive the team were in addressing the changing needs of the patient, alongside family support. This audit (in combination with other performance data) clearly demonstrates how effective the team are in addressing the specialist palliative care needs of patient and family to provide safe and excellent quality of care. The team will strive to maintain these standards in the future.

NACEL Audit

The National Audit of Care at the End of Life (NACEL) is a national comparative audit of the quality and outcomes of care experienced by the dying person and those important to them during the last admission leading to death in acute hospitals, community hospitals and mental health inpatient providers in England and Wales. NHS Benchmarking Network is commissioned by Health Quality Improvement Partnership (HQIP) on behalf of NHS England and the Welsh overnment. NA E is featured on N S England's quality accounts list for 2024/25.

Aims & objectives
Overall aim: To improve the quality of care of adults (18+) at the end of life in NHS-funded hospital inpatient settings in England and Wales

Overarching NACEL objectives:

- Improving quality of care by identifying areas for action in relation to delivery and outcomes, and adapting QI priorities in line with evidence and guidance
- Reducing unwarranted variation through benchmarking of outcome measures as well as identifying and managing outliers using the appropriate guidance
- Understanding and reducing health inequalities in relation to impact on the specified measures
- Sharing and adopting best practice including QI examples, and signposting to resources available in the wider End of Life landscape

Sources of data

NACEL collects data from four sources:

1**. Quality survey**: This is an online survey completed by relatives, carers and those important to the person who died in hospital, to report their experiences of the care and support received at the end of life. CHFT are sending out these surveys between January 24 – December 2024 (avoiding June, July, and August when the FamCare audit takes place). The findings from the first 6 months of 2024 will be reported in the second half of 2024, enabling timely actions if required.

2. **Case Note Review**: This is data collected from patient notes about the care they received during their final admission to hospital. It focusses on 10 indicators of care, including recognition of dying, timely review of the dying and deceased patient, etc. CHFT have committed to collecting 20 case note audits per quarter which is currently ongoing. Again, the results from the first 6 months of 2024 will be reported in the second half of 2024.

3. **Hospital/ Site Overview**: Questions focus on the specialist palliative care workforce, staff training, anticipatory prescribing and quality and outcomes within the hospital/site. The collection period for this is between 1st June 2024 and 30th September.

4. **Staff Reported Measure**: This survey is completed by staff who are most likely to meet dying patients and their loved ones. The survey asks questions about staff confidence and experience in delivering care at the end of life, the support they receive and the culture of their workplace. This survey is currently ongoing with the closing date for submissions being 30th June – 100 responses from staff were requested from NACEL – we have currently received 119 responses.

Learning from Deaths escalation to Serious Incident Panel:

During 2023/24 there were four confirmed incidents involving patients who had died and were identified via the learning from deaths process; all these incidents underwent an investigation. One of the incidents was investigated as a serious harm incident and the remaining three were investigated as moderate harm incidents.

Two incidents are currently under investigation and two are now completed. The following provides example of the learning collated from the two incidents:

Serious Incident 223834 reported April 2023:

- All diabetic patients are identified and verbally discussed at safety huddles and at each handover.
- All staff to be aware of the escalation process and the treatment pathways for diabetic emergencies.

- Staff to escalate blood glucose levels below 4mmol/L or above 12mmol/L to the nurse looking after the patient and to the nurse in charge/co-ordinator.

Key Learning that was shared within the wider organisation:

- Training on the management of diabetic emergencies to all clinical staff that care for patients with diabetes.
- Updated guidance in relation to Diabetic Emergencies shared with all staff that care for patients with diabetes.
- Diabetic Specialist Nurses to update referral criteria on staffing intranet.
- Diabetic Specialist Nurses to provide bulletin updates Trust wide when there are new changes to guidance, policy, and protocols.
- Diabetic Specialist Nurses to promote and train staff of the use of hypo boxes within clinical areas.

Moderate Harm 227104 reported June 2023:

- When prescribing sedative medications in elderly patients with an acute kidney injury, to liaise with pharmacy.
- Staff to regularly monitor patients' vital observations and conscious levels when sedatives are used.

HSMR:

The HSMR (Hospital Standardised Mortality Ratio) compares how many hospital inpatients die, with how many we would have predicted to die given their age, gender, diagnoses and co-morbidities. It also, in contrast to SHMI adjusts for area-level deprivation and specialist palliative care coding.

Data has been released in May for HSMR incorporating performance data up to February 2023.

As can be seen in Figure 1, following an extended period of a low HSMR throughout 2020 and 2022, this measure has then risen throughout 2023. This declining position in FT's performance seen in August, September 2023 and January 2024 has 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 and these are currently being reviewed. There has also 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 FT's expected deaths figures.

Both HSMR and SHMI are likely to take another significant upward step in the coming months at CHFT due to the reclassification of SDEC (Same Day Emergency Care) activity. Previously SDEC activity was captured as an admission and was included in HSMR and SHMI datasets. However, there is a national mandate to move SDEC activity to the ECDS (Emergency Care Dataset) by April 2025, thus removing this activity from the HSMR and SHMI calculations. Due to FT's digital maturity the Trust was chosen to be a first mover for this change and completely the reclassification in April 2024. With the Trust being the first to make this change it will likely have a negative impact when benchmarking for HSMR and SHMI as many admissions have been removed from the CHFT dataset and due to the nature of SDEC activity it will not remove many observed deaths however it will remove those 'expected deaths' from the calculation thus increasing both FT's SMR/S MI position. In addition to this, with this change it will also put the Trust in an adverse outlier position nationally until a point that all NHS Trusts have had their SDEC data removed. This will also cause increase in the HED

alerts issued to CHFT. The Trust is aware of this and has modelled the potential impact. Processes have been put in place internally to proactively identify any real excess deaths or HED alerts using a new Mortality predictor tool built by our Business Intelligence Team.

Figure 1. Month on Month Trust HSMR

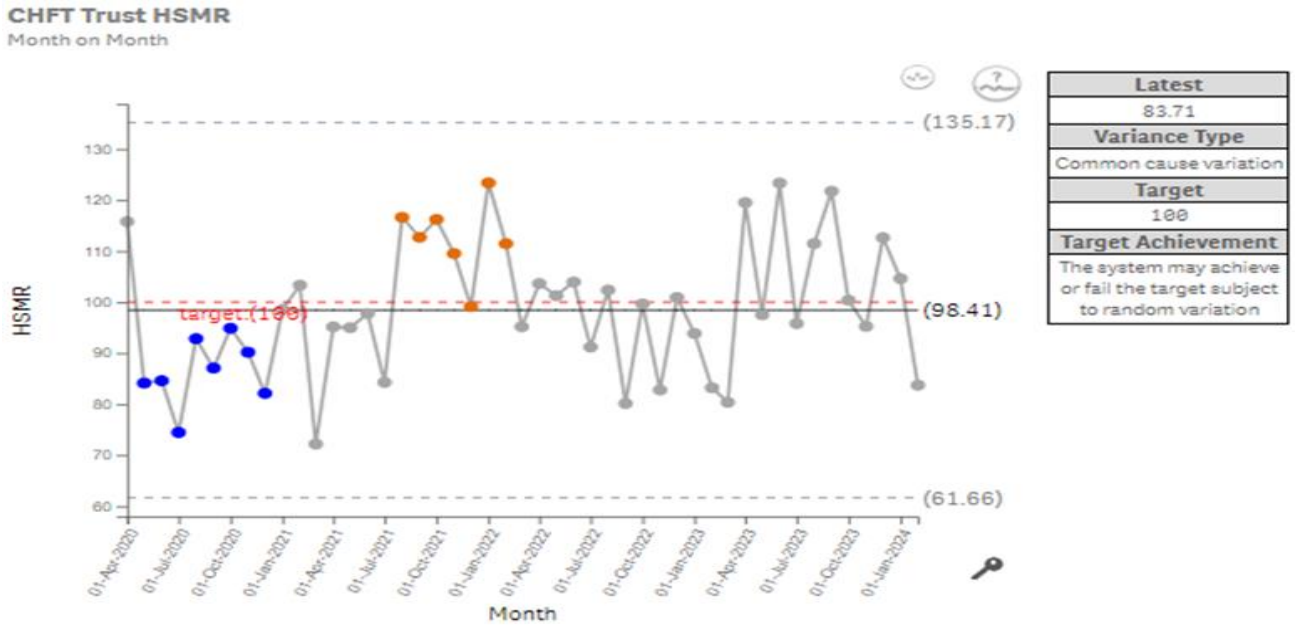


Figure 2. Poisson funnel plot HSMR

FT's national funnel plot position has remained stable throughout the past 12 months and remains within expected range nationally for HMSR performance.

A new 'mortality prediction' tool has been developed to closely replicate the SMR calculation for live trust data. This can be used to help forecast where FT's SMR performance is likely to go in the coming data releases and would give a heads up 3 months in advance of national releases. With this tool being completely live this will also allow for this tool to support

the mortality review process moving forward at CHFT and has led to a new process being implemented to support increased learning from deaths.

SHMI:

The SHMI (Summary Hospital-level Mortality Indicator) is 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. SHMI = Observed Deaths/Expected Deaths.

For the SHMI a death is attributed to a Trust if the patient dies in hospital or within 30 days of discharge.

SHMI does adjust for age, gender, current and underlying medical condition and birthweight (perinatal diagnosis group only). SHMI does not adjust for severity of condition, palliative care coding or deprivation score.

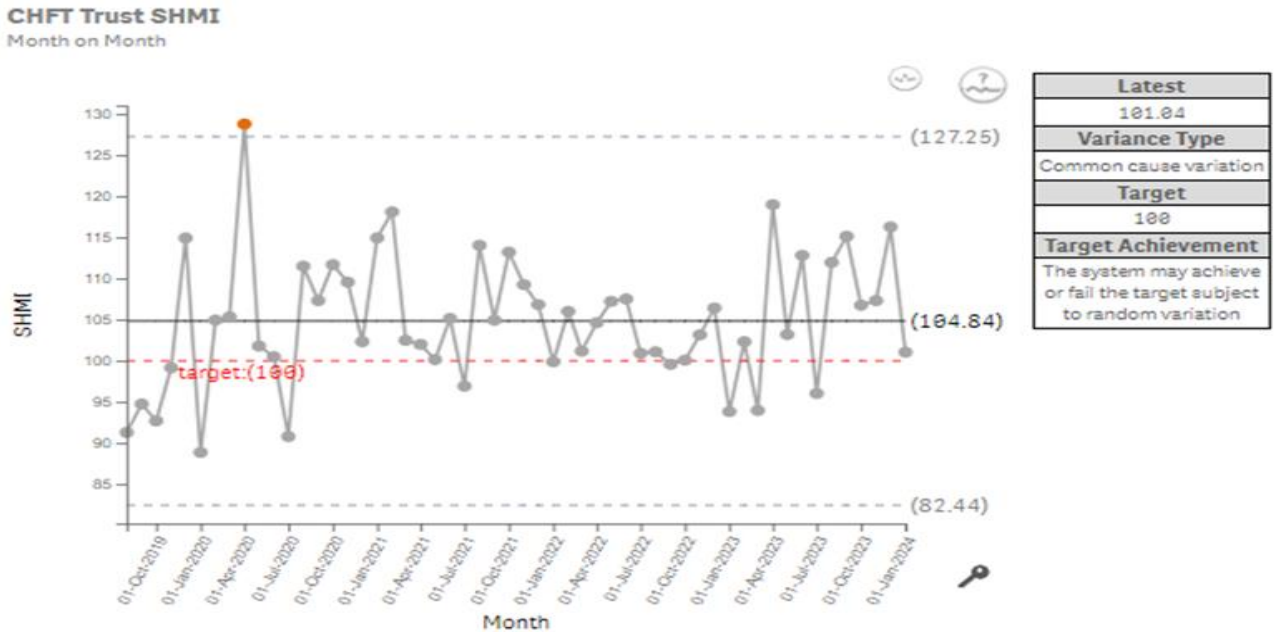
Data has been released in May for SHMI incorporating performance data up to January 2023. CHFT SHMI performance has seen an increase for the latest 12 month rolling release and shows performance of 107.07 and has risen back over the 100 mark. The site breakdown shows HRI at 104.04 and CRH 111.52. Month on Month performance has improved in January with performance standing at 101.04. Performance remains within the expected range in the latest release.

This declining position in FT's performance seen in August and September 2023 has largely been driven by performance within the 122 – Pneumonia CCS group. A review was undertaken to establish any quality-of-care concerns. There were 2 cases that were assigned as 'poor' care these were incident reported.

There has been a slight reduction in observed deaths on a national basis this does not seem to have been replicated within the FT datasets. Therefore this is affecting FT's expected deaths figures.

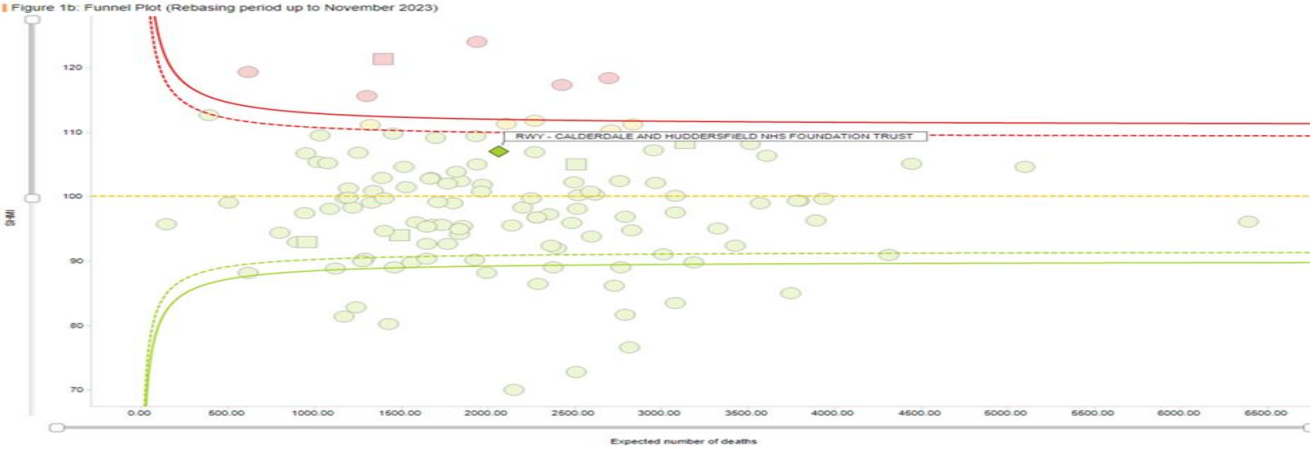
Please refer to the HSMR section above to acknowledge the impact of a change in SDEC activity on FT's mortality indicators.

Figure 4. Trust SHMI rolling 12 months



The Trust remains within the 'as expected' range illustrated in the Poisson funnel plot below.

Figure 5. Poisson funnel plot SHMI

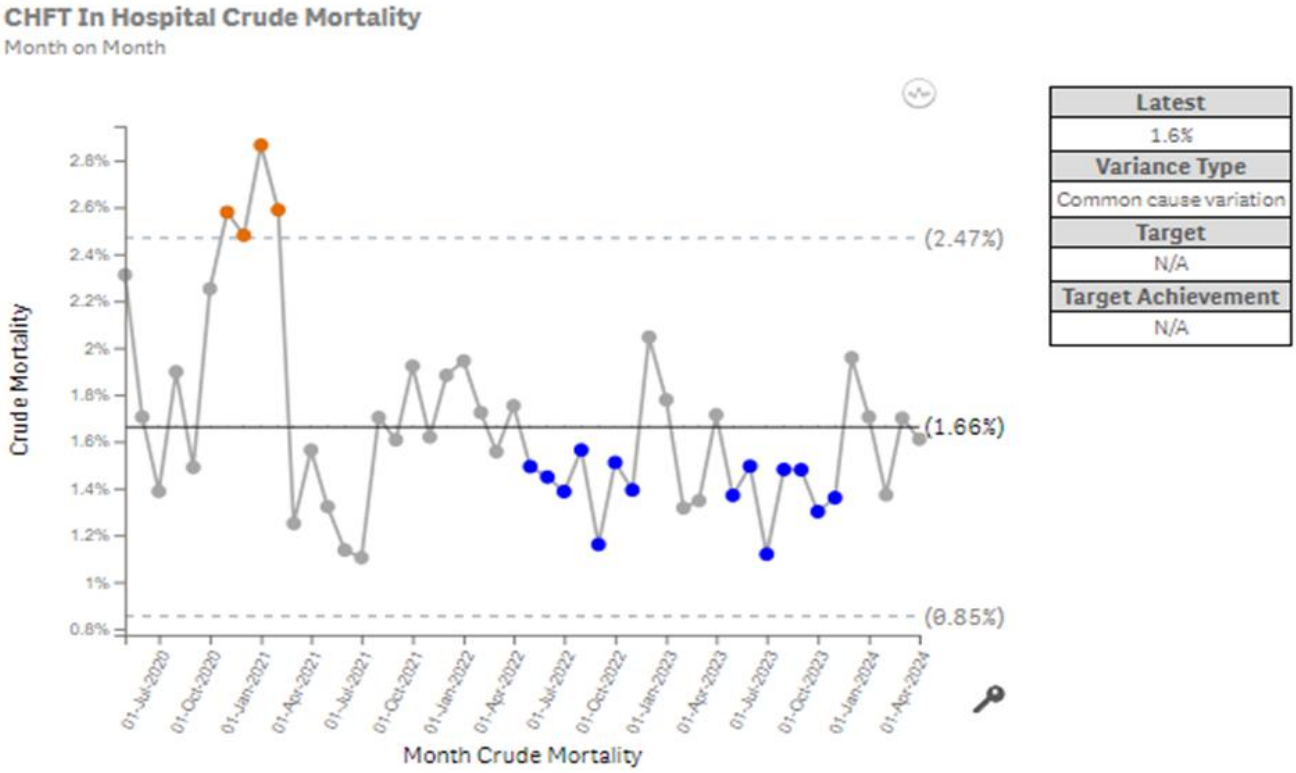


It is important to recognise that neither HSMR nor SHMI are a direct measure of quality of care. The expected number of deaths for each Trust is not an actual count of patients but is a statistical construct which estimates the number of deaths that may be expected at the Trust based on average England figures and the characteristics of the patients treated here.

Crude mortality:

Crude mortality is calculated from observed/expected deaths with no adjustments. The 12-month crude mortality for April 2023 to Mar 2024 was 1.50% compared with 1.52% in 2022/23 so a stable figure. Crude Mortality for April 24 is 1.6%, comfortably within the expected range.

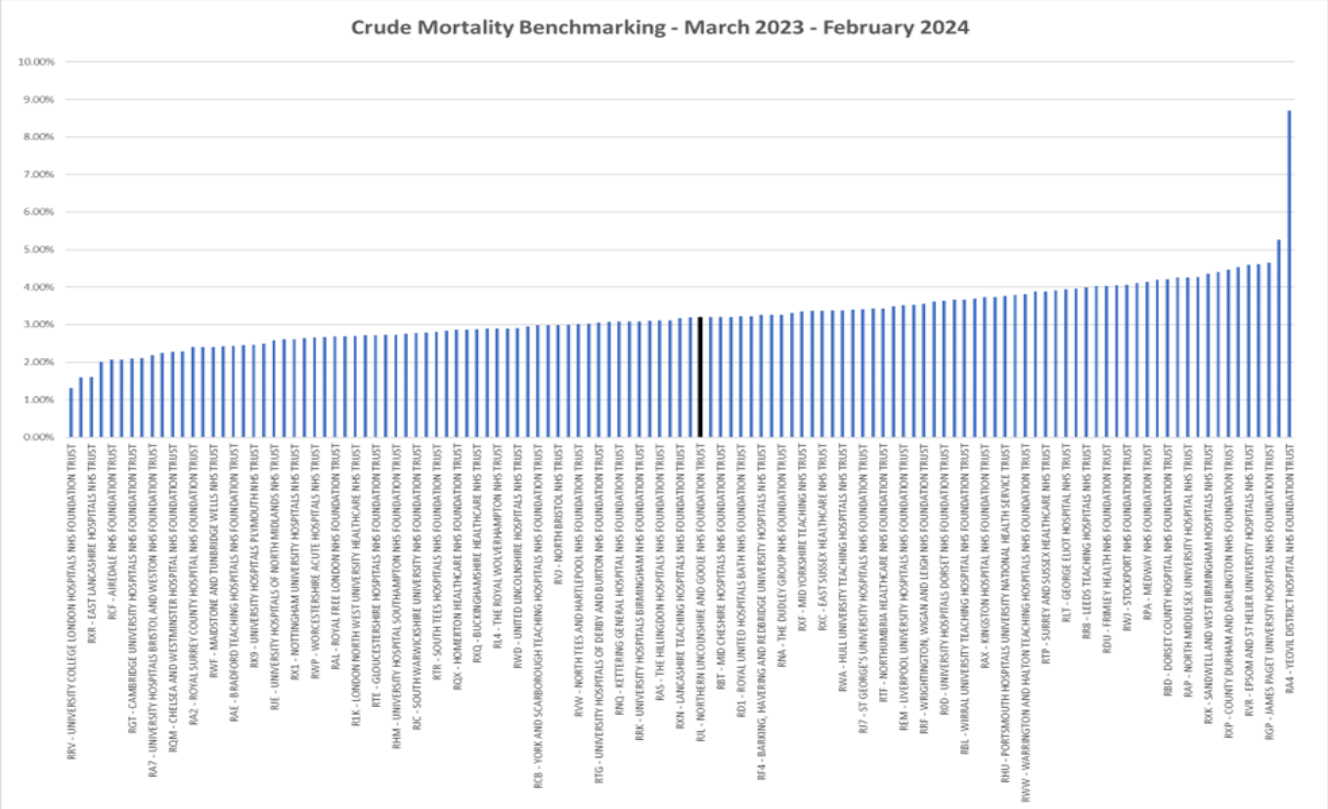
Crude mortality:



FT's crude mortality benchmarking position has improved slightly from 67th position to 64th position. This now means that CHFT has moved from the 2nd quartile of national performance to the 3rd quartile nationally.

This is contributing to the deteriorating position for HSMR and SHMI performance.

Crude mortality benchmarking (red line represents CHFT):



Medical Examiner office:

The Medical Examiner's office continues to perform scrutiny on deaths within the trust and those from the wider community. There are some significant changes on the horizon. On 9th September 2024, the Medical Examiner service will become fully statutory. This means that all deaths occurring in any health setting, which are not investigated by the coroner, will be reviewed by an NHS medical examiner.

Additionally, there are changes coming to the current rules on issuing Medical Certificates of Cause of Death (MCCDs). From 09th September 2024, medical practitioners will be able to complete an MCCD if they have seen the deceased at any point in their lifetime. This is a vast simplification of the current rules, which require a coronial referral if the deceased had not been seen by a medical practitioner within 28 days prior to death or had not been seen in person after death.

Our main purpose remains to provide independent scrutiny of each death and to ensure that acceptable wording is used for the MCCD, which will be supplied to the local registrars of births, deaths, and marriages. Medical Examiners (MEs) and Medical Examiner Officers (MEOs) can offer advice to medical staff to determine whether registration is possible or if a coronial referral is necessary. This will still be the case after 09th September 2024.

Furthermore, after 09th September 2024, the Medical Examiner service will be required to contact all bereaved relatives to explain the cause of death and ascertain whether they have any concerns regarding the death. The ME team will direct such concerns to the appropriate pathway, such as Patient Advice and Liaison Services (PALS), Structured Judgement Review (SJR), Datix, or, in a small number of cases, to the coroner.

This is a time of significant change for not just the Medical Examiner service but for the Trust as a whole. However, we will continue to provide a top-rate service to those who have lost loved ones, ensuring independent scrutiny to safeguard and enhance learning from deaths within our jurisdiction.

Please see below a report of the medical examiner's office activity for deaths occurring in April 2023 to March 2024.

Table 1. Medical examiner office activity

Number of deaths 2023/24	Deaths scrutinised	Relative contact by ME office	No relative contact	Coroner referral – after scrutiny	Coroner referral – no scrutiny	SJRs
1840	1721 (94%)	1605 (93%)	116 (7%)	151 (9%)	72 (4%)	57 (3%)

New SJR reviewers:

During 2023/24, four members of the SJR team reviewers stepped down, the LfD team wish to thank Mr Rob Adair, Dr Nick Brown, Dr Pravin Dandegaonkar & Dr Hossam Elmahy for their valuable contribution. We have recruited three new SJR reviewers and welcome Dr Luke Bishop, Consultant Anaesthetist, Dr Karim Abouelela, Consultant in Acute Medicine and Dr Sue Crossland, Consultant in Acute Medicine to the SJR team. This leaves a compliment of 7 reviewers.

SJR training:

The Yorkshire and umber Allied ealth Science Network's Improvement Academy offer half day SJR Training sessions. Feedback from these is excellent. This training has moved from once yearly to three to four sessions per year, with a small contribution from trusts to support more sessions held. This will support our newer reviewers and serve as a refresher for existing reviewers promoting consistency in our reviews.

Conclusion:
In accordance with national mortality guidance, the Trust has implemented a revised mortality review policy and will be looking at improving the process to align with the new Patient Safety Incident Response Framework in 2024/25. CHFT will continue to support the PSIRF implementation work by ensuring appropriate response to patient safety incidents, including deaths, in a way that is in line with legislation, best practice and guidance and the Trust will actively promote and support a just learning and generative safety culture across the organisation.

This paper summarises examples of the learning identified in the mortality reviews completed during 2023/24. Several developments are ongoing to enable the workstreams in relation to mortality to improve and mature.

The Medical Examiner role is now established, with good working process, governance and continues to see an increase in the quantity of reviews undertaken.

Deaths under the care of the NHS is an inevitable outcome for some patients and patients may experience good and excellent care in the months or years leading up to their death. The reporting of deaths and governance arrangements have supported CHFT to identify learning where care could be improved and where the good practice can be shared. This report had

highlighted some examples of the learning required that arises from multiple contributory factors, most of which are system-wide issues and feed into quality improvement activity to prevent reoccurrence of similar incidents.

11. Workforce Committee Chair Highlight Report – 15 August 2024

For Assurance

Presented by Denise Sterling

Calderdale and Huddersfield NHS Foundation Trust

CHAIR'S HIGHLIGHT REPORT
to the Board of Directors

Committee Name:	Workforce Committee
Committee Chair:	Denise Sterling
Date(s) of meeting:	Thursday 15th August 2024
Date of Board meeting this report is to be presented:	12th September 2024
ACKNOWLEDGE	The focus of this meeting was talent management looking at the implementation of leadership development programmes, development for all and recruitment strategies. • The Committee was briefed on the anticipated employment changes following the King's speech, such as removing the 2-year qualifying period for unfair dismissal, imposing stricter probation rules, the right to disconnect from work and mandatory reporting on ethnicity and disability pay gaps. • The Committee was privileged to hear the accounts from a number of colleagues of their experiences on the various programmes. We were encouraged that the Trust is offering a comprehensive range of opportunities. Many positive outcomes were reported including enhanced leadership skills, increased confidence, effective application of learning, increased opportunities for personal and professional growth within the Trust. - Louise Rigby, the Empower Programme. - Jenny Clarke an External Development Programme - Emily Sutcliffe New to Management - Ansah Jamil Shadow Board • A thought-provoking presentation was received on Artificial Intelligence in recruitment and the impact already being experienced within the Trust. Some of the benefits and pitfalls in the management of applications was outlined and future steps for the Trust, including developing guidance for recruiters, monitoring changes in employment law and best practice. • The Trust's Gender Pay Gap Data was presented and the action plan for 2024/5 approved. The Action Plan focuses on addressing gender imbalances through succession planning, management development, and targeted support initiatives like the Youth Network. Staff survey and gender pay gap data will be shared and discussed with the Women's Voices equality group to support change. • Widening Participation in practice: Rachel Garside, a Ward Sister, shared her involvement in recruiting HCA apprentices and championing their development. Having joined the Trust as part of the first cohort of apprentices, she exemplifies the success of this pathway.

ASSURE	• The Workforce Report highlighted strong retention performance, high mandatory training compliance, and reductions in Bank and Agency usage through May and June. Areas requiring improvement include underperformance on appraisal completions, low compliance in Safeguarding Adults and Data Security training, and an increasing substantive vacancy rate. • The Committee reviewed current recruitment strategies and noted progress in the "Grow Our Own" strategy and Widening Participation delivering a range of initiatives. Development for All was looked at with a diversity focus and it was highlighted that that there was low participation from minority groups on the leadership programmes. Discussion took place on the most appropriate approach to be used to address this and actions taken will be reported at a future meeting. • A deep dive of BAF 10a Medical Staffing has been completed and provided assurance that the risks are being actively managed and monitored. The Committee noted the update and approved the retained risk rating of 16. • The Committee's annual assessment of effectiveness was presented and the action plan for 2024/25 approved.
AWARE	• The Committee approved the WRES and WDES 2024/2025 Action Plans
ONE CULTURE OF CARE	• One Culture of Care is considered as part of the Workforce Committee reports and its discussions.
REGULATIONS	• CQC Regulation 17: Good governance • CQC Regulation 18: Staffing

12. Finance and Performance Chair Highlight Report – 3 September 2024

For Assurance

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(s) of meeting:	3 September 2024
Date of Board meeting this report is to be presented:	12 September 2024
ACKNOWLEDGE	• Diagnostic target achieved (95%) for first time in 18 months. • Improving performance in care of acutely ill patient. • Most cancer targets still performing well (early diagnosis remains a challenge). • Elective recovery and Referral to Treatment (RTT) consistently remain above target. CHFT is currently in top 30 Trusts in the country for RTT data quality assurance. • In 2024/25 the Trust is operating under the National Payment by Results (PBR) funding mechanism for activity within the scope of Elective Recovery. Pay awards and industrial action costs will be funded. • There is an improvement in identification of Cost Improvement Programme (CIP) efficiency plans.

ASSURE	At our September meeting we:
	• did a follow-up deep dive into the ED and same day emergency care (SDEC). This was previously discussed 27th February 2024 and was also brought in light of new ED opening at HRI in July.
	  ○ There is a difference in performance between HRI and CRH – largely due to higher bed occupancy status at HRI limiting flow
	  ○ Improvement noted towards target of not waiting >12 hours and in being seen within 4 hours
	  ○ Ambulance waiting >30 mins has increased (also impacted by flow)
	  ○ SDECs generally working well. Ongoing work on best modelling. Opening of medical same day emergency care (SDEC) at CRH has been successful. Looking to open SDECS in Paeds and Obstetrics and Gynaecology.
	• reviewed the audit which WYAAT had commissioned from Price Waterhouse Coopers LLP (PWC) and considered its accuracy and recommended actions. The report commented positively on robust controls in place, good engagement and strong leadership; and on the Turnaround Executive set up. Identified many areas that were expected. It also identified 8 opportunities for financial improvement and 11 key recommendations:
	  ○ Actions against these recommendations, timescales and potential values are being

	determined and will be brought the next meeting and followed up there as a new agenda item. It was also agreed that regular reports on progress with the 6 collaborative workstreams being developed with WYAAT would be brought to F&P. • Reviewed and accepted the final national cost submission. • Financial status against the plan for a £26.26m deficit was discussed. CIP Target is now £32.18m (£30m new schemes plus £2.18m Full Year Effect of 2023/24 schemes). Of the £32.18m CIP target for the year, most has now been identified and/or scoped. • The Trust is forecasting to deliver the planned £26.26m deficit, but the 'likely case' scenario suggests a gap of £5.58m due to likely slippage on delivery of efficiencies, potential shortfall on elective recovery funding (ERF) and the impact of industrial action.
AWARE	• There are some areas highlighted as special cause for concern. Some of these relate to the significant operational pressures: high bed occupancy (97% against target of 96%) and high percentage of patients no longer meeting criteria to reside in hospital (19% against target of 14.2%) as well as high numbers of patients on the transfer of care (TOC) list and proportion of ambulance arrivals delayed > 30 mins). Stroke performance is special cause for concern and will be discussed in a deep dive at the next Committee. • Summary Hospital-level Mortality Indicator (SHMI) continues to rise and is higher than national average. Some reasons for this are due to higher deprivation affecting mortality, and skewed calculations (due to inclusion / exclusion of SDEC figures). Quality does not appear a concern (and was also discussed through Quality Committee). • Use of the virtual ward is only 55% (against target of 80%). Partly due to 5 day limit of consultant cover. • Key indicators on health inequalities for Learning Disabilities, Deprivation and Ethnicity showing quarterly performance were included. • At month 4 we are reporting a year-to-date deficit of £12.14m, an adverse variance to plan of £0.29m. Partly this was due to the indirect additional costs of the Junior doctors strike plus bed capacity issues described above. • The Trust has delivered efficiency savings of £7.23m year-to-date, £0.19m less than planned. The Trust has spent £10.13m on Capital programmes year-to-date, £0.93m more than planned. These adverse variances

	have been offset by other mitigations in the year-to-date position. • The CIP requirement for this year is challenging and is weighted to the end of the year.
ONE CULTURE OF CARE	• One Culture of Care considered as part of the performance and finance reports. Senior member of Workforce and Organisational Development (WOD) now attends F&P on a regular basis plus WOD representation in deep dives. This allowed the committee to check in on workforce performance (such as sickness levels) and well-being and whether any further actions can be taken given the significant operational pressures staff are facing.
REGULATIONS	• CQC Regulation 13: Financial position • CQC Regulation 17: Good governance

13. Month 4 Financial Summary

To Note

Presented by Gary Boothby

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	12 September 2024
Meeting:	Public Board of Directors
Title:	Month 4 Finance Report
Author:	Kirsty Archer - Deputy Director of Finance
Sponsoring Director:	Gary Boothby - Director of Finance
Previous Forums:	Finance & Performance Committee
Purpose of the Report	The purpose of this report is to provide a summary of the financial position as reported at the end of Month 4 (July 2024)
Key Points to Note	**Year To Date Summary** The Trust is reporting a year to date deficit position £12.14m, (excluding the impact of Donated Assets, Impairments and the PFI remeasurement due to IFRS16), a £0.29m adverse variance to plan. The in-month position is a deficit of £2.73m, a £0.27m adverse variance. • The Trust incurred additional direct costs of £0.45m in June / July due to the Junior Doctors Strike. Elective Recovery Funding is £1.15m lower than the stretch target assumed in planning, including c. £0.30m impact of the Industrial Action, compounded by additional bed capacity open above planned levels. These adverse variances have been offset by other mitigations in the year-to-date position including higher than planned commercial income and additional income from Interest. • The CIP challenge will increase significantly as the year progresses 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 4 was broadly in line with plan, but the value of the activity delivered was less than the planned level. Overall Weighted Elective Recovery Position as a percentage of plan was 100.9% Year to Date. • Year to Date the Trust has delivered efficiency savings (CIP) of £7.23m, £0.19m lower than planned. • Year to Date Agency expenditure is £2.53m, £0.49m lower than planned. Expenditure is below the Integrated Care Board (ICB) Agency Ceiling of 3.2% of total pay expenditure.

	Key Variances • Income is £1.15m lower than planned due to: lower than planned PBR Elective Recovery Income of £1.15m, lower than planned Depreciation funding £0.7m (matched to lower than planned Depreciation cost) and slippage on the implementation of Community Diagnostic Centres (CDCs £1.19m), offset to some extent by higher than planned commercial income from both Huddersfield Pharmacy Specials (HPS) and Health Informatics. • Pay costs are £0.32m lower than the planned level year to date with the key drivers being slippage on the implementation of CDCs (£0.51m offset by lower than planned income), higher than planned vacancies (vacancy freeze (CIP)and midwifery vacancies) and lower than planned Elective Recovery costs (£0.42m). These underspends were offset to some extent by the impact of Strike action in June / July, a cost of £0.45m. • Non-pay operating expenditure is £0.42m higher than planned year to date including non-recurrent legal costs (£0.72m) and higher than planned Independent Sector spend for Elective Recovery (£0.2m). **Forecast** The Trust is forecasting to deliver the planned £26.26m deficit, but the 'likely case' scenario suggests a gap of £5.58m due to: likely slippage on the delivery of efficiencies; potential Elective Recovery Funding loss; and the impact of Industrial Action. Of the £32.18m CIP target for the year, £6.3m is not yet fully identified, (scoping or unidentified). Attached: Month 4 Finance Report
Regulation	CQC 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 July 2024.

EXECUTIVE SUMMARY: Total Group Financial Overview as at 31st Jul 2024 - Month 4

KEY METRICS

	M4				YTD (JUL 2024)				Forecast 24/25			
	Plan	Actual	Var		Plan	Actual	Var		Plan	Forecast	Var	
	£m	£m	£m		£m	£m	£m		£m	£m	£m	
I&E: Surplus / (Deficit)	(£2.47)	(£2.73)	(£0.27)		(£11.84)	(£12.14)	(£0.29)		(£26.26)	(£26.26)	(£0.00)	
Agency Expenditure (vs Plan)	(£0.76)	(£0.52)	£0.23		(£3.03)	(£2.53)	£0.49		(£9.07)	(£4.21)	£4.86	
Capital	£7.81	£9.69	(£1.88)		£9.20	£10.13	(£0.93)		£54.58	£57.38	(£2.80)	
Cash	£22.20	£28.82	£6.62		£22.20	£28.82	£6.62		£4.83	£4.83	(£0.00)	
Invoices paid within 30 days (%) (Better Payment Practice Code)	95.0%	88.9%	-6%		95.0%	91.9%	-3%					
Cost Improvement Plans (CIP)	£2.26	£2.03	(£0.23)		£7.42	£7.23	(£0.19)		£32.18	£32.18	£0.00	
Use of Resource Metric	3	3			3	3			3	3		

Year To Date Summary

The Trust is reporting a year to date deficit position £12.14m, (excluding the impact of Donated Assets, Impairments and the PFI remeasurement due to IFRS16), a £0.29m adverse variance to plan. The in-month position is a deficit of £2.73m, a £0.27m adverse variance.

- The Trust incurred additional direct costs of £0.45m in June / July due to the Junior Doctors Strike. Elective Recovery Funding is £1.15m lower than the stretch target assumed in planning, including c. £0.30m impact of the Industrial Action, compounded by additional bed capacity open above planned levels. These adverse variances have been offset by other mitigations in the year-to-date position including higher than planned commercial income and additional income from Interest.
- The CIP challenge will increase significantly as the year progresses 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 4 was broadly in line with plan, but the value of the activity delivered was less than the planned level. Overall Weighted Elective Recovery Position as a percentage of plan was 100.9% Year to Date.

- Year to Date the Trust has delivered efficiency savings (CIP) of £7.23m, £0.19m lower than planned.
- Year to Date Agency expenditure is £2.53m, £0.49m lower than planned. Expenditure is below the Integrated Care Board (ICB) Agency Ceiling of 3.2% of total pay expenditure.

Key Variances

- Income is £1.15m lower than planned due to: lower than planned PBR Elective Recovery Income of £1.15m, lower than planned Depreciation funding £0.7m (matched to lower than planned Depreciation cost) and slippage on the implementation of Community Diagnostic Centres (CDCs £1.19m), offset to some extent by higher than planned commercial income from both Huddersfield Pharmacy Specials (HPS) and Health Informatics.
- Pay costs are £0.32m lower than the planned level year to date with the key drivers being slippage on the implementation of CDCs (£0.51m offset by lower than planned income),higher than planned vacancies (vacancy freeze (CIP)and midwifery vacancies) and lower than planned Elective Recovery costs (£0.42m). These underspends were offset to some extent by the impact of Strike action in June / July, a cost of £0.45m.
- Non-pay operating expenditure is £0.42m higher than planned year to date including non-recurrent legal costs (£0.72m) and higher than planned Independent Sector spend for Elective Recovery (£0.2m).

Forecast

The Trust is forecasting to deliver the planned £26.26m deficit, but the 'likely case' scenario suggests a gap of £5.58m due to: likely slippage on the delivery of efficiencies; potential Elective Recovery Funding loss; and the impact of Industrial Action.

Of the £32.18m CIP target for the year, £6.3m is not yet fully identified, (scoping or unidentified).

Total Group Financial Overview as at 31st Jul 2024 - Month 4

INCOME AND EXPENDITURE COMPARED TO PLAN SUBMITTED TO NHS IMPROVEMENT

YEAR TO DATE POSITION: M4

CLINICAL ACTIVITY

	M4 Plan	M4 Actual	Var
Elective	1,414	1,364	(50)
Non-Elective	12,803	14,470	1,667
Daycase	16,658	17,428	770
Outpatient	153,562	152,145	(1,417)
A&E	58,981	63,309	4,328
Other NHS Non-Tariff	814,969	772,281	(42,687)
Total	**1,058,387**	**1,020,997**	**(37,389)**

TOTAL GROUP: INCOME AND EXPENDITURE

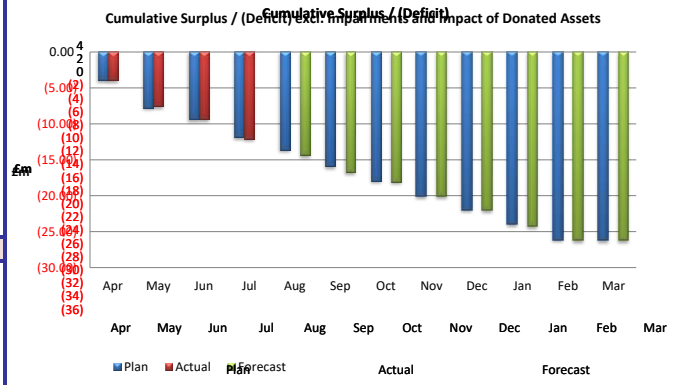
	M4 Plan	M4 Actual	Var
	£m	£m	£m
Elective	£5.96	£5.62	(£0.33)
Non Elective	£39.95	£42.20	£2.25
Daycase	£12.35	£13.05	£0.70
Outpatients	£16.55	£16.46	(£0.09)
A & E	£11.12	£11.80	£0.68
Other-NHS Clinical	£80.08	£73.44	(£6.65)
CQUIN	£0.00	£0.00	£0.00
Other Income	£18.84	£21.13	£2.28
Total Income	**£184.85**	**£183.70**	**(£1.15)**
Pay	(£123.33)	(£123.02)	£0.32
Drug Costs	(£16.56)	(£16.25)	£0.31
Clinical Support	(£13.24)	(£12.92)	£0.33
Other Costs	(£24.08)	(£25.17)	(£1.09)
PFI Costs	(£5.79)	(£5.76)	£0.03
Total Expenditure	**(£183.00)**	**(£183.10)**	**(£0.10)**
EBITDA	**£1.85**	**£0.59**	**(£1.26)**
Non Operating Expenditure	(£13.69)	(£12.73)	£0.96
Surplus / (Deficit) Adjusted*	**(£11.84)**	**(£12.14)**	**(£0.29)**

* 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

	M4 Plan	M4 Actual	Var
	£m	£m	£m
Surgery & Anaesthetics	(£35.75)	(£35.41)	£0.33
Medical	(£48.55)	(£49.93)	(£1.38)
Families & Specialist Services	(£32.94)	(£32.26)	£0.68
Community	(£11.74)	(£11.31)	£0.43
Estates & Facilities	£0.00	£0.00	£0.00
Corporate	(£19.97)	(£19.61)	£0.37
THIS	£0.46	£0.65	£0.19
PMU	£0.59	£1.25	£0.66
CHS LTD	£0.36	£0.39	£0.03
Central Inc/Technical Accounts	£136.01	£134.07	(£1.94)
Reserves	(£0.31)	£0.03	£0.34
Surplus / (Deficit)	**(£11.84)**	**(£12.14)**	**(£0.29)**

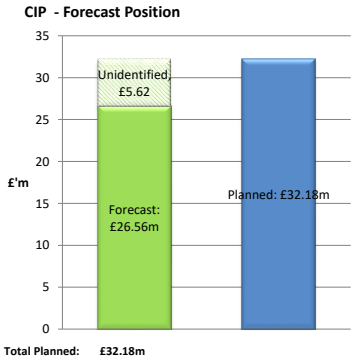
TOTAL GROUP SURPLUS / (DEFICIT)

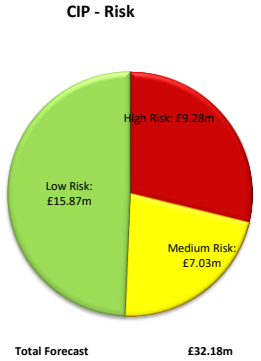


KEY METRICS

	Year To Date			Year End: Forecast			
	M4 Plan	M4 Actual	Var	Plan	Forecast	Var	
	£m	£m	£m	£m	£m	£m	
I&E: Surplus / (Deficit)	(£11.84)	(£12.14)	(£0.29)	(£26.26)	(£26.26)	(£0.00)	
Capital	£9.20	£10.13	(£0.93)	£54.58	£57.38	(£2.80)	
Cash	£22.20	£28.82	£6.62	£4.83	£4.83	(£0.00)	
Invoices Paid within 30 days (BPPC)	95%	92%	-3%				
CIP	£7.42	£7.23	(£0.19)	£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	4,105	(66)
Non-Elective	38,535	43,596	5,061
Daycase	49,622	52,240	2,618
Outpatient	452,467	449,389	(3,078)
A&E	176,460	189,434	12,974
Other NHS Non- Tariff	2,408,522	2,282,014	(126,508)
Total	**3,129,776**	**3,020,777**	**(108,999)**

TOTAL GROUP: INCOME AND EXPENDITURE

	Plan	Actual	Var
	£m	£m	£m
Elective	£17.53	£17.14	(£0.39)
Non Elective	£119.60	£126.61	£7.02
Daycase	£36.94	£39.29	£2.36
Outpatients	£48.78	£48.72	(£0.05)
A & E	£33.27	£35.30	£2.03
Other-NHS Clinical	£242.85	£227.91	(£14.94)
CQUIN	£0.00	£0.00	£0.00
Other Income	£56.58	£61.03	£4.45
Total Income	**£555.54**	**£556.01**	**£0.48**
Pay	(£365.09)	(£364.45)	£0.64
Drug Costs	(£50.08)	(£49.17)	£0.91
Clinical Support	(£37.73)	(£38.76)	(£1.03)
Other Costs	(£70.25)	(£72.71)	(£2.46)
PFI Costs	(£17.36)	(£17.27)	£0.09
Total Expenditure	**(£540.52)**	**(£542.36)**	**(£1.84)**
EBITDA	**£15.02**	**£13.66**	**(£1.36)**
Non Operating Expenditure	(£41.27)	(£39.92)	£1.36
Surplus / (Deficit) Adjusted*	**(£26.26)**	**(£26.26)**	**(£0.00)**

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

DIVISIONS: INCOME AND EXPENDITURE

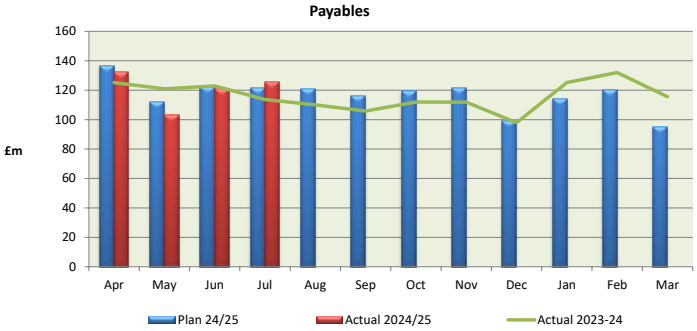
	Plan	Forecast	Var
	£m	£m	£m
Surgery & Anaesthetics	(£105.67)	(£105.80)	(£0.13)
Medical	(£144.67)	(£146.17)	(£1.50)
Families & Specialist Services	(£97.35)	(£95.93)	£1.42
Community	(£35.40)	(£35.07)	£0.34
Estates & Facilities	£0.00	£0.00	£0.00
Corporate	(£60.35)	(£60.20)	£0.15
THIS	£1.44	£1.44	£0.00
PMU	£1.78	£2.50	£0.72
CHS LTD	£0.70	£0.70	£0.00
Central Inc/Technical Accounts	£411.80	£409.72	(£2.07)
Reserves	£1.46	£2.54	£1.07
Surplus / (Deficit)	**(£26.26)**	**(£26.26)**	**(£0.00)**

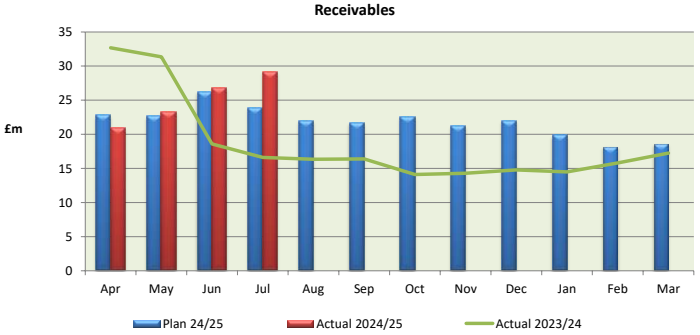
Total Group Financial Overview as at 31st Jul 2024 - Month 4

CAPITAL AND CASH COMPARED TO PLAN SUBMITTED TO NHS IMPROVEMENT

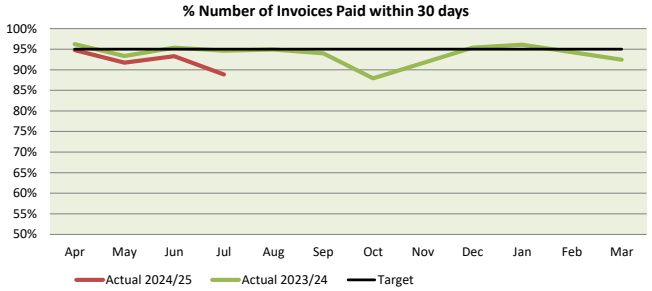
WORKING CAPITAL

	M4 Plan £m	M4 Actual £m	Var £m	M4
Payables (excl. Current Loans)	(£121.27)	(£125.43)	£4.16	
Receivables	£23.91	£29.15	(£5.24)	





BETTER PAYMENT PRACTICE CODE

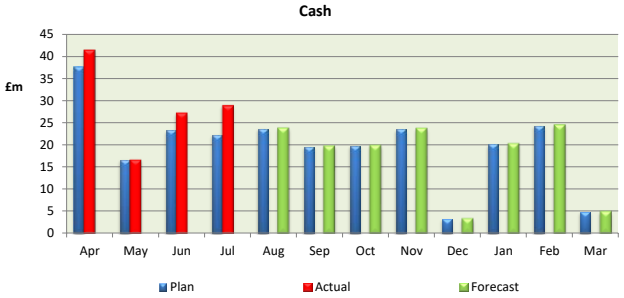


CAPITAL

	M4 Plan £m	M4 Actual £m	Var £m	M4
Capital	£9.20	£10.13	(£0.93)	

CASH

	M4 Plan £m	M4 Actual £m	Var £m	M4
Cash	£22.20	£28.82	£6.62	
Loans (Cumulative)	£12.15	£12.15	£0.00	



CASH FLOW VARIANCE

SUMMARY YEAR TO DATE

- The Trust is reporting a £12.14m deficit, (excluding the impact of Donated Assets and PFI remeasurement IFRS16), £0.29m adverse variance to plan.
- The Trust incurred additional direct costs of £0.45m in the year to date due to the Junior Doctors Strike. Elective Recovery Funding is £1.15m lower than the target assumed in planning, including c. £0.30m impact of the Industrial Action. These adverse variances have been offset by other mitigations in the year-to-date position including higher than planned commercial income and additional income from Interest.
- In 2024/25 the Trust is operating under the National Payment by Results (PBR) funding mechanism for activity within the scope of Elective Recovery.
- Delivery of planned care activity in Month 4 was broadly in line with plan, but the value of the activity delivered was less than the planned level.
- Year to Date the Trust has delivered efficiency savings (CIP) of £7.23m, £0.19m lower than planned.
- The Trust has a cash balance of £28.82m, £6.62m higher than planned.
- Capital expenditure is slightly higher than planned at £10.13m against a planned £9.20m.
- NHS Improvement performance metric Use of Resources (UOR) stands at 3, as planned, with 4 out of 5 metrics at the planned level.
- The Trust is forecasting a UOR of 3 as planned.

NOTES

- The Trust is forecasting to deliver the planned £26.26m deficit, but the 'likely case' scenario suggests a gap of £5.58m due to: likely slippage on the delivery of efficiencies; potential Elective Recovery Funding loss; and the impact of Industrial Action.
- Revised CIP Target is now £32.18m (£30m new schemes plus £2.18m Full Year Effect of 23/24 schemes), of which £6.3m is not yet fully identified (scoping or unidentified).
- The Capital forecast is to spend £56.38m, £1.80m more than planned due to confirmation of additional PDC funding for Reconfiguration and additional lease charges
- The Trust is forecasting to end the year with a cash balance of £5.07m, 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 Trust's reliance on Revenue Support Public Dividend Capital (PDC) is planned at £30.91m for the full year.

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

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

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

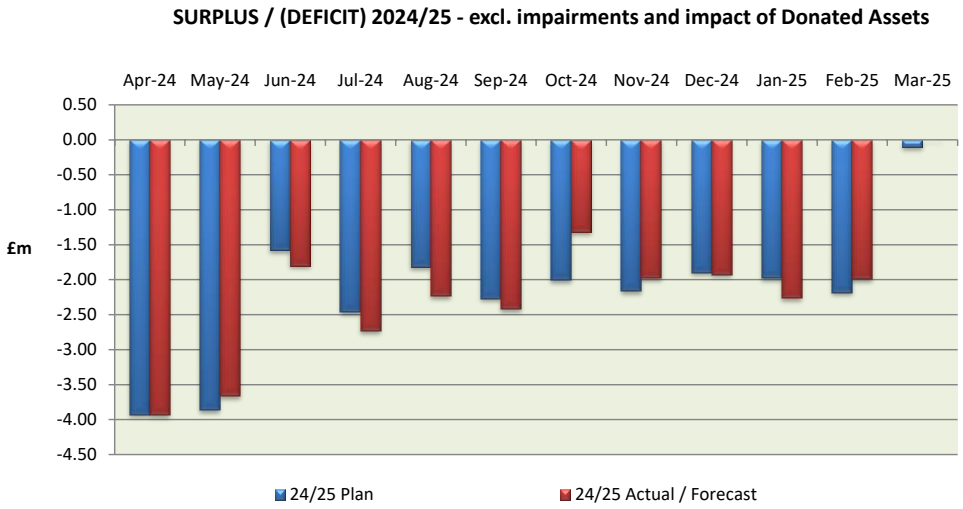
FORECAST 2024/25

24/25 Forecast (31 Mar 25)

Statement of Comprehensive Income	Plan £m	Forecast £m	Var £m	
Income	£555.62	£556.10	£0.48	
Pay expenditure	(£365.09)	(£364.45)	£0.64	
Non Pay Expenditure	(£175.43)	(£177.90)	(£2.48)	
Non Operating Costs	(£38.48)	(£47.02)	(£8.54)	
Total Trust Surplus / (Deficit)	**(£23.38)**	**(£33.28)**	**(£9.90)**	
Deduct impact of:				
Impairments & Revaluations (AME)[1]	£0.00	£9.92	£9.92	
Remeasurement of PFI (IFRS16)[2]	(£3.47)	(£3.49)	(£0.02)	
Donated Asset depreciation	£0.68	£0.68	£0.00	
Donated Asset income (including Covid equipment)	(£0.08)	(£0.08)	£0.00	
Net impact of donated consumables (PPE etc)	£0.00	£0.00	£0.00	
Gain on Disposal	£0.00	£0.00	£0.00	
Adjusted Financial Performance	**(£26.26)**	**(£26.26)**	**(£0.00)**	

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

MONTHLY SURPLUS / (DEFICIT)



The Trust's submitted a revised plan for a £26.26m deficit, reflecting an improvement of £12.3m: £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 have been realigned in M3 to reflect this revised plan.

The Trust is forecasting to deliver the planned £26.26m deficit, but the 'likely case' scenario suggests a gap of £5.58m due to: likely slippage on the delivery of efficiencies; potential Elective Recovery Funding loss; and the impact of Industrial Action.

14. Audit and Risk Committee Chair Highlight Report – 23 July 2024 - Committee Annual Reports 2023/24

For Assurance

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:	23 July 2024
Date of Board meeting this report is to be presented:	12 September 2024
ACKNOWLEDGE	• Six 2023/24 internal audit reports have been finalised since the April committee meeting with a significant assurance (or no opinion in the case of follow up of Outpatients appointment bookings). These were included within the information used by the Head of Internal Audit in forming her opinion on the Trust's internal controls and governance as part of the process for approving the 2023/24 accounts. Two of the significant assurance reports (MUST and LocSSIPs/NatSSIPs) were follow ups on previous limited assurance reports. • There are only 3 recommendations overdue from the 111 recommendations issued during the year, along with 11 recommendations which were overdue but with revised target dates. • The Local Counter Fraud annual report for 2023/24 was approved and a progress report for the current year received. The Committee was pleased to see that 2 attempts at CEO fraud had been identified and prevented by staff which demonstrates the value of the training and awareness on counter fraud which has been provided and the vigilance of staff.
ASSURE	• Limited assurance reports had previously been received from internal audit on the Mental Health Act and Management of contractors. Representatives from the relevant service areas provided an update and assurances about progress with the management responses agreed to these reports. Most of the actions in response to the audit of the Mental Health Act had already been implemented and would be completed by August. It is intended that a re-audit will be undertaken in October to provide the assurance required. Actions had also been implemented on the Management of contractors and it was agreed that further discussion would take place with the Fire Safety Officer about the arrangements for fire safety when contractors are working in Trust premises. • The Audit & Risk Committee (ARC) undertook a deep dive into the work of the Data Quality Board. This identified the work of the Data Quality Board, its successes over the last 12 months and its plans over the next year. The Committee took assurance from this presentation but also the external sources such as the Analytical

	Maturity Adoption Model where the CHFT is the only trust in Europe to achieve level 6 rating. • The terms of reference of the Audit and Risk Committee and the Chair's Job Description were reviewed and approved. • The annual reports from Finance & Performance Committee, Quality Committee, Workforce Committee, the Transformation Programme Board and the Charitable Funds Committee for 2023/24 were approved on behalf of the board. This was a change from the previous practice where these would have been reviewed at board but with the intention that ARC would attempt to triangulate the work of the committees and in future will use the committee annual reports to inform its view on the Annual Governance Statement. The Chair outlined the consistencies within the annual reports in terms of inclusion of the terms of reference, information on the review of the committee's effectiveness, details of membership and attendance and confirmation that each committee had achieved its purpose. Some differences were noted between the annual reports in terms of the addition of information about priorities and plans over the next 12 months and reviews of BAF risks. It was agreed that the following issues could be considered: – Whether we should attempt more consistency in the format of the committee annual reports and include the requirement to review the relevant BAF risks, areas of focus for the committee over the next 12 months and the outcome of the review of the committee's effectiveness. It was suggested that the self assessment of effectiveness template would have to be standardised in order to achieve this. – Whether we could coordinate the workplans across the committees to ensure that when deep dives are undertaken we bring in the different data from each committee as context.
AWARE	• Audit & Risk Committee approved an updated version of the Board Assurance Framework (BAF) Standard Operating Procedure which now incorporates reference to the arrangements within the ICS and the current version of the Board Assurance Framework. The Committee recommended that responsibility for the BAF risk in relation to cyber security be transferred to ARC and that the wording of the risk in relation to the clinical strategy be updated to reflect the recent change to the risk scoring. • The Committee noted that one limited assurance report had been issued in 2024/25 which was a follow up on the Naso gastric tube processes. It was agreed that the Executive lead would be invited to the October ARC meeting to contribute to a deep dive into this audit. • It was agreed that in addition to deep dives which ARC undertakes on limited assurance reports that the Committee would also undertake deep dives into high or significant assurance reports from which best practice could be identified and disseminated. • The terms of reference of the Data Quality Board were approved.

	• It was agreed that an update on the cyber security risk in light on recent national cyber issues and particularly in relation to gaining assurances about controls on third party systems would be undertaken at the October ARC meeting in addition to deep dives on Risk Management and Health & Safety. • The Committee was advised that new guidance had been received on the EPRR processes nationally and that further details would be provided once this has been worked through.
ONE CULTURE OF CARE	• The Committee thanked everyone involved in the deep dive discussions at the meeting.
REGULATION	• CQC Regulation 17: Good governance

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Date of Meeting:	12 September 2024
Meeting:	Board of Directors
Title:	Finance and Performance Committee Annual Review 2023/24
Author:	Andy Nelson, Chair Finance and Performance Committee
Sponsor:	Andy Nelson, Chair Finance and Performance Committee
Previous Forums:	Finance and Performance Committee 4 July 2024 Audit and Risk Committee 23 July 2024
Purpose of the Report	Good practice states that the performance Board sub-committees should be reviewed annually to determine if they have been effective, and whether further development work is required. This Annual Report summarises the activities of the Trust's Finance and Performance Committee (the Committee) for the financial year 2023/24 setting out how it has met its Terms of Reference and key priorities.
Key Points to Note	The Finance and Perfrmance Committee has carried out its business in the last 12 months in accordance with the terms of reference and the meetings have been well attended. A good balance has been achieved between financial and operational matters and there has been valuable input from other executives, clinicians and managers outside the Committee. In year regular updates have been provided overall operational and financial performance and performance against our elective recovery plans. The committee has conducted regular deep dives into aspects of operational performance. A self-assessment for the year was completed in March 2024 and actions agreed.
EQIA – Equality Impact Assessment	Individual decisions made by the committee during the year will have been required to undergo a QIA and EQIA as appropriate
Recommendation	The Board is asked to **NOTE** the attached report.

Finance and Performance Committee
Annual Review 2023/24

1. Background

Good practice states that the performance of Board sub-committees should be reviewed annually to determine if they have been effective, and whether further development work is required. This Annual Report summarises the activities of the Trust's Finance and Performance Committee (the Committee) for the financial year 2023/24 setting out how it has met its Terms of Reference and key priorities. These were reviewed and updated in February 2024 in which the key decision was to remove the section relating to Procurement as this is covered by the CHFT / CHS Joint Liaison Committee which reports into this committee.

The purpose of the Committee is laid down in its Terms of Reference. In summary, it is responsible for providing information and making recommendations to the Trust Board on financial and operational performance issues and for providing assurance that these are being managed safely. This report will consider the work of the Committee over the course of the last 12 months against each of the key areas of responsibility as laid out in the terms of reference.

2. Finance and Financial Performance

Monthly reporting is provided to the Committee by way of a comprehensive pack of financial metrics and narrative on the year to date and forecast position against the plan for the year. This pack covers the activity, income and expenditure position including cost improvement programme (CIP), capital, cash and use of resources metric. The financial risks which form part of the overall Trust risk register are reviewed against the intelligence in this report and discussed by the Committee. The financial elements and other specific risks from the Board Assurance Framework are also reviewed by the Committee against the in-year performance and longer-term outlook.

3. Performance Delivery and Assurance

The Committee receives the monthly Integrated Performance Report which is presented to draw out key messages from the comprehensive report, highlighting particularly positive performance and areas of concern and management actions to maintain the former and address the latter.

In 2023/24 further information has also been regularly received by the Committee on the Trust's elective recovery trajectories, detailing progress to date and future forecasting. These have been presented and discussed drawing out the particular challenges and achievements in specific specialty areas.

During the year, the Committee has requested a number of deep dives into specific clinical specialties or areas of performance. Examples include deep dives into the performance of ED, the challenges of length of stay/transfer of care and outpatient follow-ups. For some subjects we also had follow-ups to these dives several months later to see what progress had been made in improving performance. We also had presentations on the excellent performance in Cancer and Elective Recovery to understand the how this has been achieved. These presentations have been made directly to the Committee by subject matter experts who were

able to bring the topics to life and answer questions which was well received by committee members.

The minutes of the Access Delivery Group and Urgent and Emergency Care Delivery Group are routinely received.

4. Business and Commercial Development

The Committee's prior understanding of the long-term plan set the context for the operational and financial plans ratified in year. The committee reviewed the draft financial plans for 2024-25 but given the late provision of national guidance it was not possible to approve these plans for submission to the Board. We did however, review and approve the Capital Plan for 2024-25 for submission to the Board.

The Committee routinely receives the Board minutes and annual reports from the Trust's commercial areas, Huddersfield Pharmacy Specials (HPS) and The Health Informatics Service (THIS). The committee also reviewed the commercial plans for HPS and THIS.

In addition, minutes are received from the Capital Management Group, the Business Case Approvals Group detailing business case approvals, progress and expected deliverables. Minutes are also received from the Pennine Property Partnership Board and the Joint Liaison Committee where the relationship between the Trust and CHS, its wholly owned subsidiary is managed.

5. Treasury Management

The in-year management and monitoring of treasury matters has been reported to the committee through the monthly financial performance pack. This includes information on levels of borrowing, aged debt and performance against the Better Payment Practice Code. This information is routinely discussed and challenged by the Committee.

The activities undertaken through the Cash Management Committee are reported to the Committee through receipt of the minutes on a quarterly basis.

6. Membership, Attendance and Monitoring Effectiveness

The Committee is held monthly and was quorate at all its 12 meetings. A register of attendance is shown at Appendix 1.

A self-assessment questionnaire in relation to the effectiveness of the committee is carried out on an annual basis and was completed and discussed at the Committee in March 2024.

Summary and Recommendation

The Committee has carried out its business in the last 12 months in accordance with the terms of reference and the meetings have been well attended. A good balance has been achieved between financial and operational matters and there has been valuable input from other executive colleagues, clinicians and managers outside the Committee.

The Committee is recommended to note the contents of this report.

FINANCE & PERFORMANCE ATTENDANCE – 2023/24

	M 1 26 April	M 2 30 May	M 3 28 June	M 4 1 Aug	M 5 30 Aug	M 6 26 Sept	M 7 25 Oct	M 8 28 Nov	M 9 2 Jan 2024	M10 30 Jan	M11 27 Feb	M12 26 Mar	Total 12/12	
MEMBERS														
Andy Nelson (Chair)	√	√	√	√	√	√	√	√	√	√	√	√	12/12	
Nigel Broadbent Non-Exec (Vice-Chair)	√	√	√	√	√	√	√	√	√	√	√	√	12/12	
Anna Basford	√	√	Apols	√	√	√	√	√	Apols	√	√	√	10/12	
Gary Boothby	√	√	Apols	Apols	Apols	√	√	√	√	Apols	√	√	8/12	
Kirsty Archer	√	√	√	√	√	√	√	√	Apols	√	√	√	11/12	
Jonathan Hammond	√	√	√	Apols	Apols	√	Apols	√	Apols	√	√	Apols	7/12	
Victoria Pickles	√	√	√	√	√	√	√						7/7	No longer attending
Rob Aitchison	√	√	√	Apols	√	√	√	√	√	√	√	√	11/12	
Karen Heaton Non-Exec	√	√	√	√	√	√	√	√	√	√	√		11/11	Retired
In Attendance														
Stuart Baron	√	√	Apols	Apols	Apols	Apols	√	Apols	√	Apols	√	Apols	5/12	
Andrea McCourt	√	√	√	√	√	√	√	√	Apols	Apols	√	√	10/12	
Peter Keogh	√	√	√	√	√	√	√	√	√	√	√	√	12/12	
Philippa Russell	√	√	√	√	Apols	√	Apols	√	√	√	√	√	101/12	
Adam Matthews	√	√	√	√	√	Apols	√	√	Apols	√	√	Apols	9/12	
Rob Birkett	√	√	√	√	Apols	√	Apols	√	√	Apols			7/10	No longer attending
Governor Observer(s)														
Robert Markless	√	√	Apols	√	√	√	√	√	√	Apols	√	-	9/12	Last one teams issues
Brian Moore	√	√	Apols	√	Apols	Apols	√	√	√	√	-	-	7/12	Last one teams issues
Isaac Dziya	√	√	-	-	Apols	√	√	√	Apols	Apols	-	-	4/12	
Pam Robinson							√	√	APols	Apols	√	√	4/6	
Helen Hirst	-	√	-	-	-	-	-	-	√	-	√	-	3/12	

Date of Meeting:	12 September 2024
Meeting:	Board of Directors
Title of report:	Quality Committee Annual Report 2023/2024
Author:	Elizabeth Morley – Assistant Director for Quality and Safety
Sponsor:	Denise Sterling - Non-Executive Director and Chair of Quality Committee Chair
Previous Forums:	Quality Committee – 3 June 2024
Purpose of the Report	This annual report describes the activities of the Quality Committee between April 2023 and March 2024, describing how the Committee met the duties within the terms of reference. The report includes: ▪ An overview of the role of the Quality Committee ▪ Details of membership and attendance between April 2023 and March 2024 ▪ Information of the work of the Committee in the following areas: - quality improvement - governance and patient safety - audit and assurance - quality and safety reporting ▪ Effectiveness of the Committee – this section summarises the response of the self –assessment by members which reviewed the committee's focus and objectives, committee team working, committee effectiveness, committee engagement and committee leadership. 11 members completed the assessment.
Key Points to Note	This annual report is presented for information and assurance and will be shared with the Board of Directors on Thursday 12 September 2024.
Recommendation	The Board is asked to note the assurances in the Annual Report that the Quality Committee met its duties for the reporting period of 2023/2024.

Quality Committee Annual Report 2023 / 2024

This Quality Committee annual report for 2023 / 2024 details:

- The role of the Quality Committee, membership and attendance between April 2023 and March 2024 and the terms of reference
- The activities of the Quality Committee between April 2023 and March 2024
- Self- assessment of the effectiveness of the committee
- The Committee's commitment and focus on key priorities, additional scrutiny into subgroups and assurance to the Trust Board.

1. Introduction

Purpose of the Quality Committee

The purpose of the Quality Committee is to provide assurance to the Trust Board 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; and to ensure that the risks associated with the quality of the delivery of patient care are managed appropriately.

The Quality Committee is also responsible for reviewing proposed quality improvement priorities, monitoring performance and improvement against the Trust's quality priorities, the implementation of the Quality Account, and ongoing monitoring of compliance with national standards and local requirements.

The Quality Committee receives assurance from a number of quality sub-groups via an annual work plan structured around the CQC domains. The work plan continued to be reviewed and updated during the year.

2. Terms of Reference

Following a review of the governance reporting structure, the terms of reference were amended in February 2024 to include the removal of Trust Patient Safety and Quality Board (PSQB) as a sub-group, and the renaming of the Patient Experience and Caring Group to Patient Experience and Involvement Group, and the sub-group additions of:

- Divisional Patient Safety and Quality Board reporting
- Medication Safety and Compliance Group
- Medical Gases Group
- Clinical Effectiveness and Audit Group
- Transfusion Committee
- Resuscitation Committee
- Thrombosis Committee
- Cancer Board
- Radiation Protection Board

The current terms of reference (v8.1) are due for approval at the May 2024 Quality Committee and ratification at the Board of Directors in July 2024.

3. Quality Committee Membership and Attendance in 2023/2024

The Quality Committee met on 12 occasions between April 2023 and March 2024.

The membership and attendance at the Quality Committee during the period is given below, with one member of the Council of Governors invited to attend and observe each meeting.

Role	Number of meetings attended
Non-Executive Director **(Chair)**	11/12 = 92%
Non-Executive Director **(Vice-Chair)**	12/12 = 100%
Non-Executive Director	11/12 = 92%
Medical Director	10/12 = 83%
Chief Nurse	11/12 = 92%
Director of Corporate Affairs	10/12 = 83%
Deputy Chief Nurse	7/12 = 58%
Deputy Medical Director	7/12 = 58%
Chief Operating Officer	7/12 = 58%
Deputy Director of Workforce & Organisational Development	12/12 = 100%
Assistant Director of Quality and Safety	4/6 = 67%
Clinical Director of Pharmacy	10/12 = 83%
Associate Director of Allied Health Professionals (AHPs)	3/11 = 27%
Head of Quality and Safety	4/12 = 33%
Governance Administrator	12/12 = 100%
Public Elected Governor **(Observer)**	10/12 = 83%

- Assistant Director of Quality and Safety was vacant for six months
- Associate Director of AHPs added to membership in May 2023

4. Quality Committee Activities 2023 / 2024

The principal activities of the Quality Committee during the period are detailed below within the areas of quality improvement, patient safety, audit and assurance and quality and safety reporting from sub-groups.

4.1 Quality Improvement

The Quality Committee reviewed the following areas during the year to gain assurance regarding service quality and improvement:

- **Quality Governance Structure** – a streamlined reporting structure for the Committee was presented in April 2023, highlighting that some groups which were set up during COVID, were removed, and further groups added. Reviews of the governance structure continued throughout the year, with cross-referencing against the Quality Committee workplan to ensure relevant reports were timetabled at the appropriate time.

- **Parkinson's Update** – as part of a national pledge for Trust CEOs to support improving the timeliness of Parkinson's drugs, an update on the work done was provided in May 2023. Assurance was provided that the ongoing, comprehensive action plan was monitored at the Medicines Safety and Compliance Group.

- **Learning from Deaths Report** – the Committee received quarterly reports in May, July and October 2023, and January 2024.

- **Midwifery Staffing revised workforce model** – an update on the birthrate and revised midwifery staffing model was provided in June 2023.

- **NHS Adult Inpatient Survey 2022 Benchmark Report** – the report, with CHFT being in the top five for a number of indicators, was provided in October 2023. The key area results were integrated into an action plan, and taken through the Patient Experience and Involvement Group.

- **Medical Examiner (ME) Update –** six monthly updates were received in August 2023 and February 2024. The service expanded to include four Medical Examiner Officers, and five General Practitioners from Calderdale and Huddersfield, to provide a diverse team from both primary and secondary care to enable scrutiny of community deaths. Draft regulations of the ME service were published in December 2023, with an expected effective date from April 2024.

- **Health and Safety assurance report** – Six-monthly updates were received in May and November 2023, on standards and projects taking place during the year, and compliance demonstrated against each.

- **Annual Reports** – These were received by the Committee at various intervals throughout the year. The complaints annual report was received in June 2023; and the annual patient experience report received in September 2023. The first Controlled Drugs annual report was received in February 2024.

- **Patient Stories:**
  - learning relating to end of life care was provided in August 2023, as well as assurance of work within local and regional workstreams on benchmarking outcomes. These are also reported on a monthly basis through the Patient Safety and Quality Boards.
  - Learning from a patient journey from admission through to discharge was shared in November 2023
  - Learning from a multi-agency partnership report, based on a case of a young person who resided at CHFT for some time, was shared in March 2024.

- **Follow-up appointment concerns** – Updates from concerns regarding patients lost to follow-up were provided in April 2023, and a closing paper of completed actions provided in August 2023.

- **Maternity Reports** – monthly updates were provided to the Committee and subsequently submitted to the Board of Directors. Following a high-level provisional review of the East Kent independent investigation report against the findings undertaken at CHFT, the 3-year Delivery Plan for Maternity and Neonates was published.

- **Lucy Letby** - actions regarding the CHFT response to the Lucy Letby case were provided in August 2023, with a 'true for us' report testing how the Trust fits against learning from the case, submitted to the Board of Directors in September 2023.

- **Review of Neonatal Deaths** – an update was provided in November 2023 on the results of a cluster of neonatal deaths on the Neonatal Unit in November 2022. The cases were rapidly escalated in order for commission and review, and an external audit is due to take place.

- **Getting It Right First Time (GIRFT)** – the Committee received an update in September 2023 on the developments within the GIRFT programme. A subsequent update will be provided in April 2024.

- **Safer Staffing Report** – the Committee received the annual report in June 2023, and a six-month update in December 2023 on an overview of Nursing, Midwifery and Allied Health Professional (AHP) staffing capacity and compliance within CHFT. This report is also submitted to the Workforce Committee and Trust Board.

- **Safe Sustainable and Productive Staffing** – the first report summarising the activity within the Safe, Sustainable and Productive Staffing Meeting (SSPSM) was provided in November 2023. The SSPSM was set up in response to the National Quality Board (NQB) standards of 2016. Activity is split between the SSPSM and the Nursing, Midwifery and AHP Workforce Steering Group. The SSPSM is focused on the qualitative, outcomes and impacts on patient experience, and assurance was provided that the requirements of the NQB are being met to undertake and deliver safe, effective, caring, responsive and well led staffing levels. A subsequent report will be provided in May 2024.

- **National Improvement Board** – an update on the proposed timeline for implementing actions was provided, with transition into the new operating model becoming business as usual from Autumn 2023 onwards, which will align with the publication of the new single assessment framework for CQC.

- **Recommended Summary Plan for Emergency Care and Treatment (ReSPECT)** – an update was provided in July 2023 on the Policy, the Internal Working Group and standard operating procedure (SOP). It was agreed that the ReSPECT working group will report into the Clinical Outcomes Group.

4.2 Patient Safety

The Committee continued its focus on patient safety which included receiving updates on:

- **Patient Safety Incident Response Framework (PSIRF)** – an update was provided in July 2023 on the changes to investigations, and a further update in January 2024 on the progress made to date; training plan; patient safety priorities, and the Trust's local and national priorities.

- **Patient Safety Incident Response Plan (PSIRP)** – the PSIRP was signed off and approved in February 2024.

- **Patient Safety Incident Response Framework (PSIRF) Policy** – the PSIRF Policy was signed off and approved in February 2024

- **Patient Safety Alerts:**
  - an update on the Medicines and Healthcare products Regulatory Agency (MHRA) Valproate safety alert issued in November 2023 was provided, stating the change in legislation at the end of January 2024, and an internal task and finish group to review compliance with standards. The action plan was presented in February 2024, which continues to be monitored by the Medication Safety and Compliance Group.
  - An update on minimising time weighted exposure to nitrous oxide in healthcare settings was provided in March 2024. Next steps are to review the internal audit findings when published, and quality check the Control of substances hazardous to health (COSHH) alerts.

- **Recruitment to Experts by Experience (EBE) and Patient Safety Partners (PSP)** - an update was provided in January 2024, and both roles were recruited to by the end of March 2024.

4.3 Quality and Safety Reporting

- **Quality Priorities** – a close-down report of the three 2022-2023 quality priorities and the seven focused priorities was provided in May 2023. The three chosen approved quality priorities for 2023-2024 were:

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

  The proposed quality priorities for 2024-2025 were presented in February 2024, which were circulated to the Council of Governors for approval.

- **Commissioning for Quality and Innovation (CQUIN)** – the five CQUINs presented in May 2023, which aligned with the Quality Priorities were:

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

  Regular updates were provided via the Quality Report.

- **Quality Reports** – these were received on a bi-monthly basis, including the reporting of the three quality account priorities, five CQUINs mentioned above. A review took place in June 2023, with the report becoming streamlined and easier to read, including updates on serious incidents, Never Events, CQC, patient safety alerts, complaints, legal services, Policies, NICE guidance and the Clinical Outcomes Group dashboard.

  In December 2023, an update was provided on the approval to switch from Datix, the incident reporting system, into a new system called InPhase, which will align closely with Patient Safety Incident Response Framework (PSIRF) principles on triangulating data sets from safeguarding, freedom to speak up, incidents, complaints, risk, etc in order to identify emerging themes and manage risks differently. This went live at the end of March 2024, and will be run alongside Datix for 12 months in order to be confident with data migration.

- **Quality and Safety Strategy** – an update on the proposed Strategy was provided in October 2023, which reframed the approach to quality assurance and quality improvement. The strategy will include feedback and recommendations following the Quality Summit held in October 2023. The Strategy is due to be launched in the first quarter of 2024/25.

- **Quality Account** – Final approval of the 2022-2023 Quality Account took place in June 2023, and the draft timeline for the 2023-2024 Quality Account was received and approved in February 2024.

- **Trust Patient Safety and Quality Board (PSQB) meeting** – a proposal was provided in November 2023, with a further paper submitted in December 2023 on the governance arrangements for divisions. The last Trust PSQB meeting was held on Tuesday, 19 December 2023, with divisions due to report into the Quality Committee from quarter 1 2024/25.

4.4 Audit and Assurance

- **Board Assurance Framework** - The Committee received updates on the Board Assurance Framework (BAF) risks, which relate to achieving strategic objectives. The committee had oversight on a number of risks and deep dives on the following:

  - Patient and Public Involvement (4/19) – update received in October 2023, with a risk score of 12. The Strategy was being reviewed to ensure it met statutory obligations for patient experience and involvement.

  - Compliance with quality and safety standards (6/19) – update received in April 2023, stating the score was revised from 12 to 15 at the November 2022 Trust Board, due to limited assurance as a result of an Internal Audit during Summer 2022. Following the completion of actions, it was agreed that the risk reduced to a score of 12. A further update was received in October 2023.

  - CQC rating (4/20) – updates received in April and October 2023, with the Trust continuing to monitor the risk, and no plans to reduce the score, which remains at 12.

  - Seven-day services (3/19) - This risk was removed from the Board Assurance Framework in July 2023. The standards remained, but were no longer a key risk to the Trust's strategy. Audits of progress against the standards continue to be reported to and scrutinised by the Quality Committee, with an assurance update on compliance received in December 2023.

- **Nasogastric Tube Assurance Report** – updates from an Internal Audit commissioned following two Never Events in relation to the placement of nasogastric tubes were provided in October 2023, with a request of subsequent monthly update. A number of ongoing actions were undertaken, with a plan to carry out a re-audit by March 2024.

- **Integrated Performance Reports** – The Committee considers the Integrated Performance at every meeting with particular focus on the metrics relating to the quality agenda. Presentations were received in April 2023 on patient incidents and harm, and in November 2023 in correlation with length of stay.

- **Internal Audit: Ward to Board Reporting** - assurance on the Ward to Board reporting arrangements were provided in May 2023. The review found arrangements for quality priorities to be generally effective, with significant assurance for all audited items. There were four recommendations for improvement, which the Quality and Safety Team set a target of the end of May 2023 to achieve.

- **Electronic Patient Record issue** – Following a Health Service Journal (HSJ) article in February 2024 around Durham and Darlington's installation of Electronic Patient Records and an issue associated with 'time to be seen' either not being recorded or not being visible within Electronic Patient Record at the launch point, the Committee were assured in March 2024 that a review was undertaken to ensure the same issue and risks were not present at CHFT.

- **Quality Committee meetings** - Following discussions on the scheduling of the Board of Directors' sub-committees, it was proposed that all sub-committees take place on Tuesdays and Thursdays. From July 2024, Quality Committee meetings will take place on a Tuesday morning.

4.5 Sub-group Reporting

The following groups reported to the Quality Committee by providing progress reports during the year, as detailed in the work plan:

- Infection Prevention and Control Board – received in June, August and September 2023, and January 2024
- Trust Patient Safety and Quality Board – received in July and November 2023.
- Safeguarding Committee – annual report received in June 2023, and six-monthly report received in December 2023
- Patient Experience and Caring Group – received in July and November 2023. and March 2024.
- Clinical Outcomes Group – focussed items on sepsis in the Emergency Department (ED) and dementia screening were provided as stand-alone updates in January 2024.
- Research and Development Committee Report – annual update received in July 2023, followed by six month report in January 2024.
- Medicine Management Committee Report – received September 2023
- Medication Safety and Compliance Group Report – received January 2024.

Terms of reference for all the above groups were also received throughout the year.

5 Effectiveness of Quality Committee

The Committee has been active during the year in carrying out its duty in providing the Board of Directors with assurance that effective internal control arrangements are in place. The Committee summarises escalations to the Board at the end of every meeting.

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 a number of themes. The outcome of this is then reviewed by the Committee and an action plan developed and monitored by the Committee. The self-assessment exercise took place in April 2024.

Following the Committee's 2022-2023 self-assessment, actions were put in place in August 2023 to address the areas which had a response of *'did not agree'* or '*do not know'*, as well as proposed objectives for the Committee. These included:

- Approve and seek assurance on the first year of implementation of the Quality Strategy.
- Oversee and seek assurance on the full implementation of Patient Safety Incident Response Framework
- Provide robust reporting to the Board on the key quality indicators and priorities and reasons for any gaps in performance
- Ensuring the voice of the patient / carer / public is within discussion and decisions of the Committee

All objectives were met and signed off in May 2024.

6. Conclusion

The Quality Committee has been active during the 2023/2024 year in the carrying out of its duties. Assurance can be provided to the Board of Directors that systems and processes are in place for the delivery of safe quality services and the delivery of the quality improvement priorities.

The annual self-assessment of the committee's effectiveness was undertaken in April 2024, the themes and learning will be presented to the Committee with an action plan in July 2024.

7. Next Steps 2024 / 2025

The Committee will continue to focus its attention on the oversight of the delivery of high quality, safe and clinically effective care for the patients of CHFT, as well as the:

- Embedding of the Quality Strategy

- Oversight of the process for the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) being rolled out with CHFT and Mid-Yorks collaboratively, and across the health economy.

- The implementation of Patient Safety Incident Response Framework.

Denise Sterling
Non-Executive Director / Quality Committee Chair
May 2024

Date of Meeting:	12 September 2024
Meeting:	Board of Directors
Title of report:	Workforce Committee Annual Report 2023/2024
Author:	Tracy Rushworth, Workforce Committee Secretary Jason Eddleston, Deputy Director of Workforce and Organisational Development
Sponsor:	Jo-Anne Wass, Non-Executive Director/Workforce Committee Chair
Previous Forums:	Workforce Committee 12 June 2024 Audit and Risk Committee 23 July 2024
Purpose of the Report	The Workforce Committee annual report for 2023/2024 details:- ▪ the role of the Committee, membership and attendance between 1 April 2023 and 31 March 2024 and the terms of reference ▪ the activities of the Committee between 1 April 2023 and 31 March 2024 ▪ a self-assessment completed by core Committee members relating to the effectiveness of the Committee.
Key Points to Note	This Workforce Committee Annual Report is presented for information and assurance. The Audit and Risk Committee will receive the report at its meeting on 23 July 2024. A highlight report will be shared at the 12 September 2024 Board of Directors meeting.
Recommendation	The Board is asked to note the content of the report.

WORKFORCE COMMITTEE

ANNUAL REPORT 2023/2024

12 JUNE 2024

This Workforce Committee annual report for 2023/2024 details:-

- the role of the Committee, membership and attendance between 1 April 2023 and 31 March 2024 and the terms of reference.
- the activities of the Committee between 1 April 2023 and 31 March 2024.
- a self-assessment completed by core Committee members of the effectiveness of the Committee.

1. INTRODUCTION

1.1 Purpose of the Workforce Committee

The purpose of the Committee is to provide assurance to the Board on the quality and impact of workforce and organisational development strategies and the effectiveness of workforce management in the Trust. This includes but is not limited to recruitment and retention, colleague health and wellbeing, learning and development, colleague engagement, organisational development, leadership, workforce spend and workforce planning.

The Committee oversees that there is continuous and measurable improvement in workforce activities through review of key workforce metrics in order to support the delivery of workforce performance targets.

The Committee receives assurance in relation to internal workforce activity from a number of annual reports prior to national publication. These reports include Freedom to Speak Up, Workforce Race Equality Standard, Workforce Disability Equality Standard and Gender Pay Gap. The Committee is responsible for reviewing and monitoring performance and improvement against the associated action plans.

1.2 Terms of Reference

The Committee has approved Terms of Reference in place.

The Terms of Reference were reviewed by the Committee in April 2023. Amendments were made to the membership and attendance of the Committee:-

- Core membership comprises three Non-Executive Directors, Director of Workforce and Organisational Development, Director of Nursing and the Medical Director
- A quorum must include at least two Non-Executive Directors
- To ensure Director attendance the Committee has been assigned two Directors ‘buddies’
- Up to two Governors will observe the meeting

1.3 Workforce Committee Membership and Attendance in 2023/2024

Between 1 April 2023 and 31 March 2024 the Committee met 7 times.

The core membership and attendance at the 7 Committee meetings is set out below:-

Name	Role	Number of meetings attended
CORE MEMBERS		
Karen Heaton	Non-Executive Director **(Chair)**	7/7
David Birkenhead	Medical Director	5/7
Nigel Broadbent	Non-Executive Director	7/7
Suzanne Dunkley	Director of Workforce Organisational Development	7/7
Jonny Hammond[1]	Chief Operating Officer	2/5
Vicky Pickles[2]	Director of Corporate Affairs	1/5
Lindsay Rudge	Chief Nurse	5/7
Denise Sterling	Non-Executive Director	6/7

[1]Member until October 2023
[2]Member until October 2023

2. WORKFORCE COMMITTEE ACTIVITIES 2023/2024

At the February 2023 meeting it was agreed that in addition to workplan business items, the Committee should have a systematic approach to discussing the 6 Chapters of the People Strategy. From May 2023, one Chapter per meeting is listed for discussion. This approach allows balance in hearing about positive progress and grasping hot spot areas. There is an emphasis on divisions/leads attending Committee meetings to present their key priorities and action plans in response to hot spot areas.

The activities in 2023/2024 of the Committee are set out below.

2.1 People Strategy Chapters

2.1.1 3 May 2023 – Equality, Diversity and Inclusion (ED&I)

The Leadership Framework was launched at the 26 April 2023 Leadership Conference. The Committee received an overview of the framework that outlines 7 leadership elements that constitute effective leadership within the Trust. An ED&I data dashboard was presented to the Committee. The dashboard content incorporates comprehensive data against several metrics.

The Committee received an update from the Race, Pride and Disability Network Group Chairs. Success stories were showcased along with challenges and opportunities to further develop the groups. Divisional colleagues also attended the meeting to share their CHFT journey experiences.

The Inclusion Group has been established as a formal sub-group of the Workforce Committee. The group oversees a framework in which all our ED&I activity is commissioned, designed, delivered and managed in order to deliver our strategic objectives. The Committee noted the group's purpose, duties and guiding principles.

2.1.2 20 June 2023 – Engagement

The Committee received presentations on the following topics:

The psychology of engagement
Evolving the wellbeing offer
Directorate health heat map
Staff survey high impact action plan
Staff survey hot spot progress
Staff survey action plan case studies
Recognising colleague contribution

Divisional representatives attended the meeting to share progress and provide positive assurance on hot spot areas.

2.1.3 23 August 2023 – Talent Management

The Committee received updates on the key elements of the People Strategy.

Recruitment Strategy
Progress against the following themes was shared with the Committee:-

- Attraction and recruitment
- Developing our workforce
- Widening participation
- Why we are CHuFT about CHFT

Apprenticeship Strategy
The update demonstrated continued strong performance as an Employer Provider in terms of achievement, low attrition and income generation. Apprenticeship Levy spend increased by 8% on 2022/2023. The July 2021 OFSTED assessment rated Good (outstanding in the area of leadership, management and learner support). Evidence is being prepared for the next assessment visit. A Colleague shared her story as a CHFT apprentice.

Development for All
The suite of activity and development opportunities were outlined. External programme providers include Huddersfield Business School, Calderdale College, NHS Leadership Academy along with Place based development programmes.

2.1.4 17 October 2023 – Workforce Design

The Committee received an overview of the workforce design tool that provides a framework for teams to work together to consider all aspects of workforce design when considering service change. It focuses on five key impact areas – colleagues, patient safety and quality of care, digital system, partners and finance. The tool aligns to the 'reform' element of the NHS Long Term Plan published in June 2023.

The Committee received a presentation on the Emergency Department reconfiguration. The service reported improvements in career progression, introduction of senior medical rotas and consultants rostered for weekend working.

The Committee received a presentation about redesigned services in Ophthalmology. Positive results were achieved by listening to both staff and patients, reviewing national guidance and performance against KPIs. Different ways of working and funding to support training were explored, scoping of trials to increase capacity together with collaboration across WYAAT and ICB transformed the service.

2.1.5 18 December 2023 – Health and Wellbeing

Colleague Psychology
A presentation was provided to describe the establishment of a new service – 'critical incident peer support debriefing'. The service will be piloted in ED and maternity services between February 2024 and August 2024.

Men's Health
It was reported to the Committee that a task and finish group has been established to develop a framework for the peer support network.

FSS Wellbeing Board
Examples of initiatives and next steps to scale up activity of the Wellbeing Board were shared with the Committee.

Wellbeing Ambassador
A colleague shared their story with the Committee on what inspired them to becoming a wellbeing ambassador.

People Strategy overview
The Committee received a summary of initiatives and schemes noting the spotlight on financial wellbeing.

2.1.6 19 February 2024 – Improvement

Work Together Get Results (WTGR)
An update on 2023 activity was provided. A colleague shared her story about her experiences of using the WTGR methodology. The programme is set to expand in response to demand.

Critical Event Support Debriefing Service
The Committee received information about implementation of the service.

2.2 ESR Annual Assessment 2022/2023

In April 2023 the Committee received a graphic produced by the NHS ESR team following the Trust's annual ESR Assessment. The assessment looked across a broad range of functional areas within EST and identified usage and highlights where ESR is utilised well and where the Trust can gain further efficiencies. The Committee noted good effective use of ESR which will continue to increase as the system develops. In February 2024 the Committee received the results of the 2023/2024 annual assessment. The Committee remained assured ESR is being utilised well and benchmarks well in assessing readiness for the new system launch in 2025.

2.3 2022 Staff Survey

In April 2023 the Committee received a verbal update on hotspot management. Survey actions plans are to be finalised by 2 May 2023. Executive sponsors will connect with service engagement leads to offer support, guidance and coaching and also share good practice.

2.4 NHS Pay Offer and Industrial Action

In April 2023 the Committee received an update on trade union activity regarding the national pay offer, ballot outcomes and industrial action. At this time the Trust was awaiting news from the BMA about a third strike. Operational and clinical teams were commended in ensuring safe care was maintained during strike action.

2.5 Developing Workforce Safeguards Report

The Committee regularly reviews the progress against the 14 key recommendations as set out in the Developing Workforce Safeguards (2018). On 20 June 2023 the Committee received a report confirming the Trust is compliant with 10 recommendations. A further recommendation is progressing to green whilst 3 remain partially compliant. The Committee was assured by the improving position and agreed it no longer required to receive a regular report. An exception report would be received for any escalated issues.

2.6 Freedom to Speak Up Annual Report

The Committee received the 1 April 2022 to 31 March 2023 annual report in June 2023. The key points noted were:-

- The number of concerns raised in 2022/2023 and the number of concerns raised as per the NGO's submission categories and by staff groups.
- The themes of concerns.
- The ethnicity of the colleagues that have raised their concerns via FTSU at CHFT.
- The work being undertaken to create a culture where staff feel safe to speak up and make FTSU business as usual at CHFT.

A mid-year progress report in December 2023 showed a slight increase in the number of concerns raised by colleagues in Q2. Q2 saw a significant reduction in the number of concerns raised anonymously.

2.7 Trade Union Facility Time

In June 2023 the Committee received a paper that set out reporting requirements for public sector organisations in relation to paid trade union facility time and the Trust's data for the period 1 April 2022 to 31 March 2023. For 2022/2023 the Trust is reporting 1312.5 hours for 20 representatives with an estimated cost of £44,339.12. The unofficial benchmark set by the Government (according the NHS Employers) is 0.06% of the pay bill spent on trade union duties. The Trust's figures since reporting began in 2018/2019 have been below the benchmark figure.

2.8 Nursing and Midwifery Safer Staffing

For assurance and approval, the Committee receives an annual and bi-annual report that provides an overview for nursing, midwifery and Allied Health Professionals staffing capacity and compliance in line with the National Institute for Excellence Safe Staffing, National Quality Board and the NHS Improvement Workforce Safeguards guidance. On 20 June 2023 the Committee received and approved the annual report prior to its submission to the Board of Directors. For added assurance the Committee noted an additional recommendation would be added to the Maternity staffing workforce model. The biannual report was approved by the Committee on 18 December 2023.

2.9 NHS Long Term Workforce Plan

This plan was published in June 2023 and shared with the Committee at its August 2023 meeting. The Plan has a 15-year life cycle and focuses on 3 key areas – train, retain and reform. The key points of the plan were summarised and an analysis of national regional and Trust activity against the plan was provided.

2.10 Gender Pay Gap (GPG)

In August 2023 the Committee received the Trust data on the gender pay gap for March 2023 for submission in March 2024. As at 31 March 2023, 80.9% of the Trust's workforce were female and 19.1% of the Trust's workforce were male. Due to the Trust employing fewer men overall, the number of male Consultants as a proportion of the overall male workforce means that the male Consultant workforce will significantly contribute to the pay gap at the Trust. An action plan with a focus on addressing the disparity in Clinical Excellence Awards was shared. The Committee approved the data for publication in an updated report in February 2024.

2.11 Workforce Race Equality Standard (WRES)

In August 2023, the Committee received the Trust data for 2022/2023 and associated action plan. An overview of positive improvements included an increase in the overall BAME workforce and slight improvement in the likelihood of BMAE candidates being appointed to a post at the Trust. In October 2023 the Committee approved an updated action plan for publication on the Trust's website.

2.16 Workforce Disability Equality Standard (WDES)

In August 2023, the Trust data for 2022/2023 and associated action plan was received by the Committee. A number of areas of improvements were highlighted. The report highlighted areas for progress. Progress will be overseen by the Inclusion Group. In October 2023 the Committee approved an updated action plan for publication on the Trust's website.

2.17 Nursing, Midwifery and AHP Steering Group Programme Update

The Committee continues to have oversight of the strategic initiatives to establish safe and effective nurse, midwifery and AHP staffing. The Committee received an update on activity in December 2023.

2.18 2023 National Staff Survey Results

As the results were still under embargo a verbal update was provided at the February 2024 meeting. The comprehensive results were presented at the April 2024 meeting.

2.19 Medical Workforce Programme

The Committee continues to have oversight of medical staffing capacity, risks and compliance. An update was received in February 2024. The report identified that periods of industrial action had significant impact on activity across clinical services.

2.20 Recruitment Strategy

Further to the presentation to the Committee in August 2023 an update against progress was received in February 2024. Enhanced support offered to both applicant and manager has led to significant positive outcomes.

2.21 Apprenticeship Strategy

An update on progress against the strategy was received in February 2024 following the presentation to the Committee in August 2023. The new multi-skilled apprenticeship team structure is now embedded. Apprenticeship levy spend increased by 10% on 2022/2023.

2.22 Board Assurance Framework (BAF)

The Committee regularly reviews the BAF to ensure that all risks relating to workforce are identified and managed to mitigate the risks. Four workforce risks are noted:-

Medical Staffing (10a/19)
A deep dive report was received in February 2024. Key controls were reviewed and considered relevant and an accurate reflection. Gaps in control remain relevant. The risk rating score remains at 16.

Nurse Staffing (10b/19)
A deep dive report was received in October 2023. Key controls were reviewed and refreshed. Gaps in control remaining relevant. The risk rating score remains at 12 having been reduced prior to the deep dive.

Recruitment/Retention/Inclusive Leadership (11/19)
Deep dive reports were received in April 2023 and February 2024. Key controls were reviewed and updated to include further elements. Risk rating score remains at 12 due to gaps in control and assurance remaining relevant.

Colleague Engagement (12/19)
A deep dive report was received in June 2023. Assurance was received around the development of a Leadership Framework and introduction of One Culture of Care Charters. The risk rating remains at a score of 12 as a result of challenges regarding cost-of-living pressures and impact on colleague sense of wellbeing post-pandemic. Since June 2023 Colleague Engagement risk is merged with Colleague Wellbeing (1/22). In August 2023 the Committee received an updated report that set out activity that seeks to properly engage colleagues, promote development opportunities and the Trust's health and wellbeing offer.

2.23 Review and Monitor Key Workforce Metrics

At each of its meetings the Committee considers the Quality and Performance (Workforce) report. The report comprises of key workforce metrics:-

- Sickness absence
- Retention and Turnover
- Essential Safety Training
- Appraisal
- Recruitment
- Bank/Agency Spend

Separately, the Committee receives a quarterly vacancy report for all staff groups. The report provides information about current vacancies, recruitment activities, updates on hotspot areas and actions taken.

During the period 1 April 2023 to 31 March 2024 the Committee undertook deep dives into the following:-

Essential Safety Training
The Committee continued to monitor fire safety training which was significantly below the 90% compliance target. A detailed report was brought to the June 2023 Committee meeting. A final update was received in December 2023 to provide assurance that compliance remains on track.

Index of Multiple Deprivation
A standalone report was received in August 2023 that presented information reviewed as part of the regular Workforce Monitoring meetings. The report detailed the 7 domains of deprivation which combine to create the Index of Multiple Deprivation.

Age Profile Report
An update was received in December 2023. Since the review of 2022 data there have been no significant changes to the data at Trust level. The slow trend of small proportional increases continues in colleagues aged 31 to 45, a similar reduction in the age ranges spanning 46 to 55, and further slight increases in the proportion of colleagues remaining/returning aged 61+.

Colleague Retention Programme
The Committee received a report in December 2023 that set out the Trust's retention data and mapped out the bundles of activities against the 7 elements of the People Promise. Assurance was provided that CHFT has in place a range of activities aimed to improve retention of our workforce and work alongside other strategies across the Trust to improve our colleague experience.

2.24 Subgroup Reporting

The following groups reported progress to the Committee by way of receiving minutes of the meetings as detailed in the workplan:-

- Inclusion Group
- Education Committee

2.29 Hot House Events

Following the November 2022 Hot House that focused on the development of a Trust leadership model, a Leadership Conference was held on 26 April 2023.

On 13 July 2023 a Colleague Engagement/Staff Survey/Recognition/Appreciation themed Hot House took place. The session focused on understanding the psychology of engagement, staff survey results, progress and hotspots, CHFT's appreciation and recognition programme.

On 19 September 2023 a Hot House on Inclusion Learning Culture was held. This focused on involving colleagues in change and improvements, investing digital resources and programmes.

A Hot House planned originally 24 October 2024 on the topic of Workforce Design was rearranged to 6 February 2024 due to operational pressures. However the winter pressures continued and the material prepared for the Hot House was shared electronically with colleagues.

3. EFFECTIVENESS OF WORKFORCE COMMITTEE

On an annual basis, the Committee undertakes a self-assessment exercise to gauge its effectiveness by taking the views of Committee members and attendees across a number of themes. The outcome of this is then reviewed by the Committee and an action plan developed and monitored by the Committee. The self-assessment exercise took place, in May 2024.

4. CONCLUSION

The Committee has received assurance through the course of 2023/2024 from a number of sources. The Committee confirms it has fulfilled its role to the Board of Directors during the period, 1 April 2023 to 31 March 2024 undertaking its key functions of providing assurance that that there is continuous and measurable improvement in the development of workforce strategies, the effectiveness of workforce management in the Trust which align to One Culture of Care and which ensure workforce risks are managed appropriately.

Tracy Rushworth
Workforce Committee Secretary

Jason Eddleston
Deputy Director of Workforce and Organisational Development

June 2024

Date of Meeting:	12 September 2024
Meeting:	Board of Directors
Title:	Transformation Programme Board Annual Review 2023/24
Author:	Jackie Ryden, Governance Lead Reconfiguration Programme
Sponsors:	Peter Wilkinson, Chair Transformation Programme Board Anna Basford, Deputy CEO/Director of Transformation and Partnerships
Previous Forums:	Transformation Programme Board – 9 July 2024 Audit and Risk Committee – 23 July 2024
Purpose of the Report	This paper presents the annual report of the Transformation Programme Board for the financial year 2023-2024 setting out how it has met its terms of reference and key priorities.
Key Points to Note	This Annual Report is presented for information and assurance and will be shared with the Board of Directors on Thursday 12 September 2024.
EQIA – Equality Impact Assessment	The Reconfiguration Programme aims to address the needs of the whole population, including those who currently experience disadvantage and the plans are intended to help improve access, experience, and outcomes for all. The proposed changes do not generate differential discriminatory equality impacts.
Recommendation	The Board is asked to **NOTE** the attached report.

Transformation Programme Board Annual Report 2023/2024

This annual report of the Transformation Programme Board for 2023/2024 details:

- The role of the Transformation Programme Board including membership and attendance
- The activities of the Transformation Programme Board
- The effectiveness of the Transformation Programme Board

1. Role/Purpose of the Transformation Programme Board

The role of the Transformation Programme Board is to oversee and provide assurance on the delivery of complex transformation programmes described in the Trust's Five Year Strategic Plan.

1.1 Background

The Transformation Programme Board is constituted as a Standing Committee of the Trust Board. Its constitution and terms of reference are subject to amendment by the Trust Board.

The Committee derives its power from the Trust Board and has no executive powers, other than those specifically delegated in these terms of reference. The Committee will comply with the Trust's Standing Orders and Standing Financial Instructions and schemes of delegation.

The Committee is authorised by the Trust Board to investigate any activity within its terms of reference – it is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Trust Board to request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary.

This report describes the Committee's activities from April 2023 to March 2024 and various matters for which the Transformation programme Board has oversight for the Board to manage the programme plan and sign off the key outputs and decisions at each stage of the programme including:

- Monitoring and ensuring delivery of the plan of key activity, milestones and critical path
- Patient and staff communications and engagement
- Procurement and commercial processes and decisions
- Review of all the key deliverables and the activities required to deliver them
- The activities required to validate the quality of the deliverables
- The resources and time needed for all activities and any need for people with specific capabilities and competencies
- The dependencies between activities and any associated constraints when activities will occur
- The points at which progress will be monitored, controlled and reviewed
- The provision of regular reports, updates and assurance to CHFT Board, NHSE&I and Treasury
- Maintenance of a detailed risk register and mitigation of risk factors affecting the successful delivery of the project
- Maintenance of benefits realisation registers and monitoring of delivery
- Considering and recommending to the Trust Board any changes to the project scope, budget or timescale if required
- Review of serious issues, which have reached threshold level
- Brokering relationships with stakeholders within and outside the project to maintain positive support for the programme

- Maintaining awareness of the broader strategic perspective advising the SRO on how it may affect the project
- Approving the design brief, appointment of external consultant team and approving the programme of work and the critical path.

1.2 Terms of Reference

The Committee has approved terms of reference in place. The Committee reviewed and approved its terms of reference on 18 October 2023, with ratification by the Trust Board on 2 November 2023. The Committee currently meets monthly but, following a review of all review of all Board Sub-Committee meetings, it has been agreed to reduce the number of TPB meetings. These will be held bi-monthly from July 2024 onwards to align with the required decision points across the year. The terms of reference and annual cycle of business will be updated to reflect this decision.

The terms of reference were reviewed in detail and updated to reflect the breadth and remit of the TPB to oversee and provide assurance on the delivery of complex transformation programmes described in the Trust's Five Year Strategic Plan.

The previous clear focus around reconfiguration and strategic capital remains and the scope also includes how the Trust is progressing strategic programmes of broader transformation, including the elective, non-elective and community transformation programmes of work, delivery of the Trust's Digital Strategy, delivery of the Trust's Green Plan and work undertaken through all of those actions as an 'Anchor Partner' to support communities and add social value.

The clear remit is to continue to be the committee which manages external facing relationships and communication and involvement with local and regional stakeholders and national colleagues. There has been a slight update to the committee membership with two Non-Executive Directors and the Trust Chair as members and the Lead Governor invited as an observer.

Following approval of the terms of reference, the forward plan was updated to ensure the full scope of the remit was covered and reported at future meetings.

1.3 Transformation Programme Board Membership and Attendance in 2023/2024

The Committee met six times during 2023/2024. A decision was taken in March 2024 to stand down the TPB meetings to allow for a review and refresh of the terms of reference.

The membership of the Transformation Programme Board includes two Non-Executive Directors and the Chair of the Trust Board as noted above. Peter Wilkinson has been the Committee Chair since the Committee was set up in September 2019.

In addition, the Committee consists of the following members:

- Chief Executive
- Chief Operating Officer
- Medical Director
- Director of Nursing
- Director of Workforce & Organisational Development
- Director of Finance
- Deputy CEO/Director of Transformation and Partnerships (Programme Director)
- Deputy CEO/Operations Director for Reconfiguration
- Director of Corporate Affairs
- Managing Director Digital Health

- Managing Director Calderdale and Huddersfield Solutions Limited.

The following are also required to attend all meetings:
- Assistant Director of Transformation and Partnerships/Reconfiguration Programme Lead
- Deputy Director of Finance
- Governance Lead Reconfiguration Programme

The Lead Governor is invited to attend and observe each meeting.

A quorum will be four members of the Committee and must include at least three board members of which one must be a Non-Executive Director and one Executive Director. The meetings in 2023/2024 were always quorate and an attendance register is included in Appendix A.

After each meeting, the Chair reported back to the next Trust Board meeting, drawing attention to those matters of significance for the Board. The draft minutes of the meetings are received by the Private Session of the Trust Board.

2. Transformation Programme Board 2023/2024

The principal activities of the Transformation Programme Board during 2023/2024 are detailed below.

Monitoring delivery of the Reconfiguration Programme milestones – key milestones delivered during 2023/2024 include:

- Monitoring of the Gateway 2 Review action plan to deliver against the recommendations made following the Gateway 2 review in September 2021.
- Approval of a revised programme timeline informed by the Trust's technical advisors and construction partners regarding the phasing of works at CRH and length of construction period.
- Regular programme risk management reports presented linking with the Trust Board Assurance Framework (BAF) where appropriate.
- Regular review of the BAF for those specific risks owned by the TPB. From December it was agreed to link items on the agenda to the BAF where appropriate.
- Regular design updates and presentations received along with regular updates on the communication and engagement activities with key stakeholders throughout the programme.
- An annual review was undertaken of the cladding at HRI following the recommendations from the task and finish group in January 2022 as requested by the Programme Board to explore, consider and make recommendations on feasible Cladding options for HRI.
- Regular updates were provided to ensure the Board were apprised of the position regarding the opening the HRI A&E and the measures and remedial actions undertaken to resolve the issues with the water to allow the A&E to open in May 2024.

Communication and Engagement activity for the Reconfiguration Programme - Throughout 2023/2024, the Trust has continued to engage and involve colleagues, local people and key stakeholders including Joint Health Scrutiny Committee; DHSC; NHSE; Provider partners across WYAAT; Commissioners; Political Leaders and Officers and Community Groups and Networks in the work of the programme.

A refresh of the Communication and Involvement Strategy for the programme covering the period 2024 to 2026 was completed and approved by the TPB in March 2024. Delivery of this strategy will ensure the continuation of a robust approach to communication and engagement is delivered. In addition, project specific communication and engagement plans

have been developed to ensure the strategy aligns with each project deliverable and milestones plan. Quarterly updates on communication and engagement activity are shared into TPB.

Appointment of Principal Supply Chain Partner (PSCP) for the Design and Construction of the New Clinical Build at CRH - the process to approve the contract award for the clinical build partner was undertaken in 2023/2024 requiring a robust procurement and evaluation process. The framework used was P23, in line with the Reconfiguration of Hospital Services OBC and direction from DHSC and NHSE to award the contract. The Board were kept updated on progress throughout the process up to and including the recommendation to support the approval by the Trust Board to award the P23 NEC4 contract.

Receiving updates on Strategic Capital Projects - in February 2024 the strategic capital investments within the 2024/2025 capital plan were approved for reporting and monitoring by the TPB. The projects identified were: CRH Plant Room Extension, CRH Main Entrance, CRH Cath Lab and Daycase Unit, CRH Network Core Infrastructure, Huddersfield Pharmacy Specials (HPS) Site Development, Community Diagnostic Centre CDC) Development in Halifax and Huddersfield, CRH CT Scanner, CRH Multi-Storey Car Park (MSCP) and CRH Maternity Scheme. In addition, a proposal and timetable was approved for detailed scheme updates to be presented to TPB.

Overseeing the Green Committee - the Green Committee has developed terms of reference which are reviewed annually and shared with the Transformation Programme Board. The main areas of responsibility for this group are shown below with update reports into the Programme Board on a quarterly basis:

- Monitoring necessary actions that ensure compliance with relevant regulations / legislation
- Engaging with key stakeholders (staff, leadership, visitors)
- Responding to emerging priorities surrounding sustainability
- Fulfilling agreed objectives set out in the Green Plan
- Meeting agreed targets and milestones set out in the SAP and sustainability roadmap.

Receiving updates on the Trust Green Plan - the most recent update was provided in June 2024 into the Programme Board on the Trust Green Plan and Sustainability Action Plan (SAP). The SAP outlined individual actions across 10 key themes identifying a total of 207 interventions, of which 165 were reported as complete. In addition, key progress made in Q1 and Q2 2024 included:

- Coolnomix device installation complete and funds received from the North East and Yorkshire Net Zero Hub.
- Energy management policy approved by Green Planning Committee and Energy Efficiency Task and Finish Group.
- Application submitted to Salix Low Carbon Skills Fund (LCSF) Phase 5.
- CHS SECR report confirmed that 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%.
- Waste and sustainability action plans developed to focus on key priorities.
- A total of 153 items including furniture and IT equipment were collected following the ‘Dump the Junk’ campaign in spring 2024. 71 items have been re-purposed, saving approximately £5,700.

Receiving regular updates on HMT Approval of the Outline Business Case. A regular 'Round Table' meeting to discuss the Calderdale and Huddersfield service reconfiguration plans is held with Stakeholder representatives from NHS England (NHSE), Department of Health and Social Care (DHSC), the West Yorkshire Integrated Care Board (ICB) and Place based ICB in Kirklees and Calderdale. The Trust has also been supported and worked closely with the Infrastructure Project Authority.

The meetings of the TPB were held monthly in 2023 and reduced to quarterly in 2024.

In addition to the above, the Transformation Programme Board also received reports and updates on the following:

- Update on the transformation of elective care
- Update on the transformation of community services
- Update on the work undertaken by the Trust on social value
- Presentations on digitally supporting Same Day Emergency Care (SDEC) and the implementation of the Patient Experience Portal.

3. Review of Committee Effectiveness

The Committee has recently completed an annual self-assessment exercise to gauge the Committee's effectiveness by taking the views of Committee members and regular attendees across a number of themes. The outcome of this is shown at Appendix B and has been reviewed by the Committee. The self-assessment exercise took place in April/May 2024 and the outcome of this was presented to the Programme Board on 19 June 2024. An action plan has been developed following analysis of the results and was approved by Committee on 19 June 2024. Four actions were identified, and these will be monitored going forward. The action plan is attached at Appendix C.

4. Conclusion

The Committee has carried out its business in the last 12 months in accordance with the terms of reference and has received assurance through the course of 2023/2024 from a number of sources. The meetings have been well attended with valuable input from Executive colleagues, Non-Executive Directors and managers outside the Committee. A self-assessment has been recently completed and an action plan developed.

Peter Wilkinson
Transformation Programme Board Chair
3 July 2024

APPENDIX A –

ATTENDANCE REGISTER – TRANSFORMATION PROGRAMME BOARD
1 APRIL 2023-31 MARCH 2024

DIRECTOR	Apr-Sep Stood down	18.10.23	15.11.23	13.12.23	24.01.23	21.02.24	20.03.24	Total
Peter Wilkinson (Chair)		✓	✓	✓	✓	✓	✓	**6/6**
Andy Nelson		✓	✓	✓	×	✓	✓	**5/6**
Helen Hirst		✓	✓	✓	✓	✓	✓	**6/6**
David Birkenhead		✓	×	✓	✓	✓	×	**4/6**
Lindsay Rudge		✓	✓	✓	✓	×	×	**4/6**
Gary Boothby		✓	✓	✓	✓	✓	×	**5/6**
Jonny Hammond		×	✓	✓	×	✓	×	**4/6**
Brendan Brown		×	×	×	✓	✓	✓	**3/6**
Suzanne Dunkley		✓	✓	✓	✓	✓	✓	**6/6**
Anna Basford		✓	✓	✓	✓	×	✓	**5/6**
Rob Birkett		×	×	✓	×	×	✓	**2/6**
Stuart Sugarman		×	✓	✓	×	×	✓	**3/6**
Vicky Pickles		✓	✓	✓	✓	✓	✓	**6/6**
Rob Aitchison		✓	✓	✓	✓	✓	✓	**6/6**
Nicola Bailey		✓	✓	✓				**3/3**
Stuart Baron		✓	✓	✓	✓	✓	✓	**6/6**
Stephen Jenkins		✓	✓	✓	✓	✓	×	**5/6**
Brian Moore		×	✓	✓	✓	✓	×	**4/6**
Fran Hewitt							✓	**1/1**

Attendance	✓	Apologies	×

15. Integrated Performance Report

To Note

Presented by Jonathan Hammond

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 12 September 2024
Meeting:	Public Board of Directors
Title:	Quality and Performance Report
Author:	Peter Keogh, Assistant Director of Performance
Sponsoring Director:	Jonny Hammond, Chief Operating Officer
Previous Forums:	Finance & Performance Committee, Executive Board, Quality Committee
Purpose of the Report	To provide the Board of Directors with a single combined narrative t hat seeks to triangulate current performance for the month of July 2 024.
Key Points to Note	**Performance Summary** **Quality** indicators: Summary Hospital-level Mortality Indicator (SHMI) has seen an increase for the latest 12 month rolling release and shows performance of 111.93. The site breakdown shows HRI at 111.02 and CRH 113.43. The latest national SHMI position stands at 99.35 and CHFT now sits above this national position. We have addressed issues around excess patient deaths and here are the actions that we have been taking: • Increases were seen in HSMR (Hospital Standardised Mortality Rate) and SHMI relating to Respiratory Medicine. It should be noted that other acute Trusts in our area also reported increased respiratory deaths during the same period. • New Mortality Prediction Tool has been developed to enable a new initial screening review process to learn from deaths. • A review was undertaken for Respiratory deaths which highlighted potentially under documentation of co-morbidities as a reason for this spike, resulting in expected deaths being counted as un-expected deaths. There were no significant quality of care issues identified. • SHMI data is not adjusted for deprivation which would suggest health inequalities as factor in the gap between northern hospitals and London. • From April 2024 CHFT has reclassified Same Day Emergency Care (SDEC) activity based on national requirements with this activity now being captured within the A&E datasets. This has therefore removed these admissions from this dataset. CHFT is one of the first Trusts in the country to make this change. It is expected that this change will have an initial negative impact on mortality indicators until all organisations make this change as it has removed a high volume of patients with a low 'mortality risk' from the dataset resulting in the expected deaths for the organisation reducing in number however the observed deaths remaining stable, this therefore increases the SHMI score.

	• We are not anticipating an improvement in the position in the short term with the removal of SDEC activity from the data. Care Hours Per Patient Day (CHPPD) - The latest data reports CHFT providing 8.7 CHPPD against a peer median 8.4 and national median 8.8. Falls per 1,000 bed days, Hospital acquired Pressure Ulcers per 1,000 bed days and C.difficile Infections improved in month whilst E.coli Bacteraemia Infections increased further. There were 2 Patient Safety Incident Investigations (PSIIs) commissioned in month that have been declared and validated at the Trust Patient Safety Event Review Panel. All PSIIs are currently under investigation. % of complaints closed on time (target 95%) was 72% in July. The focus was to respond to as many overdue complaints as possible and in total 60 complaints were closed, with 43 of those being within timeframes. An extension request form is being used with strict criteria for requesting an extended timeframe, which is continuing to have an impact on performance as some extensions are being refused. **Quality Priorities** - % of patients that have been screened for dementia has improved over the last 5 months. However, Stroke - % of stroke patients admitted directly to an acute stroke unit within 4 hours of hospital admission remains 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 improved over the last 3 months and is now at 64% against a target of 70%. We continue to perform well in terms of **elective recovery** with a decrease in 52-week waits in July to 51 (ENT 41). This included 1 patient waiting over 65 weeks due to the ASI drop-off position. We also saw a fall in numbers to 654 40-week waits (reduction in ENT) at the end of July. For **diagnostics** we have achieved the 95% target in July for the first time since early 2023. **Cancer** performance continues to be excellent in July with the 28-day faster diagnosis performance achieving the new target of 77% for the third month in a row. There are issues with a small number of cancer sites including Head & Neck, Upper GI and Lower GI. Performance for 62-day referral to treatment was the best in the country for acute Trusts at 92.6%. **ED** performance improved to 70% in July and the Trust was back in the top 20 nationally for type 1 performance. Bed Occupancy and discharges the previous day are possibly the biggest factors in ED performance with HRI still having extremely high bed occupancy. TOC numbers have increased to 123. We have seen a further decrease in the number of patients waiting over 12 hours in ED.

	Proportion of **ambulance arrivals** delayed over 30 minutes has increased again to 9.3% from 4.4% in April. Length of stay for Pathway 0 patients has been impacted by the change in recording of SDEC patients in March adding up to an additional 0.5 days. In **Community** Virtual Ward occupancy has deteriorated in month to 55% against the 80% target. **Health Inequalities** - performance for key indicators for Learning Disabilities, Deprivation IMDs 1&2 and Ethnicity have been included showing quarterly performance to June. **Workforce** – Turnover and Sickness Absence lowest rates for over 3 years. ***Performance Matrix Metrics Changes*** *(green improvement, purple deterioration).* • *% of patients that receive a diagnostic test within 6 weeks – achieved for first time in 18 months.* • *Sickness Absence (Non-Covid) – consistently achieving target.* • *Hospital Discharge Pathway Activity – below upper control limit.* • *% of complaints within agreed timescale – special cause variation – cause for concern.* • *Summary Hospital-level Mortality Indicator – consistently higher than the mean.*
Regulation	CQC 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 July 2024.

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Integrated Performance Report
July 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)	• Non-site-specific cancer referrals • Maternal Mortality • Diagnostic activity undertaken against activity plan • Sickness Absence (Non-Covid)	• Personalisation of care - % of patients that have been screened for dementia • % of patients that receive a diagnostic test within 6 weeks • % 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 • Brain Injuries (maternity) • Patients dying within their preferred place of death • Core EST Compliance	• 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 • Total Patients waiting >52 weeks • Capped Theatre utilisation • Proportion of patients meeting the 62-day cancer standard • Proportion of patients meeting the faster diagnosis standard • ED Proportion of patients seen within 4 hours • Proportion of patients spending more than 12 hours in ED • Hospital Discharge Pathway Activity • Neonatal Deaths per 1,000 total • Stillbirths per 1,000 total births • Pre-Term Births • Proportion of Urgent Community Response referrals reached < 2 hours	• % of patients with a NEWS2 of 5+ that do not go on to have a higher score • % of stroke patients admitted directly to an acute stroke unit within 4 hours of hospital admission • Early Cancer Diagnosis • Bed Occupancy • Transfers of Care • Maternity Workforce
SPECIAL CAUSE CONCERN	• Total RTT Waiting List	• Summary Hospital level Mortality Indicator • % of complaints within agreed timescale • Virtual Ward	• Proportion of ambulance arrivals delayed over 30 minutes

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

Safe, High Quality Care

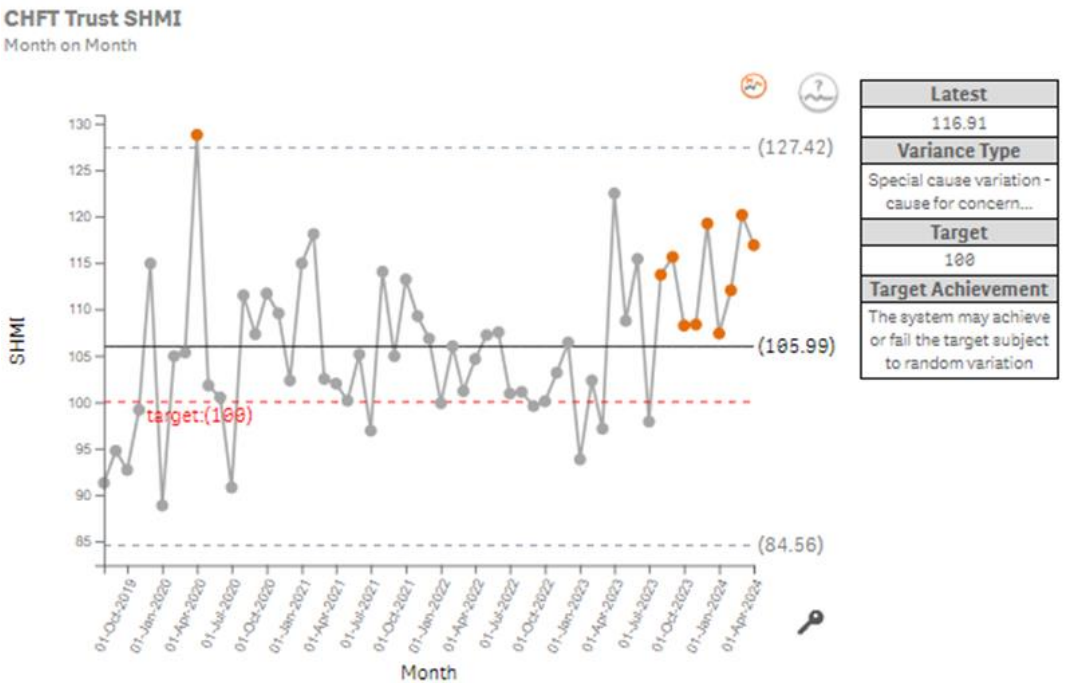
Metric	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Summary Hospital-level Mortality Indicator	April 2024	111.93	100			105.99	84.56	127.42
Care Hours Per Patient Day (CHPPD)	July 2024	8.74/ 7.83	-	-	-	-	-	-
Falls per 1000 Bed Days	July 2024	8.0	7.08			7.77	5.61	9.92
CHFT Acquired Pressure Ulcers per 1000 Bed Days	June 2024	1.19	1.76			1.65	0.82	2.49
MRSA Bacteraemia Infection	July 2024	0	0	-	-	-	-	-
C.Difficile Infection	July 2024	5	3.1			4.54	0	12.71
E.Coli Infection	July 2024	8	5.6			5.75	0	12.19
Number of Never Events	July 2024	0	0	-	-	-	-	-
Number of Patient Safety Incident Investigations (PSII)	July 2024	2	0			2.89	0	8.21
% of incidents where the level of harm is severe or catastrophic	July 2024	0.86%	2%			0.77%	0%	1.82%
% of complaints within agreed timescale	July 2024	72%	95%			87.32%	69.05%	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 111.93.
- The site breakdown shows HRI at 111.02 and CRH 113.43.
- Month on Month performance has improved in April with performance standing at 116.91.
- The latest national SHMI position stands at 99.35 and CHFT now sits above this national position.

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

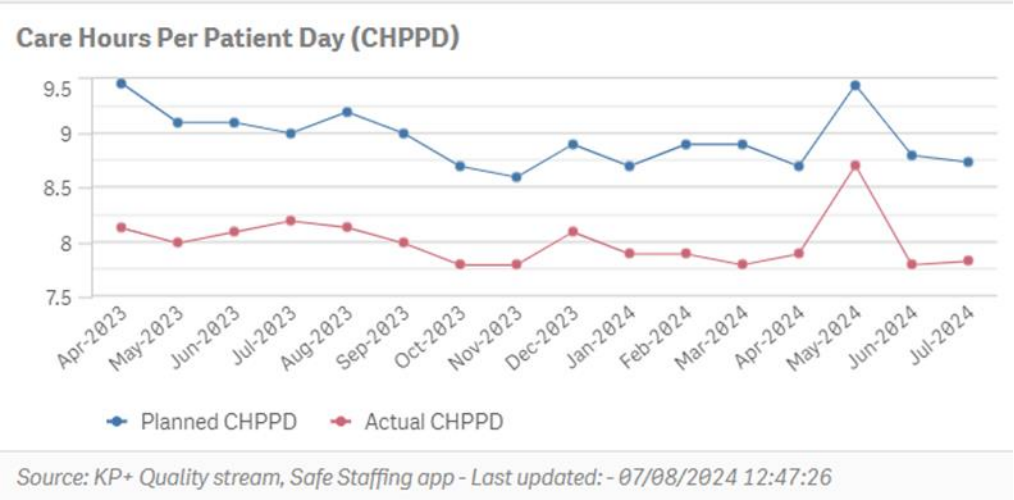
Actions:
- Clinical Lead has contacted all mortality leads in all specialties to communicate the need to increase the level of mortality reviews being carried out monthly and the timeliness of these reviews being improved.
- A new 'mortality prediction' tool has been developed to closely replicate the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

Care Hours Per Patient Day

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

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

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



What does the chart show/context:
- The actual CHPPD is less than the planned by a deficit of 1.0 care hour per patient day.
- The latest data in Model Hospital (May 2024 Data) reports CHFT providing 8.7 CHPPD against a peer median 8.4 and national median 8.8, putting us in quartile 3 for that month.

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

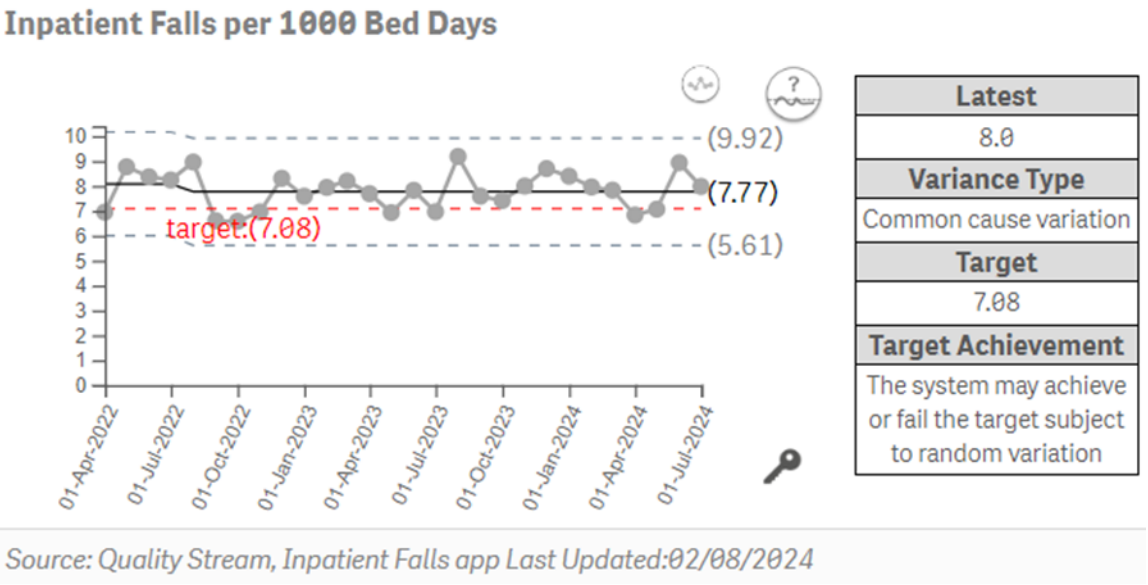
Actions:
- Undertake bi-annual Safer Staffing review. This process provides assurance of the correct workforce models based on an evidence-based methodology. The next bi-annual review will commence with the Chief Nurse panels in September 2024. These will reflect the acuity data collection from June 2024
- Ongoing monthly reviews of recruitment strategies, including employment of new graduates, midwives, Allied Healthcare Professionals (AHPs) and apprenticeships by the Nursing, Midwifery and AHP Workforce Steering Group (NMAHPWSG).The intention is to recruit to the estimated attrition over the coming months to prevent the opening of new vacancies.
- Recruitment to substantive staff 2 additional ward areas (previously extra capacity) (11a and 8b) to reduce use of agency and bank staff.
- 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



Source: Quality Stream, Inpatient Falls app Last Updated:02/08/2024

What does the chart show/context:
- The rate of inpatient falls for July was 8.0.
- Currently performance can be expected to vary from 5.61 to 9.92.
- Performance is within the expected range.

Underlying issues/Updates:
- Use of high visibility/bay tagging practice inconsistent across areas
- Awaiting EPR bed rail risk assessment build of signed-off version with Bradford and Airedale - expected completion September. *Please note CHFT remain non-compliant with national alert.*
- Falls policy review date is July 2024 - it has been circulated again, no comments received so plan is to approve at Falls Collaborative in August 2024 and send to Quality Committee for final sign-off.
- Further updates to dashboard functionality to see areas of improvement/decline at a glance which will support the collaborative meetings in focussed work.

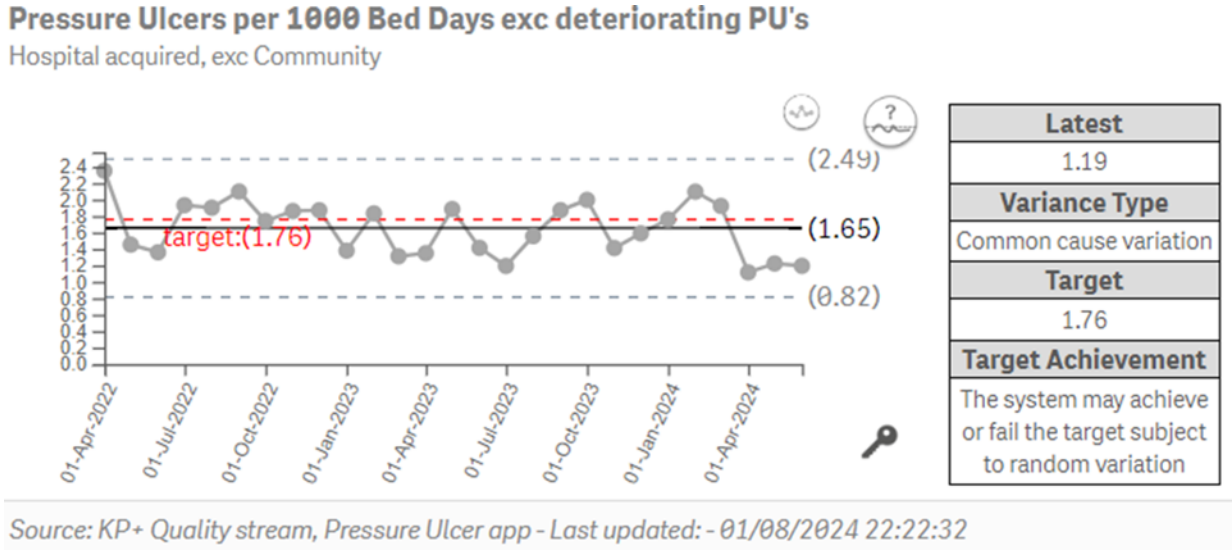
Actions:
- Approve falls policy at Falls Collaborative and send to QC for final sign-off.
- The Falls Support as required with bed rails risk assessment build.
- Use the dashboard to support focussed work in areas/better understand position.
- Review August 2024 position at September Collaborative.

Hospital Acquired Pressure Ulcers per 1,000 Bed Days

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

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

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



What does the chart show/context:
- The data continues to exclude deteriorating pressure ulcers to ensure data accurately reflects current position.
- The incidence of Hospital Acquired Pressure Ulcers (PU) excluding deteriorating PU for June was 1.19. Currently performance can be expected to vary from 0.82 to 2.49.
- KPI for reduction in pressure ulcers remains at 10%.

Underlying issues:
- PU risk assessment within 6 hours of admission has undergone a significant improvement 88.2% whereas ward transfer remains at 45.5%.

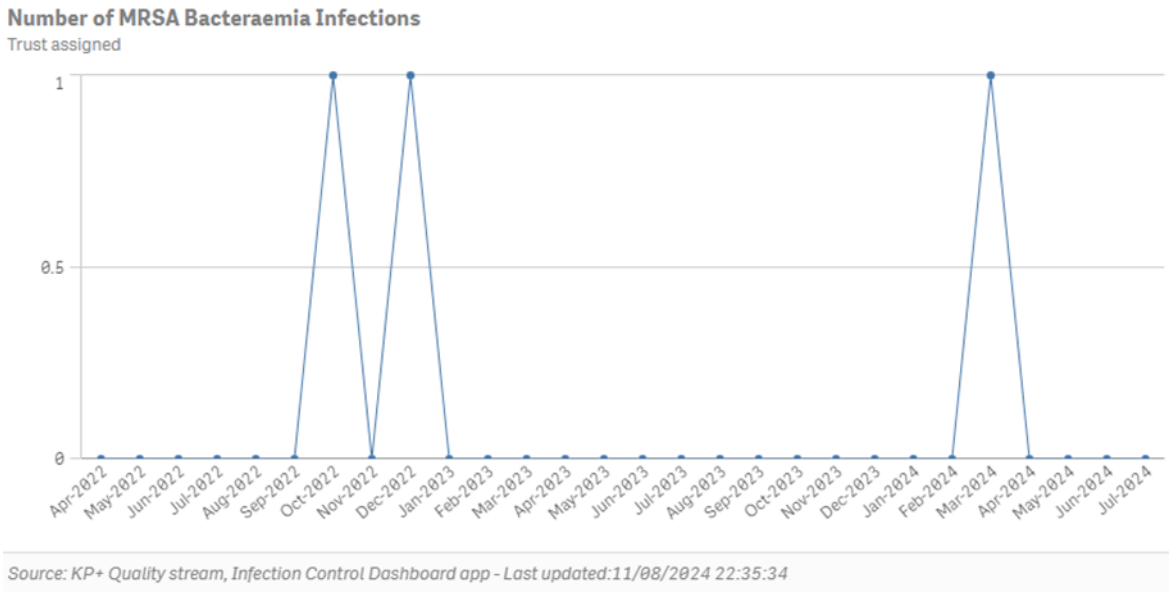
Actions:
- PU risk assessment within 6 hours of admission/ward transfer is captured on Live Assessment data within KP+ and is now RAG rated for user ease.
- Targeted improvement continues for the low performing wards via the Pressure Ulcer Collaborative and ward-based support provided by the Tissue Viability Service.
- SSKIN bundle review completed in collaboration with Bradford Teaching Hospital and Airedale, awaiting go live date.
- Patient Safety Incident Response Framework (PSIRF) Thematic Analysis of Pressure Ulcer Incidents is undergoing an initial review process.
- PSIRF Pressure Ulcer checklist and After-Action Reviews (AAR) are now active across both Acute and Community.
- Work ongoing with Clinical Coding team to ensure accuracy of data submitted to the Model Health System, CHFT currently sits within in the highest quartile locally.
- New Quality Assurance Must Do's include weekly mattress check and will be captured on KP+ to improve mattress management.
- Risk associated with the Atlas Air Mattress is now completed with removal of all devices.

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 July.
- 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.

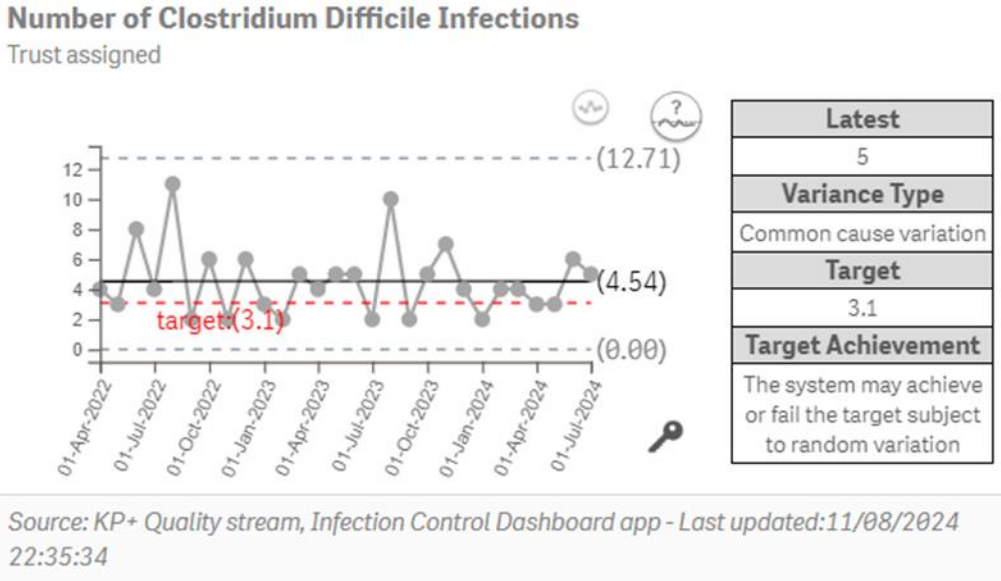
Actions:
- MRSA screening data cleanse has been completed and improvements seen.
- Colonisation suppression visual user guides have been provided to patients to ensure correct application.
- Mandatory training to be monitored through IPC Performance Board on a monthly basis.
- Any infections are investigated 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).



Source: KP+ Quality stream, Infection Control Dashboard app - Last updated:11/08/2024 22:35:34

What does the chart show/context:
- There were 5 C.diff infections in July.
- Currently performance can be expected to vary from 0 to 12.71.
- YTD 2024/25 – 17 (12 HOHA & 5 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.

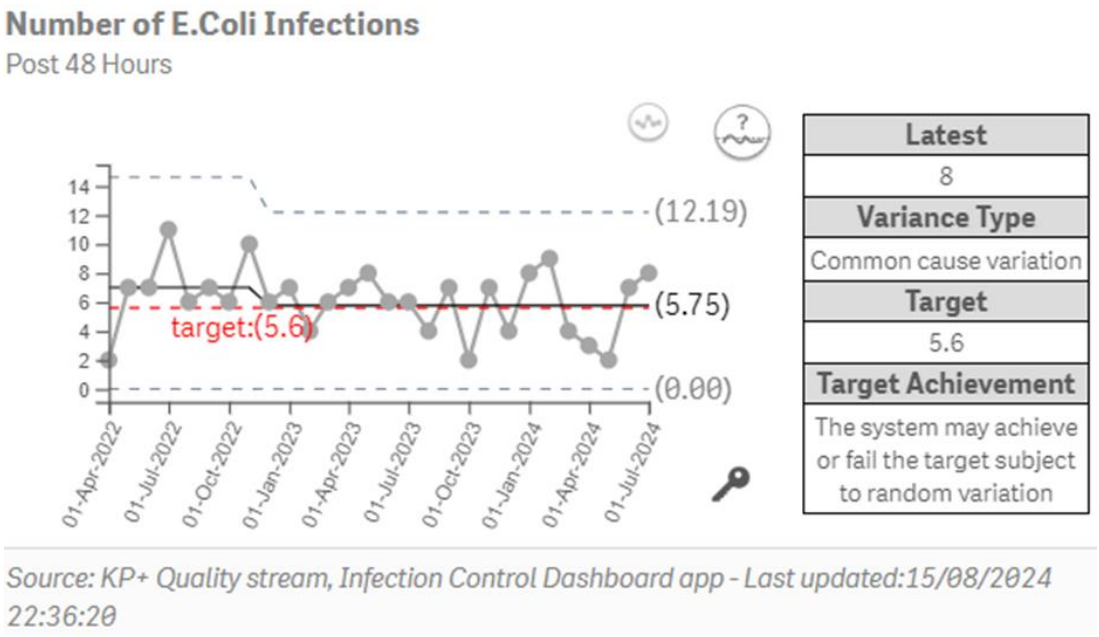
Actions:
- The Trust has implemented an improvement plan including a deep cleaning programme of HPV cleaning, this is currently taking place at the CRH site and will then continue at HRI.
- C.diff ward rounds, antimicrobial ward rounds and a review of the investigation process for cases.
- NHSEI recommendations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

E.coli Bacteraemia Infections

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

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

Target: 2024/25 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 8 E.coli infections in July.
- Currently performance can be expected to vary from 0 to 12.19.
- YTD 2024/25 – 20 (9 HOHA, 11COHA) 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.

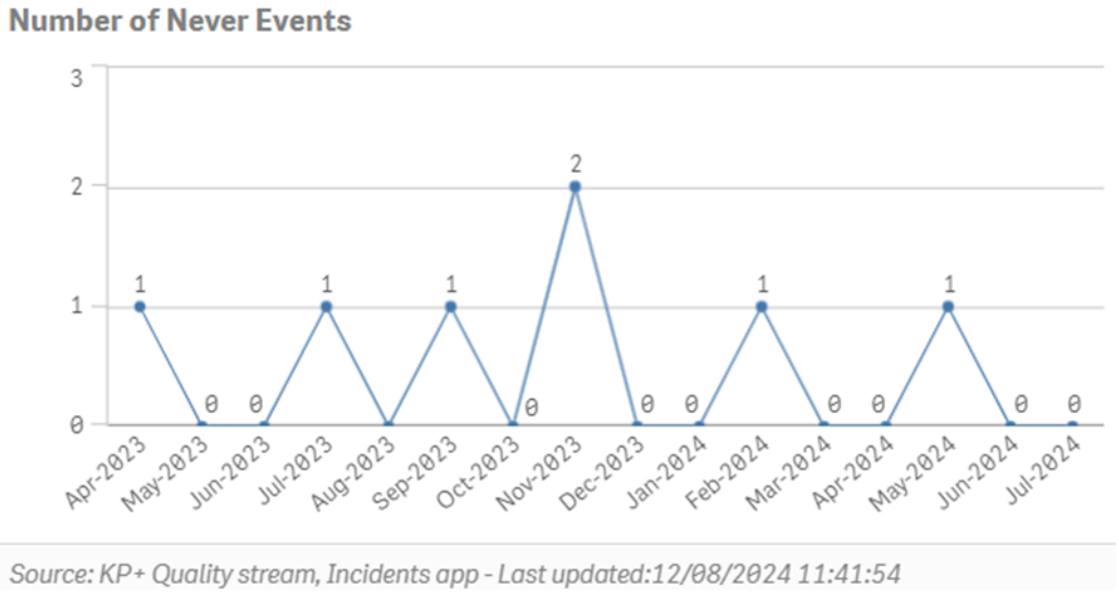
Actions:
- Extended surveillance of all the cases is conducted and uploaded to the UKHSA DCS system for national analysis.
- As part of the workplan of the IPCT, an annual audit of catheter management has been completed and recommendations shared with the divisions for implementation.
- A regional working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

Number of Never Events

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

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

Target:
To have no never events



What does the chart show/context:
- There were no never events declared by the Trust Patient Safety Event Review Panel in July.

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

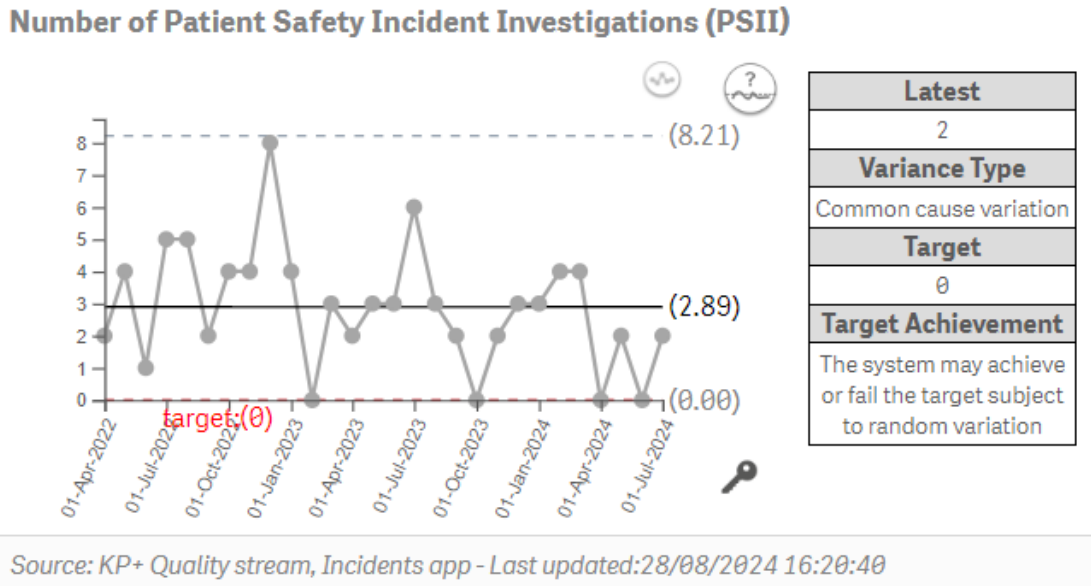
Actions:
- The Trust will continue to hold SWARM huddles as required to ensure learning is identified to keep our patients and staff safe.

Number of Patient Safety Incident Investigations (PSII)

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

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

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



What does the chart show/context:
- There were 2 PSIIs commissioned in July 2024 that have been declared and validated at the Trust Patient Safety Event Review Panel.
- In addition to the two PSIIs there are 2 external investigations commissioned by MNSI (Maternity and Newborn Safety Investigations).
- Currently performance is subject to common cause variation and can be expected to vary from 0 to 8.21.

Underlying issues:
- Of the 2 PSIIs commissioned, one was validated as a catastrophic harm incident and the other as a no harm incident.
- Both PSIIs are in the Families and Specialist Services (FSS) division.
- All PSIIs are currently under investigation.

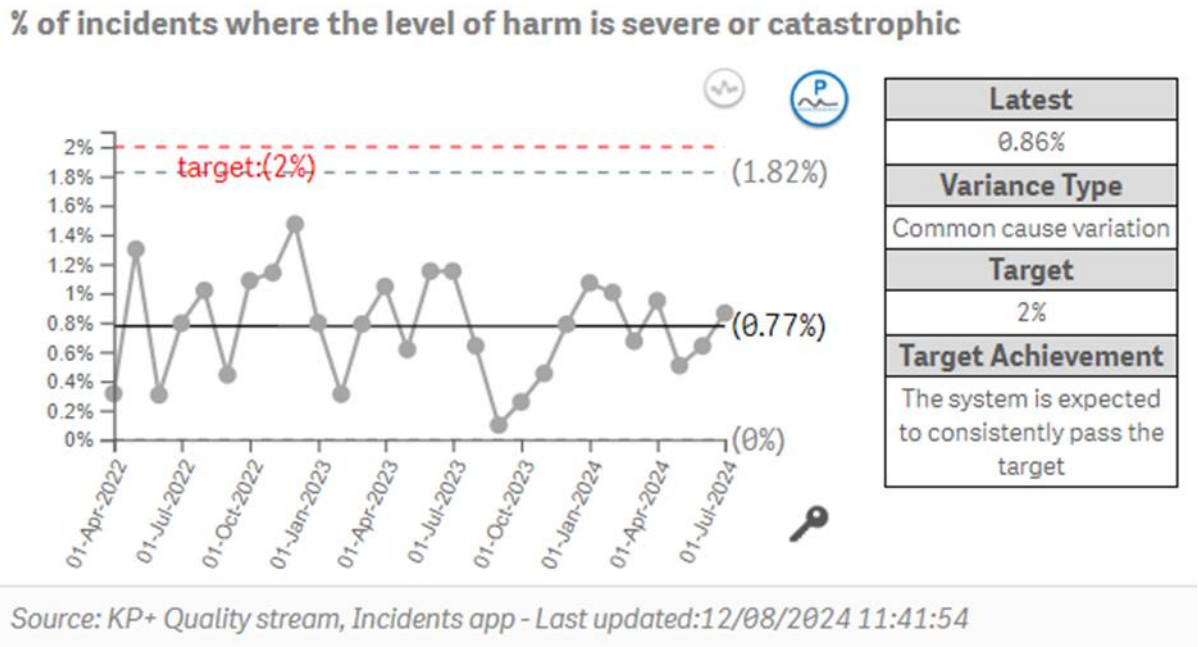
Actions:
- The Senior PSIRF Investigator is currently working with designated PSII investigators on both reports.
- The Risk management Team and the Quality Governance Leads will continue to support the Divisions to triangulate and review data for learning.
- Learning will be shared once the PSIIs are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

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

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

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

Target:
2% or less



What does the chart show/context:
- The percentage of incidents where the level of harm was severe or catastrophic was 0.86% in July 2024.
- Currently performance is subject to common cause variation and can be expected to vary from 0% to 1.82%.

Underlying issues:
- There were 2 severe harm incidents reported within this period, and both were reported in the Families and Specialist Services (FSS) division.
- One incident was categorised under assessment/treatment and diagnosis and the other as admission/transfer and discharge.
- Both incidents are currently under investigation, one of which will be investigated by the Maternity and Newborn Safety Investigation (MNSi) team.

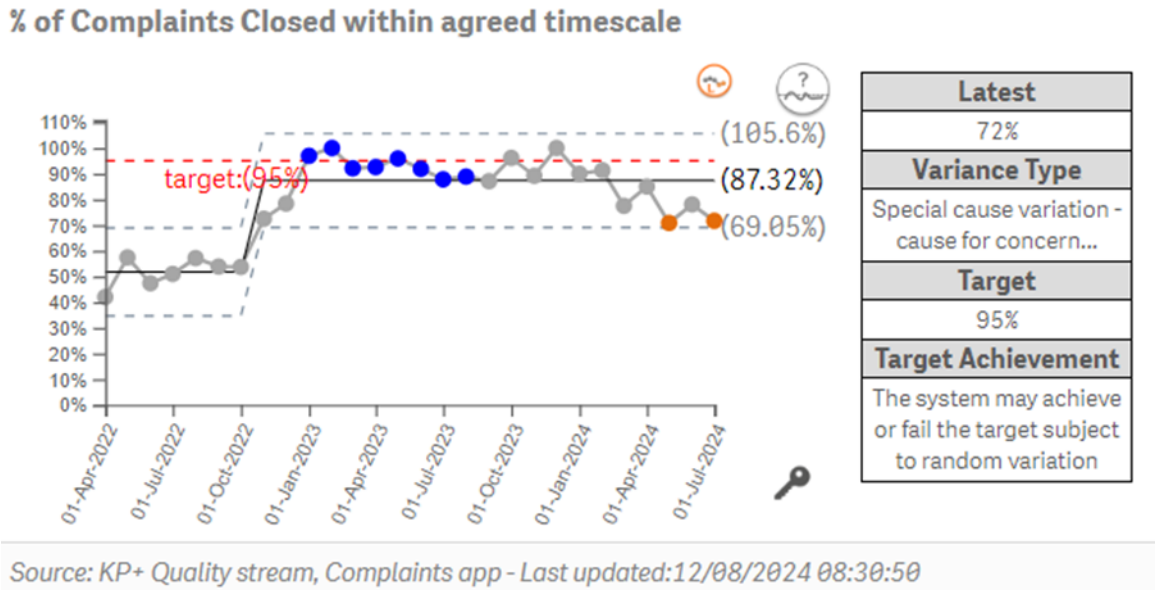
Actions:
- SWARMs and hot-debriefs continue to be held to identify learning and immediate actions.
- The Risk Management Team and the Quality Governance Leads continue to work with clinical teams/departments to identify and triangulate themes and trends for implementation of quality improvement initiatives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

% of complaints within agreed timescale

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

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

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



Source: KP+ Quality stream, Complaints app - Last updated:12/08/2024 08:30:50

What does the chart show/context:
- In July 2024 72% 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 69.05% to 100%.

Underlying issues:
- Performance has slightly dropped from last month, Medicine had a difficult month due to unplanned sickness within the team and are now back on track..
- The focus was to respond to as many overdue complaints as possible and in total 60 complaints were closed, with 43 of those being within timeframes.
- An extension request form is being used with strict criteria for requesting an extended timeframe, which is continuing to have an impact on performance as some extensions are being refused. This will take a while to embed.

Actions:
- The training day scheduled for 30th August 2024 with 25 attendees to support investigating officers with drafting good quality complaint responses will hopefully have a positive impact on performance with the importance of good communication being reiterated.
- Regular catch ups with ADNs alongside the weekly complaint meetings continue with good attendance from all Divisions to ensure responses are of good quality and within timeframes.
- Continue to monitor Trust performance daily and meet with Divisions on a weekly basis to maintain oversight of performance.

Quality Priorities:

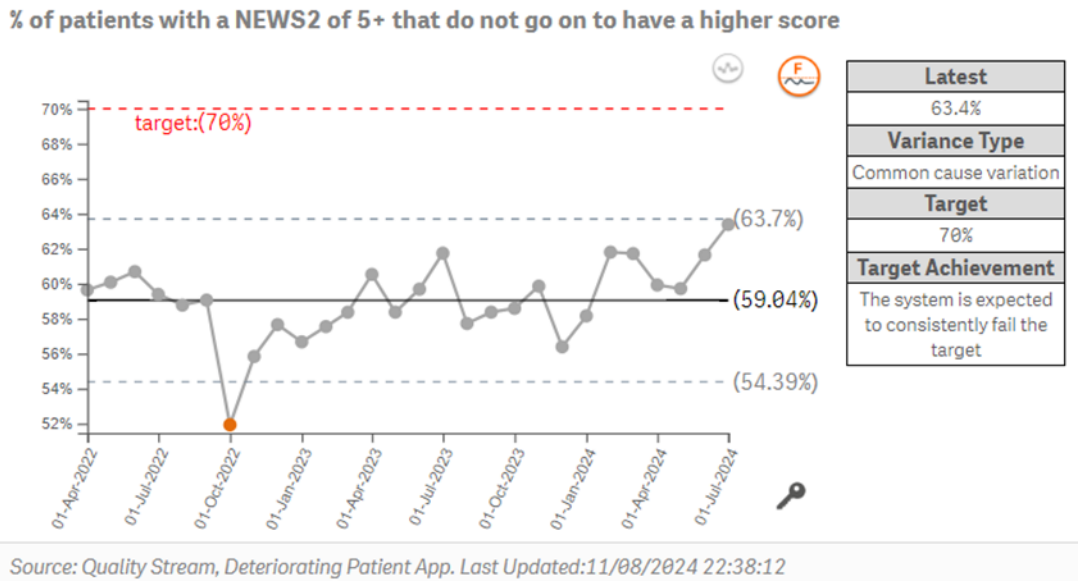
Metric	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Care of the acutely ill patient - % of episodes scoring NEWS of 5 or more not going on to score higher	July 2024	63.4%	70%			59.04%	54.39%	63.70%
Personalisation of care - % of patients that have been screened for dementia	July 2024	66.73%	90%			44.9%	31.8%	57.99%
Stroke - % of stroke patients admitted directly to an acute stroke unit within 4 hours of hospital admission	July 2024	29.82%	90%			31.25%	13.62%	48.88%

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 63.4% in July 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 54.39% to 63.70%.

Underlying Issues:
- A high volume of nervecenter alerts for routine tasks can delay response to more urgent alerts.
- 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. This will be captured in the audit.
- No replacement for nursing lead for this workstream after September 2024.

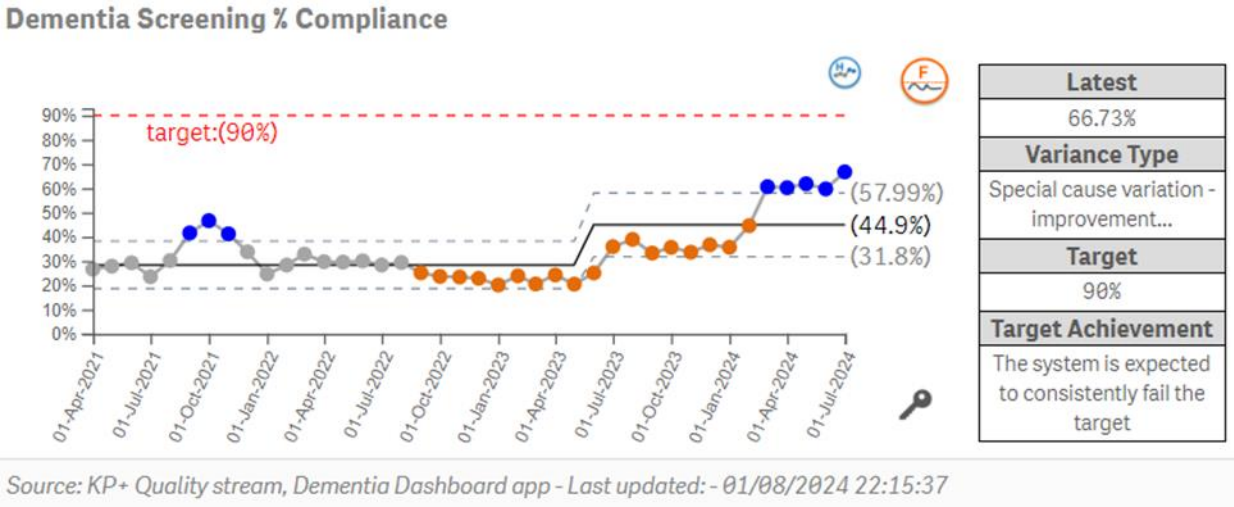
Actions:
- A quality improvement project will be undertaken to improve timely review by the Registrar or Consultant for patients with a NEWS of 7 or more. This project will focus on;
  - Reviewing the data to understand how many patients score NEWS 7 or more on which wards and whether in or out of hours.
  - Educating the ward nursing team know to contact the medical registrar or consultant for patients who score a NEWS 7 or more rather than the ward junior doctor.
  - Engaging and raising awareness amongst the Acute Response Team, resident doctors, registrars and consultants regarding the need to review patients with NEWS 7 or more within the hour.
  - The medical teams will be the initial focus, before looking at the different challenges faced by the surgical teams and other departments.

Personalisation of Care

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

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

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



What does the chart show/context:
- Performance was 66.73% in July.
- 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 31.8% to 57.99%.

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

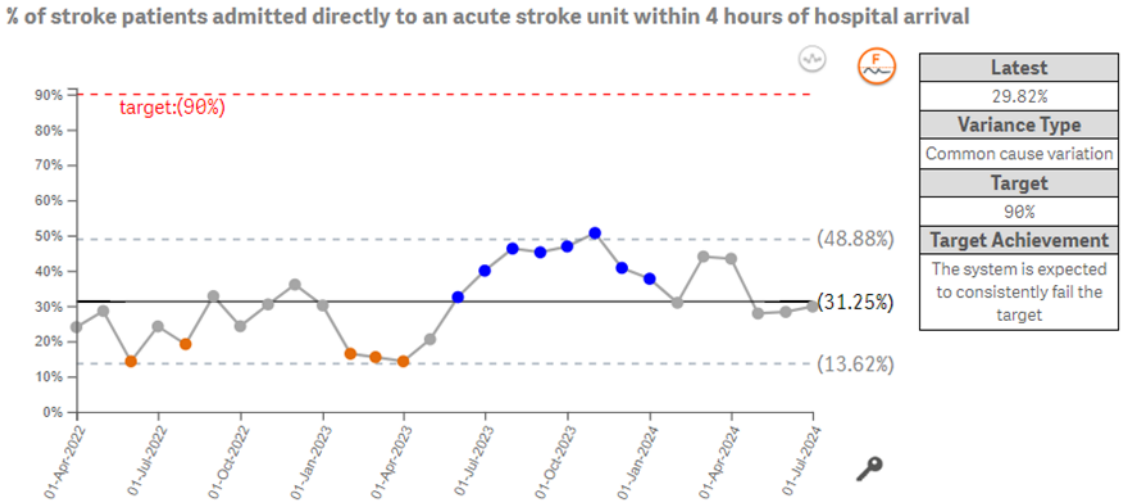
Actions:
- The dementia operational group met for the first time 4th June 2024 and highlighted the need for dementia and delirium screening to remain an area of focus.
- The enhanced care team are working with ward areas to identify dementia link nurses to lead on improving compliance with the dementia screening tools. An initial meeting has been arranged for August. The dementia matron will support the link nurses and provide training.
- The enhanced care team are providing training to ward areas on how to complete the tool and the importance of its use, this has also been incorporated into the new dementia training package which is available for all staff, there are sessions available across sites, places can be booked via the enhanced care team.

Stroke

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

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

Target:
90%.



What does the chart show/context:
- Performance was 29.82% in July 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 13.62% to 48.88%.

Underlying Issues:
- High level of demand
- 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 continues to improve.
- 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.
- Ward 8B now being used to cohort outliers from stroke rehab wards.

Elective Care:

Metric	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Total Patients waiting >40 weeks to start treatment	July 2024	654	0			-	-	-
Total Patients waiting >52 weeks to start treatment	July 2024	51	0			-	-	-
Total RTT Waiting List	July 2024	35,481	36,538			33,536	31,879	35,193
Total elective activity undertaken compared with 2023/24 activity plan	July 2024	102.0%	100%	-	-	-	-	-
Percentage of patients waiting less than 6 weeks for a diagnostic test	July 2024	95.2%	95%			88.6%	82.8%	94.4%
Diagnostic Activity undertaken against activity plan	July 2024	15,767	14,547			14,186	12,066	16,307
Total First attendances and procedures undertaken compared with 2024/25 activity plan	July 2024	113.3%	100%	-	-	-	-	-
Total Follow-Up activity undertaken compared with 2023/24 activity plan	July 2024	98.3%	100%	-	-	-	-	-
Day Case Rates	June 2024	92.2%	85%			91. 7%	89.7%	93.7%
Capped Theatre Utilisation	July 2024	82.8%	85%			81.8%	73.3%	90.4%

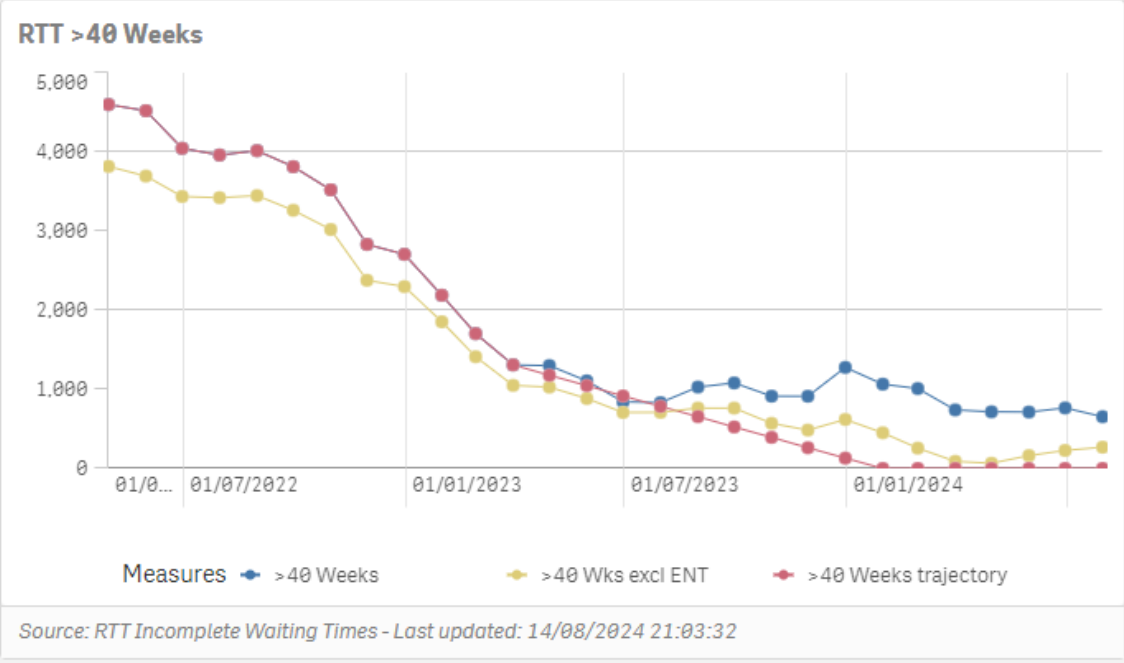
Total Patients waiting more than 40 weeks to start consultant-led treatment

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 654 at the end of July against the target trajectory of 0 (269 excluding ENT).
- Most of our remaining patients who are waiting over 40 weeks are in ENT (385), General Surgery (50), Plastic Surgery (39), Dermatology (31), Gastroenterology (22), Gynae (23), MaxFax (48) and Cardiology (14). All other specialties have 8 or less. Of the specialties listed, all have got worse in July apart from ENT and Cardiology.

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

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

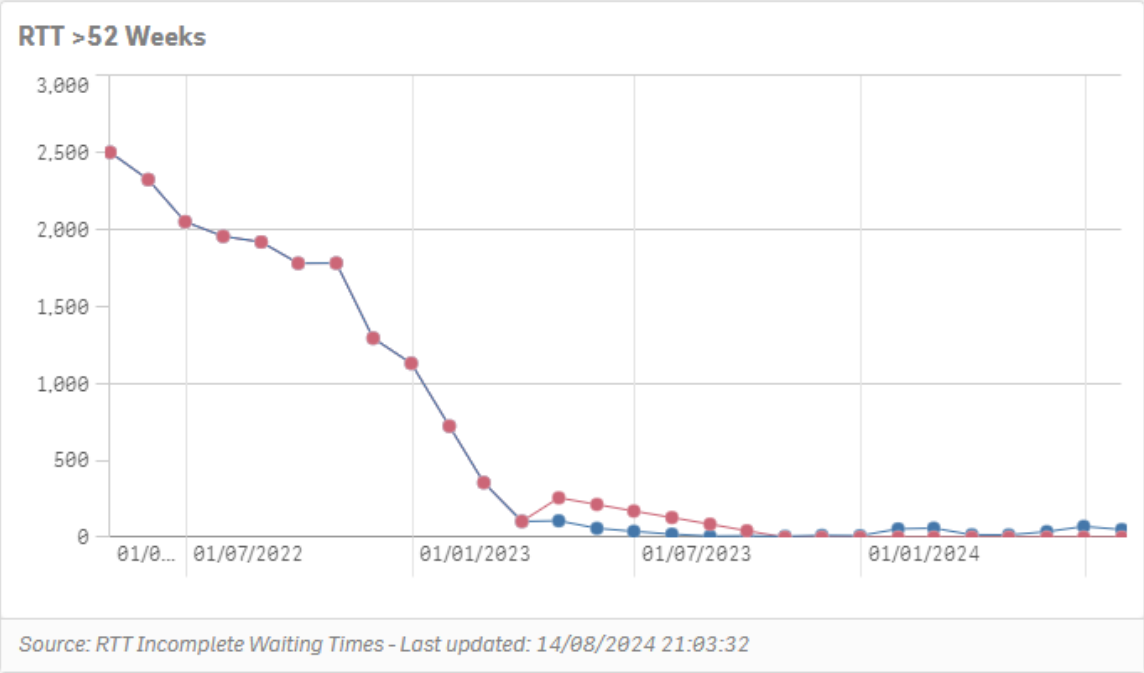
Total Patients waiting more than 52 weeks to start consultant-led treatment

Calderdale and Huddersfield NHS Foundation Trust

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

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

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



What does the chart show/context:
- Our 52-week position now stands at 51 (41 in ENT, 2 in Paediatrics, 1 each in Cardiology, Dermatology, Gen. Surgery, T&O, Ophthalmology, MaxFax, Plastic Surgery and Chemical Pathology).
- There are 147 patients waiting between 46 and 52 weeks, mainly ENT (102 – down from 174) and Dermatology (15), Gen. Surg. (7), MaxFax (4), Plastic Surgery (4).
- All other specialties have 3 or fewer patients waiting between 46 and 52 weeks.
- There is 1 patient over 65 weeks (ENT).
- There are 6 patients who have been waiting between 60 and 65 weeks (all are in ENT).

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

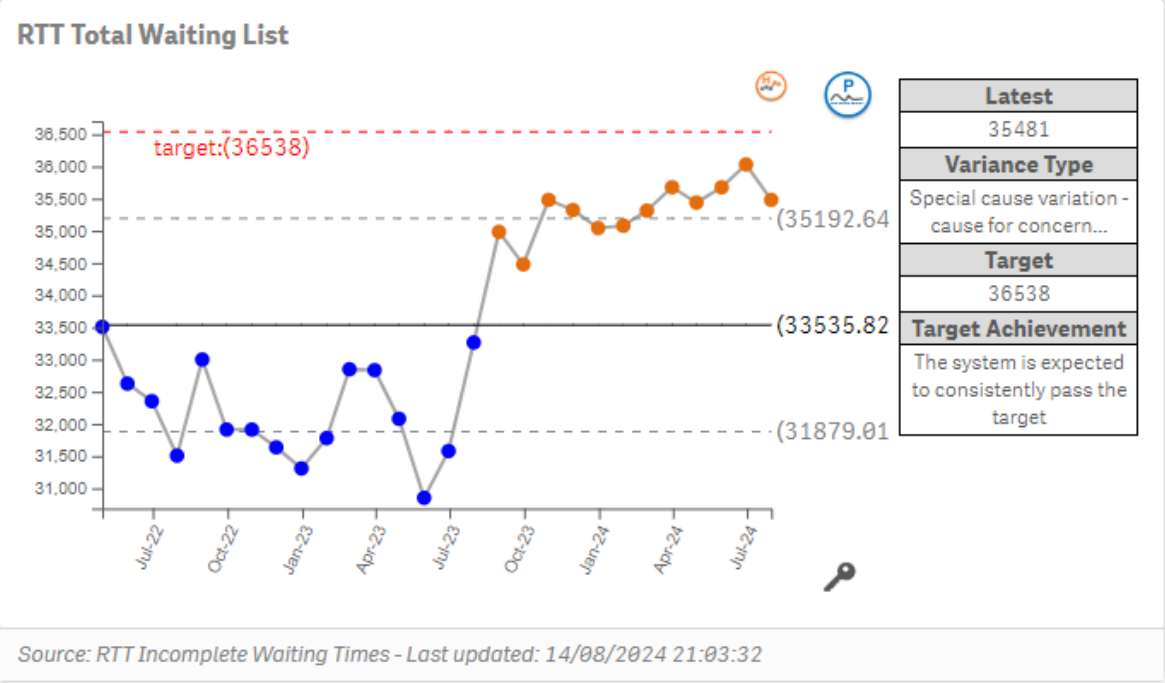
Actions:
- Operational teams to be tracking patients to at least 26 weeks.
- To support 52-week delivery and maintain delivery from May onwards - S&A have restructured A&C resource to enable greater tracking of ENT's RTT position.
- KP+ writeback model being used by all Operational teams to ensure that tracking actions are transparent and cannot be overwritten by Validation teams.
- ENT Task and Finish Group concluded with actions in place and are working to 52-week compliance.
- Actions have been identified in 3 cohort areas:
    - Demand management
    - Increasing internal capacity
    - Increasing external capacity

Total RTT Waiting List

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

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

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



What does the chart show/context:
- The list remains high and stands at 35,481 at the end of July.

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 and reduced capacity).
- 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.

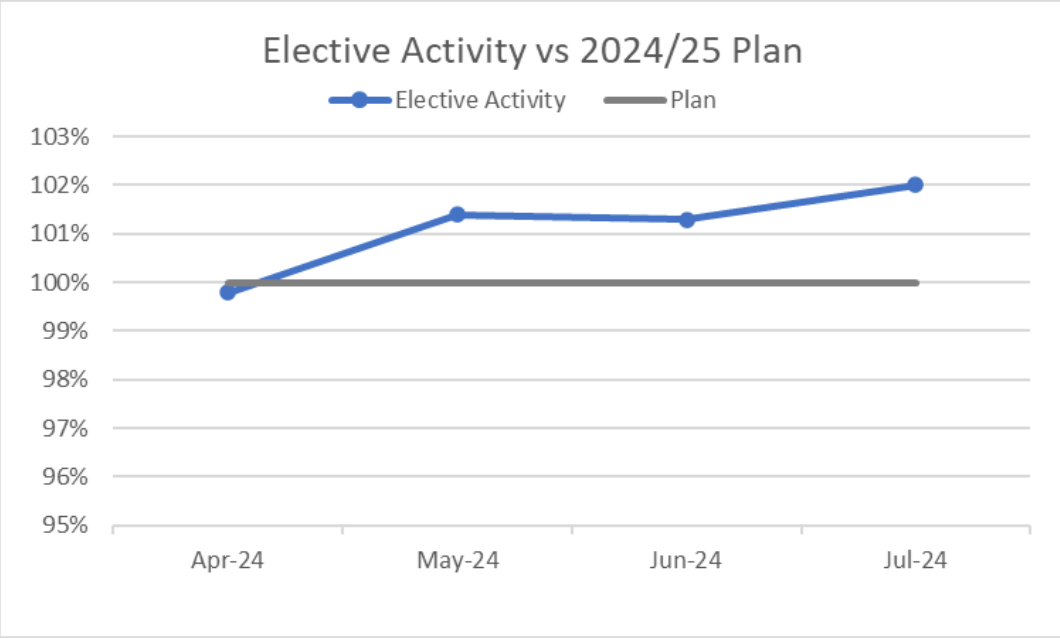
Actions:
- Validation team to monitor LUNA (National DQ RTT Benchmarking tool – currently in top 30 Trusts in the country for RTT DQ Assurance).
- Meet the trajectory for no ASIs over 18 weeks.
- Meet the trajectory for 40/52 weeks.
- Operational teams to be tracking patients to at least 32 weeks.
- Validation team to use KP+ RTT model that identifies where RTT Pathways have been created inappropriately or user has selected status code of 99 Not Known that suggests a training issue.

Total elective activity undertaken compared with 2024/25 activity plan

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

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

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



What does the chart show/context:
- CHFT has exceeded the elective activity 2024/25 plan in July 2024 with a very slight increase in the planned activity levels seen in June 2024.
- Performance in July 2024 was above plan at 102.0% in month.
- Day case activity exceeded the plan in month showing a performance of 102.5%, with elective activity showing performance of 97.2% of the planned position in month.
- The year-to-date performance for the elective activity overall has achieved activity levels that are above the planned position standing at 100.8%, which is a total of 110 spells more than the plan for the 2024/25 financial year so far.

Underlying issues:
- This data is performance against the original CHFT Plan.
- The day case position excludes ‘planned procedures not carried out’ as these are not in scope for Elective Recovery Funding.

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

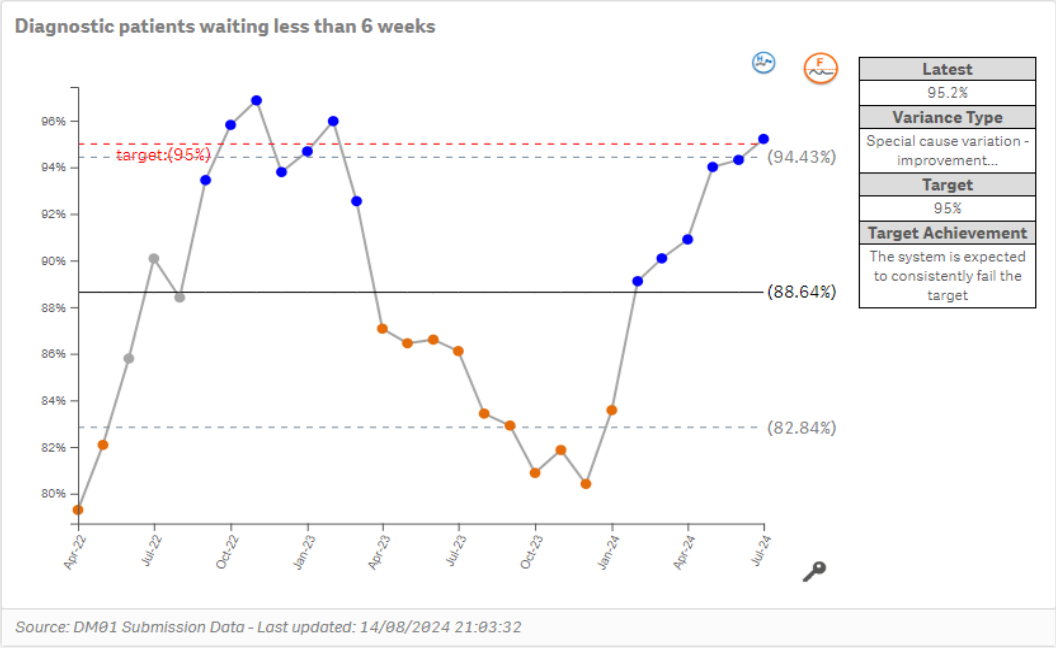
Percentage of patients waiting less than 6 weeks for a diagnostic test

Executive Owner: Jonathan Hammond
Business Intelligence Lead: Fiona Phelan

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

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

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



What does the chart show/context:
- The Trust achieved the 95% target in July for the first time since early 2023.

Underlying issues:
- Echocardiography still has significant numbers of pathways >6 weeks.
- The Cystoscopy position is in part due to the strikes. Most breaches have a TCI in August.
- Whilst the Trust performance is meeting the 95% target in most modalities, we are still consistently below this for Echocardiography (74.2% up from 70.7%). Cystoscopy is at 69.9% for July.

Actions:
Echocardiography
- Rate of recovery slowed down due to leave and sickness.
- Weekend clinics planned into September and CDC activity increasing.
- Reporting backlog now at manageable levels.
- Plan to change templates of trainees due to undertake exams giving us 12 additional scans per week, per trainee.
- Rate of recovery to increase significantly into September.

Total Diagnostic Activity undertaken against the activity plan

Calderdale and Huddersfield NHS Foundation Trust

Executive Owner: Jonathan Hammond
Business Intelligence Lead: Fiona Phelan

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

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

Target:
Recovery of diagnostic testing is key to wider elective recovery, including RTT performance. Target 14,547 (activity plan 2023/24)

What does the chart show/context:

- The Trust has been achieving levels around the target of 14,547 since May 2023, but it may achieve or fail the target subject to random variation. The activity for July 2024 is above the target at 15,767.
- Performance can be expected to vary between 12,066 and 16,307. Activity is similar to pre-Covid levels.

Underlying issues:

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

Actions:

Echocardiography

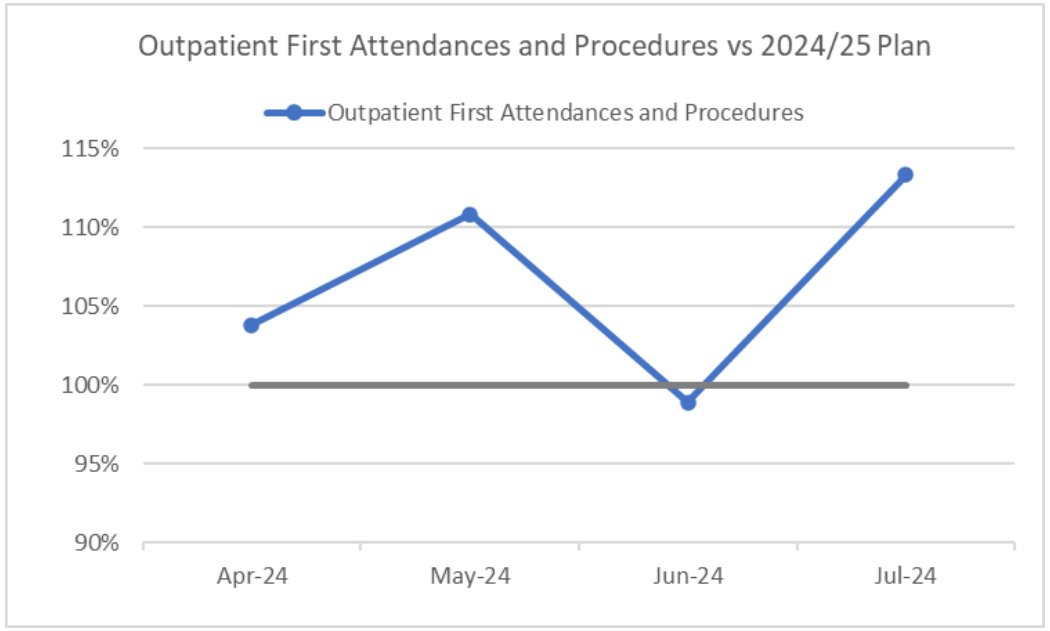
- Rate of recovery slowed down due to leave and sickness.
- Weekend clinics planned into September and CDC activity increasing.
- Reporting backlog now at manageable levels.
- Plan to change templates of trainees due to undertake exams giving us 12 additional scans per week, per trainee.
- Rate of recovery to increase significantly into September.

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 materially increased in month 4 compared to the 2024/25 activity plan having delivered 113.3% of planned activity in the month of July 2024. With first attendances increasing to 112.9% of plan and procedures remaining above planned positions at 117.2%.
- CHFT have so far delivered 107.5% of the activity plan for the year to date which represents 3,736 more outpatient first attendances and procedures than the planned position for the first 4 months of the year.

Underlying issues:
- With the increase in outpatient first attendances seen in month 4 the ASI list does still continue to track on an upward trajectory currently standing at 18,464 records.
- There has been an increase in incomplete outcomes in the first 4 months of 2024/25, this is causing some activity to not make it through to this position. This is being closely monitored and picked up in Outpatient Access meetings with all areas.

Actions:
- Cardiology have plans in place to run some extract clinics for first waiters to address the growing ASI list.
- Gynaecology have been running some ‘Super Saturday Clinics’ for extra first capacity with another clinic taking place this month, there are plans in place for further clinics in the coming months.
- ENT continue to work with Pioneer to support with the management of the waiting list.

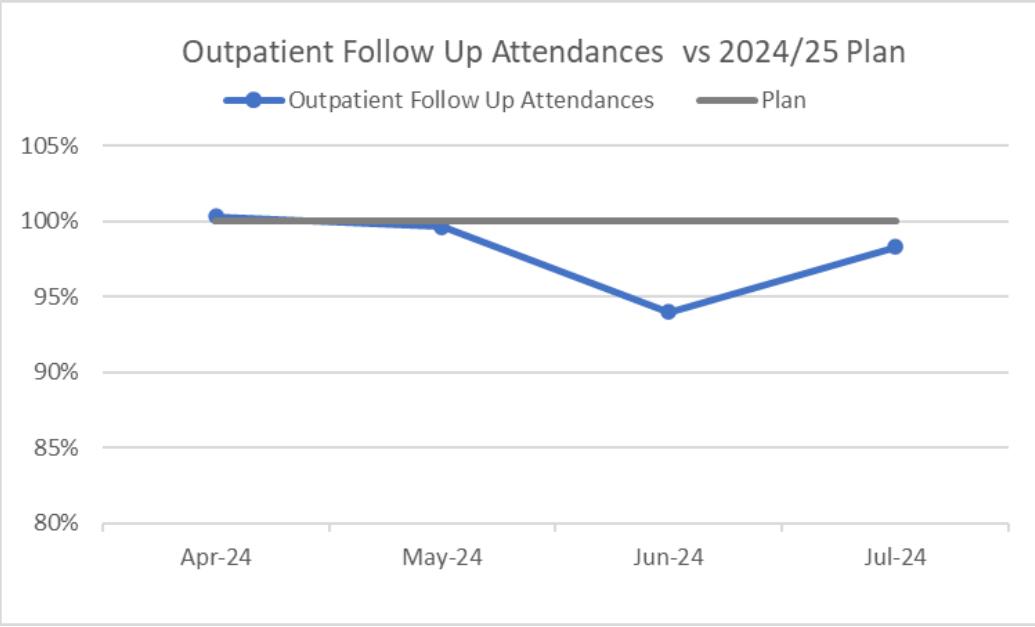
Total Follow-Up attendances undertaken compared with 2024/25 activity plan

Calderdale and Huddersfield NHS Foundation Trust

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

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

Target:
100% of 2024/25 activity plan (source: activity plan 2024/25)



What does the chart show/context:
- CHFT made the decision at the start of 2022/23 to not adopt the 25% reduction in Outpatient follow-up activity, this has continued for 2024/25.
- Activity was below the planned position in July 2024 standing at 98.3% of the planned position in-month for follow-up attendances, this does represent an improvement from the previous month.
- For the year-to-date position CHFT activity is currently showing a performance of 97.0% of the 2024/25 plan being delivered over the first 4 months of the year. This represents a total of 2,470 attendances below the planned position to date.

Underlying issues:
- 40% of the backlog has been waiting less than 12 weeks.

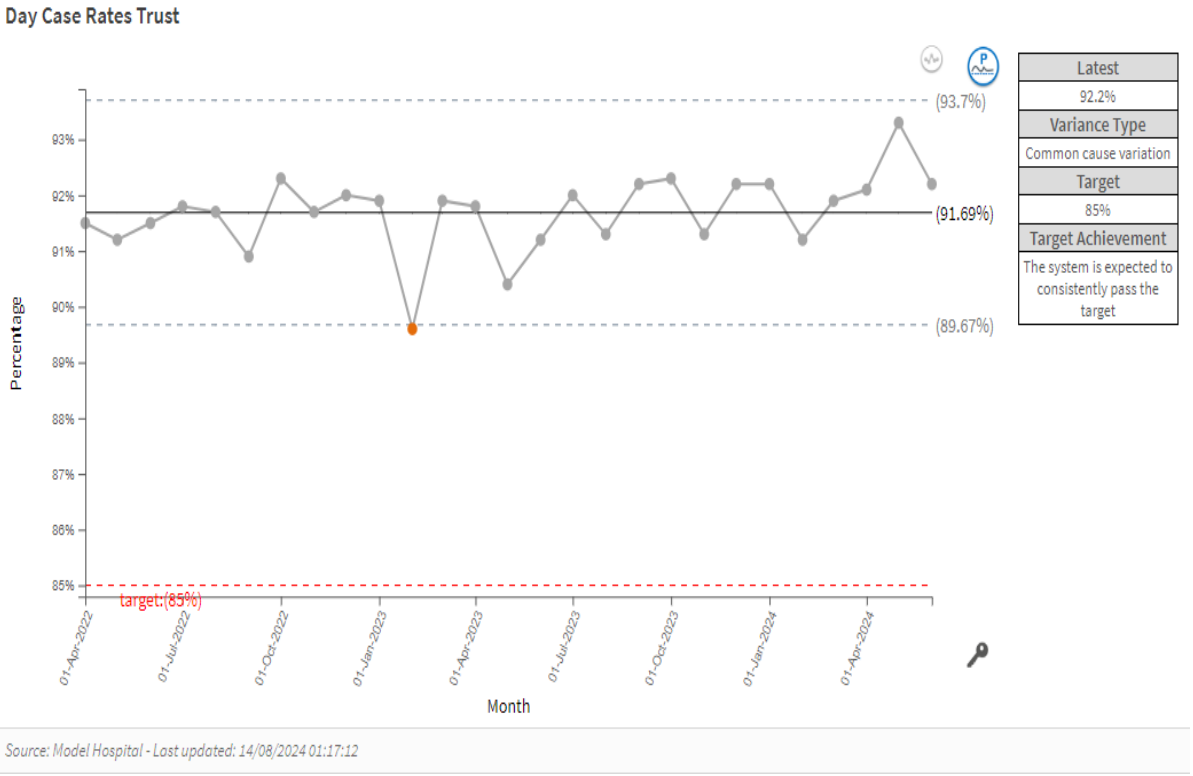
Actions:
- There are currently 6,124 (of the 31,844 backlog) records that are awaiting a clinical prioritisation within CHFT's MPage system. This is a reduction of 800 from last month but is a direct result of a reduction of admin validation in Mpage. Cohorts for incomplete outcomes have been brought into the low hanging fruit validation process. Specialties will then have a clean MPage validation list for clinical prioritisation. A WTGR session was held in August, several actions were agreed, and a follow up session has been scheduled for feedback at the end of September 2024.
- We now have 31,844 follow-up patients past see by date, and this is gradually increasing weekly.
- A regular 'Outpatient Access' meeting focussing on the follow-up backlog and capacity management has been established 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. Clear actions have now been agreed in all areas to start to address this backlog.
- The first round of the follow-up training programme has now been completed in all specialty areas. The new Access meetings will be used to identify any further training needs or booking process issues, and bespoke support / training will be provided.

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%



Source: Model Hospital - Last updated: 14/08/2024 01:17:12

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 June 2024. CHFT performance reported as 92.2% against an 85% target.

Underlying issues:

- Model Hospital have advised their intention to include BADS procedures completed in outpatient settings within overall Trust DC reporting however this will not be until later in the year. Divisional reporting now captures 3 different day case metrics but this cannot currently be presented in a SPC format until more data is captured
- 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 conversions are not counted – If a patient is listed for an inpatient stay but is completed as day case this is not reflected in our day case rate.

Actions:

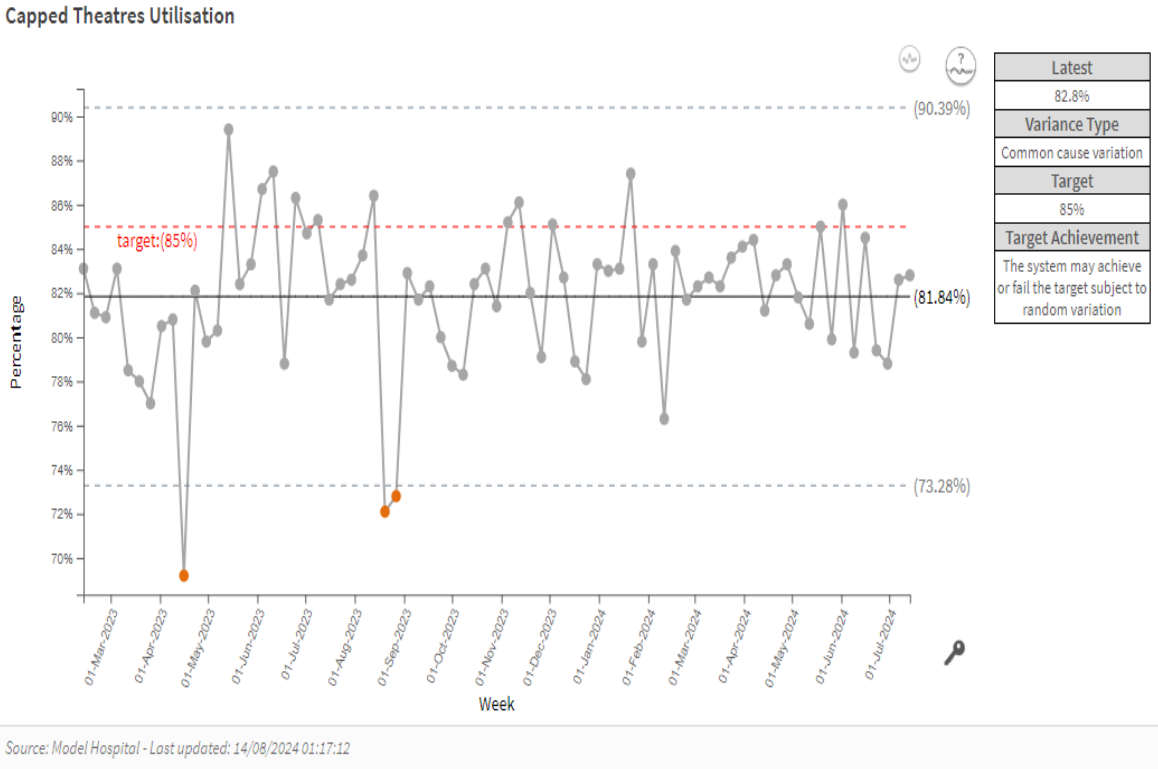
- Day case rates are monitored at a specialty level through the monthly STUG meetings.
- Procedure specific data reviewed each month to identify improvement opportunities or data quality challenges.
- Specific actions in development for procedures where CHFT are identified as true outliers
- Continue to participate in WYAAT working group to improve overall day case rates

Capped Theatre Utilisation

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

Rationale:
To measure the relative increase

Target: Over 85%



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 28th July 2024 – performance at 80.5% 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 and PM patients due to breaks and staff changes. Identified that one regional Trust has an extra member of staff in theatre to support collecting next patient to ensure quick turnaround.
- MH 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 region still operate on an AM/PM model

Actions:

- Utilisation is monitored at a specialty list level through the monthly STUG meetings to identify improvement opportunities or data quality challenges. Work with the STUG to identify themes and concerns.
- Issue with scheduling in some specialties. Working to review amount of time being allocated to specific procedures.
- Weekly 6-4-2 Scheduling meetings with specialties now working well. Working towards better communication around utilisation and scheduling.
- Trialling new start times in Orthopaedics to see if this improves.

Cancer:

Metric	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Proportion of patients meeting the 62-Day standard	July 2024	92.59%	85%			89.11%	82.5%	95.71%
Proportion of patients meeting the faster diagnosis standard	July 2024	78.17%	77%			76.93%	69.26%	84.60%
Non-Site-Specific Cancer Referrals	July 2024	35	27			23.54	9.82	37.26
Early cancer diagnosis: 75% of cases diagnosed at stage 1 or 2 by 2028	July 2024	55.5%	75%			48.52%	34.44%	62.60%

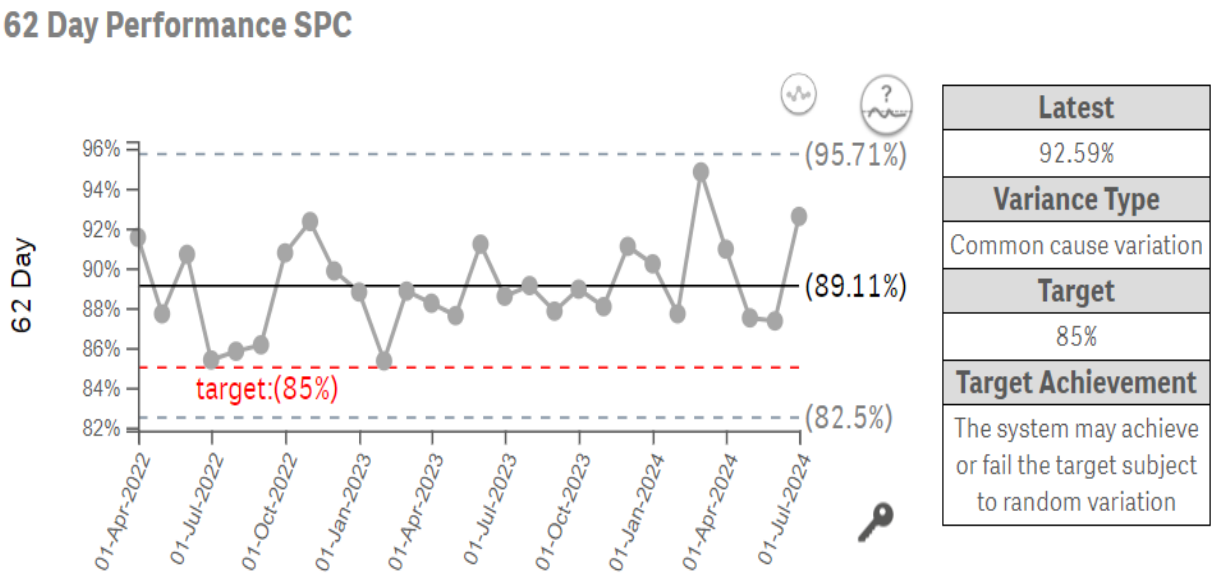
Proportion of patients meeting the 62-day cancer referral to treatment standard

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 92.59%

Underlying issues:
- Lack of capacity at first seen.
- 28-day target performance due to diagnostic capacity, Radiology and repeat tests.
- H&N at 50% in July. Issues with thyroid surgery.
- SKIN still delays in pathway with first see, diagnostic biopsies, late referral to Max/Fax and Plastics.
- Lower GI and Bowel Screening, capacity for clinics and theatre.
- 104-day pathways – this is a concern as a higher proportion of patients at this point in the pathways, some due to complexity, change in treatment plans, long waiting times for RT at Leeds plus our IPT to Tertiary centres are late in the pathway.
- Rising PTL.

Actions:
- Teams need to review their pathways from beginning to end.
- Escalation of risk at weekly meeting with PPCs, Opps/GMs.
- Continue to monitor patients on PTL between day 48 and 62 and prevent patients reaching over 104 days. Daily checks and weekly meeting to review these patients.
- Capacity to be reviewed alongside other competing pressures.
- Competing capacity for theatres with other Trust targets.

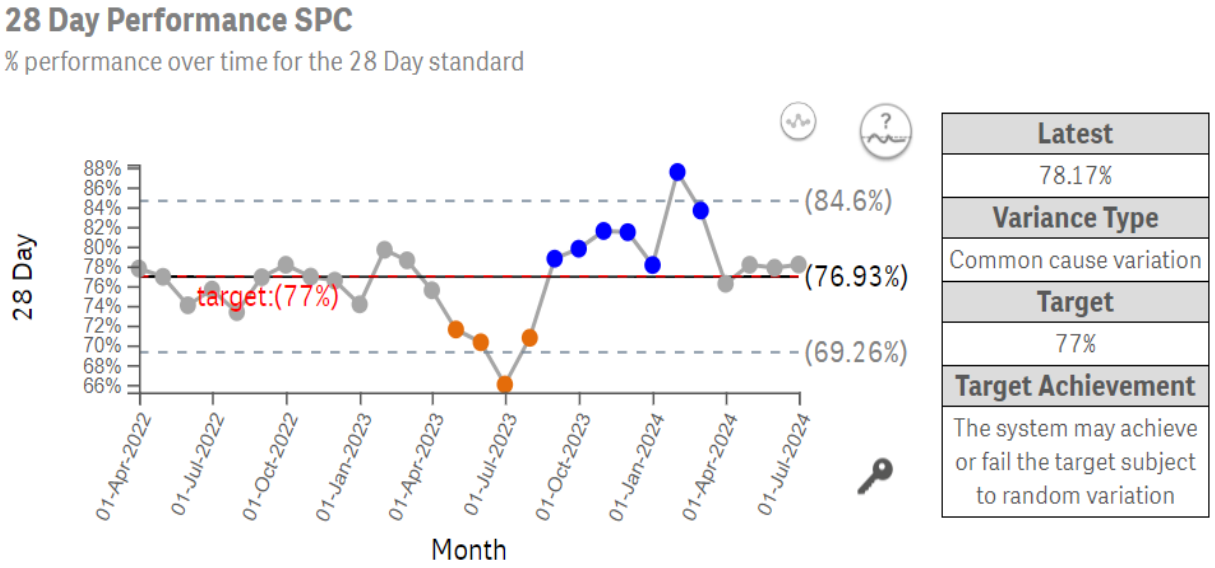
Proportion of patients meeting the faster diagnosis standard

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%.



What does the chart show/context:
- Latest monthly performance stands at 78.17% 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:
- Lower GI - 56% in July. 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.
- H&N (63% in July) - we are frequently chasing results letters/appointments for results. Slight improvement as the CNS team are helping with calls to patients to give benign diagnosis.

Actions:
- Lower GI & H&N work ongoing with team and closely monitoring of patients at weekly risk meeting.
- Proposed “Perfect week” for LGI in September.
- UGI presented a performance update at the July Cancer Delivery group, including a number of areas of focus going forward and to commence a WTGR. Progress against these will be monitored going forward.

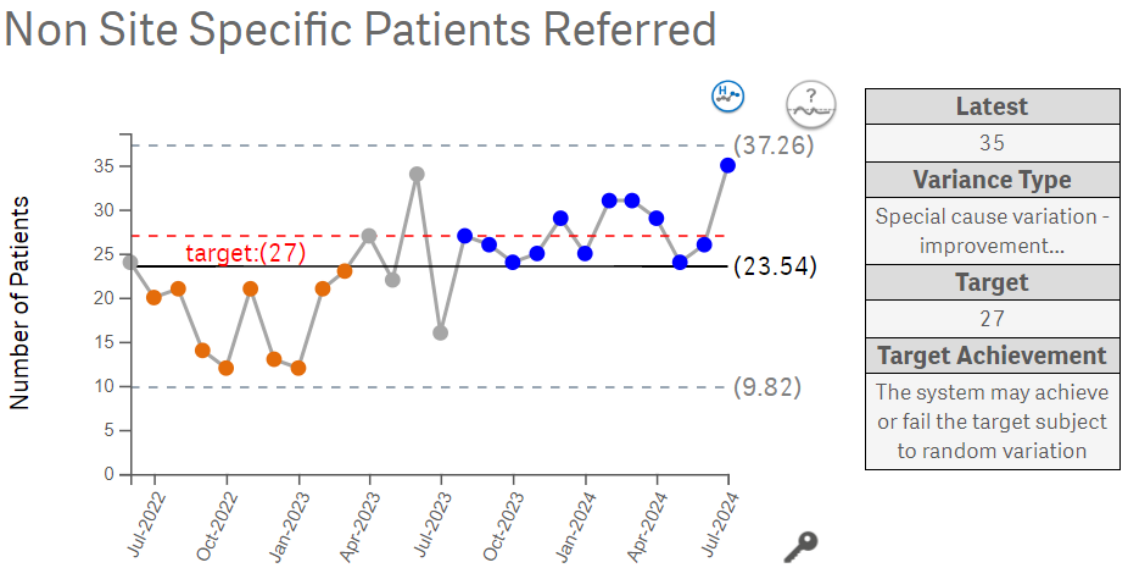
Non-Site-specific Cancer Referrals

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
35
Variance Type
Special cause variation - improvement...
Target
27
Target Achievement
The system may achieve or fail the target subject to random variation

What does the chart show/context:
- The Trust is unable to consistently meet the target of 27 and may achieve or fail the target subject to random variation. Performance can be expected to vary between 9 and 37.

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, as yet no impact.
- 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).

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

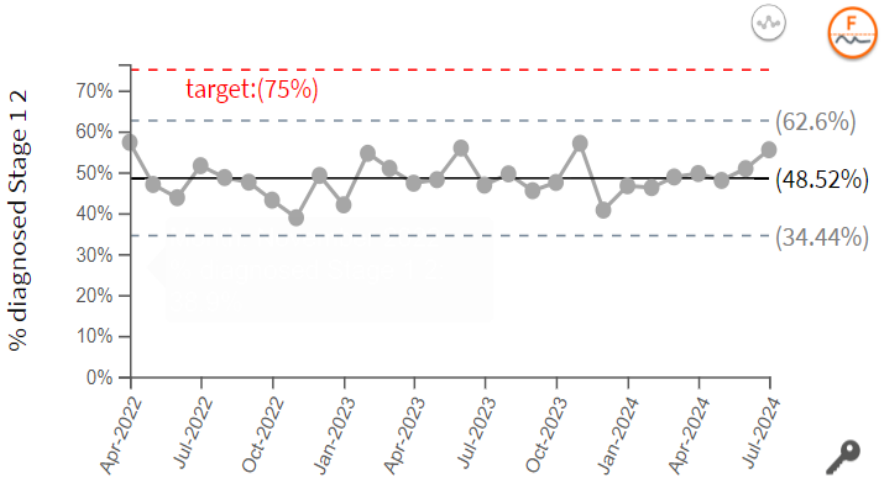
Calderdale and Huddersfield NHS Foundation Trust

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

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

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

Cancers Diagnosed by Stage 1 and 2



Latest
55.5%
Variance Type
Common cause variation
Target
75%
Target Achievement
The system is expected to consistently fail the target

What does the chart show/context:
- The Trust is expected to consistently fail the target of 75%.
- Performance can be expected to vary between 34% and 63%.
- Nationally this metric stands at 54%

Underlying issues:
- This metric is an area where CHFT need to work with partners to raise awareness and ensure that ICB colleagues are addressing the issues.

Actions:
- 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	July 2024	70.3%	78%			68.6%	60.4%	76.8%
Proportion of ambulance arrivals delayed over 30 minutes	July 2024	9.3%	0%			4.2%	0.73%	7.66%
Proportion of patients spending more than 12 hours in an emergency department	July 2024	3.07%	2%			3.43%	0.84%	6.01%
Adult G & A acute bed occupancy adjusted for void beds (Type 1 Acutes Only)	July 2024	97.0%	96%			98.2%	96.5%	100%
% of beds occupied by patients who no longer meet the criteria to reside	July 2024	19%	14.2%			20.9%	17.5%	24.3%
Hospital Discharge Pathway Activity – AvLOS pathway 0	July 2024	4.6	4.56			4.3	3.9	4.7
Transfers of Care*	July 2024	123	50*			107	67	147

* Note TOC target for 2024/25 to be agreed

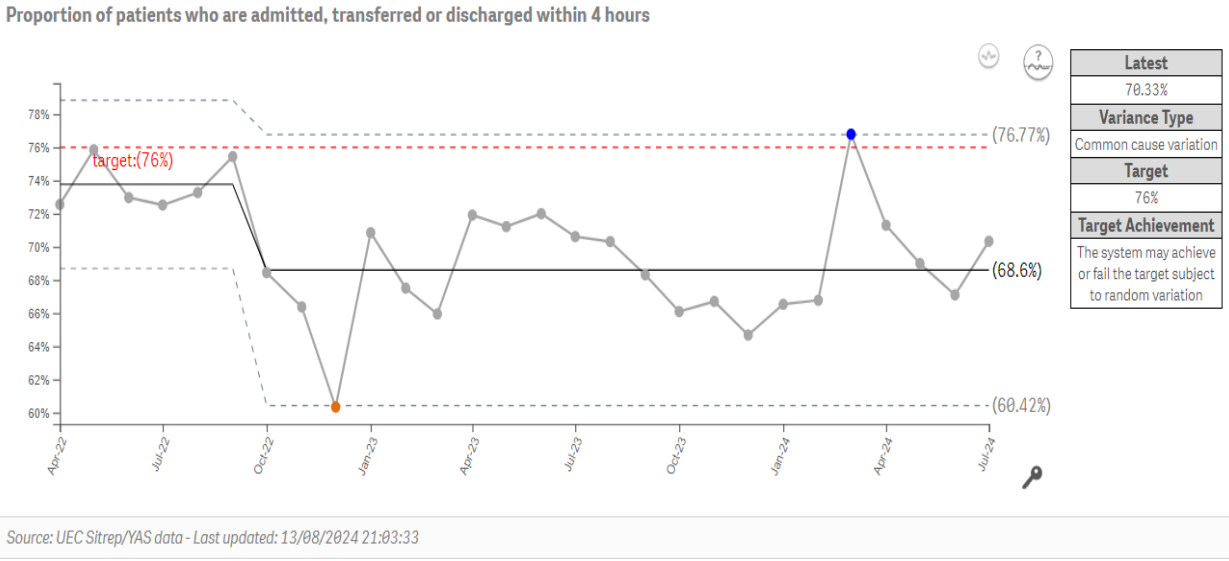
Proportion of patients admitted, transferred or discharged within 4 hours

Calderdale and Huddersfield NHS Foundation Trust

Executive Owner: Jonathan Hammond Operational Lead: Jason Bushby Business Intelligence Lead: Alastair Finn

Rationale:
To monitor waiting times in A&E.

Target:
NHS Objective to improve A&E waiting times so that no less than 78% of patients are admitted, transferred or discharged within 4 hours by March 2025.



Source: UEC Sitrep/YAS data - Last updated: 13/08/2024 21:03:33

What does the chart show/context:
- The performance for July was 70.33%.
- The performance for CRH was 74.5% 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
- Breach validation SOP completed – will ensure consistent validation process

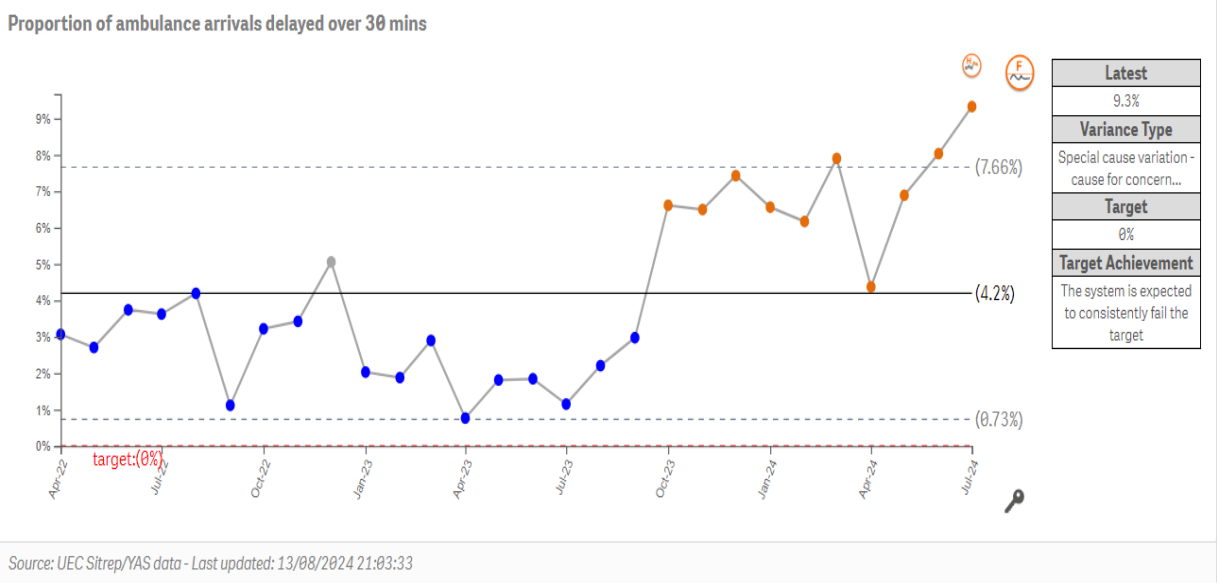
Proportion of ambulance arrivals delayed over 30 minutes

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 July was 9.3%.
- The Trust is expected to consistently fail the target of 0%. Performance can be expected to vary between 0.73% and 7.66%.

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.
- Increase in attendances.
- Increase in bed occupancy – long waits for beds.
- Increased LOS in ED means the departments can become bed blocked.
- Increased acuity (less fit to sit patients).

Actions:
- Testing of full capacity protocol is underway, aimed at supporting reducing long waits in ED.
- Meeting YAS management on site to identify and resolve issues in handovers through collaboration.

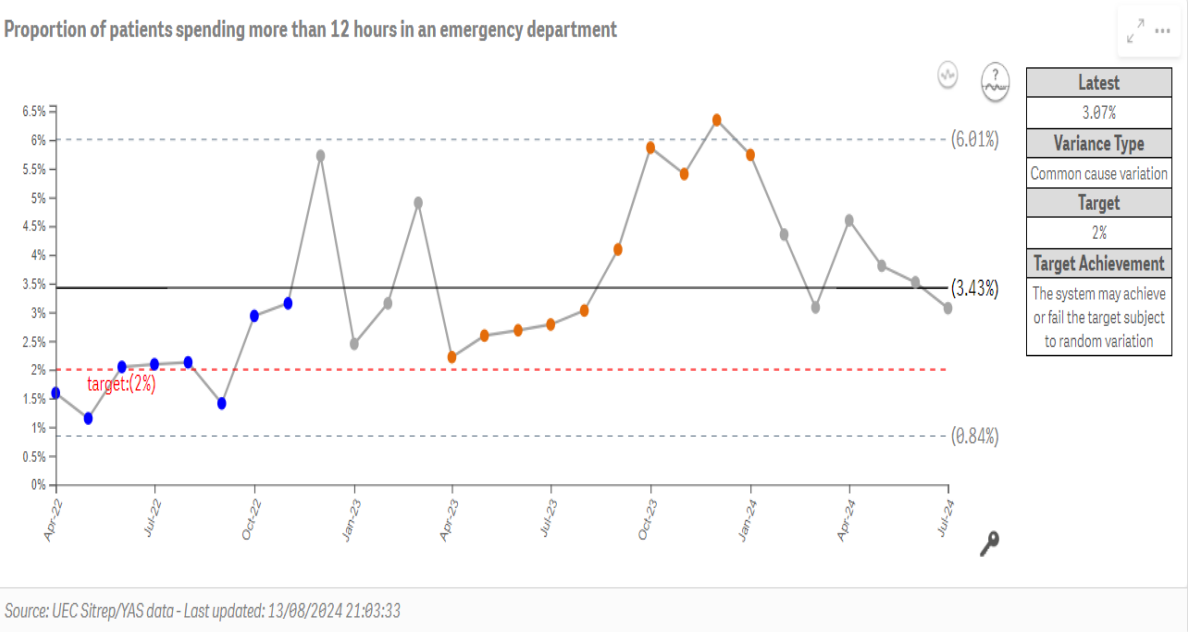
Proportion of patients spending more than 12 hours in an emergency department

Calderdale and Huddersfield NHS Foundation Trust

Executive Owner: Jonathan Hammond Operational Lead: Jason Bushby Business Intelligence Lead: Alastair Finn

Rationale:
To monitor long waits in A&E.

Target:
The number of patients that spend more than 12 hours between arrival and admission, transfer or discharge, as a proportion of total attendances. Less than 2% of patients should wait more than 12 hours (NHS Standard Contract 2023/24).



What does the chart show/context:
- Performance for July was 3.07% with 489 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
- Breach validation SOP completed – will ensure consistent validation process.

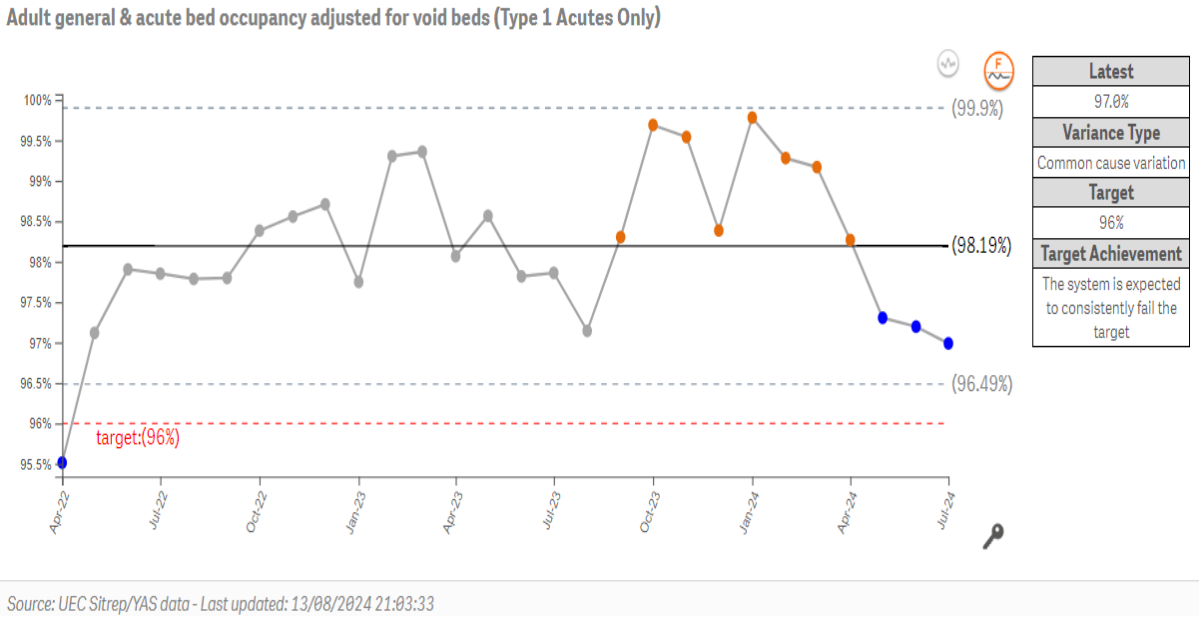
Adult general & acute bed occupancy adjusted for void beds (Type 1 Acutes Only)

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: 13/08/2024 21:03:33

What does the chart show/context:
- Adult bed occupancy in July was 97.0%. 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.

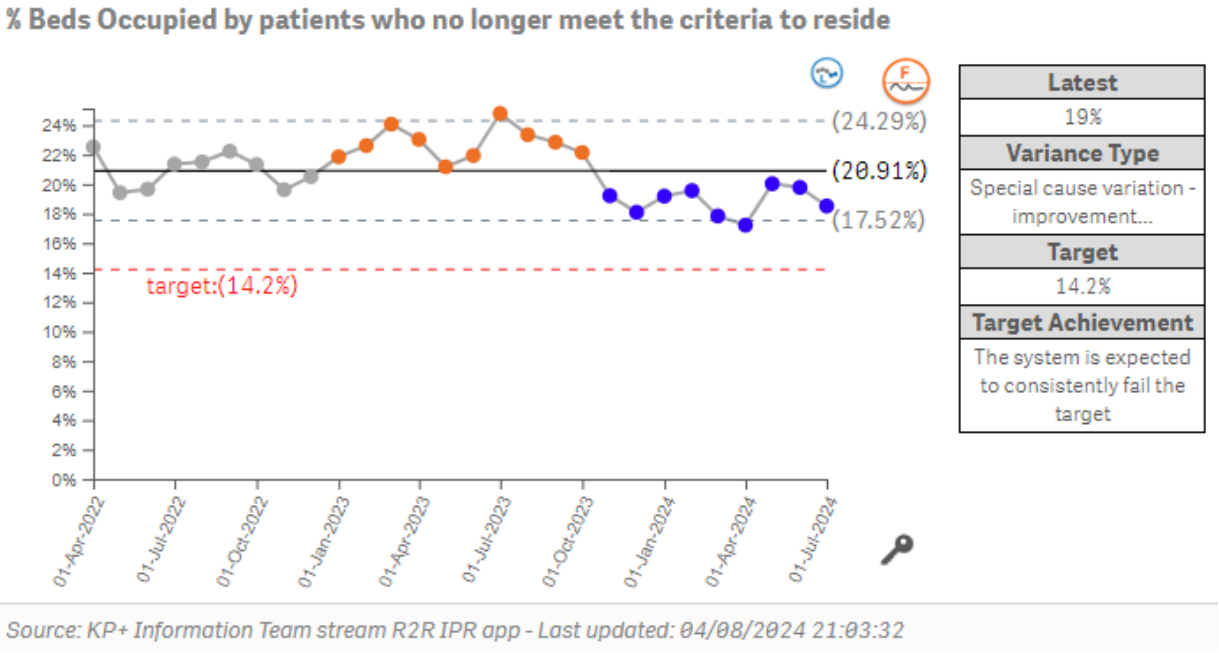
Percentage of beds occupied by patients who no longer meet the criteria to reside

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).



Source: KP+ Information Team stream R2R IPR app - Last updated: 04/08/2024 21:03:32

What does the chart show/context:

- In July 19% of patients had no reason to reside.
- Slightly more beds were occupied in July, 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 2024/25. Those targets link to reducing LOS post discharge ready and will feed into NR2R performance.

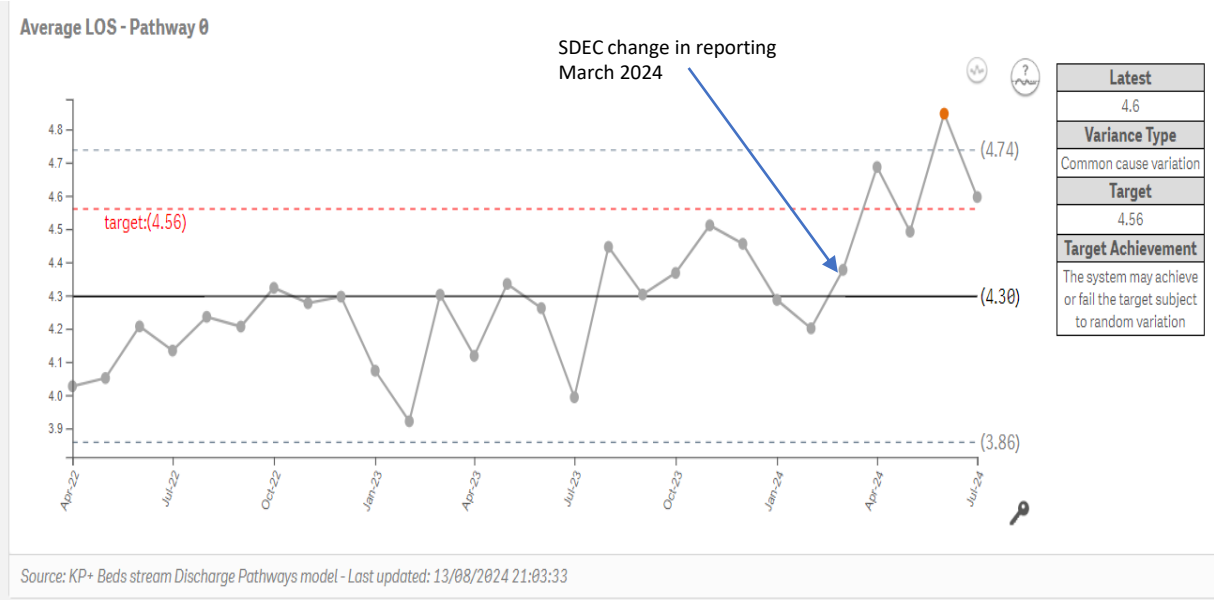
Hospital Discharge Pathway Activity

Calderdale and Huddersfield NHS Foundation Trust

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

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

Target:
Average Length of Stay for pathway 0 patients to 4.56 days.



What does the chart show/context:
- In July the average length of stay for pathway 0 patients was 4.6 days.
- Performance can be expected to vary between 3.86 and 4.74 days.

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

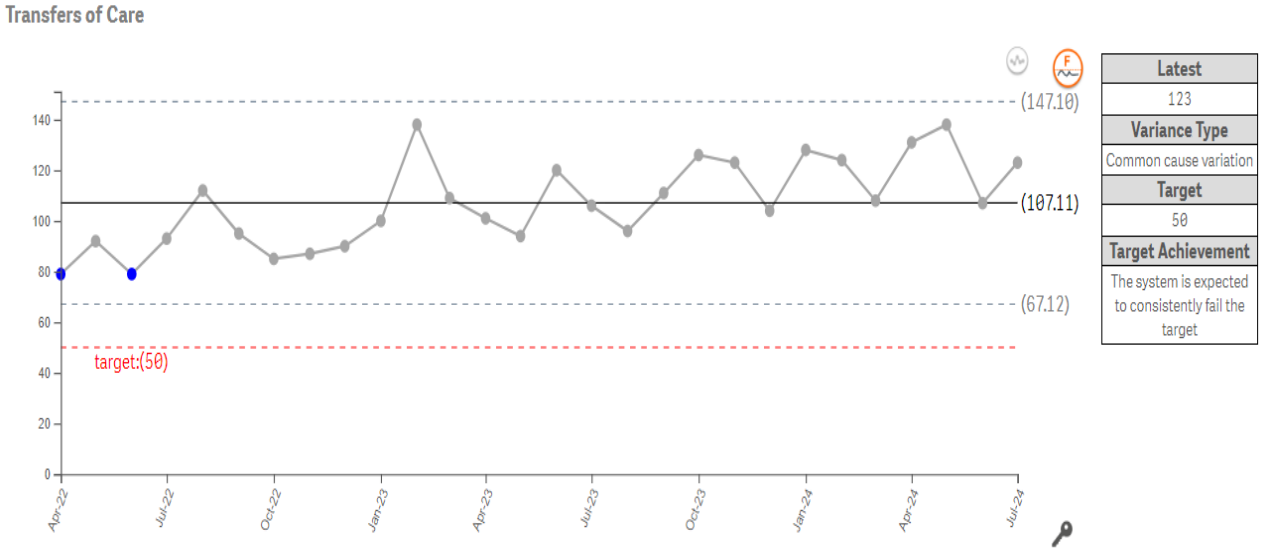
Actions:
- Improvement groups continue with PMO support to develop and improve groups.
- Launch of the Well Organised Ward (WOW) Programme.
- Approval of funding to reablement and trusted assessors.
- New pack for UECDG to help support improvements
- Governance structures defined within the divisions and through PRMs.

Transfers of Care

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

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

Target: 50



Source: KP+ DToC Stream DToC Summary model - Last updated: 13/08/2024 21:03:33

What does the chart show/context:
- The snapshot for the end of July was 123 patients on the TOC list.

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

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

Maternity and Children's Health:

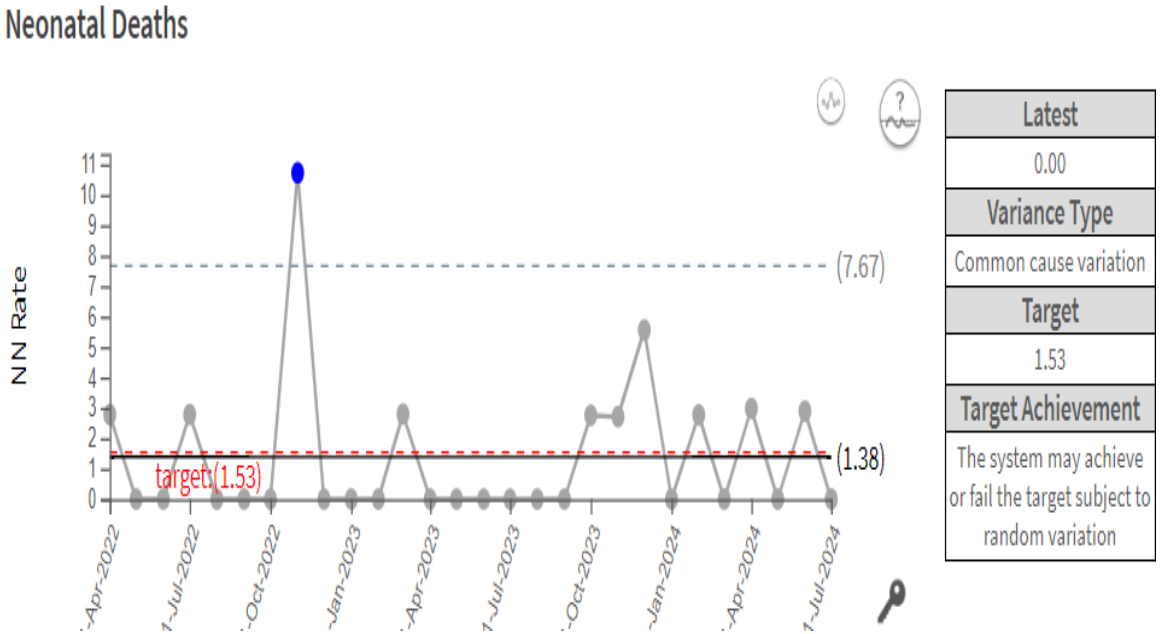
Metric	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Neonatal deaths per 1,000 total live births	July 2024	0.0	1.53			1.38	0	7.67
Stillbirths per 1,000 total births	July 2024	2.73	3.33			4.32	0	15.58
Maternity Workforce	July 2024	152.6	195			153.6	147.7	159.6
Maternal Mortality	July 2024	0	0			0.1	0	0.5
Pre-Term Births	July 2024	6.28%	8%			6.8%	2.0%	11.6%
Brain Injuries	July 2024	0	2.2			0.36	0	1.8

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 July.

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

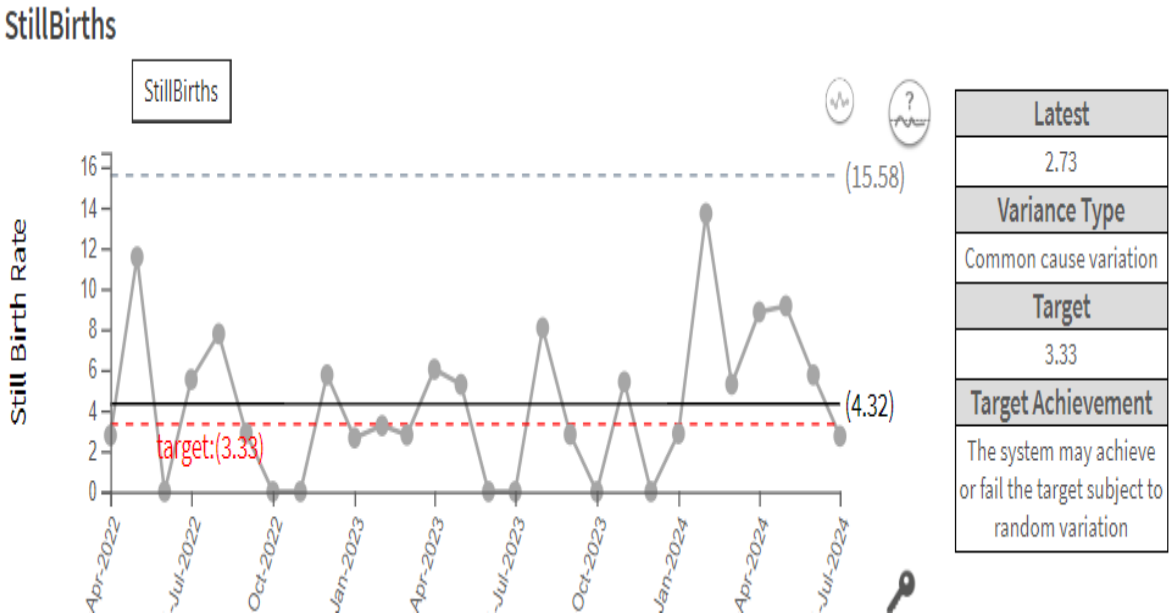
Actions:
- All early neonatal deaths reviewed at Orange Panel and weekly governance meeting.
- All neonatal deaths MDT PMRT (perinatal mortality review tool) completed.
- All term-early neonatal deaths referred to MNSI (The Maternity and Newborn Safety Investigations Programme).
- Regular quarterly stillbirth/neonatal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

Stillbirths per 1,000 total births

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

Rationale:
The government's National Ambition is to halve the rate of stillbirths from a 2010 baseline by 2025, with a 20% reduction by 2020, reducing the rate from 5.1 per 1,000 births in 2010 to 4.1 in 2020 and 2.5 in 2025.
.

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



What does the chart show/context:
- There was one stillbirth in July.

Underlying issues:
- 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.

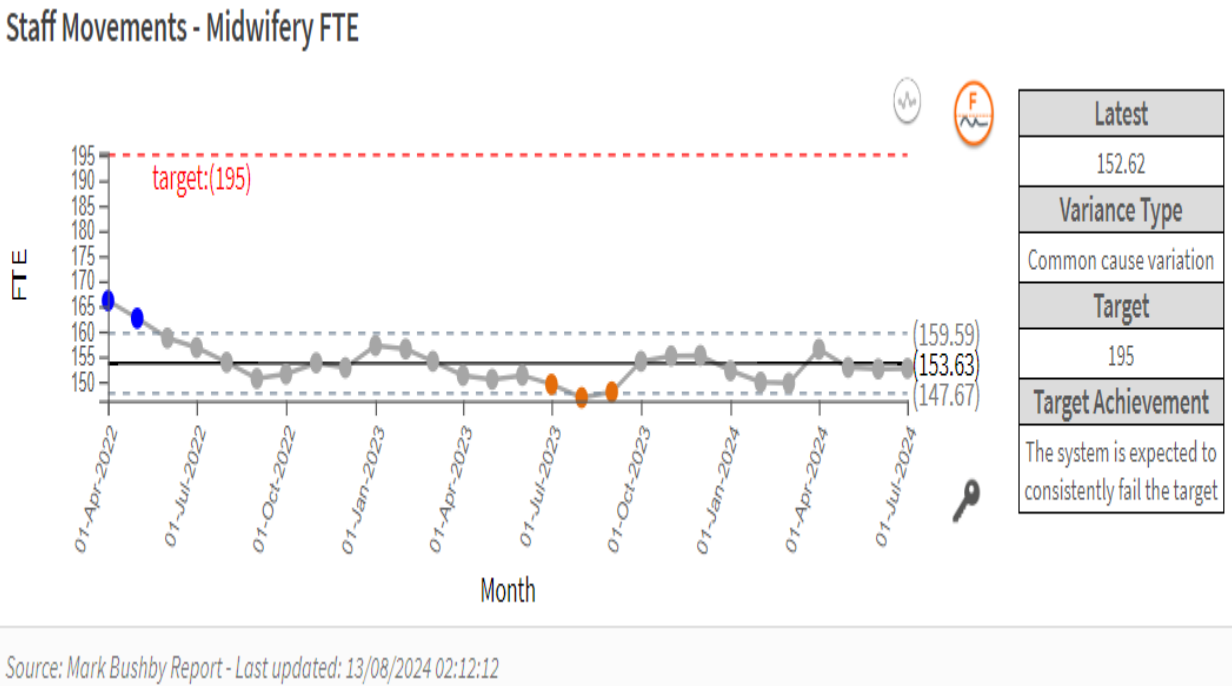
Actions
- All stillbirths are reviewed at the divisional patient safety panel and weekly governance meeting, health inequalities are considered.
- All stillbirths have an MDT PMRT completed (Perinatal Mortality Review Tool - a structured national tool that is used to review all deaths).
- All term intrapartum stillbirths are referred to MNSI.
- Regular quarterly stillbirth/neonatal audit is undertaken.
- An LMNS supported thematic review of the 2024 stillbirth cases took place on 3rd June 2024.
- A system stillbirth summit took place on 29th July 2024 and a stillbirth reduction programme will take place following this.

Maternity Workforce

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

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

Target:
195 FTE (current funded establishment)



What does the chart show/context:
- The FTE rate has increased slightly from 152.52 in June to 152.62 in July.

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

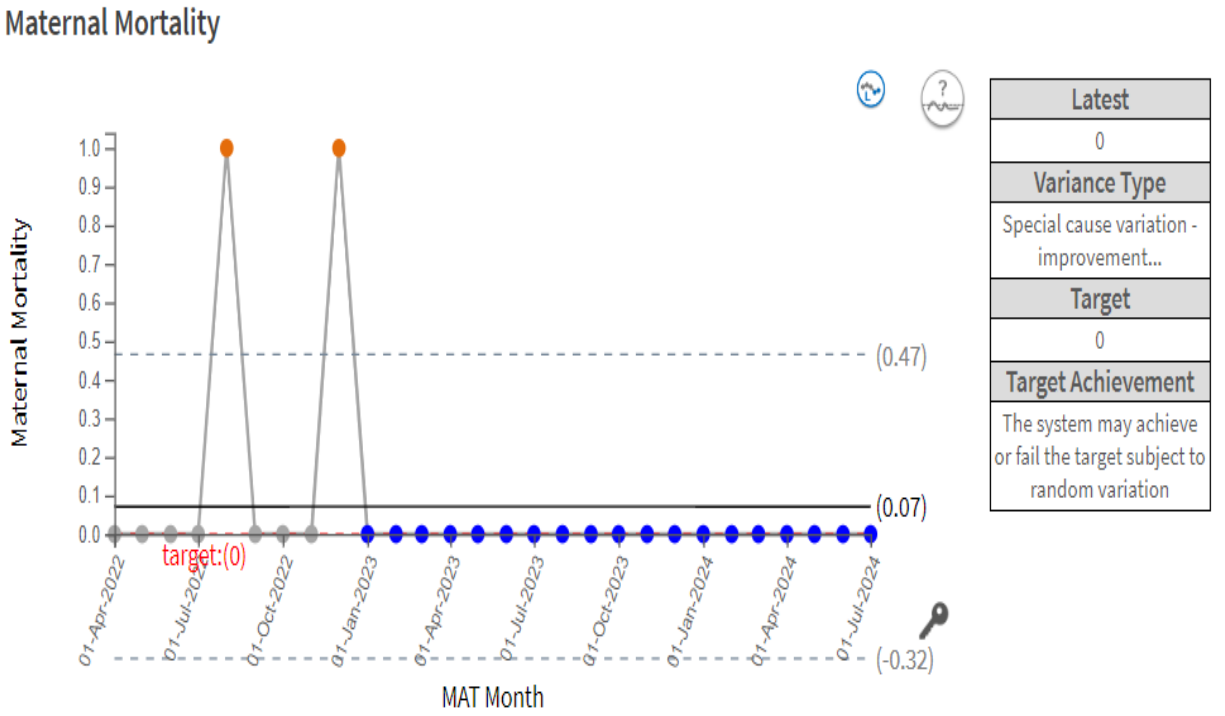
Actions:
- Birthrate plus report commissioned and report received at end of April 2024, currently being reviewed through divisional governance.
- Recruitment and retention strategy being refreshed.
- Rolling recruitment programme.
- Grow your own workforce pathways: Midwifery apprenticeship, shortened programme
- Recruitment and retention midwife employed to work alongside and support new midwives in clinical practice.
- Stay conversations implemented.
- DoM/DDoM undertaking all exit interviews, retention has improved over last 6 months.
- Recruitment films commissioned and released on social media and being used in adverts and recruitment open days.
- Use of alternative roles such as registered nurses in maternity service.
- Circa 31 WTE offered to newly qualified midwives to commence in October 2024.
- 4 WTE Band 6 midwives offered posts following interviews in July 2024.
- Robust preceptorship programme.

Maternal Mortality

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

Rationale: The government's National Ambition is to halve the rate of maternal deaths from a 2010 baseline by 2025,. with a 20% reduction by 2020, reducing the rate from 10.6 per 100,000 maternities in 2010 to 8.5 in 2020 and 5.3 in 2025

Target: 0



What does the chart show/context:
- There have been no maternal deaths since December 2022.

Underlying issues:
- 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

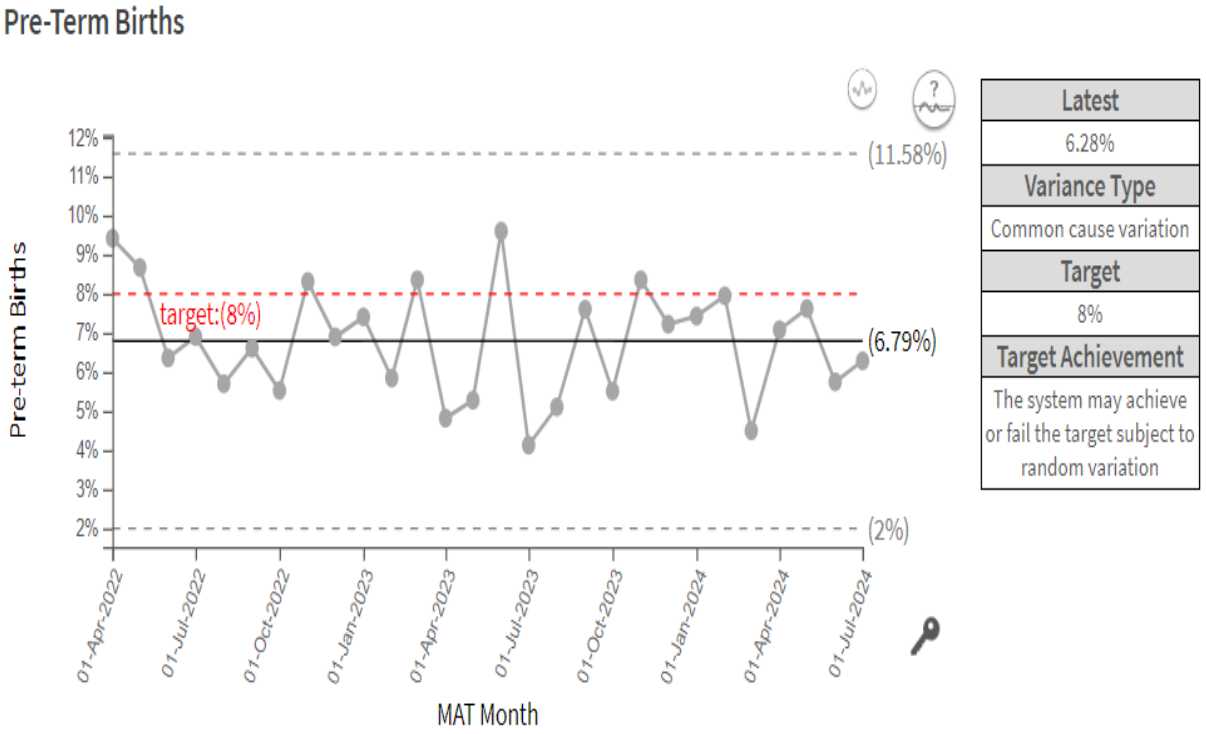
Actions:
- Implementation of MEOWS score for pregnant or postnatal women who are being cared for outside of the maternity setting
- Training sessions for key clinical areas outside of maternity setting
- Strengthening of pathway for management of pregnant or postnatal women who present to ED

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 8 months.

Underlying issues:
- No underlying issues have been identified.

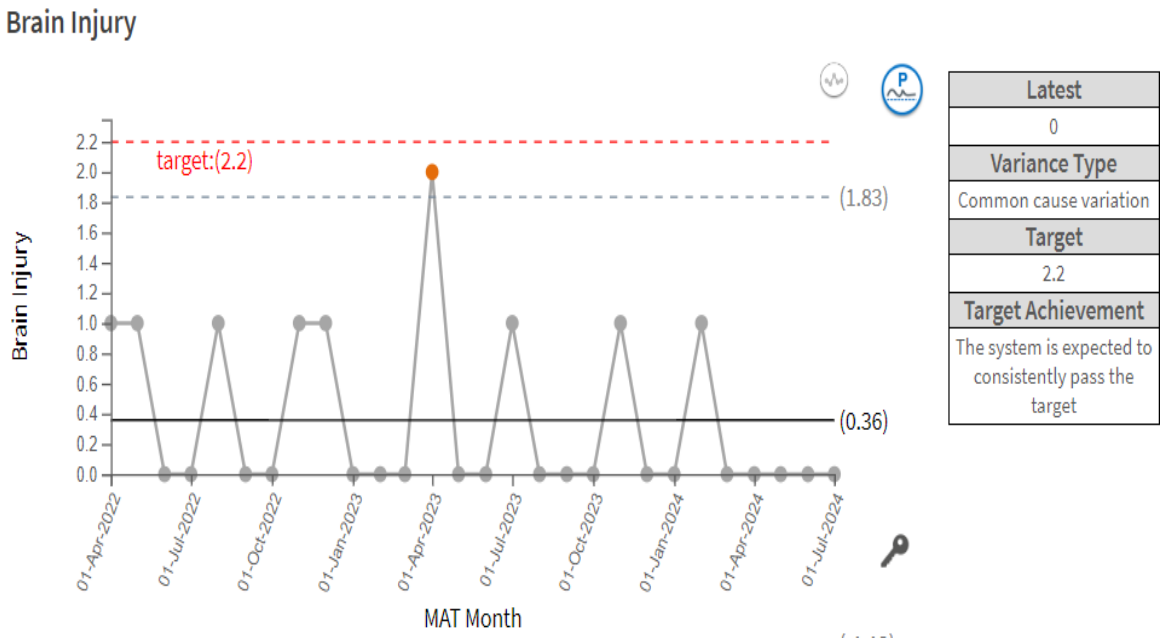
Actions:
- Continue to fully implement element 5 of Saving Babies Lives Bundle version 3.
- Continue review of all pre-term births where babies are born in a unit without the correct level of neonatal unit support.
- Continue to participate in LMNS pre-term birth workstream.
- Develop in-utero transfer 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.



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	July 2024	67.78%	70%			67.1%	50.9%	83.3%
Community Waiting List – over 52 weeks	July 2024	1,270	1,142 (Mar25)	-	-	-	-	-
Virtual Ward	July 2024	55%	80%			85.2%	49.3%	121.2%
Patients dying within their preferred place of death	July 2024	87.5%	80%			94.5%	85.4%	100%

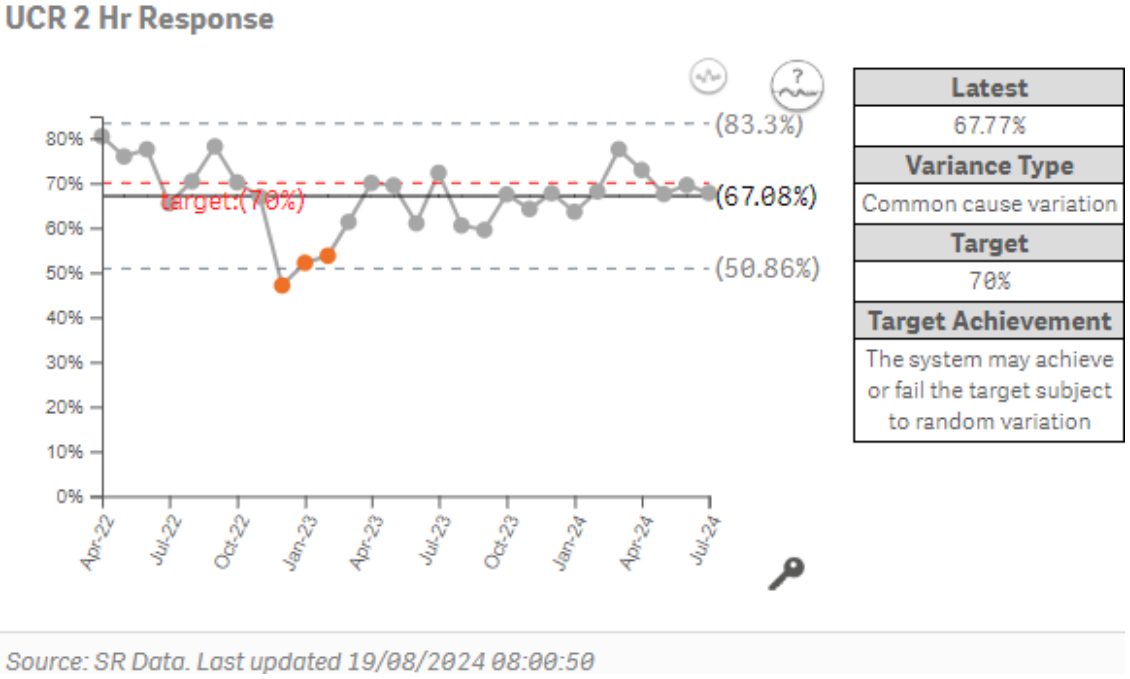
Proportion of Urgent Community Response referrals reached within two hours

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%.



Source: SR Data. Last updated 19/08/2024 08:00:50

What does the chart show/context:
- Current position for July 2024 is at 67.7%.

Underlying issues:
- Logging time of arrival is improving and less cases of obvious errors that affect data reporting, but reminders sent to team again as they are still occurring. Manual review of breached being completed every month to support accuracy or reporting into IPR.
- Complexity with LCD where their triage may mean that we have little time to get out to the properties – also some providers feeling it is a difficult and time-consuming process to do this and triage at LCD is taking too much time. Workshop organised with LCD to look at processes, what is accepted and how to ensure this is streamlined. Workshop taking place August 2024.

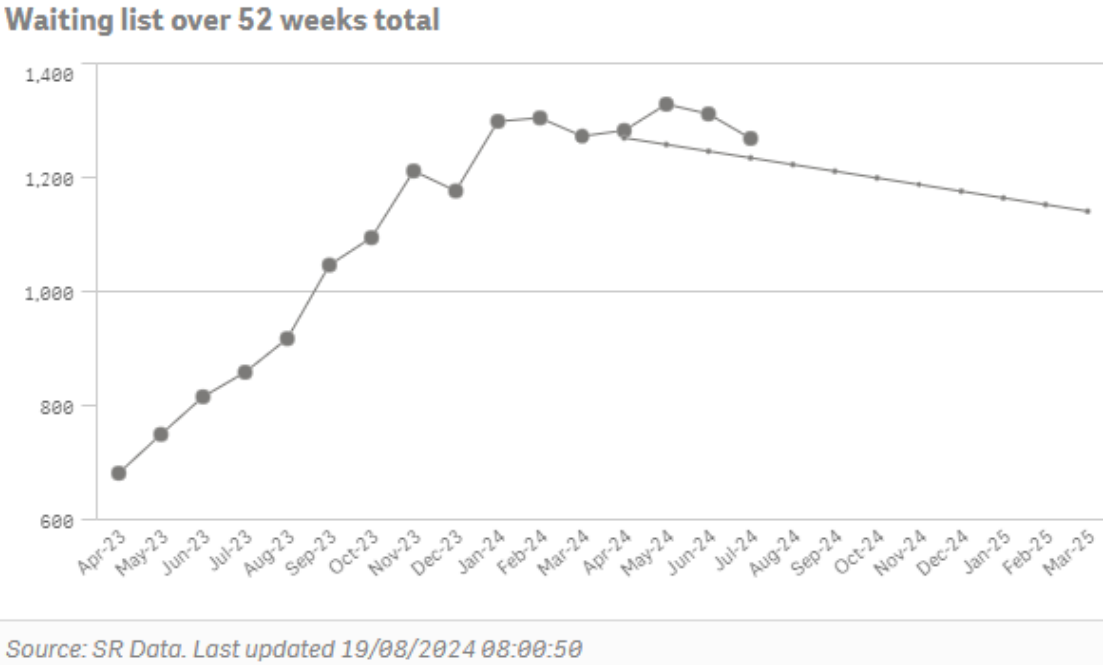
Actions:
- Communications to whole team around accurate data recording.
- Ongoing cases where 2 hours' time is taken by LCD to triage due to their processes therefore is out of the 2-hour window prior to reaching UCR – audit tool capturing these.
- Manual audit completed to examine the different elements of the 2-hour response – meeting arranged with LCD and primary care to go through the results.
- Continuing to attempt to increase referrals into the service and working with LCD and primary care to do this – audit completed and workshop now planned.
- Looking at "trusted" routes for other professionals into UCR to make the triage quicker when another healthcare professional had already assessed the patient. This will also be addressed at the workshop August 2024.

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:
- 1,270 total (all therapies) in July 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.

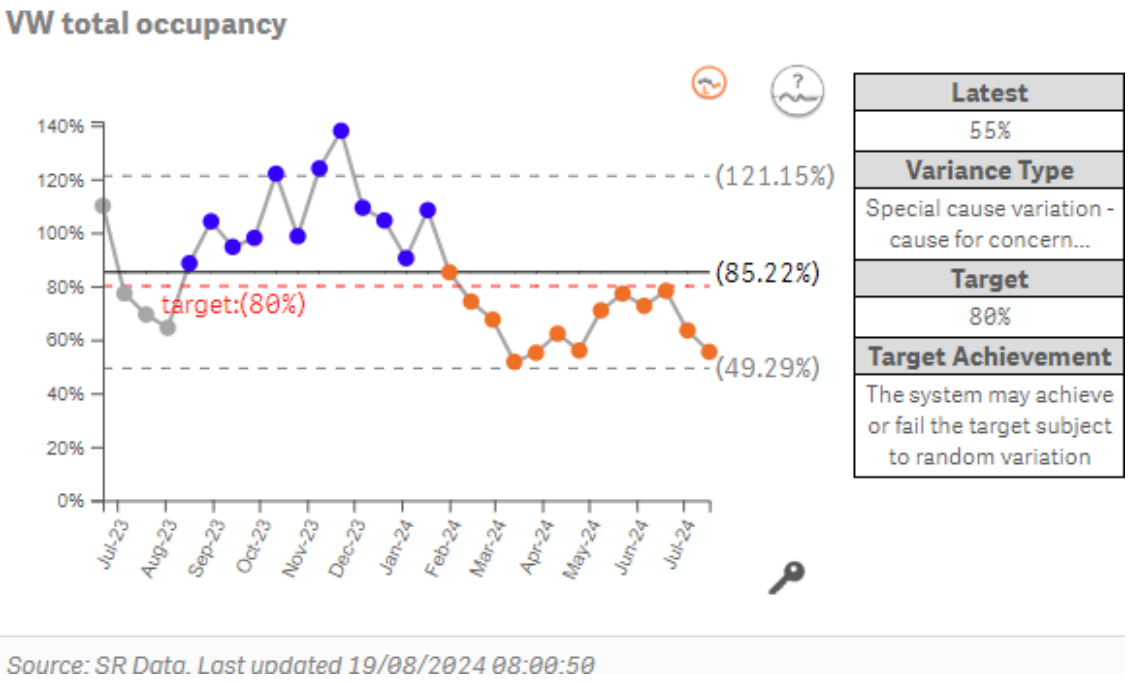
Virtual Ward

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 19/08/2024 08:00:50

What does the chart show/context:
- Current combined position for July 2024 is 55%.
- 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.

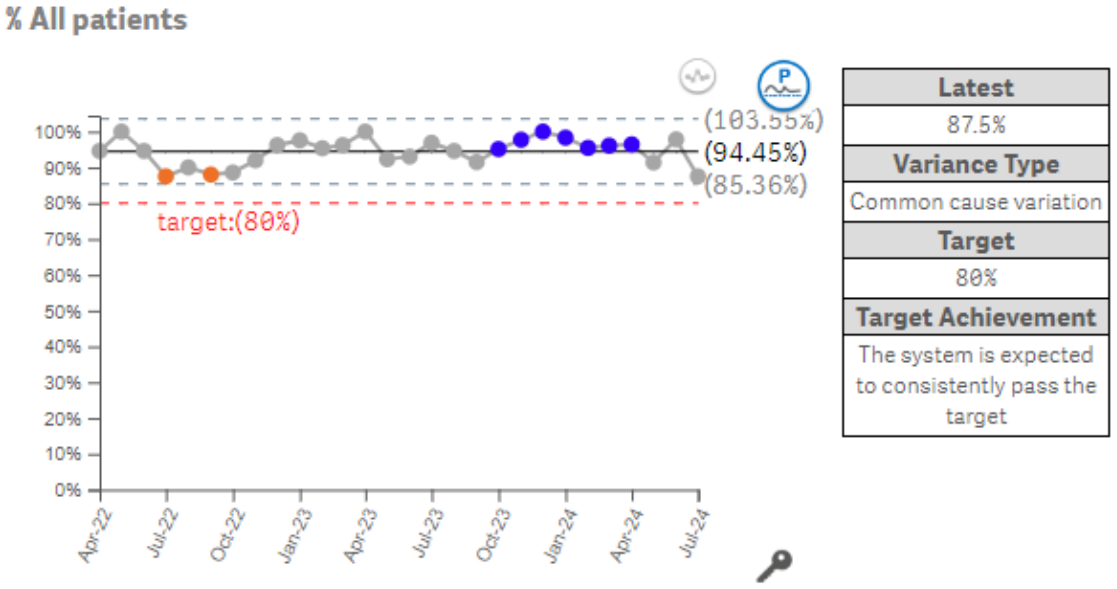
Patients dying within their preferred place of death

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 21/08/2024 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
- July 2024 total 87.5% (Out of Hours End of Life care 83.3% and Palliative 90%)
  100% died at 'home'.

Underlying issues:
- Workload pressures – high referral numbers and staff vacancies across all teams
- Acuity and complexity of need – patients are increasingly in urgent need of specialist intervention due to late presentation / diagnosis or multiple comorbidity.
- CSPCT continue to work additional hours to keep patients safe – limiting GP call-outs by utilising Independent Prescribing / assessment skills and coordinating care with Acute hospital teams to streamline patient interventions / reduce length of hospital stay (avoiding ED wherever possible).
- OOH EoLC – currently working extended hours for a further 12 months (March 2025) as result of successful Innovation bid. Need to secure funding to facilitate the new Workforce Model to include (in conjunction with existing joint service agreement with Marie Curie) from April 2025.
- HSPCT – significant staffing depletion requiring review of WFM to enable prompt review of patients to facilitate discharge to home / care home / hospice– Dashboard development ongoing.
- HSPCT In-Reach project funded by Calderdale ICB Innovation Bid commenced December 2023 – awaiting dashboard data – significant impact on facilitating patients back to home / care home or hospice – reduced in-patient admission and reduced length of stay improves achieving PPD.
- Care Home Palliative CNS project funded by Cald ICB Innov Bid commenced July 2023 –working in collaboration with QUEST - has improved patient safety and outcomes in ensuring patients not inappropriately admitted to hospital and supported to remain in care home setting.

Actions:
- To ensure continued funding for all teams (with review of WFM for HSPCT) to maintain this strong position of achieving preferred place of death, facilitating the vast majority to die at home, appropriate admission to hospice and reducing avoidable admissions and deaths in the acute hospital setting.

HEALTH INEQUALITIES

Calderdale and Huddersfield NHS Foundation Trust

1 Learning Disabilities

The report highlights disparities in cancer diagnosis, emergency care, and missed appointments (DNAs) for patients with Learning Disabilities, who face additional challenges like the need for capacity assessments, F2F appointments, and special care.

Workforce challenges also impact care quality. An audit revealed issues with the 'Was Not Brought' policy for missed appointments. Emails have been sent to divisional leads for action.

Making the right decision for the patient sometimes means not meeting the target for this population.

2 Deprivation IMD 1 & 2

The report identified a significant inequality in missed appointments, with patients from IMDs 1&2 having a higher rate of missed appointments (DNAs) on average. A pilot program aimed at reducing missed appointments in this population has been conducted, with results expected to be reviewed at the end of August.

While there is a potential risk of inequality in cancer faster diagnosis and 6-week diagnostics, these are exceptions, and the overall mean is in line with the Trust's standards. Monitoring will continue.

Although no measures have yet met the target, there has been improvement in both missed appointments and the 40-week RTT.

3 Ethnicity

The report highlights a clear inequality in missed appointments. A pilot program aimed at reducing missed appointments (DNAs) in IMDs 1 and 2 patients could benefit this population, where the disparity is the greatest compared to other groups.

While there is a risk of inequality in cancer faster diagnosis and 6-week diagnostics, these remain exceptions, with the overall mean aligning with Trust standards. Monitoring will continue.

Although no targets have been met yet, there have been improvements in both missed appointments and the 40-week RTT.

Learning Disabilities

NHS Calderdale and Huddersfield NHS Foundation Trust

Cancer Faster Diagnosis Standard

Current	Target	Trust Average
60%	77%	77.6%

VARIATION ASSURANCE

- Audit complete.
- Need capacity assessments, best interest meetings further investigation (endoscopy).
- F2F appointments deep sedation, general anaesthetic.
- Meets Legal requirement of MCA and Equality Act

- Inequality present
- Common cause variation
- May achieve or fail target

Patients waiting more than 40 weeks RTT

Current	Target	Trust Average
2.1%	0%	2.1%

VARIATION ASSURANCE

- LD flag added to 40-week RTT.
- Review of internal process to ensure LD patients are prioritised long-term.

- No inequality present
- Special cause variation - improving
- Consistently fails target

Patients waiting less than 6 weeks for a diagnostic test:

Current	Target	Trust Average
88.9%	95%	94.3%

VARIATION ASSURANCE

- Issues in Echocardiography & Neurophysiology.
- Other Modalities achieving the target.
- Risk of inequality to be monitored.
- Audit in progress, results to go to HI Meeting.

- No inequality present
- Common cause variation
- May achieve or fail target

Emergency Care standard

Current	Target	Trust Average
63%	76%	67.1%

VARIATION ASSURANCE

- Bed occupancy levels, more likely to need admission, presenting late, requiring reasonable adjustments and workforce issues.
- Further independent audit commissioned (audit Yorkshire).

- Inequality present - monitor
- Common cause variation
- Consistently fails target

Outpatient DNAs

Current	Target	Trust Average
6.7%	5%	6.1%

VARIATION ASSURANCE

- Audit completed, results reported to HI Meeting and SG Adults committee.
- Lack of awareness on 'was not brought', emails sent to divisional directors.

- Inequality present
- Common cause variation
- May achieve or fail target

Assessment:

IMPROVING **1/5**	ACTION NEEDED **2/5**
TARGET ACHIEVED **0/5**	INEQUALITY PRESENT **3/5**

Reporting Month: June 2024

Deprivation – IMD 1 and 2

Calderdale and Huddersfield NHS Foundation Trust

Cancer Faster Diagnosis Standard

VARIATION

ASSURANCE

- Issues in lower GI (56%) and H&N (62%).
- Ongoing work with teams closely monitor patients and address issues.
- Risk of inequality to be monitored.

- No inequality present
- Common cause variation
- May achieve or fail target
- Mean in line with Trust average

Patients waiting more than 40 weeks RTT

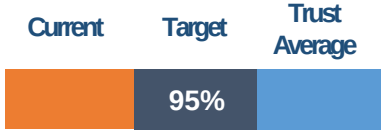
VARIATION

ASSURANCE

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

- No inequality present
- Special cause variation - improving
- Consistently fails target

Patients waiting less than 6 weeks for a diagnostic test:



VARIATION

ASSURANCE

- Issues in Echocardiography & Neurophysiology.
- Other Modalities achieving the target.
- Risk of inequality to be monitored.

- No inequality present
- Common cause variation
- May achieve or fail target

Emergency Care standard

VARIATION

ASSURANCE

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

- No Inequality present
- Common cause variation
- May achieve or fail the target

Outpatient DNAs

VARIATION

ASSURANCE

- Pilot calling IMD 1&2 patients to reduce DNAs in stage 2.
- Patient comms project to review letters.
- Targeted work with DNA outlier specialties.

- Inequality present
- Special cause variation - improving
- Consistently fails target
- Targeted work required

Assessment:

IMPROVING **2/5**	ACTION NEEDED **0/5**
TARGET ACHIEVED **0/5**	INEQUALITY PRESENT **1/5**

Reporting Month: June 2024

Ethnicity

Calderdale and Huddersfield NHS Foundation Trust

Cancer Faster Diagnosis Standard

Current	Target	Trust Average
70.4%	77%	77.6%

VARIATION 

ASSURANCE 

- Issues in lower GI (56%) and H&N (62%).
- Ongoing work with teams closely monitor patients and address issues.
- Risk of inequality to be monitored.

- No inequality present
- Common cause variation
- May achieve or fail target
- Mean in line with trust average

Patients waiting more than 40 weeks RTT

Current	Target	Trust Average
3.1%	0%	2.1%

VARIATION 

ASSURANCE 

- Mean sits slightly higher than Trust average.
- Continue monitoring Trust impacted by issues in Echocardiography and Neurophysiology.

- Slight inequality present
- Special cause variation - improving
- Consistently fails target

Patients waiting less than 6 weeks for a diagnostic test:

Current	Target	Trust Average
90.7%	95%	94.3%

VARIATION 

ASSURANCE 

- Issues in Echocardiography & Neurophysiology.
- Other Modalities achieving the target.
- Risk of inequality to be monitored.

- No inequality present
- Common cause variation
- May achieve or fail target

Emergency Care standard

Current	Target	Trust Average
71.2%	76%	67.1%

VARIATION 

ASSURANCE 

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

- No inequality present
- Common cause variation
- May achieve or fail target

Outpatient DNAs

Current	Target	Trust Average
8.5%	5%	6.1%

VARIATION 

ASSURANCE 

- Reducing missed appointments HI pilot complete, data analysis in September.
- Patient comms project.
- Targeted work with outlier specialties.

- Inequality present
- Special cause variation - improving
- Consistently fails target
- Targeted work required

Assessment:

IMPROVING **2/5**	ACTION NEEDED **0/5**
TARGET ACHIEVED **0/5**	INEQUALITY PRESENT **2/5**

Reporting Month: June 2024

Health Inequalities:

Metric		Latest Month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Cancer Faster Diagnosis (FDS)	Overall	June 2024	77.63%	77%			76.9%	68.9%	84.8%
	Learning Disability		60%				59.6%	0%	100%
	IMD 1 and 2		74.24%				75%	62.6%	87.3%
	Ethnicity		70.41%				76%	65.3%	86.7%
40-week Referral to Treatment (RTT)	Overall	June 2024	2.1%	0%			6.1%	4.4%	7.7%
	Learning Disability		2.1%				4.8%	1.8%	7.8%
	IMD 1 and 2		2.5%				6.6%	5.1%	8.2%
	Ethnicity		3.1%				7.2%	5.1%	9.3%
6-week Diagnostic Test	Overall	June 2024	94.3%	95%			88.4%	82.5%	94.3%
	Learning Disability		88.9%				83.7%	57.2%	100%
	IMD 1 and 2		90.7%				83.4%	65.8%	100%
	Ethnicity		90.7%				83.3%	65.0%	100%

Health Inequalities:

Metric		Latest Month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
4 Hour	Overall	June 2024	67.1%	76%			68.5%	60.4%	76.7%
Emergency	Learning Disability		63.0%				59.2%	45.5%	73.0%
Care	IMD 1 and 2		67.5%				69.7%	61.9%	77.5%
Standard	Ethnicity		71.2%				73.8%	64.7%	83.0%
% Did	Overall	June 2024	6.1%	5%			7.01%	6.34%	7.67%
Not	Learning Disability		6.7%				9.27%	4.34%	14.20%
Attend	IMD 1 and 2		8.7%				9.98%	8.71%	11.25%
(DNA)	Ethnicity		8.5%				10.11%	8.66%	11.55%

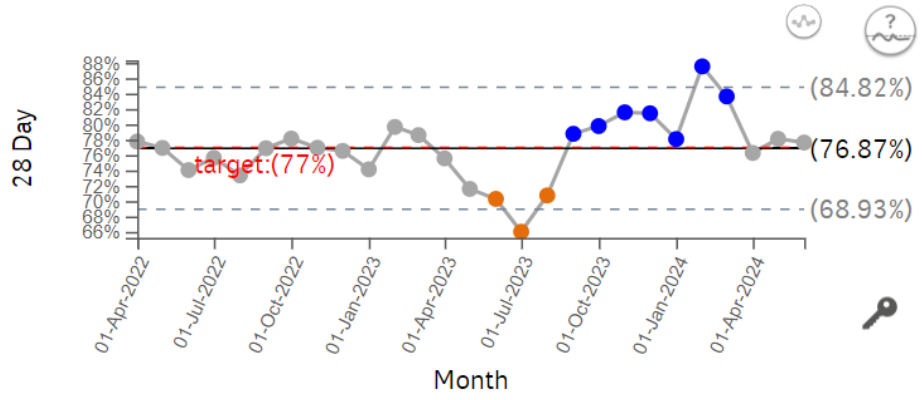
Faster Diagnosis Standard: Health Inequalities

Calderdale and Huddersfield NHS Foundation Trust

Overall:

28 Day Performance SPC

% performance over time for the 28 Day standard

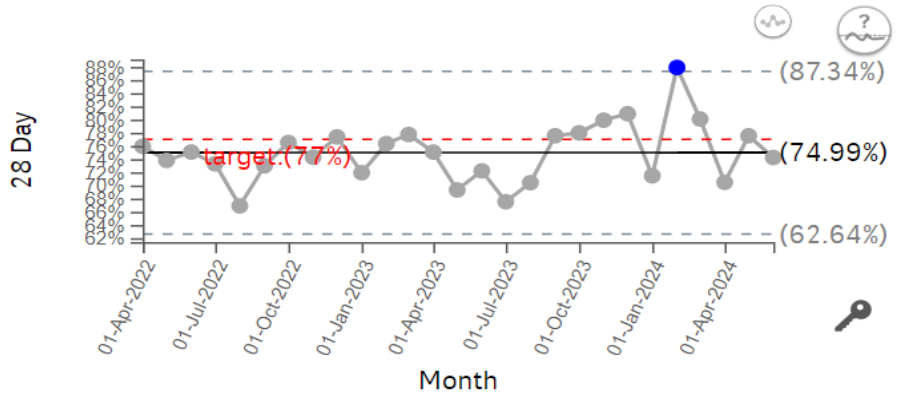


Latest
77.63%
Variance Type
Common cause variation
Target
77%
Target Achievement
The system may achieve or fail the target subject to random variation

Deprivation – IMD 1 and 2:

28 Day Performance SPC

% performance over time for the 28 Day standard

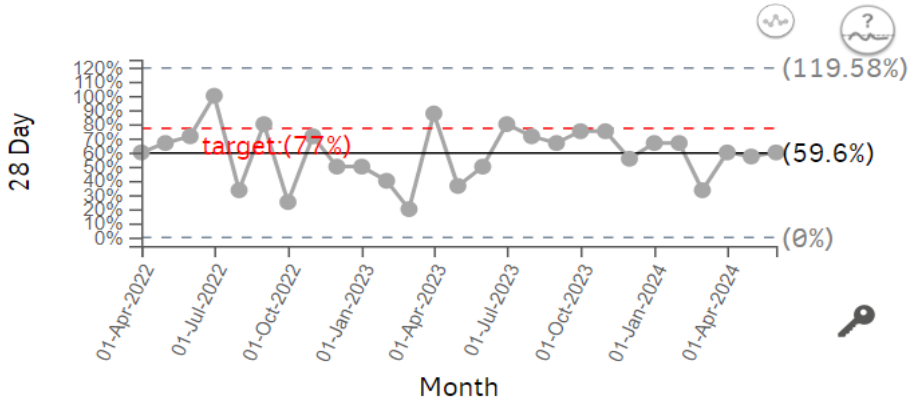


Latest
74.24%
Variance Type
Common cause variation
Target
77%
Target Achievement
The system may achieve or fail the target subject to random variation

Learning Disabilities:

28 Day Performance SPC

% performance over time for the 28 Day standard

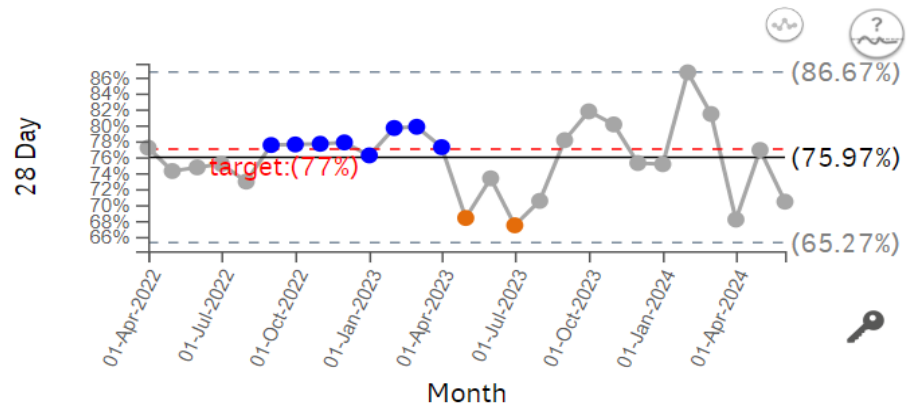


Latest
60.00%
Variance Type
Common cause variation
Target
77%
Target Achievement
The system may achieve or fail the target subject to random variation

Ethnicity:

28 Day Performance SPC

% performance over time for the 28 Day standard

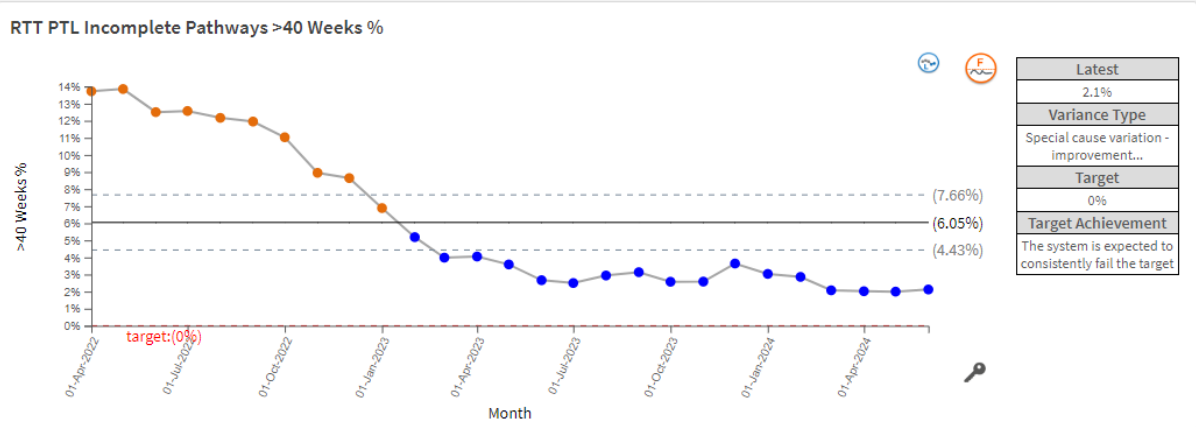


Latest
70.41%
Variance Type
Common cause variation
Target
77%
Target Achievement
The system may achieve or fail the target subject to random variation

Proportion of patients waiting more than 40 weeks to start consultant-led treatment

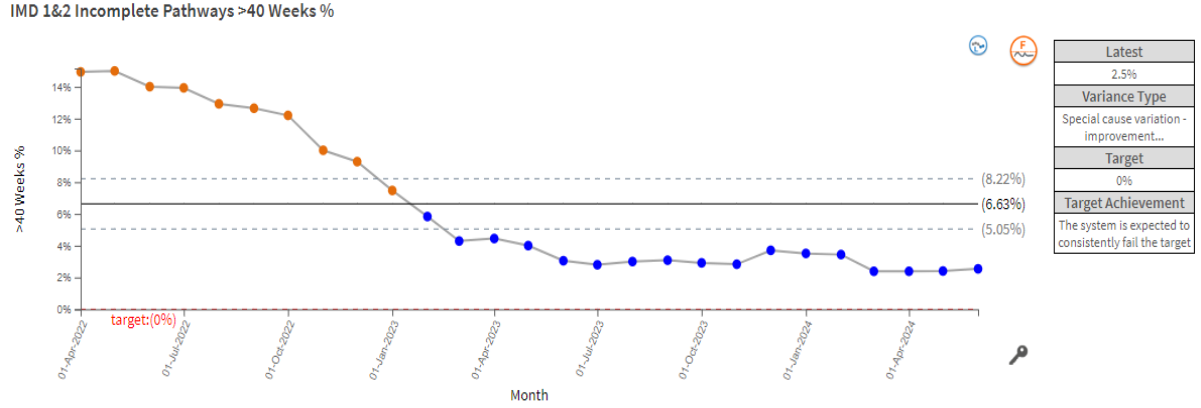
Calderdale and Huddersfield NHS Foundation Trust

Overall:



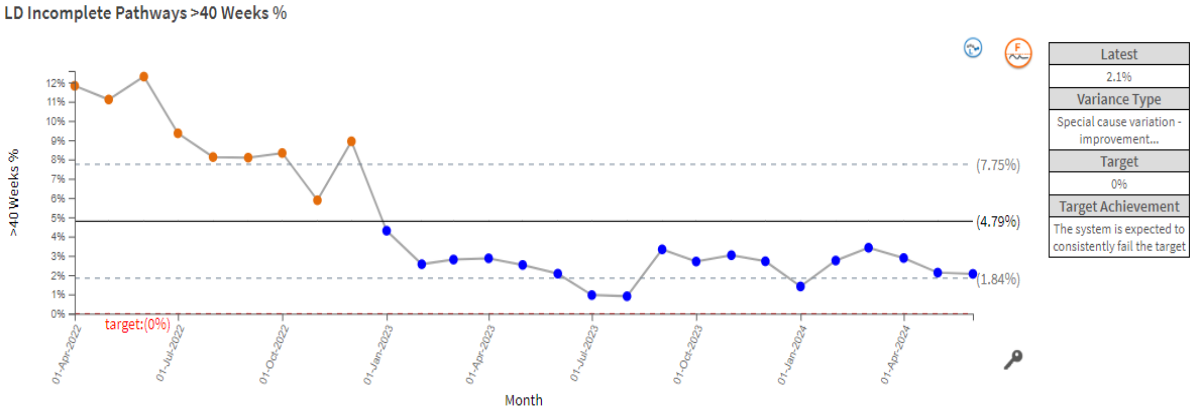
Source: RTT Incomplete Waiting Times - Last updated: 18/07/2024 15:21:18

Deprivation – IMD 1 and 2:



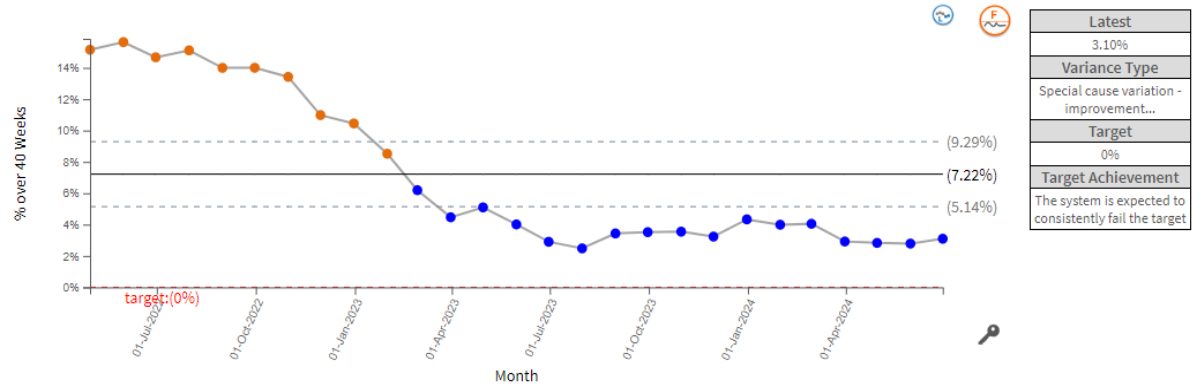
Source: RTT Incomplete Waiting Times - Last updated: 18/07/2024 10:45:29

Learning Disabilities:



Source: RTT Incomplete Waiting Times - Last updated: 18/07/2024 10:45:29

Ethnicity:

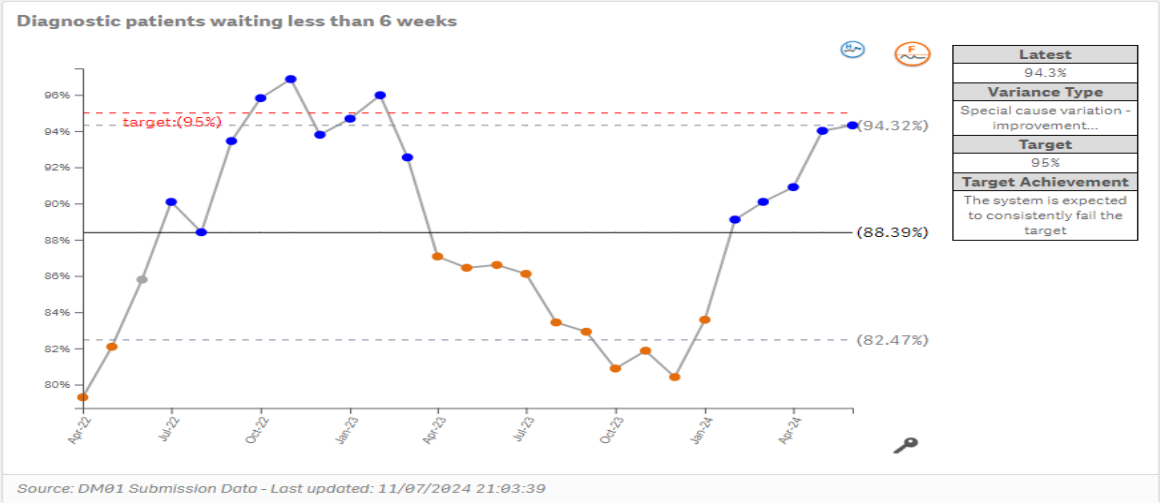


Source: RTT Incomplete Waiting Times - Last updated: 24/07/2024 09:22:45

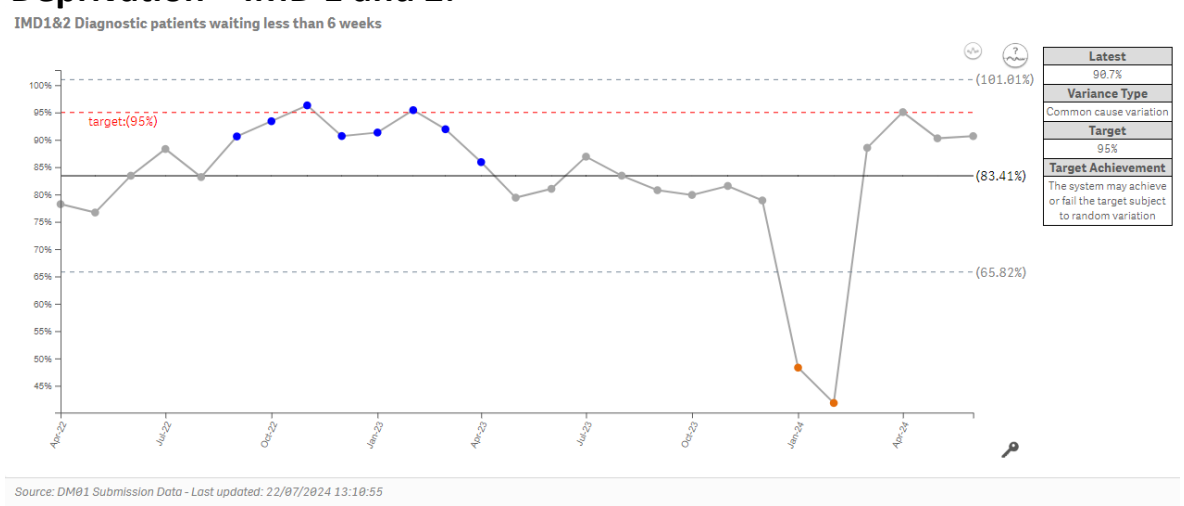
Percentage of patients waiting less than 6 weeks for a diagnostic test

Calderdale and Huddersfield NHS Foundation Trust

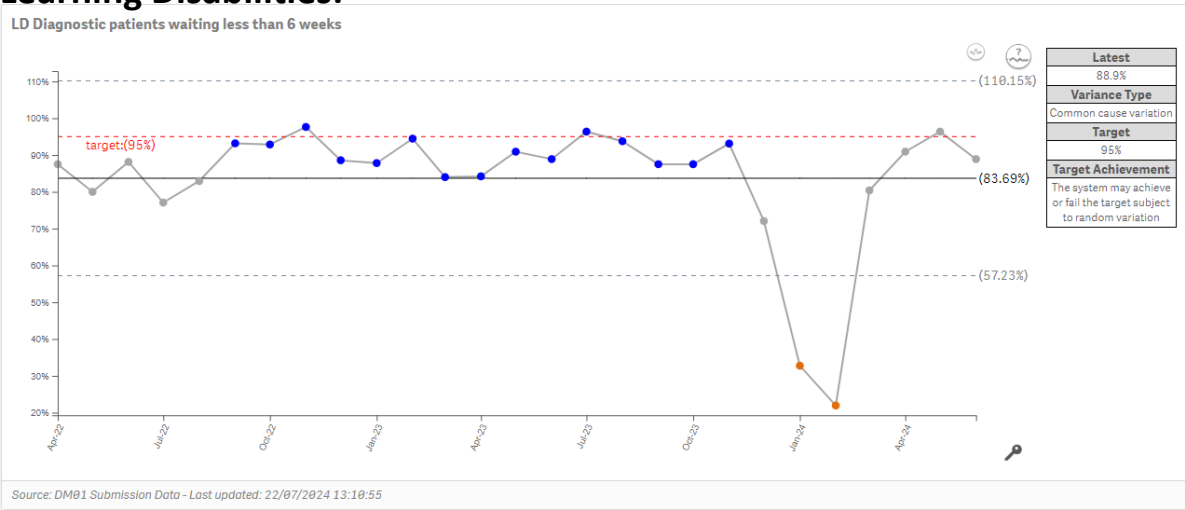
Overall:



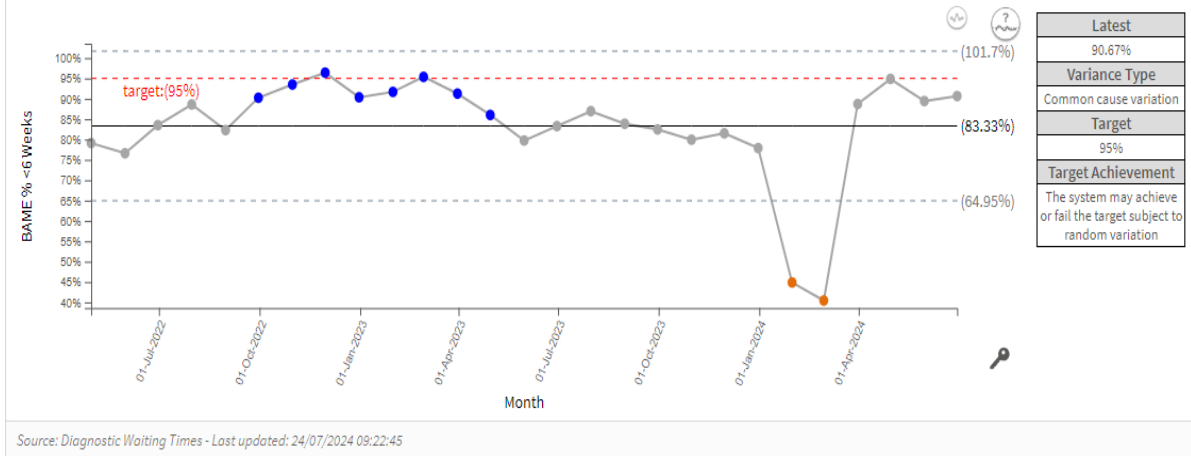
Deprivation – IMD 1 and 2:



Learning Disabilities:



Ethnicity:

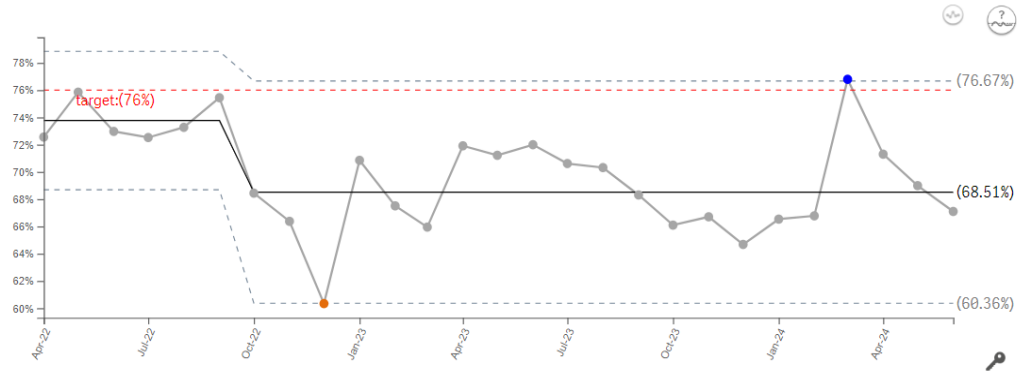


Emergency Care Standard

Calderdale and Huddersfield NHS Foundation Trust

Overall:

Proportion of patients who are admitted, transferred or discharged within 4 hours

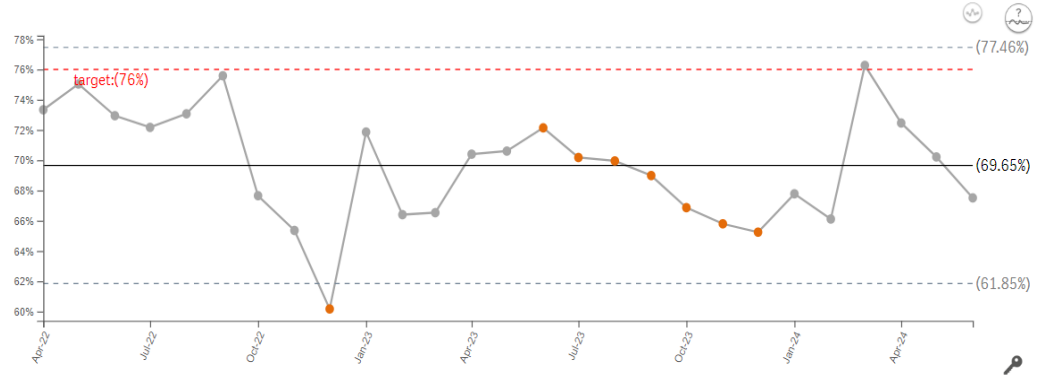


Latest
67.10%
Variance Type
Common cause variation
Target
76%
Target Achievement
The system may achieve or fail the target subject to random variation

Source: UEC Sitrep/YAS data - Last updated: 15/07/2024 21:03:37

Deprivation – IMD 1 and 2:

Proportion of IMD1&2 patients who are admitted, transferred or discharged within 4 hours

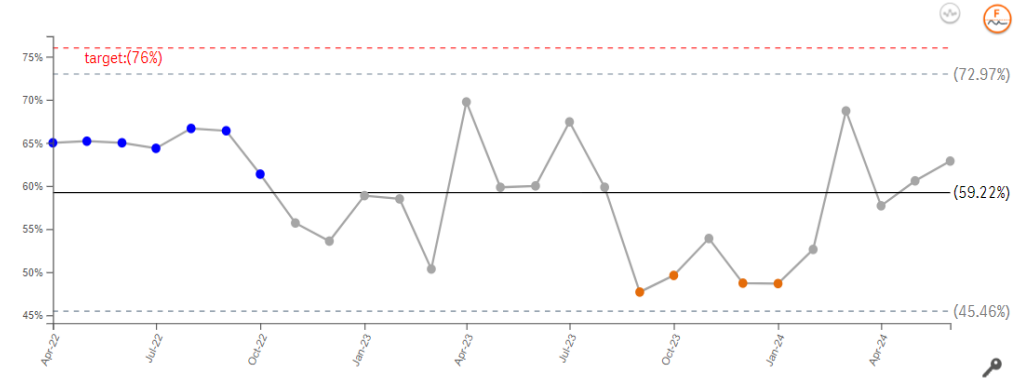


Latest
67.5%
Variance Type
Common cause variation
Target
76%
Target Achievement
The system may achieve or fail the target subject to random variation

Source: UEC Sitrep/YAS data - Last updated: 15/07/2024 21:03:37

Learning Disabilities:

Proportion of LD patients who are admitted, transferred or discharged within 4 hours

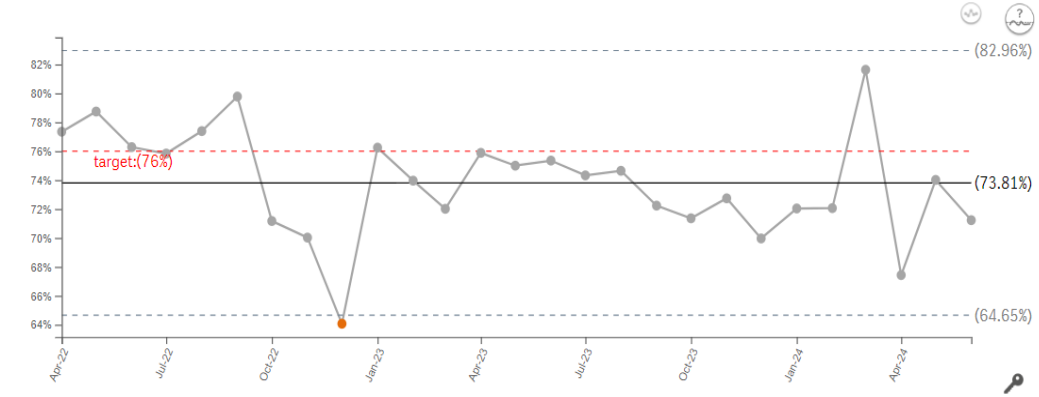


Latest
63%
Variance Type
Common cause variation
Target
76%
Target Achievement
The system is expected to consistently fail the target

Source: UEC Sitrep/YAS data - Last updated: 15/07/2024 21:03:37

Ethnicity:

Proportion of Ethnicity patients who are admitted, transferred or discharged within 4 hours



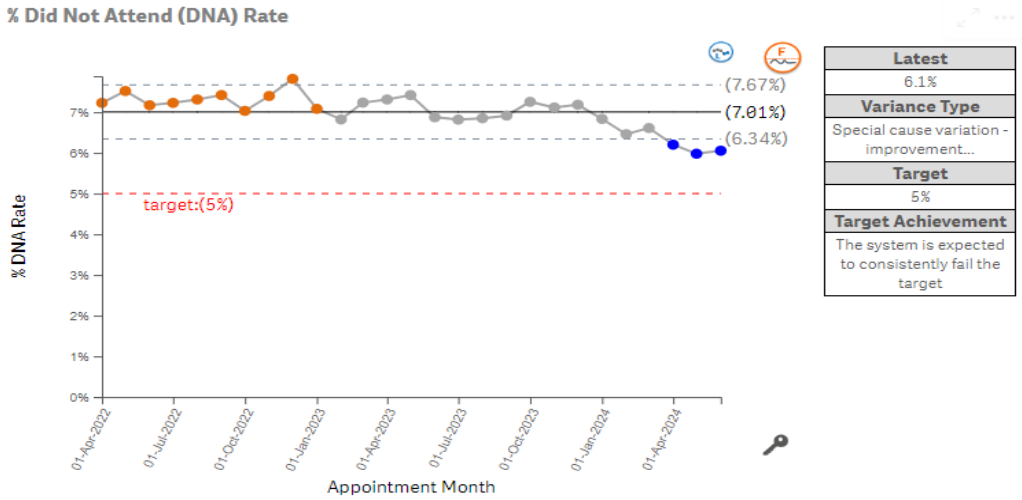
Latest
71.2%
Variance Type
Common cause variation
Target
76%
Target Achievement
The system may achieve or fail the target subject to random variation

Source: UEC Sitrep/YAS data - Last updated: 22/07/2024 21:03:32

% Outpatient Did Not Attend (DNA)

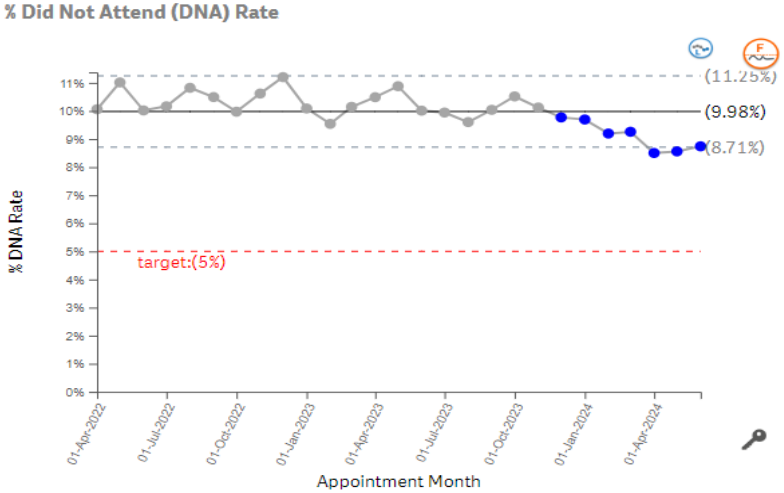
Calderdale and Huddersfield NHS Foundation Trust

Overall:



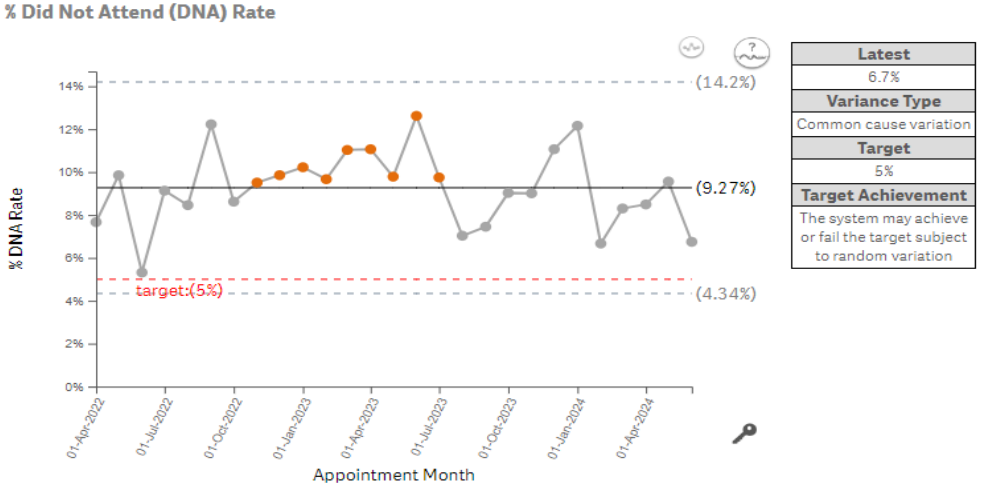
Latest
6.1%
Variance Type
Special cause variation - improvement...
Target
5%
Target Achievement
The system is expected to consistently fail the target

Deprivation – IMD 1 and 2:



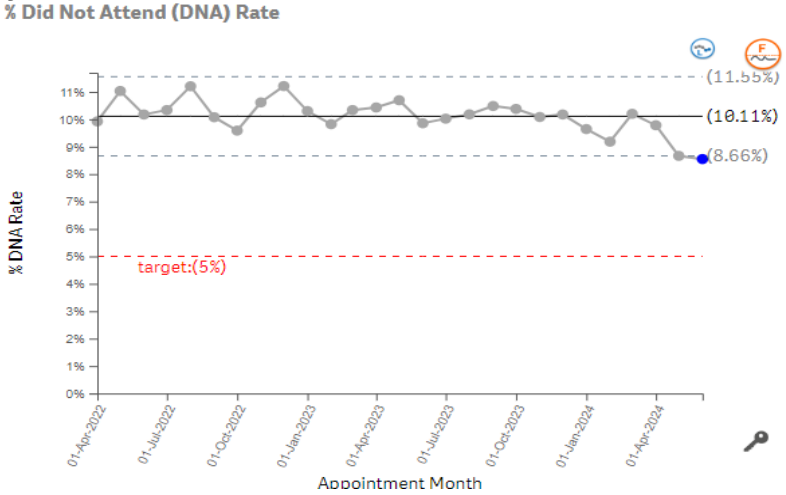
Latest
8.7%
Variance Type
Special cause variation - improvement...
Target
5%
Target Achievement
The system is expected to consistently fail the target

Learning Disabilities:



Latest
6.7%
Variance Type
Common cause variation
Target
5%
Target Achievement
The system may achieve or fail the target subject to random variation

Ethnicity:



Latest
8.5%
Variance Type
Special cause variation - improvement...
Target
5%
Target Achievement
The system is expected to consistently fail the target

Workforce:

Calderdale and Huddersfield NHS Foundation Trust

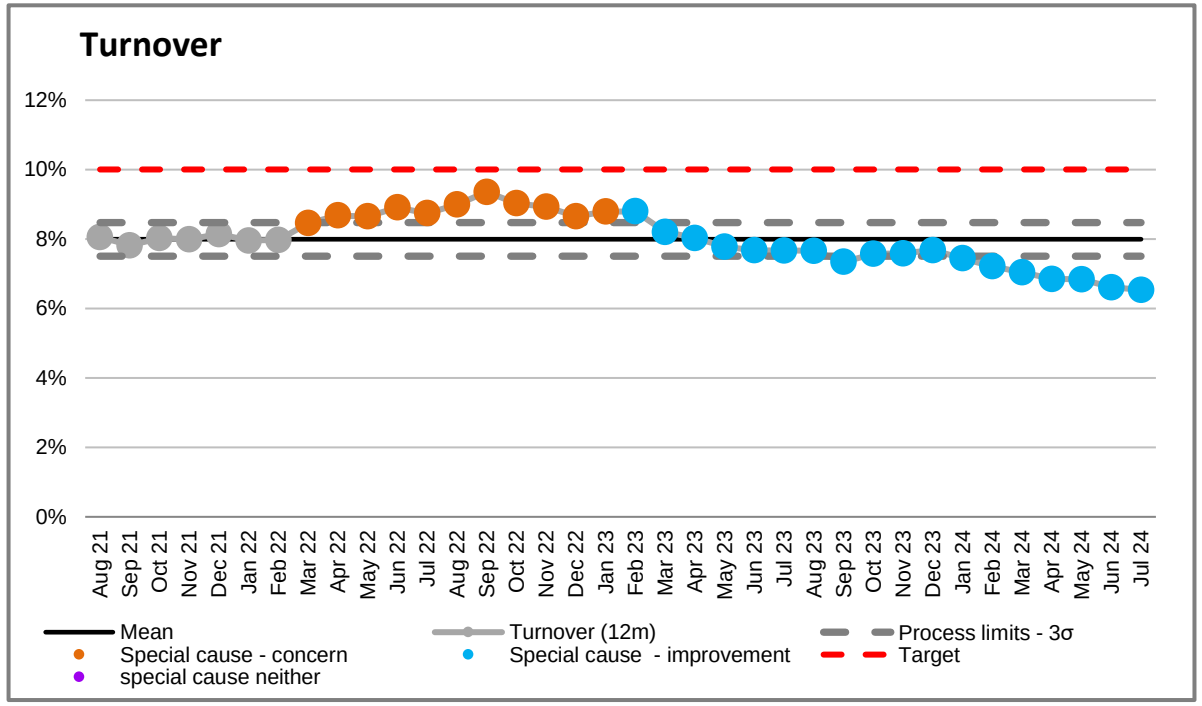
Metric	Latest Month	Measure	Target / Ceiling	Variation	Assurance	Mean	Lower process limit	Upper process limit
Staff Movement (Turnover)	July 2024	6.54%	10.00%			7.99%	7.51%	8.48%
Sickness Absence	July 2024	4.61%	4.50%			5.40%	4.09%	6.71%
Appraisal Compliance (YTD)	July 2024	31.90%	90.00%	-	-	-	-	-
Core EST Compliance	July 2024	93.47%	90.00%			93.40%	92.38%	94.42%
Bank Spend	July 2024	£3.21M	-		-	£3.17M	£2.11M	£4.24M
Agency Spend	July 2024	£0.52M	£0.76M		-	£0.83M	£0.46M	£1.19M

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: 6.54%**



What does the chart show/context:
- Total FTE lost due to colleagues leaving all employment with the Trust against the average headcount of the reporting period.
- Turnover is consistently below the Trust ceiling of 10.00%.
- Current turnover rate is below the mean average at 6.95%.
- The Trust benchmarks well against other WYAAT organisations.

Underlying issues:
- Directorates with turnover above the 10% ceiling include Workforce and OD (15.7%), FSS Management (13.4%) and Quality (10.9%).
- Healthcare Scientists and Trust Grade Doctors also have turnover rates above the ceiling rate.

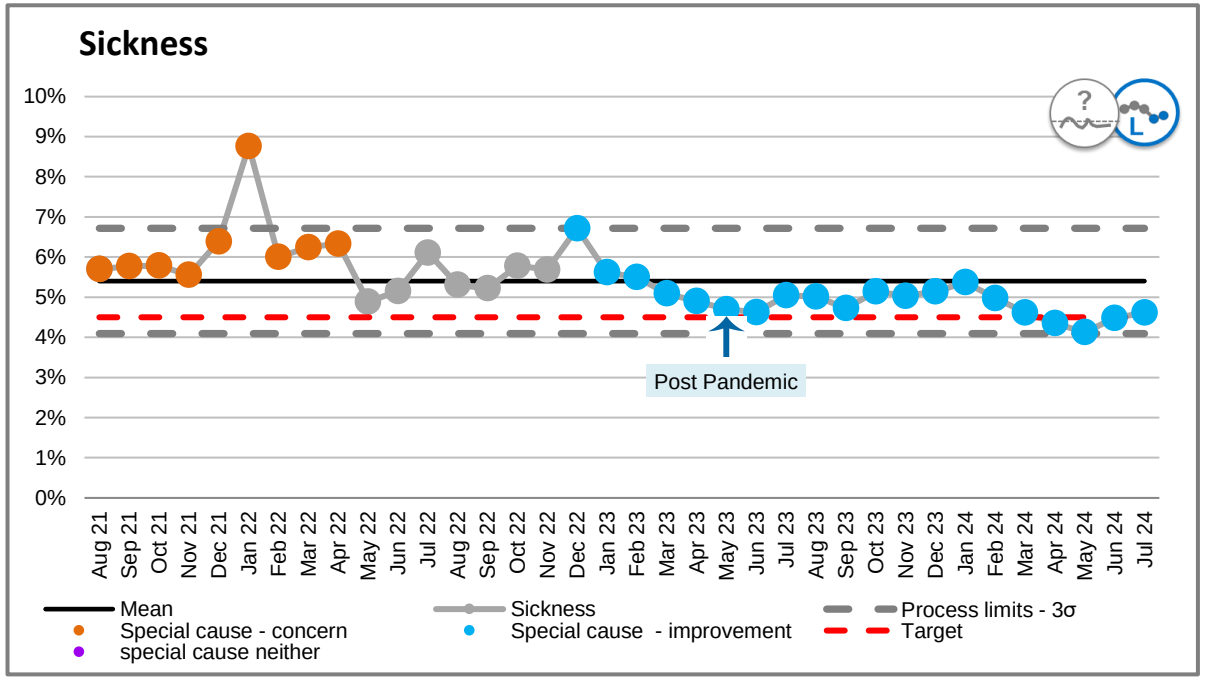
Actions:
- Trust level and local level activities underway to continue to improve the Trust retention, turnover and stability rates. These actions include:-
  - Task and finish group to review approach to exit interviews and questionnaires.
  - Review and improve ‘stay conversation.
  - Review of workforce 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**	**4.61% (in month)**	**4.80% (12m)**
		Long	**2.64% (in month)**	**2.90% (12m)**
		Short	**1.97% (in month)**	**1.90% (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 July 2024 – Anxiety/Stress/Depression, Gastrointestinal Problems and Other musculoskeletal problems

Actions:

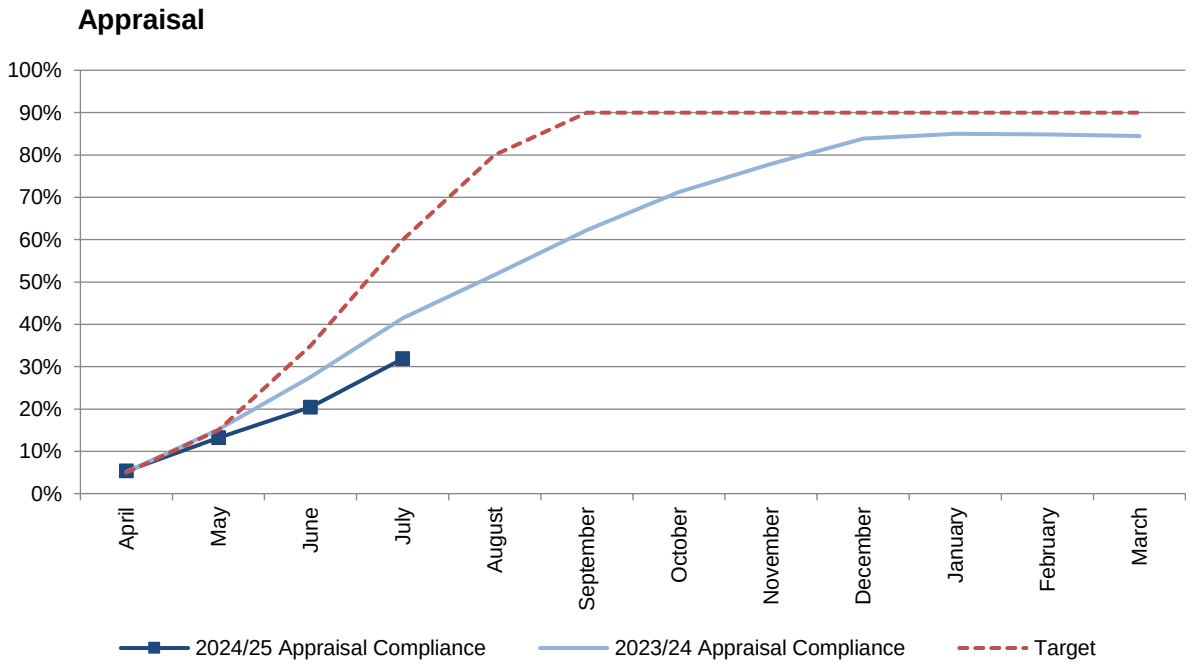
- HR teams regularly review all open ended LTS cases to ensure timely actions are taken and that where for example cases relate to an MSK issue that colleagues are aware of self-referral options for internal physiotherapy.
- Any identified hotspot areas undertake a deep dive to review cases and where 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.
- Updated guidance for H&WB support has been shared across divisions to ensure colleagues are aware of the new employee assistance programme.
- Corporate WOD colleagues are leading workforce redesign workshops with stakeholders to improve processes around attendance management. Two workshops have been on 10th May and 30th June with further workshops scheduled during August 2024.
- Corporate WOD are analysing and reviewing hotspot areas on a monthly basis. A number of areas have been identified which would give the greatest return if there is focussed attention from divisions.

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), 60.00% (in month) **Current: 31.90% (in month)**



What does the chart show/context:
- Appraisal compliance is below the in-month planned position at 31.90%.
- Appraisal compliance is performing 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.

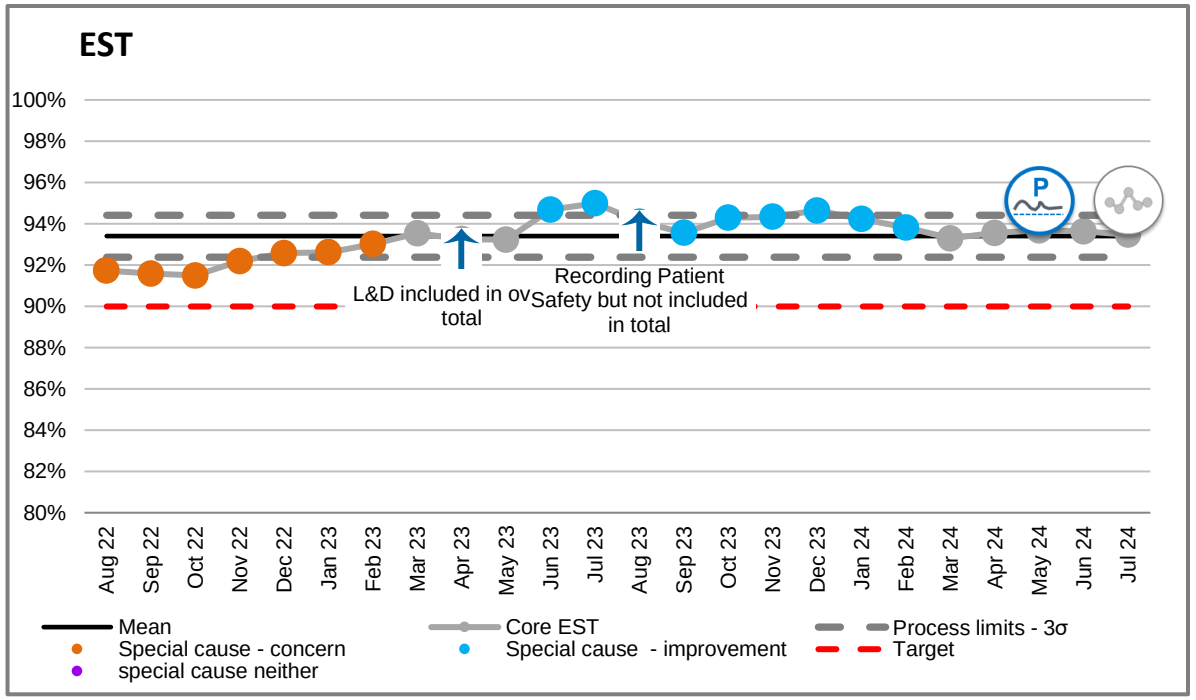
Actions:
- ‘How to’ guide to appraisals video now available as part of our management fundamentals offer, to make it a more people centred conversation.
- New to manager programme launch features appraisals in content.
- ESR recording guidance produced to support managers to ensure all activity is captured.
- 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: 93.47%**



What does the chart show/context:
- The Trust is consistently achieving the 90% target; EST compliance is slightly below the 95% stretch target at 93.47%

Underlying issues:
- Safeguarding Adults and Childrens compliance has dropped below 90%, this is likely due to a review of RST as safeguarding is tiered learning.

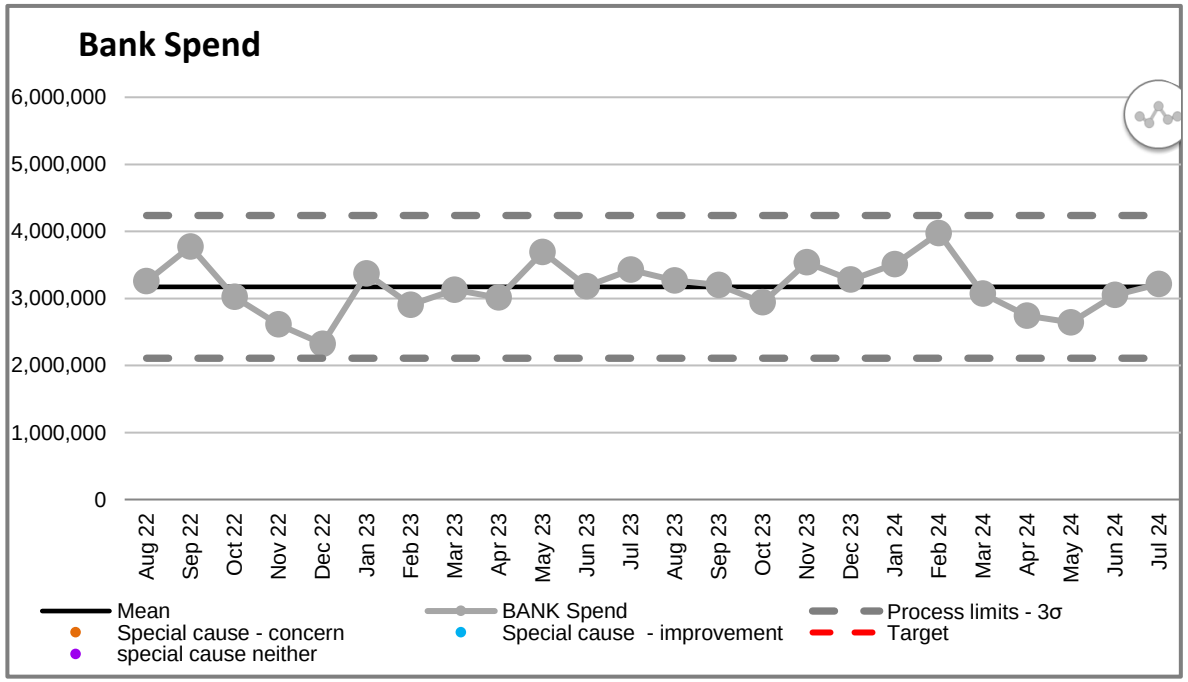
Actions:
- Compliance rates are shared with Directorates on a weekly basis.
- Enhanced Divisional accountability.
- Local campaigns to focus on mandatory learning in Divisions.
- Task and Finish group is being formed to review RST and progress will be fed back to the Education Committee.

Bank Spend

Executive Owner: Suzanne Dunkley Lead: Samuel Hall Business Intelligence Lead: Mark Bushby

Rationale:
It is important for the Trust to monitor Bank staff spend as it can help to minimise temporary staffing costs ensuring value for money and compliance.

Current: £3.21M



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 £3.21M in July 2024, an increase from £3.05M in June.

Underlying issues:
- There is a dependency on bank to support the running of extra capacity areas that flex open and closed.
- Bank and Agency workers support in covering unplanned absences (sickness etc)

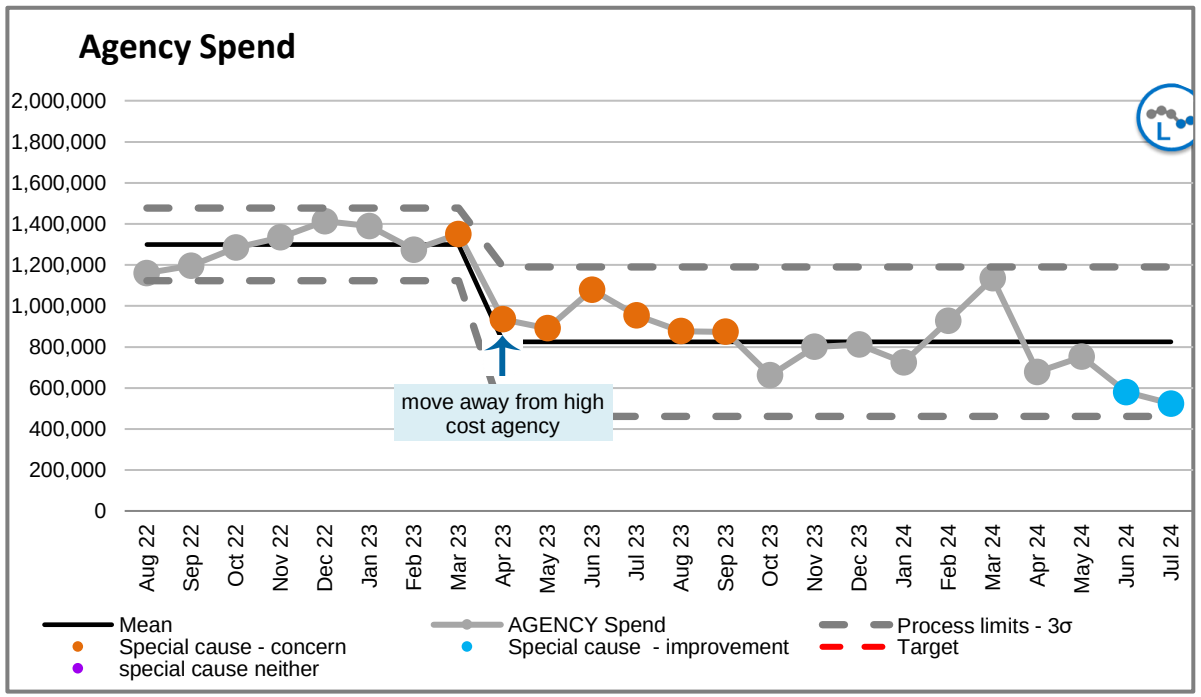
Actions:
- Bank and Agency CIP group established and closely monitoring Temporary Staffing usage throughout the organisation
- Checklist of enablers for managing bank and agency use has been implemented in divisions.
- Bank & agency activity and spend dashboards and trackers are embedded in divisions to support targeted approach to removal.

Agency Spend

Executive Owner: Suzanne Dunkley | Lead: Samuel Hall | Business Intelligence Lead: Mark Bushby

Rationale:
It is important for the Trust to monitor Agency staff spend as it can help to minimise temporary staffing costs ensuring value for money and compliance and can encourage the recruitment and retention of staff.

Target: £0.76M **Current: £0.52M**



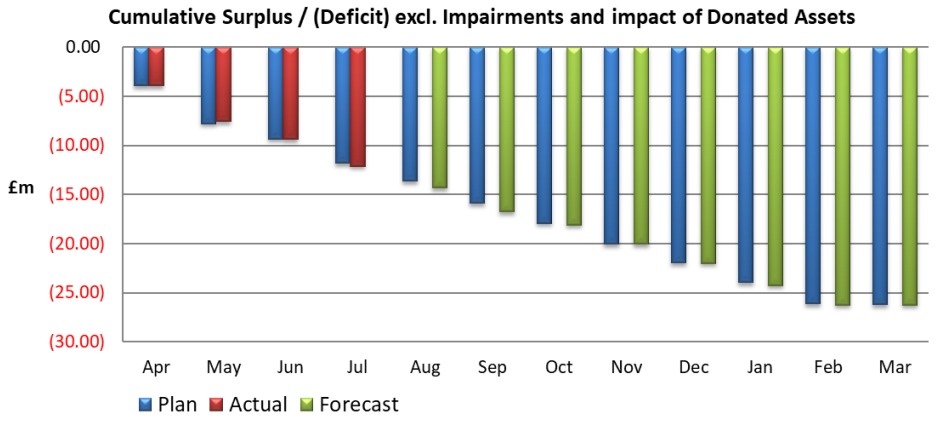
What does the chart show/context:
- The Trust moved away from high-cost agency during April 2023.
- Agency spend is now following normal cause variation from October 2023.
- Spend in July 2024 at £0.52m.
- Agency usage in July at lowest point in 2 years

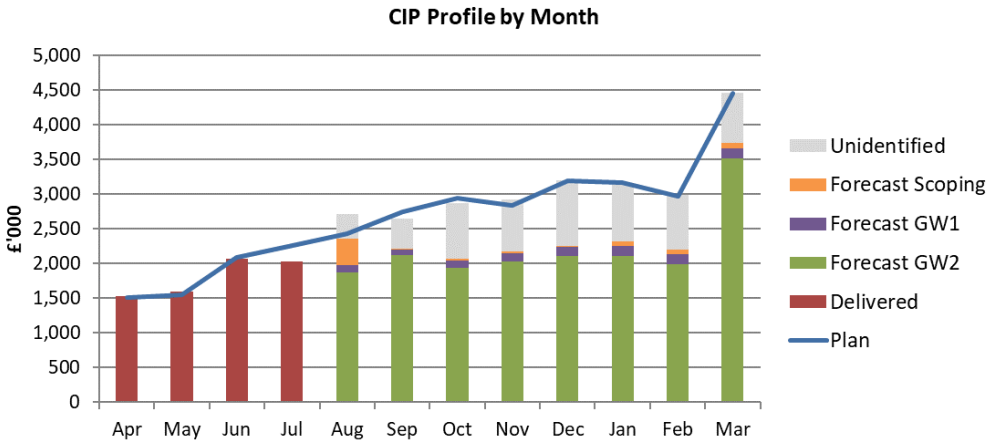
Underlying issues:
- Bank and Agency workers support in covering unplanned absences (sickness etc).

Actions:
- Bank & Agency CIP Workstream meets weekly to review bank and agency use across all divisions.
- Checklist of enablers for managing bank and agency use has been implemented in divisions.
- Bank & agency activity and spend dashboards and trackers are embedded in divisions to support targeted approach to removal.
- Consideration of Direct Engagement model to generate saving for agency medical staff
- Nursing agency lead time reduced further as part of agency retraction plan to reduce agency usage.
- Nursing Agency Retraction Plan in place, automatic agency cascade removed and shifts sent to agency subject to ADN approval.

Financial Performance

Executive Owner: Gary Boothby Finance Lead: Kirsty Archer





Rationale:

- To monitor year to date and forecast performance against the 2024/25 financial plan and efficiency target

Target:

- The Trust has a plan for a £26.26m deficit. 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 £12.14m, an adverse variance to plan of £0.29m. The Trust has delivered efficiency savings of £7.23m year-to-date, £0.19m less than planned.

Underlying issues:

- The Trust incurred additional direct costs of £0.45m in June / July due to the Junior Doctors Strike. Elective Recovery Funding is £1.15m lower than the stretch target assumed in planning, including c. £0.30m impact of the Industrial Action, compounded by additional bed capacity open above planned levels. These adverse variances have been offset by other mitigations in the year-to-date position including higher than planned commercial income and additional income from Interest.
- The CIP challenge will increase significantly in future months due to the profiling of planned savings. Achievement of the 2024/25 plan will require a significant improvement in the run-rate through full delivery of targeted savings.

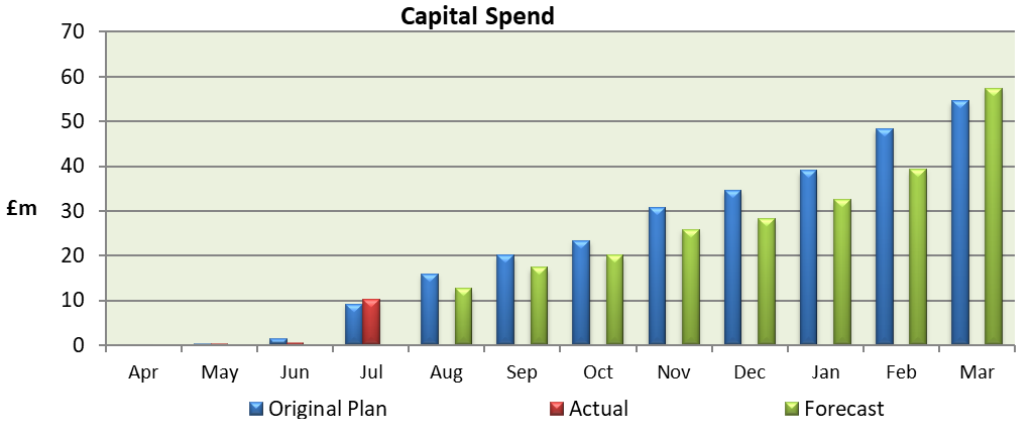
Actions:

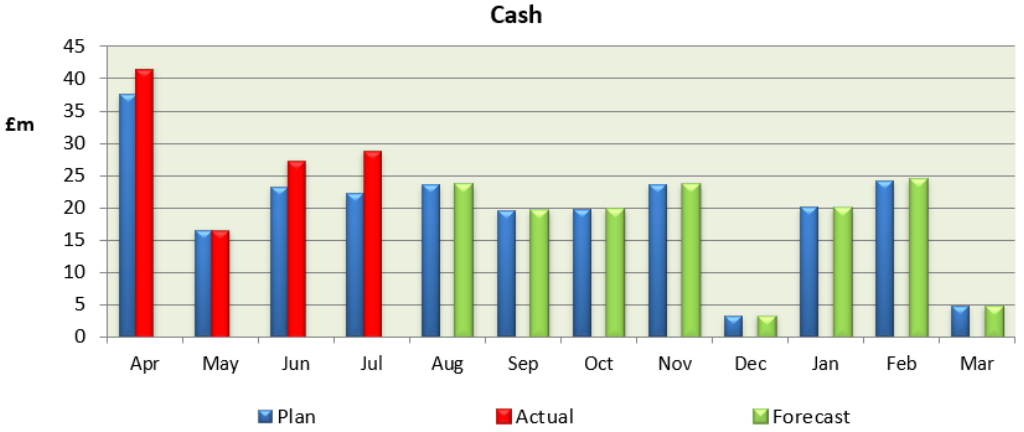
- The focus is on generating and implementing plans for the level of unidentified CIP, delivering the 2024/25 financial plan and maintaining strengthened grip and control measures including: Headcount reduction plans; Bank and Agency expenditure reduction; and Non-Pay expenditure controls.

Financial Performance: Capital, Cash and Use of Resources

Calderdale and Huddersfield NHS Foundation Trust

Executive Owner: Gary Boothby Finance Lead: Kirsty Archer





Use of Resources Metric:	24/25 Plan: 3	24/25 Actual: 3

Rationale:

- To monitor year to date and forecast Capital expenditure, Cash balance and Use of Resources metric against the 2024/25 financial plan.

Target:

- The Trust Capital Plan for 2024/25 is £54.58m. The planned Revenue Support Public Dividend Capital request for the year is £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 National Oversight Framework, with one overall score derived from the average score across 5 separate metrics: Liquidity, Capital Servicing Capacity, Income & Expenditure (I&E) Margin, Variance from I&E plan and Agency expenditure. A score of 1 is the most favourable and 4 the least favourable. Planned UOR for 2024/25 is level 3.

What do the charts show/context:

- The Trust has spent £10.13m on Capital programmes year-to-date, £0.93m more than planned. At the end of July, the Trust had a cash balance of £28.82m, £6.62m higher than planned. Use of Resources (UOR) stands at 3, as planned.

Underlying issues:

- The cash balance was £6.62m higher than planned at the end of July. This variance is due to the combination of an adverse variance in cash flow year to date of £2.66m, offset by a higher than forecast year end cash balance (£9.27m).
- The Trust's capital forecast has increased by £2.8m to £57.38m since the plan submission, this is due to increased PDC funding being received above the planned value in relation to reconfiguration at CRH and an increase on the lease forecast of £1m.

Appendix A – Variation and Assurance Icons

NHS 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

COMFORT BREAK - 10 mins

KEEPING THE BASE SAFE

16. Guardian of Safe Working Hours Quarterly Report

To Note

Presented by David Birkenhead

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Date of Meeting:	Thursday 12 September 2024
Meeting:	Public Board of Directors
Title:	**Quarterly Report (1st of April 2024 to 30th of June 2024)** from the Guardian of Safe Working Hours, CHFT
Author:	Dr Liaquat Ali, Guardian of Safe Working Hours (GOSWH)
Sponsoring Director:	Dr David Birkenhead, Medical Director
Previous Forums:	None
Purpose of the Report	The purpose of this report is to provide an overview and assurance of the Trust compliance with safe working hours for doctors/dentists in training across the Trust, and to highlight any areas of concern.
Key Points to Note	1. Exception reports 2. Information about cover arrangements for out of hours rota gaps 3. Junior doctors' strike 4.Junior Doctors Forum
Regulation	CQC Regulation 18: Staffing
EQIA – Equality Impact Assessment	The opportunity to exception report is available for all doctors in training and Trust doctors on the 2016 contract irrespective of any protected characteristics.
Recommendation	The Board is asked to **NOTE** the contents of the report.

Calderdale and Huddersfield
NHS Foundation Trust

GOSWH Quarterly Report 1st of April 2024 to 30th of June 2024

Introduction:

The purpose of this report is to give assurance to the Board that the doctors in the training are safely rostered and that their working hours are compliant with the Junior doctor's contract 2016 and in accordance with the Junior Doctors terms and conditions of service (TCS). The report includes the data from **1st of April 2024 to 30th of June 2024.**

Executive summary:

The Trust has used Allocate software since August 2017 to enable trainees to submit exception reports. All doctors in training and locally employed Trust doctors employed on the 2016 Terms and Conditions have an Allocate account. Educational supervisors and clinical supervisors also have access to this software.

There are 48 exception reports over a period of three months from 1st April to 30th of June 2024 and significant numbers of reports were submitted in the month of June 2024. Remarkable numbers of reports were initiated by FY1 and CT1 grade doctors as compared to rest of trainees. This is expected as the junior doctors are in the first year of working within the NHS and are getting familiar with how the system works. Trainees working in the medical division have generated approximately five times more exception reports versus other departments. Approximately sixty percent were related to extra hours of working. Two exception reports were relating to immediate patient safety issues. One of these two report was related to rostering at night when FY1 level doctor was asked to step up to cover ward SHO who did not turn up due to sickness and one was due to minimum staffing level in the ward and missed educational opportunities. Understaffing was due to sickness. Allocate software indicates eleven percent ERs as unresolved, include reports initiated during this quarter are carried forward next month.

All our junior doctor rotas are fully compliant with the 2016 TCs. Rota gaps remain a challenge, when/where Health Education England don't provide a trainee, however several Trust doctors are recruited to cover wherever possible. Where there are out of hours gaps, the flexible workforce team work to cover these shifts with bank/agency locums, with the junior doctor's cross-covering during the day.

Background Data:

Number of doctors / dentists in training (total): 253.86, Non -Training Junior Doctors: 158.19, vacancy:49.36 (as per data by the end of June 2024)

Administration support is provided to the Guardian: The Medical HR team manage the payment for exception reports wherever this is agreed and create Allocate accounts for all those that need access. They also do initial prompts to clinical supervisors and educational supervisors regarding exception reports. There is a regular meeting scheduled with the GOSWH and the Medical HR manager for additional support if required.

The Medical Education team manage the invites, agenda, and minutes for the quarterly Junior Doctors Forum meeting.

Safety concern raised through Exception Reports:

Two exception reports were recorded about immediate safety issues; One report was related to rostering at night when FY1 level doctor was asked to step up to cover ward SHO who did not turn up due to sickness. Educational supervisor reviewed the case and recommended this is unsafe practice and recommended additional support should be provided in term of stepping down of consultant/registrar. Second exception report was about service support and he had to cover 15 patients in addition to critical unwell patients. This has been resolved after initial review.

Work Schedule reviews:

Twelve exception reports were relevant to extra hours of working which required work schedule reviews and resolved after initial meeting with educational supervisor. None of these were escalated at Clinical Director level.

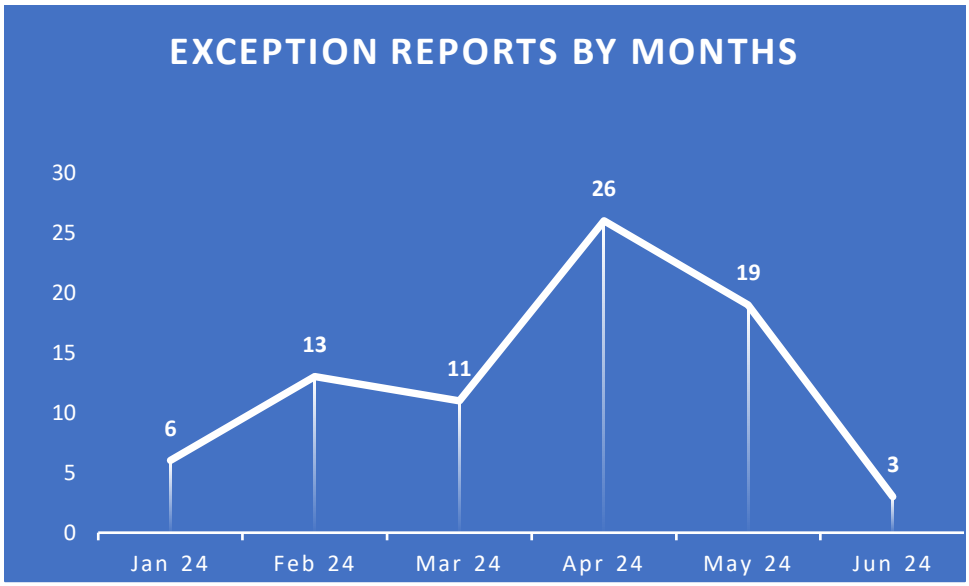
Exception Reports - details:

Total ER – 48

Distribution of exception reporting in relation to various reasons

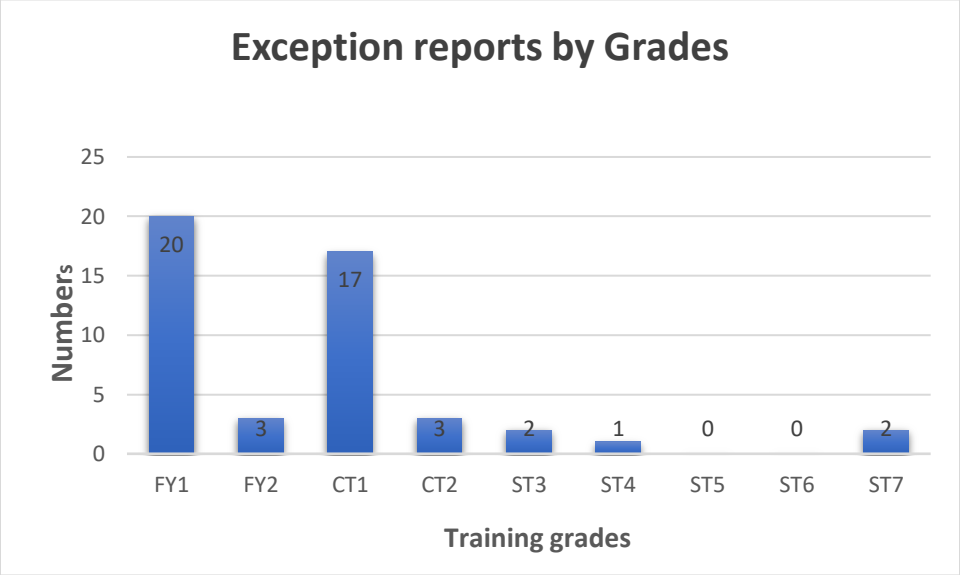
Out of these 48 reports, 29 were related to extra hours of working ,2 relating to immediate patient safety issues, six related to service support available to the doctor and 2 were related to pattern of work. 11 ERs related to missed educational opportunities (missed training day)

Exception Reports (ER) from1st of April 2024 to 30th of June 2024:



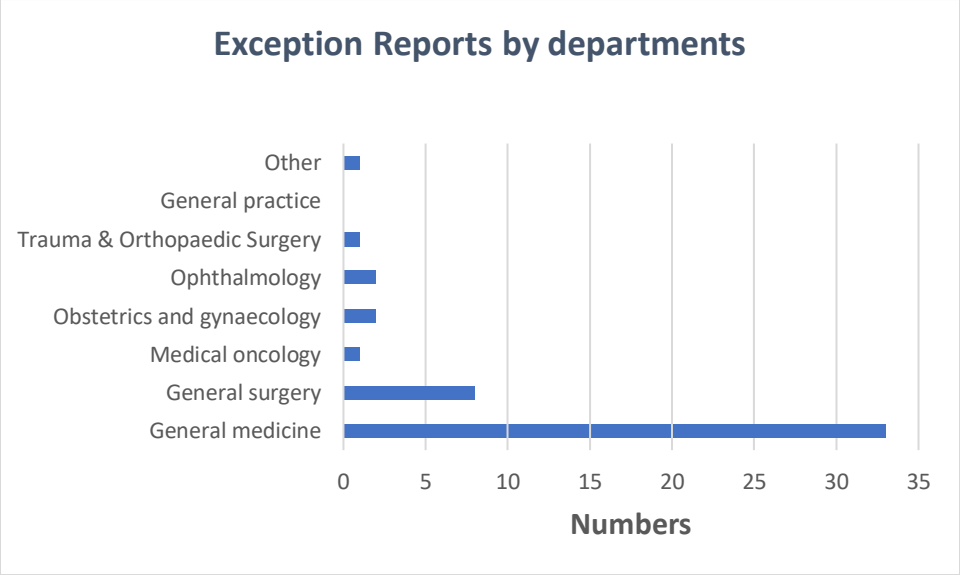
In total 48 reports were submitted over three months. As we can see, the numbers of exception reports are significant higher in April 2024 as compared to other months. This is difficult to certain underlying factors.

Exception reports by Grades



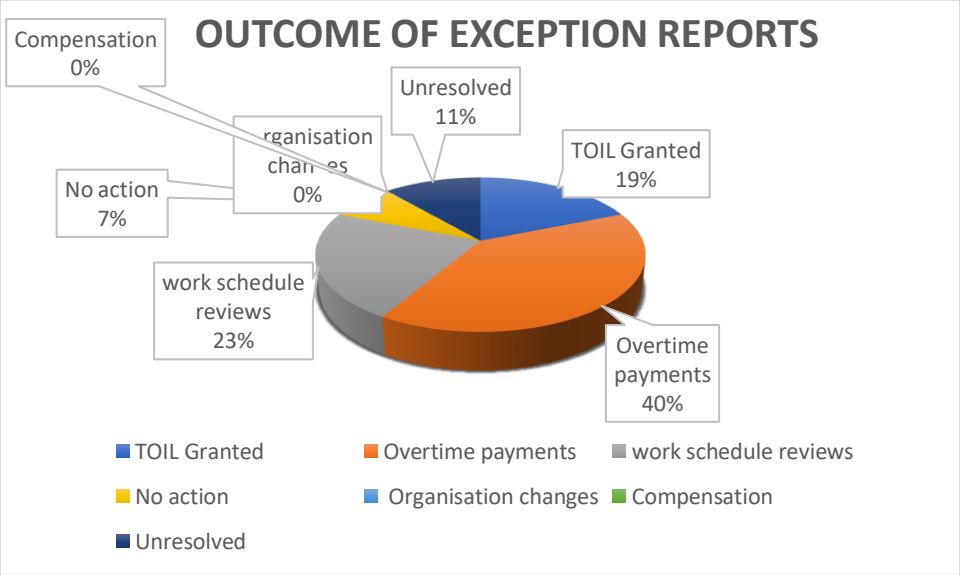
FY1 and CT1 grades doctors have initiated quite significant numbers of exception reports in contrast to other training doctors. This is expected as the junior doctors are in the first year of working within the NHS and are still getting familiar with how the system works. I have noted few exception reports from senior trainees as well.

Exception reports by Departments:



Trainees working in the medical division have generated approximately quintuple exception reports versus other departments. This is due to indirect impact of on call rota especially at night which might need look into.

Outcome of exception reports:



Not all ERs were resolved fully. Those shown as no outcome recorded include where the outcome was given by the supervisor after meeting with the trainee, but the doctor has not closed the report. Those shown as unresolved include reports initiated during this quarter were carried forward next month.

Steps from last Board meeting:

Fines:

There haven't been any fines issued in last one year.

Trainee Vacancies:

Data on Rota gaps is challenging to obtain, as most rosters up to the Consultant level are covered by a combination of doctors in training, Trust doctors and specialty doctors. Where there are trainee vacancies, a Trust doctor may be recruited for a fixed term to cover that gap. Or alternative cover may be arranged for out of hours commitments. As can be seen from the data held within ESR most of our training posts are filled currently.

Role	Apr-24 Budgeted FTE	Apr-24 Actual FTE	Apr-24 Vacancies by FTE	May-24 Budgeted FTE	May-24 Actual FTE	May-24 Vacancies by FTE	Jun-24 Budgeted FTE	Jun-24 Actual FTE	Jun-24 Vacancies by FTE
Consultant	311.26	296.27	14.99	322.86	294.55	28.31	329.19	297.20	31.99
Foundation Year 1	48.00	52.43	-4.43	48.00	51.66	-3.66	48.00	51.66	-3.66
Foundation Year 2	37.00	34.00	3.00	37.00	34.10	2.90	37.00	32.49	4.51
General Medical Practitioner	0.00	0.20	-0.20	0.00	0.20	-0.20	0.00	0.20	-0.20
Medical Director	1.00	1.20	-0.20	1.00	1.20	-0.20	1.00	1.20	-0.20
Specialty Doctor	128.56	83.53	45.03	130.43	82.28	48.15	128.43	80.92	47.51
Specialty Registrar	139.76	138.93	0.83	138.36	138.93	-0.57	141.36	135.23	6.14
Staff Grade (Closed to new entrants)	1.00	1.00	0.00	1.00	1.00	0.00	1.00	1.00	0.00
Trust Grade Doctor - Specialist Registrar Level	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Trust Grade Doctor or Dentist - Foundation Level	32.00	14.00	18.00	26.00	15.00	11.00	26.00	14.00	12.00
Trust Grade Doctor or Dentist - Specialty Registrar	43.94	57.36	-13.42	43.94	62.02	-18.08	46.94	62.27	-15.33
GP Trainees - Trust Based (Specialty Registrar)	39.00	40.22	-1.22	39.00	40.36	-1.36	39.00	34.28	4.73
Total	**781.52**	**719.14**	**62.38**	**787.59**	**721.30**	**66.29**	**797.92**	**710.44**	**87.48**

Shifts covered by Bank and Agency:

Out of hours shifts on trainee rotas can arise for several reasons. As you can see from the table below, most shifts are filled with alternative cover.

Shifts covered by Bank and Agency: April to 30 June 2024 in the following format.

GOSWH Hours report- Bank and Agency fill rates by division. April - June 2024

	FSS	Medicine	Surgery and Anaesthetics
Filled hours	81.43%	92.10%	91.30%
Unfilled hours	18.57%	7.90%	8.70%

This data provide reassurance that more bank staff (Trust staff) is used to cover unfilled shifts.

Industrial Action:

Significant planning was done within all divisions to pull together a comprehensive plan with a focus on patient and staff safety protecting critical services to deliver lifesaving care and maintaining elective care for cancer patients during junior doctor's strike. The strike actions have taken place **7am on 27th June to 7am on 2nd July 2024.**

Significant numbers of doctors participated in strikes as obvious by following data:

	27th June 2024				28th June 2024			
Area Of Work / Specialty	**# Due to Work**	**# Present for work**	**# Absent due to IA**	**% Absent due to IA**	**# Due to Work**	**# Present for work**	**# Absent due to IA**	**% Absent due to IA**
372 Families & Specialist Services L3	36	12	16	44.44%	27	12	8	29.63%
372 Medical L3	142	31	79	55.63%	120	21	70	58.33%
372 Surgery & Anaesthetics L3	61	15	41	67.21%	58	14	37	63.79%
Total	**239**	**58**	**136**	**56.90%**	**205**	**47**	**115**	**56.10%**

	29th June 2024				30th June 2024			
Area Of Work / Specialty	**# Due to Work**	**# Present for work**	**# Absent due to IA**	**% Absent due to IA**	**# Due to Work**	**# Present for work**	**# Absent due to IA**	**% Absent due to IA**
372 Families & Specialist Services L3	11	6	4	36.36%	8	4	3	37.50%
372 Medical L3	34	13	25	73.53%	31	8	15	48.39%
372 Surgery & Anaesthetics L3	18	4	14	77.78%	18	3	16	88.89%
Total	**63**	**23**	**43**	**68.25%**	**57**	**15**	**34**	**59.65%**

	1st July 2024			
Area Of Work / Specialty	**# Due to Work**	**# Present for work**	**# Absent due to IA**	**% Absent due to IA**
372 Families & Specialist Services L3	34	11	22	64.71%
372 Medical L3	120	19	74	61.67%
372 Surgery & Anaesthetics L3	59	13	37	62.71%
Total	**213**	**43**	**133**	**62.44%**

The Medical Director wrote to all medical and dental staff to confirm the details of the action, to remind colleagues to be respectful of others' views and to share a document with frequently asked questions. Well-being support was available to all and regularly referenced in Trust updates.

The industrial action is confirmed as 'Christmas Day' levels of care. This means that emergency care will continue to be provided, although elective work may need to be cancelled. The medical team was supported by physician associates, pharmacists, trust grade doctors and training doctors who did not participate in the strike action. Fortunately, no unpredictable events took place. ER were recorded during strike action. Adequate support services were available in terms of: The Safari team was available to prescribe for TTOs (take home prescriptions), and a "Floater" prescriber was available as well as Microsoft TEAM setup (CHFT – Digital Support) to act as a central resource to facilitate any issues colleagues may have with Cerner, Blood TRACK, ABG machine access and prescribing. There was a significant level of support for industrial action with approximately 90% of those eligible going on strike.

Junior Doctors Forum:

Junior doctor's forum takes place quarterly, chaired by Deputy Medical Director/Guardian of safe working hours and members include DME/deputy, LNC chair, junior doctor representatives and medical HR. This provides opportunity for junior doctors to get involved in service improvement (rota masters can be informed prior to ensure attendance). We discuss specialty specific issues, involvement in disbursement of fines, report from GSW regarding exception reports and performance manage GSW.

This time the Junior Doctors Forum meeting has taken place on 9 July 2024 and the audience was informed about post rest facilities, availability of accommodation/taxi services for colleagues finishing on a late shift or too tired to travel home. Annual summary of exception reports was presented and LNC chair discussed about access of allocate account to locally employed doctors. The HR department has given assurance about allocate account access to locally employed doctors.

Regional GOSWH conferences and webinars:

GOSWH Lead attended Guardians of Safe Working Hours - Regional Meeting – Yorkshire and the Humber on the 12th of June 2024 and topic of discussion included NHS Employers – update on business as-usual work programme followed by Q&A and networking.

Summary:

The trainees at CHFT have access to an allocate account to initiate exception reports and they have the provision if they want to raise any issue regarding safety concern, missed educational opportunities and extra work-outside their agreed rota. The rotas that are in place are fully compliant with the rules of the 2016 contract and there is scope to review these where feedback highlights when changes may be needed.

Recommendation:

The Board is asked to note the contents of the Guardian of Safe Working Hours report covering the period 1 April to 30 June 2024.

17. Medical Revalidation and Appraisal Annual Report

To Note

Presented by David Birkenhead

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 12 September 2024
Meeting:	Board of Directors
Title:	Revalidation and Appraisal of Non-Training Grade Medical Staff
Author:	Sue Burton, Revalidation and Appraisal Officer
Sponsoring Director:	Dr David Birkenhead, Medical Director
Previous Forums:	None
Purpose of the Report	To update the Board on the General Medical Council (GMC) revalidation and appraisal compliance for non-training grade medical staff for the appraisal and revalidation year 2023/2024.
Key Points to Note	The report also includes 'professional Standards: Framework for Quality Assurance and Improvement' (NHS England, NSH E) which requires Board approval prior to submission to NHSE. This is attached to the report as Annex B.
Regulation	CQC Regulation 18: Staffing
EQIA – Equality Impact Assessment	The completion of appraisals and the GMC revalidation process make an overall positive contribution to advancing quality in relation to colleague/patient safety across the NHS. The revalidation and appraisal process does not have a negative impact on equality for people with protected characteristics.
Recommendation	This report is submitted to the Board with the assurance that the agreed processes for GMC revalidation and appraisal have been adhered to. The Board is asked to **NOTE** the contents of the report.

Calderdale and Huddersfield NHS Foundation Trust

BOARD OF DIRECTORS – THURSDAY 12TH SEPTEMBER 2024

REVALIDATION AND APPRAISAL OF NON-TRAINING GRADE MEDICAL STAFF 2023/2024

1. Executive Summary

The purpose of this report is to update the Board on the progress of the Trust's management of medical appraisal and revalidation. The report will also cover the 2023/2024 appraisal and revalidation year (1st April 2023 – 31st March 2024).

Summary of key points:

- In the revalidation year from 1st April 2023 – 31st March 2024 65 non-training grade medical staff had been allocated a revalidation date by the GMC.
- The completion rate for all appraisals which were required to be completed in the appraisal year was 99.50%. For information our appraisal compliance for each year from 2021/202 is shown below:

Appraisal Year	Appraisal Completion Rate	Number of Unapproved Missed Appraisals
2023/2024	99.50	2
2022/2023	99.06%	4
2021/2022	99.30%	3

2. Background

2.1 Medical revalidation was launched in December 2012 to strengthen the way that doctors are regulated with the aim of improving the quality of care provided to patients. Revalidation is the process by which licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practice.

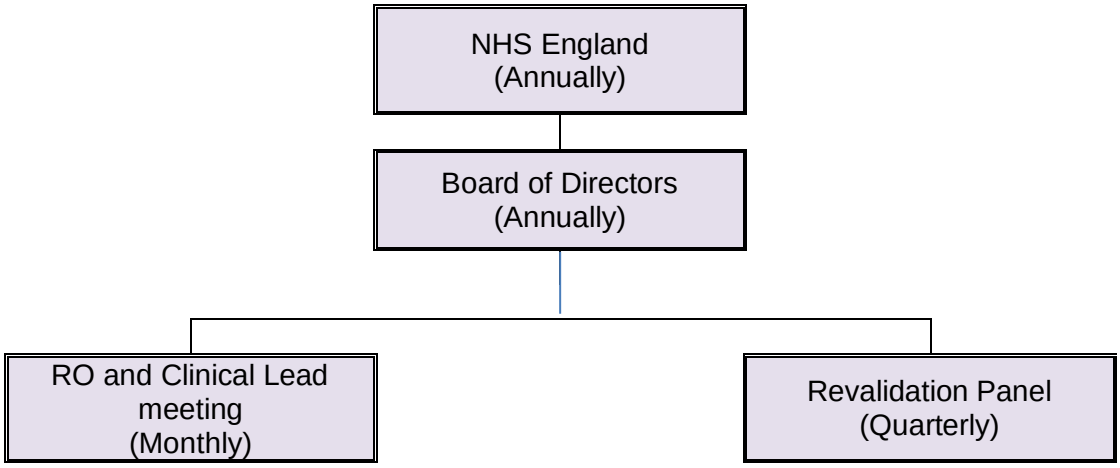
2.2 The Trust has a statutory duty to support the Responsible Officer (Executive Medical Director) in discharging their duties under Responsible Officer Regulations and is expected that the board will oversee compliance by:

- monitoring the frequency and quality of medical appraisals in their organisations;
- checking there are effective systems on place for monitoring the performance and conduct of their doctors;
- confirming that feedback from patients and colleagues is sought periodically so that their views can inform the appraisal and revalidation process;
- ensure that appropriate pre-employment checks are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

2.2 Revalidation is the process by which licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practice.

3. Governance Arrangements

3.1 The Trust's governance reporting structure for medical appraisal and revalidation is shown below:



3.2 **GMC Connect**

GMC Connect is the GMC database used by Designated Bodies (i.e. Calderdale and Huddersfield NHS Foundation Trust) to view and manage the list of doctors who have a prescribed connection with the Trust.

GMC Connect is managed by the revalidation administration team on behalf of the Responsible Officer. The Trust's Electronic Staff Record (ESR) is used as the main source in relation to starters and leavers.

4. Medical Appraisal and Revalidation Performance Data for 2021/2022

Revalidation Cycles

4.1 The first revalidation recommendations were made in January 2013

4.2 In the 2023/2024 revalidation year (Year 11) the Responsible Officer has made recommendations for doctors as follows:

Revalidation Cycle (Year 11)	Positive Recommendations	Recommendation Deferred **
Year 11, Quarter 1 (April 2023 – June 2023)	8	0
Year 11, Quarter 2 (July 2023 – September 2023)	21	0
Year 11, Quarter 4 (October 2023 – December 2023)	20	1
Year 11, Quarter 4 (January 2024 – March 2024)	16	0
Total:	**65**	**1**

** The reasons for the deferral was due long term ill health absence.

Medical Appraisal

4.3. Medical Appraisal underpins the revalidation process. Doctors are expected to complete five appraisals within the revalidation cycle.

4.4 The appraisal year runs from 1st April – 31st March (at CHFT we ask that all appraisals be completed by 28th February) . The table below shows the compliance rate at the end of the 2023/2024 appraisal year on 31st March 2024

Grade	Number of doctors with prescribed connection to CHFT	Completed Appraisals	***Approved incomplete or missed appraisal	Unapproved incomplete or missed appraisal
Consultants (permanent)	271	257	14	1
Staff Grade, Associate Specialist, Specialty Doctor (permanent)	97	82	15	1
Temporary or short term contract holders (all grades)	102	84	16	0
Total	**470**	**423**	**45**	**2**

*** Approved missed appraisals apply to:

- new starters who are not required to complete an appraisal with CHFT the specified appraisal year. This number makes up the majority of the approved missed appraisal number (40/45 in the above grid)
- non training grade medical staff who have missed an appraisal for a valid reason eg maternity leave, long term absence etc or any other reason deemed valid in consultation with the Clinical Lead for Appraisal and Revalidation (5/45 in the above grid) .

5. Allocation of Appraisers

5.1 The revalidation administration team allocates appraisers to appraisees and allocates the month the appraisal should take place.

6. Quality Assurance of the Process

6.1 The process used to monitor the quality of the medical appraisers is for the doctors to rate their appraisal experience in relation to:

- The organisation of the appraisal;
- The appraiser;
- The appraisal discussion.

We quality assure the performance of our medical appraisers by reviewing the appraiser feedback questionnaires completed by each appraisee. Completion of the feedback is mandatory part of the appraisal process for appraisees. Individual

feedback is sent to each appraiser for the appraisal year if they completed a minimum of 4 appraisals. Appendix A shows the average scores for each of the domains for active appraisers in the last appraisal year (1st April 2023 – 31st March 2024).

6.3 **Access, security and confidentiality**

Historical appraisal folders, supporting information and all correspondence relating to the revalidation processes are stored on the Trust network drive. Access to the drive is restricted to the Responsible Officer, the Clinical Lead for Appraisal and Revalidation, the Revalidation Panel clinical members and the Revalidation administrative support. All appraisals since 2017 and supporting information are stored on the PReP system which is ISO27001 accredited, GDPR compliant, 100% IG Toolkit compliant. Access to appraisals is in line with the Appraisal Policy for non-training grade medical staff.

7. Update and actions for the next 12 months

a) Framework of Quality Assurance for Responsible Officers (NHS)

This report also includes as an attachment (Appendix B), 'Professional Standards: Framework for Quality assurance and Improvement (NHS England 2024) which requires Board approval.

b) Peer Review

A peer review with a neighbouring Trust will be planned for 2025. This will help identify areas for improvement and wil be an opportunity to share good practice.

c) E-Appraisal/Portfolio System

The e-appraisal systems available will be reviewed in 2025

8 Action Required of the Board

The report is provided for assurance purposes.

Dr David Birkenhead
Medical Director/Responsible Officer
August 2024

Appendix A

Medical Appraiser Feedback Report 2023/2024

All ratings by appraisees have a numerical value and the average for each section is calculated out of 5. Categories determined by Premier IT (PReP) e-appraisal system. Scores for 58 active appraisers who had appraised 4 or more doctors as at 31st March 2024.

Period of Feedback Submitted: 1st April 2023 – 31st March 2024

Scores: Poor 1.00 – 1.99 Borderline 2.00 – 2.99 Satisfactory 3.00 – 3.99 Good 4.00 – 4.99 Very Good 5.00

Categories						
Their preparation for my appraisal	**Their ability to conduct my appraisal**	**Their ability to review progress against last year's personal development plan (PDP)**	**Their ability to help me review my practice**	**Usefulness for my professional development**	**Usefulness in preparation for revalidation**	**Usefulness of my new PDP**
Range of Scores: 4.00 (2) – 5.00 (9)	Range of Scores: 4.00 (1) – 5.00 (12)	Range of Scores: 3.75 (1) – 5.00 (15)	Range of Scores: 4.00 (1) – 5.00 (9)	Range of Scores: 4.00 (2) – 5.00 (6)	Range of Scores: 3.83 (1) – 5.00 (5)	Range of Scores: 3.83 (1) – 5.00 (6)
4.69	4.73	4.71	4.69	4.60	4.58	4.59

Calderdale and Huddersfield NHS Foundation Trust

Appendix B

Annex A

Professional Standards: Framework for Quality Assurance and Improvement (NHSE)

NHSE Statement of Compliance – GMC Revalidation and Appraisal (Period 1st April 2023 – 31st March 2024)

1A – General

The Board/executive management team of Calderdale and Huddersfield NHS Foundation Trust (CHFT) can confirm that:

1A(i): An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year:	No specific actions
Comments:	Dr David Birkenhead, Medical Director is the appointed responsible officer for CHFT Dr Birkenhead will be retiring from the role of Medical Director/Responsible Officer in October 2024. The role of Medical Director/Responsible Officer will be taken up by Mr Neeraj Bhasin, Consultant Vascular Surgeon. Mr Bhasin has completed the Responsible Officer training.
Action for next year:	To enable Mr Bhasin to settle into the role of Responsible Officer.

1A(ii): Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Action from last year:	No specific actions
Comments:	The Trust does provide sufficient funds and resources. There is a dedicated Clinical Lead for Revalidation and Appraisal (Consultant level, 1PA a week) plus a Revalidation and Appraisal Administration Team (0.40 WTE PB4 and 0.53 WTE PB3).
Action for next year:	To review the e-appraisal system used and explore IT developments

1A(iii): An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Action from last year:	No specific actions
Comments:	The GMC Connect List is checked weekly for new entries and removals. Both removals and entries are confirmed or otherwise.
Action for next year:	No specific actions

1A(iv): All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year:	No specific actions
Comments:	The Trust has in place a Medical Appraisal Policy for Medical Staff (Non training Grade Medical Staff). This policy is due to be reviewed in November 2024.
Action for next year:	Non training grade medical staff will be made aware of any revisions to the current policy.

1A(v): A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Action from last year:	No specific actions
Comments:	An audit of procedures and processes was last undertaken by Audit Yorkshire in December 2022. The Trust received a high level of assurance.
Action for next year:	The Trust look to arrange a peer review in 2025

1A(vi): A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Action from last year:	No specific actions
Comments:	We continue to conduct one to one meetings with locums/short term doctors to outline the appraisal and revalidation processes. This includes a conversation covering opportunities for continuing professional development.

Action for next year:	No specific actions

1B – Appraisal

1B(i): Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year:	No specific actions
Comments:	The annual appraisal does cover the whole scope of practice. This is highlighted in the appraisal form and is also stressed to appraisees when they join the Trust as part of the revalidation and appraisal induction and to appraisers at training sessions
Action for next year:	No specific actions

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

This question is not applicable.

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year:	No specific actions
Comments:	The Trust has a Medical Appraisal Policy for Non-Training Grade Medical Staff. The policy was ratified by the Executive Board on 11 November 2021
Action for next year:	The policy is due for revision in November 2024

1B(iv) Our organisation has the necessary number of trained appraisers1 to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year:	No specific actions
Comments:	The Trust does have enough trained appraisers and regularly recruit and train new appraisers. As at 1st April 2024 there were 76 trained appraisers
Action for next year:	To continue to recruit to the appraiser faculty.

1B(iv): Our organisation has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year:	No specific actions
Comments:	We do have enough appraisers to carry out timely annual appraisal. At the start of the appraisal year all appraisees are notified of the month their appraisal should take place. Likewise appraisers are informed of their allocation of appraisees and the month their appraisal should take place. This enables sufficient planning time.
Action for next year:	No specific actions

1B(v): Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

Action from last year:	No specific actions
Comments:	All trained appraisers are required to attend refresher appraiser sessions once every 3 years. These are held regularly. Each appraisee is required to complete a mandatory appraisee feedback survey after each appraisal. Anonymised feedback reports are sent to the appraisers annually and the clinical Lead also reviews the feedback and raises any issues of concern with the individual appraiser.
Action for next year:	No specific actions

1B(vi): The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year:	No specific actions
Comments:	An annual report is submitted to the Executive Board highlighting appraisal and revalidation performance
Action for next year:	No specific actions

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC

requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Action from last year:	No specific actions
Comments:	Recommendations are made in accordance with GMC requirements and within expected timescales
Action for next year:	No specific actions

1C(ii): Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Action from last year:	No specific actions
Comments:	Recommendations are ordinarily confirmed in writing to the doctor within 24 hours of the Revalidation Panel meeting and prior to the recommendation being made to the GMC
Action for next year:	No specific actions

1D – Medical governance

1D(i): Our organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year:	No specific actions
Comments:	The Trust has robust clinical governance processes (e.g. supporting doctors with revalidation and appraisal, continuous learning and improvement using mechanisms such as audit/review, patient feedback, investigating concerns, promoting freedom to speak, duty of candour etc).
Action for next year:	No specific actions

1D(ii): Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Action from last year:	No specific actions
Comments:	Doctors are provided with, for discussion at appraisal, details of any complaints, incidents and claims they have been named in over the past 12 months.

Action for next year:	The process for providing this information is under review.

1D(iii): All relevant information is provided for doctors in a convenient format to include at their appraisal.

Action from last year:	No specific actions
Comments:	The information provided is easily accessible, in Word and Excel format
Action for next year:	The process for providing this information is under review.

1D(iv): There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year:	No specific actions
Comments:	The Trust has a robust policy in place which complies with national and local MHPS processes.
Action for next year:	No specific actions

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Action from last year:	No specific actions
Comments:	The Board and the workforce committee (a main board subcommittee) receives a regular report which captures employees where concerns are raised, and formal processes instigated. The Trust is compliant with national and local MHPS processes.
Action for next year:	No specific actions

1D(vi): There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Action from last year:	No specific actions
Comments:	We used an adapted version of the NHSE MPIT form for transferring information to other responsible officers
Action for next year:	To formalise a procedure with timescales for providing this information.

1D(vii) Safeguards: are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year:	No specific actions
Comments:	The Trusts procedures for handling concerns regarding medical and dental staff conduct and capability sets out an informal process to initially deal with concerns pertaining to conduct/capability of medical and dental staff. A 'seek to understand' process is undertaken prior to any formal process being pursued. This is well embedded across all clinical divisions
Action for next year:	No specific actions

1D(viii): Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Action from last year:	No specific actions
Comments:	The Trust monitors NICE and other expert guidance through a committee chaired by the Deputy Medical Director. Other national reviews and reports are received by a Board subcommittee, chaired by a Non-Executive Director and supported by the Director of Corporate Affairs, to ensure actions are appropriately developed and implemented.
Action for next year:	No specific actions

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (Ref Messenger review).

Action from last year:	Development of the programmes below
Comments:	Several in-house development opportunities have been developed and are available to all healthcare professionals. These help ensure consistency and include: - Empower Programme - Management Fundamentals/Bite sized learning - New to Manager Programme - Inclusive Talent Framework - Team Engagement Development
Action for next year:	To develop and promote these opportunities further

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year:	No specific actions
Comments:	There are systems in place to ensure all appropriate pre-employment checks are undertaken. This is managed by the Workforce and Organisational Development Team.
Action for next year:	No specific actions

1F – Organisational Culture

1F(i): A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Action from last year:	The Trust developed the systems outlined below.
Comments:	The Trust has developed: Hot House sessions: engaging with colleagues to hear their views on how they can shape the people agenda. One Culture of Care Calendar: Inclusion Events ranging from Black History Month, Ramadan and Eid festival, National Hijab Day, Disability Awareness Month, Pride Parade.

	Work Together Get Results Workshops: co creating plans for change together. Wellbeing Connect implemented: ensuring colleagues who need support can access this quickly and effectively. Financial Wellbeing initiatives available: ie financial education, access to low-cost loans, top up shops (clothes and food donations to pick up in a discreet way). Active Equality Networks: peer support networks providing a safe space for colleagues to network with like-minded individuals (LGBTQ, Disability, Women's and Race equality networks). Each have an executive sponsor and a colleague volunteer chair. Wellbeing networks: Carers, menopause, wellbeing guardians and mental health first aiders.
Action for next year:	People Strategy to be reviewed/refreshed. New Workforce Inclusion Strategy to be designed/launched. One Culture of Care to be further embedded. WRES/WDES/Gender pay gap actions plans to be actioned. Work Together to Get Results improvement methodology to be further embedded.

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Action from last year:	The Trust developed the systems outlined below
Comments:	One Culture of Care Charter Freedom To Speak Up Guardians: 5 Day Cover SAS Advocate and SAS Forum Diversity in Health and Care Partners Programme 2023/2024 - NHS Employers Programme – Supporting Health and Care organisations to create more inclusive workplace cultures where difference is welcomed and celebrated. EDI Education Suite: bite size learning for all colleagues. Topics ranging from supporting international colleagues to neurodiversity.

Action for next year:	One Culture of Care to be further embedded. New Workforce Inclusion Strategy to be designed/launched. Workforce/employment policies to be reviewed/refreshed.

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Action from last year:	The Trust developed the systems outlined below
Comments:	Freedom To Speak Up Guardians: 5 Day Cover Leadership Framework Leadership Conference
Action for next year:	One Culture of Care to be further embedded. Workforce/employment policies to be reviewed/refreshed. Work Together to Get Results improvement methodology to be further embedded. Freedom to Speak Up arrangements to be further publicised/embedded.

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Action from last year:	No specific actions
Comments:	The Trust has a Complaints handling Group Policy. Each Division is required to have a structure framework for learning from mistakes
Action for next year:	No specific actions

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act

Action from last year:	The process was reviewed, as it is every 12 months.
Comments:	This is assessed by the Workforce and Organisational Development Team.

Action for next year:	The process is reviewed annually

Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Action from last year:	No specific actions
Comments:	Regional network meetings are attended by the RO and revalidation team, we liaise with the GMC and ELA and the administration team attend network sessions to discuss good practice and local developments
Action for next year:	We are planning to undertake a peer review in 2025 with a neighbouring Trust

Section 2 – Metrics

Year covered by this report and statement: 1 April 2023 – 31 March 2024

All data points are in reference to this period unless stated otherwise.

2A General

The number of doctors with a prescribed connection to the designated body on the last day of the year under review. This figure provides the denominator for the subsequent data points in this report.

Total number of doctors with a prescribed connection on 31 March 2024	470

2B – Appraisal

The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions is as recorded in the table below.

Total number of appraisals completed	423
Total number of appraisals approved missed	45 (40 of these were due to the doctors being relatively new starters to the Trust and not requiring an appraisal with CHFT within the appraisal year)
Total number of unapproved missed	2

2C – Recommendations

Number of recommendations and deferrals in the reporting period

For the period 1st April 2023 – 31st March 2024

Total number of recommendations made	66
Total number of late recommendations	0
Total number of positive recommendations	65
Total number of deferrals made	1
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	0

2D – Governance

For the period 1st April 2023 – 31st March 2024

Total number of trained case investigators	47
Total number of trained case managers	10
Total number of new concerns registered	4
Total number of concerns processes completed	3
Longest duration of concerns process of those open on 31 March 2024	6 months
Median duration of concerns processes closed	3 months on average
Total number of doctors excluded/suspended	1
Total number of doctors referred to GMC	1

2E – Employment checks

Number of new doctors employed by the organisation and the number whose employment checks are completed before commencement of employment.

For the period 1st April 2023 – 31st March 2024

Total number of new doctors joining the organisation	66 (non-training grade medical staff)

Number of new employment checks completed before commencement of employment	All employment checks required by NHSE Employers are undertaken (e.g. right to work, identity check, references, professional registration, DBS, health check etc)

2F Organisational culture

For the period 1st April 2023 – 31st March 2024

Total number claims made to employment tribunals by doctors	1
Number of these claims upheld	0
Total number of appeals against the designated body's professional standards processes made by doctors	0
Number of these appeals upheld	0

Section 3 – Summary and overall commentary

We are once again pleased with the level of engagement of our doctors with the appraisal and revalidation processes. We did notice some slippage in the last appraisal year with appraisals being completed at the time they were scheduled. There was a partial return to the historical 'end of year appraisal rush' than in previous years. We are aware this was due to workload pressures and industrial action.

Over the next 12 months we plan to:

- Undertake a peer review with a neighbouring Trust.
- Review the e appraisal processes we use.
- Develop further our induction and revalidation induction process for new starters.

Section 4 – Statement of Compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

(Chief executive or chair (or executive if no Board exists)

Official name of the designated body: Calderdale and Huddersfield NHS Foundation Trust

18. Risk Appetite Statement

To Approve

Presented by Andrea McCourt

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 12 September 2024
Meeting:	Public Board of Directors
Title:	Annual Review of Risk Appetite
Author:	Andrea McCourt, Company Secretary
Sponsoring Director:	Victoria Pickles, Director of Corporate Affairs
Previous Forums:	None
Purpose of the Report	This paper confirms the Trust risk appetite following an annual review of the existing risk appetite.
Key Points to Note	An annual review of the risk appetite has taken place resulting in the proposed addition of a new risk category of environmental sustainability and confirmation that the risk appetite remains relevant within the current operational climate.
Regulation	CQC Regulation 17: Good governance
EQIA – Equality Impact Assessment	Any issues will be identified when applying the risk appetite.
Recommendation	The Board is asked to **APPROVE** the updated risk appetite.

ANNUAL REVIEW OF TRUST RISK APPETITE

1.1 Risk Appetite

Risk appetite is “the amount and type of risk that the Trust is prepared to pursue, retain or take” in pursuit of its strategic objectives and is key to achieving effective risk management.

The Trust’s Risk Management Strategy confirms the Board sets and has oversight for the Trust’s risk appetite.

The Board needs to understand, set and apply the risk appetite as a key element of its strategic approach to risk management as it explicitly articulates the Board’s attitude to and boundaries of risk. Risk appetite also provides clear expectations for staff and managers regarding the management of risk. It allows for controlled risk taking. The risk appetite also supports the Board by ensuring that they do not expose the Trust to risks it cannot tolerate, it can choose to take opportunities when they arise and the Board is not over cautious or stifles innovation and development.

One of the key roles of the Board is to ensure that the Trust is taking the right level of risk within which to meet its strategic objectives and understand it’s risk management boundaries.

All risks on the Board Assurance Framework have an identified risk appetite and the Board reviews its risk appetite annually. The amount of risk the Trust is prepared to accept or be exposed to will vary according to the perceived significance of risks, timing and regulatory or legislative constraints. Each risk requires the exercise of judgement and risk appetite levels may need to be re-assessed and amended to reflect new and changing circumstances.

When balancing risks, the Trust will tolerate some risks more than others, for example we have a low appetite for risk relating to harm and safety whereas for quality and improvement we have a significant risk appetite, allowing the Trust to pursue areas with a higher reward potential.

The Trust has a qualitative risk appetite statement reflecting the context within which the Trust works and enabling well calculated risks to be taken to improve delivery when opportunities arise.

The risk appetite is based upon the Good Governance Institute (GGI) Risk Appetite for NHS Organisations Matrix.

1.2. Trust Risk Appetite

The Trust has four levels of risk appetite as depicted below.

To advise the Board if a risk on the Board Assurance Framework has breached its risk appetite, the 5x5 risk scoring matrix is used. The table below shows the risk score for each risk appetite level and risk tolerance and risk exposure levels which the Board has previously agreed. Risks which fall into the risk exposure category are highlighted to Boards and Committees when presenting the Board Assurance Framework, highlighting the need for a review of actions and greater oversight of these risks.

Risk Appetite Level	Risk Description	Risk Appetite	Risk Tolerance	Risk Exposure
		Risk Matrix Score 5 x 5		
LOW – as little risk as possible	Preference for ultra-safe delivery options with a low degree of inherent risk and only for limited reward potential	1-4	5-8	9-25
MODERATE – safe options with a low degree of inherent risk	Preference for safe delivery options with a low degree of inherent risk and limited potential for reward	1-8	9-12	15-25
HIGH - consider all options and choose one most likely to result in successful delivery	Willing to deliver all potential delivery options and choose while also providing an acceptable level of reward and value for money	1-10	12 - 15	16-25
SIGNIFICANT – be innovative and choose options with higher reward potential, accepting greater uncertainty	Eager to be innovative and to choose options offering potentially higher business rewards, despite greater inherent risk	1-15	16-25	

1.3 Risk Appetite Categories

The Trust had defined eleven risk categories which the Trust's risk appetite is structured around. These are the principal risks which arise from the nature of the Trust's operating environment. These key risk categories are:

- Strategic / organisational
- Quality, innovation and improvement
- Partnership
- Innovation/technology
- Reputation
- Commercial
- Financial/assets
- Regulation
- Harm and safety
- Workforce
- Legal

It is proposed that an additional risk appetite category of environmental sustainability is added, reflecting that this is key to our five year strategy and operating environment.

Definitions of each of these risk categories is given below within the risk appetite statement.

TRUST RISK APPETITE STATEMENT 2024

Risk Category / Type	Description	Risk Appetite
Strategic / Organisational	We seek out innovation to deliver higher quality patient care, accepting this brings risk.	**SIGNIFICANT**
Quality and improvement	We seek innovation in the way we develop different models of service delivery and employ staff as a key enabler for improving quality, patient safety and experience.	**SIGNIFICANT**
Partnership	We accept a level of risk in working with partners to support service transformation and operational delivery, within agreed financial limits.	**SIGNIFICANT**
Digital Innovation / New Technology	We change how we deliver care to meet the challenges of the future by actively pursuing digital innovation and new technologies, while providing safe, effective and efficient care for patients.	**HIGH**
Reputation	Where required, we will make difficult decisions in the best interests of patient safety but appreciate this may attract scrutiny / interest from stakeholders.	**HIGH**
Commercial	We explore new opportunities which will enhance and support our core business and reputation for providing patient care.	**HIGH**
Financial / Assets	We will invest resources to enable us to deliver improvements in care ensuring rigorous impact assessments. We will resource opportunities and always consider price, value, benefits, local and system impact, aiming to deliver our services within our ICS approved financial plans, retaining flexibility to capitalise on opportunities.	**MODERATE**
Environmental Sustainability	We are committed to the provision of environmentally sustainable services and having a low carbon footprint and will explore environmentally sustainable developments to deliver improvements.	**MODERATE**

Regulation	We will make every effort to comply with regulation and will explain our approach.	**MODERATE**
Harm and safety	We take as little risk as possible when it comes to harm and safety to keep our patients and colleagues safe and achieve the best clinical outcomes.	**LOW**
Workforce	We have one Culture of Care with colleagues looking after each other as well as the people we care for, ensuring patient safety, appropriate staffing levels and promoting the well-being of our staff.	**LOW**
Legal	We will comply with the law.	**LOW**

Recommendation

The Board is asked to **APPROVE** the risk appetite statement.

19. High Level Risk Register

To Note

Presented by Andrea McCourt

Date of Meeting:	Thursday 12 September 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. **Current risk profile** Currently there are 24 high scoring risks on the Trust risk register (see details at the end of the report): • 3 are scored as very high. • 21 are scored as high. • All risks have been recently reviewed and the mitigations (progress) updated. • Of the 24 risks, two have had their risk scores increased. • There was a total of seven risks have had their risk score reduced since the last report, six of those are scoring below 15 and are no longer included in the higher-level risk report. Each risk is aligned to one of the Trust's strategic objectives. The current risks scoring very high (20-25) demonstrate the following themes:

	• Keeping the base safe: - There is a risk of delayed diagnosis, treatment for cancer patients. Due to one H&N cancer consultant on long term sickness absence and the fixed term contract of 1 doctor having expired resulting in poor patient experience and potential to impact on the Trusts Cancer metrics. – 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: - 13 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. - 1 risk in relation to potential equipment failure, which will result in the inability to deliver service due at CRH. - 1 risk of fire spread at HRI due to insufficient fire compartmentation in areas. **Other risk actions** 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. All risk scoring 15 and above have had a progress update. As previously reported the current risk register system doesn't enable us to triangulate data, identify themes, and track risks. We are currently doing a data cleansing exercise to ensure all risks are reviewed and either updated or closed prior to the transfer to the new InPhase system at the end of September. There will be a period of data quality checking to ensure migration has been successful and we will then test the new reporting functionality. As part of the data cleansing process, the Risk Management team conducted an in-depth analysis of all active risks listed in the risk register, with particular attention to the review and target dates of each risk. Initially, 212 risks were identified as overdue for review. Through close collaboration with the divisions, this number has been significantly reduced to 105. Additionally, there were 121 risks that had surpassed their target dates at the start of the analysis. After working closely with the divisions, the number of risks currently beyond their target dates has decreased to 65. The Risk Management team continues to engage with divisions and risk owners to further reduce the number of overdue risks and this will be completed by the end of September.

Regulations	CQC Regulation 12: Safe care and treatment 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** - Risks that have increased in scores (High Level). **Appendix 3** - High Level Risk that have reduced in score since last report. **Appendix 4** - Risks that scored 15+ during last report but have now closed/merged.
Recommendation	The Board is asked to **CONSIDER** and discuss risks scoring 15 or more report and **NOTE** the ongoing work to strengthen the management of risks.

Appendix 1 – All Risk scoring 15 or more.

Risk Level	Risk No	Division	Directorate	Department	Objective	Risk Summary	Current Risk Score
Very High	8528	Medical	Emergency Care	Accident and emergency HRI/CRH	Transformation and improving patient care	There is a risk of a reduction in patient experience and quality outcomes due to the operational performance within the Emergency Department (ED) and the maintenance across all Emergency Care Standards due to prolonged patient length of stay within the ED and the impact this has on ED flow. Resulting in poor patient experience, reduction in quality measures and increased length of stays in the ED departments.	20 4 x 5.
Very High	8669	Surgery & Anaesthetics	Head and Neck	Ear, Nose and Throat	Keeping the base safe	There is a risk of delayed diagnosis, treatment for cancer patients' due consultant who specialise in cancer on long term sickness absence and the fixed term contract of 1 another consultant having expired.	20 4 x 5
Very High	8324	Corporate	Planned Access and Data Quality	RTT Validation	Keeping the base safe	There is a risk of high volume of outstanding clinical outpatient validation and prioritisation on Mpage system.	20 4 x 5
High	8734	Community	Community Therapies	Speech and language therapies	Keeping the base safe	There is a risk of patients not being assessed for their swallowing and communication needs following a stroke in a timely manner. due to vacancies within the speech and language therapy service.	16 4 x 4
High	8562	Family & Specialist Services	Pathology	Blood sciences	Keeping the base safe	There is a risk of Enforced removal of Siemens Track within the Biochemistry Department.	16 4 x 4
High	8161	Family & Specialist Services	Radiology	CT	Keeping the base safe	There is a risk of being unable to provide a CT scanning service in the event of a fatal breakdown of the CT scanner at Calderdale Royal Hospital due to the age of the equipment.	16 4 x 4
High	8098	Surgery & Anaesthetics	Head and Neck	Ophthalmology	Keeping the base safe	There is a risk of clinic cancelation, delays and reduced capacity in all areas of ophthalmology due to macular injection staff shortages.	16 4 x 4

High	8609	Surgery & Anaesthetics	Head and Neck	Ear, Nose and Throat	Keeping the base safe	There is a risk of prolonged waiting times for patients within ENT due to multifactorial elements including an increase in referrals over the last 6 months, and inability to return to pre-covid levels of activity.	16 4 x 4
High	8219	Family & Specialist Services	Pathology	Blood sciences	Keeping the base safe	There is a risk of loss of Cross-Site Biochemistry Service (24/7) due to the reduction in qualified BMS, inability to recruit and reduced ability to retain qualified staff. (Single qualified BMS staff covers both CRH and HRI out of core hours)	16 4 x 4
High	8009	Medical	Integrated Medical Specialties	All Departments	Keeping the base safe	There is a risk of outpatient capacity not being sufficient to ensure timely appointments for both new and follow up patients across integrated medical specialities.	16 4 x 4
High	7955	Family & Specialist Services	Radiology	Main X-Ray	Keeping the base safe	There is a risk of being unable to deliver plain film services from three plain film rooms at Calderdale Royal Hospital (CRH) due to the rooms becoming obsolete.	16 4 x 4
High	6079	Family & Specialist Services	Appointment and Records	Appointments Service	Transforming and improving patient care	There is a risk of being unable to provide sufficient appointments for patients requiring Outpatients follow-up due to capacity and demand	16 4 x 4
High	8121	Family & Specialist Services	Womens service	Gynae OPD HRI/CRH	Keeping the base safe	There is a risk of being unable to provide sufficient new and follow outpatient appointments for those patients requiring review by Gynaecology team, this is due to back log and some reduced available capacity.	16 4 x 4
High	6911	Family & Specialist Services	Women's Services	All Departments	Keeping the base safe	There is a risk of not meeting current midwifery workforce models due to current vacancies and periods of increased absence (maternity / long term sickness),	16 4 x 4
High	6949	Family & Specialist Services	Pathology	Blood sciences	Keeping the base safe	There is a risk of not being able to deliver a two site Blood Transfusion / Haematology service due to being unable to recruit and retain enough Health care professionals in Biomedical Scientists.	16 4 x 4

High	8606	Medical	All Departments Medical	All Departments	Financial sustainability	There is a risk of not being able to reduce the acute inpatient bed base due to rising patient acuity, non-elective demand and challenges in community bed and social care provision resulting in additional cost	16 4 x 4
High	7413	Corporate	Finance and Procurement	Corporate Finance	Keeping the base safe	There is a risk of fire spread at Huddersfield Royal Infirmary due to insufficient fire compartmentation in areas which could result in fire spread / damage to buildings / equipment and harm to staff, patients, and visitors.	15 5 x 3
High	8398	Surgery & Anaesthetics	General and Specialist Surgical Services	Colorectal	Keeping the base safe	There is currently a risk of high volumes of patients awaiting a follow up appointment within Colorectal surgery due to increased referrals post covid and historical patients waiting for their appointments.	15 3 x 5
High	8700	Family & Specialist Services	Childrens services	PAOU	Keeping the base safe	There is a risk of significant staffing shortfalls on the Paediatric Assessment Unit (PAU) due to no agreed workforce model for PAU and the current workforce model encompassing both ward 3 and ward 4 where staff are required to work across both areas.	15 3 x 5
High	8736	Family & Specialist Services	Family & Specialist Services	Pathology	Keeping the base safe	There is a risk of staffing shortfalls to deliver services due to planned move of services to Leeds.	15 3 x 5
High	8633	Family & Specialist Services	Women's service	Maternity	Keeping the base safe	There is a risk that there is currently insufficient Consultant Clinic capacity to deliver timely Antenatal care for the local population (this was identified as a "Must Do" in a recent CQC inspections report for Maternity services). This may result in delays to care, late detection of anomalies, budgetary pressures, and a poor patient experience.	15 3 x 5.

High	8657	Family & Specialist Services	Women's service	Maternity	Keeping the base safe	There is risk of poor outcomes for Obstetrics and Gynae patients due to the current Consultant Medical Workforce being on call or COTW for both large specialities at the same time.	15 3 x 5.
High	8712	Family & Specialist Services	Pharmacy	Pharmacy	Keeping the base safe	There is a risk that patients will receive incorrect medication or miss doses of critical medication due to a lack of pharmacy support to the emergency department (ED).	15 3 x 5.
High	8529	Medical	Emergency Care	Accident & Emergency CRH/HRI	Transforming and improving patient care	There is a risk of insufficient paediatric nurses to care for paediatric patients in the Emergency Department at HRI in line with current RCPCH guidance (2 per 24 hours 7/7) due paediatric workforce model gaps that could result in poor paediatric patient experience and inability to provide timely assessment and interventions.	15 3 x 5.

Appendix 2 – Risks that have increased in score (High Level – also included in Appendix 1)

Risk Level	Risk No	Division	Directorate	Department	Objective	Risk Summary	Risk Score
High	8736	Family & Specialist Services	Pathology	Microbiology	Keeping the base safe	There is a risk of a reduction in the number of staff to deliver service due to natural staff loss from the planned move of the service to Leeds, resulting in an inability to deliver late/weekend and on-call service, as well as a likely impact on accreditation	15 3 x 5 = Risk score Increased from 12
High	8529	Medical	Emergency Care	Accident & Emergency CRH/HRI	Transforming and improving patient care	There is a risk of insufficient paediatric nurses to care for paediatric patients in the Emergency Department at HRI in line with current RCPCH guidance (2 per 24 hours 7/7) due paediatric workforce model gaps that could result in poor paediatric patient experience and inability to provide timely assessment and interventions.	15 3 x 5 = Risk score Increased from 12
High	8098	Surgery & Anaesthetics	Head and Neck	Ear, Nose and Throat	Keeping the base safe	There is a risk of clinic cancelation, delays and reduced capacity in all areas of ophthalmology due to macular injection staff shortages resulting in permanent sight loss for patients, cancellations of non-emergency capacity and increased holding lists	16 4 x 4 = Risk score Increased from 12

Appendix 3 – High Level Risks that have reduced in score since last report.

Risk Level	Risk No	Division	Directorate	Department	Objective	Risk Summary	Current Risk Score	Reason for Risk Reduced score.
High	7078	Corporate	Medical Director's Office	Operational	Keeping the base safe	There is a risk of compromised patient care and operational challenges within medical staffing, specifically in Gastroenterology, Radiology, Dermatology, and Ophthalmology, as well as in the context of dual site working. This risk is primarily due to the difficulty in recruiting to consultant posts and the resulting impact on medical staffing rotas. The consequences of this risk include:	Risk reduced from risk score 20 to 16	Following review of Trustwide staffing risks, the risk score has been reduced to bring in line with similar staffing risks across other divisions in the Trust

Moderate	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 competent middle grade medical staff in the trust currently.	Risk reduced from risk score 15 to 9	Chest drain emergency/ urgent pathway now agreed and signed off at PSQB it). . A significant number of registrars have completed training and training sessions planned in august to cover new rotating registrars
Moderate	8509	Surgery & Anaesthetics	Head and Neck	Ophthalmology	Keeping the base safe	There is a risk of significant harm due to insufficient glaucoma appointments available to cope with demand due to increasing patient numbers and inability to recruit substantive consultant.	Risk reduced from risk score 15 to 12.	Consultant due to start 8th July 2024. Remedy insourcing has improved backlog

Moderate	8315	Surgery & Anaesthetics	Head and Neck	Ophthalmology	Keeping the base safe	There is a risk of significant of increasing waiting lists and delays to new and follow up appointments in the ophthalmology paediatric service as well as delays in improvement, quality assurance, staff development and pressure on the service due to not having enough substantive Paediatric Consultants. This could result in catastrophic or significant harm to the patient.	Risk reduced from risk score 15 to 12.	Improved position.
Moderate	8641	Surgery & Anaesthetics	Critical Care	Critical Care Outreach	Keeping the base safe	There is a risk of non-compliance with national standards (GPICS) due to inadequate pharmacy staffing in CHFT's critical care units resulting in staff burnout, increase in medication errors, risk to patient safety and exposure to legal consequences or regulatory penalties.	Risk reduced from risk score 15 to 12.	Discussed at DMT agreed to reduce risk score in line with pharmacy risk.

Moderate	6345	Corporate	Workforce & Organisational Development	Resourcing / Recruitment	Keeping the base safe	There is a risk of: insufficient Trust employed Nurses, and HCSW to deliver safe and compassionate care on a shift-by-shift basis, as defined by the agreed Workforce Models or Care Hours Per Patient Day (CHPPD)	Risk reduced from risk score 20 to 12.	Improved nursing vacancy position across divisions
Moderate	8508	Surgery & Anaesthetics	Head and Neck	Ophthalmology	Keeping the base safe	There is a live current risk to CHFT being unable to provide a Consultant Glaucoma Service due to no Consultant in post at CHFT.	Risk reduced from risk score 15 to 12.	1 Consultant in currently in Post with another to follow.

Appendix 4 – Risks that scored 15+ during last report but have now closed/merged.

Risk Level	Risk No	Division	Directorate	Department	Objective	Risk Summary	Risk Score	Reason for Risk Closure
Low	8361	Surgery & Anaesthetics	Critical Care	Pain Clinic	Keeping the base safe	There is a risk of disruption to services in the pain clinic due to impending retirement of Band 6 CNS in January 2024, and potential retirement of Band 7 (CNS) at some point (turned 55 in October 2021) resulting in only one experienced Band 6 Clinical Nurse Specialist leaving a gap in knowledge and a risk to patient care, as there will be limited resources to review patients on the wards and nurse clinics would have to stop.	Risk reduced from risk score 15 to 2	Staffing level back to full establishment

20. Green Plan Annual Report

To Note

Presented by Stuart Sugarman

Date of Meeting:	12 September 2024
Meeting:	Board of Directors
Title:	Annual CHFT Green Plan Update 2024
Author:	Grace Barrett, William Bennett
Sponsoring Director:	Stuart Sugarman
Purpose of the Report	This paper provides an annual progress update relating to the Calderdale and Huddersfield Foundation Trust (CHFT) Green Plan and Sustainability Action Plan (SAP).
Key Points to Note	The CHFT Green Plan outlines the Trust's ambition for sustainability to 2026. The Green Plan was developed alongside a corresponding Sustainability Action Plan (SAP), which spans ten key themes to address the Trust's carbon reduction commitments while ensuring integration with corporate objectives. The Green Plan was first approved by Transformation Programme Board (TPB) in March 2021, and delivery has since been managed by CHS. Progress against the SAP is monitored through the Green Planning sub-group. This update report describes each SAP theme and outlines the key progress and next steps subsequently. **What is a Green Plan?** A Green Plan is a Board approved, live strategy document outlining the organisation's aims, objectives, and delivery plans for sustainable d evelopment. This includes implementation of the NHS Long Term plan deliverables. Delivering and monitoring the Green Plan will help the CHFT to: 1. Deliver on its Long-Term plan 2. Improve the health of the local community 3. Achieve its financial goals 4. Meet its legislative requirements. A Green Plan may be valid for 3 to 5 years and should be reviewed at least once in the interim period. To ensure a Green Plan has impact and progress against the commitments set out, plans are expected to be reported to the Board or Governing Body on an annual basis. Progress against this plan is reviewed on a regular basis at TPB. The Green Plan has been submitted to relevant partners and communicated to staff and the public via intranet, newsletters and the organisation's website. It's important to note that the SAP is a live document and will continue to be developed as the strategy is delivered.
Regulation	CQC Regulation 17: Good governance

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

Integrated Facilities Management

CHFT Green PLAN

Annual Update

August 2024

Author: Grace Barrett, Environment Manager & William Bennett, Environment & Waste Coordinator

Sponsor: Stuart Sugarman CHS Managing Director

Working in partnership with

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Calderdale and Huddersfield
NHS Foundation Trust

Executive summary

This paper provides an annual progress update relating to the Calderdale and Huddersfield Foundation Trust (CHFT) Green Plan and Sustainability Action Plan (SAP). The SAP outlines individual actions across 11 key themes. In total, 165 of the 207 total interventions are designated as complete.

The themes Asset Management and Utilities and Sustainable Care Models are designated as 100% complete, however many of the actions are ongoing.

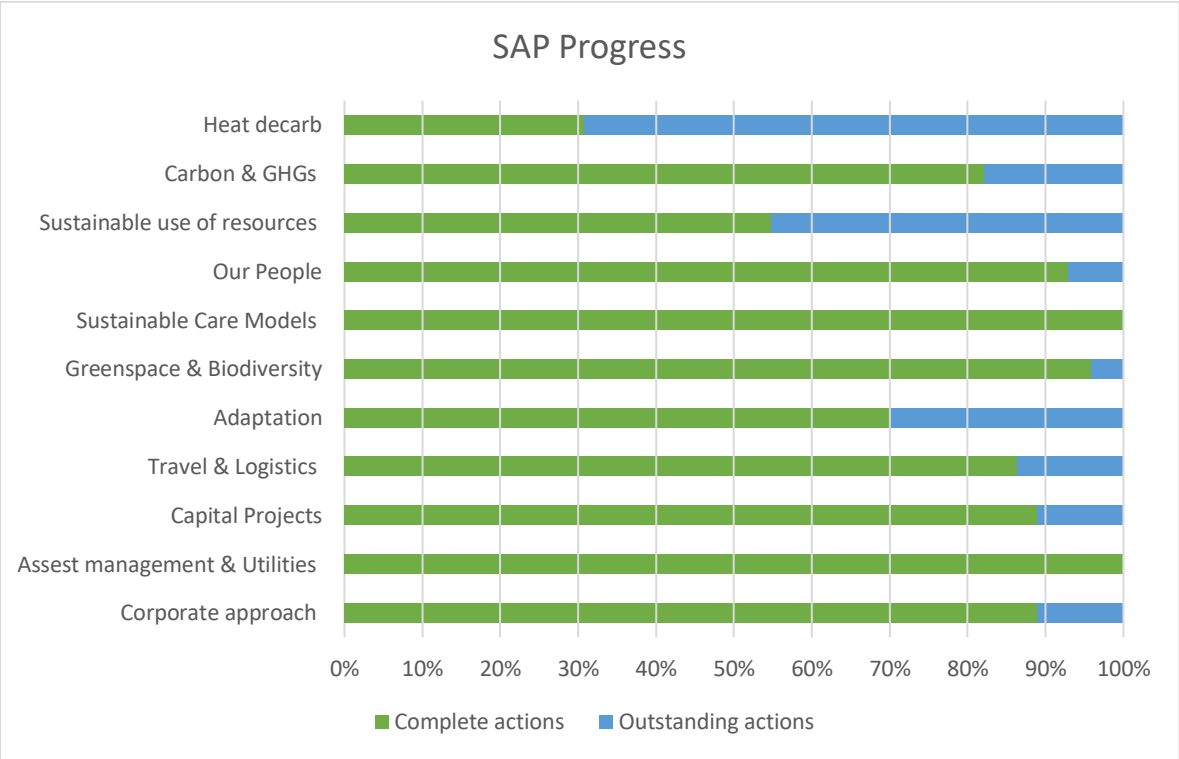
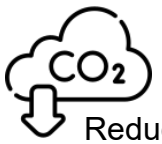


Figure 1 SAP progress tracker

2023/24 Key progress	2024/25 Key priorities
- 1.33% reduction in carbon emissions since 2022/23 - Over 800 efficient LED light fittings installed. - 97 Coolnomix energy saving devices installed at HRI and Broad Street Plaza - Steam condensate scheme completed at HRI- Summer 2024 - 400 tree saplings planted at HRI. - Nitrous oxide manifold decommissioning - 71 items re-used following 'Dump the Junk' campaign	- Approval of the CHFT Energy Management Policy - CHFT Staff Travel Survey due early 2025. - Develop network of Green Champions and increase sustainability awareness and training. - Establish pharmacy inhaler recycling waste stream. - Continued delivery of the heat decarbonisation plans and greater spotlight on net zero

Table 1. Key progress and priorities

Green Plan achievements 2023/ 24



41.6%
Reduction in CO2e since the baseline year (2013/14)

£89,375
Received in external funding and grants for energy efficiency projects

285 tonnes waste **Recycled**

3.82%
Reduction in annual electricity kWh consumption since 2022/23

1.5% Reduction in annual gas use since 2022/23
Equivalent to **107 tonnes** CO2e

0%
Waste to landfill

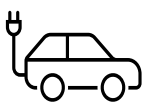
308
Unnecessary waste collection journeys prevented since installation of compactors, saving **£47,000** each year

800+
LED light fittings installed at Broad Street and Acre Mills

71 Items re-used across CHFT
Saving approx. **£5720**

400+
Trees planted on site at HRI

97 Coolnomix units installed
Saving **1.2 million kWh** electricity over the next decade



2.7 tonnes
CO2e avoided to date as a result of EV charging infrastructure enhancements

19 tonnes
CO2e avoided monthly by providing remote outpatient appointments

Figure 2. Key progress infographic

Introduction and background

The purpose of this report is to update the Public Board of Directors on the CHS Energy, Waste and Sustainability team's progress delivering Green Plan priorities over the last 12 months and outline key priorities for the year ahead.

The Green Plan was first approved by the Transformation Programme Board in March 2021 and submitted at Integrated Care System (ICS) level. Delivery has since been managed by CHS and progress against the Sustainability Action Plan (SAP) is monitored by the Green Planning Committee. The plan provides a strategic framework to address the three main areas of concern: Climate change, waste and air pollution.

Climate change poses a major threat to health and the planet. As the environment changes, this has a direct impact on our patients, public health and the NHS. In October 2020, the NHS led the way in becoming the world's first health service to commit to reaching net zero carbon by 2040, in response to the growing threat posed by climate change.

CHFT recognises that our natural environment is a precious legacy, and we thereby have a responsibility to reduce our environmental impact. Our Green Plan (2021-2026) demonstrates our Trust's commitment to meeting national NHS and government targets for reducing carbon emissions, safeguarding the environment for future generations, and delivering sustainability across our organisation.

1. Corporate Approach

Progress 2023/24

Waste and sustainability improvement plans

In April the waste and sustainability teams devised a focused waste and sustainability improvement plan to identify key projects for the year ahead. This included improving waste segregation to reduce expensive infectious waste weights, extending the usable life of sharps bins, reducing food waste by separating solid food and liquid waste and improving energy efficiency. Delivery is ongoing.

Communications and engagement

CHS Managing Director and Environment Manager attend Climate Change Workstream which includes representatives from other West Yorkshire Trusts and Local Councils.

The Environment Manager and Waste Management Officer attend regular relevant regional forums such as HEFMA, ICS Climate Change Operational Leads Meeting and WY Travel Network.

Green plan branding

Green plan branding including a new 'CHFT Green Plan' logo was created by the THIS Graphic Designer for use on all sustainability and green plan communications to ensure consistency and recognition for environment and sustainability initiatives.

Sustainable Procurement

In April the CHS Procurement Team and the Environment Manager attended the Sustainability and Social Value workshop delivered by the North of England Commercial Procurement Collaborative, to gain a better understanding of The NHS Net Zero Supplier Roadmap, Getting the most out of Social Value, Carbon Reduction Plans, The Evergreen Sustainable Supplier Assessment and Modern Slavery.

Priorities 2024/25

SIA for business cases over £50k

Investigate opportunity to introduce sustainability impact assessment for business cases over a certain limit, to encourage life-cycle thinking throughout project planning.

2. Asset management and utilities

We recognise that energy consumption is the greatest contributor to carbon emissions within the Trust. There are 10 actions within this section, many of which are linked to the Trust's net zero targets.

Progress 2023/24

Energy efficiency

- Action plan and group

The energy efficiency task and finish group meet bi-monthly to monitor progress delivering priorities outlined in the Energy Efficiency Action Plan. This group feedback relevant updates to the Green Planning Committee.

- Audit schedule

Members of the sustainability team within Estates have been conducting regular audits of wards and departments around HRI and CRH. The focus of these audits has been to identify energy usage patterns and areas for improvements to enhance energy efficiency and sustainable practice. Ward and department managers were provided with a report on the findings and assistance and guidance on addressing these which contribute to reducing energy consumption, operational costs and advancing CHFTs commitment to sustainability.

Energy Data

The graphs below provide an overview of energy consumption, cost and electrical efficiency using current and historical energy data.

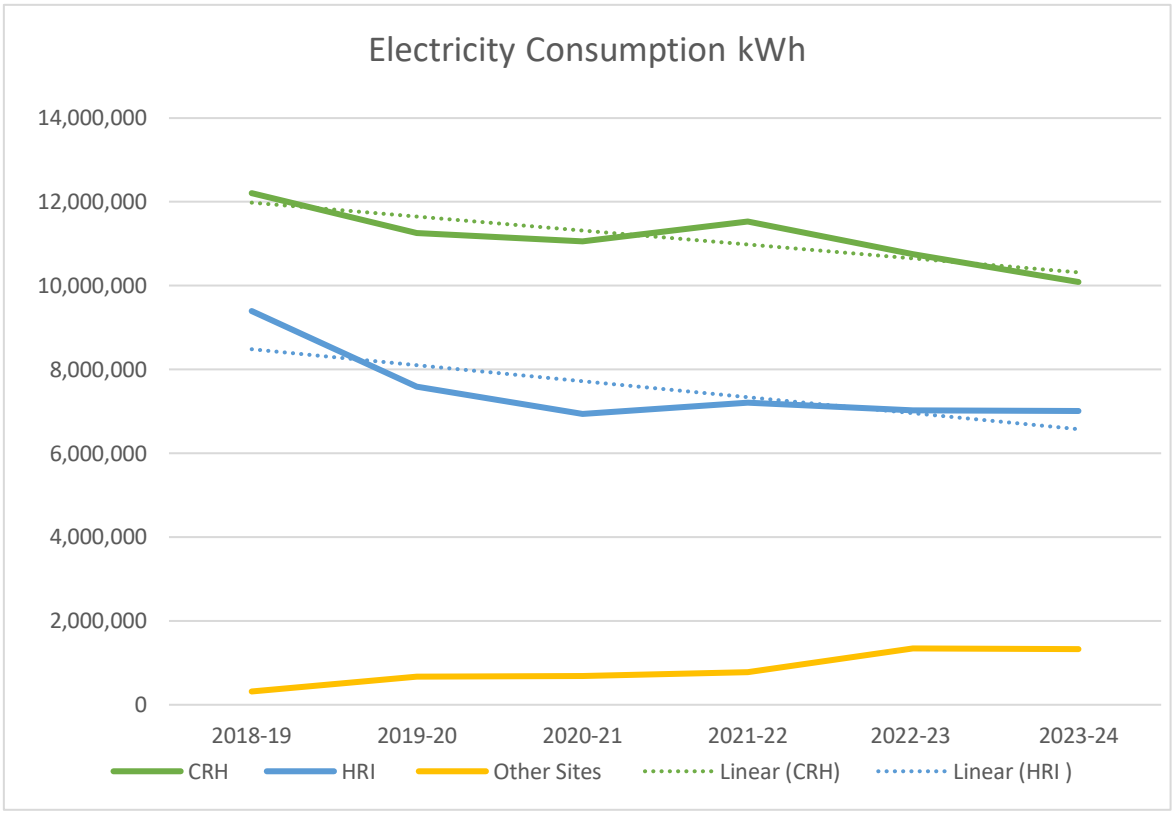


Figure 3. Electricity consumption kWh

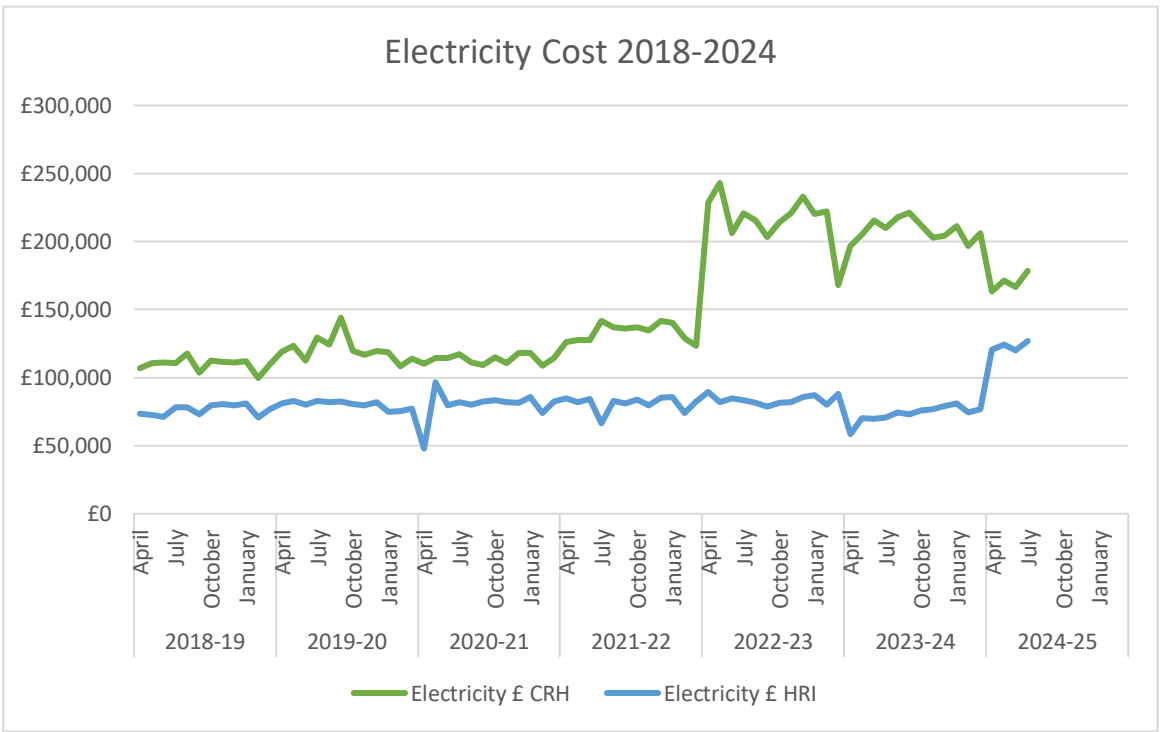


Figure 4. Electricity cost £

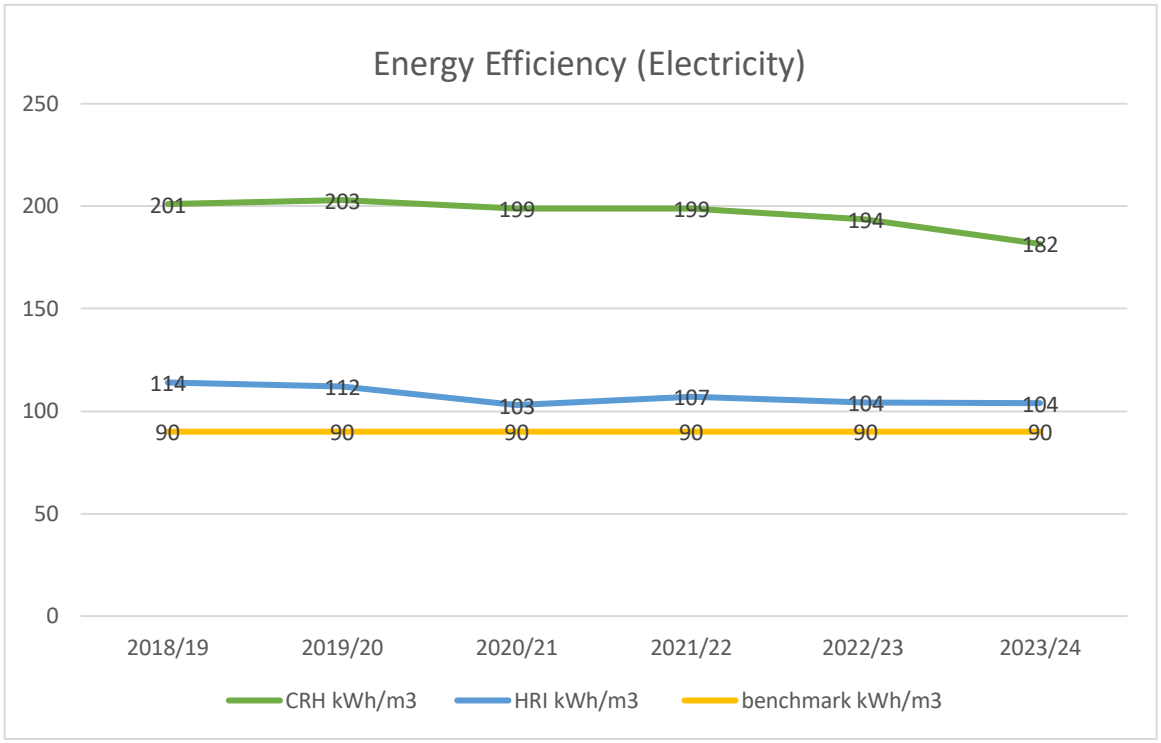


Figure 5. Electrical energy efficiency compared to acute hospital benchmark

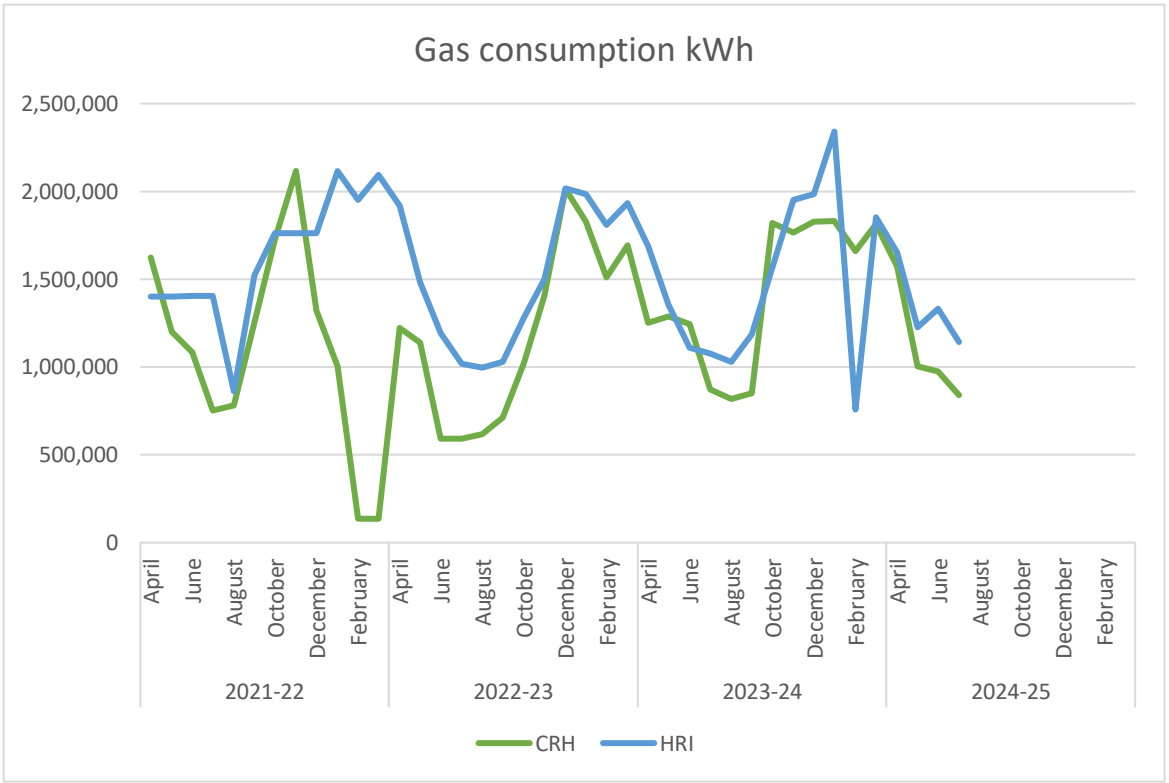


Figure 6.. Gas consumption kWh

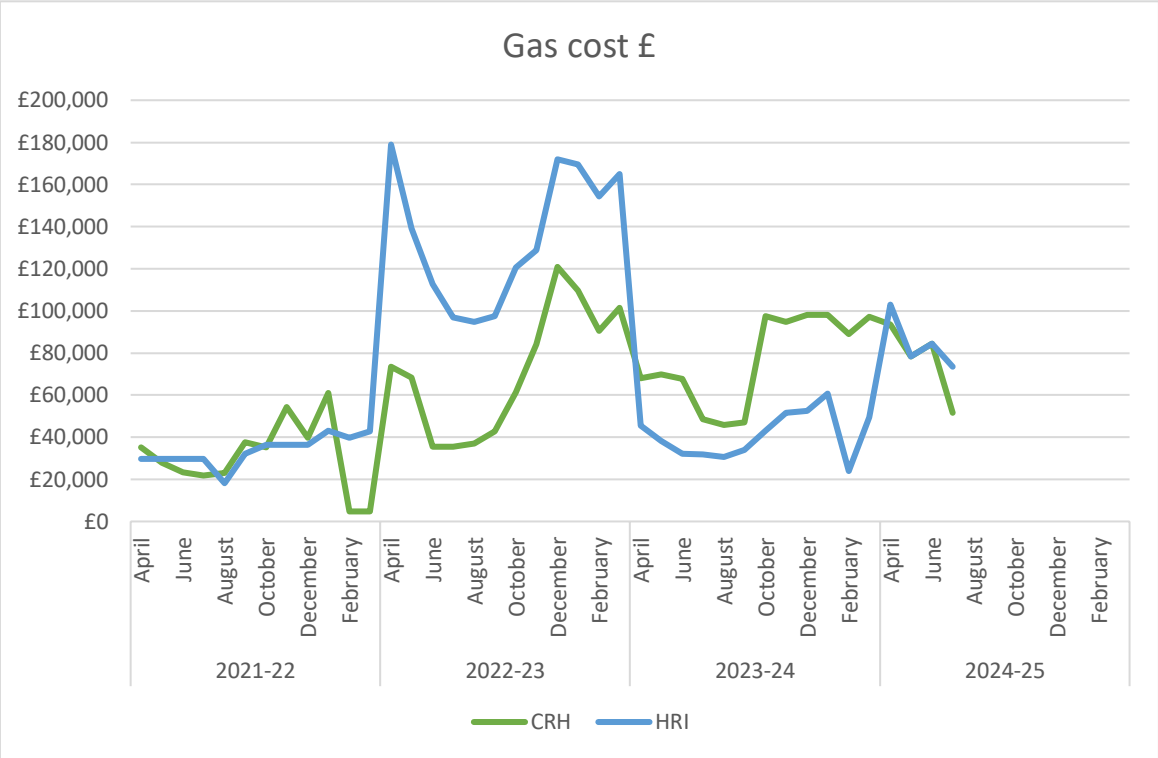


Figure 7.. Gas cost £

Steam condensate scheme

The Steam Condensate Scheme was completed at HRI in June. This is a significant project which aims to improve the efficiency of the steam heating system at the hospital by returning steam at a higher temperature and reduce the volume of natural gas needed to bring the boilers up to temperature. Gas usage will continue to be monitored going forwards.

Priorities 2024/25

Calderdale Learning and Development Centre- Energy

Once operational, the new learning and development centre at CRH will be powered using electricity only, meaning that emissions as a result of fossil fuel use at this site will be 0. In addition to this, the building will have solar PV to generate renewable power on site, reducing energy cost and reliance on the grid.

Energy management policy

Energy management policy still requires approval and will be presented at the relevant forums.

Solar proposals

CHS have received proposals to install solar PV at a number of key Trust sites including CRH and HRI. Decision needed regarding funding and next steps.

3. Travel and logistics

As staff, visitor, patient and supplier travel contributes to Trust carbon emissions, the 21 actions within this section aim to reduce the environmental impact of travel and transport and thereby reduce the Trust's contribution to air pollution.

Progress 2023/24

EV charging point installation and ongoing monitoring

In August 2023, 10 new EV charging points were installed at HRI and Acre Mill to help facilitate the transition to zero carbon travel. These facilities are available for use by both staff and visitors and their usage is monitored monthly via the EV charging dashboard. Since the initial go live, 32,188 kWh of charge has been used, equivalent to an avoidance of 2.7 tonnes CO2e (scope 3 emissions) and revenue generation of almost £7000. This data will continue to be monitored to assess demand and plan for future installations, as per the EV charging strategy.

STAXY car share platform

The CHS Sustainability and Transport teams investigated scope to implement a car share and sustainable travel platform in partnership with provider STAXY. This was paused indefinitely due to funding.

Local Authority Bus Service Improvement

Improvements to the local bus network have been made as part of the Combined Authority's Bus Service Improvement Plan (BSIP). The BSIP identified issues surrounding the connectivity of the two sites at HRI and CRH via public transport and prioritised these areas for improvement. Staff, patients and visitors will benefit from the enhanced routes between the two sites and connectivity with other key locations across Kirklees and Calderdale.

Priorities 2024/25

CHFT Staff Travel Survey

The Trust wide biennial travel survey is due in February 2025, as per the CHFT travel plan. The Survey will mirror the previous 2023 survey to enable data comparisons and progress measurement around key themes such as EV charging, public transport, active travel and car parking.

CRH Multi-Storey Car Park

The new multistorey car park development at CRH will include 40 EV charging points for use when the car park opens to staff and visitors.

4. Capital Projects

There are 14 actions within this section which support the Trust's ambition to achieve estate- wide efficiency through reconfiguration.

Progress 2023/24

LED lighting

In March 2024, CHS applied to the second round of the NHS Energy Efficiency Fund and was awarded circa £49,000 for the installation of efficient LED lighting at Broad Street Plaza Health Centre. This scheme is now complete and expected to save the Trust approximately £6500 annually.

Over 200 fittings have also been installed in the Acre Mills personnel building to improve energy efficiency at this site.

Coolnomix

Following a successful application to the North East and Yorkshire Net Zero Hub, CHS was awarded £40,375 which was match funded by the CHFT capital management group, to implement an energy efficiency project. The funding was used to purchase and install 'Coolnomix' smart thermostat devices to 97 air conditioning units across HRI and Broad Street Plaza. The devices are expected to save 120,000 kWh electricity annually.

Priorities 2024/25

Calderdale Learning Development Centre

Construction is underway for the new learning and development centre at CRH, which is being built using Modern Methods of Construction (MMC). MMC aim to reduce the embodied carbon of the build and contribute to sustainability through a variety of methods such as reducing the number of deliveries on site, reducing the build time and energy use as a result of fewer person-hours on site, decreasing the demand for heating and lighting as well as plant and equipment use, and reduced levels of waste. Modern Methods of Construction further contribute to sustainability through their encouragement of the use of sustainable materials, for example a limited use of cement and concrete due to their high levels of embodied carbon.

5. Greenspace and Biodiversity

Protecting and enhancing greenspace and biodiversity is hugely beneficial for the environment and can positively impact wellbeing. Planted trees will likely play a crucial role in offsetting future carbon emissions.

Progress 2023/24

Wellbeing Garden

The 5th of June marked the official opening of "The Wellbeing Garden" which was made possible by the funds provided by CHFT's Charity. The garden has had a positive impact on staff and visitors' wellbeing as they now have a quiet place for seclusion and reflection. As well as a health benefit for people, the garden has created an ideal spot for pollinators and insects due to the southern wildflower meadow and thoughtful selection of native shrubs and flowers. Trees have also been planted throughout the garden providing a diverse range of habitats for local wildlife and contributing to CHS's commitment to plant 6000 trees on site and within our local communities as outline in the biodiversity action plan.

Tree planting at HRI

During Spring 2024 the NHS Forest Charity provided the Trust with over 400 Trees to plant on site as part of their mission to help transform NHS green spaces to realise their full potential for health, wellbeing and biodiversity and to encourage

engagement with nature. With the help of the CHS gardening team all 400 Trees were planted at HRI and Acre Mills. The planted trees consisted of native species such as birch, beech, hazel, dogwood and cherry trees which provide a vital habitat for many of our at-risk wildlife species.

Priorities 2024/25

2024/25 Tree planting season

Continue tree planting regime at HRI in line with tree planting season including further enhancement of the hedgerow along the south boundary of the site. Investigate opportunities to apply for more tree saplings from NHS Forest/ the Woodland Trust.

6. Sustainable Care Models

Ingraining sustainability into our clinical care models is a vital consideration if the Trust is to reach net zero carbon.

Progress 2023/24

Green endoscopy

The endoscopy department at HRI have made noteworthy progress towards ingraining sustainability within their clinical practices. Some initiatives include establishing a working group to discuss how to implement change and developing a 'Green Endoscopy' checklist and pledge to proactively improve the sustainability of the service.

Figure 8. Green Endoscopy Display Board

Nitrous manifold decommissioning

As of Augst 2024, the piped nitrous system has been switched off at HRI and transitioned to a cylinder only system. Nitrous oxide alone contributes to 2% of the overall NHS carbon footprint, and 75% of the total anaesthetic gas carbon footprint

(Centre for Sustainable Healthcare). At HRI, approximately 810,000 litters N2O were used in the manifold rooms alone in 2022/23 and the average CO_2 emissions created using this agent are estimated to be approximately 39.7 tonnes CO2e per month using data from the Refine program. As significant amounts of the gas is lost from manifolds and piped infrastructure, switching to cylinder only will address unnecessary wastage and associated emissions, and allow better management of the medical gas on site.

This builds on the work already done to reduce Desflurane use across the Trust, which is another potent greenhouse gas.

Remote outpatient appointments

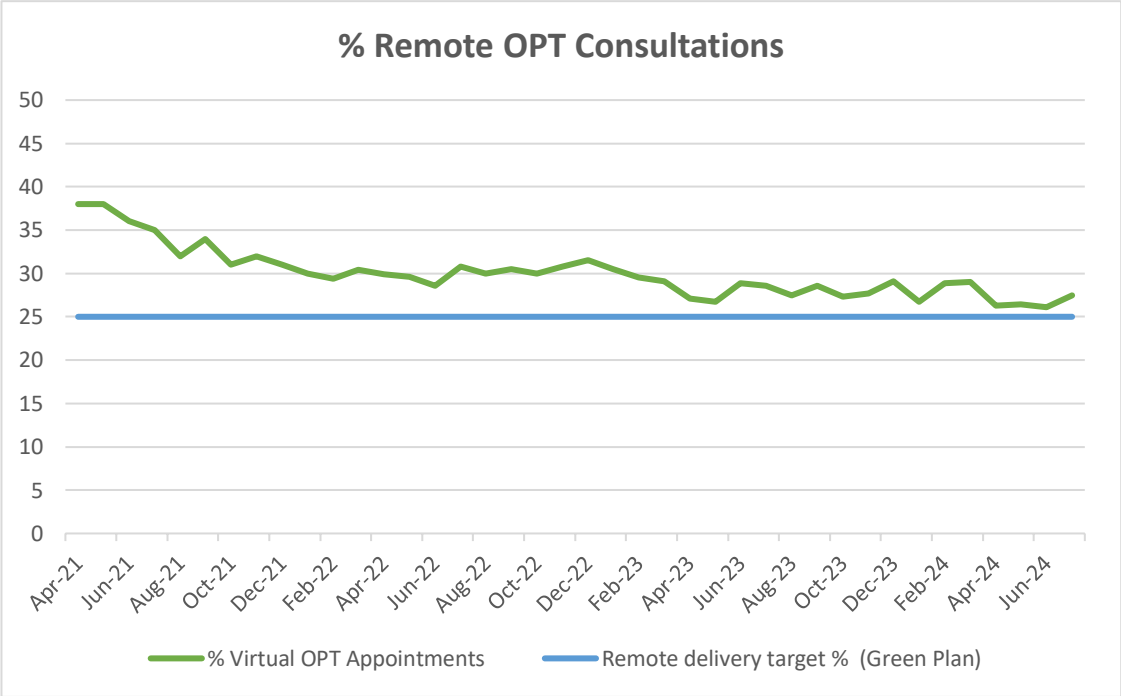


Figure 9. Remote consultations tracker

Remote outpatient consultations have dropped significantly since the removal of Covid -19 restrictions, however consistently remain about the 25% delivery target. Enabling patients to access remote appointments where appropriate limits the potential spread of infection, helps meet the rising demand for healthcare as well as reducing the Trust's scope 3 emissions resulting from patient travel. Assuming that each patient would have travelled an average of 5km to and from site in a petrol car, the Trust avoided approximately 120,000km of road travel by delivering appointments remotely in July 2024 alone, which is equivalent to 19 tonnes of CO2e.

Priorities 2024/25

Nitrous Oxide Decommissioning

Continue to monitor impact of nitrous manifold decommissioning, and gather data to monitor carbon impacts.

7. Our People

This section includes 15 actions which recognise that as people are at the heart of our organisation, it is crucial for the Trust to maintain a positive and inclsuive work environment, protect staff wellbeing and provide the best care for our patients.

Progress 2023/24

Clean air day 2024

On the 20th June, CHFT celebrated national Clean Air Day by giving away surplus tree saplings following the planting regime at HRI earlier in the year. Clean Air Day is the UK's largest air pollution campaign, and this event aimed to raise awareness whilst promoting biodiversity.

We chose to give away trees as they are proven to remove harmful pollution from the air whilst providing clean oxygen. Access to plants and greenspace is also beneficial for health and wellbeing. In total over 60 Birch and Holly Saplings were collected by colleagues from the HRI wellbeing garden, to take home, plant and enjoy in their own gardens. Members of the sustainability and grounds maintenance teams were also on hand to discuss all things clean air and biodiversity!

Figure 10. Clean Air Day event photos

CHFT Sustainability Survey/ Yorkshire Sustainability Week

In June 2024 we launched a trust wide sustainability survey to coincide with Yorkshire Sustainability week, which closed with 48 responses from colleagues. The survey aimed to determine staff awareness and attitudes towards the Green Plan, and identify any potential 'Green Champions' across the Trust.

The survey results indicated that although most staff felt that sustainability initiatives within the NHS were 'very important', over 60% of respondents were not familiar with the CHFT Green Plan. The responses also identified lack of awareness, insufficient resources/ funding and resistance to change as the main obstacles preventing the NHS from becoming more sustainable.

The survey data will be used as a baseline to measure attitudes to the Green Plan and sustainability initiatives going forwards, shape the development of further sustainability engagement and measure progress.

Priorities 2024/25

Greener NHS net zero online training

The Health Education England online training package 'Building a Net Zero NHS' will be added to mandatory training for all CHS staff, with a view to approaching the Trust Education Committee to support including Net Zero training for all CHFT staff in the long term. Training is required to increase sustainability and environmental awareness among staff and raise the profile of the Green Plan.

Green champions network

The sustainability survey identified a number of staff who volunteered to be 'Green Champions' within their work areas. Developing a network of Green Champions will be integral to ingraining a culture of sustainability across the Trust. The sustainability team are currently developing a Green Champion training package to be delivered in house/ in person, which will be rolled out in the next 6-12 months.

8. Sustainable Use of Resources

A significant amount of waste is produced across the Trust to deliver our services. Through improved waste management, the Trust can reduce the amount of waste produced, reduce carbon emissions and save money.

Progress 2023/24

40% recycling target

The graph below tracks the Trust's progress towards achieving 40% recycling, as per the Green Plan Target.

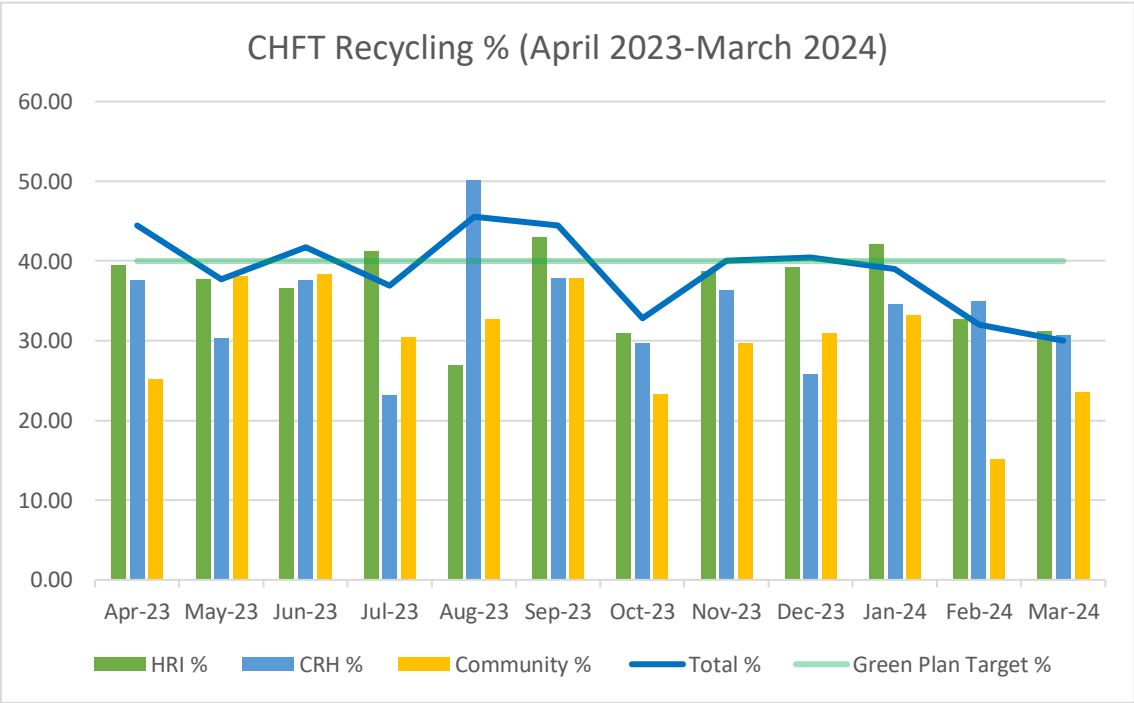


Figure 11. Recycling % tracker

Sharps extension

In an effort to reduce unnecessary wastage, Estates saw an opportunity to increase the expiry date of sharps boxes from 3 months to 6 months as during audits it was highlighted that the boxes were being disposed of half full due to the self-imposed expiry. IPC were consulted on this and agreed that this was safe to do. With the help of the comms team, ward staff were informed of these changes as well as the environmental and financial benefit.

'Dump the Junk' & Global Recycling Day 2024

Figure 12 Dump the Junk Logo

In conjunction with Global Recycling Day on 18th March 2024, CHFT launched "Dump the Junk" campaign. This initiative aimed to declutter our hospitals by encouraging staff to dispose of unused furniture, electricals, cupboards, desks, old medical equipment, and other items. The main goals were to free up space, reuse furniture and ensure proper waste disposal where necessary.

We received 42 responses and collected a variety of items, categorized as follows:

- Reusable Furniture (Desks, Chairs, Tables, Cabinets): 57 items
- Junk Furniture: 30 items
- IT Equipment: 9 items
- Reusable Other (WEE, Bins, Whiteboards, Covid Screens etc): 26 items
- Junk Other (WEE, Bins, Whiteboards, Covid Screens etc): 30 items

Impacts:

- Space Management: Cleared out a total of 153 items, freeing up valuable space.
- Cost Savings: By reusing 71 items, we saved an estimated £5720.
- Proper Disposal: Ensured items were disposed of correctly, minimizing environmental impact.

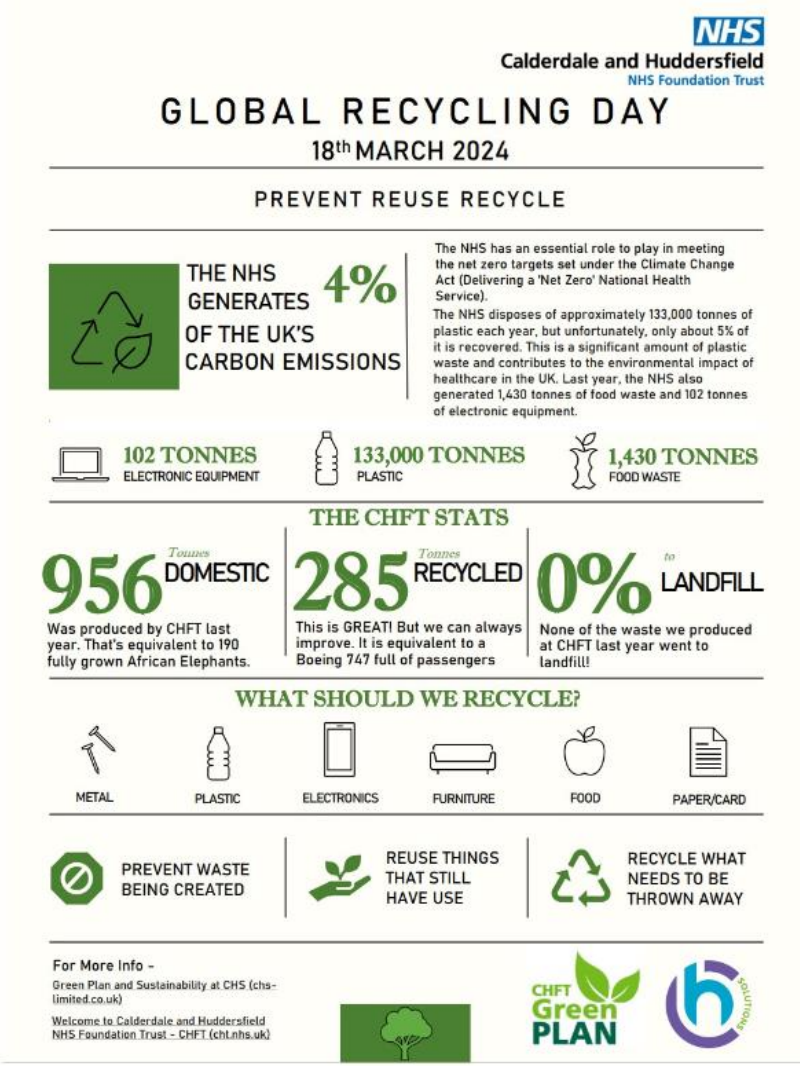


Figure 23 Global Recycling Day Infographic

In addition, CHS has rolled out battery bins to all the wards and departments to encourage staff to recycle them. The batteries are segregated depending on the type and are sent for the correct disposal treatment with all the household batteries, which accounts for around 50% of what we produce on site, being recycled.

Reupholstering scheme

As part of the CHFTs effort to promote a circular economy and reduce the amount of unnecessary waste produced by the Trust, waste management, along with members of the clinical engineering team have been encouraging ward staff to fix things rather than buy brand new. Due to the communications put out by the sustainability team, an area where this has seen a decrease in wastage and expenditure has been the padded clinical furniture. Staff have been using a reupholstery service to fix the pads on patient bedside chairs and examination couches which dramatically extends the lifetime of these items whilst costing a fraction of what it would to buy new and therefore adhering to the principals set out in the NHS clinical waste strategy. An average of 10 items have been fixed a

month saving £500 per item and preventing the unnecessary incineration of items containing persistent organic pollutants.

Waste Compactors

In October 2023, 2 compactors for offensive waste were installed at HRI and CRH. The aim being to reduce the number of unnecessary journeys to and from the waste treatment facility on Leeds Road. Before the installation of the compactors, there were an average of 34 collections a month across both sites. This has now been reduced to 6 collections a month meaning that an estimated 308 unnecessary journeys have been prevented and transportation costs and emissions for this process have been reduced significantly. The scheme will save approximately £47,000 in waste disposal costs annually.

Priorities 2024/25

Pharmacy inhaler disposal

A waste stream for the inhalers produced on site is currently being set up. The propellant gases within the inhaler produce around 4kg of CO2e per inhaler. These are currently disposed of with the other pharmaceutical waste. Estates, along with pharmacy are setting up a scheme to capture the waste inhalers produced on site and send them to a contractor who can capture these gases and recycle them. We expect to prevent an estimate of 400kg of CO2e a month by implementing this process.

Walking Aid Re-Use

A scheme to reuse and refurbish walking aids is being developed. Patients will be advised to return the walking aid to either HRI or CRH after they no longer require it. The walking aid will then be assessed by Therapy Services on whether it can be reused, if it can, it will be cleaned and put back into circulation. If it can't be reused in its current state, it will be refurbished, or the metal will be recycled. If 2 out of every 5 walking aids were returned, the Trust could save up to £46k per year.

Improving waste segregation

The waste team will continue to promote correct waste segregation across all wards and departments, including the 'bag to bed' system for dealing with clinical waste, which will in turn reduce bin numbers on wards. To deliver in person training and education to staff on wards and promote awareness via Trust communication channels.

9. Carbon and Greenhouse Gasses

Reducing emissions to net zero requires effort from all departments, operations and stakeholsers across the Trust.

Progress 2023/24

SECR 2023/24

The annual Streamlined Energy and Carbon Report demonstrates CHS's compliance with relevant legislative requirements for sustainability reporting and is

carried out on behalf of CHS by sustainability consultancy Inenco. It provides a framework for measuring CO2e emissions as a result of our operations.

The graph displays CHFT's (CHS + CRH) annual CO2e emissions as reported in the annual SECR, using the market- based methodology. Overall emissions have reduced by 1.33% compared to the previous reporting period (2022/23) and 41.6% since the baseline year (2013/14), however show a steady upwards trend since 2019/20.

The trust requires a further 65% reduction in emissions if it is to reach the 2032 target, and a 100% reduction to reach the 2040 target for net zero. As 87% of the overall Trust carbon footprint can be attributed to natural gas usage, the decarbonisation of heating systems and improving energy efficiency across the CHFT portfolio of sites will be crucial for meeting these goals and delivering associated cost savings.

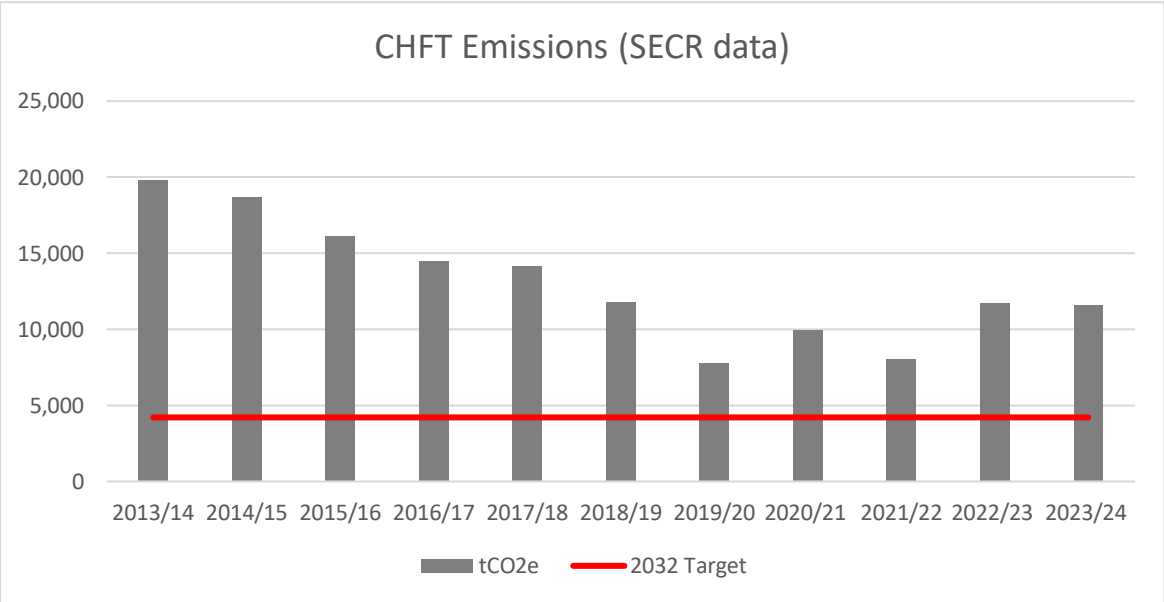


Figure 34 CHFT Annual Emissions

Priorities 2024/25

Heat Decarbonisation Plan Delivery

Continue to deliver efficiencies and actions outlined in the heat decarbonisation plan to tackle natural gas usage on our sites.

10. Heat Decarbonisation

Heat decarbonisation is a challenging but crucial aspect of our net zero aspirations. 87% of the Trust's carbon footprint results from fossil fuel boilers used on site to generate heat. Decarbonising the heating systems across our estate will require a mixed portfolio of on and off site solutions, such as heat pumps, solar PV and hydrogen. Planning for decarbonisation will require significant infrastructure projects to be implemented over several years.

Progress 2023/24

Application made to LCSF

In April, Environment Manager submitted an application to phase 5 of the Salix Low Carbon Skills Fund with support from consultants at Mott Macdonald. If successful this funding would be used to develop detailed feasibility plans to de-steam the site at HRI, and transition to a zero carbon heating system. Awaiting outcome. **HRI ED ASHP** In May, the new ED opened to the public at HRI. The new building is powered by an air source heat pump (ASHP), which is a form of low carbon heating as it does not require the input of fossil fuels. **Equans CRH Net Zero Carbon Roadmap** Equans have developed a net zero carbon roadmap for CRH which identifies a range of short and longer-term actions that will improve energy efficiency and aid the transition to net zero.
Priorities 2024/25
Salix funding Continue to monitor announcement of funding opportunities such as future phases of the Public Sector Decarbonisation scheme (PSDS).

Calderdale and Huddersfield Solutions Ltd
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Acre Street · Huddersfield · HD3 3EA

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Company registration number 11258001 · VAT number 293 0609 00

GOVERNANCE

21. Governance Report

a) Governance Structure

b) Board of Directors Workplan for 2024/2025

c) Board of Directors Meeting Dates 2025/2026

To Approve

Presented by Andrea McCourt

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 12 September 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) Governance Structure b) Board of Directors Workplan for 2024/2025 c) Board of Directors Meeting Dates 2025/2026
Key Points to Note	**a) Governance Structure - Quality Committee** The Board is asked to note there are additional groups reporting to the Quality Committee which have been added to the Governance structure which is enclosed at Appendix R2. These are: • Learning Forum – this is a quality and safety learning forum chaired by the Chief Nurse or Deputy Chief Nurse responsible for providing assurance that there is effective monitoring and oversight of lessons learnt from patient safety events • The Maternity and Neo Natal Board, which reports to the Quality Committee has been added, with the Board receiving a regular report on progress with the three year plan for maternity and neo-natal services. **RECOMMENDATION:** The Board is asked to **NOTE** the additions of the Learning Forum and the Maternity and Neo Natal Board reporting groups to the Quality Committee on the Trust governance structure. **b) 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 R3.

	RECOMMENDATION: The Board is asked to **APPROVE** the Board workplan for 2024/25. **c) Board of Directors Meeting Dates 2025/2026** The Board is asked to approve the proposed Board of Directors and Board Development meeting dates for the period April 2025 – March 2026 as scheduled at Appendix R4. **RECOMMENDATION:** The Board is asked to **APPROVE** the proposed Board meeting dates for the period April 2025 – March 2026.
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: • Board of Directors Workplan for 2024/25 • Board of Directors meeting dates for the period April 2025 – March 2026 The Board is asked to **NOTE** the: • Additions of the Learning Forum and Maternity and Neo Natal Board reporting to the Quality Committee.

GOVERNANCE STRUCTURE
September 2024

WYAAT Committee in Common
WY Community Collaborative
Kirklees Health & Care Partnership
Calderdale Cares Partnership
Reconfiguration Round Table

BOARD OF DIRECTORS

Charitable Trustees

Charitable Funds Committee
Chair: Helen Hirst (Chair)
Nigel Broadbent/ Frequency: Quarterly

Organ & Tissue Donation Committee
Chair: Helen Hirst / Frequency: Bi-annual

Council of Governors
Chair: Helen Hirst / Frequency: Quarterly

Nominations & Remuneration Committee (Sub Committee to the Council of Governors)
Chair: Helen Hirst / Frequency: Ad hoc

Audit and Risk Committee
Chair: Nigel Broadbent
Jo Wass
Tim Busby
Frequency: Quarterly

Risk Group
Chair: Director of Corporate Affairs
Frequency: Monthly

Information Governance & Records Strategy Group
Chair: CDIO
Frequency: Quarterly

Data Quality Board
Chair: COO
Frequency: Monthly

Data Quality Group

Compliance Group
Chair: Director of Corporate Affairs
Reporting: Monthly

Resilience & Safety Group (includes H&S Committee)
Chair: COO
Frequency: Monthly

Transformation Programme Board
Chair: Peter Wilkinson
Helen Hirst
Frequency: Bi-monthly

Green Planning Committee
Chair: Managing Director, CHS
Frequency: Monthly

Divisional Performance Reviews Executive Lead &
Chair: COO
Frequency: Determined by position e.g. monthly, bi-monthly or quarterly

Finance & Performance Committee
Chair: Vanessa Perrott
Nigel Broadbent
Denise Sterling or Tim Busby
Frequency: 10 per annum

Turnaround Executive

Capital Management Group

Business Case Approvals Group

The Health Informatics Service Board

Huddersfield Pharmacy Specials Board

CHS & CHFT Joint Liaison Committee

CHFT/PFI Quarterly Contract Meeting

CHFT/Pennine Property Partnership Board

Urgent & Emergency Care Delivery Group

Access & Delivery Group

Cash Committee

Nominations & Remuneration Committee (Board of Directors)
Chair: Denise Sterling
Helen Hirst, Jo Wass
Peter Wilkinson
Frequency: Ad hoc

Trust Executive Board
Frequency: Weekly
Chair: CEO
Frequency: Weekly

Workforce Committee
Chair: Jo Wass
Peter Wilkinson
Denise Sterling
Frequency: Bi-Monthly

Education Committee
Chair: Deputy Director Workforce & OD
Frequency: Bi-monthly

Inclusion Group
Chair: Deputy Director Workforce & OD
Frequency: Bi-monthly

Infection Control Performance Group

Antimicrobial Strategy Group
(formulary / policy updates)

Divisional Patient and Safety Quality Boards
Chair: Divisional Director
Reporting: Quarterly

Controlled Drugs (CD) Sub-Group

Point of Care Testing

Medical Gases Group
Chair: Acute Consultant
Reporting: 6 monthly

Quality Committee
Chair: Denise Sterling
Jo Wass
Vanessa Perrott

Frequency: 10 per annum

Research and Development Committee
Chair: Deputy Medical Director
Reporting: Annually

Safeguarding Committee
Chair: Associate Director of Nursing (AD)
Reporting: 6-monthly

Infection Control Performance Board
Chair: Medical Director
Reporting: Quarterly

Patient Experience and Involvement Group
Chair: Chief Nurse
Frequency: Quarterly

Learning Forum
Chair: Chief Nurse
Reporting: 6 monthly

CQC Group
Chair: Director of Corporate Affairs
Reporting: Monthly

Children's & Young People Board
Chair: Chief Nurse
Reporting: 6-monthly

Maternity & Neonatal Board
Chair: Chief Nurse
Reporting: 6-monthly

Medicines Management Committee
Chair: Consultant Oncologist
Reporting: 6 monthly

Medication Safety and Compliance Group
Chair: Clinical Director of Pharmacy

Medical Devices & Procurement Group

Clinical Outcomes Group*
Chair: Medical Director
Reporting: Monthly

Clinical Effectiveness and Audit Group
Chair: Deputy Medical Director
Reporting: Quarterly

Transfusion Committee

Resuscitation Committee

Thrombosis Committee

Cancer Board

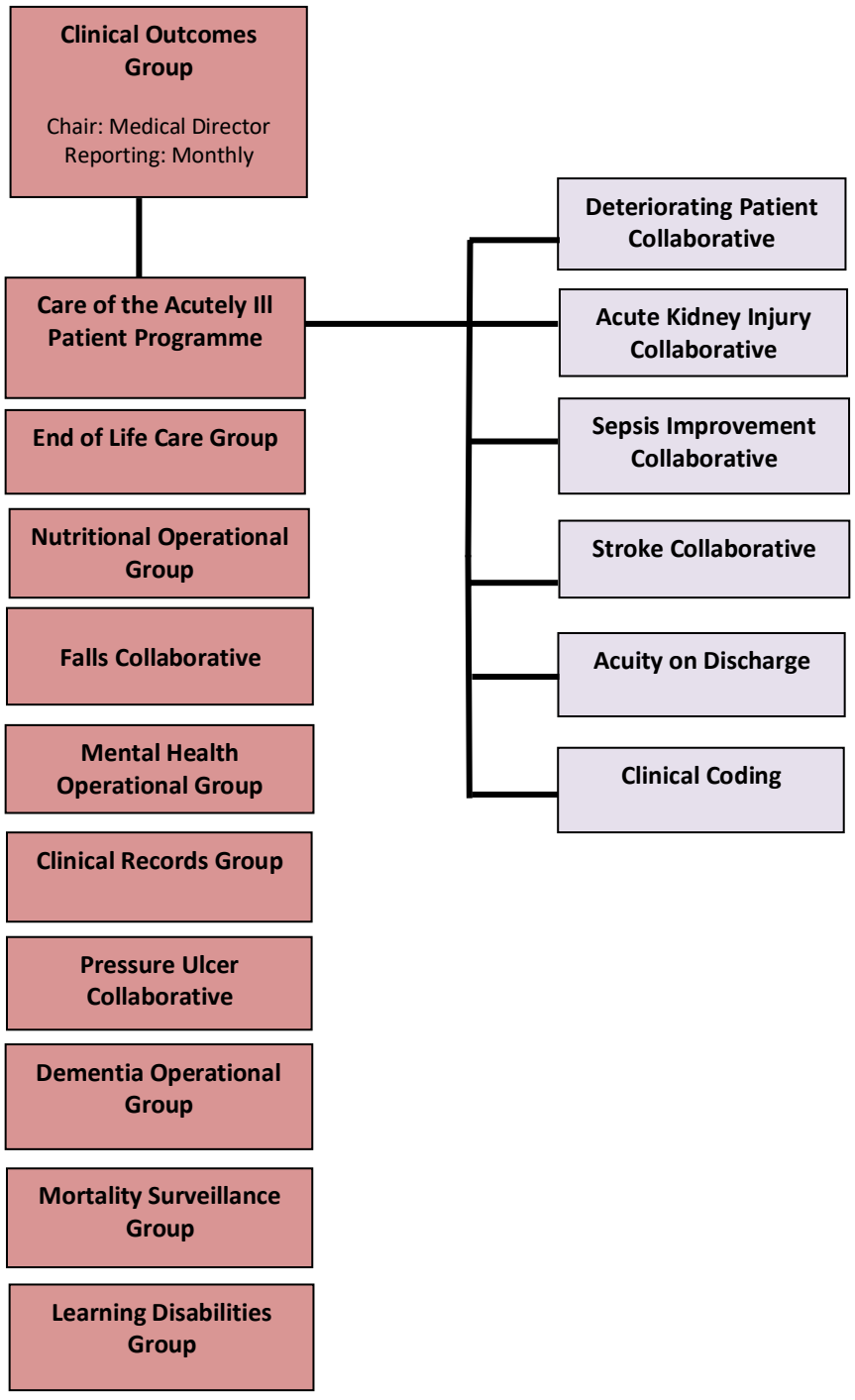
Radiation Protection Board

CDIO: Chief Digital Information Officer

COO: Chief Operating Officer

CHS – Calderdale Huddersfield Solutions

*Subgroup reporting arrangements



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	12 August 2024	2 October 2024	TBC	TBC
Date final reports required	23 February 2024	19 April 2024	21 June 2024	30 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)							
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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DATE OF MEETING	7 March 2024	2 May 2024	4 July 2024	12 September 2024	7 November 2024	16 January 2025	13 March 2025
WORKFORCE AGENDA ITEMS							
Staff Survey Results and Action Plan		✓					✓
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			
GOVERNANCE & ASSURANCE AGENDA ITEMS							
Emergency Planning Annual Report / EPRR Core Standards Submission		✓ Annual Report			B/F Compliance statement to November. Check JH	✓ 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)				Moved to Nov	✓		
Health and Safety Policy **(next due for review August 2025)**							
Health and Safety Annual Report				Moved to Nov	✓		
Board Assurance Framework	✓ 3		✓ 1		✓ 2		✓ 3
Risk Appetite Statement				✓			
High Level Risk Register	✓	✓	✓	✓	✓	✓	✓

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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
Standing Orders/SFIs/SOD review (next review due March 2025 unless changes required beforehand)							✓
Non-Executive appointments	✓				✓		✓
Annual review of NED roles					✓		
Board workplan	✓	✓	✓	✓	✓	✓	✓
Board meeting dates				✓			
Use of Trust Seal	✓		✓		✓		✓
Declaration of Interests & 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 ✓ Quality ✓ TPB ✓ CFC	✓Workforce		✓F&P ✓ NRC BOC
Trust Constitution changes (+as required)	✓	✓	✓	✓	✓	✓	✓
Compliance with Licence Conditions (final year 2022/23)		✓					
THIS Update						✓	
Fire Strategy 2021-2026		✓					✓
Annual Fire Safety Report						✓	
Audit and Risk Committee Annual Report 2023/2024			✓				

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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
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)	✓	✓	✓	✓	✓	✓	✓

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Calderdale and Huddersfield NHS Foundation Trust

Proposed Dates for Board of Directors and Board Development Sessions for 2025/26

Meeting	Date	Time	Location
Board Development Session	Thursday 10 April 2025	1:00 – 4:00 pm	Forum 1A and 1B, Sub-Basement, Learning Centre, HRI
Board of Directors	Thursday 8 May 2025	09:00 – 1:00 pm	Rooms 3 & 4, Acre Mills Outpatients
Board Development Session	Thursday 12 June 2025	1:00 – 4:00 pm	Rooms 3 & 4, Acre Mills Outpatients
Board of Directors	Thursday 10 July 2025	09:00 – 1:00 pm	Rooms 3 & 4, Acre Mills Outpatients
Board Development Session	Thursday 14 August 2025	08:00 – 3:00 pm	Rooms 3 & 4, Acre Mills Outpatients
Board of Directors	Thursday 11 September 2025	09:00 – 1:00 pm	Rooms 3 & 4, Acre Mills Outpatients
Board Development Session	Thursday 9 October 2025	1:00 – 4:00 pm	Rooms 3 & 4, Acre Mills Outpatients
Board of Directors	Thursday 13 November 2025	09:00 – 1:00 pm	Rooms 3 & 4, Acre Mills Outpatients
Board Development Session	Thursday 11 December 2025	1:00 – 4:00 pm	Rooms 3 & 4, Acre Mills Outpatients
Board of Directors	Thursday 15 January 2026	09:00 – 1:00 pm	Rooms 3 & 4, Acre Mills Outpatients
Board Development Session	Thursday 12 February 2026	1:00 – 4:00 pm	Rooms 3 & 4, Acre Mills Outpatients
Board of Directors	Thursday 12 March 2026	09:00 – 1:00 pm	Rooms 3 & 4, Acre Mills Outpatients

22. Review of Board Committee Terms of Reference

a) Quality Committee

b) Audit and Risk Committee

c) Transformation Programme Board

To Approve

Presented by Denise Sterling, Nigel Broadbent and Peter Wilkinson

Calderdale and Huddersfield NHS Foundation Trust

QUALITY COMMITTEE
TERMS OF REFERENCE – v8.2

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 Sub-groups are required to attend the meetings to present their reports, as required – see appendix 1

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.

If a Non-Executive Director member is unable to attend a meeting, they should nominate a Director to attend, subject to the agreement with the Trust Chair, and that person will be counted for the purpose of quoracy.

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.

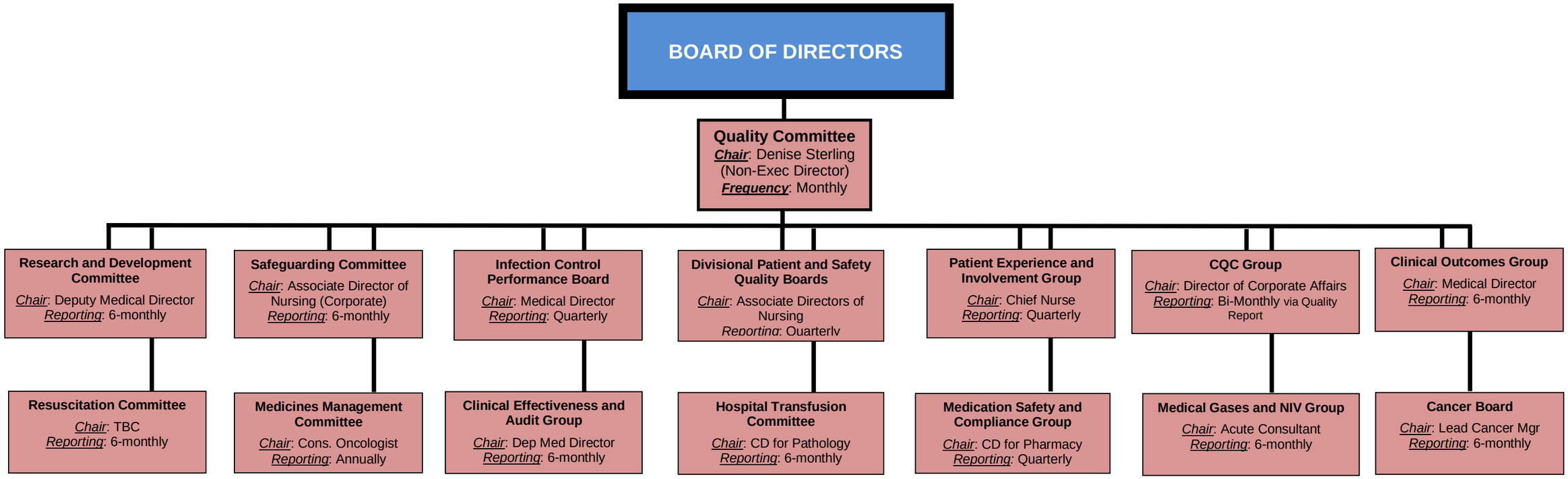
9.2. The terms of reference of the Committee shall be reviewed by the Board of Directors at least annually.

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

Appendix 1 – Sub-groups



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 2024 ▪ 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
8.2	Amendments made in August 2024 ▪ Addition to item 5.6 in relation to Non-Executive Director quoracy ▪ Removal of Thrombosis Committee as a sub-group ▪ Removal of Radiation Protection Board as a sub-group

Issued by Quality Committee and Date of Review	May 2024
Annual Date for Review	May 2025
Approved by Board of Directors	TBC – 12 September 2024

AUDIT AND RISK COMMITTEE

TERMS OF REFERENCE

Version:	6
Approved by:	Board of Directors
Date approved:	Audit and Risk Committee – 23 July 2024 tbc Board of Directors – 12 September 2024 tbc
Date issued:	12 September 2024 tbc
Review date:	July 2024
Next review:	July 2025

AUDIT and RISK COMMITTEE TERMS OF REFERENCE

1. Authority

1.1 The Audit and Risk Committee is constituted as a standing committee of the Foundation Trust's Board of Directors. Its constitution and terms of reference shall be as set out below, subject to amendment at future Board of Directors meetings. The Audit and Risk Committee shall not have executive powers in addition to those delegated in these terms of reference.

1.2 The Audit and Risk 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 on the over-arching systems of governance, risk management and internal control, together with indicators of their effectiveness. All members of staff are directed to co-operate with any request made by the Audit and Risk Committee.

1.3 The Audit and Risk Committee is authorised by the Board of Directors to obtain outside legal or other specialist ad-hoc advice at the expense of the organisation, subject to budgets agreed by the Board. The Committee is authorised by the Board of Directors to request the attendance of individuals and authorities from outside the Foundation Trust with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions.

2. Purpose

2.1 The Audit and Risk Committee will have primary responsibility for monitoring and reviewing financial and other risks and associated controls, corporate governance and assurance frameworks of the Trust and its subsidiary(ies).

2.2 The Audit and Risk Committee will have close working relationships with Quality Committee which has responsibility for oversight and monitoring of clinical risks and clinical audit.

2.3 The Board of Directors is responsible for ensuring effective internal control including:

- Management of the Foundation Trust's activities in accordance with statute and regulations;
- The establishment and maintenance of a system of internal control to give reasonable assurance that assets are safeguarded, waste or inefficiency avoided and reliable financial information produced, and that value for money is continuously sought.

2.4 The Audit and Risk Committee shall provide the Board of Directors with a means of independent and objective review of financial and corporate governance, assurance processes and risk management across the whole of the Foundation Trust's activities both generally and in support of the statement of internal control that supports the achievement of the organisation's objectives. In addition, the Audit and Risk Committee shall:

- Ensure independence of External and Internal audit;
- Ensure that appropriate standards are set and compliance with them is monitored, in all areas that fall within the remit of the Audit and Risk Committee; and
- Monitor corporate governance (e.g. Compliance with terms of licence, Constitution, codes of conduct, standing orders, standing financial instructions,

maintenance of registers of interests).

3. Membership

3.1 The Committee shall be composed of not less than three Non-Executive Directors, at least one of whom should have recent and relevant financial experience. The Trust Chair will not be a member of the Audit and Risk Committee.

3.2 A quorum shall be two members.

4. Attendance

4.1 Only members of the Committee have the right to attend. The Director of Finance, Deputy Finance Director, Director of Corporate Affairs, Company Secretary, Assistant Director of Quality and Safety, Head of Internal Audit and the Managing Director for Digital Health of the Foundation Trust shall generally be invited to routinely attend meetings of the Audit and Risk Committee.

4.2 A representative of the External Auditors may normally also be invited to attend meetings of the Audit and Risk Committee.

4.3 The Chief Executive should be invited to attend at least annually to discuss the assurance supporting the Annual Governance Statement and when considering the Internal Audit plan. Other Directors are expected to attend as required by the Audit and Risk Committee and where items relating to their areas of risk or responsibility are being considered.

4.4 The Foundation Trust Chair may be invited to attend meetings of the Audit and Risk Committee as required.

4.5 A representative of the Local Counter Fraud Service is invited to attend all meetings of the Audit and Risk Committee.

Other Executive Directors/Managers should be invited to attend, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that Director/manager.

4.6 The Chair of the Board of Directors will appoint up to two Governors to observe the meetings of the Audit and Risk Committee. The appointments will be reviewed each year.

4.7 Attendance is required by members at 75% of meetings. Members unable to attend should inform the Corporate Governance Manager as soon as possible in advance of the meeting except in extenuating circumstances.

4.8 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, seek a substitute or replacement.

5. Administration

5.1 The Corporate Governance Manager shall be the secretary to the Audit and Risk Committee and will provide administrative support and advice. Their duties include but are not limited to:

- Agreement of the agenda with the Chair of the Audit and Risk Committee and attendees together with the collation of connected papers;
- Taking the minutes and keeping a record of matters arising and issues to be carried forward;
- Agreeing the action schedule with the Chair and ensuring circulation within 48 hours of each meeting; and
- Maintaining a record of attendance.

6. Frequency of meetings

6.1 Meetings shall be held quarterly, with an additional meeting to review the annual accounts, with other meetings arranged where necessary. The Committee must consider the frequency and timing of meetings required to discharge all of its responsibilities on a regular basis.

6.2 The External Auditor shall be afforded the opportunity at least once per year to meet with the Audit and Risk Committee without Trust staff present.

6.3 The Internal Auditor shall be afforded the opportunity at least once per year to meet with the Audit and Risk Committee without Trust staff present.

7. Duties

7.1 Governance, internal control and risk management

7.1.1 To ensure the provision and maintenance of an effective system of integrated governance, risk identification and associated controls, reporting and governance of the Trust and its subsidiary(ies), unless otherwise identified in the governance reporting structure.

7.1.2 To maintain an oversight of the Foundation Trust's general risk management structures, processes and responsibilities, including the production and issue of any risk and control-related disclosure statements.

7.1.3 To review processes to ensure appropriate information flows to the Audit and Risk Committee from executive management and other Board Committees in relation to the Trust's overall internal control and risk management position.

7.1.4 To review the adequacy of the arrangements, policies and procedures in respect of all counter-fraud, bribery and corruption work as required by the NHS Counter Fraud Authority (NHSCFA).

With regards to the local counter fraud specialist, review, approve and monitor counter fraud work plans, receiving regular updates on counter fraud activity, monitor the implementation of action plans and discuss NHSCFA quality assessment reports.

7.1.5 To review the adequacy of the Foundation Trust's arrangements by which Foundation Trust staff may, in confidence, raise concerns about possible improprieties in matters of financial reporting and control and related matters or any other matters of concern.

7.1.6 To review the adequacy of underlying assurance processes that indicate the degree of achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of risk and control disclosure statements, in particular the annual governance statement, the

accompanying head of internal audit opinion, external audit opinion or other appropriate independent assurances, prior to submission to the Board.

7.1.7 The adequacy of policies and procedures for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications, including the NHS Code of Governance and NHS provider licence. Policies for approval by the Committee are identified in the Audit and Risk Committee annual workplan including Standing Financial Instructions, Scheme of Delegation and Standing Orders.

7.1.8 The Committee shall satisfy itself that the organisation's policy, systems and processes for the management of conflicts, (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with the policy and procedures relating to conflicts of interest.

7.2 Internal audit

7.2.1 To review and approve the internal audit strategy and programme, and counter-fraud plan, ensuring that these are consistent with the needs of the organisation.

7.2.2 To oversee on an ongoing basis the effective operation of Internal Audit including:

- Adequate resourcing, capacity and capability;
- Its co-ordination with External Audit to optimise the use of audit resources;

Complying with the Public Sector Internal Audit Standards 2017

- Providing adequate independence assurances;
- Having appropriate standing within the Foundation Trust; and
- Meeting the internal audit needs of the Foundation Trust.

7.2.3 To consider the major findings of Internal Audit investigations and management's response and their implications and monitor progress on the implementation of recommendations. Where such matters fall within the scope of other Board Committees, the Audit and Risk Committee may require feedback from these Committees on their review of internal audit work.

7.2.4. To review procedures for detecting and preventing fraud, bribery and corruption and receive reports of any instances.

7.2.4 To consider the provision of the Internal Audit Service annually, the cost of the audit and any questions of resignation and dismissal. The appointment/dismissal of Internal Audit remains the responsibility of the Director of Finance.

7.3 External audit

7.3.1 To make a recommendation to the Council of Governors in respect of the appointment, re-appointment and removal of an External Auditor. To the extent that that recommendation is not adopted by the Council of Governors, this shall be included in the annual report, along with the reasons that the recommendation was not adopted.

7.3.2 To discuss with the External Auditor, before the audit commences, the nature and scope of the audit, and ensure co-ordination, as appropriate, with internal audit and other external auditors in the local health economy. This should include discussion regarding the local evaluation of audit risks and assessment of the Foundation Trust associated impact on the audit fee.

7.3.3 To assess the External Auditor's work and fees on an annual basis and, based on this assessment, make a recommendation to the Council of Governors with respect to the re-appointment or removal of the auditor. This assessment should include the review and monitoring of the External Auditor's independence and objectivity and effectiveness of the audit process in light of relevant professional and regulatory standards.

7.3.4 To oversee the conduct of a market testing exercise for the appointment of an Auditor at least once every five years and, based on the outcome, make a recommendation to the Council of Governors with respect to the appointment of the Auditor.

7.3.5 To review external audit reports, including the annual audit letter, together with the management response, and to monitor progress on the implementation of recommendations.

7.3.6 To ensure national guidance is followed on the engagement of the External Auditor to supply non-audit services.

7.3.7 To consider the provision of the External Audit Service, the cost of the audit and any questions of resignation and dismissal.

7.4 Financial Reporting and Annual accounts review

The Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to its financial performance.

7.4.1 To review the annual statutory accounts, before they are presented to the Board of Directors, or on behalf of the Board where appropriate delegated authority is in place, to determine their completeness, objectivity, integrity and accuracy. This review will cover but is not limited to:

- The meaning and significance of the figures, notes and significant changes;
- Significant adjustments resulting from audit ;
- Adherence to accounting policies and practices;
- Explanation of estimates or provisions having material effect;
- The schedule of losses and special payments;
- Letter of representation;
- Any unadjusted statements; and
- Any reservations and disagreements between the external auditors and management which have not been satisfactorily resolved.

7.4.2 To review the Foundation Trust annual report and annual governance statement before they are submitted to the Board of Directors to determine completeness, objectivity, integrity and accuracy.

7.4.3 Where required by national guidance in the NHS Foundation Trust Annual Reporting Manual, seek assurances regarding scrutiny and review of specific areas by External Audit.

7.4.4 To review all accounting and reporting policies and systems for reporting to the Board of Directors.

7.5 Standing orders, standing financial instructions and standards of business conduct

7.5.1 To review on behalf of the Board of Directors the operation of, and proposed changes to, the Standing Orders and Standing Financial Instructions, the Constitution, Codes of Conduct. Standards of Business Conduct and Declarations of Interest; including maintenance of Registers.

7.5.2 To examine the circumstances of any significant departure from the requirements of any of the foregoing, whether those departures relate to a failing, an overruling or a suspension.

7.5.3 To review the Scheme of Delegation.

System for raising concerns

The Committee shall review the effectiveness of the arrangements in place for allowing staff (and contractors) to raise (in confidence) concerns about possible improprieties in any area of the organisation (financial, clinical, safety or workforce matters) and ensure that any such concerns are investigated proportionately and independently, and in line with the relevant policies.

7.6 Other

7.6.1 To review performance indicators relevant to the remit of the Audit and Risk Committee.

7.6.2 To examine any other matter referred to the Audit and Risk Committee by the Board of Directors and to initiate investigation as determined by the Audit & Risk Committee.

7.6.3 To ensure that the Quality Committee performs at least an Annual Review of the clinical audit plan and considers the findings and recommendations of in-year reports, ensuring the plan and extras are consistent with the strategic direction of the Trust.

7.6.4 To develop and use an effective assurance framework to guide the Audit and Risk Committee's work. This will include utilising and reviewing the work of the Internal Audit, External Audit and other assurance functions as well as reports and assurances sought from Directors and Managers and other investigatory outcomes so as fulfil its functions in connection with these terms of reference.

7.6.5 To consider the outcomes of significant reviews carried out by other bodies which include but are not limited to regulators and inspectors within the health and social care sector and professional bodies with responsibilities that relate to staff performance and functions.

7.6.6 To review the work of all other Board sub-committees as part of the Audit and Risk Committee assurance role. The Audit and Risk Committee will receive a self-assessment and annual report from each of the committees for approval.

7.6.7 Liaise with other Audit Committee chairs within the ICS about system wide control and governance issues.

7.6.8 Review of losses and special payments and waivers of Standing Orders.

8. Accountability and Reporting

8.1 The minutes of all meetings of the Audit and Risk Committee shall be formally recorded and submitted, together with recommendations where appropriate, to the Board of Directors. The submission to the Board of Directors shall include details of any matters in respect of which actions or improvements are needed. This will include details of any evidence of potentially *ultra vires*, otherwise unlawful or improper transactions, acts, omissions or practices or any other important matters. To the extent that such matters arise, the Chair of the Audit and Risk Committee shall present details to a meeting of the Board of Directors in addition to submission of the minutes via the Chair's highlight report.

8.2 The Audit and Risk Committee will report by a Chair's highlight report to the Board of Directors and Council of Governors in respect of the fulfilment of its functions in connection with these terms of reference. Such report shall include but not be limited to functions undertaken in connection with the governance statement; the assurance framework; the effectiveness of risk management within the Foundation Trust; the integration of and adherence to governance arrangements; and any pertinent matters in respect of which the Audit and Risk Committee has been engaged.

8.3 The Committee will report to the Board annually on its work and delivery against the terms of reference and its work in support of the annual governance statement.

8.4 The Foundation Trust's Annual Report shall include a section describing the work of the Audit and Risk Committee in discharging its responsibilities.

8.5 The Committees that report into the Audit and Risk Committee are the Risk Group, Information Governance and Risk Strategy Committee, Data Quality Board, Health and Safety Committee and the CQC and Compliance Group.

9. Behaviours and conduct

Trust values

Members will be expected to conduct business in line with the Trust values and objectives and One Culture of Care.

Members of, and those attending, the committee shall behave in accordance with the Trust's Constitution, standing orders, and standards of business conduct policy.

Equality and diversity

Members must demonstrably consider the equality and diversity implications of decisions they make.

10. Review

10.1 The effectiveness of the Audit and Risk Committee will be reviewed by members on an annual basis.

10.2 The Terms of Reference of the Audit and Risk Committee shall be reviewed by the Board of Directors at least annually.

Calderdale and Huddersfield
NHS Foundation Trust

TRANSFORMATION PROGRAMME BOARD TERMS OF REFERENCE

JUNE 2024

1. Constitution

1.1 The Trust Board hereby resolves to establish a Committee to be known as the Transformation Programme Board.

2. Authority

2.1 The Transformation Programme Board is constituted as a Standing Committee of the Trust Board. Its constitution and terms of reference are subject to amendment by the Trust Board.

2.2 The Committee derives its power from the Trust Board and has no executive powers, other than those specifically delegated in these terms of reference. The Committee will comply with the Trust's Standing Orders and Standing Financial Instructions and schemes of delegation.

2.3 The Committee is authorised by the Trust Board to investigate any activity within its terms of reference – it is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

2.4 The Committee is authorised by the Trust Board to request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary.

3. Purpose

The purpose of the Transformation Programme Board (TPB) is to oversee and provide assurance on the delivery of complex transformation programmes described in the Trust's Five Year Strategic Plan

4. Duties

The TPB will provide oversight and assurance to the Trust Board on:

- All strategic capital investments that are high value and of significant strategic importance. This includes the programme of service and estate reconfiguration.

- Elective, non-elective, and community transformation programmes of work that will deliver the Trust's Future Target Operating Models to improve the quality, safety and experience of patient care.

- Delivery of the Trust's Digital Strategy that patients and colleagues are digitally enabled to provide and receive care, in any location this is needed, to improve patient experience and outcomes.

- Delivery of the Trust's Green Plan. To achieve reduction in the Trust's impact on the environment and delivery of carbon net zero.

- Work undertaken as an 'Anchor Partner' to generate social value and support local economies in Calderdale and Kirklees.

- Involvement and communication with internal, place, regional and national stakeholders in relation to the issues described in this ToR.

The Committee is also responsible for reviewing high level risks in relation to transformation and assigned Board Assurance Framework (BAF) risks.

5. Membership and attendance

5.1 The Transformation Programme Board shall consist of the following members:

- Two Non-Executive Directors
- Chair of the Trust Board
- Chief Executive / Senior Responsible Owner for Programme of Reconfiguration (SRO)
- Chief Operating Officer
- Medical Director & Director of Infection Prevention and Control
- Chief Nurse
- Director of Workforce and Organisational Development
- Director of Finance
- Deputy Chief Executive & Director of Transformation and Partnerships (Programme Director)
- Deputy Chief Executive & Director of Operations for Reconfiguration
- Director of Corporate Affairs
- Chief Digital and Information Officer
- Managing Director – Calderdale and Huddersfield Solutions.

In the absence of a Chair, the members present will select one of their number to Chair the meeting.

5.2 The following shall be required to attend all meetings of the Committee:

- Assistant Director of Transformation and Reconfiguration Programme
- Transformation Programme Governance Lead (notes)
- Deputy Director of Finance

5.3 Other attendees may be co-opted or requested to attend as considered appropriate and may include external advisors. The Trust's Lead Governor will be invited to attend all meetings as an observer.

5.4 A quorum will be four members of the Committee and must include at least one Non-Executive and one Executive Director.

5.5 Attendance of members or their nominated deputy is required at 75% of meetings. Members unable to attend should indicate in writing to the Chair and Committee Administrator of the meeting. In normal circumstances any members who are unable to attend must nominate a deputy who is appropriately briefed to participate in the meeting.

5.6 A register of attendance will be maintained, and the Chair of the Transformation Programme Board 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 Transformation Programme Governance Lead, 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
- Ensuring a highlight report is produced and sent to the Trust Board in line with the reporting arrangements.
- 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 at least six times per calendar year. Additional meetings may be scheduled if required.

8. Reporting

8.1 The Transformation Programme Board will provide a report to bi-monthly meetings of the Trust Board and provide an annual report of work undertaken by the Transformation Programme Board. Any urgent matters requiring Trust Board approval should be discussed with the Company Secretary and Chair of the Trust Board.

8.2 The Transformation Programme Governance Lead will produce and maintain a standard agenda; any additional agenda items must be sent to the Governance Lead no later than ten working days prior to the meeting, urgent items may be raised under any other business.

8.3 An action schedule will be articulated to members following each meeting and must be duly completed and returned to the Governance Lead for circulation with the agenda and associated papers.

8.4 The agenda will be sent out to the Transformation Programme Board members five working days prior to the meeting date, together with the updated action scheduled and other associated papers.

8.5 Formal minutes shall be taken of all committee meetings. Once approved by the committee, the minutes will inform the Chair's highlight report which will go to the next Trust Board of Directors meeting.

8.6 In considering reporting to the Trust Board, the Transformation Programme Board will consider Guidance for Reserving Matters to a Private Session of the Board of Directors.

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 Trust 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 4 were fulfilled
- Members' attendance was achieved 75% of the time
- Agenda and associated papers were distributed five working days prior to the meetings
- The action points from each meeting are circulated within two working days, on 80% of occasions.

These Terms of reference will be reviewed after three years to determine if there is a continued need for the Transformation Programme Board.

Approved by Transformation Programme Board: 19 June 2024

Approved by CHFT Trust Board

23. Items to receive and note

1. Minutes of Board Committees

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

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 2nd July 2024, 14.00 – 16.30 Via Microsoft Teams

PRESENT

Vanessa Perrott (AN)	Non-Executive Director (Chair)
Nigel Broadbent (NB)	Non-Executive Director
Gary Boothby (GB)	Director of Finance
Rob Aitchison (RA)	Deputy Chief Executive (part of meeting only)
Jonathan Hammond (JH)	Chief Operating Officer
Denise Sterling	Non-Executive Director

IN ATTENDANCE

Rochelle Scargill (RLS)	PA to Director of Finance (Minutes)
Kirsty Archer (KA)	Deputy Director of Finance
Andrea McCourt (AM)	Company Secretary
Philippa Russell (PR)	Assistant Director of Finance
Krish Pilicudale (KP)	Insight Development Programme
Kimberley Scholes	General Manager – Planned Access (Deep Dive item only)
Stephen Shepley	Director of Operations – FSS (Deep Dive item only)

OBSERVERS

Pam Robinson (PRo)	Public Elected Governor
Brian Moore (BM)	Public Elected Governor
Robert Markless (RM)	Public Elected Governor
Ekanem Kofikpeme	Shadowing

APOLOGIES

Stuart Baron (SB)	Deputy Director of Finance
Adam Matthews (AdM)	HR Business Partner
Peter Keogh (PK)	Assistant Director of Performance
Anna Basford (AB)	Deputy Chief Executive and Director of Transformation and Partnerships.

ITEM

090/24 WELCOME AND INTRODUCTIONS

The Chair welcomed attendees to the meeting.

091/24 DECLARATIONS OF INTEREST

092/24 MINUTES OF THE MEETING HELD 30th April 2024

The previous minutes were approved as an accurate record.

093/24 MATTERS ARISING

094/24 ACTION LOG

The Action Log was reviewed as follows:

All actions were closed.

095/24 DEEP DIVE – OUTPATIENT FOLLOW UPS, BOOKINGS AND DNA'S.

JH introduced the deep dive. This is an update on a previous deep dive. The intention when this programme was started was to improve the number of outpatient (OPD) follow ups. Whilst there is often a focus on the front-end targets that we have to report on nationally, there is no national requirement to report OPD activity. However, it is anticipated that as more patients are being seen at the front-end the number of follow-ups will also increase. Whilst some of this care can be moved into primary care, due to their pressures and for patient satisfaction and quality, CHFT feel it is an important quality piece to optimise our own OPD appointments.
An action plan has been put in place, following training of staff, and doing some data cleansing and validation on bookings. One key issue is the number of people who can book OPD follow-ups and the lack of standardised processes. Numbers are starting to improve but are not expected to reduce quickly due to the aforementioned reasons.

SS and KS gave the presentation which was shared with the Committee after the meeting. VP thanked them for the presentation and some questions were discussed:

VP – Having reviewed the slides from the previous deep dive there was a mention of a possible consensus agreement with primary care to manage referrals. Is this still being pursued?
JH – Some work has been done with primary care and they have agreed some principles of working however these have not yet translated to practicalities which would be reflected in this work. There is a challenge around some of the transformation work such a PIFU with some in the primary care sector mistaken in that the work is being moved from acute to primary care. The volume is so big we will have to do things differently which means a need to link in and work with primary care.

VP – The previous slides also referred to pathway redesign. Has any progress been made around tailoring the follow up work to individual specialities?
KS – As more functionality becomes available in DrDoctor e.g. personalised video messages, it will help with pathway redesign.

NB – The presentation talks about training people in the booking of appointments. There is less mention of the booking process. Is this as efficient as it could be?
SS – From an appointment centre perspective the thought is that the current system is fit for purpose and considers any risks etc. A couple of years ago work was done with an external company which supported this. Training and a move to centralised booking may be challenging.

DS – Surprised at the number of different colleagues who book appointments. Would the intention be to reduce the number of individuals involved?
KS – Yes.

VP – Is there a metric that is reportable that could provide more justification for OPD appointment optimisation?

JH – There is no requirement to report nationally. Initially post covid the only level of focus was to reduce the number of follow ups undertaken by 25%. CHFT undertook more follow ups to reduce the backlog. Data is available around the overall backlog is available but there is a need to refine the details of what we monitor particularly around the ones that are overdue. Feed this back to the access meetings.

VP – DNA's were not covered within the presentation.
JH – Reducing DNA's is part of the plan and the DrDoctor portal will assist with this. The portal will send out automatic reminders and give people the opportunity to book vacant slots at short notice. This will be monitored through the access meetings. Endoscopy have reduced their DNA's to 2-3% by having a focussed effort on contacting patients who are at a level of DNA.
The DNA work also needs to overlap with the work being done around health inequalities.

ACTION: To come back to a future meeting and provide further details and progress.

FINANCE & PERFORMANCE

096/24 IPR

JH picked up some key elements in the absence of Peter Keogh. Full detail is within the papers.

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.

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.

VP – It is worth repeating the message shared at the Quality meeting this morning. Colleagues are achieving good performance despite the massive challenges and increased demand. It has been suggested that a deep dive into stroke is planned for this committee later this year.

ACTION: to plan Deep Dive into Stroke in the F and P workplan for later this year

DS – There has been a slight increase in the ambulance delays however CHFT is still in a good position when benchmarked with peers. Are there any trends when the delays are occurring?

JH - There are trends daily and weekly. Daily activity builds through early afternoon into evening. Staffing has been adjusted to cover this with Consultant cover now in place until midnight. Ideally, we would like to extend the Consultant cover overnight and we are exploring a cost neutral option. Weekly trends show the most pressure at the start of the week. There are more discharges on Thursdays and Fridays which creates a better position for the weekend. There are then less discharges over the weekend which creates pressure for Monday. Currently testing out extended hours for the SDECS at the beginning of the week to relieve the pressure.

RM – There appears to be three areas of concern, stroke, ED figures and midwife numbers. However the improvements in ECHO and Neurophysiology are noted.

VP – Workforce committee will be looking at midwife numbers.

JH – ED is a combination of increased numbers and increased acuity. We are admitting less numbers than before Covid as they are being supported through the SDECS and urgent community response. The ones that are admitted are more complex of which Stroke is one example. The same picture is reflected nationally. There is a comprehensive improvement scheme underway around managing the front door which involves both SDEC's and the well organised ward work. A programme of work with community colleagues to simplify some processes and creating more flexibility between teams. These actions will create a better experience for patients.

NB - The health inequality data that used to be in the IPR is now part of the public sector quality duty report that goes annually. Is this correct?

RA – A snapshot report was presented at the last board with a plan to report to every other board and form part of the health inequalities update.

VP – ED performance has fallen a little. Any correlation with the new ED opening at Huddersfield?

JH – There is some correlation with bedding in to be done in the new ED. Triage is being used more at the front door to direct attendees to the correct zone, and minor injuries is different. The footprint is bigger, and the ED teams have been looking at the most effective way to use the space. Overall performance at HRI ED is similar to

pre-March. ED have an internal improvement plan. We do see a differential between Calderdale and Huddersfield ED's. Calderdale has improved since the SDEC became operational.

The Committee **RECEIVED** the IPR.

097/24 RECOVERY UPDATE

The Chief Operating Officer presented the Recovery update.

CHFT is still performing well when benchmarked against other local trusts. There has been a small increased in 52 week waiters and we now have some 65 week waiters which are as a result of the ASI's drop off problem that has been discussed in this meeting previously.

The weighted total for activity against the plan for month 2 reached 102% with year to date reaching 101.5%. There was an increase from month 1 to month 2 which was largely due to day case activity. There was a small reduction in elective inpatient activity which has been looked at in detail.
Outpatient activity has further increased against plan which is positive.

KA gave a brief overview of the income.
Our plan assumes an over performance over and above our elective recovery baseline. We must exceed a certain threshold before we start attracting additional income. The dips in month 2 have been matched to staff leave and have since improved. From month 3 onwards, similar to the CIP. The targets increase and become more challenging as a result of the way the stretch target was profiled.
There are other things that contribute to achieving the target for example, advice and guidance which prevents patients needing to come in on a pathway. The majority is focussed on delivering the activity and treating the patients.

JH the 40 and 32 week waits have both seen improvement but are impacted by ENT which has a trajectory to have no patients over 52 week wait by the end of Summer.

KP – In relation to the manual process set up to catch the ASI drop-offs could the RPA assist with creating a failsafe for this?
JH – KP+ model set up to monitor patients who drop and another who is about to drop off. It is worth looking at RPA to see if this could assist.
ACTION: JH to pick up with Kimberley Scholes.

PRo – Neurology lost a staff member and there was also a decline in Cardiology. Was this as a result of an increase in patients or staffing problems?
JH – Demand is high in Cardiology but a consultant has left and another was on sick leave.

The committee **RECEIVED** the Recovery Update

098/24 MONTH 2 FINANCE REPORT

The Assistant Director of Finance covered the month 2 finance position.

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).

The Committee **RECEIVED** the Month 2 Finance report.

Risks to approve onto the risk register.

Currently recommending a risk score of 20 in relation to not achieving the 24/25 plan. Key points are the unidentified CIP and there are a number of schemes that are at scoping or high risk. There is currently £5-6m unidentified. There is a CIP scheme to deliver some reduction in bed capacity but there is a risk that this will be exceeded if last year's surge is repeated. Industrial action also continues and may impact our elective recovery.

GB – ICS finance forum on Friday the need for a consistent assessment of what the risk looks like. Categories that would be reported into were agreed.

The rest of the system are calling out risks including PLACE partners who are flagging they will not be able to deliver their plans. Resources that have been available in the past to support CHFT if our bed capacity increased will not be available this year.

This is the in-year risk. Longer term risk is on the BAF risk register.

NB – Agree with the risk score. Last year it was reduced later in the year.

Capital risk assessed at 12 as there is potential to not receive enough funding to complete the capital programme. Started at 12 last year and reduced as the year progressed.

Cash risk also scored at 12 risks with applying for PDC funding. There is a potential complication with the fact that the System is going to be cash to come into balance. It is not clear if this will flow to CHFT. Started at 12 last year and reduced as the year went on.

The committee **APPROVED** the risk scores as stated.

099/24 NATIONAL COST COLLECTION PRE-SUBMISSION REPORT

The 2023-24 National Cost Collection (NCC) collects data about the running costs of patient care in the NHS. Patient level costs (PLICS) are now collected for the

majority of services, with aggregate costs collected where it is not deemed possible to collect at patient level due to volume or legal restrictions.

Two reports are required:

- a pre-submission report – before the submission window opens for 2024.
- a final submission report – at around the time of or following submission.

This is the first of the two reports ahead of the 2023-24 NCC submission window which is 10th June – 2nd August 2024.

- The 2023-24 NCC submission window is 10th June – 2nd August 2024 and the Trust has a plan in place to ensure that this deadline is met.
- The submission is prepared in line with the Approved Costing Guidance.
- The plan ensures that adequate validation checks will be made and all identified validations will be verified.
- A Costings Standards and Information Standards gap analysis has been undertaken. Where gaps have been identified, actions are in place to address in this submission where possible. A further action plan is to be developed to ensure all are then adequately addressed for future submissions.

ACTION: To add to workplan for next year understanding that the deadline is subject to national timeframes.

NB – Happy with the assurance given. Is there anything that comes from the Benchmarking that would be useful to share with this committee?
KA – Yes. It has been shared in the past and feeds into the CIP programme.

The Committee **RECEIVED** the National Cost Collection.

100/24 TURNAROUND EXECUTIVE CIP PROGRESS

The Deputy Chief Executive A non-pay panel

The CIP is linked closely with the finance position. Refresher of the detail presented at the last meeting. Our target for this year is £32m which is made up of £30m of new schemes and £2m benefit from the schemes that had a part year effect last year.

The recurrency level is really important this year with a current figure of 68% recurrent schemes identified.

The focus and scrutiny is expected to be around the reduction of headcount previously discussed. A decision will need to be made around several posts that are frozen, looking at 50 of the 60 posts currently held. If the gap to £32m is not identified, then additional decisions in relation to the posts will need to be made.

There are a number of other things that are being done around grip and control and we are in line with other organisations and in some areas, we are ahead in terms of grip and control. For example, GB is leading a non-pay spend control panel which

while it will not significantly affect the CIP, it will make sure we are not incurring unnecessary spend.

As part of our banking agency reduction work, we will get some external support to review our medical use of bank and agency. Overall, we have good plans for the majority of the £32m with some further works still to be done.

VP – Is there any possibility of increasing the number of recurrent schemes from 68%?
RA – In the past the pattern we follow is that we start really high. What we are aiming to do is maintain the level of 68%.

RA – The main message to the committee is that the stretch is bigger this year, but we still feel it is realistic. The next part is to look at bank and agency and review the headcount. To provide assurance, there are some exemptions for some clinical posts and there will be no risk to service. It is worth noting that since 2019 CHFT headcount has increased by 500. Some of this was reasonable but we are trying to pull back some of the growth.

GB – I was sighted on the position of our peers last week and from a recurrent CIP point of view CHFT is in line with others across West Yorkshire. The 6% saving target is the average across West Yorkshire. Several other organisations set themselves a target of 9% which they are now calling out as undeliverable.

KA – Other Trusts have asked CHFT to share our grip and control processes.

The establishment approvals committee meets weekly to establish if any collective risks are created by holding cumulative posts. For example, today it was noted several Pharmacy posts have been held. The panel have gone back to Pharmacy to ask if there are performance risks or unintended consequences. This process is fully documented.

The Committee **RECEIVED** the Turnaround Executive update.

101/24 BAF RISKS

Four risks are overseen by this committee. Two performance ones which are owned by JH, two financial owned by GB.
Scores did not changes when reviewed in June.

NB – Risk 1819 - Long term financial sustainability. Mentions agreeing key metrics with system partners. What does this mean?
GB – Inability to remove beds as part of the annual plan. So much of the plan is based on the bed base and the bed risk so we have managed to agree what are the real key metrics with our partners. Which patients should we be focussing on. The community provider for Kirklees have focussed on long length of stay patients however CHFT would prefer a focus on the patients with a short length of stay.

NB – There was a recommendation from the audit that medium term financial plans should be shared with system partners. Should this be referenced in the BAF?

GB – The medium-term plan driven by the System. CHFT need to work on the longer-term financial plan.

AM – Add to cover the gap in assurance until it is in place. The action is being taken to address that gap. Reference at the board on Thursday.

The Committee **APPROVED** the risk scores as stated.

102/24 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
- HPS Board
- Urgent and Emergency Care
- CHFT / THIS SLA Meeting

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

103/24 WORKPLAN – 2024/25

A couple of items need to be added:
National cost committee add to September and this time next year for first part.

The May and August meetings have been removed in order to reduce the number of committee meetings to 10.

The Committee reviewed the plan for the absence of meetings in May and August. There was consensus to stick with this plan going forwards.

The Committee **APPROVED** the draft work plan but noted that the Deep Dive on Stroke will be added.

104/24 ANY OTHER BUSINESS

This is the last meeting for Brian Moore the committee would like to thank him for his contributions over the years.

This is also the last meeting for Philippa Russell who will be leaving us in the next couple of weeks to work as the Deputy Director of Finance at Hull. She has been instrumental in producing all the reporting in its current format.

AM raised the issue of quoracy of this meeting. The suggestion has been to have consistency in terms of quoracy across the board committees.

For F&P this would mean an increase of quoracy from 3 to 4 members – the current quoracy requirement of 3 is 2 NEDs and 1 other member (Director).
The proposal is to increase F&P quoracy to 4 for consistency, being 2 NEDs and 2 other members of the 4 below (an increase of 1) – full list of membership below.

F&P Committee members:

- Three Non – Executive Directors, one of whom will be Chair
- Executive Director of Finance
- Chief Operating Officer
- Director of Transformation and Partnerships.
- Deputy Chief Executive

For clarity if any member can't attend but nominates a deputy and agrees it with the Chair of the Committee that person counts towards quoracy.

The Committee **APPROVED** the changes to the Quoracy.

105/24 MATTERS TO CASCADE TO BOARD inc. ONE CULTURE OF CARE

- A verbal update will be shared with board due to the short turnaround time this month.

DATE AND TIME OF NEXT MEETING:
Tuesday 3rd September 2024 14:00 – 16:30 MS Teams

Chair Approved Minutes of the Audit and Risk Committee Meeting held on Tuesday 23 July 2024 commencing at 10:00 am via Microsoft Teams

PRESENT

Nigel Broadbent (NB)	Non-Executive Director **(Chair)**
Jo Wass (JW)	Non-Executive Director

IN ATTENDANCE

Andrea McCourt	Company Secretary
Victoria Pickles	Director of Corporate Affairs
Kirsty Archer	Deputy Director of Finance
Leanne Sobratee	Internal Audit Manager, Audit Yorkshire
Steve Moss	Local Counter Fraud Specialist
Matthew Moore	Senior Manager, KPMG
Amber Fox	Corporate Governance Manager *(minutes)*
Andrea Dauris	Associate Director of Nursing **(update on limited assurance report)**
Alison Edwards	Head of Safeguarding **(update on limited assurance report)**
Jordan Williams	CHS Health and Safety Advisor **(update on limited assurance report)**
Stuart Sugarman	Managing Director, CHS **(update on limited assurance report)**
Peter Keogh	Assistant Director of Performance **(for item 47/24 deep dive)**
Julian Bates	Assistant Director of Information **(for item 47/24 deep dive)**
Chris Boyne	Deputy Director, Audit Yorkshire
Helen Hirst	Chair *(Observer)*

The Chair welcomed everyone to the Audit and Risk Committee meeting.

43/24 APOLOGIES FOR ABSENCE

Apologies were noted from Tim Busby, Gary Boothby, Shaun Fleming and Robert Birkett.

44/24 DECLARATIONS OF INTEREST

The Chair reminded the Committee to declare any items of interest at any point in the agenda.

45/24 MINUTES OF THE MEETING HELD ON 25 JUNE 2024

The minutes of the extra-ordinary meeting held on 25 June 2024 were approved as a correct record.

OUTCOME: The Committee **APPROVED** the minutes of the previous meeting held on 25 June 2024.

46/24 MATTERS ARISING AND ACTION LOG

The action log was reviewed, and all actions were complete.

Limited Assurance Reports: The following limited assurance reports were received at the meeting in April 2024. The audit lead was invited to this meeting to provide assurance that action is being taken regarding the recommendations.

1. **CH/16/2024 Mental Capacity Act – Andrea Dauris / Alison Edwards**
Andrea Dauris, Associate Director of Nursing introduced Alison Edwards, Head of Safeguarding who provided an overview of the update report and re-assured the Committee of the comprehensive action plan in place. Alison explained the overall rating of limited assurance was based on a re-audit following the original audit in 2022; however, the number of steps taken to

improve training and compliance was recognised. The audit earlier this year looked at compliance with the Mental Capacity Act (MCA) including the Deprivation of Liberty Safeguards (DoLS).

Documentation of mental capacity assessments and best interests' decision-making continue to be areas of weakness.

There were four recommendations, one major, two moderate and one minor. A total of 19 initial actions were identified to address the recommendations, out of the 19 actions, 17 are completed with two still ongoing and on track to be completed by August 2024.

Next steps include the Mental Capacity Act Policy to be ratified by the Safeguarding Committee in August 2024, a flag to be added to the patient record in relation to DOLs to be agreed by September and an internal re-audit to be undertaken in October 2024 and reported to Safeguarding Committee.

JW asked if the root cause of the issue is lack of training or time pressures. Alison responded this relates to a training issue and an understanding of what is required. The training introduced following the initial audit in 2022 is much more comprehensive and more role specific and covers what paperwork must be completed. The team have also introduced some face to face 'lunch and learn' session to talk through scenarios. Alison explained the complex cases are managed well; however, it is the less complex cases where the capacity assessments are not completed as well.

JW asked if the issue lies predominantly with medical staff. Alison responded a Trust wide approach is needed in relation to this to target all groups of staff, explaining the MCA is everyone's responsibility. She explained DOLS applications are more specific to areas; however, everyone needs an awareness.

The Internal Audit Manager recognised the amount of positive work that has taken place over the last few months.

NB asked if the re-audit taking place internally will be available to Audit Yorkshire for a review. Alison confirmed they can share the audit results and they will continue to re-audit internally every six months until they see a significant improvement.

NB asked what positive impact patients will see as a result of the training and new processes and how this can be measured. Alison responded this will impact on the quality of care patients receive and patients should have a more positive experience and get the right care. This will be measured through patient experience and a review of incidents and complaints which should reduce as a result of the improvements.

2. CH/14/2024 CHS - Management of Contractors Final Report – Jordan Williams

Stuart Sugarman, Managing Director of CHS introduced Jordan Williams, CHS Health and Safety Advisor who was in attendance to share an update on how they responded to the management of contractors limited assurance report.

Jordan shared a paper detailing the three recommendations and findings following a comprehensive piece of work that had taken place.

In terms of recommendation three, Jordan confirmed the contractor induction video had been updated to highlight the fire safety procedures. However, he explained CHS will not be describing the proper use of fire extinguishers to contractors as this raise's liability issues. However, all contractors are simply now advised to leave the area on discovery of the fire and raise the alarm.

JW asked why spot checks only have a target of 20%. Jordan responded this is due to the large number of contractors coming through on a daily basis which was close to 1,000 last month. He explained they are meeting the monthly target of 20% which is close to 200 checks.

JW asked if internal audit is content the proper use of fire extinguisher is not included in the contractor induction video. Jordan confirmed they took advice from the Trust Fire Officer and Audit Yorkshire were content with this response.

NB asked if the 20% target for spot checks was sufficient in terms of identifying any issues and if the alternative would be more resource to meet a higher target. Jordan confirmed they are content with the target of 20% as this is a large amount of contractors that are being checked. NB clarified that they also spot check on a risk based approach, e.g. higher risk jobs will have several spot checks carried out.

JW asked if the evidence of insurance liability was just not checked thoroughly but were in place. Jordan confirmed when a contractor is selected, all evidence of qualifications and competencies are held in the estates department. Audit Yorkshire found a small number with evidence of insurance and qualifications missing. It was confirmed these individual companies had these insurances and qualifications and they were just not on file.

NB asked what the practical implications were in terms of the fire safety advice. Jordan responded all staff receive in house fire training and there are fire wardens on site. However, a contractor hasn't received any of the training. NB asked if part of the building was handed over to a contractor is the advice clear that the contractor should raise the alarm and vacate the premises. NB raised a concern whether a member of Trust staff would set about extinguishing the fire if part of the building was handed over to a contractor. Jordan clarified the Trust would not hand over the building to a contractor; however, recognised there might not be any Trust staff in these areas if a fire were to start in a contractor area and agreed to follow this up with the Trust Fire Officers.

JW asked why there is a different liability for employees compared to non-employees. Jordan clarified it would be an additional burden on contractors to go through the process to become fire trained and provided with equipment. The Managing Director for CHS agreed to pick this up and explained the difficulty is the time it would take for contractors to undertake the fire safety training that all Trust staff attend.
Action: Jordan Williams/Stuart Sugarman to speak to the Fire Officer regarding the fire safety advice for contractors.

OUTCOME: The Committee **NOTED** the updates to the action log and **NOTED** the updates provided on the two previous limited assurance reports.

47/24 DATA QUALITY DEEP DIVE - PRESENTED BY JULIAN BATES AND PETER KEOGH

Peter Keogh, Assistant Director of Performance and Julian Bates, Assistant Director of Information presented a deep dive presentation on data quality. The key points noted were:

An audit of the key performance indicators is a standing agenda item for each meeting, this focuses on the integrated performance report and PublicView which is a national benchmarking tool to compare Trust performance with any Trust in the country on a wide selection of indicators. They are currently exploring an inhouse solution to automate PublicView in house as a cost improvement plan scheme.

The new Data Quality and Outpatient Access Group escalates any issues to the Data Quality Board.

Information Standard Notices are assessed in detail at the Data Quality Board to ensure the Trust is delivering and keeping the base safe.

The key successes were highlighted, including the automation of Outpatient procedures, a robust process for managing appointment slot issue drop offs, the A&E spine synchronisations to ensure this links EPR to the National Patient Demographic System and over the past 12 months, 1705 out of over 1707 statutory returns were delivered to deadline.

The Assistant Director of Information was proud to report CHFT was the only Trust in the UK and Europe that achieved Stage 6 validation (0 worst 7 best) on the HIMSS Adoption Model for Analytical Maturity (AMAM).

Assessment of the private income and private health information network data had been worthwhile working through the current processes which has raised awareness. Report shared with all Divisions.

The future will focus on any new data quality challenges, maternity related data capture issues, data quality maturity index, same day emergency care impact on KPIs, Airedale joining the Trust's EPR and further work on A&E spine synchronisations and fixes.

JW congratulated the team on their successes and asked if there was a quality assurance sign off process before the statutory returns were submitted. The Assistant Director of Information assured the Committee there was a robust review process in place and confirmed a regular detailed review takes place of the long list of returns that are issued, which includes who produced and signed them off and the standard operating procedure. He explained some daily returns have a lot of indicators and is a more difficult process for sign off and they have asked how other organisations manage these.

JW asked if there is a mechanism for escalating any surprising data that could cause a reputational issue. The Assistant Director of Information confirmed there is a mechanism for raising concerns; however, a process does not exist for every return due to the volume and daily returns with over 100 KPIs; however, they actively look for any change in movement. The Assistant Director of Information stated the return relating to patients in the emergency department waiting over 12 hours for a bed receives a lot of scrutiny and there is a process for sign-off of these key indicators. The Assistant Director of Performance re-assured the Committee the Trust perform exceptional well on the decision to admit to getting a bed within 12 hours and are one of the best in the country.

JW asked about if there have been any conversations about how to analyse data to gain a better understanding of health inequalities challenges. The Assistant Director of Performance responded there is a separate Health Inequalities Group which covers a wide area of KPIs and looks at parity in waiting times and learning disabilities. He added several health inequalities indicators are reported in the quarterly Integrated Performance Report and they were currently focusing on DNA rates.

The Deputy Director of Finance asked whether the 1700 statutory returns included the monthly NHS England (NHSE) finance report or the annual accounts for example or they were statutory returns from the Health Informatics Service. The Assistant Director of Information confirmed these are the returns that have grown over time and include some finance returns; however, they are not all encompassing and 60-70% are provided by the Health Informatics Service with a sign off process at the Trust. He added there is an expectation for representatives from the Trust to attend the Data Quality Board to flag any concerns.

A discussion took place confirming there were other external tools / assessments of data quality that were shared at the Data Quality Board.

Data Quality Board Terms of Reference

The Data Quality Board terms of reference were presented with minor updates made to the membership and now includes escalation from the Outpatient Access Group which is a new group looking at follow ups and attendances.

OUTCOME: The Committee **NOTED** the Data Quality Deep Dive provided for assurance and **APPROVED** the Data Quality Board Terms of Reference.

48/24 Board Assurance Framework Standing Operating Procedure

The Company Secretary presented the Board Assurance Framework (BAF) Standard Operating Procedure which has been reviewed and cross referenced to the latest Audit Committee Handbook and Code of Governance and describes how the BAF manages the risk in the Trust. This is not a requirement under national guidance; however, it brings resilience and further national guidance on system risk is expected.

The Company Secretary explained Audit Chairs will be looking at risks across the system which will be added to the Standing Operating Procedure, which had been highlighted by NB and this and other minor changes from NB would be made to the document.
Action: Company Secretary to update the SOP to include Audit Chairs are reviewing risks across the system.

OUTCOME: The Committee **APPROVED** the Board Assurance Framework Standing Operating Procedure.

49/24 Board Assurance Framework – Update 1

The Company Secretary presented update 1 of the Board Assurance Framework which was presented to the Board on 4 July 2024. The BAF details 22 risks in total and the top three risks remained the same.

JW highlighted the deep dive on the cyber security risk scheduled in October which will focus on third party assurance.

NB asked if the responsibility for the cyber security risk is for the Board of Directors or a Committee. The Company Secretary agreed the responsibility for the cyber security risk should be the Audit and Risk Committee.
Action: Company Secretary to update the Cyber Security risk to be the responsibility for the Audit and Risk Committee.

The Chair explained wording for the Clinical Strategy risk is due to be updated following the discussion at the Board on 4 July, to reflect this being broader than new services. The Company Secretary confirmed the wording will be revised in update 2 of the BAF which will be reflected in the update to the Committee in October and presented to Board in November 2024. The Director of Corporate Affairs added that this will fit with publication of new clinical strategy and the two coming together will be helpful.

NB challenged the movement to target scores which remained the same and asked how the Trust evidence achievement of the target score, stating that they need to be realistic to achieve and aspirational. The Company Secretary explained this varies with each risk and the aim is to reduce the risk towards the target score and update actions over time. She provided an example of the partnership risk which achieved its target score and remains on the BAF for further monitoring. The Company Secretary explained the demand and capacity risk remained an operational issue; therefore, it was difficult to reduce this to the target score.

OUTCOME: The Committee **APPROVED** the Board Assurance Framework.

50/24 Executive Director of Finance's Business

1. Review of Losses and Special Payments

The Deputy Director of Finance presented the losses and special payments in adherence to the Standing Financial Instructions (SFI) of the Trust. The key points noted were:

- Total losses for the quarter of £63k in the quarter - similar level to prior years and across the same categories.
- Pharmacy losses reported in Q1 – suspected instance of theft of drugs. This was reported to the police and escalated internally. The value is minimal.
- Appendix 1 details a proposed write off from salary overpayments of £9.2k across 61 colleagues. This has arisen due to a system issue that has now been rectified and lack of clarity for expected pay rate for on call shifts. Both issues now addressed. No adverse impact to this financial year's position as cost was incurred in prior years. Agreed to write off.

NB asked if the Trust have reviewed its controls in the theft instance. The Deputy Director of Finance assured the Committee they reinforced the escalation in adherence to the Standing Financial Instructions of the Trust. She explained certain drugs are classified as control drugs and are held securely and other drugs of lower value don't have the same levels of security. The Pharmacy department have reviewed this and moved some drugs which might be deemed more at risk of theft to being controlled drugs.

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

2. Holiday Pay Resolution

The Deputy Director of Finance presented the paper to update on the position on medical bank pay with regard to holiday pay entitlements. The key points noted were:

- The Trust has an obligation to reflect a holiday pay expectation for bank workers.
- The usual/accepted payment percentage value is 12.07%.
- Medical bank rates include a level of premium which exceeds the 12.07% holiday pay expectation in all instances, but this was not historically separated out on payslips.
- CHFT have rectified the way this is presented on the payslip for Q1 to show a holiday pay element listed separately which resolves the legal challenge.
- Legal claims have been received to claim backpay and are still being received, the Trust has a level of financial provision set aside for this obligation and will respond to individual claims as received.
- These will be managed through the Divisional routes based on value and any historic claims received will be managed through Human Resources and the Division to the appropriate value.
- Lots of work being undertaken looking at how other Trusts are handling this.

NB clarified if any backdated claims exceed the element this would be reported as a pressure and come back to Audit and Risk Committee.

OUTCOME: The Committee **NOTED** the holiday pay resolution.

3. Waivers of standing orders report

The Deputy Director of Finance presented the waivers of standing orders report and highlighted the total value of activity and total value of purchase orders transacted during the quarter of £49.3m.

There were 14 instances of single source procurements under the threshold. There were no single sources over the threshold. The Deputy Director of Finance reported it was a better position than prior years due to increased awareness of the process.

JW asked if the historic position could be shared which would strengthen the report to see this reduction. The Deputy Director of Finance responded the regulations change over time; however, they will include the historic detail as a comparison to last year.
Action: Deputy Director of Finance to include historic data in the next report.

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

51/24 Internal Audit

1. Review Internal Audit Follow Up Report

The Internal Audit Manager presented the follow up report which sets out the Trust-wide position on the implementation of Internal Audit recommendations which have fallen due during Q1 2024/25. The key points were noted:

- 73 recommendations (66%) were completed in the last 12 months.
- 3 recommendations missed their original target dates – Updates have been provided for all three recommendations. One changed the target allowing for an additional three months. Two are being assessed for closure.
- 11 recommendations (10%) missed their original target dates. Revised target dates have been agreed for all of these. The majority of these relate to risk management and the Trust is introducing a new risk management system which has seen positive progress.

NB highlighted the positive progress made on the outstanding recommendations and stated a deep dive on risk management is scheduled for the October meeting.

2. Follow up of Internal Audit Progress Report

The Internal Audit Manager presented the progress report, the key points noted were:

- This year a rolling programme of verification will take place across the year and will report on a sample of recommendations in each quarter. This should provide more assurance and identify where recommendations haven't been implemented.
- A total of 60 days has been delivered which represents 17% of planned audit days.
- Six 2023/24 audit reports have been agreed with management since the last meeting.
- One audit report has no opinion.
- A limited assurance opinion was provided on Nasogastric (NG) training and competency following two never events. Overall, the recording processes relating to NG tubes has improved with a new section in EPR. However, there are still a few missing elements where clinicians are not using the correct section in EPR. Since the original audit, there has been a further never event and a near miss which was considered in giving this opinion of limited assurance.

JW asked for reflection on this issue and recognised the correlation between this limited assurance audit and the mental capacity act audit in relation to record keeping and training. The Internal Audit Manager confirmed the findings were similar across both audits and resource is an issue; however, lots of effort has been put into the training.

JW asked if there is a correlation between the areas with lower compliance for training and where incidents are occurring. The Internal Audit Manager responded there is one particular ward where more incidents have happened, and this ward no longer insert NG tubes.

Chris Boyne, Deputy Director, Audit Yorkshire confirmed there is a correlation and there is lots of effort on the training and policies to try to improve compliance across the Trust.

NB suggested Internal Audit review the incidents data when developing the 2025/26 audit plan.

NB stated in line with normal practice the Committee will ask the audit lead for NG training and competency to attend the next meeting in October to provide an update on the actions being taken. Following this deep dive, Audit Yorkshire can decide if this is re-audited.
Action: Lindsay Rudge, Audit Lead to be invited to the next meeting in October to present a deep dive into the NG Tubes Limited Assurance Report.

NB asked Audit Yorkshire to highlight any areas of good practice they identify in year to bring back to the Committee. The Deputy Director of Audit Yorkshire agreed with this and stated there are some very positive reports with significant assurance that could be focused on.
Action: Audit Yorkshire to highlight any areas of good practice for sharing at a future meeting.

OUTCOME: The Committee **NOTED** the progress made with the 2024/25 Internal Audit Plan and progress against completing Internal Audit recommendations.

3. Significant and High Assurance Audit Report
The final reports were available in the review room.

4. Internal Audit Monthly Insight Report
The Monthly Insight Reports were provided for information.

52/24 Company Secretary's Business

1. Review Audit and Risk Committee Terms of Reference
The Company Secretary presented the revised Audit and Risk Committee terms of reference which now includes a review of the system of raising concerns from the Audit Committee handbook. This will not replace the review of the Freedom to Speak Up Report by the Workforce Committee and is much broader.

2. Review Audit Chair Job Description
The revised Audit Chair Job Description was shared and has been reviewed against guidance.

3. Audit and Risk Committee Workplan 2024
The Audit and Risk Committee workplan for 2024 was shared. The cyber security deep dive will be added to the next meeting in October.

4. Review Audit and Risk Committee meeting dates 2025
The Audit and Risk Committee meeting dates for 2025 were approved.

OUTCOME: The Committee **APPROVED** the Audit and Risk Committee Terms of Reference, the Audit Chair Job Description, the Audit and Risk Committee workplan for 2024 and the meeting dates for 2025.

53/24 Local Counter Fraud

Local Counter Fraud Annual Report

Steve Moss presented the Local Counter Fraud Annual Report which confirms the work completed by the Trust's Local Counter Fraud Specialists (LCFSs) during 2023/24.

The Counter Fraud Functional Standard Return is divided into 13 requirements set out by the counter fraud authority. Prior to submission of the return, the Trust's Director of Finance and Audit and Risk Committee Chair reviewed and approved the contents of the submission which showed the Trust fully compliant on 12 of the requirements and partially requirement for number three which is encouraging.

The LCFS was in the process of embedding the prescribed fraud risk assessment methodology as required by the NHS Counter Fraud Authority (NHSCFA). The LCFS has completed an initial review of the 124 individual fraud risk descriptors set out by the NHSCFA. These have been discussed with the Director of Finance and risk owners within the Trust have been identified. If these are completed before the end of the financial year the Trust will move to a green rating. Steve Moss explained the Counter Fraud Authority estimate this could take up to five years to complete.

JW asked how this compares to other organisations they work with. Steve Moss responded it was representative for most clients in terms of trajectory.

JW asked if the report could show how many CHFT staff attended master classes to ensure the up take is good. The Deputy Director of Finance explained there were other opportunities for training such as 'Managing our Money' training which was role specific and completed by all budget holders face to face and includes a section on counter fraud.

Local Counter Fraud Progress Report

Steve Moss presented the summary of work for 2024-25.

Counter Fraud Newsletter

The latest Counter Fraud Newsletter was made available in the review room.

OUTCOME: The Committee **NOTED** the Local Counter Fraud Annual Report and Progress Report.

53/24 External Audit

Sector Update

Matthew Moore, Senior Manager, KPMG informed the Committee it is a quiet period after year end and all deadlines for the Trust were met. All external audit opinions were clean opinions. He called out there was a significant risk in value for money (VFM) planning but showed no significant weakness.

Conversations will start taking place with Finance about next year's audit process.

OUTCOME: The Committee **NOTED** the External Auditor's Sector update.

54/24 Review of Committee Annual Reports 2023/24

It is good practice for the Audit and Risk Committee to take an overview of all the Annual Reports for triangulation and assurance they have met their terms of reference. The following Committee Annual Reports for 2023/24 were shared:

1. Finance and Performance Committee
2. Quality Committee
3. Workforce Committee
4. Charitable Funds Committee
5. Transformation Programme Board

NB commented all annual reports provided a description of their terms of reference, how they have reviewed their effectiveness, fulfilled their terms of reference and attendance registers. The majority of the annual reports were a reflection on the previous financial year; however, pointed out the Quality Committee report focused on their priorities for the next 12 months. He highlighted some Committee's focused on their BAF risks more than others. NB asked if more consistency should be used as a template, including the Committee's focus over the next 12 months and greater focus on outcomes of Committee effectiveness and what has been achieved through deep dives.

The Director of Corporate Affairs responded the annual reports need to reflect that each Committee has a different focus. The Quality Committee self-assessment includes a forward view and there could be more consistency with the self-assessment questionnaires which feed into the annual reports.

Action: Company Secretary to work with each Committee to create a standard template for Committee annual reports and self-effectiveness questionnaires.

The Chair explained part of the rationale for holding Quality Committee and Finance and Performance Committee meetings on the same day was to incorporate any joint working looking at issues from the respective angles of the Committees.

The Chair suggested there could be further consideration for deep dives in terms of their outcomes, progress and what it is that needs to be achieved.

NB asked external audit how other Trusts use their annual reports. Chris Boyne, Deputy Director, Audit Yorkshire suggested a piece of benchmarking and NB agreed to ask Audit Committee Chairs in the region and find out if there is best practice.
Action: NB / Chris Boyne to review how other Trusts in the region use their annual reports.

OUTCOME: The Committee **APPROVED** the Committee Annual Reports for 2023/24.

55/24 Summary Reports (Minutes for assurance)

The following summary reports and minutes were shared.

1. Information Governance and Records Management Steering Group – 23.04.24 and 04.06.24
2. Data Quality Board
3. Resilience and Safety Group – 09.04.24 and 04.06.24
4. Risk Group – 29.05.24

Resilience and Safety Group - EPRR Core Standards
The Director of Corporate Affairs reported following all the work on the EPRR core standards, the further assessment due to take place in August was no longer taking place, following new guidance from NHSE. A self-assessment process will still take place and a further update will be provided once this has been worked through.

OUTCOME: The Committee **NOTED** the summary reports and minutes from the groups above.

56/24 ANY OTHER BUSINESS

Matthew Moore, KPMG left the meeting due to a conflict of interest.

The Company Secretary explained the three year contract with external audit came with a one year extension and the Trust are invoking the one year extension. She explained the appointment of the Trust's external auditors is a governor process and a procurement exercise will take place in Autumn for appointment of the auditor for 2025/26 onwards. She highlighted it was a challenging market for this area of work.

57/24 MATTERS TO CASCADE TO BOARD OF DIRECTORS

- BAF Standard Operating Procedure was approved.
- One limited assurance report had been issued in 2024/25 which was a follow up on the Naso-gastric tube processes. It was agreed that the Executive lead would be invited to the October ARC meeting to contribute to a deep dive into this audit.
- The Audit & Risk Committee terms of reference and the Chair's Job Description were approved.
- Deep Dive into the work of the Data Quality Board.
- High Assurance Reports - finding time to discuss positive high assurance reports from internal audit was discussed.
- Local Counter Fraud annual report for 2023/24 was approved and a progress report for the current year received.
- Committee Annual Reports for 2023/24 were received.
- New guidance had been received on the EPRR processes nationally and that further details would be provided once this has been worked through.

The meeting closed at approximately 12:20 pm.

58/24 REVIEW OF MEETING

JW felt the papers were very clear and the meeting was well chaired in the time.
NB commented it was worth spending the additional time on the deep dives.
HH provided her observation it was a good meeting and thanked the Chair.

DATE AND TIME OF THE NEXT MEETING

Date: Tuesday 22 October 2024
Time: 10.00 am – 12:30 pm
Via: Microsoft Teams

Chair Approved Minutes of the Charitable Funds Committee meeting held on Tuesday 6 August 2024, 10:30 am in Room 4, 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
Lindsay Rudge (LR)	Chief Nurse

In attendance

Helen Rees (HR)	Director of Operations, Medicine *(Deputy)*
Victoria Pickles (VP)	Director of Corporate Affairs
Emma Kovaleski (EK)	Charity Manager
Sanna Samateh (SS)	Charitable Finance Officer
Kate Wileman (KW)	Governor Representative
Zoe Quarmby (ZQ)	Financial Accountant
Julie Mellor	Lead Nurse for Children and Young People
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 Lyn Walsh and Jonathan Hammond. Helen Rees attended as Deputy for Jonathan Hammond.

18/24 DECLARATIONS OF INTEREST AND INDEPENDENCE

All present declared their independence. There were no declarations of interest.

19/24 MINUTES OF THE PREVIOUS MEETINGS HELD ON 7 MAY 2024

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

OUTCOME: The Committee **APPROVED** the minutes of the previous meeting held on 7 May 2024.

20/24 ACTION LOG

The action log was reviewed and updated accordingly.

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

21/24 CHARITY STORY: CHILDREN AND YOUNG PERSONS STRATEGY

Julie Mellor, Lead Nurse for Children and Young People thanked the Committee for the opportunity to share a presentation on the Children and Young People Strategy.

The key points noted were:

- A digital patient story is being shared alongside the strategy and the video will be circulated to the Committee.
- Logo for the strategy is the ray of sunshine campaign.
- The strategy provides a plan of a 'journey to outstanding' for the care for children and young people in CHFT.
- Integral to the strategy is listening to the voice of children and young people.
- A key focus is reducing health inequalities for children and young people – the five key clinical areas for this are asthma, diabetes, epilepsy, oral health, and mental health.

- Pet therapy dogs have a big impact which is inspirational and trying to increase the use of this.
- The strategy is supported by CHFT charity to help brighten the care and experience of children, young people and families who access services across CHFT. A few examples of past projects the charity have supported include:
    - Tickle flex for needle phobic children – Childrens Diabetic Clinic
    - A&E care bags
    - Hope packs
    - Enhancement to Orthopaedic Outpatients
    - Rainbow Community Hub
    - Children Diabetes Team Building Days
    - Shhh campaign to tackle noise at night
    - My Forever Box – an individualised resource box to help children and young people who are losing a loved one which includes craft activities and a memory box to design. Over 100 children and young people have been supported and this continues to grow. The pre child bereavement team won a CHuFT award for the Work Together Get Results category and the team have been nominated for a Nursing Times Award for 'Team of the Year' which they are proud of.
- Ray of sunshine fundraising campaign is a standalone campaign with a vision for all babies, children and young people who are cared for by CHFT, whether in hospital or in the community have their individual needs met, reducing avoidable distress and trauma.
- Co-ordinated approach is being taken to link with other strategies such as the Dementia Strategy.
- There is an overarching strategy for the next five years 2024-2029. Included in this strategy is a pilot of a national campaign called Sophie's Legacy, supported by NHSE.

The Children and Young People Strategy and patient story will be presented to the Public Board of Directors on Thursday 12 September 2024.

The Chair thanked Julie Mellor for her presentation and for demonstrating how the charity is embedded in the strategy and the Trust and how they complement each other which is positive.

NB asked how the team ensure external partners are signed up to the strategy. Julie Mellor explained how partnership working is built into the strategy and that they have senior representation at regional meetings which they will use to promote the strategy in child and mental health services. The first step is to ratify the strategy within CHFT.

The Director of Corporate Affairs shared one of the benefits of this being a joint strategy between children's services and the charity is there is a bigger audience and that we can reach different partners.

The Chief Nurse re-iterated the importance of the strategy being ratified internally and articulating this well, as the strategy involves every service that children and young people access, and this should be thought about differently.

Kate Wileman thanked Julie and the team for thinking about children's experiences and supporting children's relatives and parents. Julie Mellor explained the pens when people sign up to the pledge say, 'invest today for our adults tomorrow' which speaks for itself.

The Chair asked what support the Charitable Funds Committee can provide to deliver the strategy. Julie Mellor asked for support of the ray of sunshine campaign which helps with things from distraction toys to new builds pending from reconfiguration, ensuring these areas are child and young person friendly and safe. The Chair commented that she met the play co-ordinators on the learning disabilities walk round which she found inspiring. Jule explained they are scoping play volunteers to complement this work. EK explained the volunteering service now sits under the charity which was a positive move, and they are exploring the expansion of volunteering including specific roles like play volunteers.

Julie explained there is a national campaign called Starlight who are for improved play facilities nationally. The Trust has play provision in A&E, outpatients, and surgical day case; however, this can be expanded to improve the experience for children.

The Director of Finance asked for an overall scale of the campaign that the Committee are being asked to support.

EK responded that this is a campaign rather than an appeal and therefore doesn't have a specific target attached. The campaign is broken down into year one 24/25 and years two to five 2025 to 2029. There are seven key areas of the campaign which will require different levels of funds to support projects which are:

1. Help me sleep well.
2. Keep me entertained and distracted.
3. Provide me with a homely and visually appealing environment.
4. Offer me peer support and social activities.
5. Help me to stay calm and comfortable.
6. Provide me with play therapy support.
7. Help my parents/carers feel welcome and cared for.

Year one of the strategy is focused on the development and launch of the rays of sunshine fundraising campaign and raising funds to support the ongoing projects that enhance the experience of babies, children and young people through play, entertainment, distraction, and peer support activities. EK has undertaken an analysis of the charitable funds connected to children's services to understand the annual figure and cost to the charity to continue to provide these ongoing projects. Years two to five will focus on the longer-term ambitions of the strategy. EK explained how they will achieve this and the ambition from September is to engage with young people in primary and secondary education and use social media and a campaign mascot. The Director of Corporate Affairs explained the longer-term strategy might require an appeal; however, they are currently in a campaign for year one.

NB highlighted the great work around the use of play and asked if the different needs of young people was also a focus area. EK confirmed they are focused on the needs of young people and are already getting feedback from young people such as better wi-fi in the hospital and how to reach out to them in a different way such as the use of TikTok and snapchat. There is also a Youth Forum in place which captures the voice of young people. EK explained the charity funded the first 12 months of the transition nurse specialist and Julie explained they now have a mental health nurse liaison in post based on the children's ward who will reach out and support young people on adult wards.

OUTCOME: The Committee **NOTED** the Children and Young Persons Strategy and **SUPPORTED** the Ray of Sunshine Campaign.

22/24 CHARITY MANAGER'S REPORT

EK presented the Charity Manager's report. The key points to highlight were:

- Incredible start to 2024/25 which saw the rebrand of the charity and the opening of the wellbeing garden at Huddersfield Royal Infirmary.
- Fundraising remains challenging; however, the charity is achieving its ambition with an impactful future ahead.
- There is a total of 107 charitable funds with proposals to close and merge which would reduce the number of 'active' funds to 59.
- All KPIs for 2024/25 are on track to deliver.
- £107k income has been delivered to date against a target of £170k.
- The fundraising forecast to year end was shared including two pending donations in support of bereavement suite appeal (£66k) and Cancer services (£50k).
- A Legacy Campaign will be launched to further promote legacy giving around 'make a will' month in October.

The Chair asked how realistic the forecast is for the planning and events, given the shortfall of planned to actual, and why the legacies aren't included in the forecast. EK responded these were realistic e.g. great north run and the places that weren't secured for these events were sold back into the pot, so a loss wasn't incurred from the registration fee. She added the hospital walk did not deliver as the Trust wasn't able to secure corporate sponsorship like last year. Feedback is reviewed from each event and learning is incorporated each year to inform the forecast. The Director of Corporate Affairs agreed that legacies can be forecasted, and finance input will be needed to support the lookback. The Director of Finance highlighted the importance of flagging the risk with this. It was agreed to include a legacy forecast in the next report using historical data.

ACTION: EK / LW to include legacy forecast in next finance report

<u>Bereavement Suite Fundraising Appeal</u>

EK shared the bereavement suite fundraising appeal and the ambition. She explained the CQC report slides have been shared which confirms this is a 'should do' recommendation.

Ambition – To provide a dedicated baby bereavement suite that is calming, comfortable and private, that has access to specialist equipment in a less clinical setting.

EK explained the birth centre has moved to floor two with labour ward which has provided opportunity to roll out fundraising.

Several go-sees have taken place to look at bereavement suites in other Trusts and how these were funded and fundraised for.

EK explained a Task and Finish Group has been set up and Vanessa Perrott is a Non-Executive Director (NED) representative as Maternity NED Champion.

EK asked the Committee for endorsement of a bereavement suite fundraising appeal.

The Director of Finance asked if the charity would need to underwrite any shortfall, explaining the architects will want final designs in a month or two; therefore, any changes at CRH will need to be factored in now. EK explained they are not prepared to launch the appeal until there is commitment from the funders and she confirmed the League of Friends CRH are underwriting this.

The Director of Finance asked if this would divert the charity team's capacity from other targets and fundraising activities. EK re-assured the Committee they are balancing the team's capacity.

The Chair asked why this fundraising appeal can't be aligned to baby loss awareness week. EK explained it is too soon with the ray of sunshine promotion; therefore, they have made the decision to promote this in the new year. This will not cause a delay with informing architects.

The Director of Corporate Affairs confirmed that the pledged funds would support the building works. Further fundraising would be required for the extras to make this suite comfortable and practical for families.

OUTCOME: The Committee **NOTED** the year end Charity Manager's Report and **SUPPORTED** the Bereavement Suite Fundraising Appeal.

24/24 FINANCE REPORT – Q1

ZQ presented the year end Finance Report as at end of June 2024.

NB asked if the spend, income and financial forecast was in line with the plan or if there were any variances. The Director of Finance explained the spending element is more challenging to forecast. The Director of Corporate Affairs confirmed the historical funding allocations are being reviewed and either progressed or returned as appropriate.

ACTION: Nigel, Gary and Zoe to meet to discuss the financial forecast, the known costs, historic commitments and agree one financial report that brings it all together (income, forecast, expenditure, reserves, investment).

OUTCOME: The Committee **NOTED** the year end finance report as at end of June 2024.

26/24 CHARITY STEERING GROUP TERMS OF REFERENCE

The Director of Corporate Affairs presented the first draft of the proposed Charity Steering Group Terms of Reference required for the first meeting.

The terms of reference will be tested and reviewed in six months.

The Director of Finance flagged the overall Standing Financial Instructions (SFIs) will need to be updated to reflect the approval limits of this Group of up to £10k.

Action: ZQ to check the Trust SFI's approval limits against the Charity Steering Group Terms of Reference.

The Chief Nurse pointed out Alex Keaskin is the Lead Nurse for Patient Experience only, not complaints.

Action: Director of Corporate Affairs to amend the Terms of Reference membership.

OUTCOME: The Committee **APPROVED** the Charity Steering Group Terms of Reference.

27/24 CHARITABLE FUNDS COMMITTEE ANNUAL TERMS OF REFERENCE REVIEW

The Director of Corporate Affairs presented the annual review of the Charitable Funds Committee Terms of Reference which will go to the Board of Directors on 12 September for approval as part of the Chair's report to Board.

OUTCOME: The Committee **APPROVED** the Charitable Funds Committee Terms of Reference.

30/24 MINUTES OF STAFF LOTTERY COMMITTEE MEETING HELD ON 6 JUNE 2024

The minutes of the Staff Lottery Committee held on 6 June 2024 were received for information.

The Director of Corporate Affairs explained there is a plan to promote the staff lottery and how to better use the funds.

OUTCOME: The Committee **RECEIVED** the minutes of the Staff Lottery Committee held on 6 June 2024.

31/24 ANY OTHER BUSINESS

ZQ provided an update on the charity audit. It was noted that a full audit is not required, and a firm had been identified to undertake an independent review of the accounts following engagement with Airedale NHSFT who also use them for their charity. The work will start at the beginning of September and be complete by the end of November as the accounts must be submitted by the end of January to the Charity Commission. ZQ explained they are working with procurement to make these arrangements.

DATE AND TIME OF THE NEXT MEETING

Tuesday 5 November 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)	✔	✔			2/2
Nigel Broadbent	✔	✔			2/2
Gary Boothby	✔	✔			2/2
David Birkenhead	✔	✔			2/2
Lindsay Rudge	✖	✔			1/2
Jonathan Hammond	✔	✔			2/2
Attendance					
Emma Kovaleski	✔	✔			2/2
Victoria Pickles	✔	✔			2/2
Zoe Quarmby	✖	✔			1/2
Lyn Walsh	✔	X			1/2
Sanna Samateh	✔	✔			2/2

QUALITY COMMITTEE
Monday, 3 June 2024

STANDING ITEMS

102/24 – 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 **(DBi)**	Medical Director
Lucy Dryden **(LD)**	Quality Manager for Calderdale Cares Partnership Board
Jason Eddleston **(JE)**	Deputy Director of Workforce & Organisational Development
Jonathan Hammond **(JH)**	Chief Operating Officer
Elizabeth Morley **(EM)**	Associate Director of Quality and Safety
Victoria Pickles **(VPi)**	Director of Corporate Affairs
Gemma Puckett **(GP)**	Director of Midwifery and Women's Services
Lindsay Rudge **(LR)**	Chief Nurse
Jo-Anne Wass **(JW)**	Non-Executive Director
Lorraine Wolfenden **(LW)**	Governor
Michelle Augustine **(MA)**	Governance Administrator **(Minutes)**

In Attendance

Alison Edwards **(AE)**	Safeguarding Lead **(item 106/24)**
Sree Tumula **(ST)**	Associate Medical Director **(item 85/24)**
Caroline Summers **(CS)**	Lead Cancer Nurse **(item 109/24)**
James Houston **(JH)**	Consultant Paediatrician **(observing from Shadow Board)**
Juliet Hendrick **(JH)**	Resuscitation Officer **(item 108/24)**

Apologies

Gina Choy **(GC)**	Public Elected Governor
Jennifer Clark **(JC)**	Associate Director of Therapies
Sharon Cundy **(SC)**	Head of Quality and Safety
Joanne Middleton **(JMidd)**	Deputy Chief Nurse
Vanessa Perrott **(VPe)**	Non-Executive Director
Elisabeth Street **(ES)**	Clinical Director of Pharmacy

A copy of the attendance register was circulated at appendix A.

103/24 - DECLARATIONS OF INTEREST

There were no declarations of interest.

104/24 – MINUTES OF THE LAST MEETING AND ACTION LOG

The minutes of the last meeting held on Wednesday, 8 May 2024, circulated at appendix B, were approved as a correct record. The action log can be found at the end of these minutes.

105/24 – MATTERS ARISING

Medical Division's Policies Update

See action log.

Quality and Safety Strategy

Lindsay Rudge and Elizabeth Morley presented the updated and revised 2024/25 Strategy as circulated at appendix D.

The Quality and Safety Strategy aligns to the Trust values and behaviours in support of One Culture of Care, and sits alongside other Trust strategy documents such as Service Reconfiguration Plans, the Research and Development Strategy and the Workforce and Organisational Development Plan.

The Quality and Safety Strategy key priorities were highlighted, as well as the definitions for quality and safety, the programmes which underpin each key priority, and how the Strategy is aligned to our pillars, One Culture of Care and driving a 'Just Culture' through the organisation.

It was also noted that the first lived experience panel will be taking place later in the day, which includes patient safety partners, experts by experience and other colleagues.

JW commented on the concise and clear document, references to benchmarking and links to One Culture of Care, and asked how the Strategy will interact with colleagues on the frontline. **EM** stated that the Strategy will go through various forums to engage with divisions and colleagues, with an aim for colleagues to support and establish working groups. **EM** also stated that the Strategy will be implemented beyond 2025, due to the amount of work to be done.

JW asked how the work will be managed in a way to allow colleagues to understand the Strategy and build it into everyday practice. **LR** stated that the link with One Culture of Care will be the Work Together, Get Results (WTGR) quality improvement methodology, which colleagues are familiar with. In relation to collaboratives, it is expected that smaller groups will focus on smaller numbers of top priorities which need to be improved on the Integrated Performance Report (IPR), and subject matter experts within the collaboratives will have the right quality improvement support. The strategy fits with the nursing ambition, and the engagement work will be an opportunity to gauge colleagues' understanding.

From a medical perspective, **NBha** stated the Strategy will also go through various forums ensuring colleagues are engaged, and individual working collaboratives would have Multi-disciplinary Team (MDT) colleagues to enable any learning or share changed practice, specifically, through the clinical governance meetings where the full medical team are in attendance. This will assist getting the Strategy from paper to everyday practice.

DS mentioned the lessons learnt forum and asked how this is envisaged to work and the impacts it will have. **LR** stated that this will be part of the transitional period into Patient Safety Incident Response Framework (PSIRF), and will be a safety and learning forum to ensure learning has been embedded in the organisation.

DS asked the Committee for any views regarding a Committee objective linked to the Strategy, and **LR** suggested an objective around ensuring that the key priorities of the Strategy are delivered.

OUTCOME: The Committee noted the report.

SUB-GROUP REPORTS

106/24 – SAFEGUARDING ADULTS AND CHILDREN'S ANNUAL REPORT

Alison Edwards was in attendance to present the above report as circulated at appendix E, highlighting the key activities from the Safeguarding Team during April 2023 to March 2024, and summarising the key points to note.

JW asked about training compliance and asked when the targets are likely to be achieved. **AE** reported not having a target date, but stated that the compliance is monitored closely through the Safeguarding Committee where challenges are presented. It is anticipated that a significant improvement is achieved in the next quarter due to the engagement from divisions and their monitoring of compliance through their Patient Safety and Quality Board (PSQB) meetings. It is also hoped that this will also impact on supervision compliance.

DS asked about the high demand for safeguarding reviews and going forward, how the ability to respond will be managed. In relation to preparing for the demand, **AE** stated that work has taken place with colleagues to ascertain what is required, as colleagues now need to contribute to those reviews. They are a priority to ensure no targets or timescales are missed.

DS commented on the automated system developed to prompt colleagues to follow the Burns, Bruises and Scalds Policy when a child presents, and asked how this has impacted on increased compliance. **AE** stated that this is in its early stages as it was introduced in April, however, initial feedback is encouraging as it makes the process faster and has reduced the administrative time in relation to Mental Capacity Act (MCA) / Deprivation of Liberty Safeguards (DoLS) and freeing up the safeguarding practitioner to be able to support colleagues. Results will be presented in the next report.

In relation to the training compliance mentioned earlier, **DS** suggested that these are reported by divisions via their quarterly reporting. **EM** agreed to liaise with divisions and include this within the reporting template.

OUTCOME: The Committee noted the update.

107/24 – PATIENT EXPERIENCE AND INVOLVEMENT GROUP

Lindsay Rudge presented the above report as circulated at appendix F, highlighting the key points to note.

DS requested that the Person Centred Care promotional film mentioned in the report is shared at a future meeting.

OUTCOME: The Committee noted the update.

108/24 – RESUSCITATION COMMITTEE

Juliet Hendrick was in attendance to present the above report circulated at appendix G, highlighting the key points to note from the Resuscitation Committee.

JW asked the Committee about the impact of the move of the Learning Centre, and whether this has been mitigated in relation to training attendance levels. **JH** stated that colleagues who have completed train the trainer will be able to deliver training, and help mitigate that risk to some extent. It was suggested that this is monitored if impacting attendance.

DS commented on the transition from the old Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms to the new Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) forms, and asked if there is a target to be achieved for all DNACPR forms to be

replaced. In terms of the electronic ReSPECT form, **ST** reported that it is working well and compliance is increasing significantly, and the plan is to phase out the availability of paper DNACPR forms from 1 July 2024. Support for ReSPECT is available until September 2024, therefore, a handover to divisions is being worked through to monitor training compliance, and the training will be taken over by the Resuscitation Team.

DS asked about the clarification on the proposed plan for the Advanced Paediatric Nurse Practitioner being transferred to the CRH site. **LR** reported on a meeting taking place later today around the target operating model for paediatrics, and the plan would be for Advanced Paediatric Nurse specialists at HRI with advanced paediatric life support skills.

OUTCOME: The Committee noted the update.

109/24 – CANCER DELIVERY GROUP

Caroline Summers was in attendance to present the above report as circulated at appendix H, highlighting the key points to note, which included the implementation of the Aspirant Cancer Career and Education Development (ACCEND) framework, Radiology treatment times, Cancer Outcomes and Services Dataset (COSD) and sustainability of innovations.

JH commented on the radiotherapy treatment times and discussions had with Leeds and their interventional radiographer challenges. Discussions have also taken place with Cancer Alliance Directors and the West Yorkshire Association of Acute Trusts (WYAAT) Chief Operating Officers' meeting, which is extremely challenging due to Leeds' workforce challenges. There is no confirmed timeframe of improvements. Other regions are in a similar or worse position, and looked at mutual aid outside of the region, however, this has not been confirmed. Ongoing discussions are taking place, and from a clinician's perspective, concerns are being raised through clinical forums.

DS noted from the report on patients being informed of the longer waits and delays, and in terms of their patient experience, it was asked what additional support is available. **CS** reported that the Clinical Nurse Specialists are present when the patients see the oncologist, and are available for support, and patients are aware of the cancer information and support service to approach if they have any concerns. As yet, no concerns have been raised.

The terms of reference for the Cancer Delivery Group were ratified.

OUTCOME: The Committee noted the report.

SAFE

110/24 – NURSING, MIDWIFERY AND ALLIED HEALTH PROFESSIONAL ANNUAL SAFER STAFFING REPORT

Lindsay Rudge presented the report as circulated at appendix I, highlighting the key points to note.

JW commented on the vast improvement within the Allied Health Professional (AHP) workforce and asked whether the learning is being applied to midwifery, and how quickly similar improvements be expected in midwifery. **LR** stated that similar improvements are applied in midwifery, and a number of colleagues reduced their working hours, which in turn means an increase of four whole time equivalents. In relation to central recruitment through the Local Maternity and Neonatal System (LMNS), 17 colleagues will be joining CHFT. **JW** stated that it would be useful to demonstrate when improvements were expected.

JW asked whether the Trust could get into a better position to anticipate workforce change and turnover for the next year or two, rather than dealing with current turnover figures. **LR** reported

on the vast business intelligence support into the nursing and midwifery workstream, with a chart for planned predicted leavers, which plot ahead for the year. It was suggested that this is demonstrated outside of the Workforce Committee meeting.

GP stated that midwifery workforce has been really challenging and in 2023-2024, recruited around 30 whole time equivalent midwives, however, due to leavers, the workforce growth was not what was expected, which is being seen elsewhere. CHFT is expecting to see progress, with two outputs now from the University of Huddersfield. For the first time, there was a March output from the University which has been recruited from, and the midwives came into post in April. The Trust is also joining the Shortened Midwifery Training programme to train registered nurse who wish to become dual registered, and midwifery apprenticeships will be starting in September, with a view to have two per year. The service is optimistic to grow the workforce within the next three years, in line with the birthrate plus report. There were a reasonable amount of leavers during the first half of 2023-2024, however, this significantly reduced during the last six months of 2023-2024, and focus is now being place on retention and pastoral care and support for existing colleagues. In relation to turnover figures, the last six months will be reviewed, as well as the next six months in order to have a predictive value around growth.

In terms of midwifery recruitment, **DS** asked about the attrition rate for student midwives and asked if there was any progress. **GP** stated that the rate is still higher than hoped, and is the case across the country. **DS** noted that this is a shared challenge, and asked what is being done with the University. **GP** reported that the CHFT recruitment lead midwife spends time with students at the university talking about their careers and helping them prepare for becoming a midwife, with a detailed preceptorship programme in place, and the possibly of regular sessions between **GP** and student midwives to discuss the real expectations of midwifery.

LR mentioned that the University of Huddersfield is making significant changes and cutbacks across some health programmes, which will affect the student intake, and going forward, will need to be retained, as it is known that the turnover rate in those aged 25 and under is higher than other age brackets. A new plan will need to be created, based on the out-turn from programmes going forward, which will be brought to the Committee in more detail at a later date. **JW** also suggested working with other universities and other midwifery programmes available.

DS mentioned the encouraging number of different initiatives and various routes for ongoing training, development and progression, and asked about the approach for the Registered Nurse Degree Apprenticeship. **LR** stated that as long as career pathways are right, and people are supported, most of them stay with the Trust.

OUTCOME: The Committee noted the report.

111/24 – MATERNITY AND NEONATES: 3-YEAR DELIVERY PLAN – THEME 2 UPDATE

Gemma Puckett presented the report as circulated at appendix J, highlighting growing, retaining and supporting the midwifery workforce.

GP reported that a session on *'How to become a midwife'* will be shared in the CHFT Trust News to hear about the different routes into midwifery. In relation to neonatal nursing, recent recruitment into band 6 posts has been challenging, however, there was a great intake of newly qualified nurses for the neonatal service. The recruitment and retention strategy is being refreshed to include the different career routes.

The service is part-way through the three-year plan to meet the fill-rate, and the birth Rate Plus report is near the workforce funded establishment, however, it does not indicate what the workforce structure should look like, therefore, work is ongoing with finance teams with a 1, 2 and 3 year view of when there will be financial implications.

Maternity and neonatal MIS (Maternity Incentive Scheme) training compliance is on target to being achieved.

Data on maternity and neonatal incidents: Perinatal mortality was highlighted, as well as a briefing paper on the current Trust position on stillbirths. There have been 14 stillbirths year to date, which is in excess of the total seen last year. This has been discussed with Local Maternity and Neonatal System (LMNS) colleagues and external input to review the cases and undertake thematic reviews was requested, which took place earlier today.

LR reported on the detailed review, and engagement with external partners to help understand information which was already known. There is urgent work to be done in the two post codes and discussion has taken place with the Chief Nurse within the Integrated Care Board (ICB) about the report, however, further work may be needed with the Directors of Public Health in both Kirklees and Calderdale.

JW stated that there is a very strong health inequality angle, which suggests CHFT not necessarily being an outlier, and asked whether other Trusts serving similar populations as CHFT were seeing a similar rise. **GP** reported that the Local Maternity and Neonatal System (LMNS) and other surrounding units have not seen a similar increase, however, following the review earlier today, there is nothing that CHFT is doing which is starkly different to anywhere else.

VP stated that last year, the integrated care systems (ICS) were due to carry out a campaign around getting people to engage with services early in the pregnancy journey. CHFT wanted to be a part of that, however, the numbers were not as bad as other areas across West Yorkshire, therefore, the Trust implemented some work, but did not have the West Yorkshire support. This is an indicator of West Yorkshire as a whole for early engagement in a pregnancy journey.

JW asked what the numbers would look like if the health inequality and information about the two postcodes were taken out. **VP** stated that a significant number of pregnancies happen in areas of high health inequality, therefore needs to be addressed and requires support from the system.

DS referred to the reintroduction of the continuity of carer teams, which would be when there was an appropriate level of staffing, and asked what the appropriate level of staffing was. **GP** reported that national guidance was when safe staffing requirements were met within the service, and would be full recruitment, however, that may not be what is required. What the service would like to do is look at an alternative workforce which can support women – not necessarily midwifery - and focus on continuity antenatally and in the postnatal period, then when full continuity is introduced, to focus on the cohort of women who need it most. Until caseloads are within a normal level within the community, the continuity teams would not be introduced.

DS asked for a CHFT response to the All-Party Parliamentary Group birth trauma report at a future meeting. **GP** stated that some work is taking place on where the service is in relation to the recommendations in the report, and once a gap analysis has been carried out and taken it through divisional governance, the results can be shared at this Committee.

OUTCOME: The Committee noted the report.

CARING

112/24 – ANNUAL PATIEINT EXPERIENCE REPORT

Lindsay Rudge presented the above report as circulated at appendix K, highlighting the change of the group from the Patient Experience Group to the Patient Experience and Involvement Group in 2023-24, and established four key priorities for strategic programmes of work, which were Person-centred care; Strengthening working in Partnership with People and Communities;

Insight to inform Improvement Priorities, and Keep Carers Caring. These programmes align with the legislative changes of the triple aim which was part of the Health and Social Care Act 2022; 22 changes to the new CQC assessment framework, and the Chief Nursing Officer for England priority. The work undertaken throughout last year has supported the voice of the patient and/or carer to be heard and amplified, as a golden thread that runs throughout all the team does at CHFT.

DS mentioned reference made to training being available for colleagues who have patient involvement when looking at policy change and programmes of work being developed, and asked whether there was an expectation that colleagues do this automatically, or whether they need to be reminded of patient involvement. **LR** reported that at the moment, this is sporadic if there is a different policy change, however, what is important is where service changes are being made that people are involved as part of the duty of the Health and Social Care Act. The equality impact assessment and quality impact assessment processes have more specific guidance to ensure colleagues are being prompted to undertake the requirements under the act to involve people. The lived experience group which are meeting later today, consisting of experts by experience and the patient safety partners, will be the group that Policies can be shared with for any comments on patient involvement.

OUTCOME: The Committee noted the report.

113/24 – ANNUAL COMPLAINTS REPORT

Victoria Pickles presented the above report as circulated at appendix L, highlighting that even though there has been some variability in performance in responding to complaints over the last 12 months, the variability is limited and at a higher level than in previous years.

In relation to the forward plan for 2024-25, focus is needed in terms of learning from the complaints, equality monitoring and reporting, and the reopening of complaints.

JW was in support of the focus on equality monitoring, and asked about the reopening of complaints, and whether trying to meet the timescales was having an impact on whether complaints are reopened as people feel they need to be closed quickly, and not covering all issues.

JW also asked what kind of support, development or training is provided to colleagues around the handling of complaints, which is likely to satisfy complainants, as opposed to a satisfying the process. **LR** stated that closing of complaints is not the issue, however, it is the agreement of the number of extensions, therefore, one of the goals is to reduce the number of extensions that are made and responses right first time. Complaints training is available, as well as management fundamentals, and over the years, have provided examples of what a good complaint looks like, which divisional teams can use. **VP** commented that the single biggest difference is agreeing at the outset what is being responding to and working with the complainant from the outset about what they want from an answer.

In terms of the process, **VP** responded that all divisions have a quality governance lead who links with the complaints team and provides some support within the division and the investigators investigate complaints, and also other investigations, and have a broad range of skills. All complaint responses are reviewed by the Head of Complaints, who will provide support and feedback into the divisions followed by sign-off by an Executive.

OUTCOME: The Committee noted the report.

RESPONSIVE

114/24 – QUALITY REPORT

Nikhil Bhuskute presented the report as circulated at appendix M, highlighting:

- *Serious Incidents*: Serious incident investigations are no longer being commissioned due to the transition to Patient Safety Incident Response Framework (PSIRF). Whilst the serious incident backlog is being worked through, the first investigation under the PSIRF framework was commissioned in last fortnight.
- *Backlog of Orange incidents:* the majority of outstanding orange investigations are within the division of Medicine.
- *CQC preparation*: Divisions are currently working against a checklist to self-assess in June, along with a well-led workshop for the senior leadership teams.
- *Legal services:* Work has increased with an increase in inquests compared to the last quarter. The team is under significant pressure due to a workforce shortage, and the fixed fee inquest bundle with Weightmans is due to come to an end, with a renegotiation required going forwards.
- *Quality priorities*: Steady improvements are being made, and it is noted that the deteriorating patient team are readjusting to how they newly launched Acute Response Team is working, in order to capture deteriorating patients more effectively.
- *Summary Hospital-level Mortality Indicator (SHMI) / Hospital Standardised Mortality Ratio (HSMR):* There will be an impact on all measures, due to Same Day Emergency Care (SDEC) data no longer being included. It is anticipated that there will be a change of between five to nine points in SHMI and HSMR. All organisations will be following this new process, and CHFT is one of the first two Trusts in the country to start SDEC data removal. The CHFT position on the national benchmarking graphs will look extremely poor, and being a negative outlier.

JH noted that the change in SDEC data will also impact length of stay data, which is being analysed to understand the extent of the impact.

OUTCOME: The Committee noted the report.

115/24 – QUALITY COMMITTEE ANNUAL REPORT

Elizabeth Morley presented the report as circulated at appendix N, which describes the committee's activities between April 2023 and March 2024.

The report concludes that the Committee provides assurance that systems and processes are in place for the delivery of safe quality services and the delivery of the quality improvement priorities. The appendix of the report include the results of the Committee self-assessment, and an action plan of the results will be brought to the next meeting.

OUTCOME: The Committee noted the report.

116/24 – QUALITY ACCOUNT

Following delegated responsibility from the Board of Directors to sign-off the Quality Account, Elizabeth Morley presented the report as circulated at appendix O.

OUTCOME: The Committee approved the Quality Account.

117/24 - INTEGRATED PERFORMANCE REPORT (IPR)

David Birkenhead provided an update on the report circulated at appendix P, highlighting the Summary Hospital-level Mortality Indicator (SHMI) performance which has been increasing over the last 12 months, which has been the cause for review into a number of areas which flagged an alert. The issues with the Same Day Emergency Care (SDEC) removal as mentioned earlier will place the Trust in an outlying position. Discussions will need to take place with CQC so they are aware of the reasons why, however, at this point, remain within the expected range.

There has been some improvement in dementia scores, with work being undertaken to improve further; and some improvement within stroke, however, still challenged in relation to speech and language therapy, and the availability of colleagues to support patients on those units.

Work is being done with the Acute Response Team, a combination of the Hospital Out of Hours Team and the Clinical Outreach Team, which is now in place, to improve responses to deteriorating patients. A refresh of the sepsis policy will hopefully give greater clarity for patients who need an escalation within the Emergency Department (ED) and out.

Overall performance is challenged from an emergency perspective, the ED is 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, recognising the efforts from colleagues, including very extended hours from some consultants to support those services. ED performance is far from being where it was prior to COVID, when achieving 95% 4-hour turn around on a regular basis, however, CHFT is not unique in trying to achieve the 4-hour targets, and strive to give people the best experience.

LR mentioned flagging the speech and language therapy (SALT) issues within the West Yorkshire Association of Acute Trusts (WYAAT). **DS** commented that this must be a similar situation across the region in terms of challenges recruiting SALT colleagues with relevant experience for stroke patients. LR stated that there are issues with both adults and children, with children waiting for videofluroscopies, and do continue to flag and look at alternate ways for different programmes.

In terms of the dementia scores, **DS** asked whether the improvement is being sustained, or whether there is some variability. **LR** stated that the new lead dementia nurse is now in post and working to ensure that dementia screens are being initiated from the outset.

JH commented that colleagues are getting used to the new Emergency Department (ED) environment, and seeing a difference now between the performance at Calderdale and at Huddersfield. The Medical Same Day Emergency Care (SDEC) returned to Calderdale in March, which has made a big difference. There are plans to use the old ED space at Huddersfield for integrated hubs to help with flow, which will hopefully be in place within the next 8 to 10 weeks.

OUTCOME: The Committee noted the report.

ITEMS TO RECEIVE AND NOTE

118/24 – INTERNAL AUDIT REPORT – LOCAL SAFETY STANDARDS FOR INVASIVE PROCEDURES (LOCSSIPs)

Nikhil Bhuskute presented the report as circulated at appendix Q, highlighting that during the 2022-2023 review, there were nine internal audit recommendations, which were reaudited this year. Seven recommendations are now fully compliant and completed, with two partially compliant recommendations around performance of areas with low compliance being monitored; and timely updates on National Safety Standards for Invasive Procedures (NatSSIP) and Local

Safety Standards for Invasive Procedures (LocSSIP) compliance to senior management and Executive Directors on a regular basis.

OUTCOME: The Committee noted the report.

119/24 – MINUTES FROM:

Clinical Outcomes Group

A copy of the minutes from Wednesday, 10 April 2024 were circulated at appendix R for information.

Infection Control Performance Board

A copy of the minutes from Tuesday, 23 April 2024 were circulated at appendix S for information.

Medicines Management Committee

A copy of the minutes from Thursday, 21 March 2024 were circulated at appendix T for information.

OUTCOME: The Committee noted the minutes.

Due to the vast number of minutes received at the Quality Committee, **JW** suggested that the Chair from each sub-committee gives a list of items which the Committee needs to be aware of in relation to quality.

120/24 - ANY OTHER BUSINESS

There were no other items of business.

121/24 - BOARD TO WARD FEEDBACK

There were no items.

122/24 - MATTERS FOR ESCALATION TO THE TRUST BOARD

- Committee Terms of Reference reviewed and approved with minor changes
- Cancer Delivery Group report received, challenges with Leeds and potential impact on our patients
- Annual reports received from Safeguarding, Patient Experience, Complaints and the Quality Committee
- Quality Report
- Maternity and Neonates Report
- Sign-off of the Quality Account

123/24 - QUALITY COMMITTEE ANNUAL WORK PLAN

A copy of the above was available at appendix U for information, with additions from the Children and Young People's Board twice a year.

124/24 – QUALITY COMMITTEE TERMS OF REFERENCE

A copy of the final revised terms of reference were available at appendix V.

POST MEETING REVIEW

125/24 - REVIEW OF MEETING

JH commented on the structure of the meeting and the timescales for presenters. There have been prior discussions with presenters on how to use the time effectively, however, further work will be done on this. It was also suggested that the order of the agenda items are rotated to ensure that certain reports are given more attention. **LR** also stated that the minutes and papers of this Committee also need to be circulated in a timely manner, and asked that colleagues submit papers on the stated deadlines. Papers will not be accepted after the deadline, unless there is an exception, which has been agreed with **DS**, **LR** or **DB**.

NEXT MEETING

Tuesday, 2 July 2024
9:30 – 12:00 noon
Microsoft Teams

ACTION LOG FOR QUALITY COMMITTEE

Position as at: Monday, 3 June 2024

Red	Amber	Green	Blue
Overdue	Due	Closed	Going Forward

DATE DISCUSSED	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
08.05.24	**85/24 – DIVISIONAL REPORTING – MEDICINE - Q4 REPORT**	David Britton	**LR** asked if there were any definitive timescales as to when those outstanding Policies would be updated. **DBr** was not aware of the timescales for each of the Policies, however, this will be followed up outside of the meeting and updated at the next meeting. **ACTION:** An update on timescales for Policies to be brought to the next meeting. • **Sepsis** - with Lindsay and David B for review **Update**: Sepsis Policy now approved. • **Nutrition and Hydration** - plan for the draft to go to the June N&H group • **Implantable Cardioverter Defibrillator** - await update • **Oral hygiene Care** - SALT reviewing, await further update. **ACTION**: **MA** to follow-up on progress with other policies. **Update June:** Resuscitation – Under review. Due for ratification in August. No further update received for Nutrition, ICD or Oral Hygiene Care Policies.	Tuesday, 2 July 2024		
08.05.24	**92/24 – BOARD ASSURANCE FRAMEWORK RISK 4/20: CQC**	Lindsay Rudge	**ACTION**: Correct version of BAF risk to be re-circulated. **Update:** This will be circulated after the Audit and Risk Committee meeting on 23 July 2024	Tuesday, 3 September 2024		
08.04.24	**NASOGASTRIC TUBE UPDATE**	Joanne Middleton	**ACTION – 8 Apr 2024:** Following last month's verbal update, a report will return next month with results of the planned re-audit and assurance that all actions have been closed. **UPDATE - See item 81/24 of May's agenda** **ACTION:** Further updates to be brought to the Committee on a quarterly basis	Tuesday, 3 September 2024		
08.05.24	**82/24 – TERMS OF REFERENCE**	All	The Quality Committee agreed to approve the terms of reference once amendments made. **ACTION**: Changes to be made to the terms of reference. **Update**: See agenda item 124/24	Monday, 3 June 2024		CLOSED 3 June 2024
08.05.24	**93/24 – COMMITTEE ACTION PLAN AND PROGRESS**	Lindsay Rudge / Elizabeth Morley	**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. **Update**: See agenda item 105/24	Monday, 3 June 2024		CLOSED 3 June 2024

QUALITY COMMITTEE
Tuesday, 2 July 2024

STANDING ITEMS

126/24 – 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 **(DBi)**	Medical Director
Gina Choy **(GC)**	Public Elected Governor
Jennifer Clark **(JC)**	Associate Director of Therapies
Sharon Cundy **(SC)**	Head of Quality and Safety
Jonathan Hammond **(JH)**	Chief Operating Officer
Joanne Middleton **(JMidd)**	Deputy Chief Nurse
Elizabeth Morley **(EM)**	Associate Director of Quality and Safety
Vanessa Perrott **(VPe)**	Non-Executive Director
Victoria Pickles **(VPi)**	Director of Corporate Affairs
Gemma Puckett **(GP)**	Director of Midwifery and Women's Services
Elisabeth Street **(ES)**	Clinical Director of Pharmacy
Jo-Anne Wass **(JW)**	Non-Executive Director
Michelle Augustine **(MA)**	Governance Administrator **(Minutes)**

In Attendance

Lisa McCallion **(LMcC)**	Specialist Nurse – Blood Transfusion **(item 129/24)**
Anu Rajgopal **(AR)**	Clinical Director – Pathology / Chair of HTC **(item 129/24)**
Sarah Wilson **(SW)**	Interim Head Nurse – Community Division **(observing)**

Apologies

Lucy Dryden **(LD)**	Quality Manager for Calderdale Cares Partnership Board
Jason Eddleston **(JE)**	Deputy Director of Workforce & Organisational Development
Lindsay Rudge **(LR)**	Chief Nurse
Lorraine Wolfenden **(LW)**	Governor

A copy of the attendance register was circulated at appendix A.

127/24 - DECLARATIONS OF INTEREST

There were no declarations of interest.

128/24 – MINUTES OF THE LAST MEETING AND ACTION LOG

The minutes of the last meeting held on Monday, 3 June 2024, circulated at appendix B, were approved as a correct record. The action log can be found at the end of these minutes.

SUB-GROUP REPORTS

129/24 – HOSPITAL TRANSFUSION COMMITTEE REPORT

Anu Rajgopal presented the report as circulated at appendix C, providing assurance on progress with the transfusion service, challenges, safety improvements, and support required for the management of Serious Hazards of Transfusion (SHOT) incidents to be closed in a timely manner, in line with recommendations with the Medicines and Healthcare products Regulatory Agency (MHRA). **JMidd** stated that Patient Safety Incident Response Framework (PSIRF) offers the opportunity to provide bespoke work needed, and will address this. **SC** also offered to liaise with the Risk team regarding any outstanding incidents.

OUTCOME: The Committee noted the update.

130/24 – RESEARCH AND DEVELOPMENT COMMITTEE REPORT

Neeraj Bhasin presented the above report as circulated at appendix D, highlighting key points.

The Research and Development (R&D) team continue to perform well against benchmarking key performance indicators (KPIs), have built good external partnerships and hosted a research event, with members of the team being invited to share learning across a number of different fora. There have been ongoing challenges with the structure being an interim arrangement for the last two years, and issues with research delivery capacity, where studies were paused, and due to limited capacity in the governance team, some commercial studies were declined. Following a successful paper to the business case approval group, there is now agreement to restructure the R&D team to a non-interim arrangement and expand the governance team. There is also the option for some research delivery nurses to convert from fixed term contracts to a substantive role. A joint bid with Bradford and Mid-Yorks will be submitted to become a commercial research delivery centre / network.

This is the last Quality Committee as R&D director for **NBha**, who thanked Tracy Wood (Research and Development Lead), Lesley Thomis (Research Manager) and the team, who have helped him in the role. **DS** asked about whether anyone would be taking up the role of R&D director. **NBha** responded that there will be a new appointment to the R&D director, Caldicott Guardian and other roles within the Deputy Medical Director for Workforce in November 2024.

DS commented on the successful funding in order for changes to be made to the team and asked what other opportunities and benefits will be available if the joint bid is successful. **NBha** stated that it should bring in more commercial research and greatly increase the commercial income. A discussion will be required to agree how much of the income generated is retained within R&D to further expand.

DS also commented on the number of individuals from minority backgrounds who are participating in research, and asked what capacity or resources are available to continue to promote and get across the importance for people from minority backgrounds to be more involved in research projects. **NBha** stated that CHFT are part of the Ethnic Minority Research Inclusion (EMRI) Group, and have some patient research champions, which moving forward, should be of an ethnic minority background. The R&D team have been to the CHFT Race Equality Network to promote research and dispel myths.

JAW asked whether the approval of the business case would help clear the backlog. **NBha** stated that the governance structure will need to be sorted to enable the safety within the studies and the business case does approve an expansion in the governance of the research team..

JAW also commented on the bid with Bradford and Mid-Yorks and asked how the split would work, and whether any income generated would be kept. **NBha** stated that through the income

distribution policy, CHFT would retain some of the income generated. If successful, this could be between £100 and £150,000 per year to be used in specific ways.

On behalf of the Quality Committee, **DS** congratulated **NBha** on an amazing job steering Research and Development.

OUTCOME: The Committee noted the update.

131/24 – MEDICAL GAS AND NON-INVASIVE VENTILATION GROUP (NIV) REPORT

Elisabeth Street presented the report, circulated at appendix E, which provided an overview of the achievements from the Medical Gas and Non-invasive Ventilation (NIV) group, and was taken as read.

In relation to oxygen storage, **JH** asked whether **ES** was aware of the plan to move into the Integrated Flow Hub and the opportunity to improve storage. **ES** stated that Pharmacists have visited the hub, and would confirm with them that they are clear on what is needed.

JAW asked about the training compliance figures and the plans to get compliance back on track. **ES** stated that there has been a review of the oxygen training, and will compile an action plan to present with the next report, following a check with divisions.

JMidd provided assurance on the Acute Respiratory Care Unit (ARCU) workforce model, with work ongoing in the medical division. Extra capacity is also being run from Ward 5 and clarity is needed on the nurse ratios.

JMidd also asked about the membership of the Medical Gas and NIV Group, and asked whether the Chair had the correct support from front-end representatives, which **ES** agreed to check. **SW** suggested provided a suggestion of who could attend from the Community division.

DS asked about the NIV audit action plan and CHFT being an outlier regarding escalation to critical care. **ES** agreed to take this action away and update in the next report.

The terms of reference for the Medical Gas and NIV Group were approved by the Committee.

OUTCOME: The Committee noted the update and approved the terms of reference for the Medical Gas and Non-Invasive Ventilation Group.

RESPONSIVE

132/24 - INTEGRATED PERFORMANCE REPORT (IPR)

Jonathan Hammond and David Birkenhead presented the report, as circulated at appendix F.

DB mentioned concerns with Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR) which both increased over the last six to 12 months, and expected to continue to rise. This has been made difficult by the change in patient admission data due to the Same Day Emergency Care (SDEC), which will push both SHMI and HSMR into an outlier position. Any quality issues are being reviewed in relation to those metrics.

Complaints performance has dropped, and stroke remains a challenge in relation to therapy services and direct access to the stroke unit for acute admissions. The infection prevention and control metrics have been good, however, there is still concern around Clostridium difficile and undertaking a deep clean at CRH, which will hopefully have some impact, moving into winter, on HPV usage to reduce spore burden.

JH reported on elective recovery, which is performing well. There are currently some over 52-week waits, the vast majority being in ENT. There is a clear programme of work, with an aim to clear the over 52-week waits by the autumn and maintain that position. A number of specialities made good progress with the 40-week waits, with some challenge in cardiology and gastroenterology, and specific action plan work being done with teams. In relation to diagnostics, there are ongoing action plans in place for echocardiography and neurophysiology, which are now at 94% overall with the target for this year. In relation to elective recovery, there is a focus on day case rates and capped theatre utilisation, linked to the getting it right first time programme. In April, the day case rates were very high against the 85% target, and capped theatre utilisation was close to the 85% target. Cancer is above the target of 77% for 28-day diagnosis, and continue to perform well against 31 and 62-day targets.

The biggest challenge at the moment is acute demands. Over April, May and into June, there was an increase in attendances to the Emergency Department (ED) compared to the period last year. There is pressure on the volumes of patients waiting over 4 hours, and still perform well with no decision to admit breaches over 12 hours, in comparison to peers, both regionally and nationally. There is an impact in relation to the change in how data is measured around Same Day Emergency Care (SDEC), and further analysis is being done. This has impacted on the admitted 4-hour performance. Ambulance arrivals saw an increase in delays over 30 minutes, however, still below the average wait target of 23 and a half minutes. There are escalation processes in place to ensure ambulances are not delayed. In relation to virtual ward, occupancy has improved.

JAW asked about the Summary Hospital-level Mortality Indicator (SHMI) and the Same Day Emergency Care (SDEC) data. **DB** clarified that the rise to date is not as a result of the SDEC, and predates changes to the statistics, which will feed through over the next six months . It will push the Trust into an outlier position; however, this is separated from any quality aspects that may arise. The reason for the difficulties is that CHFT and one other organisation are reporting in accordance with the new guideline. Patients admitted to an SDEC are no longer considered admitted, therefore, they do not form part of the baseline use for the calculation of SHMI. As a result of that, there are fewer patients leaving hospital well, and more deaths than expected in the population, due to a larger proportion of those well patients, who were previously admitted, are no longer considered in the baseline statistics.

DB reported that one of the contributors to the increase in SHMI is in relation to excess deaths in respiratory medicine. A deep dive has taken place, which resulted in challenges with coding, which were not capturing comorbidities and correct primary diagnosis. It has been requested that those patients are re-coded to see whether it brings the marker down. Whenever there is an alert in relation to an outlying condition from either SHMI or HSMR, a deep dive is carried out if the alert exists for more than one month, and generally, there are no quality of care issues.

VPe asked about the quality of responses to complaints. **DB** stated that a continuing focus is required with complaints. The quality of the complaint responses is good; however, the timeliness of responses has decreased over the last few months, therefore, discussions will continue with divisional colleagues to ensure responses are produced in a timely manner and what support is required. Other challenges include varying pressures on colleagues in relation to performance, finance and day-to-day operational delivery of care. **VP** mentioned the annual complaints report at the next Board meeting sets out this year's focus as well as maintaining the levels of response times.

VPe also asked about the national escalation of Emergency Department (ED) performance and whether we are looking into and auditing the seven day service areas, particularly focusing on quality and patient experience. **JH** responded that an update will be taken to the Board meeting next week, providing an overview of the position in relation to expectations. There is a plan to address the various elements, recognising that the gradual increase in demand is a challenge, and there are plans around expansion for the seven day services. The SDECs are being piloted with extended hours on key targeted days through the week and looking at extending overnight

in order to reduce the pressure on the Emergency Department (ED). Consultant cover has been extended until midnight, and currently working up a case to extending overnight consultant cover. There are robust escalation processes and support for the EDs when they are under pressure.

JAW asked when improvements in the stroke target were due. **JH** reported being in a period of increased demand and have expanded the bed base in order to create more acute bed capacity, however, there are also challenges with discharges back into the Community. The timeframes are unable to be predicted, however, further deep dives can be carried out and reported through the Finance and Performance (F&P) Committee.

DS asked about the impact on patient outcomes and overall stroke care. **JH** responded that in terms of quality outcomes, the Sentinel Stroke National Audit Programme (SSNAP) data provides an overview of what would impact quality, and a number of those areas are performing well, which would impact on stroke outcomes.

OUTCOME: **DB** and **JH** were thanked for the update, and the Committee noted the report.

133/24 – PAEDIATRIC AUDIOLOGY ASSURANCE REPORT

Victoria Pickles presented the above report, as circulated at appendix G.

A task and finish group meets every fortnight to discuss, and the Committee were assured of the work carried out, and areas which still require work, are ongoing.

OUTCOME: The Committee noted the report.

134/24 – CQC CLOSURE STATEMENTS FOR MUST AND SHOULD DO ACTIONS AUDIOLOGY ASSURANCE REPORT

Victoria Pickles presented the above report, as circulated at appendix H.

OUTCOME: The Committee agreed to close the actions.

135/24 – QUALITY COMMITTEE EFFECTIVENESS ACTION PLAN
136/24 – QUALITY COMMITTEE 2024/2025 OBJECTIVES

The Chair thanked the Committee for completing the committee's effectiveness. In response to the committee's effectiveness feedback, an action plan was circulated at appendix I, and in support of the actions, objectives for the Committee were also set and circulated at appendix J.

SAFE

137/24 – MATERNITY AND NEONATAL REPORT

Gemma Puckett presented the report as circulated at appendix K, which was taken as read, and the key points to note were highlighted.

In terms of the lived experience, **VPe** asked how it is ensured that experiences from minority patients are represented. **GP** stated that a patient of mixed race ethnicity previously presented at the Board. It was also noted that the maternity voices partnership (MVP) source the stories and speak to women and can be difficult to access and hear the voices of women who are under-represented in that forum, therefore, links are made with other organisations, and looking at different ways to bring feedback, such as via video, and also on different topics.

VPe also asked about work with primary care partners to try to ensure there are early bookings. **GP** commented on working with local maternity system on a 'speak to a midwife' campaign which has been circulated across the whole Local Maternity and Neonatal System (LMNS); meeting

with some of the primary care GP forums and colleagues around maternity care and targeted work on the booking, and as part of that, hearing feedback and understanding why women do not book early.

In relation to stillbirths, a review took place with the Local Maternity and Neonatal System (LMNS), with some areas still to work on, including the implementation of Viewpoint - software which automatically plots growth of scans, which will impact on the growth charts currently used. This is being built into the implementation project to change the charts and train colleagues. Work is also ongoing with the Local Maternity and Neonatal System (LMNS) regarding a working group to look at a small for gestational age clinical pathways to build into a standardised guideline. In relation to the monitoring of stillbirths, it was noted that alongside the completion of a post-partum haemorrhage (PPH) review, which will be presented at the Patient Safety Incident Response Framework (PSIRF) Board, the terms of reference of the Quality and Safety learning forum will be finalised to include discussion of themes from stillbirths.

JAW stated that it would be useful to have an update at the Board on the breakdown of the workforce, to see whether it compares to the women being served, and to also have a deep dive into the workforce recruitment and retention plan. **GP** responded that the recruitment and retention strategy for maternity is due to be reviewed.

OUTCOME: The Committee noted the report.

138/24 – ACUTE KIDNEY INJURY (AKI) DEEP DIVE REPORT

Nikhil Bhuskute presented the report as circulated at appendix L.

The key summary points from the last 12 months, assessment and investigation compliance, and the further implications of non-compliance were highlighted. Actions include the clear importance of capturing hydration assessment as a primary nursing assessment; focus on fluid balance with a clear responsibility at ward level on who responsible for this being carried out; awareness and training on urine dipsticks and establishing clear role responsibilities; Acute Response Team (ART) alerts for acute kidney injuries; clear key performance indicators (KPIs) for each quarter, which will be monitored through the divisional Patient Safety and Quality Board (PSQB) meetings and the AKI collaborative; and education and training in all areas now reviewed.

VPe asked if there was a proportion of AKIs due to primary care and how many are happening in hospital, and what is being done to work with primary care partners. **NBhu** responded that data is available on who is admitted with a recognised AKI, which the AKI collaborative monitor. **NBhu** agreed to explore work with primary care.

In terms of monitoring whether length of stay will decrease, **DS** asked where this will take place. **NBhu** stated that the Care of the Acutely Ill Patient (CAIP) Programme will monitor this as part of the outcome measure. Every quarter, overall monitoring will take place to ensure that the achievable targets are being met.

OUTCOME: The Committee noted the report.

139/24 – QUALITY ASSURANCE DEEP DIVE REPORT

Jo Middleton presented the update as circulated at appendix M.

The reality, response and result of the quality assurance (formerly ward assurance) were highlighted.

VPe commented on transition of care, handovers and safety huddles, and asked what these look like, and whether they were a standardised model. **JMidd** stated that a working group are producing a standard, which is due to be launched shortly.

OUTCOME: The Committee noted the report.

ITEMS TO RECEIVE AND NOTE

140/24 – MINUTES FROM:

Clinical Outcomes Group

A copy of the minutes from Wednesday, 15 May 2024 were circulated at appendix N for information.

Infection Control Performance Board

A copy of the minutes from Tuesday, 28 May 2024 were circulated at appendix O for information.

Kirklees Quality Board

A copy of the minutes from Wednesday, 24 April 2024 were circulated at appendix P for information.

Calderdale Quality Board

A copy of the minutes from Wednesday, 6 March 2024 were circulated at appendix Q for information.

OUTCOME: The Committee noted the minutes.

141/24 - ANY OTHER BUSINESS

There were no other items of business.

142/24 - BOARD TO WARD FEEDBACK

There were no items.

143/24 - MATTERS FOR ESCALATION TO THE TRUST BOARD

- Update on sub-group reports received – Transfusion, Research and Medical Gases.
- Position on paediatric audiology assurance received
- CQC closure statements received
- Maternity and Neonates Report received
- AKI and Quality Assurance deep dive received

144/24 - QUALITY COMMITTEE ANNUAL WORK PLAN

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

POST MEETING REVIEW

145/24 - REVIEW OF MEETING

- Meting being held in the morning has been beneficial
- Good challenge and discussion of reports

- Clarity provided that reports have been read, to allow for wider debate.
- Colleagues being candid about not knowing answers to questions posed.

NEXT MEETING

Tuesday, 3 September 2024
9:30 – 12:00 noon
Microsoft Teams

MINUTEES APPROVED AT Quality Committee on 03.09.24

ACTION LOG FOR QUALITY COMMITTEE

Position as at: Tuesday, 2 July 2024

Red	Amber	Green	Blue
Overdue	Due	Closed	Going Forward

DATE DISCUSSED	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
08.05.24	**85/24 – DIVISIONAL REPORTING – MEDICINE - Q4 REPORT**	David Britton	**LR** asked if there were any definitive timescales as to when those outstanding Policies would be updated. **DBr** was not aware of the timescales for each of the Policies, however, this will be followed up outside of the meeting and updated at the next meeting. **ACTION:** An update on timescales for Policies to be brought to the next meeting. – **Sepsis** - with Lindsay and David B for review – **Update**: Sepsis Policy now approved. – **Nutrition and Hydration** - plan for the draft to go to the June N&H group – **Implantable Cardioverter Defibrillator** - await update – **Oral hygiene Care** - SALT reviewing, await further update. **ACTION**: **MA** to follow-up on progress with other policies. **Update June:** Resuscitation – Under review. Due for ratification in August. No further update received for Nutrition, ICD or Oral Hygiene Care Policies. **Update July:** • The Review of the Oral Hygiene policy has now been completed and will be shared for comments. • The Nutrition and Hydration policy is currently being reviewed and updated.	Tuesday, 3 September 2024		
08.05.24	**92/24 – BOARD ASSURANCE FRAMEWORK RISK 4/20: CQC**	Lindsay Rudge	**ACTION**: Correct version of BAF risk to be re-circulated. **Update:** This will be circulated after the Audit and Risk Committee meeting on 23 July 2024	Tuesday, 3 September 2024		See item 159/24
08.04.24	**NASOGASTRIC TUBE UPDATE**	Joanne Middleton	**ACTION – 8 Apr 2024:** Following last month's verbal update, a report will return next month with results of the planned re-audit and assurance that all actions have been closed. **UPDATE - See item 81/24 of May's agenda** **ACTION:** Further updates to be brought to the Committee on a quarterly basis	Tuesday, 15 October 2024		
08.05.24	**82/24 – TERMS OF REFERENCE**	All	The Quality Committee agreed to approve the terms of reference once amendments made. **ACTION**: Changes to be made to the terms of reference. **Update**: See agenda item 124/24	Monday, 3 June 2024		CLOSED 3 June 2024
08.05.24	**93/24 – COMMITTEE ACTION PLAN AND PROGRESS**	Lindsay Rudge / Elizabeth Morley	**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. **Update**: See agenda item 105/24	Monday, 3 June 2024		CLOSED 3 June 2024

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

Minutes of the WORKFORCE COMMITTEE: EQUALITY, DIVERSITY AND INCLUSION

Held on Monday 12 June 2024, 2.00pm – 4.30pm
VIA TEAMS

PRESENT:

David Birkenhead	(DB)	Medical Director
Suzanne Dunkley	(SD)	Director of Workforce and OD
Lindsay Rudge	(LR)	Chief Nurse
Denise Sterling	(DS)	Non-Executive Director
Jo-Anne Wass	(JW)	Non-Executive Director (Chair)
Peter Wilkinson	(PW)	Non-Executive Director

IN ATTENDANCE:

Mark Bushby	(MB)	Workforce Business Intelligence Manager (for items 27/24)
Jason Eddleston	(JE)	Deputy Director of Workforce and Organisational Development
Vicky Pickles	(VP)	Director of Corporate Affairs (on behalf of the Company Secretary)
Lis Street	(LS)	Clinical Director, Pharmacy
Kate Wileman	(KW)	Governor

PRESENTERS:

Emma Mooney	(EM)	Clinical Operations Managers for Transformation and
Amy Shedden	(AS)	Modernisation (for item 41/24)
Azizen Khan	(AK)	Assistant Director of Workforce and OD (for item 43/24)
Rachel Rae	(RR)	Associate Director of Nursing, S&A (for item45/24)
Gemma Puckett	(GP)	Assistant Director of Nursing, FSS (for item 45/24)
Andrea Dauris	(AD)	Associate Director of Nursing (Corporate) (for item 47/24)
Carol Gregson	(CG)	Freedom to Speak Up Guardian (for item 50/24)

MEETING ADMINISTRATION

38/24 INTRODUCTIONS AND APOLOGIES

Apologies received from Andrea McCourt, Company Secretary

39/24 DECLARATION OF INTERESTS

There were no declarations of interest.

40/24 MINUTES AND ACTION LOG FROM LAST MEETING

The minutes of the Workforce Committee held on 15 April 2024 were approved as a correct record.

BOARD TO WARD – COLLEAGUE/PATIENT STORY

41/24 Colleague Story – Theatre Improvement

EM and AS began by explaining how the impact of the pandemic had hugely affected elective theatre activity and also staffing levels. To redress the position the first step was to restructure roles that explicitly lead on productivity and utilisation. Specialty Theatre User Groups (STUGs) were established to deep dive into a range of metrics. The STUGs took a while to embed however over the year have evolved and are hugely successful in driving utilisation. The team have been working alongside NHS England to share their good practice with other trusts. Increased flexibility to further empower colleagues in their career development is supporting retention. Key for improvements is communication, MDT involvement and ownership and relevant data to support decisions.

DS congratulated EM and AS on the fantastic work. DS asked about the ambition to achieve and maintain pre-pandemic capacity. AS responded progress is definitely on track to hit the target for 2024/2025. Setting some small goals to achieve the bigger targets has seen great success. The improved staffing position and taking advantage of extra capacity and prioritising specialities has supported a reduction in theatre backlog.

SD recognised one culture of care and the four pillars is evident throughout the process and asked what one thing epitomised the transformation. EM responded attendance at meetings becoming business as usual and engagement from colleagues who initially pushed back. AM added that being asked to present to other trusts was remarkable.

PW asked if there are any areas that still need some focus. EM shared some examples of pinch points and explained the responses to manage these. She commented on the support from Tom Strickland, the Director of Operations for Surgery and Anaesthetics.

JW thanked EM and AS for their preparation for the meeting and noted the impressive work.

OUTCOME: The Committee **NOTED** the improvement in theatres.

MEETING FOCUS: PEOPLE STRATEGY PROGRESS ENGAGEMENT

42/24 **WORKFORCE REPORT**

MB presented the report highlighting the key points:-

Areas of strong performance

- Continued high retention performance with further reducing turnover rates and a strong vacancy position
- Ongoing overall high EST and improving RST compliance
- Low sickness absence rates versus local peer Trusts

Hot spot areas for improvement

- Bank and agency usage/spend remains high
- Safeguarding Children and Adults EST compliance rates below 90% for several months
- High absence rates within the Clinical Support and Estates/Ancillary staff groups

DS highlighted the Quality Committee in its review of the Safeguarding report discussed Safeguarding EST compliance and agreed that as part of the quarterly Divisional attendance to update on quality issues this training compliance will also be monitored. LR provided some context in that the training had been re-set in response to a change in statutory intercollegiate documents. The drop in compliance is expected and will be explained in the Safeguarding Annual Report.

DS noted the continued high absence rates in clinical support and ancillary staffing groups and asked if a different approach is being considered to address any issues. SD gave examples of issues impacting these colleagues. Solutions at Divisional and Trustwide level are being sought.

LR asked that the Committee note that overall the Trust is under target for agency spend. Whilst there is high usage in some areas we are under the Trust target of £2.6m. The Bank and Agency Group continue strong focus on the high usage areas.

JE referred to an earlier comment regarding the challenge on training – in both compliance and delivery. The Committee noted the Education Committee has commissioned a task and finish group to review all RST modules. Recommendations will be submitted to the Education Committee.

PW commented on the excellent quality of the report. In terms of workforce health inequalities, PW is pleased to see workforce ED&I moving in the right direction.

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

43/24 **VACANCY REPORT**

AK presented a new format of the vacancy report which has moved away from a data led paper and looks at the ‘so what’ position, particularly hot spots and areas of success. The report is a qualitative approach to describing our vacancy solutions. The proposal is to bring divisional colleagues into the conversation to talk about their specific actions in relation to hot spot areas and the so what question. SD added the report highlights pockets for focus. JW liked the format of the report and suggested this could be adopted for deep dives into hot spot elements of the main workforce report.

KW noted the high number of Pathology staff leaving the service and from a governor and patient point of view she asked if this is impacting patients. AK responded the close partnership working with other trusts means impact on patients is minimal.

OUTCOME: The Committee **NOTED** the report and **SUPPORTED** its new format.

44/24 **TRUST WIDE ENGAGEMENT STRATEGY**

JE presented a high level snapshot of the Strategy that describes the Trust-wide approach to colleague engagement. Engagement underpins the six chapters of the People Strategy and endorses one culture of care. The Committee noted the 2023 staff survey overall engagement score of 7, up from 6.8 in 2022. This is the highest score since 2016. A One Culture of Care event calendar has been developed in conversation with the Equality Group Networks. CHuFT awards has been rescheduled to summer 2025 and will be a celebration of the summer of sport. One of the staff survey high impact actions is to skill up leaders and managers in effective colleague engagement and the Committee noted the Management Fundamentals programme is a vehicle for the leadership framework.

DS suggested building on the Trust banners that tells us the different countries our colleagues are from. DS is keen to continue to develop allies for all our networks and asked if toolkits can be adapted for the networks. The Inclusion Group is focussed to ensure our equality groups are supported. SD commented the summer of sport is a celebration of inclusion and diversity.

OUTCOME: The Committee **NOTED** the Engagement Strategy.

45/24 **DIVISIONAL ENGAGEMENT PROGRESS UPDATES**

Surgery and Anaesthetics
RR provided an overview of the Division's high impact action plans. She explained a month-by-month approach had been undertaken and actions remain on track. A deep dive in elective orthopaedics was undertaken and responses developed. Early results are very positive and have started to embed.

Families and Specialist Services
GP explained the diversity of the division and the work to cross fertilise what is working well across the directorates. An overview of responses to staff survey hotspots particularly in Pathology, Outpatients and Radiology was shared. GP rounded up with the 'mood' of the workforce.

JW explained the two-way process where the Committee seeks assurance of progress and also provides opportunity for divisions to identify where there is need for support.

SD asked if we shared enough about how challenging the operational position is for colleagues and if we could link together better on how we are adopting and adapting activity to respond to the challenges. JW agreed and asked how to facilitate that sharing. JE recognised the targeted work by both divisions. He supports the S&A idea of bringing in equality network group members into the conversations, it reinforces building allies and could be something to advocate across services. JE asked how the FSS Wellbeing Board is progressing. GP responded the challenges in the working day have had an effect however colleagues are engaged and want to champion wellbeing. The Wellbeing Board will be re-visited to invigorate.

JW suggested developing a practical way to share good ideas. LR stated there is a commitment to distil the good practice identified at PRMs and share across all divisions.

ACTION: Explore ways to collate and share good ideas.

OUTCOME: The Committee **NOTED** the Divisions' progress.

46/24 **FOCUS ON EQUALITY, DIVERSITY AND INCLUSION/HEALTH INEQUALITIES**

JE provided an overview of the equality network groups. Four of the network groups are sponsored by a Director. He highlighted initiatives to support colleague wellbeing which included wellbeing networks, cost of living support and wellbeing support offers. A Health Inequalities plan on a page has been developed. The work is led by Rob Aitchison, Deputy Director and incorporates one element that specifically focuses on a diverse and inclusive workforce. The four primary initiatives are Shadow Board, Education Awareness Resources, Widening Participation and Quality Network Group Engagement. Progress is being made in each of these areas.

SD noted the concentrated work with BAME colleagues, which now needs to be replicated with colleagues with a disability, and more work on sexual orientation is needed. The story we need to tell better is 'can you be **you** at CHFT comfortably?'. JE believes we have a great story to tell. The Widening Participation work is realising a great dividend. JW and PW recognised the conversations in the meeting have strong links to the health inequalities work and suggested that we aren't quite joining up the narrative on all these issues.

ACTION: The Committee to identify a time to undertake a deep dive into ED&I data.

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

STATUTORY REPORTS REQUIRING APPROVAL

47/24 **NURSING AND MIDWIFERY WORKFORCE**

Nursing and Midwifery Safer Staffing Report

AD presented the highlights of the report for the period April 2023 to March 2024.

- Overall, Nursing and Midwifery vacancies at CHFT remain aligned with the national position. CHFT's band 5 nursing workforce remains one of our largest safety-critical resources.
- Since the last report operational pressures continue with multiple areas working above their baseline 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.
- 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.
- CHFT are in receipt of the recently commissioned Birthrate+ report. 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.
- Achievement of the Quality Mark against the national preceptorship framework
- The Chief Nurse has confirmed she is satisfied that staffing is safe, effective, and sustainable.

SD recognised the extra activity is impacting on the nursing workforce. SD asked what impact industrial action has had on the nursing workforce, given the action is being taken by medical colleagues. LR responded positively in terms of advance in practice for advanced clinical practitioners and also feedback from ward managers that clear decision making had good outcomes on patient and colleague experience.

DS noted the pause on the NHSE HCSW programme. AD explained this is due to parity of pay concerns. DS asked if the over recruiting of AHPs is to continue. LR confirmed the infrastructure is stabilised.

OUTCOME: The Committee **NOTED** and **APPROVED** the report

Nursing Workforce Programme Report

AD presented the key highlights:-

- A robust methodology is used to establish workforce requirements.
- Business Intelligence data is used to inform recruitment strategies.
- There has been a significant reduction in band 5 nursing vacancies.
- Model Hospital Data indicates nursing cost per WAU continues to be in quartile 2.
- International Recruitment programme completed to target and now paused.
- Ongoing Recruitment to Apprentice Trainee Nursing Associate programme.
- Ongoing Recruitment to Apprentice Registered Nurse Degree programme.
- The Clinical Placement Expansion Project (CPEP) for students continues.
- E-Rostering continues to be used to maximise effectiveness of the workforce.
- Retention Strategies have been initiated in bundles, focussing on early, mid and late career retention.

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

BAF Deep Dive 10b/19 Nursing Staffing

AD presented the key headlines:-

- BAF updates.
- The current reality of staffing shortages and availability.
- Despite relevant controls and assurances, the reality remains that nurse staffing continues to present a challenge.
- A high proportion of new graduate nurses, combined with an ambitious recruitment programme aimed at internationally educated nurses, requires a focus upon responding to the learning needs of this junior workforce.

OUTCOME: The Committee **NOTED** the deep dive.

48/24 **MEDICAL WORKFORCE PROGRAMME UPDATE**

DB presented the highlights of the report:-

- Industrial action - recurrent periods of industrial action impacting on workforce, clinical capacity, and non-clinical capacity. Pay offer to consultants has been accepted. SAS doctors have received an offer that they will vote upon, the outcome is anticipated in mid-June. Talks between doctors in training and the Government have broken down - further strike action confirmed for 27 June to 2 July 2024
- Continued engagement with the PA workforce. A PA Governance Framework is being developed by the Deputy Medical Director, Workforce and Operations
- Within the eRoster/eJob Planning team a paper has been successfully presented to BCAG to create future resource within the team. There have been some issues with the software provider, and this has combined with the capacity issues to limit our NHS Attainment Levels.
- CHFT is leading on Non-Surgical Oncology (NSO) Services work through WYAAT, to support Mid Yorks. Conversely, support is coming in to CHFT to support fragile services like Neurology.

Regarding the NSO work, LS commented on the real opportunities for skilling up the non-clinical workforce to step into enhanced roles to support gaps in some of the specialist roles. The financial resource to support this was noted. DB agreed there is high value in looking at different workforce models in delivering patient care.

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

49/24 **CHFT WORKFORCE PLANNING 2024/2025**

MB presented the Trust's final submission for 2024/2025.

OUTCOME: The Committee **NOTED** the volume of activity and was **ASSURED** a robust process had been undertaken.

50/24 **FREEDOM TO SPEAK UP (FTSU) ANNUAL REPORT**

CG presented the report that outlined FTSU activity in the Trust from 1 April 2023 to 31 March 2024. The key highlights were:-

- From 1 July there will be two FTSU Guardians, each working 0.5 WTE .
- 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.
- 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.

VP also highlighted a reluctance to speak up amongst our international recruits.

SD recognised both CG and VP are new to the FTSU roles and asked if anything had taken CG by surprise. CG responded both number and complexities of the concerns. CG is keen to invest to support colleagues.

DS was pleased to hear there is focus to increase the number of ambassadors and recognised the ongoing challenge to release colleagues to support the work. She asked if there was any more support needed to address this. DS also noted the need to encourage colleagues from diverse backgrounds to speak up adding that we must be mindful that often due to past experience there is a lack of trust and confidence. CG advised she is to attend the REN and Disability Network Group. In terms of ambassadors, a survey has already been undertaken. The survey encouraged colleagues to be open and honest in their responses. Re-engagement with managers to address ambassador availability is in motion.

JE reflected on two themes that came out of discussions at Board of Directors towards the end of last year. The testing of colleague's experience of using the process from start to finish needed more work and the sustainability of solutions to concerns. CG confirmed consideration is being given to these areas using the reflection planning tool. In terms of international recruits LR is keen to build on the research undertaken by Huddersfield University by including insights from a FTSU point of view.

KW enquired how the source of difficult issues is handled. CG responded implementation of a governance structure that links with senior management teams has received good feedback. VP added there is often a link between FTSU concerns and staff survey feedback which is usually about the culture in an area. The biggest impact is felt when division or a team respond to the issues.

With reference to the National Guardian's Office FTSU e-learning package, JW asked about the process for mandatory training and noted that the Education Committee oversees learning and development activity. SD commented on the extensive EST modules already undertaken by colleagues.

ACTION: Education Committee to consider whether FTSU training should be added to the EST portfolio.

OUTCOME: The Committee **NOTED** the FTSU Annual Report. The report will be submitted to the July 2024 Board of Directors.

51/24 **WRES AND WDES 2023/2024 DATA PUBLICATION**

MB presented the Trust's 2023/2024 WRES and WDES reporting data and analysis prior to publication by 31 October 2024.

WRES

Strengths:

- Trust Composition – an increasingly diverse workforce that mirrors our local demographics.
- Equal opportunity of appointment from shortlisting.

- Improving position for Bullying & Harassment from the public.

Areas for improvement:
- Bullying and harassment from colleagues.
- Career progression gap between BAME and white colleagues.
- Likelihood of BAME colleagues entering the disciplinary process.

WDES

Strengths:
- Narrowing of the gap between disabled and non-disabled colleagues career progression.
- Board disability representation.
- Likelihood of disabled colleagues being appointed from shortlisting.

Areas for improvement:
- A widening gap for feeling valued.
- Worsening bullying and harassment position.
- More work to do to reduce the feeling of being pressured to come to work when unwell.

A formal action plan will be developed for approval by the Committee in August 2024 prior to publication by 31 October 2024.

OUTCOME: the Committee **NOTED** the contents of the paper and **APPROVED** the data for publication.

GOVERNANCE

52/24 **WORKFORCE COMMITTEE ANNUAL REPORT**

OUTCOME: The Committee **NOTED** the content and **APPROVED** the report for submission to the Audit and Risk Committee.

53/24 **2024 WORKFORCE COMMITTEE WORKPLAN**

Dedicated time for ED&I focus to be factored into the workplan.

54/24 **EDUCATION COMMITTEE SUMMARY AND NOTES FROM MEETINGS HELD 5 APRIL 2024 AND 20 MAY 2024**

The Committee noted the Education Committee has an active role in responding to the NHS Long Term National Plan. A general discussion regarding clinical placements took place.

OUTCOME: The Committee **NOTED** the activity of the Education Committee.

55/24 **INCLUSION GROUP SUMMARY UPDATE FROM MEETING HELD ON 9 MAY 2024**

OUTCOME: The activity of the Group was **NOTED** and also that a review of membership is to be undertaken.

56/24 **ITEMS FOR ESCALATION TO THE BOARD**

A highlight report will be shared with the Board.

57/24 **ANY OTHER BUSINESS**

No other business was raised.

POST MEETING REVIEW

58/24
- Well chaired meeting that reached into the detail
- One culture of care evident
- Evident seamless transition from Trust wide wellbeing engagement into Divisions
- Quality of workforce reports excellent
- Clear, structured agenda

Discussions to take place outside the meeting to agree an approach that avoids duplication of reports presented at both Quality Committee and Workforce Committee.

NEXT MEETING:

Thursday 15 August 2024, 2.00pm – 4.30pm
*Helen Hirst to Chair

24. DATE AND TIME OF NEXT MEETING

Date: Thursday 7 November 2024

Time: 9.00 – 12.00 pm

Venue: Rooms 3 & 4, Acre Mills Outpatients

To Note

Presented by Helen Hirst